Wednesday, February 24, 2016

The US Oncology Network and Coalition Partners Urge Expansion of Site Neutral Payment Policies

The US Oncology Network and several of its allies submitted comments to the House Energy & Commerce Committee in response to their request to healthcare stakeholders for feedback related to the enactment of the site neutral payment policy included in the Bipartisan Budget Act of 2015 (BBA). **Click below.**

Avalere Study: Medicare Payments Three Times Higher in Outpatient Departments

A new study from Avalare Health confirmed and expanded on previous research studies finding that Medicare reimbursements are typically higher in hospital outpatient departments than in the ambulatory surgical center (ASC) or physician office setting. **Click below.**

CMS Mistakenly Posts Notice of New Part B Drug Payment Model

On February 5, the Centers for Medicare & Medicaid Services (CMS) posted, and quickly removed, notice of plans to test changes in the way Medicare Part B pays providers to administer treatments. **Click below.**

CMS & AHIP Release Clinical Quality Measures

On February 16, the Centers for Medicare & Medicaid Services (CMS) sand America's Health Insurance Plan (AHIP) released seven sets of clinical quality measures that support multi-payer alignment on core measures primarily for physician quality programs. **Click below.**

The US Oncology Network and Coalition Partners Urge Expansion of Site Neutral Payment Policies

The US Oncology Network and several of its allies submitted comments to the House Energy & Commerce Committee in response to their request to healthcare stakeholders for feedback related to the enactment of the site neutral payment policy included in the Bipartisan Budget Act of 2015 (BBA). Section 603 establishes a site-neutral payment policy for newly acquired, off-campus hospital outpatient departments (HOPD) as of November 2, 2015 and requires them to bill under the Medicare physician fee schedule (PFS) or ambulatory surgical center prospective payment system (ASC PPS). The Network and its coalition partners with the Alliance for Site-Neutral Payment Reform are supportive of this provision.

Excerpts from letters to the E&C Committee leaders include:

The US Oncology Network: "The US Oncology Network strongly urges Congress to stand by Section 603 of the BBA and expand site- neutral payment reform to all off-campus outpatient services which is estimated to save an additional $10-$20 billion. Medicare should be paying the same fee for the same service regardless of where it is per- formed, regardless of whether a facility was billing Medicare prior to November 2 and regardless whether a facility was under construction prior to enactment of BBA. This would level the playing field for all off-campus outpatient care and removes the need to exempt or carve out certain facilities."

Alliance for Site Neutral Payment Reform: "We commend Congress for the inclusion of the site neutral payment provision in the BBA. This provision marks an important first step in equalizing Medicare payments across sites of service, which we believe reduces unnecessary healthcare spending and provides greater patient access. We further urge lawmakers to build on this policy and consider suggested commonsense expansions to this current provision."

Blue Cross Blue Shield Association: "By maintaining the payment equalization provision in the budget deal and expanding it to encompass all outpatient off-campus facilities—not just those HOPDs that are built or purchased after the November 2, 2015 enactment date—hospital acquisition of physician practices would slow and beneficiary access to different sites of care at a lower cost would be protected. Both beneficiaries and the Medicare program would pay less for the same care and any need for carving out certain facilities would be removed."

Community Oncology Alliance: "We are especially concerned that any rollback of Section 603 or a possible extension of the 2017 effective date for the BBA fee schedule changes would have the unintended consequences of motivating hospitals to go on a "land grab" of community oncology practices. Although we

strongly recommend against any changes to Section 603, we implore the Committee to carve out oncology from any possible changes being considered."

AARP: "We urge the Committee to maintain, or possibly expand, site-neutral payment provisions for HOPDs. A rollback or retreat from site-neutral payments would undermine progress that has been made to reduce both Medicare program spending and to reduce beneficiary costs."

Avalere Study: Medicare Payments Three Times Higher in Outpatient Departments

A new study from Avalare Health confirmed and expanded on previous research studies finding that Medicare reimbursements are higher in hospital outpatient departments than in the ambulatory surgical center (ASC) or physician office setting. Among the findings include that cardiac imaging services were three times as high in HOPDs compared with physician-owned offices, averaging $2,100 versus $655.

The researchers also looked at Medicare's payments for an entire episode of care, or the 22-day period encompassing preparatory follow-up care for a given procedure. Under the measurement, Medicare's payments for echocardiograms averaged $5,148 when provided in a HOPD compared to $2,862 when provided in a physician's office.

The results also found that higher payments for procedures in the HOPD setting tend to be followed by higher payments on other services for the same beneficiary during the episode.

"This analysis raises numerous questions and issues of interest to executive and legislative policymakers interested in neutralizing site of service payment incentives, as well as stakeholders who are interested in whether and how different patient populations drive spending across settings of care," the report states.

For the full study, CLICK HERE.

CMS Mistakenly Posts Notice of New Part B Drug Payment Model

On February 5, the Centers for Medicare & Medicaid Services (CMS) posted, and quickly removed, notice of plans to test changes in the way Medicare Part B pays providers to administer treatments.

According to the CMS announcement, “The purpose of the Change Request (CR) is to instruct CMS shared system maintainers to implement a mechanism that will allow the use and testing of different Average Sales Price (ASP) payment limit values in certain defined geographic areas based on ZIP code. The replacement values would be used in Part B settings such as hospital outpatient departments, physician offices, and pharmacies that currently submit claims for Part B drugs.”

Medicare is developing methods to test the impact of changes to Part B drug payments as well as test the impact of targeted pricing changes to payments for individual Part B drugs beyond changes to the ASP-based payment.

Participation in the new models would be mandatory. The notice stated that CMS is targeting a July 1, 2016 effective date for the system changes to support the new pricing methods.

The US Oncology Network is monitoring this issue closely and will work with coalition partners to influence changes to any Part B drug payment model.

To view the CMS announcement, CLICK HERE.

CMS & AHIP Release Clinical Quality Measures

On February 16, the Centers for Medicare & Medicaid Services (CMS) sand America’s Health Insurance Plan (AHIP) released seven sets of clinical quality measures that support multi-payer alignment on core measures primarily for physician quality programs. These measures will support CMS’ implementation of the Medicare Access and CHIP Reauthorization Act (MACRA) through its measure development plan and required rulemaking.

The guiding principles in developing the core measure sets were that they be meaningful to patients, consumers, and physicians while reducing variability in measure selection, collection burden, and cost. The goal is to establish broadly agreed upon core measure sets that could be harmonized across both commercial and government payers.

The seven core measure sets include:

1. Accountable Care Organizations (ACOs), Patient Centered Medical Homes (PCMHs), and Primary Care Cardiology;
2. Cardiology;
3. Gastroenterology;
4. HIV and Hepatitis C;
5. Medical Oncology;
6. Obstetrics and Gynecology; and

7. Orthopedics

Implementation of the measures will follow several stages:

1. CMS is already using measures from the each of the core sets. Using the notice and public comment rule-making process, CMS also intends to implement new core measures across applicable Medicare quality programs as appropriate, while eliminating redundant measures that are not part of the core set;
2. The Health Care Payment Learning and Action Network (HCPLAN), a public-private collaboration established by CMS, will integrate these quality measures into their efforts to align payment model components with public and private sector partners;
3. CMS is using new tools from MACRA to support quality improvement and alignment. For example, MACRA provided additional funding to create and implement new measures where gaps exist and to align measures with the private sector. CMS has also developed a draft Quality Measure Development plan, which was informed by the development of the core measure sets and identification of key measure gaps. The plan is currently available for review and public comment here;
4. CMS is working with federal partners including the Office of Personnel Management, Department of Defense, and Department of Veterans Affairs, as well as state Medicaid plans to align quality measures where appropriate;
5. Commercial health plans will implement these core sets of measures as and when contracts come up for renewal or if existing contracts allow modification of the performance measure set; and
6. The Core Quality Measures Collaborative views the upcoming year as a transitional period, as it begins adoption and harmonization of the measures. Ongoing monitoring by the Collaborative of the use of these measures will enable modifications of measure sets, as needed and based on lessons learned, including minimizing unintended consequences and selection of new measures as better measures become available.

The Collaboration has said it will continue to monitor progress, invite broader participation, and add additional measures and measure sets.

For the press release, CLICK HERE.

For CMS' fact sheet, CLICK HERE.