Payment and Policy Reform for Medication Optimization

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ACCP Advocacy Platform

- #1 Priority: Payment & Coverage for Clinical Pharmacists' Services
  - Medicare…and commercial payers, VA, State Medicaid, etc.

- Advancing medication optimization in priority areas:
  - COVID/Pandemic Response
  - Opioid/Substance Abuse
  - Drug Pricing
  - Pharmacogenomics/Precision Medicine

Collaborating with stakeholder organizations to address public health and health care through medication optimization

https://www.accp.com/docs/govt/advocacy/ACCP_Advocacy_Platform.pdf

ACCP Priority Advocacy Issues

Legislative Initiatives:

- Advancing medication optimization: opioid management/substance abuse disorders, drug pricing policy, pharmacogenomics or precision medicine.
- COVID-19 Pandemic Response (Equitable Community Access to Pharmacists' Services Act)
- Cures 2.0 – PGx Consultations by Qualified Clinical Pharmacists
- Other issues: medication access and affordability, appropriations/funding for graduate medical education, investment in key public health infrastructure.

Regulatory/Other Issues:

Promoting CMM & innovative practice models across health payers, including the commercial sector and the Veterans Health Administration (VA).

ACCP Payment Reform Initiative

Integration of comprehensive medication management services (CMM) delivered by qualified clinical pharmacists as part of broader payment and care delivery reform.

Payment

- CMS Innovation Center (CMMI)
- Payers
- Employers
- Alliance for Addiction Payment Reform

Policy

- Legislative
  - National
  - State
- Agency Engagement
  - CMS
  - SAMHSA
  - HRSA

Practice Advancement

- Primary Care Collaborative
- National Academies
- Get the Medications Right Institute (GTMRx)

The Quadruple Aim

1. Improve population health
2. Enhance patient experience
3. Reduce costs
4. Improve the work life of health care providers (clinicians, staff)

The Quintuple Aim

1. Improve population health
2. Enhance patient experience
3. Reduce costs
4. Improve the work life of health care providers (clinicians, staff)
5. Advance health equity

JACCP August 2022: Health Equity

EDITORIAL

jaccp Journal of the American College of Clinical Pharmacy

Pharmacoequity and the clinical pharmacist: Why not us, why not now!

The COVID-19 pandemic has revealed the presence of longstanding health inequities in the United States, with vulnerable populations experiencing worsened clinical outcomes, particularly racial and ethnic minorities. These health inequities have manifested as differences in COVID incidence, disease severity, and mortality.[1] According to the US Centers for Disease Control and Prevention, health equity is achieved when every person has the opportunity to attain his or her full health potential, defined as removing barriers to achieving the best health possible for everyone.[2] At its core, the achievement of health equity requires a concerted effort among multiple stakeholders including patients, healthcare professionals, health policy experts, community leaders, and third-party payers.

Pharmacotherapy is a major component of contemporary health care. Some estimates note that nearly 131 million Americans, or 70% of adults, are on at least one chronic medication and $370 billion are spent on prescription medications annually.[3,4] Given the importance of pharmacotherapy in healthcare, equitable medication use is paramount to eliminating health disparities. However, high-quality medication use is not available to all. Lack of diversity in clinical trials suggests that treatments proven effective, may not be gener-

1 | INCREASING ACCESS TO PHARMACOTHERAPY

Healthcare access and quality is considered one of the five social determinants of health. However, defining access is a complex issue. More than 40 years ago, in their landmark paper, Penchansky and Thomas identified that access is an interplay between characteristics and expectations of healthcare providers and patients.[10] They grouped the characteristics into five categories: affordability, availability, accessibility, accommodation, and acceptability. *Affordability* relates to the patient's ability and willingness to pay for services. *Availability* is the extent to which healthcare providers have the necessary resources to meet the needs of the patient. *Accessibility* is the physical ability of patients to reach a healthcare provider's location (ie, geography). *Accommodation* refers to the ability of the healthcare provider to meet the constraints and preferences of the patient. *Acceptability* is the patient's comfortability with the healthcare provider and the services provided. Depending on the setting, clinical pharmacists have varying ability to alter these characteristics. From our perspective, availability, accommodation, and acceptability are the characteristics of access

Pharmacoequity

All patients have access to the highest quality medication therapy possible, regardless of race, ethnicity, socioeconomic status, or availability of resources.

Pharmacoequity and Comprehensive Medication Management (CMM):

1) Improve ACCESS to pharmacotherapy

2) Improve QUALITY of pharmacotherapy

3) Reduce COST of pharmacotherapy

Which of the following reflect the Quadruple Aim?

a) Improve access to care, enhance patient experience, reduce cost, advance health equity
b) Improve population health, enhance patient experience, reduce cost, improve provider work-life
c) Improve access to care, enhance patient experience, improve provider work-life, advance health equity
d) Improve population health, enhance patient experience, reduce cost, advance health equity

How can CMM services delivered by clinical pharmacists help to advance pharmacoequity?

a) By improving access, quality, affordability of pharmacotherapy
b) By reducing cost of pharmacotherapy and enhancing the patient experience
c) By increasing the fidelity of pharmaceutical care to improve health outcomes
d) By improving access and affordability to underserved populations

NASEM Report: Implementing High-Quality Primary Care

HTTPS://WWW.NATIONALACADEMIES.ORG/OUR-WORK/IMPLEMENTING-HIGH-QUALITY-PRIMARY-CARE

Definition of High-Quality Primary Care

The provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities*

* Whole-person health focuses on well-being rather than the absence of disease. It accounts for the mental, physical, emotional, and spiritual health and the social determinants of health of a person.

Five Primary Objectives

1) PAY FOR PRIMARY CARE TEAMS TO CARE FOR PEOPLE, NOT DOCTORS TO DELIVER SERVICES
2) ENSURE THAT HIGH-QUALITY PRIMARY CARE IS AVAILABLE TO EVERY INDIVIDUAL AND FAMILY IN EVERY COMMUNITY
3) TRAIN PRIMARY CARE TEAMS WHERE PEOPLE LIVE AND WORK
4) DESIGN INFORMATION TECHNOLOGY THAT SERVES PATIENTS, THEIR FAMILIES, AND THE INTERPROFESSIONAL PRIMARY CARE TEAM
5) ENSURE THAT HIGH-QUALITY PRIMARY CARE IS IMPLEMENTED IN THE UNITED STATES

CMMI Strategic Objectives

https://innovation.cms.gov/strategic-direction-whitepaper

Figure 1. CMS Innovation Center Vision and 5 **Strategic Objectives** for Advancing System Transformation.

Drive Accountable Care

Aim: Increase the number of people in a care relationship with accountability for quality and total cost of care.

Measuring Progress:

- All Medicare beneficiaries with Parts A and B will be in a care relationship with accountability for quality and total cost of care by 2030.
- The vast majority of Medicaid beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.

Advance Health Equity

Aim: Embed health equity in every aspect of CMS Innovation Center models and increase focus on underserved populations.

Measuring Progress:

- All new models will require participants to collect and report the demographic data of their beneficiaries and, as appropriate, data on social needs and social determinants of health.
- All new models will include patients from historically underserved populations and safety net providers, such as community health centers and disproportionate share hospitals.
- Identify areas for reducing inequities at the population level, such as avoidable admissions, and set targets for reducing those inequities.

Support Innovation

Aim: Leverage a range of supports that enable integrated, personcentered care such as actionable, practice-specific data, technology, dissemination of best practices, peer-to-peer learning collaboratives, and payment flexibilities

Measuring Progress

- Set targets to improve performance of models on patient experience measures, such as health and functional status, or a subset of Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures that assess health promotion and education, shared decision making, and care coordination
- All models will consider or include patient-reported outcomes as part of the performance measurement strategy

Address Affordability

Aim: Pursue strategies to address health care prices, affordability, and reduce unnecessary or duplicative care.

Measuring Progress:

- Set targets to reduce the percentage of beneficiaries that forgo care due to cost by 2030.
- All models will consider and include opportunities to improve affordability of high-value care by beneficiaries.

Partner to Achieve System Transformation

Aim: Align priorities and policies across CMS and aggressively engage payers, purchasers, providers, states and beneficiaries to improve quality, to achieve equitable outcomes, and to reduce health care costs

Measuring Progress:

- Where applicable, all new models will make multi-payer alignment available by 2030.
- All new models will collect and integrate patient perspectives across the life cycle.

What are CMMI's five primary objectives over the next 10 years?

a) Drive accountable care, enhance patient access, support innovation, address affordability, achieve system transformation
b) Advance health equity, support innovation, improve provider work-life, address affordability, achieve system transformation
c) Drive accountable care, advance health equity, support innovation, address affordability, achieve system transformation
d) Drive accountable care, advance health equity, improve provider work-life, support innovation, address affordability

Get the Medications Right Institute (GTMRx)

WWW.GTMR.ORG

Payment and Policy Recommendations

- Adopt the common definition of comprehensive medication management (CMM)
- All private and public medical benefit plans (e.g., commercial, Medicare, Medicaid, VA, Marketplace) should compensate interprofessional care teams for delivering CMM services.
- High quality, comprehensive and advanced primary care payment models should include payment to teams to deliver a comprehensive set of services, to include CMM.
- Recognition that value-based payment models are optimal for the provision and sustainability of CMM.
- Under Medicare and other fee-for-service models, allow physicians to bill for complex evaluation and management services provided by an appropriately trained clinical pharmacist, working in collaborative practice on the care team with the physician.

Payment and Policy Recommendations

- A sufficient workforce of qualified clinicians trained, credentialed and privileged to provide CMM services should be available to meet patient and population needs.
- In order to identify, assess and evaluate those patients that would benefit from CMM services, the care team should have access to clinical information at the point of care.
- CMM value should be measured on attributable patient outcome measures.
- Clinicians delivering CMM services should have access to clinical information at the point-of-care and be held accountable for related quality metrics
- Fully integrate companion and complementary diagnostic (e.g., pharmacogenomic) services into the CMM process to support useful clinical decision making and increased availability of data. For more details, see GTMRx's *Pharmacogenomics and CMM Policy Recommendations*.

Why CMMI?

An Overview of Center for Medicare and Medicaid Innovation (CMMI) and Approaches to Testing Alternative Payment Models (APMs)

Solicit Ideas for New Models	• Can be from local communities, states, private sector, or internally
Select and Develop Models	• The review process includes input from CMS, HHS, and an array of federal and external stakeholders
Test and Evaluate Models	• CMMI will work closely with partners as they implement new models
Expand Models	• CMMI will expand successful models through a variety of mechanisms

[1]HHS. "HHS FY2016 Budget in Brief. Feb 2016." Available here.
[2]CMS. "CMS Innovation Center: Report to Congress." Available here.

CMMI Models

State-Based

- California Wellness Plan (CWP)
- Maryland Primary Care Program (MDPC)

National

- Comprehensive Primary Care Plus (CPC+)
- Primary Care First (PCF)
- Advancing American Kidney Health (AAKH) initiative

California Wellness Plan

Originated from Gov Brown executive order, Let's Get Healthy California Task Force Report, and CA Department of Health

10 Year Plan: 2012 to 2022

Goals

- Healthy communities
- Optimal health systems linked with community prevention
- Accessible and usable health information
- Prevention, sustainability, and capacity

California Wellness Plan

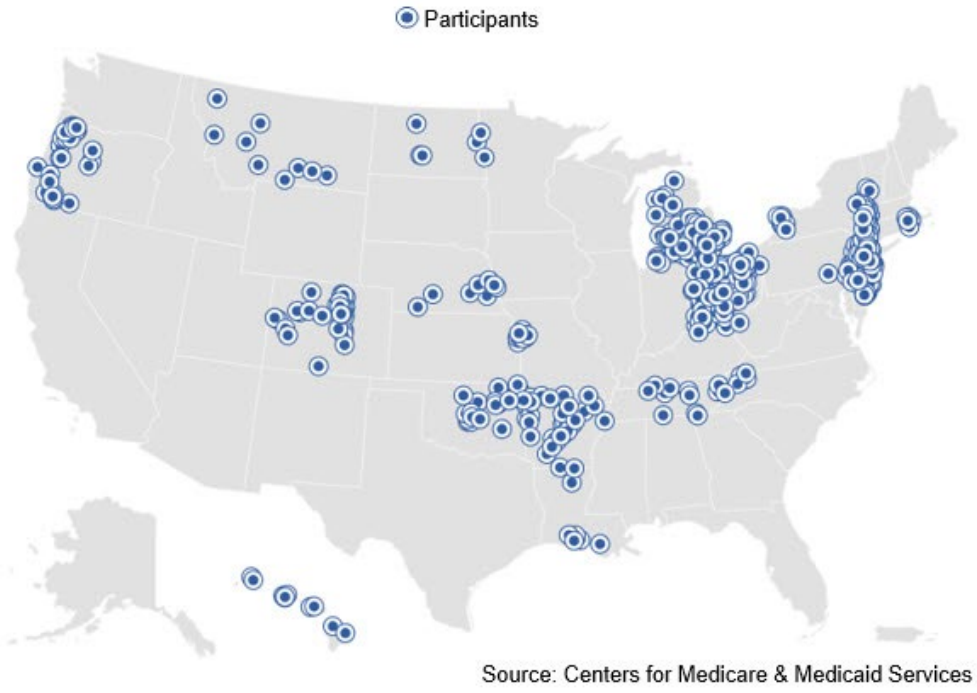
Pilot Program	Key Findings
University of Southern California (USC) School of Pharmacy/AltaMed Health Services	• CMM outperformed usual care • Program costs outweighed by cost savings • Enhanced patient and provider satisfaction
Greater Newport Physicians Ambulatory Care Clinics	• Patients met their diabetes 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	• Annual cost avoidance over $500,000 • Reduced readmissions within 30 days • Improved patient understanding of medications at discharge

California Wellness Plan

Pilot Program	Key Findings
GEMCare Medical Group, Inc.	• Decreased health care cost of almost 20% per member per month • Reduced hospital admission rate • Reduced ED visits • Improved clinical quality measures • High patient satisfaction
Sharp HealthCare	• Reduced readmission rates by half
Kern Medical Center	• Almost half of poorly controlled diabetic patients achieved blood glucose treatment goal • Decreased ED visits • Decreased hospitalizations • Reduced hospital length of stay • Annualized cost savings over $250,000 per year

Comprehensive Primary Care Plus (CPC+)

- Public-private partnership
- 52 aligned payers in 18 regions
- Seeks to improve quality, access, and efficiency of primary care
- Two different tracks, with increasing payment and care redesign expectations from Tracks 1 to 2



CPC+ Key Elements

Payment Elements

1. Care Management Fee
2. Performance-Based Incentive Payment
3. Payment under the Medicare Physician Fee Schedule

Comprehensive Primary Care Functions

1. Access and Continuity
2. Care Management*
3. Comprehensiveness and Coordination**
4. Patient and Caregiver Engagement
5. Planned Care and Population Health

CPC+ Practice Delivery Requirements

TRACK 1

Provide short-term (episodic) care management, including **medication reconciliation**, to patients following hospital admission/discharge/ transfer (including observation stays) and, as appropriate, following an ED discharge.

TRACK 2

Provide **comprehensive medication management** to patients receiving care management and in transitions of care who are likely to benefit.

CPC+ Opportunities and Challenges

CMM implemented in some Track 1 sites when not required

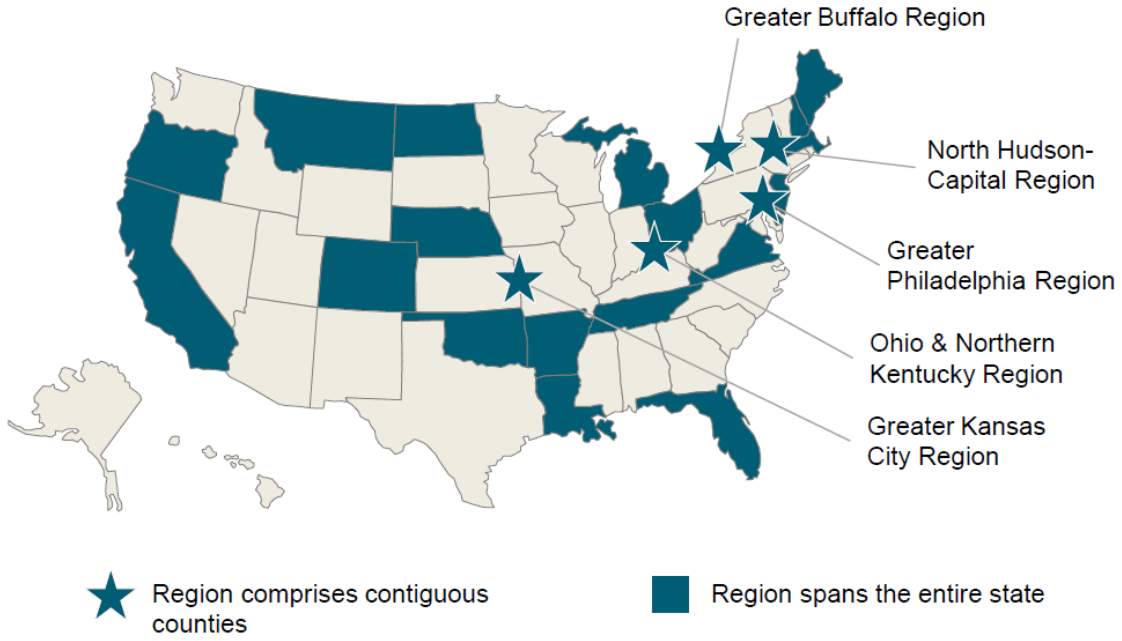
Balance between adaptability for innovation and broader uptake and variability in implementation

Resources for smaller practice sites

Concern for sustainability when model concludes

Primary Care First (PCF)

- Voluntary
- 26 Regions
- Two Cohorts
  - Cohort 1 began in January 2021
  - Cohort 2 will start in January 2022



https://innovation.cms.gov/innovation-models/primary-care-first-model-options

Primary Care First (PCF)

- Based on the underlying principles of the existing CPC+ model design
  - Prioritizing the doctor-patient relationship
  - Enhancing care for patients with **complex chronic needs and high need, seriously ill patients**
  - Reducing administrative burden, and focusing financial rewards on improved health outcomes

  - Virginia (new region) started in 2021
    - Statewide payer partners: CareFirst and Humana

Primary Care First Sites in Virginia

Practice	Address
MCV Associated Physicians - Primary Care at Callao	17452 Richmond Road, Callao, VA
MCV Associated Physicians - Family Medicine at Warsaw	16 Delfae Drive, Warsaw, VA
MCV Associated Physicians - Primary Care at King William Square	4917 Richmond Tappahannock HwyAylett, VA
MCV Associated Physicians - Family Medicine at Tappahannock	300 Mount Clement Park, Tappahannock, VA
Clarksville Primary Care Center	61 Burlington Drive, Clarksville, VA
CMH Family Care Center	1755 N Mecklenburg Avenue, South Hill, VA
MCV Associated Physicians - Tanglewood Family Medicine	9782 Highway 903, Bracey, VA
Lansdowne Travel and Family Medicine, LLC	1860 Town Center Drive, Reston, VA
Ironbridge Family Practice	11601 Ironbridge Road, Suite 117, Chester, VA
Sentara Primary Care	760 Town Center, Waynesboro, VA
Chesapeake Regional Primary Care Grassfield Office	648 Grassfield Parkway, Suite 1, Chesapeake, VA
Chesapeake Regional Primary Care Greenbrier Office	908 Eden Way N, Suite 101, Chesapeake, VA

PCF Opportunities and Challenges

CMM fidelity and variation among practice remains a challenge

Potential insights on how payment will work in transition from fee-for-service (FFS) to value-based payment (VBP)

Need to develop quality measures and metrics based on outcomes could help incentivize higher fidelity CMM

Supporting the smaller to medium-sized physician practices

LESSONS LEARNED FROM CPC+

Maryland Primary Care Program

Maryland Total Cost of Care Model (Maryland Model) January 2019 – December 2026

Objectives

- Reduce avoidable hospitalization and emergency department visits
- Better identify and respond to medical, behavioral, and social needs
- Reduce Maryland's Medicare Part A and B expenses by annual savings of $300 million by 2023

Two Practice Tracks

- Track 1 – Standard Track
- Track 2 – Advanced Primary Care
- Practices must achieve Track 2 status within three years

Maryland Primary Care Program

CARE TRANSFORMATION ORGANIZATIONS (CTO)

Private entity that hires/manages interdisciplinary care

Provides practices access to specialized staff

Services can include:

- Pharmacist services
- Health and Nutritional Counseling Services
- Behavioral Health Specialist Services
- Support from Community Health Workers

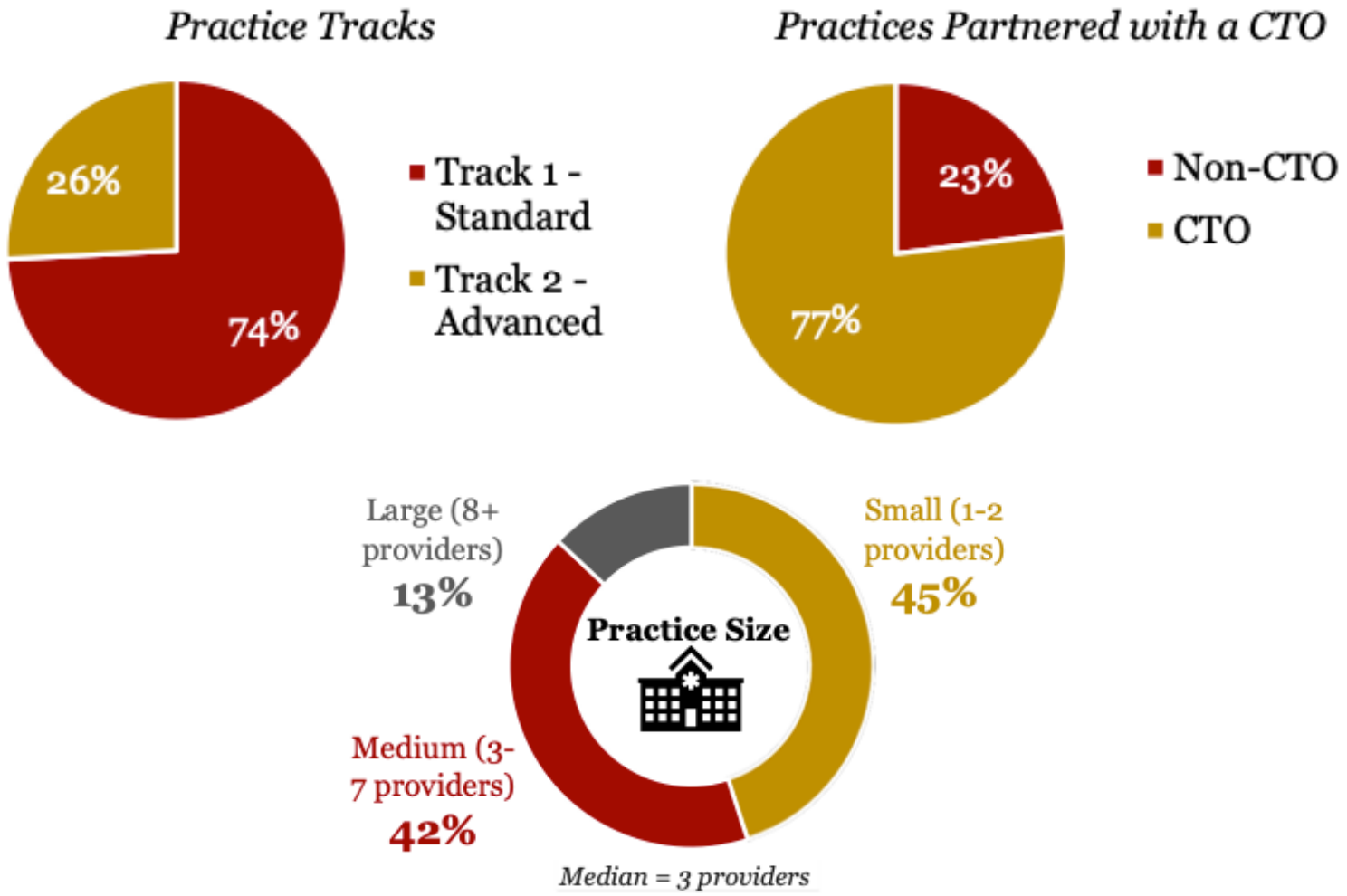
HEALTH INFORMATION EXCHANGE

All practices must participate in state-designated health information exchange, which provides access to tools

- Chesapeake Regional Information System for Our Patients (CRISP)

Practices and CTOs are also provided with additional resources

2020 MDPCP Practices



Source: MDPCP at a Glance. Maryland Department of Health; 2020.

Maryland Primary Care Program

CMM implementation requirement

Revenue Opportunities

- Care Management Fees
  - $6-$10 Per Beneficiary Per Month (PBPM)
- Performance Bonuses
  - $2.50-$4.00 PBPM, depending on risk
- Underlying Payment
  - FFS and Partial Pre-payment for Track 2
- Other Payments
  - Opportunities for QPP AAPM lump sum

Advancing American Kidney Health (AAKH)

Value-based payment models that incentivize clinicians to provide high value services focused on quality, outcomes, and cost containment

- Invest in earlier intervention in chronic kidney disease (CKD 4 and 5)
- Reward increased utilization of home dialysis
- Rewards and bonuses for transplantation

Goals

- Reduce the number of Americans developing ESKD 25% by 2030
- Increase the number of new ESKD patients in 2025 either receiving dialysis at home or receiving a transplant to 80%
- Double the number of kidneys available for transplant by 2030

Advancing American Kidney Health (AAKH)

Kidney Care Choices (KCC) – voluntary

- **Kidney Care First (KCF) Model** – nephrology practice
- **Comprehensive Kidney Care Contracting (CKCC) Models** - group of providers (Kidney Contracting Entity)
  - Payment Options:
  - Graduated
  - Professional
  - Global

AAKH and CMM

Dialysis and kidney transplantation

Slow progression of chronic kidney disease

Management of multiple chronic conditions

How can alternative payment models advance the delivery of CMM services?

a) Further the implementation of CMM in care delivery models focused on complex, chronic conditions and identify the patients that might benefit most from CMM services
b) Foster coordinated care and collaboration by identifying and addressing barriers to leveraging the expertise of all members of the care team
c) Develop sustainable team-based models and incentivize delivery of high-fidelity CMM by medication experts through robust quality measures
d) All of the above

Implications for Medication Optimization

Medication optimization through CMM delivery aligns closely with quality improvement initiatives to achieve the national goals of better care, better health, and affordable cost

CMM needs to be formally recognized as a compensated chronic care service in evolving payment models and has the potential to help health care providers maximize performance-based payments

Potential to address health disparities by increasing team efficiency, improving access to care, and enhancing quality of care with deeper patient engagement through the CMM process of care

To achieve medication optimization, care teams should understand where the opportunities lie within the evolving value-based payment models and align CMM with the specific goals and incentives of these models

Developing Future Leaders

National Academy of Medicine: Fellowship in Pharmacy

Designed to enable talented, early-career health policy or health science scholars to participate actively in health- and- medicine-related work of the National Academies and to further their careers as future leaders in the field of pharmacy

https://nam.edu/programs/health-policy-educational-programs-and-fellowships/nam-fellowship-program/nam-fellowship-in-pharmacy/

National Academy of Medicine: Fellowship in Pharmacy

- Completion of a Pharm.D. and/or Ph.D. from a relevant field of study in the pharmaceutical and clinical sciences
- Non-tenured member of an academic faculty
- Able to dedicate 10 to 20 percent of time to the fellowship for two years
- Within the first ten years after completion of postgraduate work
- Sponsorship by academic department head
- Endorsement by the dean
- U.S. citizen or permanent residency status at the time of the nomination

NAM Pharmacy Fellows

Samuel G Johnson (2012-2014)

Steven M Smith

Jonathan H Watanabe

Dima M Qato

Adam P Bress

(2020-2022)

2022-2024 Fellow:

Inmaculada Hernandez

VCU/ACCP/ASHP Congressional Health Policy Fellow

- Unique healthcare-policy learning experiences in the United States Congress and the government affairs offices of ACCP and ASHP
- 14 month program
  - 1 week Brookings Institution orientation
  - 3 weeks ACCP
  - 3 weeks ASHP
  - 10 months Congressional placement
- Qualifications
  - Pharmacists who are U.S. citizens
  - At least one year of residency training or several years of professional experience, ideally providing direct patient care
  - Preference for demonstrated awareness and/or a track record of advocacy regarding healthcare, and/or social issues

https://healthpolicy.pharmacy.vcu.edu/

What's Next?

Incorporate Comprehensive Medication Management provided by a clinical pharmacist as an essential component of High-Quality Primary Care

Advocate for payment for services provided by clinical pharmacists

Support sustainable models and scalability

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Center for Pharmacy Practice Innovation (CPPI) Seminar

Provided by Center for Pharmacy Practice Innovation/Department of Pharmacotherapy and Outcomes Science

Speaker(s): Michael Elliott, PharmD

Topic:

CPPI invites various health care professionals from around the country and globe to speak on issues relating to innovation in the health care space.

Please contact the Center for Pharmacy Practice Innovation to request a meeting password by clicking here

Please click here to join the webinar

Meeting ID: : 972 0552 6057

Purpose or Objectives: At the conclusion of this activity, the participant will be able to:

1 Review changes in health care delivery that likely impact pharmacy practice.

2 Describe current trends in contemporary pharmacy practice as they relate to interprofessional collaboration.

3 Discuss practice innovations designed to improve health outcomes.

4 Discuss role delineation for pharmacists on the interprofessional health care team.

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Date/Time: 8/23/2021 12:00:00 PM

Accreditation:

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0.75 ANCC contact hours.

This activity provides 0.75 contact hours of continuing education credit. ACPE Universal Activity Number (UAN): Pharmacist: JA4008237-0000-21-044-L01-P Technician: JA4008237-0000-21-044-L01-T

NOTE FOR PHARMACISTS: Upon closing of the online evaluation, VCU Health Continuing Education will upload the pharmacy-related continuing education information to CPE Monitor within 60 days. Per ACPE rules, VCU Health Continuing Education does not have access nor the ability to upload credits requested after the evaluation closes. It is the responsibility of the pharmacist or pharmacy technician to provide the correct information [NABP ePID and DOB (in MMDD format)] in order to receive credit for participating in a continuing education activity.

Disclosure of Commercial Support:
We acknowledge that no commercial or in-kind support was provided for this activity.

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The following planners, moderators or speakers have the following financial relationship(s) with commercial interests to disclose:

Name of individual	Individual's role in activity	Name of commercial interest/Nature of relationship
Dave Dixon, PharmD, FACC, FCCP, FNLA, BCACP, BCPS, CDE, CLS	Activity Director	Contracted Research-Boehringer Ingelheim Vetmedica GmbH - 08/04/2021
Michael I Elliott, PharmD	Faculty	Nothing to disclose - 08/19/2021
Dana Burns, DNP	Planning Committee	Nothing to disclose - 09/29/2020
Teresa Salgado	Planning Committee	Nothing to disclose - 09/29/2020
Evan Sisson, Pharm.D., MSHA, BCACP, CDE, FAADE	Planning Committee	Nothing to disclose - 05/18/2021
Madeleine Wagner, BA	Planning Committee	