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BRIDGING THE FUTURE OF PHARMACY 2022

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Quality 101: Understanding and Leveraging Value Based Care

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Disclosures

- The presenter for this activity has been required to disclose all relationships with any proprietary entity producing health care goods or services, with the exemption of non-profit or government organizations and non-health care related companies.

- No significant financial relationships with commercial entities were disclosed by the speakers.

Objectives

- Review important concepts and examples of quality programs
- Identify quality metrics pharmacists can impact
- Discuss ways in which pharmacists can become involved in supporting quality and value-based reimbursement programs

Fee for Service vs Value- Based Care

- Change from Fee for Service to Value Based Care Model
  - Model change has increased since the passage of the Affordable Care Act in 2010
  - Emphasizes quality and efficiency of care delivered rather than the number of services delivered.
  - Recognizes commitment to patients' health
  - Compensates providers for the high-quality, complex care they deliver
- Why Focus on Quality?
  - Better care for individuals
  - Better health for populations
  - Lower cost

Hospital Value-Based Purchasing (VBP) Program

Value-Based Purchasing (VBP) Program

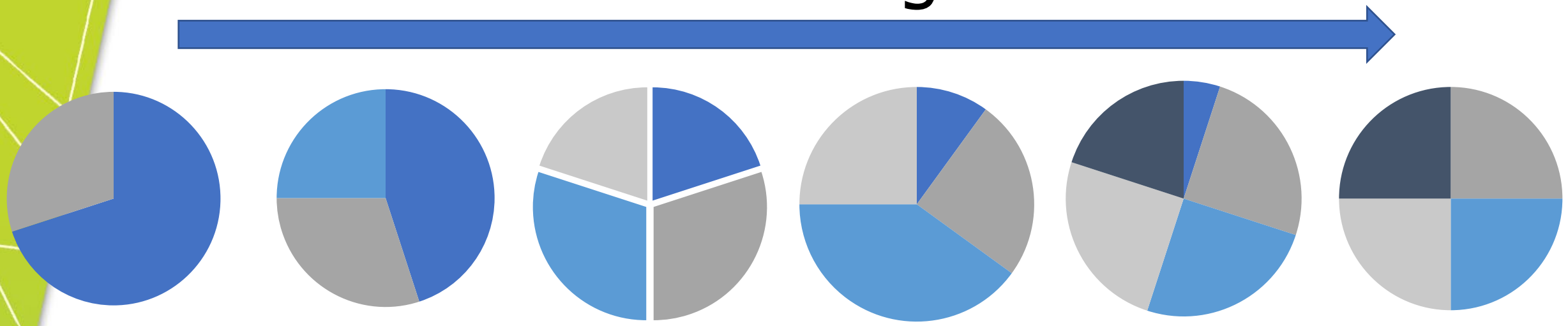
- The Hospital VBP Program is designed to make:
  - The quality of care better for hospital patients.
  - Hospital stays a better experience for patients.

- The Hospital VBP Program encourages hospitals to improve the quality, efficiency, patient experience and safety of care that Medicare beneficiaries receive during acute care inpatient stays by:
  - Eliminating or reducing adverse events (healthcare errors resulting in patient harm).
  - Adopting evidence-based care standards and protocols in order to obtain the best outcomes for Medicare patients.
  - Incentivizing hospitals to improve patient experience.
  - Increasing the transparency of care quality for consumers, clinicians, and others.
  - Recognizing hospitals that provide high-quality care at a lower cost to Medicare.

Program Incentives

- The program withholds 2.00% of total Medicare DRG (diagnosis-related group) reimbursement from hospitals, and disperses back to hospitals based on performance (program incentives)
  - FY 2013: 1.00 %
  - FY 2014: 1.25 %
  - FY 2015: 1.50 %
  - FY 2016: 1.75 %
  - FY 2017 +: 2.00 %
- To put it in perspective… National Health Expenditure (NHE) in 2019 = $3.8 trillion
  - Medicare spending in 2019 = $799.4 billion, 21% of total NHE

Value Based Purchasing



CY2013	CY2014	CY2015	CY2016	CY2017	CY2018 and beyond
• Affects 1% reimburse-ment	• Affects 1.25% • Adds outcome	• Affects 1.5% • Adds efficiency	• Affects 1.75% • ↑outcome weight • ↓clinical process of care weight	• Affects 2% • Adds safety	• Affects 2% • Removes clinical process

Value Based Purchasing

Domains	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018 +
Process of Care	70%	45%	20%	10%	5%	0%
Patient Experience of Care (HCAHPS Composite)	30%	30%	30%	25%	25%	25%
Outcome (Clinical Care)	0%	25%	30%	40%	25%	25%
Efficiency/ Cost Reduction	0%	0%	20%	25%	25%	25%
Safety	0%	0%	0%	0%	20%	25%
Total Performance Score (TPS)	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Domain Measures

- How to measure these value?

Efficiency

- Medicare spending per beneficiary (MSPB-1)

Experience of care

- HCAHPS Survey

Safety

- Healthcare-Associated Infections
  - CLABSI, CAUTI, SSI, MRSA, CDI

Clinical Outcomes

- Elective TKA/THA Complication Rate
- 30-Day Mortality (AMI, HF, COPD, PNA)

Experience of Care Domain

- What is an HCAHPS Survey?
  - Post-discharge evaluation of experience sent to patients
- Components of HCAHPS
  - Communication with Nurses
  - Communication with Doctors
  - Responsiveness of Hospital Staff
  - Pain Management
  - Communication about Medicines
  - Hospital Cleanliness & Quietness
  - Discharge Information
  - Care Transition Measures
  - Overall Rating of Hospital

Domain Measures FY 2023

FY 2023 Hospital Value-Based Purchasing Program Quick Reference Guide

Payment adjustment effective for discharges from October 1, 2022 to September 30, 2023

Clinical Outcomes — 25%

Mortality Measures

Baseline Period: July 1, 2013–June 30, 2016
Performance Period: July 1, 2018–June 30, 2021*

Measure ID	Measure Name	Achievement Threshold	Benchmark
MORT-30-AMI	Acute Myocardial Infarction 30-Day Mortality	0.866548	0.885499
MORT-30-CABG	Coronary Artery Bypass Graft Surgery 30-Day Mortality	0.968747	0.979620
MORT-30-COPD	Chronic Obstructive Pulmonary Disease 30-Day Mortality	0.919769	0.936349
MORT-30-HF	Heart Failure 30-Day Mortality	0.881939	0.906798
MORT-30-PN	Pneumonia 30-Day Mortality	0.840138	0.871741

Complication Measure

Baseline Period: April 1, 2013–March 31, 2016
Performance Period: April 1, 2018–March 31, 2021*

Measure ID	Measure Name	Achievement Threshold	Benchmark
⇩ COMP-HIP-KNEE	Total Hip Arthroplasty/Total Knee Arthroplasty Complication	0.027428	0.019779

Person and Community Engagement — 25%

Baseline Period: Jan. 1, 2019–Dec. 31, 2019
Performance Period: Jan. 1, 2021–Dec. 31, 2021

HCAHPS Survey Dimensions	Floor (%)	Achievement Threshold (%)	Benchmark (%)
Communication with Nurses	53.50	79.42	87.71
Communication with Doctors	62.41	79.83	87.97
Responsiveness of Hospital Staff	40.40	65.52	81.22
Communication about Medicines	39.82	63.11	74.05
Hospital Cleanliness and Quietness	45.94	65.63	79.64
Discharge Information	66.92	87.23	92.21
Care Transition	25.64	51.84	63.57
Overall Rating of Hospital	36.31	71.66	85.39

Domain Measures FY 2023

Safety — 25%

Patient Safety Composite

Baseline Period
Oct. 1, 2015–June 30, 2017

Performance Period
July 1, 2019–June 30, 2021*

Measure ID	Measure Name	Achievement Threshold	Benchmark
☆⇩ PSI 90	Patient Safety and Adverse Events Composite	0.963400	0.761590

Healthcare-Associated Infections

Baseline Period
Jan. 1, 2019–Dec. 31, 2019

Performance Period
Jan. 1, 2021–Dec. 31, 2021

Measure ID	Measure Name	Achievement Threshold	Benchmark
⇩ CAUTI	Catheter-Associated Urinary Tract Infection	0.650	0.000
⇩ CDI	Clostridium *difficile* Infection	0.520	0.014
⇩ CLABSI	Central Line-Associated Bloodstream Infection	0.589	0.000
⇩ MRSA	Methicillin-Resistant Staphylococcus *aureus*	0.726	0.000
⇩ SSI	Colon Surgery	0.717	0.000
	Abdominal Hysterectomy	0.738	0.000

Efficiency and Cost Reduction — 25%

Baseline Period
Jan. 1, 2019–Dec. 31, 2019

Performance Period
Jan. 1, 2021–Dec. 31, 2021

Measure ID	Measure Name	Achievement Threshold	Benchmark
⇩ MSPB	Medicare Spending per Beneficiary	Median MSPB ratio across all hospitals during the performance period	Mean of lowest decile of MSPB ratios across all hospitals during the performance period

Total Performance Score

Each hospital may earn <u>two</u> scores for each domain.

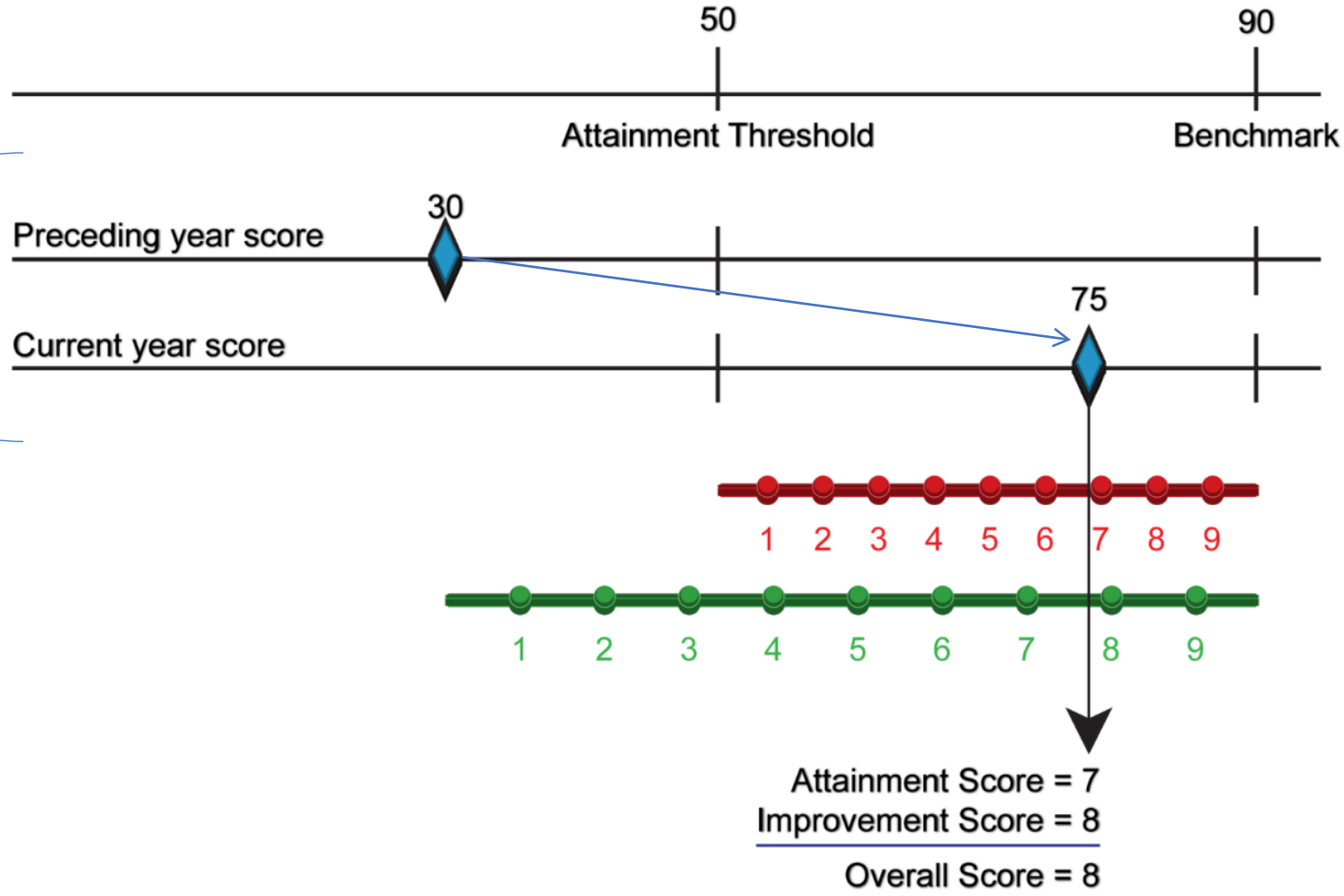
- **Achievement points** = compare to other hospitals during performance period
- **Improvement points** = comparing your hospital's rates during performance period to your rates during baseline period

- **Consistency points** = reward hospitals that have scores above the national 50th percentile in ALL 8 dimensions of HCAHPS survey
  - Incorporated into the **Patient Experience Domain** score **ONLY**

Total Performance Score = top score out of the two x weighted percentage

Domain Score

Not as simple as "preceding year" and "current year"

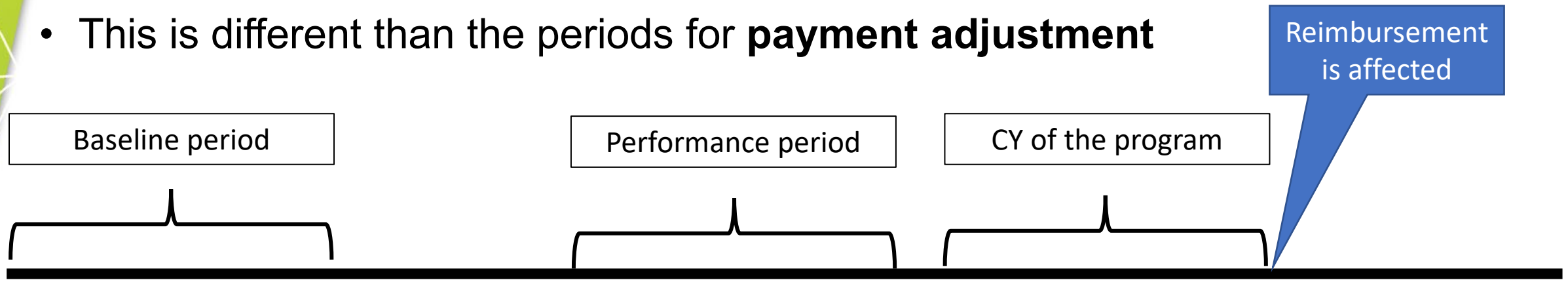


Comparison Periods – FY 2018

Domains	Baseline Period	Performance Period
Patient Experience of Care (HCAHPS Composite)	Jan 1, 2014-Dec 31, 2014	Jan 1, 2016-Dec 31, 2016
Outcome (Clinical Care)	Oct 1, 2009-June 30, 2012	Oct 1, 2013-June 30, 2016
Efficiency	Jan 1, 2014-Dec 31, 2014	Jan 1, 2016-Dec 31, 2016
Safety- AHRQ PSI-90 Composite	July 1, 2010-June 30, 2012	July 1,2014-June 30, 2016
Safety- Healthcare-Associated Infections/ PC-01, SSI, PSI-90	Jan 1, 2014- Dec 31, 2014	Jan 1, 2016-Dec 31, 2016

Value Based Purchasing - Points

- Comparison – where and when?
  - Achievement points – compared to other hospitals in **performance** period
  - Improvement points and consistency points – compares **baseline** period performance to **performance** period at the same hospital
- This is different than the periods for **payment adjustment**



Hospital Readmission Reduction Program (HRRP)

Hospital Readmission Reduction Program (HRRP)

- Reduction of Inpatient Prospective Payment System payments for excess readmissions
- HRRP encourages hospitals to improve communication and care coordination efforts to better engage patients and caregivers, with respect to post-discharge planning.
- Focus on 30 day window post discharge
  - Improve care transitions
  - Decrease hospital acquired conditions

Hospital Readmission Reduction Program (HRRP)

- Calculations are complex
- Excess readmission ratio = risk-adjusted predicted readmissions/risk-adjusted expected readmissions
- Ratio = 1 - (Aggregate payments for excess readmissions/ Aggregate payments for all discharges)
- Readmissions Adjustment Factor =
  - For FY 2013, the higher of the Ratio or 0.99 (1% reduction)
  - For FY 2014, the higher of the Ratio or 0.98 (2% reduction)
  - For FY 2015, the higher of the Ratio or 0.97 (3% reduction)

Hospital Readmission Reduction Program (HRRP)

Effective Program Year	30-day Readmission Measures
FY 2013 and FY 2014	• Acute myocardial infarction (AMI) • Heart Failure (HF) • Pneumonia
FY 2015 and FY 2016	• Above Measures • Chronic obstructive pulmonary disease (COPD) • Elective primary total hip and/or total knee arthroplasty (THA/TKA)
FY 2017- FY 2020	• Above Measures • Coronary Artery Bypass Graft (CABG) surgery

Hospital Readmission Reduction Program (HRRP)

- Understand the performance period!
  - For FY 2020, CMS calculates the payment adjustment factor and component results for each hospital based on their performance during the three-year performance period of July 1, 2015 through June 30, 2018.
  - Payment reductions are applied to all Medicare fee-for-service (FFS) base operating diagnosis-related group (DRG) payments between October 1, 2019 through September 30, 2020.
  - The payment reduction is capped at 3% (i.e., payment adjustment factor of 0.97).

Association of the Hospital Readmissions Reduction Program With Mortality Among Medicare Beneficiaries Hospitalized for Heart Failure, Acute Myocardial Infarction, and Pneumonia

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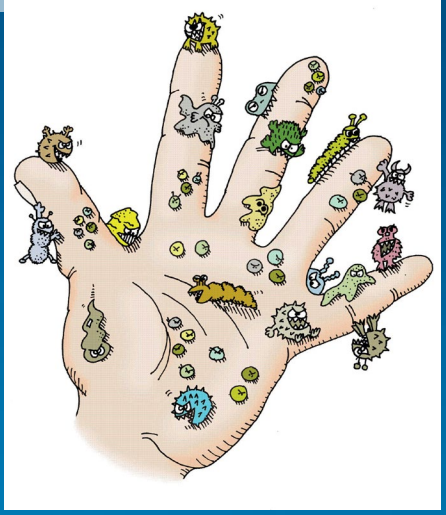
CONCLUSIONS AND RELEVANCE Among Medicare beneficiaries, the HRRP was significantly associated with an increase in 30-day postdischarge mortality after hospitalization for HF and pneumonia, but not for AMI. Given the study design and the lack of significant association of the HRRP with mortality within 45 days of admission, further research is needed to understand whether the increase in 30-day postdischarge mortality is a result of the policy.

JAMA. 2018;320(24):2542-2552. doi:10.1001/jama.2018.19232

across 4 periods from April 1, 2005, to March 31, 2015. Period 1 and period 2 occurred before the HRRP to establish baseline trends (April 2005-September 2007 and October 2007-March 2010). Period 3 and period 4 were after HRRP announcement (April 2010 to September 2012) and HRRP implementation (October 2012 to March 2015).

Hospital Acquired Conditions (HAC) Reduction Program



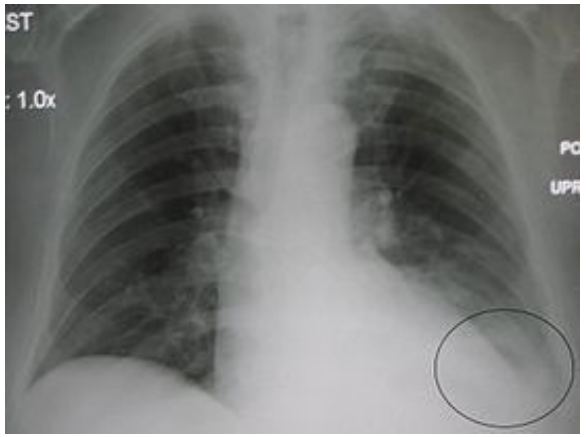
Hospital Acquired Conditions (HAC) Reduction Program

- Established by Section 3008 of the ACA
  - Incentive for hospitals to reduce HACs
  - Adjust payments to applicable hospitals that rank in the worst-performing quartile with respect to risk-adjusted HAC quality measures
  - Payments reduced to 99 percent of what would have been paid for such discharges
- "Group of reasonably preventable conditions that patients did not have upon admission to a hospital, but which developed during the hospital stay"
- Cost Control = increased quality of care

- Hospital-Acquired Condition (HAC) Reduction Program Hospital-Specific Report User Guide www.qualitynet.org

Hospital Acquired Conditions (HAC) Reduction Program

- The HAC Reduction Program saves Medicare approximately $350 million every year.
  - These savings come from reducing what we pay to hospitals that rank worst among other hospitals for how often their patients get hospital-acquired conditions.
- Hospitals with Total HAC Scores greater than the 75th percentile of all Total HAC Scores (i.e., the worst-performing quartile) will be subject to a 1 percent payment reduction.



Hospital Acquired Conditions (HAC) Reduction Program

- CMS Recalibrated Patient Safety Indicators (PSI) 90 (CMS PSI 90) measure score
- Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) hospital-associated infections (HAI) measure scores:
  - Central Line-Associated Bloodstream Infection (CLABSI)
  - Catheter-Associated Urinary Tract Infection (CAUTI)
  - Surgical Site Infection (Abdominal Hysterectomy and Colon Procedures) (SSI)
  - Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia
  - Clostridium difficile Infection (CDI)

Hospital Acquired Conditions (HAC) Reduction Program- CMS PSI 90

- The CMS PSI 90 measure includes the following ten CMS PSIs component measures:
  - PSI 03 – Pressure Ulcer Rate
  - PSI 06 – Iatrogenic Pneumothorax Rate
  - PSI 08 – In-Hospital Fall with Hip Fracture Rate
  - PSI 09 – Perioperative Hemorrhage or Hematoma Rate
  - PSI 10 – Postoperative Acute Kidney Injury Requiring Dialysis Rate
  - PSI 11 – Postoperative Respiratory Failure Rate
  - PSI 12 – Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate
  - PSI 13 – Postoperative Sepsis Rate
  - PSI 14 – Postoperative Wound Dehiscence Rate
  - PSI 15 – Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate

Hospital Acquired Conditions (HAC) Reduction Program

Measure	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
CMS PSI 90: Patient Safety for Selected Indicators	✓	✓	✓			
CMS PSI 90 Composite (modified version)				✓	✓	✓
CLABSI	✓	✓	✓	✓	✓	✓
CAUTI	✓	✓	✓	✓	✓	✓
SSI (colon and hysterectomy)	N/A	✓	✓	✓	✓	✓
MRSA bacteremia	N/A	N/A	✓	✓	✓	✓
CDI	N/A	N/A	✓	✓	✓	✓

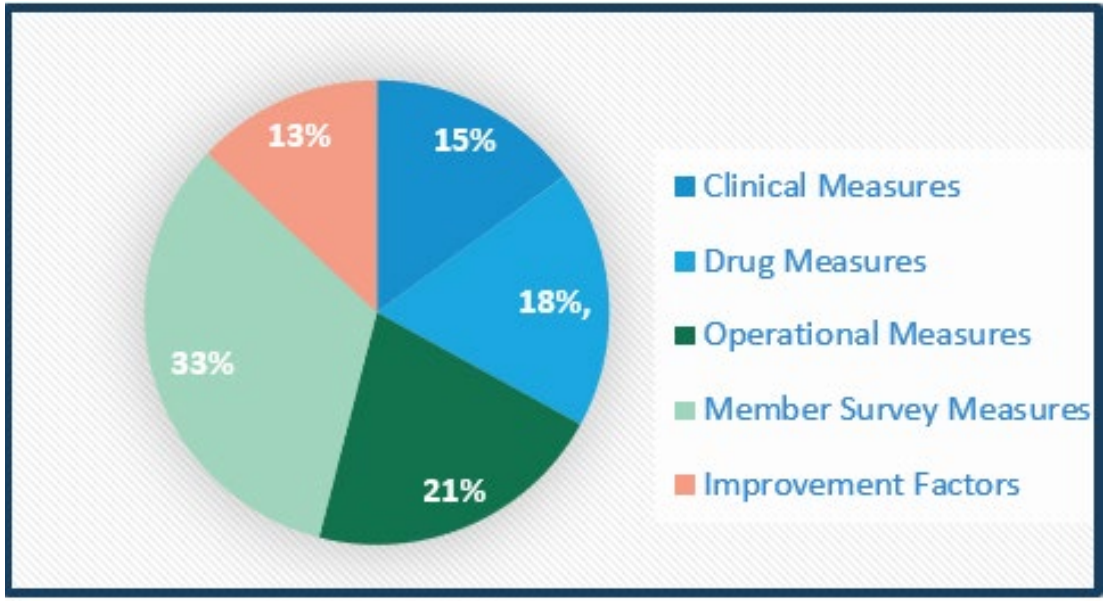
CMS STAR Rating

CMS Program Design

- Purpose of the Quality Rating Program:
  - Help consumers make informed healthcare decisions
  - Facilitate oversight of health plans
  - Provide actionable information to health plans to improve the quality of services they provide
- Uses a rating scale from 1-5
  - Health Plans scoring 4 Stars and higher receive an annual quality bonus payment
- Star Rating benchmarks are based on the collective performance of all Medicare Advantage Plans from across the country.

CMS Program Design

- Ratings are based on ~45 measures and broken down into 5 distinct categories
- Static Measures vs Dynamic Measures



HEDIS

- Healthcare Effectiveness Data and Information Set
- System of universally accepted clinical process and outcomes-based measures
- For all Part C measures

Example HEDIS Measures

- Comprehensive Diabetes Care: HbA1c Control (≤9%)
- Osteoporosis Management in Women Who Had a Fracture
- All-Cause Readmissions
- Medication Reconciliation Post Discharge

PQA

- Pharmacy Quality Alliance
- Requirements are intended to promote standardized documentation and reporting of healthcare processes, intermediate outcomes, or outcomes
- For Part D measures

Example PQA Measures

- Five PQA measures will be included in the 2023 Medicare Part D Star Ratings:

- Medication Adherence for Diabetes Medications
- Medication Adherence for Hypertension (RAS antagonists)
- Medication Adherence for Cholesterol (Statins)
- MTM Program Completion Rate for Comprehensive Medication Review (CMR)
- Statin Use in Persons with Diabetes

What?

- Wait, didn't you say the STAR ratings are for health plans?
- Health plans don't check A1Cs or blood pressures or Medication Reconciliation Post Discharge?
- How does that work?

CMS has programs for both payers and directly with providers. There are value-based programs to link provider performance of quality measures to provider payment.

CMS creates plan ratings that indicate the quality of Medicare plans on a scale of 1 to 5 stars with 5 stars being the highest rating.

- Plans have an incentive to score high because those with four or more stars get bonuses from the CMS.

Some of CMS' payer programs are then cascaded down to providers. For example, a payer will measure a provider on the metrics that CMS or HEDIS uses to measure the payer.

The overall star rating is determined through **numerous performance measures across several domains of performance**. Each measure is awarded a star rating and the individual measure stars are then aggregated at the domain and summary level.

Leveraging Value Base Care

Common Value Based Program Themes

Safety/ Experience

- Healthcare-Associated Infections
  - CLABSI, CAUTI, SSI, MRSA, CDI
- HCAHPS Survey
  - Pain Management
  - Communication about Medicines

Outcomes

- Elective TKA/THA Complication Rate
- 30-Day Mortality (AMI, HF, COPD, PNA)

Common Value Based Program Themes

Quality

- Star Measures: At least 19 Medicare Part D, Part C, and Hospital Measures are indirectly or directly related to medication management, and therefore impacted by pharmacist-led services
- HEDIS Measures – Common Examples: CDC – Comprehensive Diabetes Care HbA1c Control and Retinal Eye Exam & Comprehensive Diabetes Care – HbA1c Control (< 8%)

Cost

- Reducing Prescription Drug Spend
- Reducing Total Cost of Care
- Improving Chronic Disease State Management
- Improving Coordination of Care
- Improving Utilization Measures: Readmissions All Cause (30 d) & ED Utilization Rate

Example Measure & Description
Comprehensive Diabetes Care: HbA1c Control (≤9%)
Medication Adherence for Diabetes Medication
Medication Adherence for Hypertension: Renin Angiotensin System Antagonists
Medication Adherence for Cholesterol (Statins)
Osteoporosis Management in Women Who Had a Fracture
All-Cause Readmissions
Medication Management for People With Asthma
Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews
Statin Therapy for Patients With Cardiovascular Disease
Medication Reconciliation Post Discharge
Statin Use in Persons with Diabetes
Use of Opioids at High Dosage
Use of Opioids from Multiple Providers
Controlling High Blood Pressure
Avoid Inappropriate Ambulatory Antibiotic Use

Quality Gap Closure

- Quality Gap Closure
  - Improvement in quality measures scores
  - Pharmacists embedded within patient-centered medical homes (PCMHs) improved Blue Cross & Blue Shield of Rhode Island's prescription drug benefit rating from 3.5 to 4.5 stars, which led to a CMS-designated quality bonus payment of 5%

ASHP. (2015, September 11). Onsite pharmacist program in medical homes declared a success. Retrieved June 23, 2022, from https://www.ashp.org/news/2015/09/11/onsite-pharmacist-program-in-medical-homes-declared-a-success?loginreturnUrl=SSOCheckOnly

What's in the Literature?

- Helmons et al. 2014
- Impact of a comprehensive formulary management system on formulary compliance and pharmacy labor costs.
- Practice Report
- Expanding the pharmacists' therapeutic interchange authorities was the least labor-intensive way to manage nonformulary requests in a comprehensive formulary management system.

- Brummel et al. 2016
- Evaluate the impact of a face-to-face CMM on medication adherence across 4 chronic disease states.
- Retrospective Analysis
- Patients that had completed a face-to-face CMM had an improvement in medication adherence across multiple disease states.

- Woodwall et al. 2017
- Determine the efficacy and financial benefit provided by pharmacist led AWV.
- Descriptive Study
- Pharmacist led AWVs with CMM resulted in improved medication use with high patient satisfaction while providing a positive return on investment.

- Wells et al. 2018
- Describe the implementation of pharmacist led team huddles and the impact on clinic-based quality metrics.
- Case Study
- Pharmacist-led quality improvement team huddles can have a positive impact on quality metrics, population health, and reimbursement.

- March et al. 2020
- Create a pharmacist driven transition of care program to improve patient satisfaction and decrease 30-day hospital readmission rates.
- Retrospective Analysis
- Pharmacist transition of care models can improve patient satisfaction, prevent hospital readmissions, and generate revenue.

Conclusion

- It is important to understand how quality programs work and what quality or Value Based Reimbursement Programs are applicable to your area
- Change from Fee for Service to Value Based Care Model supports pharmacist roles outside of traditional role
- Pharmacists can be leveraged to improve quality and financial performance in hospital, ambulatory, and other non-traditional settings

Questions?