

AHEAD OF THE CURVE:

EMERGING TRENDS IMPLICATIONS FOR POLICY-MAKERS AND PATIENTS

THIS WHITE PAPER analyzes the findings in the Foundation's landmark *Top 10 Emerging Health Care Trends* report, with an eye on policy implications and policy challenges related to value-oriented approaches; integrated health care delivery; and population health improvement.

The AMCP Foundation challenges health care stakeholders to:

- Improve transparency in benefit design and prices, and simplify the complex nature of the US health care system, so that patients can be more effectively accountable for their own health management.
- Help providers leverage technologies and the expansion of patient data to drive quality in patient care, and improve care processes.
- Support payers in designing and implementing new payment models that share risk and drive accountability across stakeholders and populations with varying needs and requirements.
- Support payment reform, and provider consolidation and integration, enabling a more coordinated view of patient care and population health management, where decisions on medication and treatment choices are informed by a view of the whole patient and of populations.
- Demand proof of value in the pharmaceutical marketplace, including comparative-effectiveness information, to stem unnecessary/inappropriate use of potentially effective but costly specialty pharmaceuticals.

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Emerging Trends Implications for Policy-Makers and Patients

The special report *Ahead of the Curve: Top 10 Emerging Health Care Trends* was a collaboration between the Academy of Managed Care Pharmacy (AMCP) Foundation and Pfizer, designed to systematically identify and assess trends expected to impact patient care and managed care pharmacy. The report is a comprehensive resource for managed care organiza-

Download the full Emerging Trends report at www.amcp.org/amcp-foundation/Resources/trends/

tions, health care payers, providers, pharmaceutical manufacturers, policy-makers, patients and researchers.

The analysis also provided real-world insights

on policy priorities relevant to all health care stakeholders. In this white paper, we examine these insights under three main subject headings: value-based approaches, integrated health care delivery, and population health improvement. The AMCP Foundation believes these areas will most significantly impact benefit design and health care delivery at least through 2020.

VALUE-ORIENTED APPROACHES

The search for better value in health services has compelled policy-makers to look beyond the conventional fee-for-service (FFS) system to new provider payment models that better

align incentives for cost control and high-quality patient care. The federal government, commercial payers, and employer sponsors are recognizing that the FFS system is clearly inefficient, and incentivizes increased volume of services versus better quality of care or outcomes.

In 2014, \$2.8 trillion was spent on health care in the US. Concerns about the costs of care have fueled the spread of value-based models across the US health care spectrum. In order to obtain value in health care today, payment to health care providers must evolve beyond traditional fee-for-service, which emphasizes volume of care and not outcomes. While increasing patient and consumer cost sharing has been utilized to help shift risk away from sponsors and plans, it also encourages them to seek better value in health care decision making. Concerns over the fast-rising costs of specialty pharmaceuticals have compelled payers to seek value-oriented approaches to balance access and budgets.

In the move away from FFS-based care, value-oriented models have been gaining traction. These models include Medicare's

TOP 10 EMERGING TRENDS IN HEALTH CARE

1. Migration from Fee-for-Service to New Payment Models
2. Consolidation of Health Care Stakeholders
3. Widespread Use of Data and Analytics in Patient Care
4. Spending and Utilization for Specialty Pharmaceuticals
5. Medicaid Expansion due to Health Care Reform
6. Migration to Value-Oriented Health Care Marketplaces
7. Growth and Performance of Accountable Care Organizations
8. Role of Technology in Patient Engagement
9. Increasing Patient Cost Sharing
10. Health Care Everywhere

value-based purchasing program; pay-for-performance systems (first introduced by forward-thinking employers); innovative, clinically nuanced, value-oriented benefit designs for employer-sponsored coverage; risk-sharing concepts for physicians; and narrow networks that seek to improve outcomes by restricting access to those providers who demonstrate better efficiency and lower costs.

Value-based benefit designs are being utilized as a lever in pharmacy management to allow better patient access to medicines whose value is supported by data and evidence of effectiveness (e.g., waived or lower copayments or other reduced cost sharing). Value-based benefit designs also encourage consumers to make better health care decisions and actively pursue value in care, through variable copays or co-insurance, or direct purchases of care while meeting significant deductibles.

Evolving provider payment models are expected to become increasingly value-based and heighten the focus on high-quality patient experiences and outcomes. Additionally, new payment models are expected to reduce costs for government and commercial payers as care efficiency increases and more risk is shifted to providers and patients. The use of bundled payments, evidence-informed case rates, and shared-savings systems are all examples of modern initiatives to improve efficiency and quality of care. In a survey of hospital executives, 86% expected to have bundled payment agreements with payers in the coming years.

A critical tool in increasing population health is the improved medical technologies we use to treat disease. These technologies, such as specialty pharmaceuticals, come with a high price tag. Specialty drug spending is projected to increase by 17% to 20% annually for at least the next five years and will consume 50% of the drug budget by 2018. Yet, for large subgroups of patients with

chronic disease, these drugs have unquestionably improved health and, by some counts, greatly.

Health plans and insurers respond to the rise in specialty spending by:

1. Focusing on robust treatment guidelines and clinical pathways (to guard against inappropriate use),
2. Increasing the number of tiers in drug formulary (to better manage access),
3. Emphasizing site of care and channel management (to better manage reimbursement),
4. Increasing patient cost sharing within and across tiers, and
5. Implementing closed formularies (to better manage access).

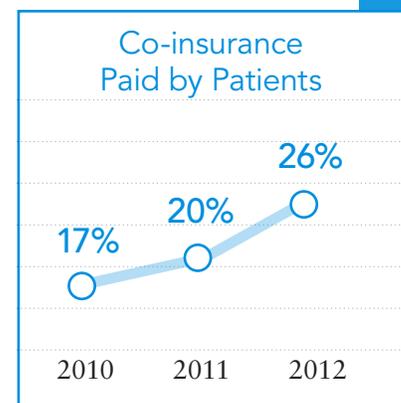
Policy Implications

Value-based benefit and insurance design, payments, and purchasing programs reach into nearly every aspect of policy decision-making for government; health plans, insurers, and other payers; and plan sponsors. They have the potential to transform not only payment systems and the cost curve, but also improve consumer empowerment. Value-based benefit and reimbursement systems can also serve as powerful incentives in moving towards population health.

The migration to new payment models has resulted in the (re) emergence of near-site/on-site primary care clinics for employers.

Overall, providers are seeking innovative ways to provide more access and care with fewer resources.

According to a survey of hospital pharmacists, approximately 70% predicted that the number



of drugs available only through specialty pharmacies will increase by 75% over the next five years. The potential of biosimilars to spur price decreases in the biologics market poses opportunities to reduce costs and increase patient access for some biopharmaceuticals. Value-oriented contracting in specialty pharmacies may mean more outcomes-based or risk-contracting for high-cost (or high-impact) medications.

By 2017, the Centers for Medicare and Medicaid Services (CMS) is seeking to tie 30% of its FFS Medicare payments to value. In 2015, Congress replaced provider payments based on the sustainable growth rate (SGR) by passing the Medicare Access and CHIP Reauthorization Act (MACRA). Under MACRA, provider payment rates will be updated by 0.5% each year through 2019, followed by a freeze in payment rates from 2020 to 2025.

In 2026, payment rates will be updated either by 0.25% annually for providers participating in the Merit-Based Incentive Payment System or by 0.75% annually for providers participating in CMS's alternative payment models. The Merit-Based Incentive Payment System adjusts payments based on quality of care, resource use, clinical outcomes improvement, and EHR use, and can result in bonuses of up to 12% or penalties of as much as 4% in 2019.

Although the government has led the way on new model development through its pilot programs, the responsibility falls to providers, payers, and employers for designing new payment models that avoid the capitation concerns raised in the 1990s—the tendency to reduce the amount of care for those with high-cost chronic diseases—and more appropriately emphasize quality and outcomes.

Policy Challenges

Policies have evolved over the past decade with the aim of improving the value of care; however, efforts to manage health system costs

and improve value have relied to a large extent on increasing consumer/patient responsibility for health costs. This has been reflected in evolving benefit designs and a reliance on high-deductible health plans, which have shifted some of the risk from payers and plan sponsors, and created an imbalance between affordable health benefits and appropriate consumer cost sharing.

Without adequate value-oriented benefit design and careful monitoring, patient out-of-pocket costs can inhibit appropriate access and negatively impact therapy adherence.

In addition, as patients are asked to make more value-based decisions, they need better information and better education regarding the value of the health interventions they purchase. This relies on increasing transparency on quality programs and improving health literacy to clarify patients' health choices and their implications.

Value-based approaches to risk-sharing must support disease management and population health efforts. However, these efforts are hampered by a lack of consensus on what represents value and how best to measure it for many disease states and therapies (e.g., the question of progression-free survival vs. overall survival or partial vs. complete remission in cancer therapy trials).

No dominant value-oriented payment model has emerged due to the lack of long-term data on performance for the range of new models in use. Uncertainties still exist about how new models will be shaped and what value they will provide over the short and long term. Data-driven insights will be necessary to measure the effectiveness of these models.

In order for specialty pharmaceuticals to pay off as a long-term investment in value, the delivery system will have to better manage the rise in their short-term costs. Personalized medicine and future advances in genomic

science can support more efficient patient selection for targeted specialty therapies. The introduction of biosimilar agents can help stem some cost increases, but this can only occur if the approval process is rapidly finalized and implemented in full. A unified managed care pharmacy stance on the use of biosimilars can accelerate development and finalization of the regulatory framework.

Additional policy challenges may be found in the political arena: the outcomes of the presidential elections and the status of a candidate to fill the Supreme Court seat vacated by the passing of Justice Scalia could have significant implications for the ability of health reform (and new payment models) to withstand future challenges.

INTEGRATION OF HEALTH DELIVERY

Accountable care organizations (ACOs) were developed as a mechanism for consolidating providers (most often hospital systems and provider practices) and encouraging a model of medical efficiency, in which any savings attained by the system are shared by the partners. The provider groups also share in the risk and rewards of meeting quality benchmarks.

Across the entire health system, we are witnessing increasing partnerships, mergers, and acquisitions. Vertical consolidations are

In order to restructure the system to achieve Triple Aim, the Obama administration has encouraged the formation and growth of accountable care organizations. They hold the promise to improve care coordination and incentivize care efficiency. The way providers are reimbursed, expectations for information technology, and patients' greater access to care, partly through the expansion of Medicaid, are helping to drive the consolidation of practices and health care systems.

forming clinically integrated organizations (e.g., networks partnering with hospitals, payers acquiring provider practices) to prepare for new payment models and horizontal transactions, in which pharmacy benefit managers (PBMs), hospitals and clinics, or insurers are merging with other like entities to gain leverage. Further, oncology practices are increasingly consolidating, joining hospitals to obtain higher Medicare reimbursement rates.

The Obama Administration's expansion of Medicaid has brought over 10 million newly insured patients into the health delivery system. Increasingly, improved outcomes under lower reimbursements will be the goal for commercial Medicaid payers and providers who contract to cover new populations.

Policy Implications

The ACO model may only expand if its integrated delivery design and dual focus on care coordination and cost outcomes can be proven to drive care efficiency. Attaining care efficiency and coordination relies greatly on a health system's ability to collect data and the capability to analyze this information (particularly longitudinal data).

Provider consolidations that result in employment of physicians in large groups instead of independent practices will change the professional role of providers from a focus on individual control over patient management to an emphasis on team-based care. The shift towards integrated delivery networks (IDNs) and clinically integrated organizations could enhance coordinated decision-making across different stakeholder groups within the health care ecosystem. Another impetus for provider group consolidation is that larger groups may be better funded to meet meaningful-use requirements for health information technology.

Access to the influx of new patients, through Medicaid and the exchanges, has fueled

marketplace competition and payment uncertainty, which also encourages stakeholder consolidation.

20% of US hospitals will seek to merge in 5–7 years

62% of hospitals purchase or own physician practices

Consolidations will likely increase centralization and standardization of decision-making across payers and

providers, but consolidations also may reduce competition and choice among them.

Policy Challenges

The long-term success of the ACO model will require investments in data infrastructure and analytics and a willingness among providers and payers to continually evolve new models of care. Organizational cultures (e.g., provider autonomy) and processes will have to change to optimize care coordination and efficiency (and thus the probabilities of success). Many ACOs are focused on primary care; scenarios exist in which some patients in ACOs receive care outside of the ACO, especially in terms of specialty care.

Future ACO growth is dependent on the success of early programs, and the results have been mixed: All 32 Pioneer ACOs improved quality and performed better in 28 of 33

Is the \$2.8 trillion spent in the US health care system an investment in the well-being of the populace and the productivity of its workforce? If so, the spotlight is on population health improvement, which relies heavily on a better understanding of where the opportunities to improve care and change behaviors lie. This implies a focus not simply on the costs of one illness, one medication, or even one episode of care, but on the long-term health of patient populations. We will look to advanced information systems that can collate data and analyze huge databases for trends and patterns. As patients access treatment in a wide array of new environments (“health care everywhere”), they will generate vast volumes of data, which can be captured and analyzed for population health efforts.

quality measures than FFS models, saving \$96 million by year two; however, more than one-third had dropped out of the Pioneer ACO program. To date, no dominant model has emerged. The next generation ACO model has been announced by CMS. It is clear that the ACO model requires more development and time to evolve.

Consolidation may lead to higher overall prices if competition is significantly hindered as a result. Early evidence from a recent wave of hospital consolidations cites price increases in the range of 10% to 40%. This increased leverage for merged entities will also influence the relationship between providers and payers, and between providers and manufacturers. Payment models may not adequately consider this shift in leverage and purchasing power.

Medicaid expansion has exacerbated the shortage of providers to treat the primary care needs of newly insured patients. Consolidated entities like ACOs and IDNs may be able to care for these patients more efficiently than small practices or local hospitals. A policy challenge remains: recruiting primary care clinicians to meet the new demand for services.

IMPROVING POPULATION HEALTH

The volume and breadth of information hidden in claims databases, integrated health system electronic health record systems, patient registries, and other sources are staggering.

The growth of longitudinal patient data assets and investment in personnel equipped to glean data-driven insights can support a transition to a long-term, 360° view of patient management. The use of sophisticated analytics provides novel opportunities for improving care effectiveness and efficiency, and as a result, population health.

Yet, given the fragmented nature of health care delivery, we fall short of obtaining a complete

picture of patient care and progression of disease. Additional data can be generated to fill the gaps from patients themselves. The availability of new tools and mobile applications is creating new opportunities for patient engagement and patient-contributed data. Google, Apple, and Samsung announced major new efforts to launch digital health care platforms for smartphones. Information is being integrated from consumer watches (Apple), wristbands (Fitbit devices), and other wearable technologies with compatible sensors.

The focus on improving population health and patient well-being is increasingly a community-wide effort. The location of care is shifting from hospitals and doctors' offices to homes, community, and workplace settings. Text messaging, video monitoring, and telemedicine allow consumers to interact with health care professionals remotely from nearly any location, bringing the vision of "health care everywhere" closer to reality.

Access to patients' personalized care management tools promotes engagement in their care. These technologies will place more disease- and treatment-specific information at patients' fingertips, enabling more informed choices as consumers. Providers are already harnessing the power of communications technology to engage patients via mobile phone text messaging, email, and online chat programs.

Policy Implications

As health care delivery is occurring outside of traditional settings, new health care delivery roles are emerging. Retail pharmacy-based clinics and pharmacy chains are offering care counseling, creating medication therapy management opportunities for pharmacists and new types of health care providers to expand their roles in patient care. Primary care clinics located at employers' facilities are also emerging. New collaborations can be explored across the health care delivery

system, leveraging health care everywhere to enhance drug delivery and support medication management in new settings.

The rise of patient-focused technologies requires increased data transparency, patient education, and coordination of tools with clinicians and other health providers.

Policy Challenges

The full potential for data-driven insights to revolutionize care is hampered by current data limitations, the lack of a robust business model for interoperable data exchange across organizations, the limited implementation of health information technology (HIT) systems by providers, and broader organizational barriers that hinder coordinated solutions across stakeholders. Patient privacy and regulatory hurdles also represent challenges to improving data analytics in medical care.

The pace of clinician adoption of electronic health record (EHR) systems and analytics has been slow, partly owing to the cost of implementation but also to the investment in resources needed to gain competency in these systems. Small medical practices and providers are at risk of being left behind if they don't embrace the use of HIT.

Furthermore, more professionals will have to be trained in health care data analytics to meet the need for an optimal population health-based environment. To fully harness the potential of data, health care stakeholders will need to invest in interoperable HIT infrastructure to link fragmented data elements.

The addition of multiple sources of health data raises issues of data storage, data portability, and integration of technology. This is particularly true as hospitals, health systems, and insurers are consolidating at a rapid pace, challenging their HIT infrastructure to do the same.

Although increased access to health care everywhere lends itself to multiple opportunities for improving population health and disease management, it also emphasizes the impor-

48% of office physicians
97% of hospitals
75% of oncologists
... adopted a basic or
advanced EHR system
in recent years

tance of care coordination along with continuity of care. Another related challenge is the availability of health care personnel in contact with patients at these uncon-

ventional sites of care. State regulations that limit the scope of practice for advance practice nurses, physician assistants, and pharmacists can hinder the spread of alternative care sites and limit the recruitment of students to these professions.

Patient education will be key to the long-term success of using new technologies to improve patient engagement and, ultimately, patient outcomes. Health literacy will be a necessary prerequisite given the complex nature of the US health care system and health care benefit design. The different levels of e-literacy across sub-populations limits a “one-size fits all” technology tool and, given limited resources to support technologies in various settings, some

populations may be underserved. Older patients use medical services more frequently but younger patients (25–44 years) utilize mobile technology to communicate with providers almost twice as much as older patients.

Personal data breaches at any point in the health delivery system can undermine the credibility of security efforts and confidence in the privacy of patient data. This could prove to be a great barrier towards reaching population health.

Overall, new approaches are needed to balance incentives for manufacturer innovation with health system affordability.

In order to ensure the long-term value (rather than a limited goal of short-term ROI) on our investments in specialty pharmaceuticals, more work should be conducted in comparative effectiveness, leading towards value-based benefit design, while not impacting access for populations who would benefit most from these high-cost but potentially effective medications.

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The AMCP Foundation, founded in 1990 as a 501(c)3 nonprofit organization, is the research and education arm of the Academy of Managed Care Pharmacy (AMCP). The Foundation advances collective knowledge on major issues associated with the practice of pharmacy in managed health care, including its impact on patient outcomes.