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Chain Pharmacy in New York State: Improving Health

Testimony for the Joint Legislative Budget Hearing on Health/Medicaid

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Hearing Room B

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Honorable Chairmen DeFrancisco, Farrell, Hannon and Gottfried and other distinguished members of the Committees, my name is Kathy Bryant. I am a pharmacist, Vice President for Pharmacy Services at Price Chopper and an Officer of the Chain Pharmacy Association of New York State. We would like to thank you for your past support of community pharmacy in New York and for the opportunity to testify today related to the SFY 2014-15 State Budget and our priorities in this regard.

We would first like to provide some background on our industry in New York State and highlight a number of priority issues that affect community pharmacies and the services they provide.

There are approximately 4,019 community pharmacies, chain and independent, across New York State which collectively employ over 137,508 full and part-time workers including almost 11,253 pharmacists. Chain pharmacies specifically employ 126,486 of the employees in New York and contribute $8.16 billion of the $8.72 billion in total taxes paid by pharmacies to New York State annually. New York's community pharmacies play a vital role across the state providing high quality pharmacy care to our residents. The services provided by pharmacies help to keep people healthy in the community, as well as preventing other more costly health interventions such as hospitalizations and emergency room and doctor office visits.

Community pharmacies are the face of neighborhood health care. The innovative programs of chain pharmacies deliver unsurpassed value - improving health and wellness and reducing health care costs. Through face-to-face counseling, the pharmacist-patient relationship helps ensure that patients take their medications correctly. This improved medication adherence means a higher quality of life and the prevention of costly treatments. Innovative community pharmacy services - vaccinations, health education, screenings, simple laboratory examinations and procedures, disease management and more - also make up the health care delivery system of tomorrow.

Fair Payment to Pharmacies

The Chain Pharmacy Association of New York State respectfully requests the State Senate and Assembly's assistance in rejecting a very problematic and inaccurate new pharmacy reimbursement proposal by the State Department of Health through the SFY 2014-15 State Budget in order to protect pharmacy care in New York State. The Department currently plans to implement new reimbursement levels on April 1, 2014.

As background, in the FY 2011-12 Final Budget, the New York State Department of Health (NYSDOH) was given authority to move away from the current Average Wholesale Price (AWP) benchmark for prescription drug reimbursement under Medicaid Fee-for-Service (FFS) to pursue an invoice-based pricing methodology called Average Acquisition Cost (AAC). In addition, the Commissioner was granted authority to establish the payments and dispensing fees for prescription drugs upon giving 60 days notice to the Legislature of a change in reimbursement. Pharmacies strongly opposed this provision.

Following passage of the 2011-12 Budget, NYSDOH began working to implement this initiative including developing the survey tools for requesting pharmacy invoice prices in order to

determine the AACs and pharmacies' costs of dispensing. During this time, pharmacy associations, focus group members and others submitted pointed criticisms of the NYSDOH's methodology, data they were requesting and their unwillingness to include certain pharmacy costs in their Cost of Dispensing survey. With few exceptions, our recommendations were not included in the final surveys. Further, we have continually questioned their rationale for devoting all of the staff time and resources to pursuing this initiative when the majority of individuals with Medicaid have been transitioned to Managed Care (a major undertaking and very challenging transition for pharmacies) with a schedule in place to transition nearly all into Managed Care in the near future.

A year ago, NYSDOH began surveying the state's pharmacies requiring them to submit the invoice and dispensing data for analysis by NYSDOH and its paid consultants at First Databank and Ernst & Young. This has been a very laborious and costly process for the state's pharmacies given the volume of information being requested, time involved to collect, input and submit it to the State and the threat of audits and sanctions for failure to complete the surveys within the time periods established by the Department.

On December 3, 2013, NYSDOH provided a PowerPoint presentation to pharmacy associations and the focus group members. They provided the proposed AAC prices for the top 100 brands and top 100 generics paid by Medicaid FFS by cost and the proposed dispensing fees that would be paid to pharmacies. They stated their goal is to promulgate regulations and request review/approval of their proposal from the Centers for Medicare and Medicaid Services (CMS) for implementation **April 1, 2014.**

Following the meeting, pharmacies compared the proposed AACs and dispensing fees to their actual costs which sparked a significant negative reaction from all participants from all pharmacy types calling the proposal fundamentally flawed and lacking credibility. Our organization joined with the other state pharmacy associations, together representing the vast majority of pharmacies in New York State and developed a detailed letter raising grave concerns with the proposal which was sent to the Commissioner on December 23rd. We have sought the expertise of a New York statistician who has reviewed the PowerPoint Presentation and other limited information provided to us by NYSDOH about how they arrived at their proposed reimbursement levels. He has identified a number of issues of concern and requested specific additional information on the methodology and analysis which we requested in a subsequent letter to NYSDOH sent on January 21st. At this point we have not heard back from NYSDOH on the many questions and concerns that we raised as well as our information request. We are hopeful that we will have the opportunity to meet directly with the Health Commissioner and Medicaid Director soon, as we have also requested.

Below we have attempted to outline our many concerns. **We respectfully request the Legislature's assistance in rejecting this flawed and inaccurate proposal through the FY 2014-15 Budget in order to protect pharmacy care in New York State.**

INACCURATE AND UNFAIR PROPOSED PRODUCT COST REIMBURSEMENT

- Consensus among pharmacy community that NYSDOH proposal is below what pharmacies pay to acquire the drugs.

- Other states have pursued AACs and CMS has conducted its own AAC survey. New York is the only state to request pharmacy rebate information in addition to invoice prices. Rebates are not reliable, can change monthly and cannot be extrapolated. As we informed NYSDOH, there is not a consistent way for pharmacies to report and the State to apply rebates to all drugs and CMS and other states do not use them. **We believe inclusion of rebates is major cause of below-cost AACs.**
- Proposed AAC prices are based on a rolling 3-month average of surveyed prices so they will always be outdated and inaccurate and will not keep pace with actual drug prices.
- According to NYSDOH, the process for appealing inaccurate AACs will be pharmacy by pharmacy, drug by drug and adjustment will only be made for the one pharmacy for the claim being appealed.

INACCURATE AND UNFAIR PROPOSED DISPENSING FEE REIMBURSEMENT

- During December presentation, NYSDOH stated that initial mean dispensing fee found by their statisticians for New York was $11.01. This seems consistent with the results of a 2006 national study which concluded that New York's dispensing fee should be $10.96 (and actually since the study is eight year old we would expect the fee to be higher now as prices go up). The initial mean of $11.01 is also consistent with the dispensing fees paid by the other six states that have AAC in place which are in the $10 and $11 ranges or higher.
- After determining the initial mean value of $11.01, NYSDOH then admitted to "smoothing" and "normalizing" the data which we believe manipulated the dispensing fee and they admitted reduced the mean by about $2. Then NYSDOH decided not to use the mean but rather to use the median point of the data which was found to be $8.01 ($3 less than the initial mean value found prior to policy decisions and data manipulations made).
- Other troubling results were shared. The NYSDOH analysis found that it is cheaper to dispense drugs in Rochester NY than in New York City, cheaper to dispense drugs in New York than Alabama, Louisiana, Idaho and other states with AACs in place and cheaper to dispense drugs in long term care pharmacies than in community pharmacies by $2. CMS requires long term care pharmacies to meet a number of additional standards and provide additional services and costs are higher.
- We believe that **these results defy logic, particularly when *Chief Executive* ranked New York 49th among Business-Friendly states with only California ranked worse at 50th. The results call into question the overall credibility and reliability of NYSDOH's analysis and proposal.**
- Finally, NYSDOH took the $8.01 median dispensing fee and arbitrarily decided to establish a tiered dispensing fee by pharmacy volume whereby in 76% of pharmacies with higher annual volumes, the fee paid per prescription will be $6.77 or $8.33 and in 24% of pharmacies it will be $14.11 (a nearly $8 difference between the highest and lowest volume pharmacies). While this proposal attempts to set up winners and losers, the consensus among the state's pharmacies is that when the proposed AACs and dispensing fees are taken together it is patently unfair and inadequate to cover costs.

IMPACT

- Consensus that proposed AAC/dispensing fee reimbursement is below actual costs so pharmacies are being asked to provide majority of drugs under Medicaid FFS at a loss. What business could survive such a payment model?
- This is on top of uncollectible Medicaid co-payments approximately 50% of the time.
- If proposed AAC/dispensing fees are established as a fair and accurate New York benchmark, they will have a ripple effect and be used by Medicaid Managed Care and commercial plans.
- Impact could be pharmacy closures and job losses, leading to patient access issues.
- Pharmacies are now asking NYSDOH about their rights to only participate in Medicaid Managed Care and not accept Medicaid FFS patients or opt to only serve Medicaid FFS patients in certain pharmacies (presumably if they have any lower volume pharmacies and would be paid $14.11). Pharmacies are also contemplating what services they would need to discontinue for all their patients to make up for losses if this proposed is enacted.
- CMS has been clear that states moving to AAC reimbursement "*would... be required to substantiate how their dispensing fee reimbursement to pharmacy providers reasonably reflects the cost of dispensing a drug and will ensure access for these drugs to Medicaid beneficiaries*." **We strongly believe that the NYSDOH proposal does not meet this requirement.**

In sum, we respectfully ask for your assistance in rejecting this highly flawed pharmacy reimbursement proposal by NYSDOH, which will jeopardize pharmacy care, through the FY 2014-15 Budget.

As a counter proposal to further decreases in pharmacy reimbursement levels, we believe New York should instead consider how pharmacists are currently being underutilized and can do so much more to improve patient care and access and reduce unnecessary hospitalizations and other more costly care. Provided below are several proposals which we believe will help move the role of pharmacists into the future and produce the real, systemic cost savings that year after year pharmacy reimbursement reductions do not.

Recognize Pharmacists as Providers

In recent years, pharmacists have played an increasingly important role in the delivery of health care services. For example, the administration of immunizations by pharmacists has gained broad public favorability, and more gradual advancements have been made in the acceptance of services such as medication therapy management (MTM). However, the lack of pharmacist recognition as a provider by third party payors including Medicare and Medicaid has limited the number and types of services for which pharmacists may be paid.

While pharmacies and pharmacists do not have provider status in Medicare, they are providers of services that go well beyond dispensing prescription drugs. Pharmacists provide MTM services to Part D beneficiaries and are authorized to administer immunizations. In addition, in Medicare Part B, pharmacies are recognized as suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), as well as mass immunizers. Pharmacies, as opposed to pharmacists, in their role as Part B suppliers, are able to provide diabetes self-management

training services so long as certain requirements are met. Pharmacies in their role as a "mass immunizer" provide certain immunizations to Part B beneficiaries.

Although pharmacists provide these services, reimbursement is to the pharmacy as a "supplier" or a "mass immunizer" and not to the pharmacist as a "provider." We believe that lack of provider status limits the ability of pharmacists to be paid for many other potential services they are trained to provide. Therefore, **we urge New York to support federal efforts to recognize pharmacists as providers, permitting them to bill Medicare directly for services performed under Medicare Part B.** Because Medicaid determines its recognition of providers on the Medicare definition, gaining provider status in Medicare may lead to recognition in the Medicaid program as well as in commercial plans.

Reform and Expand Pharmacist-Administered Vaccines

As the face of neighborhood health care, community pharmacies and pharmacists provide accessible and cost-effective health services including immunizations to their local communities. Community pharmacists in particular are valuable members of the health care team who have an important role to play in providing immunization services. Highly educated to provide patient care services, pharmacists are well-suited to help states increase their vaccination rates and reduce the incidence of vaccine preventable diseases. Notably, the Centers for Disease Control and Prevent (CDC) reports that vaccines have reduced or eliminated many infectious diseases that once routinely killed or harmed thousands each year; according to data collected by CDC, pharmacists have been instrumental in increasing the vaccination rate in the United States. Unfortunately, pharmacists are still limited in their ability to further increase vaccination rates by state laws and rules that restrict the age of patients who pharmacists can vaccinate and the vaccines that pharmacists can offer. Pharmacists should be allowed to practice to the maximum of their capabilities-partnering with other health care providers in coordinated efforts to decrease the number of under-vaccinated New Yorkers.

We strongly support allowing pharmacists to provide immunizations to those aged 11 years and older and to expand the types of vaccines that may be provided by pharmacists to all recommended by the CDC for this population. Laws and regulations that limit the ability of pharmacists to administer vaccinations should be amended to enable pharmacists to make a broader impact on vaccination rates.

Pharmacists Should be Permitted to Administer Vaccines to Adolescents

As noted in an article published in the official Journal of the American Academy of Pediatrics, the current health care system has not adequately met the vaccination needs of the adolescent population in the United States over the years. Overall vaccination rates could potentially be increased through complementing the efforts of primary care physicians with the efforts of other health care settings to deliver vaccines, such as pharmacies.

Pharmacists Should be Permitted to Administer Immunizations to the Public in Accordance with the CDC's Recommended Immunization Schedules for Adolescents and Adults

This will allow pharmacists to serve the many patients who go unvaccinated, because they do not have the time to schedule an appointment with their physician. As evidenced by the increase in influenza vaccinations once pharmacists were permitted to administer them in New York, pharmacies provide an easily accessible location for the public to obtain immunizations at their convenience.

Not only would these changes benefit public health goals by reducing the number of unvaccinated residents, but expanding pharmacists' authority in this regard could help meet growing patient demand for health care services faced by all providers as a result of health care expansion under the Patient Protection and Affordable Care Act.

Expanding pharmacists' vaccination authority can also lead to decreased health care costs for consumers, health insurers and other third party payors, including Medicaid. As noted by the Department of Defense in a 2011 final rule expanding the portfolio of vaccines that TRICARE beneficiaries may obtain from community pharmacies, significant savings were achieved under the TRICARE program when the program was first implemented to allow beneficiaries to obtain flu & pneumococcal vaccines from retail pharmacies. It was estimated that for the first six months that beneficiaries could obtain their vaccinations from pharmacists, 18,361 vaccines for H1N1, flu & pneumococcal were administered at a cost of nearly $300,000; had those vaccines been administered under the medical benefit, the cost to TRICARE would have been $1.8M. This clearly represents significant health care savings, which one would expect to be amplified and replicated if pharmacists were allowed under state laws to provide a broader portfolio of vaccines and/or immunize a broader patient population. (This would be on top of savings that would result from fewer hospitalizations and lost days at work due to more patients obtaining immunizations.) Likely this is why the Department of Defense opted to expand the types of vaccines that TRICARE beneficiaries may obtain from community pharmacies to include all CDC-recommended vaccines.

Reform Existing Pharmacist Immunizer Laws in New York

In addition to expanding the immunizations that pharmacists are allowed to administer, we urge reforms to existing laws to remove the sunset dates around pharmacist administered immunizations. Further, the requirement that the standing order given to a pharmacist must be from a physician or Nurse Practitioner (NP) in the same county is unnecessarily onerous and can be difficult to obtain. We urge that the law be changed to allow for statewide standing orders. Finally, we urge that all immunizations be permitted under a standing order. Currently the vaccine against shingles requires a patient-specific prescription.

Immunizations are the best defense against morbidity and mortality for diseases for which vaccines are available and we must remove all barriers to significantly increase vaccination rates among our population.

Collaborative Practice Agreements

Pharmacists are trained and well-qualified to provide limited, specific drug therapy management services and other prevention and wellness activities in collaboration with a patient's physician and other health care providers. In states where this type of practice is permitted, the services

offered by community pharmacists deliver unsurpassed value – improving the health and wellness of patients while reducing health care costs. Pharmacists should be permitted to practice to the fullest extent of their training; to permit this we support language in Pharmacy Practice Acts that allow physicians and pharmacists to enter into "Collaborative Practice Agreements" with one another for pharmacists to provide collaborative drug therapy management (CDTM).

Collaborative practice agreements are written agreements between a pharmacist or pharmacy and a physician or group of physicians wherein pharmacists work in collaboration with physician(s) to manage patients' drug therapy. Currently, 35 states allow these types of arrangements in a community pharmacy setting. In New York such agreements are permitted only for teaching hospitals. Under collaborative practice agreements, pharmacists are generally permitted to modify drug therapy in accordance with written guidelines; conduct tests and screenings; and order lab work in accordance with written guidelines or protocols agreed to by physicians in collaborative practice agreements. Physicians have ultimate authority to further delineate the activities that pharmacists may and may not perform in accordance with the law under the collaborative practice agreement. Under this type of arrangement, pharmacists serve as physician extenders and help to monitor and carry out physicians' drug therapy plans for their patients.

It bears noting nearly all states permit physicians' assistants and nurse practitioners to work collaboratively with physicians to modify a patient's drug therapy. Pharmacists, who have more education and training than any other health care provider on medications and their effects on the human body, should be granted this same opportunity.

Patients, physicians, and the health care system as a whole benefit from the use of collaborative pharmacy practice agreements, as this type of arrangement offers a safe, convenient, and cost-effective way to address patients' drug therapy problems. Community pharmacists continue to be regarded as one of the most trusted health care professionals in the nation. Pharmacists are capable of performing the tasks which collaborative practice agreements require.

Collaborative practice agreements improve patient care in a variety of ways. Research has shown that approximately one-third to one-half of all patients in the United States do not take their medication as prescribed by their providers. Pharmacy services administered by pharmacists in community pharmacies have been proven to improve compliance and prevent unnecessary hospitalizations caused by drug misuse. Collaborative practice agreements are another mechanism to increase the opportunities for pharmacists to contribute their expertise to drug therapies in this regard.

CLIA-Waived Testing

With the rise of chronic disease, many providers and national associations recommend regular health testing, and the convenience of community pharmacists increases the public's access to this vital service. There are many types of health tests available to the public and administered by various providers. Some common health tests provided by community pharmacist include, among others, blood glucose, A1C (diabetes), cholesterol and lipid panels, and body

composition. In addition, community pharmacists may provide consultation as to the results and follow-up with a primary care provider.

The federal government regulates clinical health testing performed on humans in the US through the Clinical Laboratory Improvement Amendments (CLIA) which sets quality standards for testing regardless of where the test was performed. Some health tests are so simple, accurate and safe that they are "waived" from CLIA requirements. All tests provided by community pharmacists are CLIA-waived, including the common tests listed above.

Although the CLIA program is a federal program and health testing providers must comply with federal laws, New York has implemented additional requirements creating barriers for pharmacists to provide these simple health tests. This includes a requirement that a physician order is required before a test can be conducted so patients may not request a CLIA-waived test for educational and self management purposes. In addition, while pharmacists are permitted to conduct select tests under the Limited Services Laboratory License, the direction of these activities would need to be conducted under a Lab Director such as physician with laboratory experience. We recommend that New York align its regulations with the federal requirements to make it easier for pharmacists to provide this safe, cost-effective health service to our patients.

Pharmacy Technicians

We believe that it is critical that pharmacy technicians be properly trained so that they can accurately and effectively perform their duties. Both chain and independent community pharmacies have developed and implemented comprehensive pharmacy technician training. In New York, we would support the registration of all pharmacy technicians. Also we support certification for technicians in exchange for expanded duties and an expansion of the pharmacist to technician ratio in New York. We have provided specific recommendations in this regard below.

Technician Training: Flexibility and Options are Key

Since pharmacy technicians work in a number of different pharmacy settings, our Association supports flexibility in the options and means for pharmacy technicians to satisfy board-imposed training and evaluation requirements. Boards of pharmacy should allow employer-based pharmacy technician training programs and evaluation exams. These programs provide technicians with hands-on training and interaction with pharmacists. They offer the advantages of teaching general and specialized skills that prepare technicians to work in particular practice settings.

Train Pharmacy Technicians for their Individual Practice Setting

According to the American Society of Health-System Pharmacists (ASHP) website, ASHP represents "pharmacists who practice in hospitals, health maintenance organizations, long-term care facilities, home care, and other components of health care systems," but not retail or community settings. While training programs accredited by ASHP may be well suited to train pharmacy technicians working in some pharmacy practice sites, and particularly in institutional settings, this may not be the best option for every practice site. Some community pharmacies have determined that an ASHP accredited training program best meets their pharmacies' needs and have therefore taken

steps to have their individual training programs accredited. However, there are many other community pharmacies that use different types of training programs. All pharmacies should be allowed to utilize pharmacy technician training programs which meet the specific needs of their pharmacy so that their employees are well trained to perform the duties expected of them.

Expand Pharmacist to Technician Ratios
In the community pharmacy setting, the extent to which pharmacists are able to engage in direct patient care activities is dependent upon pharmacists' ability to delegate non-judgmental tasks to technicians. For this reason, we support the ability of pharmacists to supervise as many technicians as they can safely monitor. New York currently has a very strict two to one pharmacist to technician ratio in place.

The concept of a pharmacist to technician ratio is an antiquated one that is no longer appropriate in today's pharmacy practice environment; arbitrary ratios prevent pharmacies from maximizing use of pharmacy technicians to perform non-discretionary tasks so that pharmacists may focus on providing cognitive services to their patients. Many state boards of pharmacy, recognizing this to be true, have over the years relaxed or eliminated restrictive ratios to allow for optimal use of pharmacy technicians. Other groups, including the National Association of Boards of Pharmacy (NABP), share the view that the pharmacist to technician ratio should be eliminated entirely.

Elimination of pharmacist to technician ratios will enable pharmacists to focus more on counseling patients, performing medication therapy management, providing disease management programs, engaging in other important pharmaceutical patient care services, and conferring with other health care professionals, thus permitting a higher level of service to patients. These services offered by community pharmacists help patients better adhere to their medication regimens and ultimately serve to improve patients' health and wellness and reduce our nation's health care costs. We urge New York to work to eliminate arbitrary limits on the number of technicians that pharmacists can oversee, as ratios hinder pharmacists' ability to best serve their patients.

Conclusion
The Chain Pharmacy Association of New York State and our member companies would like to thank the State Senate and Assembly for your continued support of community pharmacy. We wholly support reimbursement rates that are fair and adequate to the quality and comprehensive pharmacy services that our members provide. For this reason, we ask that you **reject the very problematic and inaccurate new pharmacy reimbursement proposal** by DOH, through the SFY 2014-15 State Budget, in order to protect pharmacy care in New York State. We also urge the State to consider our recommendations to expand patient access to care through expanded pharmacist-administered immunizations, pharmacist MTM and CDTM services and routine testing to increase low vaccination rates and patient medication adherence and reduce more costly institutional care. We welcome the opportunity to provide any further assistance or information that would be helpful and look forward to continuing to partner with you to ensure the highest quality of pharmacy care for all New Yorkers.