

Health Policy Update – May 7, 2019

Physician Groups Oppose Repeal of the Stark Law’s In-Office Ancillary Services Exception

A coalition of physician and provider organizations recently sent a letter to the chair and ranking members of the House Ways & Means and Energy & Commerce Committees expressing their opposition to H.R. 2143, the *Promoting Integrity in Medicare Act*, which would repeal the In-Office Ancillary Services Exception (IOASE) to the Stark Law that enables clinicians to deliver “within-practice referrals” for services such as advanced diagnostic imaging, radiation therapy, anatomic pathology, and physical therapy provided certain regulatory requirements are met.

“If enacted, this legislation would severely limit patient access to life-saving services provided within coordinated care models as well as further fragment the healthcare delivery system during the transition to value-based payments and alternative payment models,” the letter warns. “We strongly urge you to oppose H.R. 2143, legislation that would severely limit patient access to care and impede the successful implementation of innovative payment reforms currently underway.”

The groups note that the IOASE exception is vital to providing coordinated, cost-effective, and high quality care and cites a study commissioned by the American Medical Association showing that the utilization of ancillary services in physician practices makes up only a small percentage of total spending on ancillary services – and is growing at a much slower rate than use of such services in the hospital setting.

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

To read the American Medical Association study, [CLICK HERE](#).

ASTRO Survey of Radiation Oncologists Finds Prior Authorization Unnecessarily Delays Patient Access to Care

A new survey conducted by the American Society for Radiation Oncology found that insurers’ use of prior authorization often creates unnecessary delays and interference in care decisions for cancer patients – and takes up valuable time that physicians could instead spend with patients.

The survey, which interviewed nearly 700 radiation oncologists, found that almost all (93%) of respondents said their patients experience delays in receiving life-saving treatments due to prior authorization. About a third (30%) said the average length of delayed treatment is between one and three days while another third (31%) said prior authorization delays care for their patients for more than five days. The survey also found that nearly one in five radiation oncologists (17%) said they lose more than 10% of time that they could be caring for their patients dealing with prior authorization issues. An additional 39% spent 5-10% of their average workday on prior authorization matters.

In addition to the survey, ASTRO joined with the American Medical Association (AMA) and the National Coalition for Cancer Survivorship (NCCS) to hold an online briefing and publish a press kit detailing the unnecessary burden restrictive prior authorization practices cause for cancer patients.

To read an executive summary of the survey results, [CLICK HERE](#).

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

CMMI Unveils Primary Care Pilot Programs to Reform Payment to Providers

On April 22, the Department of Health & Human Services (HHS) announced the CMS Primary Care Initiative, a set of payment models through the Center for Medicare and Medicaid Innovation (CMMI) designed to improve quality and lower costs throughout the healthcare system. The models are voluntary, and HHS' goal is to allow providers to apply for the new models by this summer and to launch the programs in January 2020.

The new models are meant to encourage primary care providers to take on more financial risk for the outcomes of their patients, according to HHS. One of the new demos, called Primary Care First, is designed to increase access to advanced primary care. One of the two options under Primary Care First will provide higher payments to practices that specialize in care for patients with complex, chronic needs and seriously ill populations. The second demonstration, called Direct Contracting, is designed to test innovative payment approaches from Medicare Advantage and private sector risk-sharing agreements in the Medicare fee-for-service population.

However, the National Association of Accountable Care Organizations (NAACOS) expressed concerns about model overlap and pressed HHS to provide more details about which ACOs can participate in the pilots. HHS officials have said that Next Generation ACO Model or the Comprehensive ESRD Care Model cannot participate in the Primary Care First demonstration, but practices in both the Comprehensive Primary Care Plus+ demonstration (CPC+) and the Medicare Shared Savings Program, will be eligible to participate.

To read more about the Primary Care First model, [CLICK HERE](#).

To read more about the Direct Contracting model, [CLICK HERE](#).

House Rules Committee Holds Hearing, CBO Releases Report on Medicare for All

On April 30, the House Rules Committee held a hearing on new Medicare for All legislation (H.R. 1384) introduced recently by Reps. Pramila Jayapal (D-WA) and Debbie Dingell (D-MI). Co-sponsored by more than 100 Democrats, the legislation would create a single-payer healthcare system and eliminate private insurance. Some experts doubt that the bill will get a full floor vote in the House and even if it does, it will most likely die in the Senate or be vetoed.

Proponents argue that it will save the government money in the long-run, increase access, and improve healthcare, especially for patients who are uninsured and whose bills are already covered by taxpayers.

Critics contend that the costs of implementing Medicare for All would be enormous and could lead to pay cuts for hospitals and providers. One expert who testified estimated it would cost upwards of \$32 trillion, though he acknowledged that most of the spending would be a shift from the private to the public sector, replacing copays and premiums with higher taxes.

On May 1, the Congressional Budget Office (CBO) released a report on single-payer healthcare. Though the report did not include specifics about how much the proposal would cost, it did provide an overview of the implications of Medicare for All, including who would be covered and how they would be enrolled.

To watch a video of the full hearing, [CLICK HERE](#).

To read the text of the Medicare for All Act of 2019 (H.R. 1384), [CLICK HERE](#).

To read the CBO report on single payer healthcare, [CLICK HERE](#).

House Energy and Commerce Holds Hearing on Prescription Drug Pricing in the Medicare Program

On April 30, the House Energy and Commerce Subcommittee on Health held a hearing called “Prescription Drug Pricing in the Medicare Program.” James E Mathews, Ph.D., Executive Director of the Medicare Payment Advisory Commission (MedPAC), testified. In his testimony, Dr. Mathews told lawmakers that Medicare Part B drug spending has been growing rapidly, more than doubling between 2009 and 2017 and that Medicare Part B spending (including beneficiary cost sharing) grew from \$15.4 billion in 2009 to \$32.0 billion in 2017, increasing at an average rate of 9.6 percent per year. He also noted that price growth is the largest driver of Medicare Part B spending growth, accounting for roughly two-thirds of the increase between 2009 and 2016.

Dr. Mathews expressed several concerns about using the Average Sales Price + 6% (ASP+6%) methodology for drug pricing. Specifically, he told lawmakers that the ASP+6% methodology does not consider evidence about a drug’s comparative clinical effectiveness and may create incentives for some providers to choose higher-priced drugs over lower-priced drugs. Additionally, he said there are overall concerns about the lack of competition among drugs with similar health effects.

On May 9, the subcommittee will hold another hearing on prescription drug prices examining various aspects of the drug supply chain.

To watch a video of the complete hearing, [CLICK HERE](#).

To read Dr. Mathews’ testimony, [CLICK HERE](#).

House Judiciary Committee Marks-Up Drug Pricing Bills

On April 30, the House Judiciary Committee approved four bills - including the CREATES Act and pay-for-delay legislation - intended to improve competition and lower the cost of prescription drugs.

The Creating and Restoring Equal Access to Equivalent Samples (CREATES) Act, which penalizes drug makers that withhold samples from generic manufacturers, also passed the Energy & Commerce Committee unanimously on April 3.

The Preserve Access to Affordable Generics and Biosimilars Act would allow FTC to penalize companies that reach settlements in patent disputes to delay generic or biosimilar competition.

The Stop Significant and Time-Wasting Abuse Limiting Legitimate Innovation of New Generics Act is designed to allow the FTC to take civil action to deter drug companies from filing sham citizen petitions to delay approval of competing generics or biosimilars.

The Prescription Pricing for People Act of 2019 would require FTC to study the role of pharmacy benefit managers in the drug supply chain and produce policy or legislative recommendations to improve transparency and competition, and deter anti-competitive behavior.

To view the text of the legislation and watch the full committee markup, [CLICK HERE](#).

To read a press release about the Prescription Pricing for People Act from Ranking Member Doug Collins (R-GA), [CLICK HERE](#).