PBMI PERSPECTIVES

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THE LATEST HEALTHCARE NEWS & VIEWS FOR PRESCRIPTION DRUG PLAN SPONSORS

DEADLINE FOR SPEAKER SUBMISSIONS TO PBMI's 2017 CONFERENCE IS AUGUST 5TH!

- **Why submit?** Our conference offers an excellent opportunity for you to share ideas on the most significant pharmacy benefit issues with a wide variety of industry leaders and plan sponsors.
- **Is there a cost to submit?** Submitting a proposal is free. If selected, speakers receive a complimentary conference registration.
- **Which topics are preferred?** While all proposals will be considered, proposals of greatest interest will focus on best practices for cost containment, quality improvement, care management strategies, and emerging trends in the management of specialty and traditional drug benefits. Case studies are highly recommended.
- **Can I submit more than one proposal?** Companies can send up to three submissions. A separate submission form should be completed for each proposal.
- **Where should I send my proposal?** All proposals should be sent to marketing@pbmi.com.

To get tips for a successful submission, visit:
https://www.pbmi.com/2017-conference-call-speaker/

We look forward to receiving your proposal(s).

PBMI Member Showcase Program

Summer is here and we would like to introduce our PBMI Member Showcase Program featured in our ongoing membership newsletter.

PBMI is dedicated to creating dialogue in the industry. A critical part of that process is encouraging members to share different points of view that will challenge our readers to consider various sides of a topic and use this information to develop their own critical opinions on topics important to drug benefit management.

With this important goal in mind, we will occasionally be sharing the spotlight with PBMI members who contribute content to our newsletter. This is just another opportunity for us to show the value of your membership.

Disclaimer: The views and opinions expressed in this article are those of the author(s) and do not necessarily reflect the position of PBMI.

This month's article is written by Tony Zappa, Pharm.D., MBA, Visante Inc., and Jim Jorgenson, MS, RPh, FASHP, Visante Inc.

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REFERENCES

[1] EMD Serono. EMD Serono Specialty Digest: Managed Care Strategies for Specialty Pharmaceuticals. 2016

WANT TO COMMENT OR SUGGEST A TOPIC FOR AN UPCOMING ISSUE?

CONTACT PBMI PERSPECTIVES EDITOR, SHARON FRAZEE, AT

SFRAZEE@PBMI.COM.

VALUE-BASED SPECIALTY PHARMACY PROGRAMS:

Why PBMs and Payors Should Consider Adding Health System Specialty Pharmacies

"Value-based" is a term often used when discussing drug purchasing where costs are based on therapeutic outcomes. However, applying value-based principles can be difficult due to the lack of consensus in how value is calculated. Indeed, a recent EMD Serono report[1] noted that 26% of healthcare executives surveyed said determining the value of specialty drugs is their biggest challenge.

Value is now being applied in purchasing (i.e., reimbursement), decisions between health plan sponsors and providers, primarily hospitals and doctors. Predominant models include pay for performance, shared savings (i.e., sharing upside only), shared risk (i.e., sharing upside and downside), and capitation. Value models work with these providers because of their ability to reduce volumes and costs of care provided.

Applying these models to other parts of the healthcare system, specifically specialty pharmacies, can be more difficult.

- Specialty pharmacy's therapy management goals include increasing utilization through adherence management
- Specialty pharmacy management increases pharmacist-patient interventions, which could increase cost of care if those services are billed and reimbursed
- Specialty pharmacies have limited influence over drug selection, which is impacted more by payor formularies and prescriber incentives (including value-based payments to providers)

Specialty pharmacies will have to create a new value paradigm that eschews cost and utilization reductions and focuses instead on adherence and persistency improvements, therapeutic outcomes, and patient satisfaction. In other words, specialty pharmacies will be paid more for providing more care, not for reducing care. That said, specialty pharmacies may be able to help payors reduce costs of care by facilitating site of care shifts that lower costs (e.g., moving patients on infused drugs from hospital-based centers to community-based facilities or patients' homes), and these services will need to be considered in the value equation.

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Value determination: What measures will be needed in this new model?

At a minimum, measures of adherence and persistency will be required. Ideally, standards will be determined and set for each disease state based on the risk of treatment failure. For example, treatments for HIV/AIDS or solid organ transplant immunosuppression may have a target adherence rate of 95% to minimize resistance or rejection, respectively, whereas multiple sclerosis (MS), or rheumatoid arthritis (RA), may only require rates of 80% to achieve functional goals and slow long-term disease progression.

Likewise, persistency targets will need to be set to ensure that drugs are not only taken as prescribed but for the intended length of therapy. Again, this may differ by disease state or condition: HIV/AIDS therapies should have persistency rates of years while certain cancers and hepatitis C will be weeks to months.

Specialty pharmacies will need to be able to demonstrate that their patients are receiving care according to established protocols including lab tests and other follow-up services.

Adherence and persistency only tell part of the story. True outcome indicators will need to be developed and implemented, combining therapeutic performance with healthcare resource utilization. For example, managing people with solid organ transplants requires not only drug therapy management but also regular and routine clinic visits and laboratory testing, especially during the first 12 months after the transplant. Specialty pharmacies will need to be able to demonstrate that their patients are receiving care according to established protocols (national or program-based), including lab tests and other follow-up services (such as foot care or eye exams for people with diabetes), and that they are not accessing healthcare resources outside of the protocol (such as an ER visit for a suspected infection, or a hospitalization for an acute rejection episode).

Also, specialty pharmacies will need to start looking at their patients holistically and not just as an “MS patient” or an “RA case.” Many people with diseases and conditions treated with specialty medications often also have other chronic conditions. Specialty pharmacies do well at managing specialty drug therapies, but typically do little to assist patients with other conditions that also cause long-term problems if not controlled. Full medication reconciliations should be done with each patient, and an overall care plan designed consistent with medication therapy management principles. Adherence and persistency of all chronic medications should be considered, as well as adverse event and side effect management.

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Health system-based specialty pharmacies: Do they have an advantage?

Over the past five years, hospitals and health systems have been actively developing specialty pharmacy programs. This is for three major reasons:

1. As hospitals take on more risk, they realize that maintaining control of ALL care is critical to their performance. Allowing drug therapy, which represents 80% or more of outpatient care, to be moved to outside providers disrupts this control and causes the loss of crucial data and information collection.
2. Competition amongst hospitals is ever-increasing and maintaining a positive patient experience is important to retention efforts. The movement of patients, especially those with chronic and complex conditions, to outside providers reduces the hospital's connection and potentially negatively impacts their retention efforts.
3. Clearly, as utilization and costs of specialty drugs continues to increase, they represent a significant revenue and margin opportunity for hospital-based specialty pharmacies. This is especially true for 340B-eligible hospitals, which can see operating margins of 30% to 40% on specialty drugs.

PBMs and payors should embrace these new entrants due to the advantages they bring to care management:

- Integrated medical and pharmacy data within the electronic medical record (EMR)
  - Hospital-based specialty pharmacy (HSP) pharmacists can see diagnoses, visit notes, lab test results, and other treatment and diagnostic information not available to outside pharmacies
  - HSP pharmacists can record their interventions for other health system providers to review and include in care plan decisions
  - Care plans can be more integrated, and drug-related problems identified and handled more quickly
- Clinic-based pharmacists and technicians
  - Prior authorizations and financial assistance counseling can be done prior to prescriptions being written to minimize delays
  - Counseling, both therapeutic and financial, can be performed face-to-face before therapy and at each clinic visit (including clinic appointments specifically for medication therapy management, or MTM)
  - Prescriptions can be delivered to patients during their clinic visit, removing one barrier to optimal adherence (20% to 30% of written prescriptions are never filled). Also, patients who are not psychologically ready for specialty medications (common in patients with HIV/AIDS and cancer) can be seen in clinic and counseled until they are ready
  - Health system pharmacists are often integrated into the total patient care team through emerging vehicles like the Patient Centered Medical Home model, and can more directly influence drug selection and management
- Product knowledge and experience
  - Many HSPs are inside academic medical centers that act as referral centers and perform clinical research, so pharmacists and providers have more extensive experience with new and emerging therapies before other providers
  - Data from clinical research can inform clinical pathways and protocols and help HSP pharmacists identify patients who may be at risk for drug-related problems

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- Site-of-care integration
  - o HSP programs can coordinate care across inpatient and outpatient settings with full medication reconciliation and care planning across both sides
  - o All care is documented in a single EMR so inpatient and outpatient providers can know and understand patient histories and treatment plans
  - o Care can be coordinated amongst all available outpatient care settings including clinics, home care and home infusion, transitional care settings and patients' homes. Medications can be prescribed and given or dispensed same-day to patients needing immediate therapy changes or rapid therapy initiation (such as enoxaparin upon hospital discharge or infertility treatments)

Hospital-based specialty pharmacies, and their associated staff and management systems, are uniquely positioned to benefit patients and healthcare cost risk holders over the long term.

Why should PBMs and payors work with hospital-based specialty pharmacies?

As noted earlier, hospitals have three main objectives:

1) **Minimize risk,**
2) **Enhance the patient experience, and**
3) **Seek out new sources of revenue and margin.**

Even considering objective 3, hospitals and health systems are focused on their own patients. They don't want or need to capture the broader specialty pharmacy opportunity in their markets – they only want to manage their patients' treatments and experience across all sites of care. This limits the overall impact on competing specialty pharmacies, who can still market to and service patients outside the hospital's patient list.

HSPs are not a threat to other specialty pharmacies because of their interest in only managing their own patients. They are also not a threat to payors, since most HSPs will accept prevailing reimbursement rates for specialty drugs, or be able to substantiate higher reimbursements with data showing improved outcomes and lower costs of care. Some HSPs may be able to offer payors and plan sponsors below-market prices due to improved purchasing power, providing a short-term gain while longer-term care management savings programs are developed and implemented.

HSPs will also agree to meet payors' performance standards, both clinical and operational, to ensure that plan members are not disadvantaged by using the hospital's program. Payors will benefit from this focus on quality through better case and disease management and improvements in STARS and Healthcare Effectiveness Data and Information Set (HEDIS) scores.

"Value" may well be a buzzword in today's healthcare system. New forms of reimbursement and cost management are being developed and tested to establish and compensate for value across sites of care and treatment options. Providers who can more directly and quickly impact care will likely emerge as victors in this new environment. Hospital-based specialty pharmacies, and their associated staff and management systems, are uniquely positioned to benefit patients and healthcare cost risk holders over the long term. Payors, PBMs and other managed care entities should carefully consider the advantages of working with these new providers and not automatically block their participation in the care continuum.

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Article's Authors

Tony Zappa, Pharm.D., MBA

Since 1985, Dr. Zappa has been leading companies across several pharmacy-related industries. This experience includes 9 years with PBMs, including 3 years of international experience in London and South Africa; 12 years with specialty pharmacies, both mail order and community-based; 3 years with 340B administration; and shorter stints with home medical equipment, internet pharmacy and prescription claims auditing. His experience includes periods in both private and public companies, and in large public corporations and start-up companies including 3 as a founding member.

As part of his career, Dr. Zappa spent nearly three years with Wellpartner as VP of Operations and Business Development. He was lead designer and product manager for a novel program that allowed covered entities and health plans to collaborate on patient care programs funded by 340B savings. Prior to Wellpartner, Tony served for three years as CIO and VP of Specialty/Infusion Operations with Fairview Pharmacy Services. He led revenue growth, productivity improvements and operating cost reductions in the pharmacy operations each of his 3 years. As CIO, he was responsible for all computer applications used in the retail and mail order/specialty operations. Dr. Zappa led a team that converted the dispensing and point-of-sale systems in over 40 dispensing sites within a 9-month period.

Dr. Zappa also spent five years with Chronimed/BioScrip as Executive Vice President of Operations for retail, mail order, and clinical services. Combined with the 32 retail locations, Tony grew revenues from $300 million to $500 million over 5 years with consistent margin percentages over that time.

Prior to BioScrip, Dr. Zappa spent eight years with Diversified Pharmaceutical Services and SmithKline Beecham's PBM unit. Dr. Zappa was a founder of Interpharm, the first PBM in South Africa, and served in London as the head of SKB's international managed care business development unit. Dr. Zappa's prior clinical experience includes over five years of hospital and retail pharmacy practice.

Dr. Zappa earned his B.S. and Pharm.D. degrees from the College of Pharmacy, University of Minnesota and an MBA from the University of St. Thomas in Minneapolis.

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Chief Executive Officer and Board Chair, Visante, Inc. and Visante Limited

Jim Jorgenson is CEO of Visante where he leads national and international programs for medicines management improvement in the US, UK and Canada. His more than 30-year career includes pharmacy oversight of very large health systems and their network associations, as well as academic leadership in graduate pharmacy education.

Previous to joining Visante, Jim was Vice President, Chief Pharmacy Officer for Indiana University Health (IU Health), the largest and most comprehensive state-based healthcare system in Indiana with 18 hospitals and over 5,000 beds.

Previous to joining Indiana University Health, Jim was Administrative Director of Pharmacy Services for the University of Utah Health Care and Associate Dean for Pharmacy at the University of Utah College of Pharmacy in Salt Lake City. He also directed pharmacy services for the 2002 Winter Olympic games in Salt Lake City.

Jim's leadership has also extended to professional organizations and societies where he has served on numerous councils and committees for the American Society of Health System Pharmacists (ASHP), and is a faculty member for the ASHP Foundation Pharmacy Leadership Academy. In 2008, he received the ASHP Award for Distinguished Leadership of Health-Systems Pharmacy Practice.

Did You Know PBMI Members Can View Past Webinars for FREE?

That's right! Just browse our Webinars page, click on the webcast you'd like to see, and register to receive a link to the recording. Over the past few months, we've held several webinars on topics that address the challenges of drug benefit management.

Below is just a sampling of a few of our most recent webinar topics:

- Paying for Value: Novel Approaches to Managing Specialty Medications
- Delivering the Right Information to the Point of Care
- Strategies to Improve Medication Adherence and Help Keep People at Work
- ROI and Member Engagement Through Digital Content Delivery
- Leveraging Dedicated Pharmacists to Manage Pharmacy Benefits

To see a complete list of webcasts visit:

https://www.pbmi.com/shop-category/educational-resources/webinars/.

Sign up today.

We will ramp up our webinar calendar again in early September, so stay tuned…

WELCOME NEW PBMI MEMBER

Please join the staff of PBMI in welcoming our newest corporate member.

RelayHealth

Location: Atlanta, GA | Contact: Jan Reed, Director Health Plan Services | Phone: 843-453-8812 | Email: jan.reed@relayhealth.com

RelayHealth Pharmacy Solutions connects health plans with more than 50,000 retail pharmacies enabling them to utilize a pharmacy's accessibility to drive member engagement, medication adherence and an overall improvement in quality measures and outcomes. To learn more, visit www.relayhealth.com/interventionmessagingrx, call 800.868.1309, or email pharmacy.connections@relayhealth.com.