Aug. 23, 2018: National Advocacy Update

CMS moves to allow step therapy in Medicare Advantage plans

On Aug. 7, Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma announced that the agency would rescind previous CMS policy prohibiting the use of step-therapy protocols by Medicare Advantage plans. Starting in January 2019, Medicare Advantage plans will be allowed to use step therapy for all physician-administered drugs covered under Medicare Part B.

The administration’s new policy would also allow step-therapy protocols that span both Parts B and D, meaning a Medicare Advantage plan could require a patient to first try a drug covered under Part D before providing coverage for a Part B drug. According to the agency’s announcement, this change in policy was made as part of the administration's plans to lower drug prices.

The AMA has serious concerns about the agency's change of policy given its potential for significant impact on patient access to critical therapeutics and increased administrative burdens on physician practices. The AMA is working closely with physician specialty organizations and state medical societies to limit the potential negative impacts of this policy shift.

Significant changes proposed for accountable care organizations

CMS has issued a proposed rule outlining the future direction of the Medicare Shared Savings Program. The proposal replaces the current approach of four numbered accountable care organization (ACO) tracks with two categories, basic and enhanced, that have different levels of financial risk and other features for ACOs within the two categories. The rule also includes requirements for ACOs to advance through the categories over time.

Existing regulations allowed track 1 ACOs, which can earn shared savings but are not required to repay Medicare a share of so-called losses, to remain in track 1 for six years, but under the proposed rule, new ACOs would only be exempt from repaying losses for two years. To promote greater program stability, ACOs would have five-year agreements with CMS instead of three-year agreements.

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For the first time, CMS is proposing that risk scores could increase to a limited degree for ACO patient populations, a change which AMA has been seeking. A more controversial proposal would vary requirements for ACOs depending on their total revenues, which if finalized would likely subject hospital-led ACOs to steeper financial risk requirements than physician-led ACOs that do not include hospital participants. CMS also proposes to reduce the percentage of savings that ACOs are eligible to receive, and to count incentive payments made to ACOs under the Quality Payment Program as part of ACOs' Medicare expenditures. A 60-day public comment period on the proposal closes Oct. 16.

Drug pricing legislation would help remove barriers to care

The AMA sent a letter (PDF) on Aug. 9 to Senator Susan Collins, R-Maine, in support of addressing the varied causes driving prescription drug pricing. As amended, "The Patient’s Right to Know Drug Prices Act of 2018" which she introduced to the Senate would prohibit health insurers and pharmacy benefit managers from using "gag clauses" that prohibit pharmacists from sharing lower-cost medication options with patients.

This piece of legislation would also ensure that the Federal Trade Commission (FTC) will have the necessary authority to combat anti-competitive pay-for-delay settlement agreements between manufacturers of biological reference products and follow-on biologicals. This bill is in keeping with AMA's previous advocacy efforts for the prohibition of pharmacy gag clauses and expanded FTC authority to combat pay-for-delay agreements.

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