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Testimony for HB 49
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Chairman Hackett, Vice Chair Tavares, and members of the Senate Finance Health and Medicaid Subcommittee, my name is Antonio Ciaccia, Director of Government & Public Affairs for the Ohio Pharmacists Association (OPA). I thank you for the opportunity to speak on HB 49, a proposed budget with a myriad of pieces impacting the profession of pharmacy.

Notably, there are several pieces of interest in this budget: Another slew of changes to pharmacy laws, increased costs proposed from the Board of Pharmacy, and ultimately, a growing strain on pharmacy budgets. All of this occurs right at the same time pharmacy reimbursement cuts have taken effect in the Medicaid fee-for-service program. Of course, as we recognize and support Ohio Board of Pharmacy's work to get a better handle on the opioid crisis and to reduce medication misuse in Ohio, these Board law changes and increased fees are things that we understand and have embraced. But like all things in this budget, along with the growing administrative demands of insurers and the litany of regulatory changes incurred over the last decade, those changes come at a price.

Today, I'd like to better quantify that price, and to highlight a growing, worsening issue that our association urges action on in this budget, so that the growing cost of doing business as a pharmacy in Ohio doesn't result in decreased pharmacy jobs, less pharmacies in our communities, and an increase in outsourcing of pharmacy revenue to entities operating outside our great state.

What's the cost to fill a prescription in Ohio?
Every two years, the state of Ohio requires every pharmacy by law to complete a biennial Cost of Dispensing survey from the Ohio Department of Medicaid. That lengthy survey requires pharmacists to disclose nearly every nook and cranny of their business to the state, and then Medicaid has used and aggregated that data to determine the average cost to fill a prescription in our state. Historically, that number has increased over time, yet has never been reflected in the actual dispensing fees paid to pharmacies. For example, the 2014 Cost of Dispensing survey found that the average cost to fill a prescription was $9.22. The dispensing fee at that time was $1.80 – second lowest in the country.

Now obviously, a $1.80 margin would put many pharmacies out of business, but pharmacy reimbursement comes in two parts: ingredient cost (the cost of the drug) and professional dispensing fee (the cost of the prescription filling service). So while the $1.80 was low, like many other Medicaid programs, they tended to reimburse the ingredient cost a little bit higher than acquisition cost to alleviate some of the losses.

Fast forward to today, and the 2016 survey showed that the cost fill a prescription had increased to an average of $10.49. Because pharmacy dispensing fees are now determined in administrative rule, you may not have been aware, but Medicaid moved to a tiered dispensing fee model to better reflect economies of scale and buying power that larger pharmacies have over smaller ones. When splitting up

pharmacies based upon volume, Medicaid found that the average cost to fill a prescription varied greatly from a small to a large pharmacy. In an effort to reduce overall costs to the Department and to better reflect the true cost to dispense for pharmacies, Medicaid moved to have the fee structure altered to reflect the inherent realities of the pharmacy market. The differentials between each pharmacy size are reflected in the chart below, and ultimately, Medicaid advanced rules to reflect these numbers into their fee structure for pharmacies:

Pharmacy Volume Prescriptions per year	Average Cost to Dispense
0-49,999 prescriptions	$13.64/prescription
50,000-74,999 prescriptions	$10.80/prescription
75,000-99,999 prescriptions	$9.51/prescription
100,000 or more prescriptions	$8.30/prescription

Should the pharmacy professional dispensing fee be tiered or not?
In recent HB 49 testimony from Lora Miller from the Ohio Council of Retails Merchants, she reiterated the Council's Chain Drug Committee's opposition to this shift from a single fee to a volume-based, tiered model due to the perceived unfair treatment of large pharmacies versus small ones. While the Governor's proposal aimed to codify the tiered fee concept in statute, the House version reverted back to the single fee, and put the actual dollar figure of the fee back into statute to give lawmakers a future say if Medicaid were to ram through a fee cut in rule, as has been done in the past.

While our association is agnostic on the decision to have a single fee or a tiered one for the Medicaid fee-for-service program, we do appreciate Medicaid's philosophical acknowledgement of the realities and difficulties faced by small pharmacies trying to purchase medications at the discounted rates that larger pharmacy chains can get. That said, we do support the notion of moving the actual fee itself back into statute, as previous administrations have treated the dispensing fee as a convenient pressure valve release during tough budgetary times, and stakeholder input in those previous fee cuts have rarely resulted in positive change, nor have they really yielded serious consideration either. Putting the fee back into statute gives lawmakers a chance to weigh in on cuts, whereas in rule, the legislature's input is largely nonexistent.

Pharmacy costs are increasing, but are Medicaid reimbursements keeping up?
Regardless of which side wins out in the single fee versus tiered fee discussion, at the end of the day, either proposal will result in a net cut to pharmacies once the slashed ingredient cost rates are factored in. Under the tiered model that was advanced through rule and is currently in place, Medicaid projects significant savings once the ingredient cost cuts are factored in (Medicaid is using National Average Drug Acquisition Cost – NADAC – to determine ingredient cost now, which is largely considered the lowest floor for ingredient cost reimbursement). When both pharmacy reimbursement changes are factored in of the increased dispensing fee and the NADAC ingredient cost cuts, Medicaid projects nearly $13 million in net savings for the program (phrased a different way, $13 million cut for pharmacies).

Depending on how you pull the numbers, it's projected that the single fee of $10.49 (which is in the current version of the budget), would erode the Medicaid savings to around $10 million, rather than $13 million. So while the cost to fill a prescription has increased by more than a dollar on average in the last two years, Ohio Medicaid fee-for-service program is going to be cutting net reimbursement by $10-13

million in the current budget proposal – all while the Board of Pharmacy increases license fees and regulatory requirements.

Why isn't OPA fighting against the Medicaid fee cuts and Board of Pharmacy cost increases?
As the state of Ohio works to reduce instances of prescription drug abuse, and as insurers and their pharmacy benefit managers (PBMs) ramp up utilization of tools like step therapy, prior authorizations, and different varieties of reimbursement clawbacks, it is unfortunate timing for license fee increases from the Board and reimbursement cuts in the Medicaid fee-for-service program. However, we want to support the good work our Board is aiming to accomplish, and we feel it would be disingenuous to oppose a ~$10.49 margin on prescriptions in the fee-for-service program, when in fact it is the reimbursements within the Medicaid managed care programs that have decimated pharmacies over the course of the last 18 months.

Just as we warned back when Medicaid carved in pharmacy into managed care years ago, the costs and risks associated with prescription drug coverage within the Medicaid program have been shifted to the backs of community pharmacists across the state of Ohio. The reimbursements have gotten so bad over the last 18 months, that now Medicaid's MCOs are by far the worst payors in the marketplace, with many pharmacies not only expressing panic over the significant cuts, but perhaps more importantly, the complete lack of objectivity and rationality in reimbursement that results in wildly unpredictable margins that are completely detached from nearly every other plan in the market.

What are pharmacy reimbursements in Medicaid managed care vs all other plans?
Catching trends in reimbursement changes is not as easy as you might think. Claims are paid by different plans & PBMs at different speeds and in different ways, and often there could be differences between how reimbursements occur even within the same plan. Reimbursements can be so complicated, that OPA has found an emerging vendor class in the pharmacy space – forensic accountants. Many pharmacies must now seek out professional expertise just to ensure the inputs and outputs match up on the balance sheet, as a result of opaque pricing models used by PBMs.

Because of the complexity in reimbursement, not all pharmacies have a great sense of what specific plans are doing at any given time. So as the calls began pouring into our office in mid-2016 about substantial losses incurred within the managed care world, we began to work with pharmacies to get a better sense just how bad the problem was.

In speaking with members at some of the largest pharmacy chains in the country, hospital pharmacies, and independent pharmacies, the message became one big repetitive echo: "In 2016, the bottom fell out in pharmacy reimbursements within managed care, and neither the plans, nor their PBMs, had any real explanation for why and how it happened."

As pharmacies explained to us, contract terms never changed, but reimbursements did – significantly.

For example, several pharmacies communicated to OPA that reimbursements began falling well below what Medicaid had defined as the break-even point for those pharmacies. As explained above, Medicaid determined that in order for a small pharmacy to just break even, they need to average more than $13 per prescription in margin (revenue beyond the reimbursement for the ingredient cost) pharmacies saw two things happen from 2016 to today. 1) Pharmacies consistently maintained break-even points or better; and 2) Net margins generally trended with the pharmacy's ingredient cost, so when prices dropped, reimbursements dropped, and vice versa. This is good: the margins are fairly predictable, and the pharmacy made just enough for a small profit.

In a majority of non-MCO plans, from a margin perspective, pharmacies are generally heavily incentivized to dispense more brand name drugs. However these warped incentives are even more dramatic in the Medicaid MCO spaces, where pharmacies are far more incentivized to dispense brand name products than generic. Of course, this means that pharmacies are losing considerable money on generic prescriptions through the Medicaid MCOs, and have to rely on inflated brand name reimbursements in order to keep the lights on and continue serving Medicaid patients. You can imagine the difficult spot this puts pharmacists in.

Since the losses were so dramatic in the generic drug space (some pharmacies reported net reimbursements in the negative in summer 2016, meaning that not only did they not get paid for the service, but they lost money on the drug cost as well). The margins within the managed care program not only dipped by nearly 90 percent for pharmacies over a 6-month stretch in 2016, but pharmacies reported that the trends seen in all other plans had no resemblance to what occurred in managed care. What occurred in managed care in 2016, and what is still occurring today, is completely removed from where the rest of the market is.

What's been the net effect to pharmacies serving Medicaid MCO patients?
When further digging into the Medicaid MCO pharmacy numbers, several things jump out. Generally speaking, from 2016 to today, Medicaid has not paid much less in drug costs versus what they paid in 2015. So while pharmacies saw cuts as deep as 90+% in summer 2016, was Medicaid seeing sharp reductions in drug spend? The answer is "no." Which begs the question of where all that taxpayer money ended up going?

Besides resulting in massive cuts in pharmacy staffing spend in 2016 and now in 2017, this problem has occurred during a time when Ohio saw the steepest drop in pharmacies in my lifetime. From 2015 to 2016, Ohio lost a net of 90 community pharmacies, and as reimbursements within the program have continued down a negative path, I know we have already lost more, with others threatening to close soon. For pharmacies operating in high-Medicaid areas, shutting down is really the only option left unless something is done now.

What needs to be done?
As I mentioned above, every two years Ohio Medicaid determines what the average cost to fill a prescription is in our state. Between utilizing NADAC to estimate true ingredient cost, plus the professional fee that is set by using the survey results, the Ohio Medicaid fee-for-service program has found a way to bring pharmacies as close to a break-even point, using independently created, transparent means. Even though it should not be unreasonable to expect businesses to make some level of profit when providing service to our state, we understand the pressures of the Medicaid program, and at this point, breaking even is likely the only realistic goal we could have.

We are currently working with members of the House and Senate, asking for an amendment to be added into the budget that would require MCOs and their PBMs to reimburse pharmacies at the same rates (NADAC plus a Medicaid-defined professional fee) as the Medicaid fee-for-service program.

Do all pharmacies support this requested change?
In speaking with many pharmacies over the course of the last year, I could find not a single non-PBM-affiliated pharmacy – big or small – that didn't support this concept for an amendment. Of course, it is likely that you'll not hear from those pharmacies publicly, as the PBMs who ultimately serve as the middlemen between the MCO and the pharmacy, also own their own pharmacies and have confidentiality provisions in their pharmacy contracts that prohibit pharmacies from speaking ill about them or from disclosing some of the true financials of how reimbursement occurs at the pharmacy. I've had several pharmacies shed light on PBM business practices I the past, only to be told that shedding that

light was a breach of contract. And even if they don't throw the pharmacy out of their network, they can simply slash the pharmacy's reimbursement rates or subject them to aggressive audits.

It's a twisted model for a pharmacy to have to contract with a competitor pharmacy in order to get access to patients who want to use their pharmacy, but it's the unfortunate, conflict-laden structure that continues to persist and worsen by the day – even in our own Medicaid program.

Get pharmacy spending under better control, and keep local Medicaid pharmacy services alive
As many of my community pharmacist members live locally, buy locally, hire locally, and pay taxes locally, they ultimately pay into the system that has now taken that money and lined the pockets of their competitors, at their own expense. This is not about propping up pharmacies; it's about not taking advantage of them.

The managed care model was supposed to be one built on competition between plans to achieve better outcomes and lower costs. Prescription drug spending continues to be a major cost driver for the program, and at a time when local pharmacies saw their reimbursements slashed by more than half over the last year, Medicaid and taxpayers have not seen the savings on their end. Perhaps part of the reason is that when it comes to pharmacy benefits, the MCOs have sent a signal through their actions that they'd rather not compete against one another within that sector of business. There are two PBMs that are servicing the entire MCO program, with most of the plans using the same PBM.

From our vantage point, MCOs and PBMs have benefited from the current Medicaid pharmacy model, but pharmacies, communities, and taxpayers have received the short end of the stick. As I said, we lost 90 pharmacies last year, and our discussions with members lead us to believe more on the way – especially in high Medicaid areas. Our pharmacies have reported that the Medicaid MCOs are paying well below the break-even point for pharmacies, thus threatening the viability of those pharmacies, but also their ability to provide services safely and better monitor and prevent diversion and medication misuse.

The state and insurers continue to raise the cost to provide pharmacy services – we are simply requesting that Medicaid reimbursements reflect those realities.

I ask for your support of our requested change to the budget, I thank you for your time, and I'd be happy to answer any questions you may have.

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