Political Disruption is within reach with votesmart.org

The March for Our Lives demonstration the weekend of March 24th, in Washington, DC and in some 800 other cities and the signing of the PBM Li-censure Act in Arkansas earlier this month point to one small, but extremely important truth: people in this country have a voice. And a vote. And as long as they are willing to use one or both, the opportunity for change is within reach.

Just as students and pharmacists put their respective establishments on notice, we can do that too. But we must start with educating ourselves. Recently I came across a powerful tool that is designed to do just that “VoteSmart.org” is a site that tracks the position, votes and funding (among other details) of our state and federal politicians and gives the clearest possible picture of who’s likely to support our cause and who isn’t or can’t because of special interest funding. The votesmart.org deploys a “Political Courage Test” on each politicians. This Political Courage Test is a litmus for determining how an incumbent is likely to vote on a number of hot-button issues. And that’s just the beginning.

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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.

My last few days have been spent in Nashville at the APhA 2018 Annual Meeting “Leading Our Community Through Patient Care”. The meeting was jam packed with continuing education, for all areas of the profession. We listened to FDA and DEA updates, collaborations with other providers to improve patient care, radiopharmaceuticals, pharmacogenomics in community pharmacy, medical cannabis, opioid use, misuse, and abuse treatment, and business related issues like getting paid for providing patient services along with the medication dispensed.

I was invited to attend private receptions with the past presidents and officers of APhA, and another with the current and Incoming (now president) Nicki Hilliard, from Arkansas. She is a nuclear pharmacist, whose parents operated an independent pharmacy, and she is very aware of the difficulties of the pharmacy business owner, and their ability to serve our patients.

I was asked “where has NY BEEN?” They know we are involved, but miss us at APhA. I would urge more representation, especially now, to educate the rest of the profession about our issues. Thank you to Martha Rumore, Karl Fiebelkorn, Christopher Daly, Ryan Lindenau, for their help and support at this meeting.

And Brian Richardson for being Delegates, and Kara and Amanda for being our alternates when travel plans changed due to weather.

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**IMPORTANT ISSUES YOU MAY NOT KNOW...**

In the age of electronic prescriptions many pharmacists are unaware of the limitations on transfer of such prescriptions.

According to the New York State Board of Pharmacy a pharmacist MAY transfer one dispensing of a NON Controlled prescription medication to another pharmacy, (you may want to confirm with the patient that the transfer is really at the patient request and not being pressured by the second pharmacy). Unlike other states New York pharmacists CANNOT transfer all remaining dispensing left on file. You may transfer one dispensing at a time. You should make a note of the time and date of the transfer and to which pharmacy it is being transferred to, and get the name of the accepting pharmacist.

Now regarding controlled prescriptions, you CANNOT transfer any controlled prescription at this time. Before that can happen Sure Scripts, the DEA and the New York State Bureau of Narcotic Enforcement need to work out the bugs in such transfer technology. (remember in New York a controlled prescription needs to be either in writing or on secure electronic media.)

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**Turning to issues of payroll and paying your pharmacy staff.** Pharmacy technicians, pharmacy interns, cashiers, stock clerks, delivery staff, and other non licensed personal are subject to overtime when they work over 40 hours per week. You cannot have such staff on “salary” and have them work 45 hours or even more. If you get sued by a disgruntled employee in that position, it can cost you hundreds of thousands of dollars.

**IF** you pay your pharmacist hourly, at a flat rate, and his/her hours exceed 40 hours, you should contact your attorney to confirm that your payroll set up is within federal guidelines. As a pharmacist is considered a professional, they do not have to be paid overtime but some pharmacy owners have their pharmacists set up where overtime is paid at time and one half.

Better to be safe then out thousands of dollars in a lawsuit.

- Jim Schiffer, Senior Editor NYCPS Newsletter
A Sea Change for Healthcare

In March of 1942 Kaiser Permanente came into being, unique at the time because it offered a new idea in healthcare, the idea of a health maintenance organization. Henry Kaiser, the tycoon of the aluminum industry, began offering it to his 20,000 employees working in his factories in California. From the beginning it was about preventative medicine and educating the members about better health practices. This became the premier HMO in the United States, and spawned the proliferation of similar programs throughout the country. Locally the HIP (Health Insurance Plan of NY) was the one I remember locally. They initiated clinics throughout the five boroughs and became one of the first to offer its membership prescription drug coverage.

Groundbreaking, sure, innovative, revolutionary, a new concept in managing patient health and improving their outcomes this became the standard of modern healthcare in America. Fast forward 75 years later, there is a new paradigm for healthcare emerging due to changes in the payment model for all providers. The federal government has initiated reforms that pay based on outcomes. In New York State DSRIP (Delivery System Reform Incentive Payment) has focused on the formation of shared risk groups including hospitals, doctors, nurses and pharmacists being paid on the ability to affect better health outcomes for at risk patients in the healthcare system. The goal is to have less hospitalizations and overall to encourage improved disease state management. We have been introduced recently to CPESN (Community Pharmacy Enhanced Services Network) which is already showing its value in many states by saving healthcare organizations money. Members of NYCPs have recently formed a network and are presently setting up to work with a major NY City hospital system to bring an enhanced pharmacy centered care to their most compromised patients.

This is a departure from the dependence on declining payments from pharmacy benefit managers as the prime source of income for community pharmacy. Whether it is following up with diabetic and asthma patients on a care plan, or coordinating care with their doctors, initiating medication compliance, by establishing this enhanced relationship with the patients we can quantify our true value to the healthcare system. These members of the network offer medication synchronization, compliance, home delivery and work with their doctors and insurers to achieve better results, ultimately saving wasted return hospitalizations and unnecessary emergency room visits, while achieving better client health.

I truly believe this is the paradigm that can integrate pharmacy into the healthcare spectrum. Networks of pharmacies are safe havens against Federal antitrust laws, as we are united in a heightened care plan, not by using our numbers to affect drug reimbursement. It is all about proving our value to the medical bottom line, being able to help in complex patient management in a collaborative way. This, as was that formation of an HMO some 75 years earlier signifies a new life and a new phase in community pharmacy, a stable future for us all.

- Bill Scheer, R.Ph.

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A Message & Greetings from PSSNY Executive Director

Unprecedented Budget Results on PBM Legislation

PSSNY has been working tirelessly on PBM issues. We are in the midst of the legislative session—the State budget has passed—and now we begin work on our outstanding issues.

PSSNY successfully included several of our priority bills in the budget: gag clauses, fair audits, and immunization expansion. This is unprecedented for PSSNY. Getting non-fiscal issues addressed in the budget is an option for the most critical legislative issues. And this year, our issues were critical to our legislators. Our advocacy efforts have paid off!

See Elizabeth Lasky’s column for the details on these laws.

Do not underestimate the impact of our grassroots advocacy efforts, our media coverage and speaking with a single voice had this year. Legislators now know what pharmacy benefit managers are, what they do and are supporting community pharmacy in a way that has not happened before.

That’s a sea change from one year ago!!

How did we do it?

We accomplished this monumental accomplishment through a coordinated effort of grassroots advocacy, media coverage, and direct lobbying efforts.

Grassroots Advocacy

Last fall, PSSNY released its grassroots advocacy plan and presented it to the affiliates right around the time the continued on page 25
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A MESSAGE FROM
PSSNY CHAIRMAN
RUSSELL GELLIS

STATE BUDGET HAD MANY SUCCESSES

PSSNY just concluded its most successful budget season ever!
We were able to include several of our initiatives to address PBM practices, as well as, temper the impact of the opioid sales tax. Medicaid fee-for-service had several pharmacy proposals in the mix as well.
Please read Elizabeth Lasky’s column for details on PSSNY bills that were incorporated into the budget and Kathy Febraio’s column to learn how we made it happen.

Medicaid Fee-for-service
Even though last year’s $10 dispensing fee has barely gone into effect, a new dispensing fee is in effect as of April 1, 2018. It is now $10.08 as a result of the State budget passing—a modest increase. Like it or not, the dispensing fee is now part of State budget negotiations. It may or may not be changed every year, but the State budget process is the process for altering it.

Other proposals from the Department of Health did not survive the budget, to the benefit of pharmacy. They wanted to limit the list of OTCs covered by Medicaid and increase the co-pay by 50 cents for the remaining covered OTCs. We all know if a covered patient has to pay full price for an OTC, they are less likely to purchase the medication leading to further complications, such as a visit to the emergency department. And we all know an increase in co-pay would result in a lower payment to the pharmacy. Having both of these proposals rejected during budget negotiations at least sustains the status quo for Medicaid fee-for-service providers.

PSSNY has had several conversations with the Office of Health Insurance Plans (OHIP) regarding the retroactive reconciliation of the $10 co-pay approved last year. We do not have any new information on the process or timing of this system update. We will keep members informed as we are made aware of the details. We continue to explain the challenge pharmacies will experience if the implementation takes place over a short period of time.

Opioid Assessment
The proposal of a 2 cent per MME tax on the first sale of a medication was going to squarely hit the pharmacy and would have been disastrous for PSSYN members. To avoid having pharmacies paying the tax and the unintended consequences it would have, the final negotiations resulted in an opioid assessment on wholesalers and distributors. It is not what we hoped for, but the opioid crisis facing the state and country could not be ignored by our representatives. We will continue to support our partners who are affected by the assessment, as we also support efforts to try to stem the crisis.

To summarize, the State budget included:
• Fair Pharmacy Audits
• Prohibit gag clauses in pharmacy-PBM contracts
• Authority to administer flu vaccine to children, with a sunset date of July 1, 2020; and
• Extends the sunset on the adult immunization law to July 1, 2020; and
• Establishes an opioid stewardship fund of $100 million funded by assessments paid by manufacturers and wholesalers. Pharmacies are excluded.

The State budget excluded:
• Proposed reduction of Medicaid OTC coverage; and
• Proposed increase of Medicaid copay for OTC’s.

Overall, a very good budget!
But even with these hard-won victories, we have a long way to go. PBM transparency is on our agenda, and their anti-competitive practices must be stopped. Our members continue to be affected by unfair reimbursements that seem to favor large retail chains and we still see the steering of patients into mail order and PBM-owned pharmacies. Complex and opaque spread pricing, MAC pricing games and appeals abuses, consolidation of power as healthcare titans merge - these are issues we must continue to press forward on and demand both transparency and reform.

We continue to have our eye on the long game and ask you to do the same. We will win this battle, but we must do it together, one small victory at a time. Thank you for your advocacy and support.

Russell Gellis, RPh
PSSNY Chairman
Friends, we have just completed our annual PSSNY Pharmacy Owners Lobby Day in Albany where hundreds of your colleagues gathered together to inform our elected state senators and assembly persons of the issues we face on a daily basis in assisting our patients in their health care needs.

While in Albany many pharmacists shared their frustration with the elected officials and their staff as the pharmacists explained the restrictions we face on a daily basis from such issues as: Closed networks that prevent us from servicing particular patients, especially those enrolled in Medicaid Managed Care; then there are the underwater payments which are a consistent and growing problem with especially the generic drugs as the pharmacy benefit managers appear to be using reimbursement rates from a different era as some drugs are well below our rates of actual acquisition costs, (one member shared his/her frustration by sending a letter to the editor which appeared in the January/February edition of this newsletter sharing specific example of how underpaid their pharmacy actually is).

I want to discuss the fruits of a meeting which took place this month with the senior management of the Metro Plus Health Plan and Kathy Febraio, the PSSNY Executive Director and myself. This meeting was the product of ongoing discussions with NYC Mayor Bill deBlasio and your NYCPS leadership. As you may recall, NYCPS President Parthiv Shah had arranged a fundraising event just before the November Mayoral Election. At that meeting I spoke directly to Mayor deBlasio about the concerns we community pharmacists have with the underwater payments from CVS Caremark.

At the meeting with the Metro Plus Health management we discussed the sudden and drastic drop in generic payments which started on October 26th 2017 and which lasted for about 3 weeks. It seems that of the four senior folks in attendance, three of them were unaware of the reimbursement change and the pharmacy director was the only one at MetroPlus Health that was aware of the changes in payment. The pharmacy director said when he received calls from frustrated pharmacists, he directed those calls to the CVS Caremark help desk. We explained the severity of the change and the fact that pharmacists could not financially afford to dispense drugs to the MetroPlus patients with such severe financial implications. The management team seemed to be sincerely concerned about the potential harm that could arise from the lack of access to key maintenance medications and the financial harm that could be inflicted on the independent pharmacies in the MetroPlus network. We informed the MetroPlus management that the cuts to generic reimbursement although were stopped after about a 3 week period, there was no retroactive adjustment to the prices and some drugs were not restored to their pre October 26 2017 payment schedule. What we took away from this meeting was a better understanding of the close reliance MetroPlus (as well as the other NY Medicaid Managed Care Providers) has on CVS Caremark for their day to day pharmacy needs and how CVS Caremark is delegated to handle all patient and pharmacy complaints.

On a positive note, MetroPlus management explained how the majority of the prescriptions filled for patients of MetroPlus are filled at local community pharmacies, far more than are done at the national chains. We also learned that some (not all but enough pharmacies to be concern to MetroPlus management) of the community pharmacies who are dispensing “specialty” drugs pursuant to the New York Medicaid regulations do not provide the proper follow up, hand holding, and counseling needed for these expensive and life saving drugs. A suggestion to our members, if you have signed up to provide “specialty” medications under the New York Medicaid Managed Care program, make sure you are providing the proper care and counseling to these patients. The alternative if such community pharmacy access to specialty drugs would be curtailed is that CVS Caremark would provide such specialty medications through their mail order facilities, something we don’t want to see happen to our patients, do we?

In reviewing the key issues discussed at the meeting we agreed to keep in touch with the MetroPlus management and to let them know of any repeat occasions of the reimbursement reductions. We agreed to try and find ways to help the MetroPlus patients have better compliance on their maintenance medications and we now have opened lines of communications with this important Medicaid Managed Care provider. The NYCPS and PSSNY have made a commitment to reach out to each of the NY Medicaid Managed Care Organizations and share our concerns on the day to day concerns the pharmacy community faces in caring for the working poor of our city.

If you have any particular concerns about a Medicaid Managed Care plan contact me at: secretary@nycps.org and I will do my best to find resolution to your concerns.

- Jim Schiffer, Secretary NYCPS
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PSSNY Albany Legislative Report

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.

NEW STATE BUDGET PROHIBITS GAG CLAUSES AND CLAWBACKS; ENACTS FAIR AUDITS

PSSNY’s outreach to state leaders last fall and pharmacists’ contact with rank and file legislators in home districts and at the Capitol on March 6th produced positive results when the final budget bills were released in the hours just before the April first start of the state’s fiscal year.

Stories from pharmacists about abusive PBM tactics clearly resonated with legislators on both sides of the aisle. Bills prohibiting gag clauses and clawbacks (A8781 Rosenthal/S6940 Hannon) passed with unanimous votes in committees and in both houses before April first. And with the Governor’s support, provisions of the bill became state law when the budget passed because the language of the bill became part of the health budget. The law takes effect immediately, representing a resounding defeat for the PBM industry as lobbyists tried to derail the bill at every turn.

Here are the details:

Contracts between PBMs and pharmacies and/or PSAOs shall not prohibit or penalize a pharmacist or pharmacy from disclosing
• The cost of the prescription to the individual;
• The availability of any alternative medications; and
• The availability of any alternative methods of purchasing the medications including paying cash.

PBMs shall not impose a copayment that is more than the amount of the adjudicated amount.

According to the text, “pharmacies shall retain the full adjudicated cost of the prescription.” Once the claim is adjudicated, the PBM may not lower the “adjudicated cost” at any time, thereby prohibiting clawback. PSSNY is monitoring implementation, enforcement and related matters.

This law DOES NOT affect DIR fees. DIR fees are a federal issue in Medicare Part D plans and state laws do not have an effect on them.

This law DOES NOT authorize a pharmacist to tell the patient the pharmacy’s reimbursement amount. Do not confuse telling a patient what is less expensive for them with what your reimbursement rate is. Doing so is likely a breach of your contract.

The health budget bill (S7507-C/A9507-C) included another piece of PSSNY’s 2018 legislative agenda, namely statutory guidelines for the conduct of pharmacy audits by third parties (i.e. PBMs).

Here are the provisions that apply to on-site audits:
• Requires fifteen days written notice with receipt confirmation. Prescription numbers with or without the final two digits must be included;
• Limits look-back to 24 months and 100 prescriptions per year;
• Allows pharmacies to validate pharmacy records with written records of a hospital, physician or other authorized practitioner; and
• Prohibits denials for clerical errors (no financial harm to patient or payer);

With regard to invoice audits, the new law requires auditors to accept invoices from wholesalers registered by the State Education Department or (when applicable) authorized DME dealers. These provisions do not apply to audits in which fraudulent activity or “other intentional or willful misrepresentation is evidenced by a physical review” is suspected.

The new Public Health law includes timelines: Preliminary audit results are due in 45 days. Pharmacies have 45 days to respond. Final audit report is due 60 days after the preliminary audit is released.

The budget also extends sunsets on Collaborative Drug Therapy Management and adult immunization to July 1, 2020 and adds new authority for pharmacists to immunize children against flu with the July 1, 2020 sunset. Remaining in place are the reporting requirements, including notifying the patient’s primary care provider(s).

Pharmacies, patients, hospices and substance abuse services were specifically excluded from the new opioid assessment which the state expects will be paid by manufacturers and wholesalers and deposited into a dedicated fund to be used for treatment.

PSSNY continues to analyze budget documents. Check the weekly e-script for updates and developments.

Elizabeth M. Lasky
Capital Public Affairs, Inc.
Medicare Part D Update - What is coming in 2019…..

With the inception of Medicare Part D back in 2006 (boy does time fly as a dozen years with this program has already passed), it has become a ritual in early April that the Centers for Medicare and Medicaid Services aka CMS prepares a “Call Letter” to provide the health care community a peak at the proposed direction that Medicare Part D will take with the 2019 calendar year. As you know Medicare Part D has a process where those eligible Medicare Patients select a plan each December for the following calendar year. Those eligible Medicare/Medicaid patients (which we affectionally refer to as our “Dual eligibles”) have the luxury to change plans anytime during the year if they are unhappy with the operation of their current plan. So, with that information as a back drop is it important to know who the particular plan sponsor is as the patient’s medication needs may not match the Prescription Drug Plan (PDP) formulary. In the 2019 Call Letter this final 2019 Medicare Part D rule released in early April, CMS asserted their legal authority to require that some portion of rebates and pharmacy DIR fees be applied at point of sale. This change to the procedure in this final rule stops short of actually requiring such a change, but states, “any new requirements regarding the application of rebates at the point of sale would be proposed through notice and comment rule-making in the future.” NCPA has put a full court press on CMS and it seems that the recognition of the need to address this problem by CMS should be credited to NCPA’s continuous and forceful lobbying and input. “In this rule, CMS hints strongly that it is concerned about retroactive pharmacy DIR, that it has the statutory authority to address the issue, and that there may be further rule-making to deal with it in the months ahead,” said NCPA CEO B. Douglas Hoey, Pharmacist, MBA. “That's very promising. This rule simply telegraphs the next step in the process.”

The final rule also touches on other concerns raised time and time again by NCPA, and I list a few such issues here:

Any willing pharmacy: Although Part D plan sponsors may continue to tailor their standard terms and conditions for various types of pharmacies, the final rule clarifies that Part D plan sponsors may not exclude pharmacies with unique or innovative business or care delivery models from participating in their contracted pharmacy network simply on the basis of not fitting in a Part D plan sponsor’s particular pharmacy type classification.

Treatment of accreditation: The rule clarifies that Part D sponsors cannot limit dispensing of certain drugs (such as “specialty” drugs) or drugs for certain disease states to a subset of network pharmacies if a pharmacy is capable of and appropriately licensed under applicable law(s) and agrees to meet the sponsor’s standard terms and conditions.

Standard terms and conditions: The final rule requires Part D plan sponsors to develop standard terms and conditions and make them ready for distribution by September 15th. Part D plans must provide the applicable standard terms and conditions to a requesting pharmacy within seven business days of receipt of request.

Last important issue, is that the final rule also implements statutory provisions of the Comprehensive Addiction and Recovery Act of 2016. Regarding prescriber and pharmacy “lock-in” programs, NCPA agrees with CMS’ decision to ensure plan sponsors consider beneficiary preference. NCPA urges CMS to remain vigilant in ensuring appropriate patient access.

More Medicare Part D News

A False Claims Act Case Against Caremark (CVS Health) has been unsealed. The case centers around prescription drugs dispensed to Medicare Part D beneficiaries. In this case, the plaintiff alleges that Caremark, as a PBM (Pharmacy Benefits Manager), submitted higher prices to CMS than what Caremark was actually paying the pharmacies, despite CMS regulations that require the reporting of “pass-through” prices. Pass

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Around the Pharmacy
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through prices are understood to be a transparent process so that there are no hidden markups by the PBM and/or the Medicare Part D Prescription Drug Plan (PDP).

This alleged scheme involves independent and separate sets of contracts with Medicare Part D Plans on one side and pharmacies on the other. Pharmacies were paid lower drug prices than the government-insured PDPs were charged. Therefore, there was a “Spread” of improper profit to share between the PDP and or the PBM. The plaintiff that brought thus whistleblower case estimates that this deliberate fraud has cost CMS and beneficiaries well over one billion dollars. It seems that the person who is this whistleblower is actually an actuary for Aetna—remember CVS Health and Aetna have announced a merger. Strange, that one of the Aetna employees is blowing the whistle on his/her potential employer! You may ask what is an actuary? A review on line states the following definition: A person with expertise in the fields of economics, statistics and mathematics, who helps in risk assessment and estimation of premiums etc. for an insurance business, is called an actuary.

Back in 2010, CMS changed its regulations to require the reporting of “negotiated prices” and to eliminate any PBM spread in the reported drug costs. In addition to wanting to eliminate PBM spread from drug costs (and pay administrative expenses and profits separately), the idea behind this change was that CMS was attempting to obtain lower prices for the Medicare beneficiaries as well as overall greater transparency. Nevertheless, the lawsuit alleges that in spite of this significant regulatory change, Caremark continued the same method of price reporting that it had used prior to the change. Therefore, the suit continues, Medicare Part D beneficiaries as well as CMS have unknowingly paid higher prices for their drugs than what Caremark was actually paying the pharmacies. Additionally, Caremark’s price reporting caused CMS to overpay Reinsurance and Risk-corridor payments under Part D, and for premiums to be inflated, based on Caremark’s fraudulent reporting of the prices “actually paid” to the pharmacies. There is another overall problem with the Medicare Part D program. With the lag time between the actual payment made to the pharmacies and the review and true up of total costs paid out and then accounting for the rebates paid to the PDP...
As this occurs, the particular Rite Aid drug store pharmacy will be managed by Walgreens. Over the next approximately 18 months, the majority of these locations will convert to full Walgreens locations with the products, services and great prices found at other Walgreens stores nationwide. It is anticipated that once the full integration of Rite Aid is made into the Walgreens pharmacy chain, there will be 600 less pharmacies in the combined pharmacy operation which will occur by the closing of overlapping pharmacies within the same demographic area.

Where are we going with Medical and Recreational Marijuana?

As we all know this is 2018 and marijuana remains illegal in the United States of America. In spite of the continued federal prohibition, it has not stopped the marijuana industry from growing like a very profitable weed. Despite the fact that, Attorney General Jeff Sessions is totally opposed to any change in the Controlled Substance Act to accommodate a revised listing for Medical Marijuana to a class II drug. Although there is a very anti marijuana administration in Washington D.C., nine states and the District of Columbia now allow for recreational marijuana use and 30 allow for medical use. As we go to press, there are additional states are planning to join the legalization wave. Pot has become a huge business in the U.S. The growth of this emerging drug is huge as Marijuana took in nearly $9 billion in sales in 2017, as is reported by Tom Adams, who is the managing director of BDS Analytics, which tracks the cannabis industry. Sales are equivalent to the entire snack bar industry, or to annual revenue from Pampers diapers. These numbers do not reflect the growth in California as California has opened its massive retail market this past January. The addition of the Golden State is huge for the industry and Adams estimates that marijuana sales in the United States will rise to $11 billion in 2018, and to $21 billion in 2021.

While the Trump administration is vehemently opposed to the legalization of Marijuana even under a Controlled Substance Act re-assignment from a Schedule I to a Schedule II or Schedule III there is tremendous growth in this market. While additional states have been liberalizing the use of Marijuana for medical purposes, it still remains a stigmatized pharmaceutical. The legal changes to this drug remain on the table but it is a matter of when not if. Time will tell, we may need to wait for a different presidential administration for things to change on this drug on the federal level.

Amazon and President Trump

It never ceases to amaze me how President Trump can look the American people right in the eye and not tell them the truth. Currently the debate rages on in the White House concerning the Amazon effect on our postal System and the lack of collecting sales tax. The United States Postal Service denies they are losing money shipping Amazon packages, yet President Trump continues his attack. President Trump complains about the lost sales tax on Amazon sales, yet, his Trump organization has a web based operation (https://www.trumpstore.com/), selling throughout the entire United States but only collects sales tax in two states, Florida and Louisiana leaving 48 states without the benefit of sales tax on the various Trump products and trinkets sold on their website, while Amazon collects sales tax in 45 states. I have seen the warehouse building in Edison New Jersey that houses Amazon in one of their several facilities in New Jersey. As much as pharmacy fears the entry of Amazon in our profession, we cannot hide under a rock. Maybe the joint venture that JP Morgan Chase, Berkshire Hathaway and Amazon are working on toward a different approach to health insurance may have huge dividends for the American people. Maybe the intro of Amazon into the pharmaceutical distribution model may streamline operational costs.

Merger News

Two huge mergers in health care need to be mentioned before we conclude this report. Back in early March, Cigna announced their intention to purchase Express Scripts for a price tag of $54 billion dollars. This may be in response to the previously announced pending purchase of Aetna by CVS Health which is priced for $69 billion. It should be noted that recently CVS Health floated a huge bond issue to help pay for the costs associated with this takeover. CVS Health raised $40 billion in bonds which was grabbed up by investors in a heartbeat. The response was a 3 to 1 demand which helped lower the interest in these bonds. Amazing times we live in.

The next announcement is still in discussion states but WalMart and Humana are in discussions for WalMart to acquire the entire Humana Health insurance company. While the discussions continue, we are not certain as to what the purchase price will be but early estimates of valuation of Humana are slightly less than $40 billion, but as interest increases the price tag is still up in the air.

Folks time to wrap this up, I can go on forever. I am headed to Washington DC to attend the NCPA Congressional Pharmacy Summit. I will report on the events in our May issue of NYCPS.

Folks we need everyone to stay informed and to stay involved. The profession you save may be your own!

~ Jim Schiffer

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In the event of a pharmacy theft or significant loss of controlled substances, the pharmacy registrant is required to report, in writing, the loss within one business day upon discovery.

When DEA personnel comes into your pharmacy to investigate the theft or significant loss, this is where your nightmares will begin, and these nightmares will cost you $14,000 for errors with your required records, and $65,000 for errors found on filled controlled substance prescriptions.

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My sophomore year of college, I had the following ritual with my roommate, an engineering major. After an all-nighter cramming for a test, I would tell him “Good luck on your test.” And with the enthusiasm and hubris only found in a 19-year-old, he would reply the same way every single time: “Luck is for fools!”

“Luck is what happens when preparation meets opportunity.” That’s what the Roman philosopher Seneca the Younger said. Seneca died 2,000 years ago, but certainly he had a bead on community pharmacy today.

That’s amazing foresight.

NCPA’s marketing and communications team may have had Seneca’s thoughts in mind when they created our new Opportunity Toolkit (https://www.ncpanet.org/innovation-center/ownership-resources/opportunity-toolkit) for NCPA members. Think of a toolkit in your garage, and you have the right idea — lots of things in there, and you may not use or need all of them. But they’re there when you do.

Our toolkit is full of helpful tools to aid you in bringing in customers when a competitor closes or a local pharmacy changes ownership. Those changes are a huge opportunity for you and your pharmacy, and with this toolkit, you’re prepared to act quickly.

For example, when Walgreens decided to buy 1,932 Rite-Aid stores, they said they would close nearly 600 stores.

And when a competitor closes, preparation is everything. First, take a look at the competitor. They may be closing, but chances are there was something they offered that you don’t offer. What brought people into the business? Now, look at your business and decide which of those things you can do as well or better (home delivery, immunizations, med sync, easy parking, DME, etc.).

Next, make sure your pharmacy website is up to date. People are in a hurry these days. They expect a website that’s fast and easy to navigate. Your website is a reflection of your business — it should be friendly and informative. Make sure your address, phone number, operating hours, and a map are prominently displayed.

Once those basics are in place, talk to prescribers and employers in your area. Tell them what you offer. Make sure they understand the value of your services and ask that they refer patients to you. Reach out to the employees of the competitor — staff pharmacists, techs, and front-end employees. If they’re a good fit, hire them. They can be a champion to their former customers.

These are just a few of the great tips you’ll find in our toolkit. But we offer so much more. Effective tools are more than a tip sheet. Our Opportunity Toolkit gives you talking points to use in conversations with patients, scripts for radio ads, flyers, car magnets, posters, sample ads, social media messages, bag stuffers and sample letters.

Why did we do all this? Quite simply, it’s because our members asked us for help. We’re always looking for ways to add value to your NCPA membership. We have a robust advocacy agenda that we work hard to carry out every day. We also have a communications and marketing plan, and our goal is to give you news and information you can use to help you build and develop your business. We do that through our qAM email newsletter, The Dose blog, and America’s Pharmacist® magazine, to name just a few. But a big part of our communication strategy involves listening. We want to know what members need, and we work to provide it.

If we can help you, talk to us. Let us know what you need, and we’ll do our best to prepare or identify tools that will help you be well prepared when opportunities come your way.

Dave Thomas, founder of the Wendy’s fast-food chain, said, “I think the harder you work, the more luck you have.” That’s true — but never forget we’re your partner in that hard work. Talk to us. Tell us how we can help you get lucky.

- B. Douglas Hoey, RPh, MBA
National Community Pharmacists Association CEO
Tacrolimus – tamsulosin mix-ups. Beware of the potential for mix-ups between tamsulosin, an alpha blocker used to treat benign prostatic hyperplasia, and the immunosuppressant tacrolimus. Recently it was discovered that a pharmacy inadvertently dispensed tamsulosin instead of tacrolimus. The omission of tacrolimus places the patient at high risk of organ rejection post-transplant. Including the purpose of the medication on the prescription and opening the bag at the point-of-sale can help catch this type of mix-up.

Opioid mix-ups. ISMP continues to receive reports of mix-ups between HYDROcodone-acetaminophen and oxyCODONE-acetaminophen combination products. While the exact causes of many of these errors remain a mystery, a number of regulatory and product changes may be contributing, even though some of these changes happened a few years ago. For example, all approved opioid-acetaminophen combination products are now limited to 325 mg of acetaminophen or less. To reduce the risk of mix-ups, consider the following strategies:

• Examine where you have these products stored. Close proximity and similar looking containers can increase the risk of mix-ups.
• Consider employing name differentiation strategies (e.g., tall man letters, bolding, highlighting) for the HYDROcodone and oxyCODONE portions of the product names.
• Prescribers should indicate on the prescription how much HYDROcodone or oxyCODONE as well as acetaminophen is intended. If the combination prescribed isn’t available, the pharmacist should contact the prescriber.
• At the point-of-sale, pharmacy staff should review each prescription container with the patient.
• Educate patients about the importance of reading all prescription and over-the-counter labels to ensure they are taking the correct medication and not taking multiple acetaminophen-containing products. Provide guidance to not exceed maximum recommended daily doses of acetaminophen.

Look-alike names—ribavirin and riboflavin. ISMP received a report from a pharmacist who has intercepted a couple prescribing mix-ups. The prescribers were attempting to order riboflavine (vitamin B2) 200 mg twice daily for migraine prophylaxis (an off-label indication). Instead, they incorrectly prescribed ribavirin, an antiviral used to treat hepatitis C infections. Each error was caught by the pharmacist during prospective drug utilization review at verification prior to counseling. The pharmacist had questioned if the patients in fact had a diagnosis of hepatitis C since no other hepatitis C medications were in the medication profiles. The prescribers were contacted and the prescriptions were changed to riboflavin 200mg twice daily for migraine.

Both ribavirin and riboflavin look and sound similar. In fact, both begin with the same sequence of letters—“rib”—increasing the risk of selection errors from computer pick lists. Overlap between the 200 mg dosage strength of ribavirin and the 200mg dose of riboflavin also may contribute to confusion and selection errors from electronic medication lists. Further complicating the situation is that some prescribers’ systems, drug information content, and specific formularies may only list riboflavin by its alternative name, vitamin B2. Thus, if a prescriber attempts to find riboflavin by only typing in the first three letters of the name (a functionality common to prescribing systems), only ribavirin will show up and may inevitably be chosen.

ISMP highly recommends that prescribers include the purpose of the medication with the prescription. Most look- and sound- alike name pairs have different indications. When prescribing riboflavin, including “vitamin B2” in the prescription can also help pharmacists and other practitioners to correctly identify the intended medication. Confirm a diagnosis of hepatitis C for any patient taking ribavirin. Assign time to provide counseling to patients and/or caregivers, especially for new prescriptions and those transferred from other pharmacies.
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INDEPENDENT PHARMACY IS OUR BUSINESS
Marie Smith Schwartz

From page 1

Mrs. Schwartz served on the College’s Council of Overseers and the late Arnold Schwartz had been a member of the Long Island University Board of Trustees.

The College of Pharmacy’s relationship with Arnold and Marie Schwartz began in January 1973, when I was about to graduate from the Brooklyn College of Pharmacy, aka BCP. Arnold had been asked to provide the seed money for the Arnold & Marie Schwartz International Drug Information Center (IDIC) by Provost Dean Arthur Zupko. The center was to be managed by Dr. Jack Rosenberg, one of the early pioneers in drug information and one of the early pharmacists to receive a Pharm.D. degree.

Then in 1976, with a federal grant pending by the federal Department of Health Education and Welfare (HEW), there was a shortfall of funds to complete the planned move of BCP from 600 Lafayette Avenue to the Brooklyn Campus of LIU. The plan was to would create a new teaching and laboratory complex for the College of Pharmacy and fully integrate the College of Pharmacy with the Brooklyn campus of Long Island University. The Schwartzes’ philanthropy made this new home possible and the Brooklyn College of Pharmacy was transformed into the Arnold & Marie Schwartz College of Pharmacy and Health Sciences of Long Island University.

Mr. and Mrs. Schwartz were leading supporters of health care and young people who entered health care benefited from their generosity. LIU and the College of Pharmacy in particular have been honored to have been one of the many institutions that Arnold and Marie Schwartz championed. Their enduring legacy will continue to benefit future generations at Long Island University.

Marie’s late husband, Arnold Schwartz, predeceased her on September 7, 1979 at the age of 74. The founder and former vice president of the Paragon Oil Company, Arnold, and later with Marie, became local philanthropists to health care, education and the arts.

Some history on Arnold and Marie Schwartz is in order. In 1925, Mr. Schwartz and his brothers founded Paragon Oil Company, which was then sold to Texaco Inc. in 1959. As their company prospered, Mr. Schwartz formed the Brookdale Foundation to serve the health and educational fields. Brookdale Hospital Medical Center in one of the poorest neighborhoods in Brooklyn and was one of Mr. and Mrs. Schwartz’s early focus of their philanthropy.

At New York University, where he served for many years as a trustee at the School of Medicine, he was responsible for setting up the Howard A. Rusk Professorship in Rehabilitation Research as well as providing funds for the Arnold and Marie Schwartz lecture hall building, the Saul J. Parker Institute for Research on Diseases of the Heart and Kidney, and the Arnold and Marie Schwartz Hall of Dental Sciences. He also provided the naming gift for the new 15-story, $22 million Arnold and Marie Schwartz Health Care Center.

Mr. Schwartz was a trustee of the National Symphony Orchestra in Washington, where he endowed a series of annual concerts. Another of his gifts was to the Metropolitan Opera Association for construction funds for the institution’s new atrium. He was also a trustee of Memorial Sloan-Kettering Cancer Center, where the 12-story Arnold and Marie Schwartz International Hall for Cancer Research was named in his honor. For many years, Mr. Schwartz, was chairman of the executive committee of the American Friends, Boys from Jerusalem in Jerusalem, where a new residence center has been named in his honor.

Prior to their marriage in 1970, Marie Smith Schwartz, had been a White House correspondent for The Washington Post for 16 years and was a past president of the American Newspaper Women’s Club. Other survivors included Arnold’s daughter by a previous marriage, Constance Schwartz Harris.

During the March 1994 American Pharmaceutical Association (now the American Pharmacist Association) annual convention which was held in Seattle, Marie Schwartz was awarded an honorary membership in the APHA. This honorary membership is conferred by the APHA Board of Trustees upon individuals, either within the profession of pharmacy or outside of it, whose activities and achievements have had a significant impact on public health, the profession, and its practitioners. Marie Schwartz was not a pharmacist so this was especially fitting to recognize Mrs. Schwartz for her input in healthcare in the New York metropolitan area. Dean Stephen M. Gross held a dinner reception in Seattle during the APHA annual convention honoring Marie Schwartz for the recognition bestowed upon her by the APHA. My wife and I attended the APHA convention and were fortunate to be present at the dinner honoring Mrs. Schwartz.

The contributions to Long Island University from Arnold and Marie Schwartz are almost too numerous to count. At a time when the Brooklyn Campus needed to expand, the Schwartzes contributed millions to fund the SALENA Library Learning Center, named for the parents of Arnold, Sam and Lena Schwartz. The Dessie Marr Smith Chapel is named for Marie’s mother. Later, the Schwartzes funded a renovation of the gymnasium which was renamed the Arnold & Marie Schwartz Athletic Center. When the Brooklyn Campus needed parking facilities, Arnold helped LIU Brooklyn purchase the Goldner building, for faculty and administrators’ parking. Since his passing, in 1979, Marie Schwartz continued the work they began together at

continued on page 22
PAAS has seen quite a few desk audits for compounded products that include lidocaine as an active ingredient. We have noticed a few problems when reviewing documentation for these claims.

First, many of the compounds call for “lidocaine 5%” but the prescriptions do not specify if this “5%” is the stock or final strength. Unless clarified, the prevailing assumption is that the compound has a FINAL strength of 5% lidocaine.

A second, and more important issue involves the actual compounding and the mathematical calculations. We have seen many pharmacies use lidocaine 5% stock ointment as the base and add numerous powders or crushed tablets of other active ingredients (e.g. gabapentin, cyclobenzaprine, ibuprofen) to make a compounded product that is intended to have a final 5% strength of lidocaine – this is mathematically impossible!

**Example Prescription**
- Gabapentin 6%-Ibuprofen 10%-Baclofen 2%-Cyclobenzaprine 2%- Lidocaine 5%, quantity 240 GM

- Assuming pharmacy uses 100% stock powders for gabapentin, ibuprofen, baclofen and cyclobenzaprine these ingredients will occupy 20% (6% + 10% + 2% + 2%) of the final 240 GM, or 48 GM
- If pharmacy uses lidocaine 5% ointment as the base this ingredient can only occupy 80% of 240 GM or 192 GM
- By definition the lidocaine is being DILUTED and will be less than 5% unless pharmacy adds another source of lidocaine (e.g. lidocaine 100% powder) to supplement
- Remember the dilution formula: $c_1v_1 = c_2v_2$ à (5% lidocaine stock) (192 GM) = (X% final lidocaine) (240 GM), X=4%
- Note: if pharmacy uses tablets as the source of ingredients instead of 100% stock powders there will be a significant volume/mass occupied by inactive excipients that must also be accounted for

**PAAS National** encourages pharmacies to double check their compounding protocols and calculations to ensure that final products are prepared correctly and refer to compounding resources for any standard formulations or staff training. If you have any questions email PAAS at info@paasnational.com or call 888-870-7227.

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**Marie Smith Schwartz**

LIU, funding endowed scholarships, laboratories, computer lab, lecture hall, and naming the dean’s suite and administrative offices in honor of her dear friend, Dean Stephen M. Gross. Mrs. Schwartz’s latest gift of nearly $400,000 came just over a year ago and was used to help refurbish student lecture halls.

A memorial service will be held for Marie Smith Schwartz on Saturday April 28, 2018 at 2 pm in the Church of the Transfiguration, 1 East 29th Street, New York, New York.

God Bless Marie Smith Schwartz.

Respectfully prepared and submitted by Jim Schiffer with insight and assistance from Patrick Campbell

Prepared April 3, 2018
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Caremark reimbursement changes were going into effect. PSSNY members were immediately activated to call their legislators and file complaints with the Department of Health’s Office of Health Insurance Plans. Meanwhile, PSSNY stayed in contact with the Medicaid Inspector General, the Attorney General’s office, as well as legislators.

Critical to this issue was the fact that Caremark was out of compliance with New York’s MAC appeal law and patient access was in jeopardy.

**Media Coverage**

Through the use of our Fight the PBM funds, PSSNY secured a media consultant that has resulted in significant coverage of pharmacy issues—primarily the contractual gag clauses that prohibited pharmacists from having alternative payment discussions with patients.

This became a hot topic as more and more journalists understood that the patient would not know when a medication’s cash price was less than their insurance co-pay.

We are continuing the effort to increase public awareness of PBM practices, the role of the pharmacist on the healthcare team and the impact both have on the care of the patient.

Some of the more powerful pieces include:

- **States Fight Back Against Unfair Prescription Pricing Practices** (WNYT.com, March 5, 2018)
- **Regulators Push to End Prescription Gag Clauses** (NBC News NY, February 27, 2018)

To see the all of the coverage, please visit: [www.pssny.org/pressroom](http://www.pssny.org/pressroom).

**Lobby Days**

The March 6 Lobby Day provided an in-person opportunity for more than 130 pharmacists to educate their legislators on our positions on the Executive State Budget proposals and on the impact of PBMs have on their businesses and patients. We focused our attention on:

- Opposing the Opioid Excise Tax;
- Supporting the introduction of legislation that would require PBMS to be registered and licensed in NYS; and
- Supporting the budget proposal that would expand pharmacists’ authority to immunize children ages 2+ for flu.

The April 17 Lobby Day isn’t just for students anymore. We are continuing our discussions on PBM practices as our lobbyists work to introduce legislation that was similar to the Governor’s proposal last session on registration and licensure of PBMs. We are in conversations with AM Gottfried and Senator Hannon to negotiate language acceptable to both houses and to identify bill sponsors. Now that the budget has passed this is PSSNY’s top priority.

**Influence of Media Coverage**

PSSNY has retained a consultant to build a media presence that has helped us get to where we are today. We are continuing the effort to increase awareness of PBM practices, the role of the pharmacist on the healthcare team and the impact both have on the care of the patient.

Some of the more powerful pieces include:

- **States Fight Back Against Unfair Prescription Pricing Practices** (WNYT.com, March 5, 2018)
- **Regulators Push to End Prescription Gag Clauses** (NBC News NY, February 27, 2018)

Please follow the PSSNY the website on a regular basis, ([www.pssny.org](http://www.pssny.org)) and your email inbox for breaking news on our legislative activities. Information can change quickly and often. The information in this article was accurate at the time the Journal went to press.

- Kathy Febraio, CAE
PSSNY Executive Director
You might be surprised, as I was. Use the information to educate yourself and your customers. Remember, you are a business owner and YOU VOTE. So do your patients, with whom you have more influence than you might at first imagine. We can educate our patients with information that can encourage change in our districts. Each of our Pharmacy can become a Political Action Center. We have thousands of patients that trust us with their lives and they would trust us with making recommendations for district candidates.

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Many thanks to all the volunteers, pharmacist and owners that attend 3/6 Lobby Day. The industry appreciates your support.

Thanks for your support.

~ Parthiv Shah, R.Ph.
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