

## National Association of Managed Care Physicians (NAMCP) Value-Based Pharmaceutical Contracts - Overview Guide

### What is a VBPC?

VBPC's typically represent an outcomes-based agreement (**OBA**) between a health plan and drug manufacturer (and less commonly include an "at-risk" provider group), whereby different prices for the same medication are determined by how well the drug actually performs in real-world patients based on agreed parameters including quality outcomes, clinical interventions, and/or components of the total cost of care.<sup>1</sup> **OBA's** may also be structured to include medical devices and incorporate advanced or companion diagnostics.

### Why are they Important?

Drug pricing has continued to rise with a major focus of price control governed by negotiated rebates and formulary tier positioning- **not** by the value of the medication being linked to patient outcomes (quality and total healthcare costs). This creates a value-price mismatch and is unsustainable for manufacturers and payers. Policies and legislation are challenging current payment models.

- Prices have not historically been linked to the medications value resulting in both inappropriately high and potentially inappropriately low drug pricing (one cause of shortages)
- Population mismatch has occurred whereby the drug is not utilized by the patients that could most benefit thus creating additional cost to the health system and poorer outcomes
- Non-optimized use of a medication in appropriate patients leads to further waste (example - dosages too high or low)
- VBPC's are [critical in advancing value-based pricing](#) and the shift from FFS to VBC. For [non-optimized therapies the cost was estimated as \\$528 Billion in 2016 or 16% of total health care costs.](#)<sup>2</sup>

### What are the Benefits of Utilizing VBPCs?

- **The prospect of reducing the total cost of care by using more appropriate drugs targeted to optimizing patient outcomes.**
- Directing dollars to the drugs that deliver the most value for a given patient population and reducing cost of low value drugs (resolving the value - price mismatch)
- Setting contractual parameters that could obviate the need for restrictive formularies, PA's, out of pocket cost as a barrier, and rebates
- For manufacturers, trading potential overuse in inappropriate patients for better identification of populations that could expand use.
- Increased information sharing (drug and medical claims, and clinical) that will maximize the OBA's success.
- First-generation contracts are dollar shifting mechanisms. For manufacturers this represents a downside risk in the form of increased rebate requirements linked to specified outcomes for potentially better formulary positioning/access. With no inclusion of clinical interventions to positively impact patient outcomes or optimize the medication use, upside impact is limited for manufacturers and the plan doesn't realize any potential medical cost reduction.
- Newer 2nd generation VBPC's can serve as the **key lever in a central agreement with clinical intervention(s) in broader value-based contracts and risk transfer/sharing with provider groups** in optimizing medications for **total cost reduction and quality target achievement.**
  - Medication management **directly impacts over 50% of existing plan quality metrics** (HEDIS, MA Star, etc.) **and total cost of care** allowing for **multiple concentric VBPC's** as medications are optimized through **comprehensive medication management (CMM) interventions.**
  - Reductions in total cost of care - drug and **medical cost (hospitalizations/provider/ER visits, etc.)** and quality metrics inform the contract parameters.
  - More sophisticated management reporting, AI data analytics, and targeted clinical pharmacist intervention(s) can be enabled by sophisticated 3<sup>rd</sup> party vendors within risk partnerships.

### How Is a VBPC generally Facilitated and Executed?

**Current first generation VBPC's** or OBA participants use 3<sup>rd</sup> party vendors that at a minimum support 1) data claims/cost integration and analytics and 2) timely management reporting for financial true-up.

- Determine if an outside vendor is needed for analytics and /or the conduction of clinical intervention(s)/reporting integrity and whether internal or external analysis is agreeable to all parties.
  - Identification of responsible parties for initial and administrative cost
  - General agreement on division of savings generated if executed at conclusion of first phase parameter analysis

- **Phase 1-** First generation VBPC- consists of the VBPC parameter analysis of drug(s) of interest cost/use, targeted population claims, potential for net savings, contractual expectations, formulary/benefit design parameters, and legal/finance feasibility/terms are agreed upon possibly with an “out clause” for unforeseen changes/ or the project is halted. (**GO** or **NO-GO** decision at this point)
- **Phase 2-** the first generation VBPC is now executed with timelines and agreed upon parameters for both financial/quality with the ability (usually facilitated by the 3<sup>rd</sup> party vendor) to track the target population for agreed outcomes, drug utilization, and cost impact.
- **Phase 3-** first generation VBPC’s will end with a reconciliation of data and determination of outcomes in a transparent manner. Impact on total cost of care versus other products or optimized use of the product may inform future formulary access and benefit design parameters.

**Goals of 1<sup>st</sup> generation VBPC’s-** potential higher rebate returned to plan, or conversely lower out of pocket cost for patients in target populations, changes in PA, or even generic tiering of brand drug to encourage use. Shared learnings in operationalization and execution of contracts with data insights gained.

**Newer 2<sup>nd</sup> generation VBPC’s** seek to not only shift payment between the plans and manufacturers based on the inherent clinical use but serve as a key vehicle to drive value-based care contracts with at-risk providers. Optimization of all medications to reduce the total cost of care and improve outcomes is the goal as pharmaceutical use may appropriately increase or decrease. A clinical intervention (comprehensive medication management) focus will be at the guideline/clinical best practice informed disease state or whole person level, not at the individual drug level, encouraging a broad number of VBPC’s within the context of a master VBC provider agreement to optimize targeted patients’ outcomes and quality.

- 2<sup>nd</sup> generation VBPC’s seek to align financial and clinical incentives to optimize medications in true value-based arrangements with providers in vertically integrated scenarios for managed care and product/device/diagnostics manufacturers consistent with clinically integrated networks (CINs) and CMS innovation efforts.
- Proven 3<sup>rd</sup> party vendors that can facilitate data analytics, AI driven clinical algorithms, and accurate efficient/effective targeting and clinical interventions of patients with medication changes and demonstrated financial outcomes becomes a key factor for success- potentially as an at-risk partner.
- Phase 1-3 now incorporate the clinical intervention parameters and the at-risk provider group as a key partner. Potential savings and quality metric improvements must be modeled based on target populations baseline use of medications/claims cost and optimal use scenarios to determine financial total cost of care savings. Metrics may now ideally incorporate not only medical/Rx claims ADT, or eligibility data, but lab and EHR or HIE to inform the model and interventions.
  - Benefit design changes/out-of-pocket costs for drug class and provider KOL messaging must be key considerations for clinical intervention success to engage patients in better adherence of optimized and appropriate medications.
  - Either 3<sup>rd</sup> party clinical pharmacists or provider/plan pharmacists are necessary to facilitate provider trust and acceptance of changes based on deeply informed clinical algorithms. Any 3<sup>rd</sup> party should demonstrate very high provider acceptance rates for suggested prescription changes and the degree of sophistication/evidence whereby these recommendations are based.

**Goals of 2<sup>nd</sup> generation VBPC’s** – includes all 1<sup>st</sup> generation goals **in addition** to the improvement in quality/clinical outcomes for patients and the reduction in total cost of care (medical and Rx claims) within broader provider risk arrangements. This is achieved by optimizing the appropriate use of medications through effective and efficient clinical interventions within provider risk arrangements. Insights will inform further metric development, benefit design changes, provider risk contracting elements, and a better understanding of the financial/value proposition of the medications.

<sup>1</sup> Kannarkat, J. T., Good, C. B., & Parekh, N. (2020). Value-Based pharmaceutical contracts: value for whom? *Value in Health*, 23(2), 154–156. <https://doi.org/10.1016/j.jval.2019.10.009> (adapted definition)

<sup>2</sup> Watanabe, J. H., McInnis, T., & Hirsch, J. E. (2018). Cost of Prescription Drug–Related Morbidity and mortality. *Annals of Pharmacotherapy*, 52(9), 829–837. <https://doi.org/10.1177/1060028018765159>

