ADMINISTRATIVE FEES OR PERCENT OF VALUE

A brief discussion on paying for medication management services

Do Vendor Payment Models Support a Drive to Lowest Net Cost?

In this brief, we call out the differing areas of vendor support for controlling medication costs, and how those vendors are paid. Should these vendors be paid on an administrative fee basis, or should they be paid as a percentage of the value they generate? In models where vendors wish to be paid a percentage of the value they generate, often referred to as shared savings, they will engage with the payment model which acts to incentivize them to create even greater savings. What are the unforseen costs? Is there not incentive enough in administrative fee models in which volume of work equates to greater payment?

It is kind of like the sales professional versus operations professional. Both professionals are doing a job. Both are expected to drive the company forward, yet the sales professional is paid off a commission in which their compensation is tied directly to the clients they secure, while the operational professional is paid in accordance with their skills and execution at a competitive market rate.

Let's go back to those unforseen costs. When you have percent of value or shared savings payment models, is the unforseen cost not directly tied to an increase in overall healthcare costs? Are we treating these pharmacy medication management vendors like sales professionals when they are really providing a service and should be compensated like that operationals professional? When the vendors managing the benefit are being paid more than what is reasonable to support their operations plus a reasonable profit, that means the payer's costs remain high and ultimately health care costs for consumers remain high. With each vendor introduced into the benefit management strategy, the question becomes **"does the vendor payment model support a drive to lowest net cost?"**.

In this brief, we will explore some of the vendors and pricing models seen, and challenge our clients to ask the right questions as we assist them in navigating the best overall strategy in delivering lowest net cost medication management initiatives.

TRADITIONAL VS PASS-THROUGH

There are oodles and oodles of written details regarding Pharmacy Benefit Manager (PBM) vendor pricing models. In our early days of pharmacy benefit manager pricing models, it was mostly Traditional pricing, also known as spread pricing. 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.

Now, we often see 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).

These basic pricing models in medication cost management most frequently used by the PBM vendors is a great place to start this brief. Although the network pricing models have moved more and more to a Pass-Through pricing structure, other aspects of the PBM agreement remain focal points for how PBMs wish to be paid on value vs. operational effectiveness. Another important note for consideration is that Pass-Through is not always the better price. There is a great deal which goes into the negotiation of these price points, and some clients maintain a Traditional pricing model because in some cases it offers a more aggressive base rate to start. Either way, the

details of the pricing and understanding of the valuation, and if the pricing built into the overall contract, well beyond the network rate, there is always the need to pressure test the pricing models; Traditional may feel like that sales professional, and the Pass-Through may feel like the operational professional, yet all the other aspects of the engagement may very well swing the pendulum the other way.

REBATES

Pharmacy and Medical Rebates are a great source of financial gain by PBMs, aggregators, etc. While there are pass-through arrangements, which may include rebate guarantees, sometimes the question is "what is the pass-through value?". Others may do a share of the rebate, whereby they collect a percentage of the rebates received to yield their financial 'piece of the pie'.

Ultimately, understanding how the calculations are being made and who is involved can turn a shared model into a faux pass-through model simply through the disguise of the players. When there is transparency in the model, yet the model is not directly from the manufacturer to the PBM, it will be important to understand if the transparency they elude to is shielding the more lucrative amounts received by a vendor or intermediary (sometimes one with which there is a vested interest). This is important for those to challenge and get the most out of their rebate agreements by making sure that administrative fee models don't have a layer of shared value behind the scenes.

Another important thing for consideration is the fee structure, and what is to be kept by the PBM. Sometimes there may be fees included, which are created to allow the PBM to use rebates as a profit center and less about them recouping their administrative costs. While their contracts allow for the generation of the rebate, they have seemingly fixed costs in the administration of the rebate program. Furthermore, they have yet another profit generating piece of the puzzle that is found regardless of the model; delay of payment. Managing the timing of the reimbursements from the PBM to the payer is another area to monitor and eliminate any false increases in the share of value by PBMs.

NETWORK AUDIT

The auditing of the contracted network of pharmacy providers is another area where PBMs have various models. Some have components of the audit program, which are standard without fee, however, this is usually limited to general screenings. More commonly, auditing of the network comes with fees, but again may differ in the fee structure. In some cases, there is a PMPM (per member per month) fee for auditing services or a flat rate per audit or investigation.

In many cases, PBMs will use the statement that "a share of savings creates the incentive to drive more value to the payer by creating the incentive for them to increase audits and findings". However, this can be a double-edged sword. In some cases, the audits may generate financial value, yet, walk the line on appropriateness in claim chargebacks, which can drive network provider abrasion and in some cases member abrasion. Also, some do not create appropriate caps or ceilings on the value they can collect off a shared savings model, and that could result in huge fees being generated with very little effort on behalf of the PBM.

Furthermore, when the PBM is profiting off audit, there is little incentive for them to proactively work with the plan to put in the plan edits necessary to manage and control repetitive nature of the errors being seen. PBMs and vendors which monitor the network must be audited themselves to ensure their profits don't outweigh the value they are generating.

340B

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, but let's keep it to that simple definition for now). PBMs themselves may not directly profit off 340B, but indirectly they most certainly do. 340B value generated is supposed ("supposed" being an important word, but that is best suited for another discussion) to be used by the qualified hospital to better the treatment for the indigent, however, the slice of the pie that is being kept by others that are part of the process has increased over time.

How are PBMs profiting from this, and why is it included here where we are talking about administrative fees vs. shared value payment models? Glad you asked. The bottom line is the payers have paid for claims being fulfilled by specialty pharmacies. The pharmacies are then contracting with the 340B designated hospitals and will provide their data on claims billed to the hospital or clearing house for evaluation on classifying them as 340B. When they create the contractual relationship, it could come in differnet sizes and shapes, but in the end, the administrative fee model is quite a bit of a smaller piece of that pie than the share in value model. PBMs may also use their dispensing to favor those claims, which are more favorable from a 340B perspective.

COPAY MAXIMIZERS

In our recent white paper, we went deep on the value driven by PBMs and vendors with regards to manfacturer assistance programs to offset patient copay and plan spend. However, we did not go deep into how PBMs and these vendors are paid for these services. While we do see some PBMs with an adminstrative fee model, where they seek compensation based on the infrastructure needed to manage the program with a margin, we more commonly see shared savings payment models, in which these vendors expect payment based on the financial value they have generated to offset plan costs.

Generating a fee based model may even be loosely based off the expected share in value to be generated. Not all copay maximizers are created equal, nor the mechanism to pay those involved in the process; from the pharmacy to the PBM, and from the PBM to the third party vendors. Some are driving more into their pockets than into their client's.

ALTERNATIVE FUNDING VENDORS

Similar to the Copay Maximizers, Alternative Funding Vendors have a range of fees associated with the value they drive. However, this is an area where administrative fee models seem to be nearly non-existant. The high cost of specialty drugs in the market has become so unmanageable for some, that they turn to these more aggressive tactics of removing the drug from coverage all together, and then work with an alternative funding vendor as the intermediary to direct the patients to assistance in the way of Patient Assistance Programs (PAPs) and Copay Assistance.

While they may have been writing their own ticket with the value they could generate, payers now have more choice in these vendors and have the looming concerns of regulatory scrutiny that have many of them diving in deep into how and when to use these vendors. While the alternative funding vendors may have a cash cow, their use of a share in value model (which is a big share when you are talking about high cost specialty) may increasingly create issues. Manfacturers and regulators have a keen eye on these programs; it is one thing to drive down healthcare costs, but vendors taking such a big piece of financial value (intended for patient pay or profiting off moving burden from payers to manufacturers) is an area where these vendors and the payers contracting them are starting to look for a more straightforward cost that is appropriate to offset the operational cost of the program (which remains significant alone with the very manual nature of these programs).

DRIVE DOWN HEALTH CARE COSTS

While we have not been exhaustive in our exploration of different programs in medication cost management and whether payers are compensating the PBMs and vendors an administrative fee or as a share in the savings of value generated, one thing that is abundantly clear, is the importance of understanding and challenging these models. As the rising cost of medications and the increasing scrutiny to the normal PBM profit centers is managed, there is a new buzz about being paid a shared savings based on value driven. At the end of the day, that creates new and more hidden profit centers, which do not allow healthcare cost reduction at near the rate possible.

Analysis. Analysis. Analysis. We are in the business of analyzing the PBM and vendor payments. There may be an appropriate time and place for both administrative fee models and payment for value or share of savings models – yet compensation should always also focus on the ability to generate a lowest cost model and force value from competition in the marketplace. The more entities looking to profit from the management of healthcare leads to less overall generated net reduction in cost. As a part of the healthcare system, it is the job of all involved to drive to lower costs.

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.

