



Thursday, May 5, 2016

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Site Neutral Bill Introduced in Vermont Legislature

Vermont State Senator Timothy Ashe recently introduced S. 245, legislation that advocates for site neutral payment policies that are said to ultimately provide patients access to quality, low cost healthcare. [Read below.](#)

Inside Sources: Medicare Policies Pushing Outpatient Costs Higher

In an April 26 column in *Inside Sources*, Joel Zinberg, M.D., J.D., F.A.C.S., a visiting scholar at the American Enterprise Institute, examines how Medicare systems are moving outpatient care to more expensive venues. [Read below.](#)

Bipartisan Lawmakers Warn Against Medicare Part B Drug Demonstration



Bipartisan lawmakers in both the U.S. Senate and House of Representatives have sent letters to the Centers for Medicare & Medicaid Services' (CMS) Acting Administrator Andy Slavitt raising concerns with the proposed Medicare Part B Drug Payment Model.

On May 2, a bipartisan group of 242 House lawmakers called for the withdrawal of Medicare's proposal to test new ways of paying for outpatient drugs administered by doctors. The letter, led by House Budget Committee Chairman Tom Price, M.D. (R-GA), John Shimkus (R-IL), and Charles Boustany, M.D. (R-LA), is the first time Democrats have publicly asked CMS to pull the demonstration completely.

To view the letter from bipartisan House lawmakers, [CLICK HERE](#).

On April 28, a group of 14 Republicans from the Senate Finance Committee submitted a letter to CMS urging withdrawal of the proposal and asking CMS to work with the Congress to develop a bipartisan approach to reducing drug costs.

The Senate Republicans write, "We are dismayed that the proposal fails to indicate how CMS will assess the impact on the quality of beneficiary care. The proposal states an expectation that Part B drug spending will decrease without harming quality, yet it does not provide the specifics on how access and quality will be assessed during the experiment nor in the evaluation of it."

To view the letter from Senate Finance Committee Republicans, [CLICK HERE](#).

On April 27, a group of 12 Senate Finance Committee Democrats sent a letter CMS outlining several concerns with the Medicare Part B Drug Payment Model and asking the Medicare agency to resolve the issues they raise before proceeding. Issues raised in the letter include:

- Beneficiaries' access to Part B medications and quality of care;
- Potential impact on site of service; and
- Interaction with existing delivery and payment reform models.

To view the letter from Senate Finance Committee Democrats, [CLICK HERE](#).

On April 29, Senator Chuck Grassley (R-IA), sent a letter to HHS Secretary Sylvia Burwell expressing concern that the Medicare Part B Drug Payment Model is essentially a research project and calls for beneficiary protection for those who participate, writing, "I am concerned that throughout this proposed rule two terms are repeatedly used –

‘study’ and ‘test.’ These terms seem to indicate there is a component of research going on in this proposal. I am writing you today to see if that is true and if that is true, are adequate protections in place for the Medicare beneficiaries who will be research participants.” He further questions whether HHS has the authority to enroll beneficiaries in research without their informed consent.

To view Senator Grassley’s letter to HHS, [CLICK HERE](#).

Additional letters from both the House and Senate are expected in the coming weeks.

The US Oncology Network Joins Provider and Patient Groups in Opposing Part B Cuts

On April 25, The U.S. Oncology Network in partnership with several provider, manufacturer and disease groups launched a paid media campaign inside-the-beltway calling on Congress to stop Medicare’s experiment on senior care. The ads question the government’s authority to interfere in physician decision-making and warn against cookie-cutter policies that base treatment options solely on cost.

Other organizations supporting the inside-the-beltway advertising include the Biotechnology Innovation Organization (BIO), Cardinal Health, Coalition of State Rheumatology Organizations, Colon Cancer Alliance, Community Oncology Alliance, Healthcare Distribution Management Association, ION Solutions, National Minority Quality Forum, and The American Gastroenterological Association.

The print and digital ads are running April through June in the *Washington Post*, *Politico* and *CQ-Roll Call*.

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

CMS Releases Proposed Rule for New Medicare Physician Payment System



The Centers for Medicare & Medicaid Services (CMS) released a proposed rule outlining specifications for a new Medicare physician payment system on April 27. The proposed rule is in response to passage of the Medicare Access and CHIP Reauthorization Act (MACRA), which was signed into law on April 16, 2015. MACRA repeals the Medicare sustainable growth rate (SGR) formula ending a twelve-year cycle of Congressional action to avert significant cuts to Medicare physician reimbursement.

Under MACRA, physicians treating Medicare patients are scheduled to receive an increase of 0.5 percent per year from 2016-2019. Beginning in 2020, payment updates will be determined by physician choice between two newly designed payment paths: the Merit-Based Incentive Payment System (MIPS) or participation in an eligible Alternative Payment Model (APM). Both base payment on performance and quality metrics and participation in efforts to improve care and restrain cost growth.

The proposal defines which eligible clinicians will be able to participate in the Quality Payment Program through MIPS—physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and any other affiliations that include these kinds of professionals. The three Medicare quality programs that will be consolidated into MIPS are:

- 1) the Physician Quality Reporting System;
- 2) the Value-Based Modifier Program; and
- 3) the Meaningful Use of electronic health records.

The rule also states that eligible clinicians can become qualifying participants through the APM pathway, where they'll be able to earn statutorily specified incentives for participation. The three qualifications that advanced APMs must meet are as follows:

- 1) Required use of certified EHRs;
- 2) Payment for covered professional services based on comparable quality measures; and
- 3) Either being an enhanced medical home or bearing more than “nominal risk” for losses.

The Oncology Care Model Two-Sided Risk Arrangement (available in 2018) is included in the proposed rule's list of qualified Advanced APMS. Other Payer APMs, led by commercial payers or state Medicaid departments, can also help physicians meet the requirements to earn the Advanced APM payment incentives.

The US Oncology Network is analyzing the proposed rule and its impact and will provide greater detail and explanation in the near future. CMS is accepting comments on the proposed rule through June 27, 2016.

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

Site Neutral Bill Introduced in Vermont Legislature

Vermont State Senator Timothy Ashe recently introduced S. 245, legislation that advocates for site neutral payment policies that are said to ultimately provide patients access to quality, low cost healthcare. The bill is stated to ensure that identical care processes are reimbursed at the same payment level despite the delivery setting.

In Section 4 of the bill, a report is highlighted from the Green Mountain Care Board regarding the expansion of the site neutral payment reimbursement policy to commercial health insurers in Vermont.

The amended language in the bill prohibits the Department of Vermont Health Access from increasing a provider's Medicaid reimbursement for outpatient services at off-campus hospital departments as a result of the transfer or acquisition of the provider by a hospital. This prospective site neutral provision is estimated to save the Vermont Medicaid program \$6 million.

Inside Sources: Medicare Policies Pushing Outpatient Costs Higher



In an April 26 column in *Inside Sources*, Joel Zinberg, M.D., J.D., F.A.C.S., a visiting scholar at the American Enterprise Institute, examines how Medicare systems are moving outpatient care to more expensive venues. Because providers are paid different amounts based on site of services, Zinberg points out, beneficiaries are facing different cost-sharing liabilities depending on the setting where their care is delivered.

Zinberg writes, "Shifting services to the higher paid HOPDs has increased Medicare and patient spending with no difference in patient care or outcomes. In its March 2015 Report to the Congress on Medicare Payment Policy, MedPAC reported that between 2006 and 2013 outpatient payments per beneficiary increased 7.9 percent annually, far outpacing other care increases."

His column also highlights how Medicare is paying more for procedures at hospital outpatient departments than they do for the same services at physicians' offices and other settings, including E&M visits, ambulatory surgeries, x-rays, and diagnostic cardiology screenings. These payment differentials are incentive for hospitals to obtain physician practices and outpatient facilities, and to hire physicians to perform the same practices.

Zinberg also warns that recent legislation does little to alleviate the trend of shifting care to the most expensive venue. The Bipartisan Budget Act of 2015 states that from January 1, 2017, services performed at all newly acquired provider based off-campus HOPDs will be paid the non-hospital rate. But the thousands of off-campus facilities billing as hospital outpatient departments prior to enactment of the legislation will continue to be paid the higher hospital outpatient department rates, and all on-campus HOPDs will continue to receive higher rates.

In closing Zinberg writes, “Making Medicare an efficient purchaser of healthcare will require more comprehensive legislation. There is no advantage to overpaying HOPDs when the same services can be safely provided elsewhere for less than half the price.”

To read the entire *Inside Sources* article, [CLICK HERE](#).

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