Friday, February 28, 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….

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Dates to Know

- **March 9th**
  2020 Louisiana Legislative Session Convenes
- **March 10th**
  PBM Monitoring Advisory Council
  — LABP @ 10:00am

Members,

We are officially 10 days away from the first day of the 2020 Louisiana Legislative Session. Today marks the last day for legislators to pre-file their bills so we have a pretty good idea of what the field the looks like this year and what legislation we will see brought forth. Legislators can still introduce bills but will have to wait to file them until session begins and then their window to do so will last until March 31st, and we expect a number of bills to be filed during that time so we will monitor and report on relevant legislation that arises throughout the entirety of the legislative session.

We have remained steadfast in fostering relationships with new members of the legislature and are confident that the character of these members are aligned with LIPA and our goal of bringing effective healthcare laws to our pharmacies, patients, and their constituents. Below are a number of bills that have been pre-filed and relate to the healthcare and/or pharmaceutical industry.

HB 321 by Rep. Echols
This bill would require LDH to ensure that the generic dispensing rate within the pharmacy program of each Medicaid managed care organization is at least 90% in any calendar year.

HB 387 by Rep. Jordan
This bill looks to outline the licensing and regulation of pharmacy services administrative organizations.

HB 459 by Rep. Stagni
This bill calls for the accurate reimbursement for certain healthcare services and procedures performed by pharmacists. As the language currently reads, the proposed law would prohibit a health coverage plan, third-party administrator, or PBM of a health coverage plan from denying reimbursement to a pharmacist for a healthcare service or procedure provided within the scope of the pharmacist's license to practice. This law would apply to services or procedures that complies with both of the following:

(1) Covered by the health coverage plan when the healthcare service or procedure is provided by a physician, an advanced practice nurse, or a PA.

Continued on next page

(2) Performed by the pharmacist in strict compliance with the laws and rules related to the provision of the healthcare service or procedure and the pharmacist's license.

SB 59 by Sen. Mills

Senator Mills' bill, among other provisions, would add further requirements for the development of the step therapy or fail first protocol to be based on clinical review criteria and clinical practice guidelines. The proposed law also looks to further allow the prescriber to demonstrate that the preferred treatment is contraindicated or will cause mental harm to the patient, that the patient is stable on a certain prescription drug, or that the preferred drug is not in the best interest of the patient based on medical necessity.

SB 62 by Sen. Mills

This proposed law looks to provide a maximum patient co-pay of $100 for a 30-day supply of covered prescription insulin regardless to the quantity or type of insulin. This law would not apply to insulin drugs administered to a patient intravenously.

Breaking Insulin Pen Boxes

NCPA has released a statement joining on Monday advising pharmacists against breaking insulin pen boxes when billing third parties for payment. If you remember, LIPA covered this in our newsletter from last week so we are glad to see NCPA is helping to get the word out to community pharmacies. PAAS National recently alerted its members that updated information coming out of the FDA (via Prescribing Information and Carton labeling) leads them to the conclusion that pharmacies should not break insulin pen boxes when billing through third parties, else they set themselves up for PBM audit clawbacks.

CBD Products Containing Restricted Substances

The Louisiana Office of Alcohol and Tobacco Control (ATC) has identified three wholesalers throughout the state who were found to be administering CBD edibles containing certain restricted substances. Last year Louisiana passed the industrial hemp act (Act 164) that allows farmers to grow and cultivate the hemp crop, but with the restriction that each individual crop cannot have a THC level above 0.3% on a dry weight basis. While ATC has not released the substances found in the CBD products, ATC Commissioner, Juana Marine-Lombard, has stated their office, "will be taking an aggressive stance against the sale and distribution of any illegal or prohibited items." ATC may be vamping up their approach, but the enforcement of the law will rest with the Commissioner of the Department of Agriculture, Mike Strain.

Act 164 went into effect on January 1, 2020, and as of December 2019 Louisiana's state industrial hemp plan was approved by the United States Department of Agriculture. The state began accepting applications and have begun administering licenses as of last Thursday, February 21st.

LIPA will be working with state suppliers and wholesalers in developing accurate and reliable sources for these products. We must also be attentive to the untrained individual setting up shop with the confusion they are with a pharmacy or pharmacy related services seeing as legalization of CBD products are relatively new to Louisiana.

Recognizing DIR Fees in Your Pharmacy Contracts

This week Amplicare released an article titled, "*Recognizing DIR Fees in Your Pharmacy Contracts*" which touched on some of the things to keep an eye out for when reviewing contracts where DIR fees are being imposed on your pharmacy. For years DIR fees have been opaque and hard to track where and why the dollars are being taken out of certain claims. Today even the terminology is not straight forward as many contracts will use verbiage such as "performance adjustments" and/or "post point-of-sale adjustments" when referencing DIR and GER fees.

We encourage all of our members to read the article in its entirety to get a better grasp on what to look out for when contracting or to be aware of what PSAOs are seeing when they are working out contract negotiations. Click here for the article.

HHS Open to Medicare Drug Pricing Negotiations

U.S. Department of Health and Human Services Secretary, Alex Azar, said yesterday that the administration is open to the negotiation of drug prices in the Medicare program. Azar told House Ways & Means Committee Chairman Richard Neal (D-MA) that the administration is open to negotiations as long as they are "practical and implementable." Recently, Secretary Azar has been quoted saying the President's proposed budget supports the Senate Finance Committee's drug pricing bill which specifically does not include pricing negotiations. White House officials have gone on record saying, "Azar's comments were not consistent with the White House's position, and that the budget request does not back any one drug pricing bill."

Seeing as it is an election year, it will be interesting to see how this narrative plays out since President Trump had run on a position that government should negotiate drug prices in his 2016 campaign. House Democrats were able to pass H.R. 3 in December, which would let the government negotiate prices, but the measure does not look like it will be taken up in the Senate seeing as Senate Majority Leader Mitch McConnell has refused to bring it up thus far.

IN THE NEWS

Pharmacists, patients are stuck in the middle of a profit-before-all-else pharmacy racket

STAT News

The news that chaos reigns inside chain pharmacies, putting patients at risk, may have come as a shock to readers but it's no surprise to any pharmacist, pharmacy technician, or pharmacy student, all of whom know that the system is broken.

Ellen Gabler's exposé in the New York Times showed how big chain pharmacies sacrifice patient safety by placing unreasonable volume and speed demands on pharmacists. It highlighted how pharmacy staff are under-resourced, over-worked, and discouraged from speaking out about conditions they feel are putting patients in harm's way.

Intense financial pressure combined with the volume-based reimbursement that drive the constant push for more pills are compromising patient care and pharmacist well-being. The payment model for medications is damaged beyond repair and must rebuilt from the ground up to ensure that all prescriptions are filled correctly and safely.

As the chief pharmacy officer for the Cleveland Clinic, I've spent the last nine years working to care for patients in our hospitals, clinics, family health centers, and 20 community pharmacies.

Our teams are held to exceptionally high standards, with a multitude of payer contracts that grade our overall health system on its performance and quality and put the organization's revenue at risk when we drop the ball or achieve poor outcomes like high readmission rates. While these value-based payment models are works in progress that need to be perfected over time, they represent an important philosophical concept that patients are better served when the system pays for a desired outcome instead of the completion of a service or transaction.

Large for-profit pharmacies operate with a different set of expectations and standards. The vast majority of their pharmacy revenue streams are predicated on filling prescriptions. The payment system asks pharmacies for little more than "Did you fill it?"

It's no wonder, then, that in order to make more money you have to fill more prescriptions — and bigger profits can be generated by filling them faster and faster. As the need for speed increases, quality, error rates, customer service, and outcomes decline. But no one is tracking these metrics.

This drives up health care costs as patients take the wrong medications or incorrect doses of the right ones, or take unnecessary and duplicate medications, or those with harmful drug-drug interactions — all things a careful pharmacist can detect beforehand.

Declining quality or safety don't bother many members of the drug supply chain. They are tickled pink with this. More pills equal more cash for them.

The prescription drug supply chain and payment system are a mess. Pharmacists, who graduate as Doctors of Pharmacy after intense didactic and experiential training, are stuck in the middle of this profit-before-all-else racket — along with the patients they serve.

Pharmaceutical manufacturers, wholesalers, pharmacies, pharmacy benefit managers, insurance companies, and others have created a system that is distorted, opaque, and working against the interests of patients. The enormity of the problem leaves many of my pharmacist colleagues feeling helpless.

While there is a litany of complicated issues that must be addressed across the prescription drug supply chain, the most immediate one is delivering safe, high-quality medicines to patients. This is what pharmacists are trained to do but, as the Times showed, the industry in which they practice is taking shortcuts that compromise their ability to do what they went to school for. And it puts their patients in harm's way.

Pharmacists need to take back control of their profession from those who seek to exploit their talents to merely pump out more pills and drive short-term quarterly earnings.

Pharmacists have the skills to improve transitions of care from hospitals to home, maximize drug therapy regimens, add value to the health care team, and actively manage diseases like diabetes and high blood pressure by monitoring patients and changing and adjusting their medications. That's exactly what pharmacists do in health systems like the Cleveland Clinic, Geisinger Clinic, the Veterans Health Administration, and Kaiser Permanente, to name a few.

Community pharmacists want to do this kind of work, but often aren't allowed to do much more than fill

IN THE NEWS

prescriptions as fast as they can.
Solving the problems in pharmacy should start by elevating the role of pharmacists from one resembling fast food workers to the clinical, patient-focused positions they trained for and dedicate their professional lives to. We must end the era of high volume and speed. And we must build incentives — and disincentives — into the pharmacy care delivery model that reward those who uphold high practice standards and punish those who cut corners around safety and quality.
Fixing this mess will take serious policy changes. Pharmacists need to be the driving force to make them happen.

At Walgreens, Complaints of Medication Errors Go Missing

The New York Times

Pharmacy employees at Walgreens told consultants late last year that high levels of stress and "unreasonable" expectations had led them to make mistakes while filling prescriptions and to ignore some safety procedures.
But when the consultants presented their findings at Walgreens's corporate offices this month, there was no reference to the errors and little mention of other concerns the employees had raised.
That's because senior leaders at Walgreens had directed the consultants to remove some damaging findings after seeing a draft of their presentation, a review of internal emails, chat logs and two versions of the report shows.
In one instance, Amy Bixler, the director of pharmacy and retail operations at Walgreens, told them to delete a bullet point last month that mentioned how employees "sometimes skirted or completely ignored" proper procedures to meet corporate metrics, according to the chat logs and the draft report.
A slide detailing "errors resulting from stress" was also removed. The consultants, a group from Tata Consultancy Services that was examining the company's computer system for filling prescriptions, had included the slide among their "high level findings."
Pharmacists in dozens of states have accused Walgreens, CVS and other major drugstore chains of putting the public at risk of medication errors because of understaffed and chaotic workplaces, The New York Times reported last month.
In letters to state pharmacy boards and in interviews with The Times, pharmacists said they struggled to keep up with an increasing number of tasks — filling prescriptions, giving flu shots, answering phones and tending the drive-through, to name a few — while racing to meet corporate performance metrics they characterized as excessive and unsafe.
The pharmacy chains have pushed back on the complaints, saying staffing was sufficient and errors were rare. Walgreens told The Times that its pharmacists knew "they should never work beyond what they believe is advisable."
But the consultants heard similar complaints in interviews with workers at eight Walgreens pharmacies last year. Both versions of the consultants' report noted "a widespread perception that there is not enough time to respond to all pharmacy tasks."
In the deleted slide on stress-related errors, the consultants wrote, "We were told that pill bottles had been found to contain more than one medication."
They said they "heard multiple reports of improper behavior" that was "largely attributed to the desire" to meet a corporate metric known as "promise time," which ensures that patients get prescriptions filled within a set amount of time.
The Times reported last month that such metrics often factor into employee bonuses and performance reviews.
The final presentation was delivered about two weeks ago at the drugstore chain's corporate campus in Deerfield, Ill. The consultants had been seeking approval of the research report from various departments at Walgreens. They have since moved to the next step in the project — improving the pharmacy's computer system.
A Walgreens spokesman, Jim Cohn, said the Tata consultants had been helping the company get a "better understanding" of how employees used the computer system.
The draft report, he said, included "information gathered through informal engagement with staff at a handful of stores." Changes reflected in the final version were intended "to help ensure that the report appropriately focused on the most relevant aspects of the technology and user experience," he said.
Mr. Cohn added that Walgreens took "any concerns seriously to ensure the appropriate parties are aware and

working to address them."
A spokesman for Tata Consultancy Services, a major information technology firm based in India, declined to comment. The company recently announced it had signed a $1.5 billion deal to run Walgreens's technology operations.
Like Walgreens, CVS — the country's largest pharmacy chain — has disputed assertions from some employees and state boards that its drugstores are understaffed and overburdened.
Pharmacists have also raised concerns at CVS, the nation's largest drugstore chain.Credit...Jeenah Moon for The New York Times
In a statement posted on its website last month, CVS said, "We fundamentally disagree with the recent assertion in The New York Times that patient safety is at risk in America's pharmacies."
Since then, the Oklahoma State Board of Pharmacy released a complaint against a CVS pharmacy in Owasso, a suburb north of Tulsa, regarding a medication error made last year. The board took the rare step of citing the pharmacy in addition to the pharmacist involved in the error.
The Oklahoma board cited inadequate staffing in its investigation of the mistake, which involved a young man who received only one-fourth of his prescribed dose of anticonvulsant medication, according to the complaint.
The patient's father discovered the error, but only after the young man had taken the incorrect dose for about 18 days, during which his seizures became more frequent and more violent, according to the complaint. His mother reported that during one seizure, he fell and gashed his forehead.
After the mistake was reported to the pharmacy board, an investigator for the state checked 200 prescriptions at the Owasso pharmacy for accuracy and found a 9.5 percent error rate, according to the complaint. Some errors were minor — like portions of directions that were missing — but others were more significant. A patient was told to take the wrong dose, for instance: one tablet instead of one-half.
The board wrote in the complaint that it had received "several letters of concern from various CVS employees regarding the lack of adequate staffing" at the company's pharmacies.
Across the country, pharmacists who work at CVS and elsewhere have reported that their corporate offices have cut the hours of technicians who help behind the counter, and have pared back or eliminated shifts with overlapping pharmacists.
The Oklahoma investigator, who was at the Owasso CVS for three and a half hours, noted that the phone rang "almost constantly, with rarely a five minute break in between calls and several instances of more than one line ringing at a time," according to the complaint.
The investigator also observed "almost constant foot traffic" in the store and a routinely packed drive-through.
The complaint states that on the day of the error involving the anticonvulsant medication, the pharmacist on duty was responsible for checking 194 prescriptions in a six-hour shift — about one every two minutes.
The store's lead pharmacist told the state board that he had no control over staffing. He had complained about staffing to his district leader, but the district leader also had no power to make changes, according to the complaint.
He said that CVS had "almost completely eliminated pharmacist overlap" — meaning that only one is on duty at a time — and that pharmacists at his store worked about 20 to 30 hours per week unpaid so their colleagues were "not left in an impossible situation."
He also said that internal reports for less severe errors were sometimes not completed because of a lack of time created by staffing issues.
CVS faces up to $75,000 in fines and possible suspension or revocation of the Owasso pharmacy's license. The matter is scheduled for review at the pharmacy board's meeting in May.
A CVS spokesman said the company looked "forward to addressing the allegations" at the upcoming hearing, adding that "our record of patient safety is outstanding and we are committed to continuous improvement."
CVS and other chains have declined to provide their error rates.
In a letter to employees after The Times's article last month, Larry Merlo, the chief executive of CVS Health, said he was "deeply disappointed by the article's portrayal of our company and industry."
But this week, a company spokesman said that in response to the article, CVS planned to examine its metrics, both the quantity and how they are used to assess pharmacists.
A group called Pharmacist Moms, which says it represents 32,000 female pharmacists, also responded to the article, posting a letter on its website and social media accounts that said, "We feel strongly that patient

safety may be compromised due to the overly stressful working conditions at chain pharmacies."
The group's founder, Suzanne Soliman, said in the letter, "Pharmacists work in difficult and demanding conditions and are often unable to voice concerns over patient safety."

Stalled Initiatives to Cut Drug Prices Frustrate Trump

WSJ

President Trump is campaigning for re-election in 2020 by saying he has made great progress in reducing drug prices. But the issue has been a source of frustration for him recently, according to people familiar with the matter, as polling shows a majority of Americans disapprove of his handling of the issue and Democratic challengers for the White House focus on how his initiatives have stalled.
Key parts of the president's plan to combat prescription costs have been blocked by courts, dropped by the administration or delayed. Meanwhile, drug companies this year have raised prices for hundreds of medications.
Fifty-four percent of Americans disapprove of Mr. Trump's handling of the costs of prescription drugs, according to a January poll by the Kaiser Family Foundation.
The lack of a major success is needling Mr. Trump, who has become frustrated without a signature accomplishment on drug pricing, according to people familiar with the matter. He has taken to task Health and Human Services Secretary Alex Azar, a former pharmaceutical executive tasked with driving down drug prices, one of these people said.
Democratic rivals vying for their party's nomination have also targeted Mr. Trump on the issue. Former New York City Mayor Michael Bloomberg recently ran an ad saying "Trump did nothing" on prescription costs. Vermont Sen. Bernie Sanders, at a rally this month in Denver, said beating Mr. Trump would amount to taking on the pharmaceutical industry, suggesting the president hadn't done so. Minnesota Sen. Amy Klobuchar has repeatedly said Mr. Trump broke his promise to bring down drug prices.
Mr. Trump has publicly characterized his work on lowering drug costs as an achievement while blaming Democrats for blocking more progress. In his State of the Union speech this month, he said that the cost of prescription drugs went down.
"Because of President Trump's leadership, last year drug prices fell for the first time in almost 50 years, and he will continue to consider any and all tools to ensure that the decline continues," said deputy White House press secretary Judd Deere.
Health analysts have questioned the assertion. Deciphering price trends in drugs is difficult because many of the measurements are imperfect or incomplete. More than 60 drugmakers raised prices in the U.S. at the start of 2020, but the acceleration in prices had slowed year-to-year, according to an analysis from Rx Savings Solutions, which sells software to help employers and health plans choose the least-expensive medicines.
Consumer prices for prescription drugs rose 3% from December 2018 to December 2019, according to the Labor Department.
Some health analysts say Mr. Trump, who has built much of his health-policy platform on reducing drug prices, could feel pressure to release bolder drug-pricing regulations before the election.
"His campaign is going to be focused on health care," said Robert Blendon, a health policy professor at Harvard University. "The economy, for the average person, is getting better except for these pocketbook health-care issues. They're going to hold him responsible."
Some voters, such as Jacqueline Means, 73 years old, said they still don't know if Democratic presidential candidates or Mr. Trump offer the best approach to tackle drug costs. Ms. Means's partner, Ed, got a bone-marrow transplant to treat his leukemia. The cost of one of his drugs was $89,000 for the month.
"The drug companies are way out of whack," said Ms. Means, of Portland, Ore.
The president sounded optimistic when he unveiled his plan to curb prescription prices in May 2018 in the White House Rose Garden. Standing behind a blue banner that read 'Lower Drug Prices for Americans," Mr. Trump said his blueprint would mean "much lower

prices at the pharmacy counter."
One element of the plan called for drugmakers to put list prices in television ads. That requirement was blocked in July by a federal court, however, after Amgen Inc., Merck & Co., Eli Lilly & Co. sued.
Another part of the plan aimed to end drug rebates to middlemen in Medicare. The administration dropped that idea in July because it would cost about $200 billion over a decade.
And the plan's aim to tie some drug prices to the lower costs in other countries has stalled since it was formally proposed in October 2018. White House health officials have sparred over the policy, according to the people familiar with the matter.
Now, White House health advisers are working with congressional lawmakers to support a bill to bring down prices. Mr. Trump, who is eager for a win on drug pricing, is accusing Democrats of blocking the measure to score political points.
"We're also ready to lower drug prices very substantially," Mr. Trump told governors on a Feb. 10 White House session. "But to get them really down, we have to do exactly what we're doing. We need the votes of the Democrats, and they just didn't have time to do anything."
House Democrats in December passed legislation that would let Medicare negotiate the price for some costly drugs. Republicans remain opposed. Mr. Trump has called for bipartisan legislation and the White House has laid out what it would like in a bill.
The Trump administration has had some successes, including a faster-paced approval of new generic drugs that can drive down prices. Mr. Trump also signed legislation in 2018 that empowers pharmacists and insurers to inform consumers they could pay less out of pocket for certain drugs.
The administration has also supported states that want to re-import lower-priced drugs from Canada, even though Canadian officials have balked at the idea over concerns it could undermine their drug supply.
But many voters remain frustrated.
"Whatever they're doing, they're just talking," said Ruth Rinehart, 69, of Tampa, Fla., who has turned to getting drugs in Canada because of their cost in the U.S. "I want somebody to do something."