HEALTH HOUSING, WORKING & BUSINESS

Understaffing at some CVS pharmacies in Virginia has put patients at risk, former employees say

One location in Virginia Beach was fined $470,000 for serious dispensing errors. Pharmacists say its a systemic problem.

BY: **KATE MASTERS** - OCTOBER 11, 2021 12:05 AM

A CVS pharmacy. (Ohio Capital Journal)

Over the last two years, employees at a CVS Pharmacy in Virginia Beach have raised repeated

concerns over patient safety.

At one point, multiple pharmacy technicians told a state inspector that a pharmacist at the store had mistakenly given a patient a hundred extra doses of Percocet — a powerful prescription opioid. Another customer received an antibiotic despite a known history of not tolerating the drug and was taken to the emergency room after an allergic reaction.

In another instance, a patient received the right medication with the wrong instructions, according to another pharmacy tech, who said the oral cholesterol drug came with directions to insert the pills vaginally.

The root of the errors, employees said, was chronic understaffing and an unsustainable workload that made it impossible for pharmacists and technicians to focus on their jobs.

"The pharmacists cannot properly concentrate because they have so much to do," said Kristopher Ratliff, a member of Virginia's Board of Pharmacy, reading from a more than 600-page investigative report produced by state regulators.

"A staff pharmacist stated hours had been cut to the point where she didn't know how the pharmacy was supposed to function," added Mykl Egan, the board's discipline case manager, reading from the report. "A fourth pharmacist described the pharmacy as a 'sweatshop.'"

The findings, which covered a single CVS store, resulted in a $427,000 fine for the chain and one unannounced inspection within the next 12 months. CVS "respectfully disagree[s]" with the board's order, according to spokesman Mike DeAngelis, and is "considering our options" for potential next steps.

But news of the investigation came as no surprise to former CVS employees in Virginia, who said working conditions were so bad that they had affected their mental and physical health. Nor were the problems contained to a single store, according to two former pharmacists, who worked in multiple locations across the state and heard similar concerns from other staff members.

"The sheer number of people who go home and cry because of the pressures they're under — it's unbelievable," said Michelle Harmon, a former CVS pharmacist in the Hampton Roads region who's still part of a Facebook group for mothers in the industry. "You're so mentally drained you don't have time for your family. I was just existing — going to work, coming home, doing whatever I could to hit the numbers so my patients were taken care of."

Safety and staffing issues at national pharmacy chains have become a growing issue for state regulators both in Virginia and across the country. A 2020 investigation by The New York Times found that at least two dozen states have received multiple complaints from pharmacists and physicians worried that chain pharmacy policies are undercutting patient care.

In many cases, the errors have had significant consequences. An 85-year-old in Florida died after a Publix pharmacy dispensed a chemotherapy drug instead of the antidepressant she was

prescribed. At the CVS in Virginia Beach, a state inspector reviewed 200 hardcopy prescriptions and found 74 mistakes – an error rate of roughly 37 percent. In at least two cases, pharmacists dispensed medications at multiple times over the prescribed dosage, including cyclobenzaprine, a muscle relaxant, and dexamethasone, an anti-inflammatory drug that's been used to treat COVID-19 patients.

"Now, in my 32 years of practice in retail pharmacy, this is a classic symptom of going too fast, too distracted, to pay attention to what you're doing," Ratliff said during the hearing. At one point, he described the working conditions as "unacceptable," but the board's secretive disciplinary process makes it difficult to determine how widespread the problems are across Virginia.

Diane Powers, director of communications for the Virginia Department of Health Professions, said that board investigations are complaint-driven. However, complaints against pharmacies are considered confidential under Virginia state code, she said, making it impossible to know whether other CVS stores have experienced the same problems.

The board did release its final order in the case, but refused to provide the Mercury with a copy of the full investigative report, which was referred to repeatedly during the public hearing. Powers also said the report was exempt from disclosure under the state's Freedom of Information Act laws.

A Publix pharmacy manager retrieves medication. (Joe Raedle/Getty Images)

“Investigations are confidential under law and therefore, the board can neither confirm or deny the existence of any ongoing investigations,” she added in a follow-up statement. Nearly half of the board’s disciplinary case decisions involving pharmacies over the last 90 days have been issued in response to violations by large chain locations, including CVS, Walgreens and Rite Aid. But it’s unclear if any involved complaints similar to those filed against the CVS store in Virginia Beach.

Both Harmon and another former CVS pharmacist, who requested anonymity because she feared professional repercussions, say understaffing has been a growing problem at CVS for years. It only became worse with the arrival of COVID-19, they said.

Before the pandemic, the company had steadily been reducing the number of hours that pharmacy techs, a non-salaried position, were allowed to work every week. The former pharmacist said it was clear some stores didn’t have enough staff to meet the demands of the job, but that the stress was “manageable” until cases of the virus began to spread.

“Then COVID just made things impossible,” she said. “That tipped it over the edge.” Both pharmacists worked at high-volume stores, where they’d fill anywhere between 500 and 1,000 prescriptions a day. Harmon said her pharmacy sometimes received up to 10 phone calls at a time, which employees were expected to answer by the second ring. The pharmacies also ran drive-throughs and provided in-store services, including flu vaccines and counseling patients on their medications.

When COVID-19 hit, the pharmacies also started offering testing and — eventually — vaccinations. The former pharmacist who requested anonymity said CVS sent in additional pharmacists to administer the vaccines, but billing for the shots and registering them in the state’s immunization system fell to the regular staff.

“Before the clinic started, you’d just get pages and pages and pages,” she said. “All of that paperwork went through your pharmacy that’s filling 900 prescriptions a day.” Harmon left the company later, in July of this year, after a brain hemorrhage she said doctors attributed to stress.

“I have fully recovered and I’m thankful for that,” she said. “But as I lay in that bed, I thought to myself, ‘I’ve got to get out of this environment.’”

They aren’t the only CVS employees to report health issues traced to stressful working conditions. According to the Board of Pharmacy decision, a pharmacist at the Virginia Beach location was diagnosed with anxiety and took a medical leave of absence from the store. A technician also took stress-induced leave, and another was prescribed anti-anxiety medication “because of the stress of working” at the pharmacy.

DeAngelis, the spokesman for CVS, described many of the complaints in the report as "inaccurate or outdated" ("It should be noted that the underlying complaints from a former employee are nearly two years old and this store location has since had a change in management," he wrote in an emailed statement).

Harmon, though, said she had experienced many of the same challenges described in the hearing as recently as July. One of the main stressors, for both her and employees at the Virginia Beach location, were the metrics that CVS set for its stores. According to Harmon, expectations were broken down into a 100-point system, from how fast it took to type a prescription into the system to how quickly it was checked by a pharmacist and delivered to a patient.

But as the company cut down technician hours, Harmon and the other pharmacist said those metrics became harder and harder to meet. With the drive-through and COVID-19 testing to run, they said there was sometimes a single pharmacist and technician left to fill hundreds of prescriptions by themselves. On some days, Harmon said it amounted to filling a prescription every minute and a half in an average 13-hour shift.

There was also what pharmacy board members described in the hearing as "busywork" — other tasks that employees were assigned and rated on. The other former pharmacist said the company expected pharmacists or technicians to call at least 100 patients a week to check if they needed a prescription refilled or wanted to switch to a larger, 90-day supply.

At first, she said CVS budgeted additional staff hours for the calls, but they eventually became part of the daily workload. Harmon said patients were also given the option to request drug delivery instead of picking up the medication in-person.

But the company expected deliveries to go out at a certain time every day, and allowed customers to order additional items from other sections of the store.

"So, I'm having to have a technician stop what she's doing, filling prescriptions, to go package a non-prescription order," Harmon said. At some points during the pandemic, she estimated her store received at least 20 orders a day.

Employees said the constant distractions made it impossible to meet metrics and fill prescriptions safely. At one point, one of the pharmacists worked in a store with a backlog of more than 700 orders, when that happened, they said it was up to the salaried pharmacists to work extra hours — or come in over the weekend — to get the store caught up.

The former pharmacists said the workloads made it nearly impossible for pharmacists or technicians to take a break during the day.

At the Virginia Beach location, the Board of Pharmacy found one employee was asked to sign a waiver attesting she wouldn't take a meal break. Another "routinely" ate her lunch behind the pharmacy safe, according to the board's order, because the store was too busy to stop working. The former pharmacist who asked for anonymity told the Mercury her pharmacy

wasn't allowed to close for lunch, and there were regularly days when she didn't have time to use the restroom for an entire 13-hour shift.

DeAngelis noted that management had changed at the Virginia Beach location since the investigation. "In fact, our store's lead pharmacist and its district leader both appeared at the board hearing to refute the allegations," he wrote. New district leader Paul McCormick told the board that CVS was in the process of unrolling regularly scheduled lunch breaks at pharmacies nationwide, and that the company had reduced both the number of calls and metrics it expected employees to make and meet.

Board members, though, appeared skeptical that the personnel changes had led to a significant shift in culture. And both former pharmacists said many CVS employees weren't waiting on improvements, with staff leaving for other jobs.

"Nobody wants to make mistakes," Harmon added. "That's why we didn't take breaks. That's why we didn't go to the bathroom. That's why you come in early and stay late. You basically sacrifice yourself to make sure your patients are taken care of."

KATE MASTERS

An award-winning reporter, Kate grew up in Northern Virginia before moving to the Midwest, earning her degree in journalism from the University of Missouri. She spent a year covering gun violence and public health for The Trace in Boston before joining The Frederick News-Post in Frederick County, Md. While at the News-Post, she won first place in feature writing and breaking news from the Maryland-Delaware-DC Press Association, and Best in Show for her coverage of the local opioid epidemic. Before joining the Mercury in 2020, she covered state and county politics for the Bethesda Beat in Montgomery County, Md.

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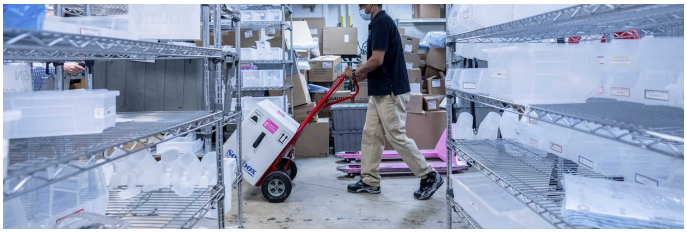

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HEALTH

Virginia's largest insurer wants investigation of Sentara for 'anti-competitive harm'

The move comes after the health system threatened to cut off some Medicaid patients from its facilities

BY: **KATE MASTERS** - OCTOBER 25, 2021 12:02 AM

Sentara Heart Hospital in Norfolk. (Ned Oliver/Virginia Mercury)

In early April, Sentara – one of the largest health systems in Virginia with 11 hospitals scattered across five regions – sent a letter to Anthem, the state's largest insurer.

Lance Torcom, Sentara's chief managed care officer, informed Anthem that the system would be terminating its contract with the insurer's Medicaid and Medicare lines of business. Effective Oct. 12, in other words, any patient who received government-provided health coverage through Anthem would no longer be able to use their insurance at Sentara's facilities. Those include not only the system's acute care hospitals, but seven affiliated surgery centers and six physician groups that also fall under its ownership.

"Please understand that it has always been our preference to avoid such action," Torcom wrote to Andy Randazzo, a regional vice president for Anthem. "In fact, we purposefully provided Anthem with advance verbal and written notice of this potential action in February in an attempt to resolve the matter and avoid escalation."

The move, which could have affected more than 525,000 of Anthem's Medicaid patients across Virginia, according to state enrollment figures, never happened. After weeks of negotiation, Sentara rescinded its termination notice on Aug. 16. Anthem's Medicaid and Medicare patients were never notified about the dispute or told their insurance would no longer be accepted at Sentara facilities, according to Christina Nuckols, a spokesperson for the Virginia Department of Medical Assistance Services, which administers the state's Medicaid program.

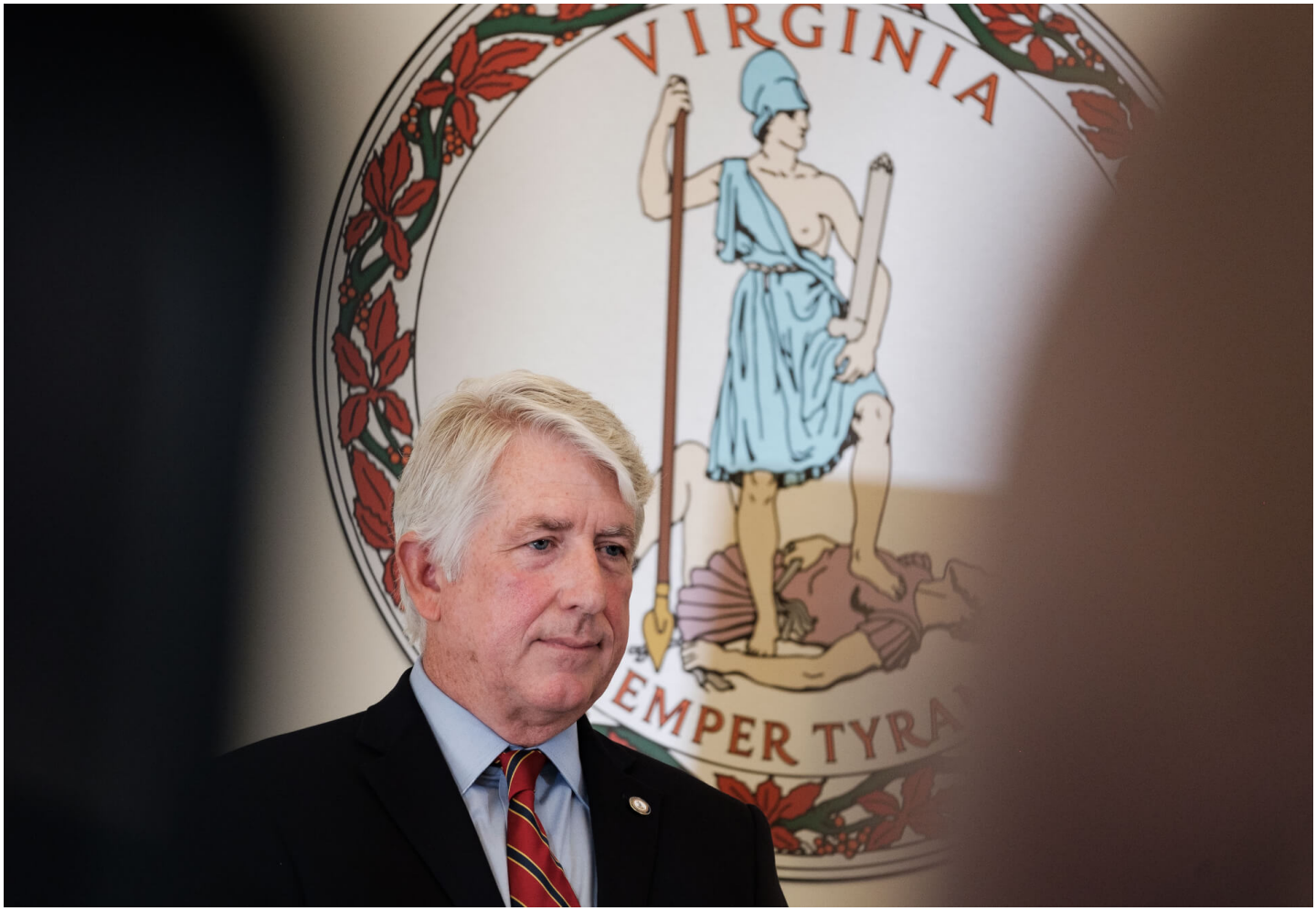
"Health care access and services for our members continued without disruption," she wrote in an email. But not before Anthem escalated the fight to state regulators. In May, the company sent a letter to Attorney General Mark Herring, asking his office to look into the "anti-competitive harm" posed by Sentara. Even after the hospital system withdrew its termination, Anthem prodded for an inquiry.

"We continue to encourage the Office of the Attorney General to investigate the anticompetitive behavior of Sentara to leverage their monopoly status in their efforts to limit payor competition," Lindsay Berry Winter, the insurer's senior director of government relations, wrote in a later email to state officials (the Mercury obtained the documents through a Freedom of Information Act request).

"While we are thankful that our members were not denied access to the monopoly hospital in the region, we do not think Medicaid and Medicare beneficiaries should be used as pawns by hospitals in contract negotiations," she added. "Especially those hospitals who have ownership stakes in competitor health plans."

The conflict speaks to Sentara's growing market dominance — largely left unchallenged by state regulators — but also a new era of scrutiny into large health systems. Earlier this summer, President Joe Biden cited hospital monopolization as a specific area of concern to competition, signing an executive order that directed federal regulators to focus their enforcement efforts on health care markets. Numerous states, including California and North Carolina, have seen officials crack down on sprawling hospital systems for stifling competition in their regions.

Virginia's Office of the Attorney General wouldn't disclose whether Anthem's complaints



Virginia Attorney General Mark Herring. (Ned Oliver/Virginia Mercury)

resulted in any action against Sentara. "We generally do not comment on pending investigations, even to confirm whether or not one may be ongoing," spokesperson Charlotte Gomer wrote in an email to the Mercury. Historically, the office's involvement in the hospital industry has been confined to "review of mergers or transfers/sales of assets," chief of staff Michael Kelly said in a follow-up email.

But growing pressure from other large health care players could shine a new spotlight onto Virginia's increasingly consolidated hospital systems, which have long enjoyed protection under the state's regulatory laws. Sentara is far from the only player, but it's also an easy target.

The system currently commands just over 72 percent of the inpatient market share in the Hampton Roads region, where seven of its 11 hospitals are located, according to a white paper commissioned by a competing health system (Sentara has not disputed the figure). Just a few weeks before its termination letter to Anthem, the system was sued by the same competitor – Chesapeake Regional Medical Center – for aggressively and intentionally crippling the smaller hospital's cardiology program, according to the lawsuit.

And in addition to its medical facilities and physician groups, Sentara owns its own health plans – Optima (which it owns in full) and Virginia Premier, of which it holds an 80 percent

majority share. It's those companies, specifically, that have attracted scrutiny for stifling competition.

"Health systems that also own health plans have the ability to limit the number of other health plans its providers contract with," Anthem spokesperson Colin Manning wrote in an email, "or set financial terms that are unfavorable to competing health plans – effectively limiting consumers' access and choice and increasing health care costs."

'It's hard to characterize this as anything more than an awful policy failure'

That kind of consolidation – hospitals that own their own physician practices and, frequently, insurance companies – is often referred to as "vertical integration." And it's a practice that's staunchly defended by the health systems who use it. Sentara spokesperson Danya Bushéy wouldn't discuss the dispute with Anthem, saying only that Sentara "does not comment on the details of our contractual relationships" but was "glad we reached an agreement ... that is in the best interest of our patients and their members."

She did, however, extol the benefits of Sentara's "integrated delivery system" – points repeated by Colin Drozdowski, the senior vice president of provider network management for Sentara Health Plans, at a recent meeting of the state's Health Insurance Reform Commission.

"We, as an integrated delivery network, can seamlessly work both with our employed physicians and our contracted partners on behalf of the member, on behalf of the patient, through a health plan that maximizes their opportunities," he told lawmakers.

Much of the argument, in other words, is that health plans owned by hospital systems work out better for consumers. In some ways, hospitals have faced real headaches from Anthem and other large insurance companies, which are currently running billions of dollars behind on payments for treatment, according to reporting by Kaiser Health News. Some hospitals – and patients – are also seeing a rise in retroactive claims denials, disrupting care and creating anxiety over who's responsible for paying large medical bills.

But when hospitals own their own health plans, those disputes tend to disappear. There's no disagreement over what kinds of treatment are reimbursable – or which providers are covered in-network – when they're all operating under the same ownership system. Sentara was an early adopter of the model, which has been progressing for at least a decade. And experts say it provides hospitals with some clear benefits, including complete control of premium dollars and more power to steer customers toward their facilities and services.

"The proven benefits...include lower provider costs, lower premiums, improved quality of care and better outcomes," Bushéy said. "We operate one of the lowest-cost, highest-quality health care systems in the commonwealth." It's an argument that's been largely accepted by Virginia legislators, as well, who have openly questioned efforts to regulate vertically integrated health systems.

"Is there any third-party data showing huge dissatisfaction with the system as it stands?" asked Del. Wendy Gooditis, D-Loudoun, at the same meeting. "Because I tend to think that hospitals

have to be supported."

Barak Richman, a professor with the Duke University School of Law who specializes in health care policy, says that's still a common sentiment for officials both in Virginia and across the country. And Virginia, like many other states, offers hospitals an extra degree of protection through its certificate of public need (or COPN) laws – regulations requiring hospitals and other medical facilities to get state approval for everything from adding new beds to purchasing new imaging equipment to establishing new surgical programs.

Today, the process is increasingly used by neighboring hospital systems to oppose new projects from their competitors. Carilion Clinic, for example, has long blocked efforts by HCA Healthcare to open a new neonatal care unit in the Roanoke region. Chesapeake Regional Medical Center's lawsuit against Sentara was based partially on the fact that its application for an open-heart surgery program was denied – but only after Sentara spoke out against the proposal.

Health care workers with the Carilion Clinic in Roanoke wear enhanced personal protective equipment inside the health system's facilities (Photo courtesy of the Carilion Clinic).

"It's hard to characterize this as anything more than an awful policy failure," Richman said. For decades, mergers and acquisitions by hospital systems have faced little scrutiny from regulators. Sometimes, they're explicitly approved by them. In Virginia, for example, two southwestern hospitals merged to form Ballad Health, now the sole health system in the

region, with the express permission of Virginia and Tennessee health authorities – and over the objections of the Federal Trade Commission.

"They're basically saying, 'Look, we know price competition is important, but we think we'll be able to prevent them from using their monopoly power,'" Richman said. "And that tends to be a pretty high form of arrogance." Like other economic experts, he says consolidation, combined with regulatory protections like COPN, has increasingly concentrated services in the hands of a few large health systems – allowing them to raise prices with little room for pushback. And that, Anthem argues, is exactly what Sentara is doing.

Cost-saving measures, or a threat to Anthem's bottom line?

The dispute started with specialty drugs and outpatient surgery. In its termination letter to Anthem, Sentara specifically cited those two policies in its decision to cut off the company's Medicare and Medicaid plans.

The first is better known as "white bagging" – requiring hospitals to source specialty medications through insurer-approved pharmacies rather than buying and billing for the drugs themselves. The second is an initiative to direct Anthem's Medicaid patients to outpatient sites for some procedures, rather than going to the hospital. And while white bagging hasn't actually been implemented in Virginia, according to Manning, Anthem's spokesperson, both policies are wildly unpopular with hospitals.

A Publix pharmacy manager retrieves medication. (Joe Raedle/Getty Images)

"It is important that Anthem understands Sentara's increasing frustration over these unilateral changes which are occurring with little notice, no negotiation and no consultation prior to implementation," wrote Torcom, the system's chief managed care officer. The American Hospital Association described them as a "bait-and-switch" for both in-network hospitals and patients, impacting services that should be covered by the insurer.

But Richman said it's important to note that both initiatives are intended to lower health care costs, a responsibility that's increasingly falling on insurance companies. Many surgeries, especially elective procedures, are one of the biggest profit-makers for health systems, even though they can often be done more quickly – and more cheaply – in outpatient settings. Torcom described the outpatient initiative as an issue of "patient and physician choice," but he also worried it would reduce "the volume of ambulatory surgeries at our hospitals."

Specialty medication can also be a big money-maker. Reports have found that some hospitals mark up the prices of certain drugs by an average of 250 percent, billing insurance for the same amount. Doug Gray, executive director of the Virginia Association of Health Plans, told the Mercury in May that white bagging was an effort to rein in those payments (though it's also helpful for the insurers' bottom line).

"The reason that the hospitals are complaining is because they mark up the drugs and keep the difference," he said. Richman, too, described the two initiatives as "pretty rudimentary" strategies to keep costs down.

"Hospital monopolies have been the primary cause of health care price inflation over the last 25 years," he said. "And for the most part, insurers have just tried to go along with the strategy – saying, 'Okay, look, we'll just have to stomach whatever price increases there are and have them reflected in our insurance premiums.'"

That's where Sentara's market dominance becomes a problem, according to Anthem. Typically, large insurance companies have leverage when they negotiate with hospitals because of the number of customers they can offer them. But in an environment where one health system commands more than 70 percent of the inpatient market – plus physicians' practices and outpatient offices – that health system has all the power. In other words, if Sentara decides to cut off Anthem's patients over cost-saving initiatives, those individuals often have nowhere else to go for care.

"Due to Sentara's market share, denying our Medicaid and Medicare members in-network access to Sentara's physicians and facilities will disrupt critically important patient-provider relationships for the most vulnerable Virginians," executives wrote in their letter to the Attorney General. That makes it far more likely the insurer will roll back its initiatives, or exempt the health system, to maintain access. (Manning would not comment on whether Anthem exempted Sentara from the policies to maintain its Medicaid and Medicare contracts with the health system).

Over the years, some large hospital systems have also gotten in trouble for so-called "anti-steerage" provisions – clauses in their contracts with insurance companies that prohibit the carriers from directing members to medical services from competing providers. Since those contracts are considered strictly proprietary, consumers usually don't know the provisions are in place, Richman said. But health systems can use them to restrict access to lower-cost services, limiting consumer choice and driving up the cost of premiums.

It's not clear whether any of Sentara's contracts include the provisions, but objecting to outpatient initiatives accomplishes the same thing, Anthem argued.

"We continue to contend that retaliatory action like terminating a contract over a site-of-service program is no different than forcing that health plan to agree to anti-steerage language in the provider agreement," Berry Winter, the carrier's senior director for government relations, wrote in her email. And there's an added layer of complexity given that Sentara owns its own health plans. Both of them, Optima and Virginia Premier, are managed care organizations for Virginia – health insurance companies contracted by the state to provide coverage to its Medicaid enrollees (many of them also provide plans to individuals on Medicare).

Anthem is also one of the state's six contracted MCOs. And while the company is the largest commercial insurer in Virginia, with roughly 40 percent of the market, Sentara's health plans account for the largest share of government-provided insurance – with nearly 32 percent of the market compared to Anthem's 25 percent, according to Bushéy, the Sentara spokeswoman.

That makes Anthem and Sentara health plans direct competitors for some of the same customers. Anthem argued that it gives the health system an added incentive to terminate Anthem's coverage. When that type of disruption occurs, the Department of Medical Assistance Services allows Medicaid members to switch health plans outside the normal open enrollment period, according to Nuckols, the department's spokeswoman. And with Anthem cut off from Sentara hospitals, many of those patients might choose to move to Optima or Virginia Premier.

"These actions serve no purpose other than to attempt to force Anthem into keeping costs high for Sentara's own gain while simultaneously limiting competition for its Medicaid and Medicare health plans," executives wrote.

A threat to Medicaid spending

Vertical integration isn't a new issue in Virginia. But it's one that's failed to shake loose a legislative solution. Back in 2019, two lawmakers filed bills that would require integrated health systems to allow public hospitals to participate in their insurance networks. The motivation, again, was Sentara – and Optima – which doesn't cover all the services offered by the nearby Chesapeake Regional Medical Center. Both bills, though, died in House committees, as did similar legislation filed the year before.

Part of the problem is that the health care marketplace is extraordinarily complicated, making it difficult for part-time legislators to absorb the issues over a typical two-month session. “I know there have been conflicts over this situation, but to be honest, I am not an expert on it at all,” said Del. Mark Sickles, D-Fairfax, a senior budget negotiator and chair of the House Health, Welfare and Institutions Committee.

Del. Luke Torian, D-Prince William, left, chairman of the House Appropriations committee, confers with Del. Mark Sickles, D-Fairfax, right, as the Virginia House of Delegates begins their special session inside the Siegel Center in Richmond, VA Tuesday, August 18, 2020. (Pool photo by Bob Brown/ Richmond Times-Dispatch)

Often, the debates seem to boil down to competition between large business interests, which the General Assembly has been historically reluctant to wade into, according to many legislators and lobbyists. Both Anthem and the hospital industry have spent millions on lobbying and political contributions over the years, which also muddies the water. But Richman said the end result is usually higher costs for consumers. There’s also concern that vertically integrated health systems may be driving up state Medicaid spending.

It’s an issue the Joint Legislative Audit & Review Commission, a legislative watchdog group, explored in 2016, as Virginia was debating Medicaid expansion. The analysis found that Virginia had weaker caps on profits made by managed care organizations than other states, and didn’t do enough to disincentivize “inefficient” medical spending like avoidable emergency room visits or excessive prescriptions.

Some of the findings resulted in tighter regulations on the companies. The next year, for example, lawmakers passed budget language reducing payments to managed care organizations based on unnecessary medical treatment. The policy provides an incentive for

companies to reduce health care costs in order to keep more of the money they're paid by the state.

But another potential spending issue, the report found, was "related-party arrangements" — another term for vertical integration. Optima, for instance, may choose to pay Sentara facilities higher reimbursement rates than other hospitals it contracts with. Those agreements are considered strictly confidential, so consumers or competitors might not know. But the Department of Medical Assistance Services could adjust its reimbursement strategy so the state isn't paying above market value for those services.

While that was one of the recommendations in the report, it's not one the department has taken up. "There is no language included in the Appropriation Act directing DMAS to take this action," Nuckols, the Virginia Department of Medical Assistance Services spokeswoman, said in an email. And with little oversight over how the arrangements impact costs, competing insurers, like Anthem, argue there's little incentive for vertically integrated systems to bring down spending.

Parsing out the impact of the arrangements is notoriously difficult without fully understanding how much insurers are reimbursing hospitals for their services — and whether vertically integrated systems are getting better rates from their sister plans. But there is some evidence Optima is paying out more for medical care than other carriers.

Virginia keeps tabs on a metric known as medical cost ratio — the amount that each plan spends on health services and treatments. The state average is 84 percent, in line with federal requirements on how much carriers should spend.

Those targets are designed to ensure insurance companies spend the majority of their revenue on health costs, analysts said, while keeping a certain amount as profit. And in Virginia, managed care organizations are required to start returning some of their profits if they exceed three percent of their revenue.

Optima's medical cost ratio is 93 percent, indicating the company spends almost all of its profits on medical care. What's not clear, though, is which facilities are receiving the money. Hospital-owned insurance companies "have an incentive to pay more to related parties," according to the state's analysis, because they can share in the profits made by those providers. And paying higher rates to their own facilities could help them avoid returning excess profits.

"I'm not saying this exact thing happens," one state policy analyst told the Mercury anonymously (legislative analysts are not authorized to speak to the media on the record). "But this is the risk to the state."

KATE MASTERS

An award-winning reporter, Kate grew up in Northern Virginia before moving to the Midwest, earning her degree in journalism from the University of Missouri. She spent a year covering gun violence and public health for The Trace in Boston before joining The Frederick News-Post in Frederick County, Md. While at the News-Post, she won first place in feature writing and breaking news from the Maryland-Delaware-DC Press Association, and Best in Show for her coverage of the local opioid epidemic. Before joining the Mercury in 2020, she covered state and county politics for the Bethesda Beat in Montgomery County, Md.

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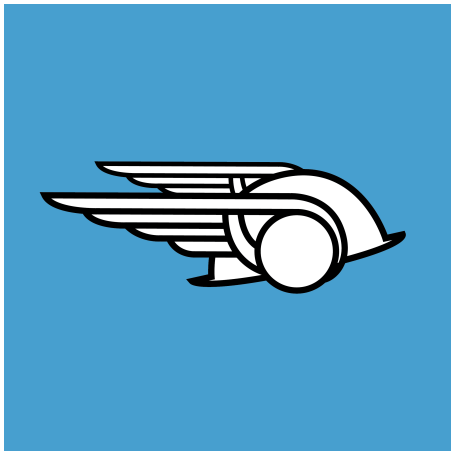

HEALTH

Specialty drugs are sparking the latest battle between Virginia hospitals and health insurers

BY: **KATE MASTERS** - MAY 21, 2021 12:03 AM

A Publix pharmacy manager retrieves medication. (Joe Raedle/Getty Images)

Some of Virginia's largest health insurers are taking more control over the supply chain for specialty – and often expensive – drugs used to treat cancer, rheumatoid arthritis and inflammatory bowel diseases such as Crohn's and ulcerative colitis.

Hospitals aren't happy about it.

The practice, known as "white bagging," isn't new. But Virginia is the latest state where hospitals say they're seeing a major expansion. United Healthcare, the state's third-largest insurer, currently has 77 drugs subject to white bagging requirements. The company will add 12 cancer drugs starting June 18, according to spokeswoman Trasee Carr.

Anthem, which commands more than 40 percent of Virginia's market share, also announced that multiple additional drugs would be subject to the requirements beginning July 1, said Julian Walker, the vice president of communications for the Virginia Hospital and Healthcare Association.

Anthem would not comment directly for this story, instead referring back to a May 18 letter in support of the practice from the Virginia Association of Health Plans, which lobbies for the industry.

White bagging refers to a new acquisition model for specialty drugs, prescribed to patients with serious health conditions requiring more complex treatment. Normally, hospitals and doctors source drugs from their own vendors, keep their supply onsite, and bill the medical side of insurance for reimbursement, said Dr. Madelaine Feldman, a practicing rheumatologist and expert on pharmaceutical supply channels who's given presentations to General Assembly members on drug pricing.

But over the last several years, a growing number of insurance companies are handling the sourcing themselves — requiring providers to purchase drugs through designated specialty pharmacies. Those medications are then shipped back to the facility to administer.

"They're saying, 'Let's not pay the provider to buy and bill,'" Feldman said. That's because hospitals, especially, are often able to source their own drugs at deeply subsidized prices and provide them to patients at a markup. That markup is then passed on to the insurance company when it's billed for reimbursement.

At the same time, it's become more and more common for large insurers to own specialty pharmacies and the companies that negotiate the cost of prescription drugs. That consolidation ensures profits and rebates from buying pharmaceuticals flow back to the insurers.

White bagging allows them to bypass providers completely, providing drugs at prices they have more control over while pocketing the savings. Hospitals say the process presents significant patient safety concerns — forcing doctors to administer drugs with no oversight over the supply chain. Insurers, on the other hand, argue it's a way to lower costs for patients.

"The practice saves consumers and payers — meaning employers — significant amounts of money," said Doug Gray, executive director of the Virginia Association of Health Plans. "The reason that the hospitals are complaining is because they mark up the drugs and keep the difference."

How white bagging will affect patients is a core component of the debate in Virginia. The state Board of Pharmacy is currently in the process of finalizing new regulations that would add

some guardrails to the practice – mostly by mandating that drugs are handled correctly and there's clear communication between the specialty pharmacy and receiving facility.

Hospitals, though, are pushing the board to consider whether the practice is legal under current state law. In addition to complaints that it violates patient choice and imposes unnecessary relationships with third-party pharmacies, they say white bagging is simply inefficient for doctors and patients.

"Just imagine your drugs going through the mail," said Matt Jenkins, the director of pharmacy services for UVA Health and president of the Virginia Society of Health-System Pharmacists. "And I don't mean this to be a shot at the postal system. But you get your infusion scheduled at the doctor's office, and we just hope the medication will arrive on time."

Stock via Getty Images.

Concerns over timing are one of many arguments against the process. In California, where providers are waging their own battle against white bagging, the state Board of Pharmacy received nearly 30 pages of comments opposing the process from hospitals and pharmacists. One hospital pharmacy director said he had to discard thousands of dollars worth of medicine when three vials were delivered to the mailroom of a separate department.

"Upon receiving and opening the container, pharmacy staff found three vials of medication that were supposed to be stored under refrigeration but had been delivered to an unlicensed

area," he wrote. "The vials totaled close to $10,000 worth of medication and the temperature was out of range."

Waste is a concern even when medication is delivered correctly. When providers source their own drugs, they can use the same medication for multiple patients – a prescription drug such as Remicade, for example, which can treat multiple autoimmune diseases. But when drugs are white bagged, they're specifically prescribed and approved for a single person.

"Chemotherapy drugs, for example, have a high efficacy and toxicity margin, meaning there's a tight window of the right dose for the right patient at the right time," said Dr. Richard Ingram, the president of a private oncology practice in Winchester. In other words, if a patient develops severe side effects to a medication, or the dose has to be adjusted based on weight or symptoms, it can't be used to treat someone else.

"The system has shipped a drug that the patient is no longer going to receive," he said. "And it can't be repurposed like general inventory. So the practice can be very wasteful."

Insurers say the real concerns come down to cost. In VAHP's letter to Virginia's Bureau of Insurance, Gray wrote that hospitals mark up the cost of some specialty drugs between 200 and 500 percent compared to private clinics. And providers already work with the same shipping companies used by specialty pharmacies, he said, making logistical arguments largely nonsensical.

"It is difficult for VHHA to argue that white bagging creates a breach of contract when their members significantly inflate the cost of specialty drugs year-over-year," Gray wrote. Some experts say the financial concerns are more valid for independent practices and infusion centers, where prices are more modestly inflated to cover staff time and basic expenses like rent.

Among providers, though, there's wide skepticism that cost savings on the part of insurance companies will be passed down to patients. Gray said white bagging works by lowering drug prices and the overall cost of premiums. But the same pharmacist in California who complained that drugs were misdelivered said one of his patients was suddenly hit with a much higher copay after the delivery model for her medication switched.

With drugs procured exclusively through insurers, Ingram said it's more likely the companies will insist on name-brand medications, which are more likely to come with rebates from the manufacturers.

"What we've seen is that we'll prescribe a biosimilar or generic version because it's less costly for the patients – particularly patients that have a copay that's a percent of cost," he said. "And the insurance company will reject that and say you have to use the name brand, which is way more expensive."

KATE MASTERS

An award-winning reporter, Kate grew up in Northern Virginia before moving to the Midwest, earning her degree in journalism from the University of Missouri. She spent a year covering gun violence and public health for The Trace in Boston before joining The Frederick News-Post in Frederick County, Md. While at the News-Post, she won first place in feature writing and breaking news from the Maryland-Delaware-DC Press Association, and Best in Show for her coverage of the local opioid epidemic. Before joining the Mercury in 2020, she covered state and county politics for the Bethesda Beat in Montgomery County, Md.

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