



Thursday, December 14, 2017

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A new study commissioned by the Community Oncology Alliance (COA) finds that profit margins on oncology drugs purchased by hospitals through the 340B drug discount program increased significantly between 2010 and 2015, while discounts provided by manufacturers have similarly ballooned. [Read below.](#)

### **MedPAC Recommends Replacing MIPS with Alternative Program**

During its December meeting, the Medicare Payment Advisory Commission (MedPAC) announced that it will recommend the elimination of the Merit-based Incentive Payment System (MIPS) in favor of a value program in which physicians can voluntarily participate. [Read below.](#)

### **CMS Cancels Mandatory Bundled Payments for Cardiac Care While Rolling Back the Comprehensive Care for Joint Replacement Program**

On December 1, the Centers for Medicare & Medicaid Services (CMS) finalized its rule to cancel Episode Payment Models and Cardiac Rehabilitation Incentive Payment Model and roll back the Comprehensive Care for Joint Replacement (CJR) program. [Read below.](#)

### **Fourteen Medical Societies Urge Congress to Protect Part B Therapy Access**

Last week, 14 medical societies signed a letter urging Congress to take action to prevent CMS from including Part B drug spending in MIPS payment adjustments. [Read below.](#)

### **Senate HELP Committee Hearing Reviews Report on Drug Prices, House Energy & Commerce Committee Examines Drug Supply Chain**

This week congressional leaders held two hearings to discuss drug prices and the state of the U.S. drug supply chain. [Read below.](#)

### **CMS Releases 2016 National Health Expenditures Report**

On December 6, the Center for Medicare & Medicaid Services (CMS) released its National Health Expenditure report, which shows that healthcare spending growth slowed in 2016. [Read below.](#)

## Study Shows 340B Program Drives Patients into Hospital Settings, Increases Costs

A new study commissioned by the Community Oncology Alliance (COA) finds that profit margins on oncology drugs purchased by hospitals through the 340B drug discount program increased significantly between 2010 and 2015, while discounts provided by manufacturers have similarly ballooned. These factors are driving more cancer patients into expensive hospital outpatient settings while increasing costs for the Medicare program and putting upward pressure on drug prices.

The study, which examines the role discounted oncology drugs have on overall drug prices was completed by the Berkeley Research Group on the behalf of COA. Among its major findings:

- The average hospital profit margin on 340B oncology drugs increased from 40 percent in 2010 to 49 percent in 2015. This creates an incentive for hospitals to administer more cancer drugs purchased at the 340B price.
- 340B hospitals now account for 67 percent of all Medicare Part B oncology drug reimbursements, up from 38 percent in 2008.
- The value of gross mandatory drug manufacturer discounts almost tripled between 2010 and 2015 for oncology drugs. In 2010, 340B rebates on oncology drugs amounted \$1 billion and about 7.4 percent of total gross sales for that year. By 2015, rebates for the same drugs were \$3 billion and about 14.4 percent of gross sales for these types of drugs.

To view the full COA study, [CLICK HERE](#).

## MedPAC Recommends Replacing MIPS with Alternative Program



During its December meeting, the Medicare Payment Advisory Commission (MedPAC) announced that it will recommend the elimination of the Merit-based Incentive Payment System (MIPS) in favor of a value program in which physicians can voluntarily participate. MedPAC previously concluded at its October meeting that MIPS is too much of a burden on physicians and won't achieve its stated goal of promoting value-based care.

Under the MedPAC proposal, clinicians would be able to join a voluntary group that receives shared payment bonuses based on the entire group's performance. Clinicians would also still have the option to join an Advanced Alternative Payment Model (APM) and benefit from its scheduled payment bonuses.

MIPS was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and has been a major fixture in the promotion of value-based care within the Medicare program. Beginning in 2019, physicians who achieve certain quality metrics will receive an annual payment adjustment in addition to their Medicare reimbursement.

Physicians who fail to meet certain metrics will face penalties. Medicare is authorized to spend \$500 million per year in MIPS bonus pay – funds that could be reallocated elsewhere within Medicare if CMS eliminates the program.

To view MedPAC's December meeting materials, [CLICK HERE](#).

## CMS Cancels Mandatory Bundled Payments for Cardiac Care While Rolling Back the Comprehensive Care for Joint Replacement Program

On December 1, the Centers for Medicare & Medicaid Services (CMS) finalized its rule to cancel Episode Payment Models and Cardiac Rehabilitation Incentive Payment Model and roll back the Comprehensive Care for Joint Replacement (CJR) program.

The Episodic Payment Model (EPM) for cardiac care and the Cardiac Rehabilitation (CR) incentive payment model will no longer begin as scheduled on January 1, 2018 while only about half of the 67 geographic areas slated to participate in the CJR program will be required to take part.

In a departure from the August proposed rule, CMS will not allow voluntary participation in the CJR program for hospitals that wish to enroll citing a short time window.

To read the final rule, [CLICK HERE](#).

## Fourteen Medical Societies Urge Congress to Protect Part B Therapy Access

Last week, 14 medical societies signed a letter urging Congress to take action to prevent CMS from including Part B drug spending in MIPS payment adjustments. Under the 2018 Quality Payment Program rule, CMS announced that the amount practices spend on Part B drugs would count towards the bonuses and penalties clinicians receive under MIPS, which could result in significant year-to-year payment swings for providers. According to the groups, this is a major departure from current policy and puts small and rural practices at risk. An October study released by Avalere showed that some specialties – particularly rheumatology, ophthalmology, and oncology – could see payment swings of up to 16 percent next year and as high as 29 percent by 2020.

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

To view the Avalere study, [CLICK HERE](#).

## Senate HELP Committee Hearing Reviews Report on Drug Prices, House Energy & Commerce Committee Examines Drug Supply Chain



This week congressional leaders held two hearings to discuss drug prices and the state of the U.S. drug supply chain.

On Tuesday, the Senate Health, Education, Labor, and Pensions (HELP) Committee held a hearing to review a new report by the National Academy of Medicine on how to make drugs more affordable. The report, titled “Making Medicines Affordable: A National Imperative” included a number of recommendations Congress and the Administration could take to lower drug prices. Among them:

- Accelerate approvals of safe and effective generics and biosimilars, foster competition
- Consolidate and apply government purchasing power
- Increase transparency of financial and profit information in the drug supply chain
- Discourage direct-to-consumer advertising and prohibit patient coupon programs
- Modify benefit designs to reduce patients’ out-of-pocket spending
- Increase oversight of the 340B program
- Revise the Orphan Drug Act to ensure focus remains on patients with rare diseases
- Implement reimbursement policies to align physician prescribing practices with treatment value.

Separately on Wednesday, the House Energy & Commerce Committee held a wide-ranging hearing to discuss the state of the country’s pharmaceutical supply chain that links drug manufacturers to patients. The hearing featured representatives from the various stakeholders within the drug supply chain and included witnesses representing hospitals, physicians, pharmacies, pharmacy benefit managers, drug manufacturers and insurance plans.

To read a summary of the National Academy of Medicine’s report, [CLICK HERE](#).

To view the Senate HELP Committee hearing, [CLICK HERE](#).

To view the House Energy & Commerce Committee hearing, [CLICK HERE](#).

## CMS Releases 2016 National Health Expenditures Report

On December 6, the Center for Medicare & Medicaid Services (CMS) released its National Health Expenditure report which showed that healthcare spending growth slowed in 2016. Healthcare spending grew by 4.3 percent last year compared to 5.8 percent in 2015 and 5.3 percent in 2014.

Though still higher than inflation, this trend is reflective of a larger slowdown in healthcare costs across the country. The U.S. spent \$3.3 trillion on healthcare services overall, accounting for 17.9 percent of Gross Domestic Product or \$10,348 per person.

Medicare accounted for nearly 20 percent of overall U.S. health spending, resulting in \$672 billion in federal outlays for fiscal year 2016. Spending growth increased by 3.6 percent last year, substantially lower than 2015's 2.8 percent. However, out-of-pocket costs grew by 3.9 percent – the fastest since 2007 – likely the result of more employers shifting consumers into high-deductible plans.

To view CMS' summary of the data release, [CLICK HERE](#).

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