John Marchica:

Welcome to season four of Health Care Rounds. Here we explore the vast and rapidly evolving healthcare ecosystem with leaders across the spectrum of healthcare delivery. Our goal is to promote ideas that advance the quadruple aim, including improving the patient experience, improving the health of populations, lowering the cost of care, and attaining joy in work.

I'm John Marchica, host of Health Care Rounds. I'm also the CEO of Darwin Research Group and faculty associate at the Arizona State University College of Health Solutions.

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My guest today is Ameet Wattamwar, Director of Specialty Pharmacy for NYU Langone Health. Prior to this role, he was Vice President of Client Strategies for PHS, AmerisourceBergen's health system facing consulting arm, where he specialized in specialty and ambulatory pharmacy development, 340B optimization and other pharmacy centric cost savings tools and efficiency-focused initiatives. Ameet has also consulted for pharmaceutical manufacturers, in addition to practicing pharmacy across various care settings.

John Marchica:

So, Ameet, first I have to ask ... We're going to be talking a lot about specialty pharmacy today ... But talk to me a little bit about your COVID-19 journey from when you started, when things started to peak, to where you are today. I think folks would be curious, especially because you were at the epicenter for a while there.

Ameet Wattamwar:

Yeah, sure. It's definitely been quite a journey. As you're aware, New York State was one of the first hotspots that this really grew quite quickly in the United States. Fortunately, I think we're kind of on the other side right now if we're talking about a first wave. We were in a position not very long ago where almost all of our surg spaces in our hospital locations were almost fully utilized. At the time the Governor had put out an ordinance indicating that hospitals needed to significantly expand their capacity to accommodate COVID patients. So we reacted, and our facilities department did incredible job converting almost every square foot available into a patient care area. Now we're at a point in New York State or at least in New York City with our health system where, I think about a week or so ago, there was 50 COVID patients within our facilities. That number actually might've dropped a little bit since then.

It's interesting now to see what's happening around the rest of the country. I think everyone knew that it would spread naturally, but I think it took a little longer than most of us expected or at least I did. Now looking at what's happening in Texas and Florida, it's very reminiscent of where we were in April and May. I think one of the pivotal reasons why we've been able to, I guess, kind of come out in a better place right now is just because of all the social isolations that were put into place. I think by following those, we've been able to really help mitigate the spread of the disease.

John Marchica:

I was just going to say, I'm in Arizona as you know, what advice would you give to a health system leader? Someone, let's say, a head of pharmacy out here at Banner? While we're going through it, what advice would you give to that person?

Ameet Wattamwar:

Yeah, so a lot probably. Depending upon who we're talking to in the health system, there's probably different advice that our health system would be able to provide. When speaking to someone within pharmacy specifically, one of the most relevant items are identifying drug shortages. What medications do you need? What do your wholesalers have? What's the delta? And to quickly identify other sources of procurement, and the specialty pharmacy is actually uniquely situated, I think because at least in our program, we've realized that we need to be able to order medications from multiple distributors. The health system was actually able to lean on the accounts that we already had in place to quickly place orders and pull in the life-saving medications that we realized we needed to have as fast as possible.

John Marchica:

So Ameet, when we get into specialty pharmacy, there will be listeners that don't understand what a specialty pharmacy is compared to, let's say, a typical hospital or retail pharmacy. So can you start by spending a little time explaining the differences and just talking about what a specialty pharmacy does generically.

Ameet Wattamwar:

Yeah, absolutely. I think that, that's a really common question. I would say that if you asked an executive at a health system five or six years ago, “What is specialty pharmacy and is it important to you?”, most of these executives probably would first ask, "Well, what's so special about this pharmacy?" So a lot of people still are unclear on exactly what the role of a specialty pharmacy is. But I think what we're finding now is as more and more patients are starting specialty medications, there's increasing awareness.

So I would say there's a couple of key fundamental differences between a health system-owned specialty pharmacy and your traditional retail pharmacy. I think at the end of the day, it really comes down to patient engagement and a level of handholding that most retail pharmacies just simply don't have the infrastructure to support. I think maybe to really articulate that, I can just give you a quick summary on well, what does the NYU specialty pharmacy program look like?

So at our institution, our specialty pharmacy team is actually broken down into three separate units that all work together with our clinicians who are providing care for our patients. So the first group that we have are what we call pharmacy liaisons. We embed these liaisons into our specialty practices, and they complete some really important administrative tasks associated with onboarding a patient onto a specialty medication.

So what are these tasks? Well, I would say almost every specialty medication requires a prior authorization. Prior authorizations are when you work with the patient's PBM to get approval to provide a specialty drug. Just simply because of the cost of these drugs, the PBMs want to make sure that it is the appropriate therapy. Unfortunately, that process takes quite a bit of time. Before we created our program, getting a PA approved so the patient can start the therapy was really the responsibility of our

providers in a practice and perhaps the receiving pharmacy. There's a lot of problems with that. Our providers in our practice, they have important things to do, and that takes away from patient care. When the pharmacy is trying to complete a PA, they don't have all the clinical notes. So patients were sometimes waiting up to two weeks or longer for a PA to be completed.

John Marchica:

Wow.

Ameet Wattamwar:

Yeah. Right. If you think about that, if your doctor just told you have cancer and you need to start this medication right away because it will save your life, and if you're standing on the sideline for two weeks, imagine what that's like after getting this diagnosis. Even at its core, just something as simple as getting a patient their medication approved and getting it in their hands is so important because you lose a lot of patients in that process. So with our specialty program, 80% of our patients get a PA approved within 24 hours now. So the time to start the therapy is dramatically faster. You've freed up your clinic staff, and now they can practice at the top of their license, actually treating patients versus getting bogged down with paperwork.

Another important role of this field-based team is understanding the financial impact on the patient. It's so important when you think about the high cost of specialty medications.

John Marchica:

Sure.

Ameet Wattamwar:

So, our pharmacy liaisons actually can check with the patient's benefits and identify exactly what the patient's copay is even before the doctor prescribes the therapy. That's another huge, I think, important point. It's a distinction between most retail pharmacy services and specialty because the doctor can find his lifesaving therapy, but if it's going to cost the patient thousands of dollars a month, most patients can't afford that or they'll go bankrupt in the process.

John Marchica:

Right.

Ameet Wattamwar:

So, our liaisons are trained to identify all sources of financial relief for our patients. So they look at manufacturer sponsored patient assistance programs. They look at other financial assistance offered by manufacturers. For patients that are not eligible for that kind of support, they also are very tightly intertwined with our local and other federal grants, charities and foundations that provide financial relief. So patients billing through the NYU Health System specialty pharmacy, their average copay is actually less than $8. Such, I think, a true testament to the work that they're doing. Since January of this year, we've actually secured over $41 million worth of financial assistance for our patients. If you think about it, that's so much money. Those are patients that might've fallen through the cracks.

This team again ... Just to close off on the liaison. They're completing this administrative task. Then they go back to the doctor and say, "I've got the PA done. The copay would have been X hundred dollars. Now it's $8. And we can now send this to the specialty pharmacy," either our NYU pharmacy or an external pharmacy if the patient prefers. But the most important thing is we know that whenever it gets to the pharmacy, it's going to be acted upon very quickly because the hard work has been done.

John Marchica:

I wanted to just even go back to the basics even more. So what defines what a specialty medication is versus a traditional drug?

Ameet Wattamwar:

That's a really great question also, and you're going to get a different answer wherever you look. There is no one definition, but what's a symptom of a specialty drug? It's a drug that is kind of a complex therapy that involves additional monitoring and oversight for a patient. It could be simply because of the toxicity profile of the drug or whether it's something that has some other clinical concerns that you need to keep close eyes on. That's one.

It could just be simply the financial cost of the drug. Very, very expensive medications are typically bucketed as specialty because there needs to be an enhanced level of stewardship before the medication's prescribed. Obviously the cost of these medications have a very significant impact on just the cost of healthcare in general. So payers, PBMs who are paying for the medications really want to ensure that, that's an appropriate therapy.

There's a whole host of other, I guess, classifications. But again, like I said, if you talk to a payer, they may kind of have one interpretation. If you talk to a clinician, they might have another interpretation. But I would say that the two biggest attributes are the clinical profile and cost.

John Marchica:

So, does it also align with certain specialties, like in oncology or rheumatology?

Ameet Wattamwar:

Yeah, absolutely. So typically your specialty medications, you're going to see in therapy areas like you just said. Oncology, rheumatology, multiple sclerosis, pediatrics. So we have started our program actually in just those same disease states, and now we continue to grow. Looking at hemophilia, looking at PAH, growth hormone medications, and the list of medications that are actually coming to market that are now considered specialty is growing year by year. If you look at the pipeline of drugs coming out, it's predominantly specialty at this point.

John Marchica:

Thinking about the specialty pharmacies that are owned by some of the big box retailers, what's your value proposition and what are the key differentiators between, let's say, an IDN-owned specialty pharmacy and one of these external big box SPs?

Ameet Wattamwar:

Yeah. I would say that you can boil that down to two major points. The first is proximity to the patient. Having that relationship, seeing them in person, knowing them and following their health care and their progress in real time, incredibly important. It's not just a name and a prescription number.

Two is having access to the EMR. Having access to the EMR is entirely, I would say, the biggest game changer that we have because now we're not just reactive. We're leveraging the EMR to confirm that we are really moving down the proper path for each individual patient by leveraging all the clinical information we have. So, kind of going back to what I was saying before, I think it's pretty related. So what is the value proposition? It's clearly having that incremental clinical support. I was saying we have the liaisons. That's one team. The second team is our dispensing pharmacy who also has access to the EMR, and they can do a sound clinical review.

But I would say the third team is actually the key differentiator. So this is our clinical pharmacy team that uses data analytics to risk stratify every single patient that fills through our pharmacy. After risk stratifying patients, we can determine the level of engagement that's appropriate to ensure that our patients are receiving the best possible care. So real world example. If after we risk stratify our patient, we identify that a patient's a high risk ... So an example might be perhaps an elderly woman, borderline dementia, not the greatest support structure at home ... We might need to call her every day, and we work with the patient to figure out what they think makes sense. But if the patient, the family, the caregivers, everyone thinks it's good if you just call her every day at 3:00 PM, remind her to take your medication, we're absolutely going to do that.

We also develop tailored questions that's for patients, depending upon the drug they're taking, their disease state, and our clinical pharmacy team documents all the patient responses to the questions in the EMR. Now when a patient comes back to see their provider ... Let's just say they saw the provider in January ... They might not come back to see them until April, but now the provider has several months' worth of progress notes at their disposal, which they can use to make informed treatment decisions. Also, because of this level of engagement, we're really probing and we're trying to provide preventative care versus being reactive. We can see that, okay, based upon what the patient's saying, I'm identifying these red flags. We bring that right back to the provider, and we create interventions and we document all of our interventions. This year, we've had hundreds and that's lead to improved clinical care. It's also helped reduce the cost burden on the payer as well because now we're preventing that readmission or perhaps organ rejection, etcetera.

John Marchica:

We're in the midst of a ... We do a quarterly survey, an online survey as well as some qualitative interviews with health system executives, including pharmacy directors. In our most recent one, we asked a question about adherence, thinking that COVID may have some kind of impact on adherence. One of the things that surprised me was that 90% of pharmacy directors said that patient adherence was maintained or improved. Actually, I think it was closer to 95. So there's very little drop off. I'm wondering if you think that, that could be a result of the kinds of outreach that you described with that elderly woman and having those daily phone calls. Do you notice in this COVID environment whether your specialty pharmacy did anything different or do you think that you'd been providing that ... How do

I say it ... A higher level of customer service? Or would you say it's about the same? By the way, my hypothesis, do you think that, that's correct about why adherence is at such high levels?

Ameet Wattamwar:

Yeah. 100% agree with you on that. We didn't see any drop-off, and I would agree with the other pharmacy directors' responses. We've seen adherence actually improve in certain cases or at least stay the same. In general, through this program, our patient adherence has already been in the 90% range or higher. That definitely didn't go down. I think one of the key value added services that our program has been able to offer in this COVID era is just maintaining a sense of normalcy to be honest. In this COVID world, a sense of normalcy, you can throw that out the window. Whether we're talking about a patient or their family, their health, their financial situation may have changed. If you think about it, I think the last report I saw is that 50 million Americans have now applied for unemployment benefits.

So, having this program helped to ensure continuity of care, in addition to a sense of normalcy and providing a sense of security for our patients. They know that they can reach us 24/7, and within 30 seconds they're going to get a human being that's going to answer their call. Chances are, if they call their liaison, liaison already has their phone number saved and knows who's calling them. So when patients are going through these changes in their life, we don't want to see them stop taking their medication for whatever reason.

So, with our higher risk patients, what we did was actually increase the frequency of our touch points to ensure that our patients are okay. None of our patients have missed any medications because they couldn't afford it. We create really whatever we need to do to ensure that the patient isn't bogged down by this financial burden by creating payment plans, really working with each of them on an individual basis. But the fact that our patients know that their specialty drugs are still going to arrive in the same way they always have, I think was invaluable to them.

John Marchica:

One thing that I've heard can be an issue with health system owned specialty pharmacies is this notion of switching out prescriptions. That, let's say a payer-owned specialty pharmacy or one of these retail pharmacies will require that the drug be filled through them. Is that an issue that you see at NYU?

Ameet Wattamwar:

No. If I'm understanding correctly. No, there's absolutely no requirement that a patient fills through a health system pharmacy. In fact, that's illegal. That's considered patient steering, and it's something that we're very sensitive to. Before we market our services, we make it very clear that the patients know they have a choice. They have a say in the matter. We let them know how we may be a better option through all the things that we've discussed. But ultimately they make that decision. I would say, however, that payers who own a PBM and a PBM who owns an SP, they don't share that same sentiment. They force patients to use their PBM-owned pharmacy because it's a vertically integrated organization.

John Marchica:

Right. That was more to my question. Whether that PBM-owned specialty pharmacy is swooping in and trying to take the patients that you already have.

Ameet Wattamwar:

Yeah, and that's to the frustration of the patient and our provider. It's interesting to see that patients are receiving two levels of care. They have this integrated care model that we can provide through the health system-owned SP or if we can't fill it because the PBMs says it has to go to the PBM-owned pharmacy, then our providers are seeing that those patients are receiving a substandard, much more inferior quality of care. So one practice, one doctor could have two patients on the same medication and you'll see differing outcomes, differing patient experiences, different adherence rates and differing readmission rates.

It's just very tough to see that you can't offer this high level of service to all your patients, whether they want it or not just because of this model that the PBMs have put in place.

John Marchica:

So, that's very frustrating. We've talked about this before in a previous conversation that if you have that data, can you share that information with the payers? Is there a way to show them that there's better value, lower costs in using your SP versus ... I mean, it's just like these incentives are totally not aligned and they're definitely not patient centric. But have you had those conversations with payers to say, "Look, there are logical reasons why, yes, I get that you have your own specialty pharmacy, but why these patients should be managed by us."

Ameet Wattamwar:

Yes. That is something that we do track. We collect the data. In fact, we're about to publish some data that shows that this type of care model shows significant improvements in the quality of care that patients receive. We share it with the payer. I think it's incredibly important, but I don't think that, that's necessarily going to be enough in every case to make a compelling argument and to get your pharmacy into the payer's network.

I honestly just think it's just purely a financial decision on the payer's part. You really have to think about it from their point of view. They're weighing two things. Well, an integrated care model can help cut my costs by improving the quality of care the patient's getting. The same time, we're losing reimbursement from our PBM-owned pharmacy. Also, notice that there's definitely a firewall between both departments. They're not necessarily communicating, they're not sitting next to each other. It's very difficult to get both of those individuals to sit at the table when you're trying to negotiate access. So whether that's by design, I'm not really sure, but if you ask more pharmacy directors, I think you're going to get a fairly similar response.

John Marchica:

So, what can be done about this particular issue? It certainly is not in any kind of violation of a Hatch Act, but just wondering, it seems like if all the things that were done with the Affordable Care Act, many of those things were done or enacted with the patient in mind and better patient care, and of course, lower costs. Triple aim is behind everything in ACA, at least theoretically. How do you address that issue? Is that a legislative issue? Is that one where you do have to have the payer and the PBM-owned SP in the room at the same time? How do we fix this problem? Or is it fixable?

Ameet Wattamwar:

Yeah, I do think that this is probably a legislative issue at the end of the day. I think there's a number of things that you can do, which we've pursued in the past with varying degrees of success. But ultimately I think it does take legislation to eliminate the ability of a PBM to force a patient to use the PBM-owned pharmacy. Because without that legislation, then the decision isn't the patient's to make and it's not the provider's decision to make. It's purely in the hands of the payer and the PBM.

John Marchica:

Yeah. That's going to be a tough one because the PBM-owned SP is going to make the argument that because of the contracts and the relationships that they have, they're lowering the cost of care or at least theoretically that would be the argument. Whereas you would have to demonstrate that you not only have lower costs, but better outcomes.

Ameet Wattamwar:

Yeah, you're right. That is a burden on the health system. And burden, I mean by not as a burden, meaning that it's not something we want to do, but we have to be able to prove it with data. If you can't show it with data, then it's tough to make a very compelling case. For us, we realized that a while back, and that's why we focused a lot of attention on really being able to objectively define what is improvement. So we track a number of things for our patients. Just off hand, in addition to PDC and adherence rates, we're looking at in MS for example, relapse rates. Patients billing through our program, how many relapses or flares did they have over a given period of time? We can then compare that to the data that was published as part of the clinical trial that got the drug approved.

Now, it's not necessarily a complete apples to apples comparison. There are other variables. So, to show significant improvement with a p-value might be challenging to do. But anecdotally, I think you're going to see a trend. So in MS for example, we are seeing that relapse rates are lower through our pharmacy.

In RA, for example, we do RAPID3 Assessments. The RAPID3 Assessments can help to really see whether is a patient moving in the right direction. Are they seeing improved quality of life? If we find that we're not seeing those subjective improvements, then we go back to the provider and we work with them to see if there's a better therapy perhaps for our patients.

Oncology, we look at ED utilization. What percent of our oncology patients had to go use the ER over a period of time? The goal is to use preventative care and leverage your clinical pharmacy team to get involved before the patient reaches that point. So we see ED's utilization actually lowering when you can provide this type of integrated care model. The list goes on ultimately at the end of the day.

But I think one other point worth thinking about more than just the clinical piece or in addition to just the clinical pieces, what does the patient feel? What is the patient's experience like in their healthcare journey? So one of the best ways to measure that is the net promoter score. Net promoter score is something that most large corporations and brands will assess. When we had completed our most recent patient satisfaction survey, our net promoter score was 80%. That's actually higher than beloved brands like Amazon. Amazon is such an easy interface to use. Obviously people love it, but they love our program more than they love Amazon. Now compare that to the PBM-owned pharmacies, which

typically have a negative net promoter score. That means more patients would say they don't recommend the PBM-owned pharmacy than the number of patients say they would recommend the PBM-owned pharmacy. That's the exact opposite experience that you're finding with patients filling through our pharmacy and I would say most health system-owned pharmacies.

John Marchica:

So, what's the role of employers in all of this? I mean, they're the ones in most cases that are footing the bill largely for health insurance for their employees. If you were to take those data like net promoter score or reduced ED use in certain patients directly to employers, do they have any leverage?

Ameet Wattamwar:

Yeah. I'm glad you asked that question because that's what we're doing right now. We're taking the show on the road, and we're meeting with leaders of other corporations and the New York City market. A lot of these self-insured employers have agreements in place with our health system to provide medical services. So now we are also approaching these same employers, and we're showing them the data. We're basically saying, "You've selected NYU for medical services because you know we are a world class organization that is going to provide the best quality of care for your employees. But why stop short there?" Providing the same level of pharmacotherapy or of pharmacotherapy service is equally important because it's like playing football. It's like bringing the ball to the one-yard line and walking off the field. If the patient doesn't take the medication that they need that's going to save their life, they're never going to get better. So you really need to be able to marry the pharmacy service with the medical service to provide one comprehensive care model. So that's something we're taking to employers right now and they're seeing that.

Large unions in New York City have already approached us asking if we can integrate this program into the health benefits for their employees. Now you're seeing happy employees with a better patient experience. Healthier employees. That's going to make them happy, that's going to save them money, and it saves the organization money. At the end of the day, it's rare to find a win-win-win like this, where it's great for the patient. It's great for the employer. It's great for our providers at the health system because it allows them to do their job better.

John Marchica:

So how long have you had this specialty pharmacy? Is this something that's been done around for some time?

Ameet Wattamwar:

We turned the lights on in September 2017. So we are about three years now.

John Marchica:

The reason I ask is that I know that a number of health systems in the last couple of years have started their own specialty pharmacy. Is it a difficult process?

Ameet Wattamwar:

It is a very, very difficult process. To do everything that we do requires a lot of infrastructure. It's a very FTE heavy type of program, just because of the fact that we need to have these field-based liaisons, you

have your dispensing pharmacy, you have your clinical pharmacists. But that's just at surface level. To support those groups, you have to have a data analytics team. You have to have a payer contracting team. You've got to be able to manage trade relations with manufacturers so you can get access to these medications. So there's so much that goes in behind the scenes. That's why when you think about a specialty pharmacy, we need to be able to have access to our patients because if we're being denied the right to care for our patients, it's so hard to support the infrastructure that you need in order to continue to grow and be able to offer to everyone within the health system.

John Marchica:

But at the end of the day, I mean, one reason why health systems do this is because it can be a substantial revenue generator. It's all about patient care, don't get me wrong. I get that. But at the same time, when we asked, going back to this latest survey, when we asked, what is your top strategic priorities, the number one response by far was growth because it's an important part of the system.

Ameet Wattamwar:

Yeah, absolutely. I think that generating revenue is essential. How are you going to support this infrastructure? So while we are generating revenue, a lot of that's just getting reinvested into the clinical care that we can provide. That's allowing us to grow our team, to be able to meet the demands of the health system and our patients. We're a not for profit organization so revenue that comes back into our health system is reinvested into the community.

We're a disproportionate share hospital. So we provide a very vital service to underserved communities in the New York City area. For example, in Brooklyn. Brooklyn, New York, historically has been the definition of an underserved geography when you think about healthcare. NYU has just invested a tremendous amount of financial resources and support into developing our hospital in Brooklyn. Now as a result, it's really changed the game in terms of healthcare for residents of the community.

So when you think about this revenue, it's really just going right back to the people who we're serving at the end of the day.

John Marchica:

Sure.

Ameet Wattamwar:

Looking at the environment that we're working in right now, I mean, there's so much to be excited about, but you have a lot of corporate interests to have a very loud voice in the room. At the end of the day where do patients land in the middle? Our goal is always to put our patients first. Nothing else matters. So we'll continue to fight for our patients whenever we can, however we can. In time, we'll see what happens.

John Marchica:

Ameet, it's always a pleasure talking to you, and I appreciate your taking the time today to spend some time with me and our listeners on Health Care Rounds. Thank you again.

Ameet Wattamwar:

Thanks so much for having me on the show. It's great to talk to you.

John Marchica:

All right. Take care.

Kim Asciutto:

From all of us at Darwin Research Group, thanks for listening. Health Care Rounds is produced by me, Kim Asciutto, and is engineered by Andrew Rojek. Theme music by John Marchica. Darwin Research Group provides advanced market intelligence and in-depth customer insights to healthcare executives. Our strategic focus is on healthcare delivery systems and the global shift toward value-based care. Find us at darwinresearch.com. See you next round!

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