

September 1, 2020

Dear Director Corcoran,

Last week, Dr. Aaron Clark, Equitas Health's Chief Healthcare Operations Officer, addressed the DAS Prescription Drug Price Transparency Council, of which you are a member. Dr. Clark's presentation focused largely on the benefit that 340B Covered Entities like Equitas Health provide to Ohio's most vulnerable populations, as well as threats to the viability of safety net providers and the 340B program. Following Dr. Clark's presentation, during the time period allotted for Council members to ask questions of the presenter, you asked Dr. Clark to change slides you believe to be misleading. Later that afternoon, you followed your verbal request with an email to Dr. Clark instructing him to "correct the misinformation in slides 10, 12, 13, and 15." This letter and the attached revised presentation serve as a response to your demand.

Slide 10

There is no misinformation on Slide 10. Rather, this slide communicates the threats to the 340B program, as Equitas Health perceives them. As Dr. Clark shared with the Council, discriminatory language in contracts between 340B Covered Entities' pharmacies and payors/pharmacy benefit managers (PBMs); the prospect of a single PBM for Medicaid managed care; payor efforts to force Covered Entities to accept Actual Acquisition Cost; and manufacturer policies relating to 340B utilization at contract pharmacies – together or alone – have the potential to significantly reduce or eliminate the 340B savings on which we depend to keep our doors open.

Discriminatory Contract Language

Contracts that payors and PBMs present to Covered Entities regularly include language that either reimburses the Covered Entity *less* for 340B drugs than for retail drugs, or adds excessive fees for filling prescriptions for 340B drugs. By way of example, one contract between Equitas Health and a payor reimburses us *30% less* for a 340B brand name drug than for a retail brand name drug. The discriminatory language in this contract *entirely wipes out* the 340B savings intended for us, the Covered Entity. Instead, the payor pockets these dollars for its own gain. Our contract with this Payor includes strict confidentiality language that, on advice of counsel, prohibits us from sharing the terms with you.

Single PBM for Medicaid Managed Care (Slide 12)

ODM recently released a Request for Proposals (RFP) for a single PBM for all Medicaid managed care plans. The RFP indicates that the single PBM model will allow the state to dictate to all Medicaid managed care plans exactly what to pay for drugs. Specifically, the RFP indicates that reimbursement for all drugs will be "ingredient cost and any applicable fees," and that 340B drugs will be reimbursed at a different rate than non-340B drugs. Ingredient cost almost certainly means the actual acquisition price paid for the drug (i.e., the fee-for-service (FFS) model), and the RFP indicates that the successful bidder must be able to pay for 340B drugs differently than non-340B

drugs. It is not clear whether the fee will be more than, less than, or equal to the FFS professional dispensing fee.

Contemporaneous with the release of the RFP, we received a contract from one potential applicant that proposes to reimburse us at Actual Acquisition Cost (AAC) plus a very low dispensing fee, *thereby wiping out the 340B margin*. It will also reimburse us for retail (non-340B) prescriptions at a very low rate. Our contract with this Payor includes strict confidentiality language that, on advice of counsel, prohibits us from sharing the terms with you.

Per your request, Dr. Clark amended his presentation to indicate that we received the letter *contemporaneous* with the release of the RFP. The RFP was released on July 24 and the letter from the payor/PBM is dated July 21, though we received it on July 28, after the RFP was released. Dr. Clark also amended the presentation to indicate that we received the letter from a *potential* applicant because, as you indicated, no applications have yet been made in response to the RFP for a single PBM. However, the payor's/PBM's intent to apply is clear in its cover letter. In it, the payor/PBM explains that the purpose of the proposed contract amendment is to extend to us the opportunity to participate in the Payor's Medicaid Plans should the Payor be awarded a Medicaid managed care contract in Ohio and the Payor-owned PBM is selected as the PBM. Our contract with this Payor includes strict confidentiality language that, on advice of counsel, prohibits us from sharing the terms with you.

Implementation of a single PBM in partnership with a PBM like the potential applicant described above and/or with a policy that seeks to reimburse the Covered Entity as poorly as the scenario described above is a grave threat to the sustainability of Covered Entities.

Payor Efforts to Force Covered Entities to Accept Actual Acquisition Cost (Slide 13)

There is no misinformation on Slide 13. As Dr. Clark shared in his presentation, some of the PBMs that contract with the current Ohio Medicaid managed care plans are already mandating that Covered Entities submit Actual Acquisition Cost which, in effect, contractually wipes out the 340B savings intended, by law, for Covered Entities. Per your request for Dr. Clark to share this information with ODM, attached please find an amendment to the Payor Sheet sent to us by a PBM that services existing Ohio Medicaid managed care plans. We are able to share this amendment to the Payor Sheet with you because it has been made public.

Manufacturer Policies Relating to 340B Utilization at Contract Pharmacies

Lastly, we are increasingly concerned about policies that drug manufacturers are beginning to implement relating to 340B utilization at contract pharmacies. As Dr. Clark indicated in his presentation to the Council, six manufacturers have in the last 60 days notified Covered Entities of the manufacturers' intent to limit or eliminate reimbursement at 340B rates for prescriptions filled at contract pharmacies.

Slide 15

This slide communicates the impact to Equitas Health of pending threats to the 340B program, as Equitas Health perceives them. As Dr. Clark shared in his presentation, there is an illusion that initiatives that result in taking the 340B margin from Covered Entities save money and lower drug costs. **That is not true.** Rather, they only result in reducing the ability of safety net providers to provide affordable medications to patients and to provide needed medical and supportive services to underserved communities. Initiatives that threaten the viability of the 340 program make it less likely that pharmacies and Covered Entities can serve patients and keep their doors open. Simply stated, eliminating 340B savings to Covered Entities will result in the loss of services, closure of facilities across the state, and increased utilization of emergency rooms. Covered Entities and 340B pharmacies are being squeezed on all sides by PBMs, payors, and manufacturers, *but the patient suffers.*

Lastly, you asked about the portion of our 340B savings that is attributable to Medicaid. We welcome a dialogue with you about Medicaid data.

I am available to discuss this response with you at any time should you have follow-up questions.

Sincerely,



Bill Hardy
President & Chief Executive Officer

CC: Aaron Clark, Daphne Kackloudis, Chairman Damschroder