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Kansas Pharmacists Association

Bob Bethel HCBS and KanCare Oversight Committee
Testimony by the
Kansas Pharmacists Association
Submitted by Douglas L. Funk, RPh
Kansas Pharmacists Association
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Chairman Pilcher-Cook and Members of the Committee:

Thank you for allowing me to submit testimony to the Bob Bethel HCBS and KanCare oversight committee today. My name is Doug Funk, and I am a practicing pharmacist and owner of Funk Pharmacy located in Concordia, Kansas. I am also immediate past president of the Kansas Pharmacists Association. The Kansas Pharmacists Association is the oldest statewide professional association of pharmacists in Kansas. We represent all Kansas pharmacists from all practice settings throughout the state.

When it was announced that Kansas would be migrating to a managed-care Medicaid structure, many pharmacists in Kansas greeted the news with trepidation. We had become used to the fee-for-service and managed-care organization (MCO) mix model that was in place at the time and we wondered what a complete overhaul of the system would bring. Fortunately for us, the Kansas Department of Health and Environment staff who were responsible for bringing KanCare into existence were very open to our suggestions and recommendations. Dr. Bob Moser and his team have, in our opinion, done an excellent job in establishing KanCare. We meet with the KanCare pharmacy team quarterly to discuss some of the issues I will discuss this morning and work closely with them to resolve these issues.

I think that it is important to point out that many Kansas pharmacists deal with two aspects of the KanCare program: prescription drugs and durable medical equipment.

The prescription drug portion of the KanCare contracts is managed by *subcontractors* to the MCOs. They are known by their initials as the PBMs or pharmacy benefit management companies. Those pharmacists that supply their patients items such as durable medical equipment (DME) such as wheelchairs, walkers, breast pumps, and oxygen contract directly with the managed-care organizations.

Virtually any community pharmacist that you talk to about filling prescriptions has had frustrating experiences with a PBM at one time or other. We have been dealing with some of these same frustrations with PBMs in the KanCare program as well. So I would like to point out that this frustration has not been exclusive to KanCare.

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As with any new program, especially one as large as KanCare is, there are bound to be problems with which to contend. Many of the processes that are utilized are new and many of the individuals running these programs are new to them. The methodologies inherent in managed care are new. It takes time for people to learn new processes and methodologies. Quite frankly everyone is still dealing with some system issues that probably should have been ready to go on January 1, 2013 when KanCare "went live".

For example with respect to durable medical equipment, (where we deal directly with the managed-care organizations Amerigroup, Sunflower State Health Plan and UnitedHealthcare of the Midwest) many of our providers are still waiting for payments for equipment that has been dispensed since January 1 of this year. Pharmacists and their staffs have spent countless hours trying to get reimbursed for this equipment when the procedures for reimbursement that the MCOs were using were, from our point of view, never correctly put into place.

At our request, the KanCare pharmacy program manager instituted a series of biweekly DME stakeholder calls. We feel that this systematic approach to tackling the issues we deal with on durable medical equipment will help whittle down these outstanding accounts receivable for many of our members. It also helps greatly that the state now tracks these issues and posts them on the KanCare website, keeping them visible not only to those involved but to anybody who is interested in how efficiently the program is working.

Prescription drugs offer a unique challenge to pharmacists with their use of medication pricing called maximum allowable cost (MAC) lists. Maximum allowable costs are the upper limits that a plan will pay for generic and brand drugs that have a generic version available. Because each of the PBMs manage their own listings, a pharmacist that has patients that utilize the three different MCOs may be reimbursed three different prices for the same drug on the same day. In many cases, the reimbursement rate is below what a pharmacist actually paid for the drug, so the pharmacy is already working "in the hole". It's important to point out that depending on when and where a drug has been obtained has a bearing on this issue as well. Sometimes, pharmacies are reimbursed more than what was paid for the drug. It's really a roll of the dice on whether a pharmacy will make money or lose money taking care of a particular KanCare patient. As you can imagine, this is been a constant source of frustration for many pharmacies and pharmacists throughout Kansas both before and after KanCare implementation. The provision in the KanCare contracts for the MCOs to tell the state how its subcontractors compute their MAC lists was seen by us as a step in the right direction. It would enable us to point out to the subcontractors the wild variances in drug prices. More importantly, it would allow the State of Kansas to realize the true costs associated with the KanCare prescription benefit.

The KanCare contracts state: "if an update [to the MAC] is warranted, the PBM shall make the change retroactive to the date of service and make the adjustment effective for all pharmacy providers in the network." It is our understanding, this would mean that the PBMs would actively make the warranted changes and it would not require a pharmacist to track the multitudes of drugs to look for changes and request adjustment. Some of our members have stated despite valid retroactive claims, they have yet to be reimbursed correctly.

Finally, the Kansas Pharmacists Association would like to point out that our colleagues in states around the country that transitioned to a managed care Medicaid program have had problems in those transitions; many more and of greater magnitude than has occurred in Kansas. The experience we have had in working with the state KanCare pharmacy team has made the transition to KanCare much smoother than originally anticipated.

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