Health Care Reform: Are You in the New Game?
Kevin J. Colgan, M.A., B.S.Pharm., FASHP
Corporate Director of Pharmacy
Rush University Medical Center
Chicago, Illinois

The Changing Landscape of Health Care: Cultivating Leadership in Health-System Pharmacy

Learning Objectives

• Describe the components of health care reform and their impact on health systems.
• Identify strategies that pharmacy leaders can employ to positively influence their institution’s ability to thrive within the new health care environment.
• List strategies and tools that will be needed in order to lead health-system pharmacy into the next decade.

What is one issue or challenge that you observe with our current health care system?

Patient Protection & Affordability Act

Cost: $940B over ten years
• Reduces Federal Deficit $143B

Assignment

Will the Patient Protection & Affordability Act.....

1. improve the health of US citizens?
2. control the escalation of healthcare cost?
3. have a positive impact on businesses and the economy?
4. increase the role that pharmacists and other physician-extenders play?

Red card
Low Impact
Green card
High Impact

Patient Protection & Affordability Act

Funding: Taxes

1. Payroll taxes for Medicare Part A increase beginning 2013
   - 1.45% → 2.35% for individual/married annual income of $200,000/$250,000
   - 3.8% tax on unearned income for higher-income tax payers
2. Excise tax of 40% on insurers of employer-sponsored health plans with values exceeding $10,200/$27,500 indexed for individual/family coverage beginning in 2020
3. 10% tax on indoor tanning
Patient Protection & Affordability Act

**Funding:** Health Insurers

1. Annual Fees of $38.8B through 2018
2. Restructuring Medicare Advantage – Cut Subsidies of $132B over 10 years
   - 22% of beneficiaries are enrolled in MA Plans nationally
   - Illinois → 9% of beneficiaries enrolled in MA Plans

Note: No price controls on pharmaceuticals except there is an Independent Payment Advisory Board to submit legislative proposals to reduce the per capita rate of growth in Medicare spending if spending exceeds target growth.

Patient Protection & Affordability Act

**Funding:** PhRMA

1. Annual Fees of $28.38B through 2020
2. Increase Medicaid Rebate Percentage
   - Brand: 15.1% → 22.1%
   - Generic: 8% → 15.1%
   - Multisource: 22 → 12%
3. Discount drugs in the Part D “donut hole” by 50%

**Rush C-Suite Presentation**

1. The Patient Protection & Affordable Health Care Act (PPACA) will exert downward pressure on hospitals from both public and private insurers to both increase quality and lower cost of patient care.
2. Pharmacists can help Rush’s bottom line by taking actions to reduce their costs while simultaneously improving the quality of care, such as:
   - Coordinating patient care:
     - Medication management
     - Transitions of care
   - Reducing hospital acquired conditions
     - Preventable adverse drug reactions
     - Preventable medication errors
   - Adopting more cost effective use of pharmaceuticals

**PPACA Timeline**

**2010**
- **Dependent Coverage Standardized ages 18-26 for employee health insurance in the workplace (12/2010)**
- **Health Care Reform Act of 2010**
- Affordable Care Act
- Health Care for All Americans Act
- Patient Protection and Affordable Care Act (PPACA)
- Health Care and Education Reconciliation Act of 2010
- Medicare’s Prevention Therapy Add-on Payment (PTAP) Program

**2011**
- **100% Medical Home Model (1/1/2011)**

**2012**
- **Patient Centered Primary Care Program (PCPCC)**
- **Affordable Care Act (ACA)**
- **Medicare’s Physician Payment System (PPS)**
- **Public Health Campaign (PHC)**

**2013**
- **Medicare’s Preventive Benefit and Article 7 of the PPACA**
- **Quality Payment Program (QPP)**

**2014**
- **2014 Medicare Access and CHIP Reauthorization Act (MACRA)**
- **National Public Health Campaign (PHC)**

**2015**
- **2015 Medicare Access and CHIP Reauthorization Act (MACRA)**
- **Quality Payment Program (QPP)**

**2016**
- **2016 Medicare Access and CHIP Reauthorization Act (MACRA)**
- **Quality Payment Program (QPP)**

**2017**
- **2017 Medicare Access and CHIP Reauthorization Act (MACRA)**
- **Quality Payment Program (QPP)**

**2018**
- **2018 Medicare Access and CHIP Reauthorization Act (MACRA)**
- **Quality Payment Program (QPP)**

**PPACA Opportunities for Pharmacists**

1. Pharamaceuticals
2. Hospital & Health Care
3. Medicare
4. Medicaid
5. Medicare
6. Medicaid
7. Medicare
8. Medicaid
9. Medicare
10. Medicaid
11. Medicare
12. Medicaid
13. Medicare
14. Medicaid
15. Medicare
16. Medicaid
17. Medicare
18. Medicaid
19. Medicare
20. Medicaid
Opportunities for Pharmacists in Health Care Reform

#1 Medication Therapy Management Grants
The Act creates two Medication Therapy Management (MTM) Programs

- Section 3503 – Medication Management Services in the Treatment of Chronic Disease
  - The Secretary of HHS may establish a program to provide MTM services to persons who are likely to benefit from such services.
  - Section 3503A - MTM Services for Patients with Complex Medical Needs
- Under this program, MTM will be targeted at individuals who:
  - Have four or more medications
  - Have at least two chronic diseases as certified by the Secretary
  - Have undergone transformation of care or other factors that are likely to create a high risk of medication-related problems

Opportunities for Pharmacists in Health Care Reform

#2 Market Expansion of Specialty Biological Products

- Section 3139 – Payment for Biosimilar Biologic Products
- Section 7002 – Approval Pathway for Biologic Products
  - 12 years market exclusivity versus 6 years that was anticipated

Opportunities for Pharmacists in Health Care Reform

#3 CMS Innovation Center

- Section 3021 – Establishment of Center for Medicaid and Medicare Innovation
  - Creates Innovation Center by January 1, 2011 to test innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid and CHIP while preserving the quality of care
  - Models will be selected by CMS, with preference given to models that address populations with deficits in care that lead to poor clinical outcomes and potentially avoidable expenditures.
  - The Secretary of HHS may limit the models tested to the following areas:
    - Medical Home
    - Chronic Care Management
    - Care for cancer patients
    - Health information technology
    - Coordinated Care
    - Collaboration amongst providers
    - Patient education
    - Alternative payment mechanisms
    - Integrated care for dual eligibles

Opportunities for Pharmacists in Health Care Reform

#4 Medical Home
Section 3502 – Establishing Community Health Teams to Support the Patient-Centered Medical Home

- “Ensure that the health team established by the entity includes an interdisciplinary, interprofessional team of healthcare providers as determined by the Secretary, such team may include medical specialists, nurses, pharmacists...”

AHRQ is required to establish a program to provide grants or contracts to eligible entities to support health teams.

A health team is required to perform a number of functions, including to:
- Support patient centered medical homes;
- Work with primary care providers to better coordinate patient care;
- Develop plans that integrate preventive services for patients;
- Provide support to primary care providers to improve access to certain services, including medication management;
- Provide 24-hour care management and support during transitions in settings of care; and
- Implement the use of health information technology.

Specialty Pharmaceuticals

- 200 products approved – 1000 in development
- Agents require special handling, administration, education, clinical support and risk mitigation
- $998 market in 2010 – 24% of total drug expenditures
- $1.7 trillion by 2030 – 44% of total drug expenditures
- Growing at twice the rate of traditional pharmaceuticals
- 45% of market is physician’s office
- Huge opportunity with external competition – Walgreens, CVS Caremark, Medco
Opportunities for Pharmacists in Health Care Reform

#5 Accountable Care Organizations

- Section 3022 – Medicare Shared Savings Program
  - Effective January 1, 2012, certain providers of services and suppliers that have established a mechanism for shared governance may work together in partnership with or under a joint venture arrangement with a hospital to manage and coordinate care for Medicare FFS beneficiaries through an ACO.
  - ACO’s will be reimbursed FFS, but those that meet quality performance standards set by the Secretary will also receive shared savings, up to an amount determined by the Secretary.
  - Hospitals may be included.
- Medication components of ACO’s should involve pharmacists.
- Section 2607 – State Demonstration Project for Pediatric Patients
  - Effective January 1, 2012, through December 31, 2016 (b) CMS may authorize states to allow pediatric medical providers to form ACO's and receive payments in the same manner as above.

Accountable Care Organizations

Components
- Local network including physicians & a hospital or hospitals
- Formal legal structure
- Participation contracts with primary care physicians
- Contracts with core groups of specialty providers
- List of primary and sub-specialty providers to CMS
- Management & leadership structure for joint decision making
- Defined processes for promoting EBM & reporting on quality, cost reduction, & coordination of care

CMS Pilot

- Developmental Leaders:
  - Dartmouth Institute for Health Policy & Clinical Practice
  - Engberg Center for Health Care Reform at Brookings Institution
- Site:
  - Carilion Clinic, Roanoke, Virginia
  - 500 physicians/100 pharmacists
  - 7 hospitals

Opportunities for Pharmacists in Health Care Reform

#6 Value-based Purchasing Program for Medicare

- Section 3001 – Hospital Value-Based Purchasing Program
  - Applies to payments made on or after October 1, 2012
  - Includes:
    - 5 conditions/procedures (AMI, HF, Pneumonia, Surgeries through SCIP, HC-associated infections)
    - Hospital Consumer Assessment of Health Care Providers and Systems Survey – NCHA HPS
    - Efficiency measures with respect to discharges
  - Currently 21 measures include medications

Opportunities for Pharmacists in Health Care Reform

#7 Hospital-Acquired Conditions

- Section 10303 – Development of Outcome Measures
  - (b) Hospital-Acquired Conditions
  - Medicare
    - Hospital-Patient Prospective Payment System Payments will be reduced with respect to discharges from hospitals in the top-quartile
    - Currently based on hospital-acquired infections
  - Medicaid
    - Based on current state practices
    - CMS must promulgate regulations specifying health-acquired conditions for which federal matching payments will not be provided to the state under their Medicaid programs [Effective July 1, 2012]
**Study of 100 Random Discharges**

Findings for May – October, 2009

Per Patient Admission

- 14.6% Med Error
- 43% Preventable
- 88% Preventable
- 0.4 Med Events
- GI discomfort from opioids
-unnecessary CT scan
- Over and under dose
- Drug without indication & vice versa
- Non-quantified costs of care

**Opportunities for Pharmacists in Health Care Reform**

#8 Preventable Hospital Readmissions

- Section 3025 – Hospital Readmissions Reduction Program
  - Adjustment factor: 0.99 (2013), 0.87 (2014), 0.77 (2015)
  - What constitutes “excess readmissions” will be determined by CMS
  - Example: Rush readmissions for HP worse than national average, pneumonia & heart attack no different than national average (www.hospitalcompare.hhs.gov)
- Section 399K – Quality Improvement Program for Hospitals with High Severity-Adjusted Readmission Rates
- Section 3026 – Community-based Care Transitions Program
  - Cognitive Impairment, Depression, History of Multiple Readmissions, Any other Chronic Disease determined by the Secretary

#9 Bundled Payments for Post Acute Services

- National pilot program to be developed by January, 2013
  - Inpatient hospital services
  - Physician services
  - Outpatient hospital services
  - Post-acute care services 3 days prior to 30 days post hospitalization
- Expansion of program in 2016 if successful

**Bundled Payments**

- Premise → traditional fee-for-service does not
  - encourage collaboration between physicians, hospitals, & other providers
  - encourage active efforts to reduce complications of care

- Commonwealth Fund & RWJ Foundation Grants provided to Prometheus to develop evidence informed case rates (NEJM 2009;361:1033-1036)

- “Potentially Avoidable Costs” account for 22% of all private-sector HC expenditures

- Pilot programs reported increase internal tension when implementing the payment system

**Bundled Payments**

- Example: Unstable angina patient admitted to hospital
  - Triple vessel disease (60% stenosis)
  - Urgent CABG with mitral valve reconstruction
  - In ICU, glucose uncontrolled, started on insulin drip – stay extra 2 days
  - Discharged 8 days post surgery – develops wound infection in the harvest site 7 days post discharge
  - Readmitted for wound debridement & antibiotics
**Bundled payments**

<table>
<thead>
<tr>
<th>Fee-For-Service</th>
<th>Bundled Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital (CABG)</td>
<td>$47,500 Hospital</td>
</tr>
<tr>
<td>Surgeon (CABG)</td>
<td>$15,000 Physicians</td>
</tr>
<tr>
<td>Hospital (+2d in ICU)</td>
<td>$12,000 Allowance PACs</td>
</tr>
<tr>
<td>Physician (post-op)</td>
<td>$2,000 Total</td>
</tr>
<tr>
<td>Readmission</td>
<td>$25,000 Severity-adjusted payment</td>
</tr>
</tbody>
</table>

Without readmission
M.D. & Hospital share a bonus of $12,800

**Study of 100 Random Discharges**

*Findings for May – October, 2009*

- Over-utilization occurred in 45% of cases
- 11% of cases with over-utilization greater than $200
  - Cases represented 97% of over-utilization by dollars
- Hard cost of over-utilization
  - $25,775.86
    - $258 per chart reviewed
    - $572 per chart reviewed with over-utilization present

**Opportunities for Pharmacists in Health Care Reform**

**#10 Comparative Effectiveness Research Trust Funds**

- Section 6302 – Federal Coordinating Council for Comparative Effectiveness Research (Founded under the American Recovery & Reinvestment Act)
- Section 399HH – National Strategy for Quality Improvement in Healthcare
  - Established a non-profit Patient-Centered Outcomes Research Institute to identify research priorities

**Comparative Effectiveness Research**

- New law infuses $3B into healthcare research - $500M in annual funding beginning in 2013
- Builds on an earlier $1.1B investment from the stimulus package
- Harvard has hired 5 faculty members for CE research in the last 9 months – received $14M in grants from stimulus package (Bloomberg Business Week)
- In March, United Healthcare purchased QualityMetrics, a firm that measures how patients rate the effectiveness of care

**Summary**

- Hospitals have 3 - 4 years to become lean and efficient
- Collaboration is the key to success
- Improving quality is a necessity to reduce potentially avoidable costs
- Pharmacy is a key player
  - Cost
  - Quality
  - Care → Physician extenders
  - Research → support to expand services

**Assignment**

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Thank you!