



# NEW MEXICO INDEPENDENT PHARMACY

New Mexico Pharmacy Business Council is an advocacy arm of Texas-based American Pharmacies, an independent pharmacy cooperative with 600+ stores in Arizona, New Mexico, Oklahoma, Louisiana and Texas. Our mission is to advance and defend the business model of New Mexico independent pharmacy by making lawmakers and policy makers aware of the critical healthcare and economic contributions we make to our communities and the growing challenges to that role. We are governed by a six-member board of New Mexico independents.

New Mexico Pharmacy Business Council is proud to represent the 75 independent pharmacies of New Mexico. These dedicated entrepreneurs weather the many challenges of pharmacy ownership to be a critical part of our state's health-care network as providers of vital medications, expert advice, immunizations and clinical care.

## WE PLAY A VITAL HEALTH-CARE ROLE

Pharmacists are often the only health care available to rural New Mexicans with no access to physician care. In many rural areas and small communities of our state, an independent pharmacy is the ONLY healthcare practitioner, as chain pharmacies are more common in populous areas. Recognizing the critical role that retail pharmacies play in rural health care, the Legislature granted prescriptive authority to 1,600 trained New Mexico pharmacists for immunizations and some other protocols in 2001. That authority has since been expanded to include tuberculosis testing, emergency contraception, tobacco cessation and now naloxone, the anti-overdose drug.

- Independent pharmacies dispense a large share of our medications. Our 75 independent pharmacies fill an average of 201 prescriptions per day — that's 15,000 per day and 5.25 million per year.
- Independent pharmacists are highly accessible health-care practitioners. They typically spend more time with patients than their chain counterparts do, counseling them on medications and chronic health conditions, giving immunizations and referring them to physicians for treatment.
- Nationwide, independent pharmacies provide many vital services:
  - 67% provide immunizations;
  - 58% provide free blood pressure monitoring;
  - 82% deliver medications to shut-ins, the disabled or those lacking transportation; and
  - 66% sell or lease durable medical equipment.

## NMBC BOARD OF DIRECTORS



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## WE PLAY A VITAL ECONOMIC ROLE

In addition to their vital health-care role across our state, independent pharmacies are important contributors to the New Mexico economy, employing more than 500 workers statewide in well-paying professional jobs. They pay millions in wages and state taxes and are important in many communities as anchors of local economic activity. As locally owned businesses, they return a far greater percentage of their income to their home communities than chain pharmacies do.

The average independent owns 1.7 pharmacies. The average independent pharmacy generates \$3.5 million in prescription sales alone each year, plus taxable sales for over-the-counter medications, medical supplies and retail goods. Each employs an average of 6.5 pharmacists and technicians, plus other employees — cashiers, bookkeepers, delivery drivers, etc.

### SPOTLIGHT: RODEN-SMITH PHARMACY | CLOVIS (NMPBC Chairman David Lansford)

Roden-Smith Pharmacy has been in business for more than 65 years and serves a large area that encompasses three New Mexico counties as well as the communities of Muleshoe, Farwell and Bovina in Texas. Roden-Smith is a family-owned and -run business: Owners David and Debbie Lansford — Pharmacist David is chairman of the NMPBC Board and also the mayor of Clovis — both work at the store, as does their son, Micah. The only independent pharmacy in Clovis, it was voted the city's best pharmacy in this year in a poll conducted by the *Clovis News Journal*.

The Lansfords and their staff of 12 provide a variety of critical services to patients in their community and a large surrounding area encompassing 60,000 people:

- Home Medication Delivery & Mail Delivery
- Medication Adherence Counseling
- Flu Shots & Immunizations
- Compounding, including Hormone Replacement Therapy
- Medication Synchronization
- Medication Therapy Management (MTM) Services
- Long Term Care Services
- Private Consultations



### SPOTLIGHT: SOUTHWEST PHARMACY | CARLSBAD (NMPBC Vice-Chair Danny Cross)



Pharmacist Danny Cross is the owner of Southwest Pharmacy, La Tienda Pharmacy and Advanced Medication Management in Carlsbad, and also Farmers Uptown Pharmacy in Roswell. He is a former president of the New Mexico Pharmacists Association and former member of the New Mexico Board of Pharmacy.

Danny's four stores employ 40 people and serve retail and long-term care clients in a multi-county area of 100,000+ residents. He consults for several nursing homes, assisted living facilities, group homes, EMS and health clinics. His stores provide DME items (such as ostomy supplies), wound care, urological testing and diabetes testing, all at little or no profit as a service to their patients.

His pharmacy is the only one in Carlsbad that delivers and provides 24-hour emergency services. His four stores fill thousands of prescriptions daily and have provided thousands of immunizations every year for more than a decade and are the go-to provider for immunizations in Carlsbad. They offer operate immunization clinics at schools and employers around the state. They were the first pharmacies in the state to offer TB testing.

His pharmacy offers customized medications and solutions through specialty compounding. The pharmacy tracks compliance for chronic disease patients, sending them automated reminders and enrolling them in its medication synchronization program.

## ISSUES & CHALLENGES

### MAC PRICING



In reimbursing pharmacies for generic drugs, each PBM uses a proprietary **Maximum Allowable Cost (MAC) formula** that has no verifiable standard of accuracy. The secrecy and constant fluctuation of MAC prices makes them difficult to track, and they rise or fall with no identifiable correlation to supply conditions or prevailing wholesale cost. There is no consistency in how PBMs set or change MAC prices. Delays of 30+ days are frequent in updating prices, especially price increases.

Increasingly, PBMs set MAC prices at or below the lowest price at which a pharmacy can acquire drugs, so pharmacies are losing money on more reimbursements.

The passage of HB 126 in 2014 increased the transparency required of PBMs in adjusting MAC prices; the provisions are not enforced because the Office of the Superintendent of Insurance is drafting rules to implement the bill's requirements. We appreciate the OSI's work on this important matter.

But even when PBMs begin providing MAC price lists and updating them weekly, pharmacies still will have no recourse if reimbursed less than what they paid for a given drug. And PBMs will not be required to justify MAC prices or disclose a source where a drug is actually available at a stated MAC price. PBMs arbitrarily set drug prices however they choose, even if those prices do not reflect actual market conditions or prevailing prices.

### COST OF DISPENSING & DISPENSING FEES

**A 2007 study by Grant Thornton set the average cost of dispensing a prescription in New Mexico at \$9.95. The Medicaid dispensing fee in 2008 was \$3.65, and drugs were reimbursed at the rate of AWP (Average Wholesale Price) minus 12.5%.**

**Since 2007, the average cost of dispensing has risen to \$12.44 in the Western/Pacific region, as determined in a 2014 study by the National Community Pharmacists Association and National Association of Chain Drug Stores (costs were highest in the western mountain states). Nonetheless, PBMs now pay Medicaid dispensing fees of 55 cents to \$1.50 and reimburse for drugs using MAC prices, which pay less than AWP-based formulas. While dispensing costs have risen 25% since 2007, our dispensing fees have been cut 60% - 85% .**



**New Mexico's average prescription cost is the lowest in the nation and has been for many years. Our generic dispensing rate in Medicaid is 85% or higher, also among the best. Pharmacy benefits are only a small percentage of Medicaid costs, and were well under control before managed care for pharmacy benefits. Cuts in Medicaid dispensing fees are nothing more than squeezing pharmacies to generate profits.**

### MANDATORY MAIL-ORDER



Insurance plans and PBMs increasingly require patients to receive maintenance medications (insulin, blood thinners, blood pressure medication, etc.) in a 90-day supply from a mail-order pharmacy instead of a retail pharmacy. Mail-order pharmacies are typically owned by PBMs, meaning PBMs directly compete with their own network pharmacies. **Mail order is a conflict of interest — PBMs can create competitive advantages for themselves and steer patients to mail order by requiring patients to pay more at network retail pharmacies for the same maintenance medications.**

**Mandatory mail-order is problematic on several fronts:**

- **Studies show that mail-order drugs are usually more expensive to health plans than drugs obtained at a retail pharmacy.** PBMs have no incentive to use the low MAC prices they apply to retail pharmacies. They can use an AWP formula that produces higher drug prices for their own reimbursement. PBMs earn rebates from drug manufacturers for using branded drugs, so they may switch patients from generic medications to higher-priced brands because it is more profitable (though not for the patient).

- **Mail order is wasteful** — A University of Arkansas study found that mail-order drug plans create 3 times more waste than plans in which patients can purchase maintenance medications at a retail pharmacy. Patients frequently receive more drugs than they need through the mail. 90-day fill periods overlap and some patients receive 15 or more months of drugs in a year, all billed to the health plan.
- **Mail order is less reliable** — Mail-order deliveries can be delayed en route or stolen from a mailbox by thieves looking for prescription narcotics. Some drugs — such as insulin — are very heat-sensitive and degrade if they spend a summertime weekend in a hot metal mailbox.
- **Studies consistently show that patients are less adherent when they receive their medications by mail.** Patient adherence is not accomplished simply by mailing someone 90 days' worth of medications; *it occurs when a patient is under the consistent care of a pharmacist who knows that patient's drug regimen and health history and can consult on a regular basis.*

### PBM TRANSACTION FEES

PBMs operating in New Mexico routinely assess a fee on each claim submitted for reimbursement by the pharmacies in their provider networks. The fees can be as little as 2-3 cents per claim to as much as \$20 or more. Because a retail pharmacy often submits hundreds of insured prescriptions daily for reimbursement, the fees quickly add up to thousands of dollars in hidden transactional costs.

A PBM is paid by an insurance plan to create a pharmacy provider network for the plan and to provide a claims transmittal network for the pharmacies participating in the plan network.

As part of joining the network, pharmacies are required to use the claims transmittal



system created by the PBM, just as physicians and other providers are required to use the claims transmittal system established by the insurance plans with which they directly contract.

**Pharmacies should never be charged for transmitting claims to a PBM; for developing, operating or joining a provider network; or for using the claims processing system a PBM mandates in its provider contracts. Physicians and other medical providers are NOT charged fees for submitting or resubmitting claims. *It is wrong that pharmacies alone among health-care providers are singled out for such charges and it is wrong to charge pharmacies for using the claims network a PBM has already been paid to provide.***

### CLAWBACKS

Some PBMs require a network pharmacy to collect an elevated copayment from a patient, then subsequently recoup the excess amount — and sometimes more — from the pharmacy. **The PBM assigns a price to the prescription claim that is far higher than the pharmacy's acquisition charge, then reduces future payments to the pharmacy that take back most or all of the copayment, producing a net pharmacy reimbursement that may be above or below the pharmacy's acquisition cost.** The clawback occurs weeks, or even months, after a drug is purchased by a patient.

Neither the copayment amount, nor the amount clawed back by the PBM, have any basis in Average Wholesale Price, Wholesale Acquisition Cost or any other drug cost standard. Clawbacks typically are used on lower-cost generic drugs where there is greater markup potential. **A survey by the National Community Pharmacists Association found that 83% of surveyed pharmacists experience clawbacks 10 or more times a month.**

**Pharmacies are specifically prohibited under most PBM contracts from offering to sell a drug at a lower cash price.** They risk expulsion from the PBM's network if they inform the patient about the clawback or if they process a transaction for a covered patient outside the insurance plan.

- Clawbacks force pharmacies to be an accomplice in a deceptive practice that arguably is consumer fraud.
- Clawbacks distort the real price of drugs and contribute to health-care inflation.
- Clawbacks make some medications less affordable, meaning some patients will choose to not purchase and use the prescription drugs they need.
- The practice prevents pharmacies from making a fair profit on a medication at a price that saves both the patient and the health plan money.

### DIR FEES (DIRECT & INDIRECT REMUNERATION)



The term “DIR” originally referred to drug maker rebate revenue in Part D plans that affects drug costs, but can’t be determined at the point of sale. **The term has been co-opted by PBMs to cover a variety of retroactive pharmacy reimbursement cuts in Part D plans (the term “DIR Fees” disguises the cuts in the post-adjudication timeframe).** The charges frequently occur months after claim adjudication and may be assessed for failure to achieve specified rates of generic dispensing or patient adherence. More often, they are vaguely defined “true-ups” between the pharmacy’s actual reimbursement and the plan’s targeted reimbursement rate.

**These payment deductions can largely be viewed as “pay to play” price concessions that pharmacies must accept in order to be part of a PBM’s preferred Part D network.** The deductions are rarely specified on the front end of a contract and are often vaguely explained in the retroactive payment adjustment. **The fees have recently started showing up in a few commercial insurance plans.**

Pharmacy DIR fees are deceptive and destroy a pharmacy’s ability to have any grasp at the point of sale of what its ultimate reimbursement will be. **They make advance planning and revenue management almost impossible. DIR recoupments can total thousands of dollars and can severely disrupt pharmacy cash flow. Furthermore, they make MAC transparency less meaningful because payment cuts can now be shifted to the more nebulous “DIR” category.**

### EVOLVING MODELS OF CARE & THE FUTURE OF INDEPENDENT PHARMACY

Independent pharmacy is at a true crossroads. Payments have fallen to levels that have forced many independents out of business. Brand inflation, declining generic prices and DIR fees make reimbursement unpredictable. Increasing federal regulation of controlled drugs, compounding and durable medical equipment make it harder to earn revenue in those channels.

But even as headwinds grow, other forces are leading retail pharmacy in promising directions, and independents are well-positioned to take advantage. Hospitals, insurers and some physician groups expect pharmacists to play an expanded role in improving patient outcomes. **Real-world results show that pharmacist clinical interventions improve patient adherence and health, improve transitions of care, reduce hospital admissions and greatly reduce costs, especially for chronically ill patients.** The capacity of clinically trained pharmacists to drive improved health while lowering costs is a huge and largely untapped potential.

**A recent *Pharmacy Times* article reported that Towncrest Pharmacy in Iowa saved a health plan \$2.4 million through clinical interventions with 600 of the insurer’s patients.** More than half the interventions identified and resolved drug therapy problems gleaned from a variety of interactions: new prescriptions, refills and patient information requests. In every patient interaction, the pharmacist asked focused questions and documented the patient’s feedback to guide therapy recommendations. Every patient encounter is treated as an opportunity for a clinical intervention that can improve the patient’s outcomes and reduce the need for more expensive physician care and hospitalization.



While PBMs continue to focus on the commodity side of retail pharmacy by manipulating MAC prices, reimbursements and networks, pharmacists are taking on a new role that brings direct reimbursement from patients, doctors, hospitals and insurance plans. The national discussion says we must improve adherence to improve outcomes and reduce costs. **What we get from PBMs is more mail order, prior authorizations, claw-backs and DIR fees. The PBMs' antiquated strategy of lowering reimbursements and tightening networks stifles the pharmacy innovation that offers real potential for greater savings through clinical intervention.**

### INDEPENDENTS ARE WELL-POSITIONED

Independents are better positioned than chain pharmacies for clinical interventions: they have more time, less staff turnover and more management and workflow flexibility. Many independents have already have such adherence-focused practice as medication synchronization, compliance packaging, automated patient engagement for refills, comprehensive medication reviews and MTM. But reimbursements for MTM are low enough in most Medicare Part D plans (typically \$75 for an initial 1-hour session and \$40 for a follow-up) that they are not practical on a large scale in most pharmacies. **Income from clinical services must be much higher for these services to be economically feasible for pharmacies on a widespread basis.**

Independents are starting to negotiate directly with employers to provide clinical services to their insured workers. Some are negotiating with hospitals to provide transitions of care for discharged patients and with insurance plans to provide more intensive interventions and compliance monitoring for chronically ill patients. These negotiated agreements are often structured to include both monthly per-patient fees as well as bonus payments for achieving specified therapeutic outcomes for certain patients or patient groups.

Pharmacists are investing time and money in data analytics programs that identify non-adherent patients and drive patient outreach that improves both adherence and pharmacy revenue. Using this data, today's clinically trained pharmacists have the expertise to improve patient outcomes at far lower costs than traditional medical care. **Until these services become more widespread — and payments for them are commensurate with pharmacists' expertise and the value of outcomes — retail pharmacies will be mired in an antiquated economic model that insists on making product cost and dispensing activity the focus of the game.**

### WE CONTINUE TO LEAD & PROVE OUR VALUE

Pharmacists have driven many innovations and advances in New Mexico healthcare. Independents have often led the way in identifying and creating solutions to our state's health challenges:

- 30 years ago we started bubble-packing medications on a monthly basis to improve compliance. Today, NM pharmacies are implementing medication synchronization and adherence programs.
- 20 years ago we realized that adult immunization rates in New Mexico were lacking. We pioneered pharmacy immunizations and now **pharmacies are the primary source of adult immunizations in our state.**
- 10 years ago the Department of Health stopped providing TB testing due to budget constraints. We worked with DOH and the Board of Pharmacy to develop a protocol to make TB testing available and affordable through community pharmacies.
- Opioid overdoses are at an epidemic level in New Mexico and pharmacy is rising to the challenge. We use the **Prescription Monitoring Program** to track opioid prescriptions; we counsel patients and prescribers on opioid therapy; and make every effort to provide Naloxone for our patients.
- New Mexico pharmacies also pioneered programs for smoking cessation and emergency contraception, and are working on programs to allow pharmacists to prescribe oral contraceptives.

**Whatever the challenge, Our commitment, expertise and dedication to our patients will fuel innovation. We have a tremendous capacity to be an integral part of the primary healthcare team to drive improved patient health and lower costs. It is ironic that we are bleeding from a thousand economic cuts as we embrace this remarkable transition. We are confident we can change the game if we can just stay in it.**

*We thank the Committee for the opportunity to present this report. We look forward to working with the Legislature to find new ways to expand our ability to improve the health of New Mexico's citizens.*