Calling All Super Heroes

Financial Hardship

The Unexpected Side Effect of Transplant

Learning objectives

- At the conclusion of this session, attendees will have the following super powers:

Describe prevalence of financial hardship among HCT recipients and families

Summarize patient resources to improve financial wellbeing

Identify strategies to decrease the impact of financial toxicity

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Let's go!

Super Speakers

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-No disclosures

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November 10, 2018

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Disclosures (non-commercial)

- NIH K23HL143164-01
- PCORI site PI
- My dream superpower:

- My favorite superhero:

https://comicvine.gamespot.com/

Financial Hardship

- Loss of income or employment with or without food, housing, or energy security

Background

- Existing literature has attempted to characterize the burden of transplant on patients and caregivers

- This data spans the transplant continuum and patient age
  - Pre-transplant:
    - Patients ranked work and financial issues as the most frequent concerns

(Sheldon et al., 2013 PPA)

Post-transplant: <1 year

- 3 months
  - Median out-of-pocket (OOP) expenses were $2,440 (range: $199-$13,769) for the first 3 months post-HCT
  - Need for temporary lodging in particular increased OOP costs
- 6 months
  - 46% reported income decline
  - 71% reported hardship
  - Hardship was associated with difficulty paying for HCT-related costs, lower quality of life and health status, and higher perceived stress

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(Majhail et al. 2013, BMT; Abel et al. 2016, BBMT)

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Post-transplant: <1 year

- Pediatric
  - 38% of families have material hardship
  - Lower income families suffer disproportionate transplant-related loss of income
  - Incidence of acute GVHD is higher among low income families

(Bona et al, 2015 BBMT)

Post-transplant: 2 years

- 54% of patients who previously contributed to household earnings had not returned to work
- 80% of patients/caregivers reported moderate to great impact on household income
- Confidence in ability to meet household financial obligations increased from baseline
- A relatively large proportion of patients reported inability to pay for medical care

(Denzen et al. 2016, BMT)

Post-transplant: >2 years

- 73% reported that their sickness hurt them financially
  - 47% experienced financial burden - household income decreased by >50%, selling/mortgaging home, or withdrawing money from retirement accounts
  - 3% declared bankruptcy
- Younger age and poor current mental and physical functioning increased the likelihood of financial burden
- 35% reported deleterious health behaviors because of financial constraints
  - These patients were likely to be younger, lower education, and longer time since HCT
- Employment decreased the likelihood of experiencing financial burden and treatment non-adherence due to concern about costs

(Khera et al. 2014, BBMT)

If this sobering data did not convince you…

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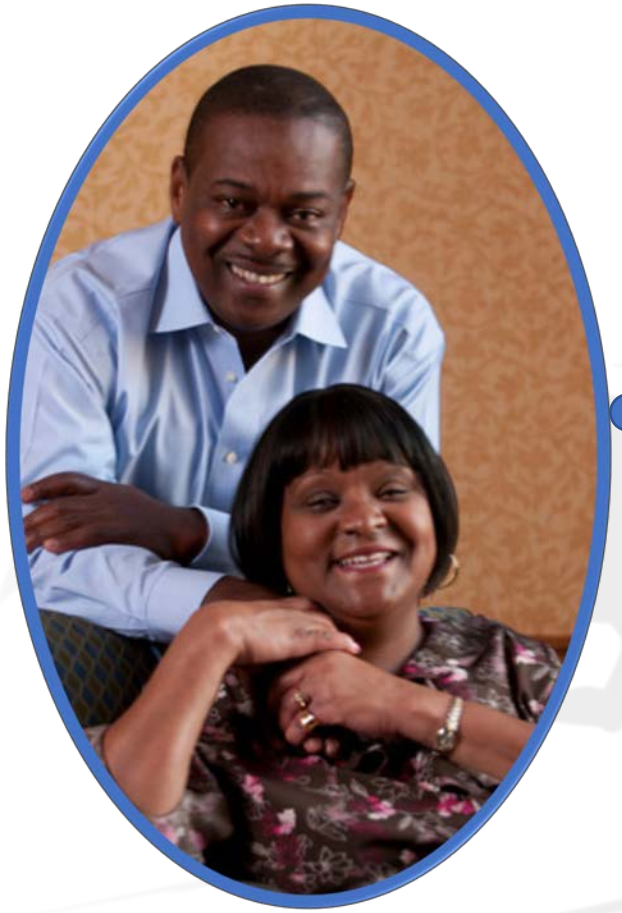
Let's go!

Not all superheroes wear capes



"We thought we'd go through the transplant process and get back to our life; it's been everything but that."

Gloria (12 year transplant survivor) and Jeff (her crusading caregiver)

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Grab your cape.

Let's go!

Patient and caregiver perspective

"Being in the working group gave us a voice" *(Burns, et al. 2018. BBMT)*

- Important for the transplant community to understand what a long road transplant can be
- If we weren't participating, transplant community wouldn't be aware of the issues that patients experience
- Hope that future patients will have a better experience
- Exposed us to information and opportunities that we didn't know existed

More attention is needed to better understand and mitigate the burden on patients and caregivers.

Solutions

- We need better resources to
  - ASSESS
    - MANAGE
      - PREVENT

        financial hardship among patients and caregivers

- Through the remainder of today's session, you will hear about some of these resources and have an opportunity to become part of the solution… then you will truly become…

SUPERHEROES

Thank you!

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Financial Hardship:
The Unexpected Side Effect of Transplant

Michelle Dodson
Financial Coordinator,
West Penn Hospital

NMDP/Be The Match Council Meeting
2018

There is a

Superhero

in all of us. We just need the

COURAGE

to put on the cape

- Superman -

Left to right: Dr. Santhosh Sadashiv, Mary Albrethsen, NP and Mo Patel, Pharm D.

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Strategies to Decrease the Impact of Financial Hardship

- Extensive benefit verification process
- Working with payers, patients and families before, during and after transplant
- It never hurts to ask, patient resources

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Role as Transplant Financial Coordinator

- Extensive benefit (medical and pharmacy) review
- Contact the insurance case manager to confirm authorization process and provide clinical updates.
- Ensure the patient has the information they need to make an informed decision
- Listen and be available

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Patient: **DOB:**	**Date:**
Address:	**Transplant Type:**
	Physician:
Phone Home:	**Coordinator:**
Cell:	
Primary Insurance Carrier	
Company Name: Medicare A & B	
Address: c/o Highmark Blue Cross/Blue Shield (claims processor)	
Fifth Avenue Place	
Pittsburgh, PA 15222	**Phone #** 1-800-633-4227
Insured:	**Relationship:** self
ID#:	**Employer:** retired
Effective Date:	**Part A Deductible:** $1,316 same as 2017
Emergency Transportation: coverage under part B	
Inpatient Coverage: Part A benefits: Once the $1,316.00 deductible is met, 100% coverage for the first 60 days of inpatient hospitalization. Days 61-90 covered after $335 per day deductible is met if you do not have a 60 day break between inpatient confinements. Days 91 – 150 covered 100% after $670 daily deductible.	
Travel and Lodging benefits: none	

Home Health and Visiting Nurse: – covered part A; port supplies/line care not covered Durable medical equipment: Part B coverage at 80% after $183 deductible. Hospice: Part A benefit - care for two 90-day periods followed by an unlimited number of 60-day periods.	**Skilled Nursing Facility:** Part A benefit The 2018 skilled-nursing facility coinsurance you pay per benefit period also varies based on the length of your stay: • 1 through 20 days: $0 coinsurance • 20 through 100 days: $167.50 per day coinsurance • 101 days and beyond: You are responsible for all costs
Prescriptions: Injectable drugs covered under part B **Coverage:** retail and specialty **Local Pharmacy:**	
Outpatient Lab/X-ray Coverage: Part B coverage 80% coverage after $183 deductible is met per year. **Retail clinic/Urgent Care**: Part B coverage 80% coverage after $183 deductible is met per year	**Outpatient therapy:** Part B coverage 80% coverage after $183 deductible is met **Infusion therapy –** Part B coverage 80% coverage after $183 deductible is met.
Professional Fees: Part B coverage 80% after $183 deductible (same as 2017) is met. Physician visit will be charged for each day in Medical Short Stay Unit after transplant.	
Emergency Room: Part B coverage 80% after $183 deductible is met	
SECONDARY INSURANCE	
Prior authorization for transplant is not required under secondary insurance	
ID#: Group: Insured:	
THE FOLLOWING IS REQUIRED FOR FISCAL CLEARANCE:	
Once patient is medical deemed a transplant candidate, medical information, including pretesting results, will be reviewed according to Medicare medical guidelines for transplant authorization.	
If your insurance information changes, please contact me as soon as possible.	
Please note that the benefits listed are based on a verbal review with your insurance carrier (s). This is not a guarantee of coverage. You will be billed for any non-covered service or unpaid balance.	

Autologous Transplant – Common Medications (Sample – Part D benefits)						Guestimated Patient co-pay
Medication	Trade Name	Dosage/ form	Frequency	Approximate Duration	Notes	Deductible may be $5 - $405 Preferred Pharmacy –No Deductible Retail up to 30 day supply/90 day supply Tier 1 Preferred Generics $/$ Tier 2 Generic $/$ Tier 3 Preferred Brand $/$ Tier 4 Non-Preferred Brand Tier 5 Specialty Initial coverage stage co-pays (details above) apply until that the total retail cost of the medications reach $3750. When this limit is reached, you exit the Initial Coverage Phase and enter the Coverage Gap The Coverage Gap, which is also known as the Donut (Doughnut) Hole is the phase of your Medicare Part D plan where you are responsible for 100% of your medication costs. During this period, you will receive a 65% discount on the total cost of their brand-name drugs purchased while in the donut hole. The 50% discount paid by the brand-name drug manufacturer will apply to getting out of the donut hole, however the additional 15% paid by your Medicare Part D plan will not count toward your True Out Of Pocket. Enrollees will pay a maximum of 44% co-pay on generic drugs purchased while in the coverage gap (a 56% discount). Catastrophic Coverage begins when the true total out of pocket retail cost of the medications reach $5,000. Generic & Preferred Multi-Source Drugs: The greater of 5% or $3.35 Other: (Brand-Name or Non-Preferred Multi-Source Drugs):The greater of 5% or $8.35

Pegfilgrastim	**Neulasta J2505**	**6mg SQ**	**Once**	**Once**	**Give once on Day +5 if low cell dose**	**Brand specialty requires prior authorization or medical benefit**
Pegfilgrastim	Neulasta J2505	12mg SQ	Once	Once	Used for mobilization	Brand specialty requires prior authorization if pharmacy or medical benefit
Mozobil	Plerixafor J2562	Weight based SQ	Once	1- 4 doses	Used for mobilization with growth factors Administered in medical short stay unit	Coverage under medical benefit; prior authorization required
Vancomycin locks	Vancocin J3370	25 mcg/ml IV Vancomycin 500mg Intravenous solution	Once daily per port	1 month	Given at home after mobilization chemotherapy until transplant	Tier 2 Preferred Generic - prior Authorization not required

Working with Payers, Patients and Families

Before transplant

- Review detailed insurance benefit information
- Appeal if necessary (out of network exception)
- Provide multitude of resources regarding support and financial resources for themselves, caregivers, and family
- Observe and listen
- Encourage patient to contact team
- Update insurance case managers

During transplant

- Update case manager
- Availability; point person for billing issues
- Insure authorizations in place (medical and pharmacy preparing for discharge)
- Team communication
- Host patient support groups in hospital

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Post Transplant

- Medications – authorizations and planning
- Realities – each patient is unique clinically and financially
- Follow-up with patient
- Continue support groups
- It takes a village of heroes to research, educate and advocate, for the well-being of our patients before, during and well after the transplant

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Who you gonna call?

- Why it never hurts to ask
  - Employer policy
  - ✓ 2 case examples of success

- Resources:
  - Be the Match/NMDP bethematch.org
  - BMT Infonet bmtinfonet.org
  - American Cancer Society cancer.org
  - National Caregivers Association caregiveraction.org
  - Local organizations
  - Fundraising organizations

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And, in closing, in the words of the immortal Dr. Peter Venkman, “Why worry? Each one of us is carrying an unlicensed nuclear accelerator on his back”.

Each of us has unique talents and the potential to be heroes for our patients!!!!

Allegheny Health Network

Michelle.Dodson@ahn.org

Allegheny Health Network

Anthem®

Financial Burden Workshop
NMDP Council Session
November 10, 2018

Patricia Martin BSN RN

Director Specialty Network Management

Payer Segmentation

Commercial

- Fully Insured
- Self-Insured Employers
- Individual

Medicare

- Medicare
- Medicare Advantage

Medicaid

- State
- Dual Eligible

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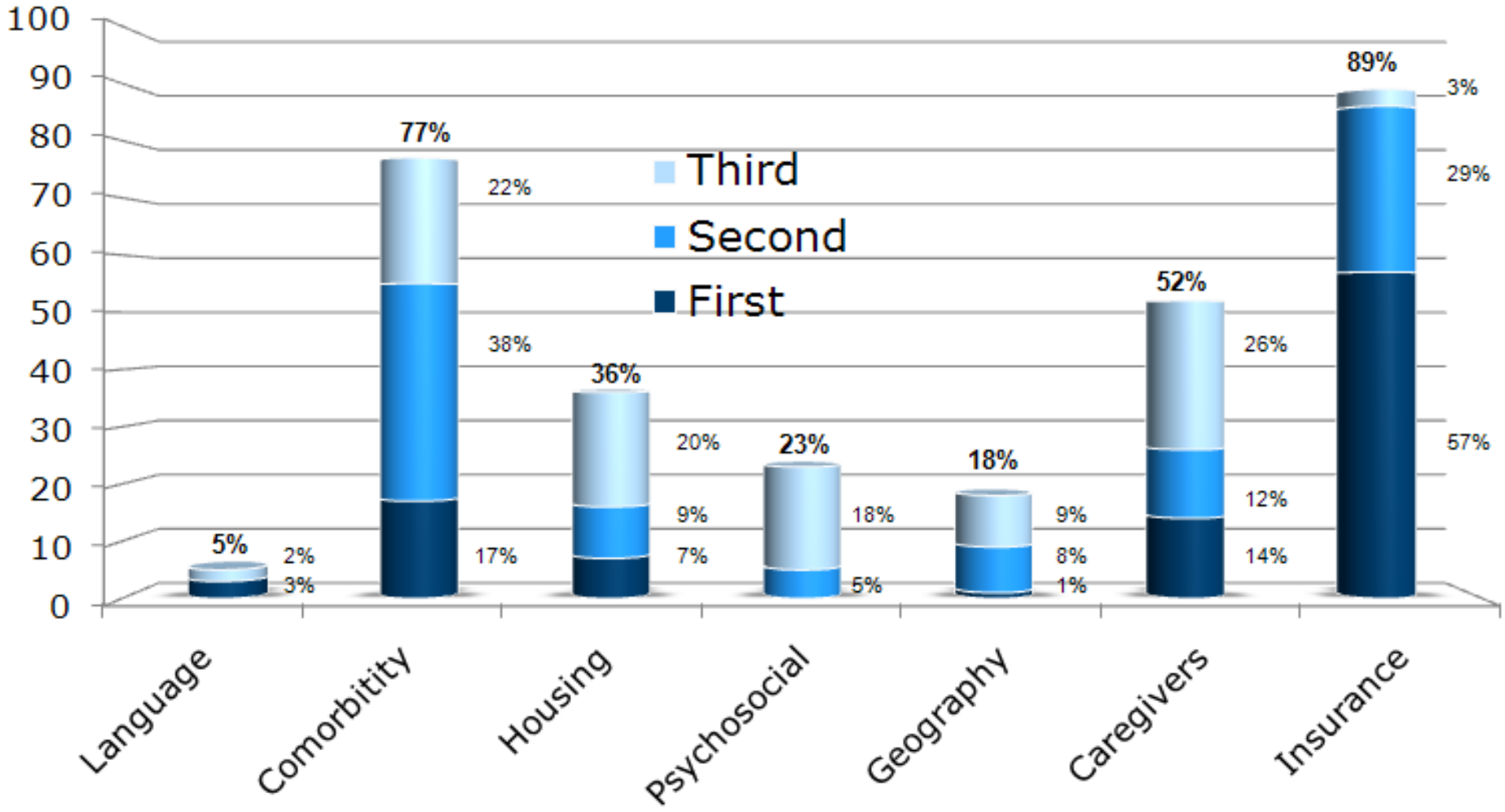
Anthem BlueCross BlueShield

Collaboration between Providers and Payers is Key to Understanding Member Medical Coverage and Benefits

Top Patient Barriers to Transplant



As ranked by System Capacity Initiative members, 2010

What is Financial Toxicity?

- Adverse economic consequences due to medical treatment that can result in
  - ✓ treatment non-adherence and lifestyle changes
  - ✓ Adverse impact on quality of life
  - ✓ increased morbidity and mortality of treatments
- May be due to medical costs, non-medical costs and indirect costs

Financial Toxicity slides courtesy of Dr. Nandita Khera, Mayo AZ

Identifying Financial Barriers Along the Continuum of Care

- Understanding where the patient is in the treatment of their underlying disease
- Who referred the patient to your transplant program? Are you In Network or Out of Network for this patient/member?
- Key stakeholders: financial coordinators, social workers, patients and care givers
- Obtaining patient insurance benefits is the 1st step!
  - "Who you gonna call"? Information is located on the back of the member's insurance card. Be specific and state that you are inquiring about transplant benefits.
  - Does the patient have specific requirements to receive the highest level of benefit? – if so, what are those requirements? Centers of Excellence
  - Has the patient changed their insurance carrier?
  - Are pharmacy benefits covered under the primary carrier or carved out to another vendor?

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A Patient's Words……

I believe everything was explained thoroughly and explicitly. But I don't think that when you face a last option to be able to live that you process it. You hear, understand and acknowledge it but only when you are on the other side of transplant you allow your mind and heart to process that it basically cost everything you own. When hope reappears, you process it because then you have a value to balance it against.

Kim et al. ASCO 2014 abstract

Toolkit

- Ask how the payer navigates from benefits to case management to follow through. (Anthem's workflows are included in your packet)
- Know how clinical trials are managed
- What clinical information does the insurer require – be sure to complete any required information in order to avoid denials. (A copy of Anthem's eTool is included in your packet)
- Review the financial checklist with both the patient and their caregiver
- Access the NMDP website for additional tools

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Thank you!

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Panel discussion / Q&A

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