

A photograph of a path of stepping stones in a pond. The stones are cylindrical and arranged in a line, leading from the foreground towards the background. The water is dark, and there are many green lily pads floating on the surface. The lighting is soft, creating a calm atmosphere.

# SIX STEPPING STONES TO ACHIEVING A VALUE-BASED PHARMACY DESIGN

Value-based designs offer benefits of traditional cost-cutting measures while promoting improvements in overall care management through better medication compliance. BY TIM WATSON

# Feature Story

Market forces and employer-driven cost-cutting strategies have combined to slow the annual growth in prescription drug spending to single digits. While relief from dramatically escalating prescription drug costs is welcome, there are still significant challenges in effectively managing the pharmacy benefit.

Even though the cost of prescription medications receives most of the attention in mainstream media, it is in fact inappropriate utilization — both over- and underutilization — that continues to drive the bulk of overall program costs for many large payers. Without implementing proven strategies to address such commonplace problems as medication noncompliance, many of the cost-cutting gains made by employers in recent years will be squandered.

As employers contemplate the next frontier of effective pharmacy program management, many are intrigued by the concept of a “value-based” plan design. The appeal of this approach is that it offers some of the benefits of traditional cost-cutting measures, such as high member cost-sharing for certain drugs while promoting improvements in overall health care management through better medication compliance — particularly by selectively lowering copayments for high-value interventions.

## Emergence of value-based strategies

In a value-based plan design, treatments are categorized according to their anticipated level of clinical benefit. Interventions shown to provide the most clinical benefit are associated with the lowest patient out-of-pocket costs. Conversely, products with modest or low-value clinical outcomes are associated with the highest cost-sharing tiers.

The goal of this design strategy is simple and intuitive: Reduce barriers to care for clinically significant and proven therapies by reducing or eliminating copays. At the same time, these plans attempt to discourage inappropriate use and minimize waste by maintaining appropriately high cost-sharing strategies for interventions of modest or low value.

Not surprisingly, early adopters of value-based design strategies have focused on medications commonly used to treat heart disease, diabetes and asthma.

While some consider value-based designs as just another fad in the wake of numerous other health care fads, a recent survey on employer attitudes toward val-

ue-based designs shows otherwise.

During its annual drug benefit conference in 2008, the Pharmacy Benefit Management Institute surveyed participants concerning their views on value-based plan designs. Eighty percent of respondents indicated that value-based plan designs offered the best chance for optimal program management in the future.

As interest in value-based designs continues to grow, it is increasingly important to start considering the best way to approach the adoption and measurement of these strategies.

## Building the business case, outcomes-management strategy

While many employers have embraced value-based design concepts, there still is considerable confusion on how to build the business case for migrating to this approach and how to implement an effective outcomes-measurement strategy. Unless there are clear and consistent methodologies for measuring outcomes from value-based initiatives, widespread adoption of these programs may be slower than initially expected.

Dr. A. Mark Fendrick, one of the primary proponents of value-based designs, has underscored the importance of establishing outcomes research/ROI evaluation, noting, “despite efforts to adopt highly valued interventions, it comes as no surprise that payers are unlikely to implement programs that increase spending — even if they are on high-value services — without precise estimates of financial impact.”

While there are many challenges to conducting outcomes research in health care — including cost and availability of data — there is a basic framework for employers to consider in assessing value-based designs.

At the outset of considering a value-based design strategy, employers should outline the rationale. In its simplest form, benefit managers must show:

1. Chronic diseases represent a significant portion of overall health care expenses, and that their impact is only going to increase over time as the population ages.
2. Prescription drugs are a vital component in effectively managing many of these diseases, yet they only work if taken appropriately.

3. Noncompliance with prescription medications is a widespread problem, and is a primary predictor of future health care utilization. (See related story on page 1.)

4. Implementing strategies to substantially improve medication compliance in targeted disease states will keep patients healthier and reduce the long-term complications associated with chronic conditions.

Once the framework for value-based designs is established, employers can construct a customized business case analysis and measurement approach using a six-point framework:

1. Determine top medical conditions and develop adherence scores by condition.

For most employers, top disease states will directly correlate to those already most commonly included in value-based plans. Once the top medical conditions are established, employers should analyze medication compliance rates for medications associated with these conditions using the Medication Possession Ratio (MPR).

MPR is a statistical technique that approximates patient compliance levels by measuring the percentage of time a patient has access to medications. While still an imperfect measure of compliance — availability of medication does not ensure that the patient is actually taking the medication — it is one of the more commonly used metrics in the industry and a methodology that has become standard.

2. Stratify individuals based on adherence levels.

Once compliance measures are known, patients can be grouped as compliant or noncompliant. Generally, an MPR score of 0.80 or better is considered compliant; 0.79 or less is considered noncompliant.

3. Track medical, absenteeism and presenteeism data to create a “before” picture of program cost, utilization and business metrics.

While medication adherence is an outcome used to measure the impact of value-based design strategies, ultimately it is the impact that improved compliance has on other medical resources that must be measured. Some employers may also wish to evaluate how improving medication compliance rates contributes to other elements of business performance, such as productivity, absenteeism and presenteeism.

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4. Establish program goals, including estimated reductions in

medical services that will offset the cost hikes associated with increased prescription drug use.

Typically, goals associated with value-based designs include:

- Improved patient compliance.
- Improved quality of care.
- Fewer adverse health events.
- Decreased hospital and ER visits.
- Decreased absenteeism.
- Increased productivity.
- Increased presenteeism.
- Decreased overall health care costs.

5. Implement elements of the value-based design strategy.

While most employers begin a value-based program through targeted copay reductions or elimination strategies, nearly every successful initiative also includes other program elements to positively impact patient behavior.

Key components include extensive member communications, provider outreach initiatives and access to health coaching.

6. Analyze baseline changes to assess overall outcomes.

In most employer settings, a pre-post study design comparing the selected outcomes-measurement variables between the control and study groups will be sufficient for measuring program performance and ROI.

This analysis also should include additional direct program costs incurred to implement the value-based strategy, such as copay offset fees and increases in drug costs due to increased compliance.

While some early adopters of value-based designs have published outcomes associated with their initiatives —see [www.vbhealth.org](http://www.vbhealth.org) for case studies — most reported outcomes focus on improvements in patient compliance, not reduced medical costs.

For value-based designs to take hold among employers, business case development and outcomes research initiatives must become more commonplace.

The approaches outlined here should provide employers with the framework to begin conducting their own evaluations as to whether a value-based plan design is right for them. —**E.B.N.**

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