MAXIMIZING VALUE IN HEALTH CARE

First in a series of articles bridging the predictions from our **Emerging Trends** body of knowledge to current health care realities

REFORM EFFORTS are bringing intense scrutiny to major components of our health care delivery system. Today, patients, physicians, health systems, and payers are asking whether the push for better value can hold back the rising tide of costs. Headlines focus on:

- The skyrocketing costs of the pharmaceuticals, e.g. Daprapriim and EpiPen
- Hospital emergency room evaluation and management codes marked up 7-fold
- Annual premiums for employer-sponsored family health coverage topping $18,000
- Sixty-five percent of employees with single coverage in small companies and 45% of those in large corporations have deductibles of at least $1,000
- Member cost sharing rose 77% over 10 years ending 2014

The move to a value-oriented marketplace was one of AMCP Foundation's *Top 10 Emerging Health Care Trends*, as published in our landmark report in 2014. Significant progress has been made on multiple fronts in the past 3 years, as the various stakeholders continue to press for new approaches to optimize value in health care. In this update, we highlight four important areas of progress.

Value in Oncology Care

From a disease category perspective, oncology has been at the forefront of value improvement. The overall cost of cancer care in the US could reach as high as $173 billion in 2020, a 39% increase since 2010. Oncology medications are among the more expensive interventions, with a pipeline that is full of new pioneering treatments (with the expectations of high price tags).

In 2015, 188 oncologists called for new approaches to lower the high cost of cancer drugs, improving access to medications that effectively treat cancers.

The American Society of Clinical Oncology is developing and testing its Value Frameworks, which calculates a "net health benefit" based on clinical effectiveness, toxicity, and additional improvements in treatment-free interval, cancer symptoms, survival curve, or quality of life.

The National Comprehensive Cancer Network introduced Evidence Blocks™ into its clinical practice guidelines in an effort to help clinicians consider treatment efficacy, safety, quality and consistency of evidence, and affordability in their therapeutic choices.

Memorial Sloan Kettering Cancer Center developed DrugAbacus, which calculates the relative value of an intervention based on several factors: its toxicity, innovative qualities, costs to develop, the frequency of the tumor treated, unmet needs, disease prognosis, and the population burden of the specific tumor.

The Institute for Clinical and Economic Review (ICER) has published assessments of multiple myeloma, non–small cell lung cancer, and prostate cancer. Reviews performed by ICER result in the estimation of cost-effectiveness ratios (cost per quality-adjusted life-year).

Utilizing an episode-based payment system to encourage improved care and lowered costs in the oncology care system, 16 payers and 190 oncology practices are participating in the Center for Medicare and Medicaid Innovation's Oncology Care Model.

Value in Reimbursement

The signing and implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Merit-Based Incentive Payment System (MIPS) has set in motion the federal government's quality payment program that can earn Medicare providers incentive payments in 2019. However, this is based on a practice or medical group's ability to record and report 2017 data to CMS on how information technology supported the practice. Those physicians already practicing in an advanced alternative payment model (e.g., accountable care organizations, oncology care model) need not report performance data but will earn the incentive payment.

Medicare providers not participating in MIPS or an alternative payment model will be disadvantaged, facing a potential 4% reimbursement penalty.

Improving the Patient Experience

In its conceptual emphasis on accentuating value, the Triple Aim includes consideration of the patient's experience of care—improving both care quality and patient satisfaction. To address in this goal, many hospitals, health systems, and health plans have recently added departments of patient experience and/or chief experience officers (CXOs). Some primary goals of these efforts are to expand the perspective of patient experience across the continuum of care (beyond inpatient settings) and to enable patients to become architects of care improvement.

This will result in a louder patient voice on what defines value. Patient-reported outcome measures will be a focus of not only CXOs but quality performance measurement as well.

Emergence of Value-Based Pharmaceutical Contracting

A new survey of 45 health plans from Avalere Health shows that roughly one-quarter have signed an outcomes-based pharmaceutical contract, and a few have implemented several. These contracts revolve around real-world health outcomes. For example, the manufacturer of an antithrombotic agent will charge a plan an agreed-upon reduced amount if its drug, used to prevent recurrent acute coronary events, does not reduce subsequent hospitalizations.

Even though outcomes-based contracts usually require additional administrative resources and monitoring by the health plans or insurer, the survey indicated that plans are seemingly ready to acknowledge their potential. An additional 30% are actively evaluating how these contracts can work towards a value-based future.

TAKEAWAYS FOR PATIENTS

- With patients and consumers asked to bear increasing costs, they must take a more active role in deciding how value is defined in health care
- Care value can only be maximized if patients are fully engaged and understand how to make good health choices
- Patients must be astute stewards of their health care dollars including deductibles, premium contributions, and cost sharing

TAKEAWAYS FOR PHYSICIANS

- The federal government's embrace of value-based initiatives implies a continuing (or greater) emphasis on quality-based reporting, which is tied directly to reimbursement
- Most stakeholders believe that providers holding more risk equals more health care value
- Cost and value are becoming a common conversation during the office visit; physicians need to be cognizant of the patient's cost-sharing concerns
- Improving the patient experience will require physicians to place a greater emphasis on patient communication (and shared decision making) in therapy management

TAKEAWAYS FOR INDUSTRY

- Payers will seek innovative value-based contracting schemes, especially for higher-cost products like specialty pharmaceuticals
- Additional incorporation of comparative-effectiveness research will help support the evidence for use of old and new products
- Biosimilars will gain a greater foothold if they represent a better value (with or without interchangeability designations)
- Drug pricing will continue to be scrutinized heavily by all health sectors; expectations for price justification will increase

TAKEAWAYS FOR PHARMACISTS

- Pharmacists are ideally suited to be an essential guide in drug value discussion (to patients, clinicians, and health systems)
- Pharmacists can be utilized as the go-to resource for patients in navigating a value-based health system
- They can help drive the value-based pharmaceutical contracting movement, and help drug makers understand what types of innovative contracts are possible and practical
- In the face of rising drug costs (conventional and specialty), pharmacists may be called upon to develop new tools to help manage the trend and assure that patients are receiving the most cost-effective medications

TAKEAWAYS FOR HEALTH PLANS AND PBMs

- Expect more flexibility from the pharmaceutical industry in discussions of value-based contracting schemes, especially for higher-cost products like specialty pharmaceuticals
- Plans will need to work closely with patients to improve patient experience and raise their level of engagement
- The continued emphasis on value from the federal government should provide plans additional opportunities to engage providers and physicians in risk-based agreements as well as in innovative payment models
- Pharmacy benefit managers are under increasing pressure to educate stakeholders on the value that they bring to the health system

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 organizations, health care payers, providers, pharmaceutical manufacturers, policy-makers, patients and researchers. Learn more and download the full report.

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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.