ACCC 2023

Oncology Reimbursement MEETINGS

Strategies for Negotiating with Payers

Association of Community Cancer Centers

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What's Going on in D.C. & my State? Why it Matters?

ACCC 2023 Oncology Reimbursement MEETINGS

- A brief overview of state and federal priorities, and its impact on patients

Pharmacy Benefit Manager (PBM) & Specialty Pharmacy 101

- 1970s: PBMs emerge to help insurers contain drug spending by managing formularies and administration
- 1980s: A small PBM, Express Scripts, negotiates the first discount
- 2020s: The 3 largest PBMs—Express Scripts, CVS Caremark, and OptumRx—control 80% of the market

Vertical Business Relationships Among Insurers, PBMs, Specialty Pharmacies, and Providers, 2022

1. In September 2022, CVS Health announced its acquisition of Signify Health. The transaction is expected to close in 2023.
2. Since January 2021, Prime's Blue Cross and Blue Shield plans have had the option to use Express Scripts or AllianceRx Walgreens Prime for mail and specialty pharmacy services. On Dec. 31, 2021, Walgreens purchased Prime Therapeutics' 45% ownership interest in AllianceRx Walgreens Prime, so this business has no PBM ownership in 2022. Effective June 2022, the company has been known as AllianceRx Walgreens Pharmacy.
3. In 2021, Centene has announced its intention to consolidate of all PBM operations onto a single platform and outsource its PBM operations to an external company.
4. In 2021, Centene sold a majority stake in its U.S. Medical Management to a group of private equity firms.
5. Since 2020, Prime has sourced formulary rebates via Ascent Health Services. In 2021, Humana began sourcing formulary rebates via Ascent Health Services for its commercial plans.
6. Cigna also partners with providers via its Cigna Collaborative Care program.
7. In 2022, Humana announced an agreement to divest its majority interest in Kindred at Home's Hospice and Personal Care Divisions to Clayton, Dubilier & Rice. In 2022, Kindred at Home was rebranded as CenterWell Home Health.

Source: *The 2022 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers*, Exhibit 212. Companies are listed alphabetically by insurer name. Published on *Drug Channels* (www.DrugChannels.net) on October 13, 2022.

DRUG CHANNELS INSTITUTE

Bagging: What Are the Differences? What Is the Impact on Patients & Your Organization?

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- **White bagging**: A specialty pharmacy ships a patient's prescription directly to the provider (hospital or clinic). The provider holds the product until the patient arrives for treatment.
- **Brown bagging**: The patient picks up a prescription at a pharmacy or has it mailed to their home, which is then taken to the provider (hospital or clinic) for administration.
- **Clear bagging**: A provider's internal specialty pharmacy dispenses the patient's prescription and transports it to the location of drug administration.

Specialty Pharmacy & Bagging Considerations

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Specialty Pharmacy	White Bagging	Brown Bagging
Delays in care	Chain of custody	Chain of custody
Increase in cost to patient	Missed appointments	Missed appointments
	Changes in therapy	Changes in therapy
	Dose reductions	Dose reductions

Louisiana's White Bagging Legislation[2]

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Link to bill:
https://legis.la.gov/legis/BillInfo.aspx?i=240483

Primary author: Senator Heather Cloud

Signed by Governor Edwards on June 1, 2021

Summary: SB 191 ensures payers cannot refuse to reimburse providers for approved physician-administered drugs and related services to covered patients even if these services are obtained via out-of-network pharmacies. SB 191 was passed with bipartisan support and is considered the first successful white bagging legislation to be enacted in the nation.

Following Louisiana's Success

- For the 2023 legislative session, more than fifteen white bagging proposals have been introduced in state legislatures across the country.
- Ohio legislation:[3]
  - Prohibits a health benefit plan from requiring that physician-administered drugs be dispensed by a pharmacy or affiliated pharmacy, limiting coverage when such drugs are not dispensed by a pharmacy or affiliated pharmacy, or covering such drugs with higher cost-sharing if dispensed in a setting other than a pharmacy.

Following Louisiana's Success

- Illinois legislation:[4]
  - Amends the Illinois insurance code.
  - Provides that a health benefit plan amended, delivered, issued, or renewed on or after January 1, 2023, prescription drug coverage, or its contracted pharmacy benefit manager shall not engage in or require an enrollee to engage in specified prohibited acts.
  - Provides that a clinician-administered drug that is supplied shall meet the supply chain security controls and chain of distribution set by the federal Drug Supply Chain Security Act.[5]
- Arizona legislation:[6]
  - Prohibits a PBM from steering or directing a patient to use its specialty pharmacy.

What's Going on in a State Near You

- **Making insulin affordable**:
  - Although the federal Inflation Reduction Act lowered the amount Medicare beneficiaries pay for insulin, affordability remains a challenge for some, including those with private insurance and the uninsured.[7]
  - 22 states have limits on the amount a person pays for insulin and at least nine more could join them.[8]
  - Proposed legislation in Oklahoma and Rhode Island would cap the amount a person pays for diabetic supplies, such as glucose monitors.
  - Legislators in Kentucky, Massachusetts, Montana, and New York introduced bills to establish a safety-net program for people who need insulin urgently.
  - California legislation passed in 2020 allows the state to explore partnerships to manufacture low-cost insulin.[9]
    - Since then, lawmakers in Connecticut, Georgia and Maine are pursuing this idea for their states.

Managing Co-Pays & Deductibles

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- In addition to reducing how much a person pays for insulin, legislators are taking a hard look at lowering consumers' out-of-pocket costs in other ways.
  - Rhode Island is considering legislation to limit co-payments for asthma inhalers.
  - Some lawmakers in Colorado, Missouri, Rhode Island, and Vermont want to extend co-payment limits to epinephrine—the drug used in autoinjectors to mitigate a severe allergic reaction.
- Another strategy is to restrict the use of co-pay accumulator policies, as 15 states and Puerto Rico currently already do and 15 more states are currently considering.[10]
  - Manufacturers may offer co-pay assistance coupons to patients to help offset the cost(s) of their prescriptions.
    - Not only do the coupons reduce the amount patients pay at the pharmacy counter when they fill their prescriptions, but the value of the coupons may also be applied to patients' annual cost-sharing requirements, such as deductibles.

Managing Co-Pays & Deductibles

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- Opponents argue that co-pay coupons incentivize the use of higher-priced medicines over lower-priced options, such as generics.[11]
- Some also say co-pay coupons do not reduce drug prices but shift the cost(s) to health plans.[12]
- Some health plans and PBMs have imposed co-pay accumulator policies that exclude manufacturer co-pay assistance from counting toward patients' deductibles or annual out-of-pocket limits.

Tackling Prescription Pricing

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- Though many policymakers are passing laws to lower the cost of drugs, some are tackling the way drugs are priced.
- Importing drugs from other countries has long been on legislators' radar.[13]
  - Eight states are in various stages of establishing their own drug importation programs.
  - Some states limit importation to drugs purchased from Canada, though laws in Florida and Colorado provide pathways to import drugs from other countries.
  - Legislators in Illinois, Nebraska, New York, Rhode Island, Texas, and West Virginia are seeking to create programs of their own.

Tackling Prescription Pricing

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- Bills in five states aim to address drug price increases by manufacturers.
  - For instance, an Arizona bill would authorize the attorney general to investigate price increases of 50% or more over the previous year paid by the state Medicaid program for off-patent or generic drugs.[14]
  - New York is considering a bill that would require investigation of prices that rise more than the cost of living on drugs the state deems critical.[15]
- Prescription drug affordability boards are independent agencies tasked with identifying and evaluating high-cost drugs.
  - Seven states—Colorado, Maine, Maryland, New Hampshire, Ohio, Oregon and Washington—have affordability boards, and four others are considering bills to establish one this session.[16-21]

Limiting Prior Authorization

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- Cost isn't the only barrier for patients trying to access certain treatments.
- To reduce costs, some health plans require providers to obtain prior authorization for certain tests, procedures, or treatments.
  - Providers say this process can be arduous and time-consuming.[22]
  - West Virginia was the first to pass legislation allowing providers who have had all their requests for a particular treatment approved in a six-month span to earn a "gold card" status, freeing them from future authorization requirements.[23]
  - Texas' law applies to providers who have had 90% of their requests approved.[24]
  - In 2022, Louisiana followed suit, and this year at least eight states—Arkansas, California, Indiana, Iowa, Kentucky, Missouri, Montana, and Nebraska—are pursuing similar gold card legislation.[25]

Overseeing PBMs

- More than a quarter of introduced legislation this year addresses PBMs, which are paid third-party administrators of prescription drug coverage for insurers and employers.[26]
  - PBMs provide a wide variety of services, including developing and maintaining formularies, processing claims, and negotiating discounts and rebates between payers and manufacturers.
  - Legislators are addressing PBMs in several ways.
- One approach ensures that rebates PBMs negotiate from drug manufacturers are passed to consumers.
  - At least 12 states have introduced bills that would require a patient's cost-sharing to be calculated at the point of sale and reduced by an amount equal to a certain percentage of those rebates.

Overseeing PBMs

- Prohibiting so-called white bagging and brown bagging policies is another growing legislative trend.[27]
- Certain providers, such as oncologists and rheumatologists, purchase medicines that need to be administered in the clinic—those that are injected or infused, for example—and prepare them for specific patients prior to administration.
  - These medicines are often costly and require special storage and handling.
  - The provider then bills the insurer or PBM for the cost of the drug.

Who's Holding the Bag?

- In response, some insurers and PBMs are shifting to white bagging and brown bagging policies.[28]
  - Proponents say these policies improve patient outcomes because pharmacists may conduct drug utilization reviews and identify circumstances where a patient might have an adverse reaction to a prescribed drug.
  - Opponents say patients sometimes are steered toward PBM pharmacies and that medicines can be mishandled, which may lead to increased costs for patients and payers.[29]
- Three states—Arkansas, Louisiana, and Virginia—have laws restricting these policies, and 18 states have proposed similar legislation for the 2023 session.[30-32]

Get Involved!
Engage Your Organization & Patients!!

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- Will my efforts make a difference?
- How the Timely Access to Cancer Treatment Act of 2021 started[33]

Speaking with Policymakers

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1. Clearly identify the issue and offer solutions
2. Identify and target specific, elected officials
3. Prepare your message
4. Why do you care about the issue? What impact will the proposed legislation have on your patients?
5. Write out the key points you'll want to make sure you remember to cover
6. Engage your patients
7. And your family, friends, and ***you***—everyone is a consumer of healthcare!

National Policies Shaping Healthcare Transformation

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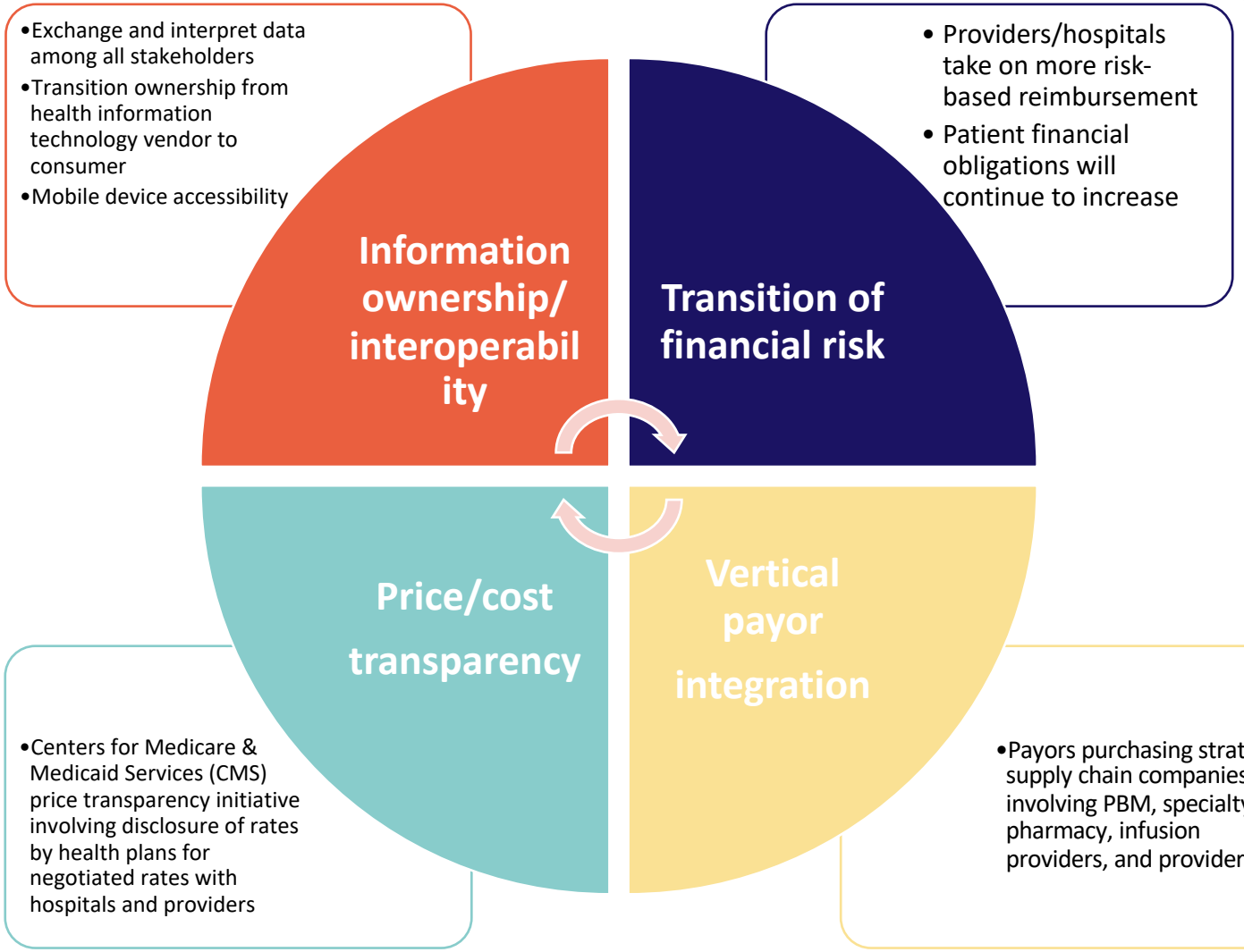
Patients' health records belong to patients, not the technology companies...
This is a good thing for patients!



We must be responsible for the cost of what we are ordering.
This is a good thing for patients!

Patients want to understand what they are paying for.
This is a good thing for patients!

Insurance companies want to control everything!!
This is a *bad* thing for patients!

Impact of Consolidation on Costs

Table 2. PPPM Total Costs in Community Practice vs Hospital-based Practice

34

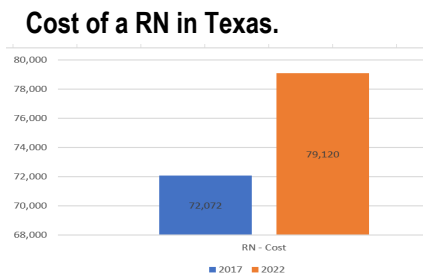
	Community Practice N=4,450		Hospital-based Practice N=2,225		*P*-value
	Mean	SD	Mean	SD	
Mean Total Costs	$12,548	$10,507	$20,060	$16,555	<0.0001
Total Medical Costs	$12,103	$10,504	$19,471	$16,476	<0.0001
Chemotherapy	$4,933	$4,983	$8,443	$10,391	<0.0001
Branded agents only	$6,674	$5,046	$10,900	$10,712	<0.0001
Generic agents only	$2,936	$2,585	$5,134	$6,306	<0.0001
Combination regimen[a]	$11,080	$5,889	$19,412	$13,869	<0.0001
Physician visits	$765	$1,607	$3,316	$4,399	<0.0001
Radiation	$1,095	$4,153	$1,430	$4,904	<0.0001
Inpatient	$1,178	$6,229	$1,498	$7,193	0.0095
ED visits	$121	$501	$168	$620	<0.0001
Outpatient	$3,838	$3,681	$3,912	$5,698	<0.0001
Other	$174	$2,405	$704	$3,353	<0.0001
Total Pharmacy Costs	$445	$1,239	$589	$1,934	0.2708

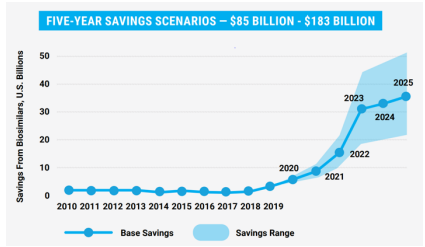
[a]Combination = chemotherapy regimen contained both branded and generic drugs.

ED = emergency department; PPPM = per patient per month; SD = standard deviation

Payment Models: Oncology Then (2017) & Now[35-38]

Novel drugs	An average of 21 new oncology drugs were launched each year from 2017-2021
Cost increase—new drugs	Average annual cost of new drugs jumped by 53%
Drug price increase	Oncology drug prices rose by 25%
Cost of a registered nurse in Texas	Increased by 10%
New drug indications	New drugs could be used to treat more cancer types
Life longevity	Patients are living longer; the 3-yearr survival rate in multiple myeloma rose from 42% to 66%
Cost effectiveness	Biosimilar utilization: To date, the U.S. Food and Drug Administration (FDA) has approved 31 biosimilars across 11 molecules. 20 biosimilars are on the market, with prices that average 30% less than their reference biologic. $12.6 billion in savings over the last 10 years.
First cancer biosimilar	Filgrastim-sndz was released in 2015.
Oncology Consultants' biosimilar footprint and cost savings	As of 2022, Oncology Consultants has a 75% conversion rate to biosimilars. Biosimilar substitution cost savings for village Md CAP lives in 2022 (Q1-Q3) was 22% or $1.38 per member per month (PMPM).





Payment Models: Fee-for-Service (FFS) Model

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	Fee for Service	Capitation
Method of payment	**N**o fixed payments. **P**roviders reimbursed on the services provided.	**A** fixed per capita payment to providers by a network/independent physician association (IPA) in return for the medical care provided to enrolled individuals (PMPM).
Risk assumed by	Payers	Healthcare providers
Focus of care/services	**V**olume over quality. **D**elayed care due to prior-authorization for services, resulting in higher cost of care. **C**ostly and cumbersome for both payers and providers. **H**igh unpredictability to providers on expected revenue. **L**ower cost controls or predictability to the payer.	**P**ayments are risk stratified with more remuneration for patients with high risks, based on factors like age, race, sex, geographical area, and degree and complexity of care required. **P**reventive care emphasized. **C**ost effective: amortize the fixed cost and align clinical initiatives. **G**lobal capitation. **C**apitation model adjudication. **A**lignment with value-based strategy.

What is the Reimbursement with Sequestration to the Provider?

FFS paid to wholesaler @ 4% of wholesale acquisition cost (WAC)

Sold at WAC (e.g., $100/vial)

Paid within 30 days @ WAC-2% PPD

DRUG MANUFACTURER
Average sale price (ASP) = $94

WHOLESALER
Net collections rate (NCR) = $6-$2 = $4

Sold to clinic at a discount of 4% of WAC

Paid within 35 days @ 96% of WAC

PROVIDER
NCR = $2.04

Net reimbursement to provider = 2.2%

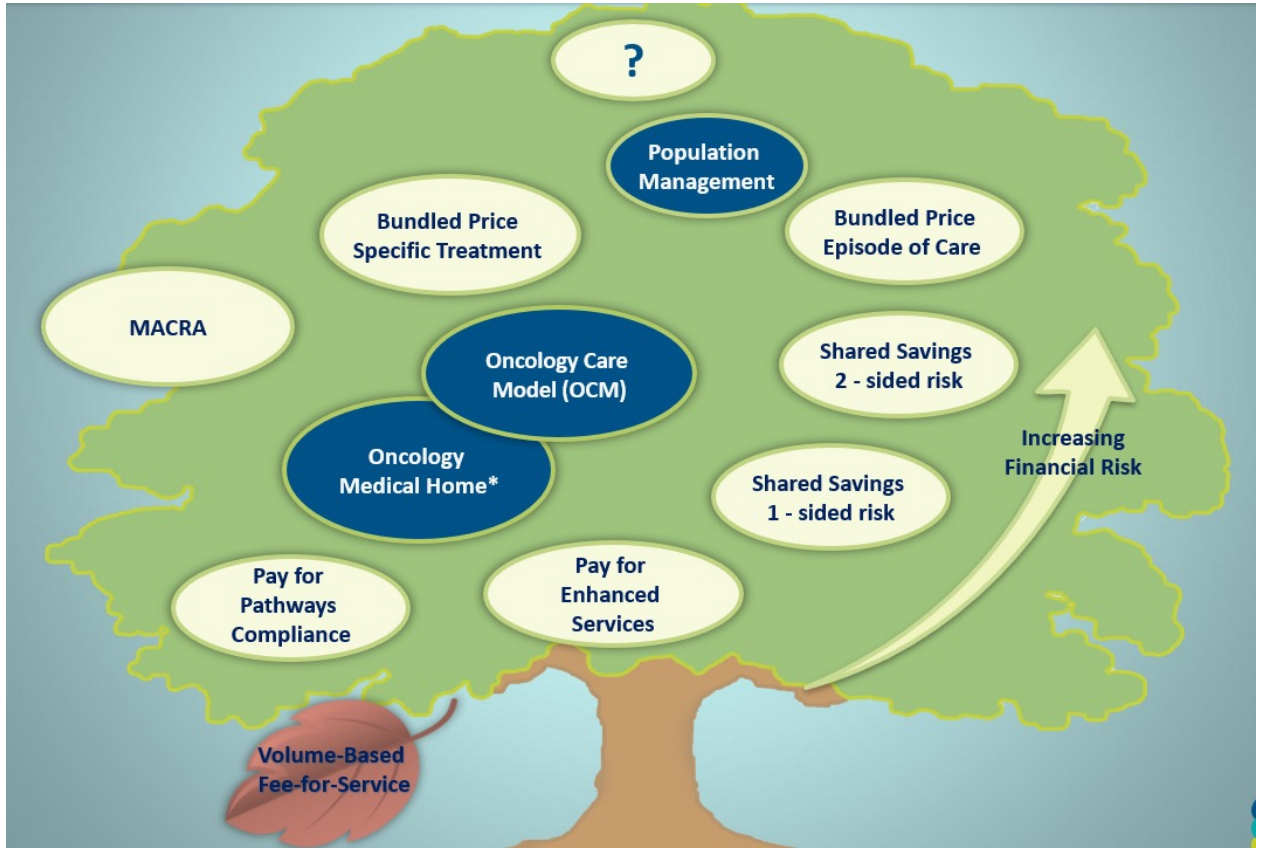
Submits ASP data quarterly

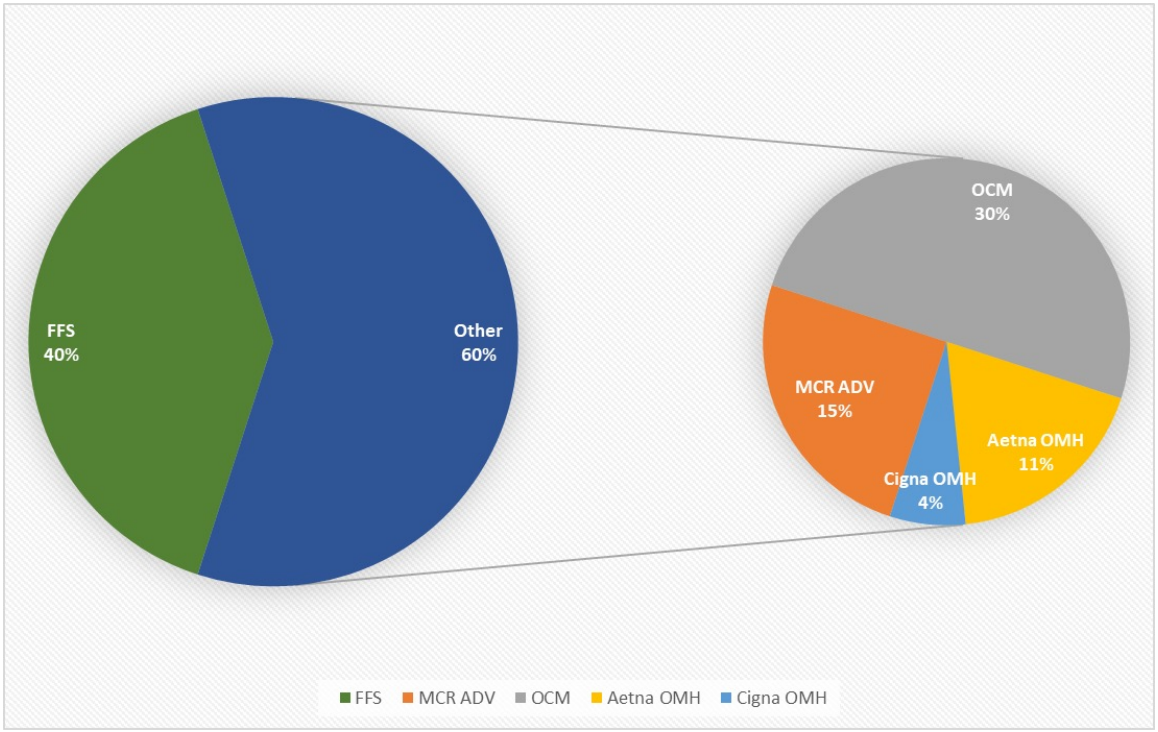
PAYER (Medicare)

Paid @ASP($94) + 4.3% in 14 days

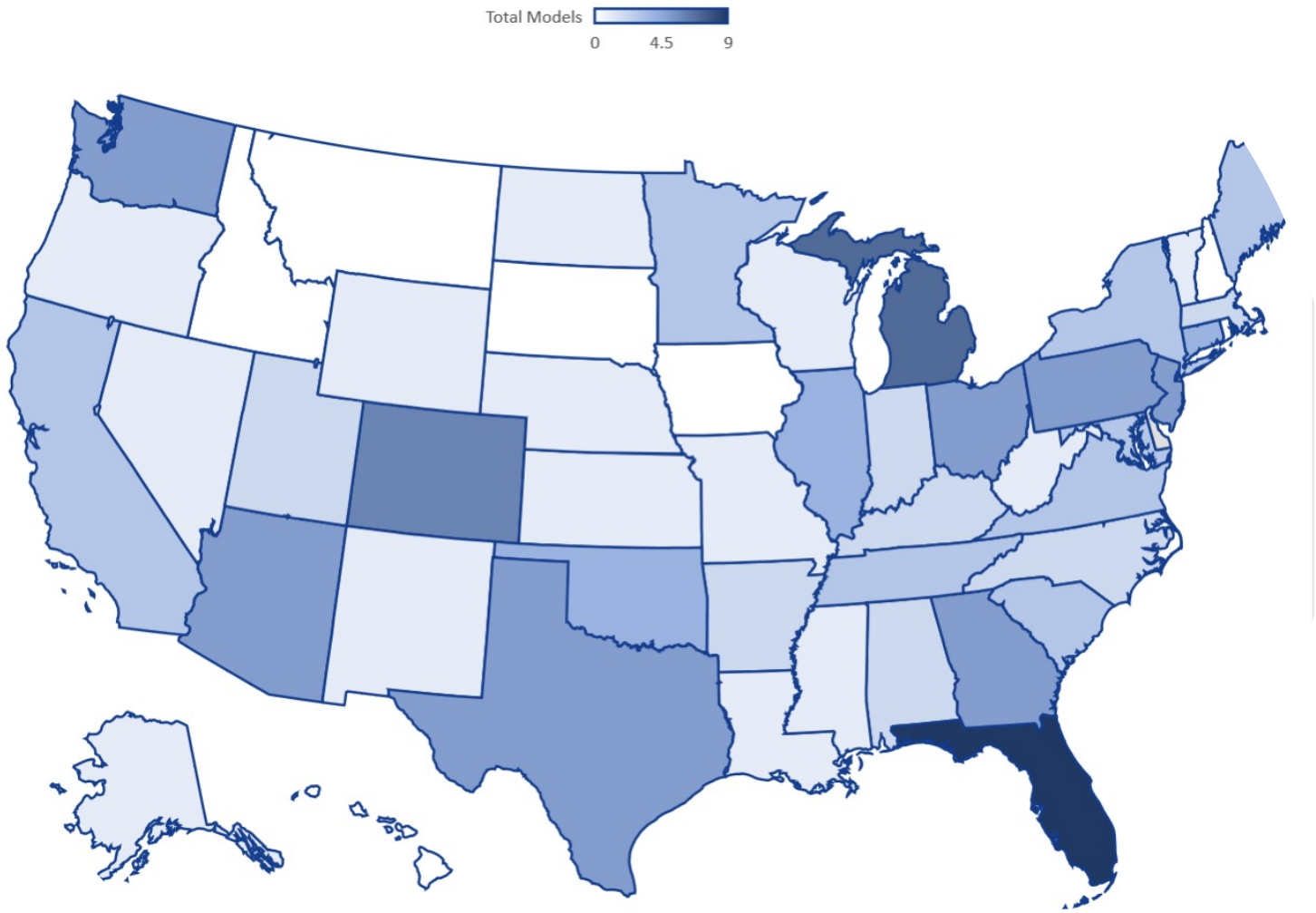
Billed to payer at patient level via claim

Various Payer Approaches





Payment Reform in Cancer Care



Approach (Payer/Patient Discussions & Financial Toxicities)

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Payor discussions

-Executive physician leadership support of the following:

-Contract negotiations focused on better generic drug returns

-Discuss therapy substitutions/ preferences with the chief medical officers of payers

-Inclusive of quality metrics that can be extracted from the electronic health record (EHR)

-Discussion of formulary inclusions based on National Comprehensive Cancer Network (NCCN) standards and pathway inclusion

Physician education

-Continuous education to physicians on drug economic decisions and impact on patient out-of-pocket costs (pocket guide)

-Discuss alternative treatments when patient asks the physician or can be deferred to financial counseling

Financial toxicities (patient)

-Managed through our automated limited resource support processes

-Pre-screening patients for potential financial challenges

-Foundation support

-Co-pay assistance

-Financial counseling

Value-Based Care Initiatives

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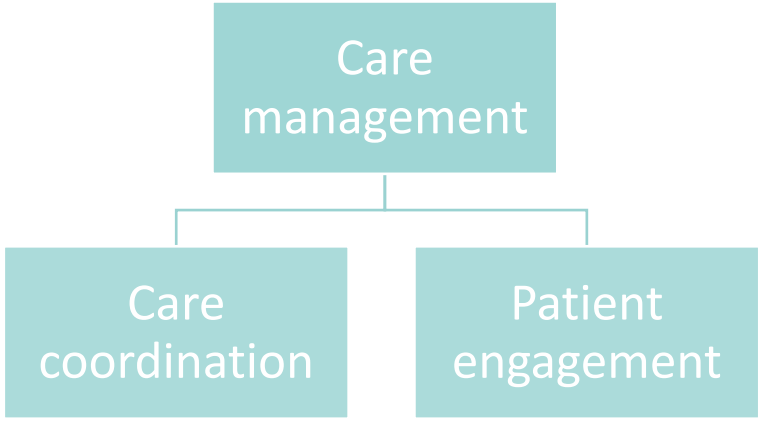
VBC Initiative	Description	Performance	Payment	Performance benchmark
Oncology Care Model (OCM)-2 sided risk	Application-based cancer quality program focused on clinical quality measures (CQM), total cost of care, and coordination of care	• Achieving predefined clinical quality measures • Measuring costs per diagnosis, hierarchical condition category (HCC) codes, age, gender • IP, ED and hospice management	• FFS • Beneficiary management fee • Retrospective performance assessment by disease	• In a 2-sided risk arrangement, the practice has trended positively (practice aggregate costs are below benchmarks resulting in capital gain sharing adjusted by CQM %)
Aetna Oncology Medical Home	Similar model to OCM	• Treatment pathway adherence • Measuring costs by diagnosis, age, and gender	• FFS • Retrospective performance assessment compared to region-based hospital and outpatient clinics	• Practice has consistently met benchmarks and earned bonus payments
CIGNA Oncology Medical Home	Measuring inpatient (IP) and emergency department (ED) utilization	• Compare practice utilization of IP and ED	• Management fee	• Cigna relaunching program
Capitation	Total population management, based on member pod assignment and PMPM payment methodology	• Assessing costs based on PMPM calculation • Cost per united member (CPUM) adjustment	• PMPM • True up adjusted with global CPUM adjustment	• CPUM assumes same cost of utilization across all socio-demographics • Pods have mixed performance comparing cap/co-pay • CPUM calculation adjusts
United Episode Program	Similar model to OCM	• Similar to OCM	• Episode-based payment • Retrospective performance assessment by disease	• Launching program in 2021
Memorial Hermann Accountable Care Organization				

Next Steps in Capitation: Shared Savings Model

- Moving from a simplified risk stratified PMPM capitated model….
- Shared savings is a payment strategy that offers incentives for provider entities to reduce healthcare spending for a defined patient population by offering them a percentage of any net savings realized as a result of their efforts.
- **Methodology**:
  - Identify the factors (e.g., inpatient and ED utilization)
  - Define how savings will be measured
  - Payers to provide trending performance data with targets and benchmarks to providers
  - Fix payer-provider split of shared savings
  - Incentivized care management



Moving to Value: Bundled-Episodic Payment Models

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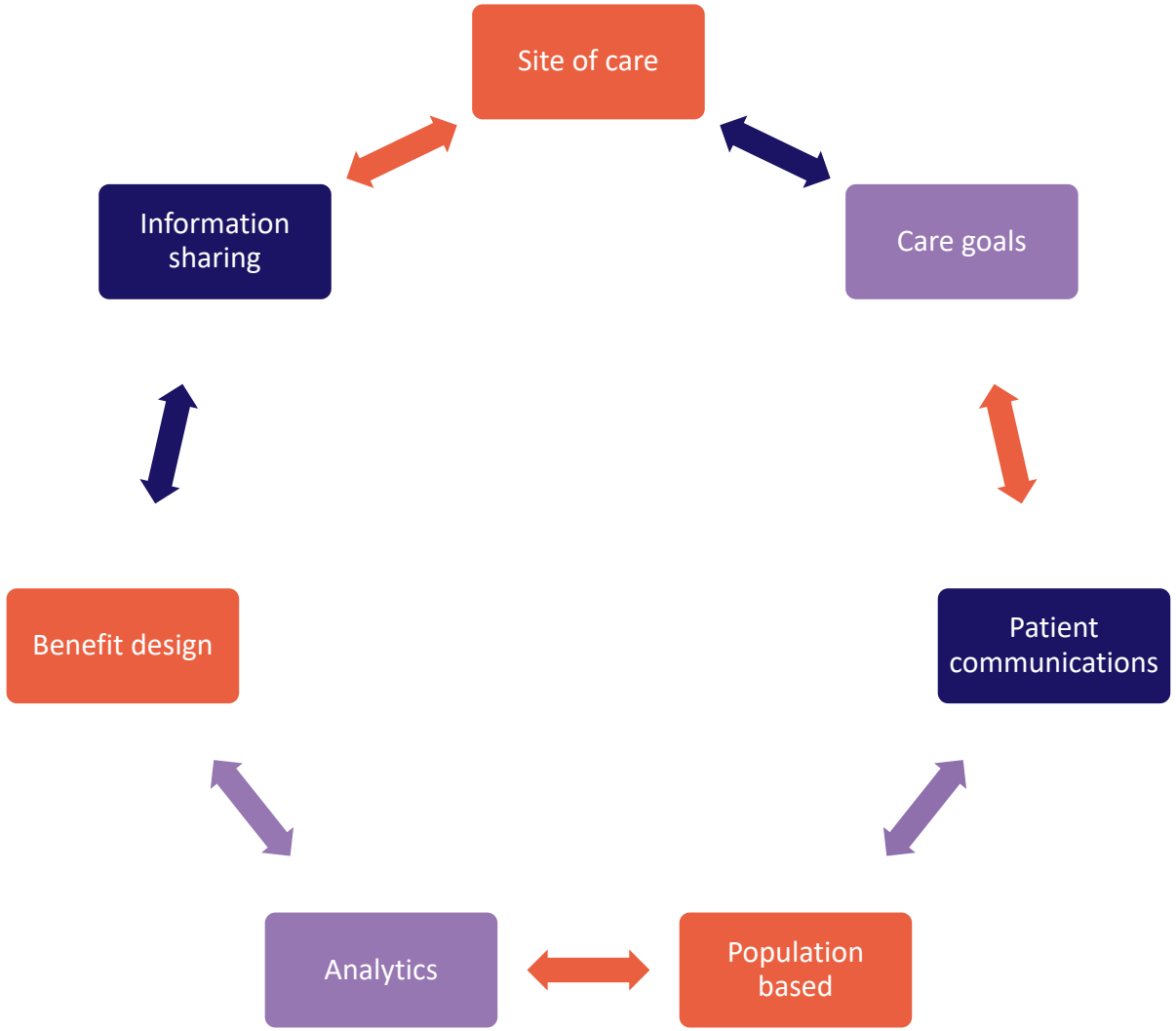
- In a bundled payment model, providers are paid a single payment for all services performed to treat a patient undergoing a specific episode of care, which are based on historical costs.
  - An “episode of care” is the care delivered within a defined period of time.
- Bundling can be done across all lines of services or a single line of service.
- **Methodology**:
  - Attribution methodology (e.g., by disease)
  - Benchmark on baseline years
  - Quality metrics required
  - Health equity plan
  - Risk tracks
- **Payments**:
  - FFS
  - A monthly or episodic payment for care management
  - Performance-based payment opportunities based on risk tracks

Collaboration Goals



Collaboration Goals: High vs. Low Value

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	Phasing out	Transition
Site-of-care alignment	Each site works on independent care goals	All sites work together with a pre-defined set of goals of care tailored to the patient
Referring relationship	Based on personal relationships	
Information sharing	All sites of care/providers maintain silos of data	Shared platform, allowing both retrospective analytics, prospective decision-making tools, aggregate claims data, and centralized patient communications
Population vs. individual approach	Each patient is managed independently	The population is managed and identified for opportunities to improve care upstream and downstream of the cancer diagnosis
Analytics	Each site of care/provider independently tracks quality and cost goals	Comprehensive analytics set across tracking the overall patient's quality metrics and cost
Care goals	Each site/provider independently develops quality goals	Shared goals across all sites of care/providers
Benefit design	All medical services (high value/low value) subject to coinsurance	Medical services structured to promote high value care (i.e., preventative services) at low/no deductible; low value care at high deductible
Navigation	Navigation services facilitated through phone and fax	Navigation services managed electronically with follow-up
Patient communications	Each site of care/provider independently communicates with the patient through various mediums	All sites of care/providers create communication mediums that synchronize pertinent aspects of patient communications

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