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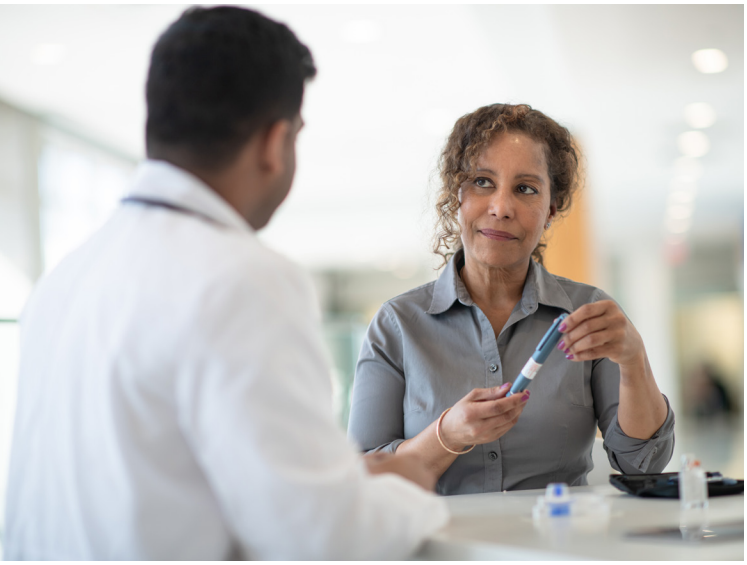

In this issue

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Health care reform

Inflation Reduction Act caps insulin costs, grants CMS drug negotiating power

Many of the health care changes in the Inflation Reduction Act, signed into law by President Biden on Aug. 16, will be rolled out over time, but the effect of the insulin cost ceiling and other aspects of the law are likely to have a more immediate impact on your patients.

Starting next year, the law limits patient cost-sharing under Medicare for insulin products to $35 a month, which will benefit millions of Medicare beneficiaries with diabetes. The law applies to "any covered insulin product" under Part D Medicare starting Jan. 1, 2023, as well as any insulin product "furnished … through an item of durable medical equipment" under Part B, such as pumps and pens, starting in July 2023.

Diabetes advocacy groups see the caps as a win. However, some groups want universal caps across all payers. The Juvenile Diabetes Research Foundation, for example, "applauds" the law but says it will continue to lobby Congress to extend patient cost savings on insulin across the board.

Inflation rebates

The drug inflation rebates, also taking effect in 2023, apply to Part B and Part D drugs. The law instructs the HHS Secretary to report on drugs that have risen in price faster than the rate of inflation by July 1, 2023. The drug manufacturers who receive notice from HHS must supply the government

with a rebate for the overage amount within 30 days. However, patients will not see an immediate benefit.

Rebates are to be paid back to the Medicare fund, and it remains unclear, pending regulation, whether this portion of the law will directly affect beneficiaries. The law includes language suggesting that recalculation of co-insurance payments on these drugs will be required; also, proponents of the law are working under the assumption that the pressure of the ongoing inflation rebates will cause manufacturers to keep back prices.

Certain drug classes will be exempted from the calculus, including those affected by exigent circumstances, such as shortage or severe supply chain disruption.

Drug negotiation

The vaunted drug price negotiation section of the law — which allows HHS to pick a small number of drugs expensive to the Medicare program and force manufacturers to work with them on prices — will start more slowly. By Sept. 1, 2023, the HHS Secretary has to pick the 10 Part D drugs with the "highest total expenditures" on which it will negotiate "maximum fair prices" with manufacturers for CY 2026. The Secretary will add 15 Part D drugs the following year, then 15 Part D and Part B drugs the next and 20 D and B drugs thereafter.

The definition of "highest total expenditures" means the highest "total gross covered prescription drug costs" for Part D drugs for the first two years, Parts B and D thereafter. It is not yet known which drugs will appear on the inaugural list.

Some drug classes, including "small biotech drugs" ands "certain orphan drugs," are excluded from consideration. Also, to be considered, drugs must be at least nine years from their FDA approval and biologicals at least 11 years.

Part D drugs and biologics that have an approved and marketed generic or biosimilar will be excluded from the list. That means, for example, that Eliquis, the blood thinner that is currently the Part D drug accounting for the most spending, may be out of the running for negotiation if its approved generic, apixaban, hits the market as expected by then.

Pharma could strike back

Manufacturers will have an opportunity to renegotiate their prices in certain circumstances, but those that fail to comply with the negotiation process and pricing are subject to civil monetary penalties, which may prompt some legal challenges from the pharmaceutical industry.

Anticipation of such a response may be why you see the phrase "shall be no administrative or judicial review" at intervals in the text of the law.

"That was by design, because Congress didn't want it to be tied up in court for 10 years," says Emily Shaw, senior associate with the Health Care Group at the Alston & Bird firm in Washington, D.C. "That said, there are still constitutional challenges, on takings clause or Eighth Amendment bases. I can't say either way how it would go. But I think that was certainly

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intended to take away some of the procedural avenues for challenging the statute."

Shaw also notes the law's sections directing the HHS Secretary to implement the drug negotiation provisions via "program instruction" or "other forms of program guidance" for the first three years. Thus, she says, "CMS will not be bound by the laws of formal rulemaking, and that will preclude some procedural challenges — like an APA challenge saying that the notice-and-comment process wasn't followed to a T."

That may be crucial, according to Anna Weinstein, senior director with the Hogan Lovells law firm in Washington, D.C., because of the aggressive timelines in the law. "They are going to have to ramp up incredibly quickly and hire a lot of staff [to implement it]," she says. "There are impediments to doing that quickly ... It's not outside the realm of possibility that some of these things will slip a little bit because operationally it's more challenging than anticipated."

Also, Weinstein poses a political question that could come into play. "What happens if the Senate flips [in the midterms] and Republicans decide to try to do a reconciliation packaging to undo some of these things?" she asks. "The agency has to proceed according to the statute, but I'm not certain that it's going to be smooth sailing."

Shaw adds that once Part B drugs are included, it's expected that the usual reimbursement formula for providers — Part B average sales price (ASP) + 6% — will become for negotiated drugs the maximum fair price (MFP) + 6%, which would mean a drop in provider payment. It's unclear whether CMS intends to make good for that to providers in regulation.

Fringe benefits

In 2025, Medicare Part D gets a "benefit structure redesign," which beneficiaries will mainly perceive as price breaks: The program's out-of-pocket drug costs will be capped at $2,000 per year, and the 5% co-insurance on catastrophic coverage for patients with big-ticket prescription needs will go away, after beneficiaries hit the limit (currently $7,050) to meet it. Also, some adult vaccines covered under Part D, such as Shingrix, will now be free of cost-sharing.

"If you're a high utilizer of drugs under Part D, this is obviously life-changing for you," Weinstein says.

ACA extension

Those carrying Affordable Care Act (ACA) plans will benefit from a three-year extension of plan subsidies which beneficiaries with income at or under 400% of the federal poverty level have been receiving since the 2021 American Rescue Plan and which were slated to end on Dec. 31.

Weinstein thinks this will help keep the ACA plans viable but doesn't foresee a run on them from people currently holding plans through other insurers, such as group plans through work. "My sense is these are really complicated calculations for people to make — trying to figure out whether would you be better off under your [high-deductible] employer plan or an ACA plan. How many people do you think are really going to take the time to make a cost comparison?" — *Roy Edroso (redroso@decisionhealth.com)* ■

RESOURCES

- Full text, Inflation Reduction Act: www.congress.gov/bill/117th-congress/house-bill/5376/text
- JDRF Statement on the Passage of the Inflation Reduction Act: www.jdrf.org/press-releases/jdrf-statement-on-the-passage-of-the-inflation-reduction-act/
- CMS Medicare Drug Spending Dashboard: www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Information-on-Prescription-Drugs

Billing

Focus on practitioner preference, end users when you update E/M templates

Make sure treating practitioners and coding staff work together when the practice revises its electronic health record (EHR) templates ahead of the next round of E/M changes (*PBN 7/11/22*). The second E/M update will move the remaining level-based codes to the office/other outpatient model and gives your practice the opportunity to rethink and improve its templates.

According to two physicians, practices should focus on three issues when contemplating template alterations:

1. What practitioners want.
2. How practitioners use the record.
3. Who will use the medical record.

At the end of an AMA-hosted webinar on July 7, *E/M Documentation and Coding: Update for Ambulatory Visits*, presenter Jeannine Engel, M.D., MACP, associate professor of medicine at University of Virginia, recommended that attendees start updating their templates. Engel revisited the topic when Kevin Hopkins, M.D., senior physician advisor for practice transformation at the AMA and west region primary care medical director with Cleveland Clinic Community Care, focused on EHR-building during an Aug. 16 follow-up webinar, *Private Practice Simple Solutions: E/M - Session Two.*

"I've started reviewing my own templates to really streamline them," Hopkins said. For example, he has removed some unnecessary information and links. He asked Engel to elaborate on why it was necessary and how to start.

"A lot of this is personal preference, what's important to you, how do you use your notes as well," Engel replied and gave the example of the documentation style of a physician who had recently retired. That doctor tended to leave a lot of information about their medical decision-making [MDM] in the note over time. Engel believes the doctor did that to better remember things, but she found it "super helpful," because she did not have to go through years of notes to find information.

Engel urged webinar attendees to think about how they use their notes and what's important to them. She also explained that when she writes a note — or reviews another physician's notes — she concentrates on the history of present illness, the reason for the visit, and the assessment and plan. "My templates don't pull in any data. If I think the data's important, I put it in myself or I say I reviewed it," Engel said.

"I think the way to do it is to look at, what do you need in your notes, what do you need in your notes to communicate with yourself and others?" Engel added. She advised physicians to ask themselves if the new, streamlined guidelines create opportunities to create a more concise note by excluding information they no longer need.

Hopkins agreed and added that a note serves multiple purposes. "It's not just about billing. Because if it was just about billing, they could actually be a lot shorter now," he said.

"But we're communicating with our future selves, we're communicating with other health care professionals, and … with open note access through patient portals and things like that, we're communicating more directly with patients, too," Hopkins elaborated.

Hopkins recommended that physicians rethink where they store data, especially data that is no longer relevant. "It may be more appropriate to store that years' worth of data somewhere else … other than the visit note." And he warned against copying and pasting unless the physician is willing to spend time updating the information. When physicians pull information that is irrelevant or out of date into the note, it can create confusion "and be less helpful rather than more helpful," Hopkins said — *Julia Kyles, CPC (jkyles@decisionhealth.com)* ■

RESOURCES

- E/M Documentation and Coding: Update for Ambulatory Visits (YouTube video): www.youtube.com/watch?v=DOwdieU0_zE&t=7s
- Documentation and Coding: Update for Ambulatory Visits – Part 2: FAQs discussion (video to be released at a later date): www.ama-assn.org/practice-management/private-practices/ama-private-practice-simple-solutions

Compliance

For patients with challenges, hearing aid rule gives providers OTC options

The final rule on over-the-counter hearing aids from HHS and the Food and Drug Administration (FDA) clears a new category of sub-prescriptive hearing devices that may offer your patients a welcome alternative.

The rule, effective 30 days after its Aug. 17 publication date, allows for a new category of over-the-counter (OTC) hearing aids that are not prescription hearing aids, but which have some of the same characteristics and should present a lower cost-of-entry for certain types of sufferers.

Previously, device manufacturers could not market products that did not meet FDA specifications for a prescription hearing aid as hearing aids. Simple amplifiers known as personal sound amplification products (PSAP) were the only market alternative. According to Amy Sarow, AuD, an audiologist in Farmington Hills, Mich., these "amplify all frequencies equally and do not discriminate between speech and noise."

(continued on p. 6)

Benchmark of the week

Medicare costs, enrollment inch up, and so does patient burden

While some of your patients will find relief under the Inflation Reduction Act (IRA), their financial contributions to coverage continue to rise, according to CMS' most recent FastFacts program data. Federal health care programs continue to grow, as well, although none of the Medicare programs are picking up members as quickly as Medicaid.

The most recent FastFacts filing, released in March, finds all CMS' preliminary beneficiary enrollment numbers for 2021 adjusted upward from its July 2021 edition (*PBN 9/27/21*). The projected enrollment for Parts A and B increases from 63.3 million to 63.8 million; for Medicare Advantage, from 26.7 million to 26.9 million; and for Part D, from 48.5 million to 48.7 million. (Note: Part D enrollment overlaps with the other programs; a recent HHS Assistant Secretary for Planning and Evaluation report estimates that, as of 2019, 74% of Medicare enrollees had Part D drug coverage.)

Rising, too, and more quickly, are what Medicare patients may expect to pay for their coverage. While the 2020-2021 estimated Part A and B population growth is about 0.8%, the increases in the Part A and B basic premiums (with no income adjustments) from 2021 to 2022 are 6% and 15%, respectively. The Part D deductible rose by 7.9% in the same period, and the Part A inpatient deductible is up 6.6%.

Under the terms of the IRA, Part D beneficiaries will see changes in their out-of-pocket threshold to a $3,000 cap in 2025, but for now they're still subject to a $4,430 initial coverage limit, which means entry to the "donut hole" in Part D coverage up till the catastrophic coverage threshold of $7,050. Unlike the "redesigned" Part D, where there's no coinsurance thereafter, currently they still have to pay 5% when they reach it (*see related story, p. 1*).

Meanwhile, there's a massive estimated Medicaid enrollment jump of 10.9% from 2020 to 2021. This may be partly due to the continued progress of Medicaid expansion in the states, but experts surmise this is largely an effect of the pandemic.

A notable sidelight: From the July 2021 report, total A and B beneficiaries receiving service under those programs in a year actually went down, from 34.3 million in 2019 to 33.4 million in 2020. – *Roy Edroso* (*redroso@decisionhealth.com*)

CMS Program Data - Populations[1]

Medicare (avg monthly)	CY 2019	CY 2020	CY 2021[1]
Parts A and/or B	61.5	62.8	63.8
Aged	53.0	54.5	55.8
Disabled	8.5	8.3	8.0
Original Medicare Enrollment	38.6	37.8	36.3
MA & Other Health Plan Enrollment	22.9	25.1	27.5
MA Enrollment	22.2	24.4	26.9
Part D (MAPD+PDP)	45.8	47.4	48.7
Medicaid (avg monthly)[2]	**FY 2019**	**FY 2020**	**FY 2021**
Total	73.9	75.3	83.5
Aged	6.1	6.3	6.5
Blind/Disabled	10.2	10.1	10.2
Children	28.9	29.1	33.5
Adults	15.2	15.4	17.0
Expansion Adult	12.1	12.8	15.0
CHIP (avg monthly)[3]	7.2	7.1	7.1
[1] Preliminary and subject to change			
[2] Projected estimates			

Sources: CMS/Office of Enterprise Data & Analytics/Office of the Actuary

Medicare Deductibles, Coinsurance, Premiums

	CY 2021	CY 2022
Part A		
Inpatient Hospital		
Deductible	$1,484.00	$1,556.00
Coinsurance/Day	$371.00	$389.00
Coinsurance/LTR Day	$742.00	$778.00
Coinsurance/SNF Day	$185.50	$194.50
Part B		
Deductible	$203.00	$233.00
Part D		
Maximum Deductible	$445.00	$480.00
Initial Coverage Limit	$4,130.00	$4,430.00
Out-of-Pocket Threshold	$6,550.00	$7,050.00
Premiums		
Part A	$471.00	$499.00
Part B	$148.50- $504.90	$170.10-$578.30
NOTE: The inpatient hospital deductible applies per benefit period.		
LTR - Life Time Reserve		
SNF - Skilled Nursing Facility		

Source: CMS/Office of the Actuary

(continued from p. 4)

The new rule stakes out technical specifications for hearing aids that can be sold without a prescription or any prior encounter with a state-licensed eye nose and throat (ENT) or audiology provider. These include an output limits on 111 decibels of sound pressure level (dB SPL), or 117 dB SPL for devices while input-controlled compression is activated. The device must also be "controllable by the user and customizable" to the needs of the user, who must be able to make "frequency-dependent changes," either via a "physical toggle switch, a selection through a software interface, or providing preferences for software to select the optimal profile dynamically," according to the final rule.

These products may be made available to persons 18 years of age or older who have "mild to moderate" hearing issues; users must be made aware that the devices are not appropriate to severe hearing issues or for children.

Christopher Hanson, a partner with Nelson Mullins in Greenville, S.C., and head of the firm's FDA Regulatory Compliance and Litigation practice group, says that there have been high-level discussions about the FDA creating an over-the-counter hearing aid product category for about a decade. The FDA Reauthorization Act of 2017 (FDARA) mandated that the FDA issue rulemaking, but the FDA missed its August 2020 deadline; a July 2021 Biden executive order prompted the agency to come across in October 2021 with a proposed rule.

The utility of the new class of hearing aid is an advance on the PSAPs. Given that prescription hearing aids generally require patient evaluations by a licensed provider and visits to fit, test and adjust hearing aids, their anticipated lower cost should extend benefits to patients who might not have considered them before, according to Hanson.

"One may liken this new option to reader glasses versus prescription glasses," Sarow says. On the other hand, some conditions will still demand professional assistance. "Those who have difficulty hearing a vacuum cleaner or a car honking, for example, will not benefit from these devices," she adds.

Have a question? Ask *PBN*

Do you have a conundrum, a challenge or a question you can't find a clear-cut answer for? Send your query to the *Part B News* editorial team, and we'll get to work for you. Email askpbn@decisionhealth.com with your coding, compliance, billing, legal or other hard-to-crack questions and we'll provide an answer. Plus, your Q&A may appear in the pages of the publication.

What will PCPs do?

Robert Wells, a shareholder with Baker Donelson in Baltimore, thinks that the new class of devices "may change some behaviors" among frontline providers whose patients have hearing complaints and who may previously have referred to an ENT or audiologist. They "may be more inclined to simply suggest that patients try to address the issue through available OTC products that will soon be available," he suggests. "This change will certainly make hearing loss care more readily available to millions of people who otherwise would have gone either undiagnosed and untreated for a variety of reasons, including lack of access to specialized hearing loss care or lack of resources to obtain any potential relief."

As for traditional hearing specialists, Sarow thinks their role will persist and evolve.

"A hearing test will still be useful to determine whether these devices will provide enough benefit for the user or whether a conventional hearing aid will be more useful," Sarow says. "Audiologists will need to learn how to incorporate these new devices and potentially incorporate them into their portfolio of hearing technology options." — *Roy Edroso (redroso@decisionhealth.com)* ■

RESOURCE

- HHS/FDA, "Medical Devices; Ear, Nose, and Throat Devices; Establishing Over-the-Counter Hearing Aids," final rule, Aug. 17, 2022: www.federalregister.gov/documents/2022/08/17/2022-17230/medical-devices-ear-nose-and-throat-devices-establishing-over-the-counter-hearing-aids

Compliance

Don't let OIG fraud alert disrupt your practice's telehealth program

The latest special fraud alert warned treating practitioners about telemedicine companies that recruit providers in order defraud Medicare and other programs (PBN 8/15/22). However, the alert should not discourage you from using the COVID-19 public health emergency (PHE) waivers to provide telehealth services to your patients.

"Both at the federal and state level, these waivers have allowed telemedicine providers to expand the reach of their services," says Amy Lerman, member of the firm with Epstein Becker Green in Washington, D.C.

"Telehealth is here to stay, and the enforcement activity should not detract from the very real benefits telehealth has provided in terms of health care access and convenience," says Ty Howard, partner with Bradley Arant Boult Cummings LLP in Nashville, Tenn.

Legal experts emphasized the importance of complying with the rules even though they've been relaxed. That means sticking with the basics, such as appropriate documentation and coding, following the rules for telehealth services that are in place during the waiver period, performing internal reviews of your claims and, if necessary, returning overpayments.

"My sense is that even with the waivers that have and continue to be in place, the emphasis behind these waivers was to ensure access to safe and effective health care services, and not to diminish the compliance obligations that providers have when providing such services," Lerman says.

Flagged activities aren't off limits

You can continue to order durable medical equipment (DME) or genetic testing for telehealth patients, even though fraudulent telemedicine schemes lean heavily on such services. Following the rules for what's clinically appropriate, medically necessary and permitted by the payer will keep your practice clear of trouble.

"Whether a given service can be appropriately provided via telehealth is highly specific," Howard says. "For example, certain types of CPT codes for DME require an in-person examination. More generally, there are specific process rules around telehealth delivery, and many of those have changed (temporarily or permanently) during the pandemic." In addition, private insurers and federal programs such as Medicare may have different requirements, Howard adds.

You should also expect closer scrutiny of services that are prone to abusive or fraudulent billing. "There are legitimate arrangements for providing these services via telehealth; however, certain laboratory tests and equipment can easily be overutilized," says Sara Shanti, partner with SheppardMullin in Chicago. "Specifically, they are generally chosen because of their low risk of physical harm to patients, broad clinical rationale, and being commonplace enough to avoid additional inquiry."

Medical reviews and audits will come, eventually

Keeping up with your compliance obligations will prepare you for the inevitable audits by Medicare administrative contractors, the HHS Office of Inspector General (OIG) and other organizations with auditing and investigational authority. Telehealth regulations will continue to change as they revert back to the more restrictive pre-PHE standards. Audits and enforcement actions to ensure compliance will also evolve, Shanti says. "Enforcement will only grow, and with digital health comes a digital footprint, which reflects a practitioner's actions."

"Over time, I expect investigations to focus on the actual reimbursement rules for telehealth (rather than broader criminal conduct) and that regulatory and civil enforcement — such as the False Claims Act — to play a significant role," Howard says. — *Julia Kyles, CPC (jkyles@decisionhealth.com)* ■

RESOURCE

- Special fraud alert, OIG Alerts Practitioners to Exercise Caution When Entering into Arrangements with Purported Telemedicine Companies: https://oig.hhs.gov/documents/root/1045/sfa-telefraud.pd

Ask Part B News

Use these strategies when a payer inappropriately uses modifier 50

Question: *We recently sent a claim to Blue Cross of Alabama that included* ***20610-LT*** *for a left shoulder diagnosis and 20610-****RT*** *for a right knee diagnosis. The payer responded that we should have billed these procedures on one claim line with a* ***50*** *modifier (bilateral procedure). We replied that this was not a bilateral procedure, but rather two separate procedures done in two separate joints. The payer then stated that because code 20610 has a bilateral surgery indicator of "1" in the Medicare physician fee schedule, modifier 50 should be used rather than RT/LT. There doesn't seem to be any way to report a major joint arthrocentesis done on different joints on opposite sides of the body. Is there a way to correct the situation?*

Answer: Some payers are interpreting Medicare's bilateral procedure policy as applying even when the same procedure is done on joints in different body areas. Because code 20610 has a "1" bilateral surgery indicator, they say, the code should be reported with modifier 50 and receive the bilateral payment reduction when done on opposite sides.

You could try sharing Medicare administrative contractors' policies with the payer to help them understand, suggests orthopedic coding consultant Margie Scalley Vaught, CPC, COC, CCS-P, MCS-P, ACS-EM, ACS-OR.

For example, Medicare Part B MAC WPS defines bilateral procedures as "procedures/services that occur on identical, opposing structures."

National Medicare policy for the bilateral indicators states that "coding claims for surgical procedures performed bilaterally depends on:

- The HCPCS code descriptor,
- The 'Bilateral Indicator' assigned to the HCPCS code (that is, whether special payment rules apply), and
- The nature of the service." (Source: MLN Matters Number: SE1422)

Explain to your payer that the nature of the services you are reporting dictate that bilateral modifier 50 does not apply — the injections were done on major joints in two different anatomic regions to address two separate conditions. If performed on the same side they would not be considered bilateral.

Further, to ensure that your claim is as accurate and specific as possible from a compliance perspective, the two injections must be reported on two separate claim lines with different diagnosis codes. — *Laura Evans, CPC (levans@decisionhealth.com)*

Ask Part B News

Turn to modifier 91 for repeat laboratory testing

Question: *We are getting some National Correct Coding Initiative (NCCI) edits for repeat laboratory services. What modifier do we use if a component of a panel test is repeated later?*

Answer: Modifier **91** (Repeat clinical diagnostic laboratory test) may be reported with laboratory CPT codes when the provider performs multiple tests on the same day to treat or diagnose the patient. Per the CPT guidelines, this modifier may not be used for laboratory tests that are repeated to confirm the initial results, or due to malfunctions of either the testing equipment or the specimen.

Sometimes a provider will need to repeat a component of the laboratory panel if the first results come back inconclusive. If only a component or maybe a couple of components of a laboratory panel were repeated, don't report the entire panel a second time. In some cases, staff may inappropriately report entire panels twice and then receive an NCCI edit stating that the panel can't be performed twice for a single patient on the same day.

A physician may perform a panel in the morning, and then later in the evening, or repeat the panel in its entirety. However, this doesn't happen often; typically, it's one or two elements of that panel that have to be checked at a later point and repeat individual component tests would be reported with modifier 91. — *Sarah Gould, CPC (sgould@decisionhealth.com)* ■

Editor's note: *This question was answered by Sarah L. Goodman, MBA, CHCAF, COC, CHRI, CCP, FCS, president and principal consultant for SLG Inc., in Raleigh, North Carolina, during the 2022 HCPro webinar NCCI Modifier Review: Navigate Chapter-specific Coding and Reporting Guidance. Learn more: www.codingbooks.com/yhha042822.*

Part B News Brief

Part D plan preference for higher-cost hepatitis C drugs led to higher Medicare and beneficiary spending

On August 11, the OIG published a review of the utilization of hepatitis C drugs in Medicare Part D compared to utilization of the same drugs in Medicaid in 2019 and 2020. The review was conducted because preliminary research indicated that Part D beneficiaries were using higher-cost hepatitis C drugs rather than the generic versions that were increasingly being used by Medicaid beneficiaries.

The OIG found that after generic versions of hepatitis C drugs were introduced in 2019, the use of the generic versions increased in Medicaid at a greater rate than they did in Part D. In 2020, some Part D plans did not cover these generic versions of hepatitis C drugs, and Part D beneficiaries without financial assistance paid an average of $2200 more out of pocket for higher-cost hepatitis C drugs. The OIG also found that Medicare spent $155 million more in catastrophic coverage payments for higher-cost hepatitis C drugs than it would have had beneficiaries been using the lower-cost generic versions. The results of the review are consistent with suggestions from others that certain Part D programmatic factors, such as manufacturer rebates, may be providing incentives for Part D plans to prefer that their beneficiaries use the higher-cost drugs.

The OIG recommends that CMS encourage Part D plans to increase access to generic versions of these drugs. CMS concurred with the OIG recommendations. Read the OIG report: *https://oig.hhs.gov/oei/reports/OEI-BL-21-00200.pdf.*