SB
255

STEVE COWPER
GOVERNOR

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

MEMORANDUM

TO: The Honorable Don Bennett

FROM: George Sullivan
Legislative Liaison
Office of the Governor

DATE: May 5, 1987

SUBJECT: SB 255

We discussed SB 255 on Pharmaceuticals/GRM and I recall you expressed concern that the Alaskan Natives that would likely participate in this program would far exceed in costs what we were projecting in savings to the state.

I am attaching a letter from Commissioner Myra Munson for your information. Her best estimate indicates that the state could still save in excess of over 1 million dollars a year by passage of SB 255.

Enclosure

cc: The Honorable Willie Hensley w/enclosure
The Honorable Johne Binkley w/enclosure
The Honorable Fred Zharoff w/enclosure
The Honorable Paul Fischer w/enclosure

Paul:

Is there any additional information we could provide you to get this bill out of your committee? If so, give me a ring at 3500.

George

MEMORANDUM

State of Alaska

TO: George Sullivan
Legislative Lobbyist
Office of the Governor

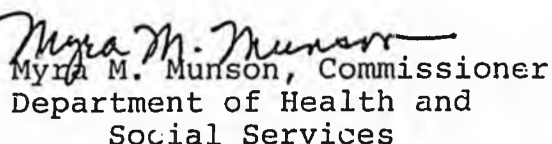
DATE: May 4, 1987

FILE NO:

TELEPHONE NO: 465-3030

THRU:

SUBJECT: Crossover of Natives into Medicaid Drug Program



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

It is correct that more Alaskan Natives are likely to participate in a Medicaid-funded pharmacy program than currently participate in the General Relief Medical Assistance (GRM)-funded pharmacy program. However, we have determined that the maximum cost to the state will not exceed $410,500 and will most likely not cost more than $136,600. The net effect of passage of SB 255 will be a 1 million dollar savings to the state, even with the crossover of Natives from GRM.

There are currently 24,000 Alaskans eligible for Medicaid. Approximately 10,500 are Natives. To qualify for Medicaid, an individual must be aged, blind, disabled, under age 21, an AFDC parent, or pregnant and impoverished. The addition of pharmacy services to Medicaid will not result in an increase in the number of Medicaid-eligible Natives; however, it is likely to result in an increase in the number of non-IHS pharmacy claims for Medicaid-eligible Natives for which the state must pay 50% of the charge. (Note: as provided under federal rules, the state can claim 100% federal reimbursement for all of the medical bills submitted from IHS facilities.)

15% of Medicaid-eligible Natives are currently recorded as using pharmacy services at a cost of $260,342 in state funds per year. However, declaration of race on the application is voluntary and experience has shown that as high as 50% of the individuals in the unknown category are, in fact, Native. Nevertheless, the average utilization of pharmacy services by other groups is 69%, so if all 69% of the Medicaid-eligible Natives purchased drugs at non-IHS facilities, it would cost the state a maximum of $410,333.

It is very unlikely that all Medicaid-eligible Natives will change their pharmacy utilization patterns because:

1. Prior experience has shown that not all Natives will use non-IHS facilities, especially in places like Bethel and Nome; and

2. at least 15% (and probably many more) of the Natives have already crossed over to the State program, especially in those areas where an IHS facility does not exist or is less convenient than private pharmacies;

3. the Native crossover phenmenon did not occur to non-IHS facilities when other, more costly services were moved from GRM to Medicaid in recent years; and

4. the amount paid per prescription will generally be less under a Medicaid drug program, resulting in an overall less expensive drug program for the state.

Finally, as you know, no savings will accrue to the state from passage of this bill until the offset for FY89. The bill's July 1, 1988 effect date allows the department to plan and to implement the changes necessary to administer a Medicaid pharmacy program at a very opportune time. The department is in the process of developing and implementing a new medical payments system that will not be operational until Spring of 1988. It is not feasible or cost-effective to make the necessary changes in the existing payment system with the current contractor while we are in the process of designing a new system with a new contractor. Although it is unfortunate that we can't begin to save money sooner, I believe that the delay carries several advantages. First, it allows the state to hire a pharmacist to assist with designing and testing the new payment system while working with pharmacists throughout the state to ensure that it is a system that they can accept and secondly, it allows the state to claim 75% FFP instead of the current 50% FFP for the actual cost of processing the pharmacy claims.

I appreciate your interest and assistance with this very important issue. If you have any further questions, please contact Kim Busch, Acting Director of the Division of Medical Assistance, at 465-3355 or me.

[illegible] OF MEDICAID EXPENDITURES ALLOCATED TO PRESCRIPTION MEDICATION

State	1981	1982	1983	1984	1985
U.S. Total	5.6%	5.3%	5.5%	5.8%	6.1%
Alabama	8.6%	8.4%	8.6%	9.6%	10.0%
Alaska	-	-	-	-	-
Arizona	-	-	-	-	-
Arkansas	8.5%	7.9%	9.0%	10.2%	10.5%
California	6.1%	6.5%	6.0%	5.9%	6.5%
Colorado	5.6%	5.9%	5.8%	5.7%	5.8%
Connecticut	4.7%	4.8%	4.3%	4.6%	4.8%
Delaware	4.4%	4.4%	4.4%	4.5%	5.0%
D.C.	3.8%	3.8%	3.7%	5.0%	3.0%
Florida	9.4%	8.8%	8.9%	10.3%	9.0%
Georgia	10.2%	8.4%	10.1%	11.4%	11.0%
Hawaii	4.3%	4.2%	4.5%	4.9%	5.0%
Idaho	4.1%	3.9%	3.9%	3.7%	3.6%
Illinois	7.5%	6.8%	7.2%	5.9%	6.6%
Indiana	7.4%	7.4%	6.6%	6.9%	7.0%
Iowa	5.6%	5.6%	6.1%	6.6%	6.9%
Kansas	6.6%	6.7%	6.3%	6.9%	7.2%
Kentucky	4.6%	4.6%	4.7%	5.8%	6.3%
Louisiana	10.6%	9.0%	8.5%	9.0%	9.6%
Maine	6.5%	5.8%	6.0%	6.3%	7.0%
Maryland	5.5%	6.0%	6.4%	6.7%	6.4%
Massachusetts	4.2%	4.1%	3.9%	4.3%	4.5%
Michigan	5.9%	5.5%	5.5%	5.5%	6.5%
Minnesota	6.0%	3.7%	3.5%	3.8%	4.2%
Mississippi	11.5%	10.8%	12.3%	12.7%	13.2%
Missouri	8.4%	6.0%	5.5%	5.9%	6.4%
Montana	4.8%	4.8%	4.6%	5.5%	5.8%
Nebraska	7.1%	7.1%	7.3%	7.5%	8.5%
Nevada	3.7%	3.7%	3.6%	4.5%	5.3%
New Hampshire	4.6%	3.9%	4.6%	4.5%	4.4%
New Jersey	6.1%	6.2%	6.2%	6.2%	6.8%
New Mexico	6.9%	7.0%	7.4%	7.3%	7.5%
New York	2.3%	2.3%	2.8%	3.0%	3.3%
North Carolina	7.2%	6.5%	6.3%	6.5%	7.0%
North Dakota	5.4%	5.2%	4.8%	4.8%	4.8%
Ohio	9.2%	7.9%	8.0%	8.8%	9.5%
Oklahoma	3.4%	3.7%	4.0%	4.1%	4.3%
Oregon	5.2%	6.1%	6.4%	6.7%	6.8%
Pennsylvania	5.1%	4.6%	5.1%	5.9%	6.6%
Rhode Island	4.8%	4.8%	4.5%	4.8%	5.0%
South Carolina	8.2%	6.0%	6.6%	7.7%	8.0%
South Dakota.	3.2%	3.8%	4.0%	3.9%	4.4%
Tennessee	10.4%	10.4%	9.4%	9.9%	11.0%
Texas	6.5%	6.6%	6.4%	6.9%	7.4%
Utah	4.5%	3.7%	4.0%	4.9%	5.4%
Vermont	5.5%	4.9%	5.2%	5.8%	6.6%
Virginia	6.3%	6.3%	6.4%	7.3%	7.8%
Washington	4.5%	4.6%	5.1%	5.2%	5.2%
West Virginia	8.7%	6.9%	4.2%	6.3%	7.3%
Wisconsin	4.9%	4.5%	4.6%	5.0%	5.0%
Wyoming	-	-	-	-	-

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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

STATE OF ALASKA 1987 LEGISLATIVE SESSION
FISCAL NOTE

Bill Version: SB255
Publish Date:

REQUEST:

Revision Date:
Title: An Act relating to pharmaceutical Med. Assist. for needy persons; efd.
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)

	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
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:

	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
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: Apr 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

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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.

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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

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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.

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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

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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.