Pharmacy Benefit News

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Commentary:
Hospital Readmissions – An Improvement in Care or In Insurance?

The Agency for Healthcare Research and Quality published data regarding the hospital readmission rate. Readmissions have become a major concern for hospitals. Under Medicare the Hospital Readmission Reduction Program penalizes hospitals for excess readmission rates. This has been going on since 2013. In 2017 79% of hospitals were penalized for a total of $528 million. The number has been rising every year with the 2017 penalty about $108 million more than in 2016. However, readmission rates for 2017 (vs. 2005-2008) are now at 22% (vs. 25%) for Heart Failure (HF), and 17% (vs.20% and 18% respectively) for heart attack and pneumonia rates.

The rationale for the penalties is the cost of readmissions that are preventable. The estimated impact of preventable readmissions is $40 billion each year. As a result, Medicare highlighted six target conditions to assess for compliance; namely, heart attack (MI), heart failure (HF), pneumonia, chronic obstructive pulmonary disease (COPD), hip/knee replacement and coronary artery bypass grafting (CABG). The idea was that good hospital care could be combined with ambulatory monitoring by physicians to keep those patients out of the acute care hospital setting.

The Kaiser Family Foundation attributes the increase in penalties to the increased number of conditions being measured. However, the numbers indicate that the type of hospital, payer type, and condition being measured are all variable. For example, penalties for hospital types vary from 9% at major teaching hospitals to 75% at urban hospitals. For congestive heart failure (CHF) readmission rates vary from 30% Medicaid and 25% Medicare to 20% private insurance and 17% uninsured. Finally, readmission rates for kidney transplants are 29% to 19% for heart valve procedures.

Hospitals seem to be doing a bit better job, but not extraordinary. Perhaps expertise has improved both surgically and medically, and perhaps the benchmarks were already improved such that only marginal benefits could be achieved. However, the type of hospital and insurance coverage seem to be more important. This issue needs more research so that we are penalizing the conditions that can be most improved.

Analytics at Work: A Real World Example

Pre-Certification of Specialty Medication™

Problem: One of our clients was concerned about comparing the medical versus the pharmacy specialty spend. Their primary concerns were the location of service and applicable costs, as well as the overall gross trend of their per-member-per-month (PMPM) trends. Separately, the clinical group within the organization wanted to know if their clinical cost control methods were effective on a total Plan as well as on a per provider basis.

Solution: We analyzed every specialty medication claim from both medical and pharmacy data for this client each month. All findings were filtered by location of service, PMPM, provider specialty, disease/condition, provider, etc.

compliance with contracts, rebates, value of wastage, etc. For the clinical group, all claims were analyzed for prior authorizations (PAs) for formulary exclusions, efficiency of prior authorizations and step therapy, adherence by drug and by category, etc.

Outcomes: Financial savings for our client were identified on average of 42-44% of paid amounts. Clinical analyses identified beginning compliance of 50% and cost control methods, including PAs at 60% efficiency. After the implementation of the new process, the compliance increased above 80% and clinical cost control efficiency was above 70%.

Commentary: Hospital Star Ratings Depend On…

The Centers for Medicare & Medicaid Services (CMS) released their first Hospital Star Ratings in 2016. They measured 64 measures of quality with 12 measures needed to receive a star rating. The goal was to receive 3 or more stars to be paid by Medicare. The results are illustrative of what must be done to improve care across the United States. The results are that:

-102 hospitals received 5 stars
-934 received 4 stars
-1770 received 3 stars
-723 received 2 stars
-133 received 1 star
-937 not rated

The real results are the reason for this commentary. Namely,

-Small, rural hospitals do better
-Teaching hospitals do worse
-Bigger hospitals do worse
-Serving the poor does worse

Only the Mayo Clinic received 5 stars from the top 20 hospitals on the US News & World Report's Best Hospitals.

What to do? Best Practices and Centers of Excellence need to teach other hospitals so that everyone benefits.

Commentary: How Do We Get People to Comply With Exercise, Food And Prevention?

Healthcare often states that patients are counseled, but do not follow preventative techniques to address their own medical problems. The rise of consumerism is placing more of the responsibility on the patient, but without a road map of what to do. Certainly, technology is providing many apps to help with exercise and diets. However, there is something to be learned from the prescription process.

Doctors use prescriptions to direct medication therapy and provide information sheets to comply with diet. Consider that diets, exercise, smoking cessation, and other preventative techniques could be "prescribed" with the same directions, oversight, goals and midcourse corrections as prescriptions. The goals would be clearly stated, and the objectives would be monitored regularly with each medical visit. Patients not reaching goals would be managed the same as a patient whose blood pressure is not at goal, etc.

Yes, some of this is already done. However, the emphasis on reaching goals coupled with increases in penalties put emphasis on positive achievements. The prescriptions for these preventative techniques require more frequent monitoring including family, friends, digital solutions and constant behavioral change place an additional emphasis on the care givers. Yet, the prevention model is based on a team approach such that the doctor is not the only provider of care.

The problem is large, because it is bigger than clinical medicine. The solution needs to be bigger as well.

MAC

Maximum Allowable Cost - Customizable MAC Fee Schedule

Generic pricing should provide normative (cost plus) pricing for both Plans and Pharmacies. MAC fee schedules should pass all savings to Health Plans and patients. To satisfy pharmacists and Plans the MAC fee schedules should be transparent, updated frequently, and based on customizable criteria.

Pro Pharma MAC lists can be accessible to all applicable pharmacists to review.

The Pro Pharma MAC is customizable by clients using approximately 50 criteria, including:

- Manufacturers
- Drug classifications
- Benchmark pricing standards
- Cost plus formulae
- Discounting
- Data sources for bases of cost
- Benefit design parameters, etc.

Changes are made based on access, shortages, and significant price changes.

Important client benefits are:

- *Anchoring overall trend by reducing generic trend*
- *Pharmacists can buy better when they know what they will be reimbursed*
- *Comply with State laws for transparency*
- *Improve relationships with pharmacy networks*

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Pro Pharma Pharmaceutical Consultants, Inc. has assisted payers and providers for over 31 years to maintain quality while controlling costs.

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