

Compensation and Reimbursement

Reimbursement and Pharmacist Compensation for Drug Product Dispensing (1807)

Source: Council on Pharmacy Management

To collaborate with payers in developing improved methods of reimbursing pharmacies and pharmacists for the costs of drug products dispensed, pharmacy and pharmacist services, and associated overhead; further,

To educate pharmacists and stakeholders about those methods.

This policy supersedes ASHP policy 1304.

Direct and Indirect Remuneration Fees (1814)

Source: Council on Public Policy

To advocate that payers and pharmacy benefit managers be prohibited from recovering direct and indirect remuneration fees from pharmacies on adjudicated dispensing claims; further,

To oppose the application of plan-level quality measures on specific providers, such as participating pharmacies.

Revenue Cycle Compliance and Management (1710)

Source: Council on Pharmacy Management

To encourage pharmacists to serve as leaders in the development and implementation of strategies to optimize medication-related revenue cycle compliance, which includes verification of prior authorization, patient portion of payment, billing, reimbursement, and financial documentation for the healthcare enterprise; further,

To advocate for the development of consistent billing and reimbursement policies and practices by both government and private payers; further,

To advocate that information technology (IT) vendors enhance the capacity and capability of IT systems to support and facilitate medication-related purchasing, billing, and audit functions; further,

To investigate and publish best practices in medication-related revenue cycle compliance and management.

This policy supersedes ASHP policy 1205.

Payer Processes for Payment Authorization and Coverage Verification (1301)

Source: Council on Pharmacy Management

To advocate that public and private payers collaborate with each other and with health care providers to create standardized and efficient processes for authorizing payment or verifying coverage for care; further,

To advocate that payment authorization and coverage verification processes (1) facilitate communication among patients, providers, and payers prior to therapy; (2) provide timely payment or coverage decisions; (3) facilitate access to information that allows the pharmacist to provide prescribed medications and medication therapy management to the patient; and (4) foster continuity in patient care.

This policy supersedes ASHP policy 1206.

Value-Based Purchasing (1209)

Source: Council on Pharmacy Management

To support value-based purchasing reimbursement models when they are appropriately structured to improve health care quality, patient satisfaction, and clinical outcomes, and encourage medication error reporting and quality improvement; further,

To encourage pharmacists to actively lead in the design and interdisciplinary implementation of medication-related value-based purchasing initiatives.

This policy was reviewed in 2016 by the Council on Pharmacy Management and by the Board of Directors and was found to still be appropriate.

Reimbursement for Unlabeled Uses of FDA-Approved Drug Products (0206)

Source: Council on Administrative Affairs

To support third-party reimbursement for FDA-approved drug products appropriately prescribed for unlabeled uses.

This policy was reviewed in 2016 by the Council on Pharmacy Management and by the Board of Directors and was found to still be appropriate.

ASHP Policy Positions 2009–2019 (with Rationales)

Pharmacy Management: Compensation and Reimbursement

1807

Reimbursement and Pharmacist Compensation for Drug Product Dispensing

Source: Council on Pharmacy Management

To collaborate with payers in developing improved methods of reimbursing pharmacies and pharmacists for the costs of drug products dispensed, pharmacy and pharmacist services, and associated overhead; further,

To educate pharmacists and stakeholders about those methods.

This policy supersedes ASHP policy 1304.

Rationale

In well-intentioned efforts to reduce healthcare costs, public and private payers often seek to minimize the reimbursement to pharmacies for drug products. Historically, those reimbursements have sometimes exceeded the simple cost of the drug product to reimburse pharmacies for associated costs (e.g., storage, compounding, preparation, dispensing). Because cost-management efforts are likely to continue to reduce pharmacy reimbursement, other means of compensating pharmacies for those expenses will need to be found, and pharmacists and other stakeholders will require education about those reimbursement methods. In addition, pharmacists and pharmacies need to be reimbursed for professional services associated with management of medications and related patient care.

1814

Direct and Indirect Remuneration Fees

Source: Council on Public Policy

To advocate that payers and pharmacy benefit managers be prohibited from recovering direct and indirect remuneration fees from pharmacies on adjudicated dispensing claims; further,

To oppose the application of plan-level quality measures on specific providers, such as participating pharmacies.

Rationale

Direct and indirect remuneration (DIR) fees are a growing concern among pharmacies that dispense medications in a retail pharmacy or outpatient clinic setting. Created under the Medicare Part D Program, DIR fees were originally intended as a way for the Centers for Medicare & Medicaid Services (CMS) to account for the true cost of the drug dispensed, including manufacturer rebates and pharmacy concessions. Often these rebates and concessions were unknown until the drug was dispensed and the claim adjudicated. Recently, a concerning trend has emerged in which pharmacy benefit managers (PBMs) charge DIR fees to

pharmacy providers, applying their own plan performance measures as a way to assess fees on pharmacies dispensing covered Part D drugs. These fees are problematic for the following reasons:

- The fees are arbitrary and appear to result from an unintended application of measures meant for total plan performance as opposed to pharmacy-level metrics.
- The quality measures applied tend to be based on maintenance medications such as blood pressure or medications used to treat diabetes. These measures were never intended to be applied to specialty medications, or other specialized disease states such as oncology, yet PBMs assess DIR fees against the gross reimbursement for all prescriptions received by pharmacy providers, not just maintenance medications.
- PBMs are not required to define, justify, or explain to providers or to CMS the rationale or process for imposing their DIR fees.

Pharmacies providing specialty medications have been especially hard hit by DIR fees, due to the fee structure. DIR fees can be a flat rate (a fixed amount per dollar per claim) or a percentage (typically 3-9%) of the total reimbursement per claim. When the percentage-based structure is applied, the fees increase markedly for specialty drugs, which are typically much more expensive than maintenance medications.

Even more disturbing is that the fees are assessed retroactively, sometimes months after the claim has been adjudicated, providing no recourse for the pharmacy impacted by the assessment. Questions also remain as to whether Part D plan sponsors have the authority to assess DIR fees on pharmacies. There are no references to DIR fees collected on pharmacies in either the Medicare Modernization Act or corresponding CMS regulations.

DIR fees have led to higher cost-sharing responsibilities for Medicare beneficiaries, causing more of them to enter the Part D “donut hole” in which they are solely responsible for the cost of a drug. Because of higher costs, adherence rates tend to be lower among beneficiaries in the donut hole. These higher costs are a perverse result contrary to the very reason DIR fees were created – passing savings onto beneficiaries.

Pharmacies are not alone in their concern. In January 2017, CMS published a [fact sheet](#) expressing concern over DIR fees and cited them as contributing to increased drug costs, beneficiary out-of-pocket spending, and Medicare spending overall. ASHP supports legislation that would address the problem of DIR fees. For example, H.R. 1038/S. 413, the [Improving Transparency and Accuracy in Medicare Part D Drug Spending Act](#), would prohibit Medicare Part D plan sponsors from retroactively reducing payment on clean claims submitted by pharmacies under Medicare Part D.

1710

Revenue Cycle Compliance and Management

Source: Council on Pharmacy Management

To encourage pharmacists to serve as leaders in the development and implementation of strategies to optimize medication-related revenue cycle compliance, which includes verification of prior authorization, patient portion of payment, billing, reimbursement, and financial documentation for the healthcare enterprise; further,

To advocate for the development of consistent billing and reimbursement policies and practices by both government and private payers; further,

To advocate that information technology (IT) vendors enhance the capacity and capability of IT systems to support and facilitate medication-related purchasing, billing, and audit functions; further,

To investigate and publish best practices in medication-related revenue cycle compliance and management.

This policy supersedes ASHP policy 1205.

Rationale

Pharmacy has an increasingly important role in optimizing revenue capture and avoiding revenue erosion resulting from improper billing or inadequate documentation of medication-related charges. Pharmacy needs to be involved in aspects of medication-related billing, including not just pharmacy drug charges and billing but also contracting and negotiating for carve-outs. Pharmacy leaders need to actively engage senior leadership and collaborate with various departments to ensure organizational success in revenue cycle management.

Recently, organizations have experienced increasing compliance pressures. This pressure comes from many sectors, including Centers for Medicare & Medicaid Services (CMS) programs plus state-specific requirements, third-party payers, and financial intermediaries. These policies impact organizations in two ways: increased requirements before the insurers will pay for a claim, and increased audit pressure to be sure the organizations are billing accurately. The frequency and nature of audits has also been changing. Insurers have increased the use of audits to control costs. Government agencies have also increased the use of audits. CMS has implemented Recovery Audit Contractor (RAC) audits, and the Office of the Inspector General is also auditing organizations. Results of the audits can have significant financial impact on the organization when money needs to be returned based on improper billing or lack of documentation.

Historically, pharmacy departments have great strength in managing supply chain issues. Drug expenditures are typically a significant portion of any hospital's budget. Pharmacy is a key leader in managing these expenses. However, pharmacy departments are involved in broader revenue cycle management in variable ways. In some organizations, the billing or patient accounting departments handle all billing issues with various degrees of pharmacy involvement. Accurate billing requires integration of the organization's clinical services, pharmacy, billing, and charge master functions. The required elements for proper billing may reside in several systems. As coverage decisions become more complex, pharmacy expertise is increasingly required in the clinical coverage decisions and information integration in order to be successfully reimbursed for services. For the healthcare enterprise to successfully manage compliance and optimize revenue capture there must be effective collaboration among various departments. Pharmacy knowledge and leadership is increasingly required to ensure organizational success in revenue cycle management.

Each insurer has different requirements for coverage determinations, and coverage decisions have become more complex. More drugs now require prior authorization processes. In some cases, even if the prior authorization process has been used, the charge is denied. Medicare has implemented requirements for self-administered drugs (SADs), and diabetic supplies are now handled under durable medical equipment (DME) requirements, which may require different data elements before a bill is processed. Medicaid requires the National Drug Code (NDC) prior to payment, and billing requirements for Medicare and Medicaid programs are not harmonized. Healthcare Common Procedure Coding System (HCPCS) codes also need to be attached where indicated. It is challenging to keep up with all the changes. International Classification of Disease 10 (ICD-10) codes further complicate required coding. Current IT solutions are inadequate and do not effectively facilitate effective billing. Current systems are often not designed to capture all necessary information required to properly document and bill. Even when necessary data is captured it often resides in different departmental computer systems that are not integrated and designed to share data. There is a need for better IT solutions to facilitate both billing and audits. Greater consistency in billing and reimbursement practices would facilitate greater compliance and enable the development of effective technology solutions to improve billing and reimbursement processes.

Since pharmacy leaders have had variable levels of engagement in revenue cycle management, there is a need for education, tools, and resources related to best practices. Some pharmacy departments have created a business manager position in part to deal with these issues. This position is often not a pharmacist, but a staff member with business training. New roles for pharmacy technicians have also emerged in this area. ASHP and the Section of Pharmacy Practice Managers are committed to developing and sharing best practices and providing education to support pharmacists in optimizing pharmacy's role in revenue cycle compliance.

1301

PAYER PROCESSES FOR PAYMENT AUTHORIZATION AND COVERAGE VERIFICATION

Source: Council on Pharmacy Management

To advocate that public and private payers collaborate with each other and with health care providers to create standardized and efficient processes for authorizing payment or verifying coverage for care; further,

To advocate that payment authorization and coverage verification processes (1) facilitate communication among patients, providers, and payers prior to therapy; (2) provide timely payment or coverage decisions; (3) facilitate access to information that allows the pharmacist to provide prescribed medications and medication therapy management to the patient; and (4) foster continuity in patient care.

This policy supersedes ASHP policy 1206.

Rationale

Patients and health care providers are required to navigate an array of payment requirements from private and public payers. Private insurers enforce their own prior authorization

procedures, state Medicaid programs have their individual program requirements, and Medicare has its local and national coverage determinations. These payment authorization and verification processes vary considerably from payer to payer and are time consuming and needlessly complex. The required data, forms of documentation required, submission processes, coverage verification procedures, and delivery of approval vary widely among payers. These processes are often not integrated into the patient-care process and require manual documentation and submission. The lack of timely review and approval may delay patient care. Payment authorization and verification processes should effectively facilitate communication among both patients and providers, should be standardized and automated, and should result in timely decisions that do not disrupt patient care.

1205

REVENUE CYCLE COMPLIANCE AND MANAGEMENT

Source: Council on Pharmacy Management

To encourage pharmacists to serve as leaders in the development and implementation of strategies to optimize medication-related revenue cycle compliance, which includes billing, finance, and prior authorization, for the health care enterprise; further,

To advocate for the development of consistent billing and reimbursement policies and practices by both government and private payers; further,

To advocate that information technology (IT) vendors enhance the capacity and capability of IT systems to support and facilitate medication-related billing and audit functions; further,

To investigate and publish best practices in medication-related revenue cycle compliance and management.

This policy supersedes ASHP policy 9902.

Rationale

Pharmacy has an increasingly important role in optimizing revenue capture and avoiding revenue erosion resulting from improper billing or inadequate documentation of medication-related charges. Pharmacy needs to be involved in aspects of medication-related billing, including not just pharmacy drug charges and billing but also contracting and negotiating for carve-outs. Pharmacy leaders need to actively engage senior leadership and collaborate with various departments to ensure organizational success in revenue cycle management.

Recently, organizations have experienced increasing compliance pressures. This pressure comes from many sectors, including Centers for Medicare & Medicaid Services (CMS) programs plus state-specific requirements, third-party payers, and financial intermediaries. These policies impact organizations in two ways: increased requirements before the insurers will pay for a claim, and increased audit pressure to be sure the organizations are billing accurately. The frequency and nature of audits has also been changing. Insurers have increased the use of audits to control costs. Government agencies have also increased the use of audits.

CMS has implemented Recovery Audit Contractor (RAC) audits, and the Office of the Inspector General is also auditing organizations. Results of the audits can have significant financial impact on the organization when money needs to be returned based on improper billing or lack of documentation.

Historically, pharmacy departments have great strength in managing supply chain issues. Drug expenditures are typically a significant portion of any hospital's budget. Pharmacy is a key leader in managing these expenses. However, pharmacy departments are involved in broader revenue cycle management in variable ways. In some organizations, the billing or patient accounting departments handle all billing issues with various degrees of pharmacy involvement. Accurate billing requires integration of the organization's clinical services, pharmacy, billing, and charge master functions. The required elements for proper billing may reside in several systems. As coverage decisions become more complex, pharmacy expertise is increasingly required in the clinical coverage decisions and information integration in order to be successfully reimbursed for services. For the health care enterprise to successfully manage compliance and optimize revenue capture there must be effective collaboration among various departments. Pharmacy knowledge and leadership is increasingly required to ensure organizational success in revenue cycle management.

Each insurer has different requirements for coverage determinations, and coverage decisions have become more complex. More drugs now require prior authorization processes. In some cases, even if the prior authorization process has been used, the charge is denied. Medicare implemented the requirements for self-administered drugs (SADs) several years ago. Diabetic supplies are now handled under durable medical equipment (DME) requirements, which may require different data elements before a bill is processed. Medicaid requires the National Drug Code (NDC) prior to payment, and billing requirements for Medicare and Medicaid programs are not harmonized. Healthcare Common Procedure Coding System (HCPCS) codes also need to be attached where indicated. It is challenging to keep up with all the changes. New International Classification of Disease 10 (ICD-10) codes will further complicate required coding. Current IT solutions are inadequate and do not effectively facilitate effective billing. Current systems are often not designed to capture all necessary information required to properly document and bill. Even when necessary data is captured it often resides in different departmental computer systems that are not integrated and designed to share data. There is a need for more effective IT solutions to facilitate both billing and audits. Greater consistency in billing and reimbursement practices would facilitate greater compliance and enable the development of effective technology solutions to facilitate the billing and reimbursement processes.

Since pharmacy leaders have had variable levels of engagement in revenue cycle management, there is a need for education, tools, and resources related to best practices. Some pharmacy departments have created a business manager position in part to deal with these issues. This position is often not a pharmacist, but a staff member with business education. New roles for pharmacy technicians have also emerged in this area. ASHP and the Section of Pharmacy Practice Managers (SPPM) should seek to develop and share best practices and provide education to support pharmacists in optimizing pharmacy's role in revenue cycle compliance.

1209

VALUE-BASED PURCHASING

Source: Council on Pharmacy Management

To support value-based purchasing reimbursement models when they are appropriately structured to improve health care quality, patient satisfaction, and clinical outcomes, and encourage medication error reporting and quality improvement; further,

To encourage pharmacists to actively lead in the design and interdisciplinary implementation of medication-related value-based purchasing initiatives.

This policy supersedes ASHP policy 0708.

Rationale

[Value-based purchasing](#) is one aspect of a portfolio of health care reform incentives based on pay-for-performance principles. It is currently constructed of 12 clinical outcomes measures and one “measure” of patient experience utilizing the Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS). CMS is expanding its Potential Future Measures for Hospital Value-based Purchasing Program to consider the following measures for the [Hospital Value-based Purchasing Program](#):

- Spending per Hospital Patient with Medicare
- Serious Complications and Deaths
- Hospital Acquired Conditions
- Emergency Department Wait Times
- Heart Patients Given a Prescription for Drugs called Statins at Discharge
- Central Line-associated Blood Stream Infection
- Surgical Site Infections
- Immunization for Influenza
- Immunization for Pneumonia
- Temperature Management for Patients after Surgery

ASHP policy 0708 needs to be broadened to include the concepts of value-based purchasing and incorporate the concepts of clinical outcomes and patient satisfaction in addition to quality. ASHP policy should recognize the pharmacist’s leadership role while explicitly acknowledging the interdisciplinary nature of initiatives designed to achieve value-based purchasing measures.