IMPLEMENTING HEALTH REFORM

The Center for Medicare And Medicaid Innovation

Next year, the federal government will launch the Center for Medicare and Medicaid Innovation, a new department to oversee the portfolio of payment pilot projects called for under the Affordable Care Act. As part of its charge, the innovation center will develop and evaluate pilot projects for new and old payment ideas that include accountable care organizations, patient-centered medical homes, bundled payments, and capitated payments. Officials at the new center, one of the Centers for Medicare and Medicaid Services (CMS), will have the authority to extend or expand projects that show the potential to improve quality or cut costs.

Stuart Guterman, who studies payment policies for the Commonwealth Fund, explains the potential and the challenges for leaders of the new center.

Clinical Endocrinology News: Why did lawmakers create this innovation center as part of the Affordable Care Act? Is it necessary?

Mr. Guterman: I think it is necessary. I think, in fact, it may turn out to be one of the most important provisions in the law. It focuses the attention of the CMS, which runs the two biggest health programs in the country, on the notion of innovation. It emphasizes the idea that we need to try new approaches to both payment and delivery of health care to get out off the path that we're on, which is leading to ever-growing health care costs and more pressure on the health care system.

We already spend 50% more than any other country in the world on health care. Everybody points to the amount of waste in the system. But it's harder to identify ways of actually getting rid of it and making the health care system work better for people. That's what this innovation center was intended to do – to focus the attention of the federal government on that issue and to bring in the other parts of the health care sector to collaborate on better ways of providing care and better ways of paying for care.

CEN: Some of the concepts – such as medical homes and capitated payments – have been tested before. What makes this effort different?

Mr. Guterman: Capitation was tried in the 1990s, but back then, we did not have the kinds of measures of health system performance that we have now. Also, the notion of capitating payments so that you provided a strong incentive to reduce costs got separated from the notion of providing care in an effective, efficient way. So we started out with a managed care movement that was focused on providing coordinated care for patients and we ended up with a movement that was focused primarily on reducing the costs, sometimes in arbitrary ways. Today, I think we have the tools to avoid going off that track. We may not get all the way to capitation, but there are bundled payments and other strategies that get us away from the current fee-for-service system.

In terms of the medical home, models are being tested by various private payers, Medicare is developing a demonstration project, and Medicaid is testing several models. But those efforts are fragmented, just like the rest of our health care delivery and financing systems. If we conduct these pilots individually, they are much less effective than if they can be coordinated and focused, using the same kinds of measures.

'We need to bring together all of the health care system's stakeholders' to make the center successful.

MR. GUTERMAN

CEN: What are the keys to making the innovation center successful?

Mr. Guterman: We need to bring together all of the health care system's stakeholders. We are currently projected to spend between $30 trillion and $35 trillion on health care over the next 10 years. The issue is not what to cut, it's how to use some reasonable amount of money to buy the kind of health care we think our system should produce. That requires the involvement of everyone – providers, patients, and public and private payers.

CEN: What challenges will officials at the innovation center face in rapidly testing new payment concepts?

Mr. Guterman: It's easy to say that everyone ought to be involved, but right now people tend to look at change as something that threatens them. We need to overcome that. Also, a lot of these projects will take time to develop and implement, and to adjust as they go along, so Congress and the American public also need to have patience and realize these strategies will take awhile to unfold.

CEN: Is the innovation center's work likely to have a significant impact on lowering costs?

Mr. Guterman: Yes, though it's hard to predict just how much. You've got a system now that pays for more care, more complicated care, and more invasive care, but not more appropriate and efficient care. So if you change the focus from more to better and from more invasive to more appropriate, then you can make some difference in lowering costs. ■

Stuart Guterman is vice president for payment and system reform at the Commonwealth Fund, a private foundation that supports research on the health care system in Washington.

POLICY & PRACTICE

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Forest to Pay $313M Fine

Forest Pharmaceuticals Inc. will pay $313 million and will plead guilty to felony obstruction of justice for distributing three drugs, including levothyroxine (Levothroid) for hypothyroidism, without Food and Drug Administration approval, the Department of Justice stated. The department also said Forest made "illegal kickbacks," such as gourmet meals and cash incentives, to entice physicians to prescribe the antidepressants citalopram (Celexa) and escitalopram (Lexapro). In its announcement, the Department of Justice detailed how Forest disobeyed FDA orders between 2001 and 2003 by ramping up production of Levothroid even after the agency told the company that it must stop. Forest discontinued its production of the unapproved version of Levothroid in 2003 and now distributes a different version of levothyroxine, also called Levothroid, under a supply agreement with Lloyd Pharmaceuticals, according to the announcement.

Society Warns of Disruptors

The Endocrine Society called on Congress to work with endocrinologists and other scientists to develop better regulations and screening programs for endocrine-disrupting chemicals. The substances "represent a significant health concern and their use has been so widespread that everyone has some level of exposure," R. Thomas Zoeller, Ph.D., coauthor of the society's scientific statement on such chemicals, told policy makers at a Capitol Hill briefing. Dr. Zoeller and two other presenters explained how endocrine-disrupting chemicals have been linked to numerous health conditions, including pediatric obesity, asthma, autoimmune disease, and infertility. They called for comprehensive screening of chemicals for their endocrine-disrupting properties and for bans on those already known to have adverse effects.

Diabetes Drug Market Hits $25B

The worldwide market for diabetes drugs grew more than 16% to reach nearly $25 billion in 2009, making it one of the fastest growing areas of the pharmaceutical sector. The change is attributed to an aging and increasingly obese world population, according to a research report from Kalorama Information. The health-market researcher firm added that the high growth rate is likely to continue. "Diabetes is seen as kind of a 'safe bet' development area" for pharmaceutical companies, Bruce Carlson, Kalorama Information's publisher, said in a statement. More than 100 new diabetes products are in the pipeline, the report said. Top companies competing to secure market positions with those products include NovoNordisk, Sanofi-Aventis, GlaxoSmithKline, Merck, and Tekada, the report said.

Diabetes Drug Use Up

The proportion of people with diabetes who took oral medications for the condition grew from 60% in 1997 to 77% a decade later, while the proportion taking insulin to control diabetes fell from 38% to 24%, according to the Agency for Healthcare Research and Quality. In addition, use of sulfonylureas to stimulate the pancreas to produce more insulin decreased over the same 10-year period, while use of biguanides to reduce the liver's excess glucose production and thiazolidinediones to increase insulin sensitivity rose, the AHRQ said.

Insulin Noncompliance Tallied

More than one in every three diabetes patients said they failed to take their insulin as prescribed or skipped doses an average of three times in the previous month, according to a survey of physicians and patients by NovoNordisk. The survey also found that three-quarters of physicians think patients may be noncompliant with their insulin therapy as many as six times each month, not three times per month as the patients had claimed. Patients blame changes in their normal routines, being too busy, or simple forgetfulness for neglecting to take their insulin, according to the survey of nearly 3,000 physicians and patients in eight countries. Fear of hypoglycemia also may play a role: Two-thirds of patients said they were concerned about it, and three-fourths of physicians said they would treat patients more aggressively if they weren't afraid of hypoglycemic events.

Study: Mistake Policies Needed

When several patients are affected by a medical mistake – even one that probably will harm none of them – the event ought to be disclosed to the public, according to authors of a study funded by the Agency for Healthcare Research and Quality and published in the New England Journal of Medicine (2010;363:978-86). The authors said that "large-scale adverse events" from around the world have included everything from equipment malfunctions to poorly sterilized laboratory equipment. They advocated reporting policies that emphasize timely disclosure of such mistakes to government authorities, to the patients potentially affected, and to the media.

–Jane Anderson