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CMM and advanced primary care were made for each other, but true integration remains elusive

Comprehensive medication management (CMM) aligns with advanced primary care, but integration remains a challenge. There are opportunities to change this, especially through alternative payment approaches such as the patient-centered medical home and other advanced models of primary care, including those offered through the Center for Medicare and Medicaid Innovation (CMMI). (See sidebar on pages 2-3).

These models allow the interprofessional care team to offer a more comprehensive set of services and actively work with patients in a healing, ongoing relationship to manage their health and care needs with enhanced access and leveraging data and technology.

Optimizing medication use at the primary care level through CMM in practice offers important value-driving elements that support this vision of more comprehensive primary care. It should, says Kathy Pham, PharmD, BCPPS, ACCP director of policy and professional affairs, be formally recognized as a compensated chronic care service in evolving payment models.

CMM has the 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, she says. (See Figure 2 on page 4.)

However, with a few exceptions such as the Veterans Health Administration, CMM has yet to be broadly integrated into primary care. That will require a change in how we pay for care.

Payment is a key lever to further spread and support integration of CMM into primary care, but it's one leg of the three-legged stool that supports not only the integration of CMM but all of primary care transformation. The other two are culture and data & technology.

"It's not just about using a regimen correctly; it's about making sure that we have all the information and expertise needed to make the most informed choices for our patients."

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

CMMI opportunities

Founded under the ACA in 2010, CMMI supports the development and testing of innovative health care payment and service delivery models. Demonstration projects allow CMMI to test and measure the likely effects of new methods of service delivery, coverage for new types of services and new payment approaches. Figure 1 illustrates CMMI's process for new models and opportunities for stakeholder input.

CMMI initiatives integrate primary care, care management, population health and management of those with multiple chronic diseases—all of which align with CMM. Pham offers a brief overview of some current models. Two are state based: the California Wellness Plan and the Maryland Primary Care Program. Three are national: Comprehensive Primary Care Plus (CPC+), Primary Care First (PCF) and the Advancing American Kidney Health (AAKH).

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The California Wellness Plan seeks to promote the improvement of chronic disease management, health and wellness, while empowering communities throughout the state. Nine CMM pilot programs were implemented, and the results were positive. They included patient and provider satisfaction, improved health outcomes, reduced hospitalizations, ED use and readmissions, as well as cost savings and cost avoidance.

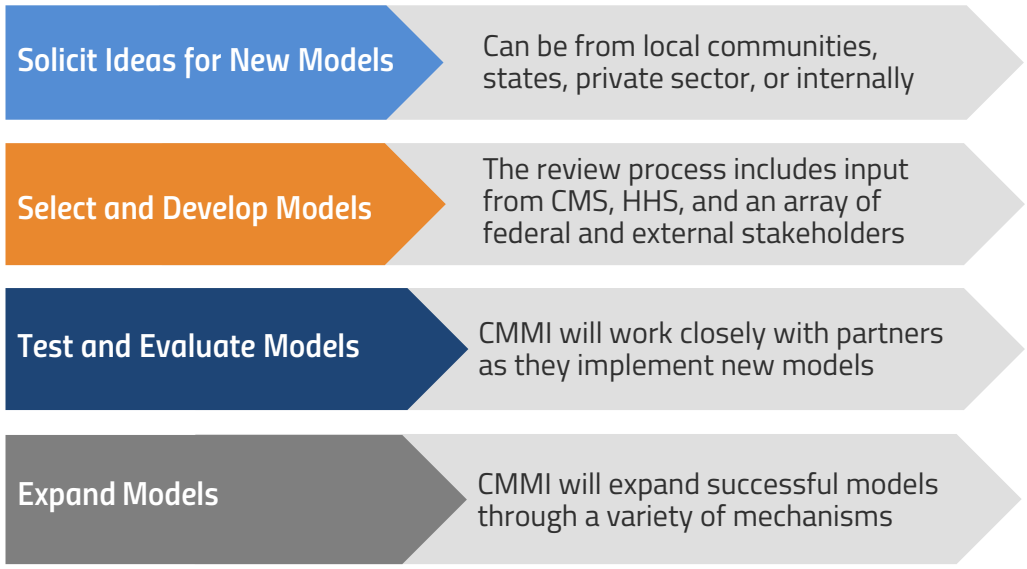
Comprehensive Primary Care Plus, or **CPC+,** is a public/private partnership in which practices are supported by 52 aligned payers in 18 regions. This care delivery and payment redesign model includes two different tracks with increasing payment and care redesign expectations. The goal is to improve care delivery across five comprehensive primary care functions: access and continuity; care and management; comprehensiveness and coordination; patient and caregiver engagement; and planned care and population health—all of which align with CMM, says Pham.

Track two practices must provide more enhanced care delivery approaches to better support patients with complex needs. Significantly, they also must provide CMM to patients receiving care management and in transitions of care, targeting those who are likely to benefit. They are expected—and incentivized—to increase the comprehensiveness of care delivered. "This incentive aligns well with CMM, which is inherently comprehensive in its process of care. It may support advancement from medication reconciliation or episodic medication management to continual comprehensive medication management," says Pham.

While CPC+ provides the resources to invest in primary care practice transformation, **Primary Care First**

(continued on page 3)

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



HHS. "HHS FY2016 Budget in Brief. Feb 2016."
CMS. "CMS Innovation Center: Report to Congress."

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Figure 1

includes voluntary five-year payment options that reward value and quality by offering an innovative payment structure to support delivery of advanced primary care. And the PCF model options will be offered in 26 regions starting in 2021.

Building on the CPC+ model, Primary Care First seeks to enhance care for patients with complex chronic needs and high-need, seriously ill patients. CMM most benefits those patients. It also prioritizes the clinician patient relationship and strives to reduce administrative burden and pay for outcomes.

Maryland and CMMI established the **Maryland Primary Care Program.** This total cost of care model sets the target for total cost of care reductions for Medicare and calls for improved population health outcomes supported by broad, innovative care redesign between hospital and non-hospital partners across the state. Modeled after CPC+, the Maryland Primary Care Program is a multi-payer program designed to transform primary care practice with the goals of lowering costs and improving outcomes. As with CPC+, track two sites are required to implement CMM—and they receive financial incentives to do so.

As part of the **American Kidney Health Initiative**, CMMI announced multiple value-based care models, using demonstration projects to test whether payment changes can improve patient outcomes. "CMM really aligns with the incentives of these new payment models by addressing medication-related barriers to home dialysis and transplantation and achieving patient-centered therapeutic goals to slow the progression of chronic kidney disease. And of course, no patient has chronic conditions in a silo, so the ability to manage multiple chronic conditions also adds to the efficiency in patient care." GTMR

Three-legged stool

Ann Greiner, president and CEO of the Primary Care Collaborative, sees considerable success on the culture front. "Health care is now a team-based sport, and I think we truly understand the importance of engaging patients and families in their care." However, much work remains. For example, she says, the percentage of patients that have a usual source of care has plateaued since the Affordable Care Act became law.

"On the data and technology front, we've made great strides," she says. Many practices have access to real-time data to manage population health, which really enables them to participate in risk-based models. "However, I also have some concerns that if we don't truly integrate technology like telehealth into medical homes, we could further fragment primary care."

It's essential to support small *and* independent practices so they have access to data and analytics *and* the capital that allows them to participate in value-based models.

> **"Payment is the least evolved leg of our stool, even though we talk about it all the time."**
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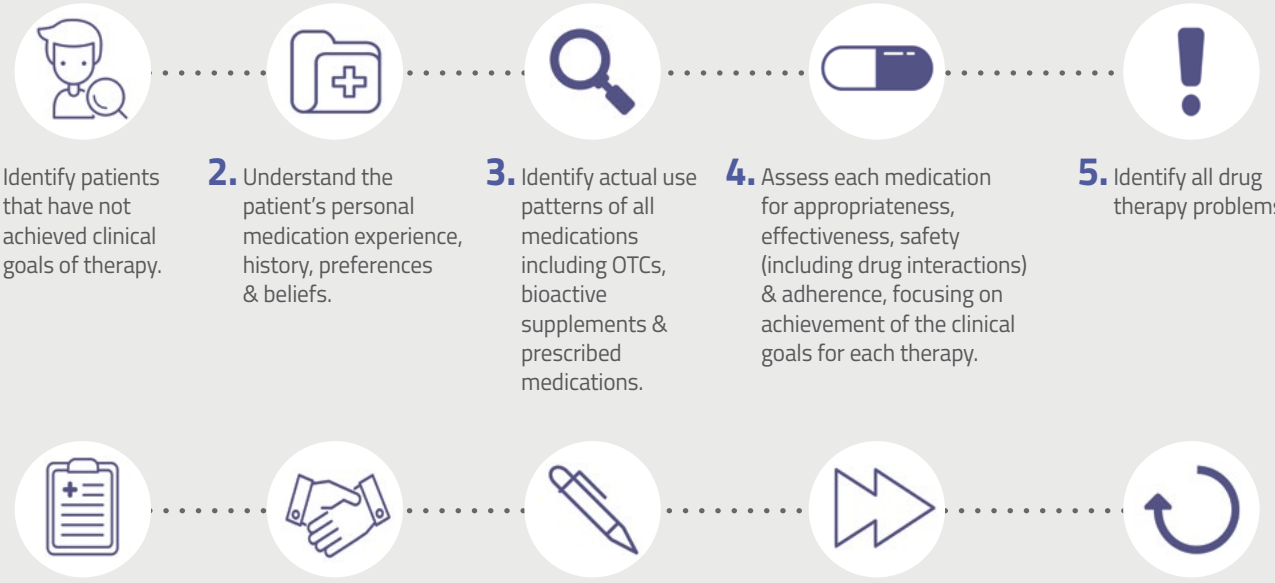
> *Ann Greiner, President & Chief Executive Officer, Primary Care Collaborative*

10 Steps to Achieve CMM



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 T, Webb E, and Strand L. *The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes,* Patient Centered Primary Care Collaborative, June 2012

Figure 2

"Payment is the least evolved leg of our stool, even though we talk about it all the time," Greiner says. Today, she says, 97% of physicians rely primarily on fee-for-service payments. And for those doctors that participate in value-based payment models—about 36%— three quarters of them receive less than 5% of their revenue through such models.[1,2]

"And that really doesn't move the needle in terms of changing behavior. That's what we've learned from the behavioral economists."

Transformation requires investment

It takes resources and investments to build the organizational competencies needed to redesign care successfully under value-based payment models, Pham and Greiner explain. And it has to be *new* investment—upfront and ongoing. We can't just take existing primary care payment models and move them from retrospective payment to prospective payment.

About 5% of health care spending goes to primary care, Greiner says.[3]

At the same time, we expect primary care to deliver an expensive set of services—integrating mental health, integrating oral health, integrating CMM, integrating and being responsive to social vulnerabilities—all on 5 cents on the dollar. "And in fact, that primary care spend has been declining. Between 2002-2016, primary care spending accounted for 6.5% of total spending and declined to 5.4% of all spending in 2016.[4] So clearly, we've got a lot of work to do."

Nevertheless, states have been making some progress in putting more dollars into primary care. Greiner points to evidence from the National Academies of Science, Engineering and Medicine that if we put more resources into primary care, we can improve population health and equity. "No other part of the health care system can say that. And these recommendations particularly on the payment front are really being embraced by the community. And I think we can be very excited about that."

Value, not short-term gains

To advance value-based models, including CMM, we need to look at value, not costs, Greiner says. "And I think to our peril, we have focused too much on costs." There's no overnight ROI. "I'd prefer for us to be looking at the 10-year window where you actually get primary care at the center of the delivery system, as it is in every well-functioning health system across the globe. *Then,* they're in the position to really deliver on ROI and really be accountable for total cost of care."

She points out that the National Academies report pushed back on the notion of short-term ROI. "It's a real conversation that we need to have in our community."

Chicken and egg: reform payment models or reward outcomes?

A more immediate task is to reform payment models in a way that supports an already-overwhelmed primary care system. "Primary care can barely lift their heads up. It's two hours of documentation for every one hour of care. And the hamster wheel seems to go faster and faster every year." There's no time in a typical 15-minute visit to thoroughly discuss a new medication and how it fits into all the other medications a patient is taking.

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Ann Greiner, President & Chief Executive Officer, Primary Care Collaborative

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1 Health Care Payment Learning & Action Network. *Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicaid, Medicare Advantage, and Traditional Medicare Programs.* October 24, 2019

2 Bethke M, Gordon R, Elsner N, Varia H. Equipping physicians for value-based care: What needs to change in care models, compensation, and decision-making tools? Deloitte Center for Health Solutions. October 2020. https://www2.deloitte.com/us/en/insights/industry/health-care/physicians-guide-value-based-care-trends.html/#endnote-sup-2

3 Martin S, Phillips RL, Petterson S, Levin Z, Bazemore AW. Primary Care Spending in the United States, 2002-2016. *JAMA Intern Med.* 2020;180(7):1019–1020. doi:10.1001/jamainternmed.2020.1360

4 Ibid.

> **"So, I'm very optimistic that if we change the payment model, we're really going to make some headway here."**
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> *Ann Greiner, President & Chief Executive Officer, Primary Care Collaborative*

"We've got to reform that payment model, so the focus is on patient outcomes." If the focus is on patient outcomes, you're going to have longer visits. You're also going to provide care in so many new and creative ways to try to optimize those patient outcomes. "So, I'm very optimistic that if we change the payment model, we're really going to make some headway here," Greiner says.

But that's a big "if." It's a bit of a chicken-and-egg conundrum, Pham says. Are you waiting for practices to *want* to be in value-based payment before moving the payment model forward? Or are you going to have the payers make value-based payment models available to encourage practices to take part? "So, from the payer side, we still have room to go. But from the practice side, I think that the pandemic has brought to light how non-sustainable fee-for-service could be in the future."

Ready for change

Primary care clinicians' experience with COVID has left many ready to make some bold changes. "They suffered a lot: $15 billion in losses in 2020. And fee-for-service payment didn't really work when nobody could come into their offices." In fact, Greiner points to a recent survey from the Green Center and PCC that showed that 46% of primary care clinicians support either value-based payments or capitation as most able to support primary care.[5]

If we want to advance the physicians' understanding of the value and utility of CMM, we need to offer it as "a solution to the clinician burnout and the workforce shortage, a solution to the ongoing need for better team and practice efficiency, a solution to the challenge of having patients reach their targeted goals," says Pham. We need to show the value of having a real partner "so that the onus isn't on any one particular individual of the team."

Part of that involves delivering an unambiguous message that CMM involves so much more than adherence, she says. "There's unrealized value that could be bringing in not just performance-based incentives but better patient outcomes."

Greiner agrees and points to another area that needs attention. "Part of our challenge is that we still train our professionals mostly in silos. And so, unfortunately, a lot of physicians don't really know how working in a team-based manner can really enhance their ability to meet patient needs." Reforming the way we educate health professionals is an immense undertaking—even more challenging than payment reform, she says.

But we don't have to wait.

Opportunities to leverage CMM through CMMI payment models

Interprofessional teams can optimize medication use and advance CMM in practice by understanding the opportunities in evolving value-based payment models. Many of those opportunities are offered through the Center for Medicare and Medicaid Innovation. (See sidebar on pages 2-3 for examples)

Pham and Greiner offer this advice: To reform primary care payment and financing in a way that fosters more comprehensive care—including CMM integration—focus on working with CMMI and others to shape the new primary care payment models.

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> *Kathy Pham, Pharm.D., BCPPS, Director, Policy and Professional Affairs, American College of Clinical Pharmacy (ACCP)*

[5] Quick COVID-19 Primary Care Survey: Series 27, March 12-17, 2021. Larry A. Green Center/Primary Care Collaborative. March 2021. Accessed October 10, 2021. https://static1.squarespace.com/static/5d7ff8184cf0e01e4566cb02/t/605cedb87d4f0745a4520e2b/1616702905239/C19+Series+27+National+Executive+Summary+vF.pdf

> **"Obviously, sustainability is important, but we have to do what's right."**
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Ultimately, Pham says, the goal needs to be optimal patient care, not chasing CMMI's incentive payment goals. "Obviously, sustainability is important, but we have to do what's right." And what's right is to ensure that those patients who have so many chronic conditions, who consume so much of the health care, demand and account for so many of the costs, are getting healthier.

Act now

Both Pham and Greiner call on their constituencies to actively support practice and payment transformation.

Team-based advocacy will strengthen primary care, and Greiner calls on other professionals to add their voices. "We will work to incorporate CMM into our payment models so that we can make the difference we all want to make in terms of patient outcomes, equity and affordability."

Those who benefit from the status quo are powerful, and they don't particularly want changes, she warns. "If we want to make changes, we have to come together with a single ask and a unified vision, and we need to engage and advocate as a team of care professionals in advocacy to achieve it. It's going to take a village to achieve bold, transformative payment care."

Pham agrees and encourages clinical pharmacists to be proactive. "Don't wait to get invited." Clinical pharmacists need to help clinicians understand how they can contribute to team-based care to achieve medication optimization. "It's not just about using a regimen correctly; it's about making sure that we have all the information and expertise needed to make the most informed choices for our patients." GTMR

About the Experts

Ann Greiner
President & Chief Executive Officer
Primary Care Collaborative (PCC)

Ann Greiner serves as President and Chief Executive Officer of the Primary Care Collaborative (PCC) where she is focused on defining and implementing an advocacy, research and education agenda that furthers comprehensive, team-based and patient-centered primary care.

Ms. Greiner is a well-recognized leader in the quality field and has worked at a number of prestigious national organizations. Prior to joining the PCC in 2017, she served as Vice President of Public Affairs for the National Quality Forum (NQF) where she increased the visibility and influence of NQF on Capitol Hill. She also served as Deputy Director at the National Academies of Medicine, contributing to the Quality Chasm series of reports and related conferences. Ms. Greiner has also held leadership positions at NCQA and the American Board of Internal Medicine.

She has a master's degree in Urban Planning from the Massachusetts Institute of Technology and a Bachelor of Arts degree in English Literature from Hobart and William Smith Colleges.

(continued on page 8)

About the Experts

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

Kathy Pham is the director of policy and professional affairs at the American College of Clinical Pharmacy (ACCP), a professional and scientific society that provides leadership, education, advocacy and resources enabling clinical pharmacists to achieve excellence in practice, research and education. Dr. Pham came to ACCP from the Pew Charitable Trusts, where she served as senior officer of the Drug Safety Project. Her previous clinical experience has been in pediatric pharmacy practice, with the majority of that time spent as the NICU clinical specialist and pharmacy residency director at Children's National Medical Center in Washington, D.C. She is also a board-certified pediatric pharmacotherapy specialist.

Dr. Pham earned her Doctor of Pharmacy degree from Rutgers, the State University of New Jersey. After completing her pharmacy residency at the University of Illinois at Chicago, she practiced as a pediatric clinical pharmacist and held faculty appointments at various schools of pharmacy including Long Island University, Rutgers, Creighton University, University of Maryland and Virginia Commonwealth University.

Dr. Pham leads ACCP's engagement, collaboration and communication with medical, pharmacy, other health professional societies, health quality organizations and payers/purchasers to promote and help achieve medication optimization for individual patients and populations. She participates as the ACCP representative in working groups and task forces of health policy development and research enterprises at the national level that address issues of interprofessional practice, research and education.

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About the GTMRx Institute

The GTMRx Institute is a catalyst for change that brings critical stakeholders together, bound by the urgent need to get the medications right. We are physicians, pharmacists, caregivers, health IT innovators, drug and diagnostics companies, consumer groups, employers, payers and health systems—aligned to save lives and save money through comprehensive medication management, or CMM. By showcasing evidence and innovation, we motivate practice transformation and push payment and policy reform. Together, we ACT to champion appropriate, effective, safe and precise use of medication and gene therapies. Learn more at gtmr.org.

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