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RE: SoonerCare Comprehensive Managed Care Program Reference 80720200002

Thank you for giving the Oklahoma Pharmacists Association (OPhA) the opportunity to provide comments on the planned comprehensive Medicaid Managed Care Implementation through the Oklahoma Health Care Authority.

OPhA is the largest community pharmacy trade association in Oklahoma representing over 400 community pharmacies in the state. Our mission is to reinforce the role of pharmacists as essential members of the healthcare team. Last year, the State's pharmacists dispensed nearly 45 million prescriptions to Oklahomans. Beyond that, Oklahoma's pharmacists helped alleviate a critical gap in access to healthcare. For many Oklahomans, their local pharmacy serves as the most convenient-and sometimes only-means to access the health system. In fact, data from the National Survey of Children's Health (NSCH), which measures the share of children who receive coordinated, ongoing, comprehensive care within a medical home indicated only 45.6% of children in Oklahoma have a medical home.[1]

The State's pharmacists have played a crucial role in both preventive and diagnostic medicine, particularly for pediatric and elderly patients. They often serve as an invaluable resource for patients who cannot and have not yet been able to consult with a physician. As an example, the

[1] Kaiser Family Foundation, State Health Facts, Percent of Children with a Medical Home available at: https://www.kff.org/other/state-indicator/children-with-a-medical-home/?activeTab=map&currentTimeframe=0&selectedDistributions=medical-home&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

parent of a sick child may seek advice from a pharmacist on the use of over-the-counter medication before a pediatrician is available.

Pharmacists in Oklahoma are authorized, trained and licensed to administer vaccines and other medications, with no age restrictions, and they perform tests for cholesterol, blood glucose, the flu, streptococcus, and COVID-19. Patients often seek their advice on matters that profoundly affect the public health from quitting smoking to managing diabetes.

OPhA understands that pharmacy costs are one of the fastest growing budget items in the Medicaid budget. In order to contain costs, OPhA would strongly urge the Oklahoma Health Care Authority to carve pharmacy benefits out of the Medicaid managed care program and continue to administer the benefit through the current fee-for-service program.

Continuing pharmacy drug coverage as fee-for-service Medicaid will allow Oklahoma to continue having transparency in its Medicaid program which increases accountability. It will ensure competitive reimbursements, improve health outcomes, and increase access to care all of which will result in cost savings for Oklahoma taxpayers.

Managing the Medicaid prescription drug benefit and pharmacy expenditures is a priority for most states. States have been given much flexibility in administering their Medicaid prescription drug programs. Many states through managed care have relied on a pharmacy benefit manager (PBM) to manage the prescription drug program. The complexity of prescription drug pricing and the lack of transparency by PBMs have created opportunities for PBMs to pocket profits that they should be giving to the state. Promised savings by PBMs have never come to fruition while the PBMs profits have soared. All over the country, community pharmacists' role in the Medicaid program is being threatened by opaque business practices, such as spread pricing, and lack of proper oversight. Even the Centers for Medicare and Medicaid Services is concerned that PBMs' use of spread pricing is inflating prescription drug costs that are borne by the taxpayer.[2] The PBM tactics have decreased reimbursement rates to such a degree that pharmacies are frequently reimbursed at rates that leave them underwater for the drugs they dispense.

Eventually, this leads to pharmacies closing and vulnerable patients left without viable healthcare. A study by the Rural Policy Research Institute found that under-reimbursement led

[2] 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

to the closure of 1,231 independent pharmacies in rural areas between 2003 and 2018. As a result, 630 rural communities nationwide that had a least one retail pharmacy in 2003 had **zero** retail pharmacies in 2018. [3] 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.[4] These pharmacy closures "are associated with nonadherence to prescription medications, and declines in adherence are worse in patients using independent pharmacies that subsequently closed."[5]

Administering drug coverage through Medicaid managed care allows PBMs to utilize abusive practices that increase costs for taxpayers.

Not only do opaque PBM practices negatively impact patients and community pharmacies, they also contribute to ever-increasing prescription drug costs for plan sponsors and taxpayers. While discussing PBMs' use of spread pricing, CMS Administrator Seema Verma acknowledged that she was "concerned that spread pricing is inflating prescription drug costs that are borne by beneficiaries and by taxpayers."[6] The State of New York also investigated PBMs and 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."[7]

Pennsylvania found that between 2013 and 2017, the amount that taxpayers paid to PBMs for Medicaid enrollees more than doubled from $1.41 billion to $2.86 billion. The Pennsylvania Auditor General determined that PBMs were getting perverse incentives and that they needed to pass legislation allowing for a full-scale review. They encouraged the State to directly manage its Medicaid prescription drug benefits instead of contracting with a managed care organization to do so. [8]

In Ohio the State Auditor found that PBMs pocketed more than $224.8 million in spread pricing in one-year period. The PBMs charged the state a spread of more than 31 percent for generic drugs- nearly four times as much as the previously reported average. Ohio audit data confirmed

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[3] 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

[4] Jenny S. Guadamuz, G. Caleb Alexander, Shannon N. Zenk & Dima M. Qato, Assessment of Pharmacy Closures in the Unites States from 2009 through 2015, JAMA Internal Medicine, Oct. 21, 2019, www.jamainternalmedicine.com

[5] *Id.*

[6] CMS Issues New Guidance Addressing Spread Pricing in Medicaid, Ensures Pharmacy Benefit Managers are no 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

[7] 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

[8] Pennsylvania Auditor General, Bringing Transparency & Accountability to Drug Pricing 6 (Dec. 11, 2018), available at https://www.paauditor.gov/Media/Default/Reports/RPT_PBM_rebates_022819_final.pdf

that cuts in pharmacy reimbursements from Medicaid PBMs resulted in a loss of 371 pharmacies since 2013, with a majority of the closures occurring from 2016 to present. [9]

According to 46brooklyn, based on the data in Auditor Yost's report, this would leave an average Ohio pharmacy with a margin of only $1.15 per prescription. [10] The most recent Ohio cost of dispensing survey (conducted in 2016) arrived at an average cost to dispense of $10.49 per prescription. [11] Auditors found that most of the financial information related to the relationships between pharmacies and the PBMs are considered proprietary and confidential and thus information was never shared with the state or with its legislators.

Auditors recommended that the State engage an independent third party to conduct a complete analysis of the impact of moving pharmacy services to a fee-for-service model similar to the change implemented in West Virginia.[12]

Complaints in Illinois were similar to those made in other states.[13] A 60 Minutes story about Rockford, Illinois illustrated the core problem with these opaque PBM practices. Rockford paid the health care costs for its city employees, and the mayor noticed a severe spike in the town's drug bill. After investigating the cause of the spike, the mayor realized the town's PBM was part of the cause, and the town sued the PBM for failing to control costs; after all, that is the PBM's job. However, the PBM argued that it was not contractually obligated to control costs![14] Even though plan sponsors are drawn to PBMs because of claims that they control drug costs, **PBMs have no statutory, contractual, or fiduciary obligation to control those costs.**

This is important information for states that run publicly funded health benefit programs, such as Medicaid. Your PBM is under no obligation to control the costs of those programs. Your PBM has no fiduciary duty to taxpayers. The obligation to control costs rests with the elected and other government officials. For this reason, Congress has introduced and is currently considering legislation prohibiting PBMs from using spread pricing in Medicaid managed care programs.[15]

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[9] Auditor of the 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

[10] Bloomberg Puts Drug Price "Markups" on the Map (Sept.13, 2018) https://www.46brooklyn.com/research/2018/9/13/bloomberg-puts-drug-price-markups-on-the-map

[11] https://pharmacy.medicaid.ohio.gov/sites/default/files/oh-pdfs-2016-report.pdf

[12] Auditor of the 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

[12] Bloomberg Puts Drug Price "Markups" on the Map (Sept.13, 2018)

[13] Dean Olsen, (2018) 'Medicaid managed-care reboot pinching pharmacies, advocates say' *The State Journal-Register, (Apr 29, 2018) available at https://www.sj-r.com/news/20180429/medicaid-managed-care-reboot-pinching-pharmacies-advocates-say*

[14] 60 Minutes, https://www.cbsnews.com/news/the-problem-with-prescription-drug-prices/.

[15] Prescription Drug Pricing Reduction Act of 2010, S. 2543, 116th Cong.§206 (2019).

In response to a state report in Kentucky it was found that PBMs kept $123.5 million in spread annually, therefore their Attorney General has launched an investigation into allegations that the PBMs have overcharged the state and discriminated against independent pharmacies.[16]

Michigan also backed away from pharmacy benefit managers (PBMs) in their Medicaid program, choosing instead to enable fee for service drug payments billed to Michigan's health department through a single, state-contracted PBM.[17]

On January 7, 2019, Governor Gavin Newsom issued Executive Order N-01-19 (EO-N-01-19) for achieving cost-savings for drug purchases made by the state. A key component of EO N-01-19 requires the Department of Health Care Services (DHCS) transition all Medi-Cal pharmacy services from managed care (MC) to fee for service (FFS) by January 1, 2021. They believe that this will standardize the delivery system, improve access to pharmacy services and strengthen the state's ability to negotiate drug rebates.[18]

In Louisiana PBMs retained $42 million that was incorrectly listed as "medical costs. "When the state chooses to do business with profit-driven entities, great effort should be made to ensure that money is not wasted," task force leaders wrote to Jen Steele, Louisiana's Medicaid director.[19]

A state Medicaid report in Maryland also found PBMs pocketing $72 million annually in spread pricing alone.[20]

Florida's MCOs and their PBMs own pharmacies that service Medicaid beneficiaries. A recent study 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."[21]

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[16]Kentucky Department of 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

[17] New Report Highlights Role of Pharmacy Benefit Managers in Manipulating Drug Costs for Michigan Patients, Pharmacists and Taxpayers Published: Apr 29, 2019 available at https://www.biospace.com/article/releases/new-report-highlights-role-of-pharmacy-benefit-managers-in-manipulating-drug-costs-for-michigan-patients-pharmacists-and-taxpayers/

[18] Medi-Cal Rx: Transition https://www.dhcs.ca.gov/provgovpart/pharmacy/Pages/Medi-CalRX.aspx

[19] Task force: Is Louisiana Medicaid drug spending inflated? Melinda Deslatte, The Associated Press (Oct 6, 2017) https://www.houmatoday.com/news/20171026/task-force-is-louisiana-medicaid-drug-spending-inflated

[20]https://cdn.ymaws.com/www.marylandpharmacist.org/resource/resmgr/legislative/mcoauditreport.pdf

[21] 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

States have successfully protected taxpayer dollars by transitioning drug coverage to fee-for-service Medicaid

In 2017, West Virginia carved pharmacy benefits out of its Medicaid managed care program and now administers the pharmacy benefits through the more transparent fee-for-service program. This decision not only saved West Virginia over $54.4 million in one year, but also increased reimbursements for the pharmacy community, benefitting patients, taxpayers, and local economies in the state. Based on their own numbers, West Virginia saved, on administrative costs, about $6.41 per claim after they carved the pharmacy benefit out of their Medicaid managed care program.[22] West Virginia's experience highlights the fact that transparency and competitive pharmacy reimbursements are both essential to controlling drug costs. Congress is also looking to increase transparency by requiring Medicaid managed care pharmacy reimbursements to be based on NADAC plus a professional dispensing fee.[23]

Benefits Provided Through MCO's

How can MCO's improve access to evidence-based behavioral health care such as Screening, Brief Intervention and Referral to Treatment (SBIRT), medication assisted treatment for opioid use disorder or, assertive community treatment?

Pharmacists' services have grown well beyond functions tied only to dispensing medications. Many pharmacists also provide such advanced patient-centered services as coordination of medications during care transitions, medication management, comprehensive medication reviews with ongoing medication monitoring, chronic disease management, disease education, prevention and wellness services, and patient education.

Many of our Oklahoma pharmacists are certified under Mental Health First Aid. This is the help offered to a person developing a mental health problem or experiencing a mental health crisis. The first aid is given until appropriate treatment and support are received or until the crisis resolves. Pharmacist intervention is not a substitute for medical care, diagnosis or treatment but it is a valuable screening tool that many of our pharmacists are now certified to do.

Improving quality of life and health outcomes in a cost-effective manner are important goals of the evolving health care system. Pharmacists are the most accessible health care provider and they have already established levels of trust with their patients. They have access to medical information, i.e. drug lists and they have established relationships with mental health providers. They are the most over-trained and under utilized health care professional in America. SoonerCare should work with pharmacy and utilize them to their benefit. Even marginal improvements would result in substantial savings for the state.

[22] 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
[23] Prescription Drug Pricing Reduction Act of 2019, S. 2543, 116th Cong. § 206 (2019)

Provider Payments and Services

Should OHCA require MCOs to maintain a minimum level of reimbursement? How should this be accomplished?

Require PBMs in the Medicaid managed care program to reimburse pharmacies at fee-for-service rates

As shown by Iowa, Kansas, Louisiana, Mississippi, Arkansas and North Carolina, state Medicaid programs have the authority to ensure reasonable contract terms between MCOs/PBMs and community pharmacies - for example, competitive reimbursement rates.

These states know how their tax dollars are being spent because they established the reimbursement rates for pharmacy services in their Medicaid managed care programs. In those states, PBMs must reimburse pharmacies at the same rates established under the fee-for-service program. [24]

States have found that increasing transparency and providing competitive pharmacy reimbursements, based on NADAC plus a professional dispensing fee, are not antithetical to controlling drug costs. In fact, transparency and competitive reimbursements are vital components of controlling costs. Therefore, OPhA recommends that pharmacies be paid NADAC plus a professional dispensing fee.

Network Adequacy

"What are reasonable time and distance standards in Oklahoma by provider type?"

According to United Health Foundation's latest rankings Oklahoma fell from number 43 to 47th as least healthy state.[25] County Health Rankings and Roadmaps (CHR&R) a Robert Wood Johnson Foundation program found that Oklahoma has the fifth fewest doctors according to a primary care doctor to population ratio.[26] Pharmacy is often the only access to care that a patient has in our state. As the most accessible healthcare provider in our communities pharmacists are critical for providing immunizations and other preventive care services. They have more interaction with the patient and they impact outcomes for a variety of disease states such as chronic asthma, diabetes, mental health, tobacco cessation, pain management, dental health, etc. Access to these services and prescription medications play a critical role in managing chronic conditions which prevent hospitalizations and further costs downstream. These are interactions that cannot be achieved through mail order.

[24] Iowa Department of Human Services, Informational Letter No. 1627-MC, (Mar.14, 2016); Louisiana Department of Health, Provider & Plan Resources: Frequently Asked Questions,

[25] United Health Foundation located at: https://www.americashealthrankings.org/learn/reports/2018-annual-report/findings-state-rankings

[26] Robert Wood Foundation Program located at: https://www.countyhealthrankings.org/reports/state-reports

PBM's should be required to follow the access standards similar to those found in HB 2632. [27] The language in HB 2632 provides standards on access benchmarks so that the health insurer networks meet minimum levels of geographic access for beneficiaries within a plan's service area. This prevents plans from establishing differentials between cost sharing at preferred versus non-preferred pharmacies that is often so significant that it discourages beneficiaries from using their local pharmacy. This language is similar to that found in CMS rules for standard pharmacy networks and ensures that patients have access to pharmacies in their community. Mail order should be excluded when determining access and patients should not be allowed to be steered or forced to use a pharmacy that is vertically integrated or owned by a PBM.

There are three national PBMs in the United States that are responsible for administering 85-90% of the pharmaceutical drugs that are reimbursed by the payors.[28] All three of these PBMs own their own retail pharmacies. Consequently, there is incentive for each of these PBMs to steer patients to use their own pharmacies and to exclude independent pharmacies from their network. Further, given the size of these PBMs, they can leverage unfavorable contract terms with independent pharmacies. Most of the independent pharmacies are located in rural areas of Oklahoma. Excluding them from a network of retail pharmacies providing pharmaceutical benefits to patients in the rural areas not only adversely impacts the independent pharmacies who are excluded but necessitates that patients travel long distances to purchase necessary medications.

Administrative Requirements

"How can MCO's help identify member and provider fraud? What methods of fraud prevention and detection should be deployed?"

The most effective method for MCO's to detect fraud is by audit. However, it has been our experience that the audit process is frequently abused by middlemen generating profits by recouping payments over technical issues that have no bearing on fraud or abuse. If MCO's use an audit they should be done in a safe and fair manner, keeping all pharmacies on an even playing field. Pharmacies should be given adequate time to respond to an audit. MCO's should not be eligible to recoup funds prior to the finalization of the audit or recoup dispensing fees if the medication was never dispensed since the pharmacy never received a fee.

Audits should be conducted in strict compliance with 59 O.S. § 356 et seq. along with the amendments found in HB 2314 (2020)[29]. Even though this bill was not passed due to COVID, it emphasizes the issues that Oklahoma pharmacists have with audits conducted by PBMs. There is little to no recourse for pharmacies and audits have allowed PBMs to assess unreasonable fees to the determent of the patient and the pharmacy.

[27] http://webserver1.lsb.state.ok.us/cf_pdf/2019-20%20ENR/hB/HB2632%20ENR.PDF
[28] CVS, Express Scripts, and the Evolution of the PBM Business Model, Drug Channels (May 29, 2019) https://www.drugchannels.net/2019/05/cvs-express-scripts-and-evolution-of.html
[29] http://webserver1.lsb.state.ok.us/cf_pdf/2019-20%20ENGR/hB/HB2314%20ENGR.PDF

PBMs should also be required to report all financial and business relationship information regarding their interactions with MCOs and Oklahoma enrolled pharmacies. They should not be shielded by claiming data is proprietary.

OPhA appreciates the opportunity to share our comments and suggestions with you on your efforts to increase accountability and transparency in the SoonerCare Medicaid program. If you have any questions about the information in these comments, please do not hesitate to contact me.

Respectfully submitted,

Debra Billingsley
Executive Director