Practice Guidelines, Physician Groups, and Drug Formularies

Medical group management of drug formularies—and, indeed, of the pharmacy portion of the health benefit—is very much in its infancy. But it has been born and is likely to grow in the future.

The problem physicians face in managing drug formularies is too much guidance from too many sources on how to administer and manage pharmacotherapy. Pharmacists, therefore, have a critical role to play in coordinating the flow of information from payor to provider and in making sure the pharmacy advice that physicians receive is based on sound clinical judgment.

For the most part, physicians' management of pharmaceutical therapy depends on the amount of financial risk their medical groups are able to assume. That, in turn, is a function of the level and sophistication of managed care penetration in their markets. But because formulary management is so closely tied to managed care contracting, physicians are faced with a dilemma. Many medical groups contract with five, 10, even 20 or more managed care payors, as well as with traditional indemnity and modified fee-for-service payors. That arrangement means that even within a single provider organization, the level of sophistication of pharmacy management can vary widely

RUSSELL A. JACKSON

Russell A. Jackson is a freelance writer based in Los Angeles, CA.

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from contract to contract.

Multiple payor contracts also force physicians to confront another pharmacy management challenge. Because payors often tweak their drug formularies to account for customized rebates and discounts they receive from drug manufacturers in exchange for bulk purchases, the physicians they contract to administer the pharmacy benefit may have as many as two dozen different drug formularies with which to comply. To add to the dilemma, it's possible that none of them correspond with formulary guidelines the physician groups have developed internally.

Further muddying the waters is the fact that payors and medical groups are increasingly developing proprietary treatment protocols. But when medical groups' internal drug formularies don't match those of their payors—and when none of the drug formularies coincide with either side's practice parameters—doctors may wonder how they're supposed to treat patients and with which chemical compounds.

The experts' advice to physicians: Develop sound pharmacy treatment guidelines with input from staff or contracted pharmacists, and then use your best judgment in treating patients; deal with the payors later.

MEDICAL GROUP FORMULARIES

Kerry Weiner, M.D., executive director of Lakeside Medical Group, Glendale, California, explains that his organization contracts with more than a dozen different managed care plans, meaning it faces compliance requirements for more than a dozen different drug formularies. No two of those managed care contracts are exactly alike, he adds. "In some, we have extreme downside risk," he says, "while in others we face limited downside risk and more of a tilt to upside benefit."

In other words, in some full-risk contracts, Lakeside is penalized for failing to meet per-member-per-month (PMPM) cost targets, while in others, the group is rewarded for meeting those

targets. Lakeside also manages two modified global-risk contracts.

"In the beginning," Weiner notes, "we tried to comply with all the plans' various drug formularies." But that was "an impossible task," he says, because "when you look at it on a purely scientific basis, some of the drug formularies look irrational." The reason is that the plan has encouraged the use of a product that would usually cost more than others in the same class, but the plan buys the product at a discount under a deal with the drug's manufacturer. With more than a dozen payors, each extracting its own deals from drug makers, the medical group's dilemma is easy to understand.

In response, Weiner continues, Lakeside has "evolved to its own formulary that encompasses most of the principles of the plan drug formularies along with the principles of good sense and good medical care." To develop its proprietary tool, he adds, the organization "is moving to have pharmacists and pharmacy benefit management (PBM) organizations help." Already, he says, the group has an affiliation with a local pharmacy and pharmacist under which the drug specialist "analyzes our utilization review data by physician each month and makes interventions, including discussing the provider's pharmacotherapy practice patterns, where necessary." In addition, Lakeside faxes prescriptions to the pharmacist before writing them for patients so physicians and the pharmacist can discuss the order in advance. In return, Lakeside funnels those prescriptions to that pharmacy when possible.

Practice guideline management is tricky as well, according to Weiner. While "HMOs in Southern California do very little to impose guidelines on us," he says, "if you ask them, they'll give you what they consider a reasonable protocol." Plans "really tried to push their guidelines in the early days," he adds, "but now they've sort of down-loaded that responsibility and pharmacy management responsibility to the medical groups."

At the same time, he adds, Lakeside has developed about 35 of its own practice parameters, but he acknowledges that "they're not as developed as they need to be and we haven't been very aggressive in promoting them." He sees that changing, however, as plans like his strive to meet requirements of the Healthcare Employer Data and Information Set (HEDIS).

Compounding the delicacy of managing disparate drug formularies and attempting to structure health care delivery through practice guidelines is the fact that "there is a disconnect between the two," as Weiner points out. "We've developed a formulary we feel is reasonable, based on looking at plans' lists and trying to pick drugs that span several. And payor drug formularies aren't always hard and fast." Still, he emphasizes, there are times when the clinician's pharmacotherapy judgment doesn't coincide with the drugs he or she is asked to use. When that happens, Weiner stresses, physicians should rely on their instincts, even if it causes problems with payors. "We'll take that risk," he says.

COMPETING FORMULARIES

Michael-Anne Browne, M.D., a family practitioner and medical director of the physician organization Alliance Medical Group of Torrance, California, agrees with Weiner on the crossed signals that can arise when payors impose drug formularies that don't always match the pharmacotherapy guidelines the physician would otherwise use.

In fact, she reports, one large HMO in the state was about to issue a formulary based on an association it had formed with a drug company. The preferred agent in one of the categories of lipid-lowering drugs would have been different from the group's internal recommendations. "We had fought hard to get physicians to use Brand A," she says, "and now one managed care company was going to start recommending that we switch to Brand B." As it happens, the association

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LEVELS OF SOPHISTICATION IN MANAGED CARE AND FORMULARY MANAGEMENT

Individual medical groups often defy statistical generalization: A group with 50 to 100 providers in a rural community in the Southeast may manage a payor contract that calls for assuming full risk for the entire medical loss ratio, while a group in California with 200 or more physicians may contract entirely on a discounted fee-for-service basis. But the sophistication of physicians' management of drug formularies is generally tied closely to the level of managed care penetration in the markets where those physicians operate. Jacques J. Sokolov, president of Advanced Health Plans Inc., a national consulting firm based in Los Angeles, outlines these parameters for the different levels of managed care sophistication and for the different levels of formulary management:

Level I: These medical groups are characterized by high managed care penetration, many globally capitated contracts, and a high number of tightly integrated staff-model medical groups.

"For all intents and purposes," Sokolov says, "physician organizations in Level I markets manage the entire medical loss ratio." The three primary revenue streams are commercial/ERISA, Medicare, and Medicaid. (ERISA is the Employee Retirement Income Security Act, and outlines operational rules for multistate employers that offer health benefits.) "Each managed care contract," he adds, "produces a number of methodologies that allow physician groups to provide the highest quality care for the lowest cost, and that's usually accompanied by physicians aggressively managing hospital bed days, the number and intensity of specialist referrals, and the pharmacy benefit piece." Physicians may manage the latter through

formulary use, relationships with pharmacy benefit management companies, or demand and disease management protocols for specific populations.

For the most part, this level of sophistication is found in California, Washington, Oregon, Arizona, and, increasingly, New Mexico. Indeed, Sokolov notes, "certainly the World Series of health care, from a physician group standpoint, is Southern California." In addition, individual groups outside the West, such as Fallon Community Health Plan and the Geisinger Clinic (Massachusetts), may have contracts as sophisticated as those in more developed markets.

Level II: This level of sophistication in managed care and formulary management is also characterized by considerable managed care penetration, but "significant components of the medical loss ratio—such as pharmacy or behavioral health care—are carved out," according to Sokolov. The pharmacy piece may be managed by the medical group, the managed care payor, or a free-standing PBM contracted through the payor or the provider group. In some cases, medical groups may manage only those carved-out pieces of the health benefit, he adds. That's accomplished internally or through a PBM contract.

Level II markets generally are characterized by a high number of mixed-model independent practice associations and group-model physician organizations. They're found predominantly in the Northeast, the Southeast, and, to a lesser extent, in the Midwest.

Level III: The third level of sophistication in managed care and formulary management is characterized by a low level of managed

care penetration. Physician groups generally manage only utilization and are compensated primarily through discounted fee-for-service arrangements. In those markets, Sokolov notes, "physicians have very little responsibility for the pharmacy piece. The formulary comes from the fiduciary or the HMO. Physicians can affect utilization of drugs, but at the end of the day it's the payor that imposes restrictions on their use." The least sophisticated managed care and formulary management markets are found in the Midwest and in rural areas throughout the country.

Interestingly, Sokolov notes, those market distinctions may soon disappear. They're "being distorted by the rise of the Medicare market, which will overtake commercial ERISA as the economic piece of the health benefit market that drives managed care sophistication—especially the sophistication of medical group management of drug formularies."

Medicare, he explains, is moving toward broader access to benefit management by "provider-sponsored networks," integrated delivery networks that can be managed and operated by physicians. Physician organizations will become far more important in the management of the pharmacy part, he says. "They'll be increasingly responsible for the type, manner, and nature of prescribing in a way that's much more accountable than we've seen historically." And as they learn sophisticated formulary management skills for the Medicare market, he adds, they'll increasingly want that same level of control for their other lines of business.

That shift, Sokolov emphasizes, is coming in the next two to four years. Indeed, he says, it's already changing market dynamics in Louisiana and the Northeast.

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between the plan and the drug maker fell through.

While such occasions are unusual, medical groups can run into trouble in treatment areas where pharmacotherapy is still changing rapidly. AIDS patients, she notes, represent one such challenge.

Browne also points out that Alliance shares Lakeside's frustration with its various payors' competing and conflicting drug formularies. "Our level of risk for pharmacy is different [from] contract to contract," she explains. To try to minimize confusion, she keeps the most restrictive formulary imposed on the organization in her lab coat pocket.

"Usually, you can use one and it will work pretty well for most of the others. An overwhelming majority of the time there's something on it that works just as well as what you had planned to use."

And, she adds, even in cases where the physician's preferred drug isn't on the formulary, "every plan has a mechanism by which you can submit documentation and ask for a formulary exception based on necessity. You may have to go through some extra paperwork, but I don't know of any cases where someone's been denied a needed drug."

UNDERSTANDING PHARMACY RISK

Still, formulary management by medical groups is a messy business in many cases, and having a pharmacist on staff or under contract who understands pharmacy risk can help. Bard Coats, M.D., medical director at Woodland (California) Healthcare, an integrated delivery system, notes that his organization cares for about 65,000 patients, half of whom are capitated through contracts with eight HMOs. The organization bears substantial pharmacy risk for three plans, he adds, covering about half of Woodland's capped patients.

And while the group does receive utilization reports from its managed care payors, they're "disparate, all over the map, inconsistent and unclear," he says. Reducing that disparity at the HMO

level is very difficult, he adds. "Each has a Pharmacy and Therapeutics (P&T) committee, but they face so many pressures that affect the way they function that they end up being advisory, not policy-setting. And the HMOs have to duck and cover and shift, trying to meet the diverse needs of their purchasers." While physicians can "go through the P&Ts and even talk to purchasers and explain their pharmacotherapy choices," he continues, that process "just doesn't work very well. It will take three or four more years to settle into a better way of doing it. In the meantime, it's very troubling trying to effect change."

And, Coats notes, while pharmacists often each have their own agenda depending on whether they're affiliated with HMO payors, PBMs or medical groups "having one working with the group can be tremendously beneficial."

MENU OF DRUGS

Leslie Fish, Pharm.D., clinical coordinator at Fallon Clinic, Worcester, Massachusetts, agrees. Fallon's physicians don't have their own formulary, but they do deal with about 20 different managed care plan lists. "This is a problem," she says. "The physicians don't really 'handle' it. They say, 'What are we going to do?'" One tactic: use of a "major menu" that lists each payor's preferred drug in a number of common categories. Physicians laminate the list and hang it on their exam room doors.

Fallon also strives for close collaboration between physicians and pharmacists. In fact, Fish says, "we want to make it as easy as possible for physicians to prescribe the right meds. We want to actually hit them before the script is written. So it behooves me to become this big, walking educator, going in and saying, 'when you think of Fallon, think of this drug in this situation.'" Also, she notes, Fallon physicians vote along with pharmacists in payors' P&T committees, helping determine how a drug is brought out, how it's restricted, whether prior approval will

be required, and whether only certain specialties will be able to prescribe the agent without advance permission.

MAKING DOCTORS ACCOUNTABLE

When collaboration isn't enough, Jack Raber, Pharm.D., owner of a consulting company called Clinipharm Services, Seal Beach, California, recommends internal policies with teeth in them and more savvy managed care contracting. "The most important thing in medical group management of the pharmacy benefit is the internal governance of the group," he says. "Even if you're a group-model organization, you should think like a staff-model group, with members working for the benefit of the group, and not for their own agendas. The group should develop agreements on prescribing habits and utilization criteria."

And if physicians won't adhere to those agreements voluntarily, he adds, they should be pressured to do so. "A lot of people say 'we can do this if we educate doctors,' he says. "But what if they don't want to be educated? The administration of the group needs to be able to address individual physicians on an educational/confrontational/disciplinary basis if they're not doing what they're supposed to do. The group has to make the physician accountable for what he or she is doing."

A little external muscle flexing can help, too. "Plans often give medical groups target numbers to work with that are somewhat unreasonable. A lot of managed care contracts stipulate a target PMPM rate and a formulary compliance rate," he explains, "so a group can be penalized for meeting the PMPM target if it doesn't meet the compliance rate as well—even if it actually uses lower-cost drugs that aren't on the formulary." His advice: "Keep those targets out of managed care contracts. The only target physicians should need to meet is a dollar target, and they should be able to meet it however they need to." ■