Affordable Care Act:
Train Wreck or Golden Opportunity?

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Disclosure

Brad Kile is an independent consultant and has no financial interest or relationships to disclose.

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Learning Objectives

- Identify the timeline for the Affordable Care Act (ACA).
- List the main implications of the ACA on providers in the pharmacy supply chain.
- Compare current reimbursement models with new financial incentives for providers under the ACA.
- Identify the structure and incentives for providers under the accountable care organizations and bundled payment programs.

Presentation Outline

- Can Clarity be Found Among Confusion?
- Do Payment Incentives Change Care Delivery?
- What Happens if a True Average Price is Publically Available?
- Q & A

46 Months After the Passage of the ACA…

- Political Context of ACA Implementation
- Budget / Debt Debate and the ACA
- What is working, what is not
- Key Themes
  - **Linking Care Across Settings**
  - **Tying Payment to Quality**

Health Insurance Exchanges

- Virtual marketplaces for individuals and employers to shop for coverage
- Distributors of health care, not deliverers
- Commercial insurers manage care within state/federal requirements
- Facilitate support/subsides based on need

HIEs – Current Status

- Healthcare.gov - Failure to Launch
- Maybe you can't keep your current coverage
- Enrollment projections v. reality
- Facilitating subsidies and income verification… waiting for the other shoe to drop

Medicaid Expansion

- Targets those individuals at or below 133% of federal poverty level
- Federal government will pay 100% of the cost for expansion for 2014, 2015, 2016
- Federal share tiers down to 90% for 2020
- State participation varies
- Help for those “left behind’ in states that do not expand eligibility
- States increasingly going Medicaid Managed Care

Take Away #1

"Confusion abound for consumers and insurance market"

Key Themes

Linking Care Across Settings

Tying Payment to Quality

Accountable Care Organizations

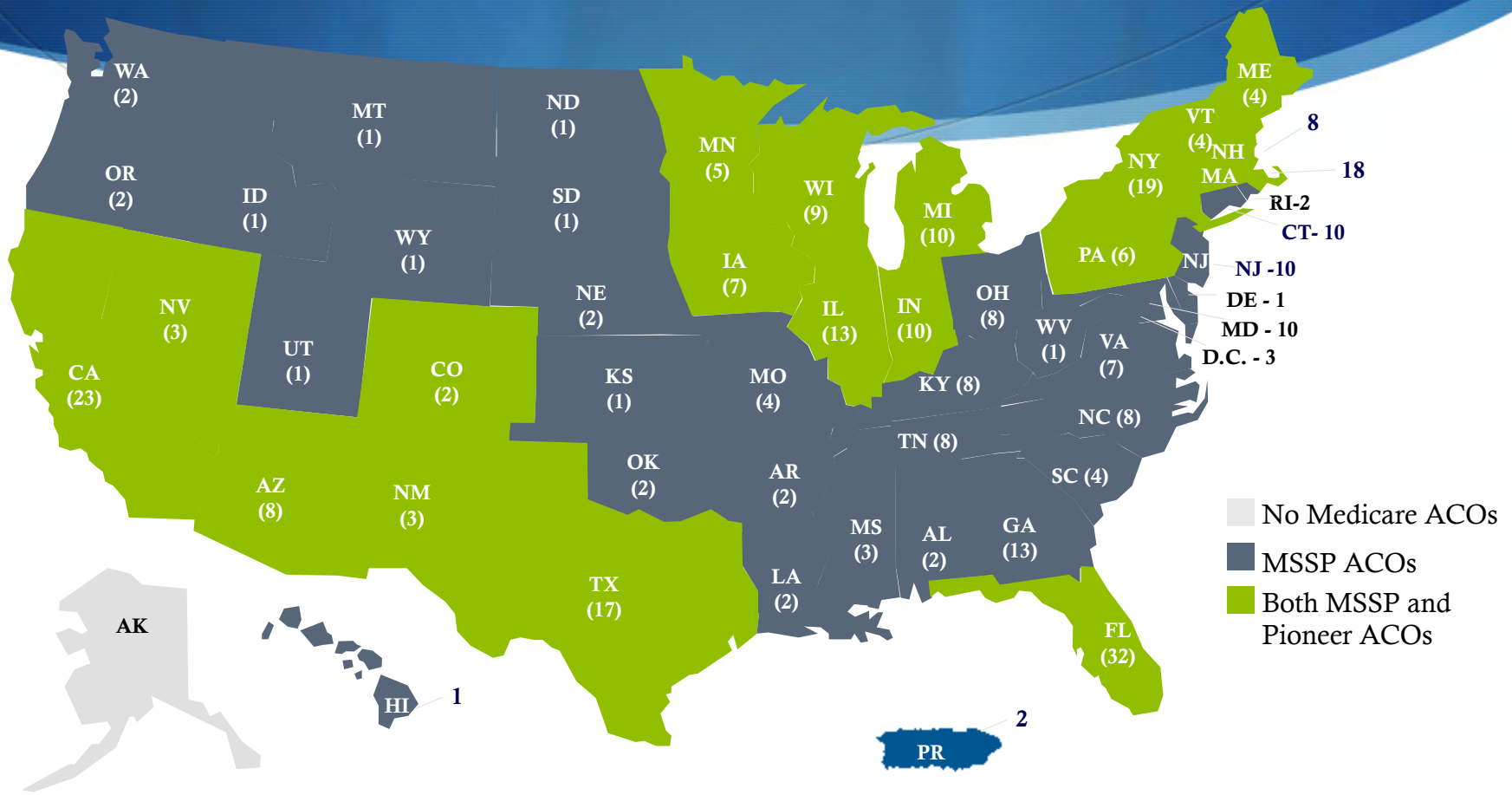
Medicare ACOs: Quality Measures

MSSP and Pioneer use the same quality measures and MUST MEET QUALITY TARGETS before they are eligible for shared savings.

- **33 Quality Measures across 4 Domains**

1. Patient/caregiver experience (7 measures)
2. Preventive health (8 measures)
3. At-risk population (12 measures)
4. Care coordination (6 measures)

States with Medicare ACOs



Source: CMS Medicare Shared Savings Program website:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram/

Bundled Payments

- January 2013, CMS announced the 450+ health care organizations selected to participate in the Bundled Payments for Care Improvement (BPCI) initiative.
- Four models tested
  - Organizations choose up to 48 clinical episodes of care to test.
- Organizations enter into payment arrangements that include financial and performance accountability for episodes of care.

Bundled Payments

- Model 1 - focused on the acute care inpatient hospitalization. Awardees agree to provide a standard discount to Medicare from the usual Part A hospital inpatient payments.
- Models 2 and 3 - retrospective bundled payment arrangement where actual expenditures are reconciled against a target price for an episode of care.
- Model 4 - prospective bundled payment arrangement, where a lump sum payment is made to a provider for the entire episode of care.

Innovation.cms.gov/initiatives/Bundled-Payments/

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Bundled Payments for Care Improvement (BPCI) Initiative: General Information

Share

On January 31, 2013, the Centers for Medicare & Medicaid Services (CMS) announced the health care organizations selected to participate in the Bundled Payments for Care Improvement initiative, an innovative new payment model. Under the Bundled Payments for Care Improvement initiative, organizations will enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality, more coordinated care at a lower cost to Medicare.

Source: Centers for Medicare & Medicaid Services

Where Health Care Innovation is Happening

See who's working with CMS to implement new payment and service delivery models.

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Hospital Readmissions

Hospital Readmissions Reduction Program

- Adjusts hospital payments based on the $ value of each hospital's % of potentially preventable Medicare readmissions
- Oct 1, 2012: three conditions: heart failure, heart attack and pneumonia
- Oct 1, 2015: COPD, coronary artery bypass graft, percutaneous transluminal coronary angioplasty, vascular surgery and others as determined by HHS
- HHS calculates and make publicly available information on all patient hospital readmission rates

Take Away #2

"Know the payment incentives to understand your customers"

Average Manufacturer Price

- Applies to Medicaid Reimbursement, Broader Implications
- 2012 Proposed Rule
- CMS proposes to define "retail community pharmacy" for manufacturer AMP calculations.
- "an independent pharmacy, a chain pharmacy, a supermarket pharmacy, and a mass merchandiser pharmacy that is licensed as a pharmacy by the State and that dispenses medications to the general public at retail prices."
- Excludes from AMP sales to PBMs, LTC pharmacies, mail order pharmacies, and others.
- CMS notice in Fall 2013, says Final Rule will be issued in January 2014

Take Away #3

"Law of averages means there are clear winners and losers"

Thank You!

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