Nos. 21-1326, 22-111

IN THE

Supreme Court of the United States

UNITED STATES OF AMERICA, ET AL.,
EX REL. TRACY SCHUTTE & MICHAEL YARBERRY,
PETITIONERS

v.

SUPERVALU, INC., ET AL., RESPONDENTS

UNITED STATES, EX REL. THOMAS PROCTOR, PETITIONER

v.

SAFEWAY, INC., RESPONDENT

On Writs of Certiorari
to the United States Court of Appeals
for the Seventh Circuit

JOINT APPENDIX

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[District Court's Opinion dated Aug. 5, 2019, Schutte Doc. 301]

IN THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF ILLINOIS SPRINGFIELD DIVISION

UNITED STATES OF AMERICA, and THE STATES OF CALIFORNIA, DELAWARE, ILLINOIS, INDIANA, MASSACHUSETTS, MINNESOTA, MONTANA, NEVADA, NEW JERSEY, NORTH CAROLINA, RHODE ISLAND, VIRGINIA, *ex rel.* TRACY SCHUTTE and MICHAEL YARBERRY,

Plaintiffs and Relators,

v.

SUPERVALU, INC., SUPERVALU HOLDINGS, INC., FF ACQUISITIONS, LLC, FOODARAMA, LLC, SHOPPERS FOOD WAREHOUSE CORP., SUPERVALU PHARMACIES, INC., ALBERTSON'S LLC, JEWEL OSCO SOUTHWEST LLC, NEW ALBERTSON'S INC., AMERICAN DRUG STORES, LLC, ACME MARKETS, INC., SHAW'S SUPERMARKET, INC., STAR MARKET COMPANY. INC., JEWEL FOOD STORES, INC., and AB ACQUISITION LLC,

Defendants.

NO. 11-3290

OPINION

RICHARD MILLS, U.S. District Judge:

This is a False Claims Act case, wherein the Relators allege that Defendant pharmacies submitted false or fraudulent claims to obtain federal funds from Government Healthcare Programs (GHP) to which they were not entitled. The Relators allege this occurred through the electronic submission of inflated usual and customary charges to GHPs because Defendants failed to report their cash price matches as their usual and customary price.

Pending is the Relators' motion for partial summary judgment. The Parties dispute the effect of the Seventh Circuit's decision in *United States ex rel. Garbe v. Kmart,* 824 F.3d 632 (7th Cir. 2016) on this case.

I. BACKGROUND

(A)

The Relators allege the price-match program for Defendants SuperValu and Albertsons began in the fall of 2006. The Defendants claim advertising of the price- match program occurred at certain times between 2006 and 2012 but Defendants have had a price match policy in place since the 1980s. A price-match program "override" occurred when pharmacy personnel replaced Defendants' then-current, reported cash "retail" price with a lower competitor price. Albertsons discontinued the price-match program in October 2013. SuperValu discontinued the price-match program in December 2016.

The Defendants offered a price match policy and a price match guarantee. The Defendants state the Court must decide how the legal definitions of "offer" and "general public" apply to the facts of this case.

All of the Defendants' banners (i.e. Cub Pharmacy, Osco Drug, etc.) advertised price matching in all states where those banners operated at various times between October 2006 and June 2012. The Defendants' advertisements publicized Defendants' practice of matching competitor prices on prescription drugs and generally included disclaimers. Defendants' price match advertisements were disseminated to the public through various means, such as in-store and pharmacy signage, fliers, circulars, in-store audio announcements, mailers, newspapers of general circulation, on the back of store receipts and Defendants' web pages. The price-match program advertisements described an offering about Defendants' price match policy.

The Relators allege the price-match program was available to anyone who would request that Defendants match a competitor's price. The Defendants say certain other requirements had to be met before receiving a competitor's lower price, including the fact that the lower price had to be available at a local pharmacy and could be verified by pharmacy staff. No fee was required of customers to participate in the price match program.

Not all price matches were the same. On a single day for the same drug, Defendants' pharmacies could match different prices charged by Rite Aid, Walmart, CVS and any other competitor, or no competitor at all. Price match transactions were not the majority of Defendants' cash transactions and only a nominal percentage-about 2%--of all Defendants' transactions overall.

Unlike Walmart and some other competitors, the

Defendants did not have an official discount drug formulary. Defendants have produced price matching advertisements and competitor drug formularies its employees collected in March 2012 from approximately 222 of Defendants' stores that can be individually identified. However, the Defendants claim they cannot determine from Relators' exhibit whether it is an accurate portrayal of all of these produced documents. Of the 222 stores, 201 self-reported and produced competitor's discount drug formularies kept in the pharmacies at those stores, including 192 stores that kept Wal-Mart's discount drug formulary in the pharmacy; Defendants' stores "most commonly would have a Wal-Mart list or-because it's very accessible off the internet, so they would have it . . . they would print them off and have them instead of having to keep going to the internet." The Defendants claim that, in addition to problems with accuracy, the Relators' information is immaterial and taken out of context because Defendants operate over 1,000 pharmacies, while the Relators' exhibit only gives information for 222.

The Defendants' price overrides grew from 8.75% of cash sales of all drugs (including drugs that were not available from the competitors at a lower cash prize) in 2007 to 39.36% of cash sales of all drugs in 2011. The Defendants allege this is immaterial because growth in number of price overrides does not go to (1) falsity, (2) knowledge or (3) materiality as to claims submitted by Defendants. Moreover, the percentages are taken out of context with respect to how many total cash transactions occurred.

The Defendants identified specific competitor price matches for 88.31% of all price overrides. Defendants identified 56.94% of all price overrides as

Walmart price matches. The Defendants claim this is immaterial because the percentage of price overrides identified as being matched to a specific competitor or Walmart in particular does not go to (1) falsity, (2) knowledge or (3) materiality as to claims submitted by Defendants. Moreover, the ratio of price matches to the total cash sales show that only about 15% of cash sales were matched to Walmart's prices.

Price match overrides occurred as frequently as 18,000 times per week. The Defendants say that, across the roughly 1,000 pharmacies that Defendants operated, this number equates to merely 17 or 18 price overrides per week-or about 2.57 price overrides per day for all drugs dispensed to customers. Moreover, the overall number of cash sales in 2011 and 2012 total 6,141,978, which constitutes an average of 59,057 per week across the two-year period. Although up to 18,000 individuals may have sought and received a price match during this time, over 41,000 customers paid the regular cash prices.

The Defendants did not submit lower matched price cash sales transactions to third-party payors, including GHPs. The Defendants would not allow lower matched prices to be submitted to third party insurance even if a customer specifically asked Defendants to process a price match transaction through the customer's insurance. The Defendants claim doing so would have violated their contracts with these payors. The customer's preference does not control. The contract does.

(B)

In October 2006, soon after Walmart announced its discount generics program, the Defendants estimated that adopting a similar discount generics program would result in tens of millions of lost profits, 90% of which "would go to PBMs, Managed Care and other payors due to co-pay and U&C contract language." The Defendants claim this was a business decision so they would not lose money.

On December 27, 2017, SuperValu Executive Ron Richmond (Director of Managed Healthcare Contracting) sent an email to SuperValu Executives Pamela Caselius (Marketing Director), Maxine Johnson (Vice President, Managed Care Operations) and Dan Salemi, writing in part:

> As for price matching on the various competitors generic programs, I believe that we have always taken a "stealthy" approach. We consider this to be something that we do as an "exception" for customer service reasons. Once we deviate to a process that is more "rule" or routine, we begin to affect the integrity of our U&C price - a slippery slope, as true U&C price is a claim submission requirement for all Medicaid and private commercial Managed Care and PBM agreements. The financial implication of this is very broad, Please communicate with Max and Dan for a broader discussion on Generic Price matching and/or promotional activities.

Doc. 164, Ex. H. The Defendants promoted price matching in part to "combat" discount generic drug programs offered by Walmart and other competitors.

The Defendants' price matching program was designed to retain existing customers and to attract new customers.

In October 2008, Defendants' ARx pharmacy application was enhanced with an ongoing price match override feature. The "Ongoing Price Override" 1) processed subsequent fills of the same prescription at the overridden price automatically; 2) maintained a record of the competitor pharmacy whose price had been matched; and 3) automatically logged notes to the prescription on which the override had been performed. The Defendants note that the pharmacist was still required to validate the competitor's price at the time of each refill. The Relators dispute that Defendants' pharmacists validated competitor prices on automatic refills. Testimony in this matter reveals that patients were not required to ask for a price match, and that refills were done automatically.

SuperValu Prescription Pricing Policy (September 2009) stated that "[t]he company will not lose a prescription because of price," and required SuperValu employees responding to price quotes to "Mention service, convenience and price match guarantee." The Defendants state this did not change their longstanding approach to price matching. Customers were still required to take an affirmative action, quote a local competitor and price, and have the pharmacy staff verify the competitor's price before providing the customer with a price match. The Relators dispute that customers had to initiate the price match transaction. They claim that was not a written requirement prior to the August 2012 revisions to the written Prescription Pricing Policy and, after implementation of the October 2008 ARx automatic refill enhancement, the patients

no longer even nominally had to "ask for a price match."

SuperValu's August 2012 Prescription Pricing Policy added the words "[i]f a customer requests that we match the price . . ." to SuperValu's "Prescription Price Match Program" and removed the requirement from the September 2009 Prescription Pricing Policy to "Mention . . . price match guarantee."

Individual pharmacies could not change the usual and customary price reported to third parties, including GHPs. The usual and customary price reported to third parties, including GHPs, "was set by Defendants' corporate pricing department." The Defendants state the usual and customary prices were controlled by applicable third-party contracts or state law.

The Defendants did not acknowledge or consider discount price match program cash prices when setting the usual and customary prices they reported to third parties. The Defendants claim that, if appropriate under an applicable contract or State Plan to include price-matched prices when reporting their usual and customary prices, however, Defendants performed back-end reconciliation. The Relators dispute that Defendants performed back-end reconciliation to include price- matched prices when reporting their usual and customary prices. The Defendants' supporting materials only address Massachusetts. The Relators also dispute the Defendants' inference that they voluntarily began reimbursing Massachusetts for overcharges. Defendants made no efforts to comply with the 2009 revisions to Massachusetts law until Defendants became aware in January 2012 that their price matching program was under investigation and a subpoena was

issued for documents related to its price matching program.

The "PBM Industry Definition of U&C Price" is "generally understood to be the cash price charged to the general public."

The Defendants allege the primary Pharmacy Benefit Managers that processed more than 92% of Defendants' total prescription records and more than 94% of their total amount paid for those prescription records did not consider Defendants' individualized price matching to have altered the usual and customary prices they submitted. Moreover, the Defendants were not required to submit lower price-match amounts as their usual and customary prices, at least for some part of the relevant time period, regardless of the Defendants' advertisements indicating their willingness to price match. The Relators dispute that Defendants were not required to submit lower price-match amounts as their usual and customary prices. Pharmacy reimbursement is governed by statutory and regulatory requirements. Contracts between Defendants and Pharmacy Benefit Managers must be construed consistent with those statutes and regulations.

The Defendants allege the enforceable regulatory Medicaid State Plans in effect in California, Illinois, Utah and Washington during the relevant time period did not capture individualized price matching as part of any definition of "usual and customary." The Relators dispute the assertion and note that Defendants were required to comply with the federal Medicaid reimbursement regulation, 42 C.F.R. § 447.512, which has governed the state Medicaid programs, usual and

customary regulations and defined usual and customary price as "charges to the general public." Moreover, whether price matching is "individualized" is immaterial to compliance with Medicaid regulatory requirements.

The Defendants allege the Pharmacy Benefit Managers and the state Medicaid programs were well aware of these types of discount programs. The Department of Justice and relevant states investigated the allegations in Relators' amended complaint for more than three years before declining to intervene. Moreover, the Pharmacy Benefit Managers and the state Medicaid programs at issue extensively audited Defendants' prescription claims. The Relators dispute that Pharmacy Benefit Managers and state Medicaid programs were "well aware" of Defendants' price match program. They allege that Defendants did not provide Pharmacy Benefit Managers and state Medicaid programs with candid and complete disclosure of the scope and operation of their price match program.

The Defendants claim customers would sometimes quote local competitor prices that were unverifiable. In those situations, the Defendants declined to sell the drug at the customer's quoted price and would deny the customer's request for a price match. The Relators dispute that Defendants denied price matches in any meaningful way when local competitor prices were not verifiable. Denial of price matches is inconsistent with Defendants' Prescription Pricing Policy (September 2009) which stated that "[t]he company will not lose a prescription because of price."

II. DISCUSSION

The Relators allege the Defendants' price match program was offered to the general public. Those discounted matched prices were not one time lower cash prices. Because California, Illinois, Washington and Utah regulations do not provide otherwise, the "usual and customary" price for Medicaid in those States is defined as the "cash price offered to the general public." Relying on *Garbe,* the Relators contend the Defendants' lower matched prices, offered to the general public and widely and consistently available, are the usual and customary prices for their drugs and, further, Medicare Part D and Medicaid were entitled to those actual usual and customary prices.

The Defendants claim that *Garbe* has a limited impact on this case, as its facts differ significantly from the facts of this case. They point to a district court case from California, *Corcoran v. CVS,* No. 15-cv-03504, 2017 WL 3873709 (N.D. Cal. Sept. 5, 2017), as being more analogous to this case. However, the Ninth Circuit has since reversed the district court's grant of summary judgment and other rulings and remanded the case for further proceedings. *See Corcoran v. CVS Health Corporation,* _ F. App'x _, 2019 WL 2454529, at *3 (9th Cir. June 12, 2019). The Defendants further allege that Relators have failed to show the submission of any false claims.

Moreover, *Garbe* does not affect the required element of "knowledge" that Relators need to prove in order to prevail. *Garbe* also does not affect the required element of "materiality" that Relators must prove in order to prevail in this case.

A.Legal standard

Summary judgment is appropriate if the motion is properly supported and "there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." *See* Fed. R. Civ. P. 56(a). The Court construes all inferences in favor of the non-movant. *See Siliven v. Indiana Dept. of Child Services*, 635 F.3d 921, 925 (7th Cir. 2011). To create a genuine factual dispute, however, any such inference must be based on something more than "speculation or conjecture." *See Harper v. C.R. England, Inc*., 687 F.3d 297, 306 (7th Cir. 2012) (citation omitted). Because summary judgment "is the put up or shut up moment in a lawsuit," a "hunch" about the opposing party's motives is not enough to withstand a properly supported motion. *See Springer v. Durflinger*, 518 F.3d 479, 484 (7th Cir. 2008). Ultimately, there must be enough evidence in favor of the non-movant to permit a jury to return a verdict in its favor. *See id.*

B.*Garbe* decision

(1)

The Relators claim that Medicare Part D and Medicaid are entitled to usual and customary prices. In *Garbe,* the Seventh Circuit stated:

> Medicare, Medicaid, and their corresponding regulations mandate that state plans ensure that "payments for services be consistent with efficiency, economy, and quality of care." [42 C.F.R.] § 447.200 (citing 42 U.S.C. § 1396 a(a)(30)).

. . . .

> Taken together, "[t]he purpose of these regulations is clear: state agencies are not to pay more for prescribed drugs than the prevailing retail market price." *United States v. Bruno's, Inc.,* 54 F. Supp.2d 1252, 1257 (M.D. Ala. 1999) (interpreting 42 C.F.R. § 447.512(b), then numbered 42 C.F.R. § 447.33l(b)). Regulations related to "usual and customary" price should be read to ensure that where the pharmacy regularly offers a price to its cash purchasers of a particular drug, Medicare Part D receives the benefit of that deal. See generally *Arkansas Pharmacists Ass 'n v. Harris,* 627 F.2d 867, 869 n.4 (8th Cir. 1980).

Garbe, 824 F.3d at 644.

In *Garbe,* Kmart introduced a policy of "setting low 'discount' prices for cash customers who signed up for one of its programs, while charging higher 'usual and customary' prices to non-program cash customers, 'to drive as much profit as possible out of [third-party] programs.'" *Id.* at 636.

Kmart contended that the term "general public," as found in the definition of "usual and customary" pricing, excludes individuals participating in its "discount programs." *Id.* at 643. Members of its discount programs "belong to a particular group" representing a subset of its customer base and thus were not members of the general public. *See id.*

The Seventh Circuit rejected Kmart's argument. "Saying that someone is a member of a 'particular' organization ... does not make it so. We are given no reason to think that there was any meaningful selectivity for the people who joined Kmart's programs, and thus

that they could be distinguished in any way from the 'general public.'" *Id.* The Seventh Circuit explained that "barriers to joining the Kmart 'programs' were almost nonexistent" and that"[c]ash customers walking into Kmart do not cease to be members of the general public the minute they are offered-or pushed into-'membership' in Kmart's discount program.'" *Id.* The court stated its interpretation of "general public" is "consistent with the regulatory structure that gave rise to the 'usual and customary' price term." *Id.* at 644.

The court in *Garbe* noted an auditor's testimony that, "under industry practice and the terms of over 1,000 contracts between Kmart and Medicare Part D Benefit Managers and Plan Sponsors, Kmart should have based its reimbursement requests to the insurance companies handling Medicare Part D on its 'discount program' prices." *Id.* at 636-37. The court further stated:

> The [usual and customary price] term is included in state regulations, plans and contracts related to Medicare Part D because the Medicare and Medicaid regulations demand that it be. *Id.* [42 C.F.R.] § 447.512(b). Its meaning in many state regulations, plans, and contracts is lifted from the federal regulations without significant modification.

Id. at 644. "Unless state regulations provide otherwise, the 'usual and customary' price is defined as the 'cash price offered to the general public.'" *Id.* at 643.

"The CMS Manual has long noted that 'where a pharmacy offers a lower price to its customers throughout a benefit year' the lower price is considered

the 'usual and customary' price rather than 'a one-time 'lower cash' price,' even where the cash purchaser uses a discount card." *Id.* at 644 (quoting CENTERS FOR MEDICARE & MEDICAID SERVS., *Chapter 14-Coordination of Benefits, in* MEDICARE PRESCRIPTION DRUG BENEFIT MANUAL 19 n. 1 (2006), https://perma.cc/MW6A-H4P6). If a pharmacy "offered the terms of its 'discount programs' to the general public and made them the lowest prices for which its drugs were widely and consistently available," those "discount" prices are the pharmacy's "usual and customary" charges for the drugs. *Id.* at 645. Medicare Part D and Medicaid are entitled to those usual and customary prices. *See id.* at 644.

(2)

The Defendants acknowledge the Court cannot disregard applicable Seventh Circuit precedent, though they believe *Garbe* was wrongly decided for a number of reasons, including what they claim is the Seventh Circuit's failure to recognize (1) that the "non-interference" clause contained in 42 U.S.C. § 1395w-lll(i) (2003) prohibits CMS from imposing any requirements on the amounts that pharmacies can charge Pharmacy Benefit Managers or Part D sponsors; (2) that the same statutory provision bars CMS both from defining the term "usual and customary" for purposes of the Part D program and from both requiring pharmacies to charge usual and customary prices for covered prescriptions; and (3) that the regulations upon which the panel relied to fashion a "usual and customary" definition for the Medicare Part D program are, in fact, regulations governing entirely different government healthcare programs that have no applicability to Medicare Part D.

Garbe makes clear that Medicare Part D and Medicaid are entitled to the benefit of the usual and customary price regularly offered by a pharmacy to its cash customers. *See Garbe,* 824 F.3d at 644. The Defendants' actual usual and customary price can be determined by noting the discount lower cash prices that were offered to the general public and accepted over the years. As in *Garbe,* those were the "lowest prices for which [their] drugs were widely and consistently available."

Significantly, the Defendants' price match program was available to anyone who requested a price match. The Defendants' nationwide advertising publicized the program. Any individual could ask for a price match as long as the programs were available at the particular pharmacy. The pharmacy would them simply verify that the lower price was available at a local pharmacy. Although Kmart required its club members to opt-in to the club, provide basic personal information and pay a $10 fee, *see Garbe,* 824 F.3d at 643, the Defendants' price match program did not have similar barriers. Relying on *Garbe,* in denying the Defendants' motion to dismiss, this Court previously stated: "The offer to the general public determines the usual and customary price-not whether the offer was couched as a discount club or whether a majority of people accepted it." Doc. No. 65 (citing and quoting *Garbe,* 824 F.3d at 645). Accordingly, the Court concludes that Defendants' price match program was an offer to the general public that determined the Defendants' usual and customary price.

Additionally, the Defendants' discounted matched prices were not one time lower cash prices. The Defendants offered these prices throughout the benefit

year over the years, beginning in 2006. Albertsons offered its price match program through October 2013, while SuperValu's program continued through December 2016. Therefore, the lower price constitutes the usual and customary price during those years. *See Garbe,* 824 F.3d at 644.

The Seventh Circuit noted that the Federal Medicaid regulations applicable to all state Medicaid programs cap pharmacy reimbursement at the "[p]rovider's usual and customary charges to the general public." *Id.* "Unless state regulations provide otherwise, the 'usual and customary' price is defined as the 'cash price offered to the general public.'" *Id.* at 643.

(3)

Upon reviewing the Medicaid regulations for the states of California, Illinois Utah and Washington, the Court finds that those regulations do not otherwise provide a definition of "usual and customary." Therefore, the applicable definition of usual and customary price for Medicaid reimbursement in the four states is the "cash price offered to the general public." *Garbe,* 824 F.3d at 643. To the extent that Defendants contend it was understood in the industry or by the States that the regulatory Medicaid State Plans in effect in California, Illinois and Washington did not capture individualized price matching as part of any definition of usual and customary, the Court is not persuaded. In determining "usual and customary" price, it is what the state regulations say or do not say that is important. Because the Defendants offered their price match program to the general public and made those lower cash prices widely and consistently available,

the California, Illinois, Utah and Washington Medicaid programs should have received the benefit of those prices. *See id.* at 644-45.

The Court also is not persuaded that *Garbe* is limited to only legally enforceable "offers," and that advertisements about Defendants' willingness to price match local competitors' prices were not legal offers because they did not include set pricing terms. The court in *Garbe* did not discuss the elements of an offer. Its concern was meeting the purpose of the regulations-that state agencies not pay more for prescriptions than the prevailing retail market rate. *See Garbe,* 824 F.3d at 644.

The Defendants also claim that because their price match transactions did not approach a majority of their cash transactions, those prices could not constitute the usual and customary price. However, the Seventh Circuit did not say that the usual and customary price was the price charged to 50.1% of a pharmacy's customers. The key factor is that "Kmart offered the terms of its 'discount programs' to the general public and made them the lowest prices for which its drugs were widely and consistently available." *Garbe,* 824 F.3d at 645. Here, the price match program was available to all of the cash customers, as long as the lower price was verified.

Accordingly, the discount cash prices are the usual and customary prices. *See id.*

Because the Defendants offered their price match program to the general public and made those lower cash prices widely and consistently available, the California, Illinois, Utah and Washington Medicaid programs should have also received the benefit of that

deal.

The knowledge and materiality elements are not addressed in the Relators' motion.

Ergo, the Relators' first motion for partial summary judgment [d/e 164] is ALLOWED.

The Court finds that Defendants' lower matched prices, offered to the general public and widely and consistently available, are the usual and customary prices for their drugs.

The Court further finds that Medicare Part D and Medicaid were entitled to those actual usual and customary prices.

ENTER: August 5, 2019

FOR THE COURT:

/s/ Richard Mills

Richard Mills

United States District Judge

[Amended Stipulation filed May 2, 2018, Schutte Doc. 152]

IN THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF ILLINOIS SPRINGFIELD DIVISION

UNITED STATES OF AMERICA, and THE STATES OF CALIFORNIA, DELAWARE, ILLINOIS, INDIANA, MASSACHUSETTS, MINNESOTA, MONTANA, NEVADA, NEW JERSEY, NORTH CAROLINA, RHODE ISLAND, VIRGINIA, *ex rel.* TRACY SCHUTTE and MICHAEL YARBERRY,

Plaintiffs and Relators,

v.

SUPERVALU, INC., SUPERVALU HOLDINGS, INC., FF ACQUISITIONS, LLC, FOODARAMA, LLC, SHOPPERS FOOD WAREHOUSE CORP., SUPERVALU PHARMACIES, INC., ALBERTSON'S LLC, JEWEL OSCO SOUTHWEST LLC, NEW ALBERTSON'S INC., AMERICAN DRUG STORES, LLC, ACME MARKETS, INC., SHAW'S SUPERMARKET, INC., STAR MARKET COMPANY. INC., JEWEL FOOD STORES, INC., and AB ACQUISITION LLC,

Defendants.

No. 11-cv-3290

AMENDED[1] STIPULATION REGARDING 30(B)(6) DEPOSITION TOPICS

NOW COME the Parties in this matter who stipulate and agree that:

WHEREAS, Relators Michael Yarberry and Tracy Schutte ("Relators") served SUPERVALU INC., AB ACQUISITION LLC, Albertson's LLC, and all of their subsidiaries and affiliates named in Relators' First Amended Complaint (collectively, "Defendants") with a 30(b)(6) deposition notice on March 20, 2018;

WHEREAS, Relators' 30(b)(6) deposition notice listed eight topics and multiple subtopics; and

WHEREAS, in lieu of taking a 30(b)(6) deposition, the Parties have reached agreements as to the below topics;

NOW THEREFORE, in consideration of the foregoing premises and subject to the approval by the Court, the Parties enter into this binding stipulation ("Stipulation") and stipulate and agree that:

A. **Authentication Of Documents Produced By Defendants**

[1] The Parties submit this Amended Stipulation to address two clerical errors in Topic A(3), adding an "s" to the word "document" and replacing the word "unusual" with "usual". This Amended Stipulation corrects and replaces d/e 150.

1. Defendants stipulate as to the authenticity of the data Defendants produced from the ARx database from September 1, 2006 through December 31, 2016, which was produced in four installments in June and July of 2017.

2. Defendants stipulate to the authenticity of the contracts and contract related documents that Defendants produced and agree that such documents constitute Defendants' business records.

3. Defendants stipulate to the authenticity of the documents used as Plaintiffs' Deposition Exhibits as business records kept in the usual course of business, except for the following:

   a) documents provided to Relators with Defendants' November 2016 production (e.g. the subpoena duces tecum);

   b) deposition documents without bates stamps including LinkedIn profiles, webpages, printouts from CMS online manuals; and/or

   c) documents originating from third-parties, including competitor price lists.

4. Defendants stipulate that SVU00503020

is identical to Exhibit 127, was in Defendants' possession, and is authentic as a government record.

5. Defendants stipulate as to the authenticity of advertising materials associated with Defendants' banners that have been produced. Defendants stipulate that competitor price lists that have been produced were in Defendants' possession but do not stipulate that such documents are authentic or are subject to the business records exception of the hearsay rule.

B. **All Audits Of Usual And Customary Pricing By Third Party Payers And The Results Of Such Audits**

1. Defendants' stipulate that the audit summary Relators received on February 16, 2018 (SVU00546942 – SVU00546947) was generated by Defendants' Prescription Audit Tracking System ("PATS") and Trish Singh, Department Specialist II in SuperValu's Pharmacy Compliance, and Defendants' Third Party Audit department pulled the report from PATS system.

2. Defendants stipulate that, in general, when Third Party Payers (TPPs) audited Defendants' claims, neither the TPPs nor their audit partners would provide Defendants with information regarding the

areas, topics, or subject matters being audited.

C. **SAM Tasks And Medicare Part D Updates**

1. Defendants stipulate that Mr. Cross testified that Ken Dickson would have prepared the December 2006 Medicare Part D update to be used in 2007 (Deposition Ex. 119).

2. Defendants stipulate that Documents SVU00477198-SVU00477200 and SVU00546274-SVU00546275 are Microsoft Word documents that are standalone files in Defendants' database system; that is, they are not documents that were sent via email as attachments. Defendants have searched for similar versions of the documents and did not locate any similar versions that were attached to an email.

D. **Marketing Or Advertising Of Defendants' Price Match Programs:**

1. Defendants stipulate to designating the following testimony as that of the Corporation relating to the extent of Defendants' Marketing or Advertising of Defendants' Price Match Programs:

   a. Allgood, Marc (12/21/17):

1. Page 68, lines 12 – 18
2. Page 69, lines 2 – 16
3. Page 70, line 2 through Page 71, line 6
4. Page 71, lines 11 – 18

b. McCann, Steve (1/4/18):
1. Page 74, line 17 through Page 75, line 5
2. Page 75, lines 16-17
3. Page 76, lines 1 – 18

c. Tsipakis, James (12/15/17):
1. Page 61, line 16 through Page 62, line 18
2. Page 64, line 13 through Page 65, line 1
3. Page 65, line 6 through Page 66, line 18

2. Defendants stipulate as follows: All of Defendants' banners advertised price matching in all states where those banners operated at various times between October 2006 and June 2012. Defendants' advertisements publicized Defendants' practice of matching competitor prices on prescription drugs and generally included disclaimers. Defendants' price match advertisements were disseminated to the public through various means, such as in store and pharmacy signage, fliers, circulars, in-store audio announcements, mailers, newspapers of

general circulation, on the back of store receipts, and Defendants' web pages. Not all stores used all of these means, but all stores publicized Defendants' price match practice in some way.

As to the timing of some of this advertising, any reference to a "Price Match" advertisement listed in a quarterly "ad messaging calendar" (see e.g., Plaintiffs' Exhibit 295A), which were distributed by Defendants' corporate headquarters to the banners, means that a "Price Match" newspaper advertisement ran for the weeks listed across the banners referenced in the relevant cells within the calendar.

3. Defendants stipulate that advertising of the Price Match program ceased in June 2012 across all banners.

F. **Any Disciplinary Actions Taken Against Any Employee Of Defendants For Offering A Price Match To A Customer Without The Customer Initiating The Request For A Price Match, Including The Name Of The Employee, The Date(s) Of The Price Match An Of The Disciplinary Action, And The Action Taken Against The Employee.**

1. Defendants stipulate that, to the best of their knowledge, no disciplinary action(s)

were taken against any employee of Defendants for matching a prescription price for a customer without the customer initiating the price match process.

G. **Whether Defendants honored any customer request to submit a price match to any customer's Third Party Payer during from 2006 through 2016.**

1. Defendants stipulate to designating the following testimony as that of the Corporation relating to whether Defendants honored any customer request to submit a price match to any customer's Third Party Payer from 2006 through 2016:

   a. Cross, Matthew (1/25/18):
      1. Page 320, lines 11 through 15
      2. Page 320, line 24 through Page 321, line 5

APPROVED AS TO FORM:

/s/Timothy Keller

* * *

Lead Counsel for Relators

SO STIPULATED:

/s/Frederick Robinson (*w/permission*)

* * *

Lead Counsel for Defendants

[Excerpts of Expert Report of Ian M. Dew dated Feb. 2, 2018 (filed May 21, 2018), Schutte Doc. 164-15]

* * *

[Pages 3-5, part of Page 6, Pages 10-40, and part of Page 42 omitted]

* * *

IN THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF ILLINOIS SPRINGFIELD DIVISION

UNITED STATES OF AMERICA, and THE STATES OF CALIFORNIA, DELAWARE, ILLINOIS, INDIANA, MASSACHUSETTS, MINNESOTA, MONTANA, NEVADA, NEW JERSEY, NORTH CAROLINA, RHODE ISLAND, VIRGINIA, *ex rel.* TRACY SCHUTTE and MICHAEL YARBERRY,
Plaintiffs and Relators,

v.

SUPERVALU, INC., SUPERVALU HOLDINGS, INC., FF ACQUISITIONS, LLC, FOODARAMA, LLC, SHOPPERS FOOD WAREHOUSE CORP., SUPERVALU PHARMACIES, INC., ALBERTSON'S LLC, JEWEL OSCO SOUTHWEST LLC, NEW ALBERTSON'S INC., AMERICAN DRUG STORES, LLC, ACME MARKETS, INC., SHAW'S SUPERMARKET, INC., STAR MARKET COMPANY. INC., JEWEL FOOD STORES, INC., and AB ACQUISITION LLC,

Defendants.

NO. 11-3290

I. Executive Summary

I was retained by the relators, Tracy Schutte and Michael Yarberry (Relators), through Aschemann Keller, LLC to provide opinions regarding claims submitted by SuperValu, *et al.* (Defendants) to Government Health Plans (GHPs) and reimbursements paid for such claims between September 1, 2006 through December 31, 2016[1]. Specifically, I was asked to identify Actual Usual and Customary Prices (AUACs)[2] appearing in the Defendants' discounted cash sales, re-adjudicate GHP claims submitted by defendants using these AUACs, identify claims with overpayments relative to the AUACs, and calculate aggregate overpayments for such claims.

In brief, I found that between September 1, 2006 and December 31, 2016, Defendants submitted 42,534,663 claims to GHPs. Defendants were paid $169,665,301 more based on 22,910,154 of these claims with the U&Cs that Defendants submitted on them (Reported U&Cs) than they would have if the Defendants had submitted claims with AUACs instead. These higher reimbursements are termed overpayments in this report. In other words, overpayments were identified on 22,910,154 of total claims submitted to GHPs. In addition, of the 42,534,663 claims that Defendants' submitted to GHPs, 39,184,779 of these list Reported U&Cs that were higher than AUACs and could have reasonably listed AUACs instead of the Re-

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[1] Through 12/31/2016 for New Albertson's, Inc. claims and through 11/9/2016 for SuperValu, Inc. claims.

[2] I was directed by counsel to use the term "Actual" in this context. I am not expressing any opinion by using it.

ported U&Cs. In other words, the Defendants' Reported U&Cs were higher than AUACs on 39,184,779 of claims submitted to GHPs. A summary of claims and results by GHP is in the table, below.

Table 1. Summary of Claims and Overpayments by GHP.

GHP	Number of Claims	Number of Overpaid Claims	Amount of Overpayment
Federal Employee Programs	1,249,047	562,125	$5,830,109
Medicaid	9,073,158	4,445,792	$34,082,810
Medicare Part D	30,141,893	17,326,453	$124,297,115
TriCare	2,012,083	563,194	$5,332,601
Department of Veterans Affairs	58,482	12,590	$122,666
Totals	42,534,663	22,910,154	$169,665,301

* * *

III. Data

* * *

To give a sense of the volume of claims over time, the table below lists the number of sales, claims, and discounted sales per year in the Defendants' data.

Table 4. Summary of Sales and Claims per Year.

Year	Sales	Claims	Cash Sales	Cash Sales with Price Override
2006	882,381	942,150	61,538	3,813
2007	25,271,285	27,687,645	1,623,962	142,154
2008	44,027,272	48,282,809	3,070,495	505,595
2009	42,684,942	47,915,590	3,300,096	983,886
2010	39,916,422	45,749,159	3,242,412	1,219,348
2011	39,139,129	45,018,958	3,180,202	1,251,883
2012	39,831,598	45,169,491	2,961,776	1,083,389
2013	37,645,186	42,625,397	2,388,881	748,347
2014	37,303,825	42,262,398	1,544,788	162,289
2015	35,628,870	40,456,492	1,347,323	132,162
2016	28,889,969	32,998,537	1,010,373	77,309
Totals	371,220,879	419,108,626	23,731,846	6,310,175

Data was produced for 24 states, with widely varying volumes of sales and claims between different states. The table below lists the number of sales, claims, and discounted sales per state in the Defendants' data.

Table 5. Summary of Sales and Claims per State.

State	Sales	Claims	Cash Sales	Cash Sales with Price Override
CA	55,505,267	60,509,969	2,972,509	581,748
DE	2,573,359	2,894,363	144,185	28,016
IA	715,539	829,357	46,678	20,760
ID	17,484,107	19,426,485	1,249,317	478,353
IL	120,527,934	137,548,117	7,359,867	1,569,124
IN	2,650,573	2,950,015	167,382	43,019
MA	7,727,905	8,947,527	425,048	145,730
MD	4,501,805	5,068,115	326,302	67,742
ME	4,693,959	5,740,372	302,865	140,212
MN	27,992,984	31,142,344	1,520,870	362,690
MO	9,734,714	11,649,974	904,847	457,229
MT	12,903,713	14,068,224	1,267,958	274,708
NC	450,150	525,584	32,436	8,809
NH	3,795,441	4,154,626	335,304	190,970
NJ	12,363,147	14,854,601	593,624	133,989
NV	9,306,075	10,611,229	560,117	120,453
OR	14,640,595	15,849,146	1,143,493	357,272
PA	12,520,317	14,603,734	712,023	162,403
RI	247,202	296,986	14,717	4,686
UT	6,008,999	6,443,371	572,434	226,555
VA	18,406,581	21,712,016	1,183,599	389,711
VT	1,227,544	1,347,898	70,590	16,562
WA	19,958,281	22,110,061	1,274,788	446,376
WY	5,284,688	5,824,512	550,893	83,058
Totals	371,220,879	419,108,626	23,731,846	6,310,175

As the tables above show, across all drugs in the Defendants' data, 6,310,175 of the 23,731,846 cash sales (26.6%) have a price override associated with them. Focusing on just the top 20 drugs in the Defendants' data, identified in terms of the magnitude of calculated overpayments associated with them, the proportion of cash sales with price overrides to all cash sales for these drugs is 48.3% (662,079 of 1,370,923). The tables below list the number of sales, claims, and discounted sales for the top 20 drugs per year and per state in the Defendants' data.

Table 6. Summary of Sales and Claims of Top 20 Overpaid Drugs per Year.

Year	Sales	Claims	Cash Sales	Cash Sales with Price Override
2006	60,884	66,678	2,233	66
2007	2,053,613	2,296,970	63,036	5,526
2008	4,038,869	4,483,049	136,361	40,213
2009	4,429,743	5,031,899	195,497	97,592
2010	4,301,451	4,972,838	222,199	132,916
2011	4,266,043	4,932,744	228,150	140,507
2012	4,229,861	4,776,972	202,202	121,382
2013	3,877,124	4,356,449	149,481	83,499
2014	3,778,656	4,238,837	67,513	18,130
2015	3,613,541	4,065,846	60,828	14,503
2016	2,962,466	3,348,998	43,423	7,745
Totals	37,612,251	42,571,280	1,370,923	662,079

* * *

V. Results and Conclusions

As stated above, I found that between September 1, 2006 and December 31, 2016, GHPs paid $169,665,301 more based on 22,910,154 claims submitted to them with the Defendants' Reported U&Cs

than they would have if the Defendants had submitted claims with AUACs. Of the $169,665,301, $154,238,013 is attributable to the federal government, and $15,427,288 is attributable to state governments for their Medicaid programs based on the application of FMAPs. In addition, the Defendants' submitted 39,184,779 claims to GHPs listing Reported U&Cs that were higher than AUACs and could have listed AUACs instead of Reported U&Cs. Summaries of claims and results by GHP and by year are in the tables, below. Note that Table 16 is the same as Table 1.

Table 16. Summary of Claims and Overpayments by GHP.

GHP	Number of Claims	Number of Overpaid Claims	Amount of Overpayment
Federal Employee Programs	1,249,047	562,125	$5,830,109
Medicaid	9,073,158	4,445,792	$34,082,810
Medicare Part D	30,141,893	17,326,453	$124,297,115
TriCare	2,012,083	563,194	$5,332,601
Department of Veterans Affairs	58,482	12,590	$122,666
Totals	42,534,663	22,910,154	$169,665,301

Table 17. Summary of GHP Claims and Overpayments by Year.

Year	Number of Claims	Number of Overpaid Claims	Amount of Overpayment
2006	9,498	5,694	$41,393
2007	1,648,632	950,853	$7,257,834
2008	3,805,600	2,331,288	$20,574,302
2009	4,621,720	2,811,445	$20,362,819
2010	4,944,571	2,866,310	$21,360,548
2011	5,275,740	2,819,625	$20,279,518
2012	7,780,978	3,939,745	$28,740,651
2013	6,870,115	3,541,012	$27,332,610
2014	3,011,822	1,617,284	$10,338,747
2015	2,822,218	1,285,027	$8,605,604
2016	1,743,769	741,871	$4,771,273
Totals	42,534,663	22,910,154	$169,665,301

* * * *

I am confident that the results and opinions in this report are accurate to a reasonable degree of certainty. If additional relevant information is provided to me, subject to the Court's permission, I reserve the right to supplement or revise this report, as necessary, to reflect the impact of such information. The approach I have taken in implementing my analyses would allow me to recalculate overpayments using different discount percentages or other criteria if so specified by counsel or the Court.

I declare, under penalty of perjury, that the foregoing is true and correct to the best of my knowledge and ability.

Respectfully submitted,

Ian M. Dew
Steck Consulting, LLC

2/1/2018
Date

[Excerpts of Utah Department of Health Medicaid Information Bulletin dated Oct. 2008 (filed May 21, 2018), Schutte Doc. 164-22]

Utah Department of Health

Medicaid Information Bulletin

October 2008

* * *

[Pages 1–16 and part of Page 17 OMITTED]

* * *

08 - 93 $4 Low-cost Generic Programs

$4.00 prescriptions offered by pharmacies with low-cost generic programs are being considered as usual and customary by Utah Medicaid. Pharmacies offering these discounts must transmit the $4.00 as the U&C. Medicaid will recoup reimbursement amounts above the $4.00 upon audit.

[Addendum A to Appellants' Brief filed Sept. 30, 2020 in *Schutte*, No. 20-2241]

* * *

ADDENDUM A

Summary of U&C Definitions in PBM Contracts

PBM	U&C Definition Excerpts
Argus SVU '01- ABS '01-'12	Retail price "charged to the public . . . including any special promotions or discounts available to the public . . . ." (Doc. 174-82, Exh. 81 Part 1, at 20, SVU00513139)
Argus ABS '12-	Lowest retail price the "[p]harmacy would charge to a cash paying customer . . . including any special promotions or discounts available to the public . . . " (Doc. 174-84, Exh. 82 Part 1, at 25, SVU00505782).
Express Scripts ABS '06-'09	"retail price of a Covered Medication in a cash transaction . . . including any discounts or special promotions offered on such date." (Doc. 174-35, Exh. 56, at 24 SVU00505016).
Express Scripts SVU '09- ABS '09-	"amount charged in a cash transaction . . . shall not include an individual pharmacist's or Pharmacy's discretionary offers, but only those offers that involve system-wide Usual and Customary Retail Price changes . . . . In addition, . . . shall include any '$4 generic' or similar programs offered on a corporate-wide, routine basis, but shall exclude; a Pharmacy's competitor's matched price discounts (Price Match) . . . ." (Doc. 174-26, Exh. 53 Part 1, at 4, SVU00526015, Doc. 174-29, Exh. 54, at 4 SVU00597404, Doc.30, Exh. 55 Part 1, at 4, SVU00506564)
Medco fka PAID Prescriptions ABS '95-'07	price Pharmacy "would have charged . . . for the prescription if that cardholder was a cash customer" and "includes all applicable discounts including . . . special customer discounts or other discounts intended to attract customers." (Doc. 174-49, Exh. 61 Part 1, at 10, SVU00546972)
Medco fka PAID Prescriptions ABS & SVU '07-'08	[Pharmacy Service manual incorporated by contract (Doc. 174, #49-Exh. 61 Part 1, at 2, SVU00546964)] "[t]he lowest net price a cash patient would have paid . . . inclusive of all applicable discounts. These discounts include . . . competitor's matched price, and other discounts offered customers . . . ." (Doc. 174-54, Exh. 62 Part 1, at 79, SVU00486985-Manual).
Medco fka PAID Prescriptions ABS & SVU '09-'11	"The lowest net cash price a cash patient or customer would have paid . . . inclusive of all applicable discounts." (Doc. 174-56, Exh. 63 Part 1, at 94 SVU00439002-Manual & Doc. 174-58, Exh-64 Part 1, at 104, SVU00487155-Manual).
MedImpact ABS & SVU '99-	[provider manual incorporated by contract (Doc. 174-76, Exh. 76, at 2, SVU00594462)] "lowest price Provider would charge to a cash paying customer . . . . This price must include any applicable discounts, promotions, or other offers to attract customers." (Doc. 174-77, Exh. 77, at 27, SVU00593940-Manual).

ADDENDUM A

Summary of U&C Definitions in PBM Contracts

PBM	U&C Definition Excerpts
OptumRx fka RxSolutions dba Prescription Solutions fka Pacific Care SVU '14-	"retail price that a cash paying customer would normally pay . . . does not include the contractual rate paid by customers who have a prescription benefit covered by an insurance plan, or those who have paid a membership fee to enroll in a provider loyalty program or utilize a consumer discount card administered by a third party." (Doc. 174-66, Exh. 69 Part 1, at 7, SVU00522502)
Prescription Solutions aka OptumRx fka RxSolutions dba Prescription Solutions fka Pacific Care SVU '01-'14	price that the Pharmacy would "have charged . . . if the Member was a cash customer. This includes all applicable discounts . . . ." (Doc. 174-63, Exh. 68 Part 1, at 13, SVU00512041).
SXC (cited as Catamaran in Doc. 176-1, ¶83, at 28) ABS '04-'13 SVU '05-'13	"Pharmacy's cash price. . . . less any discount for which the specific patient would qualify by paying cash." (Doc. 174-72, Exh. 72, at 10, SVU00594602 & Doc. 174-73, Exh. 73, at 9, SVU00594581)
Prime Therapeutics ABS '06-	"lowest price Pharmacy would charge to a particular customer if such customer were paying cash . . . . This includes any applicable discounts including . . . special discounts offered to attract customers." (Doc. 174-78, Exh. 78 Part 1, at 4, SVU00508399).
Prime Therapeutics SVU '08-	"the customary fee that the Pharmacy would charge the general public . . . ." (Doc. 174-80, Exh. 79, at 5, SVU00517286).

[Excerpts of Expert Report of James Kevin Gorospe, dated Mar. 9, 2018, (filed May 21, 2018), Schutte Doc. 172-11, Ex. 10]

[Pages 1-7, part of pages 8-9, pages 10-29, part of pages 30-31, and pages 32-35 OMITTED]

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS,
SPRINGFIELD DIVISION

Case No. 11-cv-03290

UNITED STATES ex rel. SCHUTTE, et al.

v.

SUPERVALU INC., et al.

EXPERT REPORT OF JAMES KEVIN GOROSPE
March 9, 2018

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* * *

DEFENDANTS' PRICE MATCH PROGRAM

Contrary to the assertions of relator's expert, Kenneth Schafermeyer, the evidence in this case clearly shows that the price matching program at issue was a long-standing policy and practice at Defendants' pharmacies going back to at least the 1980s.[8, 9, 10] Company records note that the practice

[8] Dony Dep., pp. 48, 49.

[9] Tsipakis Dep., pp. 49, 50.

[10] Richmond Dep., pp. 49, 50.

dates to at least March 1987, and was the subject of a number of policy statements and revisions throughout the period during which SuperValu and Albertsons were price matching.[11] I can also confirm, based on my own experience as a practicing pharmacist, that local competitor price matching was a time-honored practice in the retail pharmacy industry, whether advertised or not.

While the language used in the various SuperValu policy documents concerning price matching changed over time, the elements of the practice did not.[12] In each case, the patient had to initiate some discussion of price with a pharmacy employee.[13, 14, 15] The patient had to identify which local competitor he or she claimed had a lower price and a pharmacy employee had to verify that price.[16, 17] All three steps had to take place before a price could be matched. Essentially, to receive a price match, SuperValu and Albertsons required that a customer enter into an individualized contract with a pharmacy whereby the customer would negotiate an ad hoc price for a certain prescription drug based on evidence and confirmation

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[11] *See* SVU00487746-47; SUPERVALU Prescription Pricing policy, dated 8/22/12, reflecting five prior versions of the price matching policy, and practice dating back to March 1987.

[12] Notably, even though SUPERVALU elected to cease advertising its price match policy in June 2012, it confirmed that the policy itself remained unchanged. *See* SVU00481802-04; SVU00444174.

[13] Dimos Dep., p 164.

[14] Dony Dep., p. 52.

[15] Zook Dep., p 50.

[16] Dony Dep., p 217.

[17] Dimos Dep., p. 142, 143.

by the pharmacy that the drug was priced less elsewhere.

Dr. Schafermeyer claims a system enhancement in late 2008 changed the price matching policy by including refills or rewrites of prescriptions in the price match process. It did not. As the evidence clearly indicates, the enhancement simply automated the process of enforcing a patient's initial request for a price match when a price matched prescription was refilled; the verification of the local competitor price identified by the patient still had to be completed at each refill by the pharmacy.[18] Internal company documents also make clear that this enhancement was to be used in compliance with price matching policy; it was not a variance of or departure from that policy.[19]

In addition to ignoring record evidence that he finds inconsistent with his expressed opinions, Dr. Schafermeyer overlooks an important aspect of pharmacy practice that anyone with real world experience in the industry would think significant in analyzing a pharmacy organization. This concerns the audit process that retail pharmacies are exposed to in all aspects of their operations. The evidence in this case is that, during the 2006-2016 time period at issue, SuperValu and Albertsons were audited by third parties 12,433 times.[20] This works out to approximately 100 audits each month, throughout this period performed by both government and private payers.[21] Given the broad audit powers that payers enjoy over pharmacies, and the aggressive way in which pay-

[18] Allgood Dep., pp. 118-121.

[19] SVU00000426.

[20] SVU00546942-47.

[21] *Id.*

ments reviewed in audits are often "clawed back" by payers, the results of these audits are particularly noteworthy. Over the course of the ten years covered by the allegations in this case, the audits conducted of SuperValu and Albertsons showed a total amount recovered by payers of $1,308,407.35. Given the number of stores Defendant operated, this results in an average annual audit recovery by third party payers of less than $150 per store. All of this at a time when the organization was dispensing a million prescriptions each week.[22] In my opinion, this is data suggesting a highly compliant pharmacy organization.

* * *

Massachusetts

Until 2009, Massachusetts' State Plan defined "usual and customary" as "the lowest price that a pharmacy charges or accepts from any health insurer or PBM for the same quantity or a drug dispensed . . . on the same date of service."[126] From September 1, 2006 through August 1, 2009, Massachusetts' regulation defined "usual and customary" in the same manner.[127] Therefore, for the period prior to August 1, 2009, it is my opinion that Defendants were not required to report the price match price as its "usual and customary" charge to the Medicaid program, as a cash-paying customer who received a price match would not be considered a "health insurer or PBM" under the regulations or state plan.

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[22] Dimos Dep., p. 183.

[126] *See* Massachusetts State Plan Amendment #06-005, Attachment 4.19-B, p. 1b (eff. July 1, 2006) (Ex. 56).

[127] *See* 114.3 Mass Code Regs. 31.02 (2008).

Effective August 1, 2009, however, Massachusetts revised its regulation defining "usual and customary" as "[t]he lowest price that a provider charges or accepts from ***any payer*** for the same quantity of a drug on the same date of service, in Massachusetts, including but not limited to the shelf price, sale price, or advertised price for any drug[.]"[128] Upon revising its regulation, Massachusetts submitted SPA 09-010-B to CMS, effective August 1, 2009, which not only deleted the definition of "usual and customary" charge from Massachusetts' State Plan, it also deleted any mention of the "usual and customary" charge as a reimbursement metric for prescription drugs.[129] Even though Massachusetts has never sought to amend its state plan to include "cash paying customers" within the group of payers from which the "lowest price" would be determined, it has been generally understood within the pharmaceutical industry that the Massachusetts Medicaid agency has ***strictly enforced*** its MFN regulation with respect to U&C.

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[128] *See* 101 Mass Code Regs. 331.02 (Aug. 12, 2016), previously 114.3 Mass Code Regs. 31.02 (effective Aug. 1, 2009) (emphasis added); *see also* MassHealth Pharmacy Program "Pharmacy Facts," No. 52 (Jul. 1, 2009) (SVU00417955-56) (Ex. 57). In addition, during some portion of the relevant time period, Massachusetts' Pharmacy Online Processing System (POPS) Billing Guide provided that the "usual and customary" charge is the "pharmacy's price for the medication for a cash paying person on the day of dispensing." (Ex. 58).

[129] *See* Massachusetts State Plan Amendment #09-010-B, Attachment 4.19-B, p. 1e-1f (eff. Aug. 1, 2009) ("This payment methodology for prescribed drugs described in section 8.1 on pages 1e and 1f of Attachment 4.19-B of TN-09-010(B) supersedes the payment methodology for prescribed drugs as described in section 8.1 on page 1b of Attachment 4.19-B of TN 06-005.") (Ex. 59).

Knowing this fact and seeking to be in compliance with the state's MFN approach, I understand that, in 2012, Defendants completed a review of claims submitted to the Massachusetts Medicaid program on behalf of Shaw's Supermarkets, Inc., their Massachusetts store banner. Upon the completion of this review, Defendants reimbursed the Massachusetts Medicaid agency for any overpayments that they calculated had resulted from the company not reporting the price match price as the "lowest price" for purposes of U&C if the company "filled any Massachusetts Medicaid claims at the same store on the same day for the same drug at the same dispensed quantity at a lower price than that paid by Massachusetts Medicaid."[130] In that instance, the company calculated the price differential for "all drugs to Massachusetts Medicaid beneficiaries on that day as if they had received the lower price."[131] The company offered to reimburse the Massachusetts Medicaid program $2,855.03[132] for possible overcharges from 2005-2012.[133] Since that time, it is my understanding that the company has continued, each June, to supplement its automated systems price reporting with a manual MFN "true up" exercise for Massachusetts. In 2013, a total of $125 was identified

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[130] *See* Letter from D. Day to E. Long (June 7, 2012) (Ex. 60).

[131] *Id.*

[132] The company calculated $1,988.03 based on the same day, same drug, same store, same quantity approach for the time period August 12, 2007 through February 2012. The company offered an additional $867 to cover the time period 2005 through August 11, 2007. Data for a more specific analysis was unavailable for that period, as it was housed on a different database system, and the company was unable to use the same methodology to calculate the reimbursement amount for that period.

[133] *Id.*

as a possible overcharge, with no overcharges found during analyses completed in 2014, 2015, 2016 and 2017.

* * *

[Declaration of Trevor Douglass, dated Feb. 26, 2018, (filed May 21, 2018), Schutte Doc. 172-26, Ex. 105]

EXHIBIT 105

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS
SPRINGFIELD DIVISION

No. 11-cv-03290

THE UNITED STATES OF AMERICA, and THE STATES OF CALIFORNIA, DELAWARE, ILLINOIS, INDIANA, MASSACHUSETTS, MINNESOTA, MONTANA, NEVADA, NEW JERSEY, NORTH CAROLINA, RHODE ISLAND, and VIRGINIA *ex rel.* TRACY SCHUTTE and MICHAEL YARBERRY,

Plaintiffs,

v.

SUPERVALU INC., SUPERVALU HOLDINGS, INC., FF ACQUISITIONS, LLC, FOODARAMA, LLC, SHOPPERS FOOD WAREHOUSE CORP., SUPERVALU PHARMACIES, INC., ALBERTSON'S, LLC, JEWEL OSCO SOUTHWEST LLC, NEW ALBERTSON'S, INC., AMERICAN DRUG STORES, LLC, ACME MARKETS, INC., SHAW'S SUPERMARKET, INC., STAR MARKET COMPANY, INC., JEWEL FOOD STORES, INC., and AB ACQUISITION LLC,

Defendants.

Declaration of Trevor Douglass

I, Trevor Douglass, pursuant to 28 U.S.C. § 1746, hereby affirm that I am over 18 years of age and competent to make the following Declaration.

1. I am currently the Oregon Prescription Drug Program & Pharmacy Purchasing Director at the Oregon Health Authority ("OHA") where I have been employed for 7.5 years.

2. I have held the position of Oregon Prescription Drug Program & Pharmacy Purchasing Director since 2017. Before that, I held the following positions at OHA: Operations and Policy Analyst 3 providing program management for the Durable Medical Equipment Prosthetics, Orthotics & Supplies program, Medical Surgical Services program, Pharmaceutical Services program (2010-2013); Medicaid Policy Unit Manager (2013-2015); Provider Clinical Support Unit Manager (2015-2017). I have not held positions related to the pharmacy industry before joining OHA.

3. In my various roles, I have been responsible for, among other things, monitoring Oregon's fee-for-service Medicaid Pharmacy, Medical Surgical, and DMEPOS programs to ensure continued compliance with state and federal law; making program improvement recommendations and fully implementing those improvements once approved; analyzing proposed state legislation to predict agency impact; acting as the subject matter expert for programs previously mentioned; and providing leadership and collaborative management for Medicaid policy Unit who are responsible for Oregon Medicaid program operations; oversee the Oregon Prescription Drug Program; advise agency leadership and make pharmacy policy decisions.

4. My current responsibilities with respect to Oregon's Medicaid health care program, include, among other things, oversight over the Pharmacy

and Therapeutics Committee, and administrator for Oregon's Clinical Pharmacy Contractor.

5. In the fall of 2011, Defendants communicated with me, then serving as the Division of Medical Assistance Programs Pharmacy program manager, and with Tom Burns, the Director of Pharmacy Programs with OHA at the time. Defendants asked whether a competitor price matching program would have affected the "usual and customary charge" for prescription drugs pursuant to the amended definitions of "Usual and Customary" set forth in Administrative Rules 410-121-0000(3) and 410-121-0150(1). Mr. Burns and I confirmed that the revised "usual and customary charge" definitions effective September 1, 2011 did not apply to Defendants' competitor price matching program. *See* Exhibit A (produced in this litigation at SVU00530320-24). Therefore, a pharmacy that operated a competitor price matching program would not have been required to report the price match price as its "usual and customary" charge to the Oregon Medicaid program during the period of September 1, 2011 through 2016 because the Oregon Medicaid program did not view any advertising of the potential availability of price matching as in any way affecting the U&C price.

6. From 2006 through 2016, the Oregon Medicaid program would not have objected to a pharmacy that did not submit any price-matched amounts as U&C prices on prescription drug claims because Oregon understood that the companies' price matching did not meet the definition of U&C, as set forth above. That is, the pharmacy was not making competitors' prices generally

available to its customers. Rather, as described above, specific, local competitors' prices would be honored on a case-by-case basis.

7. Therefore, during the period from 2006 through 2016, a pharmacy retailer operating such a competitor price matching program that reported its regular cash price charged to customers who did not request or receive a price match to Oregon Medicaid would have been in compliance with the statutory and regulatory scheme in place during that period.

Dated: February 26, 2018

/s/ Trevor Douglass, DC, MPH
Trevor Douglass, DC, MPH
Oregon Prescription Drug Program
& Pharmacy Purchasing Director
Oregon Health Authority

[Declaration of Deborah Weston, dated Feb. 26, 2018 (filed May 21, 2018), Schutte Doc. 172-27, Ex. 106]

EXHIBIT 106

IN THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF ILLINOIS SPRINGFIELD DIVISION

No. 11-cv-03290

THE UNITED STATES OF AMERICA, and THE STATES OF CALIFORNIA, DELAWARE, ILLINOIS, INDIANA, MASSACHUSETTS, MINNESOTA, MONTANA, NEVADA, NEW JERSEY, NORTH CAROLINA, RHODE ISLAND, and VIRGINIA *ex rel.* TRACY SCHUTTE and MICHAEL YARBERRY,

Plaintiffs,

v.

SUPERVALU INC., SUPERVALU HOLDINGS, INC., FF ACQUISITIONS, LLC, FOODARAMA, LLC, SHOPPERS FOOD WAREHOUSE CORP., SUPERVALU PHARMACIES, INC., ALBERTSON'S, LLC, JEWEL OSCO SOUTHWEST LLC, NEW ALBERTSON'S, INC., AMERICAN DRUG STORES, LLC, ACME MARKETS, INC., SHAW'S SUPERMARKET, INC., STAR MARKET COMPANY, INC., JEWEL FOOD STORES, INC., and AB ACQUISITION LLC,

Defendants.

Declaration of Deborah Weston

I, Deborah Weston, pursuant to 28 U.S.C. § 1746, hereby affirm that I am over 18 years of age and competent to make the following Declaration.

Professional Experience

I. I am currently a Policy Analyst at the Oregon Health Authority ("OHA") where I have been employed for four years.

2. I have held the position of Pharmacy Program Manager since 2015. Before that, I held the following positions at OHA: Medicaid Policy Assistant Manager (2014 – 2015), Dental Program Manager and Pharmacy Program Co-Manager (2013 – 2014). I have not previously held any positions related to the pharmacy industry.

3. In my various roles, I have been responsible for, among other things monitoring Oregon's fee-for-service Medicaid pharmacy and dental programs to ensure continued compliance with state and federal law; making program improvement recommendations and fully implementing those improvements once approved; analyzing proposed state legislation to predict agency impact; acting as the subject matter expert for dental and pharmacy Medicaid regulations; and providing leadership and collaborative management for 12 staff members who are responsible for Oregon Medicaid program operations.

4. My current responsibilities with respect to Oregon's Medicaid health care program, include, among other things, monitoring Oregon's fee-for-service Medicaid pharmacy program to ensure continued compliance with state and federal law; making program improvement recommendations and fully implementing those improvements once approved; meeting with stakeholders; analyzing proposed state legislation to predict agency im-

pact; and acting as the subject matter expert for pharmacy Medicaid regulations.

Oregon's Medicaid Health Care Program

5. Medicaid is a program jointly funded and operated by the state and the federal government. As such, operation of state Medicaid programs, including Oregon's Medicaid health care program, must meet with the approval of federal program officials.

6. A state that participates in the Medicaid program must submit a "State Plan" for federal approval to the Centers for Medicare and Medicaid Services ("CMS"). 42 CFR § 430.10 provides that the "State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program." Each participating state has its own State Plan. They contain many of the same basic elements, but may differ considerably in the details. If a state seeks to change how it operates its Medicaid program in a way that conflicts with the State Plan approved by CMS, it must submit a "State Plan Amendment" ("SPA") to CMS detailing the proposed changes.

7. Through the Oregon Medicaid health care program, the State of Oregon has provided prescription drug coverage to eligible Medicaid beneficiar-

ies for many years, including throughout the period from 2006 through 2016.

8. The State of Oregon does not dispense prescription drugs itself to these beneficiaries; instead, it reimburses retail pharmacies (the same pharmacies that serve other Oregon residents) to dispense prescription drugs to Medicaid beneficiaries.

9. The State of Oregon reimburses pharmacies that dispense prescription drugs to Medicaid beneficiaries based on a comprehensive set of state regulations.

Oregon's Regulatory History
Defining "Usual and Customary Charge".

10. From July 1, 2010 through August 31, 2011, Oregon Administrative Rule 410-121-0000(3) defined "Usual and Customary Price" as "the amount an individual without prescription drug coverage would pay at a retail pharmacy. The usual and customary price may also be referred to as the retail price." *See* 2010 OR Reg. Text 221565. In addition, during the timeframe of January 1, 2006 through August 31, 2011, Oregon required providers to "(a) not bill in excess of the usual and customary charge to the general public . . . ." *See* OR Admin. R. 410-121-0150(1)(a) (2010).

11. Effective September 1, 2011, Oregon amended Administrative Rule 410-121-0000(3) to redefine "Usual and Customary Price" as "A pharmacy's charge to the general public that reflects all advertised savings, discounts, special promotions, or other programs including membership based discounts, initiated to reduce prices for product costs available to the general public, a special population, or an inclusive category of customers."

See 2011 OR Text 266684. In addition, Oregon amended the billing requirements found in Administrative Rule 410-121-0150 effective September 1, 2011 by adding that, when billing the Oregon Medicaid health care program for drug products, "The sum of charges for both the product cost and dispensing fee must not exceed a pharmacy's usual and customary charge for the same or similar service; and when billing the Division for a prescription, the pharmacy shall bill the lowest amount accepted from any member of the general public who participates in the pharmacy provider's savings or discount program[.]" *See* OR Admin. R. 410-121-0150(1)(a) (Sept. 1, 2011).

12. During the period from at least April 2009 to 2016, the State of Oregon's Medicaid State Plan (the "State Plan") provided that "The Division determines usual charge to be the lesser of the following unless prohibited from billing by federal statute or regulation: (i) The provider's charge per unit of service for the majority of non-Medical Assistance users of the same service based on the preceding month's charges; [or] (ii) The provider's lowest charge per unit of service on the same date that is advertised quoted or posted. . . ." The lesser of these applies regardless of the payment source or means of payment." *Id.*

13. From 2006 through 2016, the Oregon Medicaid program would not have objected to a pharmacy that did not submit any price-matched amounts as U&C prices on prescription drug claims because Oregon understood that the companies' price matching did not meet the definition of U&C, as set forth above. That is, the pharmacy was not making competitors' prices generally

available to its customers. Rather, as described above, specific, local competitors' prices would be honored on a case-by-case basis.

14. Therefore, during the period from 2006 through 2016, a pharmacy retailer operating such a competitor price matching program that reported its regular cash price charged to customers who did not request or receive a price match to Oregon Medicaid would have been in compliance with the statutory and regulatory scheme in place during that period.

Dated: February 26, 2018

/s/ Deborah Weston
Deborah Weston
Policy Analyst / Oregon Health Authority

[Excerpts of Deposition of Christina Zook taken Jan. 18, 2018, (filed May 21, 2018), Schutte Doc. 176-11, Ex. 9]

[Page 19, Pages 42-43, and part of page 133 OMITTED]

EXHIBIT 9

Discovery Deposition Of

CHRISTINA ZOOK

January 18, 2018

———

THE UNITED STATES OF AMERICA, et al. ex rel. TRACY SCHUTTE and MICHAEL YARBERRY v. SUPERVALU, INC., et al.

No. 11-cv-03290

———

Court Reporter: Cindy Splayt

Paszkiewicz Court Reporting
10 N. Martingale Road
Suite 400
Schaumburg, IL 60173
Phone: (847) 619.7155 / (855) 595-3577 toll-free

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* * *

[133]

Q. What did you set the U&C at for the Farm Fresh store in Virginia that implemented a discount generic program similar to Wal-Marts?

A. We used the Wal-Mart list.

Q. Okay. So if -- if, for instance, Pravastatin 10 milligram was being sold, a 30-day script, for $4 at that store, that $4 would be the U&C?

A. We actually set the price at 3.99 and not $4.

Q. Okay. And the 3.99 was what you set the U&C at for that store?

A. Correct.

Q. Okay. Did that store then submit third-party claims listing 3 -- $3.99 as its U&C for the discounted generics?

A. Yes.

(Plaintiffs' Exhibit 259 marked for identification.)

BY MR. KELLER:

* * *

[Declaration of Erin Shaal, dated May 15, 2018, (filed May 21, 2018), Schutte Doc. 176-17, Ex. 22]

EXHIBIT 22

IN THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF ILLINOIS SPRINGFIELD DIVISION

No. 11-cv-03290

THE UNITED STATES OF AMERICA, and THE STATES OF CALIFORNIA, DELAWARE, ILLINOIS, INDIANA, MASSACHUSETTS, MINNESOTA, MONTANA, NEVADA, NEW JERSEY, NORTH CAROLINA, RHODE ISLAND, and VIRGINIA *ex rel.* TRACY SCHUTTE and MICHAEL YARBERRY,

Plaintiffs,

v.

SUPERVALU INC., SUPERVALU HOLDINGS, INC., FF ACQUISITIONS, LLC, FOODARAMA, LLC, SHOPPERS FOOD WAREHOUSE CORP., SUPERVALU PHARMACIES, INC., ALBERTSON'S, LLC, JEWEL OSCO SOUTHWEST LLC, NEW ALBERTSON'S, INC., AMERICAN DRUG STORES, LLC, ACME MARKETS, INC., SHAW'S SUPERMARKET, INC., STAR MARKET COMPANY, INC., JEWEL FOOD STORES, INC., and AB ACQUISITION LLC,

Defendants.

Declaration of Erin Shaal

I, Erin Shaal, pursuant to 28 U.S.C. § 1746, affirm that I am over 18 years of age and competent to make the following declaration.

PROFESSIONAL EXPERIENCE

1. My name is Erin Shaal. Since 2004, I have been employed in or supported pharmacies operated by New Albertson's Inc. (Albertsons), including during the period that these pharmacies were owned by SuperValu Inc. (SUPERVALU). Starting in May 2009, I was Pharmacy Manager at Michigan City and Chesterton, Indiana, and also worked in the pharmacy in Dyer, Indiana. After my time in Indiana, I worked as a Pharmacy Manager at stores in Kankakee and New Lenox, Illinois. As a Pharmacy Manager, I was responsible for overseeing pharmacy staff and operations, and ensuring compliance with state laws and policies.

2. From July 2012 through February 2015, I served as a Clinical Point Person and I also worked simultaneously as an Operational Specialist. In my role as an Operational Specialist, it was my responsibility to visit "troubled" stores—stores with declining sales or that were deficient in overall pharmacy practices. As an Operational Specialist, I visited a total of 10 stores in the geographic area to which I was assigned. During my visits I would complete assessments of pharmacy operations. I usually visited two to three pharmacies per day. As an Operational Specialist, I carried with me a monthly checklist sheet with operational issues to monitor. In that capacity, I would position myself at the customer window and observe pharmacy staff interactions with customers and listen to such conversations. During such times, I had opportunity to listen to conversations involving price matching. As a Clinical Point Person, I visited 36 stores. When I

visited stores in my role as a Clinical Point Person, I did not position myself at the customer window, but had ample opportunity to observe and listen to similar conversations between pharmacy staff and customers.

3. I served as a Corporate Pharmacy Trainer in the Franklin Park, Illinois office. In that capacity, I trained pharmacy staff on pharmacy policies, practices and procedures, including regarding price matching.

4. I am currently the Director of Specialty Care at Albertsons Companies.

PRICE-MATCHING POLICY AND PRACTICE

5. I am aware of Albertsons' and SUPERVALU's written policies about price matching. In accordance with these policies, a customer needed to initiate a price-match transaction; a pharmacy staff member was not allowed to initiate an offer to match a competitor's price. After a customer asked the pharmacy to match a price or quoted a competitor's price, which had the effect of asking the pharmacy to match that price, the staff member was required to verify the price in real time.

6. It was not uncommon for a customer to call a pharmacy and ask for a price quote. If a customer called for a price quote for a particular drug, it was my practice and the company's practice to quote the company's "usual and customary" price for that drug and quantity on that day. In response to a customer inquiry about a drug price, we would not quote a competitor price or volunteer that the company price matches. Only if the customer

asked would we mention the company's price-match policy.

7. Upon customer request, I processed many price-match transactions for customers as a pharmacist. Also, in my role as an Operational Specialist and Clinical Point Person, I had the opportunity to observe how many different pharmacy staff handled price matching at numerous stores in Illinois, Iowa and Indiana.

8. As a Corporate Pharmacy trainer, I trained staff on the company's price match policy, and correct practices and procedures.

9. In my experience, the pharmacists whom I observed followed the written policy with respect to price matching.

10. Based on my experience and observations, Albertsons and SUPERVALU pharmacy staff did not offer discounted or price-matched prices absent a customer request. For each and every new prescription filled, a customer had to request a price match first, such as through quoting a competitor's price, and had to identify to the pharmacist the competitor that offered the lower price.

11. In my experience, after a customer requested a price match, pharmacy staff called the local competitor to verify the price. Employees were not permitted to reference printed formularies to check the competitor's price because these resources could be out of date, and the pharmacy wanted to match the local competitor's price for the same drug on the same day of service.

12. If the competitor's price could be verified, then the pharmacy charged the customer the lower price. If the employee was unable to confirm the price in the verification call—usually because the competing pharmacy was unavailable or unwilling to quote their price over the phone—then the price match was not made.

13. I observed pharmacy staff occasionally explaining to customers that the pharmacy would generally match competitors' prices upon customer identification and pharmacy verification of a specific competitor's price. Additionally, stores had signs advertising the price-matching program. These efforts, however, did not appear to me to affect the frequency of customers' asking, or not asking, for a price match on specific cash transactions.

14. As competing pharmacies learned of the price-matching program, increasingly they refused to provide to our pharmacists the prices of specific drugs. However, this did not change the company's practice—only if a competitor price could be verified would a price match be given. This led to customer-relations challenges, because the customers were disappointed that the pharmacy would not be able to honor the lower prices of competitors because of the lack of verification.

15. During my tenure, I don't recall ever witnessing a situation where a pharmacy associate did not follow the company's price match policy. The elements of the price match policy and the policy as a whole were so heavily emphasized to such a degree by Pharmacy District Managers that the policy was well understood and followed. I witnessed consistent practices in following the price match policy.

16. My recollection is that Albertsons, after the divestiture from SUPERVALU, ended its price-matching program in late 2013.

l declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, to the best of my knowledge and belief.

Executed on: 5/15/18

/s/ Erin Shaal
Erin Shaal
Director, Specialty Care
Albertsons Companies

[Excerpts of Deposition of Matthew Cross, dated Jan. 25, 2018, (filed May 21, 2018), Schutte Doc. 176-18, Ex. 23]

[Page 43, pages 183-184, part of page 306, pages 320-321, and page 344 OMITTED]

EXHIBIT 23

Discovery Deposition Of

MATTHEW CROSS

January 25, 2018

THE UNITED STATES OF AMERICA, et al. ex rel. TRACY SCHUTTE and MICHAEL YARBERRY V. SUPERVALU, INC., et al.

No. 11-cv-03290

Court Reporter: Cindy Splayt

Paszkiewicz Court Reporting
10 N. Martingale Road
Suite 400
Schaumburg, IL 60173
Phone: (847) 619.7155 / (855) 595-3577 toll-free

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* * *

[306]

Q. So if a customer goes in and asks for a price match, they can get $4 prices, correct?

A. First of all, they'd have to provide the pharmacy that they can get the pricing at. The pharmacy team -- because, unfortunately, some people are dishonest. I'd have people come in saying, oh, yeah, I can get it for

that. I'd call up and they're like no, we never quoted that price, no, we don't sell that price, so, then, I'd go back to the customer, you know, sorry, you know, that's not the price. This is what the price is, and some people would take their prescriptions back. Once again, this was a very small percentage of my business because most patients, you know, as stated before, 90, 95 percent of them [307] presented with an insurance card, and the co-pay that came out on the insurance was much lower, but, once again, we didn't -- didn't have a $4 pricing.

We had a program that Ron Richmond started, you know, what year where the patient paid a fee, and that existed, but not prior to this. I'm not aware of anything that existed that way.

Q. And then this e-mail in Exhibit 274 goes on, Mr. Richmond says to you at the top of page 88798, he says, "Matt, was the RX in question" HT -- "HTCZ." Did you ever see that? Do you know what that is?

A. Hydrochlorothiazide.

Q. "Was the RX in question (HCTZ) ever filled at our store, or was it only filled at Wal-Mart? I'm a little uncomfortable that we have and are discussing confidential information about this patient's RX if we" never -- "if we were never a party to filling the RX." Do you see that?

A. Yes.

* * *

[Excerpts of Deposition of Marc Allgood, dated Dec. 21, 2017, (filed May 21, 2018), Schutte Doc. 176-20, Ex. 27]

[Page 90, page 103, pages 108-110, page 166, pages 200-201, and part of page 252 OMITTED]

EXHIBIT 27

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS
JUDICIAL SPRINGFIELD DIVISION

Case No. 11-CV-03290

THE UNITED STATES OF AMERICA, et al. ex rel. TRACY SCHUTTE and MICHAEL YARBERRY,

Plaintiffs and Relators,

vs.

SUPERVALU INC., et al.,

Defendants.

DEPOSITION OF MARC ALLGOOD

December 21, 2017

REPORTED BY:

SUSAN SIMS, CSR No. 739, RPR

Notary Public

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* * *

[120]

A. Initially, before we set the ongoing price override, they had to request that Wal-mart or whoever they wanted us to match them, from that point forward, from a customer service perspective, we didn't ask them to tell us each and every time. We documented the name of the competitor. We knew the address, we knew the phone number, we knew the price they gave us. And we simply just called that pharmacy to validate it each and every time.

Q. Could the pharmacist verify the price by going online to the competitor's price – competitor's pharmacy site and checking out their formulary to verify that that drug is still being sold at $4, say?

A. In some instances, yes, we did do that, especially when Wal-mart was publishing that. But that was realtime checks. So we felt comfortable with that.

Q. Okay. Explain what you mean by realtime checks.

A. Realtime meaning that we could go onto the website. Wal-mart would be required to have their published list out there. And if they still had it published and you could access it via live interface with the internet, they'd have to honor that price to a customer. If they came into their store, we would

[252] refill and ongoing price override feature.

Q. With respect to the ongoing price override feature, would the pharmacist still need to verify every single time, when there was not a refill, that the price was still valid?

A. Can I clarify that question a little bit? If there wasn't a refill in the prescription, we would have had to get an authorization from the physician and it

would have forced us to do a rewrite of the prescription, which would have made us validate it.

With every single subsequent refill that we did, we had to validate with the competitor what the drug was, what the price was, what the quantity was, each and every time.

Q. So for auto refill, it didn't matter whether it was set up on auto refill, the verification would take place every time?

A. Correct.

* * *

[Excerpts of Deposition of Riley Bobbie, dated Feb. 23, 2018, (filed May 21, 2018), Schutte Doc. 176-21, Ex. 28]

[Pages 74-75, part of page 89, page 142, and part of pages 193-194 OMITTED]

THE UNITED STATES OF AMERICA, et al. ex rel. TRACY SCHUTTE and MICHAEL YARBERRY V. SUPERVALU, INC., et al.

No. 11-cv-03290

Discovery Deposition Of

RILEY BOBBIE

February 23, 2018

Court Reporter: Rose Pisano

Paszkiewicz Court Reporting
10 N. Martingale Road
Suite 400
Schaumburg, IL 60173
Phone: (847) 619.7155 / (855) 595-3577 toll-free

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* * *

[89]

A. That was always in our policy when I was in operations: A patient would ask to match a price or that they could get it somewhere else. It was initiated by the patient.

Q. Okay.

A. Wording may have changed over the years, but that was always our policy.

* * *

Q. Okay. And that also -- they used ARx automated refills for price matched drugs, correct?

MR. KOON: Object to the form.

You may answer.

THE WITNESS: If it was a medication that the [194] patient had indicated that they would want, then again -- want price matched, then it would still be automatically refilled. At the time the pharmacist refilled it, they would validate that the price was still what it was.

* * *

[Declaration of David Baker, dated Apr. 10, 2018, (filed May 21, 2018), Schutte Doc. 176-23, Ex. 41]

EXHIBIT 41

IN THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF ILLINOIS SPRINGFIELD DIVISION

No. 11-cv-03290

THE UNITED STATES OF AMERICA, and THE STATES OF CALIFORNIA, DELAWARE, ILLINOIS, INDIANA, MASSACHUSETTS, MINNESOTA, MONTANA, NEVADA, NEW JERSEY, NORTH CAROLINA, RHODE ISLAND, and VIRGINIA *ex rel.* TRACY SCHUTTE and MICHAEL YARBERRY,

Plaintiffs,

v.

SUPERVALU INC., SUPERVALU HOLDINGS, INC., FF ACQUISITIONS, LLC, FOODARAMA, LLC, SHOPPERS FOOD WAREHOUSE CORP., SUPERVALU PHARMACIES, INC., ALBERTSON'S, LLC, JEWEL OSCO SOUTHWEST LLC, NEW ALBERTSON'S, INC., AMERICAN DRUG STORES, LLC, ACME MARKETS, INC., SHAW'S SUPERMARKET, INC., STAR MARKET COMPANY, INC., JEWEL FOOD STORES, INC., and AB ACQUISITION LLC,

Defendants.

Declaration of David Baker

I, David Baker, pursuant to 28 U.S.C. § 1746, hereby affirm that I am over 18 years of age and competent to make the following Declaration.

Professional Experience

1. I am currently the Director, Pharmacy Networks for DST Pharmacy Solutions (f/k/a Argus Health Systems, Inc.) ("Argus"), a pharmacy benefit management (PBM) company operating in the United States. In this position, I manage a team of Argus employees in overseeing the management of Argus' pharmacy network.

2. I have over 10 years of experience in the pharmacy benefit industry, working at Argus, Coventry Healthcare, and Aetna.

3. My current responsibilities include, among other things, managing pharmacy relationships and negotiating provider agreements with pharmacies, ensuring network integrity, and overseeing Argus's retail network.

4. In my various roles at Argus, I have been responsible for, among other things, managing Argus's relationships with the retail pharmacies participating in its pharmacy networks, including SUPERVALU INC. (SUPERVALU) and Albertson's, Inc. (Albertson's). The management of Argus's relationships with retail pharmacies includes: assembling our pharmacy networks, negotiating our contracts with the pharmacies, enrolling pharmacies in the networks, and ensuring the pharmacies are compliant with our contracts and provider manuals.

5. Through this work and my general experience in the PBM industry, I am familiar with the concept of "usual and customary" pricing.

Low Price Drug Programs

6. In fall 2006, Walmart announced that it would begin selling a set list of generic medications for $4 to its customers. The announcement received significant attention in the healthcare industry generally and the PBM industry specifically.

7. After Walmart announced its $4 generic product list, many companies that dispense prescription drugs adopted low cost drug programs of their own. This included "big box" retail competitors of Walmart, such as Target and Kmart, as well as some pharmacies and grocery stores.

8. Competitor "price matching," i.e., matching a prescription-drug price offered by a competitor, has been a long-established practice in the retail pharmacy industry. It is my understanding that SUPERVALU and Albertson's had a price match program dating back quite a number of years. It is my assumption that their price match program was an individualized, customer-initiated process, which required a customer to take an affirmative action – such as requesting a price match or quoting a competitor price – for the pharmacy to, upon verification, honor a competitor's price and accordingly exclude that price-matched transaction from its regular cash price.

9. Unlike the Walmart $4 set list of generics, I am not aware of instances where SUPERVALU and Albertson's offered to pharmacy customers specific pricing that was discounted from their regular cash prices. It would be Argus' expectation that prices negotiated on a case-by-case basis upon some form of customer action (*i.e.*, prices not charged to all of a given pharmacy's customers) are generally not included in the pharmacy's

usual and customary price under the Argus Health Systems, Inc. Participating Agreement for Pharmacy.

10. In my experience, there was general awareness among PBMs and other third party payers of prescription drug benefits that pharmacies that were negotiating individual price matching agreements with customers were not reporting the price matches as usual and customary prices.

Argus's Contracts with SUPERVALU and Albertson's

11. Argus contracts with the retail pharmacies that participate in its networks.

12. Starting on June 1, 2001, one contract governing the relationship between Argus, Albertson's, and SUPERVALU was the "Argus Health Systems, Inc. Participating Agreement for Pharmacy Chain," effective on June 1, 2001 (the 2001 Contract).

13. One defined term in the 2001 Contract is "Usual and Customary Retail Price" (U&C). The 2001 Contract defines U&C as "the usual and customary retail price of a Covered Medication charged to the public by the Participating Pharmacy on the date that the prescription is dispensed, including any special promotions or discounts available to the public on such date of dispensing." *See* 2001 Contract, Exhibit 1, Definitions, Paragraph 1.40.

14. In January 2007, the 2001 Contract was assigned by Albertson's to SUPERVALU. It continued to govern the relationship between Argus and Albertson's until December 10, 2012. After it was assigned to SUPERVALU in January 2007, the 2001 Contract governed the relationship between

Argus and SUPERVALU through the discontinuation of SUPERVALU's price match program.

15. Starting on December 10, 2012, the contract governing the overall relationship between Argus and Albertson's was the "Argus Health Systems, Inc. Participating Agreement for Pharmacy Chain," effective on December 10, 2012 (the 2012 Contract).

16. One defined term in the 2012 Contract is "Usual and Customary Charge" (U&C). The 2012 Contract defines U&C as "the lowest retail price the Participating Pharmacy would charge to a cash paying customer for an identical prescription on the date and at the location that the prescription is dispensed, including any special promotions or discounts available to the public on such date of dispensing." *See* 2012 Contract, Exhibit 1, Definitions, Paragraph 1.40.

17. Accordingly, Argus did not expect that individualized, customer-initiated price matching by SUPERVALU and Albertson's would have met the definitions of U&C as set forth in the 2001 or the 2012 Contracts. Moreover, Argus did not view any advertising of the potential availability of price matching as in any way affecting the U&C price. In the same way that Argus did not view price matching as affecting the reported U&C price, Argus did not view advertising of the price matching initiative as doing so.

Dated: April 10, 2018

/s/ David Baker
David Baker
Director, Pharmacy Networks for DST Pharmacy Solutions, Inc.

[Declaration of Michael Viirre, dated Apr. 2, 2018, (filed May 21, 2018), Schutte Doc. 176-25, Ex. 43]

EXHIBIT 43

IN THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF ILLINOIS SPRINGFIELD DIVISION

No. 11-cv-03290

THE UNITED STATES OF AMERICA, and THE STATES OF CALIFORNIA, DELAWARE, ILLINOIS, INDIANA, MASSACHUSETTS, MINNESOTA, MONTANA, NEVADA, NEW JERSEY, NORTH CAROLINA, RHODE ISLAND, and VIRGINIA *ex rel.* TRACY SCHUTTE and MICHAEL YARBERRY,

Plaintiffs,

v.

SUPERVALU INC., SUPERVALU HOLDINGS, INC., FF ACQUISITIONS, LLC, FOODARAMA, LLC, SHOPPERS FOOD WAREHOUSE CORP., SUPERVALU PHARMACIES, INC., ALBERTSON'S, LLC, JEWEL OSCO SOUTHWEST LLC, NEW ALBERTSON'S, INC., AMERICAN DRUG STORES, LLC, ACME MARKETS, INC., SHAW'S SUPERMARKET, INC., STAR MARKET COMPANY, INC., JEWEL FOOD STORES, INC., and AB ACQUISITION LLC,

Defendants.

Declaration of Michael Viirre

I, Michael Viirre, pursuant to 28 U.S.C. § 1746, hereby affirm that I am over 18 years of age and competent to make the following Declaration.

Professional Experience

1. I am currently the Vice President, Network Relations for OptumRx, Inc. (f/k/a RxSolutions d/b/a Prescription Solutions) ("Optum"). I have held this position since June 13, 2016. As Vice President, my primary responsibilities involve negotiating contracts and managing relationships with Optum's network pharmacies, including SUPERVALU INC. (SUPERVALU) and New Albertson's, Inc. (Albertson's). Over the course of my career, I have negotiated approximately 80 contracts with network pharmacies. My other responsibilities include managing staff and setting strategy for certain lines of business.

2. Optum is a pharmacy benefit manager ("PBM"). Following its recent acquisition of Catamaran Corporation, Optum is now one of the three largest PBMs in the United States, with Express Scripts and Caremark being the other two.

3. Through this work and my general experience in the PBM industry, I am familiar with the concept of "usual and customary" pricing.

Low Price Drug Programs

4. In fall 2006, I understand that Walmart announced it would begin selling a set list of generic medications for $4 to its customers. Although the specific drugs that Walmart placed on its list changed over time, its approach – of making its set list of generic drugs available to all Walmart customers at a specific discounted price – did not change.

5. After Walmart announced its $4 generic product list, many companies that dispense prescription

drugs adopted low cost drug programs of their own. This included "big box" retail competitors of Walmart, such as Target and Kmart, as well as some pharmacies and grocery stores.

6. Competitor "price matching," i.e., matching a prescription-drug price offered by a competitor, has been a long-established practice in the retail pharmacy industry. In my experience, there was general awareness in the pharmacy and PBM industry that pharmacies were negotiating individual price matching agreements with customers. Notwithstanding these individual price matching agreements, I would not expect pharmacies would change their overall usual and customary price strategy on the basis of limited instances of price matching.

7. As Vice President, Network Relations, I believe that one or more people in our department would have been aware of price matching by SUPERVALU and Albertson's, although I understand that neither company currently has a formal price-match program. My understanding is that the companies began price matching before I assumed my current position within Optum.

Optum's Contracts with SUPERVALU and Albertson's

8. Optum contracts with the retail pharmacies that participate in its networks.

9. During the time period from at least 2006 until September 17, 2014, the contract governing the overall relationship between Optum and SUPERVALU was the "Prescription Drug Services Agreement" between Supervalu Pharmacies and RxSolutions d/b/a Prescription Solutions,"

effective on November 7, 2001 (the 2001 Optum/SUPERVALU Contract).

10. One defined term in the 2001 Optum/SUPERVALU Contract is "Usual and Customary" (U&C). The 2001 Optum/SUPERVALU Contract defined U&C as "the price that the Company Pharmacy would have charged the Member for the Prescription if the Member was a cash customer. This includes all applicable discounts including, but not limited to: Senior citizen discounts, frequent shopper and special customer discounts, or other discounts."

11. During the time period from at least 2006 until November 9, 2014, the contract governing the overall relationship between Optum and Albertson's was the Prescription Drug Services Agreement between American Drug Stores, Inc. and Pacificare, Inc. (effective June 1, 1992) (the 1992 Optum/Albertson's Contract). Optum was formerly known as RxSolutions, Inc. d/b/a Prescription Solutions, which was formerly known as Pacificare Pharmacy Centers; Albertson's, LLC, was formerly known as American Drug Stores, Inc.

12. The 1992 Optum/Albertson's Contract did not define Usual & Customary.

13. On September 18, 2014, Optum and SUPERVALU executed a new Pharmacy Network Agreement (the 2014 Optum/SUPERVALU Contract). The 2014 Optum/SUPERVALU Contract defined "usual and customary charge" as "the retail price that a cash paying customer would normally pay Company for Drug Products, devices, products and/or supplies. For the avoidance

of doubt, the Usual and Customary Charge does not include the contractual rate paid by customers who have a prescription benefit covered by an insurance plan, or those who have paid a membership fee to enroll in a provider loyalty program or utilize a consumer discount card administered by a third party." 2014 Optum/SUPERVALU Contract at Paragraph 1.41.

14. On November 10, 2014, Optum and Albertson's executed a new Pharmacy Network Agreement (the 2014 Optum/Albertson's Contract). The 2014 Optum/Albertson's Contract defined "usual and customary charge" as "the retail price that a cash paying customer would normally pay Company for Drug Products, devices, products and/or supplies. For the avoidance of doubt, the Usual and Customary Charge does not include the contractual rate paid to Pharmacy by customers who have a prescription benefit covered by an insurance plan, or those who have enrolled in a provider loyalty program or utilize a consumer discount card administered by a third party." 2014 Optum/Albertson's Contract at Paragraph 1.41.

15. These contracts governed all prescription-drug claims administered by Optum on behalf of Medicare Part D, Medicare Advantage, and Managed Medicaid. The U&C definitions in these contracts did not include competitors' matched prices.

16. Optum was aware that SUPERVALU and Albertson's were not submitting to Optum any price-matched amounts as U&C prices on prescription drug claims. Optum did not object to this approach because Optum did not view the price matching as being encompassed in the

contract definitions of U&C, as set forth in the 2001 Optum/SUPERVALU Contract, the 2014 Optum/SUPERVALU Contract, or the 2014 Optum/Albertson's Contract. That is, SUPERVALU and Albertson's did not make competitors' prices generally available to its customers.

17. Accordingly, Optum understood that individualized, customer-initiated price matching by SUPERVALU and Albertson's did not meet the definition of U&C as set forth in the 2001 Optum/SUPERVALU Contract, the 2014 Optum/SUPERVALU Contract, or the 2014 Optum/Albertson's Contract. That is, SUPERVALU and Albertson's competitor price matches were not "applicable discounts," and they were not "the retail price that a cash paying customer would normally pay Company for Drug Products." In addition, given the contract definition, Optum would not have viewed any advertising of the potential availability of price matching as affecting the U&C price.

Catamaran's Agreements with SUPERVALU and Albertson's

18. Prior to its acquisition by OptumRX, Catamaran contracted with the retail pharmacies that participated in its networks.

19. During the relevant time period, Catamaran's relationships with Albertson's and SUPERVALU were governed by Pharmacy Provider Agreements executed by Albertson's and SUPERVALU (the Catamaran Agreements).

20. The Catamaran Agreements governed all prescription-drug claims administered by Catamaran

on behalf of Medicare Part D, Medicare Advantage, and Managed Medicaid.

21. Like Optum, Catamaran understood that the companies' price matching would not have qualified as U&C under Catamaran's customary practice, and the price matching was not a price that was offered to the general public. Rather, as described above, specific, local competitor's prices would be honored on a case-by-case basis.

22. Accordingly, Catamaran understood that individualized, customer-initiated price matching by SUPERVALU and Albertson's did not meet Catamaran's understanding of U&C. Moreover, Catamaran did not view any advertising of the potential availability of price matching as in any way affecting the U&C price. In the same way that Catamaran did not view price matching as affecting the reported U&C price, Catamaran did not view advertising of the price matching initiative as doing so.

Dated: 4/2/18

/s/ Michael Viirre
Michael Viirre
OptumRx
Vice President, Network Relations

[Declaration of Brian Swett, dated Apr. 10, 2018, (filed May 21, 2018), Schutte Doc. 176-26, Ex. 44]

EXHIBIT 44

IN THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF ILLINOIS SPRINGFIELD DIVISION

No. 11-cv-03290

THE UNITED STATES OF AMERICA, and THE STATES OF CALIFORNIA, DELAWARE, ILLINOIS, INDIANA, MASSACHUSETTS, MINNESOTA, MONTANA, NEVADA, NEW JERSEY, NORTH CAROLINA, RHODE ISLAND, and VIRGINIA *ex rel*. TRACY SCHUTTE and MICHAEL YARBERRY,

Plaintiffs,

v.

SUPERVALU INC., SUPERVALU HOLDINGS, INC., FF ACQUISITIONS, LLC, FOODARAMA, LLC, SHOPPERS FOOD WAREHOUSE CORP., SUPERVALU PHARMACIES, INC., ALBERTSON'S, LLC, JEWEL OSCO SOUTHWEST LLC, NEW ALBERTSON'S, INC., AMERICAN DRUG STORES, LLC, ACME MARKETS, INC., SHAW'S SUPERMARKET, INC., STAR MARKET COMPANY, INC., JEWEL FOOD STORES, INC., and AB ACQUISITION LLC,

Defendants.

Declaration of Brian Swett

I, Brian Swett, pursuant to 28 U.S.C. § 1746, hereby affirm that I am over 18 years of age and competent to make the following Declaration.

Professional Experience

1. I am currently the Vice President, Performance & Analytics for MedImpact Healthcare Systems, Inc. (MedImpact), a pharmacy benefit management (PBM) company operating in the United States.
2. I have over 13 years of experience in the PBM industry.
3. I have held the position of Vice President, Performance & Analytics since 2015.
4. My current responsibilities include, among other things, managing and tracking client and pharmacy network pricing guarantees.
5. Through this work and my general experience in the PBM industry, I am familiar with the concept of "usual and customary" pricing.

Low Price Drug Programs

6. I am aware that Walmart and certain other retail pharmacies offer low cost generic drug programs where any customers can purchase specific generic drugs for a set low price, for example $4. Such retailers then submit their discounted prices as the usual and customary price for the discounted drugs.
7. It is my understanding that SUPERVALU and Albertson's do not have a low price program in direct competition with Walmart and others. Instead, I understand that SUPERVALU and Albertson's have a "price match" program.

8. While I am not personally familiar with the "price match" program, I understand that it is an individualized, customer-initiated process, subject to verification at each prescription fill or refill. Customers must take an affirmative action — such as requesting a price match or quoting a competitor price — for the pharmacy to, upon verification, honor a competitor's price and exclude that price-matched transaction from its regular cash price. I understand that this program differs from the Walmart, and similar, low price drug programs in that SUPERVALU and Albertson's did not offer to pharmacy customers specific pricing that was discounted from their regular cash prices, there was no formulary with set prices for drugs and the price match program was not limited to generics.

<u>MedImpact's Contracts with SUPERVALU and Albertson's</u>

9. MedImpact contracts with the retail pharmacies that participate in its networks.

10. During the relevant time period, MedImpact's relationships with Albertson's and SUPERVALU were governed by the MedCare Pharmacy Network Agreements executed by both Albertson's and SUPERVALU, and the MedCare Pharmacy Networks Policies and Procedures Manual, which is incorporated into the MedCare Pharmacy Network Agreements (collectively, the "MedCare Agreements"). These contracts governed all prescription-drug claims administered by MedImpact on behalf of Medicare Part D, Medicare Advantage, and Managed Medicaid.

11. Although the MedCare Agreements' definition of usual & customary has been amended slightly over time, the term "usual & customary" was substantively defined by the MedCare Agreements as: "the lowest price Provider would charge to a cash paying customer at that location for an identical prescription on that day. This price must include any applicable discounts, promotions, or other offers to attract customers." See, e.g., MedCare Pharmacy Networks Policies and Procedures Manual, Section 17.20.

12. Based on my understanding of the SUPERVALU and Albertson's price match program, as described herein, MedImpact does not consider the individualized, customer-initiated price matching by SUPERVALU and Albertson's to meet any of MedImpact's definitions of usual and customary for the relevant time period, regardless of whether the potential availability of price matching was advertised.

Dated: 4/10/18

/s/ Brian Swett
Brian Swett
Vice President, Performance & Analytics

[Declaration of Amber Compton, dated May 14, 2018, (filed May 21, 2018), Schutte Doc. 176-28, Ex. 48]

EXHIBIT 48

IN THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF ILLINOIS SPRINGFIELD DIVISION

No. 11-cv-03290

THE UNITED STATES OF AMERICA, and THE STATES OF CALIFORNIA, DELAWARE, ILLINOIS, INDIANA, MASSACHUSETTS, MINNESOTA, MONTANA, NEVADA, NEW JERSEY, NORTH CAROLINA, RHODE ISLAND, and VIRGINIA *ex rel.* TRACY SCHUTTE and Michael Yarberry,

Plaintiffs,

v.

SUPERVALU INC., SUPERVALU HOLDINGS, INC., FF ACQUISITIONS, LLC, FOODARAMA, LLC, SHOPPERS FOOD WAREHOUSE CORP., SUPERVALU PHARMACIES, INC., ALBERTSON'S, LLC, JEWEL OSCO SOUTHWEST LLC, NEW ALBERTSON'S, INC., AMERICAN DRUG STORES, LLC, ACME MARKETS, INC., SHAW'S SUPERMARKET, INC., STAR MARKET COMPANY, INC., JEWEL FOOD STORES, INC., and AB ACQUISITION LLC,

Defendants.

Declaration of Amber Compton

I, Amber D. Compton, pursuant to 28 U.S.C. § 1746, hereby affirm that I am over 18 years of age and competent to make the following Declaration.

Professional Experience

1. I am currently the Vice President, Retail Account Management & Compliance for Express Scripts, Inc. (Express Scripts), one of the largest pharmacy benefit management (PBM) companies in the United States. I manage, directly or indirectly, a team of approximately 50 individuals.

2. I have over fifteen years of experience in the PBM industry, working at Express Scripts.

3. I have held the position of Vice President, Retail Account Management & Compliance since 2017. My current responsibilities as the Vice President of Retail Account Management & Compliance include, among other things, managing relationships with pharmacies, ensuring network integrity, and overseeing Express Scripts' retail network.

4. Prior to my current position, I held the position of Vice President of Retail Strategy & Contracting from 2010-2017, as well as the following positions at Express Scripts: Senior Manager (2001-2005); Director (2005-2006); and Sr. Director (2006-2010).

5. In my various roles, I have been responsible for, among other things, managing Express Scripts' relationships with the retail pharmacies participating in its pharmacy networks, including SUPERVALU INC. (SUPERVALU) and Albertson's, Inc. (Albertsons). The management of Express

Scripts' relationships with retail pharmacies includes: assembling our pharmacy networks, negotiating our contracts with the pharmacies, enrolling pharmacies in the networks, and ensuring the pharmacies are compliant with our contracts and provider manuals.

6. Through this work and my general experience in the PBM industry, I am familiar with the concept of "usual and customary" pricing.

Express Scripts' Contracts with SUPERVALU and Albertsons

7. Express Scripts contracts with the retail pharmacies that participate in its networks.

8. Starting in December 2009, the master contract governing the overall relationship between Express Scripts and SUPERVALU (then including Albertsons), was the "Express Scripts, Inc. Pharmacy Provider Agreement," effective on December 24, 2009 (the 2009 Contract).

9. U&C is a defined term in the 2009 Contract. The 2009 Contract defines U&C as "the amount charged in a cash transaction by the dispensing Pharmacy at the time of dispensing for the Covered Medication (in the quantity dispensed) on the date that it is dispensed, provided that Usual and Customary Retail Price shall not include an individual pharmacist's or Pharmacy's discretionary offers, but only those offers that involve system-wide Usual and Customary Retail Price changes of Covered Medications that are implemented at a particular Pharmacy, pharmacy region, or Provider-wide. In addition, Usual and Customary Retail Price shall include any '$4 generic' or similar programs offered on a

corporate-wide, routine basis, **but shall exclude; a Pharmacy's competitor's matched price discounts (Price Match)**, and, Pharmacy offers that provide rewards that do not discount the Covered Medication price." 2009 Contract at ¶ 1.19 (emphasis added).

10. After SUPERVALU's divestiture of Albertsons in 2013, SUPERVALU continued to operate under the 2009 Contract, and Albertsons entered into a new agreement with Express Scripts on March 22, 2013 (the 2013 Contract). Like the 2009 Contract, the 2013 Contract defines U&C as "the amount charged in a cash transaction by the dispensing Pharmacy at the time of dispensing for the Covered Medication (in the quantity dispensed) on the date that it is dispensed, provided that Usual and Customary Retail Price shall not include an individual pharmacist's or Pharmacy's discretionary offers, but only those offers that involve system-wide Usual and Customary Retail Price changes of Covered Medications that are implemented at a particular Pharmacy, pharmacy region, or Provider-wide. In addition, Usual and Customary Retail Price shall include any "$4 generic" or similar programs offered on a corporate-wide, routine basis, **but shall exclude: a Pharmacy's competitor's matched price discounts (Price Match)**, and, Pharmacy offers that provide rewards that do not discount the Covered Medication price." 2013 Contract at ¶ 1.19 (emphasis added).

11. In a contract effective on January 1, 2016 (the 2016 Contract), Albertsons and Express Scripts entered into a new agreement that also excluded price matching from U&C definition. The 2016

Agreement defined U&C as "the amount charged in a cash transaction by the dispensing Pharmacy at the time of the dispensing for the Covered Medication (in the quantity dispensed) on the date that it is dispensed, provided that Usual and Customary Retail Price shall not include an individual pharmacist's or Pharmacy's discretionary offers. In addition, Usual and Customary Retail Price shall include any "$4 generic" or similar programs offered on a corporate-wide, routine basis, **but shall exclude: a Pharmacy's competitor's matched price discounts (Price Match)**, or membership program discounts." 2016 Contract at ¶ 1.17 (emphasis added).

12. During their effective time periods, these contracts governed all prescription-drug claims administered by Express Scripts on behalf of its plan sponsor clients, including, but not limited to, TRICARE, Medicare Part D plans and Managed Medicaid plans, at SUPERVALU and Albertsons.

13. Consistent with ¶ 1.19 of the 2009 Contract, ¶ 1.19 of the 2013 Contract, and ¶ 1.17 of the 2016 Contract, Express Scripts agreed that SUPERVALU's and Albertsons' Price Matches were excluded from the contractual definition of U&C.

14. Consistent with ¶ 1.19 of the 2009 Contract, ¶ 1.19 of the 2013 Contract, and ¶ 1.17 of the 2016 Contract, any advertising of the potential availability of SUPERVALU's and Albertsons' Price Matches would not have affected the exclusion of Price Matches from the contractual definition of U&C.

15. Express Scripts contracts accurately reflected its

understanding of the exclusion of SUPERVALU's and Albertsons' Price Matches with respect to the U&C definition.

Dated: 5-14-18

-

/s/ Amber D. Compton
Amber D. Compton
Vice President, Retail Strategy and Contracting
Express Scripts, Inc.

[Declaration of Robert Burge, dated Apr. 2, 2018, Declaration Ex. A, Email dated Nov. 11, 2011, Declaration Ex. B, CVS Caremark Network Update dated July 12, 2011 (filed May 21, 2018), Schutte Doc. 176-29, Ex. 39]

EXHIBIT 49

IN THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF ILLINOIS

Case No. 11-cv-03290

THE UNITED STATES OF AMERICA, and THE STATES OF CALIFORNIA, DELAWARE, ILLINOIS, INDIANA, MASSACHUSETTS, MINNESOTA, MONTANA, NEVADA, NEW JERSEY, NORTH CAROLINA, RHODE ISLAND, and VIRGINIA *ex rel.* TRACY SCHUTTE and MICHAEL YARBERRY,

Plaintiffs,

v.

SUPERVALU INC., SUPERVALU HOLDINGS, INC., FF ACQUISITIONS, LLC, FOODARAMA, LLC, SHOPPERS FOOD WAREHOUSE CORP., SUPERVALU PHARMACIES, INC., ALBERTSON'S, LLC, JEWEL OSCO SOUTHWEST LLC, NEW ALBERTSON'S, INC., AMERICAN DRUG STORES, LLC, ACME MARKETS, INC., SHAW'S SUPERMARKET, INC., STAR MARKET COMPANY, INC., JEWEL FOOD STORES, INC., and AB ACQUISITION LLC,

Defendants.

DECLARATION OF ROBERT BURGE

I, Robert Burge, pursuant to 28 U.S.C. § 1746, hereby affirm that I am over 18 years of age and competent to make the following Declaration.

1. From approximately October 2008 through April 2015, I was Director, Pharmacy Network Development for Caremark, L.L.C. ("Caremark"), a pharmacy benefit manager ("PBM") and an indirect subsidiary of what currently is known as CVS Health Corporation. During my tenure at Caremark, it was one of the three largest PBMs in the United States. Since leaving Caremark, I have continued working in the PBM industry.

2. My responsibilities as Director, Pharmacy Network Development for Caremark included negotiating contracts with pharmacies in most of Caremark's networks. On behalf of Caremark, I personally negotiated scores of contracts with network pharmacies, including contracts with Albertsons and SuperValu.

3. In total, I have over eighteen (18) years of experience negotiating contracts between PBMs and their network pharmacies. Over the course of my career, I have negotiated hundreds, and perhaps thousands, of PBM-pharmacy contracts. From those years of experience in the industry, I am familiar with the general nature of contractual relationships between PBMs and retail pharmacies in PBM networks and the concept of usual and customary pricing at pharmacies.

4. During my time at Caremark, one of Caremark's largest clients was the Blue Cross and Blue Shield Association's Federal Employee Program ("FEP"),

which provided insurance coverage to certain federal employees. Caremark provided PBM-related services to FEP, including claims adjudication and network contracting services.

5. On October 17, 2011, I forwarded to Ron Richmond a "Network Update, BlueCross and BlueShield Government-wide Service Benefit Plan Federal Employee Program (FEP)" from Caremark relating to a revised definition of "Usual and Customary Price" governing pharmacies participating in the FEP network. *See* Exhibit A (Bates No. SVU00088988-00088989). At the time, Mr. Richmond was Director, Managed Health Care Contracting for SuperValu, and was my day-to-day point of contact for contracting issues with SuperValu. The Network Update stated that, effective January 1, 2012, the phrase "Usual and Customary Price" as defined in Caremark's Provider Manual would be restated as follows for purposes of the FEP network:

   "means the lowest price Provider would charge to a particular customer if such customer were paying cash or utilizing a Promotional Pricing program for an identical prescription or on that particular day at that particular location. For the purposes of this definition, 'Promotional Pricing' means any discounts given or offered to the general public by Provider, including but not limited to:

   - *Discounts given or offered through membership, club, subscription programs;*
   - *Cash rebates;*

- *Coupons; and*
- *Other promotional or price discounts including free medications"*

See Exhibit B (Bates No. SVU00088873).

6. On November 4, 2011, Mr. Richmond sent me an email asking the following question about the Network Update:

> *"We do not have a loyalty card/program and our stores do not have the ability to manipulate our U&C price. However, we do allow the stores to price match on Cash Rx's if the customer requests it. Does price matching have to be taken into consideration with regard to the revised definition of Usual and Customary in the attached FEP Network update?"*

See Exhibit A.

7. On November 11, 2011, I replied to Mr. Richmond's email, stating:

> *"Price matches will not be in conflict to promotional pricing language in FEP contract. (revised definition of U&C)."*

8. Although I have no present recollection of this particular email exchange with Mr. Richmond that occurred more than 6 years ago, I have seen a copy of the exchange (Exhibit A) in which I clearly participated. My reply to Mr. Richmond accurately reflected my understanding of the restated definition as described, and, to this day, I have no reason to question the accuracy of my response.

9. I declare under penalty of perjury under the laws

of the United States of America that the foregoing is true and correct.

Dated: April 2, 2018

/s/ Robert Burge
Robert Burge

Exhibit A

From: Burge, Robert [Robert.Burge@caremark.com]

Sent: Friday, November 11, 2011 11:25 AM

To: Richmond, Ronald

Subject: RE: PLEASE READ: Network and Plan Updates

Price matches will not be in conflict to promotional pricing language in FEP contract. (revised definition of U&C)

Robert Burge | CVS Caremark | Director, Pharmacy Network Development | Office 480.391.4119 | Cell 801.243.5445 | robert.burge@caremark.com

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From: Richmond, Ronald
[mailto:Ronald.Richmond@supervalu.com]

Sent: Friday, November 04, 2011 10:45 AM

To: Burge, Robert

Subject: RE: PLEASE READ: Network and Plan Updates

Robert,

We do not have a loyalty card/program and our stores do not have the ability to manipulate our U&C price. However, we do allow the stores to price match on Cash Rx's if the customer requests it. Does price matching have to be taken into consideration with regard to the revised definition of Usual and Customary in the attached FEP Network update?

Thanks,

Ron

From: Burge, Robert
[mailto:Robert.Burge@caremark.com]

Sent: Monday, October 17, 2011 6:45 PM

To: Richmond, Ronald

Subject: FW: PLEASE READ: Network and Plan Updates

Ron – I am being told that you were sent this information directly via e-mail.

Sincerely,

Robert Burge | CVS Caremark | Director, Pharmacy Network Development | Office 480.391.4119 | Cell 801.243.5445 | robert.burge@caremark.com

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

From: Pharmacy Communications

Sent: Monday, October 17, 2011 4:40 PM

To: Burge, Robert

Subject: FW: PLEASE READ: Network and Plan Updates

FYI.

From: Pharmacy Communications

Sent: Wednesday, July 13, 2011 12:33 AM

To: Pharmacy Communications

Subject: PLEASE READ: Network and Plan Updates

Please review the attached files for network and plan updates.

Thank you.

Network Services | CVS Caremark |

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sender immediately by telephone and destroy all copies of this communication and any attachments.

To ensure that CVS Caremark notifications reach your inbox, please add this email address to your contacts as a safe sender.

Exhibit B

CVS CAREMARK July 12, 2011

NETWORK UPDATE

BlueCross and BlueShield

Government-wide Service Benefit Plan

Federal Employee Program (FEP)

EFFECTIVE JANUARY 1, 2012

RXBIN 610239

RXGRP 65006500

Caremark, on behalf of FEP, which is comprised of more than 2.5 million plan members nationwide, is pleased to continue serving FEP and its plan members into the 2012 plan year.

FEP will continue to use Caremark national networks (the CareValue4 and Extended Days Supply 2012 networks beginning January 1, 2012) for the purpose of administering the retail prescription benefit for those applicable FEP plan members.

Current claims processing information will not change — RXBIN and RXGRP information will remain the same. Please make sure your patient profiles reflect the current RXBIN and RXGRP indicated on this notice.

In addition, for the purposes of the FEP network, the definition of "Usual and Customary Price" (as defined in the Caremark Provider Manual) is restated as follows:

> "means the lowest price Provider would charge to a particular customer if such customer were paying cash or utilizing a Promotional Pricing program for an identical prescription or on that particular day at that particular location. For the purposes of this definition, "Promotional Pricing" means any discounts given or offered to the general public by Provider, including but not limited to:
>
> - Discounts given or offered through membership, club, subscription programs;
> - Cash rebates;
> - Coupons; and
> - Other promotional or price discounts including free medications"

Providers must also submit its U&C price with each claim, and keep adequate records showing how the U&C price was determined when based upon Provider's Promotional Pricing.

As a participating Provider, your pharmacy(ies) will be included in FEP's printed pharmacy directories distributed prior to plan member enrollment.

The reimbursement terms of this Network Update supersede all other previous agreements, writings, and understandings for the FEP network. If you have questions regarding this notice, please call Caremark Network Services at 1-866-488-4708. Thank you for continuing to serve FEP plan members.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents, is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments. This communication is a Caremark Document within the meaning of the Provider Manual.

[Excerpts of Relators' Response In Opposition to Defendants' Motion for Partial Summary Judgment as to Medicare Part D, Tricare, and FEP Claims (filed June 11, 2018), Schutte Doc. 191-1]

[Pages 2-8, part of page 9, and pages 10-52 OMITTED]

IN THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF ILLINOIS SPRINGFIELD DIVISION

No. 11-cv-3290

THE UNITED STATES OF AMERICA et al., ex rel., TRACY SCHUTTE and MICHAEL YARBERRY,

Plaintiffs and Relators,

v.

SUPERVALU, INC., et al.,

Defendants.

RELATORS' RESPONSE IN OPPOSITION TO DEFENDANTS' MOTION FOR PARTIAL SUMMARY JUDGMENT AS TO MEDICARE PART D, TRICARE, AND FEP CLAIMS

* * *

42. Relators dispute that the contracts between PBMs and pharmacies "govern the terms" by which Defendants are required to submit claims to the PBMs and in turn, whether and how much the PBMs should pay Defendants for dispensing drugs to their beneficiaries. Pharmacy reimbursement is governed by statutory and regulatory requirements. Contracts that "govern the terms by which Defendants are required to submit claims to PBMs" must be construed consistent with those statutes and regulations. As a matter of law, government programs, particularly Medicare Part D and Medicaid, are entitled to usual and customary prices. *Garbe*, 824 F.3d 632.

* * *

[Excerpt of Memorandum in Support of Defendants' Motion for Partial Summary Judgment as to Medicare Part D, TRICARE, and FEP Claims, filed May 21, 2018, Schutte Doc. 176-1]

***

[Pages 1-10, part of 11-12 and 13-66 OMITTED]

***

I. UNDISPUTED FACTS

***

B. Defendants' Claim Submission

***

9. Prescription claims include detailed information – specified by the contract for the PBM to which each claim was directed – so the payer can evaluate whether, and how much, to pay the pharmacy for the services provided. *See, e.g.*, Ex. 8, 108:12-109:2; 111:17-18.

10. One piece of information generally required for the submission of any claim was the pharmacy's "usual and customary" (U&C) price. *See* Ex. 5, 68:9-14; Ex. 8, 62:21-63:3.

***

[Excerpts of Deposition of Frank Knutson taken Jan. 31, 2018 (filed June 11, 2018), Schutte Doc. 191-7, Exhibit D-12]

* * *

[Pages 1–134, Parts of 136-138 and 139–256 omitted]

* * *

[135]

A. There is a bunch of PHI that the auditor should not be able to see. So if an auditor wants to review a record, we will provide him with that record, that screen, or the prescription or hard copy, whatever they need to, but we don't want them to search for something for themselves. They may stumble upon somebody else's PHI that they are not allowed to see.

Q. And it says "Third-party auditors should never be given copies or access to provider records such as internal reports, communications, and price lists." Do you see that?

A. Yes, sir.

Q. Why is that? Why do you restrict the auditors from seeing that type of information?

A. That's confidential information. It's internal.

Q. So the price lists wouldn't have anything to help support an audit of pricing?

A. To be honest with you, I don't even think the pharmacy computers had a list of prices.

Q. Well, it says next "If an auditor requests a list of usual and customary prices, their attention should be directed to the pharmacy audit department." Do you see that?

A. Yes, sir.

Q. Why is that?

A. Because the stores usually and – customarily prices are determined centrally. And that can be requested through our department, and we would go to the pricing department.

***

[137]

Q. Now, were you ever involved in any audits of accurate reporting of usual and customary prices by any PBM?

A. Not that I'm aware of, sir.

[138]

Q. Okay.

***

Q. Were you ever involved in any audits where a PBM would seek to audit whether member claims were processed by the pharmacy as cash claims instead of through their online processing programs?

A. If they were processed as cash claims, the PBM would not have visibility to those claims because they weren't processed through the third-party.

Q. Okay. So cash claims, the third-party doesn't know they exist because they're not processed through the plan, right?

A. Correct.

[Supplemental Declaration of Bretta Grinsteinner, dated Apr. 2, 2018 (filed June 11, 2018), Schutte Doc. 191-9, Ex. R]

***

I, Bretta Grinsteinner, pursuant to 28 U.S.C. § 1746, hereby affirm that I am over 18 years of age and competent to make the following Supplemental Declaration.

1. Attached as Exhibit A is a copy of a Declaration I signed on March 8, 2018 in my capacity as Assistant Vice President, Network Management, Prime Therapeutics LLC ("Declaration"). The Declaration was executed in response to a letter from Rick Robinson, counsel for Defendants in the above-referenced matter, dated February 5, 2018 to Prime Therapeutics LLC ("Robinson letter") and subsequent communications with Defendants' counsel.

2. With respect to the statements in paragraphs 11, 12, and 13 of the Declaration, I have no personal knowledge regarding the accuracy of any representations made by Defendants or Defendants' actual price matching practices and cash sales transaction data. The statements in paragraphs 12 and 13 were not intended to characterize or describe SUPERALU's and Albertson's actual price matching program and related practices. After signing the Declaration, Plaintiffs' counsel provided information and documents regarding Defendants' price matching practices. Based upon this information, my understanding of U&C may not be applicable as it pertains to Defendants. Accord-

ingly, the Declaration should not be construed as a determination of the Defendants' price matching program operations or the propriety of Defendants' U&C price reporting.

Executed in Dakota County, State of Minnesota, on the 2 day of April 2018.

Dated: April 2, 2018 /s/ Bretta Grinsteinner

Bretta Grinsteinner

Assistant Vice President, Network Management

Prime Therapeutics LLC

PAGES 111 – 200
INTENTIONALLY OMITTED

[Stipulations filed Nov. 28, 2018, Proctor Doc. 122]

IN THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF ILLINOIS SPRINGFIELD DIVISION

UNITED STATES OF AMERICA, *ex rel.* PROCTOR, *et al.,*

Plaintiffs and Relators,

v.

SAFEWAY, INC.

Defendant.

Cause No. 3:11-cv-3406-RM-TSH

STIPULATIONS REGARDING 30(b)(6) DEPOSITION TOPICS

In lieu of producing a corporate representative to testify in response to the Amended Notice of Deposition served upon Defendant on November 16, 2018, Defendant agrees to the following stipulations. Defendant acknowledges that it may not introduce facts that have the effect of contradicting the stipulations, but Defendant reserves the right to introduce additional facts, legal arguments, or expert testimony related to the stipulated topics or related matters. In exchange for these stipulations, Relator has agreed to withdraw the Amended Notice of Deposition.

1. Defendant stipulates to the following:

    a. The authenticity of the data that Defendant produced from its transactional databases and agrees that such documents constitute Defendant's business records.

    b. The authenticity of the contracts and contract-related documents that Defendant produced in this litigation and agrees that such documents constitute Defendant's business records.

    c. The authenticity of the documents produced by Defendant in this litigation that were generated by Defendant or any of its employees and agrees that such documents constitute Defendant's business records.

    d. The authenticity of Plaintiffs Deposition Exhibits, with the exception of (1) deposition documents without Defendant's bates stamps, including Linkedin profiles, webpages, and printouts from CMS online manuals and/or (2) documents originating from third-party sources or Relator himself.

    e. All parties reserve all other objections as to admissibility and relevance.

2. Defendant stipulates that it will not pursue affirmative defenses 1, 4, 5, 6, 8, 10, 13, 14, 15, 16, 17, 20, and 21. Defendant further stipulates

that it will not pursue the affirmative defenses of laches, waiver, and estoppel in affirmative defense 18; however, Defendant will continue to pursue the defense of government knowledge in affirmative defense 18.

3. Defendant stipulates to the following:

   a. ***Price Matching Outside the Membership Programs****:* From 2006-2015, certain of Safeway's pharmacies/pharmacists had the discretion to match the published or advertised prices of certain drugs offered by competitors by honoring a customer's request to match the price after verifying the competitor's price. Price matching was officially discontinued on or about July 15, 2015 in all stores.

   b. ***$4 Generics Program****:* Starting in March 2008, Safeway offered a pricing program for certain generic drugs at its Texas, Dominick's, and Eastern/Genuardi's divisions, Von's Las Vegas, and five pharmacies in the Denver division, referred to as the "$4 Generic Program."

   c. ***Matching Competitor Generic Program (MCGP):*** Starting in March 2008, Defendant introduced the MCGP in certain divisions. The MCGP was introduced over a period of time in 2008 in the Phoenix, Denver, Portland, Seattle, and Vons/Southern California geographic divisions. The MCGP was

introduced in one store in the NorCal division (Store #3124 Manteca) in March 2010 and was introduced in additional stores in the NorCal division beginning in April 2010. Other than in NorCal, the MCGP was terminated in July 2010 as divisions introduced the Loyalty Membership Program.

d. ***Loyalty Membership Program (LMP):*** In July 2010, Defendant introduced the LMP in all divisions other than NorCal. From July 2010 until July 2015, the LMP was Defendant's only pharmacy membership program for all geographic divisions other than NorCal, which continued to make the MCGP available.

4. Defendant stipulates to the following:

a. ***Price Matching Outside the Membership Programs:*** From 2006 through July 15, 2015, based on a pharmacist's discretion, Safeway pharmacies could give a price match to any customer who requested a price match to a lower competitor's price, and the price applied only for the transaction on the date requested and did not alter the list-price pricing formulas loaded into the PDX system. The pharmacist was responsible for verifying the competitor price before agreeing to dispense the drug to the customer at the competitor's price. To document the price match, the pharmacist would manually override the original price at the

point of sale to reduce it to the competitor's price, and the overridden purchase price would be maintained in the PDX system. Price match prices were not reported as the U&C price to health insurers that required the reporting of U&C prices (the term "health insurers" includes government health care programs).

b. ***$4 Generics Program**:* For this program, Safeway created a formulary (list) of generic drugs, which changed over time as drugs were added or removed. Each drug on the $4 Generic Program's formulary was assigned a list price through the modification of the PDX list-pricing formulas of $4 for a typical 30-day supply, $8 for a typical 60-day supply, and $12 for a typical 90-day supply. No screening process or membership was required for the $4 Generics Program because these program prices were offered to all customers, including all cash-paying customers and those insured by third-party health benefit programs. During the operation of the $4 Generics Program, the prices offered for drugs included on the program's formulary were included in Safeway's reporting of the U&C price. The $4 pricing became the Safeway U&C for all program formulary drugs during that period. The $4 generics program was discontinued in July 2010 as divisions introduced the Loyalty Membership Program.

c. ***Matching Competitor Generic Program (MCGP):*** Under this program Safeway created a list of generic drugs to be sold at discount prices of $4 for a typical 30- day supply, $8 for a typical 60-day supply, and $12 for a typical 90-day supply. In addition, for drugs not on its list, Safeway provided members with discounts of 10% on Brand prescriptions and 20% on Generic prescriptions. Members of the MCGP also could obtain a price match to a local competitor's price upon customer request and pharmacist verification of the price. There was no fee to enroll in this program and all customers were eligible to enroll if they agreed to the program's terms and conditions. To obtain the discounted prices offered under the program, the customer had to (a) pay cash; and (b) fill out a Prescription Membership Program Enrollment Form that spelled out the program's terms and conditions. The discounts provided through the MCGP program were not reported to health insurers that required the reporting of U&C prices. Membership prescription drug sales were processed through Avia Partners (formerly known as SMCRX), a wholly-owned subsidiary of Safeway. With respect to price matching that occurred for members of the MCGP, such price matches were entered as price overrides in the PDX system and processed by Avia Partners.

d. ***Loyalty Membership Program (LMP):*** Under this program, Safeway created a list of generic drugs to be sold at a discount price of $4 for a typical 30-day supply, $8 for a typical 60-day supply, and $12 for a typical 90-day supply. In addition, for drugs not on its list, Safeway provided members with discounts of 10% on Brand prescriptions and 20% on Generic prescriptions. Members of the LMP also could obtain a price match to a local competitor's price upon customer request and pharmacist verification of the price. There was no fee to enroll in the program and all customers were eligible to enroll if they agreed to the program's terms and conditions. To obtain the discounted prices offered under the program, the customer had to (a) pay cash; and (b) fill out a Prescription Membership Program Enrollment Form that spelled out the program's terms and conditions. The discounts provided through the LMP program were not reported to health insurers that required the reporting of U&C prices. Membership prescription drug sales were processed through Avia Partners (formerly known as SMCRX), a wholly-owned subsidiary of Safeway. With respect to price matching that occurred for members of the LMP, processed by Avia Partners.

5. Defendant stipulates that it has no information reasonably available to it that Safeway phar-

macy staff ever denied any customers participation in pharmacy membership programs based on whether customers were insured, uninsured, or underinsured.

6. Defendant stipulates to the following:

   a. Had Safeway reported its membership discount prices as its usual and customary prices to health insurers and their PBMs that required the reporting of U&C prices, it could have resulted in a reduction in Safeway's revenues.

   b. Safeway analyzed the potential financial impact of transitioning from the $4 Generics Program to a Membership program and projected that doing so could result in financial savings to the company.

   c. If Safeway had adopted all the features of the Walmart' s $4 program, the $4 price would have been the U&C price that Safeway would have had to report to third parties, which could have resulted in a reduction in Safeway's revenues.

7. Defendant stipulates that for price matches outside the membership programs, the price charged to customers was overridden at the point of sale, to reduce it to the competitor's price, and such information would be maintained in the PDX system. Defendant stipulates that price matches provided through the MCGP

and LMP membership programs were entered as price overrides in the PDX system and were processed by Avia Partners. Defendant further stipulates that Safeway could create price override reports from PDX data.

8. Defendant stipulates that:

   a. During the relevant time period, Safeway divisions (or stores within divisions) that price matched outside of the membership programs were not known to advertise the existence of price matching outside of the membership programs.

   b. During the relevant time period, Safeway divisions (or stores within divisions) participating in the $4 Generic Program advertised to varying degrees the availability of a set formulary of$4 generic medications. Safeway's advertisements publicized the benefits of the program and generally included disclaimers.

   c. During the relevant time period, Safeway divisions (or stores within divisions) participating in the MCGP advertised or promoted the program to varying degrees. Certain stores within divisions participating in the MCGP may not have separately advertised or promoted the program at all. Safeway's advertisements generally publicized the benefits of membership in the program and included or referenced program restrictions

or terms and conditions of membership.

d. During the relevant time period, Safeway divisions (or stores within divisions) participating in the LMP advertised or promoted the program to varying degrees. Certain stores within divisions participating in the LMP may not have separately advertised or promoted the program at all. Safeway's advertisements generally publicized the benefits of membership in the program and included or referenced program restrictions or terms and conditions of membership.

9. Defendant stipulates to the following:

   a. The LMP, also known as the Safeway Prescription Membership Program, was terminated company-wide effective July 15, 2015. In an internal communication from corporate headquarters to Safeway pharmacies, Safeway stated that the program was being discontinued following a "best practices" analysis of the program.

   b. Price matching outside of membership programs was officially discontinued on or about July 15, 2015 in all stores.

10. Defendant stipulates that pharmacy staff were instructed to enter certain plan-identifying information into the patient profiles for members of its pharmacy membership programs. Defendant stipulates that Deposition Exhibits 125 and

235, along with SW Proctor-TARN- 00297178 and SW Proctor-TARN-00838342, set out how prescriptions were processed through Safeway's system for customers enrolled in the MCGP. Defendant further stipulates that Deposition Exhibits 30 and 173, as supplemented by Exhibit 187, set out how prescriptions were processed through Safeway's system for customers enrolled in the LMP.

11. Defendant stipulates that Safeway's prescription drug membership discount programs were for cash-paying customers and were not insurance or insurance plans.

12. Defendant stipulates that Safeway pharmacy staff were instructed to forward the completed Safeway Prescription Membership Program Enrollment Forms to Avia Partners. Safeway agrees that on or before December 11, 2018, it will provide additional information in a format acceptable to Relator regarding the possession, custody, and control of hard copy and electronic enrollment forms.

13. Defendant stipulates that when Third Party Payers (TPPs) audited Safeway's claims, neither the TPPs nor their audit partners would provide Safeway with information regarding the areas, topics, or subject matters being audited. As such, Safeway is not aware of the specific topics of audits performed by or on behalf of TPPs. During the period 2006 through July 2015 Safeway is not aware of any audit of its

usual and customary pricing by or on behalf of any government health insurer.

14. Defendant stipulates that the Usual and Customary price Safeway transmitted to health insurers is the price listed by Safeway in the PDX U&C field.

15. Defendant stipulates that Safeway pharmacies could not change Safeway's U&C prices in the PDX system used by Safeway stores. Safeway's U&C prices were set by Safeway pharmacy corporate management.

16. Defendant stipulates that it has no information reasonably available to it regarding efforts Safeway made to understand or clarify its usual and customary price submission requirements for various government health programs other than that which has been reduced to writing and are contained within Defendant's response and supplemental responses to Relator's Interrogatory 16, in documents Defendant produced in discovery, or in the depositions of its current and former employees in this case. In addition Defendant stipulates to Steven Scalzo's contacts with CMS as set out in his deposition testimony and Deposition Exhibit 180.

17. Defendant stipulates to the following:

    a. Where contracts and other documents that govern applicable relationships with payers

define the values they require to be submitted in NCPDP field 426-DQ ("Usual and Customary Charge"), Defendant's Third Party Implementation personnel could use built-in PDX system functionality to reduce the business rules to a pricing schema for that payer. PDX typically stores the entries for those schema on the "Insurance Plan File," and the PDX system queries that data file when transmitting claims-related information to RelayHealth. As part of its subsequent data mappings and transformations, RelayHealth populates and submits NCPDP fields, including 426-DQ, for adjudication by third party payers.

b. Beginning in or about May 2012 Safeway used this capability to send to Oregon Medicaid and FEHBP only, certain discounts offered to customers under its prescription membership programs. Specifically, Safeway began sending to Oregon Medicaid and FEHBP the 10% discounts off brand drugs and the 20% discounts off generic drugs that were not on Safeway's discount formulary list of over 300 generic drugs. Safeway did not send to Oregon Medicaid and FEHBP the price match discounts on Safeway's formulary list of over 300 generic drugs offered to customers under its prescription membership programs.

18. Defendant stipulates that Safeway did not reference the pricing terms of specific contracts

when setting its list prices that were reported as its U&C prices, subject to the exceptions described in Paragraph 17.

19. Defendant stipulates that, for drugs within the same price zone and having the same price code, Safeway's regular business practice was to report the same list prices as its U&C prices to all health insurers that required the reporting of U&C prices, except that in or about May 2012 Safeway began reporting to Oregon Medicaid and the Federal Employees Health Benefits Program (FEHBP) U&C prices that reflected certain discounts provided to customers enrolled in its membership programs. Specifically, Safeway began reporting to Oregon Medicaid and FEHBP the 10% discounts off brand drugs and the 20% discounts off generic drugs that were not on Safeway's discount formulary list of over 300 generic drugs.

20. Defendant stipulates that Safeway did not change or modify its usual and customary price submission policies in response to the Texas Investigative Demand (Deposition Exhibit 5) served on or about December 2011 or in response to the Subpoena from the U.S. Department of Health and Human Services served on or about November 2012 (referred to in Deposition Exhibit 192).

21. Defendant stipulates that Safeway Medicare Part D contracts from 2006 to 2016 limited Safeway's reimbursement to the lower of Safeway's

usual and customary price or other reimbursement methodologies, as specified in the individual contracts between third party payers administering the Medicare Part D program and Safeway.

22. Defendant stipulates that, after a reasonable inquiry, it has no information reasonably available to it as to why the reference to California Medicaid (Medi-Cal) in the draft "U&C Pricing Amendment" was deleted or otherwise not approved. Safeway agrees to promptly notify Relator if it obtains additional information on this topic.

23. Defendant stipulates to the following:

    a. "Right Pricing" was a term its former employee, Glen Davis, used to describe a project he was undertaking in or around March 2008 to reduce the number of pricing schemes in the company's PDX system and to analyze situations where Safeway pharmacy claims were being paid on the basis of the company's usual and customary price as opposed to the contracted rate. The project also involved reviewing the company's pricing as compared to the prices of several competitor pharmacies who had begun lower cost prescription drug programs. The project involved an analysis of Defendant's list prices, first focusing on any drugs included in the recently-launched competitor generic

programs, to determine whether Defendant's list prices could be more competitive. Where the analysis revealed that a change to the list price was needed, Defendant updated its list prices in accordance with the results of this "right pricing" initiative. The results of the initiative also informed Defendant's design of the Matching Competitor Generic Program (MCGP), in which membership prices for drugs on the MCGP formulary were set based on information derived from the Right Pricing analysis.

b. One result of the Right Pricing exercise was that, in divisions participating in the MCGP, the U&C prices in the PDX system for certain prescription drugs were set to $9.99 for a 30-day supply, $10.99 for a 60-day supply, and $11.99 for a 90-day supply. For those drugs, MCGP members could obtain an override from the U&C price to the lower membership price.

24. Defendant stipulates that it has no information reasonably available to it regarding its contacts with federal or state government officials or Third Party Payers concerning this case, including any declarations sought or obtained that relate to this case, other than those identified in Defendant's responses and supplemental responses to Relator's Interrogatory Nos. 16 and 17, Defendant's initial disclosures and supplemental initial disclosures, in documents Defendant produced in this case, in the depositions

of its current or former employees in this case, and CMS officials identified in Defendant's production of email correspondence regarding its submitted Touhy requests.

25. Defendant stipulates to the following:

a. SMCRx (Safeway Managed Care Rx) was a wholly owned subsidiary of Safeway. At some point, SMCRx changed its name to Avia Partners. Avia Partners is a wholly-owned subsidiary of Safeway.

b. Relay Health acted as an intermediary in transactions of Safeway's prescription drug sales. Safeway had no ownership interest in Relay Health.

c. Relay Health transmitted Safeway prescription drug insurance claims to health insurers or their PBMs. The health insurers or their PBMs determined insurance coverage benefits, including the amount payable by insurance, any co-pay amount or deductible, and conducted a drug utilization review (DUR).

d. Under its membership discount programs, Safeway submitted prescription drug sales transactions to Avia Partners through Relay Health. Neither Avia Partners nor Relay Health paid any portion of membership purchases, transmitted the sales information to

any member's health insurer or PBM, or provided a drug utilization review (DUR). Safeway, rather than Avia Partners or Relay Health, set the pricing rules for its membership drug programs, including price matches and 10% discounts on brands and 20% discounts on generics offered to membership customers. To obtain price matches and discounts, membership customers had to pay cash. They could not use their insurance.

e. In or about February 2012, Safeway and Relay Health executed an "Amendment to Service Agreement," whereby the usual and customary prices submitted by Safeway to Relay Health for Oregon Medicaid and the Federal Employees Health Benefits Program (FEHBP) claims would be reduced by 10% on brands and 20% on generics for membership customers. In May 2012, Safeway told Relay Health that Safeway would reduce its usual and customary prices in its PDX system for Oregon Medicaid and FEHBP claims to reflect a 10% discount on brands and 20% discount on generics.

26. Defendant stipulates that it has no information reasonably available to it regarding communications with Insurers, PBMs, State Medicaid Programs, TRICARE, FEHBP, or other Third Party Payers regarding contractual or regulatory requirements to process member or beneficiary claims through the third party's applicable claims processing system, other than those

identified in Defendant's response and supplemental response to Relator's Interrogatory No. 17, in documents Defendant produced in this case, or in the depositions of its current and former employees in this case.

Dated: November 28, 2018.

APPROVED AS TO FORM:	SO STIPULATED:
/s/Timothy Keller	/s/Frederick Robinson
* * *	* * *
Lead Counsel for Relators	*Lead Counsel for Defendant*

[Excerpts of Deposition of Steven Scalzo taken Oct. 18, 2018 (filed Jan. 6, 2020), Proctor Doc. 195-10, Exhibit D-6]

* * *

[Pages 1–122 and 125–195 omitted]

* * *

Q. And he distinguishes those five divisions from Dominick's Texas and eastern as saying those three, Dominick's Texas and eastern, had a true $4 program, correct?

A. Correct.

Q. Do you know what he means by a true $4 program?

MS. COLEMAN:·Objection to form.

A. We had a true based on other pieces of information or we've seen, we had a true $4 price for certain drugs without membership necessity.

Q. What is it -- what is it that makes that a true $4 program versus a not true $4 program?

MS. COLEMAN:·Objection to form.·

A. Well, I don't -- I -- I can't define what true means under Jesse's email other than as I said, our program was straightforward $4 for a 30-day supply of those 300 generics.· No membership, no other discounts, no other advantages.

[Memorandum from Centers for Medicare and Medicaid Services dated Oct. 11, 2006 (filed Jan. 6, 2020), Proctor Doc. 195-21, Exhibit 4]

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR BENEFICIARY CHOICES

October 11, 2006

Memorandum To: All Part D Sponsors

Subject: HPMS Q & A - Lower Cash Price Policy

From: Cynthia Tudor, Ph.D., Director, Medicare Drug Benefit Group

The following question and answer on the lower cash price policy has been revised and updated in the Frequently Asked Questions Database on the CMS website at http://questions.cms.hhs.gov.

> Q: What should an individual do if he or she is able to obtain a better price on a covered Part D drug at the point of sale than the negotiated price charged by his or her Part D plan if he/she is in the coverage gap or deductible phase of his or her benefit? Will that lower amount at the point of sale count toward the enrollee's TrOOP balance?
>
> A: Although we expect it to happen rarely, an individual may be able to obtain a lower price at a network pharmacy than that which his or her plan

charges (the plan's negotiated price) in any applicable coverage gap or deductible. This may be possible if the pharmacy is offering a "special" price or other discount for all customers, or if the beneficiary using a discount card, and the beneficiary is in any applicable coverage gap or deductible phase of his or her Part D benefit and is able to receive a better cash price for a covered Part D drug at a network pharmacy than the plan offers via its negotiated price. In this situation, he or she may purchase that covered Part D drug without using his or her Part D benefit or a supplemental card. The enrollee's purchase price for the discounted drug will count toward total drug spend under his or her Part D benefit and TrOOP balance provided the Part D plan finds out about it.

The enrollee must take responsibility for submitting the appropriate documentation to his or her plan in order to have the amount count toward his or her total drug spend and TrOOP balances.[1]

[1] We note that in cases where a pharmacy offers a lower price to its customers throughout a benefit year, this would not constitute a "lower cash price" situation that is the subject of this guidance. For example, Wal-Mart recently introduced a program offering a reduced price for certain generics to its customers. The low Wal-Mart price on these specific generic drugs is considered Wal-Mart's "usual and customary" price, and is not considered a one-time "lower cash" price. Part D sponsors consider this lower amount to be "usual and customary" and will reimburse Wal-Mart on the basis of this price. To illustrate, suppose a Plan's usual negotiated price for a specific drug is $10 with a beneficiary copay of 25% for a generic drug. Suppose Wal-Mart offers the same generic drug throughout the benefit for $4. The Plan considers the $4 to take the place of the $10 negotiated price. The $4

Plans must accommodate the receipt of such information directly from enrollees and adjust total drug spend and TrOOP balances accordingly consistent with their established processes and clear instructions for enrollee paper claim submissions. These processes and instructions should be designed to distinguish between claims submitted for: (1) out-of-network coverage; (2) adjustment to TrOOP balances based on wraparound payments made by supplemental payers not previously submitted to the plan; (3) documentation submitted for a purchase made via a discount card or other special cash discount outside the Part D benefit in any applicable deductible or coverage gap phase of the benefit; and (4) documentation submitted for a nominal copayment assessed by a PAP sponsor operating outside the Part D benefit for assistance provided with covered Part D drug costs.

We note that this policy does not apply in any phase of an enrollee's Part D benefit in which he or she is liable for any less than 100 percent cost-sharing. In other words, it does not apply outside of any applicable coverage gap or deductible phase of his

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is not considered a lower cash price, because it is not a one-time special price. The Plan will adjudicate Wal-Mart's claim for $4 and the beneficiary will pay only a $1 copay, rather than a $2.50 copay. This means that both the Plan and the beneficiary are benefiting from the Wal-Mart "usual and customary" price, and the discounted Wal-Mart price of the drug is actually offered within the Plan's Part D benefit design. Therefore, the beneficiary can access this discount at any point in the benefit year, the claim will be adjudicated through the Plan's systems, and the beneficiary will not need to send documentation to the plan to have the lower cash price count toward TrOOP.

or her benefit. We have limited the policy's applicability in order to ensure that enrollees: (1) do not unwittingly forego plan funded coverage, which in most cases will be the lowest price available given the price concessions built into the plan's negotiated prices; (2) have the benefit of plan drug utilization review and other safety edits that can only be provided if the plan adjudicates the claim; and (3) proceed through the benefit as quickly as possible in order to reach catastrophic coverage. It is unlikely that this policy is likely to be a significant source of savings for most enrollees, particularly since, if an enrollee fails to submit even one claim for a purchase made under the circumstances explained above, it is almost certain he or she will ultimately spend more than he or she would have under his or her plan's negotiated prices.

We also note that organizations or entities offering discount card or other discounted price arrangements must comply with all relevant fraud and abuse laws, including, when applicable, the Federal anti-kickback statute and the civil monetary penalty prohibiting inducements to beneficiaries. The HHS Office of the Inspector General (OIG) enforces Federal fraud and abuse statutes, and all questions regarding the compliance of specific arrangements with these statutes should be referred to the OIG.

Please contact Alissa DeBoy at (410) 786-6041 if you have any questions about this guidance.

[Excerpts of Colorado Department of Health Care Policy & Financing Provider Bulletin dated Sept. 2008 (filed Jan. 6, 2020), Proctor Doc. 195-36, Exhibit 48]

* * *

[Page 1, part of Page 2, and Pages 3–7 omitted]

* * *

Pharmacy Providers

Pharmacy Discount Programs

Pharmacies who offer prescription discount programs must use their discounted prices as the usual and customary charge on Medicaid claims. Pharmacies should not submit higher prices on Medicaid claims than prices offered to the general public.

As part of its ongoing compliance monitoring requirements, the Department's Pharmacy and Program Integrity Sections are coordinating claims reviews of pharmacies offering listed drugs at the usual and customary price of $4. Beginning October 1, 2008, pharmacy providers promoting the $4 prescriptions will receive lists of claims paid at more than $4 for those drugs.

The Department encourages pharmacy providers to review these lists to identify any claims that may have been overpaid and report their findings to Program Integrity by January 1, 2009. Providers who choose not to conduct this review or do not respond by January 1,2009 will be contacted by Program Integrity for further review of the claims listed.

For further information on provider review procedures, please contact Kim Eggert, R.Ph, at 303-866-

3176 or kimberly.eqqert@state.co.us or Carol Strini, Program Integrity Reviewer, at 303-866-3148 or carol.strini@state.co.us.

[Excerpts of Expert Report of Michael S. Jacobs, dated Oct. 19, 2018 (filed Nov. 22, 2019), Proctor Doc. 176-4, Ex. 4]

[Pages 1-2, part of pages 3-5, pages 6-9, part of page 10, part of page 15, pages 16-23, part of page 24, part of page 26, pages 27-34, part of page 35, pages 36-37 OMITTED]

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS,
SPRINGFIELD DIVISION

Case No. 3:11-cv-03406

United States ex rel. Proctor, et al. v. Safeway Inc.

EXPERT REPORT OF MICHAEL S. JACOBS
October 19, 2018

* * *

C. Summary of Opinions

* * *

4. The relationships between PBMs and retail pharmacies are governed by contract; this is true whether the PBM is adjudicating commercial or government claims as part of a pharmacy benefit. The U&C price is typically defined by contract. Absent a contractual provision to the contrary, Safeway's Special-Pricing Arrangements were appropriately excluded from their reported U&C prices for several reasons. First, the PBMs' definitions of a U&C price would typically not include (1) an individualized, negotiated price concession to a cash customer for a certain prescription drug,

as done in Safeway's price-matching practices, or (2) the prices available through membership club programs. Consistent with industry norms, Safeway always treated these prices as distinct from the regular cash prices, typically reported as the U&C prices, which were established at headquarters.[6] With respect to price matches, these were driven by customer request as opposed to specific, set price concessions being offered across the board to the general public by Safeway. With respect to membership club programs, the data shows that Safeway viewed these members as separate from its cash-paying customers,[7] and PBMs have long understood that membership-club prices are distinct from U&C prices because customers must take an affirmative action to join these programs. Finally, as even Relator's expert Ian Dew concedes, the transaction-level data confirms that the Special-Pricing Arrangements were not more than the overall majority of Safeway's customers who were paying for prescriptions in cash. According to the expert report of Mr. Jed Smith, Safeway's membership club program sales represented only 26.5% of their overall cash sales, and Safeway's price overrides — not all of which were price matches — represented only 15.7% of their overall cash sales.[8] Even Mr. Dew identifies that 44.42%, less than half of cash-sales prescriptions, had a discount associated with them.[9]

* * *

[6] Deposition of Adam Meyer, p. 20-21.

[7] Deposition of Jesse Talamantez, Exhibit 187, SW Proctor-TARN-00000272.

[8] Jed Smith Report, p. 44.

[9] Ian Dew Report, p. 9.

E. The relationship between the PBMs and retail pharmacies is governed by the contractual agreement between the PBM and the retail pharmacy provider

1. PBMs negotiate and often specifically define the U&C price in the agreements that govern the relationships between PBMs and retail pharmacy providers. The following definitions of "Usual and Customary" pricing are illustrative of those commonly negotiated from the perspective of the PBM industry, and of PBM payers:

A. Certain PBMs have explicitly excluded price matching or membership program transactions, or both, from their definitions of U&C.[24] For example, CVS Caremark, which is the contracted PBM for the FEHBP, has provided explicit guidance to another pharmacy that it excluded price matches from the U&C language.[25] Specifically, an email addressing the question of a competitor pharmacy, "Does Price Matching have to be taken into consideration with regard to the revised definition of Usual and Customary in the attached FEP Network update?" states that, according to the CVS Caremark Director, Pharmacy Network Development: "Price matches will not be in conflict to promotional pricing language in FEP contract."[26]

B. Likewise, Express Scripts, a PBM that adjudicates certain Medicare Part D plans and also

[24] SW Proctor 262517 and SW Proctor 263934.

[25] Network Update, Government Wide Service Benefit Plan Federal Employees Program (FEP) July 12, 2011, SW Proctor 262583.

[26] Declaration of Robert Burge (04/02/2018) in *US ex rel. Schutte v. Supervalu, Inc.,* Case No. 11-cv-0329, Dkt. 176-29.

administers TRICARE, had agreements with Safeway that specifically defines U&C to *exclude* individualized price matches and membership programs, and as noted above, an Express Scripts representative testified that *no* Express Scripts agreement would capture discount-club pricing, which is confirmed in its agreements with Safeway.

C. For example, the Express Scripts Pharmacy Provider Agreement with Safeway, dated August 15, 2010,[27] defines the U&C Retail Price accordingly:

> 1.17 "Usual and Customary Retail Price" means the usual and customary retail price of a Covered Medication in a cash transaction at the Pharmacy dispensing the Covered Medication (in the quantity dispensed) on the date that it is dispensed, including any specific promotions on such date. In addition, Usual and Customary Retail Price shall include any "$4 generic" or similar programs offered on a corporate-wide, routine basis, but shall exclude: a Pharmacy competitor's matched price discount, cash discount networks, and Pharmacy offers that provide rewards that do not discount the Covered Medication price. (Emphasis added).[28]

D. The MedImpact agreement with Safeway also expressly excludes both price matching and discount clubs from U&C. That is, the MedImpact agreement with Safeway defines the U&C price as "the price Member Pharmacy charges at the time of dispensing a prescription to a customer who does not have any form of prescription drug coverage, and excludes all

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[27] SW Proctor 262517.

[28] SW Proctor 262517.

discounts that Member Pharmacy may offer with respect to any particular cash transaction, including, but not limited to, discounts for senior citizens, frequent shopper/cash card programs, matching competitor pricing, and any other discounts.[29]

E. In addition, based on my experience negotiating national PBM reseller Master Agreements, I know that that [sic] PBM reseller Master Agreements define Usual and Customary as a Participating Pharmacy's *usual* selling price for prescription drug.

F. Based on my experience, U&C is typically a negotiated term and definition in PBM contracts. This is true for client contracts, such as with health plans, employer groups or insurance carriers, much as it is true, based on my experience, for PBM — Pharmacy Provider contracts. It is my experience — corroborated by the statements made by PBM representatives — that any references to "discounts" typically applied to discounts provided automatically to the general public, i.e. passive customers who did not take any active role in requesting a price match or joining a membership club.

2. Based on my experience, and discussions with PBMs during my time negotiating retail pharmacy agreements, competitor price match programs and membership programs like Safeway's are NOT generally considered U&C pricing because Safeway required an affirmative action on the part of the customer. More information is set forth below. Further, for price matches, there was no set formulary or price list, and the price the customer paid for any price-matched drug was dependent on the day the prescription drug

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[29] MedImpact, Medicare Network Pharmacy Agreement, p. 2 (September 6, 2007), SW Proctor 263934.

was purchased, the store, and the competitor's price of the prescription drug. For the membership programs, in addition to requiring customers to affirmatively enroll, specific terms and conditions applied to govern the program, and customers were treated as a separate group for purposes of claim submission and claim adjudication, which – unlike cash customers – was handled by a third-party PBM, called Avia.

A. In certain contracts, discounts *offered to the general public* are included as U&C. It is my experience, corroborated by the declarations in *Corcoran v. Pharmacy, Inc.,* that discounts meant those applicable *to the general public* and received by every customer *without any customer action,* and did not include discount programs that required active enrollment or price matching that required affirmative action on the part of the customer.

B. For example, the 1995 CVS Caremark contract defined U&C as "the lowest price the Provider would charge to a particular customer if the customer were paying cash for an identical prescription on that particular day at that particular location. The price must include any applicable discounts offered to attract customers."[30] Nevertheless, as set forth above, CVS Caremark did not view membership-club prices as "applicable discounts" and did not view them as appropriate for inclusion for U&C. Further, CVS Caremark representative, Robert Burge, stated that price matches would not be "in conflict" with U&C submissions.[31]

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[30] CVS Caremark, Base Agreement, p. 9 (November 10, 1995), SW Proctor 263659.

[31] Declaration of Robert Burge (04/02/2018) in *US ex rel. Schutte v. Supervalu, Inc.,* Case No. 11-cv-0329, Dkt. 176-29.

C. Likewise, the 2000 Argus Health Systems contract defined U&C price as the "usual and customary retail price of a covered medication charged to a specific customer by the participating pharmacy on the date the prescription is dispensed, including any special promotions or discounts available to the public on such date of dispensing, if that customer is paying cash[.]"[32] Similar language is included in the 2011 contract.[33] Nevertheless, as set forth below, Argus did not view customer-initiated price matches as "special promotions or discounts available to the public" and did not view them as appropriate for inclusion for U&C.[34]

D. Along those same lines, the 2001 Prime Therapeutics contract defines U&C as "the price that Pharmacy would have charged a particular Covered Person if such person were a cash customer. This includes any applicable discounts including, but not limited to, senior discounts, frequent shopper discounts, and other special discounts offered to attract customers."[35] Nevertheless, as set forth below, Prime Therapeutics did not view membership-club prices or customer-initiated price matches as "applicable

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[32] Argus Health Systems, Participating Agreement for Pharmacy Chain, Ex. 1 (September 28, 2000), SW Proctor 262972.

[33] Argus Health Systems, Participating Agreement for Pharmacy Chain, Ex. 1 (January 11, 2011), SW Proctor 262750.

[34] Declaration of David Baker (04/10/2018) in *US ex rel. Schutte v. Supervalu, Inc.,* Case No. 1 l-cv-0329, Dkt. 176-23, ¶ 13

[35] Prime Therapeutics, Base Agreement, p. 4 (January 1, 2001), SW Proctor 264108.

discounts" and did not view them as appropriate for inclusion for U&C.[36]

3. Further, the PBM declarations and testimony discussed below confirm my experience that many PBMs considered a price to be usual and customary when the customer had a passive role, as distinguished from an active role, like requesting a price match or joining a membership club. These PBM declarations and testimony are entirely consistent with my experience that PBMs in the industry generally viewed usual and customary as "passive pricing" and thus would not have viewed a price match initiated by customer action as affecting the "usual and customary" price.

* * *

G. Audits would enable PBMs to review Special-Pricing Arrangements

1. PBMs audit the retail providers of pharmacy services to their clients and members on a consistent and thorough basis. There are a number of reasons for this activity. In my experience, the audits verify: (1) that the retail pharmacy provider is accurately following agreed upon policies and procedures of the PBM; (2) that the retailer is adhering to the contractual obligations of the relationship; and (3) that record-keeping is in order and that potential fraud waste and abuse within the retailer is monitored.[60]

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[36] Declaration of Britta Grinsteinner (03/08/2018) in *US ex rel. Schutte v. Supervalu, Inc.,* Case No. 11-cv-0329, Dkt. 176-24.

[60] *See, e.g.,* Brian N. Anderson, *Are Your Benefits Being Adjudicated Properly?,* BENEFITS MAGAZINE, Vol. 51 No. 5, 22-27 (May 2014). http://us.milliman.com/uploadedFiles/insight/2014/pharmacy-benefit-audit.pdf.

2. In the case of retail pharmacy provider audits, most measure financial issues, benefit administrative activity, compliance, billing submission errors, record keeping and statistical "outlier" audits. In the case of validating U&C pricing, audits verify that U&C is appropriately being transmitted from the retail pharmacy provider to the PBM. Audits will commonly include an analysis of statistical comparison of chains that exist as "outliers" in this dimension. The PBM will anticipate an historic average number of submissions of U&C to be maintained, unless there are known changes to the U&C formula.[61] In the case of a deep prescription discounter, for example Walmart and the $4/30 day prescription program, the PBM will have data regarding the expectation of "U&C submissions" for the Walmart retail pharmacy network and an available formulary of the products included in the program. This is often a post-PBM payment type of statistical analysis audit looking at potential excessive overrides.[62] PBMs also likely had existing historic U&C data for Safeway for ongoing comparative purposes.

3. During the relevant time period, the relevant PBMs – including the three largest PBMs in the nation, Express Scripts,[63] OptumRx,[64] and CVS Caremark[65] – all had audit rights over Safeway's

[61] *Id. at* 13.

[62] *Id* at 16, 18.

[63] Express Scripts, Inc., Pharmacy Provider Agreement, (1994), SW PROCTOR 262508; Express Scripts, Inc., Pharmacy Provider Agreement, (August 10, 2010), SW PROCTOR 262523.

[64] Prescription Solutions, Prescription Drug Service Agreement, (July 1, 1994), SW PROCTOR 264054.

[65] CVS Caremark, Base Agreement, p. 9 (November 10, 1995), SW PROCTOR 263654; CVS Caremark, Retail Addendum to

pharmacies. Typically, auditing entities would not inform pharmacies of what was being audited, although in my experience, typically audits entail reviewing contractual obligations for financials, record keeping, claim submissions and compliance considerations.[66]

4. Moreover, agreements between PBMs and Safeway support the fact that the PBMs would seek to recover funds as a result of audit findings. For instance, in the Express Scripts agreement, the following is stated: ". . . Further, in the event any final audit determination concludes that provider (or Pharmacy) was paid an amount in excess of the amount due to the Provider (or Pharmacy) pursuant to and in accordance with this Agreement, ESI shall be entitled to recover such overpayment."[67] In my experience, this is a typical contract provision.

H. The data confirms that price overrides done through the Special-Pricing Arrangements were the exception and not the rule for Safeway's customers who were paying for prescriptions in cash.

1. The transaction level data here confirm my view that the Special-Pricing Arrangements would not satisfy contractual definitions of U&C, and neither would the Membership program, as discussed above. To the extent that these price matches would have potentially affected the U&C price, the specific price-matched amount would have to account for the

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Caremark Provider Agreement in Terms of Participation in Medicare Part D, (September 7, 2006), SW PROCTOR 263610.

[66] *See* Anderson, supra n.60.

[67] SW Proctor 262523

majority (more than 50%) of the cash customers of the store for the price-matched amount to potentially affect the U&C price of a specific drug on a specific day at a specific store.

2. According to Mr. Dew's Overpayment Report, as analyzed by Mr. Smith, fewer than 50% of the prescriptions were either "price matched" or provided through membership clubs. Instead, Safeway's regular cash price was charged over 50% of the time for cash-paying customers, confirming that price matches were the exception and not the rule for Safeway's cash prescriptions. Safeway's membership club program sales represented only 26.5% of their overall cash sales, and Safeway's price overrides — not all of which were price matches — represented only 15.7% of their overall cash sales.[68]

* * *

21. From my experience, pricing programs, like Safeway's Special-Pricing Arrangements, are considered in the contract negotiations when PBMs, payers, and retail pharmacy providers negotiate and define U&C pricing in their agreements, and are known in the course of regular interactions with the pharmacy. In other words, payers are well aware of practices like price matching and have many opportunities to specifically request that pricing as the U&C price.

* * *

[68] Jed Smith Report, p. 44.

[Excerpts of Expert Report of Leslie Norwalk, dated Oct. 19, 2018 (filed Nov. 22, 2019), Proctor Doc. 176-5, Ex. 5]

[Part of page 1, page 2, part of page 3, pages 4-35, part of page 36, pages 37-57 OMITTED]

UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS

CASE NO. 3:11-CV-03406

EXPERT REPORT OF LESLIE NORWALK

My name is Leslie Norwalk. I am an attorney and the former Acting Administrator for the Centers for Medicare & Medicaid Services ("CMS"). I have been retained by Defendant Safeway Inc. ("Safeway"). In connection with the above-captioned case, I was asked by Safeway's counsel to discuss various issues related to CMS and the Medicare Part D Program. I was also asked to apply my specialized knowledge about these subjects to documents and information presented to me by counsel and to comment on the opinions of Kenneth W. Schafermeyer, John Bertko, and Ian Dew. My opinions are offered on behalf of Safeway in this matter. I am not testifying on behalf of the Department of Health and Human Services or CMS. All of the opinions stated in this report are my own and are stated to a reasonable degree of professional certainty.

PERSONAL BACKGROUND

1. From 2001 to 2007, I was employed by CMS, a division of the U.S. Department of Health & Human Services ("HHS"). CMS is the federal agency responsi-

ble for oversight and administration of the Medicare and Medicaid programs.

2. I served as Deputy Administrator of CMS from approximately April 2003 to October 2006, and then as Acting Administrator (the most senior position within CMS) from approximately October 2006 to July 2007. In these positions, I was responsible for managing the Medicare and Medicaid programs, including overseeing policies governing Medicare Part D plans.

3. In 2004 while serving as the Deputy Administrator, I was responsible for drafting the regulations implementing the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("Medicare Modernization Act" or "MMA"). These include regulations cited in Relator's expert reports.

* * *

12. CMS knew that many pharmacies — including Safeway pharmacies — made available to the public special discount prices that may have not been offered to Part D enrollees through their Medicare Part D benefit, but did not require pharmacies to pass on these special discount prices to the Part D Sponsors.

13. CMS is prohibited from interfering in the negotiations between Part D Sponsors and pharmacies and only requires the negotiated price be offered to Part D beneficiaries.

* * *

127. In fact, an email from CMS representative Todd Stankewicz expressly distinguished the "special cash prices" of discount clubs in an email sent directly to Safeway, after Steve Scalzo from the Dominick's

division of Safeway reached out to him for guidance.[136] Mr. Stankewicz said: "The difference between an 'Rx Club' and a program such as Walmart $4 generics is this — everyone who fills an Rx for a generic on the Walmart list gets the $4 pricing. *At some of the Rx clubs you only access the pricing if you enroll in the program,*"[137] and he then provides information about the lower-cash policy, including the footnote discussed above. In other words, Mr. Stankewicz drew a distinction between lower-cash prices that Medicare Part D enrollees could elect to receive by joining a pharmacy discount club, and $4 pricing that would be automatically available to all cash customers. Nothing in this email, sent by a CMS representative, suggested that discount cards were not appropriate "lower cash" options available to Medicare Part D enrollees or that they should be treated like automatic $4 pricing programs. To the contrary, Mr. Stankewicz treated these as entirely separate pricing programs, as did Safeway.

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[136] Deposition of Jessc Talamantez (Aug. 28, 2018), Exhibit 180 (SW PROCTOR 120630).

[137] *Id.* (emphasis added).

[Declaration of Bretta Grinsteinner, dated Nov. 29, 2018, (filed Nov. 22, 2019), Proctor Doc. 176-7, Ex. 7]

Exhibit 7

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS
SPRINGFIELD DIVISION

Case No. 3:11-cv-03406

THE UNITED STATES OF AMERICA, and THE STATES OF CALIFORNIA, COLORADO, DELAWARE, HAWAII, ILLINOIS, MONTANA, NEVADA, NEW JERSEY, NEW MEXICO, VIRGINIA, and the DISTRICT OF COLUMBIA ex rel. THOMAS PROCTOR,

Plaintiffs,

v.

SAFEWAY INC.,

Defendant.

Declaration of Bretta Grinsteinner

I, Bretta Grinsteinner, in accordance with 28 U.S.C. § 1746, affirm that I am over 18 years of age and competent to make the following Declaration.

My Background

1. I have been employed by Prime Therapeutics LLC ("Prime") since April of 2013. I am currently the Assistant Vice President, Network Management, a position that I have held since April of 2016. As Assistant Vice President, my primary responsibilities

involve negotiating contracts and managing relationships with Prime's network pharmacies, including Safeway. I also manage network integrity and manage a team of approximately 65 individuals, directly and indirectly.

2. Collectively, I have nearly 20 years of experience working in the pharmacy benefit management ("PBM") industry, including assembling networks of pharmacies to serve member and negotiating contracts with pharmacies.

3. Prime is currently one of the four largest PBMs in the United States. Prime is owned by several not-for-profit Blue Cross and Blue Shield health plans, subsidiaries, and affiliates.

"Usual and Customary" Pricing

4. Through my work with Prime and in the industry, I am familiar with "usual and customary" ("U&C") pricing.

5. Prime contracts with retail pharmacies for participation in Prime's pharmacy networks, and contracts with the retail pharmacies that participate in its networks.

6. Starting on January 1, 2001, one contract governing the overall relationship between Prime and Safeway was the "Prime Therapeutics, Inc. National Contracting Pharmacy Agreement," effective on January 1, 2001 ("2001 Safeway Contract")

7. A defined term in the 2001 Safeway Contract is "Usual and Customary Charge" The 2001 Safeway Contract defines U&C as "the price that Pharmacy would have charged a particular Covered Person if such person were a cash customer. This includes any applicable discounts including, but not limited to,

senior discounts, frequent shopper discounts, and other special discounts offered to attract customers" Definitions, ¶1.

8. Starting on November 1, 2007, the contract governing the overall relationship between Prime and Safeway was the "Prime Therapeutics, Inc. Pharmacy Participation Agreement," effective on November 1, 2007 ("2007 Safeway Contract")

9. The 2007 Safeway Contract does not define U&C pricing and instead states, "Pharmacy must submit the accurate Usual and Customary Charge with respect to all claims for Prescription Drug Services."

10. These contracts governed all prescription-drug claims administered by Prime Therapeutics on behalf of Medicare Part D, Medicare Advantage, and Managed Medicaid with respect to Safeway claims. The U&C definitions in these contracts did not include competitors' matched prices or membership-club programs

Safeway's Programs

11. At times during the relevant time period of this lawsuit, Safeway pharmacies honored customer requests to match a competitor's price for an individual prescription. Price matching upon customer request can produce a range of prices based on the customer's competitor source, even for the same prescription on the same day.

12. In late 2006, a number of national retailers began advertising very low prices for set lists of commonly prescribed generic drugs. In 2008, certain Safeway pharmacies implemented a $4 generic program similar to those programs. I understand that those generic-program prices were provided to all customers and were treated as Safeway's U&C prices.

Safeway later transitioned to membership programs that required customers to enroll as a member of the program in order to access lower prices for prescription drugs Safeway ceased operating these programs in 2015.

Usual and Customary Price Submission to Prime: Price Matches

13. I was aware that Safeway was not submitting to Prime any price-matched amounts as U&C prices on prescription-drug claims. Prime did not object to this approach because Prime understood that price matching did not meet the definition of U&C, as set forth in the 2001 Safeway Contract, and that the exclusion of price matches would not affect the accuracy of Safeway's U&C submissions under the 2007 Safeway Contract. That is, price matches that honored competitors' prices — upon customer request and on a case-by-case basis — were not "applicable discounts" or "discounts offered to attract customers."

14. Accordingly, Prime understood that Safeway's individualized, customer-initiated price matches did not meet the definition of U&C as set forth in the 2001 Safeway Contract, nor did they affect U&C submissions under the 2007 Safeway Contract.

15. Prime did not view any advertising of the potential availability of price matching as in any way affecting the U&C price. In the same way that Prime did not view price matching as affecting U&C, Prime did not view the advertising of price matching as doing so.

16. Generally, claims for prescriptions filled based on a price match are not submitted to PBMs. Prime had no expectation of Safeway submitting price-

matched claims for Prime's records or for any other purpose.

Usual and Customary Price Submission to Prime: Membership Clubs

17. Prime was aware that Safeway was not submitting its membership-club prices to Prime as U&C prices on prescription-drug claims. Prime did not object to this approach, because Prime did not consider these opt-in prices to be "applicable discounts" or "discounts offered to attract customers" under the 2001 Safeway Contract. Moreover, the exclusion of membership-club prices would not affect the accuracy of Safeway's U&C submissions under the 2007 Safeway Contract.

18. Accordingly, Prime understood that Safeway's membership-club prices did not meet the definition of U&C as set forth in the 2001 Safeway Contract, nor did they affect U&C submissions under the 2007 Safeway Contract.

19. Prime did not view any advertising of the potential availability of membership-club prices as in any way affecting the U&C price. In the same way that Prime did not view membership clubs as affecting the reported U&C price, Prime did not view the advertising of membership clubs as doing so.

20. Generally, claims for prescriptions filled pursuant to membership-club programs are not submitted to PBMs. Prime had no expectation of Safeway submitting membership-club claims for its records or for any other purpose.

* * *

21. Safeway's counsel provided the factual descriptions contained in this declaration about Safeway's

programs and practices. Because Prime did not conduct a specific review of each of Safeway's U&C price submissions during the relevant time period, it is not opining on the factual accuracy of each of Safeway's U&C price submissions during that period.

I declare under penalty of perjury that this Declaration is true and correct.

Dated: 11/29, 2018

/s/ Bretta S. Grinsteinner
Bretta S. Grinsteinner
Assistant Vice President, Network Management
Prime Therapeutics LLC

[Declaration of Brian Swett, dated Jan. 23, 2019, (filed Nov. 22, 2019), Proctor Doc. 176-8, Ex. 8]

Exhibit 8

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS
SPRINGFIELD DIVISION

Case No. 3:11-cv-03406

THE UNITED STATES OF AMERICA, and THE STATES OF CALIFORNIA, COLORADO, DELAWARE, HAWAII, ILLINOIS, MONTANA, NEVADA, NEW JERSEY, NEW MEXICO, VIRGINIA, and the DISTRICT OF COLUMBIA ex rel. THOMAS PROCTOR,

Plaintiffs,

v.

SAFEWAY INC.,

Defendant.

Declaration of Brian Swett

I, Brian Swett, pursuant to 28 U.S.C. § 1746, affirm that I am over 18 years of age and competent to make the following Declaration.

Professional Experience

1. I am currently the Vice President, Performance & Analytics for MedImpact Healthcare Systems, Inc. ("MedImpact"), a pharmacy benefit manager ("PBM") operating in the United States.

2. I have over 13 years of experience in the PBM industry.

3. I have held the position of Vice President, Performance & Analytics since 2015.

4. My current responsibilities include, among other things, managing and tracking client and pharmacy network pricing guarantees.

The Definition of "Usual and Customary"

5. Through my work with MedImpact and in the industry, I am familiar with "usual and customary" ("U&C") pricing.

6. MedImpact contracts with retail pharmacies for participation in MedImpact's pharmacy networks.

7. Starting on September 6, 2007, one contract governing the overall relationship between MedImpact and Safeway was the "MedCare Network Pharmacy Agreement," effective on September 6, 2007 ("2007 Safeway Contract").

8. One defined term in the 2007 Safeway Contract is "Usual and Customary Charge." The 2007 Safeway Contract defines U&C as "the price Member Pharmacy charges at the time of dispensing a prescription to a customer who does not have any form of prescription drug coverage, and excludes all discounts that Member Pharmacy may offer with respect to any particular cash transaction, including, but not limited to, discounts for senior citizens, frequent shopper/cash card programs, matching competitor pricing, and any other discounts." *See* Definitions, Paragraph 1, Page 2.

Safeway's Programs

9. While I am not personally familiar with all of Safeway's various discounts, it is my understanding that at times during the relevant time period of this lawsuit, Safeway pharmacies honored customer requests

to match a competitor's price for an individual prescription.

10. It is my understanding that until approximately 2015 certain Safeway pharmacies also offered a membership program that required customers to enroll as a member of the program in order to access certain prescription drugs at lower prices than those offered to the general public.

11. I understand that Safeway undertook various activities to advertise or promote these discount programs.

12. Based on my understanding of the Safeway discount programs, as described herein, MedImpact does not consider the individual prices charged under either of these programs to meet the definition of usual and customary charge under the 2007 Safeway Contract.

* * *

13. Safeway's counsel provided the factual descriptions contained in this declaration about Safeway's programs and practices. Because MedImpact did not conduct a specific review of each of Safeway's U&C price submissions during the relevant time period, it is not opining on the factual accuracy of each of Safeway's U&C price submissions during that period.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: 1/23, 201~~8~~9

/s/ Brian Swett
Brian Swett
Vice President, Performance & Analytics
MedImpact Healthcare Systems, Inc.

[District Court's Opinion dated Nov. 13, 2020, Proctor Doc. 211]

IN THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF ILLINOIS SPRINGFIELD DIVISION

Case No. 11-cv-3406

UNITED STATES OF AMERICA, and The STATES OF CALIFORNIA, COLORADO, DELAWARE, HAWAII, ILLINOIS, MARYLAND, MONTANA, NEW JERSEY, NEW MEXICO, NEVADA, VIRGINIA, and The DISTRICT OF COLUMBIA, *ex rel*. THOMAS PROCTOR,

Plaintiffs,

v.

SAFEWAY INC.,

Defendant.

OPINION

RICHARD MILLS, United States District Judge:

In an Opinion and Order entered on June 12, 2020, the Court granted the motion of Defendant Safeway, Inc. for summary judgment based on the U.S. Supreme Court's *Safeco*'s decision.

Pending is the Relator's Rule 59(e) motion to alter judgment and for leave to supplement the record.

I.

Federal Rule of Civil Procedure 59(e) allows for the filing of a motion to alter or amend judgment. A judgment under Rule 59(e) may be amended only if the "movant clearly establishes either (1) that the court

committed a manifest error of law or fact, or (2) that newly discovered evidence precluded entry of judgment." *Cincinnati Life Ins. Co. v. Beyrer*, 722 F.3d 939, 954 (7th Cir. 2013). "It does not provide a vehicle for a party to undo its own procedural failures, and it certainly does not allow a party to introduce new evidence or advance arguments that could and should have been presented to the district court prior to the judgment." *Id*.

In its previous Order, the Court held that the objective scienter standard articulated by the Supreme Court in *Safeco Insurance Co. of Am. v. Burr*, 551 U.S. 47 (2007), which addressed the Fair Credit Reporting Act, also applied to the False Claims Act ("FCA"), as some federal courts of appeal have determined. This Court found there was no authoritative guidance that would have warned Safeway away from what was an objectively reasonable position and, therefore, the Relator could not meet *Safeco*'s objective scienter standard and thus could not establish the FCA's "knowing" element as a matter of law. Upon determining that the Relator could not meet the FCA's "knowing" element, the Court concluded that Safeway is entitled to summary judgment.

The Relator contends the Court misapplied *Safeco* by: (1) failing to specifically identify ambiguous language in the applicable statutes, regulations and contracts; (2) accepting Safeway counsel's *post hoc* rationalizations based on inapplicable sources and failing to consider applicable statutes, regulations and contracts in finding that Safeway's litigation position was "objectively reasonable;" and (3) misapplying the appropriate summary judgment standard in determining that no "authoritative guidance" existed to

warn Safeway away from its incorrect interpretation of the law.

Citing *Safeco*, 551 U.S. at 61 and *United States ex rel. Purcell v. MWI Corp.*, 807 F.3d 281, 288 (D.C. Cir. 2015), the Relator asserts a defendant claiming a lack of scienter based on a reasonable but erroneous interpretation of a statute or regulation must satisfy a three-prong test to prevail: (1) ambiguity must be found in the applicable statute or regulation; (2) upon a determination of ambiguity, the defendant's interpretation of that ambiguity must be objectively reasonable; and (3) upon finding ambiguity and an objectively reasonable interpretation, the defendant must show that there was no authoritative guidance warning it away from its incorrect interpretation. The Relator contends all three elements must be established to warrant dismissal for lack of scienter.

The Relator alleges that under *Safeco*, the scienter analysis stops if there is no specific finding of ambiguity in the law. *See Purcell*, 807 F.3d 288. However, *Safeco* does not so provide. Relying in part on *Safeco*, the court in *Purcell* states that the FCA does not "reach those claims based on reasonable but erroneous interpretations of a defendant's legal obligations." *Id*. at 288. Although *Purcell* discussed a contractual term's ambiguity when analyzing the defendant's interpretation of that language, *see id*. at 288-89, *Purcell* did not require a specific finding of ambiguity in the law either. While a law that is subject to multiple objectively reasonable interpretations is necessarily ambiguous, none of the courts applying *Safeco* to the FCA held those issues had to be analyzed separately and none requires an express ambiguity finding separate from an "objective reasonableness" finding. As Safeway points out, the Court determined the law to be

ambiguous upon holding Safeway's interpretation was objectively reasonable because "[a]mbiguity exists if a provision is subject to reasonable alternative interpretations." *Grun v. Pneumo Abex Corp.*, 163 F.3d 411, 420 (7th Cir. 1998).

The Court finds no basis to revisit its prior finding that the law regarding usual and customary pricing was ambiguous before *United States ex rel. Garbe v. Kmart*, 824 F.3d 632 (7th Cir. 2016). After the district court in *Garbe* identified three issues for interlocutory appeal, the Seventh Circuit added the issue of "whether the district court correctly identified the 'usual and customary' price." *Garbe*, 824 F.3d at 637. As this Court observed, by adding that issue to the others, "the Seventh Circuit appeared to determine the issue of generic drug discount programs and usual and customary price was sufficiently debatable to be addressed." *U.S. ex rel. Schutte v. SuperValu, Inc.*, 2020 WL 3577996, at *9 (C.D. Ill. July 1, 2020). The Court is unable to conclude it committed a manifest error of law or fact.

The Relator next alleges the Court made no finding that usual and customary definitions in Medicare Part D contracts are ambiguous. The Seventh Circuit's reference to Medicare Part D regulations and contracts that impose legal obligations upon parties participating in Medicare Part D is borne out of duly noticed and promulgated regulations. *See* 42 U.S.C. § 423.1(b); 42 C.F.R. § 423.505(a); 42 C.F.R. § 423.505(i)(4)(iv). The Relator claims that the requirement in 42 C.F.R. § 423.505(i) that all participants in Medicare Part D "must comply" with applicable laws, regulations, and CMS instructions was discussed in the Relator's opposition to Safeway's motion for summary judgment, but not addressed in the Court's Opinion. Moreover,

Part D contractors must comply with Part D contract terms and CMS instructions as a matter of law.

As Safeway notes, the Relator did not include the Pharmacy Benefit Manager ("PBM") contracts as part of the record so the Court could not have evaluated the contractual terms. In his response to Safeway's summary judgment motion, the Relator cited PBM notices and provider manuals and not contracts. The brief cited just two PBM contracts, neither of which defined usual and customary price as including applicable discounts, and one proposed amendment to a Pharmacy Network Agreement with the State of Oregon. Accordingly, the only contracts in the summary judgment record were consistent with Safeway's objectively reasonable interpretation of the law. The Relator has not shown that the Court committed manifest error.

II.

The Relator requests leave to introduce Sealed Exhibit A, which consists of over 800 pages, and is described by the Relator as a summary of applicable terms from Government Healthcare Provider contracts between PBMs and Safeway, combined with excerpts from those contracts. The Relator states that he planned to attach Exhibit A to his motion for summary judgment, but never had the opportunity to file a substantive motion because the briefing on the motion under *Safeco* was prioritized over other dispositive motions.

In August 2019, the Court notified the Parties that the dispositive motions deadline would be postponed for two months to account for the possibility that the rulings on the summary judgment motions in *U.S. ex rel. Schutte v. SuperValu*, Case No. 11-cv-3290, will affect the scope of the rulings in this case.

Subsequently, Safeway requested and obtained further extensions of the dispositive motion deadline.

In November 2019, Safeway filed the motion for summary judgment based on *Safeco* contemporaneously with a request that it be prioritized over the summary judgment motions in *Schutte* that had been pending over a year. Safeway's request was granted. The Relator claims that the *Safeco* motion was moved to the front of the line ahead of the scheduled summary judgment filing deadline when Relator would have filed his broader motion for summary judgment with a more comprehensive record of binding contract terms that required Safeway to comply with Medicare Part D rules, regulations and CMS instructions.

The Relator states that, based on the unique procedural posture of dispositive motions at the time the *Safeco* motion was granted and the fact that the Parties agree that the contracts are relevant, there is good cause to grant the Relator leave to file Exhibit A.

The Relator had an opportunity to file the documents in Exhibit A as part of his opposition to Safeway's motion for summary judgment, but did not do so. A party should not "sit on potentially relevant evidence and allow the court to go forward with its decision, and then turn around and criticize the court for ruling without the benefit of that same evidence." *Hecker v. Deere & Co.*, 556 F.3d 575, 590 (7th Cir. 2009). Rule 59(e) "does not provide a vehicle for a party to undo its own procedural failures." *Beyrer*, 722 F.3d at 954.

Because the Relator could have included the exhibit as part of his response to Safeway's motion for summary judgment, the Court will deny the motion to supplement the record.

Ergo, the Relator's motion for leave to alter judgment and for leave to supplement the record [d/e 204] is DENIED.

ENTER: November 13, 2020

FOR THE COURT:

/s/ *Richard Mills*
Richard Mills
United States District Judge

[Supplemental Declaration of Bretta Grinsteinner, dated Nov. 29, 2018 (filed Jan. 6, 2020), Proctor Doc. 195-20, Ex. L]

***

I, Bretta Grinsteinner, pursuant to 28 U.S.C. § 1746, hereby affirm that I am over 18 years of age and competent to make the following Supplemental Declaration.

1. Attached as Exhibit A is a copy of a Declaration I signed on November __, 2018 in my capacity as Assistant Vice President, Network Management, Prime Therapeutics LLC ("Declaration"). The Declaration was executed in response to a letter from Rick Robinson, counsel for Defendants in the above-referenced matter, dated ____ __, 2018 to Prime Therapeutics LLC ("Robinson letter") and subsequent communications with Defendants' counsel.

2. As stated in paragraph 21 of the Declaration, Defendant's counsel provided the factual descriptions contained in the Declaration about Defendant's programs and practices. With respect to the statements in paragraphs 10 and 13-20 of the Declaration, I have no personal knowledge regarding the accuracy of any representations made by Defendant or Defendant's actual price matching practices and membership programs. Plaintiff's counsel has offered to provide information and documents regarding Defendant's price matching practices and membership programs. Prime did not conduct a review of Safeway's price matching practices or membership programs during the relevant time period and is not opining on Defendant's compliance with

Usual & Customary (U&C) reporting regulations and requirements. Accordingly, the Declaration should not be construed as a determination of the propriety of Defendant's U&C price reporting.

Executed in Dakota County, State of Minnesota, on the ___ day of November 2018.

Dated: Nov. 29, 2018 /s/ Bretta Grinsteinner

Bretta Grinsteinner

Assistant Vice President, Network Management

Prime Therapeutics LLC