

Health Policy Update – October 22, 2019

Network Radiation Oncologists Advocate for Improvements to CMS Radiation Oncology Model

On October 16, Network radiation oncologists met with healthcare policymakers in Washington, D.C., including Members of the House Energy & Commerce, senior staff from the Senate Finance and HELP Committees, and advisors from the Department of Health and Human Services to advocate for improvements to CMS' recently-proposed radiation oncology model. The Network physicians highlighted flaws in the model's proposed payment methodology and sought changes to the model's scope and timing. They also explained how the model as proposed would be particularly burdensome to smaller, rural practices and vulnerable patient populations.



Thank you to The US Oncology Network radiation oncologists who traveled to D.C. and helped make our Capitol Hill and HHS visits successful!

Network OCM Practices Earn High Marks from CMS

On October 8, the Centers for Medicare & Medicaid Services released the fourth set of performance results for the Oncology Care Model (OCM). All 15 of the Network's participating practices received high marks for quality performance which resulted in approximately \$35 million in savings to Medicare during the performance period compared to the established benchmark.

"The exceptional quality performance of practices in The Network participating in the OCM as well as the cost savings they delivered to Medicare and its beneficiaries provide evidence that practices can maintain high-quality care while providing value—a main goal of the OCM," said Marcus Neubauer, MD, The Network's chief medical officer in a press release. "Not only are these practices meeting the basic requirements of this complex yet important model, but they are generally showing improvement each subsequent performance period. After conquering the initial learning curve,

practices in The Network are finding ways to thrive in this program along the continuum of enhanced patient care, managing costs, and reporting clinical data to Medicare.”

The OCM is a five-year pilot program designed to provide higher quality, more coordinated cancer care at the same or lower cost to Medicare. Scheduled to sunset in 2021, the last year of the program allows participating practices to enter a two-sided risk arrangement model with a significant downside (payback) potential. While this is a difficult decision for community-based practices, as there is much at stake, many practices are expected to move forward with the program and accept the two-sided risk arrangement.

To view The Network’s press release announcing the results, [CLICK HERE](#).

Congress Focuses on Drug Pricing Legislation

Last week, the House Energy & Commerce and Education & Labor Committees passed H.R. 3, Speaker Nancy Pelosi’s drug pricing proposal after lengthy mark-ups. The Speaker’s plan aims to enable the federal government to negotiate the prices of certain drugs using an international pricing index as a basis for these negotiations. Manufacturers who refuse to enter into negotiations or who leave the negotiation before a maximum fair price is agreed to are subject to an escalating excise tax based on the selected drug’s annual gross sales. The bill would also establish an inflation penalty in Parts B and D and redesign the Medicare Part D benefit.

The Energy & Commerce Committee approved several amendments to the original version including provisions that would restrict the price of drugs when they launch, extend the government’s ability to negotiate the prices of more drugs, increase Medicare payments for certain biosimilars, and let Medicare beneficiaries who reach catastrophic spending limits early in the year make payments in installments. A provision to eliminate 340B discounts on drugs subject to price negotiation was removed after nonprofit hospital stakeholders raised objections. The bill passed the committee by a party-line vote of 30-22, with all Democrats voting in support and all Republicans voting in opposition.

The House Education & Labor Committee also approved amendments that would make insurance plans ensure copays do not exceed negotiated prices, require the Government Accountability Office to study the negotiation program in 2025, commission the Secretary of Labor to study and produce regulations governing inflationary rebates for group insurance plans, and ensure data collection is coordinated with other similar efforts. The bill passed the committee by a party-line vote of 27-21.

The House Ways and Means Committee will markup H.R. 3 this week and the full House is expected to vote on the bill by the end of October.

An estimate from the Congressional Budget Office (CBO) released last week found that the plan would save \$345 billion over six years but would also result in between 8-15 fewer new drugs coming to market over the next decade. The FDA currently approves about 30 new drugs per year.

To view the Energy & Commerce Committee mark-up, [CLICK HERE](#).

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

To view the Ways & Means Committee hearing, [CLICK HERE](#).

To read the CBO cost estimate on Speaker Pelosi’s drug pricing plan, [CLICK HERE](#).

HHS Announces Plan to Reform Stark Law

On October 9, the Centers for Medicare & Medicaid Services (CMS) and the Department of Health and Human Services' Office of Inspector General released two proposed rules that would, if finalized, update the 1989 Stark Law that prohibits physicians from referring patients to facilities in which they have a financial stake. Taken together, the proposed rules would create safe harbors and a permanent exemption to the Stark Law so that healthcare facilities who are involved with legitimate value-based care arrangements can be protected from potential penalties.

While CMS already provides waivers for Medicare-based payment models including accountable care organizations, the Administration argues these proposed rules are needed to make it clear that non-Medicare-based programs can participate in value-based care arrangements—provided the arrangements do not violate the law. CMS will monitor such arrangements to ensure compliance.

To read the proposed rules, [CLICK HERE](#) and [HERE](#).

To read HHS' press release, [CLICK HERE](#).

Amy Bassano Named Acting Director of CMMI

Amy Bassano was chosen to serve as acting director of the Center for Medicare and Medicaid Innovation (CMMI). Bassano, who was formerly the deputy director of CMMI, was selected to lead the agency in an acting capacity following departure of Adam Boehler who was confirmed by the Senate to lead the U.S. International Development Finance Corporation in September. Arrah Tabe-Bedward, who previously served as the Director of the Medicare Enrollment and Appeals Group, was promoted to deputy director of CMMI.

To read Amy Bassano's biography, [CLICK HERE](#).

Report Examines Medicare Part D Plan Design and Proposed Policy Changes

On October 11, the Kaiser Family Foundation (KFF) published a report that examined how current law will impact the Medicare Part D market for 2020 and how proposed policy changes could improve the benefit for beneficiaries. Under current law, the catastrophic threshold for 2020 is set to rise 25 percent – from \$5,100 in 2019 to \$6,350 in 2020. In other words, Part D beneficiaries are projected to spend an additional \$1,250 before Medicare's catastrophic coverage kicks in. The standard deductible and the initial coverage limit are also set to increase for 2020.

The study notes that in recent years policymakers have expressed concerns over the lack of a cap on out-of-pocket spending for Part D enrollees, the increase in Medicare spending for enrollees with high drug costs, and the relatively weak financial incentives faced by Part D plan sponsors to control high drug costs.

The analysts who authored the report signaled that recent drug pricing proposals to cap out-of-pocket costs and shift more responsibility for catastrophic coverage costs to Part D plans and drug manufacturers could help beneficiaries. "Proposed changes to the Part D benefit design would help to mitigate out-of-pocket drug cost increases for Medicare beneficiaries, particularly for those with high drug costs who currently face no limit in their annual out-of-pocket expenses—with Part D plan sponsors and drug manufacturers potentially picking up much of the additional costs," the researchers wrote.

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

Cardiac Tests in Hospital Outpatient Departments Generated \$661 Million in Extra Costs

On October 14, the Journal of the American Medical Association (JAMA) published a new study that examined the association between differential payments by care setting and the location of where cardiac tests were performed. The report, "Trends in Medicare Payment Rates for Noninvasive Cardiac Tests and Association with Testing Location," found that higher hospital-based versus practice-based payments were associated with greater proportions of outpatient noninvasive cardiac tests performed in hospital-based locations. Because of disparities in Medicare reimbursement across sites, the shift to performing tests in the hospital-based outpatient setting generated an extra \$661 million in 2015, including \$161 million in out-of-pocket costs for patients.

The study's authors highlighted site neutral payment policies as a possible way to address the cost differentials between sites of service. "Site neutral payments may offer an incentive for testing to be performed in the more efficient location," the authors wrote.

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