Pharmacists Want a More Explicit Role in ACOs

Medicare’s Hands Are Tied ... at Least Initially

Stephen Barlas

When CeutiCare, LLC, a Cleveland-based collaborative Medication Therapy Management (MTM) company, began its experiment with an Ohio Medicaid health maintenance organization (HMO) in 2008, Allen Nichol, PharmD, CeutiCare’s Vice President of Clinical Operations and Chief Operating Officer, had a strong hunch. He felt that the HMO’s pharmacists who were using CeutiCare’s proprietary smart algorithm could help physicians target the most effective medication for their patients and save the HMO big bucks in reducing hospital readmissions. One year later, Dr. Nichol had proof. Over the course of a year, treatment costs for patients seen by pharmacists wielding CeutiCare software were lower by $5,500 per patient than for patients in a control group.

“The glaring thing was that hospital readmissions for the treatment group were down 29%;” he says. “For the control group they were up 200%.” Those results were computed by Pfizer’s pharmacoeconomics division.

Flash forward to September 2011. The Centers for Medicare and Medicaid Services (CMS) was weeding through applications from physicians’ groups around the country who want to participate in the CMS’s Accountable Care Organization (ACO) program. ACOs were mandated by the 2010 Patient Protection and Affordable Care Act (PPACA), the health care reform bill passed by Congress and signed by President Obama. ACOs aim to reduce Medicare spending—now a cause célèbre, thanks in part to the debt-ceiling debate—by forcing groups of physicians to collaborate more closely among themselves, in outpatient and inpatient settings, to provide patients in five high-cost chronic-disease categories with higher-quality care at a lower cost. ACOs will function much like HMOs, assuming risk for the comprehensive care of older patients and pocketing some of the savings ostensibly accruing from coordinated care. The ability of an ACO to reduce hospital readmissions will be a key to generating those savings. The new program is expected to debut on January 1, 2012.

So one would think, given the CeutiCare results with the Ohio Medicaid HMO and numerous verified reports of health plan savings generated by MTM services, that pharmacists would be to ACOs what baseball slugger Reggie Jackson was to the Yankees at World Series time—“the straw that stirs the drink.” Think again; pharmacists aren’t even in the dugout.

Only health care providers who bill Medicare directly for Part A hospital and Part B physician-office services can participate directly in ACOs and share savings; that means physicians and hospitals. Pharmacists, except in one very narrow instance, are “missing in action” from the ACOs—they might be able to bill directly for diabetes self-management training services, which are provided under Medicare Part B. Part D outpatient drug costs are not computed when the CMS totals ACO savings to Medicare. So ACOs will have to depend on pharmacists who are stationed in hospitals and in physicians’ offices—but not in community pharmacies—to help generate savings. They just can’t make pharmacists risk and profit-sharing “partners” in the experiment, which—if it achieves some success—will become the model for a radical change in the way health care is provided and reimbursed by the federal government and private payers in the U.S.

Give the fact that pharmacists already account for significant federal and private health care cost savings, there has been a lot of unhappiness about their omission from the ACO experiment.

“I am in utter disbelief, since there are 130 colleges of pharmacy in the U.S. and licensure requirements in all 50 states and U.S. territories, that the U.S. government continues to ignore the clinical contributions that are documented in thousands of peer-reviewed journal articles,” says Dr. Nichol.

Unfortunately, it does not appear that the CMS, which is administering the ACO program, has much leeway in bringing pharmacists in from out of the cold. The language of the PPACA allows only providers who are defined as such under the Social Security Act to participate directly in ACOs and to share in their risks and rewards.

Christopher Topoleski, Director of Federal Regulatory Affairs at the American Society of Health-System Pharmacists (ASHP), says he understands that the CMS is limited in terms of allowing direct participation of pharmacists. The ASHP and other pharmacist groups would like to see CMS recognize the significant contributions made by pharmacists in caring for patients. They would also like to see ACOs pass some of those savings on to pharmacists, whether they work in inpatient, outpatient, or retail pharmacies.

Pharmacists in hospitals and physicians’ offices will have a direct role in helping ACOs meet their two primary objectives: achieving quality benchmarks and saving money. ACOs will have to meet 64 quality indicators before they can share in any savings, although that number might change in the final rule. Many of those benchmarks require careful attention to medication handling. In the area of care coordination and transition, benchmarks include medication reconciliation after discharge from an inpatient facility (Measure 10) and care-transition measurement, including the MTM component (Measure 11). Preventive health measures include influenza immunization, pneumococcal vaccination, and cholesterol management for patients with cardiovascular (CV) conditions. There are separate measures for individual at-risk populations. These measures include oral antiplatelet therapy for patients with coronary artery disease (CAD), drug therapy for lowering low-density lipoprotein-cholesterol (LDL-C) levels, and beta-blocker therapy for CAD patients with prior myocardial infarction.

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The Role of Pharmacists in Accountable Care Organizations

To the extent that quality benchmarks are based on evidence-based protocols, they presumably lead not only to healthier patients but also to fewer adverse drug reactions and shorter hospital stays. Helping hospitals adhere to those protocols is where hospital pharmacists make their contribution, and this leads to significant cost savings. After a patient leaves the hospital, a pharmacist working in a physician’s office helps reduce hospital readmissions.

Catholic Medical Partners in Buffalo, N.Y., an independent practice association that includes five hospital outpatient clinics and about 200 physicians’ offices, has been using pharmacists to reduce hospital readmissions. Michael Edbauer, DO, the group’s Chief Medical Officer, says:

Hospitals have their own formularies, and they differ from the formularies used by a patient’s health plan, which comes into play when the patient goes home. The medications in the medicine cabinet at home can be different than the medications the patient comes home with, such as two different statins or two different blood pressure medicines. Or maybe the hospital drops an ACE inhibitor the patient was taking prior to being hospitalized. These are fairly significant errors we have been able to identify.

The language of the PPACA aside, excluding pharmacists from sharing risks and rewards in ACOs makes as much sense as the Medicare program throwing money out the window. There are indications that the ACO concept works. In creating it, Congress used the Physician Group Practice Demonstration (PGPD), established by Medicare in 2005, as a model. It was the first pay-for-performance initiative for physicians under the Medicare program, and it ran for five years. It offered “performance payments” to participants that met most of 32 measures of quality—half as many as in the proposed rule—and spent at least 2% less for Medicare patients compared with a group of similar Medicare patients outside the experiment who lived nearby. Results from the five-year demonstration program were published in December 2010, and to outsiders, they didn’t look that good. That was because the data on cost savings appeared to be unconvincing. However, most of the 10 participants did save money, just not enough to get over the percentage hurdle that the CMS had established before the physicians could share those savings.

The University of Michigan Faculty Group Practice was one of the 10 participants in the PGPD. David Spahlinger, MD, Senior Associate Dean for Clinical Affairs at the practice, explains that five of 10 groups earned money back from Medicare, his group included. The university’s practice has 30 sites, some as large as 400,000 square feet, containing more than one clinic. He explains that five pharmacists are spread over those 30 sites.

He says, “If a patient has a complex pharmaceutical problem, we hand it off to the pharmacist. The Faculty Group Practice organization implemented a transition-of-care program and a complex-care management program. Pharmacists played an important role in our management of patients with multiple medical problems with complex medication regimens.”

Other physician groups outside the PGPD have also inaugurated coordinated-care models. One of them is Catholic Medical Partners. Dr. Edbauer says that the group’s clinical integration model added pharmacist participation a few years ago. The association employs three full-time pharmacists, and four others do per diem work. Those pharmacists are assigned to the larger clinics and physician practices, and more sites are being added to pharmacist coverage throughout 2011. Typically, a pharmacist spends four hours at one site, seeing patients with complex medication problems and chronic diseases.

But Dr. Edbauer says the biggest impact that the pharmacists have had is in the group’s Care Transitions Program. When high-risk patients leave the hospital, they enter the program, which provides nurse visits within 48 hours to the discharged patient’s home. Among other duties, the nurse checks the medications in the patient’s medicine cabinet and sends that list to one of the seven pharmacists, who has access to the patient’s electronic medication record, whether or not the pharmacist works at a clinic. Pharmacy students sometimes accompany the nurse to assist with collecting the medication data as well as to provide additional information to the patient. Dr. Edbauer points out that the drugs patients received from the hospital’s formulary might differ from the drugs they had been receiving at home, before hospitalization, through their health plan. When he met with members of the Catholic Medical Partners administration this past January, he stated that virtually 100% of the patients in the Care Transitions Program experienced at least one medication change when they arrived home.

“When we started the program, we weren’t anticipating that volume of opportunity,” he emphasizes. “It has shown a positive return on investment. Both the insurance companies we work with and we have been satisfied with pharmacist collaboration, so much so that we are growing the program.”

Catholic Medical Partners has also applied to participate in the pioneer ACO program, the pilot model that the CMS is now trying to get off the ground before it finalizes rules for the entire program. Neither Dr. Edbauer nor Dr. Spahlinger has comprehensive, public data about how much money their groups are saving because of pharmacist intervention in health care—but those data exist elsewhere. In its comments to the CMS about the ACO proposed rule, the National Community Pharmacists Association (NCPA) pointed to a 2010 study by Ramalho de Oliveira and colleagues, which examined MTM outcomes over a period of 10 years in a large, integrated health care system.1 Among the positive results from this study, 42.7% of diabetic patients reached all goals through MTM, and the pharmacist-estimated cost savings to the health care system was about $86 per encounter over the 10-year period. Stated differently, the estimated return on investment was $1.29 for every $1.00 spent on MTM costs.

Although MTM services are provided in hospitals and can come into play in an ACO environment, narrower medication-adherence programs are probably prevalent in Medicare Part D. These programs have shown the ability to reduce hospital readmissions too. A 2007 study by Murray and colleagues revealed that during a 9-month pharmacy intervention period, direct health care costs were lower for the intervention group by $2,960 per person. There were also fewer adverse drug-related events and medication errors in the intervention group.2

However, community pharmacists are excluded from ACOs because Medicare Part D costs are not part of the savings calculations authorized by Congress. Dr. Spahlinger thinks it would make sense to include Part D costs in ACO savings.
The Role of Pharmacists in Accountable Care Organizations

We are concerned that without specific guidance, there may be an attempt to require all patients enrolled in the ACO to fill prescriptions in an outpatient pharmacy of a 340B entity, which would subvert the intention of the program. Furthermore, absent such guidance, there is the possibility that ACOs may change their treatment protocols in a way that would move a patient from an inpatient setting to an outpatient setting in order to have access to 340B pricing discounts.

Another problem that will affect hospital pharmacies is electronic health records (EHRs). The CMS-proposed rule requires that at least half of an ACO’s primary-care physicians must be meaningful EHR users by the start of the second performance year and that ACOs must have a mechanism in place to electronically exchange summary-of-care information when patients switch to another health care provider or setting. The CMS has already established a definition of meaningful use, as required by the Health Information Technology for Economic and Clinical Health (HITECH) Act—part of the American Recovery and Reinvestment Act of 2009. Physicians and hospitals that meet this standard will be eligible for incentive payments in 2011.

The meaningful-use requirements touch on many services that involve inpatient pharmacists. But the actual technical specifications are not sufficiently robust to account for pharmacist intervention. Specifically, the meaningful-use standard addresses only electronic prescribing and does not incorporate pharmacy quality measures approved by the Pharmacy Quality Alliance. An example would be medication reconciliation. The standard does not square with the more expansive definition supported by members of the Pharmacy e-Health Information Technology Collaborative, the Joint Commission, or the Agency for Healthcare Research and Quality.

The gold standard EHR, in the view of pharmacy groups, would include the Pharmacist/Pharmacy Provider EHR (PP-EHR) functional profile. The PP-EHR was developed jointly by the Health Level Seven (HL7) and the National Council for Prescription Drug Programs work groups and has been approved through the ballot process of both all-volunteer, nonprofit organizations. However, the PP-EHR has not been blessed by an HHS-designated certification organization (there are three of these), nor has it been incorporated into EHR software. In essence, then, the CMS cannot require physicians and hospitals to use this more pharmacy-rich EHR—at least not yet.

Shelly Spiro, RPh, Director of the Pharmacy e-Health Information Technology Collaborative, says she hopes that the PP-EHR functional profile obtains American National Standards Institute accreditation this fall; however, many of the pharmacy-management software vendors who would be expected to include the PP-EHR profile in their systems are focused on the new requirements of the Health Insurance Portability and Accountability Act (HIPAA), which take effect on January 1, 2012. Moreover, she adds ruefully, “The system vendors have no incentive to incorporate pharmacist EHR functionality into their software.”

ACOs have an incentive to incorporate pharmacists into their coordinated-care model, but whether pharmacists have much of an incentive to make ACOs work—that is a different question.

REFERENCES
