A Misguided Experiment?

BY LEAH RALPH

In early March, the Centers for Medicare and Medicaid Services (CMS) issued a proposal to implement a national demonstration program that would fundamentally change the way Medicare pays physicians and hospitals for Part B drugs. While CMS has broad authority to test different models to improve quality and lower costs in the Medicare program, the agency seems to be pushing the scope of its authority, breaking from past demonstration programs to propose a mandatory model in which all Part B providers–hospital outpatient departments, physician offices, and pharmacies–would be required to participate.

The proposed Part B Drug Payment Model would consist of two phases in which providers would be divided into four groups: three experimental groups and one control group over a five-year period. Phase I would be implemented as early as August 2016 and would mandate that approximately half of all Part B providers would have their reimbursement rates reduced to ASP+2.5% plus a flat fee of $16.80 per drug per day. Importantly, Congressionally-mandated sequestration will continue to apply to payments made under the model. As a result, under the proposal the experimental group's actual payment rate will be ASP+0.86% plus $16.53 per drug per day. The remaining half, the control group, would continue to be reimbursed for Part B drugs at ASP+6%.

The agency's ambitious timeline calls for Phase II to begin as early as January 2017. Phase II would further divide the control and test groups—creating a four-arm control trial—and overlay a requirement to use value-based pricing (VBP) reimbursement strategies and clinical decision support tools to produce Medicare savings. One (unlucky) group of providers will be subject to both the reduced ASP rate and the requirement to utilize VBP tools. These tools might include:

- Reference pricing: Medicare would set a standard payment for therapeutically-similar products.
- Indications-based pricing: payment would vary for a drug based on its clinical effectiveness for different indications.
- Voluntary-risk sharing agreements: CMS would enter into voluntary agreements with manufacturers to link health outcomes with payment.
- Discounting or eliminating patient coinsurance to encourage beneficiary use of high-value drugs.

Despite a preliminary list of potential tools, CMS failed to describe these VBP approaches in any meaningful detail, leaving many questions about how the agency will develop this methodology and make determinations about high-value treatments.

Perhaps most unnerving, providers would be assigned to arms of the trial at random based on their geographic location in primary care services areas. Although CMS has structured Phase I to be budget-neutral, the proposed model is designed to redistribute drug spending by increasing payments to provider specialties, such as primary care, that use relatively inexpensive drugs, and decreasing payments to hospitals and physician specialties, such as oncology and ophthalmology, that often use more costly drugs. Under the proposed model, the tipping point is $480. Drugs that cost more than $480 per day would result in lower reimbursement, whereas drugs costing less than $480 per day would receive higher payments than what is reimbursed today.

The majority of drugs–7 of 10–that would make up the largest reduction in reimbursement are used to treat cancer. Moreover, many of these drugs do not have a lower cost alternative.[1]

On both policy and process, ACCC remains deeply concerned. Rather than working with cancer care providers to build the infrastructure needed to define quality and value in their cancer programs, CMS has responded to a call for reigning in drug costs with a myopic focus on reimbursement. Our members have partnered with CMS on meaningful payment reform—including the most recent Oncology Care Model—and will soon be dedicating extensive resources to navigating a new and complex reformed physician payment system under MACRA.

Oncologists are ready for change, but CMS' proposal reaches too far, too fast, with seemingly little understanding of the devastating impact this approach will have on community cancer care and patient access. View ACCC's comment letter to CMS on the ACCC website accc-cancer.org. OI

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References

1. Hussain F, Borden A. Proposed Medicare Part B Rule Would Reduce Payments to Hospitals and Some Specialists, While Increasing Payments to Primary Care Providers. Avalere. Available at: http://avalere.com/expertise/managed-care/insightsproposed-medicare-part-b-rule-would-reduce-payments-to-hospitals-and-some-s.