Pharmacy Benefit News

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Commentary: Insurance Cooperatives Launched With ACA Funding

The politics around the Affordable Care Act (ACA) are daunting. Medicare has had at least 11 changes, which also nfluences insurance plans. Changes, however, are frequently due to management of the programs rather than to politics. As a result, we thought that it would be interesting to look at the management changes that underlie the ACA cooperative changes scheduled for 2018. The table below summarizes these changes.

The insurance/health care cooperatives (co-ops) were an experiment. Many of the co-ops have gone under due to financial concerns. Those that focus on primary care have done better, but they are dependent on the risk adjustment formula to gain additional revenue. Unfortunately, even with good intentions, the structure of the risk adjustment did not work. This formula is changing in 2018 although many want it to change in 2017.

Issue	Rational	ACA Changes for 2018
Primary care teams composed of doctors, nurse practitioners, social workers, health care coaches	Spend more time with patients & provide primary care. Health care co-ops underpriced premiums and got sicker patients with pent up demand.	Risk adjustment paid at $0.12/$1 may cause more co-ops to go out of business.
Fee for service payments	Reason to do more unnecessary testing?	Align insurance with care. Co-ops doing primary care may be the answer.
Evidence-based medicine	Better health coverage	Emphasize value
Risk-adjustment formula	Average all diagnostic codes for members who see a doctor in the specific year	Account for partial year enrollment
	Pharmacy data not counted	Include pharmacy data to identify diagnoses even if they don't see a doctor.

	Grandfather plans allowed to exclude people with pre-existing conditions	Get rid of grandfather plans
	Plans that improve the care of patients are penalized by paying risk adjustment to Plans with sicker patients	Adjustments of risk based on changes above

Analytics at Work: A Real World Example

Something Doesn't Add Up...

A client spent an inordinate amount of resources, time and money on searching for fraudulent claims, providers and pharmacies. Pro Pharma was asked to identify, design and implement an alternative option that attacked fraud, waste and abuse (FWA).

Pro Pharma implemented an ongoing analyses that were aimed at preventing FWA. The approach used an integrated data set of medical encounter, pharmacy claims, and enrollment to identify high risk individuals, claims and situations. A tool was designed that allowed for the client to customize geography, common severity of illness, common pharmacy channels, physician specialties, and patient demographics as well as medication use in high risk categories of medications.

Prevention was the goal as it was the most cost-effective method for reducing the risks of FWA. Financial savings were in the range of $1.25 – $2.00 per-member-per-month (PMPM).

Learn More

Commentary: Some Problems with Interpreting Big Data

The goal of big data is to make health care more efficient, productive, safer and less costly. It is also a method to make management decisions about choosing drugs, devices and procedures. Yet, often we see that an association is promoted when causation is not evident or substantiated. In general, we need to ask some simple questions of all analyses or assertions. (**Note**: You don't have to be a mathematician or scientist to ask these simple questions.)

1. When a statement is made, what is the QUESTION that is being answered? If we start with an answer and work to the question, then we are providing a belief.
2. What is the proposer's bias(s)? Judge for yourself as to whether the bias leads to the assertion or association.
3. If an association is made, then what is the evidence that this is real? Associations are not causation. Studiesmust be done on large datasets (usually more than 250 subjects, but are dependent on statistical estimates) to provide evidence of causation. Be very careful, as causation is hard to demonstrate. An association may be of interest, but it is not the same, as

Immunization Registries Attempt to Coordinate Information From Different Sources

One of the problems with big data is that it does not identify patients that may be receiving medical care or therapy from different sites that don't talk to each other. As a result, the dataset does not include all information. One could say that the "big data" is really "big data with holes". It is important that the sources for a dataset are identified. We need to understand at the onset what is included and what is excluded.

As an example, immunizations are now given by physicians, pharmacists, health fairs, etc. How to collect all of this information for any given patient? State Departments of Health are now trying to coordinate all sources. However, since information is collected on a voluntary basis, there are gaps. Some States are more aggressive, for example in California:

- The California Department of Public Health (CDPH) has created a website specifically for pharmacists seeking information on how to submit vaccination

causes leading to this association.

4. Is saying the same thing over-and-over evidence? Repetition is a sales tactic. It is not the same as providing evidence of causation.

In a world of social networking, populism and constant messaging, data overload is a major concern. Noise is a problem with big data. Questioning is a method to reduce the noise!

information to the California Immunization Registry, also known as CAIR.

- **Note**: Pharmacies – not pharmacists – will need to enroll in CAIR to submit vaccination information. For questions about CAIR, pharmacists can contact the CAIR Help Desk at 800-578-7889 or CAIRHelpDesk@cdhp.ca.gov.

"Big Data" sounds good, but it may not be useful if all of the information is not included. Find out where the "holes" are and decide if they make a difference to the end result or outcome(s).

Fraud, Waste and Abuse™

It's not just a cost issue! FWA is not just a requirement for compliance with Medicare!

- **Fraud is illegal**

- **Waste is a squandering of resources**
- **Abuse is a failure of the healthcare delivery system**

Health Plans, TPAs, and PBMs monitor for FWA. Is it enough? Do we wait for an event and then respond, OR do we make **FWA** a proactive management decision?

Pro Pharma has developed a management model (**PP-FWA Management™**) based on prospective education and retrospective surveillance.

Why manage FWA?

The key to the management approach to **FWA** is to identify high risk situations and to prevent waste and abuse through management initiatives

- **The FWA management model is incorporated into current provider outreach and utilization review**
- **Providers are not antagonized as doing wrong**

What's in it for me?

- Spend your time managing rather than reacting
- Spend more time on managing those issues that will result in change
- Place your emphasis on prevention
- Save money up front rather than trying to recover it
- Demonstrate the impact of your management approach through decreased risk and impact on provider PUPM (Per-Utilizer-Per-Month)

FWA can keep you up at night wondering where and when the next axe will fall. Waste and Abuse are endemic in all healthcare systems. Be proactive. Manage it!

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