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Addressing disparities in cancer care

How to affect meaningful change in our communities

A talk by Kashyap Patel, MD, AboiM, BCMAS, CEO of Carolina Blood and Cancer Care and immediate past president of Community Oncology Alliance (COA)

Race, age, geography, and economic status all factor into the dynamics of cancer care. In 2022, AmerisourceBergen hosted its first Health Equity Summit to address the need for the industry to work together to diminish these evident disparities. Dr. Kashyap Patel, MD, launched a nonprofit foundation in 2021 to do just that. In his presentation, Dr. Patel shared his experience in working to alleviate these challenges within his community and offered key insights from his research.

To get into talking about disparities in cancer care and the social determinants of health, we first need to do a needs assessment and ask: What is the problem?

According to the Community Oncology Alliance (COA), "It is estimated that 34 percent of cancer deaths among U.S. adults ages 25 to 74 could be prevented if socioeconomic disparities were eliminated."[1] So the problem is right in front of our eyes: 34 percent.[2] Along those lines, it's important

"One in three cancer deaths are preventable if you address disparities in care."

to remember that one in three cancer deaths are preventable if you address disparities in care.[3]

I spent over a thousand hours reading about disparities in cancer care. In doing so, I've come to realize that a problem as big as this can only be solved by all of us working together. I also realized there are some key factors that lead to disparities in oncology care:

- Lack of cancer screening
- Lack of access to clinical trials
- Financial disparities
- Lack of insurance coverage

The magnitude of the problem around financial toxicities—that is, if a person does not have financial security, or if they're underinsured—is significant. Studies show that one hundred million Americans carry medical debt of a significant size.[4] That's one in three Americans with medical debts, and coverage issues (mainly on the commercial side) can be a huge problem.

Here's an example. One of my patients was a Black woman in her 30s who had triple-positive breast cancer. I wanted to put her on a course of treatment with filgrastim, and her insurance plan wouldn't approve it. Instead, they wanted her to be treated with filgrastim daily for two weeks in each cycle. So, my patient—a single mom with two kids at home who shares a car, works at Walmart, and lives 35 miles from my office—would've had to come to my clinic 84 times to finish that course of treatment when she could've done it in just six visits through my proposed protocol. If I went with what her insurer wanted, I also could've charged $8,000 more because I could've justified seeing her every time, along with administering the shot.

Instead, I pushed back. I called the CMO, and I wrote to the CEO of that company, and I said, "In a time of recovery from the pandemic, you want this girl to spend thousands in gas money to drive here 84 times in 35 months? While paying for childcare and losing 84 half-days at work?"

Fortunately, the CEO was very thoughtful. He flew in from his headquarters and spent a day with me to discuss and gain a clearer understanding. I said, "that's one thing, but what about the other people who don't have an advocate like this?"

Beyond the payer factor, here is something that breaks my heart: the social determinants of health. In a paper that came out last year, the author concluded that patients with the same stage disease, same treatment, with three or four more adverse states have a 20 percent higher risk of mortality. Which means we could be using the best medicine in the world, but if our patient doesn't have food security, reliable housing, access to transportation, or utility concerns, they could actually end up with a worse outcome. These are some of the social determinants of health that can dictate the outcome of care. Probably 20 percent of patients who have adverse experiences with economic stability, their neighborhood, a lack of education, food insecurity, or a lack of access to healthcare will see an impact to life expectancy and functional impairments.[5]

This highlights the magnitude of problem. For example, 87 percent of eligible Medicare or Medicaid beneficiaries did not receive lung cancer screening,[6] even though they qualified. And similarly, there has been a decline in women receiving breast cancer screening.[7] But if you catch these cancers at stage one and look at the economic implications for the patient, the differences are tremendous. If you identify stage one lung cancer, based on the low dose scan, the cost to the patient would be about $25,000[8] between surgery and post-operative care. If that patient

comes back with stage four lung cancer, the annual cost could be about $200,000 a year. And if that patient lives three or four years, which is the expectancy right now, the cost becomes close to a million dollars—but we are going to lose that life.

As a person of action, I envisioned starting a program at our clinic that could address some of these challenges. We started looking at the issue of access to care first, and considered: What resources would it take to help these patients? How many patients need help covering out-of-pocket costs? How many patients need cost savings for prescription drugs, and how many patients need insurance help?

In 2021, we had three full-time employees whose roles were to determine the foundations of insurance eligibility and related out-of-pocket costs, and then help patients with their financial needs. A second target for us was building greater access to biomarker testing, because implementation of the full comprehensive genomic profile (CGP) in eligible patients was a must.

I reached out to two labs, wrote a protocol, and started a research study exclusively aimed at addressing disparities in care. In the second phase, we started focusing on germline cancer testing and cancer screening. And we started a not-for-profit called No One Left Alone (NOLA) with the idea that no cancer patient in 21st century, at least in our congressional district, should feel that they're by themselves in the struggle.

I felt that for us to solve the disparity issue, we had to start somewhere—and I feel that when we get down to it, all solutions are local.

In our first year of putting the NOLA program in action, we identified and arranged for exams for more than 600 patients who didn't have cancer screening. We established the pilot on the next generation sequencing (NGS) testing, and we reached a testing rate of about 80 percent. We also raised about $2.3 million in assistance, either by providing drugs at no cost (worth $1.6 million), or about $50,000 in cash assistance for the oral prescriptions and certain other medications.

How did we do this? As I mentioned, we had three employees who evaluated the patient at their time of intake. They looked at their insurance coverage and determination, looked at the needs assessment based on out-of-pocket costs for those insured or underinsured, and looked to see if they were eligible for dual eligibility. We got them assistance. Then we looked into screening, and we looked into data collection. So, we were collecting robust data prospectively.

If a patient was fully insured and able to cover out-of-pocket costs, we verified their benefits. We calculated how to cover out-of-pocket costs and the physician treatment plan for patients who were uninsured. We began to have a roadmap in place for those who were underinsured, and that allowed us to identify each patient's unique circumstances and unique needs to ensure that at least the financial part of their healthcare would be covered.

I designed an intake form combining the social determinants of health topics and cancer screening needs. This allowed me to evaluate each patient and look at their healthcare needs.

In the first week we had a patient who told us, "I'm homeless. I live in my car." Unless we asked for that information in our intake form, we never would have known about this. We ended up seeing three homeless patients in that first week. And for a moment I wondered if I'd opened Pandora's box because I didn't have access to resources that could help them, and we were already short-staffed.

What happened next felt like divine intervention. The next week, I was invited to go on a radio interview with a talk show host. And at the end of the interview, I ran into a good friend of mine. I told him I was struggling with this observation about utility assistance and homelessness. And he told me there was a solution for that. He told me about a group called Pathways in Rock Hill, SC, and introduced me to that team.

Under one umbrella, Pathways provides shelter, assistance with food security, and utility assistance. They provide transportation help. They provide mortgage assistance. Everything that I cannot provide to build a healthy ecosystem, they provide. That 34 percent additional preventable mortality can then be addressed by building an ecosystem between a provider and a not-for-profit network like theirs. And that's what emerged out of that chance meeting.

To summarize how we provide comprehensive assistance: it starts with assessing the patient and identifying their income information. We look at their age, location, the money they have allocated to pay their bills, their access to transportation, any mental health issues, and their access to a phone or technology.

We hear so much about technology, but about 20 percent of my patients—one in five—do not have an email address. They don't even know what

email is about. One in five patients live in an area we call the broadband desert and a food desert. So as much as we want to use technology to solve the problem, we have to have a solution that fits everybody else. Our data helps us determine the unmet needs that we might otherwise ignore.

For health needs, I work to address everything that falls under cancer screening, including germline genetic testing, clinical trials, and meeting financial needs.

As far as measuring progress, we started NOLA's phase one in 2021 and completed it that December. During that time, there was not a single patient who was left behind without financial support. We also increased our biomarker testing rate to close to 85 percent. And in 2022, we opened up a couple clinical trials—this was phase three in partnership with Community Clinical Oncology Research Network, LLC (CCORN). We also signed an agreement to bring clinical trials to eight to 10 groups in South Carolina, Maryland, Florida, and Georgia. And we are opening up a second NOLA site at Myrtle Beach.

Some of my colleagues are planning to expand the same concept where they work. That teamwork and cohesive approach helps provide consistency. That gets back to what I mean when I say all solutions are local, and it takes all of us working together to solve the problem of disparities in care.

That's why it is critical to address social determinants of health. No matter how far we go in developing technology, if we do not take care of social determinants of health, we will never solve for the kind of discrepancy between the life expectancy of one zip code versus another. One key learning I made—and we are working on it with Pathways—is that even though I can help take care of the patient's financial needs for my services, that patient still faces the risk of bankruptcy when they have hospital bills to pay. I've seen it happen. To help with this, we created a separate insurance pool with funds to help patients pay for their healthcare premiums.

When I saw the first patient—when we helped her with getting insurance—she cried almost like she won the lottery. That uninsured patient got reassurance that their healthcare will be sustained. I feel that is one of the easy solutions we can offer that can solve for a lot of financial toxicities.

Financial toxicity and the struggle to pay bills affects so many people. When we analyzed the data we collected on just over 1,000 patients, we found that financial toxicity affected a significant percent. And the more I'm reading about the link between chronic stress and cancer[9] in last two years—well, it's a concern. Studies show the direct link to outcomes of cancer with chronic stress, and they've also shown the molecular link between which genes got regulated through epigenetics resulting from the chronic stress.

As we continue to explore ways to address and solve for disparities in cancer care, we want to look into expanding this program across the country. We're building up the phase one clinical trial in improving population health to address cancer and disparities, and we are looking at expanding with other partners.

We also want to continue to publish so that we have the data that helps us determine what works, and what doesn't. We started not knowing what's going to work. And like I said, this is like a phase one—studying population health—and we'll continue to trace and track improvements. We'll create a standard for the best practices. We'll do health economic outcomes research. In doing so, the theme we are trying to learn, share, and create best practices around is how to break the silos and make a cohesive collaborative approach that brings a working ecosystem to patients' lives.

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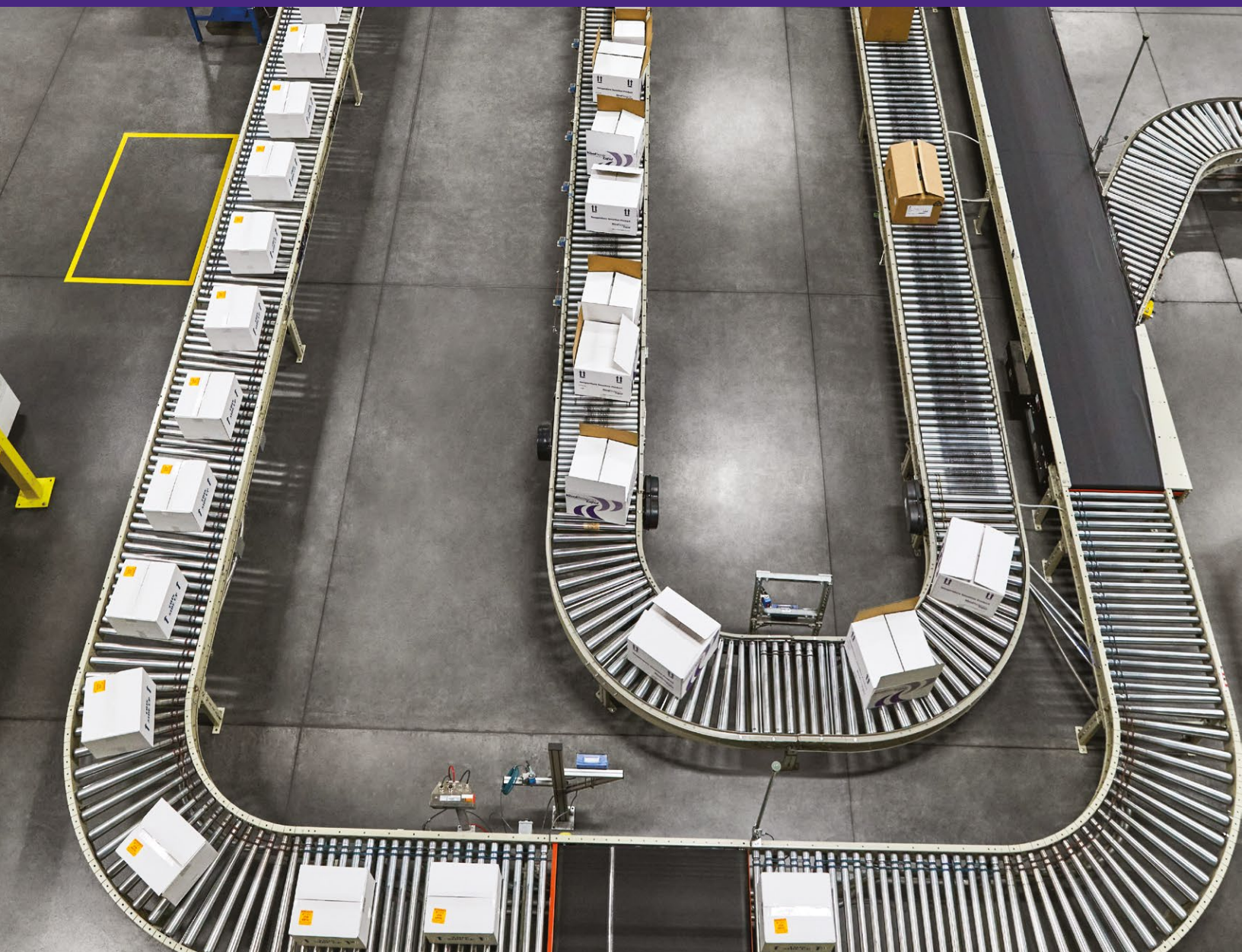

An interview with Kathy Oubre

We recently sat down with Kathy Oubre, Chief Executive Officer of Pontchartrain Cancer Center (PCC), to hear her thoughts on the advantages of cultivating a long-term partnership with a specialty distributor.

Kathy has been CEO of PCC since 2005, providing non-clinical leadership for all aspects of the practice. That includes financial counseling, policy and procedure development, billing, nutrition programs, and survivorship care. She also serves on the board of the Community Oncology Alliance (COA), is the chair for the Oncology Institute with NCODA, and is active with several editorial boards.

PCC has been an AmerisourceBergen Specialty GPOs member and specialty distribution customer for over 17 years. Located in southeast Louisiana, PCC specializes in providing access to high-quality cancer care to patients in their community through personalized treatment options and clinical trials.

At AmerisourceBergen, it's valuable for us to understand the voice of our customers. What is it that matters most to you in choosing a specialty distribution partner?

Kathy Oubre: At the end of the day, what matters most to us boils down to relationships. It is why we chose Oncology Supply and AmerisourceBergen Specialty GPOs 17 years ago. Our partnership with AmerisourceBergen is one of the longest working relationships we've had, and I'd like it to stay that way for years to come.

In a distribution partner, what matters is trusting that they truly understand our pain points. I know I'm able to contact AmerisourceBergen leaders and get a quick response, despite how incredibly busy we all are. In an emergency, I appreciate the ability to email my account manager around the clock because I need an answer to a particular drug class when we're doing in-office dispensing. These are relationships that go beyond partnership.

Our ability to deliver high-quality care to our patients is why we all get out of bed in the morning. It's clear to me that this matters to you just as much as it matters to us, and that has value—that keeps us where we are.

It's often said that solidarity really matters in our industry. Having a united business model that reflects the partnership between our Specialty GPOs and our distributors is one example of why solidarity means a lot to us. Tell me about your thoughts around that: what does that mean to you in your practice?

Kathy Oubre: Solidarity is about our relationships and it's really nothing past that. For example, we deal with hurricanes that can impact our ability to deliver care. AmerisourceBergen's willingness to work with us and be creative and unique in those moments has helped us not to miss a beat.

We've been down for a week because we had no running water and electricity, but Oncology Supply was there (more than once) getting our drugs to us as soon as we could open. After Katrina, I remember driving to Baton Rouge and meeting the FedEx planes. Even 17 years ago, it was your mission to get us the drugs we needed for the patients that we all serve and it's the same today. That commitment is what you can't replace.

If we are innovating, we're bringing new concepts to market. But what role does innovation play in your decision making when you're considering a strategic partner?

Kathy Oubre: Innovation is very important for our practice. Innovation comes in the form of insightful analysis of data and reports from the solutions AmerisourceBergen provides for our practice. That allows us to expand services for our patients and take better care of our employees. I would be remiss if I didn't call out InfoDive® because that's an amazing piece of

"There are 31 states right now with copay accumulator bans. Those kinds of things impact us, and most importantly, our patients. It's important for everyone to get involved and advocate.

technology. With the combination of business coaches, partnerships, and analytics, that's amazing stuff. It allows us to uncover or point out issues and opportunities in real time. I don't have the bandwidth to do this myself, so that is by far the best investment for our practice.

What does value mean to you and your practice when you make decisions around choosing a practice partner?

Kathy Oubre: Well, a transactional relationship with a practice partner has little value to me. I find value in the ability to create mutual and meaningful relationships. Your GPO team works hand in hand with us to understand our needs, then takes that knowledge to the manufacturers so we have competitive contracts that make sense for our practice and our payers. I also see value in partnering with you to create relevant education, like developing a podcast around biosimilars.

But value is also having a partner that offers guidance on topics such as reimbursement trends and policy, while taking the time to explain how our practice could be impacted. This partnership approach has helped our practice for 17 years—it helped me, and ultimately it helps all of us, so thank you.

I find value in your agility. We did not know what the COVID-19 pandemic was going to bring to our practices or our patients. I remember calling one of your team members because we had only one box of masks left in the practice. I was panicked, we were going to have to close because we didn't know how to stay safe. That same team member was able to deliver the package a day later. It was just a box of masks, but it's a symbol of so much more. Again, it's those types of relationships: the ones that go above and beyond.

Part of that value can be attributed to customer service. With an automated system, the relationship becomes transactional. I like that I can reach someone at AmerisourceBergen who is responsive, calm, and excels at problem solving.

Is there anything AmerisourceBergen could do differently to improve upon our current offerings?

Kathy Oubre: I would say it's really important for your team to be well-versed in government affairs and the payer landscape, because those are typical challenges we face in community care. It's important to have working knowledge of a practice's payer dynamics so that you understand the specifics—for example, that a certain payer is splitting us three different ways on our formulary management or value-based care. And that changes constantly with government reimbursement programs.

There are 31 states right now with copay accumulator bans. Those kinds of things impact us, and most importantly, our patients. It's important for everyone to get involved and advocate. Talk to your practices about how to become advocates, and how to share patient stories because that is meaningful and important for our legislators to know.

We have passion for what we do, and we feel the passion for what you do—and it feels like we are stronger because we are working together to ultimately provide the highest quality care possible to patients in our community. That's the greatest value.

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Realizing cost savings through medically integrated dispensing

Can a medically integrated dispensing model help reduce drug waste and decrease the total cost of care?

By Christie Smith, Senior Director of Payer Initiatives, AmerisourceBergen

In the oncology space, how might reducing pharmacy waste benefit community practices? AmerisourceBergen's Christie Smith shares insights from the company's partnership with Prime Therapeutics' IntegratedRx™–Oncology program.

Like many aspects of the oncology journey, the issue of how pharmacy waste[1] occurs is layered—especially when the physician and the pharmacist are not able to work in tandem.

Imagine, for example, that an oncology patient has just started a new course of treatment. Maybe the treatment causes side effects, and the patient needs to shift to a lower dosage. Or perhaps the course of treatment needs to be adjusted altogether. But what happens when a prescription has been filled and sits unused? What if the prescribing pharmacy doesn't realize that treatment has shifted, and continues to fill a prescription that's no longer needed?

Scenarios like this can lead to pharmacy waste: drug overages that go unused and that can occur at a cost to practices and patients alike. But when patients have reliable

access to oral oncolytic therapies—and when pharmacists can review real-time updates about that patient's course of treatment—practices can see a decrease in pharmaceutical waste and an increase in patient adherence. [2,3,4,5] That's where Prime Therapeutics' IntegratedRx™-Oncology comes in.

What is IntegratedRx?

AmerisourceBergen began offering Prime Therapeutics' IntegratedRx-Oncology to qualified medically integrated dispensing (MID) practices and health system pharmacies through its pharmacy services administrative organizations (PSAOs) in late 2021. This groundbreaking clinically integrated program allowed patients to experience a more holistic approach to cancer care by receiving their prescribed oral oncolytics—and other medications—in a clinical setting.

A medically integrated oncolytic dispensing program like IntegratedRx-Oncology also gives the practice's dispensing pharmacist real-time access to their patients' medical records, allowing the pharmacist to adjust prescriptions or dosages on the spot. Because of this, providers have found that filling oncolytic prescriptions in the clinic can lead to a significant reduction in pharmaceutical waste.[6] It can support better patient outcomes by creating more accessible means for patients to start (and stick to) their prescribed course of care.[7]

How is IntegratedRx-Oncology working with pharmacies to reduce waste?

In addition to real-time data sharing across its robust network, Prime Therapeutics came up with a way to partner with participating pharmacies

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to offer a greater level of accountability and support. At the start of 2023, Prime Therapeutics launched its oral oncology waste reduction program. The goal of this program is to optimize waste reduction opportunities across MID and health system pharmacies participating in the IntegratedRx-Oncology program.

Running through August 2023, this program focuses on:

- Proactively assessing pharmacy member refills
- Ensuring proper dispensing and billing frequency
- Improving coordination between drug refills, efficacy, and toxicity assessments
- Providing best practices to help achieve pharmacy waste reduction

Participating providers will also receive an incentive for meeting the target waste ratio: Prime Therapeutics will remove the 2024 escalator for participating providers, so high performers will be reimbursed at the same rate in 2024 as they were in 2023.

But participants in the waste reduction program may uncover other benefits, too. For example, a previous pilot program conducted by Prime Therapeutics led to some compelling results for practices that assessed pharmacy waste after utilizing the IntegratedRx-Oncology clinically integrated dispensing model. When the company analyzed its data to assess drug waste differences between oral cancer therapies dispensed through a clinically integrated model with that of a central specialty pharmacy, they saw "a potential average savings opportunity of $1,800 per medication dose change at a MID pharmacy compared to a central fill specialty pharmacy."[8]

To realize potentially significant cost savings through reducing pharmacy waste, it then becomes beneficial for both the practice and the patient, leading to a decrease in the overall cost of care.[9,10]

How IntegratedRx-Oncology delivers value

Prime Therapeutics understands that delivering value to the clinicians and pharmacists that partner with it's program goes beyond an assessment of cost. Helping the practice save time on administrative tasks so they can keep their focus on their patients matters, too. To that end, Prime Therapeutics is exploring how to best streamline their prior authorization process.

When a prescription requires a prior authorization from the insurance company, patients may have to wait to start treatment until the appropriate paperwork is filled out and filed. As Prime Therapeutics considers how to enhance their patient-first approach, facilitating faster starts for patients getting on new prescriptions is key. Reducing wait times by enabling faster starts for patients needing to begin a course of medication could make a difference in patient outcomes by alleviating the stress of waiting for care and offering the peace of mind that treatment can begin quickly.[11,12] So, we'll keep an eye out for potential developments like this from Prime Therapeutics in our continued IntegratedRx-Oncology partnership.

Learn more about IntegratedRx™-Oncology

This model is currently available to AmerisourceBergen's partnering community oncology physicians and health systems participating in Blue Cross plans; participating practices must have an accreditation within a year.

Contact us

If your practice is interested in this new medically integrated dispensing model, contact your pharmacy services team at practicedispensing@amerisourcebergen.com.

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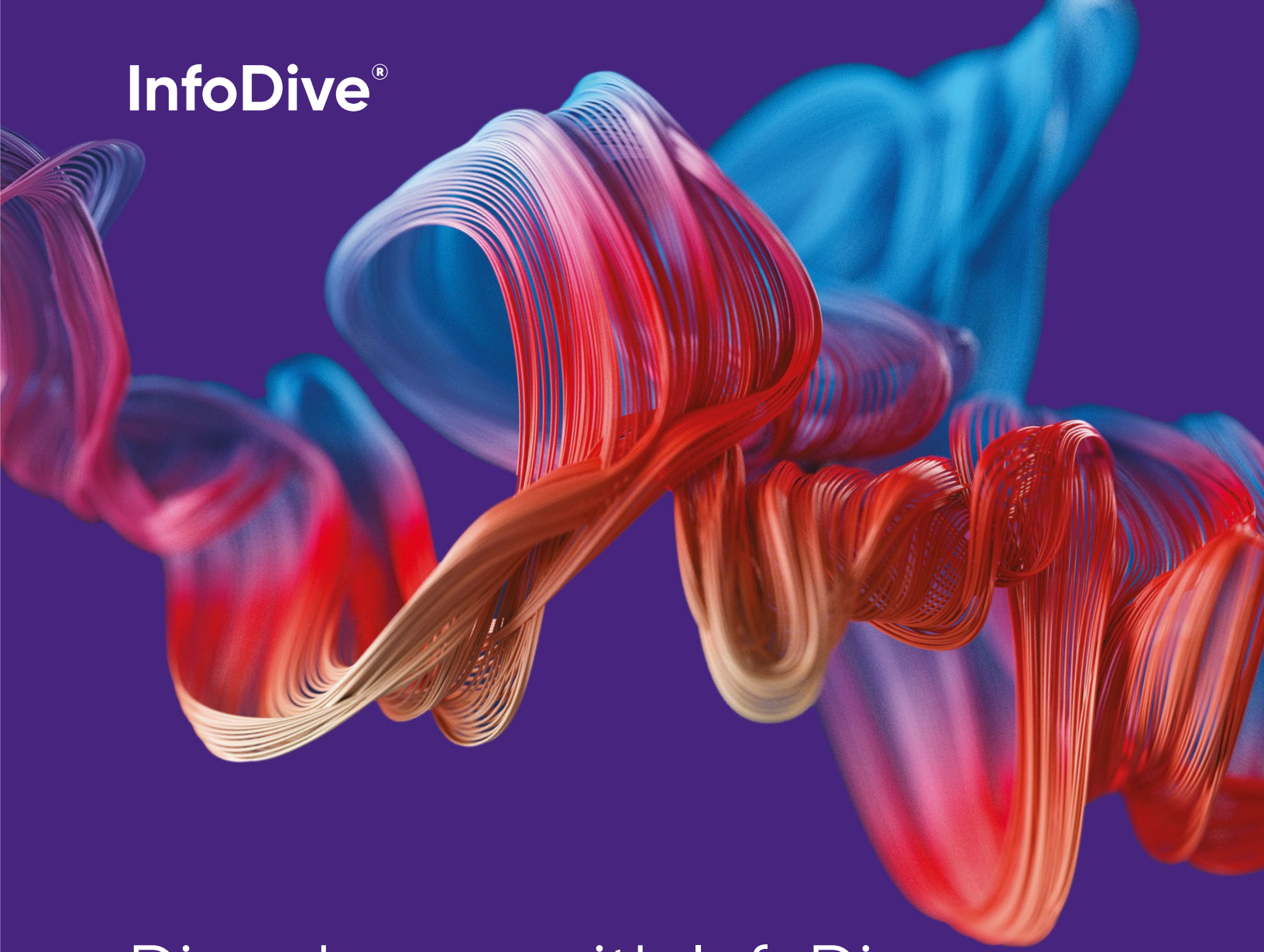

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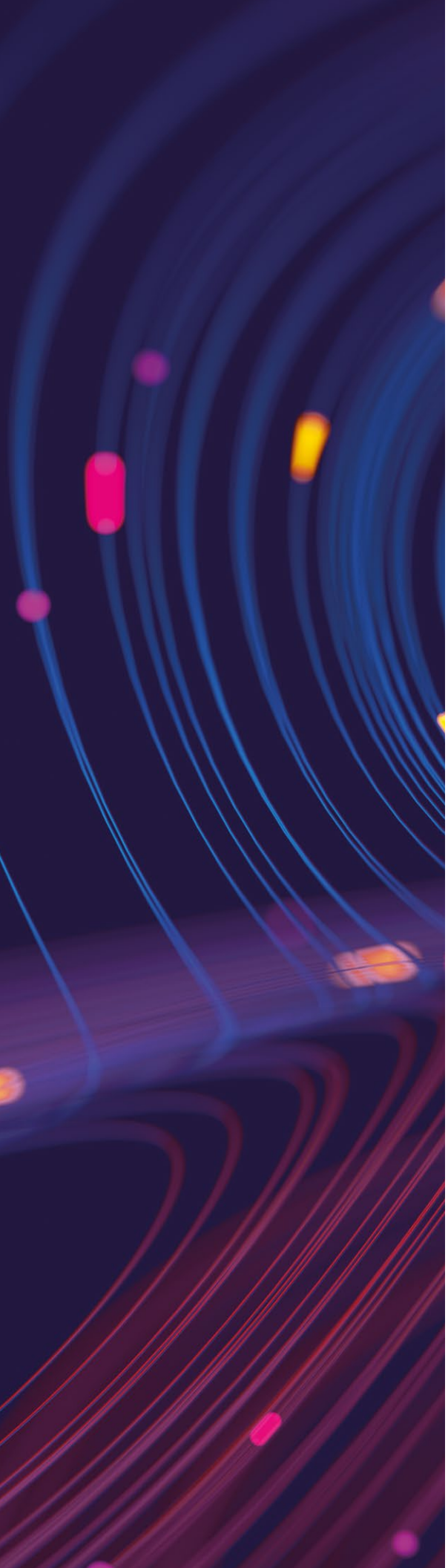
Unscripted:

Understanding the future of the biosimilar market

In our last issue, we spoke with Kathy Oubre, CEO of Pontchartrain Cancer Center, about how to best define biosimilars and how to understand interchangeability with their reference products. We also delved into what it's like to adopt biosimilars into an oncology practice. This time, Kathy shares her perspective on the FDA approval process for biosimilars, how to best operationalize biosimilars in a community practice, and how to work with payer coverage.



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Last time, we talked about biosimilars and what they are and what they aren't—biologics and generics versus the actual biosimilar. Can you talk with us about how the FDA approval process works with biosimilars, and how that might differ from some of the other therapeutics?

Kathy Oubre: Sure. The goal of a biosimilar development program is not to independently establish the safety and efficacy of the biosimilar, but to demonstrate that the proposed biologic product is biosimilar to the reference product.

Consequently, the FDA biosimilar development approach is to identify any differences between the reference product and the biosimilar, with the goal to determine what residual uncertainty about biosimilarity remains based on the potential impact of observed differences. The design is to determine whether there are any differences between the products, but the safety and efficacy has already been established in the reference product.

To go back for a minute on biologics as a whole, it's worth noting that the FDA holds all biologics[1]—the reference products and the biosimilars—to the same Current Good Manufacturing Practice (CGMP) standards. So, biosimilar manufacturers must have the same long-term commitment to quality for those biosimilars to proceed.

It's also helpful to get into the science behind it. Understanding the biologic's immunogenicity profile is very important. It's key to establishing a biologic's safety profile. In the world of biologics, you'll see head-to-head assessments comparing the immunogenicity of the biosimilar and the reference product. That's considered a key component of a biosimilar's clinical development program.

Also, there's no single study that's considered pivotal to a biosimilar application.[2] The totality of data and information submitted to the FDA supports biosimilarity, while reference products with multiple indications require clinical studies to establish safety and efficacy for each indication. Biosimilars are not required to be evaluated clinically in every indication held by the reference product for which approval is sought. Instead, a biosimilar manufacturer can extrapolate data and information supporting biosimilarity in one condition to others for which the reference product is licensed.

In general, it is likely for a biosimilar to be approved for all of the reference product's indications, but the FDA was also very clear in noting that biosimilarity is not sufficient for interchange.[3] So there's a whole different pathway if a biosimilar manufacturer wants to have interchangeability designation.

To support interchangeability, FDA guidance[4] indicates that the manufacturer is expected to conduct one or more switching studies that assess the safety and efficacy of alternating between the reference product and the biosimilar. As of July 2021, all 50 states passed legislation[5] to allow a pharmacist to substitute a biosimilar for the reference product with prescriber approval (though some states have conditions that need to be met prior to substitution).

Is that assuming that those biosimilars have completed the interchangeability studies before that?

Kathy Oubre: Yes, and for that particular legislation, we're typically talking about Part D products.[6]

How do you know if a drug has completed that interchangeability study, and has the ability to be interchangeable?

Kathy Oubre: Well, SEMGLEE® (insulin glargine-yfgn) is currently one of the only drugs that did this, but there's really not a lot of biosimilars that can be interchanged right now at your local pharmacy. I think they're looking at the road ahead.

Did pegfilgrastim go through that interchangability study?

Kathy Oubre: They didn't have to, no. But that's a Part B drug.

When I read about FDA approvals, I keep seeing something called the Biologics Price Competition and Innovation Act. What is that?

Kathy Oubre: The Biologics Price Competition and Innovation Act[7] (BPCIA) was established in 2010 to create an abbreviated approval pathway for biosimilars in the United States.[8] And because biologics and biosimilars are made from living cells, the development process is much more complex than it is for generics, which are chemically synthesized small molecules. And interestingly, a biosimilar requires the creation of a new manufacturing process and custom cell line. Since the reference product's manufacturing process is proprietary and not publicly available, that's really all it is.

What are some of the safety issues or adverse effects related to biosimilar use? If any?

Kathy Oubre: Well, because biosimilars are highly similar to the reference product, it should be less likely to see specific safety issues or adverse events in a biosimilar versus the existing profile of the reference product.

But all biologics, including biosimilars, have the potential to induce an unwanted immune response. And the impact of that immune response—which is called immunogenicity[9]—can range from no apparent effect to changes in pharmacokinetics,[10] which would be loss of effect or a serious adverse effect.

We talked about 80% biosimilar market share uptake within community practices. I would imagine that speaks very highly to how physicians view the safety and efficacy of these products.

Kathy Oubre: I think so. I mean, in the very beginning, we were a little concerned in the community oncology space. But we had the luxury of being able to see these drugs function in the EU for almost a decade. So even though we were a little concerned at first, we certainly had a higher comfort level when biosimilars pegfilgrastim and then the therapeutic agents were available.

We've talked a lot about biosimilars, their efficacy, and how a practice might consider their utilization. But I would imagine that a big factor in determining whether a biosimilar can actually be used is payer coverage. What is the role of the payer in the utilization of biosimilars?

Kathy Oubre: Well, we typically see the payers take a very active role in biosimilars, but it was really interesting from a community oncology perspective that we hadn't seen payers take an interest in formulary management until the biosimilars became available.

We saw that out of the gate in the pegfilgrastim space, and we saw that payers had preferred products. Then we started dealing with issues of preferred versus non-preferred products. And then some payers took the role of allowing biosimilars to have parity—Medicare being the biggest

"By being a biosimilar friendly practice, we actually saw increases in access to care."

payer that allows for parity—but what should the role of the payer be?

It should be to provide access to lower cost, high-quality medications with the goal of increasing access to care for their beneficiaries. However, over the years we've seen payers and pharmacy benefit managers (PBMs) put a greater emphasis on cost minimization when outcomes are equal.

So, it has trickled down to the practices on the physician level. And when you have multiple products within a space—pegfilgrastim or any of the monoclonal antibodies (mAbs)—the larger commercial payers have engaged in formulary management. For example, in the peg space, we have seven pegfilgrastim biosimilars currently on the market. That's a lot of different products to manage in one space. And I do understand that, but we've seen that the payers now approach pharmaceutical manufacturers and ask for rebates in order for the manufacturer to have access to that particular payer's formulary.

To be included on the formulary, a pharmaceutical manufacturer might offer the payer a rebate incentive. From a practice perspective, we have to be very diligent to ensure we are getting the authorized product. That's because the product the payer prefers will be authorized for their patients, and we have to ensure that patients are getting that authorized product at the point of administration.

How often do those formularies change?

Kathy Oubre: Most of them move maybe once a year, maybe twice a year. But some of the nimbler payers will move things on a quarterly basis, which is very challenging from an authorization standpoint.

Now to date, most of that would essentially be new treatments. Most of the payers don't want to get into the middle of changing drugs on a cancer care patient who is already in treatment and responding to said treatment. So usually if a patient is doing well on a particular product that was originally authorized, the payer will grandfather those in and then any new payer updates would be considered appropriate to apply to a new course of treatment.

Generally speaking, when a payer is managing a formulary and has some drugs in an un-preferred status, how many might you see in preferred status?

Kathy Oubre: Certain payers usually have one to three biosimilars listed in a preferred status. I see two being the most common number but almost no one other than Medicare—including most states' Medicaid—have engaged in formulary management. And Medicare is really the largest payer that allows for parity.

With Medicare, you can use whatever biosimilar you want. There's no formulary management. But what about Medicare Advantage Plans?

Kathy Oubre: I have seen that most Medicare Advantage Plans have engaged in formulary management as well.

What percentage of your Medicare population has an Advantage Plan?

Kathy Oubre: About a quarter—or 25 percent.

So, regardless of the payer or the circumstance, there's always the need to do benefits verification to ensure that the biosimilar that you want to use can be administered to that patient at that time.

Kathy Oubre: Yes, it's always very important to authorize the correct product for the correct patient. And then at the administrative level, when the pharmacist or the nurse goes to pull a particular product from the inventory cabinet, it's important to put some stop gaps in place to ensure that not only are you authorizing it, you're also

administering the approved product to the correct patient.

Because if you don't do that—if you administer an unauthorized biosimilar to the patient—you run a very high likelihood of not getting reimbursed. And these are expensive products, so a practice can only really afford to do that maybe one or two times before there's a financial issue for the practice.

We'd started this series by talking a little about how to adopt and operationalize biosimilars into a practice. What are some of the things a practice needs to take into consideration when putting biosimilars into a patient's treatment plan?

Kathy Oubre: I'll start with how we started operationalizing biosimilars into our organization. To do this, we followed the philosophy that it was important for all stakeholders within the practice to have a working knowledge of biosimilars. We started with our physicians and our nurse practitioners to make sure everyone had an understanding around the science behind biosimilars and why we were adopting them in our practice. And then we spent a lot of time with our nurses because, as most practices know, the patients and the nurses have a close relationship and they generally spend the most time together.

Our nurses needed to understand the "why" behind why we were doing this to their patients as they like to protect and take care of them, but we also spent time educating our financial assistance team because if they're making the phone calls to the patients, and obtaining information to be able to get financial assistance, we wanted to arm them with the "why" as well.

And you know, it's not about biosimilars as a less expensive product. We quickly dispel that kind of messaging, but what we were talking about—the way we messaged it to everyone—was the science behind the biosimilars and why they were beneficial. What we saw in our organization was that we were able to provide these high-quality, lower-cost products to our patients and to society as a whole at the practice level.

Every day, we deal with the term financial toxicity and what that means to our patients. By being a biosimilar-friendly practice, we actually saw increases in access to care—especially in the pegfilgrastim space, which is a product patients sometimes elected not to get on day two simply because of the high cost. But we also saw it be a lower cost alternative, even in the therapeutic space. And it really is important to be able to provide those kinds of things to our patients.

I kind of liken the effect of this to buying a car. Patients may have a $6,500 deductible and they're going to owe that. But the utilization of biosimilars, at least in our organization, helped lessen the financial blow up front. So, when January deductibles are due and you have a $6,500 deductible, the usage of biosimilars allowed patients to kind of stretch those payments or to pay into that deductible over a longer period of time. That helped alleviate some of that financial toxicity burden.

We're also dealing with inflation right on the heels of COVID-19. Some people lost jobs, some people had reduced wages, so those options allowed them to stay on therapy. We saw increased adherence. But it also helped alleviate that financial burden upfront, as patients were looking for ways to continue to pay rent or mortgages, and cover food and transportation costs.

What type of education have you had to provide to patients, if any, to help them feel more comfortable around utilizing a biosimilar?

Kathy Oubre: The FDA offered biosimilar education on their website, and a lot of the pharmaceutical manufacturers did the same thing. So, we shared what we could using sources like that. We were very upfront with our patients around the utilization of biosimilars, especially when we were moving them off the originator products. It also helped us keep track of utilization in our own practice.

My personal preference in our practice is to resend that information to a patient when moving them on or off biosimilars, or from an originator product to a biosimilar. Although these products are supposed to be biosimilar with no clinical meaningful differences, I feel better having informed consent—to protect our organization and to have a level of transparency with our patients.

Were there other early considerations around operationalizing biosimilars in your practice?

Kathy Oubre: Beyond educating our team and our patients about biosimilars, operationalizing these products within an organization starts with the payers because we have to obtain authorization for those products. Again, we're talking about parity preferred and non-preferred, and then it's important for a practice to have a discussion with those relevant stakeholders on how to appropriately pull these through.

So at our organization, we keep running quarterly spreadsheets in the

financial assistance office. That's the area of our business that also handles the authorizations of all of the payers and their preferred or non-preferred products or parity, per se. We also keep that information in the treatment rooms. So, when the nurses are pulling the products out, they are double checking, and we have a popup box that we built into our electronic medical records that says, "Are you sure you are giving X to Mr. Smith?"

I'm glad we did it because it created a brief little stop gap that gave our nurses pause to think, especially when they're carrying three pegfilgrastims, they've got 30 people in the treatment suite, and they're in a hurry.

Generally speaking, it sounds like the authorization process of starting someone on a biosimilar is not too markedly different than starting a patient on any other drug. You still have to go through the authorization process, you still have to make sure that the insurance company is going to approve that particular drug in that particular instance. Is that correct?

Kathy Oubre: Yes. I mean, these are just additional drugs we're incorporating into our organization. There should be no differences in obtaining prior authorization, but it is important to obtain that prior authorization for the specific product. Because again, if you administer an unauthorized drug to the patient, you run a high likelihood of not getting reimbursed.

And when you are doing a reauthorization on an existing patient, it is important to see if the payer still has that product on preferred or non-preferred parity. You don't want to get into thinking, "Well, they're going to grandfather them in," and assume you're correct.

You mentioned patient assistance programs. How robust are those types of programs in working with biosimilar manufacturers? And do you use them in your practice?

Kathy Oubre: Well, we use all patient assistance programs within our organization, regardless of the product. The only differences I can think of would be due to different manufacturers and their specific offerings. For example, to qualify for copay assistance, some may have a threshold of 300 percent of federal poverty level while others may set that threshold at 500 percent.

I do see that most biosimilar manufacturers have patient assistance programs—which they need to have to be able to compete in the space. Because certainly anything that the reference product offers from that side of the house would need to be available for an overall successful adoption of a biosimilar. It's also important to note whether these biosimilar manufacturers have free drug programs for uninsured patients: some may, and others may not.

And it's also important to note that if a patient is not eligible for manufacturer assistance, you may see some variations in what foundations offer. By which I mean, some may only offer assistance for the reference products, or they may only offer assistance for a very limited amount of the biosimilar they manufacture.

Thank you for your insights and for having this robust conversation on biosimilars with us. We appreciate it, and I know our practice partners will too.

Kathy Oubre: Thank you very much. I enjoyed it, and I hope it was helpful.

To learn more about biosimilars at AmerisourceBergen, visit: www.amerisourcebergen.com/manufacturer-solutions/biosimilars

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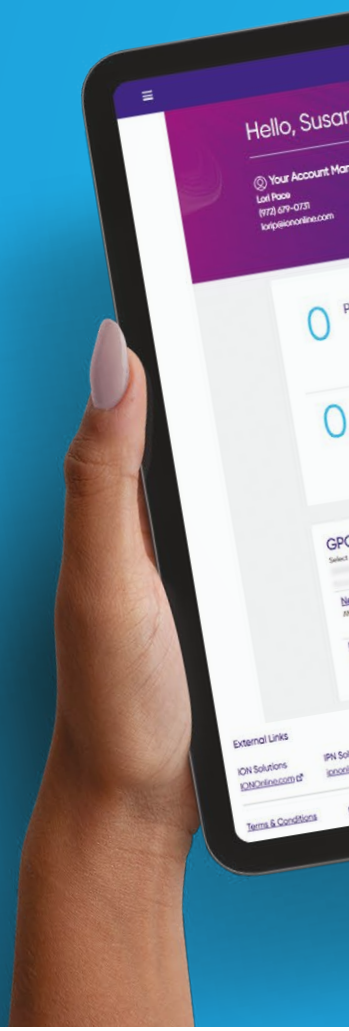

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Government affairs Q&A

The latest on Medicare Part B

Our experts weigh in on policy shifts and the potential impact to physician practices

We recently connected with our U.S. Policy and Advocacy team to get an update on Medicare Part B physician fee cuts, and we learned about newly introduced legislation that could lead to policy shifts that will have an impact for physician practices and manufacturers.

Let's start with a look at Medicare Part B physician fee cuts. In our last issue, we urged practices to prepare for cuts to Medicare physician reimbursement that were scheduled to take effect on January 1, 2023. What changed?

AmerisourceBergen U.S. Policy and Advocacy team: A meaningful portion of the cuts to Medicare Part B physician reimbursement that were expected to go into effect in the new year were averted in the end through the Omnibus Appropriations for Fiscal Year 2023 legislation[1] (officially entitled the "Consolidated Appropriations Act, 2023[1]"). Congress passed the Omnibus Appropriations on December 23, 2022, and President Biden then signed it into law on December 28. It's fair to say specialty physicians and their patients were able to make significant beneficial progress when this legislation passed.

What does the new legislation entail?

AmerisourceBergen U.S. Policy and Advocacy team: The Omnibus Appropriations legislation proposed a 4% PAYGO sequester of Medicare spending. It also proposed an annual application of the 2% Medicare sequester has gone into effect through 2031. Other significant aspects include:

- The 4% PAYGO sequester physician pay cut was stopped for two years.
- The 4.5% cut to the Medicare Conversion Factor (CF) in 2023 was lowered to a 2% reduction from the 2022 CF, with the cut rising to 3.25% in 2024.
- The value-based care incentive for participating in Advanced Alternative Payment Models (APMs) was extended, although the add-on will be 3.5% versus the 5.0% currently provided.

Our team also notes a 4.48% reduction in the Medicare physician fee schedule conversion factor, which accounts for the expiration of the temporary 3% pay increase for physicians in 2022. And budget neutrality requirements led to another 1.48% cut.

This sounds like good news for physician practices. What else do practitioners need to know about Medicare Part B physician fee cuts?

AmerisourceBergen U.S. Policy and Advocacy team: First, we'd like to assure our physician partners that our team will continue in our efforts to further educate and inform Congress on how inflation and reduced reimbursements will impact access to quality care. It's important to note that during our concentrated advocacy near the end of 2022, we heard clear indications that the new Congress will consider solutions to avoid the ongoing concern of continued physician fee cuts. We'll remain engaged in that policy discussion and will continue to keep this community informed.

The Inflation Reduction Act drew a lot of attention at the end of 2022. What's next for 2023?

AmerisourceBergen U.S. Policy and Advocacy team: After the passage of the IRA, the federal government is taking steps to implement the law into action, and these actions will have significant

bearing on AmerisourceBergen and our customers. In February, the Department of Health and Human Services (HHS) announced that the Centers for Medicare and Medicaid Services (CMS) would aim to lower the cost of prescription drugs by testing three new payment models.[2] The Center for Medicare and Medicaid Innovation (CMMI) plans to test models that intend to:

- Encourage Part D plans to offer Medicare generic prescriptions at $2 or less.
- Cut Medicaid costs for cell and gene therapies through multistate outcomes-based agreements with manufacturers.
- Impose Medicare payment restrictions on medicine approved through the Food and Drug Administration's accelerate approval pathway to ensure safety and efficacy.

These models are expected to build on the drug pricing reforms put forth in the Inflation Reduction Act (IRA).

- The generic drug model is intended to encourage Part D plans to offer prescription drugs for $2 or less per month per drug for a standardized list of generic drugs that treat chronic conditions. The model will also test whether a standard list of high-value drugs could improve access and adherence. If CMS leverages existing systems, implementation could happen quickly.
- The cell and gene therapies (CGTs) access model would allow state Medicaid agencies and CMS to coordinate and administer multistate, outcomes-based agreements with manufacturers for certain CGTs. The model will account for clinical evidence, pricing data, and utilization patterns and may allow for outcomes-based payments, outcomes-based rebates, or outcomes-based annuities. Beyond measuring for outcomes, it would hopefully improve access to CGT for Medicaid beneficiaries. The intent is to launch in 2026.
- The accelerated approval model would allow CMS to consult with the FDA to develop Part B payment methods for drugs approved through the accelerated approval pathway to encourage the timely completion of confirmatory clinical trials and access to post-market safety and efficacy data.

CMMI is also researching other potential models[3] that could align cost sharing and payment incentives for biosimilars, create shared savings arrangements for therapeutic classes, or adjust payment methods to increase competition and investment in biosimilar development. And CMMI will explore opportunities to build on previous efforts to encourage price transparency for prescription drugs so providers and beneficiaries can work together to consider the best options for every patient.

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Roundtable discussion:

How payer models and metrics can contribute to more equitable care

A conversation with Natasha Clinton, Senior Director of Medical Affairs at AmerisourceBergen; Alexandra Chong, PhD, Social Science Research Analyst at CMMI; and Angella Charnot-Katsikas, MD, Medical Director, MolDx and Chief Medical Officer at Palmetto GBA.

AmerisourceBergen's inaugural Health Equity Summit brought together cancer care executives, physicians, patient care leaders, decision makers, pharmaceutical executives, and payers to share insights and ideas. This conversation was part of that unique program, raising critical ideas to consider in transforming the cancer care landscape for underserved populations.

Natasha Clinton: Alexandra, let's get started with a look at the Enhancing Oncology Model. Can you define that model for us, and share why that's of interest as we're exploring ways to address health equity?

Alexandra Chong: Sure. The Enhancing Oncology Model (EOM)[1] is a specialty payment model in the oncology space at The Center for Medicare and Medicaid Innovation (CMMI) in which the Centers for Medicare and Medicaid Services (CMS) is the payer or Medicare is the payer. EOM is a voluntary total cost of care model for chemotherapy episodes that seems to improve patient-centered care. It is also the successor to the Oncology Care Model (OCM), which ended in June 2022. In building off that OCM experience, we had goals of improving the patient's experience as well as providing some cost savings to Medicare for EOM.

We looked to answer two primary questions in the cancer care space. First, we want to know when oncologists or care providers are held financially accountable for total cost and quality. Do they increase the use of high-value care—such as making a choice to prescribe lower cost drugs, which includes things like generic biosimilars—while improving the patient experience? Are they putting patients at the center of a care team that provides high-value equitable evidence-based care, and are they improving that type of care coordination as well as health outcomes?

As many are aware, there are so many stark inequities and disparities that exist within cancer care. And one of the new elements—or a strong focus within EOM in comparison to OCM—is having a health equity strategy in which we strive to reduce those disparities and close some of those gaps, particularly for patients who are undergoing active chemotherapy treatment.

We have a lot of our health equity strategy embedded within EOM. Some examples of this are things like the inclusion of a safety net population, and really trying to target participants that did not previously participate in OCM, especially those who serve underserved populations or may have practices in rural or remote areas. We also have flexible rules around who can participate, or the allowance of providers seeing patients in different settings, such as in critical access hospitals and federally qualified health centers. We also provide some resources for the per beneficiary per month payment that we typically provide for the provision of enhanced services. And these would be for dually eligible beneficiaries for Medicare and Medicaid.

Another component within EOM that we are explicitly identifying and addressing are things like health-related social needs, and to that end, we have implemented reporting for sociodemographic data. I think what we heard in our experience with OCM is that when participants receive data from CMS, it has been enormously beneficial in offering insight into their patient population. So, when thinking

about model design and these types of payment models for EOM, we want to be a partner in data sharing.

We also have plans within this model as well to share data that's stratified by sociodemographic variables. The idea is to offer a better understanding of how those factors play into achieving equity.

Natasha Clinton: Thank you so much for sharing that. Angella, as we think about equitable care delivery, can you share some of your thoughts related to payment model design, and what's needed to support the care delivery that happens in the community oncology setting?

Angella Charnot-Katsikas: Sure, absolutely. So, we know that understanding data drives change in many ways, but it isn't a one-pronged approach, and it's not a top-down approach. It's more of a multi-pronged approach, and so we can't expect just government or just industry to fix things.

To look at a payer model, first we have to look at the disparities,define them, and address them. And to do that, I think we have to cast a very broad net. For example, there's poverty, there's lack of access, even when hospitals are five minutes away. But there's violence, too. We have to remember that some people are afraid to open their doors at night, or open their doors in the daytime even, and walk to a bus stop. There are a lot of things to address.

Physician and patient education is another important component, and I can't stress that enough, because part of the model is going to include payment for physician services. And if the physicians aren't aware or motivated or educated on what they're supposed to do and how they're supposed to provide those services, then we can't really structure a model around that.

At the end of the day, the model is going to be evidence based. So, we have things like National Comprehensive Cancer Network (NCCN) guidelines[2] that help address this, and the models will have to be molded to fit the information. And then the last thing I want to say about that is that it's a feedback loop, right? So not only do we have to understand the problem and define the problem, then we have to measure the problem and implement change. Without that feedback loop and without that flexibility, we won't see where the imperfections are and where the flaws are even within the best models.

Natasha Clinton: Thanks, Angella. You know, it's interesting that both you and Alexandra touched on the need for data and the need to truly understand what's happening. I'd like to ask each of you, are there gaps in the data and in patient-level insights that, if captured, may help us to better understand factors that are impacting population health and inequities in care?

Alexandra Chong: I think data-driven experiences—in terms of motivating physicians and providers—can be a very powerful tool. And I think as we have begun to think a little bit more about the inequities that exist and how we can address it as a society, it makes sense for us to link data to that type of evidence-based care to help support our efforts in those areas. But I think it can be really challenging as well. One area within CMS that's part of our health equity strategies across not just EOM as a cancer delivery model, but across so many of the models that are coming out of the innovation center, is collecting sociodemographic data. That can then serve as the foundation upon which we learn and strive to achieve equitable care.

For instance, at the innovation center, we largely rely on a lot of our claims data. So, claims data that provides information regarding the services patients receive—the diagnoses, the treatments, all those kinds of things—offers a lot of rich information. But I think in seeing that disparities exist within cancer care, we need to prioritize trying to best profile what that care may look like by linking it to that type of sociodemographic data.

Getting back to that feedback loop Angella was talking about, we see the cancer profile but then we really need to look at the profile, the beneficiary, and we just don't have that level of data quite yet. And payment models are an opportunity through which we can try to receive that type of sociodemographic data. I think we can see where the gaps are, but one of the challenges that we are going to be facing is linking that new data with existing data we have through Medicare.

Natasha Clinton: Thanks, Alexandra. Angella, what's your perspective?

Angella Charnot-Katsikas: In thinking about the gaps, I would structure it in this way. There are things we know that we don't know—we know there are gaps. We know, for example, there are gaps in genomic data across populations. Although the data is growing and the genomic level information is growing, much of the information is from North America or Europe. So we're missing key elements of the population in our genomic data, such that when we're doing testing or biomarker support, that really needs to be predicated on good global data. We also know there are gaps in physician education and patient

"I think the relationship between provider and patient is so key and so critical in our goal of improving health equity."

education. It's well-published that doctors—depending on where you practice and how you practice—just don't know how to address the issue of the rapidly evolving field of genomics, for example, which is critical to any patient with cancer or to a patient with a predisposition for cancer.

So if a doctor doesn't know, and a patient doesn't know, then nobody knows, and that means nobody's getting the correct care. Those are some of the gaps. This can happen even with well-identified genes like BRCA 1 and BRCA 2.[3] About 90 percent of doctors know exactly what those genes are and what they do to people, and what you can do to prevent cancers that result from them. But a much smaller percentage of doctors will refer for the appropriate testing, even in those patients that probably have a gene like BRCA 1 and 2, if not those exact genes themselves.

Those are some of the gaps we're aware of, but we don't even know what gaps we're missing in some cases. That's where I come back to that feedback loop so that when we have some data, we try a model—and that model may or may not work. If it doesn't work for some reason, then we've missed something and there's a gap there that we haven't identified. That's where we'd have to come back and take another look and understand further. We'd have to go to the source: to the patients, to the doctors, to the practice offices, to understand what's happening. Otherwise, it'd be impossible to identify those unknown gaps.

Natasha Clinton: We've heard a little bit about what program or model design needs to look like. We've talked about the data, but how do we know if the model is successful? How do we measure that?

Alexandra Chong: That's a difficult question to answer in so many ways. I think the issue of self-equity has long been something we need to address, and in more recent years that's been at the forefront of our priorities. In my experience at CMS and in talking with physicians and oncology stakeholders, the number one way that we can start measuring access is really establishing and acknowledging a baseline metric of care, health outcomes, symptom management, and equitable access to care and treatment across patients.

I think part of that also comes from acknowledging, recognizing, and identifying where those disparities may potentially exist within your community, within your practice, and within the patient population you're seeing. And I think it's also important to continuously measure how those metrics are changing over time based on concerted implementation efforts to improve and meet that goal of equitable care. So it's about identifying where those specific or unique gaps exist and acknowledging that they are going to exist within your community, your practice, or your patient population.

I think a lot of times oncology care is focused on treatment and improved outcomes, and survivorship—which are top priorities. But taking a closer look and seeing how those things differ across various characteristics or variables is a good beginning for us to try to measure that success.

Angella Charnot-Katsikas: In thinking about how we can use this model to address equity, there are certainly metrics we can provide to measure things like disparities by zip code. If those numbers improve or that gap closes, then that that's a win. Similarly, we can look at metrics around doctor referrals for genetic counseling services or for subspecialist care. It's not easy for patients to get to a subspecialist—sometimes it's not easy for them to get to a primary care physician, either. As payers, we expect the same level of care for everybody. Now, we still have to consider the barriers because they are there and they are significant, but that isn't an excuse to allow for substandard care. So those metrics can include things like referrals to the appropriate specialists.

The evolution of genomics[4] is just huge, right? And it's a key part of the oncology care network, or ecosystem. But patients have to reach out to understand how to find those resources, and those types of referrals are key for cancer screenings. So those metrics are certainly ways to measure progress in that regard.

Natasha Clinton: Thank you both. We've talked a bit about the importance of engaging providers and payers. As we continue to learn and grow and try to address this issue together, how do you think we can work together at the provider level and the payer level to strengthen relationships and create meaningful change?

Alexandra Chong: I think the relationship between provider and patient is so key and so critical in our goal of improving health equity. I think the best way for payers and providers to really support cancer patients is to instill or encourage ways in which we can listen to patients.

I think listening to patients and giving them a voice to engage with their caregivers at every step of their care is crucial. It's also critical in any type of payment model to assess what unique barriers or concerns exist to improve that patient experience. For EOM and OCM, for example—the two payment models coming from CMMI and CMS—we have requirements that are meant to facilitate a very strong, collaborative relationship on difficult topics. We do this to encourage discussions with patients on topics that are really hard to talk about. This could cover topics like prognosis, what the out-of-pocket cost of treatments are like, their challenges around access to care, food, or housing insecurities. These things should be discussed with patients and patients should be involved in fair decision making. But I think something I have also heard from a lot of patient advocacy groups is that it's not fair for us as a payer or provider to put that responsibility or onus on the patient themselves. So while it is a collaborative relationship, I think there will be varying degrees of comfort around speaking up about their treatment plan or voicing their concerns on their care, or even sharing information about some of the access or barrier issues they may experience.

We need to meet somewhere in the middle where providers and caregivers are asking patients about this. For example, CMS hosted a roundtable discussion for the cancer cabinet as part of the cancer moonshot initiative. A common theme that came up was that so many patients feel as though they don't have a voice in their care journey and that's something that needs to change. If we can provide that type of incentive as a requirement, perhaps through a specialty payment model or an infrastructure that could be set up to encourage those types of conversations, I think that could be a win-win situation all around.

Angella Charnot-Katsikas: To add to some of this, one way to measure success is by exactly what Dr. Kashyap Patel is doing in building a care ecosystem with No One Left Alone (N.O.L.A.). I can't tell you how often I've seen patients that don't have family members that can help them at home, or that just don't have anyone to advocate for them. And yes, there are patient advocates in hospitals, but unless someone reaches out to them, they don't even know that patient exists. There are ethics groups in hospitals, but unless someone reaches out to them, that patient goes unnoticed. There are so many people that just don't have anyone to speak for them when necessary.

And this isn't even considering all the disparities we talked about, but being ill is like a disparity in itself because by being ill, you can't hear everything, you can't speak everything. You need somebody to help you. That's amplified a thousand times when you have various other barriers working against you, like the disparities we've already discussed.

We talk a lot about patient support and that's critical, right? I've been a patient, I've been a doctor, I've been a payer, and we have to have support for every one of those roles at every level because even the doctors can't do everything. There just aren't enough hours in the day. As payers, we have to remember to ask ourselves, how do we support them to do the right thing? That could look like a network of physicians. They should collaborate, and there should be support at that level as well.

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