FAQ: Value Based Payment Models

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Purpose

This document aims to answer frequently asked questions about value-based payment models encountered by pharmacists across a variety of settings. It is a summary of various sources for ambulatory care pharmacy practitioners interested in learning and applying information on value-based care.

Key Terminology and Abbreviations

Accountable Care Organization (ACO): is a healthcare delivery model that assigns accountability for the cost and quality of care of a population of patients to a high-level provider organization (often a health system or physician organization) to help drive value-based care payment reform toward more effective and affordable care. ACO contracts are used by Medicare, Medicaid agencies, Medicaid managed care organizations, and commercial insurers.[1]

Alternative Payment Models (APMs) or Value-based Payment Models (VBPMs): provide incentives for those providers who deliver care meeting quality targets. These models can focus on a variety of aspects of care including specific health conditions, types of providers, and activities within specific insurance payors.[2]

Capitation Payment: a capitation payment is when providers are given a fixed per-person payment (ie. per-member-per-month), determined and paid in advance, to deliver a defined set of services to each enrolled individual for a specified period of time.[3]

Centers for Medicare and Medicaid Services (CMS): federal agency within the Department of Health and Human Services (HHS) that administers the Medicare program and works with state governments to administer Medicaid. It is the single largest payer for healthcare in the US.

Fee-for-service (FFS): healthcare providers are reimbursed based on the volume and types of services delivered to the patient. [3]

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA): bipartisan legislation signed into law on April 16, 2015. MACRA replaces the old, sustainable, growth-rate formula for physician payment with a new model to move providers away from fee-for-service toward value-based payment. It established the Merit-Based Incentive Payment System (MIPS). [4]

Medicare Advantage (MA) (Part C): is a Medicare-approved plan offered from a private commercial payor that offers an alternative to Traditional Medicare for health coverage. These "bundled" plans include Part A, Part B, and usually Part D. Plans may offer some extra benefits that Traditional Medicare does not cover. Participants must also use a provider within the plan's network and service area and need a referral to use a specialist.[5]

Medicare Sustainable Growth Rate: formula used to control the growing cost of services. If expenses exceeded the target, physician reimbursement would be reduced. The formula was calculated yearly, evaluating the volume of beneficiaries and GDP changes. Repealed in 2015 and replaced with MACRA.

Merit-Based Incentive Program System (MIPS): moves Medicare Part B providers from a fee-for-service to a performance-based payment system. MIPS rewards clinicians for improving quality of care and reduced spending. Its predecessor is the Value-Based Modifier (VM 20116016). [6]

Patient Centered Medical Home (PCMH): is an advanced primary care practice model that relies heavily on a primary care practice to deliver and coordinate the majority of care for the beneficiary that is comprehensive, patient-centered, coordinated and team-based, accessible, high-quality, and safe. Learn more about PCMHs here: Patient Centered Medical Home - FAQ

Pay-for-performance (PFP): healthcare providers are given bonus payments (or penalties) for carrying out certain tasks or reaching certain quality targets. [3]

Quality Payment Program (QPP): created under the Medicare Access and CHIP Reauthorization Act (MACRA), it includes two tracks: 1) Merit-based Incentive Payment System (MIPS), and 2) Advanced Alternative Payment Models (APMs).[7]

Value-Based Care (VBC): describes a system that focuses on quality, outcomes and patient-focused support.[8] In this way, providers treat an individual as a whole person, rather than focusing on a specific health issue or disease.

Value-Based Payment (VBP): rewards health care providers with incentive payments for the quality of care they provide. These payments are part of a larger quality strategy to reform how health care is delivered and paid for. Value-based payments also support the triple aim of better care for individuals, better care for populations, and lower costs. [8]

FAQs

1. **What is driving the shift to value-based care?**

The US spends more on healthcare than any other country with inconsistent quality. Growth in spending is becoming unsustainable. [9] Traditional fee-for-service (FFS) payment, which is still the predominant form of payment, rewards providers for the volume of service provided, not for the quality of care provided.[10] One of the greatest criticisms of the FFS architecture has been the implication of unnecessary service provision to fragmented care and incentive misalignment. [10]

2. Previous legislation attempted some regulation of the growing cost without a focus on quality, including Medicare's sustainable growth rate.[10] Since then, there has been an increased focus and shift in priorities to focus payments more on value then volume of services completed.[10] **What are the current quality payment programs?**

The Affordable Care Act (ACA) focused on shifting away from FFS into APMs and implement new care models.[10] The 2015 Medicare Access and CHIP Reauthorization Act (MACRA) moved Medicare providers away from fee-for-service toward value-based payment models by establishing widespread value-based physician payments and providing incentives for participation in Alternate Payment Models (APMs). [11]

MACRA Quality Payment Programs

MACRA's Quality Payment Program has two pathways for provider reimbursement: Merit-Based Incentive Payment System (MIPS) and advanced APMs. [12]

- MIPS moves Medicare Part B providers from a fee-for-service to a performance-based payment system. MIPS rewards clinicians with bonus payments for improving quality of care and lowering spending. This is MACRA's base program which all providers must participate in (or get an exemption from), or face a payment cut. Those providers participating in Advanced APMs (the second pathway) are exempt from MIPS. [12]
- APMs use both quality and utilization measures to reimburse providers and hospitals based on the value of care. APMs can improve health outcomes focusing on coordination, outcomes and social determinants of health. [13]
- The QPP requires clinicians to participate in either MIPS or APMs, incentivizing providers to use cost-effective treatments to keep patients healthy. [12]

Alternative Payment Models

CMS created the Health Care Payment Learning and Action Network (HCP-LAN) in 2015 to support transition to value-based payments. [12]

HCP-LAN has defined four different categories of APMs with each category differentiated by the level of financial risk shared between payers and providers:[12]

- Category 1: Fee-for-service with no link of payment to quality
- Category 2: Fee-for-service with a link of payment to quality
- Category 3: Alternative payment models built on fee-for-service architecture
- Category 4: Population-based payment

Categories 2-4 are considered value based. As one moves from category 1 to category 4 there is an increasing shift towards population health management.[12]

CMS Value-Based Programs (or APMs)[14]

Hospital focused programs:

- Hospital Readmissions Reduction Program (HRRP)
- Hospital Value-Based Purchasing Program (HVBP)
- Hospital-Acquired Conditions Reduction Program (HACRP)

Other programs:

- Medicare Advantage Quality Star Rating Program
- Physician Value-Based Payment Modifier (VM) – and its successor, the Merit-Based Incentive Payment System (MIPS)
- Medicare Shared Savings Program (MSSP)

For more information: ASHP FAQ on Population Health Management

Who are the Payors

Multiple stakeholders have adopted value-based payment programs that aim to improve health outcomes while reducing costs. Although the Centers for Medicare & Medicaid Services (CMS) is the single largest public payer for healthcare in the US, most patients utilize commercial insurance. Commercial insurance continues to increase their role in these models with Medicare Advantage. [10] CMS has focused on payment reforms that include multiplayer engagement and support for multi-payer models inclusive of the private sector.[10] Furthermore, Medicare reforms have become a model for action by state Medicaid programs and commercial insurers. [10]

3. What components of a value-based contract are important to evaluate?

Evaluation of value-based contracts involves reviewing the pros and cons based on the healthcare organization's current capabilities and resources. Contract benefits should include care coordination, improved quality at low cost, provider partnerships, and low operating expenses.[15] Contracts can also be used as a model for arrangements with other payors.[15]

Important considerations include population of focus, infrastructure required to implement, attribution model, historic utilization patterns as well as predicting future utilization patterns, and financial model to determine acceptable level of risk.[15] Keys to success include physician engagement, availability of accurate data both internally and from the payor, transparency, accountability, performance measurement and continuous improvement.[15] Identifying the right measures and then linking them to the right payment involve difficult processes, such as attributing a patient's health outcomes to specific provider and adjusting risk to account for patient populations with different risk factors, demographics, and health conditions.[16] Understanding how patients are attributed within a contract is important to ensure appropriate evaluation of patient outcomes. It is important to understand baseline performance and any historical trends to define appropriate targets.[16] Building positive relationships with payors early can build foundations for contract negotiations. Strong relationships with payors can support effective negotiations including finalizing which measures to include within a particular contract.[15]

4. Where are these models in place across the country?

Among both commercial and government payers we are seeing a shift in payment models with a focus on care delivery models. With each passing year, the number of APMs continues to rise. The following are just some examples of the types of models and where they are occurring geographically across the United States.

- Bundled payments: CMS Bundled Payments
- Shared savings program: CMS Shared Savings Program
- ACO Investment Model, Advance Payment ACO Model, Next Generation ACO Model, Pioneer: CMS Accountable Care Organizations
- Patient Centered Medical Homes: NCQA Payer Support

5. How is performance measured within these value-based payment arrangements?

Value-based payments take a comprehensive approach to payment. Rather than basing payment only on a series of billing codes, value-based payments include consideration of quality through a set of evidence-based measures.[17] Multiple entities disseminate measures. Commonly used indicators include Medicare quality measures, Healthcare Effectiveness Data and Information Set (HEDIS) measures from the National Committee for Quality Assurance (NCQA), and measures from Battelle's Partnership for Quality Measurement (PQM). These payments encourage improvement in clinical practice and outcomes. Payers are using different measures, even with a particular patient population or contract type, such as bundled payments.

Besides quality, contracts typically also include a cost component. The total cost of care is determined via a formula evaluating physicians' base claims, rate of cost of care growth, and incorporating an adjustment factor. Value-based payments take into account total costs per visit and total annual costs per patient. [16]

MIPS has 4 performance categories [18]

- Quality
- Cost
- Improvement activities
- Promoting interoperability

Performance measures should focus on processes and outcomes that matter most to patients and have the greatest impact on overall health and unnecessary spending. VBP measures, as well as the mechanisms of measurement, should be economical and aligned across payers to reduce unnecessary administrative burden.

Being able to improve quality measures for individuals and populations is an essential component to being able to create a sustainable practice for any provider. Measures are not stagnant, they can change based on changing contracting requirements, new contracts, or legislative changes so it is important to stay engaged in that discussion. Additionally, CMS allows selection of measures that best fit your practice.

Additional Resources:

- Agency for Healthcare Research and Quality. Measuring and Benchmarking Clinical Performance. Available at: Measuring and Benchmarking Clinical Performance
- NCQA. State of Healthcare Quality HEDIS Measures of Care. Available at: NCQA State of Health Care Quality Report
- Pharmacy Quality Alliance. PQA Performance Measures. Available at: PQA Measures Overview
- Partnership for Quality Measurement by Battelle. Repository Measure Database. Available at: Submission Tool and Repository Measure Database

6. Could collaborative practice impact the pharmacist role on the care team within the value-based payment models?

Yes, collaborative practice can indeed impact the pharmacist's role within APMs. While this can differ from state to state due to variability in state laws and practice acts, collaborative practice models will allow pharmacists to play a bigger role in direct patient care activities such as prescribing authority and improve the value proposition.[19,20] Collaborative practice promotes enhanced access to care and improves quality of care, both essential to optimal performance in an APM.

7. What is the pharmacist's impact on total cost of care within value-based payment models?

Total cost of care is often an important measure of value within an APM, and there are a variety of ways that pharmacists can impact overall cost. Some payment arrangements may provide a financial incentive (e.g. shared savings) to reduce the total cost of care for a covered population. Therefore, it is important to identify relevant ways that pharmacist-provided services can positively and negatively impact this metric.

- Formulary management can help control prescribing practices and ensure the most cost-effective use of medication therapy and reduce clinical variation.[21]

- Collaborative practice agreements can also increase access to care and provide for closer management of the highest risk patients, contributing to decreased utilization of high-cost venues of care including the ED and hospital.[22]
- Transitions of care programs can directly reduce readmission rates as well as ED utilization.[23]
- Population health efforts including pharmacy-delivered immunizations, virtual or telemedicine comprehensive medication management, and adherence support can expand access to care and improve quality of care.

While the impact of pharmacist-provided care is mostly in favor of reduced total costs, it must also be acknowledged that pharmacists can also inadvertently increase the total cost of care because of their interventions.

Ways that pharmacists can *decrease* total cost of care:

- Pharmacists can identify "high utilizers" of clinical services and design care pathways or specific interventions to lower total cost of care[24]
- Pharmacists providing comprehensive medication management via collaborative practice agreements can offload routine appointments with PCPs for chronic disease management. This potentially reduces duplicate appointments for the same condition.[25, 26]
- Incorporate more telemedicine outreach/medication management calls to alleviate use of in-clinic appointments
- Having an integrated/onsite 340B pharmacy can offset the increase in pharmacist FTE cost and help with overall drug spend
- Pharmacist involvement in P&T activities (e.g. formulary management, prescribing limitations, publishing prescribing standards of care, medication use evaluations) can help to control prescribing practices across the health system, especially for high cost medications[21]
- Pharmacist-led population health initiatives to ensure safe and effective use of high-cost specialty medications[27]
- Pharmacists addressing routine health maintenance screenings and immunizations during their visits prevent repeated in-clinic appointments
- Medication safety initiatives can help prevent added costs associated with adverse medication events, and reduce ED visits
- Transitions of care activities can help to reduce the number of outpatient post-discharge follow-up visits and ED visits/hospital readmissions

Ways that pharmacists can *increase* the total cost of care:

- Higher salary, benefits when compared with other ancillary staff if not utilized for top of license work
- Higher frequency of patient care visits and associated co-pays[28, 29]
- Potentially more prescribing of higher-cost medications (e.g. GLP1-RAs, SGLT-2 inhibitors) needs to translate into better outcomes and downstream reduction in medical spending[28, 29]

- Potentially more frequent laboratory monitoring
- Increased referrals to other ancillary services (e.g. Behavioral health, occupational therapy, registered dietician)

8. How do you determine where to invest pharmacy resources?

The choice of where to invest pharmacist or pharmacy technician resources should be determined by considering organization specific factors:

- Identify organizational priorities
    - This can go beyond specific quality measures
- Identify your organization's value-based arrangements and assess both performance and opportunities for improvement
    - Determine if performance improvement would also translate to improved financial performance
    - Will likely need to engage with key stake holders such as ACO, clinic, pharmacy, and medical leadership Determine what other resources are being deployed and how pharmacy could best coordinate with these existing tactics
- Identify metrics and measures that may benefit from pharmacist or technician support
    - May want to prioritize measures that can be improved with low volume of work
    - Learn more here: https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/ambulatory-care/docs/ASHP-Value-Based-Care-Implementation-Resource-Guide.pdf
- Consider how resources may be implemented in an equitable manner to improve health equity
    - Some clinics or measures may have greater health equity gaps that can be improved with pharmacy services
    - Design interventions in a manner that can improve outcomes for all patients, not just specific patients in a high-priority VBC arrangement
- Consider available resources that could potentially be redirected to pilot interventions to demonstrate value
    - Examples: Pharmacy resident projects, leveraging existing services, or utilizing learners on rotation
    - Identify models which have already demonstrated success and begin there
    - It is critical to customize any model adopted to individual practice settings
    - Staffing models vary among organizations and can depend on numerous factors:
        - Are the pharmacy team members only focused on specific quality measures or are they also involved in other work?
        - Certain populations, such as Medicare, likely have a higher need for clinical pharmacy services compared to other populations, such as Medicaid or Commercial populations, that may have a much higher percentage of patients that are pediatric or younger adults
        - Utilization of pharmacy technicians or other disciplines may facilitate reaching more patients and allow pharmacists to focus on top of license work

- Determine if virtual, embedded in clinics, or a hybrid approach is the most feasible
- Embedded services may better facilitate relationship building with other providers and the implementation of collaborative practice agreements. Embedded services may also expand the available billing options. However, virtual services can overcome space challenges in clinics, better facilitate having dedicated time for proactive population health outreach, and make it easier to reach populations across many clinics

Refer to the ASHP SAG document "Key Steps to Implementing Provider Status" for additional considerations that may be helpful for developing staffing models

9. How should pharmacists prepare for inclusion in APMs?

APMs will come in all shapes and forms over the coming years as the system tries various forms in search of ones that will improve cost, quality, and patient experience. Pharmacists should not expect payment models to remain constant for any significant measure of time. As a result, pharmacists at all levels of health-systems should be aware of the impact of changing payment models and begin preparing for inclusion in APMs if they are not already in one. Those already in these models should consistently prepare for changes to the models to ensure pharmacy efforts are appropriately directed.

The following strategies are useful in preparing for inclusion in APMs:

- Learn the APMs in your geographic region and connect with other participating health-systems
  - Ask colleagues already in APMs to share their experiences and lessons learned
  - Leverage peer groups to build knowledge of differing APM structures
- Be at the table early in the planning phase; developing relationships to get a seat at the table is critical.[30]
- Pharmaceutical spend is a significant focus of APMs, so pharmacy leaders should articulate the importance and necessity of their inclusion in APM conversations[31]
- Track the impact and value of services developed and be able to speak to the value of pharmacy services in conversations with payers[30, 31]
- Stay informed of changes in market players (payers, health-systems, other service providers) and market disrupters (tech and service industry entries to health care)
- Develop a credentialing and privileging process for pharmacist practitioners

Additional Resource:

Academy of Managed Care Pharmacy: https://www.amcp.org/resource/value-based-contracts-resources

10. What are the ways to maximize success when participating in value-based payment models?

To maximize success, critical factors include:

- **Avoid chasing metrics that don't matter** – Given the frequency at which metrics change, large amounts of resources can be invested in developing systems that generate little to no meaningful return while reducing staff satisfaction.
- **Understand current performance** – Avoid dedicating costly resources to metrics that are already meeting goals
- **Be sure to track impact** – As resources are allocated within a system, they will go to areas which have demonstrated value. Tracking should include productivity, outcomes, qualitative metrics, patient and provider satisfaction. Finding a balance in what is tracked is important and the data should be meaningful to the department and decision makers. However, it can be challenging to attribute value to the actions of a specific department or service. Explore various embedded tools to highlight the pharmacy enterprise's contributions to improvements in quality measures, productivity, revenue and overall value.
- **Avoid starting too big –** Projects with large scale and delayed results are meaningful in the long run but can negatively skew value-based performance in the short term. Strategies to address this include 1) focusing on "low hanging fruit" first to get some quick wins, and 2) making sure payers are aware of the work being done and the long-term nature of the project. Example: efforts to address hepatitis C will increase pharmaceutical spend short term but address a public health concern and reduce risk of long-term complications and costs. Inquire about the potential for these types of populations to be excluded from data or given separate consideration
- **Lack of awareness of work happening across the organization** - This can lead to duplication of efforts or utilization of resources in the wrong areas
- Pay attention to downside risk contracts – Not all VBP arrangements involve shared savings or "upside risk" only. Be aware of the financial risks associated with downside risk arrangements. However, more financial risk often means greater opportunity for reward.
- **Quality metrics don't necessarily measure "quality"-** Clinical targets commonly used in VBP arrangements (e.g. A1c, BP) may not fully acknowledge the ways that pharmacists are providing value.[32] For example, a pharmacist-led service may result in improved medication adherence and fewer patients with an A1c above 12%, but if the metric target is A1c <9%, then this "value" may not be fully captured. Find additional ways to demonstrate value beyond the specified metric target.
- **Incentive "bonus" payments often aren't enough** – The return on investing in a team-based care model that includes pharmacists often relies on more than just incentive payments or shared savings alone.[32]

- **Consider advocating for alternatives beyond VBP** – Redesign payment models to individually address wellness care, chronic condition management and non-emergency acute care.[33]

11. Where have pharmacists been shown to add value?

There are a variety of programs that have demonstrated the pharmacist's contribution to value. A few examples can be accessed via the links below.

1. Transitions of Care (ToC)
    a. Pharmacist-integrated ToC and population health services significantly reduced all-cause readmission rates at 30, 60, and 90 days in a Medicare value-based program (MV-BP) population.[34]
2. Primary Care/ACO
    a. Patients referred to a clinical pharmacy practitioner had greater reductions in HbA1c and were more likely to achieve HbA1c goals included in the organization's quality measures. [35]
    b. Pharmacists can assist primary care providers in the ACO setting meet CV- and diabetes-related CMS quality measures, demonstrating the value of the pharmacist in value-based health care settings. [36]
3. Community pharmacy
    a. This study found that community pharmacies were transforming their practices to be successful under a commercial value-based payment program. The pharmacies tended to build on care processes already established (e.g., medication adherence, patients with diabetes or cardiovascular conditions) and developed new processes to address emerging metrics and associated patient needs (e.g., collecting and documenting blood pressure and hemoglobin A1c levels). Future research is needed to identify best practices for patient care and pharmacy success under broad value-based pharmacy programs such as the one studied here.[37]
    b. Using a novel pay-to-engage alternative payment model to provide comprehensive medication management in community pharmacies, the authors found considerable adoption and variation in the implementation of services across participating organizations.[38]
    c. Community pharmacy participation in research is vital to inform the advancement of accessible, community-pharmacy-based patient care interventions that improve healthcare access, efficiency and outcomes.[39]

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