Medicare Changes Include New Part D Rules and Possible Cuts to Hospitals

Stephen Barlas

Medicare is a complicated issue these days. Attempts are being made from both outside and inside the Centers for Medicare and Medicaid Services (CMS) to cut the program’s costs, with significant implications for providers, including hospitals, drug manufacturers, and Part D plans.

The Republican House and the Democratic Senate have weighed in on how to cut Medicare costs, as has the Obama administration. Away from Capitol Hill, the CMS published its 2014 Call Letter, which includes changes to Medicare Advantage (Part C) plans and outpatient drug (Medicare Part D) benefits. Those changes take effect on January 1, 2014; no congressional approval is needed. The Call Letter makes administrative changes, which might be deemed less significant than the “big dollar” program changes that Congress can—and will—make, but it affects hospital pharmacies more directly and more immediately.

For instance, Medicare Part D doesn’t pay for drugs that patients receive in a hospital except when these patients are admitted for observation. Theoretically, during that period, patients can bring in drugs they take at home, which are paid for through Part D. In May 2012, however, the CMS issued a final rule allowing hospitals to provide these “observation” patients with drugs from the hospital’s inpatient pharmacy. The patient must then bill Part D for reimbursement. Part D’s reimbursement to patients does not always cover the cost of the inpatient pharmacy-supplied drug.

In the 2014 Call Letter, the CMS says that it expects Part D plans to reimburse patients in hospitals, if warranted, and if the dispensed drug is on the Part D plan’s formulary or is otherwise covered under the plan pursuant to a formulary exception. Yet patients must pay the difference between the higher inpatient pharmacy price and the lower Part D price. So when trying to collect balances on the cost of inpatient pharmacy drugs during observation, hospitals may face resistance from both patients and Part D administrators.

The Call Letter also addresses automatic prescription refill operations run by Part D, most often through mail-order pharmacies but sometimes through retail networks. In the Call Letter, the CMS notes complaints it received about Medicare recipients getting prescription refills by mail that they did not order or need. “Automatic delivery practices are potentially generating significant waste and unnecessary additional costs for beneficiaries and the Part D program overall,” the Call Letter says.

This problem led to a new rule that will start in coverage year 2014; Part D sponsors will require their network retail and mail-order pharmacies to obtain patient consent for delivering new or refill prescriptions before each delivery.

The Call Letter also warns Part D plans broadly for using what are, in some cases, illegal prior-authorization forms. Some of these more comprehensive forms contain the elements that, under state laws, technically constitute a valid prescription. The forms have subsequently been used as prescriptions to be filled by the sponsor’s or the pharmacy benefit management (PBM) company’s own mail-order pharmacy instead of the pharmacy where the beneficiary presented the original prescription. According to Part D rules, this practice is not permitted and bypasses protections that allow beneficiaries to use the pharmacy of their choice.

Some of these measures and others in the Call Letter are significant, but they will not have the kind of impact on provider reimbursement that congressional changes in Medicare will have. President Obama’s proposed fiscal year 2014 budget (starting October 1, 2013) includes a reduction of $374 billion for Medicare (of which $306 billion would be paid by health care providers) and a reduction of $18.9 billion for Medicaid. The budget proposal would cancel the Budget Control Act’s sequester, including the annual 2% cut to hospitals’ Medicare payments.

That is the only good news in the President’s proposal. The budget would also reduce “bad debt” payments to providers by $23.5 billion, Medicare graduate medical education payments by $10.98 billion, and critical-access hospital payments from 101% to 100% of reasonable costs. The plan also recommends saving $79.04 billion by reducing Medicare payment updates for skilled-nursing facilities, long-term-care hospitals, and inpatient rehabilitation facilities; $8.16 billion by implementing bundled post-acute-care payments; and $9.46 billion by streamlining clinical laboratory payments.

The President also proposes reducing Medicaid payments to disproportionate-share hospitals, which are safety-net providers, in 2016 and 2017, mostly because those hospitals will receive new funding from the government’s coverage of new Medicaid patients under the Patient Protection and Affordable Care Act (PPACA) starting in 2014. American Hospital Association President and Chief Executive Officer Rich Umbdenstock says:

Even though Congress already cut Medicare and Medicaid payments for hospital services by billions of dollars, the administration has proposed additional reductions. The solution to what ails our nation’s fiscal health is not further cuts to providers that care for millions of America’s seniors but creative solutions to modernize the Medicare program.

Creative solutions are clearly in short supply in Washington.

REFERENCE