The New Frontier: Value-Based Payment Models
Target Audience: Pharmacists and Pharmacy Technicians

ACPE#: 0202-0000-18-026-L04-P/T

Activity Type: Knowledge-based
Disclosures

Barnes - None
Brummel - Johnson & Johnson
Choe - None
Moose - None

The American Pharmacists Association is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.
Learning Objectives

- Describe the goals of value-based health care models and highlight the latest trends in key programs, such as accountable care organizations, the Medicare Access and CHIP Reauthorization Act (MACRA), Comprehensive Primary Care Plus, and the Part D Enhanced Medication Therapy Management program.

- Describe how pharmacists can impact quality and cost measurement requirements in value-based payment models.

- Discuss examples of how pharmacists are integrating into these models, including the value proposition that supports pharmacists’ inclusion.

- Describe strategies to adapt the attendee’s pharmacy practice to participate in these new models.
1. Assessment Question

Medicare has a goal of X % of fee-for-service payments tied to quality or value by the end of 2018.

A. 50%
B. 75%
C. 90%
D. 100%
2. Assessment Question

The Merit-based Incentive Program (MIPS):
A. Is Budget-neutral
B. Begins in 2019
C. Applies only to hospitals or facilities
D. Includes pharmacists as eligible clinicians
3. Assessment Question

Pharmacists engaging in value-based healthcare models are using the following as support for inclusion on the healthcare team:
A. Improvement in quality metrics increasing performance-based incentive payments
B. Providing care via care management and population health management
C. Traditional billing for MTM and other disease state management
D. All of the above
4. Assessment Question

Pharmacists can bring value in population health management roles by:

A. Promoting evidence-based guidelines to prescribers
B. Administering flu shots
C. Performing medication reconciliation during care transitions
D. Providing diabetes education
Overview of Value-Based Payment Models
A journey...

VALUE-BASED PROGRAMS


LEGISLATION PASSED
- MIPPA
- ACA
- PAMA
- MACRA

PROGRAM IMPLEMENTED
- ESRD-QIP
- HVBP
- HRRP
- APMs
- MIPS
- VM
- SNF-VBP

LEGISLATION
- ACA: Affordable Care Act
- MIPPA: Medicare Improvements for Patients & Providers Act
- PAMA: Protecting Access to Medicare Act

PROGRAM
- APMs: Alternative Payment Models
- ESRD-QIP: End-Stage Renal Disease Quality Incentive Program
- HACRP: Hospital-Acquired Condition Reduction Program
- HRRP: Hospital Readmissions Reduction Program
- HVBP: Hospital Value-Based Purchasing Program
- MIPS: Merit-Based Incentive Payment System
- VM: Value Modifier or Physician Value-Based Modifier (PVBM)
- SNFVBP: Skilled Nursing Facility Value-Based Purchasing Program

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html
Movement towards Value

In January 2015, the Department of Health and Human Services announced new goals for value-based payments and APMs in Medicare.

**Medicare Fee-for-Service**

**GOAL 1:** 30%

Medicare payments are tied to quality or value through alternative payment models (categories 3-4) by the end of 2016, and 50% by the end of 2018.

**GOAL 2:** 85%

Medicare fee-for-service payments are tied to quality or value (categories 2-4) by the end of 2016, and 90% by the end of 2018.

**STAKEHOLDERS:**

Consumers | Businesses | Set internal goals for HHS
Payers | Providers |
State Partners | Invite private sector payers to match or exceed HHS goals

The move to alternative payment models requires a fundamental change in how we organize healthcare.

**Traditional FFS**
- Sick Care / Hospital Care
- Episodic care
- Individuals practicing in silos
- Variations in care

**Alternative Payment Value-Based Care**
- Population Health + Sick Care / Hospitals
- Longitudinal care
- Team-based, coordinated, integrated care
- Evidence-based standards
Many quality measures/programs
What is “MACRA”? QUALITY PAYMENT PROGRAM

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a bipartisan legislation signed into law on April 16, 2015.

What does Title I of MACRA do?

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Changes the way that Medicare** rewards clinicians for **value** over volume
- **Streamlines** multiple quality programs under the new **Merit-Based Incentive Payments System (MIPS)**
- Provides **bonus payments** for participation in **eligible** alternative payment models (APMs)
WHO IS IMPACTED?

Affected clinicians are called "MIPS eligible clinicians" and will participate in MIPS. The types of Medicare Part B eligible clinicians affected by MIPS may expand in future years.

Physicians (MD/DO and DMD/DDS), PAs, NPs, Clinical nurse specialists, Certified registered nurse anesthetists

Physical or occupational therapists, Speech-language pathologists, Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals

Secretary may broaden Eligible Clinicians group to include others such as

Where’s the Pharmacist?

Overview of General MIPS Reporting Requirements

**Quality**
- Replaces the Physician Quality Reporting System (PQRS)
- Report up to six measures – including an outcome measure – for a minimum of 90 days

**Cost**
- Replaces Value-based Modifier
- Calculated from claims; no data submission required
- Counted in score beginning in 2018

**Advancing Care Information**
- Replaces Medicare EHR Incentive Program for Providers (Meaningful Use)
- Report four required measures for a minimum of 90 days
- Submit up to eleven measures for a minimum of 90 days for additional credit

**Improvement Activities**
- Attest to completion of up to four activities for a minimum of 90 days
- Special consideration for smaller practices, patient-centered medical homes, and certain APMs

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**Components of MIPS Performance Periods 2017-2019**

<table>
<thead>
<tr>
<th>Year</th>
<th>Improvement Activities</th>
<th>Advancing Care Information</th>
<th>Cost</th>
<th>Quality</th>
</tr>
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<tbody>
<tr>
<td>2017</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>60%</td>
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<tr>
<td>2018</td>
<td>15%</td>
<td>15%</td>
<td>30%</td>
<td>50%</td>
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<tr>
<td>2019</td>
<td>15%</td>
<td>15%</td>
<td>30%</td>
<td>30%</td>
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</tbody>
</table>
Select Improvement Activities

Showing 1 Activities

Implementation of medication management practice improvements

Manage medications to maximize efficiency, effectiveness and safety that could include one or more of the following: Reconcile and coordinate medications and provide medication management across transitions of care settings and eligible clinicians or groups; Integrate a pharmacist into the care team; and/or Conduct periodic, structured medication reviews.

Activity ID | Subcategory Name | Activity Weighting
---|---|---
IA_PM_16 | Population Management | Medium

https://qpp.cms.gov/measures/ia
Advanced Alternative Payment Models

APM Track

- Significant revenue share with two-sided risk
  - Quality measurement
  - EHR requirements

An Advanced APM must meet the following three criteria:
  - Require participants to use certified EHR technology
  - Provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of the Merit-based Incentive Payment System (MIPS); and
  
Either be:
(1) be a Medical Home Model expanded under CMS Innovation Center authority; or
(2) require participating APM Entities to bear more than a nominal amount of financial risk for monetary losses.

Putting it all together:

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<tbody>
<tr>
<td>+0.5% each year</td>
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<td></td>
<td>+0.25% or 0.75%</td>
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</table>

Max Adjustment (+/-) |
4 5 7 9 9 9 9 9

+5% bonus (excluded from MIPS)
2018 ONWARDS

Moving forward in year 2

- Additional flexibility for small or solo practices
  - Groups with <$90K in Medicare Part D or those with <200 Medicare Part B patients are exempt.
- More will qualify for APMs
- Cost will be scored and impact the final score (10%)
- Some bonus point changes
  - Small practice groups, complex populations, performance improvement

MIPS Future at Stake?

- In January, Medicare Payment Advisory Commission (MedPAC) voted to repeal & replace MIPS
  - Want to establish a new voluntary value program where providers are compared to each other on quality of care
  - Feel current program is too burdensome
- Others criticized MedPAC’s vote, feel MIPS should stay in place.
CPC+ | Comprehensive Primary Care Plus

Comprehensive Care Functions

- Access and Continuity
- Care Management
- Comprehensiveness and Coordination
- Patient and Caregiver Engagement
- Planned Care and Population Health

Payment Elements

- Care Management Fee (CMF)
- Performance-Based Incentive Payment
- Payment under the Medicare Physician Fee Schedule

Source: https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus
EMTM | Enhanced Medication Therapy Management

**Objectives**
- Learn how to “right-size” their investment in MTM services
- Identify and implement innovative strategies to optimize medication use
- Improve care coordination
- Strengthen health care system linkages.

**Program Details**
- 5-year performance period that began January 1, 2017.
- Model tested in 5 Part D regions
- Participating basic stand-alone PDPs
- Programs can vary the intensity and types of MTM items and services based on beneficiary risk level

Source: [https://innovation.cms.gov/initiatives/enhancedmtm/](https://innovation.cms.gov/initiatives/enhancedmtm/)
The Bottom Line – Why this matters to you

- Choosing six reported metrics
- Understanding payment adjustments
- Determining areas of greatest impact
- Emphasizing quality
- Preparing internally for coming changes
- Navigating both tracks: APMs/MIPs
Panelist Perspectives and Experiences with Value-Based Models
Joe Moose, PharmD
Community Pharmacy Perspective
Moose Pharmacy Vice President
CPESN- USA-Director of Strategy and Luminary Development
Different Expectations of Our Pharmacy Team

If we are going to be different in the marketplace...

...We need to deliver services differently
It’s Not Only About Community Pharmacy...It Takes the Entire Team
Clinical Services at Moose Pharmacy

- Medication Therapy Management (MTM)-**FFS, PMPM**
- Population Health Management-CPESN **RB, PMPM, F4T**
- Moose MAP-Medication Adherence Program **RB, PMPM**
- Immunizations **FFS**
- Diabetes Education

- Pharmacogenomics- **FFS**
- Employer-based wellness education programs **PMPM, RS**
- Transitions of Care Management **FFS, referral**
- Spencer Device **F4T**
- Foster Care Med Optimization and care coordination **FFS, PMPM**

**FFS**= Fee for Service  
**PMPM**= Per Member Per Month  
**RB** = Referral Based  
**RS** = Risk Sharing  
**F4T**= Fee for Time
## Alternative Payment Model

*Tested Under CMMI Award*

<table>
<thead>
<tr>
<th>Patient Risk Score</th>
<th>Pharmacy’s Most Recent Performance Score</th>
<th>Review for Network Inclusion (0-3 Points)</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 85</td>
<td>$$$$$ PMPM</td>
<td>$$$$$ PMPM</td>
</tr>
<tr>
<td>75-84</td>
<td>$$$$ PMPM</td>
<td>$$$ PMPM</td>
</tr>
<tr>
<td>60-74</td>
<td>$$$ PMPM</td>
<td>$$ PMPM</td>
</tr>
<tr>
<td>50-59</td>
<td>$$ PMPM</td>
<td>$ PMPM</td>
</tr>
<tr>
<td>&lt; 50</td>
<td>$ PMPM</td>
<td>$ PMPM</td>
</tr>
</tbody>
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PMPM payments based on patient risk AND pharmacy performance (payment rate based off of current Medicare Chronic Care Management codes)

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Building a Network of Networks
Hae Mi Choe, PharmD
Chief Quality Officer
Director of Pharmacy Innovations
University of Michigan Medical Group
Associate Dean and Clinical Associate Professor
College of Pharmacy, University of Michigan
Michigan Medicine
(University of Michigan Health System)
14 primary care clinics serving adult patients with chronic medical conditions
Pharmacist Services in Primary Care

- **Disease Management Services**
  - Focus on diabetes, hypertension, and hyperlipidemia
  - Proactively identify potential candidates through disease registry and/or provider clinic schedule

- **Comprehensive Medication Review (CMR) Services**
  - Initial appointment:
    - Focus on patient’s medication concerns, confirm medication use, assess patient’s understanding of disease states and treatment plan, and identify potential barriers to treatment including drug cost.
  - Follow up appointment (2 weeks); discuss new treatment plans to improve efficacy, safety and lower drug costs
Specialty Clinics/Services

- CKD Clinics
- Psychiatric Clinic: Michigan Psychiatric Assessment and Care Transition (MPACT)
- Anticoagulation Services
- Transitions of Care Services
- Palliative Care Services
- Transplant Clinics
- Oncology Clinics
- GRACE Program/House Calls
- MedOp Program
- Endocrine Clinic (HTN Services)
Value-based Programs

- Provider Delivered Care Management Uplift
- Capitated Primary Care Services
- MTM Program
  - CMR Completion
  - MTM Incentive Program
- Provider Recognition Program
- CPC+
- State Innovation Model (SIM)
INNOVATIVE PHARMACY PRACTICE AT OSU GENERAL INTERNAL MEDICINE

Kelli D. Barnes, PharmD, BCACP

The Ohio State University
Wexner Medical Center
OSU General Internal Medicine Network

- 6 NCQA Patient-centered medical homes (PCMH)
- 50 Attending physicians
- >90 Medical Residents
- 9 Pharmacists (6.3 FTE)
- 2 Pharmacy residents
- Nurses
- Medical Assistants
- Social Workers
OSU General Internal Medicine Pharmacy Services

- Team-based Care
- Pharmacist-only visits
- Telephonic and patient portal management
- Population health management
- Scheduled Visits
- On-demand Care
- Diabetes Clinic
- Anticoagulation Clinic
- Polypharmacy Clinic
- Transitional Care Management
- Pharmacy Consult Visits
- Population health management
VALUE-BASED PAYMENT PROGRAMS

- Comprehensive Primary Care Plus (CPC+)
- Ohio Comprehensive Primary Care (Ohio CPC)
- Other Value-based models
  - Care management fee (per member per month)
  - Performance-based incentive payments
  - Fee for service
- Million Hearts® Cardiovascular Disease Risk Reduction Model
Fairview Health Services (ACO/IDN)

Amanda Brummel, PharmD, BCACP
Fairview Health Services provides a full continuum of health and medical services

<table>
<thead>
<tr>
<th>By the Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1906</td>
</tr>
<tr>
<td>Fairview is established as a nonprofit</td>
</tr>
<tr>
<td>1997</td>
</tr>
<tr>
<td>Fairview partners with the University of Minnesota</td>
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<tr>
<td>2017</td>
</tr>
<tr>
<td>Fairview acquires HealthEast system</td>
</tr>
<tr>
<td>32,000+</td>
</tr>
<tr>
<td>Fairview/HealthEast employees across Minnesota</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>PreferredOne Health Plan</td>
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<td>2,400</td>
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<tr>
<td>Affiliated Providers</td>
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<td>11</td>
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<tr>
<td>Hospitals/medical centers</td>
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<td>56</td>
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<tr>
<td>Primary care clinics</td>
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<tr>
<td>65+</td>
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<tr>
<td>Specialty clinics</td>
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<td>60+</td>
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<td>Senior housing locations</td>
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<tr>
<td>35+</td>
</tr>
<tr>
<td>Community pharmacies</td>
</tr>
<tr>
<td>40+</td>
</tr>
<tr>
<td>CMM practices</td>
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</table>
Fairview Pharmacy Services provides comprehensive pharmacy services that cover the entire spectrum of patient needs

For consumers and patients:

- Community pharmacies
- Hospital pharmacies
- Specialty Pharmacy (patients in all 50 states)
- Infusion services
  - Fairview Home Infusion
  - Infusion centers
- Comprehensive Medication Management
- Mail Service Pharmacy
- Compounding Pharmacy
- Central Packaging
- Long Term Care/Assisted Living Pharmacy
- Clinical Trials Services
- Anti-coagulation clinics
- Wholesale pharmacy
- Advanced Drug Therapy Program
- Center for Bleeding and Clotting Disorders
Fairview Pharmacy Services provides comprehensive pharmacy services that cover the entire spectrum of patient needs

For employers and health systems
- ClearScript<sup>SM</sup> prescription benefit management
- Fairview Purchasing Network
- Excelera© Network

1,500+ FPS and inpatient pharmacy employees
$14 million in 1996 to nearly $1 billion in revenue
Pharmacist’s Population Health Approach

Direct Patient Care
- Comprehensive Medication Management
- Care Transitions
- Medication/Disease Therapy Management
- Community Pharmacy Clinical Interventions

Population Health Management
- Integrated Database Analysis
  - Medication utilization/safety/gaps in care
- Developing Care Management Pathways
Payment Models

Value-based payment models
- Pay-for-performance incentives
  - All major payers
- Shared Savings (one sided risk)
  - Multiple Commercial Payers
- Shared Savings/Loss (two-sided risk)
  - NexGeneration ACO
  - Medicaid ACO
- Narrow Network Products
  - 3 Products developed
- Global budget (PMPM) – Full or partial capitation models
  - Fairview Partners
What trends have you seen in the evolution of value-based payment models over the past year?
Value Proposition: How do pharmacists bring value to the organization and to value-based payment models?
How do you measure ROI and create the business case for pharmacist involvement in these models?
What quality metrics do payers and organizational decision makers most highly value that can be impacted by pharmacists?
What lessons have you learned about integrating pharmacists into care teams?
How have initial and ongoing barriers to pharmacist participation in these models been addressed in your practice?
What tips do you have to help audience members engage in these models?
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