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Alternative payment approaches for advancing comprehensive medication management in primary care

Katherine PHAM.

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Abstract

The increasing prevalence of complex, chronic conditions has profound implications on the growing demand and cost of health care. The Center for Medicare and Medicaid Innovation is testing data-driven approaches to care delivery and payment that are drawn from innovative practices of health care providers and other partners in the health care community. The shift from fee-for-service to value-based care and performance-based payment places increased priority on improved outcomes at lower costs. To advance comprehensive medication management, pharmacists need to understand the opportunities in the evolving value-based payment models and align medication optimization with the specific goals and incentives of these models.

Keywords

Pharmacists; Pharmaceutical Services; Medication Therapy Management; Chronic Disease; Medicaid; Medicare; Delivery of Health Care; Health Care Costs; Fee-for-Service Plans; Value-Based Purchasing; United States

INTRODUCTION

The increasing prevalence of chronic disease and complex conditions has profound implications on the growing demand and cost of health care. The Centers for Medicare & Medicaid Services (CMS) is the single largest payer for health care in the United States with an urgency to address health expenditure for the sustainability of Medicare and Medicaid programs. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established models focused on shifting health care from fee-for-service to value-based care via the Quality Payment Program. The Quality Payment Program is focused on rewarding the delivery of high-quality patient care through the Merit-Based Incentive Payment System (MIPS) and advanced alternative payment models. An alternative payment model is a payment approach that gives added incentive payments to provide high-quality and cost-effective care. With higher risk comes higher reward, and practices can receive higher bonus payments on advanced alternative payment models than in MIPS because practices incur more risk in alternative payment models.[1] To address the burden of chronic health conditions in the Medicare program, a shift from fee-for-service (FFS) to value-based payment and launching of performance-based alternative payment models intends to reward comprehensive, coordinated care and improvement of health outcomes. Prior to the global COVID-19 pandemic, this shift was warranted for sustainability of the United States health system. With the pandemic, the viability of primary care practices is in danger, and the shift to value-based payment becomes more urgent.[2] A recent review provides an overview of primary care delivery in the United States.[3]

Katherine PHAM. PharmD, BCPPS. American College of Clinical Pharmacy. Washington, DC (United States). kpham@accp.com

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Founded under the Affordable Care Act 2010, the Center for Medicare & Medicaid Innovation (the Innovation Center or CMMI) with CMS supports the development and testing of innovative health care payment and service delivery models. CMMI plays a critical role in implementing the Quality Payment Program. CMMI is driving a national public-private effort to adopt alternative payment models that reward the quality of health care over quantity. As the primary evaluator of alternative payment models, CMMI is testing approaches to care delivery and payment that are drawn from the clinical experience and innovative practices of health care providers and other partners in the health care community. Demonstration projects allow for CMS to test and measure the likely effects of potential program changes, including new methods of service delivery, coverage for new types of services, and new payment approaches.

Comprehensive medication management (CMM) is a holistic, consistent patient care process that ensures each patient's medications are individually assessed to determine that each medication is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications being taken, and able to be taken by the patient as intended.[4] As part of the CMM service, the clinical pharmacist develops an individualized medication therapy care plan in collaboration with the patient and the health care team that achieves the intended goals of therapy with appropriate follow-up to ensure optimal medication use and outcomes.[5] CMM has been shown to improve health outcomes, reduce hospitalizations and readmissions, and improve access to care.[6-14] Through these improvements, CMM can enhance performance-based incentives in value-based payment models. CMM also shows value on total cost of care with a decrease in total health expenditures and cost avoidance.[6,7,9,13,15] The purpose of this commentary is to illustrate opportunities for integrating CMM services to achieve medication optimization in evolving CMMI payment models and demonstration projects focused mostly in primary care settings.

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CMMI INITIATIVES

California Wellness Plan

In 2012, Gov. Jerry Brown of California issued an executive order calling for the development of a 10-year plan to improve the well-being of Californians by controlling costs, improving quality, advancing health equity, and identifying obstacles to improve care. Subsequently, the California Department of Public Health drafted the California Wellness Plan, California's chronic disease prevention and health promotion plan.[16] The California Wellness Plan seeks to promote the improvement of chronic disease management, health, and wellness while empowering communities throughout the state to achieve equity in health and wellness for all Californians. The four primary goals of the California Wellness Plan include:

1) Healthy communities;
2) Optimal health systems linked with community prevention;
3) Accessible and usable health information; and
4) Prevention, sustainability, and capacity.

Each California Wellness Plan Goal has measurable and reportable objectives that serve as guidelines for efforts to make California the healthiest state in the United States by 2022. Goal 2 of the plan aims for health system interventions and efforts to be linked with community programs and clinical services to meet the needs of populations with the largest health disparities. Optimal medication use through CMM aligns with California Wellness Plan Goal 2 as a preventive clinical service shown to decrease costs and improve outcomes through team-based care and deeper patient engagement.[17] Nine CMM pilot programs were implemented within Southern California, six of which are summarized in Table 1.[17]

Table 1. Sample of comprehensive medication management pilot programs in southern California[17]

Pilot program	Delivery of CMM	Key findings
University of Southern California School of Pharmacy/AltaMed Health Services	• $12 million CMMI grant to integrate pharmacy teams into 10 outpatient clinics • Under CPAs, pharmacists had the ability to start, stop, adjust, or substitute medication therapy and order medication-related tests • CMM delivered by team of clinical pharmacist, pharmacy resident, and clinical pharmacy technician • Algorithms identified patients with poorly controlled chronic illness	• CMM outperformed usual care • Cost savings outweighed program costs • Enhanced patient and provider satisfaction
Greater Newport Physicians Ambulatory Care Clinics	• Pharmacists on multidisciplinary team provide medication education, perform a medication review, and adjust medication therapy per protocol • Pharmacists order labs and adjust anticoagulation therapy under CPAs	• Patients met their diabetes goals within first 180 days of enrollment • Met quality measure goals for blood pressure control, high cholesterol, and nephropathy screening • Reduced hospitalization and ED visits • Lowered readmission rate • Enhanced patient satisfaction • Cost savings $100 per patient per year
University of California San Diego Health System	• CMM implemented to help high-risk heart failure patients transition from hospital to outpatient setting • Services included medication reconciliation, medication management during admission, discharge medication reconciliation, discharge education, and extensive post-discharge follow up	• Annual cost avoidance over $500,000 • Reduced readmissions within 30 days • Improved patient understanding of medications at discharge
GEMCare Medical Group, Inc.	• Chronic disease therapy management, including CMM, provided by advanced practice pharmacist • Fully leveraged scope of practice through CPA	• Decreased health care cost of almost 20% per member per month • Reduced hospital admission rates • Reduced ED visits • Improved clinical quality measures • High patient satisfaction
Sharp HealthCare	• CMM provided to patients with heart failure and physician-referred complex high-risk patients • CMM incorporated in geriatric trauma, inpatient psychiatry, skilled nursing facilities, home health, and COPD patients	• Reduced readmission rates by half
Kern Medical Center	• Pharmacists in Diabetes Care Clinic can initiate, discontinue, and adjust medications for diabetes, dyslipidemia, and diabetic neuropathy through CPA • Pharmacists can perform medication-related medication assessments, order lab tests and exams, and refer patients to PCP and specialists	• Almost half of patients with poorly controlled diabetes achieved blood glucose treatment goal • Decreased ED visits • Decreased hospitalizations • Reduced hospital length of stay • Annualized cost savings over $250,000 per year

CMM, comprehensive medication management; CPA, collaborative practice agreement; ED, emergency department; COPD, chronic obstructive pulmonary disease; PCP, primary care providers

Comprehensive Primary Care Plus

The Comprehensive Primary Care Plus (CPC+) program seeks to improve quality, access, and efficiency of primary care. CPC+ is a unique public-private partnership, in which practices are supported by 52 aligned payers in 18 regions. This partnership gives practices additional financial resources and flexibility to make investments, improve quality of care, and reduce the number of unnecessary services their patients receive. The framework for transformation includes a progressively advancing set of care delivery requirements with the aim to improve care delivery across five comprehensive primary care functions:

1) Access and continuity,
2) Care management,
3) Comprehensiveness and coordination,
4) Patient and caregiver engagement, and
5) Planned care and population health.

The 3,070 primary care practices in CPC+ fall into two tracks with different levels of care delivery requirements. Track 1 continues to bill and receive payment from Medicare FFS as usual and provide episodic care management, including medication reconciliation, to patients following hospital admission, discharge, or transfer and, as appropriate, following an emergency department (ED) discharge. Track 2 practices are required to provide more enhanced care delivery approaches to better support patients with complex needs. They receive additional financial support and a greater shift from FFS toward population-based payment. Most notably, Track 2 practices are required to provide CMM to patients receiving care management and those in transitions of care who are likely to benefit. Track 2 practices are expected to increase the comprehensiveness of care delivered, and they are compensated by the Comprehensive Primary Care Payments that should increase the amounts they would have received from FFS payments. This incentive aligns well with CMM, which is inherently comprehensive in its process of care, and may support advancement from medication reconciliation or episodic medication management to continual medication management.[18]

While CPC+ provides the resources to invest in primary care practice transformation, a new model tests these investments and provides performance-based incentive payments. The Primary Care First (PCF) Model includes voluntary five-year payment options that reward value and quality by offering an innovative payment structure to support delivery of advanced primary care. Building on the CPC+ model, PCF seeks to enhance care for patients with complex chronic needs and high need, seriously ill patients – CMM most benefits these patients. PCF Model options will be offered in 26 regions starting in 2021.

Maryland Primary Care Program

The state of Maryland and CMMI established the Maryland Total Cost of Care Model that sets the target for total costs of care reductions for Medicare and calls for improved population health outcomes supported by broad, innovative care redesign between hospital and non-hospital partners across the state. The model hopes to achieve this through its three programs: Hospital Payment Program, Care Redesign Program, and Maryland Primary Care Program (MDPCP). The MDPCP is a multi-payer program designed to transform primary care practice with the goals of lowering costs and improving outcomes. Its specific objectives are to reduce avoidable hospitalization and ED visits and build a strong, effective primary care delivery system to identify and respond to medical, behavioral, and social needs while contributing to lower Maryland's Medicare Part A and B expenditures by an annual saving target of USD 300 million by 2023. Practices are required to provide comprehensive primary care services and expand patients' access to care; empanel patients to providers; implement data-driven, risk-stratified care management; provide transitional care management; coordinate care with specialists; enhance patient engagement; integrate behavioral health; screen for social needs; and use health information technology tools to continuously improve quality. Participating practices receive prospective payments for these services known as care management fees.[19]

Informed by lessons learned from CMMI's Comprehensive Primary Care (CPC) and CPC+ models, MDPCP seeks to address the challenge for small and medium-sized practices to hire clinical pharmacists, care managers, and other staff. Similar to CPC+, MDPCP also includes two practice tracks. Track 2 practices are required to provide access to CMM services for patients receiving longitudinal care. To meet program requirements, practices have the option to receive operational and administrative support from the Practice Management Office and Care Transformation Organizations (CTOs). CTOs are private entities that hire and manage the interdisciplinary care management teams that provide care coordination services at the direction of the participating practices. CTOs also offer support for care transitions, standardized beneficiary screening, data tools and informatics, and practice transformation. Small and medium-sized practices can therefore include team members who they would otherwise have difficulty acquiring on their own, such as clinical pharmacists, licensed clinical social workers, community health workers, and data analysts. Twenty-four CTOs are supporting 77% of the practices in Maryland as of mid-2020.[19] CMM can be provided by clinical pharmacists hired through these CTOs, but it is essential to maintain fidelity to the CMM process of care by integrating clinical pharmacists into the care teams of these small and medium-sized practices.

Advancing American Kidney Health

To lower costs and improve outcomes for nephrology patients, the United States Department of Health and Human Services announced the Advancing American Kidney Health initiative on July 10, 2019. The three main goals of this initiative are to 1) reduce the number of Americans developing end-stage renal disease (ESRD) by 25% by 2030, 2) increase the number of new patients with ESRD in 2025 either receiving dialysis at home or receiving a transplant to 80%, and 3) double the number of kidneys available for transplant by 2030. To further this initiative, CMMI announced new value-based payment models, four voluntary and one mandatory, utilizing demonstration projects to test whether payment changes can improve patient outcomes.

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Table 2. Overview of comprehensive medication management (CMM) initiatives in alternative payment models

CMMI initiatives	Timeline	Goals/Target outcomes	Integrating CMM
California Wellness Plan (CWP)	2012 to 2022	• Increase access to primary and specialty care • Increase coordinated outpatient care/increase people receiving care in an integrated system • Increase control of high blood pressure and high cholesterol • Decrease adult and childhood asthma • Increase hospital safety and quality of care	Integrated advanced practice pharmacists providing clinical services in team-based care
Comprehensive Primary Care Plus (CPC+)	2017 to 2022	• Improve access to primary care services • Improve quality and efficiency of care • Improve health outcomes • Lower costs	Implementing CMM as Track 2 requirement
Maryland Primary Care Program (MDPCP)	2019 to 2026	• Reduce avoidable hospitalizations and emergency department (ED) visits • Build a strong, effective primary care delivery system • Lower Maryland's Medicare Part A and B expenditures by an annual saving target of $300 million by 2023	Access to CMM as a Track 2 requirement Smaller practices can utilize care transformation organizations to hire clinical pharmacists
Advancing American Kidney Health Initiative (AAKHI)	2020 to 2026	• Reduce the number of Americans developing end-stage renal disease by 25% by 2030 • Increase the number of new patients with end-stage renal disease in 2025 either receiving dialysis at home or receiving a transplant by 80% • Double the number of kidneys available for transplant by 2030	CMM to maintain patient health; slow disease progression; decrease hospitalizations and mortality

The four voluntary models (Kidney Care Choices) were built on the existing Comprehensive ESRD Care model with the goal of improving the transition from chronic kidney disease (CKD) to ESRD. These voluntary models focus on kidney transplants and incentivize delaying progression to ESRD, managing transition to dialysis, supporting transplant process, and maintaining patient health after transplant. Clinical pharmacists can optimize medications as an integrated team member in a nephrology practice in the Kidney Care First model or as part of a group of providers (Kidney Contracting Entity) in the Comprehensive Kidney Care Contracting models. The Comprehensive Kidney Care Contracting models contain three payment options – Graduated, Professional, and Global – with different levels of risk and reward. The ESRD Treatment Choice model is a mandatory payment model that aims to test whether greater use of home dialysis and kidney transplantation for Medicare beneficiaries with ESRD will reduce Medicare expenditures, while preserving or enhancing the quality of care furnished to beneficiaries with ESRD.[20]

CMM aligns with the incentives of these new payment models by addressing medication-related barriers to home dialysis and transplantation and achieving patient-centered therapeutic goals to slow progression of CKD. Medication management in patients with CKD should be comprehensive, continuous, and ongoing. Although transitions of care services (e.g., medication reconciliation) can be useful, the episodic nature of transition of care services can limit the full benefit of medication optimization for chronic care management of CKD or ESRD. When CMM is integrated into these payment models, the process of care provides the necessary follow up on patient care plans to achieve the targeted outcomes for nephrology patients.[20]

CONCLUSION

The transition from FFS to value-based payments provides further opportunities for pharmacists to be integrated into team-based care. The rewards for efficient, high-quality patient care provided by the Quality Payment Program position pharmacists to leverage their training and expertise in collaborative care teams to enhance performance-based incentive payments, increase patient satisfaction, and achieve other practice or system goals.

CMM aligns closely with quality improvement initiatives to achieve the quadruple aim of improving population health, increasing patient satisfaction, reducing per-capita health care costs, and addressing provider satisfaction (Table 2).[5,18] Although medication management has been tied to transitions of care payment structures, CMM needs to be formally recognized as a compensated chronic care service in evolving payment models. CMM has the potential to help health care providers maximize performance-based payments by improving health outcomes that are tied to performance-based incentives, thus creating a sustainable model for this team-based service. As the medication experts, clinical pharmacists integrated as accountable members of the care team can improve team efficiency and achieve medication optimization. To advance CMM, pharmacists need to understand where the opportunities lie within the evolving value-based payment models and align CMM with the specific goals and incentives of these models.

CONFLICT OF INTEREST

None.

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None.

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