PARD
An Association of Community Pharmacies

Established 1898

Peter Mucchetti, Chief
Healthcare and Consumer Products, Antitrust
Department of Justice
450 Fifth Street NW, Suite 4100
Washington, DC 20530

Dear Mr. Mucchetti

Attached please find multiple reasons why CVS should not be able to purchase Aetna. CVS has shown through the years that they cannot be trusted as they try to change healthcare in the country in the best way for their treasury

CVS is in the midst of multiple lawsuits because of their deceptive practices that are increasing healthcare costs. It would be timelier for your Antitrust Division to review some of CVS's practices as being Antitrust violations.

Please review

Mel Brodsky, RPh
Executive Director

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THE PBM INDUSTRIES DECEPTIVE PRACTICES THAT ARE COSTING HEALTH CARE EXPENSES IN THE UNITED STATES TO CONTINUOUSLY INCREASE?

Community pharmacy concerns are being ignored in these trying times; nobody is listening and patients are being harmed financially as well as losing access. Reimbursement has gotten to point that they are losing money on 20-25% of the prescriptions they fill, with no recourse to be made whole. The PBM's have become one of the most profitable business categories in our country where their CEO's are earning over $15 million dollars per year.

Medicare Part D was such a good idea initially, but now certain Insurance companies along with their PBM partners are setting reimbursement without regards to pharmacies cost of ingredients along with ignoring the pharmacies cost of filling an Rx. Complaints to CMS, who set the guidelines for Medicare D, are returned over and over again with the response "we do not get involved in contractual issues". If not them, then who? I understand that CMS is trying to keep the Medicare market-place premiums competitive – How is that working? My personal Part D plan increased in price 30% in 2017 over 2016 price.

PBM's, a business category with no oversight are doing whatever they want whenever they want. As the gatekeepers of these federal regulated plans, and the commercial plans, the PBM's are only looking out for one entity; themselves.

As legislation is passed throughout the country, especially about Maximum Allowable Cost (MAC) pricing and transparency, the PBM's are already finding ways around the legislation while they continuously ignore the legislation. Do we have to spend our time in the courts fighting these gate-keepers (PBM's) that are stealing millions of dollars daily?
Can community pharmacy financially compete with them in courts?

Deceptive Practices:
Mail-Order Discounts? – The PBM owned mail-order facility promises greater discounts to their customers (the actual payers) and do not. These facilities re-package products, reassign their own NDC number and inflate the product by 30-40%; then give their customer (the payee) a 10% discount. This amounts to a larger reimbursement to them. Impossible for the payers to audit this with the documentation they are given. Not transparent! The FDA can easily stop this practice by requiring original manufacturer's AWP & WAC price be used by repackagers and not allow them to assign their own AWP. Our pharmacies are not permitted to use repackaged products as per PBM policy, not State Law.

DIR's (Direct & Indirect Remuneration) – The original intention for these fees was a good one, but now the PBM's are requesting DIR's that cause the pharmacy to lose money on most prescriptions. They are taking back these fees that are well above the profit from an Rx, CMS is ignoring the deceptive practices being used to profit from these DIR's by the PBM's and CMS is not following the money trail. Patients who were supposed to benefit with lower premiums are seeing premiums increase yearly.

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GER's (Generic Equivalent Rate) – The PBM's method to replace MAC pricing with a method that does not take into consideration the cost of the ingredient cost or the cost of filling an Rx. Mandating GER's of 90 – 94% is impossible in these days of high priced specialty drugs, branded products and insulins. GER limit should be regulated at no more than 75% or be completely made illegal.

Spread Pricing – Everybody know about it, but it seems the PBM customers are unconcerned. Are these dollars being shared with the contract signers, the TPA's, the Insurance Brokers, the insurance companies & the PBM treasury? Transparency is nowhere to be seen and health dollar expenses are continuously increasing at the expense of the patient. When a store is reimbursed $10.00 for a prescription and the payer is billed $25-$40 – we are seeing unjustified health care costs going "under the table" which should be stopped.

Claw backs – The newest intervention by the PBM's where a patient is charged their whole co-pay when the prescription would be less than their co-pay if they did not have an Rx plan. This is outrageous. These extra dollars are going directly to the PBM treasury. If the pharmacy suggests to the patient that it would be cheaper not to use their insurance plan, the pharmacy could be dropped from PBM network per contract language that should not be permitted to be included in the contract.

PBM formulary: New single source generics that come to the market are excluded from the PBM formulary ONLY because the Branded product offers high rebates to the PBM to exclude the generic. Who benefits from this? Only the PBM and the branded manufacturer.

PSAO (Pharmacy Services Administration Organizations): Only needed because of Antitrust regulations. Have shown to a be useless in their ability to negotiate reimbursement on behalf of their membership.

THE FIX:

1. **Pharmacists should be included federally as "health care providers", which they are proving they are daily.**
2. **Community pharmacies PSAO's must start to say NO to plans that they know are losers and start to negotiate better terms. We must affect their network of pharmacies. The largest PSAO's (owned by wholesalers) know what stores are paying and where reimbursement should be set.**
3. **Community pharmacies must be able to say No to an Rx where they are losing money without retaliation from the PBM's. PBM contract wording must be changed.**

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4. **Community pharmacies MUST not undermine the rejection of a plan by their PSAO by signing on to that plan individually.**
5. **Believe it or not, PSAO's in itself are not profitable – Monies are earned by reconciliation and other programs within their realm.**
6. **Until Independent Pharmacy can obtain an antitrust exemption, we cannot even legally sit down with all the PSAO's in one room to discuss a fix.**
7. **Congress must review and fix the PBM industry and not allow them to remain a non-transparent business category. Millions, if not billions, of dollars captured by these PBM's are increasing health care dollar expenses. Follow the money trail.**
8. **Manufacturers are paying PBM's excessive rebates which are passed on to all of us by increasing drug costs way above the cost of living index. This should also be reviewed by Congress.**
9. **Professional Dispensing Fees must be set using information about the cost of filling an Rx in each category separately – Independent, Chain, LTC, Mail-order, HMO, etc. All commercial and federally funded plans must follow suit. Seeing 10 cent & 25 cent "professional dispensing fees" are a joke.**
10. **Mandate the use of NADAC plus a professional dispensing fee calculated from a State's Cost of Dispensing Report that considers all overhead expenses and a R.O.I. This should be updated yearly. There should be a minimum reimbursement allowed by State law.**
11. **Stop claw-backs on audits that mandate the use of VAWD approved vendors unless mandated by State Law, NOT PBM LAW.**
12. **Stop claw-backs on audits that mandate purchasing from an "authorized distributors" till the manufacturer stops making lower priced alternatives readily available in the market-place and THEY police the availability of their products from unauthorized distributors.**

We all hear that Congress is having "hearings" about the topics above – It's about time to stop having meetings and start doing something about it. PBM's have been slapped on their hands with multi-million dollar fines (which they consider a small expense) that allows them to do business as they like and have not taken any action to change the way they do business.

The PBM industries propaganda states that they negotiate better pricing from the drug manufacturer's – Who sees these savings other than the PBM treasuries?
Insist on complete transparency and save everyone money.

The PBM industry, NEED CONGRESSIONAL OVERSIGHT; EITHER STATE OR FEDERAL.

Thank you,

Mel Brodsky R.Ph.
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When it comes to administration of the prescription drug benefit, there are alternatives to the current Medicaid managed care model. For instance, last year, West Virginia Medicaid carved out the prescription drug benefit from its Medicaid managed care program. As you'll read here, the cost savings have been extraordinary.

But even if carve-out is not politically feasible in your state, there are several common-sense actions states can take to assure not only transparency and accountability for taxpayer dollars allocated to the Medicaid program, but also that local pharmacies are fairly reimbursed and local patients have convenient access to medications.

As the 2019 state legislative sessions approach, the time is now to work with your state pharmacy association and other partners in developing strategies for raising this issue with policymakers and in crafting legislative solutions that will rectify the problems.

SOME SOLUTIONS

What Medicaid reforms will work in your state? The following are a few ideas. But remember: Not every reform translates immediately into fair reimbursement for pharmacists. Some do, but that's really not the only goal. What is sorely needed in the Medicaid space is transparency in pricing and wise use of taxpayer dollars. Those, in turn, are likely to result in better treatment of community pharmacies such as yours.

"Carving out" the prescription drug benefit. In July 2017, the West Virginia Medicaid agency started managing the Medicaid prescription drug benefit directly, effectively carving it out of managed care. An actuarial study showed that the state could save money and pump money back into local economies with reasonable pharmacy reimbursements. Going into the carve-out, West Virginia Medicaid officials forecast a $30 million savings for the state. After the first year, West Virginia is expected to announce actual savings far greater than that forecast.
Why it works: It's been a big win for the state and community pharmacy. All pharmacies, both community and chain, now receive NADAC plus a $10.46 dispensing fee on generics. With the carve-out, West Virginia was able to save money and preserve access to community pharmacies in medically underserved areas, where a local pharmacist is often the most accessible health care provider. And according to West Virginia Department of Health and Human Resources Director of Pharmacy Vicki Cunningham, the state only added one staff person as a result of the carve-out.

Establish fee-for-service as a reimbursement floor in Medicaid managed care. It's not always the standard. It should be, NCPA's State Government Affairs Director Matt Magner says. "Fee-for-service is more accurate now," he says. "The rates are spelled out in the contract. They're much clearer. The PBM can't play games." With the fee-for-service model, the state only pays for services actually used, and that usually results in savings. Pharmacies are paid for ingredient cost plus dispensing fee. FFS as a floor is working well in Iowa and Kansas, for instance.
Why it works: PBMs are ratcheting down reimbursements but charging states more. Using fee-for-service takes away the PBM's ability to arbitrarily increase its spread.

Require states to have greater oversight of PBM contracts and reimbursements. Earlier this year, Kentucky enacted one of the most comprehensive PBM Medicaid managed care contract oversight laws in the nation. At the heart of it: PBMs are now required to disclose certain information concerning the use of tax dollars, such as the PBM spread and direct and indirect fees imposed on network pharmacies. The Medicaid department is allowed to review the PBM's reimbursement rates to ensure the state is getting a fair deal. "States have contracts with MCOs, but little oversight of PBMs," Magner says. "That is one reform we'd like to see right away."
Why it works: It's all about transparency. This gives the state greater control over how its tax dollars are spent. In Kentucky, a PBM's accountability is directly to the state via insurance commissioner oversight, not buried deep in an inaccessible MCO contract.

Make sure state contracts give Medicaid a right of action against PBMs. In managed care, the contract is usually between the MCO and the PBM, not between the PBM and the state. When there is no contract between a PBM and the state, the state often may have obstacles to pursuing an action against a PBM or subcontractor if there's a claim of wrongdoing.
Why it works: It gives the state greater ability to hold PBMs accountable.

Require a pass-through pricing model for compensating PBMs. Paying PBMs via a pass-through model gives them a flat administrative fee — no secretive rebates or deals and no spread pricing. "It's hard to get information on PBM revenues," Magner says. "A pass-through model keeps everything above board." In a pass-through model, he says, the state pays the actual contracted discounted pharmacy price and dispensing fee that the PBM has negotiated with the retail pharmacy network.

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Executive Director

KEYSTONE
Pharmacy Purchasing Alliance, Inc.

Mel Brodsky, R.Ph.
CEO

Same Terms & Conditions ----- Not a level playing field

Mail order uses re-packaged product with much higher AWP's (Brand & Generic). They do not allow us to use a re-packaged product. The differential in submitted pricing more than makes up for the mail-order promised reimbursement savings at AWP-25% over Pharmacy's reimbursement at AWP-15%. Looks like a 10% savings as promised – **IS NOT TRUE**

Example:

Drug A has an TRUE AWP of $100 (from pricing guide) our stores reimbursed at AWP -15= $85.00

The repackaged drug has an AWP of $130 Mail order reimbursed at AWP-25% = $97.50

Same drug with a different NDC # --- Plan Sponsors have no way to audit this.....

Mail-Order facilities reimbursement formulas do not include MAC's for generics– while we are always waiting up to 6 months for the MAC price to be updated when manufacturer increases their price. When asked how the MAC Price is calculated – we are told that it is proprietary. The mail-order price is always updated as soon as AWP is increased by the manufacturer.

Rebates received by the PBM's are also proprietary and payers are only seeing a small share, if any. These dollars should be sent to Plan Sponsors to decrease their costs minus a small administrative fee; the opposite is being done at present. These rebates can be $40.00/Rx or even more.

PBM's pay Pharmacy one price and bill the payer another inflated price – This is called "SPREAD PRICING" and amounts to millions of dollars in the PBM's profits.

The monthly invoice sent to payers is impossible to audit as they do not explain:

- How drug prices are calculated,
- How much is actually the administration fee,
- What % of rebates are included to lower the price,
- Or what they actually paid the pharmacy or mail-order facility.

Transparency would make audits possible and payers would see the above "tricks".
Again, the plan sponsors have no way to audit this at present.

A Level playing field will save plan sponsors millions of dollars that are presently being held by the PBM's

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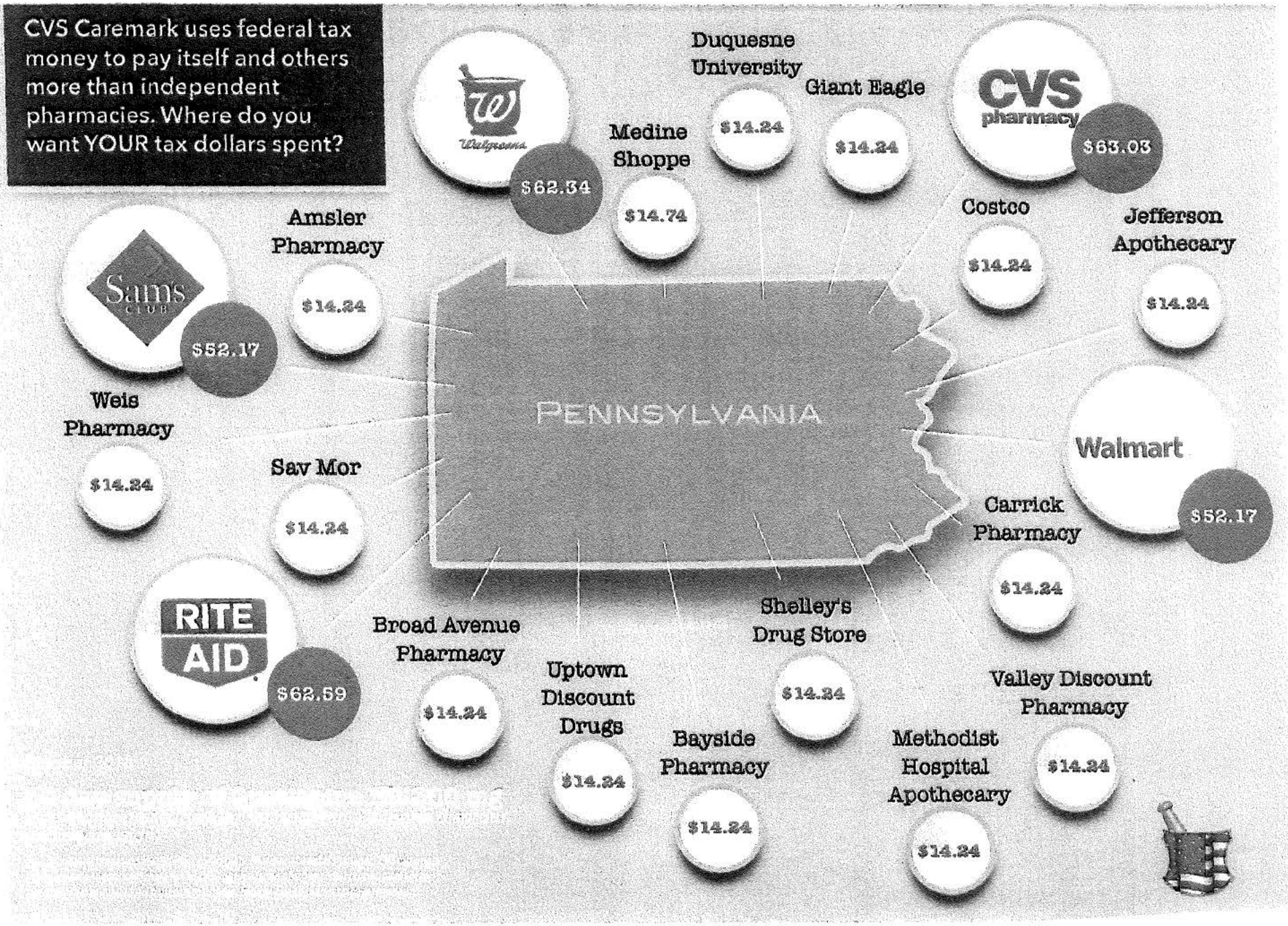
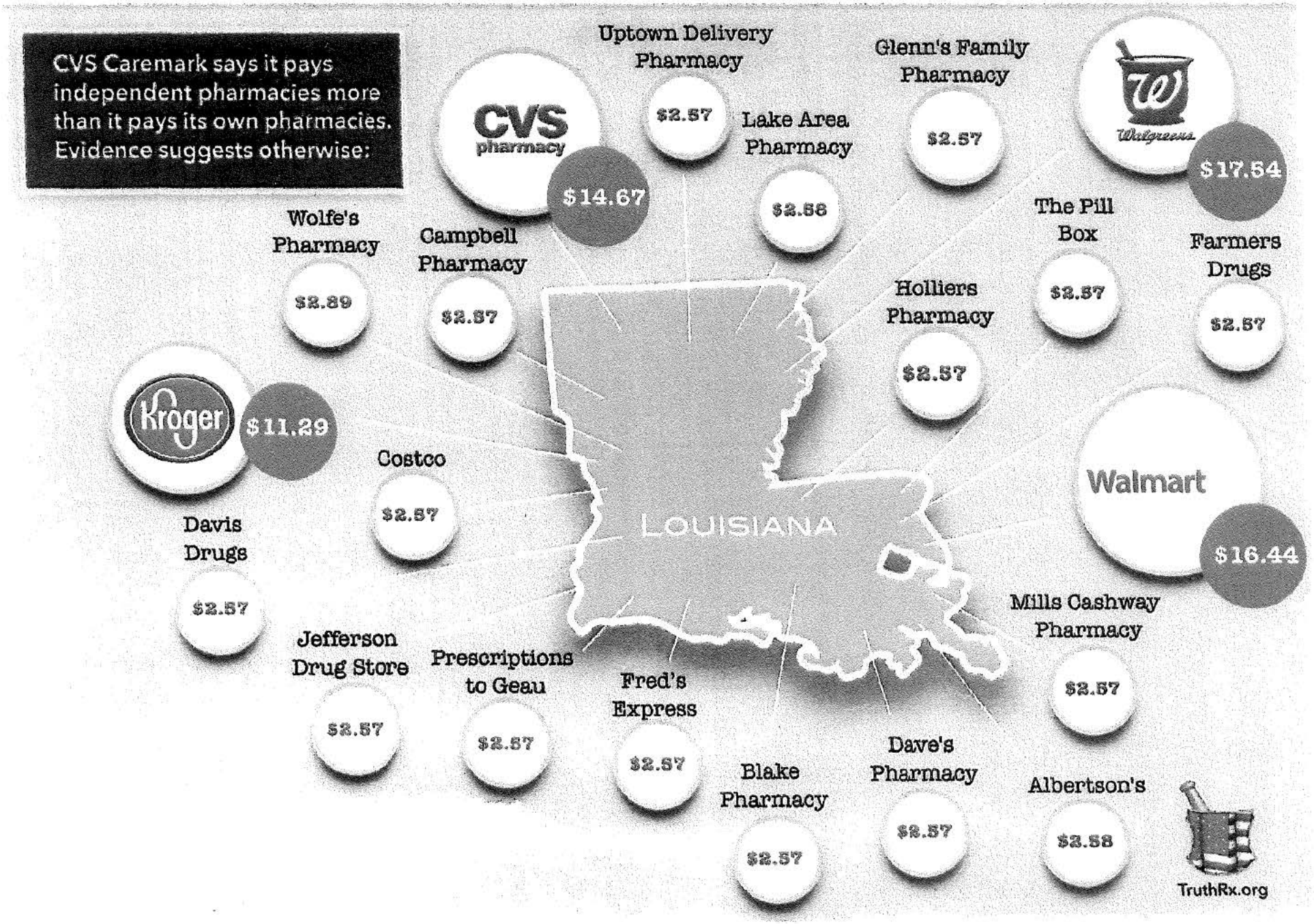
FEDERAL TAX DOLLARS USED AGAINST INDEPENDENT PHARMACIES



Federal Tax Dollars Used Against Independent Pharmacies



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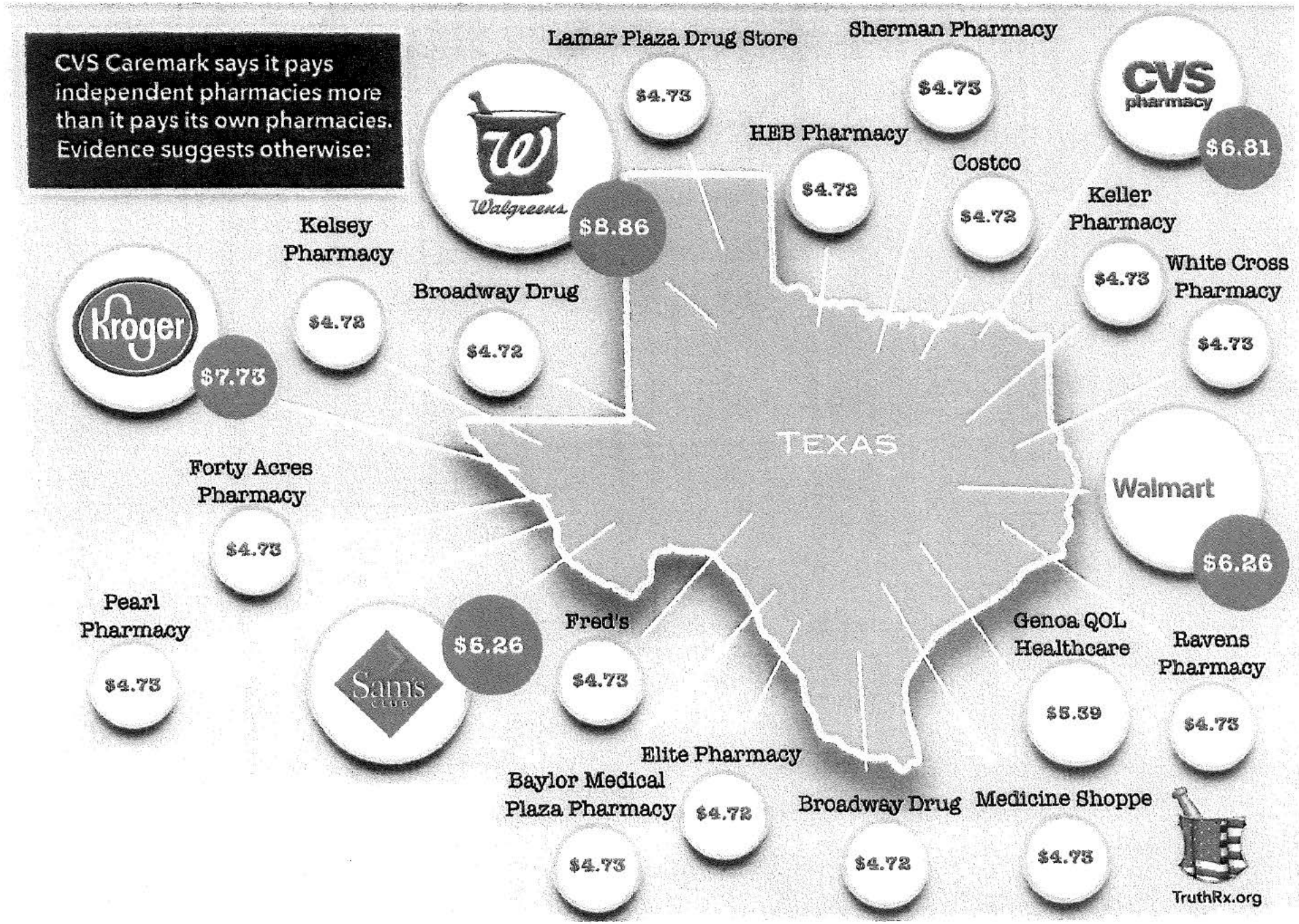

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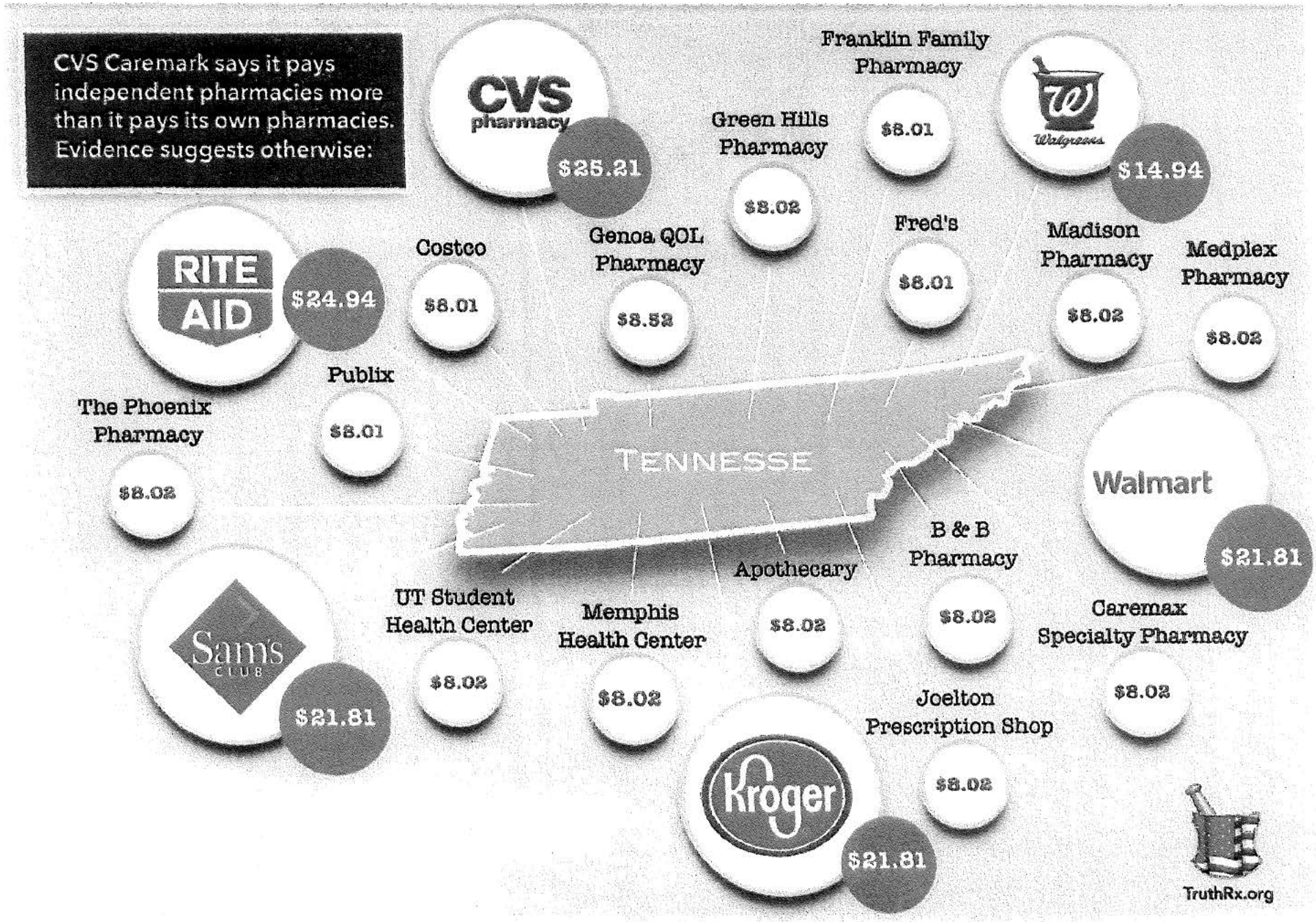

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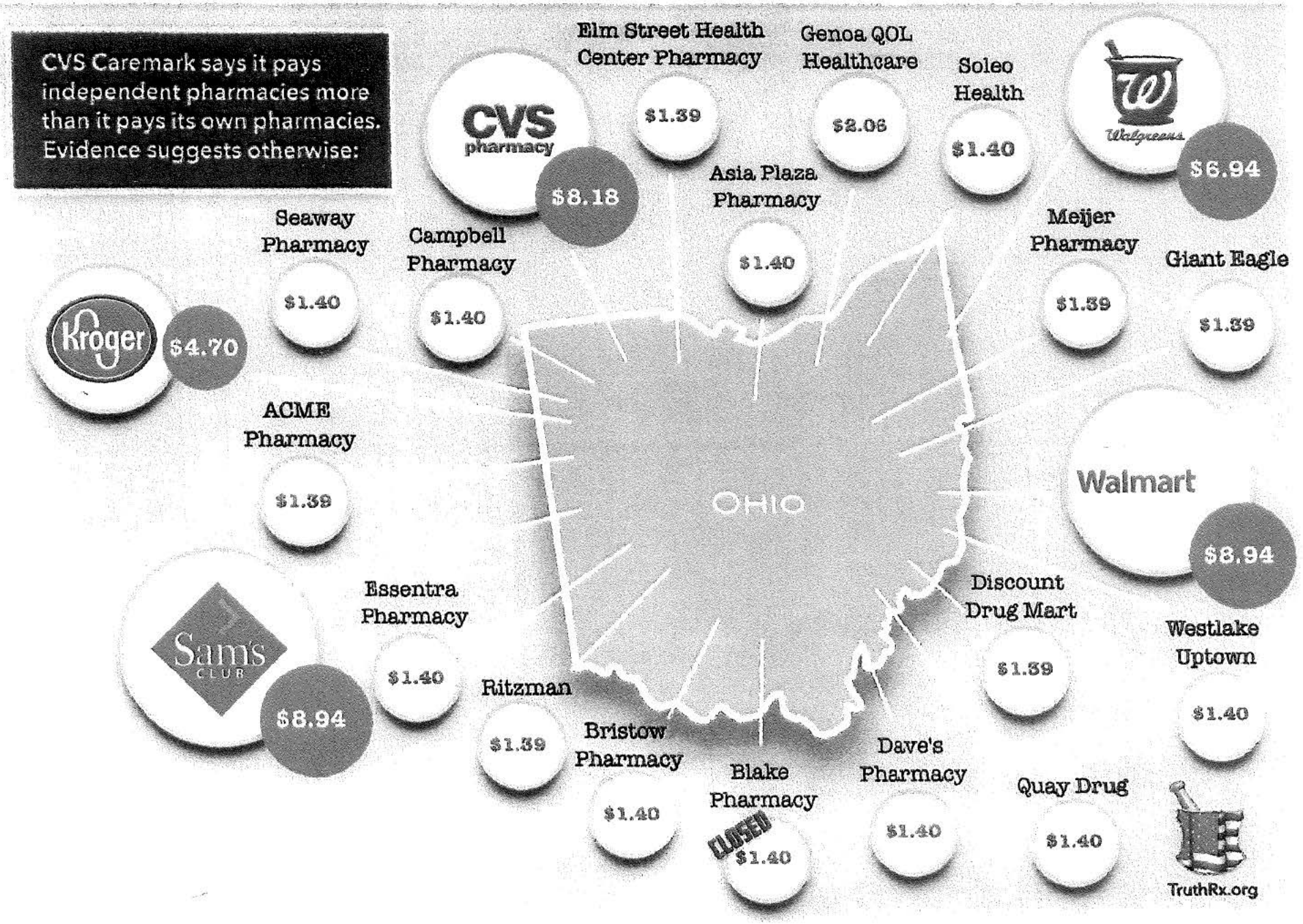


CVS pharmacy®

Kenny Sanders
Call me anytime at:
1-205-690-4952

Ever wondered what your pharmacy business is worth? If so, we should talk.

I'm a pharmacist myself. I know what independents are experiencing right now: declining reimbursements, increasing costs, a more complex regulatory environment.

Mounting challenges like these make selling your store to CVS Pharmacy® an attractive and practical option.

I can help you understand what your store is worth.
Whether you're considering selling right now or in the future, it's simply good business to know the facts. I can answer all your questions and give you a good idea how much your store is worth.

We'll take care of your patients. You can rest easy knowing we will remain in the same location and continue to provide the same level of high quality care as you did.

We always need strong professionals.
Our goal is to bring as many of your employees into the CVS Pharmacy family as possible. We provide competitive salaries and comprehensive benefits.

We can help make the acquisition process easy.
I'll work with you throughout the process and help you every step of the way. We want to work with you to maintain the level of service you worked so hard to create.

Why CVS Pharmacy is a comforting choice.
Our reputation for helping people on the path to better health is well known. We were the first national retail pharmacy chain to stop selling cigarettes. We answered the urgent need for a low-cost epinephrine auto-injector. Whether it's questions about drug interactions or lower cost generics, we're here for your patients. You couldn't leave your pharmacy in better hands.

Call me today at 1-205-690-4952 or visit **cvs.com/pharmacyvalue** to find out more. We can meet at your convenience, even outside business hours.

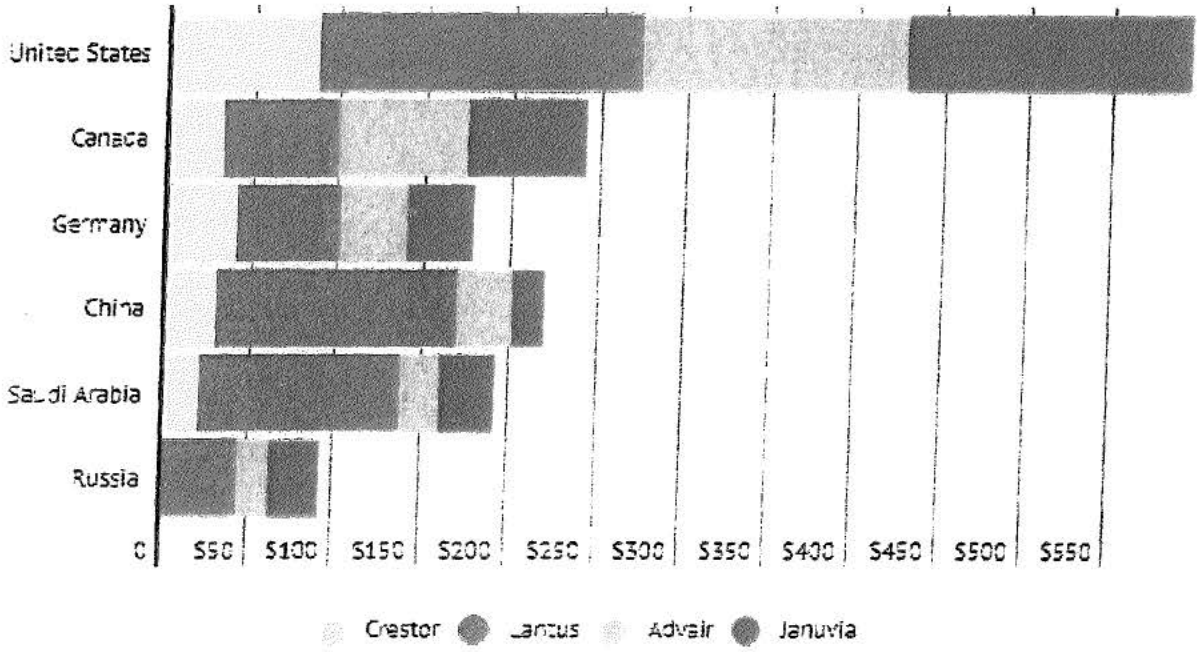
You've put a lot into your pharmacy. Maybe now's the time it pays you back.

I look forward to speaking with you soon.

Sincerely

Kenny Sanders
Regional Director of Acquisitions
You can reach me at 1-205-690-4952.

Drug price comparison between United States and 5 other countries



TARBELL

Through Tarbell, we want to shed light on these harmful systems that citizens do not know about or have accepted as unchangeable. Our series on the obscene costs of drugs aims to do just that: make sure you understand the reason why you're paying so much, and the forces that are behind your massive bills.

The system is daunting, but in a functioning democracy, there is hope. There are solutions you can take, and we aim to highlight them alongside our reporting, as we did in this series.

Over the next few weeks, I will be highlighting some of the incredible investigations, like our dive into sources of American pharmaceuticals, that we have been able to explore in our first full year of reporting.

Investigations like these would not have been possible without your support as members of Tarbell. We run campaigns like NewsMatch in order to bring you

[redacted]

Date: 11/21/18

BIN: 610279 PCN: 9999 RX#: [redacted]

NDC: 00527-0586-01

Fill Date: 11/13/18 Quantity: 30 Days Supply: 10

Acquisition Cost: $4.71 Reimbursement: $2.10

Dispensing Fee: Ø [redacted]

DAW: n/a

BIN: 610011 PCN: CTRXMEDD RX#: [redacted]

NDC: 49884-0726-01

Fill Date: 11/13/18 Quantity: 30 Days Supply: 30

Acquisition Cost: $6.39 Reimbursement: $3.73

Dispensing Fee: 35¢ [redacted]

DAW: n/a

BIN: 610502 PCN: 00670000 RX#: [redacted]

NDC: 65862-0782-01

Fill Date: 11/13/18 Quantity: 60 Days Supply: 30

Acquisition Cost: $45.86 Reimbursement: $38.77

Dispensing Fee: 35¢ [redacted]

DAW: n/a

** PAID CLAIM INFORMATION **

Patient: [redacted] ID: [redacted]
ADDR:

Drug: DICLOFENAC SODIUM (E-R) 100MG ER Qty: 30 NDC: 00591-0676-01
Cvg: HP Phone: [redacted] Ref#: [redacted]

Rx# [redacted] Date: 5-25-18 Trans. Date: 5-25-18 Time: 14:35

	Transmitted	Received	Difference
Cost	84.43	9.13	75.30 (89.19%)
Fee	5.07	1.00	
Tax		0.00	
Cost+Fee+Tax	89.50	10.13	
Copay		1.00-	
Amt.Paid		9.13	

PAYMENT

13.85 Acq Cost STORE COST

---------- Drug Utilization Review ----------

Conflict: Drug-Drug Interaction
Other Pharmacy: This Pharmacy
Previous Date: 4-27-2018
Severity: Minor
Database Used: First Databank
Free Text: VALSARTAN 320 MG TABLET

Insurance Information

Group ID: HCAP
Plan ID:
Network Reimbursement ID: NET=9431
Payer ID Qualifier:
Payer ID:
Cardholder ID:

BIN: 600428

PCN: 02530000

URL:

Patient Information

First Name: [redacted]
Last Name:
Date Of Birth:

---------- Optional Data Review ----------

Network Reimbursement ID: NET=9431
Copay/Coinsurance Amount: 1.00
Basis of Reimbursment: MAC Pricing Cost Paid to MAC Price

** PAID CLAIM INFORMATION **

Patient: [redacted] ID: 31289844
ADDR:

Drug: ESOMEPRA MAG 40MG DR CAP Qty: 90 NDC: 00093-6451-98
Cvg: HS Phone: [redacted] R[redacted]

Rx# [redacted] Date: 5-31-18 Trans. Date: 5-31-18 Time: 09:49

PAYMENT

	Transmitted	Received	Difference	
Cost	767.00	20.68	746.32	(97.30%)
Fee	5.25	0.40		
Tax		0.00		
Cost+Fee+Tax	772.25	21.08	30.95	Acq Cost
Copay		1.25-		
Amt.Paid		19.83		

---------- Drug Utilization Review ----------
Conflict: Underuse Precaution
Database Used: Medi-Span
Free Text: 29 DAYS LATE REFILLING

Benefit Stage Qualifier	Benefit Stage Amount
Initial Benefit	21.08

CIGNA
HEALTH
SPRING

BIN. 017010
PCN: CIHSPRE

Insurance Information

Group ID:
Plan ID: MPDMCARE
Network Reimbursement ID:
Payer ID Qualifier:
Payer ID:
Cardholder ID: [redacted]

URL:

Patient Information

First Name: [redacted]
Last Name:
Date Of Birth:

---------- Optional Data Review ----------
Plan Identification: MPDMCARE
Accumulated Deductable Amount: 99,999.99
Remaining Benefit Amount: 99,999.99
Copay/Coinsurance Amount: 1.25
Basis of Reimbursment: MAC Pricing Cost Paid to MAC Price

** PAID CLAIM INFORMATION **

Patient: [redacted] ID: 100480006
ADDR:

Drug: NYSTATIN SUSPENSION 100000 Qty: 60 NDC: 60432-0537-60
Cvg: HP Phone: [redacted] Ref#: [redacted]

Rx# [redacted] Date: 5-25-18 Trans. Date: 5-25-18 Time: 14:49

	Transmitted	Received	Difference	
Cost	16.94	5.51	11.43	(67.47%)
Fee	5.01	1.00		
Tax		0.00		
Cost+Fee+Tax	21.95	6.51	6.95	Acq Cost
Copay		0.00-		
Amt.Paid		6.51		

BN: 600478
PCN: 0259 0000

Insurance Information

Group ID: HPED
Plan ID:
Network Reimbursement ID: NET=9431
Payer ID Qualifier:
Payer ID:
Cardholder ID:

URL:

ATTN: RAKESH OR DANIELLE OR SHELLY
WHAT'S WRONG WITH THIS CLAIM??

Patient Information

First Name: [redacted]
Last Name: [redacted]
Date Of Birth: [redacted]

---------- Optional Data Review ----------
Network Reimbursement ID: NET=9431
Basis of Reimbursment: MAC Pricing Cost Paid to MAC Price

HOW DO YOU GIVE TO THE INFANT KNOWING YOU ARE PAID LESS THAN IT COSTS?? WHAT WOULD YOU DO?? SHAMEFUL DISGRACE EMBARASSING - YOU DON'T DESERVE TO BE PHARMACISTS!!

** PAID CLAIM INFORMATION **

Patient: [redacted] ID: [redacted]
ADDR: [redacted]

Drug: METOPROLOL SUCCINATE (ER) 200MG ER Qty: 9 NDC: 62037-0833-01
Cvg: HS Phone: [redacted] Ref#: [redacted]

Rx# [redacted] Date: 5-30-18 Trans. Date: 5-30-18 Time: 15:59

	Transmitted	Received	Difference	
Cost	226.76	23.49	203.27	(89.64%)
Fee	5.19	0.40		
Tax		0.00		
Cost+Fee+Tax	231.95	23.89	44.07	Acq Cost
Copay		2.00-		
Amt.Paid		21.89		

Drug Utilization Review

Conflict:	Drug-Drug Interaction
Other Pharmacy:	This Pharmacy
Previous Date:	5-12-2018
Severity:	Major
Other Prescriber:	Diff Doctor
Database Used:	Medi-Span
Free Text:	AMIODARONE TAB 200MG

Benefit Stage Qualifier	Benefit Stage Amount
Initial Benefit	23.89

R.N: 0.7012
PCN: CIHSCALE

** PAID CLAIM INFORMATION **

Patient: [redacted] ID: [redacted]
ADDR:

Drug: AMLOD/BENAZP 10-40MG CAP Qty: 90 NDC: 65862-0587-01
Cvg: HS Phone: [redacted] Ref#: 181514294559114999

Rx# [redacted] Date: 5-31-18 Trans. Date: 5-31-18 Time: 12:55

	Transmitted	Received	Difference	
Cost	440.69	8.04	432.65	(98.18%)
Fee	5.06	0.40		
Tax		0.00		
Cost+Fee+Tax	445.75	8.44	13.28	Acq Cost
Copay		1.25-		
Amt.Paid		7.19		

Benefit Stage Qualifier	Benefit Stage Amount
Coverage Gap	8.44

BIN: 017010
PCN: CHSCARE

Insurance Information

Group ID:
Plan ID: MPDMCARE
Network Reimbursement ID:
Payer ID Qualifier:
Payer ID:
Cardholder ID: [redacted]

URL:

Patient Information

First Name: [redacted]
Last Name:
Date Of Birth:

---------- Optional Data Review ----------
Plan Identification: MPDMCARE
Accumulated Deductable Amount: 99,999.99
Remaining Benefit Amount: 99,999.99
Basis of Reimbursment: MAC Pricing Cost Paid to MAC Price

FEDERAL MONEY - MEDICARE D - HOW IS IT THAT OUR U.S. CONGRESSMEN ARE NOT BEING MADE AWARE OF THIS SITUATION?? WHY IS THIS NOT BEING PRESENTED TO THE PRESS?? IF THIS DOESN'T CHANGE BY YEAR END I AM DONE.

** PAID CLAIM INFORMATION **

Patient: [redacted] ID: [redacted]
ADDR: [redacted]

Drug: BICALUTAMIDE TAB 50MG Qty: 30 NDC: 47335-0485-83
Cvg: HS Phone: [redacted] Ref#: [redacted]

Rx# [redacted] Date: 5-31-18 Trans. Date: 5-31-18 Time: 15:47

	Transmitted	Received	Difference	
Cost	556.00	3.43	552.57	(99.38%)
Fee	5.25	0.50		
Tax		0.00		
Cost+Fee+Tax	561.25	3.93	7.50	Acq Cost
Copay		1.25-		
Amt.Paid		2.68		

Benefit Stage Qualifier	Benefit Stage Amount
Deductible	3.93

Insurance Information

Group ID:
Plan ID: MPDMCARE
Network Reimbursement ID:
Payer ID Qualifier:
Payer ID:
Cardholder ID: [redacted]

URL:

Patient Information

First Name: [redacted]
Last Name:
Date Of Birth:

Optional Data Review
Plan Identification: MPDMCARE
Accumulated Deductable Amount: 99,999.99
Remaining Benefit Amount: 99,999.99
Amount Applied to Perodic Deductable: 1.25
Basis of Reimbursment: MAC Pricing Cost Paid to MAC Price

Bin: 017010
PCN: CIHSCARE

THIS IS TOTAL B.S. - NOT ONE GENERIC IS PAID ABOVE COST BY CIGNA HEALTHSPRING HOW IS THIS NOT BEING PUBLICIZED ??

[redacted]

Date: 11/21/18

BIN: 015814 PCN: 06430000 RX#: [redacted]

NDC: 60505 - 2656 - 01

Fill Date: 11/16/18 Quantity: 90 Days Supply: 90

Acquisition Cost: $5.75 Reimbursement: $5.65

Dispensing Fee: Ø [redacted]

DAW: n/a

BIN: 610014 PCN: n/a RX#: [redacted]

NDC: 68682-0998-98

Fill Date: 11/19/18 Quantity: 30 Days Supply: 30

Acquisition Cost: $11.17 Reimbursement: $6.50

Dispensing Fee: 10¢ [redacted]

DAW: n/a

BIN: 610502 PCN: 00670000 RX#: [redacted]

NDC: 68462-0711-71

Fill Date: 11/20/18 Quantity: 8 Days Supply: 28

Acquisition Cost: $63.80 Reimbursement: $63.24

Dispensing Fee: 35¢ [redacted]

DAW: n/a

Happy Thanksgiving 

[redacted]

Date: 11/21/18

BIN: 610279 PCN: 9999 RX#: [redacted]

NDC: 00378-1620-05

Fill Date: 11/14/18 Quantity: 90 Days Supply: 30

Acquisition Cost: $5.92 Reimbursement: $4.97

Dispensing Fee: Ø [redacted]

DAW: n/a

BIN: 610014 PCN: n/a RX#: [redacted]

NDC: 67877-0220-01

Fill Date: 11/20/18 Quantity: 20 Days Supply: 5

Acquisition Cost: $1.72 Reimbursement: $1.56

Dispensing Fee: 10¢ [redacted]

DAW: n/a

BIN: 610014 PCN: n/a RX#: [redacted]

NDC: 00406-8892-01

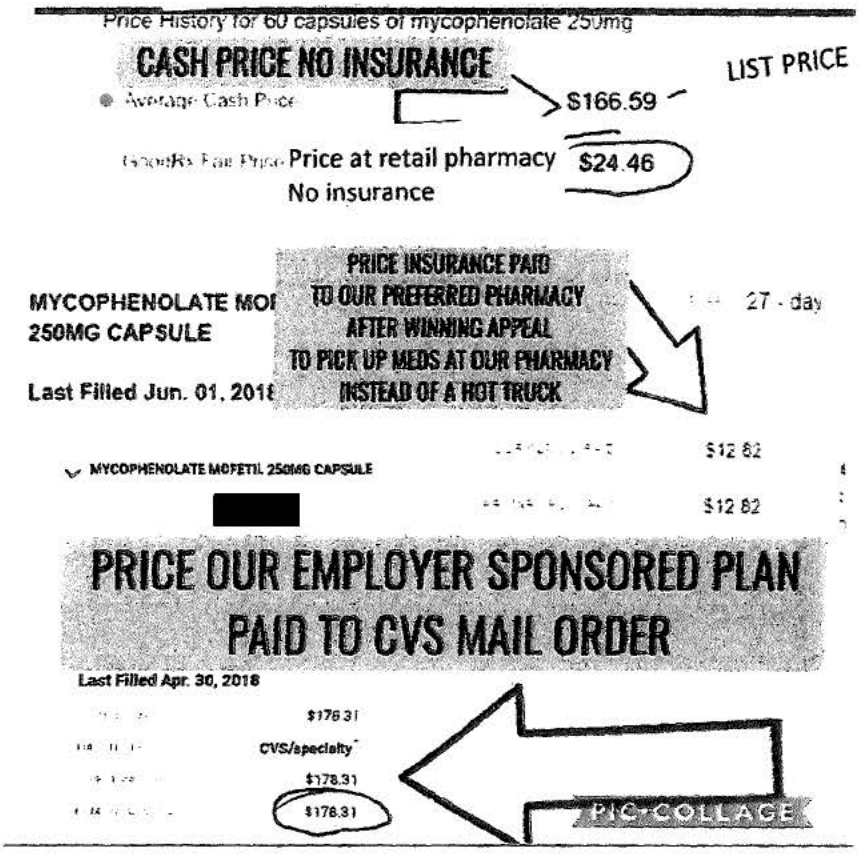
Fill Date: 11/16/18 Quantity: 75 Days Supply: 25

Acquisition Cost: $24.00 Reimbursement: $11.07

Dispensing Fee: 10¢ [redacted]

DAW: n/a

MAIL-ORDER



They pay a pharmacy $12.82 while their mail-order facility bills the payer $178.31

DIR FEES A Quick Overview

Summary and breakdown written by PDS member Traci Shell from Corner Drug Store.

DIR stands for Direct and Indirect Remuneration. In a nutshell, these are fees paid back to the PBM (pharmacy benefit manager) after the point of sale transaction or time of adjudication. Fees are typically collected at the time of third party payment, however some are taken far past that. **The fees discussed below and detailed on the second page only apply to MEDICARE DRUG PLANS.**

What makes DIR fees so "dangerous" is the fact that they are not easily identifiable at the time a claim is processed. This pain point is exaggerated by the fact that these fees vary by not only the PBM, but by the drug, the pharmacy, and by our performance.

It's not expected for EVERYONE to know EVERYTHING about these fees, however, it is crucial that their existence be acknowledged. Each day we encounter low or below cost reimbursement by PBMs. We are forced to determine how little we are making on that claim or how much we are losing.

Many times a prescription is sent through under the assumption that we're "only losing $2", or "at least we're making $1". The problem with this thought process is failure to calculate in the DIR fee the PBM will expect to be paid. Often times after assessing the estimated DIR fee, that small "profit", is now a loss.

Up until this point, most were completely unaware of these fees. While DIR fees have been around since 2006, it wasn't until 2013 when they began to show up in PBM's pharmacy contracts. Since that time, DIR fees have gradually grown, evolved, and become the monster we can no longer hide in the closet.

Attached you will find a breakdown of how you can estimate what each PBM's DIR fee will be.

pharmacy development services

PBM DIR Breakdown

Aetna *(this one is a biggie)*

Generic - Aetna will recoup 86% of AWP so you want to make sure the claim is paying at least 14% of AWP
AWP per unit x Quantity dispensed = AWP total
AWP total x 0.14 (this is what remains after GDR) = Net Reimbursement
Ingred. cost paid - Net Reimbursement = DIR Fee

Brand - 4% of ingredient cost paid

CVS Caremark

Fees are based on six performance levels. Assessed DIR amounts will be between 1.5% and 5% per claim

Magellan

Fees are based on percentage of generics dispensed quarterly. Fees per claim will be between 0 and 3.1%

Prime Therapeutics

Fees are based on performance, including GDR and high risk meds. Fees range from $4.50 to $7.50 per claim.

Express Scripts

Fees are based on GDR and formulary compliance. Fees range from $4.25 to $5.75 per claim.

Cigna

For 1 to 33 day supply fee is 9% of ingredient cost. For 34 days or more fee is 11% of ingredient cost. (per claim)

Optum

Fees are based on performance. Fees range from 0 to $4 per claim for non-specialty drugs

Envision

Fees are a flat $8.50 per claim for low income patients and $9.50 for all others.

Humana

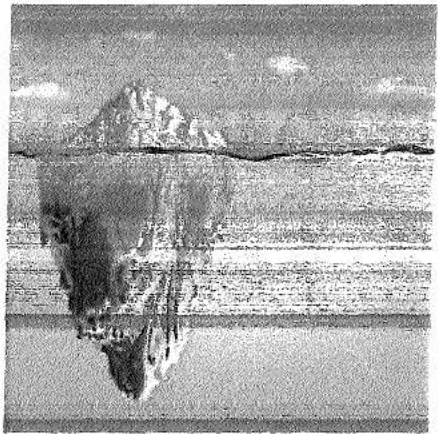
Fee is a flat $5 for each Medicare claim.

(There are opportunities in place for the pharmacy to have a payback on claims based on performance, however, these are not a guarantee.)

pharmacy development services

Pharmacists and owners know about DIR fees and the dangers it means for retail pharmacies. But for most of the world, the term "DIR fees" sounds like another industry buzzword. One of our PDS members, Traci Shell from Corner Drug Store in North Carolina sent us a summary that was so spot-on and well written, we had to share it.

BONUS: Look below for an easy download of this summary and a breakdown of DIR fees per PBM.



You can share this with...

1. The team at your next team meeting (that's what Traci did!), so they can stay current with the issues your pharmacy faces and understand that the goals you set are around combating these fees. Read below to learn how pharmacies like you are making them irrelevant.
2. Elected officials so they can begin to comprehend the plight of the independent. The more they understand the gravity, the greater the chances to spur legislation that drives real change in the industry.

What are DIR Fees?

DIR stands for *Direct and Indirect Remuneration*. In a nutshell, these are fees paid back to the PBM (pharmacy benefit manager) after the point of sale transaction or time of adjudication. Fees are typically collected at the time of third-party payment. However,

some are taken far past that date. The fees discussed below and detailed on the second page only apply to Medicare Drug Plans.

What Does this Mean for Independent Pharmacies?

What makes DIR fees so "dangerous" is the fact that they are not easily identifiable at the time a claim is processed. This pain point (https://www.pharmacyowners.com/pbms-duping-pharmacy-owners) is exaggerated by the fact that these fees vary by not only the PBM, but by the drug, the pharmacy, and by performance.

It's not expected for EVERYONE to know EVERYTHING about these fees. However, it is crucial that their existence is acknowledged. Each day we encounter low or below-cost reimbursement by PBMs. We are forced to determine how little we are making on that claim or how much we are losing.

The Problem with PBMs

Many times, a prescription is sent through under the assumption that we're "only losing $2," or, "at least we're making $1." The problem with this thought process is a failure to calculate in the DIR fee the PBM will expect to be paid. Often after assessing the estimated DIR fee, that small "profit," is now a loss.

Up until this point, most were completely unaware of these fees. While DIR fees have been around since 2006, it wasn't until 2013 when they began to show up in PBM's pharmacy contracts. Since that time, DIR fees have gradually grown, evolved, and become the monster we can no longer hide in the closet.

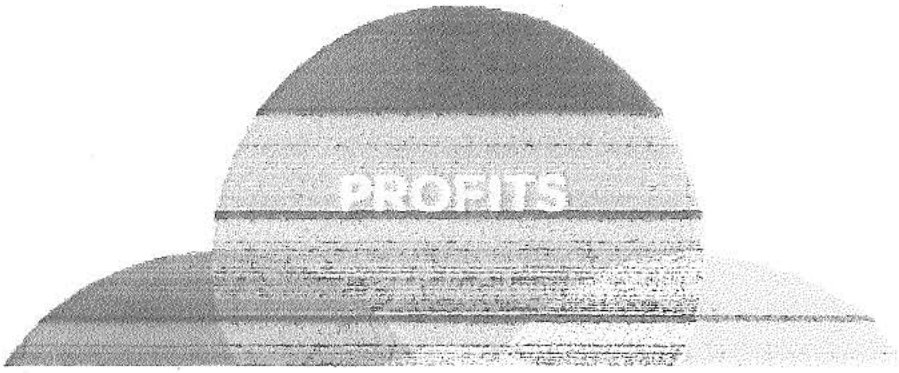
How Independent Pharmacies Can Combat DIR Fees

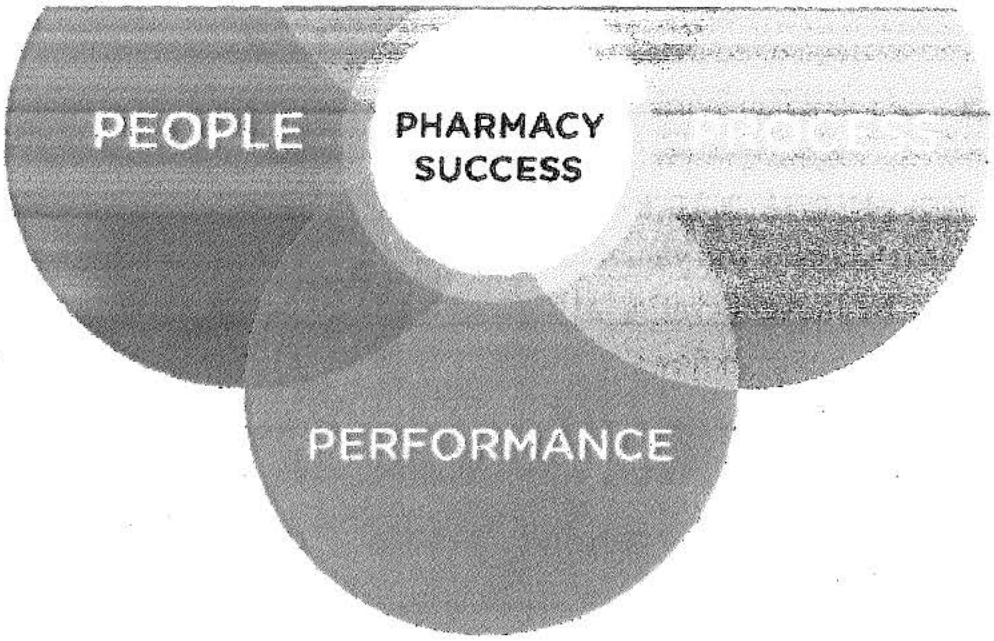
While this summary may seem dark, there is hope! Pharmacies just like you around the country are discovering ways to undermine the cost of these fees on their business. It's not luck that makes a pharmacy successful. It's not even one single strategy, applied well. It is a combination of unique variables that sparks the development and profitability of your pharmacy while providing a system to sustain the growth.

After 20 years, and through a relentless mission to help pharmacies maximize their potential, PDS has identified these 4 "it" factors for pharmacy success.

People

Your business is nothing without a high-performance team to align with your vision as a leader. Too often, owners are mired in the chase for more profits that they forget the bedrock of their business: their people. A successful owner sets forth a plan to hire and train the right people and focuses on culture to engage their team. You will be unstoppable with an empowered staff that is powering on all cylinders. Keep in mind, people work harder when they know they are valued, appreciated, and set up for success.





Profits

Pharmacy owners too often think that the variable to achieve pharmacy profitability is volume. They would be mistaken. Long gone are the days when pharmacies have to settle for every prescription that walks through the door. It is vital for owners to shift their mindset on what will move the needle in their business. For example, ask yourself which prescriptions are making the most money? The least? It's critical to identify where you are making money - and doing more of that - and where you are losing money - and doing less of that. Your success should not be measured by script volume, but rather, profit per script. Would you rather fill 100 $4 prescriptions or four prescriptions with a $100 profit each? Which requires more effort?

This is only one of the many ways to impact your profitability. PDS has identified many ways to increase your profits. Find out more here. (https://www.pharmacyowners.com/talk-to-an-expert)

Process

Resting on your past successes is a prescription for failure. Doing something because you've always done it will cost you valuable time, money and resources. Ask yourself: is every corner of your business operating at peak performance? Auditing how your pharmacy works, from your workflows to your inventory will show you the changes you need to make to maximize efficiencies in your pharmacy. Do your employees adhere to structured systems and processes that set them up for success and smooths operations? Do you have a handle on your inventory so you're not allowing any stockpiling? Are you managing your will-call bins? Do you have expired or dead products? These are all questions to ask yourself as you look around your pharmacy.

Every corner of your business can benefit from a good audit. The key is to audit consistently and implement process change swiftly before you lose any more valuable resources.

Performance

Pearson's Law: *Everything measured improves, and everything measured and reported on improves exponentially.*

This factor in pharmacy success is all about numbers. Understanding your numbers will help you identify and set your goals and listen to what the data is saying to make informed decisions. It's how you measure whether or not your pharmacy is on the right track towards achieving your goals. Are you financially literate? Do you know how to read, understand and interpret your financial statements along with other pharmacy data to help you make better management decisions, course-correct and seize opportunities? If this is an area in your pharmacy you are falling behind on, it's vital for you to secure the right tools and resources to help you become literate in your business so you can measure profitability and growth in your pharmacy. (Hint: PDS can help!)