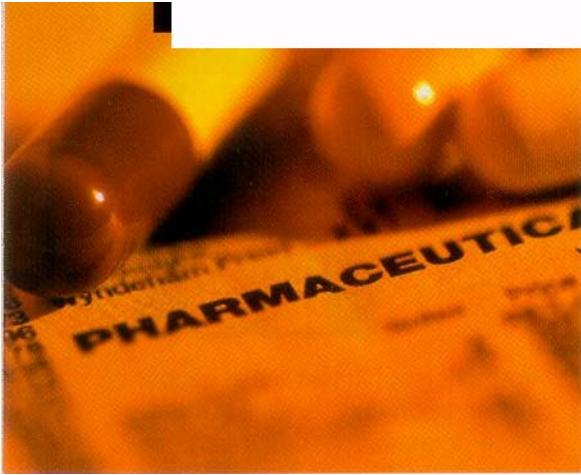


Key Issues Often Not Addressed in Physician Organizations' Pharmacy Benefit Contracts



BY CRAIG STERN, PharmD, MBA

"We found that the vast majority of contracts between groups and health plans lacked the most elemental safeguards for the groups."

PHARMACY utilization is a factor in health plan contracts with physicians, whether it is explicitly stated or not. Implicit risk is included in lowered medical reimbursement schedules that factor in pharmacy losses. Explicit risks are addressed by and included in risk contracts. In consulting with groups for the last 15 years, our firm has seen the entire spectrum of risk to no-risk contracts. This article is an overview of what we have learned from this experience.

While there are several reasons why groups assumed pharmacy risk, their signed contracts generally contain short, detail-deficient paragraphs with few safeguards. Pharmacy risk should be considered as a business like any other, and entered into with the same due diligence. We found that the vast majority of contracts between groups and health plans lacked the most elemental safeguards for the groups. As a result, we designed a model contract that could be used as a basis for groups, their attorneys and consultants to construct mutually beneficial contracts.

In our experience group governance, implementation strategies, and market factors are crucial elements to establish before entering into any agreement or risk contract. After the

infrastructure issues are addressed, attention should be focused on revenues, billing, exclusions, guarantees and other key issues. The following discussion contains general considerations that apply equally to risk, capitation and non-risk agreements.

Revenue allocation issues

While mutually agreed upon rates on a per-member-per-month (PMPM) basis for all members assigned to the group are basic, data and cost analysis are equally vital. Agreements should include provisions for plans to provide electronic data for pharmacy claims, analysis of historical costs, and ongoing advice and support in managing the pharmacy costs for the mutual benefit of both parties. In addition, health plans should agree to operate under the group's best practice guidelines and/or formulary, and must agree to provide a specific stop-loss per member at a trigger point to be mutually agreed upon prior to implementation of the agreement.

Plans should pay or allocate expenses to the group based on current actual experience of the group, minus some mutually agreed upon discount (e.g., 10%) plus an inflation factor (e.g., 18%). This should include eligible membership for capita-

tion-based agreements. In subsequent years the billing or allocation rate should be based on the prior year's experience, minus some agreed upon discount plus a fee (e.g., the Consumer Price Index + 3 %). The CPI represents the CPI for pharmacy inflation, which is generally greater than the general health care market basket CPI. Yearly adjustments in rates should be based on the CPI for prescription medications.

If the CPI used is the general health care CPI, or the market basket CPI, then the inflation factors must be renegotiated each subsequent year to ensure that the inflation formula is tracking the drug cost inflation on a yearly basis.

The "actual amount paid" or allocated for medication cost should include a formula (e.g., Ingredient Cost + Pharmacy Fee - Copay), to ensure that expenses are equitably allocated. Agreements may include brand and generic costs. Brand costs should be based on Average Wholesale Price (AWP), while generic costs should be based on Maximum Allowable Cost (MAC). "Usual and Customary" (U&C) fees should generally be excluded from consideration.

In order to ensure appropriate allocation of funds and to monitor the progress of the group in its utilization programs, accurate data is critical. All agreements must include the provision of pharmacy electronic claims detail supplied in a standard, currently NCPDP3.2, format. Data should be evaluated for eligibility to ensure that the group has not been charged for non-participating physicians, and that the claims paid are complete and valid for physician identifiers (e.g., DEA), pharmacy identifiers (NABP) and member numbers.

In addition, groups should reserve the right to audit all data elements related to the computa-

tion and reporting of pharmacy experience, including adjustments for formulary changes that adversely impact the group. All expenses must be accounted for monthly, and in the event that the plan does not provide data in a timely manner, the plan should neither allocate nor indemnify the group for any deficits for the period that data was not submitted.

Dealing with exclusions

If the plan changes the pharmacy benefit plans and copays, the price paid to the pharmacy, or the dispensing fee, the pharmacy allocation must be adjusted to reflect any changes in cost. In addition, the following benefit modifications should be excluded from consideration:

1. Pharmaceutical agents utilized for the purpose of weight reduction
 2. Over-the-counter products currently not included as a benefit
 3. Smoking cessation products currently not included as a benefit
 4. Pharmacy-related devices, appliances or diagnostics not included in the covered benefit
 5. Medications and supplies otherwise recoverable under Workers' Compensation, medically indigent (MIA) programs, or any other state or federal government programs for which no charge is made to the patient
 6. Dietary supplements
 7. Medications administered to the member by the physician (or other provider) or a member of the physician's staff
 8. Pharmacy impact on medical utilization
- The group should track the PMPM for drugs by primary care

physician and compare that figure with the PCP's hospital, emergency department, surgical, encounter and lab billings on a quarterly or bi-yearly basis. Results for PCPs with high-cost pharmacy PMPMs, but lower-cost global medical indicators, should be shared with plans annually and used as a basis for re-negotiation of the risk or allocation rate based on the per-capita impact.

If the acuity of the group's population increases each year as measured by the age/sex distribution of the pharmacy claims, or the appearance of catastrophic newly diagnosed illness, then the rates or allocations should be renegotiated each year to reflect the inflation factor adjustments required for a more acute population.

Handling carve-outs

In developing contracts, the group should carve-out high cost drug classes for cancer chemotherapy, immunosuppressive agents, cystic fibrosis agents and AIDS medications. A regional and statewide benchmark PMPM for each of these categories should be required of the plan. In tandem, the group should establish best practice guidelines for the prescribing of these medications and a drug utilization review program that calls for regular review and management.

It is also important that the plan evaluate the impact of new technology, therapeutic modalities, or vaccines and biotechnology agents that are included in the pharmacy benefit. Appropriate adjustments should be made to the allocation formula, including adding a 10% risk corridor to be applied to the group, and the plan should cover residual reinsurance. As a practical matter, the risk adjustments should occur within the next succeeding quarter after the new technology is implemented and/or the plan approves the therapeutic modality.

Allocating surpluses and deficits

In the event that medical rates could be increased if pharmacy utilization improves, any surplus or deficit from pharmacy should be allocated on an equitable basis. Surpluses should be distributed 100% to the group, and deficits shared on an equitable basis between the two entities. In addition, the contract should allow the group to receive a maximum or 100% of applicable rebates collected by plan in relation to the group's pharmacy experience, minus an administrative fee of 10% to 12%.

Best practice and formularies

Changes in the pharmacy benefit generally include changes in the formulary and changes in the global medical costs impacting pharmacy, for example, vaccine coverage. Any changes made by the plan must be evaluated for their impact on the group's pharmacy expense - with an appropriate adjustment made in the group's medical allocation. Ideally, these changes must be applicable to the results of the succeeding quarter after the plan has approved the formulary changes.

Catastrophic illness or adverse selection covered by health plan language, or changes in the benefit/formulary, should include changes in the allocation rate plus a 10% stop loss corridor - with the plan assuming responsibility for residual reinsurance.

Insisting on annual review

It is important that the contract call for the group and the plan to meet annually to review changes in the factors impacting pharmacy costs, including the age and sex mix of members. In addition, the method of budgeting or allocating pharmacy ex-

penses should be set on a consistent year-by-year basis, using a base year's expenses as the starting point. Subsequent-period budgets should be based on the actual experience of the prior periods.

One of the most critical pieces of any agreement is a reciprocal performance guarantee. In our experience, these are almost universally absent in agreements we have reviewed. The following examples cover applicable guarantees:

Performance guarantees

Pharmacy data must be complete and available on a monthly/quarterly basis. Data not delivered to group within the contracted time will be grounds for refusal of assumption of pharmacy allocation for the unreported time period.

The pharmacy claims detail must include a written summary of the quantity and totals of data tape content. The minimum summary must include a total number of valid claims (total claims amendments), total number of claims reversals or amendments, and the total ingredient cost.

Plan provides regional and statewide benchmark data on a quarterly basis: including PMPM; Rx PMPM; generic substitution rate percentage; and for selected therapeutic categories the PMPM, Rx PMPM or number of prescriptions per 1,000 population.

The pharmacy allocation will be reconciled quarterly, with applicable adjustments accruing to group within the next calendar quarter and including applicable rebates credited to the group.

All claims fields must be completed accurately and according to established audit criteria by which the plan audits pharmacies for compliance. Every effort should be made by the plan to

verify and audit the veracity of a prescription by including prescriber name and DEA number. The results of such audits must be made available to the group every six months.

A method for dispute resolution must be established with mutually agreed upon response times, but within no more than two weeks of the date of the original complaint.

Group performance guarantees

All parties will make every reasonable effort to educate physicians in the terms of participation in the agreement.

The group will maintain and provide to the plan on a monthly basis a complete listing of authorized panel prescribers including: first and last name, DEA number, medical specialty, subgroup or IPA, or residency or emergency medicine affiliation. Manage the carve-out medication categories as per group's best practice and formulary guidelines, and report compliance with pre-established quality indicators, clinical and financial results on an annual basis.

The above criteria should be used as a template for contracting or agreements. While not all elements may be included in these agreements, all elements should be considered for their appropriateness within the context of each group and the achievement of its financial goals. Educated and prepared groups have the opportunity to optimize their revenues and minimize their risks, especially when pharmacy costs are a factor.

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