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**Testimony for HB 49**
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Chairman Oelslager, Vice Chair Manning, Ranking Member Skindell, and members of the Senate Finance Committee, 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.

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 Ohio. Historically, that cost has increased over time, yet has never been reflected in the actual dispensing fees paid to pharmacies.

The 2016 survey showed that the cost fill a prescription had increased to an average of $10.49. This year, Medicaid finally increased the dispensing fee to the rates reflected in the survey. However, to make up for it, Medicaid switched their formula for ingredient cost (reimbursement for the actual drug), and when combining the ingredient cost changes, along with dispensing fee increases, it actually results in a net cut to pharmacies.

While Medicaid fee-for service is currently using a tiered fee based upon volume, the House inserted language to move all pharmacies to a single fee of $10.49, which is a shift OPA is neutral on. 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. 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.

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 from Medicaid once the slashed ingredient cost rates are factored in – all while the Board of Pharmacy increases license fees and regulatory requirements, and costs to dispense grow. Despite these fiscal challenges, 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 now, that now Medicaid's MCOs are by far the worst payors in the marketplace. The reimbursements are well below the cost to dispense, and further they are completely detached from the rest of the market, resulting in wild uncertainty and predictability for pharmacy managers and owners.

Despite issues with some outlier plans and pharmacy benefit managers (PBMs) operating in the private sector, when it comes to all plans besides Medicaid MCOs, pharmacies saw two things generally 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 in general, pharmacies made just enough for a small profit. We believe a lot of these trends are a result of language passed in the previous budget to bring better accountability to generic pricing standards developed by PBMs. Unfortunately, these trends were not replicated within the MCOs during the same time period.

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.

The losses were so dramatic in the MCO generic drug space that 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.

When further digging into the Medicaid MCO pharmacy numbers, 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, 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.

Of course, this has a disproportionate effect on the poorest, most underserved parts of our state. If Medicaid MCOs are the worst payors, then pharmacies serving high-Medicaid areas stand to be the pharmacies most adversely impacted. This only works to exacerbate the problems facing our struggling communities, where now a central fixture in their local pharmacy is facing economic hardships that are

not being felt in other, wealthier communities. The problem is that there is no long-term planning or accountability when it comes to these policies that further gut local resources and jobs in Ohio's underserved areas. A rural pharmacy could have around half their patient base tied up in Medicaid. If Medicaid is reimbursing at rates well below the rest of the market, then it is likely that that pharmacy will cut local jobs, limit services, or worse, close for good. Unfortunately, we're now seeing all of the above.

As I mentioned above, the Ohio Medicaid fee-for-service program has found a way to bring pharmacies as close to a break-even point as possible, 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 again 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.

While I have been given informal cost estimates for this amendment, the truth is that any estimates are guesses at best, because Medicaid does not have data on what is ultimately paid to pharmacies on a claim-by-claim or even aggregate basis. I'm aware of new language in the sub-bill that aims to give finally give Medicaid that data, as they are currently unaware of true drug costs, as well as whether or not supply chain middlemen are adding layers of cost to the program. This is a good thing.

Regardless, there is a more fundamental issue at hand. Pharmacies are closing in high-Medicaid areas, and MCO reimbursement trends are already getting worse. Pharmacies are shredding staff, freezing hiring, and some owners are not taking a paycheck just to keep the business afloat. The MCOs remain profitable and Medicaid entitlements grow, but the cost has been absorbed back home in your districts.

So what happens next? Without an amendment to reform these reimbursement policies, I'm not sure. Medicaid informed us that part of the problem was that their actuaries misjudged prescription drug spending by approximately $200 million in 2016, which according to our estimates, each dollar and then some were passed down in the form of cuts to pharmacies. I can no longer trust that the actuaries know what they're doing when it comes to drug spending, because Medicaid already gave indicators that they got pharmacy spend wrong in 2017 as well – and I believe them – according to my members, 2017 is already starting significantly worse than 2016. And just like 2016, pharmacies are the ones who incur the burden of those poor forecasts – not the actual companies tasked with managing risk.

OPA obviously can't wait around for the MCOs to cost shift more of their business onto the backs of local pharmacies, and your local communities can't wait either. This legislature should act now to remove Medicaid's pharmacy pressure valve release that the MCOs are using to fortify their bottom lines.

No one expects Medicaid to be a profit center anymore (except MCOS and PBMs), but cuts to this degree will restrict access and cut the legs out of family-run businesses that have served their communities for decades. The local jobs they provide go away, and now an already-depressed area becomes even worse.

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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