**Purpose:** The purpose of this tool is to share strategies to optimize WAC account purchasing in 340B hospitals subject to the GPO Prohibition (DSH/PED/CAN). It is important to assess the drug purchases across all three accounts (340B, GPO, and WAC) to effectively reduce excess expenditures while maintaining 340B Program compliance. These purchasing strategies are based on operational best practices that covered entities across the country have implemented, and not based on HRSA policy.

**Background:** To effectively use this tool, it is important to understand WAC and sub-WAC pricing. Wholesaler acquisition cost (WAC) pricing is the price charged by pharmaceutical manufacturers to wholesale drug distributors. Prime Vendor Program (PVP) sub-WAC pricing is a contracted price loaded onto the WAC account that allows PVP member entities subject to the GPO Prohibition to purchase covered outpatient drugs at a negotiated price that is lower than the WAC price. For more information on compliant account contract load options, please see the “[Non-GPO/WAC](https://www.340bpvp.com/Documents/Public/340B%20Tools/non-gpo-wac-and-340b-contract-load-options.docx) and 340B Contract Load Options” PVP tool.

**Instructions:** Follow the steps below to ensure that you are optimizing your entity’s purchases across all three accounts.

**Step 1:** Calculate Weighted Pricing

Weighted pricing is a method to calculate the weighted average price for an NDC, which factors in the price and utilization of that product across all three accounts (340B, GPO, and WAC). This approach may be used to assist with making purchasing decisions. Calculate the weighted price for each NDC within a therapeutic drug class or generically equivalent group to identify the product with the lowest overall price based on utilization. To account for Public Health Service (PHS), PVP, WAC, and other contract pricing changes, perform a weighted pricing analysis monthly (best practice) or quarterly (at a minimum).

**Example of weighted pricing calculation:**



| **Step 1: Calculate Weighted Pricing** |
| --- |
| 1a: Obtain wholesaler drug catalog   | * Obtain your entity’s wholesaler drug catalog from your wholesaler or split-billing software. Ensure that this drug catalog includes price points for each account type (340B, GPO, and WAC) for each NDC. Ideally, your entity’s wholesaler drug catalog will include the following data points:
	+ NDC
	+ 340B Account Price
	+ GPO Account Price
	+ WAC Account Price
* Include some kind of identifier to “link” like medications together (e.g., generic code number [GCN] for generic interchanges or American Hospital Formulary Service [AHFS] code for therapeutic interchanges). This type of code is often readily available in the wholesaler catalog information.
 |
| 1b: Obtain purchase history  | * Purchase history information is used to determine the percentage of purchases of each NDC on each account (340B, GPO, and WAC).
* Obtain your entity’s purchase history from your wholesaler, split-billing software, or inventory management system. Run the most recent 3–6 months of purchase history data for the group of products you are analyzing to get an accurate picture of recent product utilization. Ideally, your entity’s purchase history will include the following data points:
	+ Purchase date
	+ Account (340B, GPO, or WAC)
	+ NDC
	+ NDC description
	+ Purchase quantity
	+ Total extended cost
* Consider any anticipated short-term changes to purchases or utilization that may affect how a newly selected product would be used (e.g., bulk purchases for shortages, initial purchases for establishing neutral inventory).
 |
| 1c: Calculated weighted pricing | * After pulling these data, calculate the weighted price for each NDC within your wholesaler’s drug catalog using the methodology describe in the preceding example.
	+ This can be done through logic built into an Excel spreadsheet or Access database.
* Compare the weighted price for NDCs in your entity’s purchase history to alternative NDCs available within the wholesaler catalog.
* Identify generic alternatives with a lower weighted price and evaluate savings opportunities.
* Consider wholesaler availability of alternative products and operational updates to relevant systems (e.g., inventory management system, electronic medical record/billing software, split-billing software).

Note: PVP participants can download the PVP Weighted Pricing Tool from the 340bpvp.com secure website (under “Purchasing Decision Resources”), which helps automate the weighted pricing calculations.  |

**Step 2:** Assess WAC Account Purchases

Once you have selected your entity’s preferred products based on weighted price analyses, the next area of focus is to assess your entity’s WAC account purchases to identify areas for optimization. Note that not all WAC spend is “bad”—in fact, some WAC spend is necessary for hospitals subject to the GPO Prohibition to maintain 340B Program compliance. The table below describes the different types of WAC spend, including examples of where you might find each type.

|  |  |  |
| --- | --- | --- |
| Type of WAC Spend | Definition | Examples |
| Compliance WAC | Required for 340B program compliance | * Covered outpatient drug dispensed or administered to an ineligible patient (e.g., seen by an ineligible physician or at an ineligible site)
* Medicaid carve-out
* WAC-based neutral inventory
 |
| Intentional WAC | Chosen for cost savings | * WAC price point advantageous (e.g., individual or sub-WAC contract)
* Ineligible patients intentionally captured (e.g., employees not meeting the patient definition filling prescriptions at entity-owned retail pharmacies)
 |
| Unintentional WAC | Defaulted to WAC, but may have been eligible for 340B or GPO accumulations | * Waste, charge capture, or data integration issues
* Incorrect mapping or conversion factor in split-billing software
* Orphan drugs with voluntary, 340B-like pricing not loaded to purchasing accounts
 |

Many covered entities find that even after they have set up their replenishment models for inventory management, there are specific areas where medications are not accounted for and therefore the purchases default to the WAC account (i.e., unintentional WAC). Follow the steps below to identify the products and root causes for your entity’s unintentional WAC. Then review best practices to address the unintentional WAC.

| **Step 2: Assess WAC Account Purchases** |
| --- |
| 2a: Track WAC spend over time to develop internal benchmarks  | * Track your entity’s purchase data over time to establish internal benchmarks.
	+ Include your entity’s purchases through your wholesaler as well as purchases made directly from the manufacturer.
* Consider including the following data points in your dashboard and build in the ability to filter by various attributes (e.g., timeframe, wholesaler account name/number, product name, NDC, AHFS therapeutic category):
	+ Total spend
	+ 340B account spend
	+ 340B account spend as a % of total spend
	+ GPO account spend
	+ GPO account spend as a % of total spend
	+ WAC account spend
	+ WAC account spend as a % of total spend
* Once you have tracked your WAC account data for a period of time, you can determine your entity’s “normal” WAC account spend as a % of total spend.
* Consider using principles of statistical process control to identify significant changes to your WAC account spend (i.e., “special cause” variation) to avoid reacting to normal changes (i.e., “common cause” variation).
* Entities should avoid trying to benchmark externally because sub-WAC spend can vary greatly from site to site based on 340B program implementation and examples of factors that can affect this include:
	+ Carve-in/out decisions and Medicaid population
	+ Utilization of contract pharmacies that have no corresponding sub-WAC purchases
	+ Entity-owned pharmacies that only serve 340B eligible patients
	+ 340B-only inventories such as offsite infusion centers
	+ Intentional sub-WAC spend due to compliance mitigation or contract price availability
	+ Split billing software settings
	+ Intentional capture of ineligible patients (e.g., as service for employees)
 |
| 2b: Analyze WAC purchases | * Run a 3-month purchase history of your 340B, GPO, and WAC accounts. If possible, include purchases made directly from the manufacturer or through limited distribution channels.
	+ Identify products contributing the most to your entity’s WAC spend by sorting purchases from highest to lowest WAC spend.
	+ For each product or NDC, compare the WAC to 340B purchase quantities (not dollars) and calculate the % of packages purchased on the WAC account (% WAC account):
		- % WAC account (by packages purchased) = packages purchased on the WAC account ÷ total packages purchased
			* Depending on the product, there may be variances in what is considered a “normal” % WAC account
		- Note: PVP participants can view % WAC Account (by Total Packages Purchased and by Total $ Purchased) for products purchased within the Purchase Overview report on the 340bpvp.com secure website (login required).
	+ Calculate the WAC impact compared with the 340B and GPO account pricing for each product:
		- WAC impact (compared with 340B) = (WAC account price – 340B account price) × purchase quantity
		- WAC impact (compared with GPO) = (WAC account price – GPO account price) × purchase quantity
* Run a 3-month drug utilization history from your electronic medical record or 340B split-billing software.
	+ Identify the % outpatient (340B-eligible), % outpatient (non-340B eligible), and % inpatient utilization for each product or NDC.
* Prioritize reviewing products or NDCs with:
	+ High WAC spend and % of purchases on the WAC account, greatest WAC impact (compared to 340B), and high % outpatient (340B-eligible) utilization
	+ High WAC spend and % of purchases on the WAC account, greatest WAC impact (compared to GPO), and high % inpatient utilization
* Identify and address the root causes for WAC spend for each product (see Step 3).
 |

**Step 3:** Identify and Address the Root Cause(s) for WAC Account Spend

Identify and address the potential root causes for WAC spend by understanding the process whereby a medication is ordered in the electronic medical record (EMR) to the point where it accumulates within the 340B split-billing software and is subsequently replenished by the wholesaler. The figure below describes the process of medication order to replenishment for areas where a virtual replenishment inventory model is used. The bottom line is that if a product does not achieve accumulations at the 11-digit NDC level, then it is not able to be replenished on the 340B or GPO account, and the purchases default to the WAC account. The table that follows outlines the potential root causes of unintentional WAC spend as well as best practices for addressing each root cause.



| **Step 3: Identify and Address Root Cause(s) for WAC Account Spend** |
| --- |
|  3a: Review product/NDC setup in the EMR  |

|  |  |
| --- | --- |
| **Root Cause** | **Best Practice(s)** |
| NDC selected within the EMR does not match the NDC administered, leading to accumulating to the wrong NDC within the split-billing software. | * Update the EMR system (e.g., medication lists or preference lists) to select the NDC that is purchased by the system.
* If multiple NDCs are purchased for a single medication strength and vial size, consider segregating the different NDCs to different locations, so you can select a single NDC for a particular location.
 |
| Same billing code or charge description master (CDM) assigned to a product with multiple vial sizes, leading to accumulating to the wrong vial size within the split-billing software. | * Work with your clinical teams to consolidate to a single vial size if possible.
* If unable to consolidate to a single vial size, work with your pharmacy informatics and operations teams to assign a unique billing code or CDM for each vial size.
 |
| Billing code or CDM not assigned to the product, leading to not accumulating for the product within the split-billing software. | * Work with your pharmacy informatics and revenue cycle teams to assign a billing code or CDM to the product.
* Ensure that billing units are also assigned to the product.
 |
| Waste from a single dose or single-use vial not captured, leading to not accumulating for the wasted portion of the product within the split-billing software. | * Understand which products are wasted and focus on high-cost products first.
* Identify ways to capture waste that can be attributed back to a specific patient and maintain auditable records to demonstrate that the waste is attributed to a patient who meets the patient definition (if waste is not able to be attributed back to a patient, then the product will need to be replenished on the WAC account).
* Consider 340B- or GPO-only inventory if appropriate (see Step 4b for additional considerations on 340B- or GPO-only inventories).
 |

 |
|  3b: Review product/NDC setup in the hospital billing system  |

|  |  |
| --- | --- |
| **Root Cause** | **Best Practice(s)** |
| Medication not charged for or charged for in a different system, leading to not accumulating for the product within the split-billing software. Examples include: * Code cart medications that are not separately billed
* Medications administered or billed through a different system (e.g., the OR)
* Areas that bundle-bill and therefore do not submit individual charges (e.g., bone marrow transplant [BMT])
* Ambulance or other emergency response services
 | * Implement a manual billing capture system and maintain auditable records to support use of a 340B purchased product for a 340B eligible patient.
 |
| Other charge capture issue, leading to not partially or fully accumulating for products (e.g., medications dispensed as a bulk product, such as inhalers or creams).  | * Consider optimizing billing for bulk dispensed medications (e.g., bill for the entire inhaler or tube of cream) if possible, keeping in mind billing compliance requirements.
 |

 |
| 3c: Review product/NDC setup in the 340B split-billing software system  |

|  |  |
| --- | --- |
| **Root Cause** | **Best Practice(s)** |
| NDC not mapped (or incorrectly mapped) to the CDM within the split-billing software crosswalk, leading to not accumulating (or incorrectly accumulating) on the NDCFor areas with a virtual replenishment inventory model, the split-billing software will direct all purchases of a new NDC to the WAC account until the NDC is mapped to a CDM.  | * Map the NDC to the CDM.
* Implement a process to proactively review and map the unmapped CDMs and NDCs (many split-billing software vendors will have a report or functionality to identify unmapped CDMs and NDCs).
 |
| Incorrect billing units per package (BUPP) assigned to the CDM–NDC relationship, leading to incorrect accumulation of the NDCNote: an incorrect BUPP may cause increased WAC spend if it leads to under-accumulation or decreased WAC spend if it leads to over-accumulation. | * Update the BUPP.
* Note: If the incorrect BUPP led to over-accumulation, then identify the scope of the problem, evaluate for material breach per your entity’s policies and procedures, and work with the manufacturer on repayment.
 |
| Missing or corrupt data files from the EMR or wholesaler | * Work with your pharmacy informatics or data warehouse teams to identify and address the root cause for the missing or corrupt data files.
* Resubmit missing data files to the split-billing software.
 |

To prevent these root causes, dedicate appropriate resources for split billing software maintenance. Ensure that the following are performed regularly: * Review unmatched CDMs and NDCs and appropriately match them as soon as possible.
* Review the CDM-to-NDC crosswalk to ensure that the appropriate NDC is mapped to each CDM.
	+ In cases in which multiple NDCs are assigned to the same CDM, you may need to manually update the NDC mapped to the CDM.
* Review the BUPPs for each CDM-to-NDC match to ensure that the BUPP matches how the CDM is billed for within the EMR and hospital billing system.
* Develop a checks-and-balances system to ensure that data files are loaded correctly to the split-billing software and the 340B team is notified ahead of changes that could affect the files.
 |
| 3d: Review replenishment process with pharmacy supply chain team and wholesaler  |

|  |  |
| --- | --- |
| **Root Cause** | **Best Practice(s)** |
| Product replenishment occurs before accumulations are received in the split-billing software, causing the purchases to default to the WAC account. | * Work with the pharmacy supply chain team and wholesaler to understand ordering frequencies and requirements.
* Consider adjusting periodic automatic replenishments (PARs) and ordering timeframes to allow for accumulation capture prior to placing orders.
 |

 |

**Step 4:** Consider Other Ways to Optimize WAC Spend

In addition to identifying and addressing potential root causes for WAC spend, the following table outlines additional methods for optimizing your entity’s WAC spend.

| **Step 4: Consider Other Ways to Optimize WAC Spend** |
| --- |
| 4a: Review the definition of covered outpatient drug  | * Define covered outpatient drug (COD) in your covered entity’s policies and procedures in accordance with section 1927(k) of the Social Security Act.
	+ This definition should be applied consistently across all areas of the organization.
* Products that do not meet the COD definition may be purchased using a GPO while remaining compliant with the GPO Prohibition.
	+ Develop and maintain a list of non-COD drugs and ensure that the drugs on the non-COD list consistently meet the criteria across all areas of the organization.
 |
| 4b: Evaluate for potential to establish 340B- or GPO-only inventory areas | * **340B-only inventory areas:**
	+ Sites that carve in Medicaid and dispense or administer products to 340B-eligible patients only may consider using a 340B-only or physical 340B inventory.
	+ Document the 340B-only inventory areas in your policies and procedures and ensure that you maintain auditable records to support 340B product going to 340B eligible patients only.
	+ Operationalizing a 340B-only inventory may involve:
		- Ordering on a 340B account that is separate from the split-billing software and blocking administrations or dispensations from the 340B-only areas from feeding into the accumulations within the system, or
		- Creating a separate instance of your split-billing software for the 340B-only inventory areas to support maintaining auditable records.
* **GPO-only inventory areas:**
	+ Sites that administer products to inpatients only may consider using a GPO-only or physical GPO inventory.
	+ Alternatively, medications that are restricted and administered only to inpatients may be designated as inpatient use only and purchased exclusively on the GPO account.
		- Ensure that the products on the inpatient-use-only list are truly only used for inpatients and not used for inpatients “most of the time” (e.g., bedded outpatients located on inpatient units).
	+ Document the GPO-only inventory areas or products in your policies and procedures and ensure that you maintain auditable records to support GPO product going to inpatients only.
	+ Operationalizing a GPO-only inventory may involve:
		- Ordering on a GPO account that is separate from the split-billing software system and blocking administrations from the GPO-only areas from feeding into the accumulations within the system, or
		- Adding the inpatient-use-only products to the GPO Prohibition exemption list within your split-billing software, which will cause the products to be replenished exclusively on the GPO account.
 |
| 4c: Evaluate ability to use GPO for purchasing CODs | * In certain cases, a GPO may be used to purchase covered outpatient drugs without violating the GPO Prohibition.
* An offsite outpatient facility must meet all of the following criteria to use a GPO for purchasing CODs:
	+ Be located at a separate physical address from the parent hospital
	+ Not be registered on 340B OPAIS
	+ Use a separate wholesaler account from that of the parent hospital
	+ Maintain records demonstrating that GPO drugs are not used or transferred to the parent hospital or any child sites that are registered on 340B OPAIS
* Refer to HRSA’s 2013 Guidance: [Statutory Prohibition on Group Purchasing Organizations Participation](https://www.hrsa.gov/sites/default/files/opa/programrequirements/policyreleases/prohibitionongpoparticipation020713.pdf) for additional information.
 |

*This tool is written to align with Health Resources and Services Administration (HRSA) policy, and is provided only as an example for the purpose of encouraging 340B Program integrity. This information has not been endorsed by HRSA and is not dispositive in determining compliance with or participatory status in the 340B Drug Pricing Program. 340B stakeholders are ultimately responsible for 340B Program compliance and compliance with all other applicable laws and regulations. Apexus encourages each stakeholder to include legal counsel as part of its program integrity efforts.*

*© 2023 Apexus. Permission is granted to use, copy, and distribute this work solely for 340B covered entities and Medicaid Agencies.*