PHARMACISTS SOCIETY OF THE STATE OF NEW YORK

TESTIMONY

JOINT LEGISLATIVE BUDGET HEARING
HEALTH AND MEDICAID

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Honorable Chairmen Senator DeFrancisco, Assemblyman Farrell, Senator Hannon, Assemblyman Gottfried, and other distinguished members, my name is Tracy Russell. I am the Executive Director of the Pharmacists Society of the State of New York (PSSNY), a 137-year old state organization advocating for the profession of pharmacy and practicing pharmacists in a variety of settings with affiliated organizations throughout the state with the largest percentage of licensed professionals living and working in the five boroughs of New York City and Long Island. A majority of PSSNY's members practice in community pharmacy settings as either the owner or an employee, this will be the primary focus of my remarks today.

Your past support of pharmacists and pharmacy owners over many years has been recognized and greatly appreciated. In particular I thank you for your intervention last year when you stopped the department of health from putting into effect the results of its pharmacy cost surveys. You agreed that the methodology used with this survey was seriously flawed and the proposed reimbursement cuts based on these flawed results would have caused irreparable harm to pharmacies and to New Yorkers who rely on the state's Medicaid program for their healthcare needs. It is unfortunate that I have to return to you so soon to once again as for your support as the department did not follow through with the legislature's direction in the budget language.

Background

As you know, surveys continue to find that people place a great deal of trust in their community pharmacist, and pharmacists are on the front line every day earning that trust. Pharmacies and pharmacists play a vital healthcare role in every community across our state. For most, the community pharmacist is the most accessible healthcare professional around -- available without an appointment, without a co-pay for the visit and at times 24 hours a day. Pharmacists may not be the first group that comes to mind when one thinks about healthcare delivery, however according to Gallup's annual honesty and ethics poll[1], pharmacists are consistently among the most highly regarded and trusted professionals. According to the most recent poll, 67% of Americans rate the honesty and ethical standards of pharmacists as "high" or "very high," ranking them second (behind nurses) on the list of 21 professions included in the poll.

The patient care that pharmacists provide extends beyond the accurate dispensing of prescriptions. Pharmacists educate patients about their medication and the condition for which it is prescribed, review the patient's medication history, monitor the patient's drug therapy over time, screen for potential adverse effects of the medication, and monitor the patient's ability to take medication correctly. These services are invaluable to all healthcare consumers, but they are a crucial component of any successful chronic care management program.

The direct personal care that pharmacists provide is especially important in the Medicaid program. During the transition of the pharmacy benefit into Medicaid Managed Care, pharmacists spent many uncompensated hours assisting individuals with managed care problems such as new formularies and prior authorization requirements as well as the more typical medication management questions such as, how and when to take prescribed medications, how to manage side-effects and what to do about missing doses. Now, not only does the department not compensate for the consult time with patients, they also want to cut the reimbursement of the medication below the cost that it can be acquired by more than 50% of the pharmacies in the state.

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[1] *Results are based on telephone interviews with 1,017 national adults, aged 18 and older, conducted Nov. 22-24, 2002. For results based on the total sample of national adults, one can say with 95% confidence that the maximum margin of sampling error is ±3 percentage points.

While the population of the Fee-For-Service Medicaid beneficiary is dwindling, they are still among the most chronically ill and the most fragile population. Community pharmacies are essential to the well-being and improved health of this population. Challenges in chronic care management include making the best use of medications and helping patients comply with medical regimens. A cost-of-illness model appearing in the Archives of Internal Medicine stated that costs could be cut by more than 50% if pharmaceutical care was provided to all patients. If it is cost savings that the Department of Health wants to achieve, pharmacy should be embraced as a partner and incentivized with a fair reimbursement, not offered a disincentive in payment that does not even cover costs.

Another Drastic Pharmacy Cut to Pharmacy Proposed in the Executive Budget

At the Legislature's request last year's state budget included language directing the Department of Health to meet with pharmacy stakeholders to determine a new Medicaid reimbursement that would be both transparent and adequate. This mandate was clear, after years of budget proposals to cut reimbursement to pharmacies and our annual calls on members of the Legislature to restore those cuts, the parties were to meet and come to terms so that the issue of pharmacy reimbursement in Medicaid Fee-for-Service (FFS) would finally be settled and the annual routine would end. Unfortunately, this is not the case and we are once again at a Legislative Budget Hearing asking you to restore funding. This year it is $36 million the Executive plans to extract from FFS pharmacy providers unless you intervene.

The Stakeholders were surprised by this budget cut. As directed, we met with Medicaid officials monthly throughout the summer. The Department cancelled meetings in September and October, then at the November 2014 meeting we were told that the Department had no plans to change pharmacy reimbursement in the FFS program because of the shift to managed care and the Department's focus on the Delivery System Reform Incentive Payment (DSRIP) Program. We took this to mean that we could now move to more meaningful conversations that should result in greater healthcare savings for the state and improved health for those lives covered by this program. Unfortunately, the department was not being honest with the stakeholders, or with the state legislature.

A few points to consider:

- Throughout the meetings in the summer and up to the January 23rd meeting, the department continued to refer to the discredited 2012 cost surveys as justification for cuts to reimbursement. It was also their reasoning for disagreeing with options that we presented.
- This year's proposed pharmacy cut is far worse that was proposed last year. The legislature understood that it was an unrealistic and unsustainable cut then, making it a deeper cut only adds emphasis to the same facts.
- Stakeholders offered reimbursement models that have been proven cost effective and fair in other states, along with supporting documentation and the expectation of a meaningful dialog to come to an agreement.
- New York is already among the very lowest of other states in the amount paid to pharmacies for brand name drugs under FFS. At the same time NY is ranked in the top 3 most expensive states to live and work.[2]

[2] These states are ranked in order based on their overall cost of living. All cost of living index data comes from the Missouri Economic Research and Information Center (MERIC) first-quarter report, and pricing data comes from Zillow, Numbeo.com, and other resources.

Pharmacists are once again calling on the Legislature to restore this cut that is unworkable and unsustainable for pharmacies and potentially harmful to patients. There is no other profession in healthcare or otherwise that is asked to provide uncompensated services, while at the same time be reimbursed for the products delivered at below cost. It is very plain to see that no one could sustain a business model like this. In this case it is not only unfair to the business owner and essential healthcare partner, it is also unfair to the patients that require the attention and care provided by the pharmacist.

As an alternative to the constant battle over reimbursement rates, we would suggest that the department investigate avenues that pharmacy can assist in cutting overall health costs while improving patient outcomes. This would be a win for all involved.

Additional Budget Elements Raise Concern

While the first concern is on the previously discussed most egregious proposal, the pharmacy community is also concerned about two other aspects of the Medicaid budget.

1. Enacted as part of the 2013-2014 budget was an amendment to Social Services Law to make it possible for local pharmacies to provide so-called specialty medications that have always been available under the FFS program but which had been excluded under managed care pharmacy policies. Thank you for your wholehearted response to fix this problem. Pharmacies and patients continue to benefit from this change in the law. However, this is now being threatened.

   The plan in the current budget proposal is to issue an RFP for a "specialized pharmacy vendor" which will limit access to certain medications to a selected pharmacy distributor. If such a program were to take effect, community pharmacies would be kept from dispensing medicines that are urgently needed by the most fragile, clinically compromised Medicaid patients. For these very reasons, these expensive products should be handled by local pharmacists who see the patients or their caregivers and can provide the support and counseling necessary to ensure that they are used appropriately and consistently. If these medications are relegated to a mail order pharmacy, patients will be at the mercy of a telephone consult; an 800 number and the delivery person do not provide an adequate substitute for the delivery of such sensitive medications. Keeping in mind that the population that we are trying to help will have a greater level of difficulty understanding someone that they cannot develop a relationship and therefore trust, which will have the direct result of non-compliance and unacceptable outcomes. This will result in waste of expensive medications therefore not saving anyone.

2. The Department has two Medicaid Managed Care "shared savings" items proposed to cut capitation rates. One is generalized, that greater "efficiencies" can be achieved in administering the pharmacy benefit. The second is specific, that plans are overpaying for diabetic supplies. These cuts to plans will either force plans out of Medicaid or reduce payments to providers.

   Once again, the Department is being shortsighted on the reality of these cuts. With pharmacists interventions there will be less waste and better health outcomes. These cuts again do not bode well for patients. Policy makers should look elsewhere for savings.

Moving Forward: Steps to Achieve Real Savings and Improve Healthcare

Community pharmacies are in a unique position to advance the Department's goals to move toward a more integrated, patient-focused healthcare model that will avoid unnecessary hospital admissions and strengthen the financial viability of the state's healthcare delivery system. Increasingly pharmacists are being called upon to provide targeted interventions and enhanced services such as adherence programs, medication synchronization, medication therapy management and comprehensive medication management and medication reconciliation upon discharge from hospital or nursing home. Payment models and incentives are being tested in pilot programs. Outcome are being measured and savings calculated. Several studies have shown positive outcomes with pharmacy interventions.

On December 3, 2008, New York State law authorized pharmacists to immunize adults against flu and pneumococcal disease. Today more than 11,000 pharmacists in New York have become certified immunizers, demonstrating that pharmacists welcome opportunities to broaden their role as healthcare providers. Vaccines are considered to be one of the most cost-effective preventive measures against certain diseases, and the Centers for Disease Control and Prevention (CDC) declared vaccinations to be one of the top 10 public health achievements of the 20th century, saving lives and healthcare dollars.[3] Immunizations are crucial to protecting patients from developing and dying from vaccine-preventable diseases, and in order to be successful, a team effort is required for all health care professionals to increase immunizations.[4] Pharmacists are in a pivotal position to increase awareness about the importance of vaccinations and identify those patients who may benefit from specific vaccinations. By increasing access to immunizations at community pharmacies we open the opportunity for a healthier community base. This access is even more essential for the Medicaid populations.

Delivery System Reform Incentive Payment (DSRIP) Program.

This year New York is embarking on a new venture, supported by federal Medicaid dollars, to radically change the healthcare system through payment reform, the Delivery System Reform Incentive Payment (DSRIP) Program. One of the factors for this program to be successful is to have a deliberate and all fully integrated sharing of patient information between providers. With encouragement from the pharmacy stakeholders, the Department has allowed pharmacy to join the Value-Based Payment Work Group to provide input on the development of these models. While this is a positive move, based on recent attitudes from the Department, we remain cautiously optimistic.

Today pharmacists practice in an information silo. Except for pharmacists with collaborative privileges in teaching hospitals or consultant pharmacists in skilled nursing facilities, the majority of pharmacists have no access to patient medical records/health information systems. The only data they have are what they have entered into their pharmacy patient drug profiles. For example, a pharmacist dispensing a prescription refill does not know that the patient had been in the hospital, is taking additional medications or had recent laboratory tests that would make the prescription refill unnecessary, unwarranted, or potentially dangerous. Countless opportunities for appropriate interventions or guidance are lost every day due to the profound lack of data available to pharmacists. When pharmacists have access to clinical data, they have the background

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[3] State of the world's vaccines and immunization. World Health Organization Web site. http://www.who.int/immunization/sowvi/en/. Accessed November 26, 2009. - See more at: http://www.pharmacytimes.com/publications/issue/2010/January2010/FeatureFocusVaccinations-0110#sthash.I9VOhxOJ.dpuf

[4] Gatewood S, Goode JR, Stanley D. Keeping Up-to-Date on Immunizations: A Framework and Review for Pharmacists. J Am Pharm Assoc. 2006;46(2):183-192. - See more at: http://www.pharmacytimes.com/publications/issue/2010/January2010/FeatureFocusVaccinations-0110#sthash.I9VOhxOJ.dpuf

and training to make meaningful improvements in clinical outcomes and patient care. Bi-directional data sharing among all providers, including pharmacist is an important and essential first step in building a system that will result in better care and improved outcomes.

We have closely followed the regional efforts with RHIOs and the state's effort with SHIN-NY, noting that substantial progress has been made. However, accessing these systems come with toll charges. Beyond the access charges, pharmacies would face additional financial costs and operational challenges such as investment in the systems necessary to access Health Information Exchanges, new data bases, software systems that process the billing for enhanced clinical services such as Medication Therapy Management, workflow adjustments, and staff re-allocations to name a few. Even if state funds were to be appropriated to offset access charges, substantial additional investments would be necessary. We encourage the state to take the first step.

We recommend that DSRIP funds be allocated to fully absorb any costs for pharmacies and other health care providers to access RHIOs and to link to SHIN-NY. Offsetting these costs would demonstrate the state's full commitment toward a fully operational bi-directional clinical information highway. Without a fully operational data-sharing system, structural healthcare reforms would not be possible.

Pharmacists' Role in Healthcare Is Evolving

The Report to the Legislature entitled **The Impact of Pharmacist-Physician Collaboration on Medication-related Outcomes: Results of the NYS Collaborative Drug Therapy Management Pilot Project** was released May 6, 2014 by the NYS Board of Pharmacy, as required by statute. The report documents results obtained from eleven participating New York State teaching hospitals including:

Anthony Jordan Health Center, Rochester
Bassett Healthcare Network, Cooperstown
Bronx-Lebanon Hospital Center, Bronx
Brooklyn Hospital, Brooklyn
Kingsbrook Jewish Medical Center, Brooklyn
Memorial Sloan Kettering Cancer Center, NY
Montefiore Medical Center, Bronx
Rochester General Hospital, Rochester
Roswell Park Cancer Institute, Buffalo
United Health Services, Binghamton
Upstate Medical Center, Syracuse

A total of ten different disease states were managed at these sites. Pharmacists utilized written agreements or protocols with participating physicians to manage drug regimens of patients being treated by those physicians for a specific disease or disease state. Managing drug regimens could include adjusting the drug, drug strength, frequency of administration, and/or route of administration. Pharmacists could also order and evaluate clinical laboratory tests related to drug therapy management for the specific disease or disease state being treated. Data was collected, submitted and analyzed.

The report is extensively documented and results are reported using published literature and well accepted evidence-based clinical criteria. At each site and for each disease state studied, pharmacist collaborations achieved higher values than expected with usual care. Results of the pilot were extrapolated into cost savings across the population of New York. Here is a snapshot of the results:

- Control of anticoagulation: Based on the current disease burden of atrial fibrillation in NYS, it is estimated that increased access to pharmacist-managed anticoagulation could potentially translate into prevention of 9,000 deaths, 15,000 adverse events and $214 million savings annually.
- Comprehensive diabetes management: Extrapolating results to the 10.4% of NYS adults with diabetes could result in an annual savings of $1.5 to $5.3 billion.
- Heart failure: This significant cause of hospitalization and readmissions costs New Yorkers over $2 billion annually. By improving medication adherence, monitoring lab results and correcting suboptimal medication utilization, the programs decreased re-hospitalization rates by 62% for a projected state savings of $600,000,000 annually.
- HIV: The multidisciplinary team included pharmacists who provided strategies for medication adherence and therapeutic care plans for chronic disease management.
- Oncology: Pharmacists provided supportive care for patients undergoing intense chemotherapy treatments and associated side effects.
- Asthma: Documented pharmacist-managed asthma programs have been shown to reduce the number of hospitalizations and emergency room visits by 30% to 75%. While this data was not specifically collected in the pilot sites, improvements in medication utilization and adherence more than doubled. The economic impact has a potential range of $150 to $400 million annually.

Most states have laws that allow pharmacists to practice collaboratively with physicians and other primary care providers. The results from the pilot in New York mentioned above clearly indicate that the profession has much to offer in terms of improved clinical outcomes for patients and controlling healthcare costs. The evidence in New York is consistent with a report released by the National Governor's Association, **The Expanding Role of Pharmacists in a Transformed Health Care System:** "Studies of pharmacists providing medication therapy management services to improve therapeutic outcomes indicate that such services can improve outcomes and reduce costs." We are pleased to note that the 2015-2016 budget proposes to extend the pilot in teaching hospitals for another three years, but to truly maximize the clinical benefit and cost savings associated with an expanded role for pharmacists, scope of practice should be broadened so that pharmacists can provide advanced clinical services throughout the healthcare system.

In Conclusion

In calling on the legislature to reject the Governor's proposed Medicaid budget cut for pharmacies in the Fee for Service program, we recognize that you will need to find $18 million dollars somewhere. Consider the enormous savings potential that pharmacists can bring not only to the Medicaid program but also to every payer if pharmacists were able to practice their profession at their full potential. Other states have recognized their value as has the federal government. It's time, New York!