
Tuesday, January 14, 2019

## Texas Oncology's Dr. Wilfong Co-Authors Commentary on Patient-Reported Outcomes in Medicare Oncology Payment Models

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## Network Members Discuss Proposed Radiation Oncology Model in JCO Oncology Practice Blog

In late December, three representatives from The Network authored a blog post in the Journal of Clinical Oncology's *Oncology Practice* Blog analyzing CMS' forthcoming radiation oncology payment model and making recommendations for improvement. **Read below.**

## The Network Responds to Cures 2.0 RFI

On December 16, The Network sent a letter to Representatives Diana DeGette (D-CO) and Fred Upton (R-MI) responding to the lawmakers' Cures 2.0 Request for Information (RFI). **Read below.**

## President Signs End of Year Spending Deal; Tees Up Health Legislation in Spring

On December 20, President Trump signed into law a $1.4 trillion spending bill that included key extensions of Medicare and Medicaid policy through May 2020. These short-term extenders will likely force congressional action on healthcare legislation in the spring, providing a potential vehicle for other health-related priorities, such as drug pricing and surprise billing. **Read below.**

## Brad Smith Named New Head of CMMI

On January 6, the Department of Health and Human Services and the Centers for Medicare & Medicaid Services announced that Brad Smith will serve as Director of the Center for Medicare & Medicaid Innovation (CMMI) at CMS and Senior Advisor for Value-Based Transformation to HHS Secretary Alex Azar. **Read below.**

## Avalere Releases Analysis on Part D Formularies

Last month, Avalere Health released a report that analyzed 2020 Medicare Part D formularies by comparing Prescription Drug Plans (PDP) and Medicare Advantage Prescription Drug Plans (MA-PDs). **Read below.**

## Study Finds 340B Hospitals Reimbursed at a Higher Rate Than What They Pay for Drugs

On December 16, the healthcare consulting firm Milliman released a new analysis that found that hospitals participating in the 340B drug pricing program are reimbursed for physician-administered medicines at a rate that is three times what they paid to acquire the medicine on average. **Read below.**

## Study Finds Increase in Hospital Mergers Has Not Led to Improvements in Quality

On January 2, *The New England Journal of Medicine* published new research that shows the surge in hospital merger-and-acquisition activity has not resulted in quality improvement. **Read below.**

**FULL STORIES**

## Texas Oncology's Dr. Wilfong Co-Authors Commentary on Patient-Reported Outcomes in Medicare Oncology Payment Models

On January 2, the *Journal of the American Medical Association* published a commentary discussing the opportunities and challenges of including patient-reported outcome measures in Medicare's value-based oncology payment models including the Oncology Care Model (OCM) and its successor, the Oncology Care First (OCF) model. The commentary was co-authored by Lalan Wilfong, MD, a practicing physician and medical director for quality programs at Texas Oncology.

Approximately 140 practices are currently participating in the OCM, which represents about 10 percent of oncology practices in the U.S. and about 25 percent of total patients receiving systemic cancer treatment. The US Oncology Network has more than 900 physicians participating in the model, managing care for more than 65,000 patients.

To view the commentary, CLICK HERE.

## Network Members Discuss Proposed Radiation Oncology Model in JCO Oncology Practice Blog

In late December, three representatives from The Network authored a blog post in the Journal of Clinical Oncology's *Oncology Practice* Blog analyzing CMS' forthcoming radiation oncology payment model and making recommendations for improvement.

Authored by Dr. Nikhil Thaker of Arizona Oncology, and Stuart Staggs and Rehman Meghani of The US Oncology Network and McKesson Corporation, the blog post expresses concern with the model's proposed payment methodology. The authors argue that the proposal reward high-cost practices while penalizing practices with lower costs, running counter to the model's stated goal of incentivizing high-quality, efficient, and cost-effective care. It also challenges the model's approach to establishing appropriate site-neutral payment rates.

To view the blog post, CLICK HERE.

## The Network Responds to Cures 2.0 RFI

On December 16, The Network sent a letter to Representatives Diana DeGette (D-CO) and Fred Upton (R-MI) responding to the lawmakers' Cures 2.0 Request for Information (RFI). In its response, The Network applauded the Representatives' dedication to advancing patient-centered medical research and recommended a number of issues lawmakers should consider when developing the Cures 2.0 legislation.

The RFI identified congressional interest in policies related to digital health, personalized medicine, data utilization, and caregiver support. While The Network expressed broad support for these efforts, it also suggested lawmakers consider related policy changes, including prior authorization reform, step therapy reform, coverage of genetic counselor services in Medicare, and supporting families and caregivers of patients.

To read the full response from The Network, CLICK HERE.

To read the RFI, CLICK HERE.

## President Signs End of Year Spending Deal; Tees Up Health Legislation in Spring

On December 20, President Trump signed into law a $1.4 trillion spending bill that included key extensions of Medicare and Medicaid policy through May 2020. These short-term extenders will likely force congressional action on healthcare legislation in the spring, providing a potential vehicle for other health-related priorities, such as drug pricing and surprise billing.

Included in the legislation are extensions of Medicaid funding for the territories, a delay of the Medicaid disproportionate share hospital (DSH) payment reductions, and funding extensions for community health centers, the National health Services Corps, and teaching health centers that operate graduate medical education (GME) programs. The deal also permanently repealed three Affordable Care Act taxes: the medical device tax, the health insurance tax, and “Cadillac” tax on high-value insurance plans.

## Brad Smith Named New Head of CMMI

On January 6, the Department of Health and Human Services and the Centers for Medicare & Medicaid Services announced that Brad Smith will serve as Director of the Center for Medicare & Medicaid Innovation (CMMI) at CMS and Senior Advisor for Value-Based Transformation to HHS Secretary Alex Azar. He will oversee CMS’ effort to create and implement value-based payment models, such as the Oncology Care First and Radiation Oncology Models, that move Medicare beyond the traditional fee-for-service system.

Prior to his nomination, Smith served as Chief Operating Officer of Anthem’s Diversified Business Group. He was previously co-founder and CEO of Aspire Health, which was sold to Anthem in 2018. Smith will succeed Adam Boehler, who was confirmed by the U.S. Senate to lead the International Development Finance Corporation.

To read the official announcement from the Department of Health and Human Services, CLICK HERE.

## Avalere Releases Analysis on Part D Formularies

Last month, Avalere Health released a report that analyzed 2020 Medicare Part D formularies by comparing Prescription Drug Plans (PDP) and Medicare Advantage Prescription Drug Plans (MA-PDs). The analysis found increases in utilization management practices, particularly prior authorization (PA). Among PDPs, 69% of drugs on specialty tiers require PA, and increase of 3% over 2019. Similarly, 64% of drugs on MA-PD specialty tiers require PA, an increase of 2% over 2019.

On average, only 38% of Part D drugs covered by PDPs and 43% of drugs covered by MA-PDs are available without utilization management. The percentage of drugs not covered in both categories slightly increased from 2019. In addition to utilization management, the analysis also considered changes to plan tier structures, coverage and tier placement, and cost sharing.

To read the complete report, “2020 Medicare Part D Formularies: An Initial Analysis,” CLICK HERE.

## Study Finds 340B Hospitals Reimbursed at a Higher Rate Than What They Pay for Drugs

On December 16, the healthcare consulting firm Milliman released a new analysis that found that hospitals participating in the 340B drug pricing program are reimbursed for physician-administered medicines at a rate that is three times the average of what they paid to acquire the medicines. The analysis underscores many stakeholder concerns regarding how hospitals are using the spread they receive through the program to improve care.

The analysis, based on 2016 claims data, found that on average across all hospital types, reimbursement for physician-administered brand medicines were roughly 247% of acquisition costs. In its review of just 340B-participating hospitals, the average reimbursement increased to 294% of acquisition costs. The Milliman report was commissioned by the Pharmaceutical Research and Manufacturers of America.

To read the complete Milliman analysis, CLICK HERE.

## Study Finds Increase in Hospital Mergers Has Not Led to Improvements in Quality

On January 2, *The New England Journal of Medicine* published new research that shows the surge in hospital merger-and-acquisition activity has not resulted in quality improvement. The findings of the study, among the first of its kind, undercut the argument that consolidation improves hospital quality and patient outcomes.

In analyzing nearly 250 hospitals acquired in vertical integration deals between 2009 and 2013, the researchers found that being acquired was associated with a modest differential decline in performance on the patient-experience measure, while having no significant differential change in 30-day readmission or 30-day mortality rates. On a fourth quality metric (process measures of quality), the effects were inconclusive.

To read the full study, “Changes in Quality of Care after Hospital Mergers and Acquisitions,” CLICK HERE.