

# WHAT IS ESMO DOING TO SUPPORT EU HTA?

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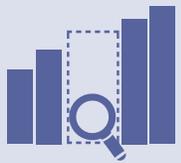
# ESMO'S TOOLS AND RESOURCES TO SUPPORT EU HTA



1. **ESMO-MCBS**
2. **ESCAT:** The ESMO Scale for Clinical Actionability of molecular Targets (ESCAT)
3. **Approach to identify bias in studies:** ESMO has described a structured approach to identify bias that may distort the results of clinical studies.
4. **Value-based reimbursement model**
5. **ESMO Clinical Practice Guidelines**
6. **ESMO surveys**
  - on the availability, out-of-pocket costs, and accessibility of antineoplastic medicines (ANMS) - **ongoing**
  - on availability and accessibility to biomolecular technologies in oncology in Europe

# 1. ESMO-MCBS

## Why was the ESMO-MCBS developed?



- Disparities in Europe in cancer outcome and in access to anticancer medicines between and within European countries
- Novel anticancer medicines not sustainable for all European countries and countries outside Europe

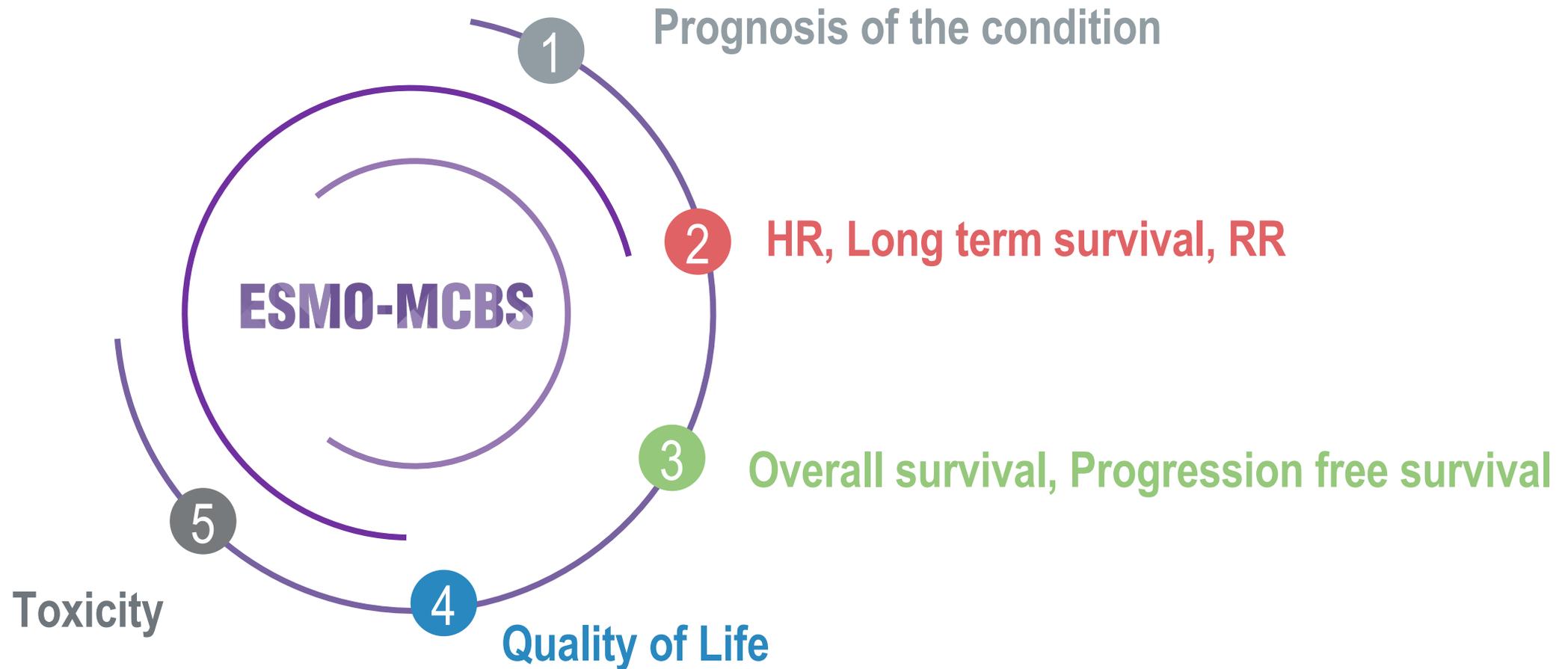
## Aims of the ESMO-MCBS



- To develop a validated and reproducible tool to assess the magnitude of clinical benefit of anti-cancer interventions
- To present clear and unbiased statements regarding the magnitude of clinical benefit from new treatments based on credible research
- To highlight treatments which bring substantial improvements to the duration of survival and/or the quality of life of patients with cancer

# ESMO-MCBS ENDPOINTS

Factors taken into account



**ESMO-MCBS**

# SCORING WITH ESMO-MCBS V1.1

Five forms in 2 settings and various endpoints



## Curative setting

Adjuvant/Curative therapy

Form 1 - Grades A, B, C

## Non-curative setting

OS

PFS

Comparative: QoL or RR

Form 2a - Grades 5,4,3,2,1

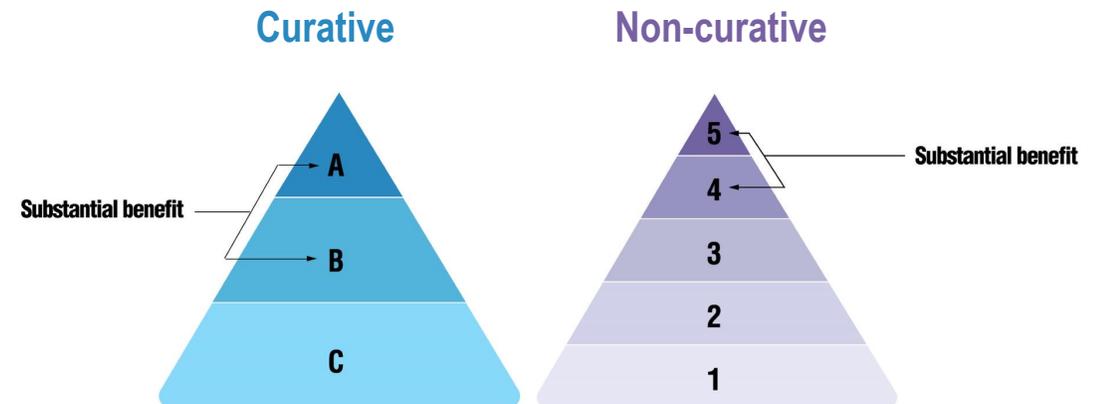
Form 2b - Grades 4,3,2,1

Form 2c - Grades 4,3,2,1

## Non-curative setting

Single arm studies

Form 3 - Grades 4,3,2,1



## Substantial magnitude of clinical benefit scores:

- in the curative setting an A and B
- in the non-curative setting a 5 and 4

# ■ Form 2a

For therapies that are not likely to be curative with primary endpoint of OS

Three prognostic groups if median OS when standard treatment is:

- $\leq 12$  months
- $> 12$  months and  $\leq 24$  months
- $> 24$  months

If median OS with the standard treatment  $> 24$  months

If median OS with the standard treatment  $> 12$  months  $\leq 24$  months

If median OS with the standard treatment is  $\leq 12$  months

<b>GRADE 4</b>	HR $\leq 0.65$ <u>AND</u> gain $\geq 3$ months Increase in 2 year survival $\geq 10\%$	<input type="radio"/>
<b>GRADE 3</b>	HR $\leq 0.65$ <u>AND</u> gain $\geq 2.0$ - $< 3$ months	<input type="radio"/>
<b>GRADE 2</b>	HR $\leq 0.65$ <u>AND</u> gain $\geq 1.5$ - $< 2.0$ HR $> 0.65$ - $0.70$ <u>AND</u> gain $\geq 1.5$ months	<input type="radio"/>
<b>GRADE 1</b>	HR $> 0.70$ <u>OR</u> gain $< 1.5$ months	<input type="radio"/>

Mark with  $\checkmark$  if relevant

<b>Preliminary magnitude of clinical benefit grade (highest grade scored)</b>	<b>4</b> <input type="checkbox"/>	<b>3</b> <input type="checkbox"/>	<b>2</b> <input type="checkbox"/>	<b>1</b> <input type="checkbox"/>
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# Form 2a



## Quality of life/Grade 3-4 toxicities\* assessment

Does secondary endpoint QoL show improvement?

Are there statistically significantly less grade 3-4 toxicities impacting on daily well-being?\*

## Adjustments

- 01. Upgrade 1 level if improved QoL and/or less grade 3-4 toxicities impacting daily well-being are shown
- 02. If there is a long term plateau in the survival curve, and OS advantage continues to be observed at 5/7 years, also score according to form 1 (treatments with curative potential) and present both scores i.e. A/4.



**Final adjusted magnitude of clinical benefit grade**

5

4

3

2

1

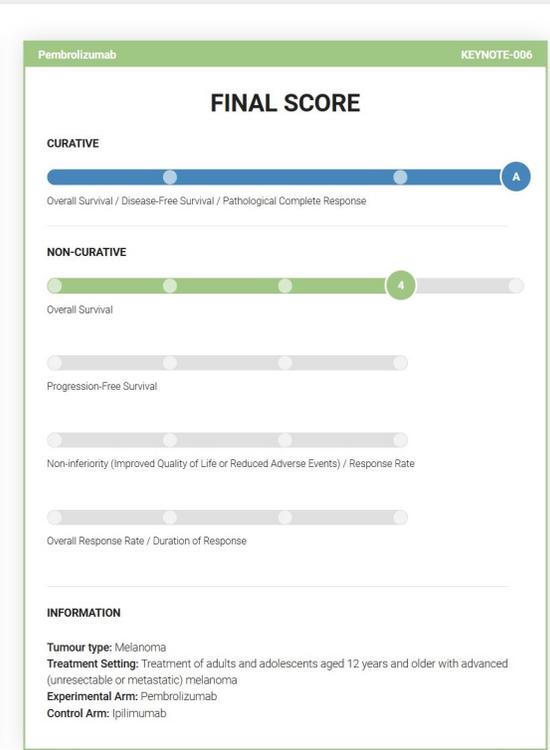
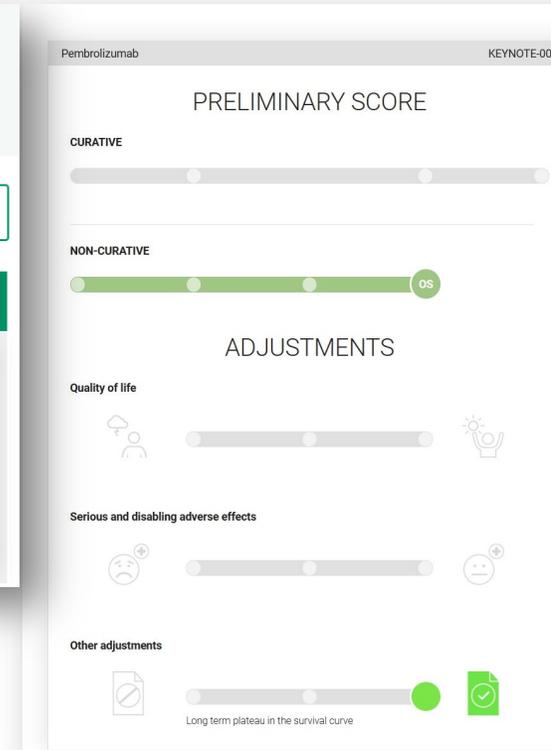
# ESMO-MCBS SCORECARDS: AN EXAMPLE

ESMO-MCBS V1.1 - Evaluation Forms

Evaluation form 1
  Evaluation form 2a
  Evaluation form 2b
  Evaluation form 2c
  Evaluation form 3
  Quality of Life Checklist

Column view
  Table view
  Table with visualisation

✕	Tested Agent(s)	Combined Agent(s)	Control Arm	Treatment Setting	Tumour Sub-type	Ref.	Score	Scorecard
<input type="checkbox"/>	Pembrolizumab	-	Ipilimumab	Treatment of adults and adolescents aged 12 years and older with advanced (unresectable or metastatic) melanoma KEYNOTE-006	Cutaneous Melanoma		<b>A</b> 4	<p><b>PRELIMINARY SCORE</b> NON-CURATIVE OS </p> <p><b>ADJUSTMENTS</b>  </p> <p><b>FINAL SCORE</b> NON-CURATIVE / CURATIVE F2a/F1  <b>4</b> <b>A</b></p>



# ONLINE TUTORIALS



Interactive learning tools



How to use the ESMO-MCBS & the QoL checklist



Form by form instructions: written and visual



# WHAT'S NEW?



ESMO-MCBS v2  
under field-testing,  
addresses previously  
identified  
shortcomings on V1.1  
- ongoing



ESMO-MCBS for  
hematological  
malignancies (ESMO-  
MCBS:H) in  
collaboration with the  
EHA



Defining standards for  
scorable QoL data  
and development of a  
user-friendly checklist  
In collaboration with  
EORTC

# POTENTIAL USES OF ESMO-MCBS

## CLINICAL GUIDELINES

- provide a clear, well-structured, and validated mechanism to indicate the magnitude of clinical benefit.
- this in addition to the level of evidence, can inform national and international guidelines



## PUBLIC POLICY

- provide a backbone for value evaluations.
- help public policy-makers in the advancement of 'accountability for reasonableness' in resource allocation deliberations



## CLINICAL DECISION

- ESMO-MCBS scoring can help clinicians weigh the relative merits of competing therapeutic options.
- Can assist in explaining relative merit of therapeutic options to patients and their families.



## EDITORIAL DECISION

may be of use to editors, peer reviewers, and commentators in considering the clinical significance of research findings



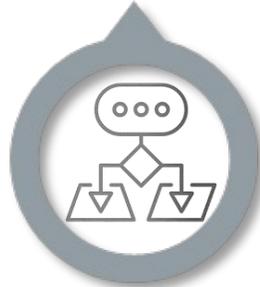
## EDUCATION

- a powerful tool to teach a disciplined and validated approach to data interpretation.
- valuable for oncologists in training and in journal club discussions.



## RELEVANT TRIAL DESIGN

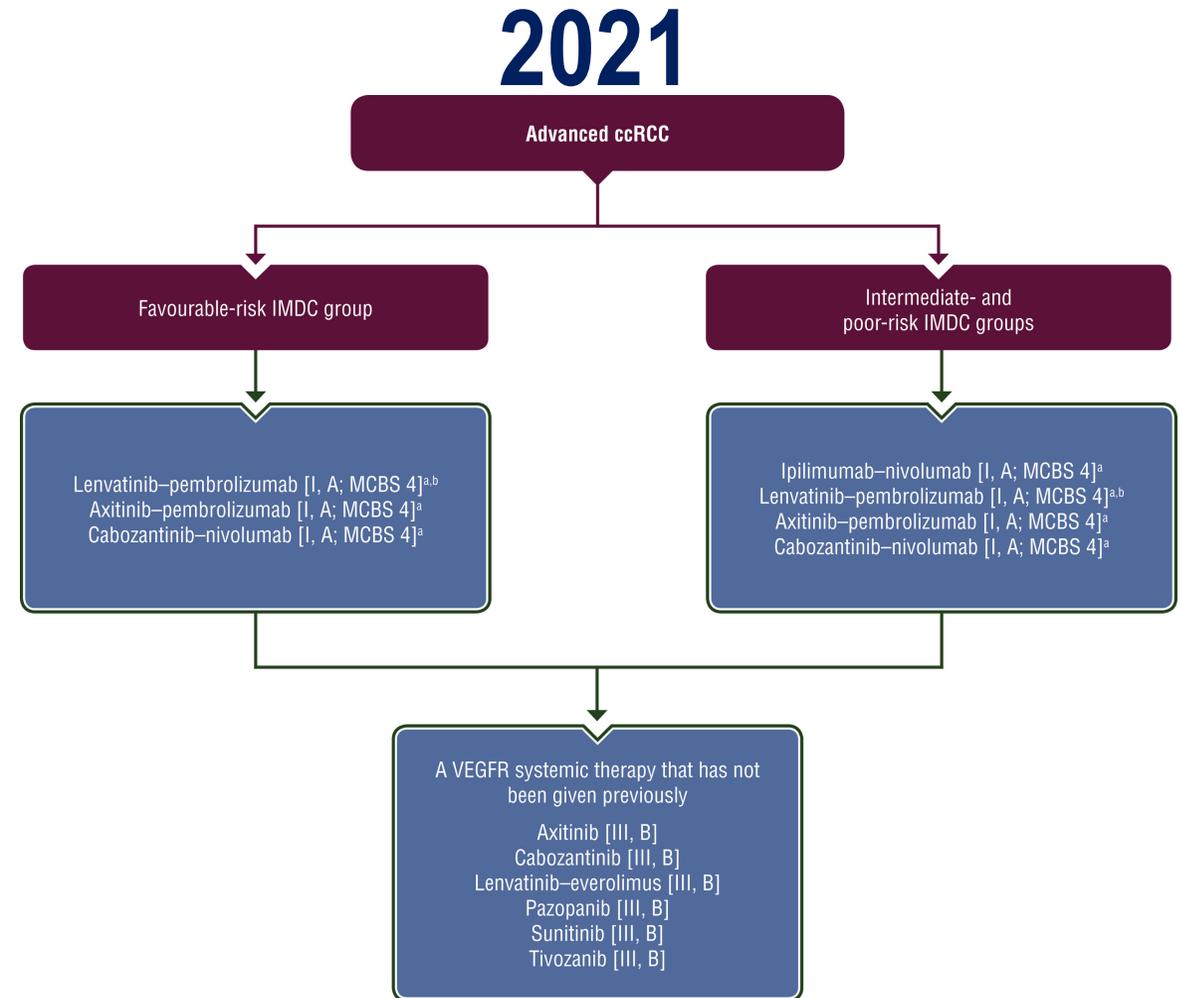
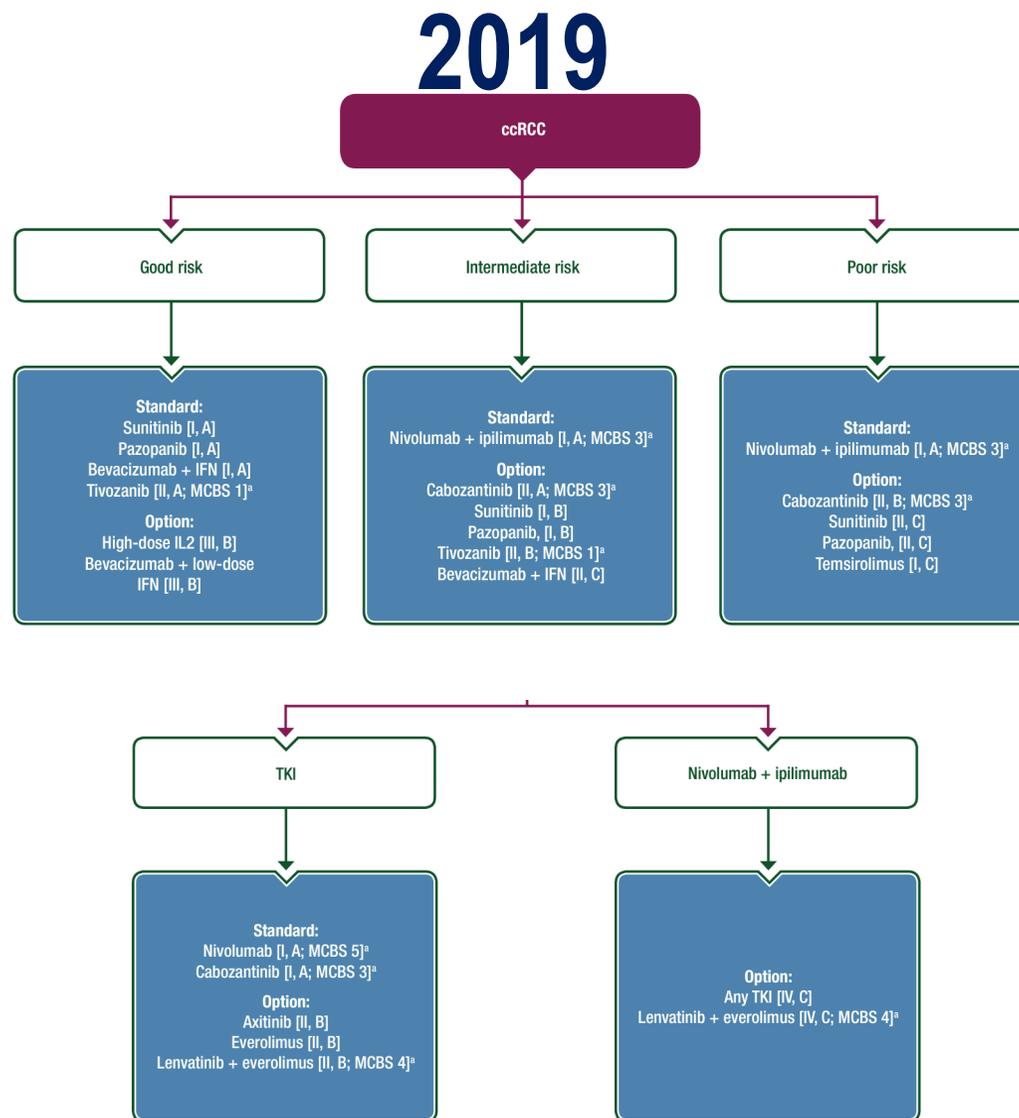
address bias by flawed design, implementation, or data analysis and identify shortcomings needing amendment



**ESMO-MCBS**

# ESMO GUIDELINES RENAL CELL CANCER

THERAPIES CAN BECOME OBSOLETE



# ESMO-MCBS AND THE WHO MODEL LIST OF ESSENTIAL MEDICINES

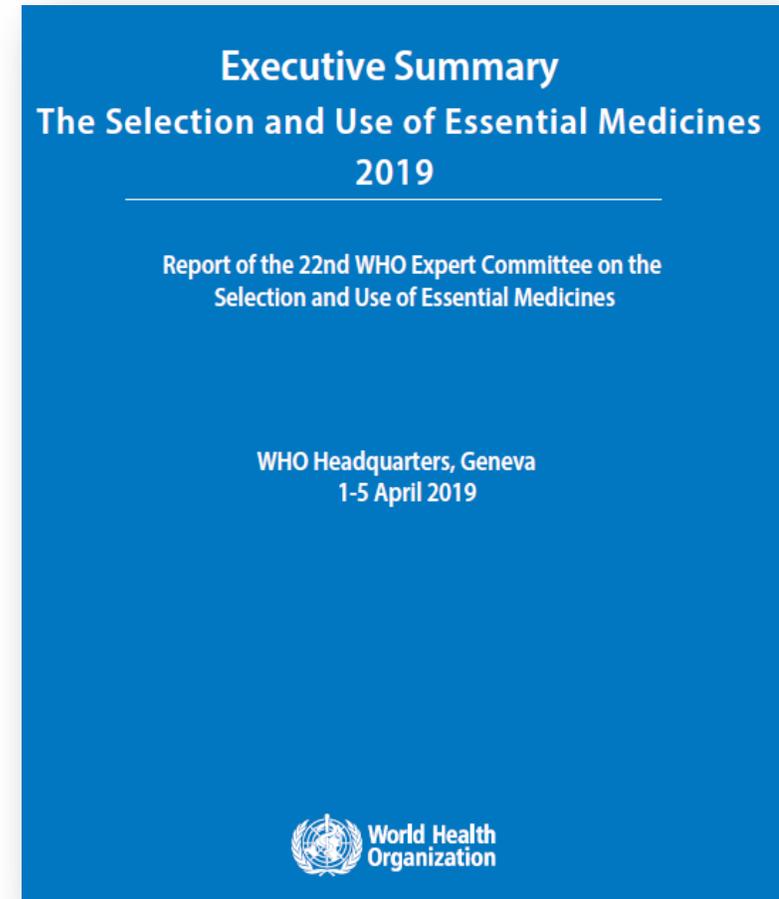


## Essential Medicines List Updates

### From 2019

Potential new EML cancer medicines, should have a score on the ESMO-MCBS of A or B in the curative setting and of 4 or 5 in the non-curative setting.

These scores would support a medicine being evaluated by the Expert Committee for possible inclusion in the EML through a full application.

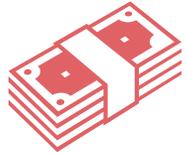


WHO Executive summary: the selection and use of essential medicines 2019: report of the 22nd WHO Expert Committee on the selection and use of essential medicines.

2019 Available from: <https://apps.who.int/iris/handle/10665/325773>

**ESMO-MCBS**

# 23<sup>rd</sup> WHO ESSENTIAL MEDICINES LIST AND ESMO-MCBS (2023)



The main reason for rejection was the **high cost** of these medicines, as well as a need for infrastructures for companion diagnostics and toxicity management



Although they had a clinically meaningful benefit (ESMO-MCBS 4, 5, A, B)



This highlights the issue of **clinically meaningful but unaffordable** medicines, which limits access to essential cancer medicines to patients worldwide

# USE OF THE ESMO-MCBS IN PUBLIC POLICY



Often there is no relation between price and clinical benefit. The ESMO-MCBS can help:



1

Rationalise use and allocation of resources



2

Help to prioritise treatments with higher anticipated benefit



3

Assist in HTA decision making regarding reimbursement/funding

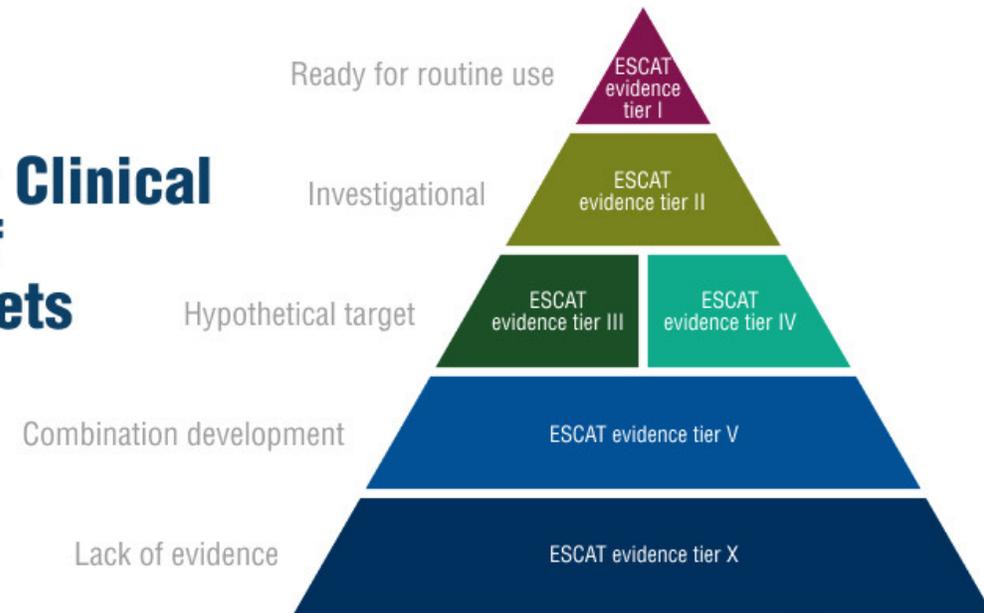
## 2. ESMO SCALE FOR CLINICAL ACTIONABILITY OF MOLECULAR TARGETS (ESCAT)

A framework to rank genomic alterations as targets for cancer precision medicine: the ESMO Scale for Clinical Actionability of molecular Targets (ESCAT)

How 'actionable' is a tumor molecular aberration?

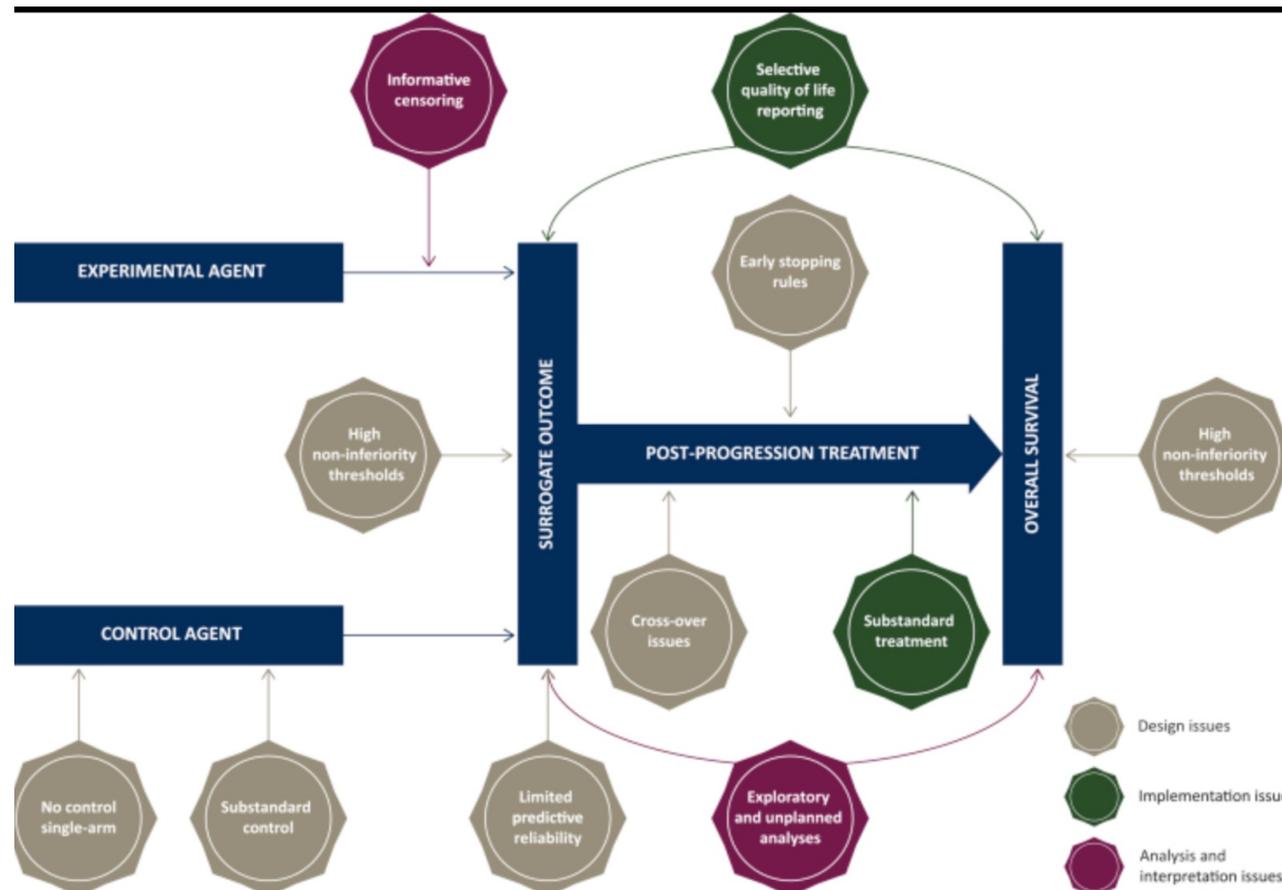
### ESCAT

### ESMO Scale for Clinical Actionability of Molecular Targets



# 3. APPROACH TO IDENTIFY BIAS IN STUDIES

ESMO has described a structured approach to identify bias that may distort the results of clinical studies



# 4. ESMO VALUE-BASED REIMBURSEMENT MODEL

## AIM OF THE ESMO MODEL



- To develop a model to facilitate reimbursement in line with the clinical benefit of the medicine (building on the work done with the ESMO-MCBS) and the local economic realities where the medicine is used.
- To develop a model for sustainable reimbursement of new cancer medicines that is geographically adapted.

# OUTLINE OF THE MODEL

Reimbursement based on local-referenced value



**Clinical benefit  
(value)**

## **Clinical benefit of medicines**

- ESMO-MCBS
- HE parameters
- Frequency of the disease

**Geographically  
adapted**

## **Adapt to the country/region level:**

- GDP and/or % of GDP in health expenditure

**Affordability**

## **Planned outcome**

- New value framework whose outputs can be used to serve reimbursement needs of different stakeholders
- Support price negotiations
- Percentage of reimbursement

## 5. ESMO CLINICAL PRACTICE GUIDELINES



Prepared and reviewed by leading experts and based on the findings of evidence-based medicine



Living Guidelines: clinical practice guidance in a modernised format that focuses on visual representation of recommendations for quick and easy reference by practicing clinicians



To provide a set of recommendations to help patients with the best care options

# 6. ESMO INTERNATIONAL CONSORTIUM STUDY OF THE AVAILABILITY OF ANTINEOPLASTIC MEDICINES (ANMS) 2.0

The preliminary results of the version 2.0 ESMO survey on the Availability and Accessibility of Antineoplastic medicines presented at ESMO Congress 202: showed in low middle- and low-income countries:



**‘Essential’** and ‘old, inexpensive’ cancer medicines

- Are more commonly available only at full cost as an **out-of-pocket expenditure (OOP)**
- Are often unreliably accessible with **non-continuous** availability and **unreliable** procurement



**‘Novel’**, ‘essential’ medicines (ESMO-MCBS 4-5 scores and A –B scores)

- Are largely unavailable, and when available, only at full (high) out-of-pocket expenditure
- Have very limited accessibility

Final data currently under **open peer review** to support the robustness of the information provided, to indicate discrepancies in the data, and to provide additional information on the actual situation of countries.





# BIOMOLECULAR TECHNOLOGY SURVEY

## Background

### ESMO's vision

ESMO is committed to ensuring the timely and optimal treatment of cancer patients, which includes the usage of biomolecular technologies.



### The issue

These technologies, which include biomarkers, are extremely important in the treatment of patients with cancer, but there is very little data regarding their availability, use or costs and reimbursement



To advocate for increased access and availability to these technologies the data from this survey helps to frame and to facilitate a dialogue with health authorities.

# BMT SURVEY RESULTS

## AVAILABILITY & PRICE

**Large NGS panels** (and more) remain largely inaccessible in clinical routine:

- Reserved for clinical trials or basic research (even in EU countries)
- With **cost differences** that are greater as the technique becomes more extensive

## BIOMARKERS

**“Simple validated biomarkers”** (= those that can be tested using relatively simple techniques, not requiring extensive panels) are relatively widely tested across countries

**“More advanced biomarkers”** are rarely tested outside clinical trials or research

- Even in EU countries
- Even for some ESCAT 1 biomarkers despite available drugs (anti-NTRK, anti-RET, Immunotherapy for TMB high...)

## BARRIERS

Two main barriers:

1. **Financial reimbursement** of the biomolecular test
2. **Availability** of a suitable medicine

ESMO stands ready to help the EU institutions, HTA bodies, and the wider healthcare professional community implement the HTA Regulation through the support of its dedicated tools and members' expertise.

**THANK YOU!**