It’s time to hit pharmacy’s reset button

Antonio Ciaccia
Senior Advisor for Disruptive Innovation and Practice Transformation
American Pharmacists Association

For Every Pharmacist. For All of Pharmacy.

pharmacist.com

It’s time to hit pharmacy’s reset button - 4/26/2021

Provided by Center for Pharmacy Practice Innovation/Department of Pharmacotherapy and Outcomes Science

Speaker(s): Antonio Ciaccia

Topic: CPPI invites various health care professionals from around the country and globe to speak on issues relating to innovation in the health care space.

Purpose or Objectives: At the conclusion of this activity, the participant will be able to:

► List the different types of prescription drug price distortions.

► Explain the recent trends in drug price changes.

► Describe how rebates on brand name drugs create price discrimination for payers.

► Describe the function of Average Wholesale Price for generic medications, and its central role in creating drug pricing distortions.

► Identify incentive design shortcomings in the pharmacy business model and current initiatives underway to pivot the pharmacy practice model.

Date/Time: 4/26/2021 12:00:00 PM

Location: Zoom

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This activity provides 0.75 contact hours of continuing education credit. ACPE Universal Activity Number (UAN): Pharmacist: JA4008237-0000-21-044-L01-P Technician: JA4008237-0000-21-044-L01-T

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Credit Designation(s):
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OPA
OHIO PHARMACISTS ASSOCIATION

- After years of government affairs work at the Ohio Pharmacists Association, a few anecdotal reimbursement complaints from pharmacies grew into a loud chorus that pushed me into the bowels of the prescription drug supply chain.
- Severe pharmacy margin pressure in Ohio Medicaid managed care during a period of massive state drug spending growth pushed me to search for where the money was going.
- Years of learning and digging led to the uncovering of hundreds of millions of dollars in hidden drug costs and a nationwide push for drug pricing reform.
- Launched 46brooklyn Research in 2018 to publish and translate publicly-available drug pricing data for free.
- Launched 3 Axis Advisors in 2019 to help others solve drug pricing riddles using more extensive data research and analysis. Clients include provider groups, research firms, technology companies, law firms, investment analysts, employers, benefit consultants, and private foundations.
- Within these roles, serve as senior advisor to American Pharmacists Association, Ohio Pharmacists Association, and American Pharmacy Cooperative, Inc.

APhA
American Pharmacists Association
For Every Pharmacist. For All of Pharmacy.

APCI
American Pharmacy
COOPERATIVE, INC.

Introduction

Pharmacist compensation is largely derived from dispensing revenue

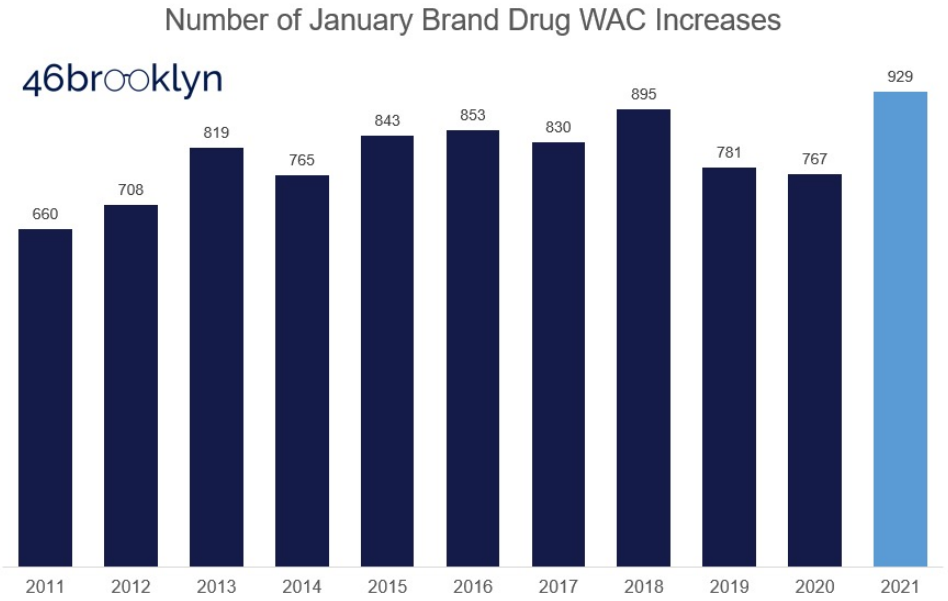
Follow the money to figure out where pharmacy is … and where it's heading

The capabilities and scope of the pharmacist has been growing, but the reimbursement model hasn't evolved in unison. As such, dispensing remains the financial oxygen for most pharmacies, and because of this, pharmacist compensation is embedded in the transaction for medications and heavily influenced by issues surrounding drug pricing.

So what's happening with drug prices?

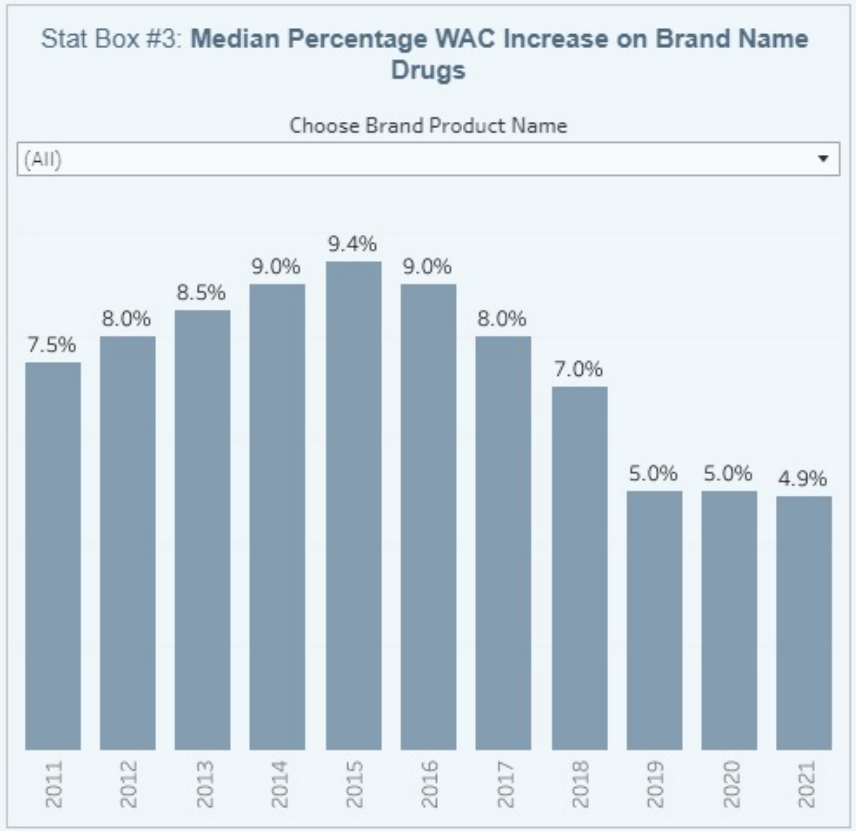
More brand drugs are going up in price

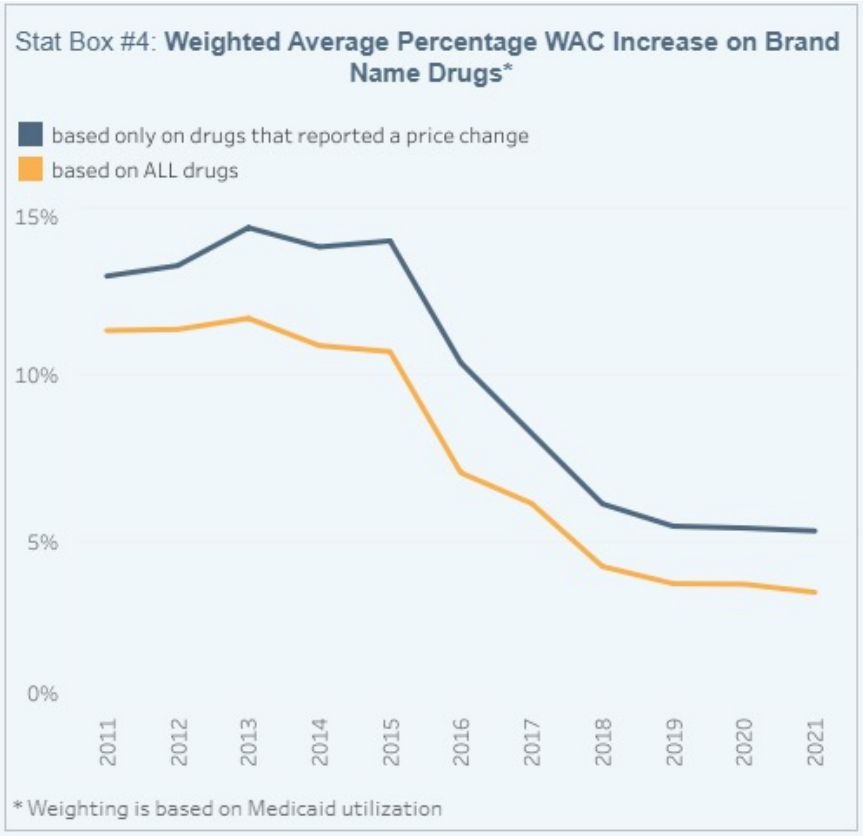
- The number of annual drug price increases on brand-name drugs have declined each year since 2015
- However, 2021 is appearing to alter this trends
  - With 929 price increases in January 2021, **this year has the highest number of January increases in over a decade.**



Source: 46Brooklyn Research

But the size of those increases are smaller





Source: 46Brooklyn Research

Median price increase is down to 4.9% - the lowest amount in a decade
Weighted average price increase is down to 5.3% - also lowest amount in a decade

But those are just list prices. What's happening to net costs?

DRUG CHANNELS

Expert Insights on Pharmaceutical Economics and the Drug Distribution System

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TUESDAY, AUGUST 04, 2020

The Gross-to-Net Bubble Hit $175 Billion in 2019: Why Patients Need Rebate Reform

Last Friday's Executive Orders revived the government's effort to reform rebates in federal programs. Whether that effort succeeds, today's update reminds us what's still at stake in reforming rebates within the U.S. drug channel.

For 2019, Drug Channels Institute estimates that the **gross-to-net bubble**—the dollar gap between sales at brand-name drugs' list prices and their sales at net prices after rebates and other reductions—reached $175 billion.

The bubble reflects—and drives—many of patients' problems and misunderstandings of U.S. drug prices.

However, the political and practical challenges to rebate reform remain daunting. Few people grasp the complex economic interplay of patient out-of-pocket spending, cost-shifting, premiums, and payer incentives.

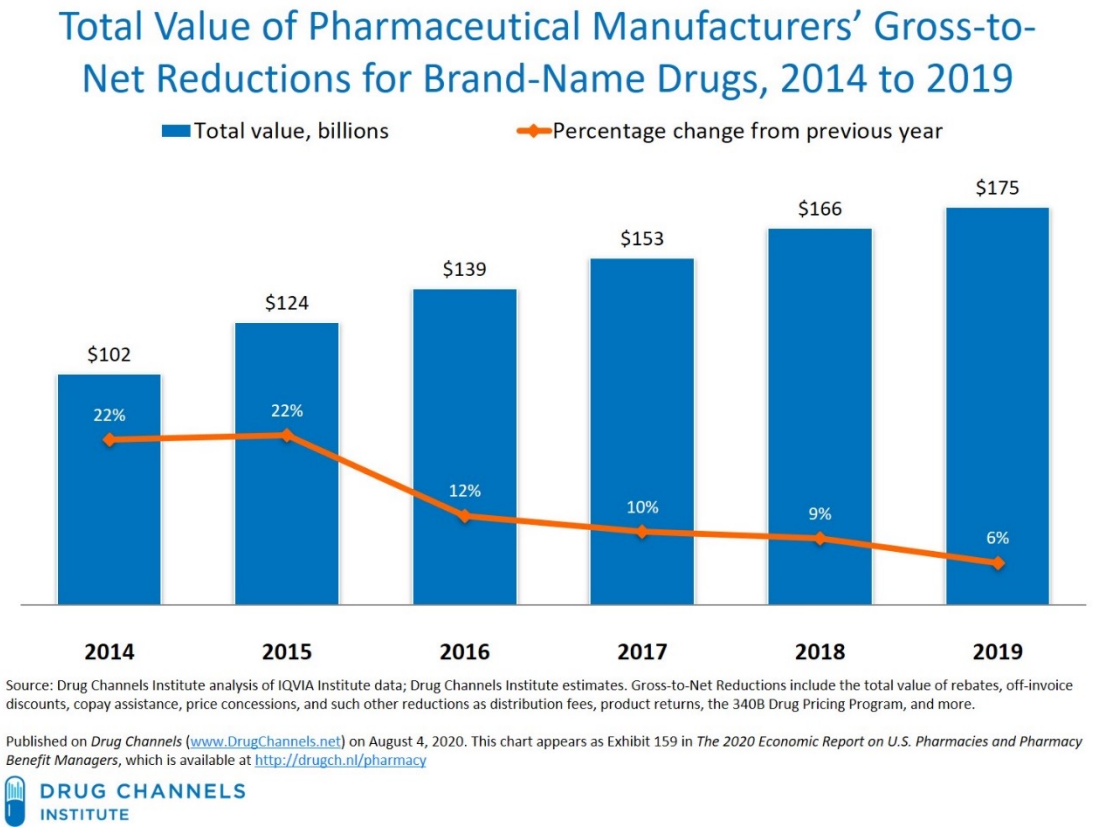
Despite the pandemic, I remain hopeful that we can help this bubble pop.

Brand drug manufacturers offer rebates to insurers and pharmacy benefit managers (PBMs) for preferential formulary placement, thus lowering net costs.

However, federal officials have questioned the utility of rebates, due to the likelihood that manufacturers are inflating their list prices in order to accommodate for rebate concessions.

Source: https://www.drugchannels.net/2020/08/the-gross-to-net-bubble-hit-175-billion.html

Drugmaker discounts and rebates are growing faster than list prices.



Source: https://www.drugchannels.net/2020/08/the-gross-to-net-bubble-hit-175-billion.html

Are true brand drug costs going up or down? Are we getting a good deal? It's complicated.

- Because brand drug manufacturer rebates to PBMs and insurers are confidential and vary widely from plan to plan, program to program, it's extremely difficult to pin down the net price being paid.
- Because government entities (VA, Medicaid, etc.) command such large rebates, smaller payers and patients who pay out-of-pocket pick up a disproportionate share of the overall cost.
- Because each plan/PBM promote utilization of different drug mixes, apples to apples comparisons of overall net costs is extremely difficult.
- **The inability to objectively determine what a fair price should be hinders the ability for true market forces to pressure drug supply chain margins and promote quality & efficiency.**

The system is built on “fake prices”

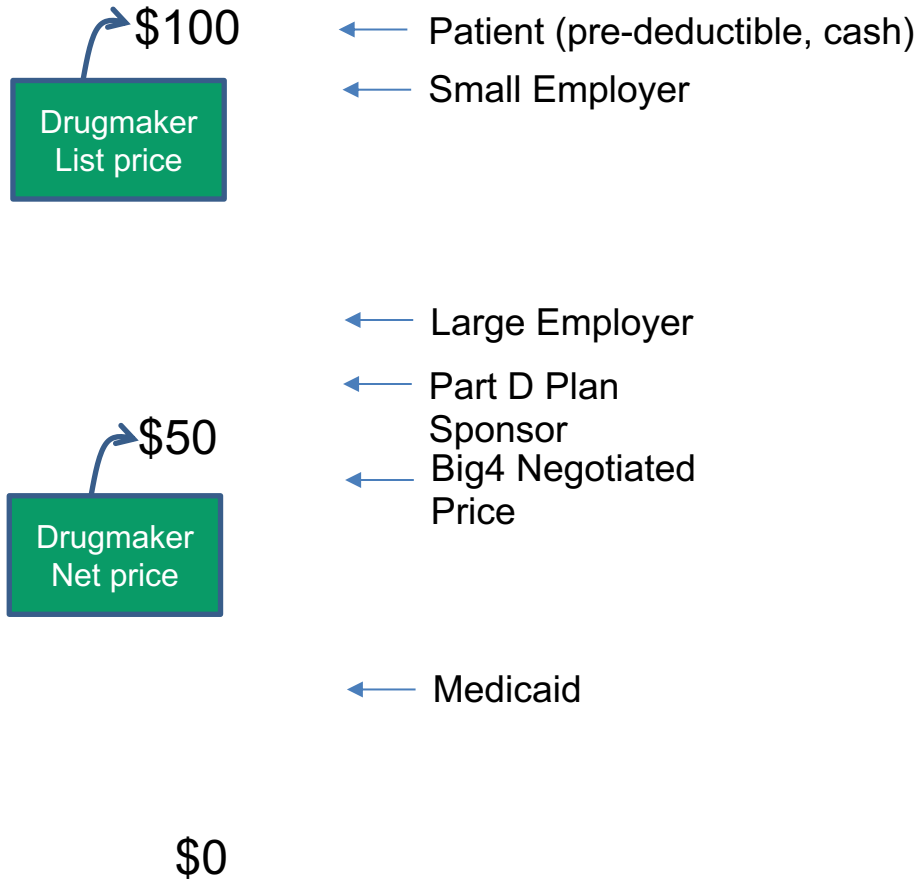
- List prices for prescription drugs are wildly overinflated relative to their actual cost.
- PBMs use those list prices (AWP) as the basis for their pricing guarantees to pharmacies and plan sponsors.
- Brand name drugs have high AWPs that are offset by negotiated rebates and discounts that make those net prices much lower.
- Generic drugs have high AWPs (derived from brand drugs) that in no way reflect the actual prices pharmacies pay to acquire those drugs.
- **In both regards, the “actual” prices of both brand and generic drugs are hidden from the plan sponsor and patient.**

The fallout of fake prices

BRAND DRUGS

The fallout of fake prices: Brands

- **Price discrimination** is a strategy that charges customers different prices for the same product based on what the seller thinks they can get the customer to agree to.
- PBM and drug manufacturer negotiate a net price, but the extent to which that true net price is captured by the payer depends on the payer's access to information and negotiating leverage
- Hidden rebates are the key enabler allowing the drug supply chain to capture benefits of drug price discrimination



Where are those savings for small U.S. employers?

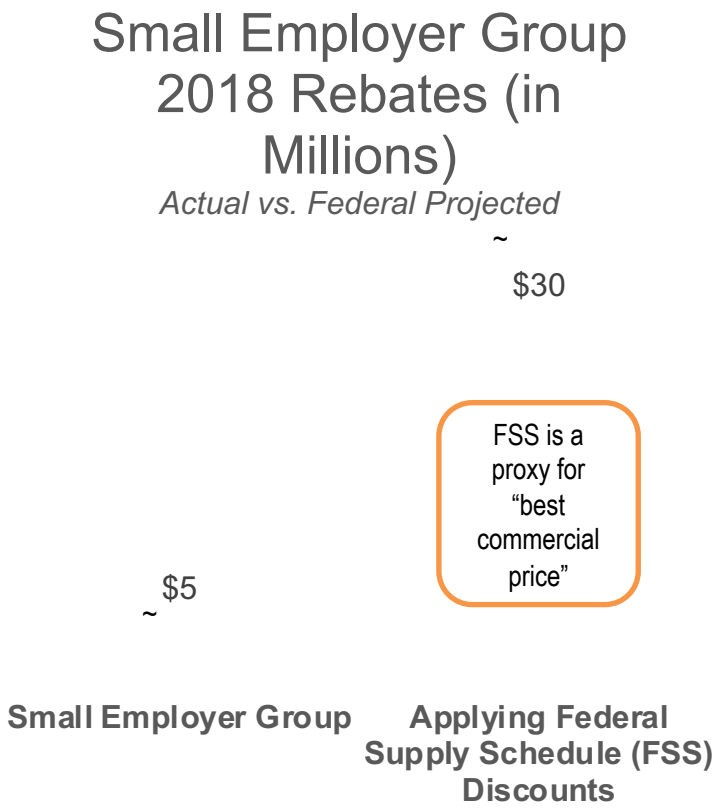
We had the opportunity to analyze data for a group of small self-insured employers

Total group spending on brand name drugs exceeded $110 million in 2018

On that spend, we identified only ~$5 million in rebates

In a world free from drug price discrimination, where all employers received the “best commercial price”, **their rebates would have been roughly 6x higher**

PBMs (and/or affiliated insurance companies) appear to have retained these rebates



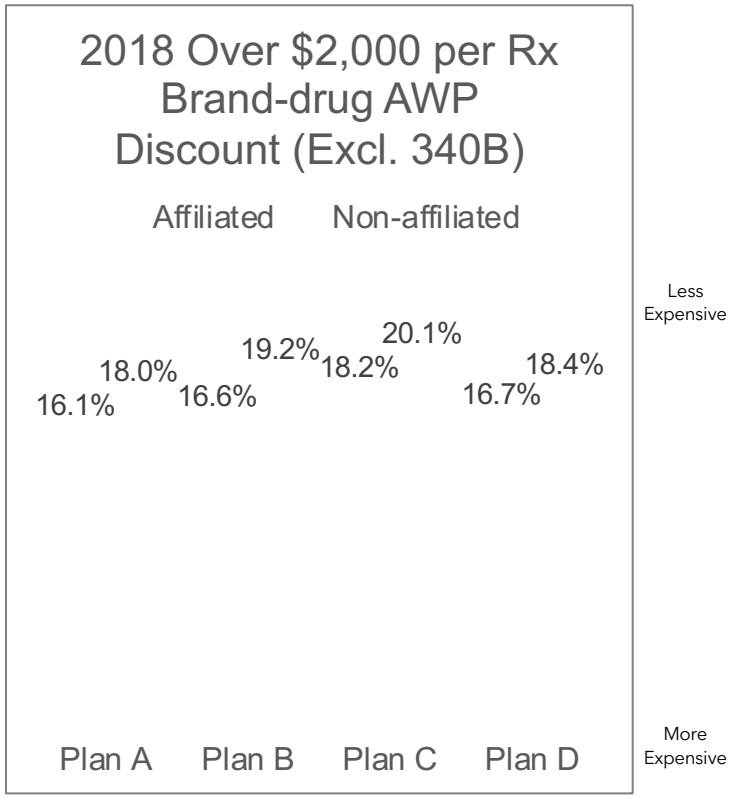
Source: 3 Axis Advisors analysis

Insurer #1	5%	75%
Insurer #2	38%	85%
Insurer #3	21%	68%
Insurer #4	5%	81%
Insurer #5	3%	93%
Total	**16%**	**76%**

The fallout of fake prices: Brand specialty drug differential pricing

Percentage of Brand Drug Claims Filled by Affiliated Pharmacy
Florida Medicaid Managed Care Claims Data (excl. 340B)

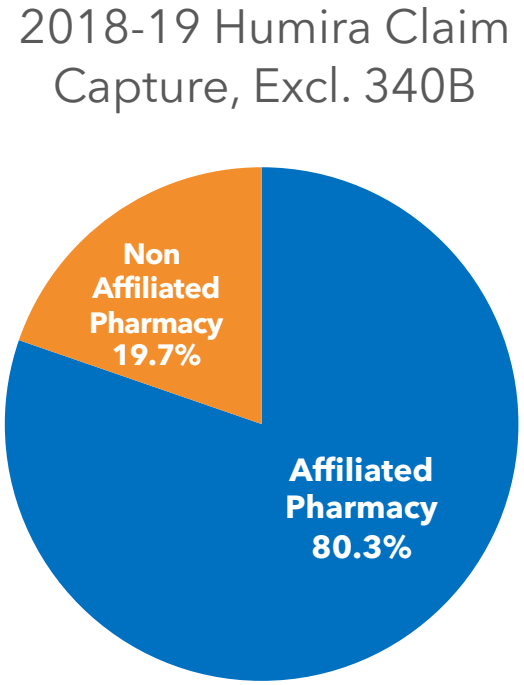
2018-19	Under $2,000 per Rx	Over $2,000 per Rx
Plan A	0.6%	60.2%
Plan B	0.4%	53.0%
Plan C	0.3%	18.2%
Plan D	0.2%	44.9%

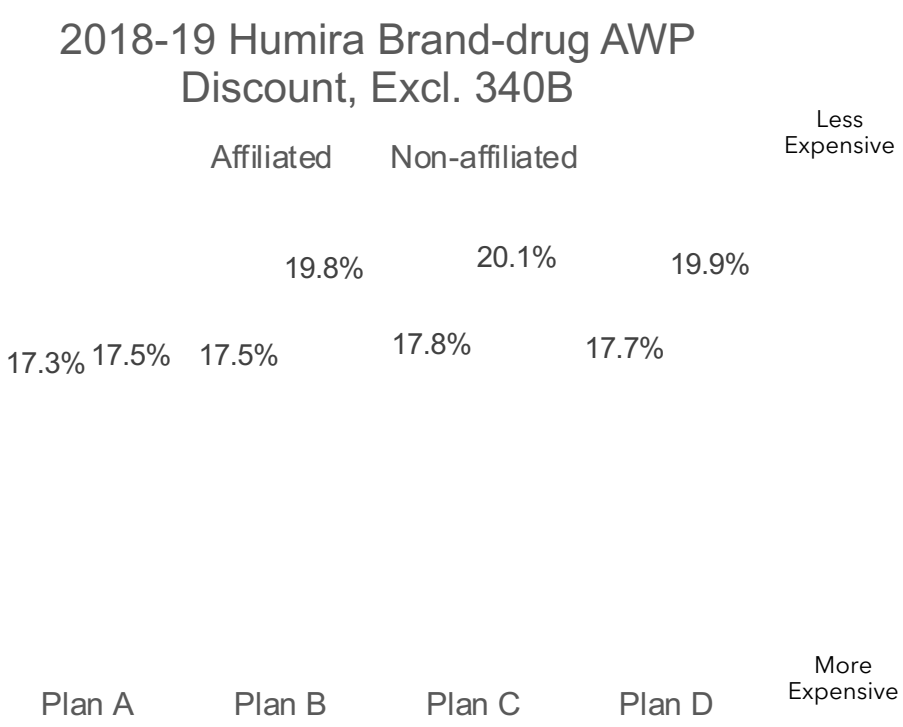


In Florida, specialty drugs are not only steered to affiliated pharmacies, but they are also more expensive at affiliated pharmacies!

https://www.3axisadvisors.com/projects/2020/1/29/sunshine-in-the-black-box-of-pharmacy-benefits-management

The fallout of fake prices: Humira differential pricing





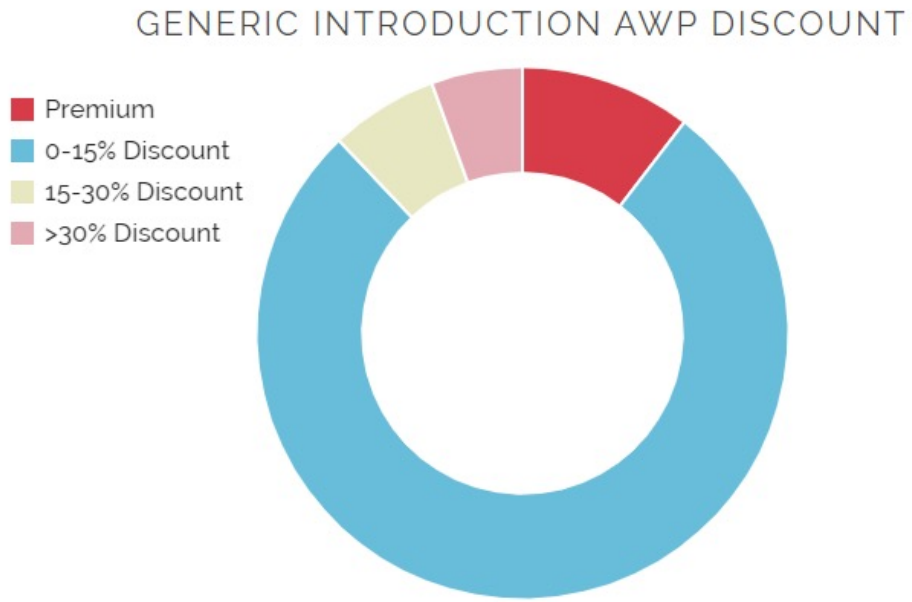
If Florida Medicaid would have recognized the non-affiliated pharmacy cost on the claims within the affiliated pharmacies, over $1.5 million in savings would have been realized on Humira alone.

The fallout of fake prices

GENERIC DRUGS

High-priced brands give birth to high-priced generics

- 1,247 different brand drugs lost patent exclusivity from 2005 to September 2019.
- For each brand drug in the sample, we found the first generic version brought to market and compared the generic's launch AWP with the AWP of its equivalent brand the month prior to its launch.
- The key takeaway from this analysis is that **77% of newly-released generics were launched with an AWP that was a 0-15% discount to the brand-name medication it was designed to replace.**



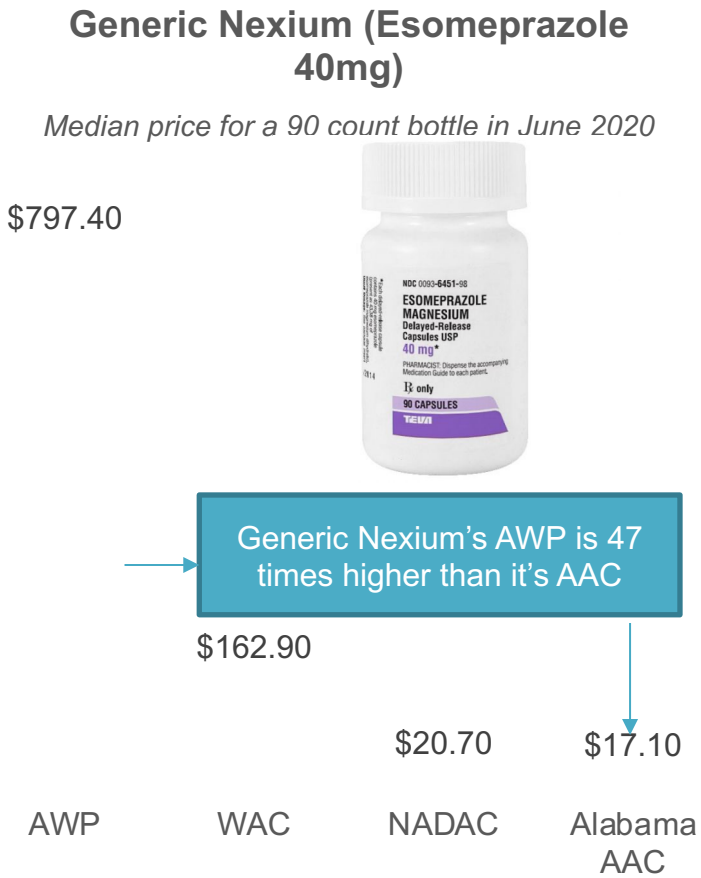
Source: 46brooklyn Research (derived from raw data from Elsevier Gold Standard) ; sample size = 1,247

https://www.46brooklyn.com/research/2019/10/11/three-two-one-launch-rfmyr

Generic drug pricing benchmarks

In the U.S., every drug has multiple, different prices

- **Average Wholesale Price** (“AWP”) and **Wholesale Acquisition Cost** (“WAC”) are both unilaterally set by the manufacturer
  - Not dictated by competitive market forces
- National Average Drug Acquisition Cost (“NADAC”) is based on a voluntary national survey of pharmacy invoice costs
  - Is dictated by competitive market forces
- Alabama Actual Acquisition Cost (“AAC”) is based on a mandatory survey of pharmacy invoice costs
  - Is dictated by competitive market forces
  - Ohio Medicaid pursuing their own AAC survey under PBM redesign



Source: MediSpan Price Rx, Elsevier Gold Standard Drug Database, CMS, 3 Axis Advisors

The million-dollar truck

Think of AWP as the drug's "MSRP"… if MSRPs were **TWENTY-ONE TIMES** higher than a vehicle's true cost!*

This is the median AWP to AAC relationship for generic drugs

The Kelly Blue Book "Fair Purchase Price" for a 2020 Ford F-150 SuperCrew Cab Platinum is $53,015 and its MSRP is $56,865

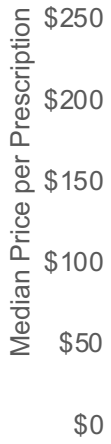
If the AWP-to-AAC relationship for the median generic drug applied to this vehicle, it's MSRP would be $1,113,315

* Based on a 3 Axis Advisors analysis of the prices of 20,205 generic drugs in 2020. The median AWP was $2.75 per unit while the median Alabama AAC was $0.13 per unit. Raw pricing data for this analysis was pulled from a combination of MediSpan Price Rx, Elsevier Gold Standard Drug Database, and CMS

came to market, the price drops precipitously
- NADAC is down 96% from May 2015

The **light blue line** shows that **WAC** declines with increased competition, but not nearly as responsively as surveyed pharmacy invoice costs
- Remember, WAC is set by the drugmaker, not the marketplace

Lastly, the **blue line** is **AWP**. This price benchmark is completely immune to the effects of competition, ***increasing*** since the drug's launch



Source: MediSpan Price Rx, Elsevier Gold Standard Drug Database, CMS, 3 Axis Advisors

AWP is designed to increase over time for generic drugs

We calculated pricing for ALL generic capsules and tablets dispensed in Ohio Medicaid

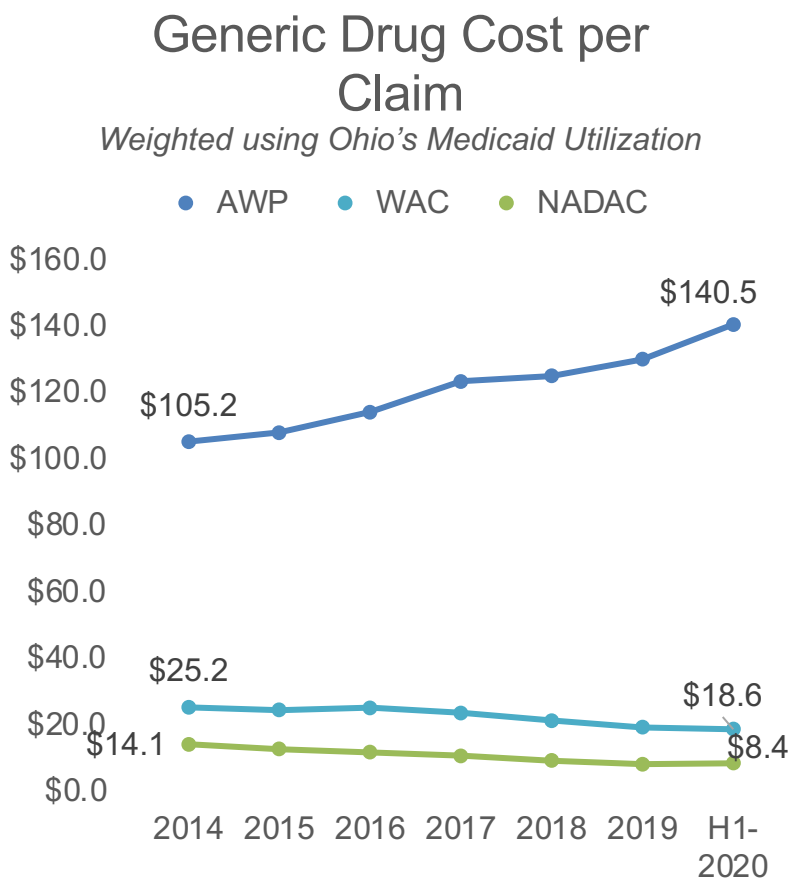
- Total of $2.6 billion in drug spending between 2014 and H1 2020*

The true cost of generic drugs (**NADAC, light green line**) has declined by **40%** over 5.5 years, to $8.40 per claim

Against that backdrop, the **AWP** of the exact same collection of generic drugs has increased **34%**, from $105 per claim to $141 per claim

- The lack of market-based pricing, combined with more expensive drugs coming to market naturally pushes AWP up over time

PBMs cannot claim they are working to lower drug prices **and then use a benchmark designed to increase them**



Source: MediSpan Price Rx, Elsevier Gold Standard Drug Database, CMS, 3 Axis Advisors

* This is the total Medicaid spending between Q2 2016 and Q1 2020 on generic drugs with a published NADAC

How PBM generic drug pricing arbitrage (a.k.a. “spread pricing”) works

PBM signs contract with payer/client guaranteeing a discount to AWP for generic drugs
Example: AWP – 82%

PBM signs contract with pharmacy/PSAO* with a more aggressive discount to AWP (or no guarantee at all)
Example: AWP – 89%

PBM sets different “MAC”** rates for client and pharmacy to meet its separate guarantees, adjusting frequently, and truing up afterwards if necessary

PBM locks in a percentage of AWP – the spread between what it charges its client and what it pays the pharmacy
Example: 7% of AWP
7% of Ohio’s weighted average generic AWP is $9.87 per claim – almost as much as Ohio’s professional dispensing fee for its pharmacies!

Levers to increase PBM profits in this business model:

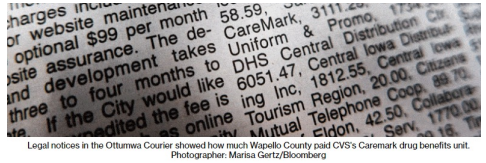
1) **Increase the gap between client’s discount and pharmacy’s discount**
2) **Choose a benchmark price that is naturally designed to increase: AWP**

* Pharmacy Services Administration Organization

* Maximum Allowable Cost: a proprietary PBM benchmark for generic drug ingredient cost that can differ from one client to the next, and one pharmacy to the next, and need not have any relationship to actual acquisition cost

Spread pricing hits home in Ohio

- Ohio Medicaid audit revealed $244 million in SPREAD PRICING from Q2 2017 to Q1 2018
- Spread pricing = the difference between the reimbursements paid to pharmacies and the rates reported back to the payer; PBM retains the difference
- Ohio's state Auditor David Yost conducted his own audit, and found that spread equated to 31.4% of gross generic spending in Ohio Medicaid managed care



Legal notices in the Ottumwa Courier showed how much Wapello County paid CVS's Caremark drug benefits unit.
Photographer: Marisa Gertz/Bloomberg

The Secret Drug Pricing System Middlemen Use to Rake in Millions

By Robert Langreth, David Ingold and Jackie Gu
September 11, 2018

Not everybody reads the legal notices inside the Ottumwa Courier. But in January, Iowa pharmacist Mark Frahm noticed something unusual in the paper.

AXIOS

Bob Herman July 31, 2018 | updated August 1, 2018

The data showing drug pricing games

Illustration: Sarah Grillo/Axios

Data analyses from 46brooklyn Research, a new firm started by two people with experience in the pharmacy industry, outline historic trends of drug prices and costs in Medicaid programs across the country in an open, transparent format.

The Columbus Dispatch

SUNDAY

HAPPY FATHER'S DAY!

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Sunday, June 17, 2018 | You can find $146.64 worth of savings in today's newspaper. | High: 91 Low: 73 Details, B12 | dispatch.com | $2.50

DISPATCH INVESTIGATION

Medicine middlemen reap millions

By Lucas Sullivan and Catherine Candisky
The Columbus Dispatch

A middleman company hired to keep the state's prescription-drug prices in check for Ohioans on Medicaid is receiving millions in taxpayer money meant to provide medications for the poor and disabled.

Records of transactions provided to The Dispatch from 40 pharmacies across Ohio show that CVS Caremark routinely billed the state for drugs at a far higher amount than it paid pharmacies to fill the prescriptions. The state-sanctioned practice, known as "spread pricing," allows the middlemen, called pharmacy benefit managers, to keep the difference on medications used to treat health concerns ranging from mental illness to osteoporosis.

CVS Caremark received more than $1.6 million for

See MIDDLEMEN, A3

Press Releases · Ohio Auditor of State

Auditor's Report: Pharmacy Benefit Managers Take Fees of 31% on Generic Drugs Worth $208M in One-Year Period

Geographic Price-Spread Disparities Found in Medicaid Pharmacy Payments

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Thursday, August 16, 2018

Columbus - Ohio's Pharmacy Benefit Managers (PBMs) charged the state a "spread" of more than 31 percent for generic drugs – nearly four times as much as the previously reported average spread across all drugs, according to a new report by Ohio Auditor of State Dave Yost.

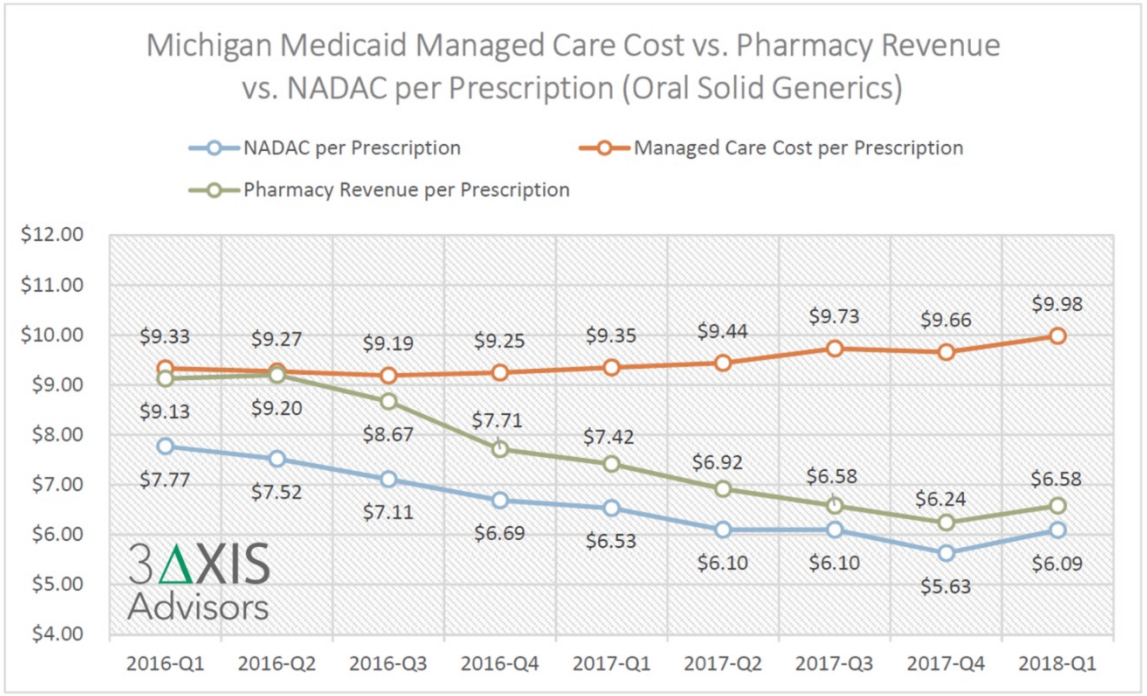
https://www.axios.com/data-showing-pbm-medicaid-drug-price-manipulation-1533059892-c2a97bcd-8874-42c2-a161-503e89666678.html
https://www.bloomberg.com/graphics/2018-drug-spread-pricing/ https://ohioauditor.gov/news/pressreleases/Details/5042
https://stories.usatodaynetwork.com/sideeffects/cost-cutting-middlemen-reap-millions-via-drug-pricing-data-show/

Ohio isn’t alone

3AA analysis of Medicaid managed care pharmacy claims in Michigan showed:

- Drug costs going down
- Pharmacy margins going down
- PBM spreads going up
- State costs going up

Spread pricing allows pharmacy-affiliated PBMs to shift traditional pharmacy margins to the PBM side of their enterprise.



https://www.3axisadvisors.com/projects/2019/4/28/analysis-of-pbm-spread-pricing-in-michigan-medicaid-managed-care

National backlash against spread pricing

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Monday, November 30, 2020

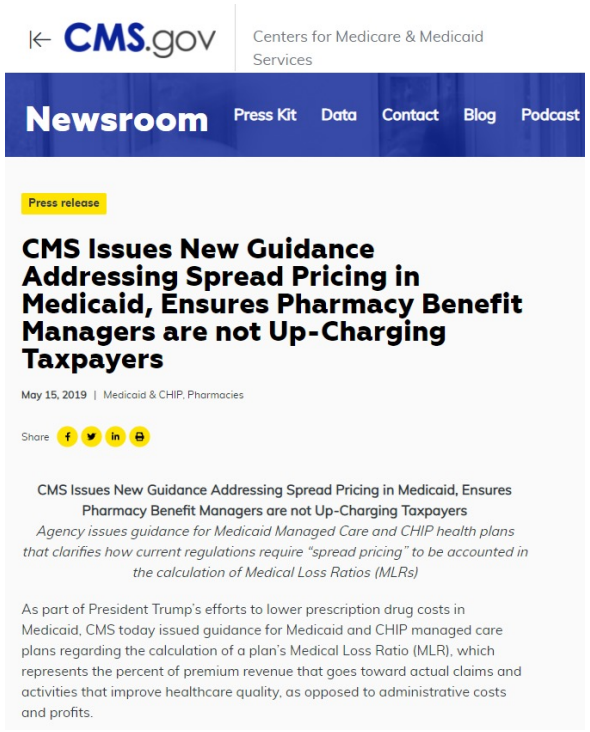
Inside Drug Pricing

Maryland Bans Spread Pricing Following Report On The Practice's Cost

By John Wilkerson / January 17, 2020 at 5:08 PM

Tweet Share

The Maryland Health Department will ban spread pricing in its Medicaid program next year after an audit found the practice cost the state $72 million in 2018, which at $6.96 per claim appears to be the biggest spread margin per prescription spread reported to date, according to 3 Axis Advisors. The department will mandate that Medicaid managed care plans use a pass-through pay model that requires PBMs to charge the exact amount they pay for prescriptions and dispensing fees. There...



CMS.gov Centers for Medicare & Medicaid Services

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Press release

CMS Issues New Guidance Addressing Spread Pricing in Medicaid, Ensures Pharmacy Benefit Managers are not Up-Charging Taxpayers

May 15, 2019 | Medicaid & CHIP, Pharmacies

Share

CMS Issues New Guidance Addressing Spread Pricing in Medicaid, Ensures Pharmacy Benefit Managers are not Up-Charging Taxpayers

Agency issues guidance for Medicaid Managed Care and CHIP health plans that clarifies how current regulations require "spread pricing" to be accounted in the calculation of Medical Loss Ratios (MLRs)

As part of President Trump's efforts to lower prescription drug costs in Medicaid, CMS today issued guidance for Medicaid and CHIP managed care plans regarding the calculation of a plan's Medical Loss Ratio (MLR), which represents the percent of premium revenue that goes toward actual claims and activities that improve healthcare quality, as opposed to administrative costs and profits.

UNITED STATES SENATE COMMITTEE ON FINANCE

MENU

SEPTEMBER 23,2019

Grassley op-ed: Let's prescribe a dose of common sense: End spread-pricing in Medicaid

Let's prescribe a dose of common sense: End spread-pricing in Medicaid

By Senate Finance Committee Chairman Chuck Grassley

Americans from coast to coast disagree about plenty of issues. As a U.S. senator, I know at least one issue that unites all Americans: Drug prices are too high.

The soaring cost of prescription medicine has struck a nonpartisan nerve. Sticker shock is hitting consumers at the pharmacy counter and socking it to taxpayers who foot the bill for government health programs. While most Americans agree the U.S. healthcare system provides the most innovative cures and quality care available in the world, they also know the delivery system is too complex, too secretive, too confusing and too expensive.

Complicated formulas along the pharmaceutical supply chain let drug manufacturers, wholesalers, retailers and pharmacy benefit managers hide behind a thicket of obscure payment arrangements to bilk public health insurance programs, including Medicaid.

National backlash against PBM pricing games

Sept. 30, 2020

PRN

PHARMACY RELATED NEWS

A dose from MPA

Breaking News: Governor Signs Budget into Law

Language benefiting independent pharmacies included

(Lansing, Mich.) - The Michigan Pharmacists Association is applauding Governor Gretchen Whitmer today for signing the 2020-21 budget into law, including Sec. 1625 pertaining to pharmacies.

MPA CEO Larry Wagenknecht said MPA's legislative team has been working tirelessly since February to ensure this language was included in the final budget bill.

"This legislation is a big step for many of Michigan's struggling independent pharmacies," Wagenknecht said. "We are pleased the Governor decided to sign the budget into law and would like to thank our partners in the Legislature for helping to get this done, as well as our members for their support and advocacy to make it possible."

The budget language will require Medicaid managed care to use the same reimbursement methodology as fee-for-service. This methodology consists of the National Average Drug Acquisition Cost, plus a professional dispensing fee. Additionally, the state will move to a single

CareSource

Newsroom / Press Releases / CareSource Moves to Reference-Based Prescription Drug Pricing

PRESS RELEASE

CareSource Moves to Reference-Based Prescription Drug Pricing

OCTOBER 27TH, 2020 | 2 MIN READ

Health Insurer Seeks to Lessen the Volatility of Drug Pricing for Ohio's Independent Pharmacies

(DAYTON, Ohio – October 27, 2020) – CareSource, a nationally recognized nonprofit health plan, announced starting February of 2021, they will begin basing prescription drug reimbursement for small, local pharmacy chains across the state of Ohio on National Average Drug Acquisition Costs (NADAC). Using NADAC pricing, which is surveyed through the Centers for Medicare & Medicaid Services (CMS), as a prescription drug reimbursement benchmark follows the Ohio Medicaid Fee-for-Service prescription drug reimbursement methodology. The announcement was made by Steve Ringel, CareSource Ohio Market President.

"This move magnifies the importance of our commitment to local, independent pharmacies by providing both transparency and stability to our critical access providers in order to help us achieve the highest quality of patient care for our members, particularly in rural and underserved patient populations," said Ringel.

NCPA

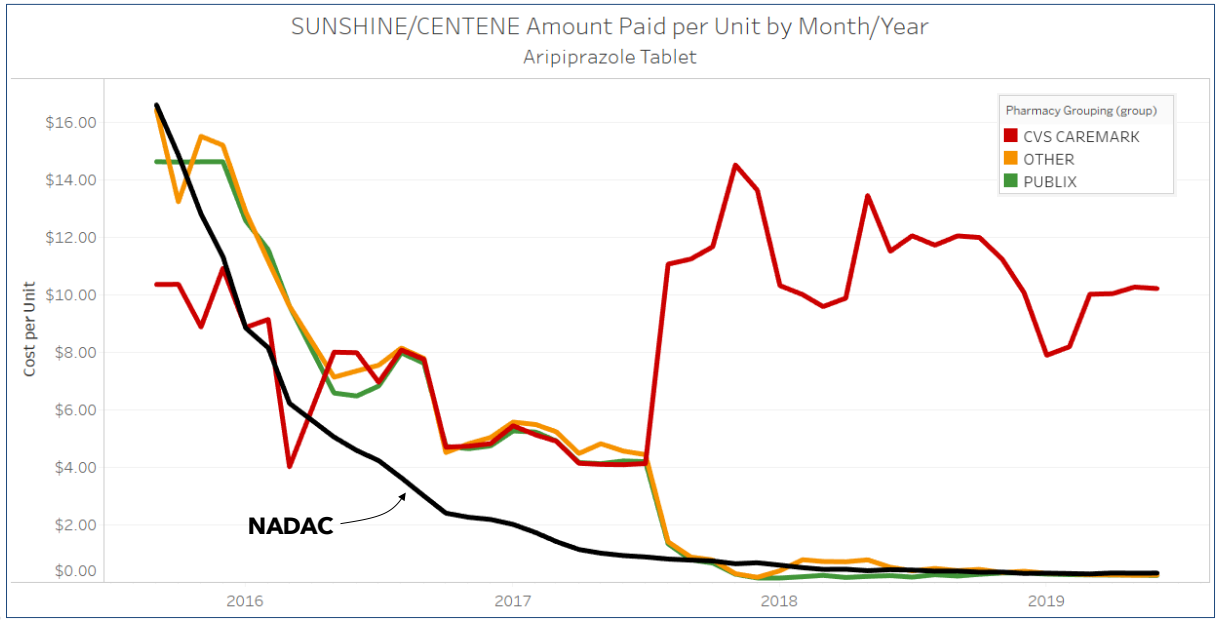
New York carves pharmacy benefits out of Medicaid managed care

NCPA · April 8, 2020

N.Y. Gov. Andrew Cuomo (D) signed the New York state budget bill for FY2021, which contains a provision directing the Department of Health to carve the Medicaid prescription drug benefit out of the managed care program and into the state-administered fee-for-service program beginning in April 2021. Under this move, PBMs will have less control over a patient's choice of pharmacy and pharmacy reimbursement amounts. In 2017, West Virginia saved $54 million by making a similar move. Congratulations to the Pharmacists Society of the State of New York and all pharmacy advocates for this great win for N.Y.'s Medicaid beneficiaries and their trusted community pharmacies!

Differential generic drug pricing hits a post-spread world

- In 2017, Caremark joined Envolve (owned by Centene) as the provider of Sunshine's (owned by Centene) PBM services in Florida
- The same month, Caremark dramatically increased the rates reported on claims dispensed at its affiliated CVS pharmacies on generic Abilify - Florida Medicaid's #1 spend generic antipsychotic drug
- At the same time, it dramatically reduced the rates paid to all other pharmacy groups in the state.



Overall, in 2018, 94% of the margin (revenue above acquisition cost) reported on generic drug claims by Sunshine/Centene was reported on claims dispensed at CVS pharmacies!

https://www.3axisadvisors.com/projects/2020/1/29/sunshine-in-the-black-box-of-pharmacy-benefits-management

margin off 0.5% of its generic claims.

- **For expensive specialty generics, the markups were more than 150% higher at affiliated pharmacies vs non-affiliated pharmacies.**

Insurer #1	5%	$55.02	$20.36	40%	$4,765	$1,530
Insurer #2	39%	$13.13	$7.82	81%	$3,000	$1,263
Insurer #3	4%	$35.74	$12.87	40%	$2,759	$1,053
Insurer #4	4%	$77.45	$17.54	47%	$2,448	$1,468
Insurer #5	3%	$33.52	$12.43	85%	$2,272	$302
Total	**11%**	**$26.02**	**$15.72**	**51%**	**$3,448**	**$1,339**

Differential generic drug pricing & steering

- In Ohio, after spread pricing was eliminated in Medicaid, PBMs began overpaying pharmacies on specialty drugs, which PBMs tend to steer through their own pharmacies.
- This enabled PBMs to margin-shift dollars from spread to specialty medications filled at their affiliated pharmacies.
- These problems persist today but are by no means unique to Ohio and by no means unique to Medicaid programs.

Special prices

CVS Caremark already was charging a healthy price markup in providing specialty prescription drugs to some Ohio pharmacies through the Medicaid program in 2018. But when the state removed the pharmacy benefit manager's "spread pricing" revenue stream in 2019, the prices went way up — far above the National Average Drug Acquisition Cost maintained by the federal government. The move by CVS' PBM presumably benefited the company greatly because it requires many specialty drugs to be bought from CVS' own pharmacies. The prices below are per pill.

Specialty drug	2018 price for Ohio	2018 US avg price	2018 markup	2018 % markup	2019 price for Ohio	2019 US avg price	2019 markup	2019 % markup
SILDENAFIL 20 MG TABLET	$3.45	$0.24	$3.21	1,338%	$3.90	$0.16	$3.74	2,338%
IMATINIB MESYLATE 400MG TAB	$120.00	$83.00	$37.00	45%	$270.00	$14.50	$255.50	1,762%
ENTECAVIR 0.5 MG TABLET	$5.70	$4.21	1.49	35%$	30.00$	1.86	$28.14	1,513%
CAPECITABINE 500 MG TABLET	$7.40	$5.40	$2.00	37%	$29.00	$3.33	$25.67	771%
TACROLIMUS 5 MG CAPSULE	$2.20	$2.86	$(0.66)	-23%	$3.50	$1.52	$1.98	130%
OTEZLA 30 MG TABLET	$51.00	$49.88	$1.12	2%	$58.00	$54.75	$3.25	6%

SOURCE: DISPATCH ANALYSIS OF MEDICAID PRESCRIPTION DATA FROM SOME THREE DOZEN OHIO PHARMACIES

Reference: https://www.46brooklyn.com/research/2019/4/21/new-pricing-data-reveals-where-pbms-and-pharmacies-make-their-money; https://www.dispatch.com/news/20190430/ohio-medicaid-officials-to-crack-down-on-pbm-specialty-drug-practice

It gets worse.

Patients are paying more

The Columbus Dispatch

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Prescription costs jump for state workers

By Cathy Candisky
The Columbus Dispatch

Out-of-pocket prescription drug costs for state workers and their families increased 18% last year, a new report shows.

The increase was greater than the 5.7% hike in total prescription costs for the health insurance plan covering state employees, suggesting beneficiaries are bearing the brunt of rising drug prices.

Meanwhile, the analysis by the state's pharmacy benefit manager, OptumRx, showed that its own specialty pharmacy, BriovaRx, received the biggest piece of the plan's prescription drug business.

Hired by the state to keep drug costs down, OptumRx paid BriovaRx $58.2 million to fill fewer than 1% of all prescriptions in the fiscal year ending June 30, 2019.

The earnings were three times more than the next highest paid pharmacy, Kroger, which took in $18.6 million from the plan last year.

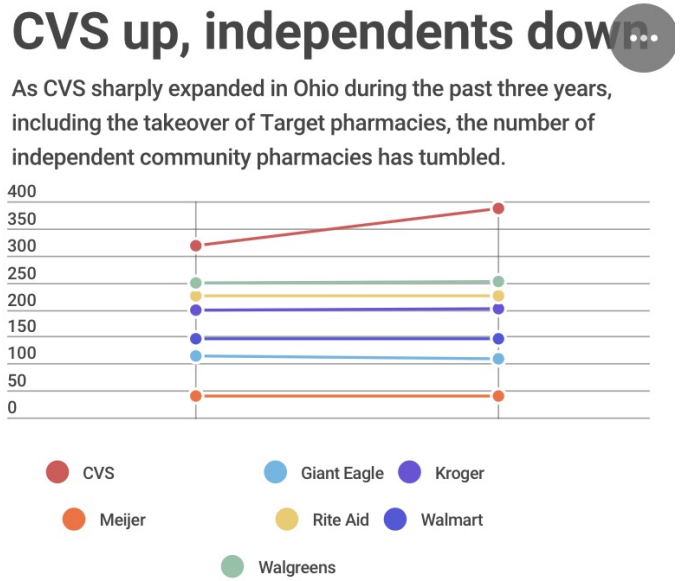
The report illustrates a trend of pharmacy benefit managers (PBMs) boosting their earnings with more costly specialty drugs used to treat complex conditions such as hepatitis and HIV and through consolidation in the health-care industry.

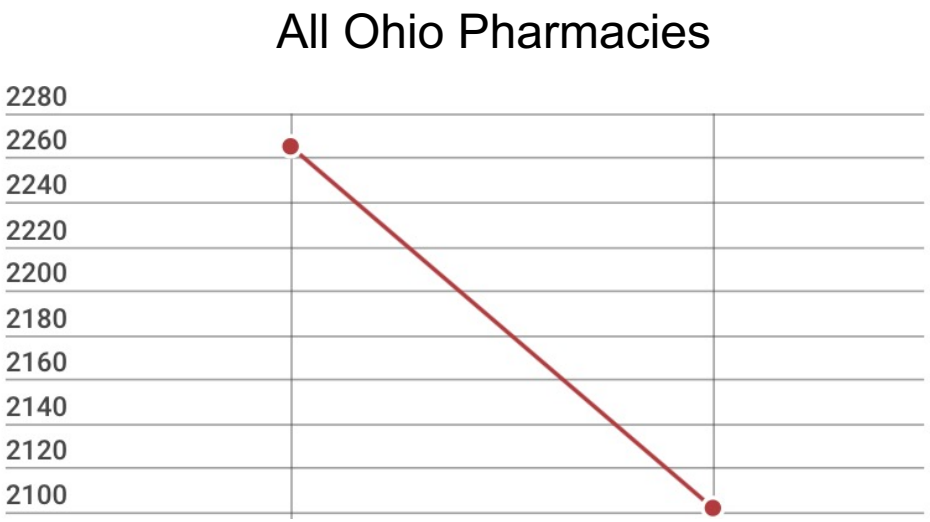
See COSTS, A3

Cost shift: 2020 report showed prescription drug costs for the Ohio state employees' health plan increased by 5.7%, while patient out-of-pocket expenses increased 18%.

https://www.dispatch.com/news/20200210/prescription-costs-jump-for-ohiorsquos-state-employees

Less pharmacy diversity and access





For roughly three years prior to spring 2018, Ohio saw a net loss of 164 retail pharmacies.
Over that time period, all major chain pharmacies saw little to no growth …
Except CVS pharmacies, which grew by 68 locations.

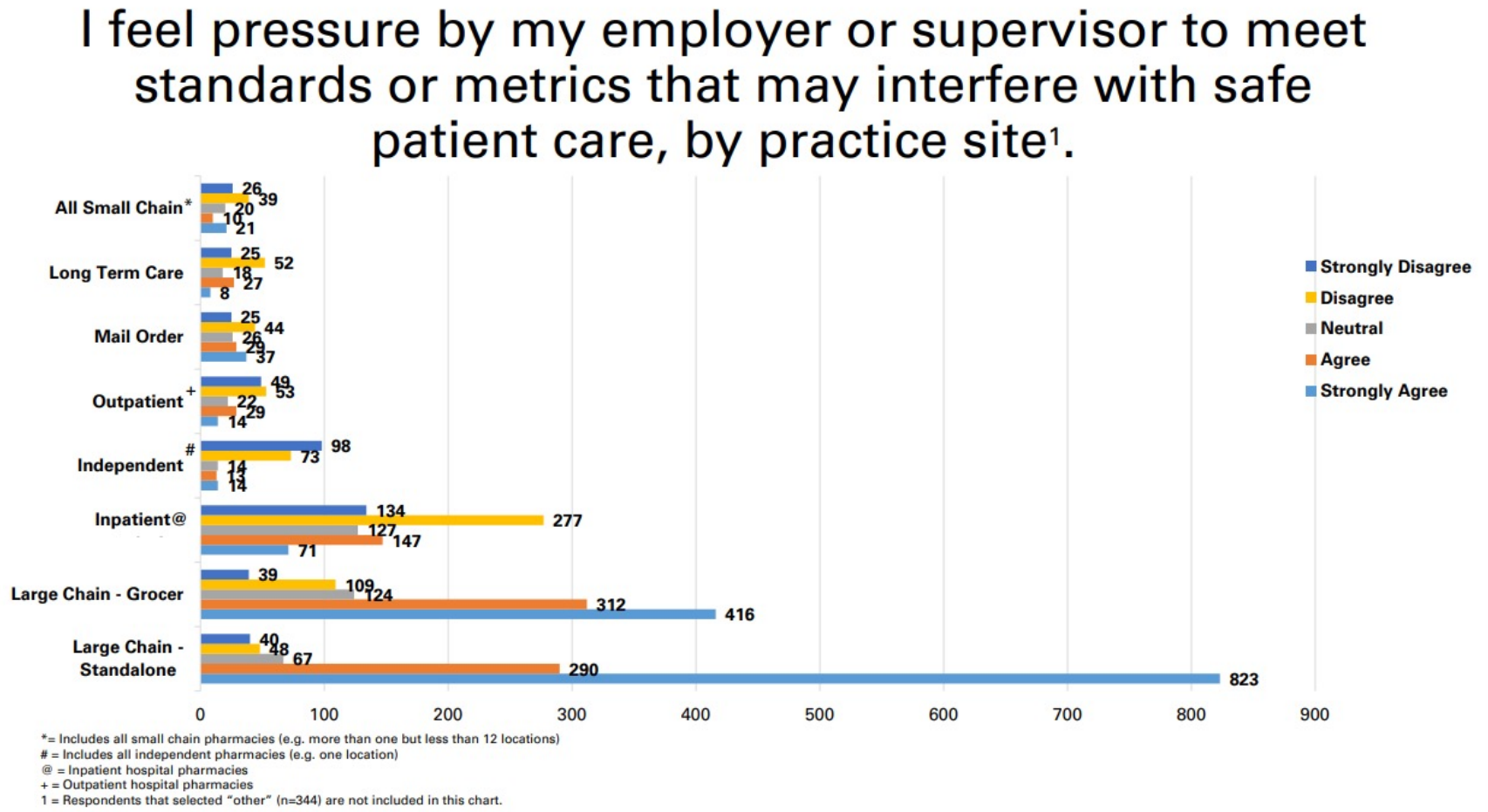
https://www.dispatch.com/news/20180415/three-cvs-actions-raise-concerns-for-some-pharmacies-consumers

Pharmacists are doing more with less

"The mistakes I have seen occur in this environment are both frightening and understandable when we are under the gun to perform the impossible." – *New York Times, 1/31/20*

https://www.nytimes.com/2020/01/31/health/pharmacists-medication-errors.html

Pharmacists are doing more with less

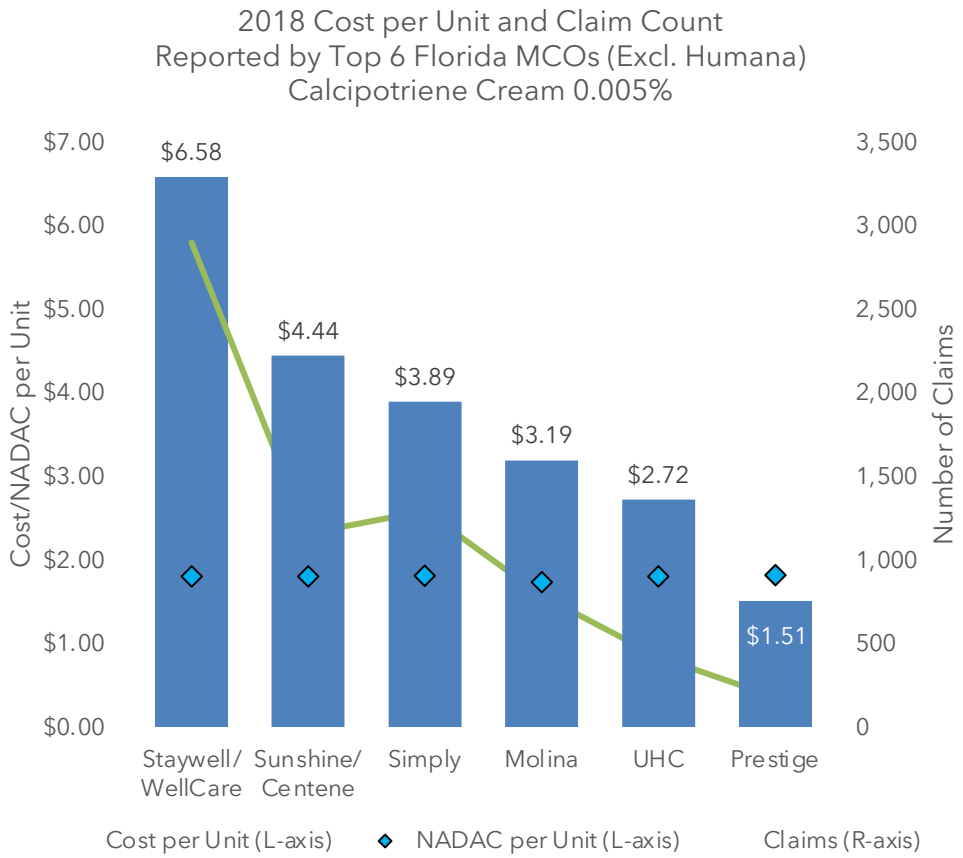


"The working conditions are very dangerous … They are constantly cutting hours and expecting us to do more with less." – *Ohio Board of Pharmacy 2020 Workload Survey released April 2021*

https://www.pharmacy.ohio.gov/Documents/Pubs/Reports/PharmacistWorkloadSurvey/2020%20Pharmacist%20Workload%20Survey.pdf

Pharmacies are pushed to the brink, and search for new revenue

- As pharmacies are pressured by PBMs on a majority of the drugs they dispense, it makes smart business sense to find medications that PBMs selectively choose to overpay for.
- Within the Florida Medicaid program, PBMs set prices for different MCOs wildly different for the same drug at the same time.
- The higher the payment, the more prescriptions were dispensed.



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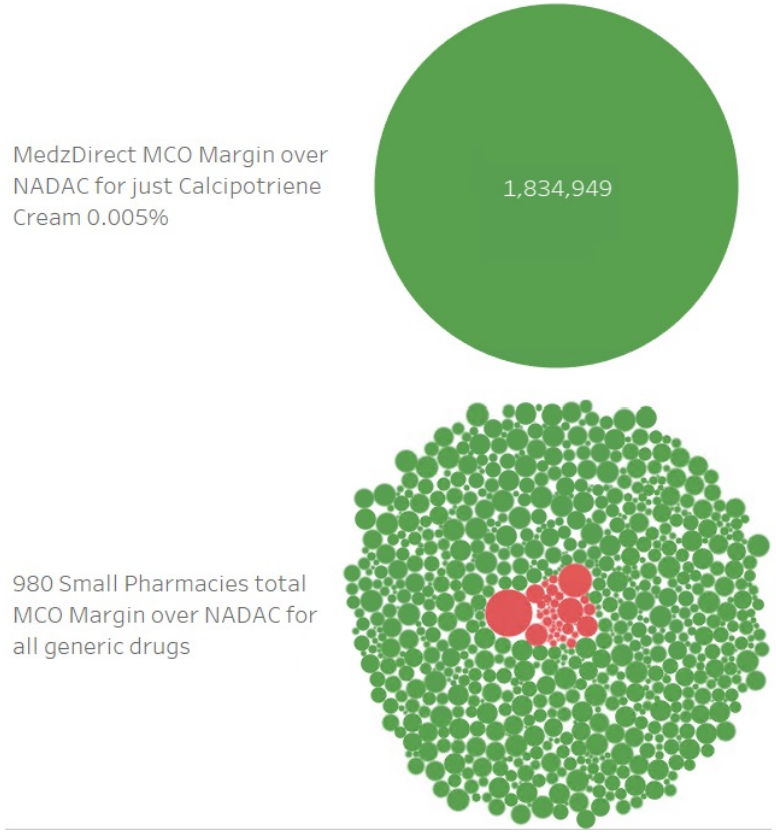
Margin seeking

As an example, one Florida pharmacy followed the PBMs' pricing signals on Calcipotriene Cream so well that the total profit reported on this one drug at just one pharmacy was equal to the total profit reported by Florida MCOs on *all generic drugs* dispensed at 980 of Florida's Small Pharmacies.



https://www.3axisadvisors.com/projects/2020/1/29/sunshine-in-the-black-box-of-pharmacy-benefits-management

Impact on pharmacies: Bad incentives all over

- Aside from the anti-competitive concerns with the PBM industry are the very real challenges of diminishing pharmacy access, an eroded standard of care in pharmacies, and the perverse incentives that can over-reward pharmacies with questionable ethics.
- The biggest problem in pharmacy is that when you are paid to fill a prescription – whether you're paid too much or too little – the best ways to maximize profitability is to maximize arbitrage opportunities and to fill more prescriptions, fill those prescriptions faster, and fill them with less invested resources.
- **Following the current business model in pharmacy, the pharmacies that work hardest for the patient are also the pharmacies that put themselves at the greatest economic disadvantage.**

Don’t just pay pharmacies more. Pay smarter.

Pharmacist scope of practice and engagement is evolving

- Many states are expanding collaborative practice laws, empowering pharmacists to order labs, prescribe medications, and administer those medications as well – under a collaborative practice agreement with a physician or nurse practitioner.
  - Chronic disease management focuses: Diabetes, hypertension, asthma, pain management
- Many states are also empowering pharmacists to prescribe more medications (tobacco cessation, contraception, OTC products, certain dermatologicals, naloxone, etc) under standing orders.
- States are enabling pharmacists to conduct lab tests, and in some instances, prescribe medications based on the results of those tests.
- Many states are allowing pharmacists to administer medications.

… but payment models aren’t evolving in unison

- Despite the growth in pharmacist capabilities and the expanded education & training, a lack of compensation for many of these services make many of these advancements more aspirational than operational.
- In a world where the current pharmacy business model is being squeezed, “no margin, no mission.”

It’s time to hit the reset button

- Pharmacies are over-reliant on dispensing margins as their primary means of sustainability and profitability.
- Those margins are being siphoned at a disproportionate level to PBM/insurer-owned pharmacies.
- Traditional pharmacies are stuck with more and more underwater claims and less overpaid claims over time.
- The pressures are eroding access, pharmacy resources, and the overall standard of care in pharmacy.
- The resulting assembly line culture in pharmacy is increasingly difficult to interrupt with new, time-consuming clinical services.
- Pharmacists face increasing debt, dwindling employment options, growing burnout rates, lessened job satisfaction, and increasing patient challenges.
- **The payment model must change.**

How we did it in Ohio

- Amplify drug pricing distortions, pharmacy pressures, poor system incentives, excessive costs, less-than-desirable provider/patient experience.
- Be unafraid to address bad actors or negative pharmacy stories within our own industry and profession.
- Used heightened awareness and focus on pharmacy due to PBM problems, and rather than fight for more money in an old, broken system, we have fought for fundamental payment reform and raising the bar in pharmacy.

How we did it in Ohio

What is happening in Ohio now…

APhA Membership Continuing Education Publications Resources

Home / Ohio hits provider status milestone with new law

JANUARY 15, 2019

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Ohio hits provider status milestone with new law

The law sets the stage for direct relationships with payers

Ohio Gov. John Kasich has signed a new Ohio law that authorizes payment to pharmacists by the state's Medicaid plan sponsors and other health plans. SB 265, which was introduced by Sen. Matt Dolan, is expected to become effective in April.

"What you have with this bill is a unanimous vote of an entire general assembly and the signing of a governor stating their endorsement that the pharmacist is a health care provider, and can and should be recognized by every other member of the health care team," said Antonio Ciaccia, director of government and public affairs at the Ohio Pharmacists Association (OPA).

The new law is a green light for pharmacists to start working with payers in a more direct fashion, rather than a mandate for coverage. "From a legal standpoint, the law puts pharmacists on the same playing field as any other provider rendering a service, which means that they have the same rights and responsibilities as a doctor, a nurse, nurse practitioner, physician assistant, you name it," Ciaccia said. "It enables a direct payer and provider relationship, so individual pharmacists can start working on a contractual basis with a payer."

The Columbus Dispatch

Monday, April 13, 2020 Get the Dispatch on mobile dispatch.com

UHC, pharmacists step up to help

Marty Schladen

UnitedHealthcare is working with some community pharmacies in Ohio to deliver primary care to its Medicaid patients.

The Minnetonka, Minnesota, health care giant last week told The Dispatch of plans to pay pharmacists to spend time with patients in an effort to better manage chronic conditions such as diabetes, high blood pressure and other problems.

Keeping those populations healthy would free up precious hospital beds during the coronavirus outbreak and keep people more productive and reduce medical expenses in the long run, said Mike Roaldi, CEO of UnitedHealthcare's Community Plan of Ohio.

"We hope this will take pressure off the acute-care facilities that are on the front lines of the response," he said.

UnitedHealthcare is one of five Medicaid managed-care organizations in Ohio. It's preparing to pay two northeastern Ohio pharmacies for time spent consulting with patients about their overall health: Brewster Family Pharmacy in Stark County near the edge of Ohio's largest Amish population and Franklin Pharmacy in economically stressed Warren in Trumbull County.

See UHC, Page A7

Ohio pharmacists enlisted to provide new health-care services

BUY HIDE CAPTION

Nnodum Iheme poses for a portrait in the file room at Zik's Family Pharmacy in the Wright-Dunbar neighborhood in West Dayton in May 17. [Matt Lunsford/For The Dispatch]

https://www.pharmacist.com/article/ohio-hits-provider-status-milestone-new-law
https://www.dispatch.com/news/20200413/unitedhealthcare-working-to-re-make-care-model-at-ohios--community-pharmacies-amid-coronavirus
https://www.dispatch.com/news/20200811/ohio-pharmacists-enlisted-to-provide-new-health-care-services

What is happening in Ohio now…

https://www.modernhealthcare.com/providers/pharmacists-ohio-managing-care-providers-and-getting-paid-it-too

What is happening in Ohio now…

- Ohio moving to strip PBMs of price setting capability.
- Ohio implemented provider ID numbers for pharmacists in Medicaid, where pharmacists are paid for services rendered in coordination with MDs, PAs, and NPs.
- All Medicaid plans mandated to do MTM.
- Pharmacy steering is being restricted by Medicaid, with likely more holistic legislation on the horizon.
- Value-based reimbursement contracts beginning to take shape.
- Four of the five Medicaid MCOs started paying pharmacists as providers in early 2020 programs (United Healthcare, Centene, CareSource, Molina) that seek to assess value beyond Medicaid's provider ID number approval.
- Today, all Medicaid plans are live, including MyCare (Medicare/Medicaid)

But Ohio isn’t alone

- Provider status programs are off the ground in Washington, Iowa, Tennessee, and more
- Massachusetts provider status law signed in January 2021
- Innovative pharmacist services models growing through CPESN and other networks
- PSAOs starting to evolve into medical services contracting
- Humana paying for diabetes outcomes in Medicare
- Large insurers investing in internal resources to get pharmacist services off the ground

What's in store for the future

The necessary realignment

Rather than a model predicated on speed, volume, and arbitrage, pharmacy should and will shift to a more service-oriented role, with a gradual shift in incentives from dispensing to outcomes.

Which of the following is not a drug pricing distortion?

A) The difference between AWP and actual pharmacy acquisition cost
B) The usual and customary price of an over-the-counter medication
C) The hidden rebates that flow from manufacturers to PBMs
D) The clawback that a PBM assesses a pharmacy through its PSAO

How are pharmacies primarily compensated for their services?

A) Co-pays from cash-paying customers
B) Medication therapy management
C) Rebates from Medicare and Medicaid programs
D) Reimbursement for dispensing drugs

True or False

A pharmacist can make any clinical decision and prescribe any medication, independent of a physician.

Which of the following is not part of the pharmacist's scope of practice?

A) Diagnosing lung cancer
B) Chronic disease management
C) Ordering medications through collaborative agreements
D) Interchangeable biosimilar substitution

Questions

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