Advising the Congress on Medicare issues

Part B drug payment policy issues

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Outline of presentation

- Average sales price (ASP) add-on
- Broader policies to increase competition among Part B drugs or put downward pressure on ASP
- Part B dispensing and supplying fees

Background on Part B drugs and Medicare payment

- In 2014, Medicare and beneficiaries spent over $20 billion on Part B covered drugs paid 106% of ASP, including:
  - Drugs administered by physicians and outpatient hospitals
  - Certain drugs furnished by DME and pharmacy suppliers
- ASP is the average price realized by the manufacturer for sales to all purchasers (with some exceptions) net of rebates, discounts, and price concessions
  - The prices individual providers pay for a drug may differ from ASP for a variety of reasons (e.g., price variation across purchasers, 2-quarter lag in ASP payment rates, prompt pay discounts)

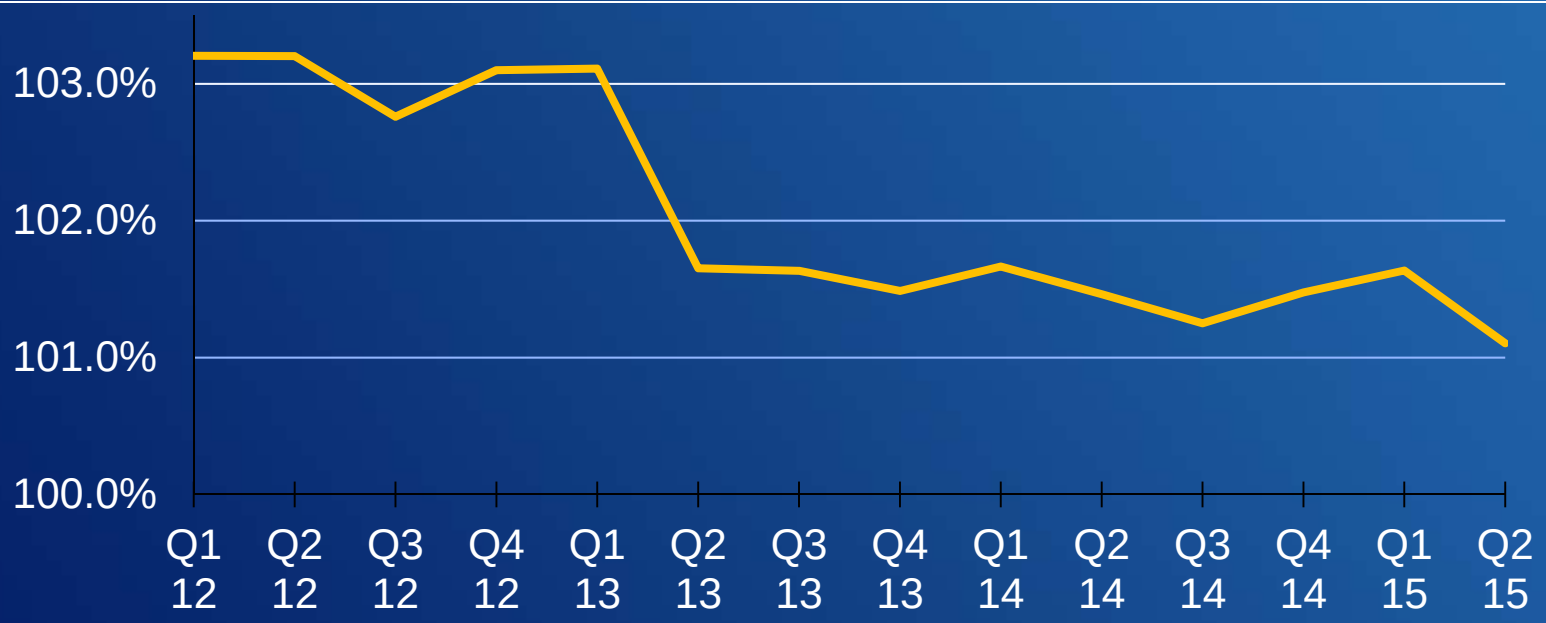
Recap of November meeting

- The 6% add-on to ASP may incentivize use of higher-priced drugs, although few studies exist examining this issue
- We modeled two budget-neutral options to convert the add-on to a reduced percentage plus a flat fee
- Commissioners' feedback
  - Concern about whether providers could purchase drugs within the Medicare payment amount
  - Consider options that generate savings
  - Consider broader approaches

Analysis of distribution of invoice prices as a percent of ASP

- Proprietary invoice price data from IMS Health for clinic channel of purchasers
- Analysis of 34 Part B drugs that accounted for about two-thirds of Part B drug spending in 2014
- We analyzed the ratio of the invoice price to ASP and summarized the results across the 34 drugs

The median 75th percentile invoice price as a percent of ASP across 34 Part B drugs



Note: The data are for the clinic channel (physician offices, HOPDs, non-hospital surgical centers, and dialysis facilities). Analysis focuses on 34 high expenditure Part B drugs. For drugs with multiple NDCs, the highest volume NDC was used. Data come from a sample of wholesalers and do not include direct sales by manufacturers. The percentile distribution of invoice prices is at the drug unit level. Invoice prices reflect on-invoice discounts and rebates, but not off-invoice rebates. Invoice prices for each quarter are divided by 100% of the ASP in effect for Medicare payment purposes that quarter.

Source: MedPAC analysis of Price Trak data from IMS Health Incorporated and ASP pricing files from CMS.

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Data are preliminary and subject to change

For two-thirds of the 34 drugs, at least 75% of the volume had an invoice price less than 102% ASP

Ratio of 75th percentile invoice price to ASP, 1st quarter 2015	Percent of 34 drugs
<100%	35%
100% - 101.9%	29%
102% - 103.9%	12%
104% - 105.9%	12%
106%+	12%

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Policy option to restructure add-on

- 103.5% of ASP + $5 per drug per day
- Overall savings for program and beneficiaries of about 1.3% (estimated annual savings of $270 M)
- Increases add-on for drugs with ASP per administration less than $200; decreases add-on for higher-priced drugs
- Reduces the difference in add-on payments between a high-priced and low-priced drug by about 40%

Data are preliminary and subject to change

Revenue effect of policy option: 103.5% of ASP + $5 per drug per day

	Percent change in Part B drug revenues	Percent change in total Medicare revenues
Physicians	-1.0%	-0.2%
Oncologists	-1.5	-1.1
Ophthalmologists	-2.0	-0.9
Rheumatologists	-1.8	-1.3
Primary Care	1.5	0.1
Hospitals	-2.1	-0.1
Suppliers	0.1	0.0

Source: MedPAC analysis of Medicare claims data.

Data are preliminary and subject to change

Potential policies to promote competition or put downward pressure on ASP

- ASP inflation cap
- Consolidated billing codes
- Restructure competitive acquisition program

ASP growth

- No limit on how much Medicare's ASP+6 payment rate for an individual drug can increase over time
- Median ASP growth for the 20 highest-expenditure drugs was slower than inflation from 2005 to 2010, but has exceeded inflation since then
- Between January 2015 and 2016, 10 out of the 20 highest-expenditure drugs had an ASP increase of 5 percent or more

Data are preliminary and subject to change

Policy option: ASP inflation cap

- Could consider placing a cap on how much Medicare's ASP+6 payment for a drug can increase over time
- Possibly operationalized through a rebate
  - Could require manufacturers to pay Medicare a rebate when ASP growth exceeds an inflation benchmark (e.g., similar to inflation portion of the Medicaid rebate)
- Policy option would:
  - Protect against the potential for a dramatic increase in the Medicare payment rate for a product
  - Generate savings for drugs with ASP growth exceeding the inflation benchmark

Strengthening price competition under the ASP payment system

- Single source drugs and biologics receive their own billing codes and are paid based on their own ASP
- Separate billing codes for products with similar health effects do not promote price competition
- Examples of high-expenditure competitor drugs with stable or increasing ASPs
- CMS finalized a policy to group biosimilars in one code, but the reference product remains in a separate code and paid its own ASP+6 rate

Policy option: Secretarial authority for consolidated billing codes

- The Commission has held that Medicare should pay similar rates for similar care
- Option: give the Secretary the authority to put drugs with similar health effects in the same billing code
- This would promote price competition and generate savings for beneficiaries and taxpayers

Competitive acquisition program for Part B drugs

- Voluntary CAP Program: July 2006 - Dec. 2008
- Physicians who enrolled would obtain CAP drugs through vendor:
  - Physician submits a prescription for an individual patient to the vendor before the patient's visit
  - Vendor supplies the drug to the physician
  - Medicare pays physician for administration of drug
  - Medicare pays vendor for drug and vendor collects drug cost-sharing from beneficiary
- Vendor selected and prices set through competitive bidding process. One organization, Bioscrip, was vendor.

Original CAP program faced challenges

- Low physician enrollment
- Vendor had little leverage to negotiate discounts
- Medicare paid vendor more than ASP+6
- Vendor declined to renew contract
- Program suspended at the end of 2008

Illustrative example of restructured CAP program

- Voluntary program but encourage physician enrollment by:
  - Offering shared savings for physicians,
  - Reducing or eliminating the ASP add-on in traditional buy and bill system, and
  - Restructuring CAP to be a stock replacement model
- Permit vendor to operate a formulary and provide vendor with shared savings opportunities
- Beneficiaries also share in savings through lower cost sharing if prices are lower

How illustrative CAP program might work

- $2.6B in physician drug spending for ophthalmology, concentrated among competitor drugs
- ASP add-on lowered or eliminated in traditional buy and bill system
- Potential vendors bid a price for each drug to Medicare; organization(s) with lowest prices selected
- Physicians and vendor share in savings if Medicare spending declines
- Beneficiaries save through lower cost-sharing

Part B dispensing and supplying fees

- Total spending of $155M on these fees in 2014
- Dispensing fee for inhalation drugs is $33 per 30-day supply and $66 per 90-day supply
- Supplying fee for oral anticancer, oral anti-emetic, and immunosuppressive drugs is $24 for 1st script and $16 for each additional script in a 30-day period
- These dispensing and supplying fee rates were set in 2006 based on limited data
- OIG reported that Medicare Part D and Medicaid paid dispensing fees of less than $5 per script in 2011

Discussion

- Reactions to:
  - 103.5% ASP + $5 per drug per day
  - ASP inflation cap
  - Consolidated billing codes
  - Restructuring CAP program