RESEARCH REPORT

Advisory Board

New plan strategies to assess drug value

Four emerging techniques for managing specialty drug costs

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RECOMMENDED FOR

Plan strategy officers, chief pharmacy officers, pharmacy leaders, P&T committees

READING TIME

20 min.

Emerging best practices in drug value assessments

Plans must adapt for more complex therapies that have limited evidence

This year, we spoke to dozens of health plan pharmacy executives to ask how they assess a drug's "value" when reimbursing for drugs or choosing which drugs to put on their formularies. Traditionally, plans evaluate drugs following a strict rubric of safety, efficacy, and unit cost. They often curate internal expertise and make decisions independently within the plan, then notify providers about drug coverage preferences.

But disruptive forces—such as the high upfront cost of new treatments and the lack of comparators for first-in-class and orphan drugs—require plans to change their evaluation techniques. Progressive plans are adopting these four emerging best practices:

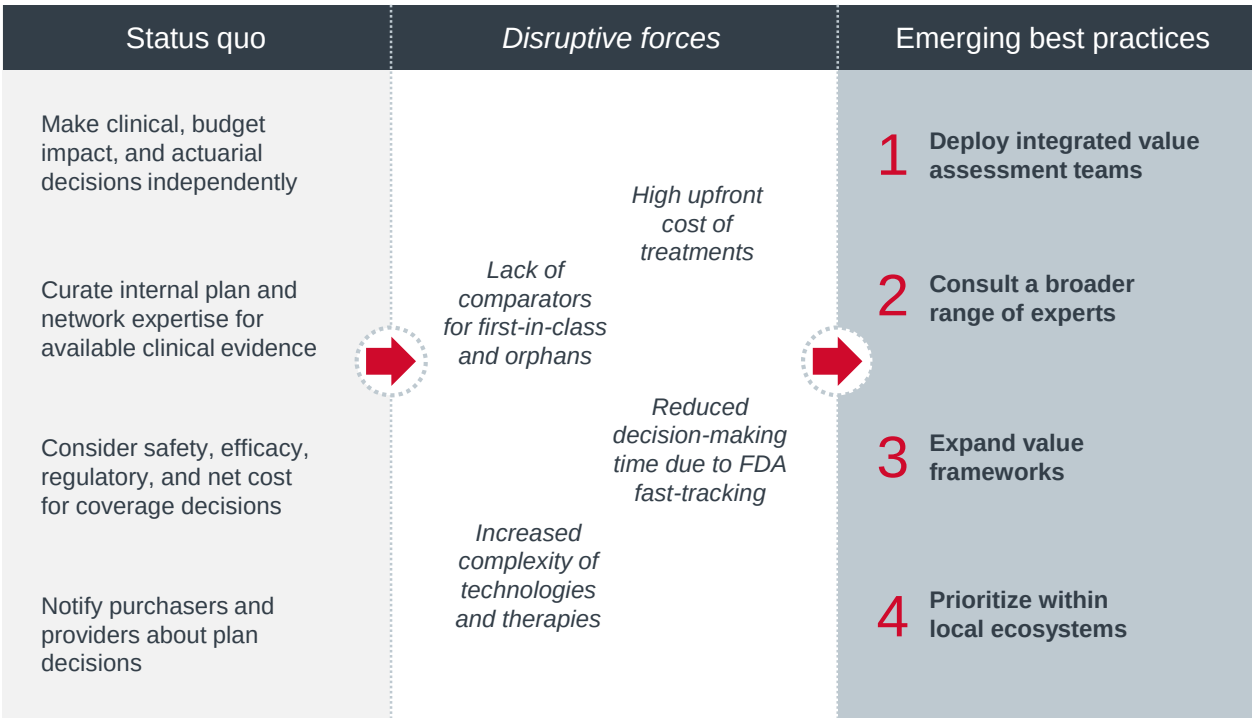
1. Deploy integrated value assessment teams: Form multidisciplinary teams which include representatives from pharmacy, medical, utilization management, and behavioral health to bust internal plan siloes (see page 3).

2. Consult a broader range of experts: Expand plan assessments of definitions of value by using reports from third-party health technology assessments (see page 6).

3. Expand value frameworks: Systematically broaden internal criteria for value to account for more member and population health considerations (see page 10).

4. Prioritize within local ecosystems: Work with providers, purchasers, and patients in each local "ecosystem" to prioritize and act on different aspects of value (see page 14).

Changes in plan drug value assessment techniques



Source: Advisory Board Research interviews and analysis.

Section

1

Deploy integrated value assessment teams

In this section:

- How some plans are establishing multidisciplinary drug evaluation committees
- A checklist of plan considerations for evaluating drug evidence
- **Case study:** Creating a preferred drug list

Plan Medical Technology Assessment Committees

Plans recognize the need to gather diverse, internal feedback on drug value

Most plans evaluate technologies and drugs in silos: pharmacy and therapeutics (P&T) and medical committees have distinct purviews, and they weigh financial impact only after clinical assessments are complete. But a handful of plans (especially large regional plans with clinically integrated networks and/or provider-sponsored plans) are establishing multidisciplinary Medical Technology Assessment Committees designed to evaluate treatments in the context of all intervention types, and to assess clinical and financial impact simultaneously.

To stay competitive, more plans should develop these multidisciplinary committees to take full advantage of the variety of expertise and perspectives already housed within the health plan.

The committees typically include representatives from pharmacy, medical, utilization management, and behavioral health; they prioritize evaluation of expensive therapies that incur both medical and pharmacy costs (e.g., CAR-T, gene therapies) as well as treatments with alternatives that span distinct intervention types (e.g., bariatric surgery vs. medication vs. lifestyle changes for weight loss). Because they include diverse perspectives, the committees can maximize treatment impact within a more holistic value framework.

Once the committee has been established, use the checklist of plan considerations below to guide value conversations between internal plan departments, or between the plan and the drug manufacturer.

CHECKLIST

Plan considerations when evaluating drug evidence

Ask these questions before accepting manufacturer-provided data on a new drug:

1. Has the study been conducted for a long enough time with a large enough group of people?
2. Is the study population similar to your membership population?
3. At which site of care was the study conducted (e.g., hospital, PCP office, trial center, etc.)?
4. Is the study design transparent (e.g., algorithm, economic model, etc.)?
5. Has the study considered other variables that could impact outcomes, including adherence?

Source: Advisory Board Research interviews and analysis.

Evaluation committees in action

WS-HCA created a single preferred drug list for Washington Medicaid plans

Plans are not the only ones able to create these internal, holistic evaluation committees. Washington State Health Care Authority (WS-HCA) researched and implemented a single preferred drug list in 2018 for five Managed Medicaid plans.

By proactively evaluating the value of each drug in a holistic manner, WS-HCA was able to not only ease the burden on these Managed Medicaid plans to create unique formularies but also standardize the formularies for providers' sakes as well.

While WS-HCA is somewhat unique in its position as the "all in one" purchaser, plan administrator, and health care provider network, it is clear that having committees dedicated to drug evaluation can enact real change.

Interestingly, Washington is also unique in that it has recently received CMS approval (June 2019) to develop a "Netflix model" for Hepatitis C drugs, wherein the state pays a fixed amount plus a nominal fee to contracted manufacturers in exchange for population-wide access to its antiviral therapies.

CASE EXAMPLE

Washington State Health Care Authority

2M+ members; largest health care purchaser in Washington

On January 1, 2018, implemented the Apple Health (Medicaid) Preferred Drug List (PDL) – a single preferred drug list for five Managed Medicaid plans

Goal to **standardize entire list by 2020** without disrupting care for patients on existing medications

Phased quarterly roll-out of PDL by drug class; **team implemented list for 27 drug classes in 2018,** prioritizing categories by utilization and rebate potential

Initial feedback has been **overwhelmingly positive;** standard PDL reduces administrative burden for providers and patients switching plans

Source: Advisory Board Research interviews and analysis.

Section

2

Consult a broader range of experts

In this section:

- How Health Technology Assessors (HTAs) have progressed to be more valuable for plans
- The four main types of HTAs and when to use them
- Rising open-source data aggregators, an alternate to HTAs

Rise in Health Technology Assessment organizations

Scale and scope of support has evolved well beyond passive reports

Third-party health technology assessors (HTAs) have long been a passive voice of objectivity on the value of specific drugs and devices—they were available in the background to support an organization's already-formed idea of value. Their primary function was to collate published literature into a meta-analysis rooted in various proprietary assessment frameworks.

But now, many HTAs are evolving and new firms are emerging to drive market-wide adoption of a stance on value, while others are focused on embedding systems to drive adoption of guidelines at an institution level.

Plans increasingly need to consider HTA reports and advice when making drug evaluations rather than making evaluations independently from everyone else in the industry. These HTAs will help plans keep a pulse on how other plans, regulatory organizations, and purchasers are evaluating drug value.

There are a growing number of third-party assessors influencing plan and provider perspectives on value. These largely fall into one of four types of influence: regulatory, policy, advocacy, and advisory HTAs. The exact type(s) your plan chooses to use will depend on your plan's specific goals:

1. **Regulatory HTAs** when you want to develop innovative pricing models to support market-wide adoption, especially for public entities
2. **Policy HTAs** when you want to join or align your drug evaluations with national conversations on pricing and coverage
3. **Advocacy HTAs** when you want to learn about provider and patient perspectives on drug evaluations and care pathways
4. **Advisory HTAs** when you want consultative services to embed your evaluations into physician strategy or workflows

Main types of HTAs

Regulatory

Traditional HTAs at the state and/or federal level, making coverage decisions for public entities

Name you know: VA CHOIR, Oregon HERC

Rising in influence: Washington State HTA Program, Louisiana Department of Health

Policy

These policy and PR engines aim to influence regulations and, more broadly, the national conversation around pricing and coverage

Name you know: ICER

Rising in influence: AHRQ

Advocacy

Patient and provider advocates create clinical guidelines to promote high quality, standardized care at the national level

Name you know: NCCN

Rising in influence: AMCP

Advisory

Emerging advisors form continuous relationships with individual orgs via consultative and analytic decision support, coupled with traditional product/category assessments

Name you know: ECRI Institute, Hayes Inc.

Rising in influence: Lumere, IPD Analytics

Market-wide adoption ← → *Org-specific implementation*

Source: Advisory Board Research interviews and analysis.

Close up on the main players: ICER, IPD, Lumere

Plans use these HTAs for objective, tailored assessments of value

Third party HTAs are emerging as a potential solution for plans to support objective, appropriately tailored assessments of value.

Unlike traditional HTAs, which typically produce static reports for regulatory and policy audiences, an evolving group of HTAs couples objective assessments with institution-specific advisory services. Organizations like Lumere and IPD Analytics provide resources and tools that aggregate multiple sources of evidence, provide real-time efficacy and pricing data, and can embed their data in an organization's existing analytics platforms and decision processes.

	IPD Analytics	Lumere
	"The right lessons from the past can help you plan for and predict the future."	*"We aim to democratize access to comprehensive clinical evidence."*
PLAN PAIN POINT	• Lack of visibility into new market entrants and loss of exclusivity • Difficulty with optimal comparison sets	• Incomplete product, category knowledge • Limited insight into recalls, adverse events • Physician buy-in and compliance
SOLUTION	• Aggregates disparate data sources on clinical trials, pipelines, regulatory filings, past launches, and relevant IP cases to help plans' assess impact of market changes and anticipate future scenarios • Provides real-time legal, regulatory, clinical alerts • Legal, pharmacy experts advise on relevant comparisons and category definitions	• Web-based analytics platform combines broad base of clinical evidence with product details as well as pricing and cost data • Covers 30,000+ drugs/devices • Draws on 120,000 journal articles, plus relevant data on recalls and adverse events • Monitors physician utilization, flags variation • Integrates into product, category evaluation workflows

For a detailed 101 on ICER, one of the major HTAs driving how the industry perceives value, read our article at https://www.advisory.com/daily-briefing/2019/12/09/icer

Source: Advisory Board Research interviews and analysis.

Open-source data aggregators are another option

Plans also use or create open-source data aggregators to help assess value

An alternative to HTAs in the market is open-source data aggregators. Plans can also use or even create open-source data aggregators to help assess drug value.

Open-source data aggregators could be the next frontier for developing transparent, objective assessments of medical value. Platforms like the Innovation and Value Initiative (IVI) crowdsource information from peer-reviewed journals, real-world evidence studies, and cross-sector thought leaders—allowing users to perform custom analyses based on their organization's specific needs and interests.

In fact, some plans have already started sponsoring their own open-source data organizations. Organizations like VITAL, a plan-sponsored program designed to generate real-world evidence, is committed to data transparency. VITAL, which is funded by Highmark Health, "owns" the generated data, but collaborators are free to access and interpret it for themselves.

IVI[1] piloting radically transparent and collaborative value platform

Open-source data platform for simulating outcomes to assess relative treatment value

- Online simulator uses peer-reviewed literature, real-world data, and cross-sector expert input to inform baseline model, generate cost effectiveness analysis, and aggregate value score
- Platform is publicly available for any stakeholder to input custom factors and assess relative value of therapies
- Users can input population-specific characteristics (patient age, gender, treatment history), organization-specific costs (drug unit price, price rebate, infusion cost) and member experience values (treatment ease of use, quality adjusted life year)

VITAL speeding time-to-market for innovative technologies

Highmark Health funded program for accelerating adoption of new-to-market technologies

- Manufacturers submit proposals for newly launched products with limited adoption; participating providers gain early access to innovative products that lack coverage
- VITAL aggregates claims, clinical outcomes, and cost data to generate real-world evidence
- Providers and plans can access data to inform coverage and appropriate use; manufacturers can use data to support further adoption
- Areas of focus to date include cardiology, oncology, women's services, chronic conditions, personalized medicine, and clinical transformation

1) Innovation and Value Initiative.

Source: Advisory Board Research interviews and analysis.

Section

3

Expand value frameworks

In this section:

- A new framework for drug value assessments
- **Case study:** Expanding drug access to lower total cost of care
- **Case study:** Expanding drug access by removing prior authorizations

Evolving framework for medical value assessments

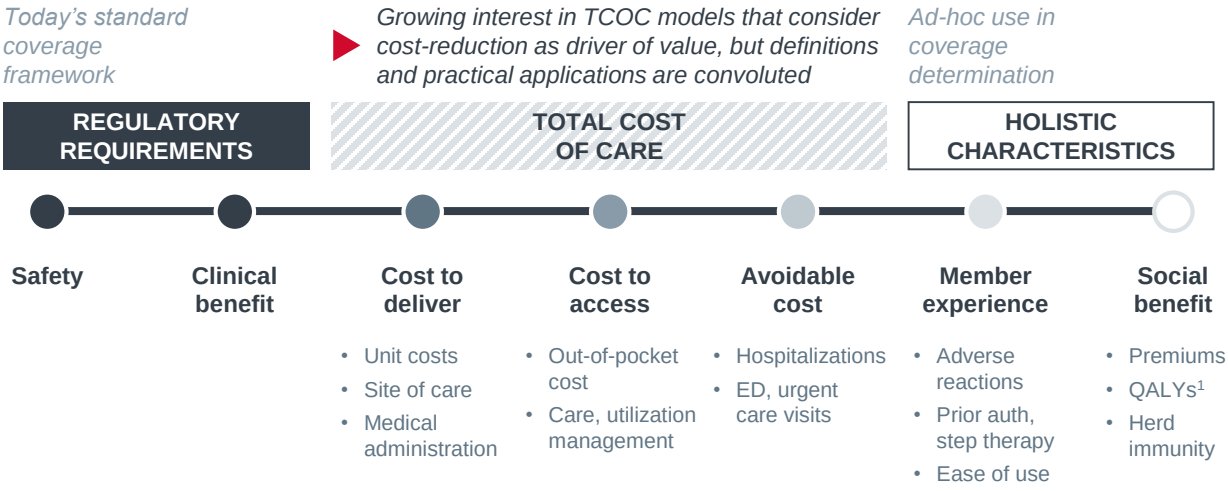
Plans will need to evolve a 'rubric' for accommodating broader evidence

Currently nearly all tend to determine drug value using a framework composed of safety, efficacy, whether coverage is mandatory in the first place, and unit costs (when they get high enough with no other affordable options).

Lack of data to disentangle distinct components of value—coupled with siloed decision processes—means plans lack the ability to assess value in a nuanced, holistic way. In the absence of guiding principles, plans have reluctantly relied on this core framework, and only consider additional value drivers such as patient access or member experience in committee discussions ad hoc.

Plans acknowledge the need to assess more than safety, efficacy, and unit cost—but weighing the relative impact of distinct *drivers* of value is complex. The center and right of the graphic below shows the other areas that pharmacy leaders shared with us as emerging strategic priorities. For example, a plan using the traditional three-part framework might decide to not cover a drug because it is not mandatory and expensive, but another plan using the extended approach might decide to cover the drug in certain situations because it reduces enough ED visits to make up for its high price.

Major drivers of value, by frequency of use



While it is key for your plan to form an organizational viewpoint on these emerging drivers of value and which ones to prioritize, it is not enough to know what your plan values on this matrix. It's also important to know what members and purchasers value as well. Plans must make sure there's a dynamic and flexible process to incorporate these stakeholders' viewpoints into the drug value valuation as well.

To further emphasize the importance of these additional drivers, these drivers of value are key considerations for all outcomes-based drug deals as well. At a high level, deals are often driven by payers looking for a guarantee, pharmaceutical companies looking for evidence or volumes, and/or payers looking for better rebates or prices. But all outcomes-based deals will require plans to consider and have numbers for the drivers in the total cost of care and holistic characteristics sections below.

> "We're far down the road in discussions about value-based contracts with some drug and device manufacturers, but we haven't transacted any. How are we going to define 'value'? I think we have a **fundamental disagreement on what value is**."
>
> *Chief Medical Officer, large provider-sponsored health plan*

1) Quality-adjusted life years.

Source: Advisory Board Research interviews and analysis.

Some plans will pay more now to save costs later

Use claims, EHR data to revise access protocols and scope appropriate use

In an effort to incorporate operational cost and member satisfaction as major value drivers, plans are now asking for evidence that articulates *which sub-populations* will see added clinical benefit, not an extrapolation of study results to their member demographics.

For example, Nordic Health Plan (a pseudonym) found that for a subset of patients, immediate access to the more expensive treatment, rather than the more restrictive step therapy approach, actually led to cost-savings and improved outcomes by reducing Emergency Department (ED) utilization.

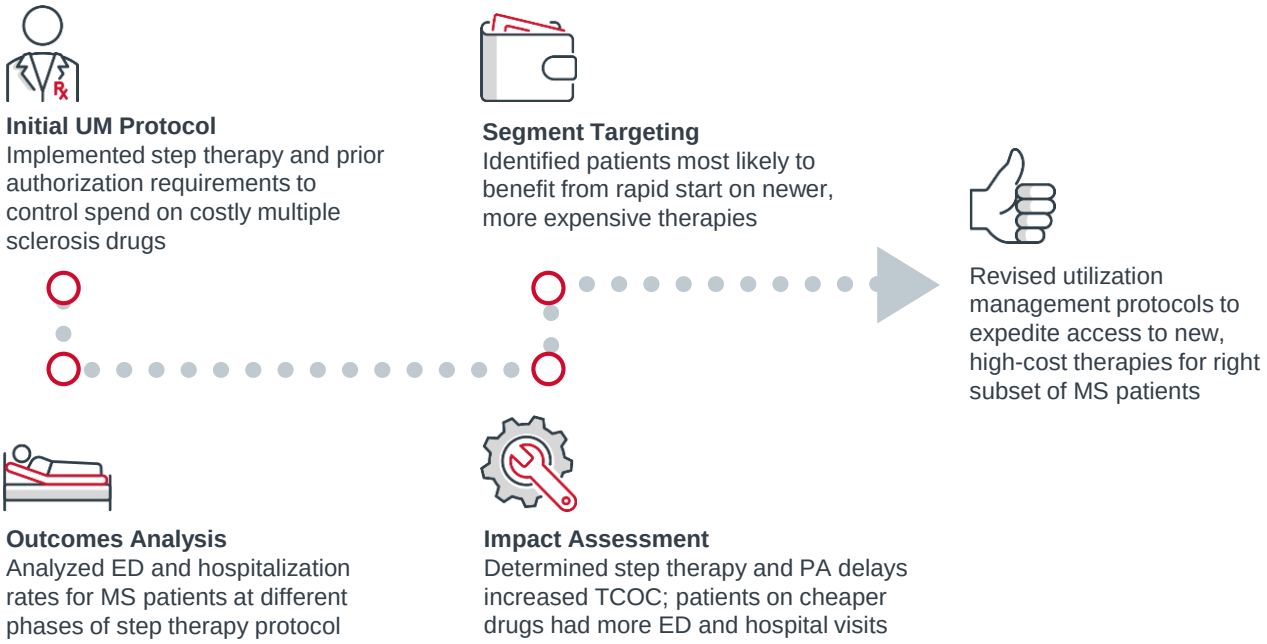
They initially implemented step therapy and prior-authorization (PA) requirements to manage the high-costs associated with Multiple Sclerosis (MS) drugs. But an analysis of ED visits and hospitalization rates helped them realize they were actually increasing total cost of care by using a blanket approach for higher-cost treatments.

Now, Nordic expedites access for the subset of patients who will benefit most. By using the real world data on their membership and looking at outcomes trends for different member segments by demographic and disease phase, Nordic is able to identify the member segments with the most need. For segments where they see poor overall results and outsized patient burden from using a lower-cost therapy, they're now fast-tracking them to the more expensive therapy.

CASE EXAMPLE

Nordic Health Plan (pseudonym)
Provider sponsored health plan

Nordic Health Plan expands access to lower total cost of care (TCOC)



1) Pseudonym.

Source: Advisory Board Research interviews and analysis.

Real-time reviews flag spikes in utilization

Allows plans to increase patient access by cutting prior authorizations

Plans are also evolving their value criteria by considering access issues as well as traditional utilization issues. For example, by removing prior authorizations in a calculated way to prevent overutilization.

Indigo Health Plan (a pseudonym) sets bold targets for PA reduction. In just 2 years, they were able to remove over 400 codes—representing 40% of their total requirements. They can also boast that they did not see a single spike in utilization or cost during these two years.

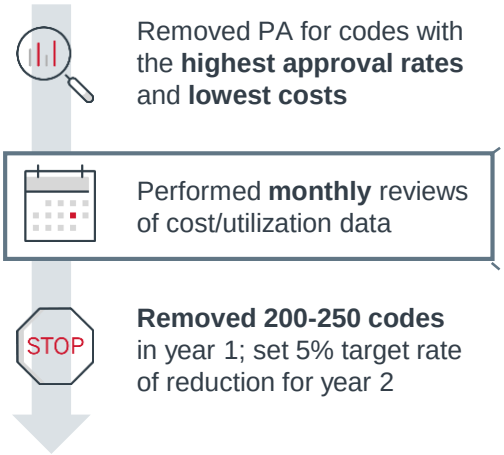
They credit this reduction to two actions. First, they use internal data to examine which codes had the highest approval rates across all providers, lowest costs, and highest volumes. From there, they chose to eliminate those from PA to limit the risk on the plan (example codes include CT scans and ultrasounds).

Second, and arguably more important, they monitored the utilization data frequently. Indigo performed monthly reviews, rather than the typical 3-6 month lookbacks. This allowed the plan to identify potential issues early on as well as recognize high performers sooner.

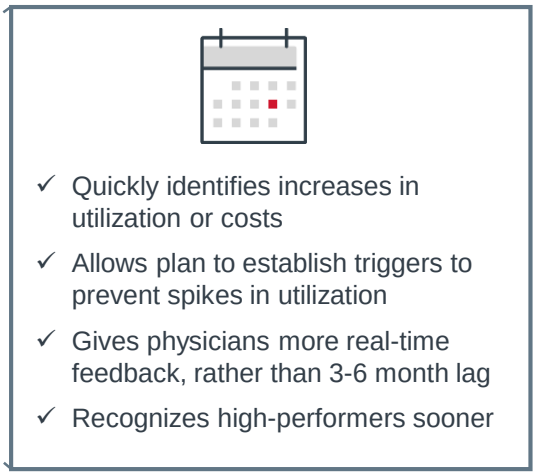
CASE EXAMPLE

Indigo Health Plan (pseudonym)
Health plan in the North East

Indigo Health Plan's[1] PA removal process



Benefits of monthly data monitoring



0	**Spikes** in cost or utilization	416	Total PA **codes removed** over 2 years	40%	Total **reduction** in PA codes over 2 years

1) Pseudonym.

Source: Advisory Board Research interviews and analysis.

Section

4

Prioritize within local ecosystems

In this section:

- Four topics to guide plan conversations with employers on drug benefit design
- Three factors that influence provider bargaining power
- **Case study:** Using a pharmacist to engage PCPs

Local ecosystems must shape drug value priorities

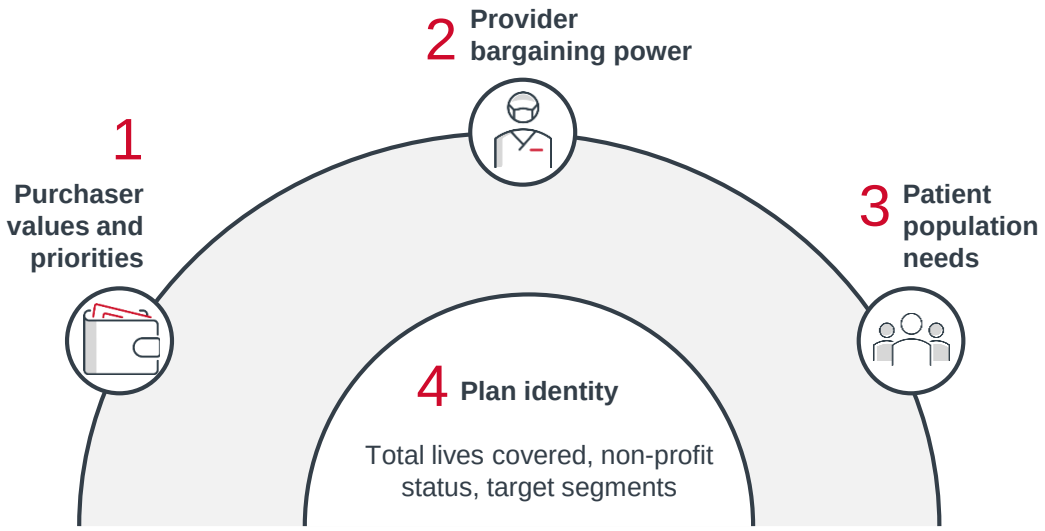
National trends exist for local ecosystems' purchasers and providers

Drug value is not an area that can be standardized for all players. All plans should *not* have the same priorities when determining drug value because not all plans play in the same ecosystem. In fact, large plans might have differing value definitions for the various markets they are in.

The local "ecosystem"—i.e., the interplay among purchasers, providers, and micro populations within a defined geography—should significantly impact how plans define value, make trade-offs, and address customer needs. Below are the four main factors that make up a local health care ecosystem for plans to consider when determining drug value definitions.

In this section, we will dive into the first two, purchaser values and priorities and provider bargaining power, because there are larger trends in these areas whereas patient population needs and plan identity are very specific to every market.

Four factors that make up the local health care ecosystem



Source: Advisory Board Research interviews and analysis.

Trends in purchaser values and priorities

Four topics to guide plan conversations with employers on drug benefit design

Plans should ask their purchasers about their values and priorities before forming a drug value definition for the plan. Often, purchasers don't know their own perspective on drug value so plans must interpret it based on the purchaser's values and priorities. Purchaser values and priorities—especially those of employers—are influenced by the four factors below. Use these topics to guide your conversations with employers on drug coverage and benefit design.

Factors that influence employer values in drug coverage

1. **War-on-talent:** Competition for specialized, in-demand talent often pressures employers to offer more generous benefit packages – typically with wide networks, open formularies, and broad coverage. Tech and oil companies offer lucrative benefits and open formulary designs to attract top-notch talent to their rapidly expanding companies, whereas companies with high turnover (e.g. Dick's Sporting Goods) have little incentive to invest in health care programs with long-term ROI and therefore offer less lucrative benefits.

2. **Tolerance for administrative burden:** Some employers want to minimize any utilization management, coverage restrictions, or financial assistance programs (including co-pay coupons) that increase process steps for providers and patients. For example, government and labor employers prefer plans with high-cost premiums and few restrictions on drugs, so they don't have to manage the complexity of prior authorizations.

3. **Company budgets and industry cost-pressures:** Employers in industries facing long-term cost pressures (e.g., manufacturers, retailers, health systems) prefer closed benefit designs, narrow networks and more prior authorizations to reduce spend. For example, retail industries often provide average benefits for employees, or will ask plans to restrict high-cost medications in order to cut costs and/or stay in business. Some employers are even asking commercial plans to exclude all specialty drugs from the formulary, because they cannot afford them.

4. **Regional and cultural perspectives:** Local, cultural influences inform employers' desire to cover specific "optional" services such as family planning, HIV[1] prevention, alternative medicine, or nutrition. One striking example uncovered through the research -- specific regional employers request for plans to not cover HIV pre-exposure drugs, but to cover HIV care.

1) Human immunodeficiency virus.

Source: Advisory Board Research interviews and analysis.

Proactively incorporate local provider preferences

Elevate opinions of community providers, not only traditional key opinion leaders

Rather than risk a standoff, plans must strive to proactively incorporate local provider preferences on top of purchaser preferences, especially providers with high bargaining power. The bargaining power of providers can vary significantly, and that power is influenced by three locally determined factors:

Factors that influence provider bargaining power

1 Providers' culture of medicine

- Reliance on evidence and willingness to adhere to clinical guidelines
- Relationship with patients and caregivers
- Attitude towards new/alternative therapies
- Preferences for devices/procedures

> "The west is more progressive in its physicians' willingness to manage disease and its emphasis on evidence [relative to the east coast]. Western care sites will allow midlevel practitioners to do more…New England has been slower to adopt these values."
>
> Pharmacy Director, *Large Regional Health Plan*

2 Provider dynamics

- Number of physicians and practice groups
- Prevalence of specialists and key opinion leaders
- Involvement of community providers
- Presence of AMCs[1] and Centers of Excellence; participation in clinical trials

> "Who is doing the care? [This] informs how much control the plan has… Provider groups, particularly in imaging, demand that certain things be covered or they will threaten to leave the network."
>
> VP of HHS[2] Consulting, *The Lewin Group*

3 Level of shared risk

- Integration with provider network
- Financial risk agreements (upside, downside)

> "Because of our relationship with our provider parent… when we put guidelines in place, we want to follow the local standard of care."
>
> CMO[3], *Large Provider-Sponsored Health Plan*

"Traditional" key opinion leaders—highly specialized, academic clinicians—are perceived as necessary voices, especially when considering complex conditions. But plan decision makers must also recognize that these individuals only spend a portion of their time seeing patients in standard care settings, have a bias toward clinical innovation as researchers, and often partner with life sciences firms. The same characteristics that make these individuals great partners in evidence-generation and communication also make them a better fit for spot testimonials rather than ongoing input into plan decision processes.

In an effort to strive for balance, several plans are elevating the voice of local, community providers with seats on clinical assessment committees. Specialist nurses, primary care physicians, and community-based oncologists are key participants in collating evidence and holding seats on P&T or medical technology assessment groups.

1) Academic medical center.
2) Health and Human Services.
3) Chief Medical Officer.

Source: Advisory Board Research interviews and analysis.

Meet local providers with local providers

Clinical pharmacist visits individual provider practices to discuss pharmacy

CASE EXAMPLE

Blue Cross Blue Shield of Vermont
250K-member health plan in all lines of business • Montpelier, VT

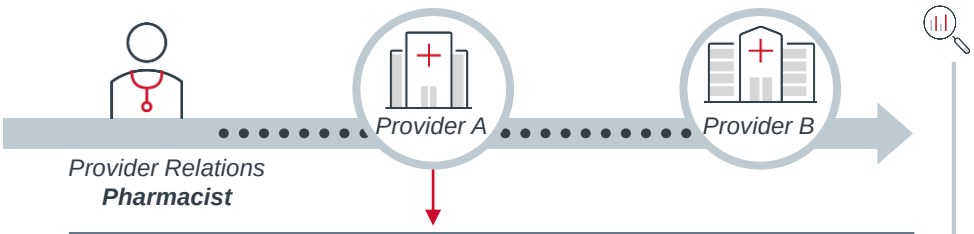
To incorporate the priorities of local providers during implementation, Blue Cross Blue Shield of Vermont (BCBSVT) shares pharmacy utilization data and protocol with local providers through a local pharmacist.

The pharmacist starts by providing general pharmacy information with providers that is not specific to a payer and builds that rapport with the providers. Then, the pharmacist can start sharing payer-specific formulary information and the providers are more likely to listen.

The majority of the pharmacist's time is spent helping providers identify cost management opportunities and educating them on formulary changes. Because it's a *pharmacist* speaking to providers, a peer-to-peer conversation takes place and providers are more receptive to advice. For example, the pharmacist would inform providers if two 500mg capsules for one drug costs significantly less than one 1000mg capsule for the same drug.

Providers find value in having access to a pharmacist and even invite her to host discussions with their practice staff on relevant topics including opioid abuse, diabetes drug options, and medication therapy management (MTM).

BCBS Vermont's Pharmacist Delivers Pharmacy Data to Providers



Pharmacist Responsibilities

Share pharmacy scorecard that compares their costs to **peer benchmarks**

Sample scorecard metrics:

- Formulary adherence rates
- Total pharmacy costs

Present on **provider-requested topics** at practice lunch-and-learns

Sample provider-requested topics:

- Formulary diabetes drug options
- Targeting members for MTM

DATA SPOTLIGHT

Pharmacist Program Results

1,159	Providers reached by pharmacist, 2018
69%	Success rate in switching diabetes medication, 2018
$100K+	Saved by BCBSVT from members participating in MTM, 2018

Source: Blue Cross Blue Shield of Vermont, Montpelier, VT; Chief Medical Officer Roundtable interviews and analysis.

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