



# Trends in Oncology Care Institute of Medicine National Cancer Policy Forum Workshop

Marc Hartstein

Director, Hospital and Ambulatory Policy Group

June 9, 2014

# Statutory Background: Benefit Category

- In order for Medicare to pay for any item or service, it must have a benefit category in the Medicare statute. Examples of benefit categories for items and services provided by Medical Oncologists:
  - 1861(s)(1) of the Social Security Act (the Act): “Physicians’ services”
  - 1861(s)(2)(A) of the Act: “services and supplies (including drugs and biologicals which are not usually self-administered by the patient) furnished as an incident to a physician’s professional service, of kinds which are commonly furnished in physicians’ offices ”
  - 1861(s)(2)(B) of the Act: “hospital services (including drugs and biologicals which are not usually self-administered by the patient) incident to physicians’ services rendered to outpatients”

# Common Items and Services Provided by Oncologists

- Medical Visits:
  - Benefit Category: 1861(s)(1) Physician Services
  - Payment Methodology: Physician Fee Schedule
- Drug Administration Under the Direct Supervision of Oncologists:
  - Benefit Category: 1861(s)(2)(A) or (B)
  - Payment Methodology: Physician Fee Schedule (1861(s)(2)(A)) or outpatient prospective payment system (OPPS, 1861(s)(2)(B))
- Chemotherapy Drugs:
  - Benefit Category: 1861(s)(2)(A) or (B)
  - Payment Methodology: 106% of Average Sales Price (ASP) in physician office. 106% of ASP if paid separately in the outpatient department

# Payment History – Physician Offices

- Physician Services and Drug Administration:
  - Prior to 1992: “Reasonable Charge”
  - 1992 until present: Physician fee schedule
- “Incident to” Drugs:
  - Prior to 1997: Lower of estimated acquisition costs or average wholesale price (median of generic and brand name for multi-source drugs)
  - 1997 to 2003: 95% of average wholesale price (or AWP for single source drugs) or lower of 95% of AWP or lowest brand name drug (multi-source drugs)
  - 2004: 85% of AWP
  - 2005: 106% of ASP

# Payment Trends in Physician Offices

- MedPAC, 2003:
  - Spending went from \$400 million to \$7 billion from 1992 – 1999, up another \$1 billion in 2000 and up 26% (\$1.5 billion) from 2001 to 2002
  - Attributes growth to “increased volume of drugs used and the substitution of newer and more expensive medications for older therapies”
  - “A series of studies by the General Accounting Office and Office of Inspector General showed that the current Medicare payment method leads to payments that far exceed providers’ costs”
  - Hematology Oncology, Medical Oncology and Urology received 58% of payment for Part B drugs

# Medicare Modernization Act

- Oncologists agreed that drugs were overpaid but argued that administration was underpaid
- Drugs: Changed payment to 85% of AWP for 2004 and 106% of ASP beginning in 2005
- Drug Administration: Increased payment for drug administration services beginning in 2004
  - Therapeutic Injection: \$3.98 in 2002 to \$18.57 in 2005
  - 1<sup>st</sup> Hour of Chemotherapy Administration: \$55.75 in 2002 to \$172.43 in 2005

# Payment History – Hospital Outpatient Departments

- Drug Administration:
  - Prior to 2000: “Reasonable Cost”
  - 2000 until present: OPPS
- Incident to Drugs:
  - Prior to 2000: Reasonable Cost
  - 2001 to present: Packaged unless estimated per day cost exceeds threshold (\$90 in 2014)
    - ❖ 2001 to 2012: Average of estimated costs for all separately paid drugs expressed as an ASP equivalent for separately paid drugs
    - ❖ 2013 to present: 106% of ASP

# Payment History – Physician Fee Schedule

- Medicare payment in 2010 changed due to Physician Practice Expense Information Survey (PPIS)
  - 1<sup>st</sup> Hour of Chemotherapy Administration: \$161.49 in 2009 to \$147.51 in 2010
  - PPIS was highly redistributive: Largest reductions to cardiology (10%), oncology (5%), nuclear medicine (15%), interventional radiology (9%), radiology (14%)
- Possible that adoption of PPIS accelerated hospital purchasing of physician practices
  - MedPAC, 2014: Echocardiograms declined 9.9% in physician offices and increased 33.3% in OPDs from 2010 to 2012

# Physician/Outpatient Hospital Payment

- Physician Offices:
  - Physician fee schedule at the higher non-facility rate
  - Receive no payment for facility services
  - Beneficiary Coinsurance – 20% of the physician fee schedule amount
- Hospital Outpatient Departments:
  - Physician fee schedule at the lower facility rate
  - Hospital receives OPPS payment for facility services
  - Beneficiary coinsurance – 20% of the physician fee schedule amount and 20% (or potentially higher) of the OPPS payment amount for facility services

# When a Hospital Purchases a Physician Practice

- The Provider-Based Rules:
  - An off-campus “provider-based department” of a hospital can be up to 35 miles from the hospital’s main campus
  - A provider-based department may, but is not required to, attest that it meets the provider-based rules. If found out of compliance:
    - ❖ An attestation limits recoupment (difference between provider-based and office payments) retroactive to the date of attestation
    - ❖ No attestation means hospital is liable to for recoupment retroactive to first becoming provider-based
- MedPAC, 2014: “Rapid growth of hospital purchases physician practices” citing AHA data that hospital employed physicians grew 55% from 2003 to 2011.
- 340B Drug Purchasing Program: Reduced pricing on outpatient drugs to covered entities, including many acute hospitals and cancer hospitals

# Policy Solutions?

---

- MedPAC:
  - Pay evaluation and management services in hospitals (on or off-campus OPDs) at physician fee schedule rates
  - Pay other services meeting specific criteria (generally those routinely performed in physician offices with comparable patient severity that are not emergency services, not global surgery and minimal OPPS packaging) at physician fee schedule rates both on and off-campus
- CMS:
  - Off campus OPD services more comparable to physician services; CMS cannot distinguish among off and on-campus services in the Medicare claims data
  - Discussed collecting data on Medicare claims to identify services provided in off-campus OPDs to inform potential policy changes

# Thank You and Questions