

## **Frequently Asked Questions (FAQs) About Pharmacy “DIR” Fees**

### **Q. What does “DIR” stand for?**

**A.** “DIR” stands for “direct and indirect remuneration” and was initially a term coined by the Centers for Medicare and Medicaid Services (CMS) related to the Medicare Part D benefit to address price concessions (e.g. drug manufacturer rebates) that would ultimately impact the gross prescription drug costs of Medicare Part D plans that were not captured at the point of sale. Plans/PBMs are required to submit an annual “DIR” report to CMS, which is used by CMS in tandem with Prescription Drug Event (PDE) data to “true up” what is paid to a Medicare Part D plan by CMS for a given plan year.

### **Q. Exactly what are pharmacy “DIR Fees”?**

**A.** The use of the term “DIR Fee” to describe arrangements between Plans/PBMs and pharmacies is somewhat of a misnomer--it is really a “catch-all” term designed to encompass a number of different types of “fees” including “pay to play” fees for network participation as well as periodic reimbursement reconciliations. For example, Plans/PBMs have used the term “DIR Fee” to describe a “true-up” between a target reimbursement rate in a participating pharmacy agreement and the aggregated effective rate actually realized by a pharmacy as well as a “true up” between the aggregate MAC/adjudicated rate and the aggregate contracted rate. In addition, the term “DIR fee” is also used to refer to a payment mechanism to pharmacies for the fulfillment of various quality measures or alternately a fee assessed to pharmacies for non-compliance with quality measures.

One reason why the term “DIR fee” may be used by a Plan/PBM is to bolster their assertion that these fees cannot be determined at the point of sale—which would explain why these fees are collected from pharmacies after claim adjudication.

### **Q. Are DIR fees assessed to pharmacies legal?**

**A.** As mentioned above, “DIR fee” is simply the terminology that Plans/PBMs are currently using to categorize certain pharmacy network participation fees and the reconciliation of certain contractual terms with actual reimbursement. When CMS defined DIR and mandated the annual reporting of DIR, the intent was mainly to capture rebates from pharmaceutical

manufacturers to Plans/PBMs related to formulary positioning and other similar remuneration which impacts a Medicare Part D plan's gross prescription drug cost that is not passed through at the point of sale. CMS certainly did not foresee that "DIR fees" would be used to describe the types of fees charged by Plans/PBMs to pharmacies under this moniker. The fees themselves are legitimate; however, it could be argued that there does not seem to be adequate disclosure to the pharmacies or the contracting entities by the Plan/PBM as to exactly how these fees are calculated either at contract initiation or at the time these fees are actually assessed and reported to the pharmacy or contracting entity. The detail level of the disclosure of assessed DIR fees varies based on the information provided by the Plan/PBM. As such, more transparency around "DIR Fees" is needed.

**Q. How Are "Pay to Play" DIR Fees Assessed at the Pharmacy Level?**

**A.** Sometimes, pharmacies will be assessed a fee to participate in a "preferred" network. These types of fees are typically assessed as a flat fee per-claim or as a flat percentage that is assessed at regular intervals. The "fees" are essentially price concessions and Medicare Part D plans typically reflect them in their annual DIR report to CMS rather than at the point of sale in PDE records.

**Q. How are "Payment Reconciliation" DIR Fees Determined and Assessed at the Pharmacy Level?**

**A.** Sometimes pharmacies will be assessed DIR Fees that are the result of a "true-up" of a target reimbursement rate in a participating pharmacy agreement to an aggregated effective rate across all prescriptions, branded prescriptions and/or generic prescriptions at designated intervals. The reconciliation process is usually conducted at certain intervals (usually quarterly or annually).

**Q. How are the Performance Metric DIR Fees Assessed to Pharmacies?**

**A.** Some of the different performance metrics that pharmacies are evaluated under include refill rates, generic dispensing rates, preferred product rate, audit performance/error rates and other quality measures in comparison to other pharmacies in network. A pharmacy's performance on any of these factors could be tied to a "fee" or reimbursement reduction and at least theoretically could be tied to a bonus payment to the pharmacy.

**Q. Are Pharmacy DIR Fees Only Present in Medicare Part D?**

**A.** The use of DIR fees initially started in Medicare Part D but are now being extended into commercial network arrangements—often under different names.

**Q. Why are pharmacy DIR fees starting to become more and more prevalent?**

**A.** One theory is that DIR fees charged to pharmacies have risen in popularity (particularly in the commercial marketplace) in response to the increasing number of state MAC transparency laws that have been enacted over the past few years. It is likely that the Plans/PBMs have determined that utilizing DIR reconciliation processes after claim adjudication allows them to keep published MAC amounts high while ultimately reducing the aggregate reimbursement for generic drugs at the end of an established reconciliation period, further obscuring true reimbursement amounts to pharmacy.

**Q. Shouldn't DIR Fees Show Up or Be Reflected in Claim Adjudication Amounts?**

**A.** Many DIR fees are the result of a reconciliation between a contractual term and actual reimbursement realization. Typically, the Plan/PBM will conduct periodic “reconciliations” every few months and charge pharmacies for the difference a month or two later. Precisely because of this “lag time,” it is extremely difficult for pharmacies assess what their actual reimbursement rate truly is at the outset of the contract, at the time of dispensing and also at the end of the contractual term. It is NCPA’s position that all of these reported DIRs could be reasonably estimated at point of sale and reflected in the adjudication process.

**Q. As a Pharmacy Owner, What Can I Do to Manage These Fees?**

**A.** First and foremost, you must do your due diligence when evaluating contracts and make sure you are aware of and understand all of the different terms and conditions contained in your contract including network pharmacy manuals when incorporated by reference into a contract. Alternately, make sure any contracting entity that might negotiated on your behalf (PSAO) explains to you the parameters of all of your contractual terms.

**Q. Are federal regulators aware of these “DIR fees” being charged to pharmacy in the Part D marketplace?**

**A.** CMS is aware of these arrangements in the Medicare Part D marketplace and has serious concerns that pharmacy DIR fees have resulted in preferred pharmacy prices appearing lower than they actually are. In addition, CMS is also concerned that post point of sale concessions from pharmacies to Plans/PBMs result in bids reflecting higher amounts and premiums. These are ultimately reconciled in year-end process-- but amount to an interest-free loan from the Medicare Trust Fund to the plans.

The Final 2014 Part D rule established a new definition of “negotiated price” (effective 2016) to include all pharmacy price concessions which can be reasonably determined at point of sale. Proposed CMS guidance (still pending) interpreted “reasonably determined” to include fees that could be reasonably estimated or approximated at the point of sale. If finalized, this guidance should ensure greater transparency to pharmacies about their actual reimbursement at claim adjudication as well as greater transparency to CMS and plan beneficiaries about the true costs of prescription drugs at each network pharmacy- both preferred and non-preferred- under each Medicare Part D plan. However, it is anticipated that some Plans/PBMs may intentionally structure their programs for 2016 to make it more difficult for their DIRs to be “reasonably determined” at the point of sale in anticipation of the pending CMS guidance.

**Q. What is NCPA doing to address these types of “DIR fees” that are charged to pharmacies post claim adjudication in Part D and in the commercial marketplace?**

**A.** In the Part D marketplace, NCPA is strongly advocating for the final adoption of the proposed CMS guidance (referenced above) that essentially states that all of these types of pharmacy price concessions can be determined at the point of sale or at least “reasonably estimated” at the point of sale. If finalized, this CMS guidance would require the Plan/PBM to reflect these “fees” in the adjudication process—and would bring clarity to the pharmacy in terms of his or her true reimbursement rate. If this federal guidance is finalized, it could also be utilized to spur similar changes in the commercial marketplace.

In addition, NCPA is advocating for greater transparency and additional disclosures to pharmacies by the Plans/PBMs and/or the contracting entities about how these fees are determined both at contract initiation and at the time they are actually assessed.