

# The Role of Pharmacy in Alternative Payment Models

July 15, 2015



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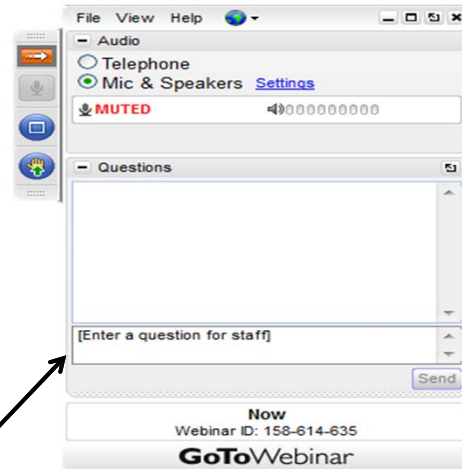
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## Today's Facilitators



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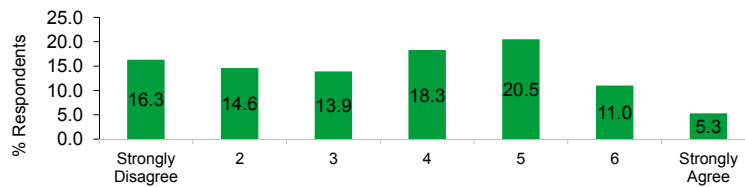


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## Recent Research: Pharmacist Perspectives on the ACA

SURVEY QUESTION: "I understand the major provisions of the health care reform law (Patient Protection and Affordable Care Act)" (N = 1,217)



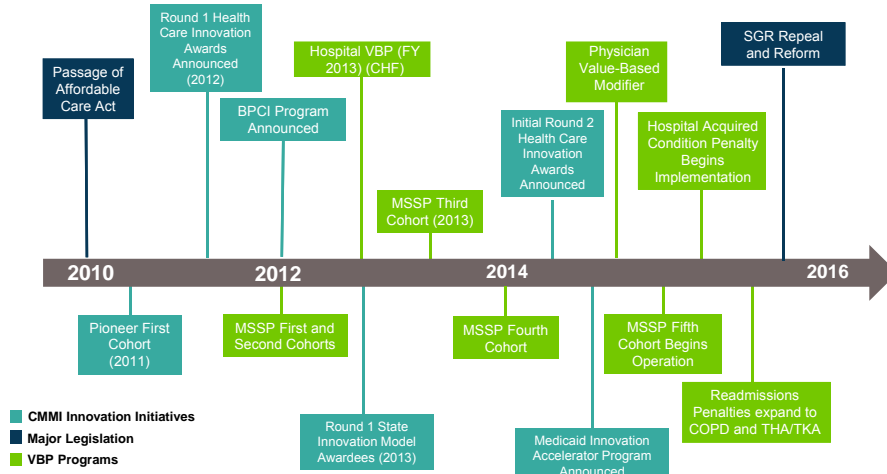
Sample Respondents by Practice Setting (%)		Sample Respondents by Job Title (%)	
Chain Community	23	Owner/Partner	8
Independent Community	14	Staff/Employee Pharmacist	52
Hospital Pharmacy	31	Manager/Director	28
Specialty Pharmacy	7	Other	11
Other	25		

Source: Khanna R, Mahabaleshwar R, Holmes E, Jariwala K. Pharmacists' Perspectives on the Patient Protection and Affordable Care Act. *Research in Social and Administrative Pharmacy*. April 28, 2014; 1-10.  
 Note: Survey administered to pharmacists in Louisiana, Oregon, Mississippi, Minnesota and Tennessee during August and September 2013  
 ACA = Affordable Care Act



## The ACA Has Accelerated Payment and Delivery Reform

Post-ACA to Present

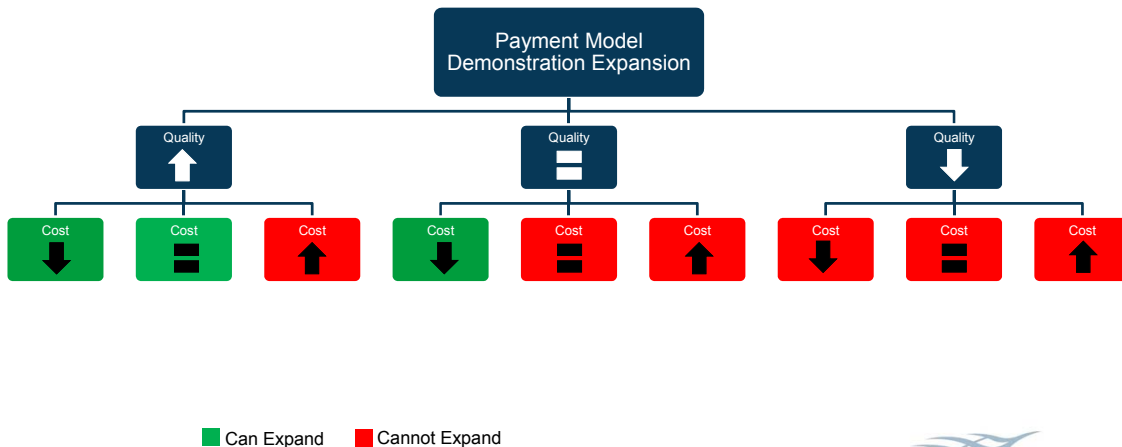


P4R: Pay-for-Reporting; HQID: Hospital Quality Improvement Demo; PGP: Physician Group Practice; HAC: Hospital Acquired Infection; ESRD: End Stage Renal Disease; ACE: Acute Care Episode; VBP: Value-Based Purchasing; PPS: Prospective Payment System; P4P: Pay-for-performance; CHF: Chronic Heart Failure

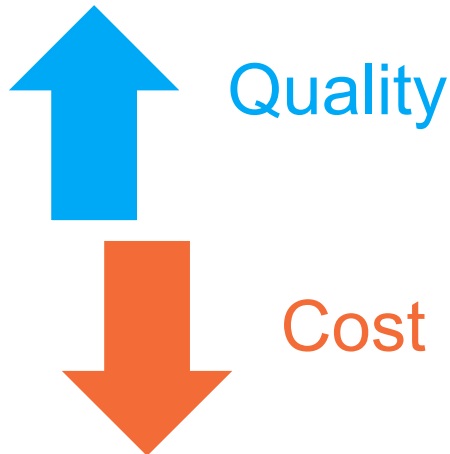


## Spreading Innovation From ACA

ACA Section 3021 allows the HHS Secretary to expand payment model demonstrations under certain conditions, as determined by the CMS Actuary:



## The Role of Pharmacists within New Payment and Delivery Models



- Pharmacists will play a critical role in alternative payment models
  - ACOs
  - PCMHs
  - Episodic bundles
- Unique role of pharmacists:
  - Provide high-touch, high-value care via access to patients
  - Play central role in care management, especially for chronic care patients
  - Prevent downstream costs for payers

ACO: Accountable Care Organization  
PCMH: Patient Centered Medical Home



## More Direct Patient Care through Pharmacist Services

- Comprehensive medication management
  - Includes MTM and more comprehensive services
- Disease management
- Medication reconciliation
  - Addresses transitions of care across settings
- Preventive services
  - Immunizations
- Disease screening and point-of-care blood testing



## Medication Management Services within the ACO and PCMH

### Embedded Model

- Pharmacists employed directly by physician practice and deliver care onsite

### Virtual Care Team

- ACO/PCMH develops arrangement with community pharmacists to provide coordinated services

- Research is ongoing related to outcomes from pharmacists' collaborative care contribution
- The community pharmacist "virtual care team" model can improve chronic disease through MTM, medication synchronization, and adherence programs
- Community pharmacists can:
  - Work directly with patients, scheduling monthly meetings to deliver medication management
  - Provide timely medical information to PCPs, facilitating a multifaceted approach to comprehensive patient care
- Pharmacists with integrated HIT and access to medical records will deliver optimal care

**Findings from local experiences will have broader national implications that will follow as learnings are applied**

Source: Schnur ES et al. PCMHs, ACOs, and Medication Management: Lessons Learned from Early Research Partnerships. 2014. JMCP. 20 (2): 201-05  
 ACO: Accountable Care Organization  
 PCMH: Patient Centered Medical Home  
 PCP: Primary Care Providers



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## Pharmacist Services' Value in ACOs and Bundled Payment Programs

- Pharmacist involvement can avoid downstream costs
- Incentives may be derived through sharing in any savings achieved against the benchmark

### ACO

- ACOs will be looking to foster comprehensive partnerships with pharmacists to improve performance on ACO quality measures
- Pharmacists will be able to have partnerships with multiple ACOs, unlike PCPs who can only contract with one
- Each ACO has the flexibility to compensate pharmacists how it chooses
  - In near-term, internal reimbursement will probably be productivity-based
  - Process for payment and contracting would be facilitated with more formal recognition of pharmacists as providers

### BPCI

- Pharmacists can be of greatest value to Model 2 and 3 BPCI participants
- MedRec/MTM services offer real value to bundled payment providers because they can prevent costly readmissions
- Because the BPCI timeframe is so short, and pharmacists can impact it so meaningfully, they may be able to negotiate a greater share of any realized savings

1 ACO: Accountable Care Organization  
 2 APM: Alternative Payment Model  
 3 BPCI: Bundled Payment for Care Improvement Initiative  
 4 MedRec: Medication Reconciliation  
 5 MTM: Medication Therapy Management



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## Use of Pharmacies within ACOs: Recent Survey Research

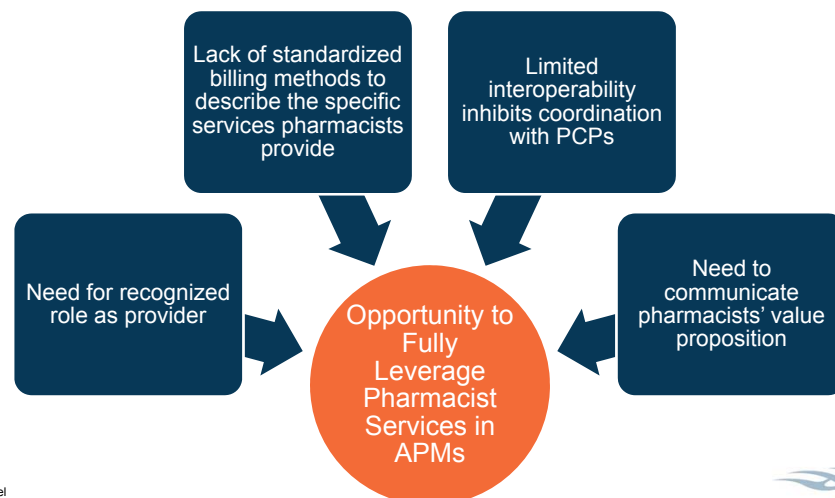
- Survey of 270 ACOs across commercial, Medicare and Medicaid plans showed that **45.7%** had engagement with a pharmacy as part of their ACO approach.
- Of commercial ACOs reporting, **76.8%** included pharmacy costs as part of the total cost for performance under their largest contract.
  - Of commercial ACOs, **53.3%** reported having an engagement with a pharmacy inside the ACO or contracted with one outside of the ACO organization.
- The more advanced ACOs were more likely to include a pharmacy as part of their ACO, specifically, those with:
  - More payment reform experience
  - Multiple contracts
  - Diversity of providers
- Authors indicated that these organizations value the importance of ensuring effective and efficient prescribing and adherence to achieving quality and cost goals and may choose to integrate with pharmacy to accept new payment risk.

Source: Colla CH et al. Role of Pharmacy Services in Accountable Care Organizations. 2015. JMCP. 21 (4): 330-43.



## Critical Factors to Fully Leverage Pharmacist Services in APMs

Lack of reimbursement mechanisms has been identified as one of the top challenges to pharmacists' being able to feasibly provide expanded patient care services, including integration into APMs. Critical factors to improve likelihood of integration include:



PCP: Primary Care Provider  
APM: Alternative Payment Model



## Pharmacist-led Medication Management Program within a PCMH

- Study to determine impact of clinical pharmacist within a PCMH team
- Comparison cohorts were established between the intervention group and standard of care (SoC):
  - Pharmacist interventions included:
    - Coordination of care (medication reconciliation, provision of drug information, medication counseling)
    - Disease management (disease education, laboratory monitoring)
    - MTM (refill orders, adjustment of drug therapy)
  - Cohort of PCMH patients not referred to the pharmacist
  - Cohort of non-PCMH patients
- Results: Intervention Group had ↓ Hospitalizations
  - vs. PCMH SoC patients: Lower rates of hospitalizations (52% reduced risk) & higher rates of ambulatory visits
  - vs. non-PCMH SoC patients: Significantly lower rates of hospitalizations (60% reduced risk) & ED visits (30% reduced risk)

Source: Romanelli RJ et al. Pharmacist-led Medication Management Program within a PCMH. 2015. AJHP. 72: 453-9.  
PCMH: Patient Centered Medical Home



## Examples of Integrating Pharmacist Services in ACOs

- Fairview Health Services
  - Comprehensive MTM Services
- Cigna Medical Group
  - Anticoagulation Clinics
- Norton Healthcare
  - CHF Discharge/Re-Admission Initiative
- Carillion Clinic
  - Intensive Therapeutic Management

Source: Amara S. Accountable Care Organizations: Impact on Pharmacy. 2014. Hospital Pharmacy. 49 (3): 253-9.  
ACO: Accountable Care Organization



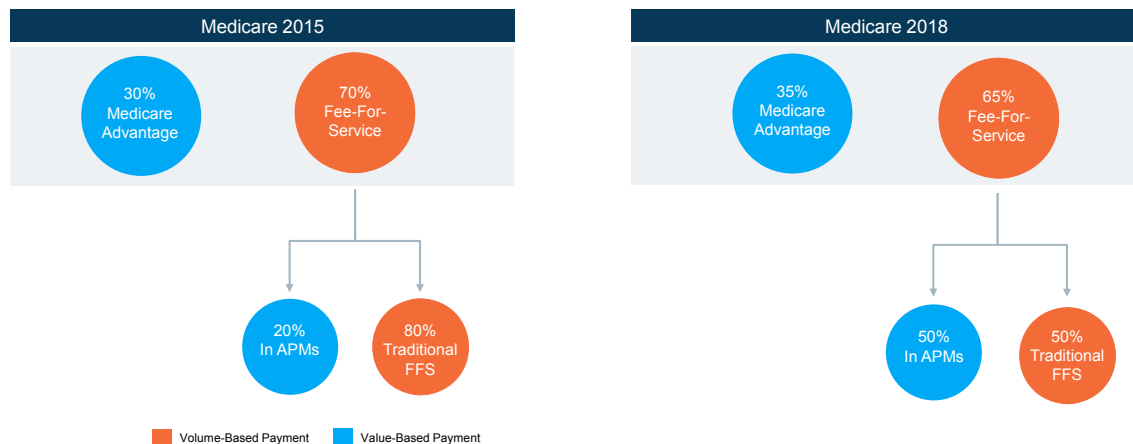


## Sample of CMMI Awards include Integrated Pharmacist Services

- Center for Medicare and Medicaid Innovation (CMMI) established two rounds of Healthcare Innovation Awards, the first being announced in June 2012
- Of 107 Round 1 projects, 15 of them specified integration of pharmacist services
- Of 39 Round 2 projects, 3 grants specifically involve pharmacist services
- Specific pharmacist services being integrated include:
  - Leveraging pharmacists in collaborative practice models
  - Engaging in medication management to improve adherence, outcomes & savings
- Community Care of North Carolina (CCNC) awarded grant in 2014
  - Formed the Community Pharmacy Enhanced Services Network
  - Will leverage a health information exchange platform: PHARMACeHOME
  - 160 network pharmacies will serve as extensions of the PCMH managers

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## Shift from Volume to Value will Require Care Delivery Model Changes



Half of all Fee-for-Service payments will be made under alternative payment models by 2018.

APM: Alternative Payment Model; MA: Medicare Advantage; FFS: Fee-for-Service

\* Of note, the split between MA and FFS is with respect to beneficiaries, whereas the split between APMs and Traditional FFS is with respect to dollars.

\* Included in APMs are: models with: some payment linked to effective management of a population or episode of care (payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk) OR payment is not directly triggered by service delivery so volume is not linked to payment (clinicians and organizations are paid and responsible for the care of a beneficiary for a long period, e.g. >1yr).

<http://www.hhs.gov/news/press/2015pres/01/20150126a.html>; <https://www.cbo.gov/sites/default/files/cbofiles/attachments/44205-2015-03-Medicare.pdf>

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## The Importance of Defining Alternative Payment Models

In January 2015, HHS announced its goal of situating 50% of traditional FFS payments in APMs by 2018. Reaching that goal may require definitional changes of APMs, leading to unintended consequences in other programs.

### Achieving 50% Goal

HHS may need to do some creative accounting to get **50% of Medicare FFS payments into APMs by 2018**. Currently, only payment models that fit into the following definitions count toward that goal:

- **Some payment is linked to the effective management of a population or episode of care.** Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk
- **Payment is not directly triggered by service delivery** so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥ 1 year)

Because reaching the 50% goal is ambitious, **HHS will likely relax their definition of APM** and allow more inclusion along the spectrum of accountability.

### Unintended Consequences

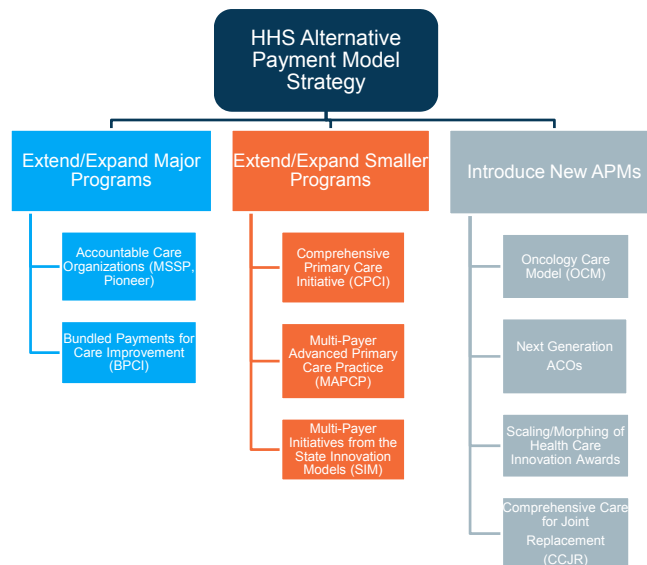
The definition for APMs will have a broader impact than just meeting the Secretary's goal.

Wider definitions of APMs increase the opportunity for providers to qualify for benefits under MACRA (and avoid the MIPS), but may ultimately undermine the intent of the incentives.

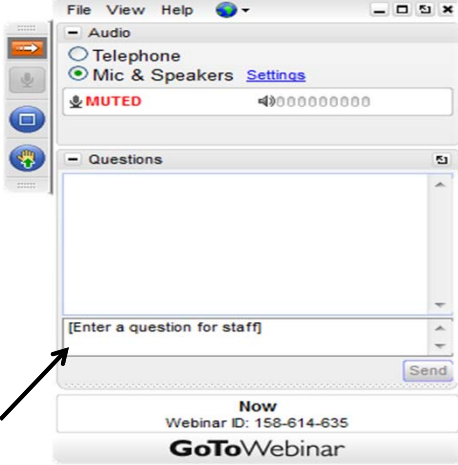
By including providers operating in less accountable parts of the spectrum, **HHS would depart from its goal of transitioning payments into true Alternative Payment Models.**

1 FFS: Fee-for-Service; HHS: Department of Health and Human Services; APM: Alternative Payment Model; MACRA: Medicare Access and CHIP Reauthorization Act of 2015 (or SGR Fix); MIPS: Merit-based Incentive Payment System; MPFS: Medicare Physician Fee Schedule


## HHS Likely Alternative Payment Model Strategy



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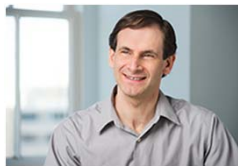


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## Today's Facilitators



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