FDSAMPLICARE
now part of EnlivenHealth™

DIR Fees 101 Guide

Understanding the basics of direct and indirect remuneration

www.fdsamplicare.com

Summary

Introduction

If you own or manage a pharmacy, your business' success is dependent on many factors. One important factor is direct and indirect remuneration (DIR), which has a significant effect on the profitability of a pharmacy. In recent years, pharmacy DIR fees have come under scrutiny for their lack of transparency, retroactive nature, and the financial impact they have on both pharmacies and patients.

Understanding DIR fees is not a straightforward process. This guide explores the basics of DIR fees, providing a look at how they are calculated, influencing factors, and what steps you can take to stay ahead – in other words, all you need to know to begin to comprehend how these fees affect your business.

What Are DIR Fees?

The Centers for Medicare & Medicaid Services (CMS) originally created the concept of DIR to account for rebates or other adjustments Part D sponsors or PBMs may receive from manufacturers, pharmacies, or similar entities after the point of sale. These price concessions are expected to be passed back to the payer – i.e., the federal Medicare program – which would enable Part D plan sponsors to accurately account for the costs of their plans. In recent years, pharmacies have seen an increase in these retroactive fees, which may now also include network access fees, quality-based price adjustments, or pay-to-play fees between health plans or PBMs and pharmacies.

In contracts, DIR fees often show up as either flat dollar or percentage-based fees. Historically, they were predominantly dollar based; however, nearly all contracts have now shifted to percentage of ingredient cost, which allows for much larger fees on brand medications. For example, say a plan sets $1,000 as the ingredient cost of a specific medication, with an 8$ DIR. This would yield $80 a month in DIR fees or $960 annually. But, say the same plan used to have a flat $5 DIR, which would equal fees of $60 annually. The switch to percentage-based calculations increased the DIR clawback by $900.

In contracts, DIR fees often show up as either flat dollar or percentage-based fees

The Connection to Performance Metrics

In the past, DIR fees were based on preferred network participation. More recently, however, DIRs have shifted to being based on the performance metrics used to evaluate pharmacies. These metrics, set at the discretion of plans, frequently include medication adherence, generic dispensing rates, preferred product rates, achieved market share, and rates of medication therapy management completion. But not all these categories are created equal – because they are weighted, some metrics have a larger impact on your pharmacy's overall performance than others. And, depending on how well your pharmacy performs, you may receive reduced fees or bonus payments (this differs by plan contracts so be sure to read them carefully).

Here's something to consider: there is an inverse relationship between a pharmacy's performance measures and its DIR fees. Lower-performing pharmacies are assessed higher DIR fees while higher-performing pharmacies are assessed lower fees.

Performance metrics are determined at either the individual pharmacy level or the aggregate PSAO level, depending on the plan. This is an important distinction to note as it dictates how much influence a pharmacy can have over where it falls within the various DIR brackets (i.e., the cut-offs in which your pharmacy can fall depending on how well you fare on certain performance metrics). Both the metrics and the resulting brackets differ by plan.

At the PSAO level, plans aggregate each metric across the organization's entire network of pharmacies. This means that the amount of DIR fees your pharmacy is likely to pay is dependent on the performance of thousands of other pharmacies in your PSAO. Therefore, your singular store has minimal ability to move the needle on the outcome of its DIR fees.

When a plan measures performance at the store level, on the other hand, your pharmacy can tangibly influence where it falls within the DIR bracket scale. In this case, a percentile ranking is used to determine which bracket your pharmacy would fall into. This percentile ranking compares your store against every pharmacy in the nation that accepts the plan.

Prioritizing plans with metrics that are weighed at the store level and emphasizing outliers can have a positive effect on your pharmacy's bottom line. The example below demonstrates just how much one patient can affect a pharmacy's profitability.

Projected DIR offsets based on a pharmacy or PSAO's adherence levels. In this example, a PSAO that falls into the fifth bracket and achieves a 98% adherence level will have no DIR fees.

Thresholds	Adherence	DIR Offset
Baseline	89%	Baseline
Initial	90%	5%
Second	92%	10%
Third	95%	25%
Fourth	97%	50%
Fifth	98%	100%

* This example is not derived from a specific plan.
** Adherence levels are on a percentile ranking

Example

A pharmacy in North Carolina had a patient who was habitually non-adherent with their statin. This patient kept the pharmacy from obtaining the second DIR bracket for this adherence metric with a plan. As a result, the pharmacy had to pay an extra $0.80 in DIR fees for every claim filled under this plan. In total, the pharmacy filled over 30,000 claims that year on this plan and had to pay an extra $24,000 in DIR fees.

If you're not sure whether a plan's metrics are weighed at the PSAO level or the store level, reach out to your PSAO.

Star Ratings vs. Performance Metrics

As already noted, performance metrics are determined by plans and used to measure a pharmacy's ability to meet certain standards. But there's another rating system that's intertwined with performance metrics and often incorrectly used interchangeably. These are Star Ratings.

Star Ratings are a five-star quality rating system developed by CMS and used to measure the quality of services that Medicare Part D plans provide. CMS actively encourages plans to improve their Star Ratings and offers incentives or penalties based on performance. High-scoring plans are rewarded with incentives such as major bonuses (only for Medicare Advantage Prescription Drug or MA-PD plans) and the ability to enroll patients year-round (for five-star health plans). Plans with low ratings may be penalized by not being eligible for bonuses (MA-PD plans) and no longer being a Medicare plan (if a plan has received poor ratings over a period of time).

Star Ratings are focused one evaluating a plan's performance, but what does this mean for your pharmacy? It is in a plan's best interest to have high-performing pharmacies in its network so it also encourages pharmacies to improve performance with incentives or penalties that are connected to DIR fees. Remember, the better your pharmacy performs, the lower your DIR fees. This makes it important for you to be aware of how you are doing within each plan's respective metrics.

Identifying DIR Fees in Pharmacy Contracts

Details of how a plan calculates its DIR fees are outlined in pharmacy contracts; however, these fees are not always explicitly labelled, making it essential to know what to look for in order to recognize them. This is also true of generic effective rates (GER), which are contractual rates that require the full cost (reimbursement plus copay) of all generic drugs over a certain time frame equal a certain percentage of the average wholesale price (AWP).

Additionally, contracts may refer to "reconciling" the difference between the system adjudicated rate and the effective rates in order to achieve the contracted effective rates. This is how the GER amount is calculated. Most contracts also follow a lesser of or lower of logic in which the reimbursement you receive is equal to whichever of the possible models or payment methods is lower. These models usually include — but are not limited to — the usual and customary price (U&C), AWP discount, maximum allowable cost (MAC) list pricing, and the provide ingredient cost + dispensing fee.

In some instances, there may be an overlap between PBM and plan sponsor contracts. This means that the reimbursements or pricing rates outlined in one contract may be described as being superseded by the reimbursement or pricing of another contract. The contracting language may also note that more than one rate or discount may be in effect. This means that either rate may apply.

It is essential to know what to look for in order to recognize them

Remittance Statements

Similar to contracts, the ability to accurately review your pharmacy's remittance statements is invaluable to understanding your business' finances. Some PSAOs will provide the DIR estimates for the pharmacies in their networks. But, if you're going through your remittance statements, here are some common adjustment codes to help you identify DIR/GER:

- **B2:65, B2:66, B2:67, FB:CF, AH:43**
- **CS:62, CO:89**
- **CS:32D, AH:32T**
- **CS:QUAL NTWK FEE**
- **CS:2**
- **CS:03**
- **AH:CSDIR**
- **CS:Med D Dir Fee**

When reviewing pharmacy contracts, you may come across phrases such as "rate guarantees," "performance adjustments," or "post point-of-sale adjustments." These are just some of the many terms often used to signify DIR fees. Some alternate terminology includes:

- **Post settlement adjustments**
- **Performance reconciliation**
- **Withhold amount**
- **Network variable rate**
- **Network participation fee**
- **Network processing fee**
- **Program fee**
- **Administrative fee**

GERs may also appear as the following terms:

- **Effective rate**
- **Effective rate guarantees**
- **Effective average discount guarantees**
- **Average Discount Aggregate**
- **Med D Aggregate**

What DIR Fees Mean for Patients

Typically, DIR fees are applied retroactively, making it difficult to know exactly how much the fee on a prescription may be (although you may be able to calculate an estimate). You are likely familiar with how this affects your business, but DIR fees can have a negative impact on your patients as well.

Copayments for non-dual eligible patients are based on the point-of-sale adjudicated price, excluding any retroactive DIR, so these patients are more likely to pay a higher copay for a drug than it would cost without insurance. They also do not benefit from any discounted drug prices since DIRs are applied after the point of sale.

For instance, say a patient is in the initial coverage phase and paying a 25% copay. For a medication with a full cost of $100, the patient will have a copay of $25. However, the plan later takes back a $10 DIR. This means the real full cost of the medication is $90, and the patient's copay should be $22.50. In this case, the patient has overpaid by $2.50. When this amount is applied to multiple medications and refills for one patient, the numbers go up. When applied to the millions of Medicare beneficiaries, the total overpayment by the patient population increases considerably.

The inflated prices also rapidly drive patients toward their initial coverage limit and into the Medicare Part D donut hole, where their copays increase.

With all that said, it's worth noting that high cost-sharing leads to lower premiums for beneficiaries. This means that many patients who take prescription drugs pay high costs through their drug copays, which is then used to essentially subsidize premiums for all beneficiaries. In 2017, CMS released a study suggesting that higher DIRs help reduce premiums for Medicare beneficiaries. According to CMS, "under the Part D payment rules, rebates and price concessions received after the point-of-sale are factored into the calculation of beneficiary premiums and Medicare's direct subsidy payments to Part D sponsors. As a result, a higher level of DIR places downward pressure on beneficiary premiums."

DIR fees can have a negative impact on your patients as well

Addressing DIR Fees

DIR fees remain a reality of doing business in the pharmacy industry, but there are still some ways to mitigate these fees and their effect on your pharmacy. One of the easiest steps you can take is to load the DIR information from your contract into your pharmacy management system. At the point of adjudication, most systems will project your profitability margin after the DIR fee is assessed. You can then employ other tactics to improve performance metrics that affect your DIR fees. Adherence-related metrics are the most prevalent, so it is imperative that you take steps to keep patient adherence as high as possible. A few suggestions on how to do this are listed below.

Load your contract information into your pharmacy management system to get DIR estimates.

Prioritize outliers

In this context, outliers are patients who are not considered adherent to their hypertension, statin, or cholesterol medication, or are diabetic and not taking a statin, and have the greatest effect on a pharmacy's bottom line. Outliers are particularly important for plans that solely weigh the pharmacy's performance. Focusing on helping these patients improve their adherence will ultimately benefit your pharmacy. Amplicare provides tools to help you identify patients at risk of low adherence or with gaps in therapy so you can prioritize outreach to help keep them on track.

Send refill reminders - Address nutrient depletion

A refill reminder solution is a great way to reach outliers, but also to prevent your patients from becoming non-adherent because they forgot to call in or pick up prescription refills. Pharmacists using Amplicare platform are able to automate patient outreach by scheduling personalized calls to remind patients when medication is due to be refilled. This kind of personalized communication has the added benefit of increasing patient satisfaction and overall pharmacy growth.

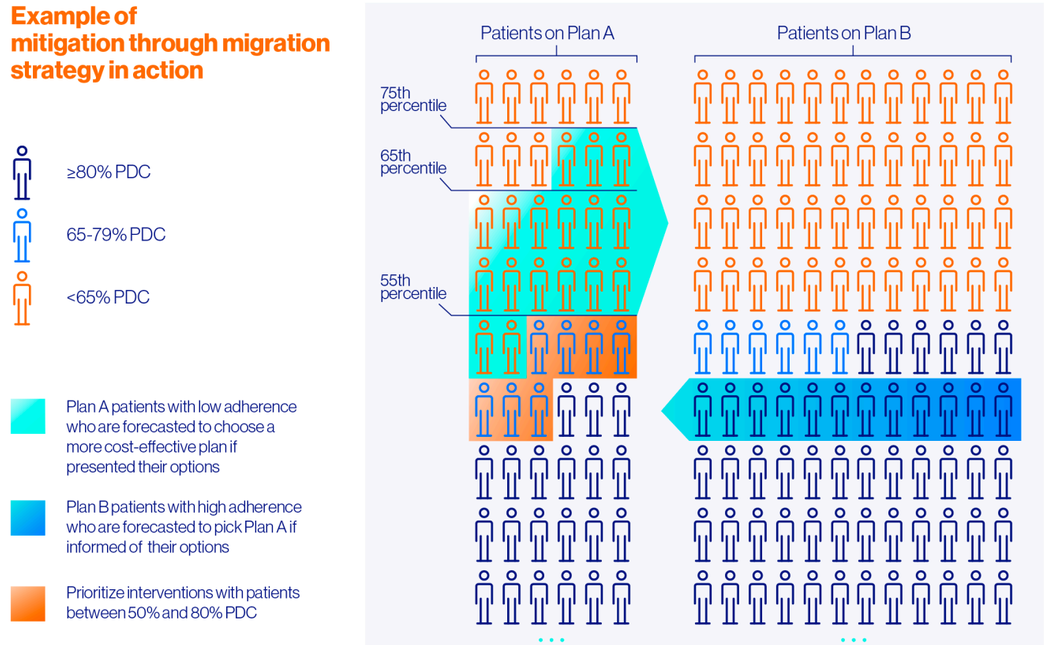
Address nutrient depletion

Another way to prevent non-adherence is to address the reason why your patients stop taking their medication in the first place. Negative side effects caused by drug-induced nutrient depletion or a perceived risk of side effects is a major contributing factor to patient non-adherence. With this in mind, you can offer supplements or alternative treatments that mitigate side effects or help patients course correct if they are experiencing symptoms. Amplicare helps identify patients who may be experiencing adverse side effects from their prescription and provides information to help facilitate patient counseling.

In addition to providing tools to help improve patient adherence, Amplicare also helps mitigate DIR fees through a plan migration approach that takes into account the way plans measure adherence. For instance, certain health plans apply higher DIR fees based on the medication remedy of patients with low adherence. PLAN A's logic for expensing DIR fees to a pharmacy takes into account the adherence levels of patients with diabetes, high cholesterol, and hypertension. For each pharmacy being evaluated, PLAN A applies a percentile scoring on the groups of patients that improve their adherence measures and key metrics. If a pharmacy improves these measurements for their patients with these chronic conditions and score in the 80th percentile, PLAN A will provide rebates and return all DIR fees collected.

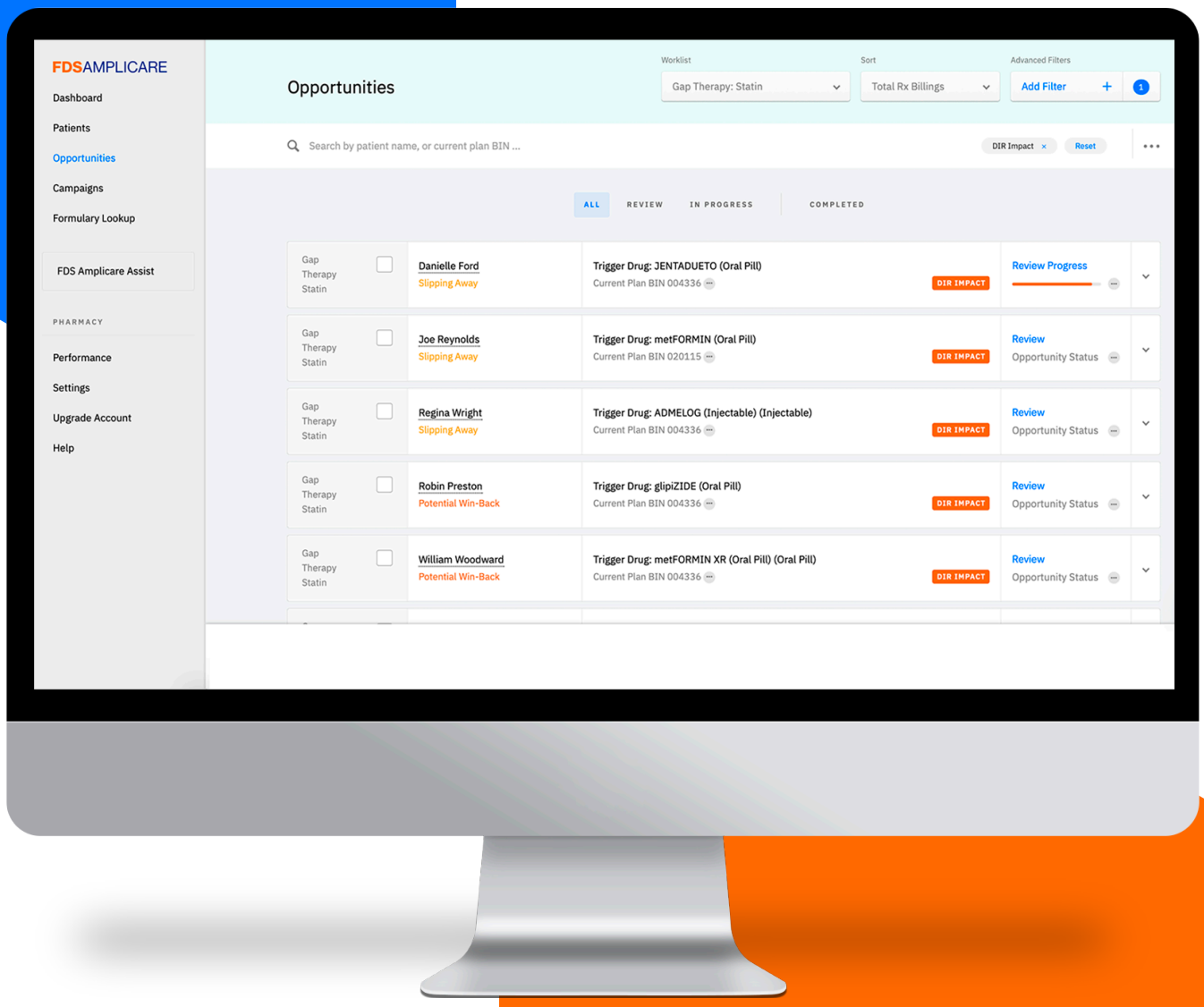
Amplicare identifies these patients, their current health plans, and the maximum DIR fees your pharmacy may incur, and provides recommendations for plans that have the lowest out-of-pocket cost for the patients as well as a positive impact on the pharmacy in terms of reducing DIR fees. The identified patients are forecasted to choose a more cost-effective plan if presented with their options, making plan comparisons a priority for them during the Annual Enrollment Period.

Example of mitigation through migration strategy in action



FDSAMPLICARE

now part of EnlivenHealth™



Learn more about how FDS Amplicare's solutions help you manage your DIR fees. Reach out to: **growth@amplicare.com** or visit **www.fdsamplicare.com**