

H

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SB 255

Downtown Recall Drug

Pharmacy -

manufacturer - establishes price

drug wholesaler - $2/3$ % markup

Pharmacy -

- very competitive market

Medicaid will only affect pharmacy, not the manufacturer with its fixed price

- independent pharmacies would close out

- high cost of keeping inventory

- fee doesn't cover overhead

Pharmacy - don't involve federal govt.

- marginal people need the small pharmacies

- costs shift to private paid clients

"usual and customary" would work but not allowed

must go along with other states

Kodiak

Valdez Drug - agrees w/ previous testimony

Kodiak Drug - won't keep in business, infringe on other customers

Bethel

Swanson's - closure would affect entire area

Binkley - 2% that are Medicaid eligible
20-25%

Doctor Schroeder - will not affect \$HS much

HS in

15% pop. served is Medicaid eligible

- cross over didn't occur with dental

Seward

Jim Warren - can't afford to discount prices

Warren Drug

- shouldn't subsidize state program

Bill
Pate
in WA

- Pharmacy consultant for Medicaid in WA

- nearly complete participation

- variable dispensing fee

\$12.12 - average in WA

\$12.54 - national average

7% of the budget

Sitka

Syb Fryc - DHSS cant tell us what the cost will be

White Pharmacy -

Homer

Anch Pt. Pharmacy - we'd lose money
- feds wont pay for some drugs
- can't live w/ wholesale minus
- one wholesaler in Ak

Homer Phar. - 30% are Medicaid eligible

Lynn Chase - support 255

Pres. Hospital
- a lot of people in need
- hospital pharmacy already under Medicaid

Dove
OAC - supports 255
- no decrease of benefits to senior citizens

Joy Donohue - can not fill special prescriptions at
wholesale plus \$5 or \$10
\$372 - cost
\$5 - DHSS fee
- no questions ~~to~~ of hospital costs for drugs

Hensley - why do you anticipate losses
- feds wont allow fair remuneration for special
drugs

Halford - do you have to take Medicaid patients
14.8% are Medicaid

Uehling - ~~would~~ ^{would} special drugs ~~not~~ be available under 255
- probably not

Program is working, AK has lowest piecemeal
budget in the country

Chris Coursey — if 255, some businesses will fail, others
AK. Ther. Assoc. will lay off employees

- have to deal w/ mail order competition now
- average is 20% are Medicaid
- professional fee doesn't cover fixed expenses
- 1/2 will consider dropping out of program
- Senator Stur. has agreed to examine alternatives or figure out what the costs will be

Hensley — bill has been around — why hasn't communication happened

- have provided input but haven't been able to create an entire package

Deck White (critic)

- \$17.71 average for GRM program
- we are not making a killing
- want treat welfare patients the same if they don't get fair compensation

Hulford — can you select sales

- it's all or nothing

Hensley - what would happen to people not served
- I don't know

(co-pay programs)

under GRM patient must pay \$1 for each
prescription

Harlan Knudsen - Medicaid is a painful program
- nursing homes + hospitals to support 255
 ↳ rural system is fragile
 ↳ \$2 million in liability
 ↳ we need the feds matching dollar
 in the overall health system

Haltiner - what happens to people not served
either go mail order or to hospital

Ross Sedgewick - a 50% difference in methods of
reimbursement. Medicaid would give 50% less
than GRM

we have ← must maintain provider network

we have ← low cost per recipient 140/yr ^{\$213/reactional}

need to work on ← obtain fed matching \$

- no more administrative costs for pharmacists

Pharmacist is in state budget

Monsieur

Use same form

Special fees for sole providers

Generous rates for other programs to make

Pharmacy program only 3%

~~2.50~~

- co-payment possible under Medicaid
- considerable variation available within guidelines
- all states use a set fee, no percentage

[90% of usual + customary costs]

2.30

continue to have legislative oversight on what
the Dept. does

sunset attribute - ~~revised~~ 1 yr. trial balloon
if it doesn't work, it disappears

January program in place, in effect

Minson affirmative action to end
↳ Halfad no

1 year sunset to bill + title

FACTS - MEDICAID PHARMACY PROGRAM
SB 255

- All medical providers except pharmacists in Alaska participate in the Medicaid program.
- The majority of pharmacies will continue to serve Medicaid and GRM clients. 95% of the pharmacists in Washington State participate in the Medicaid pharmacy program. National statistics show the same high rate of participation.
- The Medicaid pharmacy program will not force small, independent pharmacists out of business. The majority of pharmacists in Washington state are independent pharmacists and many are sole community providers.
- Adding Pharmacy as a Medicaid-covered service saves 50% in state funds.
- If Alaska had adopted a Medicaid Pharmacy Program in FY85, the State would have already saved over 4.5 million.
- If SB 255 passes it will save a minimum of \$5.5 million in state general funds thru FY90.
- The purpose of SB 255 is to gain federal matching funds not to pay pharmacists less.
- Native "cross-over" is a non-issue. The majority of IHS - eligibles are already using the pharmacy of their choice - whether it is a private pharmacy or an IHS facility. Nationally, and in Alaska changes in Native utilization patterns have not occurred due to a change in payment sources.

SB 255

- The changeover to a Medicaid pharmacy program will be invisible to clients.
- Alaska Pharmacists are the only medical provider in the state and in the nation paid out of 100% state funds for Medicaid clients' services.
- Alaska is the only state not claiming federal funds for pharmacy services under Medicaid.
- Legislative Audit has recommended that the Legislature adopt a Medicaid Pharmacy bill.
- The Alaska Health Association has recommended adoption of a Medicaid pharmacy program.
- The Governor's Interim Health Care Commission in its final draft has recommended adoption of the Medicaid pharmacy option.
- The Department will enact no changes in payment to pharmacies without publishing regulations and holding public hearings across the state.
- The passage of the Medicaid Pharmacy option will not change the paperwork or the billing process for pharmacists.

SB 55

-- A Medicaid Pharmacy Program can pay geographic differentials.

-- A Medicaid Pharmacy Program can pay a differential for "Mom and Pop"
pharmacies.

Excerpt from: "A Follow-up Review ON The
Department of Commerce and Economic
Development, Board of Pharmacy"
November 14, 1985

The Division of Legislative Audit

Medicaid Drug Program

During the 1985 legislative session, HB 209 was introduced by the Rules Committee at the request of the Governor. The purpose of the bill was to allow the State to request participation in the Federal Medicaid prescribed drug program. Medicaid offers a program by which it will pay half of the costs of prescribed drugs for covered individuals. Under this program Medicaid allows payment of a dispensing fee in addition to the cost of the prescribed drug. This dispensing fee would be established by the State based on a variety of factors. In effect, under this bill the State would be telling pharmacists how much they can charge for prescribed drugs paid for under the Medicaid program.

We can find no evidence that the Board of Pharmacy formally opposed HB 209. While many pharmacists, including past and present Board members, testified against HB 209 before both the House Finance and the House Health, Education, and Social Services Committees, they have done so on their own behalf and not at the formal request of the Board.

Currently, prescribed drugs for qualified individuals are paid for by the State under the General Relief Medical (GRM) program, which is funded entirely by the General Fund. Under the General Relief Medical program, prescribed drugs are paid for at the price set by the pharmacist. If HB 209 is adopted, the costs would be split with the Federal government. Alaska is only one of two states who do not participate in this program. The Department of Health and Social Services (DHSS) estimates that the cost savings to the State, by enactment of this bill, would be approximately \$1.4 million annually.

At the end of the 1985 session, HB 209 had been passed by the House, but not the Senate. In September 1985, DHSS met with pharmacists and tentatively agreed to a collection of alternative cost saving measures in lieu of HB 209. If these measures are implemented, the State's General Relief program would save approximately \$700,000.

Although the proposed compromise between DHSS and the Pharmacy Association would reduce the cost of the prescribed drug program to GRM, all expenditures would still be General Fund monies. In our opinion the implementation of HB 209

would be preferable to this compromise. Participation in the Medicaid program would allow the State to provide eligible recipients the same level and quality of service at almost half the cost to the General Fund. Using schedules prepared by DHSS's Division of Medical Assistance, we determined that if the Medicaid Drug program had been in effect during FYs 84 and 85, the State would have saved over \$2 million.

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: An Act relating to pharmaceutical medical assistance for needy persons.
Sponsor: _____
Requestor: _____

Agency Affected: Health and Social Services
BRU: HA Administration/Medical Assistance
Components: Claims Processing/General Relief Medical, Medicaid Non-Facility

EXPENDITURES/REVENUES: (Thousands of Dollars)

| OPERATING | FY 88 | FY 89 | FY 90 | FY 91 | FY 92 | FY 93 |
|-------------------|-------|-------|-------|-------|-------|-------|
| PERSONAL SERVICES | | | | | | |
| TRAVEL | | 10.0 | 10.8 | 11.7 | 12.6 | 13.6 |
| CONTRACTUAL | | 106.0 | 99.4 | 107.3 | 115.9 | 125.2 |
| SUPPLIES | | 1.5 | 1.6 | 1.7 | 1.9 | 2.0 |
| EQUIPMENT | | | | | | |
| LAND & STRUCTURES | | | | | | |
| GRANTS, CLAIMS | | | | | | |
| MISCELLANEOUS | | | | | | |
| TOTAL OPERATING | | 117.5 | 111.8 | 120.7 | 130.4 | 140.8 |

| | | | | | | |
|---------|--|--|--|--|--|--|
| CAPITAL | | | | | | |
|---------|--|--|--|--|--|--|

| | | | | | | |
|---------|--|---------|---------|---------|---------|---------|
| REVENUE | | 1,429.3 | 2,029.5 | 2,191.8 | 2,367.2 | 2,556.5 |
|---------|--|---------|---------|---------|---------|---------|

FUNDING: (Thousands of Dollars)

| | | | | | | |
|---------------|--|-----------|-----------|-----------|-----------|-----------|
| GENERAL FUND | | (1,311.8) | (1,917.7) | (2,071.1) | (2,236.8) | (2,415.7) |
| FEDERAL FUNDS | | 1,429.3 | 2,029.5 | 2,191.8 | 2,367.2 | 2,556.5 |
| OTHER | | | | | | |
| TOTAL | | 117.5 | 111.8 | 120.7 | 130.4 | 140.8 |

POSITIONS:

| | | | | | | |
|-----------|--|-----|-----|-----|-----|-----|
| FULL-TIME | | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| PART-TIME | | | | | | |
| TEMPORARY | | | | | | |

ANALYSIS : (Attach a separate page if necessary)

SEE ATTACHED

Prepared by: Kim Busch, Director *Kim Busch* Phone: 465-3355
Division: Medical Assistance Date: 2-1-88

Approved by Commissioner: Myra M. Hanson *Myra M. Hanson* Date: 2-2-88
Agency: Health and Social Services

Distribution (by preparer):

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

FISCAL NOTE ANALYSIS

HB 315

"An Act relating to pharmaceutical medical assistance for needy persons, and providing for an effective date"

FY89 Governor's Medical Assistance Request

| | <u>GF</u> | <u>Total</u> |
|--------------------------------|----------------|----------------|
| GENERAL RELIEF MEDICAL Request | 9,380.4 | 9,380.4 |
| C-4 Transfer to Medicaid | [1,370.6] | [1,370.6] |
| Decrement to Remove Pharmacy | [1,370.6] | [1,370.6] |
| REVISED | <u>6,639.2</u> | <u>6,639.2</u> |

| | <u>FED</u> | <u>GFM</u> | <u>Program</u> | <u>Total</u> |
|-------------------------------|-----------------|-----------------|----------------|-----------------|
| MEDICAID NON-FACILITY Request | 17,145.4 | 17,213.2 | 169.0 | 34,527.6 |
| C-4 Transfer from GRM | -0- | 1,370.6 | -0- | 1,370.6 |
| Increment for Federal | <u>1,370.6</u> | <u>-0-</u> | <u>-0-</u> | <u>1,370.6</u> |
| REVISED | <u>18,516.0</u> | <u>18,583.8</u> | <u>169.0</u> | <u>37,268.8</u> |

With a move of prescription drugs for Medicaid recipients from the General Relief Medical (GRM) Component to the Medicaid Non-Facility Component, Medicaid funds would become available at a 50/50 federal financial participation ratio. The Governors FY 89 General Relief Medical budget request for Title XIX pharmacy is \$3,654.8. This fiscal note assumes an October 1, 1988 implementation date.

The national rate of increase for prescription drug costs in 1987 according to the U.S. Department of Labor was 8%. For purposes of this fiscal note the Department has assumed 8% as the annual rate of inflation for prescription drugs.

Medical Assistance Administration - Claims Processing

The administrative costs except for the \$14,000 for computer programming changes will not be necessary if the increment in the Governor's budget is approved as introduced.

Travel:

On-site pharmacy reviews for dispensing fees,
 validating acquisition costs for drugs, \$10,000
 meetings with the pharmacy association, and
 gathering data for pricing compounded drugs.

Contractual:

| | |
|--|------------------|
| Professional services contract for pharmacist/ pharmacy services* | \$84,000 |
| One time funding for fiscal intermediary to change computer system documentation including provider manuals, change the collocation code table to shift expenditures from GRM to Medicaid, change pricing logic, and add new edits | \$14,000 |
| On-going funding for fiscal intermediary for Blue Book update of average wholesale prices into MMIS claims processing system | \$ 3,000 |
| Space Rent \$1.25/sq. ft. X 200 sq. ft. | \$ 3,000 |
| Communications - Long Distance and Printing | \$ 1,000 |
| Advertising and Printing | \$ 1,000 |
| Supplies: | <u>\$ 1,500</u> |
| Total | <u>\$117,500</u> |
| Federal | \$58,750 |
| SGFM | \$58,750 |

Increases from fiscal year to fiscal year are projected at 8%.

* The Department proposes using the services of a contractor to do the initial work of design, development, and implementation of a Medicaid pharmacy program. However, the Department may elect in subsequent years to seek legislative approval of a permanent position for these services.

2-2-68

WE OF THE PHARMACY COMMUNITY IN SITKA APPLAUD YOUR EFFORTS TO ADD HOME HEALTH CARE LANGUAGE AS SPECIFIED IN HB 315. ALREADY IN ALASKA THIS NEW TREND CAUSED BY RISING HOSPITAL COSTS HAS FORCED PEOPLE TO BE CARED FOR OUTSIDE THE HOSPITAL ENVIRONMENT SOONER. MANY CASES DOCUMENT THAT COSTS TO THE FIRST, SECOND OR THIRD PARTY ARE 1/3 OR 1/2 AND IN SOME CASES AS LITTLE AS 1/10TH THE COST OF HOSPITALIZATION, SIMPLY BY PROVIDING HOME CARE THROUGH AN AGENCY AND A DURABLE MEDICAL EQUIPMENT PROVIDER WHILE A PATIENT RECOVERS FROM AN ILLNESS OR AS AN ALTERNATIVE TO LONG TERM CARE IN AN INSTITUTION. WE SEE JUSTIFICATION FOR KEEPING MORE PATIENTS HOME IN ALASKA WHERE THEY RECOVER FASTER AND MORE COMPLETELY THAN EXCURSIONS TO OUT OF STATE HOSPITALS.

AS PROVIDERS FOR BOTH PHARMACY AND DURABLE MEDICAL SERVICES, WE HAVE SOME VERY REAL CONCERNS ABOUT THE FUTURE. ARE WE TO EXPECT TO PROVIDE USUAL AND CUSTOMARY QUALITY FOR OUR PRODUCTS AND SERVICES AND IN TURN BE PAID A USUAL AND CUSTOMARY RETURN? OUR COSTS OF DOING BUSINESS IN OUR AREA CONTINUE TO RISE YET WE ARE BEING TOLD WHAT WE ARE TO BE PAID BASED NOT ON THE QUALITY OF GOODS AND SERVICES BUT ON THE CHEAPEST PRICE IN THE INDUSTRY. WE FEEL AN OBLIGATION TO SERVE OUR PATIENTS WITH THE BEST CARE FOR THE BEST PRICE; HOWEVER, WE STILL MUST MAINTAIN AN INVENTORY OF GOODS AND BE ABLE TO PAY OUR PROVIDERS IN A TIMELY MANNER AND COVER THE OVERHEAD COSTS TO ALLOW US TO DO BUSINESS THE NEXT MONTH WHEN SOMEONE ELSE REQUIRES OUR SERVICES. A GOOD EXAMPLE ARE WHEELCHAIRS AND BEDS. THESE ARE EXPENSIVE ITEMS RUNNING ANYWHERE BETWEEN \$250 AND WELL OVER \$1000. THERE ARE MANY TO CHOOSE FROM AND MOST PATIENTS REQUIRE SPECIAL NEEDS IN THEIR CHAIRS AND BEDS OR WHY WOULD THEY NEED THE SERVICE IN THE FIRST PLACE. WILL YOU PAY THE \$750 FOR THE RECIPIENTS PROPER CHAIR OR ONLY \$250 FOR THE "CHEAPEST" CHAIR BECAUSE IT'S AVAILABLE? THE RECIPIENT'S ABILITY TO PAY A FEW DOLLARS ABOVE YOUR MAXIMUM ALLOWABLE COST OF A DRUG IS ONE MATTER WHILE \$500 WILL ALMOST CERTAINLY BE A BARRIER TO GOOD MEDICINE.

NOTIFICATION WAS SENT RECENTLY ABOUT A COMPANY IN TENNESSEE BEING AWARDED THE ALASKA MEDICAL PAYMENTS ASSISTANCE (AMPS) CONTRACT. WE ARE TO UNDERSTAND THE TRANSITION WILL OCCUR OVER THE NEXT FEW MONTHS TO BE COMPLETED IN MAY BUT, WE DO NOT UNDERSTAND THE FULL IMPACT OF THE CHANGES THEY INTEND TO MAKE. IT APPEARS THEY INTEND TO PURSUE THE METHOD WHEREBY PHARMACIES GET

REIMBURSED ONLY A PORTION OF THEIR COSTS THROUGH A MAXIMUM ALLOWABLE COST BASIS PLUS A PRE-DETERMINED FEE. WE DO NOT KNOW WHAT THIS FEE IS. SEVERAL YEARS AGO THIS MATTER WAS ADDRESSED AND MANY PHARMACIES STATED THEY MIGHT NOT BE ABLE TO DO BUSINESS WITH AMPS IF USUAL AND CUSTOMARY WAS NOT REIMBURSED. THE STATE, AT THAT TIME INSTITUTED THE ONE DOLLAR CO-PAY TO HEDGE AGAINST RISING COSTS. WE SEEM TO HAVE MISSED NOTIFICATION OF THIS NEW ACTION.

PHARMACY IS NOT ASKING FOR A HAND-OUT. WE ONLY ASK TO BE ALLOWED TO DO BUSINESS AND PROVIDE THE BEST CARE AT THE MARKET VALUED PRICE. LET FREE ENTERPRISE DETERMINE OUR PRICES. HELP US BY GETTING OUR PAYMENTS TO US WITHIN 30 DAYS AND TRY TO MAKE THE SYSTEM SIMPLER BY NOT REQUIRING A REFUSAL FROM MEDICARE WHEN EVERYONE KNOWS THEY REFUSE 100% OF SUCH CLAIMS. GIVE US SOME LEVERAGE TO FALL BACK ON WHEN YOUR CONTRACTED INSURANCE CARRIER DECIDES NOT TO PAY 50% OF YOUR CLAIMS BECAUSE THEY ARE "PENDING". (WE HAVE NEVER BEEN GIVEN A CLEAR DEFINITION OF "PENDING" AS IT IS REFERRED TO BY INSURANCE COMPANIES.) FINALLY, GIVE US A LITTLE RECOGNITION FOR THE JOB WE DO IN OUR COMMUNITIES. ALLOW OUR CONTINUATION OF PROVIDING HIGH QUALITY HEALTH SERVICES.

THANK YOU FOR REQUESTING INPUT ON THIS AND OTHER CONCERNS AFFECTING LEGISLATION THIS SESSION. WE APOLOGIZE FOR NOT SPEAKING WITH YOU PERSONALLY.

SINCERELY,

DAVID E. MOORE R.PH. &
JOHN W. COOPER R.PH.
OF SITKA PHARMACY, INC.

TRISH WHITE R.PH. &
DIRK T. WHITE R.PH
OF WHITE'S, INC.

STATE OF ALASKA
THE LEGISLATURE

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-2800

LEGISLATIVE AFFAIRS AGENCY
LEGISLATIVE REFERENCE LIBRARY

May, 1988

Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS database CMPR. In order to save space copies of minutes have not been left in the files.

Mary Van Nimwegen

H HESS

2-2-88

8:30 a.m.

HB 315

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

I. Purpose of HB 315:

The purpose of HB 315 is to allow the Department of Health and Social Services to increase federal revenue by funding prescribed drugs for Medicaid recipients under the Medicaid Program rather than under the 100% state general funded General Relief Medical Program (GRM).

II. Sectional Analysis:

- Section 1 establishes prescribed drugs as a Medicaid service which allows the Department to claim 50 percent federal Medicaid funding. This alone will result in an estimated \$1,311.8 million savings of state general funds in FY89.
- Section 2 adds prescribed drugs to AS 47.07.035 and provides the Department with legislative direction on the priority of prescribed drugs in the event of a funding shortfall.
- Section 3 requires adoption of federal Medicaid procedures for purchasing prescribed drugs.
- Section 4 gives "prescribed drugs" the same meaning as in federal Medicaid regulations.
- Section 5 provides an effective date of July 1, 1988.

All states, except Alaska, that offer full prescription drug coverage for their Medicaid-eligible citizens, have chosen to fund this coverage through the federal Medicaid program. There is no indication that this has in any way harmed medical assistance recipients or resulted in withdrawal of pharmacies from participation as medical assistance providers.

III. Background

The governor first introduced legislation for the addition of coverage for prescription drugs under the Medicaid program in 1985. If this legislation had been adopted the state would have saved an estimated \$4.5 million that could have been claimed in federal funds for those years. Today, pharmacy

remains the single service provided to Medicaid recipients for which the State of Alaska cannot claim federal matching dollars.

Basically, four arguments have been made against adding pharmacy services to the Medicaid program:

Argument: "The Medicaid rules concerning payment for drugs would cause Alaska pharmacies to lose money".

Response: The Medicaid rules concerning payment for drugs were amended last October. The new rules offer the state substantial flexibility including increased freedom from federal rules in setting payment rates for drugs. Under these rules there are two categories of drugs defined as follows:

1. Multiple Source Drugs

These drugs are commonly referred to as "generic" drugs. They are therapeutically equivalent drugs that can be purchased from three or more suppliers. The Health Care Financing Administration (HCFA) publishes a list of these drugs. There are approximately 134 drugs listed. For these drugs only the State cannot pay more in the aggregate than a dispensing fee plus an amount established by HCFA that is equal to 150 percent of the published price for the least costly therapeutic equivalent. According to Region X HCFA, the payment for these drugs in Alaska could be increased in recognition of the cost of shipping and handling. Further, if Alaska can show that the listed drugs are not available at these prices we can pay a higher price using the methodology established for the second category of drugs, "other drugs".

B. Other Drugs

These are all drugs that are not contained on HCFA's list. The State payment for these drugs cannot exceed, in the aggregate, more than the lower of the estimated acquisition cost plus a dispensing fee or the pharmacist's usual and customary charges to the general public. The estimated acquisition cost can be determined through a variety of methods. One method is to obtain a monthly microfiche of wholesale costs from the pharmaceutical distributors in the state.

The dispensing fee can also be established by several methods. One method would be to survey Alaska pharmacies to gather cost data for dispensing drugs. The dispensing fee may allow for geographical differentials and differentials in the volume of business conducted by the pharmacies.

The Department is proposing to either contract with or hire a pharmacist. The pharmacist's role would be to first work with the pharmacies throughout the state to design a program that would be

least disruptive to their businesses and that would ensure continued access for Medicaid and GRM recipients. The pharmacist would also:

- Ensure that Alaska's payments do not in the aggregate exceed the federal limits;
- Set prices above the federal limits for multiple source drugs that are documented as not available in Alaska at the federally listed prices;
- Establish codes and payments for FDA approved compounded drugs (drugs which are not contained in a national drug compendia);
- Work as liason with HCFA to ensure that any future federal changes in Medicaid payments for drugs allow sufficient flexibility for Alaska implementation;
- Work with pharmacies to ensure efficient and rapid processing of claims for payment.

Argument: "Many pharmacies would not participate in a drug program under Medicaid".

Response: In Washington State 1,156 pharmacies which comprise 95+% of the pharmacies in the state participate in the Medicaid drug program. Most states have little problem attracting pharmacies to participate in this program.

Argument: "Medicaid recipients will be forced to use generic drugs which will result in lower quality care".

Response: This legislation will have no impact on current practice regarding whether a generic drug is dispensed. Both Alaska and federal laws state that a generic drug should be dispensed when possible (i.e. available and therapeutically equivalent) but are clear that the ultimate choice always remains with the medical provider.

Argument: "A large number of Alaskan natives would cross over from using Indian Health Service (IHS) pharmacies to using non-IHS pharmacies, costing the state 50 percent where the previous financial participation had been zero".

Response: The shift in Medicaid coverage from the 100% state funded General Relief Medical Assistance program to the 50 percent federally funded Medicaid Program caused no noticeable increase in utilization by natives. In the Department's estimation the majority of natives who wish to purchase drugs at non-Indian health facilities are already doing so through the General Relief Medical Assistance

Program. The shift in funding sources from GRM to Medicaid is unlikely to have any effect on the utilization patterns of most Medicaid-eligible natives. In rural areas, the IHS facility or contractor will remain the pharmacy of choice because it is either the most convenient or the only available provider. In urban areas the cross over has already occurred largely because IHS does not stock many of the drugs commonly prescribed to a large group of these recipients, IHS rules and hours of operation have already made this an unavailable option, and any recipient who wishes to can avoid restriction by not declaring his or her ethnic heritage.

Conclusion:

The Department believes that a Medicaid drug program will continue to result in reasonable payments to pharmacies, will not discourage the participation of this provider group, will not effect the quality of service, and will not result in the state assuming costs formerly borne by the IHS. Most importantly, the Department can assure that the addition of this option will result in a significant annual cost savings to the state without compromising services to Alaskans.

IV. Recommendations

The Department recommends amending Section 5 to change the effective date from July 1 to October 1, 1988. The delay in implementation is necessary to allow the Department time to amend the Medicaid state plan, promulgate and adopt regulations, contract with or hire the pharmacist, and effect changes in the claims processing system.

The Department strongly recommends passage of HB 315 so that the state may begin to receive 50 percent federal financial participation for prescribed drugs through the Medicaid Program. The savings will begin to accrue to the State in October, 1988.

Recommended by: Kim Busch
Kim Busch, Director
Division of Medical Assistance

Date: 2-1-88

Approved by: Myra M. Munson
Myra M. Munson, Commissioner
Department of Health and
Social Services

Date: 2-2-88

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: An Act relating to pharmaceutical medical assistance for needy persons.
Sponsor: _____
Requestor: _____

Agency Affected: Health and Social Services
BRU: MA Administration/Medical Assistance
Components: Claims Processing/General Relief Medical, Medicaid Non-Facility

EXPENDITURES/REVENUES: (Thousands of Dollars)

| OPERATING | FY 88 | FY 89 | FY 90 | FY 91 | FY 92 | FY 93 |
|-------------------|-------|-------|-------|-------|-------|-------|
| PERSONAL SERVICES | | | | | | |
| TRAVEL | | 10.0 | 10.8 | 11.7 | 12.6 | 13.6 |
| CONTRACTUAL | | 106.0 | 99.4 | 107.3 | 115.9 | 125.2 |
| SUPPLIES | | 1.5 | 1.6 | 1.7 | 1.9 | 2.0 |
| EQUIPMENT | | | | | | |
| LAND & STRUCTURES | | | | | | |
| GRANTS, CLAIMS | | | | | | |
| MISCELLANEOUS | | | | | | |
| TOTAL OPERATING | | 117.5 | 111.8 | 120.7 | 130.4 | 140.8 |

| | | | | | | |
|---------|--|--|--|--|--|--|
| CAPITAL | | | | | | |
|---------|--|--|--|--|--|--|

| | | | | | | |
|---------|--|---------|---------|---------|---------|---------|
| REVENUE | | 1,429.3 | 2,029.5 | 2,191.8 | 2,367.2 | 2,556.5 |
|---------|--|---------|---------|---------|---------|---------|

FUNDING: (Thousands of Dollars)

| | | | | | | |
|---------------|--|-----------|-----------|-----------|-----------|-----------|
| GENERAL FUND | | (1,311.8) | (1,917.7) | (2,071.1) | (2,236.8) | (2,415.7) |
| FEDERAL FUNDS | | 1,429.3 | 2,029.5 | 2,191.8 | 2,367.2 | 2,556.5 |
| OTHER | | | | | | |
| TOTAL | | 117.5 | 111.8 | 120.7 | 130.4 | 140.8 |

POSITIONS:

| | | | | | | |
|-----------|--|-----|-----|-----|-----|-----|
| FULL-TIME | | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| PART-TIME | | | | | | |
| TEMPORARY | | | | | | |

ANALYSIS: (Attach a separate page if necessary)

SEE ATTACHED

Prepared by: Kim Busch, Director *Kim Busch* Phone: 465-3255
Division: Medical Assistance Date: 2-1-88

Approved by Commissioner: Mvra Munson *Mvra Munson* Date: 2-2-88
Agency: Health and Social Services

Distribution (by preparer):

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

FISCAL NOTE ANALYSIS

HB 315

"An Act relating to pharmaceutical medical assistance for needy persons,
and providing for an effective date"

FY89 Governor's Medical Assistance Request

| | <u>GF</u> | <u>Total</u> |
|--------------------------------|----------------|----------------|
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| Decrement to Remove Pharmacy | [1,370.6] | [1,370.6] |
| REVISED | <u>6,639.2</u> | <u>6,639.2</u> |

| | <u>FED</u> | <u>GFM</u> | <u>Program</u> | <u>Total</u> |
|-------------------------------|-----------------|-----------------|----------------|-----------------|
| MEDICAID NON-FACILITY Request | 17,145.4 | 17,213.2 | 169.0 | 34,527.6 |
| C-4 Transfer from GFM | -0- | 1,370.6 | -0- | 1,370.6 |
| Increment for Federal | <u>1,370.6</u> | <u>-0-</u> | <u>-0-</u> | <u>1,370.6</u> |
| REVISED | <u>18,516.0</u> | <u>18,583.8</u> | <u>169.0</u> | <u>37,268.8</u> |

With a move of prescription drugs for Medicaid recipients from the General Relief Medical (GRM) Component to the Medicaid Non-Facility Component, Medicaid funds would become available at a 50/50 federal financial participation ratio. The Governor's FY 89 General Relief Medical budget request for Title XIX pharmacy is \$3,654.8. This fiscal note assumes an October 1, 1988 implementation date.

The national rate of increase for prescription drug costs in 1987 according to the U.S. Department of Labor was 8%. For purposes of this fiscal note the Department has assumed 8% as the annual rate of inflation for prescription drugs.

Medical Assistance Administration - Claims Processing

The administrative costs except for the \$14,000 for computer programming changes will not be necessary if the increment in the Governor's budget is approved as introduced.

Travel:

On-site pharmacy reviews for dispensing fees,
validating acquisition costs for drugs, \$10,000
meetings with the pharmacy association, and
gathering data for pricing compounded drugs.

Contractual:

| | |
|--|------------------|
| Professional services contract for pharmacist/ pharmacy services* | \$84,000 |
| One time funding for fiscal intermediary to change computer system documentation including provider manuals, change the collocation code table to shift expenditures from GRM to Medicaid, change pricing logic, and add new edits | \$14,000 |
| On-going funding for fiscal intermediary for Blue Book update of average wholesale prices into MMIS claims processing system | \$ 3,000 |
| Space Rent \$1.25/sq. ft. X 200 sq. ft. | \$ 3,000 |
| Communications - Long Distance and Printing | \$ 1,000 |
| Advertising and Printing | \$ 1,000 |
| Supplies: | <u>\$ 1,500</u> |
| Total | <u>\$117,500</u> |
| Federal | \$58,750 |
| SGFM | \$58,750 |

Increases from fiscal year to fiscal year are projected at 8%.

* The Department proposes using the services of a contractor to do the initial work of design, development, and implementation of a Medicaid pharmacy program. However, the Department may elect in subsequent years to seek legislative approval of a permanent position for these services.

Alaska State Legislature

Senate Advisory Council



PO Box 11
State Capitol
Juneau, Alaska 99811
Phone (907) 465-3114

MEMORANDUM

TO: Senator Faiks
Alaska State Senate

ATTN: Jens Zehbe

FROM: Maureen Weeks
Senate Advisory Council

DATE : March 25, 1988

SUBJECT SB 255; IR# 88-003261

In a recent memo you asked for statistical data on the type and number of businesses that sell prescription drugs in Alaska; whether Alaska pharmacies are predominantly small "mom and pop" operations or large companies; what percentage of pharmaceutical sales are Medicaid reimbursed; and other pertinent data. I am responding to these questions in the order in which they were asked.

I. THE TYPE AND NUMBER OF PHARMACIES IN ALASKA.

1. Number.

The Board of Pharmacy lists 125 in-state licenses expiring June 30, 1988.

2. Type.

After consulting with the president of the Alaska Pharmacy Association, Chris Coursey, I have divided the types of pharmacies into chains, non-chains, facilities contracting with non-chain pharmacies, facilities contracting with chain pharmacies and state and federal pharmacies. They are listed on Table I below.

Table 1 shows that 24 percent of pharmacies are chain stores and 50 percent are non-chain stores. When facility contracts with non-chain pharmacies are included, 58 percent of Alaska's pharmacies are non-chain pharmacies.

TABLE 1
Types and Number of Alaska Pharmacy Licenses

| Type of license | Number | Percent of total (%) |
|---|--------|----------------------|
| Chain pharmacies:* | 30 | 24 |
| Non-chain pharmacies: | 63 | 50 |
| Facility contracts with non-chain pharmacy: | 10 | 8 |
| Facility contracts with chain pharmacy: | 2 | 2 |
| Facility owns pharmacy: | 14 | 11 |
| State purchases pharmaceuticals: | 3 | 2 |
| Federal government purchases pharmaceuticals: | 3 | 2 |
| Total: | 125 | |

Source: Alaska Board of Pharmacy

* The 30 chain pharmacies are in the Railbelt area and in Juneau. They include 4 in Fairbanks, 20 in Anchorage, 2 in Kenai-Soldotna, 3 in Palmer-Wasilla and 1 in Juneau.

II. PERCENT OF PHARMACY SALES REIMBURSED BY MEDICAID

1. Dittman Poll. Dittman Research is currently conducting a poll for the Alaska Pharmacy Association to determine what percent of pharmaceuticals are Medicaid reimbursed. The poll will be complete next week, according to the association president.


I have asked for a copy for your office. When I receive it, I will send it to you.

2. Informal survey. An informal telephone survey of a small number of pharmacists was conducted from this office. The survey shows the following estimates of Medicaid-reimbursed pharmaceuticals:

| | |
|--------------------------------|--------|
| Carrs at Gambell in Anchorage: | 18-25% |
| Hewitt's Drug in Spenard: | 45% |
| Ron's Apothecary in Juneau: | 10% |
| White's Pharmacy in Sitka: | 15-20% |

3. Medicaid reimbursement in pharmacy contracts. Some private pharmacies contract to provide pharmaceuticals to hospitals, long-term care (including all Pioneer Homes) and mental health facilities. Following are reports from two of these pharmacies, selected at random.

* None is Medicaid
It is GRM reimbursed



- A. Hewitt's Drugs in Spenard. Owner Dennis Jurgens says Hewitt's contracts with the Anchorage Pioneer Home and with all the mental health intermediate care facilities in Anchorage. Jurgens estimates that 45 percent of his business is Medicaid reimbursed. (If the Pioneer Home is not counted, 30% of Hewitt's business is Medicaid.) Jurgens says chain stores probably aren't interested in competing for high-volume Medicaid business because it is too time-consuming. He said a chain looked at buying him out and declined for that reason.
- B. White's Pharmacy in Sitka. Co-owner Trish White says the pharmacy contracts to the Sitka Pioneer Home where 17 of the 112 residents are Medicaid patients. White estimates that 20 percent of the pharmacy's business is Medicaid-reimbursed. (If the Pioneer Home is not counted, 15-20 percent of the pharmacy's business is Medicaid reimbursed.) This is a "mom and pop" pharmacy (White co-owns the pharmacy with her husband). White says in the past two years, the number of non-Pioneer Home Medicaid clients using their pharmacy has doubled. There are two other pharmacies in Sitka.

4. The proportion of Medicaid recipients who use Medicaid each month. Nancy Bennett of the Department of Health and Social Services reports there are 25,000 Medicaid-eligible Alaskans and that out of these, 36 percent (about 9,000) use Medicaid-reimbursed pharmaceuticals. This is about two percent of the Alaska population of 537,800.

III. OTHER PERTINENT DATA.

1. Income of pharmacists

- A. Wages paid to registered pharmacist employees. The Alaska Career Information System, published in 1987 by the Alaska Department of Labor, surveyed pharmacists for a report on wages paid to Alaska pharmacists. The results are on Table 2 below.

TABLE 2

Wages Paid to Alaska Pharmacist-Employees -- 1987*

| Level | Average per month (\$) | Range per month (\$) |
|----------------|---------------------------|-------------------------|
| Entry wage: | 2,900 | 2,400-3,100 |
| After 2 years: | 3,200 | 2,900-3,400 |
| Maximum: | | 3,300-3,700 |

Source: Alaska Department of Labor

* There are about 220 licensed pharmacists in Alaska. About 25% are self employed.

B. Income of self-employed pharmacists. Following are three examples of income reported earned in non-chain pharmacies:

- 1) Ron's Apothecary, Juneau. Co-owner Ron Sedgwick is a volunteer lobbyist for pharmacists and formerly was on contract with the Department of Health and Social Services. He reports his pharmacy netted \$52,000 in 1987, after expenses and before wages. Sedgwick and his wife, both pharmacists, are the only employees. Sedgwick says between them, they work 100 hours a week and make \$10 an hour each.
- 2) A Southeast Alaska pharmacy (not in Juneau). This pharmacy reports a net profit of \$43,659 in 1987. It is a "mom and pop" pharmacy, owned by a husband and wife pharmacist. They estimate they earn \$5.25 an hour. (The pharmacist asked to remain anonymous.)
- 3) An Anchorage pharmacy. The owner says over the past ten years he has broken even. Last year he earned \$42,000 and the business made a profit of \$15,000 after paying other employee wages. He said he works 10-12 hours a day and could make the same wages at a chain store in an eight hour day with less headache. He recently sold his business.

C. The price of pharmaceuticals.

Background. Pharmacists say there has been an influx of expensive drugs on the market in the last two years. They say this impacts their business because competition forces them to use a "sliding scale" profit margin, making less margin on expensive drugs. State officials say the cost of Medicaid pharmaceuticals to the State increased by \$1 million in the past two years.

- 1) The average cost of prescriptions. In 1973, the average cost to the consumer of pharmaceuticals statewide was \$7. In 1985, the average cost of pharmaceuticals was \$16 at McCorkle's Pharmacy and \$18.67 at Ron's Apothecary (both stores are in

Juneau). Today the average cost of prescription drugs at Ron's Apothecary is \$25.61. McCorkle's went out of business in 1985. (Source: Sedgwick).

- 2) Expensive prescription drugs. Table 3 shows the wholesale prices of certain costly prescription drugs. The prices were provided by pharmacists during telephone conversations.

TABLE 3

Wholesale Price of Certain Costly Prescription Drugs -- 1988

| Name of drug | Cost per month (\$) | Quantity |
|--|---------------------|-------------------|
| Navane (a psychotropic drug): | 143 | 200 |
| Loxitane (for mental health patients): | 102 | 100 |
| Tagomet (for ulcers): | 64 | 100 |
| Mevacor (anti-cholesterol) | 90 | bottle (\$2/pill) |
| AZT (AIDS) | 1,000 | ? |

Note: The AZT cost was estimated by R. Sedgwick.

- 3) Increases in cost of pharmaceuticals. The nationwide cost increase in pharmaceuticals between 1986 and 1988 is as follows:

Cost to druggist: 8% increase

Cost to consumer: 18% increase

Two explanations have been advanced to explain this discrepancy:

- (a) Chris Coursey, president of the Alaska Pharmacy Assn., speculates that the discrepancy reflects what paying customers are charged to make up for the federal government's fixed dispensing fee policy.

- (b) Ron Sedgwick, pharmacist lobbyist, says the discrepancy reflects the recent influx of new, expensive drugs. He points to his own profit margin, which fell from 51.9% in 1985 to 37% in 1987, while the average price of the pharmaceuticals he sold rose from \$18.67 in 1985 to \$25.61 in 1987. Sedgwick says his margin fell because the market place will not allow a 50% markup on expensive drugs.

*How is the
affected by
Medicaid?*

(Note on markup: Hewitt's Drug in Anchorage marks its prescription drugs up an average 28 to 29 percent. Dennis Jurgens says that some Anchorage pharmacies have higher markups.)

2. Pharmacists' objections to SB 255.

- A. "A fixed fee concept will not work on a profit margin system." Pharmacists say pharmacies will get a lower return, forcing them to do one of three things: 1. Charge more to paying customers. 2. Go out of business. 3. Stop serving Medicaid patients. Pharmacists object that they are the only retail merchants asked to support the federal government.

The Department of Health and Social Services says a fixed dispensing fee is adequate. Why should a pharmacist who takes two bottles -- one expensive and one inexpensive-- out of a box and gives them to customers be paid more for handing over the expensive bottle? Remember that the pharmacist is already paid for the cost of the drug. The Department's 2/2/88 position paper says there is "no indication" federal Medicaid coverage in other states has "resulted in withdrawal of pharmacies from participation".

- B. "Small pharmacies were forced out of business when the federal government took over Medicaid payments for pharmaceuticals in the late 60's and early 70's." Virtually every Alaska pharmacist interviewed said the professional journals were full of "horror stories"

recounting the "devastation to Mom and Pop pharmacies" after the federal switch over in the Lower 48.

My efforts to check these assertions with the National Association of Retail Druggists as well as the executive directors of pharmacy association in other states have been unsuccessful because those with historical perspective are all in an annual meeting in Phoenix this week. I will have more information on this later.

- C. Pharmacists are being asked to buy a "pig in a poke". Pharmacists say they do not want to put their imprimatur on a plan they haven't seen. They say the State has not set a fixed dispensing fee or determined how the base cost would be calculated.

The Department has included funds to hire a pharmacist consultant to design a program that would be least disruptive to pharmacists. A Department official two years ago told pharmacists the fixed dispensing fee would be about \$5.

- D. "The reimbursement price on expensive items could be less than the wholesale cost of the product." Pharmacists say one popular method used in the Western States to determine base cost is "Average Wholesale Price" minus an 11 percent discount (for bulk buying) OR the pharmacist's usual and customary price -- whichever is lower. They say this is unworkable because small Alaska pharmacies do not get a discount for bulk buying. They cite as an example a bottle of Mevcor, an anti-cholesterol drug, which costs the pharmacist \$90 a bottle wholesale. At a 11 percent discount, the reimbursement would be \$80.10 plus a dispensing fee. If the dispensing fee were \$5, the pharmacist would be paid \$85.10 -- which is less than the product cost him.

- E. "Alaska is unique."

- 1) Distance from the market forces Alaska pharmacists to stock inventory for two weeks in order to have a supply. Trish White, co-owner of White's Pharmacy in Sitka, said Alaska pharmacies must stock an inventory two to three times that of pharmacies in the Lower 48. She made that estimate after attending a Pharmacy Management Clinic at the University of North Carolina

in Chapel Hill this year. She said that compared to Lower 48 pharmacies, her pharmacy's turn-over rate is "amazingly low". If pharmacies in Lower 48 cities don't have a bottle on the shelf, "they can run over to a chain store and get it," she said. "We can't."

*DHSS Position
Paper: this can
be compensated
thru dispensing fee
allowances.*

- 2) Alaska pharmacists have to pay high freight costs, while those in the Lower 48 have low trucking costs. A small box of prescription drugs costs \$10 through the mail (pharmaceuticals are mailed to keep the product fresh). White says that the policy in her store is to absorb the air mail or Gold Streak cost if the pharmacy must special order a drug which is normally stocked.
- 3) Rural paying customers may be charged more for drugs. Eleven rural towns in Alaska have only one pharmacy (list attached). Pharmacists contend that under the new plan, paying customers will surely be charged more in one-pharmacy towns to make up for losses from Medicaid, there being no local competition to keep the prices down.
- 4) Rural areas may be left without Medicaid service -- or without a pharmacy. Pharmacists contend that in the 12 one-pharmacy towns, pharmacists may be forced by economics to stop serving Medicaid-reimbursed clients. Those pharmacists who feel an ethical obligation to continue serving Medicaid clients may be forced out of business, leaving the entire town without a pharmacy.
- 5) Region X is unwilling to consider alternative suggestions. Pharmacists contend that Region X does not appear willing to accept alternatives put forth by pharmacists, both in Alaska and other states. Pharmacists say Hawaii, which has problems of distance similar to Alaska's, has tried twice to modify its Medicaid-reimbursement plan (the latest try was this year), with no luck. A long-time Oregon pharmacist and consultant agrees. Stan Hartman of Beaverton says Region X is concerned about "sovietizing" the Medicaid pharmacy plan, but that if the State is "firm" and has back up in the law, it can prove the legality of a proposed alternative and go back to national headquarters to force Region X to accept the plan.

3. An alternative suggestion. In a recent telephone conversation, Stan Hartman, an Oregon pharmacist and author of articles in trade journals, recommended that Alaska use a plan in place in his state. This plan is the Pharmacists Service Group.* It has been in place for four years and sells its services to insurance companies to fulfill health plans. The group competes with national companies providing similar services in Oregon. These companies use a payment plan similar to that used for Medicaid reimbursement: an average wholesale price less 11 percent, plus a \$2.70 dispensing fee. But the Pharmacists Service Group uses a usual-and-customary charge plan with a cap at the 90th percentile (the payment is not more than that charged by 90 percent of participating pharmacies).

In 1987, the plan had 10,000 recipients; it has added the Oregon State Employees as well as other organizations and will number over 150,000 recipients next year.

Why the plan is "better", according to Hartman:

- A. The plan saves more money than a dispensing fee system.
- B. Pharmacists on this plan show a higher use of generic drugs than pharmacists on competing fixed-fee plans.
- C. The plan cuts down on drug costs by allowing up to a 90-day supply (Alaska has a 30-day supply system, in order to reduce consumer abuse.) Audits show that a 90-day supply of one drug sold for \$47 while three 30-day supplies of the same drug cost \$19 more. The decreased cost was the result of the economy of scale plus lower administrative costs. Under a fixed fee system, pharmacists are encouraged to dispense smaller amounts of the drug in order to reap more dispensing fees.

* Information about this plan was supplied by Hartman and by lobbyist Ron Sedgwick. The plan's state director was out of the office this week and I was unable to contact him. I will contact him next week for written information on his plan and when it arrives, I will send it to your office. Should you wish to contact him yourself, his name is Robin Richardson, 503-585-4887. The plan's designer is Dr. Lee Strandberg of the School of Pharmacy at Oregon State University. His telephone number is 503-754-3424.

- D. The Oregon plan uses a "co-pays" system (the recipient pays a fee when the prescription is picked up). The aim is to reduce utilization. (In Alaska, the Bristol Bay Hospital, which buys its drugs through the Public Health Service, requires a fixed pick-up fee of \$10.) See Table 3.

TABLE 3

Amount charged customer compared to the average per capita prescription cost under the Oregon Pharmacists Service Group plan

| Amount co-paid for prescription | Percent of utilization (%) | Average per capita amount spent monthly on prescription (\$) |
|------------------------------------|----------------------------------|--|
| \$2.00 | 57.5 | \$4.90 |
| \$2.50 | 48.6 | \$4.72 |
| \$3.00 | 38.9 | \$3.19 |
| \$4.00 | 32.4 | \$2.18 |
| \$5.00 | 35.6 | \$1.75 |

Source: Ron Sedgwick

Enclosed for your information is a position paper by Ron Sedgwick explaining these and other pharmacist objections in detail. Also enclosed are the bill's fiscal note and a 2/2/88 position paper by the Department of Health and Social Services entitled "SB 255". Other enclosures include a list of possible reimbursement schemes proposed by pharmacists Ron Sedgwick of Juneau and Bill Larson of Anchorage; the Department of Labor list of pharmacist-employee salaries; a list of Alaska towns with a single pharmacy; the Federal Register with an explanation of new Medicaid regulations concerning pharmaceuticals; and the Board of Pharmacy list of pharmacy licenses which expire in June of 1988.

If you require additional information, please let me know.

Attachments