

Hello,

I am a pharmacist and Director of Pharmacy at a Federally Qualified Health Center. We are a 340B entity, so I have insight not just into retail pharmacy, but also the 340B space. It is this expanded perspective that gives me more insight into the practices of PBMs. I review all of our contracts and watch our diminishing reimbursement.

I sent the majority of what follows to Congressman Walden in August, 2018. I have taken out other issues from my letter and updated a bit to reflect my concern over the anti-competitive practices of CVS Health in particular, although the major PBMs are doing very similar things.

In regards to PBMs, I have several concerns:

1. Size and spread of PBMs
2. Discriminatory contracting (both historically and new) by PBMs with 340B pharmacies.
3. Fall of independent pharmacies, especially in rural areas where they are desperately needed
4. Anti-competitive practices

PBM's

When I saw that CVS Health was buying Aetna, I was appalled. It became very clear to me what has happened. CVS was a fast-growing pharmacy chain, and Caremark was a spinoff of Baxter that was focused on specialty medications and then became a PBM. CVS pharmacies also had started their own smaller PBM. The two merged in 2007, and the giant has been swallowing up just about every sector of the industry they can. If you look at their history online, you can see what they choose to share. (<https://cvshealth.com/about/company-history>).

What happens when you have a PBM that owns pharmacies, and is the payer for the competition, is a company who not only knows exactly what it takes to run a pharmacy, and all the costs, but it has very in-depth information on ALL of its competition. It knows its patients and their demographics, where they receive their care, what medications they receive, how many pharmacists are employed, and so much more. It is no surprise that in 2015, I saw 3 Medford independent pharmacies go out of business. CVS is not huge in our area, but this is not the only PBM that has this information on its competitors. They also have bought out large portions of specialty pharmacy, long term care, and home infusion.

I bring up CVS because of some of the very quick and calculated moves it is making as the merger with Aetna comes to a close.

340B Space:

CVS Health neglected to mention online that in 2017 they bought Wellpartner, a 340B contract pharmacy third party vendor. I believe it's the biggest one in the US. CVS now has access to: 340B acquisition prices; the contracts that other pharmacies have with covered entities; prescribing information specifically coming from 340B covered entities, and more. Two things have happened in the past 2 months that are DEEPLY concerning for me. I will share the synopsis here and then have appendices with the actual letters.

1. I received notice from a colleague that CVS had sent discriminatory contracts to 340B pharmacies in 6 states. The new reimbursement rates, should CVS be the major payor, could be enough to put those pharmacies out of business. See Appendix A, which gives more detailed information on pricing and such. Should those 340B pharmacies go out of business, CVS would

just buy the patient files and transfer them over to CVS pharmacies. If the 340B pharmacy wanted to stay in business, they could propose that they become their own contract pharmacy through their very own Wellpartner. It's a win-win any way for CVS, and a huge loss for the entities. The intent of the 340B program is to get paid the same amount as another pharmacy and use the savings to help more patients with more services. Any practice that eats into those savings defeats the entire purpose of the 340B program. I will add that this is not new. I will share pricing issues with another payer after I finish this complicated story. (See letter, Appendix A)

2. Very shortly after the notice of discriminatory contracting, I received a letter from the third-party administrator (TPA) we are switching to, which is CaptureRx. Seems that CVS is requiring all of their pharmacy contracts with other TPAs to go through Wellpartner. Now, I know that Safeway created their own TPA called 340BDirect, but they worked with TPAs in a duplicative fashion. CVS is taking millions (billions?) of dollars of business away from TPAs, and putting it back into their laps. Not only are their pharmacies getting paid a dispense fee by the covered entity, but Wellpartner is also getting paid an administrative fee + a percentage of the total reimbursement, by the covered entity. Since CVS is also the PBM, they are creating a system where they pay themselves right and left. The amount that Wellpartner gets is largely based on what the reimbursement is to the pharmacy. The only part that CVS doesn't own to my knowledge, is the wholesaler and the actual drug company. That is especially true with the merger with Aetna(See letter, Appendix B)
3. Other PBMs have 340B discriminatory contracting. Below is from one payer in particular, which is largely a Part D payer.
 - a. I have an example in Appendix C of the difference between reimbursement for a 340B pharmacy and a non-340B pharmacy.
 - b. I also just received a letter this week requiring that for a pharmacy filling for both 340B and non-340B, we are required to submit a clarification code for the 340B medications, which would likely result in reduced reimbursement.
4. Rural, independent pharmacies are going out of business. See brief here from the RUPRI Center for Rural Health Policy Analysis: <https://www.public-health.uiowa.edu/rupri/publications/policybriefs/2018/2018%20Pharmacy%20Closures.pdf> . Some key points and dates below:
 - Over the last 16 years, 1,231 independently owned rural pharmacies (16.1 percent) in the United States have closed. The most drastic decline occurred between 2007 and 2009. This decline has continued through 2018, although at a slower rate.
 - 630 rural communities that had at least one retail (independent, chain, or franchise) pharmacy in March 2003 had no retail pharmacy in March 2018.
5. The newest change I have heard from CVS is that they are requiring ANY pharmacy with any 340B medications to accept a reduced reimbursement. This will dissuade pharmacies to use 340B medications and goes against the intent of the program.

Overall, I see CVS (and other PBMs) leveraging their control in the market space to drive out independent pharmacies. I don't understand how companies have been allowed to contract to their direct competitors, and determine the reimbursement for their competitors, without any regulatory oversight.

The first oversight that needs to happen is a look at the discriminatory reimbursement for competitors, as well as 340B pharmacies. Are PBMs paying their own pharmacies more than the competitors? Additionally, the entire reach of the company needs to be taken into account. I have not heard any public mention of acquisition of Wellpartner by CVS and the ramifications of the power it holds. The recent move to force their pharmacies to contract with their own TPA, thus stealing business away from other TPAs is clearly anti-competition. I want to take advantage of this comment period to bring these acts to the attention of the FTC.

Thank you for reading and considering what I bring forth.

Sincerely,
Amy Baker, PharmD

APPENDIX A

DATE: August 11, 2018

RE: Major reduction in CVS-Caremark reimbursement for drugs dispensed by in-house pharmacies: What I know so far, and how you can help

In the past week, a very concerning development has been brought to my attention. While the situation is still evolving, I'd like to fill you all in on what I know to date, what we're exploring, and how you can help.

WHAT IS HAPPENING: CVS-Caremark is the second-largest PBM in the country, covering roughly one-third of commercially-reimbursed pharmaceuticals nationwide. In late July, CVS-Caremark sent letters to health centers with in-house, closed-door (meaning they dispense drugs only to their own patients) pharmacies in at least six states (AZ, CA, SC, TX, WA, WI.) These letters state that effective September 1, 2018, CVS-Caremark will dramatically reduce reimbursement for drugs dispensed through these pharmacies (except those covered under Medicare Part D.) The new rates will be Average Wholesale Price (AWP) minus 30% for brand-name drugs, and minus 20% for generics, with a 50-cent dispensing fee. Health centers are required to either accept these lower rates, or withdraw entirely from all CVS-Caremark plans, which cover roughly one-third of commercially-reimbursed pharmaceuticals nationwide.

In addition, at least one in-house open-door pharmacy has received the same letter, and when they called CVS-Caremark they were told that they were not exempt from the changes.

TWO AREAS OF UNCERTAINTY: I am still unclear about two important issues regarding the extent of this new policy:

- Whether these reductions will apply to Medicaid Managed Care Organizations (MCOs) that work with CVS/ Caremark, or only to private insurance plans.
- Whether CVS-Caremark is sending these letters to every health center with an in-house closed-door pharmacy, or only to those in certain states or regions.

My suspicion is that this is a nationwide-policy, that will encompass both private and Medicaid MCO plans, but have yet to confirm this.

WHAT I DO KNOW:

- For many drugs, this new reimbursement (AWP minus 20% brand/30%, generic with a 50-cent dispensing fee) will be less than health centers' actual costs.
 - The basic 340B price is AWP minus 23.1% for brands and 13.1% for generics. While additional discounts are available if the drug's price increases faster than inflation and/or Apexus negotiates a discount with the manufacturer, these are not guaranteed.
 - A 50-cent dispensing fee is significantly less than costs – well below the amounts recently determined by State Medicaid programs based on surveys, etc. (These amounts were – roughly – in the \$10-\$12 range.)

- Health Centers appear to be the only type of 340B-eligible provider receiving these letters from CVS-Caremark at this time. (I've reached out to organizations representing other provider types, and none of their members are currently receiving such letters.)

WHAT CAN WE DO?

- Unfortunately, at this time, there is nothing in statute or regulation that prevents CVS-Caremark's actions. (And there is no opportunity to "fix" this in the near future.) Here's Apexus' Q&A on the topic:

FAQ ID: 1336

Last Modified: 11/10/2014

Q: We received a pharmacy reimbursement contract from a payer that we feel discriminates against us based upon our status as a 340B entity. Who may we notify about this issue?

A: There is no statutory provision in section 340B of the Public Health Service Act prohibiting a payer from reimbursing a 340B covered entity at a level that may be different than a non-340B entity. HRSA OPA strongly encourages the covered entity to reach out to the payer to craft an alternative business solution that permits each of the parties to fulfill their goals.

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- I'm checking with legal counsel about our options, and will be back in touch.
- We've considered encouraging health centers with closed-door pharmacies to consider becoming open-door. However, given CVS-Caremark's response to the one open-door health center that received the letter, I'm not optimistic this is a viable approach.

APPENDIX B

From: Paul Melancon, RPh, MBA

Sent: Wednesday, October 3, 2018 4:14 PM

To: Amy Baker, Pharm.D.

Subject: Your options regarding CVS pharmacies

Your patients, program and choice are important to us.

Many of our customers have advised us that CVS is requiring they use WellPartner as their 340B administrator as a condition for their patients continuing to have access to CVS pharmacies.

We understand that you may be forced to make this very difficult decision. Honoring your agreement with CaptureRx is a concern. Choosing to switch to WellPartner may cause you financial difficulties based on the pricing differences between WellPartner and CaptureRx. Potential financial loss would directly affect your ability to provide the expanded patient services that the 340B program is designed to support.

We regret that you have been placed in this position.

Our Mission at CaptureRx is to deliver technology and service that enables you – our customers – and the patients you serve to achieve the best versions of yourselves and to receive the best possible care at the most economical price. We are committed to working with each of you to ensure we deliver on our mission. We realize and understand the difficulty in this decision for you.

If you have questions or concerns about your contract with CaptureRx and the mandate by CVS to terminate all or a portion of that contract, please contact your customer relationship manager so we can work together on the best solution for you and your patients.

We appreciate your business and look forward to our continued partnership with you.

Paul Melancon, RPh, MBA
VP, Client Management

Connect with us!

APPENDIX C
Retail pricing

EXHIBIT D

PROVIDER REIMBURSEMENT

Retail Pharmacy Services

Up to Ninety (90) Day Retail Supplies

	A	B	C	D	E
	Brand	Brand	Generic	Generic	MAC
Rate	WAC	Disp Fee	WAC	Disp Fee	Disp Fee
	- 0.05%	\$1.00	+ 20.75%	\$1.00	\$1.00

340B pricing

Jan. 9. 2014 5:01PM Community Health Center No. 1531 P. 29

PROVIDER REIMBURSEMENT

340B Pricing

Up to Ninety (90) Day Retail Supplies

Rate	A Brand WAC	B Brand Disp Fee	C Generic WAC	D Generic Disp Fee	E MAC Disp Fee
	-31.25%	\$1.50	+11.50%	\$1.50	\$1.50

H.R. 592/S. 109, the *Pharmacy and Medically Underserved Areas Enhancement Act*