Assessing Cost vs Margin of Care for Cancer Drugs in Pharmacy Practices

Scott Soefje, PharmD, BCOP, FCCP, FHOPA, MBA, addresses some of the key steps pharmacists should take when conducting a financial analysis for cancer drugs.

Pharmacy Times interviewed Scott Soefje, PharmD, BCOP, FCCP, FHOPA, MBA, director of pharmacy cancer care at Mayo Clinic, on his presentation at the Hematology/Oncology Pharmacy Association (HOPA) Annual Conference 2024 in Tampa, Florida titled "The Great Financial Debate: Cost vs Margin for Cancer Care Drugs." Soefje discusses recommendations for pharmacists when conducting a financial analysis for cancer drugs and calculating cost.

***Pharmacy Times*:** What are some key points pharmacists should understand regarding this debate of cost vs margin for cancer drugs?

Scott Soefje, PharmD, BCOP, FCCP, FHOPA, MBA: I think what we were trying to show in our presentation was that there's no real answer. There are times when you look at cost and it becomes your driving factor. There are times when margin has to be looked at. I think what we would like to see is health care get to the point where we're trying to drive down the cost, but we do it in a way where we're not losing money. I think it's not fair to ask an institution to use the lowest cost drug if that drug is not getting the reimbursement for the cost of the drug. So, I think what pharmacists have to understand is, it's not one or the other. It's how do you put this together in a balanced approach to make those pieces work together.

***Pharmacy Times*:** What are some of the key steps for pharmacists when conducting a financial analysis for cancer drugs?

Soefje: I think the first step, and the hardest step, is getting is gathering the data. What do the drugs cost? What are you being reimbursed? What are your major payers paying for? What is something simple as your payer mix, between government and commercial insurance? Putting all of that information together becomes very difficult. So, what it generally means is that you get involved with a whole bunch of different stakeholders. You're going to talk to finance, you're going to talk to purchasing and reimbursement supply chain, however your institution is set up. So those are some of the big key steps is getting that information together.

I think the other important part is 'Okay, I've gathered all the information and I've run my numbers, I can show what our costs are, I can show what are what are reimbursement and margin is, what is it that the administration is going to want to see.' Is your organization focused on cost? Is your organization focused only on margin? Are you willing to take a balanced approach in between? What is your basic philosophy on how you're going to approach these financial tough discussions. Then I think it's also very important for you to present the analysis, present some options, present alternatives, and then choose one and go with it.

But the analysis doesn't stop. Then once you implement it, then you got to reanalyze it to see are you getting what you thought you were supposed to get? And then it becomes that sort of QI type circle, where you're constantly reanalyzing and readjusting and reanalyzing and readjusting. The caveat with all this though, is there's a cost to change. So, you got to be careful how often you're

changing things. And so, it's this balance, again, that's coming back to is it cost or is it margin that's driving your decision making.

***Pharmacy Times*:** How would you recommend pharmacists calculate cost in a cancer drug financial analysis?

Soefje: I'm going to tell you the real world and the perfect world. So, let's start with the perfect world. In a perfect world, you would know what it costs your organization to buy the drug, you would know what your discounts are, you would know what your rebates are, and how often they're paid and when they come in, and that would go into calculating your total costs. The problem in there in the real world is we generally can figure out what we're paying for the drug from an acquisition perspective. What we don't always know is the rebate perspective of it because the rebates tend to come in later, some companies lump their rebates altogether, so you get one big check for from one company for all of the drugs for that company. So how do you know which one attributes to each drug? If you're like us, we have some hospital-based clinics, some infusion-based clinics, we get different rebates for those, but it may all come into one group. So how do you figure that all out? So, a lot of times the rebates become a real problem. It's probably best in that scenario just to not even worry about the rebates, just kind of figure that that's money coming later, we'll worry about it [then]. It's going to be at least this amount, and at least this margin based upon what I can show, and I think that's the best way to go at this point in time

The final kicker to all of this though is we tend to focus on the cost of the drug and forget there's a whole lot of other things that go along into compounding and preparing a drug: needles, syringes, alcohol wipes, the electricity to run the infusion center IV hood, the soap to wash the floor and the ceilings and the walls, the people that you pay to do all of that kind of work, and the technicians and pharmacists that are preparing the products. All of that is a cost that gets added somewhere, and our margin has to pay for that. I would argue most of us don't know what the cost is to run an infusion center, and it's probably something we should look at and at least develop some sort of benchmark around to say it needs at least this amount of recovery to be able to offset those costs.

***Pharmacy Times*:** What are some of the key financial information needed when calculating margin, including revenue generated by the different types of reimbursement?

Soefje: You need to know the cost, and you also need to know how many units you use, and in an ideal world, you'll need to know your payer mix. Because the reimbursement from your government side and your reimbursement from the commercial side are different. So, you need to know how many units to allocate to commercial, how many to allocate to payer. And then if you really want to get accurate with this, then you would go into your payer mix, and you would look at what percentage does each one of the units go to each one of your payers, and what percentage of reimbursement are they paying you—and you would really get an accurate number. Many institutions will go and just divide it into government and commercial and have an average reimbursement based upon government, we average this amount for reimbursement, and that's generally close enough when you're making these kinds of calculations. Sometimes

pharmacists—you know, we're precision oriented. So, we want that exact number, and sometimes it's extremely difficult to get.

The other problem around this sometimes is you also got to look at your denials. Just because you got prior authorization doesn't mean that was actually paid for. So, it's one of those things, how often are you getting denials? Are your denials being ultimately paid for? What percentage don't get paid for? What is written off as bad debt? All of that then has to go into this total calculation at some point in time.

***Pharmacy Times*:** What are some of the steps needed to decide which product should be the "preferred" product based on a financial analysis?

Soefje: I wish it was as simple as to say, 'We're going to pick the cheapest product, that's our preferred product.' It's gotten a lot more complicated than that, particularly, in our talk, we use the biosimilars as an example. The biosimilar market has gotten really, really complex. There are multiple cases now where we are losing money when we dispense a biosimilar to the government, but we still make money when we dispense it to the commercial insurance. So, you're having to say, what's the balance here. So, it's not just looking at the cost, it's looking at the revenue, it's looking at the margin, and the final result, and it's figuring out what you need to do to say, 'Okay, we're willing to choose this one as our preferred product.'

It may also be things like, what is your contract with that company? How reliable has a company been in delivering the medications? Is your institution willing to spend more money, because they can make a little bit more margin on the back side? A lot of those things then come back to that philosophical discussion about how you're going to approach this. As I said earlier, the cost of change isn't cheap, so changing from one preferred to another may be something that's a little more costly than you think it is. So, you got to make sure that if I'm making that change, I'm not adding to those overall total costs. And I actually ended up losing money because it cost me more to change than I gained. And I think this is the kind of thing that people are looking at. Then from a clinical side, people don't like it when we change preferred products too fast. So again, it's what's that cadence, what's that sequence, that you're going to be looking at it to make that change, and how do you pull that off.

***Pharmacy Times*:** What are some of the differences in site of care to be considered, such as inpatient care, hospital-based infusion centers, physician-based infusion centers, and home care?

Soefje: It's one of those things that's really starting to rise to the top as a focus of financial analyses. So, the first step in all of this is that there are different reimbursement patterns depending upon the site of care. Inpatient is typically capitated DRG [diagnosis related group]-based for the government. And then in most cases, it's some sort of fee for service percentage of care reimbursement for commercial.

Hospital-based you have the ability to charge a facility's fee. Whereas in physician's practice, you don't always do that. We're finding that in physicians practices, they generally bill or charge less than hospital-based outpatient clinics do, but they also get the drugs cheaper than hospitals do.

Then home infusion tends to be almost exclusively through the pharmacy benefit through some sort of specialty pharmacy that's buying the drug and using it for home infusion. So, you got different prospects on how things are being reimbursed. There are different rates that things are being reimbursed. There's also differences in the cost of the drugs, when you purchase them between the pharmacy, the physician-based practice, and the hospital setting.

The new kicker to all of this is that payers are making demands. Now, payers are saying, we will not pay for a hospital-based practice. Or if you're going to do hospital-based practice, you have to white bag the drug, meaning they're going to send it from their specialty pharmacy. So, you sometimes have to move patients into a different site of care just to be able to be reimbursed at all, and those are the complexities on how you look at this, how you make it work, and how do you put it together? And how do we make sure that patients are getting the right drug at the right place at the right time, so that the reimbursement flows through the way you want it to?

***Pharmacy Times*:** How would you recommend pharmacists go about including considerations of both cost and margin when determining the drug therapy for patients?

Soefje: I wish we had the electronic systems available to us now that when a pharmacist pulled up a drug, they could see exactly what the whole treatment plan was going to cost. Most of us aren't at that point. So, I think it's having a good understanding of how these processes work. You may not know the exact numbers; I may not know exactly that this drug is going to cost less than this drug. But I know that this drug is relatively more expensive than this one. Insurance is pushing back on hospital-based practice on drug A, but they'll pay for drug B. The rebates are better, or the reimbursement is better. I think learning those kinds of things and just getting a general overall kind of high level picture so that you can then help make the best decision. I think it falls back on to the formulary managers, the leadership of the institution to really identify those preferred products and explain why they're the preferred product so that the pharmacist can pass that on to patients, pass it on to providers as necessary.

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