PRO PHARMA
PHARMACEUTICAL CONSULTANTS, INC.

Pharmacy Benefit News

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01 | Commentary: Who Do Physicians Work For?

The era of independent physician practice is less common. A new study by the Physicians Advocacy Institute indicates that 42% of physicians were employed by hospitals in 2016. This happened quickly as just 25% were employed by hospitals in 2012. Just from 2015 to 2016 the number of US physicians employed by hospitals grew by 14k.

These numbers do not include physician practices owned by corporations, health plans, or other organizations. The trend is to include and manage physician practices so that their "pen" when writing prescriptions is controlled to reduce costs, utilization and shifting of practices to less expensive ambulatory sites. This presumably also shifts fee-for-service based on the volume of work to the value or results of the work. These results seem to indicate that if you want physicians to do what the health care system wants, then they need to work for "you".

Source: NetAtlantic

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Analytics At Work | Quality Management Program

Problem: A client asked us how to measure pharmacy quality improvement so that their CFO and

savings.

Methodology: We established an overall pharmacy intervention program based on physician prescribing practices using a main intervention group, a control group, State Medicaid as well as a State Employee group for comparisons.

Our approach was based on a monthly communication of actual physician prescribing, behavior modification program tracking trends in spend and per-utilizer-per month costs vs. Best-In-Class comparators that included over 70% of pharmacy spend. The reference group was formed based on similar Plan type, benefits, patient volume, diagnostic profiles, severity, physician specialty, and geography. State Medicaid and State Employees were used as additional comparators trended over the same time periods. The program continued uninterrupted for eight (8) years and was re-evaluated every year.

Outcomes: Savings were quantified on a quarterly, bi-yearly and annual basis every year for 8 years. Annual trends were consistently less than 2% vs. national trends of 11%. The comparators were never less than 11+% trends annually, while the Medicaid and Employee Plans averaged 7% and 12%.

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02 | Commentary: Geography Matters When It Comes to Paying for Health Care

In the 1980s Dr. John Wennberg did studies indicating that the delivery of health care had different costs depending on your location in the United States. The result was “The Dartmouth Atlas of Health Care”.

site of care, the volume of services delivered, hospital and physician salaries, and other indicators were presumably associated with the varying costs.

Now the San Francisco Chronicle reports that health care costs in Northern California are 30% more than in the rest of California. The Chronicle refers to a study by UC Berkeley's Petris Center on Health Care Markets and Consumer Welfare. The Chronicle cites consolidation in hospitals, insurance and physician practices between 2010 and 2016 are primary reasons for the differences. They cite a 20-30% higher cost for medical procedures, 32% higher for inpatient, 28% higher for outpatient and premiums 10% higher. These figures adjust for the higher cost of living and wages. If the gross differences are cited, then inpatient care is 70% higher, outpatient care is 17-55% higher and premiums are 35% higher.

These results point to the discussion of the value of mergers and acquisitions in the health care space. Essentially, do national mergers of health plans and PBMs, plans and doctor practices, plans and pharmacies produce a more competitive lower cost market? This data indicates NO! Realize that this data does not include the rising cost of expensive Specialty Medications treating orphan disease, previously untreatable conditions, new treatments for chronic conditions, etc.

What is to be done? Market place competition, including technology assisted solutions, telehealth, international competitors, and ads by competitors, even in the same state, will probably leverage these cost differentials. However, Wennberg's results continue to prevail over 20 years later, so market competition may not be that effective.

Source: San Francisco Chronicle, petris.org

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PBMI Webinar | Headaches No More...Improving Parity in Medical Specialty Reimbursement

A large public health plan in California identified issues in the payment of specialty pharmacy claims paid under the medical benefit. During this webinar, you'll learn what steps this health plan took to make Specialty Rx more efficient, accurate, and less costly.

Date: June 13th
Time: 1:30 pm EDT

Reserve Your Seat >

03 | Commentary: What Is an Alternative to Opiates for Acute Pain?

The American Dental Association (ADA) released new guidelines for the use of opiates in acute pain. Their guidelines a no more than 7 days of treatment with opiates. They call for more continuing education for dentists and prescription drug monitoring programs to prevent opiate misuse.

They also performed reviews of the literature and determined that for acute pain Ibuprofen 400mg plus Acetaminophen 10000mg was better than opiates for the relief of postoperative dental pain.

How does the ADA guideline compare with other guidelines? The CDC recommendations are for =< 3 days of opiates for acute pain is enough, but that no more than 7 days is “rarely needed”.

CRUCIAL CAVEATS, are that all the guidelines should emphasize, but are commonly missing are:

- Opiates no more than (NMT) 20 mg morphine equivalent – NMT 5-6 TABLETS Hydrocodone/APAP 5/300 per day
- Ibuprofen no more than 3000mg per day – i.e., NMT 8 tablets of Acetaminophen Extra Strength 500mg per day
- Acetaminophen no more than 4000mg per day (preferentially NMT 2900mg day) – i.e., no more than 8 tablets of 500mg per day

Sources: ADA, CDC

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Pro Pharma Pharmaceutical Consultants, Inc.
P.O. Box 280130
Northridge, CA 91328-0130
www.propharmaconsultants.com