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# Chain Pharmacy in New York State: Improving Patient Care & Outcomes

## Testimony for the Joint Legislative Budget Hearing on Health/Medicaid

## February 2, 2015
## 10AM
## Hearing Room B


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Honorable Chairmen DeFrancisco, Farrell, Hannon and Gottfried and other distinguished members of the Committees, my name is Mike Duteau. I am a pharmacist, Vice President of Business Development and Strategic Relations at Kinney Drugs and President of the Chain Pharmacy Association of New York State. We 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) 2015-16 State Budget.

We would first like to provide some background on our industry in New York State and highlight priority issues that affect community pharmacies and the services they provide to New Yorkers.

There are approximately 4,201 community pharmacies. Chain and independent pharmacies across New York State collectively employ over 125,361 full and part-time workers including almost 11,784 pharmacists. Chain pharmacies specifically, employ 114,246 of the employees in New York and contribute $1.311 billion of $1.379 billion in total taxes paid by pharmacies to New York State annually. New York's community pharmacies play a vital role across the state providing high quality pharmacy care to our residents. The services provided by pharmacies help to keep people healthy in the community, as well as preventing other more costly health interventions such as hospitalizations and emergency room and practitioner office visits.

Community pharmacies are the face of neighborhood health care. The innovative programs of pharmacies deliver unsurpassed value- improving health and wellness and reducing health care costs. Through face-to-face counseling, the pharmacist-patient relationship helps ensure that patients take their medications correctly. This improved medication adherence means a higher quality of life and the prevention of costly treatments. Innovative community pharmacy services - vaccinations, health education, screenings, simple laboratory examinations and procedures, disease management and more - also make up the health care delivery system of tomorrow.

**Fair Payment to Pharmacies**

**The Chain Pharmacy Association of New York State respectfully requests the State Senate and Assembly's assistance in rejecting a very problematic and flawed pharmacy reimbursement proposal included in the Executive Budget to protect pharmacy care in New York State.** The Budget proposes to cut pharmacy reimbursement under Medicaid Fee for Service (FFS) by $36 million gross ($18 million state share) in 2015-16 by reducing pharmacy payments for brand name drugs from Average Wholesale Price (AWP) minus 17 percent and a $3.50 dispensing fee to AWP minus 24 percent with an $8.00 dispensing fee.

Like last year, the State Department of Health (DOH) is proposing to set a level of reimbursement that would pay New York's pharmacies (chain and independent) at below their costs to acquire these medications. And like last year, the basis for this devastating reduction is the highly flawed and inaccurate analysis of pharmacy acquisition cost surveys conducted in 2012, as stated by the State Health Department at a pharmacy stakeholder meeting held on January 26, 2015. Last year DOH admitted that less than 50% of pharmacies would be able to purchase medications at the proposed reimbursement levels. The overall financial impact of this year's FFS proposal is a deeper cut. If enacted, it would provide an unsustainable payment model for pharmacies. Are other businesses in New York asked to provide products at below

their costs? Further, this is on top of uncollectible co-payments for one and every two Medicaid prescriptions, on average.

We have grave concerns with this year's proposal and the negative impacts it would have if pharmacies cannot afford to purchase and provide these medications for patients enrolled in Medicaid FFS. Patients who remain in FFS and who have not transitioned to a Managed Care plan have complex care needs, often co-morbidities and may require multiple prescription medications which ultimately help to prevent the need for more advanced and costly care. Given this, a proposal to deeply reduce payments to the pharmacies that serve these patients seems to be extremely misguided.

What's more, New York is already among the very lowest of other states in the amount paid to pharmacies for brand name drugs under FFS. And while DOH is not taking a savings in the budget by requiring Medicaid Managed Care plans to reduce pharmacy reimbursement in a similar manner this year, they have been very clear on their intent to do so. If AWP-24% is set as the New York benchmark, as proposed, it will have a ripple effect and be adopted by Medicaid Managed Care and commercial plans. Without question, the impact of this of community pharmacies (chain and independent) could be pharmacy closures and job losses, leading to patient access issues.

Medicaid Managed Care plans now manage the pharmacy benefit for the overwhelming majority of Medicaid patients. We thought it would be important to remind the panel that we learned last year that through the shift to Managed Care the State has saved hundreds of millions, almost double what was budgeted for the transition since it began. This is due to a number of factors including more narrow networks, mail order and reduced reimbursement, all of which has had a significant impact on community pharmacies. Given this, we fail to understand why DOH continues to be so focused on imposing very deep cuts to pharmacies under the FFS program.

Finally, due to the efforts of the Senate and Assembly, the Final State Budget for 2014-15 rejected DOH's proposed reimbursement based on their highly flawed analysis of pharmacy acquisition cost surveys conducted in 2012. In addition to rejecting their proposal, the Budget directed DOH to consult with pharmacy stakeholders to develop a new methodology of Medicaid Fee-for Service reimbursement that is transparent and adequate.

Our Association and others representing all sectors of pharmacy stakeholders were invited to participate in meetings over the summer and fall with the Department of Health to discuss alternative methodologies that would meet the standards set forth in the law. Three monthly meetings were held during the summer of 2014 where we participated and presented ideas related to alternative reimbursement structures. September and October meetings were scheduled but subsequently cancelled by the Department. When we reconvened on November 17th, the Department provided a presentation outlining the areas where there appeared to be agreement and areas where we had not yet reached consensus. In the last slide (attached to this testimony), the Department listed a number of next steps including monitoring national reimbursement models including NADAC and a national pharmacy dispensing fee survey (CCPA) and continuing monthly meetings.

The stakeholders present November 17th posed a very direct follow up question asking whether the State plans to pursue pharmacy reimbursement changes in the upcoming State Budget. In response, DOH stated that there were no plans to pursue changes to Medicaid pharmacy reimbursement in the upcoming budget given the transition to managed care and a diminishing Fee-for-Service patient population.

As a result, we requested that the focus of pharmacy stakeholder meetings be broadened to look at the major health care system transformations that the State is undertaking through DSRIP and the goal of value-based payments to 90% of providers by 2020. We have been working to identify ways that pharmacists, one of the most accessible healthcare providers, can partner with the State, other providers and health plans to pursue programs and interventions utilizing pharmacy clinical services and medication adherence programs to improve patient care, health and outcomes. This is discussed in further detail below. We believe this is the way to truly control and reduce Medicaid costs. However, if pharmacies are unable to afford to participate in Medicaid, the entire foundation of DSRIP and the safety net is jeopardized without access to medication and pharmacy services.

Given the chain of events over the summer and fall, we were shocked and greatly disappointed to see that the SFY 2015-16 Executive Budget includes this proposal to reduce pharmacy reimbursement under Medicaid FFS for brand name drugs by $36 million. This is contrary to what we were told by the Department and in our view, does not meet the charge of the law enacted in the Final State Budget last year requiring the Department to develop a new reimbursement methodology that is *transparent and provides an adequate level of reimbursement to pharmacies.* We participated in all of the stakeholder meetings held by the Department and presented and exchanged information and ideas in earnest. There was no final agreement, nor any discussions related to pursuing a FFS reimbursement cut because consensus had not been reached.

**In sum, given the impact of the proposed reimbursement cut on community pharmacies and the patients we serve and the fact that it is neither transparent nor adequate as the law requires, we respectfully ask for your assistance in rejecting this highly flawed pharmacy reimbursement proposal in the Final State Budget.**

As a counter proposal to further decreases in pharmacy reimbursement levels, we believe New York should instead consider how pharmacists are currently being underutilized and can do so much more to improve patient care and access and reduce unnecessary hospitalizations and other costly care. Provided below are several proposals which we believe will help move the role of pharmacists into the future and produce the real, systemic cost savings that year after year pharmacy reimbursement reductions do not.

**Reform and Expand Pharmacist-Administered Vaccines**

As the face of neighborhood health care, community pharmacies and pharmacists provide accessible and cost-effective health services including immunizations to their local communities. Community pharmacists in particular are valuable members of the health care team who have an important role to play in providing immunization services. Highly educated to provide patient care services, pharmacists are well-suited to help states increase their vaccination rates and

reduce the incidence of vaccine preventable diseases. Notably, the Centers for Disease Control and Prevent (CDC) reports that vaccines have reduced or eliminated many infectious diseases that once routinely killed or harmed thousands each year; according to data collected by CDC, pharmacists have been instrumental in increasing the vaccination rate in the United States. Unfortunately, pharmacists are still limited in their ability to further increase vaccination rates by state laws and rules that restrict the age of patients who pharmacists can vaccinate and the vaccines that pharmacists can offer. Pharmacists should be allowed to practice to the maximum of their capabilities-partnering with other health care providers in coordinated efforts to decrease the number of under-vaccinated New Yorkers.

We strongly support allowing pharmacists to provide immunizations to those aged 11 years and older and to expand the types of vaccines that may be provided by pharmacists to all recommended by the CDC for this population. Laws and regulations that limit the ability of pharmacists to administer vaccinations should be amended to enable pharmacists to make a broader impact on vaccination rates.

*Pharmacists Should be Permitted to Administer Vaccines to Adolescents*

As noted in an article published in the official Journal of the American Academy of Pediatrics, the current health care system has not adequately met the vaccination needs of the adolescent population in the United States over the years. Overall vaccination rates could potentially be increased through complementing the efforts of primary care physicians with the efforts of other health care settings to deliver vaccines, such as pharmacies.

*Pharmacists Should be Permitted to Administer Immunizations to the Public in Accordance with the CDC's Recommended Immunization Schedules for Adolescents and Adults*

This will allow pharmacists to serve the many patients who go unvaccinated, because they do not have the time to schedule an appointment with their physician. As evidenced by the increase in influenza vaccinations once pharmacists were permitted to administer them in New York, pharmacies provide an easily accessible location for the public to obtain immunizations at their convenience.

Not only would these changes benefit public health goals by reducing the number of unvaccinated residents, but expanding pharmacists' authority in this regard could help meet growing patient demand for health care services faced by all providers as a result of health care expansion under the Patient Protection and Affordable Care Act.

Expanding pharmacists' vaccination authority can also lead to decreased health care costs for consumers, health insurers and other third party payors, including Medicaid. As noted by the Department of Defense in a 2011 final rule expanding the portfolio of vaccines that TRICARE beneficiaries may obtain from community pharmacies, significant savings were achieved under the TRICARE program when the program was first implemented to allow beneficiaries to obtain flu & pneumococcal vaccines from retail pharmacies. It was estimated that for the first six months that beneficiaries could obtain their vaccinations from pharmacists, 18,361 vaccines for H1N1, flu & pneumococcal were administered at a cost of nearly $300,000; had those vaccines

been administered under the medical benefit, the cost to TRICARE would have been $1.8M. This clearly represents significant health care savings, which one would expect to be amplified and replicated if pharmacists were allowed under state laws to provide a broader portfolio of vaccines and/or immunize a broader patient population. (This would be on top of savings that would result from fewer hospitalizations and lost days at work due to more patients obtaining immunizations.) Likely this is why the Department of Defense opted to expand the types of vaccines that TRICARE beneficiaries may obtain from community pharmacies to include all CDC-recommended vaccines.

*Reform Existing Pharmacist Immunizer Laws in New York*

In addition to expanding the immunizations that pharmacists are allowed to administer, we urge reforms to existing laws to remove the sunset dates around pharmacist administered immunizations. .

Further, the requirement that the standing order given to a pharmacist must be from a physician or Nurse Practitioner (NP) in the *same county* is unnecessarily onerous and can be difficult to obtain. We urge that the law be changed to allow for statewide standing orders. Finally, we urge that all immunizations be permitted under a standing order. Currently the vaccine against shingles requires a patient-specific prescription.

Immunizations are the best defense against morbidity and mortality for diseases for which vaccines are available and we must remove all barriers to significantly increase vaccination rates among our population. **The existing law permitting pharmacists to administer the shingles vaccine expires this year and for other vaccines the law expires in 2016. We believe this is the year to make the law permanent and to reform and expand it.**

## Collaborative Practice Agreements

Pharmacists are trained and well-qualified to provide limited, specific drug therapy management services and other prevention and wellness activities in collaboration with a patient's physician and other health care providers. In states where this type of practice is permitted, the services offered by community pharmacists deliver unsurpassed value – improving the health and wellness of patients while reducing health care costs. Pharmacists should be permitted to practice to the fullest extent of their training; to permit this we support language in Pharmacy Practice Acts that allow physicians and pharmacists to enter into "Collaborative Practice Agreements" with one another for pharmacists to provide collaborative drug therapy management (CDTM).

Collaborative practice agreements are written agreements between a pharmacist or pharmacy and a physician or group of physicians wherein pharmacists work in collaboration with physician(s) to manage patients' drug therapy. Nearly all 50 states allow these types of arrangements in a community pharmacy setting. In New York such agreements are permitted only for teaching hospitals. Under collaborative practice agreements, pharmacists are generally permitted to modify drug therapy in accordance with written guidelines; conduct tests and screenings; and order lab work in accordance with written guidelines or protocols agreed to by physicians in collaborative practice agreements. Physicians have ultimate authority to further delineate the activities that pharmacists may and may not perform in accordance with the law under the

collaborative practice agreement. Under this type of arrangement, pharmacists serve as physician extenders and help to monitor and carry out physicians' drug therapy plans for their patients.

It bears noting nearly all states permit physicians' assistants and nurse practitioners to work collaboratively with physicians to modify a patient's drug therapy. Pharmacists, who have more education and training than any other health care provider on medications and their effects on the human body, should be granted this same opportunity.

Patients, physicians, and the health care system as a whole benefit from the use of collaborative pharmacy practice agreements, as this type of arrangement offers a safe, convenient, and cost-effective way to address patients' drug therapy problems. Community pharmacists continue to be regarded as one of the most trusted health care professionals in the nation. Pharmacists are capable of performing the tasks which collaborative practice agreements require.

Collaborative practice agreements improve patient care in a variety of ways. Research has shown that approximately one-third to one-half of all patients in the United States do not take their medication as prescribed by their providers. Pharmacy services administered by pharmacists in community pharmacies have been proven to improve compliance and prevent unnecessary hospitalizations caused by drug misuse. Collaborative practice agreements are another mechanism to increase the opportunities for pharmacists to contribute their expertise to drug therapies in this regard.

**CLIA-Waived Testing**

With the rise of chronic disease, many providers and national associations recommend regular health testing, and the convenience of community pharmacists increases the public's access to this vital service. There are many types of health tests available to the public and administered by various providers. Some common health tests provided by community pharmacist include, among others, blood glucose, A1C (diabetes), cholesterol and lipid panels, and body composition. In addition, community pharmacists may provide consultation as to the results and follow-up with a primary care provider.

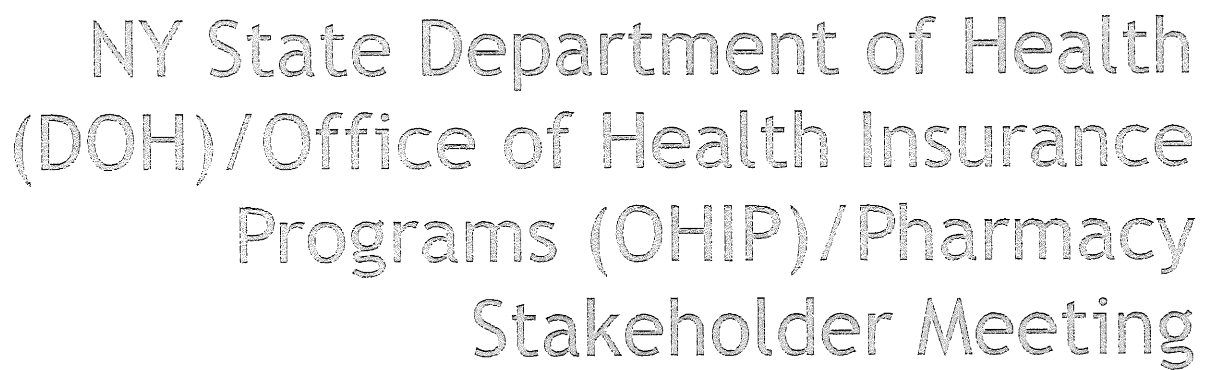
The federal government regulates clinical health testing performed on humans in the US through the Clinical Laboratory Improvement Amendments (CLIA) which sets quality standards for testing regardless of where the test was performed. Some health tests are so simple, accurate and safe that they are "waived" from CLIA requirements. All tests provided by community pharmacists are CLIA-waived, including the common tests listed above.

Although the CLIA program is a federal program and health testing providers must comply with federal laws, New York has implemented additional requirements creating barriers for pharmacists to provide these simple health tests. This includes a requirement that a physician order is required before a test can be conducted so patients may not request a CLIA-waived test for educational and self management purposes. In addition, while pharmacists are permitted to conduct select tests under the Limited Services Laboratory License, the direction of these activities would need to be conducted under a Lab Director such as physician with laboratory

experience. We recommend that New York align its regulations with the federal requirements to make it easier for pharmacists to provide this safe, cost-effective health service to our patients.

**Conclusion**

The Chain Pharmacy Association of New York State and our member companies would like to thank the State Senate and Assembly for your longstanding and unwavering support of community pharmacy. We wholly support reimbursement rates that are fair, adequate and commensurate with the quality and comprehensive pharmacy services that our members provide. For this reason, we ask that you **reject the very problematic and inaccurate new pharmacy reimbursement proposal** by DOH in the Final State Budget in order to protect pharmacy care in New York State. We also urge the State to consider our recommendations to expand patient access to care through expanded pharmacist-administered immunizations, pharmacist MTM and CDTM services and routine testing to increase low vaccination rates and patient medication adherence and reduce more costly institutional care. We welcome the opportunity to provide any further assistance or information that would be helpful and look forward to continuing to partner with you to ensure the highest quality of pharmacy care for all New Yorkers.



# NY State Department of Health (DOH)/Office of Health Insurance Programs (OHIP)/Pharmacy Stakeholder Meeting

November 17, 2014

# Summary/Next Steps

**Summary:**

- DOH/Pharmacy Stakeholder Positions: There is consensus in a couple of areas, but there continues to be differences in positions in two key areas; the definition of transparency and interaction between FFS and Managed Care.
- WAC: While WAC is a published price and used widely in the market, it bears no significant benefit over AWP other than its availability from more than one publisher.
- NADAC: While NADAC provides a benchmark for states, it does not currently take into consideration "off invoice" discounts.
- CCPA Cost of Dispensing Survey
  - Results not yet been published
  - DOH will monitor. However, concern remains regarding our ability to have input into cost components and methodology

**Next Steps:**

- Modify statute to enable the use of WAC in the event that AWP is no longer published
- Continue to monitor NADAC, including survey for "off invoice" discounts
- Continue to monitor CCPA Survey
- Continue discussions in monthly meetings