ACO Final Rule Slights Pharmacy
No “Give” on Drug Pricing, Cost Shifting, and Other Concerns

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With the King-Burwell decision out of the way, Sylvia Burwell, Secretary of Health and Human Services, is now free to focus on issues other than the potential death of subsidies under the Patient Protection and Affordable Care Act. The day after the Supreme Court ruling, Burwell said her two immediate priorities are convincing more states to expand Medicaid and extending payment options within Medicare.

So it is worth noting the new rule that the Centers for Medicare and Medicaid Services (CMS) published in the days before the high court’s decision. That rule focused on accountable care organizations (ACOs). There are about 400 ACOs in the CMS shared-savings program, in which hospitals join with physician groups to coordinate care and try to prevent unnecessary or avoidable hospitalizations. If they do, Medicare saves money; the ACOs earn money when coordination leads to lower costs.

Although paid on a fee-for-service (FFS) basis, the ACOs have a tinge of value-based pricing because they must meet quality standards before they can earn profits. At least 20 of the quality measures set by CMS relate in some way to safe and effective use of medications.

The CMS final rule makes changes meant to encourage ACOs to extend their three-year commitments, and to make it easier for them to get health care data on their members so the ACOs produce better outcomes and lower costs. Since ACOs are paid on a FFS basis, in that sense they are not subject to the value-based system that the CMS uses in part to pay hospitals. The ACOs are paid only for Medicare Part A hospital and Part B physician services. So ACOs get no credit for controlling Part D patient drug costs, and conversely, the Part D plans don’t get any incentives for using their resources, and spending their money, to keep patients out of hospitals.

Hospitals have been the big players in ACOs. They were mildly pleased with the CMS changes, but they want more. So do pharmacy players, whose pleas to the CMS for reforms were ignored.

To a large extent, pharmacies, insurance companies, and pharmacy benefit managers are on the outside looking in at ACOs because Medicare’s Part D out-patient drug program is beyond the realm of the ACO program. Typically, a Medicare recipient whose physician is participating in an ACO is automatically assigned to that ACO. Any pharmaceuticals the physician infuses or injects in his or her office count against the ACO’s costs, and therefore its ability to share in savings.

However, here is the kicker for the pharmacy and pharmaceutical industries: If a patient has hepatitis C and gets sofosbuvir (Sovaldi, Gilead Sciences) from the local drugstore—thereby, hopefully, avoiding surgery—those hospital savings go to the hospital. The Part D drug plan gets nothing for its contribution, despite having shelled out $80,000 a year (or whatever the cost may be based on the plan’s formulary) for the hepatitis C medication. That example explains why pharmacy groups and Part D plans urged the CMS to make Part D plans players in the ACO game.

Larry Burton, Senior Vice President for CVS Health, asked the CMS to “develop a Part D attribution payment model that rewards ACOs and Part D sponsors for savings generated in Part D.” The CMS declined, noting: “As we explained in the November 2011 final rule, we do not believe it is appropriate to consider Part D spending in our calculation of benchmark and performance year expenditures.” Chris Cramer, a CVS spokeswoman, says her company has no comment on the final rule.

Potential cost shifting is also a worry for Part D plans. There is an incentive for an ACO physician to prescribe an outpatient drug available on the patient’s Part D plan formulary when he or she might otherwise provide a similar, maybe even more effective nonformulary drug in his or her office. “ACOs may have an incentive to shift Parts A or B expenditures to Part D,” explains Steve Phillips, Senior Director of Health Policy at Johnson & Johnson (J&J). “This incentive may be particularly strong in cases where self-administered drugs available on Part D may treat the same clinical conditions as physician-administered Part B drugs. Such substitution could motivate ACOs to encourage physicians to write prescriptions for Part D drugs in patients already well controlled and managed on a Part B agent.”

J&J and other drug manufacturers also wanted the CMS to give them the flexibility to make “outcomes-based” pricing arrangements with ACOs, and they sought adjustments to the ACO benchmark comparisons for the costs of adopting new breakthrough treatments. In both instances, the CMS declined to do so.

“While we would have preferred a direct response from CMS to our recommendation on outcomes-based pricing in the final rule, we recognize that it is a complicated issue that involves multiple offices within CMS,” Phillips states. “We are also continuing to raise the breakthrough drug cost and drug cost shifting from Part B to D with CMS and are confident they will eventually be appropriately addressed.”

The ACO final rule makes changes mostly around the edges of the program, which has been no more than mildly successful. Integrating outpatient drug responsibilities, by bringing Part D plans into the mix, would certainly give the program a boost.

REFERENCE