



Thursday, September 7, 2017

The Network Submits Comments on CMS CY 2018 Quality Payment Program Proposed Rule

On August 21, The US Oncology Network submitted comments to the Centers for Medicare & Medicaid Services (CMS) regarding the CY 2018 Quality Payment Program Proposed Rule. [Read below.](#)

The Network Responds to House Ways & Means Committee “Medicare Red Tape Relief Project” Request for Feedback

Last week, The US Oncology Network responded to the House Ways & Means Committee’s call for provider feedback on the “Medicare Red Tape Relief Project,” an initiative that aims to identify opportunities to reduce legislative and regulatory barriers within the Medicare program. [Read below.](#)

Senate HELP Committee to Hold Hearings on Bipartisan ACA Fix

This week, the Senate Health, Education, Labor, and Pensions Committee will hold hearings to explore possible bipartisan fixes to the Affordable Care Act. Currently, two hearings are scheduled for Wednesday and Thursday that will feature testimony from both Democratic and Republican Governors, state insurance commissioners and outside health policy experts. [Read below.](#)

Anthem Suspends Payment for In-Hospital MRI and CT Scans Performed on an Outpatient Basis

In an attempt to cut costs, Anthem recently announced that it will no longer provide reimbursement for MRI and CT scans performed by hospitals on an outpatient basis. Instead, patients in need of imaging services will have to visit a free-standing imaging center where costs are often significantly lower than they would be at a hospital. [Read below.](#)

New Studies Show Adverse Effects of Hospital-Physician Practice Consolidation

Two recent studies revealed how hospital-driven physician practice consolidation is limiting patient choice, driving up costs and possibly pushing patients to choose more expensive care when other affordable options are available. [Read below.](#)

CMS Advisory Panel Recommends Against Cuts to Hospital 340B Reimbursement

Last week, CMS’s Advisory Panel on Hospital Outpatient Payments recommended the agency discontinue its outstanding proposal to cut reimbursement for 340B drugs purchased through Medicare. [Read below.](#)

HHS Office of the Inspector General Releases Two Medicare Part B Payment Reports

On Tuesday, the Department of Health and Human Services Office of the Inspector General (OIG) released two reports concerning Medicare Part B Drug payments. [Read below.](#)

The Network Submits Comments on CMS CY 2018 Quality Payment Program Proposed Rule

On August 21, The US Oncology Network submitted comments to the Centers for Medicare & Medicaid Services (CMS) regarding the CY 2018 Quality Payment Program Proposed Rule. While The Network broadly appreciates CMS' intent to provide flexibility to eliminate burdens on physicians as they transition to the second year of the Merit-Based Incentive Payments System (MIPS), the oncology community has several recommendations regarding the rule's implementation.

Namely, The Network is asking for additional clarity regarding whether Part B drugs will be included in MIPS payment adjustments, prefers a more gradual ramp-up of the 2018 performance period and would like to see additional exemptions for practices with a low volume of Medicare patients. Additionally, The Network supports CMS' decision to delay adoption of 2015 Electronic Health Records by an additional year as well as its efforts to expand opportunities for participation in Alternative Payment Models (APMs).

To view The Network's complete comment letter, [CLICK HERE](#).

The Network Responds to House Ways & Means Committee "Medicare Red Tape Relief Project" Request for Feedback

Last week, The US Oncology Network responded to the House Ways & Means Committee's call for provider feedback on the "Medicare Red Tape Relief Project," an initiative that aims to identify opportunities to reduce legislative and regulatory barriers within the Medicare program.

In a letter to Chairman Pat Tiberi (R-OH), The Network outlines five recommendations that the committee should consider. Among them:

- Adjusting the Medicare Part B drug sequester cuts
- Expanding site neutral payment policies to include all off-campus outpatient services
- Streamlining prior authorization requirements for oncology services
- Extending clinical lab reporting flexibility for rural and low-volume providers
- Revisiting the Stark Law's application for emergency radiation treatment referrals

To read The Network's recommendations to the W&M Committee, [CLICK HERE](#).

To access more information about the Medicare Red Tape Relief Project, [CLICK HERE](#).



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This week, the Senate Health, Education, Labor, and Pensions (HELP) Committee will hold hearings to explore possible bipartisan fixes to the Affordable Care Act. Currently, two hearings are scheduled for Wednesday and Thursday that will feature testimony from both

Democratic and Republican Governors, state insurance commissioners and outside health policy experts.

While no solid plan has been agreed to, Republican Chair Lamar Alexander (R-TN) is said to be working closely with his Democratic counterpart, Ranking Member Patty Murray (D-WA) on a bipartisan plan to stabilize state insurance markets, permanently fund the ACA's cost sharing subsidies and make other changes such as expanding Medicaid waivers and boosting Health Savings Accounts.

To view the September 6th HELP Committee hearing, [CLICK HERE](#).

To view the September 7th HELP Committee hearing, [CLICK HERE](#).

Anthem Suspends Payment for In-Hospital MRI and CT Scans Performed on an Outpatient Basis

In an attempt to contain costs, Anthem recently announced that it will no longer provide reimbursement for MRI and CT scans performed by hospitals on an outpatient basis. Instead, patients in need of imaging services will have to visit a free-standing imaging center where costs are often significantly lower than they would be at a hospital. The company announced that exceptions would be made if a patient's physician determined the scan to be medically necessary.

According to Anthem, the policy is a response to growing costs of imaging services provided by hospitals, which average \$1,567 for a limb MRI, compared to \$504 for the same procedure at an outpatient clinic.

Fourteen states will be affected by the policy in March 2018, although the policy is currently in effect for several states already. An estimated 4.5 million plan members will be impacted.

New Studies Show Adverse Effects of Hospital-Physician Practice Consolidation



Two recent studies reveal how hospital-driven physician practice consolidation is limiting patient choice, driving up costs and possibly pushing patients to choose more expensive care when other affordable options are available.

One study, published in [Health Affairs](#), demonstrates how large physician practices are able to create concentrated monopolies under the nose of federal regulators by gradually acquiring small practices.

The study finds that because many such acquisitions occur on such a small scale, the Federal Trade Commission (FTC) is powerless to block or undo these mergers even as they create highly concentrated markets that would otherwise warrant federal intervention to preserve a competitive atmosphere. Nearly 43 percent of the physician markets examined by researchers are deemed to be either "highly" or "moderately" concentrated, according to federal guidelines

that measure monopoly power. The researchers also find that half of all large practice growth was driven by acquisitions of practices with fewer than 10 doctors at a time.

A [second study](#), by the National Institute for Health Care Management (NIHCM), examines how hospital consolidation of physician practices affects patient treatment choices. The study finds that patients are between 16 and 33 percent more likely to choose a hospital that owns his or her doctors' practice as their primary source of inpatient care, even if the costs are higher and the quality is lower than at other nearby hospitals. Without such influence of practice ownership, the researchers find that patients are more likely to choose a lower cost, higher quality option.

These results are particularly concerning because hospital ownership of physician practices has increased rapidly over the past decade. By 2015, nearly four in 10 practices were owned by a hospital. This limits patient choice and needlessly pushes patients into high cost settings.

CMS Advisory Panel Recommends against Cuts to Hospital 340B Reimbursement

Last week, the Center for Medicare & Medicaid Services' (CMS) Advisory Panel on Hospital Outpatient Payments recommended the agency discontinue its outstanding proposal to cut reimbursement for 340B drugs purchased through Medicare. Instead, the panel recommended that CMS collect additional data and public comments as well as conduct an assessment of the regulatory burden of the proposed policy.

According to the 2018 Hospital Outpatient Proposed Pay Rule, reimbursement for 340B drugs could be cut from the current Average Sale Price (ASP) plus 6 percent to ASP minus 22.5 percent – an estimated \$900 million cut that would be offset by a 1.4 percent payment increase to other outpatient services. The proposed drug payment cut has been met with opposition from several healthcare stakeholder groups including the American Hospital Association and 340B Health.

To access the Advisory Panel's Recommendations, [CLICK HERE](#).

To comment on the OPPS proposed rule, [CLICK HERE](#).



HHS Office of the Inspector General Releases Two Medicare Part B Payment Reports

On Tuesday, the Department of Health and Human Services Office of the Inspector General (OIG) released two reports concerning Medicare Part B Drug payments.

The first report recommends CMS expand its policy of substituting an ASP-based payment approach with a different calculated average if the Average Sale Price (ASP) exceeds the Average Manufacturer Price (AMP) by more than five percent. If implemented, the policy could have saved Medicare an additional \$9 million per year based on 2014 data. The agency has yet to concur with the policy change.

The second report notes that Medicare would have saved up to \$1.8 billion if CMS adopted inflation-indexed rebates for Part B drugs. However, the report also cautions that administrative issues may hamper rebate collection, potentially eating into those savings. That's because Medicare does not currently get drug rebates the way Medicaid does. If CMS were to establish such a rebate program for Medicare, it would face many of the same difficulties associated with the Medicaid 340B program, such as identifying eligible drugs and preventing manufacturers from providing duplicate discounts for drugs purchased under the program.

To read "Medicare Part B Drug Payments: Impact of Price Substitutions Based on 2014 Average Sales Prices," [CLICK HERE](#).

To read the second report, "Calculation of Potential Inflation-Indexed Rebates for Medicare Part B Drugs," [CLICK HERE](#).

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