Out is in; in is out
Reform law lowers drug prices—for outpatient only

The healthcare reform law opens the door for more hospitals to purchase discounted drugs through a government program, though some industry executives say the absence of an inpatient drug option will reduce its savings potential and discourage participation.

While pleased that some types of critical-access, children’s and cancer hospitals will be able to purchase outpatient drugs at lower prices through Medicaid’s 340B discount drug program, the American Hospital Association and others in the industry were disappointed that lawmakers chose to leave out inpatient drug purchasing from the program changes passed as part of the healthcare reform package.

The 340B program allows hospitals serving large numbers of low-income and uninsured patients to purchase their outpatient drug supplies through the same manufacturers’ rebate program used by Medicaid. By law, drugmakers are required to provide the discount to Medicaid.

The inclusion of inpatient drugs in the law definitely would have lowered costs for hospitals and patients and saved the federal government money, producing opportunities to pay for other things, said Don May, vice president for policy with the AHA. For these reasons, hospitals will undoubtedly be leaning on Congress to include inpatient drugs in future legislation, he said.

Two-hospital Truman Medical Centers, Kansas City, Mo., currently participates in the program and averages about $6 million worth of purchases through 340B each year, said John Bluford, the system’s president and CEO. The program saves Truman “at least $1.2 million annually and basically helps about 90,000 patients,” said Bluford, who’s also the AHA’s chairman-elect.

Adding inpatient drugs would have produced another $1 million in annual savings, however, helping an additional 18,000 patients at his hospital system, Bluford estimated.

Likewise, two-campus Halifax Health, a public hospital system in Daytona Beach, Fla., estimates it “could have saved $3 million per year in discounted drugs” if inpatient drugs had been included, said Dee Schaeffer, governmental affairs officer.

Previously, the 340B program applied only to those hospitals that had a disproportionate-share hospital adjustment of 11.75% or higher. The health reform law lowered that threshold to 8%, “which let in a whole group of rural hospitals, free-standing cancer hospitals and sole community hospitals,” as well as certain types of critical-access hospitals, May said.

The AHA estimates that 1,300 to 1,400 hospitals will be newly eligible for the 340B program. Overall, hospitals should save

Stalling states
AHRQ’s infection program sees slow enrollment

Six months after the Agency for Healthcare Research and Quality announced it would begin a nationwide expansion of a program credited with successfully reducing healthcare-associated infections, some state organizations and hospitals are taking their time getting onboard.

The program, called the Comprehensive Unit-Based Safety Program, or CUSB, was developed by the Johns Hopkins University Quality & Safety Research Group, and was used in a much-publicized initiative known as the Keystone project, which successfully lowered the rate of central-line-associated blood stream infections by two-thirds in more than 100 intensive-care units in Michigan.

After Michigan’s success, AHRQ extended funds to 10 more states in early 2009 to use the CUSB model, which emphasizes team-building and culture change, as a strategy to reduce blood stream infections. In October 2009, the agency expanded funding further, awarding $8 million to implement the program in all 50 states, on a voluntary basis.

The project’s initial focus has been on central-line-associated blood stream infections, but AHRQ also allotted money to apply the model to other future goals including reducing the number of catheter-associated urinary tract infections.

More than 30 states are currently participating in the initial project, called On the CUSB: STOP BSI, according to Peter Pronovost, an anesthesiologist and patient-safety expert, who heads the program.

But newly released data show that each state varies widely in the number of hospitals it has enrolled and their level of involvement, Pronovost said. For instance, Connecticut has some of the highest enrollment numbers with 15 of its 27 hospitals, or 56%, enlisted to participate.

Thirty-five of Illinois’ 149 hospitals, or 23%, are enrolled, while other states such as Minnesota hover around the 9% mark.

That’s a problem, Pronovost said, because checklists, despite their promise of low-cost, high-impact quality improvement, will likely do little to reduce infection rates if they are not accompanied by significant cultural changes.

“I always ask, ‘If a nurse in your hospital saw a senior physician not complying with a checklist, would he or she speak up?’” Pronovost said. “Almost unanimously, I am laughed at. … But if that’s the case, your system is not working.”

Ensuring that physicians, nurses, clerks and other hospital staff work together to achieve common safety goals takes time and effort, said Darlene Swart, vice president and director of the Tennessee Center for Patient
between 15% and 30% on outpatient drugs, May added.

Although they had been added to a list of covered 340B items in the larger health reform bill, inpatient drugs were taken out by the House’s reconciliation bill (March 29, p. 22). “The program could have been close to doubling in size if expanded to inpatient drugs because many hospitals have a larger inpatient drug program than outpatient program,” said Christopher Hatwig, vice president of Apexus, the company tasked with securing additional discounts for all participating hospitals on covered drugs in the program for the government.

The absence of inpatient drugs may be a significant driver in a low participation rate for critical-access hospitals, Hatwig said. At least 1,200 not-for-profit critical-access hospitals will be able to purchase drugs at 340B prices, making up the majority of the newly eligible, “but many of these hospitals don’t have much in the way of outpatient pharmacy programs,” so the program may not have much value for them, he said.

Nevertheless, Maria Ryan, CEO of 25-bed Cottage Hospital, a critical-access facility in Woodsville, N.H., estimates the hospital could save 25% in its annual pharmacy budget through 340B. Although disappointed the program is not intended for inpatient use, the outpatient portion could still save significant dollars for critical-access hospitals because technically, “340B covers outpatient departments such as oncology day surgery,” creating an opportunity Cottage Hospital won’t want to pass up, Ryan said.

There are other reasons that could prevent hospitals from participating in 340B, sources say.

Newly eligible providers will have to apply for the program through the Health Resources and Services Administration. This is not an automatic perk, May said. “Some may choose not to do it because of the paperwork,” or they’re buying drugs elsewhere through group purchasing organizations, he said.

“It’s not a hassle-free program,” said Eric Zimmerman, a healthcare lawyer who is a partner with McDermott Will & Emery in Washington. “Hospitals will need to take steps to ensure compliance,” such as ensuring the adequate separation of outpatient and inpatient drugs and not commingling the two, he said. “This brings administrative challenges and complications.”

Despite these potential headaches and the lack of inpatient drugs, expansion as a whole will be a great benefit to those hospitals that qualify for it, Zimmerman said.

“I think there continues to be a good deal of interest in expanding inpatient drugs to the program,” Zimmerman said. “It’s appealing to large numbers of members in the House. It will certainly get another hearing.”

Rep. Henry Waxman (D-Calif.), chairman of the House Energy and Commerce Committee, is likely to take up the issue in his panel. Several weeks ago at a healthcare conference, Waxman said drug prices, specifically changes to the outpatient 340B drug discount program, may be addressed in a separate bill in the future. For the time being “we’re not there yet,” he told reporters. <<

Safety, a Nashville-based quality improvement organization that coordinates the state’s participation in the CUSP program. Tennessee ranks second in hospital enrollment with 55 of its 91 hospitals, or 60%, participating. Hawaii tops the list with 16 of its 18 hospitals enrolled, or 89%.

The Tennessee center organizes regular networking meetings led by hospital staff members who present stories of overcoming difficult safety setbacks, Swart said. The organization also helps hospitals as they form safety teams composed of nurse managers, physician champions and senior executive partners. The initiative has been so successful that recently, the Tennessee Hospital Association set a goal of zero preventable infections within three years, said Jim Bexler, president and CEO of Erlanger Health System, Chattanooga, which includes 560 staffed beds in its only owned hospital.

“You won’t see long-term improvements if you don’t change your processes and create a team-oriented environment,” Bexler said. “We get down to the unit level and make sure that it is OK and expected for any staff member to speak up if there is a breach in protocol.”

Other states have engaged in the program more slowly at least in part because of increasing demands from a wide range of quality-improvement initiatives. Colorado’s On the CUSP: STOP BSI kick off meeting is planned for May 13, said Crystal Berumen, director of patient-safety initiatives at the Colorado Hospital Association, but only three of the state’s 60 hospitals plan to participate.

Most of the state’s large hospitals are already reporting low rates of blood stream infections, Berumen added, saying she didn’t feel the need to push the CUSP program on them. “You have to prioritize because if you enroll in everything, you dilute your efforts,” she said.

Jim Kranz, vice president, professional activities, for the West Virginia Hospital Association, agreed saying it can be difficult to manage the demands of multiple quality projects. Twenty-three of the state’s 52 hospitals, or 44%, are enrolled in the CUSP program, and Kranz credits that above-average level of participation to focusing on one main safety initiative.

The cultural changes under CUSP have proved helpful in reducing infections, Kranz said, particularly when the initial excitement of a new project wears off and the numbers start to creep back up. But he also acknowledged that these efforts require time and money, and states have to make hard choices when deciding which programs to implement.

Spurred by success in preventing blood stream infections, West Virginia hospitals have also begun to apply CUSP in other units. At 483-bed West Virginia University Hospitals, Morgantown, the multidisciplinary model has been deployed in respiratory therapy units and the system’s children’s hospital, said Frank Briggs, director of WVUH’s Center for Quality Outcomes.

“I think the reason why it has worked so well is that it is unit-specific and really requires senior leadership to step up and get involved,” Briggs said. <<

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