# Buy and Bill Drugs 101

Module 2: Health Plan Perspective

**PUBLISHED BY**

Health Care Industry Committee

# Health Care Industry Committee


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# Overview of health plans

Health plans are under increasing pressure to manage costs so that they can keep insurance premiums affordable and stay competitive in both the employer and individual markets. Buy and bill drug spend is a major concern as it represents one of the fastest growing categories of medical benefit spending.

### Top health plan priorities

- Manage costs
- Keep insurance premiums affordable
- Connect patients with high quality care
- Stay competitive in employer and individual markets

**38%**

Approximate percentage increase in spending per member per month on injectable cancer drugs, 2008-2013, for UnitedHealthcare[1]

### Incorporating evidence into practice

**17 years**

Average amount of time it takes physicians to incorporate new evidence into their practice

To date, health plans have been reluctant to limit coverage of buy and bill drugs because patients who needs these drugs tend to be seriously ill, and there aren't necessarily lower cost treatment options available. That said, multiple studies have found that cancer patients often receive treatments that are not evidence-based, and health plans understandably don't want to pay for low quality or sub-optimal care.

Health plans want assurances that their beneficiaries are receiving evidence-based care, and when appropriate, they are receiving the lower cost treatment option. To that end, health plans are experimenting with three different strategies.

### Common health plan strategies for managing buy and bill drugs

1. Put controls in place to manage utilization of high-cost drugs, often through prior authorizations (PAs) or clinical pathways
2. Remove physicians' financial incentive to prescribe higher-cost drugs through a practice called "white bagging" or through value-based payment models
3. Institute site of care management policies that direct patients to the lowest cost site of care appropriate for their treatment

Source: UnitedHealth Center for Health Reform & Modernization, "The Growth of Specialty Pharmacy," 2014, available at: https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2014/UNH-The-Growth-Of-Specialty-Pharmacy.pdf; Oncology Roundtable, "Reduced Unwarranted Care Variation in Oncology," 2018, available at: https://www.advisory.com/research/oncology-roundtable/studies/2018/reduce-unwarranted-care-variation-in-oncology; ZS Morris, S Wooding, and J Grant, "The answer is 17 years, what is the question: understanding time lags in translational research," *Journal of the Royal Society of Medicine* 2011, available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3241518/; Advisory Board research and analysis.

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# Prior authorizations

Prior authorizations (PAs) require providers to submit documentation to the health plan to get approval for an individual patient's treatment. Importantly PAs do not guarantee that the health plan will reimburse the provider for the treatment, but failure to secure a PA may be a reason for the plan to deny a claim.

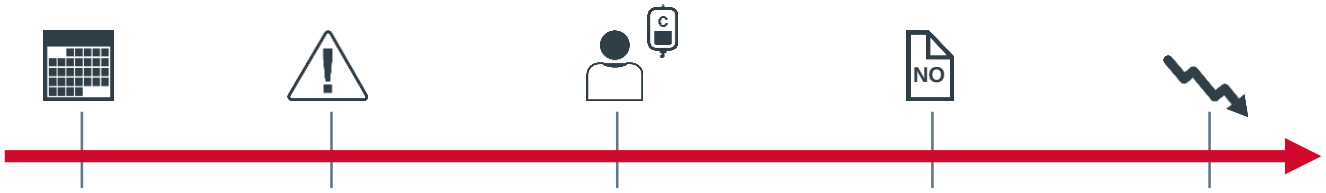
**Payers' top five criteria for approving prior authorization requests**

Appropriate indication | Appropriate dose | Applicable labs and results | Appropriate duration | Previous therapies used

Most often the provider organization's nursing or clerical staff prepare the PA request and submit it to the health plan via fax or an online portal. Often the prescriber will have to help prepare the documentation.

Providers are supposed to submit PA requests before administering the patient's treatment. In certain cases, health plans may be willing to grant PAs retrospectively (i.e. after the treatment was administered), but that practice is becoming less common.

**Steps leading to drug administration without a PA and the resulting financial consequences**




Patient scheduled prior to PA | Staff does not check for PA before dispensing drug | Patient gets infusion without a PA | Claim denied because drug was dispensed without a PA | Infusion center loses revenue

Traditionally, health plans have focused PAs for drug therapy on high-cost drugs. But as drug prices have risen, health plans have increased the number of drugs (including buy and bill drugs) requiring PAs as well as the amount of information that providers must submit to secure a PA. For example, plans may require providers to report lab values or documentation that another drug was tried and failed.[1]

These requirements not only increase administrative work for providers, they also increase the health plan's administrative costs. To that end, some plans are investing in claims data mining tools to reduce the burden on provider organizations and streamline the review process.

Source: Advisory Board, "Stop losing drug revenue to prior authorization denials," available at: https://www.advisory.com/research/care-transformation-center/care-transformation-center-blog/2017/12/losing-drug-revenue; Oncology Roundtable, "Prior Authorizations for Physician-Administered Drugs," 2017, available at: https://www.advisory.com/research/oncology-roundtable/studies/2017/prior-authorization-for-physician-administered-drugs; Advisory Board research and analysis.

1) See "step therapy" in the glossary for more information.

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# Clinical pathways

The term “clinical pathways” is used inconsistently, but for the purposes of this paper, it refers to a set of narrowly defined treatment algorithms that are designed to increase adherence to evidence-based standards and reduce costs. Unlike clinical guidelines, which may recommend two or more treatment protocols for any one diagnosis, clinical pathways narrow the options to the one optimal treatment regimen based on patient outcomes. If there are multiple treatment regimens that yield equivalent outcomes, then pathways favor the least expensive option.

## Benefits of clinical pathways

**Ensures Adherence to Guidelines**

Pathways built on guidelines, therefore adherence establishes baseline for care quality

**Accounts for Cost**

Pathways developed through an evaluation of guidelines to determine which regimen is most effective, least toxic, and – all else equal – least costly for a particular diagnosis

**Reduces Care Variation**

Target compliance rate ensures majority of patients receive care on optimal pathway

**Enables Comparative Outcomes Assessment**

Allows benchmarking of outcomes over time to identify optimal pathway

Clinical pathways may be developed by a health plan, provider organization, or a third-party vendor. Most often they are paired with decision support tools, documentation systems, and financial incentives to encourage providers to treat patients “on pathway.” In some cases, health plans may require providers to demonstrate that their treatment plan is “on pathway” to secure a prior authorization before administering a buy and bill drug. In other cases, health plans may set a target for pathway compliance with providers and review performance retroactively. For example, providers may be required to treat 70% of their patients “on pathway” in order to receive a bonus payment.

CASE EXAMPLE

### Anthem’s Cancer Care Quality Program

- Anthem worked with benefits manager AIM Specialty Health to develop clinical pathways for medical oncologic treatment of 14 tumor sites
- Program applies to cancer patients with Anthem coverage
- Fee-for-service payments plus $350 PMPM[1] payment for patients whose treatment regimens are pathway-concordant
- No penalty for treatment plans that are not pathway-concordant
- PMPM payments initiated when provider enters treatment plan into AIM Specialty Health CDS portal and bills PMPM S-code
- Provider must bill one PMPM S-code per month to receive PMPM payments
- PMPM payments last duration of active treatment
- Anthem predicts savings of 3-4% of current oncology costs

**$350**

Additional PMPM[1] payment for each patient treated on pathway

Source: Oncology Roundtable, “A Primer on Clinical Pathways for Cancer Care,” 2013, available at: https://www.advisory.com/research/oncology-roundtable/events/webconferences/2013/a-primer-on-clinical-pathways-for-cancer-care; Anthem Insurance Companies, Inc., Minneapolis, MN; Oncology Roundtable interviews and analysis; Advisory Board research and analysis.

1) Per member per month.

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# “White bagging”

White bagging[1] refers to health plans’ practice of shifting buy and bill drugs from the medical to the pharmacy benefit. So instead of reimbursing the provider for the drug, the health plan purchases the drug through a specialty pharmacy, which delivers the drug to the providers’ office or infusion center for administration to the patient. The provider is still reimbursed for administering the drug but is cut out of the drug revenue stream.

**Two types of physician buy and bill drug reimbursement**

1. Payment for drug (ASP + X%)
2. Reimbursement for drug administration and clinical care

**Prevalence of “white bagging” by share of volume, 2014**

| 14% | 15% | 12% |
|---|---|---|
| Community-based oncology practices | Hospital-based oncology practices | Academic medical center-based oncology practices |

White bagging has two potential advantages. First, health plans can potentially negotiate lower reimbursement rates with a specialty pharmacy than with providers. Second, when drugs are reimbursed under the pharmacy benefit, the health plan receives more details about the patient’s treatment than when the drug is billed under the medical benefit.[2] Accumulating this data over time can potentially help health plans improve coverage policies, benefits management, and care management.

White bagging also has potential drawbacks for health plans. First, for example, physicians or hospitals may be able to purchase drugs at lower prices due to class of trade pricing. Second, depending on the plan’s cost sharing structure, patients’ out-of-pocket expenses may be higher when the drug shifts to the pharmacy benefit. Higher out-of-pocket costs mean reduced medication adherence, eventually leading to higher costs for health plans. Third, and perhaps most importantly, white bagging removes an important source of income for private practice physicians, and so may encourage more to sell their practices to hospitals. Hospitals can in turn negotiate higher reimbursement rates due to their larger size.

## Advantages and disadvantages of “white bagging” for health plans

### Advantages

- Potentially lower reimbursement rates
- More details regarding patient treatment
- More data can lead to improved coverage policies and care management

### Disadvantages

- Potentially higher patient out-of-pocket costs
- Remove income source for private practice physicians

1) See “brown bagging” in the glossary for more information on variations on this practice.
2) Pharmacy claims use national drug codes or NDCs which indicate the manufacturer, distributor, strength, dose, formulation, and package size of the medication. In contrast, medical claims use j-codes which indicate just the drug and vial or package size.

Source: Peter Wehrwein, “Should Specialty Drugs Be Shifted from Medical to Pharmacy Benefit?,” Managed Care, 2015, available at: https://www.managedcaremag.com/archives/2015/1/should-specialty-drugs-be-shifted-medical-pharmacy-benefit; Drug Channels, “How Specialty Pharmacy Is Penetrating Buy-and-Bill Oncology Channels,” 2016, available at: https://www.drugchannels.net/2016/07/how-specialty-pharmacy-is-penetrating.html; Advisory Board research and analysis.

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# Value-based payment

To date, most value-based payment programs involving buy and bill drugs have focused on oncology. Health plan leaders believe that cancer care is a good target because of the opportunity to encourage providers to select lower cost drugs and to provide better care management to patients, thus avoiding costly complications.

While there are various types of oncology value-based payment programs, all of them remove the financial incentive for physicians to prescribe higher-cost drugs. The most common mechanisms are bundled payments or shared savings models. Sometimes these payment models focus just on medical oncology. In other cases, they incorporate all aspects of cancer care.

**FOR MORE RESOURCES**

To explore bundled payments, shared savings models, and other payment innovations, see our C-Suite Cheat Sheets at https://www.advisory.com/research/health-care-industry-committee/members/resources/cheat-sheets/cheat-sheet-series

To date, the results of these oncology value-based payment models have been inconclusive. Most involve relatively small groups of providers and patients. The providers that volunteer to participate tend to be very progressive and so not necessarily representative of the larger provider community. Moreover the administration of the payment programs is often burdensome to both providers and health plans, and so the programs are often discontinued or modified after the initial trial period.

When developing value-based payment models, health plans most often work with private practice physicians. They find that physician groups tend to be more nimble and entrepreneurial, and so easier to work with than IDNs. At the same time, both physicians and health plans are eager to find a new payment methodology that rewards physicians for delivering higher-value and stabilizes practice finances. In turn, this new methodology would enable private practices to maintain their independence from hospitals and IDNs.

## UnitedHealthcare's episode-based payment pilot

CASE EXAMPLE

### UnitedHealthcare[1]

- Pilot conducted from October 2009 through December 2012
- Five independent oncology practices participated
- Enrolled 1,024 patients; 810 patients' data used for cost analysis
- Pilot included breast, lung, and colon cancer patients with one of 19 clinical conditions
- United collaborated with practices to develop over 60 quality measures
- Practices met twice to compare and discuss performance data

These results have not been replicated

**34%**
Reduction in cancer care costs

**179%**
*Increase* in spend on chemotherapy drugs

**Drugs reimbursed at ASP**

- Removes incentive to prescribe high cost drugs
- Each medical group selected a single chemotherapy regimen for each adjuvant therapy episode
- There was no standardization of regimens for metastatic disease

**Episode payment**

- Replaces drug margin and FFS[2] payments for physician hospital care, hospice management, case management
- Adjuvant episodes defined as length of therapy plus two months
- Metastatic episode defined as 4 months

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2) Fee for service.

Source: Oncology Roundtable, "What can we learn from United's medical oncology episode-based payment pilot?", 2014, available at: https://www.advisory.com/research/oncology-roundtable/oncology-rounds/2014/07/what-can-we-learn-from-uniteds-medical-oncology-episode-based-payment-pilot; Advisory Board research and analysis.

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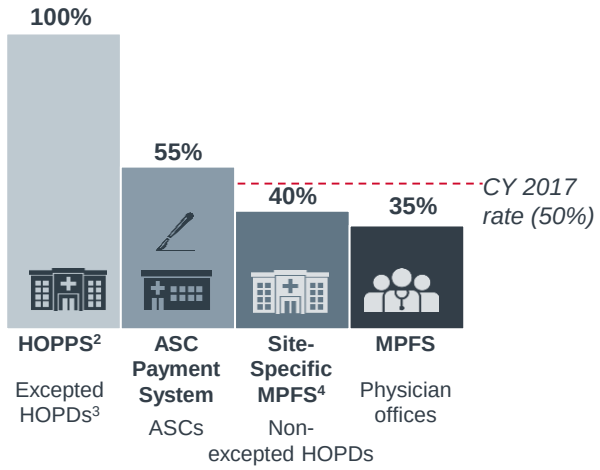
# Site of care management

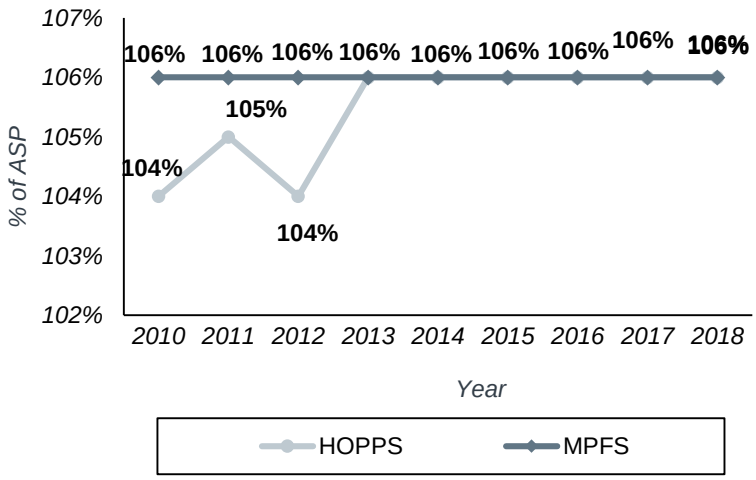
Health plans routinely pay different reimbursement rates for the same health care services delivered at different sites of care. For example, Medicare pays $641 for an echocardiogram in the physician office and $2,198 for the same test when it is provided in a hospital outpatient department (HOPD). Although Medicare reimburses both physician offices and HOPDs for Part B drugs at the same rate, it does pay HOPDs slightly higher reimbursement rates for drug administration.

In recognition of this site of care differential, many health plans are trying to lower their costs by shifting patients from the HOPD setting to a physician office or even home infusion services whenever possible. These "site of care management" policies can take many forms.

**Relative outpatient payment rates in CY 2018[1]**

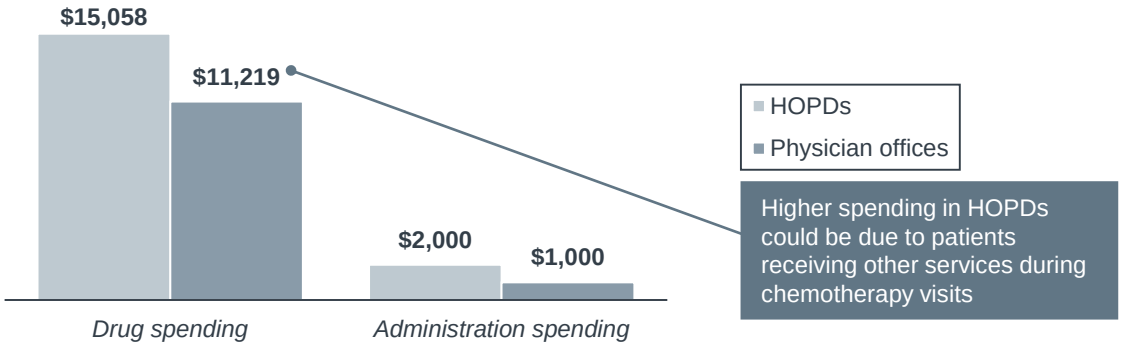



**Medicare reimbursement for separately payable drugs**




Some health plans mail letters to their beneficiaries explaining the difference in cost to the plan and the patient's out of pocket costs, and encourage patients to seek treatment at a lower cost site. Other plans refuse to reimburse for certain treatments in the HOPD setting. Often they begin by targeting lower acuity patients, such as those with rheumatoid arthritis, and lower toxicity treatments, such as IVIG.

**Chemotherapy drug and administration spending per Medicare beneficiary, 2010-2013**




Commercial payers tend to reimburse HOPDs at higher rates for both buy and bill drugs and drug administration. Hospital systems and IDNs are able to negotiate higher rates than private practice physicians due to their larger size and market share. They justify their higher rates because they provide unreimbursed care and other forms of community benefit and must meet more stringent regulatory requirements.

1) HOPPS and MPFS relativity determined by CMS, using 22 highest-volume off-campus HOPD HCPCS codes.
2) Hospital Outpatient Prospective Payment System.
3) Hospital Outpatient Department.
4) Medicare Physician Fee Schedule.

Source: CY 2018 Hospital Outpatient Prospective Payment System Final Rule, CMS; Oncology Roundtable, "2018 Medicare Reimbursement Changes for Oncology Programs," 2018, available at: https://www.advisory.com/research/health-care-industry-committee/members/events/webconferences/2018/navigating-the-2018-oncology-provider-landscape/2018-medicare-reimbursement-changes-for-oncology-programs/ondemand; Avalere Health, "Medicare Payment Differentials Across Outpatient Settings of Care," 2016, available at: http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/Payment-Differentials-Across-Settings.pdf; Y Kalidindi, J Jung, R Feldman, "Differences in Spending on Provider-Administered Chemotherapy by Site of Care in Medicare," *American Journal of Managed* Care 2018, available at: https://ajmc.s3.amazonaws.com/_media/_pdf/AJMC_07_2018_Kalidindi%20final.pdf; Advisory Board research and analysis.

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   Overview of buy and bill basics
2. **Health plan perspective**
   Health plans' top priorities and strategies for managing buy and bill drugs
3. **Physician practice perspective**
   Physician practices' top priorities and strategies for managing buy and bill drugs
4. **HOPD infusion center perspective**
   HOPD infusion centers' top priorities and strategies for managing buy and bill drugs
5. **Glossary**
   Buy and bill glossary of key terms

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