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Community Pharmacy Association
of New York State

Focus of Community Pharmacy:
Access. Trust. Wellness.

Testimony for the
Joint Legislative Budget Hearing on Health/Medicaid

January 29, 2020
9:30AM
Hearing Room B

Community Pharmacy Association of NYS
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Albany, NY 12210
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The Community Pharmacy Association of New York State would like to thank you for your strong past support of community pharmacy in New York and for the opportunity to testify today related to the State Fiscal Year (SFY) 2020-21 State Budget.

The Community Pharmacy Association of New York State represents pharmacies of all types and sizes, and in every county across the State. Together, we are focused on protecting patient access to pharmacy care and strengthening the role that pharmacists can play in improving patient health outcomes while reducing costs. In this regard, we would like to comment on six specific Executive budget proposals as outlined below.

(1) OPPOSE: Cuts to Pharmacy Services as Part of Medicaid Reform

On January 1, 2020, a 1% across-the-board Medicaid cut was enacted to providers including community pharmacies. We do not believe that the State has the ability to impose this cut on pharmacies under Fee-for-Service Medicaid, since such pharmacy reimbursement is dictated federally by the Center for Medicare and Medicaid Services (CMS) rules which require that pharmacies be paid under FFS program through an actual acquisition based method determined by state and regional surveys. We have raised this concern with the Governor's office and Health Department and await a resolution (please see attached letter sent to Administration).

More broadly, community pharmacy has seen very significant cuts over the last several years, namely due to the move of the state's Medicaid pharmacy benefit to Managed Care (MC) for most beneficiaries (with the exception of less than one million individuals who remain in FFS as referenced above). Pharmacies are now paid at or below their actual costs by MC plans and their Pharmacy Benefit Managers (PBMs). This model is untenable and there is no ability to sustain any further cuts.

We are concerned that the Executive Budget proposal to address the stated $2.5 billion Medicaid shortfall through the creation of a Medicaid Redesign Team (MRT) 2 provides for many uncertainties and it appears to say that if the Legislature does not accept the recommendations that come out of MRT 2, due April 1, 2020, across the board cuts will be implemented against most Medicaid providers including community pharmacy.

When discussing the Medicaid shortfall, the Governor stated that there should be "zero impact to beneficiaries." This is critical, but it is also critical that the Administration understand that **cuts to services will impact beneficiaries and cuts to struggling pharmacies will impact beneficiaries as we work to remain open and continue to provide high quality pharmacy services for our patients**.

We would respectfully offer the following recommendations in this regard:

- ✓ Unlike MRT 1, community pharmacy should be represented at the table of MRT 2 (we have also made this request to the Administration).
- ✓ Across the board cuts like the 1% enacted 1/1/20 should not be applicable to pharmacy under Medicaid FFS per CMS rules.
- ✓ Further cuts to community pharmacy are unsustainable. Instead, we can recommend other ways that pharmacists can improve outcomes and reduce costs

by better managing medication and health needs of patients, including some proposals described below.

(2) SUPPORT: Pharmacist-Administered Immunizations (Part I of S.7507/A.9507)

Since 2008, pharmacists have had the ability to assist with providing immunization care in New York State. Current law is set to sunset this year and the Executive Budget makes pharmacist immunization administration authority permanent for CDC-recommended vaccines for adults.

High rates of immunization are our best defense against vaccine-preventable disease and help avoid far costlier care for the treatment of these diseases. It is in the best interest of the state and public health overall to ensure that patients have seamless access to vaccinations seven days a week including evenings and weekends. This is the value pharmacies add.

Currently in New York, pharmacists lack the ability to comprehensively serve their communities since they are only authorized to give certain vaccines (influenza, pneumococcal, meningococcal, tetanus, diphtheria, pertussis and herpes zoster vaccinations). Because they lack the authority to give the remaining vaccines recommended for adults (hepatitis A, hepatitis B, MMR, varicella, and HPV), pharmacists have had to turn patients away who requested them. This includes adults seeking the MMR vaccine last year during the height of the outbreak in New York. With vaccines, there should be no wrong door for a patient who needs and is interested in getting a vaccine from an authorized immunizer.

Over a decade of compelling research supports the ability of pharmacists to improve health by increasing access and opportunity for vaccine delivery. Pharmacists are well positioned to expand on public health efforts to reduce preventable diseases given their clinical expertise and integration in communities across the state, but only to the degree that they are authorized by law. New York is currently the only state that does not allow pharmacists to administer hepatitis A and hepatitis B vaccinations, and New York is one of two states that do not allow pharmacists to administer MMR, varicella, and HPV vaccinations to adults.

We would respectfully offer the following recommendations in this regard:

- ✓ We strongly urge New York to join nearly all other states by allowing pharmacists to administer the remaining vaccines recommended by the CDC for adults and to make this law permanent, as proposed in the Executive Budget. This will protect New Yorkers from death and disability caused by all vaccine-preventable diseases. This will not only save lives but it will save limited health care dollars in Medicaid and other programs.
- ✓ We urge inclusion of this proposal in the Final State Budget.

(3) SUPPORT: Regulation of Pharmacy Benefit Managers (Part U of S.7507/A.9507)

The Executive Budget includes a proposal to regulate Pharmacy Benefit Managers (PBMs) through licensure and a series of other requirements. This includes provisions to:

- Require PBMs that are involved with the commercial market, Medicaid, NYSHIP and Workers Compensation be initially registered with the State Department of Financial Services (DFS) and follow minimum standards and code of conduct, established in regulation by DFS, in consultation with the State Department of Health (DOH). Included is a prohibition on spread pricing across markets and new pharmacy network standards.
- On or after January 1, 2022, require PBMs be licensed by DFS and follow standards focused on conflicts of interest, deceptive practices, anti-competitive practices, unfair claims practices and others protecting consumers, as set forth by DFS, in consultation with DOH, in regulation.
- Require PBMs to follow reporting requirements including disclosure of any financial incentive or benefit for promoting the use of certain drugs or other arrangements affecting health insurers, their insureds and any other information related to the business, financial condition or market conduct of the PBM. This would include reporting any pricing discounts, rebates, inflationary payment, credits or other incentives received by PBMs. They would also have to disclose terms and conditions of contracts including financial and reimbursement incentives related to PBMs services, including reporting on dispensing fees paid to pharmacies.
- Assess PBMs for the operating expenses of DFS solely attributable to regulating PBMs.
- States that failure to comply with such requirements could result in revocation of registrations or licenses.

We would respectfully offer the following recommendations in this regard:

- ✓ We support the need to regulate PBMs in New York. They are currently the one entity in the healthcare continuum that is not regulated like pharmacies, wholesalers, manufacturers, hospitals, long term care facilities, health insurance plans/MCOs and other health providers. We believe the time is now to close that gap as other states have and ensure that the state has oversight over PBMs and that they must comply with state laws and are held to robust standards and a code of conduct in New York State.
- ✓ Patients and providers need these protections to end prevent unfair practices. We urge immediate action to regulate PBMs in New York through the Final State Budget.

(4) SUPPORT: Recognizing Registered Pharmacy Technicians in all Pharmacy Settings (Part H of S.7507/A.9507)

A law enacted in 2019, created the title of "Registered Pharmacy Technician" for nationally supervised individuals directly supervised to assist licensed pharmacists. Unfortunately, the law only allows for their practice in Article 28 facilities.

The Executive budget would recognize these individuals regardless of practice setting. A person who has become nationally certified and meets all other qualifications of the title should not be faced with the decision of only practicing in a hospital setting, or otherwise being considered unlicensed personnel. The budget proposal corrects this inequity, while also expanding the number of unlicensed personnel and registered pharmacy technicians that a licensed pharmacist may supervise to 6:1 and 4:1, respectively.

We would respectfully offer the following recommendation in this regard:

- ✓ We support this proposal and urge that it be enacted in the final State Budget.

(5) REQUEST FOR EXPANSION: Collaborative Drug Therapy Management (CDTM) (Part I of S.7507/A.9507)

The current law which allows for the use of collaborative drug therapy management (CDTM) protocols between physicians and pharmacists in Article 28 facilities is scheduled to sunset this year. This Executive Budget proposal makes the current CDTM law permanent and expands the settings where it may be utilized. While we appreciate the intent of this proposal, the qualification requirements for pharmacists to participate in CDTM are more focused on and relevant to hospital practice. They are not germane to community pharmacy, so despite there being a need for far more medication management for patients on an outpatient basis, community practicing pharmacists are not likely to participate. As a result, we would urge that this proposal be expanded to make CDTM permanent while also authorizing Comprehensive Medication Management (CMM) for patients with chronic diseases in the community setting.

Given the State's continued efforts around health care transformation and moving to value-based care, the need has never been greater for pharmacists to play a bigger role in ensuring that the medication needs of patients with chronic diseases are properly managed, that they are taking the right medications and that they are adherent to their drug regimens.

According to the American College of Clinical Pharmacy, 57% of medication therapy problems are the result of inadequate therapy. Including the reasons *dose too high* (6.83%) and *unnecessary therapy* (6.68%) brings the number to just over 70%. The primary reason these problems occur is that, after clinicians prescribe a medication, time paucity during subsequent visits or hospital episodes makes it difficult to review and optimize therapy on a continuous basis.[i] This is where New York is missing an opportunity to better utilize the skills and expertise of pharmacists to identify and address inadequate therapy. Pharmacists are specially trained in understanding and managing medications for patients and New York should empower them to do so as part of a patients' care team by authorizing CMM.

CMM will improve patient health and outcomes while also saving money. One report, *Get the Medications Right*, summarized the responses of 935 pharmacists and found a variety of positive outcomes and cost reduction results achieved by programs and organizations across the country. For instance, the study identified demonstrated reductions in emergency department and hospital admissions and improvements in

metrics related to chronic conditions such as asthma, diabetes and hypertension, and other illnesses, including schizophrenia. Cost savings reported by survey participants showed financial return on investments that ranged from 2.8-to-1 to 12-to-1. [ii]

We would respectfully offer the following recommendation in this regard:

- ✓ We urge that this proposal be expanded to also authorize Comprehensive Medication Management in the Final State Budget, similar to legislation we support (S5296/A3849) in this regard.

(6) REQUEST FOR PARTICIPATION: Creation of a Prescription Importation Commission

In his State of the State Address book, the Governor called for the creation of a Prescription Importation Commission to bring together insurers, consumers, health providers and other stakeholders to identify any potential consumer savings from importing drugs from Canada and compile a list of drugs that could be imported through such a program.

There are certainly many safety, pedigree (track and trace) and pharmacy practice concerns with regard to such an initiative. Our Association would be very interested in participation in such a Commission to ensure that all aspects are thoroughly studied and considered with regard to drug importation.

We would respectfully offer the following recommendation in this regard:

- ✓ We would ask that community pharmacy be represented on this Commission among other experts and will make this request of the Administration once more details are known about the creation of this Commission.

Thank you for your consideration of our comments regarding the SFY 2021 budget. The goal of our members is to ensure patient access to high quality pharmacy and related care throughout the State. Please continue to see our Association and members as a resource on any medication or health care topic where we can provide insights or assistance.

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[i] Comprehensive Medication Management in Team-Based Care, American College of Clinical Pharmacy, https://www.accp.com/docs/positions/misc/CMM%20Brief.pdf as referenced in https://blog.cureatr.com/comprehensive-medication-management-standard-of-care

[ii] McInnis, T. Capps, K. Get the medications right: a nationwide snapshot of expert practices—Comprehensive medication management in ambulatory/community pharmacy. Health2 Resources, May 2016 as summarized in https://blog.cureatr.com/comprehensive-medication-management-standard-of-care

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January 28, 2020

Honorable Andrew M. Cuomo
Governor of the State of New York
Executive Chamber
State Capitol
Albany, NY 12224

Honorable Donna Frescatore
Medicaid Director
NYS Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Applicability of 1% Medicaid Cut to Fee for Service Pharmacy Services

Dear Governor Cuomo and Medicaid Director Frescatore:

On behalf of the community pharmacies across New York State that we collectively represent, our Associations are writing to express our concerns regarding the applicability of the recently announced 1% Medicaid Cut to pharmacy services under Fee-for-Service (FFS), effective January 1, 2020. We respectfully request that the cut be restored.

Unlike most other Medicaid providers, pharmacy reimbursement for patients with coverage under Medicaid FFS is dictated by the Centers for Medicare and Medicaid Services (CMS). Under the CMS *Covered Outpatient Drug Final Rule*, published February 1, 2016, states are required to **use an actual acquisition cost (AAC)** to reimburse pharmacies for their ingredient costs under their FFS programs 42 C.F.R. § 447.518(b), while also **having a professional dispensing fee that is sufficient to cover a long list of specified pharmacy costs**

associated with operating pharmacies and employing pharmacists to provide services to Medicaid patients.[1] 42 C.F.R. §§ 447.502, 447.512(b), 447.514(b)(1).

Further, in developing their acquisition-cost reimbursement, states must "*provide adequate data such as a State or national survey of retail pharmacy providers or other reliable data other than a survey to support any proposed changes to ... the components of the reimbursement methodology.*"[2]

To be in compliance with this requirement, New York changed its laws in 2017 to begin reimbursing pharmacies under FFS using CMS' National Average Drug Acquisition Cost (NADAC) survey data for drug ingredient costs and a dispensing fee that NY Medicaid calculated based on regional state surveys and related studies and codified in law.

The CMS rule also requires states to review their current professional dispensing fee whenever they propose to change their reimbursement methodology. *[W]hen states are proposing changes to either the ingredient cost reimbursement or professional dispensing fee reimbursement, they are required to evaluate their proposed changes in accordance with this final rule, and states must consider the impacts of both the ingredient cost reimbursement and the professional dispensing fee reimbursement when proposing such changes to ensure that total reimbursement to the pharmacy provider is in accordance with the requirements of Section 1902(a)(30)(A) of the Act.* 81 Fed. Reg. at p. 5201.

Given the CMS rule, we are very concerned that the 1% Medicaid cut to pharmacy providers, enacted to address the state's budget gap, is in violation of federal requirements. The cut is not based on any study or new survey or "data" to support it, and, in fact, the existing data on cost to dispense data available and used in the past in New York *undermines* the validity of this proposed cut. It appears to fail to meet the required legal standard for dispensing fees under CMS requirements and consequently appears to contradict CMS' requirements for acquisition-cost based reimbursement to pharmacies under FFS.

Finally, of note, when Washington State attempted to implement changes to how they reimburse pharmacies under Medicaid, CMS denied their State Plan Amendment because it was inconsistent with the requirements of:

- *Section 1902(a)(30)(A) of the Social Security Act (the Act) which requires, in part, that states have a state plan that provides such methods and procedures 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 plan at least to the extent that such care and services are available to the general population in the geographic area; and*

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[1] As CMS made clear in its implementation guidance to the states, it is not the purpose of the CMS Final Rule to ensure a cost neutral outcome for the states. *See* CMS FAQ, July 6, 2016, Q&A 4 at https://www.medicaid.gov/federal-policy-guidance/downloads/faq070616.pdf (describing the rule's purpose as "to more accurately reflect the pharmacy providers' actual prices paid to acquire drugs and the professional services required to fill a prescription.").

[2] *Id.*

- *Federal regulations at 42 CFR 447.502, 447.512 and 447.518 which provide that payments for drugs are to be based on the ingredient cost of the drug based on AAC and a Professional Dispensing Fee.*

We believe the same issues apply with the recent 1% Medicaid cut. New York is no longer using NADAC or state-based survey data to reimburse pharmacies for drug ingredient costs under Medicaid. Instead, New York is paying NADAC minus 1%. Similarly, New York is no longer paying pharmacies a professional dispensing fee determined by regional survey and studies. Instead, New York is paying a professional dispensing minus 1%. To reiterate, the 1% cut was not determined to be necessary or valid because pharmacy dispensing costs had decreased in New York or that the survey for ingredient costs had decreased. Instead, New York has a budget gap and assessed a 1% cut to pharmacy reimbursement to address a shortfall.

For these reasons, **we respectfully ask that New York reconsider its imposition of the 1% cut to pharmacy reimbursement under Medicaid FFS.** We would welcome further discussion on this important request with you and your staff.

Thank you for your consideration of this letter.

Sincerely,

Michael Duteau RPh
President
Community Pharmacy Association of NYS

Steve Moore Pharm D
President
Pharmacists Society of the State of NY

Cc: Robert Mujica, Director of the Division of the Budget
Beth Garvey, Counsel to Governor
Megan Baldwin, Assistant Secretary for Health
Amir Bassiri, Chief of Staff to Medicaid Director
Janet Zachary-Elkind, Deputy Director, Division of Program Development & Management, OHIP