

Carrie Rand-Anastasiades - Executive Director
Testimony Before The Human Services Committee
Re: SB 392 AAC Pharmacy Medicaid Reimbursement

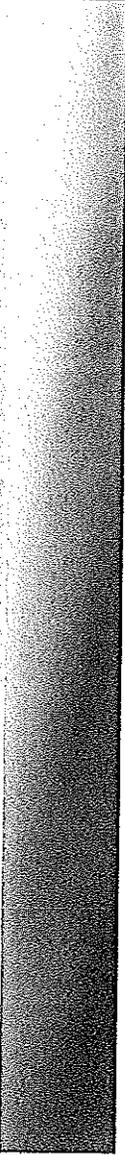
Good Morning. My name is Carrie Rand-Anastasiades and I am the Executive Director of the Connecticut Association of Community Pharmacies. We represent chain pharmacies around the State such as Walgreens, Stop & Shop, and PriceChopper to name a few. I am here today to testify against SB 392 AAC Pharmacy Medicaid Reimbursement.

Last year with the budget deficit at record heights, the pharmacy community, both chains and independents alike, took a drastic cut in Medicaid reimbursement. Those who suggest that Medicaid pharmacy reimbursement should be tiered may assume that chain-operated pharmacies will be less seriously impacted than independent pharmacies. This flawed assumption fails to take into account that the majority of Medicaid prescriptions - seventy percent- are filled by chain pharmacies. As the primary providers of both Medicaid and Medicare Part D prescriptions, fair and accurate reimbursement in public programs is critical for chain pharmacies.

Some also erroneously suggest that chains consistently purchase and dispense prescription medication at lower prices than independent pharmacies, failing to take into account that independent pharmacies band together in buying groups to take advantage of economies of scale, mimicking the purchasing power of chain pharmacies.

Last year this issue was brought up through the Appropriations Committee. In a white paper (document attached- pages 5,6,7) done by former Medicaid Director David Parrella, it was found that CMS will not approve a State Plan Amendment that is based on independent versus chain reimbursement; it must be based on patient access to pharmacies. A two tiered reimbursement schedule that adversely impacts chain pharmacies could have a negative impact on access for Medicaid recipients. A 2007 study of consumer access found that out of 41,717 pharmacies located in urban areas in the country where the Medicaid population is concentrated, 28,189 of them (69.8%) were chain pharmacies. In Connecticut in 2007 462 of the 622 pharmacies in the state were chain pharmacies (74%). In addition the State would have to do a cost of dispensing study to back up the differential reimbursement. The State has not done a cost of dispensing study for years. It was concluded that tiered reimbursement would not hold water with CMS because CT does not have an access problem and there is no documentation to justify increases for independents. It was for these reasons the measure did not go forward and an equal reduction to chain and independent pharmacies was instituted. In light of these findings we urge rejection of SB 392 AAC Pharmacy Medicaid Reimbursement.

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A Policy Analysis of the Provisions of House Bill 6222, “An Act Concerning State Prescription Drug Purchasing”

Prepared by David Parrella, Partner

Alicia Smith & Associates

For the Connecticut Association of Community Pharmacies

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Introduction

Over the past decade, Connecticut has adopted several initiatives to contain the costs of prescription drugs purchased by the state Medicaid program. These measures include:

- Mandatory generic substitution
- Prior authorization
- Section 340(b) pharmacy programs at Federally Qualified Health Centers (FQHCs)
- Supplemental rebate programs under a Preferred Drug List (PDL), and
- Significant reductions in the dispensing fee and the material drug costs paid to pharmacies for both generic and brand name drugs. The current dispensing fee for brand name drugs is now \$2.90. Brand name drugs are reimbursed at Average Wholesale Price (AWP) – 14%. Generic drugs are reimbursed at Wholesale Acquisition Cost (WAC)¹ plus 50% in lieu of a dispensing fee.

The General Assembly is currently considering several initiatives aimed at increasing the cost savings in the Medicaid pharmacy program including House Bill 6322, “An Act Concerning State Prescription Drug Purchasing”. This bill is part of Governor Malloy’s budget package and would place the administration of the Medicaid pharmacy benefit under the same Pharmacy Benefit Manager (PBM) contract with Caremark that the Office of Comptroller currently administers for state employees and retirees. The savings that are expected from this merger would result from:

- Greater leverage in the marketplace with both pharmacy manufacturers and pharmacies
- The adoption of the dispensing fee paid to pharmacies by Caremark for state employees by the Medicaid Program (\$1.45)
- The adoption by Medicaid of the reimbursement rates paid by Caremark for generic (AWP-68%) and brand name products (AWP-17% or 18.5%)

This paper will examine the policy considerations contained in this initiative in light of the federal statutory and regulatory context for the Medicaid program with special emphasis on the recently published National Proposed Rule Making (NPRM) on the Methods for Assuring Access to Covered Medicaid Services (CMS-2328-P) which was published in the Federal Register on May 5, 2011.

The Single State Agency

One of the basic federal Medicaid law is the identification of a single state agency for the administration of the Medicaid program (SAA 1902(a)(5), 42CFR431.10). The requirement recognizes the uniqueness of the Medicaid program as a medical entitlement program jointly administered and financed by the state and federal government. In Connecticut, the Single State Agency is the Department of Social Services (DSS).

This requirement does not necessarily preclude the Single State Agency from delegating some aspect of program operations to another state agency. In Connecticut there are several examples of this kind of collaboration. The Department of Developmental Disabilities has operational responsibility for the section 1915(c) Medicaid home and community based waiver for persons with cognitive disabilities under the terms of a Memorandum of Understanding (MOU) between that agency and DSS. The Department of Children and Families has the lead on clinical policy and care management for children enrolled in HUSKY A and HUSKY B under the Behavioral Health Partnership.

There are even examples where states have moved the purchasing of prescription drugs for the Medicaid program under inter-state or inter-agency partnerships in the effort to contain costs. With regard to the latter, in 2001 Georgia moved the purchasing of prescription drugs for Medicaid and state employees under a new state agency, the Department of Community Health. Although the program did succeed in slowing the rate of growth in prescription drug expenditures, by 2005 the legislature acted to remove Medicaid from the joint purchasing arrangement. The state found that the savings realized by the initiative overwhelmingly came from the administrative measures adopted to better manage the Medicaid pharmacy benefit, rather than joint purchasing, itself (i.e. adoption of a three-tier formulary, increased client cost-sharing, mandatory generic substitution, etc.).ⁱⁱ

Washington State was on the verge of implementing such a joint purchasing initiative with state employees when it encountered difficulties in with the state contractor in the integration with the Medicaid Point of Sale (POS) system for drug transactions. Having recently approved funding for a new Medicaid management Information System (MMIS) for Washington, CMS was unwilling to support the additional costs of building interoperability with the PBM for state employees.

Why have not more states adopted this approach?

- Medicaid has special beneficiary protections such as Notice of Action and Fair Hearing Appeals in the event of denials of coverage that have no corollary in the commercial market. Connecticut has experienced issues with operationalizing these requirements with the HUSKY Managed care Organizations (MCOs) in the past that gave rise to the litigation that influenced the decision by Governor Rell to cancel the MCO at-risk contracts in 2007.
- Medicaid benefits from the drug rebate provisions in the Omnibus Budget Reconciliation Act of 1990 that requires the manufacturers to rebate to the Medicaid program the difference between the rate the state pays for drugs and the best price available. Consolidation of Medicaid purchasing with other state programs would require strict separation of claims by program in order to prevent inappropriate rebate claims to the manufacturers.

- Medicaid pharmacy claims data is an essential component of disease management programs, especially for the Aged, Blind, and Disabled population. Methods to ensure timely access to this data are critical for any organization charged with the management of Medicaid benefits, whether that organization is an MCO or an Administrative Service Organization (ASO).
- Medicaid pharmacy claim data must be integrated into the Medicaid Statistical Information System (MSIS) compiled by the Centers for Medicare and Medicaid Services (CMS).

The Adoption of the State Employee Reimbursement Schedule

Leaving aside the components of the Governor's proposal to pursue joint purchasing, there is the proposal to match the state employee model for reimbursement as it applies to chain pharmacies. Proposal includes a the creation of a two-tiered dispensing fee where the chains would be paid \$1.45 per script with a discount off of AWP of somewhere between 17% and 18.5% for brand name drugs and a discount of 68% for generic products.

The concept of a tiered dispensing fee is not new in Medicaid. Several states operate tiered dispensing fees to encourage the dispensing of generic drugs (Washington, North Carolina, Florida, Massachusetts, and Missouri).ⁱⁱⁱ The benefits of this strategy result from the increase of the total number of scripts filled as generics as opposed to higher cost brand name products. Connecticut could potentially look to this approach as an alternate method of achieving savings in the Medicaid pharmacy program. During the second quarter of State Fiscal Year 2010, Connecticut Medicaid filled 64% of its scripts with generic products. By contrast, Massachusetts Medicaid filled 76% of its scripts with generics. Nationwide, generics accounted for 75% of all prescriptions, including those paid privately.^{iv}

A 2010 study by the National Association of State Medicaid Directors found that the overwhelming issue for Medicaid Directors in pharmacy pricing is the movement away from AWP as a reference point towards a new benchmark.^v The recommendation of this report is to move to **actual acquisition cost (AAC)** as the benchmark for future drug material costs. Both Oregon and Alabama have filed state plan amendments to begin this transition. However, in both cases the states *increased rather than decreased* their dispensing fees to compensate pharmacies for the cognitive services they provide to Medicaid clients. That seems to be recognized in the Connecticut proposal with regard to independent pharmacies where the dispensing fee is listed as high as \$7.90. In neither Oregon nor Alabama was there a difference in the dispensing fee based on chain versus independent pharmacies.

The adoption of the state employee dispensing fee for the chain pharmacies could have unintended consequences that speak to the differences between the Medicaid and the state employee populations.

- State employees enjoy greater health literacy and English language proficiency than the Medicaid population. The time required to assist Medicaid recipients with their pharmacy regimens is much greater than for state employees.
- Medicaid recipients have a much higher prevalence of complex co-morbidities, including cognitive and behavioral conditions that place an additional burden on pharmacy providers. The

risks of non-compliance with complicated regimens are much greater and require additional counseling by their providers.

A two tiered dispensing fee that adversely impacted the chain pharmacies could have a negative impact on access for Medicaid recipients. A 2007 study of consumer access found that out of 41,717 pharmacies located in urban areas in the country where the Medicaid population is concentrated, 28,189 of them (69.8%) were chain pharmacies.^{vi} In Connecticut in 2007, 462 of the 622 pharmacies in the state were chain pharmacies (74%).^{vii}

There is evidence that two-tiered dispensing fee strategies could actually compel a pharmacy chain to leave the Medicaid program, or at least provoke a strong legal challenge. In 2009 Walgreens announced that it was leaving the Medicaid program in Delaware.^{viii} Walgreens later was able to negotiate a more favorable rate with Delaware Medicaid and did not actually exit the program. In Washington State, Walgreens did stick to its decision to withdraw from the Medicaid over a similar issue. In Arkansas, a Federal Circuit Court ruled that a two-tiered Medicaid pharmacy reimbursement system was unconstitutional as a violation of the 14th amendment in a case brought by Walmart

With regard to the proposal to follow the state employee principles on reimbursement for the material cost of the drugs, we see no issue with pursuing additional discounts to save money for the Medicaid program. .

It is not the amount of the discount off AWP *per se* that raises the greatest concerns about a strategy that is based on state employee contract terms. Our understanding is that pharmacies negotiate with state employee plans individually. The rate of reimbursement for both generic and brand name drugs can vary from pharmacy to pharmacy within a defined range.

That methodology may be perfectly appropriate for commercial world. However, in Medicaid variance from a fixed price per NDC code creates a new level of complexity in calculating the amount of rebate due to the state from each manufacturer. This is not insurmountable, but it would place an additional burden on MMIS at a time when the Department needs to invest its resources in preparing for health care reform. Challenges to the accuracy of rebate invoices by pharmacy manufacturers are not uncommon even today, and the state can ill afford to experience any interruption in rebate revenues.

The CMS NPRM

Section 1902(a)(30(A) of the Social Security Act requires the states "to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the [Medicaid State] plan at least to the extent that such care and services are available to the general population in the geographic area".

In a multi-state call hosted by CMS on the proposed rule on Tuesday May 11th, Cindy Mann (the Director of the Center for Medicaid, CHIP, and Survey and Certification within CMS) indicated that she viewed the proposed rule, not as a payment regulation, but as an access regulation. Ms. Mann and her staff

were very clear that they did not intend to set a standard for payment for services, nor did they intend to dictate the data to be consulted to measure the impact of any reimbursement change proposed by the states.

Ms. Mann did specify three general areas that must be addressed by the states with regard to each service paid under the Medicaid State Plan as part of fee-for-service. Managed care services would be exempt from the new reporting requirement.

1. Recipient need
2. Service availability
3. Service utilization

The NPRM contemplates that Medicaid would publish data on access for all the services covered under the State Plan over the next five years beginning January 1st of the year that begins within 12 months of the date of the publication of the final rule. It would be up to the State to determine which subset of services it would report on for each subsequent January 1st deadline.

However, for each State Plan Amendment that the State submitted within the 12 months prior to the final rule that would have the effect of reducing or restructuring provider rates, the State must submit the access report described at the amended section 42CFR447.203. That means, if Connecticut amends its State Plan to reduce or restructure the dispensing fees paid to the chain pharmacies, it must also submit a report that details:

1. The extent to which enrollee needs are met
2. The availability of care and providers
3. Changes in enrollee utilization
4. An estimate of the proposed Medicaid reimbursement as a percentage of average customary charges
5. An estimate of the proposed Medicaid reimbursement in terms of percentiles of one or more of the following:
 - a. Medicare payment rates
 - b. The average commercial payment rates
 - c. Medicaid allowable costs

Connecticut has not conducted a comprehensive dispensing fee cost study in some time. An often quoted 2007 study conducted by Grant Thornton found that the cost of a dispensing fee in Connecticut should be \$12.34/script. While the state would probably dispute that finding, nevertheless even the *current fee* of \$2.90 is less than 25% of the 2007 cost estimate.

CMS has taken the initiative to issue the NPRM because of outcries from the state about their increasingly dire situation with regard to their Medicaid budgets. The additional federal Medicaid match that was available under American Recovery and Reinvestment Act of 2009 (ARRA) has now ended. However, in the face of an ongoing economic recession States are still under Medicaid Maintenance of Effort (MOE) restrictions that prevent them from reducing eligibility for adults until 2014 and for

children in Medicaid until 2019. With the hands virtually tied on Medicaid eligibility, States have looked to the other two legs of the stool (benefits and provider rates) for budget cuts.

The proposed rule reflects CMS' concern that excessive reliance on provider rate reductions to balance the budget could seriously impact recipient access. Given the proactive stance by the Administration, it is likely that the proposed rule will become final. It is even more likely that no additional financial relief on Medicaid will be forthcoming from Congress.

As Connecticut moves towards an Administrative Service Organization (ASO) model to manage not just HUSKY but the entire Medicaid population, one question that arises is will the new rule apply? In Connecticut currently, pharmacy is carved out of the at-risk managed care contracts with the HUSKY MCOs; and is provided under fee-for-service for the Aged, Blind, and Disabled population. So the answer under current Medicaid would be "yes".

An ASO can start to look a lot like some of the non-risk contracting options that appear in the Medicaid managed care regulations. The distinction that the Connecticut has drawn in past discussion with CMS about the carve out plans for behavioral (Value Options) and dental service (Benecare) is that those ASO arrangements use the Department's provider network and the Department's fee schedules. The fact that they are not *proprietary* to the managed care entity is enough to keep the ASO from being classified as managed care.

At this time, we do not know exactly how the ASO will function in the future. Will pharmacy be included, or will it be carved out? If pharmacy is not carved out, will the ASO follow the Department's fee schedules and use the Department's provider network? If the answer to all those questions is "yes", then we can assume that the new NPRM will apply.

Connecticut will need to be prepared to submit an access report should it adopt the Governor's proposal to move to a two-tiered dispensing fee that replicates the model used for state employees.

Conclusions

1. Purchasing Medicaid pharmacy benefits through the state employee contracts administered by the Office of the Comptroller is a progressive step towards bulk purchasing, but there are many administrative details that need to be addressed so that the Medicaid program and Medicaid recipients do not suffer.
2. The adoption of the reimbursement strategy for chain pharmacies in the State employee contracts by the Medicaid program is a half-step in that direction. However, a two-tiered dispensing fee structure based on chain vs. independent pharmacies may prove to be counter-productive given the dominant role that chain pharmacies play in serving the Medicaid population.
3. The NPRM makes it increasingly likely that Connecticut Medicaid will need to undertake some sort of access study for the dispensing fees that it pays today, as well as any changes that it

contemplates for the future. Dispensing fees have not been studied in Connecticut in some time and the last study (Grant Thornton 2007) would appear to support higher dispensing fees.

4. Recognizing that the State of Connecticut does need to achieve savings in the Medicaid budget, the State should look to the percentage of Medicaid scripts filled with generic drugs as a potential source of savings. For some reason, despite the fact that Connecticut has enacted a policy of mandatory generic substitution, Connecticut Medicaid's use of generic products is lower than the national average and significantly lower than in Massachusetts. In order to achieve additional savings in the Medicaid pharmacy budget the State should consider alternative measures to:
 - a. Pay a differential dispensing fee to all pharmacies based on generics
 - b. Include generic dispensing in a pay for performance initiative with prescribing physicians
 - c. Expand the Preferred Drug List (PDL) to include additional therapeutic classes where the State could derive the benefit of supplemental rebates

5. The State should consider enacting legislation that directs the Department to conduct an updated study of dispensing fees. The study should be completed and submitted to the Committees of Cognizance in time for consideration of the recommendations during the 2012 session of the General Assembly. The study should weigh the relative benefits of:
 - a. An increased dispensing fee, coupled with a reduction in material cost reimbursement.
 - b. A two-tiered dispensing based on chain vs. independent pharmacies
 - c. A two-tiered dispensing fee based on generic vs. brand name drugs

ⁱ Wholesale Acquisition Cost (WAC) is the list price for wholesalers, distributors, and other direct accounts before any rebates, discounts, allowances or other price concessions that might be offered by the supplier of the product. The WAC is what the wholesaler buys the drug for from the manufacturer.

ⁱⁱ <http://ncsl.org/programs/health/bulkrx.htm>

ⁱⁱⁱ <http://www.health.utah.gov/Medicaid/stplan/legreports.htm>

^{iv} Bloomberg Government reports from CMS Data

^v <http://www.hsd.aphsa.org/home/doc/Summary/Whitepaper.pdf>

^{vi} <http://pcmanet.org/assets/2008-03->

^{vii} <http://www.nhpf.org/IssueBrief/839>

^{viii} <http://www.chaindrugreview.com>