THE PHARMACY PERFORMANCE IMPERATIVE

A guide to help independent pharmacies adapt to the shift to star ratings and narrow networks
The U.S. healthcare system is quickly moving from fee-for-service toward value-based purchasing, with the intent to reduce costs while improving quality of care. Payers, like the Centers for Medicare and Medicaid Services (CMS), are making providers accountable for patients’ health outcomes by tying reimbursement to performance.

For example, Medicare Advantage prescription drug plans receive quality bonus payments and other benefits based on the CMS Five-Star Quality Rating System, commonly known as star ratings. Additionally, patients are choosing to enroll in the health plans that receive higher star ratings. (Read on in this guide for an explanation of how star ratings work.)

“A pharmacy business model that relies primarily on filling prescriptions may be in trouble over the next 5 to 10 years,” wrote Fred M. Eckel, RPh, MS, the editor of Pharmacy Times, in May 2010. This prediction — and the need for you to show how your clinical activities deliver better patient care — is already becoming a reality.

Today, drug reimbursement is declining, and independent pharmacies are losing some patients to “preferred” pharmacies in networks whose prescriptions cost less. Tomorrow, if independents aren’t able to demonstrate that they can improve adherence and outcomes, they may be left out of the performance-based model entirely. However, there’s still opportunity for independents that actively embrace these shifts in healthcare.

A 1% INCREASE in the number of prescriptions filled by Medicare beneficiaries would cause Medicare spending on medical services to DECREASE total Medicare spending on service by roughly 0.2% (approximately $1.7 billion).↑
WHAT’S HAPPENING AND WHY?

HEALTHCARE SPENDING: SEEKING BETTER QUALITY FOR OUR INVESTMENT

Healthcare spending has a tremendous impact on our national economy. The U.S. spends more than any other country in the world on healthcare. In fact, 17% of the GDP, or nearly $1 out of every $5 dollars produced, is spent on healthcare.

Yet according to the World Health Organization, the United States ranks in the mid-30s in healthcare quality. The huge gap between investment in healthcare and quality of outcomes is leading many experts to look for ways to improve the quality of each dollar spent, and to create tangible changes in how health systems are incentivized. This impacts every aspect of the healthcare system, including your pharmacy.

DRIVING ADHERENCE DECREASES HEALTHCARE COSTS

Although adherence has always been an important part of medical care, the healthcare industry now has an impetus for change: cash. Medication noncompliance is costing between $100 billion to $289 billion a year, up to 13% of total healthcare expenditures. With the unsustainable growth of healthcare costs in the U.S., many experts are looking for lower-cost, high-impact interventions — such as improving adherence. Therefore, incentives are now aligning to support adherence in an effort to reduce overall costs and increase quality outcomes.

In the past, the effort to decrease healthcare costs focused on individual pieces of the healthcare puzzle, such as reducing lengths of hospital stays and decreasing use of or reducing reimbursements for retail drugs. The government and payers are now recognizing that it’s more effective — both from a cost and patient outcomes perspective — to look at the overall performance of all healthcare professionals involved with a patient’s care.

Case in point: if patients take their medication as prescribed, they don’t end up in the hospital as often. As a pharmacist, you play a critical role in promoting adherence with patients and improving medication utilization by coordinating with other providers.

“DRUGS DON’T WORK IN PATIENTS WHO DON’T TAKE THEM.”
— C. Everett Koop, M.D., and former Surgeon General
INVOLVING PHARMACY IN COORDINATED CARE IMPROVES PERFORMANCE

For decades, independent pharmacists have collaborated with physicians to optimize care and avoid unnecessary spending through medication reconciliation reviews. You’re a credible, trusted resource who usually sees patients more often than their physician. The 2013 NCPA Digest noted that independent pharmacists consulted with doctors about prescription drug therapy 7.5 times per day on average, including suggestions for cost-saving generic substitutes. Pharmacists’ recommendations were accepted over 80% of the time.

New healthcare delivery models that focus on outcomes — such as Accountable Care Organizations (ACOs) and patient-centered medical homes — also indicate that integrating a community pharmacy into the care team helps patients and the whole system gain the full value of medication use. Pharmacists help to avert downstream episodes of care by resolving medication-related problems, performing comprehensive therapy reviews of prescribed and self-care medications, optimizing complex regimens, monitoring adherence, and alerting providers to gaps in care.

Research shows that pharmacists are delivering cost savings to hospitals, health plans, physicians and the government when asked to perform clinical services. In fact, every $1 invested in pharmacist clinical services resulted in nearly $5 in cost savings.

Research also found that pharmacists at a retail store are the most influential healthcare “voices” for getting patients to take medicine as prescribed. Pharmacists’ face-to-face discussions were twice as effective at boosting adherence rates compared to programs where pharmacists talk with patients on the telephone. And, when asked what would help them take medications as instructed, 1,000 patients cited refill reminders (39%), easier-to-understand instructions (34%), and someone to follow up with them or provide encouragement along the way (15%).
SHIFT TO FEE-FOR-PERFORMANCE MEANS GREATER FOCUS ON DESIRED OUTCOMES

The healthcare industry is migrating away from a fee-for-service reimbursement model and moving to fee-for-performance. What does this mean for medical professionals?

You won’t get paid simply for providing a service, such as dispensing a drug. You will be paid for achieving a desired outcome, such as the patient taking a medication correctly for the prescribed amount of time.

Public and government programs, most notably Medicare Advantage plans, are leading the change to outcome-based reimbursements. Medicare is driving greater attention to medication-related quality by tying financial consequences to star ratings.

Although the change is beginning with the government sector, commercial companies administer most government plans. As these commercial companies start to see savings tied to quality, changes will be integrated into commercial plans as well. Plus, with the Affordable Care Act and other changing dynamics, more and more claims are being paid for by these government entities, making it critical for all healthcare professionals to pay attention.

<table>
<thead>
<tr>
<th>FEE-FOR-SERVICE MODEL</th>
<th>FEE-FOR-PERFORMANCE MODEL</th>
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<tbody>
<tr>
<td>In the past and present, providers were paid when they …</td>
<td>In the future, providers will get paid when …</td>
</tr>
<tr>
<td>DISPENSED A DRUG</td>
<td>PATIENT TAKES THE MEDICATION</td>
</tr>
<tr>
<td>GAVE A DIAGNOSIS</td>
<td>DIAGNOSIS IS CORRECT</td>
</tr>
<tr>
<td>PERFORMED A SURGERY</td>
<td>SURGERY IS BENEFICIAL</td>
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90% or more of your accounts receivable comes from health plans, with less than 10% coming from patients paying out of pocket.
YOUR CORE CUSTOMERS INCLUDE PATIENTS AND PAYERS

As a pharmacist, you probably see your core customer as the patient who walks through your door. And they are important; they’re the ones you interact with on a face-to-face basis. But your other big customer is the payer, or health plan.

Health plans control your access to patients when they determine how much of the cost they are willing to cover when a patient purchases from you — which means health plans strongly influence your store’s bottom line. Because health plans have such influence, you need to work as hard to meet the needs of payers as you do to meet the needs of your patient customers.

TYPES OF PBM PHARMACY NETWORKS

Open Pharmacy Network
Consumers’ out-of-pocket costs and co-payments are identical regardless of which pharmacy in the retail network dispenses the prescription. Open pharmacies are the most broad and often include the more than 60,000 retail pharmacies in the U.S.

Narrow Pharmacy Network
Consumers receive financial incentives to use particular pharmacies that offer lower costs and/or give payers greater control. Pharmacies are willing to accept reduced reimbursement rates in exchange for participation in a narrow network in order to boost store traffic.

• Preferred Pharmacy Network
Consumers can choose any pharmacy in a plan’s network, but they pay a lower out-of-pocket cost when getting their prescription drugs from a subset of preferred pharmacies — usually 20% to 50% of all retail pharmacies — instead of a non-preferred pharmacy.

• Limited Pharmacy Network
In this most restrictive model, consumers can choose any pharmacy within the network, but they must use the specific pharmacies or dispensing formats the payer designates. Consumer pharmacy choices are typically 50% to 80% smaller than an open network, usually fewer than 20,000 pharmacies.
GROWTH OF NARROW PHARMACY NETWORKS TO CONTROL COSTS

Payers are using the more tightly controlled pharmacy network models to seek additional drug spending savings. Narrow networks aren’t a new concept in healthcare; they use the same logic behind preferred provider organizations (PPOs) and health maintenance organizations (HMOs) where preferred or exclusive providers agree to special pricing terms. However, their rapid expansion is catalyzing change in retail pharmacy.

MEDICARE: In 2014, preferred pharmacy networks will dominate Part D. It’s estimated that there will be 56 plans with a preferred pharmacy network, up from only 16 in 2013, and 72% of nearly 1,200 regional prescription drug plans will have a preferred network.\(^1\)

Medicare Part D PDP Enrollment, January 2013

<table>
<thead>
<tr>
<th>PARENT ORGANIZATION</th>
<th>2013 ENROLLMENT (MILLIONS)</th>
<th>PERCENT OF Enroll-ment in Preferred Networks</th>
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</thead>
<tbody>
<tr>
<td>UnitedHealth Group, Inc.</td>
<td>4.9</td>
<td>92%</td>
</tr>
<tr>
<td>CVS Caremark Corporation</td>
<td>4.5</td>
<td>11%</td>
</tr>
<tr>
<td>Humana Inc.</td>
<td>3.1</td>
<td>98%</td>
</tr>
<tr>
<td>Express Scripts Holding</td>
<td>2.8</td>
<td>0%</td>
</tr>
<tr>
<td>Coventry Health Care Inc.</td>
<td>1.4</td>
<td>47%</td>
</tr>
<tr>
<td>CIGNA</td>
<td>1.2</td>
<td>0%</td>
</tr>
<tr>
<td>WellCare Health Plans, Inc.</td>
<td>0.8</td>
<td>0%</td>
</tr>
<tr>
<td>Aetna Inc.</td>
<td>0.6</td>
<td>79%</td>
</tr>
<tr>
<td>All Others</td>
<td>3.1</td>
<td>10%</td>
</tr>
<tr>
<td>Total</td>
<td>22.4</td>
<td>42%</td>
</tr>
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Source: 2012–13 Economic Report on Retail, Mail and Specialty Pharmacies
Table 1: Enrollment in Medicare Part D PDPs, by Parent Organization, January 2013

The Part D preferred pharmacy network wave began in 2011, when Humana and Walmart launched their first plan. In 2013, more than 4 out of 10 seniors were enrolled in a Medicare Prescription Drug Plan (PDP) with a narrow pharmacy network design.\(^2\) And, most seniors (85%) were satisfied with the preferred pharmacy plan, especially the cost savings from lower premiums and co-pays.\(^3\) What happens in Medicare trickles down to other healthcare sectors.
**MEDICARE TRICKLES DOWN TO OTHER HEALTHCARE SECTORS**

**COMMERCIAL:** Although slower in their adoption, commercial plans are moving to these new models, primarily choosing to use preferred networks. One of the first commercial preferred networks was the Caterpillar-Walmart trial program, which began in September 2008 and has subsequently expanded to include Walgreens, Kroger and a group of independent pharmacies.

Walmart, the third-largest retail pharmacy, estimates that 25% of its 2012 prescription volume came from participation in narrow networks, up from just 1% in 2009. CVS Caremark’s Maintenance Choice is the most prominent limited network model, with more than 1,000 commercial plans with 14.5 million covered lives using this narrow network of retail outlets.

**CONSUMERS:** More than 90% of Americans live within five miles of a retail pharmacy. Given this relatively saturated marketplace, plans can establish narrower networks with minimal consumer disruption. While a preferred or limited network causes consumers some degree of inconvenience, consumers are willing to switch pharmacies for even very small monetary rewards.

In a national survey, 85% of consumers said they would switch their pharmacy to avoid higher co-payments at their usual pharmacy. Historically, consumers have considered only service and location when choosing a pharmacy, but narrow networks are teaching consumers to shop for prescriptions by price.

**HEALTH PLANS CREATE PREFERRED PHARMACY NETWORKS BASED ON PERFORMANCE**

Today, health plans’ pharmacy benefits managers (PBMs) select pharmacies to include in their organizations’ preferred pharmacy networks based on specific, measurable criteria, including geographical coverage, cost and quality of care. And, a pharmacy’s participation in a PBM’s narrow network is primarily based on its willingness to accept reduced reimbursements.

Recently, quality of care has taken on an added significance. This shift will affect your pharmacy’s access to insured patient lives. CMS has begun providing substantial financial bonuses to health plans based on their ability to measurably impact care outcomes. Instead of being measured solely on how effectively they drive down costs, today PBMs must also demonstrate improved patient outcomes in order to receive reimbursements and earn cash incentives.

PBMs, in keeping with their health plans’ fee-for-performance model, will likely add new selection criteria for pharmacies that wish to be included in their network, such as higher generic substitution rates or how well they perform on quality measures such as adherence rates. A reimbursement model based on performance is the future for pharmacies.
PERFORMANCE MATTERS, AND STAR RATINGS MEASURE IT

It’s easy to grasp conceptually that performance — or achieving better patient outcomes — matters. But how is it measured?

CMS is using Five-Star Quality Ratings (known as star ratings) to measure performance. This five-star rating system has been around since 2008 but recently has gained importance because CMS is starting to use it to determine quality bonus payments back to health plans.

HOW STAR RATINGS WORK

It’s important to understand that health plans, not pharmacies, receive star ratings. However, as a pharmacist, it’s equally important to understand that your patient outcomes directly affect the ratings of the health plans, which means you play a key role in driving higher overall ratings.

The Five-Star Quality Ratings system essentially “grades” Medicare plans annually on their quality and performance. This rating system is similar to product ratings on an online retail site, where a rating of 1 star is the poorest and a rating of 5 is the best.

HEALTH PLAN INCENTIVES FOR HIGH (4- AND 5-STAR) RATINGS

CMS gives incentives, in the form of quality bonus payments (QBPs), to Medicare Advantage plans with star ratings of 4 and 5. This can add up to a 5% QBP for a star rating of 5 — a substantial incentive for a Medicare Advantage plan to increase its rating.

Medicare Advantage as well as stand-alone PDPs with high star ratings also receive marketing and enrollment benefits:

- Members can join at any time during the year, not just during open enrollment.
- Members can switch from a low-rated to a high-rated plan at any time during the year.
- New Medicare beneficiaries are choosing plans based on star ratings.
WHY YOU SHOULD CARE

If you don’t help keep your health plans’ star ratings high, there’s a good chance you’ll be dropped from their preferred pharmacy networks and as a result lose access to many of your insured patients. In fact, it’s already happening to some pharmacies, who are seeing higher co-pays for some health plans.

Many national pharmacy chains already have begun focusing on improving the quality measures that help health plans improve their star ratings. To stay competitive, independents need to do so as well.

ADHERENCE MEASURES DEFINED

One of the challenges in driving better quality of medication-related care is agreeing how to define and measure it. The shift from cost to value is also occurring in the metrics that PBMs/health plans are using.

PBMs are moving from relying primarily on cost measures that look at a single area, like Drug Trend Measurement (i.e., the increase in medication drug spend per month) and the Medication Possession Ratio (i.e., the sum of the days’ supply for all claims during a defined time period divided by the number of days elapsed in that period).

Newer medication-related measures — like those being developed by the Pharmacy Quality Alliance (PQA), a nonprofit that has taken the lead in this area — evaluate the impact on patient care, blending total cost and quality. Community pharmacies can use these measures to demonstrate and differentiate their performance to health plans, PBMs and employers.

Payment incentives are based on the prior two years. This means outcomes you achieve in 2014 will directly impact the payment PBMs and health plans receive in 2016. What you do today to understand and impact patient adherence will matter to your future.
KEY AREAS WHERE PHARMACIES CAN DIRECTLY IMPACT STAR RATINGS

Two of the nine star ratings domains can be directly impacted by pharmacies. Due to the higher weighting of clinically relevant measures, the five medication-use–related measures (PQA measures) account for 48% of Part D summary ratings in 2014.

Star ratings are determined by a number of different factors, but they essentially measure how consistently patients stay on their prescribed medications as a way to assess the effectiveness of a therapy.

2014 Star Rating System Breakdown

MEASURES FOR WHICH PHARMACIES HAVE A DIRECT IMPACT ON A HEALTH PLAN’S STAR RATINGS

1. Three measures of medication adherence
   - PDC measure “Measured by PDC” (percentage of days covered): for chronic disease medications, what percentage of days does the patient have the medication

   **Example:**
   - Statin 1st fill on 1/10/13
   - Refilled 8 times over the year
   - Last fill on 11/20/13

   \[
   \frac{8 \times 30}{365 - 10} = \frac{240}{355} = 68\% \text{ PDC}
   \]

   - Looks specifically at:
     - Oral diabetes medications
     - Cholesterol medications (statins)
     - Blood pressure medications (renin-angiotensin system antagonists)

2. Two measures of medication safety
   a. High-risk medications in the elderly
   b. Appropriate treatment of blood pressure in patients with diabetes

3. Another area is currently a display measure but will be a full measure in 2015 and pharmacies play a critical role
   - Comprehensive medication reviews (CMRs) completion rates

The five medication-use–related measures that pharmacies can impact account for 48% of Part D summary ratings in 2014.
EQuIPP Performance Report

New tools have been developed to help pharmacies understand how they are performing on the types of quality measures that now matter to health plans and PBMs. One tool is EQuIPP™ (Electronic Quality Improvement Platform for Plans and Pharmacies) developed by Pharmacy Quality Solutions (PQS). PQS is a joint venture between CECity and the Pharmacy Quality Alliance (PQA), a nonprofit with over 100 member organizations that collaboratively develops strategies for measuring and reporting performance information related to medication, including those currently being used for CMS Medicare Plan Star Ratings. EQuIPP is a web-based performance-management tool that makes unbiased, benchmarked performance data available to both health plans and community pharmacy organizations via user-friendly dashboards to bring a level of standardization to the measurement of the quality of medication use.

Sources:
Plan Strategies for Improvement of Medicare Star Ratings. Part 1 – CMS
WHAT YOU CAN START DOING NOW

BETTER CARE MEANS BETTER HEALTH FOR PATIENTS, YOUR BUSINESS AND THE ECONOMY

Focusing on quality care — and specifically adherence — is an obvious choice from numerous vantage points. Here’s why:

1. Adherence has a huge impact on total health costs.
2. It’s critical to stay relevant to changes in health plan networks; with pharmacies’ significant impact on star ratings, pharmacies that can’t show improved adherence will be left out.
3. Focusing on adherence will drive additional refills, generating additional revenue for your store.
4. It’s the right thing to do for patient care.

Beginning in early 2014, Health Mart® will provide more detailed information about star ratings, including individual pharmacies’ quality measure numbers, how to overcome hurdles to quality outcomes, and how quality measures make you more effective at improving adherence. You can take steps today to start improving patient adherence and your impact on star ratings.

SIX STEPS TO TAKE TODAY

1. Become an expert on medication management of chronic conditions.
2. Counsel each patient and drive awareness.
   - Includes both behavior and dose counseling plus comprehensive medication reviews.
3. Use technology to keep patients accountable.
   - Includes clinical refill reminders via email, text and phone.
4. Implement an appointment-based model for medication synchronization.
5. Start using dose-reminder packaging.
   - Includes coldseal blister packaging, medication pouches and medication trays.
6. Make physicians and other providers aware of your skills.
McKesson and Health Mart are committed to helping you understand your pharmacy’s quality measures and provide tools and resources to ensure you continue to have access to patient lives and that your business can thrive into the future.

ADDITIONAL RESOURCES FOR HEALTH MART PHARMACIES

In the coming months, Health Mart pharmacies will receive communications, tools and other resources to help you “Know Your Number” that PBMs are using to evaluate your contributions to adherence and quality care, and what you can do to improve your impact. Right now:

• Check out the Health Mart Operations Manual for additional background information including:
  – Adherence Overview
  – Preferred and Performance Networks
  – Star Ratings

• Take a related course available on Health Mart University
  – Improving Adherence to Impact Practice with CE
  – Pharmacy Quality: It’s Written in the Stars with CE
  – Star Ratings, Performance-Based Pharmacy Networks and You: A Quick Overview for Independents

• Visit the Know Your Number center available via McKesson Connect℠

For questions:

• Talk to your retail sales manager
• Email HealthMartOperations@mckesson.com

Not a Health Mart Pharmacy but Want Help?

Health Mart and McKesson can help you navigate the shifting retail pharmacy landscape today and maintain access to lives in the future:

• Stay informed of the latest developments with articles and other education available at Smart Retailing Rx.
• Visit Better Pharmacy Health to learn more about how we help you build a better business, deliver better care, and ensure a better future for your pharmacy.
• Contact us at 866.329.0113 to have your local McKesson pharmacy advisor stop by for a quick chat about how we can help you compete and thrive.
FOOTNOTES


19 Ibid.

20 Ibid.
TO LEARN MORE ABOUT QUALITY MEASURES:
Visit www.SmartRetailingRx.com, or email us directly at SmartRetailingRx@mckesson.com.

For Health Mart, visit the Know Your Numbers page on the Health Mart Operations Manual on McKesson Connect, or call 855.HLTH.MRT (855.458.4678) or email HealthMartOperations@mckesson.com.

TO LEARN MORE ABOUT McKesson OR BECOMING A HEALTH MART:
Visit www.BetterPharmacyHealth.com
Visit www.BecomeaHealthMart.com

And let us know when you’re ready to have a McKesson retail sales manager visit you to discuss what’s keeping you up at night and how we can help:
• Fill out a Contact Us form
• Call us at 866.329.0113