Pharmacy Benefit News

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Three Years Later, Where Are We Now with Accountable Care Organizations?

In a report published on August 29, 2017, the Office of Inspector General (OIG) concluded that Accountable Care Organizations (ACOs) saved about $1 billion for the Centers for Medicare & Medicaid Services (CMS) while providing high-quality care. ACOs are established as a part of the CMS's shared-saving program initiative under the Affordable Care Act (ACA). This initiative – which accounted for $168 billion in Medicare expenditure over the past three years – focused on paying providers based on value rather than volume.

The report analyzes CMS data from 428 ACOs over the first three years of the program. About 82% of ACOs improve the quality of care based on CMS's 33 individual quality measures. ACOs also outperform the traditional fee-for-service providers on 81% of the quality measures. In term of cost, 282 of the 428 ACOs (67%) reduced spending for at least one of the first three years. The remaining 146 ACOs exceeded their spending, compared to their benchmarks, for all three years. Notably, ACOs that generate savings have higher benchmarks on average.

Commentary:
ACOs are groups of providers and hospitals who come together to coordinate care for Medicare patients with two major goals: provide quality care and decrease health care spending. When an ACO achieves both goals, the CMS will share a portion of the saving with the organization. The goal for healthcare spending is set based on each ACO's historical benchmark. In terms of quality, there are four major domains established by the CMS: patient/caregiver experience, patient safety/care coordination, preventive health, and at-risk population.

This report shows that ACOs are improving quality of care as compared to the fee-for-service models. The cost-saving aspect of the shared-saving program is not universal. The net $1 billion in saving is only a small fraction of the $168 billion investment in the program. Moreover, using the historical benchmark benefits ACOs that have high baseline spending. This is evident since most ACOs that share the savings are those that have high spending benchmark initially. Health systems that already have low spending at baseline often struggle to reduce spending further.

Indeed, the ACO model is still not the perfect model for value-based payment nor it is the "silver bullet" for solving our increasing healthcare spending problem. However, the ACO model is a step in the right direction. The OIG report proves that, with the right incentives, the US healthcare system is capable of spending less while also delivering quality care.

Reference:
1. Office of Inspector General, Department of Health and Human Services. "Medicare Shared Savings Program Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality." Office of Inspector General - US Department of Health & Human Services, Office of Inspector General, 29 Aug. 2017, oig.hhs.gov/oei/reports/oei-02-15-00450.asp

Analytics at Work: A Real World Example

Those Who Do Not Learn History Are Doomed to Repeat It

Problem: A common request these days is -- Can an audit help me to understand why costs are high, as my PBM is not helpful? At the same time other PBMs say they can help, but I am unsure if this is just marketing on their behalf. A client contacted Pro Pharma for an expedited Retrospective Audit to determine the drivers of cost and the options available for change.

Methodology: Pro Pharma/Pro Data performed a Retrospective Audit including tests for eligibility, benefit compliance, brand and generic pricing, specialty pricing/utilization, benchmarking to national and local standards, and transparency in bases of cost. The Audit was expedited by 100% electronic/digital analyses to facilitate quick turn-around time to significantly reduced Audit Costs, and available for desk and mobile devices. Findings included potential problems with formulary claims that were coded as Brand when the Plan expected Generics; problems with transparency such that AWP was inflated from national reference databases; specialty approved for total Rx without tests for FDA approvals, quantity, dosage and companion diagnostic tests; pricing above benchmarks, discount generic programs, Medicare/Medicaid when applicable, and patients paying more than cost of drug.

Results: The client used the findings to redirect coding options to include only Generic formulary options for multisource (especially timed-release products), OTC, store brands and private labels. They worked with the PBM to correct inflated AWP issues, and variances from Medicare and Medicaid. They moved specialty to Prior Authorization (PA) and improved criteria. They expanded the benefit to include payments for discount generic programs, and removed zero-balance options. The result was normative pricing that was measurable and validated, low single digit point-of-sale trends, and a methodology for analyzing future spend.

Concurrently, with a plan, an understanding of the drivers of cost, a methodology for matching actual spend to expectations, and improved satisfaction, the client felt that they now had control.

Learn More

Who Is a Diabetic?

In July 2017, the Centers for Disease Control (CDC) released "The National Diabetes Statistics Report" that estimates the 2015 prevalence and incidence of diabetes and prediabetes, risk factors for complications, deaths from diabetes, and cost. Prevalence is the total of all cases of diabetes in the US. Incidence is the number of new cases. The results are:

- For prevalence: 1 out of 10 people in the US have diabetes and 1 out of 3 adults have prediabetes.
- In term of awareness: 1 out of 4 don't know they have diabetes and 9 out of 10 people don't know they have prediabetes.
- For incidence, there is about 6.7 new cases of diabetes per 1,000 people.
- The top three risk factors for diabetes-related complications are overweight/obesity, high blood pressure, and high cholesterol. Other risk factors are physical inactivity and smoking.
- Diabetes is also reported as the seventh leading cause of death in the US.
- People with diabetes have medical costs that are 2 times higher than people without diabetes. The total direct and indirect costs from diabetes are estimated to be about $245 billion.

For further details about this report, go to https://www.cdc.gov/diabetes/data/statistics/statistics-report.html

Commentary:

If Clinical Guidelines Are Not Followed, Then Why Have Them?

A recent study found that while many primacy care providers (PCPs) think they are following the most recent diabetes guidelines, their actual practices differ significantly. The study conducted an online survey to assess PCPs' understanding and adherence toward the type 2 diabetes screening guidelines from the American Diabetes Association (ADA) and 2008 US Preventive Services Task Force (USPSTF). Researchers then analyzed electronic health records (EMRs) data from each PCP to confirm adherence to the guidelines.

While 40% of physicians responded that they use both guidelines to screen all patients, the EMR data did not support about one-thirds of the responses. While most PCPs answered that they often screen at-risk patients for diabetes, at least 1 out of 4 physicians' responses was not supported by the EMRs data. There is also a lack of referrals to diabetes educational programs. Researchers concluded that more understanding of the barriers to guideline uptake and adherence is needed.

Commentary:
In the study above, there are only 40% of physicians who report their use of the diabetes screening guidelines. In other words, there are 60% of physicians who do not know or are not following the guidelines. This is of concern because clinical practice guidelines are rulebooks for best practices and standards of care for managing specific diseases. Quality of patient care can suffer when physicians are not following these best practices.

To understand the implications of the data discussed above, it is imperative to observe overall trends over time. In recent years, the prevalence of diabetes had been steady with only a minor increase. According to the United States Diabetes Surveillance System (USDSS), the prevalence for diabetes in 2012, 2013, and 2014 was estimated to be about 9.0%. Compare this to 2005 in which the disease prevalence was 7.3%. What is the explanation for this increase? Aside from the increasing incidence of obesity, diabetes might have been under-diagnosed in the past.

As public awareness of diabetes increases over time, more testing is being done and thus more diagnosis of diabetes. Due to a recent major change in CDC's data collection methodology, new data after 2012 cannot be accurately compared to past estimates. Moreover, these estimates are calculated based on survey data which can have biases that lead to inaccurate results. In interpreting data and statistic, it is important to consider the overall trend and understand the possible cause of such trend.

References:
1. Centers for Disease Control and Prevention. National Diabetes Statistics Report, 2017. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2017.
2. "Methodologic Changes in the Behavioral Risk Factor Surveillance System in 2011 and Potential Effects on Prevalence Estimates." Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, 06 Feb. 2013. Web. 06 Sept. 2017.
3. "U.S. Diabetes Surveillance System." Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, n.d. Web. 06 Sept. 2017. https://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html

One barrier to the implementation of the guidelines is the lack of immediate feedback to the provider's performance, both from patients as well as from other providers. Unlike in acute care, the outcomes of a provider's clinical decisions in managing a patient's chronic disease are not immediately measurable. A providers' performance is often not compared with their peers. with our current health technologies. This lack of feedback gives little incentive for experienced providers to adhere to newly published guidelines.

Another barrier is that patients are complicated with multiple comorbidities while guidelines are usually disease-specific. Moreover, deciding which guidelines to use is also another barrier. There are often multiple guidelines from different organizations to treat just one disease. For example, the study discussed above used two guidelines from two different organizations just for diabetes.

Data analytics and health informational technologies such as EMRs can play an important role in enhancing guideline's adherence and uptake. Data analytics can provide frequent feedback to providers by tracking patients' charts and comparing providers' performance among their peers. The institution's EMRs can adopt clinical support tools that will remind providers of the standards of care during the patient encounter. These tools can improve efficiency of care, reduce waste, and improve overall quality of care.

References:
1. Mehta S, Mocarski M, Wisniewski T, et al. Primary care physicians' utilization of type 2 diabetes screening guidelines and referrals to behavioral interventions: a survey-linked retrospective study. BMJ Open Diabetes Research and Care 2017;5:e000406.
2. New England Healthcare Institute. Improving Physician Adherence to Clinical Practice Guidelines: Barriers and Strategies for Change. 2008.

PRODATA ANALYTICS

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Retrospective Audit™

Pro Pharma performs Retrospective Pharmacy Claims Audits to ensure compliance with PBM contracts. These audits fall under the accounting rules for Attestations. Pro Pharma is sensitive to conflicts over audits and makes every effort to identify areas requiring validation and to work with all parties to ensure contract compliance.

Pro Pharma's Retrospective Auditing of Pharmacy Claims is a Management Tool that maintains contract compliance as well as identifying management targets. Pro Pharma...

- *Performs 100% Pharmacy Claims Audits and places them on the cloud for immediate review and validation*
- *Has a digital approach to pharmacy claims audits provides fast, efficient, and affordable auditing*
- *Is always the lowest cost option for auditing to ensure contract compliance*
- *Utilizes digital supporting information to expedite the process and make it exhaustive, but affordable*
- *Provides peripheral identification of Physician and Pharmacies responsible for outlier and/or for potential "abuse"*

Fundamental areas for audit are, but not limited to:

- *Formulary Compliance*
- *Eligibility*
- *Pricing/MAC Compliance*
- *Invalid Claims*
- *Excluded Benefits*

These audits review invoices with the pharmacy claims over the audit period. These screens also target the Providers, Physicians and Pharmacies responsible for rejected claims that did not meet contract requirements, or for which continued monitoring is recommended.

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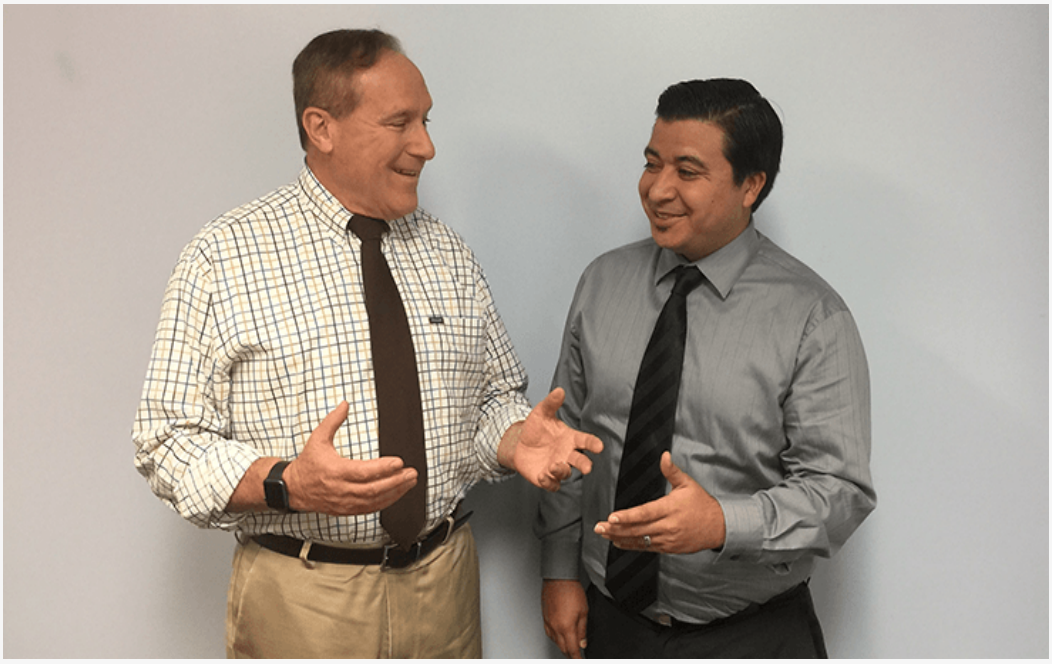

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Live on Facebook, Twitter and YouTube

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

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