

LEWIN'S MEDICAID PHARMACY MANAGED CARE REPORT: BOUGHT AND PAID FOR BY PBMs

THREATENS PATIENT HEALTH, COMPROMISES STATE MEDICAID PROGRAMS, REDUCES PATIENT ACCESS TO PHARMACIES

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A recent Lewin Group report extolling the potential savings of moving Medicaid pharmacy programs into managed care programs – run by large, corporate pharmacy benefit managers (PBMs) - is flawed for a myriad of reasons. The Lewin Group is owned by a health care conglomerate that also owns a PBM and the study was commissioned by the PBMs and accordingly recommends that Medicaid Fee for service (FFS) pharmacy programs be administered by the PBMs instead of state Medicaid programs.

It is not surprising that the large PBMs would produce a biased report that would seek to pad their recent record-breaking profits. However, the report's suggestions for achieving Medicaid savings would threaten patient health, cost state jobs and taxes, and shred the low-margin highly-efficient highly-accessible community pharmacy network in states.

PBMs Seek Profits at Expense of Vulnerable and Sick Patients: Showing incredible insensitivity, most of the savings in the report would be achieved by switching very sick blind and disabled Medicaid patients to low cost drugs, rather than the drugs they need.

- The Lewin Group focuses specifically on the savings that could be realized by moving a specific disability category—the blind and disabled—into managed care, citing the fact that this population “experiences a high per capita pharmacy cost.” However, this particular beneficiary class also presents its own set of specific challenges, including multiple chronic conditions and the need for specific high-cost drug therapies in some cases.
- The Center for Health Care Strategies published a report for state policymakers who were considering expanding the number of adults with disabilities receiving Medicaid managed care. *This report specifically recommends that the pharmacy benefits for the blind and disabled NOT be administered via managed care due to concerns that this would not be sufficient to meet this population's complex medical needs.*

PBMs Under Constant Fraud Investigation: PBMs are corporate middlemen who add little value to the health care system but have massive overhead and administrative costs to support their excessive profits.

- The Lewin Group study was commissioned by the Pharmaceutical Care Management Association (PCMA), the national association that represents pharmaceutical benefit managers.

- The Lewin Group is owned by United HealthCare, a healthcare conglomerate whose holdings include Prescription Solutions— a PBM that serves over 10 million people. A top United Healthcare executive serves on the PCMA Board of Directors.
- The PBM industry today has come under fire for widespread allegations of fraudulent and deceptive conduct. Between 2003 and 2007 numerous enforcement actions were brought against these companies resulting in over \$370 million in damages.

PBMs Can't Get Medicaid Better Prices on Drugs: By law, Medicaid programs get the manufacturer's "best price" for a particular drug. PBMs simply cannot negotiate better prices for drugs than Medicaid. Moreover, PBMs are notorious for retaining a large percentage of the rebates that they coerce from manufacturers. These rebates belong to the plan sponsor, but PBMs often keep a large percentage of them, hiding them in all kinds of innovative ways from the plans. Why would a Medicaid program want to turn their Medicaid program over to a PBM when – by Federal law – Medicaid is already getting the full benefit of the best price that manufacturers offer to any purchasers in the marketplace?

PBMs Don't Increase Generic Dispensing Rates – Pharmacies Do! Using lower-cost generics is an important strategy for managing Medicaid drug costs, except that PBMs don't dispense generics, pharmacies do. The generic utilization rates in Medicaid are already very high, but more savings could be achieved in Medicaid by having the pharmacist seek the physician's permission to change brand medications to lower cost generics, if appropriate. However, it is the pharmacist who would do this, not the PBM.

- The U.S. Department of Health and Human Services Office of Science and Data Policy recently released a study (December 2010) entitled "Expanding the Use of Generic Drugs". This report stresses the key role of the pharmacist in expanding the use of generics via generic substitution and notably does not cite the use of a PBM as a potential strategy to encourage the use of generics.
- A number of the existing state Medicaid generic dispensing rates cited by the Lewin report have been called into question for their accuracy and seem to be at odds with figures state pharmacy associations have received from their own state Medicaid Drug Utilization Review Boards and/or state Medicaid claims processors. In a number of cases, the figures cited by the Lewin group are ten percentage points lower than those received by other sources. These discrepancies call into question the accuracy of the potential savings cited by the report.
- With respect to generic dispensing, PBMs simply don't "walk the talk". PBM generic dispensing rates are consistently 10% lower than that of independent community pharmacies. In 2009, the average independent community pharmacy had a stellar generic dispensing rate of 69%. The comparable numbers for Medco and CVS/Caremark were 58% and 57%, respectively. The difference can be attributed to PBMs' addiction to brand name rebates, which discourage them from dispensing lower-cost generics.

PBMs Cost States Jobs and Revenues, Look to Eliminate Small Businesses: The study ignores the potential loss of jobs and tax revenues to the state by driving Medicaid prescription revenues to out-of-state PBMs. The study also ignores the multiplier effect that the loss of jobs and taxes would have in local communities.

- Shifting administration of the Medicaid drug benefit to out-of-state PBM-operated Medicaid managed care programs will cost state jobs. Moreover, as pharmacies are excluded from networks, in-state pharmacy workers will lose their jobs, too.
- All of the “big three” PBMs own and operate their own mail-order pharmacies. It is inevitable that if PBMs are charged with administering state Medicaid programs, they will require these vulnerable patients to utilize their out-of-state mail order pharmacy in spite of the documented benefits of providing these patients face-to-face interaction with their community pharmacist. Moreover, many of these patients may not have a permanent address at which to receive chronic care medications by mail. In addition, driving patients to the PBM’s out-of-state mail order facility at the expense of in-state small businesses will ultimately damage local economies.
- The loss of jobs and pharmacies under a Medicaid managed care system operated by PBMs will also cost states and localities tax revenue. Pharmacies and the workers that they employ generate tax revenue for states. When pharmacies close shop and in-state workers lose their jobs, the associated tax revenue disappears and, in this case, moves out of state. In the name of profit, PBMs will siphon off both money and jobs from many states under the Lewin Group plan.

PBMs Charge States for Massive Administrative Costs: The study fails to recognize that PBMs would charge the states for massive administrative costs as compared to existing state Medicaid programs, which are run more efficiently through fiscal intermediaries. This means that states would spend more money on bloated PBM middlemen rather than patient care.

- While the report suggests states spend less on beneficial medical care for Medicaid patients, it would require that they pay the PBMs substantial fees. PBMs are nothing more than middlemen in this process, and they will not offer their services for free; quite the contrary. The Lewin Group proposal increases the Medicaid bureaucracy and the costs associated therewith. Instead of spending money on patients to improve health outcomes, state Medicaid spending will be siphoned off by the PBM intermediaries as pure profit.
- Under a managed care approach, the PBMs will most likely attempt to secure a percentage of the manufacturer rebates that otherwise would simply go to the States. Also, a major revenue stream for most PBMs is to drive brand market share for pharmaceutical manufacturers-- which would seem to be at odds with the PBMs’ interest in driving the increased use of generics.

PBMs’ Strategy Shreds Community Pharmacy Network: PBMs seek to also achieve massive savings by reducing access to prescription drugs and pharmacy services. These reductions would force many small pharmacies to close, reducing access not only to medications but other critical health care services such as vaccinations and durable medical equipment in rural and urban communities.

- Pharmacies derive a significant percent of their operating revenues from Medicaid prescription reimbursement. This is particularly true for small independent pharmacies where more than 90% of all revenues are derived from prescriptions.

- Medicaid is a significantly large payer for almost all pharmacies, especially independents, which tend to exist in rural and urban areas. Managed care will force many pharmacies to close due to restrictive networks; incentives to use their own or related pharmacies; and take it or leave it contracts.

Restrictive networks and pharmacy closures will have a negative effect on Medicaid beneficiaries' access to pharmacy providers and needed medications in violation of federally mandated Medicaid access standards under 42 U.S.C. 1396a(30)(A), leading to a likely increase in downstream medical costs (such as emergency room visits).

- Many Medicaid patients take multiple medications and frequently require an increased level of oversight and care on the part of the pharmacist to ensure that the patient is utilizing the medications properly and adhering to their treatment regimens.
- Pharmacists are frequently the most accessible healthcare providers in many communities and are critical for the provision of immunizations and other preventative care services in the community. Compromising access to community pharmacies through restrictive networks and pharmacy closures will disrupt access to critical preventative services.
- The expansion of Medicaid under Federal healthcare reform will require an increase in pharmacy providers and any proposal that would compromise access to their services should be carefully considered

Pharmacy's Medicaid Savings Recommendations:

- Pharmacies can work with prescribers to increase generic use.
- Pharmacies can help better manage patient drug use, especially for those taking multiple medications.
- Pharmacies are critical public health access points for immunization and preventative services.
- States should use pharmacists to provide medication therapy management for high-cost Medicaid patients.