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In this Issue:

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On November 17, myriad stakeholders submitted comments to the Centers for Medicare & Medicaid Services (CMS) in response to the agency's Request for Information (RFI) regarding implementation of the Merit-Based Incentive Payment System, promotion of Alternative Payment Models, and incentive payments for participation in eligible alternative payment models. **Read below**

New ACS Report On Cancer Drug Coverage and Transparency

The American Cancer Society Cancer Action Network (ACS CAN) released an updated report from 2014 that analyzed coverage of cancer drugs in the health insurance marketplaces, which concludes transparency of coverage and cost-sharing requirements are insufficient to allow cancer patients to choose the best plan for their needs. **Read below**

Coalition Holds Congressional Briefing on Site-Neutral Payment Reform

On November 17, the Alliance for Site-Neutral Payment Reform, a coalition of healthcare providers, patient and consumer groups and insurers created to advocate for policy reforms that eliminate disparities in payments between the same clinical services provided in different healthcare settings, hosted a policy briefing on Capitol Hill detailing the need or payment parity across sites of service in order to decrease Medicare and commercial spending, ensure patient access to the right care in the right setting and lower taxpayer and beneficiary costs.

Speakers representing AARP, independent oncologists, private insurers and state government discussed the rising healthcare costs, increased healthcare marketplace consolidation and reduced patient choice resulting from site of service payment disparities. Representatives from more than 50 Congressional offices were in attendance.

The briefing was timely as the Bipartisan Budget Act, which was signed into law on November 2, included a site-neutral payment policy that prohibits any new off-site hospital location that is more than 250 yards from the main campus from billing under the Outpatient Prospective Payment System (OPPS) and aligns their payments with other physician practices paid under either the Ambulatory Surgical Center (ASC PPS) or the Medicare Physician Fee Schedule (PFS).

Additionally, The Alliance for Site-Neutral Payment Reform sent a letter to both House and Senate leaders on November 17, applauding the provision in the budget deal and stating, “While some hospital outpatient departments are seeking exemptions from this new payment policy, we urge lawmakers to stand by the budget deal and support site-neutral reform. It is time to expand site-neutral payment policies, not reverse recent progress that hasn’t had the opportunity to illustrate its value.”

To view the Alliance’s letter to Congress, CLICK HERE.

To read the Inside Health Policy story, CLICK HERE.

Healthcare Stakeholders Submit Comments on MACRA

On November 17, myriad stakeholders submitted comments to the Centers for Medicare & Medicaid Services (CMS) in response to the agency’s Request for Information (RFI) regarding implementation of the Merit-Based Incentive Payment System (MIPS), promotion of Alternative Payment Models (APM), and incentive payments for participation in eligible alternative payment models, which will be implemented under the Medicare Access and CHIP Reauthorization Act of 2015

(MACRA). MACRA was passed earlier this year to replace the Sustainable Growth Rate formula (SGR) to transform Medicare provider reimbursement.

In one letter, dozens of provider groups – including the American Medical Association, the American Academy of Family Physicians, and the American College of Surgeons – outline broad principles they urge CMS to follow as it implements the MACRA legislation. The letter calls on CMS to eliminate constraints on physicians trying to provide care under APMs and to ensure that providers can choose from an array of models. They also ask CMS to streamline quality reporting requirements in order to reduce administrative burdens for physicians and providers.

To read the provider group letter to CMS, CLICK HERE.

In its letter to CMS, the American Society of Clinical Oncology (ASCO) released 11 overarching principles and detailed guidance for implementation of MIPS and APMs. To view ASCO's guiding principles for the development of a sustainable Medicare payment system for clinical oncology, CLICK HERE.

New ACS Report On Cancer Drug Coverage and Transparency

The American Cancer Society Cancer Action Network (ACS CAN) recently released an updated report from 2014 that analyzed coverage of cancer drugs in the health insurance marketplaces created by the Affordable Care Act (ACA), finding that transparency of coverage and cost-sharing requirements were insufficient to allow cancer patients to choose the best plan for their needs.

The new report incorporates 2015 data from marketplaces in California, Illinois, North Carolina, Texas, and Washington, showing that coverage transparency has improved somewhat since 2014, but significant barriers remain for cancer patients. Specifically, ACS CAN found the following:

- Coverage of newer oral chemotherapy medications was limited in some states in 2015;
- Coverage for intravenous medications, while noted more often than in 2014, was still unclear in most plans;
- Cost-sharing structures presented in plan formularies did not match those presented on marketplace websites nearly half of the time;
- Plans continue to place most or all oral chemotherapy medications on the highest cost-sharing tier, presenting transparency and cost barriers for patients; and,
- Nearly half of plans placed a generic oral chemotherapy drug on the highest cost-sharing tier, which may constitute a discriminatory cost-sharing design.

Following the findings, ACS CAN has recommended that the U.S. Department of Health and Human Services pursue the following policy changes to help ensure adequate, timely, and affordable access to prescription drugs to treat cancer:

- Monitoring prescription drug benefits for evidence of discrimination against patients with high-cost conditions;
- Requiring the use of copayments instead of coinsurance;
- Requiring insurers to provide direct search links to searchable prescription drug formularies for each qualified health plan;
- Clearly label drugs listed in formularies with a cost-sharing tier matching those displayed on the marketplace and in the Summary of Benefits and Coverage;
- Expanding comparative information on healthcare.gov and state-based marketplaces to include cost-sharing information for plans with five or more tiers in their prescription drug benefit;
- Creating standardized cost-sharing for qualified health plans to improve transparency and reduce ability to design plans that discourage enrollment by high-cost consumers;
- Strengthen and enforce exceptions policy allowing enrollees access to non-covered drugs when medically necessary;
- Clearly describing quantity limits in formulary documents; and
- Developing tools allowing consumers to search for plans that cover their prescription drug costs.

For the full report, CLICK HERE.