Alaska Native
Tribal Health Consortium

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June 20, 2014

Via E-mail
(gennifer.moreau-johnson@alaska.gov)

Ms. Gennifer Moreau-Johnson
State Plan Coordinator
Alaska Department of Health and Social Services
4501 Business Park Blvd., Building L
Anchorage, Alaska 99503

Re: Proposed Medicaid State Plan Amendment (SPA)
Regarding Setting the State Maximum Acquisition Cost (SMAC)
for Outpatient and Physician-Administered Drugs at the Unadjusted
National Average Drug Acquisition Cost (NADAC)

Dear Ms. Moreau-Johnson:

Thank you for notifying us that the Department intends to submit an amendment to the Alaska Medicaid State Plan that would cap reimbursement for outpatient and physician-administered drugs at the National Average Drug Acquisition Cost (NADAC). We write to express our deep alarm and strong objection to the proposal, which is coming on the very heels of the WAC-15% drug cost cap for tribal pharmacies that took effect just one month ago and, if implemented, would be the *third* dramatic reduction in payment caps for pharmacy drug acquisition costs in just three years.

As we explain below and hope to discuss with you further in a meeting we understand will be held next week, setting the State Maximum Acquisition Cost (SMAC) at unadjusted NADAC rates would surely under-compensate Alaska tribal health providers. It would also dramatically reduce revenue to tribal pharmacies, especially in combination with the new WAC-15% rate, to the point that tribal pharmacy services may have to be significantly restricted or curtailed. The financial losses we anticipate would be particularly devastating and difficult to absorb at this time, when we and Medicaid providers across the State are suffering lengthy Medicaid payment delays due to flaws in the new Medicaid Management Information System (MMIS). For all these reasons, we urge the Department to defer submitting the proposed change for at least a year, to allow further study and discussion with tribal pharmacies and other affected providers.

We also take this opportunity to ask that the Department revisit its policy and procedures for obtaining tribal advice on proposed Medicaid State Plan Amendments (SPAs), and that the Department hold meetings with tribal health programs to discuss how they may be improved. We ask this because we have found, in this and other recent instances, that the fifteen days currently allowed for requesting a meeting on a proposed SPA, and the thirty days allowed for submitting written comments on it, are too short for us to thoroughly analyze the proposals and determine whether a meeting is needed and to present a detailed and thoughtful written response. Further, in order for our advice and consultation to be effective and meaningful, and to help us seize mutually-beneficial opportunities and avoid preventable harm to tribal health programs, tribal consultation and advice should occur much earlier in the

Department's own policy-formulation process, while proposals are still being developed, and not at the "eleventh hour" as unfortunately occurred in this instance.

1. NADAC appears to be a good starting point for setting SMAC and other drug acquisition cost caps, but it must be adjusted upward to reflect higher regional and rural costs, margins of error, and cost factors it excludes.

We agree that the newly-available NADAC is a valuable tool and appears to be a good *starting point* for States to determine reasonable and data-based payment caps for pharmacy drug acquisition costs. However, as a national average of ingredient costs as reported by a few hundred pharmacies, NADAC should not simply be adopted "as is" and applied to Alaska without adjustment to reflect our higher costs, shipping and other cost factors NADAC excludes, and NADAC's margin of error. Further, because NADAC is a new tool whose virtues and shortcomings are not yet fully known, Alaska would be wise to defer adopting it as a payment benchmark until there is more evidence of its strengths and weaknesses.

1.1. As national averages, NADAC rates are by definition below true costs in higher-than-average regions like Alaska.

It is important to bear in mind that NADAC reports only *national average ingredient costs*. Because Alaska is rarely "average" in any category, including costs, adopting NADAC rates here without adjustment would under-compensate Alaska pharmacies for our true acquisition costs, because those costs are surely much higher than the national average.

In a report describing NADAC and its methodology[1] (the "December 2012 CMS Report"), the Centers for Medicare and Medicaid Services (CMS) has acknowledged that true costs vary by geographic region, with costs in the South, for example, being up to 6% higher than average for generic drugs.[2] CMS clearly anticipated that costs in Alaska and Hawaii would also exceed national averages, but it was unable to quantify the differential, because it had "received limited invoice data from pharmacies in Alaska and Hawaii upon which to draw conclusions."[3] It seems clear that NADAC rates will have to be significantly adjusted upward to reflect true drug acquisition costs in Alaska.

1.2. NADAC rates are demonstrably lower than average costs in rural areas.

The December 2012 CMS Report also demonstrates that acquisition costs are higher for pharmacies in rural areas than those in urban centers, particularly for generic drugs. According to the Report, "[a]verage generic drug costs for rural pharmacies are approximately 2% – 3% higher than urban pharmacies."[4] Given the essentially rural character of much of Alaska, and how far away even our urban

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1 Centers for Medicare and Medicaid Services & Myers and Stauffer LC, "CMS Retail Price Survey, Overview of Draft Reference File Results, Draft Monthly New Drug Report, Draft NARP and Draft NADAC," December 5, 2012, available on-line at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/FUL-NADAC-Downloads/NADACMethodology.pdf (hereafter, "CMS December 2012 Report").

2 CMS December 2012 Report, page 60.

3 CMS December 2012 Report, page 61.

4 CMS December 2012 Report, page 54.

centers are from pharmaceutical suppliers, it is reasonable to anticipate that true costs here will equal or exceed those reported by "rural" pharmacies participating in the NADAC cost surveys.

1.3. NADAC rates exclude the cost of shipping drugs to Alaska and other significant drug acquisition cost components.

NADAC does not claim to reflect all costs pharmacies incur to acquire their drug stock. Rather, it reflects only the amount pharmacies reported they were invoiced for the product itself. NADAC *excludes* key cost components that are actually borne by Alaska pharmacies and not compensated through our dispensing fees, most notably the cost of shipping the drug to the pharmacy.[5] As every Alaskan knows, shipping costs to Alaska are among the highest in the nation, and for low-cost products shipping fees can exceed the charge for the product itself. We anticipate that NADAC rates would have to be adjusted upward dramatically to account for shipping costs to Alaska pharmacies, particularly for low-cost generic drugs, which we estimate comprise about 80% of the prescriptions filled by Alaska tribal pharmacies.

1.4. NADAC's margin of error alone warrants setting payment at least 10 points above NADAC for generics and 5 points above NADAC for brand-name drugs.

Finally, it is important to recognize that NADAC is based on a relatively small number of responses from surveyed pharmacies, and like any sample-based analysis, has a resulting margin of error.

CMS reports that NADAC is based on voluntary responses from about 500 – 600 monthly.[6] Although CMS considers the sample size large enough to yield reasonably precise results, the margin of error is almost 5% for brand-name drugs and almost 10% for generics.[7]

Accordingly, even without taking into account the higher-than-average costs that likely prevail in Alaska and shipping costs, to ensure pharmacies are not compensated below their true drug acquisition costs, SMAC rates should be set above NADAC + 10% for generics and above NADAC + 5% for brand-name drugs.

2. NADAC rates are dramatically lower than current SMAC rates for generics.

We understand the Department's own informal comparison of NADAC to current SMAC rates shows NADAC lower than SMAC for about 80% of generic drugs and higher than SMAC for 20%.

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5 Centers for Medicare and Medicaid Services, "National Drug Acquisition Cost (NADAC) Questions and Responses," available on-line at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/FUL-NADAC-Downloads/NADACQA.pdf, (hereafter, "CMS Q&A"), page 12. According to the CMS Q&A, NADAC also excludes "warehousing and administrative costs" for which pharmacies are invoiced. *Id.*

6 CMS Q&A page 15.

7 CMS December 2012 Report, pages 42 (brand name drugs) and 44 (generics); see also Centers for Medicare and Medicaid Services, "Methodology for Calculating the National Average Drug Acquisition Cost (NADAC) for Medicaid Covered Outpatient Drugs," November 2013 (hereafter "CMS November 2013 Report") p. 18 available on-line at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/FUL-NADAC-Downloads/NADACMethodology.pdf.

Alaska Native Medical Center (ANMC) pharmacists recently found similar results for the ten most-prescribed generic drugs.

Not only is NADAC lower than current SMAC for 80% of these drugs; the ANMC pharmacists' preliminary review indicates NADAC is *dramatically* lower than current SMAC rates. While they are still analyzing the data, it appears that NADAC rates are approximately 15% lower than current SMAC rates, so that a rate of NADAC + 15% would be needed to keep a NADAC-based SMAC in line with current payment caps.

3. NADAC rates are also far below recent actual purchase prices for 40% of ANMC's most-dispensed generics.

They are still analyzing the data, but the ANMC pharmacists report that current NADAC rates are far below recently-invoiced purchase prices for many of ANMC's most-dispensed generic drugs. They report that current SMAC rates are lower than recent purchase prices for 18% of generic drugs, while current NADAC rates are below actual invoiced prices for a whopping 40% of generic drugs. A shift from current SMAC methodology to setting SMAC at NADAC would thus mean an additional 22% of these generic drugs would be reimbursed at below their actual recent purchase prices.

We are still in the process of reviewing how setting SMAC at NADAC would impact payment for brand-name drugs.

4. Setting SMAC at NADAC will dramatically lower tribal pharmacy revenues.

As you know, the Medicaid pharmacy payment regulations were recently changed to cap payment to tribal pharmacies (and other pharmacies that obtain drugs from federal supply sources) at WAC-15%, while all other pharmacies were capped at WAC+1%. The WAC-15% rate is a huge reduction from the previous cap of WAC+8% that was adopted in 2011, and an even larger reduction from the AWP-5% rate that was in place before 2011. Tribal providers are still calculating the financial impact of the recent change (which took effect on May 18, 2014), but the ANMC pharmacists are predicting it will lower annual revenue for their ambulatory pharmacies[8] by over $1.3 million this year. Although they are still analyzing the numbers, their preliminary estimate is that setting SMAC at NADAC would further reduce revenues by another $1.2 million for generic drugs alone. That is, the estimated combined impact of the recent WAC-15% change and the proposed SMAC = NADAC change is $2.5 million for the ANMC pharmacies. Presumably the loss for other Alaska tribal pharmacies will be similar in magnitude. Losses of this magnitude cannot help but impact the scope or quality of care, and are likely to compel tribal pharmacies to reduce or curtail pharmacy services.

For all the reasons explained above, we urge the Department to withdraw the current proposal and work closely with us and other tribal health programs to devise a NADAC-based SMAC rate that will better reflect our true drug acquisition costs and ensure continued State-wide access to this vital health care service.

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[8] These are the outpatient pharmacy at the Alaska Native Medical Center, the ANMC Mediset pharmacy, the Anchorage Primary Care Center pharmacy, and the Rural Alaska Service Unit pharmacy.

Thank you for the opportunity to comment. We look forward to discussing this further in the meetings next week.

Sincerely,

Nacole Heslep

Nacole Heslep
General Counsel

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