



FAQ: Value Based Payment Models

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1. Why do public and private sector payers (i.e., Medicare, Medicaid, etc.) want to change from Fee-for-Service (FFS) healthcare payment models?

A: Rising health care costs continue to stress payers, health care providers, and patients and all parties desire better value and improved outcomes. In a FFS payment model, the provider or facility gets reimbursed for *each* service provided. In this model, health care providers are incentivized to increase volume and profitability of care provided rather than quality of care provided. This model can also drive up cost through fragmentation and unnecessary non value-added services. Many private insurers, following the lead of CMS in its push toward alternative payment models (APMs), have already invested broadly in value-based payment programs.

<https://catalyst.nejm.org/economic-investment-journey-health-care-value-part-i/>

2. What types of payment models exist?

All value-based reimbursement arrangements emphasize quality over quantity of services provided. The terms “value based care” or “value based payment” include a variety of reimbursement arrangements including: alternative payment model (APM), advanced APM, bundled payments for episodes of care, pay for performance, shared savings programs, and “full” or “capitated” payments. APMs can apply to a specific clinical condition, a care episode, or a population.

Advanced APMs are a subset of APMs and allow clinics to earn more for taking on some risk related to their patients' outcomes.

Accountable care organizations (ACOs) are groups of providers across different settings who share responsibility for overall quality and cost of care for a population of patients. Overall cost and quality is measured within an ACO and compared against benchmarks to determine opportunity for shared savings or penalties. Additionally the Patient-Centered Medical Home (PCMH) model can help patients avoid costly complications catching the eye of both commercial and government payers. PCMH recognition can lead to incentive payments on top of fee for service payments.

The repeal of the Sustainable Growth Rate and its replacement with the Medicare Access and CHIP [Children’s Health Insurance Program] Reauthorization Act of 2015 (MACRA) authorized CMS to establish the new Quality Payment Program (QPP) to promote the transition of medical payments from volume to value. The QPP reimburses Part B medical services through one of 2 methodologies:

- The first track reimburses through the Merit-based Incentive Payment System (MIPS)
- The second track promotes payment through advanced Alternative Payment Models (APMs).

Table of Types of Payment Models

Payment Model	Description
Fee-for-Service	A method in which providers are paid for each service performed such as tests and office visits.
Pay-for-Performance	Healthcare providers are only compensated if they meet certain metrics for quality and efficiency.
Value-Based Purchasing	A payment structure in which different health care providers who are treating a patient for the same or related conditions are paid an overall sum for taking care of a condition rather than being paid for each individual treatment, test, or procedure. In doing so, providers are rewarded for coordinating care, preventing complications and errors, and reducing unnecessary or duplicative tests and treatments.
Bundled Payment	A payment structure in which different health care providers who are treating a patient for the same or related conditions are paid an overall sum for taking care of a condition rather than being paid for each individual treatment, test, or procedure. In doing so, providers are rewarded for coordinating care, preventing complications and errors, and reducing unnecessary or duplicative tests and treatments.
Shared Savings	Key component of the Medicare delivery system reform initiatives included in the Affordable Care Act and is a new approach to the delivery of health care. Congress created the Shared Savings Program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO).

Global Payment/Capitation	Under global capitation, whole networks of hospitals and physicians band together to receive single fixed monthly payments for enrolled health plan members. Payment is made on a per member basis. Generally, providers sign a single contract with a health plan to cover the care of groups of members, and then must determine a method of dividing up the capitated check among the provider group. Under a partial or blended capitation model, a single payment is made for a defined set of services, while other services involved in a patient's care are paid for on a fee-for-service basis. Under each model of capitation, risk adjustment is essential to adequately compensate providers for the risk they take-on. Payments are differentiated based on the characteristics of the enrollees in each provider patient group. Common risk adjustment factors include age, sex, health status, and prior health care utilization, as well as socio-demographic factors such as residence, income, etc.
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<https://www.brookings.edu/blog/health360/2014/07/23/the-beginners-guide-to-new-health-care-payment-models/>

<https://qpp.cms.gov/>

<https://catalyst.nejm.org/economic-investment-journey-health-care-value-part-i/>

<https://innovation.cms.gov/initiatives/bundled-payments/>

<https://revcycleintelligence.com/features/understanding-the-value-based-reimbursement-model-landscape>

<https://qpp.cms.gov/>

3. How does a value-based cost of care model differ from a traditional FFS model?

Under FFS models, cost variations exist and the healthcare industry spends more to treat patients even though patient outcomes are not necessarily improved. This model also challenges provider workflows because physicians must see more patients and in many cases, each claim is processed in a fragmented network.

Value-based reimbursement programs and care models hinge on advancing quality of care while increasing patient access and accounts for price at the point of care.

Value-based reimbursements are calculated by using numerous measures of quality and determining the overall health of populations. Unlike the traditional model, value-based care is driven by data because providers must report to payers on specific metrics and demonstrate improvement. Providers may have to track and report on hospital readmissions, adverse events, population health, patient engagement, and more.

Under the new models, providers are incentivized to use evidence-based medicine, engage patients, upgrade health IT, and use data analytics in order to get paid for their services. When patients receive more coordinated, appropriate, and effective care, providers are rewarded.

A few ways value-based payments differ from FFS:

	Fee-for-service	Value-based payment
Relation of charges to profit	Increasing volume and charges will result in more profit	Decreasing volume (of high-cost populations) or lowering costs will result in more profit
Collection of revenue	Revenues are collected after services are provided (i.e. at a loss until breakeven point is met)	Varies depending on the model
Variability of payments	Payments do not vary based on the health of the population, just level of complexity of visit	Risk-based; may vary based on health of the population (i.e. payments usually higher in higher-cost populations)
Risk to providers, insurance, purchaser/patient	<u>Providers</u> bear little risk because they get paid based on each service they will provide; <u>Insurance</u> bears short-term risk, but can increase premiums next year to offset losses; <u>Purchaser/patient</u> bears long-term risk because insurance can increase premiums	<u>Providers</u> bear short-term risk because cost may exceed revenues (hard to predict high-cost outliers: atypical patient that requires numerous intensive services that are expensive); <u>Insurance</u> bears long-term risk because providers can increase their contract at renewal; <u>Purchaser/patient</u> still bears ultimate risk because insurance can increase premiums

<https://revcycleintelligence.com/features/what-is-value-based-care-what-it-means-for-providers>

Source: American College of Healthcare Executives (Chapter 20: Capitation, Rate Setting, and Risk Sharing)

4. What components of a value based contract are important to evaluate

Evaluation of value-based contracts involves identifying and weighing the potential pros and cons based on the health care organization's current capabilities and resources. Potential benefits should include: effective population health management through coordination of care, with improved care quality at the lowest-possible cost; a bottom-line impact that is sustainable into the future; facilitation of a closer partnership

with physicians in the community; lower administrative and operating expenses; and a model to use for contractual arrangements with other payers

Important considerations include population of focus, infrastructure required to implement, attribution model, historic utilization patterns as well as predicting future utilization patterns, financial model to determine acceptable level of risk. Keys to success include physician engagement, transparency and accountability, and performance measurement and improvement. Identifying the right measures and then linking them to the right payment involve difficult processes, such as attributing a patient's health outcomes to a specific provider and adjusting risk to account for patient populations with different risk factors, demographics, and health conditions. In negotiating contracts, providers should remember that measures often are negotiable and should be regularly reviewed and updated.

<http://www.hpoe.org/Reports-HPOE/Value-Based Contracting KaufHall 2013.pdf>

5. 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 continue 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: <https://innovation.cms.gov/initiatives/bundled-payments/>
- Shared savings program: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/about.html>
- ACO Investment Model, Advance Payment ACO Model, Next Generation ACO Model, Pioneer: <https://innovation.cms.gov/initiatives/map/index.html#model=aco-investment-model+advance-payment-aco-model+next-generation-aco-model+pioneer-aco-model>
- Patient Centered Medical Homes <http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh/why-pcmh/payer-and-medical-board-support/payer-support-federal-state-and-commercial>

6. 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. 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, and National Quality Forum measures. NQF has endorsed approximately 700 measures that are included in its Quality Positioning System database. 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 payment.

As an example, the Merit-based Incentive Payment System (MIPS) is one of two tracks of the CMS quality payment program and includes four performance categories that affect Medicare payments.

Under MIPS, which consolidates 3 separate programs, physicians report on:

- Quality (formerly the Physician Quality Reporting System or PQRS)
- Cost/resource use (formerly the Value-Based Modifier program)
- Advancing care information (formerly Meaningful Use)
- Improvement activities

Physician and practice performance in 2017 will be analyzed in 2018, and adjustments to the physicians' fee schedules will be released in 2019. Physicians may report individually or as an entire practice, and scores will be based upon reported activities and ranked against all others who report under MIPS. Physicians or practices that rank ahead of their peers will be eligible for a fee schedule increase of up to 4% in 2019, and those ranked behind their peers face a decrease in their fee schedule of up to 4% in 2019. The potential fee schedule gain or loss will witness an annual increase to 9% in 2022. The good news is that CMS has deemed 2017 as a preparation and transition year (termed "Pick Your Pace"); a physician can avoid the 4% reduction from MIPS in 2019 by reporting 1 measure for only 1 patient for the entire year.

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. More information about quality measures can be found at:

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/index.html?redirect=/QualityMeasures/>

Quality Resources:

- Agency for Healthcare Research and Quality. Measuring and Benchmarking Clinical Performance. Available at: <https://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod7.html>.
- Agency for Healthcare Research and Quality. Practice Report Card Measures. Available at: <https://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/fig7.1.html>.
- NCQA. State of Healthcare Quality HEDIS Measures of Care. Available at: <http://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality/2016-table-of-contents>.
- Pharmacy Quality Alliance. PQA Performance Measures. Available at: <http://pqaalliance.org/measures/default.asp>.
- National Quality Forum (NQF) is a not-for-profit, nonpartisan, membership-based organization that works to catalyze improvements in healthcare: https://www.qualityforum.org/Field_Guide/List_of_Measures.aspx

For more information on the quality payment program, as well as evidence-based metrics see the links below.

http://www.qualityforum.org/Measures_Reports_Tools.aspx

<https://pqaalliance.org/measures/default.asp>

7. Could provider status impact the pharmacist role on the care team within the alternative payment models?

Yes, provider status 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, pharmacists being recognized as providers will allow pharmacists to play a bigger role in direct patient care activities and improve the value proposition. Many states have adopted language into state law to allow for collaborative practice models allowing for varying levels of prescribing authority under the supervision of a physician. Additionally both Washington and Oregon have passed legislation to allow for pharmacists to be included in health insurance provider networks and to receive reimbursement for performing clinical services. Provider status promotes enhanced access to care as well as improvement in quality of care provided both essential to optimal performance in an APM.

Source: http://www.pharmacytimes.com/publications/career/2016/pharmacycareers_february2016/the-state-of-provider-status-an-update-for-pharmacy-students

<http://pharmacist.com/article/oregon-expands-prescribing-pharmacists>

8. What is the pharmacist's impact on total cost of care within APMs?

There are a variety of ways that pharmacists can impact overall cost of care within an APM. For example, formulary management can help control prescribing practices and ensure the most cost-effective use of medication therapy and reduce clinical variation. Collaborative drug therapy management activities can also increase access to care and provide for closer management of the highest risk patients contributing to utilization of high cost venues of care including the ED and hospital. Additionally, transitions of care programs can directly reduce readmission rates as well as ED utilization. Lastly, population health efforts including pharmacy delivered immunizations, virtual based comprehensive medication management, and adherence support expand access to care and improve quality of care.

- Ways that pharmacists can decrease total cost of care:
 - Pharmacists can target "high utilizers" for clinical services
 - Pharmacist involvement with collaborative drug therapy management (CDTM) activities can offload routine appointments with PCPs for chronic disease management
 - Incorporate more telephone-based 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
- Pharmacists taking care of routine health maintenance screenings and immunizations during their visits to prevent repeated in-clinic appointments
- Medication safety initiatives can help to prevent added costs associated with adverse medication events, and reduce ED visits
- Transitions of care activities can help to reduce the number of post-discharge follow-up visits and ED visits
- Ways that pharmacists can increase 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 needs to be offset by less utilization of higher cost venues of care
 - More prescribing of higher-cost medications (e.g. GLP1-RAs, DPP-4 inhibitors, SGLT-2 inhibitors) needs to translate into better outcomes and downstream reduction in medical spend
 - More frequent laboratory monitoring must be offset by improved patient outcomes

9. How do you determine where to invest pharmacist resources?

Begin with the big picture in mind. Metrics are consistently changing, but the goals of achieving the Quadruple Aim, reducing cost, improving quality of care, improving the patient experience, and reducing provider burnout, remains constant. The choice of where to invest pharmacist resources should be determined by considering several organization specific factors:

- Assess the organizations performance in the value-based payment structure
 - Learn what areas are performing well and what areas need to be improved
 - Identify which of these areas would benefit from pharmacist involvement
 - Determine what other resources are being deployed to address the deficiency
- Identify metrics and measures within the value-based payment models that are medication related and that would benefit from pharmacist intervention
 - Select measures that will be meaningful to improving the quality or cost of care
 - Avoid measures which require high volumes of work for minimal change in quality
- Evaluate current internal and external systems and supports needed to be successful in achieving the measures
 - Addressing measures often requires improving system processes and documentation
 - Explore partnerships with other disciplines as this allows pharmacists to direct their efforts to the areas where they will have the greatest impact (working to the top of their license)
- Consider what pharmacist resources are currently available that could potentially be re-directed to pilot interventions to demonstrate value

- Utilizing multiple small pilots to identify areas of greatest impact is a useful way to test interventions before investing resources fully.
- Resident projects can serve as a spring board for testing and demonstrating value
- Leveraging existing services, look at what work pharmacist are currently doing, and how that can be translated into meeting value-based payment model goals
 - Example: Referral based, pharmacist managed diabetes clinics could begin utilizing patient lists from payers identifying patients with uncontrolled diabetes and engaging the patients in clinic without the need for referral
- Moving beyond one on one patient engagements and developing processes that systematize simple interventions and screening processes
 - Patient lists should be refined to exclude those who would not benefit from intervention to maximize efficiency
- Identify models which have already demonstrated success and begin there
 - It is critical to customize any model adopted to individual practice settings and organizations to ensure success.

<https://www.jmcp.org/doi/pdf/10.18553/jmcp.2017.23.5.541>

10. How should pharmacists prepare for inclusion in APMs?

The need to contain rising health care costs necessitates changes to the delivery of health care. 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 until ones have been identified to work. 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 what the APMs are in your geographic region and what other health-systems are participating in
 - 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 on; developing relationships to get a seat at the table is critical
Pharmaceutical spend is a significant focus of APMs, so pharmacy leaders should articulate the importance and necessity of their inclusion in APM conversations
- Track the impact and value of services developed and be able to speak to the value of pharmacy services in conversations with payers
- Stay informed of changes in market players (payers, health-systems, other services providers) and market disrupters (tech and service industry entries to health care)
- Develop a credentialing and privileging process for pharmacist practitioners

<http://www.amcp.org/WorkArea/DownloadAsset.aspx?id=19246>

Dubois RW, Feldman M, Lustig A, et al. Are ACOs ready to be accountable for medication use? *J Manag Care Pharm.* 2014;20(1):17-21. Available at: <http://www.jmcp.org/doi/10.18553/jmcp.2014.20.1.17>.

11. What are the pitfalls pharmacists should avoid to ensure success?

To maximize success, critical success factors include:

- Engage key stakeholders - Stakeholders include clinicians, administrative leadership, billing, finance, IT department, managed care contracting, compliance, legal, data and analytics, and the patients themselves. Pharmacists should work within their organization to identify current payment models in place and determine specific areas of need
- Avoid chasing metrics that don't matter – given the frequency that metrics change, large amounts of resources can be invested in developing systems which generate little to no meaningful return while reducing staff satisfaction.
- Understand current performance – avoid dedicating costly resources to metrics that are already meeting goals
- Failing to track impact – as resources are allocated in 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.
- Starting too big – projects with large scale and delayed results are meaningful in the long run but can negatively skew APM performance in the short term. Strategies to address this included:
 - 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. Ask about the potential for these types of populations to be excluded from data or given separate consideration.
 - Address low hanging fruit first - get some quick wins.
- Lack of awareness of work happening across the accountable care organization (ACO) – this can lead to duplication of efforts or utilization of resources in the wrong areas.
- Not having the ACO contract include all aspects of the pharmacy enterprise – there are instances where ACO contracts hold health-systems accountable for pharmaceutical spend while the corresponding pharmacy benefits manager (PBM) contract excludes the health-systems pharmacies from preferred networks.
 - Leveraging ACO contracts may improve pharmacy arrangements, to ensure elements of the business are not being left out.

12. Where have pharmacists been shown to add value?

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

Collaborative drug therapy management results in improvement in quality and financial outcomes in a cardiac risk service <https://www.ncbi.nlm.nih.gov/pubmed/27605323>

Pharmacists' involvement in a population health initiative focused on chronic disease management results in fewer ED visits, hospitalizations, and reduction on overall cost of care <https://www.ncbi.nlm.nih.gov/pubmed/28887344>

Medication therapy management programs can play a crucial role in an accountable care organization (ACO) meeting quality and financial benchmarks <http://www.npcnow.org/system/files/research/download/best-practices-mtm.pdf>

<http://capg.org/Modules/ShowDocument.aspx?documentid=3768>

<https://www.advisory.com/research/pharmacy-executive-forum/expert-insights/2017/5-innovative-strategies-to-advance-pharmacy-impact>

<https://www.advisory.com/-/media/Advisory-com/Research/PHA/White-Papers/2014/Integrated-Pharmacy-Models-in-Primary-Care/29994.pdf>

<http://www.amga.org/wcm/PI/Collabs/MPMCC/Compendiums/Novant%20Final.pdf>

[http://mcpigojournal.org/article/S2542-4548\(17\)30134-0/abstract](http://mcpigojournal.org/article/S2542-4548(17)30134-0/abstract)

<http://www.jmcp.org/doi/abs/10.18553/jmcp.2014.20.12.1152>.

<http://www.jmcp.org/doi/10.18553/jmcp.2013.19.2.102>. [Link](#)

Resource Documents:

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