

Health Policy Update – October 2, 2019

The Network Submits Comments on Physician Fee Schedule, Outpatient Prospective Payment System Proposed Rules

On Friday, September 27, The Network submitted comments in response to the CY2020 Medicare Physician Fee Schedule (PFS) proposed rule. The Network stated its support for CMS' proposal to retain current payment rates for certain radiation therapy codes through 2020 and commended CMS for recognizing the need to provide payment stability while the radiation community prepares for implementation of the radiation oncology model.

The Network also expressed support for CMS' proposal to adopt the American Medical Association (AMA)/ CPT Editorial Panel recommendations for evaluation and management (E/M) visit codes. In the CY2019 PFS proposed rule, CMS had proposed significant reforms to E/M codes that would have disproportionately affected cancer care, and The Network had urged CMS to not finalize this proposal and instead engage stakeholders to develop an alternative. In its comments on the CY2020 PFS proposed rule, The Network commended CMS for acknowledging stakeholder concerns and adopting the AMA/ CPT Editorial Panel recommendations.

The Network also submitted comments in response to the CY2020 Outpatient Prospective Payment System (OPPS) proposed rule. The Network stated its strong support for CMS' proposal to continue implementation of site neutral payments for all clinic visit services performed at off-campus provider-based departments and encouraged CMS to explore additional opportunities to expand site neutral payments for all clinically appropriate outpatient services.

To read The Network's comments on the CY2020 PFS proposed rule, [CLICK HERE](#).

To read The Network's comments on the CY2020 OPPS proposed rule, [CLICK HERE](#).

House Committees Hold Hearings on Pelosi Drug Pricing Plan, Ways & Means Committee Report

Last week, the House Energy & Commerce and Education & Labor Committees held hearings on House Speaker Nancy Pelosi's drug pricing plan, which was formally released on September 19 as the Lower Drug Costs Now Act of 2019 (H.R. 3).

Pelosi's bill is substantially similar to a draft that had been circulating Congressional offices in the weeks prior and directs the Department of Health and Human Services (HHS) to negotiate prices for at least 25 or as many as 250 different drugs. These negotiated prices would apply throughout the entire U.S. healthcare system, including the prices paid by private insurers. The plan would require all public and private payers to pay no more than 120 percent of the volume-weighted average of prices in six countries (Australia, Canada, France, Germany, Japan and the United Kingdom) and would apply steep taxes on the gross sale of drugs whose manufacturers raise their prices above the threshold.

The plan also caps Medicare beneficiaries' annual out-of-pocket costs by requiring insurers and drug companies to pay a greater share of beneficiaries' catastrophic costs.

Also last week, the House Ways & Means Committee's Democratic staff released a report which found that U.S. drug prices are nearly four times higher than the combined average of 11 other similar countries, and that Americans pay as much as 67 times more than consumers in other nations for prescription drugs, even when accounting for rebates. The

committee staff analyzed 2018 pricing data for 79 drugs sold in the United States, the United Kingdom, Japan, Canada, Australia, Portugal, France, the Netherlands, Germany, Denmark, Sweden, and Switzerland.

To read Pelosi's drug pricing plan, [CLICK HERE](#).

To read the House Ways & Means Committee report, [CLICK HERE](#).

To view the Energy & Commerce Hearing, [CLICK HERE](#).

To view the Education & Labor Committee Hearing, [CLICK HERE](#).

Judge Rules Against CMS Site Neutral Payment Policy

On September 17, a U.S. District Court judge ruled against the Centers for Medicare & Medicaid Services (CMS) policy to implement site neutral payments for clinic visits furnished in the off-campus hospital outpatient setting in response to a lawsuit filed by the American Hospital Association and other industry groups.

CMS had argued that it's non-budget neutral approach to implement the site neutral policy was authorized by a provision of the law that lets CMS propose a method for controlling unnecessary volume increases. In her ruling, Judge Collyer wrote, "Nothing in the adjustment or payment scheme permits service-specific, non-budget-neutral cuts."

The hospitals also asked the court to refund the payment reductions stemming from the policy, which went into effect on January 1, 2019, but the judge did not grant this request. Instead, she ordered CMS to submit a joint status report by October 1, 2019 to determine if additional briefing on remedies is required.

The Alliance for Site Neutral Payment Reform expressed its disappointment with the ruling, warning it "remains concerned by the adverse impact it will have on patients and payers, who will be forced to pay higher rates for the exact same services provided by independent physician practices.....and will lead to greater consolidation of healthcare providers, as it will encourage hospitals to continue acquiring community practices to take advantage of higher prices charged in the hospital-based outpatient departments (HOPD) setting."

To view the Alliance's full statement, [CLICK HERE](#).

Senate Finance Committee Urges DIR Payment Reforms

On September 11, the Senate Finance Committee sent a letter to HHS Secretary Alex Azar and CMS Administrator Seema Verma urging HHS to use its regulatory authority to reform direct and indirect remuneration (DIR) payments by pharmacies under the Medicare Part D program. The bipartisan letter encouraged HHS to finalize the DIR reforms included in the 'Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out-of-Pocket Expenses,' (CMS-4180-P) proposed rule.

Underscoring the need for reform, the Senators noted that CMS documented a 45,000 percent increase in DIR fees paid by pharmacies from 2010 to 2017. Since DIR fees are driving prices up for patients at the counter, as well as the Medicare system as a whole, the Senators "urge[d] the agency to redefine 'negotiated price' to include all pharmacy price concessions at the point-of-sale and establish a broader definition of 'price concession' to bring clarity to the true price Medicare pays for a Part D drug and provide financial relief to beneficiaries, many of whom struggle to afford their medications."

To read the full text of the bipartisan Finance Committee letter, [CLICK HERE](#).

To read a fact sheet on the 'Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out-of-Pocket Expenses,' (CMS-4180-P) proposed rule, [CLICK HERE](#).

Healthcare Groups Urge Congress to Protect Medicare Advantage Patients from Prior Authorization

On September 9, 370 healthcare organizations sent a letter to Congress urging lawmakers to pass bipartisan legislation that will reform prior authorization requirements that can delay or deny Medicare Advantage (MA) patients access to care. The letter was signed by leading physician, patient, healthcare professional and other stakeholder organizations including the American Medical Association (AMA) and the Medical Group Management Association (MGMA).

The groups call upon Congress to pass the Improving Seniors' Timely Access to Care Act of 2019 (H.R. 3107), a bipartisan piece of legislation that will require CMS to regulate the use of prior authorization by MA plans in order to make it easier for patients to access the treatments their doctors prescribe. By facilitating electronic prior authorization processes and mandating that health insurance plans report to CMS their prior authorization usage rates and the frequency with which they approve or deny coverage, the bill would improve patient access to care, boost patient outcomes, and increase transparency.

To read the full text of the letter, [CLICK HERE](#).

To read the Improving Seniors' Timely Access to Care Act of 2019, [CLICK HERE](#).

New Study Examines Hospital Profits from Physician-Administered Drugs

In mid-September, the Partnership for Health Analytic Research, LLC (PHAR) released a new analysis that found hospitals receive a disproportionately large share of the gross profits for treating commercially insured patients with physician-administered drugs.

The report, "Estimation of Hospital Share of Gross Profits for Physician-Administered Medicines Reimbursed by Commercial Insurers," revealed that while hospitals served just 53 percent of patients receiving physician-administered medications, they collected 91 percent of the gross profit margin. This is disproportionately higher than the nine percent of gross profits that physician offices collect, despite serving 47 percent of patients in the commercial market.

In addition, the report revealed that hospitals retain more than biopharmaceutical manufacturers for medicines administered in the outpatient setting, suggesting that hospitals are earning more from administering medicines than the manufacturers who created the medicines. Specifically, for every \$100 spent on physician-administered drugs in the hospital outpatient setting, hospitals retain \$58, while manufacturers retain less than \$42.

To read the report, [CLICK HERE](#).