Third Party Prescription Programs

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Learning Objectives

- Recognize the types of managed care organizations
- Discuss managed care techniques used to influence the use of medications
- Describe the claims submission and payment process for pharmacy services
- Describe the impact of third party payers on pharmacy practice

National Health Expenditures

- Total health expenditures (2000) = $1,311 billion – 84.6% paid by third parties
- Total health expenditures (2010) ~ $2,637 billion – 84.7% paid by third parties
- From: http://www.hcfa.gov/stats/NHE-Proj

National Drug Expenditures

- Total drug expenditures (2000) = $117 billion – 65.7% paid by third parties
- Total health expenditures (2010) ~ $366 billion – 71.0% paid by third parties

Third Party Payers

- Private insurers
  - Employer-sponsored
- Governmental programs
  - Federal programs
  - State and local programs

Private Insurers

- Employer-sponsored insurance – 43.9% of drug expenditures in 2000
- Greater use of managed care organizations
- Concerned about rising health care costs

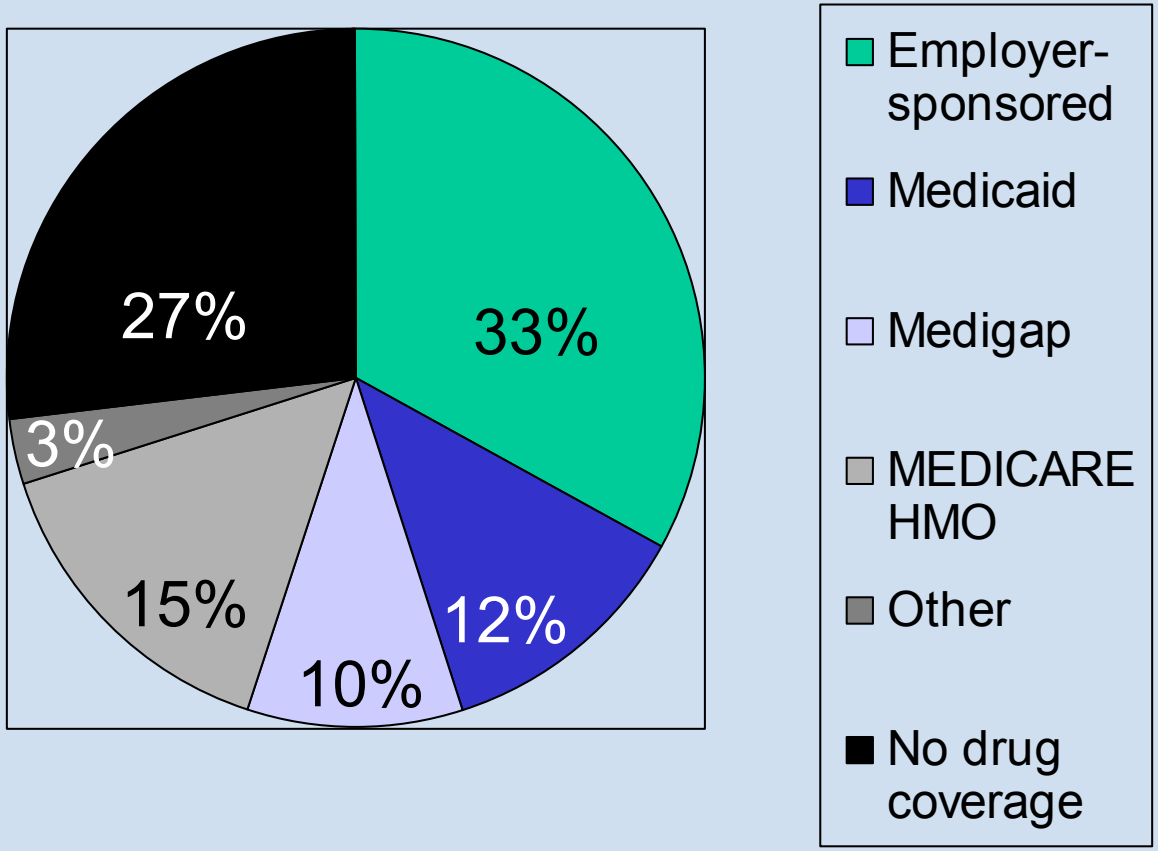
Federal Programs

- Administered by the Centers for Medicare and Medicaid Services (CMS)
- Medicare – program for elderly and disabled
- Medicaid – program for indigent

Medicare

- In 2001 covered 34 million elderly (ages 65 and older) and 5 million disabled
- Part A – covers institutional care (e.g. hospitals, skilled nursing facilities)
- Part B – physician and outpatient services
- Outpatient prescription drugs not covered, except by some Medicare HMOs

Source of Prescription Coverage for Medicare Beneficiaries

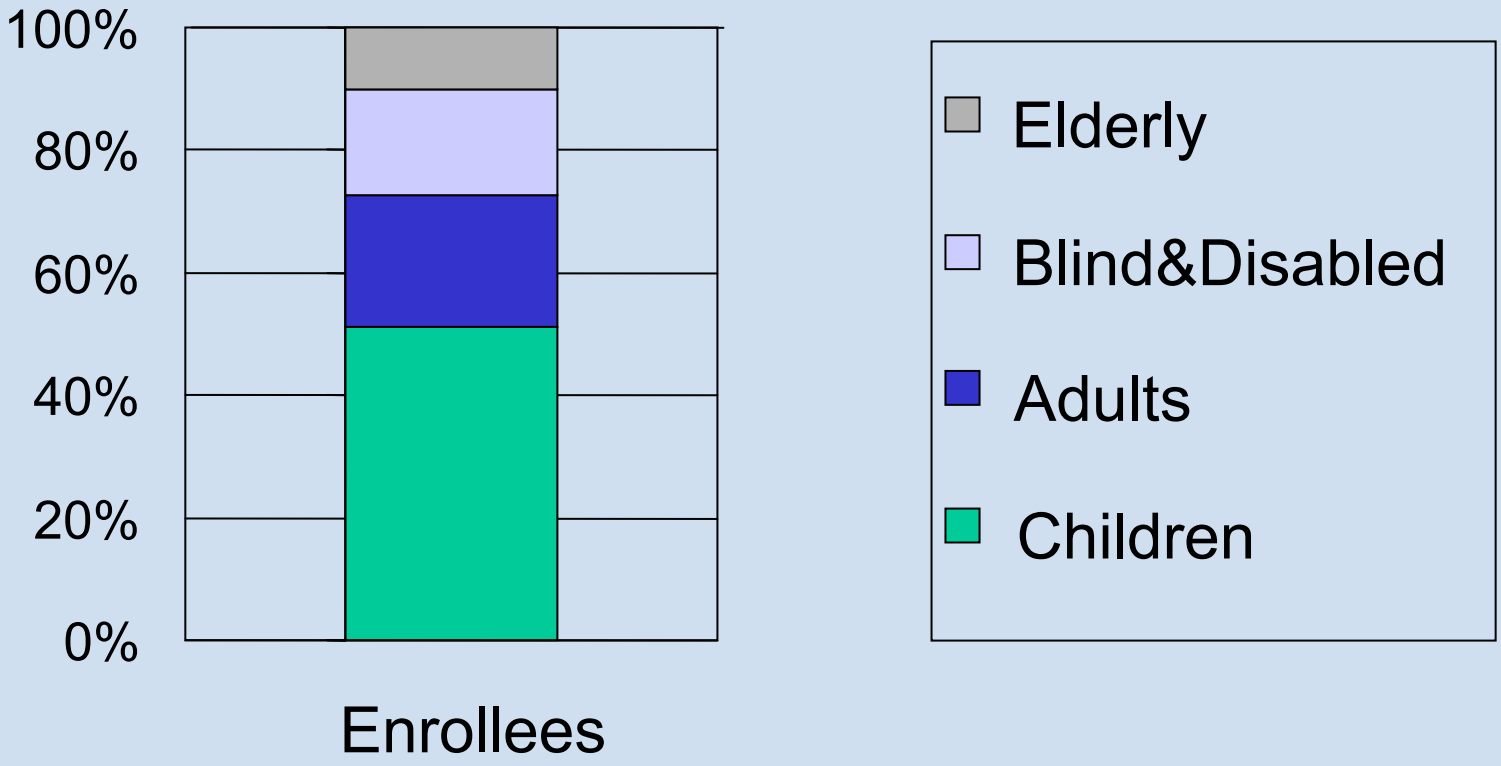


Source: Poisal JA and L Murray. *Health Affairs*, Mar/Apr 2001

Medicaid

- In 1998, 40.4 million people were enrolled – at a cost of $169.3 billion
- Covers hospital, medical, long-term care are mandated covered services
- Prescription drug coverage is optional, but is commonly offered by states

Medicaid Enrollees



Source: Urban Institute estimates, 2000

Managed Care

- Managed care – A system that integrates the financing and delivery of health care
- Managed care organizations form networks of providers, formed through contracts, to deliver care to groups of enrollees

Components of Managed Care

- Contracts with selected health care providers
- Prospective payment levels
- Assumption of financial risk by providers
- Utilization and quality controls

Provider Contracts

- MCO contracts with providers (e.g. hospitals, physicians, pharmacies)
- Some level of discounted payment in exchange for patient volume
- Exclusivity may be part of agreement

Prospective Payment

- Payment level is determined before care is provided
- Actual payment made subsequent to claim submission process

Assumption of Risks by Providers

- Some MCO's assign risk to providers by setting payment levels
- Diagnostic-related group (DRG) in hospitals
  - Sets payment by diagnosis of admission
  - Example: uncomplicated appendectomy

Assumption of Risks by Providers

- Capitation – used commonly with physicians
  - Sets payment per person for a period of time

Utilization and Quality Controls

- MCO's use a variety of techniques to control the utilization of care
- Some controls target providers, while others target patients
- Quality assurance is applied to many care processes

Organization of Managed Care

- Managed care often viewed as a continuum of degree to which care and costs are controlled

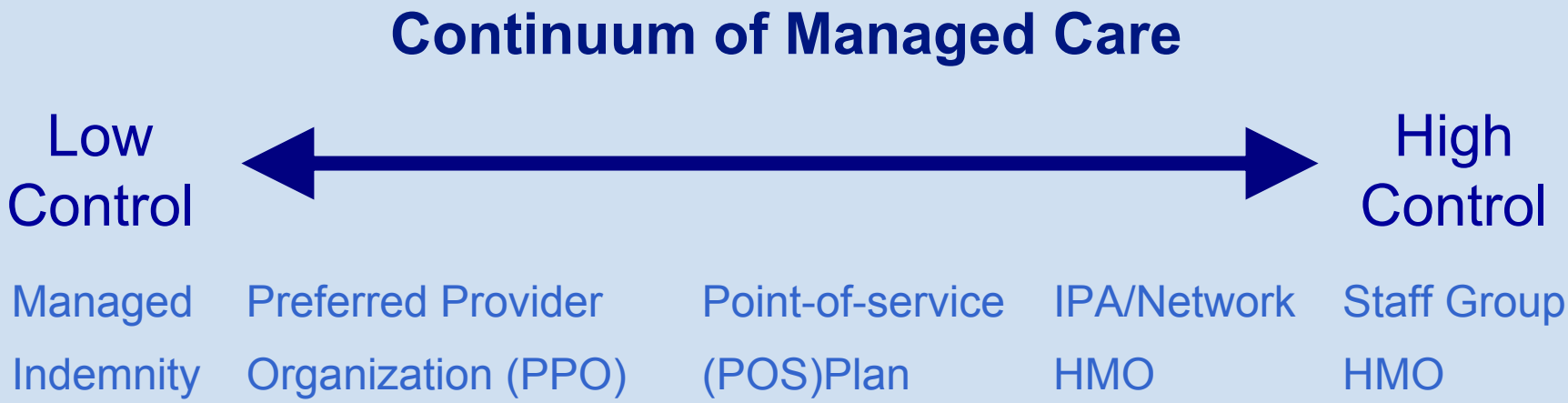


Figure adapted from Navarro and Cahill 1999

Managed Indemnity

- Have overlaid some control onto traditional indemnity plan
- Lacks a contract with providers
- May include pre-certification of elective procedures and limited case management

Preferred Provider Organization (PPO)

- Affiliations of providers that contract with MCO's – discounts common, capitation is not
- Often have nonexclusive arrangements
- Financial incentives for patients to receive care from PPO member provider

Point-of-Service (POS) Plan

- Patient has a choice to use a provider within the network or one outside
- MCO covers non-network services to a lesser degree than those received from network providers
- Patient chooses the provider when the care is needed – at the point of service

Health Maintenance Organization (HMO) Models

- Four common models of HMOs
  - IPA (independent practice association) model
  - Network model
  - Group model
  - Staff model
- Many insurers have created hybrids of the four HMO types

IPA Model HMO

- HMO contracts with an IPA, which is comprised of independent practitioners who also see non-HMO patients
- A versatile model – the IPA may be community-based or hospital-based
- Limited control since have independent practice

Network Model HMO

- HMO contracts with more than one group practice to provide medical services
- Groups usually provide a mix of primary care and specialist physicians
- Less control when multiple groups involved

Group Model HMO

- HMO contracts with a multi-specialty physician group to provide medical services
- Usually have exclusive agreements
- More control since involves a single group and exclusivity is present

Staff Model HMO

- HMO employs its own staff to provide medical services
- Have become less common
- Employment relationship provides a relatively high level of control

Pharmacy Benefit Manager (PBM)

- PBM's administer the prescription drug part of health insurance plans for the plan sponsors (e.g. indemnity insurers, HMOs, self-insured employers)
- Manage pharmacy network through different features in drug benefit
  - Utilization management techniques
  - Pharmacotherapy management techniques

Utilization Management

- Utilization management – techniques used to manage patient access to care, and subsequent utilization
  - Prior authorization
  - Gatekeepers

Prior Authorization

- Used to control access to expensive care (e.g. hospitalizations, costly medications)
- Practitioner (e.g. physician) must apply to the MCO for authorization for the patient to receive the care of interest

Gatekeepers

- All health care must be accessed through the gatekeeper or primary case manager
- Gatekeeper usually is a primary care physician

Pharmacotherapy Management

- Pharmacotherapy management – utilization management activities undertaken by an MCO to control the use of medications
  - Cost Sharing
  - Formulary Management
  - Practice Guidelines
  - Quality Improvement and Drug Utilization Review (DUR)
  - Educational Activities

Cost Sharing

- When a patient is responsible for paying for part of the price of a delivered health service
- Intended to make patients sensitive to the cost of their care
- Common types
  - Co-payment
  - Co-insurance
  - Deductible

Cost Sharing

- Co-payments are a fixed amount paid for a service (e.g. $10 per prescription)
- Commonly used in a tiered manner
- Co-insurance makes a patient pay a percentage of the cost of a service (e.g. prescription)
- Deductible – a fixed amount that the patient pays before MCO pays for service

Formulary Management

- Ongoing process in which drugs are evaluated and those most useful to patients are identified
- Formulary – a compilation of selected drug products that has been approved for use within the MCO – drugs covered by the plan

Formulary Management

- Pharmacy & therapeutics committee (P&T committee) oversees formulary management process – comprised of physicians, pharmacists, and administrators

Formulary Management

- Types of formularies: 1) open, 2) closed
- Open formulary – few restrictions are placed on approved medications, so most drugs are available in the MCO
- Closed formulary – a limited set of medications is approved for use in the MCO

Practice Guidelines

- Practice guidelines – systematically developed statements about how care should be provided for patients with a specific clinical condition
- Usually are evidence based
- Practitioner acceptance is variable
- Intent is to eliminate use of unproven therapies

Quality Improvement

- Quality improvement – coordinated activities to continuously monitor and improve the quality of care delivered to MCO enrollees
- A system-wide perspective and a concern for structure, processes and outcomes

Quality Improvement

- Some HMOs follow quality indicators developed by the National Committee for Quality Assurance (NCQA) – www.ncqa.orgM

Quality Improvement

- Structure – capital resources (e.g. facilities, equipment), personnel and how the resources are organized
- Process – what happens during the delivery of care (e.g. type of cancer treatment received)
- Outcomes – the end result of a health care service (e.g. quality of life, patient satisfaction)

Drug Utilization Review (DUR)

- Drug utilization review – an authorized, structured and continuing program that reviews, analyzes and interprets patterns of drug use against predetermined standards
- Usually involve pharmacists
- Typically are linked to educational activities intended to correct problems identified during the review

Drug Utilization Review (DUR)

- DUR typically uses MCO's prescription claims to provide data needed to evaluate drug use
- DUR can focus on a class of medications, a clinical condition or can be organized to profile physicians' prescribing patterns
- DUR often done retrospectively, though concurrent also is used

Educational Activities

- Educational activities provide information to practitioners and patients about preferred approaches to managing a clinical condition
- Intended to get target audience to perform desired behavior (e.g. follow practice guidelines, change lifestyle)
- Variety of methods can be used: printed materials, group meetings and one-on-one discussions

Educational Activities

- Printed materials include formularies, newsletters, brochures and booklets
- Group meetings include lectures and symposia
- One-on-one discussions with practitioners is also called academic detailing

Pharmacy Contracts

- Pharmacy payment based on formula for dispensing a prescription
- Payment = Ingredient cost estimate + dispensing fee

Ingredient Cost Estimates

- Methods used to estimate ingredient cost
  - AWP less percent (e.g. AWP – 15%)
  - Maximum allowable cost (MAC)

Dispensing Fees

- Conceptually represents payment for professional services
- Usually fixed amount

Payment Calculation Example

- Assume contract will pay: (AWP-12%) + $3.50
- Assume AWP = $50.00
- Payment = [$50 – ($50 x .12)] + $3.50
- Payment = $44.00 + $3.50
- Payment = $47.50

Pharmacist Dispensing Under Third Party Contracts

- The dispensing process for patients with prescription coverage includes activities involving the insurance
- This adds cost for the pharmacy
  - Personnel time
  - Processing costs

Third Party Dispensing Process

Dispensing a third party prescription involves a number of steps:

1. Prescription order and insurance card presented
2. Patient information verified or entered into pharmacy computer
3. Prescription order processed by pharmacy staff

Third Party Dispensing Process

1. Claim submitted to MCO via computer
2. Message received back from MCO
3. Transfer medication to patient with counseling
4. Collect patient's portion of payment

Third Party Dispensing Process

- Prescription order and insurance card presented
  - Prescription brought in by patient or phoned/faxed in from physician
  - Patient presents insurance card
- Patient information verified or entered into pharmacy computer

Third Party Dispensing Process

- Prescription order processed by pharmacy staff
  - New medication checked for appropriateness

Third Party Dispensing Process

- Prescription order processed by pharmacy staff
  - Medication counted, packaged and labeled

Third Party Dispensing Process

- Claim submitted to MCO via computer
- Message received back from MCO

Third Party Dispensing Process

- Transfer medication to patient with counseling
  - Most states require an offer for counseling by a pharmacist
  - Many pharmacies have patients sign a waiver for counseling

Third Party Dispensing Process

- Collect patient's portion of payment

Impact of Third Parties on Pharmacy Practice

- Increased revenue and reduced profitability
- Greater operational efficiency
- Shifted roles for pharmacists

Increased Revenue and Reduced Profitability

- More people with prescription coverage has increased revenue from prescriptions
- Discounted prices for third party contracts has reduced profitability

Greater Operational Efficiency

- Pressure on margins pushed for labor substitution
  - Automation
  - Use of technicians
  - Patient self service

Shifted Roles for Pharmacists

- Supervisory role more common
- Administrative activities added to clinical role
- New clinical activities in some pharmacies

Conclusion

- Third party contracts are common and have had a strong influence on pharmacy practice