

Controlling Costs and Enhancing the Patient Journey in a Changing Pharmaceutical Landscape

ROSE MCNULTY

At a recent event of *The American Journal of Managed Care* Institute for Value-Based Medicine titled “The Intersection of Medicine and Pharmacy,” pharmacy stakeholders discussed timely topics in formulary management, the ever-evolving drug landscape, and value-based initiatives.

The event, held in partnership with Providence, was chaired by Elie M. Bahou, PharmD, MBA, chief pharmacy officer at Providence, and Sophia Humphreys, PharmD, MHA, BCBBS, director of system pharmacy formulary management and clinical programs at Sutter Health and clinical assistant professor at the University of Washington School of Pharmacy in Seattle.

A roster of experts in the field spoke on a range of topics, with Humphreys kicking off the evening with her talk “Formulary Management Is a Team Sport.” Humphreys began with an overview of current national health expenditure projections, noting that CMS estimates that nearly 20% of the United States’ gross domestic product will be spent on health care by 2031. Part of the problem is health care labor challenges, with many health care workers reporting signs and symptoms of burnout both during and after the COVID-19 pandemic. Meanwhile, the health care workforce is aging, which causes labor cost increases and high turnover and therefore raises the cost of care, Humphreys added. “When we think about our health care and when we study the health systems across the globe, from Europe to Asia to North America, our industry is quite fragmented compared with other systems—especially compared with the European Union and Canada,” Humphreys explained.

She noted that spending on medications in the United States in 2022 exceeded \$429 billion, and 51% of those medications were specialty drugs—a significant shift from 32% a

decade ago. Immunology, oncology, and diabetes drugs are large drivers of these costs.

Formulary management is one route to mitigating drug costs, Humphreys said, explaining that Providence, Sutter Health, and other integrated delivery networks (IDNs) they have collaborated with have aimed to standardize the formulary processes. This helps reduce duplicate work and designates system-preferred agents for specific therapeutic classes and subclasses.

Simplifying workflows for physicians is also key to optimizing management, she said. “When we design a formulary or when we design a direct therapeutic interchange, we try to collaborate with our [physicians], either do those rounding [or] do any CDTAs [collaborative drug therapy agreements] to have pharmacists take away the repetitive work and take away the regular routine monitoring,” Humphreys said. “Then we can leave our physicians to have [a simpler] workflow and to see more complicated cases.”

Of course, optimizing the purchase of medications is another measure to control costs. This can be addressed through price parity, a pipeline for generic and biosimilar monitoring, and enhancement of 340B programs. Additionally, maximizing rebates to support the contracting team can help reduce costs and simplify workflows, Humphreys said.

Promoting biosimilars to reduce spending on biologics, expediting the review process for high-impact utilization management initiatives in collaboration with physician specialty leaders, and leaning on electronic health records (EHRs) to guide physicians in prescribing can also streamline workflows. Leveraging internal multidisciplinary teams for feedback and external sources for drug procurement are additional strategies employed to rein in the costs of drugs.

Humphreys again stressed the importance of collaborating with frontline physicians to ensure that operational matters and the needs of patients will be met in light of formulary decisions—and soliciting input before decisions are finalized is key. Formularies must be flexible to meet the needs of physicians and patients, she explained.

Challenges and Strategies for Success in an Ambulatory Infusion Center

Jorge Garcia, PharmD, MS, MHA, MBA, FACHE, assistant vice president of system oncology, infusion, and investigational drug pharmacy services at Baptist Health South Florida, spoke about the potential benefits of creating or expanding an ambulatory infusion service line as well as keys to success in the implementation of ambulatory drug infusion. The nononcology infusion service line launched almost 3 years ago at Baptist Health, and the idea was born from a need to provide simple infusion services without sending patients to emergency departments or admitting them to the hospital when infusion chairs were unavailable. First, he turned to the oncology infusion line, only to find that patients with cancer already faced wait times and that providing chairs for nononcology infusion would not be possible without detrimental effects on wait times.

“I would hear these stories about patients traveling across county lines to get infusions, especially for high-cost products that other infusion centers were not comfortable providing,” Garcia said. “So with that background, we said, ‘Maybe we have an opportunity here to bring a new service to patients and possibly provide new value to our organization.’” He noted patients with Alzheimer disease as an example of a population who could benefit greatly from dedicated nononcology infusion centers once the right drugs hit the market. Garcia highlighted 2 keys to success: the structure of the center and the process considerations that have helped ensure things run smoothly.

First, the center was made open for referrals from both Baptist Health providers and providers in the community, which is especially useful for those without infusion capabilities. The center also has an open formulary, subject to payer approval.

“We didn’t have to make it open formulary, but if you think about how we operate specialty pharmacy—where we have open formulary so long as the payer provides an authorization—if the patient is indicated [for] the therapy and the payer is covering infusion, then we would be in an enabling role. So that was important as well,” Garcia said.

Drug protocols were also developed with medical director oversight to make sure that all infusions could be done

properly. Garcia cited this as a critical partnership because every treatment is different and may entail varied laboratory capabilities, monitoring processes, and other considerations.

The infusion center was also designed as an outpatient department of the hospital, allowing for 340B discount access and the payer contracts associated with the hospital. The contracting process can take a lot of time and payment rates would be different under new agreements, making the design as an outpatient center important to the success of the center. Pricing strategy is also important, and it must account for the time and work that goes into successfully testing and caring for patients receiving a treatment, even when the drugs themselves are inexpensive.

From a process perspective, Garcia emphasized the importance of a pharmacy-driven payer authorization team to call payers and obtain authorizations for everything from imaging to drugs. “We felt strongly that to get authorizations for drugs, we needed to understand the pharmacy lingo. We needed to understand what the payers were looking for. There is some sort of clinical input that comes in if the payers claim that medical necessity is not met, if we need to appeal, if we need to have a peer-to-peer [discussion],” Garcia said. “We were able to convince our [patient] access team that we needed to drive that authorization process that has been key to success.”

Once these resources are exhausted, an escalation process, which entails enlisting top executives in managed care to communicate directly with health plans in Garcia’s case, is also important, he said. The center also aims to ensure patients are getting as much financial assistance as possible, including from industry partner programs.

Navigating site of care from the provider side, not just on payer terms, is also crucial, Garcia explained. If a payer will not authorize treatment outside of the hospital, there are other options to ask about: pharmacy benefit, clear bagging, white bagging, or home infusions. To try to retain treatment in the outpatient setting, a tiered system of potential strategies to try before returning to the prescriber and creating a new plan of care has been another key to success.

Claims tracking and denial prevention are the final process aspects that Garcia highlighted, noting that some drugs, such as cell and gene therapies, could cost approximately half a million dollars per dose. Therefore, ensuring payment for these agents is crucial and requires consistent quality improvement. Because some health plans will deny claims for authorization not obtained, it is key to keep proof of authorizations and show them when needed to avoid lost payments. Main challenges to the center have included indigent care economics, decentralized teams, and payer white bagging and site-of-care mandates.

Continued on page 76

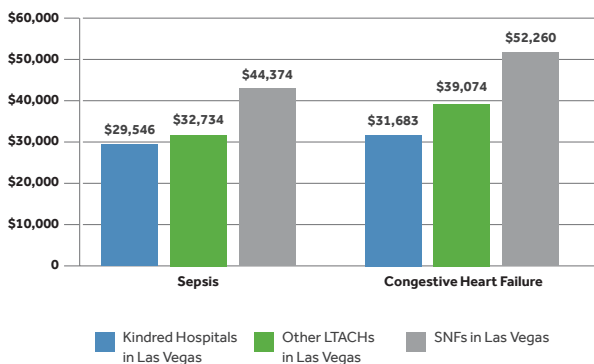


Achieve *High-Quality Care* through Collaboration with Kindred Hospitals

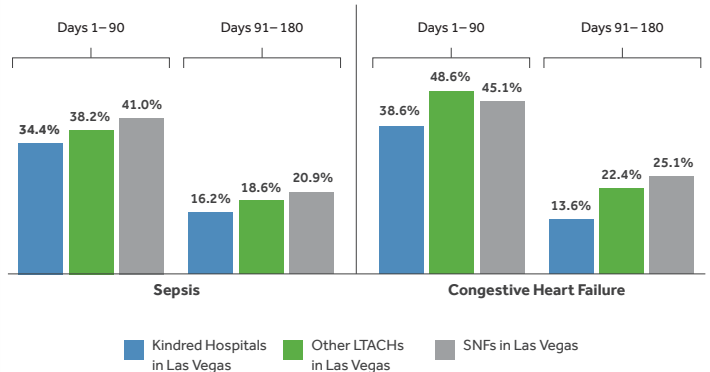
Reducing Readmissions and Spending for Medically Complex Patients

Accountable Care Organizations (ACOs) have been able to reduce readmissions and spending by collaborating with hospitals that specialize in treating medically complex patients. A recent case study of ACO members in Las Vegas revealed that when critically ill patients with sepsis and congestive heart failure were discharged to Kindred Hospitals in the area, both spending and readmission rates were lower than when they were transferred to skilled nursing facilities or other long-term acute care hospitals.

Risk-Adjusted Spending for Episodes Following Discharge from Initial Post-Acute Care Setting



Readmission Rate after Discharge (by Chronic Condition and Comparison Group)



Elevating the Care at Kindred through a National Quality Program

Kindred Hospitals, part of ScionHealth, is committed to being a high-reliability provider of long-term acute care.

With the establishment of its National Quality Program, both the community and long-term acute care hospitals operated by ScionHealth are held to the same standard of becoming high-reliability providers. This program provides a structured approach to enable and empower hospitals to continuously improve patient care, safety, and satisfaction. The initiative promotes process improvements, the cultivation of speak-up culture, and a relentless focus on safety. The National Quality Program is structured around the ScionHealthSix, derived from the six domains of healthcare quality established by the Institute of Medicine.

With a shared goal of zero patient harm, Kindred Hospitals is committed to improving outcomes and reducing unnecessary spending.



SAFE

By approaching patient safety initiatives in a wholistic and systematic way, we strive to make safe care ordinary and routine.



TIMELY

Timeliness of care is a crucial aspect of improving outcomes. By accurately assessing and appropriately addressing urgency of care, we strive to reduce harmful delays and minimize waste.



EFFICIENT

Through strong teamwork and open communication, our hospitals are reducing waste, allowing time and resources to be optimized toward effective patient care.



EFFECTIVE

We provide evidence-based care to all who could benefit and refrain from providing services to those not likely to benefit, avoiding both underuse and misuse.



PATIENT-CENTERED

Our patients are our priority. We are concerned with each patient's physical comfort and emotional well-being and respect patient and family preferences and values.



EQUITABLE

All of our patients have the opportunity to achieve their highest health potential, regardless of socially determined circumstances.

Promoting Excellence in Care with Proven Results

The National Quality Program is just one of many innovations that improve quality outcomes.

Others include:

- **Joint Commission Certification:** All Kindred Hospital locations have now received at least one Disease-Specific Care Certification from The Joint Commission in respiratory failure, sepsis, pulmonary rehabilitation, or wound care. Certification by The Joint Commission ensures a standardized, evidence-based approach to care and to performance measurement and improvement.
- **Move Early Program:** Kindred Hospitals' Move Early program incorporates movement into our patients' care plans as soon as is safe, even for those on mechanical ventilation. As a result of this program, 89% of patients at Kindred are able to reach a high level of mobility, based on the Johns Hopkins Highest Level of Mobility Scale.
- **AfterCare Program:** Kindred Hospitals' AfterCare program is designed to support patients even after they have been discharged from a Kindred Hospital through a series of follow-up communications. Patient needs are identified and addressed in 70% of post-discharge engagements, potentially preventing a significant number of readmissions.

To learn more about collaborating with Kindred Hospital, visit [kindredmanagedcare.com](https://www.kindredmanagedcare.com).



¹ Kindred Internal Data, 2022 Average; https://www.hopkinsmedicine.org/physical_medicine_rehabilitation/education_training/amp/toolkit.html; "high level of mobility" defined as a score of 4 or better.

² Kindred Internal Data, November 2022-October 2023.

The term "ScionHealth" refers to Knight Health Holdings LLC and its subsidiaries. Knight Health Holdings LLC is a holding company whose subsidiaries own and operate hospitals and facilities. The terms "hospitals" and "facilities" refer to entities owned or operated by subsidiaries of Knight Health Holdings LLC. References herein to "our," "we" or "us" refer to subsidiaries and employees of subsidiaries of Knight Health Holdings LLC.

Continued from page 73

Garcia explained that mitigating losses due to making therapies available that Medicaid will not cover, for example, must be part of the strategy. But in return for serving such populations, hospitals are provided 340B benefits, which can help maintain balance. Another challenge can be decentralized teams. Garcia noted that although he goes to hospitals and guides teams on providing services, they do not report to him, which can make the process more challenging in terms of prioritization.

The highest barrier to entry from Garcia's standpoint, however, is dealing with payer white bagging or site-of-care mandates. Making sure that contracts do not allow for gray areas in this regard is key, but Garcia noted that it has taken resilience to ensure authorizations, which the model would fail without.

Overall, the center has been successful and has helped meet increasing patient needs, reduce use of acute care services, and facilitate a new revenue stream for the hospital. But diligence and navigation of the pharmacy landscape have been key to the center's success.

Approaching With Caution: Industry Partnerships and Value in Health Care

Value-based care initiatives have been increasingly common, with an overall goal of improving care for patients in a cost-minded way. In another presentation, Harry Peled, MD, FACC, medical director of cardiology and critical care at St Jude Medical Center and cochair of the Providence System Pharmacy and Therapeutics Committee, discussed strategies to innovate and collaborate with industry partners.

Partnerships with industry stakeholders can benefit quality initiatives, although Peled noted that approaching with caution and due diligence is important to try and avoid misalignment between pharmaceutical industry partners and health systems. "Industry has a lot of valuable stuff that's out there," Peled said. "They have high-quality presentations, they have speakers, they're gathering the data for us. At the same time, when we're doing initiatives, we have to have some questions, because you have to realize that there are times when our interests may be misaligned.... I think where that misalignment may occur is when, in good faith, there is more than one legitimate way to [manage] something or the evidence base is not as strong as we would like."

Still, agreeing to disagree on some topics is part of forging relationships, Peled explained. He cited examples such as the antipain campaign encouraging the use of high-risk opioid medication, the Enhanced Recovery After Surgery program recommending alvimopan use, and the recommendation of specific and expensive drugs to address problems that may be exaggerated.

In value-based initiatives, Peled explained, when industry is involved, there may be emphasis on using certain drugs over others—and if an initiative suggests a more expensive drug for a total cost decrease, it warrants a critical look. He noted the importance of looking out for spin, which entails only presenting the positive study results or data and causes negative outcomes to fall out of view.

Key considerations for clinicians, he said, are factors that may contribute to study bias. These include whether studies are observational or randomized, whether they are placebo controlled, and whether the intervention group received other care that was better than placebo or the placebo group received lesser care in any way. Blinding of participants and evaluators, the clinical importance of outcomes, follow-up duration, funding, and additional factors are key to consider when interpreting study results, according to Peled.

"The important take-home [message] is that when you're using a drug—and this is what academic detailing is about—is it a clinical end point or is it a surrogate end point?" Peled noted. When studies report on positive surrogate end points, he said, it can be easy to miss that clinical end points were relatively unchanged.

Overall, to benefit from industry partnerships, Peled said, a main area of importance is performing due diligence to ensure a drug carries the benefits claimed by main end points in industry-backed studies. Asking about the clear-cut benefits of drugs is something clinicians should aim to do when things are not clear. If high-quality evidence is lacking, he encourages acknowledging this fact and taking it into account in decision-making.

IDN Financial Sustainability and Biologic Medication Use Management

Humphreys presented a second talk with Bahou with a focus on IDN financial sustainability and managing biologic medication use. Biologics and medication spending has only increased in recent years, and Humphreys noted that despite accounting for 51% of total spending, specialty medications only account for 3% of prescriptions. "More and more biologics are coming, and they're more expensive," Humphreys said.

Biosimilars represent a potential solution to the astronomical costs of medications, Humphreys explained. These costs can mostly be attributed to immunology, oncology, HIV, and anti-diabetic drugs, she added.

"With large-molecule medications, you cannot have a generic because the structure is so complicated and the molecule is so large, there's no way to make an identical copy," Humphreys said. "Then there [are] biosimilars. They're highly similar to the reference product, and when they're marketed, on average,

they're about 30% to 50% of the cost of the reference product." And when multiple biosimilars hit the US market, reference drug prices also tend to decrease, she said.

In hospitals falling under 340B programs, new biosimilars are also paid the average sales price (ASP) of the biosimilar plus 8% of the ASP of the reference product compared with typical 340B medications, which are paid ASP plus 6%. In many cases, companies manufacturing biosimilars also have similar patient assistance programs and prior authorization assistance, Humphreys noted. These and other factors make biosimilars an attractive option wherever possible to reduce overall costs and expand access to care for patients.

Bahou noted the difficulties of knowing all available drugs, which makes it important to use the EHR to make biosimilar adoption simpler for physicians. At Providence, the EHR is hard coded and has a function for automatic substitution with a drug that delivers the same outcomes or better with a better cost. It then follows up to let physicians know what the pharmacy did for that patient.

It comes down to controlling costs and making sure patients get the best possible outcomes, Bahou explained. The focus is on top-spend large-molecule drugs, which present the biggest opportunity to mitigate cost. Optimizing the purchase of drugs through wholesale contracts is also crucial.

Additionally, aside from simply promoting biosimilars, the clinical review of biosimilars was expedited, Bahou said. "Why did we do that? Because it was costing us 20 to 30 cents on the dollar for the same drug. Think of a biosimilar as a generic. But it's not a generic; it's very similar," Bahou said. "But you're getting the same outcomes at a fraction of the cost. Why would I not want to use it?"

Overall, Bahou noted 4 key takeaways, first emphasizing the importance of increasing efficiency to ensure as smooth a workflow as possible and encourage biosimilar use. Doing the research before trying to push for implementation is also key, he said. Another crucial measure is ensuring buy-in from key stakeholders, including the physicians who will be electronically prescribing these drugs through the EHR. Finally, Bahou stressed the importance of communication with all stakeholders to successfully implement the adoption of biosimilars.

The Complicated Landscape of Pharmacy Coverage Policy and Benefits

In a final panel discussion, moderator Robert Gluckman, MD, MACP, chief medical officer at Providence Health Plan, facilitated discussion of common themes throughout the evening. "We don't know all the answers, but we are going to have to figure it out because health care is too complicated. We're not serving the patient as well as we need to. We've got terrible issues about provider burnout

and workforce challenges, and there's not enough money to do everything that we want," Gluckman said.

He started with guideline and policy development, noting that we cannot ignore there are conflicts of interest in health care from a financial perspective and that transparency is needed to mitigate this issue. Guidelines can be informed by individuals with conflicts of interest, but they must be created by individuals with none, he said.

Peled noted that price should ideally be tied to evidence from a societal point of view and linked to the amount of benefit. "What I want to see happen as a payer is that we get on the same page and then we're honest about where there isn't...sufficient evidence to make a widespread practice," Gluckman said. "That's the construct or the belief system that we [need] to have with academic detailing. And when the payers are telling providers what to do, it's never going to work. That's the idea about having value-based payment models that get people more on the same page."

Prior authorization, Gluckman noted, is a process not well liked by any stakeholders in care. However, it is a process that helps ensure standardized care.

"I think balance is good. The health plan spent a lot of resources trying to vet this process. We outgrew our cancer center because of all the people who needed to be seeking these authorizations," Garcia said. "We have armies of people doing this work. It's a major effort."

Garcia sees opportunity to save time if clinicians are following guideline-approved therapies and reserving the authorization dialogue for particularly challenging cases that do not fit the norm. This would also improve the patient journey, Garcia noted, because delays in treatment can directly affect those receiving these treatments. Peled agreed, adding that a process such as the one outlined by Garcia would also encourage physicians to stay on the designated path.

Gluckman also highlighted the consideration of cost-effectiveness—namely, what level of cost-effectiveness should be the standard. In this regard, he noted the importance of stakeholders coming together rather than pursuing siloed goals.

"My hope is that if all the stakeholders can recognize the need, we can get to a better place. As long as each individual stakeholder is only thinking about their own stake, we're going to have a lot of problems in this country," Gluckman said. "And my dream is that we're going to be honest with one another about what we need."

Author Information: Ms McNulty is an employee of MJH Life Sciences, parent company of the publisher of *The American Journal of Accountable Care*.