Final Rule on ACOs Raises Concerns About Medication Cost-Shifting

Pharmacists to Play a Secondary Role in New Physician–Hospital Organizations

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The final rule that the Centers for Medicare and Medicaid Services (CMS) published at the end of October basically simplifies and improves the financial aspects of the Accountable Care Organization (ACO) program in an effort to convince physician groups and hospitals to participate. It doesn’t change the rules as to who can share in cost savings to Medicare that are produced by ACOs.

An ACO is a new type of integrated health care organization, formed by physician groups and, in some cases, hospitals with staff physicians. The aim is to provide comprehensive care to Medicare patients, thereby lowering the costs of that care and producing savings for the agency. The Patient Protection and Affordable Care Act (PPACA) specifies that only physicians and hospitals can share in the savings. The CMS’ proposed rule followed that edict; pharmacists, chiropractors, nurses ... all were deemed to be “out of the money.” The final rule adheres to that decision. That said, medication management services provided by pharmacists in large physician practices and hospitals will be crucial to the success of any ACO.

Dave Rhew, MD, Chief Medical Officer of Zynx Health, a provider of evidence-based and experience-based clinical decision-support solutions to hospitals, says that physicians tend to prescribe the same drugs that they have traditionally prescribed and that they can sometimes be behind the curve on current changes in drug profiles because of time constraints. It will be up to the pharmacist to update physicians and hospital formulas when a manufacturer voluntarily re-calls a product. For example, drotrecogin alfa (Xigris, Eli Lilly), which is used for severe sepsis, was pulled from the market in October because of the FDA’s concerns about the drug’s lack of effectiveness in reducing mortality rates.

Pharmacist interventions in ACOs come into play only when drugs are supplied to a fee-for-service Medicare patient by a physician in the office (Part B coverage) or in a hospital (Part A coverage). An ACO participant’s Part D drug costs will not be part of the “shared savings” calculations. This may turn out to be problematic in some instances, such as in cancer care and cardiac ablation for atrial fibrillation, areas in which ACOs may have an incentive to switch patients to Part D therapies and away from appropriate treatments or procedures that are reimbursed through Medicare Parts A or B. The CMS acknowledged that these are important concerns, but the program’s quality-measurement and monitoring activities will help us to prevent and detect any avoidance of appropriately treating at-risk beneficiaries. Furthermore, to the extent that these lower-cost therapies are not the most appropriate and lead to subsequent visits or hospitalizations under Parts A and B, then any costs associated with not choosing the most appropriate treatment for the patient would be reflected in the ACO’s per capita expenditures.

It is impossible to know whether this concern about medication cost-shifting from Medicare Part A or B to Part D will actually bear fruit. The CMS will apparently be looking over the shoulders of ACOs on this issue.

“The financial incentives could cause physicians that are part of ACOs to increase the use of Part D medications to decrease the use of Part B medications or appropriate medical procedures. The Academy shares this concern,” said Marissa Schlaifer, Director of Pharmacy Affairs at the Academy of Managed Care Pharmacy.

Of course, the number of program integrity “watchdogs” at the CMS and other federal health agencies is decreasing, with federal budget cuts being the order of the day. Even in the halcyon days of federal spending with bigger staffs, Department of Health and Human Services watchdogs were rather passive policemen. The Office of Pharmacy Affairs, which administers the Section 340B Drug Discount Program, is a good example of a department in which the “detectives” have had their feet up on their desks, according to a September 23 report from the Government Accountability Office.

Section 340B also comes into play because of concerns about medication cost-shifting in ACOs. The 340B program allows safety-net hospitals with large Medicaid populations to buy discounted drugs but restricts who can receive these drugs from hospitals. Recipients must be patients of the hospital, they must be seen by a hospital physician, and the drugs must be purchased at an outpatient (not an inpatient) pharmacy. The drug manufacturers loathe the 340B program, which requires them to sell drugs at a lower cost than they would otherwise have to. They worry that safety-net hospitals that join an ACO might expand their purchases of 340B drugs and provide those drugs to, for example, a medical group with whom it has partnered in an ACO. That allows physicians to substitute a cheaper drug (at the 340B discounted price) for the more expensive one that they would have used. Therefore, in this scenario, the ACO’s costs would be reduced, because drug costs within Medicare Part B are calculated in the ACO equation.

Hospital pharmacists are knee-deep in the 340B program. So while they and their brethren stationed in physician offices will not be able to share in ACO savings, it looks as if they will have their hands full preventing ACO headaches.