
Health Policy Update – October 1, 2018

ASP Coalition Hosts Hill Briefing on Step Therapy Challenges

On September 20, the Part B Access for Seniors and Physicians (ASP) Coalition hosted a briefing on Capitol Hill to inform members of Congress about the difficulties and delays patients face in accessing needed treatment – and what can be done to ensure treatment access under the Medicare Part B program is protected in the future. The briefing took place amid CMS' recent decision to allow Medicare Advantage plans to implement step therapy for Part B drugs, which would force patients to try treatments preferred by their insurance company before receiving the one recommended as the first choice by their providers.

Urging lawmakers to understand the effects of the policy change, physicians and patient advocates described their frustrating experiences with step therapy and how even small delays in care can be debilitating.

The briefing also focused on recent data showing that drug payment rates through the Medicare Part B program, as set by the Average Sales Price (ASP), have almost no significant impact on the utilization of high-cost drugs. The study suggests that physicians do not significantly prescribe drugs with high add-on payments because of financial incentives.

According to the researchers, "Overall, treatment choice does not appear to be driven by the margin physicians are paid on a drug, indicating that the ASP+6% payment rate does not drive high-cost drug utilization."

To read ASP's press release on the briefing, [CLICK HERE](#).

Alliance for Site Neutral Payment Reform Submits Comments on OPPS Rule

Last week, the Alliance for Site Neutral Payment Reform submitted comments to the Centers for Medicare & Medicaid Services (CMS) regarding the agency's CY 2019 Outpatient Prospective Payment System (OPPS) proposed rule.

The Alliance commended CMS for proposing to expand site neutral payments for clinic visits and new clinical families of services to all hospital off-campus departments. According to estimates from CMS, this policy would save patients \$150 million in lower copays while the Medicare program will save \$610 million in 2019.

The Alliance notes that payment differentials between the OPPS and Medicare Physician Fee Schedule creates an incentive for hospitals to acquire physician practices in order to receive a higher reimbursement rate. Between 2014 and 2015 alone, the number of hospital-owned practices grew by 18,000.

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

Congress Reaches Deal on Opioids Package

On September 25, the bipartisan, bicameral group of congressional conferees agreed on the provisions that would be included in a final bill designed to address America's opioid epidemic. After months of work, the bill is widely expected to pass both chambers and be sent to the President for his signature by the end of this week.

The final package will include a partial repeal of the IMD exclusion, and allow Medicaid funds to cover treatment for adults ages 21-64 with substance abuse disorders in institutions of mental disease over the next 5 years. The bill, introduced by Senator Rob Portman (R-OH) in partnership with Senators Dick Durbin (D-IL), Ben Cardin (D-MD), and Sherrod Brown (D-OH), would repeal the longstanding prohibition on using Medicaid funds to cover treatment for such patients in such facilities with more than 16 beds.

Many advocates agree the bill is a step in the right direction. The bill also includes key provisions to crack down on illicit substances like fentanyl sent through the U.S. Postal Service, authorizes new grants and demonstration programs to expand access to medication-assisted treatment (MAT), expands authority for prescribing buprenorphine, and encourages the development of non-opioid pain therapies.

To read a summary of the bill's key provisions, please [CLICK HERE](#).

To view the entire bill, please [CLICK HERE](#).

American Hospital Association Unveils 340B Good Stewardship Principles

Last week, the American Hospital Association (AHA) released a set of principles intended to promote transparency and good stewardship of the 340B drug discount program. The principles have also been endorsed by the American Association of Medical Colleges, the Catholic Health Association of America, the Children's Hospital Association and 340B Health.

According to the principles, each 340B hospital commits to:

- Communicating the value of the program by publishing a narrative touting how the savings are used to benefit the community and vulnerable populations.
- Publicly disclosing estimated 340B savings on an annual basis using a single, standardized model that compares the 340B acquisition price to group purchasing organization price.
- Continue internal oversight to ensure that each hospital 340B program meets all HRSA program rules and guidance through periodic training for all involved staff.

The 340B program has come under criticism for enabling some hospitals to take advantage of cheaper drugs without having to show how the resulting savings are used to provide better patient care.

To view the principles, [CLICK HERE](#).

Congresswoman DelBene Circulates Letter Urging CMS to Expand MIPS Low-Volume Threshold

Congresswoman Suzan DelBene (D-WA) is urging her congressional colleagues to support a letter asking the Centers for Medicare & Medicaid Services (CMS) to adjust the low-volume threshold to include more providers in the Merit-based Incentive Payment System (MIPS) as part of the final 2019 Physician Fee Schedule. Under CMS' proposal, first unveiled in July, some previously excluded providers would be able to opt-in to MIPS; however, the threshold criteria was not lowered to require more doctors to participate. As a result, DelBene and stakeholders, including the American Medical Group Association and the National Association of Accountable Care Organizations, argue that limiting the number of physicians in the program would lower the size of available bonuses, significantly weakening pay incentives for higher performance.

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

Bills Banning PBM “Gag Clauses” Headed for President’s Signature

Last week, the House of Representatives approved two Senate-passed bills that would ban pharmacy benefit managers (PBMs) from inserting so-called “gag clauses” into contracts with pharmacies. Gag clauses prevent pharmacists from informing patients about the true cost of their medications, such as when the out-of-pocket cost may be lower than their copay.

The bills, Know the Lowest Price Act and the Patient Right to Know Drug Prices Act, ban gag clauses in Medicare Advantage and Part D plans and private health plans, respectively. According to a recent study published in the *Journal of the American Medical Association*, gag clauses resulted in patients overpaying for prescription drugs 23 percent of the time during a six-month period in 2013.

To view the bills, [CLICK HERE](#) and [HERE](#).

To view the JAMA study, [CLICK HERE](#).