Comprehensive Care Sustainability Collaborative

National **Bleeding Disorders** Foundation

NEWS

Collaborating for Patient Access and Optimal Outcomes:

Key Takeaways from the CCSC Symposium at the 75th Annual Bleeding Disorders Conference

RECOMMENDED RESOURCES

Drive greater value and better outcomes through integrated pharmacy and medical benefits
- *Blue Cross Blue Shield Association*

Managing chronic conditions through medical and specialty benefits integration
- *United HealthCare Services, Inc*

Effect of clinical pharmacist interventions on cost in an integrated health system specialty pharmacy
- *Journal of Managed Care & Specialty Pharmacy*

Key metrics that support the integrated specialty pharmacy model
- *Pharmacy Times*

How medical and pharmacy benefit integration drives savings
- *CarelonRx, Inc*

Best Practices — The health system specialty pharmacy integrated care model: Delivering patient-centric care
- *Health System Owned Specialty Pharmacy Alliance*

Now in its tenth year, the Comprehensive Care Sustainability Collaborative (CCSC) initiative was founded to support the sustainability of the integrated comprehensive model of care and improve patient access to care. CCSC has sought to achieve this aim by facilitating value-based dialogue and payer/provider collaboration. A cooperative working relationship and mutual understanding among all stakeholders are needed now more than ever, considering a rapidly changing therapeutic landscape.

At the National Bleeding Disorders Foundation's (NBDF) 75th Annual Bleeding Disorders Conference (BDC), leading hemophilia treatment center (HTC) and payer/employer stakeholders offered key insights on behalf of CCSC. The session began with an overview of CCSC, the related Value-Based Chronic Disease Collaborative (VBCDC) initiative, and current threats to patient care access and optimal care. HTC leadership presented on selling the value proposition of the integrated comprehensive care model, including an overview of key messaging and resources available from CCSC. Case studies were also presented with the format centered on a faculty panel offering diverse perspectives and engaging in robust dialogue to highlight CCSC's successes and lessons learned to improve patient access **(Figure 1)**. In closing the session with a networking lunch, attendees were offered the opportunity to engage in Q&A with the panelists in an informal setting.

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>
> **Jeff Blake, MBA,**
> Senior Vice President,
> Member & Community Relations
> for the Hemophilia Alliance

Considering the threats currently facing the integrated comprehensive care model and patient access among people with bleeding disorders (PWBD), Kollet Koulianos, MBA, Senior Payer/Provider Consultant for NBDF, presented current barriers associated with specialty drug utilization management (UM). These payer-aimed initiatives include prior authorization (PA), prescription drug lists (PDLs), quantity limits, copay accumulator adjustment programs (CAAPs), copay maximizer programs, specialty drug exclusion programs (i.e., alternate funding schemes), step therapy/fail first policies, and ceiling limits on spend for rare diseases (Figure 2). Noting that PWBD are among the highest cost claimants and often a target for cost management programs, Ms. Koulianos also outlined orphan drug exclusions, rare disease policy management, and challenges to current 340B funding arrangements as current threats to access. Compounding these issues, current minimum coverage requirements under the Affordable Care Act (ACA) are inadequate for PWBD, sparking action on the part of NBDF and other organizations, according to Jeff Blake, MBA, Senior Vice President, Member & Community Relations for the Hemophilia Alliance. Collectively, these threats to care access for PWBD were noted as an impetus for HTC stakeholders to consider the value proposition for the integrated comprehensive care model delivered by their centers. CCSC leadership encouraged attendees to pull from the collection of resources developed by the initiative, outlining what makes medical and specialty pharmacy integration critical for persons with chronic and complex health conditions. The panelists contributed guidance on which stakeholders should be engaged according to line of business and plan type, including insights from Sheri Dolan, BSPharm, Clinical Pharmacist at the University of Illinois at Chicago and Illinois Medicaid, and Sal Morana, RPh, PhD, Senior Vice President and Pharmacy Practice Lead for Hospitals & Health Systems at Alliant Employee Benefits.

Offering practical examples of how HTC leadership can engage payer and employer stakeholders via CCSC and share their value proposition, three case studies were presented documenting current threats and resulting successes in garnering improved patient access to care. These case studies highlighted the challenges associated with the rise of alternate funding schemes, the clinical and economic benefits of the HTC integrated comprehensive care model, and the adverse consequences of CAAPs, respectively. Alternative funding models arose in 2020 and are impeding patient access of previously covered treatments, with 10% of Employee Retirement Income Security Act (ERISA) plans implementing such arrangements and an even greater share considering future use. These models, being marketed through several third-party companies, encourage employers to revise their benefit design for high-cost therapies by excluding coverage and forcing employees to apply directly to drug manufacturers for patient assistance programs. While alternative funding models may appear to provide early savings for health care purchasers, such programs ultimately increase the total cost of care. As such, these models are unsustainable and have many unintended consequences, including delays in treatment. These delays can cause increased utilization of emergency and hospital-based services, with accompanying worsening patient outcomes and increased costs, as demonstrated in the case study.

> “In addition to the lower price per unit, HTC dispensation was able to save the plan an excess of $320,000 annually in specialty drug costs for just one patient.”

The second case study—presented by Dr. Morana through his experiences at Alliant Employee Benefits—demonstrated the benefits of effective collaboration between a self-funded employer and an HTC for dispensation of factor in a patient with severe hemophilia A. Compared with the specialty pharmacy provider previously used by the employer for factor dispensation, the HTC was able to accrue substantial cost savings via lower per-unit factor pricing and tighter assay management. Specifically, the HTC vial availability report was able to identify opportunity to reduce the dispensed amount and maintain the dose within the prescribed ±10%; in addition to the lower price per unit, HTC

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dispensation was able to save the plan an excess of $320,000 annually in specialty drug costs for just one patient.

Similar to the first case study, the final case study highlighted the adverse impact of CAAPs on clinical and economic outcomes in PWBD. CAAPs prevent patient copay assistance dollars from counting towards a member’s deductible/out-of-pocket cost, which actually contradicts the ACA definition of cost sharing, resulting in current legal challenges. The result is sizeable unintended cost toxicity among PWBD and other chronic/rare diseases, where no generic alternatives to available therapies exist. As demonstrated in the presented case study, CAAPs make PWBD vulnerable to significant up-front costs early in their coverage year, often resulting in deferral of necessary services. As outcomes worsen because of this deferred care, costs invariably increase. As was seen in this case, deferred care resulting from CAAPs even has the potential to result in disability. After each of these case studies were presented, the panelists were engaged to share their own perspectives on how current trends threaten care access and affordability for PWBD and how these challenges can be met with a carefully crafted HTC value proposition and assistance via the CCSC initiative. Furthermore, the attendees were encouraged to adapt cases from their own HTC as part of their value proposition to facilitate improved access to care for PWBD.

Throughout the program, the panelists remained vocal about the fact that HTC leadership should remain cognizant of the current threats to care access and affordability for PWBD. To facilitate sustainability among centers, the attendees were encouraged to proactively address these threats by formulating their own value proposition, using the guidance and case studies presented as a template. By sharing these insights from both payer/employer and HTC decision makers at BDC, CCSC remains aligned with its original mission to facilitate access, affordability, and the sustainability of the HTC integrated comprehensive care model.

Call to Action: *Start the Conversation at your HTC*

What are the most prominent opportunities to improve patient access at *your* HTC?

What is the best way for *your* HTC to get more involved in enhanced patient access?

How have you already acted, or what action is planned for the near future?

Figure 1. Faculty panel at CCSC's BDC symposium.

James Kenney, RPh, MBA
Moderator
Founder and President
JTKenney, LLC

Jeff Blake, MBA
Senior Vice President,
Member & Community Relations
Hemophilia Alliance

Jennifer Borrillo, MSW, LCSW, MBA
Executive Director
Louisiana Center for Bleeding &
Clotting Disorders at Tulane University

Sheri Dolan, BSPharm
Clinical Pharmacist
University of Illinois at Chicago/
Illinois Medicaid

Kollet Koulianos, MBA
Senior Payer/Provider Consultant
National Hemophilia Foundation

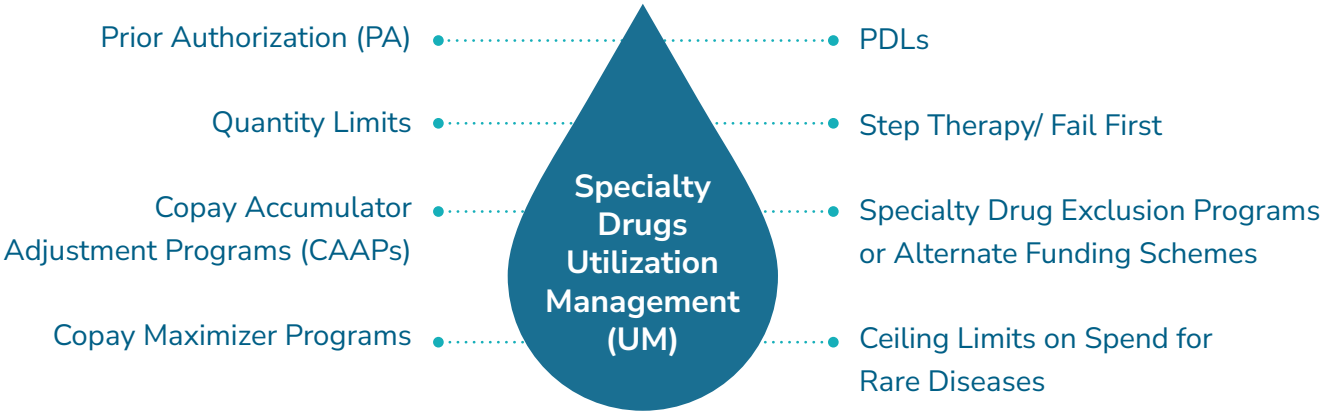
Sal Morana, RPh, PhD
Senior Vice President,
Pharmacy Practice Lead –
Hospitals & Health Systems
Alliant Employee Benefits

Mark T. Reding, MD
Professor of Medicine
Director, Center for Bleeding and
Clotting Disorders
University of Minnesota Medical Center

Len Valentino, MD
President and CEO
National Hemophilia Foundation

Michael Wang, MD
Director
Hemophilia & Thrombosis Center
Children's Hospital Colorado
Anschutz Medical Campus

Figure 2. Current threats to care access associated with specialty drug UM among PWBD.



To access available resources developed by CCSC or find out how you can get involved, please visit CCSChemo.com.

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