January 31, 2024

Improving Appropriate and Equitable Use of Prescription Drugs:
Leveraging Value-Based Payments to Achieve Aligned Population Pharmacy Reforms

Duke
MARGOLIS INSTITUTE *for*
Health Policy

EXECUTIVE SUMMARY

- **Substantial policy activity aimed at improving affordability and access to prescription drugs, and drug and care delivery reforms need to align in order to have the greatest impact.**
- **Value-based payment models focused on care delivery offer another opportunity to impact the appropriate and equitable use of prescription drugs by aligning care and prescription drug therapies, but need to be designed thoughtfully to do so.**
- **In the short term, value-based payment models, especially population-level reforms that leverage total cost of care arrangements, can be modified to incorporate drugs through better data feedback and quality measures.**

INTRODUCTION

Rising prescription drug costs continue to outpace inflation and remain one of the fastest growing components of health expenditures. From 2016 through 2021, gross pharmacy-dispensed prescription drug spending (drugs covered under Traditional Medicare Part D and often managed by pharmacy benefit managers) increased almost 13 percent and physician-administered prescription drug (drugs infused by clinicians at the point-of-care) expenditures increased 25 percent across both public and private payers. In particular, Traditional Medicare Part B drug spending (physician-administered) on a per enrollee basis has grown rapidly, averaging a 9.2 percent increase year-over-year from 2008 through 2021. The annual per enrollee spending on prescription drugs for Medicaid beneficiaries grew from $445 to $530 between 2009 and 2018, and from $957 to $1,073 across all payers nationally in the same time frame. In one analysis, half of the drugs examined for Medicare Part B had an average annual cost-sharing of at least $1,000.

An increasing number of patients have skipped, delayed, or reduced their dosage to extend their supply of drugs due to high cost. People who stop taking their prescribed drugs because they cannot afford them often have suboptimal outcomes, especially for chronic conditions where medications are vital for managing their chronic disease. Some patients may lack access to both new and existing drugs, and notable disparities in appropriate medication use exist. These barriers are significant because underserved populations have higher prevalence of many complex conditions, especially for low-income and certain racial and ethnic minority beneficiaries.

Policymakers have responded with a wide range of initiatives aimed at slowing these trends. Most prominently, the Inflation Reduction Act (IRA) authorizes the Centers for Medicare & Medicaid Services (CMS) to negotiate prices for the highest expenditure drugs in the Part D and B programs, and caps out-of-pocket spending for many Medicare beneficiaries; other Part D benefit changes also have been implemented. Some states have implemented reforms focused on reducing the unit price of drugs, such as preferred drug lists, multi-state purchasing collaboratives, or prescription drug affordability boards. Additional work is needed to understand the success and scaling of these models. Legislation under consideration in Congress includes modifications for pharmacy benefit managers (PBMs) practices, such as changes in transparency, rebates, spread pricing, and fee models. Other proposed reforms include patent reform, international reference pricing, and out-of-pocket spending caps.

The diverse range of proposed interventions stems from the complex system used to determine drug prices and payment for drugs overall, with different systems for physician-administered and pharmacy-dispensed drugs. The complexities make it difficult to design policies, as changes

to one aspect of prescription drug policy can have spillover effects in other areas of pricing, payment, or coverage.

Policies focused on drugs in isolation are unlikely to be as effective if they are not integrated with care delivery models to ensure patients receive the right drug at the right time. For example, drugs may be readily available and fairly priced, but the drug will not be used by all those who appropriately need it unless clinicians identify patients with the relevant condition and comorbidities, prescribe the appropriate therapy, and manage its ongoing use.

Value-based payment (VBP) models, especially population-based payment reforms, provide an avenue for aligning prescription drug reforms with health care delivery. However, most VBP models to date, such as accountable care organizations (ACOs) or specialty care models, have not been designed to incorporate all types of drugs, and their quality measures, data feedback, and incentives are not aligned with drug policy reforms to increase the benefit to patients. Many VBP models involve some focus on physician-administered drugs, but few assess the utilization of pharmacy-dispensed drugs. While nascent, VBP models can provide incentives and support for clinicians to ensure the appropriate use of prescription therapies, reduce disparities so that all those who would benefit are prescribed and utilize necessary therapies, and improve overall affordability of people's care.

This issue brief provides a roadmap for implementing well-targeted, efficient VBP-related policy reforms that reduce total costs of care, improve health outcomes, and increase access to the right drug at the right time by improving infrastructure and better aligning incentives across physician-administered and pharmacy-dispensed drugs. It includes background on current reimbursement practices for physician-administered and pharmacy-dispensed drugs (and the related incentives for each), details the challenges and considerations for integrating drugs into VBPs, highlights promising use cases, and concludes by outlining a vision for short- and long-term reforms (with a stepwise set of recommendations). Our work is based on a comprehensive literature review; over 30 semi-structured interviews and a private convening with private payers, integrated delivery systems, primary care and specialty physicians, pharmaceutical manufacturers and benefit managers, trade associations, and policy and accountable care experts; and two public panels to gain feedback from a broader set of health care stakeholders. This issue brief is accompanied by a focused article that highlights the key takeaways from this research, with this issue brief including additional background to assist with implementation of different recommendations.

Differing Incentives Exist for Physician-Administered Versus Pharmacy-Dispensed Drugs

Drugs are managed and reimbursed differently depending on whether they are administered by physicians or other prescribing clinicians or dispensed by pharmacies. For Traditional Medicare, physician-administered drugs are covered by Medicare Part B, while pharmacy-dispensed drugs are covered by Medicare Part D. For commercial payers, physician-administered drugs are paid under the medical benefit, while pharmacy-dispensed drugs are paid under the pharmacy benefit (and may be further carved out for the payer). In addition, pricing and payment varies for these different categories of drugs.

For physician-administered drugs, providers (health system, hospital, or most often, specialty practice) typically buy the drugs in bulk, often through group purchasing organizations (GPOs) that can achieve substantial volume discounts depending on the contract. Providers may purchase these drugs at variable times and prices throughout a given year. Traditional Medicare uses an administratively set price for these drugs based on average net prices paid by all (non-Federal) purchasers of the drug, plus an add-on percentage of six percent. For newer drugs that lack average net sales price information, Traditional Medicare reimburses based on wholesale acquisition cost, which is a discount from the list price and higher than the average sales price, plus three percent. Once sufficient sales price information is collected on new drugs, Medicare use its average sales price policy.

Many hospitals also receive 340B discounts on these drug purchases, which can range from 20 to 50 percent off the

average sales price, but still receive the full reimbursement rate. While 340B sales are exempt from average sales price calculations and serve as an important support program for safety net providers, the incentives implicit in the discount program compound the issues and complexities already present in the fee-for-service (FFS) drug reimbursement systems. Indeed, concerns about program transparency and the program's impact on access and affordability resulted in both CMS reform proposals and litigation.

Multiple researchers have raised concerns that the process of buying and billing for physician-administered drugs, with administrative fees set as percentages of the drug's price in Traditional Medicare, creates incentives to prescribe higher-cost drugs even if not the most appropriate option for the patient. Medicare Advantage (MA) and commercial plans can pay different prices for physician-administered drugs, such as through direct negotiations between the provider and payer, but often the price for physician-administered drugs is based on negotiated percentages of Medicare rates. Further, commercial payers use a variety of tools—utilization management, tiered networks of physicians, white and brown bagging, and step therapy—to manage prescription drug prescribing and spending, but these levers are limited or less commonly used for Traditional Medicare.

In contrast, pharmacy-dispensed drugs are typically covered under a prescription drug benefit through pharmacy benefit managers (PBMs) that compete to provide coverage in Medicare Part D, MA, commercial, and managed care organizations (MCOs), and PBMs, which have incentives to limit pharmacy costs, negotiate prices and discounts. Manufacturers may accept lower prices in exchange for greater volume, and PBMs may affect utilization by setting formularies, prior authorization, out-of-pocket payments by beneficiaries, and other tools. The negotiated discounts, commonly in the form of rebates from the manufacturer back to the PBM for use of certain drugs, may be modest for brand-name drugs with no direct competitors but may be large for brand-name drugs with similar competitors. The result is that rebates (and therefore the effective net price) for specific pharmacy-dispensed drugs may be quite different depending on the PBM and plan.

Medicaid differs from other payers in that Medicaid programs receive the "best price" for a drug and receives mandatory rebates.

Additional Challenges to Incorporating Drugs into VBP Models

Beyond differences in physician-administered and pharmacy-dispensed drugs, additional barriers have challenged VBP models from incorporating drugs, including the following:

- **Different financing and structure for different payers:** Medicare has different funding streams for pharmacy-dispensed drugs (Part D) and physician-administered ones (Part B). CMS directly administers Part B, paying for drugs based on statutory payment methodology that leverages commercial list prices and has direct coverage authority. In contrast, Part D is directly administered by plans that are private payers and entities with their own business model and incentives, with Star Quality measures and the competitive bidding process providing incentives for efficient and appropriate drug spending. Separate funding streams limit CMS' ability to design all-encompassing, holistic VBP models, such as accountability for Part D drugs, in Traditional Medicare. Medicare Advantage and commercial plans, who do not face the same bifurcated financing and management of benefits, may more easily develop VBP models that include all types of care.
- **Competing incentives from other programs and processes:** As noted above, there are several programs that affect drug costs and prices, including the 340B program, average sale price + six percent reimbursement for Medicare Part B drugs, drug coupons, group purchasing organizations, and pharmacy benefit manager negotiations and rebates. Financial incentives from these programs may often be stronger than a countervailing incentive from a VBP model.

- **Different ability to affect appropriate utilization for specific categories of drugs:** Unique considerations exist across each segment of the drug market. Conceptually, the drug market can be divided into three categories:
  - **Single-source drugs:** Representing only a small fraction of the total drugs prescribed, but a substantial portion of drug expenditures, single-source drugs often specialty prescribed.
  - **Branded drugs with some therapeutic alternatives:** A growing portion of overall expenditures and often specialty prescribed, clinicians have the best opportunities to affect drug utilization when there are multiple therapeutic options, such as alternative drugs in the same or a similar class, procedures or surgeries, and other alternatives to prescribing drugs (e.g., behavioral interventions).
  - **Generic (off patent) drugs with competing manufacturers:** Generally very low cost and often prescribed by primary care physicians, the challenge for these drugs is often to increase utilization as many people with chronic conditions are not on any therapy, even though there are low-cost effective generics drugs available for managing those chronic conditions.

Each segment of the drug market presents unique opportunities to tailor value-based payments for maximum impact to ensure optimal drug utilization by aligning incentives across unique drug market attributes.

The prices vary for different categories of the drugs types described above. List and net prices for drugs under patent protection are generally much higher than their cost of production, while generic drug prices are generally much closer to net costs of production and some generic drugs may have prices below a penny. PBMs design benefits to provide strong incentives for beneficiaries to choose generic drugs when they are available, generally achieving generic drug use rates averages over 90 percent, although this varies by class.

- **Providers often lack actionable information when prescribing:** A challenge to integrating drugs in VBP models is limited data for clinicians. It was repeatedly acknowledged in interviews and convenings that clinicians often do not know a patient's drug coverage, cost-sharing, or other financial implications of their prescribing decision. (Generic substitution at a pharmacy provides a patient a lower-cost option, but that strategy does not help if the therapy does not have a generic but does have some other therapeutic option.) The difference in benefit design and arrangements between payers and PBMs makes it challenging for clinicians to understand cost sharing for a given drug for a given patient. Progress has been made on implementing more real-time pharmacy benefit information at the point-of-care, and real-time information about preferred drugs is generally available to pharmacies, although these tools may not be integrated into electronic health records (EHR) systems. Even when data exist, they can be out of date (given regular changes in negotiated prices and formulary placements).

In addition, limited real-world evidence (RWE) exists on the effectiveness of a drug at or close to its introduction, especially as it pertains to important subgroups of patients who are often excluded from clinical trials. The lack of RWE limits the ability of clinicians to identify the most appropriate option and manage drug spending by focusing therapies on the patient who would most benefit from them. Even when available and incorporated into formulary design and coverage, RWE on effectiveness is often not integrated into the clinical workflow, except for safety and EHR pop-ups that seek to prevent adverse drug interactions.

Policy Context of Current and Proposed Drug Policies

Several states have implemented new payment models for prescription drugs, such as population-based payments (sometimes called subscription models) or outcomes-based contracts. For example, Washington State and Louisiana have leveraged subscription models to reduce the unit price of drugs that treat and eliminate hepatitis C. Oklahoma has implemented a value-based contract for certain antipsychotic drugs, whereby if outcomes are not met as agreed upon, then the manufacturer will return to the state a portion of the drug's cost. Commercial payers and integrated delivery systems have implemented these types of models as well.

Several major changes were made to drug pricing by the passage of the IRA, which has implications for drug prices, rebates, PBM practices, and interest in value-based payment models. Given that Part D plans now will be responsible for a greater share of drug costs, such as through the beneficiary out-of-pocket limits, there may be more interest by standalone Part D plans in VBP initiatives. That interest could be further encouraged by aligned standards, such as common performance measures for Part D Star Ratings and VBP models.

An October 2022 Executive Order contained complementary provisions to the IRA and also encouraged CMS to consider whether and how the Centers for Medicare and Medicaid Innovation (CMMI) could test new payment and delivery mechanisms that could lower drug costs and improve access to therapies. In response to the executive order, CMMI published a report that identified three opportunities:

- providing new payment reforms for accelerated approval drugs,
- producing a standardized Medicare list of high-value generic drugs available for $2 copays, and
- coordinating multi-state agreements for novel cell and gene therapies.

However, these proposals are unlikely to reach their full potential without being integrated with care delivery. For example, without supporting care management services for glucagon-like peptide-1 drugs used to improve blood sugar control in diabetic patients and in some cases help patients use weight, including counseling and behavioral health support, medication management, and other services--patients may not maintain healthy weight in the long-term.

Additional PBM reforms are the focus of policy initiatives aimed at addressing drug spending and several congressional committees are advancing legislation concerning PBMs. The efforts include: Requiring PBMs to give employers and plan sponsors additional details on drug spending, including acquisition costs, total out of pocket spending and rebate information—aiming to enhance PBM competition through greater transparency;

- banning spread pricing in public programs, in which PBMs charge payers more than the pharmacy drug cost, keeping the difference as profit; and
- passing 100 percent rebates, fees, and other remuneration received from the manufacturer to the plan sponsor.

As with other drug reforms, the above policies will be limited unless integrated with value-based care.

TABLE 1 | How VBP Can Extend and Complement Drug-Focused Policies

Existing Drug-Focused Reforms or Structures	How VBP Can Complement
Value-based contracting for drugs (e.g., subscription and outcomes-based models)	To be most effective, value-based contracts need to integrated with care delivery in order to ensure adequate screening, diagnoses, prescription, ongoing management, and wrap-around services for condition management. VBP for care delivery can help encourage that level of alignment.
Medicare Part D and PBMs	Recent policy changes, such as the IRA, will encourage a greater focus on value by Part D plans and PBMs. This change can lead to a greater willingness to partner with VBP models, which can be encouraged through common quality measures between VBP and Part D plans.
Utilization review, step therapy, and tiered physician networks	VBP allows for reimagining utilization management when clinicians are accountable for the total cost of care (including drugs) and health outcomes. Example changes of prior authorization under VBP models include gold card programs, electronic or automated prior authorization, and prior authorization waivers.

The Vision and Promise of Aligned Care and Pharmacy Through VBP

Leveraging total cost of care models to align pharmacy reimbursement systems and reforms under the umbrella of population-based payments can have important population health implications. Improving drug utilization, especially improving upstream drug use to better manage patients' chronic conditions, through these population-health focused VBPs has spillover implications, including increased access to drugs, improved health care quality, and reduced costs and disparities.

The benefits of coordinating, if not integrating, drug pricing policies with VBP reforms is exemplified in the challenges to eliminate hepatitis C. Since curative direct-acting antiviral (DAA) therapies have been available since 2013, the net price has fallen by more than 80 percent, and several states have gone further to implement novel "subscription" arrangements (an expenditure cap through a supplemental drug rebate once utilization exceeds a certain level). However, hepatitis C remains endemic in the U.S. Even though "subscription" models make providing the antiviral therapy more financially feasible, challenges remain because of the limited capacity of primary and specialty care providers to identify, engage, and successfully treat hepatitis C patients in their population. Successful models, such as that used by the Veterans Administration, which combines a low (negotiated) out-of-pocket price for a DAA with payment and care reforms that hold providers accountable for screening and treatment, demonstrates the benefits of aligned care delivery reforms that advance accountability for longitudinal, coordinated care and improved health outcomes. Care delivery reforms to increase access and adherence to treatment tied to using low-cost drugs—and potentially encouraging manufacturers to be more willing to reduce net prices further, given greater confidence that volume will go up--can result in improved quality of care and savings overtime as costly complications are prevented and transmission is reduced.

Integrating payment and delivery issues around drugs also can advance broader efforts to align our fragmented health care system, reduce provider burden, and unify patient care approaches regardless of payer. For example, aligned cost and quality data can make it easier for providers within ACOs to identify high-value specialty providers, whose work often involves the prescribing of expensive Part B drugs and other high-cost interventions, increasing opportunities for shared savings and overall care improvements. VBP models inclusive of drugs align approaches among providers responsible for Part B spending and plans responsible for Part D. Finally, they improve the functionality of other core components of the health care system. Risk adjustment models, for example, can more accurately assess need and shift funding to encourage care for high-need, high-cost patients.

Examples of Integrating Drugs into VBP

While substantial activity has been focused on drug prices and other specific drug policies, other opportunities remain. In particular, new payment and delivery models potentially can improve drug access and utilization through aligned incentives that support a population health approach. Well-designed, population-level VBPs can overcome many of the limitations and challenges that pricing reforms, PBMs, and other reforms face on their own. While to date most VBPs have not been purposefully designed to include all types of drugs and overcome those challenges and limitations, payers have taken important steps in developing and implementing models that do include certain types of drugs.

One area where certain drugs have been incorporated into VBP models is oncology. For example, the Oncology Care Model (OCM), launched in 2016 by CMS, offered a per-beneficiary, per-month payment (PBPM) for care management and performance-based payments for quality and cost, but did not substantively change how Medicare would pay for drugs under either Parts B or D. The model saw a "relative reduction" in Part A and Part B payments, largely due to the use of more biosimilar and lower-cost, non-chemotherapy drugs. However, OCM also led to a slight increase in Part B spending for low-risk episodes, saw limited changes in the use of Part B for chemotherapy drugs, and had no impact on Part D payments. CMS' new Enhancing Oncology Model reduces the PBPM payment and focuses more directly on patients receiving chemotherapy—the source of most high-cost drugs—but the drug approach is not significantly different than under the OCM. A significant challenge that oncologists reported for OCM was that many chemotherapeutic agents are the sole therapy for a particular type of cancer (or patient

circumstance), and a clinician has extremely limited (or no) ability to affect drug price. Moreover, there are often new drugs introduced in oncology, and it is difficult to continually update value-based payment model benchmarks to reflect the prices of new therapies. (There are other offsetting incentives for oncologic drugs, with many such drugs being purchased under the 340B program at a substantially lower net cost to the eligible providers.) The combination of these factors made it hard to manage drug spending overall for oncology, since utilization and price were difficult to change. Some oncologists have raised the concept of being assessed based on whether they follow evidence-based prescribing pathways versus being held accountable for the drug spend overall. The structure of the oncology drug market is changing as well, with an increasing number of chemotherapeutic agents that are pharmacy-dispensed (while traditionally chemotherapeutic drugs are physician-administered). If pharmacy-dispensed drugs are excluded from the cancer VBP model, it can create a non-level playing field of incentives for different therapies.

Medicare's Shared Savings Program (MSSP) also includes Part B physician-administered drugs in its design. Specifically, the benchmark set for each MSSP entity includes the historical spending for clinical care delivery and physician-administered drugs. However, the evidence to date, while limited, has not demonstrated the impact of MSSP on pharmacy-dispensed drug utilization and spending.

Policy Recommendations for Creating Aligned Incentives for Improving Drug Utilization

VBP models can help align health care delivery and prescription drug reforms, which can improve the equitable and appropriate use of drugs. This alignment is possible through modifications of existing models as well as through incorporating certain features into new VBP models. From our background research, interviews, convenings, and stakeholder feedback, we have identified several strategies that can help VBP models better align with other drug-focused reforms.

Enhancing Data and Quality Measures that Engage Specialists

Many of the costliest prescriptions, especially for physician-administered drugs, are prescribed by specialists, which have been less engaged in accountable care to date. Data to improve specialist engagement may look different for types of VBP models, organization, and payers. For example, physician-led ACOs generally have few affiliated specialists, so specialist engagement for these ACOs is primarily through referrals. Physician-led ACOs can leverage claims data they receive (MSSP ACOs receive data on Part B and D drug utilization) to understand how different specialists prescribe physician-administered drugs for their attributed patients, and these ACOs can encourage referrals to specialists prescribing the most appropriate therapeutic option for a given condition. CMS can help these efforts by providing more actionable, analyzed data beyond the claims files they already provide these ACOs. These efforts are complimentary to CMS' shadow bundle strategy, which is geared toward improving primary care referrals to "high-value specialists" by providing ACOs pricing information on specialists treating certain episodes of care, like certain procedures,

ACOs may leverage internal data on physician-administered drug utilization patterns to provide feedback to their specialists (and become more learning health systems). For example, Coastal Carolina Quality Care, an Enhanced Track Medicare Shared Savings Program ACO participant, performed an intensive data analysis of affiliated orthopedists related to medications for osteoporosis (bone density). The ACO found substantial variations in clinician prescribing patterns for osteoporosis, and it assessed the outcomes for patients on these different therapies. The ACO used a combination of RWE and published literature to implement an evidenced-based clinical pathways for its orthopedists. The maturity and growth of RWE applications creates a greater potential for these applications for accountable payers and providers.

A critical step forward for better integrating drugs into VBP is integrating quality measures focused on specialized conditions affected by prescription drugs. There are several existing utilization measures focused on specialized conditions, such as the Pharmacy Quality Alliance developed measures on completion of therapy

for chronic hepatitis C and adherence to non-infused biologic medications for rheumatoid arthritis. The next phase in measure development is more meaningful outcomes measures for such conditions. In our research, stakeholders emphasized the importance of outcome measures, recognizing that health outcome measures that capture the impact of drugs can be difficult to develop and difficult to attribute results. Including condition-focused outcome measures in broad VBP models focused on population health could incentivize appropriate drug access at the condition level.

Provide Additional Data Feedback to Encourage Appropriate and Equitable Drug Utilization

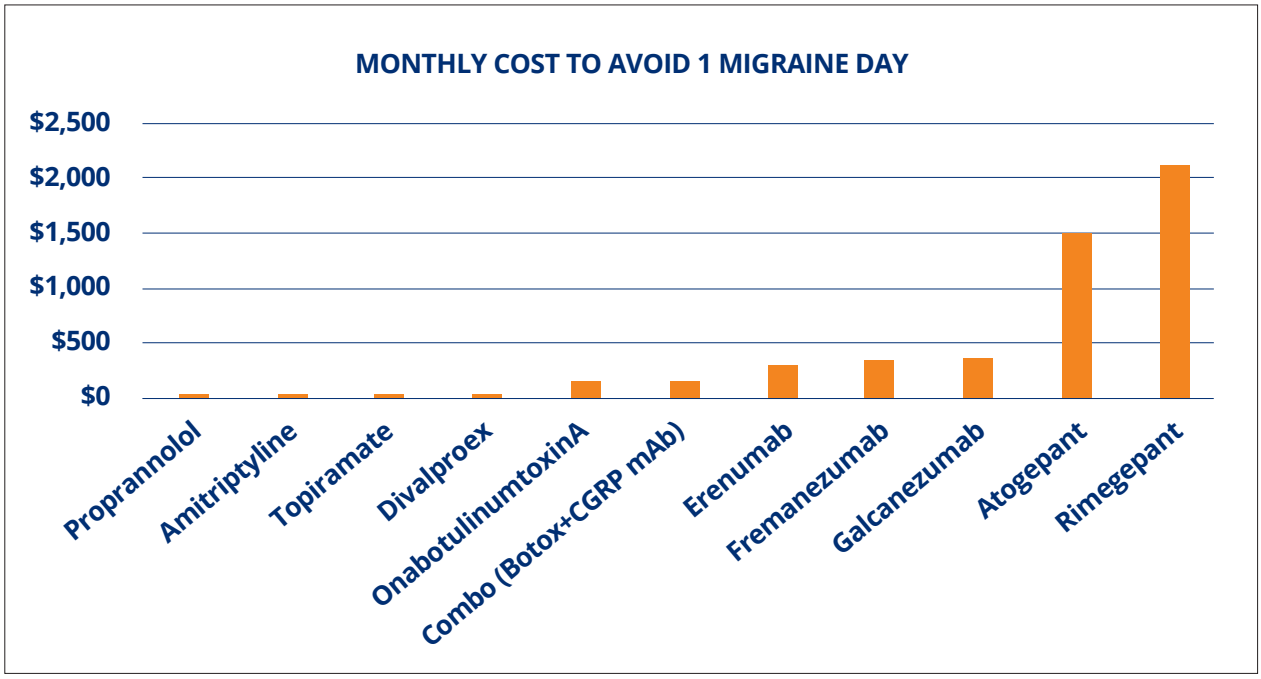
For both physician-administered and pharmacy-dispensed drugs, opportunities exist to advance real-time pharmacy tools that are integrated at the point-of-care. Beyond broadly implementing the CMS proposed shadow bundle policies, expanding data feedback to primary care and specialty clinicians at the point of prescribing is a critical step forward, For example, improving clinician understanding of which drugs are most effective and have the lowest out-of-pocket costs, relative to their patient's health needs. For example, Optum has created a pharmaco-economic tool to help primary care physicians identify the most cost-effective migraine treatment based on their patient's overall health care utilization **(Exhibit 1).** CMS also can work with MA and standalone Part D plans to establish pharmacy data sharing standards; similar efforts can align standards across other public and private payers.

Advancing Drug Related Quality Measures in VBP and Align with Other Programs

Quality measures play a critical role in assessing high performance within VBP models. However, only a limited set of quality measures within VBP models are linked to drug-related aspects of care.

For example, the Comprehensive Primary Care Plus (CPC+) model had quality measures tied to prescription drug usage (recognizing variance across regions), such as whether statin therapy was prescribed and filled and a safety measure about the use of high-risk medications in

EXHIBIT 1 | Using Pharmaco-Economics for Optimal Drug Selection



Note: Provided by and Copyright by Optum, Inc. All rights reserved.

the elderly. The Bundled Payment for Care Improvement-Advanced (BPCI-Advanced) model included a diverse set of episodes, with quality measures relevant to prescription drug use, including beta blocker for heart failure, and discharged on statin medication (stroke). CMS' largest value-based purchasing program, MSSP, had a quality measure in 2023 focused on pharmacy drugs, statin therapy, although some outcome measures also depend on appropriate use of drug therapies. Overall, current drug-related measures focus mostly on medication safety (e.g., use of high-risk medications in the elderly) and improving consistent therapy use for chronic conditions (e.g., statin therapy for prevention and treatment of cardiovascular disease).

One opportunity for better drug-related quality measures is related to patient experience and patient-reported outcome measures, which can assess how well a medication regimen has met patient care goals. For example, the Medication Satisfaction Questionnaire is one validated tool that assesses experience across three domains: effectiveness (e.g., symptom control, outcomes), side effects (e.g., adverse drug reactions, impact on quality of life), and convenience (e.g., ease of use, including dosing frequency, administration, and storage). Other efforts, especially in areas like rheumatology and cardiovascular care, could assess changes in patient functional status and how well a course of treatment affects a patient's quality of life.

Align Quality Measures Between VBP Models and Medicare Part D Plan Rating Systems

As noted earlier, the IRA's drug benefit reforms provide stronger financial motivation for Medicare Part D plans to engage health care providers in VBP models that encourage appropriate use. Aligning quality measures, especially outcome measures, between VBP models and the Medicare Part D Stars Rating System can be an important step to encourage collaboration. For example, the Merit-Based Incentive Payment System includes a hepatitis C screening measure that could be paired with Part D measures to ensure the optimal therapy use in the population. Ideally, this measure could move from screening to focus more on treatment completion and disease elimination over time.

Summary of Recommendations

- **Payers should engage specialists in VBP models** to encourage appropriate use of specialty drugs, such as through additional data feedback to care delivery organizations participating in VBP models and clear metrics that recognize appropriate and well-coordinated use of clinician-administered specialty drugs.
- **CMS should align quality measures between VBP models and Part D Star Ratings,** such as outcomes for specialized conditions that depend on medication therapies, treatment completion and disease elimination for specialized conditions where therapies have been underused, and reducing inappropriate therapy use for patients with polypharmacy.
- **Accountable payers and providers should provide additional relevant and timely data feedback** to encourage appropriate and equitable drug utilization, leveraging existing data tools to increase the availability of real-time, point-of-care information on utilization, out-of-pocket cost, and effectiveness.
- **CMS and measurement stakeholder should improve upon existing and develop additional drug-related quality measures** in VBP models, with a focus on outcomes and patient-reported measures. In the short term, the greatest opportunity may be for utilization measures tightly aligned with outcomes.

CONCLUSION

While there are many reforms currently focused on drug pricing, patients remain challenged in accessing affordable medication and costs continue to rise. VBPs aligned with other drug reforms can support appropriate and equitable drug utilization. Currently, VBP models provide incentives for considering the cost of clinician-administered drugs but generally exclude pharmacy-administered drugs. These models can be improved through several design and implementation strategies, such as better data to inform clinician drug prescribing and referrals, more meaningful outcomes-based quality measures for conditions affected by drug utilization, and engaging specialists to impact specialty drug use. For pharmacy-administered drugs, there are additional opportunities to leverage recent IRA reforms and align quality measures between Medicare Part D and VBP models. Integration across total cost of care VBP models that emphasize whole-person care will further ensure that high-value drugs are used to treat the right patient at the right time, advancing needed innovation in prescription drug development--and broader population access--to improve population health.

Authors

Frank McStay
Mark Japinga
Christina Bush
Nitzan Arad
Robert Saunders

Acknowledgements

This work was supported by The Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice and policy. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund, its directors, officers, or staff.

We would like to thank all of those who took part in our interviews, panel presentations, and private convening. We would also like to thank Patricia Green, Luke Durocher, Hannah Vitiello, and Laura Hughes for editorial, design, event, and communications support.

About the Duke-Margolis Center for Health Policy

The mission of the Robert J. Margolis, MD, Institute for Health Policy at Duke University is to improve health, health equity, and the value of health care through practical, innovative, and evidence-based policy solutions. For more information, visit healthpolicy.duke.edu and follow us on LinkedIn @www.linkedin.com/company/margoliscenter