



## MedPAC Explores Fixes To Part B Drug Payment Policy, Calls Current System 'Perverse Incentive'

Posted: November 12, 2014

Congressional Medicare advisers are looking at policy alternatives to CMS' current payment model for Part B drugs -- those medications administered in doctors' offices such as oncology drugs -- that the Medicare Payment Advisory Commission (MedPAC) chair called troubling because the model incentivizes physicians to opt for more expensive drugs. At their recent meeting MedPAC commissioners looked at consolidating payment codes for Part B drugs, paying a flat fee to physicians for managing Part B medications and bundling options based on a recent pilot done by UnitedHealthcare in its private insurance plans in lieu of CMS' current average sales price plus 6 percent policy.

Under the current ASP plus 6 percent approach, if the average sales price of a Part D drug is \$100 a physician would get \$106 from Medicare, regardless of the price the physician actually pays for the medication. In situations where there are two drugs that have a similar health effect for a given condition, MedPAC analysts explained Friday (Nov. 7), doctors will make more money from Medicare by administering the more expensive product. Given the choice between two alternatives -- one drug with an ASP of \$100 and one with an ASP of \$200 -- many providers will choose the latter because they would be paid an add on of \$12 for the more expensive drug as opposed to \$6 for the lesser-priced medication, MedPAC staff said.

MedPAC commissioners agreed that this payment policy creates a “perverse incentive” for providers to use more expensive medications rather than trying to control costs.

“In terms of incentives created by the payment policy I think we're depending a lot on the professionalism of our physicians,” MedPAC chair Glenn Hackbarth said.

Commissioner Rita Redberg, of the University of California San Francisco School of Medicine, agreed and said while many providers try to “do the right thing,” they are still human and under a fee-for-service system that rewards high volume are prone to try to make the most money they can.

**The commission first looked at tweaking current policy to a consolidated payment model in which CMS would take the average weighted cost of two drugs that give similar outcomes plus 6 percent and**

pay based on that formula. That means in the previous scenario detailed by staff the average price of the two drugs would be \$150 and providers would be paid \$159 regardless of which medicine they chose.

But many commissioners were lukewarm to the idea of the consolidation model. Commissioner Jay Crosson, of the American Medical Association, pointed out that this means a physician could make \$59 if he or she chose the lower-priced drug, but would lose \$41 in choosing the higher-priced medication.

“That seems to be a pretty draconian design for changing incentives,” Crosson said.

Commissioner Katherine Baicker, of the Harvard School of Public Health, worried that under this system patients would not be able to pay out of pocket if they wanted the more expensive drug, or, if they were allowed to pick up the cost difference themselves, lower income beneficiaries wouldn't be able to afford it.

**This led commissioners to suggest that rather than consolidating prices MedPAC should offer providers a flat fee** for Part B medication management. They said such an approach should be designed in a way to incentivize physicians to control costs, which in turn might also incentivize drug manufacturers to lower the cost of drugs based on market competition -- especially as more follow-up biologics come on line.

Commission staff said they would research bringing up the flat fee medication management option for further discussion at a future meeting.

**MedPAC commissioners also looked at bundling payments for Part B drugs**, and were intrigued by a pilot done by UnitedHealthcare in its private plans that saw savings of \$33 million dollars for cancer treatments, of which providers got \$11 million in shared savings.

In the UnitedHealthcare model, the insurer bundled payments for oncology drugs where the medications were paid for at the ASP plus 0 percent and included a flat per-episode fee instead of the drug add-on. Under this model, MedPAC staff said, drug usage actually increased, but hospital admissions went down while survivability rates remained stable.

Commissioners were unconcerned about drug usage going up in the UnitedHealthcare model, because ultimately the quality of care wasn't negatively affected and savings were achieved. They wondered how a similar bundling system could be applied in Medicare Part B.

Commissioner Craig Samitt suggested that the UnitedHealthcare model could be tried through accountable care organizations (ACOs).

Hackbarth responded that there is an inherent limitation in the ACO model: ACOs would need to bring oncologists on board with the program and then if cost savings were achieved they would have to go back and ask the oncologists for their share of the savings.

This led to commissioners suggesting that perhaps an oncology-specific ACO demo could be set up that mirrored the dialysis ACO demo that CMS is running.

MedPAC staff said it would further research how a UnitedHealthcare-style bundling program could be applied to Medicare Part B.

**A small number of commissioners voiced support for allowing CMS to return to the controversial “least costly alternative” model** it used from 2005 to 2010 that [MedPAC discussed at its September meeting](#), although this wasn't the focus of Friday's discussion.

In response to MedPAC's meeting, patient advocacy group Partnership to Improve Patient Care (PIPC) said it was concerned that reauthorizing CMS to use the least costly alternative model was still on the table.

Other commissioners said they felt the least costly alternative model would not work well for oncology, because many patients respond differently to various cancer treatments and doctors often combine drugs and therapies to find what works best for a given individual.

“As the Commission moves forward in their deliberations to improve outcomes and reduce costs in the Medicare program, PIPC hopes that MedPAC will pursue policies that activate patients and lead to long-term health improvements, rather than focusing on those that could threaten to jeopardize the nature of the doctor-patient relationship,” said PIPC chairman Tony Coelho

**Hackbarth stressed that the discussion was part of a wider-ranging effort to overhaul Part B payment policy.** Ideas explored were by no means an exhaustive array of options, he said, and initial policy recommendations could take many forms as part of a multi-track approach.

“There's a much larger universe of potential options that goes way beyond what we've talked about here,” Hackbarth said. “What I'm wrestling with is how do we get traction.”