Developing payment policy to promote use of services based on clinical evidence

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November 7, 2014

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Recap

- At the March and September 2014 meetings, Commission discussed linking the payment rate of Part B drugs to comparative clinical evidence
- *Least costly alternative (LCA) polices*: For two or more drugs that clinicians prescribe for the same condition and produce a similar outcome, the policy sets the payment rate based on the least costly drug
- Medicare applied LCA policies to Part B drug payment between 1995 and 2010
- Linking payment to clinical evidence better ensures that beneficiaries are getting the best value for their health care dollar

Obtaining the best price for beneficiaries

- CBO estimated savings of $500 million if the LCA policy was applied to Part B drugs for drugs used for osteoarthritis of the knee
- OIG estimated one-year savings of $33 million if Medicare had continued its LCA policy for prostate cancer drugs
- OIG estimated savings of nearly $1.4 billion if payment for drugs used for macular degeneration had been based on the least costly product

Data are preliminary and subject to change.

Today's session

- *Consolidated payment codes*: Combines products with similar health effects that treat a given condition into a single payment code
- *Bundling*: Combines the collective costs of care for a patient with a specified condition over a defined period of time into a single payment

Medicare payment for Part B drugs

- Most Part B drugs are furnished by physicians
- Medicare pays physicians 106% of a drug's average sales price (ASP)
- ASP is the manufacturer's average price for sales to all purchasers net of rebates, discounts, and price concessions
- The 6 percent add-on may create an incentive for some providers to select higher-cost products

Consolidated payment codes

- Group two or more drugs that clinicians prescribe for the same condition and produce a similar outcome into a single payment code
- Medicare's payment would be based on the volume-weighted average of the program's payment (ASP plus 6 percent) for these products
- Intent of policy is to obtain the best price for beneficiaries

Illustrative example of two drugs that have similar health effect for a given condition

- Under separate payment codes, incentive is to select higher-cost product (assuming acquisition cost=ASP)
  - Drug 1: ASP + 6%=$106, drug add-on=$6
  - Drug 2: ASP + 6%=$212, drug add-on=$12
- Under consolidated payment code, incentive is to select lower-cost product
  - ASP + 6% (volume-weighted based on both products)=$159, drug add-on (assuming select lower-cost product)=$59
- Over time, Medicare payment rate should decline as volume shifts to the lower-cost product, and price competition between products should increase

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Implementation issues: Consolidated billing codes

- Considers evidence on the comparative clinical effectiveness of drugs
  - MEDCAC, Evidence-based Practice Centers
- Posts draft and final policies on-line
- Seeks and considers comments from beneficiaries and other stakeholders
- Includes a process for medically necessary exceptions
- Process for revisiting policy over time

Bundling and episode payments

- Fixed payment amount for a combination of drugs and services required to treat a condition
  - What conditions are amenable to bundling?
  - What should be included?
  - Who gets paid?
  - How much to pay for each bundle?
- Examples
  - Peter Bach's proposed cancer bundles
  - UnitedHealthcare's oncology episodes

Bach, et al. bundling concept (2011)

- Relatively narrow bundle
  - Defined by an oncology event or episode
  - Would cover the costs of chemotherapy drugs and administration for predetermined period of time
- Incentives
  - Use low-cost but effective drugs
  - Would need to address issues such as cost shifting, upcoding, and stinting on care

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UnitedHealthcare oncology episodes

- Goal: remove revenue incentive to prescribe one drug over another, strengthen incentive to prescribe on quality basis
- Most services still paid under FFS
  - Drugs are paid ASP + 0%
  - Flat episode fee instead of drug add-on
- A further incentive to reduce overall spending was the potential for shared savings, if groups:
  - Lowered the total cost of care
  - Improved the survival rate for the episode
- Between 2009 and 2012, reduction in total spending, but increase in drug spending

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For Commissioner discussion

- We could assess flexibility of Medicare Advantage plans and Accountable Care Organizations to apply approaches
- Status quo for FFS policies results in FFS beneficiaries not obtaining best value
- FFS approaches that aim to motivate selection of lower-cost products and generate price competition between products: LCA policies, consolidated payment codes, Bach bundled payment approach, and United HealthCare approach