Government Affairs Division

Assembly Budget Committee Testimony on the Proposed Fiscal Year 2013-2014 State Budget by The Independent Pharmacy Alliance
March 19, 2013

Good afternoon Chairman Prieto and Members of the Assembly Budget Committee. I am John Covello, Executive Director of Government and Public Affairs for the Independent Pharmacy Alliance, a trade group representing approximately 750 independently owned pharmacies in all size communities throughout New Jersey.

As this committee is well aware, nearly 300 IPA pharmacies are located in poorer and more urban New Jersey communities and thus serve a disproportionately higher number of Medicaid, PAAD/Senior Gold and AIDS patients than the more suburban stores – including most New Jersey chain store locations. They serve as the backbone of a crucial healthcare delivery system providing needed prescription drug services that keeps New Jersey’s most vulnerable citizens - children, poor, aged and disabled – able to manage their disease conditions, avoid more intensive and expensive health care treatments from doctors, nursing homes and hospitals. So many New Jersey independent pharmacies that serve these patients are being financially squeezed to levels that really jeopardize their ability to continue to serve their communities.

Medicaid Managed Care for Rx

For IPA, the major problem with this budget proposal concerning pharmacy services remains is the same issue that IPA objected since the FY 2012 budget - the shift of what turned out to be nearly 40,000 Medicaid Aged, Blind and Disabled (ABD) population's prescription drugs to Medicaid Managed Care Organizations (MCO) along with all Medicaid psychotropic drugs. Continuing this shift of Medicaid pharmacy services from fee-for-service (FFS) to managed care has been detrimental to patients and the urban pharmacies who serve their needs.

IPA believes this shift has not served the State or Medicaid patients well because:

1. There is no indication Medicaid's rebate collections are any better under managed care.

2. Patients are seeing disruptions in services, including their ability to seeking prescription and other pharmacy services from pharmacies of their choice.

3. Pharmacies – especially in urban locations – are seeing reduced margins and patient exclusions that threaten their ability to continue serving these patients.

Pharmacies are being excluded from Medicaid MCO networks for specialty drugs and DME. They are also seeing an increasing change to drug exclusions from formularies that require time consuming prior authorization approvals to keep patients on their medications. There are even efforts now to “lock out” ABD managed care patients from local urban pharmacies by directing them to other pharmacies – whether or not it is more convenient for them. In the end, all this hurts is the most vulnerable patients.
The savings claims from shifting Medicaid pharmacy services from fee-for-service to managed care are still questionable. Notwithstanding the Affordable Care Act’s (ACA) requiring Medicaid MCO’s provide the same drug rebates to the states as they receive with Medicaid FFS, there has been little evidence that CMS or NJ Medicaid has received all the prescriptions rebates to offset program costs. In fact, since 2012, Medicaid and the MCO’s have yet to provide MCO drug rebates back to the state whenever it has been requested by the federally mandate Medicaid Drug Utilization Review Board (DURB). There are major fiscal policy questions as it relates to the Medicaid shift of pharmacy to managed care: Where is the verification from Medicaid that these MCO’s have collected all eligible rebates and they have been received by the State? Secondly, couldn’t the State net even greater Medicaid drug rebates by controlling the prescription program through having all Medicaid pharmacy services in fee-for-service?

When the state last tried this type of HMO mandate for Medicaid SSI and ABD in the early 2000’s, IPA questioned both the savings determination for this proposal. Ultimately, the state agreed it was not receiving all the drug rebates it was entitled to through the Medicaid managed care system and reverse the Medicaid prescription program back to a fee-for-service.

The other area where pharmacies are seeing problems is with the MCO’s reimbursement system. The first is with their generic drug prescription reimbursements, Maximum Allowable Costs (MAC) prices. Basically generic drug prices are going through a period of increases, yet the four Medicaid MCO’s rarely make timely updates of these prices. And when they do, it is not retroactive and the reimbursement is under acquisition costs. With pharmacy reimbursement already so low – especially for Medicare Part D – with generic drug use rising and more brand drug due to hit the “patent cliff” over the next two years, high impact Medicaid pharmacies cannot afford such below cost reimbursement. Moreover, the Medicaid FFS that remains makes timely adjustments to the MAC prices and will retroactively adjust the price when documented to be below a pharmacy’s cost.

Second, any reimbursement rate change under the Medicaid managed care system is never transparent. Just this year, Horizon NJ is proposing to reduce the Medicaid reimbursement rate for brand drugs by 60% without any approval or oversight by the state (see attached).

The MCO’s and their PBM’s are reaping the financial gain from below cost MAC pricing and cutting the drug reimbursement formula through contract amendment.

IPA still believes that Medicaid pharmacy access as a fee-for-service is a sounder way for New Jersey to provide this benefit than having it subcontracted to the PBM’s. It comes down to an issue of the state maintaining control and ensuring access over the program. It also is a matter of having clear transparency so the state knows what it is paying for regarding prescription services. But the key reason why the state should have Medicaid pharmacy services paid through a fee-for-service system rather than a Medicaid managed care model is that, unlike other Medicaid providers, the state is federally mandated to receive rebates for prescriptions. The state can only guarantee full Medicaid rebate recovery and control drug reimbursements through a fee-for-service system.
IPA appreciates that each of the last two budget cycles the Legislature has pushed for fee for service for Medicaid non-dual eligible recipients to receive pharmacy services even though it could not convince the Administration. We thank Assemblyman Coutinho for introducing legislation (A-3447) to shift the non-dual Medicaid prescription services from managed care back to a fee for service system.

If the Legislature cannot prevail on the Administration - either through the budget act or separate legislation - to “carve out” Medicaid prescription services from Medicaid MCO, then the Legislature must provide clear rules for Medicaid HMO’s and their PBM’s behavior. The state must insist on a MAC process by the MCO’s that mirrors the state’s own process for setting the generic drug State Upper Limits (SUL) under what is still left in the Medicaid prescription fee for service system. There must be transparency on how MCO’s calculate MACs, provide for timely price updates and utilize a fair appeal process to allow retroactive increases to when below cost reimbursement is documented. Also, the state, not the MCO’s, should determine what is a specialty drug. All these patients are forced to use PBM-owned mail-order for these drugs. Such a system undermines pharmacies’ abilities to keep these patients adherent and assumes mail order of these expensive drugs works well in many urban areas.

If the Medicaid managed care program is going to continue for pharmacy, there needs to be these reforms to make sure it is fair to both Medicaid patients and their pharmacy providers in order to ensure access. These protections will be even more necessary now that the State is committed to expanding Medicaid eligibility under ACA.

State Health Benefits Pharmacy Program

The one other pharmacy area of concern is with the State Health Benefits Program (SHBP) and School Employees Health Benefits Program (SEHBP) prescription benefit.

Currently, the health benefits design review process is looking to add a medication adherence program through Express Scripts/Medco for 2014. The so-called “Socrates program” has many benefits for these patients and independent pharmacies are willing to be such providers of an adherence program designed to save the state money. IPA has been informed that independent pharmacies will be eligible to be providers of this Socrates program. We are looking for assurances that all independent pharmacies will be able to be such providers so their SHBP/SEHBP patients can see success in this program by getting such adherence services at the pharmacy were they receive their prescriptions. But more importantly, this program cannot work if these SHBP/SEHBP patients feel they have been coerced or deceived into receiving their disease maintenance medication only through Express Script’s mail order program.

IPA strongly believes that for the Socrates program to work at improving public employees’ health while saving the state health benefit expenditures, the program and the drug benefit should be directed toward services through the pharmacy, not through mail-order and phone interactions. Every annual survey show local pharmacies rank second in trusted professions and first in consumer satisfaction. These programs will serve the state and the patient better by stopping practices that have allowed the PBM to direct patients towards its mail house.
Conclusion

Before Medicare Part D, independent pharmacies were already seeing razor thin operating margins. That trend is only getting worse and the stress of the system is shown by the changing nature of New Jersey independent pharmacy community. Since Part D started in 2006, over 155 New Jersey independent pharmacies serving urban and suburban poor and elderly patients have closed -- including 15 in the past year alone.

With the shift of a significant portion of the Medicaid population to “for-profit PBM’s middlemen” without any controls, this situation has become worse and has yet to prove to save the state money in the process.

Many pharmacy patients that are covered by Medicaid, PAAD, Family Care, Senior Gold and ADDP who lost pharmacy care access especially in the urban areas and, where there are no chain pharmacies, will seek more intensive and expensive health care services. The state will in turn see health care budget costs increase not decrease.

The Legislature needs to act to prevent MCO’s and their PBM’s from financially gaining from how they manage the prescription benefit at the expense of Medicaid patients and their pharmacy providers. And with the State public employee prescription benefits programs, any effort to save the state money will only succeed by having these services provided at the retail pharmacy level, not steered towards the state’s PBM’s mail order program.

IPA looks forward to working with the committee to address these concerns as you develop this year’s budget and I would be happy to answer any questions. Thank you.

Respectfully Submitted,

John A. Covello
January 28, 2013

Dear Participating Pharmacy:

Effective May 1, 2013, Horizon NJ Health will be implementing a change in the reimbursement rates to its Participating Pharmacy Provider Network. The attached Amendment outlines the new reimbursement rates.

In order to continue to provide services to Horizon NJ Health members your original signed Amendment must be received by March 28, 2013. Pharmacies that do not return the signed Amendment will no longer be able to service our members effective May 1, 2013.

If you would like to continue to provide service to Horizon NJ Health members, please sign the enclosed Amendment and return it to Horizon NJ Health by March 28, 2013.

Horizon NJ Health
210 Silvia Street
West Trenton, NJ 08628
Attention: Pharmacy Network Manager

For quicker service, you may fax one signed copy of the Amendment to 609-538-1698; however, the original signed Amendment must be received by March 28, 2013.

Pharmacies that do not respond by March 28, 2013, will no longer be eligible to provide services to Horizon NJ Health members effective May 1, 2013. In order to insure participation the original copy of the Amendment must be forwarded to the address listed above.

Sincerely,

Peter Portalatin
Manager, Pharmacy Networks

Attachment
AMENDMENT #8
TO THE PARTICIPATING PROVIDER AGREEMENT

The Participating Pharmacy Agreement (the "Agreement") entered into by Pharmacy, and Horizon Healthcare of New Jersey, Inc., a licensed New Jersey health maintenance organization (hereinafter referred to as the "Plan"), acting by and through its authorized agent, Horizon NJ Health, a New Jersey general partnership (hereinafter referred to as "Horizon NJ Health"), whose principal office is located at 210 Silvia Street, West Trenton, NJ 08628 and dated September 1, 2003 is amended as follows:

- This Amendment shall take effect May 1, 2013.
- Exhibit B of the Agreement is deleted in its entirety and replaced with the following:

EXHIBIT B
PHARMACY REIMBURSEMENT

Horizon NJ Health (HNJH) shall reimburse Pharmacy the following as total compensation for covered Pharmacy Services to covered Members:

1. Pharmacy reimbursement shall be the lessor of the following:
   a) Submitted Charge or
   b) Pharmacy’s Usual and Customary Charge, or
   c) For Brand Name drugs:
      WAC plus [2]% and a $[2.00] dispensing fee.
   d) For Brand Name drugs without a WAC:
      AWP* minus [15]% plus a $[2.00] Dispensing Fee
   e) For Generic drugs:
      CMS MAC plus a $[2.00] dispensing fee, or HNJH MAC plus a $[2.00] dispensing fee, or
      AWP* minus [30]% plus a $[2.00] dispensing fee for non-MAC generics.
   f) For Compounds with at least one legend ingredient:**
      Above ingredient cost determination plus a $[5.00] dispensing fee.

* AWP methodology implemented post September 29, 2009.

** The reconstitution of a commercially available product with distilled water, alcohol or diluents does not constitute a compound product.

2. If Pharmacy’s contract reimbursement rate is less than the Co payment, then Pharmacy will collect the lessor of the Submitted Charge, the Usual and Customary Charge or the HNJH system calculated price.
3. All other terms and conditions stated in the Agreement shall remain in effect.

4. The following definitions are incorporated as stated herein.

**Wholesale Acquisition Cost (WAC)**
As published by First Data Bank represents the manufacturer's published catalog or list price for a drug product to wholesalers. WAC does not represent actual transaction prices and does not include prompt pay or other discounts, rebates or reductions in price.

**Submitted Charge**
Amount submitted in each electronic transaction by the pharmacy that is found in the Gross Amount Due field. This charge is independent of the Usual and Customary charge or the system calculated price.

**Average Wholesale Price (AWP)** - Means the average wholesale price for a dispensed pharmaceutical product, as published by First Data Bank.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by their respective authorized representatives.

Horizon Healthcare of New Jersey, Inc.  
by and through its authorized agent  
Horizon NJ Health

Pharmacy: __________________       
NPI#  ______________ NABP  ____________
Chain Code # (if applicable)  ____________

By: [Signature]  
Name: Karen L. Clark  
Title: VP, Medicaid HBCBSNJ; President Horizon NJ Health  
Date: May 1, 2013

By:  
Name:  
Title:  
Date:  