Thursday, August 13, 2015

In this Issue:

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In a new op-ed published in the American Journal of Managed Care entitled “Equalize Payment Across Site of Service,” The US Oncology Network’s Barry Brooks details the need for payment reforms that neutralize Medicare payments for cancer care services across sites of service. **Read below**

New Report Shows States Falling Behind in Efforts to Prevent Cancer

The American Cancer Society Cancer Action Network (ACS CAN) released a report on August 6 entitled *How Do You Measure Up?: A Progress Report on State Legislative Activity to Reduce Cancer Incidence and Mortality*, which rates states on the strength of implementing policies that have proven effective in preventing cancer. **Read below**

Senate Finance Committee Posts 530 Submissions to Chronic Conditions Work Group

On July 29, the Senate Finance Committee (SFC) posted 530 recommendations responding to the Committee’s bipartisan initiative to explore cost effective solutions to improve health outcomes for Medicare patients living with one or more chronic conditions. **Read below**

Bipartisan Think Tank Recommends Near-Term Improvements to ACO Model

On July 30, the Bipartisan Policy Center (BPC) released a report focusing on Accountable Care Organizations (ACOs) and the role they play as Alternative Payment Models (APMs) in delivery system reform. **Read below**

Dr. Barry Brooks: Equalize Payment Across Site of Service

In a new op-ed published in the *American Journal of Managed Care* entitled "Equalize Payment Across Site of Service," The US Oncology Network's Barry Brooks details the need for payment reforms that neutralize Medicare payments for cancer care services across sites of service.

Due to current Medicare payment policies, there are wide disparities between reimbursement for the same cancer care administered in the physician's office and the hospital outpatient department (HOPD). Despite costs for treating cancer patients being significantly lower to both patients and Medicare when care is delivered in community cancer clinics, Medicare reimburses HOPDs at a much higher rate.

Data show these payment disparities result in higher beneficiary costs, reduced patient choice and accelerated consolidation across the cancer care delivery marketplace.

"For many US community cancer centers, keeping the doors open has often meant making the difficult decision to consolidate with hospitals and large hospital systems. Site neutrality is a critical step in the journey toward better healthcare for all Americans and a healthy future for Medicare," Dr. Brooks writes.

The US Oncology Network strongly support site-neutral Medicare reforms for the delivery of cancer care and has been working diligently with Congress to advance such reforms. In June, Representatives Mike Pompeo (R-KS) and Don Beyer (D-VA) introduced the Medicare Patient Access to Treatment Act (H.R. 2895), legislation to establish a more adequate reimbursement structure for cancer care delivered in the community setting. The bipartisan bill would equalize payments for oncology care across sites of service to help ensure patient access to high-quality cancer care in the community-based setting.

Dr. Brooks' op-ed will also appear in the August print edition of *Evidence-Based Oncology.*

To read Dr. Brooks' op-ed, CLICK HERE.

To access The US Oncology Network Site-Neutral Issue Brief, CLICK HERE.

New Report Shows States Falling Behind in Efforts to Prevent Cancer

The American Cancer Society Cancer Action Network (ACS CAN) released a report on August 6 entitled *How Do You Measure Up?: A Progress Report on State*

Legislative Activity to Reduce Cancer Incidence and Mortality, which rates states on the strength of implementing policies that have proven effective in preventing cancer.

The report concludes a majority of states are not measuring up on legislative solutions that prevent and fight cancer:

- Only half of all U.S. states reached two or fewer of the nine legislative priority areas measured by ACS CAN;
- 22 states and the District of Columbia measure up in just three to five areas;
- Only three states – Maine, Massachusetts and Vermont – meet benchmarks in six of the nine categories; and
- No state met benchmarks in seven or more policy areas.

According to a press statement, ACS CAN President Chris Hansen, states, "Most states are failing to implement laws and policies that not only prevent cancer and save lives, but lower health care costs and generate revenue at the same time. By enacting evidence-based policies that encourage cancer prevention, guarantee access to affordable health care, curb tobacco use and improve patients' quality of life, state lawmakers can create a legacy of better health."

To view the full ACS CAN report, CLICK HERE.

Senate Finance Committee Posts 530 Submissions to Chronic Conditions Work Group

On July 29, the Senate Finance Committee (SFC) posted 530 recommendations responding to the Committee's bipartisan initiative to explore cost effective solutions to improve health outcomes for Medicare patients living with one or more chronic conditions. In May, SFC leaders issued a letter asking for input from various stakeholders on how to best improve health outcomes for Medicare patients living with multiple chronic conditions.

In a joint press statement, SFC Chairman Orrin Hatch (R-Utah) and Ranking Member Ron Wyden (D-Ore.) said, "We appreciate the input from members of the health care community and are thrilled so many weighed in on this important bipartisan issue… We look forward to partnering with our colleagues to review the submissions as we work toward a common goal of developing bipartisan legislative solutions this Congress."

To access all the submissions, CLICK HERE.

To read the letter submitted to the SFC by The US Oncology Network, CLICK HERE.

Bipartisan Think Tank Recommends Near-Term Improvements to ACO Model

On July 30, the Bipartisan Policy Center (BPC) released a report focusing on Accountable Care Organizations (ACOs) and the role they play as Alternative Payment Models (APMs) in delivery system reform. It also provides an update on federal action since they recommended proposals encouraging patients and providers to sift from fee-for-service (FFS) care to more efficient delivery models that promote better care coordination, improve quality of care, and slow cost growth.

The report includes estimates of savings to the Medicare program associated with several policy recommendations including modernization of the basic Medicare benefit, an expansion of differential updates to all Medicare providers, and changes in Medicare reimbursement for Part B drugs to more accurately reflect acquisition costs and to remove unintended, counterproductive incentives in the current formula.

The report also finds that provider-administered drugs covered by Medicare Part B should be reformed to establish neutral incentives for providers to prescribe and administer the most appropriate, high-quality treatment options, and to more accurately reflect ingredient costs. Specifically, the report recommends the following:

- Authorize the Secretary of HHS to create separate ASPs for provider types with systematically different drug-acquisition costs;
- Authorize the Secretary to incorporate projects of pricing trends into the ASP calculation in those instances when she determines a systematic tendency for a published ASP to lag the current market price;
- Reimburse for Part B drugs with 100 percent of ASP plus a flat add-on payment per diagnosis and therapeutic class; and
- The Part B add-on payment for new drugs would be based on the existing flat payments amounts for the particular diagnosis and therapeutic class.

To download the BPC report, CLICK HERE.