Buy and Bill Drugs 101

Module 3: Physician Practice Perspective

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Overview of private practice physicians

The physician specialists that most often prescribe buy and bill drugs include: oncologists, rheumatologists, gastroenterologists, neurologists, and ophthalmologists. For some of these physician specialists, a relatively small portion of their patients require buy and bill drugs, and so it may be more efficient for them to refer patients elsewhere for treatment. But others, especially oncologists and large gastroenterology practices, own and operate their own infusion centers, and as a result, a significant portion of practice revenues (and physician income) come from buy and bill drugs.

15%

Average percentage of oncology practice revenues that came from drugs[1] in 2014

Infusion centers are operationally complex, patients are often acutely ill and frail, and revenue cycle operations are challenging. Despite these challenges, many physician practices have developed considerable skill and expertise in managing infusion center operations because it is a major component of their businesses. Those practices that have struggled with financial and operational management have by and large chosen to leave the business by selling their practices or merging with larger physician networks.

Physician revenues from buy and bill drugs have declined precipitously since 2005

The Medicare Prescription Drug Improvement and Modernization Act changed the formula Medicare used to reimburse physicians for buy and bill drugs (known as “separately payable drugs” in Medicare terminology). Prior to 2005, Medicare reimbursed providers a percentage of AWP (average wholesale price). AWP was not defined by law or regulation and generally represented the manufacturer’s recommended price. Usually providers were able to negotiate significant discounts or rebates, and as a result, were able to earn a substantial margin on buy and bill drugs.

Starting in 2005, Medicare reimbursement changed from a percentage of AWP to ASP (average sales price) plus a fixed percentage mark up. Because ASP is calculated after the application of discounts and rebates, it was lower than AWP. According to one estimate, ASP was approximately 26% lower than AWP for brand drugs and 68% lower for generic drugs.

Following the change in Medicare reimbursement, commercial health plans took the opportunity to renegotiate their payments for buy and bill drugs, and many adopted the “ASP plus” methodology. As a result, many physicians saw their practice revenues - and incomes – decline after 2005.

Sequester cuts to Part B drugs added further margin pressure

Congress sets reimbursement for Part B drugs at ASP + 6%. However, in 2013, Congress imposed a 2% "sequestration" cut to all Medicare reimbursement rates. The cuts were intended to be temporary, but since then, Congress has extended them multiple times. The cuts are expected to continue for the foreseeable future.

According to one analysis, the sequester cut resulted in an average quarterly loss of

$67,243

per practice in the first quarter of 2016 and grew to

$124,902

per practice at the end of 2017.

1) Measured as average net drug revenue (from all drugs) as percentage of cost of goods paid for.

Source: C Balch, JD Ogle, JL Senese, “The National Practice Benchmark for Oncology: 2015 Report for 2014 Data,” 2015, *Journal of Oncology* Practice, available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5015450/; Brenda Langlais, “Drug Reimbursement Methods—A Moving Target,” 2015, available at: https://www.mediware.com/home-care/blog/drug-reimbursement-methods-a-moving-target/; L Gordan, C Schaedig, and S Weidner, “The Financial Impact of the Sequester Cut to Medicare Part B Drug Reimbursement in Community Oncology,” *Evidence-Based Oncology* 2018, available at: https://www.ajmc.com/contributor/coa/2018/08/the-financial-impact-of-the-sequester-cut-to-medicare-part-b-drug-reimbursement-in-community-oncology; Advisory Board research and analysis.

Physician practice financial management strategies

Sequester cuts to Part B drugs added further margin pressure

As margins on buy and bill drugs have declined, physician practices have had to develop more sophisticated financial management capabilities to ensure they remain profitable. The most common include:

1. Sending unprofitable patients to a hospital or another safety-net provider for treatment
2. Adopting clinical pathways to reduce reimbursement risk
3. Partnering with health plans to develop new payment models that reward value
4. Merging with other physician practices or selling to the hospital
5. Diversifying revenue streams, including investing in specialty pharmacy

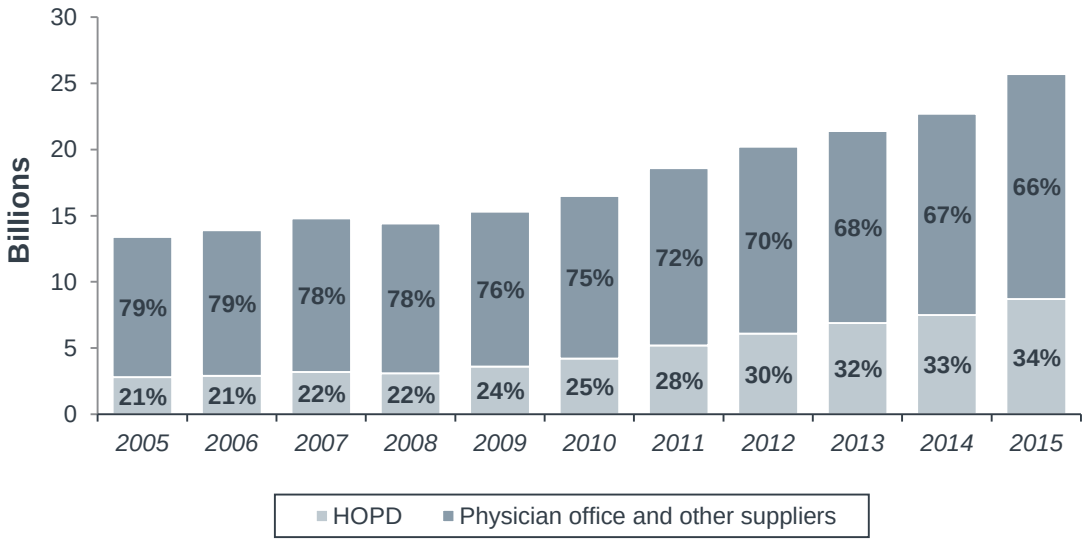
#1: Sending unprofitable patients to a hospital or another safety-net provider for treatment

In the past, when physician practices earned relatively generous margins on buy and bill drugs, many treated uninsured and underinsured patients. However as margins have shrunk, subsidizing uncompensated care has become more difficult. In response, many practices began referring uninsured and Medicaid patients to a hospital or safety-net provider for treatment. Over time, more practices have developed financial tools to help them calculate the profitability of individual patient's treatment regimens, taking into account their drug acquisition costs and the patient's health benefits. As a result, they are better able to sort profitable patients from unprofitable patients.

Multiple drivers of site of care shift

- Physicians sending unprofitable patients to the hospital
- Physicians selling their practices

Medicare Part B spending on outpatient drugs by site of care



Source: Adam Fein, "New Part B Buy-and-Bill Data: Physician Offices Are Losing To Hospital Outpatient Sites," *Drug Channels* 2017, available at: https://www.drugchannels.net/2017/08/new-part-b-buy-and-bill-data-physician.html; Advisory Board research and analysis.

Physician practice financial management strategies

#2: Adopting clinical pathways to reduce reimbursement risk

Private practices were early adopters of clinical pathways. They were eager to demonstrate their adherence to evidence-based guidelines and gain assurance that they would be reimbursed for the drugs they administered to patients. In addition, by standardizing their use of drugs, some practices may have been able to increase their purchase volumes and so secure lower prices.

42%

Percent increase in oncology practices using clinical pathways, 2014-2016

#3: Partnering with health plans to develop new payment models that reward value

Declining reimbursement has led many independent physician groups to conclude that fee for service (FFS) reimbursement will become financially unsustainable over time. To that end, many are eager to develop new value-based care reimbursement models that reward them for the value of care they provide, rather than the quantity or cost. Some have partnered with commercial health plans to test alternative payment models, such as ACOs and bundled payments.

For example, in Cigna's Collaborative Care for Oncology model, the payer and the providers work together to enhance overall patient care. Cigna provides resources such as patient databases and operational support, and, in turn, providers employ oncology care coordinators, integrate evidence-based guidelines for care, and report quality measures back to Cigna.

CASE EXAMPLE

Cigna Collaborative Care for Oncology

Both Payer and Providers Commit Resources to Enhance Patient Care

Cigna

- Financial incentives (i.e. patient management fee and opportunity for shared savings)
- Patient database (i.e. daily inpatient admission report and quarterly patient utilization reports)
- Operational support (i.e. access to non-clinical navigator, case manager, next-day admitted patient reports, learning collaborative)

Oncology Practices

- Provide 24/7 patient access
- Employ an RN oncology care coordinator for attributed patients
- Engage patients in shared decision making supported by evidence-based guidelines
- Report on six quality measures, including palliative care assessment and distress screening

Source: B Daly, et al., "Oncology Clinical Pathways: Charting the Landscape of Pathway Providers," *Journal of Oncology* Practice, 2018, available at: http://ascopubs.org/doi/full/10.1200/JOP.17.00033; Oncology Roundtable, "State of the Union," 2018; Advisory Board research and analysis.

Physician practice financial management strategies

#4: Merging with other physician practices or selling to the hospital

Many factors, including reimbursement cuts, the shift to value-based payment, and increased reporting requirements, have led physicians in all specialties to sell their practices to other physician groups, hospitals, or IDNs. Physicians whose income depends to a large extent on buy and bill drugs, such as oncologists, have been additionally motivated to leave private practice by the declining profitability of the infusion center business. These physicians typically see multiple advantages, including the opportunity to:

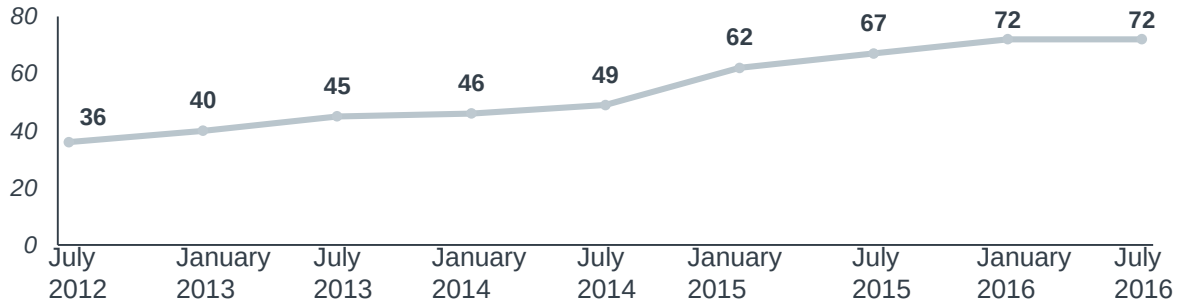
- Realize economies of scale
- Relinquish responsibility for running an increasingly complex business and navigating the transition from fee for service to value-based payment models
- Stabilize income
- Begin the transition to retirement, in some cases

Oncology practice consolidation and acquisition, 2008-2018

658
Oncology practices acquired by hospitals

168
Oncology practices merged or acquired by a corporate entity

Hospital-owned physician practices on the rise
Number of hospital-owned practices (in thousands)



#5: Diversifying revenue streams, including investing in specialty pharmacy

Another response to declining reimbursement for buy and bill drugs has been to diversify revenue streams. Practices have invested in imaging, radiation therapy, and other forms of procedural care to create new sources of income. The largest oncology practices have even invested in specialty pharmacy so that they can dispense and bill for oral oncolytics.

Results from the 2017 Trending Now in Cancer Care Survey

25%
Percentage of facilities that own a specialty pharmacy

20%
Percentage of facilities that do not currently own a specialty pharmacy, but plan to start one in the next 12 months

FOR MORE RESOURCES
To learn more about specialty pharmacy, view our Health System Specialty Pharmacy white paper at: https://www.advisory.com/research/pharmacy-executive-forum/white-papers/2016/health-system-specialty-pharmacy?WT.ac=Inline_PEF_ExRb_x_x_x_CTC_2018Mar01_Eloqua-RMKTG+Blog

Source: Community Oncology Alliance, "2018 Community Oncology Alliance Practice Impact Report," 2018, available at: https://www.communityoncology.org/portfolio-items/2018-coa-practice-impact-report/; Physician Advocacy Institute, "Updated Physician Practice Acquisition Study," 2018, available at: http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/2016-PAI-Physician-Employment-Study-Final.pdf; Oncology Roundtable, "Insights from the Trending Now in Cancer Care Survey," 2018, available at: https://www.advisory.com/research/oncology-roundtable/expert-insights/2018/insights-from-the-trending-now-in-cancer-care-survey; Advisory Board research and analysis.

Buy and bill drugs 101: roadmap

Next up in the buy and bill drugs 101 series

1. **Introduction**
   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

The best practices are the ones that work for **you.**SM

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