Oppose S. 413/H.R. 1038: Improving Transparency and Accuracy in Part D Spending Act

S. 413/H.R.1038 would prohibit Medicare Part D Plan (PDP) sponsors/PBMs from retroactively reducing payment on claims submitted by pharmacies, even when the reduction results from not meeting performance or quality measures. The bill would insulate pharmacies from competition and increase both beneficiary premiums and taxpayer costs.

This Bill Would Increase Beneficiary Premiums

This legislation would shield pharmacies from competition based on quality and would increase beneficiary premiums as plans could no longer use performance-based savings to reduce premiums. CMS found that in 2015, negotiated price concessions lowered per-beneficiary costs in Part D 28 percent on average.[i]

This Legislation Undermines Competition and Negotiation in Medicare Part D

The noninterference provision prohibits the government from interfering in negotiations between insurers and drug manufacturers or pharmacies. By injecting the Secretary into PDP-pharmacy contracts, this legislation would upend the cornerstone of the Part D program, which relies on private market negotiations to deliver consistently high beneficiary satisfaction and lower-than-projected costs.

This Legislation is a Step Backward to Outdated Payment Methods

Congress and both Republican and Democratic Administrations have encouraged Medicare providers to shift from wasteful fee-for-service models to payments based on quality and value.

- PDPs and PBMs use performance-based payments to reward high-performing pharmacies that improve quality through, for example, increasing generic dispensing, improving medication adherence, and reducing inappropriate drug use;
- Alternatively, pharmacies that underperform and do not meet the performance metrics are penalized by reduced payments. Rarely can a typical pharmacy's performance be determined at point of sale;
- These arrangements are agreed upon and acknowledged in advance by pharmacies in their network contracts.

This Legislation Would Open the Part D Program to Fraud

The only exception in the bill to guaranteed payment is if, on "routine audits" agreed to by the pharmacy in its contract with the plan, the claim is determined not to be a clean claim. This is problematic for many reasons:

- PDPs/PBMs must be able to conduct audits beyond "routine" audits. PDPs need to be able to do "unscheduled" audits especially where there is a suspicion of fraud, waste, or abuse (FWA). Under the bill, deficient claims detected in these cases could not be subject to reduction. This should be major concern to those seeking to reduce the opportunities for FWA.
- Government agencies such as CMS, OIG, and GAO can conduct or request a range of audits. All PDPs/PBMs are required to include these audit provisions in their downstream contracts, but under this proposal it seems these audits are not considered "routine" and therefore any payments based on fraudulent or compromised claims could not be reversed.
- This bill will result in significant additional costs because plans/PBMs will not be able to use incentives to manage utilization. PDPs/PBMs would also not be able to able to use standard audit tools to ferret out problematic claims.

[i] CMS, "Medicare Part D – Direct and Indirect Remuneration (DIR)" See Figure 3, January 19, 2017. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-01-19-2.html