Seeing the Value and Transparency of Medicare Part B: Four Case Studies of Medicare Successes

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As the largest payer of healthcare services in the United States, the Centers for Medicare & Medicaid Services (CMS) often sets the trend for healthcare delivery and reimbursement. Over the past few years, there has been talk about Medicare reform and how to better pay for value. But we don't always take the time to step back and appreciate what works well in Medicare and what has been emulated by other stakeholders.

For example, when Congress enacted the Average Sales Price (ASP) reimbursement methodology for Part B drugs in 2003, many commercial payers followed suit. This was with good reason: ASP is a transparent and stable metric that aligns reimbursement with market prices. Most recently, Medicare has again led the charge in adopting value-based reforms, creating ripple effects throughout the healthcare marketplace.

Four areas where we think Medicare has got it right are reimbursing physician-administered drugs, enabling beneficiary choice through Medicare Advantage, looking at total cost of care and tying payment to quality.

01 Transparency of Drug Payments Under Part B

Medicare Part B generally pays for qualifying physician-administered drugs based on ASP plus 6% of ASP (4.3% after sequestration). This methodology relies on manufacturers' sales data, including commercially-negotiated rebates and discounts, to set the Medicare payment amount for a particular drug. Manufacturers report sales data to CMS, and the agency adjusts the drug payment amounts and posts them on its website every quarter. Noncompliance with ASP reporting rules may result in heavy fines.

Medicare's ASP system is transparent, showing how Part B prices change on a quarter-by-quarter basis. By its very nature, ASP is the "average" price paid by providers, which means some are paying more and others are paying less for the same Part B drug. The ASP methodology incentivizes providers to negotiate lower drug acquisition prices. This competitive, dynamic environment helps restrain prices, especially year-over-year price increases, in the market.

Under Part B's buy-and-bill drug acquisition model, doctors must order drugs by first buying them outright (usually from a wholesaler), stocking them, and billing Medicare only after a drug has been administered to a patient. This requirement incentivizes providers to maintain moderate inventory and mitigate financial risk to their clinics with conservative prescribing practices.

Critics have said the Part B program lacks adequate mechanisms for competition and cost control. Some suggest reforms that would replace the buy-and-bill model for Part B drugs or dramatically change coverage under the program, potentially limiting access to care.

By failing to recognize the built-in strengths of the existing program, some proposed changes to the buy-and-bill model could shift this risk from community physician practices to profit–driven outside entities such as specialty pharmacies, pharmacy benefit managers, group purchasing organizations, commercial insurance companies, or other contractors.

This could actually increase costs for the Medicare program through:

- Greater waste when prescriptions go unused
- Adding an administrative layer resulting in potentially fragmented care
- Inefficiency by forcing a third party into the doctor-patient relationship
- Patients pushed to be treated in sites of care that are higher cost and higher intensity such as the hospital setting

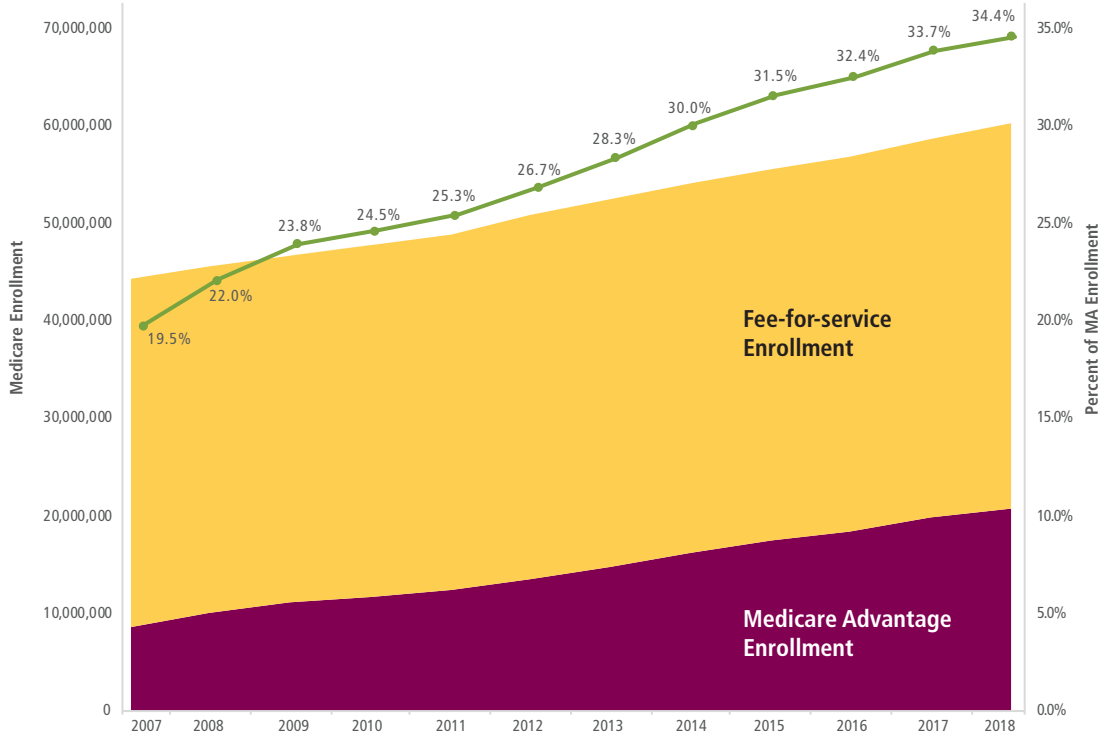
02 Enabling Beneficiary Choice through Medicare Advantage

Medicare beneficiaries have a choice of enrolling in Original Medicare or opting to receive care through a private Medicare Advantage plan. A growing share of Medicare enrollees now opt to receive their Part A and Part B benefits through these commercial health insurance plans, which, for many, more closely resembles what they might have had with employer-sponsored insurance.

Medicare Advantage plans often leverage the transparent ASP system, but also have added flexibility to negotiate contracted payment rates and manage utilization of Part B drugs. Approximately 40% of Medicare Advantage plans give some products in competitive therapeutic classes preferred access or employ utilization management techniques for Part B medicines. These tools most commonly include prior authorization (51%) and case management (16%), but can also include step edits, clinical pathways, alternative payment models, and enhanced reimbursement for providers prescribing preferred drugs.[1]

Enrollment in Medicare Advantage has been increasing steadily. Since 2012, beneficiary enrollment has grown over 40%. Since the cohort of patients aging into Medicare are more comfortable with managed care than any previous generation, enrollment is unlikely to slow down anytime soon.

Figure 1. The Share of Part B Enrollees in Medicare Advantage Continues to Grow[2]



03 Considering Total Cost of Care

CMS is a steward of the taxpayer dollar and, as such, Medicare is testing a growing array of value-based or alternative payment models (APMs), which give added incentives to deliver high-quality and cost-efficient care. APMs can apply to a specific clinical condition, an episode of care, or a population. Most Medicare APMs encourage providers to keep spending under a pre-defined benchmark.

Seven active Medicare APMs call on providers to manage Medicare Part B drug spending, in addition to other Medicare Part A and/or B services.[3]

APMs That Include Part B Drugs	
Bundled Payments for Care Improvement	Comprehensive Care for Joint Replacement
Oncology Care Model	Comprehensive End-stage Renal Disease Model
Shared Savings Program	Next Generation Accountable Care Organizations
Comprehensive Primary Care Plus	

The Oncology Care Model (OCM) is a case example of how Medicare Part B is evolving. Under OCM, practices are encouraged to reduce unnecessary spending and improve care quality for patients receiving chemotherapy through several mechanisms. Providers are held accountable to spending targets that include all Medicare Part A and B services, including both Part B medicines and some Part D drug costs. In addition, practices must comply with a series of care improvement activities, including documenting use of clinical guidelines to direct prescribing decisions.

Nearly 200 oncology practices are currently participating in the model,[4] and early reports suggest that one-quarter of those practices achieved a performance-based payment in the first reconciliation period, with many more making significant progress in achieving performance targets. The model also provides an option for commercial payers to participate by aligning their own reimbursement methods with OCM. As a result, OCM affects the market more broadly.

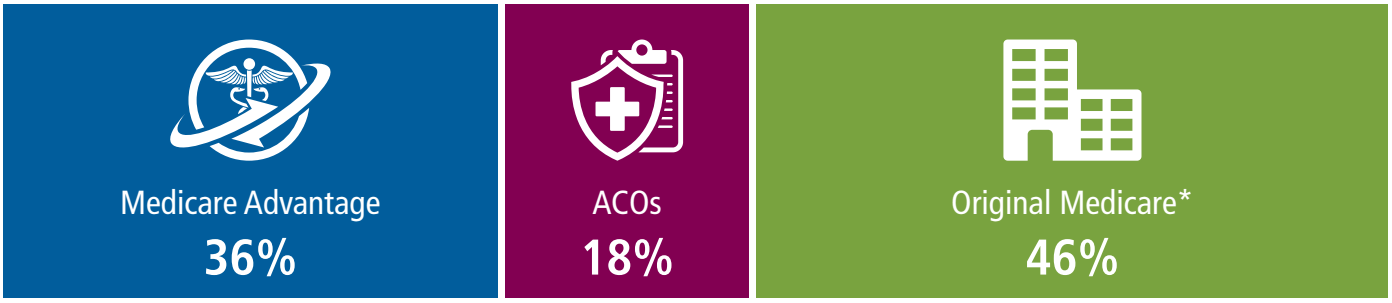
The Medicare Shared Savings Program (MSSP) is also playing a growing role in how care is delivered in Part B. In the MSSP, groups of doctors, hospitals, and other healthcare providers join together to form Accountable Care Organizations (ACOs) and agree to take on financial risk for Part A and Part B spending, including spending on Part B drugs. MSSP is CMS' largest APM, and 9 million Part B fee-for-service beneficiaries received their care from Medicare Shared Savings Program ACOs in 2016.[5]

04 Value-based Payment in Part B Will Continue to Increase

We expect the movement toward value-based payment to increase over the next few years. Congress recently enacted legislation that encourages provider participation in APMs that further promote efficient, high-quality care in Medicare Part B. These dynamics are working to moderate cost growth while ensuring that seniors have access to needed care.

If you look at where the current Part B enrollment is, you can see that value-based payment is impacting a growing share of Medicare beneficiaries.

Figure 2. Medicare Part B Enrollment Is Experiencing Value-based Payment[6]



* Includes other Innovation Center demos and value-based incentives through the Quality Payment Program.

Under the new Part B physician payment system, the Quality Payment Program (QPP), physicians have significant incentives (eg, a 5% bonus payment) to participate in qualifying APMs. The number of physicians in value-based payment programs that include Part B drug spending, such as the OCM and MSSP, is expected to grow as they respond to these incentives.

Even physicians who do not sign up to participate in APMs will be paid under performance-based methodologies. For example, under the new Merit-Based Incentive Payment System, physicians must demonstrate their performance on measures of quality, cost, advancing care information, and improvement activities.

And when providers adapt their practices to meet the requirements of the QPP, all their patients potentially benefit—not just those with Medicare.

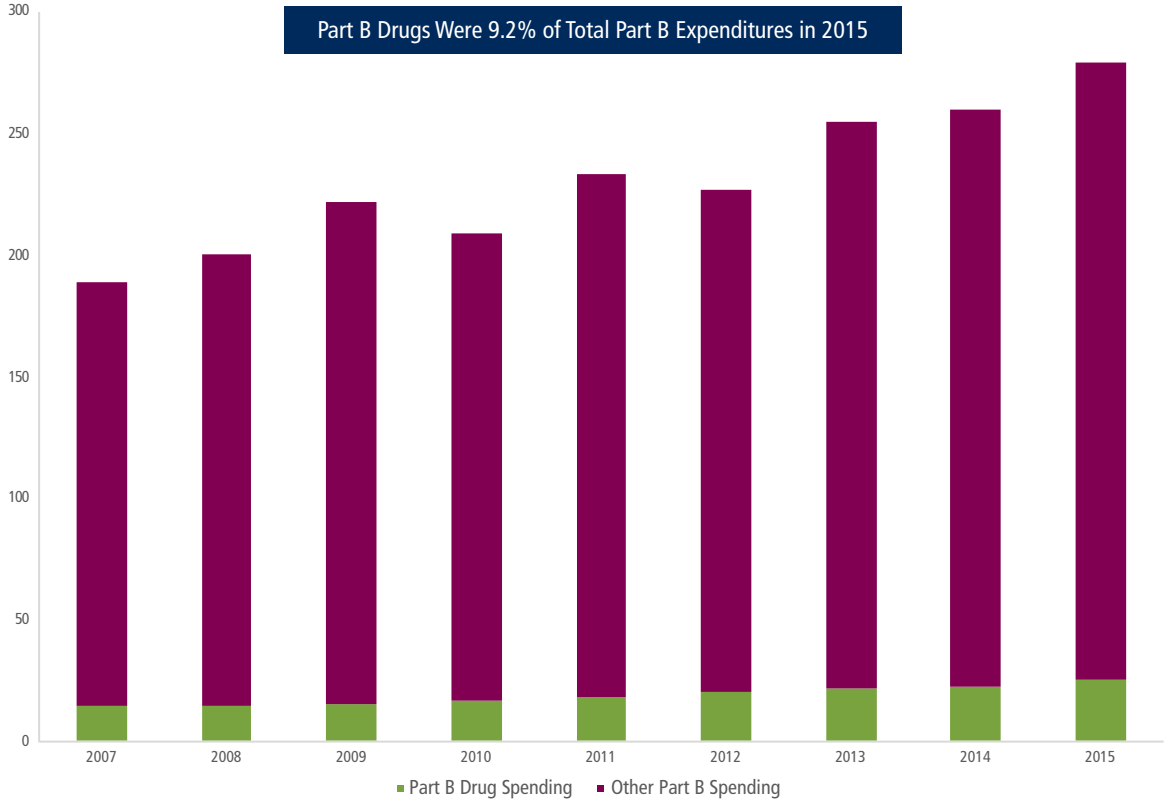
Conclusion

There are calls to change how Medicare pays for drugs, which are sensationalized by near-daily stories in the news about high drug prices and costs. What these stories fail to capture is that Medicare pays a lower and more transparent rate than other payers, and the way it is currently structured benefits physicians and patients.

Part B drugs are a relatively small share of the benefit (9.2% in 2015). The advantages to gain from altering such a stable marketplace vs tackling much larger spending line items, appear to be minimal. The number of beneficiaries who decide to enroll in Medicare Advantage continues to increase, which means a larger percentage of people have Medicare benefits administered by private plans, which offers the flexibility to more tightly manage Part B drugs and the Medicare benefit overall.

Overall, the Medicare program continues to provide both value and choice to patients through transparent reimbursement and a range of value-based incentives. Short-sighted proposals to change Medicare because it "feels" like it should change ignore the market realities (and wins) that we already have.

Figure 3. Part B Drug Expenditures Are a Small and Stable Share of Part B Spending[7]



1. Medical Pharmacy Trend Report: Seventh Edition. Magellan Rx. 2016. 2. Medicare Trustees Report, 2017. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2017.pdf. Accessed March 29, 2018. 3. Alternative Payment Models Overview. Centers for Medicare & Medicaid Services website. https://qpp.cms.gov/apms/overview. Accessed March 6, 2018. 4. Oncology Care Model. Centers for Medicare & Medicaid Services website. https://innovation.cms.gov/initiatives/Oncology-Care/. Accessed March 29, 2018. 5. Fast Facts: All Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs). Centers for Medicare & Medicaid Services. January 2017. 6. Medicare Enrollment Dashboard. Centers for Medicare & Medicaid Services website. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html. Accessed March 29, 2018. 7. Fast Facts: All Medicare Shared Savings Program (Shared Savings Program). Centers for Medicare & Medicaid Services. January 2018. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/SSP-2018-Fast-Facts.pdf. Accessed March 29, 2018. 8. 2017 Medicare Trustees Report. Centers for Medicare & Medicaid Services. Table III(C4). https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2017.pdf. 9. 2016 Medicare Trustees Report. Centers for Medicare & Medicaid Services. Table III(C4). https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2016.pdf. 10. Health Care Spending and the Medicare Program. MedPAC. June 2017;Data Book(Chart 10-1). http://www.medpac.gov/docs/default-source/data-book/jun17_databookentirereport_sec.pdf?sfvrsn=0.