

# BUYER BEWARE: RECOGNIZING THE PITFALLS OF PER-DIEM DRUG PRICING

## CareRX

### PER DIEM PRICING

*The popular model is presumed to be cost effective, but the devil may be in the details—often making fee-for-service a better option*

On the surface, the per-diem or daily drug pricing model offered to hospices in lieu of a fee-for-service structure appears to meet a number of objectives. It's easy to understand. It simplifies budgeting. And because it appears to offer a "known"—and capped—daily rate for drugs, hospice administrators can turn their attention to other matters.

Unfortunately, it's not that simple. Here's why: The daily rate doesn't reflect all of a hospice's pharmacy costs. "Per-diem drug pricing is conceptually simple and appealing, but it can be a misleading indicator of costs," says Jason Tran, Pharm.D., Managing Director of CareRx, an Irvine, California company that provides pharmacy advisory services to hospices, long-term care facilities, and at-home care programs. "Some pharmacies are skilled at designing carve-outs and adding other fees, such as high

delivery charges. The added cost of drugs excluded from the per-diem rate and the other added fees can be significant, and frequently they do not enter into the discussion when a pharmacy and a hospice negotiate a contract."

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Mr. Tran maintains that organizations that enter into a per-diem contract must carefully review exactly how charges for excluded drugs and delivery charges, especially after-hours deliveries, will be calculated.

The per-diem rate also has a hidden cost that is not raised by pharmacies--the per-diem rate may lock in poor utilization patterns, plus a premium for the

risk accepted by the pharmacy. Hospices with poor utilization or that use expensive medications will have locked-in high pricing based on their usage patterns.

"Hospices that have access to unbiased clinical pharmacists to assist with appropriate utilization, to advise on the use of lower-cost therapeutic equivalents, and who understand the hospice covered drug benefit, can significantly lower total drug costs. In most cases, Mr. Tran says, "those hospices find that they are better served by a fee-for-service pricing." For example, a hospice can often substitute generic Ambien for expensive Restoril 7.5mg, which is a savings of \$5 per dose. At one dose per day, this equates to a savings of \$150 per month. Under a fee-for-service model, the savings flow to the hospice rather than remaining with the pharmacy.

There is an additional concern with per-diem pricing:

The incentive pharmacies have to consider drugs as not covered by the hospice benefit in order to separately bill medications under Medicare Part D. Hospices cannot abrogate their responsibility to ensure that drugs related to the terminal illness are covered under their Medicare Part A payments. "If hospices are using a per diem pricing model, they should have procedures and contractual protection against the incentive pharmacies have to bill drugs to Part D, outside of the daily rates paid by hospices to pharmacies," Mr. Tran explains.

### **Revisiting fee for service**

These pitfalls of the per-diem pricing model suggest that some organizations might actually fare better in the long run by shifting to fee-for-service pricing and simultaneously engaging in an overhaul of their entire approach to drug selection and pharmacy management.

There are several good reasons to explore this strategy. One is that the per-diem model in essence encourages hospice staff behavior that may not help the cause. For instance, staff may adopt a "buffet line, load-it up" mentality, ordering multiple medications without giving a great deal of thought to their cost or whether those

medications are related to the terminal diagnosis. The sense is that per diem pricing provides cost protection while allowing staff to meet the pharmaceutical needs of patients. Unfortunately, this eventually drives up the per-diem rate as well as fees from excluded drugs.

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Also, many hospices suffer from poorly designed processes for ensuring that admission coordinators, nurses, and physicians are ordering formulary-approved drugs for conditions related to the terminal diagnoses. As a result, high price drugs may be unnecessarily ordered and drugs unrelated to the terminal illness may be charged to the hospice. Both of these common scenarios raise a hospice drug spend.

To address all of these issues, care providers should consider tapping the expertise of an independent clinical

pharmacist to help them evaluate their options, because in some cases, a well-designed fee-for-service fee model can produce a net savings of 20% to 45% compared to per-diem pricing.

### **Fee-For-Service Program Implementation**

This recommendation comes with a warning. To implement and replace a per-diem model with an effective fee-for-service program, the following are among the issues that may--and likely will--need to be addressed:

#### **Changing staff's behavior.**

Intensive education and training to instill a heightened awareness for utilization control. Staff should be educated on the true cost of medications, on lower-cost alternatives to drugs they're using, on formulary management, and on the proper evaluation and documentation of whether or not a particular drug is a hospice-covered benefit.

#### **Making strategic procedural**

**changes.** The hospice formulary should prioritize drugs of choice by clinical conditions, specifically indicating those that may be either ordered with or without a clinical pharmacist's approval. The clinical pharmacist should be consulted for formulary

exceptions, for high-priced drugs or those exceeding a specified dollar threshold, such as \$275, and whenever prescribers or staff members are unclear whether a drug is a hospice covered benefit. As a first step, consider indicating on patients' medication profiles the drugs that are covered and not covered by the hospice benefit and discussing these determinations in interdisciplinary group meetings. It is vital that a hospice is making the correct determination as to whether drugs are or not covered under the hospice benefit.

**Ensuring access to clinical pharmacists.** Ideally, staff should have phone access to clinical pharmacist to consult on drug choice, need, efficacy, dosage, therapeutic and generic substitution, potential side effects, or other medication-related issues. Preferably, the clinical pharmacist is independent of the dispensing pharmacy and free from considerations such as how much margin or rebates the pharmacy may earn. All medication profiles should be reviewed by the clinical pharmacist upon admission as well as when changes occur. Depending upon the facility or program's size and needs, the clinical pharmacist might be

included as a proactive member of the interdisciplinary group meetings.

Additionally, the clinical pharmacist should review the monthly pharmacy invoice to identify possible trends, such as repetitive use of high priced or questionable drugs, excessive after hour delivery charges, and whether overall pricing is reasonable.

**Stepping up managerial oversight.** Hospice management should review monthly the total per month drug costs per patient day, with a focus on identifying variance from budget and determining whether additional analysis of unexpected deviations is required. In addition, management should analyze and act upon drug-related service failures, such as frequent urgent delivery request for non-urgent drugs, which indicates hospice staff might have not stayed on top of patient's medication refill need. This ultimately will contribute to high overall pharmacy cost, despite having a low baseline per diem charge.

Hospice management should consider tracking drug cost and usage by case manager or prescribing provider. With an eye on, for example, whether certain clinicians continuously use high

price branded drugs when less expensive alternatives are available, or prescribe medications not on the formulary for a given clinical condition.

### **OIG intensifies**

In the near term, other big-picture considerations may soon figure in hospice providers' need to revisit their pharmacy-management activities and possibly consider shifting to FFS. The Office of the Inspector General (OIG) has expressed concern over the Medicare Part A hospice covered drug benefit, in light of problems that have arisen in the wake of the introduction of the Medicare Part D program. In a June 2012 report to the Centers for Medicare & Medicaid (CMS), the OIG stated: "Hospice care is a Medicare Part A benefit, and prescription drugs related to beneficiaries' terminal illnesses are covered under the per diem payments made to hospice organizations; therefore, Medicare Part D should not pay for them. When Part D pays for these drugs, the Medicare program, in effect, is paying twice."

To ensure that double payments don't occur, the OIG made the following recommendations to CMS:

- Educate sponsors, hospices, and

pharmacies that it is inappropriate for Medicare Part D to pay for drugs related to hospice beneficiaries' terminal illnesses;

- Perform oversight to ensure that Part D is not paying for drugs that

Medicare has already covered under the per diem payments made to hospice organizations; and

- Require sponsors to develop controls that prevent Part D from paying for drugs that

are already covered under the per-diem payments.

As hospices are ultimately responsible for covering the cost of drugs related to the terminal illness--not the

### Outside guidance in managing drug utilization may pay dividends

Following are two examples of ways an independent clinical pharmacist provided guidance to improve hospice pharmacy utilization and reduce costs:

**In-depth evaluation of high-cost drug use:** The pharmacist was made available to consult with hospice staff on their use of Lyrica, a drug used to treat certain types of nerve pain and the condition fibromyalgia. As Lyrica is under patent protection until 2018, it is highly marketed and therefore frequently ordered. When consulting with hospice staff, the pharmacist addressed two issues. First, was the clinical condition for which Lyrica was ordered the cause of the patient's failure to thrive and related to the terminal diagnosis? It was related, but if it was not, then the drug could have been paid for under the Medicare Part D drug program (the patient is a Medicare beneficiary) and not as a hospice covered benefit. Second, the pharmacist explored possible therapeutic alternatives. The pharmacist reviewed with staff the conditions being treated, the status of the patient, and potential side effects. In this case, gabapentin was a less expensive alternative. Making the switch from Lyrica saved \$250 per month. These types of savings quickly multiply given the number of medications patients are on.

**Thorough monthly review of the pharmacy invoice:** By conducting a painstaking review of all elements of the pharmacy invoice, an independent clinical pharmacist can ensure that the appropriate allowable charges are applied and see trends not easily noticed in the daily routine. For example, one such review uncovered two related trends--First, the pharmacy was shipping 15-day fills of inexpensive OTC drugs, such as Colace and Senakot. These orders were simply converted to 30-day fills, which saved a fill (dispensing) fee and simultaneously eliminated an additional delivery charge. The cost of the dispensing fee and delivery charge surpassed the cost of the drugs.

Second, one nurse refilled medications every two weeks for all hospice patients. This practice led to frequent refills for patients on hospice service for longer terms, such as non-cancer, dementia patients. As a result, for some patients the hospice was paying for extra fills and delivery charges, as well as urgent, after-hours charges when the nurse forgot to renew the order in time. Now, the length of a fill is discussed in interdisciplinary group meetings and staff has been trained to consider the fill length when ordering medications.

Of course, savings begin with an appropriately structured contract, but hospices with ongoing expert guidance can also identify process improvements that will yield significant savings.

dispensing pharmacies--making the correct determination is important. A hospice may have recourse against a pharmacy that mistakenly or otherwise submits Part A covered drugs for Part D reimbursement, but the hospice

still has exposure. The program could be pulled into an investigation and subjected to Medicare re-payments and even penalties. And that's not to mention the substantial associated operational disruption that would attend

responding to an investigation. The independent clinical pharmacists have a heightened and important role in consulting with hospice staffs on covered drug benefit analyses and clinical documentation.