Pharmacy Benefit News

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Majority of Cardiologist Depend on PhRMA for Drug Information

1. Cardiologists rely on pharma sources roughly twice as much as they do independent sources (65%, vs. 35%)
2. 59% prefer to get info about pre-launch drugs directly from pharma reps, compared to 38% of all physician
3. Cardiologists average 4 meetings with tablet reps in the past month, with average meeting time of 9 minutes vs 3 minutes/month @12 minutes for all MDs
4. 73% rate lunch-and-learn meetings with reps as being influential on their prescribing decisions, compared to 54% of all physicians
5. 52% say their patients' sensitivity to cost increased over the past 12 months

Comment:
The information above is interesting and perhaps troubling. It is important that we understand where information comes from in order to put it in context. Especially at a time when politicians and others rank lying as an acceptable form of communication, we need to ensure that management in health care is based on fact. It is critical that evidence and fact are paramount when judging how to use information for patient care.

The information above is probably representative of the profession (depending on the survey pool), and generally true. Patients may wish to know where their cardiologists and internists get their information. They may also wish to test this information against their own research on the web, and they may also wish to learn if the physician's choices lead to more expensive options. What is concerning is that the many sources of comparative reviews, comparative value and pricing, and objective critical appraisal is not the primary source of information.

The information from pharmaceutical manufacturers (PhRMA) is one source. However, if therapy is to be placed in context, then the sources of comparative information must find simple, available, and inexpensive methods of distribution. Clearly, digital media presents an option. It is, therefore, incumbent on patients, government, and insurers to demand other options for comparative clinical and pricing information. All physicians and patients must have information that allows for the price sensitivity of patients and the time restrictions of physicians to find a common ground.

Source: DRG Digital Innovation Blog

Analytics at Work: A Real World Example

Prevention, Not Cure

Problem: Fraud is generally rare, expensive to prove, and requires attorneys to pursue and prosecute. Medicare and Medicaid have emphasized prevention as the preferred route. As a result, the target is to prevent fraud, waste and abuse. Pharmacy Benefit Managers (PBMs) address the problem at point of care. However, prevention requires behavior changes that must be accomplished through regular and consistent communications including peer-to-peer comparisons. Pro Pharma had one Health Plan who requested a solution in addition to their PBM approach.

Methodology: Pro Pharma Consultants and ProData Analytics deployed a methodology that had been validated in a multi-year provider intervention. A study group was age/gender/specialty/severity/geographically matched with a control group. Hundreds of compliance metrics were analyzed electronically with emphasis on opiates, Scheduled agents, timing of prescription fills, quantity/days' supply, and other Plan pre-selected metrics. All study and control providers were statistically analyzed over pre-program data such that providers who trended above matched averages were grouped into probability bands. For example, in probability quartiles providers were placed in high risk pools of potential fraud, waste or abuse. The providers were analyzed each month and reported in comparison to their matched peers. Every provider was trended to their individual experience and to their matched peers.

Outcomes: Over the first year, and subsequently and ongoing, study providers demonstrated improvements in selected metrics and cost on a per-utilizer-per month (PUPM) basis. PUPM reductions were in the range of 20-30% each year. Compliance with opiates and Scheduled agents were reduced the most at 30-50% or more, while other metrics were reduced at 20% or more depending on the priority of each metric. This was valuable information for the Health Plan and assisted not only with cost controls and compliance with Federal, State and National Regulatory Associations.

Learn More

Commentary: Poloticians Need to Know

As politicians argue how best to design health care for the US population, changes in Medicare and Medicaid are active targets for change. Yet, it is important that they understand the numbers. Twenty percent of people on Medicare (about 11 million beneficiaries) also receive Medicaid assistance. These are often referred to as “duals”.

Who are the major Medicare-Medicaid (Medi-Medi) recipients? Forty percent are less than 65 years old with significant disabilities. Two-thirds of Medicaid spending is for long-term care services. Two-thirds of nursing home residents are Medi-Medi and are women. Finally, federal and state Medicaid spending was almost $147 billion in 2011 according to the Kaiser Family Foundation
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Source: KFF

The Medi-Medi patients are a large subset of the patients covered under the Affordable Care Act (ACA). There is also over 100 million people with pre-existing conditions. These populations add to the use of Emergency Medicine, acute care hospitals and other expensive “primary” care sites.

As we argue about how to support these patients, they were are significant concern, because they either are without insurance or paid high fees. Access has always been available. Approximately two-thirds of the insured population paid for some insurance even if it was not adequate.

The others had access but couldn’t afford it. The Medi-Medi and pre-existing illness patients are the most expensive. Do we choose access that they already have, or find some ways to pay for their care?

What Were the Top Five Prescription Medications by Revenue in 2016?

1. Humira (AbbVie) $16.078 billion
2. Harvoni (Gilead Sciences) $9.081 billion
3. Enbrel (Amgen and Pfizer) $8.874 billion
4. Rituxan (Roche [Genentech] and Biogen) $8.583 billion
5. Remicade (Johnson & Johnson and Merck) $7.829 billion

Source: Genetic Engineering & Biotechnology News

Comment:
These medications are all specialty. Traditional medications are already giving way to specialty medications. It is important to note that these medications are for chronic diseases, except for Harvoni. The challenge is how to pay for these medications and the new ones in the pipeline? In the short term, we must evaluate them at least by approved diagnoses, dosing compliance and quantities that do not lead to stockpiling.

In the long term we must find new methods for financing these medications, as well as choosing care based on comparative

analyses of clinical value as well as affordability. This problem is significantly larger than the issue of whether the US stays with the Affordable Care Act or changes to the American Health Care Act. Either approach will be rendered a failure as these costs dwarf hospital and other expensive sites of care.

PRODATA ANALYTICS

FWA

Fraud, Waste, and Abuse™

FWA is a problem based on the IDENTIFICATION of high probability offenders (fraud) and a program to PREVENT high probability abuse and waste. Since FWA can occur when prescribers, patients, or pharmacists err for any one of multiple reasons – e.g., intentional fraud, careless waste, or abusive behaviors – management must attack the problem using multiple strategies.

These strategies target prevention while the most egregious offenders are targeted for fraud.

What are the high probability intervention opportunities?
What interventions are possible at point-of-sale?
What are the opportunities for preventing further abuse or waste?

Important client benefits are:

- *Make FWA a resource-efficient and cost-efficient process*
- *Target prevention to limit the time and resources spent on prosecuting fraud*
- *Target high value fraudulent opportunities*

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