Estimated Cost Savings Associated with the Transfer of Office-Administered Specialty Pharmaceuticals to a Specialty Pharmacy Provider in a Medical Injectable Drug Program

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ABSTRACT

BACKGROUND: A large managed care organization (MCO) in western Pennsylvania initiated a Medical Injectable Drug (MID) program in 2002 that transferred a specific subset of specialty drugs from physician reimbursement under the traditional “buy-and-bill” model in the medical benefit to MCO purchase from a specialty pharmacy provider (SPP) that supplied physician offices with the MIDs. The MID program was initiated with 4 drugs in 2002 (palivizumab and 3 hyaluronate products/derivatives) growing to more than 50 drugs by 2007-2008.

OBJECTIVE: To (a) describe the MID program as a method to manage the cost and delivery of this subset of specialty drugs, and (b) estimate the MID program cost savings in 2007 and 2008 in an MCO with approximately 4.6 million members.

METHODS: Cost savings generated by the MID program were calculated by comparing the total actual expenditure (plan cost plus member cost) on medications included in the MID program for calendar years 2007 and 2008 with the total estimated expenditure that would have been paid to physicians during the same time period for the same medication if reimbursement had been made using HCPCS (J code) billing under the physician “buy-and-bill” reimbursement rates.

RESULTS: For the approximately 50 drugs in the MID program in 2007 and 2008, the drug cost savings in 2007 were estimated to be $15.5 million (18.2%) or $290 per claim ($0.28 per member per month [PMPM]) and about $13 million (12.7%) or $201 per claim ($0.23 PMPM) in 2008. Although 28% of MID claims continued to be billed by physicians using J codes in 2007 and 22% in 2008, all claims for MIDs were limited to the SPP reimbursement rates.

CONCLUSION: This MID program was associated with health plan cost savings of approximately $28.5 million over 2 years, achieved by the transfer of about 50 physician-administered injectable pharmaceuticals from reimbursement to physicians to reimbursement to a single SPP and payment of physician claims for MIDs at the SPP reimbursement rates.

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What is already known about this subject

• Specialty pharmaceuticals include injectables as well as some oral drugs that are expensive or warrant close monitoring to ensure appropriate use. National trend data show that spending for specialty drugs increased by 19.5% from 2008 to 2009, compared with an increase of 4.8% for traditional drugs and 6.4% for all prescription medications; spending for specialty drugs is projected to rise by more than 20% annually for 2010 through 2012.

• Injectable specialty pharmaceuticals may be covered and managed by managed care organizations (MCOs) under the medical or pharmacy benefit, or both, often determined by whether the drug is more often administered in the physician’s office, referred to as an office-administered agent (OAA), or more commonly self-administered by the patient and referred to as a self-administered agent (SAA). About 55% of specialty pharmaceuticals are covered under the medical benefit.

• OAAs billed under the medical benefit pose challenges in the areas of cost containment for the payer, financial risk and administrative burden for the physician, and possible barriers in access to quality, affordable health care for the patient.

• By December 2008, 96% of health plans reported present or pending contracts with 1 or more specialty pharmacy providers (SPP) to contain costs and manage the utilization of specialty pharmaceuticals, and nearly one-half of health plans contracted with 1 SPP exclusively.

What this study adds

• This MCO’s solution to the clinical, financial, and operational challenges of managing office-administered specialty pharmaceuticals involved (a) the transfer of certain office-administered, nononcology medical injectable drugs (MIDs) from “buy and bill” physician reimbursement using HCPCS (J codes) to purchase from a single, exclusive SPP at discounted reimbursement rates based on National Drug Code (NDC) numbers, and (b) reduction in physician reimbursement for MIDs to the SPP rates for medical offices that opted to continue to use the buy-and-bill method.

• Significant drug cost savings of approximately $0.25 PMPM over 2 years in 2007 and 2008 were realized from this MID program; however, because physician participation in this program was not mandatory in all geographic areas, 28% of all MID claims in 2007 and 22% in 2008 were paid to physicians under the “buy-and-bill” method.
Prescription drug spending is a relatively small proportion of total national health care expenditures compared with spending on hospital services and physician/clinical services. Spending on hospital services accounted for 31% of total health care spending in 2008, versus 21% for physician-clinical services, and 10% for prescription drugs. The rate of increase in prescription drug spend—once one of the fastest growing components of total health care expenditures—has slowed to single-digit annual increases in recent years. Possible drivers of this trend include patent expirations for commonly used brand-name drugs, more frequent use of benefit management policies, and the transition of some previously prescription-only brand-name products to over-the-counter status.

In contrast to the deceleration in overall prescription spending growth in recent years, spending for specialty drugs covered under the pharmacy benefit continued to rise sharply. Specialty drug spending per member per year increased by 19.5% from 2008 to 2009, compared with an increase of 4.8% for traditional drugs and 6.4% for prescription medications as a whole. The primary contributors to this trend for specialty medications are greater increases in both unit cost and utilization.

Increases in utilization can be attributed in part to increased supply from an extensive biotech pipeline—about 30% to 40% of the medicines in late stage development are specialty drugs—and increased demand associated with new U.S. Food and Drug Administration (FDA)-approved indications for existing specialty products, resulting in an expanded population of patients with a medical need for such drugs. Spending on specialty drugs is projected to increase by more than 20% per year for 2010 through 2012.

The term “specialty drugs” typically refers to medications that have some or all of the following characteristics: (a) specialized delivery, storage, handling, or administration requirements; (b) significantly higher cost than traditional medications; (c) customized treatment protocols and requirements for close clinical monitoring and management; (d) availability through limited distribution channels; (e) derived via biotechnology; (f) often administered via injection or infusion; and (g) use that is limited or for the treatment of uncommon conditions. Since some specialty medications require administration by a health care professional in the office setting (office administered drugs [OADs]) while others may be self-administered by the patient at home (self-administered agents [SAAs]), specialty pharmaceuticals may be managed under the pharmacy benefit, the medical benefit, or both.

Survey data obtained from a sample of health plans for year-end 2008 show that coverage of specialty pharmaceuticals varies by type of drug, with 58% of health plans reporting coverage of SAAs under the pharmacy benefit only, 13% under the medical benefit only, and 25% under both the medical and pharmacy benefit. Stern and Reissman (2006) described the cost and utilization management strategies for specialty pharmaceuticals as often “stop-gap” approaches developed in response to rising costs, and concluded that the determination of coverage in pharmacy versus medical benefits could be related to categorization of injectable drugs as either SAAs or OADs.

Traditionally, specialty drugs covered under a medical benefit have been purchased and reimbursed through a buy-and-bill model in which a medical office would purchase a specialty medication, administer it, and subsequently bill an insurer for the drug and drug administration services. The purchase and administration of specialty drugs under the buy-and-bill model may present financial risk and operational challenges for some medical practices, but may also be a significant source of revenue for medical practices that have enough volume of these products to yield a profit. Financially, prescribing physicians may not be aware of whether they will be reimbursed until after a specialty drug is administered, based on traditional post-payment review procedures for medical benefits. The risk posed by uncertain reimbursement could result in drug administration being inappropriately delayed or omitted altogether. The administrative burden and financial consequences of the collection of member payment for denied services pose further risk for the medical practice. For those medical practices that have adapted well to the buy-and-bill model, such a model may generate considerable revenue, and there may be physician resistance to its discontinuation for certain services.

The objectives of this article are to describe a program employed by a managed care organization (MCO) to manage the cost and delivery of a subset of primarily office-administered specialty drugs, and to estimate the cost savings associated with operation of this program during 2007 and 2008. The MCO in this study is a regional Blues plan located in western Pennsylvania. For the years examined in the present study, 2007 and 2008, total MCO membership was 4.6 million and 4.8 million, respectively.

Methods

Description of the Medical Injectable Drug Program

In 2002, the MCO recognized an opportunity to implement a program designed to address some of the challenges surrounding specialty drugs that are paid under the medical benefit through the traditional buy-and-bill model. The Medical Injectable Drug (MID) Program was created to allow the strategic management of certain specialty drugs while maintaining the balance between quality, cost, and access.

The MID program specifically focuses on an MCO-defined set of specialty drugs that possess certain characteristics that make them conducive for inclusion in the program. First, the drug has to be covered under the medical benefit. The drug may also be covered under the pharmacy benefit, and in such cases the MID program would manage only those services that...
are reimbursed through the medical benefit (i.e., through the buy-and-bill model). Second, the drugs are commonly administered in a physician’s office, but do not have to strictly meet the definition of an OAA. The specialty drugs included in the program (Table 1) are specified by the plan and may be either OAAs or SAAs. For SAAs that are included in the program, such as etanercept, growth hormone products, and the interferons for the treatment of multiple sclerosis (MS), the MID program applies only when the drug is administered in the medical office (e.g., first dose administration when monitoring for adverse events or hypersensitivity). Subsequent fills are shipped directly to the patient’s home for self-administration and are reimbursed under the pharmacy benefit, not through the MID program. Lastly, the specialty drug must be available to the exclusive specialty pharmacy provider (SPP) responsible for the distribution of the program drugs.

The MCO initiated a phased roll-out of the MID program in 2002 by initially transitioning 4 specialty drugs (palivizumab [Synagis], sodium hyaluronate [Hyligan and Supartz]; and hylan G-F 20 [Synvisc]) from the traditional buy-and-bill model to an average wholesale price (AWP)-based reimbursement formula facilitated by the distribution of the program drugs through an exclusive SPP, Walgreen’s Specialty Pharmacy, LLC. The MID program included more specialty injectable drugs in subsequent years (Table 1).

The SPP’s distribution system allows for timely delivery of medications to medical offices, which can be coordinated with patients’ scheduled appointments, decreasing the amount of injectable medication that must be kept on hand in the medical offices. The SPP’s ancillary care and disease management services include dissemination of disease- and patient-specific educational materials, as well as telephonic interactions (outbound educational and care coordination calls and inbound patient information lines) with plan members and prescribing physicians. The SPP has disease-focused teams that provide counseling and assistance in the coordination of benefits and reimbursement, compliance monitoring, nursing and social work support networks, and clinical management of disease-specific programs (Table 2).

In 2007, claims for drugs in the MID program that were submitted by the SPP were billed using Healthcare Common Procedure Coding System (HCPCS) J codes and were reimbursed based on the median of AWP values for all the National Drug Code (NDC) numbers in each J code, less an additional negotiated discount that was deeper (greater) than the standard physician network discount (“standard discount”). The standard discount is the percentage off the median AWP that is applied to reimbursement for non-MID program drug products. The additional negotiated MID program discount was calculated for all NDC numbers in each HCPCS J code (Table 3). The negotiated additional discounts were specific to individual drugs in the MID program, and the size of the additional discount varied by drug (i.e., reimbursement for
MIDs was calculated as the median of AWP values minus the standard discount minus an additional discount for each drug. The terms of the MCO-SPP contract dictated that if the SPP dispensed a drug product with an AWP less than the median AWP for the HCPCS J code, the lower AWP cost was submitted.

New claims processing functionality was introduced in the MCO in January 2008 that allowed the SPP to submit claims with a HCPCS code and a specific NDC for the dispensed drug. The NDC-specific claims processing functionality allowed the MCO to reimburse the SPP more precisely by using the actual product AWP as opposed to the median AWP. The MID program reimbursement formula in 2008 therefore became actual AWP for the dispensed drug minus the standard MCO network discount percentage minus the additional negotiated discount.

The new NDC-specific reimbursement was implemented to improve the accuracy and consistency of claims payment and did not represent additional cost savings to the MID program. Table 3 shows the specific reimbursement formula that was applied to each provider type in 2007 and 2008.

When the MCO implemented the MID program in 2002, physicians were encouraged but not required to participate; however, physician reimbursement for the drugs in the MID program was limited to the reimbursement rate for the SPP. Physician participation in the MID program was based on physician networks and was mandatory in western Pennsylvania where the MID program was part of the physician network contractual agreement. In other regions, such as central Pennsylvania and the Lehigh Valley, participation was optional; however, payment to physicians who opt out is limited to the SPP-contracted reimbursement rates for all drugs included in the MID program (Table 3). Because claims submitted by physicians outside of western Pennsylvania who opt out of the MID program are submitted using a HCPCS J code rather than an NDC number, reimbursement for these claims is less specific.

In such cases, reimbursement is based on the median AWP for all of the NDC numbers for each HCPCS J code.

The SPP does not charge additional fees for dispensing, delivery, or administrative costs other than the contracted reimbursement rate for each specific drug in the program. The SPP ships the medication(s) directly to the physician’s office, and reimbursement of that medication is made by the MCO directly to the SPP. The member cost share associated with the medication is collected by the SPP. When a physician administers a medication to a patient, there can be 3 separate charges: the charge associated with the physician visit, the charge for administration of the drug, and the charge for the drug itself. Physician medical offices that order MIDs continue to be reimbursed under the traditional reimbursement model for the office visit and medication administration services, when applicable, and any member cost share related to such services is collected by the medical office.

Utilization management criteria are applied prospectively in the MID program, and coverage is confirmed prior to the distribution of the drug by the SPP. Under the traditional buy-and-bill model, the vast majority of utilization management criteria are applied on a retrospective, post-pay basis. This aspect of the MID program removes a level of risk and uncertainty for physician practices for their administrative management of specialty drugs (e.g., inventory management, reimbursement confirmation, and collection of member cost share for services provided). A pharmacist from the SPP obtains any information needed from the physician’s office and, as an authorized agent of the MCO, the SPP pharmacist then reviews the request based on the MCO’s utilization management criteria (e.g., omalizumab, Figure 1). The SPP pharmacist can approve coverage for cases that meet the clinical criteria established by the MCO, but all cases that do not meet the MCO’s utilization

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**Table 2**

<table>
<thead>
<tr>
<th>Therapy Management Services Provided by the Specialty Pharmacy Provider for MIDs</th>
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<tbody>
<tr>
<td>Multiple sclerosis</td>
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<tr>
<td>Rheumatoid arthritis</td>
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<td>Juvenile rheumatoid arthritis</td>
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<tr>
<td>Hemophilia</td>
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<td>Immune disorders</td>
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*MID = medical injectable drug; RSV = respiratory syncytial virus.

**Table 3**

<table>
<thead>
<tr>
<th>Reimbursement Formula for Medical Injectable Drugs by Provider Type – 2007 and 2008</th>
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<tbody>
<tr>
<td>Provider Type</td>
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<tr>
<td>----------------</td>
</tr>
<tr>
<td>Specialty pharmacy provider</td>
</tr>
<tr>
<td>Physician (buy-and-bill)&lt;sup&gt;d&lt;/sup&gt;</td>
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</table>

<sup>a</sup>Median AWP refers to the median of AWP values for all NDC numbers in each HCPCS J code. Standard discount refers to the MCO discount applied to medical claims for drugs billed under the medical benefit.

<sup>b</sup>In 2007, the basis for payment to the specialty pharmacy provider (SPP) was the lower of the discounted median AWP price for the HCPCS J code or the discounted NDC-specific AWP. In 2008, the basis for reimbursement to the SPP was the discounted NDC-specific AWP.

<sup>c</sup>Additional discount refers to the negotiated reimbursement rate specific to MID program drugs. The discount varies by individual drug and is in addition to the standard MCO network discount.

<sup>d</sup>Physicians practicing outside of western Pennsylvania were permitted to opt out of the MID program distribution channel in 2007 and 2008, but were reimbursed at the same rate as the specialty pharmacy provider.

AWP = average wholesale price; HCPCS = Healthcare Common Procedure Coding System; MCO = managed care organization; MID = medical injectable drug (Table 1); NDC = national drug code.
management criteria are forwarded to the MCO's medical directors for individual case evaluation. All policies and criteria are created and maintained by the MCO. The MCO conducts quarterly reviews/audits of the SPP to confirm accuracy and consistency in applying the MCO's prior authorization and utilization management criteria, compliance with timeliness guidelines, and requirements from all applicable regulatory bodies.

Pre-Implementation Steps for the MID Program

Prior to the implementation of the MID program, the MCO took multiple steps to minimize member, employer group, and physician disruption, and to increase acceptance of the program. Throughout the implementation period in 2001 and 2002, network physicians were educated and feedback was solicited. A dialogue between the MCO and network primary care physicians and specialists was identified as an essential component for the initiation and long-term viability of the MID program. Pre-implementation strategies were focused on achieving understanding and acceptance among those physicians (and affected members) who were to be mandated to participate in the program.

Pre-program implementation activities in 2001 and 2002 included the following:

- Presentations and announcements by the MCO's sales staff to affected medical groups
- Notification to the physician community at multiple points in the implementation process through mailings and electronic communications
- Utilization of historical claims data to send targeted...
physician letters that identified specific health plan members who would be affected by implementation of the MID program
- Internal staff education and training for the pharmacy, member services, provider contracting, and other departments affected by MID coverage and payment
- System changes to the medical claims processing system including expanding capabilities to allow future enhancements to the program, such as creating crosswalk tables for J codes and NDCs, allowing for NDC-specific reimbursement
- Face-to-face meetings with key physicians and decision makers to highlight the benefits of this program

**Calculation of Cost Savings**

The calculation of cost savings was performed by comparing the actual total expenditures (plan cost plus member cost) for the drugs in the MID program in 2007 and 2008 with the estimated payments that would have been made under the buy-and-bill model had the MID program not existed. These expenditure estimates were calculated by multiplying the actual utilization for the individual drug by the negotiated additional discount for the given drug (i.e., the total cost savings from the MID program are attributed to the additional discount that was negotiated for each drug included in the program). Cost savings were calculated and aggregated by month based on the dates of service for medical claims for drugs included in the program, from January 1, 2007, through December 31, 2008. For drugs that were added to the MID program mid-year, the total amount paid and total savings were calculated from the time of inclusion of each drug in the MID program.

Per member per month (PMPM) savings were calculated from the sum of cost savings for the 12 months for each of the 2 calendar years and divided by the average MCO membership in each year (approximately 4.6 million members in 2007 and 4.8 million in 2008) divided by 12.

**Results**

The total amount spent on drugs that were included in the MID program was approximately $69.4 million in 2007, and the estimated amount that would have been paid for these same claims using the reimbursement rate for physicians under the traditional buy-and-bill model (i.e., median AWP less standard MCO network discount) was $84.9 million (Table 4). The net drug cost savings generated by the additional negotiated discounts for the MID program in 2007 were approximately $15.5 million (18.2%) or an average of $290 per claim or $0.28 PMPM. In 2008, the total amount spent on drugs that were included in the MID program was approximately $89.9 million, and the estimated amount that would have been paid for these claims using the traditional buy-and-bill reimbursement rate was approximately $102.9 million. For 2008, the net drug cost savings generated by the additional negotiated discounts for the MID program drugs were approximately $13.1 million (12.7%) or an average of $201 per claim or $0.23 PMPM. Of the medical claims for drugs included in the MID program, 28% in 2007 and 22% in 2008 (average 25% for the 2 years) were paid to physicians under the traditional buy-and-bill model, and all were all reimbursed at the SPP reimbursement rates (i.e., the medical offices were reimbursed based on the median of AWP values for the drug or drugs in each HCPCS J code minus the standard discount minus the additional discount that was applied to the SPP, Table 3).

**Discussion**

The published literature to date does not contain an example of a specialty drug management program that is directly comparable with the MID program described here. However,
a survey conducted in late 2008 of 69 health plans with a total of 83 million members reported that 72% of Medicaid plans, 71% of Medicare Advantage Prescription Drug (MA-PD) plans, and 67% of commercial health plans engaged in some form of reduced reimbursement for specialty drugs (not limited to the specific drugs included in the MID program) to non-oncology physicians.13 The survey also reported that 87% of Medicaid plans, 85% of MA-PDs, and 69% of commercial plans had implemented mandatory use of an SPP for SAAs in 2008. Mandatory use of an SPP for OAAs is less common, with requirements for members to obtain some or all OAAs reported by 54% of Medicaid plans, 33% of MA-PDs, and 35% of commercial health plans.13

When determining how to manage specialty drugs, MCOs may choose to contract with a single (exclusive) SPP or a small network of 2 or more SPPs, and the use of the SPP may be voluntary or mandatory. Survey data from 2008 show that 96% of health plans contracted with 1 or more SPPs, an increase from 78% in 2005.13,15 Regarding the use of a single, exclusive SPP versus multiple SPPs, 45% of health plans contracted with a single SPP exclusively in 2008, reflecting a decrease from 60% reported in 2005.13

Published studies exploring the advantages and disadvantages of exclusive versus small network versus open network arrangements with SPPs are lacking. The potential benefits of using a single, exclusive SPP may include a more consistent level of service and improved clinical collaboration with the health plan, physicians, and members. If the responsibility for essential components of care management and coordination is delegated exclusively to a single SPP, the MCO should be able to expect that the care provided is more consistent from patient to patient. For example, the SPP for this MID program supplies the MCO with a single report that documents intervention detail and frequency including contacts with individual patients and/or physicians, and the nature of the interactions that take place between the SPP and all of the MCO’s members with a given disease state who are being treated with a drug in the MID program.

Further, an exclusive arrangement between an MCO and an SPP may allow for a plan to better engage an SPP in plan-specific initiatives that require a modest to high level of customization. Managing even moderately customized initiatives across multiple SPPs may be difficult given operational, contractual, and other variations among organizations. Depending on the level of the individual plan’s interest in engaging SPPs in more intensive clinical or other collaborative activities, the decision to contract with an exclusive SPP and, moreover, the organizational characteristics to be desired when choosing an exclusive SPP become rather important.

In the case of the MID program in this MCO, an exclusive arrangement with an SPP allowed the MCO to negotiate deeper reimbursement discounts for the specialty drug products that are included in the program, which generated cost savings for the plan. Specifically, the MID program generated estimated drug cost savings of approximately $28.5 million over 2 years in 2007 and 2008 or about $0.25 PMPM. The impact of these savings is realized not just by the MCO, but by plan members as well. Members who have a coinsurance benefit design realize direct savings because the price discounts for drugs in the MID program are included in the allowable charge, which is used to determine the member financial responsibility. Members in high-deductible health plans are also likely to see a decrease in out-of-pocket cost share as a result of lower reimbursement rates for drugs in the MID program.

The savings reported here include only those associated with a decrease in the unit cost of the medications included in the MID program. Changes in utilization patterns may also impact the actual savings a plan can expect to realize from such a program. It is possible that the MID program contributed to an increase in utilization by facilitating physician access to MID drugs including reduction in provider financial risk through prospective utilization management and eliminating inventory costs for medical offices. Thus, although price savings were achieved in the MID program, it is possible that some of these price savings were offset by increased utilization. However, any increased utilization of the MIDs would appear to be appropriate because utilization management was an integral part of the MID program.

The implementation of NDC-specific billing and reimbursement to the SPP in 2008 may in part explain the decrease in the calculated cost savings from 2007 to 2008. While NDC-specific billing is more accurate, it may also cause the plan to incur additional costs because reimbursement is based on the actual AWP for a product as opposed to the median of AWPs for the drugs in each J code. Any NDC with an AWP above the median value for a specific J code would result in a higher payment amount from the health plan to the SPP after conversion to NDC-specific reimbursement. In 2007 prior to NDC-specific billing, the SPP was contractually obligated to submit the lower of the discounted median AWP price for the HCPCS J code or the NDC-specific reimbursement amount. The exact amount that this lower-of-provision may have saved in 2007 was not calculated.

MID Program Obstacles
The MID program and its implementation encountered several obstacles. One of the main barriers to the development of the MID program was resistance by physicians, fueled in part by the perception that this distribution system would reduce access, create an obstacle to obtaining medications, or reduce physician revenue. Most of the initial resistance toward this program came from orthopedists, which would be expected since 3 of the first 4 medications included in the MID program were orthopedic drugs (hylan G-F 20 and 2 brands of sodium hyaluronate). Although a systematic assessment of physician opinions of or satisfaction with the MID program was not
conducted, we observed anecdotally that physician opinions were mixed. Smaller physician offices tended to favor the MID program because they felt that it removed a level of administrative burden from the office and freed up cash flow for the practice. Perception of the program was more negative among some larger medical practices, because they viewed the transition to the MID program as lost revenue. This negative perception appears validated by the fact that 28% of claims for MID drugs were submitted using HCPCS codes via the “buy-and-bill” method in 2007 and 22% in 2008. These statistics suggest that there remains a significant physician provider base that is able to profit under the traditional buy-and-bill model despite the decreased reimbursement for the MID program drugs.

In an effort to minimize physician resistance, MCOs considering implementation of such a program should also give consideration to (a) the types of medications that are added to the program and (b) the medical specialties that would be affected by such additions. For example, this MID program did not include chemotherapy drugs, and expansion of this program to oncology could be expected to be met with greater resistance because oncologists traditionally have generated a large share of their office revenue from the purchase and administration of certain chemotherapeutic agents. A recent analysis showed that reduction in reimbursement rates for specific chemotherapeutic agents had no negative effect on access to medications but was associated with a shift in the medications that were used, away from the agents for which reimbursement had been reduced and toward similar agents with higher reimbursement margins.16

In an attempt to minimize resistance from physicians and other stakeholders, the MCO in the present study developed and distributed comprehensive educational materials that emphasized the positive attributes of the MID program including simplification of the distribution process. The communication campaign included frequent updates to all network physicians highlighting the details and advantages of the new MID program, pre-implementation notices to employer groups, and targeted communication to affected members. Furthermore, despite some resistance to the MID program, the MCO believes that simply decreasing reimbursement of the drugs in this program across all physician groups without providing another means to obtain these medications would have been much more disruptive and likely would not have been sustainable. This outcome would likely have been due to the community outcry as many physician offices would not have been able to buy and bill at the new, lower SPP rate, and therefore would have lost money on many of the drugs in the program.

Limitations
Aside from the limitations associated with the implementation of programs such as MID that affect provider reimbursement, particularly physician resistance, there are limitations to the present analysis. Foremost, we performed a cost savings analysis that estimated what would have been paid in 2007 under the reimbursement formula that existed prior to the MID program (i.e., we did not compare spending under the MID program compared with actual spending prior to the MID program). Second, we did not assess financial effects of the MID program on members. However, because most medical benefits require member coinsurance (e.g., 20% of the allowed charge), most MCO members would have had lower cost-share amounts, in proportion to the lower reimbursement rates for the MIDs. Third, we did not examine the financial effects on members from the transfer to the pharmacy benefit of certain MIDs after the first fill. Effective and efficient management of specialty pharmacy programs that involve drugs that are commonly administered in medical offices requires MCO consideration of the design and administration of pharmacy and medical benefits. For example, our MID program was designed with the recognition that more than one-quarter of our members have pharmacy benefits that are carved out (30.1% in 2007 and 29.5% in 2008), and many high-volume drugs in the MID program such as etanercept and the injectable drugs for MS (i.e., beta-interferons and glatiramer acetate) are covered only in pharmacy benefits after the first fill. Health plans vary considerably in these characteristics.

Fourth, as noted previously, this cost savings analysis is primarily a price savings analysis because we did not attempt to examine how the MID program might have increased utilization. Fifth, the present analysis did not investigate the source of MID program savings by individual drug. Sixth, we did not assess other outcomes associated with the MID program such as member satisfaction; however, the MID program was expected to be primarily transparent to health plan members. Seventh, we did not investigate the source of the smaller cost savings per claim as a percentage of MID spending in 2008 under NDC-specific reimbursement compared with 2007.

Finally, we did not assess the administrative costs associated with implementation of the MID program, such as (a) physical mailings that included targeted letters to the providers and articles in provider and member newsletters and face-to-face meetings with key stakeholders; and (b) establishment of internal workgroups to address system coding and enhancements, internal communications, and training. Other ongoing costs and resource requirements include compiling the necessary claims reports, performing an ongoing business analysis, and performing routine oversight audits to ensure that the SPP is consistently and appropriately applying the MCO’s utilization management criteria and meeting any contractually defined thresholds for measures such as timeliness and accuracy. These administrative costs, while potentially substantial, were ultimately nominal for the MCO relative to the savings that the MID program has generated. However, these administrative costs and organizational commitments may present a significant barrier for smaller health plans. Other health plans will need to assess potential savings based on their own
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Conclusions

Specialty pharmaceuticals provide hope for patients with chronic, complex, or rare disease states that do not respond to traditional drug therapies as well as challenges for providers and payers who must address issues of limited distribution, administrative burden, high cost, and appropriate clinical management. The MID program was developed as a method to manage specialty pharmaceuticals that are commonly administered in physician offices and reimbursed under the medical benefit. The MID program was initiated in this MCO in 2002 and grew to more than 50 medications by 2007, generating an estimated $15.5 million in injectable drug cost savings in 2007 and about $13 million in 2008. Anecdotal reports from smaller physician offices suggested that the MID program helped to reduce financial risk and transfer the administrative burden associated with MIDs from physicians to the MCO and SPP. Nevertheless, about 25% of the MID claims in 2007 and 2008 were submitted by physicians under buy-and-bill reimbursement rather than using the SPP.

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DISCLOSURES

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