NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

December 10, 2019

Ms. Maureen M. Corcoran
Medicaid Director
Ohio Department of Medicaid
50 West Town Street, Suite 400
Columbus, Ohio 43215

**RE: Ohio Medicaid Managed Care Pharmacy Reimbursement**

Dear Ms. Corcoran:

On behalf of the 1,600 chain pharmacies operating in the state of Ohio, the National Association of Chain Drug Stores is writing to express our concerns with the Ohio Department of Medicaid (ODM) Managed Care Program's current reimbursement rates and methodology that is used to reimburse participating pharmacy providers. In order to protect patient access to prescription drugs and other valuable services provided by community pharmacies, ODM must set a minimum reimbursement level and dispensing fees for Managed Medicaid to ensure that pharmacies receive fair and adequate reimbursement plans.

Community pharmacies acknowledge ODM's efforts to reform and restore transparency and accountability to the Ohio Managed Care Plans. It is also notable that beginning in January 2019, ODM has adopted requirements for all pharmacy benefit managers (PBM)s to use a pass-through model that would require the managed care plans to report the exact amount the PBM pays pharmacists for prescriptions, including the product cost and dispensing fee. Additionally, we understand that the adoption of the pass-through model was targeted to ending unfair spread pricing practices where state funds that were paid to plans for prescription drugs were not being reflected in the actual reimbursements that participating pharmacies were receiving. However, despite these intentions and efforts, these changes have not fully translated into fair and accurate reimbursement levels for pharmacies.

Although spread pricing has been prohibited and pass-through models are required in the Ohio Managed Care program, pharmacy reimbursement rates are still at levels that are insufficient to cover the full price of acquiring and dispensing prescription drugs in the Medicaid program. In fact, reimbursement levels under some of the current managed care plans are even lower with covered drugs being reimbursed below acquisition cost and absent a professional dispensing fee. Even with the adoption of pass-through models and the removal of spread pricing, lack of further attention and adjustments to pharmacy reimbursement rates will result in an extreme financial burden on pharmacies. It is extremely important that ODM not stop at requiring pass-through models and prohibiting spread pricing. ODM must also further these efforts by continuing to fully review the current reimbursement structures, methodologies, and rates that managed care plans are using to pay participating pharmacies and make the necessary adjustment to ensure that pharmacies receive reimbursement that is truly reflective of the cost to acquire and dispense prescription drugs in the Medicaid program. Below we offer suggestions that would not only assist with these efforts to ensuring fair and accurate reimbursement rates for pharmacies.

**The Setting of a Medicaid Rate Floor for Pharmacy:** As a part of the efforts to increase accountability in Ohio's Medicaid Pharmacy Program, beginning July 1, 2020, ODM is proposing to adopt an appeals process for pharmacies that will ensure that the cost of pharmacies doing

business is met. Like the initiative to prohibit spread pricing and require the use of a pass-through model, this is also a notable effort to ensuring that reimbursement rates adequate to accommodate the cost to acquire and dispense prescription drugs within the Medicaid program; however, this initiative is void of a standard for payment. While an appeals process provides a mechanism for pharmacies to contest low reimbursement, it does not set a standard or a framework that the plans should follow for establishing reimbursement. Community pharmacies strongly believe that in addition to and before an appeals process can be established and adopted, the state should establish a reimbursement rate standard or adopt a minimum reimbursement rate that pharmacies should receive that will at least cover the true cost of purchasing and dispensing prescription drugs. Additionally, this standard for payment should be adopted well before July 1, 2020, to provide relief to participating pharmacies that are currently bearing the finical burden of substantially low reimbursement rates.

Like many other states, Ohio has a fairly large managed care population. However, unlike other states, Ohio has not created a reimbursement rate floor for participating providers which would guarantee that providers are not paid below the current Medicaid fee-for-service (FFS) rates. By establishing a standard of payment and reimbursement rate floor, these same payment reassurances and protections can be extended to pharmacy providers when prescription drugs are carved into the managed care program. Establishing the same reimbursement rate floor for pharmacies will increase transparency as well as create a level playing field for all providers, thereby allowing for some financial stability and predictability of reimbursement in these private contracts.

In addition to adopting the FFS rate as a rate floor for the drug product, it is also imperative that managed care plans are required to address pharmacy reimbursement comprehensively and adopt cost-based professional dispensing fees. A fair and accurate dispensing fee takes into account a wide variety of factors such as payroll and personnel expenses, inventory services and warehouse expenses, insurance, building, computer, and rental of equipment. Similar to the considerations for establishing a professional dispensing fee for the FFS program, Ohio Medicaid should also consider adequate dispensing fees that incorporate a built-in inflationary component per annum of Consumer Price Index for its dispensing fee its managed care program. By incorporating a built-in inflationary component of the dispensing fee, pharmacy providers will receive reimbursement that is much more reflective of the cost to provide healthcare services in the marketplace. Furthermore, dispensing fees should be based on an annual comprehensive cost of dispensing surveys, like the Ohio Medicaid Survey of the Average Cost of Dispensing a Medicaid Prescription to accurately represent the cost of dispensing a Medicaid Prescription to accurately represent the cost of dispensing Medicaid prescriptions.

When considering the adoption of a reimbursement rate floor, ODM and managed care plans should take into consideration the fact that the FFS reimbursement rates are based on either a state or national pharmacy survey of the actual invoice cost of prescription drugs as required by the 2016 Covered Outpatient Drugs Final Rule. In 47 states, the cost is determined by the actual prices paid by pharmacy providers to acquire drug products marketed or sold by specific manufacturers. Thus, if states and managed care plans were to use the FFS rate as a reimbursement ceiling, as opposed to a floor, it would result in pharmacy providers being reimbursed below the actual cost of acquiring the drug products. Accordingly, pharmacies would face increasing financial burdens,

which could potentially lead to access issues for Medicaid beneficiaries. By adopting the National Average Drug Acquisition Cost (NADAC) as approved in the current state plan as the rate floor in its managed care plan, ODM would not only be ensuring that reimbursement rates are accurate and relevant, but they would also allow pharmacies to be paid at rates that are reflective of the true cost to dispense prescription drugs to Medicaid beneficiaries.

The adoption of the FFS rate as a rate floor for managed care plans would not only ensure adequate reimbursement rates, but it would also be aligned with other proposed federal regulations and legislate initiatives. Specifically, in the November 2018 Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care Proposed Rule[1], CMS recognized that some states are experimenting with payment models that use cost-based reimbursement models. To encourage states to develop these payment models and to eliminate the need for states to modify their payment models as only minimum or maximum fees schedules, the Proposed Rule gives states the authority to require managed care plans to adopt cost-based rates for network providers that furnish a particular service under the contract. Lastly, because these rates have already been approved as a part of the state plan, the Proposed Rule removes requirements for prior approval for payment arrangements that are based on the state plan approved rates, thus making it easier for such rates to be applied to managed care plans.

Similarly, on September 25, the U.S. Senate Committee on Finance released the text of the Prescription Drug Pricing Reduction Act (PDPRA) of 2019 (S. 2543) to reform drug pricing, which also includes provisions that would require payments to be made in the same manner as the cost-based reimbursement requirements in Federal regulation as set forth for FFS programs. Specifically, the provision would require plans to not only use a pass-through model, but it also requires plans to reimburse pharmacies at rates that are limited to the ingredient cost and a dispensing fee, which can be no less than the rates that the state is paying under the state plan or waiver for the FFS population. While this language has not been passed by Congress, it is a clear indication that efforts are targeted to ensuring that managed care pharmacy reimbursement rates are fair and adequate to cover the true costs to acquire and dispense prescription drugs to Medicaid beneficiaries. As such ODM should also adopt similar requirements to ensure that pharmacies are reimbursed accordingly for prescription drugs dispensed to managed care beneficiaries.

As ODM works to create a framework for managed care plans, we strongly urge you to ensure that payment rates are at levels that help to preserve patient access once transitioned to managed care. The adoption of the FFS reimbursement rate as a rate floor in managed care plans would ensure that pharmacy providers receive fair and adequate reimbursement rates that truly reflect costs. Currently, Kansas, Kentucky, Louisiana, North Carolina, and Pennsylvania are using their current FFS rates for pharmacy reimbursement in their managed care programs. Additionally, Virginia, Michigan, and New York are all actively considering proposals to also establish a reimbursement rate floor by using their approved fee for service rates in their managed care programs. As these other states have recognized the importance of maligning fair and accurate reimbursement rates in their managed care programs, we implore ODM to do the same to ensure continued patient access to needed prescription drugs and services.

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[1] 83 Federal Register 57264; CMS 2408-P

**Single PBMs Should be Carved-out of National Pharmacy Contracts:** As the state considers the above reimbursement suggestions, it is imperative that any contracts for the single PBM are free of requirements that would result in negative downstream impacts on pharmacy providers and the payments they receive. Another option that achieves greater pricing transparency is requiring carve out, from national pharmacy contracts, of pass-through rates for health plans specific to Ohio. If Ohio maintains the current pass-through model with no state-specific carve-out from national pharmacy contracts, the state may be subsidizing spread model profits in other states and plans, while not obtaining actual costs. In national pharmacy contracts, Ohio would have limited to no knowledge if it is subsidized or being subsidized by other states under the current model. Carving out reimbursement rates ensures that Ohio is remunerating the true and actual economics for the state. Therefore, we urge ODM to require PBMs to carve the Medicaid managed care plans for Ohio out of the national pharmacy provider agreements.

**Plans Should Meet the 85% Medical Loss Ratio (MLR) Requirements:** In the May 2016 Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability Final Rule[2], CMS adopted rules that required managed care plans to calculate and report their MLR experience for each contract year and was to apply to rate periods for contracts starting on or after July 1, 2017. The rule stated that actuarially sound rates were to be set to achieve an MLR of at least 85% and should apply to rate periods for contracts starting on or after July 1, 2019. Additionally, states are given the flexibility to set a standard higher than 85% and/or impose a remittance requirement. Based on the extremely low rates that pharmacy providers are receiving, we are concerned that ODM is not enforcing this minimum.

Because of the excessively low reimbursement rates that pharmacies are receiving despite recent efforts to remove spread pricing practices, we question if ODM is requiring Medicaid managed care plans in Ohio to maintain Medical Loss Ratios at or above 85%? Our concern is based on the August 16, 2018, report by the state auditor[3] stating that the Medicaid "Department's contract with its Plans indicates that the minimum medical loss ratio shall not fall below 85 percent". As such, we seek clarification on exactly how medical loss ratios calculated for Medicaid managed care plans in Ohio and further question what cost elements are considered pharmacy care costs as opposed to overhead and other non-care costs?

Per the May 15, 2019 CMS Informational Bulletin[4], CMS has provided guidance on calculating and reporting the MLR. Specifically, the guidance says that states are responsible for ensuring that managed care plans are complying with the MLR requirements and thus should routinely audit reported data and MLR calculations to ensure that revenues, expenditures, and other amounts are appropriately identified and classified within each managed care plan's MLR. This will allow states to distinguish which amounts were actually paid for benefits, or activities that improve health care quality, and which amounts were actually paid for administrative services, taxes, or other activities. That said, we strongly urge ODM to audit the reported data and MLR calculations to ensure that plans did, in fact, discontinue all spread pricing practices that may be hidden due to

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[2] 81 Federal Register 27497; CMS 2390-F

[3] https://ohioauditor.gov/auditsearch/Reports/2018/Medicaid_Pharmacy_Services_2018_Franklin.pdf

[4] https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf

misrepresented ratios. Additionally, we strongly urge ODM fully utilize the CMS guidance on calculating and reporting the MLR to avoid further decreasing the already low pharmacy reimbursement rates.

Additionally, because pharmacies are still being reimbursed below cost, in conjunction with the audits of the reported data and MLR calculations, we strongly urge ODM to commission a follow-up study to determine if the move to pass-through rates on January 1, 2019, provided any savings to the state and if so seek opportunities to reallocate such savings to provide cost-based dispensing fees to pharmacies. In doing such a study the state should focus on the following topics.

- Spread amounts as calculated prior to 2019 and broken down by PBM
- Spend trend year over year is broken down by utilization and per prescription trend
- Comparison to spend trends of key players in consultants' databases
- Spread amounts are broken down between adjudicated and reconciled rates (if possible)

**Conclusion:** NACDS thanks you for the opportunity to share our views. Community pharmacies are committed to serving Medicaid patients and providing them with quality care and services. However, in order to preserve the continuity of care and maintain patient access to prescription drugs and the other valuable services that community pharmacists provide, it is imperative that the Ohio Department of Medicaid takes the necessary steps to ensure that pharmacy providers are reimbursed fairly and accordingly. NACDS is committed to working with you to implement and adopt reimbursement provisions that are not only in compliance with federal requirements but are also targeted towards ensuring patient access to prescription drugs and pharmacy services in the Ohio Managed Care Program.

Sincerely,

Steven C. Anderson, IOM, CAE
President and Chief Executive Officer