9/11 HEALTH WATCH
c/o New York State AFL-CIO
100 South Swan Street, Albany, New York 12210
646-634-9103 • www.911healthwatch.org



Dr. Mandy Cohen, MD, MPH
Director
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329

April 11, 2024

Dear Dr. Cohen,

On behalf of the Board of Directors of *9/11 Health Watch, Inc.*, I am writing to you regarding the Center for Disease Control (CDC) Contract Office and their administration of contracts for the World Trade Center Health Program, this time regarding their administration for the program's Pharmacy Benefits Management (PBM) Contract.

As you know we have shared our concerns regarding the CDC contract office and their administration of the National Provider Network (NPN) in our letter for February 6, 2024, and our concerns regarding their administration of the WTC Health Program's Third-Party Administrator (TPA) contract in our letter of March 20, 2024. The CDC contract office regularly issues a solicitation for a PBM to provide pharmacy services to the World Trade Center Health Program. Initially this was awarded to Emdeon/Walgreens, then to Optum and now resides with Express Scripts.

Each time a new vendor has been selected the members of the WTC Health Program have had to suffer through difficult transitions from one PBM to the other that could have been avoided if the contract staff had taken some simple direction from the Clinicians at the program's centers of Excellence. (CCE)

Before each of these contract solicitations concerns have been raised with the Program.

Once a contract was awarded, clinical supervisors from the WTC Health Program Clinical Centers of Excellence (CCE) along with NIOSH WTC Health Program leadership have met with the PBM to explain past errors/concerns providing detailed suggestions for preventive/corrective actions. And yet the same or similar problems repeatedly occur despite assurances received that these issues are solvable and reforms will be in place by the time the new PBM is activated. With the most recent PBM transition from Optum to Express Scripts, the hope was that given Express Script's preeminent position in the PBM landscape, and the contract initiated longer PBM transition time periods, these promises would for the first time be fulfilled. Unfortunately, that was not the case.

Importantly, it should be noted that with rare exceptions, these problems (many of which are detailed below) are solvable. The proof that these issues are solvable is that with each PBM, problems initially occurring in year one of the contract are for the most part rectified by the mid- to end- of their contract period.
Given the repeated issues with now 3 different PBMs, we have every concern that the same issues will occur with the next solicitation for a PBM.

To improve this process, it is our hope that when the next contract solicitation and implementation occur, the following specific recommendations will be included:

1. Transition from one PBM to the Next PBM: At the conclusion of each PBM contract, the WTC Health Program has in the past awarded the contract to a new PBM. This transition is always fraught with errors. The PBMs always state that it is industry standard procedure to pass on the unexpired prescriptions and the approved pre-authorizations to the newly awarded PBM. However, with each of the PBM transitions (Emdeon/Walgreens -> Optum -> Express Scripts) there have been significant errors of omission. And many times, these omissions go unnoticed until the patient complains that their medication(s) have not been received.

2. Errors due to members being covered by more than one health insurance carrier (Medicare, Medicaid, private) in addition to the WTC Health Program. The pharmacist's computer system incorrectly associates the prescription issued under the WTC Health Program with a non-WTC Health Program health insurance carrier and this then causes (a) the member to be incorrectly charged a copay leading to either the member refusing the medication or the member accepting and the CCE having to spend time obtaining reimbursement; (b) the prescription denied due lack of a

preauthorization required by the non-WTC Health Program health insurance carrier that is not required by the WTC Health Program; or (c) the prescription denied outright. There are many people in the US that are covered by more than one healthcare plan with different coverage rules, so it is bizarre that this problem occurs a new with each transition.

3. Inaccurate expiration of prescriptions. Industry standard, confirmed by everyone of the PBMs, is that when a prescription is renewed by a provider, the expiration date should be updated to reflect the new prescription date. Instead, too often, the PBM system ignores the new updated date and rejects the medication based on an older now expired date.

4. Client Service Call Center is poorly trained. Service centers need to be held accountable for providing correct information to the patient or pharmacist. Too often the members are told that they do not belong to the WTC Health Program. This error makes no sense since typically the member has belonged to the WTC Health Program from its inception; has previously received medications through the prior PBM and sometimes even through the current PBM; and a complete electronic list is provided to the PBM and updated regularly. Another common error perpetuated by the client service center is that the member is told by the local pharmacist that their prescription is not covered or requires prior authorization. As stated above this error occurs because the member is covered by other health insurance (Medicare, Medicaid, private) in addition to the WTC Health Program. The pharmacist's computer system denies the prescription because it incorrectly associated the prescription with a non-WTC Health Program. The client service center should be able to solve this problem as it is not unique to just the WTC Health Program. But instead of solving this problem by directing the pharmacist to re-bill under the WTC Health Program, the client service center provides no answer or re-directs the question back to the CCE.

5. Managing the WTC Health Program formulary:

    a. The formulary should be proactively updated and not rely so heavily on CCEs to request specific medications to be added. There should be a system for adding new drugs once they are approved or including classes of medications (when appropriate) rather than adding one specific medication at a time. These requests often occur when a member's prescription is denied. This leads to delays in treatment until the medication is added to the formulary. The onus should be on

the PBM to proactively update the formulary while allowing CCEs to request additions for those unforeseen medications.

b. The formulary has certain medications that require pre-authorizations and then once approved, these prior authorizations must be resubmitted for reapproval on an annual basis. We agree that this is an important requirement for cost-and quality-controls. However, certain medications still require a prior authorization years after the medication has been on the market and for which pre-authorizations should no longer be required. An example is the numerous inhaler medications prescribed for patients with Obstructive Airways Diseases. The program should consider updating their decisions as to whether prior authorizations or annual renewals of prior authorizations are still required. Especially for annual renewals, this requirement often leads to delays in treatment until the preauthorization is submitted and/or approved.

6. Consulting with the CCEs on the Pharmacy formulary. Pharmacy formularies need to be updated regularly as new drugs come out, drug uses expand, brands become generics and costs change. Healthplans and hospitals have formulary committees for decisions as to whether a drug should or should not be covered. These committees typically have a pharmacist, a PBM representative and clinicians. For the WTC Health Program, CCE clinician input is intermittently asked for. There is no formal representation on the pharmacy committee. Only NIOSH (administrator and pharmacist) and the PBM are represented. This leads to lengthy delays and occasional inaccurate decisions in updating the formulary.

7. Need for the WTC Health Program Medication Formulary to be available to members and their prescribing clinicians. The prescription medication formulary covered by the WTC Health Program is not publicly available preventing members and their clinicians from seeing for themselves if coverage extends to specific medication(s). This list should be available and regularly updated by the PBM or the WTC Health Program.

8. Performance Statistics. Any future contract should require the periodic public release of contract performance statistics. The current contracts drafted by the contract office preclude the public release of contract performance statistics by vendors, hiding the details of their performance or nonperformance from the public and we are told by your contract office that this is to protect the contractor and is meant to ensure "fairness" to the

contractor, but no mention of the impact to WTC Health Program members by this lack of transparency.

9. Termination Provision. First and foremost, as with the Sedgwick's contract for the NPN, we would expect that any future PBM contract provides that the contract can not only be terminated for nonperformance but that the vendor would be required to continue to perform until another vendor is obtained. As with the NPN contract, any PBM contract should have a provision that if an option to terminate is exercised, the contractor must continue to provide services until another contractor takes over.

10. Financial Penalties. Any future contract needs the means to enforce the contract short of full termination. It is our understanding that contracts issued by the Veterans Administration contain financial disincentives and incentives whereby failure to adequately perform the contract results in penalties, and conversely better-than-minimum performance merits rewards. These penalties need to be significant enough that they would impact any future PBM vendor who is not meeting contract performance requirements. Currently the CDC has few, if any tools, to hold a company accountable. This must change.

These are just some of the many issues that should be addressed in any future contract. For the next PBM contract, we are hopeful that the above issues and solutions will be strongly considered.

Because with each of the PBM transitions, these errors occur and for the most part are solved by the mid to end of the contract, we strongly recommend that the PBM contract be for longer than 3-5 years, preferably 10 years, to reduce the number of transitions that occur during the lifetime of the WTC Health Program.

We would appreciate a reply from your office and/or the CDC Contracting Office in charge of oversight and the development of the RFP for the next PBM contract.

Thank you for your attention to this matter.

Sincerely,

Benjamin Chevat
Executive Director