Panel: Help Needed With Out-of-Pocket Drug Costs

BY JENNIFER SILVERMAN
Associate Editor, Practice Trends

WASHINGTON — The full cost of drugs obtained through patient-assistance programs should be counted as out-of-pocket expenses under the new Medicare Part D prescription drug benefit, according to council members at a meeting of the Practicing Physicians Advisory Council.

The Centers for Medicare and Medicaid Services (CMS) should work with the Health and Human Services Department's Office of Inspector General to give final guidance on this issue, the panel stated.

Under the coming Part D benefit, until the patient has met his or her out-of-pocket expense limit, the patient has to pay for the drug, said PPAC member Barbara McAneny, M.D., an oncologist from Albuquerque. If the patient can't afford it, but "we obtain it for free from the pharmaceutical companies, and if it doesn't count toward true out-of-pocket expenses, the patient will never get through the out-of-pocket [limit] and into the benefit."

Jeffrey Kelman, M.D., medical officer with the CMS Center for Beneficiary Choices told the council that there are circumstances in which out-of-pocket expenses would be covered: Payments made by qualified state pharmaceutical assistance programs toward copays or other cost-sharing would count toward true out-of-pocket expenses, for example, in terms of reaching the $3,600 out-of-pocket limit before reinsurance, he said.

However, payments from a third-party insurance company—or from government agency policies—would not, he said.

"There needs to be guidance as to what that means," he acknowledged.

For the Part D benefit, CMS has divided the country into 34 regions, and all will have robust coverage with several Part D drug plans available for beneficiaries of all incomes and for dual eligible patients in the Medicare and Medicaid programs, Dr. Kelman told the PPAC.

He expressed confidence that beneficiaries would be able to afford the benefit. The average monthly premium for the benefit is $32.30 nationally, lower than what the agency expected, he said.

"All regions will have plans with premiums well below that average," he said. (See box.) In addition, all of the formularies submitted for the program are much more robust than most commercial formularies or any state formulary. "That's going to make the transition in January much easier," Dr. Kelman said.

Dr. McAneny noted that rumors were floating around regarding whether Part B drugs—such as oral chemotherapy agents that are covered under the medical benefit as opposed to the pharmacy benefit—would be moving over to Part D.

"At the moment, those drugs aren't moving anywhere," Dr. Kelman said. "There's talk of it because, starting in January, there will be two drug benefits, and there is a potential for confusion, particularly over the oral drugs or chemo drugs, because all those drugs in theory could be [Part] B or D drugs."

It's an issue that will be looked at again, he said.

In the months leading up to the January start of Part D, CMS has actively been spending time on the education of, communication with, and enrollment of beneficiaries, but outreach to physicians about the drug benefit is an area that needs work, Dr. Kelman said. "Is it toolkits, training sessions, CME?" he asked the panel.

Such tools are important, he noted, as "it's very clear that the practicing physician will be the point of contact for the beneficiary" who needs guidance on what to do about the new benefit.

No physician wants patients to miss out on the Part D benefit, Dr. Kelman noted, "especially because the low-income subsidy is a good benefit. There [are] no premiums, no gap, a minimum copay, no deductible, and a full catastrophic benefit."

Medicare also needs input on how it could interact with physicians on formulary changes, such as matching the formulary with the patient's current drug list, he said.

In a resolution, PPAC indicated it would complement the efforts of CMS to disseminate information to the public about the Part D benefit program.

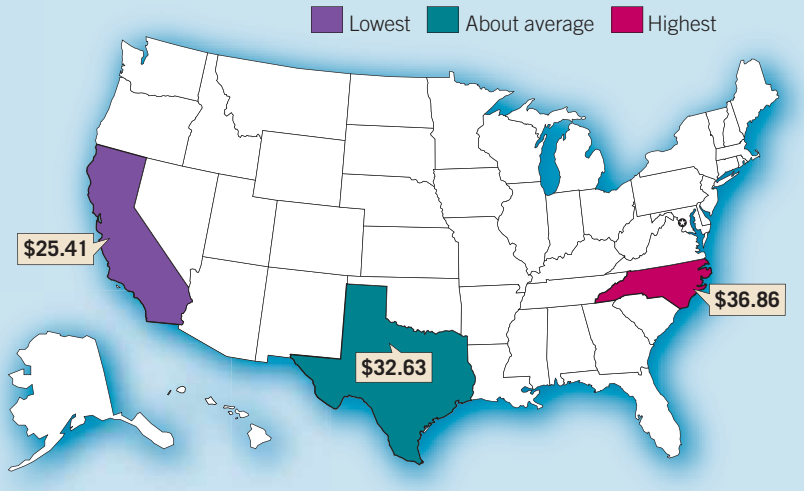
CMS, in the meantime, is developing a new Web tool to help facilitate the enrollment process of the new Part D benefit, Dr. Kelman said.

This new tool "will allow the beneficiary and the physician to identify the plans that the [beneficiary] has been auto-enrolled into or has actively enrolled into," with additional information on the Medicare drug cards.

Auto-enrollment has been a big question in particular for the full-benefit dual-eligibles (those patients who are eligible for Medicare and Medicaid), he said. "Now they can do it on the Web or, more likely, their physician, pharmacist or social worker can do it on the Web."

The council meets quarterly to advise the Department of Health and Human Services on proposed changes in Medicare regulations and carrier manual instructions related to physicians' services. ■

Average Monthly Premiums for Medicare Prescription Drug Plans



Note: The averages are weighted based on the number of plans offered in each state or region.
Source: Centers for Medicare and Medicaid Services

Council Endorses 2.7% Increase in Medicare Payments

BY JENNIFER SILVERMAN
Associate Editor, Practice Trends

WASHINGTON — The Centers for Medicare and Medicaid Services should not institute the 4.3% decrease proposed in the 2006 physician fee schedule, a federal advisory panel recommended.

As it works to fix the sustainable growth rate, CMS should, instead, adopt the Medicare Payment Advisory Commission's recent recommendation to increase payments by 2.7% to keep pace with the cost of care, the Practicing Physicians Advisory Council recommended.

The council meets quarterly to advise the Department of Health and Human Services on proposed changes in Medicare regulations and carrier manual instructions related to physicians' services.

MedPAC advises Congress in a similar manner.

Physician reimbursements under Medicare will be cut 26% over the next 6 years unless the sustainable growth rate (SGR) formula is changed. Although the PPAC recommendation calls on CMS to take action, only Congress has the statutory authority to fix the formula.

The average physician facing these cuts "is stuck," Ronald Castellanos, M.D., PPAC chairman, told CMS officials who presented a summary of the proposed fee schedule at the meeting. Reductions in Medicare payments have forced some physicians to do ancillary procedures in their offices to make up for the lost income, he said.

Leroy Sprang, M.D., an ob.gyn. who was recently named to the panel, said he's seen at least a dozen ob.gyns. in his area of Evanston, Ill., leave the profession due to the pressures of medical malpractice combined with reduced Medicare payments. While they don't deal with older patients as much as do other primary care physicians, some ob.gyn. practices have stopped seeing Medicare patients, he said.

In another avenue for addressing low physician reimbursement, the PPAC asked CMS for a report on whether Medicare Part B drugs could be removed retrospectively, using an administrative methodology.

The council asked that the report be ready in time for its December meeting.

"We've been talking about this for the past 2 years," said PPAC member Gregory Przybylski, M.D. The question is whether CMS could do this administratively by a certain date, he said.

Testifying before the panel, Ardis Hoven, M.D., who spoke on behalf of the American Medical Association, said the AMA was confident of CMS' authority to remove the drugs. "Drugs are not paid under the Medicare physician fee schedule, and it is illogical to include them in calculating the SGR," Dr. Hoven said in her testimony.

If CMS adopted a revised definition of "physicians' services" that excludes drugs, it could revise its SGR calculations going back to 1996 using its revised definition, although the revisions would affect payment updates in future years, she said.

Leslie Norwalk, CMS deputy administrator, conceded that Congress needed to institute a more rational approach to physician payments.

Addressing other possible options, HHS's Office of Inspector General may take another look at "gainsharing," an arrangement where physicians could make suggestions on ways to improve care, and in return receive a portion of the cost savings achieved when their ideas are implemented. "The OIG has permitted physicians to engage in this, but only with respect to supplies, not specifically to medical savings," Ms. Norwalk commented.

To her knowledge, Congress has engaged in some ideas where physicians would be able to share in hospital savings for instance, "without it being a kickback violation," she told the advisory panel.

CMS also has the ability to change payment systems statutorily through its practice group demonstration projects, Ms. Norwalk said. Several projects are currently testing pay-for-performance systems.

For the first time, Congress, MedPAC, CMS, PPAC, and all of the medical specialties are in agreement about something: that the SGR is flawed, Dr. Castellanos said. For that reason, "maybe something constructive can come out of this." ■