From: Matthew Magner
To: solicitation.questions
Subject: NCPA Response to RFI 014-21/22
Date: Friday, June 3, 2022 11:10:50 AM
Attachments: NCPA response to RFI 014-21-22 .docx

Good morning,

I have attached the National Community Pharmacists Association's response to RFI 014-21/22. The letter in its entirety is suitable for release to the public, as it does not contain any confidential or trade secret information. I appreciate the opportunity to provide this response on behalf of NCPA. If you have any questions about the information contained in the response, please let me know.

Best,
Matt Magner

Matthew Magner, JD
Director, State Government Affairs
National Community Pharmacists Association
100 Daingerfield Road
Alexandria, Virginia 22314-2888
(703) 600-1186

Founded in 1898, the National Community Pharmacists Association is **the voice for the community pharmacist**, representing nearly **19,400 pharmacies** that **employ 215,000 individuals** nationwide. Community pharmacies are **rooted in the communities where they are located** and are among **America's most accessible health care providers**. To learn more, visit www.ncpa.org.

June 3, 2022

Cody Massa
Procurement Officer
Florida Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

RE: NATIONAL COMMUNITY PHARMACISTS ASSOCIATION RESPONSE TO RFI 014-21/22 RE-PROCUREMENT OF THE STATEWIDE MEDICAID MANAGED CARE PROGRAM

Dear Mr. Massa:

I appreciate the opportunity to provide comments on behalf of the National Community Pharmacists Association (NCPA) in response to the Agency for Health Care Administration's request for information on the re-procurement of the Statewide Medicaid Managed Care Program. NCPA represents the interest of America's community pharmacists, including the owners of more than 19,400 independent community pharmacies across the United States and 1,164 independent community pharmacies in Florida.

More than any other segment of the pharmacy industry, independent community pharmacists are often located in the underserved rural and urban areas of Florida that are home to many Medicaid recipients. Pharmacists are frequently the most accessible healthcare providers in many communities and are critical for the provision of immunizations and other preventive care services in the community. Access to pharmacy care services and prescription medications play a critical role in managing chronic conditions and staving off costly downstream medical interventions.

We applaud the Agency's efforts to improve the SMMC Program to better serve the state's Medicaid beneficiaries. As the voice for America's community pharmacists, NCPA is in a unique position to highlight best practices and innovative ideas to increase access to community-based pharmacists within prescription benefit manager networks. We are familiar with the obstacles keeping Medicaid beneficiaries from accessing their local pharmacies and the innovative solutions that states have created to remove those obstacles.

As I will explain below, Florida can address those obstacles by (1) removing inherent managed care organization (MCO) and pharmacy benefit manager (PBM) conflicts of interest with "any willing provider" requirements, (2) adopting a transparent reimbursement methodology, and (3) creating greater oversight over the MCOs and PBMs managing the SMMC Program's prescription drug benefit.

Remove inherent MCO/PBM conflicts of interest with "any willing provider" requirements

One issue preventing Medicaid beneficiaries from accessing community-based pharmacists is "patient steering." Patient steering occurs when an MCO/PBM requires a beneficiary to utilize a particular pharmacy as a requirement for coverage of the drug. Patient steering is possible because of MCOs'/PBMs' outsized role in the pharmacy supply chain. As provider network creators, MCOs/PBMs can determine which pharmacies a patient must use. And many

100 Daingerfield Road
Alexandria, VA 22314-2888
703.683.8200 PHONE
703.683.3619 FAX

MCOs/PBMs own their own pharmacies, creating incentives for MCOs/PBMs to force patients to use those affiliated pharmacies.

Patient steering is anticompetitive and hurts both Medicaid beneficiaries and local community pharmacy businesses in the state. It allows MCOs/PBMs and their affiliated pharmacies to avoid competition with non-affiliated community pharmacies for patients' business. According to a 2020 NCPA survey, 79% of respondents said their patients' prescriptions were transferred to another pharmacy in the previous six months without their patients' knowledge or consent.[1] Community pharmacies lost a median of 12 patients during that time period.[2]

Patient steering also hurts the taxpayer, because it creates a clear conflict of interest, which has not gone unnoticed by several states. The California Task Force on Pharmacy Benefit Management Reporting found that patient steering may create "misaligned incentives" that may lead a PBM to "favor an integrated pharmacy even if competing pharmacies have lower costs."[3] A similar task force in Minnesota came to the same conclusion, finding "these circumstances present obvious conflict-of-interest concerns" because "a PBM could engage in business practices that steer purchasers and payers to buy a drug from a pharmacy the PBM owns, even if the price of the drug is cheaper at a competing pharmacy."[4] A New York Senate committee determined "the strong possibility of a conflict of interest arises," giving PBMs the "opportunity to manipulate drug dispensing at their mail order pharmacies to enhance their own profits at the expense of plans and its members."[5] Finally, a Wisconsin task force also identified the inherent conflict of interest, finding that "when PBMs own pharmacies, they might favor their own pharmacies, even if other pharmacies have lower costs."[6]

The problem is particularly egregious when "specialty drugs" are involved because the practice is incredibly lucrative for MCOs/PBMs. In 2021, the top four specialty pharmacies were all fully or partially owned by one of the largest PBMs.[7] Those four pharmacies accounted for 75% of total prescription revenues from pharmacy-dispensed specialty drugs.[8] The problem was made apparent in Florida by this Agency's audit, which found MCO/PBM-owned pharmacies were

[1] "Patient Steering a Massive Problem for Community Pharmacists, New Survey Shows," NCPA (Sept. 17, 2020) https://ncpa.org/newsroom/news-releases/2020/09/17/patient-steering-massive-problem-community-pharmacists-new-survey.
[2] *Id.*
[3] California Department of Managed Health Care Task Force on Pharmacy Benefit Management Reporting, *Report to the Legislature* 6 (Feb. 2020), https://www.dmhc.ca.gov/Portals/0/Docs/DO/PharmacyBenefitManagementLegislativeReportAccessible.pdf.
[4] *Report of the Minnesota Attorney General's Advisory Task Force on Lowering Pharmaceutical Drug Prices* 44, (Feb. 2020), https://www.ag.state.mn.us/Office/Communications/2020/docs/DPTF_Feb2020Report.pdf.
[5] New York Senate Committee on Investigations and Government Operations, *Final Investigative Report: Pharmacy Benefit Managers in New York* 22, (May 31, 2019), https://www.nysenate.gov/sites/default/files/article/attachment/final_investigatory_report_pharmacy_benefit_managers_in_new_york.pdf.
[6] *Report of the Governor's Task Force on Reducing Prescription Drug Prices* 21, (Oct. 2020), https://oci.wi.gov/Documents/AboutOCI/RxTaskForceFinalReport.pdf.
[7] Adam J. Fein, "DCI's Top 15 Specialty Pharmacies of 2021 – and Three Factors that will Reshape 2022," DRUG CHANNELS (May 4, 2022) https://www.drugchannels.net/2022/05/dcis-top-15-specialty-pharmacies-of.html.
[8] *Id*.

reimbursed at higher rates than non-affiliated pharmacies for dispensing the same specialty drugs.[9]

The solution is to open the pharmacy provider networks to all pharmacies that are willing to meet the terms and conditions of network participation and to allow Medicaid beneficiaries the opportunity to utilize the in-network pharmacy of their choice. This will require all pharmacies in the state to compete for patients' business, giving patients the opportunity to choose the pharmacy that best meets their needs.

Establish transparent reimbursement methodologies

Another issue interfering with patient access to community pharmacy services is opaque reimbursement practices that lead to routine under-reimbursements. As a result of MCO/PBM ownership of pharmacies, community pharmacies are reimbursed by their competitors. MCOs/PBMs are thus incentivized to adopt reimbursement methodologies that limit competition with community pharmacies.

This has led to drastic negative effects on pharmacy providers as well as the vulnerable Medicaid beneficiaries who they serve. A study by the Rural Policy Research Institute found that under-reimbursements led to the closure of 1,231 independent pharmacies in rural areas between 2003 and 2018. As a result, 630 rural communities nationwide that had at least one retail pharmacy in 2003 had **zero** retail pharmacies in 2018.[10] The situation is no better in urban areas; between 2009 and 2015, 1 in 8 pharmacies closed as a result of under reimbursements in government programs (e.g., Medicaid), disproportionately affecting independent pharmacies and low-income neighborhoods.[11] These pharmacy closures "are associated with nonadherence to prescription medications, and declines in adherence are worse in patients using independent pharmacies that subsequently closed."[12]

This issue can be resolved by requiring that reimbursements mirror the transparent methodology of the Medicaid fee-for-service program. This reimbursement approach is not a new concept. Iowa, Kansas, Kentucky, Louisiana, Mississippi, Michigan and Arkansas all have adopted nearly identical reimbursement benchmarks in their respective Medicaid managed care programs. These states know how their tax dollars are being spent because they establish the reimbursement rates for pharmacy services in their Medicaid managed care programs.

Requiring this type of reimbursement transparency not only helps community pharmacies remain open to continue serving patients, but it also helps the taxpayer. States that have adopted this

---

[9] Milliman, *Florida Agency for Health Care Administration: Pharmacy Benefit Manager Pricing Practices in Statewide Medicaid Managed Care Program* (Dec. 2020).

[10] Abiodun Salako, Fred Ullrich & Keith Mueller, *Update: Independently Owned Pharmacy Closures in Rural America, 2003-2018*, RUPRI Center for Rural Health Policy Analysis, July 2018, Rural Policy Brief No. 2018-2, available at https://rupri.public-health.uiowa.edu/publications/policybriefs/2018/2018%20Pharmacy%20Closures.pdf.

[11] Jenny S. Guadamuz, G. Caleb Alexander, Shannon N. Zenk & Dima M. Qato, *Assessment of Pharmacy Closures in the United States From 2009 Through 2015*, JAMA Internal Medicine, Oct. 21, 2019, www.jamainternalmedicine.com.

[12] *Id.*

transparent reimbursement methodology have not reported an increase in costs, in fact, it appears to be just the opposite. The Congressional Budget Office found that adopting this Medicaid managed care pharmacy payment reform nationwide would save the federal government almost $1 billion dollars over ten years.[13] That is just the federal savings.

Under this reimbursement methodology, what a PBM reimburses a pharmacy must be based on the national average drug acquisition cost, or NADAC, plus a professional dispensing fee. NADAC is "a simple average of the drug acquisition costs submitted by retail community pharmacies."[14] The professional dispensing fee is established by the state and is supported by Florida-specific data.[15] These two benchmarks are evidence-based and accurately reflect a pharmacy's true cost of dispensing a drug.

Create greater oversight over the MCOs and PBMs managing the prescription drug benefit

It has become clear through state audits and academic research of MCOs and PBMs that they serve their own interests over the interests of Medicaid beneficiaries, taxpayers, and the states they work for. The New York Senate Committee on Investigations and Government Operations put it best when they released a report finding that "PBMs often employ controversial utilization and management tools to generate revenue for themselves in a way that is detrimental to health plan sponsors, patients, and pharmacies."[16] An audit subsequently found that New York overpaid its Medicaid managed care PBMs $605 million in unnecessary costs over four years, because the PBMs created drug formularies that resulted in rebates that were in the best interest for the PBM, not the state.[17] Researchers at the University of Southern California found that "U.S. consumers and employers and the government often overpay for generics as pharmacy benefit managers (PBMs) and their affiliated insurer companies game opaque and arcane pricing practices to pad profits."[18]

The Agency has a responsibility to be good stewards of the public's tax dollars and ensure Florida is not overpaying as a result of MCOs/PBMs' "opaque and arcane pricing practices." As such, all those involved in the administration of the Medicaid prescription drug benefit must be

---

[13] Congressional Budget Office, Analysis, *Prescription Drug Pricing Reduction Act of 2019, page 6, section 10206,* https://www.finance.senate.gov/imo/media/doc/2020-03-13%20PDPRA-SFC%20CBO%20Table.pdf (March 2020).

[14] Centers for Medicare & Medicaid Servs., *Methodology for Calculating the National Average Drug Acquisition Cost (NADAC) for Medicaid Covered Outpatient Drugs* 15 (Nov. 2013).

[15] *See* 42 C.F.R. 447.518(d).

[16] New York Senate Committee on Investigations and Government Operations, *Final Investigative Report: Pharmacy Benefit Managers in New York,* (May 31, 2019), *available at* https://www.nysenate.gov/sites/default/files/article/attachment/final_investigatory_report_pharmacy_benefit_managers_in_new_york.pdf.

[17] Office of the New York State Comptroller, Medicaid Program: Cost of Pharmacy Services Under Managed Care, (Sept. 2020), https://www.osc.state.ny.us/files/state-agencies/audits/pdf/sga-2020-19s11.pdf.

[18] Erin Trish, Karen Van Nuys, & Robert Popovian, *U.S. Consumers Overpay for Generic Drugs*, University of Southern California Leonard D. Schaeffer Center for Health Policy & Economics, (May 31, 2022), available at https://healthpolicy.usc.edu/research/u-s-consumers-overpay-for-generic-drugs/.

accountable to the state. Fortunately, states across the nation have created innovative ways to ensure their tax dollars are being spent efficiently.

One innovative method that has been successful is the "carve-out" method. Under this method, the state carves the pharmacy benefit out of the SMMC Program and administers it under the fee-for-service program. This gives the state ultimate control over pharmacy networks, the drug formulary, reimbursements, and all other decisions impacting beneficiaries' access to pharmacy services. West Virginia implemented this policy and saved $54 million in the first year.[19] North Dakota saved $17 million in one year by carving the pharmacy benefits out of managed care for the expansion and CHIP populations.[20] California carved the pharmacy benefits out of managed care beginning in January 2022, and the state estimates that it will save at least $150 million a year.[21]

Another innovative model is the "single PBM" model in which a state contracts directly with one PBM to serve the entire Medicaid managed care population. This model allows the state to increase accountability of those who handle public tax dollars. It gives the state greater authority over preferred drug lists (PDLs), provider network creation, and reimbursements. It also gives the state the opportunity to ensure its PBM has no conflicts of interest, such as owning pharmacies, which put the PBM's financial interests at odds with the Agency's interests of providing cost-effective care for its Medicaid population. Ultimately, it puts the state in a better position to ensure its PBM is using its tools and resources in a manner that benefits the state's Medicaid population and taxpayers, instead of in a self-serving way that benefits only the PBM. Kentucky implemented the "single PBM" model in July 2021,[22] and Ohio is set to implement it in July 2022.[23]

Conclusion

Community pharmacists are proud to play a vital role in the Medicaid program as the backbone of its drug benefit. Protecting patient access to community pharmacy services is a necessary component of improving the health of patients and the surrounding community. The biggest threat to access to community-based pharmacist services for the Medicaid population is the outsized role of MCOs/PBMs and their inherent conflicts of interest. Controlling those conflicts of interest will give Medicaid beneficiaries more opportunities to select the pharmacy that is right for them. Moreover, it will ensure that more tax dollars are going towards the beneficiaries' care and less is remaining with administrative middlemen.

Thank you for the opportunity to share these comments. If you have any questions about the information in this letter, please feel free to contact me at (703) 600-1186 or matthew.magner@ncpa.org.

---

[19] Navigant Consulting, Inc., Pharmacy Savings Report: West Virginia Medicaid 5 (2019), *available at* https://dhhr.wv.gov/bms/News/Pages/West-Virginia-Medicaid-Pharmacy-Savings-Report-is-Now-Available!-.aspx.
[20] https://www.nd.gov/dhs/info/testimony/2021/house-approp-hr/hb1012-medical-services-overview-expansion-1-14.pdf.
[21] https://lao.ca.gov/reports/2020/4161/Medi-Cal-Budget-021420.pdf.
[22] https://chfs.ky.gov/agencies/dms/dpo/ppb/Pages/default.aspx.
[23] https://managedcare.medicaid.ohio.gov/managed-care/single-pharmacy-benefit-manager.

Sincerely,

Matthew Magner, JD
Director, State Government Affairs