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Pharmacy-Led Revenue Cycle Program: Optimizing Medical Drug Reimbursement Capture

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Learning Objectives

- Identify medical reimbursement gaps to justify dedicated pharmacy staff.
- Explain how to integrate pharmacy staff into prior authorization and claim denial workflows for buy-and-bill medications.
- Discuss how to optimize use of free drug programs in a large, multi-site healthcare system.

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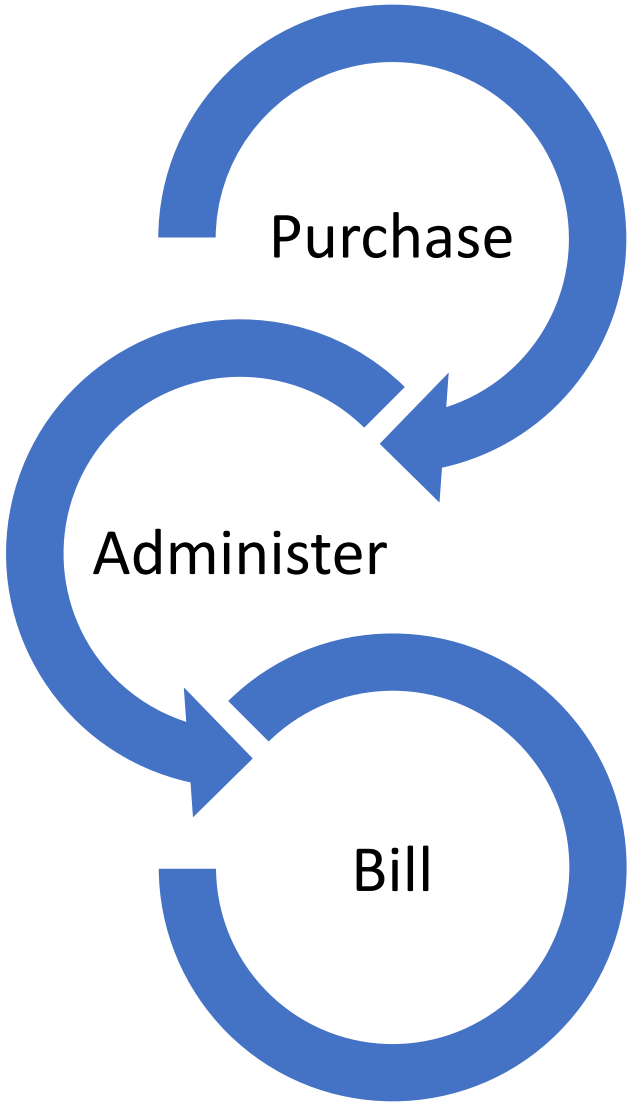
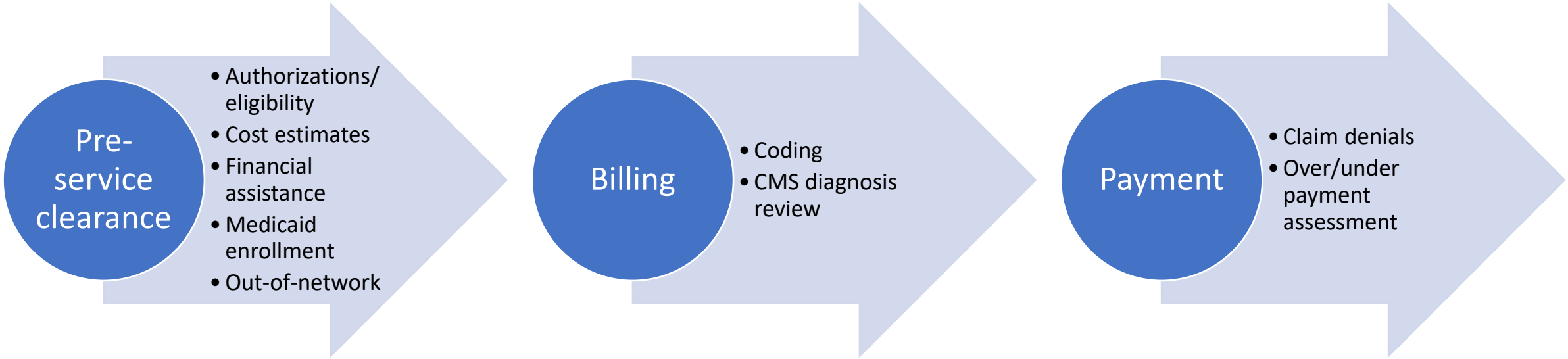
Background

What is buy and bill?

- The health system owns the entire process for procuring, storing, managing, administering and billing medications.
- The hospital takes on the financial risks of inventory cost, medication waste, reimbursement and the potential of no reimbursement.



Revenue Cycle Standard Model



Medical Drug Reimbursement

- Insurance policies getting stricter
  - Product preferences
  - Site of care/pharmacy benefit restrictions
- Payer shift to not requiring prior authorization → still requires medical necessity review
- More branded generics and biosimilars coming to market with unique billing codes

According to Access Market Intell, in early 2020, United Health CEO Dirk McMahon said, the insurer sees an opportunity to shift more than 20% of medical spend to what it terms "more effective sites."

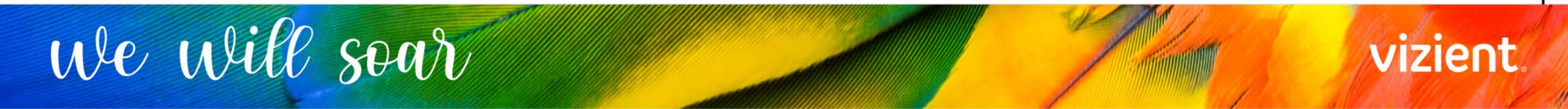
1. Santilli, John. Insurers Using Site of Care Optimization to Reduce Specialty Drug Costs. *Access Market Intelligence.* 22 April 2020. Accessed 31 July 2023 at https://accessmarketintell.com/2020/04/22/insurers-using-site-of-care-optimization-to-reduce-specialty-drug-costs/

Increasing Drug Prices

- Cancer drug prices rise 53% in 5 years[1]
- Overall, medication expenses projected to rise between 6-8% in 2023[2]
  - Hospitals expected 1-3% increase
  - Clinics expected 6-8% increase
- Increasing inventory prices → large financial risk

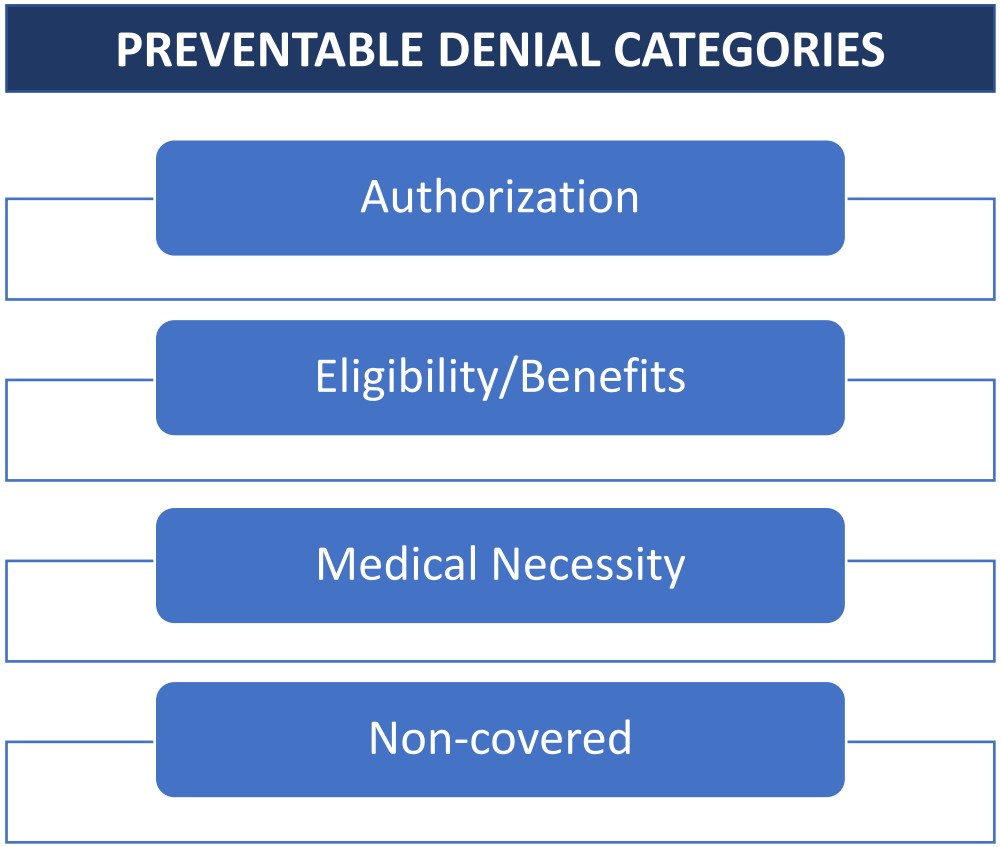
1. Beasley, Deena. New U.S. cancer drug prices rise 53% in five years – report. *Reuters.* 2 Nov 2022. Accessed 24 Jul 2023 at https://www.reuters.com/business/healthcare-pharmaceuticals/new-us-cancer-drug-prices-rise-53-five-years-report-2022-11-02/
2. Tichy, Eric Eric M, PharmD, et al., National trends in prescription drug expenditures and projections for 2023, *American Journal of Health-System Pharmacy*, Volume 80, Issue 14, 15 July 2023, Pages 899–913, https://doi.org/10.1093/ajhp/zxad086

How to Justify Pharmacy Staff



Financial metrics

- Pull the following metrics over the last 3 years showing annual trend
  - Total number of claim denials
  - Claim denial %
    - Goal = less than 5% of accounts
    - Best practice = less than 3% of accounts
  - Total dollars written off
  - Underpayment data (if readily available)



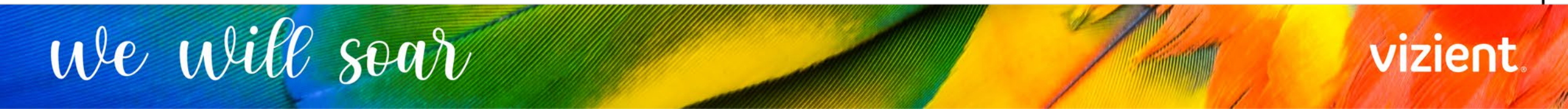
Survey teams

- Survey providers and clinic staff
  - Do providers have time for peer-to-peers or appeal letters?
  - Are peer-to-peers and appeals typically justified for clinical reasons or a waste of a provider's time?
  - How much time is spent on insurance issues per week per clinic?
- Survey revenue cycle teams
  - Are providers responsive to revenue cycle team members to requests in order to receive payment?

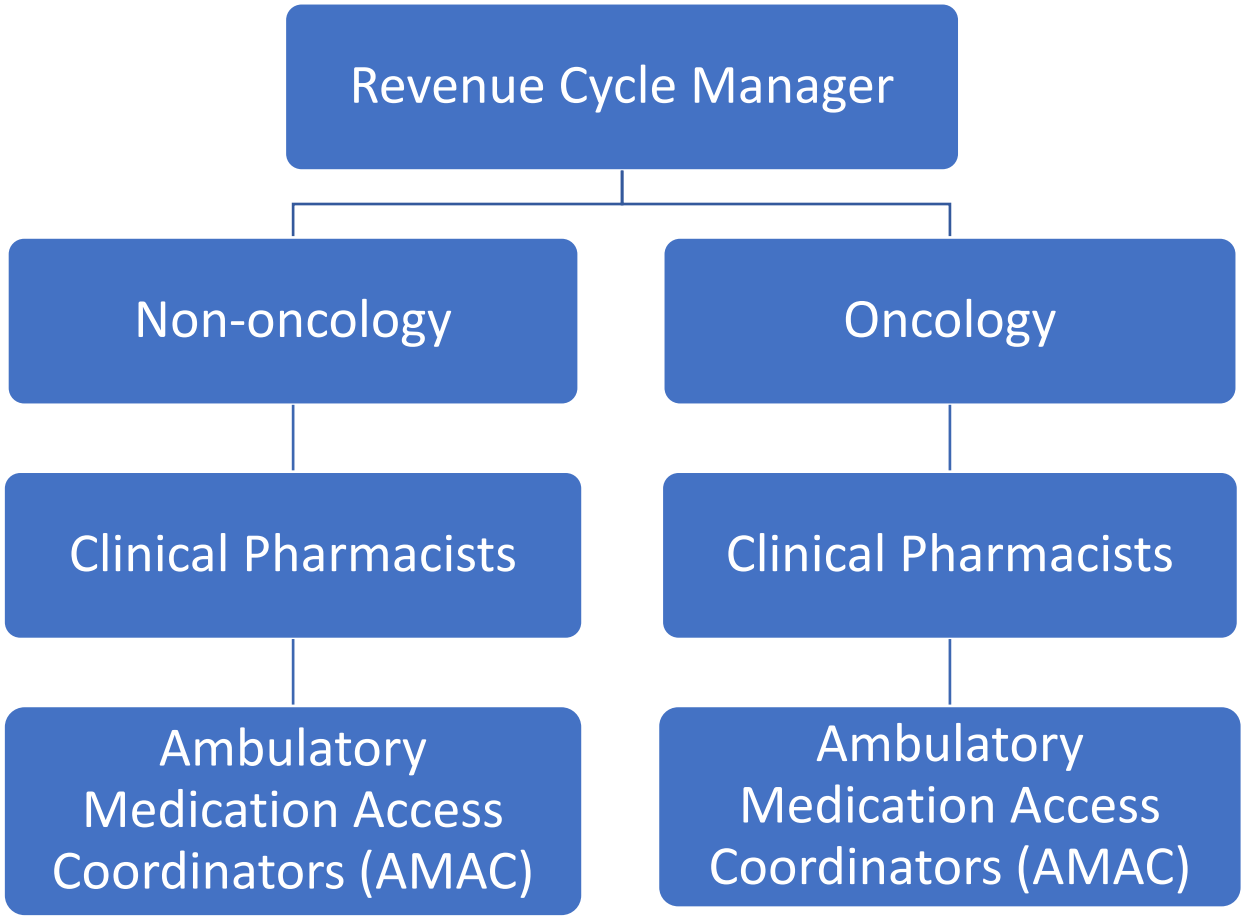
Pharmacy liabilities

- Pharmacy inventory spend
  - Show inventory purchase trend over last 5 years
- Unique drug payment programs
  - JW/JZ drug waste modifiers
  - New Technology Add-On Payment (NTAP)
- 340B compliance
  - Free drug program oversight
  - Mixed regular inventory with unique billing codes
    - Biosimilars
    - Branded generics

UCM Pharmacy Revenue Cycle Program



Department Organization



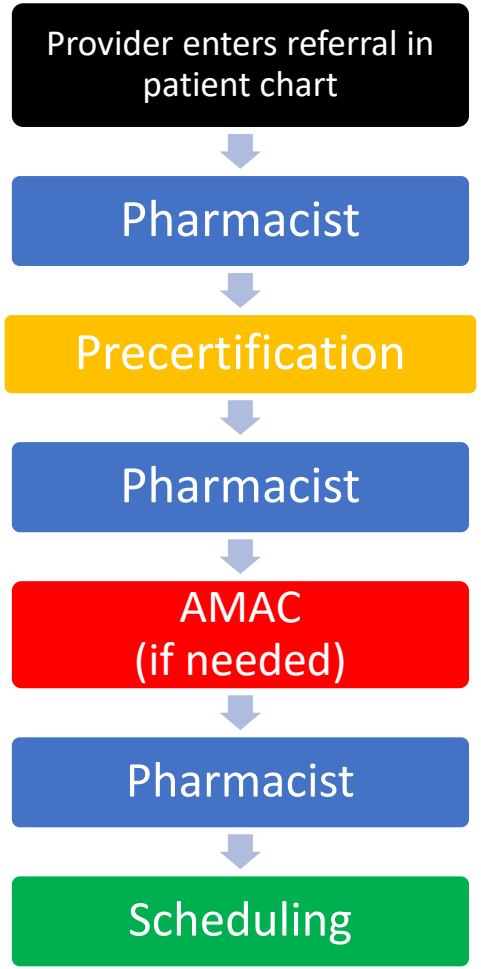
Clinical Pharmacist Roles

Insurance Authorization

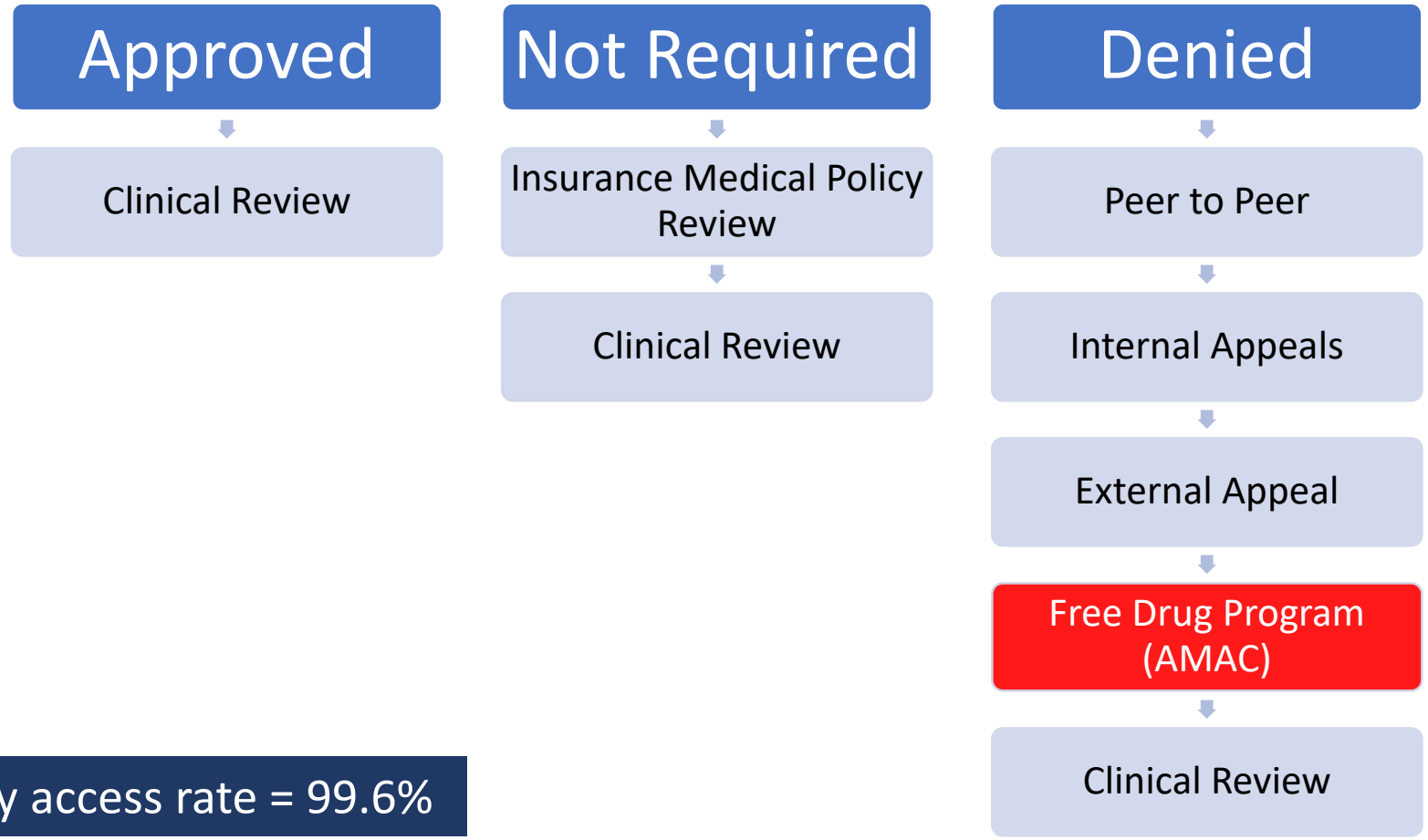
Financial Assistance

Clinical Review

Referrals and Work Queues



Precertification Status



Medical necessity access rate = 99.6%

Prior Authorization Status Caveats

Site of Service Policies

- Insurance restricts level of care to **non-hospital site**:
  - Stand alone infusion center
  - Home infusion
  - Doctor's office
- Pharmacist reviews medical necessity for hospital
  - <u>If hospital-level appropriate:</u>
    - Peer to peer calls and appeals
  - <u>If lower level appropriate:</u>
    - Referral to internal (external last resort)

Pharmacy Benefit Restrictions

- Medication must be billed through pharmacy benefits and/or drug filled through preferred pharmacy
- University of Chicago Medicine has a strict policy against "white bagging" or "brown bagging"
- Pharmacist attempts the following:
  - Override to bill medical benefits
  - Override to "clear bag" drug through University of Chicago specialty pharmacy

AMAC Role: Financial Assistance

Manufacturer Free Drug Programs	Manufacturer Copay Assistance	Financial Assistance Program

• Authorizations denied after appeal
• Drug is not a covered benefit
• Patient cannot afford out of pocket cost
• Patient loses insurance
 	
• <u>AMAC role:</u>
  • Complete initial application
  • Set up drug shipments for each infusion appointment
  • Application renewals
	• All patients with commercial insurance
	
	• <u>AMAC role:</u>
	  • Enroll patients in copay card
	  • Application renewals
		• Patient cannot afford out of pocket costs
		• Patient loses insurance
		
		• <u>AMAC role:</u>
		  • Refers patient to University of Chicago Medicine's income-based financial aid program

Clinical Review

- Confirm patient clinically ready to start drug (labs, immunizations, etc.)
- Patient education calls for all new start patients:
  - Review insurance coverage, cost, and financial savings options
  - Review dosing, side effects, and monitoring
  - Complete medication history
  - Assess drug interactions
- Enter orders into treatment plan on behalf of provider
- Send to scheduling queue

Additional Pharmacist Clinical Roles

- Onboard new-to-market infusion drugs
- Provide in-service education to infusion nursing staff
- Triage clinical questions from patients, infusion nurses, and clinic providers
- Assistance with claim denial letters of medical necessity as needed

Revenue Impact

- Oncology infusion program pilot
- Goal set to reduce claim denials by 10%
- Exceeded goal reducing claim denials by 19% (total 1.2% reduction)
- Plan to expand to other sites this year with goal to further reduce claim denials by 10%

Quarter	Denial %
Q1 FY22	3.1%
Q2 FY22	3.6%
Q3 FY22	5.9%
Q4 FY22	6.5%
Q1 FY23	6.8%
Q2 FY23	5.4%
Q3 FY23	6.2%
Q4 FY23	5.2%

Outside 5% goal identified

Average claim denial % = 6.4%

Pharmacist hired

Provider compliance

Copay Assistance and Free Drug Savings

Copay Assistance 7/1/22-7/1/23	
Number of accounts	1,344
Applied copay dollars	$1,615,028

Free Drug Program 4/1/22-3/31/23	
# of free drug doses dispensed	662
Total medication dollars saved at WAC (wholesale acquisition cost)	$5,742,041

Lessons Learned

- Treatment plan referral IT issues
- Provider compliance difficult
- Third party companies – still facing peer-to-peer issues with pharmacists
- Do not open up clear-bagging with payers! Contracting is the way to go

Key Takeaways

- Revenue Cycle is a learning curve for pharmacy staff so set reasonable goals
  - Hire someone with experience
  - Start building a relationship now
- Provider time saved – invaluable
- Free drug programs are not just for self-pay patients
- Incorporating pharmacy team members into the revenue cycle process results in:
  - Cost savings
  - Overall improvement of medication access

Questions?

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This educational session is enabled through the generous support of the Vizient Member Networks program.