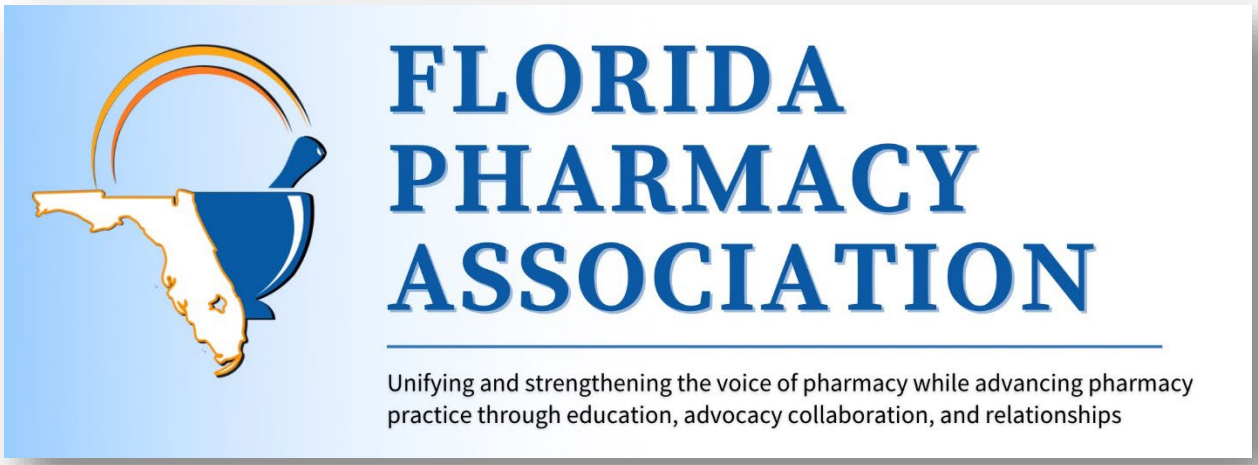
From: T.J. Morton
To: solicitation.questions
Cc: Michael Jackson
Subject: Florida Pharmacy Association - Response to RFI 014-21/22
Date: Friday, June 3, 2022 11:33:01 AM
Attachments: Florida Pharmacy Association - Response to RFI 014-2122 - final.docx

---

Please find attached the Florida Pharmacy Association's response to AHCA's RFI 014-21/22 regarding re-procurement of the statewide Medicaid managed care program.

Thanks,

T.J. Morton
The Lockwood Law Firm
106 E. College Ave., Suite 810
Tallahassee, Florida 32301
Office: 850.727.5009
Cell: 850.284.8769



June 3, 2022

Cody Massa
Agency for Healthcare Administration
Procurement Officer
solicitation.questions@ahca.myflorida.com

RE: Request for Information
RFI 014-21/22 Re-Procurement of the Statewide Medicaid Managed Care Program

Mr. Massa:

This correspondence is provided on behalf of the Florida Pharmacy Association, Inc. ("FPA"), a not-for-profit corporation organized under the laws of this state which seeks to preserve and advance the practice of pharmacy and serves the professional needs of all pharmacists, pharmacy students, and pharmacy technicians in Florida. The FPA is the state's largest and oldest professional society representing Florida pharmacists and pharmacies with over 3,500 members. The FPA is also a member of the Empower Patients Coalition which is focused on empowering Floridians to take control of their health care and increasing access to affordable medication.

The purpose of this letter is to respond to the Agency for Health Care Administration's Request for Information regarding best practices and innovations in business models as well as service delivery for Medicaid managed care. The FPA is providing this information on behalf of its members who have direct experience in the managed health and long-term care industries, many of whom participate in Florida's Medicaid managed care program.

610 North Adams Street
Tallahassee, Florida 32301
(850) 222-2400

A. Respondent's Information

Florida Pharmacy Association
610 North Adams Street
Tallahassee, Florida 32301
www.FloridaPharmacy.org

Contact:
Michael Jackson
(850) 222-2400
jackson@pharmview.com

Alternate Contact:
T.J. Morton
(850) 284-8769
tj@lockwoodlawfirm.com

B. A description of how the Respondent's approach will offer advantages or improvements over existing processes of the SMMC Program. The description should also identify known or potential concerns with the approach.

Enhance specialty health plans services to improve outcomes for recipients. Increase the number of plans to address target populations with specific health conditions or needs.

Because of the traditional methods of pharmacy pricing, specialty pharmaceuticals are the largest growing cost center within the pharmacy space, also the most profitable in the supply chain. As a result, health plans and PBMs are incentivized to keep those prescriptions "in house" whenever possible, a process known as "steering". In doing so, they are choosing to maximize their own profits but at the expense of general patient care. For example, "networks within a network" will force a patient to use a certain, and often PBM or health plan affiliated, pharmacy for specialty medications.

In the current Florida SMMC program, steering leads to PBM owned and affiliated pharmacies taking a disproportionate share of the segment's prescriptions and profits. Milliman's 2020 report to AHCA on PBM pricing practices in the SMMC program (Milliman 2020) revealed that PBM owned/affiliated pharmacies took more claims for specialty drugs than did non-PBM owned/affiliated pharmacies.[1] Additionally, Milliman 2020 shows that the payments per specialty prescription were higher to PBM owned/affiliated pharmacies than to non-PBM owned/affiliated pharmacies. Milliman 2020 goes on to recommend that "retail pharmacy

[1] Milliman 2020 is available at:
https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3090&Session=2021&DocumentType=Meeting+Packets&FileName=ffs+2-18-21.pdf

reimbursement rates for specialty drugs to be at parity as PBM-owned pharmacy payment rates, including mail order and specialty pharmacies."[2]

By steering Florida patients on specialty medications, PBMs are targeting some of Florida's sickest patients. Patients who are battling life threatening diseases such as cancer and HIV are disproportionately steered from the pharmacy or dispenser of their choice and forced to use PBM owned or affiliated pharmacies.

The practice of steering not only can increase costs to the state and rob patients of the choice to use their trusted provider, but it also leads to delayed care, fragmentation of care, and compromised care. Patients on specialty medications often have fast moving diseases which require aggressive treatment quickly and so delay of a week or more can in and of itself have adverse effects. It also makes adjusting dosage of potent medications harder and more expensive to do. Finally, these patients often have complex disease states requiring multiple medications and fragmenting care increases the risk of adverse effects and drug-drug interactions.

Recommendation: AHCA should include a contract requirement for participants in the SMMC program that prohibits the PBM from denying fulfillment of a claim for all medications, and specifically specialty medications, from non-PBM owned or affiliated pharmacies and prohibits PBM steering to PBM owned or affiliated specialty, mail order, or retail pharmacies.

Increase access to community-based pharmacists within prescription benefit manager networks.

The FPA is heartened to see that increasing access to community pharmacies is a priority for the state. Access to community-based pharmacies is vital to the well-being and success of the SMMC program and its beneficiaries. Many community pharmacies offer enhanced services such as courier delivery of medications, clinical services, and expanded vaccination offerings. Community pharmacies were instrumental in the testing and vaccination efforts during the COVID pandemic, and it is very evident that community pharmacies are uniquely and well positioned to care for those in their community.

While the FPA has several recommendations to increase access to community pharmacies, the most important is also the most obvious, community pharmacies should be afforded the opportunity to be included in all networks in SMMC program. Currently the SMMC program has several plans which do not at all seek to achieve this goal. Humana, for example, excludes virtually all community independent pharmacies from its network.

In addition, all community pharmacies should be able to fill all prescriptions for patients in the networks. PBMs continue to steer patients who are on specialty medications, as addressed above, but also patients battling chronic diseases such as diabetes, heart disease, and high blood pressure. PBMs do this by creating narrow networks consisting of PBM owned pharmacies and

[2] *Id.* at p. 22

610 North Adams Street
Tallahassee, Florida 32301
(850) 222-2400

requiring the patients to fill maintenance medications in a 90-day supply from these PBM affiliated pharmacies. And so, while community pharmacies may be in a PBM's broad network, patients on specialty medications and maintenance medications are forced to use PBM affiliated pharmacies and, in turn, lose access to their community pharmacies for purposes of filling these prescriptions.

Moving passed the threshold issues of allowing community pharmacies access to networks and allowing patients to fill their specialty and maintenance medications at the community pharmacy of their choice, other PBM practices should also be reined in to improve access to community pharmacies. For example, when a health plan/PBM/retail pharmacy network is vertically aligned (meaning the plan, PBM and pharmacy are under common ownership or otherwise affiliated), the PBM can artificially underpay itself in order to offer the same below-market-rate contract to its competitors. This disincentivizes true competition, thereby decreasing the freedom of choice for beneficiaries, and, ultimately, driving up overall costs to the pharmacy benefit.

Predatory PBM reimbursement practices also threaten the sustainability of community pharmacies throughout the state. As more fully elaborated in the section below, community pharmacies should be reimbursed fairly for the ingredient costs of medications and should be paid a fair dispensing fee.

Additionally, any RFP or prospective plan design should also include those methods already identified by Milliman 2020. Specifically:

1. Pass through pricing should be truly an accurate passthrough
2. Transaction fees should be tracked and counted as plan revenue
3. Claims offset via GER or other effective rate strategies should be prevented
4. Reimbursement rates for retail pharmacies should be at parity as PBM-owned pharmacy payments[3]

Instituting these suggestions from Milliman into any new SMMC pharmacy program will improve provider-payor relations and encourage further participation in the network. A network that truly looks after its pharmacy providers will ensure a thriving and resilient partnership, ultimately improving patient outcomes and reducing costs.

Recommendation: AHCA should include a contract requirement for participants in the SMMC program that directs the PBM to contract with any pharmacy within a network that meets permitting and licensing criteria issued by the Board of Pharmacy.

Recommendation: AHCA should include a contract requirement for participants in the SMMC program that requires annual auditing that provides full documentation showing:

[3] *Id.* at p. 4.

610 North Adams Street
Tallahassee, Florida 32301
(850) 222-2400

1. The reimbursement that the plan was charged by the PBM to fill the top 50 prescriptions by volume with back up documentation by transaction.
2. The reimbursement that the PBM paid to the pharmacies for the top 50 prescriptions by volume with backup documentation by transaction.
3. Identify the difference between these two reimbursements by transaction.
4. Identify those transactions where the PBM reimbursed pharmacies less than what the State reimbursed the PBM for the same prescriptions.
5. Identify the amount the PBM retained as part of its spread pricing practices.

Recommendation: AHCA should include a contract requirement for participants in the SMMC program that requires the PBM to reimburse at the same rate for retail pharmacies as they reimburse PBM-owned or affiliated pharmacies, while ensuring the rates are not artificially lowered to benefit the PBM and its entities.

Recommendation: AHCA should include a contract requirement for participants in the SMMC program that prohibits a PBM from charging a fee to pharmacies that is not negotiated openly and fairly between the parties. Further, the contract should require that the PBM reimburse the retail pharmacy the same charge approved at the initial remittance (Claim Adjudication at Point of Sale).

Recommendation: AHCA should include a contract requirement for participants in the SMMC program that prohibits the PBM from retroactive payment reductions (i.e., "clawbacks") by imposing new fees (called Generic Effective Rates, Brand Effective Rates or Direct and Indirect Remuneration (DIR) fees).

Improving Providers' Experience with the SMMC Program.

We applaud AHCA for seeking information regarding improving providers' experiences with the SMMC program. The quality of provider experience in a health care plan is often discounted as not being directly related to a plan's primary focus of improving patient outcomes and reducing costs. However, studies have shown that provider satisfaction is directly associated with patient satisfaction and quality of care.[4]

To have a positive and fulfilling experience with the SMMC program, providers should be fairly compensated for their products and professional services delivered to beneficiaries. A robust Medicaid program is one that has a wide variety of pharmacy providers and encourages and incentivizes participation by a broad network of providers. While the fee-for-service has evidence-based product and professional fee reimbursement methodology, no similar standard exists in the SMMC program. As a result, many providers are systematically underpaid – driving good pharmacies and pharmacists out of the program and leaving decreased options for beneficiaries. The SMMC program should ensure that, like the fee-for-service model, providers

[4] *See, e.g.*, Physician Satisfaction with Health Plans Results from a National Survey, available at: https://www.ajmc.com/view/physician-satisfaction-with-health-plans-results-from-a-national-survey

610 North Adams Street
Tallahassee, Florida 32301
(850) 222-2400

are compensated fairly to cover the cost of their product and the standard cost for professional dispensing.

Participation in the SMMC program should not be contingent on participation in a PBM's other programs, and it should not be upset by changes in total volume or differences in volume between a particular PBM's other lines of business.

Additionally, pharmacy audits should be fair and standardized, balancing the need to search out fraud, waste, and abuse with the undue burden that can be placed on providers when faced with arbitrary and capricious tactics. Pharmacies should be entitled to adequate notice of the audits, a procedure for disputing audit findings and unfair audit practices, and a written explanation as to why a claim is denied.

Recommendation: AHCA should include a contract requirement for participants in the SMMC program that imposes a requirement to reimburse retail pharmacies for prescription fulfillment based on National Average Drug Acquisition Cost (NADAC) plus a dispensing fee.

Recommendation: AHCA should include a contract requirement for participants in the SMMC program that requires participants and their subcontractors to provide the following audit rights:

1. Notify the pharmacy of the onsite audit at least seven calendar days prior to the audit.
2. Not schedule an onsite audit during the first three calendar days of a month.
3. Limit the duration of the audit period to 24 months after the date a claim is submitted.
4. To the extent the audit requires clinical or professional judgment, conduct the audit in consultation with a pharmacist.
5. Allow the pharmacy to use medical records to validate the pharmacy records.
6. Reimburse the pharmacy for a claim that was retroactively denied due to a clerical, computer, or scrivener's error.
7. Provide the pharmacy with a copy of the preliminary report within 120 days of the conclusion of the audit.
8. Allow the pharmacy to produce documentation to dispute an audit finding within 10 business days after the preliminary audit report is delivered to the pharmacy.
9. Provide the pharmacy with a copy of the final audit report within six months of receipt of the preliminary audit report.
10. Calculate recoupment or penalties based on actual overpayments and not according to extrapolation.
11. Allow the pharmacy to appeal the audit findings and procedures pursuant to section 408.7057, Florida Statutes.

<u>Increase timely access to providers and services.</u>

The current SMMC program allows pharmacies to be excluded by the PBMs from participation for virtually any reason desired. As a result, beneficiaries experience vastly

610 North Adams Street
Tallahassee, Florida 32301
(850) 222-2400

different network options based only on their geographic location. To increase timely access to providers, all qualified pharmacies should be invited to participate in the SMMC's pharmacy network, and they should be offered reasonable and customary contract terms. Because certain providers are vertically integrated as to the health plan/PBM/retail pharmacy enterprise, any contract should represent a fair and reasonable approximation to fee-for-service reimbursement methodology, and no pharmacy should be offered a competitive advantage for payment whether affiliated or non-affiliated to the PBM itself.

Further, there is a proliferation of automated pharmacy systems (vending machines) being installed in non-pharmacy or hospital locations. The legislature approved in 2020 the use of these vending machines and the Board of Pharmacy promptly withdrew all its rules providing safety guidelines for their use. There is no requirement for a licensed person to fill the vending machines and there is no requirement that a pharmacist oversee in person the filling and dispensing of the vending machine. There is no definition of where they can be located except a simple statement of an "indoor environment area", similar to a Redbox for dispensing of movie videos. They are being placed in doctor offices with no pharmacist in the building, office buildings, retail stores, etc. The system is required to be under the supervision of a pharmacist, but the pharmacist could be located out of the country, providing virtually no supervision and where enforcement efforts would be difficult. There is no limitation on the number of machines a pharmacist may supervise and there is no additional funding for the Department of Health to inspect. The vending machines could be located from Key West to Pensacola by the same pharmacist with no physical ability to check the contents of the machine. These vending machines are only intended to "enhance the ability of a pharmacist to provide pharmacy services" in certain locations; not to replace pharmacies.[5] Accordingly, the vending machines should not be considered for network adequacy purposes.

Recommendation: AHCA should include a contract requirement for participants in the SMMC program that requires inclusion of all pharmacies that meet licensing requirements. Further, the contract provisions should prohibit the use of an automated pharmacy system from meeting network adequacy standards.

Achieving Cost Savings throughout the SMMC Program

Opaque PBM practices in state Medicaid managed care programs have led to increased costs to taxpayers across the country. These practices include but are not limited to using trade secreted reimbursement methodologies, engaging in spread pricing (charging the state more for a drug than a pharmacy is reimbursed), and effective rate pricing and clawbacks (reimbursing a pharmacy a high amount at the point of sale and recouping that money months later).

These practices should be prohibited by contract in the SMMC Program and robust oversight should be contemplated and executed. The potential savings for a program as large as

[5] §465.0235(5), Fla. Stat.

610 North Adams Street
Tallahassee, Florida 32301
(850) 222-2400

Florida's SMMC would be significant. In addition, trade secreted reimbursement methodologies should be replaced, and pharmacy reimbursement should be based on NADAC.

Additionally, agreements with PBMs (whether directly or through MCOs) should be transparent and require pass-through pricing, with attention paid to contractual definitions. By way of example, many PBM contracts allow PBMs to define what constitutes a specialty drug. In addition, there are PBM agreements that contemplate rebates being passed back to the client but then exclude from the definition of "rebate," key discounts from drug makers such as discounts paid for specialty medications and discounts paid to PBM affiliated pharmacies.

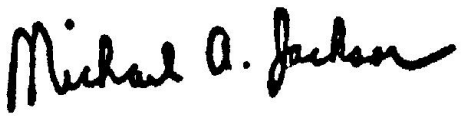
Further, when AHCA transferred pharmacy services to the managed care plans, the agency did not address the significant revenue and income that PBMs would be earning under the new structure and AHCA did not address the need to include the income as part of the medical loss ratio compliance requirements. The medical loss ratio calculation shall utilize uniform financial data collected from the plan's annual reporting requirements and computed for each plan.

Recommendation: Prohibit PBM practices including spread pricing, generic effective rate pricing, and reimbursement to pharmacies based on trade secreted methodologies. Increase transparency vis-a-vis instituting a National Average Drug Acquisition Cost model, maintain robust oversight, and implement transparent pass-through contracts.

Recommendation: AHCA shall include a provision that holds the managed care plan responsible for including revenue in the calculation of the medical loss ratio for each plan.

Finally, should AHCA hold a meeting with stakeholders to discuss the comments received in response to the RFI, we ask that the FPA and other members of the Empower Patient Coalition be invited to attend the meeting. Thank you for your time and consideration in reviewing these comments and please do not hesitate to contact me should you have any questions.

With kindest regards,



Michael A. Jackson, BPharm, CPh
FPA Support

610 North Adams Street
Tallahassee, Florida 32301
(850) 222-2400