Insight

CMS is at it Again…Increasing Rx Costs for Seniors

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Despite the public outcry last spring, the Centers for Medicare and Medicaid Services (CMS) has once again issued guidance that could create serious risks in the Medicare Part D prescription drug program. Instead of burying changes in a 1,000 page proposed rule, CMS has issued draft sub-regulatory, informal guidance that impacts the stakeholders in the Medicare Part D program.[1] The guidance, issued on September 29, 2014, has not generated much attention but has policy implications that completely change the way pharmacies and prescription drug plan sponsors negotiate payments for prescription drugs.

By design, Part D bidding rules provide strong incentives for plans to reduce costs. Each year, the Part D plan sponsors submit bids to CMS for the cost of their Part D plans. In order to stay competitive, prices must be readjusted and renegotiated so they can reduce their bids (and thereby enrollee premiums) and increase enrollment. This saves money both for seniors and the disabled enrolled in Part D plans, and for taxpayers. However, this new draft guidance artificially restricts the type of contracts that Part D plans can enter into with pharmacies. This restriction will limit plan sponsors' ability to reduce costs, and force them to increase their bids. This will increase costs for seniors, disabled Medicare enrollees, and taxpayers.

THE WAY PAYMENT NEGOTIATIONS WORK

In general, there are two sets of payments pharmacies receive from plan sponsors in the Part D payment process. The first payment is received based on the price at the point of sale for the drug, reported to CMS as the "negotiated price" of a prescription. The negotiated price is the price determined by the contracts between the pharmacy and the plan sponsor. Some pharmacies agree to deeper discounts for prescriptions, lower dispensing fees, and set other point of sale price concessions. These pharmacies are designated as preferred pharmacies because of the lower cost-sharing they can offer seniors based on these special, deeper discount contracts with the Part D plan sponsor.

The second set of payments occur after the point of sale for a prescription. These payments are reported to CMS as direct and indirect remuneration (DIR), and come in the form of bonus payments, rebates, and/or additional discounts negotiated between pharmacies and plan sponsors for meeting certain performance goals. These performance goals could include meeting generic drug dispensing rates, discounts for administrative fees, and other post-point of sale price concessions, such as rebates from drug manufacturers. These post-point of sale payments generate savings on the whole, as they are received as lump sum payments to pharmacies spreading the savings over all of the prescriptions in the Part D plan.

WHAT THE GUIDANCE IMPACTS

CMS' new guidance, if implemented, effectively eliminates one of these key features of the negotiation process, the post-point of sale payments. Instead of allowing plan sponsors to report these payments separately after the point of sale, CMS is requiring plan sponsors to *approximate* the amount that will be paid to pharmacies in most

DIR payments, and report these add-ons as part of the negotiated price. So, the agency is requiring plan sponsors to bake the amount of most DIR payments into the initial negotiated price. Though it is a weedy concept in pharmacy pricing negotiations, this change in policy effectively eliminates the use of incentive and bonus payments that have been a feature of Part D negotiations since the program's inception which has helped to drive savings.

Ignoring the Non-Interference Clause, Again

The non-interference clause in the Part D statute prohibits CMS from interfering in negotiations between plan sponsors and pharmacies. By requiring that plan sponsors report the approximation of bonus payments as part of the front-end negotiated price, CMS is effectively eliminating the back-end payments. The elimination of these payments removes one of the negotiating tools for plan sponsors and pharmacies, explicitly interfering in the negotiation process between the two entities.

Working to Eliminate Preferred Pharmacies, Again

By interfering in the negotiation processes between plan sponsors and pharmacies, CMS could eliminate preferred pharmacy networks. As mentioned in previous AAF publications, preferred pharmacies are pharmacies that negotiate deeper discounts with Part D plan sponsors, gaining higher patient volume through lower cost sharing and increased beneficiary savings. If one of the main mechanisms through which prescription drug price negotiations are conducted is removed from the process, then deep discounts may not be as easily negotiated.

Decreasing Generic Drug Utilization, Increasing Costs

Finally, the draft guidance could increase the cost of prescriptions for seniors. From 2007-2011 the percent of generic prescription drug use has increased from 67 percent to 80 percent[2], while Part D plan sponsors encouraged increased dispensing of generic prescriptions[3] in pharmacies. This is largely the result of generic drug dispensing performance goals and bonus payments.[4] For pharmacies that dispense a certain percentage of generic drugs, a bonus payment will be awarded. This is an incentive for pharmacies to dispense more generics, and receive a payment for their work once they report their generic utilization amounts to plans. This generic incentive payment decreases the costs for plan sponsors because beneficiaries filling generic prescriptions will cost less than beneficiaries filling brand name prescriptions in the plan.

If bonus payments are incorporated into the front end of pharmacy payments, the incentive to increase performance –ndash; for example, increasing the utilization of generic prescriptions – is greatly diminished since the pharmacy will receive the discounts regardless. If the incentive to prescribe generics is diminished, Part D beneficiaries could end up with more expensive, brand name drugs, and plan sponsors could see their costs increase.

The following graphic provides a hypothetical example of the shift that would occur if the guidance is implemented. Since pharmacies will receive the bonus payment upfront, no incentive exists to meet a performance goal for generic drug utilization. This is depicted through the shift in the 80 percent/ 20 percent ratio moving to a 60 percent generic/ 40 percent brand name drug ratio. This shift increases the overall average cost of the drugs and does not incent pharmacies to dispense less costly generic drugs to seniors.

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CONCLUSION

CMS' guidance is a second attempt to interrupt the negotiations that create preferred pharmacy networks and drive savings in Medicare Part D. Much of Part D savings come from the negotiation process, and this draft guidance handcuffs plan sponsors to the use of negotiation tools that CMS sees fit. In a recent study, Milliman estimated that the removal (or effective removal in the case of this guidance) of the post-point of sale price concessions/DIR in Medicare Part D could result in 2.5 to 10 percent increases in Part D plan bid prices.[5] The increase in plan bids will only increase costs for CMS – which covers 75 percent of the plan cost – and most importantly, for Part D beneficiaries, who are responsible for the other 25 percent. The new guidance from CMS should not be implemented.

[1] http://www.tpadministrator.com/internet/cssc3.nsf/files/CY16_DIR_Price%20Concessions.pdf/$FIle/CY16_DIR_Price%