June 18, 2012

Cindy Mann, Director
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 21244

Subject: Status of Medicaid Pharmacy Reimbursement Changes

Dear Cindy:

On behalf of NCPA, I am writing to express serious reservations about how the Centers for Medicare and Medicaid Services (CMS) is moving forward with Medicaid pharmacy reimbursement changes. As you know, we represent independent community pharmacy, which includes 23,000 locations around the country. For the average independent community pharmacy, Medicaid is an important source of revenue. We serve a disproportionate share of elderly and low income individuals, and we are the primary source of pharmacy services in urban and rural areas.

Medicaid patients have more intensive health care needs than other populations and disproportionately rely on community pharmacies for their prescriptions and other general health care needs. Access to care is critical to these patients. We consider ourselves partners with CMS and the states to help implement the most cost effective, patient centered Medicaid prescription drug program. Yet, CMS seems intent on assuring that small pharmacies are driven out from this program through a series of possible reimbursement changes and proposals that appear to be at best, not well thought through, and at worst, harmful for patients and small businesses.

Draft FUL Lists for Multiple Source Drugs Continue to be Flawed: CMS has now released nine draft Federal Upper Limit (FULs) lists. While we appreciate that the agency has yet to make them final, the lists remain seriously problematic for small pharmacies. How many more drafts will CMS put out before the conclusion is made that the process is fundamentally flawed? These lists simply cannot be used for reimbursement. It is not clear what purpose the continued publication of these lists is serving since CMS is apparently not using the feedback to refine the lists.

The FULs for hundreds of products remain below our acquisition costs, and the FULs fluctuate from month to month. How can this be good for states or small pharmacies? And, while states are not required to use the FULs yet for the purposes of Federal matching funds, the lists are sending signals to Medicaid agencies as to what the FULs would look like if ever made final. States are adjusting downward their generic reimbursement based on these so-called drafts, and CMS is directly benefitting from the reduction in state MACs keyed off these flawed lists.

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NCPA has conducted an analysis of the 9th draft FUL list released on June 4th by CMS. As is the case with the previous eight lists, the economic consequences for small pharmacies are stark. Between the February and March lists, the total number of products with an FUL increased from 959 to 1,000, while the percentage of products with an FUL below AAC remained constant at 40.5% of all products. For those products with an FUL above AAC, the average gain per product decreased from 42.6 cents per product to 41.1 cents per product. The average loss for products with an FUL below AAC decreased from 31.4 cents to 30.1 cents per product. However, these values must be applied to a market basket of Medicaid drugs to determine the true economic impact to pharmacies.

That is, applying these draft FULs to a typical market basket of Medicaid generic drugs dispensed by a small independent pharmacy, ingredient revenues lost (FUL value set below state MAC) for low Medicaid utilization pharmacies were $32,177, for a net loss of 46% of Medicaid revenues. Ingredient revenue lost for medium Medicaid utilization pharmacies were $33,830 for a net loss of 40% of Medicaid revenues. Finally, ingredient revenues lost for high Medicaid utilization pharmacies were $75,304 for a net loss of 37% of Medicaid revenues. These losses are unsustainable for these pharmacies that rely on prescription revenues to remain in business and serve all patients, including Medicaid patients,

No Relationship between FULs and NADAC: To date, CMS has not provided any insight on how these FULs and the National Drug Acquisition Cost (NADAC) survey, which CMS seems intent on publishing without Congressional authority, will work together. Even if CMS had the authority to publish these NADACs, about which we have significant concerns, why would a state Medicaid program set reimbursement rates at NADAC if the FULs are lower? We believe that the FULs would be lower than the NADACs based our analysis of the data from states that have similar types of acquisition cost methodologies in place. Therefore, it is not clear why states would use generic NADACs for reimbursement when the FULs are likely lower.

In addition, CMS has said in its June 1 letter requesting pharmacy participation in the NADAC survey that, "If a Medicaid program chooses to utilize the NADAC reference file for drug reimbursement, we expect that states will simultaneously evaluate their Medicaid dispensing fees." This statement has many issues and problems. First, states MUST use the FULs for multiple source drug reimbursement. If the NADACs are higher than the FULs, then states are not going to pay at the NADAC and absorb 100 percent of the cost difference with state funds.

Moreover, if the FULs are lower than NADAC, why would a state use the NADAC to begin with? And, if a state uses FULs because they are lower, the state is not required to "evaluate" its dispensing fee according to CMS. They are only required to make that evaluation if they use NADAC. Indeed, the word "evaluate" does not even require the states to appropriately adjust dispensing fees. To date, CMS has approved two states to use AAC based reimbursement methods if they increased their fees. However, CMS seems unwilling or unable to impose that same requirement on states to actually increase their fees to reflect pharmacy's costs to dispense whether they use NADAC or FULs.

For the sake of tens of thousands of small businesses that serve Medicaid patients, create jobs, pay taxes, and give back to our communities, we urge you to do the following:

- Stop publishing draft FULs until a regulation is final. Thereafter, CMS should collect several months of data to determine if the FULs are any more reflecting of pharmacy purchasing costs;

- Make it clear to states that, in order to reimburse pharmacies fairly and preserve patient access, they must increase their dispensing fees to pharmacies if they use NADAC or FULs. Pharmacies expect CMS to uphold their end of the bargain regarding dispensing fees if the agency expects pharmacies to provide their invoice data. Requiring the states to "evaluate" their fees is meaningless because it doesn't send the message to states that they must increase their fees to reflect pharmacy costs of dispensing. Moreover, if FULs remain lower than pharmacy acquisition costs, the need to increase fees is even more important given that no small business can operate at a loss.

CMS has not yet demonstrated that it has a well conceived, rational, integrated plan to assure that Medicaid pharmacy reimbursement is adequate to maintain access to pharmacy services. Throwing new metrics into the marketplace without adequate and proper determination about how they will be defined, how they will be used, and how they will work together is a prescription for disaster. We urge the agency to assure that tens of thousands of small businesses, the backbone of the Medicaid program, can continue to serve patients and survive in their communities. Thank you.

Sincerely,

John M. Coster

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

cc: The Honorable Max Baucus
The Honorable Orrin Hatch
The Honorable Fred Upton
The Honorable Henry Waxman
Barbara Edwards, CMS
Larry Reed, CMS Medicaid Pharmacy Team