August 16, 2012

Cindy Mann, Director
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 21244

Subject: Impact of 11th Draft Medicaid FUL Generic List on Small Pharmacies

Dear Cindy:

The National Community Pharmacists Association (NCPA) is writing to provide our feedback on the 11th draft Federal Upper Limit (FUL) list for multiple source drugs released by CMS on July 30th, 2012. NCPA represents the owners and operators of the 23,000 small independent pharmacies in the United States which serve as a primary source of health care and prescriptions for Medicaid patients in outpatient and long term care settings.

Consistent with the other FUL lists that CMS has released, and we have analyzed, the impact of imposing these FUL reimbursement cuts on small independent pharmacies would have a significant and negative affect on Medicaid patients’ access to pharmacy services. As we have stated in the past, independent community pharmacies serve a disproportionate share of Medicaid patients. If our Medicaid revenues are significantly reduced – as they would under these FULs – many of our pharmacies could close or reduce hours, impeding access to care, especially in urban and rural areas.

FUL Trends Remain Troubling for Small Pharmacies: The trends remain troubling consistent in all the FUL drafts that CMS has published to date. In fact, in our analysis of the eleven draft FUL lists taken together, about 38 percent of the FULs were lower than small pharmacies’ acquisition costs, while 62 percent were above the acquisition costs. Furthermore, the average loss per unit product has steadily increased over the eleven drafts. The first draft had an average loss per unit product of 21.6 cents, but by the eleventh draft list, the average loss per unit product rose to 41 cents. This represents an astonishing 89% increase in the average per unit product loss over the eleven draft FUL lists.

While the average gain per unit product rose by 53% over this same time period, past experience suggests that states will reimburse less than the FULs. Therefore, it cannot be assumed that states will maintain the reimbursement at the FUL for those products whose FULs are above pharmacy acquisition costs, offsetting the loss from those that are not. Therefore, if CMS believes that the publication of these draft lists is leading to revisions and refinements that will make them more palatable for independent community pharmacies, the data do not bear that out.
Furthermore, CMS needs to clarify the methodology it uses when deciding the products for which it will set an FUL. Over the eleven draft FUL lists, CMS has added or removed an average of 60 products per list. In addition, 128 products with an FUL value were dropped from the draft list at one point in time, never to be added back to the list. Moreover, 110 products were added, and then dropped, only to be added at a later date. Nearly as many products were added and dropped a multiple of times. This type of fluctuation in the content and scope of the FUL list results in inconsistent reimbursement, and is harmful to states, pharmacies, and patients.

**Small Pharmacies Adversely Impacted by New FULs:** Despite aggressive, continuing efforts to negotiate and obtain lower prices, our small business community pharmacies, including smaller chains, purchase generic drugs at a relative premium. This can result in acquisition costs that are often at least 25% to 50% higher than those of publicly-held chain pharmacies. For that reason, small pharmacies will likely always face tighter margins for prescriptions dispensed to Medicaid beneficiaries than national chains for the same multiple source drug.

An example by type of pharmacy is illustrated in the table below. Based on the eleven draft FUL lists, the low volume Medicaid pharmacy, on average over the eleven draft lists, would suffer a 33% reduction in Medicaid pharmacy reimbursement; the medium volume Medicaid pharmacy a 31% reduction; and the high volume a 29% reduction in reimbursement. These types of reductions in pharmacy revenues are unsustainable and will compromise access and patient care.

<table>
<thead>
<tr>
<th>Current Reimbursement</th>
<th>New Reimbursement</th>
<th>Percent Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low-Volume Pharmacy</td>
<td>$31,812</td>
<td>$21,314</td>
</tr>
<tr>
<td>Medium-Volume Pharmacy</td>
<td>$35,519</td>
<td>$26,578</td>
</tr>
<tr>
<td>High-Volume Pharmacy</td>
<td>$81,234</td>
<td>$57,676</td>
</tr>
</tbody>
</table>

As we have stated in the past, and repeat again here, we ask that: 1) no FULs be made final until a final AMP regulation is published and several months of data are collected and analyzed; 2) that the FUL be set at no less than the National Average Drug Acquisition Cost (NADAC) value, and even higher for small independent pharmacies who do not have the purchasing leverage of large chains; and 3) that CMS require that all states evaluate and increase their dispensing fees to reflect pharmacy costs of dispensing, given that the FULs will be set closer to pharmacy acquisition costs.

Thank you for giving us the chance to review these lists and provide feedback to CMS. We would be happy to answer any questions regarding this analysis.

Sincerely,

John M. Coster, Ph.D., R.Ph
Senior Vice President, Government Affairs

CC: Barbara Edwards, CMS
Larry Reed, CMS Medicaid Pharmacy Team
Rima Cohen, Counselor to the Secretary of HHS