GTMRx Institute™

Get the medications right

www.gtmr.org

Alternative payment approaches for advancing comprehensive medication management in primary care

The Get the Medications Right Institute

Vision Enhance life by ensuring appropriate and personalized use of medication and gene therapies.

Mission Bring critical stakeholders together, bound by the urgent need to optimize outcomes and reduce costs by getting the medications right.

Focus Areas

- Practice and Care System Transformation
- Payment & Policy Solutions
- Precision Medicine via Advanced Diagnostics
- Health IT to Support Optimized Medication Use

Multi-Stakeholder Coalition:
Launched April 2019 – 1415+ members & 895+ companies

Board of Directors, Founding Funders, Executive Members and Strategic Partners

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We Believe

A personalized, patient-centered, systematic and coordinated approach to medication use will vastly improve outcomes and reduce overall health care costs.

We must align systems of care to integrate comprehensive medication management, engaging patients to ensure that they are willing and able to take those medications that are indicated, effective, and safe, to optimize their outcomes.

We need immediate delivery system, payment, and policy transformation to streamline clinical trials and reduce costs of bringing drugs to market while enabling successful, broad-scale adoption of integrated, comprehensive medication management (CMM) services.

Appropriate diagnosis and access to advanced diagnostics with companion/ complementary and pharmacogenetics testing is essential to target correct therapy.

Success requires team-based, patient-centered care models that recognize appropriately skilled clinical pharmacists as medication experts who work in collaborative practice with physicians and other providers.

Many medicines, too little time

Medications are involved in **80%** of all treatments & impact every aspect of a patient's life.

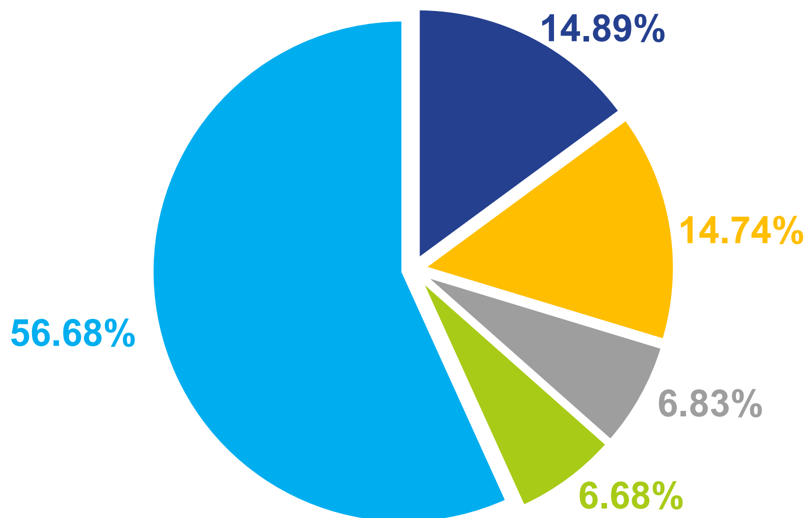
Nearly **30%** of adults in the U.S. take **5+** medications.

10,000 prescription medications available on the market today.

49 seconds spent between physicians and patients talking about new medication during a **15-minute** office visit.

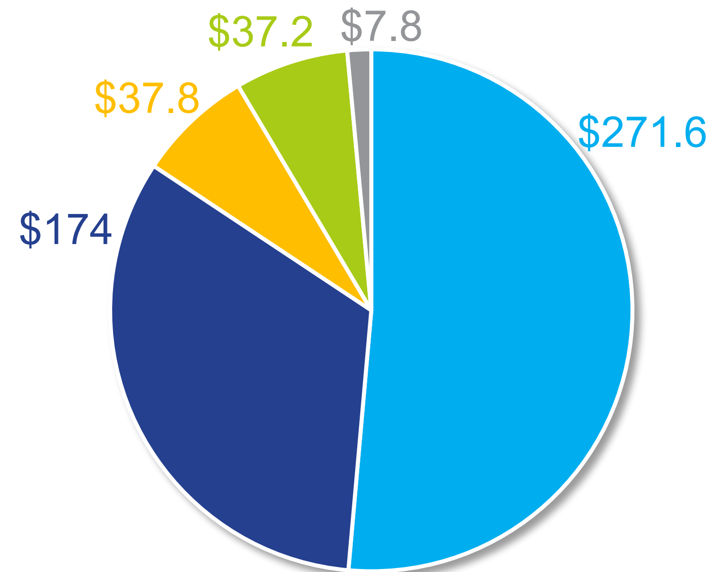
Types and Consequences of Medication Therapy Problems

Medication Therapy Problems



- Non-Adherence
- Adverse Reaction
- Dose Too High
- Unnecessary Therapy
- Inadequate Therapy

The Costs of Non-Optimized Medications : $528B



$528.4B in 2016 cost of non-optimized medication therapy

$174 billion **hospitalization** costs

$271.6 billion **long-term care** admissions

$37.2 billion **emergency department** visits

$37.8 billion additional **provider visits**

$7.8 billion **additional prescriptions**

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How We Practice: Optimize Medication Use Through Comprehensive Medication Management (CMM) in Practice

*CMM: A systematic approach to medications where physicians and pharmacists ensure that medications (whether they are prescription, non-prescription, alternative, traditional, vitamins or nutritional supplements) are individually assessed to determine that each medication is 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.**

* McInnis, Terry, et al., editors. ***The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes***. 2nd ed. PCPCC Medication Management Task Force collaborative document.

How we practice

GTMRx Institute™

10 Steps to CMM:

How we use technology

How we use diagnostics

How we pay

#1

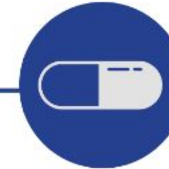
Identify patients that have not achieved clinical goals of therapy.

#2

Understand the patient's personal medication experience, history, preferences, & beliefs.

#3

Identify actual use patterns of all medications including OTCs, bioactive supplements & prescribed medications.



#4

Assess each medication for appropriateness, effectiveness, safety (including drug interactions) & adherence, focusing on achievement of the clinical goals for each therapy.

#5

Identify all drug-therapy problems.

#6

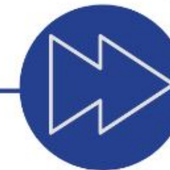
Develop a care plan addressing recommended steps including therapeutic changes needed to achieve optimal outcomes.

#7

Ensure patient agrees with & understands care plan which is communicated to the prescriber or provider for content & support.

#8

Document all steps & current clinical status vs. goals of therapy.



#9

Follow-up evaluations are critical to determine effects of changes, reassess actual outcomes & recommend further therapeutic changes to achieve desired clinical goals & outcomes.

#10

CMM is a reiterative process! Care is coordinated with other team members & personalized goals of therapy are understood by all team members.

McInnis, Terry, et al., editors. *The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes*. 2nd ed., Patient-Centered Primary Care Collaborative, PCPCC Medication Management Task Force collaborative document.

Return on investment for CMM

Cost savings associated with comprehensive medication management

ROI around **3:1 to 5:1** &
can be as high as **12:1**

Savings: **$1200 — $1872**
per patient per year

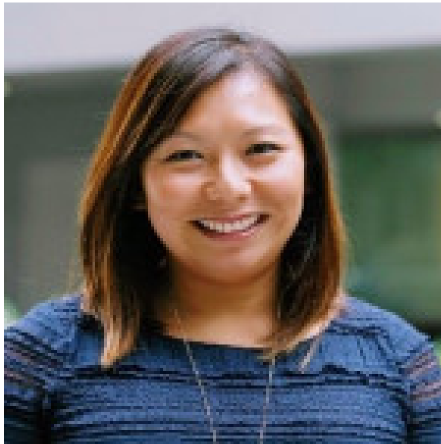
It has been shown to:

- improve the health of populations,
- enhance the experience of care for individuals,
- reduce the per capita cost of health care and
- improve physician satisfaction.

Fulfills all four elements of the Quadruple Aim:

- improve clinical quality,
- cost savings,
- patient outcomes and
- physician satisfaction.

Our Presenters



Kathy Pham, Pharm.D., BCPPS
Director, Policy and Professional Affairs
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Ann Greiner
President, Chief Executive Officer
Primary Care Collaborative (PCC)

"Alternative payment approaches for advancing comprehensive medication management in primary care"

Kathy Pham, Pharm.D., BCPPS
Director, Policy and Professional Affairs
American College of Clinical Pharmacy

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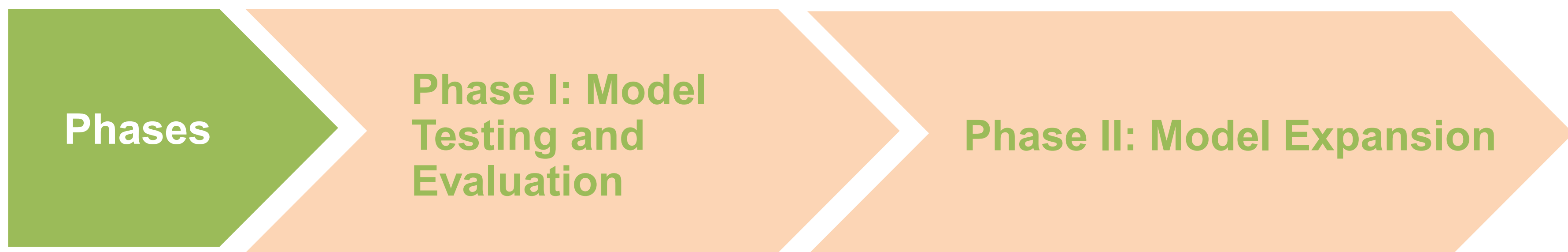
Why CMMI?

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

The ACA Created CMMI to Test Innovative Payment and Delivery Models

CMMI Mission: CMMI is designed to test "innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care."[1] The Secretary of HHS has authority to expand a model on a nationwide basis if the model reduces spending without reducing the quality of care, or improves the quality of care without increasing spending, and does not deny or limit the coverage or provision of any benefits.[2]

CMMI model demonstrations move through **two phases**:



[1] The CMMI is established under section 1115A of the Social Security Act, which was added by section 3021 of the ACA
[2] CMMI Model Certifications. CMS. March 23, 2016. Available here.
CMMI: Center for Medicare and Medicaid Innovation; HHS: Department of Health and Human Services, ACA: Affordable Care Act

CMMI Process to Develop, Implement, and Evaluate New Models Seeks Stakeholder Considerations

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

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

Ongoing Demonstration Models

CMMI Has Developed and Tested a Variety of Delivery Models

CMMI: Center for Medicare & Medicaid Innovation

CHIP: Children's Health Insurance Program

NextGen ACO: Next Generation Accountable Care Organization Model

BPCI-Advanced: Bundled Payments for Care Improvement Initiative

OCM: Oncology Care Model

CPC+: Comprehensive Primary Care Plus

MDPP: Medicare Diabetes Prevention Program

e.g., NextGen ACO Contracting; CPC+

e.g., BPCI-A; OCM

e.g., Direct

e.g., Maternal Opioid Misuse (MOM) Model

e.g., Financial Alignment Initiative

e.g., Health Care Innovation Awards

e.g., MDPP

The Medicare Payment Advisory Commission (MedPAC) has recently called for CMMI to simplify its portfolio, focusing on a smaller set of harmonized models. New CMMI leadership agrees and acknowledged value-based care is at a "critical juncture."

1. HealthcareDive. "Value-based care at 'critical juncture. 2021." 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

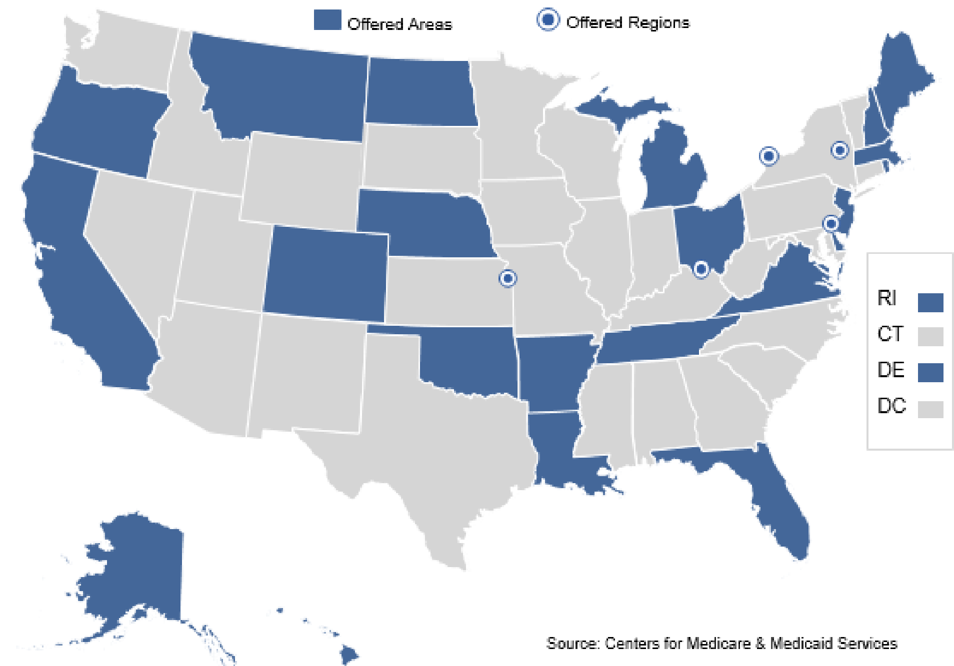
- Provide **comprehensive medication management** to patients receiving care management and in transitions of care who are likely to benefit.

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



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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

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)

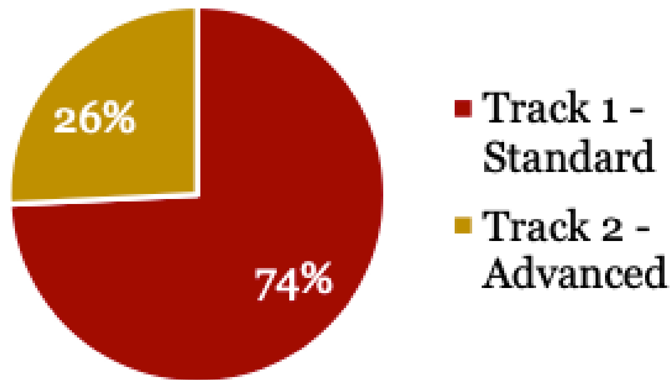
- Private entity that hires/manages interdisciplinary care
- Provides practices access to specialized staff
- Services can include:
  - Pharmacist services
  - Health and Nutritional Counseling Services
  - Behavioral Health Specialist Services
  - Support from Community Health Workers

Health Information Exchange

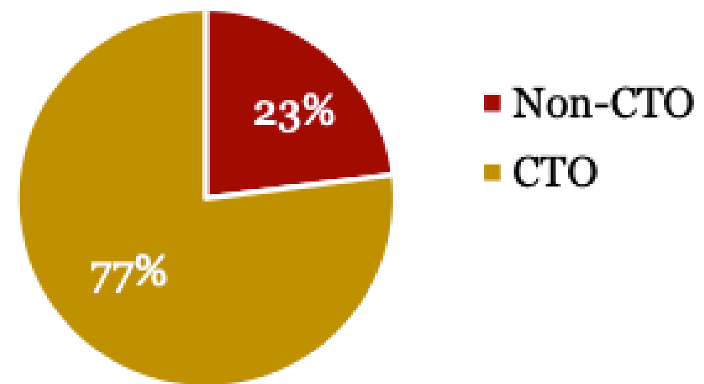
- All practices must participate in state-designated health information exchange, which provides access to tools
  - Chesapeake Regional Information System for Our Patients (CRISP)
- Practices and CTOs are also provided with additional resources

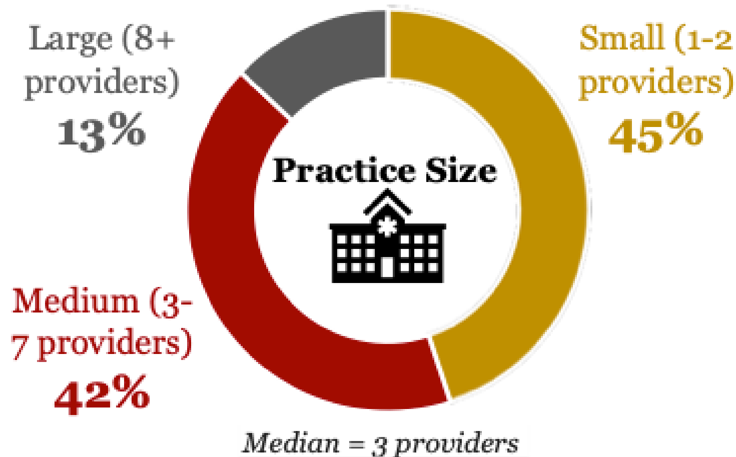
2020 MDPCP Practices

Practice Tracks



Practices Partnered with a CTO





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

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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

ESRD Treatment Choice model

- Mandatory
- Medicare beneficiaries with ESRD
- Greater use of home dialysis and kidney transplantation

AAKH and CMM

- Dialysis and kidney transplantation
- Slow progression of chronic kidney disease
- Management of multiple chronic conditions

Implications for Medication Optimization

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

2. 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

3. 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

4. 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

Reactor

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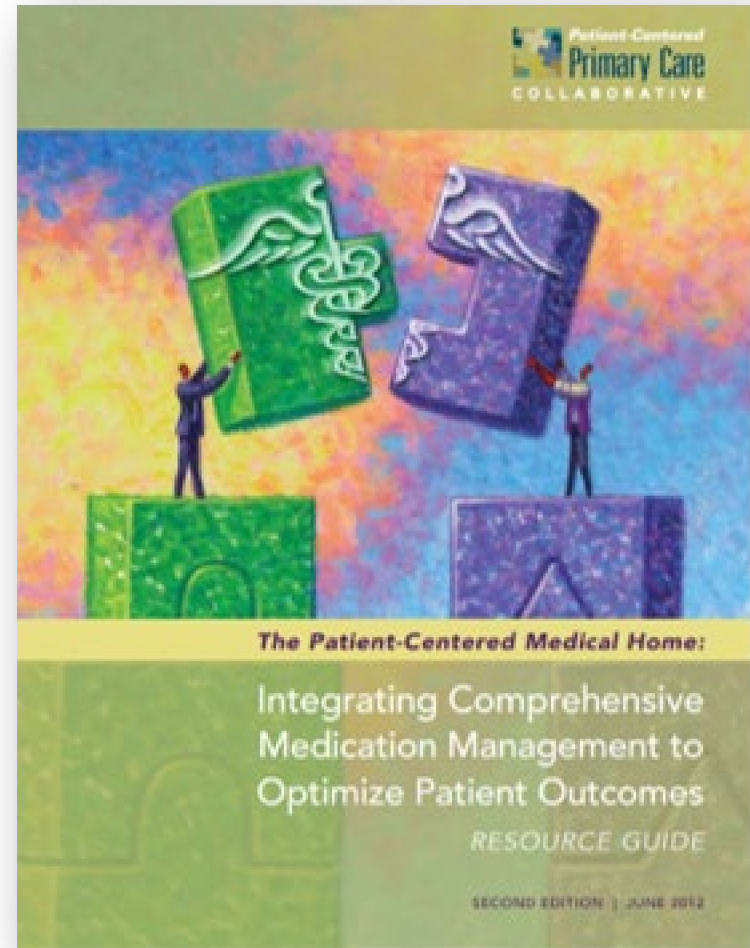
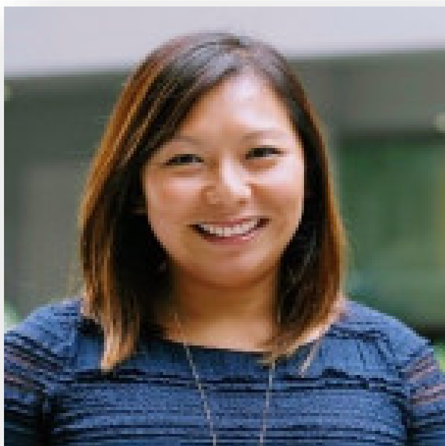


Q&A



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