Business of Rheumatology Seminar Series

In-Office Dispensing: March 23, 2023

Q&A

- **We are in Connecticut – how do we find a vendor?**
  The following companies have indicated to CSRO that they are working to set up in-office dispensing for offices in their network, and CSRO can connect interested offices with one or all of the below:
  - Bendcare
  - HouseRx
  - McKesson
  - United Rheumatology, a Specialty Networks Company

- **Are audits inevitable? IE., PBMs audit every year?**
  PBM audits are built into their contracts but are not anything to fear as long as offices adhere to state regulations, PBM contracts, and the pharmacy training from their vendor.

- **Have there been studies done showing that compliance and patient outcomes are better when they get their medications from their doctor's office?**
  By having the patient and care team involved in the authorization, approval, and dispensing of the medication, it has been shown that patients receive a higher-level of care, a greater touchpoint with their provider, are more compliant with their medication adherence and it saves the overall healthcare system by avoiding product waste.

  Read more on this research from the Employee Benefit Research Institute here.

- **What is the profit margin range on an injectable like Enbrel?**
  It depends on the acquisition cost. A practice will only be successful/profitable in dispensing specialty drugs if they have a GPO contract on the product being dispensed.

- **How does it differ from buy and bill?**
  Pharmacy billing is very different than Buy and Bill. When billing a prescription claim, you are required to have pharmacy software and the claims are adjudicated in real time. Therefore, you know before you fill the prescription what your margin will be.

- **Does anyone know when North Carolina made this a possibility? Previous understanding is that we were shut out of in office dispensing.**
  Physicians in NC have been able to dispense under state regulations at least since 2014 (there are several urology practices in NC dispensing to their patients).

- **This is all done under your TIN so there are no Stark concerns?**
  Correct, dispensing falls under the ancillary exception clause to the federal Stark rule.

- **What is the incentive for PBMs to allow this in their network?**
  They are required under Medicare Part D, to adhere to the Any Willing Provider Law and show adequate coverage for Medicare patients. For patients with commercial Rx insurance, you may be able

to fill the 1st or 1st and 2nd scripts before sending the prescription to the PBM owned specialty pharmacy. That said, not all plans have a closed/preferred pharmacy network.

It is possible that a practice could participate in a PBM network that allows dispensing to patients in commercial plans. The PBM may decide that there is value in a practice participating in their network due to your location or other features related to its network and the market.

- **How does the pharmacy board view in office dispensing? Any issues with them?**
  There are no regulatory concerns. There is a clear delineation in each state on whether physicians can dispense, what they can dispense, to whom they can dispense, and who oversees the regulations (usually the Board of Pharmacy or the Medical Board).

- **Is there a role for a practice-owned pharmacy for a young practice that doesn't have substantial volume yet?** The volume would need to be sufficient enough to cover the expense of a pharmacist salary, and other overhead.

- **How do practices approach newer therapies with a temporary j-code - is risk stratified or different based on payer type (Medicare, commercial, etc.)?**
  J Codes are not used in pharmacy. Drugs are covered by their NDC code. You can send the prescription to your dispensary, create the prescription and adjudicate the claim in real time. If the NDC is not covered, you will receive a rejection message through the pharmacy software, indicating that another drug must be used.

- **Do you need to have a separate area for the IOD from the rest of the practice? Can it operate out of an existing suite that has infusions, or another ancillary?**
  It depends on your state regulations. Practices often use an exam room or office, as many states only require a secure area with limited access.

- **What are most common drugs dispensed in IOD setting in rheumatology?**
  Any self-administered medication can be dispensed provided there are no state-level restrictions. However, as mentioned previously, when it comes to the high-cost specialty drugs, a GPO contract is needed to significantly reduce your acquisition cost and be profitable. Schedule 2 and 3 drugs are being regulated separately and restricted for IOD in many states.

- **Has PBM and insurance control/restriction affected the TX business model?**
  No more than anywhere else, noting that Texas is the only state that prohibits physician dispensing, but permits physicians to own a licensed pharmacy. Thus, in Texas, you would be required to have a licensed pharmacy with a dedicated minimum size and a pharmacist.

- **For the rheumatology practices, are you dispensing monthly or 3 months at a time?**
  Most payer contracts will only allow 30 days max supply. If the plan allows 90, you want to make sure the reimbursement isn't reduced, as that is sometimes the case with 90-day fills.

- **We had patients who got retroactively disenrolled from their insurance and our reimbursement was taken back by the insurance. How does it affect dispensed prescriptions?**
  Would need more information on this rare case (for example, if they lost their health insurance or their prescription insurance).

- **When you say supportive meds, do you mean methotrexate or other meds?**
  Generally, a provider is permitted to dispense any drug they prescribe.

  In the case of the Corpus Christi, Texas rheumatology practice that ran a free standing pharmacy, the manager indicated that "supportive meds" such as methotrexate can have a higher margin between reimbursed and acquisition cost producing a financially a better mix of drug dispensed.

- **How do you split the profit among the group?**
  In adherence with the regulations pertaining to ancillary services.

- **How have you handled payer & OIG scrutiny around anti-kickback & steering?**
  Since it's an ancillary service, it is considered part of the practice of medicine if recognized as such by the state. Document that the patient is given a choice of where to fill their medications in the EHR.

- **Who provides the shipping materials? Any temperature controlled?**
  Your vendor can provide the best practice on all aspects related to dispensing, as well as the best sources for dispensing materials. However, keep in mind that the IOD model calls for the patient to pick the medication up from the practice.

- **What if you order an expensive med like Humira to have it ready for a patient then change the therapy at time of visit?**
  Best practice is not to order the medication until it's discussed with patient, prescribed to IOD, and paid. You can return unopened items to your distributor. Generally, most dispensing practices do not have significant inventory and use "just in time" deliveries of medication from the distributor to try to minimize cost and loss of income from a drug that will not be dispensed to patients.

- **Can a patient send their family member to pick up their meds? If so, do we need a sign auth from patient?** Depends on the state regulation, but most states will allow a family member to pick up the patient's medications. While some states require a Power of Attorney or attestation signed by the patient, it would be a best practice to have something in writing, even if not required.

Answers provided by United Rheumatology, a Specialty Networks Company, and reviewed by CSRO.

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UNITED RHEUMATOLOGY
A Specialty Networks Company