MEDICAID REIMBURSEMENT IN WORKERS' COMPENSATION: A TOUGH PILL TO SWALLOW

WHY MEDICAID REIMBURSEMENT LEVELS DO NOT WORK IN WORKERS' COMPENSATION

A White Paper Produced by CompPharma, LLC
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SUMMARY

The purpose of this white paper is to illustrate the differences in processing and dispensing prescription medications in Medicaid versus workers' compensation. The White Paper has been produced to provide state legislators, regulators and other workers' compensation stakeholders with information regarding the processes of managing a pharmacy transaction in workers' compensation. Its goal is to demonstrate why reimbursement levels for workers' compensation need to be separately recognized and should not be linked to state Medicaid fee schedules.

BASING REIMBURSEMENT ON MEDI-CAL INCREASES WORKERS' COMPENSATION COSTS AND REDUCES ACCESS

There are two significant problems with California's Medi-Cal-based workers comp pharmacy fee schedule. First, it may lead to a significant reduction in claimants' access to drugs; and second, there is little evidence that it has controlled cost. It may well have increased workers' comp pharmacy costs for California's employers.

Access

Linking the reimbursement of workers' compensation prescriptions to Medicaid reimbursement levels is, as demonstrated in New York and described below, raises a very real risk that PBMs will exit a state.

Three of CompPharma's members have indicated they have stopped actively marketing for new business in the state of California because of the reimbursement link to Medi-Cal while all members have suffered some measurable financial losses.

If the workers; compensation drug fee schedule continues to be based on Medi-Cal, some of these PBMs – if not all – will pull out of the state, leading to reduced access and higher costs. Without the PBM, pharmacies face additional administrative burdens, extra costs, uncertain reimbursement and slow payment. They will not have any incentive to fill workers' compensation prescriptions. Ultimately pharmacies will likely stop handling workers' compensation scripts, essentially denying pharmaceutical access to injured employees.

Cost

The 2003-2004 reforms were intended in part to reduce workers' compensation pharmacy expenses. However, costs have actually gone up, driven by significant increases in both the average number of prescriptions per claim and the average payments per claim for prescriptions. In addition, payments for Schedule II narcotics, categorized as having a high potential for abuse and addiction, increased nine-fold post reforms. Schedule II drugs are also strongly associated with extended disability duration, driving up both medical and indemnity costs.

According to the California Workers Compensation Institute, the average number of first-year prescriptions per claim increased 25 percent after implementation of the Medi-Cal link, while average drug cost per claim went up 37 percent. (Changes in Pharmaceutical Utilization and Reimbursement in the California Workers' Compensation System, September 2009.)

Clearly, linkage to Medi-Cal has not reduced drug costs for California's employers.

WORKERS' COMPENSATION AND MEDICAID PHARMACY - TWO VASTLY DIFFERENT OPERATING MODELS

The key difference between Medicaid and workers' compensation is "eligibility" or "is the prescription eligible for reimbursement?" In Medicaid, each "member" has "positive" eligibility. That is, before the member presents their prescription at the pharmacy, they have been entered into Medicaid's system and electronic pharmacy processing systems as an

eligible member. If for some reason the Medicaid member is not in the system, the member has a card identifying their coverage and stating their "entitlement" to a pre-determined set of benefits. The pharmacy knows each prescription is covered, how to process the claim, how much they will be paid, and who will be the payer. In addition, payment usually occurs within seven to 10 days.

In contrast, few workers' comp claimants present a drug program card at the pharmacy. Very few are already entered into an electronic pharmacy processing system and almost none know who their workers' compensation insurer is before the first prescription is filled. Further, once eligibility is established, the pharmacy has to ensure that each prescription is payable under workers' compensation or risk non-payment. Unlike Medicaid, workers' compensation only covers drugs specific to that work-related injury or illness.

The questions that pharmacies **must** answer for workers' compensation include:

- Is the injured person really an injured employee of a company responsible for medical bills?
- Is there an insurance company or employer who will cover the bill?
- Which pharmacy benefit manager (PBM) should handle the transaction?
- Is the prescribed drug for treatment of the work comp injury, or is it for some other health condition not related to that injury?

In workers' compensation, injured employees usually do not bring a card and they understand there is no co-pay or out-of-pocket expense for prescriptions. The pharmacy has no way of knowing if the prescription is eligible for reimbursement under workers' compensation, who will reimburse the pharmacy or if the pharmacy will receive full or partial reimbursement or any payment at all. In 12 to 15 percent of prescriptions, reimbursement from the insurance carrier or employer is either reduced or denied, compared to 1–3 percent for Medicaid. In addition, payment for workers' compensation scripts can take 60 days or more as compared to 7 to 10 days for Medicaid.

It costs more to dispense a workers' compensation prescription than a Medicaid script. A 2007 St. Louis College of Pharmacy study of the additional cost of dispensing workers' compensation prescriptions sampled 30 store-level pharmacy staff members involved in submitting and processing prescription claims for the Texas Mutual workers' compensation program. The results showed that "the median of the sample pharmacies' additional costs for dispensing a workers' compensation prescription was estimated to be at least $9.86 greater than for a cash prescription." A description of the study is available at www.ncbi.nlm.nih.gov/pubmed.

The average national cost of dispensing a (Medicaid) prescription is $10.50, not including the medication, according to the Coalition for Community Pharmacy Action, a coalition between the National Association of Drug Stores and the National Community Pharmacists Association. The Coalition study is available at http://www.rxaction.org/publications/COD_Study.

It costs retail pharmacies nearly twice as much to process workers' compensation claims as it does for Medicaid scripts.

Administrative issues

Processing a pharmacy claim in workers' compensation requires more entities and people "touch" the claim than in Medicaid. Physicians, employers, insurance carriers, nurse case managers, adjusters, pharmacists, and the injured worker are all involved in a workers' compensation claim. Communicating with all these entities promptly and accurately is needed to resolve claims as soon as medically possible. The comp claim receives five to seven touches, compared to three in Medicaid pharmacy (physician, claimant and pharmacist). More entities are involved, which means managing a comp claim takes more time and costs more money than a Medicaid pharmacy claim.

Compliance

While all pharmacy providers must comply with myriad state laws, including rules and regulations to follow when dispensing medication through any plan, there are even more regulatory burdens for workers' compensation. The state's workers' compensation agency often imposes additional handling, billing and reporting requirements. Some states limit the dispensing of brand drugs without written approval and require the use of specific billing and payment forms. Other state regulations allow payers to reduce or deny payment without providing notice to the pharmacy, and then prohibit the pharmacy from collecting from injured workers.

Perhaps the most burdensome regulation is the imposition of reimbursement caps. These are short-sighted attempts to control pharmacy costs by limiting amounts paid to providers, rather than addressing the main system cost drivers which include over-prescribing, over utilization and unnecessary use of brand medications and more recently, the dramatic growth in the use of Schedule II narcotics.

Managing utilization

Managing drug utilization and cost is markedly different in the two models. In many instances, Medicaid/Group requires a patient co-payment for prescriptions. The co-pay serves as a deterrent for patients who might otherwise request expensive brand name drugs. With workers' compensation, there is no copay whatsoever, and therefore no incentive for the patient to switch to a generic drug. As a result, workers' compensation patients may their doctor to prescribe and thus receive prescriptions for brand drugs when generics are available. Moreover, Medicaid has a formulary which tightly restricts which drugs can be dispensed; there is no formulary per se in workers' comp, and thus expensive medications, like Actiq - a powerful drug used to breakthrough intense pain of cancer - are commonly prescribed for work comp patients. At $2,500 per monthly prescription, Actiq certainly can drive up pharmacy costs on a claim.

Managing drug costs and spend requires PBMs to invest heavily in data mining and analysis tools and processes, develop notification and alert systems, and employ pharmacists and physicians to interact with the prescribing physician and dispensing pharmacist in an effort to ensure claimants receive the right drug for her/his condition.

Further, drug mix is completely different for the two patient populations. Most workers' compensation drugs fall into three categories: pain medications, anti depressant and muscle

relaxants. Medicaid's drug profile is both more and less comprehensive. As Medicaid covers all medical conditions, drugs for those conditions are all available under Medicaid – medications for diabetes, asthma, cardiovascular conditions, cancer - are available and routinely dispensed. However, drugs available in each category tend to be limited to those approved – via formulary - by the State, and the list of approved drugs can be quite narrow. In contrast, workers compensation conditions are primarily musculoskeletal in origin and the medications reflect that reality. But, because there is no formulary, physicians prescribe, and pharmacies dispense, a wide variety of drugs based on the physician's personal preference. Unlike Medicaid, there is no pre-set "formulary" in workers comp, so physicians can, and do, prescribe whatever they want.

The lack of a pre-set formulary makes it incumbent on the pharmacy to ensure the medication prescribed will be "accepted" by the workers comp payer as related to the injury. This can, and often does, requires the pharmacy to communicate with the workers' compensation claims adjuster and/or PBM whenever a new drug is prescribed for a claimant.

HOW A WORKERS' COMPENSATION PRESCRIPTION IS PROCESSED

The cost differences become clearer when examining steps involved in filling a workers' compensation prescription. In the typical work comp scenario, an injury has occurred that same day or within the past day or two. In all likelihood, the full claim has not yet been filed with insurance company or employer. If it has been filed, data has not necessarily been electronically entered into a tracking or treatment system, so there is no way for any pharmacy to electronically ascertain eligibility.

The injured worker has no card, doesn't know who their insurance carrier is or anything about a pharmacy benefit program; at best they may know their employer.
Except in a rare case when an injured worker presents a card, there is nothing for the pharmacy to connect patient to prescription to payer. (In workers' compensation, payers are insurance carriers, third-party administrators, self-insured employers, and municipalities or other government agencies.)

The pharmacy has a couple of options:

- Refuse to fill prescription unless injured worker pays out of pocket
- Assume financial risk for cost of prescription and seek reimbursement later

Despite the risk, pharmacies often fill prescriptions because they have contracts with several Pharmacy Benefit Management firms (PBMs) that manage pharmacy programs for payers. Pharmacies are hoping that one of them will accept the claim. However a pharmacy runs the risk of having a claim denied or having reimbursement reduced to an amount less than the pharmacy's billed amount. With an average price tag of $93 per script and five prescriptions per patient, the pharmacy may be taking a $465 risk.

The pharmacy sends a paper copy of the bill to the worker's employer or other payer if known. Each payer has its own system for processing bills and reimbursing pharmacies, so the pharmacist has to wade through bewildering options and multiple forms to receive

reimbursement. Then the employer may direct the pharmacy to an insurance carrier or PBM, adding another barrier to reimbursement.

When a prescription reaches the PBM, and PBM determines its eligibility, it accepts the claim and reimburses pharmacy. In addition, the PBM creates an electronic file that clears the way for future transactions. At this point, the risk and payment delays are eliminated for pharmacy. However, it may take six weeks or more for a claim to find its way to the PBM.

Keep in mind that only two to three percent of all scripts filled by pharmacies are for workers' compensation; pharmacies are set up to process Medicaid, group health, and Medicare prescriptions which comprise the vast majority of their business. Filling a comp script takes more time, creates an administrative burden and creates a risk of not being paid at all or being reimbursed less than the pharmacy's cost.

For the retail pharmacy, workers' compensation prescriptions are more complicated, more uncertain and far more time-consuming than Medicaid. Payment is slower. **Pharmacies are not required by law to treat injured workers, so there is little incentive for them to handle workers' compensation without PBMs.**

Additionally workers' compensation PBMs have "buffered" pharmacies from realities of price cuts also known as fee-schedule reductions. Recognizing higher administrative burdens and financial risks a pharmacy takes to fill a work comp script, PBMs pay pharmacies more for workers' compensation drugs than their counterparts pay for group health, Medicaid, or Medicare scripts.

WHERE THE REAL COSTS ARE

In this paper, "cost" is defined as total drug expense; "price" refers to price per pill or price per prescription. When calculating work comp pharmacy costs, two factors go into the equation: price + utilization = cost.

Most state policy efforts focus only on price per pill; fee schedules address the ingredient cost and often include a dispensing fee as well, but there is no consideration given to volume of drugs dispensed. While workers' compensation PBMs do negotiate prices with pharmacies to provide cost reductions for the system, studies show that utilization – number of prescriptions and type of drugs prescribed – is the main cost driver.

Historically, utilization has been a much bigger contributor to overall drug cost than price, typically by a factor of four to one. Although price has become more significant of late, it appears this is due primarily to across-the-board price increases by pharmaceutical manufacturers anticipating national health reform.

The National Council of Compensation Insurance (NCCI) has conducted several studies on workers' compensation pharmacy and its Workers Compensation Prescription Drug Study 2008 Update shows that setting reimbursement rates too low can diminish or destroy access to pharmacy care. Reducing reimbursement of drug prices is a vain attempt to control overall pharmacy costs because price per pill is only one part of cost, and not the most important part. ***Utilization* is the key cost driver.**

The latest research from CWCI (California Workers' Compensation Institute) supports the assertion that utilization is a much more significant contributor to drug cost than medication price. After implementation of the Medi-Cal link, the average number of first-year prescriptions per claim increased 25 percent, while the average first-year drug cost per claim went up 37 percent. (CWCI Research Update Sept. 2009: Analysis of Post-Reform Outcomes: Changes in Pharmaceutical Utilization and Reimbursement in the California Workers' Compensation System by Alex Swedlow, MHSA and John Ireland, MHSA)

The primacy of utilization is supported by yet another study focused on workers compensation pharmacy management. Health Strategy Associates, LLC, a national managed care consulting and research firm specializing in workers' compensation and particularly in comp pharmacy, has surveyed work comp payers on the topic of pharmacy programs and recently published results of its sixth annual survey. Results consistently show that while payers expect negotiated prices to be lower than a state's fee schedule, they also recognize that utilization is the key cost driver. In the six years since payers began participating in the survey, they have dramatically increased their utilization management efforts and almost all payers rely on their PBMs for this vital service.

THE ROLE OF A WORKERS' COMPENSATION PBM

Workers' compensation PBMs manage pharmacy programs for payers of workers' compensation claims. Payers encompass insurance carriers, municipalities, third-party administrators and self-insured employers. PBMs process, monitor and pay pharmacy claims. They also negotiate prices with pharmacies to provide discounts to payers and provide numerous vital utilization management services.

While operations vary among PBM firms, typically PBMs pay pharmacies for the prescription and bill a payer for reimbursement. In addition some payer contractors include a modest dispensing fee to help cover administrative costs. Many PBMs offer mail order services to serve critically injured workers. Mail order further reduces the costs of drugs, although due to the Medi-Cal link, the differential in California is only about one percent.

Most importantly, PBMs provide utilization management services that include:

<u>Prospective Drug Utilization Review (DUR)</u>
Prospective DUR blocks questionable transactions. The prescription data is routed through a series of electronic gates, which either permit a transaction to continue or block it. Reasons for blocks:

- The patient attempted to refill a prescription too soon
- The drug not typically used in workers' compensation care
- Drug not related to patient's injury
- Drug not a standard or commonly utilized work comp drug (e.g. HIV or Cardiac)
- Drug is a brand for which a generic is available
- Drug conflicts with another medication patient is taking

Formularies

PBMs develop and use formularies, essentially a list of medications which do not require prior authorization before filling, to facilitate pharmacy transactions. If a prescription is blocked, the pharmacist checks with the PBM to see if there is a way to override the block. Unlike Medicaid, these are not "hard" formularies, in that physicians can and often do prescribe drugs that are not "on" the formulary. This requires the pharmacist to check with payer or PBM to ensure a drug is covered.

Retrospective DUR

Retrospective DUR involves routing scripts through a computer software system to detect duplicate prescriptions, potentially addictive drugs, medications that may interact badly with each other or drugs that could worsen other medical conditions. It is common to find a patient taking three or four drugs for the same condition when of the entire claim (prescription history) is reviewed by the PBM.

A patient may have two prescriptions of Vicodin or Valium, for example, and they may be taking three different types of sleep aids, four types of muscle relaxants and several antacids for digestive problems caused by the mix of drugs. Not only is the combination dangerous for the patient, it exponentially multiplies claim cost and often leads to inappropriately lengthy treatments and unnecessary disability.

Multiple identical scripts and similar prescriptions occur because workers' compensation patients often see more than one physician and these doctors tend to not communicate with each other on treatment methodologies or see a patients complete medical record. To reduce the number of prescriptions on a claim, PBMs contact treating physicians to discuss medication therapies. Some PBMs use physician peer review to help educate doctors, encouraging them to prescribe less expensive drugs and alerting them to new, more effective therapies based on evidenced-based medicine and best-practices.

It is important to note, that if a patient develops new medical problems or an addiction because of his/her workers' compensation medications, the workers' compensation payer **is responsible** for additional medical costs, such as detox or even death claims. This came to light as recently as 2005 when Cox2 inhibitors taken to relieve pain caused heart attacks in a number of work comp patients.

Clinical reviews save lives along with saving significant amounts of money.

Reduced Processing Time/Cost Through Electronic Files

PBMs provide administrative efficiency by converting bills from paper into electronic files and electronically processing pharmacy bills. Without a PBM, paper bills are mailed to payers and processed manually. Information may be gathered, but if not transferred to an electronic format, chances of detecting interactions, potential health risks, and multiple scripts are diminished. Meanwhile, the patient continues taking these prescriptions. Manual processing could take a month to six weeks, and the patient could be receiving one or possible two courses of expensive medications not covered or appropriate to their injury. Electronic adjudication occurs in real-time in most instances

HOW COMP PBMS MAKE THEIR MONEY

Workers' compensation PBMs make their money on the "spread," the difference they pay pharmacies prescription claims and the amount of reimbursement received from the payer. PBMs, which have long-term contracts with pharmacies and payer clients, base their business models and investments in utilization controls on their ability to pay for the investments based on the spread.

When states implement low fee schedules, including workers comp fee schedules based on Medicaid, the spread is significantly reduced. When a fee schedule is reduced to below payer's contracted rate with the PBM, the payer may well reduce its payment to the PBM, but the PBM cannot automatically reduce payment to the pharmacy because of the PBM's pharmacy contracts. This does not result in a reduction of PBMs operating cost, but does result in a reduction to PBMs operating budget, with strong likelihood that some PBMs will decide they cannot afford to do business in that state. Of note, in 2007 workers comp PBMs were on the verge of exiting New York due to that State's adoption of a Medicaid-based fee schedule for workers compensation drugs. However, after PBMs and their advocacy group CompPharma, LLC met with Zachary Weiss, Chairman of New York's Workers Compensation Board, the fee schedule was delinked from Medicaid and set at a level enabling PBMs to continue to operate in New York.

If the majority of PBMs leave a state, pharmacies are left not knowing who will handle and reimburse them for workers' compensation prescriptions. The administrative burden and financial risks PBMs have removed from pharmacies will fall back on them.

Workers' compensation PBMs are critically important entities that ensure injured employees receive prescribed medications promptly and safely and without having to pay for drugs themselves. As mentioned before, PBMs remove financial risk from the pharmacies, enabling them to dispense workers' compensation prescriptions profitably. Passing a bill electronically to the PBM virtually eliminates all administrative and compliance burdens from pharmacies.

WITHDRAWAL OF COMP PBMS

If most worker's compensation PBMs determine they cannot profitably do business in a state, payers will face the following consequences:

- **Loss of claimants' access to drugs** – In California it is illegal for a pharmacy to require a claimant to pay for workers comp medications out of pocket. Without PBMs, pharmacies would be forced to revert back to paper bills or refuse to dispense medications to claimants.
- **Increased costs due to unmanaged utilization** – California's current low reimbursement rates have dramatically reduced PBMs' ability to fund utilization management programs. A continued linkage to Medi-Cal will, in all likelihood, exacerbate the problem as PBMs seek additional efficiencies and eliminate more utilization management programs. Should some PBMs withdraw from the market, there will be even less control over utilization, leading to even higher costs for California's employers.

- **Loss of "real-time" adjudication functions** – Without PBMs, prescriptions will be dispensed by a pharmacy and the bill sent directly to the carrier via regular mail. This manual process will may result in an injured worker receiving a medication not tied to a compensable claim or non-appropriate pharmacy treatment which may be harmful to the injured worker. The claims adjuster will receive a paper bill several days or weeks later after prescriptions have already been filled.
- **Loss of cost savings derived from drug utilization review and formulary management** – Without PBMs' ability to use carrier/client-defined formularies to provide utilization drug review to prevent health issues based on over utilization of narcotics and other drugs, drug costs and patient risk will increase. Without a workers' compensation PBM, there is a risk that no entity will screen transactions to ensure non-compensable or non-injury related prescriptions are blocked, or the current generic mandate is enforced.
- **Loss of centralized function to retail pharmacy providers** – Without PBMs the retail pharmacy will be forced to transmit and communicate directly with the payer, and administrative functions of handling claims would fall on the pharmacy increasing their cost of filling workers' compensation prescriptions, possibly to a tipping point.
- **Loss of administrative efficiency and audit controls** – Without centralized services such as pharmacy bill review, administrative processing functions will either not be performed or shifted to individual insurance carrier claims adjusters increasing claims processing time and cost.

Without PBMs to buffer these risks, pharmacies may decide that filling workers' compensation prescriptions is not worth their time and efforts and financially acceptable. The pharmacies may:

- Refuse to fill scripts without specific notice from an insurance carrier
- Bill workers' compensation scripts to the injured workers' group health or Medicaid PBMs, shifting workers' comp costs to other payers
- Stop accepting any and all workers' compensation prescriptions

THE RISKS OF TYING WORKERS' COMPENSATION PHARMACY REIMBURSEMENT TO MEDICAID

The main problem with linking reimbursement of workers' compensation prescriptions to Medicaid reimbursement levels is, as demonstrated in New York, the very real risk that PBMs will exit a state. Medicaid-level reimbursement erodes the PBM's spread. If the spread continues to decrease, PBMs may conclude they cannot profitably do business in the state.

Three of CompPharma members have indicated they have not tried to build upon existing business in California because of the Medi-Cal reimbursement link. All the members have suffered financial losses and reduced their investments in utilization management.

If the workers compensation drug fee schedule continues to be based on Medi-Cal, some of these PBMs – if not all of them – will pull out of the state, causing results outlined in the previous section. Without the PBM, pharmacies face additional administrative burdens, extra costs, uncertain reimbursement and slow payment. They will not have any incentive to fill workers' compensation prescriptions. Ultimately pharmacies will likely stop handling

workers' compensation scripts, essentially denying pharmaceutical access to injured employees.

Another inherent issue with linkage lies in limitations of the Medi-Cal formulary, as it does not include all drugs commonly prescribed for workers compensation. As a result, drugs that are not on the Medi-Cal formulary are priced at the pre-reform fee schedule rate, unnecessarily increasing the cost for those scripts.

SOLUTION

CompPharma recommends delinking the workers' compensation pharmacy fee schedule from Medi-Cal and replacing it with a fee schedule based on industry-accepted standards reflecting the uniqueness and extra costs of dispensing and managing workers' compensation prescriptions.

This will enable PBMs to enhance the services they provide that truly control pharmacy costs, while increasing the number of PBMs competing for business California. It is clear that the Medi-Cal-based fee schedule has not reduced drug costs; replacing it with a reimbursement mechanism that allows pharmacies to continue to provide drugs to injured workers, and PBMs to better control utilization, will reduce California's workers comp drug costs while ensuring access to treatment for injured workers.

Failing to address the very real problems created by the Medi-Cal linkage will reduce claimant access to care and result in a continued increase in employers' costs.

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