A couple of pharmacy issues are hanging in the balance as the Centers for Medicare & Medicaid Services (CMS) considers changes to Medicare hospital inpatient reimbursement in 2014. One change would require that patients be discharged and readmitted each time they are transferred as inpatients between a cancer center and a co-located hospital. This change has implications for medication management.

The second proposal clarifies that a physician’s order triggers an “inpatient” status (a hospital stay of longer than two midnights following an inpatient admission). This change has implications for costs. First, it would become more difficult for hospitals to move inpatients to “outpatient observation” status (a hospital stay of less than two midnights), thereby allowing hospitals to include these patients among those who are eligible for 340B drug discounts (which helps hospitals build revenue).

Drug companies, which are required to sell medications at large discounts to 340B-eligible patients, strongly oppose the Section 340B Drug Discount Program and are solidly behind the anti-340B change proposed by the CMS. Prescription benefit management (PBM) companies and community pharmacies also support the proposal; they claim that they are disadvantaged by 340B, a program in which a select group of hospital outpatient pharmacies undersell other neighborhood pharmacies and mail-order companies by virtue of low prices that these select pharmacies pay for prescription drugs.

Raymond Frost, Vice President of Government Affairs, Public Policy & Advocacy at Bayer HealthCare, explains: Bayer is concerned that a number of 340B hospitals are manipulating the Medicare and 340B programs to improperly access 340B prices. Because “covered outpatient drugs” are limited to outpatient settings, hospitals have incentives to categorize patients as ‘outpatients’ for as long as possible to capture the difference between the 340B price and the standard retail price, otherwise known as the ‘340B spread.’ By manipulating inpatient services and by mischaracterizing them as observation stays, 340B hospitals are able to obtain the deeply discounted 340B acquisition price that would otherwise be unavailable.

Bayer and the rest of the advocates for the proposed CMS change say that it will help Medicare recipients by reducing the incentive for hospitals to treat them as outpatients. Patients classified as outpatients would have higher expenses because of cost sharing under Part B rather than under Part A (inpatient status), which covers patients’ charges in the hospital. However, drug companies, retail pharmacies, and PBMs clearly have an economic interest in seeing Medicare make the change.

The pharmacy position differs slightly regarding the CMS proposal pertaining to patient discharge and readmission from cancer centers to hospitals. R. Donald Leedy, Executive Director of the Alliance of Dedicated Cancer Centers, says that a discharge at a co-located cancer center would cause medications to no longer be visible in the hospital pharmacy or to the nurse because they would not appear in the electronic medication administration record. The rewriting of any orders, especially those for chemotherapy, could put readmitted patients at risk for complications and even death. Hospital pharmacists would be deeply involved in the rewriting of those orders.

The CMS-proposed rule covers much more ground and includes other planned changes, besides these two, with pharmacy implications that would have a much larger impact on hospitals. These changes refer to those policies governing (1) reduced payments to hospitals stemming from excessive hospital readmissions; (2) value-based purchasing; and (3) the Hospital-Acquired Conditions (HAC) Reduction Program, to start in 2015.

The major controversy concerns the HAC plan. The hospital industry opposed this program when it was proposed as one of the elements of the Patient Protection and Affordable Care Act (PPACA), but the program was eventually included. Now, with implementation of the PPACA around the corner, hospitals are trying to convince the CMS that the HAC program is either unnecessary or ill conceived.

Beginning in 2015, the PPACA will require the CMS to impose a 1% reduction in Medicare payments for hospitals in the top quartile of risk-adjusted national HAC rates. Rick Pollack, Executive Vice President of the American Hospital Association (AHA), says his group has significant concerns about the measures and the scoring methodology proposed by the CMS rule. One of the AHA’s concerns is that the selected measures for the HAC program inappropriately overlap with Medicare’s Hospital Value-Based Purchasing Program, which was initiated on October 1, 2012 (fiscal year 2013). This program provides incentive payments to hospitals based on their performance on quality measures. Rick Pollack adds:

While we certainly support programs to eliminate patient harm from hospital-acquired conditions, this [PPACA provision] is not well conceived or designed, for a number of reasons. The AHA strongly opposed the inclusion of the HAC Reduction Program in the [PPACA]. We believe it is arbitrary to assess penalties on hospitals regardless of the overall progress the field has made in improving performance on measures.

The CMS will issue a final rule in the fall—but don’t expect the agency to make any major U-turns on any of these proposals.