

June 21, 2010

Ms. Cindy Mann, Director
Center for Medicaid and State Operations
Centers for Medicare and Medicaid Services
United States Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Subject: Views on Alabama Pharmacy State Plan Amendment (AL-10-008)

Dear Director Mann:

The National Community Pharmacists Association (NCPA) is writing to provide our views to CMS as it considers this potentially precedent-setting pharmacy Alabama State Plan Amendment that would shift the benchmark for state Medicaid pharmacy reimbursement from Average Wholesale Price (AWP) to Average Acquisition Cost (AAC).

NCPA represents the pharmacy owners, managers and employees of more than 22,000 independent community pharmacies across the United States. The nation's independent pharmacies, independent pharmacy franchises and independent chains dispense nearly half of the nation's retail prescription medications. At the present time, there are 600 independent community pharmacies in the state of Alabama.

Benchmarks for Pharmacy Reimbursement

In the wake of the First DataBank/Medi-Span AWP Settlements, state Medicaid programs will have to determine which benchmarks they will use to reimburse pharmacies for brand-name and multiple source drugs. As an alternative to AWP, NCPA favors the use of a WAC-based reimbursement benchmark for brands, and an appropriately-determined state Maximum Allowable Cost (MAC) approach for multiple source drugs with three or more sources of supply. While the majority of states have used AWP as the reimbursement standard, there are a number of states that have used WAC for a number of years. With respect to generics, we believe that reimbursement policies should encourage the appropriate use of generics, and that policies that set reimbursement for generics based on actual costs could discourage their use.

The state of Alabama has submitted a State Plan Amendment (SPA) to CMS that would base reimbursement on AAC, determined based on periodic surveys of participating retail pharmacy providers' invoices. The SPA also includes a proposed \$10.64 dispensing fee, which reflects an Alabama pharmacy's approximate cost to dispense a prescription. Taking these two proposals together, we believe that such an approach can be an appropriate way to reimburse pharmacies for Medicaid prescription services, under certain conditions as described below. We commend the state of Alabama for working with pharmacy providers to develop this new model. We urge all states to work with the pharmacy community to reform pharmacy reimbursement because we can be effective partners with the states in controlling costs and improving quality.

Issues Relating to the Use of Average Acquisition Cost (AAC) as a Benchmark

We understand that Alabama will collect invoices from pharmacies and base AAC on these invoices. Because price changes occur frequently in the market, these benchmarks must be updated frequently. AAC can rapidly become an outdated price. For example, NCPA prefers WAC as a real-time benchmark for brands rather than AAC because brand manufacturers frequently increase prices to pharmacies. As the price to pharmacies increases, the WAC increases as well, so that pharmacies are reimbursed for their actual costs of buying the medication. For that reason, we believe that the SPA should only be approved if the frequency of reimbursement updates is specified. We understand that Alabama intends to update the prices weekly based on manufacturer price changes, as well as make provisions for emergency situations where prices change suddenly. This should be specific in the SPA so that pharmacists have recourse in the event that a future Alabama Medicaid Director decides not to update prices as frequently.

With respect to multiple source drugs, it is critical, if states adopt an AAC benchmark, that they also maintain incentives to dispense lower-cost generic drugs. It is also important to recognize that, because generics are purchased in a 'commodity' market, there are a wide range of manufacturers' prices for generics. Smaller pharmacies tend to purchase at a higher price than large publicly traded self-warehousing chains, meaning that states should consider using a "median" reimbursement benchmark rather than an "average" to reimburse pharmacies for generics. Or, a state could adopt a different model for larger chains – such as using an average for those corporations – and use a median for the other non-warehousing chains. In reforming the Medicaid pharmacy reimbursement provisions of the Deficit Reduction Act of 2005 in the recently-enacted health care reform law (P.L. 111-148), Congress acknowledged that smaller pharmacies could be reimbursed at a higher rate for generic drugs. This is especially important in urban and rural areas where many Medicaid patients live and independent pharmacies are the primary providers of pharmacy care.

Another critical concern related to the use of AAC as the new pharmacy pricing benchmark is the heightened need to pay pharmacies based on the cost of dispensing prescriptions. These amounts should be determined based on regularly-updated cost of dispensing studies. Most states have traditionally underpaid pharmacies for dispensing. In addition, if AAC is to be used, it is critical to keep the calculation of the total pharmacy reimbursement irrevocably tied to the dispensing fee. We are encouraged that Alabama included both the proposed switch to the AAC as well as the increase to the dispensing fee in the single State Plan Amendment.

Under the AWP benchmark system, the pharmacist reimbursement-- that includes a reasonable margin as well as other ancillary costs of handling-- is essentially split between the ingredient cost (factored into the AWP) and the dispensing fee. If states move to an AAC reimbursement method, the entirety of the reimbursement--ancillary costs and a reasonable margin-- will be wholly contained within the dispensing fee. For this reason, if states divorce the AAC from the consideration of the dispensing fee, states may be more likely to manipulate the dispensing fee amounts in order to remedy or mitigate unrelated state budget crises. In the event of state legislative efforts or executive branch efforts to generate additional monies for the state to the detriment of the dispensing fee, pharmacies would suffer and be less inclined to participate in the Medicaid program, generating potential patient access issues.

CMS Role in Development of New Pharmacy Reimbursement Benchmark

NCPA does recognize the need for states to adopt a new pharmacy pricing benchmark and believes that CMS should recognize both WAC and AAC as legitimate pharmacy pricing models at the present time. It is possible or likely that, in the short term, many states will be better able to make the transition from AWP to WAC than a transition from AWP to AAC.

Looking to the future and the possibility of AAC emerging as more of a long-term solution to the pharmacy benchmark dilemma, NCPA would recommend that CMS seek to provide some guidance as to the various factors that states should use and consider when implementing AAC in order to provide some consistency in Medicaid pharmacy reimbursement from state to state.

Specifically, CMS should ensure that AAC and the dispensing fee are always considered in tandem with one another in order to ensure that pharmacists are reimbursed adequately to cover the ancillary costs of handling the prescription drug—over and above the simple acquisition cost. In addition, CMS should determine the appropriate source of the pricing information (manufacturer, wholesaler, pharmacy or electronic pharmacy switch) and whether or not a multiplier needs to be used to account for regional differences (such as urban vs. rural) or differences between pharmacy business models (such as independent vs. chain). To the extent that the states are interested in pursuing AAC as a potential pharmacy benchmark, CMS needs to provide guidance—either in the form of official meetings or communications with the states—or in terms of the types of AAC State Plan Amendments (or portions thereof) that the agency approves.

As the result of the passage of federal health care reform and the imminent expansion of Medicaid enrollees across the board, it is likely that states will need to recruit additional community pharmacy providers in order to ensure that all beneficiaries have adequate access to services. In light of this fact, we feel that it is critical that issues of reimbursement are dealt with in a comprehensive and coordinated way and when possible with the active participation of the pharmacy provider groups.

In addition, we would urge CMS and state Medicaid programs to make greater use of community pharmacy providers to more aggressively manage the drug therapy of Medicaid recipients—similar to the way pharmacy providers are utilized under Medicare Part D to maximize positive patient outcomes and lower overall costs. We welcome the opportunity to work with CMS during this transitional period to ensure that issues of reimbursement are resolved to the satisfaction of all interested parties.

Thank you for your interest in our views.

Sincerely,

A handwritten signature in cursive script that reads "John M. Coster".

John M. Coster, Ph.D., R.Ph.
Senior Vice President, Government Affairs

cc: Larry Reed, Medicaid Pharmacy Team