Friday, February 7, 2020

Louisiana Independent Pharmacies Association

What's New and What to Watch

LIPA Newsletter:

Bringing you the latest news and information concerning independent pharmacies and the profession at-large….

In this week's issue:

- LABP Board Meeting
- LA House of Representatives Committee Assignments
- Amplicare Webinar: How to Identify Outliers to Improve Patient Adherence
- Patient Safety: Priority Number One
- NCPA: Too-low pharmacy reimbursement leads to chaos

Members,

On Wednesday of this past week the Louisiana Board of Pharmacy held their first board meeting of the year in New Orleans, hosted by Xavier University. LIPA staff and a number of our pharmacists were able to attend the meeting and speak with board members and students throughout the day. Below are some of the agenda items we were watching closely as they were presented to the board.

Regulatory Proposal 2019-G – Pharmacy Benefit Managers
The proposal was ultimately approved and added to the regulatory rules during the meeting, and the main objective is to clearly outline the necessary process PBMs must take in order to be licensed to conduct business in Louisiana. The license will remain valid for a period of two (2) years after the initial issuance and must be renewed every two years on the anniversary date of the initial issued permit.

Regulatory Project 454-2019 – Item 4 Pharmacy Interns
This project was brought before the board as a push by chain pharmacies to eliminate staffing ratios for pharmacy interns. The purpose of an internship for pharmacy students is to allow students a chance to operate in and get a sense of how a working pharmacy functions as well as gaining valuable insight on patient safety and counseling.

Fortunately, the board realized that the quality of the internship would be negatively impacted. The project was rejected by the board and no further action has been taken. The board followed guidance directed by pharmacists contacting them in rejecting changes to intern and tech ratios requested by some chain pharmacy companies, but proposed by their pharmacists.

Regulatory Project 454-2019—Item 12
This regulatory was brought up to discuss the amount of hours of practical experience pharmacy technician candidates must possess before they are able to become a licensed pharmacy technician. The law currently states that these candidates must receive 600 hours of practical experience in a pharmacy, and the board was approached about reducing the time requirement to 400 hours. The board ultimately rejected the regulatory project and no further action has been taken.

Continued on next page

Dates to Know

- **February 18th**
  Amplicare Webinar: How to identify outliers to improve patient adherence
- **March 9th**
  2020 Louisiana Legislative Session

Regulatory Proposal 2020-B – Drugs of Concern
The drugs of concern proposal was introduced in order to amend the state controlled substances law, to add additional drugs to various schedules, consistent with state and federal scheduling actions. Several drugs were added to Louisiana's Drug List of Concern including gabapentin and promethazine in oral liquid form.

Legislative Proposal 2020-C – CDTM & Pharmacist Prescriptive Authority
The Collaborative Drug Therapy Management & Pharmacist Prescriptive Authority proposal, if passed this legislative session, would amend the definition of "pharmacy collaborative drug therapy management" in the Pharmacy Practice Act as well as provide a new section to create limited prescriptive authority for pharmacists. It also states that a pharmacist may discontinue a medication or device based on his judgement that the treatment in question poses a health risk to the patient. The proposal was ultimately approved for filing by the board and should be seen this coming session, which begins March 9th, 2020.
In the proposed legislation the language states a pharmacist may prescribe drugs or devices if the following circumstances are adhered to first:

- The prescription does not require a new diagnosis
- Based on a test that is used to guide clinical decision making that is waived under federal law
- Circumstances where the patient faces an immediate health risk

LA House of Representatives Committee Assignments
Early this week we saw House leadership release committee chairmanships and member assignments earlier this week. The majority of our legislation is typically in Health & Welfare or Insurance committees, but we intend to track measures through all committees that may affect independent pharmacies. Once the dust settled we see Republicans chairing 11 of the 16 committees, which was expected due to a conservative leadership in the House under Speaker Clay Schexnayder (R-Gonzales) and a near republican supermajority in the chamber. Below we have listed all of the committees and their chairmen.

Agriculture – Rep. Jack McFarland
Appropriations – Rep. Jerome "Zee" Zeringue
Civil Law – Rep. Greg Miller
Commerce – Rep. Paula Davis
Criminal Justice – Rep. Ted James
Education – Rep. Ray Garofalo
Governmental Affairs – Stephen Dwight
Health & Welfare – Rep. Larry Bagley
Insurance – Rep. Chad Brown
Judiciary – Rep. Randal Gaines
Labor – Rep. Barbara Carpenter
Municipal – Rep. Mike Huval
Natural Resources – Rep. Jean-Paul Coussan
Retirement – Rep. Lance Harris
Transportation – Rep. Vincent Pierre
Ways & Means – Rep. Stuart Bishop

Amplicare Webinar: How to Identify Outliers to Improve Patient Adherence
In the coming weeks Amplicare will be hosting a webinar for their users on "How to Identify Outliers to Improve Patient Adherence" that we encourage our members to check out. To improve patient adherence, having a set plan in place early in the year makes all the difference. Learn why and how to address non-adherence at your pharmacy and develop a plan to set yourself up for success this year through Amplicare's webinar on February 18th at 1:00 p.m. CST. Click here to register for the Webinar.
In this webinar, you'll learn:

- Why this is the best time of year to focus on outliers
- How performance affects your DIR fees
- How to easily identify outliers with Amplicare
- What steps to take to keep patients adherent

Patient Safety: Priority Number One

In last week's newsletter we included an article that highlighted some of the accidental mishaps that are happening due to the increased workload in chain pharmacies. Corporations such as CVS and Walgreens tend to be on the constant search for ways to maximize profits margins while remaining unaware of the effects these decisions may have on the community and patients. In the article, published by The New York Times, chain pharmacists who have written in letters to authorities and officials are quoted saying they are a danger to the public due to the volume of work being pushed on them by these corporations. As you all know, filling prescriptions is one of the many tasks pharmacists encounter on a daily basis among other duties including patient counseling, clerical duties, the list goes on and on.

This article has gotten a lot of traffic since it was published last Friday and was even discussed in this past week's LABP Board Meeting on Wednesday. Vocal comments offered by students and pharmacists highlighted these concerns. While we realize this is not necessarily happening in independent pharmacies, we do believe it is important for our pharmacists and their patients to realize the pressure being forced on chain pharmacists is affecting the community's well-being. When a healthcare professional feels the need to cry out to their employers and state officials due to their inability to safely perform their job, there is a problem. Fortunately the LABP rejected any request to change the staffing ratios for pharmacy technicians in Louisiana seeing as this would only pile on more oversight and liability on the pharmacist.

NCPA: Too-low pharmacy reimbursement leads to chaos

NCPA released an executive update earlier this morning going into detail on some of the drivers that are contributing to the "pharmacy chaos" that has been highly covered in that last month in particular. One of the leading causes that was cited is the lessening of prescription reimbursements year after year and the strain that it puts on independent pharmacies that don't have an "in-house" PBM like the chain pharmacies are seeing. Independent pharmacies are told they have a choice to accept their contracts when in reality there's really no other option than to accept the agreements where the PBMs stand to reign as the judge, jury, and executioner. The uncertainty of independent pharmacy is scaring fresh pharmacy graduates which in turn is forcing them to chain pharmacy jobs. The lack of independent pharmacies then translates to a higher volume of traffic in chain pharmacies and it is quickly becoming too much for the chain pharmacists to handle. We have seen evidence of the large employers cutting salaries and higher salary pharmacists from their roles.

LIPA stands in support of NCPA's initiatives to change the pharmacy payment model so that the lack of transparency will be a thing of the past. The current payment model is confusing, complex, and convoluted for consumers and pharmacies, benefitting only the PBMs who thrive on opaqueness. NCPA has been highly instrumental in pooling together independent pharmacies and their resources to combat entities that may try to infringe on our business.

IN THE NEWS

Are chain pharmacies repeating the errors that caused Wells Fargo to open unauthorized bank accounts?

Public Citizen

A recent NY Times article, Chaos at Chain Pharmacies Is Putting Patients at Risk, reminded me of how the Wells Fargo quotas drove Wells employees to open unauthorized accounts. There's a lot in the article, but here are two excerpts:

[CVS] Staff members were supposed to persuade 65 percent of patients picking up prescriptions to sign up for automatic refills, 55 percent to switch to 90-day supplies from 30-day, and 75 percent to have the pharmacy contact their doctor with a "proactive refill request" if a prescription was expiring or had no refills, the documents show.

Dr. Mark Lopatin, a rheumatologist in Pennsylvania, says he is inundated with refill requests for almost every prescription he writes. At times Dr. Lopatin prescribes drugs intended only for a brief treatment — a steroid to treat a flare-up of arthritis, for instance.

But within days or weeks, he said, the pharmacy sends a refill request even though the prescription did not call for one. * * *

Aside from creating unnecessary work, Dr. Lopatin believes, the flood of requests poses a safety issue. "When you are bombarded with refill after refill, it's easy for things to fall through the cracks, despite your best efforts," he said.

Pharmacists told The Times that many unwanted refill requests were generated by automated systems designed in part to increase sales. Others were the result of phone calls from pharmacists, who said they faced pressure to reach quotas.

In February, a CVS pharmacist wrote to the South Carolina board that cold calls to doctors should stop, explaining that a call was considered "successful" only if the doctor agreed to the refill.

"What this means is that we are overwhelming doctor's office staff with constant calls, and patients are often kept on medication that is unneeded for extended periods of time," the pharmacist wrote.

An unauthorized account is bad enough but unneeded medication can have serious health consequences. If pharmacy staff is evaluated by whether they secure prescription refills, regardless of whether the meds are in the patient's best interests, staffers may respond to the incentive to save their jobs rather than the incentive to save patients. The result may be that patients are misled into thinking they should take medication that they not only don't need, but that may be harmful to them. The drug stores should learn from Wells Fargo and change the incentives their employees face.

PBMs favor their own pharmacies in the Florida Medicaid program

STAT News

As angst rises over the prices paid for medicines, a new analysis finds some pharmacy benefit managers that contract with Medicaid managed care organizations in Florida are pushing prescriptions to drugstore chains they control, raising costs for consumers and taxpayers.

The report, which analyzed approximately 350 million state Medicaid pharmacy claims from 2012 through 2019, noted that PBMs sometimes reimbursed their own pharmacies for certain medicines at substantially higher rates than what other drug stores received, and payments to their affiliated pharmacies greatly exceeded the cost to dispense the drugs.

One company singled out was CVS Health (CVS), which runs more than 9,900 pharmacies in the U.S. and one of the largest PBMs, which is called Caremark. As an example, Caremark paid small pharmacies and the Publix supermarket chain at or below 50 cents a pill for generic Abilify, which is used to treat schizophrenia and bipolar disorder. However, CVS pharmacies were paid $11.18, according to the report.

Meanwhile, specialty pharmacies that are affiliated with a PBM or a Medicaid managed care organization collected 28% of the available profit paid to all pharmacies in the Florida Medicaid managed care program in 2018, up from just 5% in 2014. This occurred despite dispensing only 0.4% of all managed care pharmacy claims, according to the report.

"Ultimately, this highlights the question of vertical integration in the pharmaceutical supply chain. We've turned to PBMs to act as a needed check on the system, but once they're also a direct participant, all of a sudden, their traditional incentive and role has flipped upside down," said Antonio Ciaccia, a cofounder at 3

IN THE NEWS

Axis Advisors, a market research firm that ran the analysis for the Florida Pharmacy Association and the American Pharmacy Cooperative, a group purchasing organization.

"It is imperative that taxpayer dollars are efficiently and effectively used to support appropriate access to cost-effective prescription drugs in Florida's Medicaid program. We are reviewing the findings of this report, and we have initiated a comprehensive analysis of prescription drug reimbursement practices by Florida Medicaid managed care plans. We will act accordingly based on these reviews to ensure appropriate access to high quality, affordable medicines within the Medicaid program," said Mary Mayhew is Secretary of the Florida Agency for Health Care Administration, in a statement sent to us.

The findings come as a growing number of state governments are grappling with rising drug costs and have begun examining the behind-the-scenes role played by PBMs. These companies act as middlemen by negotiating prices with drug makers to create formularies, or lists of medicines for insurance reimbursement. In the process, PBMs collect rebates from the drug makers. And they also contract with managed care organizations, or MCOs, and pharmacies, and collect various fees.

Over the past year, several states have taken steps to alter their relationships with PBMs after running audits that found some of the middlemen were profiting from spread pricing, which refers to the fees these companies pay pharmacies and then bill back to state Medicaid programs. In Ohio, the attorney general filed a lawsuit against OptumRx, a unit of UnitedHealth Group (UNH), the health insurer.

We asked the Agency for Health Care Administration, which administers the Medicaid program in Florida, for comment and will pass along any reply.

Florida, meanwhile, eliminated spread pricing from its contracts with PBMs last year, noted Ciaccia, who also works as director of the government and public affairs at the Ohio Pharmacists Association, which has been critical of PBMs. But he maintained the findings suggest that the middlemen are now increasingly turning to such reimbursement schemes to pharmacies in order to compensate.

One Florida legislator recently introduced legislation that would eliminate the practice of "steering" patients to pharmacies owned by PBMs and also prohibit predatory practices that threaten to pressure independent pharmacies. "What they're doing is hurting patients and driving out competition from local, independent pharmacies," state representative Jackie Toledo told The Tampa Bay Times.

In response to the report, the trade group for independent pharmacies suggested the data underscores that the potentially long-term consequences for consumers is grim. How so? The argument goes that as more mom-and-pop drug stores may be forced to close as they are financially squeezed, leaving consumers with fewer choices that are increasingly controlled by PBMs.

"It's a bright red flag for policymakers in every state to scrutinize their respective Medicaid programs for this kind of anti-competitive, anti-patient behavior," said Douglas Hoey, who heads the National Community Pharmacists Association.

But the Pharmaceutical Care Management Association, a trade group for pharmacy benefit managers, slammed the report.

"The group behind the report is founded and operated by special interests — independent pharmacy lobbyists — that are seeking higher profits on the backs of patients, who would pay more for prescription drugs. Pharmacies are very profitable, more so than PBMs. In fact, there are over 32% more independent pharmacies open today in Florida than 10 years ago," a PCMA spokesman wrote us.

He also maintained that the legislation will strip the ability of PBMs to lower drug costs and would increase health care costs for many Floridians, their employers, and the state while lining the pockets of independent pharmacists. In Florida, he continued, PBMs will save consumers and health care programs more than $43 billion over 10 years, and PBMs helped the state Medicaid program save $2.3 billion.

As for CVS, a spokesman for the health care company later wrote us to say that "Misinformation and falsehoods continue to be spread by big pharma and independent pharmacists around the role of CVS Caremark and other pharmacy benefit managers in the prescription drug delivery system… Our members have access to a broad and diverse pharmacy network beyond CVS, including independent pharmacies. We never force members to use a CVS Pharmacy.

"… CVS Caremark reimburses them at a higher rate than chains, including CVS Pharmacy. Data from the National Community Pharmacists Association shows that the number of independent pharmacies in the state actually increased from 2011 to 2018."

Too-low pharmacy reimbursement leads to chaos

NCPA

Pharmacy has been in the news over the last week highlighting the importance of Changing the Pharmacy Payment Model.

Last week, the *New York Times* published a story titled, "How Chaos at Chain Pharmacies Is Putting Patients at Risk." Less than a week before, the *Wall Street Journal* ran a story, "The Pharmacist is Out: Supermarkets Close Pharmacy Counters."

For community pharmacists, neither story provided information that we didn't already know. However, for millions of *NYT* and *WSJ* readers, it was an eye opener.

The *NYT* story focused mostly on reported the abysmal working conditions at CVS, which are leading to prescription errors. ZDoggMD, alias Dr. Zubin Damania, the physician-turned-social media health care provocateur, recorded his always thought-provoking and entertaining take on the story. As I'm writing this, over 42,000 people had viewed it. You should, too.

The *NYT* story did talk about one of the causes of the chaos, reimbursement for prescriptions. Prescription reimbursement has been in this vicious cycle for years. Every year, we think prescription reimbursement has hit a "floor," and every year PBMs drive the reimbursement lower and lower. (It's important to note that, despite pharmacy reimbursement being driven lower each year, prescription drug costs and PBM profits have gone in the *opposite* direction.) While reimbursement is going down, the number of prescriptions is going up, as is the number of pharmacy school graduates. And, as the old saying goes, what goes up, must come down. That's what has happened to the demand for pharmacists.

In a normal economic world, when reimbursement got too low to make a profit, they would stop being accepted. But the pharmacy payment model is not a normal economic model. Three PBMs control more than 85 percent of consumers' prescription drug benefits, making the pharmacy's "choice" to accept their contracts more like a judge's sentence where the PBM judge is also the jury and executioner.

The *WSJ* article reported on the number of pharmacies in grocery stores that are closing. For most of those pharmacies, the closures are because of too low prescription reimbursement. In fact, as I wrote in October, we estimate that the number of pharmacy choices available to consumers has gone down 4 percent in just the last 18 months. Those closures include chains, grocery stores, mass merchandisers, and independents, leaving more than 10 million consumers without the pharmacy of their choice!

Changing the Pharmacy Payment Model was the theme of NCPA's 2019 Annual Convention and has been our broken-record message for several years. The current payment model is confusing, complex, and convoluted for consumers and pharmacies, benefiting only the PBMs who thrive on the opaqueness. Changing the Pharmacy Model is not just about the need to change how prescriptions are reimbursed. The prescription reimbursement battles have been being waged for decades. We are seeing signs of the battle getting out of hand, but even if reimbursement sanity suddenly materialized, prescription reimbursement pressures would not disappear. CPESN®, the Community Pharmacy Enhanced Services Network, is the key to a new payment model that puts pharmacist services at the center and the prescription as a vital byproduct of the pharmacist's expertise.