WRITTEN TESTIMONY SUBMITTED REGARDING HF1752
Prescription drug purchasing program and benefit carve-out

By Adam Pavek, PharmD – Itasca Medical Care (Itasca County)

March 2, 2023

Thank you Chair Liebling, and Health Care Finance & Policy Committee Members. I am submitting this testimony in writing conveying my serious concerns about **HF1752** because I could not make the trip from my office in Grand Rapids.

My name is Adam Pavek, a pharmacist and the current Director of Pharmacy for Itasca Medical Care, Minnesota's original County-Based Purchasing (CBP) plan serving Itasca County. I have worked at three Minnesota-based pharmacy benefit organizations in my career. One of these jobs was for Minnesota DHS, managing the formulary and running the DHS Formulary Committee for five years.

I want to share with you my concerns with HF1752 and ultimately **ask the Committee to table the bill until clearer language can be crafted, a fiscal note completed and that fiscal note verfied by an independent third party**.

In general, **this bill as proposed lacks clear purpose, definable objectives and a fiscal note**. It appears to be written in a vague manner to carve out pharmacy adminstration to DHS, away from managed care and CBP. This kind of intent is more defined in HF693, a bill cleary stating its goal to eliminate managed care in public programs.

Here are my specific concerns and questions I have regarding the language in HF1752 as proposed:

1. The bill states that a duty of the commissioner shall be to make prescription drugs available "at the lowest possible cost" to program participants. In Minnesota, the commissioner has no authority to alter the cost of drugs to program participants.

   (Subd. 2. **Duties of commissioner.** The commissioner, through the Minnesota prescription drug purchasing program shall:

   (1) make prescription drugs available at the lowest possible cost to program participants;

2. How is the commissioner proposing to promote health through taking on the administration of the pharmacy benefit? How, specifically, will this promote the health of program participants?

   (2) promote health through the purchase and provision of discounted prescription drugs and coordination of comprehensive prescription benefit services for program participants;

3. How will these recommendations work? Who do they come from? How do you know they are at the best possible prices? What process is followed to ensure this?

   (3) maintain a list of prescription drugs recommended as the most effective prescription drugs available at the best possible prices.

4. Based on current DHS practices, those authorized to administer this program will likely be contracted out to third party vendors who do not live or operate their businesses in Minnesota. At IMCare we have local nurses, local pharmacists and local physicians who administer our pharmacy benefit and utilization management programs, focused on responding to local needs with transparency and accountability. By carving out pharmacy benefits, program participants and providers will suffer with remote call centers and long wait times, dealing with staff and administrators far removed from rural Minnesota.

5. How do you ensure continuity of care and ease of pharmacy benefit navigation if DHS FFS is made to be the only choice? Who will respond in the best interests of enrollees when this proposed system fails them and their providers?

6. Again, there is no fiscal note. Has DHS considered what it would cost to provide or contract for staff capacity necessary to administer the proposed prescription drug program and carve-out? Where is the cost-benefit analysis confirmed by an objective third party?

Thank you for allowing me to share these concerns and for your attention to this important matter. HF1752 as written and proposed would constitute a huge disservice to the people for whom we care for in rural Minnesota.

Sincerely yours,

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