Site of Care Shift for Physician-Administered Drug Therapies

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Introduction

In June 2017, BRG professionals estimated that brand 340B drug sales represented 7.7 percent of the addressable market (i.e., brand, outpatient drugs).[1] As part of that research, we studied three conditions commonly treated using brand drugs in the outpatient setting—breast cancer, rheumatoid arthritis, and multiple myeloma—and found in some cases that as much as 30 percent of 2015 Medicare Part B reimbursement was at 340B hospitals.

In this white paper, we analyze seven additional years of historical data to further explore how 340B Drug Discount Program utilization rates for these conditions have evolved between 2008 and 2015. We also discuss the potential effects of this shift in site of care.

Background on the 340B Program and Shift in Site of Care

The 340B Drug Discount Program provides qualifying hospitals and federal grantees with discounts on brand drugs for medications administered or prescribed in outpatient settings. These discounts are calculated based on a statutory formula and typically range between 25 percent and 50 percent. As part of the 340B program, certain hospitals obtain 340B discounts for patients seen at hospital outpatient departments (HOPDs) if they meet certain eligibility criteria and comply with guidance that states HOPDs are an integral part of a hospital, as evidenced by the HOPD being listed as a reimbursable facility on the hospital's Medicare cost report. In many instances, these HOPDs have previously been independent physician offices that were purchased by the hospital and converted to outpatient facilities. Because independent physician offices are not eligible for 340B discounts, the conversion to HOPD status can establish 340B eligibility for patients seen at the physician office and also contributes to a shift in site of care from the physician office to the hospital outpatient setting.

Summary of Findings

- Analysis of Medicare Fee-for-Service claims data shows a substantial shift in site of care for outpatient drug therapies from the physician office to the 340B hospital outpatient setting from 2008 to 2015.
- The Bipartisan Budget Act of 2015 and a recent Centers for Medicare & Medicaid Services (CMS) proposal to reduce Medicare hospital outpatient payments for 340B drugs may reduce certain Medicare costs, but will not directly impact costs for other payers and will not fully eliminate the 340B margin available to hospitals that acquire physician offices.

Shift in Site of Care for Common Drug Therapies

To estimate a 340B utilization rate, we calculate Part B drug reimbursement to 340B-enrolled covered entities based on enrollment data maintained by the Health Resources and Service Administration Office of Pharmacy Affairs.[2] For the three conditions included in our June 2017 study, we focused on the top ten drugs, as measured by Part B drug reimbursement, indicated for treatment of the conditions. By comparing Part B drug reimbursement to 340B covered entities with total Part B reimbursement for these drugs, we can develop a proxy for a 340B utilization rate, or the share of sales to 340B-enrolled entities.

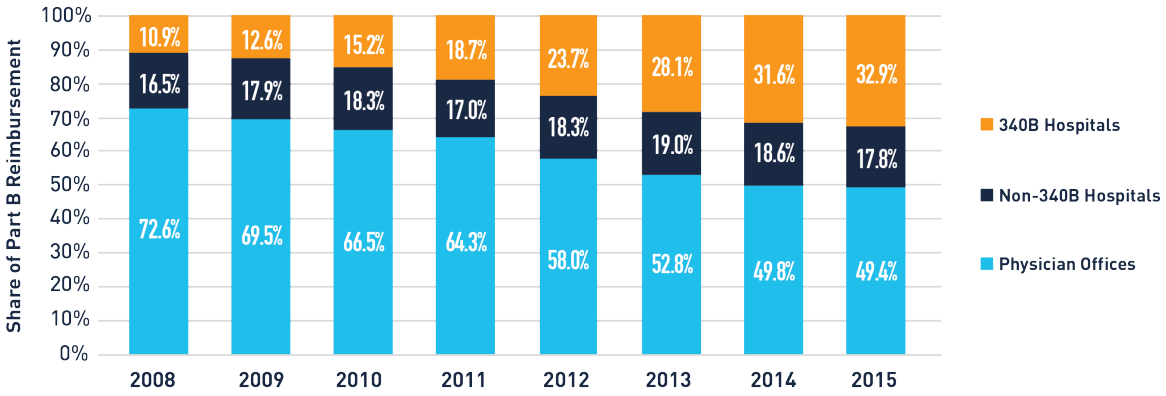
Figure 1 depicts how 340B utilization rates for the top ten drugs indicated for treatment of each condition have evolved since 2008. **The data reveal a marked shift in site of care from the physician office to the 340B hospital outpatient setting that steadily increased from 2008 through 2015.**

1 Aaron Vandervelde and Eleanor Blalock, *Measuring the Relative Size of the 340B Program: 2012–2017*, BRG white paper (July 2017), available at: https://www.thinkbrg.com/newsroom-publications-vandervelde-blalock-340b-size.html

2 Health Resources & Services Administration Office of Pharmacy Affairs Covered Entity Database, available at: https://340bopais.hrsa.gov/coveredentitysearch.

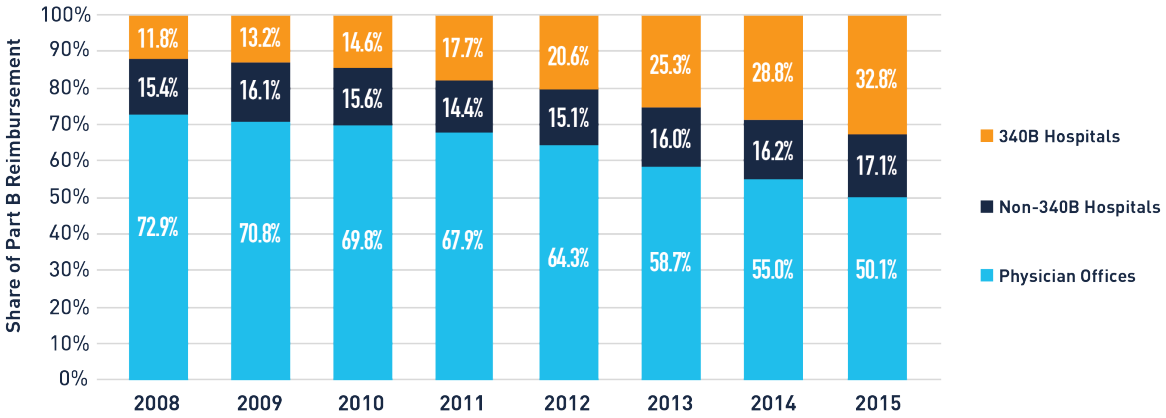
FIGURE 1

Site of Care for Breast Cancer Drug Therapies Reimbursed in Medicare Part B (2008-2015)



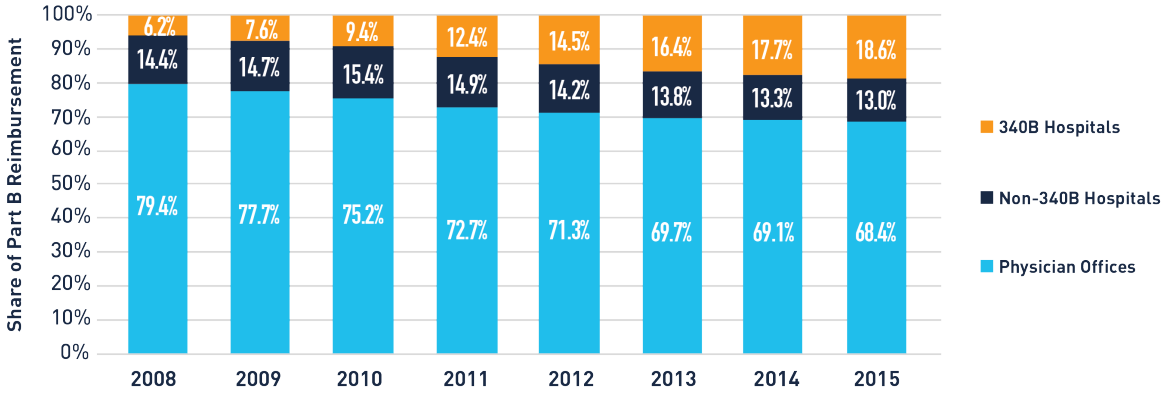
Note: Analysis includes top ten drugs reimbursed under Part B and used for breast cancer treatments.

Site of Care for Multiple Myeloma Drug Therapies Reimbursed in Medicare Part B (2008-2015)



Note: Analysis includes top ten drugs reimbursed under Part B and used for multiple myeloma treatments.

Site of Care for Rheumatoid Arthritis Drug Therapies Reimbursed in Medicare Part B (2008-2015)



Note: Analysis includes top ten drugs reimbursed under Part B and used for rheumatoid arthritis treatments.

Although the shift in site of care for an individual drug or therapeutic category will vary, our prior research demonstrates a broad-based shift in site of care for drug therapy from the physician office to the hospital outpatient setting.[3] In this white paper, we will further explore whether recent legislation and proposed legislation is likely to limit this shift in site of care.

3 Aaron Vandervelde, Henry Miller, and JoAnna Younts, *Impact on Medicare Payments of Shift in Site of Care for Chemotherapy Administration*, BRG white paper (June 2014), available at: https://www.thinkbrg.com/newsroom-publications-vandervelde-miller-younts-siteofcare.html

Potential Implications of Shift in Site of Care

The scale and consequences of the shift in site of care to the hospital outpatient setting have been widely observed. In its 2016 annual report, Magellan Rx Management reported on medical-benefit drug costs for commercially insured patients receiving treatment for autoimmune disorders and cancer.[4] Magellan reported that medical-benefit drug costs for these patients in the hospital outpatient setting cost more than twice as much as in the physician office setting. Due to these types of price differences, the hospital outpatient setting is typically the highest-cost setting for administration of medical benefit drugs.[5] In addition, a Milliman analysis of cancer patients found that, had chemotherapy infusions not shifted into the hospital outpatient department from 2004 to 2014, spending would have been 7.5 percent lower for Medicare patients and 5.8 percent lower for commercial patients.[6] Similarly, in its March 2017 Report to Congress on Medicare Payment Policy, MedPAC found that "[a]mong other effects, the shift in care setting increases Medicare program spending and beneficiary cost-sharing liability because Medicare payment rates for the same or similar services are generally higher in HOPDs than in freestanding offices."[7]

Congressional and Regulatory Action

In an effort to prevent hospitals from being overpaid for items and services under the historically more generous Hospital Outpatient Prospective Payment System (HOPPS), Congress passed a hospital site-neutrality payment provision in section 603 of the Bipartisan Budget Act of 2015 that changed reimbursement for certain "off-campus outpatient departments" beginning after January 1, 2017. Section 603 will make it more difficult for hospitals that acquire physician practices in the future to bill Medicare under the HOPPS.

However, in 2016 Congress granted an exemption for "mid-build" sites that allows more sites to be paid under the HOPPS system if they meet certain requirements.[8] In July 2017, CMS introduced a proposed "HOPPS Rule" that seeks to reduce by almost 27 percent Medicare Part B reimbursement on drugs purchased at the 340B price. Our analysis suggests that the proposed rule would reduce Part B drug reimbursement by almost $1.5 billion annually.[9]

Analysis of the Potential Impact of Congressional and Regulatory Response

Reductions in reimbursement that would occur as a result of site-neutral payment and the proposed HOPPS Rule are limited in scope to patients enrolled in traditional Medicare. Reimbursement for Medicare Advantage, Medicaid, and commercially insured patients is not directly affected by these measures. To better understand the potential impact of the HOPPS Rule on hospital financial incentives, we estimated total margins realized by Disproportionate Share Hospitals (DSH) on 340B purchased drugs and the reduction in hospital margins if the proposed HOPPS Rule were implemented. **Figure 2 demonstrates that DSH hospitals will experience, on average, a 13 percent decrease in margin on 340B purchased drugs.**

4 Medical Pharmacy Trend Report: 2016 Seventh Edition. Magellan RX Management. 2017

5 Medical Pharmacy Trend Report: 2016 Seventh Edition. Magellan RX Management. 2017

6 Bruce Pyenson et al., *Cost Drivers of Cancer Care: A Retrospective Analysis of Medicare and Commercially Insured Population Claim Data 2004–2014*, Milliman report (2016), available at: http://www.milliman.com/insight/2016/Cost-drivers-of-cancer-care-A-retrospective-analysis-of-Medicare-and-commercially-insured-population-claim-data-2004-2014/.

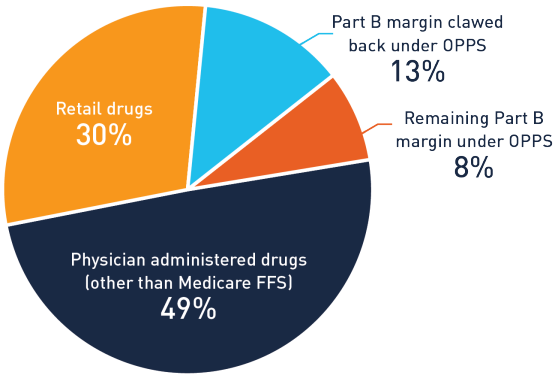
7 MedPAC, *Report to Congress: Medicare Payment Policy* (March 2017), accessed at http://www.medpac.gov/docs/default-source/reports/mar17_entirereport224610adfa9c665e80adff00009edf9c.pdf?sfvrsn=0 (see p. 70)

8 Sections 16001 and 16002 of the 21st Century Cures Act.

9 Estimates presented in this white paper are greater than those estimated by CMS, primarily due to our use of a 47 percent discount from WAC for 340B purchased drugs as derived from the MACPAC's reporting on the average Medicaid discount amount.

FIGURE 2

DSH Hospital Margins for Medicines Purchased through the 340B Program



Total DSH Hospital Margins = $10.7 B

Source: BRG analysis of Apexus disclosures of 2016 total sales at the 340B price; analysis of the typical 340B discount off of Wholesale Acquisition Cost (WAC), and analysis of typical payer reimbursement as a percentage of WAC.

Conclusion

Both Section 603 of the Bipartisan Budget Act of 2015 and the HOPPS Rule will result in a reduction in hospital reimbursement from Medicare to 340B hospitals. However, the direct effect of these measures is limited to traditional Medicare beneficiaries. Based on the limited scope of these measures and the significant margin potential on 340B purchased drugs, we believe the 340B program will continue to create incentives for consolidation. The site of care for drug therapies like those we analyzed will likely continue to become more concentrated in the higher-cost hospital outpatient setting due in part to incentives from the 340B program.

About the Authors

Aaron Vandervelde and Eleanor Blalock are part of BRG's Healthcare Analytics practice. Based in Washington DC, they routinely advise clients on healthcare policy and perform data analytics on a broad range of topics related to Medicare, Medicaid and the 340B program.

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