



Data-Driven Decisions: Leveraging Analytics To Transform Business Strategies

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Disclosure Statement

There are no relevant financial relationships with ACPE defined commercial interests for anyone who was in control of the content of the activity.

Pharmacist and Technician Learning Objectives

1. Review useful key performance indicators (KPIs) and how to calculate them.
2. Describe how to use e-prescription data to identify patients for additional services like blood pressure management or insurance agency.
3. Discuss how to use 4Rx information (BIN/PCN/Group/Cardholder ID) to segment patient populations by third-party payer type (Commercial, ACA, Medicare PDP, Medicare Advantage, Medicaid, and dual eligible).

Speaker



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Key Performance Indicators

Key Performance Indicators are measurable outcomes of the MOST important things that drive business success that allow you to see how your business is doing.

- Leading KPIs - quickly measurable figures that LEAD TO success
- Lagging KPIs - figures that require more time to calculate, actual metrics of success

What KPIs do you use?

Inventory Value

Inventory Turns

Transfers In/Out

of Sync Patients

Sync % of revenue/rx volume

Labor Hours

Labor % of Revenue

Special initiatives?

Scripts per day/week/month

Gross Margin/script

Revenue/day

“I just look at my bank account”

New Patients per day

Immunizations per day

Immunizations per encounter

Payroll Ratio

$$\frac{\text{All Expenses Related to Payroll}}{\text{Total Revenue}} = \text{Payroll Ratio}$$

The most recent NCPA digest, sponsored by Cardinal Health, says that the average survey respondent had a payroll % of 10.6%.

Medication Synchronization

- If you're not syncing your patients, you must start Monday
- You can not control your inventory with a high level of service, without sync
- Inverse relationship between sync and inventory value
 - Sync goes up, inventory goes down
- Fewer phone calls
- Better forecasting of workload
- More efficient scheduling

Sync KPIs

- **Leading**
 - New Patient Enrollments Per Day
 - Offers to Synchronize made
- **Lagging: Total Patient Enrollments**
 - % of patient profiles touched that are enrolled
 - % of Rx Volume filled through sync
 - Inbound Phone Call Volume
 - Rx Count per delivery package
 - Total Revenue and Gross Margin compared to pre-sync

Vital Signs on eScripts

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Note: kilograms and centimeters

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eScript Data

10/10/19

170.2

Centimeter

78.9

Kilogram

122 / 78

Diastolic

10/10/19

4Rx as an abbreviation

PBM Industry Term for the 4 main identifiers used to bill Rx claims:

1. Bank Identification Number/Issuer Identification Number (BIN/IIN)
2. Processor Control Number (PCN)
3. RxGroup (Group Number)
4. Cardholder ID

Crosswalks of Plan to BIN-PCN

- Over the next few slides, I'll be discussing 4Rx to actual underlying plan crosswalks. For Medicare, you can find such a crosswalk from CMS here under "BIN-PCN" followed by the date that the file was uploaded.
- <https://www.cms.gov/medicare/coverage/prescription-drug-coverage/part-d-information-pharmaceutical-manufacturers>
- Most PSAOs maintain a crosswalk for Commercial and Medicaid plans as well as digesting the data in the above file.

Benefits Coordination

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Benefits Coordination

PBM: Express Scripts

4Rx:

BIN/IIN: 610014

PCN: MEDDPRIME

Group: 2FGA

Cardholder ID: Omitted due to HIPAA

Medicare Contract ID: S4802

Prescription Benefits Plan: 021

Medicare Region: 31

If we then cross-reference S4802-021 against a list of plans, we find that this patient is on Wellcare Classic Rx (S4802-021), which allows us to know what is on/off formulary, what their copays will be, whether the plan is Part D or Medicare Advantage, which drug benefit type the plan has.

Benefits Coordination Data

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<PayerName>RELAYHEALTH/PHI-SELECT HEALTH</PayerName>

<CardHolderName>

<LastName>HIPAA</LastName>

<FirstName>HIPAA</FirstName>

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<GroupID>**I100000740A2090**</GroupID>

</BenefitsCoordination>

Benefits Coordination

- PBM: Select Health Pharmacy Services
- PBM Member control number: SEL0540HIPAA
- Physician EHR MRN: 3fb75165d81349dda91fb0805HIPAA
- Group number: I1000007
- Plan Policy control number: 40A2090

Coverage Period: 01/01/2025 - 12/31/2025

Coverage for: Single/Family | Plan Type: HMO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs



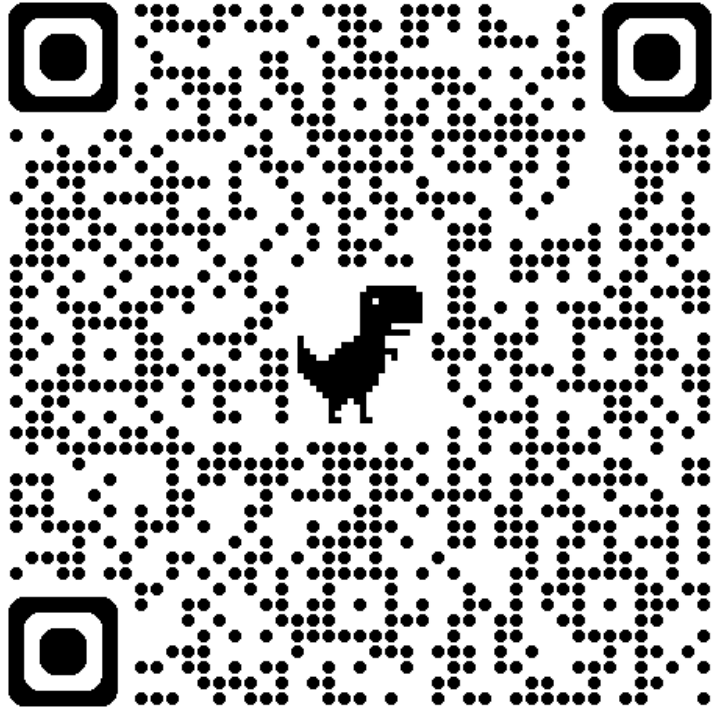
Value Expanded Bronze 6900 Medical Deductible



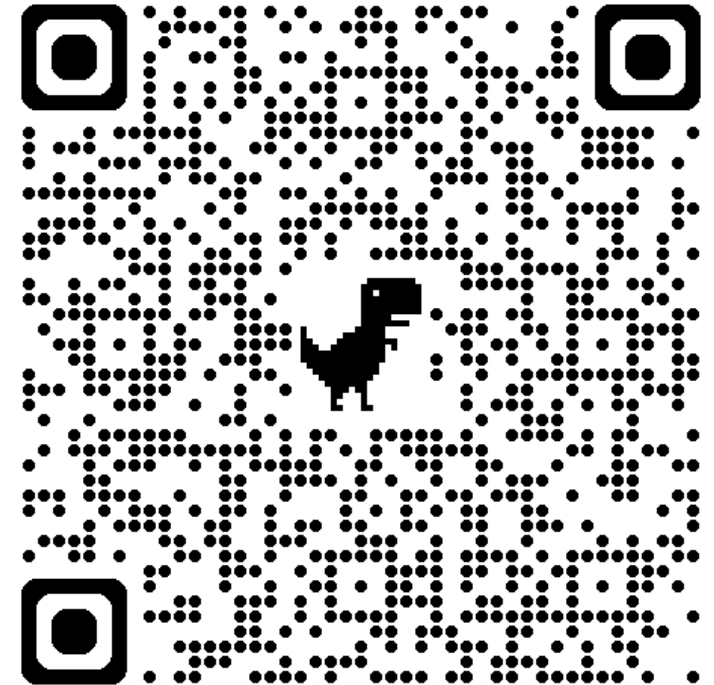
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately. **This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit selecthealth.org or call 800-538-5038. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at selecthealth.org/sbc or call 800-538-5038 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$6,900 person/ \$13,800 family in-network per calendar year.	Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of deductible expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Prescription drugs, <u>Preventive</u> Services, and office visits are covered before you meet your <u>Deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. \$1,500 person/ \$4,500 family for prescription drugs. There are no other specific <u>Deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$9,200 person/ \$18,400 family in-network per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.

Third Party Plan Segmentation

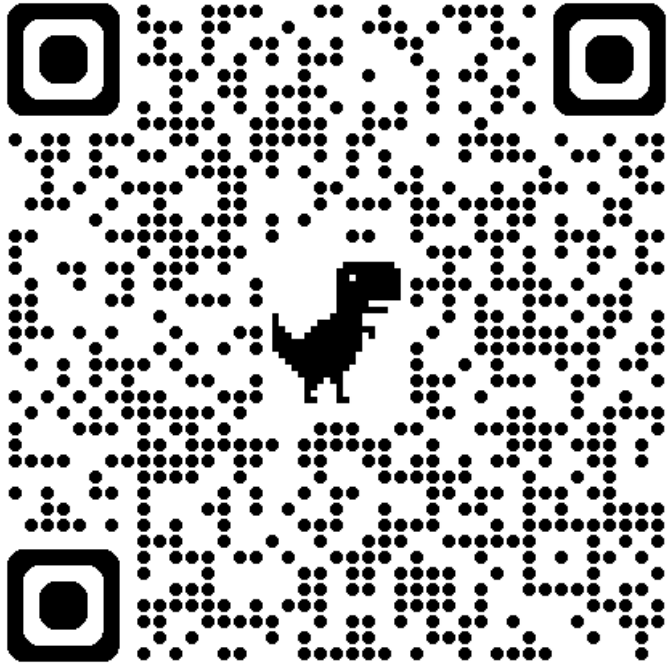


Medicare

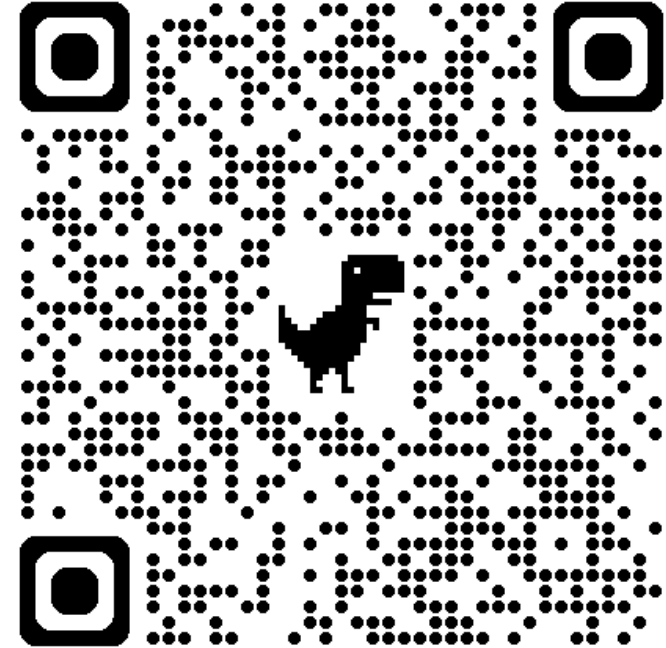


Medicaid

Third Party Plan Segmentation



ACA



Commercial

KPIs - Third Party Segmentation

% of patients on “mismatch” reporting

% of patients with recent Eligibility Checks performed (This Year)

For insurance agency:

- % of patients on ACA
- % of patients on Medicare
- # of patients that are agency clients



Questions?

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