THE AFFORDABLE CARE ACT: KEY POINTS FOR PHARMACISTS

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Douglas H. Kay Symposium

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Objectives

1. Summarize the major changes the Affordable Care Act (ACA) will have on the practice of pharmacy as a whole
2. Discuss the current role of the community pharmacist in Medication Therapy Management and how this role is expected to change as the ACA is rolled out
3. Identify the major changes to medication coverage outlined in the ACA
4. Describe the potential role of the pharmacist in Integrated Care Models

Test Your Knowledge

According to the Organization for Economic Cooperation and Development (OECD), the United States ranks __________ for life expectancy at birth among 36 other developed countries within the OECD.

a) 5th
b) 18th
c) 26th
d) 36th

OECD (2013), "Life expectancy at birth", in Health at a Glance 2013: OECD Indicators, OECD Publishing.
http://dx.doi.org/10.1787/health_glance-2013-5-en

Test Your Knowledge

According to the Organization for Economic Cooperation and Development (OECD), the United States spends ___________ of its Gross Domestic Product on health care.

a) 24%
b) 3%
c) 17%
d) 8%

OECD (2013), "Health expenditure in relation to GDP", in Health at a Glance 2013: OECD Indicators, OECD Publishing. http://dx.doi.org/10.1787/health_glance-2013-65-en

7.2.1. Health expenditure as a share of GDP, 2011 (or nearest year)

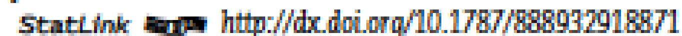
Current / Capital

% of GDP

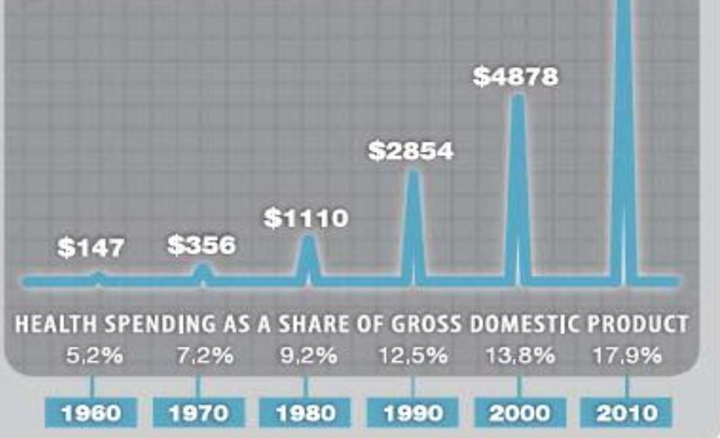
Country	% of GDP
United States	17.7
Netherlands	11.9
France	11.6
Germany	11.3
Canada	11.2
Switzerland[1]	11.0
Denmark	10.9
Austria	10.8
Belgium	10.5
New Zealand	10.3
Portugal	10.2
Japan[2]	9.6
Sweden	9.5
United Kingdom	9.4
OECD34	**9.3**
Spain	9.3
Norway	9.3
Italy	9.2
Greece	9.1
Iceland[1]	9.0
Finland	9.0
Australia[2]	8.9
Ireland	8.9
Brazil[1]	8.9
Slovenia	8.9
South Africa[1]	8.5
Slovak Rep.	7.9
Hungary	7.9
Israel[1]	7.7
Chile	7.5
Czech Rep.	7.5
Korea	7.4
Poland	6.9
Luxembourg	6.6
Russian Fed.[1]	6.2
Mexico[1,3]	6.2
Turkey[3]	6.1
Estonia	5.9
China[1]	5.2
India[1]	3.9
Indonesia[1]	2.7

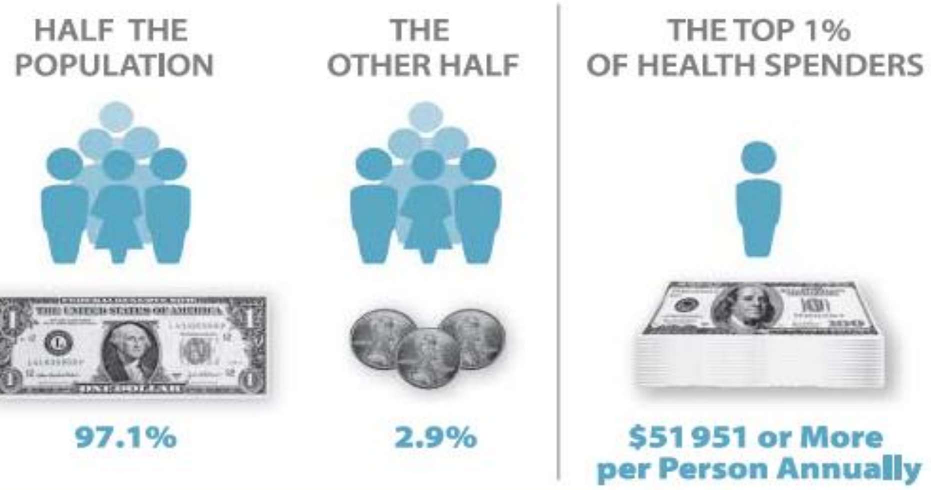
1. Total expenditure only.
2. Data refers to 2010.
3. Data refers to 2008.

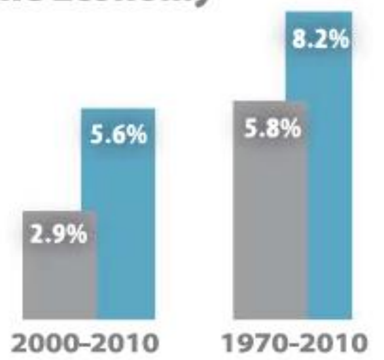
Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en; WHO Global Health Expenditure Database.



COSTS



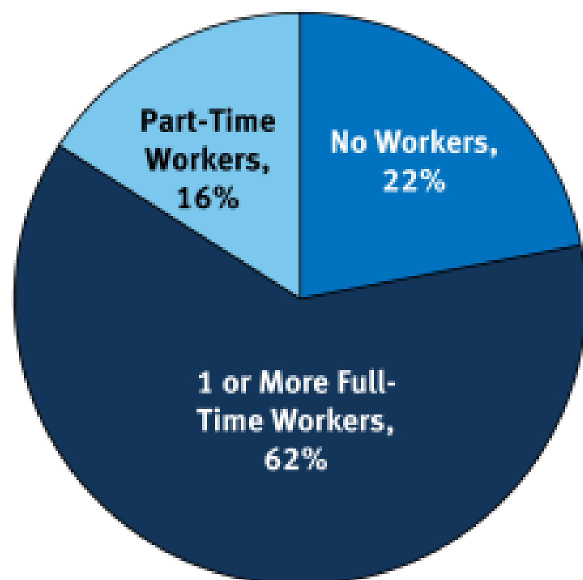




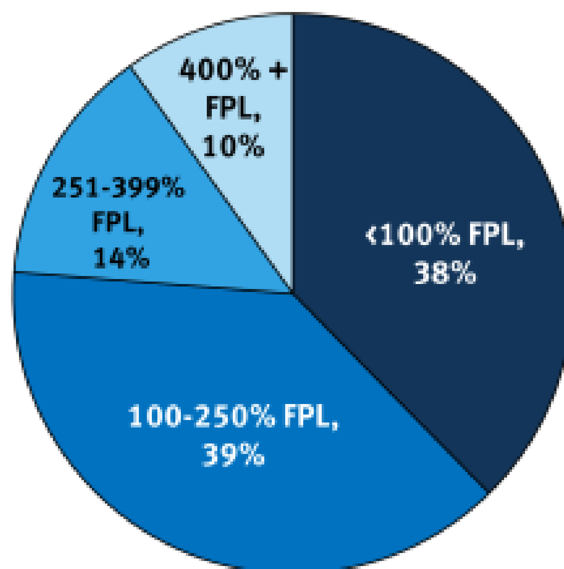
Source: Kaiser Family Foundation (http://www.kff.org) analysis. Original data and detailed source information are available at http://facts.kff.org/jama_092612.
*Produced by: Nirmita Panchal, MPH, Matthew Rae, MPH, MPA, Larry Levitt, MPP, Gary Claxton, Anne Jankiewicz, and David Rousseau, MPH.

Characteristics of the Nonelderly Uninsured Population, 2011

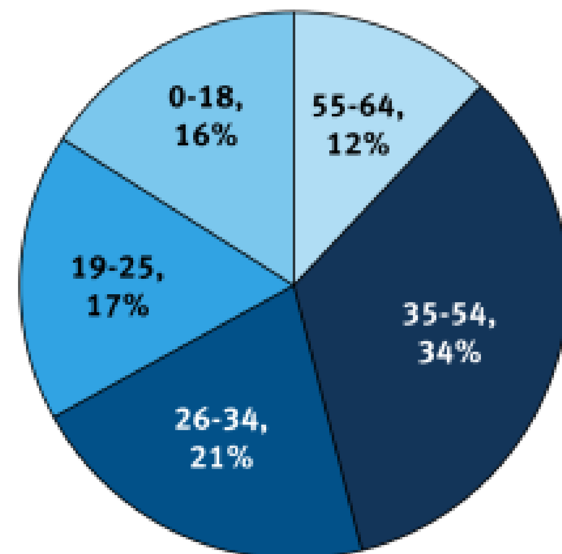
Family Work Status



Family Income



Age



Total = 47.9 Million Uninsured

NOTE: The federal poverty level was $22,350 for a family of four in 2011. Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2012 ASEC Supplement to the CPS.

THE HENRY J. KAISER FAMILY FOUNDATION

How We Measure Up

Exhibit ES-1. Overall Ranking

Country Rankings	
(dark)	1.00–2.33
(medium)	2.34–4.66
(light)	4.67–7.00

	AUS	CAN	GER	NETH	NZ	UK	US
OVERALL RANKING (2010)	3	6	4	1	5	2	7
Quality Care	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centered Care	2	5	3	6	1	7	4
Access	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Healthy, Productive Lives	1	2	3	4	5	6	7
Health Expenditures/Capita, 2007	$3,357	$3,895	$3,588	$3,837*	$2,454	$2,992	$7,290

Note: * Estimate. Expenditures shown in $US PPP (purchasing power parity).
Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, OECD Health Data, 2009 (Paris: OECD, Nov. 2009).

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http://www.commonwealthfund.org/

Background

- The Patient Protection and Affordable Care Act (PPACA or ACA)
  - Signed into law by President Barack Obama on March 23, 2010
  - Major goals:
    - Expand access
    - Improve quality
    - Reduce costs

- The Health Care and Education Reconciliation Act of 2010
  - Signed into law by President Barack Obama on March 30, 2010
  - Added changes to the PPACA

Breakdown

- 2010
  - Patient's Bill of Rights
  - Young adults allowed to stay on parents' insurance until age 26
- 2011
  - Medicare—reduction in "donut hole" medications
  - Medicare—key preventative services now free

Key Features of the Affordable Care Act by Year. http://www.hhs.gov/healthcare/facts/timeline/timeline-text.html

Breakdown

- 2012
  - Accountable Care Organizations
  - Value-Based Purchasing
  - Reducing paperwork and administrative costs
- 2013
  - Open enrollment in the Health Insurance Exchange (HIE) Marketplace begins
  - Payment bundling
  - Medicaid prevention coverage incentives

Key Features of the Affordable Care Act by Year. http://www.hhs.gov/healthcare/facts/timeline/timeline-text.html

Breakdown

- 2014
  - All Americans required to have insurance
  - Tax credits for middle and low-income families
  - Medicaid expansions
  - No annual limits on coverage
  - Fees on the health insurance sector
  - Reduction of Medicare payments for Hospital-Acquired Infections

Key Features of the Affordable Care Act by Year. http://www.hhs.gov/healthcare/facts/timeline/timeline-text.html

Major Regulatory Events in the Last 20 Years that have Impacted Pharmacy

- **1990:** OBRA 90
- **2000:** Doctor of Pharmacy entry-level degree for new Registered Pharmacists
- **2003:** Medication Therapy Management (MTM)
- **2010:** PPACA signed into law

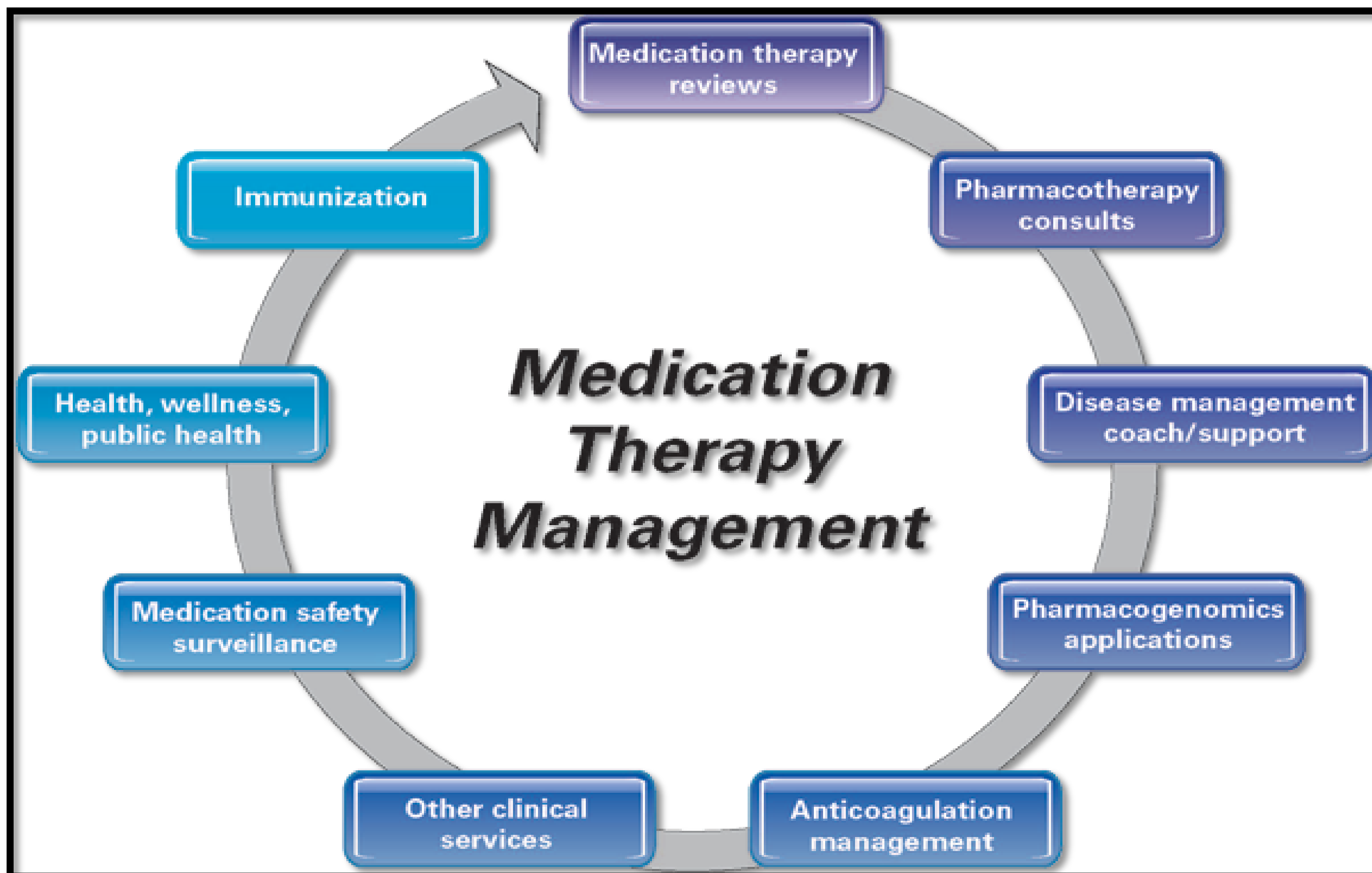
How is the ACA Going to Impact Pharmacy?

- **Practice Expansion**
  - MTM expansion
  - Pharmacists' roles in novel integrated care models

- **Insurance reform**
  - Better access to affordable medications
  - Improvements in Medicare and Medicaid

- **Prevention and Wellness**
  - Emphasis on prevention vs. "sick care"

MTM



http://www.pharmacist.com/mtm

Medicare Modernization Act: Introduction to MTM

- Medicare Part D Prescription coverage
- All prescription drug plans (PDPs) had to have MTM
- Assured optimal drug therapy
- Reduce adverse events and interactions

Problems with MTM under Medicare Modernization Act

1. PDPs could design their eligibility criteria
2. $4,000 annual true-out-of-pocket spending threshold for identifying beneficiaries
3. Provider of service did not have to be a pharmacist
4. Payment for services was never described
5. Scope of MTM services was loosely defined

http://www.ashp.org/s_ashp/docs/files/GAD_SummaryofMTMP0806.pdf

Solutions to MTM Problems

- Section 3503
  - Medication management services in treatment of chronic disease
- Section 10328
  - Improvement in Part D MTM programs

MTM Described in the ACA: Section 3503

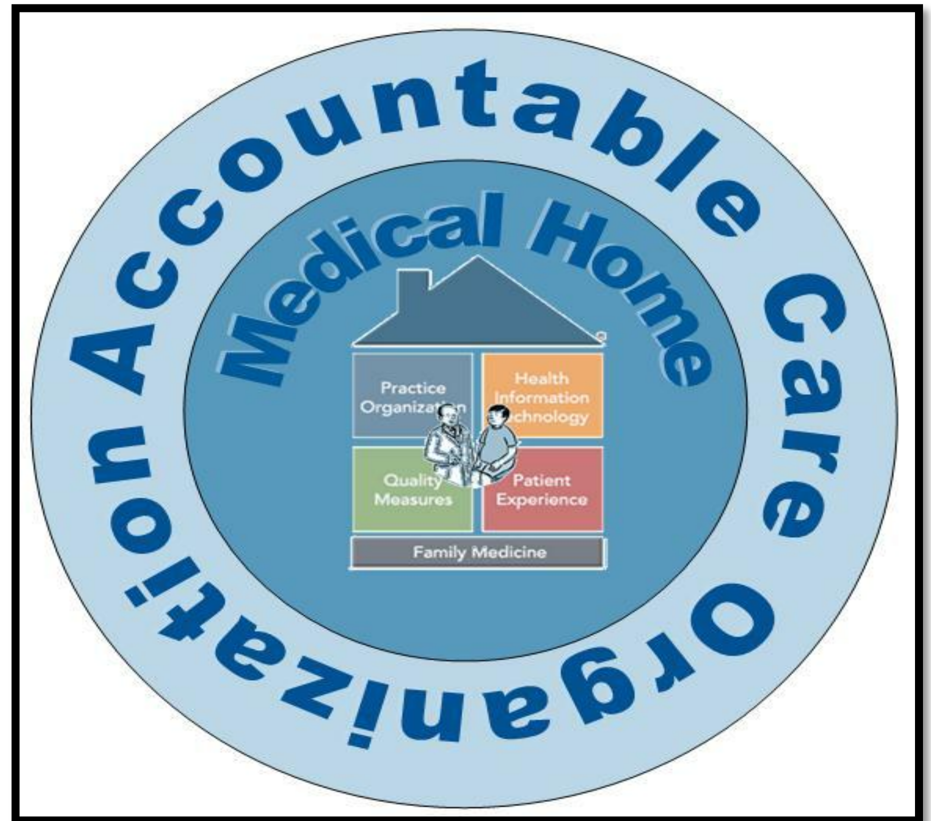
- “MTM grant program”
- Patient Safety Research Center (AHRQ)
- Targets beneficiaries who
  - Are taking 4 or more prescribed medications
  - Are taking high-risk medications
  - Have 2 or more chronic diseases
  - Have undergone a transition of care

MTM Described in the ACA: Section 10328

- Improving adherence and management of chronic disease
- Yearly, required comprehensive medication review
- Must monitor people who are not enrolled in MTM but are high-risk → automatic enrollment for certain targeted beneficiaries
- Opens up funding for new MTM methods under the Center for Medicare and Medicaid Innovation

Integrated Care Models

- Accountable Care Organizations (ACOs)
- Patient-Centered Medical Homes (PCMHs)



http://blog.galenhealthcare.com/2012/09/24/accountable-care-organizations-what-hit-professionals-need-to-know/

ACOs: Defined

- Generally
  - Network or group of healthcare providers and hospitals that
    - Provide the care together AND
    - Share responsibility for cost and quality of that care
- Reimbursement
  - Tied to quality improvement and reductions in cost for care
  - Incentives for more efficient and effective care
- Populations
  - Medicare → 5,000 beneficiaries for 3 years

ACOs: Defined

- Medicare Programs

  1. Medicare Shared Savings Program
  2. Advance Payment ACO Model
  3. Pioneer ACO Model

- Quality Measures and Performance Standards

Pharmacist Role in ACOs

- Drug Therapy Management Clinics
- Medication Reviews and Medication Reconciliation
- Drug Utilization Reviews and Identification of Under or Over Medicated Patients
- Prescription Medication Adherence Clinics

Pharmacist Role in ACOs: Examples

- Blue Shield of California
  - Encouraging pharmacists to work at the top of their license
  - 10 ACO arrangements
  - Moving retail pharmacists from dispenser to consultant

- Kelsey-Seybold in Texas
  - NCQA approved ACO
  - 20 locations, 12 of which have pharmacies on-site
  - MTM, therapeutic interchange and adherence clinics

ACOs in Maine

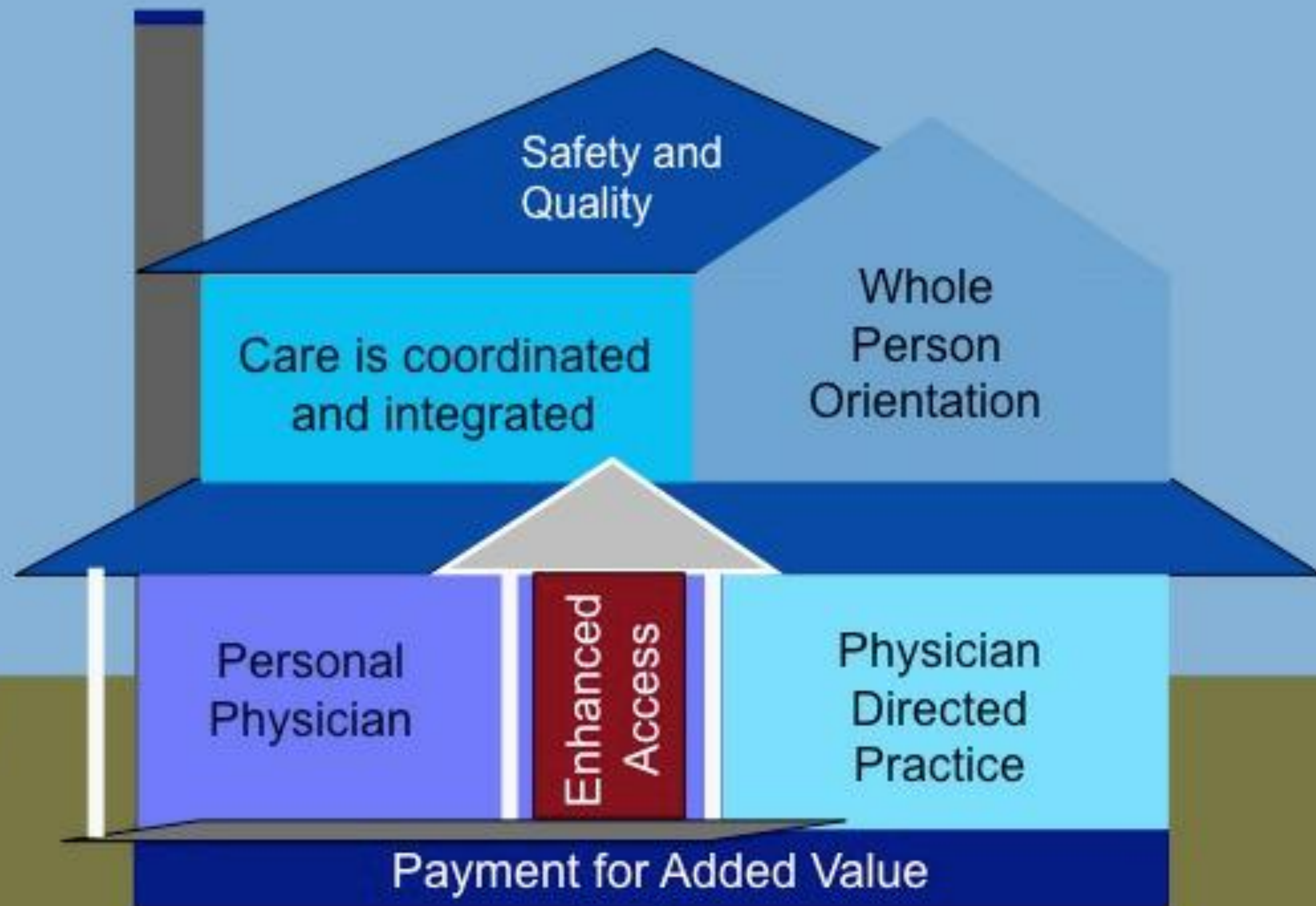
- Medicare
  - Beacon Health, LLC (Pioneer)
  - MaineHealth (Shared Savings)
  - Central Maine ACO (Shared Savings)
  - Maine Community Accountable Care Organization, LLC (Shared Savings)
- Medicaid
  - Accountable Communities Initiative
- Employer-Provided
  - MaineGeneral—State Employee Health Commission (SEHC)

PCMH: Defined by AHRQ

1. Comprehensive Care
2. Patient-Centered
3. Coordinated Care
4. Accessible Services
5. Quality and Safety

http://pcmh.ahrq.gov/page/defining-pcmh

PCMH



http://www.orlandohealthdocs.com/orlandointernalmedicinegroup/files/2012/12/orlando_internal_medicine_practice_is_patient_centered_medical_home.jpg

Pharmacist in a PCMH: Example

- Veterans Affairs Health Care System
  - Clinical pharmacists function as members of the primary care team within a “Scope of Practice”
  - Anticoagulation clinic
  - Disease state management clinic
  - Medication reconciliation and adherence
  - Shared Medical Appointments
  - Close follow-up if needed

PCMHs in Maine

- Community Care Teams (CCT)
  - Working with the pilot PCMH practices
- There are many pilots across the state
- Expected to meet 10 “Core Expectations”
  - 18 “Must Pass” elements

http://www.mainequalitycounts.org/page/896-659/patient-centered-medical-home.

Exemplary Projects Involving Community-Based Pharmacy Care

- Asheville Project—1997
  - Community pharmacists managed patients' chronic conditions
  - Set and monitored treatment goals
  - Assessed laboratory values and adherence
  - Paid via fee-for-service by employers
  - At the first 6-month follow-up, 24% more patients had A1c <7%
  - ROI on the diabetes program was 4:1
  - Cardiovascular program also showed significant cost savings and improvement in clinical measures

Exemplary Projects Involving Community-Based Pharmacy Care

- Fairview Health System in Minnesota—1998
  - Integrated system of PCMH, hospitals, specialty clinics and community pharmacies
  - Provided MTM services across these clinics
  - Began with employees and members of the Fairview Health Plan
  - Expanded this model to cover patients enrolled in Minnesota Medicaid

Exemplary Projects Involving Community-Based Pharmacy Care

- 10-City Diabetes Challenge Project—2007
  - 30 employers—similar to Asheville model
  - Saved $1079 per year per patient

- Everett Clinic, Washington State
  - Multi-specialty group practice, hired 2 clinical pharmacists
  - Focused on hypertension and DVT prevention

- Connecticut Medicaid transformation project
  - Face-to-face MTM
  - Yielded cost-effective improvement in outcomes

Insurance Reform—Access to Affordable Medications

- Affordability
  - Provides subsidies and tax credits for those unable to afford
  - Limits on Medical Loss Ratios
- Individual Responsibility—those remaining uninsured
  - Certain populations exempted from paying tax penalty—ex. undocumented immigrants and prisoners
  - Flat payment increases over time
  - Can also pay a certain percent of income

Insurance Reform—Access to Affordable Medications

- Employer Responsibility
  - Businesses with <51 FTEs—can receive tax credits if offer insurance
  - Businesses with 51-200 FTEs—penalized if don't offer insurance or expensive insurance
  - Businesses with >200 FTES—must automatically enroll employees

- Coverage
  - Dependent children up to age 26 can stay on plans
  - Health Insurance Exchanges (HIEs) run by states
  - No annual or lifetime limits on the amounts insurers pay out for policies
  - No more denying pre-existing conditions
  - Coverage of Essential Health Benefits

ESSENTIAL HEALTH BENEFITS

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity & newborn care
- Mental health services
- Prescription drugs
- Rehabilitative services
- Laboratory services
- Preventative & wellness care
- Pediatric services

Medicare Drug Coverage

Improvements in Part D	When this occurs
$250 rebate to those who fall into the "donut hole"	2010
Pharmaceutical companies to pay 50% of brand name rx that fall into the "donut hole"	2011
Federal subsidies to pay 75% of generic rx that fall into the "donut hole"	By 2020
Patient will only be responsible for 25% of the drug cost when in the "donut hole"	By 2020

Medicare Drug Coverage

- Other Improvements to Medicare Drug Coverage
  - Certain drugs now included under Part D that were not before
    - Benzodiazepines, barbiturates
- Medicare Part D Plans offering more extensive MTM plans than what is required will receive performance bonuses

Medicaid Drug Coverage

- Medicaid Expansions
  - All non-Medicare eligible individuals under age 65 with incomes of up to 133% of the FPL
  - This is OPTIONAL for the states to participate in
  - Maine is NOT expanding Medicaid at this time
    - ~24,000 Mainers who are not eligible for the subsidies but would be eligible under Medicaid expansion

Prevention and Wellness

- Task Force on Community Preventative Services
- Medicare coverage of annual wellness visit and “personalized prevention plan”
- Medicaid tobacco cessation coverage
- Incentives for the prevention of chronic diseases in Medicaid
- Evaluation of community-based prevention and wellness programs for Medicare beneficiaries

Prevention and Wellness

- Demonstration program to improve immunization coverage
- Demonstration project concerning individualized wellness plan
- Prevention and wellness research
- Employer-based wellness programs
- Grants for small businesses to provide comprehensive workplace wellness programs
- Comparative effectiveness research

Other Major Impacts on Pharmacy

- Biologics
  - Allows a pathway for approval as generics through the FDA

- 340(b) Drug Discount Program
  - Eligibility expanded to include safety net hospitals, children's hospitals, freestanding cancer hospitals excluded from the Medicare prospective payment system, rural referral centers, and sole community hospitals

- Health Professionals and Workforce Initiatives

Other Major Impacts on Pharmacy

- Providing adequate pharmacy reimbursement
- Exemption of certain pharmacies from accreditation requirements
- Reduction of wasteful dispensing of outpatient drugs in long-term care facilities
- Prescription drug sample transparency
- Pharmacy Benefits Managers (PBM) transparency

Post Question #1

Which of the following is a major change created by the Affordable Care Act (ACA)?

a. Nondependent children up to age 29 can stay on their parents' insurance plan

b. Lifetime benefit limits are now prohibited

c. All patients enrolled in insurance plans will need to have a primary care provider or they will face penalties

d. A and B are both changes created by the ACA

e. All of the above

Post Question #2

What was a major limitation to the MTM programs brought forth by the Medicare Modernization Act of 2003?

a. Not all Medicare Part D prescription plans were required to have an MTM program

b. There was no standardized format for the delivery of MTM services, resulting in great variability between programs

c. Eligibility was open to too many patients, and pharmacists could not keep up with the demand

d. All of the above were limitations

Post Question #3

How is the ACA going to help close "the donut hole" for certain Medicare Part D beneficiaries? (Select all that apply)

a. In 2010, seniors got a one-time, $250.00 tax-free rebate check when they entered the donut hole

b. After July 2010, the Medicare Coverage Gap Discount Program was established which allows a 50% discount to beneficiaries from the drug manufacturers on brand name drugs when they are in the donut hole

c. By 2015, beneficiaries in the donut hole will not have to pay anything for generic drugs

d. By 2020, beneficiaries in the donut hole will only be required to pay for 25% of the cost of a brand name drug

Post Question #4

What should be included in the definition of a patient-centered medical home per the Agency for Healthcare Research and Quality?

a. Comprehensive care team—interdisciplinary teams making decisions together

b. Patient-centered approach—treating the patient holistically

c. Coordinated Care—transitions are streamlined

d. Services that are accessible—patients can easily and efficiently receive care

e. High quality and safe care—engaging in evidence-based medicine and quality assurance

f. All of the above should be included

Further Reading and References

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QUESTIONS OR COMMENTS? THANK YOU FOR ATTENDING.