Pharmacy Benefits Manager Toolkit

for Ryan White HIV/AIDS Program
AIDS Drug Assistance Programs

January 2019

Purpose Statement

This toolkit is designed to assist Ryan White HIV/AIDS Program (RWHAP) AIDS Drug Assistance Programs (ADAPs) through the planning, selection, and implementation of a pharmacy benefits manager (PBM) contract for administrative management of their program.

ADAPs are funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. These programs provide life-saving HIV treatments to low income, uninsured, and underinsured individuals living with HIV in all 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, the Republic of Palau, the Federated States of Micronesia, American Samoa, and the Republic of the Marshall Islands. Since the advent of highly active antiretroviral treatment (HAART) in 1996, AIDS deaths have declined and the number of people living with HIV has markedly increased. ADAP has played a critical role in making antiretroviral treatments more widely available.

NASTAD is funded under Health Resources and Services Administration (HRSA) Cooperative Agreement U69HA26846 to provide states and territories with technical assistance on RWHAP Part B and ADAP administration. RWHAP Part B recipients (including ADAPs) may also obtain technical assistance through their HRSA project officer.

Table of Contents

What is a PBM?

Overview: Pharmacy Benefits Managers (PBMs)

Ryan White HIV/AIDS Program (RWHAP) AIDS Drug Assistance Programs (ADAPs) often contract with third parties to provide pharmacy services to their clients. These services can generally be divided into two categories: direct pharmacy services provided by Pharmacy Benefits Managers (PBMs) and benefit coordination services provided by Insurance Benefits Managers (IBMs). Direct pharmacy services are typically designed for uninsured ADAP clients, while benefit coordination services support insured ADAP clients. Direct pharmacy services may include the establishment and maintenance of an ADAP formulary, establishing a network of pharmacies that distribute drugs to uninsured ADAP clients, negotiating contracts with wholesalers and pharmacies, and processing the delivery of drugs to uninsured ADAP clients. Benefit coordination services may include coordinating cost-sharing payments to pharmacies, establishing a network of pharmacies that accept ADAP cost-sharing payments, processing claims data to support ADAP rebate submission, and facilitating insurance premium payment for ADAP clients.

PBMs are the contractors for direct pharmacy services. While many ADAPs may use the same contractor for both their direct pharmacy services and benefit coordination services, PBM services only include direct pharmacy services. This is consistent with industry definitions of a PBM; typically, PBMs coordinate the pharmacy benefit design for an insurance company, establishing the formulary and pharmacy network. When utilizing the same contractor for both direct pharmacy services and benefit coordination services, ADAPs should separate the two sets of services to ensure clear and explicit contracting. The type of direct pharmacy services and benefit coordination services contracted by an ADAP will vary widely, depending on whether the ADAP uses a central pharmacy model for either insured or uninsured clients.

Source

The following information is an excerpt from the HRSA's HIV AIDS Bureau (HAB) Division of State HIV/AIDS Programs ADAP Manual (2016). The Manual can be accessed online here.

> *ADAPs can choose to utilize a PBM to provide administrative and pharmacy claim adjudication services. PBM services can include: contracting with a network of pharmacies; establishing payment levels for provider pharmacies; negotiating discount arrangements with wholesalers; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs. Many PBMs also operate mail order pharmacies or have arrangements to include prescription availability through mail order pharmacies. In addition to a PBM's combined purchasing power, it can provide a wide-range of administrative and drug utilization services that can benefit an ADAP. Administrative functions typically include:*

- *Establishing and maintaining a network of providers (recruit and manage a network of pharmacies that fill prescriptions for Ryan White HIV/AIDS Program (RWHAP) ADAP clients; negotiate prices and payment terms and contract with pharmacies, monitor/audit performance).*
- *Centrally process claims in real time, claim adjudication, record keeping and reports to clients, payment to providers and fiscal intermediaries (e.g., processing of co-payments, deductibles for medications; track data required to receive rebates; performing electronic split billing at pharmacy point of service, pay pharmacy invoices, and bill ADAP; manage rebates and discounts with pharmaceutical companies; serve as electronic data transfer agent to meet all requirements related to Medicare True Out-of-Pocket (TrOOP) payments [serve as TrOOP coordinator and prepare reports]; paying health insurance co-payments and deductibles).*
- *Assist with benefit design and business rules (covered drugs, exclusions, limits cost-sharing provisions [differential co-payments for generic or preferred drugs], mail-order dispensing).*
- *Information management (risk assessment, profiling).*
- *Continuous electronic insurance eligibility checking.*
- *Pharmacoeconomic studies.*

In addition, PBMs perform a variety of drug utilization functions. These services generally involve "managing" drug utilization to reduce costs and maintain or improve quality. These functions include policies and programs to affect prescribing and dispensing patterns and are targeted towards pharmacists, patients, and prescribers. The range of drug utilization functions that a PBM can offer include:

- *Formulary and formulary related activities (e.g. rebate management, prior authorization therapeutic interchange).*
- *Drug use review (retrospective-drug utilization review (DUR), prospective-DUR [some PBMs use the term "concurrent-DUR"], DUR interventions, "academic detailing," provider education).*
- *Disease management (therapeutic outcomes management).*
- *Patient compliance (patient education, e.g., newsletters; phone reminders).*

PBMs may charge a per transaction administrative fee, depending on the number and extent of services that they are contracted to perform. The fees charged, if any, are dependent on the contract terms negotiated between the ADAP and PBM. ADAPs that contract with a PBM pay for the cost of the drug, the pharmacy dispensing fee, and an additional per claim administrative fee. In some cases, the administrative fee is rolled into the dispensing fee charged per prescription. The costs of a PBM are considered a "direct service" and do not count against a Ryan White HIV/AIDS Program Part B recipient's 10% administrative cost cap.

ADAPs and PBMs

States and territories may choose to use a PBM to provide administrative and pharmaceutical claims adjudication services for at least a portion of their traditional ADAP (full payment of medications). ADAPs cite many reasons why they have contracted with a PBM, including:

- Reduction in administrative costs;
- Improvement in the efficiency of services provided to clients;
- Assistance in eligibility screening to ensure payer of last resort;
- Streamlining of the ADAP prescription and payment delivery system, including inventory control;
- Management of rebate processing;
- Assistance with contract and compliance monitoring of ADAP providers;
- Development, implementation, and maintenance of an online claims processing database that will track and approve medication dispensing claims;
- Creation and submission of monthly invoices on behalf of the ADAP pharmacies with preapproved ADAP allowable claims;
- Production of bi-weekly, client-level data regarding number of clients that picked-up their medications on time. This information can be shared with case managers to contact clients to assist with addressing any mitigating barriers;
- Ensuring accurate third-party billing occurs at each dispensing transaction by rejecting medication dispensing claims submitted by pharmacist for clients that have other insurance types;
- Assistance with claims data and aggregate reporting to submit to pharmaceutical companies to begin receiving rebates.

Client information utilized by contracted PBMs contains protected health information (PHI) and is often considered part of a client's medical record. This makes the information subject to privacy and confidentiality standards, including the Health Insurance Portability and Accountability Act (HIPAA). ADAPs must ensure that its contracted PBMs utilize security and administrative controls to protect client information and should work with their legal counsel to determine the appropriate language to be included in contracts. A sample business association agreement (BAA) is available to view here.

Insurance and PBM Utilization

ADAPs and Insurance

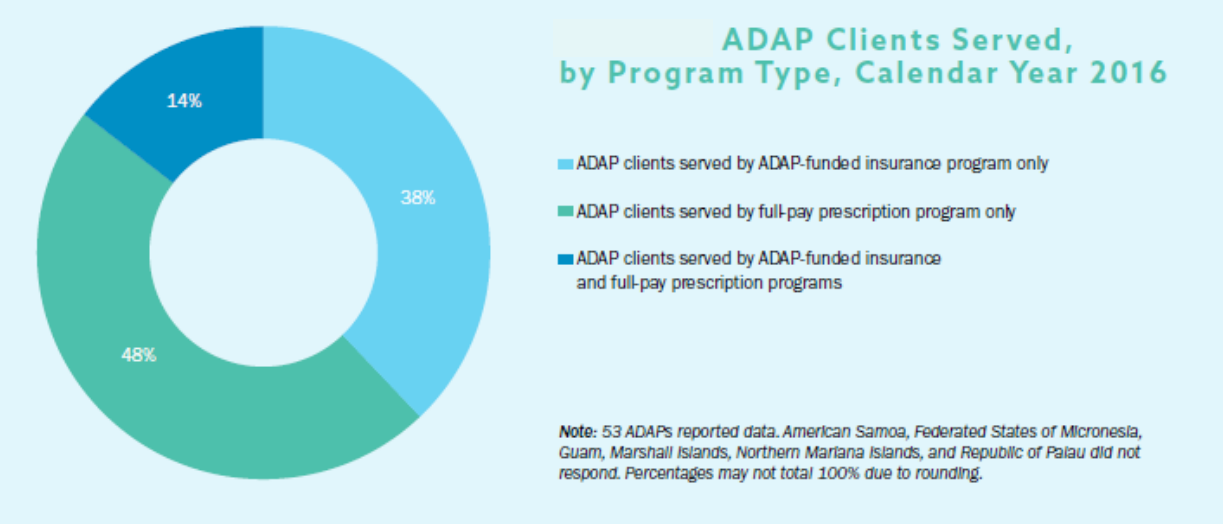
The RWHAP legislation allows states and territories to use ADAP dollars to purchase health insurance and pay insurance premiums, co-payments and/or deductibles for individuals eligible for ADAP, provided the insurance has comparable formulary benefits to that of the ADAP and is cost-effective to the ADAP.

Per HRSA guidance, funds designated to carry out the provisions of Section 2616 of the Public Health Service Act may be used to purchase health insurance whose coverage includes the full range of HIV treatments and access to comprehensive primary care services, subject to the conditions:

1. Funds must continue to be managed as part of the established ADAP.
2. ADAPs must be able to account for and report on funds used to purchase and maintain insurance policies for eligible clients including covering any costs associated with these policies.
3. Funds may only be used to pay for health insurance plans that at a minimum provide prescription coverage that includes at least one U.S. Food and Drug Administration (FDA) approved medicine in each drug class of core antiretroviral medicines per the U.S. Department of Health and Human Services' Clinical Guidelines for Treatment of HIV.
4. The annual aggregate amount spent on insurance coverage (e.g., premiums, cost-sharing assistance) cannot be greater than the aggregate annual cost of maintaining that same population on the full-pay prescription program.
5. Funds may be used to cover any costs associated with the health insurance policy, including co-payments, co-insurance, deductibles, or premiums to purchase or maintain insurance policies.
6. Current client eligibility guidelines, set under Section 2616(b) of the Public Health Service Act, must be followed.
7. The States and territories must maintain their contributions to their HIV-related activities as required under Section 2617(b)(7)(E).
8. RWHAP funds must be the payers of last resort for pharmaceuticals.
9. The state/territory must assure that ADAP funds will not be used to purchase health insurance deemed inadequate by the state/territory in its provision of comprehensive primary care services. [1]

States and territories are increasingly using ADAP funds for health insurance assistance. According to the National RWHAP and ADAP Monitoring Project *Annual Report* released in May 2018, the majority of clients served by ADAPs in calendar year 2016 received services via an ADAP-funded insurance program (i.e., a premium, deductible/co-payment/cost-sharing payment was made on their behalf by the ADAP).

[1] HRSA policy notice 18-01



ADAP Expenditures for Insurance

- Fifty-one ADAPs reported using funds for insurance purchasing/continuation representing $398 million in estimated expenditures in calendar year 2016.
- In calendar year 2016, over 120,000 ADAP clients were covered by such arrangements.
- Spending on insurance purchasing/continuation represented an estimated $3,301 per capita in calendar year 2016 and 20% of the total ADAP budget.

For more information, see the National RWHAP Part B and ADAP Monitoring Project *Annual Report*.

As first specified in a HRSA program letter dated April 29, 2005, ADAPs are permitted to file for full rebates on partial payments of health insurance expenditures, though some company-specific rebate agreement restrictions may apply. Below are key resources NASTAD has produced related to ADAPs and rebates:

- Best Practices for Shared ADAP and 340B Drug Pricing Program Clients
- Back to Basics: ADAP and the 340B Program - 101

Summary of Services ADAPs May Contract via PBMs

The following details ADAPs' possible uses of PBMs, AIDS Service Organizations (ASOs)/Community Based Organizations (CBOs), and internal systems to operationalize services and program responsibilities (e.g., payment of premium/deductibles, prescription co-payments, and medical co-payments):

- **ADAP Coordination with Insurance and Other Payers:**
  - Premiums/deductibles payments
  - Medical co-payments/co-insurance
  - Prescription co-payments/co-insurance
  - Coordination of benefits
  - Cost-recovery from other payer sources (i.e., Medicaid, Medicare, private insurance)
  - Eligibility/enrollment with other payer sources
  - Electronic claims adjudication
- **Pharmacy Management and Drug Pricing:**
  - 340B inventory management
  - Pharmacy network management
  - Prescription co-payments/co-insurance
  - Pharmacy reimbursement
  - Collection of rebates
- **Clinical Management:**
  - Clinical support (i.e., adherence monitoring)
  - Step therapy/prior authorization
- **Program Administration:**
  - Data collection and management
  - Eligibility management
  - Formulary management
  - Member identification card processing
  - Production of data reports
  - Trainings
  - Utilization evaluation

PBM: From Request for Proposal (RFP) to Implementation

Example of PBM Selection and Implementation, Step-By-Step

Request for Proposal (RFP)

1. Prepare the Scope of Services
2. Compare the state/territory's Scope of Services with other Ryan White HIV/AIDS Programs' Scope of Services
3. Submit the Scope of Services for approval as per state/territory procurement process
4. Publish RFP as per state/territory procurement process
5. The procurement staff reviews proposals
6. Ensure that all requirements of the RFP are responded to as written and requested
7. The procurement staff conducts an Interview and Evaluation process in conjunction with Ryan White HIV/AIDS Program staff
8. Select the PBM which best meets state/territory's needs

Implementation

- Pre-implementation meetings
  - Discovery meeting held with PBM
  - Schedule weekly implementation calls with PBM
- Contract status
  - Discuss contract strategy with PBM, (e.g., point of contact, staff responsible for managing contract)
  - Finalize and execute contract
- Eligibility Process
  - Discuss eligibility process, update frequency, and type of file
  - Determine method of transmission
  - Determine ID number origin and additional requirements
  - Perform first eligibility test file
  - Discuss test results with PBM
- Medicare Part D Data Sharing
  - Determine that PBM will assist with Centers for Medicare and Medicaid Services (CMS) file submission/data sharing
  - PBM initiate contact with CMS to begin data exchange implementation
  - PBM will send first test file to CMS
  - PBM will send first production file to CMS
- Finance
  - Determine billing/finance point of contact

    - Determine billing frequency
    - PBM provide a sample of invoicing reports and billing information

- ID Card Production
    - Discuss ID card layout with PBM
    - Determine mode of distribution and timeline for delivery of cards
    - Receive ID card and welcome letter draft from PBM
    - Provide approval of ID card and welcome letter

- System Access
    - Provide staff names for access to PBM system
    - Implementation of set-up and training by PBM

- Member Service
    - Set-up services support needs, i.e., business hours, after-hours, weekends, holidays
    - Implement dedicated PBM toll free number for pharmacy services

- Pharmacy Network
    - PBM execute contracts and set-up with pharmacies

- Reporting
    - Provide PBM with reporting needs and frequency of plan performance reviews

- Rebate Administration
    - Discuss rebate needs and the need for recoupment services

PBM Contact List

The following details contact information for the primary points of contact for the PBMs with which ADAPs most frequently contract.

CVS Caremark
Name: Jackie Holtorf
Phone: 480-391-4652
E-mail: jacquelyn.holtorf@cvshealth.com
Mailing Address: 9501 E. Shea Blvd.
Scottsdale, AZ 85260

Name: Prem Shah
Phone: 401-447-7220
E-mail: Prem.Shah@cvshealth.com
Mailing Address: 2211 Sanders Road,
Northbrook, IL 60062

Name: Yordans Mosquera
Phone: 401-335-7297
E-mail: Yordans.Mosquera@caremark.com
Mailing Address: 2211 Sanders Road,
Northbrook, IL 60062

Data Rx
Name: Louise Gustafson
Phone: 678-845-7591
E-mail: louise.gustafson@data-rx.com
Mailing Address: 5920 Odell Street
Cumming, GA 30040

DXC Technology
Name: Karen G. Mariano, RPh
Phone: 401-784-3824
E-mail: karen.mariano@hpe.com
Mailing Address: 301 Metro Center Blvd.
Suite 300
Warwick, RI 02886

Magellan Health Services
Name: Lisa Irwin
Phone: 717-421-4907
E-mail: LMIrwin@magellanhealth.com
Mailing Address: Willard Office Building,
1455 Pennsylvania Ave NW # 40
Washington, DC 20004

Molina
Name: Zachary Garnes
Phone: 304-340-2773
E-mail:
zachary.garnes@molinahealthcare.com
Mailing Address: 200 Oceangate, Suite 100
Long Beach, CA 90802

MC-21, Corp.
Name: Mari Tere Ramos
Phone: 787-286-6032
E-mail: mramosa@mc-21.com
Mailing Address: MC-21 Call Box 4908
Caguas, P.R. 00726

NuCara Pharmacy
Name: Julia Johnson
Phone: 641-777-0159
E-mail: jjohnson@nucara.com

PANTHERx Specialty Pharmacy
Name: Robert Snyder, PharmD, MBA
Phone: 724-971-3378
E-mail: rsnyder@pantherspecialty.com
Mailing Address: 24 Summit Park Drive,
Pittsburgh, PA 15275

Perform Rx
Name: Correen Macchi
Phone: 314-872-1334
E-mail: cmacchi@nextgen.com
Mailing Address: HSI/NextGen Healthcare
1836 Lackland Hill Parkway
St. Louis, MO 63146

ProCare Rx
Name: Wendy Bruce
Phone: 678-622-9499
E-mail: wbruce@procarerx.com
Mailing Address: 1267 Professional Pkwy
Gainesville, GA 30507

Ramsell Public Health Corporation
Name: Chris Hanson
Phone: 510-219-6061
E-mail: chanson@ramsellcorp.com
Mailing Address:
200 Webster Street, Suite 200
Oakland, CA 94607

Name: Sophia Byndloss
Phone: 510-587-2606
E-mail: sbyndloss@ramsellcorp.com
Mailing Address:
200 Webster Street, Suite 200
Oakland, CA 94607

ScriptGuide Rx
Name: Ime Ekpenyong;
Phone: 313-498-8981
E-mail: iekpenyong@scriptguiderx.com
Mailing Address: 15400 E Jefferson Ave
Grosse Pointe Park, MI 48230

Name: Heather Hage Kosalski
Phone: 313-498-8981; 313-821-3200
E-mail: hhagekosalski@scriptguiderx.com
Mailing Address: 15400 E Jefferson Ave
Grosse Pointe Park, MI 48230

Conduent State Healthcare
Name: John Lafranchise, Sr., RPh,
Phone: 410-230-5451
E-mail: john.lafranchise@conduent.com
Mailing Address:
6800 Deerpath Road, Suite 105
Elkridge, MD 21075

State Examples

The following are links to examples of states' PBM RFPs and contracts. These and other resources are available in NASTAD Benefits Management Toolkit, released in April 2016.

State and Date	Resource Type and Link	Description
Colorado, Spring 2018	PBM RFP	RFP between ADAP and a PBM.
Utah, January 2018	PBM RFP	RFP between ADAP and a PBM.
Alabama, November 2017	PBM RFP	RFP between ADAP and a PBM.
Washington, August 2017	PBM RFP	RFP between ADAP and a PBM.
Arizona, May 2017	PBM Contract Language	Contract language used between ADAP and a PBM.
Virginia, December 2016	PBM RFP	RFP between ADAP and a PBM.
Iowa, October 2016	PBM RFP	RFP between ADAP and a PBM.
California, March 2016	PBM RFP	RFP between ADAP and a PBM.
Georgia, September 2013	PBM RFP	RFP between ADAP and a PBM.
Montana, September 2013	PBM Contract	Contract between ADAP and a PBM.
Washington, September 2013	PBM Contract	Contract between ADAP and a PBM.
North Carolina, July 2013	PBM RFP	RFP between ADAP and a PBM.
Montana, June 2013	PBM RFP	RFP between ADAP and a PBM.
South Carolina, August 2012	PBM RFP	RFP between ADAP and a PBM.
Oregon, March 2011	PBM Contract	Contract between ADAP and a PBM.
Michigan, February 2010	PBM RFP	RFP between ADAP and a PBM.

PBM Contract Language Bank and Things to Consider

The following are examples of language from existing PBM contracts for services often requested and provided, as well as language specific to costs and fees related to these services. Contract language can either be very simple or very detailed. These examples are meant to assist your program in writing a RFP or contract to ensure ADAPs receive the appropriate PBM services.

Issues to Consider: Contracted Services

Before drafting a RFP or contract with a PBM:

- Evaluate the ADAP program to determine current staff and system capacity
- Determine which services to administer in-house and which to outsource
- Speak with other programs within your health departments and ADAPs in other states and territories that have established PBM contracts
- Use contract language bank to help draft RFP and/or contracts
- Consult with NASTAD during the review and drafting process for additional technical assistance

Coordination of Benefits/Claims Processing

Example:

The CONTRACTOR shall provide pharmacy benefits management services to the DEPARTMENT and eligible clients starting April 1, 2013. Specifically, the CONTRACTOR shall provide pharmacy benefits management services, including claims adjudication, coordination of benefits and point-of-sale processing services to eligible clients with coverage through Medicare Part D, the [State/Territory] Comprehensive Health Insurance Pool (HIP[State]), and private insurance, as well as those who are uninsured and receive medication benefits through the [State/Territory] ADAP.

1. The CONTRACTOR's electronic claims processing shall allow pharmacies to do online adjudication and split billing, resulting in pharmacies and/or clients not being required to submit manual claims for secondary payment.
2. The CONTRACTOR shall allow for coordination of primary, secondary and tertiary payers of prescription claims. The CONTRACTOR shall have the ability to transmit primary, secondary, and/or tertiary insurance information to pharmacies.
3. Prescription claims shall pay with the DEPARTMENT as final payer based on other payers' payment of claim using lesser-of-logic. The DEPARTMENT shall be the payer of last resort.
4. The CONTRACTOR shall coordinate coverage and benefits with insurance providers including Medicare Part D Prescription Drug Plans (PDPs) and shall ensure that applicable expenditures are credited toward meeting clients' true out-of-pocket (TrOOP) expenditure requirement. The CONTRACTOR shall participate in the electronic data exchange processes as specified by the [State/Territory] Medicaid

Program for reporting eligible client TrOOP expenses to the [State/Territory] Medicaid Program Data Contractor.

5. The CONTRACTOR shall ensure that the DEPARTMENT does not pay for a medication(s) not on the [State/Territory] ADAP Formulary or on the formulary for the specific insurance or Medicare Part D plan in which an eligible client is enrolled.
6. The CONTRACTOR shall maintain, for the DEPARTMENT, a unique Prescription Benefit International Number (RXBIN) and a unique Pharmacy Benefit Processor Control Number (PCN) to code for coverage that is supplemental to Medicare Part D

Example:

The Contractor will provide electronic pharmacy claims processing for pharmacies in the network. Point-of-Sale (POS) claims will be transmitted and adjudicated online according to National Council for Prescription Drug Programs (NCPDP) standards. The Contractor will provide the capacity for pharmacies to transmit claims via old NCPDP standards as well the most up to date NCPDP standards as they are promulgated.

Pharmacy providers must request prior authorization from the Contractor to process claims for any ADAP client with private or other insurance coverage. This will ensure that the health department is the payer of last resort while allowing the secondary claim to HD to be transmitted and adjudicated on line.

Pharmacies must bill the other payers prior to billing the Contractor. The pharmacy must fax to the Contractor the label (POS printout) showing the co-pay amount requested by the private insurance carrier along with a prior authorization form. The Contractor may also independently verify the status of a HD client's private insurance benefit with the insurance carrier. Prior authorization (PA) numbers will be issued and returned to the pharmacy. The Contractor will ensure that pharmacies will be paid only the approved co-pay amount for these transactions.

Once the prior authorization is issued, the pharmacy may transmit the claim and receive online claim adjudication. Though the mechanism is in place to allow pharmacies to split bill, there are some pharmacies that are still limited by their pharmacy software system capabilities. Pharmacies that cannot bill two insurance plans (i.e. split bill) through their POS system shall use the Contractor's prior authorization form to request manual secondary claim processing. In these instances, an approval response is generated for their PA request, with a notation that no further processing is required. The Contractor will process the claim and append that claim information to the individual client's claim history. The claim will appear on the explanation of benefits and will be billed appropriately to HD just as any claim transacted and adjudicated online.

For those clients with primary payer sources other than HD, the Contractor will assign group numbers that indicate the existence of other insurance coverage. The Contractor's database will contain fields recording private insurance deductibles and HD co-payments.

The Contractor's prior authorization process will enforce HD's formulary guidelines and restrictions on pharmacy claim processing. Prior authorization will be required for exceptional requests such as vacation fills, or early fills due to dosage change or lost medications.

Pharmacies will use the Contractor's Prior Authorization Request Form to obtain a prior authorization. Pharmacies will submit prior authorization (PA) request forms to the Contractor via the Contractor's toll-free fax. The form may be completed by the pharmacist or pharmacy technician and can accommodate up to eight separate transactions. There will be a section included on the form requiring the pharmacy to indicate the reason for the PA request. There will also be a section for comments/explanation for pharmacies to notate any additional information. In select situations, pharmacies may be requested to supply additional information before a prior authorization can be approved, such as a copy of the prescription, or completion of an additional form requiring additional clinical information to justify the prescription.

The Contractor pharmacy technician, under the oversight and supervision of one of the Contractor's pharmacists, will receive, review and process prior authorization requests. After review and processing of the prior authorization request, pharmacies will receive a computer-generated fax back form containing a prior authorization number(s) for approval, or explanations for authorization denials. Exceptional requests will not transmit without the Contractor's prior approval. The Contractor will process prior authorization requests within one business day or faster.

The Contractor will generate quality assurance reports that verify the accuracy of invoices submitted to HD, and to verify the accuracy of reimbursements issued to pharmacy providers. The Contractor will generate the following reports:

- Pharmacy File Errors – i.e. Duplicate NABP codes;
- Drug File Errors – i.e. Duplicate NDC codes;
- Patient File Errors – i.e. Duplicate Patient ID or Federal ID Codes;
- History File Errors – i.e. Duplicate claim reference numbers, duplicate prescriptions;
- Incorrect Claim Prices – i.e. Variances in claim prices in comparison to drug prices from the Contractor's Drug Pricing Source;
- Claim Back-out Processing – Identifies each pharmacy claim back-out;
- Quality Performance Measures – The Contractor will work to develop a performance measure with HD that monitors client antiretroviral adherence based on prescription refills or other Medication Possession Ratio semi-annually.

These reports identify for further review, transactions that are for unusual quantities and/or dosages, and those that may represent a duplicate transaction.

For online prescription transactions, the Contractor will use an electronic screening procedure to do the following:

- Flag transactions transmitted outside of a client's eligibility dates with a message indicating, "Filled after coverage terminated" and for transactions transmitted for invalid clients, with a "Non-matched Cardholder ID" on-line message.
- Flag the day's supply of a new fill or refill dispensed product, with an "Incorrect Metric Quantity" on-line message to enforce a 30-day minimum supply for maintenance drugs, unless client's insurance requires more than 30-day fill at a time.
- Flag "Too Soon Refill" when less than 80% of the total quantity in the previous fill has been used. This technique is used to review and process changes in prescription directions and prevent duplicate claim processing. All too-soon refill rejects cannot be transmitted without prior approval.
- Flag a pharmacy claim at the point of service with a message to the pharmacy alerting the pharmacist to a variety of treatment standards using the Proactive Drug Utilization Reviews (PRODUR). Examples of such standards include low or high doses, drug-drug interactions, therapeutic duplication of products, and allergies to specific products as reported to the pharmacy by the client.
- Flag non-formulary products with a "NDC Not Covered" on-line message, and prompt the pharmacy to inquire by phone for more detail or to initiate a prior authorization request. This prevents the dispensing of non-formulary drugs without Prior Authorization.
- Flag a pharmacy claim when plan limitations are exceeded.
- Flag specific transactions for clients having other primary/secondary coverage, with a message transmitted on-line to the pharmacy that states, "Prior Authorization Required". This forces the pharmacy to obtain prior approval from the Contractor for clients with other third-party prescription benefits.
- Flag specific formulary products, with a "Prior Authorization Required" on-line message. For example, this message would be used to force a pharmacy to obtain prior approval before dispensing a drug with state/territory-imposed criteria for use.

The Contractor must achieve HIPAA compliance according to the federal timelines. Pharmacy claims processed through the Contractor's Point of Sale network will be transmitted and adjudicated through NDC/HealthTrans.

The Contractor will have the capacity and infrastructure to fully implement the data exchange necessary to meet the requirements of the CMS ADAP Data Sharing Agreement. The purpose of the ADAP data sharing agreement process is to coordinate the prescription drug benefits between Medicare Part D plans and ADAPs, as specifically required by the MMA and subsequent law. This collection of all prescription drug related benefits will facilitate the tracking of TrOOP expenses incurred by each Medicare beneficiary. Monthly tasks necessary to complete the requirements of the CMS DSA are:

1. Each month the Contractor (as the ADAP designated partner) submits an electronic input file of all enrollees to the Coordinator of Benefits Contractor (COBC) over the Internet using Secure FTP or HTTPS or via an existing T-1 line.
2. The COBC edits the input file for consistency and attempts to match those enrollees with Medicare Part D enrollment.

3. Where the COBC determines that an enrollee on the ADAP file is a Medicare Part D beneficiary, the COBC updates that record to the CMS Medicare Beneficiary Database (MBD), which holds prescription drug coverage information on all Medicare Part D beneficiaries. The MBD will send daily updates of all prescription drug coverage of Part D beneficiaries to the TrOOP Facilitation Contractor and to the Part D plan that the beneficiaries are enrolled in.
4. The COBC then submits a response file to the Contractor via the same method used to submit the input file. This file contains a response record for each input record the ADAP submitted. The response record shows if the ADAP enrollee is a Part D beneficiary, if the COBC applied the record to the MBD, if the record was not applied to the MBD, and why (e.g., the record contained errors or the record did not provide enough information about the enrollee), in which Part D plan the beneficiary is enrolled, and other Part D enrollment information.
5. The Contractor then examines the response file to determine whether: The records were applied; the COBC was not able to match the ADAP enrollee in the CMS systems; or the records were not applied because of errors. (The Contractor must correct any records so that from subsequent full replacement input files the corrected records can be applied to the MBD.)
6. The Contractor updates its internal records on the Part D enrollment of its enrollees.
7. When the Contractor submits the next monthly full input file, it also sends corrections of all the errors from the previous submission.
8. The Contractor must obtain and use a unique TrOOP facilitation RxBIN and RxPCN as identifiers to the benefits coordination network.

Pharmacy Network

Example:

The CONTRACTOR shall provide an adequate number of Network Pharmacies that will be available to dispense Covered Drugs on behalf of the DEPARTMENT in the various geographical areas where the eligible clients are located. The CONTRACTOR shall audit selected pharmacies as it deems necessary. The CONTRACTOR shall correct any errors detected through such an audit and shall adjust back to the DEPARTMENT.

The CONTRACTOR shall adjudicate electronic claims received from the Network Pharmacies in accordance with the terms of this Contract. Twice a month, the CONTRACTOR shall provide to the DEPARTMENT an invoice, an Import Report, and a Claims Data Report of pass-through claims as defined in the Contract.

The CONTRACTOR shall pay the Network Pharmacies in a timely manner, according to individual Contracts between the CONTRACTOR and the Network Pharmacies and in accordance with the National Council for Prescription Drug Programs (NCPDP) Guidelines. The DEPARTMENT shall pay the CONTRACTOR for claims submitted by the Network Pharmacies through the Delegation of Limited Purchasing Authority.

Example:

The Contractor will establish and maintain a state/territory-wide pharmacy network to serve HD clients, which includes the following:

1. Over-the-counter (chain store and independent pharmacies)
2. Institutional (i.e. University based hospitals, county hospitals, Health Maintenance Organizations)
3. Specialty (i.e. HIV targeted services)
4. Mail order

The Contractor will maintain an open enrollment process that will allow additional pharmacies to enter the network that meet the following criteria:

1. Have no licensure encumbrance by any state/territory or federal law;
2. Have a license issued by the residing State/Territory; and
3. Be willing to accept reimbursement provided by the Contractor.

In the open enrollment process, pharmacies enter a contractual agreement with the Contractor. The contract will stipulate that pharmacy providers are independent contractors. As independent contractors, the Contractor will not supervise, direct or otherwise intervene in their provision of pharmacy services. The contract shall also state that providers must operate in compliance with service standards, maintain adequate inventory, and fill prescriptions promptly.

If a pharmacy provider does not meet the Contractor's service, inventory and timeliness standards, the Contractor will notify HD to discuss whether the pharmacy provider should be allowed to enter or stay in the pharmacy network.

The Contractor will inform HD when there are changes in the pharmacy network and notify HD in a timely manner of problems or emergent situations.

The Contractor will routinely communicate with pharmacies in the network to inform them of program issues, such as formulary updates, changes in how HD interacts with insurance companies or other government payers, and other relevant issues. The Contractor will use its Fax-Broadcast System, which allows it to distribute program information to network pharmacies via facsimile. The Fax-Broadcast System will function by faxing text documents to designated recipients overnight. The Contractor will also provide HD with copies of broadcast faxes that go to the entire network.

The Contractor will also provide relevant information on its non-secured web site, which has a menu option for pharmacies. The web site has a section for non-participating pharmacies as well as pharmacy providers in the network. Pharmacies that have Internet access may use the web site to obtain updated program information. The network pharmacy section of the Contractor's web site will be password protected and contain the following:

- A list of covered medications, with an option to print the most recent formulary;
- Pharmacy provider forms, with an option to print the selected form(s); and

- Pharmacy provider notices/documents that have been sent via the Contractor's fax-broadcast system.

The Contractor will also use its Pharmacy Provider Manual as an additional communication tool. The Contractor will provide the Pharmacy Provider Manual to HD by January 1, 2012. The manual will contain the following items regarding the State/Territory's prescription drug program:

- General program information;
- Prescription processing: prior authorization procedures, exceptional prescription processing, supplemental forms used in prescription processing;
- Program administration information;
- Client service information; and
- Master forms for reproduction.

Clinical Management/Formulary Services

Example:

Contractor will support the State/Territory's clinical and formulary management by:

1. Providing clinical management services such as formulary management, step therapy, monitoring prior authorization requests, therapeutic duplication edits, and retrospective and concurrent DUR.
2. Collaborating with the State/Territory on an approach for Trend [Cost] Management including strong emphasis on generics.
3. Abiding by the State/Territory's formulary list (subject to change).

Example:

HD will define the program's formularies, which includes individual drugs and classes of drugs. The Contractor will provide the following formulary management services:

1. Selection and maintenance of all current data elements for drugs included on each formulary.
2. Notification of pharmacies, and HD staff of formulary changes.
3. Electronic update of formulary prices every week.
4. Provision of secure telephone access for all pharmacies to verify any formulary drug with the use of their NABP number and the National Drug Code.
5. Maintenance of a Contractor web site providing formulary information.
6. Enforcement of prior authorization or code 1 diagnosis requirements for selected formulary items.

HD will direct the Contractor to add or subtract specific drugs or classes of drugs. The Contractor will automatically add drugs to the approved classes when new drugs in those classes are approved by the federal Food and Drug Administration. The Contractor will add or subtract individual drugs identified by HD within 24 hours. The Contractor will notify HD of the need to add or subtract drugs in the approved classes within two business days of FDA approval or updates.

For the purpose of adding drugs to approved classes when the FDA adds new drugs to those classes, entire classes of drugs will be linked by a unique identifier code, known as the "therapeutic class code" within the Red Book database, or known as the "HIC3" code within the First DataBank database. The Contractor will flag these classes for notification to and approval from HD for addition to the formulary to ensure that they are added upon FDA approval.

The Contractor will take the following steps when HD requests a formulary change:

1. Drug activation will be initiated within the Contractor system and at the claims adjudicator. The drug selection may be National Drug Code (NDC#) specific, generic formulation code (GFC#) or generic code sequence number (GCN#) specific, or drug class specific. A start date and any dispensing restrictions will be posted. Reimbursement rates for state/territory invoicing and pharmacy reimbursement will be entered.
2. Preparation of a fax broadcast within 24 hours that will notify all pharmacies within the dispensing network of the planned change. HD will also receive a copy of this fax broadcast.

Example:

The DEPARTMENT shall provide the [State/Territory] ADAP Formulary to the CONTRACTOR prior to the start date of this Contract. The DEPARTMENT shall provide written notice to the CONTRACTOR of any modifications of the [State/Territory] ADAP Formulary within at least thirty (30) days of the DEPARTMENT's notification of such modification. If such modifications are not unreasonably burdensome and are without additional costs to the CONTRACTOR, modifications shall be implemented within a mutually agreed upon time frame.
The CONTRACTOR shall provide management and administrative services for a [State/Territory] ADAP Formulary to Ryan White HIV/AIDS Program Part B eligible clients as determined by the DEPARTMENT.

Drug Benefit/Identification Card

Example:

The Contractor will produce prescription drug cards for use when clients go to the pharmacies to get their prescriptions filled. The Contractor will mail eligibility cards to HD within seven business days of being notified by HD that the client is eligible for the program. Any items mailed to HD will be sent in corporate envelopes and identified as confidential and without any reference to HIV or AIDS on the outside of the envelope. HD will mail the cards to clients.

The prescription drug cards will contain patient identification information that pharmacy providers use to identify eligible clients. Fields of information will be limited to client name, date of birth, gender, member ID number, eligibility begin and end date, EIP and identifiers for other insurance coverage. The Contractor may include other fields of information with HD approval. The cards will also have the Contractor's toll-free phone number and logo

preprinted on the cards. Information will be typed or printed on the cards. For confidentiality purposes, they must not include HIV or AIDS anywhere on the cards.
The Contractor must have procedures for pharmacies to verify the eligibility of a client when there is no eligibility card available. Providers may call the Contractor's toll-free line and speak to any of the Contractor's help desk staff during regular business hours or they can use the Contractor's touch tone operated automated system 24 hours a day to verify a client's eligibility status.

The Contractor must be in compliance with HIPAA's Privacy Standard for Individually Identifiable Health Information.

Things to Consider: Insurance Coordination

- How often will the health department be able to pay/reimburse the contractor for insurance related costs?
- Is the ADAP planning to use a local CBO to make payments? If so, will up-front payments to the CBO be necessary?

Insurance-Related Costs and Reimbursement

Example:

The Contractor shall develop and maintain a system for paying pharmacies for insurance co-pay and deductible costs and passing on those costs, without markup or fees, to the State/Territory for reimbursement.

Example:

The Contractor will pay pharmacies and submit invoices to HD for reimbursement on a weekly basis. Prior to submitting the weekly invoice, the Contractor will verify and correct each claim identified in its claim error reports. Once all transactions are complete, the Contractor will process a weekly invoice to HD in a format specified by HD. The invoice shall include all fees and costs and be accompanied by a cover page that includes miscellaneous charges or credits to HD. The Contractor will pay pharmacies on a weekly basis. The three-week waiting period from the start date of the contract is necessary to allow time to cycle through pharmacy claim reversals, back-outs and suspensions.

Once per month, the Contractor will provide a data file in a suitable electronic format specified by HD that contains all of the previous month's claims-level detail and any necessary adjustments from prior transactions. HD will reconcile the monthly data with the invoices that the Contractor submitted for the month prior to paying the final claim for the month. The Contractor will also provide paper backup documentation on a monthly basis that includes claims-level detail that is organized by client group number.

To pay pharmacies, the Contractor will generate a weekly Pharmacy Payment Report. The Contractor's Pharmacy Payment Report will list all pharmacies eligible for pharmacy payment within the invoicing period. This report will be generated within five days of the end of the invoicing period. Once the Pharmacy Payment Report has been generated, payments are sent to the providers either by check or electronic funds transfer, within ten days from the date the Pharmacy Payment Report was generated. The Contractor will send with each payment, a remittance advice giving the provider a line item detail of the claims submitted and the corresponding payment. The remittance advice will include information regarding paid claims, pharmacy back-out claims, and claims that have been suspended as a result of our claims processing quality assurance protocols. The remittance advice will not include client names.

Example:

The CONTRACTOR shall submit claims to the DEPARTMENT twice a month for payment of pharmacy billing services. The DEPARTMENT shall pay the CONTRACTOR for administrative costs as set forth in the Fee Schedule, Attachment C.

The CONTRACTOR shall submit a separate invoice for each group described in the Fee Schedule (Attachment C) for the defined and pass-through cost of prescription drugs and dispensing fees. This invoice shall consist of a Billing Statement, an Import Report and Claims Data Report. The DEPARTMENT shall pay the CONTRACTOR within 30 days of receiving undisputed invoices.

The Network Pharmacies on behalf of the DEPARTMENT shall charge or bill the CONTRACTOR for eligible clients' co-payments as provided in the Prescription Drug Benefit Plan. The DEPARTMENT shall pay the CONTRACTOR for the pass-through co-payments.

1. Eligible clients shall not pay co-payments up front and then seek reimbursement from the DEPARTMENT. The Pharmacy shall bill the CONTRACTOR for co-payments on behalf of insured eligible clients; the DEPARTMENT shall then pay the CONTRACTOR for co-payment claims.
2. The DEPARTMENT shall not pay the dispensing fee associated with the co-payment; the fee shall be charged to the eligible client's primary insurance.
3. The CONTRACTOR shall have a detailed, mapped recoupment process for instances where other prescription coverage has been identified, so that claims can be reversed and re-billed to other payers.

Back-Billing

Example:

The Contract shall develop and maintain a system for recoupment services (e.g. assistance with back-billing insurances such as Medicaid, when coverage was retroactive).

Things to Consider: Data

- Determine if the PBM/insurance benefit manager data system is independent or integrated into existing data systems.
- Evaluate the costs of integrating with systems versus using a new independent system.
- Is the data system secure? How does pertinent staff gain access?
- Who will run required and specialty data reports (i.e., the PBM or ADAP staff)?
- Does ADAP staff have the ability to query information at any time, or will requests for data have to be formally made?
- Does the PBM/insurance benefit manager utilize security and administrative controls to protect client information?

Data Processing System

Example:

Provide the State/Territory a secure, unlimited remote access to a password-protected electronic pharmacy claims processing and reporting system accessible to the PBM, the State/Territory, and the designated ADAP pharmacies. The electronic claims system must allow for confidential communications of claims, product cost, individual prescription history, and client demographics. The Contractor will work with the State/Territory to accomplish any necessary data transfers.

The minimum data set includes full name, date of birth, ID and Social Security numbers, case management area, gender, federal poverty level and race. Full drug utilization and prescription data is also required.

Access to this system is to be determined by the State/Territory and administered by the contractor (i.e. training, user setup, password reset, technical support, etc.).

The Contractor shall provide notification via on-line claims adjudication system to applicable Participating Pharmacies regarding Terminated Members.

Example:

The Contractor will receive updated client demographic and eligibility information from HD via facsimile, Internet-based ADAP Enrollment Application, and/or other electronic data transfer means such as secure transfer file. Once received, the Contractor's Client Support Services Representatives will update client information simultaneously in the Contractor and HealthTrans client databases. The update process will take approximately three to twenty-four hours, during office hours seven days a week. During emergency enrollment situations during the Contractor's business hours, HD staff may call the Contractor to enroll a client within 30 minutes after the call. Only authorized HD personnel, including HD Client Service Representatives and their supervisor, may enroll clients.

On a weekly basis, the Contractor will archive on CDROM all faxes received through the Contractor's fax system. The Contractor will use these archives as part of its Quality Assurance process to make sure that enrollments are processed within the required timeframes.

The Contractor's database will track information required for prescription invoicing, demographic reporting and other data elements as requested by HD for use in obtaining drug manufacturer rebates. Client prescription transaction information is downloaded on a daily basis from NDC/HealthTrans. This information will be posted to the Contractor database within two hours of the download.

- NDC/HealthTrans: The Contractor will submit client, drug formulary and pharmacy provider files electronically to NDC for Point-of-sale (POS) reference. The Contractor will also configure within the NDC mainframe, dispensing controls, reimbursements, and client eligibility status that trigger POS responses to the pharmacies. The Contractor and NDC/HealthTrans systems will operate 24 hours a day, seven days a week.
- Contractor's In-house Data Processing: The Contractor's data systems will be scalable and accommodate increases in the client database and claims processing that will result from services provided to HD.
- Contractor's Fax Servers: The Contractor's fax servers will receive client enrollment and re-certification applications 24 hours a day, seven days a week. These fax documents will be processed by the Contractor's Client Support Services Representatives during business hours and shredded for purposes of confidentiality. All faxes received will be stored electronically and can be reproduced or viewed if necessary.

Data Management and Reporting

Example:

The Contract shall possess expertise in data analysis and AIDS Drug Assistance Program-specific reporting requirements. The Contractor shall develop and maintain systems to collect Client/patient-level demographic data in a format usable by the State/Territory for quarterly federal reporting.

Example:

Contractor will provide HD staff with training and technical assistance on their online reporting system and on other ways we can use this site to generate our own reports and monitor/improve work processes. Contractor will provide reports to HD via their online system for weekly data files on prescription utilization with the necessary data elements to effectively submit pharmaceutical rebate requests and reports on agreed upon quality performance measures. HD expects all Contractor reports to be checked for accuracy and quality assurance before being sent to HD, such as no "0" identification numbers, when client Identification number is not known.

Examples of reports:
Drug Usage by Manufacturer (Quarterly) - This data should match the invoice weekly files for the quarter.

- Name of Manufacturer
- NDC Number
- Drug Name
- Quantity (or units)
- Rx Count (or # of claims/prescriptions)
- Total Cost
- Average Cost

Antiretroviral Adherence Performance Measure (Semi-annually) - The Contractor is to provide semi-annual reports to HD on the number of times their adjudication system with pharmacies identifies and rejects an inappropriately prescribed antiretroviral drug dosage, so that HD can use this information in our quality management reports.
HD also anticipates brainstorming with Contractor staff to develop a stronger process and possible additional Contractor reporting on client antiretroviral adherence and utilization.

The reporting formats and processes will be determined at a later date.

The Contractor will also maintain the capacity to provide ad hoc reports to HD. The cost of the reports will depend on the complexity and desired turnaround time, and will be negotiated between the Contractor and HD at the time HD requests the reports. Once the Contractor receives a written request for information from HD, the Contractor will review the specifications. If any clarification is needed, the Contractor will seek clarification in writing. At the completion of the data request assessment, the Contractor will notify HD of the date when the requested reports will be available. This time frame can be anywhere from 48 hours to 10 days.

Technical and Customer Support

Example:

- Customize and freely adapt to the specific needs of the ADAP program. The Contractor must offer a hands-on approach provided by dedicated account management and clinical support staff.
- In addition to interaction with the State and ADAP-specific pharmacies, the Contractor is expected to advise and/or cooperate with case managers at multiple sites, a formulary advisory committee, a public planning body, the State/Territory, and federal grant officials.
- Shall communicate various types of claims, eligibility, and other information related to the claims services to and from the State/Territory, members, participating pharmacies, and other authorized third persons for purposes of PBM administration.
- Respond to inquiries and complaints from participating pharmacies with regard to the contractor services under the subsequent contract.

- Staff a help desk to provide information to members and participating pharmacies regarding the PBM.
- Assign an account team to assist the State/Territory to answer and resolve questions and issues that arise with respect to the contractor's administration of the PBM.

Example:

The Contractor will provide technical support to HD staff, pharmacies, and clients. The Contractor will maintain a staff that includes licensed pharmacists, pharmacy technicians, and additional staff that assist in the enrollment and eligibility process. The Contractor's Client Support Representatives will provide support to clients and HD staff. The Contractor's Provider Support Representatives consist of pharmacy technicians that provide technical support to pharmacy providers, clients, and HD staff.

The Contractor will maintain business hours of Monday through Friday 9am-7pm, Saturday 9am-5pm and Sunday 11am-4pm Pacific Time. The Contractor will provide direct telephone access to its staff during business hours and to a Contractor supervisor Monday – Friday and on-call during weekend hours. Pharmacy providers, clients, and/or HD staff who call the Contractor to speak to a live person will have a maximum hold time of three minutes.

The Contractor will also provide a secure telephony system (Electronic Eligibility Verification System (EEVS)) for pharmacy providers and HD staff to access 24 hours a day. To use the Contractor's EEVS, pharmacy providers and/or HD staff may call the Contractor toll-free and select the appropriate phone menu option. By entering an assigned password, pharmacy providers may use the Contractor's EEVS to verify client eligibility status and program formulary status. HD staff may use the Contractor's EEVS to verify client eligibility status.

Web Site Availability

Example:

The Contractor will provide an Internet web site that will be available 24 hours a day. The Contractor's web site will contain secure and non-secure web sites. The non–secure web site will be available to anyone with Internet access and feature the following:

- Updated program information (i.e. program eligibility requirements);
- A search tool used to identify participating pharmacy providers by city, zip code, or county;
- The formulary, with an option to print the latest version.
- The Contractor's non-secured web site will have a menu option for pharmacies. This portion of the web site will have a section for non-participating pharmacies as well as pharmacy providers in the network. Pharmacies that have Internet access may access the Contractor's non-secured web site to obtain information on how to become a participating pharmacy. The participating pharmacy section of the Contractor's web site will be password protected and will contain the following:
- The HD formulary, with an option to print the latest version;

- The Contractor pharmacy provider forms, with an option to print the selected form(s); and
- Pharmacy provider notices/documents that have been sent via our fax-broadcast system

Overpayment or Payment of Invalid Claim

Example:

In the event the contractor pays an Invalid Claim or makes an Overpayment, the contractor, at the State/Territory's option and discretion, will undertake one or more of the following actions unless the payment of the Invalid Claim or Overpayment is the result of inaccurate or untimely information provided by the State/Territory:

Contact the recipient of the improper payment and request a refund from the recipient. If the recipient fails to refund the amount of the improper payment, the contractor will offset the amount of the improper payment against future payments for Claims submitted by the same recipient.

In the event of an overpayment as a result of the contractor's failure to require the dispensing pharmacy to collect the correct amount of co-pay(s) and/or deductible(s), the contractor will refund the amount of the overpayment to the sState/Territory provided that the contractor is not precluded by the sState/Territory from recovering past and/or present Members' non-payment or underpayment of copayments, and the SState/Territory provides all available address and similar information with respect to past and present Members who benefited from the Member nonpayment or underpayment of the copayment; and/or reimburse the sState/Territory.

Example:

A. Beginning on June I, 2010, Contractor shall implement its comprehensive plan, as described in the Proposal, including automated systems, to detect and prevent internal and external fraud, malfeasance, criminal and improper activity and other similar abuses and improprieties, including, but not limited to intentionally perpetrated fraud, theft, embezzlement, misappropriation of funds, commingling, misuse of ADAP, overcharges, overpayments, wrongful and incorrect payments, deceptive, and duplicate or suspicious billings, and the failure to disclose material information in connection with ADAP (hereinafter collectively "Improprieties") by Contractor, as that term is defined in this Contract and including, but not limited to Contractor's officers, employees, affiliates, subsidiaries, agents, independent contractors, and subcontractors; ADAP members; and ADAP clinical sites. Whether or not an impropriety exists or may have been committed, includes, but is not limited to, by way of example, the following circumstances and/or factors: i. If a person or entity, either intentionally or negligently, presents or causes to be presented to Contractor, the State/Territory or a Provider, a claim for benefits, services, coverages, equipment, supplies or products or for any other manner of payment or reimbursement that (a)

contains any statement or representation that the person or entity knows or reasonably should have known was false, and/or (b) fails to disclose material information; or, ii. If an ADAP clinical site fails to provide an individual with any benefits, services, coverages, equipment, supplies or products that are required to be provided under this Contract or applicable laws and regulations in connection with the ADAP; or, iii. If an ADAP clinical providing prescription drugs, services, equipment, supplies, coverages or products for clients, in relation to ADAP, either intentionally or negligently, provides a materially false or misleading representation, or fails or refuses to provide information required to be provided to the State/Territory or Contractor by law or this Contract in order to obtain payment, reimbursement, or restock of medication inventory or to establish the legitimacy of a claim, charge or billing or to avoid any damages or penalties otherwise payable in connection with the Contract; or, iv. If any person or entity misappropriates from or commits any malfeasance in connection with the State/Territory's account, or any ADAP member information; or, v. If a ADAP clinical site engages in actions that indicate a pattern of wrongful denial of services, benefits, equipment, supplies, coverages or products that are required to be provided under this Contract or applicable laws and regulations, or that indicate a pattern of wrongful requests for payment for services, benefits, equipment, supplies, coverages or products not performed, delivered, or provided or improperly billed or that are not medically/pharmaceutically necessary.

B. Contractor shall enforce and implement all aspects of its comprehensive plan and the requirements of this Contract in order to prevent, detect, investigate and eliminate improprieties. Contractor shall conduct investigations on its own, in cooperation with ADAP clinical sites and other carriers or administering firms, when directed by the State/Territory or as Contractor otherwise deems in good faith to be appropriate in the exercise of reasonable due diligence, with regard to improprieties, and as further provided in the RFP.
C. Contractor shall notify the sState/Territory immediately whenever it reasonably believes that any of the improprieties described herein by way of example, or other similar improprieties not so specifically identified, have occurred in connection with ADAP and in connection with Contractor's performance under the Contract.
D. Contractor shall also provide reports to the State/Territory regarding such improprieties immediately upon their detection by Contractor and also as may be requested by the State/Territory.
E. Contractor shall comply with all future additional the sState/Territory policies or directives, as they are developed by the sState/Territory and provided to Contractor, in connection with the prevention, detection, investigation and elimination of fraud, abuse and other improprieties in connection with ADAP and as they may apply to Contractor.
F. Contractor shall further maintain all the sState/Territory and ADAP-related information and claims records as required by the Contract, and Contractor acknowledges and agrees that the State/Territory or its designated representatives shall have reasonable and timely access to all such information related to the State/Territory, ADAP, and its members.

G. Contractor warrants and represents that it shall fully assist and cooperate with the State/Territory, the Office of the Attorney General, any other applicable State/Territory or federal agency and law enforcement authorities in the prosecution of administrative and civil actions and/or criminal prosecution of those individuals or entities who have engaged in the commission of improprieties.

Grievance Procedures

Example:

The Contractor will provide grievance procedures for clients and pharmacy providers to address grievances regarding the provisions of the services or related to a Contractor contract or administration issue.

Grievance procedures for pharmacy providers will be as follows:

1. Disagreement or disputes related to specific prior authorization requests should be resolved with the Contractor pharmacy technician concerned whenever possible or the pharmacy provider should request assistance from the pharmacy technician supervisor.
2. All other issues and disputes should be directed to one of the members of the Contractor's executive staff. Pharmacy providers should include any documentation with as much information as possible to support the grievance. Grievances will be reviewed objectively and fairly considering information provided by all sides. A response will be conveyed to the involved parties within 72 hours.
3. If the grievance is not resolvable by the Contractor, the pharmacy provider will have the right to contact the HD contract monitor who oversees the contract performance of the Contractor.
4. Written grievances that pharmacy providers forward to HD require supporting documentation. The Contractor will forward to HD copies of the Contractor actions taken to resolve the grievance upon notification by HD.
5. Both the pharmacy provider and the Contractor will be obliged to work towards a resolution as stated in the Pharmacy Provider Contract.

Grievance procedures for clients are as follows:

1. Disagreement or disputes should be resolved with the Contractor staff person concerned whenever possible.
2. If the disagreement or dispute is not resolvable at the staff level, the client may request a meeting with the immediate supervisor of the staff person.
3. If the disagreement or dispute still is unresolved at the first level supervisor or with the pharmacy manager, the client should be instructed to contact the Contractor executive staff to document the grievance and/or forward it by fax or mail to the Contractor executive staff.
4. The situation will be investigated considering information provided by all sides. The client must provide necessary documentation when applicable to support the grievance being reviewed. The facts and documentation will be reviewed objectively and fairly. All parties involved in the grievance will be interviewed and a resolution determined.
5. If the grievance is not resolvable by the Contractor, clients may then complete the Contractor grievance form and forward it to HD.

The Contractor will maintain records of all documented pharmacy provider and client grievances. As part of the Contractor's Quality Assurance Plan, the Contractor will document

all grievances and review them for the effectiveness of the process and appropriateness of the response. The Contractor will share its findings with HD.

Things to Consider: Performance Monitoring

- Ensure language in the contract stresses the PBM and all sub-contractors/pharmacies are acting as agent(s) on behalf of the ADAP and therefore must maintain compliance with Ryan White Program legislation, additional HRSA/HAB policies, as well as State/Territory and federal law.

Performance Reviews and Audits

Example:

Performance reviews and audit participating pharmacies as it deems necessary or as reasonably requested by the State/Territory. The Contractor shall report to the State/Territory any errors or improper activity detected through such an audit and shall take such corrective action as appropriate to prevent future errors or improper activity.

Example:

The Contractor shall provide right of access to its facilities to Department of Health (DOH), or any of its officers, or to any other authorized agent or official of the State/Territory or the federal government, at all reasonable times, in order to monitor and evaluate performance, compliance, and/or quality assurance under this contract. The Contractor shall make available information necessary for DOH to comply with the client's right to access, amend, and receive an accounting of disclosures of their Personal Information according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or any regulations enacted or revised pursuant to the HIPAA provisions and applicable provisions of State/Territory law. The Contractor's internal policies and procedures, books, and records relating to the safeguarding, use, and disclosure of personal information obtained or used as a result of this contract shall be made available to DOH and the U.S. Secretary of the Department of Health & Human Services, upon request.

Example:

The Contractor shall permit the State/Territory, any other governmental agency authorized by law, or an authorized designee thereof, in its sole discretion, to monitor all activities conducted by the Contractor pursuant to the terms of this contract. Monitoring may consist of internal evaluation procedures, reexamination of program data, special analyses, on-site verification, formal audit examinations, or any other procedures as deemed reasonable and relevant. All such monitoring shall be performed in a manner that will not unduly interfere with contract work.

Issues to Consider: Contract Costs

- Confer with other ADAPs about existing negotiated costs in contracts to ensure your program is getting a fair and reasonable price.
- Determine whether the ADAP will have one flat fee or variable fees (e.g., monthly, per claim, percentage of expenditure)
- Factors to consider in negotiations:
  - Full-pay prescription vs. insurance client
  - Brand name vs. generic
  - Antiretrovirals (ARVs) vs. non-ARVs
  - In-network pharmacy vs. out-of-network pharmacy
  - Pharmacy pick vs. mail-order delivery (may include shipping costs)
- Determine all reporting needs prior to contract signing. Data reports are commonly included in the service fees, but additional costs may be associated with new data requests.

Service Fees

Example:

The Department shall pay the service fee of $XX.XX per claim. Contractor will bill the Department twice a month electronically or by mail. Contractor shall also make claims detail available as of the date of the invoice. The Department's obligation to pay invoices from contractor is not in any way contingent on The Department's receipt of payment from other sources. The Department will pay in full, via electronic funds transfer, all invoices submitted by contractor within 10 days of the date of receipt of the invoice. Invoices that are not paid within 10 days of the date of receipt of the invoice shall be deemed late.

Example:

HD will pay a processing fee of $X.XX for every approved prescription submitted by any participating pharmacy provider. HD will pay this in addition to the net reimbursable amount eligible for payment to any participating pharmacy provider for any processed and approved prescription (Drug ingredient plus dispensing fee).

When Contractor issues a credit to HD for any reversed transaction that has been invoiced and paid by HD, the credit will equal the net amount paid, excluding the $X.XX claims processing fee paid to Contractor. Contractor will issue credits to HD for any reversed transaction that has been invoiced and paid by HD on or before the final invoice cycle within each quarter.

Example:

A. Contractor's administrative fees, if any, and compensation structure for the services, coverages, benefits, equipment, supplies and products that Contractor is required to perform, deliver or provide in connection with, arising out of or related to its

performance of this Contract shall be only those specifically agreed to and accepted by the State/Territory and the Board and that are reflected in the Budget attached hereto and fully incorporated herein as Exhibit X. Administrative fees, if any, and compensation shall remain unchanged for the Contract Term unless in accordance with provisions in this Contract. Notwithstanding the foregoing, the parties acknowledge that the pricing terms in the Contract are based on the Plan design and program specifications set forth in the RFP. The State/Territory must approve in writing any material modification of the Plan design or program specifications prior to any implementation thereof. If such modifications, including modifications to the formulary, as that term is defined in Article 2 herein, are material and are initiated or approved by the State/Territory, the State/Territory shall notify Contractor of the required modifications, and Contractor and the State/Territory understand and agree that such material Plan modifications may result in a corresponding increase or decrease in Contractor's pricing or compensation terms as reasonably necessary to reflect such material modification of the Plan design or specifications. Any Plan changes or program specification modifications that are not considered material shall be communicated to Contractor and implemented in a timely manner by Contractor.

B. The State/Territory and Contractor agree that Contractor shall not receive or charge any administrative fees or any other costs, expenses or fees in connection with the Contract unless it is included in the administrative fees, if any, accepted by the State/Territory. If applicable, the parties also agree that the State/Territory may select one or more of Contractor's additional management programs identified in Contractor's Proposal for the fees agreed to by the parties as reflected in the Budget.

The "claim processing fee" includes the following services, which will be provided at no additional cost to the State/Territory, ADAP members, or ADAP clinical sites:

a. Access to/use of the Contractor ADAP data management system, as described further in this Attachment
b. Processing of paper claims
c. ID cards issued at enrollment or renewal
d. Electronic eligibility management
e. Electronic claims adjudication
f. Coordination of benefits
g. CMS data exchange file processing
h. Member help desk
i. Pharmacy help desk
j. Toll free telephone number
k. Pharmacy network administration
l. Pharmacy reimbursement
m. Provider management and education
n. Drug utilization review (prospective/concurrent)
o. Basic formulary management
p. Plan analysis, design, and setup
q. Standard reports
r. Online reports or queries

s. Prior authorizations
t. Step therapy
u. Account management services (including quarterly face-to-face meetings)
v. 3408 inventory management services
w. w. Training for State/Territory staff, ADAP clinical sites, and mail order provider

The "claim processing fee" also includes the following functions of the Contractor web site. Additional web site capabilities, with associated additional fees, are described under "Additional Fees" in this Attachment.

a. Member services
    i. Locate a participating pharmacy based on specific geographic requirements.
    ii. View formulary
    iii. View health education materials
    iv. Submit appeals
b. Services available to State/Territory ADAP staff
    i. i. Real time access to claims data, including all data elements consistent with the National Council of Prescription Drug Program's (NCPDP) 5.1 standards or any updates to these standards Real time ability to enter, access, and edit eligibility and enrollment data
    ii. Create reports online
c. Services available to staff at ADAP clinical sites and the mail order provider
    i. On-line pre-certification
    ii. Point of service adjudication
    iii. Access PHR (with member's written permission)
    iv. View formulary

Service Fees

Example:

Contractor will charge a $0.XX data transmission fee to participating pharmacy providers per approved transaction. When pharmacies cannot "split bill" through point of service due to limitations of their 'turnkey' pharmacy system, Contractor will deduct $0.XX per line item from the calculated pharmacy reimbursement to process the claim within the Contractor manual claim processing system. The Contractor will not pass either of these charges on to HD.

Mail-Order Pharmacy Fees

Example:

The "mail order dispensing fees" include the following services, which will be provided at no additional cost to the State/Territory, ADAP members, or ADAP clinical sites:

a. Adherence counseling
b. Pharmacist consultation
c. Involvement of pharmacists suitably trained in HIV-specific issues

d. Involvement of support staff with specialized training in HIV and providing a welcoming patient experience
e. HIV side effect management
f. Refill and medication management so all fills can be complete the same day
g. A seven-day pill container and a magnet with pharmacy hours, location, and phone number (provided on the first fill)
h. Refill reminder calls, non-compliant calls, and drug assessment for new medications
i. Patient assistance specific to State/Territory, including assistance regarding insurance, reduction of copayments through "co-pay cards," and State/Territory's HIV care program

The "mailing order shipping fees" include prescription delivery services, assessed per package delivery (not per claim).

Late Fees

Example:

Payment for invoices deemed late will accrue interest from the invoice date at a rate of (1.5%) per month, or prorated portion of a month, on the outstanding balance.

Other Fees

Example:

Any fees and charges for services not specifically listed in this Schedule or in the body of this Agreement will be mutually agreed upon by contractor and the Department prior to performance of the service. Upon request by the Department, contractor will submit a written estimate of the fees and charges for the service in question, and the Department will notify contractor in writing, whether or not it will accept or reject contractor's offer for performing the services in question.

Example:

A. If the State/Territory exercises its option to require one annual financial or process audit of the Contractor, the additional fee will be $X,XXX in each year in which such an audit is conducted.
B. The following web-based member services may be developed and implemented by the Contractor, at the option of the State/Territory. Before commencing with the development of these services, the Contractor shall submit a budget to the State/Territory for approval, at the rate of $XXX per hour. Such services include, but are not limited to, member ability to:
    a. Submit an initial ADAP application and ADAP member eligibility renewals
    b. Place a refill order and track the status of a mail order prescription.
    c. View claims data and other protected health information

C. The State/Territory may request system enhancements. Before commencing with the development of such enhancements, the Contractor shall submit a budget to the State/Territory for approval, at the rate of $XXX per hour.
D. The State/Territory may request additional consulting services. Before commencing with the delivery of such consulting services, the Contractor shall submit a budget to the State/Territory for approval, at the rate of $XXX per hour.
E. The State/Territory may request ad hoc reports beyond the standard reports currently available. Before commencing with the development of such ad hoc reports, the Contractor shall submit a budget to the State/Territory for approval, at the rate of $XXX per hour.
F. In regard to mail order services, the mail order dispensing fees do not include Medication Therapy Management services, including service in regard to appropriateness of therapy (up to two interventions per year), poly pharmacy, and inappropriate medications for the elderly. If the State/Territory decides to add these Medication Therapy Management services, a contract amendment (with associated budget) will be initiated.

Acknowledgements

This publication was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $500,000 with zero percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.

January 2019 | Terrance E. Moore, Acting Executive Director
Jacquelyn Clymore, North Carolina, Chair