The Progression of Value-Based Care: Pharmaceutical Landscape Perspectives

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Value in the Healthcare System

The measurement of value remains an evolving challenge in the healthcare system as value is complex – perspectives, methods, data and outcomes that should be used to define value vary; “value” can mean different things to stakeholders in the healthcare system.

There are a number of tools in play aimed at addressing or better understanding the value of medical products and treatment interventions to patients and the healthcare system as whole.

Health economics and outcomes research (HEOR) can help healthcare decision-makers in comparison of treatment options.

Real world evidence (RWE)

In response to concerns about healthcare spending, there has been a growing interest in measuring the value of treatments and services across the US through value assessment frameworks.

Value assessment frameworks are intended to be used as tools in measuring the value of health interventions and treatments.
Several organizations have developed value assessment frameworks; each designed with different end-users and decision-makers in mind, and vary across methods and data inputs when evaluating a healthcare intervention

- American College of Cardiology/American Heart Association
- American Society of Clinical Oncology (ASCO)
- Innovation and Value Initiative (IVI)
- Institute for Clinical and Economic Review (ICER)
- Memorial Sloan-Kettering Cancer Center (DrugAbacus)
- National Comprehensive Cancer Network (NCCN)

Each framework tends to reflect the interests and expertise of the developing organization and has been designed with different end-users and types of decisions in mind.

A comprehensive approach to measuring value must be used for assessing the societal value of treatments and services – including incorporating patient-centered outcomes and impacts.

WHERE WE NEED TO GO: GUIDING PRINCIPLES FOR VALUE ASSESSMENT

- Value assessment should focus broadly on all aspects of the healthcare system
- Methods should be based on established health economic methodologies, consistent with accepted standards
- Methods, models, and assumptions should be transparent and assessment results should be reproducible
- Base case assumptions must represent reality
- Sensitivity analyses should be performed, taking into account input from external stakeholders
- Weights should be included to accommodate varying user preferences

Collaborations with 3-P Stakeholders: Case Examples

**Patient Advocacy, Professional Organizations, Payer Institutions**

► **Patient Advocacy: Real-World Data Collection**
  - Collaborated with two different patient advocacy organizations focusing on autoimmune disorders
  - Care Gap: Increased flare frequency negatively impacted QoL, work productivity and healthcare resource use
  - Customer Insights: Highlights importance of patient / societal perspectives in optimizing disease management

► **Professional Societies and Provider Groups: Real-World Data Collection**
  - Collaborated with two large provider organizations focusing on autoimmune disorders
  - Care Gap: Less than half of patients had clinical disease activity documented in the electronic health record
  - Customer Insights: Opportunity to further partner on QI initiative to improve performance measures

► **Payers and Hospital Institutions: Real-World Data Collection**
  - Collaborated with a large integrated delivery network / health plan on perioperative care
  - Care Gap: One in ten patients had a complication which was associated with increased mortality, LOS, costs
  - Customer Insights: Opportunity to further partner on QI initiative to reduce complication rate
The Progression of Value Based Care

Financial Incentive Alignment
About M Health Fairview

A Full Spectrum of Services:
- Based in Minnesota
- 11 hospitals, including an Academic Medical Center (AMC)
- 40+ clinics
- 30+ pharmacies
- 90+ senior housing facilities
- 100+ specialties
- $6.1B+ total revenue
- Network of 5,000+ providers
- 34,000 employees
- 389,000 Health Plan Members

**As of 2/1/2021**
Value Based Care Risk Continuum

Increased risk requires organizational capability for success

Pay for Performance*  
Shared Savings  
(upside only)  
Shared Savings/Risk  
(up and downside)  
Bundles  
Capitation

**Pay for Performance**
- Financial incentives rewarding clinical performance and improved quality scores. Measure achievement is not dependent on reducing spend.

**Shared Savings**
- Financial models measuring actual medical spend compared to target. When savings is generated the health plan and health system share in the net savings created.

**Shared Savings/Risk**
- Financial models measuring actual medical spend compared to target. When savings is generated the health plan and health system share in the net savings created. In risk models the parties also share in a deficit.

**Bundles**
- Set payment for a discrete episode of care. Payment rates are generally set to provide value, with opportunities to improve margin by controlling costs.

**Capitation**
- Global Payment for the care of identified groups of patients.
Promise of Value Based Care

• Fee-for-service model – Payment for each service provided
  – Provider Incentive – Provide services efficiently. Provision of more services allows for economies of scale
  – Health Plan incentive – Reduce unit rate paid for services. Deny coverage of services, redirect business to lower cost providers,

• Aligned Incentive model – Payment has incentives to manage member costs
  – Provider Incentive – Provide services that add value to members in the lowest cost setting. Keep overall costs down.
  – Health Plan Incentive – Support providers who demonstrate ability to better manage costs.

Fairview
M Health Fairview’s Path to VBC

- 2009: First Commercial TCOC shared savings agreement
- 2011: TCOC agreements with all significant commercial payers
- 2012: CMS ACO products
- 2013: First Commercial ACO agreement
- 2017: TCOC risk arrangement for Medicaid
- 2019: Medicare Cost products discontinued in Twin-Cities
- 2021: TCOC agreements with all Medicare Advantage products in Market

Fairview
Obstacles to Capitation

- Predominance of self-insurance in group commercial market
- Shift of health care costs to members
- Government restrictions
  - Requirements for open access
  - First dollar out of pocket for non-preventive services
- Financial model transition creates conflict of incentives
- Reserve requirements to take on risk by provider organization
Healthcare Leadership Council

Carrie Nelson, MD, MS, FAAFP
System VP & CMO for Pop Health and Health Outcomes
10.27.2021
BY THE NUMBERS

26 HOSPITALS
500+ SITES OF CARE

Top 12 NOT-FOR-PROFIT HEALTH SYSTEM

Top 10 IN QUALITY AMONG NATIONAL HEALTH SYSTEMS

70,000+ TEAM MEMBERS

22,000+ NURSES
10,000+ PHYSICIANS

10,000+ VOLUNTEERS

53 INTEGRATED HEALTH & SAFETY MEASURES TRACKED

NEARLY $2.2B COMMUNITY BENEFITS IN 2019

3M UNIQUE PATIENTS
1.3M VALUE-BASED LIVES

1M+ LIVEWELL APP DOWNLOADS
Value

Caring for 1.3 million lives in 30+ value-based contracts

- Commercial Shared Savings: 577K lives
- Commercial HMO: 221K lives
- Medicare Shared Savings Program: 205K lives
- Medicare Advantage: 98K lives
- Advocate Aurora Team Members: 87K lives
- Managed Medicaid: 87K lives
Value-Based Care At Scale

Medicare Shared Savings Program (MSSP) Program in IL and WI

• One of the largest ACOs in the country
  ✓ $1.97B spend from 179K beneficiaries
  ✓ 520 Practices, 8,000+ clinicians, 23 Hospitals

• Consistent performance
  ✓ 96% Average quality score since 2012
  ✓ $414M+ in savings generated since 2012
  ✓ $190M+ in savings distributed to physicians/hospital
  ✓ 110M+ in savings generated in 2020

Medicare Bundles (BPCI-A and CJR)

• BPCI-A and CJR program participants
  ✓ $581M spend, 18.5K episodes
  ✓ 125 Practices, 2,000+ clinicians, 23 Hospitals

• Early performance
  ✓ $20.5M in savings generated since October 2018
  ✓ $12.4M available for distribution to hospitals and physicians since 2018
  ✓ $2.8M in CJR savings distributed 2016-2020 (WI)

In 2020 Advocate Aurora generated the most savings of any integrated delivery system in the U.S.
Making Care More Affordable

- National health care costs have reached over $3.81 trillion
- Medical costs have risen approx. 6% nationally per year
- Advocate Aurora has been able to control this increase at 1% to 2% per year for patients in our value-based plans
Innovative Contributors to Success

- Integrated Care Management
- Post-Acute Programs
- Social Determinants of Health Screening and Referral
- Pharmacy Programs
- People + Technology
Balancing the Evolving Demands of Value-based Care

Susan Weidner
Senior Vice President, IntrinsiQ Specialty Solutions
October 26, 2021
Involvement of all stakeholders is paramount to the success of value-based care

**Payers**
Investigating alternative payment models while implementing new services and treatments for personalized care

**Specialty Providers**
Optimizing care delivery to ensure access to the most appropriate treatments and services

**Pharmaceutical Manufacturers**
Identifying the most effective ways to ensure patient access while balancing drug costs and outcomes
Balancing the demands of payer and pharma contracts

Specialty providers do not get to select which patients walk into their practices

Provider treats the Patient

- Based on the current disease(s), status, and other attributes
- Selects treatment options based on clinical guidelines and available evidence

Value-based payer contracts

- Episode-based payment periods which may be inconsistent across treatment regimens
- May require incremental medical services to ensure appropriateness
- Inclusive of expenses occurring outside of the practice

Drug rebate contracts

- Typically driven based on volume and market share
- Limited contracts for therapies to treat rare patient populations
- Limited adoption/use based on payer coverage

Precision medicine testing

- Use of biomarkers to determine appropriate treatment options
- May be diagnostic or prognostic
- May be used to measure disease status and/or treatment response
- Inconsistent coverage across payers and related contracts

Multi-drug regimens

- Becoming the norm across specialties
  - 65+% of all oncology treatment regimens contain more than 1 drug
- Now includes IV and oral combinations
- Biosimilars are not generics, requiring the same authorization as the originator
- May be therapeutic and/or supportive care
How AmerisourceBergen is involved

**Advocacy**
Represent our specialty providers and other stakeholders in the impact of proposed value-based models

**Evidence-driven Contracts**
Support the implementation of evidence-driven drug contracts where the focus is on appropriate use

**New Model Participation**
Support the assessment and implementation of new models, including network access, education, and practice impact modeling

**Integrated Solutions**
Enable new solutions that allow providers to have improved access to information and insights at the point of care