June 14, 2019
Interested Party Testimony on Am. Sub. HB 166
before the Senate Finance Committee
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Owner of:
Uptown Pharmacy - Westerville, Ohio serving community for over 100 years
Essentra Pharmacy - Marengo, Ohio serving community 3 years this December
RxScan, Ltd. – Lewis Center, Ohio established in 1997

Hello, Chairman Dolan, Vice Chair Burke, Ranking Member Sykes, and members of the Senate Finance Committee, my name is Max Peoples. I thank you for the opportunity to testify and give my perspectives as an interested party on Am. Sub. HB 166, the State's Operating Budget.

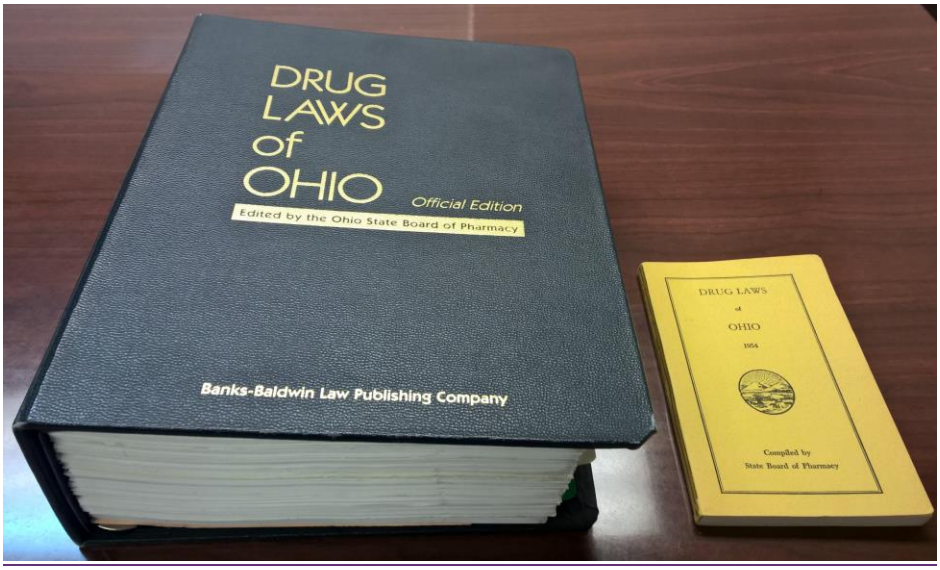
I am speaking today as both a taxpayer, owner of two community pharmacies, and a software development company. I am an employer of over 20 people.

After years of dwindling payments, I am here today to ask the state to reimburse pharmacists and pharmacies adequately for the services they provided Medicaid covered patients.

I would like to start by showing you the Drug Laws of Ohio books compiled by the State Board of Pharmacy from:

1954 - 3.75" x 5.75", 3/8" thick, 153 pages

Current - 7.75" x 10", 3" thick, too many sections and pages to count.



These are the laws that pharmacists and pharmacies must follow. And they are growing by the day, thanks to the work of this legislature and our states regulatory agencies.

I am not here to ask you to eliminate or decrease these laws and rules*; I am asking you to pay us what it costs to follow them.*

Unlike many parts of the prescription drug supply chain, the state actually knows what it costs a pharmacy to provide a prescription, because state law requires us to submit our financials for a study on this cost every two years. I am mandated to submit to the state what a spend on rent, salaries, benefits, taxes, utilities, pill bottles – you name it; I am required to report it.

I respectfully ask you, does the great state of Ohio expect the builders of its bridges, the pavers of its roads, the suppliers of its office supplies, etc. to supply them at a loss?

Of course not. Then why for decades has the state been doing so to pharmacies through our Medicaid program? And it is getting worse with each passing year.

If the state tells me how I should run my business, if the state requires me to tell them how much it costs to run my business, if the state can revoke my license if I fail to meet their standards at my business, is it too much to ask for the state to pay for the service that they expect me to provide at my business? Especially for patients that oftentimes take the most time and resources to provide that service? It should not be too much to ask to be paid what the state's own study says we should be paid.

In my pharmacies, we have historically gone above and beyond to innovate, evolve, and do whatever it takes to care for our patients. My pharmacies are the exact kind of small businesses that lawmakers love to put on a pedestal. And in a healthcare context, we are the exact kind of providers that lawmakers say they want to drive competition, disruption, and patient-focused care.

I challenge myself to be a forward-thinking medical provider and business owner.

- In the 1990s, I was the first pharmacist in Ohio to provide flu shots to patients. Today, it is the healthcare norm and has saved our state countless dollars and saved patients from hospitalizations and death.

- We have run an anticoagulation clinic since the mid-90s so that patients with conditions such as heart disease and strokes taking Coumadin would have a convenient location for monitoring their drug therapy and stay out of the hospital.

- We provide free diabetes, cholesterol, high blood pressure education programs at the Westerville Senior Center, senior subsidized housing such as Harris House in Westerville and local churches.

We provide these services, because we were trained to do so, it's what's best for the patient, and it's the right thing to do. Years ago, the financial reimbursement model in pharmacy provided the ability to offer these services without concern. Today, as Medicaid managed care PBMs have sucked the revenue out of the system, it has compromised our ability to continue to offer services that are in the best interest of the patient.

Because of unsustainable reimbursements in the Medicaid managed care program, we are now faced with the ethical dilemma of keeping our businesses afloat and our staff employed versus choosing not to give patients the medication they need. What am I supposed to say to the children and seniors that make up a majority of the Medicaid program? "Sorry, Medicaid doesn't pay their bills anymore, so we can't help you?"

I'll give you an example of how backwards this system has become. Last year, starting at the end of October, we were being reimbursed around $50 less than our acquisition cost for generic Suboxone, an opioid addiction treatment drug.

So, the state wants to treat addicts, but then the pharmacies have to quit stocking the drug because they cannot afford to lose $50 per prescription monthly on one of the most commonly dispensed medications for Medicaid patients. Lots of pharmacies – big pharmacy chains included – had to stop stocking it. *Now what are the patients to do?* Congratulations, you have a pharmacy that now can't afford to stock the medications, because the state program can't even cover the drug cost, let alone the service. It wasn't until access dried up and the state intervened that the cuts on this drug were reversed. But that was a temporary fix buried within a broken system.

This is what happens when conflicted vendors with no fiduciary duty and no accountability are free to do as they please. That $244 million that PBMs siphoned out of the system over just one year cost each Ohioan $20. What did they get for that $20? Local pharmacies closing, less choice, and a lower standard of pharmacy care.

Four years ago, we were asked by members of the Marengo community, represented by local leaders Jack Fishburn and Steve Denovchek and a Morrow County hospital representative to consider opening a pharmacy because it was a 20-25 minute drive in any direction to reach a pharmacy. Patients had to drive to Mt. Gilead, Mt. Vernon, or Sunbury.

After lots of discussions and consideration, we decided to help the community and open a 750 square foot pharmacy called Essentra Pharmacy. It is in the Cardinal Health Center, 73 Sportsman Drive, in Marengo, located just off the I-71 and State Route 61 intersection.

It opened in December 2016, right around the time Medicaid managed care reimbursements went from average to disastrous.

About 30% of the prescriptions prepared by Essentra are paid for by Medicaid, and in a small community like Marengo, the lack of volume makes dealing with below cost claims nearly impossible.

To date, it has cost us nearly $400,000 to get the pharmacy up and running, and since the Medicaid reimbursement fiasco blindsided us, we do not see a way to ever getting that paid back, let alone any kind of a return on the investment.

So, a Business 101 decision has to be made. We will have to decide by December 2019 if we will have to discontinue Medicaid services or just close the pharmacy.

What happens with Medicaid payments will determine whether we can continue to serve Medicaid patients.

Here is what we need to not only keep our pharmacy open, but to ensure other high-Medicaid patient pharmacies can have a shot at staying open as well:

1) Reimbursement for the prescription drug should actually be based on the cost of the prescription drug.

   When I purchase a drug, the state should do their best to make sure that reimbursements for that drug are based on the actual cost of the drug, rather than subjectively set by industry middlemen who profit off the transaction. The state should use reference-based pricing benchmarks like the National Average Drug Acquisition Cost (NADAC) to ensure payments to pharmacies and PBMs are not too low or high.

2) Pharmacies should receive a reasonable dispensing fee to cover the cost of providing their service.

   Not only do I have to comply with the growing amount of laws and rules, but I have to pay my staff, rent, taxes, and more. For the actual dispensing, I have to pay for the bottle, the label, the computer system, the bag, the transmission fee, the transaction fee, and more. The current reimbursements do not cover these costs, and that needs to change. A predictable, set dispensing fee floor needs to be set to ensure that the funds necessary to provide the service you require me to provide are available.

3) Pharmacies should receive reimbursement for added services that we routinely offer, but are not compensated for.

   In order to improve our patient's health we offer a number of value-added services like compliance packaging, lab tests, medication reconciliation, drug therapy follow-up, and more, but we are not reimbursed for these services. Any new payment

model should reward pharmacies that go above and beyond just the dispensing of drugs. This will not only help us sustain these types of services, but it will incentivize other pharmacies to enhance their service offerings as well.

If you do not reimburse pharmacists enough to cover the cost of their services, and you do not build incentives to push pharmacists to do more than fill prescriptions, then pharmacies will position their staff to fill prescriptions as fast as they can, because that's the only way they have any chance of keeping the doors open in this current system.

In the current model, the state doesn't pay pharmacists enough to adequately perform their full range of services.

By paying the cost of the drug and the cost of providing the drug, we can begin to lay the foundation for new incentives, new services, and new payment models, much like the ones that were intended with the recent signing of Senator Dolan's provider status legislation from the previous General Assembly.

How can I begin to invest in the resources necessary to begin providing more clinical services, when the foundation of my business can be destroyed with one whimsical change of a PBM pricing list?

Some pertinent facts:

1) $528 Billion in U.S. annual spend on medication-related problems including medication non-adherence[1]

2) 50% of patients who are prescribed medications for chronic diseases do not take their medications correctly[2]

3) A third of community-dwelling adults, ages 62 to 85, take five or more medications[3]

Problems with medication therapy will never be resolved if the state doesn't start paying for the services of the one and only medical professional trained to be a medication therapy expert, the pharmacist.

If medical doctors could solve drug issues, we wouldn't currently have drug therapy problems. Think of the percentage of doctor visits that really deal with just medication issues.

1. Watanabe, J.H., McInnis, T., & Hirsch, J.D. (2018). Cost of Prescription Drug-Related Morbidity and Mortality. Annals of Pharmacotherapy, 52(9), 829-837.
2. Sabaté E, editor, ed. Adherence to Long-Term Therapies: Evidence for Action. Geneva, Switzerland: World Health Organization; 2003.
3. Qato DM, Wilder J, Schumm LP, Gillet V, Alexander GC. Changes in prescription and over-the-counter medication and dietary supplement use among older adults in the United States, 2005 vs. 2011. *JAMA Intern Med.* 2016;176(4):473-482.

What kind of medication issues and pharmacist services are we talking about?

Here are three recent examples from my pharmacies.

Case 1: A 83-year-old patient on warfarin (brand name Coumadin, which lengthens the time it takes for blood to clot) was scheduled to have an invasive procedure and was prescribed enoxaparin injections (this drug also slows the blood clotting time to avoid blood clots).

When she found out that what her doctor prescribed was injections (not pills), she refused to pick them up. She was nervous to give them to herself and didn't feel like she could do it. She stated she would rather just stop her warfarin for the procedure and risk a blood clot rather than take the injections. She said she was at a point in her life that she didn't care if she got a clot and died, and "God will do whatever he wants to do" with her; whether to live or die.

Our pharmacist sat down with her for 30 minutes, listening to her concerns and used motivational interviewing techniques with a goal of bringing her around to doing what would be in her best interest from a health standpoint. After their discussion, she said she would go home and think about it. The next day, she came back and said she would take the injections, but only because she trusts her pharmacist, "not because the doctor said to take them."

The pharmacist then sat down with her for her first injection, and walked her though how to do it until she felt comfortable. He watched as she gave herself her first injection and told her she could come in every day, so he could coach her through each injection, or he would come to her house and coach her if need be. She continued the injections through her surgery and after until her INR (blood clotting time) was in range. She had no clots in the process. She was very appreciative of his help through the process. Unfortunately, the pharmacy did not get paid for the medication treatment intervention, the counseling on how to inject, or the follow-ups. Years ago, our dispensing revenues may have been adequate enough to offer these services for free, but today, those margins are gone.

Case 2: A 77-year-old patient transferred all 19 chronic medications to our pharmacy.

She cannot drive, and the person that had been picking up her medications for her could no longer do so. Since she was a new patient and her refill dates were all over the place, our pharmacist sat down with her to do a medication review and sync up her medication refills. By syncing her meds, her compliance would increase and it makes it easier to determine if a patient is taking all of their meds as prescribed.

During this consultation, our pharmacist found out that she always had a lot of chest pain, and she had to take nitroglycerin tabs multiple times a week and sometimes had to go to the ER. Our pharmacist saw that she was on primidone to control her seizures and Ranexa to try to control her chest pain. There is a drug interaction between these two meds, and it decreases the effect of the Ranexa, which is the reason she was having so much chest pain. We reached out to the doctors who prescribed each medication. They didn't know that she was on both. The primidone doctor did not want to change this medication since she was stable and not having seizures, so the pharmacist got the other doctor to increase the Ranexa dose, so she could get more benefit from the drug.

Since then, her chest pain has lessened, her nitroglycerin dosing has dropped, and her ER visits have dropped. Additionally, she is more adherent to her meds since they are being delivered to her at the same time each month from the pharmacy that she now knows and trusts. We have more work to do with her and her doctors to try and deprescribe some of the 19 medications. Unfortunately, our pharmacy did not get paid for the medication review, for reaching out to the doctors about the drug interaction, or making the recommendation to them on adjusting her Ranexa dose. Again, in the past, our dispensing revenues may have been adequate enough to offer these services for free, but today, those margins are gone.

Case 3: A 77-year-old female came to get a refill on her Eliquis (slows blood clotting) a month after being discharged from the hospital and diagnosed with atrial fibrillation.

She had gotten her first fill of the medication at another pharmacy on a Sunday after her discharge. When she came to our pharmacy the next month for more medication, she showed us the prescription bottle from the other pharmacy, and it did not have any refills. We contacted her doctor to get a new prescription, and when we were completing her medication review, we found that she had a drug interaction with her primidone. It decreases the effectiveness of Eliquis. We reached out to both her new cardiologist and primary doctor to find a solution for this patient. She did not want to stop her primidone because it has been working well for her tremors, but after talking to both offices, it was decided to discontinue it and start propranolol in its place. The patient went home while we were waiting to hear back from her doctors, so we delivered her medication that night. We did not want her going without the Eliquis for another day. The pharmacist counseled her on discontinuing the primidone, starting propranolol for her tremor, and the importance of continuing to take her Eliquis daily as prescribed. Unfortunately, the pharmacy did not get paid for this medication review (that kept her most likely from having a stroke) or the follow-up visit with the pharmacist. Again, in the past, our dispensing revenues may have been adequate enough to offer these services for free, but today, those margins are gone.

If the state is serious about maximizing the return on the Medicaid dollars spent and wants to slow the increase in healthcare costs, then it needs to start paying what it costs to achieve quality pharmacy services.

As a taxpayer, I want the state to do this.

As a pharmacist, my patients need you to do this.

The Ohio Pharmacists Association and myself have been working to fix these problems in the Medicaid program for more than three years now. We have received all the false promises of reform that we can stomach. The Medicaid Department has done its own commissioned analysis. The state auditor did his own as well. Even the Columbus Dispatch is providing this state with free data analytics work at this point.

How many more times and how many more ways does the state need hear these two irrefutable facts:

1) The state is getting ripped off by the PBMs that the state contracts allowed free rein to do as they pleased;

2) The state is drastically underpaying pharmacy providers and destroying access and quality in communities across Ohio.

We have waited three long years for this state to address these problems. Please do not kick the can again. Support Senator Burke's amendment to hit the reset button on this fundamentally backwards and horribly flawed system.

Chairman Dolan, I have tremendous respect and admiration for what you have done to help evolve our profession. I have waited my entire professional career (36 years) to be recognized as an actual healthcare provider, and I will never forget that it was you who helped change that. I am here to tell you that if we do not fix this broken payment system for providing medications, my pharmacies will not be around to actually exercise these new capabilities.

Thank you, Chairman Dolan and members of the Senate Finance Committee for the opportunity to share my thoughts on Am. Sub. HB 166. I would be happy to take any questions you or members of the committee might have.

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Uptown Pharmacy - Westerville, Representative – Mary Lightbody, Senator – Tina Maharath
Essentra Pharmacy - Marengo, Representative – Riordan McClain, Senator – Dave Burke