OncoHealth - Former SVP of Corporate Operations at Trellis Rx

Interview conducted on January 06, 2023

Topics
340B Program, Specialty Pharmacies, Oncology Practice, Pharmaceutical Industry, Discount Negotiations, Data Management, Insurance Contracts, In-Network Status

Summary
A Tegus Client speaks with a former SVP of Corporate Operations at Trellis Rx about the 340B program, including the manufacturers' requirement for data to prevent double rebates, the flow of dollars in the program, and the challenges of billing for infusions. They also discuss the profitability of oncology practices, drug buying MSOs, and the potential for direct dispensing in the oncology and rheumatology markets. The conversation touches on negotiating with insurance companies, the regulatory gray area surrounding 340B, and the potential for joint ventures between community oncologists and health systems. The expert also explains the process for qualifying infusion segments and prescribing REMICADE.

Expert Details
Former SVP of Corporate Operations at Trellis Rx, leaving September 2022. Expert can speak to the 340b program as it relates to specialty pharmacy and retail pharmacy.

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Prior to Trellis Rx, the expert was the Director of Specialty Pharmacy at Sova Pharmaceuticals, leaving January 2019.

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Q: Can you speak in depth to the 340B drug pricing program?
A: I am happy to speak with your clients. I can speak to the 340b program as it relates to specialty pharmacy and retail pharmacy.

Tegus Client
Thank you for taking the time to speak with me today about the 340B program. To start off, could you please give us a quick overview of your background and experience in this space?

Former SVP of Corporate Operations at Trellis Rx
Yes, absolutely. So most recently, I was the Senior Vice President at Trellis Rx. I oversaw our implementation team for new programs along with our trade relations team. So that's the team that's working with the manufacturers. And then I also oversaw our clinical team, our training team and our outcomes group. So kind of everything that was not on-site as far as the day-to-day goes.

Prior to joining Trellis, I started a specialty pharmacy, where it was for a couple of owners, they had a long-term care business which they've since sold and then a retail business, but they didn't have a specialty business. So I started that program for them.

And then prior to that, I worked for an independent specialty pharmacy, called the Apothecary By Design. I was fortunate that's actually where I started my career as a pharmacist with Apothecary By Design. We grew really large. We were the fourth largest independent specialty pharmacy in the country, and we were sold then off to CVS. So they're still around, but they're CVS nowadays. So yes, that's a little bit about me.

Tegus Client
Awesome. Maybe just to start, would love to just hear your kind of quick summary of the 340B program and kind of how it's changed over the last few years?

Former SVP of Corporate Operations at Trellis Rx
Yes, absolutely. So the 340B program, I'll tell you kind of from where it started to where it ended up, in my experience, was basically the 340B program came about, it was really, I think, in the early days, the health system is really focused on their inpatient side.

And then we saw a shift to the outpatient side. We started in Maine, working with one health system in terms of their 340B program and then later with a city's Community Health Center as far as 340B goes. This is all on the outpatient side.

I've worked with various groups in my career, whether that be a health system, a federally qualified health center, the smaller like the Community Health Center is smaller. Obviously, it's not a health system, Ryan White Programs, so that would be like your HIV patients. Worked with some of those, and then on to hospitals.

Well, I should say, I don't know everything changes a lot. But the biggest change, I think, we've seen in the last couple of years, obviously, is the data space, right. So the manufacturers requiring data, which makes sense to me. They want to make sure that they're giving the rebate, not giving both the rebate to the manufacturer or to the hospital and to the PBM. So they're looking for that data.

That's been a big shift that we've seen. Hospitals have kind of taken their stances on that as far as which way they're going to go. Some have decided to provide that data. Others have decided not to provide that data. But I think for the most part, they're all providing that data.

Tegus Client
Can you double click on that? Because it sounds like a little bit controversial. I'm curious what data a hospital is meant to provide, and then what are the circumstances where a PBM would get a rebate for this? I would have thought it would be only hospital.

Former SVP of Corporate Operations at Trellis Rx
Yes. So I guess the way the manufacturers look at it is, right, so they're going to give their 340B price, say, on a medication like, let's take, for instance, HUMIRA is, let's say, their 340B price is half price. So let's say, it's $2,500 instead of $6,000. So they're providing that at a 340B cost to the hospital, to the qualified health center.

And then on the same side, that claim is built through to the insurance. The insurance remits what their normal would be. So the hospital has been making, say, $3,500 on that claim. But the PBM still gets their rebates, their negotiated rebate with the manufacturer. So if they've negotiated that HUMIRA is 50% off, that's their rebate, they're getting 50% off. So now the drug company is giving the drug away for free.

Tegus Client
I see. And what is the drug company's recourse in that case? Like do they have to pay the PBM a rebate?

Former SVP of Corporate Operations at Trellis Rx
They have to pay the PBM, yes, I mean, the reason they're paying the PBM the rebate is because they want to be on that formulary with the PBM. So that's all been negotiated already. So the PBM is going to get that rebate.

And there's been all this talk all this time about this, what they're calling double dipping, because they're saying, well, because the health systems aren't providing the data to anybody, really, the manufacturers can't track this.

So the manufacturers then have to go through auditing processes to make sure, but they're basically kind of

getting hosed there. So there's some new programs out there that, I can't remember the name of the company that's working with those manufacturers to make sure that they're getting the data they need.

Again, what is the hospital's responsibility for reporting that? I mean, they don't have any responsibility for reporting that. The problem is, when you don't report it, you don't get the 340B pricing is what the manufacturers are trying to say, and that's what's going through all those legal back and forth. 340B Health is a good resource to kind of keep up with that.

Tegus Client
Makes sense. Maybe just a quick follow-up question on that. So in that case, the hospital has written a prescription for HUMIRA. And they get their $6,000 they bill the insurance company for $6,000. Where does the discount to the hospital system come from? And where does the distributor get there like whatever the retail or whatever the normal price would be? And then the like the next pharma company pays the hospital, like what is the average like flow of dollars?

Former SVP of Corporate Operations at Trellis Rx
Yes. So let's start with the new prescription. So let's say that the health system has an oncology provider and they're writing for the medication SPRYCEL. And SPRYCEL is $18,000 a month. What happens is that's sent down to the pharmacy. The pharmacy then builds the claim in their pharmacy dispense system.

The first dispense is almost always dispensed at the full cost. And the reason being is when the pharmacy gets that medication, even though they know it's from their provider, they know that it's their patient within the health system. All of those things, they know those things. They're dispensing that medication at the full cost. So say they're dispensing at $18,000, the insurance company is going to pay them $18,200. They'll make a $200 profit. That's the first claim.

And the reason being is what they do is, they do what's called a virtual inventory. So once that claim has been processed and the patient gets their medication, the claim goes through what's called a third-party administrator. So Macro Helix is one of those.

As an example, Verity. So Verity, Macro Helix, those are good examples of that. They determine the eligibility of that claim. And when they say, okay, that claim was eligible for 340B. So what you get is you get an accumulation on your 340B inventory. So the next time you go to refill that prescription for that patient, that SPRYCEL, it will now be $10,000, let's say $18,000, you'll bill it for $18,000 and you'll make $8,000, if that makes sense. So you basically have two different inventories. One is your 340B inventory and one is your, what we call, WAC inventory, Wholesale Acquisition Cost inventory.

Tegus Client
Got it. But in that case, the pharmacy is billing the insurer?

Former SVP of Corporate Operations at Trellis Rx
Yes. There's no difference for the pharmacy, as how they bill the insurer.

Tegus Client
And like they're buying the drugs from their distributor or from a manufacturer? And is the amount that they're paying for those drugs in month two, lower?

Former SVP of Corporate Operations at Trellis Rx
Yes, in month two.

Tegus Client
In month one and month two?

Former SVP of Corporate Operations at Trellis Rx

Yes. So in month one, they'll pay the full price, they'll buy the $18,000 SPRYCEL, but in month two, month three, month four, month five, they'll get the $10,000 price.

Tegus Client
Got it. And why do they do it at full price in month one, should still qualify, right?

Former SVP of Corporate Operations at Trellis Rx
So yes, it does still qualify. The reason they do that is you can do your inventory one of two ways. You can do a virtual inventory or you can do a physical inventory. The virtual inventory is basically, let this third-party administrator determine whether or not the claim is 340B eligible and then you get an accumulation for it. So next month, you can order it on the 340B.

The reason that a lot of them like that is if you were to do it the other way, which is the physical inventory, that would basically be, so I get a prescription into the pharmacy for SPRYCEL. I would have to then, as the pharmacist determine, is this going to be an eligible claim or not and then pull it out of my 340B physical inventory that opens you up for errors, if somebody makes a mistake there and you get audited, then you're going to get slapped.

Tegus Client
Got it. So you're willing to give up the first month, in exchange for like more grace in the audit?

Former SVP of Corporate Operations at Trellis Rx
Yes.

Tegus Client
Interesting. And are most of these drugs passing through a distributor? Or are they procured directly from the manufacturer?

Former SVP of Corporate Operations at Trellis Rx
No. 99% of them are direct from wholesalers, yes. So AmerisourceBergen, McKesson, Cardinal, 99% of them are coming direct from the wholesaler, very few of them come from the manufacturers themselves.

Tegus Client
Makes sense. And then those distributors, like AmerisourceBergen are saying, okay, we had this many like full price or like I guess, they're saying, we have this many like 340B discounted sales last month and they go to the manufacturer and say, hey, like you need to reimburse us for X amount of discounts?

Former SVP of Corporate Operations at Trellis Rx
Yes. I'll be honest. I think the wholesalers do get more money out of the 340B program than they do on their general program. I don't know the economics of that. But yes, so what you get set up with, as a pharmacy, is you get two accounts. You get one that's your full price account and one that's your 340B account. So you have to like basically sign into which account you want to order off of.

Tegus Client
Yes. So maybe we can dig into a little bit of just the like private practice, hospitals. I don't know how familiar you are with some of this stuff. But we've been reading a lot about, there's probably like around 2,000 hospitals that sort of qualify for 340B, but then they extend that qualification to different affiliated centers, outpatient centers and things like that. And so the total number is around like 30,000.

And I think the thing that we're wondering is, from what we've read, there's like a lot of different rules. You have to like manage bill under their Medicare number. You have to be within like 35 miles and all of that stuff.

But we've been hearing that some independent kind of practices have been able to kind of take advantage of

the 340B program without doing necessarily like all of that work. And just curious, from your experience, if you have heard about that or have any thoughts on that.

Former SVP of Corporate Operations at Trellis Rx
Yes. So as long as they're registered with HRSA as a child site, yes, and there are specifics as far as like distance from the health system that they are. So I know, for instance, I've worked with a consulting gig with one client who one of their specialists was like 200 feet down or 200 yards down the road and somebody else was like 75 yards across the parking lot. And the ones across the parking lot qualified because of the length, but the ones that were further out did not.

So yes, you're right, if you're within the right area, you can definitely qualify within the health system. And then what they call that as like a child site, so they call it a child side and you can look these up on HRSA's website. They have that nice search function of entities. And so you can see kind of what offices are associated with that.

So from an outpatient side, if you had, say, a rheumatologist or a rheumatology group within that area, you can register them as a child site, and that office is now going to qualify, which is a big deal. If you get with rheumatology or oncology, you're always going to do really well with 340B.

Tegus Client
I'd like to know a little bit like maybe what are the requirements? So like I think this is happening all over the place, but like the health system will acquire or affiliate in some manner with an oncology practice. And so that, that practice can get through 340B status. Like what are all the things that need to be true about that relationship for the practice to get 340B status?

Former SVP of Corporate Operations at Trellis Rx
There are a couple of things. I'm sure it's outlined on HRSA's website, what they have to do to qualify in terms of their proximity and so forth. And then what the relationship is with the physicians.

For a lot of physicians, there's a lot of hesitancy as far as like you guys had mentioned, billing under the Medicare number. There's a lot of hesitancy. We see a lot of hesitancy out there with providers being okay with that because now when you register as a child site, you're now billing, basically like you're a hospital, an outpatient hospital visit, and then you get a separate bill from the physician. So now patients are getting two bills instead of one bill.

So there's always a lot of pushback on that, but the financial value to the health system is great. So they generally push through that. There also have been some rules that changed during COVID to make it easier on these health systems to qualify different locations. So that might change some of that as well. But I don't know the specific rules. I'm sure it's on HRSA's website. I've never actually had to convert a clinic. That would probably be within their business department.

Tegus Client
I'm curious if you've heard of any specialty pharmacies that are helping kind of private practices get 340B rates without having to go through a health system. We've heard of like House Rx and others trying to look into this, but curious if you have any experience with that.

Former SVP of Corporate Operations at Trellis Rx
I don't have any experience with it. I know, yes, House Rx is putting together a model for, to help, I've read about that, the community centers. As far as getting 340B rate, I would highly doubt that, to be honest. I would be surprised if that were the case.

It's very difficult to negotiate with the manufacturers in terms of rates. They have historically always said, well, get bigger, get bigger. Really where you can negotiate with them is if you hold the data. So any time a prescription is processed, if you have the prescription software, the pharmacy software, you hold the keys to the data. They're willing to pay for that data. That's always been the case.

That's why you see a lot of independent pharmacies have gone underwater, especially like the big independent specialty pharmacies have sold, Diplomat, Avella, AVD all sold because they weren't getting enough money out of the manufacturers to succeed, whereas groups like Optum and CVS who purchased them, they can get that money out.

Tegus Client
What sort of data is available to them?

Former SVP of Corporate Operations at Trellis Rx
Usually dispensing data. So usually with pharmacy software systems. So you think of somebody like PioneerRx is a huge pharmacy software system out there. When part of your agreement with PioneerRx or any of those pharmacy software systems as a pharmacist when you're starting a pharmacy is that they get all your data.

So they're getting all your processing data, so they're getting some basic patient demographics. Whether the patient got a starter kit, they're getting how long has the patient been on the medication, how many refills did they get? Who is their insurance company? What did it cost the patient? Who is the provider? So forth.

So most of that data is sold for like Rx30, PioneerRx, a lot of that data is sold to IQVIA, and that's how those companies make their money. So a lot of those health systems of data is just going into IQVIA anyway. So they're already reporting it, they probably just don't even realize it because a lot of health systems aren't bill-savvy with outpatient pharmacy.

Tegus Client
Got it. How familiar are you with House Rx's model and kind of similar models focused on primarily like specialty pharmacy integration within the vendor practices?

Former SVP of Corporate Operations at Trellis Rx
Very familiar. We did specialty pharmacy implementations for health systems at Trellis Rx and House Rx does it for community practices.

Tegus Client
Okay. I'm just curious because we're mostly interested in this from actually the oncology practice side. And just understanding if and when, like community oncology practices become good investments. Because right now, they're not.

I would say that they're basically losing the health system, and then you're seeing some kind of MSO players like OneOncology or US Oncology, way back when. And then the more like drug-focused ones like AON or House Rx, like starting to be a little bit more like bit simple and pure play.

But what's cool with that model is like you can still acquire the practice out from underneath, like not out from underneath, but like they can be a House Rx customer and you can do a practice consolidation, whereas if you're working with OneOncology or US Oncology, like they can actually sell to you. Because they've already sold like 20% US Oncology or OneOncology. And so it presents further consolidation.

Like I'd love to learn a little bit more about roughly how the Trellis model works, but then like how does it work with an independent like oncology practice, for instance? Because my understanding is that the vast majority of practices are already doing their infusions in clinic and like that's buy-and-bill, and how they make all their money. But like how does the House Rx model actually work like what value do they create for independent practice? Like how do they work with that practice?

Former SVP of Corporate Operations at Trellis Rx
Yes. I can't speak to that. But I can say that for Trellis and what I've done in the past, I've never worked on the infusion side. There's not a lot of players as far as the infusion side goes. A lot of these health systems or

the community offices, from my understanding, are doing the buy-and-bill like you're saying on their own.

I don't know what their economies look like in that sense. But I think that's kind of a place where I could see a value need in the marketplace is with infusion. And the reason being is multifaceted.

When we bill a prescription for, like, say, for an oral chemo drug in the pharmacy, it's really easy. And like I hate to downplay it because it's my profession. But compared to the medical side and infusion, infusion is very difficult.

What we do is on the pharmacy end is we bill through, we type up a prescription, we hit send. It goes to the insurance company, and it immediately comes back and says either accepted the claim and this is your reimbursement or it says rejected the claim and it tells you why it rejected. And that could be for prior authorization, that could be for, it needs a drug utilization review, it could be for a number of things as far as the rejection goes. But at least we have real-time billing.

Medical side, infusion side, it's not real-time. So what you see is you have to do the prior authorization, it's more manual, generally paper. And then you have to make sure every single month that, that patient has not had a change in their insurance because you're not billing real-time.

So you have to bill and then wait for your money to come in. Well, if the patient changes his insurance and you've been giving them an infusion for the last six months, well, you just gave them six months' worth of free infusion, essentially, because you didn't have a prior authorization under their new insurance.

So somebody has to do that work. And then in addition to that, we hear it a lot from health systems. They don't want help with the actual like administering of the infusion. What they want help with is the revenue cycle management of it, making sure they got paid for that infusion and then the prior authorization and financial assistance is where they're looking for value.

I think that's where infusion is going. And a lot of times, I think if you can do, I would think, with community practices, if you can get somebody who can manage three or four offices, and that's three or four employees across four sites that the office doesn't have the staff.

Tegus Client
Yes. I think one reason why the typical like independent oncology practice is so focused on infusion is that if they are prescribing like an oral oncolytic, they don't get paid for that.

Former SVP of Corporate Operations at Trellis Rx
They can.

Tegus Client
Like so that's actually was my next question like, how do they get paid for that?

Former SVP of Corporate Operations at Trellis Rx
Yes. So oncology is a very interesting space. They've done a great job in terms of advocating over the years for in-office dispensing. I mean, for instance, it's hard because you don't want to have this kickback, right. Or any inference of a kickback.

So a lot of states like Connecticut, it's an absolute no. Doctors they can't even hold like a share of CVS in that state. But states like Maine, New England here, they can dispense it right out of the office. So the physicians themselves can dispense it, it's out of a pharmacy dispensing system. They bill it just like a pharmacy would and they get all their remit and everything like that, just like a normal pharmacy would, but it's just right out of a closet.

So a good example of that is Mission Health used to have an oncology center when they were a 340B entity. They're no longer a 340B entity because they were acquired by HCA. And the oncology practice spun off from the hospital after that acquisition. And they still have, I think, three or four pharmacists and pharmacy technicians working in there for their patients on either infusion or on their outpatient kind of pharmacy and

for their orals.

But I will say I think that's the tricky part is when you get in there because it's not 340B pricing, what do you do. And that's where you have to work with the manufacturers on getting a bigger discount. And different trades have different discounts from the wholesalers.

So for instance, when I was in independent specialty pharmacy, I purchased my drug at wholesale acquisition cost minus 2%, okay. A hospital buys that wholesale acquisition price minus 6.5%. And there's no rhyme or reason to it, it's just that's the class of trade that the wholesalers have decided.

So that's, again, why you don't see a lot of independence anymore. But I'm sure they're giving physicians' offices, wholesale acquisition cost, minus 6.5% as well. So you can make money, you just probably have to run a little bit more lean and mean.

Tegus Client
Right. Would you have a sense for how much you can make on like the oral, because like there was a big trend in oncology away from infusion, towards orals. Might be a byproduct by COVID and accelerated by like, concerns around like doing care, and it's like way better for the patients, like there's a whole a lot of reasons to do that. But obviously, oncologists theoretically would be really resistant to it because they're not getting buy-and-bill margin.

And I would say like on the buy-and-bill side, you're probably familiar with this, but oncologists make anywhere from like ASP minus 1% or 2%, if you're literally like just dependent oncology branch which more all the way to like if you're OneOncology, like ASP minus 12%.

It's like you give massive discounts. Do you have a sense for like comparable profitability like for in-house dispensing? Like do you think it's like WAC minus 6.5%? Or is it like another like formula we should have in our head?

Former SVP of Corporate Operations at Trellis Rx
Yes. I think they probably purchased at WAC minus 6.5%. So if you take the WAC cost of those drugs, and you should make a 6.5% margin. Now with Medicare, there's something called direct and indirect remuneration where they take back 10% of what they pay you after a few months.

Tegus Client
What do you mean?

Former SVP of Corporate Operations at Trellis Rx
Yes. So direct and indirect remuneration came around 2015. It's always been in contracts with the insurance companies. But basically, because of the blow up and how big specialty pharmacy got, they came up with this, of a way of basically they pay you, and then they come back and they take back 10% of what they paid you every quarter.

So the FTC, that's why they're investigating the PBMs is because of these direct and indirect remunerations in their practices. But essentially, if you did WAC minus 6.5%, calculated your total profit and then just subtracted 10% of that total profit, that's what you're going to make on a community oncology claim.

Tegus Client
I see. So it's not like you're not giving up 3.5% at the end of the day?

Former SVP of Corporate Operations at Trellis Rx
No.

Tegus Client
You're giving up, like 6,5 basis points?

Former SVP of Corporate Operations at Trellis Rx
Yes. So when I was working as an independent specialty pharmacy, I was making 2% overall was my profit. Now I was buying again at WAC minus 3%, you would be buying at WAC minus 6.5%. So you're getting an extra 3.5%. So you can assume about 5.5%. And when I say I was making 2% that's after my direct and indirect remuneration, my DIR fees.

Tegus Client
Yes. I'd love to just learn a little bit about like what contracting looks like with, like for these parties that are getting drug distribution discounts like I'm curious like House Rx is like a new start-up, obviously.

If you think about how OneOncology started, they basically got like two massive practices and then started piggybacking on their rates. How would like a new start-up actually work? Because like my understanding is that there aren't like a lot of big unaffiliated practices in like maybe rheumatology, but like not oncology anymore. Like what is like minimum scale look like to actually start getting discounts from distributors?

Former SVP of Corporate Operations at Trellis Rx
Yes. That's a good question. I actually don't know. There are a lot of large rheumatology programs. They're still kind of independent. You can always look up the Medicare value of what the doctors in the practice are prescribing. So that's all public information on Medicare's website.

So I can look up, say there's five providers in a oncology practice. I can look up and see what they're prescribing for all their Medicare patients and the total cost of those drugs. So are they prescribing $20 million in REVLIMID each year. I can look all that up on Medicare's website.

So you can kind of evaluate what the size of that clinic is going to look like. I think in terms of how do you decide which is going to be viable or not. That's tough. I've seen that in the past with health systems where if they're just too small, we just won't approach them. Or we either don't approach them or we'll tell them they're too small, and they should just start their own program.

But with smaller practices, like smaller oncology practices, honestly, if it's like one provider, I would think that you would just tell that provider to use whatever pharmacy the patient has to use rather than try and do it in-house.

Tegus Client
Yes. And how differently are like the infusion drugs versus the orals dealt with by the distributor?

Former SVP of Corporate Operations at Trellis Rx
By the wholesaler?

Tegus Client
Yes, by the wholesaler.

Former SVP of Corporate Operations at Trellis Rx
Nothing. There's no difference. The wholesalers make more money on the infusion line. And I think that's because if you factor in the infusion, you factor in things like saline, things like the piping, all the supplies will all come through that wholesaler. They do better on those.

And the reason I know that is because that's factored in, that's part of the reason they get that WAC minus 6.5% versus me at an independent pharmacy. I'm not buying any of that stuff. So I'm not getting that percentage. So they want those deals. They're very driven for high infusion or even like health systems are the same way, anybody that's in the hospital because all those supplies, I think they do really well on those.

Tegus Client
Okay. But in terms of like my leverage with the wholesaler?

Former SVP of Corporate Operations at Trellis Rx
Yes.

Tegus Client
Because I'd love to understand the point at which you start to get like wholesaler's attention, because like even this like WAC minus 6.5%, like I would assume there's a lot of variability underneath that, right. Like if I'm like the biggest health system in the U.S., I'm like kind of look at WAC minus 6.5% so like you got to do better than that, right?

Former SVP of Corporate Operations at Trellis Rx
Absolutely. That's the biggest thing you can try in effect, right. I have had a lot of success with wholesalers in terms of getting a discount, better success with the manufacturers when it comes to getting an additional discount, to be honest with you. And that usually includes some sort of data.

So for instance, in my past when working in fertility, in fertility space, the two big players, Merck and EMD Serono, they'll give you a bigger discount based on your market share. So what they want to see is that you're basically exclusively using their products. They don't want you using the competitors. So they'll give you a bigger discount if you're more exclusive to them.

Things like AbbVie is usually a good partner to work with in terms of data and getting extra money. But again, I don't know what their cutoffs are. I know with like, for instance, we were doing probably $25 million a year in hepatitis C, dispensing at Apothecary By Design, and we still couldn't get Gilead to give us any kind of additional discount.

Tegus Client
Yes, so in that case it's like a real monopolist. How do you actually get that discount from the manufacturer? Because you said you're buying like 99% of the drugs through the wholesaler. Do they then give you a discount after that? How does that work exactly?

Former SVP of Corporate Operations at Trellis Rx
Yes. So that's usually, again, in order for them to do that, we have to provide them with something of value. So that's usually data. So some sort of dispensing report or along those lines.

I mean, like manufacturers have tried to do things like, for instance, is ZEPATIER with the Merck product for hepatitis C that nobody ever used. Unfortunately for them, they came in late, Gilead had the product to try and get people to use it more, what they did was they included it in a GPO price, and you could get a bigger discount with your wholesaler if you were in, like, say, Asembia, their GPO, you could get a bigger discount on ZEPATIER.

But again, nobody used ZEPATIER. It wasn't in the guidelines. So it didn't really benefit anyone in that sense, unless you got somebody who had failed the treatment with a couple of other agents. But GPOs are another way to get additional discounts on top, that's working with the manufacturer, being a GPO, getting additional discounts at that point.

Tegus Client
That makes sense. So like in the oncology practice setting, I think it's AON, they have something like 100 different practices that they work with. And my understanding is that they have pretty attractive discounts or like enough in discounting to have like a real business where they're saving the practice's money and they're generating real EBITDA. What does the minimum efficient scale look like for one of these kind of drug buying MSOs? Like how many practices do you think you need or how much volume do you need?

Former SVP of Corporate Operations at Trellis Rx
I don't know. We never went down that path with any of my former businesses. We probably should have at Trellis, to be honest with you, just given their size, but we never did.

Tegus Client
Makes sense. What's your sense in terms of the extent to which rheumatology has, so like in oncology, I think like I'm surprised that House Rx has found any practices and are dealing with some sort of drug buying MSO today. Is it as saturated as I think?

Or maybe people are switching off AON or let this free agent or something like that? And my next question is like, to what extent is like rheumatology the same way? Or is actually there's a lot of like independent rheumatologists that don't have?

Former SVP of Corporate Operations at Trellis Rx
I think as far as like oncology goes, I'm not sure, to be honest with you, just because I haven't worked in that space as far as to me, health clinics. But as far as rheumatology goes, I would say that, that's wide open.

I think that they're doing their own infusion, a lot of them. The reason I know about rheumatology better than oncology is, that was basically when I was an independent specialty, that's what I went after was rheumatology. Because oncology, again, a lot of them are already doing it, like you said, but rheumatology, they're doing their infusion, but they're not doing their self-administered stuff. So that stuff is wide open.

I worked with rheumatology associates here. Atlantic Digestive is a big GI practice. Again, none of those practices have in-office dispensing or anything along those lines. I don't know of any rheumatology program that does. Asheville Arthritis was a huge rheumatology practice that I worked with. They did the infusions, but they didn't do the outpatient pharmacy stuff.

Tegus Client
And how much volume would you say a practice like that does in terms of like the direct dispensing that they could do?

Former SVP of Corporate Operations at Trellis Rx
Yes. So Rheumatology Associates in Maine, I think there were six providers, I'd say, they probably do somewhere between $30 million and $40 million a year in just outpatient medications. That would be the total cost. So say $6,000 a pop, $40 million worth. And then Asheville Arthritis is a much bigger program. So I would say they're probably bigger than that. They're probably $50 million or $60 million.

Now you won't be able to fill for every single patient. That's the tricky part. You have to get the insurance contracts, just like you would as a pharmacy, that's the tricky part, getting in network with all these things.

One thing that I think community practices have a better ability to do is they're contracting with a Blue Cross Blue Shield of Maine to take the patient's insurance and come to the office. Rheumatology Associates in Maine is a great example because I think they're pretty much the biggest rheumatology group in Maine and service most of Maine.

So they're negotiating with Blue Cross Blue Shield. When you're going to Blue Cross Blue Shield, you say, okay, but you also have to let me in network for your pharmacy benefit. So now I can bill medications under the pharmacy.

They have a better opportunity to do that than a pharmacy would. So a pharmacy would have to go through accreditation. We'd have to go through hoops and all that stuff as far as any willing provider will allow us to go.

But we would have to make a case like, for instance, when we were at Apothecary By Design, we were in the Blue Cross Blue Shield of Maine network, but they wouldn't let the hospital in. They wouldn't let the hospital pharmacy into it. So it's just a matter of somehow getting a leg up on someone in a sense, but health institutions and community offices generally have that ability.

Tegus Client
That's super interesting. And so if you think about Rheumatology Associates in Maine, they do $40 million of volume that's at presumably ASP minus 6.5%.?

Former SVP of Corporate Operations at Trellis Rx
No, not ASP because I'm talking non-infusion.

Tegus Client
Yes, right. That would be WAC?

Former SVP of Corporate Operations at Trellis Rx
Correct.

Tegus Client
So that's like $2.5 million of theoretical margin and then you have to give 10% of that back to the health plan under your like 10% rebate program. But that's like six providers who are basically picked up like a couple of hundred thousand dollars.

Former SVP of Corporate Operations at Trellis Rx
Yes.

Tegus Client
Not accounting for cost of running the program?

Former SVP of Corporate Operations at Trellis Rx
Yes. If I knew anything about being a broker, what I would do is broker a deal between Rheumatology Associates in Maine Medical Center because if Maine Medical Center took them under their 340B network, I mean that's an extra $15 million a year that they're making on 340B, all profit.

Tegus Client
Right. And so in that circumstance, it sounds like there's an opportunity to do direct dispensing in small brackets, but like it pales in comparison to the 340B opportunity for that practice. The issue is like those docs don't want to work for Maine Medical Center. They don't want Maine Medical Center to do the scheduling. And I've heard that House Rx has figured out a way to get 340B coverage for some practices under some circumstances and without necessarily having to like sell the asset to the health system. And I'm not sure how they're doing it. If it is some joint venture or something along those lines.

But do you have any like hypothesis on how that could work? Because I think it's one of these like regulatory gray areas and I think that 340B has been in this like regulatory gray area forever, right. Like I think there's a lot of like creatively qualifying health systems.

Former SVP of Corporate Operations at Trellis Rx
Yes.

Tegus Client
If you had to like just guess how that might work, what's your hypothesis?

Former SVP of Corporate Operations at Trellis Rx
I'm guessing that's not the case. I don't see how they could ever view that. I mean, the only thing I could think of any way that they could do that is if somehow they were saying that the referral from a health system to the oncology center qualifies that patient and their claim for 340B. But I think that's really gray.

I would be surprised if that were the case. So we do see some kind of referral loops like that, for instance, you might see, say you have an employee of a health system who has to go to a specialist, so the health system that they work for refers them to a specialist at, say the Cleveland Clinic.

The patient then comes back, they fill their prescription at the health system. But because the provider

works for the Cleveland Clinic, they are still considering that 340B because they referred that patient. But I don't know, I still don't know that I've seen it. I don't know that, that's legitimate.

Tegus Client
Yes. The other model that I'm curious about is like if I were a community oncologist, and wanted to do a deal with the health system and assuming that this health system doesn't have employed oncologist, which I think is like the big question.

And there's some markets where this is the case and some markets where it isn't. And down the street from the 340B eligible health system, and we were going to do some sort of affiliation deal where I had admitting privileges, but I also could refer all my patients to health system X or Y.

And then as part of that relationship, maybe I have some deal with the health system where I am like on staff in some form or anyway, it just allows me to like get some of the economic value more at that 340B eligible infusions and dispensing that's happening in the health system. But maybe that would be like an obvious like kickback situation. And instead you'd have to strike some sort of joint venture?

Former SVP of Corporate Operations at Trellis Rx
Yes, I guess if the patient is coming into a qualified site location and the physician works at a nonqualified site location, but the patient is being seen at the qualified location for their infusion and the physician is creating an encounter, they're going to qualify that claim. So the patients being seen at their, what's that?

Tegus Client
So it's the segment where the infusion is happening.

Former SVP of Corporate Operations at Trellis Rx
If that's qualified, then they're probably qualifying it, yes. The other thing, I mean, the other thing I've seen is like a referral from an outside provider to the health system to say, hey, this patient needs to be started on REMICADE. And so as the provider from the outside program, say it's an affiliated provider, but not an actual like provider of the health system.

They send that into the, say, start this patient on REMICADE and it comes to the infusion center, which is a qualified area, what will likely happen is that someone at the qualified area will figure out what the dose needs to be based on the patient's weight, they'll put in the prescription. Therefore, that script now qualifies because the person at that site is eligible or it can qualify scripts. The patient comes into that site to get the infusion and now all of that has qualified.

Tegus Client
Makes sense. Well, thank you again for taking the time to speak with us today. This was very helpful. Enjoy the rest of your day.