LVBGH/Lehigh University

Moving the Needle on Costs

February 4, 2020

LEHIGH UNIVERSITY | Healthc. Systems Engineering

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PBGH Mission:

To be a change agent creating increased value in the healthcare system through purchaser collaboration, innovation and action, and through the spread of best practices

Purchasing Value

- Employers Center of Excellence (ECEN)
- Purchaser Value Network (PVN)
- Maternity Payment Reform
- Meaningful Measures/Common ACO Measures
- Accountable Pharmacy
- Low Value Care
- Mental health/Primary Care integration
- Benefit design best practices

Functional Markets

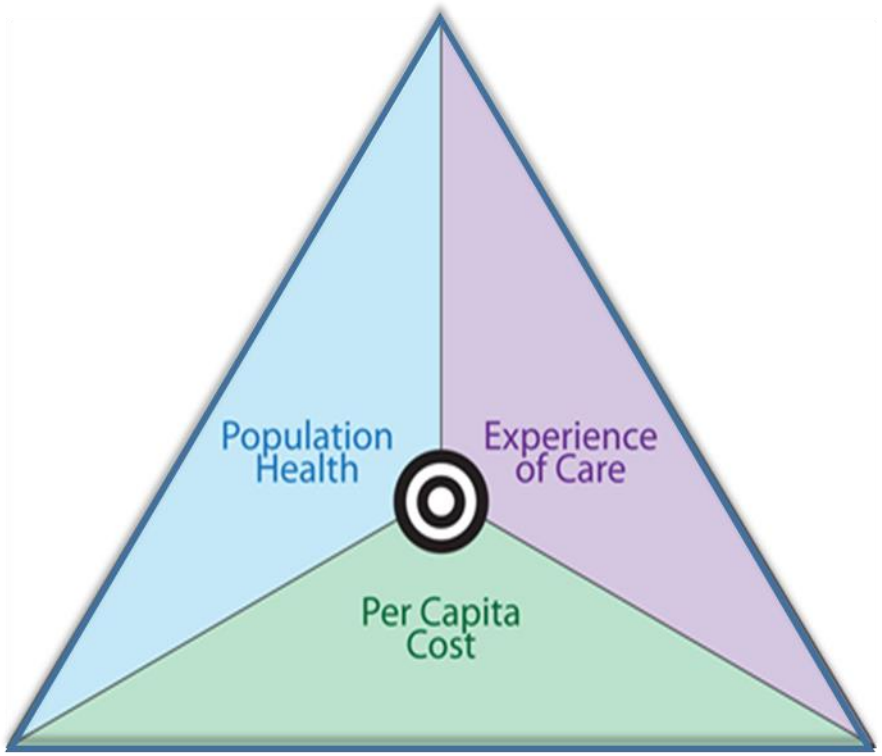
- Influence CMS Policy
- Health Care Payment Learning and Action Network (HCPLAN)
- Health Care Transformation Task Force (HCTTF)
- Antitrust advocacy
- Drug Pricing Policy
- Measurement/transparency

Advanced Primary Care (Care Redesign)

- Intensive Outpatient Care Program (IOCP/AICU)
- Practice Transformation
- California Quality Collaborative (CQC)
- Maternity Transformation
- Patient Reported Outcomes
- Measurement/transparency

Agents for Change
PBGH Members - Partial List

What MUST we solve for?



Quality and Measurement

Waste

Misaligned Incentives

Poor Patient Experience

High Prices (Consolidation)

The good news: there is low hanging fruit.

The bad news: one person's "low fruit" is another person's profits.

Agenda

- Drugs
  - Waste Free Formulary
  - Biosimilars
- Centers of Excellence
- Integrated Delivery Systems (IDS) and TCOC contracts
  - Low Value Care
  - Everything Else
- Pulling it together: PBGH's Health Plan Playbook

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The PBM Business Model is a problem

National Pharmaceutical

Search

Search

BENEFITS BROKER

BENEFITS MANAGER

Mon, Sep 03, 2018

Newsweek

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The Health 202: 'Gag clauses' mean you might be paying more for prescription drugs than you need to

By Paulina Firozi

July 5

A prescription is filled at a pharmacy in Sacramento. (AP Photo/Rich Pedroncelli)

THE PROGNOSIS

Using your insurance plan isn't always the cheapest way to buy prescription drugs. But your pharmacist might be banned from telling you that.

MANAGED Care

NEWS POL

DRUG MANAGEMENT

PBMs: Ma… Hearing W…

The industry has been cri… mergers with insurers an…

June 3, 2018

…ES AND …ISIS

…ng

…est life lesson he ever received cost him $80. It came from

PBM Revenue Streams are an intermingled mess…that you can't see through the sauce!

- **Rebate negotiations with pharma will impact formulary design and PBM revenues**
- Non "rebate" revenue from pharma also impact formulary placement
- Rebates and fees associated with one drug will often be connected to, or "bundled" with other drugs
- Rebate negotiations are impacted by pre-authorization protocol
- Pre-authorization can impact number of scripts, and the drugs selected, all of which impacts PBM bottom lines
- PBM collects UM fees from clients and utilizes pharma-supplied UM services, for which they might also get paid.
- **PBMs pay pharmacies less than they charge employers (spread)**
- PBM management of generic definition, AWP source, and AWP date will embellish revenues
- Pharmacy relationships will impact DIR and other fees
- Pharmacies might be owned by PBM
- Mail order might imply more fees for packaging/labeling drugs
- PBMs will aggregate rebates for a "wholesaler" market

- Rebate "pass through" for jumbo employers will increase market share (and rebate retention) for smaller clients
- **ETC.!!!!**

Managing a formulary pays off

The Commonwealth Fund

NEWSROOM TO THE POINT LOG IN SEARCH

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What's Trending: Medicaid Work Requirements High-Need, High-Cost Patient Personas Non-ACA-Compliant Health Plans

Reducing Wasteful Spending in Employers' Pharmacy Benefit Plans

August 30, 2019 | Lauren Vela

ABSTRACT

- **Issue:** Large self-insured employers and other health care plan sponsors are concerned about rising prescription drug costs. Formularies developed on their behalf by intermediaries like pharmacy benefit managers (PBMs) and health plans can ensure drug safety and support negotiating with manufacturers. But

Toplines

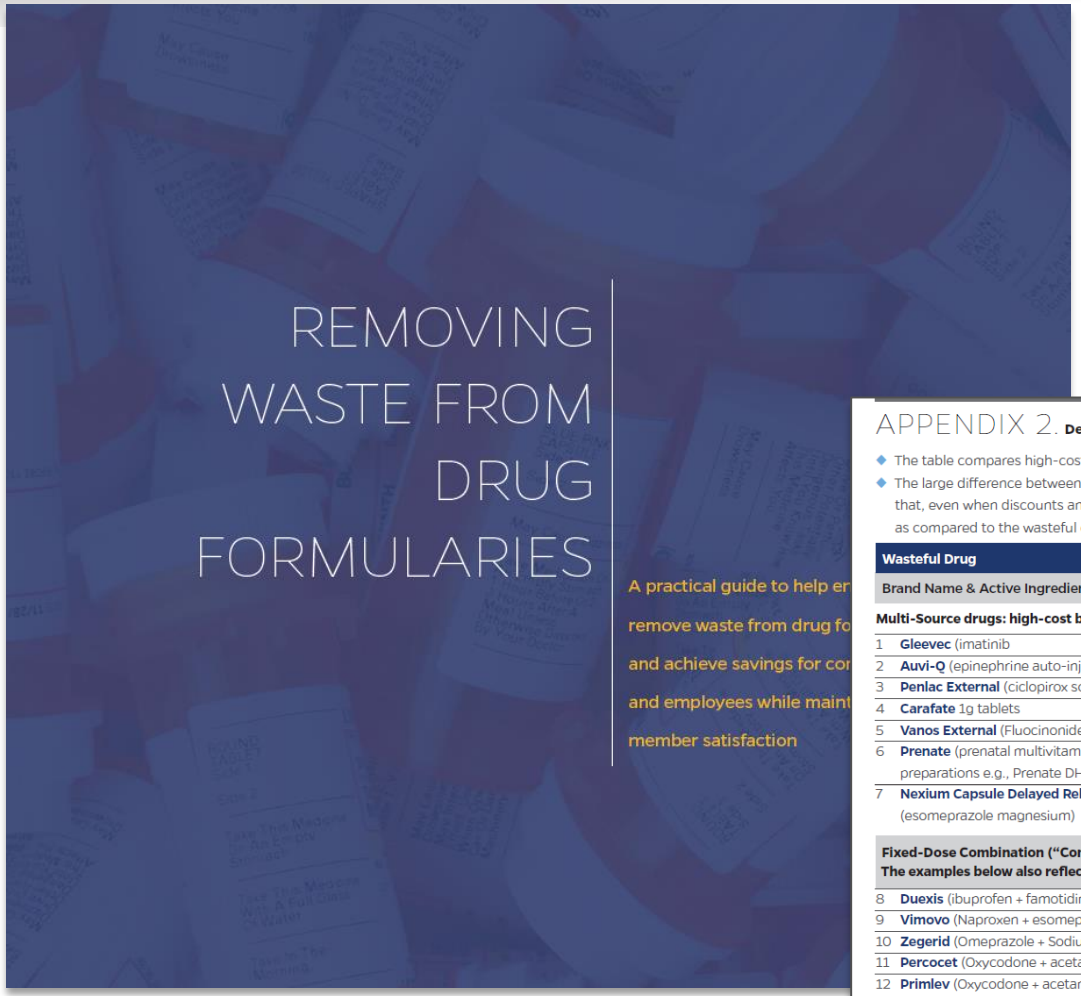
Pharmacy benefit plan sponsors could lower drug spending and out-of-pocket costs for enrollees by reducing the use of high-cost, low-value drugs

1. Is there substantial waste on the formularies of large, self-insured employers?
2. Would doctors prescribe to a common, waste-free formulary?
3. Would employers adopt a common waste-free formulary?

PBGH Waste Free Formulary Project

- 15 Data Donors submitted data (4 ESI, 8 CVS, 3 Optum)
- 2,543,907 claims evaluated of which 6% were wasteful, consisting of 868 different drugs
- Data was limited, assumptions were conservative
  - No controversial drugs (.01% specialty)
  - Only considered if excluding the drug saved ≥ 25%
  - Savings had to apply across formularies, i.e. specific formulary "deals" were excluded
  - Case study-based assumptions about patients' behavior
  - Savings were 11% less than comparative case studies due to conservative assumptions
- Estimated savings of this data set was $63.3 million
- Represented 2.8% to 24% of total PBM spend (for 9 data donors for whom we knew total spend. 10-24% for 7 of the 9. Two of the 9 had already begun managing their formulary.

3. Will employers remove waste?



http://www.pbgh.org/news-and-publications/pbgh-in-the-news/539-save-4-25-off-your-pbm-spend

APPENDIX 2. **Demonstration List of Wasteful Drugs, Less Expensive Therapeutic Alternatives, and Per-Unit Savings Potential**

- The table compares high-cost wasteful drugs with their less expensive therapeutic alternatives.
- The large difference between the prices of the wasteful drugs and the therapeutic alternatives indicates that, even when discounts and rebates are accounted for, the therapeutic alternative will still offer savings as compared to the wasteful drug.
- The total savings obtained from removing each wasteful drug from the formulary will depend on the utilization levels. Removing a wasteful drug with high utilization may provide great savings even if the price of its therapeutic alternative represents a low per-unit discount.

	Wasteful Drug			Less Expensive Therapeutic Alternative		
	Brand Name & Active Ingredient	Main Indication	Unit Price[1]	Therapeutic Alternative[2]	Unit Price[3]	Per-Unit Discount[4]
Multi-Source drugs: high-cost branded or generic drugs for which less expensive options are available						
1	**Gleevec** (imatinib	Leukemia and gastrointestinal tumors	$112.37	**Generic Imatinib**	$4.09	96%
2	**Auvi-Q** (epinephrine auto-injector)	Acute allergic reactions	$2,940.00	**Generic Epipen**	$247.01	92%
3	**Penlac External** (ciclopirox solution 8%)	Toenail fungus	$204.93	**Generic ciclopirox external solution 8%**	$8.02	96%
4	**Carafate** 1g tablets	Duodenal ulcer, short term treatment	$4.88	**Generic Sucralfate** 1g tablets	$0.33	93%
5	**Vanos External** (Fluocinonide 0.1% cream)	Itching of the skin (Pruritus)	$32.82	**Generic fluocinonide** 0.01% cream	$0.54	98%
6	**Prenate** (prenatal multivitamins) - multiple preparations e.g., Prenate DHA, Prenate Star, et	Nutritional supplement for pregnancy	$9.19	**PreNata** (Chewable tablet	$0.10	99%
7	**Nexium Capsule Delayed Release** (esomeprazole magnesium)	Gastroesophageal reflux disease	$10.04	**GoodSense Esomeprazole Oral** (Capsule, delayed release)	$0.25	98%
Fixed-Dose Combination ("Combo Drugs"): drugs with two or more ingredients in one pill costing substantially higher than the individual ingredients in separate pills The examples below also reflect drugs for which over- the-counter (OTC) options are available						
8	**Duexis** (ibuprofen + famotidine)	Pain in osteoarthrosis and arthritis	$33.10	**Generic ibuprofen** (OTC) + **Generic famotidine** (OTC)	$0.58	98%
9	**Vimovo** (Naproxen + esomeprazole)	Pain in osteoarthrosis and arthritis	$49.64	**Generic naproxen** (OTC) + **generic esomeprazole** (OTC)	$0.38	99%
10	**Zegerid** (Omeprazole + Sodium bicarbonate)	Gastroesophageal reflux disease	$132.27	**Generic omeprazole** (OTC) + **sodium bicarbonate** (OTC)	$0.60	99.5%
11	**Percocet** (Oxycodone + acetaminophen)	Acute Pain	$28.10	**Generic oxycodone** (Rx only) + **acetaminophen** (OTC)	$1.44	95%
12	**Primlev** (Oxycodone + acetaminophen)	Acute Pain	$22.10	**Generic oxycodone** (Rx only) + **acetaminophen** (OTC)	$1.44	93%
Me- too drugs: immaterial tweaking of a particular ingredient results in a "new" more expensive drug that adds no clinical value as compared to the less expensive original version.						
Example 1: Difference in the salt or chemical form of the active ingredient						
13	**Dexilant** (dexlanzoprazole)	Gastroesophageal reflux disease	$11.30	**Generic lanzoprazole**	$0.30	97%
14	**Aplenzin** (bupropion hydrobromide)	Smoking Cessation, Major Depression	$165.56	**Generic bupropion hydrochloride**	$16.0	90%
Example 2: Difference in the formulation: cream vs. lotion, capsule vs. tablet, packet vs. capsule, etc						

Biosimilars =

Specialty drugs manufactured using same processes as their “reference drugs” with NO clinical difference

Patent “Thicket”

26 Approved Biosimilars

-12 Launched Biosimilars

= 14 Tied up in a Patent Thicket

Problem YOU Can Solve.
12 biosimilars launched. Uptake slow.

Health plan /PBM Rebates

Buy and Bill

As EASY as 1-2-3

1. Ask your health plan to report on the opportunity for you to save if biosimilars were used
2. Ask your health plan their coverage policies for all biosimilars
3. Talk with your providers about why they are not using biosimilars

The Building Blocks of a COE

High Quality Providers

Facilities and Surgeons Qualified

Continuous Quality Improvement

Prospective Bundled Payments

Meaningful Measurement and PROMS

High Touch Concierge/ Navigation

Benefit Design Incentive (consider a mandate)

Doctors access their performance data about Total Cost of Care (TCOC), quality metrics, and utilization practices. They learn from each other. They are paid based on their TCOC and outcome metrics. They are supported by a multidisciplinary team to meet varied patient needs.

Rx is integrated with medical care. The ACO determines the formulary, step therapy protocol, and PA standards for their population. Physician point of service prescribing is simplified & streamlined. Patients don't have issues at the drug store counters.

EMRs and digital technology work together to provide information and decision support at the time of care and can be exchanged appropriately among providers. Data is captured and shared systematically to support outcome measurement.

Financial incentives are shared among doctors, hospitals, ambulatory centers, diagnostic centers, etc. in a way that promotes high efficiency and high value care. Underlying payment structures incent care redesign and efficiency.

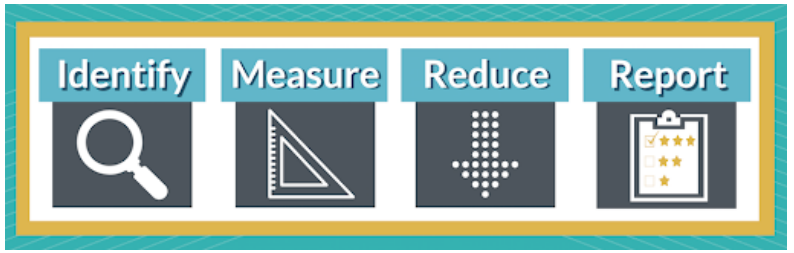
Patients are treated as whole persons with consideration of their psychosocial profile, personal goals and their risk preferences. Mental health is integrated and addressed as a medical condition.

Integrated Care Paid for Differently (APMs; NOT FFS!)

IDS and the hope for Low Value Healthcare

Choosing Wisely
An initiative of the ABIM Foundation

VBIDHEALTH



- Pre-authorization can impact much wasteful spending but are too blunt/disruptive
  - PA programs have substantial "Member Experience" risk. Once patients hear doctors order/prescribe an intervention….from their perspective, they need it!
  - Therefore, purchasers want/need providers (doctors) to be the solution!
- Plans' attributed or opt-in value-based programs that reward management of total cost of care have not had tremendous impact…but….moving AWAY from FFS will reduce waste.
- Consumer education is great but not particularly effective, e.g. Choosing Wisely
- Benefit design can/should play a role, i.e. steerage to higher performing networks.

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Leveraging the Collective Power of PBGH Members to Impact Health Care Delivery

Playbook for Successful and Collaborative Health Plan Management

Collective action among purchasers is one of the most constructive strategies we can deploy to send clear and concise messages to health plans; "we insist on higher quality and higher value care for our members and our plan". Please refer to this Playbook as a roadmap in your plan discussions and let them know you are committed to these priorities.

PBGH will facilitate these health plan discussions with you and on your behalf. We will access your permission for plans to report the measures to us (there is no data shared and certainly no PHI involved). Then, we can meet with you and the plan(s) to track progress. We welcome the opportunity to be your project manager on this initiative, allowing us to leverage the collective influence for better results across all PBGH Members.[1]

Measurement and Reporting	Employer POV	Potential Plan Pushback Employer Response
Benchmark **primary care spend** as a percentage of overall spend using this standardized methodology[2]	Studies show that more primary care is better by improving care coordination and reducing avoidable specialty spend.	There is no good reason for plans to not do this and in fact, should already be doing it on your behalf.
Report current use (volume of unique providers) and payment (aggregate payment per employer) for **Collaborative Care Management** (CoCM) codes (CPT codes 99492-99494) per employer. If plan pays for **depression screening** (96127, CPT II codes: G8510/G8431 or relevant HCPCS codes), report use (volume of unique providers) and payment (aggregate payment per employer).	Primary care integration of behavioral health helps address access, identification and treatment for individuals with mental health needs. This "ask" is for the plan to report the number of providers using these codes (which is a proxy for portion of PCPs with integrated behavioral health services) and total payments for these codes per employer.	Plans might say that not many providers are meeting the requirements for CoCM. Ask the plans what they are doing to help providers meet the requirements for CoCM payments. If they don't pay for these codes, ask why not?

[1] PBGH routinely discusses these topics with all national carriers and typically engages with the SMEs. It will be more effective to access and track progress using PBGH Member experience and strengthening the message with Member support.
[2] Standardizing the Measurement of Commercial Health Plan Primary Care Spending, Milbank Memorial Fund. See pp 5-7, https://www.milbank.org/wp-content/uploads/2017/07/MMF-Primary-Care-Spending-Report.pdf

	Employer POV	Potential Plan Pushback Employer Response
	Depression is under diagnosed. Primary care is a point of entry and important opportunity for engaging patients in emotional and mental health needs. Primary care integration of behavioral health helps address access, identification and treatment for individuals with mental health needs. Employers want to factor and budget appropriately for this important service.	The plan may not be able to administer payment for select CPT II codes for depression screening You are not asking the plans to administer this (yet). This request is for the plan to model the costs so that you can make an informed decision. Plans not yet capable of paying differently for depression, anxiety, and SUD screening should have a roadmap including timeline for doing so.
	The key objective to real reform is to align incentives by paying providers differently.	Plans might harangue you about how to measure this, i.e. variation in definition. Allow plans to use their definition and report to you what it is.

	Employer POV	Potential Plan Pushback Employer Response
	s can be identified and intervention. The plan ess the top 5% over-utilizers h, QI, and on-going nt. uld report on expenditures ocedures and present a discontinuation of purchasers are paying for that are "D" rated, i.e. ed to NOT happen. epend on their plans to lans that do not pay for D-s.	Measurement is challenging due to nuanced nature of the measures. • There are data specs available for select measures, let's start with that. • Milliman has developed a waste calculator, they can engage Milliman to do this work for them if they can't do it.
	ffer hope for competition in drug space where it is needed. Estimates suggest 0%-60% depending on the big money. If we don't biosimilars are getting used, ontinue to be available.	Plans might suggest that "discounts" are much bigger for reference products now. Ask them to show you where you are 1) paying less, or 2) getting the rebates. Remember, a rebate is NOT a discount if it doesn't go back to entity paying the bill, it's a kickback.

vided at the links below, might be appropriately used as opment of a bell curve of providers is for discussion. The point op a plan to address their practice patterns and/or limit their use by plan members.
[4] The low back imaging measure has been in practice for some time and may be an existing measure for your plan, in which case using it as a performance guarantee might be appropriate. The other measures with specs supplied (vitamin D screening and unneeded testing and lab work) might be more nuanced and therefore more appropriate for reporting to establish baseline.

cific Business Group on Health
ember Playbook for Health Plan Discussion
cember 2019

Measurement and Reporting	Employer POV	Potential Plan Pushback Employer Response
easure site of care savings portunity for Remicade and port on progress converting tients. Consider other drugs as ell.	Site of care represents huge opportunities for savings and member experience. If plans won't do this effectively, know that there are "clinical concierge" vendors able to do this with a clear ROI. Then, discount ASO fees to plan because they are not doing their job.	The plan may point to administrative challenges. This issue has been ongoing and recognized for years and exists. Send your plan this RECENT study and tell them you demand results! Use this sample if your plan is unclear about what you're asking for.
ans are asked to report on the A-PBGH Common ACO Measure t, which streamlines easurement and reporting for oviders. A collaborative effort in A identified 18 current core easures and 17 developmental easures. r what percentage of the plans' COs are the core measures utinely captured? (Please be ecific about which measures).	The Common ACO measures focus on a narrower set of high value metrics. Twenty leading ACOs and health systems and five plans (Aetna, Anthem, Blue Shield, Health Net and UnitedHealthcare) have endorsed this set. • Measure set emphasized measures that are clinically impactful and represent high value care. Included measures of behavioral health, maternity, and opioids since these are all important priorities for purchasers. • PBGH has prioritized adoption of depression screening, improvement, and remission as a patient-reported outcome measure.	The plans will say that the data is not always available and that they are hesitant to open contracts. Ask them for a roadmap for plans' inclusion of these measures in their ACO contracts.
nce mental health is a key PBGH ember priority, emphasize that ans should *report* on the pression screening and mission measures (which are signated as developmental easures as they may require source investment/new data reams): Screening for Clinical Depression & Follow Up Plan Depression Remission at 6 months	Patient Reported Outcome Measures (PROMs) are the optimal measure of meaningful outcomes for patients and can be used to improve the delivery of care; employers want to see movement towards measures that demonstrate high value care.	Plans will say this is very hard to do and the data is unavailable. Ask the plan to report on a roadmap for adoption.