Finance and Reimbursement Trends in Oncology

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Objectives – Quality, not Quantity Care

- Value Based Purchasing
  - Where is the best site of service
- Reimbursement regulations
  - Bundled Payments
  - Changing reimbursement away from fee for service
- Mergers and Acquisitions
  - Accountable Care Organizations
  - Integration
  - 340B

Now What? Or So What?

- How can the pharmacy manager position themselves with administration?
  - New high cost drugs
  - Expanded uses of high cost drugs
  - Increasing drug budgets and financial pressure
  - Complicated Medicare changes are hard to stay abreast of
  - Is there an answer to administration’s expense reduction scenario?

The Vision

- Interdisciplinary teams delivering safe, effective, and timely care that is culturally and linguistically appropriate within and across settings
- Aligning
  - Clinical care (individuals)
  - Public health (populations)
  - Health policy (payment and organization of services)
CMS Value-Based Purchasing

- A Medicare P4P program mandated by the Affordable Care Act (ACA) of 2010
- Links hospital incentive payment to quality scores calculated from two defined data periods
- Budget neutral program funded by across-the-board reductions to IPPS payments
- Reductions start at 1.0% in FY2013, the first year of the program, and increase 0.25% per fiscal year to 2.0% in FY2018

Quality-Based Payment Initiatives

- The VBP program is one of multiple reforms that are dramatically changing how Medicare pays hospitals. Others include:
  - Payment adjustments based on Inpatient Quality Reporting program
  - Payment adjustments based on readmissions
  - Payment adjustments based on Hospital Acquired Conditions (HACs)
  - Payment incentives for implementing electronic health records (Meaningful Use)

Cross Continuum Care Plan: Reducing ED Frequent Users and Preventable Readmissions

- Accountable Care contracts have grown over time; average ACO has 1.4 contracts, commercial leads pack

Currently there are over 1000 ACOs covering ~33 mm Americans
Evolution of Value Based Programs

Accountable Care Objectives
- Create efficient teams of hospitals, primary care physicians and specialists
- Reduce or eliminate duplication of services and fragmented care
- Reduce costs – Shared savings
- Improve quality and outcomes
- Bundle payments for total patient care – Financial integration

Some Elements of Care Common to Most of the Transitions Models
- Medication Management
- Assessing Patient’s Understanding/Ability to Follow Care Plan
- Discharge Support
- Coaching for Primary Care Physician Visit
- Use of Home Visits Screening for cognitive ability
- Use of Centralized Health Record
- Involving Family and other Caregivers
- Arranging Community-Based Support Services

Barriers to Effective Care Transitions
- Lack of integrated care systems
- Lack of longitudinal responsibility
- Lack of standardized forms and processes
- Incompatible information systems
- Lack of care coordination and team-based training
- Lack of established community links

The Accountable Care Transition (or one foot in each of two canoes)

1. Place canoes side by side in the water.
2. Place one foot in each canoe.
3. Do not tip over or fall into the water.
Deductibles Account for less than 30% of cost-sharing payments in 2006, but almost half in 2016.

Source: Data from the Commonwealth Health Insurance Commercial Insurers Annual Report.

Pharmacy was Leading Driver of Mass. Total Healthcare Expense in 2016.

Source: 2017 Massachusetts CMS report.

Specialty Pharmacy Spending is Largely Driven by Price.

Bundled Payments
- CMS seeking participation in bundled payment
- Single payment for a diagnosis to all providers
- Voluntary program
- Begins the journey to full Accountable Care
- Commercial insurers are participating and developing bundled payments

So What is the Answer for the Oncology Program?
- What is the best, cost effective site of care?
- Need to look beyond the expense line of pharmaceuticals
- Need to look at Revenue
- Hospital needs to separate Inpatient and Outpatient expenses
- Understand reimbursement differences
- Oncology is an outpatient program

History of Pharmacy at the APC Panel
- ACCC Pharmacist testifies to APC Panel at CMS
- Practical testimony based on actual experience
- Believable example
- Build a coalition of stakeholders
Who Are We?

- A group of individuals working together to improve drug reimbursement under OPPS. We loosely call ourselves “The Pharmacy Stakeholder Group” and now have 37 members.

Presenters include:

- Ernest R. Anderson, Jr., M.S., R. Ph., System Vice President of Pharmacy, Steward Health Care System, and Immediate Past President, Association of Community Cancer Centers (ACCC)
- Justine Coffey, Director, Federal Regulatory Affairs, American Society of Health-System Pharmacists (ASHP)
- Stuart Yael Gordon, Director, Legal and Regulatory Affairs, Safety Net Hospitals for Pharmaceutical Access (SNHPA)
- Jay Greissing, Director, Federal Affairs, Plasma Protein Therapeutics Association (PPTA)
- Jugna Shah, MPH, Consultant, Alliance of Dedicated Cancer Centers
- Laurel Todd, Director, Reimbursement and Economic Policy, Biotechnology Industry Organization (BIO)

Medicare Reimbursement Structure

- Transitional pass-through drugs
  - Orphan drugs
  - Brachytherapy
  - Current radiopharmaceuticals
  - Current cancer drugs/biologicals
- New drugs/oct/other drugs
- Cancer therapy drugs and supportive care drugs paid at 95% of AWP for >2 but <3 years
- After the end of this time, products will either be assigned an APC based on cost or included in another APC

- Budget neutral – pass through not >2.5%
- 4/02 many devices incorporated into APC
- 4/02 drugs reduced by an average of 19%
- 1/03 drugs reduced to 50-60% AWP or incorporated into procedural APC
- 1/04 drugs increase to 88% of AWP
- 1/05 drugs @ 83% of AWP
- 1/06,07 drugs @ ASP +6%, 1/08 drugs @ ASP +5%
- 1/09–1/12 drugs @ ASP +4%
- 1/13–1/18 drugs @ ASP +6%
- 1/13 Sequestration of 2% = ASP + 4.3%
- 1/18–340B ASP (–) 22.5%

Basic CMS Rate-Setting Methodology

- Numerous analyses show that CMS’s current methodology for estimating total costs produces drug payment rates that do not represent hospital acquisition cost and pharmacy services and handling costs
- CMS acknowledges that it does not have ASP data specific to sales to hospitals, and it is not sufficient to cover hospital costs
- Neither the GAO nor CMS have conducted surveys of hospital acquisition cost since 2004, so payment at ASP + 6% complies with the statute and establishes parity for drug acquisition across sites of service
- CMS’s rate-setting methodology includes charges from 340B hospitals but are excluded in the ASP calculation
Key Points: Pharmacy Services and Handling

- CMS’s methodology does not reimburse hospitals sufficiently for the significant costs of safely preparing drugs for administration.
- Analyses have revealed that the costs of pharmacy services and handling are at least 25%, and could be as much as 33%, of the department’s costs.
- CMS’s proposed pharmacy overhead pool is equal to only 12.7% of the costs associated with packaged and separately-payable drugs – far less than the 25% estimated to be attributed to pharmacy services and handling.
- CMS’s analysis does not include the substantial number of drugs that do not have HCPCS codes or ASPs, yet have significant pharmacy service and handling costs.

Follow the Money
The ABC’s of Reimbursement

- Inpatient Pharmacy
  - Since 1983 Medicare DRG system which predetermines reimbursement by Diagnosis including drugs
  - Other payers are often reimbursing on per diem rate
  - Incentive – Reduce expenses

- Outpatient Pharmacy
  - Track expense, revenue and profit margin on injectable drugs with Medicare APC’s and discounted fee for service or fee schedules from other payers

<table>
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<tr>
<th>Code</th>
<th>Trade name for drug</th>
<th>Generic name for drug</th>
<th>HCPCS Code</th>
<th>Billing code</th>
<th>Positions</th>
<th>Dose</th>
<th>SI</th>
<th>Charge</th>
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<th>Estimated Net Revenue</th>
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Pharmacy Presence with C-Suite

- Understanding the context
  - Accountable Care Organization
  - Managed Care Contracts
  - Healthcare Reform Implications
  - Alignment of incentives
  - Pharmacy’s contribution
  - Selling pharmacy to the C-Suite
    - Corporately
    - Locally
  - Positioning Pharmacy for growth
    - New Revenue opportunities

Pharmacy Presence with Oncology

- Understanding the context
  - Role of pharmacists clinically in patient care
  - Role of pharmacists with internal Specialty Pharmacy Programs
  - Role of pharmacists with PA process
  - Role of pharmacists with revenue cycle
  - Pharmacy’s contribution to revenue
  - Pharmacy’s knowledge of drug profitability (or not)
  - Pharmacy’s education of Managed Care department related to contracting
Sphere of Influence for Pharmacy

- Know your Corporate audience
- Understand incentives from their perspective
  - CMO
  - COO
  - CFO
  - CIO
  - CEO
  - Oncology leadership
  - Community leadership
- Know your individual hospital audience
- Understand incentives from their perspective
  - VPMA’s
  - Presidents
  - COO’s
  - CFO’s
  - Pharmacy Directors
  - Pharmacy Clinical Coordinators
  - Information Technology implementation team

Oncology Care Model

- Tenets of the model to bend the cost curve
  - Provide the right care at the right time
    - Genetic indicators
  - Reduce over-treatment and under-treatment
  - Reduce hospital admissions and re-admissions
  - Appropriate specialist utilization

OPPS in 2018

- Separately payable drugs reimbursed at ASP +6% - sequestration = ASP +4.3% SI = G or K
- New drugs paid at WAC+6% before ASP is available
- Packaged drugs less than $120/day are bundled – SI = N
- 340B covered entity drugs are reimbursed at ASP - 22.5%
- Biosimilar products have separate code for each biosimilar product and are eligible for pass-through status
- Note: Always bill drugs with SI of G, K, N regardless of payment

Proposed OPPS in 2019

- Separately payable drugs reimbursed at ASP +6% - sequestration = ASP +4.3% SI = G or K
- New drugs paid at WAC+3% before ASP is available
- Packaged drugs less than $125/day are bundled – SI = N
- 340B covered entity drugs are reimbursed at ASP - 22.5%
  - Expand rate to off campus Provider Based Departments of ASP - 22.5% (To prevent patient shifting)
- Biosimilar products have separate code for each biosimilar product and are eligible for pass-through status
- Consolidation of Administration E & M codes 2-5
- Note: Always bill drugs with SI of G, K, N regardless of payment

340 Change Impact

- 1,300 hospitals with 340B status state cuts will harm access to care for low-income and rural patients
- Congress only looks at drugs and not purpose of the program to alleviate uncompensated care
- PhRMA companies are mandated to provide drugs at discounts
- Congress is looking to further limit the 340B program
- AHA continues to fight
- ASHP continues to provide testimony
- Health-systems are now feeling the impact

Items to Watch

- HHS Blueprint to Lower Drugs Prices and Reduce out of pocket costs
  - CAP Program (was not successful in the past)
  - Multiple concerns that hinder patient care
  - Potentially move drugs from part B to part D
  - Limit access to drugs
- Further changes in the 340B program
- Changes in traditional supply chain
  - Address drugs shortages
  - Provide new incentives for competition
- M&A of insurers and PBMs
Value: keep care in right place, at right time, at right cost

- Academic / Tertiary / Quaternary
- Community Hospital
- Physician office / Clinic
- Home

There is a 20%–25% drop in cost as you move care from high cost to low cost settings.

Summary

- Keep abreast of changes through your society involvement and advocacy
- Follow policy changes from CMS and local insurers
- Understand the details of drug reimbursement and educate others in your practice
- Position pharmacy as a solution and not a problem
- Always follow the money

Conclusions

- It’s been my pleasure
- Any other questions?

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Thanks for your attention!