AMERICAN SOCIETY OF **CONSULTANT PHARMACISTS**

February 15, 2007

Leslie Norwalk, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-2238-P, Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: Comments on Proposed Rule Implementing Average Manufacturer Price Under Medicaid

Dear Ms. Norwalk:

The American Society of Consultant Pharmacists (ASCP) is pleased to submit the following comments regarding the notice of proposed rulemaking implementing a new federal upper limit (FUL) for multiple source medications under Medicaid based upon average manufacturer's price (AMP).

ASCP is the international professional society that provides leadership, education, advocacy and resources to advance the practice of senior care pharmacy. ASCP's 8,000 members manage and improve drug therapy and improve the quality of life for geriatric patients and other individuals residing in a variety of environments, including nursing facilities, sub-acute care and assisted living facilities, psychiatric hospitals, hospice programs and in home and community-based care.

While many of the elderly patients our members serve are now participating in the new Medicare Part D prescription drug program, there are some who continue to receive Medicaid drug benefits. In addition, most Medicaid programs provide coverage for medications that are excluded from Part D coverage. As such, we are concerned that the recent proposed rule to implement federal upper limits based upon average manufacturer price (AMP) will adversely affect pharmacies that continue to serve Medicaid patients.

According to the proposed rule, CMS has defined AMP as the price paid by wholesalers for drugs distributed through the retail class of trade. As such, medications purchased by long-term care pharmacies are not included in the AMP calculation. ASCP agrees with CMS that these medications would be inappropriate to include in AMP calculation. However, we believe there are other price concessions not available to pharmacies that should also be excluded from AMP calculation. For example, mail order discounts and discounts to other entities such

as pharmacy benefit managers (PBMs) are generally not passed on to pharmacies. Our concern is that if these price concessions are included in AMP, the resulting baseline AMP will be artificially low.

Further, we are deeply concerned about the impact this is likely to have on smaller, independent pharmacies that serve Medicaid patients. Our concern is that under the proposed rule, pharmacy acquisition costs may exceed reimbursement levels, especially with respect to independent pharmacies. Many of these smaller, independent pharmacies do not have the cash flow to continue operating at a loss, and may either stop serving Medicaid patients, or close their doors altogether. ASCP is concerned that this situation may cause a disruption of Medicaid services to patients whose pharmacy has gone out of business due to reimbursement rates that are lower than acquisition costs.

A recent report by the Government Accounting Office (GAO) estimated that for the 77 multiple source drugs included in the study, the AMP based federal upper limits were on average 36 percent lower than the average retail pharmacy costs. While it was indicated in the regulatory impact analysis of the proposed rule that retail pharmacies would be able to make up the difference through sales of non-prescription drugs and other items, many pharmacies serving long-term care and other institutional settings are closed door pharmacies that do not sell prescription drugs or other items at retail to members of the general public.

Another concern we have is that AMP could become the standard by which other payers reimburse for pharmacy services. The proposed rule would require AMP listings to be published on the CMS web site, thus making them available to the general public. This could trigger private payers to begin reimbursing pharmacies at the AMP rate. As indicated earlier, retail pharmacies do not have access to price concessions given to mail order pharmacies and PBMs.

Dispensing fees

Compensation to pharmacies for dispensing a prescription includes reimbursement for the drug product and a dispensing fee. The combined total must be adequate to ensure ongoing financial viability of the pharmacy. If the pharmacy margin on product reimbursement is decreased, the dispensing fee must be increased by an equivalent amount to maintain the viability of the pharmacy.

ASCP agrees with CMS that dispensing fees may be higher with respect to a higher level of service provided to the patient. In fact, CMS recognized that in a March 15, 2005 guidance document that outlined ten service and performance criteria for long-term care pharmacy services under Medicare Part D. These services include 24-hour emergency services, delivery and specialized packaging. Results from a 2002 study that examined the cost of dispensing a prescription in long-term care estimate that it costs more than $11.00 (http://www.ltcpa.org/pdf/BDO.pdf). Additionally, long-term care pharmacies dispense IV medications which tend to be more costly than

non-IV medications. CMS should consider exempting IV medications from the AMP calculation. Further, ASCP recommends that CMS urge states to adopt higher dispensing fees for those pharmacies that provide additional services such as those outlined in the CMS long-term care pharmacy guidance.

According to a national study conducted by Grant Thornton LLP on behalf of the National Association of Chain Drug stores and the National Community Pharmacists Association, the national average cost of dispensing was $10.51 per prescription and $12.81 per pharmacy (http://www.ncpanet.org/pdf/codstudy-execsumm.pdf). The cost of dispensing per prescription combines low volume and high volume pharmacies. Typically, high volume pharmacies have a lower cost of dispensing than low volume pharmacies. Conversely, the cost of dispensing per pharmacy treats every pharmacy equally, regardless of prescription volume. The report concluded that cost per prescription is generally lower than cost per pharmacy since lower cost prescriptions make up a larger portion of the population when calculating cost per prescription. This study would suggest that dispensing fees must be high enough to accommodate lower volume pharmacies whose cost of dispensing appear to be higher than pharmacies that have a high volume of prescriptions.

For the reasons mentioned above, ASCP is respectfully requesting CMS to re-evaluate this new FUL based upon AMP and take into account national studies outlining the cost of dispensing, the unique nature of long-term care pharmacies, and the impact this proposed rule will likely have on rural, independent pharmacies. Additionally, we ask that CMS revise its calculation of AMP to exclude drugs purchased through mail order and PBMs. Thank you for the opportunity to provide comments on this proposed rule.

Sincerely,

Thomas R. Clark, RPh, MHS
Director, Policy and Advocacy

cc.

Senator Max Baucus
Senator Charles Grassley
Representative John Dingell
Representative Joe Barton

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