Opportunities and strategies for improving pharmacy financial performance

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What are the most challenging drivers impacting the pharmacy's bottom line?

Ramona Seabaugh: There are several factors influencing pharmacy financial performance.

For example, at Banner Health, a key performance driver is pharmacy drug spend. Hospital drug spend continues to grow as reimbursements decrease. One of the ways we try to address this is through tight formulary management. We work hard to keep a standard formulary and only allow exceptions under specific circumstances. Physicians and facilities have their drug preferences, making it difficult to maintain a consistent formulary across the enterprise.

Another hurdle relates to hospital-based infusions. Many of the simple and profitable infusions are performed in physician offices while the more complicated and less profitable infusions are routed to hospitals, driving down the average net margins within the outpatient setting.

Page Smith: From my perspective as a 340B program director for Banner, supply cost and product availability are primary challenges. It's always a bit of a juggling act between which manufacturer has the best cost, and how switching to that product may impact the organization's 340B accumulation. For certain medications, you must change products frequently depending on where you're able to get the drugs for the patient. This can drive the supply costs higher as we often can't take as much of a 340B benefit on those pricing options.

Paul Athilingam: One of the biggest pieces for University of Rochester Medical Center is supply cost and that has a lot to do with shortage management. We are not always able to get the drugs we prefer at the prices we want. "We have a disproportionate share hospital (DSH) and rural referral center (RRC) 340B hospital in our system, meaning we don't ever buy a drug at just one price point. We can buy it at wholesale acquisition cost (WAC), 340B cost or group purchasing organization (GPO) pricing based on eligibility status, using third-party accumulation software to determine at which price we can procure [a given drug]. We try to limit our amount of WAC purchases because the price is much higher than 340B or GPO. However, when we don't qualify, or we don't have enough documentation to buy a drug at 340B or GPO, we end up paying WAC prices, which negatively effects how much we're spending for the drug.

In addition to navigating supply concerns, there is also a lack of knowledge sharing between pharmacy and the organization's financial departments. Traditionally, the financial aspects related to medication haven't been a pharmacy-specific function. They are usually left to the claims department or other revenue cycle areas. However, one of the difficulties we are seeing is by not having a pharmacy expert embedded in financial operations, the business office may not account for critical factors like supply costs, dispensing effort, patient mix and how we're getting drugs to the patient. On the other side, the pharmacy expert doesn't necessarily have the coding or reimbursement knowledge to ensure optimal reimbursement. To truly make strides in improving pharmacy financial performance, both functions need to get on the same page.

Another roadblock relates to the data for managing some of this work. Although the pharmacy generates charges by taking the drug cost, applying a markup, administering the drug to the patient and then generating the charge, we don't necessarily know what we are getting paid for the drug and its administration—especially in the inpatient setting. What our department is trying to do is understand a little more about the health plans and how they're reimbursing the organization for drugs. We are looking at our procurement, charge and reimbursement amounts and trying to determine how much is being covered by insurance, how much is the patient's responsibility and how much is being written off. To gain this level of transparency, we need access to the data.

Bonnie Kirschenbaum: The drivers behind pharmacy performance are changing, and there are new and emerging implications to the department's decisions and actions for which pharmacy departments are not well prepared. It's important for pharmacies to recognize that some of the approaches that worked well in the fee-for-service model or the inpatient-focused environment that prioritizes reducing patient costs, may not translate well to a model emphasizing continuum of care across sites. Making this shift without knowing the basics of reimbursement will be

challenging. Identifying key strategies for change will be difficult without knowing what issues currently are problematic or contributing to financial loss. Key to all this is knowing the payer and what its requirements are and then making sure the pharmacy meets those requirements. This demands a strong revenue cycle relationship to fully appreciate all the nuances.

Pharmacies also need to consider multiple supply chain acquisition avenues, including GPO, 340B or even zero-priced options from the health plan. All the options need to be on the table to make sure the department is keeping costs low while ensuring appropriate availability.

What strategies has your organization used to address the challenges?

Seabaugh: Banner Health created Banner Pharmacy Services—a centralized pharmacy operation made up of clinical and financial pharmacy experts that work together to provide inpatient, outpatient and ambulatory pharmacy services for the Banner Health system. Part of this group's role is to educate facilities about pharmacy rules and requirements and how they relate to reimbursement. For instance, for outpatient infusion, we created a team within pharmacy services that educates the various facilities on how to approach infusion. Subject matter experts within this group discuss the information needed for approval, such as prior authorization for the medication and the procedure. They also teach the level of coding for optimal reimbursement and help everyone appreciate the typical causes of denials, short payments and lower-than-expected reimbursement. This initiative has been highly successful. Many of the facilities just didn't know why denials were happening. Or, if they were being reimbursed, they assumed that the lower amount was correct, not realizing they should receive payment for both the drug and the infusion procedure.

In addition to better education, we've also done a lot of work around formulary management with clearly defined policies that explain why we add or don't add drugs. As part of this, we created tiered nonformulary exemptions that are quite specific about when deviations are permitted. For example, one tier addresses when there is a drug shortage, allowing specific drugs to be used only in that situation. Another tier includes drugs that could be available if the patient can't tolerate the preferred formulary drug or if there are efficacy or physician concerns. In these situations, the physician would need to clearly and completely document the reason why the exception should be made. There is also one tier where drugs are not permitted under any circumstances. Having this tiered approach helps everyone understand the severity of going off formulary and when variances are allowed and when they are not.

Athilingam: One thing University of Rochester Medical Center has done is seek technology that will assist in managing big data sets to closely examine our pharmacy purchases and identify improvement opportunities. We're also working to have more communication around pharmacy issues throughout the organization. We have bi-weekly meetings with representatives from compliance, hospital billing, professional billing, IT and pharmacy leadership, where we talk through some of the issues and questions that come up. We also use a ticketing system to communicate requests between financial services and the pharmacy. Traditional tasks that a billing analyst would do manually, the pharmacy now addresses. For instance, if there's a request from a health plan for a pharmacy audit for medical necessity, we can handle that, auditing the chart to demonstrate

progress notes, diagnosis, dosing, recommendations from literature and the rationale behind the medication decision. We're pursuing collaboration in areas where we can show our expertise. Claim denial management, medically unlikely edit management, Healthcare Common Procedure Coding System (HCPCS) updates and cost updates are logical areas to work together.

Kirschenbaum: Getting greater clarity around the reimbursing payer also can be extremely beneficial. When IT systems are structured so the pharmacy knows the payer(s) covering the drug and what payment requirements are, then the pharmacy can ensure documentation and coding meet all the requirements. Without this transparency, the pharmacy is always going to struggle to know whether its charges are appropriate or whether it is at risk for being denied reimbursement. Payment denied due to lack of medical necessity because the pharmacy did not provide adequate documentation is an avoidable error.

It is also beneficial for organizations to synch their formularies with their major health plans to avoid situations where the health plan only allows drug A, but the health system's pharmacy and therapeutics (P&T) committee only permits drug B. If the pharmacy isn't aware of the key health plans for the health system, then it may not be aware of the formulary differences. By syncing formularies, a health system can avoid losing patients to other organizations that are better aligned with the health plan and avoid choosing drugs that are not going to be reimbursed.

Mark Slykhouse: Developing partnerships between pharmacy and revenue capture teams is critical. This allows organizations to leverage the unique skill sets each function brings to the table and helps entities more collaboratively address larger challenges surrounding pharmacy operations. Enhanced communication ensures each participant within these teams better understands the downstream effects of their work. Striving for mutual respect and appreciation is the foundation for improvement and allows the various stakeholders to come together as a team to solve problems that are bigger than just one department.

What are some key measurements you use to track your financial performance in the pharmacy?

Slykhouse: It's valuable to collect supply chain, operational and revenue measurements. Regarding the supply side, appropriate things to monitor could include cost drivers, sourcing compliance and total spend for your top drugs. Whether an acquisition is through a GPO or some other cost basis like 340B, it is imperative that an organization understand the actual costs and what that means for the inventory on hand.

Operational measurements could include things like cost-per-patient. Ideally, that's broken down into greater detail by the patient mix or therapy complexity. Some patients require much more in-depth therapy and therefore change the average cost-per-patient. As such, it may be helpful to look at these costs by department, procedure or diagnosis.

In terms of revenue, it's critical to identify your revenue capture rate. You can do this by looking at your total reimbursements—whether through insurance or patient pay—as compared to your dispensing activity. This metric reveals charge capture and denial issues that you'll want to fix to optimize financial performance.

Kirschenbaum: It's also important to track the number of claims returned for lack of medical necessity or those submitted with missed HCPCS numbers or without the corresponding National Drug Code (NDC) numbers when using miscellaneous HCPCS codes. These metrics could indicate lost revenue on high-investment drugs, and they are relatively straightforward to fix if the pharmacy and financial department work together to get more clarity on what information is needed for reimbursement.

Seabaugh: Banner Health collects a wide range of metrics, such as drug spend per billable charges, reimbursement per billable charges, revenue-generating drug spend versus non-revenue-generating drug spend and several 340B-related metrics. All the data is reflected in a comprehensive dashboard that has robust analytics behind it. There is a scorecard for every facility that shows drug spend and revenue trends for that facility. These roll up to the division or region level and also to the system level.

What recommendations do you have in pricing medications given the heightened focus on price transparency?

Athilingam: To reduce the complexity for the patient, University of Rochester Medical Center bills are based on a price in the middle of acquisition costs, so they make sense and remain consistent from a patient perspective.

Slykhouse: When an organization is trying to price its medications, it must first fully understand the dispensing cost in its entirety. There are some complex distribution contracts out there, as well as variations in formularies. An organization may buy a drug for one patient, and it costs 20 times as much as it would for another patient who is eligible for a 340B discount. It is incredibly difficult to make this complexity easy to understand for patient consumption. I would say organizations could try to use an average cost-based price, and when thinking about making prices transparent to patients, they should try to bundle what they can into common procedures. For example, if pharmacy costs are built into a bundled procedure like total knee replacement, then when the patient is considering knee replacement surgery, he or she knows not only the costs of the procedure but also the costs of the anesthesia and other medications associated with the procedure. Bundling the pharmacy costs into the total cost of the procedure can help put those medication costs in better context and make it more understandable to the patient.

Kirschenbaum: To lay the foundation for pharmacy cost and pricing work, the pharmacy and financial services departments need to partner to clean and simplify the chargemaster (CDM) and remove duplication. Next, they should think about organizing the CDM by dosage form, creating no more than 10 categories. They can determine the markup for each category, keeping in mind that they should not be the same—for example, oral solids or liquids should not have the same markup as high-investment drugs. Optimizing the CDM requires a collaborative effort and one in which all stakeholders participate.

How would you recommend prioritizing pharmacy financial improvement work?

Slykhouse: First and foremost, focus your efforts on high-volume and high-cost issues. Try to catch those small mistakes in your coding, documentation or billing that are causing issues that could end up as significant underpayment or compliance problems. Next, I would advise regularly reviewing formulary compliance, drug cost variations and pricing variations. Although some of these may entail small fluctuations, when taken in the context of a large volume of drug purchases, small differences can translate into substantial impacts to the bottom line. When you regularly monitor these changes, you can quickly adjust your formulary and avoid larger financial effects without appreciably impacting patient care.

Athilingam: You must get access to the data; that's the big one. We use a pharmacy-specific data warehouse to pull in data from our various systems to evaluate revenue integrity instead of charge integrity. We review our purchase data, charge data and payment data, as well as our 340B qualification data and put all of that in one place.

What are some ways pharmacy and finance can better collaborate to improve financial performance?

Seabaugh: Some simple things you can do are incorporating standardization, education and partnership opportunities within the system. Anything you focus on is going to improve, so start with areas that have high-dollar impacts, such as infusions. By implementing protocols that standardize the approach to infusions, you can avoid denials related to lack of pre-authorization or medical necessity. If you can prevent these, you could see immediate benefits to your bottom line.

Smith: In addition, look for novel opportunities to capture savings from a 340B perspective. For our critical access and sole community hospitals that are 340B, for instance, we have had our 340B analyst go to the manufacturers of orphan drugs and get a 340B-like pricing agreement with several of them, so that we don't lose the savings opportunity due to 340B regulation. This is not something that we can guarantee year after year because it is a pricing agreement that's subject to change at the manufacturers' whim, but this has contributed to millions of dollars each year in savings that these facilities otherwise would not be able to capture.

Slykhouse: Most of the organizations with which we work will have weekly or biweekly meetings between pharmacy and financial stakeholders. It's usually weekly until they get their status quo under control, and then it's less frequent. They come together to make sure they have optimal formulary compliance; that dispensing activity is appropriately coded to capture revenue; and that purchases are consolidated and reflect sourcing agreements. Technology can facilitate this collaboration and communication. When organizations use a common platform in which pharmacy and finance can engage around revenue capture, it can close the knowledge gaps between departments and foster awareness of each group's perspective. Ultimately, this commitment to partnership allows everyone to get on the same page and move forward together.