Survey of Community Pharmacies
Impact of Pharmacy Benefit Manager (PBM) Contracting and Auditing Practices on Patient Care

National Results
September 2012

The Medicare Pharmacy Transparency and Fair Audit Act of 2012 (H.R. 4215) would make several reforms to the unregulated Pharmacy Benefit Management (PBM) marketplace. These reforms would help community pharmacies serve patients and assure that there is a strong, accessible community pharmacy network.

Among other provisions, the bill would require PBMs to disclose the source of reimbursement to pharmacies for generics and update them no less than every seven days. The bill would also make PBM auditing practices more focused on fraud rather than administrative and technical issues and make these audits more consistent among PBMs.

This survey provides important information to policymakers regarding the challenges that over 350 pharmacies report having with PBMs. This survey was conducted in August, 2012.

SUMMARY OF RESULTS

● 96.2% of independent community pharmacies stated that a typical PBM contract has minimal or no transparency on how generic pricing is determined.

● Almost 50% of respondents said that PBMs set reimbursement for generics below the acquisition cost to the pharmacy more than 10% of the time.

● 76.6% of independent community pharmacies stated that auditing requirements across Part D PBMs is not consistent at all.

● over 58.7% of independent community pharmacies stated that PBM reimbursement and auditing practices are very significantly affecting their ability to provide patient care and remain in business.
I - A provision of H.R. 4215 would require PBMs to disclose more information to pharmacies in contracts regarding MAC reimbursement for generics. In a typical PBM/pharmacy contract, how much information or specificity is usually given regarding either how MAC pricing is determined (methodology) or how often these prices will be updated?

![Transparency of Generic Pricing Graph]

II - How often is it the case that PBMs set reimbursement for generics below the acquisition cost to your pharmacy?

<table>
<thead>
<tr>
<th>Percent of Time MAC Pricing Below Acquisition Cost</th>
<th># of Respondents</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% or less</td>
<td>188</td>
<td>51%</td>
</tr>
<tr>
<td>Between 11% and 20%</td>
<td>104</td>
<td>28%</td>
</tr>
<tr>
<td>more than 20%</td>
<td>78</td>
<td>21%</td>
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III - It has been suggested that PBMs reduce their MACs faster for products that have gone down in price rather than increasing MACs for products that have gone up in price. Do you believe that this statement is true?

![Generic Price Adjustment Graph]
IV - Several provisions of H.R. 4215 would reform the manner in which PBMs could conduct audits. How consistent are the auditing requirements across Part D PBMs?

V - How often is extrapolation used in a Medicare Part D PBM pharmacy audit?
VI - How often do Medicare Part D PBM auditors require (and accordingly harshly penalize pharmacies for even minor noncompliance) recordkeeping requirements that go above and beyond what is required under state or federal law?

VII - How significantly are PBM reimbursement and auditing practices affecting your ability to provide patient care and remain in business?
Open-Ended Responses

Please provide examples of contentious Medicare Part D auditing practices that are affecting your ability to provide patient care and remain in business:

- Audits take 4 to 5 hours of my professional time in addition to 4 to 5 hours to pull Rx hard copies to prepare for the audit. Then I spend my 16 to 24 hours of staff time rebutting the audits, and prescriber time, for what are mostly clerical errors.
- One audit required invoices be pulled on hundreds of products to prove we had bought them. It took my main tech at least 12 hours over several days to pull and copy all the paperwork.
- We fill a monthly prescription for Provigil 200mg (#90) for a patient. Every time a new prescription is issued by the physician, we are audited by the PBM. Twice they have claimed that we did not respond to audit and that it would result in an automatic charge back (one month is approximately $3000).
- Minor recordkeeping errors like missing a doctors ID number on the face of Rx that they won't let us correct.
- Requiring pharmacy to obtain written documentation from physician for a prescription that was telephoned in 8 or more months in the past.
- Require NPI and we have to constantly look them up because not on hard copy or e-script.
- The NPI lookup website had the wrong # for an md and we were penalized
- Auditing records from 5 or 6 years ago prior to us having electronic records. It is very hard to find paper copies from that long ago.

Please give examples of drugs for which MAC pricing was set below acquisition cost:

- Over 600 drugs were identified. Some of the most commonly identified drugs included:
  - Budesonide (Asthma)
  - Atorvastatin (Cholesterol)
  - Clarithromycin (Antibiotic)
  - Fentanyl Patches (Pain)
  - Hydrocodone (Pain/Inflammation)
  - Methylprednisolone (Steroid)