Ohio Hematology Oncology Society
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Ohio Hematology and Oncology Society
House Bill 63 proponent statement
House Health Committee
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Chairman Merrin, Vice Chairman Manning, Ranking Member Boyd, and members of the committee I am Dave Dillahunt, Executive Director of Ohio Hematology Oncology Society (OHOS). On behalf of the 160-member oncology and hematology physicians of the Society, we are thankful to Representatives Lipps and West for bringing legislation to address a situation that has garnered a tremendous amount of attention in the media that I know has dominated much of the discussion around prescription drugs. Pharmacy Benefit Managers (PBMs), their business practices, and activities in Ohio have been the subject of intense media scrutiny for over a year and have been a point of discord for practices and practice pharmacies for many years.

I appreciate the opportunity to provide a proponent statement on House Bill 63. The "clawback" issue has a very significant financial impact on the specialty pharmacies that are operated by oncology practices. This issue has a real impact on patient cancer care, but House Bill 63 is just the starting point. While these are very narrow business practices in which PBMs engage, there are many others that OHOS members want to bring to your attention that members are facing from these PBM practices. The need to reform PBMs from the prospective of an oncology practice is literally a life or death matter. All the issues below have an impact on patient care and health care costs. Issues that OHOS member pharmacies deal with on a regular basis are the following:

- Excluding physician-owned pharmacies from an insurance network and/or limiting pharmacies to the initial script only;
- Delays in deliveries of cancer drugs to patients and the start of their treatment;
- Steering patients to their own pharmacies;

Many of the points above are significant enough that they deserve a separate bill to address them and OHOS will seek that legislation. However, an item that OHOS believes is appropriate to address in House Bill 63 by amendment deals with the undefined and inappropriate application of quality metrics for oncology drug dispensing.

Quality measurements are nothing new to oncology practices as insurers and Medicare use them extensively. However, in those cases the practices typically know what they are being measured on and have the opportunity to improve their scores. On the other hand, PBMs will use metrics unrelated to what the specialty pharmacy is actually prescribing, fail to tell the practice why they are taking back/withholding funds and utilize the takebacks are pure revenue. There is no benefit to patients or improvement in quality and it puts physician-owned pharmacies in financial risk.

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Under these quality programs, the amount of fees assessed against a pharmacy depends on the pharmacy's performance in certain categories, with lower performing pharmacies being assessed a higher fee (clawback) and better performing pharmacies being assessed lower fees. Fees can be a flat fee, or a percentage of total claims submitted.

For example, a flat fee performance metric would have the PBM withhold $5.00 from each claim submitted by the pharmacy to the PBM. The PBM will review the pharmacy's performance and will refund the pharmacy $0.50 for each category in which the pharmacy performs in at least the 50^{th}-79^{th} percentile. For each category that the pharmacy performs above the 80th percentile, $2.25 will be refunded. Thus, if a pharmacy performs between the 50th to 79th percentile for all categories, the pharmacy will receive a $1.50 refund and will forego the balance—$3.50—to the PBM. Effectively, the pharmacy has paid a $3.50 fee to the PBM to be measured. Flat fee fees are especially dangerous to community retail pharmacies as the $5 clawback can actually cause pharmacies to lose money by filling the prescription.

Performance metric fees based on a percentage of the drug cost can be especially profitable to the PBM on high cost medications, such as cancer drugs provided by specialty pharmacies. For example, in the case of Xalkori for lung cancer, a 5.5% fee would result in the PBM clawing back over $1,000 on just that one claim alone.

This is extremely problematic, as these higher-cost specialty medications have slim gross percentage margins, and the 3% to 9% fees may eat up all of the pharmacy's modest margins or cause them to actually lose money.

For pharmacies providing a large percentage of higher cost specialty medications, the aggregate impact of clawbacks can be staggering. Some pharmacies have reported being charged over $200,000 in fees per quarter, per PBM, as evidenced by a publicly traded specialty pharmacy announcing over $10 million in fees from PBMs in 2016.

Whether the fees are a fixed rate or percentage based, neither provides additional payment incentives over the contracted and adjudicated price of the drug. Rather, a strongly performing pharmacy can only hope to minimize the amount clawed back by the PBM.

The use of PBM quality metrics is a big challenge for specialty pharmacies because they are unrelated to what they do. Current quality metrics used to measure performance includes patient adherence in therapeutic categories such as diabetes, congestive heart failure, hypertension, respiratory, coronary artery disease, depression, and cholesterol. Drugs used in these disease states are rarely dispensed by oncology practice pharmacies. How is it possible to score 60% compliance with a PBM's quality metrics when you don't dispense any drugs they measure? The pharmacy constantly operates in a position of failure in a system that is rigged against them.

Based on the pharmacy's performance in these quality categories, they are assessed a fee. However, specialty pharmacies are assessed fees based on quality metric categories regardless of whether the pharmacy has any claims subject to the reporting and measurement criteria. Said another way, each pharmacy is judged by using the same set of quality metric categories, even if the specialty pharmacy's business model renders the quality metric categories wholly inapplicable.

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For example, CVS Caremark scores pharmacies based on the drugs for therapeutic categories mentioned above (drugs specialty pharmacies don't dispense). If you miss target compliance, then they take back 3-9% of claims in the measurement period over an 8-week time frame. This can amount to $15,000-$20,000 quarterly because CVS Caremark is taking back that money on all drugs dispensed, not just on the drugs they are grading the pharmacy on. Since specialty pharmacies don't dispense the drugs, they face that takeback every quarter because they can't do anything to increase compliance or adherence. No benefit to patient, employer, or payer is gained just profit to CVS Caremark**.**

Specialty pharmacies have no ability to influence, control, or drive the quality measurements utilized by PBMs in many of their current quality programs. For many specialty medications, the result of these fees has often led to unreasonable, below-acquisition reimbursement rates which severely negatively impact specialty pharmacies. Far beyond merely reducing profits, fees force specialty pharmacies to often times dispense drugs far below their acquisition costs or make the difficult decision to not dispense the drug at all.

This all results in horrible patient care at the expense of profit for the PBM. Oncology specialty pharmacies have the drug on site but have to decide whether the practice can afford to dispense the drug. This results in delay in treatment and inconvenience for the patient.

OHOS requests the sponsors and the committee consider an amendment to House Bill 63 addresses the inequity of pharmacy benefit managers and a system of vague quality metrics that are used against oncology physician-owned dispensing pharmacies.

OHOS physician-owned pharmacies want to comply with quality metrics, but only those that make sense for the patients we serve. Thank you for the opportunity to share these perspectives.