

Through the C-Suite Lens

Cost Management, Drug Spend, and What It All Means for the Front Lines

A Moderated Panel Discussion

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Conflict of Interest Disclosures

- The speakers have no conflicts of interest with ineligible companies to disclose



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Learning Objectives

- Examine the key drivers of rising hospital drug expenditures and the financial strategies health-system leadership uses to manage them.
- Analyze practical, front-line strategies that pharmacists and pharmacy technicians can apply to support institutional drug-spend management initiatives in daily practice.
- Evaluate methods for communicating the value and financial impact of front-line pharmacy work to hospital administration and the C-suite.



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Meet the Panel



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Panelists

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 - Advocate Health
- Jennifer Halsey, Director of Ambulatory Pharmacy, Assistant Professor
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Meet Patient B. Sim

- Admitted with worsening bloody diarrhea, abdominal pain, and fever
- GI recommends starting infliximab to induce remission
- Your hospital formulary does have infliximab

As the inpatient pharmacy covering this patient, how do you proceed?



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Setting the Stage

National & Institutional Drug Spend Trends



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U.S. Pharmaceutical Spending: The Big Picture

- 2025 U.S. pharmaceutical expenditures grew 12.7% over 2024, reaching \$915.2 billion

Top Drug Expenditures by Drug Class: 2025

Drug Category	% of Total Expenditures	% Change From Previous Year
Antineoplastics	19.6	21.5
Immunologics	8.0	7.7
Hemostatic Modifiers	7.9	7.5
Biologicals	7.8	7.1
Hospital Solutions	6.6	6.5

Adapted from: Vogenberg FR, et al. Am J Health Syst Pharm. 2026



Health-System Drug Expenditures

- Nonfederal hospital drug expenditures rose 9.6% to \$42.9 billion in 2025
 - Driven overwhelmingly by utilization growth (9.3%)
 - Not by new drug approvals (0.9%) or price increases (1.2%)
- Ambulatory infusion and hospital specialty pharmacy
 - Expected to be the fastest-growing segments, expanding at annual rates of roughly 9% and 21% respectively
 - Prescription drug spending increased 7.9% to \$467.0 billion in 2024, slower than the 10.8% growth in 2023.



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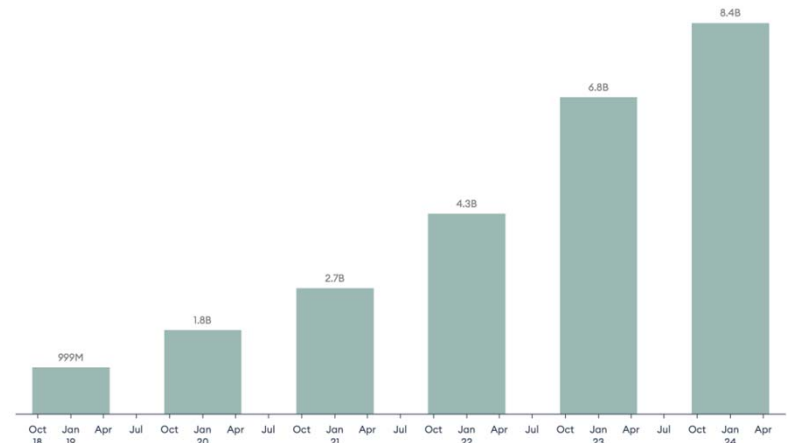
What's Driving the Growth?

Market & Clinical Drivers

- **Specialty & infusion growth:** ambulatory infusion +9%/yr, hospital specialty pharmacy +21%/yr projected
- **Site-of-care migration:** freestanding infusion centers on pace to overtake hospital outpatient volume by 2029 (12.5%/yr growth, 30–40% cost advantage)
- **Specialty & GLP-1 demand:** overall drug expenditures growing ~8–9%/yr through 2029, driven by utilization

Number of Medicaid GLP-1 Prescriptions from 2019-2024

Includes all FDA-approved GLP-1s



[Medicaid Coverage of and Spending on GLP-1s](#). KFF. Accessed June 23, 2026.



What's Driving the Growth?

Federal Payment Policy Drivers

- **Payment parity by site:** CMS rule pays hospital-owned outpatient departments the same (lower) rate as freestanding clinics for drug administration — removing the financial incentive to keep infusions in-hospital
- **Inpatient-only list phase-out:** 3-year elimination expands the pool of procedures eligible for outpatient delivery
- **Increased CMS oversight:** New NPI requirements for off-campus departments improve federal visibility into site-of-care shifts
- **Multi-year trend:** CMS is actively considering further site-neutral expansion — this is ongoing policy direction, not a one-time change



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Why This Matters to the Front Line

- Front-line staff often operate without full visibility into the cost implications of daily decisions.
- AHA's 340B Hospital Commitment to Good Stewardship Principles calls for interdisciplinary training spanning C-suite, pharmacy, legal, and finance
 - Financial/regulatory literacy is a *shared organizational responsibility* across levels, not a frontline knowledge gap
- Without this context, staff may be less engaged in cost-management initiatives (biosimilar substitution, waste reduction, formulary compliance)



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Panel Discussion — Round 1

Describe the key drivers of rising hospital drug expenditures and the financial strategies health-system leadership uses to manage them.



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Panel Discussion — Round 1

- *Describe the key drivers of rising drug expenditures and the financial strategies health-system leadership uses to manage them.*



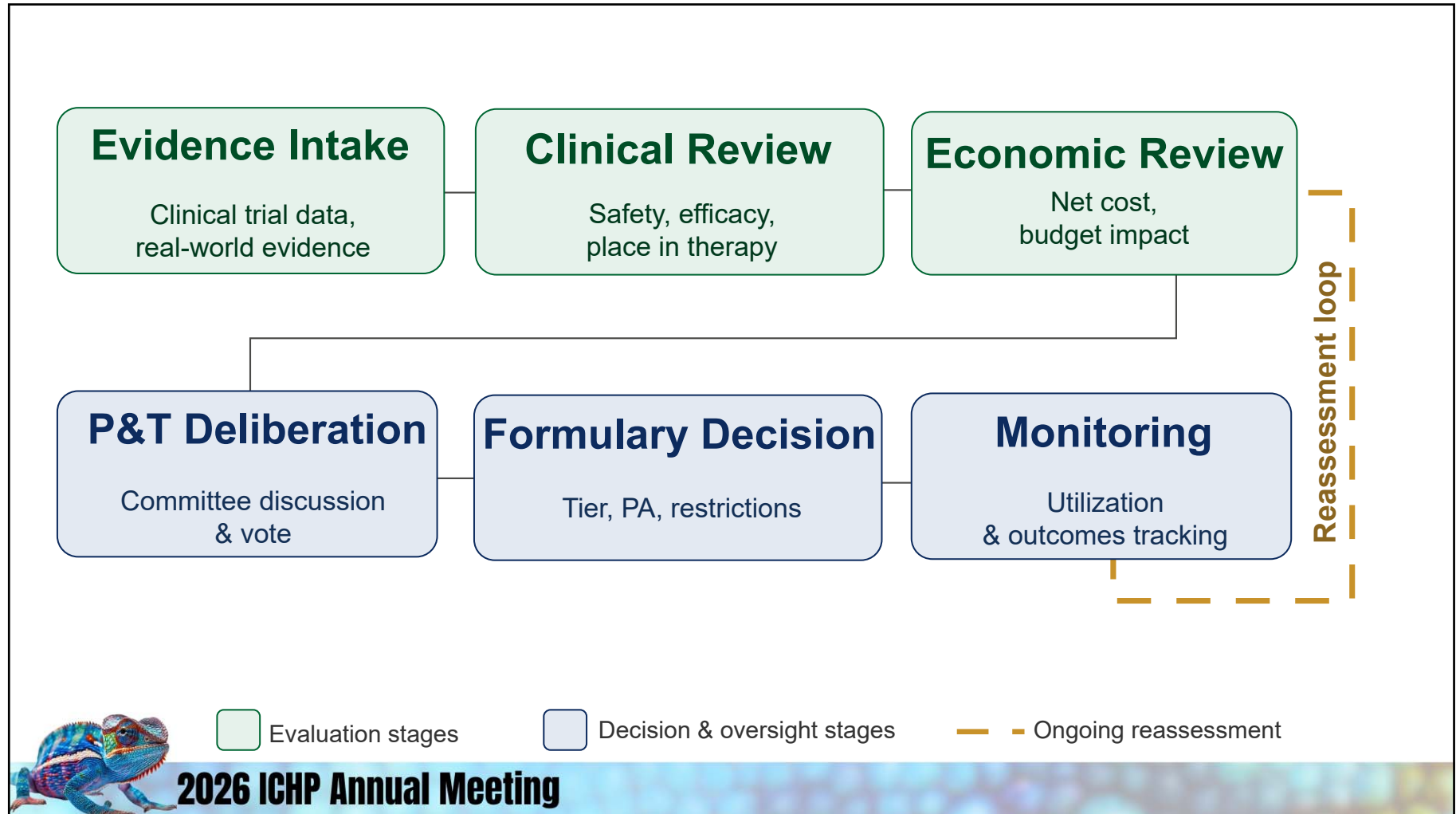
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Panel Discussion — Round 1

- *Walk us through how your P&T committee or formulary team balances clinical need against cost pressures, and how your approach differs between inpatient versus outpatient formularies.*



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340B Oversight Committee — Governance Structure

Interdisciplinary governance, reporting, and core program functions



Patient Case: B. Sim

- Admitted with severe ulcerative colitis flare
- Request to start inpatient infliximab
- The inpatient pharmacist recommends IV corticosteroids per guideline-directed acute management to stabilize the patient first
 - Avoids initiating a high-cost specialty therapy in a setting where it isn't yet clinically indicated
 - Prevents an unnecessary inpatient drug-spend
 - Allows the care team to properly assess the most appropriate long-term biologic agent
 - The transitions of care technician takes ownership of the prior authorization process gathering documentation, submitting the PA, and following up with the payer.
 - This prevents a discharge delay, avoids a gap in therapy that could trigger a readmission, and ensures the patient leaves with a clear, approved care plan



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Panel Discussion — Round 2

Identify practical, front-line strategies that pharmacists and pharmacy technicians can apply to support institutional drug-spend management initiatives.



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Panel Discussion — Round 2

- *Drug-spend management can sometimes be perceived as a cost-cutting exercise rather than a clinical stewardship one. How have you seen that attitude shift among staff, and what's helped front-line pharmacists and technicians see themselves as active owners of these initiatives rather than just participants in them?*



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Panel Discussion — Round 2

- *In what ways have you seen AI start to reshape financial stewardship? How would you coach a new pharmacist or technician to evolve their practice alongside these tools, and help them see that shift as an opportunity rather than a threat to their role?*



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Back to Patient B. Sims

- The patient is connected with the GI Clinic Pharmacist after discharge
- The clinic pharmacist works with GI to convert their prescribed biologic to a clinically equivalent biosimilar
 - Reduces per-dose cost without compromising efficacy
- The pharmacist also spends time educating the patient on self-administration technique, what symptoms warrant a call to clinic versus the ER, and adherence strategies
 - Directly reducing risk of a preventable readmission.



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Front-line interventions with measurable drug-spend impact

Intervention	Source	Measured impact
Dose rounding to nearest vial size (Mayo Clinic, EHR-automated)	<i>AJHP, 2022</i>	9,814 vials saved across ~40,000 chemo doses over 6 months — \$7,284,796 total savings (\$5.7M biologics, \$1.6M oncolytics)
Dose rounding, single academic center (bevacizumab, paclitaxel protein-bound)	<i>JHOP, 2025</i>	\$66,631.74 saved over 3 months across 240 administrations; 91 vials avoided via 10% dose-rounding policy
Dose rounding, rural ambulatory infusion center	<i>Pharmacy Practice News, 2020</i>	\$201,048 saved over 11 months across 276 patient orders — ~600% above projection; pharmacist-led, no physician consult required
Optimal vial-size selection	<i>HealthTrust (Sherman & Teague)</i>	Average of \$2,826 saved per dose by aligning package sizes to most commonly administered doses
Biosimilar adoption, system-wide	<i>AAM / IQVIA 2025 Savings Report</i>	\$20.2 billion in biosimilar savings in 2024 alone; \$56.2 billion cumulative since 2015



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Panel Discussion — Round 3

Discuss methods for communicating the value and financial impact of front-line pharmacy work to hospital administration and the C-suite.



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Panel Discussion — Round 3

- *Drug-spend impact isn't always a clean dollar figure. Sometimes it's indirect savings/cost-avoidance. At the front-lines, how can pharmacists and technicians articulate that kind of value, and how do you translate it for audiences outside pharmacy, like the C-suite or the board, who often expect a hard number.*



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A front-line pitch to leadership

Helps the ask

Leads with the ask

States the recommendation first

One clear metric

Not a data dump of every measure

Comes prepared

Anticipates the follow-up question

Speaks their language

Frames it as cost, risk, throughput

Hurts the ask

No clear recommendation

Describes a problem, no next step

Too much clinical detail

Buries the ask in data

Catches them off guard

No dedicated time requested

No follow-up plan

Ask dies with no proposed next step

Sources: AHRQ / IHI SBAR communication framework; ASHP, "Proving Pharmacy's Value Is All About Outcomes" (2025); ASHP, "Making the Case for New Roadmaps for Pharmacy Technicians" (2024)

Which of the following best pairs the primary driver of recent drug-expenditure growth with an appropriate health-system leadership strategy?

- A. Introduction of newly approved drugs; restrictions on all nonformulary medications
- B. Manufacturer price increases; shifting all specialty medications to the inpatient setting
- C. Increased medication utilization; formulary management and biosimilar adoption
- D. Increased inpatient admissions; eliminating ambulatory infusion services



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A patient is hospitalized with a severe ulcerative colitis flare, and the care team requests initiation of infliximab. Which front-line pharmacy response best supports both clinical care and institutional drug-spend stewardship?

- A. Initiate infliximab immediately because it is available on the hospital formulary
- B. Recommend guideline-directed intravenous corticosteroids initially and begin coordinating outpatient biologic access
- C. Delay all treatment until the patient's outpatient insurer approves infliximab
- D. Recommend the least expensive biologic without considering the intended site of care



A pharmacy team wants executive support for expanding a tech-check-tech initiative. Which presentation approach would be most effective when communicating the proposal to hospital leadership?

- A. Begin with a detailed review of the literature and allow leadership to determine the next step
- B. Present every available process and outcome measure to demonstrate the initiative's complexity
- C. Lead with a specific recommendation, support it with one meaningful metric, and propose a clear next step
- D. Focus exclusively on pharmacy workload because operational and financial outcomes will be evaluated separately



Audience Questions



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Key Takeaways

1. Drug-spend growth is driven by utilization

- Formulary management, biosimilar adoption, 340B stewardship, and drug contracting remain leadership's core levers, but each depends on consistent adoption at the point of care.

2. Value within the front lines

- Dose rounding, biosimilar substitution, and formulary compliance require no new clinical skill, only formulary visibility paired with clear policy and a mechanism to track impact.

3. Cost literacy is a shared responsibility

- Sustainable medication-use governance depends on interdisciplinary alignment across pharmacy teams, finance, legal, and the C-suite.

4. A focused ask travels further than a well-supported one

- Leading with a single clear metric, naming the specific recommendation, and preparing for one objection in depth is what turns frontline insight into leadership action.



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