Top 5 Factors for Pharmacy Revenue Integrity

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PHARMACY REVENUE INTEGRITY CAN BE PRESERVED BY USING LONGITUDINAL DATA TO UNDERSTAND RISK VERSUS VALUE.

According to the Centers for Disease Control and Prevention, prescription drugs account for nearly 10 percent of national health expenditures. With that much invested in pharmaceuticals, it's crucial for hospital executives to understand the factors necessary for maintaining pharmacy revenue integrity and avoiding revenue leakage.

Reducing Unwarranted Variations in Treatment

Physicians decide on treatment protocols based on many factors—including guideline-directed medical therapies, advice of colleagues, specifics of each patient case, cost of care, and knowledge of the latest research. Over many years, physicians learn that certain treatment protocols yield the best patient outcomes for the least amount of money spent, and certain treatment protocols become "standard" (e.g., aspirin for patient's who've had a heart attack).

Yet despite these standards, treatment variations are prominent. "Studies around the world show that the frequency with which procedures are performed varies dramatically among doctors, specialties, and geographical regions. Patients with identical clinical problems receive different care depending on their clinician, hospital, or location," according to an article published in the *BMJ*.

Some variations in care are necessary based on individual patient cases. However, it's necessary to reduce unwarranted variations in treatment wherever possible, to keep both patient outcomes and costs steady.

Over time, hospitals should be accumulating and analyzing valuable data about which treatment protocols, including medications prescribed, yield the best results in terms of financial value and patient outcomes for each service line, from acute myocardial infarction to knee replacements. Nishaminy Kasbekar, PharmD, director of pharmacy at Penn Presbyterian Medical Center, agrees. "The problem is that the data needed to support one outcome over another is very hard to come by. We used to focus on a physician spending $500 per case versus another spending $300 per case," she says. "Now, we're starting to dig much deeper into the data to see what really makes sense."

Identifying tried-and-true treatment plans and reducing deviations from those plans are key contributors to revenue integrity. What is needed to accomplish this is a longitudinal patient dataset (data that track the same patients over the course of many years) that will guide physicians to make the best treatment decisions based on real-life experience.

Incorporating Social Determinants of Health

However, reducing unwarranted variations in care and narrowing options down to standard, successful treatment regimens for any condition is not good if patients won't—or can't—comply.

The World Health Organization (WHO) defines social determinants of health as "the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the

distribution of money, power, and resources at global, national, and local levels. The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries."

Taking these social determinants of health into account is crucial when determining treatment protocols—both from patient outcome and revenue integrity points of view. If physicians prescribe medications that patients are unlikely to fill because they can't afford the copayment or full payment because of lack of insurance, or the benefits of medications are not communicated at proper patient education levels, it's likely that prescriptions will go un-filled, contributing to revenue leakage.

Kasbekar confirms this is what she is seeing at Penn Presbyterian. "We see this problem with outpatient prescriptions," she says. "A physician will prescribe an expensive medication for asthma. In our EHR, when we enter a prescription for an inhaler, it does not pull in the patient's insurance and the copay. Then the physicians get a phone call from the pharmacy, saying either that the patient can't afford to pay or that the drug is not covered by their insurance."

Evolving Formulary Management

Physicians must take into account the cost per episode of care, and also bear in mind the department in which drugs are dispensed. For example, physicians might dispense different drugs, with different delivery methods (i.e., oral versus intravenous), depending on whether they are practicing in teaching hospitals or hospice settings. Formularies that don't take this into account are setting their organizations up for revenue leakage.

Traditionally, formularies have determined which drugs should be included by way of pharmacy committee systems, but this method needs to evolve. For example, if physicians decide to deliver drugs through IV rather than orally, or to prescribe higher than usual doses of pain medications in particular cases, the drugs they are recommending may not be on formularies for those particular uses. Often, older drugs or different drugs than what is on formularies could be just as effective, depending on the environment and particular circumstances.

What's needed are re-conceptualizations of formulary management, so that drugs are considered in relationship to episodes of care, rather than just decided through pharmacy committee systems. By deciding which drugs to cut and which drugs to include in formularies based not only on drug costs themselves but on costs per episode of care—taking into consideration the added future costs of readmissions and other data—downstream revenue leakage can be avoided.

Kasbekar agrees. "There used to be a traditional formulary, and policy was that if the drug was not on formulary, the patient didn't get it," she says. "But now that inpatient versus outpatient lines are blurring a little bit, it's not that simple. We really don't have a good way of looking at formulary management and tying that in to cost of care."

Applying Population Health Data

One of the realities that physicians must face when making care decisions is that treating certain populations (e.g., the elderly), will be different in the Midwest than in the Northeast, in terms of access to medical facilities, patients' lifestyles, and other factors. Maintaining pharmacy revenue integrity will mean looking at data outside the walls of individual hospitals, taking into consideration geographic population health data, to make prescribing decisions that are in line with proactive (value-based) rather than reactive (fee-for-service) healthcare.

"One thing I appreciate about the population health conversation is that it considers the entire continuum of care," says Kasbekar. "Hospitals have traditionally been siloed into how our accounting budgets are set up—inpatient, outpatient, infusion, and so on. But now, with population health, we can look at how each aspect affects the bigger picture of care."

Population health means looking at data and information on full cohorts, such as the elderly or people with heart disease, across entire populations, irrespective of geographic barriers. For example, physicians with access to longitudinal databases could look at medications prescribed, drug interactions, and co-morbidities in elderly populations across the Midwest, rather than just their own hospitals, to determine the best course of care. For the elderly, treatments would allow patients to maintain their lifestyles most independently, in the least restrictive environments possible—whether that's in their homes with home health aide visits a few days a week, assisted living facilities, or nursing homes with 24/7 direct care and supervision.

In value-based care environments, population health data will play a crucial role in making care decisions that lead to fewer readmissions and better patient outcomes, which contributes to revenue integrity.

Understanding Risk Versus Value in Prescribing Habits

Physicians inherently understand the balance of risk and benefit when it comes to medications. For pharmacy revenue integrity, they must weigh the risks of prescribing certain drugs against not only the benefits (or value) for patients, but also for payers. They should ask the question, "What value does this drug deliver in exchange for what patients/payers are willing to pay for it?"

It turns out that "value" is in the eye of the beholder. For patients, the value of medications lie in their ability to improve quality or quantity of life. For payers, drugs have value if they effectively treat patients, to be sure, but that value comes from the idea that payers won't have to cover repeat hospital admissions or clinical intervention costs down the line. Healthy patients are the end goal for all stakeholders, but the bottom line is different for each party. Measuring that value with precision is not always easy.

The problem is that physicians often do not see the benefits of many drugs for a long time. It's only with the help of a longitudinal patient database that includes the 11-digit National Drug Code pharmacy data that providers can extricate the necessary data from within the four walls of hospitals. When providers can tie the value of medications to proxy measures, such as length of stay, readmissions, or medication changes, then payers will be able to deliver financial rewards, and providers, specialty pharmacies, and patients will reap the benefits.

Through value-based care initiatives, payers are increasingly holding providers accountable for choosing the right combination of drug regimens and treatment protocols to deliver the best possible outcomes at the lowest total cost of care; it is only by understanding risk versus value, through use of longitudinal data, that pharmacy revenue integrity can be preserved.

Understanding that Drug Costs Aren't Everything

In addition to the factors discussed here, it's important for physicians, pharmacy managers, and hospitals executives to understand that it's more than just the straight cost of any one prescription that matters to the big picture. In value-based care landscapes, we need to tie pharmacy initiatives to what hospital leadership teams are trying to accomplish, which is a

decrease in readmissions, says Kasbekar. "We should look at cost per service, cost for participation, cost for full-time employees, and so on, so that we can, over the course of a year, analyze that information and come up with a realistic baseline of cost per service," she says.

What is needed to come up with realistic costs that take into account the entire journey of care, rather than siloed information from each hospital department, is a longitudinal database and an analytics solution that can identify higher-level reports, tying in pharmacy data to metrics such as readmissions and length of stay. For example, a physician might be using a diabetes drug that is 25 percent more expensive than the drugs his colleagues prescribe, yet his patients are consistently experiencing lower lengths of stay and fewer readmissions. "From a pharmacy perspective, this physician will be penalized because the drug he is using has a higher cost. However, from a system perspective, his patients are getting better faster and saving the hospital money, thus preserving revenue integrity," says Kasbekar. The industry needs analytics solutions capable of tying these data sources together to show the ROI (or lack thereof) of high-cost drugs.

Fitting the Pieces Together

Maintaining pharmacy revenue integrity is about having accurate, longitudinal data available; having the right people (both physicians who understand how their prescribing decisions affect revenue integrity and specialists who understand how to analyze the data and derive actionable insights); and having the right technology that enables the data management and analysis to occur in real-time.

Yet it's not enough simply to have the data. It needs to be applied strategically to effect results, in three ways:

- Aggregation—Data from individual patient cases must be pulled together into a longitudinal patient database that looks at many cases, over many years, to establish patterns.
- Amalgamation—The data must be looked at cohesively (population health, social determinants, disease cohorts) and treatment decisions must be based on this longitudinal information.
- Benchmarking—Looking at the data, physicians must become comfortable comparing their patient outcomes and cost-effectiveness against their peers in the industry, and be willing to make adjustments as necessary.

If physicians and hospital executives are willing to acknowledge the powerful role data can play, the impact on both patient outcomes and revenue integrity can be tremendous.

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