PRE-CONFERENCE TRACK
MEDICALLY INTEGRATED DISPENSING 101: UNDERSTANDING PBMS, GPOS, AND MORE

Moderator:

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Panelists:

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LEARNING OBJECTIVES

- Identify the key points of comparison and differentiation between medically integrated dispensaries of varying sizes and scope and how their workflows differ
- Identify key roles of physician, pharmacist Tech, RN, financial counselor, prior auth, Management, etc. to ensure accountability, compliance and an efficient, productive workflow
- Identify the external entities impacting the MID; payers, PBM-SP entities, distributors, GPOs and manufacturers
- Identify key success factors of the MID
- Respond to audience questions.

MEDICALLY INTEGRATED DISPENSING - EVOLUTION

~2000-2005 - MIDS begin to pop up in private oncology practices

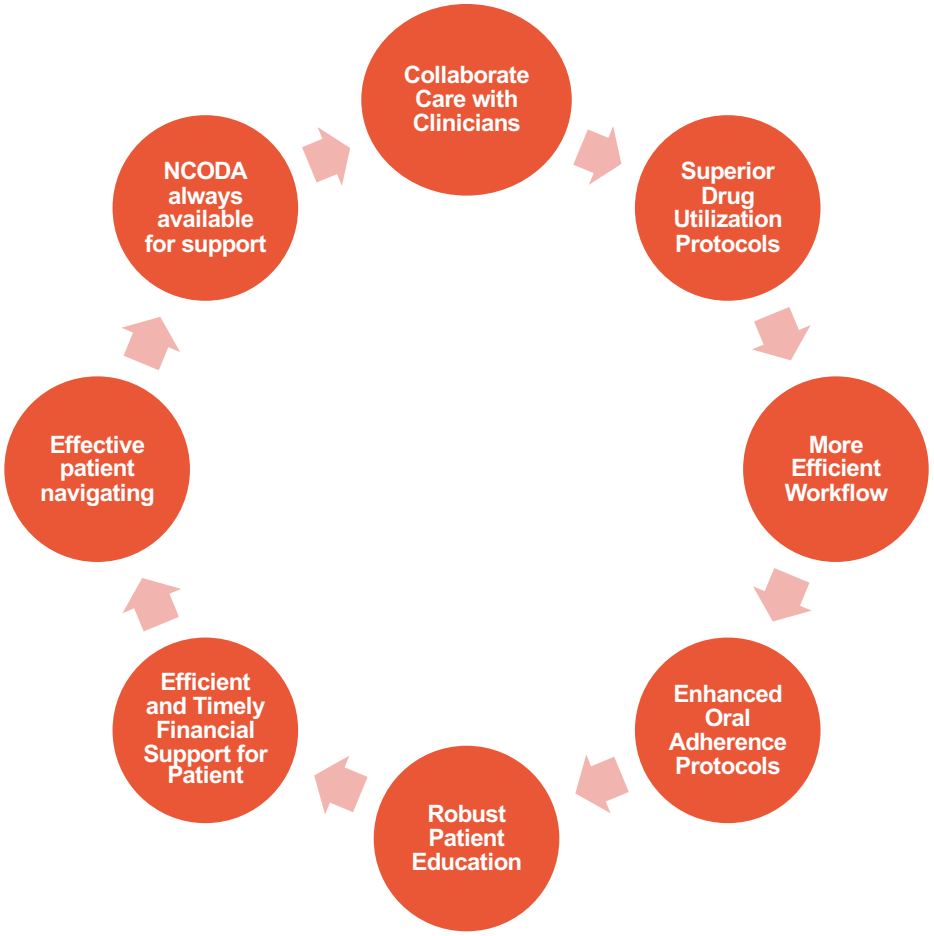
2006 - Introduction of ASP impacts drug pricing

Growth – Number of MIDS increase

Mail-Order Pharmacy Networks Develop

THE MID VALUE PROPOSITION:

RIGHT DRUG, RIGHT PLACE, RIGHT TIME



HOW DO YOU DEFINE YOUR MID'S SUCCESS?

QUALITY PATIENT-FOCUSED CARE

ENGAGED PRESCRIBERS AND STAFF

EFFICIENT; REMOVE BOTTLENECKS & DELAYS

ACCURATE; DO IT RIGHT THE FIRST TIME

PRODUCTIVE; MINIMIZE WASTE AND COSTS

PROFITABILITY

PATIENT SATISFACTION

GROWTH (SURVIVAL)

BARRIERS

Prior Authorizations

Step Edits

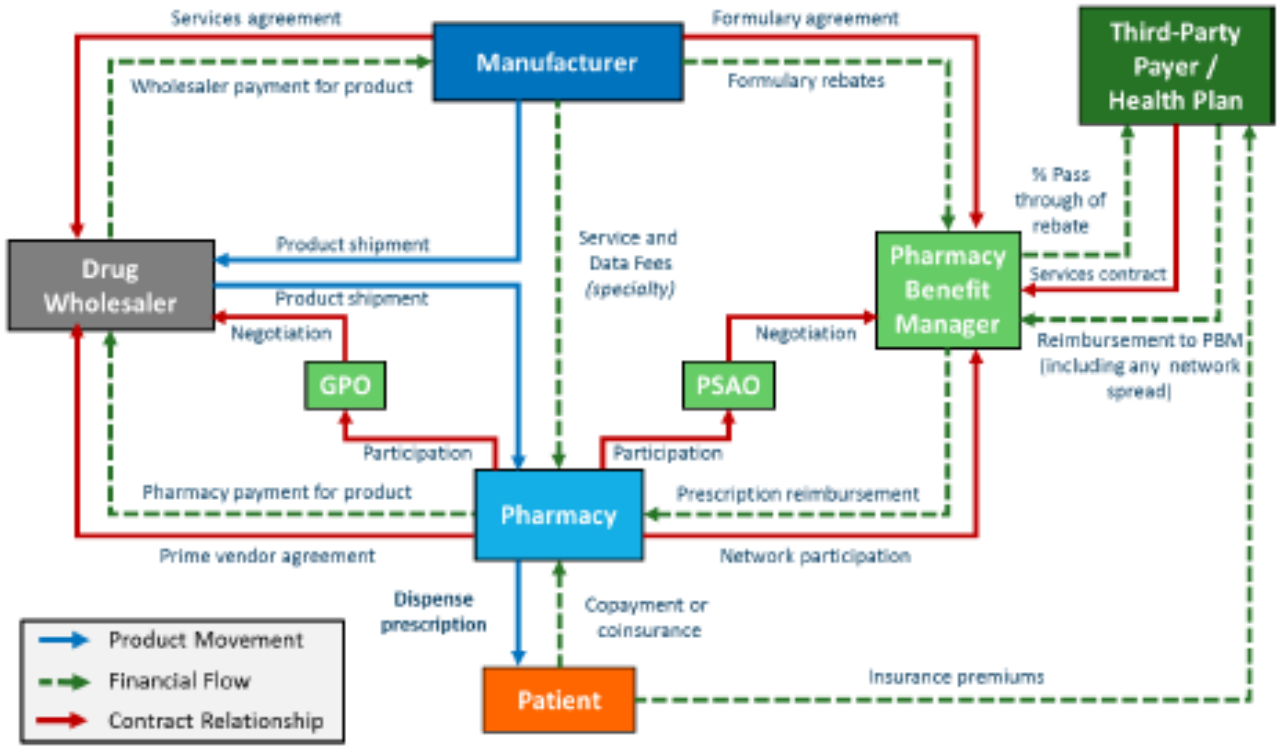
Formulary exclusions

Single source specialty pharmacy- Health Plan directed

Specialty contract rates leaving many claims underwater if MID buys & bills for the medicine

Organization's Internal Work Flow & communication

The U.S. Pharmacy Distribution and Reimbursement System for Patient-Administered, Outpatient Brand-Name Drugs



PSAO = Pharmacy Services Administration Organization; GPO = Group Purchasing Organization
Source: Pembroke Consulting research. Chart illustrates flows for **patient-administered, outpatient drugs**. Please note that this chart is illustrative. It is not intended to be a complete representation of every type of financial, product flow, or contractual relationship in the marketplace.

GPOS

Group Purchasing Organizations

GROUP PURCHASING ORGANIZATIONS

Access to variety of goods and services

Aim to reduce costs (add value) by:

- aggregating demand **AND**
- drive market share

Approximately 600 active GPOs serving healthcare providers

GROUP PURCHASING ORGANIZATIONS

For hospital class of trade…

- Top 10 include: MedAssets, Amerinet, Novation/Provista, Premier, MAGNET, HealthTrust, Managed Healthcare Assocs., Hospital Central Services Cooperative, GNYHA Ventures and the U.S. Dept. of Veteran's Affairs

~ 97% of hospitals belong to at least one GPO

GPOs collect administration fees from

- vendors cover costs and share with members (sometimes)

GROUP PURCHASING ORGANIZATIONS

In community oncology….

- fewer distributors and growth of GPOs, state societies and hybrid buying entities not fully functioning as GPOs

Control access to contracts

- providers align with a given distributor who also owns their own GPO.

Mfg. contract with each distributor/GPO not always identical

Examples include:

- ION
- Cardinal Health
- McKesson

NCODA is distributor & GPO agnostic

GROUP PURCHASING ORGANIZATIONS
THE MOVING PARTS

Explosion of competing drugs

biosimilars, I/O, contracting strategies with mfg.

Distributor / GPO solutions offerings

Support community oncology

Advocacy

operational intel & tools, reports, consultants and payment terms

Other ramifications:

ASP & payer reimbursement

buy & bill methodology

payer pathways

VBC, OCM, MIPS

PBMS

Pharmacy Benefit Managers

INDUSTRY ECOSYSTEM

Plan Sponsors:

- **Anthem**, **Blues, United HC, Aetna, Silver Script, Tricare, Cigna, Humana**

PBMs:

- **Anthem**/Ingenio Rx PBM, **Blues**/Prime Therapeutics, **UHC**/Optum, **Aetna**/ CVS Health & CVS Caremark, **Humana**/Humana Pharmacy Solutions, Envision Rx, **Tricare**/Express Script

PBM-owned "Specialty" Mail-Order Pharmacy (SP):

- **Anthem**/ **Blues**/Prime Therapeutics/Blues/Prime Thera. SP, **UHC**/OptumRx/Briova-Rx/CatamaranRx, **Aetna**/CVS Health/Humana Pharmacy Solutions/Humana SP, Envision Rx/Walgreen's SP (Rite Aid SP), **Silver Script**/CVS Caremark/CVS Specialty, **Tricare**/Express Script/Accredo

PBM-owned Chain Pharmacy

- Walgreen's / Rite Aid

THE PHARMACY BENEFIT MANAGER (PBM): WHO OR WHAT ARE THEY?

What are PBMs?

Manage Rx drug benefits for health insurers, Part D plans and large employers

PBMs role in Rx drug spend?

PBMs are in the middle of the drug value chain.

Develop formularies of meds for health insurers and the employers who buy the insurance

Use purchasing power for rebates (often as a % of the mfg's list price) & discounts from drug manufacturers

Contract directly with pharmacies to reimburse them for drugs the SP sends to the patient

Potential Downsides

Script leakage outside practice

PBM poaching tactics at the Clinic and patient level

Pharma limited or directed distribution

THE PBM: ISSUES & CONTROVERSIES

Lack of transparency

Vertical integration of payer, Mail-Order, and PBM

Spread pricing

PBM charges the health plan customer (Employer) a higher price for a drug than the PBM reimburses the Mail-Order Pharmacy.

Pass through any rebates to payers or to patients

TRANSPARENCY IN THE MARKETPLACE: WHAT IS A DIR FEE?

DIR stands for “direct and indirect remuneration”

DIR was a term coined by the Centers for Medicare and Medicaid Services (CMS)

Drug prices do not reflect what most people eventually pay for the medicines, and secret rebates and discounts flow between various middle-cycle players

CMS was concerned that the actual cost for a drug under a Part D Plan was being obfuscated by price concessions (e.g. manufacturer rebates) that were not captured at the point of sale

PBMs have applied the term “DIR” to extract fees from Providers after the point-of-sale and after the claim has been adjudicated.

DIR fees used to be ~2%, now as high as 10%

THE PBM: MAIL-ORDER "SPECIALTY" PHARMACY ISSUES

The top 15 pharmacies account for ~ 75% of all Rx's by revenue in 2016. This is a $400 billion industry.

Multi-billion dollar M&A activity to more tightly vertically integrate occurring

CVS Caremark moved to shift all dispensing practices to "out of network" for Medicare Advantage plans effective January 2017

- Indications were that Express Scripts was ready to follow CVS lead
- Massive practice, media, and state/federal legislative effort stopped CVS

Absurd DIR fees (from ~4% to >10% over 4 years)

- Charge what they want, how they want, when they want

Express Scripts tightening "formulary" access to treatments and steering business to Accredo

With more oral oncolytics in the pharma R&D pipeline, expect more attempts to capture this business

- Payer/PBM cabal will aggressively target not only dispensing practices but also the retail pharmacies and health systems' pharmacies
- *Profits and stock price before patient needs!*

THE PBM: ISSUES & CONTROVERSIES

Prior Authorizations initiations will generate scripts that will be auto faxed to your doctors— be vigilant and intercept them

Confusing letters might be sent to the patients

Computer generated scripts will continue to go to the practice even after it has filled the original script

Some PBM pharmacies will even call patients and confuse them or “suggest” they’ll have higher copays if they do not switch to that PBM

PBM Pharmacies have called patients and told them they will have high “doughnut” copay if they use the MID pharmacy but no copay if they switch to the PBM

MAIL-ORDER, PBM AND PAYER ECOSYSTEMS INDUSTRY: TRENDS AND CHALLENGES IMPACTING PATIENTS AND COSTS

- The “800” number merry-go-round
- Big Box versus personalized care
- Which pharmacies and where fills which drug, when & how?
- Can medication arrive before IV Chemo or Radiation is scheduled, or if pathology or lab results ok?
- Can medication arrive before the patient progresses?
- Will the mail-order offer financial assistance opportunities or free drug to the patient?
- Will the mail-order pharmacy aggressively seek a prior authorization and how much disruption will they cause our prescribers?
- Are Social Workers and ancillary caregivers offered?

DRUG DELIVERY MODELS: PRIVATE, MEDICARE AND COMMERCIAL PAYERS

The value equation among the players; Pharma, Payers, mail-orders, PBMs, Providers and Patients; a zero sum game

Cost, Access and Quality issues; can we really have all three?

Oral chemo growth

In-office dispensing ("MID") vs SP Mail Order Pharmacies

Quality = services, time to therapy, Rx control, safety

Right place, drug, time, with lowest cost and min waste

Quality does *NOT* mean stock price or channel control

CO-PAY ACCUMULATOR TECHNOLOGY

Oral oncolytics are often used to treat cancer.

836

drugs are currently in clinical development.

25%

are oral agents.

With copay accumulators, the health insurer prevents patients from fully taking advantage of their coupons—**collecting the patient's deductible each time the patient returns to the pharmacy counter!**

Don't get caught by surprise. You can help make a difference. Help spread the word!

Contact your HR department or insurer to check if your plan is making this change and tell them copay accumulator programs cost you more in the long run and are the wrong choice for patients.

Copay Accumulators Increase Patient Costs

Many patients have plans with high levels of cost sharing and high deductibles, meaning they are responsible for substantial out-of-pocket healthcare costs.

Prescription drug manufacturers provide coupons to help these patients afford new and innovative medicines they need to stay healthy.

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CO-PAY ACCUMULATORS (CONT'D)

New payment structures called accumulator adjustment programs

- Designed to prevent manufacturer coupons from counting towards a patient's annual deductible
- Could lead to higher out-of-pocket costs and fewer patients adhering to treatment programs that help them stay healthy

As health plans (insurance companies) & employers embrace these programs

- More Americans will face higher out-of-pocket costs throughout the year
- Receive bills for treatment that would have otherwise been covered because manufacturer coupons helped meet their [high] deductibles.

Further interest? Full session on DIR/Copay Accumulators Friday 10/25 2:00-2:45 PM

CO-PAY ACCUMULATOR EXAMPLE

A. How manufacturer coupons help patients afford their medicines:

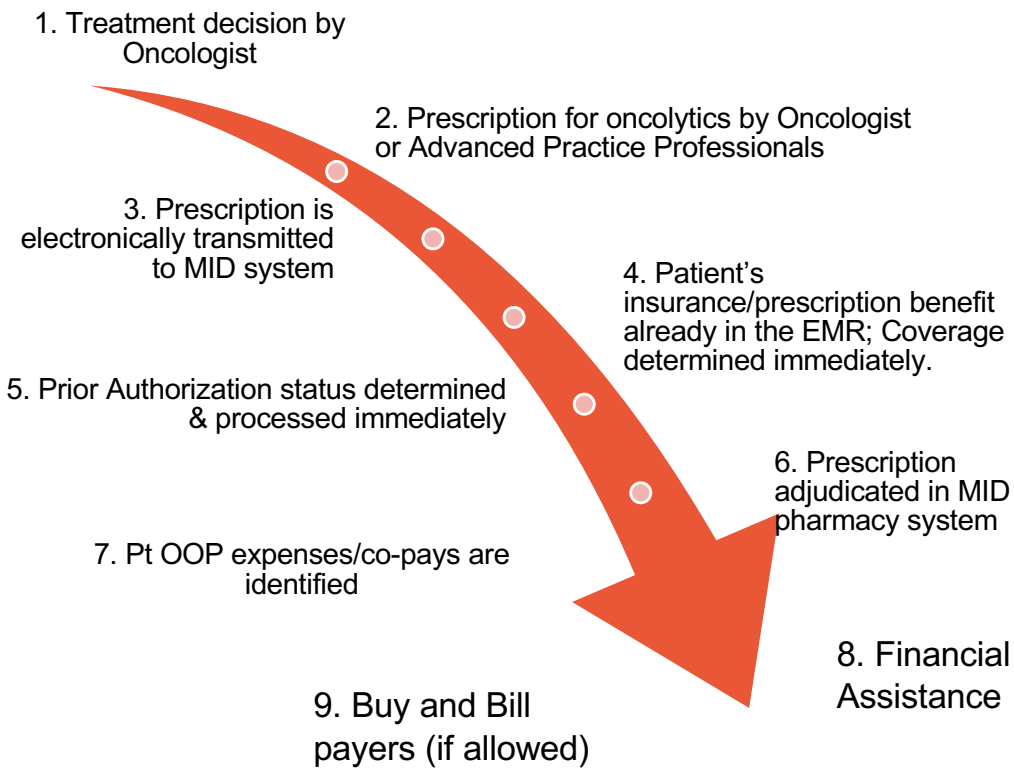
- Rx drug cost $2,000 Mfg. co-pay coupon value = $1995
- Total patient cost $5.00
- Remaining Deductible after coupon = **$0**

B. How the accumulator adjustment program makes patients pay more out-of-pocket:

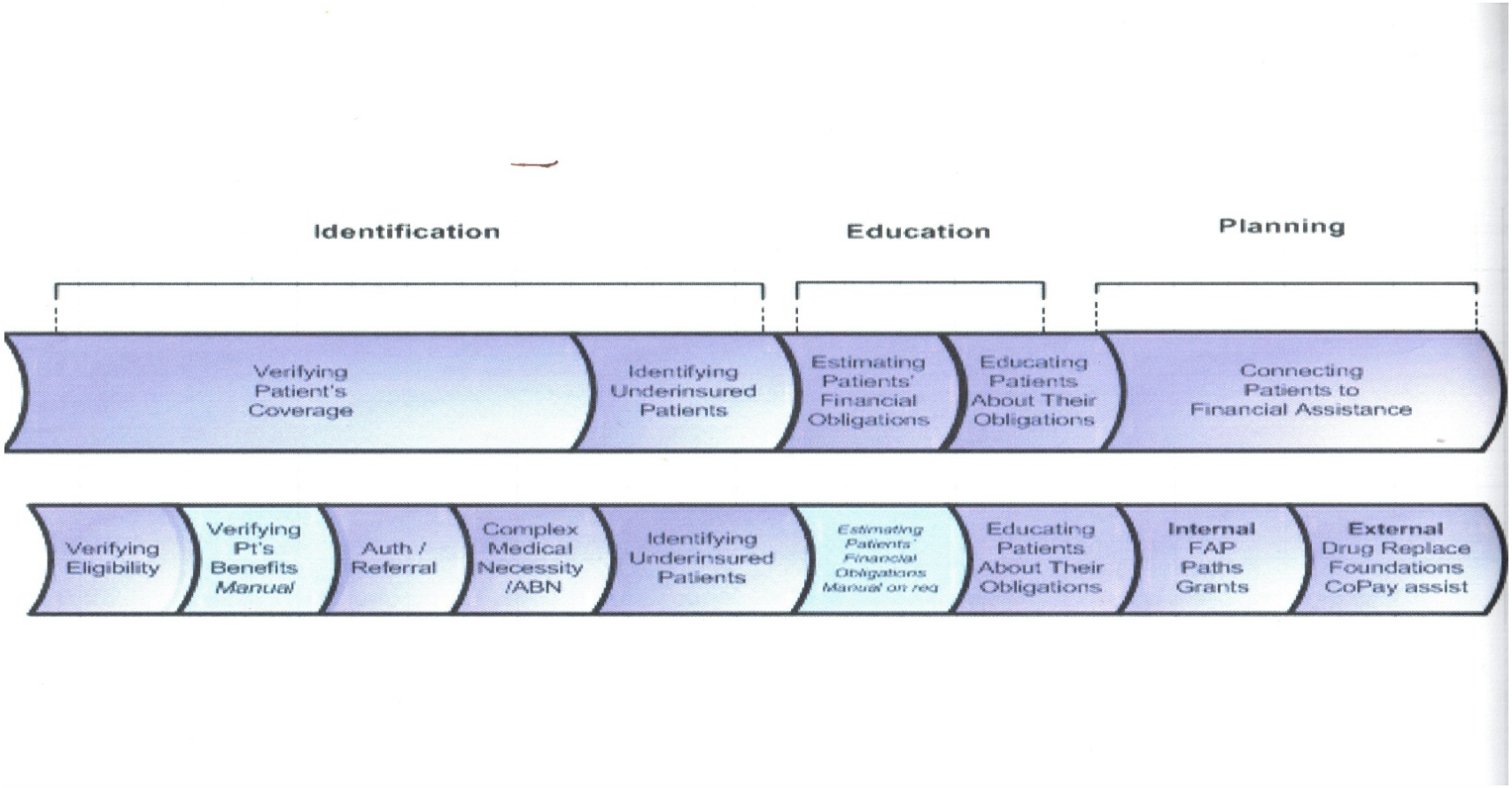
- Rx drug cost $2,000 Mfg. co-pay coupon value = $1995
- Total patient cost $5.00
  - Remaining Deductible After Coupon* = **$1,995**

  - ***Only $5 counts toward the patient's deductible and health insurers keep the $1,995 coupon!***

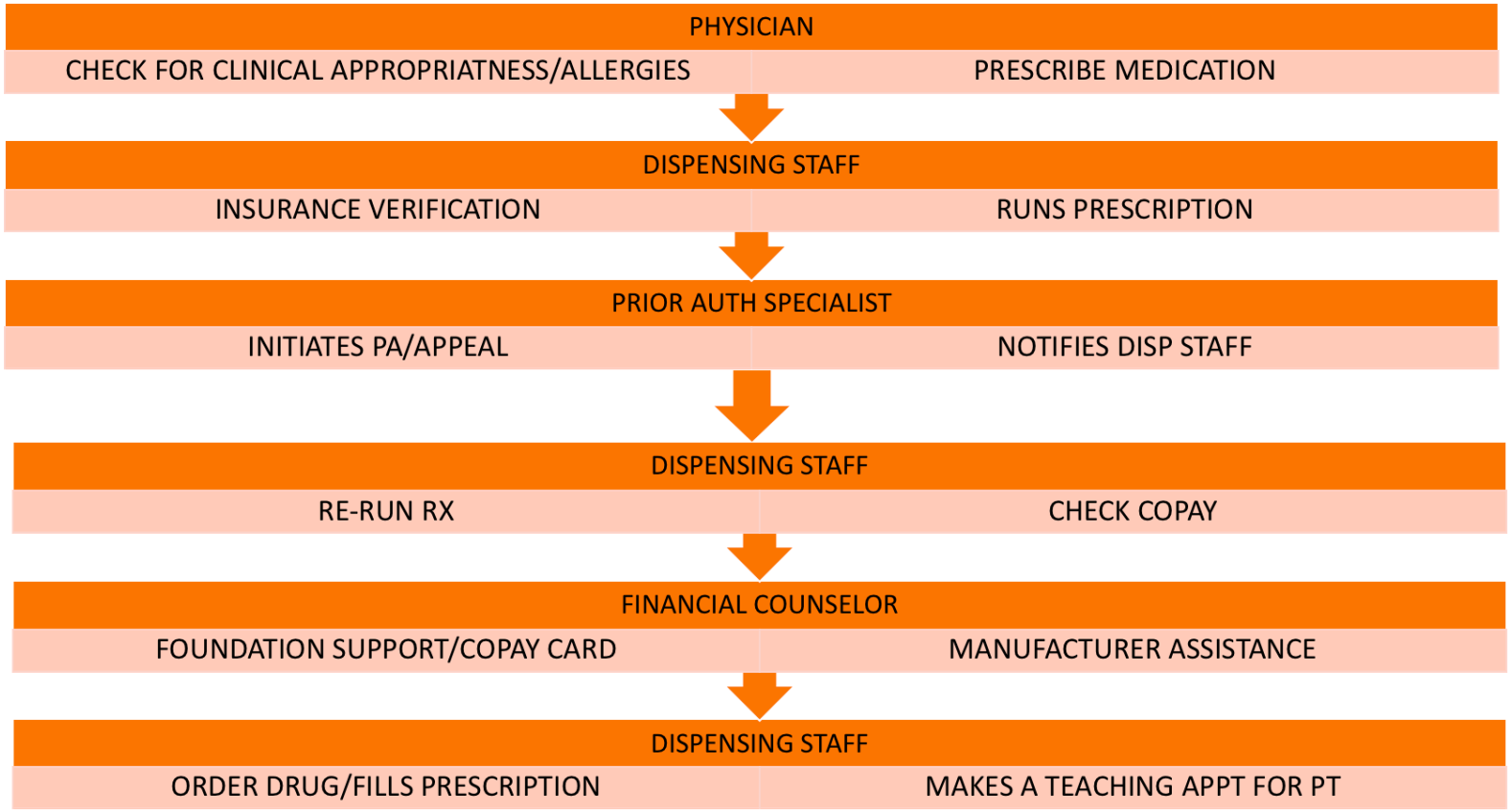
CURRENT MODEL: LIFE OF AN MID RX



MID PROCESS FLOW (ILLUSTRATIVE)



WORKFLOW PROCESS EXAMPLE



MID ECONOMIC CONSIDERATIONS

Drug purchasing

- Wholesaler discounts
- GPO contracting-OID and Rebates, contract design issues
- Availability
- Direct debit or prompt pay discounts

Reimbursements

- PSAO / PBM contracts
- Individual payer contracts-first fill and beyond?
- DIR Fees
- Pre-Post Edits
- Financial Assistance or PAPs

AR Management

- Collecting patient copays
- Medicare Part B billing
- PBM Audit management
- AR Reports
- Leverage technology (software for analytics)

MID FINANCIAL DATA

P&L Primer (Cash versus Accrual)

- Expected Revenues
- Cost of Goods
- Gross Margin
- Direct Expenses
- Variable Expenses
- Payroll cost
- Shipping cost
- Pre-tax Income

MID DASHBOARD DATA

Other important operational metrics

- Accounts Receivables
  - % AR over 60 days
  - DRO (Days of Revenue outstanding)
- Inventory management
  - Inventory turns
  - Just in time buying
- Revenues
  - Average revenue per prescriber
  - Script Capture

MID OPERATIONAL ISSUES

Patient Management

- Refill calls
- Adherence/compliance strategies
- Waste management
- Cost avoidance
- Impacts on alternative payments models (OCM)
- P&T Formulary management
- Disease state sequencing - IV versus Oral

PRODUCTITIVY METRICS & THE MID

"WE CAN'T MANAGE WHAT WE CANNOT MEASURE"

Why track productivity metrics?

- Reduce bottlenecks, breakdowns, costs and errors

Efficiency is not the same as productivity

- Key Success Factors:
  - Financial Viability, Quality, Growth & Patient Satiosfaction

PRODUCTITIVY METRICS & THE MID

Must know costs, processes, tasks and accountabilities

Must have tools (software), Models, and Dashboards

RACI model

- R=RESPONSIBLE
- A= TO WHOM “R” IS ACCOUNTABLE
- C= TO BE CONSULTED
- I= TO BE INFORMED

PRODUCTITIVY METRICS & THE MID

Sample metrics:

- Medication Possession Ratio (measure of adherence using refill records)

The sum of the days' supply for all fills of a given drug in a particular time period, divided by the # of days in that time period. Warning! This can overestimate adherence.

- MPR= $\frac{\text{sum of days' supply for all fills in period}}{\text{Number of days in period}}$ X100%

SAMPLE ROLES AND RESPONSIBILITIES

Technician responsibilities

- Once the Rx is written by the physician, the Pharmacist or Technician runs the scripts to learn if the organization can dispense the drug
- If it is a new patient, all demographics, insurance, and allergy info is entered into the pharmacy management software

Prior Authorization Specialist

- If PA is denied, the prior authorization specialist appeals the decision and pursues a *peer-to-peer* in an attempt to get the drug covered
- The prior authorization specialist alerts the dispensing team at every decision tree branch
- Once approved, the Rx returns to the team and the Rx is re-run
- Route 1 = Using in-house pharmacy
  - Check patient's co-pay
  - The financial counselor researches availability of any assistance
- Route 2 = Sent to mail-order pharmacy
  - If to mail-order, Rx sent electronically
  - _____ Software reveals a successful transmission
  - In-house Rx voided
- After either of these routes
  - The patient is contacted by the _____ and scheduled for oral chemo teaching
  - RN (?) teaches patient and then the drug is dispensed if possible, or patient receives the telephone # to the mail-order
  - After the drug is dispensed or received by the patient at their home, the RN (?) initiates contact with the patient regularly and documents every encounter in the EMR
- Patient is scheduled for F/U appointments as appropriate

SAMPLE SOP TABLE OF CONTENTS

Human Resources – Work environment expectations, general admin (ACHC standard - STD-DRX4-2H)

Regulatory Compliance – HIPAA, infectious and communicable diseases, other compliance programs

Patient Care and Services – Clinical, fiscal, communication and counseling, documentation of care processes

Practice Operations – Prescription delivery services, supply management, equipment maintenance and cleaning

Controlled Substances

Business Continuity – Continuity and recovery (ACHC standard - STD-DRX7-4C)

General and Administrative - Record retention, safety, OSHA, USP <797> or <800>

Quality Assurance and Performance Improvement – Patient satisfaction, performance committee roles, monitor quality & performance, improvement goals and plans, plan implementation (ACHC standard - STD-DRX6-3C)

NCODA: VALUE PROPOSITION

- Improved Collaboration of Care with ***All*** Clinicians
- Superior Drug Utilization Protocols
- More Efficient Workflow
- Enhanced Oral Adherence
- Robust Patient Education & S/E Management
- Efficient Financial Support

NCODA: STRATEGIC INITIATIVES

- Going Beyond the First Fill Capability
- Monthly National Membership Webinar Engagements – ***Clinical Corner***
- Data Aggregate Studies
- Patient Satisfaction Survey
- Positive Quality Interventions (PQI)
- Cost Avoidance Waste Tracker (CAWT)
- Oral Chemotherapy Education Sheets (OCE)
- Treatment Support Kits (TSK)
- Oncology Pharmacy Technician Association (OPTA)
- Credentialing Committee
- Financial Assistance Tool
- Collaborate with BE THE MATCH®

COST AVOIDANCE WASTE TRACKER

Featured Initiative

NCODA | COST AVOIDANCE & WASTE TRACKER

An important cost & waste reporting tool to make the case for the medically integrated practice.

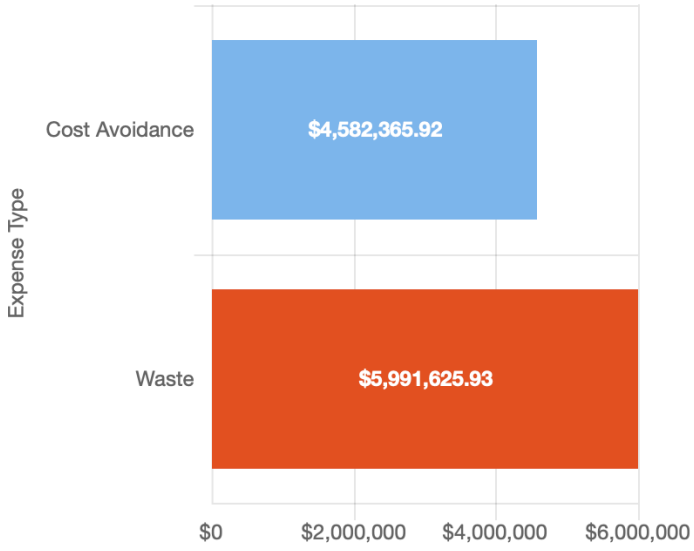
Cost Avoidance

Interventions made before the drug being dispensed to the patient that preclude an unnecessary Rx from being filled and sent to the patient.

Waste

Drugs that have been processed or prescriptions filled and then for any reason, the drug is not used by the patient.

LOGIN | NEW USER? REGISTER NOW



PATIENT SATISFACTION SURVEYS

National Community Oncology Dispensing Association, Inc.
PASSION FOR PATIENTS

< HealthCare Facility >
< Street >
< City, ST Zip >
< Phone >

Please take a few minutes to tell us how we can best meet our patient's needs.

Where do you get your **oncology** medication(s)? ❑ Pharmacy in doctor's office ❑ Mail-Order

Are you **required** to use a mail-order pharmacy for any of your medications?
❑ Yes ❑ No ❑ Don't Know

If yes, explain why? _____

Please rate the following areas of your pharmacy type selected above:

	Dissatisfied	*Dissatisfied*	*Neutral*	*Satisfied*	*Very Satisfied*	*Don't Know*
Convenience of receiving prescriptions		❑		❑	❑	❑
Time involved to receive prescription			❑		❑	❑
Your interaction with the staff		❑	❑	❑		❑
General satisfaction		❑	❑	❑		❑

Has the pharmacy helped you with any difficulty/found on assistance?
❑ Yes ❑ No ❑ Don't Know

If yes, how satisfied are you with the assistance you received?
❑ Very Dissatisfied ❑ Dissatisfied ❑ Neutral ❑ Satisfied ❑ Very Satisfied

Where would you **prefer** to fill your oncology medications?
❑ Pharmacy in doctor's office ❑ Mail-Order ❑ No preference

Please add additional comments or explanations to previous question(s). _____

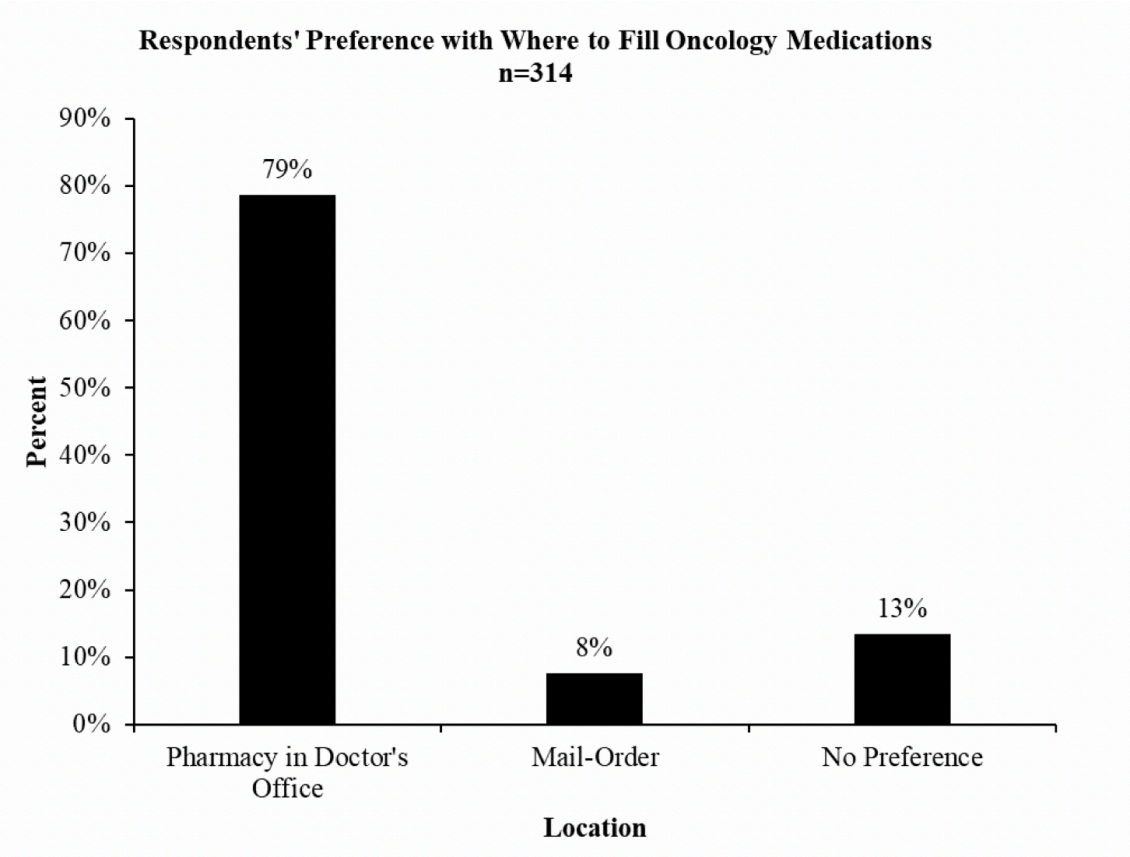
Gender: ❑ Female ❑ Male

Zip Code _____ Date _____

98%

2019 NCODA Fall Summi

NCODA PATIENT SATISFACTION SURVEYS (SPRING 2019)



FINANCIAL ASSISTANCE TOOL

National Community Oncology Dispensing Association, Inc.
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Discussions | Shared Files | Events | Members | Your Profile | Waster Tracker | Financial Assistance | Admin | Sponsors

Logged in as Michael Reff - Account Settings - Log Out

Financial Assistance Programs

Search by keyword [search]

Showing 1-72 of 72 add filters export

100 per page

Name	Generic Name	Drug	Phone	Manufacturer	Manufacturer Starter Kit	Commercial Co-Pay Card	Commercial Co-Pay Card	Patient Assistant Program	Trial Program	Website
Afinitor	everolimus	Website	(877) 577-7756	Novartis	yes; see sales rep	$25 copay; annual max $15,000; expire 12/31/17	Website	Website	14 day sample; see sales rep	
Akynzeo	netupitant/palonosetron	Website	(855) 347-2448	Helsinn Eisai	NONE	$0 copay; max $1800 per year	Website	Website		
Alecensa	alectinib	Website	(855) 692-6729	Genentech		$25 copay; $25,000 annual max	Website	Website		
Arimidex	anastrazole	Website	(855) 748-2655	Astra Zeneca		none		Website	none	
Aromasin	exemestane	Website	(877) 744-5675	Pfizer		$4 copay for Brand; Max $300 per 30 days; max annual $3600; Expire 12/31/2018	Website	Website		

SUMMARY

NCODA can help the remaining private community oncology practices regain control of their patients, Rx for them, and dispense to them.

NCODA has a successful playbook with the goal of obtaining payer cooperation that may allow you to complete the first fill through your MID, thus ensuring timely application of all prescribed medications *

Several payers in certain states are cooperating with those local MIDs

** List available upon request*

NCODA is uniquely positioned to support you in your quest to provide effective, efficient, patient-centered, high quality cancer care compared to traditional SP or Mail Order Pharmacies.

CONCLUSIONS

The oncology practice and their MID are uniquely positioned to continue providing effective, efficient, patient-centered, high quality cancer care compared to traditional Mail Order Pharmacies.

Cancer therapies are increasingly complex & expensive.

Physician and staff on-site are required and capable to assume greater role, ensure increased convenience, satisfaction, response time, adherence, toxicity management and cost control.

We already Rx and dispense to Medicare patients, and have done so for years.

Patients and physicians should make cancer care decisions, not Payer/PBM cabals

MID 101

LIVELY & SPIRITED DISCUSSION NOW

THROUGHOUT THE SUMMIT

THANK YOU FOR SUPPORTING NCODA!

2019 NCODA Fall Summit