June 26, 2020

1115 MMA Waiver Extension Request
Bureau of Medicaid Policy
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, FL 32308

RE: FLORIDA MANAGED MEDICAL ASSISTANCE PROGRAM 1115 WAIVER EXTENSION REQUEST (PROJECT NUMBER 11-W-00206/4)

To whom it may concern:

The National Community Pharmacists Association (NCPA) appreciates the opportunity to provide comments to the Agency for Health Care Administration (AHCA) on its 1115 waiver extension request. NCPA represents the interest of America's community pharmacists, including the owners of more than 21,000 independent community pharmacies across the United States and 1,349 independent community pharmacies in Florida. These Florida pharmacies filled over 80 million prescriptions last year, including over 13 million Medicaid prescriptions, impacting the lives of thousands of patients in your state.

NCPA supports AHCA's goal to transform Florida's Medicaid delivery systems with the aims of "improving the recipient's experience of care, improving the overall health of the Medicaid population, and continuing to bend the Medicaid cost curve."[1] For this reason, NCPA is concerned about the decision to seek an extension of Florida's 1115 waiver without addressing the role of pharmacy benefit managers (PBMs) in the administration of the prescription drug benefit under the managed care program. NCPA requests that AHCA refrain from applying for an 1115 waiver extension until the serious shortcomings present in the prescription drug benefit program have been addressed.

PBMs have been found to utilize practices that benefit themselves at taxpayer expense

Florida's MCOs and their PBMs own pharmacies that serve Medicaid beneficiaries. A recent study has found that PBMs have utilized practices that increase the profitability of these "affiliated pharmacies" at taxpayer expense. In fact, "when it comes to dispensing brand name drugs, MCO/PBM-affiliated pharmacies are making 18x to 109x more profit over the cost of the drugs than the typical community pharmacy."[2] PBMs did this by steering patients with high-cost, high-profit prescriptions to affiliated pharmacies while avoiding patients with lower cost, lower profit prescriptions.

This steering comes at a cost for taxpayers. For example, the study found that Humira, a high-cost drug, was generally more expensive at affiliated pharmacies than at non-affiliated pharmacies.

[1] Florida Agency for Health Care Administration, *Florida Managed Medical Assistance Program: Extension Request Public Notice Document* 4 (June 2020), https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/mma/1115_MMA_Waiver_Extension_Request_Public_Notice_Document_FINAL_2020-24.pdf.
[2] 3 Axis Advisors, *Sunshine in the Black Box of Pharmacy Benefits Management: Florida Medicaid Pharmacy Claims Analysis* 126 (Jan. 27, 2020).

100 Daingerfield Road
Alexandria, VA 22314-2888
(703) 683-8200 PHONE
(703) 683-3619 FAX

Even though prescriptions for the drug would have likely been cheaper from non-affiliated pharmacies, only one in five prescriptions for Humira were filled at a non-affiliated pharmacy.[3]

Self-serving PBM practices are not unique to the Florida Medicaid program. All over the nation, government officials have investigated PBMs' role in administering Medicaid prescription drug benefits. Regarding PBMs' use of spread pricing in Medicaid programs, CMS Administrator Seema Verma is "concerned that spread pricing is inflating prescription drug costs that are borne by beneficiaries and by taxpayers."[4] The state of New York found "PBMs often employ controversial utilization and management tools to generate revenue for themselves in a way that is detrimental to health plan sponsors, patients, and pharmacies."[5]

This was certainly the case in Ohio, where the Auditor of State found that, of the $2.5 billion spent annually through PBMs on Medicaid prescription drugs, the PBMs pocketed $224.8 million through spread pricing alone during a one-year period.[6] Similarly, Kentucky found that PBMs in the Medicaid program keep $123.5 million in spread annually, prompting the Attorney General to launch an investigation into allegations that the PBMs have overcharged the state and discriminated against independent pharmacies.[7]

The findings of self-serving practices in Florida and elsewhere raise the question: who exactly is benefitting from PBMs' role in state Medicaid programs? Unless AHCA can verify that the state's PBMs are working in the best interest of Medicaid beneficiaries and other Florida taxpayers, NCPA urges AHCA to refrain from requesting an 1115 wavier extension.

PBMs role in Florida Medicaid threatens patient access to community pharmacy services

Community pharmacists are proud to play a vital role in the Medicaid program as the backbone of its drug benefit. More than any other segment of the pharmacy industry, independent community pharmacists are often located in the underserved rural and urban areas of Florida that are home to many Medicaid recipients. Pharmacists are frequently the most accessible healthcare providers in many communities and are critical for the provision of immunizations and other preventive care services in the community. Access to pharmacy care services and prescription medications play a critical role in managing chronic conditions and staving off costly downstream medical interventions.

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[3] *Id.* at 127-28.

[4] *CMS Issues New Guidance Addressing Spread Pricing in Medicaid, Ensures Pharmacy Benefit Managers are not Up-Charging Taxpayers*, (May 15, 2019), *available at* https://www.cms.gov/newsroom/press-releases/cms-issues-new-guidance-addressing-spread-pricing-medicaid-ensures-pharmacy-benefit-managers-are-not.

[5] New York Senate Committee on Investigations and Government Operations, *Final Investigative Report: Pharmacy Benefit Managers in New York,* (May 31, 2019), *available at* https://www.nysenate.gov/sites/default/files/article/attachment/final_investigatory_report_pharmacy_benefit_managers_in_new_york.pdf.

[6] Auditor of State of Ohio, *Auditor's Report: Pharmacy Benefit Managers Take Fees of 31% on Generic Drugs Worth $208M in One-Year Period*, (Aug. 16, 2018) https://ohioauditor.gov/news/pressreleases/Details/5042.

[7] Kentucky Department for Medicaid Services, *Medicaid Pharmacy Pricing: Opening the Black Box* 5, 8 (Feb. 19, 2019), https://drive.google.com/file/d/1f0eZyVg5e-lmUOS4VQhQLQHfsVId_XEL/view. Kentucky Attorney General, *Beshear Launches Investigation into Inflated Prescription Drug Prices*, (Mar. 21, 2019), https://kentucky.gov/Pages/Activity-stream.aspx?n=AttorneyGeneral&prId=739.

However, community pharmacists' role in the Medicaid program is being threatened by the opaque reimbursement practices of PBMs. Because of these opaque practices and lack of proper oversight, PBMs are able to ratchet down reimbursement rates, and pharmacy providers are frequently reimbursed at rates that leave them "underwater" on the medications they dispense. In Florida, pharmacies that are not affiliated with an MCO/PBM are reimbursed an average of $1.97 per claim, even though the state has determined that pharmacies incur a cost of at least $10.24 per claim.[8]

Eventually, this leads to drastic negative effects on pharmacy providers as well as the vulnerable Medicaid beneficiaries who they serve. A study by the Rural Policy Research Institute found that under-reimbursements led to the closure of 1,231 independent pharmacies in rural areas between 2003 and 2018. As a result, 630 rural communities nationwide that had at least one retail pharmacy in 2003 had **zero** retail pharmacies in 2018.[9] The situation is no better in urban areas; between 2009 and 2015, 1 in 8 pharmacies closed as a result of under reimbursements in the Medicaid and Medicare programs, disproportionately affecting independent pharmacies and low-income neighborhoods.[10] These pharmacy closures "are associated with nonadherence to prescription medications, and declines in adherence are worse in patients using independent pharmacies that subsequently closed."[11]

Unless AHCA can verify that PBM practices will not threaten patient access to community pharmacy services, NCPA urges AHCA to refrain from requesting an 1115 wavier extension.

AHCA should review PBMs' role in the Medicaid program

PBMs' role in state Medicaid managed care programs has been undergoing intense scrutiny recently. This scrutiny has led a number of states to minimize that role by carving pharmacy benefits out of managed care and administering the benefits under the fee-for-service program. West Virginia saved $54 million in the first year after carving pharmacy benefits out of managed care, and California and New York will make a similar move in 2021.[12] Louisiana has enacted legislation authorizing the Department of Health to carve pharmacy benefits out of the state's Medicaid managed care program in an effort to control costs.[13] Increased PBM scrutiny has also led Congress to consider legislation prohibiting PBMs from using spread pricing in Medicaid managed care programs.[14]

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[8] 3 Axis Advisors, *supra note* 2, at 2.

[9] Abiodun Salako, Fred Ullrich & Keith Mueller, *Update: Independently Owned Pharmacy Closures in Rural America, 2003-2018*, RUPRI Center for Rural Health Policy Analysis, July 2018, Rural Policy Brief No. 2018-2, available at https://rupri.public-health.uiowa.edu/publications/policybriefs/2018/2018%20Pharmacy%20Closures.pdf.

[10] Jenny S. Guadamuz, G. Caleb Alexander, Shannon N. Zenk & Dima M. Qato, *Assessment of Pharmacy Closures in the United States From 2009 Through 2015*, JAMA Internal Medicine, Oct. 21, 2019, www.jamainternalmedicine.com.

[11] *Id.*

[12] Navigant Consulting, Inc., Pharmacy Savings Report: West Virginia Medicaid 5 (2019), *available at* https://dhhr.wv.gov/bms/News/Pages/West-Virginia-Medicaid-Pharmacy-Savings-Report-is-Now-Available!-.aspx. California Executive Department, Exec. Order N-01-19. New York S7506B (2020).

[13] La. Rev. Stat. § 46:450.7.

[14] Prescription Drug Pricing Reduction Act of 2019, S. 2543, 116th Cong. § 206 (2019).

There is evidence to suggest that the PBM practices that led states to reconsider their relationships with PBMs are present in Florida, as well. AHCA must thoroughly review PBMs' role in the Medicaid program to determine how Medicaid patients and taxpayers are impacted by PBM practices. NCPA urges AHCA not to request an 1115 waiver extension until the state's PBMs have been fully investigated and the public has had the opportunity to weigh in on the findings.

Conclusion

NCPA appreciates the opportunity to provide these comments. If you have any questions about the information contained in this letter or wish to discuss the issue in greater detail, please do not hesitate to contact me at matthew.magner@ncpa.org.

Sincerely,

Matthew Magner
Director, State Government Affairs