2018 is shaping up to be the year of “value.” And the Academy of Managed Care Pharmacy is poised to be at the forefront of what is one of the most promising developments in health care in recent years: the shift away from cost models based on fee-for-service and towards those based on rewording value and improved outcomes.

In short, AMCP’s mantra has become “value, value, value.”

The focus on value could not only change how we pay for health care but significantly improve how we deliver patient care. The shift to value over volume also will transform how AMCP’s 8,000 members design and manage the pharmacy benefits for more than 270 million lives.

In the coming year, AMCP will build on value-based health care initiatives started in 2017 through several AMCP Partnership Forums, the AMCP Foundation Annual Symposium and our legislative and regulatory advocacy. Here are some details.

**Value-based contracting**

Value-based contracting (VBC) is a still relatively new but promising model that bases payments on predetermined criteria aimed at improving patient outcomes. A 2017 AMCP/Xcenda survey of AMCP members found that interest in VBC is increasing and growing. According to the survey, one in five payers have value-based contracts in place, as do one in three manufacturers. But two-thirds of payers and half of all manufacturers say they are interested in implementing value-based contracting.

An AMCP Partnership Forum in June brought together diverse stakeholders all interested in advancing VBC. Participants included representatives from health plans, integrated delivery systems, pharmacy benefit managers, data and analytics experts, and biopharmaceutical companies.

One key outcome was simply to define VBC. Not having an accepted definition has hobbled progress by AMCP and others to advocate for process improvements and policy changes, which I address below. The consensus at the forum was: “Value-based contracting is a written contractual agreement in which the payment term for medicinal(s) or other health care technologies are tied to agreed-upon clinical circumstances, patient outcome measures.”

**Forum attendees also identified various barriers that must be addressed before VBCs can be widely adopted, including a lack of provider adoption of data that VBCs reduced pharmaceutical spending and the inability to obtain outcomes data during the contract negotiations. There was strong agreement that one of the greatest challenges with the VBC model is selecting appropriate outcomes to measure and determining how much value to assign them. Outcomes should be easily measured, clinically relevant, and associated with financial and/or clinical improvements. They include:

- Hard clinical endpoints (e.g., all-cause mortality, cancer-related death)
- Hard clinical endpoints (e.g., hospitalization, ER visits)
- Hard clinical endpoints (e.g., hospitalization, ER visits)
- Cancer-free survival and progression-free survival
- Adverse events
- Quality of life and activities of daily living (e.g., patient-reported outcomes)

Regulatory and legal barriers also are a priority. These include the federal Anti-Kickback Statute, which prevents parties from giving something of value with the intent of influencing a purchase under a federal program. AMCP will advocate for a new safe harbor for VBCs that covers services such as wrap-around patient services.

The second major regulatory obstacle is the Medicaid Best Price Rule. This becomes a problem if a contract includes a large discount or refund for treatment failure, as that discounted price could set a new lower price point. “AMCP again will advocate for solutions on this issue, including through calls for the Centers for Medicare and Medicaid Services (CMS) to create an exception from the Medicaid Best Price rule for VBCs.”

**Value in oncology**

Another area ripe for adoption of value-based concepts is oncology. Cancer care costs are poised to be one of the largest growth areas as new medicines offer dramatic advances in the way we treat some of the most common cancers.

At the same time, oncology costs have grown rapidly, challenging the health care system as it seeks to afford cutting-edge cancer care. In the coming year, AMCP will focus on recommendations developed at a recent Partnership Forum, including calls to:

- Define key data sets that support value-based partnerships and payment models between biopharmaceutical companies and payers.
- Improve decision-making support tools — such as value frameworks and prior authorization criteria — by incorporating real-world evidence and diagnostic and genomic data.
- Improve data fragmentation and interoperability by developing greater access to better oncology data collection and sharing, and reducing the administrative burden on providers and pharmacies.

AMCP is also working to address the tremendous financial burden on cancer patients. In a separate oncology forum, participants suggested solutions to address patient financial burden. One key consideration is the cancer patients in our decentralized health care system confront information gaps in treatment costs, high nonmedical treatment costs, inadequate integration and portability of electronic health records, and issues around end-of-life planning, all of which contributed to their financial burden.

**Value-based health care involves multiple stakeholder perspectives**

The perception of what is considered “valuable” in any particular therapeutic intervention can vary widely between providers, patients and payers. That was the conclusion of panelists at the AMCP Foundation’s 7th Annual Research Symposium held in October 2017.

Symposium moderator Clifford Goodman, senior vice president and director of the Center for Comparative Effectiveness Research at the Lewin Group, noted, “The challenge involved in value formulations need to recognize that our perspective is not the only perspective, that different stakeholders have different perspectives and realities for the stakeholders and gatekeepers, and that all have their own inherent value equations. If I’m ignoring those perspectives, then my value calculus is going to be suboptimal."

This point was echoed by many at the symposium. The current approach to understanding value and utility in the health care system falls short of capturing many aspects of care that really matter to patients, including variations in preferences based on type of disease, stage of disease, socioeconomic and other characteristics that shape patient preferences.

Read the symposium meeting report at www.amcp.org/FdnSymp_2017Report/.