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## NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: L. Douglas Ried, PhD and Betsy M. Elswick, PharmD  
(Name)

01/16/2018  
(Date)

Texas House Delegation and Texas Pharmacy Association  
(Organization)

**Subject: Direct and Indirect Remuneration Fees**

**Motion: Move to adopt the following policy statements.**

1. APhA supports legislation that would prohibit retroactive direct and indirect remuneration (DIR) fees on pharmacies.
2. APhA supports prospective, transparent disclosure to pharmacies, employers and consumers, of all fee structures, performance-based network payments and penalties, and network participation requirements for any pharmacy benefit administrator
3. APhA opposes percentage-based or flat-rate, plan-based performance assessments in lieu of assessments based on a pharmacy's performance on pharmacy specific quality metrics.

### **Background:**

Relatively recently, Part D plan sponsors and Pharmacy Benefit Managers (PBMs) have begun to extract DIR (Direct and Indirect Remuneration) fees from community and specialty pharmacies. At present, nearly all pharmacy DIR fees are clawed back retroactively months later rather than deducted from claims on a real-time basis which makes it extremely difficult for community pharmacists to operate their small businesses.

The "Improving Transparency and Accuracy in Medicare Part D Drug Spending Act"<sup>1</sup> S. 413/ H.R. 1038 will prohibit Medicare Part D plan sponsors/PBMs from retroactively reducing payment on clean claims submitted by pharmacies under Medicare Part D. According to one report<sup>2</sup>, the bill would:

- Lower Medicare costs for taxpayers.
- Boost transparency in drug pricing.
- Give seniors reduced cost-sharing and greater budget predictability.
- Preserve access to independent community pharmacies.
- Address the concerns of Centers for Medicare & Medicaid Services (CMS) and Medicare Payment Advisory Commission (MedPAC).

A recent OIG report documented “a sharp increase in government spending on catastrophic coverage under Medicare Part D that has coincided with the steep jump in the prevalence and magnitude of pharmacy DIR fees”.<sup>3</sup> OIG determined that these costs—borne completely by Medicare and the taxpayers who support it—have gone from \$10 billion in 2010 to \$33 billion in 2015. Similarly, the Medicare Payment Advisory Commission (MedPAC) has expressed concern that these post point-of-sale price adjustments shift more liability to the Medicare program and the federal government.<sup>2</sup> Moreover, most PBMs do not provide sufficient rationale for the fees. For example, approximately 67 percent of survey respondents said that PBMs provide no information as to how much and when DIR fees will be collected or assessed.<sup>4</sup>

The original purpose of DIRs as intended by the CMS was to lower the drug cost to the “true cost”, such as including manufacturer rebates. In the case of flat fee or percentage DIRs, these are known to both parties before the transaction takes place and can be conveniently assessed at the time of the transaction. However, in other cases, even though a medication doesn’t have a rebate assessed, such as on certain brand name products, pharmacies were assessed DIRs on these non-rebateable claims.<sup>6</sup>

In addition, a comprehensive report examining PBM DIR fees concluded that they “...have no legal basis in regulation and may, in fact, violate certain laws”.<sup>5</sup> Examples of regulatory and statutory violations may include the Administrative Procedure Act, the Federal Any Willing Provider Law and the Federal Prompt Payment Law.

Moreover, DIR fees on pharmacies do not reduce the cost of drugs for beneficiaries at the point of sale and in fact push seniors into the 'donut hole' or catastrophic phase of the Part D benefit faster. Patients pay the higher prescription cost. If the cost was determined in real time, the savings that is clawed back from the pharmacy would be passed on to the patient and it would take longer for the patients' expenditures to reach the donut hole levels. Instead, the savings are retained by the PBM ostensibly to offset higher premiums. However, in evaluating the impact of HR 1038/S 413, the Wakely Consulting Group concluded that any minor increase in beneficiary premiums would be largely offset by out-of-pocket savings at the pharmacy counter (i.e., 0.15 percent per year or a 1.5 percent increase in net costs over the course of 10 years).<sup>7</sup>

## Sources:

1. 115th Congress (2017-2018). <https://www.congress.gov/bill/115th-congress/house-bill/1038>. (Accessed 10/1/2017).
2. National Community Pharmacists Association. Medicare Part D Pharmacy 'DIR' Fees—S. 413 / H.R. 1038. <http://www.ncpanet.org/advocacy/pbm-resources/lack-of-transparency-and-higher-costs/dir-fees/fact-sheet-on-h-r-1038>. (Accessed 10/1/2017).
3. National Community Pharmacists Association. NCPA Reacts to New Medicare DIR Fee Analysis. <http://www.ncpanet.org/newsroom/news-releases---2017/2017/01/19/ncpa-reacts-to-new-medicare-dir-fee-analysis>. (Accessed 10/1/2017).
4. National Community Pharmacists Association. Pharmacists Survey: Prescription Drug Costs Skewed by Fees on Pharmacies, Patients. <http://www.ncpanet.org/newsroom/news-releases---2017/2016/06/28/pharmacists-survey-prescription-drug-costs-skewed-by-fees-on-pharmacies-patients>
5. Frier Levitt, LLC. PBM DIR Fees Costing Medicare and Beneficiaries: Investigative White Paper on Background, Cost Impact, and Legal Issues. Commissioned by the Community Oncology Alliance, January 2017.
6. Michael Deninger. <http://www.thethrivingpharmacist.com/2015/09/16/the-dir-and-the-pharmacy-rebate/>. (Accessed 10/1/2017).
7. Wakely Consulting Group. Impact of H.R. 1038/S. 413 on CMS Payments Under Part D. Wakely Consulting Group, Atlanta, GA. 2017. <http://www.ncpa.co/pdf/wakely-report.pdf>. Accessed October 18, 2017.

## Current APhA Policy & Bylaws:

To the best of my knowledge, while there is current APhA Policy on reimbursement, there is no specific policy on DIR fees and claw backs.

## 2017 Pharmacy Performance Networks

1. APhA supports performance networks that improve patient care and health outcomes, reduce costs, use pharmacists as an integral part of the health care team, and include evidence-based quality measures.
2. APhA urges collaboration between pharmacists and payers to develop distinct, transparent, fair, and equitable payment strategies for achieving performance measures associated with providing pharmacists' patient care services that are separate from the reimbursement methods used for product fulfillment.
3. APhA advocates for prospective notification of evidence-based quality measures that will be used by a performance network to assess provider and practice performance. Furthermore, updates on provider and practice performance against these measures should be provided in a timely and regular manner.
4. APhA supports pharmacists' professional autonomy to determine processes that improve performance on evidence-based quality measures.

*(JAPhA 57(4): 441 July/August 2017)*

**\*\*Phone numbers will only be used by the New Business Review Committee in case there are questions for the delegate who submitted the New Business Item Content.**

New Business Items are due to the Speaker of the House by **February 14, 2018** (30 days prior to the start of the first House session). Consideration of urgent items can be presented with a suspension of the House Rules at the session where New Business will be acted upon. Please submit New Business Items to the Speaker of the House via email at [hod@aphanet.org](mailto:hod@aphanet.org).