Exhibit 1

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA, ET AL., EX REL. MARC SILVER, Plaintiffs,	No. 1:11-cv-01326-NLH-JS
v.	
OMNICARE, INC., ET AL. Defendants.	

EXPERT REPORT OF LOUIS F. ROSSITER, PH.D.

December 3, 2021

CONFIDENTIAL

TABLE OF CONTENTS

I. Qualifications 3

II. Case Background and Assignment 4

III. Summary of Opinions 5

IV. Relevant Background 5

A. Long-Term Care Pharmacies 5

B. Medicare and Medicaid Payments to LTC Pharmacies 7

i. Medicare Part A 7

ii. Medicare Part D 9

iii. Medicaid 11

V. Opinion I: PharMerica's Medicare Part A Per Diem Rates Were the Natural and Expected Results of Interactions Between Willing Buyers and Sellers in a Competitive Market. **12**

A. The LTC Pharmacy Services Market Is Highly Competitive. 13

i. The Market Is Served by Many LTC Pharmacies, Big and Small, and Exhibits Low Barriers to Entry. 13

ii. The Rates for Per Diem Services Are Determined Through a Competitive Process, Not Set by PharMerica. 15

B. Low Profit Margins Are to Be Expected in the Market for Medicare Part A LTC Pharmacy Services. 16

i. The Prospective Payment System Encourages SNFs to Negotiate Low Prices for LTC Pharmacy Services. 17

ii. Vigorous Competition Results in Market-Driven Per Diem Rates for LTC Pharmacies. 19

iii. The Decrease in Medicare Funding in Fiscal Year 2012 Further Limited LTC Pharmacies' Ability to Increase Prices and Profitability. 20

C. Because of the Nature of PPS, SNFs Sometimes Prefer Per Diem Contracts, Which Can Occasionally Prove Unprofitable for LTC Pharmacies Despite Their Best Efforts. 21

D. PharMerica's Policies and Practices During the Relevant Time Period Were Consistent With That of a Profit Maximizing Company Operating in a Highly Competitive Market. 25

i. PharMerica Lost Business to Competitors Offering Lower Rates. 25

ii. PharMerica's Stated Policy Was to Have a Positive Margin on All Medicare Part A Contracts. 28

iii. PharMerica Employed and Sought to Improve Procedural Safeguards to Decrease the Probability of Suffering Losses on Its Per Diem Contracts. 30

iv. PharMerica Included Reset Provisions in Its Contracts and Routinely Reset Per Diem Rates. ... 34

v. PharMerica Utilized Contractual Remedies to Mitigate the Risk of Losses on Its Per Diem Contracts. 35

vi. PharMerica Actively Walked Away from Less Profitable Contracts. 36

VI. Opinion II: PharMerica's Per Diem Rates Had No Impact On Government Decisions Regarding Medicare Part D or Medicaid Payments. 39

I. QUALIFICATIONS

1. My name is Louis F. Rossiter. I am a Research Professor in the Public Policy program at the College of William & Mary. I received my Ph.D. degree in Economics from the University of North Carolina at Chapel Hill.

2. I was previously a Professor of Health Administration at Virginia Commonwealth University from 1982 to 2000. I took a leave of absence from the university from 1989 to 1992 to serve as deputy for policy to the Administrator of the Centers for Medicare and Medicaid Services ("CMS"). My responsibility was to guide all CMS policy initiatives through the federal legislative process and direct the development of the agency's strategic plan which involved extensive health information technology plans and projects. In this role, I reported to and worked directly with the Administrator of CMS to implement CMS's policy objectives. My duties included overseeing the creation of a $7 billion Medicare prospective payment system for reimbursing hospitals nationwide for new capital spending. The system revolutionized the way every hospital in the country is paid by Medicare, Medicaid, and private payers. One other major policy issue I directed was the CMS position on the 1990 Medicaid drug rebate legislation and subsequent regulations.

3. Several years later, I was appointed Secretary of Health and Human Resources for the Commonwealth of Virginia. As Secretary, I was responsible for over 15,000 employees in 13 agencies, including Virginia Medicaid. In that role I oversaw the Medicaid Drug Utilization Board. The Medicaid Drug Utilization Board is responsible for the promulgation of regulations regarding payments for certain generic drugs and defining the Average Manufacturer Price ("AMP") that is used in administering a rebate program designed to align pharmacy payments with the acquisition cost of drugs.

4. I previously served on the Board of Regents of the National Library of Medicine, National Institutes of Health (2008-2012); the Board of Directors of AcademyHealth; and was the 2010-2011 Chair of the Board of Directors of the Coalition for Health Services Research, the lobbying arm of AcademyHealth, as the Affordable Care Act passed through Congress. I have served on numerous advisory groups including the National Advisory Council of the U.S. Agency for Healthcare Research and Quality, DHHS. I am currently a Trustee and Chair Emeritus of the Williamsburg Health Foundation.

5. I am the author of 14 edited books, one sole-author book published in 2001 on Medicare managed care plans, and over 50 journal publications on health economics and the role of competition in the

CONFIDENTIAL

financing and delivery of health services.

6. I have testified or been an expert in the following areas: competition in the financing and delivery of health services, reimbursement economics, managed care organizations (especially Medicare Advantage and Medicaid Managed Care), prescribed medicines, survey research, and health information analytics.

7. My curriculum vitae, which includes a list of cases in which I have testified as an expert within the preceding four years, is attached hereto as **Appendix A**: *Curriculum Vitae*.

II. Case Background and Assignment

8. Relator Marc Silver brought an action against PharMerica Corporation ("PharMerica"), among several other institutional pharmacies, alleging that PharMerica violated the federal Anti-Kickback Statute ("AKS") by engaging in a practice called "swapping."[1]

9. Specifically, Relator alleged that PharMerica arranged to provide prescription drugs to Medicare Part A-eligible residents of certain skilled nursing facilities ("SNFs" or "SNF" in the singular) at prices below cost or below fair market value in exchange for supplying prescription drugs to those facilities' Medicare Part D and Medicaid patients, at considerably higher rates.[2]

10. I have been retained by PharMerica, through its counsel Holland & Knight, to analyze and opine on (i) how long-term care pharmacies ("LTC Pharmacies" or "LTC Pharmacy" in the singular) compete in a highly competitive and highly regulated environment and the economic outcomes expected in such an environment (such as low profit margins and occasional losses); and (ii) whether PharMerica's per diem rates have any impact on the government's Medicare Part A, Medicare Part D, or Medicaid payments.

11. A complete list of the documents and data that I relied upon in reaching my conclusions in this matter is provided in **Appendix B**: *Materials Relied Upon.*

12. The current hourly rate for my work is $725. My compensation is not affected by my findings or the

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[1] Relator's Fourth Amended Complaint Pursuant to the Federal False Claims Act, 31 U.S.C. §§3729 *et seq.* and Pendent State False Claims Acts. *United States, et al. ex rel. Marc Silver v. Omnicare, Inc., et al*. (D.N.J. No. 1:11-cv-01326-NLH-JS) (Apr. 23, 2021) ("Relator's Complaint") ¶¶ 4-13, 231-234.

[2] *Id.* ¶ 228.

outcome of this litigation. I supervised and directed a team at Vega Economics to assist me in this assignment. Their compensation is not affected by my findings or the outcome of this litigation.

13. I hold the opinions stated in this report with a reasonable degree of professional certainty. I reserve the right to amend or supplement my opinions and report, if appropriate, based on any additional discovery, or in response to opinions or reports of other experts in this matter.

III. Summary of Opinions

14. PharMerica's Medicare Part A per diem rates reflect the natural and expected results of interactions between willing buyers and sellers in a competitive market. Both SNFs and LTC Pharmacies transact in an open and highly competitive market with many participants and low barriers to entry and the prices in the market are determined through a competitive process between willing buyers and sellers. The outcome of such a process is often described as "fair market value."

15. It is my professional opinion that PharMerica's policies, procedures, and actions during all times relevant to Relator's Complaint ("Relevant Time Period") were those of a profit maximizing company operating in a highly competitive and regulated environment, instead of as a company engaged in swapping, as alleged by Relator. These included policies to have positive margins on all Medicare Part A contracts, using reset provisions in its contracts with SNFs, utilizing other contractual remedies to mitigate the risk of losses on its per diem contracts, actively renegotiating contracts to maximize profits, and, in some instances, simply walking away from the negotiating table.

16. Finally, the amounts PharMerica was paid by its SNF clients to dispense drugs covered by Medicare Part A have no impact on whether or how much the government pays under Medicare Part D or Medicaid.

IV. Relevant Background

A. Long-Term Care Pharmacies

17. Residents of SNFs are typically frail and elderly individuals who frequently require intensive

CONFIDENTIAL

medication management and/or alternative forms of medication administration.[3, 4] Meeting these special needs and protecting the health and safety of these residents requires specialized knowledge, and clinicians and pharmacists must regularly monitor patients for drug interactions and other adverse reactions to medications.[5]

18. To receive payment under state and federal programs such as Medicare, SNFs must comply with "conditions of participation," which are prerequisites related to the types of care available to long-term care ("LTC") patients. The conditions of participation include a "complex set of Federal and state regulations governing the provision of prescription drugs in the LTC setting."[6] These regulations included requiring LTC facilities to retain a licensed pharmacist to provide each resident with a monthly "drug regimen review."[7] Pharmacists caring for Medicaid beneficiaries must also undertake comprehensive "drug use reviews,"[8] create standards for patient counseling,[9] and maintain specific documentation of each resident's medication regimen.[10]

19. Given the large number of conditions of participation and their operational complexity, together with the serious consequences of non-compliance, it is standard industry practice for a SNF to contract for

[3] Levinson, Daniel R. "Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries." *Department of Health and Human Services Office of Inspector General* (Feb. 2014) at 3; "CMS Review of Current Standards of Practice for Long-Term Care Pharmacy Services: Long-Term Care Pharmacy Primer." *The Lewin Group* (Dec. 30, 2004) ("Lewin Group Report") at 1, 3.

[4] For example, SNF residents may be recovering from surgical procedures such as hip or knee replacements or from medical conditions such as heart failure.

[5] Medication-related adverse events are a common risk in the nursing home setting, but many are preventable. Levinson, Daniel R. "Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries." *Department of Health and Human Services Office of Inspector General* (Feb. 2014) at 23-24. Because of this dynamic, research has found that competent pharmacy services contribute substantially to positive patient outcomes in nursing homes and other LTC facilities. Lee, Shaun W. H., et al. "Pharmacist Services in Nursing Homes: A Systematic Review and Meta-Analysis." *British Journal of Clinical Pharmacology* 85.12 (2019): 2668-2688 at 2668; Nachtigall, Angela, et al. "Influence of Pharmacist Intervention on Drug Safety of Geriatric Inpatients: A Prospective, Controlled Trial." *Therapeutic Advances in Drug Safety* 10 (Apr. 16, 2019): 1-15 at 1.

[6] Lewin Group Report at 1.

[7] 42 C.F.R. § 483.45(c).

[8] 42 U.S.C. § 1396r-8(g)(2)(A)(i).

[9] 42 U.S.C. § 1396r-8(g)(2)(A)(ii).

[10] 42 U.S.C. § 1396r-8(g)(2)(A)(ii)(II).

CONFIDENTIAL

pharmacy services with a single LTC Pharmacy.[11, 12] In addition to prescription processing and drug dispensing, the LTC Pharmacy provides all the pharmacy services necessary to meet the SNF's conditions of participation, including, but not limited to, daily drug delivery, 24/7 emergency coverage, medication return and destruction, unit dose packaging, compounding, maintenance of emergency kits, provision of medication carts, medical record management, receipt of electronic orders, consultant pharmacist services, mandatory monthly drug regimen reviews for each resident, assistance with regulatory compliance, survey preparation, and response, drug utilization review, and formulary management.[13]

20. The employees of LTC Pharmacies have the specialized knowledge and experience to provide pharmaceuticals to SNF residents. LTC Pharmacies thus play a vital role in ensuring that a SNF can meet its obligations under federal and state regulations. The importance of LTC Pharmacies has been recognized by private insurance and legislators, among others.[14]

B. Medicare and Medicaid Payments to LTC Pharmacies

21. Relator's allegations concern three types of prescription drug coverage: Medicare Part A, Medicare Part D, and Medicaid. I discuss below how these separate systems are organized.

i. Medicare Part A

22. Medicare Part A generally covers inpatient care in hospitals, skilled nursing facility care, hospice

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[11] Lewin Group Report at 16-17. Whereas retail pharmacies dispense prescriptions to the general public, LTC Pharmacies, including PharMerica, are institutional pharmacies that provide specialized services that address the specific and complex needs of SNF residents. *Id.* at 1.

[12] As I discuss below, the costs of care provided by SNFs are paid for through a variety of programs, including private long-term care insurance and government payors. Payment flows from the majority payor, Medicare, follow two entirely different streams with different financial incentives, depending on whether the patient is eligible for Medicare Part A or Medicare Part D. Medicaid, the next largest payor, uses an entirely different system to make payments. Despite the marked differences in payment, however, the provision of drugs for these diverse patient groups is typically provided by a single LTC Pharmacy because this approach enhances patient safety, operational efficiency, and contract management.

[13] Lewin Group Report at 8-16.

[14] *See, e.g.*, *id.* at 1. *See also* "Becoming a Long-Term Care Pharmacy: Opportunities and Important Considerations." *McKesson* (2015) at 6, 7.

care, and home health care[15] for people aged 65 or older or those younger than 65 with disabilities.[16]

23. Under the Prospective Payment System ("PPS"), CMS pays SNFs a fixed, daily amount for each Medicare Part A-eligible resident.[17] This amount is based on the historical national average costs of care, adjusted for patient characteristics and other factors.[18, 19] From this fixed sum, the SNF must pay for health care goods and services provided to the resident during each day of a Medicare-covered nursing home stay, including prescription drugs and over the counter medications.[20] Under PPS, SNFs get to keep any excess of the PPS payment over their daily costs; they are at financial risk, on the other hand, if their costs exceed the daily payments.[21]

24. As described above, it is standard industry practice for a SNF to contract for pharmacy services with a single LTC Pharmacy.[22] The prices a SNF pays for such services are negotiated as part of the contract between the SNF and the LTC Pharmacy.[23] The contract between a SNF and an LTC Pharmacy regarding drugs provided to residents covered under Medicare Part A, along with other services the LTC Pharmacy would provide to the SNF, is typically known as a "pharmacy services

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[15] "Parts of Medicare." *Medicare.gov*. <https://www.medicare.gov/basics/get-started-with-medicare/medicare-basics/parts-of-medicare> (accessed Nov. 23, 2021).

[16] "Who Is Eligible for Medicare?" *HHS.gov* (Sept. 14, 2014). <https://www.hhs.gov/answers/medicare-and-medicaid/who-is-eligible-for-medicare/index.html> (accessed Nov. 23, 2021).

[17] "Skilled Nursing Facilities: Services Excluded from Medicare's Daily Rate Need to Be Reevaluated." *United States General Accounting Office* (Aug. 2001) at 5.

[18] *Id.* at 1, 5. National average costs are calculated from cost reports, which each facility is required to file on an annual basis. *See, e.g.*, "Cost Reports." *CMS.gov* (Oct. 22, 2021). <https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports> (accessed Nov. 16, 2021).

[19] PPS payment rates to SNFs are updated annually using a SNF market basket index that differentiates among various costs incurred in providing services to SNF patients, including wages and salaries, utilities, and prescription drugs, among others. *See* "Skilled Nursing Facility PPS." *CMS.gov* <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS> (accessed Nov. 30, 2021); "Skilled Nursing Facility Market Basket." *CMS.gov* <https://www.cms.gov/files/document/websnf04pdf.pdf> (accessed Nov. 30, 2021).

[20] "Skilled Nursing Facilities: Services Excluded from Medicare's Daily Rate Need to Be Reevaluated." *United States General Accounting Office* (Aug. 2001) at 1, 5. CMS pays medical practitioners separately for the cost of their professional services, and it does pay separately for a limited number of high-cost services such as cardiac catheterization, magnetic resonance imaging ("MRI"), radiation therapy, and selected chemotherapy services provided to SNF residents in hospital outpatient departments. *See id.* at 6-7.

[21] "Skilled Nursing Facilities: Services Excluded from Medicare's Daily Rate Need to Be Reevaluated." *United States General Accounting Office* (Aug. 2001) at 5.

[22] Lewin Group Report at 1, 16-17.

[23] "Long-Term Care Pharmacy: The Evolving Marketplace and Emerging Policy Issues." *Avalere Health LLC* (Oct. 2005) at 11.

agreement" or "PSA."[24] Pricing for pharmacy services under Part A is primarily "fee for service" ("FFS"), though some contracts use "per diem" pricing.[25]

25. Under a per diem contract, which mimics the PPS system, the LTC Pharmacy establishes a formulary, a list of approved and preferred drugs,[26] and the SNF pays the pharmacy a fixed price per day, per Medicare Part A resident, for those drugs listed on the agreed-upon formulary.[27] The flat per diem rate is independent of the number of on-formulary prescriptions dispensed to each individual patient. For this reason, expensive and infused drugs are generally excluded from per-diem formularies.[28] Excluded drugs are billed separately at FFS rates.[29]

ii. Medicare Part D

26. Medicare Part D is an optional prescription drug benefit program pursuant to which the government subsidizes the cost of prescription drug insurance.[30] The most frequently prescribed drugs under Medicare Part D generally treat persistent chronic conditions such as cardiovascular conditions, asthma, and diabetes.[31] The government does not directly administer the dispensing of drugs in the Medicare Part D program and it does not pay for or reimburse for individual prescriptions.[32] Rather, commercial insurance companies called Medicare Part D Plan Sponsors ("Plan Sponsors") compete to offer prescription drug insurance with standardized benefits to Medicare-eligible individuals.[33] The government then pays the Plan Sponsors certain fixed, prospective, monthly payments, known

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[24] *See, e.g.*, Pharmacy Services Agreement (Katyville Nursing and Rehabilitation Center). *PharMerica* (Dec. 29, 2005) (PMCSNJ1844827).

[25] Lewin Group Report at 18-19, 23.

[26] *Id.* at 9-10.

[27] *See, e.g.*, Pharmacy Services Agreement Preferred Provider Agreement (Delta Health Group). *PharMerica* (May 12, 2005) (PMCSNJ0879507 at PMCSNJ0879514).

[28] *Id.*

[29] *Id.*

[30] Kirchhoff, Suzanne. "Medicare Part D Prescription Drug Benefit." *Congressional Research Service* (Dec. 18, 2020); "CMS' Program History." *CMS.gov* (Jan. 13, 2020). <https://www.cms.gov/About-CMS/Agency-Information/History> (accessed Nov. 29, 2021).

[31] Burch, Martin. "Top Prescription Drugs in Medicare Part D." *Wall Street Journal* (May 5, 2015). <http://graphics.wsj.com/medicare-prescription-drugs/> (accessed Nov. 16, 2021).

[32] *See* "Long-Term Care Pharmacy: The Evolving Marketplace and Emerging Policy Issues." *Avalere Health LLC* (Oct. 2005) at 11.

[33] Kirchhoff, Suzanne. "Medicare Part D Prescription Drug Benefit." *Congressional Research Service* (Dec. 18, 2020) at 1, 8, 10.

as "subsidies," for each person who enrolls in the Plan Sponsor's plan.[34] The amount of each subsidy to Plan Sponsors is based on an annual competitive bidding process that estimates yearly costs, and a reconciliation process allows Plan Sponsors to recoup a portion of any shortfall in the estimates.[35]

27. Plan Sponsors deliver the Medicare Part D benefit by contracting with individual pharmacies to create a network compliant with applicable rules to provide beneficiaries with adequate access to prescription drugs.[36] Medicare requires that these networks include LTC Pharmacies like PharMerica so that Medicare-SNF residents who are not receiving benefits under Medicare Part A also have access to prescription drugs.[37]

28. Network pharmacies might contract directly with the Plan Sponsor; more often, however, the Plan Sponsor will engage a subcontractor called a pharmacy benefits manager ("PBM") to create and manage its pharmacy network, including processing and paying claims submitted by pharmacies.[38] In this situation, the pharmacies contract directly with the PBM.[39]

29. Each contract between a Plan Sponsor (or its PBM) and a pharmacy is negotiated separately. The Part D program's establishment as a private market model is codified by statute; CMS "may not interfere with the negotiations between drug manufacturers and pharmacies and [Plan Sponsors]" and "may not require a particular formulary or institute a price structure for the reimbursement of covered part D drugs."[40] This means that the prices a pharmacy negotiates might differ from plan to plan[41] and, concomitantly, the prices each Plan Sponsor pays each of its network pharmacies also

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[34] Levinson, Daniel R. "Medicare Part D Sponsors: Estimated Reconciliation Amounts for 2006." *Department of Health and Human Services Office of Inspector General* (Oct. 2007) at 1 ("CMS makes monthly prospective payments to sponsors for providing prescription drug coverage to Medicare beneficiaries.").

[35] "Part D Payment System." *The Medicare Payment Advisory Commission* (Nov. 2021) at 1-3. <https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_partd_final_sec.pdf> (accessed Nov. 30, 2021).

[36] *See* 42 C.F.R. § 423.100 (defining "network pharmacy"), 423.120(a), 423.120(a)(5) (requirements assuring access to pharmacies).

[37] 42 C.F.R. § 423.120(a)(5). Medicare-covered SNF residents who are not receiving benefits under Medicare Part A can include Medicare beneficiaries with a SNF stay longer than 100 days or who did not have a qualifying inpatient admission within the previous 30 days. *See* "SNF Care Past 100 Days." *Medicare Rights Center*. <https://www.medicareinteractive.org/get-answers/medicare-covered-services/skilled-nursing-facility-snf-services/snf-care-past-100-days> (accessed Nov. 17, 2021).

[38] Kirchhoff, Suzanne. "Medicare Part D Prescription Drug Benefit." *Congressional Research Service* (Dec. 18, 2020) at 52.

[39] *Id.*

[40] 42 U.S.C. § 1395w-111(i).

[41] For instance, plan prices may vary by geography.

might differ from pharmacy to pharmacy.[42]

iii. Medicaid

30. Medicaid is a joint federal and state program that pays for healthcare provided to low-income and disabled individuals eligible according to state-specified criteria.[43] Some state Medicaid programs pay for services on a claim-by-claim basis, whereas some states offer or require Medicaid Managed Care.[44]

31. With respect to state Medicaid programs that pay for services on a claim-by-claim basis, states directly pay the LTC pharmacy on an FFS basis using state regulated rates.[45]

32. Medicaid Managed Care, on the other hand, works very much like Medicare Part D in that the state Medicaid agency contracts with one or more commercial insurance companies, often referred to as "managed care organizations" or "MCOs," to make managed health care benefits available to Medicaid enrollees.[46]

33. As under Medicare Part D, neither the state nor CMS pays individual healthcare or pharmacy claims. In fact, states are expressly prohibited from making a payment to a provider for services available under the contract between the state and the managed care plan.[47] Instead, the state pays a fixed amount per member per month ("PMPM") to the MCO, with CMS reimbursing the state for part of the payment.[48] Once set, the state is obligated to make these monthly payments "regardless of

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[42] For instance, some pharmacies may be able to negotiate higher prices than other pharmacies based on a variety of factors.

[43] Snyder, Laura. "Medicaid Financing: How Does It Work and What Are the Implications?" *The Kaiser Commission on Medicaid and the Uninsured* (May 2015). <https://files.kff.org/attachment/issue-brief-medicaid-financing-how-does-it-work-and-what-are-the-implications> (accessed Nov. 11, 2021); "Federal Requirements and State Options: Eligibility." *MACPAC: Medicaid and CHIP Payment and Access Commission* (Mar. 2017). <https://www.macpac.gov/wp-content/uploads/2017/03/Federal-Requirements-and-State-Options-Eligibility.pdf> (accessed Nov. 23, 2021).

[44] "Provider Payment and Delivery Systems." *Medicaid and CHIP Payment and Access Commission*. <https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/> (accessed Nov. 11, 2021).

[45] *Id. See also* Dolan, Rachel and Marina Tian. "Pricing and Payment for Medicaid Prescription Drugs." *Kaiser Family Foundation* (Jan. 2020). <https://www.kff.org/medicaid/issue-brief/pricing-and-payment-for-medicaid-prescription-drugs/> (accessed Nov. 29, 2021).

[46] 81 Fed. Reg. 27498, 27500 (May 6, 2016).

[47] 42 C.F.R. § 438.60.

[48] Levinson, Daniel R. "Fee-For-Service Payments for Services Covered by Capitated Medicaid Managed Care." *Department of Health and Human Services Office of Inspector General* (July 2008) at 1; *see also* 42 U.S.C. §

whether the particular beneficiary receives services during the period covered by the payment."[49]

34. From this fixed, monthly payment, the MCO must pay for all of the enrollees' covered healthcare services and prescription drugs.[50] Again, as with Medicare Part D, MCOs contract with individual pharmacies, either directly or through a PBM, and pay them directly for prescription drugs dispensed to the MCO's enrollees.[51] The "payment terms negotiated between a managed care plan and its network pharmacies are outside the scope of [the Medicaid managed care regulations]" and are "negotiated as part of the contract between the managed care plan and its participating [pharmacy] providers."[52]

V. OPINION I: PHARMERICA'S MEDICARE PART A PER DIEM RATES WERE THE NATURAL AND EXPECTED RESULTS OF INTERACTIONS BETWEEN WILLING BUYERS AND SELLERS IN A COMPETITIVE MARKET.

35. A market consists of a group of buyers and sellers of a particular good or service.[53] The buyers as a group determine the demand for the product, and the sellers as a group determine the supply of the product.[54] In a competitive market, prices are not set by any one seller or buyer, but are rather the result of a competitive process in which informed and willing buyers and sellers interact and seek to obtain the best outcome for themselves (i.e., the lowest price for buyers and highest price for sellers). As an informed buyer can always find another seller within a competitive market, the seller is therefore constrained by this competitive process and cannot unilaterally set the price for its good or service.[55] The resulting market price thus necessarily reflects the interactions of willing buyers and

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1396b(m)(2)(A)(iii) (permitting federal matching dollars for state expenditures to a risk bearing entity for Medicaid services).

[49] 42 C.F.R. § 438.2 (defining capitation payment).

[50] 81 Fed. Reg. 27498, 27588-89 (May 6, 2016) ("Inherent in the transfer of risk to the MCO [through capitated payments] is the concept that the MCO has both the ability and the responsibility to utilize the funding under [its contract with the State] to manage the contractual requirements for the delivery of services," including provider reimbursement.).

[51] *See* 81 Fed. Reg. 27498, 27543 (May 6, 2016).

[52] *Id.*

[53] Mankiw, N. Gregory. *Principles of Microeconomics 5th ed*. Mason: South-Western Cengage Learning (2009) at 66.

[54] *Id.*

[55] *Id.*

sellers in a competitive market, and is also often called the "fair market value."[56]

36. As described below in greater detail, the market for LTC Pharmacy services during the Relevant Time Period was highly competitive and involved many informed buyers and sellers. Pharmacies such as PharMerica engaged in competition with other pharmacies offering similar services. As in any competitive market, the per diem rates in the market for Medicare Part A LTC Pharmacy services were therefore the natural and expected outcome of the competitive process between willing buyers and sellers in that market. As such, they represented fair market value.

37. Moreover, given the nature of the regulatory and competitive environment for LTC Pharmacies, low profit margins for their Medicare Part A contracts are not only unsurprising but expected. Indeed, PPS was expressly designed to give SNFs strong incentives to control costs and act as prudent purchasers on behalf of CMS.[57] Despite the fact that SNFs worked to aggressively control costs, PharMerica strove to maintain positive margins. Based on my review of PharMerica's policies and practices during the Relevant Time Period, I conclude that PharMerica's actions were consistent with a profit-maximizing firm operating within the highly competitive market for LTC Pharmacy services.

A. The LTC Pharmacy Services Market Is Highly Competitive.

38. The market for LTC Pharmacy services is highly competitive. As I describe below in greater detail, many entities operate in the market and vie for the right to provide pharmacy services to SNFs. Moreover, low barriers to entry in the market allow potential new entrants to increase competition in the market. As a result of the highly competitive nature of the market for LTC Pharmacy services, individual pharmacies, including PharMerica, do not have the ability to unilaterally set rates. Instead, the rates agreed upon by LTC Pharmacies and SNFs represent the natural outcome of a competitive process between willing sellers and buyers.

i. The Market Is Served by Many LTC Pharmacies, Big and Small, and Exhibits Low

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[56] *See* "Fair Market Value." *Dictionary of Finance and Investment Terms.* Eds. J. Downes and J.E. Goodman. New York: Barron's (1998) at 192-193.

[57] *See, e.g.*, "Provider Reimbursement Manual, Part 1, Chapter 21 - Costs Related to Patient Care." *Centers for Medicare and Medicaid Services*. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929> (accessed Dec. 2, 2021) at 21-2.5. *See also* "Skilled Nursing Facilities: Services Excluded from Medicare's Daily Rate Need to Be Reevaluated." *United States General Accounting Office* (Aug. 2001) at 4.

CONFIDENTIAL

Barriers to Entry.

39. Many entities compete for the right to provide pharmacy services to SNFs. There is a mix of large chain and independent LTC Pharmacies, as well as vertically integrated LTC Pharmacies that are owned and operated by LTC facilities.[58] In fact, in addition to a few major corporations, such as PharMerica and Omnicare, there are over 1,000 independent LTC Pharmacies servicing the market.[59]

40. The presence of a vast number of smaller LTC Pharmacies results in real competition for larger entities such as PharMerica. For instance, in 2008, PharMerica was competing with five other LTC Pharmacies of various sizes for the contract with the Skilled Healthcare chain: Omnicare, Pharmacy Advantage, Rx Two Pharmacy, Modern Health Pharmacy, and Premier Pharmacy.[60] Omnicare, a large player having $7.5 billion in assets on its balance sheet as of December 31, 2008,[61] proposed a $9 per diem rate, whereas Modern Health Pharmacy, which describes itself as a "locally-owned community pharmacy,"[62] proposed a $10 per diem rate.[63] PharMerica's initial proposal of $9 and updated proposal of $12, which was ultimately accepted, fell in the middle of all the bids made, which ranged from $7.50 to $25.00.[64] Neither public/private ownership, national/community focus, nor balance sheet size prevented the six pharmacies from pursuing the same SNF client.

41. In addition to the many existing LTC Pharmacies competing to serve SNF residents, the market also exhibits low barriers to entry that allow potentially new LTC Pharmacies to enter the market. For example, retail pharmacies with a history of serving a specific community can easily enter the LTC Pharmacy market to compete with existing LTC Pharmacies,[65] as they already have the relevant

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[58] PharMerica. *Form 10-K* (Feb. 24, 2017).

[59] "Becoming a Long-Term Care Pharmacy." *McKesson* (2015) at 2. *See also* Singh, Douglas A. *Effective Management of Long-Term Care Facilities, Third Edition*. Burlington, Massachusetts: Jones & Bartlett Learning (2016) at 67.

[60] "Skilled Healthcare, Inc. RFP Pharmacy Pricing Summary." *Skilled Healthcare* (Oct. 13, 2008) (PMCSNJ1587248), attached to Email from Jose Lynch to Larry A. Litzmann, *RFP Pharmacy Pricing Summary for Pharmerica* (Oct. 13, 2008) (PMCSNJ1587247).

[61] Omnicare, Inc. *Form 10-K* (Feb. 26, 2009).

[62] "About Us." *Modern Health Pharmacy.* <https://www.modernhealthpharmacy.com/about-us> (accessed Nov. 24, 2021).

[63] "Skilled Healthcare, Inc. RFP Pharmacy Pricing Summary." *Skilled Healthcare* (Oct. 13, 2008) (PMCSNJ1587248), attached to Email from Jose Lynch to Larry A. Litzmann, *RFP Pharmacy Pricing Summary for Pharmerica* (Oct. 13, 2008) (PMCSNJ1587247).

[64] *Id.*; Email from Jose Lynch to Larry A. Litzmann, et al., *Pharmerica Pricing Proposal Review & Termination Notice (updated 12/12/08)* (Dec. 12, 2008) (PMCSNJ1587226); Litzmann, Larry. Deposition Exhibit 26 (Jan. 22, 2009) at SKILL000000146-154.

[65] *See, e.g.*, "Becoming a Long-Term Care Pharmacy." *McKesson* (2015) at 7.

licenses, contracts with suppliers, facilities, and computer systems that they can leverage to source drugs for delivery to an LTC facility.[66]

42. The presence of a large number of competing vendors and low barriers to entry, as evident in the market for LTC Pharmacies, is a defining feature of a highly competitive market.

ii. The Rates for Per Diem Services Are Determined Through a Competitive Process, Not Set by PharMerica.

43. Economists use the term "market power" to refer to the ability of a single entity to heavily influence market prices.[67] An entity could have the ability to set prices in a given market if that entity were the sole provider of the good or service being sold in that market.[68] This was not the case in the market for the Medicare Part A pharmacy services during the Relevant Time Period. While PharMerica was one of the many corporations operating in the LTC Pharmacy market, the presence of many competitors (and potential competitors) meant that PharMerica did not have the market power to unilaterally set prices. The highly competitive nature of the LTC Pharmacy Market virtually guaranteed that PharMerica would lose business to its competitors if it demanded a price beyond what a SNF was willing to pay and this is borne out by the documentary record, as discussed below.

44. The process by which SNFs contract with LTC Pharmacies to procure drugs for their Medicare Part A patients involves bilateral negotiations. SNFs negotiate, either individually or as part of a chain, with one or more LTC Pharmacies.[69] Although the process typically occurs through informal sales and marketing efforts or other interactions, at times a formal request for proposal ("RFP") process is employed by a SNF or SNF chain. SNFs and LTC Pharmacies are aware of and familiar with the negotiation process and are willing participants in such negotiations.

45. To identify the provider offering the lowest prices for drugs and high-quality services, SNFs often engage in concurrent negotiations with several LTC Pharmacies. Consider the same example, in 2008, when PharMerica was under contract to provide LTC Pharmacy services to the Skilled Healthcare chain. Pursuant to the "market check" provision of its contract with PharMerica, Skilled Healthcare solicited bids from five additional LTC pharmacies, yielding offers of $7.50, $9.00,

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[66] *Id.*

[67] Mankiw, N. Gregory. *Principles of Microeconomics 5th ed*. Mason: South-Western Cengage Learning (2009) at 12.

[68] *See id.*

[69] "Long-Term Care Pharmacy: The Evolving Marketplace and Emerging Policy Issues." *Avalere Health LLC* (Oct. 2005) at 11.

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\$10.00, \$11.00, \$12.50, \$15.00, and \$25.00.[70] Skilled Healthcare sought these bids in an attempt to identify the lowest competitive price offered by a pharmacy capable of servicing its affiliates' needs.[71] According to Skilled Healthcare, Omnicare's \$9.00 bid proved to be "the most competitive […], based on [its] ability to offer superior services."[72] PharMerica moved to match Omnicare's bid.[73] Nonetheless, Skilled Healthcare terminated its contract with PharMerica.[74] However, Omnicare subsequently revised its bid to a higher but all-inclusive per diem at \$12.00.[75] PharMerica matched Omnicare's revised per diem price with limited exclusions and Skilled Healthcare accepted PharMerica's revised bid.[76] Despite the negotiations, PharMerica's ultimate offer was still in the middle of the range of the other pharmacies' RFP bids.

46. The competitiveness of the RFP process meant that PharMerica could not unilaterally set a per diem rate with no regard to its competitors' actions, as evidenced by Skilled Healthcare's initial rejection of PharMerica's first bid. Instead, the final agreement between PharMerica and Skilled Healthcare was the outcome of a competitive process between a willing seller and buyer, as one would expect in a competitive market.

B. Low Profit Margins Are to Be Expected in the Market for Medicare Part A LTC Pharmacy Services.

47. The PPS payment mechanism creates incentives for SNFs to negotiate for low prices for LTC Pharmacy services covered by Medicare Part A. This, combined with the aggressive competition in the LTC Pharmacy market, results in low prices for Medicare Part A LTC Pharmacy services.

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[70] "Skilled Healthcare, Inc. RFP Pharmacy Pricing Summary." *Skilled Healthcare* (Oct. 13, 2008) (PMCSNJ1587248), attached to Email from Jose Lynch to Larry A. Litzmann, *RFP Pharmacy Pricing Summary for Pharmerica* (Oct. 13, 2008) (PMCSNJ1587247); Letter from Jose Lynch to Larry A. Litzmann, *Re: Notice of Intent to Begin RFP Process* (Aug. 15, 2008) (PMCSNJ1587242) (stating that Skilled will exercise its rights under Section 3.1 of the January 1, 2006 Amendment of the Pharmacy Services Agreement).

[71] Email from Jose Lynch to Larry A. Litzmann, *Re: Pharmerica Pricing Proposal Review & Termination Notice (updated 12/12/08)* (Dec. 12, 2008) (PMCSNJ1587226 at PMCSNJ1587226).

[72] Email from Jose Lynch to Larry A. Litzmann, *RFP Pharmacy Pricing Summary for Pharmerica* (Oct. 13, 2008) (PMCSNJ1587247).

[73] Letter from Larry Litzmann to Jose Lynch (Nov. 21, 2008) (PMCSNJ1587228); "Skilled Healthcare Proposal: Pricing and Business Terms." *PharMerica* (PMCSNJ1587229 at PMCSNJ1587230).

[74] Letter from Jose C. Lynch to Larry Litzmann, *Re: Pricing Re-Opener Process* (Dec. 12, 2008) (PMCSNJ1587246).

[75] Email from Pat Keefe to Jose Lynch, *Re: I never heard back from you* (Dec. 18, 2008) (SILVERNJREV01179496).

[76] Amendment No. 2 to Pharmacy Services Agreement Between PMC and Pharmacy Services, Inc. d/b/a Kindred Pharmacy Services and Alexandria Care Center, LLC. *PharMerica* (Jan. 16, 2009) (PMCSNJ0952179).

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Additionally, a decrease in Medicare funding in fiscal year 2012 further contributed to the low prices and profit margins prevalent in the market.

48. Other outcomes that are to be expected in highly competitive markets, such as loss of business due to undercutting by competitors, are common and occurred in the Medicare Part A LTC Pharmacy services market during the Relevant Time Period, as reflected by the documentary record.

i. The Prospective Payment System Encourages SNFs to Negotiate Low Prices for LTC Pharmacy Services.

49. The PPS payment mechanism for SNFs currently in place was introduced by CMS in 1998.[77] Prior to the introduction of PPS, Medicare Part A paid SNFs based on their actual expenditures.[78] In contrast, as described above, under PPS, SNFs receive a fixed per diem payment from CMS that is intended to cover most costs of providing patient care in a SNF setting.[79] The PPS system was introduced to control CMS's spending on care provided through SNFs.[80, 81]

50. Under the system in place prior to 1998, if a SNF paid excessively high prices for pharmaceutical drugs, for instance, the SNF itself would not incur any financial harm, instead simply passing on that cost to CMS. Thus, there was no incentive, prior to 1998, for a SNF to control costs.

51. The conversion to PPS was expressly promoted to combat this issue.[82] Specifically, PPS was designed to give SNFs strong incentives to control costs and act as prudent purchasers on behalf of

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[77] "Skilled Nursing Facilities: Services Excluded from Medicare's Daily Rate Need to Be Reevaluated." *United States General Accounting Office* (Aug. 2001) at 1, 5.

[78] *Id.* at 4.

[79] CMS directly pays SNFs for certain high-cost services in order to ensure that SNFs are not financially disadvantaged by making these services available. The services excluded from the per diem rate are determined by statute and by the Health Care Financing Administration, and include expensive services that are generally not provided in SNFs, such as cardiac catherization, magnetic resonance imaging, radiation therapy, and select chemotherapy services. *Id.* at 1, 6.

[80] *Id.* at 1.

[81] O'Sullivan, Jennifer, et al. "Medicare Provisions in the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33)." *Congressional Research Service* (Aug. 18, 1997) at 17-18.

[82] *President's Fiscal Year 1998 Budget Proposal For Medicare, Medicaid, and Welfare: Sen. Hearing 105-85, Before S. Comm. on Fin.* (1997) (Prepared Statement of Joseph P. Newhouse, Chairman of the Prospective Payment Assessment Commission) ("Moving away from cost-based reimbursement systems can slow expenditure growth while encouraging providers to deliver care in the most efficient manner possible."); *Magnitude of the Financial Crisis in Medicare: Sen. Hearing 105-306, Before S. Comm. on Fin.* (1997) (Prepared Statement of Marilyn Moon, Senior Fellow at The Urban Institute) ("[J]ust adopting the prospective payment systems proposed for home health and skilled nursing services would save about $10 billion over five years.").

CMS.[83] Under PPS, SNFs receive a fixed per diem rate for each patient, based on national average costs of care (adjusted for patient characteristics), to cover most services provided to beneficiaries during a stay covered by Medicare Part A.[84] This system provides a clear incentive for SNFs to keep their costs down.

52. Consider a hypothetical patient that requires six doses of Drug X on each day that she stays at a SNF, in addition to all the other services that the patient requires that are covered by CMS's per diem payment. If the amount that the SNF pays to obtain six doses of Drug X, when combined with the costs of providing the patient with all other services covered under the per diem payment, is greater than the per diem payment it receives from CMS, then the SNF takes a loss. However, if the SNF can procure six doses of Drug X, and all other applicable services, at a cost less than the per diem payment it receives from CMS, the SNF profits by keeping the excess per diem payment. Thus, PPS highly incentivizes SNFs to control the cost of procuring services covered by the per diem payment from CMS.

53. As a result, SNFs aggressively negotiate with their vendors, including LTC Pharmacies, to identify the providers with the lowest prices for the drugs and services they require.[85] This is not simply a consequence of PPS but is, in fact, the main purpose of it. CMS explicitly requires SNFs to be prudent purchasers and to "seek to economize by minimizing cost."[86] Because the per diem rates paid by CMS are based on average costs of care, SNFs that succeed in obtaining care at lower-than-

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[83] *See, e.g.*, "Provider Reimbursement Manual, Part 1, Chapter 21 - Costs Related to Patient Care." *Centers for Medicare and Medicaid Services*. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929> (accessed Dec. 2, 2021) at 21-2.5. *See also* "Skilled Nursing Facilities: Services Excluded from Medicare's Daily Rate Need to Be Reevaluated." *United States General Accounting Office* (Aug. 2001) at 4.

[84] "Skilled Nursing Facilities Services Excluded from Medicare's Daily Rate Need to Be Reevaluated." *United States General Accounting Office* (Aug. 2001) at 1, 5; *see also* "Cost Reports." *CMS.gov* (Oct. 22, 2021). <https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports> (accessed Nov. 16, 2021).

[85] A SNF may contract with an LTC Pharmacy using prospective per-patient-per-day (i.e., per diem) rates, fee-for-service rates (retrospective payments), or some combination of both. Typically, PharMerica's per diem contracts with SNFs during the Relevant Time Period included coverage of all drugs on the formulary, and fee-for-service payment for drugs excluded from the formulary. The exact combination of drugs covered by the per diem payment versus those drugs that were excluded was dictated by the formularies negotiated by PharMerica and its facility clients. Bloechl, Diane. Deposition (Feb. 18, 2016) ("Bloechl Dep.") 39:1-7 ("We would perhaps provide [LTC facility clients] with information regarding their expensive drugs, especially if there were formulary-preferred drugs that we could use to drive down their costs. We could provide them with information regarding alternative formularies if they wished a per-diem formulary.").

[86] "Provider Reimbursement Manual, Part 1, Chapter 21 - Costs Related to Patient Care." *Centers for Medicare and Medicaid Services*. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929> (accessed Dec. 2, 2021) at 21-2.7.

average costs are effectively rewarded for their prudent purchasing, whereas SNFs that obtain services at higher-than-average costs are effectively penalized.

ii. Vigorous Competition Results in Market-Driven Per Diem Rates for LTC Pharmacies.

54. To survive in a market with a multitude of existing competitors and potential new competitors, market participants naturally have to keep their prices low or risk losing business.[87] Given the highly competitive nature of the market, and the fact that buyers have strong incentives and the ability to seek the lowest possible price point among various competing sellers, it is unsurprising, and consistent with economic principles, that the market is characterized by low prices, resulting in low profit margins for LTC Pharmacies.

55. In a highly competitive market, in addition to low prices and low profit margins, one would also expect to see instances of businesses undercutting one another on pricing in attempts to divert business from competitors to themselves.[88] This, in turn, forces companies to further lower their prices or lose business altogether.

56. There are several instances in which PharMerica lost business to competitors offering lower rates, as described below in Section V.D.i. At other times, PharMerica had to lower its pricing because its competitors offered lower rates. For example, as described above, the Skilled Healthcare chain of facilities, with which PharMerica did business, was easily able to solicit bids from five other LTC Pharmacies in an attempt to elicit a lower per diem payment bid from PharMerica.[89] PharMerica was only able to retain its business with the chain upon lowering its rates and offering a more inclusive set of services at the lowered rate.[90]

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[87] Mankiw, N. Gregory. *Principles of Microeconomics 5th ed*. Mason: South-Western Cengage Learning (2009) at 289-290, 305.

[88] *See, e.g.*, King, Stephen P. "Chapter 2: Competition Policy and Regulation." *The Cambridge Handbook of the Social Sciences in Australia*. Eds. Ian McAllister, Steve Dowrick, and Riaz Hassan. Cambridge: Cambridge University Press (2003): 31-44 at 31 ("When consumers can choose between actively competing suppliers, those suppliers can only profit by producing high-quality products that satisfy consumers' needs, using cost-efficient production, and then selling these products at prices that match or undercut their competitors.").

[89] "Skilled Healthcare, Inc. RFP Pharmacy Pricing Summary." *Skilled Healthcare* (Oct. 13, 2008) (PMCSNJ1587248), attached to Email from Jose Lynch to Larry A. Litzmann, *RFP Pharmacy Pricing Summary for Pharmerica* (Oct. 13, 2008) (PMCSNJ1587247).

[90] *See* Email from Jose Lynch to Larry A. Litzmann, *RFP Pharmacy Pricing Summary for Pharmerica* (Oct. 13, 2008) (PMCSNJ1587247); Email from Jose Lynch, to Larry A. Litzmann, *Re: Pharmerica Pricing Proposal Review & Termination Notice (updated 12/12/08)* (Dec. 12, 2008) (PMCSNJ1587226); Email from Pat Keefe to Jose Lynch, *Re: I never heard back from you* (Dec. 18, 2008) (SILVERNJREV01179496); Amendment No. 2 to

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iii. The Decrease in Medicare Funding in Fiscal Year 2012 Further Limited LTC Pharmacies' Ability to Increase Prices and Profitability.

57. In addition to the competitiveness of the market, other factors, such as reductions in Medicare reimbursement during the Relevant Time Period, limited the ability of LTC Pharmacies to raise their rates, and thus, increase profitability.

58. In August 2011, CMS published a rule severely reducing the size of PPS payments to SNFs for fiscal year 2012. CMS decreased payments by approximately 11.1 percent, amounting to a $3.87 billion cut in funding.[91, 92] The change to fiscal year 2012 payments commenced a period of sustained low payments from CMS. While SNF PPS rates increased slightly after fiscal year 2012, the increases hardly made up for the fiscal year 2012 decrease. As shown in **Table 1**: *SNF PPS Payment Change (2012-2015)*, over the next three years, from fiscal year 2013 through fiscal year 2015, CMS only increased payments by approximately $1.9 billion, cumulatively—only 48 percent of what was cut in fiscal year 2012.

Table 1: SNF PPS Payment Change (2012-2015)[93]

Fiscal Year	Percent Change	Amount Change
2012	(11.1)	($3.87 B)
2013	1.8	$0.67 B
2014	1.3	$0.47 B
2015	2.0	$0.75 B

59. The decreased PPS payments substantially affected SNFs' ability to pay their bills and consequently, affected LTC Pharmacies' (including PharMerica's) ability to increase pricing. The availability of

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Pharmacy Services Agreement Between PMC Pharmacy Services, Inc. d/b/a Kindred Pharmacy Services and Alexandria Care Center, LLC. (Jan. 1, 2009) (PMCSNJ0952179).

[91] 76 Fed. Reg. 48486, 48536 (Aug. 8, 2011).

[92] In comments submitted to CMS in response to the proposed rulemaking, SNFs emphasized that the decrease in payment was unreasonable, and it unnecessarily penalized SNFs that provided a high level of complex care to residents, and it would potentially put their companies out of business. *See, e.g.*, Emeritus Senior Living. "Emeritus Response to CMS 2012 Medicare SNF Payment Rates Proposal." (July 27, 2011). <https://www.regulations.gov/comment/CMS-2011-0060-0151> (accessed Nov. 14, 2021); New Jersey Hosp. Ass'n, "NJHA's comment letter on the proposed SNF PPS Update for FY12." (June 24, 2011) <https://www.regulations.gov/comment/CMS-2011-0060-0079> (accessed Nov. 14, 2021); Therapy Specialists. "Comment Letter on Proposed Rule to CMS FY 2012 Payments for Medicare Skilled Nursing Facilities." (June 24, 2011). <https://www.regulations.gov/comment/CMS-2011-0060-0111> (accessed Nov. 14, 2021).

[93] 76 Fed. Reg. 48486, 48536 (Aug. 8, 2011); 77 Fed. Reg. 46214, 46230 (Aug. 2, 2012); 78 Fed. Reg. 47936, 47966 (Aug. 6, 2013); 79 Fed. Reg. 45628, 45655 (Aug. 5, 2014).

funds can be understood as a "budget constraint" in economics, which reflects the fact that the amount of goods and services a purchaser can buy is constrained by its budget.[94] When PPS payments to SNFs were reduced, their budget constraints tightened. In order to continue to operate their businesses under such a tightened budget constraint, SNFs had to either cut back on the goods and services they purchased (while continuing to meet conditions of participation, i.e., providing adequate care) or obtain lower prices from their vendors, such as LTC Pharmacies.

60. For example, in renegotiating Alaris's agreement with PharMerica, Alaris employee Avery Eisenreich stated that "[t]he draconian rates PharMerica is proposing at each of the facilities is simply not something that is affordable in an environment of shrinking reimbursement. . . In an environment of shrinking reimbursement, these proposed increases would have a catastrophic effect on the facilities and the staff it employs."[95] This rejection of PharMerica's proposal was a direct result of the budget constraints imposed by the decrease in Medicare funding to SNFs.

C. Because of the Nature of PPS, SNFs Sometimes Prefer Per Diem Contracts, Which Can Occasionally Prove Unprofitable for LTC Pharmacies Despite Their Best Efforts.

61. A significant subset of SNFs tend to prefer per-diem contracting as a hedge against the uncertainty and risk they bear under PPS. SNFs stand to potentially take losses if their cost of providing Medicare Part A services exceeds the per diem dollar amount CMS pays them.[96] By contracting with LTC Pharmacies on a per diem basis, a SNF shares the drug-utilization portion of this risk with the LTC Pharmacy with which it contracts.[97] If the cost of providing the drugs included on the agreed-upon formulary exceeds the fixed per diem amount paid by the SNF, the pharmacy, rather than the SNF, bears the financial consequences.[98] LTC Facilities also like per diem pricing because having a

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[94] *See, e.g.*, Emerson, Patrick M. *Intermediate Microeconomics: 1st Edition*. Oregon State University: Open Educational Resources at Module 3 – Budget Constraint.

[95] Email from Avery Eisenreich to Gregory Weishar, *RE: Response to your memo.* (Mar. 7, 2014) (SILVERNJREV05727981); Email from Avery Eisenreich to Gregory Weishar, *RE: Response to your memo.* (May 7, 2014) (SILVERNJREV05727981).

[96] *See* McKay, Robert. PharMerica Rule 30(b)(6) Deposition (Oct. 8, 2015) ("McKay Dep.") 34:18-36:11 (testifying that nursing homes wanted to avoid risk by fixing their costs with downstream vendors in order to avoid risk by entering per diem arrangements). This is because under per diem arrangements, SNFs pay a fixed per diem rate to pharmacies such as PharMerica that includes all the drugs on an agreed upon formulary. Bentley, Donovan. Deposition (May 24, 2016) ("Bentley Dep.") 18:4-19:16.

[97] *See* McKay Dep. 34:18-36:11.

[98] The risk involved in this system is a potential reason PharMerica preferred FFS pricing when possible. However, negotiating FFS contracts was not always feasible in the intensely competitive market for Medicare Part A, which emerged as a direct result of the incentives produced by PPS, as described in Section V.B.i. *See* McKay Dep. 74:10-

partially fixed cost for pharmaceutical services facilitates budgeting.[99] The SNFs that remain at issue in this case primarily contracted with PharMerica for their Medicare Part A business on a per diem basis.

62. It should be noted that PharMerica's "per diem" contracts generally included fee-for-service components as well as the per diem. The per diem payment covered an agreed formulary of "included drugs." Other, typically higher-priced drugs were excluded from the formulary and PharMerica charged the SNF on a fee-for-service basis for these "excluded drugs." PharMerica also excluded intravenous drugs from the per diem and billed these to the customer on a fee-for-service basis. For convenience, I will use "per diem" to refer to all three components.

63. Because the per diem contracting that many SNFs favor involves significant risk and uncertainty for LTC Pharmacies, especially with regard to utilization,[100] LTC Pharmacies occasionally have to contend with negative outcomes. Negative outcomes are a possibility in most markets for goods and services, and especially so in markets where outcomes are heavily dependent upon factors outside of the entities' control. In other words, there is a gap between the *ex-ante* (before the fact) expectations of entities and the *ex-post* (after the fact) outcomes that they face.[101] Because of this gap, it is not logically sound to infer from *ex-post* outcomes that entities intended for those outcomes to occur *ex-ante*.

64. The fallacious tendency to view an event as predictable after it has already happened is referred as

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16 ("It is in the case where we can't have the opportunity to even win the business or retain the business in the face of competition where we have to offer per diem product."); Pompeo, Kirk. Deposition (Jan. 29, 2016) ("Pompeo Dep.") 83:15-84:2 ("It was a very, very competitive market and particularly the smaller providers, pharmacy providers would use per diem pricing to be competitive and to differentiate themselves.").

[99] Pompeo Dep. 78:24-79:11 ("[T]hey liked the per diem pricing because they didn't have any of the risks. The other thing that they liked, reason that they liked it was because they could basically budget. They could say that, okay, we're going to pay $20 a day per patient, or whatever the number is, and we can budget that for the year. And we know what we're going to spend on our medications. Whereas, if they're paying fee-for-service, they have no idea. And the reason why I say that is because, again, utilization, the number of drugs that are being written, the number of patients that they have, how sick the patients are, that all changes.").

[100] McKay Dep. 34:1-7, 36:1-11 ("Under a per diem, you could be assuming a degree of risk. Everything could be just fine. It could go on for years where the agreement that you've entered into satisfies the nursing home, satisfies you, and then all of a sudden, the nursing home takes on a dramatically dramatic set of cases where the drug utilization that is included in the per diem is completely abnormal, but is realistic; it occurred. Well, all the per diem -- all that allowed us to do is charge the per diem rate, and so that risk ran to us and we could lose money in that case.").

[101] *See, e.g.*, Steiger, O. "Ex Ante and Ex Post." *The New Palgrave Dictionary of Economics*. Eds. S.N. Durlauf and L.E. Blume. London (2008): Palgrave Macmillan at 1879-1881.

"hindsight bias" in economics.[102] To illustrate how hindsight distorts the inferences drawn, consider an investor who is evaluating whether or not he should purchase a share of stock. His investment decision would be based on an *ex-ante* expectation of the outcome. Suppose the investor anticipates that he has a 99 percent chance of making a $10 profit but has a one percent chance of losing $2. If the investor decides not to purchase the stock, he will neither profit nor have a loss. Prior to his investment decision, this investor does not know with certainty the outcome of his investment. After the stock was purchased, the investor would either end up with a $10 profit or $2 loss. This *ex-post* investment outcome can be better or worse than not investing.

65. Of course, when evaluating the investment decision, the investor will compute the expected return. In this example, the expected gain is $9.88, computed by multiplying the expected return for each possible outcome by the probability of its occurrence (i.e., $10 × 0.99 - $2 × 0.01). Thus, without the benefit of clairvoyance, this would be considered a good investment, and the decision to make that investment is sound. Of course, *ex-post*, the investor will either make $10, or lose $2.

66. Suppose the economy tanks, and the investor loses $2 on his share of stock in this example. With a hindsight bias, one would conclude that this investor had made a bad investment decision because he could have "saved" $2 by not investing. However, the fact that the investor lost money does not imply that the investor made the wrong decision at the time he evaluated and purchased the stock. In this example, the $2 loss on the stock (the *ex-post* outcome) is improperly used to conclude that the investor's decision at the time the investment was analyzed and purchased (the *ex-ante* decision) was a bad one.

67. This is particularly true with respect to per diem arrangements in the market for Medicare Part A pharmacy services, due to the considerable uncertainties faced by LTC Pharmacies, as I detail below. Naturally, pharmacies like PharMerica seek positive profit margins, as is clear from testimony.[103]

68. In fact, during the Relevant Time Period there were several specific sources of uncertainty that could have caused PharMerica's cost of providing goods and services to a SNF to be greater than the per diem rate that it agreed upon with the SNF, thus resulting in negative profit margins. These sources of uncertainty included, but were not limited to, the following:

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[102] *See, e.g.*, Camerer, Colin, George Loewenstein, and Martin Weber. "The Curse of Knowledge in Economic Settings: An Experimental Analysis." *Journal of Political Economy* 97.5 (1989): 1232-1254.

[103] *See* Section V.D.ii, describing PharMerica executives' testimony that PharMerica's goal was to achieve positive profit margins.

- *Changes in Patient Composition and Acuity*: The Medicare Part A patient population of SNFs might change after the per diem pricing had been set. More high-need patients that require a greater quantity of included drugs or more expensive included drugs would erode PharMerica's profit margin.[104]

- *Inaccurate Information or Lack of Information Supplied by Customers*: Part of PharMerica's per diem pricing process involved forecasting expected drug use. To do this, PharMerica made use of data on historical drug use at a given facility. However, the drug utilization data provided by prospective new customers was not always accurate or complete, which could also lead to actual usage exceeding per diem rates set in the contracting process.[105] Alternatively, potential clients might supply no data at all during the contracting process, in which case PharMerica's pricing teams had to rely upon average utilization for existing clients.[106] However, this approach could lead to an inaccurate estimation of the facility's drug usage and consequently result in setting per diem rates that ultimately underestimated the actual needs of that facility.

69. Negative profitability from a contract with any particular SNF or even a number of SNFs therefore does not mean that PharMerica intentionally entered into deals that it knew would lead to negative outcomes. As explained above, occasional negative outcomes are not surprising in a market where outcomes are hard to predict. Relator's assertion that the mere occurrence of such outcomes means that PharMerica knowingly entered into unprofitable contracts is a fundamentally flawed premise.

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[104] McKay Dep. 34:1-7 ("Do we understand the attributes of the low-cost nursing homes versus the high-cost nursing homes? It's an inexact science … to say the least. And what's more inexact about it is that the nature of the nursing home can change from one period to the next."); Lindemoen, Mark. Deposition (Jan. 27, 2016) ("Lindemoen Dep.") 123:11-15 (confirming that one of PharMerica's clients had changed its utilization due to a strategy of purposefully acquiring patients that were "a lot sicker"). *See also* McKay Dep. 32:23-33:18; Bentley Dep. 133:10-134:5.

[105] *See, e.g.*, McKay Dep. 54:6-15 ("[T]he nursing home is not really going to be very forthcoming and tell us really what we need to know, or they don't have the utilization and things of that nature. We have to rely on the nursing home actually telling us how many per diem days each person had. How many days they actually got a per diem payment from the government. They could just lie. They could just lie and say, 'Well, only got 15 days on this one,' all right, when they actually got 20.").

[106] *See, e.g.*, Bloechl Dep. 79:23-80:16 ("When it became apparent that we would not always get NDC numbers with invoices from our prospective customers, I created a query that would pull out all of the prescriptions dispensed to a per-diem account within PharMerica. […] I would use the word average, but I don't think that's the specific word I want to use. But I'm looking at all of our customers and saying, Well, if everybody had the same per-diem formulary, and if everybody was using the same calculator rate, this is what the per-diem rate would calculate out at. This is what you would get if you rolled everyone up into a big ball and applied the calculations.").

D. PharMerica's Policies and Practices During the Relevant Time Period Were Consistent With That of a Profit Maximizing Company Operating in a Highly Competitive Market.

70. PharMerica operated in a highly competitive market. However, despite the competitive nature of the market, PharMerica always had the policy and goal of achieving profitability on its Medicare Part A per diem contracts, as is made clear by PharMerica documents and testimony.

71. To increase the likelihood of achieving this goal, PharMerica had standard processes and safeguards meant to flag struggling accounts for intervention and to manage the uncertainty inherent in the per diem system. As an initial matter, PharMerica generally excluded high-cost drugs and intravenous drugs from the per diem formulary. It billed the customer separately on a fee-for-service basis for these "excluded drugs."

72. PharMerica also actively sought to maintain and increase profitability by implementing contractual rate resets, managing costs, or, when appropriate, by terminating contracts. The care and effort put into this process, as well as the resources expended to maintain and improve the per diem pricing model over time, are entirely inconsistent with the actions one would expect from a firm intentionally engaged in swapping.

i. PharMerica Lost Business to Competitors Offering Lower Rates.

73. As is expected in a competitive market, there were several instances in which PharMerica lost business to competitors offering lower per diem rates to SNFs, some of which I describe below:

- **Preakness Healthcare**: Preakness Healthcare, then a per diem customer of PharMerica, initiated an RFP in 2014.[107] Documentation of PharMerica's planning process regarding responding to the RFP shows that PharMerica submitted a proposal that sought to increase the SNF's projected Medicare Part A gross profit per prescription from $0.72 to $4.88 or higher under a $12 or $14 per diem.[108] Preakness rejected PharMerica's attempt to raise the per diem, instead choosing Geriscript, a regional LTC Pharmacy operating out of New York,

[107] Email from Joshua Bucy to Mark R. Lindemoen, *URGENT - Preakness Approval* (Mar. 24, 2014) (PMCSNJ1441573) (referencing proposals for an RFP); "Meeting Agenda- Chem Rx South Plainfield, NJ." *PharMerica* (2014) (PMCSNJ1865281 at PMCSNJ1865283) (referencing RFPs for Preakness and stating that as of July 11, 2014, PharMerica was considering "moving facility from a per diem pricing to a fee for service option A").

[108] Email from Joshua Bucy to Mark R. Lindemoen, *URGENT - Preakness Approval* (Mar. 24, 2014) (PMCSNJ1441573).

New Jersey and Pennsylvania, as its new pharmacy provider.[109] PharMerica officially stopped service to Preakness Healthcare on September 8, 2014.[110]

- **Alaris Health**: PharMerica attempted over time to improve the profitability of its business with the Alaris Health chain,[111] which had amassed an unpaid accounts receivable balance with $1,341,192.96 outside of terms by September 2013.[112] Following a sweeping reset that raised the rates charged to the chain by 260 percent, Alaris issued an RFP.[113] PharMerica submitted a bid that Alaris strongly rebuffed, stating that it was "approximately $140,000 higher per month than [one] pharmacy and approximately $120,000 higher per month than the other. Some specific examples include (note that this is not an exhaustive list): Per diem rate is approximately $40,000 higher[;] IV costs were approximately $40,000 higher[;] Lovenox were approximately $48,000 higher[;] Pump charges were approximately $17,000 higher."[114] After Alaris refused to entertain PharMerica's offer, PharMerica sued Alaris in federal court to collect the unpaid accounts receivable.[115]

- **Northern Oaks**: PharMerica faced fierce competition from Omnicare when attempting to negotiate an agreement with Northern Oaks, as PharMerica refused to match Omnicare's $7-8

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[109] "Meeting Agenda- Chem Rx South Plainfield, NJ." *PharMerica* (2014) (PMCSNJ1865281 at PMCSNJ1865283); "Geriscript Pharmacy." *geriscript.com*. <https://www.geriscript.com/> (accessed Nov. 12, 2021).

[110] "Meeting Agenda- Chem Rx South Plainfield, NJ." *PharMerica* (2014) (PMCSNJ1865281 at PMCSNJ1865283-84).

[111] *See* Email from Mark R. Lindemoen to Gregory Weishar, *Alaris- ChemRx* (Nov. 13, 2013) (PMCSNJ0794721) (proposing per diem pricing to increase the chain's gross profit per prescription to $5.00 for Medicare Part A); Email from Matthew J. Flagg to Gregory Weishar, *Alaris Per Diem Option A, B,C* (Nov. 21, 2013) (PMCSNJ0880673) (examining the possibility of using other per diem formularies for Alaris to increase the gross profit per prescription to $5.00).

[112] "Alaris Health." *PharMerica* (SILVERNJREV01513045).

[113] Email from Avery Eisenreich to Gregory Weishar, *RE: Response to your memo.* (Mar. 7, 2014) (SILVERNJREV05727981); Email from Avery Eisenreich to Gregory Weishar, *RE: Response to your memo.* (May 7, 2014) (SILVERNJREV05727981).

[114] Email from Gregory Weishar to Avery Eisenreich, *precall level set*.... (July 11, 2014) (PMCSNJ0892658). Gregory Weishar's responses are noted in red on top of an original email from Avery Eisenreich, from which the cited quotation is sourced.

[115] This litigation was settled in 2017 for $2,475,000, with the settlement amount to be paid off in full by September 2019. Settlement Agreement. *Chem Rx Pharmacy Services, LLC f/k/a Chem Rx Acquisition Sub, LLC, As Assignee of Chem Rx Corporation d/b/a/ Chem Rx New Jersey v. Parkway Healthcare, LLC, et al.* (D.N.J. No. 2:14-cv-07393-SDW-SCM) (Oct. 17, 2017).

CONFIDENTIAL

per diem rates.[116] Nonetheless, by the end of 2006, PharMerica and Northern Oaks agreed to a PSA that set a per diem rate of $13.[117] This new contract commenced on February 1, 2007.[118] Northern Oaks subsequently grew upset about PharMerica implementing price resets in light of competitors' better rates.[119] After discussion with the facility, PharMerica offered to reduce the per diem rate back to $13 as long as Northern Oaks would agree to a more restrictive formulary that excluded additional drugs.[120] Despite this attempt to placate the facility, in August 2010, Northern Oaks sent its termination notice and cited PharMerica's pricing rather than its service as the reason for its decision.[121] PharMerica determined that it was acceptable to let go of Northern Oaks' business "based on the GP/Rx."[122] Northern Oaks thereafter entered into an agreement with BestMed.[123]

- **Freedom Village**: PharMerica provided pharmacy services to Freedom Village Health Care Center ("Freedom Village") from February 15, 2004 to June 30, 2009.[124] During this period, PharMerica consistently reset the SNF's per diem rate, increasing it from its initial level of $11 in 2004 to $21 as of September 2009.[125] On May 20, 2009, the administrator for Freedom

[116] Email from Joy Parrish to Michael Alisanski, *RE: Stop loss at Northern Oaks.* (Oct. 15, 2004) (PMCSNJ1991529 at PMCSNJ1991531-32).

[117] Pharmacy Services Agreement (Ensign). *PharMerica* (Feb. 2007) (PMCSNJ1937209 at PMCSNJ1937209-213).

[118] *Id.*

[119] "New Chain High Threat." *PharMerica* (PMCSNJ1996217).

[120] PharMerica also discussed adding a clause to the contract that allowed it to reset rates if Northern Oaks' Part A census exceeded 15 percent of its total resident population. Email from Cynthia Britton to Arlette B. Moussa, *Re: Ensign Call today* (Mar. 31, 2009) (PMCSNJ1991735).

[121] Email from Todd Dipprey to Charles Ashy, *Ensign facility termination notice* (Aug. 3, 2010) (PMCSNJ1994708).

[122] Email from Lisa Oare Shanks to Contracting et al., *Re: Northern Oaks Termination* (Aug. 5, 2010) (PMCSNJ1997118).

[123] Email from Todd Dipprey to Charles Ashy, *Ensign facility termination notice* (Aug. 3, 2010) (PMCSNJ1994708).

[124] "Amendment Request." *PharMerica* (Feb. 6, 2004) (PMCSNJ1974144); *see* Letter from Joel Niblett to Raffaella Meyer, *RE: Cancellation Notice* (May 20, 2009) (PMCSNJ0756745).

[125] "Sample of 30 Independent Customers with Without Cause Contracts." *PharMerica* (Oct. 17, 2008) (PMCSNJ2027649) (showing $11 initial rate and $19 "Current Rate" as of October 2008); Email from Lorri A. King to Raffaela Meyer, et al., *March 2007 Resets - Cypress, CA #7036 - Freedom Village # 140* (Mar. 15, 2007) (PMCSNJ1994274) (showing a current per diem of $16 as of March 2007 and increasing the per diem to $17); Email from Lorri A. King to Raffaela Meyer, et al., *March Per Diems - Cypress, CA # 7036 - Freedom Village # 140* (Mar. 13, 2008) (PMCSNJ1975205) (showing a current per diem of $18 as of March 2008 and increasing the per diem to $19); Email from Lorri A. King to Raffaela Meyer, et al., *September 2008 Resets - Cypress, CA # 7036 - Freedom Village # 140, Pacific Haven # 013* (Sept. 22, 2008) (PMCSNJ1991338) (showing a current per diem of $19 and increasing the per diem to $20); "September 2009 Per Diem Resets." *PharMerica* (Sept. 1, 2009)

Village sent a notice of termination effective June 30, 2009, explaining that the SNF would "continue to endorse" PharMerica and that the decision to terminate was "made in large part due to current economic factors."[126]

- **Pacific Haven**: PharMerica and Pacific Haven Healthcare Center ("Pacific Haven") executed a PSA beginning September 1, 2004 at a $9 per diem rate.[127] Thereafter, PharMerica increased Pacific Haven's per diem rate, often by the maximum amount allowed under the contract.[128] PharMerica subsequently received a termination letter from Pacific Haven on March 29, 2010.[129] PharMerica's post-loss review indicated that Pacific Haven terminated its contract due to better pricing it had found with Premier Pharmacy.[130] Because other LTC Pharmacies were offering rates lower than what PharMerica was charging, PharMerica lost Pacific Haven's business.

74. These examples demonstrate the highly competitive nature of the market in which PharMerica participated during the Relevant Time Period as a provider of Medicare Part A pharmacy services.

ii. PharMerica's Stated Policy Was to Have a Positive Margin on All Medicare Part A Contracts.

75. Contemporaneous records related to PharMerica's contracting practices and the testimony of its employees at deposition show that PharMerica operated its Medicare Part A per diem business with the goal of making a positive margin. These *ex-ante* intentions are consistent with a firm selling goods and services in good faith, and not with a firm engaging in swapping.

76. The testimony of at least thirteen separate PharMerica employees (both current and former

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(PMCSNJ1909218) (showing a "[c]urrent" per diem of $21 for Freedom Village as of September 2009). These resets were conducted under the constraint of at $1 reset cap. Untitled Spreadsheet. *PharMerica* (Dec. 16, 2011) (PMCSNJ1863336).

[126] Letter from Joel Niblett to Raffaella Meyer, *RE: Cancellation Notice* (May 20, 2009) (PMCSNJ0756745).

[127] Pharmacy Services Agreement (Swan Care Group). *PharMerica* (Aug. 9, 2004) (PMCSNJ1909596).

[128] Email from Lorri A. King to Raffaela Meyer, *Re: September 2008 Resets - Cypress, CA # 7036 - Freedom Village # 140, Pacific Haven #013* (Sept. 22, 2008) (PMCSNJ1991338) (showing a current per diem of $12 as of September 2008 and increasing the per diem to $13). PharMerica's agreement with Pacific Haven was subject to a $1 reset cap. Untitled Spreadsheet. *PharMerica* (Dec. 16, 2011) (PMCSNJ1863336). Accordingly, the per diem rate of $12 in 2008 means that PharMerica would have exercised its right to reset three times in the four years following the contract's inception, if the resets were all in the maximum allowable amount of $1.

[129] "Pharmacy Received Term Consol." *PharMerica* (May 10, 2010) (PMCSNJ1411609).

[130] *Id.* (PharMerica's notes on the termination read, "[r]eceived Better pricing from competitor. New pharmacy has a better medication return policy. Went to Premier Pharmacy.").

employees as of the time of their depositions) explicitly confirms that it was PharMerica's policy and goal to achieve positive margins on all its Medicare Part A per diem contracts. Some of the examples include:

- Diane Bloechl, who oversaw the per diem pricing team from approximately 2006 to 2008,[131] stated that during her time in the position, management set a goal of per diem profitability that PharMerica always met, to her knowledge,[132] and that her supervisors "always stressed that we were not to go below cost" in per diem pricing.[133]

- Donovan Bentley, who performed and later oversaw per diem pricing analyses at PharMerica,[134] confirmed that the profitability targets that PharMerica set for per diem accounts "were always positive."[135]

- Robert McKay affirmed that it was "not [PharMerica's] policy to sell Med-A below cost or to take a loss on Med-A"[136] and PharMerica did not have a policy to offer loss leader pricing.[137]

- William Monast similarly testified that it was PharMerica's policy and management's directive to make as much money as possible on each of its contracts, including for the Medicare Part A business.[138]

77. Over and over at deposition, these and other PharMerica employees confirmed that PharMerica's pricing policy was to achieve positive Medicare Part A margins on its per diem contracts.[139]

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[131] Bloechl Dep. 17:23-18:12. From 2002 until her title change, Ms. Bloechl also assisted with per diem rate resets in her capacity as a Clinical Pharmacist. *Id.* 17:13-25.

[132] *Id.* 101:13-102:2.

[133] *Id.* 77:4-7.

[134] *Id.* 11:24-13:25.

[135] *Id.* 148:2-149:4. Specifically, the goal early on in Mr. Bentley's tenure was to achieve a positive gross profit per prescription and cover the cost of goods sold. *Id.* 149:9-12. As pricing models evolved, the goal was to cover the variable operating expenses with a gross profit per prescription of six to ten dollars. *Id.* 149:12-150:24.

[136] McKay Dep. 116:21-22. McKay further clarified that Medicare Part A losses occurred "not when selling," but instead after the fact, because unexpectedly acute patients, dishonesty from nursing homes regarding utilization, or changing conditions could cause a contract to "turn unprofitable." *Id.* 116:21-117:4.

[137] *Id.* 95:5-7.

[138] Monast, William Edward. Deposition (June 27, 2016) 145:12-146:2.

[139] Keith Medley testified that it was not acceptable to PharMerica to have a negative gross margin for its Medicare Part A business at a given SNF, even if the overall margin for the SNF was significantly positive. Medley, Keith.

CONFIDENTIAL

78. As its per diem pricing model evolved over the years, PharMerica set specific profitability targets, beyond simply aiming for positive margins.

- Former Vice President of Sales Kirk Pompeo[140] stated that during his employment, the Medicare Part A gross profit per prescription ("GP/Rx") target evolved from being simply "north of zero" to being $5 per prescription by the time he left the company.[141]

- Tyler Oakes, who was Manager of Margin Management beginning in 2011 and was later director of the pricing department,[142] testified that the target GP/Rx was $11 for per diem accounts at the time of his deposition in 2016.[143]

- Mark Lindemoen similarly testified that, as of 2016, PharMerica wanted the per diem GP/Rx to be "at 11 or as high as we can."[144]

79. The documentary record confirms that PharMerica did not just pay lip service to these policies. For example, as I describe in Section V.D.i, there were multiple instances in which PharMerica lost customers, either during the normal course of business or subsequent to RFP processes, to competitors offering lower rates. PharMerica's refusal to lower its per diem offerings below internal objectives to undercut its rivals in these cases demonstrates PharMerica's commitment to aiming for positive Medicare Part A margins.

iii. PharMerica Employed and Sought to Improve Procedural Safeguards to Decrease the

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Deposition (Aug. 3, 2021) 81:21-82:6. Russell Alan Scott confirmed that PharMerica's "goal" was to have profitable business, including on Medicare Part A. Scott, Russell Alan, Deposition (July 27, 2021) 134:15-135:7. William Tartar stated that PharMerica's leadership had a certain gross profit per prescription goal that they wanted to meet for items billed to a facility (e.g., Medicare Part A), and that it was above zero. Tartar, William Timothy. Deposition (Mar. 29, 2016) ("Tartar Dep.") 119:10-120:19. Kevin Stydinger stated that prices for new per diem facilities would be set above expected ingredient costs. Stydinger, Kevin. Deposition (Mar. 9, 2016) ("Stydinger Dep.") 106:13-107:6. Larry Litzmann testified that, to his knowledge, PharMerica never offered per diem rates on a SNF's Medicare Part A business that would cause PharMerica to lose money on the Medicare Part A business. Litzmann, Larry. Deposition (Sept. 2, 2021) ("Litzmann Dep.") 25:1-6. Similarly, Greg Weishar testified that PharMerica did not engage in loss leader pricing, to his knowledge. Weishar, Greg. Deposition (Sept. 28, 2016) 122:15-18.

[140] Pompeo Dep. 17:7-14.

[141] *Id.* 60:8-24.

[142] Oakes, Tyler. Deposition Volume I (Oct. 7, 2015) ("Oakes Dep. Vol. I") 10:25-12:21.

[143] Further, this $11 rate was "adjusted" to include the costs of providing consulting services, medical records management, and other costs. Oakes, Tyler. Deposition Volume II (Nov. 3, 2015) ("Oakes Dep. Vol. II") 131:9-132:1.

[144] Lindemoen Dep. 114:2-7.

Probability of Suffering Losses on Its Per Diem Contracts.

80. Beyond the clearly stated policies described in the above section, PharMerica also had specific procedures and safeguards in place to lessen the chance that Medicare Part A per diem contracts would fall short of this goal. These safeguards changed and evolved over time with the per diem pricing model.

81. Prior to 2008, the Bloechl pricing spreadsheets used by the per diem pricing team reflected significant safeguards that were meant to prevent sales personnel from offering unprofitable per diem contracts. Specifically, the spreadsheets expressed a "break even" price that was "the lowest possible per diem needed to remain in the black."[145] That "low price" was calculated with a significant cushion in PharMerica's favor, as it only counted revenue from the drugs included in the per diem formulary and not the revenue PharMerica would earn from excluded drugs that PharMerica billed to the nursing home on an FFS basis.[146] PharMerica itself viewed profitability for Medicare Part A as a function of all its components taken together, bundling per diem revenue with that for excluded drugs, intravenous drugs, and other items for which the facility was responsible.[147]

82. As another cushion, the spreadsheets used the published wholesale acquisition cost ("WAC") price in their formulas, as opposed to the much lower price that PharMerica actually paid for the drugs.[148]

83. PharMerica continued to implement evolving safeguards after 2008. Robert McKay, PharMerica's Senior Vice President of Purchasing and Trade Relations,[149] testified that proposals for new contracts were required to meet PharMerica's basic pricing standards, which ensured that the cost of the services bundled into the per diem, such as deliveries, would be covered by the expected "profit and margin" from the contract.[150] If any contract terms fell out of these bounds of normal acceptability, the contract would need to be escalated to him and potentially up to the CEO for approval.[151] Around 2013, a cross-functional per diem management services team was created within PharMerica specifically to analyze accounts during their periods of reset and renewal to identify issues with

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[145] Bloechl Dep. 83:1-5.

[146] *See id.* 106:1-2, 183:2-6.

[147] *See, e.g.*, Oakes Dep. Vol. II 12:6-13:10. *See also* Bentley Dep. 120:5-15.

[148] Bloechl Dep. 25:9-25, 74:7-21, 77:21-24, 94:1-21, 109:21-25. *See also* McKay Dep. 219:12-16.

[149] McKay Dep. 95:21-22.

[150] *Id.* 23:20-24.

[151] *Id.* 21:1-23:25.

CONFIDENTIAL

utilization or pricing.[152] PharMerica's pricing department also began conducting monthly meetings in 2014 or early 2015 to discuss all per diem clients that were up for renewal within the next six to eight months and flag for special review any per diem client that fell below a $10 GP/Rx threshold.[153]

84. Other than requiring these specific checks, PharMerica also continually refined and improved its pricing models in order to better assess and predict Medicare Part A per diem profitability. In particular, PharMerica expended significant time, effort, and resources over nearly two decades to improve and to automate this pricing process.[154]

85. Prior to 2008, PharMerica used a manual process to analyze the anticipated profitability of per diem contract proposals.[155] PharMerica's sales people were required to fill out a "pricing profile" that specified the desired per diem price, formulary, exclusion pricing, and other services to be offered.[156] They were also required to obtain as much information as possible about the prospective customer's then-current drug utilization including, when available, 90 days of invoices from the prospective customer's then-current pharmacy.[157] PharMerica's pricing and reset models in this period used manually-manipulated Excel spreadsheets,[158] and only included basic data on drug cost, as the per diem pricing team did not have access to data on other costs.[159]

86. To estimate a profitable price, the per diem pricing team manually entered into the pricing profile all the drugs used by the prospective customer, their volume of use, and their publicly published WAC. The profile would then analyze factors such as "the number of prescriptions dispensed," "the pricing attached to those prescriptions," and "the number of Medicare Part A days billed" with respect to those prescriptions to compute potential per diem pricing options based on the drugs included and

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[152] McKay, Robert. Deposition (Sept. 29, 2016) 197:1-198:7.

[153] Oakes Dep. Vol. II 130:21-131:14, 132:6-12.

[154] McKay Dep. 27:17-29:14; Oakes Dep. Vol. II 10:4-11; Bentley Dep. 22:23-25, 63:9-64:2, 143:1-4; Stydinger Dep. 204:15-205:2.

[155] Bloechl Dep. 17:9-20:1. From approximately 2006 until 2008, Diane Bloechl oversaw the pricing team. *Id.* 17:23-18:12. Ms. Bloechl was not a trained analyst and did not have any prior pricing experience, and was originally hired as a clinical pharmacist. *Id.* 24:20-25, 17:21-18:12.

[156] "Pricing Profile 4.0." *PharMerica* (July 25, 2005) (PMCSNJ0713657); Bloechl Dep. 96:18-99:15.

[157] Bloechl Dep. 100:14-16; Tartar Dep. 193:13-195:24.

[158] Bloechl Dep. 100:9-101:12; Burgard, John. Deposition (Apr. 29, 2016) 17:22-18:6.

[159] Bloechl Dep. 75:23-76:25; Stydinger Dep. 195:23-198:21.

excluded in PharMerica's various per diem drug formularies.[160] The pricing team would provide these pricing analyses to the account management team, "so they could run [different pricing] scenarios before they made a commitment" to the customer.[161] As mentioned above, there were various profitability targets over time and multiple levels of approval that were required when projections did not achieve these targets.

87. Starting in 2008, new management sought to make PharMerica's pricing process more transparent, accurate, and efficient by "upgrad[ing] the technology and upgrad[ing] the processes" for pricing.[162] Consequently, all pricing and contracting functions were relocated to PharMerica's corporate headquarters in Louisville, Kentucky. A new pricing team was formed under the direction of Kevin Stydinger, the former Director of Marketing, and was led by Donovan Bentley, former Manager of Pricing.[163]

88. Under this revised process, the sales team would submit a redesigned pricing profile to the pricing team.[164] The pricing team entered the data from the pricing profile into a pricing model that calculated an expected gross margin based on the facility's utilization data. When available, this utilization data was supplemented with information contained in PharMerica's internal databases, allowing PharMerica to compare prospective customers against other facilities in the same region with roughly the "same number of beds."[165] Based on this profitability assessment, PharMerica would "set an initial per diem rate based upon the best of [PharMerica's] knowledge" that would "be above [PharMerica's] cost."[166]

89. The goal of this process, as expressed by Mr. Bentley, was to ensure that every contract his team modeled was priced to make money on Part A.[167] The pricing team then provided these pricing profiles to the sales team, which would use these models to negotiate contract prices.[168] As Kirk

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[160] Bloechl Dep. 70:15-23, 100:22-25; Email from Diane Bloechl to Kathryn Johnson, *Re: prospective pd account* (Dec. 4, 2007) (PMCSNJ0712994).

[161] Bloechl Dep. 89:8-10.

[162] Stydinger Dep. 91:23-92:1, 196:24-197:15, 204:15-205:2.

[163] *Id.* 78:1-16, 96:7-17, 212:4-7.

[164] Pompeo Dep. 68:6-69:21.

[165] *Id.* 62:19-63:17; Stydinger Dep. 106:13-21, 112:17-113:15.

[166] Stydinger Dep. 106:13-21, 107:4-6, 114:7-10, 116:6-15.

[167] Bentley Dep. 157:19-158:7.

[168] Pompeo Dep. 63:6-7; Stydinger Dep. 227:10-16, 233:19-23.

Pompeo, PharMerica's former Vice President of Sales, explained, he could only approve the pricing ultimately proposed by the sales team if it was within PharMerica's "established guidelines" for Medicare Part A GP/Rx ratios, which were always above zero and increased to a minimum of approximately $5 by the time he left in 2013.[169]

90. The care shown by PharMerica in pricing its per diem contracts demonstrates an earnest concern with the profitability of its Medicare Part A business and would simply not make sense in the context of a swapping scheme.

iv. PharMerica Included Reset Provisions in Its Contracts and Routinely Reset Per Diem Rates.

91. PharMerica implemented the pricing policies and safeguards described above to mitigate the risks inherent in per diem pricing and to protect its profits.

92. In addition, the contracts between PharMerica and the SNFs that are at issue in this matter included rate reset provisions that allowed PharMerica to increase or decrease the per diem rates.[170] These rate reset opportunities typically arose every six months, but could range from once every 90 days to once a year.[171] These reset terms were meant to help balance the competitive pressures from SNFs with the need for profitability.[172]

93. As Robert McKay explained in his deposition, rate resets were included in PharMerica's contracts with SNFs to allow PharMerica to react to circumstances that could not be predicted during the contracting process.[173] Similarly, Tyler Oakes testified at deposition that resets acted as a risk management tool or a "backstop" for PharMerica in the event that a SNF's utilization exceeded PharMerica's forecasts.[174]

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[169] Pompeo Dep. 52:5-15, 57:4-18, 59:17-61:6, 63:6-10, 66:2-19.

[170] *Id.* 143:18-24. *See also* McKay Dep. 73:5-8.

[171] *See, e.g.*, Pharmacy Services Agreement (North Mountain Healthcare). *PharMerica* (Feb. 2008) (PMCSNJ1996885); Pharmacy Services Agreement (Northern Oaks Healthcare). *PharMerica* (May 8, 2009) (PMCSNJ1776556); Pharmacy Services Agreement (Casa de las Campanas). *PharMerica* (Dec. 2004) (PMCSNJ0968106); Pharmacy Services Agreement (Pilgrim Place Health Services). *PharMerica* (Aug. 2006) (PMCSNJ2033202); Pharmacy Services Agreement (Regent Management Services). *PharMerica* (Nov. 2004) (PMCSNJ1978990). *See also* McKay Dep. 195:24-196:7.

[172] *See* McKay Dep. 72:22-74:3.

[173] *Id.* 67:7-16, 243:7-12.

[174] Oakes Dep. Vol. I 27:9-28:2.

94. Consistent with its profit maximizing practices, PharMerica regularly availed itself of this opportunity. PharMerica monitored facilities that were eligible for rate resets, automatically generated monthly reports on such contracts,[175] and routinely exercised its reset rights as mutually agreed upon and written into the contract.[176]

95. The fact that PharMerica's contracts included resets, and that it routinely exercised its right to adjust prices upward, indicates there was no swapping.

v. PharMerica Utilized Contractual Remedies to Mitigate the Risk of Losses on Its Per Diem Contracts.

96. Apart from exercising resets, PharMerica took additional steps to ensure the profitability of its contracts going forward, such as actively managing the formularies that dictated which drugs would be included within the per diem rate it offered to particular SNFs. The inclusion or exclusion of certain drugs from the formulary was used as a risk management tool.[177]

97. As noted herein, SNFs paid FFS rates to PharMerica for excluded drugs that were not included under the per diem payment in the formulary.[178] By excluding more drugs from the formulary, PharMerica could therefore lessen the risk that it took on under the per diem contract.[179] I list a few below as examples:

- **<u>Alaris Health</u>**: PharMerica proposed a new formulary for Alaris Health with different exclusions and goals for exclusion utilization aimed at reversing negative margins,[180] after its analysis revealed that Alaris Health's per diem formulary was too broad, non-standard, and had annual reset provisions that were not reasonable.[181] Alaris Health resisted PharMerica's

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[175] McKay Dep. 117:5-7; Tartar Dep. 58:5-59:7, 112:1-19.

[176] McKay Dep. 206:14-208:13 ("Oh, characterized it as less than 20 times…[I] had the authority to waive or put a hold on a particular reset[.]").

[177] Oakes Dep. Vol. II 75:17-76:5.

[178] *Id.* 11:12-12:5.

[179] Moreover, the FFS rates for excluded drugs were typically higher than the rates that would be negotiated on PharMerica's wholly fee-for-service contracts. *See* Oakes Dep. Vol. II 116:10-20. The higher rates for excluded drugs could thus help PharMerica maintain its profitability in the event of a shortfall, because PharMerica viewed Medicare Part A profitability as a sum of its component parts, considering revenues from per-diem rates and excluded drugs together. *See* Bentley Dep. 87:2-10. *See also* Oakes Dep. Vol. II 12:9-11.

[180] "Alaris Health and PharMerica Business Review." *PharMerica* (PMCSNJ0681295).

[181] *Id.*

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attempts to improve the margins associated with the chain, initiating an RFP process after PharMerica reset the chain's rates and subsequently rejecting PharMerica's RFP bid.[182]

- **SCM-Kissito**: Internal PharMerica documents also show similar steps taken with the SCM-Kissito group when its contract was up for renewal, such as switching the customer to a "more manageable" formulary.[183]

- **Northern Oaks and Willow Bend**: PharMerica offered to reduce the per diem to $13 in exchange for Northern Oaks and Willow Bend agreeing to a more restrictive formulary that excluded additional drugs.[184]

98. These measures taken by PharMerica, in addition to the procedural safeguards it had in place, helped PharMerica minimize its risk of negative profit margins, and are demonstrative of PharMerica's proactive approach to seeking profits.

vi. PharMerica Actively Walked Away from Less Profitable Contracts.

99. Apart from the proactive approach that PharMerica employed with respect to new and existing contracts, PharMerica also sought to protect its profitability and avoid losses by walking away from contracts when necessary. Specifically, in several instances, PharMerica walked away from deals in which the per diem rates were not where PharMerica wanted them to be, even if the margins were still positive.

100. For example, Mark Lindemoen, PharMerica's Senior Vice President of Sales and Client Services,[185] specifically stated that, in 2015, he "fired" numerous customers whose Medicare Part A margins were negative or "insufficiently" positive, but whose overall margins (when including Medicare Part

[182] *See* Email from Gregory Weishar to Avery Eisenreich, *precall level set….* (July 11, 2014) (PMCSNJ0892658); Email from Avery Eisenreich to Gregory Weishar, *RE: Response to your memo.* (Mar. 7, 2014) (SILVERNJREV05727981); Email from Avery Eisenreich to Gregory Weishar, *RE: Response to your memo.* (May 7, 2014) (SILVERNJREV05727981).

[183] Email from Lisbeth Chernesky to Jay Palin, James Loftin, and Nancy Hoffman, *Re: FW: SCM Q4 2007 GM BY PS UPDATED* (Dec. 7, 2007) (PMCSNJ1422277).

[184] PharMerica also discussed adding a clause to the contract that allowed it to reset rates if Northern Oaks' Part A census exceeded 15 percent of its total resident population. Email from Cynthia Britton to Arlette B. Moussa, *Re: Ensign Call today* (Mar. 31, 2009) (PMCSNJ1991735).

[185] Lindemoen Dep. 17:21-24.

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D and Medicaid lines of business) were positive,[186] amounting to roughly 5,000 beds in total.[187] This included many homes from the Ensign chain,[188] as well as Ohio-based Peregrine, which had 1,600 beds and a positive Medicare Part A margin.[189]

101. Of course, in line with the behavior of a profit-maximizing firm, PharMerica did not blindly terminate every single customer whose Medicare Part A margins were low or negative in a given period, especially in light of the numerous potential remedies described above. Whether to terminate an unprofitable contract was instead a case-by-case decision that could not be reduced to any universal rule.[190]

102. PharMerica also took a similar approach with respect to its acquired accounts, walking away when it was unable to remedy unprofitable accounts. PharMerica acquired a number of its underperforming per diem contracts through purchases of struggling companies. From an economic perspective, it makes perfect sense that many of these contracts would initially be poor performers. Firms that are bankrupt are under severe operating and financial pressure and must often sell their assets at a discount. In many cases, this discount exceeds that offered by distressed firms that submit to mergers.[191] However, there is no guarantee that the acquiring firm would immediately realize a benefit from a discounted price. In fact, research has shown that shareholders of the purchasing firm do not begin to realize acquisition premiums until a year after the acquisition.[192]

103. PharMerica's acquisition of ChemRx, another LTC Pharmacy, was consistent with these dynamics. In November 2010, PharMerica purchased ChemRx's troubled assets for $70.6 million, a substantial (roughly 50 percent) discount relative to ChemRx's valuation of $139.3 million as of May 2010.[193] The fact that some of the contracts PharMerica obtained via to the ChemRx acquisition may have

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[186] Specifically, where the "all-in" (profit of all lines of business that PharMerica provided to the customer) was "12, 13, 14, $15." Lindemoen Dep. 320:24-321:1.

[187] *Id.* 320:24-322:7.

[188] *Id.* 321:20-22 ("We fired a lot of the un-signs [sic] because they're unwilling. And I even met with their general counsel[.]").

[189] *Id.* 321:18-20.

[190] McKay Dep. 109:7-111:7.

[191] *See* Precourt, Elena and Henry Oppenheimer. "Acquisitions of Bankrupt and Distressed Firms." *International Journal of Bonds and Derivatives* 2.1 (2016): 1-39 at 1-3.

[192] *Id.* at 33-34.

[193] PharMerica. *Form 8-K/A* (Nov. 4, 2010) at 2; "Presentation to Board of Directors of PharMerica Corporation." *PharMerica* (Sept. 24, 2010) (SILVERNJREV05288362) at 3.

had low or negative Medicare Part A margins is hardly surprising, given that ChemRx was bankrupt, and is not indicative of any scheme, much less a kickback scheme, on the part of PharMerica.

104. Subsequently, PharMerica planned to sort through the assets it acquired in the normal course of business and make reasonable determinations about the ongoing value of those assets as they were integrated into PharMerica's operations. Soon after it acquired ChemRx, PharMerica implemented the "ChemRx Profitability Process" (the "Profitability Process") to turn ChemRx's struggling contracts into positive business assets.[194]

105. The Profitability Process was a playbook PharMerica developed to address the profitability concerns raised by certain legacy ChemRx contracts, wherein PharMerica planned to offer each of the identified facilities a new PSA that would remedy PharMerica's concerns regarding the profit margins associated with that facility.[195] Specifically, it stated that if the facilities declined to accept the proposed new PSAs, PharMerica would simply "stop service."[196]

106. As a result of this process, for example, PharMerica terminated the Feigenbaum Group, an eleven home New Jersey chain comprising over 1,700 beds, within six months of acquiring the ChemRx assets.[197] PharMerica's diligent efforts to improve the profitability of its acquired accounts are not consistent with a swapping scheme.

107. As demonstrated by this example, as well as my above discussion of the market that PharMerica operated in and the steps that PharMerica took to ensure profitability, PharMerica's actual business practices are consistent with a profit-maximizing firm operating in a highly competitive market. Contrary to Relator's swapping allegations, PharMerica always attempted to achieve positive margins on its Medicare Part A business standing alone, and employed numerous procedures and safeguards to ensure that this occurred. PharMerica also expended significant time and resources to

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[194] "ChemRx Customer Profitability Process." *PharMerica* (Mar. 16, 2011) (PMCSNJ1587992 at PMCSNJ1587995).

[195] *Id.*

[196] *Id.*

[197] Email from Jim Pierce to Gregory Weishar et al., *ChemRx Weekly Update w/e 3/18/11* (Mar. 19, 2011) (PMCSNJ1587989 at PMCSNJ1587991); "ChemRx Customer Profitability Process." *PharMerica* (Mar. 16, 2011) (PMCSNJ1587992 at PMCSNJ1587999); Email from Peter Marcus to Jim Pierce et al., *NJ* (Apr. 27, 2011) (PMCSNJ0881416 at PMCSNJ0881417) ("The elimination of low performing Feigenbaum business … per my calculations increases the remaining business 0.9%[.]"). PharMerica had marked this account as among the list of "priority" groups in New Jersey. "ChemRx Customer Profitability Process." *PharMerica* (Mar. 16, 2011) (PMCSNJ1587992 at PMCSNJ1587999).

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improve its pricing model over the years, demonstrating that it cared about the accuracy of Medicare Part A pricing. PharMerica had tools to improve contract profitability, such as reset provisions and formulary management, and used them frequently. When remedies such as resets did not work, PharMerica did not indefinitely hold on to negatively profitable accounts, but instead showed its willingness to walk away from such customers. These actions are not consistent with the conduct of a firm engaging in swapping.

VI. OPINION II: PHARMERICA'S PER DIEM RATES HAD NO IMPACT ON GOVERNMENT DECISIONS REGARDING MEDICARE PART D OR MEDICAID PAYMENTS.

108. The per diem rate offered by an LTC Pharmacy to an individual SNF does not have any impact on either Medicare's decision to pay Part D Plan Sponsors or any state Medicaid agency's decision to pay PharMerica for drugs dispensed to Medicaid beneficiaries. This is for three reasons, as described below.

109. *First*, Medicare Part A and Medicare Part D operate under entirely distinct and separate payment systems, and there is no information regarding Medicare Part A rates or payments between SNFs and LTC Pharmacies that flows to the government as it decides whether to make a payment under Medicare Part D to a Plan Sponsor. Accordingly, any reduction in an LTC Pharmacy's per diem rates for a SNF's Medicare Part A residents would not have any impact on whether, or how much, the government pays for patient care under Medicare Part D.

110. Relatedly, and again reflecting that Medicare Part A and Medicare Part D operate under entirely separate payment systems, neither SNFs nor LTC Pharmacies have any say or control over whether the government pays Medicare Part D Plan Sponsors. Moreover, SNFs do not make any payment to LTC Pharmacies for any prescriptions provided under Medicare Part D (because they are not Plan Sponsors). Therefore, there is simply no relationship between an LTC Pharmacy's Medicare Part A per diem rates and the government's decisions to make payments under Medicare Part D.

111. *Second*, because the government makes payments under Medicare Part D to Part D Plan Sponsors—not LTC Pharmacies—there is simply no process or reasonable mechanism by which the government would decline to make payments to the Medicare Part D Plan Sponsors who might happen to service Medicare Part D beneficiaries in certain SNFs.

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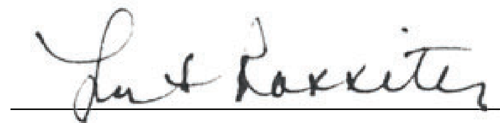
112. To illustrate, consider a typical Plan Sponsor such as Aetna or UnitedHealth. As described above,[198] government payments are made to a Plan Sponsor based on prospective bidding and an annual reconciliation process. At no point in making these payments does CMS evaluate whether any of that Plan Sponsor's enrollees were residents in a particular SNF or the specifics of contracts, including pricing, between those SNFs and any LTC Pharmacies. CMS simply does not collect such information or have access to it. These are private contracts. There is simply no process that I am aware of by which CMS would go to a Plan Sponsor and decline to make payments (which is determined in advance based on costs unrelated to the contract between the SNF and LTC Pharmacy) related to a subset of that Plan Sponsor's enrollees based on the profitability of privately negotiated per diem contracts between SNFs and LTC Pharmacies. In other words, the government's decision to pay Plan Sponsors is entirely separate from the specifics of contracts and profitability between a SNF and an LTC Pharmacy.

113. *Third*, federal Medicare Part A and state-level Medicaid are also entirely distinct and independent payment systems, operated by two separate levels of government. Thus, no Medicaid decisions are made based on any knowledge of Medicare Part A rates or payments.

114. In other words, the decision-making in the payment systems for Medicare Part A, Medicare Part D, and Medicaid are entirely independent. There is no mechanism by which the profitability of privately negotiated per diem contracts between SNFs and PharMerica for drugs covered under Medicare Part A, much less the contract for any individual SNF, affects the government's decision to pay Plan Sponsors or the state-level payment flows under Medicaid.

Dated: December 3, 2021



Louis F. Rossiter, Ph.D.

[198] *See* Section IV.B.ii, *supra*.

Appendix A

Curriculum Vitae

Louis F. Rossiter, Ph.D.
Curriculum Vitae

Current Position: Research Professor
Program in Public Policy
The College of William & Mary PO Box 8795
Williamsburg, VA 23187-8795
e-mail: lfross@wm.edu

Education: 1977 Ph.D. Economics, University of North Carolina at Chapel Hill, NC
1972 M.A. Economics, University of South Carolina, Columbia, SC
1971 B.A. Economics, Lenoir-Rhyne University, Hickory, NC

Prior Experience:

THE COLLEGE OF WILLIAM & MARY
Williamsburg, Virginia
2013 - 2018 Director, Health Sector, MBA, Raymond A. Mason School of Business
2006 - 2009 Director of Schroeder Center for Healthcare Policy and Research Professor of Public Policy
2002 - 2005 Senior Research Fellow

OFFICE OF THE GOVERNOR, COMMONWEALTH OF VIRGINIA
Richmond, Virginia
2001 - 2002 Secretary of Health and Human Resources (Cabinet Appointment)
Managed the administrative, jurisdictional, program operation and policy development of 13 state agencies. Directed the formulation of the comprehensive budget for the Secretariat. Held agency heads accountable for performance. Developed and directed the Secretariat strategic plan. Saw Virginia awarded a first-place ranking by the Center for Digital Government for the social services category. (The state was ranked 21st in the 2001 survey.) Numerous reforms achieved in social services, Medicaid and state mental health hospitals. Oversaw secretariat emergency response during and after 9/11 and anthrax.
2000 - 2001 Deputy Secretary for Operations of Health and Human Resources

MEDICAL COLLEGE OF VIRGINIA CAMPUS, VIRGINIA COMMONWEALTH UNIVERSITY (VCU)
Richmond, Virginia
1992 - 1996 Director, Office of Health Care Policy and Research, Office of the Vice President for Health Sciences, VCU
1989 - 2000 Professor, Williamson Institute for Health Studies, Department of Health Administration

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) (OR HCFA)
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Washington, DC (on leave from MCV/VCU)
1989 - 1991 Senior Policy Advisor to the Administrator

Managed day-to-day activities of Office of the Administrator. Daily represented the Administration on Capitol Hill and to industry on matters pertaining to budget requests for the Medicaid, Medicare and reforms. In cooperation with a staff of 40, directed the policy content of dozens of appearances before U.S. Congressional committees by the Administrator.

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Oversaw creation of $7 billion Medicare system of reimbursing hospitals nationwide for new capital spending. The Congress approved the plan in 1991, the federal regulations were issued in 1992 and the system was phased in through the year 2002. The system has revolutionized the way every hospital in the country is reimbursed by Medicare, Medicaid as well as private payers. Advised on new comprehensive rules for paying physicians under Medicare, which has now become the standard for paying most physicians in the U.S.

Formulated policy initiatives through the legislative process. Successful legislative outcomes include new rules for marketing health insurance policies that supplement Medicare; payments under Medicare that bundle the physician and hospital bill for complex procedures; Medicaid best price, and redesign the work of organizations that review the quality of care for Medicare and Medicaid patients to reflect a quality improvement approach.

Daily direction for policy communication to Washington press corps and Capitol Hill staff.

1986 - 1990 Director, David G. Williamson, Jr., Institute for Health Studies, MCV/VCU
1985 - 1989 Associate Professor, Department of Health Administration, MCV/VCU
1982 - 1985 Assistant Professor, Department of Health Administration, MCV/VCU

NATIONAL CENTER FOR HEALTH SERVICES RESEARCH, DEPARTMENT OF HEALTH & HUMAN SERVICES
Washington, DC
1977 - 1982 Senior Researcher/Economist

Teaching: Introduction to Public Policy (PUBP 600-04)(Graduate) since 2008, Health Care Organization, Financing and Performance (BUAB 598J)(Graduate) 2015-2018, Health Policy (PUBP 614) (Graduate) 2010, Policy Research Seminar (PUBP 610) (Graduate) 2002-2008, Economic Aspects of Biotechnology (ECON 310) (Undergraduate) 2006, 2009, Health Economics (HADM/ECON 624 and HAE 624) (Graduate) 1982-1999, Health Care Financing and Delivery Systems (HADM 702) (Doctoral) 1986-1999, Health Program Evaluation (HADM 763) (Doctoral) 1986-1999

Chaired or served on 37 doctoral dissertation committees

Current Service (Boards of Directors and Officer Positions):

2008 - present New Health Analytics, Chief Scientific Officer
2012 - present Williamsburg Community Health Foundation, Trustee, Chairman
2011 - present Quarterpath Community Development Association, Virginia CDA, Vice Chairman
TPMG Accountable Care Organization, LLC, Citizen Member, Board, Edlogics, Member Advisory Board

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Prior Service:

2004 - 2012	Numerous departments, school and university committees at Virginia Commonwealth University Center for Excellence in Aging and Geriatric Health
1998 - 2011	Member Board of Directors and Chairman Nominating Committee, National Advisory Council, Health Care Financing and Organization Initiative, Robert Wood Johnson Foundation
2007 - 2011	Member, National Library of Medicine, National Institutes of Health, DHHS
2005 - 2012	Member Board of Regents, AcademyHealth, the professional home for health services researchers, policy analysts, and practitioners, and a leading, non-partisan resource for the best in health research and policy
2004- 2007	Member Board of Directors, Member Finance Committee, Member Nominating Committee, and Chair Health Services Research Impact Award Committee Virginia Veterans Care Center Advisory Committee, Department of Veterans Services
2002 - 2004	Member, Appointed by Governor Warner VCU Health System, Board of Directors
2001 - 2003	Member of Board of Directors; Chairman of the Quality, Risk Management and Safety Committee; Member of the Executive Committee, Appointed by Governor Gilmore Coalition on Donation, a national alliance of organizations dedicated to educating the public about organ and tissue donation
1997 - 2000	Member of Board of Directors, Virginia Health Quality Center, $5 million revenues, 60 employees, 501(c)3
1997 - 1999	Member of Board of Directors and Treasurer, Governor Gilmore's Commission on Community Services and In-Patient Care
1996 - 2000	Member, Appointed by Governor Gilmore Virginia Blood Services, $18 million revenues, 217 employees, 501(c)3
1992 - 1996	Chairman of the Board, National Advisory Council to the Agency for Health Care Policy and Research, Member Appointed by Secretary Louis Sullivan, MD

Sole-Authored Books or Monographs:

Understanding Medicare Managed Care: Meeting Economic, Strategic, and Policy Challenges (Chicago, IL: Health Administration Press 2001)

Rising Costs for Healthcare: Implications for Public Policy, National Federation of Independent Businesses (NFIB) Research Foundation, Washington, DC, monograph, 2009.

Thesis:

A Transcendental Production Function for Health Services: The Community Pharmacy, University of North Carolina at Chapel Hill, dissertation, 1977. (373 pages)

Published Papers in Peer-Reviewed Journals and Books in the Past Ten Years:
(1) First Author, (2) Second Author, (3) Third Author, etc.

"Question Medicare: But Can You Ignore It? The Well-Managed Care Health Plan Has a Medicare Strategy," *Healthplan July/August* 42(4) (2001) 32-7. (1)

"A Comprehensive Strategy for The Evaluation and Triage of the Chest Pain Patient: A Cost Comparison Study," with others, *Journal of Nuclear Cardiolology* May-Jun;10(3), (2003) 284-90. (4)

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"Medicaid Disease Management Programs: Findings from Three Leading U.S. State Programs," with JL Gillespie, *Disease Management and Health Outcomes*, 11, 6 (2003) 345-361. (2)

"Vaccines and the Next Pandemic," *Health Affairs* Sep-Oct;24(5) (2005) 1380. (1)

"Medicaid, State Finances, and the Bottom Line for Businesses," with RF Neice, *Business Economics* 41(3) (July 2006) 49-54. (1)

"Evaluation of Chronic Disease Management on Outcomes and Cost of Care for Medicaid Beneficiaries," with NJ Zhang, TTH Wan, MM Murawski, and UB Patel, *Health Policy.* (3)

"Medical Cost Savings Associated with an Extended-release Opioid with Abuse-deterrent Technology in the U.S.," with NY Kirson, A Shei, AG White, HG Birnbaum, R Ben- Joseph, E Michna, *Journal of Medical Economics* Apr 17(4) (2014) 279-87. (1)

"Societal Economic Benefits Associated with an Extended-Release Opioid with Abuse- Deterrent Technology in the U.S.," with NY Kirson and others, *Pain Medicine* 15(9) Sep 2014 1450-1454.

"Assessment of Work Loss and Costs Associated with Opioid Abuse: A Retrospective Claims Analysis," with AG White and others, *Value in Health* May 21(1) (2018) S185-S186.

"Telebehavioral Health: the ROI for Long-Term Care," with W Austin and J Gammon, *Healthcare Financial Management*, February 2018.

"Expenditures and Quality: Hospital and Health System Affiliated Versus Independent Physicians in Virginia," *Southern Medical Journal* 111, 10 (2018) 597-600.

"Hospital Overstays: Manage Them, Help the Bottom Line, Improve Care," with K Masiulis, T Schaich, J Thomas, *Healthcare Financial Management*, November 2018.

Chapters in Books:
(1) First Author, (2) Second Author, (3) Third Author, etc.

"The Magnitude and Determinants of Physician Initiated Visits in the United States," with GR Wilensky, in Health, Economics and Health Economics, J van der Gaag and M Perlman, eds. (Amsterdam: North-Holland Publishing Co.), 1981. (2)

"The Retail Market for Prescription Drugs: A Duopoly Model," in Advances in Health Economics and Health Services Research, R Scheffler and LF Rossiter, eds., (Greenwich, Connecticut: JAI Press), 1982. (1)

"Health Manpower and Questions of Turf," with L Dodini, Pharmacy in the 21st Century (Millwood, VA: Project HOPE Health Sciences Education Center), 1984. (1)

"The Reported Use of Non-Brand Name Medicines: The Effect of Reimbursement, Patient Characteristics and Health Status," with James Begun in Generic Drug Laws: A Decade of Trial-A Prescription for Progress, T Goldberg, I Raskin, and C Devito (eds.), 1986. (1)

"Operational Issues for HMOs and CMPs Entering the Medicare Market," with K Langwell and others in New Health Care Systems: HMOs and Beyond, Washington, DC: Group Health Association of America, Inc., 1986. (1)

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"Medicare's Expanded Choices Program: Issues and Evidence from the HMO Experience," with K Langwell, R Brown, KW Adamache, and L Nelson in Advances in Health Economics and Health Services Research, Vol. 10, 1989. (1)

"The Research Agenda in Managed Care," Making Managed Healthcare Work: A Practical Guide to Strategies and Solutions, P Boland (ed.), New York, NY: McGraw-Hill Book Company, (1991). (1)

"Strengths and Weaknesses of the AAPCC: When Does Risk Adjustment Become Cost Reimbursement?" HMOs and the Elderly, H Luft (editor), Ann Arbor: Health Administration Press, 1994. (1)

"The Health Economy and Political Forces on Provider Behavior," Exploring Collaborative Research in Primary Care. BF Crabtree and others (eds.), Thousand Oaks, CA. SAGE Publications, 1994. (1)

"The Role of Medicaid," with A Weil in Restoring Fiscal Sanity 2007: The Health Spending Challenge. AM Rivlin and JR Antos (editors), Washington, DC: Brookings Institution Press, 2007. (2)

"Decision-Making by Public Payers," in Decision Making in a World of Comparative Effectiveness Research: A Practical Guide, HG Birnbaum and PE Greenberg (eds.), Singapore: Springer Nature, 2017.

Edited Books:

Advances in Health Economics and Health Services Research, Volume 3, editor with R Scheffler, (Greenwich, CT: JAI Press 1982).

Research on Competition in the Financing and Delivery of Health Services, editor, DHHS Pub. No. (PHS) 82-33282. U.S. Department of Health and Human Services, National Center for Health Services Research, November 1982.

Advances in Health Economics and Health Services Research, Volume 4, editor with R Scheffler, (Greenwich, CT: JAI Press 1983).

Advances in Health Economics and Health Services Research, Volume 5, editor with R Scheffler, (Greenwich, CT: JAI Press 1984).

Advances in Health Economics and Health Services Research, Volume 6, Biased Selection, editor with R Scheffler, (Greenwich, CT: JAI Press 1985).

Advances in Health Economics and Health Services Research, Volume 7, Mergers and Acquisitions in Health Care: Performance Issues, editor with R Scheffler, (Greenwich, CT: JAI Press 1986).

Advances in Health Economics and Health Service Research, Volume 8, Economics and Mental Health, editor with R Scheffler, (Greenwich, CT: JAI Press 1987).

Advances in Health Economics and Health Services Research, Volume 9, Private Sector Involvement in Health Care, editor with R Scheffler, (Greenwich, CT: JAI Press 1988).

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Advances in Health Economics and Health Services Research, Supplement 1, Comparative Health Systems, editor with R Scheffler and J Rosa (Greenwich, CT: JAI Press 1990).

Advances in Health Economics and Health Services Research, Volume 11, Health Economics and Health Policy in the 1990's: Surprises from the Past, Forecasts for the Future, editor with R Scheffler, (Greenwich, CT: JAI Press 1990).

Advances in Health Economics and Health Services Research, Volume 12, Health Risk Adjustment and Health Insurance, editor with R Scheffler and M Hornbook, (Greenwich, CT: JAI Press 1991).

Advances in Health Economics and Health Services Research, Volume 13, editor with R Scheffler (Greenwich, CT: JAI Press 1992).

Advances in Health Economics and Health Services Research, Volume 14, The Economics of Mental Health, editor with R Scheffler (Greenwich, CT: JAI Press 1993).

Advances in Health Economics and Health Services Research, Volume 15, State Health Care Reform, editor with R Scheffler and Joel Cantor (Greenwich, CT: JAI Press 1996).

Testimony in the Past Four Years:

Trinity Health Michigan v. Blue Cross Blue Shield of Michigan (Mich. Oakland County. No. 2018-167493-CB).

Christopher Dicesare, et al. v. The Charlotte-Mecklenburg Hospital Authority, d.b.a Carolinas Health System (N.C. County of Mecklenburg. No. 16-CVS-16404).

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New Mexico Oncology and Hematology Consultants, LTD v. Presbyterian Healthcare Services (D.N.M. No. 1:12-cv-00526).

Carmignac Gestion, S.A. v. Perrigo Company PLC, et al. (D. N.J. No. 2:17-cv-10467).

Mason Capital L.P., et al. v. Perrigo Co., PLC, et al. (D. N.J. No. 2:18-cv-01119).

Pentwater Equity Opportunities Master Fund Ltd., et al. v. Perrigo Co., PLC, et al. (D. N.J. No. 2:18-cv-01121).

Harel Insurance Company, Ltd., et al. v. Perrigo Company PLC, et al. (D. N.J. No. 2:18-cv-02074).

First Manhattan Co. v. Perrigo Company PLC, et al. (D. N.J. No. 2:18-cv-02291).

TIAA-CREF Investment Management, LLC, et al. v. Perrigo Company PLC, et al. (D. N.J. No. 2:18-cv-08175).

Nationwide Mutual Funds, on behalf of its serries Nationwide Geneva Mid Cap Growth Fund and Nationwide S&P 500 Index Fund, et al. v. Perrigo Company PLC, et al. (D. N.J. No. 2:18-cv-15382).

Schwab Capital Trust on behalf of its series Schwab S&P 500 Index Fund, et al. v. Perrigo Company PLC, et al. (D. N.J. No. 2:19-cv-03973).

Hudson Bay Master Fund Ltd., et al. v. Perrigo, et al. (D. N.J. No. 2:18-cv-16206).

WCM Alternatives: Event-Driven Fund, et al. v. Perrigo, et al. (D. N.J. No. 2:18-cv-16204).

Discovery Global Citizens Master Fund, Ltd., et al. v. Perrigo, et al. (D. N.J. No. 2:19-cv-21502).

York Capital Management, L.P., et al. v. Perrigo, et al. (D. N.J. No. 2:19-cv-21732).

Burlington Loan Management DAC v. Perrigo, et al. (D. N.J. No. 2:20-cv-01484).

Sculptor Master Fund, Ltd., et al. v. Perrigo Co., PLC, et al. (D. N.J. No. 2:19-cv-04900).

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CONFIDENTIAL

Appendix B

Materials Relied Upon

Materials Relied Upon[1]

Legal

42 C.F.R. § 423.100.

42 C.F.R. § 423.120(a).

42 C.F.R. § 423.120(a)(5).

42 C.F.R. § 438.2.

42 C.F.R. § 438.60.

42 C.F.R. § 483.45(c).

42 U.S.C. § 1395w-111(i).

42 U.S.C. § 1396b(m)(2)(A)(iii).

42 U.S.C. § 1396r-8(g)(2)(A)(i).

42 U.S.C. § 1396r-8(g)(2)(A)(ii).

42 U.S.C. § 1396r-8(g)(2)(A)(ii)(II).

76 Fed. Reg. 48486, 48536 (Aug. 8, 2011).

77 Fed. Reg. 46214, 46230 (Aug. 2, 2012).

78 Fed. Reg. 47936, 47966 (Aug. 6, 2013).

79 Fed. Reg. 45628, 45655 (Aug. 5, 2014).

81 Fed. Reg. 27498, 27500, 27543, 27588-89 (May 6, 2016).

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[1] In preparing my report, I relied upon the documents listed here along with any items cited or referenced in the body and footnotes of my report.

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