

Medicare Part B Drug Reimbursement Program Distresses Pharmacy Players

Program Seeks to Reduce Use of Expensive Biologics

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The new Medicare drug-pricing program¹ aimed at cutting reimbursement for Part B drugs will hit hospitals hardest, according to the Centers for Medicare and Medicaid Services (CMS). The drugs at issue are typically chemotherapy, ophthalmic, or rheumatoid arthritis drugs infused in a physician's office or a hospital outpatient clinic. Medicare reimburses either the physician or the hospital—and sometimes a specialty pharmacy—under Medicare Part B. Very occasionally those drugs are paid for under the Part D outpatient drug program.

The plan has proven controversial. Oncologists have led the charge to force the CMS to backtrack, and allies, both Republican and Democrat, in Congress have sent the CMS letters of opposition and, in at least one case, introduced Republican-sponsored legislation to thwart the plan. The AARP and parts of the insurance industry are trying to stiffen the CMS's spine.

Medicare spent \$22 billion on Part B drugs in 2015. In 2007, the total payments were \$11 billion; the average annual increase since 2007 has been 8.6%. This growth has been driven largely by spending on separately paid drugs in the hospital outpatient setting, which more than doubled between 2007 and 2015, from \$3 billion to \$8 billion, respectively. Currently, physicians and clinics receive 6% of the average sales price (ASP) of the drug as their "profit" on infusion. But in reality, that 6% margin was reduced to 4.3% because of language in the 2012 Congressional budget sequester legislation that cut federal spending in most programs.

The CMS announced a five-year test program in which the first phase will see

Part B drug reimbursement changed to a payment of 2.5% of ASP plus a payment of \$16.80 per drug per day. The CMS believes that some physicians and chemotherapy clinics choose more expensive drugs to infuse when less expensive, equally effective alternatives are available, with the intent of driving up their reimbursement. The second half of the CMS Part B reimbursement project will introduce "value-based" or "indication-based" payment models. That would begin in the third year of the five-year program.

The CMS estimates that, in phase 1, spending on drugs given in the office setting will increase while spending on drugs given in the hospital setting will decrease. That decrease will be an estimated 2.3%. Kyle Skiermont, PharmD, Chief Operating Officer of Fairview Pharmacy Services, says, "The key takeaway is that we are looking at a cut in reimbursement but will offer the same services we always have. The question is how do we do that for lower reimbursement. We are not doing anything extraneous now and will have to find ways to become more efficient, ways to further utilize our protocols and order sets so that people are using the most cost-effective drugs." Fairview has seven hospitals in the Minneapolis/St. Paul area (all with outpatient infusion centers) and one freestanding infusion clinic. Dr. Skiermont is responsible for all pharmacy services except inpatient acute care.

But some community clinic executives argue the change in reimbursement will result in revenue shortfalls for them, reducing the number of patients they can see, some of whom will go instead to hospital infusion clinics. Melissa Dinolfo, PharmD, BCOP, Pharmacy Director for the UCLA Department of Medicine, runs 14 community oncology clinics. She argues patients do much better receiving chemotherapy at clinics like hers as opposed to infusion clinics at hospitals. But the reduced payment for Part B drugs will make it hard for her to keep some of her clinics from running deficits, especially

where there are no generics available, as is the case for 65% of her formulary. "This will put us under water on brand-name treatments," Dr. Dinolfo says. "The flat fee that is being proposed is completely inadequate to cover the shortfall."

So far, it has been oncologists, not hospitals, who have voiced the loudest opposition to phase 1, which the CMS plans to inaugurate in certain geographic areas by the end of 2016. A preliminary analysis by the American Society of Clinical Oncology of the reduced reimbursement rate suggests practices will, on average, lose \$30,000 to \$35,000 per physician. Here, also, there is a potential silver lining for hospitals if office-based oncologists decide that it makes sense to affiliate with a hospital—particularly a 340B hospital, which buys all drugs at deep discounts—in order to access cheaper biologics, even if their "profits" decrease.

The point of the CMS plan is to pressure physicians to prescribe generics, which are easier on consumer pockets. "Last year Medicare Part B spent \$22 billion on prescription drugs, double the amount spent in 2007," said Nancy LeaMond, Chief Advocacy and Engagement Officer at AARP. "This spending escalation is simply unsustainable. We cannot continue to ask taxpayers and Medicare beneficiaries to pay for exorbitantly priced prescription drugs without any consideration of whether their money is being well spent."

There are no generic competitors for some expensive Part B drugs. This program may have been better received had the CMS limited the reimbursement reductions to Part B drugs with less expensive, equally effective alternatives. Combining its plan with an attack on out-of-control specialty drug prices would have won the agency additional political support, which it apparently badly needs.

REFERENCE

1. Department of Health and Human Services. Medicare program; Part B drug payment model. *Fed Regist* 2016;81(48):13230-13261. Available at: www.gpo.gov/fdsys/pkg/FR-2016-03-11/pdf/2016-05459.pdf. Accessed April 26, 2016. ■

