UNDERSTANDING AND NEGOTIATING—

Pricing with Your Pharmaceutical Representative

On Jan. 1, 2005, the Centers for Medicare & Medicaid Services (CMS) began using a new methodology to reimburse practices for drugs used in cancer care—average sales price (ASP). With this in mind, it will become imperative that oncology practices negotiate the best possible purchase price for all their oncology drugs. The negotiation process should address drug procurement and utilization from a strategic perspective and should include ongoing review and approval of contracts and efficient delivery of chemotherapy services. Ultimately, this type of drug negotiation process will allow for sound use of purchasing dollars and help position the practice for success now and in the future.

For oncology practices, negotiating with your "pharmaceutical representative" may actually mean negotiating with manufacturers, wholesalers, distributors, and/or group purchasing organizations (GPOs). Even though your oncology practice has come to terms with a drug manufacturer on a contract, you must still negotiate and review all potential drug purchases available through your GPO and/or distributor to ensure that your practice is receiving the best possible price and terms.

WHY FOCUS ON DRUG COSTS?

Annual drug cost per physician approaches three times the cost of support personnel and also more than three times the cost of rent, depreciation, and all other practice costs.[1] As the Medicare Prescription Drug, Improvement and Modernization Act (MMA) reduces compensation to oncology practices in 2005 and 2006, practices must analyze and follow optimum drug protocol economics. Medication management will be a critical component in whether an oncology practice survives in 2005 and beyond, and engaging personnel in the effective procurement and utilization of drugs in their daily activities is key to this effort. Bottom line—the economics of running and managing an outpatient oncology clinic in the near future will require extraordinary care and attention. Below are several tactics that have proven helpful in developing successful drug management practices.

1. ***Use Trained Pharmacy Staff.*** Pharmacy personnel can help your practice work smarter. Most oncology clinics are now realizing the benefits of using pharmacists and pharmacy technicians in their drug procurement and utilization efforts. These staff members efficiently manage the purchase and use of each drug in order to maximize inventory and prevent potential losses from waste.

Experienced pharmacy staff can closely manage, mix, stock, and prevent drug losses more efficiently than a nurse that is required to order, stock, mix, and also infuse chemotherapy.

Pharmacy staff can also provide mixing services to the treatment nurses, which will allow the nurses to focus on patient care. By giving the nurses more time to dedicate to patient care, the clinic will operate more efficiently.

The staff member ultimately responsible for negotiating and understanding your practice's pharmaceutical contracts should make a point of talking to those staff members who order and/or mix chemotherapy and listen to any issues that might be affecting proper drug use.

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2. ***Best Practices for Inventory Control and Ordering.*** Many factors go into the decision to order chemotherapy agents. Some oncology practices order drugs daily, but then staff has to spend a certain amount of time every day unpacking, verifying, and storing stock. To improve staff time-management skills and increase efficiency, consider ordering drugs on a weekly basis at the beginning of the week. By ordering drugs once a week, your practice may also save money on containment and shipping costs.

Review and set par levels, i.e., inventory stock levels, for both drugs and supplies in order to minimize expenses.

Simplify the drug ordering process by using preprinted order forms and designating an "inventory control person" to monitor drug costs. Practices with multiple clinic sites should consider submitting all drug orders through a designated control person. This individual—a nurse, pharmacist, and/or technician—would then be responsible for reviewing the new orders, considering the stock on hand across all sites, and determining if requirements can be met by shifting stock from one location to another rather than ordering additional stock. This simple step also allows for greater contract compliance and generic substitution of drugs. No drug order should be sent to the distributor until it has been reviewed and approved by the inventory control person. Even if your practice has an automated drug cabinet, it is still a good idea to have an inventory control person review the drug order first.

On a quarterly basis, conduct a physical inventory to track excess or unused inventory and try to rotate your stock and/or return drugs for credit as soon as possible to manage cost. Good inventory control not only positions your practice to save money by buying under the correct contracts, but it also prevents disruption in patient infusion services by ensuring adequate drug supplies.

3. ***Contract Strategies.*** When negotiating with your pharmaceutical representatives, use a variety of contract strategies.

Look at the portfolio-base of companies your practice is dealing with and try to understand the relationship between the different manufacturers, wholesalers, distributors, and GPOs. Determine how the oncology practice and the partner companies can improve or help each other by forming a stronger business relationship. Develop a service-based strategy with the goal of identifying which organizations or companies will best understand and compliment your oncology practice and service any unique needs. For example, what value-added services does the company offer? Is extending the billing cycle a possibility? Does the company offer education or training programs?

Using a value-added service strategy, consider the advantages offered by a drug distributor or GPO, such as good pricing and a comprehensive portfolio for all classes of trade, i.e., for all products offered including items such as tubing and IV bags as well as drugs.

Once these companies have been identified, use a compliance-based strategy for pricing to do business with and show loyalty to these companies. Using a compliance-based strategy can mean that during negotiations the distributor agrees to a better price on drugs if the customer commits to ordering a certain dollar amount per quarter. This price will apply as long as the customer "complies" and orders that dollar amount each quarter.

According to a recent article in *Insight,* a publication of the GPO Innovatix, paying attention to the bottom line, pricing, and process efficiencies may mean more resources for enhanced clinical outcomes.[2] Identification of these "value-added" services can help a practice purchase new technologies and improve medication protocols and patient care. In addition, working with a good distributor and/or GPO can help prevent your supply chain from becoming too fragmented. For practices that are short on staff and extremely busy, value-added services can save time, enhance productivity, and generate cost savings.

Whatever contract strategies your practice chooses to use, partnering and working closely with your pharmaceutical companies, wholesalers, distributors, and GPOs is more important than ever if you are going to be able to continue to offer quality care to your cancer patients.

DRUG CONTRACTS WITH MANUFACTURERS

Many administrators do not have the time and, in some cases, the level of understanding and expertise required to properly negotiate a pharmaceutical contract to their practice's best benefit. Working together as a team can help an oncology practice realize the full potential of its drug contracts.

Most pharmaceutical manufacturers employ contract specialists who review and write practice-specific drug contracts. It is also a common practice for most drug companies to monitor and trend practices to either maintain or gain market share from their competitors. On the other side of the equation, oncology practices usually do *not* have a contract specialist and must depend on existing resources to review and analyze their drug contracts. To survive under ASP, private oncology practices must develop a process and designate resources to understand the opportunities involved with drug pricing negotiations, if they have not already done so.

When negotiating and/or reviewing a contract, several items may provide leverage opportunities to better

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negotiate your practice's position. Here are some tips to help you in this process.

Rebates. Take a look at any rebates included in the drug contract. Rebates are important because they can bring dollars back into the practice. Drug manufacturers may be willing to consider a rebate because it can mean that the customer will order larger quantities on an accelerated timeline. Find out if your drug contract spells out any performance expectations that may be required before a rebate can be given. Identify the parameters of the rebate—is it 5 percent or 10 percent off the total contract? For cash rebates, is the manufacturer responsible for providing the rebate dollars or must the rebate go through a GPO or distributor? Is the rebate in the form of a product credit?

Discounts. Another contract item that bears close scrutiny is the availability of any discounts. Does the contract offer upfront discounts? If so, when do these discounts expire? Does the contract allow the upfront rebate to be converted to a rebate at a later date?

Competitive Comparisons. When reviewing your drug contracts do competitive comparisons. Oncology practices should never assume that they are getting the "best-tier" price on any given drug. Once your practice has finished negotiating a contract with a manufacturer, do some competitive comparisons *before* you sign on the dotted line. Know which buying group and/or GPO the drug company works with and if that GPO is really offering your practice the best upfront discount terms. Check with your other vendors and GPOs and see if

Understanding Drug Purchasing from the *Hospital Perspective*

by Joseph F. Woelkers, MA , Fred Payne, RPh, and Allan Knudsen, MS, RPh

Most hospitals—from large academic medical centers to small community hospitals—purchase drugs through a Group Purchasing Organization (GPO). The centralized GPO negotiates, bids, and contracts for all medications, using the volume of drugs ordered to drive down the per drug unit cost for the entire group. This model works on the premise that the greater the volume of drug purchases, the greater the ability of the GPO to negotiate "best-tier" pricing with the manufacturers.

Purchasing drugs through a GPO is crucial for smaller community hospitals because their purchasing power is significantly less when compared with larger, multi-hospital healthcare systems and academic medical centers. By using a GPO that pools the drug purchase volumes of many different-sized hospitals, a small community hospital can take advantage of the lower unit cost negotiated by the GPO.

Hospitals do not negotiate with more than one GPO at a time; however, contracts can be renegotiated at any time. In fact, every three years hospitals should ask all the major GPOs to participate in a contract bid to see whether it's more beneficial to stay with their current GPO or sign-on with a new GPO.

Joining an integrated delivery network (IDN) is another way to enhance drug purchasing power, particularly for smaller community hospitals. Hospitals that vary in size and have different drug supply needs can form an IDN in order to obtain best-tier pricing for their drug purchases. Similar to a GPO, the IDN then negotiates, bids, and contracts for all medications for its member hospitals. The key to a successful IDN is hiring contract managers or administrators to oversee the purchasing process.

Still, the GPO and IDN models do face certain barriers to achieving lower unit costs. For example, the federal government has enacted legislation requiring that the Veterans Administration (VA), the Center for Medicare & Medicaid Services (CMS), and other government entities receive the most favorable drug pricing. This "best price" legislation has caused drug manufacturers to create "price floors" which they will not go below for non-government buyers.

Certain hospitals with disproportionate share hospital (DSH) designation and a public health mission and contract can avoid the government's best price restriction by qualifying for 340B pricing. Established as part of the Veterans Health Care Act, the 340B program enables hospitals, community health centers, clinics, and other "safety net" providers to purchase outpatient pharmaceuticals at discounted pricing, thereby expanding care to low-income populations. Hospitals designated to use 340B pricing can purchase medications for eligible outpatients at a price equivalent to Medicaid pricing, including the required vendor rebate to Medicaid. Any additional discounts negotiated by hospitals eligible for 340B pricing are also exempt from the government's best price calculations. Overall, 340B drug

they can meet or beat the new price. Remember, manufacturers give GPOs and distributors a certain percent off of the drug's price, and if this company wants your business it may give you a better price or deal.

Billing. When negotiating and/or reviewing your drug contracts consider the ability to be reimbursed in a timely manner. Identify any billing issues with current or new products. Always ask your distributor, GPO, or manufacturer for longer payment terms in order to give your billing department time to bill the product before payment is due. These steps may seem simple, but they are necessary if your practice wants to protect its cash flow.

Use a multidisciplinary team approach to review and analyze contracts. The success of the multidisciplinary team will depend on team members' professional background, experience, ability to network and communicate as a team and with other clinics that comprise the practice, and how much time each team member has to review and question the contract for accuracy and completeness. Have each member of the team read and review the contract(s) and schedule a review meeting to determine the contract's overall value to the practice. Simply put, a contract should be seen and reviewed by multiple people, multiple times before it is finalized.

A successful model established at one private oncology practice uses its accountant and pharmacist in key roles. The accountant reviews the accuracy of the financial data and trends used in the contract. Typically, this initial review step will determine if the data, calculations, and past drug utilization are true and correct. Incorrect pricing averages 20 to 24 percent less than what most hospitals will pay for drugs through their GPO.

On Jan. 1, 2004, inpatient drug pricing was also granted exclusion from the government's best price calculations. Most of the hospitals eligible for this exclusion are considered safety net hospitals, which traditionally see a high volume of Medicaid and uninsured patients. Drug manufacturers can now voluntarily offer drug price reductions to these eligible hospitals, many of which are also academic medical centers. While it is still too early to determine the fiscal impact of this change, significant price reductions for key inpatient supportive care medications used in the oncology setting have already occurred.

When looking at financial modeling and budgets, it is vital to understand that inpatient treatments are reimbursed differently than in the outpatient setting, so cost alone should never be the sole determinant in purchasing decisions. In the end, cost is just one element in the hospital's formulary decision to purchase a certain drug. The pharmacy and therapeutics (P&T) committees consider all the relevant clinical science of a drug—regardless of the price—before making any formulary decisions.

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Sole-Source Drugs

While the GPO model of negotiating and purchasing drugs works well with generic medications and medications determined to be "therapeutically equivalent," such as epoetin and darbapoetin or omeprazole and lansoprazole, pharmaceutical manufacturers do not usually contract with GPOs for sole-source or brand-name drugs. In addition, bundled contracts with generic or therapeutically equivalent drugs may sometimes exclude specific, commonly used products.

For sole-source and brand name drugs, hospitals must negotiate directly with the manufacturer for best-tier pricing. Typically hospitals use their patient volume and drug purchase volumes to negotiate drug cost savings from the wholesaler. In the case of smaller hospitals, the hospital must demonstrate that it controls a significant market share and has significant physician collaboration within its community.

For therapeutically equivalent drugs, hospitals should consider using a negotiating tactic that would leverage drug A against drug B.

In large hospitals, the pharmacy department typically negotiates with manufacturers for best-tier pricing. In smaller hospitals, the pharmacy and material managements departments often work together to negotiate prices with the manufacturer.

"Incorrect data collection is a major cause of contract errors and unnecessary cost."

data collection is a major cause of contract errors and unnecessary cost. The pharmacist brings clinical oncology experience and product management and utilization knowledge to the team. The pharmacist analyzes the growth and performance factors specified in the contract. Each product is evaluated to determine if the anticipated utilization growth and expected contract performance are realistic and valid.

Review and question all data. One of the fundamental steps in contract analysis is to review and question *all* data presented. Knowing the drug product, the patient population, the physicians' prescribing habits, and the practice's growth pattern trends will assist you in negotiating or renegotiating the terms of your contracts.

For example, sometimes drug contracts have unrealistic expectations and dictate that a practice perform or grow at an extremely aggressive percentage during the term of the new contract. The ability to recognize the contract language that addresses growth and to determine if the hurdle is too high for your practice gives you the opportunity to decline the contract or request that the drug company re-evaluate the contract and/or lower the expected performance of your oncology practice.

Many contracts are based on historical data, and most drug manufacturers collect your individual product utilization data from different sources. Sometimes the past product utilization numbers presented in the new contract are not accurate. If you are not familiar with your practice's numbers or not careful about reading the contract language, you may sign a contract that requires a higher level of performance by the practice. In this situation, your practice would have to purchase and use more drugs before it would be able to reach the best tier and or performance level as stated in the contract.

Survey your GPOs and distributors regularly. Drug prices are changing rapidly, and one of the most practical actions a practice can take is to survey their GPOs and distributors on a regular basis. Not only is this step an important part of your practice's inventory management and handling, it can bring substantial cost-savings. Select and work with suppliers that provide best possible pricing coupled with optimal service. As mentioned above, the supplier should also offer customized "extra value" services, such as product utilization information, staff education, billing and coding updates, and information on any specific potential issues relating to your practice based on your region of the country.

Before you sign any contract, determine if the drug manufacturer is interested in forming a long-term relationship with your practice for the purchase of their product. Of course, the goal of your oncology practice is to make sure the drug company understands your perspective and position.

In the end, your practice and whatever organization you contract with—manufacturer, GPO, distributor—*both* must understand what is required to make the contract goal achievable and mutually beneficial.

AN EYE TO THE FUTURE

As long as oncology practices continue to administer chemotherapy in the office setting, drugs will continue to play a significant role in the practice's management and livelihood.[3] Under MMA, office-based oncology practices will need to become more educated and precise in the procurement and delivery of chemotherapy services to their patients. Oncology practices are at a critical juncture, and drug practice management must become paramount in order survive under the new reimbursement methodology.

Oncology practices must identify and determine their most pending issues and/or problems and then begin to deal with each one. To do so, your practice should answer several key questions. For example, know who in your practice has extensive knowledge of the drugs themselves. Ask yourself if someone in the practice has evaluated the drug utilization process from start to finish. Find out if any staff has invested the time to evaluate the process and validate how efficiently drugs are being mixed and dispensed on a daily basis. Finally, develop a standard when calculating drug dosages that rounds dosage calculations up or down so your practice is not wasting thousands of dollars and not realizing true drug efficiencies.

In real estate, the key to success is said to be "Location, Location, Location." In the private oncology clinic setting, "Negotiation, Negotiation, Negotiation" will become the number one key to your practice's success, followed closely by education and communication. Establishing practical standards for daily operations will allow oncology practices to minimize the effect of the reimbursement cuts and still provide the highest level of patient care and safety.

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REFERENCES

[1]National Institute for Health Care Management. *Prescription Drug Expenditures 2000: The Upward Trend Continues.*

[2]Geba W. Savings partner, value producer. *Insight*. 2004; 2(1):18.

[3]Stone J. Should practices make changes in today's uncertain reimbursement climate? *Oncol Issues*. 2004;19(2):31-32.