Practice Economics

Dispensing oral medications: why now and how?

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Dispensing oral medications in your clinic presents a significant opportunity to better serve your patients and your practice.

Here are some stark statistics on the oncology drug market and oral oncology prescriptions: In 2007, the world oncology drug market was $40–$45 billion,[1] of which $6 billion (13.3%) was oral.[2] Overall, 35% of the oncology drug pipeline is for oral drugs.[3] The world oncology market is estimated to be $55 billion in 2009.[4] It is estimated that the generic oncology market in the US alone will be $35 billion after 2011.[5] Although the US drug market is expected to grow 2% in 2009, oncology drugs are expected to grow 15%–16%.[6] The US constitutes about 37% of the world drug market.[6] The US market for oral oncology drugs is expected to be between $5 billion and $7 billion in 2010 and to continue growing at a 20%–30% annual rate.[7] The average unit price of an oral oncology prescription is estimated to be $500.[8]

So if you decide *not* to dispense oral oncology drugs, what will that cost your practice and your patients?

The first step in answering this question is to analyze your expenses associated with writing prescriptions filled by outside pharmacies. These costs include phone and fax exchanges, which in a non-oncology practice cost $5–$7 per contact.[8] Forrester Research estimated the number of prescription-related telephone calls at 900 million, with one in three prescriptions requiring pharmacy call backs.[9] In a typical practice where physicians see 25 patients per day, that "cost of not dispensing" nears $30,000 annually, not including lost physician time.

A recent article in Drug Topics[2] gives pharmacists the following instructions for handling oral oncology prescriptions:

- Plan for at least 20 minutes per prescription for telephone exchanges.
- If a drug is not on formulary, try to work with the physician to change the regimen before giving the patient the option to pay for it out of pocket.
- Keep the patient advised of every development; explain that the pharmacy is the middleman and keep the patient updated on the estimated time it will take to resolve the problem.
- Work with the physician to obtain the proper forms, and if possible notify the pharmacy 5 days in advance of the need for the oncology medication so that prior authorization can be started early.

In addition to these items, you should provide for your own prior authorization and patient counseling. You and a nurse are probably handling these tasks. With full consideration for staff time and overhead, the out-of-pocket cost to your clinic simply to prescribe an oral oncology therapy may

KEY POINTS

Oral oncology drugs are already a significant part of oncology treatment, and the number is increasing dramatically.

The counseling and instructions needed for adhering to oral regimens are significant.

Retail pharmacies do not generally carry oral oncology medications and lack the ability to counsel and instruct.

Dispensing oral oncology drugs in the office is safer and more convenient for patients.

Community oncologists need to look at which cost centers can be turned into profit centers as they take care of patients.

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be near $50. The pharmacist functions as a "middleman," brokering any "blame" on either the physician or the payer when difficulties arise filling a prescription. Add to this the lost opportunity cost in using physician time in this process, and the old mantra "cut out the middleman" becomes a mandate.

According to the Association of American Medical Colleges, there were 9,584 oncology/hematology physicians engaged in patient care in 2007.[10] The current political and economic environment does not bode well for new oncologists, and a shortage is predicted for the next 2 decades.[11] By 2010, the estimated number of oral oncolytics filled annually per oncologist would be 1,200. Assuming that the $50 cost per prescription written is correct and applying it *only* to prescriptions filled, the unreimbursed cost per oncologist for oral oncolytics is $60,000 annually.

It is generally estimated that one-third of all prescriptions are not filled. The two main reasons are cost and convenience. Although there are no statistics available for unfilled oral oncolytics, their cost and inconvenience are significant. As this market increases at a 20%–30% rate, both the unreimbursed physician costs and the harm to patients failing to fill their medications will increase.

Most oncologists write several hundred other prescriptions per month for ancillary medications necessary for disease management. Many assume responsibility for all medications. The cost of not dispensing those other prescriptions needs to be added to the above.

To this we must also add e-prescribing costs. MIPPA (Medicare Improvements for Patients and Providers Act of 2008) authorizes the Centers for Medicare & Medicaid Services to pay financial incentives to "successful" e-prescribing "eligible professionals." The financial incentives are a percentage payment of the eligible professionals' total Medicare Part B charges per calendar year. For 2009 and 2010, the percentage payment is 2%. The incentive payment drops to 1% in 2011 and 2012, 0.5% in 2013, and is eliminated thereafter. *Eligible professionals who do not e-prescribe will have their Medicare Part B payments reduced by 1% in 2012, 1.5% in 2013, and 2% in 2014 and subsequent years.*[12]

Simple stand-alone e-prescribing systems are offered anywhere from "free" to $2,500 per prescriber per year.[13] The maintenance on "free" systems is charged on a per prescriber basis and raises the cost to near that of the others. If e-prescribing is integrated into your electronic medical record or electronic health record system, the cost and maintenance can be multiples of the above.[14] What do you get for this additional cost? You get the ability to deliver a clean claim to a pharmacy at your expense and, after 2011, a reduction in your Medicare Part B payments if you do not conform.

When you dispense, patients benefit

The patient and overall healthcare benefits touted for e-prescribing are listed in *The Physicians' Guide to EMR Solutions*:[15]

- Improves patient safety and overall quality of care: the problem of illegible handwriting is eliminated, warning and alert systems are provided, and patients' medical histories are accessible.
- reduces or eliminates phone calls and call backs to pharmacies,
- eliminates faxes to pharmacies,
- streamlines refill requests and authorization processes,
- increases patient adherence,
- improves formulary adherence,
- increases patient convenience by reducing trips to the pharmacy and wait times,
- offers true provider mobility: he or she can write or authorize prescriptions anytime from anywhere,
- improves reporting ability.

The exception is controlled substances; currently, the law prohibits filling them electronically.

It is self-evident that dispensing drugs for your patients using the right in-office software provides all of these benefits. The controlled substance exception becomes moot when you dispense from your clinic. To use a football analogy, all of the benefits cited above are designed to eliminate errors in the handoff from the physician to the pharmacy. In-office dispensing provides the real solution—that is, no handoff. From the current staggeringly high level, errors are reduced to a minimum.

For oral oncology, the issues are heightened. Most pharmacies do not keep oral oncolytics on hand; the timing of billing for payment also can be an issue.[2] Your ill patient is "ground up" by a completely inefficient system.

The authors have found that dispensing physicians quickly become aware of the cost of the various medications. All use generics when available, but cost savings are achieved as dispensing physicians select therapeutic alternatives for a patient who cannot afford a more expensive medication. In many cases, the physician has been writing the higher-priced alternative without considering cost. By matching affordability with need, the patient is ensured of receiving therapy.

A survey conducted by Opinion Research Corporation in 2007 reports that 75% of patients would prefer getting their medications in their doctor's office.[16] In the same survey, 62% said getting medications from their doctor would help them better manage their health. A JD Power study in 2008 concluded that nearly 90% of the buy decision for medications is based on convenience, staff, and trust; only 10% is based on price.[17] In the group of dispensing physicians we serve, *the average price of a prescription is reduced*

more than 50%. It is evident to us that in-office dispensing provides better and lower cost healthcare.

It should be noted that specialty pharmacies are generally remote, and counseling by phone or e-mail is inadequate, impersonal, inaccurate, ineffective and sometimes dangerous.[18(p 18–20)]

When you dispense, you benefit

Operational issues and profit aside, it is rewarding to have happier and healthier patients receiving better and lower-cost healthcare. Greater patient service is a natural byproduct of physician dispensing.

In-office dispensing allows you to test a patient's tolerance for a drug before giving him or her a full prescription. Often, specialty pharmacies call clinics to get a prescription started a few days before the end of a cycle so that their delivery inefficiencies can be accommodated. But you may not have had a follow-up visit.[18(p 18)] With physician dispensing, patient care, efficiency, and cost savings merge.

Dispensing oral oncology drugs still needs to be interfaced with an e-prescribing system to avoid the Medicare Part B penalty. Structured correctly, this cost can be minimized.

There are no published statistics on profitability from in-office dispensing in an oncology practice. Our anecdotal evidence is based on some of the practices we serve. These statistics cover almost all of the medications written and delivered in an oncology practice, including oncolytics. The average overall profit per unit in 2008 was $23.62. Profit from erlotinib (Tarceva), pegfilgrastim (Neulasta), temozolomide (Temodar), epoetin alfa (Procrit), capecitabine (Xeloda), and imatinib (Gleevec) averaged in the $100–$300 range. Others, such as prednisone, yielded a $4 profit. Depending on the payer, some infusion drugs may be processed profitably as a pharmaceutical claim. As in-office dispensing increases, the unreimbursed labor and costs associated with pharmacy callbacks and faxes decrease. Seldom is there additional cost associated with dispensing oral oncology drugs; usually practices realize overall savings. By dispensing these drugs properly, oncologists should be able to generate close to $100,000 in additional net income with no associated increase in overhead.

Essentials for physician dispensing

The greatest difficulty that oncologists and clinic managers have is trying to make in-office dispensing fit into the buy-and-bill model. But it doesn't fit, and it never will. Based on experience in the field, we estimate there are more than 11,000 different plans and payers that reimburse dispensing physicians. All have their own mechanisms for reimbursement. You will lose money on some drugs and make money on others. The medications need to be repackaged in units of use and must be identifiable electronically. Price is not that relevant. The system must be efficient, fully accurate, and fast.

There are five keys to successful in-office dispensing:

1. The entire staff must encourage point-of-care dispensing and be willing to discuss with each patient the opportunity to obtain his or her prescribed medications at your clinic.

2. The clinic must gather prescription drug benefits information on all patients as a routine part of patient check-in.

3. Dispensing oral drugs must be done in an area of the clinic that maximizes the efficiency of dispensing relative to patient flow and individual state requirements.

4. The clinic must be prepared to transition the current unreimbursed effort to point-of-care dispensing and devote the necessary time to successfully train all personnel.

5. The clinic must try to stock all medications generally required by its patients, understanding that success involves volume and averages.

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Conflicts of interst: None to disclose.