HB

209

Senate Health, Education and Social Services Committee

Legislation Checklist

Bill number: HB 209

Sponsor: Governor

Date referred to committee: 5/11/85

Synopsis completed:

Fiscal note:

Further referrals: JUDICIARY, FINANCE

CONTACTS:

Kim Buscher/Rod Betit - DHSS 3355

Dave Swanson H 452-2463
W 452-2556 / 452-1514

Tom Miklautsch
456-8679 W
456 7606 H

file HB209

MEMORANDUM

TO: FILE
FROM: SANDRA
RE: STATE PAYMENTS TO PHARMACISTS UNDER G.R.MED
DATE: JULY 17, 1985

updated 8/14/85 (see next page)

Current Procedure

General Relief Medical Assistance (GRM) is provided under the General Relief program (AS 47.25.120). Under the broad authority of the statute the amount of financial assistance, the eligibility requirements (based on financial status), the medical programs covered, and how providers will be reimbursed are all determined by departmental regulation. Prescription drugs is one of the programs covered under GRM (7 AAC 47.200); pharmacists bill DHSS based on what they charge their customers.

HB 209

Introduced by Governor; passed House 22-18; currently in Senate HESS Committee. Would move prescription drugs out of the GRM program and under Medicaid (a federally regulated program with costs shared 50-50 by the state and federal governments). Opposed by many pharmacists because it establishes price controls (federal government sets standard rate per drug; DHSS reimburses based on the set rate rather than on the pharmacist's actual cost).

Emergency Regulations

Filed 6/29/85; public comment period (no hearings will be held) ends 7/31/85. Permanent regulations must be in place 120 days from filing date; won't differ substantially from emergency regulations. Establishes a price control. DHSS will not pay for a brand name drug when a generic one is available; reimbursement will be based on an estimated acquisition cost (per the "Blue Book") plus a dispensing fee ($5.15 in Anchorage; $5.50 elsewhere in state) plus a compounding fee (40¢/minute) less a $1 copayment required of each recipient, rather than on the pharmacist's actual cost; will not pay for over the counter drugs.

The emergency regulations are in response to the fact that the amount budgeted (proposed by the Governor and adopted by the legislature) for the GRM program was based on passage of HB 209 and is inadequate to continue the current reimbursement procedure. DHSS considered asking for a supplemental, but decided against it because of current budget restraints.

NOTE: Over the last two years DHSS has been revising its Medicaid and GRM programs with an eye toward cost containment.

Physicians - rates are based on the "usual, customary, and prevailing" rate for a specific service with reimbursement based on the 75th percentile (the reimbursement is what 75% of physicians charge for a specific service). Currently, rates are updated quarterly; emergency regulations filed 6/25/85 eliminate this provision for FY 86.

same for FY 87 —

Hospitals - regulations are being developed which would apply a 75th percentile criteria to the length of stay in a hospital (based on a national "patient activity" study).

Nursing Homes - emergency regulations were filed 6/25/85 which would limit the number of allowable physician visits per nursing home patient.

Prospective Rate Setting - under AS 47.07.070, rates of payment to a health facility are based on "a fair rate for reasonable costs incurred by the facility" as determined by the state Medicaid Rate Commission.

Concern: Pharmacists stand to lose money under the emergency regulations just as they would under the Medicaid price control. According to Swanson, a study published in American Pharmacy states that "58% of all responding pharmacists fill prescriptions with a product priced above the Medicaid limit and absorb the loss". (Medicaid and GRM specifically prohibit physicians/pharmacists from collecting a fee from the recipient in addition to what the programs pays, except for the copayment provision which is minimal.) The larger concern is that some pharmacists may "boycott" and refuse to serve Medicaid/GRM patients (as some physicians have done); DHSS says if this occurs they will contract with individual pharmacists to provide the service.

generally $1.00

Status. Some features of the emergency regulations are supported by the pharmacists, and were in fact recommended by them (copayment provision, no coverage of over-the-counter drugs). On 7/16/85 Miklautsch reported that DHSS (Betit) would reconsider a supplemental budget request for early next session if he had a commitment from a majority of legislatures to support it; Miklautsch is working on this. Meanwhile, the pharmacists are considering filing an injunction against the "acquisition cost" provision of the emergency regulations. They are interested in working with DHSS to find a middle ground -- a way of reducing state costs while not creating an economic hardship for the pharmacists and, ultimately, a potential hardship on persons in need of pharmaceutical services.

Contacts: Kim Busch (Rod Betit), DHSS 465-3355
Dave Swanson 452-2463 (H), 452-2556 (W)
(Tom Miklautsch)

8/14/85 Kim -

final regs -
no brand name if generic authorized by prescriber
can fill more than a 30-day supply
¢/ copayment
no OTC drugs
→ But no restriction on what pharmacists —

Need $896,000 supplemental

Will go back in Oct. w/ emergency regs. if looks like must get supplemental.

Sitka pharmacist - is only one — refused to serve!

rec 8-14-85
Revised per pharmacists concerns.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

7 AAC 47.200 is amended to read:

7 AAC 47.200 (12) prescribed drugs; (Eff. 3/23/78, Register 65; am 5/2/79, Register 70; am 4/15/82, Register 82; am 9/23/84, Register 91; am / / , Register)

Authority: AS 47.05.010
AS 47.25.195

7 AAC 47.270 is amended by adding a new section to read:

7 AAC 47.270 PRESCRIBED DRUGS AND MEDICAL SUPPLIES. (a) The division will not pay for a brand name multi-source prescription drug when a non-brand name drug of equal effectiveness is available and substitution is permitted by the prescriber.

(b) The division will pay the pharmacist's usual and customary charge to the public less the recipient co-payment amount.

(1) The co-payment is the financial obligation of the recipient, not the division, and must be collected by the pharmacist at the time of service.

(2) The co-payment amount is $1 for each prescription drug or supply.

(c) The division will not pay for more than a 30-day supply of a prescribed drug unless prior authorization has been obtained by the pharmacist from the division.

(d) The division will not pay for non-prescription drugs except insulin. The division in its discretion may grant an exception based on written information submitted on a request for authorization form.

(e) The division will only pay for prescribed medical supplies that have been assigned a current specific billing code number by the division. The division in its discretion may grant an exception based on written information submitted on a request for authorization form.

Authority: AS 47.05.010
AS 47.25.170

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

7 AAC 47 is amended by adding a new section to read:

7 AAC 47.290 DEFINITIONS. In 7 AAC 47.020--7 AAC 47.270

(1) "prescribed drug" means simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are prescribed by a physician or other licensed practitioner of the healing arts within the scope of this professional practice as defined and limited by federal and state law; and dispensed by a licensed pharmacist on a valid prescription that is recorded and maintained in the pharmacist's records. (Eff. / / , Register)

Authority: AS 47.05.010
AS 47.25.170

FEB 3 1986
FEB [illegible] 1986

FAIRBANKS
PROFESSIONAL PHARMACY, INC.

1001 NOBLE STREET
FAIRBANKS, ALASKA 99701
MAIL: P.O. BOX 1 – 99707
PHONE: (907)452-2556

January 30, 1986

Senator Bettye Fahrenkamp
Post Office Box V
Juneau, Alaska 99811

Attention: Sandra Shubert

Dear Sandra:

Enclosed please find copies of the documents we discussed on the phone yesterday. Hopefully this will serve to "clear the air" a bit regarding HB209 as passed by the House.

Should you or Bettye require further details regarding conversations recently held among Tom Miklautsch and myself with the Governor, Commissioner Pugh and Rod Betit, please do not hesitate to contact Tom and me. Tom is currently out of town, but I anticipate his return to the office on February 3.

Thanks for calling and for your concern.

Sincerely,

Dave Swanson

David L. Swanson

How compare to regs?

House-passed HB209? (see attached)

↳ simply reads, "DN will not pay for brand name prescription drug when non-brand name of equal effectiveness is available & substitution is permitted by the prescriber."

So no mention of: lower cost
notice posted at pharmacy

MEMORANDUM State of Alaska

TO Medical Care Advisory Committee Members

DATE December 19, 1985

FILE NO

TELEPHONE NO 465-3355

FROM Rod Betit, Director
Division of Medical Assistance

SUBJECT FY87 Budget

Governor Sheffield's FY87 budget decisions are now official. As promised, I am forwarding a copy of Governor Sheffield's budget letter, and the budget page disclosing the Governor's request for the Division of Medical Assistance (DMA). Some comments about the FY87 budget:

** The FY87 DMA budget request contains adequate additional funds to provide medical care for all new Medicaid clients expected in FY87.

** Additional funds are also included to pay for the new Soldotna nursing home, which is expected to serve primarily Medicaid eligible persons.

** No funds are included for increases in medical provider fees (i.e. hospitals, nursing homes, physicians, dentists or rural health claims, etc.).

** The dollars available to operate the GR Medical Program have been reduced by 50%. Only major medical problems that require hospital care, and pregnancy related services will be covered in FY87. Deductibles and other limits will also be implemented.

** No funding is included to add personal care services under Medicaid, or for continuation of GR Medical waivers. However, these services will likely be dealt with by the Legislature separate from the Governor's budget.

** While all funds have been removed from the Medical Assistance budget for prescription drugs, it is not the Governor's intent to eliminate prescription drug coverage in FY87. Rather, the plan is to use HB 209, which passed the House last session, as the vehicle to debate the issue of whether drugs should be funded under Medicaid or GR Medical. The Administration and the Pharmacy Association are already discussing this issue in a cooperative spirit in preparation for legislative hearings.

** The Catastrophic Illness Program will be reduced to $1.3 million.

** The MCAC budget is held at the FY86 level.

Overall the Department fared very well as pointed out in Governor Sheffield's letter. The choices confronting the Governor were obviously

very difficult. In the Department of Health and Social Services, priority was placed on children, elderly and disabled.

I look forward to working with the MCAC budget subcommittee as the debate on the FY87 Governor's budget gets underway. I hope to see you in March at the next MCAC meeting.

cc: Division of Medical Assistance Staff
Commissioner John R. Pugh
Deputy Commissioner Connie Sipe
Assistant Commissioner Karen Perdue
Jim Benz, HCFA Region X
Bill Parker, Special Assistant to
Governor Sheffield

STATE OF ALASKA 1985 LEGISLATIVE SESSION

FISCAL NOTE

Page 1 of 2 Revision Date:

REQUEST

Bill/Resolution No.: CSHB 209(Fin)
Title: Act relating to Pharmaceutical Med. Assistance for needy persons
Sponsor: Rules Committee
Requestor: House Finance Committee
Date of Request: 4/27/85

FISCAL DETAIL

Agency Affected: Health & Social Services
Program Category Affected: Social Economic Assistance for the General Population
BRU, Program or Subprogram(s) Affected: Medical Assistance

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL		25.0	0	0	0	0
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS		1450.0	1537.0	1629.0	1727.0	1830.0
800 MISCELLANEOUS						
TOTAL OPERATING		1475.0	1537.0	1629.0	1727.0	1830.0
CAPITAL						
REVENUE		1475.0	1537.0	1629.0	1727.0	1830.0

FUNDING: (Thousands of Dollars)

GENERAL FUND		325.0	318.0	337.0	357.0	378.0
FEDERAL FUNDS		1150.0	1219.0	1292.0	1370.0	1452.0
OTHER						
TOTAL		1475.0	1537.0	1629.0	1727.0	1830.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: Attach a separate page if necessary

Prepared By: Al Adams, Chair Phone: 465-3706
Division: House Finance Committee Date: 4/27/85

Approved by Commissioner: Date:
Agency:

ANALYSIS CSHB 209(Fin) Page 2 of 2

"An Act relating to pharmaceutical medical assistance for needy persons"

Fiscal impact is in three parts: 1) added federal revenue earned by moving prescribed drugs under Medicaid; 2) increased state funds needed to pay pharmacists above the Medicaid price as required by Section 5 if permitted by federal law; and 3) increased state funds to modify the department's data processing system to effect the payment requirements of Section 5. This would be a one-time expense.

FY 86 Governor Request

Added Federal Revenues

	GF	TOTAL
General Relief Medical	10,769.1	10,769.1
Remove Pharmacy	(1,100.0)	(1,000.0)
GRH Balance	9,669.1	9,669.1

	FED	GFM	I.A.	TOTAL
Medicaid	32,909.5	33,696.5	633.3	67,239.3
Add Pharmacy	1,150.0	1,100.0	-0-	2,250.0
Medicaid Balance	34,059.5	34,496.5	633.3	69,489.3

With a move of prescription drugs from General Relief Medical Component to Medicaid component, Medicaid funds would become available at a 50/50 ratio. However, attendant to the federal funds would come mandatory federal regulations defining which pharmaceuticals are allowable and the prices to be paid for each.

6% is assumed as annual inflation for prescription drugs.

This fiscal note replaces the fiscal note dated 2/13/85 which shows overall program savings. This fiscal note reflects budget changes needed to the Governor's proposed FY 86 budget and does not show the $1,400.0 state G.F. savings already incorporated into the Governor's G.R. Medical budget.

Increased State Expenditures Related to Section 5.:

If the department were to pay pharmacists at their usual and customary price rather than the Medicaid allowable price, the difference in total prescribed drug payments could be $300.0 annually. None of this added expense would be federally reimbursable. This $300.0 is not included in the Governor's FY 86 budget request. The Senate version of the FY 86 budget already contains this $300.0 special fund. The House budget does not.

System Modification Expenses:

The Department's data system is presently capable of processing pharmacy billings using federal Medicaid pricing rules. If the provisions of Section 5 were to be adopted, the department's data system would require modification to compute the state only payments required in addition to the Medicaid payments. This is a one-time system change. This price, $25,000, is a "best guess" pending detailed analysis of the actual effort required to effect this change.

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

POUCH K – STATE CAPITOL
JUNEAU, ALASKA 99811
PHONE: (907) 465-3600

December 20, 1985

M E M O R A N D U M

TO: Honorable Bill Sheffield
Governor

FROM: Harold M. Brown
Attorney General

RE: Attached Committee Substitute for CSHB 209(Fin), relating to the substitution of generic drugs by pharmacists
Our file: 377-059-86

Attached is a Senate Committee Substitute (SCS) for CSHB 209(Fin), relating to substitution of generic drugs by pharmacists. The Department of Health and Social Services (DHSS) originally requested a new bill on this subject, and the request was approved by Ray Gillespie on September 17, 1985. In subsequent discussions with DHSS staff, it was decided to draft an SCS for CSHB 209(Fin). The SCS would make it easier for pharmacists to substitute generic drugs for more expensive, but nearly identical, brand name drugs, and it would require pharmacists to notify purchasers if a cheaper substitute is available in the state but is not provided.

HB 209 was introduced at your request last session (our file 377-163-85) to bring payment for prescription drugs under the medicaid program, which imposes cost limits, instead of under the general relief assistance program, which does not impose cost limits. Provisions very similar to those in the attached SCS were added by the House Health, Education and Social Services Committee in CSHB 209(HESS), and maintained by the House Finance Committee in CSHB 209(Fin). CSHB 209(Fin) passed the House, and currently resides in the Senate HESS Committee.

Industry opposition to the original medicaid provisions of the bill, and potential Senate opposition, have prompted DHSS to request this SCS which eliminates those provisions. Please note, however, that DHSS wishes this committee substitute to be held in your office. The department will pursue passage of the current version, CSHB 209(Fin). If unsuccessful, the department will request that the attached version be forwarded to the committee. If the Senate HESS Committee passes CSHB 209(Fin) out of their committee, and the bill becomes permanently stalled in another committee, the bill

designation for the committee substitute, and the transmittal letter, will need to be changed accordingly before delivery to that other committee.

Attached is a draft transmittal letter to the chair of the Senate HESS Committee, explaining the differences between the attached version of HB 209 and the version currently before the committee.

HMB:PBF:md

cc w/enc.: Hon. John Pugh, Commissioner
Dept. of Health & Social Services

Hon. Loren Lounsbury, Commissioner
Dept. of Commerce & Economic Development

William Larson, Chair
Board of Pharmacy
Dept. of Commerce & Economic Development

D R A F T

Honorable Bettye Fahrenkamp
Chairman, Health, Education and
Social Services Committee
Alaska State Senate
P.O. Box V
Juneau, Alaska 99811

Dear Senator Fahrenkamp:

Attached for consideration by your committee is a proposed committee substitute for CSHB 209(Fin), relating to the substitution of generic drugs by pharmacists.

CSHB 209(Fin), currently before your committee, relates to that substitution and to a change to the Medicaid program regarding pharmaceuticals. The attached version of the bill sets out only AS 08.80.295. It makes minor changes in CSHB 209(Fin)'s amendments to AS 08.80.295(a), including relocating the substance of AS 08.80.295(d) to page 1, lines 15 and 16 (subsection (d) is subsequently deleted on page 2 of the bill). Another minor change in wording appears on page 1, lines 10 and 11. In addition, on page 1, lines 21 -- 24, language is added to require pharmacists to inform purchasers of prescription drugs if an appropriate substitute generic drug is available in Alaska but is not substituted. The repeals of AS 08.80.295(b), (c), and (f) in sec. 8 of CSHB 209(Fin) appear as deletions of those subsections on pages 1 and 2 of the attached version. New AS 08.80.295(i) and (j), added in sec. 2 of CSHB 209(Fin), appear as new AS 08.80.295(h) and (i), on pages 3 and 4 of the bill. Existing subsection (h), containing definitions for the section, is redesignated as subsection (j). The unnecessary phrase "in some cases," which appears on page 2, line 1, of CSHB 209(Fin), has

been dropped from what is AS 08.80.295(i) in the attached version of the bill.

The changes to AS 08.80.295(g), on pages 2 and 3 of the bill, are stylistic changes only.

This revised and shortened version of the bill also eliminates all changes, additions, and repeals relating to AS 47.07, concerning medicaid, which are made by secs. 3 -- 7 and 9 of CSHB 209(Fin).

I urge adoption of this proposed committee substitute to make it easier and more common for pharmacists to substitute generic drugs for more expensive, but nearly identical, brand name drugs.

Sincerely,

Bill Sheffield
Governor

Original sponsor: Rules/Governor

IN THE HOUSE

BY THE HEALTH EDUCATION AND SOCIAL SERVICES COMMITTEE

SENATE CS FOR CS FOR HOUSE BILL NO. 209(HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to substitution of generic drugs by pharmacists; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 08.80.295 is amended to read:

Sec. 08.80.295. SUBSTITUTION. (a) Unless the prescriber states in writing on a prescription that the prescription is to be dispensed only as written, a [EXCEPT AS LIMITED BY (b) AND (c) OF THIS SECTION, WITH THE CONSENT OF THE PURCHASER, THE] pharmacist may substitute a drug product with the same generic name in the same strength, quantity, dose and dosage form as the prescribed drug, if the substitute drug is less costly and [WHICH] is, in the pharmacist's professional opinion, therapeutically equivalent and meets the standards of (g) of this section. The [UPON SUBSTITUTION THE] pharmacist shall notify the purchaser [AND THE PERSON WHO PRESCRIBED THE DRUG] of the substitution, and shall record on the prescription and keep a record of the name and manufacturer of the drug substituted. If an appropriate substitute drug is available in the state but is not substituted by the pharmacist, the pharmacist shall so inform the purchaser and provide the reason it was not substituted.

added from House-passed version

added - not in House-passed version

(b) [A PERSON AUTHORIZED TO PRESCRIBE DRUGS SHALL SPECIFY IN WRITING OR BY ORAL COMMUNICATION WHETHER OR NOT THE PHARMACIST MAY SUBSTITUTE A DRUG UNDER (a) OF THIS SECTION. WRITTEN SPECIFICATION MAY BE ACCOMPLISHED EITHER BY (1) THE PHYSICIAN PERSONALLY INITIALING OR CHECKING THE APPROPRIATE BOX ON A PRESCRIPTION ORDER FORM LABELED

"DISPENSE AS WRITTEN" OR "SUBSTITUTION ALLOWED"; OR (2) BY HANDWRITING ON THE PRESCRIPTION ORDER. IF THE PHYSICIAN FAILS OR NEGLECTS TO GIVE WRITTEN SPECIFICATION, THE PRESCRIPTION SHALL BE DISPENSED AS WRITTEN. IF THE PERSON COMMUNICATING THE SPECIFICATION DOES SO ORALLY, THE PHARMACIST SHALL INDICATE THAT FACT IN HANDWRITING ON THE WRITTEN COPY OF THE PRESCRIPTION ORDER.]

(c) [PREPRINTED PRESCRIPTION ORDER FORMS USED BY A PERSON AUTHORIZED TO PRESCRIBE DRUGS SHALL CONTAIN BOXES LABELED "DISPENSE AS WRITTEN" AND "SUBSTITUTION ALLOWED" TO BE CHECKED OR INITIALED BY THE PERSON ISSUING THE PRESCRIPTION.]

(d) [A PHARMACIST SHALL SUBSTITUTE A DRUG PRODUCT UNDER (a) OF THIS SECTION ONLY WHEN THERE WILL BE A SAVINGS IN COST TO THE PURCHASER.] not repealed in House version.

(e) Repealed by sec. 31, ch. 6, SLA 1984.

(f) [IF A PERSON AUTHORIZED TO PRESCRIBE DRUGS IS TEMPORARILY UNAVAILABLE, THE PHARMACIST MAY, IF THE PHARMACIST CANNOT SUPPLY THE DRUG REQUESTED, SUBSTITUTE A DRUG OR PREPARATION OF APPROXIMATELY EQUAL THERAPEUTIC VALUE SO LONG AS THE PHARMACIST NOTIFIES THE AUTHOR OF THE PRESCRIPTION AT AN EARLY OPPORTUNITY. THE PHARMACIST IN ALL CASES OF SUBSTITUTION, EXCEPT WHEN SPECIFICALLY INDICATED TO THE CONTRARY BY THE PRESCRIBER, SHALL RELATE THE NATURE OF THE CHANGE TO THE PURCHASER.]

(g) A pharmacist may not substitute a drug [PRODUCT] under [THE PROVISIONS OF] this section unless the manufacturer of the substitute drug has met [IT HAS BEEN MANUFACTURED WITH] the following minimum good manufacturing standards and practices: wording not changed in House - passed version.

(1) maintain quality control standards equal to those of the Food and Drug Administration;

(2) comply with regulations promulgated by the Food and

Drug Administration;

(3) mark products with identification code or monogram;

(4) label products with expiration date;

(5) provide reasonable services to accept returned goods that have reached their expiration date;

(6) maintain 24-hour resources for product information where practicable and financially feasible;

(7) maintain recall capabilities for unsafe or defective drugs;

(8) has [SHALL] not refused [REFUSE] to sell to any properly licensed pharmacy.

(h) A pharmacist who substitutes a drug in compliance with this section incurs no greater liability in filling the prescription by dispensing the equivalent drug product than would be incurred in filling the prescription by dispensing the prescribed brand name drug.

(i) Every pharmacy shall post a sign in a location easily seen by patrons at the counter where prescriptions are dispensed, stating that "Under Alaska law a therapeutically equivalent but less expensive drug may be substituted for the drug prescribed by your doctor. Please consult your pharmacist or physician." The printing on the sign must be in block letters not less than one inch in height.

(j) As used in this section, unless the context requires otherwise,

(1) "brand name" means the proprietary or trade name selected by the manufacturer and placed upon a drug, its container, label, or wrapping at the time of packaging;

(2) "generic name" means the official title of a drug or drug ingredients published in the latest edition of a nationally recognized pharmacopoeia or formulary;

(3) "substitute" means to dispense without prescriber's express authorization a different drug product in place of the drug ordered or prescribed;

(4) "therapeutically equivalent" mans drugs that will provide essentially the same efficacy and toxicity when administered to an individual in the same dosage regimen.

* Sec. 2. This Act takes effect October 1, 1986.

+ House-passed version added pharmaceuticals to Medicaid (for 2 yrs. only)

MEMORANDUM State of Alaska

TO: Honorable John Pugh
Commissioner
Department of Health & Social Services

DATE: November 21, 1985

FILE NO: 377-059-86

TELEPHONE NO: 465-3600

FROM: Harold M. Brown
Attorney General

By: Peter B. Froehlich
Assistant Attorney General
Legislation/Regulations Section

SUBJECT: Proposed CS for HB 209 on substitution of generic drugs by pharmacists

I have attached a copy of a draft CS for HB 209 which deletes all provisions relating to medicaid, maintains the provisions added by the House Health, Education and Social Services Committee CS on drug substitution by pharmacists, and adds a requirement that pharmacists notify purchasers when a less costly substitute exists but is not used. This latter addition is an alternative to making substitution mandatory as you originally proposed on your August 21, 1986 Legislative Request Form and discussed at our September 17th meeting with Ray Gillespie.

Kim Busch and Rod Betit of your division of medical assistance agree in concept with this alternative approach. In your November 19th meeting with Art Peterson you suggested that we draft this proposal as a CS rather than as a new bill.

We plan to deliver this CS to the governor's office in final form on November 29th so please give us your comments before that date.

PBF:md

cc w/enc.: Hon. Loren Lounsbury, Commissioner
Dept. of Commerce & Economic Development

Richard Long, Acting Director
Div. of Occupational Licensing
Dept. of Commerce & Economic Development

Rod Betit, Director
Div. of Medical Assistance
Dept. of Health & Social Services

William Larson, Chair
Board of Pharmacy
Dept. of Commerce & Economic Development

Offered: 4/29/85
Referred: Rules

Original sponsor: Rules/Governor

IN THE HOUSE BY THE FINANCE COMMITTEE

CS FOR HOUSE BILL NO. 209 (Finance)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to substitution of generic drugs by pharmacists; adding pharmaceuticals to the Medicaid program; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 08.80.295(a) is amended to read:

(a) Unless the prescriber expressly states that a prescription is to be dispensed only as written [EXCEPT AS LIMITED BY (b) AND (c) OF THIS SECTION, WITH THE CONSENT OF THE PURCHASER], the pharmacist may substitute a drug product with the same generic name in the same strength, quantity, dose and dosage form as the prescription, provided the substitute drug [PRESCRIBED DRUG WHICH] is, in the pharmacist's professional opinion, therapeutically equivalent and meets the standards of (g) of this section. The [UPON SUBSTITUTION THE] pharmacist shall notify the purchaser [AND THE PERSON WHO PRESCRIBED THE DRUG] of the substitution, and shall record on the prescription and keep a record of the name and manufacturer of the drug substituted.

* Sec. 2. AS 08.80.295 is amended by adding new subsections to read:

(i) A pharmacist who substitutes a drug in compliance with this section incurs no greater liability in filling the prescription by dispensing the equivalent drug product than would be incurred in filling the prescription by dispensing the prescribed brand name drug.

(j) Every pharmacy shall post a sign in a location easily seen by patrons at the counter where prescriptions are dispensed stating that "Under Alaska law a therapeutically equivalent but less expensive

drug may, in some cases, be substituted for the drug prescribed by your doctor. Please consult your pharmacist or physician." The printing on the sign shall be in block letters not less than one inch in height.

* Sec. 3. AS 47.07.030 is amended to read:

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include inpatient hospital, outpatient hospital, rural health clinic, outpatient surgical care centers, laboratory and X-ray, refractions and eye examinations by ophthalmologists or optometrists, eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, inpatient psychiatric hospital for persons age 65 or older and persons under age 21, skilled and intermediate nursing home, physician, nurse midwife, home health care services, early periodic screening diagnosis and treatment of persons under 21 years of age, clinic services, treatment of speech, hearing and language disorders, physical therapy, occupational therapy, prosthetic devices and medical supplies, long-term care noninstitutional services, <u>prescribed drugs,</u> and reasonable transportation to and from the point of medical care. Additional services may not be provided unless approved by the legislature.

* Sec. 4. AS 47.07.035 is amended to read:

Sec. 47.07.035. PRIORITY OF SERVICES. If the funding in a fiscal year is inadequate to finance the total medical assistance program under this chapter, the department shall, to the extent that federal law and funding permits, provide medical assistance in the following order:

(1) aged, blind, or disabled persons who

(A) do not receive supplemental security income under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act) because

they do not meet income and resources requirements; and

(B) are eligible to receive an optional state supplementary payment;

(2) persons in a medical or intermediate care facility

(A) whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act); and

(B) who would not be eligible for an optional state supplementary payment if they left the facility;

(3) persons under 21 years of age

(A) who are under the supervision of the department;

(B) whose maintenance is paid in whole or in part from public funds; and

(C) who are in foster homes or private child-care institutions;

(4) persons under 21 years of age who

(A) receive treatment in a psychiatric hospital; and

(B) are financially eligible as determined by the standards of 42 U.S.C. 601 - 615 (Title IV-A, Social Security Act, Aid to Families with Dependent Children);

(5) persons under 21 years of age who are

(A) in an institution designated by the department as an intermediate care facility for the mentally retarded; and

(B) financially eligible as determined by the standards of the federal aid to families with dependent children program;

(6) women who are pregnant;

(7) persons under 21 years of age who do not qualify for

benefits under the federal aid to families with dependent children program because they are not dependent children;

(8) intermediate nursing home services;

(9) prescribed drugs;

(10) eye examinations by an ophthalmologist or optometrist; or eyeglasses prescribed by a physician skilled in the diseases of the eye or by an optometrist;

(11) [(10)] treatment of speech, hearing, or language disorders;

(12) [(11)] physical or occupational therapy;

(13) [(12)] care at an intermediate care facility for the mentally retarded;

(14) [(13)] care at an inpatient psychiatric facility;

(15) [(14)] community mental health clinic services;

(16) [(15)] surgical care center services;

(17) [(16)] nurse midwife services;

(18) [(17)] medical supplies and equipment;

(19) [(18)] long-term care noninstitutional services.

* Sec. 5. AS 47.07 is amended by adding a new section to read:

Sec. 47.07.200. PAYMENT FOR PRESCRIBED DRUGS. Payment to a pharmacist for that portion of prescribed drug expenses reimbursable under Medicaid shall be made in accordance with 42 C.F.R. 447.331, 447.332, 447.333, and 447.334. If permitted under federal law,

(1) the payment to a pharmacist for prescribed drugs shall be made in accordance with a formula based on the usual and customary charges for those drugs; and

(2) an amount equal to the usual and customary charges for the drugs minus the portion of the drug expenses reimbursable under Medicaid shall be paid from state general relief medical funds.

* Sec. 6. AS 47.07.900 is amended by adding a new paragraph to read:

(7) "prescribed drugs" has the meaning given in 42 CFR 440.120.

* Sec. 7. AS 47.07.030 is amended to read:

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include inpatient hospital, outpatient hospital, rural health clinic, outpatient surgical care centers, laboratory and X-ray, refractions and eye examinations by ophthalmologists or optometrists, eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, inpatient psychiatric hospital for persons age 65 or older and persons under age 21, skilled and intermediate nursing home, physician, nurse midwife, home health care services, early periodic screening diagnosis and treatment of persons under 21 years of age, clinic services, treatment of speech, hearing and language disorders, physical therapy, occupational therapy, prosthetic devices and medical supplies, long-term care noninstitutional services, [PRESCRIBED DRUGS,] and reasonable transportation to and from the point of medical care. Additional services may not be provided unless approved by the legislature.

* Sec. 8. AS 08.80.295(b), (c), and (f) are repealed.

* Sec. 9. AS 47.07.035(9), 47.07.200, and 47.07.900(7) are repealed.

* Sec. 10. Sections 1 - 6 and 8 of this Act take effect October 1, 1985.

* Sec. 11. Sections 7 and 9 of this Act take effect July 1, 1987.

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAL ASSISTANCE

BILL SHEFFIELD, GOVERNOR

POUCH H-07
JUNEAU, ALASKA 99811
PHONE:
(907)
465-3355

February 4, 1985

The Honorable Joe Josephson
Pouch V
Juneau, Alaska 99811

Dear Senator Josephson:

During a recent Senate HESS Committee meeting you requested copies of any bills previously filed in the Legislature that would have moved prescribed drugs from General Relief Medical to Medicaid in order to earn federal funds.

Per our conversation on January 31, 1985 I was not able to come up with all the legislative proposals that have been considered because our records only go back three years. However, I did locate our documents on Senate Bill 817 from the 1982 session.

The April 6, 1982 Committee Substitute for SB817 wbuld have added prescribed drugs to Medicaid (please note line 25 on page 1). Commissioner Helen Beirne sent letters to several Legislators explaining the affect of this change (please note attached copies dated April 23, 1982). Senate Bill 817 was subsequently passed by the Legislature without the prescribed drug change included (please note copy of final bill).

House Bill 41 during the 1981 session also attempted this change. I do not have copies of that in my files.

If I may provide any additional information, please let me know.

Sincerely,

Rod Betit
Director

cc: Commissioner Pugh
Deputy Commissioner Sipe

LAWS OF ALASKA

1982

Source
CSSB 817(Fin)

Chapter No.
132

AN ACT

Relating to medical assistance for needy persons; and providing for an effective date.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

THE ACT FOLLOWS ON PAGE 1, LINE 9

UNDERLINED MATERIAL INDICATES TEXT THAT IS BEING ADDED TO THE LAW AND BRACKETED MATERIAL IN CAPITAL LETTERS INDICATES DELETIONS FROM THE LAW; COMPLETELY NEW TEXT OR MATERIAL REPEALED AND RE-ENACTED IS IDENTIFIED IN THE INTRODUCTORY LINE OF EACH BILL SECTION.

Approved by the Governor: June 24, 1982
Actual Effective Date: June 25, 1982

Chapter 132

AN ACT

Relating to medical assistance for needy persons; and providing for an effective date.

---

* Section 1. AS 47.07.020(b) is amended by adding new paragraphs to read:

(8) persons under 21 years of age who would be eligible for benefits under the federal aid to families with dependent children program, but who do not qualify because they are not dependent children;

(9) women who are pregnant.

* Sec. 2. AS 47.07.030 is amended to read:

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include inpatient hospital, outpatient hospital, rural health clinic, outpatient surgical care centers, laboratory and X-ray, refractions and eye examinations by ophthalmologists or optometrists, eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, inpatient psychiatric hospital for persons age 65 or older and persons under age 21, skilled and intermediate nursing home, physician, nurse midwife, home health care services, early periodic screening diagnosis and treatment of persons under 21 years of age, clinic services, treatment of speech, hearing and language disorders, <u>physical therapy, occupational therapy, prosthetic devices and medical supplies, long-term care noninstitutional services,</u> and reasonable transportation to and from the point of medical care. No additional services may be provided unless approved by the legislature.

* Sec. 3. AS 47.07 is amended by adding a new section to read:

Chapter 132

Sec. 47.07.035. PRIORITY OF SERVICES. If the funding in a fiscal year is inadequate to finance the total medical assistance program under this chapter, the department shall, to the extent that federal law and funding permits, provide medical assistance in the following order:

(1) aged, blind, or disabled persons who

(A) do not receive supplemental security income under Title XVI of the Social Security Act because they do not meet income and resources requirements; and

(B) are eligible to receive an optional state supplementary payment;

(2) persons in a medical or intermediate care facility

(A) whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under Title XVI of the Social Security Act; and

(B) who would not be eligible for an optional state supplementary payment if they left the facility;

(3) persons under 21 years of age

(A) who are under the supervision of the department;

(B) whose maintenance is paid in whole or in part from public funds; and

(C) who are in foster homes or private child-care institutions;

(4) persons under 21 years of age who

(A) receive treatment in a psychiatric hospital; and

(B) are financially eligible as determined by the standards of Part A of Title IV of the Social Security Act;

(5) persons under 21 years of age who are

(A) in an institution designated by the department as an intermediate care facility for the mentally retarded; and

(B) financially eligible as determined by the standards of the federal aid to families with dependent children program;

(6) women who are pregnant;

(7) persons under 21 years of age who do not qualify for benefits under the federal aid to families with dependent children program because they are not dependent children;

(8) intermediate nursing home services;

(9) eye examinations by an ophthalmologist or optometrist; or eyeglasses prescribed by a physician skilled in the diseases of the eye or by an optometrist;

(10) treatment of speech, hearing, or language disorders;

(11) physical or occupational therapy;

(12) care at an intermediate care facility for the mentally retarded;

(13) care at an inpatient psychiatric facility;

(14) community mental health clinic services;

(15) surgical care center services;

(16) nurse midwife services;

(17) medical supplies and equipment;

(18) long-term care noninstitutional services.

* Sec. 4. AS 47.07.080(4) is repealed and reenacted to read:

(4) "clinic services" means services provided by state-approved outpatient community mental health clinics that receive grants under AS 47.30.520 - 47.30.620, state-operated community mental health clinics, and physician clinics.

* Sec. 5. This Act takes effect immediately in accordance with AS 01.10.-070(c).

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

POUCH H 01
JUNEAU, ALASKA 99811
PHONE: 465-3030

April 23, 1982 DOCUMENT NO. 150-82

The Honorable Arliss Sturgulewski
Senator
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Re: Senate Bill 817

Dear Senator Sturgulewski:

You requested clarification of the pharmaceutical issue involved in CSSB 817 and the Department's position on its deletion from the bill. From the outset I would like to make it clear that the Department strongly supports CSSB 817 even if the pharmaceutical change is deleted. Although for reasons elaborated below the pharmaceutical transfer would increase our FY83 purchasing power by nearly $1 million, the remaining provisions of CSSB 817 are even more critical and require legislative passage this session.

As you know, pharmacies currently provide drugs to Medicaid and General Relief Medical recipients through the General Relief Program paid solely from state funds. Pharmacy costs are expected to be $1.7 million in FY83.

Senate Bill 817 would, among other things, move pharmaceuticals for Medicaid recipients under Medicaid where the State would receive 48% cost sharing by the federal government for pharmaceutical costs. The sole federal condition for accepting a 48% cost sharing for pharmaceuticals is that Alaska begin paying pharmacists on a formulary basis rather than actual charges. As the Department intended to establish a formulary anyway in FY83, this federal requirement did not present a major problem. On the average this could represent a 15% reduction below actual charges for pharmacists.

It is our understanding that pharmacists oppose this change primarily because of the greater reimbursement flexibility they perceive under General Medical than Medicaid. Although we appreciate this view, the Department will be reimbursing all medical providers, to include pharmacists, at a reduced rate in FY83 if CSSB 817 fails to pass this session.

The purpose of CSSB 817 is to stretch the purchasing power of limited state funds by maximizing federal earnings in order to ensure that all of Alaska's needy children continue to receive a full range of medical services in FY83, and that provider rate reductions are minimized.

Removing the pharmaceutical transfer from CSSB 817 does not make the bill any less critical, but will reduce our purchasing power by nearly $1 million as we will not be earning federal funds for this item so long as it remains under GR Medical. This $1 million would, by our estimate, have purchased medical services for approximately an additional 1000 persons in FY83.

Again, the Department very strongly supports passage of CSSB 817 even without the pharmaceutical transfer included, as without the remaining provisions of CSSB 817, a great many children from low-income families may be limited to receiving only emergency medical services in FY83. The remaining provisions of CSSB 817 would prevent this from happening.

I sincerely hope this letter has served to clarify the Department's views on the pharmaceutical issue, and the criticality of CSSB 817 to our FY83 medical program even if the pharmaceutical transfer is removed from the bill.

Sincerely,

Helen D. Beirne
Commissioner

cc: Allen Korhonen
Rod Betit

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

POUCH H 01
JUNEAU, ALASKA 99811
PHONE: 465-3030

April 23, 1982 DOCUMENT NO. 150-82

The Honorable Richard Eliason
Senator
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Re: Senate Bill 817

Dear Senator Eliason:

You requested clarification of the pharmaceutical issue involved in CSSB 817 and the Department's position on its deletion from the bill. From the outset I would like to make it clear that the Department strongly supports CSSB 817 even if the pharmaceutical change is deleted. Although for reasons elaborated below the pharmaceutical transfer would increase our FY83 purchasing power by nearly $1 million, the remaining provisions of CSSB 817 are even more critical and require legislative passage this session.

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Senate Bill 817 would, among other things, move pharmaceuticals for Medicaid recipients under Medicaid where the State would receive 48% cost sharing by the federal government for pharmaceutical costs. The sole federal condition for accepting a 48% cost sharing for pharmaceuticals is that Alaska begin paying pharmacists on a formulary basis rather than actual charges. As the Department intended to establish a formulary anyway in FY83, this federal requirement did not present a major problem. On the average this could represent a 15% reduction below actual charges for pharmacists.

It is our understanding that pharmacists oppose this change primarily because of the greater reimbursement flexibility they perceive under GR Medical than Medicaid. Although we appreciate this view, the Department will be reimbursing all medical providers, to include pharmacists, at a reduced rate in FY83 if CSSB 817 fails to pass this session.

The purpose of CSSB 817 is to stretch the purchasing power of limited state funds by maximizing federal earnings in order to ensure that all of Alaska's needy children continue to receive a full range of medical services in FY83, and that provider rate reductions are minimized.

Removing the pharmaceutical transfer from CSSB 817 does not make the bill any less critical, but will reduce our purchasing power by nearly $1 million as we will not be earning federal funds for this item so long as it remains under GR Medical. This $1 million would, by our estimate, have purchased medical services for approximately an additional 1000 persons in FY83.

Again, the Department very strongly supports passage of CSSB 817 even without the pharmaceutical transfer included, as without the remaining provisions of CSSB 817, a great many children from low-income families may be limited to receiving only emergency medical services in FY83. The remaining provisions of CSSB 817 would prevent this from happening.

I sincerely hope this letter has served to clarify the Department's views on the pharmaceutical issue, and the criticality of CSSB 817 to our FY83 medical program even if the pharmaceutical transfer is removed from the bill.

Sincerely,

Helen D. Beirne

Helen D. Beirne
Commissioner

cc: Allen Korhonen
Rod Betit

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

POUCH H 01
JUNEAU, ALASKA 99811
PHONE: 465-3030

April 23, 1982 DOCUMENT NO. 150-82

The Honorable Frank Ferguson
Senator
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Re: Senate Bill 817

Dear Senator Ferguson:

I would like to provide additional clarification of the pharmaceutical issue involved in CSSB 817 and the Department's position on its deletion from the bill. From the outset I would like to make it clear that the Department strongly supports CSSB 817 even if the pharmaceutical change is deleted. Although for reasons elaborated below the pharmaceutical transfer would increase our FY83 purchasing power by nearly $1 million, the remaining provisions of CSSB 817 are even more critical and require legislative passage this session.

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Removing the pharmaceutical transfer from CSSB 817 does not make the bill any less critical, but will reduce our purchasing power by nearly $1 million as we will not be earning federal funds for this item so long as it remains under GR Medical. This $1 million would, by our estimate, have purchased medical services for approximately an additional 1000 persons in FY83.

Again, the Department very strongly supports passage of CSSB 817 even without the pharmaceutical transfer included, as without the remaining provisions of CSSB 817, a great many children from low-income families may be limited to receiving only emergency medical services in FY83. The remaining provisions of CSSB 817 would prevent this from happening.

I sincerely hope this letter has served to clarify the Department's views on the pharmaceutical issue, and the criticality of CSSB 817 to our FY83 medical program even if the pharmaceutical transfer is removed from the bill.

Sincerely,

Helen D. Beirne
Commissioner

cc: Allen Korhonen
Rod Betit

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

POUCH H 01
JUNEAU, ALASKA 99811
PHONE: 465-3030

April 23, 1982 DOCUMENT NO. 150-82

The Honorable Don Bennett
Senator
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Re: Senate Bill 817

Dear Senator Bennett:

I would like to provide additional clarification of the pharmaceutical issue involved in CSSB 817 and the Department's position on its deletion from the bill. From the outset I would like to make it clear that the Department strongly supports CSSB 817 even if the pharmaceutical change is deleted. Although for reasons elaborated below the pharmaceutical transfer would increase our FY83 purchasing power by nearly $1 million, the remaining provisions of CSSB 817 are even more critical and require legislative passage this session.

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Senate Bill 817 would, among other things, move pharmaceuticals for Medicaid recipients under Medicaid where the State would receive 48% cost sharing by the federal government for pharmaceutical costs. The sole federal condition for accepting a 48% cost sharing for pharmaceuticals is that Alaska begin paying pharmacists on a formulary basis rather than actual charges. As the Department intended to establish a formulary anyway in FY83, this federal requirement did not present a major problem. On the average this could represent a 15% reduction below actual charges for pharmacists.

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Removing the pharmaceutical transfer from CSSB 817 does not make the bill any less critical, but will reduce our purchasing power by nearly $1 million as we will not be earning federal funds for this item so long as it remains under GR Medical. This $1 million would, by our estimate, have purchased medical services for approximately an additional 1000 persons in FY83.

Again, the Department very strongly supports passage of CSSB 817 even without the pharmaceutical transfer included, as without the remaining provisions of CSSB 817, a great many children from low-income families may be limited to receiving only emergency medical services in FY83. The remaining provisions of CSSB 817 would prevent this from happening.

I sincerely hope this letter has served to clarify the Department's views on the pharmaceutical issue, and the criticality of CSSB 817 to our FY83 medical program even if the pharmaceutical transfer is removed from the bill.

Sincerely,

Helen D. Beirne

Helen D. Beirne
Commissioner

cc: Allen Korhonen
Rod Betit

Offered: 4/6/82
Referred: Finance

Original sponsor: Health, Education and Social Services Committee

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

IN THE SENATE

CS FOR SENATE BILL NO. 817 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWELFTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to medical assistance for needy persons; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 47.07.020(b) is amended by adding new paragraphs to read:

(8) persons under 21 years of age who would be eligible for benefits under the federal aid to families with dependent children program, but who do not qualify because they are not dependent children;

(9) women who are pregnant.

* Sec. 2. AS 47.07.030 is amended to read:

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include inpatient hospital, outpatient hospital, rural health clinic, outpatient surgical care centers, laboratory and X-ray, refractions and eye examinations by opthalmologists or optometrists, eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, inpatient psychiatric hospital for persons age 65 or older and persons under age 21, skilled and intermediate nursing home, physician, nurse midwife, home health care services, early periodic screening diagnosis and treatment of persons under 21 years of age, clinic services, treatment of speech, hearing and language disorders, <u>physical therapy, occupational therapy, prescribed drugs, prosthetic devices and medical supplies, long-term care noninstitutional services,</u> and reasonable transportation to and from the point of medical care. No additional services may be provided unless approved by the legislature.

* Sec. 3. AS 47.07 is amended by adding a new section to read:

Sec. 47.07.035. PRIORITY OF SERVICES. If the funding in a fiscal year is inadequate to finance the total medical assistance program under AS 47.07, the department shall, to the extent that federal law and funding permits, provide medical assistance in the following order:

(1) aged, blind or disabled persons who

(A) do not receive supplemental security income under Title XVI of the Social Security Act because they do not meet income and resources requirements; and

(B) are eligible to receive an optional state supplementary payment;

(2) persons in a medical or intermediate care facility

(A) whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under Title XVI of the Social Security Act; and

(B) who would not be eligible for an optional state supplementary payment if they left the facility;

(3) persons under 21 years of age

(A) who are under the supervision of the department;

(B) whose maintenance is paid in whole or in part from public funds; and

(C) who are in foster homes or private child-care institutions;

(4) persons under 21 years of age who

(A) receive treatment in a psychiatric hospital; and

(B) are financially eligible as determined by the standards of Part A of Title IV of the Social Security Act;

(5) persons under 21 years of age who are

(A) in an institution designated by the department as an

intermediate care facility for the mentally retarded; and

(B) financially eligible as determined by the standards of the federal aid to families with dependent children program;

(6) women who are pregnant;

(7) persons under 21 years of age who do not qualify for benefits under the federal aid to families with dependent children program because they are not dependent children;

(8) intermediate nursing home services;

(9) prescribed drugs;

(10) eye examinations by an ophthalmologist or optometrist; or eyeglasses prescribed by a physician skilled in the diseases of the eye or by an optometrist;

(11) treatment of speech, hearing, or language disorders;

(12) physical or occupational therapy;

(13) care at an intermediate care facility for the mentally retarded;

(14) care at an inpatient psychiatric facility;

(15) community mental health clinic services;

(16) surgical care center services;

(17) nurse midwife services;

(18) medical supplies and equipment.

* Sec. 4. AS 47.07.080(4) is repealed and reenacted to read:

(4) "clinic services" means services provided by state-approved outpatient community mental health clinics that receive grants under AS 47.30.520 - 47.30.620, state-operated community mental health clinics, and physician clinics.

* Sec. 5. This Act takes effect immediately in accordance with AS 01.10.-070(c).

file HB 209

My name is Thomas Miklautsch, residing in Fairbanks. I am a pharmacist and I am testifying against HB 209 which deals with Medicaid, specifically its inclusion of prescription medications in its program.

MAR 22 1995

Since this committee considers health and social services in the public's best interest, my comments here are to emphasize these aspects although some remarks may overlap with the area of economics. They should also be considered and understood from the standpoint of health.

First of all, having prescribed medications in Medicaid without an understood and economically workable program is not in the best interest of the public. They will either be poorly served or not at all. The most critical reason for this would be the absence of pharmacies participating in the program. If the pharmacies cannot work with the program as set up, then the patient has to accept the stress. This means seeking out a pharmacy that would be participating in the program, if any, possibly having to travel longer distances at additional self-cost or at cost to the State for transportation to and from medical care.

In the case of areas of single store providers, it would simply be disastrous for the patient who would be forced to find a provider in another city or town, having to go there at self-expense (or the State's), OR mail in their prescriptions to a provider somewhere and wait a week or so to receive them, OR ELSE simply have them filled at their nearest pharmacy and pay for them somehow. Is this the manner intended to provide for the needy?

When Medicaid first came to Alaska and the State attempted to include prescription medications in the program, the program was so unworkable for the

pharmacies that none of them agreed to participate. As a result that portion of Medicaid was dropped. In 1982, the Dept. once again submitted an unworkable program which was also defeated by the Legislature.

Secondly, you have been told in your Legislative Update that the State expects to save $1.4 million with a footnote that reduction of this amount has already been made in the Governor's FY86 budget request, and that if this bill is not passed Major GR Medical reductions will be necessary. Simply stated, medical care will be reduced in a vital area.

The above information certainly prompts various questions that, although touching on economics and finance, still have a relationship to proper medical care. Do you know (or does the Legislature know) how the $1.4 million in savings has been calculated? We don't because we don't know what the program is. We know that the Federal Government will pay one-half the cost of the program. We also know that the total program FY84 was $69 million and that the cost of prescribed medications for the whole state was under $1.6 million which is about 2.3% of the program. We also know that the largest and costliest item in medical care is hospitalization, and we know that what keeps thousands of patients out of the hospital is self treatment by prescribed medications. Let's just say that because of inaccessible care, on an annual statewide basis, 25 patients per month need to be hospitalized for just 4 days. This would be 100 hospital days per month x 12 months x $500 per day equaling $600,000. It's very likely that the additional patient hospitalizations of 25 per month is a conservative figure. Is the State then realizing a cost saving? Further, what's the risk of death because of lack of proper care when it's first needed?

Other questions:

Is the Dept. aware of all the Federal requirements for participation in the program? Establishing MAC's, (Maximum Allowable Costs), EAC's (Estimated Allowable Costs), Establishing fixed fee for all AK pharmacies.

What will it cost to establish, monitor and update the program?

What is the cost of computer changes by CSC to comply with Federal regulations?

How many additional employees will be required to run the program?

Finally, we seriously wonder if this committee realizes what ic is considering. HB 209 is essentially an amendment to an Alaska Statute by adding two words, "prescribed drugs" and giving it a priority number. Has a program backing this bill been unveiled and does the Committee know what it is?

We don't know what it is, so we don't know if it is workable. We do know that the Dept. has had two years to draft a plan, however, we have had no input into it. In the past, we have recommended to the Dept. ways of cutting costs but have received no response. We cannot testify for HB 209 without knowing the program and we cannot recommend its passage for the same reason.

Just a few days ago we received a verbal invitation to meet with the Dept. and consider a proposed draft of a program. We most certainly wish to accept this offer but we need time for preparation. We need time to arrange our schedules, time to analyze the Dept.'s draft, time to respond and eventually come with a program satisfactory to all parties. Some of our participants

are out of the State at present and we will need time for them to be involved.

We don't wish to leave the impression that we have a closed mind to HB 209 if a program can be found to be satisfactory and workable for pharmacies. We are willing to work with the Dept. to find this common ground but please understand we need time for this.

We feel that there is a definite lack of information on HB 209 and that it should not proceed beyond this point. We ask you, our Legislators, to agree with our request.

We too believe in our State and in the best interest of the public. We think that over the years we have discharged our professional conduct and responsibilities remarkably well.

We also believe in what our State Constitution says in its first paragraph about all persons having a natural right to the enjoyment of the rewards of their own industry.

March 10, 1985

My name is David L. Swanson, a 20 year Alaska resident, practicing pharmacist and general manager of two pharmacies located in Fairbanks. I have served six years as a member of the State's Medical Care Advisory Committee (2 years as Chairman), a Committee which meets quarterly in an advisory capacity to the Commissioner and the Department of Health and Social Services. I wish the following to be entered as testimony regarding HB209.

I. Background

When the State of Alaska adopted the Federal Medicaid program, payment for pharmaceuticals was and still is an optional service to be provided. Initial efforts in the early 1970's to place pharmacy under the Federal program were unsuccessful due to marginal savings and opposition from pharmacy providers. The most recent attempt to move pharmacy into Medicaid was in 1982 via SB817. The Legislature in 1982 chose not to change the program, and today pharmaceutical services are funded through the General Relief-Medical component of the budget for the Department of Health and Social Services.

II. Why I am opposed to HB209

On the surface, one would wonder why any group or individual would be opposed to a plan that would supposedly save money for the State of Alaska. My opposition is based upon the following.

A. HB209 should be viewed as enabling legislation which allows the State of Alaska to claim 50% of monies spent for pharmaceutical services from the Federal Medicaid program. Unfortunately, these Federal funds are not granted without strings attached. My opinion is that the Department of Health and Social Services has not closely examined the Federal requirements for payment for pharmaceutical services. If HB209 is enacted, the Department must do the following to qualify for Federal Medicaid funds. The State or its agency (in this case the Department of Health and Social Services) must adopt Title 45 - Public Welfare, Subtitle A - Department of Health and Human Services, Part 19 - Limitation on Payment or Reimbursement for Drugs. This Federal regulation forces the Department to adopt the Federal schedule of Maximum Allowable Cost (MAC) for some twenty to thirty drug products and to establish an Estimated Acquisition Cost (EAC) and a method of updating these costs for all other drug products. In addition to establishing estimated acquisition costs of literally thousands of drug products, the Department must establish a dispensing fee to be paid to Alaska's pharmacies in addition to the Maximum Allowable Cost or Estimated Acquisition Cost. Because of the Sherman Anti-Trust Act, the dispensing fee must be established unilaterlly by the Department and cannot be negotiated with participating pharmacies.

These regulations which arbitrarily determine costs of purchasing drug products and unilaterally sets payment for services rendered and unacceptable to me as a practitioner and I believe to the great majority of pharmacists in Alaska. Studies in the continental United States have shown that a substantial percentage of participating pharmacies cannot purchase pharmaceuticals for what the Federal government has determined to be the Maximum Allowable Cost. A study published in the August 1982 issue of American Pharmacy statesthat "58% of all responding pharmacists stated they fill prescriptions with a product priced above the MAC limit and absorb the loss". Other studies have shown that those pharmacies continuing to participate in the Medicaid program are doing so at an economic loss and are raising prices charged to non-Medicaid patients to offset the losses.

B. Pharmacy participation

Under the current system of the State paying usual and customary charges to pharmacies, I believe there is 100% participation in the program. Should HB209 become law, I believe the resultant mandatory regulations outlined above would force many pharmacies to seriously reconsider their participation in the program. There is a strong probability that many pharmacies would choose not to provide pharmaceuticals to Medicaid eligibles. This could result in an enormous impact on the cost of health care in other areas should these patients require additional hospitalizations or incur state funded travel expenses to obtain medications.

C. Cost savings

The term "cost savings" is really a misnomer and should correctly be called "cost shifting". It should be obvious that if the State does not pay usual and customary charges, the private sector will have to pay the difference for a pharmacy to remain profitable. Pharmacy is already a highly competitive business with the Lilly Digest, the financial benchmark of the industry, indicating a consistent decline in net profits over the past several years. Net profit after taxes for the average pharmacy for the last year reported (1983) stood at less than 3% of sales. It is my belief the Department's projection of a cost shifting of $1.4 million is highly suspect. Total expenditures for FY84 for pharmaceuticals was $1.592 million, and the Medical Payments Section could not give me an estimate of payments for FY85. Assuming an annual 10% increase over FY84 would result in an expenditure of approximately $1.926 million for FY86. From these numbers, I cannot determine how the Department expects to "save" $1.4 million. In addition, I am unaware of any estimates of additional costs that would be incurred by the Department to establish, monitor and update the program as required by the Federal government. Furthermore, as alluded to by Commissioner Pugh as recently as March 4, 1985, in an address to the Alaska State Hospital Association in Juneau, there is a possibility that a Federal Medicaid Cap would preclude the State from any Federal funding for pharmacy under Medicaid. I quote from Commissioner Pugh's prepared address as distributed; "I'd like to mention

our support of HB209. This is a bill designed to move the purchase of drugs from General Relief Medical to Medicaid. This would allow for 50% Federal funding instead of the current 100% cost to the General Fund and would save the State $1.4 million in FY 86. That money has already been removed from the Department of Health and Social Services' budget and passage of the bill is imperative. Of course, this is another issue that could be affected by a Medicaid Cap. At the present time, however, we are moving forward as if that possibility did not exist and hoping that we get some support on the waiver and the equity issue. If the Cap occurs, we will be forced to reconsider our priorities and make choices about what we will be able to fund."

I must question the fiscal soundness of a decision to remove $1.4 million from the Department's budget based on two highly speculative assumptions; these being that HB209 will become law and that there will not be a Federally mandated Medicaid Cap.

Another potential area of impact that the Department has apparently ignored is the potential utilization of the entire Medicaid system by those beneficiaries currently receiving services from the Alaska Native Health Service. Earlier studies conducted by the State have indicated that the increased utilization of Medicaid services by this "crossover" would negate any potential savings.

D. Pharmacy and the Department of Health and Social Services

It is my understanding that the Department strongly supported the introduction of HB209 with the knowledge that Alaska's pharmacists would strongly oppose the bill. To the best of my knowledge, no pharmacist or pharmacy organization was approached to determine if there might be a common "middle ground" from which we could work together to curb the cost of pharmaceuticals. The Department has been uncommunicative with the profession regarding how HB209 would be implemented should it become law. An example of this is a formulary of drugs which would or would not be covered. A formulary is a State option under Medicaid, and has been implemented in about half the states, with equivocal results. Should the Department try to impose a formulary, I think it would require a legislative change in the State's anti-substitution law which prohibits drug product selection by the pharmacist unless authorized by the prescriber. I believe this change would be unacceptable to most prescribers.

The Department has not explored other alternatives within the General Relief - Medical program for cost containment. Suggestions made to the Department by the Alaska Pharmaceutical Assoc. in 1982 have never been acknowledged nor discussed with the profession. These suggestions included dispensing quantity limits, limitations on over-the-counter medications and non-covered drugs. The Department has also ignored the recommendation of the Medical Care Advisory Committee of June 5, 1982 that pharmacy not be tranferred to Medicaid and that the Department consider the cost containment suggestions offered by the Alaska Pharmaceutical Assoc. In conclusion, I would hope that HB209 be held in committee and the Department and pharmacy representatives work together to develop an acceptable plan for cost containment that will continue to provide the highest quality of pharmaceutical services.

Danny - there's a house bill - Start file
MAR 27 1985

ALASKA STATE SENATE

JOE P. JOSEPHSON
DISTRICT H — ANCHORAGE
1526 F STREET
ANCHORAGE, ALASKA 99501
(907) 277-4419

WHILE IN JUNEAU
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OFFICE OF MINORITY WHIP

COMMITTEES

BUDGET & AUDIT
HEALTH, EDUCATION & SOCIAL SERVICES
RULES
TRANSPORTATION

SENATE CHAIR, ANCHORAGE CAUCUS

March 26, 1985

The Honorable Jan Faiks
The Honorable John Sackett
Co-Chairs, Senate Finance Committee
The Honorable Al Adams
Chair, House Finance Committee
Pouch V
Juneau, Alaska 99811

Dear Jan, John and Al:

As we consider all the ways through which we can reduce our operating budget, it has come to my attention that the 12th Legislature failed to incorporate an amendment to Medicaid law which would have added prescribed drugs to the Medicaid system, transferring them from the present total involvement with the General Relief Medical category.

As former Commissioner Beirne explained in her letter of April 23, 1982, the moving of pharmaceuticals for Medicaid recipients under Medicaid. State expenditures for pharmaceuticals would thus be reduced.

It would appear that the change was opposed by pharmacists who have greater reimbursement flexibility under GR Medical than would be the case under Medicaid. According to Representative Koponen, this position has been reiterated recently by Fairbanks pharmacists.

Nevertheless, I transmit the materials on this subject to you for your consideration because of our mutual interest in reducing the operating budget consistent with the public safety and health.

With best wishes, I am

Sincerely,

Joe P. Josephson
State Senator

JPJ:rak
Enclosures

cc: The Honorable John Pugh
The Honorable Bettye Fahrenkamp
The Honorable Niilo Koponen
Mr. Rod Betit, Division of Medical Assistance
Ms. Connie Sipe, Deputy Commissioner for Social Services

Sec. 47.25.110. When not applicable to Indians and Eskimos. [Repealed, § 1 ch 118 SLA 1968.]

Article 2. General Relief Assistance.

Sec. 47.25.120. Eligibility for assistance. Financial assistance may be given under AS 47.25.120 — 47.25.300, so far as practicable under the conditions in this state, to a needy person who is eligible under the regulations of the department. (§ 2 ch 110 SLA 1953; am § 1 ch 38 SLA 1957)

NOTES TO DECISIONS

A statutory prohibition of welfare benefits to residents of less than a year creates a classification which constitutes an invidious discrimination denying such residents equal protection of the laws. Shapiro v. Thompson, 394 U.S. 618, 89 S. Ct. 1322, 22 L. Ed. 2d 600 (1969).

Collateral references. — 79 Am. Jur. 2d, Welfare Laws, § 1 et seq.

81 C.J.S., Social Security and Public Welfare, § 1 et seq.

Liability of governmental agency for medical or surgical services rendered to poor person in emergency, without expressed authority, 93 ALR 900.

Status of one as poor person for purpose of statute entitling him to relief as affected by extent of his financial resources, 98 ALR 870.

Sec. 47.25.130. Amount of assistance. The amount of assistance for a needy person shall be determined by the department with regard to the resources and needs of the person and the conditions existing in each case. Where possible, assistance shall be sufficient to provide the applicant with reasonable subsistence according to standards of assistance established by the department. However, the amount of assistance for subsistence needs may not exceed $80 a person a calendar month. (§ 3 ch 110 SLA 1953; am § 2 ch 38 SLA 1957)

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Sec. 47.25.140. Residence in institution. Payment under AS 47.25.120 — 47.25.300 may not be made to or in behalf of an individual who is a resident of the Alaska Pioneers' Home or other public institution, except as a patient in a public medical institution, or an individual who is a patient in a public or private institution for tuberculosis or mental disease. A resident of the Alaska Pioneers' Home or other public institution who is otherwise eligible to receive an allowance under AS 47.25 120 — 47.25.300 may apply for the allowance instead of the support and maintenance provided in the home or public institution. (§ 4 ch 110 SLA 1953)

Sec. 47.25.150. Application for assistance. A person requesting assistance shall apply for it, either personally or through another person, upon forms furnished and under regulations adopted by the department. (§ 5 ch 110 SLA 1953)

Sec. 47.25.160. Investigation of applicant. The department shall promptly investigate each applicant to determine the applicant's eligibility. (§ 6 ch 110 SLA 1953)

Sec. 47.25.170. Granting of assistance. Upon the completion of its investigation, the department shall decide whether the applicant is eligible for and should receive assistance promptly under AS 47.25.120 — 47.25.300, the amount of assistance, the manner of paying or providing it, and the date on which the assistance shall begin. The department shall notify the applicant of its decision. (§ 7 ch 110 SLA 1953)

Sec. 47.25.180. Appeal. An applicant whose application is not acted upon or is denied, discontinued, or modified by the department shall be granted an opportunity for fair hearing before a representative of the department appointed for that purpose. The hearing shall be held within a reasonable time after demand for it. A representative designated to conduct the hearing shall be governed by the regulations adopted for that purpose by the department. (§ 8 ch 110 SLA 1953)

Sec. 47.25.190. Payment to guardians. When a guardian is appointed by the court for a person receiving assistance, the department may pay the assistance to the guardian. (§ 9 ch 110 SLA 1953)

Sec. 47.25.195. Payment to health facilities for treatment of needy persons. (a) The department may make payments to a health facility for the treatment of a needy person.

(b) A health facility receiving a payment under this chapter is subject to the requirements of AS 47.07.070 — 47.07.075.

(c) For purposes of this section, "health facility" includes a hospital, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, and outpatient surgical clinic. (§ 7 ch 95 SLA 1983)

Sec. 47.25.200. Review of eligibility. Assistance grants under AS 47.25.120 — 47.25.300 shall be reviewed by the department as frequently as it considers necessary, and the amount of assistance may be changed or entirely withdrawn if the review of the circumstances warrants this action. (§ 10 ch 110 SLA 1953)

Sec. 47.25.210. Alienation and attachment. Assistance granted under AS 47.25.120 — 47.25.300 is inalienable by assignment or transfer and is exempt from garnishment, levy, or execution as provided in AS 09.38 (exemptions). (§ 11 ch 110 SLA 1953; am § 8 ch 62 SLA 1982)

Effect of amendments. — The 1982 amendment substituted "as provided in AS 09.38 (exemptions)" for "under the laws of this state."

Sec. 47.25.220. State's claim for assistance. The total amount paid in assistance to a recipient constitutes a claim against the recipient and the recipient's estate. On the death of a person receiving assistance the total amount paid as assistance shall be allowed by the court having jurisdiction over the estate. (§ 12 ch 110 SLA 1953)

Sec. 47.25.230. Persons liable for support and burial. Every needy person shall be supported while living and upon dying, shall be given a decent burial by the spouse, children, father, mother, grandfather, grandmother, grandchildren, brothers or sisters of the needy person, if they, or any of them, have the ability to do so, in the order named. Every designated person who fails to support the needy person when directed by the department to do so, or fails to give the needy person a decent burial shall reimburse the state or a municipality for the funds expended by either the state or a municipality for the relief or burial of the needy person, and these sums with interest and costs may be recovered by the state or a municipality of the state in a civil action. (§ 13 ch 110 SLA 1953)

Cross references. — For duty of parent and child to maintain each other, see AS 25.20.030.

Collateral references. — Nature of care contemplated by statute imposing general duty to care for indigent relatives, 92 ALR2d 348.

Sec. 47.25.240. Action against person liable for care of recipient. If, during the continuance of an allowance, the department ascertains that a person liable for the support of the recipient of assistance is able to provide the necessary care and support of the recipient, and the person liable for the care and support of the recipient fails or refuses to support and care for the recipient, the state has a claim for the assistance against the person liable for it. This claim may be enforced by civil action brought in the name of the state by the attorney general against the person liable for the recovery of the amount of money, with interest, paid to the recipient, together with the costs and disbursements of the action. (§ 14 ch 110 SLA 1953)

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Sec. 47.25.250. Temporary relief. When a needy person is not entitled to assistance under AS 47.25.120 — 47.25.300 and has no relatives in the state liable for support under AS 47.25.230 and 47.25.240, the needy person may receive temporary assistance in the form and amount which the department considers necessary. Temporary assistance for needs other than transportation and medical care may not exceed $80 per person per month. (§ 15 ch 110 SLA 1953; am § 4 ch 221 SLA 1976)

Sec. 47.25.252. Discretionary assistance. When a needy person is not entitled to assistance under AS 47.25.120 — 47.25.300, the needy person may receive assistance in the form and amount that the department considers necessary. (§ 14 ch 138 SLA 1982)

Sec. 47.25.255. Catastrophic illness. [Repealed, § 2 ch 107 SLA 1978. For current law concerning catastrophic illness assistance, see AS 47.08.]

Sec. 47.25.260. Recovery and disposition of allowances improperly granted. If the department finds that a general relief allowance has been improperly granted, it shall investigate, and if it appears from the investigation that the assistance was improperly granted, the department may cancel the allowance and notify the recipient of the cancellation. The state then has a claim against the person who received the improper allowance. The claim may be enforced by civil action in the name of the state by the attorney general to recover the amount paid to the person, with interest, together with the necessary costs of the action. (§ 16 ch 110 SLA 1953)

Sec. 47.25.265. Cancelation of warrants. (a) Warrants issued to a general relief assistance recipient after the date of death of the recipient shall be returned to the Department of Administration and canceled.

(b) General relief assistance warrants issued before the death of the recipient but not negotiated at death shall be returned to the Department of Administration, and shall be canceled, unless claimed by the authorized representative of the estate of the recipient within 90 days of the date of death.

(c) The state shall not be liable to the estate, heirs, or creditors of the deceased general relief assistance recipient for payment on warrants canceled under (a) and (b) of this section. (§ 1 ch 52 SLA 1964)

Sec. 47.25.270. Agreements with federal government. The department may enter into agreements, arrangements, or contracts with any federal agency, department, or official under which funds made available to the federal agency, department, or official may be transferred to the department and spent in accordance with AS 47.25.120 — 47.25.300 for assistance to needy persons. (§ 18 ch 110 SLA 1953)

Sec. 47.25.280. Obtaining assistance by fraud. [Repealed, § 42 ch 143 SLA 1982.]

Sec. 47.25.290. Penalty for violation. A person who violates a provision of AS 47.25.120 — 47.25.300 is guilty of a misdemeanor and upon conviction is punishable by a fine of not more than $1,000 or by imprisonment for not more than one year, or by both. (§ 19 ch 110 SLA 1953; am § 2 ch 116 SLA 1975)

Sec. 47.25.300. Definitions. In AS 47.25.120 — 47.25.300

(1) "assistance" means financial assistance to or on behalf of a needy person, including subsistence (food, shelter, fuel, clothing, and utilities) and transportation, medical needs (including, but not limited to, hospitalization, nursing, and convalescent care), burial, and other determined needs;

(2) "department" means the Department of Health and Social Services;

(3) "needy person" means a needy resident of the state who is not eligible for aid from another public agency or department providing similar services in the state;

(4) "public medical institution" means a public hospital or medical institution, except an institution for the treatment of tuberculosis or mental disease. (§ 1 ch 110 SLA 1953; am § 2 ch 32 SLA 1971; am § 6 ch 104 SLA 1971)

NOTES TO DECISIONS

A statutory prohibition of welfare benefits to residents of less than a year creates a classification which constitutes an invidious discrimination denying such residents equal protection of the laws. Shapiro v. Thompson, 394 U.S. 618, 89 S. Ct. 1322, 22 L. Ed. 2d 600 (1969).

Article 3. Aid to Families with Dependent Children Act.

Sec. 47.25.310. Eligibility for assistance. The department shall grant assistance to the family of each dependent child and each pregnant woman it determines is eligible for assistance under AS 47.25.310 — 47.25.420, or to employers under a work incentive program established by AS 23.15.650, and by 42 U.S.C. 633(e)(1) (Social Security Act, Win Program), as amended. (§ 51-2-32 ACLA 1949; am § 2 ch 57 SLA

Chapter 05. Administration of Welfare, Social Services and Institutions.

Sec. 47.05.010. Duties of department. The Department of Health and Social Services shall

(1) administer adult public assistance, aid to families with dependent children, and all other assistance programs, and receive and spend funds made available to it;

(2) adopt regulations necessary for the conduct of its business and for carrying out federal and state laws granting adult public assistance, aid to families with dependent children, and other assistance;

(3) establish minimum standards for personnel employed by the department and adopt necessary regulations to maintain those standards;

(4) require those bonds and undertakings from persons employed by it which in its judgment are necessary, and pay the premiums on them;

(5) cooperate with the federal government in matters of mutual concern pertaining to adult public assistance, aid to families with dependent children, and other forms of public assistance;

(6) make the reports, in the form and containing the information, which the federal government from time to time requires;

(7) cooperate with the federal government, its agencies or instrumentalities in establishing, extending and strengthening services for the protection and care of homeless, dependent and neglected children in danger of becoming delinquent, and receive and expend funds available to the department by the federal government, the state or its political subdivisions for that purpose;

(8) cooperate with the federal government in adopting state plans to make the state eligible for federal matching in appropriate categories of assistance, and in all matters of mutual concern, including adoption of the methods of administration which are found by the federal government to be necessary for the efficient operation of welfare programs;

(9) adopt regulations, not inconsistent with law, defining need, prescribing the conditions of eligibility for assistance, and establishing standards for determining the amount of assistance which an eligible person is entitled to receive; the amount of the assistance is sufficient when, added to all other income and resources available to an individual, it provides the individual with a reasonable subsistence compat-

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HB 209

HEALTH CARE

Hospitals May Gripe, but They're Making More Under Medicare

Profits rose in first year of new payment system

By Spencer Rich
Washington Post Staff Writer

Hospitals, which feared they would suffer substantial losses under government rules that limit Medicare payments, actually posted above-average profits in the program's first year, a government study reveals.

Hospital profit margins on Medicare operations rose to 14 percent in 1984, the first year of the Reagan administration's prospective payment system, about triple the average profit margin for all patients in recent years, according to an internal report by Richard P. Kusserow, inspector general of the Health and Human Services Department.

"They're doing better under Medicare than anybody thought they would," says Kusserow, who did not release the report but agreed to comment after a copy was obtained by The Washington Post.

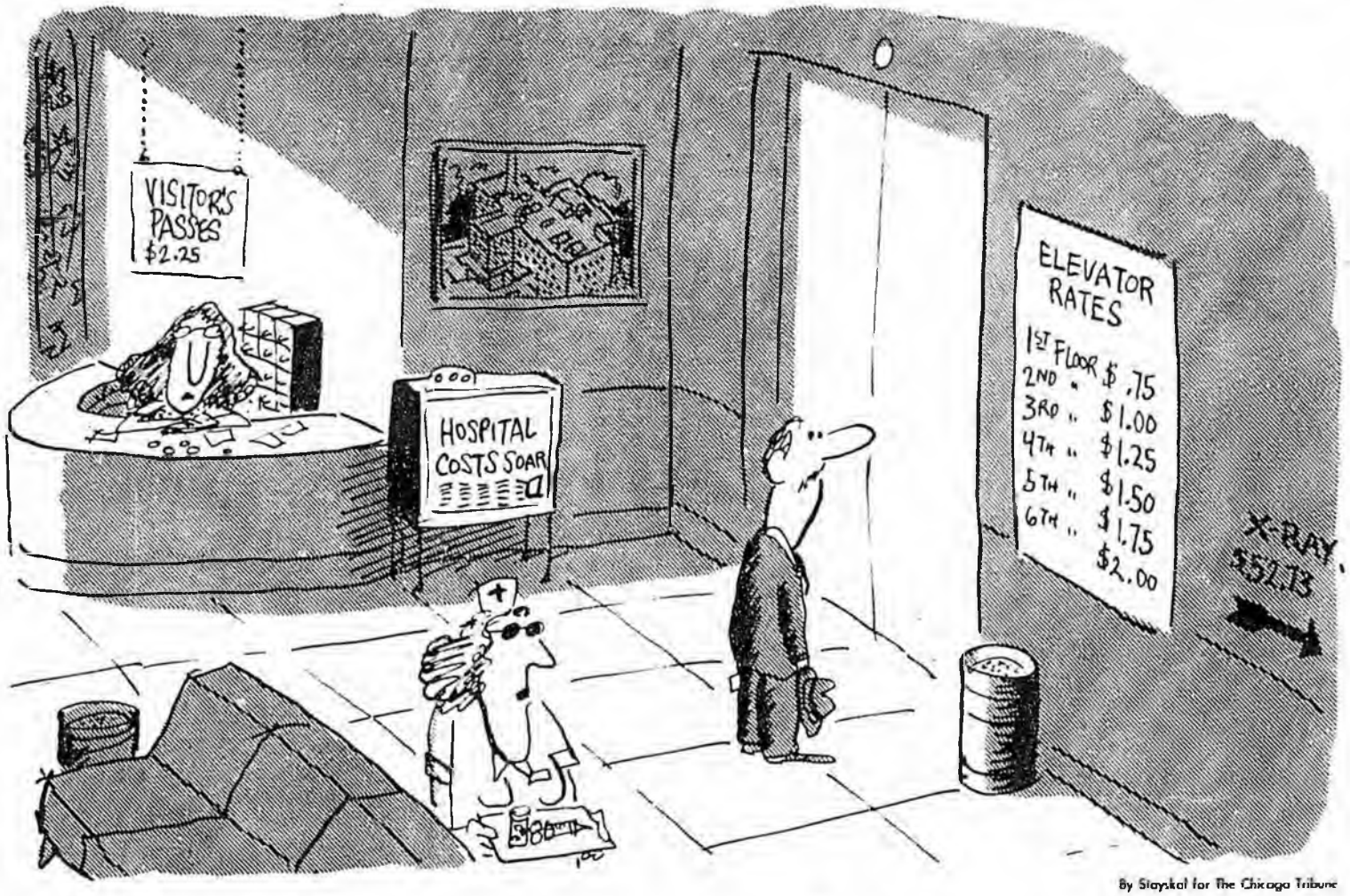
The report says the profit margins "raise questions" as to whether the Medicare rate schedule provides "excess payments" to hospitals.

Kusserow says his office's survey of about one-sixth of the hospitals operating under the system shows that Medicare is paying its way and is not being subsidized by higher charges for private patients where, he says, the profit margins are apparently smaller.

The prospective payment system was instituted at the end of 1983 to try to curb years of explosive growth in Medicare outlays. It sets a flat payment in advance for each hospital patient, based on the diagnosis. Since the payment remains the same regardless of the length of stay or the number of tests given, hospitals are discouraged from stretching out treatment or conducting needless tests.

For example, the fixed payment for cases of heart failure and shock might be $2,790. Whether the patient was hospitalized for 7.6 days (the national average in such cases) or for 10 days, the hospital would receive $2,790. Previously, hospitals were paid a fee based on the number of days a patient was admitted.

Kusserow's report comes as Congress nears a decision on how much to raise the rates Medicare will pay hospitals in 1986. The administration wants rates frozen at 1985 levels, with no increase to cover inflation. The House has approved a 1 percent increase, and the Senate, 0.5 percent.



By Stayskal for The Chicago Tribune

Jack Owen, executive vice president of the American Hospital Association, and Mike Bromberg, director of the Federation of American Hospitals, say that assuming Kusserow's figures for 1984 are correct, they merely reflect tough cost-cutting efforts by hospitals, such as a 3 percent personnel slash, to prepare for the start of the prospective payment system. They say such savings cannot be repeated year after year.

Owen says that despite the profit margins found by Kusserow, the cost-cutting efforts resulted in Medicare paying $2 billion less than anticipated in 1984.

He says that for 1985, Congress increased hospital rates less than 4 percent, a figure 2 percentage points below the rate of inflation for things hospitals buy. "We'll be lucky to get an increase of three-fourths of 1 percent in 1986 while estimated inflation is running 4 percent," so any earlier-year profits will be quickly eaten up, he says.

A Medicare spokesman says the report is being studied but that the government goal is not to limit hospital profits but to control Medicare costs. He says the new system held the 1985 increase in Medicare payments to hospitals to 6 percent, the lowest since the program began.

Kusserow's office surveyed unaudited records of 892 hospitals, both for-profit and nonprofit ones, in nine states. For nonprofit hospitals, it calculated profits as the difference between operating revenues from Medicare and operating costs. The 892 represented a sixth of the 5,405 hospitals subject to the new system. The survey found that:

- "Hospitals earned a net average of 14.12 percent profit under the Medicare prospective payment reimbursement system." Net profits at these hospitals were $833 million. Four-fifths of this was at nonprofit hospitals and therefore not taxable. Projected nationwide, the report says, the figures suggest $5 billion in profits on Medicare operations.
- If profit is measured as the percent of return on investment, instead of the surplus of revenues over costs, average net profit was 24.17 percent. ■

Sandra - from Senior Voice 9/85

New Medicaid rules Rx now $1

by Rita R. Robison

Under state rules adopted August 1, Medicaid recipients must now pay some of the costs of medications and medical supplies that formerly were provided under the program for no charge.

Here's how the new fees and other parts of the program stack up:

- Recipients pay $1 for each prescription drug received.
- Over-the-counter drugs are no longer covered under Medicaid.
- Only medical supplies on an approved list are available, unless a physician indicates the supplies are medically necessary. Recipients must pay $1 each time they receive supplies.
- Over-the-counter drugs, except insulin, are no longer covered under Medicaid.
- Physicians are being encouraged to prescribe as many generic prescription drugs as possible. Generics are less expensive drugs sold by a name referring to their chemical make-up rather than a brand name chosen by the manufacturer. If generic substitution is permitted, the state will require the pharmacist to actually dispense the less expensive product.
- Under a provision being deferred for 60 days, a schedule of fees to be paid to pharmacists for Medicaid prescription drugs would be developed by the Department of Health and Social Service's Division of Medical Assistance. Currently the state pays pharmacists whatever they want to charge.

The emergency rules were enacted by the department to cut Medicaid costs when the Alaska State Legislature failed to fully fund the state's Medicaid prescription drug program.

Before the emergency rules can become permanent, hearings must be held. That likely will take place before November.

While $2.9 million was estimated as needed to provide prescription drugs to Medicaid recipients, only $1.7 was appropriated. Lawmakers who drafted the budget expected the legislature to opt to join a federal Medicaid prescription drug program which reimburses the state for 50 percent of the cost of prescription drugs.

Although a bill to participate in the federal program passed the House, it bogged down in the Senate in the final days of this year's session. By the time legislators realized the bill would not pass, it was too late to appropriate the $1.2 million extra to fully fund the state program, said Rep. Don Clocksin, D-Anchorage and House Majority Leader.

Pharmacists blocked passage of the bill, Clocksin said, and he calls their action "unreasonable and irresponsible."

"Pharmacists want to continue their soft deal," said Clocksin of the state program which pays pharmacists 100 percent of what they charge.

"I am not happy with pharmacists . . . They just care about their own pocketbook."

Pharmacists fought against the bill because of the restrictions of the federal program and limits on what can be charged for prescriptions, said Chuck Rush, pharmacist for the wholesale firm, B.F. Grace.

Rod Betit, director of the Division of Medical Assistance, said not all pharmacists oppose the state opting to join the federal Medicaid prescription drug program. Part of the pharmacy community supports the change, but a few vocal pharmacists strongly oppose it, Betit said.

Only two other states do not participate in the federal Medicaid prescription drug program —Arizona and Wyoming.

While the new Medicaid regulation will cut the costs of the state Medicaid prescription drug program, a $300,000 to $400,000 shortfall is still likely, Betit said.

For more information on the new regulation, call the Division of Medical Assistance in Juneau at 465-3355 or write Department of Health and Social Services, Division of Medical Assistance, Pouch H-07, Juneau 99811.