National Association of Managed Care Physicians (NAMCP) Value-Based Pharmaceutical Contracts (VBPCs)- Facilitation and Execution Considerations[1]

Before entering into a VBPC, several key strategic considerations should be considered:

What is our priority/desire and "readiness" as an organization to enter into VBPCs based on estimated financial and quality impact?

- Determine and include when necessary, stakeholders with financial responsibility for the various populations of interest for contract fidelity and fund flow. For example, large employers with ASO contacts (may need allowances/provisions) versus fully insured, DOD, VA, Medicaid agencies, or Medicare, etc.
- Have we identified a credible patient population/segmentation (Medicare, Medicaid, Commercial, SNP, disease prevalence, etc.) whereby a particular medication or class of medications is having a significant financial cost or quality impact. (An example may include GLP 1 agonists in a Medicare Advantage population).
    - Are our data analytics capable (internal or 3rd party) of defining the financial and quality impact (opportunity cost/savings) of medication/device/diagnostic optimization versus current state across populations and products? NOTE: This will give credible financial estimates of the potential $$ impact of a fully executed VBPC which include clinical/benefit design interventions to optimize usage.
    - Are our data analytics robust in the ability to 1) determine credible contract parameters/metrics 2) point to what clinical interventions may have the most impact (benefit design- ex. remove PA/step edits, formulary realignment, OOP cost lowering, inclusion of clinical pharmacist services, align contract parameters with at risk providers in VBC arrangements, etc.) 3) monitor intervention changes in near real-time with management reports to all parties and 4) is trusted by all potential contract participants for contract metrics, financial validation, and true-up at conclusion. NOTE: Robust, trusted data analytics through a 3rd party is often a critical feature in agreement on contract parameters and all financial considerations for VBPC participants. However, initial data analysis internally can steer the decision as to whether a VBPC in a given population is viable to pursue for an organization.
- As a pharmaceutical manufacturer, device manufacturer, or diagnostic lab - do you have a medication, device, or diagnostic whereby you can make a credible financial argument as to **significant** plan impact related to total cost of care and quality if your product was optimized. NOTE: Smaller patient populations and niche products- although having potentially large ROI's may not prove to be viable for VBPC's when considering real $$ to the overall plan finances.
- If viable populations/products are identified whereby one or more VBPCs could have a significant financial/quality impact, has this successfully been communicated internally and considered a fit for the culture and priorities of your organization?

Go/No Go Decision: Only proceed if initial analysis and organizational culture/priorities are aligned to pursue a VBPC.

Identifying team leaders/members and responsible organizational parties for contract development and exploration

- Assure the "team" has the authority and buy-in of all executive management to enter into a VBPC **with outside organizations.**
    - Are all key internal functions including legal, regulatory, policy, contracting, finance, IT/analytics, medical/pharmacy/clinical, and C suite aware of the intention to enter into VBPCs and have had the opportunity to voice any and all concerns that may arise to prevent final contract execution?
    - Has your organization made this a "priority" in their strategic or operational plans so that resources will be available and forward progress aligned and expected (including in organizational, departmental, and individual performance metrics)?
    - Do you have the right people on the team including all of the key functions necessary for plan development, facilitation, and execution with GO/NO GO authority

[1] This document is part of a series that further expands key points of the NAMCP VBPC- Overview Guide published in 2023

Note: Having documented internal agreement for all parties necessary to negotiate and execute VBPC's will greatly reduce early execution risk.

- Explore Provider arrangements including employed providers, contracted at-risk providers, and ACO/VBC arrangements
    - Do you have arrangements with providers that align to the patient population and medication/products of interest whereby the at-risk contract or ACO/other shared savings/cost could align with the VBPCs?
    - Does the leadership/culture and contracts between the plan and providers facilitate an inclusion of the providers in the VBPC around established quality and financial metrics within regulatory, and clinical guidelines consistent with good patient care?
    - Does the provider organization have leadership capable of introducing/supporting/ educating providers or members on the impact of a clinical intervention such as clinical pharmacist delivery of comprehensive medication management services (by plan or provider organization pharmacists), reductions of OOP costs for patient participation in services/interventions/products, or inclusion of diagnostics for aiding medical/medication decision making.

Note: Next generation VBPC's can be an integral part of a health plan's overall successful VBC/risk transfer strategy with IDN's and health system providers. Aligning optimized medications and clinical care fits with reductions in overall cost of care and improved quality of care. Provider leadership, ability to execute/align resources and gain buy-in for the clinical interventions and acceptance of financial terms are key elements.

- Make inquiries to outside organizations with the products/medications/class of interest (biopharma, device manufacturers including diagnostics) as to their readiness and willingness to explore a VBPC
    - All organizations should assure that the respective "teams" organized have the authority and commitment to move forward
    - Look for the "track record" of other organizations and any experience in Value-based care and VBPCs.
    - For those manufacturers of medications, devices, or diagnostics that are committed to VBPCs- can your organization submit financially viable data based on solid analytics of the opportunity to significantly reduce overall costs and improve quality which would arise to the level of contracting and executing a VBPC? Note: Understanding your level of $$ risk/reward and those of all parties will determine the viability of this strategy versus others for all organizations.
    - In addition to medications and gene therapies with high cost, consider broad and inclusive disease state VBPCs open to multiple companies where more than one medication is in the same class (or device/diagnostics) have similar efficacy. Regulatory and legal parameters must be considered and vetted, but these may allow for provider choice with benefit design considerations available for all products to increase appropriate use and adoption with established parameters for efficacy and cost effectiveness. Note: The NAMCP survey indicated that common conditions such as diabetes, obesity, and cardiovascular disease among others drive large costs. Classes of medications could be considered under broad categories such as the GLP-1 agonist for VBPCs.

Go/No Go Decision: Only proceed with VBPC development if you have identified viable organizations with the critical leadership, cultural competence, and analytical/financial/ and contracting skills necessary to move forward.

In conclusion: Careful consideration of organizational readiness with product and population "fit" closely aligns with well accepted value strategy frameworks. This includes the **Healthcare Transformation Task Force – The Transformation to Value: A Leadership Guide**. Continuing awareness and compliance with governmental regulations in the U.S. (for example the CMS rule which went into effect July 2022 allowing a second mechanism by which discounts under VBA can be excluded from best price setting in Medicaid includes multiple best pricing reporting) and worldwide can significantly impact the adoption of VBPCs by manufacturers, plans, and providers. Ultimately reducing total cost and improving quality for the ultimate payers and patients while having acceptable margins for manufacturers, providers, and plans are key objectives of VBPCs.