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BIOSIMILAR REIMBURSEMENT

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EXPLAINED



The clear choice for patient support



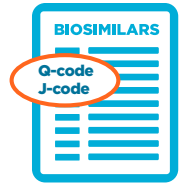
Centers for Medicare and Medicaid Services (CMS) supports the use of biosimilar drugs to reduce drug costs for patients.

Biosimilar products are typically covered under Medicare Part B.

Effective **January 1, 2018**, CMS guidance requires each biosimilar to be assigned a unique Healthcare Common Procedure Coding System (HCPCS) code.¹

Product-specific HCPCS codes allow for product-specific reimbursement.

Modifiers are no longer required.



BIOSIMILAR PRODUCT-SPECIFIC CODES AND REIMBURSEMENT

- CMS established **payment guidelines** to ensure that biosimilar reimbursement is not disadvantaged by the rates for the originator product
- The add-on percentage will differ depending on
 - Whether the product is the originator or biosimilar
 - Reimbursement status of the product following its launch

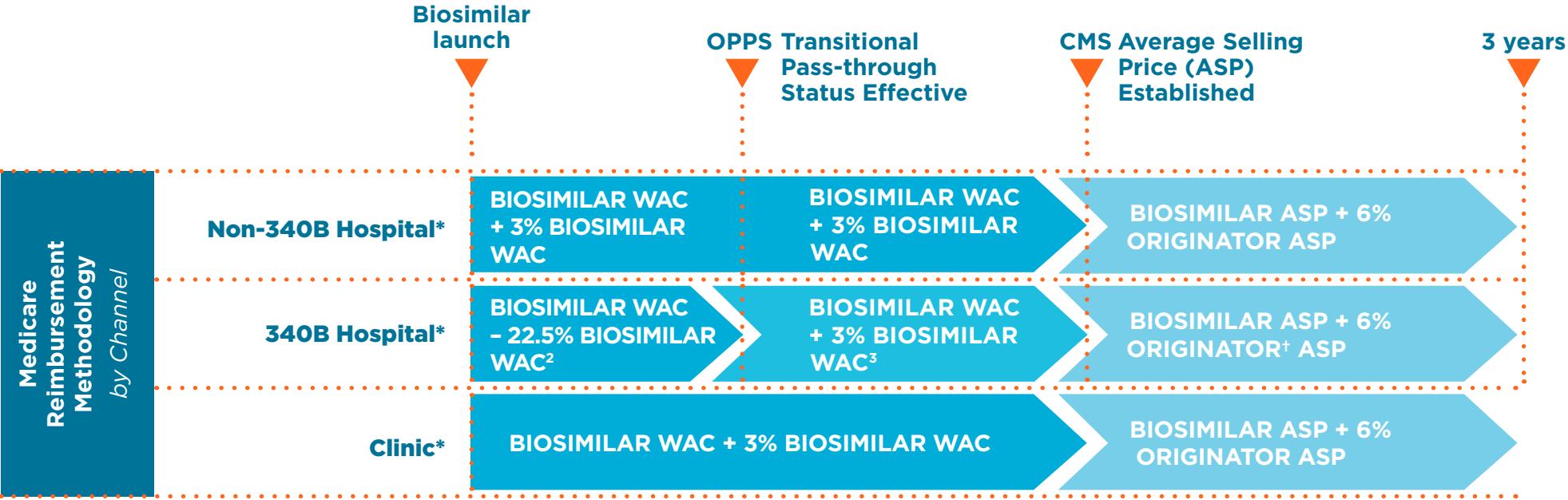
Following FDA approval, CMS assigns each biosimilar a product-specific Q-code or J-code

Each product-specific Q-code or J-code is associated with its own unique payment rate and Average Selling Price (ASP), published by CMS on a quarterly basis

Product-specific reimbursement rates may differ based on

- **Site of care**
- **Type of payer**
- **Provider contracts**

BIOSIMILAR REIMBURSEMENT POLICY



Once Transitional Pass-through Status has expired

- **All non-340B sites** of care are reimbursed at **Biosimilar ASP + 6%** (originator ASP)
- **340B Hospital outpatient centers** are reimbursed at **Biosimilar ASP - 22.5%** (biosimilar ASP)

*ASP or Wholesaler Acquisition Cost (WAC) “plus” reimbursement references herein are exclusive of any federal sequestration on current reimbursement rates.

[†]Per CMS Guidelines, when the biosimilar payment rate is ASP + 6%, the originator’s ASP is the basis for the 6% add-on rate.

BIOSIMILAR REIMBURSEMENT

- Each Biosimilar has its own **unique product-specific billing code** to simplify billing and reimbursement
- **Payment rates will vary**, based on the reimbursement status, site of care and payer type

References

1. CMS.gov. Medicare Physician Fee Schedule CY 2019. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-F.html>. Accessed January 8, 2019.
2. CMS.gov. Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs. <https://www.federalregister.gov/documents/2018/11/21/2018-24243/medicare-program-changes-to-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center>. Accessed November 15, 2018.
3. CMS.gov. Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Correction. <https://www.federalregister.gov/documents/2018/12/28/2018-28348/medicare-program-changes-to-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center>. Accessed May 20, 2019.