# THE INS AND OUTS OF PBM AUDIT

## A white paper on analyzing your PBM

### Making sure your PBM is meeting your expectations

PBMs are in the business to make money. It's a fact that we all know, but the contractual agreement that third parties have with the PBM is critical in making sure that they are being paid for their value and not a penny more. While procurement and utlimately contracting will set the platform for your pharmacy management value story, MANAGING that contractual agreement is important to ensure that the PBM is meeting all of its contractual obligations in delivering the benefit in a contractually/financially appropriate manner, and not allowing your pharmacy management strategy to unjustly create PBM value at the detriment of your bottom line.

### DEFINITIONS

No, we aren't talking Websters here. Most of our crazy definitions in this business wouldn't even be found in these sources. Definitions in the world of pharmacy benefit management are not all created equal either. While some of the more clearly defined terms like Ingredient Cost may have industry-wide definitions established by organizations like NCPDP (National Council for Prescription Drug Programs), other items that are integral in the processing of pharmacy benefit claims can be interpreted differently by payers and PBMs. Interpretation also tends to be stretched or used to the advantage of the PBM when reporting values to their clients, so auditing against the agreed upon definitions is key.

There are some key definitions in the pharmacy benefit space that are important terms for which we pay particular attention to as we audit against the contract. Typically the RFI/RFP process with its Q&A, and the final Agreement signed between the parties will be needed to confirm some of the manners in which the definitions were memorialized. Definitions like Brand and Generic drug categories can vary. General pricing fields that will be used in claims adjudication and payment is another area of importance. Other specific definitions around exclusions or terms used in the calculation of guarantees are also of significance.

One of the most important, as mentioned before, is the classification of Brand and Generic drug categories. The way that each medication is classified is important to adequately calculate that the PBM is meeting the contractual rates within each channel, and is also used to calculate the per brand rebate values. The biggest concern in this area has been the use of simple and or/vague definitions in the Agreement around the guarantees, which allows for the PBM to ultimately make adjustments (which are financially adverse to the third party) to meet contractual obligations. Let's use single-source generics as an example. A single-source generic refers to a generic drug that has one generic drug manufacturer, which makes the single-source generic drug treated like a brand drug. Often times, we will see that although the single-source generic drug is identified as a generic in Medi-Span, a drug database that is used industry-wide, the PBMs will treat the drug as a brand; the single-source generics are included in the brand discount guarantees so that the PBM can meet their year-end pricing guarantee reconciliation. In this example, it is important to make sure that single-source generics are defined in the Agreement, or include detailed definitions around Brand and Generics with a reference to the specific indicators used in a drug database such as Medi-Span.

### TRADITIONAL VS PASS-THROUGH

The auditing of the pricing arrangement within the PBM payer agreement starts with understanding the pricing methodology. If the PBM and client have a more **Traditional Pricing Structure**, the PBM charges the payer more than what is being reimbursed to the pharmacy. The difference between those two amounts is known as 'spread'

  

and is the PBM's profit. Rebates are another area where the PBM is likely to share in their profitability; either directly through a share of the rebates received or through a minimum rebate guarantee. In Traditional Pricing, there is typically little transparency to the financial benefits of manufacturer rebates. While traditional pricing allows for a lack of transparency, it can also, arguably, allow for a deeper overall rate. (This is widely debated, but ultimately is part of the discussion on procurememt of the PBM and is not part of this white paper, which assumes the Agreement is already in place.)

Brand and generic drug classification, drug distribution channels including retail 90 definitions, specialty networks, and language on per claim discounts are just a few important things to assess at the start of the review. With per claim discounts, it is imporant to review individual claims for the specified channel to ensure that the discount guarantee and dispensing fees in the Agreement have been met.

Alternatively, the payer agreement could have a **Pass-Through Pricing Structure**. In this more transparent model, the price paid to network pharmacy providers is disclosed and is equal to the amounts paid by the payer. There are typically administrative fees charged to the payer to create value for the PBM, which can vary; it could be on a per claim basis or per member per month (PMPM). Even within these administrative fees, it ties back to how the PBM defined a claim, the timing, and also the membership count for the PMPM fee model.

Auditing a Pass-Through Pricing Structure is a slightly different process; the amounts billed to the payer reflects the amounts paid to the pharmacies, the discount guarantees are almost always measured in aggregate, and the PBMs usually pass the greater of 100% of rebates received or the rebate guarantees to the payer.

With both Traditional and Pass-Through Pricing Structures, it is important to make sure the PBM has the pharmacies, drug types, pricing fields, and several other key indicators classified correctly according to the terms of the Agreement.

## EXCLUSIONS LANGUAGE

Exclusions are not straightforward. Why should or should not a claim be excluded from a calculation can be a combination of understanding the definitions, and also understanding how variations in interpretation of that definition will change the outcome.

340B. Oh no, not 340B. We are not going to go into detail in this white paper about the 340B program, but let's use it as an example of where understanding exclusions is vital. The 340B program is a government program in which designated health care facilities who disproportionately serve the underprivledged can use their designation to garner more aggressive discounted pricing on medications (yes, we could go really deep on this topic and maybe will on a future white paper, but let's keep it to that simple definition for now). While there are more than 50,000 340B covered facilities in the United States, there are pharmacies contracted as 'down-stream' entities to service patients. Pharmacies who are contracted to serve these designated facilities may see patients that are in vulnerable communities, however, typically also see patients whose claims will never fall under a 340B designation. Now, back to our statement on "how variations in interpretation of the definition will change the outcome". Let's use this example; a PBM states that 340B is excluded from discount and/or rebate guarantees, and the PBM excludes all claims dispensed from this pharmacy provider because they are listed as a 340B contracted pharmacy. In actuality, the reference to 340B exclusions are for 340B claims and not all claims dispensed by the 340B contracted pharmacy.

While 340B is one example, LDD (limited distribution), biosimilar designations, COB (Coordination of Benefit) claims, LTC (long term care), Home Infusion, Indian Health claims, compounded drug claims, paper claims, and new-to-market drugs are just some of the other exclusionary language, and the need to monitor these exclusions are important in audit methodology. Bottom line, a focus on evaluation of exclusions to the definitions within the Agreement, and the manner in which they are used in calculations such as discount and rebate guarantees is vital.

## OFFSETTING LANGUAGE

Offsetting is another common concern that should be the focus of an audit effort. A simple way to define offsetting is allowing a surplus in one component to offset or balance out a shortfall in another. Let's take discount guarantees as an example. The discount guarantees are ususally broken out by channel (retail, retail 90, mail, and specialty) along with the brand and generic drug types. For each guarantee, the actual performance for the discount and dispesning fee guarantees are measured and will result in an overall shortfall or surplus. Even if there is a shortfall in this example, the settlement is determined based on the PBM and payer Agreement. The contract should have clear langugage on whether or not offsetting is allowed, and if so, include details on whether or not it is allowed within the channel ( brand and generics) and/or across all or specific channels ( e.g. retail and retail 90).

In addition to offestting within discount guarantees, there are also PBMs that will offset any shortfalls across rebate guarantees, Generic Dispensing Rate (GDR) performance, discount guarantees, and even other measurable components within the PBM and payer agreement. The defined terms within the contract related to offsetting as a whole are very important, and when unclear or vague can favor the PBM by allowing all shortfalls to be offset.

## NETWORK MONITORING

Another area ripe for PBM misalignment, which can be evaluated during a PBM audit, are the different components that make up the management of their network. A few areas to consider include:

1. Network List – there may be discrepancies in the list of providers versus what is applied in the claims data, which then effects the associated network rates
2. Mail Order/Specialty Pharmacy Designations – claims for mail order and specialty pharmacies that are included in the guarantees should be only applicable to the list of pharmacies in each network and applied appropriately
3. MAC List – there can sometimes be multiple MAC lists applied to certain networks and even specific distribution channels and these can be implemented or applied incorrectly
4. Specialty Discounts – the specialty discount rates can vary based on the networks. When there are multiple rates for one drug, it is important to ensure that the rate being applied aligns with the correct network
5. Pharmacy Network Audits – during pharmacy network audits, which is when the PBM is auditing its contracted pharmacy network, there are often times when there is an adjustment made after the audit. Some things to pay attention to is if the payer is appropriately being compensated based on the adjustment and if necessary, were the adjustments reported. For example, the Centers for Medicare and Medicaid Services (CMS) requires Prescription Drug Events (PDEs) to be submitted for every Medicare Part D prescription that the beneficiary fills. Although this is a summary level record, this record needs to include any adjustments that were made to the claim.

The Agreement may have had specified networks and associated rates, but there can always be errors; it could have been incorrectly coded within the claims processing system, which may also have been the result of networks being layered on top of each other and the appropriately coded values not being included in claims adjudication. Errors can also be found within the many adjustments made to claims, such as not making the necessary reimbursements. With that said, the need to review each component within the network is necessary to ensure that the networks have been set-up as intended, while also making sure the areas the networks touch are complete.

## GENERIC DISPENSING RATE (GDR) and PENALTY

The Generic Dispensing Rate (GDR) can also act as an important part of pharmacy management as the use of generics can keep the overall plan costs reduced. PBMs guarantee to drive network pharmacy adoption of the use of generics, which is represented in the GDR, and associates the guarantee around how effective the PBM believes it can be at driving this value. Sometimes the calculation as to if the PBM met the GDR is only half the battle. Understanding if they met the promised GDR can be evaluated and is dependent on the definitions in the Agreement, a common theme within this white paper.

Outside the calculation of the performance of the PBM to the contractually obligated value of the Agreement is only step one. An equally important part of the audit in reference to GDR is the calculation of the penalty and payment if the GDR is not met. Understanding how the penalty was calculated, which claims were included/excluded, timing of submission/paid/rejected, etc., is vital, and ensuring the payment accuracy and payment to the client is all part of the audit analysis.

## REBATE GUARANTEES

The audit of rebates is yet another significant component. It may be our last topic of this white paper, but it is not last as far as the value by which can be driven by a well-designed and executed audit plan to confirm that the client is getting all of the intended value from their agreed upon rebate guarantee.

Review of the Agreement and all of the rebate reports is crucial in identification of discrepancies and to determine if the PBM has appropriately allocated rebates in accordance with the terms of the Agreement. Again, the definitions are a vital piece of the audit, and helps to determine how different components of the rebate guarantees were intended to be calculated (e.g., brand drug classification, exclusions, specialty, channels, etc.). It is important to also note the allocation language around the rebate guarantees. As an example, if the contract indicates that the client will get the greater of three values: 1. rebates received, 2. credits, or 3. minimum rebate guarantees, our audit process sometimes finds that the payout to clients were not allocated correctly, and the clients did not receive the greater of the three values as contractually required.

## INS & OUTS

While we have not been exhaustive in our exploration of auditing PBMs, this hopefully has given some insight to the Ins and Outs of what is faced during an audit. While the process of auditing the pharmacy benefit can be explained sometimes in a fairly straightforward manner, the expertise of the auditing staff that have worked across the PBM industry know exactly what to watch out for, and what areas need a deeper dive, which is key.

We also know that the process should be cyclical. The audit is intended to find issues or concerns, however, having a partner to assist in ongoing maintenance to prevent reoccurrences, commit to enhance future agreement language such as changes to the unclear and vague definitions, or help with defining processes and reporting allowances is needed to ensure ongoing success of pharmacy benefit management cost containment.

Although we focused here on the auditing of an existing PBM payer agreement, there are other areas beyond the financial guarantees that can be audited such as benefit design and clinical management review. These areas can be reviewed annually or during a pre- and post-implementation audit. Pre-implementation audits ensure that the PBM has all components tested, reviewed, and ready for go-live, while a post-implementation audit checks all areas against real claims for the first quarter. Regardless of which aspect of the strategy is being audited, the use of audit to verify benefit management is a key to cost containment success.

  

## Who is PayerAlly?

PayerAlly's mission is to provide cutting-edge support for our clients as they look to better manage their medication costs. We offer best-in-class clinical, financial, and consultative solutions to help better manage costs and improve performance.

  