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Are Value-Based Contracts Slipping Under the Radar?

By Karen Blum

BOSTON—Value-based contracts that tie pharmaceutical drug coverage and reimbursement levels to their performance may be more prevalent than is thought, because many of these deals aren't disclosed, an industry expert said at the Academy of Managed Care Pharmacy's 2018 Managed Care & Specialty Pharmacy annual meeting.

In round numbers, the deals kept confidential versus made public run at about a 3:1 ratio, noted Robert W. Dubois, MD, PhD, the chief scientific officer and executive vice president of the National Pharmaceutical Council in Washington, D.C. "For every one you know about, there's probably two or three out there that you don't know about," he said during a panel on the value-based contracts (VBCs).

In a recent survey of 11 pharmaceutical manufacturers and nine payors conducted by the National Pharmaceutical Council and the Duke-Margolis Center for Health Policy, manufacturers reported that they engaged in 88 VBCs, about 26% of which have been publicly disclosed. Similarly, payors reported engaging in 122 contracts, about 29% of which have been publicly disclosed.

The survey participants cited a few common reasons to keep their deals confidential, Dr. Dubois said. First, it's frequently part of the culture to not disclose these relationships publicly. In addition, keeping the arrangement private helps avoid public scrutiny in case there are negative consequences. Finally, the privacy might help the partners maintain a competitive advantage over others.

Both manufacturers and payors said when negotiations for these contracts break down, it occurs most frequently during the early dialogue, sometimes during formal negotiations and less often during implementation. “There are a lot of reasons why these things aren’t more prevalent,” Dr. Dubois said.

Why do many dialogues fail? The manufacturers and payors surveyed said the most common reasons are the risk-sharing structure, a perceived lack of buy-in from the potential partner and disagreements on drug pricing. Manufacturers also cited issues with partners gathering sufficient data or evidence, implementation costs, and difficulty identifying appropriate outcome measures. Payors also noted disagreements with partners on the incentive mechanisms and financial terms.

Asked to rank the top five negotiation and/or implementation factors in VBCs, manufacturers reported their partners having the necessary capabilities for data collection and analysis; the availability of measurable outcomes clearly tied to product use; a target patient population that is easily identifiable in claims; a reasonable administrative burden; and the need for partners to be committed to the agreement.

Payors cited three of the same factors but in a different order: At the top of their list was the availability of measurable outcomes tied to product use, followed by the target drug having a potentially high budget impact, a target population that is easily identifiable in claims, a reasonable timeline for collection and analysis, and a reasonable administrative burden.

On the horizon, Dr. Dubois said, these arrangements could become more sophisticated and more common. He said he was particularly interested to see if VBCs could be packaged to include multiple manufacturers within a contract, such as having three tumor necrosis factor (TNF) inhibitors on a formulary with three risk-sharing deals in place.

Given the high prevalence of specialty pharmacy–managed diseases treated with TNF agents, including rheumatoid arthritis and ankylosing spondylitis, such packaged deals may well be an attractive option for market players seeking more value in their contract terms.