



Friday, September 14, 2018

## **The Network Submits Physician Fee Schedule Comments, Expresses Concern with Proposed E/M Service Cuts**

This week, The Network submitted a comment letter to the Centers for Medicare & Medicaid Services (CMS) regarding the CY 2019 Medicare Physician Fee Schedule. [Read below](#)

## **240 Stakeholder Groups Call on Congress to Ask CMS to Reverse Step Therapy Proposal**

This week, The US Oncology Network along with a coalition of 240 patient and provider groups circulated a letter calling on lawmakers to encourage CMS to reverse its proposal to allow Medicare Advantage plans to implement step therapy measures. [Read below](#)

## **CMS to Allow Indication-Based Formulary Design for Part D Plans**

Last week, the Centers for Medicare & Medicaid Services (CMS) issued a guidance allowing Medicare Part D prescription drug plans to tailor their formularies to exclude certain disease indications for covered drugs - as long as the plans cover an alternative therapy for the excluded indication. [Read below](#)

## **Hospital Groups Refile Lawsuit to Challenge 340B Cuts, Force Implementation of Ceiling Pricing Rule**

On September 5, the American Hospital Association, the Association of American Medical Colleges, America's Essential Hospitals and three other hospital systems refiled their lawsuit against the Trump Administration on 340B changes. [Read below](#)

## **PhRMA Report Finds Hospitals Mark-up Prescription Drugs by up to 500 Percent**

A new report from Pharmaceutical Research and Manufacturers of America (PhRMA) found that hospitals typically markup prescription drugs by about 500 percent on average. [Read below](#)

## **E&C Leaders Seek More Information on Role of PBMs in Impacting Drug Prices**

On August 30, the House Energy and Commerce Committee sent letters to seven pharmacy benefit managers (PBMs) asking for additional information about their role in the drug supply chain. [Read below](#)

## **House E&C Committee Advances PBM Gag Clause Ban**

This week, the House Energy & Commerce Subcommittee on Health advanced a bill to ban pharmacy benefit managers (PBMs) from inserting so-called "gag clauses" into contracts with pharmacies. [Read below](#)

## **E&C Committee Leaders Ask MedPAC to Study Hospital Consolidation**

Last week, the House Energy & Commerce Committee Chair Greg Walden (R-OR) along with Congressmen Michael Burgess, MD (R-TX) and Gregg Harper (R-MS), sent a letter requesting the Medicare Payment Advisory Commission (MedPAC) conduct research on the financial impact of hospital consolidation on patients and the Medicare system. **Read below**

### **Full Stories...**

## **The Network Submits Physician Fee Schedule Comments, Expresses Concern with Proposed E/M Service Cuts**

This week, The Network submitted a comment letter to the Centers for Medicare & Medicaid Services (CMS) regarding the CY 2019 Medicare Physician Fee Schedule. Among chief concerns is the agency's proposal to consolidate the five current payment rates for Evaluation and Management (E/M) office visits down to two with a proposed single rate of \$93 for existing patients and \$135 for new patients. Reimbursement for level 4 and 5 E/M visits would be dramatically reduced - negatively impacting physicians caring for patients with complex and chronic conditions like cancer. While CMS claims these changes will reduce documentation burdens for physicians, the creation of "add-on" codes mitigates the benefit from the proposal and may actually increase oncologists' documentation burden. .

"While we appreciate CMS' stated goal of simplifying documentation requirements for physicians, we are concerned that the proposal lacks recognition of the practical demands of cancer care," the letter reads. "The Network strongly urges CMS not to finalize its proposal to reform E/M visit codes and instead engage stakeholders to identify and analyze policies to achieve simplification of documentation and payment for E/M services that will result in reduced burden and improved patient care."

In the comments, The Network also:

- urges CMS to reconsider its proposed reduction to the add-on payments for new Part B drugs, which would cut reimbursements to the drug's Wholesale Acquisition Cost (WAC) plus 3 percent down from WAC plus 6 percent;
- expresses concern with a CMS contractor's analysis of direct practice expense inputs, including its methodology and lack of stakeholder input;
- suggests changes to the agency's proposed telehealth proposals, and;
- provides feedback on the proposed changes to the Medicare Quality Payment Program.

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

## **240 Stakeholder Groups Call on Congress to Ask CMS to Reverse Step Therapy Proposal**

This week, The US Oncology Network along with a coalition of patient and provider groups sent a letter to Senate and House leadership calling on lawmakers to encourage CMS to reverse its proposal to allow Medicare Advantage plans to implement step therapy measures. The groups instead want CMS to consider alternative utilization management solutions that incorporate evidence-based guidelines designed with the input of medical practitioners, patients and advocates.

The groups worry that the current proposal lacks basic patient safeguards, including adequate standards and transparency that ensure step therapy policies are clinically appropriate and rooted in evidence. It also expresses concern that the proposed policy does not provide an adequate process for patients to seek exceptions to step therapy, as well as the “aggressive implementation timeline” which aims to for the new policy to go into effect January 1, 2019.

To view the complete text of the group letter, [CLICK HERE](#).

## CMS to Allow Indication-Based Formulary Design for Part D Plans

Last week, the Centers for Medicare & Medicaid Services (CMS) issued a guidance allowing Medicare Part D prescription drug plans to tailor their formularies to exclude certain disease indications for covered drugs - as long as the plans cover an alternative therapy for the excluded indication. Previously, plans were required to cover each on-formulary drug for all indications approved by the FDA.

This action is the next step in the Administration’s “American Patients First” drug pricing blueprint to reduce prescription drug prices through better negotiation. The Administration claims that this action will increase the number of drugs available on formularies and promote diversity of formularies. The Network will continue to examine the impact of this announcement and work with CMS to ensure cancer patients maintain access to appropriate treatment.

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

## Hospital Groups Refile Lawsuit to Challenge 340B Cuts, Force Implementation of Ceiling Pricing Rule

On September 5, the American Hospital Association, the Association of American Medical Colleges, America’s Essential Hospitals and three other hospital systems refiled their lawsuit against the Trump Administration. The groups are challenging the Administration’s decision to pay separately payable, nonpass-through drugs and biologicals (other than vaccines) purchased through the 340B program at the average sales price (ASP) minus 22.5 percent rather than ASP plus 6 percent.

In July, the District of Columbia Circuit Court of Appeals threw out the case, stating that the groups did not have standing to sue at the time because the cuts had not yet taken effect when the original suit was filed. Now that the cuts have taken effect, the hospital groups petitioned the court for expedited relief.

Separately, another coalition of hospital groups filed a lawsuit aimed at challenging the Administration's delays of a January 2017 rule that would set ceiling prices for 340B drugs and fine drug manufacturers if they intentionally overcharge eligible hospitals. The Administration has repeatedly delayed this rule and has hinted that it might be doing so in order to avoid conflicting with future forthcoming 340B-related regulations.

To read the AHA statement, [CLICK HERE](#).

## PhRMA Report Finds Hospitals Mark-up Prescription Drugs by up to 500 Percent

A new report from the Pharmaceutical Research and Manufacturers of America (PhRMA) found that hospitals typically markup prescription drugs by about 500 percent on average. At least one in six hospitals charged prices seven times above what they originally paid for them.

The report analyzed federal cost reports from 3,800 U.S. hospitals and compared their purchase price for certain drugs with the maximum amount they can charge. However, the report also notes that insurers often pay much less than the hospital's listed sticker price, so the real mark-up for these may actual be less than 500 percent.

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

## E&C Leaders Seek More Information on Role of PBMs in Impacting Drug Prices

On August 30, the House Energy and Commerce Committee sent letters to seven pharmacy benefit managers (PBMs) asking for additional information about their role in the drug supply chain. The request for stakeholders' perspectives came one month after the Committee requested the Federal Trade Commission conduct a retrospective review of PBM mergers and their effects on consumer prices.

Since PBMs serve more than 266 million Americans, the Committee is closely examining how their practices, including proposed mergers between CVS and Aetna, as well as Cigna and Express Scripts, are influencing the cost of prescription drugs.

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

## House E&C Committee Advances PBM Gag Clause Ban

This week, the House Energy & Commerce Committee advanced a bill to ban pharmacy benefit managers (PBMs) from inserting so-called "gag clauses" into contracts with pharmacies. Gag clauses prevent pharmacists from informing patients about the true cost of their medications, such as when the out-of-pocket cost may be lower than their copay.

In the Senate, a bipartisan bill banning gag clauses from Medicare Advantage and Part D plans, the Know the Lowest Price Act (S. 2553), passed the chamber on September 5. A related bill, which would ban gag clauses in employer-sponsored plans, is currently awaiting amendments before it can be put to a vote.

To view the discussion draft advanced by the Committee, [CLICK HERE](#).

To view the Committee mark-up hearing, [CLICK HERE](#).

## E&C Committee Leaders Ask MedPAC to Study Hospital Consolidation

Last week, the House Energy & Commerce Committee Chair Greg Walden (R-OR) – with Congressmen Michael Burgess, MD (R-TX) and Gregg Harper (R-MS) – sent a letter requesting the Medicare Payment Advisory Commission (MedPAC) conduct research on the financial impact of hospital consolidation on patients and the Medicare system.

The letter notes the trend of hospital consolidation has been increasing in recent years, especially as large health systems purchase physician practices and convert them into hospital outpatient departments (HOPD) and specifically calls out site neutral payment policies - which mandate that Medicare reimburse HOPDs at the same rates as other physician offices for performing the same services.

The lawmakers also want MedPAC to determine whether consolidation leads to higher patient costs.

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