February 8, 2017

Harry Hendrix, Chief
Pharmacy Benefits Division
Department of Health Care Services
PO Box 997413 MS: 2000
Sacramento, CA 95899

RE: Mercer Professional Dispensing Fee and Actual Acquisition Cost Analysis for Medi-Cal-Pharmacy Survey Report

Dear Mr. Hendrix,

On behalf of the chain pharmacies operating in the state of California, the National Association of Chain Drug Stores (NACDS) and the California Retailers Association (CRA) are writing to share our perspectives on the Mercer Professional Dispensing Fee and Actual Acquisition Cost Analysis for Medi-Cal Pharmacy Survey Report (“Report”) and to express our concerns with some of the Report’s recommendations for pharmacy reimbursement for prescription drugs dispensed to Medicaid beneficiaries. More specifically, we urge the California Department of Health Care Services (DHCS) to reconsider the adoption of a tiered dispensing fee as suggested by the Report.

In the report and based on data received from participating pharmacies, Mercer recommended several options for DHCS to accommodate the requirements of the Centers for Medicare & Medicaid Services (CMS) Medicaid Covered Outpatient Drugs Final Rule (“Final Rule”). While we understand the intent and need of such survey and the results, we have great concerns that some of the recommendations are not fully consistent with the requirements of the Final Rule and could result in pharmacies being reimbursed below the cost to acquire and dispense prescription drugs in the Medicaid program.

**Ingredient Cost Reimbursement**

In the report, Mercer suggested three possible options for product cost reimbursement. Those three options include:

- Adopt the CMS National Average Drug Acquisition Cost (NADAC) Rates for brand and generic products, with wholesale acquisition cost (WAC) as a backup for drug with no available NADAC;
- Adopt brand and generic actual acquisition cost (AAC) rates based on Medi-Cal provider surveys; or
- Adopt NADAC for brand and generics with a 38.2 percent discount off NADAC for generic drugs.
Based on the available options, we strongly support DHCS’s decision to adopt NADAC rates for brand and generic products, with wholesale acquisition cost (WAC) as a backup for drug with no available NADAC. While the alternative to use DHCS specific AAC rates appears to be a workable option, there are potential budgetary issues that could prevent continued use and access to readily available data from an outside contractor.

Although DHCS has selected NADAC with WAC as an alternative for product reimbursement, we still have concerns with other recommendations that were included in the report and the potential of these options being used for future pharmacy reimbursement. We strongly oppose the third option to adopt NADAC for brands and generics with a 38.2 percent discount off NADAC for generic drugs. Based on the report, it appears that the data suggests that pharmacies in California are buying at rates below the national average for generic products. As such, Mercer is suggesting NADAC minus 38.2 percent for generics only. In addition to indicating that pharmacies are being overpaid for generic drugs, Mercer has also referenced Texas’ pending reimbursement methodology as a precedent for the proposal of NADAC less a percentage. We strongly disagree with this rationale. We believe that unless there is data that suggests that acquisition costs have historically been lower and there is empirical evidence to indicate that these costs are expected to continue to be lower than NADAC, this proposal would result in pharmacies being reimbursed below cost and not in compliance with the intent of the Final Rule.

Additionally, we believe that the cited references to Texas’ pending methodology are inaccurately stated. The Texas Medicaid reimbursement that is being used as the rationale for this recommendation is still pending and has not received approval from CMS. Furthermore, the referenced Texas methodology was not as aggressive with respect to the percentage that is reduced from NADAC. Finally, the referenced Texas methodology only applied to specialty and drugs dispensed in long-term care facilities, not all generic drugs, as stated in the Mercer recommendation. With this in mind, and since CMS continues to maintain that it will not accept reimbursement methodologies that will result in below cost reimbursement for pharmacies, we strongly urge DHCS to avoid adopting any methodologies that would discount NADAC as a basis for setting pharmacy reimbursement.

**Tiered Dispensing Fees**

Based on the findings of the study, Mercer has identified three possible recommendations for DHCS to adopt increased professional dispensing fees as required by the Final Rule. In the report, Mercer has offered suggestions that would pay professional dispensing fees that are either a flat fee, a two-tiered fee based on total annual prescription volume, or a four-tiered fee based on total annual prescription volume. Based on these recommendations, DHCS has selected to use a two-tiered professional dispensing fee based on total annual prescription volume for retail and long-term care pharmacies. Our members across the state have serious concerns about, and strongly oppose any proposals or adoption of tiered dispensing fees and strongly urge DHCS to reconsider the use of a two-tiered dispensing fee for participating pharmacies.

We believe that paying a lower reimbursement to certain providers based on certain characteristics is anti-competitive and creates an unfriendly and unfair business environment. To maintain equitable standing among pharmacy providers within the California Medicaid program, we urge DHCS to adopt one flat dispensing fee to ensure that dispensing fees cover the cost of dispensing for all pharmacies.
As stated above, Mercer has suggested a tiered dispensing fee based on total annual prescription volume, as follows:

Two-Tier Alternative for retail community and long-term care pharmacies:

1. for pharmacies reporting fewer than 89,999 prescriptions, a dispensing fee of $13.20; or
2. for pharmacies reporting 90,000 or more prescriptions, a dispensing fee of $10.05.

Based on market analysis, any tiered dispensing fee system that reimburses pharmacies below $12.29 will result in about 40% of all California pharmacies being reimbursed below cost. Our analysis shows that 1,005 pharmacies out of 2,537 in the state of California would fall into Mercer’s recommended bottom two dispensing fee tiers. Considering the constantly escalating pharmacy costs driven by pharmacist labor shortages and manufacturer drug price increases, the proposed tiers could potentially leave a large portion of the cost of dispensing a Medicaid prescription un-reimbursed to pharmacies. We urge DHCS to implement the flat dispensing fee of $12.29 from Mercer’s cost of dispensing study, which adequately covers the cost of dispensing for all pharmacies rather than a tiered dispensing fee approach based on volume (or any other characteristics such as ownership or location).

Despite our concerns, if DHCS’s proceeds with the adoption of a tiered system, at a minimum, we ask DHCS to adopt the flat fee from its cost of dispensing study, $12.29, as the lowest tier, with $13.20 and $12.29 being the applicable tiers in a two-tier system. Since $12.29 plus the ingredient cost represents actual pharmacy costs, any dispensing fee below that combined amount would inadequately reimburse pharmacies, inconsistent with the Final Rule, which requires that pharmacies be reimbursed at cost.

We believe that setting a differential reimbursement rate for one type of Medicaid provider based on size or type of business within an industry like pharmacy sets a disturbing precedent in the state. Recent government studies have failed to find a consistent differential in the product acquisition costs among chain and independent pharmacies, as independent pharmacies are achieving increased discounts through purchasing groups. In addition, federal courts have raised doubts about the legality and constitutionality of tiered reimbursement schemes.

Moreover, as a matter of public health policy, a tiered system that pays lower dispensing fees to higher volume pharmacy locations creates harmful disincentives against pharmacies from pursuing growth in their Medicaid business and against pursuing opportunities to provide better and more efficient service to Medicaid patients as well as other patients that rely on pharmacy services. Under DHCS’s proposed tiered system, the greater the volume for a pharmacy and the more efficient a pharmacy becomes, the lower their dispensing fee. We urge DHCS to reconsider its decision to adopt tiered dispensing fees as this imposes perverse economic incentives on California pharmacies that could result in access problems for Medicaid patients to their prescription medications.

Overall, Medicaid reimbursement for prescription drug product and dispensing costs should be based on the cost of the product delivered and the costs incurred in dispensing that product, not on the size or nature of the pharmacy. We support fair and adequate reimbursement under Medicaid and other public programs for all pharmacies throughout the state to help protect access to the highest quality pharmacy services for all California residents.
Inflationary Factors
In addition to the abovementioned concerns, it is also important that dispensing fees that are adopted take into consideration the employment cost index (ECI) adjustment and other inflationary factors. This would show a cost increase and inflation pattern that would affect dispensing fee on the yearly basis. Over time, dispensing fees must be increased to keep up with inflation. This is especially important because the Mercer study is based on data from 2015. When taking into account the projected 2018 implementation date the recommended dispensing fees will be outdated and will not accurately reflect the true cost to dispense at the time of implementation. Therefore, an inflation factor should be included to account for these differences.

Pharmacy Participation in Survey
While we believe that Mercer has made efforts to use the data collected in as fair a way as possible, we are concerned about the low participation rate by independent pharmacies. The response rate for independent pharmacies was below 10 percent. In fact, Mercer received only 123 usable responses from independent pharmacies, out of a total of 1,957. We are concerned that the survey responses underrepresent the data from lower volume pharmacies and do not present an accurate picture of the overall cost of dispensing in California. The weighted winsorized cost-of-dispensing (COD) that the Mercer study found was $12.29, where the CCPA sponsored study found a COD in California of $12.44 using calendar year 2013 data.

Impact on Patient Access
With respect to patient access, we believe any changes in reimbursement that would ultimately result in pharmacy payments that are below cost would be inconsistent with CMS policies to ensure that rate setting in the Medicaid program can sustain beneficiary access. We have concerns that the currently proposed tiered dispensing fees would set reimbursement levels that are inconsistent with efficiency, economy, and quality of care. These proposed changes could leave overall reimbursement levels too low to enlist a sufficient number of providers to ensure that services are available to program recipients at the same level as those services are available to the general population as required by §1902(a)(30) of the Social Security Act. This is extremely concerning as it potentially jeopardizes availability and access to care and providers. This could have a detrimental effect on overall California Medicaid program costs as beneficiaries who are not able to access prescription drugs on a timely basis, or access them at all, would be forced to seek higher cost care such as more frequent visits to hospitals, emergency rooms, and doctors’ visits.

Chain pharmacy recognizes the tremendous budgetary challenges that the state of California is facing and the subsequent need to control Medicaid program costs to help balance the state budget. However, the average net profit margin for pharmacies is just 2 percent, a profit margin that has been continuously shrinking due to increasing product, labor, and administrative costs. The implementation of below-cost tiered dispensing fees on the heels of already reduced reimbursement rates will pose a real threat to California pharmacies continued financial viability and, in turn, to the ability of low-income California residents to access prescription drugs and pharmacy services. We urge DHCS to reconsider adopting the tiered dispensing fee proposal, as we believe it would compromise beneficiary access to prescription drugs and vital pharmacy services. In addition, we urge DHCS to make the necessary adjustments to ensure that California pharmacy access is maintained at the levels required under federal law.
Conclusion
Ensuring that dispensing fees are fair and adequate is of paramount importance as California moves to product reimbursement based on acquisition cost. This especially important given the recently implemented average manufacturer price (AMP) based federal upper limits (FUL) for multiple source drugs, which has had a significant impact on pharmacy reimbursement. The implementation of AMP-based FULs was officially the first step of moving pharmacy reimbursement to a cost-based reimbursement methodology for prescription drugs dispensed to Medicaid beneficiaries as required by the Final Rule. Although the Final Rule requires states to review reimbursement comprehensively with adequate adjustments to professional dispensing fees when moving to cost-based reimbursement methodologies, states are not required to adjust their professional dispensing fees with the adoption of the new AMP-based FULs. As a result, participating pharmacies have suffered recent cuts in generic product reimbursement with no increase in professional dispensing fees to offset the shift in payment methodologies. Therefore, it is critically important that pharmacy dispensing fees be adjusted to cover the cost of dispensing for all pharmacies as soon as possible.

Community pharmacies fully understand the level and complexity of changes that are required for states to fully accommodate the requirements of the Final Rule. We remain committed to preserving Medicaid beneficiary access to their needed medications and the ability of local California pharmacies to provide services to this important population. We strongly support CMS’ goal that chain pharmacies receive fair and adequate reimbursement that is based on the cost of acquiring and dispensing prescription drugs in the Medicaid program. We will continue to work with DHCS as it makes the necessary changes to adopt cost-based reimbursement methodologies that are required by the Final Rule. We believe that if implemented properly, cost-based reimbursement methodologies can lead to fair and adequate payment levels that reflect the cost of providing needed healthcare services to Medicaid beneficiaries.

On behalf of chain pharmacies operating in California, we thank DHCS for the opportunity to present our views and we welcome the opportunity to respond to any questions you may have. We look forward to meeting with DHCS to discuss concerns in more detail and to continuing to work with you in your efforts to ensure needed services to Medicaid beneficiaries.

Sincerely,

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cc: Jennifer Kent, Director, California Department of Health Care Services
    Robert Ducay, Assistant Secretary, Office of Program and Fiscal Affairs, California Health and Human Services Agency