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Workers' Comp

Out-of-Network Dispensing Channels and Their Unique Challenges

July 22, 2024
11 MIN READ

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Join Tom Kerr as he interviews Nikki Wilson, Senior Director of Clinical Pharmacy Services to dive deeper into part two of our annual drug trends series. In this short video they will discuss aggregate trends and challenges within our combined in- and out-of-network channels to address the total view of prescription activity.

Tom Kerr (TK): Hello, and thanks for joining us as we take a deeper dive into our annual drug trends report. I'm Tom Kerr, and today we'll be featuring key trends within our combined in- and out-of-network channels to address the total view of prescription activity. The trend data we'll be covering here reflects all calendar year transactions billed through Enlyte pharmacy solutions in 2022 and 2023.

TK: Joining me today is Nikki Wilson, senior director, clinical pharmacy services. Hi, Nikki. Thanks for joining us.

Nikki Wilson (NW): Hi, Tom. Excited to be here with you today.

TK: Great. Let's start off with the first question here. Can you just start by walking us through what the set of data represents in more detail? And how is it different from our first drug trends report?

NW: Yes. So this, this report is going to talk about our so called total view of pharmacy data. So in the report that we're covering today, the data includes any of our clients where we have both in-network and out-of-network bill review prescriptions available for analysis. And we include that client base to allow us the most accurate representation of the overall trend experience. So we're seeing things from two different spaces. And another way to think about this is to consider the prescriptions flowing through, the various in-network and out-of-network channels as prospectively managed, where we have controls in place that can be applied at the point of sale before a script is in the hands of the patient and then retrospectively managed. So after dispensing and the prescriptions that we have here in our data, we are still managing these are just after the fact, after they're in the hands of the, of the patient after they've already been dispensed.

NW: So the things that make up these two different channels, if you wanna illustrate the proportion of scripts and cost made up of in-network versus out-of-network prescription volume, are in-network or a prospectively managed is what we reported on in the first report. It was solely those prescriptions coming through retail

pharmacies, mail-order pharmacies, and other contracted partners with the pharmacy network. What makes up our retrospectively managed space or that out-of-network volume, which was about 25.9% of our total prescription utilization in 2023 and made up about 32.5% of the cost in 2023. So it's a smaller volume overall.

NW: Our, our entities that make up that space are typically third-party billers, clinics, physicians doing in office dispension dispensing, hospitals, any non contracted specialty or compounding pharmacies. So interestingly, just one thing I noticed in in sort of slicing and dicing this and looking at this, our data shows that the average age of claim filling in-network is around six years, while out-of-network, it's around one year. So a lot of the newer claims are falling into that space, possibly because they aren't, processing yet with the right information. We have we catch those scripts from out-of-network.

NW: We might convert them in-network. And the majority of the claims filling only out-of-network in our data for 2023 was in that bucket of claims. One year or younger in-network only fills had just over half of those fills within the same claim age group. So that younger claim age group with the next largest bucket, at just over a quarter of the scripts flowing through falling into that six plus your claim age grouping.

NW: In fact, the average claim age for in-network only fills that fell in the six plus year range was 20 years. So these are our older legacy long established claims that are getting the benefit of those in-network clinical and cost controls and program savings.

TK: Great. So let's talk more about dispensing channel challenges we see in the out-of-network space. Why is this category of pharmacy spend and utilization so impactful?

NW: Yeah. So I've touched on it a tiny bit already where, we're seeing those prescriptions coming out-of-network as a post fill, a post dispense, situation. So we aren't able to get in front of those prescriptions and apply controls upfront.

NW: So cost controls aren't in place, clinical controls aren't in place. Our out-of-network pharmacy spend and utilization continues to be an area of focus for comp for that reason, especially because by the time the payer or the benefits manager sees a bill for medications from these channels, the medication or pharmacy product, like I said, is already in the hands of that patient. So the bills presented retrospectively, as we just discussed, for a payment authorization versus a real time approval or denial at the point of sale. So that timing becomes so important, not only because of cost controls that get circumvented, but also because this impacts optimal claim management overall.

NW: The importance of having that 100% view, being able to see everything that's flowing in- and out-of-network and apply equal controls to both, whether it's post-dispense or pre-dispense, pre-fill, post-fills another way to think about that. It just fosters better clinical intervention and better outcomes. So clinical controls are allowed to be applied if we can pull in all of that data, either way. So we can make recommendations based on, client's plan design, formulary, drug utilization review, step therapy, safety edits, different program applications.

NW: We can identify price opportunists that are cost drivers in the space. Being able to apply prior authorizations and other pricing and intervention rules to both sets of data can allow us to better route or identify opportunities for additional services such as UR or formal medication or peer review to those transactions. And then finally, just that overall drug therapy management opportunity, being able to, apply clinical program and oversight, including targeted specialty services for outreach education and coordination among the different stakeholders, whether that's the patient or the prescriber or the claims adjudicator, applying risk scoring, pulling that full view into, any of our risk modeling, surfacing information to a clinician, engaging them early, preventing adverse outcomes, applying a basically in general, a more holistic care approach across the breadth of treatment we're able to see. So we do wanna be able to intake, those fills, whether they're in- or out-of-network,

from bill review and from the retail point of sale for the best picture of management.

TK: Yeah. Last year, Nikki, we talked about physician dispensing during our drug trends analysis, and I know it's continued to be a focus. So how does physician dispensing impact out-of-network spend?

NW: Yeah. Physician dispensing as most of us probably listening in has long been an area of concern for workers' compensation first, because it may circumvent some of those clinical checks in place to support injured workers as we've just reviewed. And secondly, physician dispensing is a possible channel for a rising trend that we've been following for a while in so called price opportunist drug products that are consistent pharmacy cost drivers, some with little to no proven clinical benefit. We'll explore those categories in more detail in our fourth installment of the drug trends release.

NW: But one thing to note is some of these categories come almost exclusively through out-of-network channels. One in particular is the PLTAs or the private label topical analgesics. So just really big impacts from spend in that space. And we know there's significant spend in the physician dispensing arena, given what we've seen in our own trend data, but the industry is also taking note of this as well.

NW: There was a study that's been published, from WCRI examining 28 different jurist states and what's going on within them, looking specifically at physician dispensed meds, and they've made a tie, in particular to topicals driving some of those issues. So by dollar amount, physician dispensing of dermatological, also known as topical agents, accounted for the majority of payments they found for the drug group in 15 of the 28 study states. And physician dispensing has also contributed to rapid growth in the topical therapeutic class payment shares. So the study also found that in most states with physician dispensing, a larger proportion of payments for dermatological agents were paid to physician dispensers than to pharmacies. So certainly an area we want to be monitoring and be mindful of.

TK: Yeah, so let's dig deeper into that. Topicals appear to be a significant portion of the spend, especially with the WCRI analysis on physician dispensing that you mentioned. Was that true of our recent trend analysis as well, or how did our data compare?

NW: In particular, when we include the broader dataset, so pulling in those out-of-network prescriptions that we're able to see an insight alongside what we've already discussed in part one of our drug trend series to the retail. We see a shift in the trends where topicals actually bubble up to the top spot by cost. They made up about 19% of the cost in 2023, but the and so they were in that number one ranking. But they were number five by utilization where when we only looked at the network data that was in-network, all that prospectively managed data that we covered in part 1 of our drug trend analysis, it has opioids in that top spot by cost ranking. Topicals as a percentage of total script volume was up slightly in 2023 compared to 2022.

NW: It rose just slightly 0.4%, and they climbed 0.9% as a portion of overall pharmacy costs. So they're on the rise. But one thing I think is so important to understand is it shows the importance of being able to insight that data that's coming from non-retail and out-of-network channels and being able to apply some of those same management controls, albeit retrospectively.

NW: It just shows that total view of pharmacy spend that we might be missing if we're only looking at traditional channels, those things that are typically reported on by a PBM is only in-network. So there's a space, and trends that we might be missing if we're not looking at that full view. And we'll we'll dive into just another promise, more that topical category and some of the unique challenges of drug mix seen from that out-of-network channel or dispensers with those high dollar topicals living almost exclusively in that category. And thus driving up overall spend for the therapeutic class when we're seeing that total view. That's one of the reasons they jump up is those out-of-network topicals usually have pretty high dollar amounts, attached. So we'll

talk about that in a later installment of the drug trend series.

TK: Okay, Nikki. We're gonna hold you to that promise. But in the in the meantime, for today, what are some things employers and payers can consider when addressing out-of-network issues? And what approaches might be helpful for curbing practices such as physician dispensing?

NW: So that's the big question, isn't it? We've covered a number of dispensing channel challenges that can impact overall pharmacy performance, timeliness of bill receipt from a medication dispensed in office is certainly a challenge as we just discussed. And beyond that, the ability to identify pharmaceutical charges on a bill due to differences in coding and the commingled pharmacy line item charges on a bill that also might have codes for the office visit charge and the physician professional services, it can make it difficult to accurately separate out true spending utilization for pharmacy across all these channels, as well as limit the ability to carve those pharmacy specific charges out for clinical management and pharmacy program design controls. So what do we do about it? The first step is really that identification piece. That's the very first challenge.

NW: Just looking for how can we see these in the bills? How can we intake those? How can we apply controls? And there are different approaches available to attempt to curb position dispensing practices. A lot of these vary by juris. A lot of regulations that are spinning today on trying to get control around this issue that we know is becoming a huge challenge, especially in the comp space. One example, Florida had a new rule that went into effect, mid last year, mid 2023 around physician dispensing, in particular, considering medical necessity where all doctor dispensed meds require prior authorization. And if that authorization was not requested, the payer was allowed to administratively deny the prescription. So we're continuing to track with our compliance team, how many of these states are targeting those practices from a policy and program within the pharmacy benefits management and bill review as well.

NW: Also, another option is to be working with your provider network partner to review contract language and enforce or encourage dispensing only from an in-network pharmacy, as well as analyzing population level statistics to identify outliers or so called problem providers to engage. It's just another lever to pull to try to sort of step in front of this problem. And then the key is really just ongoing oversight, continuing to manage, continuing to address leakage and see where you can move to in-network where we've got the benefit of all those great, guardrails and controls. So strategies to identify and impact out-of-network challenges, including drug mix and physician dispensing practices are really essential to effective clinical pharmacy management as well as to overall claim outcomes.

NW: Great. And, this concludes our review of key pharmaceutical trends. Thanks again, Nikki Wilson, for your terrific insight, and thank you for joining us. Stay tuned for more drug trends analysis as we continue to produce more content throughout the year.

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