GI Alliance Payer Summit

A Meeting Proceedings Summary

GastroIntestinal Health Foundation

GI Alliance Payer Summit

A GI Mega-practice and Payer Summit meeting was held on May 3, 2024 to pursue alignment on treatment guidelines and quality metrics relating to IBD. A total of 6 gastroenterologists, APPs, and pharmacists participated in the event.

The meeting objectives were to:

- Evaluate the regional issues impacting access and reimbursement of therapies for IBD
- Pursue alignment on treatment guidelines and quality metrics in IBD

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Agenda

Discussion topics	Time
Introductions and Review of Meeting Objectives	3:00 PM–3:15 PM
IBD Treatment Guidelines in the Real World	3:15 PM–3:45 PM
How Centers of Excellence Drive Achieving Quality Metrics	3:45 PM–4:15 PM
The Role of the APP in Ensuring Access and Reimbursement	4:15 PM–4:45 PM
Closing the Gaps: Educational and Other Initiatives	4:45 PM–5:45 PM
Q&A/Discussion	5:45 PM–6:00 PM

IBD Guidelines in the Real World

Clinical guidelines for the management of Crohn's disease and UC have been published by both the American College of Gastroenterology (ACG)[1,2] and American Gastroenterological Association (AGA).[3-5] Although specific recommendations vary, these guidelines have evolved towards an individualized, risk-stratified approach that emphasizes the early integration of biologic therapy for high-risk patients. Importantly, the AGA guidelines recommend early introduction of biologic therapies in patients with moderate to severe disease rather than delaying their use until after failure of conventional therapies (ie, 5-aminosalicylates and/or corticosteroids).[4,5] This change reflects the potential that using minimally effective agents for a prolonged duration allows for continued inflammation and the development of tissue damage.[6]

Acknowledging the need to identify and treat high-risk patients early and aggressively, the group noted that treatment algorithms followed at GI Alliance are typically more aggressive than those in published IBD guidelines. The group also commented that because most IBD guidelines were published at least several years ago, they do not reflect state-of-the-art evidence. Further, as the treatment of IBD becomes increasingly patient-focused, the guidelines cannot account for the myriad of nuances that influence decision-making. For example, the presence of certain comorbidities and/or extraintestinal manifestations is a key factor in driving treatment selection. One gastroenterologist noted that IL-23 antibodies are often the treatment of choice in patients with skin diseases, whereas anti-TNF therapies may be more appropriate in those with concomitant arthritis. Patient preference is also a key factor in treatment selection, as some patients have strong preferences for the route of administration or other factors.

Although payers understand that there are nuances that drive treatment decisions, they need a framework to help them understand the common factors that prompt clinicians to prescribe differently from the guidelines. The group agreed that it is essential to educate payers on these nuances so they can understand both the rationale and benefit of tailoring therapy to individuals.

"You don't make treatment decisions based on the guidelines. You make treatment decisions based on patients. And sometimes there are many, many factors with patients."

"The treatment of IBD is so patient-focused now, so tailored, there is no one answer for every patient. But contracts are on the drug, not the patient."

Barriers to IBD Care

The experts acknowledged that prior authorization (PA) policies pose a significant barrier to providing care for their IBD patients. In contrast to typical PA requirements, step-up therapy is falling out of favor with most gastroenterologists, except for patients with very mild disease. On the contrary, IBD experts are increasingly risk-stratifying patients to identify those who need early, advanced therapy in hopes of altering their disease course.

Despite the need to initiate early advanced therapy in such patients, the group noted that the PA process often delays treatment initiation. One clinician noted that it usually takes weeks for the initial denial, then several more to set up a peer-to-peer appeal, often leading to a significant delay (up to 10 weeks) before a therapy is approved. Given this barrier, practitioners may be forced to prescribe therapies that they know will be approved expeditiously rather than the optimal therapy for a particular patient.

Payer-mandated nonmedical switching from originator biologics to biosimilars poses another barrier to IBD care. These changes are typically forced by insurance companies, often through a letter sent to the patient, without consideration for patient-centered care or the patient-provider relationship.[7] Commenting on this issue, the participants noted that biosimilars are not identical to the originator drugs and are not considered interchangeable as generic drugs are. Further, because these changes require new PA approval, they can disrupt treatment with potential for uncontrolled disease, immunogenicity, and drug discontinuation.[8]

> We feel so frustrated when we try to make a thoughtful and reasonable decision with the patient... but then we have take time to explain plan B when it gets shot down by insurance, and it is so unfortunate.

Leveraging Centers of Excellence to Improve IBD Care

A promising strategy for improving the quality of care and outcomes in IBD is to create Centers of Excellence (COEs) to address chronic disease management and complex care coordination. At GI Alliance, COEs are staffed by physicians and APPs with expertise in IBD, with the aim of having a select group of providers treating these patients. This approach should not only standardize care, but also improve the cost effectiveness of treatment. The group anticipates that other providers in the practice will be very open to sending their patients to COEs to achieve disease control, after which patients can be sent back to their regular providers.

In addition to standardizing care, establishing COEs can provide a network for providers to share practices and potentially lead to better outcomes. Some clinicians are already working with others to compare quality metrics and learn from each other. Practices are also sharing their experience in obtaining reimbursement on multidisciplinary care, such as incorporating dietitians, social workers, and other clinicians into their practices.

Some practices are now working together to aggregate EMR data into a functional, usable dashboard that will be able to associate certain therapies, or sequence of therapies, with better outcomes. The dashboard will consolidate information about quality metrics in IBD, such as steroid usage and initiation of advanced therapies. Once these data are available, providers can show payers that treating patients a certain way can improve outcomes and reduce cost. Although payers may vary in how they perceive these kinds of data, the group noted that due to the competitive nature of payers, they are likely to pay attention to strategies that they see are working for other payers.

In addition to demonstrating a link between quality care and outcomes, data from the dashboard will also be used to identify areas throughout the group where focused education regarding IBD treatment is needed.

Working Towards A Solution

In reviewing the recent 12-point plan outlined by the AGA to reduce barriers to IBD care imposed by cost-containment policies,[7] the group agreed that education, collaboration, and leveraging technology are key to improving the care of patients with IBD.

Education

The group agreed that face-to-face education is far superior to written educational materials for both patients and physicians. The participants described several examples of successful educational programs that have been offered at their practices. For example, one practice arranges for a Medical Science Liaison to present an update after every major GI congress, including DDW, ECCO, and ACG. These sessions have been very well attended and have proven very useful in keeping their clinicians up-to-date with the latest advances. A foundational course in IBD (eg, IBD Boot Camp, GIANT LEAP FOUNDATION medical education program) is another initiative that has been successful in educating APPs who are new to IBD management.

Patient-centric care

Recognizing the need for early advanced therapy in high-risk patients, the group noted that tools designed to promote patient-centric care will be helpful in improving outcomes. Examples of such tools include tests that help predict patients' likelihood of durable response to anti-TNF therapy or determine their risk for antibody formation to these therapies.

Technology

The use of point-of-care technologies and AI can facilitate more efficient prior authorization approvals as well as promote quality care. For example, some practices within the GI Alliance are integrating AI pathways into EMRs to prompt physicians to order appropriate tests and vaccinations when patients are diagnosed with IBD.

Collaboration

The group reiterated that collaboration is key to improving outcomes in IBD. Collaboration between providers, particularly those within COEs, can help clinicians learn from each other and adopt best practices for providing high-quality care and obtaining reimbursement. Collaboration between providers and payers can help payers understand why step therapy and FDA label restrictions lead to suboptimal care and incorporate the influx of new evidence into policies.

AGA 12-Point Plan For Improving IBD Care[7]

1	Reflect state-of-the-art data in the field and incorporate the input of expert clinicians and patients.
2	Recognize the power of tailoring therapy to individuals based on risk, comorbidities, and response.
3	Move beyond step-therapy or fail-first policies.
4	Cover disease activity and drug level monitoring to achieve treat-to-target–driven outcomes.
5	Guarantee streamlined and expedited expert reviews when they are needed.
6	Require that payors publish data on denials and appeals for transparency and accountability.
7	Cover holistic multidisciplinary patient care to improve resilience and well-being, for improved clinical outcomes and decreased health care utilization.
8	Support patient education and activation programs.
9	Improve patient access to expert clinical care with flexible delivery models to reach underserved populations, and education of specialty providers across the spectrum of practice.
10	Pilot innovative, shared-incentive partnerships between high-value subspecialty care practices and payors.
11	Engage pharmaceutical partners in developing equitable programs to address prohibitive drug costs for expanded patient access as well as patient support.
12	Advocate for legislation to make access to therapy equitable for Medicare and Medicaid patients.

References

1. Rubin DT, Ananthakrishnan AN, Siegel CA, Sauer BG, Long MD. ACG clinical guideline: Ulcerative colitis in adults. *Am J Gastroenterol*. 2019;114:384-413. **2.** Lichtenstein GR, Loftus EV, Isaacs KL, Regueiro MD, Gerson LB, Sands BE. ACG Clinical Guideline: Management of Crohn's disease in adults. *Am J Gastroenterol.* 2018;113:481-517. **3.** Feuerstein JD, Isaacs KL, Schneider Y et al. AGA clinical practice guidelines on the management of moderate to severe ulcerative colitis. *Gastroenterology.* 2020;158:1450-1461. **4.** Feuerstein JD, Ho EY, Shmidt E et al. AGA clinical practice guidelines on the medical management of moderate to severe luminal and perianal fistulizing Crohn's disease. *Gastroenterology*. 2021;160:2496-2508. **5.** Ko CW, Singh S, Feuerstein JD et al. AGA clinical practice guidelines on the management of mild-to-moderate ulcerative colitis. *Gastroenterology.* 2019;156:748-764. **6.** Dulai PS, Osterman MT, Lasch K, Cao C, Riaz F, Sandborn WJ. Market access analysis of biologics and small-molecule inhibitors for inflammatory bowel disease among US health insurance policies. *Dig Dis Sci*. 2019;64:2478-2488. **7.** Sofia MA, Feuerstein JD, Narramore L, Chachu KA, Streett S. White paper AGA: American Gastroenterological Association Position Statement: the future of IBD care in the United States—removing barriers and embracing opportunities. *Clin Gastroenterol Hepatol*. 2024;22(5):944-958. **8.** Mehta SA, Ritter TE, Fernandes CC, et al. S837. Payor-mandated non-medical switching from infliximab to biosimilar creates dosing delays. *Am J Gastroenterol.* 2021;116(Suppl):S388.