

WHAT YOU NEED TO KNOW ABOUT CONTRACTING WITH YOUR PBM

Contracting with a pharmacy benefit manager (PBM) has become increasingly difficult. With new "transparent" arrangements, contract terms must be more explicit so that all the parties understand the terms and the operating conditions. Medicare Part D also has complicated the contracting process by adding services required by Medicare Part D providers. Even traditional, nontransparent arrangements must be carefully documented so that both the PBM and the client clearly understand the basic financial terms.

Start with a contract that your own plan has developed, not one offered by the PBM.

When a PBM wants to renew a client's business, the first item sent to the client is a contract from the PBM's legal department. There are many acronyms that must be deciphered in the PBM world: WAC, MAC, BLP, AWP. The PBM's contract is designed to protect the PBM's interests and document how the PBM wants to do business. Rarely is the PBM contract aimed at protecting the interest of the client. In today's "transparent" marketplace, more and more PBMs are accepting contracts initiated by the client.

A "red flag" should go off if the PBM refuses to accept the client's contract for services --if the contract is "reasonable." A reasonable contract is not so one-sided that the PBM cannot administer the plan. For example, don't have performance standards in the contract that are impossible to measure or achieve, such as discounts off average wholesale price (AWP) that are not available in the market place like AWP minus 30% for brand mail order claims. If the PBM turns down a reasonable client-issued contract, it is usually for two primary reasons. The first reason is that the PBM is so inflexible and dominated by its own legal department that it cannot accept any deviation from its standard format. This is a clear sign that the PBM will resist any of the client's requested changes. The second reason is that the PBM does not intend to offer a real transparent relationship. The contract serves to "disclose" what you are not being told, rather than disclosing what you need to know. For example, the contract might disclose that the PBM is retaining "some" rebates but does not disclose the specific type or amount of rebates being retained.

When developing your own contract, ensure that it clearly defines the PBM's responsibilities. Many PBM-developed contracts will have pages of details on what *the plan sponsor's responsibilities* are, such as sending eligibility files timely or providing plan design information 15 days prior to implementation. But the PBM's responsibilities also must be clearly defined. There are seven key pharmacy benefits plan elements that plans want PBMs to "manage" - the "M" in PBM: eligibility, plan design, payment and funding, the account, the pharmacy network, the clinical/rebate/formulary, and information/data. The contract should detail your plan's specific requirements. For example, do you want a dedicated account manager? How often should the account manager meet with you? How quickly do you expect the account manager to respond to your e-mails and phone calls? Do you seek a customized retail pharmacy network? How often do you want the network re-contracted? Make a list of the services and time frames you require from the PBM in each of these areas and then write these expectations into the contract.

If your plan has "special needs," for example, your employees are dispersed throughout 50 locations nationwide or the billing for expenses incurred must be broken down and sent to each accountable location, make sure there are no surprises in extra costs when you ask your PBM to collect 50 wire transfers a month instead of just one from your corporate office.

Major "special needs" clients are Medicare Advantage Prescription Drug Programs (MA-PDs) and Prescription Drug Programs (PDPs) under the Medicare Modernization Act (MMA) that delegate to a PBM all or some pharmacy responsibilities. In 2008, these organizations required transparency at all levels (no additional hidden profit retained between retail payments to the

pharmacies and the amount charged to the plan for the same transaction, no PBM retention of hidden rebates) and will need enhanced reporting and services. In 2010, DIR (direct and indirect reimbursement) must be disclosed to the plan (and that will take a rebate audit to accomplish properly). In particular, these clients need to develop their own contracts that have the appropriate service levels and delegation duties clearly delineated in the contract. Enhanced Fraud, Waste and Abuse (FWA) programs required by Medicare Part D need to be documented in the contractual relationship that include specific Centers for Medicare and Medicaid Services (CMS) required audits of first tier entities (the PBM) and downstream entities (the pharmacies). All downstream entities (meaning all retail and mail order pharmacies and pharmacy personnel) must have Fraud, Waste and Abuse training. Code of ethics programs of the MA-PD or PDP must extend now to the PBM and its retail, mail order, specialty, home infusion and long term care pharmacies. If you are a MA-PD or PDP, don't be afraid to offer the PBM your contract specific to your arrangements with CMS. In fact, you will need your own enhanced contract terms with your programs and procedures documented in order to pass a CMS audit.

Once you have established the services you want from your PBM (or have negotiated with the PBM or documented the services you currently have with your PBM), obtain assistance from in-house counsel (or external counsel) on standard legal phrases that also need to be included in the contract. Key clauses in a standard contract include *termination rights, payment terms, audit rights, indemnification, dispute resolution, confidentiality, exclusivity and general notices*.

Give the PBM a chance to review your contract to make sure it meets the PBM's standard operating procedures. Contract negotiation by definition is a give and-take situation, so allow yourself the same flexibility that you expect from your PBM. For example, will paying the PBM within five days, instead of ten days of receiving its invoice, work with your system? Comply immediately with the PBM's funding requirements to pay the network pharmacies promptly, but ensure that you can dispute flawed invoices after payment.

Define EVERYTHING

The definition section of a contract is vital and should be as specific as possible. In an industry with as many unique terms as the PBM industry has, make sure both you and your PBM clearly understand key terms. Here are several examples of terms that should be defined:

● **MAC pricing.** The list used to price generics should be clearly defined: what source is the basis of generic pricing? How often is the list updated? Does the plan sponsor have the right to refuse MAC pricing (pricing should be "market competitive" - your MAC list should not include prices like \$150 for 30 days of generic Prozac)? Is there a performance standard that MAC pricing should be applied to at least 90% of the claims and in aggregate perform at AWP minus 60% for both retail and mail order prescriptions?

● **Brand and generic drugs.** It may sound like simple terms, but how should branded generics be categorized (inexpensive brand drugs used as the generic)-as a brand or generic? What if the brand drug is not allowed to be substituted with a generic drug in a given state? How are copayments assigned to these drugs that are both "brand" and "generic"? How are these drug categorized for calculation of generic performance standards?

● **Rebates.** What rebates are considered to be manufacturer money paid to the PBM? Rebates come in all sorts of shapes and colors: base rebates, access rebates, cost effectiveness rebates, market share rebates, disease management fees, administrative fees, data selling fees, information access fees, sales target fees, discounted goods, prompt payment discounts...which ones of these "rebates" accrue to the plan sponsor and which ones does the PBM retain? Defining exactly what is a rebate and what the PBM retains is important in making sure you get what you bargained for.

● **Transparency.** What is a "pass-through" deal? Transparency does not necessarily mean disclosure. Some PBMs sell a "transparent" arrangement and when the contract comes out, transparency means that the PBM discloses what they are not telling you (i.e., the PBM takes additional profits on retail claims, but the plan sponsor can't know how much). Make sure your definition of transparency is the same as the PBMs.

● **Paid Claim.** Does a paid claim mean one that is approved by the PBM and later is reversed or "backed out" by the pharmacy because the patient never picks up the prescription order? Do you pay a claims processing fee on both the paid claim and the reversed claim?

● **AWP Rollback.** On September 26, 2009 the two industry pricing guides "rolled up" all AWP pricing as a result of a court settlement requirement. Essentially, the court settlement required a small subset of brand drugs, which the pricing guides had allegedly artificially increased the AWP price from Wholesale Acquisition Cost (WAC) times 1.25 to be rolled back to 1.20. Instead of the small subset, all brand drugs which the pricing guides had set at AWP times 1.25 were rolled back to 1.20, affecting 92% of brand costs. This caused the PBMs in their mail order facilities to lose money – and their "retail pharmacy partners" to also lose out. As a reactive strike against plan sponsors, PBMs then rolled up the roll back to make sure pharmacies (both retail and owned mail order) didn't lose out at the detriment of plan sponsors. Make sure you know what your PBM did, that you agreed to what your PBM did and that what was done was a contract amendment that you can use to audit to make sure the PBM did what they said would happen with this industry change.

Understand Your Rights to Audit

No one likes the auditor. But it is good business practice to make sure you received the terms you contracted for with your PBM. Average wholesale price (AWP) is the price basis today of all discounts in prescription drug programs (i.e., retail discounts are typically 15% off AWP). Medispan (a Wolters Kluwer Publication) and First DataBank publish AWP information, which is the price recommended by drug manufacturers. So, each drug has a corresponding AWP price. Since AWP information is not readily available (it is "sold" by Medispan and First DataBank and is not available without a purchasing license), a plan sponsor cannot check to see if the discounts off AWP were taken correctly by the PBM. Many plan sponsors must then outsource for an audit. But what happens when the PBM refuses to allow your auditor to audit your program? "A mutually acceptable auditor" is not a clause that should ever be in a contract. If you retain a qualified audit firm (with years of experience, clinical and financial staff), the firm that you select should be acceptable to your PBM. A PBM that has "mutually acceptable" language rarely finds an auditor that is "mutually acceptable," unless, of course, the auditor has a conflict of interest because the PBM retained it to perform services for the PBM. Make sure your contract allows only the plan sponsor, not the PBM, to select the auditor.

The scope of the audit is another issue that the contract must document. A client thought it had a transparent relationship with its PBM and requested an audit. Although the PBM complied with the audit request, it limited the audit to five rebate contracts (most PBMs contract with anywhere from 20 to 80 prescription drug manufacturers). This severely limited the audit and in essence did not provide meaningful results to determine if the PBM was administering the rebate contracts in accordance with the contract terms (or "100% pass through" of rebates). Other PBM audit "scope limiting" practices include having the auditor sign a confidentiality agreement that exceeds the scope of the audit (i.e., auditors cannot work for plaintiff's attorneys) and limits the audit to samples, rather than 100%, of the claims.

Document ALL pricing terms

Of course, the contract must document specific negotiated discounts and arrangements. Most contracts do document the discounts off AWP and dispensing fees for brand drugs. Some contracts even will state that generic drugs will be charged at MAC prices plus a dispensing fee. MAC prices apply to generic drugs and are developed by each PBM as the price list for generic drugs. But how should generic drugs be priced when a MAC price is not available (meaning MAC pricing applied to generics with more than two manufacturers, therefore, new generics do not have MAC pricing typically established for six months)? Also, even with brand name drugs, are the discounts absolute (meaning that ALL brand claims will be paid at AWP minus 15%) or an average (meaning that some will be paid at AWP minus 14% and some at AWP minus 16% and on average, brand claims will be priced at AWP minus 15%)?

Specialty drug pricing is often not included in contracts. Specialty drugs are those very expensive biotechnologically-developed drugs. There are no established lists of biotech drugs, and specialty drug classification is not obvious to plan sponsors. There is nothing "biotech" about the drug Neurontin, but one PBM "assigned" specialty pricing of AWP plus \$6 to the claims when the claim should have been paid at the mail order brand rate of AWP minus 22% with no dispensing fee. Make sure that the PBM contract includes a separate list of drugs the PBM considers specialty drugs and the specific price for every specialty drug. Specialty drug pricing can range from AWP minus 15% (specialty pricing should never be higher than retail pricing because then the member should obtain the medication at a retail pharmacy) to AWP minus 50%. On a drug price of \$1,000 a month, there is a huge financial difference between a 15% discount and a 50% discount. Make sure each drug is listed on an exhibit to your contract and the discount off AWP is clearly stated.

Compounds, drugs that are mixed at the pharmacy, should also be stated in terms of what the discount arrangement should be under the contract. Typically, only the prescription ingredient is paid and at the corresponding discount (AWP off the brand discount if the ingredient is a brand and the MAC price if the ingredient is a generic). Some PBMs will add a slightly higher dispensing fee for the pharmacist's efforts. Nonetheless, the discount terms for compounds should be in the contract. Sales tax applies in some states (Illinois and Louisiana) and the PBM's system should never allow more than the state imposed sales tax (for Illinois, the limit, based on the municipality, is 2.5%).

If you contract with medical providers to also provide pharmacy services (on a minimum premium or self insured basis), make sure all of the pricing terms are documented in the contract. Some medical insurers will not document pharmacy discounts in the contract with clients. Stay away from those providers. Pharmacy discount arrangements that cannot or will not be documented mean that the subcontracted or wholly owned PBM of the insurance company can charge you whatever they want for pharmacy claims and you have to pay that price.

Get Help

Whether you are developing your own PBM contract or trying to negotiate your PBM's contract, you are not alone. Certainly, as the person responsible for the pharmacy benefit, you need to first consult your own internal resources. The legal and finance departments within any corporation can provide first level assistance with the contract design and financial terms, respectively. But, typically, in-house corporate counsel are not PBM industry experts. Therefore, you may need to seek external counsel that has expertise in the pharmacy benefit industry. Make sure external counsel knows the difference between AWP and MAC, for example, and has prior experience with the PBM industry. Litigators who have tried PBM cases are particularly good at finding clauses within the contract that can later derail your program.

PBM consultants and auditors are also good sources to add when developing or negotiating these contracts. The contract should also be reviewed by a pharmacist (especially for the Specialty Drug list). Contracts cannot be reviewed too many times. Obtain consensus within your

organization and with outside assistance. Sometimes three months may be required to develop a contract that meets the needs of your organization before the contract is given to the PBM to review. You will be better off for doing the homework up-front rather than leaving it to the PBM to "develop it for you."

Pharmacy benefit management has become more complicated, with the following litany of factors: 55,000 pharmacies, 12,000 unique drugs, over 500,000 physicians in the United States, pricing terms that are misunderstood, a multitude of acronyms, and the status of PBMs as the "middleman" between plans and patients. Thus, it is no wonder that contracting a relationship that governs all of these parties can be cumbersome. However, with some internal and external help, you can customize your contract and save your plan from costly mistakes.