



VALUE BASED PAYMENT AND PAY FOR PERFORMANCE SUMMIT

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FEBRUARY 18, 2016

GORMAN
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OUR PANEL

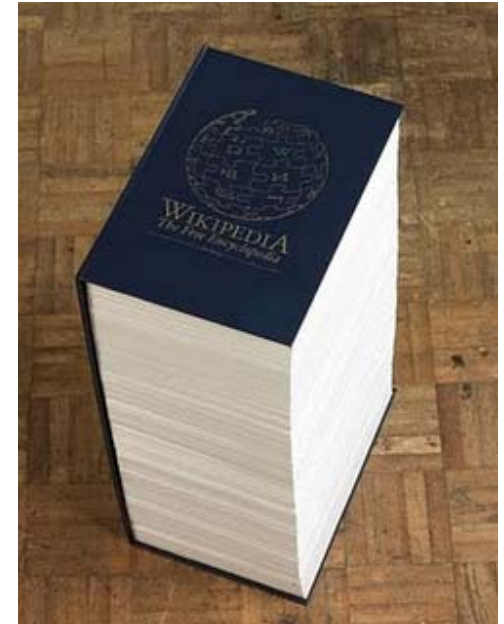
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- Eric Yarnell RPh, MPM Director, Pharmacy Business Administration & Client Experience Gateway Health
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- Nancy Djordjevic Sr. Consultant Gorman Health Group

OUR PROGRAM

- Introductions
- Current state of pharmaceutical pricing and trends
- Specialty pharmacy-hurdles and strategies
- Strategies for designing a pharmacy benefit
- The new disease management utilizing data analytics
- Q & A

SETTING THE STAGE

- Medicare Part D implemented during 2005-go live 1-1-06
- Thousands of pages of regulation and more come almost weekly
- Medicare ≠ Medicaid
- Health plan management of Part D functions
 - Fully delegated to fully in-house
- Evolution from keeping the lights on to data driven land rush to get enrollment



P4P IN MEDICARE-QUALITY BONUS PROGRAM

- Commonly called Star Ratings
- >4 stars = \$\$
- 50% of star measures are based on member experience
 - Provider office visits, network pharmacy
- As soon as you get good at it they retire it
- If you keep doing the same things you lose ground
- Bad data bumps you to 1 star



VALUE-BASED PHARMACY BENEFITS

REWARDING OUTCOME NOT VOLUME



PHARMACY DRUG SPEND

Factors Driving The Trend

- Specialty Drugs – Biologics
- Brand Name Drug Inflation
- Generic Drug Inflation
- Affordable Care Act and Medicaid Expansion
- Aging Population – Medicare

EXPRESS SCRIPTS 2006-2014



SPECIALTY DRUGS

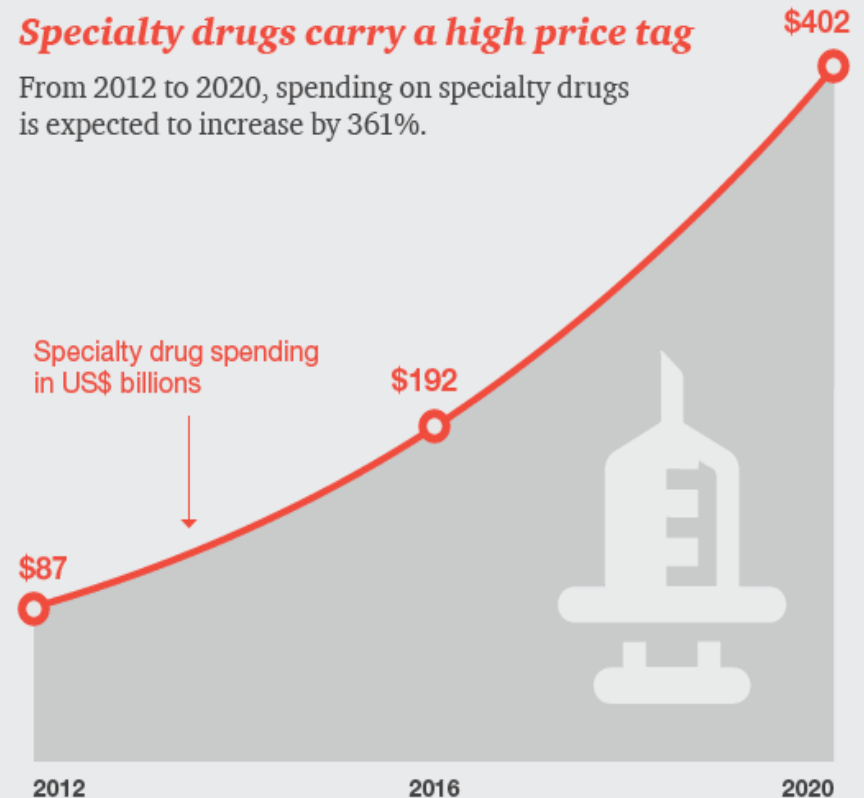
Pushing the Spending Curve

- Specialty drugs are the main driver at 30.9% of drug spend in the US in 2014
- Oncology drug spend \$100B in 2014
- Hepatitis C Drugs Account for 45% of Specialty Drug increase in 2014



Specialty drugs carry a high price tag

From 2012 to 2020, spending on specialty drugs is expected to increase by 361%.

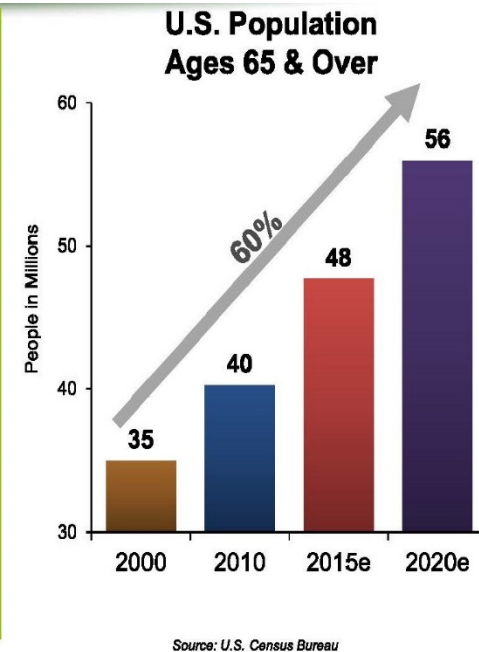
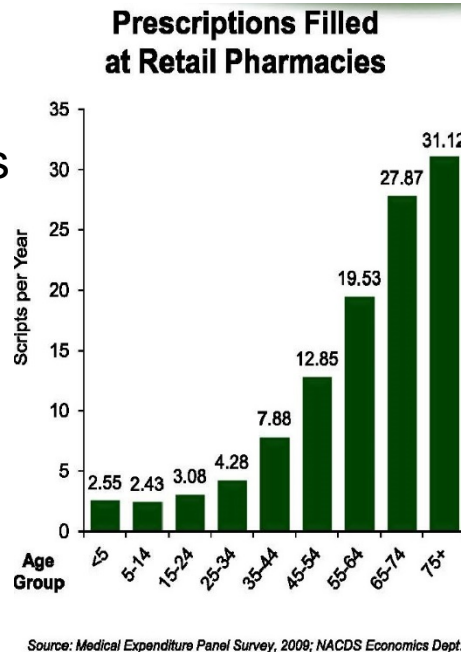


Source: PwC's Health Research Institute: *Behind the Numbers 2015* and analysis of CVS Caremark data.

US HEALTH CARE DEMAND

ADDED GROWTH THROUGH NEW ENROLLMENT

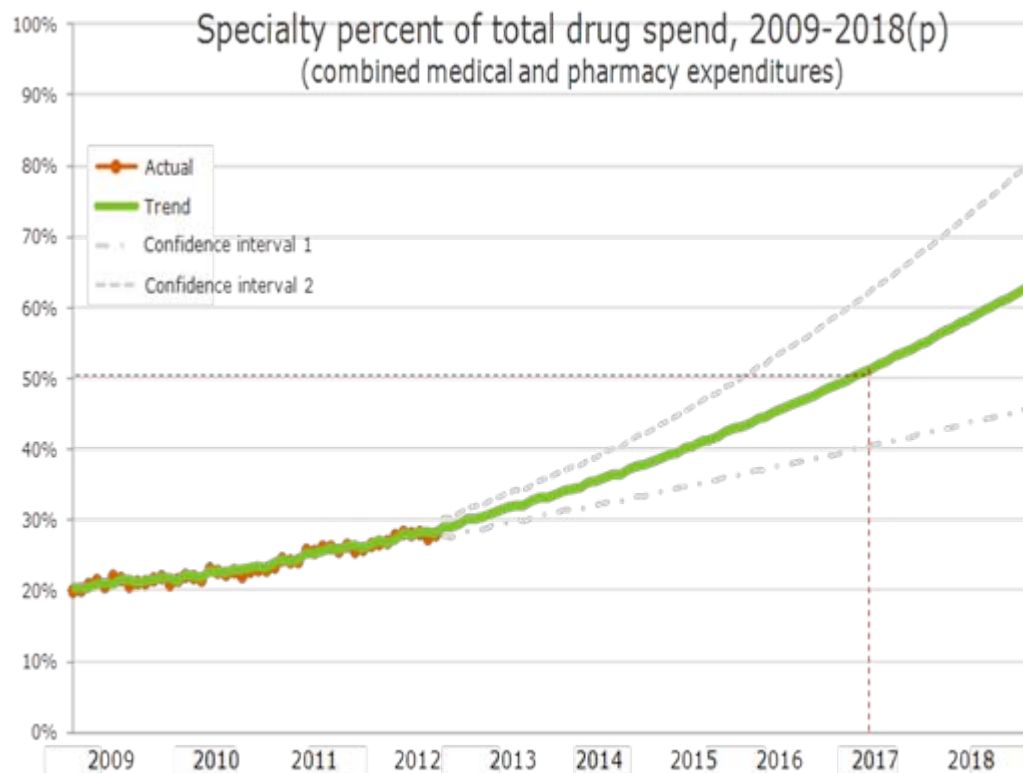
- Medicare Age-Ins
 - According to Pew Research center, 10,000 Baby Boomers turn 65 daily for the next 19 years
- Medicaid Expansion
 - Increase of 24% in 2015 to 71,754,506 Members
- Federal Exchanges
 - Added 16.4 million new members in 2015 according to HHS



CHANGE: MOVING THE MOUNTAIN

VALUE BASED PROPOSITION

- Drug Spending Growth is Unsustainable
 - Increased 13.1% in 2014 (ESI Trend Report)
 - The PMPY Medicare spend in 2014 is \$2,987.36
 - Traditional \$2,262.41
 - Specialty \$724.94
- Tipping Point 2017

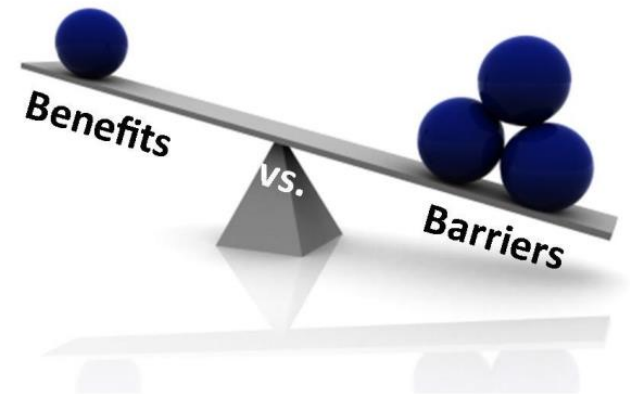


Source: Forecast based on Prime commercial BOB, 4Q2012

CHANGE: BARRIERS TO PROGRESS

VALUE BASED PROPOSITION

- Barriers Preventing Benefit Change
 - Integrate spending across entire health care system
 - Government Regulations limit options for change
 - Consumers face increasing high deductibles and cost-sharing
 - Providers are paid for volume, not quality



REDESIGNING FOR VALUE

TRIAD: OUTCOMES, SOLUTIONS, TECHNOLOGY



- ✓ Value-Based Formulary and Benefit Design
- ✓ Integration: Merging Medical and Pharmacy Data
- ✓ Partner with patients physicians and, pharmacists
- ✓ Measure and report performance
- ✓ Align reimbursement with Outcomes

REDESIGNING FOR VALUE

VALUE BASED PROPOSITION

- Effectively Engage and Integrate ALL Partners

- Pharma

- Evidence-Based
- Value-Based pricing agreements
- Targeted-Marketing

- PBM

- Ensure pharmacy and medical benefits are not misaligned.
- Link data between the two in order to evaluate cost and outcomes
- Focus on value, not price



REDESIGNING FOR VALUE

VALUE BASED PROPOSITION



- Effectively Engage and Integrate ALL Partners (Cont'd)
 - Providers
 - Integrated with performance based incentives, bear risk, value-based payment agreements
 - Leverage information technologies to make better decisions.
 - Consumers
 - Facilitate the right incentives to induce consumers' medication compliance.
 - Make the right care accessible and affordable



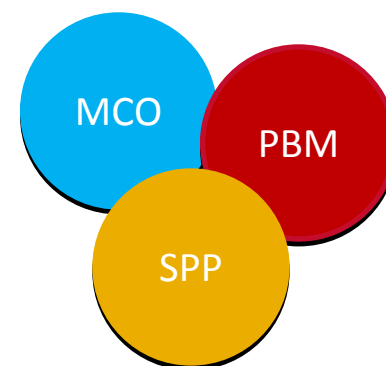
Value Based Payment and Pay for Performance in Specialty Pharmacy

Eric Yarnell, BSPharm, MPM

Specialty Pharmacy is Somewhat Defined

- One or more characteristic
 - High cost (CMS >\$600 per month)
 - Complex diseases
 - Limited distribution
 - Special shipping and/or handling
 - Special administration and close monitoring
- Common disease states in specialty pharmacy
 - Hepatitis C
 - Multiple Sclerosis
 - Rheumatoid Arthritis
 - Crohn's Disease
 - Pulmonary Arterial Hypertension
 - Injectable Atypical Antipsychotics (LATs)
 - Hereditary Angioedema

- Hemophilia
- Transplant
- HIV/AIDS
- Cystic Fibrosis
- Oncology
- Growth Hormone



These Are the Facts

- Specialty drugs have been estimated to make up to 50% of the total spend of prescription medications by 2018.¹
- Projections also estimated that specialty drug expenses would increase 67% by the end of 2015 and will continue to increase through 2018.²
- Today specialty makes up 25-30% of pharmacy benefit expenses and may be even higher considering a calculation combining drugs from the medical benefit as well. One study in 2012 showed that up to 53% of the specialty spend came from the medical benefit.³
- While increasing in cost, specialty still makes up only a small percentage of overall drug utilization.

We're Uncovering What's Driving this Increase

- Increased specialty drug use
 - Higher cure rates or efficacy
 - Less side effects
- Inflation and double-digit price increases of some specialty drugs
- Higher margins for dispensing - creating an incentive to over supply
- Specialty drug growth and speed to market
 - Niche drugs
 - Little competition
- Loss of brand patents – the “patent cliff” is over
- ACA exchanges related insurance expansion
- Ethical dilemma
 - What is a fair price for higher efficacy and increased survival rates?

What We Can Do to Manage Now

- How do we add value to this expanding sector?
- Take advantage of additional high-end services through contractual arrangements
 - Specific clinic management criteria: hepatitis C, HAE, hemophilia
- Add additional performance standards and metrics with associated penalties
 - Assay management
 - Customer service
 - Claims accuracy
 - Turnaround/Delivery times
 - Notifications and referrals
 - Chain of custody
 - Accreditation and training
 - Reporting
 - Inventory management
 - Safety
 - Education
 - Adherence
 - “Pay for non-performance”

We Can Partner with Our Specialty Networks

- Look at the largest specialty pharmacies and what they offer
- Narrow networks to high performers by contract compliance and reporting
- Drive down unit cost
- Look into contracting lower mark-up rates on high-cost specialty drugs...FAST
- Barriers “any willing provider” monitoring reports and audits
- Political backlash (contact state reps)
- Enlist stakeholders up front by showing your plan to regulators and agencies in advance with your goal at driving down unit cost and increasing value

Assess Your SWOT

- Potential threats and weaknesses
 - Pipeline
 - Price increases
 - Consolidation and loss of competition
 - Counter detailing / DTC advertising
- Mitigate with opportunities and strengths
 - Pipeline management
 - Contract negotiations
 - UM policies
 - Advanced analytics – tracking utilization, expenses, variances, shared-risk clinical indicators

Additional Strategies for Managing the Cost

- Tighten the formulary wherever possible with preferred agents that have higher clinical efficacy
- PA policies on complex treatment regimens can generate savings if balanced with drug rebate opportunities
- Cost sharing and specialty tiers
 - Co-insurance Vs flat co-pay
- Prior authorization
 - Monitoring
 - Diagnostic testing
 - Genetic testing
- Inventory validation
- QLs
- Split-fills
- Biosimilars
- Rebates – federal mandate 23.7%, CPI penalty

There are Even More Cost-Savings Strategies

- Tiers and cost-sharing don't work in Medicaid
- Use “lock-in” programs
- Edits (gender, age, max dose), QLs 30-day supply, ICD-10 diagnosis codes, step therapy
- High-cost generics and price change analytics
- What was strategically a good financial move last year may have now become a liability due to price increases and a reduction in rebate terms
- Drive down MAC pricing below the FUL
- Don't forget 340B

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Managing Pharmaceutical Costs in a Value-Based Payment Environment

Sharon K. Jhawar, PharmD, MBA, CGP
Corporate Vice President, Pharmacy



About SCAN Health Plan



- MAPD plan
- Special Needs Plans
 - ✓ Institutional
 - ✓ Dual
 - ✓ Chronic care

170,000 members



*4.5-Star rating applies to all plans offered by SCAN Health Plan (HMO) in California except Healthy At Home (HMO SNP) and VillageHealth (HMO SNP/HMO POS-SNP). Medicare evaluates plans based on a 5-Star rating system. Star Ratings are calculated each year and may change from one year to the next.



Network model:

60+

Medical Groups

**Mission-driven
not-for-profit**

38 years



Traditional Strategies to Manage Pharmaceutical Costs



Formulary



Utilization
Management



Generics



Tier
Placement



Rebates

Newer Strategies to Manage Pharmaceutical Costs



Advanced Analytics



Preferred Value Pharmacy Network



Value Based Contracting



Portfolio Rebate Contracting



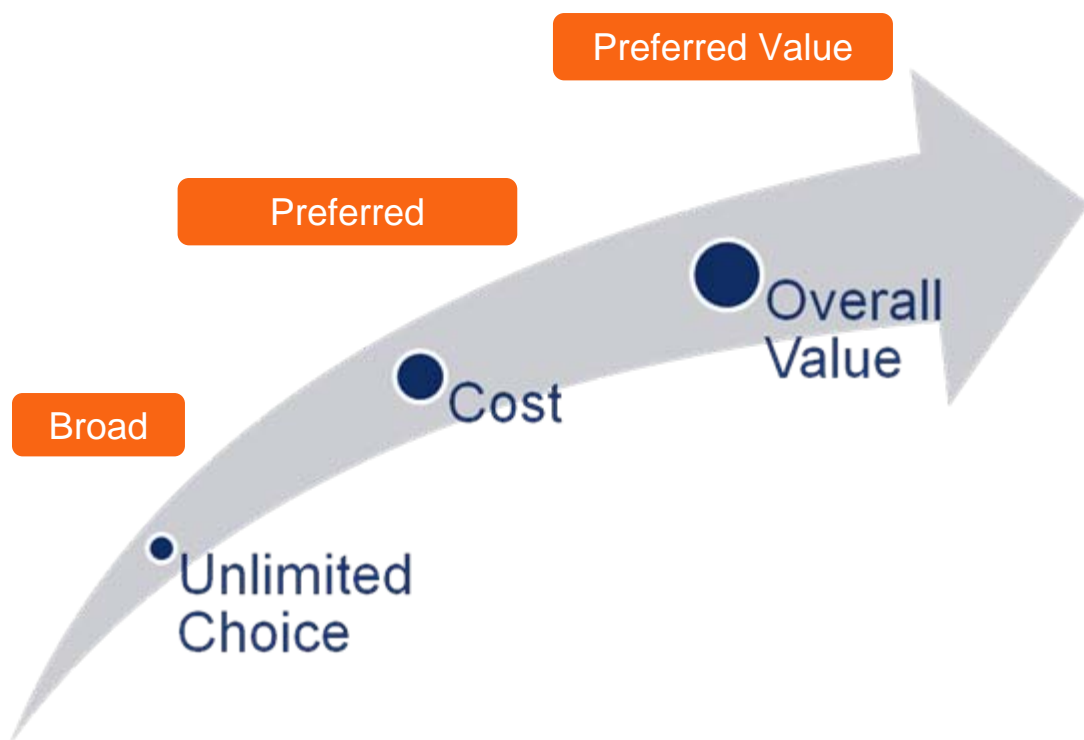
Inflation Protection

Advanced Analytics

- Data on Demand



Preferred Value Pharmacy Network



Value defined

- High quality
- High savings
- High performance (CMS Star Ratings)
- Better health outcomes





'And then I thought, what would the pharmaceutical industry do?'

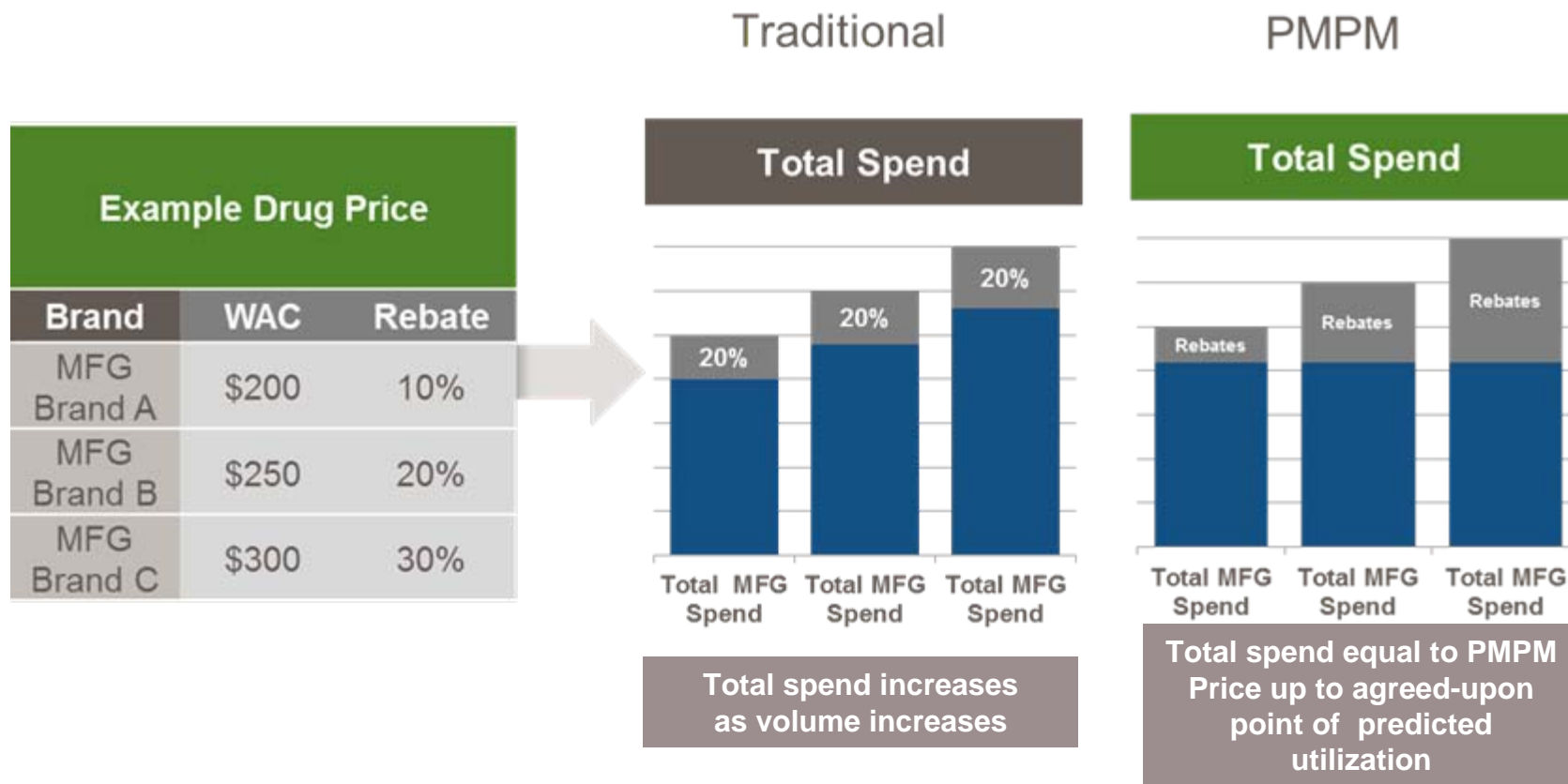
Value-Based Contracting

- aka
 - Outcomes-based contracting
 - Pay for performance
 - Additional dollars above rebates which are tied to outcomes
 - Contracts often involve tracking certain health measures and outcomes
 - HbA1c for diabetes patients or HDL/LDL/TG levels for patients with high cholesterol
- Recent Example: PCSK9
 - Harvard Pilgrim: In addition to providing a discount, Amgen will be at risk financially if health plan members' cholesterol levels aren't lowered enough.
 - Amgen will have to provide larger rebates to Harvard Pilgrim if patients' low-density lipoprotein cholesterol levels are not lowered to “what was observed during clinical trials.”
- The cost and complexity of such tracking can offset the benefits, and may limit the uptake of this approach



Rebate Portfolio Concept

- Fixed pmpm rate for therapeutic category



Inflation Protection

- Express Scripts' Inflation Protection Program
 - First in the industry program
 - Goes above and beyond garden variety price protection agreements
 - Absorbs the financial risk when ESI contracted price protection manufacturer limits are higher than the guaranteed price increase caps to ESI clients



Key Takeaways

- Traditional levers to manage costs must be operating at optimal levels
- As consolidation, inflation and innovation continue to drive increased drugs costs, newer levers to manage costs have to be explored



VALUE OF ANALYTICS

In Pay for Performance and Value Based Design

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FEBRUARY 18, 2016

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CMS SCORECARD

11/20/2015 Andy Slavitt HHS Pharmaceutical Forum
Value and value based payments

- How to define value and quality
 - Reduce PMPM cost over time
 - Reduce mortality
 - Reduce institutional residency – more people live independently (but this can be a matter of choice and circumstances- lack of family or resources vs a choice)
 - Determine impact of other conditions – member compliance

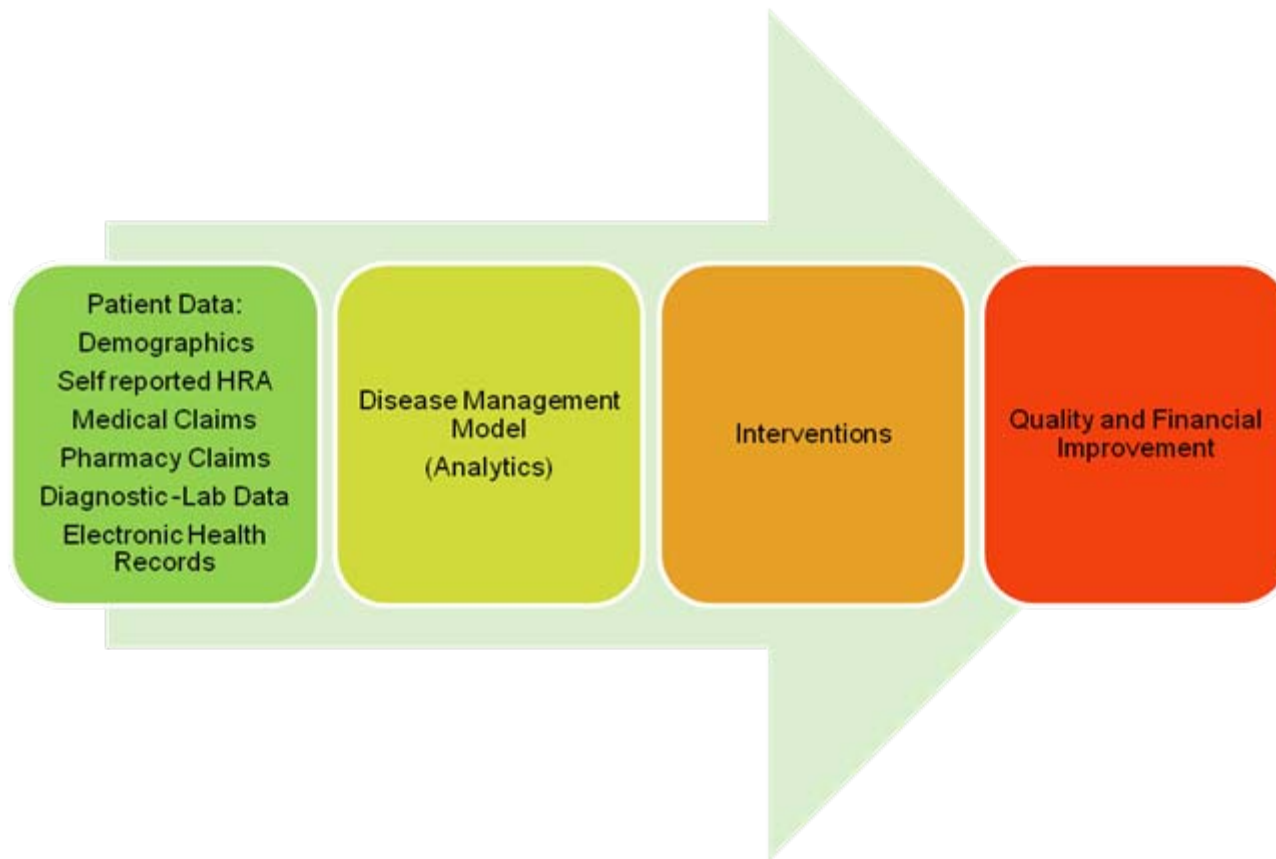
CMS SCORECARD

11/20/2015 Andy Slavitt HHS Pharmaceutical Forum
Partner with Pharmacy Sector

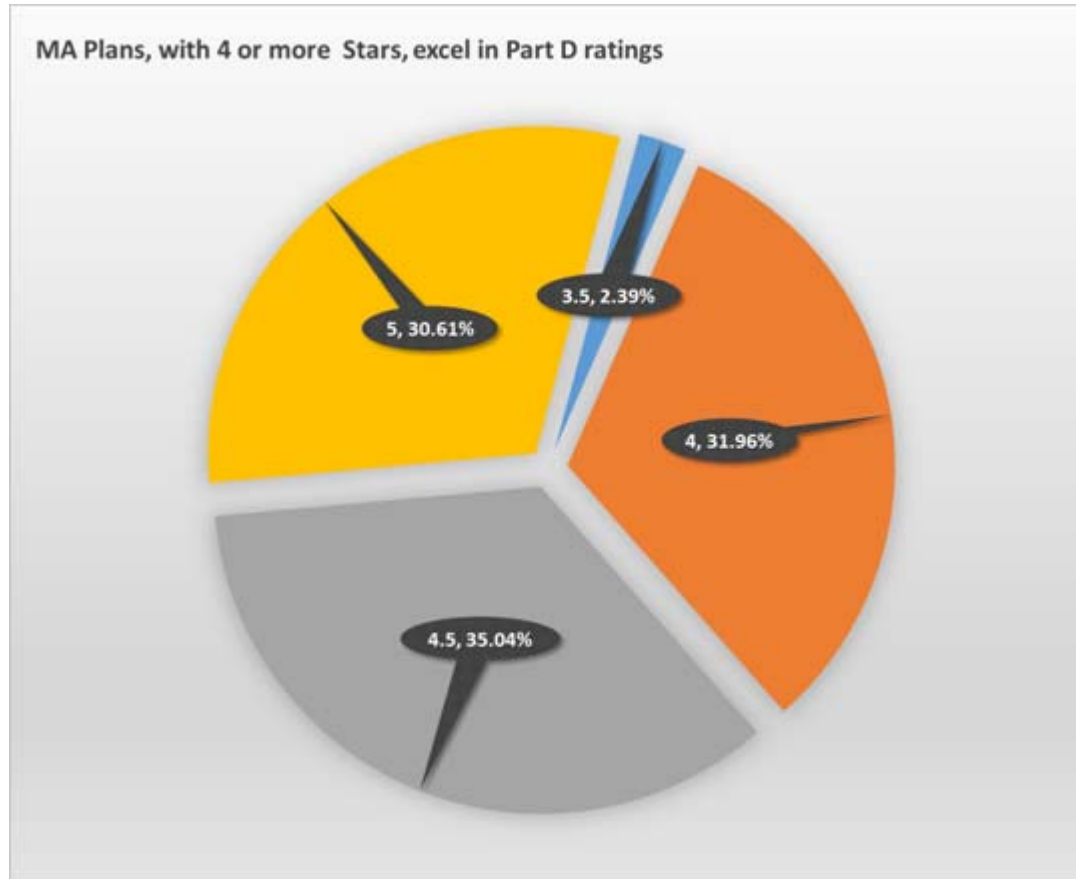
- Improved information transparency and availability
 - Pricing – plan vs. beneficiary (AWP, rebates, etc.)
 - Access – formulary
 - Compounds, specialty drugs, experimental
 - Need vs. want – generic substitutions, advertising, member specific
- Participate in incentives and hurdles
 - Physicians
 - Hospitals
 - Pharmacies

***Integrate pharmacy data with medical data to increase interventions
and enhance outcomes***

CURRENT DISEASE MANAGEMENT MODEL

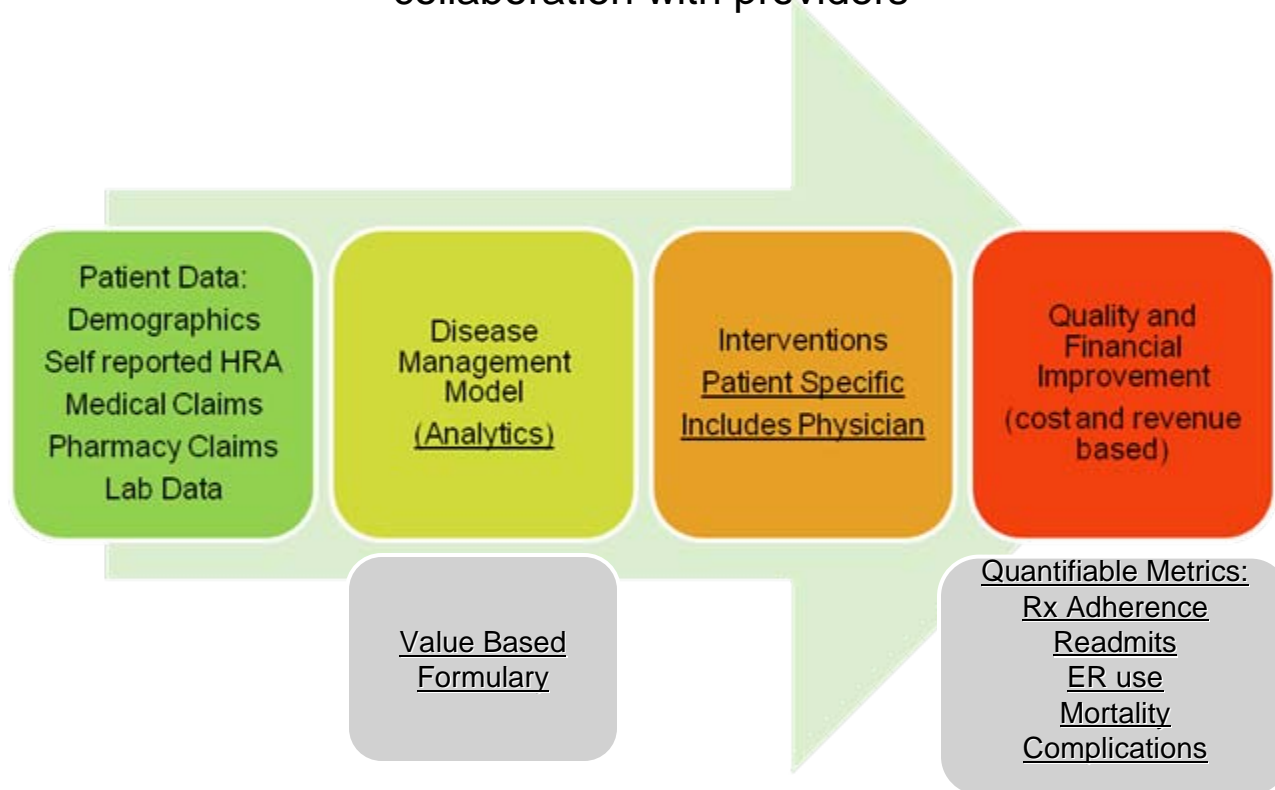


TOP RATED HEALTH PLANS USE PHARMACY DATA TO IMPROVE QUALITY AND OUTCOME



VALUE BASED DISEASE MANAGEMENT MODEL

Value Based Formulary leverages Member and PBM accountability to improve measurement of cost containment and quality measures as well as enhanced collaboration with providers



TRADITIONAL USE OF OUTDATED, INCOMPLETE MEDICAL RECORDS MUST BE ENHANCED WITH PHARMACY AND E H R DATA

Integrate Pharmacy with Primary Care



Medical

- Detailed CPT information
- Standardized data
- Place of service info
- Referral patterns
- HCC information
- 60-90 day lag with billing



Pharmacy

- Timeline of member compliance and disease progression (change in prescriptions – change in disease and/or provider)
- Reflects diagnostic results
- Rx HCC data
- More complete, more timely
- Reflects prescribing physician and specialty
- % total claims cost



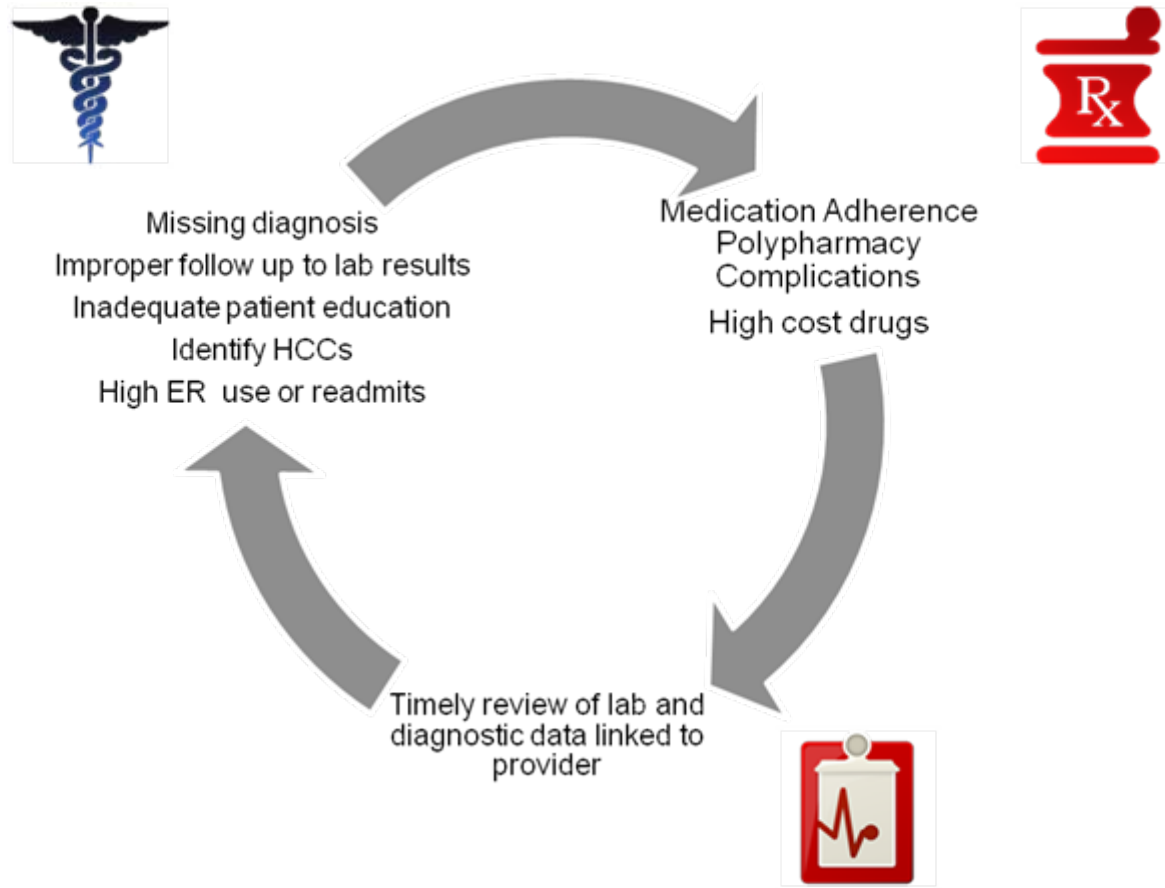
EHR

- Key indicators for notes and lab/diagnostic results
- Timely
- Including diagnostic lab and radiology

Common Cause = the member's health and wellbeing

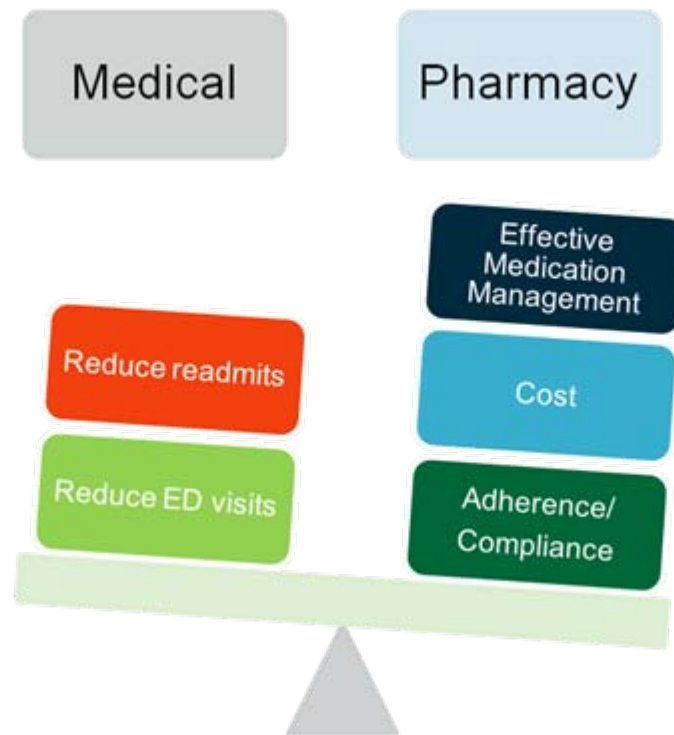
IDENTIFY GAPS IN CARE

Match formulary to population and monitor results



IT TAKES TWO: PHARMACY AND MEDICAL

More Pharmacy Costs can (and should) Improve
Medical and Total PMPM Costs



VALUE BASED PHARMA MODEL

How to Impact Pharmacy Costs at the Source

Value Based Outcomes

Clinical Data Bases

History of outcomes by disease and treatment

Include value based metrics – align with payers, providers and members

Covers local, regional, national, global

Large Resources

Target marketing to achieve metrics

Downstream partnership with payers and patients

Value Based Formulary

Customize to disease state and risk factors (maximize HCCs and RxHCCs)

Customize drugs and pricing

Target benefits through cost share for effective cost and utilization patterns

VALUE BASED HEALTH PLAN MODEL

How to impact Pharmacy Value to the Patient

Value Based Outcomes

Partner with PBMs:
In-house or External

Focus on Member

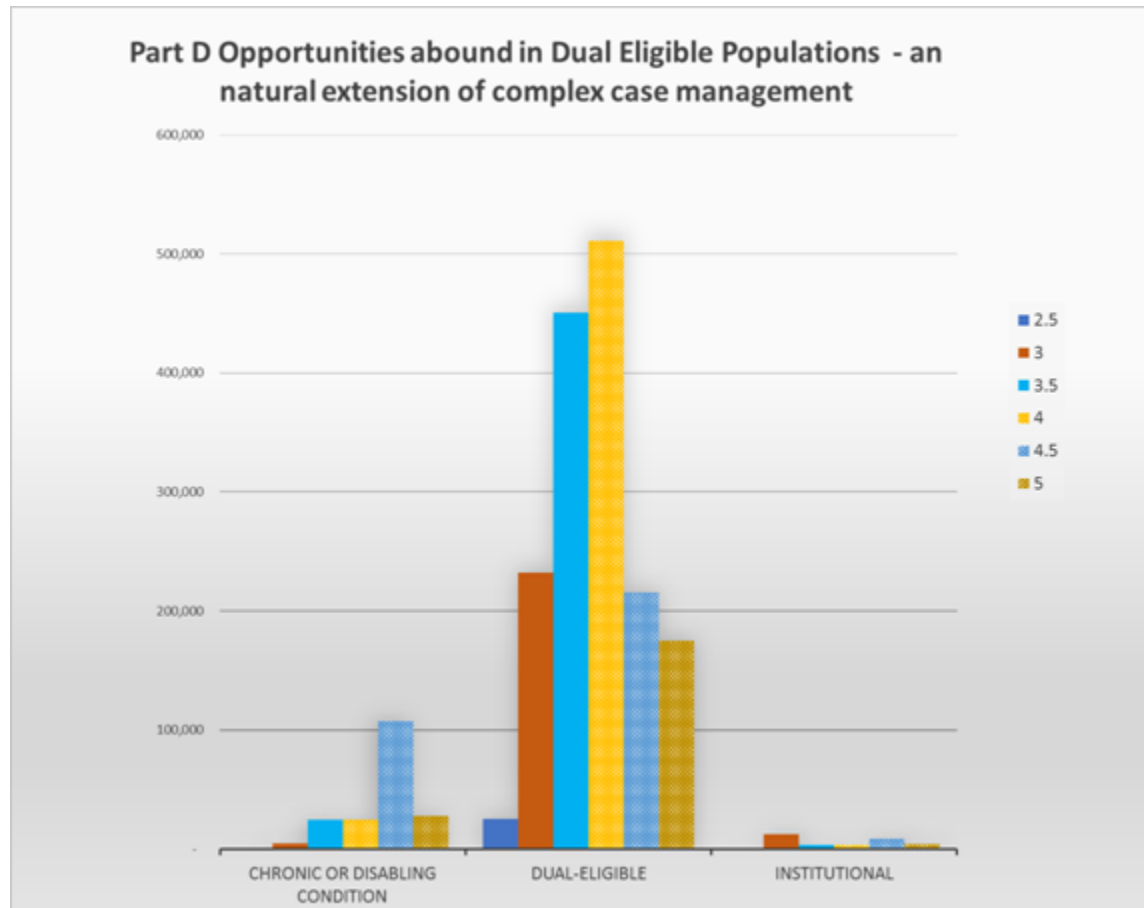
Leverage Pharma
Companies
Develop value based
formularies

Leverage Pharmacies

Engage providers
Leverage risk adjustment
Incent member behavior
Validate and focus on risk
scores and root causes

Focus on MTM and
complex case
management

NEXT STEPS: FOCUS ON HIGH RISK POPULATIONS LIKE DUALS



AS TOP OF THE SUPPLY CHAIN, HOW TO INTEGRATE PHARMA COMPANIES IN VALUE PROPOSITION

- Current proposition for pharma companies
 - Leverage R&D to maximize utilization and costs by targeting patients and providers
 - But forced to put more emphasis on long term value (especially cost review panels in Europe), not just meeting a medical need
 - Will delay market entrance and shift risk onto manufacturers
- Proposed – Pharma companies to take more leadership
 - Strategic
 - Do pharma companies want to partner in member treatment and structure products and services to improve quality and value to member
 - Organizational
 - Leverage R&D for population outcome
 - Accept a leading role in managing development with outcome based value
 - Partner with health plans, providers, pharmacies and PBMs to achieve best outcome for patient

QUESTIONS/COMMENTS





GORMAN 2016 FORUM

HEALTH GROUP

SAVE THE DATE: APRIL 19-20, 2016

Worthington Renaissance Fort Worth Hotel
Fort Worth, TX