Practice Advancement Issue Brief

Payment Methods in Outpatient Team-Based Clinical Pharmacy Practice, Part 2: MACRA for Pharmacists

Purpose

ACCP Practice Advancement Issue Briefs are developed and published to provide concise information and insights for clinical pharmacists and their medical and practice administration colleagues involved in direct patient care. They are intended to help support the development, advancement, and positioning of clinical pharmacists as integrated direct patient care providers within team-based medical practices and delivery systems. The issue briefs are regularly updated to ensure alignment with developments in the advancement of clinical pharmacy practice.*

The information contained in these issue briefs can be useful in both initial and ongoing discussions and decisions about the scope of services and collaborative practice responsibilities of clinical pharmacists, particularly when physicians or medical administrators are exploring or being encouraged to consider incorporating or expanding clinical pharmacists within practices. The greatest utility and value of this information may lie in supporting specific conversations with medical directors, finance and revenue directors, practice managers, and others involved in the business operations of practices once the decision to incorporate or increase the number of clinical pharmacists within the practice has been made.

Background

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established compensation models focused on shifting health care from fee-for-service to value-based care with a payment approach called the Quality Payment Program (QPP). The QPP is focused on rewarding the delivery of high-quality patient care through two avenues: the Merit-Based Incentive Payment System (MIPS) and advanced Alternative Payment Models (advanced APMs).[1]

How Pharmacists Can Add Value Under MIPS

Initially, most eligible providers will fall into MIPS, which aims to shift payment to Medicare Part B clinicians using a performance-based payment model. The practice will receive bonuses or penalties, depending on the quality and cost of the care provided. CMS determines the payment adjustments according to a MIPS composite score with four performance categories: quality, promoting interoperability (PIs), improvement activities (IAs), and cost.[2,3]

MIPs-eligible clinicians will have to choose and report the activities and measures most meaningful to their practice. Although pharmacists are not currently MIPS-eligible clinicians, they can contribute to the key performance categories, given that pharmacists

*ACCP Clinical Practice Advancement Resources include issue briefs, products, services, and educational resources essential for integration of clinical pharmacy services into contemporary team-based health care delivery. Topic areas include, but are not limited to, Standards of Practice; Clinical Services Operations (e.g., payment mechanisms, collaborative practice agreements and business structures); Medication Use Quality Improvement through Outcome Measurement; and Leadership in Practice Advancement and Transformation.

can directly influence many of the medication-related measures (Table 1) such as chronic anticoagulation therapy, persistence of β-blocker treatment after a heart attack, and adherence to antipsychotic medications for individuals with schizophrenia. While Table 1 specifically analyzes these medication-related measures, pharmacists can also indirectly contribute to many more of the quality and improvement activity measures, such as managing pain control for patients within 48 hours, establishing standard operations to manage transitions of care, and engagement of patients, family and caregivers in developing a plan of care.

Table 1. Medication-Related MIPS Performance Measures

Performance Measure Category[a]	% MIPs Composite Score[a]	% Medication-Related Measures[b]
Quality	50	~25
Improvement Activities	15	~25
Promoting Interoperability	25	~20
Cost[c]	10	N/A

[a]Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS). The quality payment program. Available from www.qpp.cms.gov. Accessed August 29, 2018.

[b]CMS measures in each category (275 for quality, 114 for improvement activities, 15 for promoting interoperability) determined, according to clinical judgment, to be medication related. The total number of medication-related measures for each category was used to determine the percentage of medication-related measures for the respective category.

[c]The two cost measures [Medicare Spending Per Beneficiary (MSPB) and Total Per Capita Costs (TPCC)] are not directly medication-related, however, by contributing to the measures in the other categories, pharmacists may help decrease these measures.

Chronic care management consumes 37% of primary care providers' time. This often entails managing complex medication regimens.[4] Pharmacists who are integrated into a value-based model can focus on the medicated-related measures of MIPS so that physicians and other members of the care team can focus on their respective measures to achieve highest value and cost savings. Pharmacists can also play an essential role in developing and prioritizing services in order to align them to the performance measures through discussions with the organization's leaders.[5]

In addition to contributing directly to the MIPS performance measures in a wide range of primary care and specialty practices, pharmacists have an enhanced opportunity to contribute in patient-centered medical homes (PCMHs),[6] which automatically receive full credit in the IA category.[7] Because IAs contribute 15% to the composite score for payment, it would be strategic for pharmacists to leverage their value and integrate into PCMH settings, given that PCMHs are better organized to meet quality measures.

One of the most valuable ways pharmacists can contribute to the PCMH is through providing comprehensive medication management (CMM) services. CMM is defined as the standard of care that ensures each patient's medications are individually assessed to determine whether they are 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.[8] Each year, 4.5 million adverse drug events are estimated to occur in the ambulatory setting, associated with 400,000 hospitalizations.[9] Return on investment of medication management services has ranged from 3:1 to 12:1 annually, with the ability to decrease hospital admissions, physician visits, emergency department admissions, and the inappropriate use of medications.[10,11] By integrating CMM into a PCMH, patients' medication use can be optimized, resulting in increased quality and payment for the medical practice.[6]

How Pharmacists Can Add Value Under Advanced APMs

Advanced APMs, such as the Next Generation ACO Model, Oncology Care Model, Comprehensive Primary Care Plan program, and Comprehensive ESRD Care Organizations, use a payment approach that provides added incentives to practices that provide quality and cost-efficient care to patients. Practices can receive higher bonuses in advanced APMs than in MIPS because of the increased risk incurred by the practice in advanced APMs.[12] Currently, PCMHs are not considered advanced APMs under MACRA. However, many of the requirements to be a PCMH will position practices to meet the requirements of an advanced APM. Having practices shift to an APM model is the ultimate goal of MACRA. Therefore, pharmacists who can integrate CMM within PCMHs can also contribute to the cost savings in advanced APMs.

To sustain and enhance their revenue stream, providers are adapting their business model to ensure value generation. The lack of discrete payment and billing for pharmacists' services has been a historical barrier to integrating pharmacists into team-based care. However,

the MACRA environment allows pharmacists to be increasingly integrated into the value-based model in team-based practices. For example, MACRA provides an economic rationale for practices to pay a salary for pharmacists to be part of their team to drive health outcomes and generate value-based revenue for the practice. Moreover, pharmacists can be embedded in primary care practices through a co-funded partnership between the practice and a health system or pharmacy school. Organizations may also create a shared resource contractual agreement in which the pharmacist provides medication management services for multiple practices that share the overhead costs.[5]

As pharmacists' involvement in value-based care evolves and until other payment mechanisms are in place, pharmacists can now be seriously considered for inclusion in team-based practices because of the improved health outcomes and enhanced value they have been shown to produce. MACRA and its impact on transitioning health care to a value-based environment positively incentivizes practices to integrate pharmacists into the team-based care structure.

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