MILLIMAN WHITE PAPER

PBM Best Practices Series: Clinical programs and value-based decision-making

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Pharmacy benefit managers offer a wide range of clinical programs designed to improve health outcomes for members while reducing overall healthcare costs. Plan sponsors may find it challenging to develop a process that effectively evaluates these programs. How should plan sponsors evaluate which programs to implement, maintain, or discontinue? This paper explores industry best practices plan sponsors can use to consistently assess the value of both new and existing clinical programs.

The role of clinical programs in pharmacy benefits

Pharmacy benefit managers (PBMs) offer numerous clinical programs focused on disease management, utilization management, and medication adherence. These programs are designed to improve health outcomes through patient-focused education, provider intervention, and other clinical services. One of the advantages of PBM-offered clinical programs is they are tailored specifically for a plan sponsor's drug coverage and benefit design. This enables programs to maximize their potential clinical benefits for enrolled members through continuous, personalized care.

However, PBMs may unintentionally complicate the decision-making process as they have an interest in achieving their own internal financial targets.

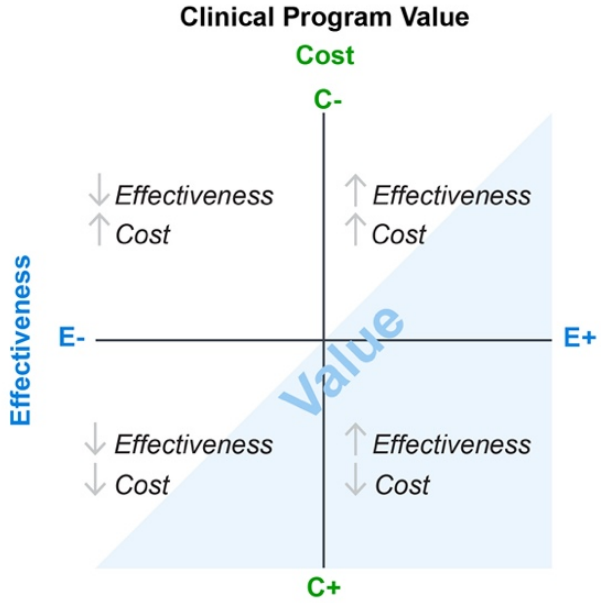
> *Think of this common scenario: March or April comes around and your PBM account services team is ready to present last year's plan performance review. They walk you through a PowerPoint presentation aimed at covering all aspects of plan performance using plan metrics and statistics. Within the meeting, the PBM's account executive takes a few minutes to review a portfolio of new clinical programs aimed at plan savings and/or improved member healthcare experience.*

The dilemma in this scenario is how to vet these program offerings constructively, eliminating the less meaningful programs and electing the programs with higher likelihoods of success.

A value-based approach to evaluating clinical programs

The selection of clinical programs can be a difficult decision due to the complexity from a health economics perspective, especially for plan sponsors that are uncomfortable making decisions requiring expert clinical knowledge. Plan sponsors employing a pharmacy director can leverage that person's expertise, but not all have extensive experience with clinical program evaluation. This paper outlines a value-based approach to assist plan sponsors in determining which programs are most meaningful to their members and what the short-term and long-term financial impacts might be. Figure 1 is a visual tool plan sponsors can use to decide whether a prospective clinical program is appropriate for a pharmacy program. Figure 1 defines value as the relationship between effectiveness and cost.

FIGURE 1: COST-EFFECTIVENESS QUADRANTS



Any program that falls into the bottom right quadrant (i.e., highly effective and low-cost) should be considered, whereas programs falling into the top left quadrant (i.e., low effectiveness and high cost) should not be implemented. Programs falling in the remaining quadrants may require a more detailed analysis and the decision often depends on member demographics, culture, utilization patterns, plan design, and other individualized plan nuances.

Three pillars of value-based decision-making

To determine which quadrant a prospective clinical program might fall into, plan sponsors can focus on three major pillars: *clinical effectiveness, financial impact, and member engagement*. The first two pillars align with the axes of the coordinate plane in Figure 1 whereas member engagement is a key factor for success of the program over both dimensions. It is important to note that each pillar does not necessarily carry equal weight, that is, the relative importance of each may vary by plan sponsor.

Clinical effectiveness. Evaluate the clinical effectiveness of a program by considering which outcomes are measured and the potential of the program to achieve those outcomes.

When evaluating the outcomes being measured, it is important to identify outcomes having direct clinical significance as opposed to outcomes only functioning as surrogate markers. For example, one PBM might offer a diabetes clinical program with a measurable outcome of increasing diabetic drug adherence within one year. This metric is not ideal because, although this program can measure whether patients are filling their prescriptions, claims utilization is an oversimplified metric that does not measure:

- Actual and proper usage of medication
- Long-term blood glucose control
- Effects on medical outcomes

A better outcomes measurement is monitoring hemoglobin A1c, a patient-specific marker, which is the gold standard for measuring blood sugar levels in diabetics and is a more accurate long-term representation of blood glucose control. Most importantly, studies have identified this marker as strongly correlated with lower hospitalizations and overall diabetes-related spend.[1]

Once outcomes measures are evaluated, plans should consider the likelihood a program will achieve positive outcomes. A PBM should be able to provide information describing the number of other clients that adopted the program, as well as real-world examples of successful results. It is vital to understand how successful the program is across the PBM's book of business and for plan sponsors of comparable size and structure. Review return on investment (ROI) studies and other cost-benefit analyses from the PBM carefully to ensure they are relevant and broadly applicable to your organization. Ask the PBM if the studies were conducted by an outside third party. Outcomes and studies from other PBMs can also be applicable to this effort.

Financial impact. Evaluate the financial impact of a program by considering several financial components: up-front costs, ongoing fees, and potential member and/or plan sponsor savings. The up-front costs comprise both the PBM implementation fees and the costs associated with the variable full-time employee (FTE) hours increase allocated to manage the program, as plan sponsors often do not consider the extra man-hours needed to implement, run, and report program results back to their organizations. This makes the potential program savings variable and more difficult to determine, but a necessary part of properly understanding the financial impact of any value-based program.

The calculation of up-front costs can differ not only across PBMs, but among programs within the same PBM. Some PBMs will charge a per member per month (PMPM) or per enrolled member fee. An up-front cost often overlooked is the additional amount of time a plan sponsor will need to evaluate, internalize, and digest the program's outcomes. Plan sponsors may need to either hire additional personnel or reallocate workloads to accommodate an increase in FTE hours associated with evaluating and overseeing clinical programs.

The potential savings can be a challenging task to quantify over a brief period. ROI for clinical programs is typically low in a first year but may improve in subsequent years and, in some cases, return to lower levels, following a bell curve path of ROI when looking over many years of a program's performance. Initially, members may need time to adjust their lifestyles and treatment habits. Ideally, over time, these adjustments may become permanent and lead to improved member health and well-being. A plan sponsor may expect short-term cost increases for any program related to drug adherence because increases in adherence may drive higher drug utilization. These types of treatment-related cost increases can be viewed as an investment because they can drive long-term cost savings in the form of medical cost savings and improved clinical outcomes for certain conditions. If possible, evaluate financial impacts across both pharmacy and medical benefits to understand the total impact to a plan sponsor, especially with certain medications covered through the medical benefit.

[1] Maureen J. Lage & Kristina S. Boye (2020). The relationship between HbA1c reduction and healthcare costs among patients with type 2 diabetes: Evidence from a U.S. claims database. *Current Medical Research and Opinion*, 36:9, 1441-1447.

Member engagement. The plan sponsor should evaluate member engagement by monitoring initial member disruption, program enrollment, program retention, and overall satisfaction. When PBMs present a program to a plan sponsor, it is important to understand enrollment by considering the following items:

- How does the PBM identify qualifying members?
- What percentage of qualifying members enroll in the program?
- How does the PBM define an enrolled member within the program?
- What is the member enrollment process?
- Is there an enrollment period and, if so, what does this period look like?

Monitoring and maintaining high member retention are also important to the program's success. Some considerations include:

- How the program measures member retention and attrition rates
- The frequency with which these rates are measured
- The current retention and attrition rates of the program
- Understanding common reasons for member abandonment

Answers to these detailed questions can provide the plan sponsor with an understanding of how the program will attract, enroll, and retain members. Plan sponsors must ensure all these considerations are included in either the master agreement or a contract amendment so terms and conditions can be referenced and enforceable.

Member satisfaction is another key aspect to member engagement. Plan sponsors should understand how PBMs are evaluating member satisfaction, often done through a voluntary survey. Plan sponsors should evaluate not only the results of these surveys, but the effectiveness of the questions asked, the scaling of the metrics for the evaluation, and where and how the surveys are conducted.

For each clinical program, measurements for member engagement should be clearly defined and results should be presented to plan sponsors frequently, i.e., quarterly. The success of a clinical program often hinges on active monitoring and follow-up.

Next steps for plan sponsors

Plan sponsors should implement an objective and consistent decision-making process to select clinical programs and regularly evaluate their effectiveness over time.

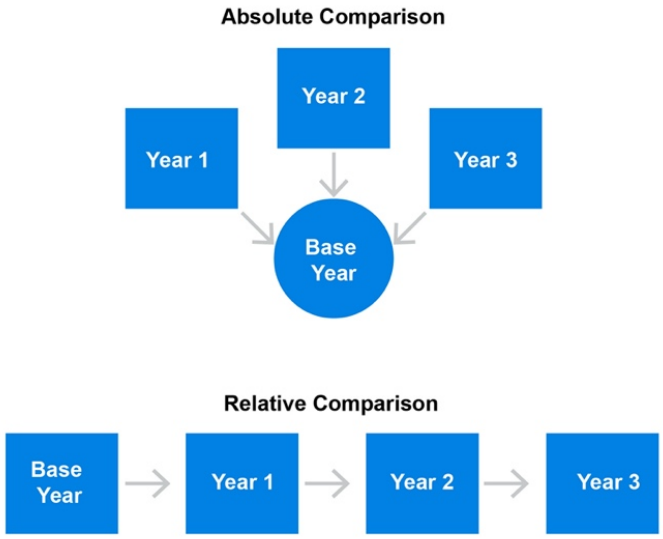
Establish a consistent program and services evaluation plan. Plan sponsors should set consistent evaluation parameters across all clinical programs, including proposals for new programs. Some examples may include the following:

- Require PBMs to use the plan sponsor's own utilization and data in all analyses. "Book of business" data or aggregate program results can skew projections and may not be applicable to a plan sponsor's individual member characteristics or plan design.
  - If possible, require the use of the most recent plan sponsor data to reflect the current member population. If full-year data is not available, then only the most recent quarterly data should be used and adjusted for factors like seasonality. This enables a fair comparison because outdated data can misrepresent potential program results.
- Set the expectation with the PBM account team that plan performance reviews may not be the most appropriate setting to present clinical programs. These clinical program presentations are better conducted separately from financial reviews to ensure adequate time and focus is devoted toward evaluating the program.
- Require PBMs to clearly define (e.g., outline in the agreement) how patient outcomes or program outcomes are measured and, when reporting, provide the detailed calculations to support the measurements. This helps plan sponsors accurately evaluate program ROI and limits the potential for ambiguous measurements and calculations.
- Some clinical programs charge a fee per PBM intervention. Plan sponsors should require PBMs to explicitly define what classifies as an intervention. For example, an intervention could be defined as a telephone call, a 20-minute period of counseling, or another outreach method defined by the PBM.
- Plan sponsors should explicitly identify the member population, including the demographics of those enrolled in a clinical program, to budget costs and calculate ROI.

Let's say you decided to implement a clinical program. Fast forward three to five years—by then the conversations about the program utility or relevance have fallen out of focus and what was once a major decision has been forgotten. But the program and fees continue. How does a plan sponsor ensure the continued success of a clinical program if it is not reviewed year over year?

Develop a multiyear reporting plan. Always evaluate program performance in two separate measurements over time, as depicted in Figure 2. The first measurement is the absolute difference, comparing the year prior to program implementation, the base year, to each individual year that follows. The second measurement is the relative difference, comparing consecutive year-over-year differences. Using this combination of comparisons will comprehensively demonstrate how well the program is actually performing.

FIGURE 2: THREE-YEAR PROGRAM EVALUATION



Understanding how well the program is performing is important to evaluate performance over time and adapt when necessary. Some PBM clinical programs come with an ROI performance guarantee, so a plan sponsor must keep track of all performance year-over-year (note: understand *how* ROI is being calculated!)

Finally, it is important to know when a program no longer has value and has moved to quadrant I in Figure 1 above (i.e., low effectiveness, high cost). The goal of clinical programs is to achieve long-lasting effects without requiring indefinite, high-touch patient outreach. As member behaviors become ingrained habits or markets change, programs can become obsolete or less effective over time. Knowing when to turn off a program is as important as knowing when to implement a new one. Again, continuous monitoring is essential to success, as not all clinical programs are appropriate for every plan sponsor and they can become less effective over time.

Conclusion

Clinical programs can be effective strategies for improving members' health outcomes while also reducing long-term overall healthcare costs for a plan sponsor. Plan sponsors can turn the clinical program decision-making process into a simple and productive exercise delivering value through a consistent process following best practices.

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