

Hospitals Prepare for Medicare Cuts

The Need to Reduce the Federal Deficit Puts Seniors and Providers on Notice

Stephen Barlas

Last June, Sarasota Memorial Hospital in Florida signed a pioneering contract with pharmacy retail giant Walgreens. The hospital, with 50% to 60% of its patient mix receiving Medicare benefits, has been trying for a decade, with some success, to prevent hospital readmissions of those experiencing heart failure relapse. Walgreens is now pursuing similar contracts with many hospitals around the country. In the case of Sarasota Memorial, the hospital pays Walgreens, which has been running an outpatient pharmacy for Sarasota for 4 years, \$40 per discharged, high-risk patient for follow-up services such as medication education, counseling, and physician visit coordination.

In view of changing Medicare payment policies, hospitals throughout the U.S. are reassessing their pharmacy policies and operations. Readmission penalties, which went into effect on October 1, 2012, are only one example. Although Congress cracked down on readmissions in one of the few Medicare cost-cutting efforts of the Patient Protection and Affordable Care Act (ACA), Medicare now has a big target on its back as Congress and President Barack Obama take on the huge task of trimming the federal deficit.

In June, former Senator Pete Domenici and former Budget Director Alice Rivlin, co-chairs of the Bipartisan Policy Center Debt Reduction Task Force, told the Senate Finance Committee, "The principal driver of future federal deficits is the rapidly mounting cost of Medicare."

Medicare cost-cutting will affect inpatient and outpatient pharmacies alike.

Bonnie Kirschenbaum, MS, is a health care consultant and member of the American Society of Health-Systems Pharmacists (ASHP) committee on quality and compliance. She was an Assistant Vice President for Pharmacy Services for 15 years at Tenet at one point in her career. She explains:¹

Medicare reimbursement to hospitals has a huge impact on inpatient pharmacy, since pharmacy represents a significant component of patient costs. And I don't think of the outpatient pharmacy as only providing discharge medications (Medicare Part D). Medicare outpatient reimbursement rules (Part A and B) cover drugs used in all treatment areas as long as the patient is considered an outpatient at an ambulatory clinic, [emergency department], or infusion clinic.

Medicare readmission penalties had a lot to do with Walgreens' initiation of its WellTransitions program and Sarasota Memorial's decision to be among the first partici-

pants. The agency will cut 2013 Medicare Part A payments to hospitals based on 30-day readmission rates for patients with heart failure, heart attacks, or pneumonia. Penalties can be as much as 1% of a hospital's billings and may cost some hospitals more than \$1 million. Hospitals with lower readmission rates will pay much lower penalties. Some hospitals will lose no money. The Sarasota contract calls for the hospital to designate



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which patients enter the WellTransitions program. David W. Jungst, RPh, PharmD, BCPS, Director of Pharmaceutical Care Services at Sarasota Memorial Hospital, says that number will be about 200.

But congressional efforts plus those of the President to sweat some serious fat out of Medicare costs, will result in much more significant changes to the program, which is considered the poster child for fiscal obesity. The heat is going to be turned up on all Medicare programs, not just Part A's inpatient benefit. Cost-cutting pressures will affect Part B's

outpatient physician program; Part C's Medicare Advantage plans; and even Part D's outpatient pharmaceutical program, which is considered well run and economical.

Even so, Part D costs are substantial and increasing, and the congressional "barbers" may well perform some cost-shaving there too. As with the readmission penalties, future Medicare reimbursement changes will not only affect pharmacy operations across the board; they will also present opportunities for expanded roles in Medicare cost containment for pharmacies and pharmacists, particularly in counseling and medication therapy management (MTM)—a beachhead that pharmacy groups have tried to expand over the past few years with limited success.

Both inpatient and outpatient drug costs are a juicy target for budget cutters. Medicare's total bill for drugs is unclear; this is because drug costs are bundled into the Diagnosis-Related Group (DRG) payment in the \$228 billion that the government spent on the Hospital Insurance (HI) program, better known as Part A, in calendar year 2011.

Tami Holzman, a spokesperson for the Centers for Medicare & Medicaid Services (CMS), says that Medicare doesn't compute Part A drug costs. Part B costs of \$233 billion included reimbursement to physicians for drugs they purchased and administered in the office as well as some outpatient drug costs for a category called "Separately Payable Drugs and Biologicals" to the tune of \$9.6 billion. In 2011, the Part D outpatient program cost \$67.4 billion.

Despite the huge contribution of drug costs to Medicare's budget, until now the agency has not focused heavily on reducing those costs. The one area in which Medicare did wield a razor has been with separately payable drugs and biologicals, namely expensive outpatient drugs generally used

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for chemotherapy (e.g., injectables, vaccines, and antibiotics). These drugs cost more than \$80 per day. Although they are considered outpatient drugs, they are reimbursed under Part B because they are typically administered in outpatient settings within a hospital.

Many hospital pharmacy directors are pleased that the CMS seems likely to set the payment rate for this drug category in calendar year 2013 at the average sales price (ASP) plus 6%. However, this ASP-plus number has been lower in previous years and may drop in future years as the Medicare budget comes under political pressure. Moreover, some hospitals with high Medicaid populations who fit the “safety net” definition, and therefore qualify for the Section 340B Discount Drug Pricing Program, argue that even ASP-plus 6 doesn’t do their costs justice.

Tammy Logsdon, a financial analyst in Owensboro Medical Health System, says:²

We are concerned that the analysis of ASP to cost is not an apples-to-apples comparison as it incorporates data from hospitals that receive 340B program discounts for drugs they purchase. The ASP calculation excludes 340B sales, which underestimates the aggregate costs of drugs for most hospitals and the ASP-based rate that CMS produces by comparing aggregate costs to ASP is too low.

Another Medicare cost-containment area likely to heat up as Congress turns up the political flame is hospital audits. Pharmacy operations will be affected both indirectly and directly as that tourniquet, which is already being tightened, gets cinched even more. Steve Speil, Senior Vice President of Health Finance and Policy at the Federation of American Hospitals, explains:³

There has been a rise in Recovery Audit Contractor (RAC) recoveries related to overturning ‘short stay’ inpatient admissions because, in the RAC’s opinion, the inpatient admission was not medically necessary. There even have been cases alleging that certain inpatient determinations are fraudulent and should be sanctioned under the Civil False Claims Act or other fraud and abuse authorities. In many instances, the same clinical services are being furnished to patients regardless of whether the patient can qualify for in-patient status, yet they are being paid much less than the cost of providing that care under CMS’s ‘Part B only’ payment policy.

Inpatient drug reimbursement can be affected when an audit shows that a patient was switched from Medicare Part A to Part B. At that point, of course, the patient’s drug costs are picked up by a Medicare Part D prescription drug plan if the patient has signed on with one. Part D has been a success in many ways, with Medicare payments having been less than expected since the program was first established in 2006. Maybe in part because of that thriftiness and the sense that Part D is sound, and because of a perceived political advantage, the ACA made Part D less costly by closing the so-called donut hole, or the gap in coverage that forces recipients to pay 100% of out-of-pocket costs for all drugs after their Part D expenses surpass a certain dollar amount. For 2013, the donut hole phase of Part D coverage begins when the beneficiary’s total retail drug costs reach \$2,970. By 2020, seniors will pay only 25% of the costs

in the donut hole.

Despite its bravura reviews, Part D will not be immune to congressional cost-cutting. In fact, Mark Merritt, President and Chief Executive Officer of the Pharmaceutical Care Management Association (PCMA), which represents the pharmacy benefit management (PBM) industry, suggests where Part D costs can be cut. He advocates eliminating the “protected” status of six drug classes for which a Part D plan is obligated to provide recipients “all or substantially all” of the medications in those classes. These classes include antipsychotic, antidepressant, anticonvulsant, immunosuppressant, antiretroviral, and antineoplastic agents.

“When manufacturers are guaranteed that their drug will be covered, they have no incentive to offer price concessions to Part D, exchange plans, or beneficiaries,” Mr. Merritt explains.⁴

The protected drug class rule in Medicare Part D makes it virtually impossible to negotiate price concessions on certain brand drugs and has, according to an actuary at the CMS, increased prescription drug costs by \$4.2 billion. Mr. Merritt also believes claims that Part D savings can come from maximizing generic and therapeutic interchange opportunities and by reducing generic cost-sharing for enrollees in the Part D Low Income Subsidy (LIS) Program.

Because of its sacred political status with seniors, the topic of Part D costs did not come up during the 2012 presidential campaign as an area where changes were needed to get the financially failing program on sounder footing. In fact, neither President Obama nor former Massachusetts Governor Mitt Romney brought up details about Medicare cost reductions. President Obama avoided the subject of Medicare for the most part, preferring to attack Mr. Romney’s plan to convert Medicare to a voucher program for individuals younger than age 55. Mr. Romney attacked the President in relation to his siphoning off \$710 billion of payments from Medicare over a period of 10 years and using that money to fund ACA programs. Mr. Romney also criticized the ACA’s creation of the Independent Payment Advisory Board in 2010, which was seen as a way to standardize care and eliminate dubious procedures.

However, neither a repeal of this board—to which no members have yet been appointed anyway—nor a restocking of Medicare with the \$710 billion subtracted in the ACA would save Medicare from its front-of-the-line status at the edge of the “fiscal cliff” (a phrase coined by Federal Reserve Chairman Ben Bernanke). The cliff looms because of the 2011 Budget Control Act, which was passed in August 2011. In exchange for increasing the debt limit, the bill reduced government-wide appropriations for fiscal 2012 by \$917 billion and set up a bipartisan congressional committee charged with cutting another \$1.5 trillion over 10 years starting January 1, 2013. Because this committee’s Democrats and Republicans failed to reach an agreement, the bill mandated that federal spending be cut by an *additional* \$1 trillion over a period of 10 years starting January 2013. In 2013, these reductions would amount to about \$100 billion.

Those automatic cuts are technically, in legislative jargon, called “sequestration.” The tax deal that President Obama and congressional Republicans agreed on in early January simply delayed the day of reckoning for sequestration cuts until late February or early March, when they will have to make a deal

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on raising the U.S. debt limit.

All of the \$917 billion in cuts in 2012 came out of *discretionary* funding, such as appropriations for programs at the Department of Housing and Urban Development, the Department of Commerce, and agencies such as the National Aeronautics and Space Administration. Pete Domenici and Alice Rivlin told the Senate Finance Committee last June.^{5,6}

So far, Congress has imposed virtually 100% of deficit reduction on less than 37% of the budget. ... In short, we believe that further significant cuts in discretionary spending will do little to improve long run fiscal sustainability and risk harming investment, recovery, and future growth.

So Medicare is front and center as Congress and President Obama begin to think through deep, long-term cuts in the program in the name of deficit reduction. How dangerously tottering are Medicare's finances?

In their March 2012 report, the Medicare trustees said that the hospital insurance program (Part A), under its current status, would be bankrupt in 2024, because money going into the program since 2008 has fallen short of expenditures. The shortfall required dipping into the Medicare trust fund; this is expected to continue until the fund goes broke in 2024—that is the optimistic view. However, the report also said that at least three assumptions made by the Trustees about prospective cost reductions—which would extend the health insurance program solvency until 2024—were unlikely to prove true, namely that:

- Congress would allow payment cuts to physicians to proceed.
- productivity improvements throughout the health care system would materialize.
- the Independent Payment Advisory Board created by the ACA could be sustained over the long term.

The Independent Payment Advisory Board would be charged with recommending cost savings as necessary to hold overall per-capita Medicare growth to the average of the Consumer Price Index (CPI) and CPI medical increases from 2015 to 2019 and to the per-capita rate of Gross Domestic Product (GDP) growth plus 1 percentage point thereafter, subject to certain limits.

Medicare Part B and Part D are in better shape than Part A because their costs are paid mostly out of congressional appropriations, which are set each year based on the anticipated costs of both programs. Therefore, if costs increase by 10%, Congress appropriates another 10%. If this means that the federal Treasury kicks in more, then taxpayers will have to pay more—unless the economy is booming, which is probably not going to be the case any time soon. Part B and Part D Medicare costs have been increasing rapidly, averaging 5.9% and 7.2% annual growth, respectively, over the past 5 years.

It could be argued that, in contrast to the trustees' gloomy view, the ACA established programs that were meant to reduce federal Medicare payments to hospitals and to improve care. Two of those programs get under way for the first time in fiscal 2013 (which started October 1)—value-based purchasing and readmission penalties.

Under Medicare's value-based reimbursement program, the CMS grades hospitals; 70% of the score is based on 12 measures that show how frequently hospitals performed recommended protocols, such as giving antibiotics to surgical patients within an hour after surgery. The other 30% of the score is based on how the hospital fared on random surveys of patients taken after they were discharged. In a dry run using older data, 1,405 hospitals would get back some money but would still come up short; 550 hospitals would break even, and 1,448 hospitals would receive bonuses. Medicare estimates that about \$850 million will be reallocated among hospitals under this program. Of course, the expectation is that as all hospitals improve care, total Medicare costs will be reduced.

Readmission penalties are slapped on hospitals with higher-than-expected readmission rates. Hospitals with the highest rates of patients with heart attacks, heart failure, and pneumonia will lose 1% of their regular reimbursements. Medicare expects that hospitals as a group will forfeit about \$280 million in 2013. The maximum penalty grows to 2% in 2014 and to 3% in October 2015.

These penalties are forcing hospitals to make several changes, such as paying more attention to discharged patients' adherence to prescriptions, particularly those with chronic conditions. In some hospitals, outpatient pharmacies or even specially designated pharmacists track patients after they arrive home and might conduct medication reconciliation. The entrance of Walgreens into this equation underlines the importance of the pharmacy to a hospital's fight to reduce readmission rates.

Not only is Walgreens signing contracts with hospitals such as Sarasota Memorial; it has also inked new deals with Humana, Inc.; UnitedHealth Group, Inc.; and a new Medicare Part D program offering SmartD Rx to become the preferred network for those Part D plans.

Of course, greater medication adherence by Medicare patients also means higher Part D costs. That will be one of the issues to be debated; that is, will better adherence, in part spurred by hospitals worried about readmissions, equate to federal government health savings after higher Part D costs are measured against lower Part A readmission costs?

Studies have shown that medication therapy management (MTM) outpatient program settings improve health outcomes and lower patient medical costs, including those stemming from hospital readmissions. So it is no surprise that hospitals are engaging pharmacy departments in the fight against readmissions. Ernie Anderson Jr., M.S., System Vice President of Pharmacy at Steward Health Care, says that pharmacies in all 11 Steward hospitals are involved in such a program.

Congress will probably have to move beyond the "penalty" approach to forcing cost containment by hospitals, physicians, and insurance companies. Despite President Obama's vehement opposition to a transition to a voucher system for Medicare, some form of voucher system seems likely; it is probably the only way to wring significant, excess costs out of Medicare. Costs are raised, for instance, when doctors prescribe a brand-name drug instead of a generic alternative or equivalent.

Bipartisan committee chairs Pete Domenici and Alice Rivlin foresee a system starting in 2016 in which Medicare recipients would choose from a menu of private plans and fee-for-service

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Medicare, each meeting federally set minimum benefits, with the federal government providing an annual “premium support” payment equal to either the second-lowest priced private plan or fee-for-service Medicare, whichever is lower. The increase in year-to-year premium support payments would be capped at some level. If all that doesn’t work, Medicare beneficiaries at higher income levels would pay higher premiums.

Early in 2012, Senator Ron Wyden (D-Ore.) stuck his neck out by announcing that he was working with Representative Paul Ryan (R-Wisc.) on a Medicare reform plan. Mr. Wyden refused to call what the two were considering a voucher proposal, because he said that vouchers were not guaranteed to keep up with the rising costs of health insurance and they break what he referred to as the “Medicare guarantee.”

“Unlike a voucher program that would give seniors a fixed amount of money to purchase health plans, Wyden–Ryan would adjust premium support payments each year to reflect the actual cost of health insurance premiums,” Mr. Wyden says.⁷

Everyone in Washington realizes—even if not everyone will admit it—that Medicare costs can’t simply be chipped away at; they have to be slashed. So readmission penalties are fine as far as they go. But a more “macro” attack is necessary. That is why there is a good chance that Ron Wyden and Paul Ryan will revisit their partnership and make some adjustments to get a serious, bipartisan Medicare cost-control plan through Congress. Democrats and Republicans will both have to show some “give,” as will seniors and providers—neither of whom may have much of a choice unless they are willing to let the Medicare program flop face-up like a dead whale whose ocean has slowly evaporated around it.

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