Medicare Part B drug payment policy issues

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MEDPAC

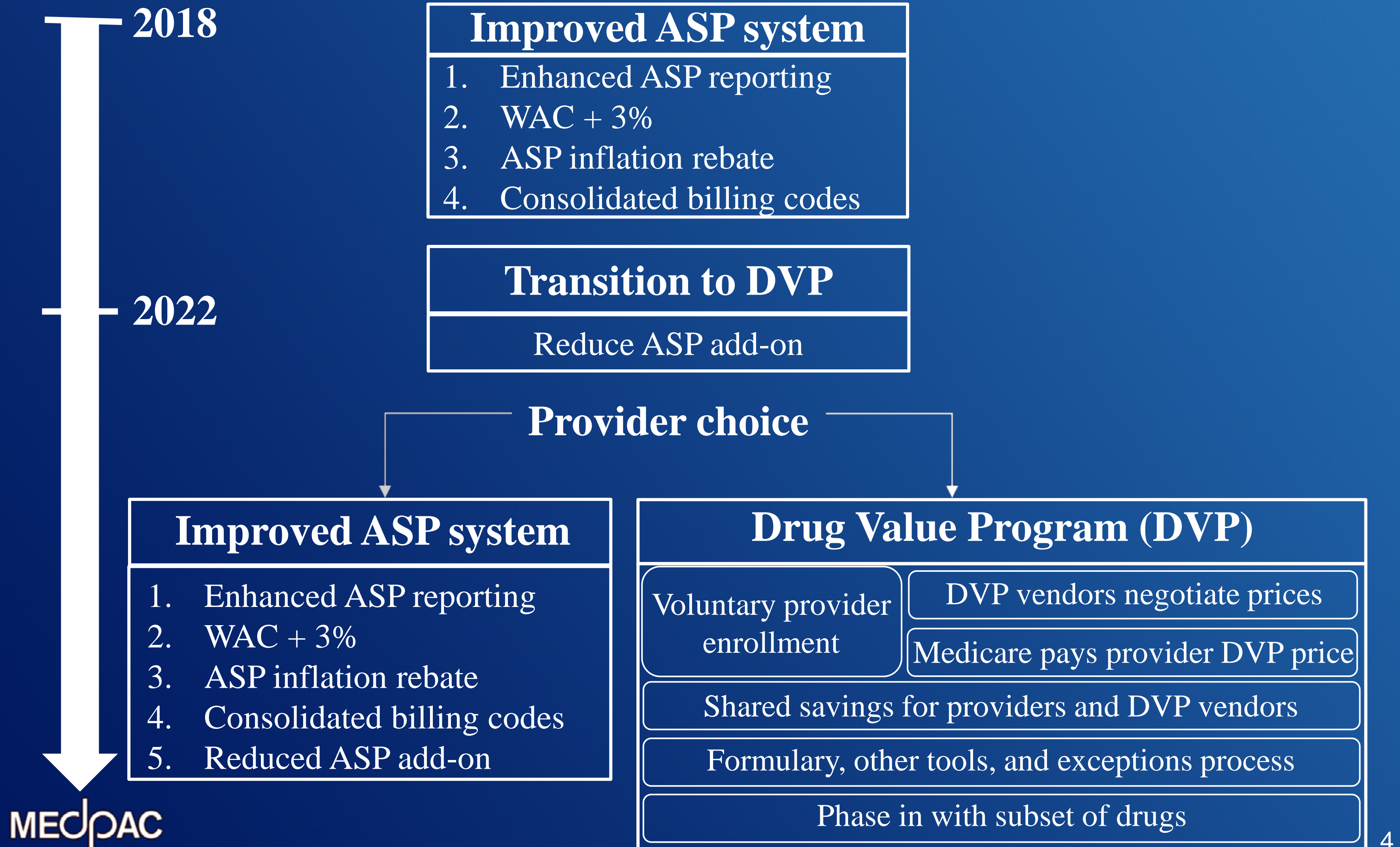
Presentation overview

- Background
- Package of potential reforms:
  - Improvements to current average sales price (ASP) system
    - Improved ASP data reporting
    - WAC + 3%
    - ASP inflation rebate
    - Consolidated billing codes
  - Reduce ASP add-on to encourage enrollment in Drug Value Program (DVP)
  - DVP: market-based alternative to ASP payment system
- Draft recommendation

Background

- In 2015, Part B drug spending was $26 billion (up from $23 billion in 2014)
  - $21 billion program spending
  - $5 billion beneficiary spending
- ASP+6 payment system may provide incentive to use higher-priced products
- Part B drug spending has grown 9 percent per year since 2009
  - Half of growth in expenditures accounted for by price growth from 2009 to 2013

Overview of potential reforms



Policy: Improving ASP data reporting

- Only Part B drug manufacturers with Medicaid drug rebate agreements currently required to submit ASP data
- This policy would:
  - Require manufacturers to report ASP data for all Part B drugs
  - Increase penalties for non-reporting
  - Give the Secretary authority to exempt repackagers

Policy: Modifying payment rate for drugs paid at WAC + 6%

- Wholesale acquisition cost (WAC) is a manufacturer's undiscounted price to wholesalers or direct purchasers
- Analysis of subset of new, high-expenditure drugs – modest discounts (0.7% to 2.7%) common
  - Because discounts are not incorporated into WAC, Medicare pays more for the same drug when WAC-priced vs. ASP-priced
- This policy would:
  - Reduce payment rate for WAC-priced drugs by 3 percentage points (i.e., WAC + 3%)
  - Reduce WAC add-on further if ASP add-on is reduced to maintain parity between WAC-priced and ASP-priced drugs

Data are preliminary and subject to change

Policy: ASP inflation rebate

- No limit on how much Medicare's ASP+6 payment rate for an individual drug can increase over time
  - Manufacturer pricing decisions drive ASP payment rates
  - Between 2010 and 2017, ASP annual growth of 5% or more for 9 of the top 20 highest-expenditure drugs
- This policy would require manufacturers to pay Medicare a rebate when their product's ASP exceeds an inflation benchmark, and tie cost-sharing and the ASP add-on to the inflation-adjusted ASP
  - Exempt low-cost drugs, and on a case-by-case basis, exempt high-cost drugs under shortage
  - Avoid duplicate discounts
  - Inflation benchmark: CPI-U or alternative

Policy: Consolidated billing codes

- Separate billing codes for a reference biologic and its biosimilars do not maximize price competition
- This policy would require the Secretary to use a common billing code to pay for a reference biologic and its biosimilars
  - The Secretary would rely on FDA approval process to group reference biologic and biosimilars
  - The Secretary could consider implementing a limited payment exception process
- The Secretary could study the use of a consolidated billing code more broadly for groups of products with similar health effects

Policy: Drug Value Program (DVP)

- This policy would give the Secretary authority to create a Part B DVP that would use private vendors to negotiate prices and offer providers shared savings opportunities
- Informed by lessons learned from the Competitive Acquisition Program (CAP) for Part B drugs
- Structured differently to increase vendors’ negotiating leverage and encourage provider enrollment

Policy: Drug Value Program – key design elements

- DVP would be voluntary for physicians and hospitals
- Reduce ASP add-on to encourage DVP enrollment
- Medicare contracts with a small number of private DVP vendors
- DVP vendors negotiate drug prices
- DVP prices are not public
- DVP vendors do not ship product
- Participating providers buy drugs in the marketplace at their selected DVP vendor's negotiated price

Policy: Drug Value Program – key design elements (continued)

- Provider payment:
  - Drug payment=DVP price
  - Additional payment for drug administration under PFS or OPPS
  - Provider opportunity for shared savings
- Vendors would be paid an administrative fee, with opportunity for shared savings
- Beneficiaries share in savings through lower cost sharing
- Medicare shares in savings

Policy: Drug Value Program – key design elements (continued)

- Tools to increase DVP vendors' negotiating leverage
  - Formulary (with exceptions process)
  - Limit prices under DVP to no more than 100% of ASP
  - Additional tools such as step-therapy and prior authorization
  - Binding arbitration could be used in the DVP for expensive drugs without close substitutes
- DVP prices would be excluded from ASP
- Phase in DVP beginning with a subset of drug classes

Provider incentives to join DVP

- Providers on higher-end of the price distribution would have strong incentive to join DVP
  - Movement of these providers into the DVP would be expected to reduce the future ASP payment rates
- Reducing ASP add-on gradually from 6 percent to 3 percent creates broader incentives to join DVP
- Provider input into formulary and other tools that DVP uses may increase attractiveness of joining DVP
- Providers share savings from:
  - DVP vendors negotiating lower prices for individual products
  - Providers' shift in utilization toward lower-priced products where clinically appropriate

Overview of potential reforms