

The emergence of value-based contracting



As the U.S. health care system continues its transition to value-based care in an effort to stem the rising costs of care, the current contractual agreement landscape between payers and pharmaceutical manufacturers is giving way to a more innovative reimbursement methodology — **value-based contracting (VBC)**.

Regardless of the term used — value-based contracting, outcomes-based pricing or risk-share agreements — the goal of VBC is to lower drug cost while improving both quality of care and member experience. This is achieved by tying reimbursement with how well the drug performs its intended use. VBC isn't exactly new to the pharmaceutical industry, but it has been slow to take off. So why all the attention now?

Determining the value of therapy interventions

The current contractual agreement system has been dominated by the traditional purchase discounts and rebate arrangement in exchange for product formulary access. The level of control through therapy interventions (step-edits, prior authorization, higher differential co-pay tiers) exhibited by a particular formulary is tied directly to a manufacturer's motivation to reduce the net drug spend through higher rebate payments.

Unfortunately, despite the advent of price protection terms in formulary contracts, the cost of many drugs has risen to an unsustainable level, and the true value of some medications is being called into question.



Medicare payments will increase from
30% to 50%
in VBR by 2018.

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The term value depends on the constituency weighing it. Unlike Europe, where the quality-adjusted life-year (QALY) is routinely used in an economic evaluation to assess the value for money spent on medical interventions, there is currently no standard for the evaluation of the cost-effectiveness of drug therapy in the U.S.

For payers, value has a financial implication that is based on the cost of the medication or procedure and any cost offset that may occur as a result of the use of that medication.

For providers, the Centers for Medicare & Medicaid Services (CMS) is driving a fee-for-value reimbursement model with the intention to systematically improve care outcomes and reduce costs across the continuum of care through more collaborative and coordinated treatment. However, this shift in focus for providers will not be successful unless payers have a similar approach — emphasizing value of money spent on medical interventions as a basis for contracting with manufacturers.

Performance vs. outcomes

As drug prices continue to escalate, it is clear that the traditional model of purchase discount and rebate payments in exchange for access is not sustainable for many drug categories, in particular so-called specialty drugs.

While payers have long been utilizing levers that shift the financial responsibility for the cost of medications to the patient, employers recognize that there is a limit to this strategy. In response, payers have been experimenting with new contractual agreements that focus on the performance of a drug. It is an important distinction to use the word “performance” rather than “outcome.” An “outcome” implies a broader view of care, often in a longitudinal setting, which may draw conclusions of a pharmacoeconomic nature (for example, patient or disease state morbidity and mortality). For that reason, contractual agreements aimed squarely at evaluating the performance of a drug in the real world setting are using the moniker “value-based” rather than “outcome-based.”

Given all the requisite caveats associated with the real-world use of medicines, the primary aim of VBC is to manage cost more effectively by tying reimbursement to the actual performance of the drug. Currently, there is no recommended standard for contracting in this manner.

While many competing PBMs have claimed to have multiple value-based contracts in place, this contracting effort is in its infancy with many key questions yet to be addressed, including:

- What metrics should be used (subjective vs. objective) for drug performance?
- What is the timing of reported data for rebate payment?
- How should rebate payments be structured to associate with drug performance?

Even if the basic construct is easily built, the challenges of potential financial impacts to government pricing calculations for the manufacturer, as well as avoidance of anti-kickback statutes and privacy concerns, remain.

Why value-based contracts work

Value-based contracts work when great care is taken to ensure it a collaborative process among all stakeholders — and when stakeholders are engaged early in the process. It has been our experience that an effective and executable VBC incorporates flexibility and alignment of both clinical and business perspectives.

MANUFACTURER pain points

As prices increase and payers begin focusing on the clinical value, access to patients and providers becomes more challenging.

Rebates are becoming unsustainable for manufacturers due to increasing rebate rates and cumulative price protection models.

SHARED pain points

There is a need to quantify clinical outcomes and to find common value metrics between payers and manufacturer.

Pipelines are dominated by specialty products, forcing payers to focus on heavy control and favoring exclusions.

PAYER pain points

Payers need supplemental means in addition to rebates to offset the significant costs of medications.

Payers are struggling to qualify and quantify the clinical value of products and robustly correlating them to health care resource utilization.

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When executed correctly, a value-based contract offers significant benefits to both the payer and manufacturer in the ways that it:

- Quantifies clinical value into meaningful metrics between payers and manufactures
- Reduces the burden or supplements rebates
- Provides an objective evaluation of a products impact on overall health care
- Enables payers to quantify/qualify clinical value
- Is design-driven and supported by robust data

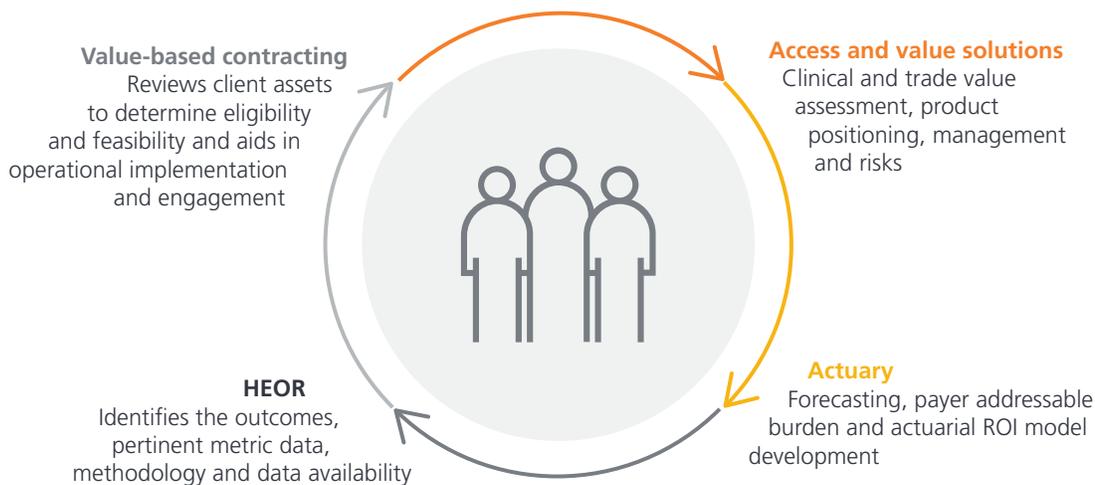
The right VBC partner

Optum is uniquely positioned to help you design and develop value-based contracts with payers. The life sciences value-based contracting team at Optum offers an end-to-end contract development service from strategy inception to contract execution. We use a three-stage process to target appropriate assets and build meaningful contracting strategies that are operationally feasible and applicable across multiple payer archetypes. This approach also helps you engage stakeholders to ensure alignment and progression toward contract execution.

With deep experience negotiating contracts for a leading PBM, our core team is complemented by a depth of expertise in data and analytics, health economics and outcomes research, and actuarial analysis.

Using our broad range of capabilities and expertise, we provide support in clinical and trade evaluation, data analytics and actuary analysis. There is also a built-in data and a process for management and adjudication.

Optum value-based contracts are developed from a payer perspective, which helps you save valuable time and expense. Through our relationship with UHC, contracts accepted by UHC are more likely to be accepted by other payers.



Components of a successful value-based contract

- 1 **Creates** value for all stakeholders
- 2 **Balances short-and long-term opportunities and risks** — want more than a one-year deal
- 3 Brings together groups critical to **value-based contracts** — HEOR, actuarial and across-Optum, risk-based contracting groups
- 4 Employs a patient/physician engagement program to **drive outcomes and compliance**
- 5 Leverages a predefined adjudication criterion that is **simple to execute**
- 6 Leverages claims and select clinical data to **ensure understanding** of outcomes and patient segments
- 7 Leverages a “pilot” to **test uncertainties** if there are significant unknowns
- 8 **Adjudicates quarterly**, but squares up at year-end

To learn more about how Optum can help you with VBCs, contact us now.

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