Navigating The Reimbursement & DIR Fee Maze

Back to The Start

Pharmacy Benefit Managers (PBMs) were first introduced into the pharmaceutical industry in the 1960s when prescription drug benefits were made available to employees, retirees and their dependents. Their original purpose was to serve as middlemen to reduce administrative costs for insurers, validate patient eligibility, administer plan benefits, and negotiate costs between pharmacies, drug companies, and health plans. As their business model matured, PBMs were able to take advantage of their strategic position between the insurer and provider, and take control over most aspects of prescription drug pricing and transactions.

PBMs & Their Pricing Models

A large part of what PBMs have become responsible for is implementing Maximum Allowable Cost (MAC) pricing lists for plan sponsors, which was originally intended to be a payment model including both payers and pharmacies. A MAC list is a list of products, including the upper limit (or maximum amount) a plan will pay for generic drugs and brand name drugs with generic versions available (multi-source brands). Each PBM creates its own MAC list, each using its own criteria and formula to derive pricing for the lists.

The model is intended to ensure that both employers and consumers, those purchasing health insurance benefits, receive the lowest possible price on generic drugs. Unfortunately, current PBM strategies and MAC pricing algorithms do not reflect this initial purpose, and the rationale used to derive these lists is not made publically available.

While there is no industry regulation or standardization regarding the criteria involved with building MAC lists, some PBMs may take the following into consideration:

- Availability of the product in the marketplace
- Whether the product is obtainable from more than one manufacturer
- How the product is rated by the FDA in relation to the innovator drug
- Price differences between the brand and generic products

However, PBMs can chose to include or exclude any drugs that they'd like. For example, the PBM can choose to include 600 drugs, or 3,000 drugs. Moreover, the PBM can change the drugs included or excluded at any time.

PBMs justify withholding the formulas for calculating MAC rates with the concept that health plans and PBMs operate in a highly competitive marketplace. As such, there's incentive to ensure their contracted pharmacies compete with each other for the lowest possible price. In other words, if MAC pricing information was publicly disclosed it would create an anti-competitive effect on the market, and could potentially lead to an opportunity for pharmacies to price fix, thus driving up drug prices for health plans, employers, other payers, and consumers.

What Makes PBMs so Profitable?

The lack of industry regulation and clarity surrounding MAC lists and pricing standards gives PBMs freedom to use their MAC lists to generate significantly higher revenue for themselves. Typically, PBMs negotiate two types of contracts, one with pharmacies, and another with plan sponsors. The PBM uses a low MAC price list to reimburse contracted pharmacies, and then use a different, higher

list of prices when selling to plan sponsors. Many of these plan sponsors, and pharmacies, are left in the dark about the existence of these multiple MAC lists, and the stream of revenue the PBMs are raking in because of them.

Additionally, many PBMs incentivize using their own in-house mail-order pharmacies, and do not apply MAC pricing standards to them. Instead, PBMs offer a discount off the Average Wholesale Price (AWP) for mail order generic drugs at a rate agreed upon by the PBM and plan sponsor. Then, the PBM incentivizes patients to leave their community pharmacy, and fill prescriptions at a cheaper rate with a the mail-order pharmacy. Encouraging patients to purchase drugs from mail-order pharmacies ultimately saves and makes the PBMs money, at the same time.

Nowhere else in the healthcare industry is a benefits manager allowed to also be a provider.

So, How Did Pharmacies Get Involved in the PBM Scheme?

Being that PBMs are the entity in charge of negotiating plan formularies and pricing with drug companies, pharmacies are forced to depend on and work with them to ensure they are contracted with insurance plans and can ultimately provide prescriptions to their patients. Pharmacies either negotiate their contracts directly with PBMs, or are a part of a Pharmacy Services Administrative Organization (PSAO), which negotiates on behalf of a group of pharmacies for contract rates.

Cue the DIR Fees

On top of the questionable pricing models PBMs apply to MAC lists affecting pharmacies, Direct and Indirect Remuneration (DIR) fees are an even more ill-fitting block to piece into the PBM puzzle.

Medicare initially created DIR fees as a way to collect rebates that PBMs were receiving from pharmaceutical manufacturers. The rebates PBMs collect from a drug manufacturer are rewards for allowing their products to be included on different plan formularies, and essentially helping a drug company reach a particular share of the market for a given therapeutic class. The DIR fees were not meant to be kept by the PBM, rather passed back as savings to the payer, Medicare. Instead, PBMs created a new equation to solve their rebate issue, one which involved pharmacies.

To justify pharmacies taking on the DIR fee burden, PBMs explained them to be the fees for a variety of different 'perks' provided to them. Some include: fees for participating in preferred pharmacy networks, network access fees, administrative fees, technical fees, service fees, credentialing fees, refill rates, generic dispensing rates, audit performance rates, error rates, and more. The fees are referred to as DIR fees, because of the PBM's assertion that the fees cannot be determined at point-of sale, and must be collected from pharmacies after adjudication.

To start, PBMs typically keep published MAC prices high, and initially reimburse pharmacies for that amount. Then, they charge pharmacies DIR fees months after the initial claim adjudication. These fees reduce the overall net reimbursement cost for PBMs, and cut into pharmacy's profit margins, leaving many underwater for the scripts they're filling.

These DIR fees are structured one of two ways:

- a flat dollar fee per prescription claim
- a flat percentage rate

The DIR fees are charged to pharmacies months after the initial claim adjudication. In order to know what it actually made at point of sale, the pharmacy would need to be able to identify each eligible DIR claim and apply a corrected calculation to the reimbursement for each sale. However, the lengthy time span between these events makes it difficult for pharmacies to determine how much they'll ultimately receive for dispensing a drug. The major issue with this overall mess of an equation is that the actual cost of the medication to the pharmacy is not once considered.

Additionally, some plans document DIR payments by attaching the DIR fee to a different prescription and fill date during the following remittance period. Think about this for a moment. There is no possible way for the pharmacy to double check the DIR calculation, because the prescription it is attached to is not the prescription the DIR fee represents.

Hopes for a More Transparent Future

While DIR fees were initially tied to Medicare Part D, they are starting to extend into commercial network arrangements, sometimes under different names. Additionally, DIR fees were originally solely associated with plans in a pharmacy's preferred network. Offering patients lower copays on preferred network plans is assumed to be an incentive to gain and retain more patients, thus filling a higher volume of scripts. However, recently, plans outside of pharmacies' preferred networks have begun to include DIR fees.

DIR fees are a quickly growing buzz world in the world of pharmacy. In part, this is due to the increasing number of state MAC transparency laws being enacted. Effective in January 2016, CMS began to require MAC drug pricing set by PBMs to be shared with in-network pharmacies, in a format to allow them to validate drug prices before PBMs can use them to determine reimbursement rates. The rule also requires PBMs to publicly update MAC lists on a weekly basis to accurately reflect the market price of acquiring the drug.

As for future changes to MAC legislation, improving standardization to foster more transparency throughout the pharmaceutical industry is extremely important.

To start, the following may provide solutions to the various problems our industry is currently up against:

- Provide clarity to plan sponsors and pharmacies as to how MAC pricing is determined
- Establish an appeals process in which a dispensing provider can contest a listed MAC price
- Create standardization for how pharmaceuticals are selected for inclusion on a MAC list
- Enforce PBM disclosures to plan sponsors and pharmacies about the use of multiple MAC lists, and disclose the utilization of MAC pricing for mail order pharmaceuticals

Providers Versus Middlemen

At the core of this issue, what's important are patients, their providers, and pharmacies that have been unfairly involved in an unfortunate money-making scheme. Pharmacies should not have to worry about being paid fairly for the drugs they provide to patients.

At iMedicare, we feel that hazy pricing schemes should have their veils of obscurity lifted. Presenting pharmacies with reimbursement and DIR fee information is meant to provide transparency-- it's meant to give back the power of knowledge. It's meant to help pharmacies stay proactive in managing their businesses -- businesses which serve and interact with so many patients.

Pharmacies are providers, and should not be the middle-man in this equation.

To learn more about how iMedicare helps your pharmacy manage DIR fees and increase reimbursements.

Shoot us an email at:
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call **(704) 769-0540 ext. 3**

Sources:

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