SB
255

SENATE COMMITTEE REPORT

FIRST COMMITTEE OF REFERRAL

Date of 4/21/88 5-DAY NOTICE
IN ACCORDANCE WITH UNIFORM RULE 23

FURTHER:

**FISCAL NOTE(S) ATTACHED _____ **
IN ACCORDANCE WITH AS 24.08.035
(see below)

2/24/88
Mr. President:

DATE TURNED INTO OFFICE 4/29/88

Finance Committee considered SB 255

pharmaceutical medical assistance for needy persons; efd

and recommended:

[✓] replace with CS SB 255 (FIN) [ ] same title [✓] new title

[ ] attached amendment(s) and

[ ] do pass

[ ] do not pass

[ ] no recommendation

[ ] individual recommendations

[ ] further referral to _____

[✓] letter of intent adopted and attached

** Committee [ ] attached or [ ] adopted fiscal note(s)
[ ] zero [✓] fiscal impact
17.0

MEMBERS SIGNING DO PASS

OTHER RECOMMENDATIONS

Rick Halford (do pass)
Chairman signature and recommendation

[ ] Committee Backup Attached

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION: CS SB 255 (FIN)
PUBLISH DATE: 4/29/88

FISCAL NOTE

REQUEST:

Revision Date:
Title: Relating to pharmaceutical medical assistance for needy persons
Sponsor:
Requestor:

Agency Affected: Health/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						
CONTRACTUAL		17.0				
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING		17.0	0	0	0	0
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND		(1412.3)				
FEDERAL FUNDS		1429.3				
OTHER						
TOTAL		17.0				

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

See attached.

Prepared by: Rick Halford
Division: Senator Rick Halford, Co-Chairman Senate Finance Committee
Phone:
Date: 4/29/88

Approved by Commissioner:
Agency:
Date:

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

FISCAL NOTE ANALYSIS

SB 255

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

FY89 Governor's Medical Assistance Request

	GF	Total
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	6,639.2	6,639.2

	FED	GFM	Program	Total
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	1,370.6	-0-	-0-	1,370.6
REVISED	18,516.0	18,583.8	169.0	37,268.8

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.

↑ in Senate budget

Travel:

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

~~$10,000~~

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:	~~$ 1,500~~
Total	~~$117,500~~ 17,000
Federal	~~$58,750~~ 8,500
SGFM	~~$58,750~~ 8,500

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

Committee on Finance

Official Business

P.O. Box V
State Capitol
Juneau, Alaska 99811

LETTER OF INTENT ON SB 255

It is the intent of the Legislature that as regulations are developed to implement this legislation that the form of the current general relief medical pharmacy program be duplicated to the extent consistent with federal guidelines. The goal of the Department of Health and Social Services shall be to seek a reimbursement system consistent with the usual, customary and reasonable fees charged by pharmacies to the Alaskan general public. The regulations should avoid harsh economic impact on the pharmacy provider community to insure the participation of the largest number of pharmacy providers across the state to allow the maximum access to pharmacy services by the medicaid recipient community. Legislative Audit shall perform a review of the program and report to the Legislature by February 1, 1989.

go1167sB
Hein
4/27/88

Original sponsor: Rules/Governor

IN THE SENATE BY THE FINANCE COMMITTEE

CS FOR SENATE BILL NO. 255 (Finance)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FIFTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to pharmaceutical medical assistance and authorizing payment for prescribed drugs for a period of one year; for needy persons; and providing for an effective date."

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

* Section 1. PRESCRIBED DRUGS UNDER MEDICAID. (a) Notwithstanding other provisions of law, the Department of Health and Social Services may offer (1) prescribed drugs as an optional service under AS 47.07.030(b).

(b) For purposes of AS 47.07.035, (2) prescribed drugs shall be eliminated as an optional medical service after personal care services in a recipient's home and before long-term care noninstitutional services.

(c) (3) Payment for prescribed drugs under AS 47.07 shall be made in accordance with 42 C.F.R. Part 447, Subpart D.

(d) In this section, "(4) prescribed drugs" has the meaning given in 42 C.F.R. 440.120.

* Sec. 2. This Act is repealed July 1, 1989.

* Sec. 3. This Act takes effect July 1, 1988.

Introduced: 4/10/87 wol167s
Referred: Health, Education & Social Services, & Finance

IN THE SENATE

BY THE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

SENATE BILL NO. 255

IN THE LEGISLATURE OF THE STATE OF ALASKA

FIFTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to pharmaceutical 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 47.07.030(b) is amended to read:

(b) In addition to the mandatory services specified in (a) of this section, the department may offer only the following optional services: personal care services in a recipient's home; emergency hospital services; long-term care noninstitutional services; medical supplies and equipment; clinic services; inpatient psychiatric facility services for individuals age 65 or older and individuals under age 21; physical therapy; occupational therapy; chiropractic services; treatment of speech, hearing, and language disorders; adult dental services; prosthetic devices and eyeglasses; optometrists' services; intermediate care facility services, including intermediate care facility services for the mentally retarded; skilled nursing facility services for individuals under age 21; <u>prescribed drugs;</u> and reasonable transportation to and from the point of medical care.

* Sec. 2. AS 47.07.035 is amended to read:

Sec. 47.07.035. PRIORITY OF MEDICAL ASSISTANCE. If the department finds that the cost of medical assistance for all persons eligible under this chapter will exceed the amount allocated in the state budget for that assistance for the fiscal year, the department shall eliminate coverage for optional medical services and optionally

eligible groups of individuals in the following order:

(1) chiropractic services;

(2) adult dental services;

(3) emergency hospital services;

(4) treatment of speech, hearing, and language disorders;

(5) optometrists' services and eyeglasses;

(6) occupational therapy;

(7) prosthetic devices;

(8) medical supplies and equipment;

(9) clinic services;

(10) physical therapy;

(11) personal care services in a recipient's home;

(12) prescribed drugs;

(13) long-term care noninstitutional services;

(14) [(13)] inpatient psychiatric facility services;

(15) [(14)] intermediate care facility services for the mentally retarded;

(16) [(15)] intermediate care facility services;

(17) [(16)] individuals under age 21 who are not eligible for benefits under the federal aid to families with dependent children program because they are not deprived of one or more of their natural or adoptive parents;

(18) [(17)] skilled nursing facility services for persons under age 21;

(19) [(18)] aged, blind, and disabled individuals who, because they do not meet the income requirements, do not receive supplemental security income under Title XVI of the Social Security Act, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility, to receive an

optional state supplementary payment;

(20) [(19)] individuals in a hospital, skilled nursing facility, or intermediate care facility whose income while in the facility does not exceed 300 percent of the supplemental security income benefits rate under Title XVI of the Social Security Act, but who, because of income, are not eligible for the optional state supplementary payment;

(21) [(20)] individuals under age 21 under supervision of the department, for whom maintenance is being paid in whole or in part from public money and who are in foster homes or private child-care institutions.

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

Sec. 47.07.200. PAYMENT FOR PRESCRIBED DRUGS. (3) Payment for prescribed drugs must be made in accordance with 42 CFR Part 447, Subpart D.

* Sec. 4. AS 47.07.900 is amended by adding a new paragraph to read:

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

* Sec. 5. This Act takes effect July 1, 1988.

Effect of amendments. — The 1986 amendment in subsection (b) in paragraphs (3), (5) and (7) substituted "age 21 who are" for "21 years of age," in paragraph (8) substituted "age 21 and not covered under (a) of this section," for "21 years of age" and "except that they have the care and support of both their natural and adopti ve parents" for "but who do not qualify because they are not dependant children," in paragraph (9) deleted "women who are" at the beginning of the paragraph and added the language beginning "women not covered," made minor punctuation changes in paragraph (3), inserted "and" following "mentally retarded" in paragraph (5), and inserted "and" following "psychiatric hospital" in paragraph (7).

Sec. 47.07.030. Medical services to be provided. (a) The department shall offer all mandatory services required under 42 U.S.C. 1396 — 1396p (Title XIX of the Social Security Act).

(b) In addition to the mandatory services specified in (a) of this section, the department may offer only the following optional services: personal care services in a recipient's home; emergency hospital services; long-term care noninstitutional services; medical supplies and equipment; clinic services; inpatient psychiatric facility services for individuals age 65 or older and individuals under age 21; physical therapy; occupational therapy; chiropractic services; treatment of speech, hearing, and language disorders; adult dental services; prosthetic devices and eyeglasses; optometrists' services; intermediate care facility services, including intermediate care facility services for the mentally retarded; skilled nursing facility services for individuals under age 21; and reasonable transportation to and from the point of medical care. (§ 1 ch 182 SLA 1972; am § 1 ch 35 SLA 1973; am § 2 ch 105 SLA 1974; am § 1 ch 12 SLA 1976; am § 2 ch 221 SLA 1976; am § 1 ch 82 SLA 1978; am § 25 ch 40 SLA 1981; am § 2 ch 132 SLA 1982; am § 1 ch 20 SLA 1986; am § 4 ch 105 SLA 1986)

Effect of amendments. — The 1986 amendment rewrote this section. The 1986 amendment of this section by ch. 20 was incorporated in ch. 105.

Sec. 47.07.035. Priority of medical assistance. If the department finds that the cost of medical assistance for all persons eligible under this chapter will exceed the amount allocated in the state budget for that assistance for the fiscal year, the department shall eliminate coverage for optional medical services and optionally eligible groups of individuals in the following order:

(1) chiropractic services;
(2) adult dental services;
(3) emergency hospital services;
(4) treatment of speech, hearing, and language disorders;
(5) optometrists' services and eyeglasses;
(6) occupational therapy;
(7) prosthetic devices;
(8) medical supplies and equipment;
(9) clinic services;

(10) physical therapy;
(11) personal care services in a recipient's home;
(13) (12) long-term care noninstitutional services;
(14) (13) inpatient psychiatric facility services;
(15) (14) intermediate care facility services for the mentally retarded;
(16) (15) intermediate care facility services;
(17) (16) individuals under age 21 who are not eligible for benefits under the federal aid to families with dependent children program because they are not deprived of one or more of their natural or adoptive parents;
(18) (17) skilled nursing facility services for persons under age 21;
(19) (18) aged, blind, and disabled individuals who, because they do not meet the income requirements, do not receive supplemental security income under Title XVI of the Social Security Act, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility, to receive an optional state supplementary payment;
(20) (19) individuals in a hospital, skilled nursing facility, or intermediate care facility whose income while in the facility does not exceed 30 percent of the supplemental security income benefit rate under Title XVI of the Social Security Act, but who, because of income, are not eligible for the optional state supplementary payment;
(21) (20) individuals under age 21 under supervision of the department, for whom maintenance is being paid in whole or in part from public money and who are in foster homes or private child-care institutions. (§ 3 ch 132 SLA 1982; am § 2 ch 20 SLA 1986; am § 5 ch 105 SLA 1986)

Effect of amendments. — The 1986 amendment rewrote this section. The 1986 amendment of this section by ch. 20 was incorporated in ch. 105.

Sec. 47.07.040. State plan for provision of medical assistance. The department shall prepare a state plan in accordance with the provisions of 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act, Medical Assistance) and submit it for approval to the United States Department of Health and Human Services. The plan shall designate that the Department of Health and Social Services is the single state agency to administer this plan. The department shall act for the state in any negotiations relative to the submission and approval of the plan, The department, including the Medicaid Rate Commission, may make those arrangements or regulatory changes, not inconsistent with law, as may be required under federal law to obtain and retain approval of the United States Department of Health and Human Services to secure for the state the optimum federal payment under the provisions of 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act, Medical Assistance). In addition, the department shall provide a re-

Alaska State Legislature

Senate Advisory Council

P.O. Box V
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.

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 psychotrophic 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.

(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."

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.

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* 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

Introduced: 4/10/87
Referred: Health, Education & Social Services, & Finance

wol167s

IN THE SENATE

BY THE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

SENATE BILL NO. 255

IN THE LEGISLATURE OF THE STATE OF ALASKA

FIFTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to pharmaceutical 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 47.07.030(b) is amended to read:

(b) In addition to the mandatory services specified in (a) of this section, the department may offer only the following optional services: personal care services in a recipient's home; emergency hospital services; long-term care noninstitutional services; medical supplies and equipment; clinic services; inpatient psychiatric facility services for individuals age 65 or older and individuals under age 21; physical therapy; occupational therapy; chiropractic services; treatment of speech, hearing, and language disorders; adult dental services; prosthetic devices and eyeglasses; optometrists' services; intermediate care facility services, including intermediate care facility services for the mentally retarded; skilled nursing facility services for individuals under age 21; <u>prescribed drugs;</u> and reasonable transportation to and from the point of medical care.

* Sec. 2. AS 47.07.035 is amended to read:

Sec. 47.07.035. PRIORITY OF MEDICAL ASSISTANCE. If the department finds that the cost of medical assistance for all persons eligible under this chapter will exceed the amount allocated in the state budget for that assistance for the fiscal year, the department shall eliminate coverage for optional medical services and optionally

eligible groups of individuals in the following order:

(1) chiropractic services;

(2) adult dental services;

(3) emergency hospital services;

(4) treatment of speech, hearing, and language disorders;

(5) optometrists' services and eyeglasses;

(6) occupational therapy;

(7) prosthetic devices;

(8) medical supplies and equipment;

(9) clinic services;

(10) physical therapy;

(11) personal care services in a recipient's home;

(12) prescribed drugs;

(13) long-term care noninstitutional services;

(14) [(13)] inpatient psychiatric facility services;

(15) [(14)] intermediate care facility services for the mentally retarded;

(16) [(15)] intermediate care facility services;

(17) [(16)] individuals under age 21 who are not eligible for benefits under the federal aid to families with dependent children program because they are not deprived of one or more of their natural or adoptive parents;

(18) [(17)] skilled nursing facility services for persons under age 21;

(19) [(18)] aged, blind, and disabled individuals who, because they do not meet the income requirements, do not receive supplemental security income under Title XVI of the Social Security Act, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility, to receive an

optional state supplementary payment;

(20) [(19)] individuals in a hospital, skilled nursing facility, or intermediate care facility whose income while in the facility does not exceed 300 percent of the supplemental security income benefits rate under Title XVI of the Social Security Act, but who, because of income, are not eligible for the optional state supplementary payment;

(21) [(20)] individuals under age 21 under supervision of the department, for whom maintenance is being paid in whole or in part from public money and who are in foster homes or private child-care institutions.

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

Sec. 47.07.200. PAYMENT FOR PRESCRIBED DRUGS. Payment for prescribed drugs must be made in accordance with 42 CFR Part 447, Subpart D.

* Sec. 4. AS 47.07.900 is amended by adding a new paragraph to read:

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

* Sec. 5. This Act takes effect July 1, 1988.

CONTACT: RON SEDGWICK, REGISTERED PHARMACIST
LOBBYIST VOLUNTEER REPRESENTING ALASKAN
PHARMACISTS
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789-0458 WK 789-9628 WK 789-9522 HM

SB255

"AN ACT RELATING TO PHARMACEUTICAL MEDICAL ASSISTANCE FOR NEEDY PERSONS AND PROVIDING FOR AN EFFECTIVE DATE.

PURPOSE:

THE PURPOSE OF SB 255 IS TO ALLOW THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES TO OBTAIN 50/50 FEDERAL MATCHING FUNDING FOR DRUGS PRESCRIBED FOR MEDICAID RECIPIENTS UNDER THE FEDERAL MEDICAID PROGRAM RATHER THAN FUNDING THE PRESCRIPTIONS UNDER THE STATE GENERAL FUNDED GENERAL RELIEF MEDICAL PROGRAM AS HAS BEEN THE PRACTICE SINCE THE EARLY 1970'S.

BACKGROUND:

IN THE EARLY 1970'S, ALASKA JOINED THE FEDERAL MEDICAID PROGRAM INTENDING TO OFFER ALL ESSENTIAL MEDICAL SERVICES TO MEDICAID ELIGIBLES INCLUDING PHARMACEUTICALS.

BECAUSE OF THE CRUSHING ECONOMIC IMPACT OF THE MANDATED REIMBURSEMENT SCHEME IMPOSED BY FEDERAL REGULATIONS UPON PHARMACIES, THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES WAS UNABLE TO ENLIST PHARMACY PROVIDERS IN ANY AREA OF THE STATE. IN ORDER TO RESOLVE THE PROBLEM AND PROVIDE PHARMACY SERVICES, THE DEPARTMENT WITHDREW PHARMACEUTICAL SERVICES FROM THE MEDICAID PROGRAM AND PLACED IT UNDER THE STATE FUNDED GENERAL RELIEF MEDICAL PROGRAM, THUS ALLOWING REIMBURSEMENT TO BE SET AT MARKETPLACE LEVELS AS WELL AS REMOVING A PROPOSAL FOR A RESTRICTIVE FORMULARY THAT LIMITED THE DRUGS THAT A PHYSICIAN OR OTHER PRESCRIBER HAD AVAILABLE TO USE. THE NEW PROGRAM, FREE FROM UNREASONABLE FEDERAL RESTRICTION WAS WELL ACCEPTED STATE-WIDE AND HAS SINCE PROVEN TO BE AN EASILY ADMINISTERED EFFECTIVE PROGRAM. MEDICAID RECIPIENTS RECEIVE THE MAXIMUM BENEFITS FOR THE DOLLARS SPENT AND THE PHARMACY AND MEDICAL COMMUNITIES FIND THE PROGRAM FAIRLY STRUCTURED AND EASY TO WORK UNDER.

WITHIN THE EXISTING SYSTEM MEDICAID PRESCRIPTIONS CAN BE TREATED IN THE SAME MANNER AS ALL OTHER PRESCRIPTIONS BY THE PHARMACIST AND THE RECIPIENT RECEIVES THE SAME MEDICATIONS

AS THE GENERAL PUBLIC DOES. THE PHARMACY IS NOT FORCED TO STOCK A SEPARATE INVENTORY OF EXTREMELY LOW COST ITEMS JUST TO MEET FEDERAL PRICE CRITERIA IN DISPENSING MEDICAID PRESCRIPTIONS.

WE HAVE BEEN TOLD BY THE DIVISION OF MEDICAL ASSISTANCE THAT THEIR ONLY MOTIVATION TO CHANGE FROM THE EXISTING SYSTEM IS TO OBTAIN THE FEDERAL MATCHING FUNDS.

ARGUMENTS:

"THE MEDICAID RULES CONCERNING PAYMENT FOR DRUGS WOULD CAUSE ALASKA PHARMACIES TO BE REIMBURSED FOR SERVICES AT LEVELS FAR BELOW CURRENT MARKETPLACE LEVELS"

EVEN THOUGH FEDERAL MEDICAID RULES CONCERNING PAYMENT FOR DRUGS WERE AMENDED LAST OCTOBER AND NOW ALLOW SOME STATE LEVEL FLEXIBILITY, THE RULES STILL WILL ONLY ALLOW REIMBURSEMENT UNDER AN ACQUISITION COST PLUS A FIXED FEE SYSTEM.

MOST PHARMACIES, LIKE ANY TYPICAL RETAIL OPERATION, OPERATE UTILIZING A PERCENTAGE MARKUP SYSTEM. AS THE ACQUISITION COST OF AN ITEM INCREASES, THE MARGIN OF GROSS PROFIT INCREASES PROPORTIONATELY. A 33% MARGIN IN NOT AN UNUSUAL RETAIL MARGIN TO USE AS AN EXAMPLE. THUS A TYPICAL ITEM WITH AN ACQUISITION COST OF $1.00 MIGHT BE SOLD AT $1.50. LIKEWISE AN ITEM WITH AN ACQUISITION COST OF $100.00 WOULD BE SOLD AT $150.00 TO MAINTAIN THE SAME GROSS MARGIN.

A FIXED FEE SYSTEM DOES NOT ALLOW FOR THE FEE TO VARY UPWARD AS THE ACQUISITION COST INCREASES. USING A TYPICAL MEDICAID FEE AS CURRENTLY USED IN SEATTLE FOR AN EXAMPLE ($3.40) WE CAN APPLY THE FEE SYSTEM TO THE EXAMPLES ABOVE. IF THE ACQUISITION COST OF $1.00 IS ADDED TO THE FEE EXAMPLE ($3.40) THE SELLING PRICE WOULD BE $4.40. THE FEE ADDED TO THE $100.00 ACQUISITION COST WOULD GIVE A SELLING PRICE OF $103.40. (IN ACTUAL PRACTICE PRESCRIPTION PRICES FALL WITHIN A RANGE OF 1.50 TO 125.00 WITH SOME HIGHER EXCEPTIONS AND THE AVERAGE PRICE FALLING IN THE 20.00 TO 25.00 RANGE)

THE TOTAL REVENUE PRODUCED BY THE PERCENTAGE MARKUP SYSTEM EXAMPLE IS $151.50. THE TOTAL REVENUE FROM THE FEE SYSTEM EXAMPLE IS $107.80. THE LOSS IN REVENUE PRODUCED BY THE MANDATED FIXED FEE TYPE SYSTEM IS OBVIOUS EVEN IF A SOMEWHAT HIGHER FEE IS SET FOR USE IN ALASKA.

ANOTHER MANDATED FEDERAL RULE ALSO COMES INTO PLAY. THIS RULE STATES THAT THE REIMBURSEMENT WILL BE EITHER THE

ACQUISITION COST PLUS THE FIXED FEE AS ABOVE OR "THE USUAL AND CUSTOMARY CHARGE TO THE PUBLIC" WHICHEVER IS LESS.

IN THE ABOVE EXAMPLES, SINCE THE "USUAL AND CUSTOMARY" PRICE FOR THE $1.00 COST ITEM IS $1.50, THIS IS THE AMOUNT THAT WOULD BE REIMBURSED. SO THE FEDERAL SYSTEM WOULD REALLY ONLY REIMBURSE A TOTAL OF $104.90 AN EVEN GREATER LOSS IN REVENUE!

THERE IS YET ANOTHER ASPECT OF MEDICAID SYSTEMS AS THEY EXIST IN OTHER STATES THAT FURTHER CUTS REVENUE TO THE PHARMACY.

THE TYPICAL PHARMACY USES AN ACQUISITION COST BASIS OF "AVERAGE WHOLESALE PRICE". THESE PRICES ARE EASILY AVAILABLE IN EITHER PRINTED FORM OR ON MAGNETIC MEDIA READABLE BY COMPUTER SYSTEMS AND BASED ON AVERAGES OF WHOLESALE PRICES ACROSS THE UNITED STATES AS COMPILED BY ONE OF SEVERAL SERVICE COMPANIES. THESE LISTS ARE CONSTANTLY UPDATED AND MADE AVAILABLE ON UP TO A WEEKLY BASIS IF REQUIRED. THESE PRICES ARE USED BY ESSENTIALLY ALL PHARMACY COMPUTER SYSTEMS IN THEIR AUTOMATED PRICING FUNCTIONS. MOST DRUG WHOLESALERS ALSO BASE THEIR INVOICING TO THE PHARMACY ON THESE "AWP" LEVELS.

MANY MEDICAID REIMBURSEMENT SYSTEMS IN THE WESTERN STATES AND ELSEWHERE NOW MANDATE THAT PERCENTAGES UP TO 11% BE SUBTRACTED FROM "AVERAGE WHOLESALE PRICE" BEFORE ADDING THE FIXED FEE. THIS IS BASED UPON THE THEORY THAT BECAUSE SOME WHOLESALERS MAY EXTEND DISCOUNTS TO SOME PHARMACIES BASED UPON PAYMENT IN ADVANCE FOR GOODS, TIMELY PAYMENT OF INVOICES, PURCHASES EXCEEDING SET QUANTITY LEVELS, TOTAL OF MONTHLY VOLUME OF PURCHASES ETC. OR OTHER EARNED DISCOUNTS, THESES "DISCOUNTS" SHOULD BE PASSED ALONG TO THE MEDICAID PROGRAM REGARDLESS OF WHETHER ALL PHARMACIES RECEIVED THEM OR NOT! ONE MORE INCREMENTAL LOSS IN REVENUE FROM THE MEDICAID RULES.

THE RECENT CHANGES IN THE FEDERAL RULES DEAL MAINLY WITH THE "INGREDIENT COST" PORTION OF THE REIMBURSEMENT FORMULA. THEY MAY VERY WELL HELP TO ALLOW THE STATE TO GET CLOSER TO REALITY IN REIMBURSING FOR THE INGREDIENT COST BUT DO NOT ALLOW FOR A REALISTIC OVERALL APPROACH TO REIMBURSE AT FAIR MARKETPLACE LEVELS FOR THE TOTAL PRESCRIPTION AS IS NOW DONE WITH THE EXISTING PROGRAM.

UTILIZING AN ANALYSIS OF A SAMPLE OF ABOUT 11,000 ACTUAL PRESCRIPTIONS OVER A 6 MONTH PERIOD FROM AN ALASKA PHARMACY, THE FOLLOWING STATISTICS WERE GATHERED.

THE PRICES WERE COMPUTED UTILIZING "AVERAGE WHOLESALE PRICE" AS THE ACQUISITION PRICE COMPONENT.

THE AVERAGE PRESCRIPTION PRICE WAS $25.61

THE AVERAGE GROSS PROFIT MARGIN WAS $9.56 OR 37% MARGIN

IF THE MEDICAID FEE AS USED IN SEATTLE ($3.40) WAS INCREASED BY AN "ALASKA COST OF LIVING" TYPE INCREMENT OF 20% WE WOULD HAVE A FEE OF $4.08. IF WE USE THIS FEE BASIS AND APPLY IT TO THE SAMPLE ABOVE WE FIND THAT THE TOTAL GROSS MARGIN WOULD BE REDUCED BY 57%!

THIS REDUCTION DOES NOT TAKE INTO ACCOUNT THE FURTHER LOSSES OCCURRING FROM THE APPLICATION OF THE "LOWER OF " USUAL AND CUSTOMARY OR COST + FEE AS EXPLAINED ABOVE OR THE UP TO 11% REDUCTION FROM "AVERAGE WHOLESALE PRICE" AS USED IN SEATTLE AND OTHER AREAS! THIS COULD INCREASE THE LOSS OF GROSS PROFIT ON MEDICAID PRESCRIPTIONS TO AS HIGH AS 70% BELOW THE CURRENT LEVEL OF REIMBURSEMENT. HOW CAN THIS POSSIBLY BE CONSTRUED AS "REASONABLE PAYMENTS TO PHARMACIES" AS TOUTED BY THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES UNDER THE PROPOSED LEGISLATION.

THE TOTAL IMPACT OF THIS LEGISLATION ON EACH INDIVIDUAL PHARMACY WOULD OF COURSE DEPEND ON THE VOLUME OF MEDICAID PRESCRIPTIONS FILLED BY THAT PHARMACY. AT THIS TIME WE HAVE RECEIVED ESTIMATES FROM AROUND THE STATE VARYING FROM 10 PERCENT TO 33 PERCENT OF TOTAL PRESCRIPTIONS FILLED. THE PERCENTAGE VARIES WITH THE DEMOGRAPHICS OF THE TRADE AREA SERVED BY THE PHARMACY. IT IS QUITE OBVIOUS THAT A PHARMACY WITH A HIGH VOLUME OF OF MEDICAID PRESCRIPTIONS COULD EASILY BE FORCED INTO BUSINESS FAILURE BY ADOPTING THIS LEGISLATION. SIX PHARMACIES IN THE ANCHORAGE AREA ALONE HAVE ALREADY CLOSED BECAUSE OF EXISTING ECONOMIC PRESSURES OVER THE LAST YEAR. ADDING THE ADDITIONAL NEGATIVE IMPACT OF THIS LEGISLATION COULD EASILY PUSH ADDITIONAL PHARMACIES OVER THE EDGE TO BUSINESS FAILURE. FAILURE OF A PHARMACY NOT ONLY AFFECTS THE MEDICAID RECIPIENTS BUT ALL ALASKANS IN THE TRADE AREA. THE SCENARIO OF THE LOSS OF A PHARMACY FROM AN ALASKAN TOWN WHERE ONLY ONE PHARMACY EXISTS COULD BE DEVASTATING TO HEALTH CARE IN THAT COMMUNITY FOR ALL ITS RESIDENTS.

ARGUMENT: "ALL OTHER STATES HAVE A PHARMACY MEDICAID PROGRAM WITH PLENTY OF PHARMACY PROVIDERS ENLISTED, THEREFORE THE FEDERAL MEDICAID SYSTEM MUST BE A GOOD ALTERNATIVE."

OVER THE PAST 15 TO 20 YEARS THE IMPACT OF THE MEDICAID PROGRAMS IN THE VARIOUS STATES HAS BEEN THE SINGLE MOST IMPORTANT ISSUE IMPACTING THE INDEPENDENT PHARMACIES IN THE NATION. MONTH AFTER MONTH WE HAVE FOLLOWED THE HORROR STORIES OF THE ECONOMIC IMPACT OF MEDICAID ON SMALL

BUSINESSES IN OUR PROFESSIONAL JOURNALS. THE SMALL FIXED FEE PER PRESCRIPTION, CONFISCATION OF EARNED DISCOUNTS, SLOW PAYMENT CYCLES, REJECTION OF BILLINGS FOR "ADMINISTRATIVE" REASONS HAVE ALL HAD THEIR IMPACT ON THE SURVIVAL OF THE SMALLER, INDEPENDENT PHARMACIES. SMALL MOM AND POP TYPE BUSINESSES, ESPECIALLY THOSE IN HIGH PERCENTAGE MEDICAID AREAS (IE NEW YORK AND LOS ANGELES) WERE, AND CONTINUE TO BE, ONE BY ONE FORCED OUT OF BUSINESS. SINCE MANY STATES STARTED THEIR PROGRAMS IN THE LATE 1960'S AND EARLY 1970'S, BY TODAY THE LARGEST PART OF THE SHAKEOUT HAS ALREADY OCCURRED AND THE SURVIVORS ARE MAINLY THE LARGE CHAIN-STORE OPERATIONS. THE TYPICAL LARGE CHAIN OPERATION UTILIZES THE PHARMACY DEPARTMENT NOT AS A MAJOR PROFIT CENTER WITHIN THE LARGE BUSINESS OPERATION, BUT AS A "TRAFFIC CENTER" OR A MEANS TO ATTRACT CUSTOMERS INTO THE STORE SO THAT OTHER PURCHASES ADD UP TO THE NECESSARY PROFITS AND THE PHARMACY DEPARTMENT OPERATES SLIGHTLY ABOVE OR BELOW THE BREAK-EVEN POINT. THIS MAKES THIS TYPE OPERATION MORE LIKELY TO SURVIVE A FIXED FEE SYSTEM. A SMALL PHARMACY DEPENDS ON THE PRESCRIPTION SERVICES PROVIDED AS ITS MAJOR SOURCE OF INCOME AND THEREFORE WHEN MARGINS ARE CUT SEVERELY, THE IMPACT IS NATURALLY MUCH GREATER.

THE "SHAKE-OUT" WE HAVE OBSERVED IN THE LOWER FORTY-EIGHT IS EXACTLY WHAT WE FEAR HERE IN ALASKA. THIS IS ESPECIALLY TRUE BECAUSE THE MAJORITY OF PHARMACIES STILL FALL INTO THE "MOM AND POP" TYPE CATEGORY. THE POTENTIAL FOR HARM IS EVEN MORE IMPORTANT IN THOSE SMALL TOWNS IN ALASKA WHERE ONLY ONE PHARMACY EXISTS. IF THESE SMALL TOWN PHARMACIES ARE HIGHLY IMPACTED BY A LARGE MEDICAID POPULATION THE POTENTIAL FOR LOSS OF SERVICE TO THE ENTIRE COMMUNITY OF THIS SINGLE SOURCE PROVIDER WOULD INDEED BE DEVASTATING TO THE ENTIRE HEALTH CARE PICTURE OF SUCH A COMMUNITY. THE ANCHORAGE/RAILBELT, FAIRBANKS AND JUNEAU ARE THE ONLY AREAS OF THE STATE THAT HAVE CURRENTLY ATTRACTED THE LARGER CHAIN TYPE OPERATIONS THAT MIGHT HAVE A BETTER CHANCE OF SURVIVING A FIXED FEE MEDICAID SYSTEM.

THE CURRENT ECONOMIC PRESSURES OF THE EXISTING MARKETPLACE SUCH AS THE GROWING ONSLAUGHT OF MAIL-ORDER PRESCRIPTION PLANS PUSHED BY VARIOUS INSURANCE COMPANIES ARE ALREADY MAKING IT TOUGHER ON THE INDEPENDENT PHARMACIES TO REMAIN PROFITABLE. ADDING A DEVASTATING FEDERAL MEDICAID PROGRAM IN ALASKA WOULD DEFINITELY MAKE THE FUTURE EVEN BLACKER FOR MANY.

CONCLUSION:

WE BELIEVE THAT THE PRESENT STATE-FUNDED PROGRAM IS WELL WORTH KEEPING.

IT PROVIDES THE MEDICAID RECIPIENT WITH AN UN-RESTRICTED PROGRAM UNDER WHICH ANY NEEDED PRESCRIPTION IS AVAILABLE.

IT ALLOWS THE PHYSICIAN TO CHOOSE THE DRUG THERAPY HE DEEMS NECESSARY AND HE IS NOT ENCUMBERED BY RESTRICTIVE FORMULARIES THAT FORCE DRUG SELECTION BASED ON INGREDIENT COST RATHER THAN THERAPEUTIC EFFECTIVENESS.

IT ALLOWS THE PHARMACIST TO TREAT THE MEDICAID PATIENT IN THE SAME MANNER AS THE GENERAL PUBLIC, BE REIMBURSED FAIRLY FOR HIS SERVICES, AND BE FREE FROM OVERLY ENCUMBERING PAPER WORK. THE CURRENT PER RECIPIENT COSTS ARE NOT NOW OUT OF RANGE WITH PROGRAMS IN OTHER STATES.

IT ALLOWS THE STATE ADMINISTRATORS THE TRUE VERSATILITY TO SHAPE A PROGRAM THAT WORKS WELL IN ALASKA WITHOUT THE PRESSURES FROM THE FEDERAL GOVERNMENT TO CONFORM TO THEIR "STANDARDS". ONCE WE ACCEPT THE "HELP" OF THE FEDERAL ADMINISTRATORS, WE NO LONGER CONTROL THE PROGRAM, THEY DO!

BECAUSE WE ARE TALKING ABOUT SUCH A SMALL PERCENTAGE OF THE MEDICAID BUDGET BEING SPENT FOR PHARMACEUTICALS AT PRESENT (ABOUT 3-4%), THE SMALL OVERALL SAVINGS AFTER PAYING FOR THE ADDITIONAL ADMINISTRATIVE COSTS CAN NOT POSSIBLY JUSTIFY HURTING MEDICAID RECIPIENTS AND PHARMACY PROVIDERS ALIKE BY CHANGING TO THE FEDERAL NIGHTMARE WE HAVE SEEN IN THE OTHER STATES.

BEFORE WE SHIFT DOLLARS FROM GOOD PATIENT CARE TO ADMINISTERING THE ADDED LAYERS OF FEDERAL RESTRICTIONS IN A MEDICAID PHARMACY PROGRAM, WE SHOULD BE SURE THAT THERE ARE BENEFITS OTHER THAN EXPANDING THE BUREAUCRACY AND A MINIMUM OF DETRIMENTS TO RECIPIENTS, PRESCRIBERS AND PHARMACY PROVIDERS.

RECOMMENDATIONS:

IF IT IS TRULY POSSIBLE TO PROTECT OURSELVES FROM THE WHIMS OF THE FEDERAL BUREAUCRACY BY SETTING UP AN ALASKA PHARMACY MEDICAID PROGRAM THAT MEETS THE FEDERAL STANDARDS BUT KEEPS CONTROL WITHIN ALASKA STATUTE THAT ONLY THE ALASKA LEGISLATURE CAN CHANGE AND CAN'T BE CHANGED AT THE WHIM OF CHANGES IN THE STATE ADMINISTRATORS, THEN AND ONLY THEN PERHAPS GOING AFTER THE FEDERAL MATCHING MONIES WOULD BE ADVISABLE. THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES

SEEMS TO THINK SUCH A PROGRAM IS POSSIBLE UNDER THE LATEST FEDERAL REGULATIONS, BUT OUR DIRECT CONTACTS WITH FEDERAL OFFICIALS DO NOT CONFIRM THE OPTIMISM OF THE DEPARTMENT. THE WORKINGS OF A FEDERAL/STATE FUNDED PHARMACY PROGRAM SHOULD BE NAILED DOWN FIRST BY OUR ADMINISTRATION OFFICIALS IN A COOPERATIVE EFFORT WITH THE ALASKAN HEALTH CARE COMMUNITY TO INSURE THAT THE OUTCOME WOULD BE WORKABLE FOR ALL. PHARMACY PROVIDERS SHOULD NOT BE FORCED TO ACCEPT AN UNDEFINED PROGRAM NOW AND THEN "WAIT AND SEE" HOW IT ACTUALLY TURNS OUT. OUR OBSERVATIONS OF THE WOES THAT PHARMACISTS FACE IN THE OTHER STATES MANDATE OUR ATTITUDE IN THIS REGARD.

PHARMACISTS WOULD LIKE TO SEE THE PRESENT GENERAL RELIEF MEDICAL/STATE FUNDED PHARMACY PROGRAM FUNDED AS IN THE PAST AND AN INTERIM WORKING COMMITTEE STRUCTURED TO COME UP WITH POSSIBLE LEGISLATION FOR THE NEXT LEGISLATIVE TERM.

IF THIS IS NOT POSSIBLE, THEN LANGUAGE SHOULD BE INCLUDED IN SB255 TO INSURE THAT FULL PHARMACY SERVICES ARE PROVIDED TO MEDICAID RECIPIENTS AND THAT PHARMACY PROVIDERS ARE REIMBURSED FOR THEIR SERVICES AT TRUE MID-RANGE MARKET-PLACE LEVELS WITH CONTROLS TO PREVENT THE STATE FROM PAYING ABOVE THESE LEVELS.

ORGANIZED PHARMACY IN ALASKA IS WILLING AND ABLE TO WORK CLOSELY WITH THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES AND THE LEGISLATURE TO REACH THE GOALS OF ALL SIDES AND WOULD WELCOME A STRONG OVERSIGHT FUNCTION FROM THE LEGISLATURE IN ACCOMPLISHING THESE GOALS.

ALL FEDERAL MATCHING FUNDS ARE NOT NECESSARILY WORTH JUMPING FOR IMMEDIATELY WITHOUT CAREFULLY CONSIDERING THE CONSEQUENCES TO ALL AFFECTED PARTIES. LET'S NOT FALL INTO THE TRAP AS HAVE SO MANY OTHER STATES AND CREATE SOME UNNEEDED DEVASTATION WITHIN THE PHARMACY PROVIDER COMMUNITY IN ALASKA.

Alaskan Communities with One Pharmacy
March 1988

Anchor Point
Bethel
Cordova
Delta Junction
Girdwood
Glenallen
Petersburg
Seldovia
Seward
Wrangell
Valdez

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.

d255

STEVE COWPER
GOVERNOR

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

April 9, 1987

The Honorable Jan Faiks
President of the Senate
Alaska State Legislature
P.O. Box V
Juneau, AK 99811

Dear Senator Faiks:

Under the authority of art. III, sec. 18, of the Alaska Constitution, I am transmitting a bill that will add coverage of prescribed drugs to the medicaid program. The effect of this is to transfer from the general relief medical assistance (GRM) program funding for pharmaceuticals for medicaid-eligible people. This transfer will make payment of these benefits eligible for 50 percent federal financial participation instead of being paid entirely from the state general fund.

Sections 1 -- 4 of the bill provide coverage of "prescribed drugs" in the medicaid statutes. Section 5 provides a July 1, 1988 effective date because FY88 is a year of transition between medical claims payment systems and a savings cannot be effected immediately.

Currently, prescribed drugs for eligible needy persons are provided under the state general relief medical assistance program (AS 47.25.120, et seq.) wholly from state money. Because federal financial participation for the cost of prescribed drugs is available to the state if it instead offers prescribed drugs through the state medicaid program, a substantial cost savings to the state will be realized by simply offering prescribed drugs through another assistance mechanism.

The benefit of this bill is the substantial cost savings to the state with no adverse effect on needy persons served. Your favorable action on this measure will significantly improve the financial handling of this service and relieve the burden on the general fund -- a necessity at this time of state fiscal crisis.

Sincerely,

Steve Cowper
Governor

OSITION PAPER/Department of Health & Social Services

SB 255

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

I. Purpose of SB 255:

The purpose of SB 255 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 of dental coverage from the 100% state funded General Relief Medical 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 SB 255 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: 2-2-88

Approved by: Myra M. Munson

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

Date: 2-2-88

ALASKA PHARMACEUTICAL ASSOCIATION

Box 10-1185 Anchorage, Alaska 99510

POSITION PAPER

SB 255

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

PURPOSE: To allow the Department of Health and Social Services to obtain federal revenue by funding prescribed drugs for Medicaid reciepients under the Federal Medicaid program rather then under the state funded General Relief Medical Program.

BACKGROUND

ARGUMENT: "All states, except Alaska, 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."

RESPONSE: Most states began participation in the Federal Medicaid program 15 to 20 years ago. Many independent, small pharmacies were unable to survive under the imposed fees and bureaucracy of the program. It is probably true that there is little withdrawal of pharmacies from the program today. However, this is only because the devastation was wrought in these states many years ago, when the programs were begun, leaving the large chain store operations and a few independent pharmacies who had enough non-Medicaid business to survive.

ARGUMENT: "The Department believes that a Medicaid drug program will continue to result in reasonable payments to pharmacies. The Medicaid rules concerning payment for drugs were amended last October. The new rules offer the state substantial flexibility....in setting payment rates for drugs."

RESPONSE: The Department is asking pharmacists to blindly accept and embrace participation in a program with no set guidelines of operation and no established rates, fees, or levels of reimbursement. To this date, the amended Medicaid rules have not resulted in any significant change in payment rates for any state. In response to the issue of reasonable payments to pharmacies, the Association references the previously submitted position paper of Ron Sedgwick, Registered Pharmacist. The Association agrees with and supports Mr. Sedgwick's

observations and arguments. The Department implies that the Medicaid rules and reimbursement would not necessarily cause Alaska pharmacies to lose money. There is no question that the operating margins of those pharmacies participating in this program would be significantly reduced. It is only a question of how much Medicaid business each individual pharmacy has and whether the new bottom line will sustain operations.

ARGUMENT: "The shift in funding sources from GRM to Medicaid is unlikely to have any effect on the utilization patterns of most Medicaid-eligible natives."

RESPONSE: The Association disagrees with this assessment. In addition, there will also be a percentage of the current GRM covered population who will not qualify for Medicaid participation under the more stringent Federal eligibility rules. Funding for this group will remain entirely with the state. The Department of Health and Social Services has not identified this financial responsibility.

ARGUMENT: "The Department can assure that the addition of this option will result in a significant annual cost savings to the state without comprimising services to Alaskans."

RESPONSE: Can the Department assure that Alaskans will not lose their jobs or their businesses by the addition of this option to the Medicaid program? Can the Department assure that these Alaskans will maintain their standard of living for those fortunate enough to retain their jobs or businesses after the addition of this option?

How will the Department assure that service will not be comprimised to Alaskans if a small pharmacy, serving a rural Alaskan area, fails because of reduced operating margins as a result of adding this option? Loss of a single source provider for a rural area will affect not only the Medicaid population, but the entire community and service area. How can this not comprimise Alaskan health care?

CONCLUSIONS

The present state funded program well serves both the health care community and the medical assistance recipients.

Physicians are able to select drug therapy for the patient based on therapeutic effectiveness rather than be restricted to a drug formulary based on drug acquisition cost.

Pharmacists are able to serve the medical assistance patient in the same manner as the general public and is compensated fairly and on the same basis as they are for the general public.

Passage of SB 255 at this time would severely impact the financial picture of Alaskan pharmacies, ultimately resulting in some business failures. The net effect will be loss of jobs for Alaskans and comprimised health care for those

residents of rural areas served by single pharmacies which do not remain financially viable.

Independent pharmacies are already subjected to a barrage of economic pressures such as mail order prescription programs and physician dispensing of drugs for profit. In Anchorage alone, five pharmacies have already closed over the past year due to the existing economic climate. How many more businesses will be condemned to failure and jobs lost by the addition of one more unfair economic burden?

Under current reimbursement rates used in the lower 48 states for Medicaid patients, the legislature and State of Alaska would be asking pharmacies, their employees and their non-Medicaid customers to further subsidize health care for this population.

The amount spent for pharmaceuticals at present is a very small percentage of the Medicaid budget. Are the above impacts and offsets to cost savings truly worth the 50% Federal funds the state stands to gain?

RECOMMENDATIONS

The Alaska Pharmaceutical Association strongly urges defeat of SB 255 at this time. We cannot endorse acceptance of an undefined program, which as administered in the lower 48 states, would be economically devastating to the members of our association.

The Department of Health and Social Services appears to believe that under amended Medicaid rules, it would be possible to design a program and establish acceptable payment rates for drugs. Their <u>own</u> position paper <u>implies</u> that previous Medicaid regulations and rules (most of which still exist) did not provide enough flexibility and freedom for the state in establishing this program.

The Association is willing to work closely with the Department of Health and Social Services in designing a Medicaid program and establishing a reimbursement system which is reasonable and fair to pharmacy providers and which allows the state to realize actual savings.

The Alaska Pharmaceutical Association recommends that the Senate direct the Department of Health and Social Services to work with the Association over the next year in designing such a program. If this cooperative effort produced a program which would be accepted in writing at the Federal level, the Association would be happy to support new legislation at the next session.

As an interim measure, the Alaska Pharmaceutical Association urges defeat of SB 255 this year, and asks that the General Relief Medical Program be funded to provide pharmaceutical medical assistance for FY 89.

CONTACT

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Alaska State Legislature

SENATE

Committee on Finance

Official Business

P.O. Box V
State Capitol
Juneau, Alaska 99811

LETTER OF INTENT ON SB 255

It is the intent of the Legislature that as regulations are developed to implement this legislation that the form of the current general relief medical pharmacy program be duplicated to the extent consistent with federal guidelines. The goal of the Department of Health and Social Services shall be to seek a reimbursement system consistent with the usual, customary and reasonable fees charged by pharmacies to the Alaskan general public. The regulations should avoid harsh economic impact on the pharmacy provider community to insure the participation of the largest number of pharmacy providers across the state to allow the maximum access to pharmacy services by the medicaid recipient community. Legislative Audit shall perform a review of the program and report to the Legislature by February 1, 1989.

JB

2/20/88 S (Hss) Hsm Fin

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION: SB 255
PUBLISH DATE: _____

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: 465-3355
Division: Medical Assistance Date: 2-2-88

Approved by Commissioner: Myra Munson Myra 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)

RECEIVED
FEB 19 1988
LEGISLATIVE FINANCE

page ____ of ____

SB255

FISCAL NOTE ANALYSIS

SB 255

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

FY89 Governor's Medical Assistance Request

	GF	Total
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	6,639.2	6,639.2

	FED	GFM	Program	Total
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	1,370.6	-0-	-0-	1,370.6
REVISED	18,516.0	18,583.8	169.0	37,268.8

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, meetings with the pharmacy association, and gathering data for pricing compounded drugs.	$10,000

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:	$ 1,500
Total	$117,500
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.

STATE OF ALASKA 1987 LEGISLATIVE SESSION
FISCAL NOTE

REQUEST:

Bill Version : SB255
Publish Date :

Revision Date:
Title : An Act relating to pharmaceutical Med. Assist. for needy persons; eff.
Sponsor :
Requestor :

Agency Affected : Health and Social Services
BRU : Medical Assistance

Components : General Relief Medical

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
PERSONAL SERVICES		48.6				
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS		1,100.0	1,166.0	1,235.9	1,310.1	1,388.7
MISCELLANEOUS						
TOTAL OPERATING		1,148.6	1,166.0	1,235.9	1,310.1	1,388.7
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND		1,124.3	1,166.0	1,235.9	1,310.1	1,388.7
FEDERAL FUNDS		24.3	1,166.0	1,235.9	1,310.1	1,388.7
OTHER						
TOTAL		1,148.6	2,332.0	2,471.8	2,620.2	2,777.4

POSITIONS:

FULL-TIME		1.0				
PART-TIME						
TEMPORARY						

ANALYSIS :

SEE ATTACHED

Prepared by : Kim Busch, Acting Director (Nancy Bennett for)
Phone : 465-3355
Division : Medical Assistance
Date : 4/9/87

Approved by Commissioner : Myra M. Munson
Date : April 9, 1987
Agency : Health and Social Services

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)
Senate Secretary

SB255

ANALYSIS

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

With a move of prescription drugs from the General Relief Medical Component to the Medicaid Component, Medicaid funds would become available at a 50/50 federal financial participation 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.

The July 1, 1988 effective date of the bill would preclude any federal financial participation for prescription drug reimbursement for FY 88, but will capture federal matching funds related to the new position.

6% is assumed as annual inflation for prescription drugs.

Division of Medical Assistance

Personal Services:

1 - New Chief Pharmacist position
at Range 18A $3,113 x 12 months x 30% benefits = $48,562

The position costs are matched 50/50 with federal dollars.

SB255

FISCAL NOTE ANALYSIS

Background

The governor first introduced legislation for the addition of coverage for prescription drugs under the Medicaid program in 1985. In the past, this change was depicted as an immediate cost savings with the state claiming federal dollars for fifty-percent of every Medicaid pharmacy claim.

It is certain that this legislation will still result in a substantial cost savings to the state. However, as depicted in the fiscal note, since FY88 is a year of transition between medical claims payment computer systems and contractors, the savings could not be effected immediately. This change in the fiscal note and delay in general fund savings is due to the three transitional factors described below. In FY89, these factors will no longer be relevant and full savings will be achievable.

The Department is in the initial phase of designing, developing, and implementing a new Medicaid Management Information System (MMIS). The current contractor, Computer Science Corporation, is completing their final year as the fiscal intermediary for medical claims payment. The new contractor will be The Computer Company, and the new MMIS system is tentatively scheduled to be operational April 1, 1988.

Based on the minimum estimated time for design and implementation of a Medicaid drug program (6 months), we do not believe the current contractor is capable of cost-effective implementation of the highly complex changes which are described below. A work order costing at least $20,000 would be necessary to change the current payment system to make payments under a

federally approvable methodology. Further, we do not believe it would be cost effective for the state to implement a new drug payment system twice in one fiscal year.

Implementation of a Medicaid drug program requires the following actions:

A. The state must establish a federally-approvable methodology for determining the ingredient cost of each covered prescribed drug. The ingredient cost must be no more than the estimated actual cost of what the pharmacist pays the wholesaler for the drug. This methodology must be approved by the federal government and programmed into the claims payment system.

B. The state must establish a dispensing fee. A survey of Alaska pharmacies to gather cost data on dispensing costs must be completed prior to establishing the fee. The fee may allow for geographical differentials and differentials in the volume of business conducted by the pharmacies.

C. The state must use "Blue Book" computer tapes at least monthly to keep drug prices current in the payment system. The new MMIS will use "Blue Book" tapes which the contractor will buy. The current payment system uses "Blue Book" tapes but is programmed only to update national drug codes (NDC) and not average wholesale prices.

D. A pharmacist must be hired to conduct the research necessary to establish ingredient costs, conduct the survey necessary to establish dispensing fees and provide maintenance of the on-going system. Maintenance requirements include:

1. ensuring that the federal maximum allowable costs for specific generic drugs are not exceeded;

2. trouble shooting between the payment system and the pharmacists on individual claims;

3. establishing codes and payments for FDA approved compounded drugs (drugs which are not included on the Blue Book tape and which do not have a national drug code);

4. working as liasion with Health Care Financing Administration to ensure that federal changes in Medicaid payment for drugs are made accurately and timely; and

5. working as a liasion with the Alaska Pharmacy Association members to ensure that Medicaid and General Relief Medical Assistance recipients continue to have adequate access to pharmacy services.

The design, development, and implementation of the $10 million MMIS will require the dedication of a substantial portion of current division staffs' time. A Medicaid drug program can be made part of the current work plan

for MMIS. However, there is not sufficient staff to also develop a Medicaid drug program for the current payment system prior to April 1, 1988, which is the date on which the new MMIS should be fully operational.

The federal government is likely to issue new guidelines this fiscal year which will alter Medicaid drug payments. In August, 1986, the federal government published proposed regulations which described three separate methodologies which may substantially change the requirements for coverage of drugs under Medicaid. The Health Care Financing Administration does not have information on when the final regulations will be published. However, they intend to publish the regulations prior to October 1, 1987. The new MMIS can be flexibly programmed to adapt to the proposed federal changes.

Even with the coverage of drugs under Medicaid, the Department still intends to continue coverage of drugs for indigent people who are not eligible for Medicaid. Therefore, a portion of the budget must still be allocated to provide payment for drugs for General Relief Medical Assistance recipients.

Summary

The Department believes that the coverage option for prescribed drugs should be added to Alaska's Medicaid program. Further, the Department assures that with the new MMIS and sufficient staff this change can be made efficiently and save the state fifty-percent of the annual expenditure for drugs for Medicaid-eligible people.