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| **From:** | Vicki Cunningham |
| **To:** | solicitation.questions |
| **Subject:** | Response to RFI 041-21/22 Re-procurement of the Statewide Medicaid Managed Care Programged Care |
| **Date:** | Friday, June 3, 2022 6:24:36 PM |
| **Attachments:** | Letter to ACHA (edited).pdf |

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Please find my response attached.

Regards,

Vicki M. Cunningham

Sent from Mail for Windows

Vicki M. Cunningham, R.Ph.
1 Kori Road
Charleston, West Virginia 25304
304-444-9030
vickicunninghamrx@gmail.com

Mr. Tom Wallace
Deputy Secretary
Florida Agency for Health Care Administration
Director
Florida Division of Medicaid
2727 Mahan Drive
Tallahassee, FL 32308

I am writing in response to the Florida Agency for Health Care Administration (ACHA) RFI (AHCA RFI 014-21/22) seeking ideas to improve your Medicaid program and its responsiveness to your members and providers.

I served as the West Virginia Medicaid Pharmacy Director for six years and was a member of the staff for thirteen years before becoming director. The West Virginia Medicaid program had contracted with managed care for medical benefits for several years and then, like many other states in the wake of the 2008 Great Recession and the implementation of the Affordable Care Act in 2011, "carved in" the pharmacy program to managed care in 2011. From almost the start of the implementation of the carve in, my office became the "office of complaints from prescribers, pharmacy providers and Medicaid members". It was a very frustrating time because we, as the West Virginia Medicaid pharmacy staff, had no control over the level of service provided by the Pharmacy Benefits Managers (PBMs) contracted by the West Virginia managed care companies providing health care benefits for West Virginia Medicaid members.

After many months of complaints regarding pharmacy benefits and in the face of rising per capita rates from the contracted managed care companies, WV Medicaid commissioned an actuarial study to determine if it would be financially feasible to "carve out" the pharmacy program from the West Virginia Medicaid Managed care program and have it managed once again as a Fee for Service benefit. The study predicted a savings of $30 million annually, while paying pharmacies at the CMS approved dispensing fee of $10.49 per prescription and the actual cost of the drug. During this time, many pharmacies had reported actual losses on the drug they dispensed, and the average dispensing fee was 59 cents per prescription.

As you can imagine, pharmacies had started to turn away Medicaid members and access became a real problem. In addition, prescribers called constantly to complain about burdensome prior authorization processes that were designed to discourage them from prescribing and prevented Medicaid members from obtaining the medications they needed to maintain their health, especially expensive ones.

In 2017, the West Virginia Medicaid pharmacy program was carved out from the Medicaid Managed Care program and the benefits administered by an agent contracted directly with West Virginia Medicaid. At the end of that year, another actuarial company performed a study to determine if there

had been savings. The study showed a savings of $54.5 million to the Medicaid program, even though $116 million had been paid out to pharmacies to cover their cost of dispensing and allow them a reasonable amount of profit to stay in business.[1] (The MCO contracted PBMs had paid out only $4 million to pharmacies in the previous year.) The prior authorization agent used was the West Virginia University School of Pharmacy, directly contracted with Medicaid. This was a great relief to pharmacy providers because it allowed them to provide prescriptions to Medicaid members and to stay in business and to Medicaid because it provided better patient access. And West Virginia taxpayers saved money in the process each year while also preserving Medicaid members access to prescription drug benefits.

Prescribers were pleased because they had an agent that was responsive to their requests. We, as administrators of the West Virginia pharmacy program, were pleased because we had transparent contracts with the businesses providing services to our members and could act quickly when a problem was reported.

Since retirement, I have worked with both Kentucky and Michigan to implement transparent payment models and they have benefitted greatly. It is a system that allows greater access for Medicaid members, fair payment for pharmacies, and relieves the burdens of dealing with multiple Preferred Drug Lists and tortuous prior authorization processes for prescribers.

I am sharing this to suggest that a transparent, cost-based, pass-through prescription reimbursement payment model in which ACHA contracts directly with their pharmacy benefit manager (and has complete oversight) could help the Florida Medicaid Program, its recipients, and Florida taxpayers.

There are many other benefits to this model, and I would be happy to answer any questions that you might have. I will be available as a resource for advice as AHCA develops a formal Request for Proposal (RFP) for the next Florida Medicaid managed care 2022 re-procurement process. Thank you for your consideration of this information and the opportunity to submit suggestions for this part of the re-procurement process.

Respectfully,

*Vicki M. Cunningham*

Vicki M. Cunningham, R.Ph.

[1] - https://dhhr.wv.gov/bms/News/Documents/WV%20BMS%20Rx%20Savings%20Report%202019-04-02%20-%20FINAL.pdf