PAYER EXCHANGE SUMMIT
ONCOLOGY PAYMENT REFORM
OCTOBER 28-29, 2019 | TYSONS CORNER, VA

A VISION FOR THE FUTURE OF COMMUNITY ONCOLOGY: INTEGRATED NETWORKS

Ted Okon, Community Oncology Alliance

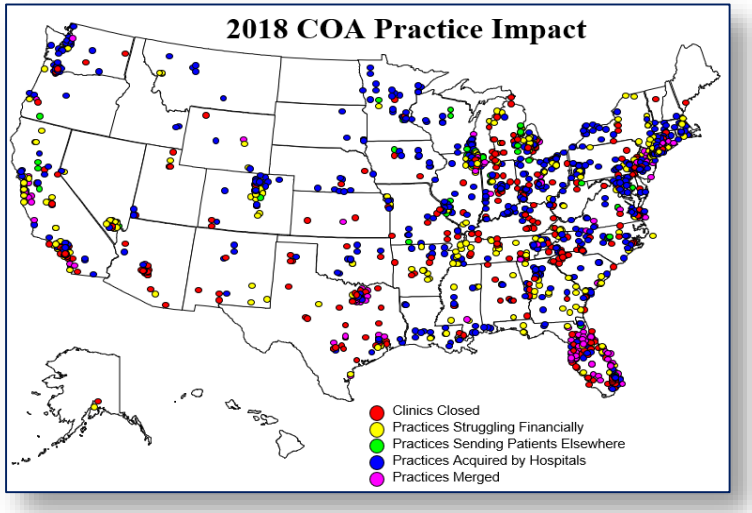
ISSUES FROM THE COA PERSPECTIVE

- Costs of treating cancer increasing
  - Drug costs are unsustainable but all the cost drivers of cancer care, especially hospital costs, are increasing
- Good news: Immunotherapies and gene therapies like CAR-T show so much promise and biosimilars promise to help bring down drug costs
  - Bad news: How do we pay for new therapies and create a healthy biosimilar market?
- "Old" solutions not working; in fact, driving up costs and harming patients
  - Prior Authorization
  - "Fail First" Step Therapy
- Guidelines/Pathways already are standard of care
- More oral cancer drugs, which increases issues of compliance and patient care
- PBMs are increasingly delaying and denying care as more oral drugs being used
- Magnitude and scope of 340B discounts increasing, fueling both consolidation and drug prices and enticing PBMs to become contract pharmacies

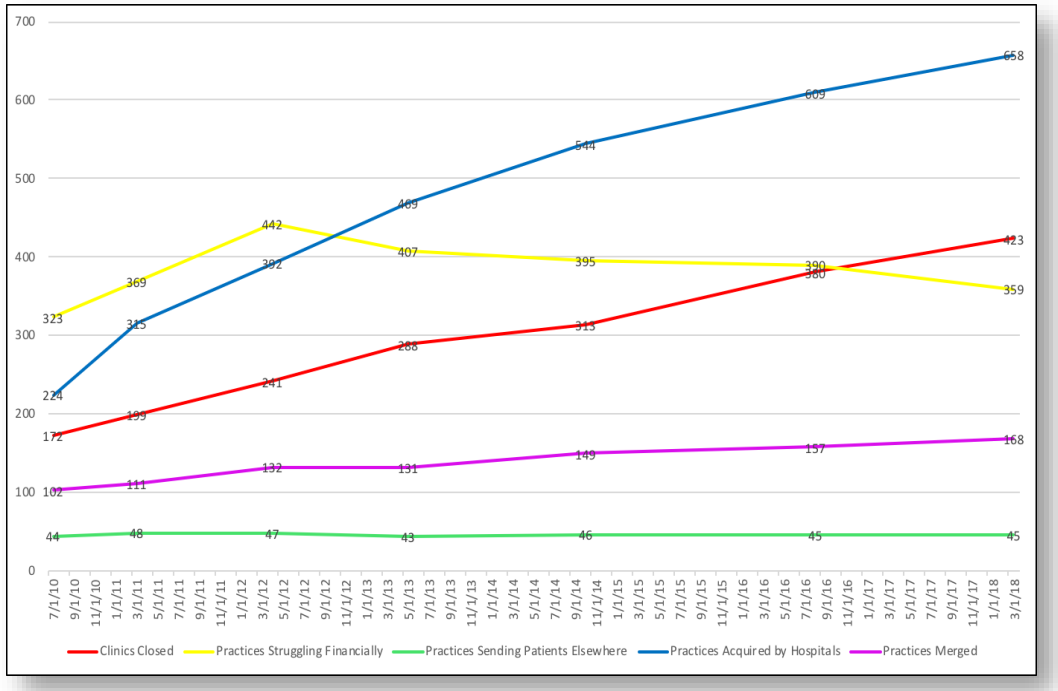
BOTTOM LINE…

- Cancer treatment costs continue to climb
- Quality of care is getting worse in certain situations due to PBM intrusion
- Physicians (oncologists) are increasingly being overruled or dictated to regarding patient treatment
- Cancer care has consolidated
  - *And not for the better!!!*
- Cancer care “landscape” more difficult to navigate and understand for employers and patients
  - Who is making decisions for patients (employees) that is in their best interest
  - How to understand new treatment options, both in terms of effectiveness and efficiency

CANCER CARE CONSOLIDATION



1,654 clinics and/or practices closed, acquired by hospitals, merged, report financial struggles from 2008-2018



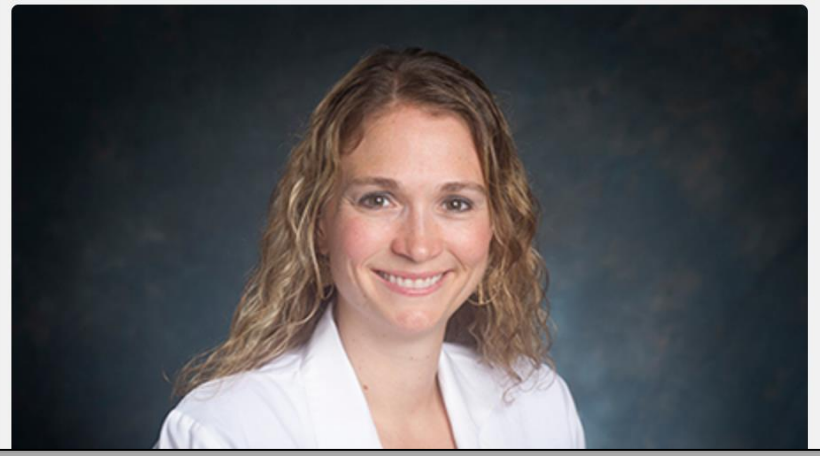
- 11.3% increase in closings, 8% increase in consolidations since 2016 report
- See full report at CommunityOncology.org

IMPACT OF CONSOLIDATION

Cancer clinic closures limit access to care, increase Medicare spending

"Longer travel time for cancer care is associated with greater Medicare spending and patient cost responsibility, adding to the evidence that decreasing local access to care may have consequences," Rocque explained. "Limited access to cancer care in rural communities could contribute to the substantial disparities in cancer outcomes."

From 2008 to 2016, 380 cancer treatment facilities closed nationally, and another 390 practices struggled to stay open due to financial stress. According to the Community Oncology Alliance, cancer clinic closures place an additional burden on the nearly 20 percent of Americans living in rural areas due to limited local access to oncology care, forcing patients to travel farther for treatment.



COST OF CONSOLIDATION

PROGNOSIS PROFITS

Prices soar as hospitals dominate ca

AMES ALEXANDER, KAREN GARLOCH & JOSEPH NEFF - AALEXANDER@CHARLOTTEOBSERVER.COM, KGARLOCH@CHARLOTTEOBSERVER.COM AND JNEFF@NEWSOBSERVER.COM
APRIL 22, 2015 12:14 AM, UPDATED APRIL 23, 2015 03:46 PM

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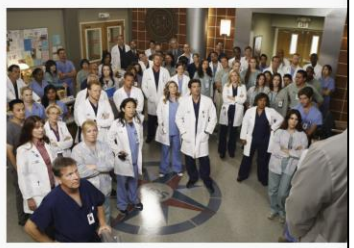
Hospital Mergers: The Forgotten Proble American Health Care

Posted on September 23, 2019 by Stefano Feltri

In the US, there are more than 100 hospital mergers every year. This increasing co the promised savings, nor to better services, but politicians are not interested in tac



The merger's announcement on Grey's Anatomy. Photo by Grey's Anatomy fandom CC BY 2.0

Springfield Hospital in Vermont filed for bankruptcy in June and is now trying to rest Michael Hasted, the interim CEO, said that the hospital's survival would be "virtually merger with other hospitals in the region. It is one of the many mergers that are ma increasingly concentrated. ***Grey's Anatomy,*** the popular medical TV show, even staged a merger between the Seattle Grace Hospital and the Mercy West Medical Center.

COSTS & SPENDING

By Zack Cooper, Stuart Craig, Martin Gaynor, Nir J. Harish, Harlan M. Krumholz, and John Van Reenen

Hospital Prices Grew Substant Faster Than Physician Prices Hospital-Based Care In 2007–

ABSTRACT Evide growth in healt existing work h rate of hospital in both types o services using a in the period 2 physician price while physician outpatient care grew 6 percent hospital-based not physician p spending shoul rather than phy of options to a enforcement, a incentivizing re

The New York T

THE NEW HEALTH CARE

Hospital Mergers Improve Health? Evidence Shows the Opposite

The claim was that larger organizations would be abl offer better care.

By Austin Frakt

Feb. 11, 2019

Many things affect your health. Genetics. Lifestyle. Modern medicine. The environment in wh you live and work.

But although we rarely consider it, the degree of competition among health care organizations does so as well.

Markets for both hospitals and physicians have become more concentrated in recent years. Although higher prices are the consequences most often discussed, such consolidation can als result in worse health care. Studies show that rates of mortality and of major health setbacks grow when competition falls.

Hospitals are some of America's toughest debt collectors

BY MEGAN CERULLO
SEPTEMBER 17, 2019 / 1:02 PM / MONI

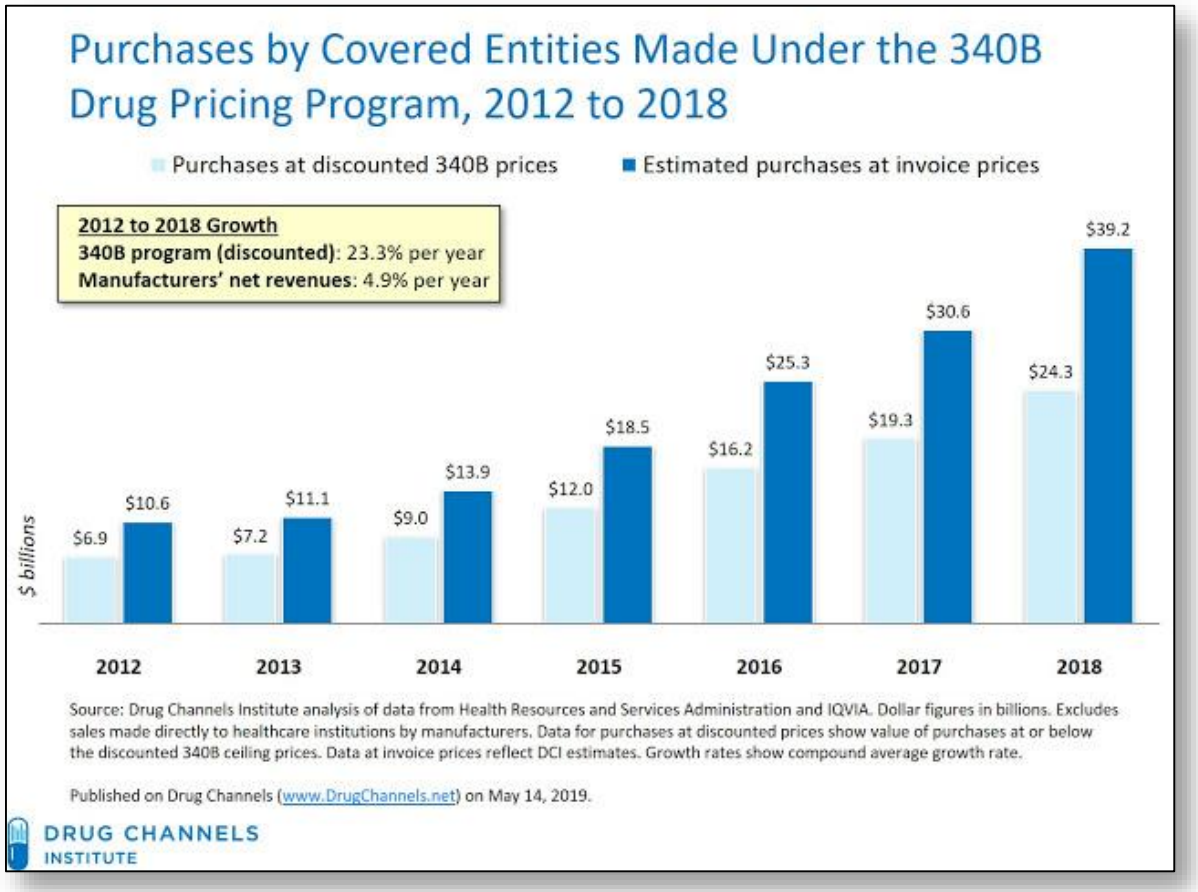
- Some hospitals are using including garnishing pati
- The University of Virginia over six years.
- Carlsbad Medical Center years.

Massive insurer UnitedHealth is forcing more patients to get care outside of hospitals

Caitlin Owens, Axios Oct 18, 2019, 9:49 AM

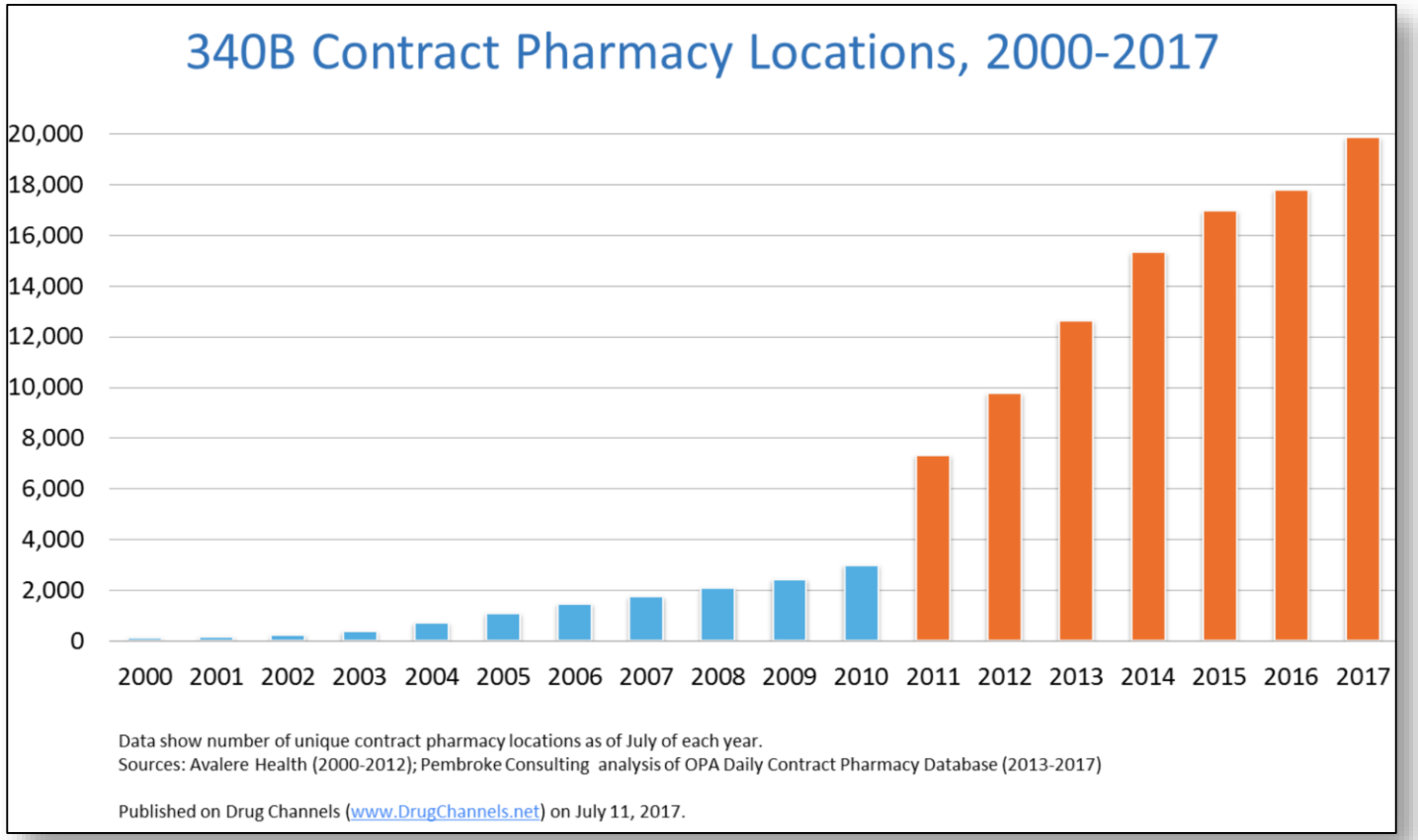
UnitedHealthcare is trying to direct patients towards cheaper facilities. Reuters

GROWTH OF 340B



Source: *340B Program Purchases Reach $24.3 Billion—7+% of the Pharma Market—As Hospitals' Charity Care Fluctuates,* Drug Channels, May 2019

CONTRACT PHARMACY EXPLOSION



Source: *The Booming 340B Contract Pharmacy Profits of Walgreens, CVS, Rite Aid, and Walmart,* Drug Channels, July 2017

340B VERY PROFITABLE TO HOSPITALS

FierceHealthcare

HOSPITALS & HEALTH SYSTEMS TECH PAYER FINANCE PRACTICES REGULATORY SPECIAL REPO

Hospitals & Health Systems

Moody's: Hospitals can gain profits from outpatient specialty drugs, but with major risks

by Robert King | Oct 23, 2019 1:06pm

Hospitals are likely to turn to outpatient specialty drugs as new sources of income, but ratings agency Moody's warns of downward pressure on drug prices and 340B. (Getty/ADragan)

"Income from purchasing outpatient specialty drugs will help ease these margin constraints," Moody's analysts said. "Hospitals can make a profit on outpatient specialty drugs, which they can bill separately. By contrast, hospitals need to absorb the cost of inpatient drugs because they are reimbursed a flat fee per admission."

Safety net hospitals participating in the 340B program are eligible to get even greater margins because they can get such outpatient specialty drugs at a discount.

Hospitals don't have many tools to negotiate for better prices on specialty drugs, but 340B-eligible hospitals "receive a much larger discount on the price of eligible outpatient drugs purchased for all patients, regardless of how they are insured," Moody's said.

340B PROFITS & CONSOLIDATION

Cancer provider merging into rural hospital

creenshot

Email | Share | Share | Tweet

By Tracey Drury
a day ago

COMPANIES IN THIS ARTICLE
Brought to you by
Deloitte Private

Jones Memorial Hospital
Wellsville, NY
Hospital & Health Care
$48.2M Revenue **440** Employees

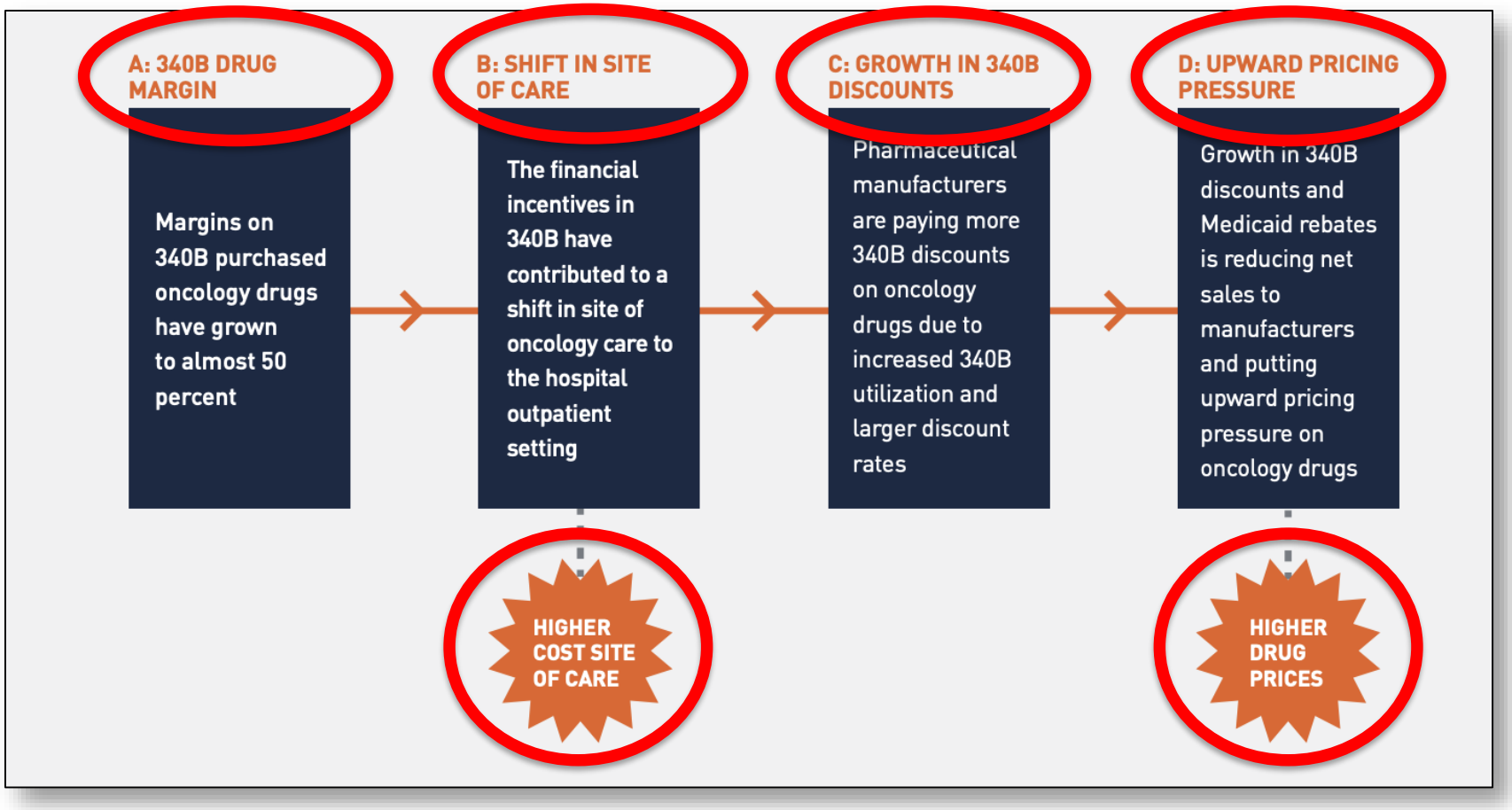
See full profile ›

A private oncology
Hospital to cut cost
patients.

Pending regulatory approvals, Southern Tier Cancer Center will convert to a hospital-based service, bringing $800,000 in new income to the Wellsville-based hospital, a **part of the UR Medicine** system.

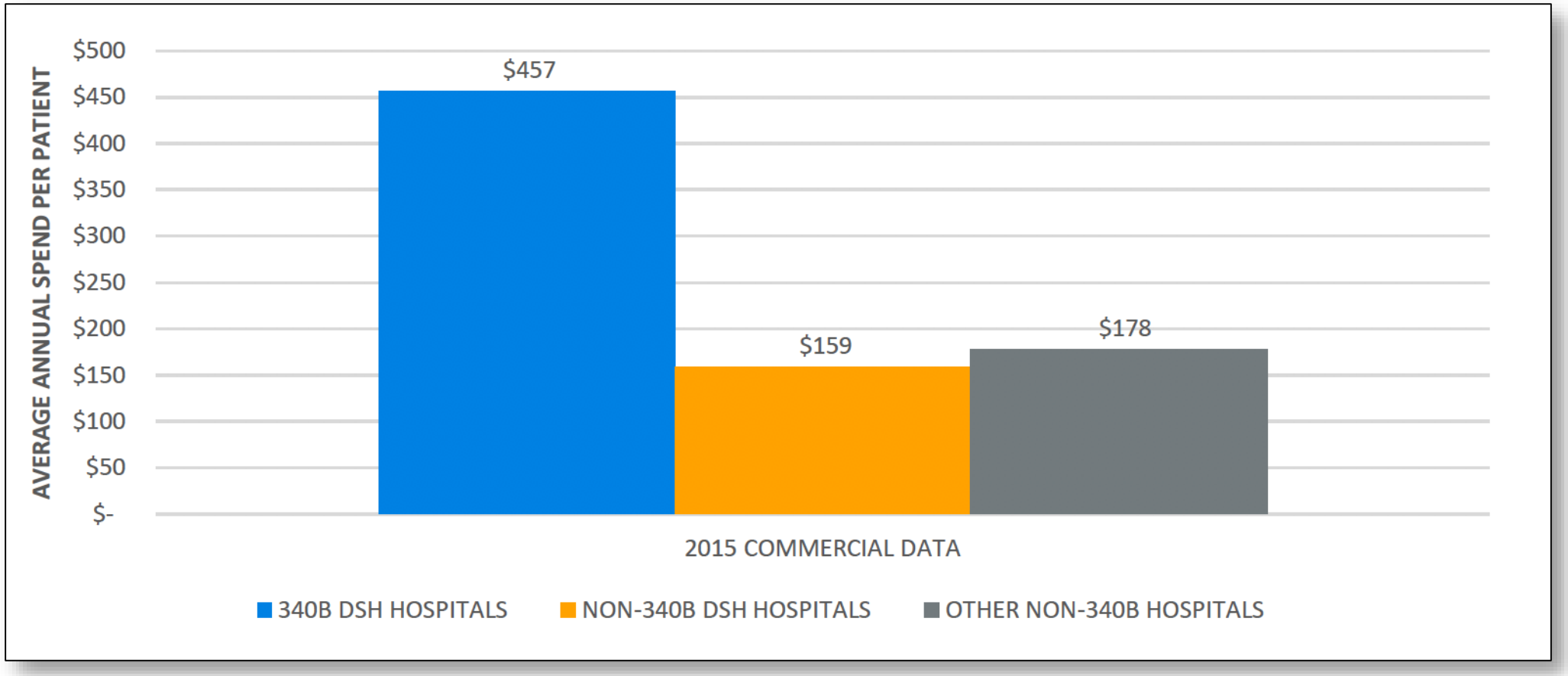
According to plans filed with the state Department of Health, the partnership is tied to changes in federal 340B pharmaceutical pricing rules. Without the partnership, hospital officials told the DOH the cost of acquiring specialty drugs will be out of reach for the private practice. At the same time, the move strengthens Jones Memorial's finances.

SITE OF CARE SHIFT & HIGHER PRICES



Source: *The Oncology Drug Marketplace: Trends in Discounting and Site of Care,* Berkeley Research Group, December 2017

HIGHER COSTS FOR EMPLOYERS



Source: *Commercial payers spend more on hospital outpatient drugs at 340B participating hospitals,* Milliman, March 2018

PBMS IMPACTING PATIENT CARE

April 2019

Dangerous Health Care Middlemen & Bureaucracies:

Pharmacy Benefit Manager Horror Stories — Part V

The Pharmacy Benefit Manager (PBM) industry lobby claims that it successfully achieves drastic price reductions on medications. They say this comes from PBMs negotiating with competing drug companies and by "encouraging consumers to use the most cost-effective drugs."

Setting aside clear evidence that secretive PBM rebates and fees are actually driving drug prices higher, the last claim should give all Americans pause. How exactly does a PBM "encourage" a treating physician to use cost-effective but life-saving drugs? How do they know what is right for each individual patient and disease? What tactics or methods do PBMs use to do this? And are the changes in the patients' best interests, or simply to save money for PBM profit margins?

Unfortunately, time after time, PBMs have been exposed for abusing their position to do this, getting between the patient with cancer and their physician to dictate care. All too often, the PBM bureaucracy does this by simply and heartlessly delaying or denying make patients' access to needed medications. Perhaps most egregiously for patients facing a ticking clock of cancer, PBMs deny prescribed treatments and demand that patients first fail on a list of 'approved' drugs before receiving the medication that their physician prescribed in the first place.

For patients with cancer, this intrusion into their care plans is painful, potentially life-threatening, and unnecessarily stressful. For oncologists it is yet another bureaucratic burden placed between them and caring for a patient, wasteful of scarce health care resources, and insulting to the doctors that went to medical school and prescribe treatment plans.

These and other monstrous by-products of the PBM system are further exposed here, as the Community Oncology Alliance (COA) presents the fifth in a series that focuses on the very real and negative impact PBMs continue to have on patients with cancer today. The infuriating stories presented here are real but made anonymous with personal details changed to protect the privacy of the patients.

A NARROW WINDOW FOR TREATMENT

Brian, a married social worker with two young children, was in his early 30s in February 2014, when he was diagnosed with a relatively rare form of cancer in his appendix. Brian underwent surgery and chemo at a large hospital system, and for the next few years, his life went back to normal.

In late 2017, however, Brian suffered a relapse. He underwent surgery to remove all traces of the cancer, and his oncologist followed up with a round of chemotherapy. Despite the metastasis, Brian's doctors thought he had a good chance at survival, and recommended that he immediately begin a six-month regimen of oral medication to help keep the cancer at bay. He was young, strong, and had everything to live for; they were optimistic the cancer might never return.

On February 8th, Brian's oncologist sent a prescription for the pills to the local pharmacy his clinic worked with. They informed him that while they had the medicine in stock, Brian's insurance and PBM prohibited them from filling the prescription. Instead, they forwarded the prescription to a PBM-mandated specialty pharmacy to receive prior authorization.

PBM Horror Stories Series | 1

August 2018

Danger, Delay, Denial:

Pharm… Horror…

September 2017

Bureaucracy, Deadly Delays, and Apathy:

Pharmacy Benefit Manager Horror…

May 2017

Unaccountable Benefit Managers:

Real H… How P…

April 2017

Delay, Waste, and Cancer Treatment Obstacles:

The Real-Life Patient Impact of Pharmacy Benefit Managers

Over 15 Years of Making a Difference in Cancer Care

There is growing awareness of the problems and pitfalls with Pharmacy Benefit Managers (PBMs) in the United States health care system. Contracted by insurance carriers to negotiate on their behalf with pharmaceutical companies, these 'middle men' corporations have quietly become an unavoidable part of our nation's health care system. Controlling at least 80 percent of drug benefits for over 260 million Americans, PBMs have the power to negotiate drug costs, what drugs will be included on plan formularies, and how those drugs are dispensed. Oftentimes, patients are required to receive drugs through PBM-owned specialty pharmacies.

However, while the role PBMs play in the U.S. health care system is complex and under scrutiny by policymakers and the public, with much of the debate focusing on economics, little discussion takes place of the impact PBMs have on patients.

This paper is the first in a series that will focus on the serious, sometimes dangerous, impact PBMs are having on cancer patients today. These are real patient stories but names have been changed to protect privacy.

AN AVOIDABLE DEATH?

Derek, a young husband, was diagnosed with advanced melanoma with brain metastases. Prognosis was grim, yet a ray of light appeared in the form of a new drug prescribed by his doctor. Proven to have the potential of significantly extending life, the drug offered Derek and his wife real hope. Located in his doctor's office was the clinic's pharmacy, where this potentially life-prolonging medication was simply waiting on the pharmacy shelf— but not for Derek. Derek's PBM mandated that Derek purchase his meds from one of their own mail-order specialty pharmacies. The clinic immediately faxed to the PBM all the necessary information for receiving prior authorization, and for the next ten days, Derek and his wife waited to hear that the prescription had been approved. Upon receiving the go-ahead, they then faxed the prescription to the PBM's specialty pharmacy, and sat back to wait again.

One week later, the drug still had not appeared; instead, the couple was notified that they first had to remit the drug's $1,000 co-pay, an amount they were unable to afford. Derek's wife now began arranging co-pay assistance, but she had to deal with the matter on her own at this point, because Derek had been admitted to the ICU. Several days later, she received approval for co-pay assistance, and forwarded the information to the PBM's pharmacy, which then FedExed the drug to Derek. The medication finally arrived— only there was no one to take them. By this time, Derek could no longer swallow pills, and sadly, shortly after, he died.

The most common and devastating issue that cancer patients face with PBMs is the fact that they must wait, for weeks or even months, to obtain medication that they could have received within 24 hours, had they been permitted to get it at the point of care from their oncologist. Beyond the stress and aggravation incurred, delays in receiving medication often translate into delayed treatment and worsening of the patient's condition, and in the most tragic of cases, possibly contributing to the patient's death.

PBM Horror Stories Series | 1

THE NORMA SMITH STORY

LOCAL

Cancer patients are being denied drugs, even with doctor prescriptions and good insurance

BY CARMEN GEORGE

AUGUST 02, 2019 06:40 AM, UPDATED AUGUST 02, 2019 04:50 PM

Cancer patient Norma Smith and husband Rod battle the disease as well as PBMs – pharma
Specialty Pharmacy in trying to secure proper treatment as prescribed by her oncologist D

Smith's story is "an example of how bad things can get" for cancer patients who require different medications than what pharmacy benefit managers consider standard protocol.

"My husband would call and be on the phone for five and six hours trying to advocate for me," Smith said, "trying to find out how he could work the system so he could get the needed drug for me so that I would live.

"I'm a human being. I'm not a used car. I have feelings. I'm a person. I want to live. I want to spend time with my grandchildren. I want to quilt. I want to do things. I want to live."

PREVIEW OF NEW INITIATIVES

- Work closer with employers, and groups representing them, to help cancer employers and patients navigate an increasingly costly and not-patient-friendly cancer care environment
  - Produce unbiased materials and information sources on a variety of important topics for employers and patients
    - Employer guide to enhancing cancer treatment outcomes and controlling costs
    - Navigation guide for the new cancer patient and caregivers
    - What's new in diagnostic testing that can improve cancer treatment?
    - What are biosimilars; are they safe and effective?
    - What's CAR-T and other gene therapies?
    - And much more…

PREVIEW OF NEW INITIATIVES *(CONTINUED)*

- Creating a National Cancer Treatment Alliance
  - Enhance COA advocacy and related issues with a vehicle for focused employer involvement by networking oncology providers
- Provide the Oncology Care Model version 2.0 (OCM 2.0) as an adaptable value-based model of cancer care
  - Includes both services and drugs based on value
- Offer a national Clinically Integrated Pharmacy Network to provide oral cancer drugs efficiently and effectively
  - Goal is to enhance patient care and reduce costs in part by minimizing/eliminating PBM middlemen that delay/deny treatment and increase costs
  - Explore innovative technologies, such as blockchain, to increase transparency and efficiencies

COA 2020

Community Oncology Conference

FOCUS ON THE FUTURE OF CANCER CARE

SAVE THE DATE

APRIL 23–24, 2020

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#COA2020

THANKS!

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