Disclosure and Conflict of Interest

I have the following financial relationships to disclose: Employee of Pharmacy Quality Solutions

Pharmacist Objectives

At the conclusion of this program, the pharmacist will be able to:
1. Describe key pharmacy quality measures that pharmacies can impact in 2017 and 2018
2. Describe how quality metrics are calculated
3. Outline how to best position your pharmacy for success in quality improvement programs and value-based reimbursement opportunities
4. Implement a plan of action on how to incorporate quality performance into the workflow process

Pharmacy Quality Measures: What They Are and How Community Pharmacies Can Impact Them in Their Practice

Zac Rentro, PharmD, Pharmacy Quality Consultant Pharmacy Quality Solutions
At the conclusion of this program, the technician will be able to:
1. Describe key pharmacy quality measures that pharmacies can impact in 2017 and 2018
2. Describe how quality metrics are calculated
3. Describe how pharmacy technicians can play a role in improving pharmacy quality measures

The Shift to Value-Driven Healthcare

"Value" is the balance of quality and costs.
Value is optimized by improving quality while reducing costs

Pre-Test Questions: Yes or No?

1) Beneficiaries can move between any Part D Medicare plans without penalty at any time
2) The Star Rating thresholds a plan must reach are equivalent across all quality metrics
3) PDC (proportion of days covered) is the adherence metric used by CMS
4) Pharmacies and Health Plans both receive Star Ratings from CMS

The Shift to Value-Driven Healthcare

Forbes  Pharma & Healthcare

White House Plans To Shift Medicare Away From Fee-For-Service; 50% Of Payments Tied To Quality By 2018

The White House wants the Medicare program to shift away from fee-for-service payments and focus more on savings, quality of care, and cost savings. This shift towards value-based payments is expected to improve outcomes for Medicare beneficiaries and reduce costs. The move to value-based payments could result in higher quality care and more efficient use of healthcare resources. The goal is to achieve 50% of payments tied to quality by 2018.
**The Shift to Value-Driven Healthcare**

**Not Just Medicare!**

- HHS has set a goal of tying 90 percent of all Medicare fee-for-service to quality or value by 2018.
- At 85 percent as of 2016
- Aetna Commercial has targeted 75 percent of their spend to be in value-based contracts by 2020


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**Pharmacy Quality Alliance (PQA)**

Develops, tests, validates, and endorses medication-related quality metrics

**Who adopts these measures?**

- CMS Part D Plan Ratings
- URAC accreditation programs
- National Business Coalition on Health (NBCH)
- State/Federal Exchange

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**Medicare Star Ratings**

- Annual ratings of Medicare plans that are made available on Medicare Plan Finder and CMS website (began in 2008)
- 2 year data lag; 2017 Ratings represent 2015 performance
- Ratings are displayed as 1 to 5 stars
- Stars are calculated for each measure, as well as each domain, summary, and overall (applies to MA-PDs) level

<table>
<thead>
<tr>
<th>Overall (MAPD)</th>
<th>Summary</th>
<th>Domain</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

[In 2017 - 32 Part C; 15 Part D]

Ratings of all Medicare plans can be found at:
[http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGrnts/PerformanceData.html](http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGrnts/PerformanceData.html)

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**2017 CMS Stars: Part D**

Medicare drug plans receive a summary rating on quality as well as four domains, and individual measures (15 individual measures)

- Five measures are from PQA (2017): 2 measures of medication safety or MTM
  - High-risk medication use in the elderly
  - Will move to display measure in 2018
  - Plans continue to evaluate pharmacy on HRM in some performance programs
- CMR Completion Rate
  - Added in 2016

- 3 measures of medication adherence (PDC)
  - Non-insulin diabetes medications
  - Cholesterol medication (statins)
  - Blood pressure (renin-angiotensin system antagonists)

Due to the higher weighting of clinically-relevant measures, these PQA measures account for 42% of Part D summary ratings in 2017
Medicare Part D: Display Measures

- Display measures are not part of the Star Ratings, but are used to provide benchmarks and feedback to plans.
- CMS also monitors display measures to assess plan performance; poor performance can lead to compliance actions by CMS.
- Display measures (from POA):
  - Drug-Drug Interactions
  - Excessive doses of oral diabetes medications
  - HIV antiretroviral medication adherence (only in safety reports)
  - Statin Use in Persons with Diabetes (will remain a display measure thru 2018)
    - Slated to move to a scored measure in 2019
    - Plans are already evaluating pharmacy on SUPD in some performance programs

Future Changes to Star Ratings Metrics 2018 & Beyond

- **Asthma Measure Suite**
  - NCDM is currently testing three asthma measures for members 5-64 years of age
    - Use of Appropriate Medications for People with Asthma
      - Asthma Medication Rate

- **Antipsychotics evaluation**
  - Antipsychotic use in persons with dementia
    - Slated as 2016 Display measure

- **Opioid Overutilization**
  - Use of opioids from multiple providers or at high dosage in persons without cancer
    - Slated as 2019 Display measure

- **Drug-Drug Interactions**
  - Currently a display measure

2016/2017 MAPD Star Thresholds

<table>
<thead>
<tr>
<th>MAPD</th>
<th>2016/2017 5 Star</th>
<th>Change</th>
<th>2016/2017 4 Star</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cholesterol PDC (Statins)</td>
<td>79% / 82%</td>
<td>+3 points</td>
<td>73% / 77%</td>
<td>+4 points</td>
</tr>
<tr>
<td>Diabetes PDC (Non-insulin)</td>
<td>82% / 83%</td>
<td>+1 point</td>
<td>75% / 79%</td>
<td>+2 points</td>
</tr>
<tr>
<td>Hypertension PDC (RASA)</td>
<td>81% / 83%</td>
<td>+2 points</td>
<td>77% / 79%</td>
<td>+2 points</td>
</tr>
<tr>
<td>HRA High Risk Medication Use in Elderly</td>
<td>&lt;6% / &lt;3%</td>
<td>-3 point</td>
<td>&lt;8% / &lt;5%</td>
<td>-3 point</td>
</tr>
<tr>
<td>CMR Completion Rate</td>
<td>76% / 76.8%</td>
<td>+0.8 points</td>
<td>48.6% / 56.1%</td>
<td>+9.5 points</td>
</tr>
</tbody>
</table>

2016/2017 PDP Star Thresholds

<table>
<thead>
<tr>
<th>PDP</th>
<th>2016/2017 5 Star</th>
<th>Change</th>
<th>2016/2017 4 Star</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cholesterol PDC (Statins)</td>
<td>83% / 84%</td>
<td>+1 points</td>
<td>83% / 82%</td>
<td>-1 point</td>
</tr>
<tr>
<td>Diabetes PDC (Non-insulin)</td>
<td>95% / 86%</td>
<td>-9 points</td>
<td>83% / 82%</td>
<td>-1 point</td>
</tr>
<tr>
<td>Hypertension PDC (RASA)</td>
<td>85% / 85%</td>
<td>No change</td>
<td>82% / 83%</td>
<td>+1 point</td>
</tr>
<tr>
<td>HRA High Risk Medication Use in Elderly</td>
<td>&lt;6% / 63%</td>
<td>No change</td>
<td>&lt;10% / &lt;8%</td>
<td>-2 points</td>
</tr>
<tr>
<td>CMR Completion Rate</td>
<td>36.7% / 51.6%</td>
<td>+14.9 points</td>
<td>27.2% / 33.9%</td>
<td>+6.7 points</td>
</tr>
</tbody>
</table>

How Does This Affect Health Plans?

- Enrollment Implications
  - Quality Bonus Payments (MA-PD)
  - High performers identified on CMS website
  - Poor performers identified on CMS website
  - Removal from Medicare for continued poor overall performance (< 3 stars for 3 years in a row)

Importance of Star Ratings – For Plans

<table>
<thead>
<tr>
<th>MA-PD Plans</th>
<th>PDP Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Additional revenue in the form of quality bonus payments provided to top performing plans</td>
<td>• Marketing opportunities</td>
</tr>
<tr>
<td>• Revenues used to support initiatives and to keep member premiums low</td>
<td>• Extended open enrollment periods</td>
</tr>
<tr>
<td>• Bonus payments necessary to maintain competitive stance in marketplace</td>
<td>• Penalty for consistent poor performance</td>
</tr>
<tr>
<td>• Marketing opportunities</td>
<td>• PDP plans are not eligible to receive quality bonus payments</td>
</tr>
<tr>
<td>• Extended open enrollment periods</td>
<td></td>
</tr>
<tr>
<td>• Penalty for consistent poor performance</td>
<td></td>
</tr>
</tbody>
</table>

How Are Health Plans Responding?

- Formulas, clinical strategies, network contracts, marketing/promotions, all aligning with Star Ratings measures
- Plans are making significant investments in “Drive to 5”
- Recognizing the importance of engagement strategies with pharmacy networks, physicians, and other providers including the use of performance-based incentives

How is this Impacting Pharmacies?

- Preferred network implications
- Potential reimbursement implications
- Pay-for-Performance (P4P) bonus payment programs
- Quality-Based Networks (QBNs)
The Evolving Roles in Community Pharmacy

New & expanded services/roles in the community pharmacy:
- Immunizations
- MTM
- Point of care testing
- Disease state management
- Transition of care management
- Adherence management
- Provider status
- Chronic Care Management

What can community pharmacies do to succeed in this type of healthcare environment?

Examples of Strategies Employed

Incentive/Performance Programs— may vary in how each are created, how payment is delivered and calculated
- IEHP (southern CA) – nearly $1M paid out in first year to approx. 400 participating pharmacies
- Healthfirst of NY (pilot) – over $100K paid to over 100 pharmacies for participation in the pilot
- Caremark Performance Network Program (national)
- UHC pilot (SC & GA) – true P4P started in 2016 and continued in 2017
- UHC pilot (TX) – starting this year as a modified version of the program in SC & GA
- Prime Quality Bonus Network (QBN) - for participating Blues Plans

This as an opportunity to improve the quality of care for your patients as well as gain incentive dollars that can be used to strengthen your pharmacies infrastructure, update dispensing system, add staff members, etc...

How much $ is on the line?

- Nearly all community pharmacies have at least one payer that has moved to quality-based incentives, and many pharmacies are affected by 3 or more of these programs
- Regionally-focused plans have their patients concentrated in a small group of pharmacies (e.g., <300 stores) and thus these stores have “opportunity” related to quality in the range of $15,000 to $30,000 per store per year from a regional plan
- National plans may use a combination of bonus payments and DIR adjustments, and the $$ become more difficult to quantify
- Pharmacies with moderate-sized Medicare patient volumes (150-300 Medicare patients) should expect that they will have $25K to $75K per year at stake in quality-based incentives other than MTM starting in 2017

Caremark Performance Network Program (national)
Focus on Adherence

“Drugs don’t work in patients who don’t take them.”

- **Adherence**: the extent to which patients take medications as prescribed by their healthcare providers
- **Non-Adherence**: to medication regimens is a very common, costly & complex issue
  - Encompasses a wide array of behaviors, both intentional and unintentional, which may lead to an overdose or underuse of medication.
- Barriers to adherence are varied & individual and may include:
  - Medication Cost
  - Acceptance of disease state
  - Fear of side effects
  - Health literacy
  - Forgetfulness
  - Complex drug regimen
  - Difficulty with medication technique (inhalers, injections)
  - Socio/Cultural factors

Community Pharmacists Can Affect Adherence Rates

- Engage with your patients
  - Screen high priority patients to identify non-adherence risk
  - Talk to your Medicare patients on cholesterol, diabetes, or RASA medications
  - Offer patient-centric educational documents as supportive materials
  - Ask directly if they have any of these concerns, contact provider and offer suggestions & alternatives as appropriate:
    - Side effects, costs, lack of effectiveness (I.e., isn’t really helping me)
- Implement Med Synchronization Program and/or Adherence Packaging
  - Start with a few “high priority” patients (e.g., diabetics enrolled in Medicare plans that have a P4P program)
  - Use Time My Meds ABM for more comprehensive RX review or med checkup
    - Med Sync typically increase RX volume per medication
  - Focus on Medicare patients with diabetes

Using Technology for Quality Measurement

- What quality solutions are your pharmacy engaging in today?
  - Med Sync, refill reminders (Ex: Appointment based model)
  - MTM activities, including CMR activities Patient centered care
  - Disease state management

- What information does the pharmacist need to get the conversation regarding medication use started?

- Will the pharmacy staff play a role in moving quality forward?
  - Is staff educated on their role?
  - Teamwork is essential

Positioning your Pharmacy

- How to best position your pharmacy for success in quality improvement programs and value-based reimbursement opportunities
  - Leverage resources (adherence example)
    - Prospective / Proactive
    - Technicians
    - Packaging
    - Medication Synchronization
    - Adherence handout
    - Barrier to adherence
    - Team approach
Plan of Action

- Understand the challenge of moving toward a culture of quality
- Assessment
  - Where are you today & where do you want to be tomorrow?
- Survey Resources
  - One size does not fit all
- Review Alternatives
  - What is best for YOUR pharmacy and patients
- Commit to the plan to achieve your goals
  - This alone can impact your performance for Value-Based Networks

Plan of Action

- Prospective actions to “plan” for quality continuous assessment
  - of data to evaluate appropriateness of the plan
- Training / Training / Training
  - This time will pay off in the long term
- System/Structure
- Process (how care is provided to the patient)
- Outcomes – what are you striving for
  - Need both structure AND process to change

Plan of Action

- Consistency of work flow process
  - Add a new philosophy of Quality and performance
    - The triple check is not a quality innovation nor a patient centric process
- Continuous Improvement
- Empower entire pharmacy team to be quality driven
- Cannot change all at one time
  - Focus on a specific area instead of all at once
- Review and re-evaluate the plan regularly

Post Test: Question #1

Benefits can move between any Part D Medicare plans without penalty at any time

False. Beneficiaries can’t switch their Part D plans during open enrollment unless they are moving from a lower-Star plan to a 5-Star plan.
Post Test: Question #2

The Star Rating threshold a plan must reach are equivalent across all quality metrics

FALSE. Each measure has their own specific threshold it must meet for each Star Rating.

Post Test: Question #3

PDC (proportion of days covered) is the adherence metric used by CMS.

TRUE. PDC is the “gold standard” way to measure adherence, as used by CMS and PQA.

Post Test: Question #4

Pharmacies and Health Plans both receive Star Ratings from CMS

FALSE. Health plans are the only ones that receive Star Ratings. Pharmacies currently do not have Star Ratings.

Take Home Points

Quality metrics are driving action amongst health plans and PBMs. Pharmacies are being evaluated on quality measures related to Part D stars.

- A growing number of prescription drug plans are implementing performance-based incentives for network pharmacies:
  - Pay-for-performance models that include bonus payments to top-performing pharmacies
  - Preferred networks that include star-performance as a criterion for inclusion as a preferred pharmacy
- Pharmacies need to track their quality to compete in a value-based contracting environment
  - Now is the time to start assessing whether your pharmacy is meeting quality goals and how you rank compared to peers
- EQuIPP continues to expand the number of plans and pharmacies who use this platform as a “neutral intermediary” for calculation of pharmacy quality scores
  - Utilize this tool to ensure you have all of the data possibly available to improve the quality performance at your pharmacy
Resources & References

- World Health Organization. www.who.int/

Speaker Contact Information

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