

# K&LNGAlert

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## Retail Pharmacy Alert

### *O'Hare, et al. v. UPMC Health Plan, Inc.:* Open-Price Terms in Preferred Provider Agreements Pose Substantial Risks for Retail Pharmacies and Pharmacy Benefit Managers

#### INTRODUCTION

A recent decision of the Pennsylvania Superior Court in the matter of *O'Hare, et al. v. UPMC Health Plan Inc.* (No. 1397 WDA 2003) illustrates the risks inherent in preferred provider agreements for both retail pharmacies and pharmacy benefit managers ("PBMs"). While re-argument has been requested and a petition for review by the Supreme Court may be filed, the Superior Court's decision demonstrates the need for a careful review of the terms of preferred provider agreements by both retail pharmacies and PBMs, particularly in situations in which pharmacies have a limited ability to independently verify the accuracy of pricing determinations and instead rely on calculations made by PBMs through on-line claims adjudication procedures.

In *O'Hare*, the Superior Court held that pharmacies are liable to repay a health plan for \$1.8 million of alleged overpayments made due to errors in calculation of amounts paid for medications, even where the pharmacies purportedly lacked the ability to independently verify the accuracy of pricing determinations made by PBMs and relied in good faith on pricing determinations communicated to them through on-line claims adjudication procedures. This *Alert* provides an overview of some of the problems typically encountered in PBM pricing calculations; reviews the issues in dispute in *O'Hare*; and suggests several practical measures that pharmacies and PBMs can take to minimize the likelihood of becoming ensnared in disputes regarding the recovery of alleged overpayments.

#### PROBLEMS ENCOUNTERED IN PBM PRICING CALCULATIONS

Most pharmacy preferred provider agreements pose challenges to retail pharmacies and PBMs because of the difficulty inherent in determining whether payments received have been properly calculated. While the agreements often set forth a basic payment formula, such as average wholesale price ("AWP") minus a fixed percentage discount plus a designated dispensing fee, and both pharmacies and PBMs generally have access to current AWP, retail pharmacies have only a limited ability to independently determine the accuracy of payment calculations and instead rely upon determinations made by PBMs. For example, benefit managers may not utilize the same pricing service as pharmacies for the calculation of AWP; may use AWP for different package sizes than the product dispensed; may update AWP at different intervals than pharmacies; and may utilize AWP based upon different National Drug Control numbers ("NDCs") than reported on claims submitted.

The difficulties posed by pricing calculations become more significant for payments subject to maximum allowable cost ("MAC") limitations also typically imposed by PBMs, especially when PBMs adopt MACs more stringent than the upper limits upon Medicaid reimbursements calculated and mandated under federal law. Detailed information regarding MAC formulas and calculations are rarely disclosed by PBMs to retail pharmacies, and in many cases the formulas are treated as proprietary and confidential. It

is, therefore, often difficult, if not impossible, for retail pharmacies to monitor the accuracy of pricing determinations made by PBMs. Similar problems also emerge when PBMs rely upon wholesale acquisition costs (“WACs”) rather than AWP, because information regarding WACs is rarely available at the retail pharmacy level.

The uncertainty created by the lack of transparency in most PBM pricing calculations is compounded by the rapid pace at which changes occur in the competitive and dynamic wholesale drug marketplace. Because of the limited availability of information and the complexity inherent in most pricing determinations, errors in pricing calculations are difficult to avoid and may occur with more frequency than is generally understood or acknowledged by both pharmacies and PBMs.

Fortunately, the lack of certainty in PBM pricing is offset in most cases by the availability of real-time on-line claims adjudication. Using identification cards issued to patients, before accepting a prescription and submitting a claim for reimbursement, pharmacies are usually able to ascertain the amounts that will be paid for a particular medication and decide on a case-by-case basis whether to accept a prescription. Where pharmacies elect to accept payments offered, however, and PBMs subsequently attempt to retroactively adjust payment amounts, pharmacies may be denied the compensation they agreed to accept. The *O’Hare* litigation evidences these perils.

#### **THE O’HARE, ET AL. V. UPMC HEALTH PLAN DISPUTE**

In *O’Hare*, the UPMC Health Plan established a pharmacy integrated delivery system as authorized by the Pennsylvania Insurance Code pursuant to a contract awarded by UPMC, as the result of an RFP process, to Giant Eagle, Inc. The contract designated Giant Eagle as the exclusive chain pharmacy authorized to provide services to its policyholders in portions of Western Pennsylvania based upon a pricing proposal submitted by Giant Eagle, but authorized additional independent pharmacies, which agreed to accept the payment terms negotiated by

UPMC and Giant Eagle, to participate in the network as necessary to provide adequate access to pharmacy services for UPMC’s policyholders.<sup>1</sup> Once the Giant Eagle network was established, UPMC contracted with ProVantage to provide claims processing and administrative services. The agreement between ProVantage and UPMC was terminated, however, on June 1, 2001, when ProVantage was acquired by Merck-Medco. Thereafter, UPMC contracted with Argus Health Systems, Inc. for pharmacy claims processing services.

The dispute that led to the litigation arose when, according to UPMC, Argus erroneously overpaid pharmacies participating in the Giant Eagle network between June 1, 2001 and May 31, 2002 by approximately \$9 million. The errors by Argus primarily involved the manner in which payments were calculated for generic medications, especially medications subject to MAC limits. On August 7, 2002, UPMC advised members of its pharmacy network that it intended to recover the alleged overpayments as an offset against future accounts receivable. Giant Eagle, as a party to pricing agreement with UPMC and as a significant beneficiary of the closed pharmacy network, elected not to challenge the reduced payments. The majority of the independent pharmacy members of the network, however, initiated an action in the Allegheny County Court of Common Pleas seeking to block the recovery of approximately \$1.8 million of the alleged overpayments.

On December 17, 2003 the Court of Common Pleas issued a permanent injunction barring the recovery of the alleged overpayments made to the independent pharmacy plaintiffs. The Court of Common Pleas held that the health plan had entered into participating provider agreements with an “open price term” subject to determination through an on-line claims adjudication process. According to the Court of Common Pleas, the agreements between the health plan and participating pharmacies provided that UPMC would electronically advise pharmacies of amounts to be paid for particular prescriptions, which

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<sup>1</sup> UPMC also administered a similar Medicaid pharmacy network, but pursuant to Pennsylvania’s “any willing provider” law was required to allow unrestricted participation in the network by other pharmacies willing to accept the same pricing parameters as established by UPMC and Giant Eagle.

might change literally from prescription to prescription, subject to acceptance or rejection by participating pharmacies. Although the participating provider agreements also authorized audits to be conducted by UPMC or its agents and provided for the recovery of payments not supported by audit findings, the Court concluded that audits were limited to a review of the books, records, invoices and files of participating pharmacies and did not provide for recovery of alleged overpayments made because of unilateral errors committed by Argus.

In a terse and sparsely explicated decision, on January 25, 2005, the Superior Court reversed the ruling of the Court of Common Pleas and held that, because the agreements between the health plan and network pharmacies set forth pricing formulas based upon benchmarks, such as AWP, MACs and usual and customary charges, price was not an “open element” under the agreements. Without acknowledging or even discussing any of the complexities of AWP or MAC calculations, the Court concluded that “the agreement between UPMC and each pharmacy specifically delineates a specific and verifiable pricing methodology.”

Responding to the trial court’s finding that the pharmacy agreements provided for an on-line claims adjudication process pursuant to which retail pharmacies could accept or reject specific prescriptions based upon the amount of payment offered, the Superior Court interpreted the preferred provider agreements as only allowing a pharmacy to refuse to dispense prescriptions based upon issues of professional judgment and not based upon concerns regarding the adequacy of reimbursement. Although the Superior Court acknowledged that a report prepared by UPMC regarding the overpayments acknowledged that in practice pharmacists “may either accept the price presented and complete the transaction, or elect not to fill the prescription if the pharmacist feels the reimbursement amount is not comparable with cost,” the Court disregarded the report as “not a part of the agreement between UPMC and the appellees.” Unfortunately, the Superior Court failed to address the extent to which the report prepared by UPMC provided documentation of a custom and usage that may be relied upon to interpret

or supplement the terms of a written agreement pursuant to Article II of the Uniform Commercial Code and well-recognized principles of common law.

The Superior Court also reversed the finding of the trial court that UPMC could not recover overpayments because the overpayments were not the result of the conduct of pharmacies as discovered pursuant to audits. Although the Superior Court acknowledged that the preferred provider agreements only authorized the recovery of payments not supported by audits of pharmacy records, the Court found that there was no basis in the trial court’s decision upon which “to conclude that [access to pharmacy audits] was not, in fact, necessary in order for UPMC to discover the pricing error.” In arriving at this conclusion, the Superior Court apparently overlooked or disregarded the trial court’s finding that the pricing errors occurred through no fault of the retail pharmacies, but instead “was the fault of either UPMC or its agent, Argus.”

#### **STEPS TO MINIMIZE THE RISK OF PAYMENT CALCULATION DISPUTES**

Regardless of whether the January 24, 2005 decision of the Pennsylvania Superior Court is subsequently modified or vacated, a review of the dispute as presented by the *O’Hara, et al. v. UPMC Health Plan, Inc.* litigation suggests the need for more careful scrutiny of the terms of preferred provider agreements by retail pharmacies and PBMs. In particular, pharmacies and PBMs may wish to consider modifications in preferred provider agreements in the following areas to avoid payment disputes:

##### ***1. Extent of Reliance on On-Line Claims Adjudication.***

Preferred provider agreements should carefully describe the extent to which on-line claims adjudications procedures will be utilized and should specifically address the question of whether pharmacies may refuse to dispense prescriptions based on on-line pricing calculations. To the extent PBMs wish to guarantee access to service for policyholders, but retail pharmacies are unwilling to provide *carte blanche* to PBM pricing calculations, agreements should either specify classes of prescriptions (based upon types of medications or payment metrics) for which pharmacies may turn away patients or allow pharmacies to dispense the prescriptions and request an override of on-line payment calculations.

## 2. Scope of Audit Authority.

Pharmacy agreements should clarify whether the recovery of overpayments is limited to situations in which pharmacies fail to utilize proper dispensing practices or whether broader authority is provided for retrospective claims review. For example, agreements should clarify the extent to which overpayments can be recovered for good-faith errors in payment calculations by PBMs and whether payments to pharmacies may be denied or reversed based upon subsequent reviews of the medical necessity or appropriateness of particular prescriptions. One useful approach may be to allow the recovery of payments inconsistent with usual and customary practices or based on manifest error, but to otherwise allow pharmacies to rely upon on-line claims calculations. In this regard, the inclusion of a reasonable set of mutual warranties and representations in preferred agreements defining the roles and responsibilities of pharmacies and PBMs may be helpful to minimize not only payment disputes, but a variety of other difficult issues that may arise under preferred provider agreements.

## 3. The Importance of Transparency.

There is no better mechanism for minimizing payment disputes than seeking greater clarity and an enhanced understanding of payment policies and practices. While there will always be uncertainty in any payment calculations, to the extent payment formulas are described in greater detail, especially for the establishment of MAC limits, the potential for

misunderstandings will be reduced. Where it is impossible or impractical to set forth detailed payment practices in preferred provider agreements, periodic notifications regarding detailed payment policies for particular health care plans or employers should be provided to pharmacies and pharmacies should be afforded an opportunity to accept, reject or seek modifications of payment terms.

## 4. Reliance on Alternative Dispute Resolution.

While many lawyers justifiably caution clients against the risks of binding arbitration, the length and complexity of the *O'Hare* litigation illustrates the substantial efficiencies that alternative dispute resolution procedures may provide. Retail pharmacies and PBMs should evaluate whether mediation and arbitration protocols can be established that are speedy, efficient and ensure mutual confidence in the fairness and impartiality of decisions, even if specific outcomes are at times inherently unpredictable and somewhat arbitrary. In particular, through negotiation and the avoidance of cookie-cutter mediation and arbitration clauses, retail pharmacies and PBMs should give careful consideration to whether alternative dispute resolution processes can be implemented that incorporate procedures and personnel well-adapted to the realities of the retail pharmacy industry.

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