Evolving Pharmacy Payment Strategy and Quality Measures

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Partnering for Quality
Learning Objectives

- Describe current and potential quality measures applicable to the community pharmacy organization
- Compare effective payment and network strategies that pharmacies are engaged with relating to quality measure performance
Pharmacy Services

- As pharmacists, we deliver high quality, safe and trusted health care services to patients we serve.
- 92% of Americans live within 1.6 miles of a pharmacy.
- Pharmacy continues evolving to deliver additional health care services (immunizations, health screenings, medication management, specialty pharmacy).
- New opportunities open new revenue streams and adequate pay for services delivered.
- But, the primary role of the pharmacist will always be tied to safely and effectively delivering the RIGHT medications to the right patient in the right manner!
- Does the current pharmacy reimbursement method account for that level of care?
The shift to Value-Driven Healthcare

- The U.S. health care system is rapidly moving to value-based purchasing or “value-driven healthcare”

- Value is the balance of quality and costs, thus we can optimize value by improving quality while reducing costs

- One of the biggest challenges in driving better quality is that we can’t always agree on how to define and measure quality

- PQA takes the lead on development of medication-related quality measures for evaluation of health plans, PBMs and pharmacies
Medicare Part D Star Ratings

- Medicare drug plans receive a summary rating on quality as well as four domain, and individual measure, scores (13 individual measures in total)

- Five measures are from PQA:
  
  2 measures of medication safety
  
  High risk medications in the elderly
  Appropriate treatment of blood pressure in persons with diabetes (retired)

  3 measures of medication adherence
  
  Non-insulin diabetes medications
  Cholesterol medication (statins)
  Blood pressure (renin-angiotensin system antagonists)

Due to the higher weighting of clinically-relevant measures, the PQA measures can account for up to 50% of Part D summary ratings in 2015
*New* Star Ratings Measure for 2016

- Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews (CMRs)
  - Highlights:
    - PQA-endorsed measure
    - Measures the percentage of beneficiaries who met eligibility criteria for the MTM program and who received a CMR with a written summary in the CMS standardized format.
    - 2016 stars will be based on 2014 measurement period
    - This measure will be assigned a weight of “1”
    - For complete measure details, please see the PQA measure listing on the website [http://pqaalliance.org/measures/default.asp](http://pqaalliance.org/measures/default.asp)
2017 and Beyond...

Potential new measures:

- **Statin Therapy in Diabetes**
  - PQA endorsed this measure in 2014
  - Tracks the use of statins in diabetes patients aged 40-75 yr
  - CMS stated that the measure will be a 2017 Display Measure (based on 2015 data) and may become a Star measure for 2018.

- **Opioid Overutilization**
  - PQA recently endorsed 3 measures evaluating multi-provider, high dosage opioid use among individuals 18 years and older without cancer and excluding hospice
Why invest in Star Ratings Improvement

**MA-PD Plans**
- Additional Revenue
  - CMS publishes benchmark rates (i.e. average monthly costs to care for a Medicare member)
  - MA-PDs submit bids to CMS that they can manage their members for a lower cost than the benchmark
  - CMS pays a portion of the difference between the benchmark and the bid as a rebate back to the plans
  - Plans that score a 4-Star rating or above can receive additional bonus payment
- Marketing opportunities
- Extended open enrollment periods
- Penalty for consistent poor performance

**PDP Plans**
- Not currently tied to additional revenue
- Marketing opportunities
- Extended open enrollment periods
- Penalty for consistent poor performance
- Note: Obama administration proposal includes expanding quality bonus payments to PDP plans in the future!
Leveraging the Pharmacy Network to Improve Quality

**Advantages**
- Trusted healthcare practitioners
- High encounter rate between members and pharmacists
- Programs implemented with pharmacy partners are often scalable
- Unprecedented access to real-time data
- Integrated with other health care providers (i.e. nurses, physicians, etc.)
- Underutilized/untapped healthcare practitioner

**Disadvantages**
- Lack of direct connection to health plan
- Unaccountability on quality improvement
- Lack of knowledge on quality improvement programs and measures
- Lack of knowledge on how to measure and how they are performing
Pharmacy Pay-for-Performance Programs

- Hybrid Model Example:
  - Based on PDC-adherence (3 rates) and “Gaps in Care” measures
  - Combination of payment for gap closures delivered through MTM provider and bonus on reaching performance goals

- Multi-metric Model Example:
  - Based on Star measures plus asthma and GDR
  - Pharmacies will receive bonus depending on their performance on each measure:
    - 3-star attainment = small bonus
    - 5-star attainment = large bonus

- Star-metric Model with Commitment Incentive Example:
  - Based on PDC-adherence measures
  - Combination of payment for program commitment and for reaching performance goals
P4P strategies that worked...

- **Multi-channel communication campaign**
  - Health plan to corporate pharmacy contacts
  - Health plan/PBM to pharmacy network
  - Work groups, town halls, webinars with participants
  - Reinforcement of message among all engaged partners
  - Frequent communications with participants (e.g. newsletters, webinars, training, etc.)

- **Transparency of measurement and incentive/ recognition design**
  - Available online resources and program materials

- **Incentive/ Recognition**
  - Outcome/overall performance based incentive
  - Combination of performance and improvement recognition
  - Frequent recognition/incentive reporting
  - Comparative performance between participating pharmacies and top performers (i.e. how much was left on the table)
Considerations on Funding Value-Based Arrangements

- Bonus payments accounted for in overall Star’s budget

- Reductions in rates (or dispensing fees) from low performing pharmacies to be provided as bonus to top performing pharmacies by percentile

- Rates determined on past performance and incorporated into subsequent year’s contracts (matching the timeline for Star Rating scores)

- Reductions in rates (or dispensing fees) for all pharmacies to fund performance guarantees that are paid back for hitting quality performance thresholds

- Reductions in rates (or dispensing fees) for broad network/preferred network pharmacies to fund bonus pools that can be added to plan/PBM contribution for incentivizing top performers
Preferred Pharmacy Networks

- Based upon accepted reimbursement rates for medications
- In 2015, 86% of PDPs and 27% of MA-PDs have a preferred pharmacy network
- 81% of Med D enrollees in 2015 have access for preferred pharmacy networks
- Patients may have lower costs for using a preferred pharmacy network
- Advantage: lower costs to patient, pharmacy increases patient volume, health plan improves performance (at lower cost!)

But...
- CMS evaluating preferred pharmacy networks for patient accessibility
- NCPA (among others) pushing “any willing provider” legislation
- Preferred pharmacy networks based upon quality scores?
Summary

- Value-based payment arrangements are growing and will increase consistent with HHS directives

- Similar systems already prevalent in both physician and hospital-payer arrangements

- A growing number of prescription drug plans are implementing performance-based incentives for network pharmacies, such as:
  - Pay-for-performance models that include bonus payments to top-performing pharmacies
  - Preferred networks that include star-performance as a criterion for inclusion as a preferred pharmacy

- Tools and technology are needed to support tracking of quality measure performance
  - Supports collaboration and transparency between payer and provider