Hospital Outpatient Pharmacies Win Higher Medicare Payments for 2011
But They Are Not Yet Recovering Overhead Costs for Expensive Drugs

Stephen Barlas

Mr. Barlas is a freelance writer based in Washington, D.C., who covers issues inside the Beltway. Send ideas for topics and your comments to sbarlas@verizon.net.

There is both good news and bad news this month from Medicare on reimbursement for hospital outpatient pharmacies in calendar year 2011. The good news: payments to the pharmacies are up over calendar year 2010, although just slightly.

The bad news: systemic problems in the Medicare reimbursement formula remain; some pharmacies will continue to be woefully underpaid for expensive drugs that require special handling. More broadly, pharmacies that are spending considerable sums to meet requirements such as the U.S. Pharmacopoeia’s Chapter 797 (“Standards on Compounding Sterile Preparations”) are not able to recoup those capital costs through Medicare reimbursement.

The descent of pharmacies down the slippery cost slope began with the passage of the Medicare Modernization Act (MMA) in 2003, which stated that Medicare would begin paying hospitals for outpatient pharmacy drugs on the average sales price (ASP), which drug manufacturers report to the Centers for Medicare and Medicaid Services (CMS) quarterly. The CMS then determines the reimbursement rate based on a hospital billing for that drug across the nation.

Unfortunately, for the expensive drugs listed earlier, which all have Healthcare Common Procedure Coding System (HCPCS) codes, the Medicare reimbursement comes out to the ASP minus a certain percentage. (HCPCS alphanumeric codes are assigned to drugs, procedures, supplies, and equipment.) Unfortunately, that less-than-ASP total puts hospital pharmacies into a deep financial hole because Medicare does not reimburse them for overhead costs, which can be expensive and can range from the cost of compounding a cancer drug to building a clean room.

Michael J. Bonck, RPh, Pharmacy Manager at St. Joseph Medical Center in Tacoma, Wash., explains that waste disposal costs for the unused portions of hazardous medications, such as oncology drugs, are a major item.

What the CMS began to do in 2010, and will continue to do in 2011, is take some of the reimbursement it would have spent elsewhere for other Medicare services and transfer that sum to reimbursement for separately payable drugs. In 2011, that CMS “Robin Hood” move resulted in an additional $200 million being tossed into the separately payable-drug reimbursement pool. As a result, the average reimbursement went from a rate of ASP minus 1% (which is what the CMS formula would have dictated) to the ASP plus 5%. That is 1% higher than the 2010 amount. Although hospitals are appreciative of the increase, they point out that physicians will get the ASP plus 6% for the same drugs, even though their overhead costs are less than those of a hospital pharmacy.

However, hospital pharmacy executives say they are still losing money on many of their most expensive drugs. Ernest R. Anderson, Jr., MS, System Vice President of Pharmacy at Caritas Christi Health Care, the second largest health system in Massachusetts, estimates that he loses money on 40% to 50% of the separately payable drugs that he buys. If Medicare were to pay a fair price for each of those drugs, reflecting overhead costs, that reimbursement would be ASP plus 25% to 30%.

Part of the systemic problem is that hospitals do not report their pharmacy overhead costs on the cost reports that they send to Medicare, much less those costs associated with specific drugs, a point that MedPac made in its 2005 report. Therefore, data on the cost of disposing of toxic chemotherapy agents, for example, are nonexistent.

The six hospitals that make up Caritas Christi Health Care may have the power in their Massachusetts market to force private insurance companies to reimburse for cancer and other expensive drugs at the ASP plus 25% to 30% rate. But Mr. Anderson points out that many insurance companies do not pay for drugs based on an ASP methodology. In the future, if hospitals continue to lose money on 40% to 50% of drugs that they buy, they may think about backing out of oncology services and, instead, expanding in cardiology, orthopedics, or another...
PRESCRIPTION:
WASHINGTON

continued from page 11

field in which insufficient drug reimbursement is not a problem.

MedPac has already pointed the way forward. Its 2005 report gave a group of hospital pharmacists 205 high-cost drugs and asked them to break them down into nine categories, based on handling costs. MedPac then recommended that Medicare conduct a broader survey along the same lines and develop payment codes that hospitals could use for handling fees.

Medicare hasn’t done that, and there is no evidence that it intends to do so.