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The Latest in the Move to Value-Based Reimbursement and Remaining Challenges

Author: Laura Joszt

Although there has been an increased interest in value-based contracting, the most common type, pay-for-performance, has had mixed results to date, and many challenges remain.

Panelists, during a session on value and value-based reimbursement at the Academy of Managed Care Pharmacy Annual Meeting, held March 27-30 in Denver, Colorado, discussed the benefits and challenges of value-based contracting and the current and evolving use of value frameworks.

Tomas J. Philipson, PhD, Daniel Levin Professor of Public Policy Studies at the University of Chicago, started the session by outlining the 5 challenges that have faced value-based contracting so far:

1. There is a need for stronger incentives. According to Philipson, efforts in this space have so far been small, with maybe 1% to 2% of payments being on quality and the rest still on volume.
2. Value needs to be measured appropriately. Pay-for-performance has focused on processes because measuring outcomes is more difficult. In order to have more of an impact, there needs to be an understanding of what measures are valuable to patients.
3. Patient preferences need to be accommodated.
4. Don't get too complex. These contracts should start simple and not get too complex too quickly.
5. Innovation should be rewarded.

Peter Neumann, ScD, director of Center for the Evaluation of Value and Risk in Health Tufts Medical Center, said all the efforts to measure value has created an “interesting period of value frameworks.”

He finds it important that the value frameworks out there, such as the National Comprehensive Cancer Networks' Evidence Blocks, the Institute for Clinical and Economic Review (ICER)'s Value Assessment Framework, and Memorial Sloan Kettering Cancer Center (MSK)'s DrugAbacus, are all coming from the private sector.

“You may not like them, but you can’t blame the government for doing this to you,” he said.

In other countries, the value frameworks are a government function, and the fact that they are coming from the private sector is not only uniquely American, but means that they are here to stay, Neumann said.

That these frameworks all have different approaches does make it difficult to compare them. They all measure clinical benefit in some way, but only MSK considers novelty of treatment and the rarity and burden of the disease, and only ICER takes into account budget impact.

Meanwhile, there are other attributes of value that are not explicitly in these frameworks, Neumann pointed out. Other attributes he highlighted included equity, work productivity, option value (the acknowledgement that a patient might live longer until a new, better treatment comes along), value of hope, and caregiver effect (if someone is willing to pay more for a treatment, such as an Alzheimer’s drug, for a family member or loved one who requires a caregiver).

Ultimately, it’s challenging to assess value in these frameworks.

“We’re potentially leaving a lot of value on the table as we try to do these exercises,” Neumann said.

Unfortunately, at this point it’s hard to know the impact these frameworks are having, he added. While there is awareness of frameworks and some payers are using them, there is a lot of variation of who is using them and how.

Jeremy Schafer, PharmD, MBA, senior vice president and director of specialty solutions at Precision for Value, presented the results of a survey that analyzed how payers are using value frameworks. The survey, which was conducted January 2016, found payers are using these frameworks to select preferred products or to create pathways or to educate providers on the cost of treatments.

At the time, only 26% of respondents were using value frameworks, while another 22% were planning to use frameworks within 12 months, and 19% had plans to use a framework further than 12 months out. Only 19% had no plans to use a framework and 15% were unsure of plans.

“Value frameworks are increasingly being used by payers,” Schafer said. “And this is for many of them creating almost a foundation or benchmark they can rest upon when going out there and working with manufacturers on potential value-based arrangements.”

In particular, outcomes-based contracting has grabbed people’s interest because it is fairly simple,

said Dean Hakanson, MD, chief medical officer of Otonomy, Inc. Recently, Novartis made deals with Aetna and Cigna for the heart drug Entresto and Harvard Pilgrim Health Care has an agreement with Amgen for the cholesterol-lowering drug Repatha. In the Repatha deal, if the insurer's members don't have cholesterol reduced to what was observed during the clinical trials, then Harvard Pilgrim would receive a rebate from Amgen.

The benefits of these outcomes-based contracts include faster access to formularies, data that demonstrates real-world outcomes specific to the population in the agreement, and discussions will move from just cost offsets to quality of care, Hakanson said.

However, there are more obstacles that still exist than there are benefits at this point, he added. These obstacles include implications for federal best price, challenges in measuring relevant real-world outcomes, payer concerns about adverse patient selection, and lack of control over product use.