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CMS Proposes Changes to Medicare Part B Drug Payment System

Extending the life of the Medicare Trust Fund is as an important political topic as ever, with over 59 million Americans enrolled in Medicare as of July 2018. On Thursday, October 25, 2018, President Trump and the Secretary of the Department of Health and Human Services ("DHHS"), Alex Azar, announced a strategic plan to reduce Medicare spending by amending the way that Medicare reimburses physicians for drugs and biologicals under the Part B program.

Along with the announcement, the DHHS published a paper which indicated that Part B spending doubled from 2006 to 2016, despite comparatively lower enrollment growth as compared to the Part D drug program. The paper compares the costs currently paid in the United States for drugs administered by health care professionals (Part B drugs) with costs paid for drugs administered by health care professionals in economically similar countries, concluding that the current U.S. fee-for-service model, under which providers purchase drugs and are reimbursed by Medicare at a fixed rate (average sales price + 6%), lead to higher drug fees than the international models, which more often engaged in negotiation and "formulary" establishment. A copy of the paper can be accessed here.

In response to the findings, DHHS has put forward an Advanced Notice of Proposed Rule Making ("ANPRM") to solicit comments from concerned stakeholders regarding the Centers for Medicare & Medicaid Services ("CMS") adoption of the International Pricing Index ("IPI") model, as opposed to the existing fee-for-service model. The proposed IPI model would build upon a prior CMS initiative, the Competitive Acquisition Program ("CAP"), through which providers would have patient-specific drug orders filled through a CAP vendor, and the CAP vendor would collect payment from Medicare directly, as well as any applicable co-pay from the beneficiary. The ANPRM details CMS' expectation that allowing private vendors to negotiate sales prices for drugs by leveraging their status as an approved vendor and competing for provider business will lead to lower Part B prices that more closely resemble provider drug costs paid internationally. Further, CMS believes that the adoption of this model will correct a system in which providers are incentivized to prescribe higher cost drugs and that the IPI model will also shift the risk of drug purchasing from providers to vendors. A copy of the ANPRM can be accessed here.

CMS will take comments from the stakeholder community for 60 days following the publication of the ANPRM in the Federal Registrar, which occurred on October 25, 2018. Presently, CMS is stating that a proposed rule could be issued by spring 2019 and that the IPI model could be tested in specific geographic areas for a five year period, beginning in 2020.

As the Medicare-aged population continues to grow, CMS will need to continue to take steps to preserve the viability of the Medicare program. Cost savings initiatives, such as what is currently being proposed, will continue to be analyzed until maximum efficiencies are achieved. The goal to reduce Part B costs to prices achieved internationally certainly appears to further this end. If the U.S. acquisition costs of the 27 drugs and biologicals analyzed in the study were reduced to the average costs of the comparator countries, this would reduce U.S. Part B prices by approximately 45%.

As referenced above, shifting the billing and reimbursement for Part B drugs to vendors may also help to correct a system of bad incentives. Under the current program, Medicare pays health care professionals an additional 6% above the average sales price for a drug or biological. This was intended to help health care professionals cover the costs of drug ordering, storage, and handling. However, it is believed that this premium has incentivized health care

professionals to utilize higher cost Part B drugs or biologicals to obtain a profit and to avoid lower cost Part B drugs or biologicals where the add-on payment might fail to cover the acquisition-related costs. If health care professionals no longer “buy and bill” Medicare for Part B drugs and biologicals, the financial incentives are eliminated, and the type of Part B drugs and biologicals being utilized may change, resulting in an overall savings for Medicare.

Reductions in the Medicare reimbursement rates for Part B costs will not only benefit the Medicare program but can also benefit parties required to reimburse Medicare and protect their interest under the Medicare Secondary Payer Act. Cost reductions are always a welcome prospect. However, since the IPI model will only potentially be entering a test phase in 2020 and the impact may not be fully known until 2025, the Medicare Part B landscape is not going to change overnight. Regardless, this does appear to be a welcome step towards curbing high drug costs.

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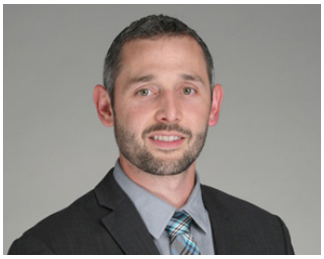
W. Brian Rambin



Michael D. Bergonzi
412-392-5451
mbergonzi@dmclaw.com

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