



HCR/regulatory scorecard:

What is happening NOW!

Proposed regulations receiving public comments

- ❑ FDA: June 24–25 public workshop on reduction of medication errors through improved naming, labeling, and packaging practices (comments close July 23).
- ❑ FDA regs on direct-to-consumer advertising (comments close June 28).
- ❑ FDA collecting information on experimental study of patient information prototypes (comments close July 1).

Regulations whose comment periods have closed

- ❑ DEA request for comment on interim final rule on electronic prescribing of controlled substances.

Regulations recently finalized

- ❑ **Medicare Coverage Gap Discount Program:** When Medicare Part D beneficiaries hit the doughnut hole next year, the pharmacist will once again be a key messenger about what the 50% discount on applicable medications will mean to them. But, as APhA told CMS in comments filed on May 14, patients will need to realize that the pharmacist is only conveying information calculated by Part D plans through the claims adjudication process. APhA recommended that CMS work with APhA and other pharmacy stakeholders in developing and disseminating educational tools, point-of-service messaging, and patient-education materials. Within a week of receiving comments, CMS finalized its guidance and in that,

Continued on page 10

The new law: Divide and analyze

Implementation of the Affordable Care Act (ACA) is now in full swing at the Health and Human Services Secretary's office, CMS, FDA, and other federal agencies responsible for various aspects of this complex law. APhA has a yeoman's task before it in keeping up with proposed regulations, identifying provisions that affect pharmacy and pharmacists, calling for input from members, formulating a response, and then working to make sure the profession's voice is heard before the rules are finalized.

Beginning this month and in future installments of the Hub, both in *Pharmacy Today* and also on the Health Care

Reform Hub page in the Government Affairs section of pharmacist.com, the many facets of ACA will be evaluated, explored, and explained. Specifically, plans are to cover one major aspect of the new law in each remaining 2010 issue, starting with accountable care organizations this month.

Most of the analyses will cover sections of ACA that are directly relevant to the profession of pharmacy and therefore are being regularly monitored by APhA. Other parts of the bill will be covered briefly—including aspects with the potential to affect APhA members as pharmacy owners or employees.

ACOs coming, and pharmacy can help

The Affordable Care Act (ACA) has been labeled the reform of the American health insurance, not care, system. That is true to some degree, but many elements of the new law will affect the daily practice of pharmacy and medicine. These were mostly ignored during public and congressional debate over HCR.

Leaders of APhA's three Academies were briefed in detail on April 17 about one of the most important practice-related provisions of ACA: accountable-care organizations (ACOs). ACOs feature a new type of payment model that seeks to address some of the problems inherent in the two dominant models in use—fee for service and capitation.

Under the new law, many ACOs will likely emerge from existing patient-centered medical homes. The two terms are not synonymous. A medical home is more a care model in which primary care practitioners take responsibility for coordinating services provided to a group of patients. Medical homes use tools such as electronic medical records and multidisciplinary care. Certified patient-centered medical homes can receive additional compensation for care coordination.

ACOs are more a payment or financing model. These organizations assume some of the risk involved in patient care,

as described below. Certified patient-centered medical homes can morph into ACOs, but ACOs do not have to be medical homes.

"Patient-centered medical homes or care models will be important, and how pharmacy fits into those will be important," Thomas E. Menighan, BPharm, MBA, ScD, Executive Vice President and CEO of APhA, told the leaders. "I've seen this model described as a house with information technology and systems on the first floor, primary care on the second floor, specialists on the third floor, and so on. But there's still room for growth and improvement in the design. And we're in a position now to design how pharmacy will fit into this model."

What are ACOs?

Essentially, an ACO shares risk between payer and provider, and providers can be reimbursed at higher levels for attaining quality goals. The cost of care is attributed to providers in the ACO, said S. Lawrence Kocot, MPA, JD, LLM, Deputy Director of the Engelberg Center for Health Care Reform at the Brookings Institution in Washington, DC, and Senior Counsel at Sonnenschein, Nath and Rosenthal, a firm that worked with APhA throughout the health care reform debate.

acknowledged the need for education and awareness activities. It held a public hearing on June 1 to get feedback on an agreement manufacturers must sign to participate in the discount program, which launches on January 1. Beneficiaries who hit the gap this year will receive a one-time federal payment of \$250.

Etc.

- ❑ **What is the name of the health care reform law?** HCR took an unusual path in Congress as Democrats chose to avoid a second vote in the Senate, which had approved the bill on Christmas Eve. Thus, the HCR bill signed by President Obama on March 23 was the Patient Protection and Affordable Care Act (Pub. L. 111-148). It was then amended by section 1101 of the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), signed a week later. Because neither bill title alone is accurate, the Obama administration is using "Affordable Care Act," or ACA, to refer to these bills collectively, and **Pharmacy Today** will adopt that phrase in its reporting.
- ❑ Be sure to **thank your Members of Congress** for considering pharmacy's position during the HCR debate. APhA members can use the Legislative Action Center in the Government Affairs section of pharmacist.com to access preformatted letters, one for Members who supported HCR and another for those who opposed the bills.
- ❑ For a list of all the issues and regulations being monitored and acted on by APhA, access the **Government Affairs section** of pharmacist.com. Also, readers of the print version of the Hub should know that hyperlinks to pharmacist.com, *Federal Register* notices, and other useful websites can be accessed in the online version of the Hub, located at www.pharmacytoday.org.

hub on health care reform

Take rehospitalizations, for example; under a fee-for-service model, these generate additional payments. Under capitation, each admission generates a payment based on the diagnosis, even if the hospitalization is the result of poor care during a previous stay.

Under such models, providers quickly learn how to manipulate the system, Kocot said, recalling his experiences at CMS with physician fees and imaging. When payments for fees were restricted, service intensity and billings went up.

ACOs add cost and quality components. "ACOs allow physicians to group together, if they have a minimum of 5,000 covered lives," Kocot said. "Physicians bill fee for service, just as they do today. But at the end of a year, 2 years, or 3 years, their goal is to look at the spending growth target, and if they beat the target, they may share in the savings. But in addition to the cost target, they must meet certain quality standards. The quality standards are there to be sure the physicians don't skimp on the costs. This system starts to realign the incentives so that the physician does the right thing for the patient."

Thus, in the case of rehospitalization, all of the costs are attributed to the ACO. With too many rehospitalizations, an ACO may miss its cost target, its quality standards, or both.

ACO pilots are already under way at the Carilion Clinic in Roanoke, VA, Norton Healthcare in Louisville, KY, and Arizona's Tucson Medical Center.

Where does pharmacy fit in ACOs?

Pharmacy will play an important role in ACOs, but whether the profession does so from within the organization (and therefore accepts risk with the other providers) or as a contracted, external entity remains to be seen. But one thing seems clear, especially when it comes to cost and quality: The ACO will have difficulty meeting its goals without partnerships with pharmacists.

"The ACO will bring to physicians the recognition that there are other providers in the community who can do a lot more for them, be cost-effective, and

improve their bottom line," Kocot said. "As physicians start looking at this a little more methodically, they're going to realize the pharmacist is their savior, not their enemy."

Increased use of nurse practitioners and other nonphysician providers, improved care coordination, reduced waste, better management of chronic diseases, and point-of-care reminders are just some of the ways in which ACOs can control costs, Kocot said.

"Pharmacists very well could be part of an ACO," Kocot added. "But I don't know if that's really that important ... because any doctor in the community is going to realize that pharmacists are key to the practice.... The issue is what pharmacists can do. Literature supports that pharmacists play a key role in improving patient adherence to recommended care, care coordination across providers, and avoidable complications. Pharmacists have a big role in being the bricks, or the cement, for the primary care physicians, if the pharmacists position themselves right."

The other point to remember is that ACOs are "not some big monolithic system that you have to penetrate," Kocot said. "These are your local providers. Some ACOs are very small. There is no choice but to rely on the pharmacist. Pharmacists need to get with these community groups as they start planning. Pharmacists need to be at these meetings to emphasize their roles from the very beginning."

What happens next?

The next two steps spelled out in ACA are coming up fast, making it important that pharmacists engage others in their communities now. Being established in CMS is a Center for Medicare and Medicaid Innovation. It has \$10 billion in authorized funds (for use over 9 years) to begin testing payment and delivery models by January 1, 2011, Kocot said. A year later, a Medicare shared-savings program based on ACOs will begin.

"The time is now to change the system," Kocot said. "Pharmacists can and should be a part of this."

—L. Michael Posey, BPharm

HUB ON HEALTH CARE REFORM

provides readers with practical information on health care reform issues, what APhA is doing to keep pharmacists' important role front and center with decision makers, and simple ways for pharmacists to participate in the processes that will determine the structure, function, and processes of a reformed

American health care system. Send an e-mail message to APhA at gvtaff@aphanet.org to offer suggestions for future content, ask questions, make comments, or request permission to use or copy this issue. © 2009 by the American Pharmacists Association. All rights reserved. Printed in U.S.A.



American Pharmacists Association
improving medication use. Advancing patient care.