HB 116 Proponent Testimony

Anthony J. Caraballo
Hometown Pharmacy
3623 South Meridian Road
Youngstown, Ohio 44511

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Senator Dave Burke
Chair, Senate Medicaid Committee
Ohio Statehouse
Columbus, Ohio 43215

Dear Chair Burke, Vice-Chair Manning, Ranking Member Cafaro, and Other Respected Members of the Committee:

My name is AJ Caraballo, and I am a pharmacist employed by Hometown Pharmacy in the Youngstown area. Hometown Pharmacy is a small, family-owned chain of pharmacies which has six locations in Ohio, stretching from Brookfield in Trumbull County down to Columbiana in Columbiana County, as well as four locations in western Pennsylvania. By far, my favorite aspect of working for a small pharmacy is being able to truly become a member of the community in which I serve by being flexible enough to offer services and programs that fit the community's needs. I am writing today to ask for your support of Representatives Brown and Ginter's House Bill 116, which if passed, will greatly expand patient access to one such service that we offer—medication synchronization.

As a patient's disease state(s) get more advanced or complicated, it often leads to the patient seeing multiple specialists in addition to his or her primary care physician. Naturally, it also leads to more complex drug regimens. The end result of multiple appointments with multiple prescribers writing for multiple medications on multiple days is that a patient will end up making multiple trips to the pharmacy each month for his or her various refills. This inconvenience can quickly wear down a patient, and the last thing I want as a healthcare professional is for a medication (which the patient does not want to take in the first place) to be inconvenient. Inconvenience breeds non-adherence, and non-adherence leads to worsened health outcomes for patients and sky-rocketing healthcare costs. According to the American College of Preventative Medicine, non-adherence to prescribed medications is responsible for between 10-25% of hospital and nursing home admissions each year, resulting in an annual economic burden of $100-$300 *billion* nationally. While there are many factors contributing to non-adherence, the inconvenience of multiple trips to the pharmacy each month is a senseless and very eradicable one.

With a medication synchronization program, when a patient brings in a new prescription, the pharmacist will fill the prescription for less than a 30-day supply (a "short fill") in order to make that new prescription come due at the same time as his or her other medications. For example, if all of a patient's prescriptions are due to be filled on May 30th but the patient brings in a

prescription for a new medication on May 15th, the pharmacist would only fill that prescription for a 15-day supply. By doing this, the new medication would be due for a full refill (30-day supply) on May 30th with all of his other prescriptions, thus eliminating the inconvenience of an additional trip to the pharmacy each month.

An issue arises however when it comes to that patient's copayment for this initial "short fill". With many private prescription drug plans, the patient has a fixed copay regardless of how many pills the patient receives. In the example above, the patient could have a $50 copay whether the new prescription is filled for a 15-day supply or for a 30-day supply, thus presenting a barrier to medication synchronization and ultimately patient adherence. The great majority of patients with private insurance opt not to short fill their medications because of this added cost, and who can argue with them? With fixed copayments, if a patient opts to short fill all of their medications in order to sync them to one pick-up date, the patient's medication cost for that month can increase by as much as twofold. Keep in mind that the above example of syncing one medication is simplified. In practice, it is not unusual to see patients on ten medications making six trips to the pharmacy each month. Doubling the out-of-pocket medication cost for ten medications is simply not affordable for the majority of the population.

As a real life example, my patient "JK" has private insurance and is on four medications which he picked up on four separate days each month. JK requested to have his medications synced to decrease his number of trips to the pharmacy; however since his insurance charged him the same copay for a short fill as a full fill, JK had to pay his full $20 copay *twice* on three medications during the initial sync month even though some of those fills were for less than a full 30-day supply. JK is financially well-off, so he was more than willing to incur the extra expense for the added convenience. However, the area in which I serve is a fairly indigent, and the extra expense is undoubtedly a deterrent for the majority of patients which we have tried to sync. It is well understood amongst pharmacists and physicians that the first fill is the most important one, and removing unnecessary hurdles to getting that first fill is paramount. The opportunity to simplify a patient's medication regimen and increase adherence should not be limited to those who can afford to double their medication budget for the initial month.

What is proposed in HB 116 is a common sense solution—pro-rated copays for patients wishing to synchronize their medication fill dates. If a patient's copay for a 30-day supply is normally $20, then his copay for a 15-day supply would only be $10; thus the patient is only paying for the medication he actually receives. While HB 116 would require that a pharmacy benefits manager (PBM, which is the insurance company middleman that pays the pharmacy and determines copays) pro-rate copays for patients attempting to sync their medications, it would prohibit a PBM from also pro-rating the dispensing fee which it pays to the pharmacy per prescription fill. While PBMs or health plans may oppose the language which prohibits them from also pro-rating a dispensing fee, I can assure you that these multi-billion dollar companies can afford to pay the "extra" nominal fee. I say "extra" because although the PBM may argue that short-filling a medication and then refilling a full prescription for the same medication in the same month is double-dipping, I can assure you that it requires the same amount of work to process a partial prescription as it does a full prescription. If anything, short-filling a medication requires *more* work on my end to work with the doctor and to calculate how many days' supply the patient will need to sync up the new medication. Also, please consider that this dispensing fee is supposed to

cover our professional services offered to patients, such as educating patients on their medications. While I may dispense less than a full 30-day supply in order to sync medications, I do not provide less than a full counseling session to the patient, so why should my professional fee be pro-rated?

I would now like to take this opportunity to mention that HB 116 has something very important that all legislators love to see—HB 116 has precedent. The Centers for Medicare and Medicaid Services (CMS) has recognized the importance of medication synchronization for patient adherence and safety, and as of January 1, 2014, Medicare Part D plans were required to pro-rate copays for patients for short fills. Moreover, as of January 1, 2016, Part D plans will no longer be allowed to pro-rate dispensing fees paid to pharmacies for short fills.

Because of CMS's action to remove these barriers, I have been able to personally see the benefits realized by many of my Medicare Part D patients as we have worked together to synchronize their medication fill dates. For instance, I am happy to serve a husband and wife couple, "RC" and "MC." Each having multiple disease states, RC is currently on 12 medications, and MC is on 10 medications. Between the two of them, they had been making eight visits to the pharmacy each month. When they would call in refills, it was not uncommon for a few to be missed, as they would be shuffling around multiple bottles to read the refill numbers. This led to mass confusion when they would come to pick up their prescriptions, because they thought they had called in more refills than what was ready for pick up. Instead of me being able to talk with them about their medications, my time was spent trying to track down what could be missing from their order. Now, however, we have all of MC's medications synced to fill around the 1st of the month, and all of RC's medications synced to fill around the 15th of the month. Not only have we reduced the number of trips to the pharmacy down to two per month, but now, instead of scrambling to figure out what is due to be filled, I am able to use that time to extensively discuss the medication regimens with MC and RC individually.

I have another patient, "CH," who is on 23 medications that were refilled at six different times of the month. CH does not drive, and has to rely on either our free delivery service or on her friends and family to get her to the pharmacy. As you can imagine, keeping track of refills on 23 medications is no easy task. Understandably, every time CH would call in refills, there would always be one or two that had zero refills remaining. This would lead to unnecessarily missed doses of medication while waiting for the physician to authorize refills and while waiting for the patient to either receive a ride to the pharmacy or receive delivery. Every month, it was not uncommon for CH to miss upwards of 25 doses of all her medications combined because of this. Now that we have her synced to fill all of her medications on one day, it allows us to look ahead and ensure she has refills on all of her medications prior to her refill date. CH now only comes to the pharmacy once a month and has not missed a refill in more than nine months!

This last example occurred while this bill was making its way through the House. "DP," an elderly patient with Alzheimer's, has a daughter who takes care of her 11 medications. To help reduce the number of trips the daughter was making to the pharmacy each month, we synchronized all of her mother's refills. April 2015 was the first time all of her medications were due to all be filled on the same day. Upon processing the prescriptions (old and new), it was obvious that the patient was unnecessarily on two medications from the same drug class for her

dementia, and each was written by a different prescriber. Since both medications act in the same way in the body, there is no benefit to being on both. I immediately consulted with both physicians who agreed to stop the more expensive of the two medications. This perfectly demonstrates how the medication synchronization process allows a pharmacist to more effectively evaluate a patient's entire drug regimen to identify drug therapy problems. Had DP's daughter continued calling in prescription refills one-by-one, this duplication in therapy could have continued for months, had we not caught it. I'm sure this patient's daughter would agree—the elimination of the more expensive unnecessary medication saved her (and the insurance company) hundreds of dollars per year. That seems to more than justify accommodating for the pharmacy's customary professional dispensing fee!

In closing, I would like to ask for your support of HB 116. By pro-rating a patient's copays and ensuring the pharmacist receives their customary dispensing fee, HB 116 will remove barriers to the invaluable service of medication synchronization for *all* patients. As demonstrated by the success we have already had in offering medication synchronization to our Medicare Part D patients, med sync helps simplify a patient's medication regimen (thereby decreasing costly non-adherence) and helps increase the amount of time a pharmacist is available to speak with patients about their medications. It also affords the pharmacist a golden opportunity to evaluate a patient's entire drug profile for efficacy and safety issues. Simply put, medication synchronization allows me and all of my colleagues the opportunity to be better pharmacists for our patients.

Thank you for your time and consideration,

Anthony J. Caraballo, PharmD, RPh

AJ.CARABALLO@thehometownpharmacies.com