Survey of Community Pharmacies

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

Kansas

The Patient Choice and Pharmacy Competition Act of 2011 (H.R. 1971/S. 1058) 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 a minimum level of reimbursement transparency in the contracts that PBMs have with pharmacies for Part D and commercial insurance plans. For generic drugs, pharmacies generally don’t know how much they will be reimbursed or when it will change. 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 1,800 pharmacies nationally report having with PBMs. This survey was conducted between June and July 2011. Attached is the data for the State of Kansas. 32 pharmacies from the State of Kansas participated.
Part I – Transparency of Generic Drug Reimbursement in PBM Contracts

I - A provision of H.R. 1971 would require PBMs to disclose greater 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 for generics is determined (methodology) or how often these prices will be updated?

II - Have you ever used or tried to use a PBM’s MAC appeal process?

III - If you answered yes, did you find the process or overall experience to be:
Part II – PBM Auditing Practices of Community Pharmacies

IV - Several provisions of H.R. 1971 would reform the manner in which PBMs could conduct audits. How often is extrapolation used in a PBM pharmacy audit?

V - Which PBM typically conducts the most aggressive audits?

VI - In general, how many years back does a PBM go when auditing your pharmacy’s claim data?
VII - How consistent are the auditing requirements from PBM to PBM?

VIII - How often do 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?

IX - How significantly are PBMs reimbursement and auditing practices affecting your ability to provide patient care and remain in business?
If you answered no (to question II above) please explain why or if you would like to offer any other comments on the MAC appeal process please do so below:

The PBM will decrease my MAC price in days when the market price goes down, but when the market price goes up it will take months to update MAC prices. Always in the PBM's favor. Patients suffer because of this because drugs need to be changes so pharmacies don't lose money. Sometimes it causes prices to go up.

The process is extremely burdensome and slow to positive yield results, if any. The forms we've had to complete are extensive and retrieving invoice documentation from our suppliers to prove what we pay for the product is another burdensome part of the process.

Please provide brief examples of the most egregious PBM audit examples you have experienced in your pharmacy.

1) PBM spread billing of a hospice. They billed the hospice $1,081.84 more than they paid the pharmacy. It was an average of $32.78 per prescription. This is almost 10 times the amount the pharmacy made per prescription.

2) PBM called my patient within 3 hours of my filling a prescription at my store. They told the patient that next month they could fill those prescriptions at mail order. I am not offered the ability to fill those prescriptions. My contract is different and the reimbursement is different from retail to mail order. The contract I am offered is below my cost and they know it.

3) Documentation showing that the PBM mail order company paid its mail order division $1.98 per unit of Omeprazole 20mg and it only paid me $0.77 per unit of Omeprazole. This information is from 2007.

4) PBM's pocketing rebate money and preventing my patients from getting access to generic drugs, therefore driving up costs. If you need me to come to Washington to testify, please call 785-483-1423

#1, I OVERRODE A HIGH DOSE RX, WITH PERMISSION FROM THE DOCTOR FOR ABILIFY 30MG 2 TABLETS DAILY FOR A TOTAL OF 60MG. HOWEVER I DID NOT WRITE HIGH DOSE APPROVED ON THE RX COPY. THEY RECOUPED $4,704.00 AS THE RX WAS FILLED 4 TIMES. I COULD HAVE FILLED THE RX WITH ABILIFY 30MG & 2 ABILIFY 15MG FOR A TOTAL OF 60MG. NOT REQUIRING A HIGH DOSE OVERRIDE COSTING THE TAX PAYERS AN ADDITIONAL $1900.00. #2 FILLED RXS FOR CHANTIX STARTER PAK WITH TAKE AS DIRECTED INSTRUCTIONS, AS THE DIRECTIONS ARE PLAINLY STATED ON THE CARDBOARD BOXES THE DRUG IS PACKAGED IN.

Member Health (Community Care Rx) audit result was a charge-back of over $9,000. We have appealed and not heard back yet. There were charge backs for Lantus which lasts 28 days after opened, but they thought the vials should last 90 days based on the dose, so they tried to pay for only 1 of each 3 for the year. Also, on a Namenda prescription we had "capsule" in the sig
instead of tablet and they tried to recoup the whole $200 amount for all 8 refills saying we billed for capsules when the Rx was for tablets, even though it was only a typo in the sig. There was one Rx for Oxycontin and they were recouping it for the Rx not having the Rx # on the hard copy. It was on there when we sent it the first time so we never did figure out why they thought they needed that $3000 back. We spent 6 weeks coming up with all the documentation they wanted, then they still tried to take $9000 away and we spent another 2 weeks working on the appeal. This is 8 weeks that we don't really have in a small, independent, busy, limited-staff pharmacy.

One of my prescriptions, in the auditing process was transferred from another pharmacy to me. All of the information required by state and federal law was on the prescription 1st fill, last fill, patient name address physician info.... etc, etc, etc. The PBM decided it was not a valid Rx due to some contract non-compliance issue, invalidating a Federal and State approved transaction between 2 pharmacists. They recouped/stole back from me over $300.

Currently, Humana is trying to withhold over $11,000 for a clerical error made on the Physician NPI number on claims that we submitted. We filled the claims with the correct drug, directions, quantity and doctor name, but had a clerical input error on the Dr. NPI number. They concluded this to be a fraudulent claim and are withholding over $11,000 from future reimbursements. Our cost of drug on this $11,000 was $10,000 so we have negative $10,000 plus time and administration on these claims. We have tried to contact Humana 8 separate times and they have not responded once. Second example, Humana communicated that they were going to audit a full years worth of claims and we should have all available at time of audit. This was over 3,000 claims and took us hundreds of hours to pull files for them and get all of the documents ready. We have no problem with audits, but need appropriate lists of specific prescriptions that will be audited, so we can be prepared to make it efficient for them when they come.