How To Survive A DEA Inspection Series: Pharmacy Use of DEA CSOS

Recently the Drug Enforcement Administration (DEA) Office of Diversion Control has taken some strong administrative and civil actions against independent pharmacies for the failure to use the Controlled Substances Ordering System (CSOS) in the way DEA regulations approved it. A DEA administrative action will revoke your CSOS privileges requiring the use of paper DEA Forms 222 or the revocation of the pharmacy Schedule II privileges. On the civil side, the fine is $14,739 per violation plus the cost of legal counsel.

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PSSNY
PRESIDENT’S MESSAGE

President’s Message

We Are The Night’s Watch

Pharmacy is centuries old. But even in modern times no one can just open up a pharmacy and start selling prescriptions. There are levels of education and certification required, not to mention patience and a commitment to care. No one knows better than we do what it takes to work with patients (who some of you still refer to as “customers”), physicians, other licensed prescribers and health insurance companies and those wonderful middlemen known as PBMs.

And yet it seems our profession is under threat at nearly every turn. It’s not just the clawbacks or the DIR fees. It’s the subtle messaging delivered to the public that somehow commoditizes and potentially erodes the value of the pharmacy profession. We all know that the true value to pharmacy is far greater than handling over a bottle of medication. It’s the service and the knowledge that goes beyond the bag of medicine.

Much like the Night’s Watch from Game of Thrones, we have a duty to serve and protect our profession and the public (our patients). If you’re not familiar with the series, the Night’s Watch guards the great Wall that separates and protects the Seven Kingdoms from the evil that lies beyond the Wall to the north. To be a member of the Night’s Watch continued on page 22
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PSSNY President's Message

Roxanne Richardson was installed as the 128th president of the Pharmacist Society of the State of New York on June 24th, 2017. Roxanne is currently a pharmacist working in a local hospital in the Auburn New York region.

PSSNY had an excellent Mid-Winter meeting last weekend in Albany, with the theme being "Law, Rule and Regulation." We had the largest attendance of both pharmacists and students that I can remember. It was great to see familiar faces and new faces alike. Students presented posters on a variety of practice related projects, and competed in the Student Business plan competition, also, for cash and prizes, and bragging rights.

I want to thank all the attendees that participated as well as the presenters, vendors, and many sponsors, including affiliates, that made the meeting a success. Thank you to the Convention committee and the PSSNY staff, and student volunteers for all the hard work and planning.

During the meeting, we had a videographer present to develop (video) news releases to promote pharmacy issues, and to promote the profession of pharmacy itself. Thank you to all that participated in the filming, especially Dr. Charles Rothberg, MSSNY president that stopped by to weigh in on Healthcare in NY. Look for the finished product soon! This is one more piece in our PR arsenal.

The meeting provided attendees with a copy of the PSSNY “Patient’s Right to Care” Legislative agenda for 2018. This includes both business issues that impact the way pharmacists are able to give their patients optimal healthcare, and clinical initiatives to move the profession forward:

- Patient protection from clawbacks and gag clauses,
- Pharmacy fair audits,
- Medication synchronization,
- Comprehensive medication management,
- Immunization expansion and student involvement and
- Oversight of PBMs

The public has heard more about PBMS and the high cost of prescription medication in the last few months, than ever before. We have to capitalize on the movement. The fact that Amazon is planning on partnering with Berkshire Hathaway and JP Morgan to “fix healthcare for their employees” sent shock waves through the healthcare industry, even though the press release had no details. As pharmacists, we have to adapt to change and expand our role in the healthcare spectrum.

That’s why we need to be supportive of our efforts, no matter what your practice setting. What directly effects the independent owner, will have an effect on the chain and its employee pharmacists and/or student interns. If the community pharmacist can’t fill prescriptions and perform other services, it will have an effect on the institutional system, with more emergency room visits, and hospital admissions. Thirty day re-admission rates will increase and this is one of the primary targets of the value based payment system being developed by Medicaid. The same amount of pharmacy staff, with additional admissions, means less time for student/pharmacist training-a primary concern for the pharmacy colleges educating the next generation.

So, everyone has a stake in our legislative agenda and moving the profession of pharmacy forward in NY, by increasing our “clinical expertise” and sustaining our businesses in all practice settings.

Please join us on Community Pharmacy Lobby Day on March 6th, in Albany, and Student Lobby Day on April 17th. We need pharmacists to tell their stories to the Legislature. I hope to see you soon.

~ Roxanne Richardson, R. Ph.
PSSNY President

Thank you to Barbara Trimachi

Many of our members have spoken to Barbara Trimachi from time to time as they would call the PSSNY office for assistance on various matters. Well one member was so happy with the help that she prepared a plaque in honor of Barbara’s assistance. Marva Walme is a pharmacist that had operated a independent community pharmacy in Brooklyn for decades. Last summer, Marva who had been in touch with the PSSNY office over the years, expressed an interest in a phone call to Barbara in retiring. Barbara put Marva in touch with me and I was able to assist Marva in finding a neighborhood pharmacy who was willing to acquire the inventory and records of Marva’s pharmacy. Then in November Marva’s family threw Marva a surprise retirement party in Brooklyn. While both Barbara and I were invited, Barbara was unable to attend. At the recent PSSNY Mid Winter meeting I along with PSSNY President Roxanne Richardson presented Barbara with the framed special recognition plaque which Marva’s family had prepared to present to Barbara. Our hats are off to recognize how Barbara went above and beyond the normal course of her duty to help along time PSSNY member’s exit strategy becoming a reality.
UPDATE FROM THE 2018 MIDWINTER PSSNY CONVENTION

This past month pharmacists and pharmacist students gathered for the PSSNY’s annual midwinter convention in Albany. This year was a banner year for attendance. Pharmacists came to hear varied topics relevant to their practice including an update from the current Secretary of the NYS Board of Pharmacy.

Discussed in our house of delegates meeting was the response PSSNY has spearheaded on the “below water” reimbursement issue in New York State. The new legislative session is beginning and we heard from Assemblyman John McDonald, a pharmacist and legislator, with a pharmacist’s take on what pharmacy can expect in this new session. A lengthy discussion followed on the legislative agenda PSSNY is pursuing this session on the behalf of pharmacists in this state.

There were many CE classes throughout the weekend. Opioids of course were one of the topics as we learned how we can provide a crucial part in the safety of patients taking opioid prescriptions. We heard of the new Naloxone initiative which provides free Naloxone injectors to patients at risk of overdosing on opioids. We heard from the chief investigator of the Office of Professional Discipline on the guidelines they follow when inspecting pharmacies and when following up on complaints, making a traumatic situation for most pharmacists better understood. We also were reminded of the ethics involved in pharmacy practice and the consequences and co-responsibility the pharmacist and prescriber have on each prescription we fill.

The most interesting CE to me was the Community Pharmacy Enhanced Services Network presentation on clinically integrated networks, which are moving pharmacists from the prescription to the patient and the outcomes of their prescription therapies. As we see Medicare moving toward a payment scale based on good outcomes, fewer hospitalizations and lifestyle changes, we as pharmacists are going to have to move toward providing more than just prescription to our patients. Patient coaching, MTM, Synchronization of medications, monitoring of patient progress to name a few areas, will be most important to you ability to survive in the new landscape. CPESN has already been active in starting networks in most state. Here in New York we have members on the verge of launching their network presently. This does require changing our mind set and our business plan. We are going to have to focus on the patient outcomes as opposed to quantity of prescriptions. As we have seen with New York State’s DSRIP (Design System Reform Incentive Program) the focus is on an integrated system (Hospitals, Doctors, Nurses and Pharmacists) working to achieve better patient health results.

This is a glimpse at the benefits a pharmacist can get from attending the state PSSNY conventions, practical, informative CEs, about pressing issues we see each day, and a chance to meet other pharmacists and network. You will have another opportunity this June, in Buffalo as the Pharmacists Association of Western New York (PAWNY) hosts the Annual 2018 PSSNY Convention. Don’t miss this great opportunity to be on the cutting edge of your profession.

- Bill Scheer, R.Ph.

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A MESSAGE & GREETINGS FROM PSSNY EXECUTIVE DIRECTOR

We had a fabulous Mid-Winter Meeting last month. I hope you were able to attend and take advantage of the great CE, phenomenal networking and a robust Solutions Center filled with vendors offering answers to a variety of pharmacy issues.

We tried some new things this year that were very well-received: a student networking event, a Meet and Greet with Buffalo trivia and chicken wing hats (you had to be there!), and a Jeopardy Law game that stumped the best of them!

We also had a gentleman videotaping various pharmacists talking about our legislative agenda, the role of the community pharmacist, and the challenges of working in an environment controlled by a middleman: the pharmacy benefit manager.

The end result is an hour-long documentary that educates the public on the mission of PSSNY, the challenges pharmacists are facing, the critical role that the legislative agenda items in our Pharmacy Patient’s Right to Care plays in the lives of the patient, and the ever-increasing role of the pharmacy benefit manager.

Pharmacists discuss expanding their ability to improve patient care through medication synchronization, expanded immunization authority, authorization continued on page 18
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Thanks to the efforts of PSSNY members, leadership and staff on the PBM reimbursement issues this past fall, the legislature is hard at work on pharmacy bills at the start of the legislative session.

During the early stages of the legislative session, when the Executive’s State Budget is being released the Senate and Assembly focus their efforts on moving bills of the utmost importance to them. The goal is to get traction on their priorities before the distraction of budget negotiations kick-in.

I am proud to say that the PSSNY Fair Audits bill (A6733 Lavine/S2763-A Golden) has moved out of the Assembly Health committee and has been referred to the Assembly Codes committee. In the Senate, it has been referred to the Health committee.

A second bill (A8781 Rosenthal/S6940 Hannon) has been introduced to allow a pharmacist to talk to a patient when their co-pay is more than the pharmacies usual and customary cash price for the prescription so that the customer can decide if they want to bill the insurance or not. The bill also prohibits the PBM from charging a copay that exceeds the total price paid by the PBM to the pharmacy thereby preventing negative paid claims.

PSSNY will continue to keep these bills moving before budget negotiations take priority. It is critical for pharmacy to know that the legislature recognizes the actions of a single PBM can change the entire healthcare landscape in New York State and legislation must address the problem.

PSSNY will be researching and investigating the potential for a PBM licensure and registration bill. It was introduced by the Governor last year, embraced by the Department of Financial Services and unfortunately, was dropped from budget negotiations at the last hour. We believe it is critical that we keep an active discussion in New York State. We cannot leave the viability of community pharmacies up to the whims of pharmacy benefit managers.

To learn more about how we are using the funds we raised to address PBM issues, read Kathy Febraio’s column. We have created video programming that will help educate the public and legislature on a pharmacist’s role in healthcare and the legislative priorities of the Society.

In addition, Elizabeth Lasky’s column provides a review of the State Budget and our positions on the various proposals.

Please join us for Lobby Day, March 6 to help us move our priorities forward. www.pssny.org/2018lobbyday.

Russell Gellis, RPh
PSSNY Chairman

HUMANA IS SLAMMING PHARMACIES FOR INCOMPLETE TRANSFER RXS

Humana is hitting pharmacies with full recoupment discrepancies on incomplete transfer Rxs based upon the individual pharmacy’s state laws. Typically, no post audit documentation has been allowed for challenging these “LAWF” discrepancies and of course Humana is picking out the high dollar $200 - $1000 prescriptions where they can.

PAAS recommends that you self-audit all of your transfer prescriptions and make sure they have all elements required under your state law. As an example of their egregious actions, Humana was taking back on prescriptions in Arkansas for non-controlled substances because the transfer Rx did not contain the DEA# of the transferring pharmacy on the transferred Rx. Make sure you follow your own state law requirements for a prescription transfer and avoid the wrath of Humana’s heavy handed audit tactics.

And remember, a transfer Rx is origin code #5. If you get this wrong they will charge you $5.00 for every refill!

Some of the items you might need include but may not be limited to include:
1. The words “Transfer Rx” or “Rx Transfer”
2. The original Rx #
3. The name address and phone number of the transferring pharmacy (possibly DEA# also)
4. Today’s date
5. Original date of the Rx
6. Last fill date of the Rx
7. Original # of refills
8. # of refills remaining
9. Transferring Out pharmacist’s name or initials
10. Transferring In pharmacist’s name or initials.
We have just returned from a very successful and informative PSSNY Mid Winter meeting.

I would estimate that over 200 pharmacists and pharmacy interns from our New York colleges of pharmacy attended this gathering in Albany the weekend before the Superbowl.

Once again, as has been the case time after time at these events, we were treated to a weekend of expanded pharmacy knowledge with a nice social twist to it. Plus -- plenty of continuing educational events to help you satisfy your Board of Pharmacy requirements as well as to keep you abreast of today’s changing health care environment.

There are developments going on in our profession on the national level as well as in other states which may have a positive effect on our survival as an independent pharmacy. For instance, in the state of Arkansas the Attorney General has launched an investigation into the sudden reduction in reimbursement that CVS Caremark has instituted across the board on the generic drugs. As I put the finishing touches on this message I have learned that CVS Caremark has rolled back the reimbursement on generic drugs—nationwide—back to the reimbursement rates that were in effect prior to the drastic cuts implemented on or about October 26, 2017. I must wonder where the pressure came from to come clean and fix this mess.

And in Washington, there is legislation proposed in both the House of Representatives and the Senate which would rein in the PBMs and the related Prescription Drug Plans that are stealing money out of the purses of retail pharmacy owners by the implementation of these unfair Direct and Indirect Remuneration charges (DIR). To try and explain the concept of DIR fees, here it is: Part D plan sponsors and Pharmacy Benefit Managers (PBMs) extract DIR (Direct and Indirect Remuneration) fees from community pharmacies as well as from the manufacturers through rebates on the drugs on each Medicare Part D formulary. Nearly all pharmacy DIR fees are recovered or as is commonly called, “Clawed Back” retroactively several months later rather than deducted from claims on a real-time basis. This process of adjusting reimbursement retroactively makes it extremely difficult for community pharmacists to operate their small businesses. Moreover, in January 2017 the Centers for Medicare & Medicaid Services (CMS) warned the rise in pharmacy DIR fees has increased Medicare costs to the government and forced more beneficiaries into the coverage gap (or “donut hole”).

As the result of a national effort and extensive pressure as well as lobbying by the NCPA leadership and management team in Washington DC, a group of Senators and Congressman and women, who are troubled by the recent expose of these DIR charges have drafted legislation to address the DIR charges on pharmacies. The “Improving Transparency and Accuracy in Medicare Part D Drug Spending Act,” S. 413 / H.R. 1038 will prohibit Medicare Part D plan sponsors/PBMs from retroactively reducing payment on clean claims submitted by pharmacies under Medicare Part D, which would force such charges to be done at the point of sale. We must give a thank you shout out to Congressman Earl “Buddy” Carter our only pharmacist in Congress who worked on this effort behind the scenes. I have personally met with Congressman Carter on several occasions and he believes his best work on pharmacy issues is not to take the lead but to work with other congressional members to get our needs heard. I believe he is correct. For if he were to be front and center on the issues, the perception of the general public could be perceived one of a selfish self-serving interest.

While this proposed legislation does not eliminate these charge backs, it does make it more transparent to the pharmacist who are footing the bill on these charges.

If after reading my short message here, you still think you can go it alone and not be involved in your state and national pharmacy groups, I must warn you that the road ahead is going to get much tougher. If were not for those soldiers both women and men who step up and get involved in organized pharmacy we would be extinct. Independent pharmacists have only their fellow colleagues as their true friends, not the chain managers, not the PBMs and not any other aspect of the pharmacy food chain.

This April 11th and 12th, I will once again travel to Washington DC to attend the NCPA annual Congressional Pharmacy Summit to meet with our national elected officials and present our issues and the issues that affect our patients. For more information see www.ncpanet.org check out meetings and see “Congressional Pharmacy Summit.”

Keep the faith and please stay involved not for me but for YOU!

- Jim Schiffer, Secretary NYCPS
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This is an update on several key issues, which affect the practice of pharmacy here in New York State. You should already be familiar with the terms relating to these proposed pieces of legislation.

As soon as the Governor delivered his 2018 Executive Budget on January 18th, we began scouring budget bills for any impact on pharmacy operations and the profession generally. It offered a mixed bag.

Medicaid
Medicaid changes were relative few. The Health Department proposed raising the professional fee to $10.08, an eight-cent increase that agency staff described as based on their analysis of recent cost surveys from states similar to New York. In a related development, the Department announced it would begin implementing the new NADAC-based reimbursement and the $10 fee (approved in the 2017 budget) on February 22nd.

This year's Executive Budget includes a fifty-cent increase in co-pay for OTC's and also a reduction in covered OTC's, removing cough and cold and digestive products. In written testimony PSSNY points out that this loss of coverage means that patients will either pay cash or go without the OTC. The co-pay increase is a cut to pharmacy.

Surcharge/Excise Tax on First Sale of a Prescription Opioid in New York
The Governor's budget includes a tax on opioid prescriptions, estimated to raise revenues of $125 million in the first year and another $170 million in the next. The surcharge is 2-cents per morphine milligram equivalent (MME) and is to be collected by the "establishment" making the "first sale in the state." Pharmacies are included as "establishments" as are wholesalers and manufacturers, but in reality, pharmacies are most likely to be impacted. If enacted, the tax cannot be passed onto consumers.

The 2-cent MME tax is significant. A bottle of 100 Morphine tabs 30mg equals 3,000 MME x .02 or a tax of $60. The same quantity of 100 mg Morphine tabs equals 10,000 MME which translates to a tax of $200.

"Establishments" would be expected to pay the tax by the 20th of the month following the month in which the opiates were dispensed. Whether a pharmacy would know with certainty whether dispensing a certain prescription is considered the "first sale in the state" is one problem, but the main issue is cost and the fundamental unfairness of imposing any tax on pharmacies or wholesalers. The idea of taxing prescription medications is another problem. Patients who rely on opiates to relieve intractable pain would no doubt have problems finding the drugs since the most obvious way to avoid the tax is not to carry the products. Another likely result is increased costs for prescription opioids in New York.

The stated public health goal is to discourage inappropriate use of opioids. New York has already implemented a number of policies that have effectively reducing over-prescribing: the robust Prescription Monitoring Program with current prescription data submitted daily by pharmacies (now interoperable with 25 states and D.C.), mandatory prescriber education, the 7-day limit on initial supplies and mandatory electronic prescribing.

Another goal is to reduce opioid usage by 20% to 25% and to increase the use of alternatives such as NSAIDS, but NSAIDS are not recommended for the elderly due to the increased incidence of GI bleeds that can be fatal.

The new tax would not apply to opioids dispensed through Part D plans. Another likely result is increased costs for prescription medications. Another goal is to reduce opioid usage by 20% to 25% and to increase the use of alternatives such as NSAIDS, but NSAIDS are not recommended for the elderly due to the increased incidence of GI bleeds that can be fatal.

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Medicaid Inspector General Seeks Authority to Audit PBMs
PSSNY supports this proposal to amend the OMIG law and give the Medicaid Inspector General clear statutory authority to audit Medicaid managed care subcontractors, specifically PBMs. This direct language removes any uncertainty and grants authority to the Medicaid Inspector General to follow the taxpayer's Medicaid dollar and meet his responsibility to protect the program from fraud, waste and abuse. Auditors in the Louisiana Medicaid program found $42 million in Medicaid overpayments to PBMs.

Unlike pharmacy benefit managers that are unlicensed, unregulated entities, pharmacies are regulated and are subject to inspections and audits by state and federal agencies (Medicaid, BNE, OPD, DEA, etc.). In supporting this budget proposal PSSNY's written testimony calls for licensing PBMs, pointing out that if PBMs were to be licensed and regulated by the Department of Financial Services, the audits of PBMs conducted by OMIG would be more effective.

PSSNY's Budget Testimony Hits PBMs Hard
In remarks before the Legislative Hearing on the Medicaid and Health Budget in Albany on February 12th, PSSNY President Roxanne Richardson and Executive Director Kathy Febraio urged legislators to consider the unregulated multi-billion dollar industry responsible for raising the cost of prescription drugs for consumers, health plans and the State of New York itself:

- “The state has been paying dearly for the lack of transparency and the lack of oversight over Pharmacy Benefit Managers.”
- “While states across the country are enacting legislation to license, replace, force transparency, and in some states like West Virginia eliminating PBMs from the management of the Medicaid prescription drug benefit, here in New York we have nothing.”
- “When the middleman fails to reduce costs, and instead actually raises costs and keeps the increased revenue for themselves, we must ask the question - What is the benefit?”

The focus of the upcoming Pharmacy Lobby Day on March 6th will be on the effort to require Pharmacy Benefit Managers to be licensed in New York.

Elizabeth Lasky
Capital Public Affairs, Inc.
Happy New Year?

How does a pharmacist say Happy New Year? By being glad that he/she made it through another difficult year and the hope that things are going to get better. We are all hoping that Congress will finally act on the abuses of the Pharmacy Benefit Managers who along with the Medicare Prescription Drug Plans have created a nice little cash cow called DIR (Direct and Indirect Remuneration) fees. NCPA is trying their best to let the Senate and Congress become aware of the legislation intended to require the PDPs and PBMs to have online DIR adjudication so that the pharmacist will be able to see up front their exposure for these unfair and unexpected charge backs. More on this subject later in this column. In the meantime, there are some reports that the generic drug industry’s price model for community independent pharmacies are charged about 150% to 250% more for generic drugs than the national pharmacy chains. It seems some one got their hands on a packing slip for a CVS Pharmacy and the generic prices shown were about 65% cheaper than what is traditionally charged to community pharmacies. This entire pricing model including the involvement of the PBMs must be exposed.

DEA goes on Full Court Press against ….Pharmacies

United States Attorney General Jeffrey Sessions, has recently announced that the Drug Enforcement Administration (DEA) is focusing on the nation’s pharmacies and prescribers in a national crackdown against opioid abuse. Sessions made this announcement in front of DEA agents in Louisville, Ky., in late January and he stated that over the next six weeks the DEA will begin a nationwide investigation of pharmacies and drug prescribers that are issuing “unusual or disproportionate” numbers of opioid prescriptions. Sessions stated that the “DEA collects some 80 million transaction reports every year from manufacturers and distributors of prescription drugs. These reports contain information like distribution figures and inventory. DEA will aggregate these numbers to find patterns, trends, statistical outliers—and put them into targeting packages,” as was seen in the transcript of his presentation. Sessions went on to say, “That will help us make more arrests, secure more convictions—and ultimately help us reduce the number of prescription drugs available for Americans to get addicted to or overdose from these dangerous drugs.” If any of you out there have not adjusted your dispensing habits to reflect a concern over the DEA interpretation of Red Flag Rules, I suggest you get into high gear and go to “YouTube” and watch the DEA Pharmacy Red Flag Rules video. Then after you watch the video, start implementing the things you learned in that video (unless you are already practicing such cautious dispensings.) Why do pharmacies get so much attention from the government officials for audits and compliance? One reason is that with all of the fraud waste and abusive behavior in healthcare we are all subject to added review and oversight, and secondly, we are easy targets, much easier than the other areas of healthcare.

Interesting change of DEA policy recently was that wholesalers will now have access to the names of the controlled substance suppliers their respective pharmacy clients utilize. This is done with an effort to give the suppliers added ammunition to curb the quantity of controlled substances sold to their pharmacy clients under the DEA policy of “Knowing your customer”. For many years wholesales were not given official access to who their pharmacy clients used as other suppliers. Now that this added information is being shared, it may result in increased oversight of the suppliers to see if they are actually checking to see what their pharmacy clients are buying.

Marijuana Anyone?

During the campaign of Donald Trump to be elected president of the United States, he repeatedly stated that he would leave the issue of legalizing marijuana to the states to decide. Well as things turned out, since President Trump appointee Jeff Sessions as Attorney General, or as President Trump has recently called him, Mr. Magoo, AG Sessions is opposed to legalizing Marijuana for any purposes never mind recreational usage. So it was no surprise that on January 4, 2018, the Justice Department announced that they would be rescinding Obama administration policies not to interfere with state laws allowing people to use pot for medical and recreational uses. Attorney General Jeff Sessions referenced this policy change as a “return to the rule of law” in a memo outlining the change. But at the time of this announcement Justice Department officials could not answer whether people selling or using marijuana – in certain states where it’s considered
legal – would now be more at risk of prosecution. According to recent polls, nearly 70 percent of Americans believe in some form of legalized marijuana, but does the nascent marijuana industry have the power to rewrite nearly 50 years of federal drug policy? Or will it remain a splintered coalition of investors, libertarians, concerned parents of sick kids, cancer sufferers, and traumatized veterans, who have the numbers but not the detailed and concerted lobbying effort necessary to finally remove marijuana from the crosshairs of DEA schedule I status? Time will tell as this issue will not go away quietly and Mr. Sessions has created more confusion on a very complex matter. According to the White House Press Secretary, Ms. Sanders, President Trump supports Mr. Sessions’ position on this subject.

Chain Drugstore News

Somewhat surprising news was announced on February 20th by the Albertson Grocery chain. Albertson’s announced they will be acquiring the remaining more than 2,500 Rite Aid pharmacies (which are located in 19 states) that aren’t being sold to Walgreens Boots Alliance. In this new proposed merger, Albertson’s will stretch the Rite Aid brand in their grocery outlets across the country. Under terms of this proposed deal, Albertson’s, which is not publicly traded, will buy Rite Aid in a combination cash and stock deal, giving Rite Aid shareholders with ownership of between “28% to 29.6% of the combined company,” the companies said. This deal should close by the end of this calendar year and the combined company will trade publicly on the New York Stock Exchange. Rite Aid’s current chairman John Standley will become chief executive officer and Albertsons Companies chairman and CEO Bob Miller will become chairman of the larger combined company. After the deal is completed, which the FTC will probably approve, the combination of Rite Aid and Albertsons “will operate approximately 4,900 locations, 4,350 pharmacy counters, and 320 clinics across 38 states and Washington, D.C.” The Rite Aid name will remain on the existing Rite Aid pharmacies and will be presented in most if not all of the Albertsons locations which will have their pharmacies rebranded as Rite Aid, and the combined company will continue to operate Rite Aid stand-alone pharmacies.

This deal is occurring as Rite Aid is transferring 1,932 of their existing stores to Walgreens as part of an earlier deal. Before Walgreens agreed to their Rite Aid deal in September to buy 1,932 Rite Aid locations, Walgreens had been trying to buy all of Rite Aid before antitrust scrutiny from the Federal Trade Commission that ultimately rejected the Walgreens proposal to buy the entire Rite Aid operation. Besides the 1,932 stores Walgreens is buying from Rite Aid they are also acquiring three distributions centers and the total purchase prices is nearly $4.4 billion in cash.

By the way the PBM which Rite Aid had previously acquired will be brought over to the Albertson operation. You recall that Rite Aid had purchased EnvisionRx, which focuses on employers and government health programs like Medicare to contain drug costs.

In the meantime, Walgreens has been making news of their own of late. Walgreens (corporately known...
as Walgreens Boots Alliance) already owns about 25% of the AmeriSource Bergen Corporation (ABC), a national pharmaceutical wholesaler. Now there are signals that Walgreens is in discussions with ABC to purchase the remaining portion of ABC that they already don’t own. How would that affect the relationship that ABC has with their thousands of independent pharmacies? What about the PSAO that is operated by ABC known as Elevate. As February ticks away, it seems this marriage of ABC and Walgreens Boots Alliance may not come to pass. It seems that the stock market doubts this will occur, but one never knows. Shares of Walgreens Boots Alliance stock as well as AmeriSourceBergen shares also dropped after CNBC reported that as far as they can see, the pending deal talks have cooled and that a takeover looks unlikely.

Unnamed sources told CNBC that Walgreens Chief Executive Stefano Pessina and AmeriSource Chief Executive Steven Collis did meet to discuss a potential tie-up, but those early-stage explorations ended without an agreement. The sources, who cautioned the deal talks could once again resume, declined to be named because the information is confidential. Shares of both companies have dropped but ABC had increased significantly after these merger talks started. We must watch this potential marriage as it will have a very powerful effect on the marketplace issues and where community pharmacies will turn for their purchases.

**April NCPA Congressional Pharmacy Summit**

For several decades NCPA which is the National Community Pharmacists Association, in case you didn’t know that (and they were formerly known as NARD - National Association of Retail Druggists) has held an annual meeting in the Washington area for about 30 years, it used to be called a Legislative Conference and then a couple of years ago they tried to update it and they changed the theme to a Legislative Fly-In and this year the meeting will be known as the NCPA Congressional Pharmacy Summit. Over the years some powerful folks on Capitol Hill have addressed the pharmacists in attendance and each event includes lobbying of our respective Representatives and Senators on the issues which are near and dear to us and our patients. This year the meeting will be on April 11th and 12th and the issues which will be focused on include important items which the members of NCPA have reported to the NCPA leadership are most important such as: (i) The Improving Transparency and Accuracy in Medicare Part D Drug Spending Act (S. 413/H.R. 1038): which is legislation which would end retroactive pharmacy DIR fees that create havoc in pharmacy operations predictability and push Medicare patients more quickly into the Part D coverage “donut hole”; (ii) The Prescription Drug Price Transparency Act (H.R. 1316), this proposed legislation would create more transparency for generic prescription drug pricing and reimbursement in federal health programs; (iii) The Ensuring Seniors Access to Local Pharmacies Act (S. 1044/H.R. 1939) this proposed legislation would give Medicare beneficiaries more access to discounted copays for prescription drugs at their pharmacy of choice and finally (iv) The Pharmacy and Medically Underserved Areas Enhancement Act (H.R. 592/S. 109), which is passed into law would recognize pharmacists as providers under the Medicare Part D program enabling them to more fully utilize their education, training, and expertise in areas if their located in a medically underserved area, health professional shortage area, or medically underserved population. Now this is a nice wish list for our profession but it only can become reality if we act in a unified and professional way to educate our elected officials in Washington about the issues that are interfering with our ability to service our patients. In addition to these four legislative goals each time we are in Washington we discuss the issues of PBM abuse with our representatives and more and more of them are getting the message about the added costs to prescription drugs that the PBMs cost taxpayers. Nevertheless, the PBMs constantly preach how much healthcare dollars are being saved by their interventions. Pharmacists many times get bogged down behind their prescription counters and don’t fight for their rights like they should but there are many pharmacists that are struggling to keep their pharmacies open and they don’t have the resources to bring someone in to work as a pharmacist employee to give the pharmacist owner the opportunity to promote his/her professional views on important pharmacy matters.

This annual NCPA meeting in Washington will prove to be very interesting. I have been attending these annual congressional/legislative meetings since the early 1980’s and I have always found them to be informative and worth the time in our nation’s capital. Getting to speak one on one with your elected officials always puts a chill down my spine. Seeing our government work (somewhat from the inside) is an awe inspiring thing. Back during the Clinton error, NCPA was able to arrange a meeting in the old Executive Office Building, part of the Executive Branch of our government. This year will be even more informative and more important to our profession. President Trump has tried to dismantle Obamacare on a few occasions and President Trump seems hold a grudge against Arizona’s senior senator John McCain for voting against ending Obamacare, and by the way, Senator McCain is currently being treated for a serious and apparent inoperable brain tumor.

Does our POTUS (President of the United States) really understand the scope and responsibility placed on his shoulders? Is the White House really in turmoil? Is the White House turning into the D.C. version of the Apprentice? Time will tell, but it is indeed a strange time in history.

Friends we are living through truly challenging times, and as many of us have lived through other national scandals with past presidents, this too shall pass.

Stay well, hope that the snow is gone for this season and spring is in the air.

~ Jim Schiffer
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“Want to Pay DEA $10,000 Per Pharmacy Record and Security Violation?”
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For some, the temperatures have been positively balmy — if you’re a penguin or a snowman. Winter + cold = snow, and snow means delays in the delivery of mail order prescriptions.

I came across this recent blog post for workerscompensation.com, written by Bob Wilson, titled “I Hope Your PBM Doesn’t Treat Your Injured Workers This Way” (https://www.workerscompensation.com/news_read.php?id=28230). It describes the author’s ordeal getting his asthma inhaler. He had been coerced into getting his prescriptions through the mail only to find out he was out of refills a few days before Christmas. He called the PBM and was directed to a brick-and-mortar pharmacy to save the day — a CVS, which didn’t have the inhaler he needed in stock. That was just the beginning of the back-and-forth between Mr. Wilson, the pharmacy, and the PBM. He went four days without his asthma maintenance medication as the weekend and the Christmas holiday fast approached.

Here’s an excerpt from his blog:

Day 4 Without Medication:

This was a Saturday with peak frustration, as I was audibly wheezing, had to use an emergency inhaler for the first time in years, and spent almost 4 hours trying to get this resolved. I phoned Walgreens, assuming they had old insurance information. They did not. The refill had simply been declined by my PBM.

I called my PBM. They told me they issued an override approval, and I should call the pharmacy back. The pharmacy attempted to run it, and the prescription approval was declined.

The resolution didn’t come until Bob played the “I’m the decision maker for my organization’s health insurance plan” card. That’s when the PBM finally said they would pay the nearly $300 for the prescription at the brick-and-mortar pharmacy.

For community pharmacists, this is the same rigmarole you’ve experienced hundreds of times.

As temperatures and snow fall, the number of delayed mail order prescriptions will be on the rise. A few years ago, a weekend snowstorm dropped about a foot of snow on the D.C. area. Mail wasn’t delivered at my house for over a week.

I don’t know what patients choosing or forced to rely on a mail order pharmacy for their prescriptions did. Most likely, they had to do what Bob Wilson did — go to a pharmacy to rescue them, then beg and cajole their insurance company to pay for the prescription or just pay cash.

Arguably, mail order prescription delivery delays and icy liquid medications on your doorstep in the winter are just as dangerous as the wilting summer heat that can expose the chemicals in prescription medications to temperatures hot enough to fry an egg — significantly higher than the manufacturer’s maximum recommended temperature.

Of course, when patients receive propaganda from their health plan promoting “convenient, home delivery” of mail order prescriptions, they fail to mention the potentially dangerous temperature exposure or the delivery delays. As this new year begins, plans will be pushing hard — some of our members have told us patients are being pushed harder than usual this year — into a mail order pharmacy.

That’s one of the reasons NCPA created the Talk to Your Pharmacist First (ttPh1st). One of our members called me last month to say he has used NCPA’s ttPh1st materials and even changed the recorded hold message on his pharmacy phone to encourage patients to talk with him before making changes to their pharmacy or prescription benefit plan. He said more than 40 patients had come in — marketing letters from their insurance companies in hand — to get help determining the best option for them.

Help your patients understand that having the security of being able to access their prescription medicine — unadulterated by extreme temperatures or delays — is right in front of their cold noses.

- B. Douglas Hoey, RPh, MBA
National Community Pharmacists Association CEO
of pharmacy interns as immunizers, expanded patient services through a comprehensive medication management agreement between a pharmacist and a physician, as well as, patient choice between local access to a pharmacist and mandatory mail order, and the need for discussion between a patient and his/her pharmacist on the most economical option to fill a prescription. In addition, pharmacists explain how fair audits and appropriate pharmacy reimbursements through an appeals process stabilizes the foundation of the community pharmacy and assures local access to necessary medications. Throughout the program, the critical role of the pharmacist is explained in addition to the barriers preventing the pharmacist from doing more.

The ultimate message is that PSSNY’s Pharmacy Patient’s Right to Care will provide the pharmacy patient sustainable access to medications, vaccinations, and counseling in a timely, convenient manner at an affordable cost.

View the full video here: www.pssny.org/pressroom search under video releases

PSSNY will ‘pitch’ use of this video to local access television stations across the State. As we learn of broadcast dates, we will share them with members. We also encourage you to play the program in your store. It is a great way for your patients to better understand the challenges you face and your deep concern for their well-being.

We have also broken the piece into shorter, single topic videos. These will be better suited for use in social media, advocacy and media news stories.

View the segments here: www.pssny.org/pressroom search under video releases

This video was made possible by our Fight the PBM funds and will provide as with a strong educational foundation for those that do not work in pharmacy. Please join us on Community Pharmacy Lobby Day on March 6 where we will continue this conversation with our Legislators. www.pssny.org/2018lobbyday

- Kathy Febraio, CAE
PSSNY Executive Director

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**Message from PSSNY Executive Director From page 4**

I received the following from a NCYPS Member who will remain anonymous but is troubled by the lack of adequate payments....

Dear NYCPS Editor:

I try and follow all the rules, bill the proper NDC for what is dispensed, making sure that all medications are picked up or reversed within 2 weeks or less and I do my best to educate my patients on the proper use of their medications. Then the good part occurs, I have a computer which shows me the dead acquisition cost for the medications and when I am paid below cost a flashing message appears on the remittance screen. Am I the only one that notices—especially on NY Medicaid Managed Care plans — that we are losing big bucks on the generic drugs being dispensed?

Here are a handful of the recent billing nightmares: (Reimbursed includes patient copays and dispensing fees)

- Clindamycin Topical Gel 1% 30 gram costs $44.73 reimbursed $24.75
- Norethindrone Acetate 5 mg 60 tablets cost: $86.30 reimbursed $8.49
- Labetalol 200mg 60 tablets costs $15.44 reimbursed $4.18
- Timolol Maleate 0.5% Eye Drop Gel 5 ml cost $172.79 reimbursed $77.25
- Mometasone Furoate 0.1% cream 45 gram cost $9.57 reimbursed $5.31
- Low-Ogestrel 0.3mg /0.03mg Tablets cost $11.62 reimbursed $4.27
- Metronidazole Vaginal gel 0.75% 70 gram cost $81.73 reimbursed $13.20

Respectfully,
A Frustrated NYCPS Member

Is this member the only one finding this problem? Question..... What ever happened to the NYS MAC bill? Is it really serving the intended purpose?

The names of the Medicaid Managed Care plans which are paying at these horrific rates are being kept confidential as is the name of the pharmacy. This is being introduced to see if our other members are watching their reimbursement rates.

Comments? Send an email to Secretary@nycps.org
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Express Scripts Medicare Value and Choice (Preferred Provider)
Express Scripts Saver Plan
Gateway Health (Preferred Provider)
Humana Enhanced, Preferred Rx, and Walmart Rx Plans*
Magellan Rx (Preferred Provider)
MedImpact
OptumRx (LGE Network-Preferred Provider)
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(Preferred Provider in some regions)
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INDEPENDENT PHARMACY IS OUR BUSINESS
NYCPS NEWSLETTER JANUARY/FEBRUARY 2018 PAGE 21

NYS MEDICAID BEGINS PHARMACY PAYMENTS WITH NADAC METHODOLOGY

After many months of delay, NYS has begun paying pharmacy providers under the NYS Medicaid Fee for Service Providers using the federal NADAC payment formula, this process became live and in effect on Thursday February 22nd. This pharmacy pricing data is now available on Data.Medicaid.gov which allows you to view, filter, sort, visualize and share this data online. Data.Medicaid.gov also allows you to export the data in a variety of formats including Excel. According to NYS DOH plans, this reimbursement formula will be retroactively calculated back to April 1, 2017 and such adjustments will be coming in the next few months, so watch your Medicaid remittance statements! For more details on this pricing model see the NYCPS December 2017 newsletter, page 14 for the detailed explanation.

Prices are now calculated pursuant to federal guidelines as net cost of the drug (for brands, generics and recognized over the counter drugs). These cost prices are an effort to establish NET price payment (sometimes they are below your individual net costs—as you will soon learn—but there is an increased dispensing fee for all affected pharmaceuticals—including OTC pharmaceuticals, at a $10.00 dispensing fee. Remember you will only be eligible for the increased dispensing fee if your pharmacy has a usual and customary pricing methodology which is higher than the net price of the pharmaceutical plus this $10.00 dispensing fee. If your pharmacy has discounted cash pricing such as a $4.00 generic plan, you will not capture this increased dispensing fee because the Medicaid program utilizes a formula which pays the lower of your retail cash prices versus the calculated Medicaid formula.

Some of the brand name drugs with high price tags have been noted to be below your actual cost under this NADAC formula. Hopefully the increased dispensing fee and the added levels of reimbursement on OTC pharmaceuticals will serve to offset any losses, but each pharmacy has unique dispensing activity and there is no way to estimate how this will affect your pharmacy practice.

Note: For pharmacies that want to challenge the accuracy of pricing (due to market fluctuations or price increase) call the Myers & Stauffer helpdesk at 855 457 5264.


~ Jim Schiffer

GOVERNOR CUOMO EXTENDS EMERGENCY EXECUTIVE ORDER TO PROMOTE VACCINATION AS FLU EPIDEMIC CONTINUES

On January 25, 2018, Governor Andrew M. Cuomo declared a Public Health Emergency for all of New York State in response to this year’s increasingly severe flu season. The Governor issued an Executive Order which allows NYS certified pharmacists to administer flu vaccinations to patients between 2 years and 18 years of age. This Order suspends, during the period that the disaster emergency remains in effect, the section of State Education Law that limits the authority of NYS certified pharmacists to administer immunizing agents only to individuals 18 years of age or older. This executive order has been extended through March 22, 2018.

Administration of flu vaccines to Medicaid enrolled children between the ages of 2 years and 18 years by qualified pharmacists employed by, or under contract with, Medicaid enrolled pharmacies is reimbursable under NYS Medicaid for the duration of the Executive Order.

NYS certified pharmacists may secure flu vaccine to administer to Medicaid enrolled and uninsured children through the Vaccine for Children Program (VFC). Pharmacies not already enrolled in VFC are strongly encouraged to enroll to enable access to flu vaccine for both Medicaid and uninsured children. For VFC enrollment information, go to: https://www.health.ny.gov/prevention/immunization/vaccines_for_children/ The flu vaccine is provided free of charge by Centers for Disease Control (CDC) to the VFC and in turn to enrolled pharmacies. Pharmacies may bill for the administration. Pharmacies enrolled in the VFC program must use procedure code 90460 for administration of a VFC vaccine, and reim-

continued on page 26
Ask about safety caps. An elderly patient with multiple myeloma suffered a spiral fracture of the humerus with 15 mm of posterior displacement while trying to remove the child-resistant cap on her medication bottle. The simple act of trying to push down and twist broke the weakened bone and caused the fracture. These bottles are designed to protect children from accidental overdoses but, in this case, ended up harming an elderly woman (Figure 1). The point is, pharmacists need to talk to patients periodically to discuss any problems they may have accessing their medications. If difficulty is expressed, patients should be offered the choice of having their prescription(s) dispensed in a bottle without a safety cap. Some pharmacists never ask about this while others routinely ask when filling a prescription for a new patient. This type of information needs to be updated periodically. When safety caps are not used, it is critically important to educate patients about the risk of accidental poisonings of children and safe medication storage (www.upandaway.org).

Make allergies clearly visible. A long-term care (LTC) resident with multiple sclerosis had difficulty swallowing and was thought to have aspirated. The doctor wanted to start the resident on an antibiotic right away. He called in an order for AUGMENTIN (amoxicillin clavulanate), a form of penicillin. Unfortunately, the doctor failed to notice that the resident had an allergy to “ticarcillin,” also a form of penicillin, documented in the resident’s office record. In order to start therapy as soon as possible, the nurse at the LTC facility administered the first dose from the emergency drug box. The nurse also did not notice the resident’s allergy. The pharmacy caught the error when reviewing the order after the first dose was given. Fortunately, the resident did not experience a serious reaction.

This incident highlights the importance of ensuring that drug allergies are clearly visible in the resident’s medical record and medication administration record (MAR), and why these should be checked before the first dose is administered. The event also shows how vulnerable the resident is to medication errors when appropriate safety checks are skipped. Work with LTC facilities to make sure there is a process in place for a pharmacist to review an order before administration for all but a few true emergency drugs.

Ideas for how you can become part of our “Night’s Watch” include:

- Join a committee
- Donate monthly or help fundraise for specific events for Rx PAC
- Educate yourself by attending conferences and CE meetings
- Register for PSSNY Lobby Day which is coming up soon.

Our PSSNY organization just concluded a very informative, and successful Mid Winter event in Albany. Those that attended came away with an expanded value of our profession. Those that did not make it, missed another opportunity to learn how to expand their practice and learn some tools of survival.

In the meantime, Tuesday, March 6th is the perfect opportunity to get involved and be heard as part of PSSNY’s 2018 Independent Pharmacy Lobby Day. Join OVER 300 fellow pharmacist & pharmacy owners in speaking out against issues which are affecting our industry and preventing us from caring for patients and making it difficult for us to operate our small businesses in New York. Let’s all STAND UP together and make a difference. We will take the battle to Albany and let them hear our voices. The last official day to register is February 16. Go to PSSNY.org

Thank you,
~ Parthiv Shah
NYCPS President
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Some pharmacist and pharmacy owners don’t fully understand their requirements to comply with DEA CSOS regulations. So, let’s start educating you to prevent DEA from taking you into an administrative or civil action.

CSOS is a four-step process. First, the person with a CSOS password places the Schedule II order. Second, the supplier acknowledges receiving the order. Third, the supplier ships the order. Fourth, you acknowledge receiving the order. Therefore, you physically open the Schedule II totes and confirm the quantity received and the date received by the pharmacy. Folks, the CSOS system DOES NOT AUTOMATICALLY do that for you. Someone with CSOS privileges needs to enter the information into the CSOS system. They need to list the quantity received and the date received by the pharmacy. So, every time you don’t confirm take the checkbook and a calculator out and multiple it by $14,739 per line item ordered which is considered an error by DEA.

The DEA regulations require you, the pharmacy owner, to make the electronic DEA Forms e222 from CSOS “readily retrievable” during a DEA inspection. If your supplier tells you that you don’t need to do it, ask them if they would pay your civil fine and legal counsel to defend your pharmacy.

Recently, I was involved with Attorney Jim Schiffer on several DEA actions on a few New York and New Jersey pharmacies for failure to comply with DEA CSOS regulations. Look, in plain English, you need to understand, “You NEED to CONFIRM CSOS Orders!!!”

Another suggestion, if you are using your wholesaler’s computer for your CSOS software, consider moving your software to your own desktop or laptop. Folks who become unhappy with their wholesaler and change suppliers suddenly find that their CSOS database has been taken away by the wholesaler (as they take back the computer you had been using) when the relationship ends. Consider using your own desktop/laptop for something as important as CSOS data storage.

DEA requires a pharmacy to have two years of records including the CSOS DEA Forms e222. In New York, BNE requires five years. The one thing you need to check is does your supplier maintains “two years of CSOS records on your computer”? You can check before DEA gets there or just wait until DEA visits your pharmacy and find that you don’t have two years of records. DEA will NOT fault the supplier but will take the action against you. The supplier will provide DEA a record that you signed acknowledging the CSOS regulations.

There are other records you need to provide to include the Power of Attorney for each person having access to CSOS. If you are sharing your password, you will feel the strength of their powers. By the time DEA is done with their investigation, you will need to be prepared to lose your DEA registration or to pay fines exceeding a $1 million dollars and legal counsel fees more than $100K to defend your mistakes. Why wait?
Emergency Executive Order

From page 21

bursement for such is $17.85. The cost of the flu vaccine should not be billed to Medicaid when it is obtained through the VFC program.

During the period the Executive Order remains in effect, pharmacies not enrolled in the VFC program may bill the acquisition cost of the vaccine and its administration. The procedure code for administration of a non-VFC vaccine is 90471 and reimbursement for such is $13.53. Procedure codes for flu vaccines obtained outside the VFC program can be found on eMedNY at: https://www.emedny.org/ProviderManuals/Pharmacy/index.aspx (click on “OTC and Supply Fee Schedule”). Services must be provided and documented in accordance to NYS Department of Education laws and regulations. Visit http://www.op.nysed.gov/prof/pharm/pharmimmunizations.htm for links to additional information, including the reporting of all immunizations administered to persons less than 19 years of age to the New York State Department of Health using the New York State Immunization Information System (NYSIIS).

Please note that NDCs are not to be used for billing the vaccine product. Reimbursement for the product will be made at no more than the actual acquisition cost to the pharmacy. No dispensing fee or enrollee co-payment applies. Pharmacies will bill with a quantity of “1” and a day supply of “1”.

Billing Instructions: Providers must submit via NCPDP D.0, in the Claim Segment field 436-E1 (Product/Service ID Qualifier), a value of “09” (HCPCS), which qualifies the code submitted in field 407D7 (Product/Service ID) as a Procedure code. In field 407-D7 (Product/Service ID), enter the Procedure code.

This information has been provided to our NYCPS members as a courtesy by the Pharmacists Society of the State of NY.
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