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 New Jersey. 30 pharmacies from the State of New Jersey 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 can arbitrarily, and does, deny the appeal despite evidence showing that they are paying well below current cost of medication...meanwhile the process can take weeks to get a response back, the plan requires the claim to have been processed, and the patient has gotten the medication already.  MAC appeal tends to be a process to appease plan sponsors that the PBM is concerned about the pharmacy, when in fact it is just allowing them to shoplift product on behalf of the patient.

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

"During a recent PT audit, we were placed on a ""Corrective Action Plan"" and our wholesaler was notified of this after the initial audit, before we had a chance to challenge any of the findings. The chief auditor quoted my questioning of this process (what happened to due process letter) and then proceeded to slam us in the audit and deny most of our supportive information. In particular there were two issues. In one, we had erred in the sig which allowed the patient to get 120/month of a medication when 90 should have been the limit. Rather than adjust the rx to 90 they made full recapture on the original and all refills because of ""the possibility of patient harm"". How could a clinical issue be tied to a reimbursement issue in this way? Who gives them this authority?

THE AUDITORS ARE NOT KNOWLEDGABLE ON METRIC INJECTABLE PACKAGE SIZES CAUSING HUGE PROBLEM.
2)DRUG DISPENSED AND BILLED CORRECTLY, METRIC QUANTITY WAS 1.0 REPRESENTING 2 PREFILLED SYRINGES. THE AUDITOR THOUGHT WE WERE OVERBILLING. HE DEMANDED A LETTER FROM THE MD TO SUPPORT OUR POSITION. A MAIL ORDER PHARMACY OUT OF STOCK WILL NOT GIVE ANOTHER PHARMACY AN OVERRIDE TO BILL FOR THE PRODUCT.  THE PATIENT MUST PAY CASH.

Instead of having package size checks and balances at time of processing on Edex (some plans bill by ml, others by syringes), plan allows claim to process and pay properly (with no feedback about billing quantities being incorrect), but then they come back and uses that as a trigger for auditing. The plan paid the claim properly, but then upon auditing required all sorts of verification from patient and invoicing from wholesaler to support the claim as it was ""processed wrong"" according to them. This is a common problem with no consistency between plans on injectables, kits, and other items...there should be standardization of billing methods on quantities.

The plan will make you jump thru all kinds of hoops on prior authorizations, rebilling, and all kinds of other stuff they require (and charge you for each transmission), then use that claim as a trigger for coming and doing an audit on it and other claims, fishing for technicalities. My personal favorite is when twins are in some systems (particularly Caremark, but others too)...instead of making them individuals, they reject claim, you try and figure it all out, end up spending time and energy contacting the help desk, and finally getting an override because their system doesn't do twins well. And again, all of those transmissions are trigger reasons for them to come in and audit and go fishing.

CVS/caremark have the most unfair auditing practices which should be considered illegal. They perform desk audits in which they want 200 to 300 prescription and drug invoices for 1 year on over 50 drugs. This is a very time consuming audit and I have been getting this yearly. They try to recoup money unfairly on very expensive drug claims that would be considered acceptable for other insurances. You really don’t want to fill these expensive drugs for patients because you know that the PBMs will try to recoup the money on those claims.

I had a N.J. Medicaid audit conducted by HMS citing me for "missing fax elements" on refill authorizations sent from a doctor’s fax. All super expensive drugs.. They are literally stealing $ from us. Also, for using generic Prilosec OTC (which is all NJM will cover) when a doctor write for Prilosec and not documenting "ok per MD on the rx"
Frivolous nonsense!! It is a total disgrace and injustice. Reimbursement is so low, then they steal $ back. Something must be done or we are done!!!