Chain Pharmacy in New York State

Community Pharmacists:
Among the Most Trusted and Accessible
Health Care Professionals
Focused on Medication Safety and Improved
Patient Outcomes

Testimony for the
Joint Legislative Budget Hearing on Health/Medicaid

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Hearing Room B

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Honorable Chairwoman Young and Chairmen Farrell, Senator Hannon, Assembly Member Gottfried and other distinguished members of the Committee, my name is Mike Duteau. I am a pharmacist, Vice President of Business Development and Strategic Relations at Kinney Drugs and President of the Chain Pharmacy Association of New York State. We would like to thank you for your strong past support of community pharmacy in New York and for the opportunity to testify today related to the State Fiscal Year (SFY) 2017-18 State Budget.

The Chain Pharmacy Association of New York State and our member companies across the State are focused on protecting patient access to pharmacy care and strengthening the role that pharmacists can play in improving patient health outcomes while reducing costs. In this regard, we would like to comment on four specific proposals in the Executive Budget as outlined below.

(1) Proposal to Change Pharmacy Reimbursement under Medicaid fee for service (FFS) to a cost-based reimbursement with a professional fee

- The Chain Pharmacy Association of New York State is opposed to the new pharmacy reimbursement formula proposed in the Executive Budget which ***fails to provide fair and adequate reimbursement to community pharmacies*** for the services they provide to those enrolled in Medicaid FFS.

- The Executive budget proposes to change to cost-based reimbursement for prescription drugs pursuant to the CMS Covered Outpatient Drug Final Rule using the National Average Drug Acquisition Cost (NADAC) benchmark for product cost reimbursement and proposing a $10 professional fee per prescription. Importantly, where no NADAC exists for a drug, the state would use the Wholesale Acquisition Cost (WAC) benchmark discounted by 3.33% for brand drugs and by 17.5% for generics. Finally, the new professional fee would apply to all prescriptions drugs and some over the counter OTC) drugs that meet the federal definition of covered outpatient drug.

- The state's decision to use NADAC represents a *significant reduction* in pharmacy reimbursement from the current formula. NADAC, taken alone would have a dramatic impact on operating margins of community pharmacies that are already razor-thin. DOH has stated that they expect to *save $48 million gross* per year by moving to NADAC for product cost reimbursement. As other states have moved to NADAC they have at the same time provided an adequate total reimbursement for pharmacies based on a fair professional fee and a fair benchmark alternative when no NADAC exists for a drug. Unfortunately, New York's proposal does not and could result in pharmacies being reimbursed *below* the cost to acquire and dispense prescription drugs in Medicaid by *at least $3.4 million.*

- Here are the facts with our recommendations underlined:
  - Many other states that have already received CMS' approval to use NADAC generally use WAC – 0% as an appropriate substitute when there is no NADAC. New York's proposal to discount WAC to minus 3.33% for brands and minus 17.5% for generics, is likely to reimburse pharmacies below cost for new, often very high cost or specialty drugs which could be devastating to pharmacies and their ability to continue to stock these drugs to serve patients. <u>We strongly recommend that New York use WAC without a discount in these instances</u>.

- A number of other states that have or are moving to NADAC are providing pharmacy professional fees higher than New York's proposed $10. Such states have fees ranging from near or exceeding $11 and up to $12, $13 or higher. Notably, according to the Tax Foundation's 2017 Index, New York ranks among the very highest (49th) on its cost burdens for businesses. Given this, we would expect New York to pay a professional fee higher than these other southern and Midwestern states, yet at $10 we would unfairly be among the lowest. The proposed professional fee must be increased to reflect the actual costs of dispensing drugs and other professional services provided by pharmacies.

- The proposed $10 professional fee is based on the findings of the 2012 New York State Cost of Dispensing Survey, which the Legislature rejected and prohibited the use of due to many concerns regarding the statistical validity of the study. The 2012 NY survey should not be able to be utilized in the development of New York's new pharmacy reimbursement methodology.

- DOH has said that the professional fee proposal of $10 will cost $59 million gross. That is $44.6 million for prescription drugs and $14.4 million for the new fee that would need to be paid for OTCs per the federal rule which would not directly offset losses on the prescription drug side. At the same time DOH is proposing to reduce Medicaid OTC coverage saving about $12.6 million, close to the amount they would spend on the OTC professional fee.

(2) Proposal to Impose a Surcharge on Certain Drugs Deemed as High Cost Drugs on Establishment Making First Sale of Drug in the State

- The Executive Budget includes a proposal to cap pharmaceutical costs for certain drugs deemed to be "high cost" by identifying a benchmark price and imposing a 60% surcharge on the difference between the benchmark and the manufacturer's price. We recognize that prescription drugs can be very expensive. They are expensive for pharmacies to purchase and expensive for consumers to access. We support efforts to bring down these costs to ensure that pharmacies can afford to stock them and that the patients who need these lifesaving therapies can access them.

- While supportive in principle, upon reviewing the Executive Budget proposal we are concerned that when it defines "establishment" for the purpose of identifying the entity which would be responsible for paying the surcharge if they are the one making the "first sale in the state" of the drug, it goes beyond manufacturer and would apply to a pharmacy if it is the entity making that first sale. Pharmacies cannot be placed in this position.

- Expensive drugs are not expensive because pharmacies price them at a high level. Manufacturers set the price. When a patient comes to pick up their prescriptions, the pharmacy submits the claim to the patient's public or commercial insurance plan and then charges any required copay/ coinsurance. The payer then remits payment to the pharmacy. The pharmacy is not a price setter by any means. Pharmacies merely pay the price for the drug charged to them by the wholesaler/manufacturer so they can stock the drug and then hope that what they will be reimbursed for the drug by the payer is enough to cover their costs. This surcharge could impact patient access to these expensive drugs if pharmacies are unfairly penalized in a manner that forces them to subsidize manufacturers' high prices.

- We believe that well-intended efforts to reduce the cost of drugs deemed "high cost" should be focused on the manufacturers without putting pharmacies at risk for having to pay a tax.

(3) Proposal to Create a Program for Improved Management of Medications for Patients with Chronic Diseases

- We support the Executive Budget proposal to create a program for patients with a chronic disease(s) who have not met clinical goals, are at risk for hospitalization, or are otherwise deemed in need of greater medication adherence services to be referred by a physician or nurse practitioner (NP) to a qualified pharmacist to provide comprehensive medication management services, pursuant to a written service protocol with the physician or NP. Participation by patients and the providers would be voluntary and having integrated medical records between the pharmacist and physician or NP for the patient would be required to ensure integration and real-time communication.

- It is estimated that the cost of avoidable medical spending for drug-related problems in the ambulatory setting totals nearly half a trillion per year and contributes to as many as 1.1 million deaths annually in this country. Drug-related problems include untreated conditions, improper drug selection, sub-therapeutic dosage, failure to receive prescribed drugs, over dosage, adverse drug events, drug interactions and drug use without indication. The IMS Institute estimates that savings from appropriate medication use could actually cover most of the $374 billion (2014) spent on medications annually. More importantly, appropriate use will save lives and improve health.

- More than two-thirds of the states in this country allow community pharmacists to have written agreements/protocols with medical practitioners that authorize them to provide services similar to what is being proposed through this program.

- New York currently allows pharmacists employed by or affiliated with hospitals and certain nursing homes (with on-site pharmacies) to enter into collaborative practice agreements with physicians. This is not currently allowed for community pharmacists.

- Importantly, this proposal is more limited in scope than the hospital program. This proposal authorizes a patient specific protocol and the patient would be specifically referred by their physician. Also this proposal is limited to those patients with a chronic condition(s). Finally, the qualification requirements in this proposal are more specific to the services pharmacists would be providing in the community setting for a less complex, low acuity patient population, as compared to those in the inpatient setting.

(4) Proposal to Regulate Pharmacy Benefit Managers

- We support the Executive Budget proposal to regulate Pharmacy Benefit Managers (PBMs) in New York. Specifically, the proposal would initially register PBMs and later license them. Also the proposal would impose a series of reporting requirements and the Department of Financial Services would establish minimum standards for all PBMs to follow to ensure they operate with fair and legal business practices. Failure to comply with such requirements could result in revocation of registrations or licenses.