Nov 18, 2007

Board

Here is my view of the Dispensing fee Hearing on Nov 14. Those present without giving testimony were the staff of Medicaid, Jim Smith, Mark Eichler, Ron Klein (ED of the Board of Rx) and Stuart Doggett. Let me know if I missed anyone. Any comments would be welcomed by me.

All that gave testimony met at the SM office prior to the hearing. We divided the testimony into three groupings with specific people assigned to address those issues. They are as follows:

General: Lis Houchen (Nat'l Assoc of Chain Drug Stores), Jim Seifert (MPA Pres.)

Specialize Packaging for extended-care facilities: Eric Sheilds (A&C Drug Msla), Jim Seifert

Compounding: Holly Graff Rotar (Rocky Mt Phar. Bozeman), Mark Jurovich (Juro Medical, Billings), Peter Wolfgram (Bungalow Drug stores, South Central Mt)

General

The Medicaid group had worked for about a year on this proposal. Their work was precise and competent. The tone of the meeting was not adversarial but a meeting of compromise with most suggestions encouraged. I believe that with both Mt Medicaid and MPA, patient care for a reasonably fee was foremost. Mt Medicaid has to comply with many CMS regulations and guidelines as CMS pays 75% of the bill. Both Lis & I thanked Mt Medicaid for their diligence. We both embraced the dispensing fee as proposed. This fee (with one standard deviation) is determined by a dispensing fee survey done by each pharmacy. The fee will range from $6.16 to a Max of $10.00. The average fee will be about $8.75. Pharmacies can obtain what fee they are assigned by calling Mt. Medicaid. This dispensing fee is for generic drugs and drugs on the Medicaid preferred drug list. All other non-preferred drugs will receive a fee of $5.50. This new dispensing fee will go into effect Jan 1, 2008, only if AMP is implemented (which includes Max Baucus's, revised AMP bill)

I did thank and encourage Medicaid to Pay Pharmacist for fees for services rather than tying our reimbursement to the commodity. This is a step in that direction.

Any new store would only be assigned a 6 month interim dispensing fee of $5.50, until the new store developed a history to fill out a new dispensing survey. I proposed the average fee of $8.75 be assigned, as new stores have not built up volumes so their costs would be high. Also, I thought this would be a discouragement for start-up pharmacies in rural Mt such as Forsyth. It, also, would be discriminatory for Chain Store start-ups.

I also asked if the dirty word "profitability" was calculated into the dispensing fee formula. It was not. Usually it is 1-2 percent of the total gross of a pharmacy. It is also what pays the taxed which pays the Medicaid fees. Owner's salaries were included in the survey.

Specialty Packaging

We brought to the hearing several examples of packaging used for long term care facilities. These included Doc-u-dose, Opus, bubble packaging and Medicine-on-time. Eric explained how the various systems worked. The time and packaging expenses were explained along with additional costs of delivery and pharmacist services to this vulnerable, needy population group. We both explained the higher level of care that these groups needed, especially when they may be administered drugs by non health care professionals. Because CMS will not allow for additional expense for unit dose, it was suggested to give a higher dispensing fee for patients in long term facilities. (see letter to Mt Medicaid from MPA).

Compounding

Compounding is not just crushing some tablets, putting them in a solution and putting a shake well label on a bottle. With compounding comes specialty equipment, schooling, accreditations, research, standardization of produced products and a host of other items that make a compound safe, eloquent, and effective. When Medicaid reimburses for Premarin, are they reimbursing for just the cost of the ingredients or are they reimbursing for R & D, liability concerns, overhead, promotions and all the other expenses that a pharmaceutical company tags on to the price of a drug? Examples were given where the cost of the non drug (non reimbursable) items in a compound were often greater than the dispensing fee. Also the time for research and the time for physically making these drugs under special equipment (laminar flow hoods) could often greatly exceed the time that a $22.50 dispensing fee would come close to covering. Also to be considered in this time constraint is the prior authorization and the cumbersome billing procedure.

It was explained to Medicaid that many times pharmacies will give breaks to patients who can't afford their medications, even to the extent of giving them to individual patients at no cost. All three compounding pharmacists who spoke, said at these reimbursement rates, they would not be able to serve the Medicaid population. It would create a program like the dentists have with Medicaid. They have very few available providers.

The problem Mt Medicaid has with compounding is that, CMS will only reimburse the state for their 75% share of the drug, if the compound contains at least one rebate able ingredient. If this does not occur, then the state has to pay for 100% of the drug. This also applies if dummy codes are used. From what I understand, PCCA has no rebate able products and requires their new pharmacies to use their products, exclusively.

Our group position is that we want no change in the program as it exists now. We are now paid a usual and customary fee. Compounding is less than 1% in the Medicaid prescription budget. The program as now proposed is unworkable. We would be willing to forge ahead, and explore any future workable solutions with Mt Medicaid. This might include building a formulary with fees attached to each individual compounds. This would be in conjunction with the prior authorization unit.

Conclusion

The Mt Medicaid pharmacy group primary interests in serving the Medicaid population at a reasonable cost with the best of Pharmacy care. The history of Pharmacy fees for service has been set by Medicaid. All our billing procedures, with third party payers, have come from the Medicaid format. I believe that this history will repeat itself. AMP will probably be in force on Jan 1 of 2008.

I believe that MPA had a very strong and effective showing at this hearing, which will have lasting effects on all pharmacies and pharmacist in the future. I believe that this is one of the many reasons that all Pharmacists and Tech, where ever they work, should belong to MPA.

Jim Seifert, Chair
Montana Pharmacy Association