

# Health Care Reform Update

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American Pharmacists Association  
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## HCR Timeline

- Late 2009: bills pass in 3 House and 2 Senate committees
- 11/07/09: House passes their bill (H.R. 3962)
- 12/24/09: Senate passes their bill (H.R. 3590)
- Two proposals are very different
- 03/21/10: House concedes; passes Senate bill (H.R. 3590)
- 03/21/10: House passes reconciliation bill (H.R. 4872) (amends HCR bill)
- 03/23/10: President signs H.R. 3590 (P.L. 111-148)
- 03/25/10: Senate passes H.R. 4872 as amended
- 03/25/10: House passes H.R. 4872 as amended
- 03/30/10: President signs H.R. 4872 (P.L. 111-153)

## Areas of Interest

- Access to Products and Services; 340B; Biosimilars
- Anti-Discrimination
- Comparative Effectiveness Research
- Drug Information
- Fraud, Waste, and Abuse
- Generics
- HIT
- Health Plan Benefits
- Hospital Acquired Conditions
- Immunizations
- Indian Health
- Integrated Care Models
- LTC "waste"
- Medicaid & Medicare
- MTM
- Pain Care
- Prevention & Wellness
- Quality
- Transitions of Care
- Transparency
- Value-Based Purchasing
- Workforce

## Access to Drug Products

- Removes smoking cessation drugs, barbiturates, and benzodiazepines from Medicare Part D's excluded list (2502)
- Establishes regulatory process for determining what categories and classes of drugs are considered "exempted", requiring Part D plans to cover all of these drugs (3307)
- Counts ADAP and Indian Health Service-provided **medications** towards a Medicare Part D beneficiary's true out-of-pocket costs (TrOOP) (3314)

## Access to Drug Products

- Increases the number of areas to include in 2011 in the DME competitive bidding program; requires the Secretary to use payment information from such programs to adjust the payment amounts in unaffected areas(6410)
- Addresses Health Savings and Other Similar Accounts (9003)
  - Limits **medication**-related reimbursements to prescribed medications or insulin

## Access to Drug Products

- Waives accreditation for **pharmacies** that supply DMEPOS (3109)
- Exempts pharmacies if they:
  - Have been issued a provider number for at least 5 years and have not had a fraud-related adverse determination in the last 5 years;
  - Attest that DME billings are less than 5% of total sales; and,
  - Are willing to submit verifying documentation
- Authorizes the Secretary to determine pharmacy "appropriate" requirements

## Fraud, Waste & Abuse (FWA)

- Establishes new Medicare, Medicaid & CHIP Supplier and Provider Provisions (6401)
  - Increases oversight, particularly of new providers and suppliers
  - Adjusts payments
  - Requires compliance programs
- Expands the Recovery Audit Contractor (RAC) Program to Medicaid, and Medicare Parts C & D (6411)
  - Requires plans to have anti-fraud plans

## FWA

- Establishes new Medicare & Medicaid Integrity Programs (6402)
  - New penalties, including for Federal health care fraud offenses or conspiracy to commit one
  - Reduces timeframe to report and return overpayments
  - Evaluations at least every three years
  - Requires surety bonds
  - Suspends payments pending an investigation of credible allegations of fraud
  - Increases funding for fighting fraud, waste and abuse

## Health Information Technology (HIT)

- Addresses Administrative Simplification (1104)
  - Establishes uniform standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
  - Directs the Secretary to adopt a single set of operating rules for plan eligibility (unique plan identifier), electronic fund transfers, health care payment and remittance advice, health claims, enrollment and disenrollment, premium payments, and referral certification and authorizations
  - Beginning January 1, 2014, requires Medicare Part A or B payment be done by an electronic funds transfer or electronic remittance

## Health Plan Benefits

- Develops standards for insurers to use in compiling and providing to enrollees a summary of benefits and coverage explanation (1001)
- Includes **prescription drug** coverage, preventive and wellness services, and chronic disease management in Essential Health Benefits (1302)
- Establishes American Health Benefit Exchanges in States no later than January 1, 2014 (1311)

## Health Plan Benefits

- Section 1311 (continued)
  - Plans in the Health Exchange must implement a quality improvement strategy that provides a payment structure or other incentives for:
    - Improving health outcomes through **...medication and care compliance activities;**
    - Preventing hospital readmissions through a comprehensive program for hospital discharges that includes comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional

## Hospital Acquired Conditions

- Incorporates State practices that prohibit payment for healthcare –acquired conditions into the Medicaid program(2702)
- Addresses Payment Reductions (3008)
  - Reduces Medicaid hospital payments for hospital acquired conditions
  - Studies expanding the payment policy to the Medicare program

## Integrated Care Models

- **Accountable Care Organization (ACO)**
  - Financing model; accountable for the quality and cost of patient care; shares risk and year-end savings if quality & cost thresholds are met
  - Minimum 5,000 covered lives
  - Pharmacists unlikely to be part of entity but entity may contract with pharmacists to meet goals
- **Medical Home**
  - Care model; team-based approach to comprehensive primary care coordinated by a personal physician
  - Providers eligible to receive additional compensation for care coordination
  - Pharmacists more likely to be members of this team

## Integrated Care Models

- Establishes a State plan amendment option to provide health homes for Medicaid beneficiaries with chronic conditions; teams may include **pharmacists** (2703)
- Establishes a Medicare shared savings program “Accountable Care Organizations” (3022; 10307)
  - Pharmacists unlikely part of entity, but entity may contract with pharmacists
- Establishes a Medicare demonstration program to test a home-based primary care teams “Independence at Home” (3024)
  - Teams include **pharmacists**

## Integrated Care Models

- Establishes Community Health Teams to support the Patient-Centered Medical Home (3502; 10321)
  - Health teams, which may include **pharmacists**, must:
    - Provide support necessary for local primary care providers to provide access to **pharmacist-delivered medication management services, including medication reconciliation**

## Integrated Care Models

- Section 3502 (continued)
  - Health teams must also provide a transitional care program that:
    - Provides **medication reconciliation** upon admission/discharge
    - Assures that post-discharge plans include **medication management**
- Establishes a Medicare grant program for community-based collaborative care networks (10333)
  - Focused on low-income populations

## Medicaid Payment

- Amends the Average Manufacturer Price (AMP) for generic reimbursement in Medicaid(2503)
  - Requires FDA to rate 3 or more products therapeutically and pharmaceutically equivalent before establishing a federal upper limit (FUL) for a multiple source drug
  - Changes the federal upper limit (FUL) to no less than 175% of the weighted average AMP
  - Calculation of AMP & definition of “retail community pharmacy” more closely reflects true “retail” pharmacy

## Medicaid Payment

- Addresses the duties of the Medicaid and Children’s Health Insurance Program (CHIP) Payment Commission (MACPAC) (2801)
- Directs Medicare Payment Advisory Commission (MedPAC) to review and report on trends in spending, utilization & financial performance for dual-eligibles (2801)

## Medicaid Enrollment Increases

- Increases coverage for non-elderly adults to 133% of the federal poverty level (\$14,404 for an individual, \$29,327 for a family of four)
- Virginia current coverage is up to 30% of the FPL for non-elderly adults (Ranked 44<sup>th</sup> in country) and no coverage for childless adults
- Estimated increase of almost 400,000 Virginians into the Medicaid program

## Medicare Payment

- Establishes an Independent Medicare Advisory Board (3403; 10320) to reduce the per capita rate of growth in spending
  - May not recommend to ration health care, raise premiums, increase cost-sharing, or modify eligibility criteria
  - May recommend to reduce Medicare payments under Parts C and D
  - Establishes rules on how fast and in what manner the House and Senate must act on the Board's reports
    - A clear directive to take action

## Medicare Part D

- Establishes a Medicare Coverage Gap Discount Program (3301)
  - Beginning in 2011, enrollees receive a 50% discount in the gap on all applicable drugs
    - Does not affect payment of a dispensing fee
  - By 2020, enrollees are responsible for 25% of the cost of drugs in the gap
  - Discounts are provided at the point-of-sale (POS) or, during start up, as soon as practicable after POS
  - No later than the applicable number of days after dispensing, the pharmacy is reimbursed the difference between the negotiated and discounted price

## Medicare Part D

- Section 3301 (continued)
  - Overtime, reduces the catastrophic coverage threshold
  - Provides an immediate reduction in the gap (Reconciliation Bill 1101)
    - Part D enrollees who hit the gap in 2010 receive a \$250 rebate
  - Defines "manufacturer" as an entity engaged in ...**compounding**...Such term does not include a wholesale distributor of drug or a retail **pharmacy** licensed under State law"

## Medicare Part D

- Establishes a Federal Coordinated Health Care Office to better integrate Medicare & Medicaid benefits and improve the coordination of benefits for dual-eligibles (2602)
- Improves information for subsidy eligible beneficiaries reassigned to a Part D plan (3305)
  - Within 30 days, information on formulary differences between new and old plan is shared w/beneficiary
- Reduces cost-sharing for dual-eligibles who would be institutionalized if not for receiving home and community-based services via a Medicaid MCO (3309)

## Medicare Part D

- Directs the Secretary to require PDPs to utilize specific, uniform dispensing techniques, as determined by the Secretary, in consultation with stakeholders (including **pharmacy**) (3310)
  - Techniques include daily, weekly, or automated dose dispensing when dispensing Part D drugs to enrollees who reside in LTC facilities
  - Goal is to reduce waste associated with 30-day fills

## Medication Therapy Management (MTM)

- Establishes a Center for Medicare and Medicaid Innovation within CMS (3021; 10306)
  - To test payment and service delivery models to reduce program expenditures while preserving or enhancing quality of care
  - Must begin no later than January 1, 2011
  - Phase I: test payment and service delivery models
    - Models of care may include “utilizing **medication therapy management services**.”
  - Phase II: through rulemaking, expand the duration and scope of a model that is expected to meet quality & cost goals

## MTM

- Establishes care coordination and management performance bonuses for Medicare Advantage plans (3201)
  - Eligible programs include **medication therapy management** programs that are more extensive than is required under Medicare Part D MTM
- Establishes a **Medication Management** grant program (3503)
  - Administered through the Patient Safety Research Center at the Agency for Healthcare Research & Quality (AHRQ)

## MTM

- Section 3503 (continued)
  - Provides grants or contracts to implement MTM provided by **pharmacists** as part of collaborative, multidisciplinary, inter-professional approach
  - Grantees must submit a plan for long-term financial sustainability
  - Services are similar to what are included in the profession’s MTM consensus definition
  - Eligible patient population is broad
  - Secretary must consult with stakeholders, including pharmacy and pharmacist organizations, in designing and implementing the MTM services

## MTM

- Section 3503 (continued)
  - Secretary must submit a report to Congress assessing the program’s impact on various markers
    - Must evaluate the extent to which pharmacists who maintain a dispensing role have a conflict of interest in providing MTM services
  - NOT specific to Medicare Part D
  - The grant program is NOT yet funded
  - Focus of grants still to be determined

## MTM

- Improves Medicare Part D **MTM** (10328)
  - Starting in 2013, requires plans to offer MTM services to targeted beneficiaries that include, at a minimum, services to improve adherence:
    - An annual comprehensive medication review furnished person-to-person or using telehealth technologies by a licensed **pharmacist** or other qualified provider. The review:
      - May result in the creation of a recommended **medication action plan**; and
      - Must include providing the individual a written or printed summary of the review results
    - Follow-up interventions as warranted

## MTM

- Section 10328 (continued)
  - PDP sponsor must have a process to:
    - Assess, at least quarterly, the medication use of individuals who are at risk but not enrolled in the MTM program, including individuals who have experienced a transition in care
    - Automatically enroll targeted beneficiaries, including those identified a chronic care improvement program; and provide for an opt out

## Pain Care

- Addresses pain care (4305)
  - Convenes a conference on pain to increase awareness of pain; evaluate pain care; and identify barriers to appropriate pain care and ways to reduce such barriers
  - Encourages the NIH Director to expand the research agenda on causes of and treatments for pain
  - Establishes an Interagency Pain Research Coordinating Committee
  - Authorizes grants/contracts to health professions schools to develop and implement education and training

## Prevention & Wellness

- Establishes the National Prevention, Health Promotion, and Public Health Council (4001)
  - Provides Federal Agency coordination;
  - Develops a national strategy
- Establishes a Prevention and Public Health Fund (4002)
- Increases access to immunizations (1001; 4002; 4103; 4106, 4204)
  - GAO to study the impact of Part D on Medicare beneficiary access to Part D vaccines(4204)

## Prevention & Wellness

- Increases access to/provides incentives for preventive services (4104; 4106; 4108; 4201; 4202; 5502; 10406)
  - Some address promotion of chronic disease self-mgmt
- Adds Medicare coverage for an annual wellness visit (4103)
  - Assessment includes a list of prescribed **medications**
- Establishes wellness and diabetes programs (4108; 4201; 4202; 4206; 4303; 4402; 10407; 10408; 10501):
  - Employer-based; community-based; Medicaid; Medicare; community health centers

## Prevention & Wellness

- Requires Medicaid coverage of counseling and pharmacotherapy (Rx and OTC) for cessation of tobacco use by pregnant women (4107)
  - Counseling is furnished:
    - By or under the supervision of a physician; or
    - By any other health care professional who:
      - Is legally authorized to furnish the services under State law; and
      - Is authorized to receive payment for other services under this title or is designated by the Secretary for this purpose
  - Removes co-pays for these products and services

## Quality

- Develops Quality and/or Value Measures (2701; 3013; 3014; 5605; 10303; 10329)
- Develops Reporting Requirements (1001; 3004)
  - Insurer reporting requirements on reimbursement structures that improve health outcomes such as **medication and care compliance** initiatives
- Establishes Strategies to Improve Quality (3011; 3014; 10302)
- Addresses Availability of Data, Data Analysis, and Public Reporting of Data (3015; 10332)

## Quality

- Addresses Training in the Area of Quality (3501; 3508)
- Enables AHRQ's Center for Quality Improvement & Patient Safety (3501) to:
  - Identify, develop, evaluate, disseminate, and provide training in innovative strategies for quality improvement in the delivery of health care services that represent best practices in health care quality, safety, and value
  - Provide technical assistance grants to implement models
- Establishes demonstration program to integrate quality and safety into clinical education of health professionals (3508)
  - Grantee may be a **school of pharmacy**

## Transitions of Care

- Establishes a Medicaid demonstration project to evaluate the use of bundled payments around a hospitalization(2704)
  - Hospitals must have “robust discharge planning”
- Establishes a Medicare pilot program to evaluate the use of payment bundling around a hospitalization (3023; 10308)
  - Payment methodology tested must include payment for certain services including **medication reconciliation**
- Establishes a Hospital Readmissions Reduction Program (3025; 10309)

## Transitions of Care

- Establishes a program to assist eligible hospitals to improve readmission rates via Patient Safety Organizations (PSOs)(3025)
- Establishes a Community-Based Care Transitions Program (3026)
  - Services for high-risk Medicare beneficiaries
  - Duration and scope may be expanded if it is expected to reduce spending without reducing quality
  - An application for the funding must include a detailed proposal for at least one care transition intervention, which may include conducting **comprehensive medication review and management** (including, if appropriate, counseling and self-management support)

## Transparency

- Requires manufacturers that provide payment or other transfers of value to a physician or teaching hospital must submit certain information on the payment or transfer (6002)
  - Defines manufacturer to include “compounding”
- Requires manufacturers and authorized distributors of record to submit to the Secretary information on the drug samples requested and distributed (6004)
- Establishes Pharmacy Benefit Manager (PBM) transparency requirements (6005)

## Transparency

- Section 6005 (continued)
  - PBMs must share information with Secretary and plans with whom they contract:
    - The percentage of drugs dispensed at retail and mail-order; and cases in which a generic drug is available and dispensed
    - The aggregate amount and types of rebates/discounts that the PBM negotiates that are attributable to patient utilization under the plan, and what are passed through to the plan sponsor
    - The aggregate amount of the difference between the amount the health benefits plan pays the PBM and the amount the PBM pays retail and mail-order pharmacies

## Workforce

- Establishes a National Health Care Workforce Commission (5101)
  - Purpose is to determine if workforce demand is being met and to address barriers
  - Defines health care workforce as all health care providers with direct patient care and support responsibilities, such as...**pharmacists**
  - Defines health professionals as including **clinical pharmacists**...representatives of **schools of pharmacy**...educational programs for **pharmacists**

## Workforce

- Addresses Geriatric Training and Education (5305)
  - Authorizes grants for geriatric education centers to offer “fellowships” focusing on geriatrics, chronic care management, and long-term care
  - Provides training for faculty members in ...health professions schools with programs in...**pharmacy**
  - To be eligible, an individual must be...a **pharmacist**
  - 1 of 2 activities include developing material on...**medication safety issues** for older adults
  - Establishes Geriatric Career Incentive Awards
    - To foster interest in entering the fields of geriatrics, long-term care, and chronic care management

## Workforce

- Section 5305 (continued)
  - To be eligible, an individual must be...a **pharmacist**
  - Expands eligibility for geriatric academic career awards
    - To be eligible, an individual must...have a junior (non-tenured) faculty appointment at an accredited school of...**pharmacy**
- Addresses cultural competency, prevention and public health, and individuals with disabilities training (5307)

## Workforce

- Authorizes the establishment of a U.S. Public Health Sciences Track (5315)
  - To grant appropriate advanced degrees that uniquely emphasize team-based service, public health, epidemiology, and emergency preparedness and response
  - Must graduate no less than...50 **pharmacy** students annually
  - Secretary will give priority to:
    - Students from rural communities and underrepresented minorities
    - Training institutions that train students for some significant time together (at a minimum have a discrete and shared core curriculum)

## Workforce

- Section 5315 (continued)
  - Requires a service contract; in exchange for tuition:
    - Student completes a residency or internship;
    - Serves 2 years for every one year enrolled at the College
- Adds two new Area Health Education Centers (AHEC) awards(5403)
  - Eligible activities include conducting and participating in interdisciplinary training that involves...**pharmacists**

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Questions?