Friday, July 21, 2017

CMS Releases Proposed Medicare Payment Rules, HOPPS Rule Includes Proposal to Significantly Reduce 340B Drug Reimbursement

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House Energy & Commerce Hearing Holds 340B Drug Pricing Program Hearing

On July 18, the House Energy & Commerce Subcommittee on Oversight and Investigations held a hearing regarding the 340B Drug Pricing Program. The hearing focused on the program's growth, the HRSA's 340B audits, regulations and authority, as well as a need for legislation to clarify the framework of and eligibility for 340B. **Read below.**

Future of Senate Healthcare Bill Remains Unclear

The future of the Senate's Affordable Care Act (ACA) repeal and replace bill, the Better Care Reconciliation Act (BCRA), remains unclear. On Wednesday evening, GOP Senate leaders met in an effort to revive the bill after Senate Majority Leader Mitch McConnell (R-KY) announced earlier in the week that the bill vote was delayed due to an inability to reach the votes needed to pass the measure. **Read below.**

The US Oncology Network Joins Patient Advocates, Provider Groups in Support of Bipartisan Senate Prompt Pay Bill

Last week, The US Oncology Network signed a letter with more than a dozen provider and patient advocate groups in support of bipartisan legislation that would protect community-based oncology providers and ensure more accurate alignment in drug reimbursement. **Read below.**

House Budget Committee Unveils FY2018 Budget Resolution

On July 18, the House Budget Committee released its budget resolution for Fiscal Year (FY) 2018. The plan includes deeper spending cuts than what was proposed under the Administration's FY2018 budget as well as reconciliation language to start the process of reforming the tax code. **Read below.**

Medicare Trustees Release Annual Report, Delay IPAB Trigger Until at Least 2019

On June 13, the Medicare Trustees released their 2017 Medicare Trust Fund Report, which provides an annual update on the fiscal health of the Medicare Part A Trust Fund. **Read below.**

CMS Releases Proposed Medicare Payment Rules, Includes Proposal to Significantly Reduce 340B Drug Reimbursement

The Centers for Medicare & Medicaid Services (CMS) released two proposed rules last week, the Medicare Physician Fee Schedule (PFS) and the Hospital Outpatient Prospective Payment System (HOPPS) for 2018 payment policies and rates for services.

Physician Fee Schedule Proposed Rule

The PFS payment policy proposal increases the CY 2018 PFS conversion factor to an estimated $35.9903 from the 2017 PFS conversion factor of $35.89. The change will not impact Hematology/Oncology specialists, but will have a positive one percent impact on Radiation Oncology and Therapy Centers. Other provisions include:

- A reduction in off-campus hospital outpatient department payment rates to better align them with private physician practices. CMS is proposing to reduce rates for HOPD-based services from 50 percent to 25 percent of the HOPPS rate.
- An expansion of Medicare telehealth services and the elimination of the required reporting of the telehealth modifier for professional claims.
- The adoption of Current Procedural Terminology (CPT) codes specifically for care management and similar services.
- An adjustment of the Clinical Laboratory Fee Schedule (CLFS) rule for lab testing payments to generally equal the weighted median of private payer rates.
- Additional time for advanced diagnostic imaging services practitioners to prepare for and adjust to the Medicare Appropriate Use Criteria (AUC) under the Quality Payment Program.
- A replacement of the Physician Quality Reporting System (PQRS) downward payment adjustment with the Merit-based Incentive Payment System (MIPS) as well as reduced reporting requirements under the PQRS.
- Additional changes to the previously-finalized policies for the 2018 Value Modifier's reporting and adjusting requirements.

Hospital Outpatient Prospective Payment System Proposed Rule

CMS is proposing to pay separately payable, non-pass-through drugs purchased at a discount through the 340B drug pricing program at the average sales price (ASP) minus 22.5 percent rather than ASP plus 6 percent. ASP minus 22.5 percent was the Medicare Payment Advisory Commission's (MedPAC's) estimate of the average minimum discount eligible hospitals received for drugs acquired under the 340B program. Applicable drugs not purchased under the 340B drug program would continue to receive ASP plus 6 percent payment.

CMS is accepting comments on both proposed rules until September 11. The finals rules will be decided by November 1 and enacted January 1, 2018. The US Oncology Networks will submit comments on both proposed rules.

To view the CMS fact sheet on the PFS proposed rule, CLICK HERE.

To view the proposed rule in its entirety, CLICK HERE.

To view the CMS fact sheet on the HOPPS proposed rule, CLICK HERE.

To view the proposed rule in its entirety, CLICK HERE.

House Energy & Commerce Hearing Holds 340B Drug Pricing Program Hearing

The House Energy & Commerce Subcommittee on Oversight and Investigations held a hearing on July 18 regarding the 340B Drug Pricing Program. The hearing focused on the program's growth, the Health Resources and Services Administration's (HRSA) 340B audits, regulation and authority, as well as the need for clarification within the framework of and eligibility for 340B.

Bipartisan support solidified the program's importance, but not without both sides expressing a greater need for more transparency and regulation.

Members also voiced concern about duplicate discounts and drug diversion. Numerous Members probed how hospitals employ program savings, with HRSA repeatedly saying the "statute is silent" on the issue. Members also asked about whether access to 340B discounts plays a role in hospital consolidation, particularly acquisition of oncology practices.

Universal concern stemmed from HRSA's lack of knowledge about how hospitals spend 340B savings and who qualifies as an eligible patient for the program. These questions reinforced the need for regulatory reforms within the 340B drug pricing program overall.

To view the hearing online and see witness testimony, CLICK HERE.

To view the Committee's background document, CLICK HERE.

Future of Senate ACA Repeal and Replace Bill Remains Unclear

As of July 20, the future of the Senate's Affordable Care Act (ACA) repeal and replace bill, the Better Care Reconciliation Act (BCRA), remained unclear. A day earlier, GOP Senate leaders had met in an effort to revive the bill after Senate Majority Leader Mitch McConnell (R-KY) announced earlier in the week that the bill vote was delayed due to an inability to reach the votes needed to pass the measure.

According to reports, following the July 19 meeting, Republican lawmakers remained at an impasse on how to move forward with ACA repeal. A plan floated by Senate Leadership to repeal the ACA before creating replacement legislation has also garnered opposition among GOP Senators, suggesting the approach would not pass the upper chamber. Meanwhile,

President Donald Trump urged Senators not to leave DC for August Recess until action on ACA repeal was complete.

On July 13, Senate Republicans released an updated version of the Better Care Reconciliation Act (BCRA), which included the creation of a two-track health insurance system where individuals could choose between cheaper, less regulated health plans and more expensive, comprehensive ones that remained ACA-compliant. Less healthy Americans and those with preexisting conditions would be forced to choose the latter, as insurers would be allowed to only offer the cheaper plans to those they believed would have low medical costs. Additionally, the bill would add $45 billion to fight the opioid epidemic. It would also still significantly cut the Medicaid program and bring tax cuts of $657 billion.

On July 20, the non-partisan Congressional Budget Office (CBO) released estimates that the revised Senate Republican plan to repeal and replace the ACA would leave 22 million more Americans uninsured over a decade. However, the bill would also cut the federal deficit by $321 billion over 10 years, driven by deep cuts to Medicaid and less aid for people purchasing private coverage. These estimated savings exceed the $119 billion target set by the House bill.

For the full draft of the BCRA bill, CLICK HERE.

For a summary of the BCRA bill, CLICK HERE.

For the CBO score, CLICK HERE.

The US Oncology Network Joins Patient Advocates, Provider Groups in Support of Bipartisan Senate Prompt Pay Bill

Last week, The US Oncology Network signed a letter with more than a dozen provider and patient advocate groups in support of bipartisan legislation that would protect community-based oncology providers and ensure more accurate alignment in drug reimbursement.

The bill (S. 1304), sponsored by Senators Pat Roberts (R-KS), Debbie Stabenow (D-MI), Sherrod Brown (D-OH) and Bob Casey (D-PA), aims to exclude prompt pay discounts from Average Sales Price (ASP) when calculating Medicare payments for Part B drugs. This policy would help community-based providers as many currently struggle to absorb Medicare's lower reimbursement rates for Part B drugs.

To view the coalition letter, CLICK HERE.

To view the complete text of S. 1304, CLICK HERE.

House Budget Committee Unveils FY2018 Budget Resolution

On July 18, the House Budget Committee released its budget resolution for Fiscal Year (FY) 2018. The plan includes deeper spending cuts than what was proposed under the Administration's FY2018 budget as well as reconciliation language to start the process of reforming the tax code.

Additionally, the House budget assumes that all of the provisions in the American Health Care Act (AHCA), which the House passed in March, become law. It also revives cuts to the Medicare program through a premium support program. In total, the House budget expects to save $1.5 trillion over 10 years in Medicaid spending and an additional $487 billion through Medicare premium support.

To download the complete budget proposal, CLICK HERE.

Medicare Trustees Release Annual Report, Delay IPAB Trigger Until at Least 2019

On July 13, the Medicare Trustees released their 2017 Medicare Trust Fund Report, which provides an annual update on the fiscal health of the Medicare Part A Trust Fund. According to the report, the fund is projected to remain solvent until 2029, one year later than last year's report.

The Trustees also announced that the Independent Payments Advisory Board (IPAB) cuts will likely not have to go into effect this year due to a slower-than-expected increase in healthcare spending. Previously, analysts had warned that the cuts would need to be triggered in 2017, but that has now been delayed until at least 2019.

IPAB was created as a part of the Affordable Care Act as a way to control excessive Medicare spending. As written, the 15-member panel of experts would propose recommendations for cutting costs in years that Medicare growth rates exceeded a target rate. These cuts would then go into effect automatically unless overridden by Congress. Since its inception, IPAB has never been triggered. And because none of the positions on the panel have ever been filled, the decision to recommend cuts lies with current Health and Human Services Secretary Tom Price.

To read the full Medicare Trustees Report, CLICK HERE.