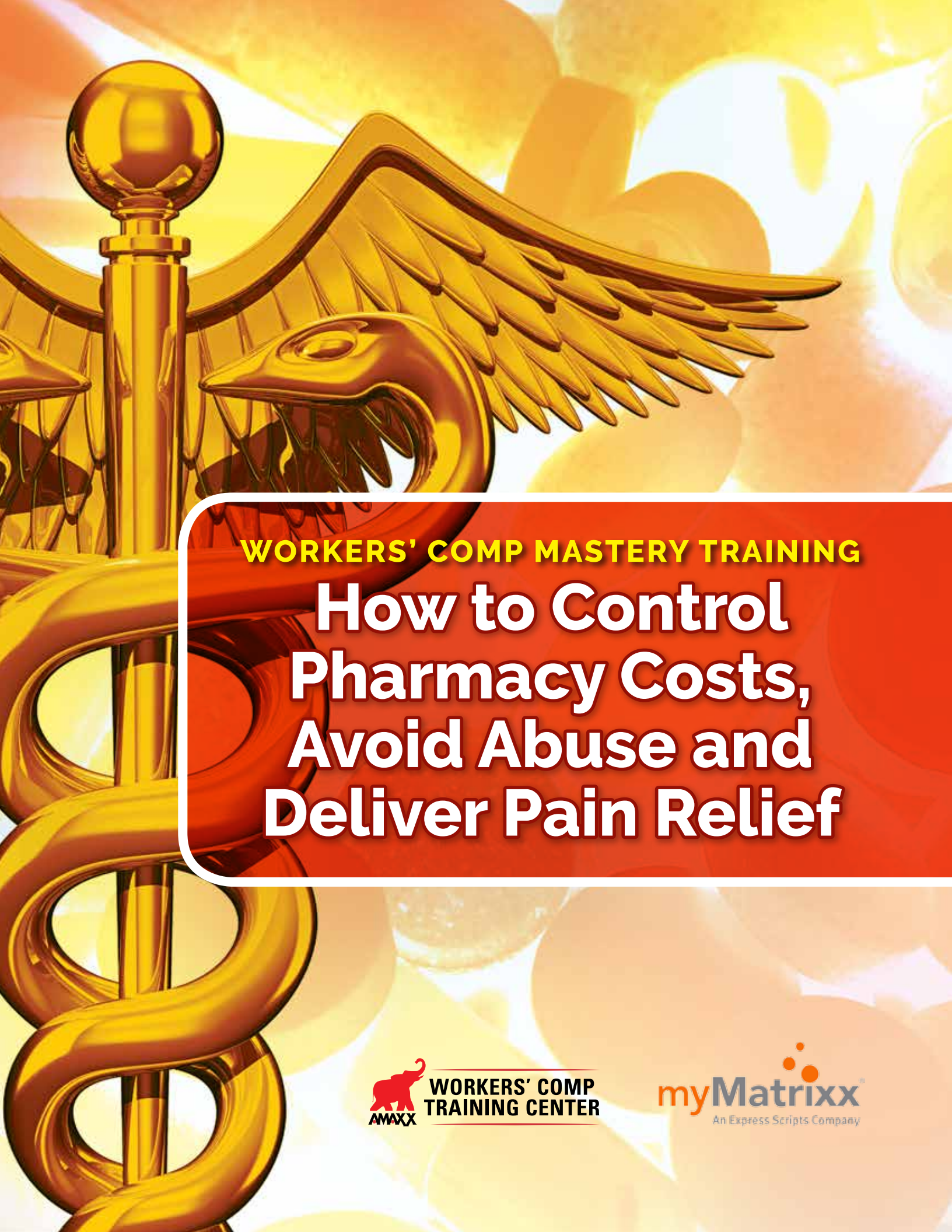

WORKERS' COMP MASTERY TRAINING

How to Control Pharmacy Costs, Avoid Abuse and Deliver Pain Relief

AMAXX WORKERS' COMP TRAINING CENTER

myMatrixx
An Express Scripts Company

How to Control Pharmacy Costs, Avoid Abuse, and Deliver Pain Relief

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Workers' Comp Mastery Training

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Introduction

When used properly, prescription drugs can have a significant positive effect on injured workers by helping them recover and return to work as soon as possible. However, the issue is fraught with peril due to two powerful forces:

- **Financial Greed:** misaligned financial incentives
- **Addiction:** potential misuse, abuse, and addiction

This book outlines the strategies to control these negative forces to allow prescription medications to deliver positive outcomes, under the three major points:

1. The Role of the Pharmacy Benefit Manager (PBM)
2. Controlling Pharmacy Cost Drivers
3. A Team Approach with the PBM & Third-Party Administrator (TPA)/Carrier

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Jacob Lazarovic, MD, Medical Advisor to Amaxx

Direct quotes and contributions from Phil and Dr. Jake in italics

Point #1: The Role of the Pharmacy Benefit Manager

The role of the pharmacy benefit manager (PBM) can be simply understood with the key phrase in the title, ***management.***

Unlike a pharmacy benefits administrator that merely administers prescriptions, the main goal of a PBM is to manage the pharmacy benefit, in order to:

- Prevent inappropriate use of medications by injured workers
- Ensure the drugs prescribed and dispensed are clinically appropriate and based on evidence-based medicine
- Protect the patient and employer against the potential misuse and abuse of certain medications.
- Achieve the lowest cost and best patient care

PBMs provide solutions to the main concerns workers' compensation payers have about pharmaceuticals:

- Fraud, waste, and abuse
- Drug diversion
- Skyrocketing costs

Phil Walls: The management piece is where the real value comes…providing a safety net for both our clients and injured patients. That safety net should look at a variety of factors, with patient safety and health outcomes first, then all things being equal clinically, looking at the lowest possible cost to make sure that our payers are not being taken advantage of in this market.

I tell my pharmacists all the time, and I truly believe this, they are literally saving patients' lives. The number of patients in which we've worked with the prescriber and helped wean people off of opioids, knowing the dire statistics associated with opioid use, I have no doubt that we really are saving lives. That's not just the role of a PBM, that's the role of a pharmacist, that's what we're here for, it is a huge positive outcome from the individual perspective.

PBM Results

Pharmacy benefit management organizations have only been used in the workers' compensation industry for approximately the past 25 years. Over this time frame, the impact and effectiveness of this service has been impressive.

A. **CompPharma 2018 report** (based on 2017 data):

- ❖ 9.84% year over year decrease in overall drug costs
- ❖ 31.5% decrease in costs over 8 years

As quoted in the CompPharma report: *"Total drug costs dropped by 9.84% year over year, and costs are down 31.5% over the last eight years. In contrast, according to IQVIA's April 2018 "Medicine Use and Spending in the US" total national spend on medicines across all payer types declined by 2.1% last year. Clearly, the work done by regulators, PBMs and payers to attack what was once the fastest-growing component of workers' compensation medical expenses has paid off.*

After a 15-year downward trend (with occasional hiccups) one could reasonably expect some leveling off if not an actual increase in costs. That has yet to occur; why and how long this will last is a matter of keen interest to all stakeholders."

B. **myMatrixx annual Drug Trend Report**, based on 2018 client data (direct statements from the report in quotation marks)

- ❖ 15.0%% decline in opioid spending year over year.
  - o "Average spending on opioids declined 15.0% from $316.40 to $268.88 per user per year"
  - o 4 out of 1000 (0.40% up from 0.19% in 2017) injured workers filled an opioid overdose agent prescription in 2018"In the fight against opioids, some states added naloxone and/or its branded counterparts, Narcan® and Evzio®, to their formularies per practice guideline recommendations. Thirty-three states and the District of Columbia now provide legal immunity for individuals who seek medical aid for a potential opioid overdose victim.1 As of July 1, 2017, every state has at least one law that eases access to naloxone. As a result, opioid overdose deaths have decreased by 9% to 11%."
- ❖ 85.6% generic fill rate
  - o "Using more-expensive drug strengths or dosage forms when equally effective, lower-cost equivalents are available creates waste."
- ❖ 24.1% decline in spending on compound medications

- "Compounded medications are not considered first-line therapy for pain or other common conditions of injured workers, according to industry treatment guidelines, including Official Disability Guidelines (ODG) and American College of Occupational and Environmental Medicine (ACOEM)."

Jacob Lazarovic, MD: In my former experience as a medical director of a TPA, we worked very, very closely with our PBMs. We saw these kinds of results, so we can certainly attest to the fact that a PBM has to be part of a total, comprehensive managed care program in workers compensation. It's very unlikely that the TPA itself has the necessary expertise and resources.

It's essentially mandatory for a TPA or insurance carrier to work with a PBM and to select the PBM that will do the best job for them.

"It's essentially mandatory for a TPA or insurance carrier to work with a PBM." – Jacob Lazarovic, MD

Point #2: Controlling Pharmacy Cost Drivers

Managing your pharmacy spend must start with understanding the biggest cost drivers. Some have remained consistent while other, newer cost drivers have emerged in recent years.

Opioids

According to myMatrixx 2018 drug trend report (based on 2018 data), opioids continue to be the most expensive and highly utilized class of drugs for work-related injuries. While total spending has decreased, opioids are the highest per patient per year spend (PPPY) at $268.88 of the top 10 drug therapy classes, , 42.8% of injured workers filled at least one opioid in the first year of their injury, , and 17.6% used opioids for greater than 30 days (down from 21% in 2017)

In addition, the cost of opioids increases as claims age. According to NCCI, after 10 years opioids account for 50% of the claim costs, and myMatrixx drug trend report found the total pharmacy cost per injured worker increased dramatically with time:

a. $205 average cost per injured worker in the first year ($52.72 on opioids)
b. $3,593 average cost after 10 years ($1,967.93 on opioids)

Brand-Name Pharmaceuticals vs. Generic

Generic substitution is a vital component of cost management. Your Pharmacy Benefits Manager should have the ability to proactively identify generic substitution opportunities with a policy of mandatory generic replacement.

According to the FDA "A generic drug is a medication created to be the same as an already marketed brand-name drug in dosage form, safety, strength, route of administration, quality, performance characteristics, and intended use…it works in the same way and provides the same clinical benefit as its brand-name version."

Phil Walls: There is no excuse for paying brand name prices when a generic is available.

"There is no excuse for paying brand name prices when a generic is available."
– Phil Walls

Specialty Drugs

Specialty drugs are a specific subset of prescription drugs used to treat uncommon illnesses such as HIV, and hepatitis C. These drugs are rarely used in workers' compensation (1,7% of all prescriptions, up from 0.6% in 2017), yet account for 7.1% of total pharmacy spend (up from 6.3% in 2017). (myMatrixx 2018 drug trend report)

Phil Walls: The pharmaceutical industry has made great strides so that a patient with hepatitis C can be cured, but the price tag for that cure is around $120,000. If you're a small payer or a small self-insured with one patient that needs a specialty drug then this one case can change your entire financial outcome.

Biosimilars

A developing cost containment strategy for specialty drugs is ***Biosimilars.*** These drugs differ from generic drugs, in that they are similar to the original drug but not exactly the same.

Phil Walls: I think biosimilars are going to be an interesting concept for the workers' compensation industry, and in the future, it will be one of our cost-saving techniques for part of the specialty market.

Compound Medications

Compound medications are made from combinations of regulated and/or over the counter drugs. In workers' compensation these are typically topical medications which may be prepared from standard drug recipes from multiple reference sources. The cost of these drugs is significantly higher than standard market drugs, there is little to no regulation, and they often provide no additional value to the patient. A thorough review and strong control is a must with any compound medication.

Dr. Jake: A compound is not an FDA-approved formulation, so the FDA has not studied the combination of agents to determine that they are effective, or even absorbed into the body. For the bad-actors, it is a money-making scheme, and it's not unusual to see a 30-gram tube of a compounded medication costing $1,000 -$2,000 when the cost of the ingredients in the compound might be $5.

Phil Walls: There is a limited role in modern patient care for compounds, but it should be very limited use. It should be for about one in a 1,000, or one in 10,000 patients, that have the unique need for a product that is not available from any commercial

manufacturer. That's where compounding is effective. It was never intended to be an idea that every pain patient needs a topical pain gel.

We examined compounds and found there was very little evidence for the efficacy of these pain gels, along with very serious concerns about their lack of safety.

Compounds were in the top 10 therapy classes in workers' compensation for the last several years; however, proactive and effective management by PBMs have moved compounds off that list.

Physician Dispensing

Physician dispensing is when the employee's medical provider dispenses and charges for medication given to the injured employee from the provider's office. Typically, dispensed drugs cost more than the same drug purchased at a retail pharmacy.

Similar to compounds, this practice has bad-actors who undertake to dispense prescriptions as a money making scheme. It creates a significant conflict of interest as physicians make more money by writing scripts for more prescriptions.

Several states have addressed the issue legislatively. While some of these have worked initially, bad-actors have come up with more creative ways to get around the laws.

Phil Walls: The repackagers [companies that produce these] need to be scrutinized in the same way as retail pharmacy dispensing. In other words, it has to be looked at from a clinical point of view.

1) *Is it an appropriate therapy?*
2) *Does it make sense?*
3) *Do the benefits of all the drugs that are being prescribed outweigh the risk?*

States have attempted to legislate their way out of the physician dispensing problem, and some have been more effective than others. One legislative approach that is proving to be quite effective is for a state to allow payers to have networks in place. When payers take advantage of this law they can eliminate physician dispensing simply by not allowing them in their dispensing network.

We have developed what we call our extended network. In addition to retail pharmacies, this includes mail order facilities, specialty distribution networks, and physician dispensers. It gives us an opportunity to negotiate with them, and to also put the same clinical programs we have in place to apply to them.

An effective drug management technique is to not allow physician dispensing. If the employee's medical provider has been dispensing medication to the injured employee from the provider's office, send a letter to the employee, employee's attorney, and the doctor advising that the PBM should provide all medications through the pharmacy benefit card provided to the employee. Encourage PPOs to create policy forbidding network physicians to dispense drugs.

An effective drug management technique is to not allow physician dispensing.

Components of Pharmacy Cost Control

Financial greed, addiction, drug diversion — all add up to unnecessary expenses. Controlling these, as well as the other pharmacy cost drivers can be done prospectively, at the point of sale, and retrospectively.

Two primary issues drive up prescription drug costs:

a) Cost management (cost of the pill)
b) Utilization management (curbing the unnecessary use of pills)

Prospective, Point of Sale, & Retrospective Components

Your pharmacy management program should have prospective, point of sale, and retrospective elements. Prospective elements are those done before the prescription is filled, while retrospective elements completed after.

Prospective & Point of Sale components include:

- Formulary and prior authorization (PA) program: list of specified drugs that are approved, not approved, or require authorization for use.
- Mandatory generic substitution
- System to flag drugs for review before dispensing:
    - Duplicate drugs
    - Drug interactions & combinations
    - Early refills
    - Step therapy:
        - When a physician has prescribed an expensive brand-name drug the PBM can trigger an alert to the dispending pharmacist to contact the prescriber regarding a therapeutically equivalent, less expensive alternative.
    - Concurrent utilization reviews
        - The PBM can trigger concurrent alerts to inform the dispensing pharmacist about possible reasons a medication should be questioned before filling. This practice ensures that prescriptions are not filled at the point-of-sale unless the medication is allowed.
    - Triggered alerts when a patient exceeds pre-defined morphine equivalent dose (MED)

Retrospective components include:

- Targeted medication review
- Intervention programs such as in-network and out-of-network transactions, risk assessments, prescriber "alerts" about employees going to other doctors to obtain multiple prescriptions, and screening for fraud and abuse
- Proactive communication via letter to physicians with inappropriate prescribing patterns
- Proactive educational communication with injured workers regarding drugs they have been prescribed
- Triggered alerts for review when data indicates the need for urine drug testing

Formularies

A drug formulary is a list of specified drugs that are approved, not approved, or require authorization for use. Your pharmacy benefits manager should have a technology interface and capability to recognize when inappropriate or non-compensable medication is being dispensed.

Formularies allow employers to be confident employees are given the proper medication, while being denied improper medications.

Formularies allow employers to be confident employees are given the proper medication, while being denied improper medications.

Phil Walls: Formularies in workers' compensation are more complicated than those in general healthcare because what is related to the injury and what is compensable may vary according to patient, or location.

Cardiac drugs are a great example. Say a cardiac claim is compensable and that patient needs access to cardiac drugs, but the payer doesn't want to pay for cardiac drugs for all their other workers. Often, the formulary has to be set at the individual patient level.

In terms of physician dispensing, their formulary will not be very complex because they typically have few drugs in their offices. You want the drugs being offered to be generics rather than brands. In addition, the formularies should not include addictive, controlled substances.

Morphine Equivalent Dose (MED)

Morphine Equivalent Dose (MED) is a way to compare the relative potency of different opioids relative to morphine. If the MED total of medications an injured worker is taking exceeds a certain amount based on current medical evidence, then a red flag should indicate that the total opioid amount being prescribed is excessive.

Triggered alerts should occur at the point of sale. Identifying these safety concerns is not the job of the pharmacist who is filling hundreds of prescriptions per day, the claims

adjuster who may be handling 100 or more claims per day, or the risk manager who has other responsibilities. This is an area where a PBM's expertise can be invaluable.

The PBM's focus is on data and trends. A PBM armed with sufficient pharmacy data can identify certain markers or alerts that indicate there is a problem at the point of sale. They can spot patterns that are outside of best practices and intervene.

Phil: A PBM excels at analyzing large amount of pharmacy data to identify certain markers or alerts that can indicate there is something going wrong with a patient's Rx care…that his patterns are outside of best practices and an intervention is necessary.

Our interventions are typically directly with the prescriber. We want to provide the prescriber with non-biased, educational information. I say non-biased because so much of what a physician receives comes from the drug company, which is very biased because they want to sell more drugs. We're trying to counteract that effect by providing them information they can use in their everyday practice to help know why they shouldn't prescribe a sedative-hypnotic for longer than three weeks, or combine benzodiazepines with opioids, for example. By looking at the data we can demonstrate to our client the impact of the interventions, and prescribing patterns improve.

Predictive Analytics

Predictive analytics refers to using data to predict an outcome based on past history. Ideally, predictive analytics assess the risk an injured worker might face based on the type of drugs he is taking, the length of time he has taken them, and combinations with other medications.

Phil Walls: At myMatrixx, we put predictive analytics into a package that we refer to as CARE, which is Clinical Analytics and Results Engine. It has the advantage of taking many different data points and converting them into a score for each injured worker that we're managing. That score is a way to evaluate our clinical effectiveness in terms of something other than just looking at dollars saved. Saving dollars is obviously important; but equally important are patient outcomes. Seeing their score improve is a direct correlation that we're improving outcomes for the patient, and their risk is going down.

Good decisions can only be made with good information. Predictive analytics, along with artificial intelligence (AI), help gather the data points and provide triggers that indicate something is amiss with an injured worker's prescription. Touching more claims earlier in the process, through education and intervention is the ultimate goal of a good PBM. This goal can be more easily accomplished with solid analytics.

Predictive analytics, along with artificial intelligence (AI), help gather the data points and provide triggers that indicate something is amiss with an injured worker's prescription.

Phil Walls: For years, the industry has been talking about patient advocacy, and I want to take that to another level. I want the industry to start thinking about a holistic approach to managing patients' drug therapy. That means looking at everything that's going on with that individual, not just the injury and associated drugs. As the workforce is aging, we're going to be dealing with a lot more complicated claims because those individuals are also going to have heart disease, diabetes, COPD, or any number of conditions that will affect their recovery. We've got to start taking this holistic approach when we're managing claims.

Doing the right things clinically helps everyone win. Patient outcomes improve, fewer drugs are used, costs are decreased, and the prescriber's liability is reduced.

"Doing the right things clinically helps everyone win. Patient outcomes improve, fewer drugs are used, costs are decreased, and the prescriber's liability is reduced. "– Phil Walls

Leverage your PBM relationship and ask questions about how they are leveraging data to make better prescription and claim decisions.

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Point #3: Team Approach with PBM & TPA/Carrier

Proper utilization of pharmacy benefits management (PBM) can result in substantial savings. Several steps should be undertaken to get the most out of the relationship between the employer, PBM, TPA/carrier, and adjuster to deliver positive outcomes.

1. Layout a clinical strategy

Establish a clear understanding of your needs as an employer with your PBM and lay out a customized clinical strategy. Obtain feedback from your nurses, physicians, and other medical advisors to develop and implement strategies, such as:

- Create and customize a drug formulary to make sure it accounts for all the various injury types in that particular organization. When injured workers have a positive experience at the pharmacy counter, they are less inclined to call attorneys.
- Define triggers to intervene early in a claim.

Phil Walls: Laying out a clinical strategy is all about us understanding and knowing our clients. There is not one strategy that is going to work for everyone. We have to know what their capabilities are, who their partners are, and who we're going to be working with for the most effective collaboration. The strategy is also going to depend on their population of workers, which has a very big impact. What we do for first responders and healthcare workers is very different from manufacturing, etc. Looking at these factors, customizing the drug formulary, and making sure that we account for all the different injury types are all important elements. The goal needs to be to have the most positive injured worker experience at the pharmacy counter possible, because when things go wrong there, that's when injured workers call attorneys, and that's when pharmacists resort to third-party billers.

2. Nurse case management referral for intervention

Nurse case managers (NCMs) assist by managing the medical components of a claim and coordinating medical care. Whether an employee of the client or outside vendor, when used appropriately NCMs are among the most effective tools to manage not only the pharmacy aspect, but entire claims.

By coordinating and following the medical treatment of the injured worker, the nurse case manager is in the best position to identify questionable drug treatment outside of the formulary or best practice clinical guidelines. When appropriate, the nurse can make a referral to the PBM for intervention.

Phil Walls: One of the most effective interactions that I have seen is when we're able to work with a nurse case manager as it changes the whole dynamic. Ordinarily, my pharmacists are having a phone interaction with the physician, but when the nurse has a scheduled time to meet with the prescriber, they get our pharmacist on the phone during that interaction and the collaboration yields phenomenal results. Many of our clients have bumped opioids out of their number one spot, in terms of numbers and dollars, and this practice is a main contributing factor.

3. Continuing education courses

Insurance professionals need to learn and understand the basics of pharmacy management through continuing education courses.

Knowing what questions to ask can be invaluable.

Phil Walls: Empowered insurance professionals should know what questions to ask. They should know when it is appropriate to challenge, and when is it right to just raise their hand and say, "can you help me?" The number one question we get through our live chat feature is if there is a better or less expensive alternative to a specific drug…it's a great question to ask.

4. Share data

A simple and key aspect of an effective PBM relationship is the sharing of data. Without a complete data set the PBM will not deliver maximum results. The technical barriers to sharing and merging such data are often low, so this step should not be overlooked.

Phil Walls: I can't overemphasize the significance of sharing data. The data can be everything from the most basic approach, which is paper bills, to things such as your urine drug screening. Provide that information to us.

"I can't overemphasize the significance of sharing data."
– Phil Walls

Reviewing Your PBM Program

When initially reviewing your program, or the program of your TPA or insurance carriers, ask:

- What percentage of your medical costs is related to pharmacy benefits?

Then . . .

- Ask for a current results report.
- Determine if you are in a "mandatory" state where substitution of generic medications is required.
- If not, ask the PBM how substitution is monitored.
- Do a full evaluation of the program currently in place, if there is one.
- Ask for the generic fill rate and cost trends of generics and brand name drugs.

Before choosing a vendor, do your homework and compare several services. These services are easiest to integrate if they are aligned with the company handling your claims. But, consider using unbundled programs if your claims administrator allows you to use services other than their own.

When reviewing current reports look at these three points:

1. **Employee Use:** How extensively do the employees use the pharmacy network, called the "penetration rate?" If penetration is low, what will the PBM do to increase program usage? Employees have to use the program for it to be effective.

   Most PBMs or TPAs/carriers mail cards or provide a letter to an employee at the time of injury designed to cover a "first fill" up to a set dollar amount and others offer further personalized service to increase penetration.

   Most programs have credit card-type access, and employees are provided with a card to use when purchasing medication. Establish a predetermined period for card use and allow the adjuster to extend or limit the period as an effective management tool.

2. **Adjuster Use:** It is important that the program has the flexibility to coordinate the medical prescription benefit efficiently between the employee, the pharmacy, and the medical provider with minimal involvement of the adjuster. The more automated the process is for adjusters and employees to use, the more likely they are to use it.

Review ease of use from both perspectives. Ask your adjusters how much coordination is required. This discussion can occur on the phone or when you visit with your claims administrator.

3. **Technology Interface:** Find out the technology used and its benefits. It is preferable to have seamless transactions and easy-to-generate management reports. It is important to have online access to data with an agile system allowing drill down and analysis of costs as needed.

   You need the ability to detect high-cost claimants and prescribers. Employers must be confident employees are given the proper medication, while being denied improper medications according to the formulary.

Dr. Jake: Unless you're a self-administered employer, and you're handling your own benefits, you're probably using a carrier, TPA, or other managed care organization and your likely not dealing directly with a PBM. You should be aware that TPAs and carriers do a lot of due diligence to determine which PBM they want to work with…some PBMs are great, and some are not so great. In collaboration with your TPA or carrier evaluate PBMs: what kind of performance do they have, what do they deliver, what are their outcomes, how easy are they to work with, etc.

There are a whole number of issues that need to be decided as part of the relationship between the TPA or carrier and the PBM. In addition, there needs to be oversight. Typically, you have regular reports and meetings with the PBM to monitor their performance, make sure they're doing what they have promised, and to determine whether there needs to be any modifications in the relationship. It's an ongoing process.

Ask your adjusters how much coordination is required and ease of use working with the PBM.

Phil Walls: If you're considering changing PBMs, ask them the basic question, "show me, and demonstrate that you accomplish what you say you do…also, let me talk to like clients." If you're a TPA, talk to the TPA clients. If you're self-insured, talk to other self-insureds. If you're a Texas subscriber, talk to Texas subscribers. Whatever niche you're in, you need to be talking to someone that walks the same walk you do.

Get Started Now

This book covered a large amount of information and implementation can often feel overwhelming. While there are many tactics to best-in-class workers' compensation management, the key to successful implementation of this content is to START SMALL.

Go back through this book and identify ONE item which you will address in the next 14 days. Significant change does not happen all at once; it is a series of small steps

About the Authors

Michael Stack, CEO of Amaxx LLC, is an expert in workers' compensation cost containment systems and provides education, training, and consulting to help employers reduce their workers' compensation costs by 20% to 50%. He is a co-author of the #1 selling comprehensive training guide *"Your Ultimate Guide to Mastering Workers' Comp Costs: Reduce Costs 20% to 50%."* Stack is founder and lead trainer of Amaxx Workers' Comp Training Center, an exclusive training organization teaching workers' compensation cost containment best practices for the Certified Master of Workers' Compensation designation.

Phil Walls, Chief Clinical Officer for myMatrixx. Phil is a clinical pharmacist with over 40 years of experience in pharmacy, healthcare informatics and workers' compensation. Previously he served in leadership positions within the industry with Health Information Designs, Inc., PMSI and Cigna Healthcare of Florida, Inc. He is a published author and frequent national speaker on clinical issues in workers' compensation. In recognition of his contributions to the industry, Phil named CompPharma's 2015 Person of the Year and received the Dorland Health People Pharmacist Award. He is a member of the AMCP, APhA, APS, ASAP, ASHP, FPA and the International Society for Pharmacoeconomics and Outcomes Research.

Jacob Lazarovic MD, Medical Advisor at Amaxx LLC, has considerable experience in managed care, including 18 years as chief medical officer at Broadspire, a leading TPA. His department produced clinical guidelines and criteria to support sound medical claim and case management practices; participated in analysis, reporting and benchmarking of outcomes and quality improvement initiatives; developed educational and training programs that updated the clinical knowledge and skills of claim professionals and nurses; provided expertise to enhances the medical bill review process; and operated a comprehensive and unique in-house physician review (peer review) service.

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