

The Kentucky Medical Assistance Program's Dispensing Fee Reimbursement to Pharmacists



Research Report No. 163

LEGISLATIVE RESEARCH COMMISSION

Frankfort, Kentucky

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Prepared by
Gerry Kiefer

Research Report No. 163

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FOREWORD

During the 1978 session of the Kentucky General Assembly, pharmacists participating in the Kentucky Medical Assistance Program (KMAP) presented testimony before the Appropriations and Revenue Committee stating that neither the dispensing fee in effect at that time (\$1.80 per prescription) nor the proposed increase of the dispensing fee to \$2.15 was adequate to compensate pharmacists for expenses incurred in the filling of a prescription for a KMAP recipient.

Officials of the Department for Human Resources, which administers the program, defended before the Appropriations and Revenue Committee their contention that an increase in the KMAP dispensing fee from \$1.80 to \$2.15 per prescription would represent a fair and reasonable level of reimbursement to pharmacists participating in the KMAP. The dispensing fee was subsequently increased to \$2.22 for FY 1978-79 and to \$2.35 for FY 1979-80. Questions remained about the fairness of the fee, however, and the highly technical, multi-faceted and conflicting documentation presented by representatives for the pharmacists and for the Department for Human Resources, impressed members of the General Assembly with the complexity of this issue.

This report was mandated by Senate Concurrent Resolution No. 45, which was passed during the 1978 session of the Kentucky General Assembly. SCR No. 45 directed the LRC to study the costs to pharmacists of dispensing prescriptions under the KMAP. It represents the collective intent of the members of the Kentucky General Assembly to have a resource document available for their review and evaluation which delineates and explains the complex variables involved in the determination of dispensing fees in layman's terms. Gerry Kiefer of the LRC staff prepared the report. It was edited by Charles Bush. The cover design was done by Sue Casey.

VIC HELLARD, JR.
Director

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R. Paul Baumgartner, Jr., R.Ph.
Assistant Dean
College of Pharmacy
University of Kentucky

Paul F. Davis, R.Ph.
Executive Director
Kentucky Pharmaceutical Council, Inc.

Kenneth E. Hanson, R.Ph.
Vice President
National Pharmaceutical Council, Inc.

Thomas X. Johnson
Supervisor
Recipient Utilization Review
Kentucky Medical Assistance Program
Bureau for Social Insurance
Kentucky Department for Human Resources

Edna Pray
Librarian
College of Pharmacy Library
University of Kentucky

Harry A. Smith, Ph.D.
Professor, Pharmacy Administration
College of Pharmacy
University of Kentucky

Gene A. Thomas, R.Ph.
Pharmacist Consultant
Kentucky Medical Assistance Program
Bureau for Social Insurance
Kentucky Department for Human Resources

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6.	"Save a Pharmacist" in <i>Drug Topics</i> . October 24, 1978. (Available through the LRC Library)	
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SUMMARY

This study endeavors to analyze and evaluate the problems inherent in the determination of dispensing fees for pharmacists and the difficulties these problems impose on medicaid administrators responsible for ensuring an appropriate level of reimbursement to pharmacists participating in medicaid programs. A "dispensing fee" consists of a fee paid to pharmacists for expenses incurred in the process of dispensing a prescription; it does not include reimbursement for drug ingredients, which constitutes a separate reimbursement procedure.

The controversy between some pharmacists participating in state medicaid programs and medicaid officials continues because there is no one universal methodology or generally accepted set of standards for the determination of dispensing fees. There is thus a wide range in the actual dispensing fees paid by both state medicaid programs and by insurance companies.

The difficulties associated with the determination of dispensing fees can be attributed to the conditions set forth below:

1. The limitations inherent in cost studies attempting to ascertain pharmacist dispensing fees.
2. Poor record keeping practices on the part of many pharmacists, resulting in the reporting of inaccurate data in cost studies.
3. The refusal of a significant number of pharmacists to participate in cost studies developed by state medicaid programs or their contractual agents for the purpose of determining an equitable dispensing fee. Federal guidelines specify that state medicaid programs must conduct these studies.
4. Most schools of pharmacy generally do not include required instruction in business accounting procedures relating to the operation of a pharmacy, which results in pharmacists going into practice ill-equipped to generate reliable financial information.
5. Lack of initiative at the federal level.

In spite of the considerations noted above, a number of measures can be taken to *improve* significantly the quality of the pharmacy component of the Kentucky Medical Assistance Program:

1-a. *The Kentucky Department for Human Resources should implement a variable fee reimbursement mechanism for pharmacists dispensing fees under the Kentucky Medical Assistance Program by June 30, 1981.*

1-b. *The 1980 regular session of the Kentucky General Assembly should appropriate for fiscal years 1980-82 sufficient funds to accomplish the conversion of the present fixed fee system to a variable one under the KMAP.* In January of 1979, officials of the Department for Human Resources estimated the projected cost for implementation of a variable fee system (over an eighteen-month period) at \$96,404.

2. *If the KMAP implements a variable fee system, the Department for Human Resources should promulgate a regulation requiring an annual review of the pharmacist dispensing fee under the KMAP.* The regulation also should provide for special annual meetings of the KMAP staff with members of the Pharmacy Technical Advisory Committee of the Advisory

Council for Medical Assistance for the exclusive purpose of reviewing the existing dispensing fee in relation to the results of the annual cost survey.

3. *If the Department for Human Resources elects to retain the fixed fee system, the Department should take immediate steps to promulgate regulations and revise provider agreements to require mandatory participation by all KMAP participating pharmacists in the KMAP Prescription Department Operational Cost Survey and specify that a failure to respond to the Survey or the submission of an inadequate response will result in a penalty of suspension from participation in the program until these requirements are met.*

4. *Pharmacists participating in the KMAP should make a concerted effort to apply basic business accounting principles to the operation of their pharmacies. Relevant cost information can thus be easily accessed. The implementation of the Uniform Cost Accounting System in each participating pharmacy is the suggested vehicle for accomplishing this goal.*

5. *The University of Kentucky College of Pharmacy should devote serious consideration to including a required course in business accounting principles in the pharmacy curriculum. The course should address the accounting needs unique to the operation of a pharmacy. It should also be offered in the pharmacy continuing education program so practicing pharmacists can take it.*

6-a. *The 1977 KMAP Prescription Department Operational Cost Survey Report accepted all reported data without placing any limitations on the reported amounts of such items as supplies, delivery services, salaries and return on investment. Failure to impose such restrictions can produce a serious distortion of data, resulting in an upward bias in the derivation of the final dispensing fee. Therefore, the methodology developed for the analysis of the 1980 KMAP Prescription Department Operational Cost Survey Report should include the application of upper limits to such items as salaries, delivery expenses, supplies, and return on investment.*

6-b. *An addendum published six weeks after the distribution of the 1977 KMAP Prescription Department Operational Cost Survey Report described the methodology used in the Survey to compute return on investment and inflationary adjustment. The body of the 1980 report should include a clear statement of the specific method used to address these factors.*

6-c. *KMAP officials, participating pharmacists and the Pharmacy Technical Advisory Committee should all work together on the development of the methodology to be used in the 1980 KMAP Prescription Department Operational Cost Survey Report. In order to avert the kind of misunderstanding which occurred over the 1977 KMAP Prescription Department Operational Cost Survey Report, it is essential that all parties involved clearly understand the method of analysis that ultimately will be used to devise the final dispensing fee(s).*

6-d. *If the compliance audit for the 1980 KMAP Prescription Department Operational Survey Report reveals an audit exception rate (the degree of error identified by auditors in the data reported on the survey forms) which exceeds .15, the Department for Human Resources should refrain from publishing it, as the results would be invalid. If such a situation should occur, the Department for Human Resources should reject any proposals from participating pharmacists to increase the dispensing fee until such time as pharmacists take the measures necessary to equip themselves with the capability to submit accurate data.*

6-e. *The Department for Human Resources should promulgate regulations which provide DHR auditors access to audit any and all participating pharmacies for the purpose of*

verifying data reported in the KMAP Prescription Department Operational Surveys and specify that provider failure to allow such audits shall result in suspension from participation in the program until the provider allows DHR auditors access to his records.

7. The Department for Human Resources should improve its system for processing provider claims in order that pharmacists would no longer feel the need to submit magnetic tapes prepared by private organizations and paid for by the pharmacists. Approximately 13.9% or 130 pharmacists participating in the KMAP presently send their claims to a private organization which, for a fee, makes any necessary corrections and puts the claims on a computer tape, which is then sent to the KMAP. These computer tapes facilitate the processing of claims by the KMAP, which results in more rapid reimbursement to the pharmacists who use this system.

8. The Department for Human Resources should collaborate with the University of Kentucky College of Pharmacy and the Kentucky Pharmaceutical Association in submitting a grant application to the Health Care Financing Administration for the purpose of securing funding for the demonstration and evaluation of alternatives to the current method of reimbursing for pharmacy services under the KMAP.

CHAPTER I

INTRODUCTION

The Mandate of Senate Concurrent Resolution No. 45

Senate Concurrent Resolution No. 45, adopted by the Kentucky General Assembly during the 1978 regular session, directed the Kentucky Legislative Research Commission to "conduct an independent study and survey on the costs to Kentucky pharmacists to dispense prescriptions paid for by the medicaid program," with the findings and recommendations to be reported to the Interim Joint Committee on Health and Welfare no later than June 1, 1979. (See Appendix No. 1 for the complete text of SCR No. 45.)

SCR No. 45 was the cumulative legislative response to apparently conflicting testimonies concerning the equity of the medicaid dispensing fee presented during the 1978 Appropriations and Revenue Committee budget hearings by some practicing Kentucky pharmacists and by officials of the Kentucky Department for Human Resources.

Limitations of Study

Many earlier studies have attempted to determine an equitable dispensing fee for pharmacists. For several reasons it appeared inappropriate for the Kentucky Legislative Research Commission to initiate still another cost analysis. Budgetary restrictions incorporated into SCR 45 precluded the launching of a comprehensive dispensing fee study; however, it is doubtful that such an endeavor would have been fruitful anyway. This conclusion is based on the observation that the bookkeeping practices of many pharmacists are generally poor and on the diversity of the results already obtained by a variety of cost studies, each of which manipulated the resultant data in a different manner. The importance of these factors in understanding the elusive nature of the dispensing fee issue will become more readily apparent as the complexity of the dispensing fee issue is developed in this report.

Because SCR 45 mandated a study only of the medicaid "dispensing fee," the scope of this report has been limited to this legislative directive, as it relates primarily to outpatient pharmacy reimbursement. A discussion of reimbursement to pharmacists dispensing prescriptions to medicaid recipients in inpatient facilities is only briefly addressed in this study for the following reasons:

1. SCR 45 was passed in response to a controversy relating primarily to outpatient dispensing fee pharmacy benefits under the KMAP.
2. Federal laws and regulations provide for different methods of reimbursement for outpatient and inpatient pharmacy services under the medicaid program. For example, while participating pharmacists who provide outpatient services are reimbursed directly by the KMAP, pharmacists who provide services in an inpatient setting receive payment indirectly. In the latter case, the pharmacist bills the institution each month. The institution bills the KMAP program through the patient's account; the KMAP pays the institution and the institution reimburses the pharmacist. At the end of each fiscal year the facility is audited and retroactive adjustments in reimbursement are made, according to the results of the audit.

3. A thorough evaluation of the inpatient pharmacy program under the KMAP would require that several auditors review the audit reports of the facilities served by participating pharmacists. The budgetary limitations of SCR 45 ruled out such an analysis. While reimbursement to pharmacists serving medicaid recipients in inpatient facilities is addressed only briefly in this report, it is an area which should receive careful attention by officials of the KMAP, as the indirect method of reimbursement appears to prevent close monitoring by the KMAP.

Also beyond the scope of this study—considering time, money and legislative mandate—is a discussion of other issues integral to an understanding of the entire pharmacy component of the KMAP. These issues include:

1. Utilization review, including the extent of program fraud and abuse;
2. Ingredient cost reimbursement to pharmacists participating in the KMAP.

Purpose of Study

The purpose of this study is to respond to the intent of SCR 45 by assisting members of the Kentucky General Assembly in their efforts to understand the many complex variables involved in the dispensing fee issue. Pursuant to this goal, this study endeavors to respond to the following questions:

1. What is a "dispensing fee?"
2. How do federal laws, regulations and guidelines affect the dispensing fee under the KMAP?
3. How is the amount of the dispensing fee determined under the KMAP?
4. Why is it so difficult for participating pharmacists and KMAP officials to agree on the amount of the dispensing fee?
5. How much has the KMAP spent on dispensing fee benefits since the inception of the program?
6. How does the amount of the medicaid dispensing fee in Kentucky compare with the amount of the medicaid dispensing fee in other states?
7. Does the present dispensing fee reimbursement rate of \$2.22 for FY 1978-79 and \$2.35 for FY 1979-80 fairly compensate participating pharmacists?
8. Do the many issues raised by pharmacists during the 1978 session of the Kentucky General Assembly have a substantive basis?
9. Does the existing system of reimbursement for dispensing fees under the KMAP need improvement; if so, (a) what alternatives are feasible, and (b) what can KMAP officials, participating pharmacists, educators, and legislators do to facilitate program improvement?

Unfortunately, there are no clear-cut answers to some of these questions, which is the reason continual controversy exists. However, an attempt is made in this study to describe the issues involved so that the reader will be in a better position to understand the problems.

CHAPTER II

HISTORY OF THE DISPENSING FEE UNDER THE KENTUCKY MEDICAID PROGRAM

The Kentucky Medical Assistance Act, (1960) created the Kentucky Medical Assistance Program. The purpose of the legislation is to provide needed medical services to both categorically and medically needy Kentuckians by reimbursing providers who voluntarily agree to furnish such medical services. "Categorically" needy recipients include those who are both members of certain categories eligible to receive public assistance and are economically needy. "Medically" needy recipients include those who can pay for basic living expenses but cannot afford medical care.

The Kentucky Medical Assistance Act was implemented on January 1, 1961. Because of funding limitations, the program initially included only physician, hospital, dental and pharmacy services. Beginning under the Kerr-Mills Program (Social Security amendments of 1960) in 1961, the Kentucky Medical Assistance Program reimbursed pharmacists according to a sliding fee scale based upon the wholesale cost of the drug, which is set forth below:

Drug Cost	Professional Fee
\$0.01 to \$1.00	\$0.50
\$1.00 to \$1.74	\$0.70
\$1.75 to \$2.99	\$1.20
\$3.00 and over	\$1.50

Source: "Prescription Department Operational Cost Survey Report"—April 15, 1977
Kentucky Medical Assistance Program

In January, 1962, the KMAP adopted a flat fee system. A dispensing fee of \$1.10 was paid for prescriptions of all covered drugs dispensed to eligible recipients by participating pharmacies.

On July 1, 1966, the KMAP implemented Title XIX (Medicaid) of the Social Security Act, which allowed the program to benefit from a match of state funds with federal money, and which further enabled the program to increase the dispensing fee to \$1.20 per prescription.

The dispensing fee was adjusted upward in July of 1967 to \$1.40, and again in July of 1972 to \$1.65, for those pharmacies which were exempt from the then imposed Wage/Price Freeze of 1972.

In May of 1974, all pharmacies received the dispensing fee of \$1.65 retroactive to February of 1974. Other increases in the dispensing fee since May of 1974 are as follows:

\$1.80	July 1, 1974
\$2.22	July 1, 1978 to June 30, 1979
\$2.35	July 1, 1979 to July 1, 1980

KMAP officials assert that the dispensing fee reflects available funds. Pharmacists contend that funds are only made available when they launch a major lobbying effort. Because of the difficulties associated with computing pharmacy costs, it is not possible to determine with any real degree of certainty whether the dispensing fees cited above represent reimbursement equivalent to the actual cost to a pharmacist to dispense a prescription under the KMAP, with a fair return on his investment.

Although the KMAP includes outpatient pharmacy services in its scope of coverage, it should be recognized that the Department for Human Resources is not required by federal laws or regulations to provide outpatient pharmacy services. It is an optional benefit and its inclusion in state medicaid programs is the result of policy decisions in each state.

Pharmacists voluntarily participate in the KMAP. There are 884 licensed retail pharmacies and ninety-six licensed institutional (hospital and nursing home) pharmacies in Kentucky for a total of 980 licensed pharmacy outlets in the state. Approximately 94% , or 925 pharmacies, participate in the KMAP.

CHAPTER III

DEFINITION OF DISPENSING FEE

A "dispensing fee" consists of a fee paid to pharmacists for their expenses incurred in the process of filling or dispensing prescriptions. These expenses are generally referred to as "operational costs." A fair dispensing fee compensates pharmacists for the operational costs of the prescription department component of the pharmacy and includes a reasonable allowance for profit. Specifically, the dispensing fee reimburses the pharmacist for his judgment and surveillance, which includes, "dispensing the proper drugs in appropriate containers with appropriate labeling including administration directions, storage instructions, and labeling and filing information, and appropriate counseling with patients regarding the prescription, and notification of prescribing physician regarding possible drug interactions."¹

Most pharmacies today sell toys, cosmetics and other sundries in addition to prescription and over-the-counter drugs. The dispensing fee is only concerned with those activities in a pharmacy that relate specifically to the prescription department. The dispensing fee does not include payment for drug acquisition costs. Reimbursement to pharmacists for their costs associated with the acquisition of drug products constitutes a reimbursement procedure separate from that of the dispensing fee. Although both federal and state reimbursement policies for drug ingredients are topics presently embroiled in as much controversy as dispensing fees, those policies are nonetheless independent to dispensing fees and therefore are not addressed in this report.

The most commonly used method of third party reimbursement (e.g., insurance companies, medical assistance programs) to pharmacists for dispensing prescriptions are fixed fees and variable fees, which are discussed below:

1. *Fixed fee*—identical dispensing fee for all participating pharmacies. It presently is the most widely used method of reimbursement by third party payors, including medicaid programs; however, it has several serious disadvantages, which include:

- (a) overpayment of pharmacies which have a low per-unit dispensing cost;
- (b) underpayment of those pharmacies that have relatively high costs even though they are providing necessary pharmacy services at an efficient level;
- (c) reimbursement of the inefficient pharmacy at the same rate as the efficient pharmacy, which can destroy incentive for cost containment;
- (d) failure to provide any adjustment for the difference of operating pharmacies in particular geographic locations; for example, rural vs. metropolitan;
- (e) penalizing "full-service pharmacies, those which provide a wide range of services to the public (e.g., delivery service, 24-hour service for emergencies, the maintenance of medication records or "patient profiles" in order to protect patients from drug interactions and allergies, etc.). These pharmacies realize, of course, a lesser profit than pharmacies that provide only the bare minimum of service.

The fixed fee can thus discourage professionalism, because it provides no incentive to pharmacists to improve the level of services to patients. Rather, the economic incentive is to

reduce the total level of pharmacy services provided to medicaid patients in order to maximize profits.

2. *Variable fee*—variable fees seek to compensate for the deficiencies inherent in the fixed fee. There are three disadvantages, however, to the variable fee system:

(a) The high cost in terms of actual dollars and staff time in the development and analysis of cost surveys for each participating pharmacy. Such surveys should be conducted on an annual basis so the fees will be reflective of market conditions and changes in levels of services.

(b) The cost surveys are usually based upon each participating pharmacist's self-reported data; therefore, extensive audit capability is required in order to verify the accuracy of the reported data.

(c) The high cost of modifying computer programming to handle this type of fee system.

Set forth below are the two types of variable fees:

Individual variable fee—reimbursement for each pharmacy is based upon costs unique to its operation, after adjustments are made for overhead costs, location, volume, etc. Only five medicaid programs have adopted an individual variable fee system to date; however, several other states are seriously considering implementing the variable fee system, primarily because (1) DHEW guidelines encourage it; (2) given the present state of the art, it appears to provide one of the most equitable approaches to the dispensing fee dilemma; and (3) the individual variable fee system has an established track record. This method of deriving an individual dispensing fee was first utilized by the state of Kansas Medicaid Program in 1970. The success of the Kansas program has been widely recognized and continues to be used as a model by programs in states seeking to develop such a mechanism. (See Chapter X for a detailed explanation of the individual variable fee system of the Kansas medicaid program.)

Categorically Variable Fee—pharmacies are placed into categories according to their location (urban, rural); type of ownership (proprietorship, corporation, partnership); and type of pharmacy (independent, chain). A "fixed fee" is then assigned to each category.

The private patient is usually billed according to the "mark-up" system. The *mark-up system* does not constitute a true "professional dispensing fee" because it includes ingredient costs. Two factors are involved in the mark-up system of pricing a prescription. The acquisition cost or drug ingredient cost is added to the gross income or gross margin (the excess of the average selling price per prescription over the average drug cost).

The mark-up method is not allowed under the medicaid program because this method fails to take into account the actual cost of filling a prescription, and because the cost of the drug has no bearing on the amount of the dispensing fee, since the drug ingredient cost has no relationship to the amount of professional time and overhead involved in the dispensing of a prescription.

When a pharmacist participating in the KMAP dispenses a prescription to a medicaid recipient, he is reimbursed by the KMAP for, (1) the ingredient cost of the drug; and (2) a dispensing fee. Specifically, all outpatient pharmacy benefits provided to KMAP recipients are billed to the Program at the usual and customary charge to the general public for the same product and service(s), and reimbursement to the pharmacy consists of the lowest of: (1) the usual and customary charge; (2) the Maximum Allowable Cost (MAC), if any, plus dispensing fee; or (3) the Estimated Acquisition Cost (EAC), plus dispensing fee.

CHAPTER IV

LEGAL REQUIREMENTS AFFECTING THE DISPENSING FEE

The Federal Law

Title XIX of the Social Security Act, as amended, serves as the basic authority for Medical Assistance, generally referred to as Medicaid. Under this grant-in-aid program, the Federal and State governments share the costs of medical care for certain groups of people with low incomes. The inclusion of prescribed drugs for out-of-hospital patients in a State plan is optional; 46 of the 52 jurisdictions with approved Medicaid plans include prescribed drugs

Paragraph 30 of Section 1902(a) of Title XIX states: "A State plan for medical assistance must provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care."²

The Federal Regulations

In August of 1976, the federal Maximum Allowable Cost (MAC) Drug Reimbursement Regulations, Section 250.30(b)(2) of Part 250, Chapter II, Title 45, became effective and were implemented by the Kentucky Medical Assistance Program.

The *Code of Federal Regulations*, as revised, is set forth below:

CFR 250.30 Reasonable charges

(b) Upper limits.

(2) Drugs. The upper limit for payment for prescribed drugs—whether legend items (for which a prescription is required under Federal law) or non-legend [non-prescription] items—shall be based on the lower of the cost of the drug (as determined in accordance with paragraph (b)(2)(ii) or (iii) of the section) plus a dispensing fee established by the State, or the provider's usual and customary charge to the general public.

(i) In establishing the dispensing fee, States should take into account the results of surveys of costs of pharmacy operation. States shall periodically conduct such surveys of pharmacy operational data including such components as overhead, professional services and profits.

(a) The dispensing fee may vary according to the size and location of the pharmacy and according to whether the dispensing is done by a physician or by an outpatient drug department of an institution and according to whether the drug is a legend or a non-legend item.

(b) The dispensing fee may also vary for prescribed drugs furnished to Title XIX recipients in an institutional setting by a pharmacy employing a unit dose system. In such instances the dispensing fee may be either: (1) an amount added to the cost of each unit dose furnished by the pharmacy, or (2) a daily or monthly capitation rate per resident for whom prescribed drugs are being furnished. [*“Capitation,” as it relates to the pharmacy component of state medicaid programs, refers to a system of reimbursement based upon costs per capita or per recipient rather than upon the number of prescriptions dispensed.*] In either case, the dispensing fee is added to the ingredient cost of the prescribed drug which is actually consumed.

(ii) For each multiple-source drug designated by the Pharmaceutical Reimbursement Board [*This Board determines which drugs will be subject to a Maximum Allowable Cost and the amount of the MAC for each drug.*] and published in the Federal Register, cost will be limited to the lowest of (a) the maximum allowable cost established by the Board for such drug, and published in the Federal Register, or (b) the estimated acquisition cost (as defined in paragraph (b)(2)(iii), or (c) the provider’s usual and customary charge to the general public; except that such limitation shall not apply in any case where a physician certifies in his own handwriting that in his medical judgment a specific brand is medically necessary for a particular patient. The form and procedure for the certification shall be prescribed by the State. An example of an acceptable certification would be the notation “brand necessary.” A procedure for checking a box on a form will not constitute an acceptable certification. At the discretion of the State, the certification may be retained by the provider rather than submitted with the claim form with the understanding that it will be available for inspection by the State and by the Department of Health, Education and Welfare.

(iii) For all other prescribed drugs, cost shall not exceed an upper limit established by the State. This shall be the State’s closest estimate of the price generally and currently paid by providers. Such estimates shall be based on the package size of drugs most frequently purchased by providers. To aid States in making cost estimates, the Department will make available information on a current basis on acquisition costs of the most frequently purchased package size of drugs. These data will cover the majority of the most frequently prescribed drugs.

(iv) The upper limits governing reimbursement by State agencies to providers of prescribed drugs specified in this section shall also apply in cases where prescribed drugs are furnished as part of skilled nursing facility or intermediate care facility services or under prepaid capitation arrangements. Contracts between the State agency and the underwriter, carrier, foundation, health maintenance organization or other insurers containing the terms of such prepaid capitation arrangements shall include a provision imposing the same upper limits for reimbursement on prescribed drugs as are imposed by paragraph (b)(2) of this section on the State agency.

The Federal Guidelines

The federal guidelines regarding pharmacy reimbursement are quite lengthy. Thus, selected portions of the guidelines relating to issues discussed in this report may be referenced in Appendices 2 and 3 of this study.

CHAPTER V

THE PROBLEMS ASSOCIATED WITH THE DETERMINATION OF DISPENSING FEE

The reason for the continuing controversy between some pharmacists and medicaid administrators over dispensing fees can be summarized in one statement: No methodology has yet been developed which includes a "generally accepted set of standards which can be used to identify the dispensing costs of a pharmacy."³ A 1971 dispensing fee study conducted by Berki, Richards and Weeks observes that:

It is apparent that neither the majority of third-parties or pharmacists is satisfied with the current methods of fee determination. The third-party may argue that the fee offered is in general equitable while the pharmacist argues that the fee is not sufficient for his individual pharmacy. Given current data and methodologies neither party can verify its position.⁴

These conclusions are reinforced by Campbell and Dixon in a 1975 study:

There has not developed a system for pricing prescriptions that is satisfactory to the individuals involved. Consumers, third-party planners, and pharmacists all seem to be upset about the subject of prescription pricing.⁵

In 1977, Siecker notes in the *Journal of the American Pharmaceutical Association* that:

Little evidence can be identified . . . to indicate that reimbursement formulas in any way approximate the true economic cost of providing pharmacy services. Neither state Medicaid program administrators nor participating pharmacists have a firm grasp on the costs involved.⁶

Unfortunately, what was true in 1971, 1975, and 1977 remains true in 1979 as well. This rather bleak state of affairs is descriptive of the situation in Kentucky and perpetuates an on-going, unresolvable deadlock between, on the one side, medicaid administrators, who are charged with the dual responsibility of ensuring program accountability for public monies spent, plus ensuring that pharmacists receive fair reimbursement for their services, and, on the other side, some pharmacists participating in the Kentucky medicaid program who contend that the dispensing fee is so inadequate that the pharmacist who participates in the medicaid program actually subsidizes the medicaid program, because he assumes a loss each time he dispenses a medicaid prescription.

Because there is no universally acceptable methodology to determine dispensing fees, each organization charged with the necessity of developing a reimbursement rate can use just about any standard it chooses, within certain general guidelines, to set a rate and not have to be very concerned about even the most objective criticism, since critics are in no better position to

justify their assertions than are those who determine the amount of the dispensing fee. In addition, this *laissez faire* approach to the determination of dispensing fees results in a wide range of fees, as identified by dispensing fee studies, and of actual fees paid by state medicaid programs and by insurance companies, as demonstrated by the following illustration:

1. Under the medicaid program, California's fixed dispensing fee is the highest in the nation at \$3.07. Maine and Vermont have a \$2.00 fixed dispensing fee, the lowest in the nation. Five states have adopted variable fee systems. The lowest fee paid in these states is \$1.30; the highest fee paid is \$3.25. (NOTE: This range in dispensing fees should not be used to compare existing dispensing fees under state medicaid programs, because such a comparison would be totally invalid. See Chapter VIII and Tables II and III.)

2. Dispensing fees paid by insurance companies are usually fixed fees. Listed below are the dispensing fees presently paid by carriers of insurance in Kentucky:

Blue Cross and Blue Shield of Kentucky	\$2.50
Aetna Life and Casualty Company	\$2.40
Travelers	\$2.40
Metropolitan Life Insurance Company	\$2.15
CHAMPUS (Civilian Health and Medical Program of the Uniformed Services)	\$2.00

Reimbursement rates for each insurance organization vary from state to state. Officials of most of these insurance companies contacted by this author were somewhat less than eager to discuss the specific methodology used to determine their fees, only offering the explanation that their rate of reimbursement is based upon a number of factors, including, but not limited to, a review of existing dispensing fee studies and data collected through in-house investigations.

3. No two dispensing fee studies identify the same fee. One or more dispensing fee studies can be found in the existing literature to support a fixed dispensing fee within the range of \$2.00 to \$3.25.

The obvious question must be raised: Why is it so difficult to determine the cost to a pharmacist to dispense a prescription?

The answer is fivefold:

1. The limitations inherent in cost studies attempting to ascertain pharmacist dispensing fees.

2. Poor record keeping practices on the part of many pharmacists, resulting in the reporting of inaccurate data in cost studies.

3. The refusal of a significant number of pharmacists to participate in cost studies developed by state medicaid programs or their contractual agents, for the purpose of determining an equitable dispensing fee. Federal guidelines specify that state medicaid programs must conduct these studies.

4. Most schools of pharmacy generally do not include instruction in business accounting procedures relating to the operation of a pharmacy, which results in pharmacists going into practice ill-equipped to generate reliable financial information.

5. Lack of initiative at the federal level.

It is appropriate that each of these factors be addressed individually because of their importance in understanding the variance in dispensing fees identified by cost studies.

Limitations of Cost Studies

There are three major elements unique to the operation of a pharmacy which make it difficult to analyze pharmacy costs. First, "the practice of pharmacy generates a high number of transactions, often in excess of twenty, thirty, or even fifty thousand prescriptions annually."⁷ Secondly, a typical transaction produces a rather small dollar value. Therefore, errors of as little as ten cents per prescription may represent thousands of dollars over a twelve-month period.⁸ Finally, the problem of determining the cost of providing prescription services is muddled with a large number of "joint costs,"⁹ i.e., a cost that is "shared with, or is common to, more than one functional segment of an organization."¹⁰ The difficulty occurs when an analyst attempts to isolate the costs associated with the prescription department from the costs incurred as the result of other goods and services provided in the store, the salary of a cashier, for example.

The cost study, with its many variations, traditionally has been and continues to be the vehicle commonly utilized to determine dispensing costs. The diverse results of dispensing fee studies is directly attributable to the great latitude which can be exercised in the type of methodology selected and the subsequent manipulation of data which occurs as the result of the method selected to allocate costs, without escaping the bounds of "acceptable" cost accounting procedures. Ahart reviewed four papers which attempted to establish a method for determining dispensing fees. He accurately points out that, "it is the allocation methods which are non-uniform and result in different amounts. Each of the four papers contains different allocation methods and thereby report different dispensing costs. Each of the papers contains valid methods of allocation, although some methods are more logical and rational than others."¹¹ The adage that "you can prove anything with statistics" is never more applicable than in the area of statistical computations designed to determine dispensing fees.

There are basically three ways to conduct a cost study of pharmacy operations: "(1) On-site visit of pharmacies by analysts who collect data" (including the time and motion study whereby an analyst observes and records the time a pharmacist takes to complete each activity associated with the act of dispensing a drug); "(2) Computer programs designed to possess the alleged capability to predict costs for each pharmacy, and (3) the fee survey, which consists of a questionnaire sent to a sample of pharmacists."¹²

Very little work has been done in the area of time and motion studies because of the expense involved and because of certain other problems inherent in the methodology, e.g., the presence of the person conducting the study in the pharmacy could modify the pharmacists' behavior, thus biasing the results of such a study.

The difficulty in depending upon any one of the methods cited above to yield an accurate statement of dispensing fees is succinctly stated by Siecker:

Traditional (cost study) approaches . . . appear to have two universal characteristics. First, the comprehensiveness and uniformity of each pharmacy's system for recording economic events are assumed. In other words, the analyst takes the accounting system of the pharmacy as a "given" and

continues as though the ingenuity of the questionnaire will somehow erase any problem of a different measurement base. A second major characteristic of survey methods is that the participating pharmacy is left with no rigorous method of determining its costs in a meaningful way after the survey is completed. It is as though the need for cost information in a pharmacy—for pricing decisions, for more efficient management, and the like—is evident only when a survey analyst or drug program administrator says it is. What remains are the very same procedures of record-keeping that the pharmacy had when the survey began. The community pharmacist cannot be sure of the adequacy of his records in attempting to answer the pertinent economic questions.¹³

The cost study conducted by mailed survey forms has a number of drawbacks in addition to the ones already mentioned. Self-report surveys traditionally have a low return rate, denoting one or both of the following conditions:

1. The pharmacist does not maintain the type of data requested and feels it would not be worth his time and/or effort to accumulate it;
2. The pharmacist believes the survey form to be too complex.

A number of dispensing fee studies which have been conducted have not incorporated into their methodology a follow-up audit of a valid sample of the participating pharmacies. Such an omission can prove very serious in a dispensing fee analysis, since some studies that have performed such an audit have found such high error rates in pharmacists' records or in their reports of costs that the validity of the studies was destroyed. One state medicaid program contacted for this study reported that the data received from pharmacists was so poor that they did not attempt to analyze, audit or publish it.

The Impact of Pharmacists' Poor Bookkeeping Practices Upon Dispensing Fee Studies

A cost study is only as good as the data it attempts to analyze. A well-constructed study can be demolished and invalidated by pharmacists' reporting their costs inaccurately.

Pharmacists in Kentucky and in the nation are, in general, poor bookkeepers, a condition which is acknowledged openly by many pharmacists, and a problem which is discussed periodically at professional gatherings of pharmacists and in their professional journals.

The seriousness of this situation in Kentucky was demonstrated by the audits conducted by the Department for Human Resources audit staff to verify costs reported in the 1977 KMAP Prescription Department Operational Cost Survey. Prior to the distribution of the survey forms, thirteen pharmacists were randomly selected to participate in the compliance audit, all of whom signed written statements indicating their agreement to participate voluntarily. A March 21, 1977 memorandum from the Department for Human Resources Audit Branch Manager to the Director of the KMAP¹⁴ notes that of the seven pharmacies the auditors had attempted to examine to date, two pharmacies refused to allow the auditors to examine their records and another pharmacy's accounting records were unavailable because of a change in ownership. The following excerpt from this same memorandum diplomatically points out that, based upon the statistical sample and the results of the audits, the study is invalid:

At this point, we are questioning the statistical validity of continuing our examinations. Even if the remaining five pharmacies fully cooperated, we believe the resulting reliability of your sample would be unacceptable for cost determinations. Because we could not examine the accounting records at three pharmacies, we calculated the following reliability factors in your random sample: Confidence Level 80%, Upper Precision Level 50%. In other words, you could be 80% confident that the random sample was representative of the total surveyed population if you accepted a 50% error rate.

In addition, our examinations of the four attached reports revealed erroneous cost information in 80% of the reported data.

Until pharmacists adopt sound business accounting procedures, it seems rather pointless to continue to conduct expensive cost studies. This viewpoint was echoed by the National Pharmaceutical Council during its 1977 annual meeting when, in recognition of the poor quality of data being gathered in cost studies, the Council recommended a moratorium on cost studies until such time as pharmacists could implement accounting procedures which would yield reliable data. Present federal guidelines suggest that each state medicaid program conduct a cost study of dispensing fees every three years. Failure to comply with federal guidelines ultimately can result in a loss of federal funds.

The impact of poor accounting procedures upon cost studies is profound. As previously noted, many cost studies rely upon the accuracy of information provided by individual pharmacists. The fallacy of this approach is clear—if a pharmacist cannot document his costs, he certainly cannot submit an accurate report. Such surveys result in “guesstimating” and reported data sometimes has a surprising range. Many survey forms are excluded from cost studies because of this very factor.

Still another spin-off which frequently occurs when data are either improperly reported or not reported at all by pharmacists, and which jeopardizes the integrity of the study, is that analysts suddenly find themselves with a data vacuum which must be filled in order to complete their analysis, so they promptly retreat to the Lilly Digest (a nationally recognized compilation of pharmacy statistics published annually by Eli Lilly and Company) or a similar source and substitute its data for the data they were unable to obtain.

Voluntary Participation In Cost Studies

A cost study is also negatively affected when pharmacists simply do not participate in it. Participation in medicaid cost studies traditionally has been on a voluntary basis. Many pharmacists do not participate in these studies, despite their belief that the fees are too low and despite the fact that the results of the study should help determine an equitable dispensing fee—a fee which some pharmacists continue to complain is too low. Many an analyst has found himself resorting to statistical gymnastics in an effort to “adjust” or compensate for the lack of a representative sample of pharmacists in a cost study.

The dispensing fee study for the State of Georgia conducted by Stauffer and Meyers, Certified Public Accountants, and published in March, 1977, is illustrative of the problem.

They note in their report that, "Because of the substantial proportion of pharmacies that did not respond the possibility of bias in the responding sample must be considered."¹⁵ To the credit of Stauffer and Meyers, they address this problem in a straightforward manner by including in their study the recommendation, "that the Department [of Human Resources of the State of Georgia] modify provider agreements and regulations to require participation in cost surveys or other data gathering efforts, and to provide for a lower reimbursement rate if a provider refuses to participate. This requires immediate action and we strongly urge its implementation."¹⁶

This problem probably would be alleviated under a variable fee system, which provides a direct economic incentive to pharmacists to complete the survey form. Pharmacists who do not submit an annual cost report are assigned the lowest fee within a range of dispensing fees.

Chapter IX of this study recommends that the KMAP adopt a variable fee system. However, should the Department for Human Resources elect to retain the fixed fee system the Department should take immediate steps to promulgate regulations and revise provider agreements to require mandatory participation by all KMAP participating pharmacists in the KMAP Prescription Department Operational Cost Surveys, and specify that a failure to respond to the survey or the submission of an inadequate response will result in suspension from participation in the program until these requirements are met.

This recommendation is based upon the taxpayer's right to know how his money is being spent. If dispensing fees are to be determined on a cost-related basis and if a participating pharmacist is unwilling to submit a cost report once every three years, he should receive no taxpayer monies—either federal or state. It is an inappropriate expenditure of taxpayer monies to reimburse providers who have not documented their expenses.

The Responsibility of Pharmacy Schools to Provide Instruction In Business Accounting Procedures

Discussions with recognized authorities in the field of pharmacy leave the general impression that schools of pharmacy throughout the nation have failed to prepare their graduates with an understanding of business accounting procedures necessary to economic survival. Some individuals have indicated that many schools of pharmacy apparently regard such instruction within the colleges of pharmacy as "unrelated to the professional concerns of pharmacy" and feel that such courses would not be of interest to pharmacy students.

Although it is true that education in business accounting for pharmacists is not directly related to the professional discipline of pharmacy, it is not true that it is unrelated to the professional concerns of pharmacists. Pharmacists have to compete successfully in the marketplace just like everyone else, if they want to continue to practice their chosen discipline. A pharmacist must know how to account for his profits and losses, especially if he is an individual proprietor. Medicaid prescriptions alone account for about 15% of the total prescription market nationally.¹⁷ State Medicaid programs are required by federal guidelines to conduct dispensing fee surveys every three years, and dispensing fees are supposed to be established on a cost-related basis. Given these facts, it becomes readily apparent that the pharmacist who does not know how to account for his costs jeopardizes his livelihood.

Business accounting may not interest pharmacy students, but money does seem to interest many pharmacists, as attested to by the many articles continually appearing in the phar-

macy trade and professional journals that allege unfair treatment of pharmacists in regard to federal and state reimbursement rates.

Over 50% of the pharmacists presently practicing in Kentucky are graduates of the University of Kentucky College of Pharmacy.¹⁸ The University of Kentucky College of Pharmacy should recognize that the success of the pharmacy profession is related to the economic survival of practicing pharmacists and should devote serious consideration to including a required course in business accounting procedures in the curriculum of the College of Pharmacy by 1980. Such a course should be directed toward the accounting needs unique to the operation of a pharmacy. If the course included nothing more than instruction on implementation of the Uniform Cost Accounting System, this would be an invaluable service to the students. In addition, the course should also be offered in the pharmacy continuing education program, in order that practicing pharmacists might have the opportunity to benefit from it. Professional pharmacy organizations should encourage other colleges of pharmacy throughout the nation to require at least one course in business accounting procedures related to pharmacy operations.

Lack of Initiative At Federal Level

We have examined the problems of the limitations of cost studies, the inadequacy of pharmacists' records, the failure of many pharmacists to participate in cost studies, and the failure of schools of pharmacy to educate pharmacy students about basic business accounting procedures. In addition, federal regulations and guidelines have failed to include a uniform dispensing fee methodology to be used by all states in their three-year cost studies. Thus, each state is given great latitude within certain general federal guidelines, in the design of their dispensing fee studies, which results, of course, in a bewildering array of dispensing fees.

This decision at the federal level probably was not an accident. It seems readily apparent that federal bureaucrats are just as lost as legislators, state medicaid administrators, participating pharmacists and anyone else attempting to grapple with the dispensing fee issue. They too recognize the methodological deficiencies of existing dispensing fee studies.

Ambivalence at the federal level is best illustrated in the following statement from the introduction to the federal guidelines for implementation of the MAC regulations:

Current policy governing payments for prescription drugs under the Medicaid program does not require that participating state agencies follow uniform procedures. Since there is no single ideal system of reimbursement in a government-sponsored prescription drug program, and conditions vary from state to state, flexible policy has purposely been established to permit the states considerable latitude in setting an upper limit of payment. Moreover, the policy reflects the view that experimentation with various methods and combinations of methods, accompanied by an evaluation plan based on the sound research design, can prove a valuable means of developing workable and efficient alternative procedures tailored to specific circumstances within the states.¹⁹

It would not be an unlikely hypothesis to suggest that present federal regulations and guidelines constitute a massive experiment to see which state(s) can devise the best scheme to determine dispensing fees.

Federal concern over present reimbursement mechanisms in the entire medicaid program is illustrated in the April 13, 1978 edition of the *Federal Register*, in which the Health Care Financing Administration offered money grants to qualifying state or nonprofit organizations which will undertake research into alternative methods of reimbursement under state medicaid programs (e.g., capitation, fee-for-service, fixed budget, etc.).

The implementation of federal policies regarding the dispensing fee issue has thus far not produced a universal dispensing fee methodology; however, it has produced a seemingly endless flow of studies using different methodologies of varying quality, yielding diverse results. In addition, these federal policies have created a whole new industry, since most state medicaid programs have not conducted the federally mandated studies themselves, but have contracted them out to professional pharmacy organizations (e.g., the American College of Apothecaries), consulting firms, and universities which have a pharmacy school. Such contracts have been let for as little as \$5,000; however, a substantial study usually costs anywhere from \$40,000 to \$50,000. Thus, while a universally acceptable methodology remains to be discovered, thousands of tax dollars continue to be distributed to contract recipients throughout the nation for the purpose of generating still more cost studies. Thus, an economic incentive has been created which *discourages* the establishment of a universal dispensing fee methodology, and favors perpetual reassessment and determination of dispensing fees on a state-by-state basis.

The KMAP has never conducted extensive research into alternative methods of reimbursement of pharmacists. This type of research is both time-consuming and expensive and the KMAP presently does not have the resources necessary to conduct such a project.

A demonstration project may or may not result in the ultimate solution to reimbursement to pharmacists, but a well constructed study conducted in Kentucky could provide invaluable data which would enable KMAP officials to make better informed decisions regarding pharmacist reimbursement. This demonstration project should be undertaken immediately while 100% federal funding is available through the Health Care Financing Administration for approved grants.

The KMAP submitted a grant proposal to the Health Care Financing Administration; however, it was turned down. It would seem that the chances of securing a grant from the HCFA would be greatly facilitated by: (1) requesting an adequate amount of money to conduct a substantial study of alternative reimbursement mechanisms; and (2) submitting a grant which would involve the combined efforts of representatives from the KMAP, the Kentucky Pharmaceutical Association and the University of Kentucky College of Pharmacy.

Thus, it is recommended that the Department for Human Resources collaborate with the University of Kentucky College of Pharmacy and the Kentucky Pharmaceutical Association in submitting a grant application to the Health Care Financing Administration for the purpose of securing funding for the demonstration and evaluation of alternatives to the current method of reimbursing for pharmacy services under the KMAP.

CHAPTER VI

THE PHARMACISTS' RESPONSIBILITY

Pharmacists participating in the KMAP *must* consider how difficult it is for medicaid administrators to devote serious consideration to pharmacists' charges of inequity when the following conditions prevail:

1. pharmacists cannot document their costs and therefore cannot identify the source of their alleged losses;
2. 131 of the 300 pharmacists selected to participate in the 1976 KMAP Prescription Department Operational Cost Survey Report failed to return their survey form for analysis in the study;
3. some participating pharmacists have acted inconsistently; e.g., three of the thirteen pharmacists who had agreed voluntarily in writing prior to the distribution of the 1976 survey forms to participate in a follow-up compliance audit later refused to allow the Department for Human Resources audit staff access to their records to verify the data they reported on the survey forms, thereby destroying the validity of the sample and the study. Also, during the course of the development of this report, the author received conflicting reports from officials of both the Kentucky Pharmaceutical Association and the pharmacy Technical Advisory Committee of the Advisory Council for Medical Assistance regarding the adequacy of the present dispensing fee of \$2.22 for FY 1978-79 and \$2.35 for FY 1979-80. Some stated that the present arrangement was adequate; others were emphatic that these amounts were far from adequate and that pharmacists participating in the KMAP continue to subsidize the Program; and
4. pharmacists continue to participate in the KMAP; it is doubtful that pharmacists would continue to participate in a program in which they sustained a continuous economic loss.

Some pharmacists claim that they cannot afford to provide an accurate representation of their costs, in view of the tremendous amount of time required to assign the variety of activities of their operation to various cost centers, and the great amount of time it takes to fill out dispensing fee surveys.

In response to these concerns, attention should be devoted to the following considerations:

1. Unpleasant as it may be, it is a fact of life that we have now entered the age of accountability. Pharmacists voluntarily participate in the medicaid program. The rules of the game require pharmacists to account for their costs. Therefore, if pharmacists want to be equitably reimbursed, they must maintain complete and accurate records and be prepared to justify their costs. There is nothing unreasonable about such a requirement. Taxpayers have a legitimate right to know specifically how their money is being spent.
2. If pharmacists would systematically employ basic business accounting principles to keep track of costs and expenditures, the data for cost assessments would be the natural product of such a system. The Uniform Cost Accounting System (UCAS) developed by Siecker represents one such straightforward record-keeping procedure. The UCAS is predicated on the

recognition that pharmacists should not have to be accountants, yet it acknowledges “the need for more sophisticated answers in a more sophisticated society.”²⁰ Some pharmacists charge that the UCAS is too complex and would cost too much to implement; however, neither of these allegations has been substantiated.

3. The KMAP dispensing fee survey is not difficult for a pharmacist to complete if he has applied basic business accounting procedures to the operation of his business. It would probably be a nightmare to pharmacists who have not followed such practices. Much of the data requested in the KMAP survey can be found on the pharmacist’s income tax return. The survey form directs the pharmacist to the precise place on the income tax forms where the information may be found. (See Appendix No. 4 for actual survey form, available through the LRC Library.)

4. Sound business practice dictates the use of simple business accounting procedures. The implementation of such a system is truly helpful to third-party payors attempting to develop an equitable dispensing fee, but pharmacists should realize that the real advantage is theirs. A pharmacy that can delineate with accuracy its costs is in a far better position to identify the source of its profits and losses.

CHAPTER VII

KMAP EXPENDITURES FOR OUTPATIENT PHARMACY DISPENSING FEE

Table I (below) presents a composite picture of expenditures for the outpatient dispensing fee component of the KMAP.

Pharmacists allege that one of the reasons the dispensing fee fails to reimburse them adequately for their services is that the KMAP does not annually adjust the dispensing fee to the rate of inflation. The present dispensing fee of \$2.22 for FY 1978-79 and \$2.35 for FY 1979-80 are "negotiated fees," and as such fail to reflect actual costs. However, the 1977 KMAP Prescription Department Operational Survey Report identified the final dispensing fee, adjusted to June 30, 1977, at \$2.04. This figure does include an adjustment for inflation. Some pharmacists do not accept the \$2.04 as a legitimate figure, however, because they disagree with the manner in which the survey data was analyzed.

Current federal medicaid guidelines for drug reimbursement state that provider reimbursement levels be evaluated annually; however, there do not appear to be any federal or state regulations or guidelines which relate to annual adjustment of provider reimbursement levels to reflect inflationary trends. The KMAP does not presently have a formally codified procedure for reviewing dispensing fees.

It is true that the KMAP conducts a cost survey every three years, and that there is a flurry of "evaluation" of the dispensing fee at the time the Kentucky General Assembly meets, if pharmacists have been exceedingly vocal in their complaints. However, the pharmacist dispensing fee is a serious issue which deserves objective evaluation on an annual basis outside of the political arena.

If the KMAP implements a variable fee system, the annual cost reports submitted by each pharmacist would provide the basis for annual review of the dispensing fee(s). Should the Department for Human Resources implement the recommendation of this report that a variable fee system be adopted, it should then promulgate a regulation requiring an annual review of the pharmacist prescription dispensing fee(s) under the KMAP. The regulation also should provide for special meetings of the KMAP staff with members of the pharmacy Technical Advisory Committee for the exclusive purpose of reviewing the dispensing fee(s) in relation to the results of the annual cost survey.

Pharmacists have protested that levels of reimbursement to other types of providers participating in the KMAP have increased significantly during the past few years, while expenditures for the KMAP pharmacy program have remained relatively static. One of the reasons for this situation is undoubtedly the difficulty associated with determining actual costs to pharmacists to dispense prescriptions. In any case, it seems inappropriate to use this argument as a justification for increasing the dispensing fee. The issue, however, is not which providers are receiving the biggest slices of the medicaid pie, or even if one type of provider's fee has kept pace proportionately with another type of provider's fee over the years, since the costs of providing these services vary greatly. The issue remains, are pharmacists being fairly reimbursed according to present economic conditions for their services to medicaid patients?

OUTPATIENT PHARMACY EXPENDITURES
Kentucky Medical Assistance Program
HISTORICAL DATA

Table No. I

Fiscal Year	Dollar Amount of Dispensing Fee Per Prescription	Dollar Amount of Outpatient Pharmacy Expenditures			Total General & Federal Funds	Dollar Amount Due to Payment of Dispensing Fee *	Percent of Total Outpatient Pharmacy Expenditures Due to Payment of Dispensing Fee **	
		General	Federal					
1961	Drug Cost							
	Dispensing Fee							
	\$0.01-1.00	\$0.50						
	1.00-1.74	0.70						
1.75-2.99	1.20							
3.00 & Over	1.50							
1962		--	Not Available--					
1963		--	Not Available--					
1964		--	Not Available--					
1965		\$ 597,430	\$1,818,382	\$2,415,812				
1966		849,000	2,584,078	3,433,078				
1967		1,383,374	4,144,679	5,528,053				
1968		1,514,448	4,875,627	6,390,075				
1969		2,373,699	7,217,005	9,590,704	--Not Available--			
1970		3,124,733	9,500,451	12,625,184				
1971		2,684,361	7,760,624	10,444,985				
1972		3,177,763	9,187,073	12,364,836				
1973		3,112,125	8,627,313	11,739,438				
1974		3,160,008	8,760,053	11,920,061		\$6,130,956	51.4%	
1975		3,016,817	7,803,904	10,820,721		6,014,254	55.6	
1976		3,420,248	8,847,499	12,267,747		6,440,202	52.5	
1977		3,795,299	9,461,073	13,256,372		6,705,922	50.6	
1978		3,517,526	8,768,628	12,286,154		6,237,182	50.8	
1979		3,754,279	8,832,331	12,586,610		6,280,234	49.9	
1980		885,640**	2,038,228**	2,923,868**		1,586,925**	54.3**	
* This is an estimate only based on the assumption that any claims paid during the fiscal year also had a service date of that fiscal year.								
** July-September, 1978, figures only.								

CHAPTER VIII

A SURVEY OF DISPENSING FEES IN 13 STATES

The thirteen states comprising DHEW Regions IV and VI were surveyed in an attempt to determine if Kentucky's medicaid dispensing fee is comparable to medicaid dispensing fees in other states. The results of this survey appear in Tables II and III (below).

This data is presented primarily for the benefit of those persons interested in making comparisons; the data has the following major deficiencies, however:

1. During the course of compiling this survey, it became readily apparent that some states' ability to retrieve the type of data requested in the survey form was very limited. This body of information should therefore be evaluated with this factor in mind.

2. A comparison of Kentucky's dispensing fee with the dispensing fees in the thirteen states comprising DHEW Regions IV and VI is a dangerous exercise and can be misleading. In some instances the fee is determined by factors unrelated to actual demonstrated cost. For example, in some states, the dispensing fee is determined by the successful efforts of organized pharmacists in persuading the legislature to accept their recommendations. In other states, the dispensing fee is based upon the results of federally mandated, state conducted dispensing fee cost studies of varying quality; and in still other states the dispensing fee is a "negotiated" figure, which ostensibly takes into consideration both the recommendations of provider pharmacists and the results of the dispensing fee cost study conducted by the state.

3. The data which appears in Tables II and III can be easily misinterpreted. For example, Table II indicates that Kentucky's present dispensing fee of \$2.22 is the lowest of the thirteen states included in the survey. Beside the dispensing fees of the other states, this amount does not appear equitable until one takes into consideration the factors discussed below, any one of which affects the total amount of compensation pharmacists receive in dispensing fee benefits under the Kentucky Medical Assistance Program:

- A. State medicaid programs frequently impose restrictions upon the outpatient pharmacy component of the program either in an effort to contain costs, control program abuse, or both. These restrictions frequently include one or more of the following limitations:

- (1) Limiting the number and/or types of drugs which qualify for reimbursement under the medicaid program.

- (2) Requiring medicaid recipients to share the expense of the drugs by paying a certain amount of money for each prescription purchased (co-payment).

- (3) Imposing no requirements for maximum quantities per prescription (fewer refills means fewer dispensing fees).

- (4) Requiring minimum quantities per prescription.

- (5) Limiting the number of prescriptions a medicaid recipient may have filled per month for which the state medicaid program will provide reimbursement.

- (6) Limiting the number of dollars the state medicaid program will pay for drugs per month for each medicaid recipient.

Table III shows that while Kentucky has the lowest dispensing fee of the thirteen states surveyed, it is the only state that has no major program limitations, while South Carolina has four limitations; Florida, New Mexico, Arkansas, Texas, Georgia, and Oklahoma, three limitations; North Carolina, Mississippi, Louisiana, and Alabama, two limitations; and Tennessee, one limitation.

B. Table II shows that of the thirteen states surveyed, Kentucky has the highest percent of outpatient pharmacy expenditures from dispensing fees.

C. Table II demonstrates that Kentucky's medicaid program has the lowest average prescription cost of the thirteen states surveyed. One of the major reasons for this condition is the fact that Kentucky pharmacists dispense multiple small-quantity prescriptions. This practice produces a low average prescription cost but it means that a high percentage of drug expenditures are due to the dispensing fees thus generated. Another factor which contributes to low average prescription cost is that the KMAP has utilized both federal and state maximum allowable costs on multiple-source drug categories.

When all of the aforementioned factors are considered within the context of total benefits to pharmacists, it is apparent that pharmacists participating in the KMAP are being reimbursed in an equitable manner, and in fact enjoy more opportunities to obtain benefits from the KMAP than do pharmacists participating in medicaid programs in the other states surveyed, where such programs impose anywhere from one to four major limitations on pharmacist reimbursement from the Medical Assistance Program.

TABLE II
 MEDICAL PHARMACY SURVEY OF 13 STATES

General Outpatient Pharmacy Program Information

FY 1977-78

State	Number of Eligible Medicaid Recipients	Number of Outpatient Prescriptions Paid by Medicaid	Dollar Amt. for Outpatient Pharmacy Expenditures	Average Medicaid Prescription Cost	Current Dispensing Fee Exclusive of any Co-Pay by Recipient	Recipient Payment Per Prescription (Co-Pay)	Outpatient Dispensing Fee As A Percent Of Outpatient Pharmacy Expenditures	Dollar Amount Due to Payment of Dispensing Fee	If a Dispensing Fee Survey(s) has been conducted since Sept., 1976, list dispensing fee(s) according to survey
N. C.	343,000	3,900,000	\$26,206,000	\$7.25 includes co-pay	\$2.50	50¢	34%	\$9,000,000	Survey identified dispensing fee of \$2.71
KY.	339,154	3,488,722	\$12,583,226	\$3.61	\$1.80-FY 1977-78 \$2.22-FY 1978-79 \$2.35-FY 1979-80	None	50%	\$6,279,700	Survey identified dispensing fees: FY 1976-77 Median Reasonable fee-\$2.04 FY 1977-78 \$2.04 adjusted with inflation factor-\$2.15
TEX.	632,978	6,420,492	\$52,288,497	\$8.14	\$2.32 to \$2.52 for 1977 \$2.25 to \$2.75 for 1978 (Variable)	None	30%	\$14,333,813	Survey identified the following fee: \$2.32 to \$2.82

TABLE II (Continued)

MEDICAID PHARMACY SURVEY OF 13 STATES

General Outpatient Pharmacy Program Information

FY 1977-78

State	Number of Eligible Medicaid Recipients	Number of Outpatient Prescriptions Paid by Medicaid	Dollar Amt. for Outpatient Pharmacy Expenditures	Average Medicaid Prescription Cost	Current Dispensing Fee Exclusive of any Co-Pay by Recipient	Recipient Payment Per Prescription (Co-Pay)	Outpatient Dispensing Fee As A Percent of Outpatient Pharmacy Expenditures	Dollar Amount Due to Payment of Dispensing Fee	If a Dispensing Fee Survey(s) has been conducted since Sept., 1976, list dispensing fee(s) according to survey
LA.	*	*	*	*	\$2.35-8/15/77 to 7/14/78 \$2.80-Effective 7/15/78	None	*	*	Survey Identified Dispensing fee of \$2.80 as of 12/31/77
GA.	415,000	5,914,397	\$32,862,013	\$5.56	\$2.35	50¢	39%	\$12,952,529	Survey Identified the following fees: 7/1/77 \$2.19 7/1/78 \$2.35
N. Mex.	78,000	573,670	\$ 4,033,907	\$7.03	\$2.50	25¢	N/A at time survey conducted	N/A at time survey conducted	No survey during this time
FLA.	Approximately 445,000	Approximately 4,800,000	Approximately \$27,000,000	\$5.65	\$2.75-after 7/1/78 \$2.40-prior	None	Approximately 42%	Approximately \$11,500,000	The last fee study completed on 6/76 recommended a dispensing fee of \$2.65 based on Actual Acquisition Cost, to be adjusted downward if the Estimated Acquisition Cost is used for ingredient cost

TABLE II (Continued)
 MEDICAID PHARMACY SURVEY OF 13 STATES

General Outpatient Pharmacy Program Information

FY 1977-78

State	Number of Eligible Medicaid Recipients	Number of Outpatient Prescriptions Paid by Medicaid	Dollar Amt. for Outpatient Pharmacy Expenditures	Average Medicaid Prescription Cost	Current Dispensing Fee Exclusive of any Co-Pay by Recipient	Recipient Payment Per Prescription (Co-Pay)	Outpatient Dispensing Fee As A Percent of Outpatient Pharmacy Expenditures	Dollar Amount Due to Payment of Dispensing Fee	If a Dispensing Fee Survey(s) has been conducted since Sept., 1976, list dispensing fee(s) according to survey
MISS.	285,000	3,758,069	\$23,724,564	\$6.31	\$2.25	50¢ for 6 mos. (7/1/77 to 12/31/77)	Unknown	Unknown	No published survey available for review
ARK.	216,127	2,147,789	\$15,332,506	\$7.14 without co-pay \$7.64 includes 50¢ co-pay plus 3% sales tax	\$2.87	50¢	31.4%	\$4,807,553	According to survey: Average cost to dispense a prescription in Arkansas is \$2.21. Usual & Customary Charge is \$2.70 Present fee is \$2.70, plus 17¢ inflation factor for a total dispensing fee of \$2.87
TENN.	408,413	4,628,211	\$30,013,876	\$5.33	\$2.30	None	43.15%	\$12,951,588	Survey identified "cost" to dispense drug ranging from 99¢ to \$6.08 with a mean cost of \$2.87

TABLE II (Continued)
 MEDICAID PHARMACY SURVEY OF 13 STATES
 General Outpatient Pharmacy Program Information

FY 1977-78

State	Number of Eligible Medicaid Recipients	Number of Outpatient Prescriptions Paid by Medicaid	Dollar Amt. for Outpatient Pharmacy Expenditures	Average Medicaid Prescription Cost	Current Dispensing Fee Exclusive of any Co-Pay by Recipient	Recipient Payment Per Prescription (Co-Pay)	Outpatient Dispensing Fee As A Percent Of Outpatient Pharmacy Expenditures	Dollar Amount Due to Payment of Dispensing Fee	If a Dispensing Fee Survey(s) has been conducted since Sept., 1976, list dispensing fee(s) according to survey
S. C.	228,406	2,240,000	\$11,900,000	\$5.31	\$1.90	50¢	36%	\$4,256,000	Survey identified mean average cost to dispense a prescription at \$2.25
OKLA.	207,700	803,266	\$ 6,243,545	\$7.77	\$2.50 Maximum	None	31%	\$1,951,936	\$2.14
ALA.	336,722	3,238,000	\$ 7,859,247	\$5.52	\$2.25	50¢ on each prescription and refill	37%	\$7,285,000	No survey during this time period

*Data Unavailable. Louisiana does not separate outpatient pharmacy expenditure data from inpatient pharmacy data.

SOURCE: LRC Survey of 13 State Medicaid Programs

TABLE III

MEDICAID PHARMACY SURVEY OF 13 STATES

Outpatient Pharmacy Program Requirements and/or Limitations

FY 1977-78

State	Recipient Payment Per Prescription (Co-Pay)	Reimbursable Drugs		If Difference Between Legend & Non-Legend Dispensing Fee, Specify Difference	Maximum Quantities Per Prescription	Minimum Quantities Per Prescription	Limit on Number of Prescriptions Per Recipient	Limit on Dollars Paid for Prescriptions Per Recipient
		Legend (Prescription)	Non-Legend (Non-Prescription)					
KY.	None	Legend drugs included on the KMAP Drug List & approved under the Drug Pre-Authorization Program are covered for Program payment	Non-Legend drugs included on the KMAP Drug List & approved under the Drug Pre-Authorization Program are covered for Program payment	No Difference	Maximum quantity limitations were in effect from 7/68 to 7/78. In 1977, the average number of days supply of medication dispensed per was 16 days	None	None	None
N.C.	50¢	All legend drugs	Insulin only	No Difference	None	None	None	None
TEX.	None	Only those drugs listed in the Texas Drug Code Index are compensable	Only those drugs listed in the Texas Drug Code Index are compensable	Legend-Acquisition cost of drug plus assigned variable dispensing fee Non-Legend - Acquisition cost plus 50% of cost not to exceed variable dispensing fee	Maximum legal quantities for controlled drugs or up to a six months' supply	None	3 prescriptions per month per recipient	None

TABLE III

MEDICAID PHARMACY SURVEY OF 13 STATES

Outpatient Pharmacy Program Requirements and/or Limitations

FY 1977-78

State	Recipient Payment Per Prescription (Co-Pay)	Reimbursable Drugs		If Difference Between Legend & Non-Legend Dispensing Fee, Specify Difference	Maximum Quantities Per Prescription	Minimum Quantities Per Prescription	Limit on Number of Prescriptions Per Recipient	Limit on Dollars Paid for Prescriptions Per Recipient
		Legend (Prescription)	Non-Legend (Non-Prescription)					
ARK.	50¢ per	All legend drugs except amphetamines, Schedule V narcotics, Nicotinic Acid, Ferrous sulfate and gluconate, calcium lactate, contraceptive foams & jellies, Meclizine HCl, Pediatric Vitamin Drops	Analgesics, Laxatives & Stool Softeners	None	One month supply	None	Limit of 4 prescriptions per month per recipient as of 2/1/78. Prior to that time, the limit was 3 prescriptions.	None
TENN.	None	All legend drugs except anorectics compounded prescriptions non-narcotic analgesic compounds & some psychotropic drugs	Insulin only	No Difference	One month supply	None	None	None
S.C.	50¢	700 Drugs (Closed Formulary)	100 Drugs (only those in Formulary)	Legend Drugs - \$1.90, Non-Legend - Actual Wholesale Cost plus 50% mark-up	Varies according to type drug	None	None	None

TABLE III
 MEDICAID PHARMACY SURVEY OF 13 STATES
 Outpatient Pharmacy Program Requirements and/or Limitations
 FY 1977-78

State	Recipient Payment Per Prescription (Co-Pay)	Reimbursable Drugs		If Difference Between Legend & Non-Legend Dispensing Fee, Specify Difference	Maximum Quantities Per Prescription	Minimum Quantities Per Prescription	Limit on Number of Prescriptions Per Recipient	Limit on Dollars Paid for Prescriptions Per Recipient
		Legend (Prescription)	Non-Legend (Non-Prescription)					
FLA.	None	Legend drugs are covered with the following exceptions: anorexic drugs, experimental drugs, blood plasma derivatives, and drugs costing in excess of \$22 per month or \$33 per month if the recipient resides in a nursing home	Insulin is the only reimbursible non-legend drug	None	None	One month maintenance medication	None	Each recipient is entitled to \$22 per month of prescribed medicine benefits, or \$33 per month if the recipient resides in a nursing home. Recipients may request an excess drug grant which will exceed the established cap which may be approved contingent upon medical review
MISS.	50c for 6 months (7/1/77 to 12/31/77)	Approximately 1,800	47 items	None	None	Quantity varies by type of drug	None	None

TABLE 111

MEDICAID PHARMACY SURVEY OF 13 STATES

Outpatient Pharmacy Requirements and/or Limitations

FY 1977-78

State	Recipient Payment Per Prescription (Co-Pay)	Reimbursable Drugs		If Difference Between Legend & Non-Legend Dispensing Fee, Specify Difference	Maximum Quantities Per Prescription	Minimum Quantities Per Prescription	Limit on Number of Prescriptions Per Recipient	Limit on Dollars Paid for Prescriptions Per Recipient
		Legend (Prescription)	Non-Legend (Non-Prescription)					
LA.	None	All legend drugs except some less essential categories	Limited to: Calcium Gluconate, Calcium Lactate, Calcium Phosphate Contraceptive Supplies, Ferrous Gluconate, Nicotinic Acid, Insulin, Diabetic Testing Supplies, Insulin Syringes, Indwelling catheters, Catheterization trays	Payment for non-legend drugs may not exceed 50% of the wholesale cost	Greater of 100 units or one month's supply	None	None	None
GA.	50¢	12,000 items (includes both legend & non-legend drugs)	Limited to: Insulin, Diabetic Supplies, ASA (Acetaminophen with specified diagnosis -- Arthritis	No Difference	One month's supply	None	None	None

TABLE III
 MEDICAID PHARMACY SURVEY OF 13 STATES
 Outpatient Pharmacy Requirements and/or Limitations

FY 1977-78

State	Recipient Payment Per Prescription (Co-Pay)	Reimbursable Drugs		If Difference Between Legend & Non-Legend Dispensing Fee, Specify Difference	Maximum Quantities Per Prescription	Minimum Quantities Per Prescription	Limit on Number of Prescriptions Per Recipient	Limit on Dollars Paid for Prescriptions Per Recipient
		Legend (Prescription)	Non-Legend (Non-Prescription)					
N. MEX.	25¢	All legend drugs except amphetamines, long-acting iron salts and hematinics, ineffective drugs, laxatives and stool softeners and hypnotic drugs	Limited to: Salicylate and acetaminophen anal antacids, non-long-acting iron salts, and insulin	No Difference	Six months' supply limit	None	None	None
OKLA.	None	4,164 items	None	No Difference	Maximum 34 supply or 100 units	None	3 prescriptions per month per recipient	None
ALA.	50¢	Those listed on Alabama Drug Code Index	Insulin and ferrous sulfate	No Difference	None at this time	None at this time	None (Subject to surveillance and utilization Review)	None

SOURCE: LRC Survey of 13 State Medicaid Programs

CHAPTER IX

ALTERNATIVE REIMBURSEMENT MECHANISMS

The Variable Fee System Under the Kansas Medicaid Drug Program

In 1968, Kansas pharmacists requested that the State Department of Social and Rehabilitation Services determine a more equitable method of reimbursement for Title XIX prescriptions. The research that subsequently was conducted in response to this request resulted in a 1970 implementation of the first variable fee system in the United States. Five other states have adopted a variable fee system since that time.

The variable fee system individualizes fees paid, based on individual costs of dispensing a prescription. Pharmacy cost study reports are filed annually by most participating pharmacies and the dispensing fee is determined annually. The information collected in the Kansas annual survey helps determine the operational costs involved in dispensing a prescription in each participating pharmacy. The Kansas program incorporates an incentive to pharmacist providers to complete and return their survey forms, as described below:

Hospitals, state institutions with pharmacies, out-of-state pharmacy providers, and new in-state pharmacies are not required to file and are assigned the state average dispensing fee. In-state pharmacies may decline to file the cost study report and still participate in the program if they agree to accept the lowest computed dispensing fee determined from analysis of filed cost study reports. Usually the reason for such action is the pharmacy has a very low volume of Title XIX prescriptions and they will take the low fee rather than file the cost study report. The pharmacies participating in the program that do file cost study reports account for well over 90% of all Title XIX prescriptions filled for Kansas Medicaid recipients.²¹

The results of the Kansas Medicaid program pharmacy surveys reveal that operating costs vary significantly between pharmacies, as evidenced by the dispensing fee range in Kansas for fiscal year 1978-79 of \$1.30 to \$3.25. The dispensing fee assigned to a pharmacy is based upon data contained in the individual cost survey form filed by each participating pharmacy and is computed on the basis of "the total of the allocated operating cost plus a 30 cents profit factor. Reimbursement to a pharmacy provider is the total of the dispensing fee plus the allowable drug cost. Effective July 1, 1976, a recipient co-pay charge of 50 cents was applied to each new refill prescription."²² If a pharmacy fails to collect the co-pay, this becomes grounds for dismissing a pharmacy from further participation in the program.

This cost-based method of reimbursement is probably the best functioning system in pharmacy today. The primary advantage of the variable fee system over the fixed fee system, as noted earlier in this report, is that the former system reimburses each pharmacy according to costs unique to its operation, while the fixed fee reimburses all pharmacies the same fee, regardless of the level of service provided.

However, the variable fee system, as it is administered by the Kansas state medicaid program, appears to have four major drawbacks.

First, this system requires an annual survey that is expensive and time-consuming for both participating pharmacists and medicaid staff. On the positive side, though, Kansas has found that the quality of the data received from pharmacists has improved each year—partially as the result of efforts to educate pharmacists, and partly as the result of the assignment of the lowest filed fee to any pharmacy failing to file an annual survey. Kentucky apparently has a very serious difficulty in obtaining accurate cost survey data under the present fixed fee method of reimbursement. A variable fee system, requiring an annual cost survey, with appropriate audits and the assignment of the lowest fee identified in the survey to those pharmacies who do not submit a cost report, may be the provision needed to correct this condition.

Secondly, the variable fee system requires computer capability to process annual survey forms, a resource the KMAP presently does not possess.

Thirdly, there seems to be some question as to whether the Kansas program, with its one full-time auditor, is capable of providing the audit staff required to monitor the costs submitted on the survey forms by each participating pharmacist. Costs submitted are based on usual and customary charge and may not be justifiable.

Finally, the variable fee system in Kansas imposes a recipient co-pay charge of 50 cents for each new refill prescription. Third-party payor administrators are divided on the issue of the feasibility of co-payment. Proponents of co-payment contend that co-payment reduces program costs and provides an incentive to recipients to use the program prudently, avoiding excessive services, and to seek low-cost alternatives. Critics of co-payment charge that collection of co-payments is unworkable and that many recipients who cannot afford the co-payment cease taking their medication, risking hospitalization and increased physician services.

From January 1, 1972 until June 30, 1973, an experiment was conducted with California Medi-Cal patients where a \$1.00 co-payment was imposed for physician visits and a 50 cent co-payment for prescription drugs . . . It was found that following the start of co-payment, the utilization rate of outpatient physician visits and other services associated with them showed a decline relative to the non-co-payment group. After a brief lag, however, it was found that hospitalization rates among the co-payment group rose to levels higher than those of the non-co-payment sample. These rates more than offset any savings from the reduction of ambulatory service use rates. Higher hospitalization use rates suggest that financial deterrents to the excessive use of ambulatory services such as physician visits and prescription drugs by poor people are penny-wise and pound-foolish. This is presumably due to the neglect of earlier medical care because of the inhibiting effects of co-payments.²³

Thus, KMAP officials should carefully weigh the advantages and disadvantages of co-payment under either a fixed or variable fee system, since the net result of initiation of a co-payment requirement may be to reduce expenditures in the pharmacy program while increasing expenditures in other KMAP areas, such as hospitalization and physician services.

The variable fee system is clearly a more equitable system than the fixed fee system presently in use in Kentucky. DHR and KMAP officials have given every indication that they support the implementation of a variable fee system. If the Kentucky General Assembly supports the implementation of the variable fee system, it must be prepared to budget the funds needed for the conversion process. Although the initial outlay of funds may be high, there may be some money saved eventually, if the experience of other states with the variable fee system is repeated in Kentucky. These other states have found that while their payments are more equitably distributed, the total payments under the program have actually been reduced.

Dual-Fee System

Other states are experimenting with different reimbursement methods. For example, from 1974 to 1976 the Wisconsin medicaid program used a "dual fee system," which paid "general service" pharmacies one fee and "special service" pharmacies a higher fee. In order for a pharmacy to be classified as a "special service" pharmacy, it was required to "provide 24-hour emergency service, emergency prescription delivery service at no additional cost to the program, a patient drug profile service for all medicaid recipients, and all pharmacists practicing full time in the pharmacy must attend and participate in at least four hours of approved continuing education programs each year."²⁴

Capitation System

On July 1, 1977 the New Jersey medicaid program became the first state medicaid program to pay a capitation fee to providers of pharmaceutical services to medicaid-eligible recipients in long-term care facilities, for dispensing and non-dispensing activities of pharmaceutical service. And Iowa's medicaid program, in conjunction with the Iowa Pharmaceutical Association and Blue Cross of Iowa, initiated a two-year experimental program based upon capitation in July of 1976.

Payment based upon capitation is not a new concept; it has been used by health maintenance organizations for several years. It has several advantages over either the fixed fee or variable fee systems, and has some interesting possibilities, insofar as it simultaneously encourages pharmacists to practice their profession more fully and increases the level of service to recipients while holding down costs. The monitoring and management of a capitation system is conducive to inpatient settings; however, there is not enough evidence presently available to demonstrate whether it can be successfully implemented for outpatient pharmacy services.

If the combined forces of the KMAP, the Kentucky Pharmaceutical Association and the University of Kentucky College of Pharmacy apply for and are granted monies for a demonstration project through the Health Care Financing Administration, as recommended earlier in this study, this would provide an ideal vehicle with which to investigate and evaluate the feasibility of managing a capitation system of reimbursement in Kentucky's medical assistance program, as well as an opportunity to review other alternative methods of reimbursement. At the very least, KMAP officials should monitor medicaid programs in other states where the capitation method of reimbursement has either been adopted or is under investigation and weigh the feasibility of substituting reimbursement by capitation for the fixed or variable fee-for-service mechanisms in Kentucky's medical assistance program.

In the meantime, the KMAP should proceed with the development of a variable fee system, since the documentation needed for responsible evaluation of a capitation reimbursement mechanism may be several years away, and Kentucky needs a more equitable method of reimbursement for pharmacy payments now.

Alternative Reimbursement Mechanisms and the Role of the Pharmacist

The role of the pharmacist today is not always clearly understood, as demonstrated by the following comment by Chief Justice Burger in a Supreme Court decision:

. . . the pharmacist performs three tasks: he finds the correct bottle; he counts out the correct number of tablets or measures the right amount of liquid; and he accurately transfers the doctor's instructions to the container . . . It is clear that in this regard he no more renders a true professional service than does a clerk who sells law books.²⁵

Although it is true that many pharmacists do little more than Chief Justice Burger charges, a pharmacy conducted in a truly professional manner is involved in much more relevant activity. The knowledge and expertise of pharmacists is one of the nation's most underutilized resources in the maintenance of health care. It is a readily available resource, the value of which is only being recognized in recent years. Unfortunately, the reimbursement systems most frequently used today all emphasize the *distributive* nature of pharmacy and de-emphasize the *service* component of pharmacy. Solomon, *et al.*, aptly describe the dilemma: "In general, pharmacists presently are paid solely for their distributive rather than service functions." In the "mark-up" and "professional fee" systems, "pharmacist reimbursement is associated exclusively with dispensing the *actual drug product*." These two "reimbursement mechanisms for pharmacy services present one of the greatest impediments to expansion of the responsibility and role of the pharmacist in health care by limiting reimbursement to the pharmacist for services only when dispensing a drug product."²⁶

The capitation system of reimbursement does recognize both the distributive and the service aspect of pharmacy. A major challenge to third-party payors, however, would be to arrive at a method of monitoring such a system for outpatient pharmacy services.

The importance of developing a workable reimbursement system which provides an economic incentive to pharmacists to use their knowledge is best illustrated by pointing out the seriousness of drug-related problems as a significant factor in the origin of illness and hospitalization. For example, data from two studies relating to misuse of medications indicate that anywhere from 59% to 62% of home health patients take at least one medication incorrectly, and 30% to 31% of all drugs taken by home health patients are taken incorrectly.²⁷ Common reasons patients misuse drugs are:

1. The patient does not understand the instructions for administering the medications.
2. The patient does not perceive the need to continue the drug regimen.
3. The patient does not like taking the drug.
4. The patient believes an extra dose is needed.
5. The patient has side effects from a drug or combination of drugs.

6. The patient is allergic to a drug or combination of drugs.

7. Patients "borrow" medications from friends.

Solomon, *et al.*, reported in one study that 63% of the patients involved in the study "were taking drug combinations reported in the literature as capable of producing drug-drug interactions." From this patient population they detected "ten drug interactions of major clinical significance, fifteen of moderate clinical significance and twenty-four of minor clinical significance."²⁸

The incidence of drug-induced disease has been well documented. So have the links between inadequate drug surveillance and increases in human suffering and the cost of health care:

Intensive epidemiologic surveillance of hospitalized patients in the United States and abroad has shown that 2 to 5 percent of patient admissions to the medical and pediatric services of general hospitals are attributable to drug-induced disease. Five to 30 percent of patients experience adverse reactions to drugs during hospitalization. An unknown proportion of fetal abnormalities may be attributable to drugs taken by the mother during pregnancy or administered during parturition. An undetermined number of illnesses caused by drugs are responsible for visits of patients to physicians' offices. Conceivably, some diseases for which causes have not been demonstrated or which are widespread may have been induced by drugs.²⁹

The economic impact of the situation described above upon medical assistance costs is obvious. Drug misuse results in KMAP expenditures for hospitalization and physician services. Thus, those pharmacists who maintain patient profiles in order to monitor the interaction of drugs for their patients, and those pharmacists who counsel with their patients about their drug regimen are providing a service which not only may be resulting in a more healthy population, but may also constitute a method of cost containment for medical assistance programs, if their efforts prevent client hospitalization or physician visits.

Thus, the underutilization of the pharmacist as a valuable health resource continues, partly because the value of their knowledge and their role are not truly understood by the general public or by many other health professionals, and partly because the economic interest discourages pharmacists from becoming more involved in patient care. This picture is slowly beginning to change, as demonstrated by the advent of experimental reimbursement programs based upon capitation and by the utilization of pharmacist expertise in the total care of patients in some in-patient facilities.

It does not appear that a method of reimbursement for outpatient pharmacies has yet been devised which simultaneously encourages pharmacists to provide optimal patient services, while maintaining adequate controls to ensure that such services are actually being provided; however, such a concept should be the goal of any demonstration project grant submitted to the Health Care Financing Administration. In addition, KMAP officials and other third-party payors should follow all developments carefully which seek to achieve this type of reimbursement arrangement.

CHAPTER X

THE RESPONSES OF THE DEPARTMENT FOR HUMAN RESOURCES AND THE KENTUCKY PHARMACEUTICAL ASSOCIATION TO ISSUES RELATING TO THE DISPENSING FEE

During the 1978 regular session of the Kentucky General Assembly, pharmacists participating in the Kentucky Medical Assistance Program criticized the program, alleging, among other things, that: (1) KMAP officials were unresponsive to their concerns; (2) The 1976 KMAP Prescription Department Operational Cost Survey Report published in April of 1977 was "absolutely without statistical validity or practical meaning";³⁰ and that (3) The \$1.80 dispensing fee in effect at that time was not in compliance with the legal intent of state or federal laws and regulations.

During the 1978 regular session of the Kentucky General Assembly, much confusion ensued in regard to the dispensing fee as the results of conflicting testimony presented about this complex issue during the budget hearings. In an effort to substitute understanding for the confusion that occurred during the 1978 session, this Chapter sets forth the issues raised by the pharmacists at the time of the 1978 regular session, as well as those of current concern to them, accompanied by a response by the Department for Human Resources to these issues and additional comment by the author of this report when appropriate.

The specific issues addressed in this Chapter are:

- A. The Equity of the KMAP Dispensing Fee
- B. Cost Containment Proposals
- C. Claims Submission
- D. Comparison of the Reimbursement Rates for Pharmacists and Other Providers
- E. Alternative Fee Structure (Variable Fee System)
- F. Summary of Major Concerns of Pharmacists
- G. Enforcement of MAC Regulations
- H. The 1977 KMAP Prescription Department Operational Cost Survey Report

A. THE EQUITY OF THE KMAP DISPENSING FEE

LRC Staff Inquiry No. 1-A

State the amount that the Kentucky Pharmaceutical Association believes would be an equitable dispensing fee under the Kentucky medicaid program for the following fiscal years:

FY 1978-79

FY 1979-80

FY 1980-81

FY 1981-82

K.Ph.A. Response to LRC Staff Inquiry No. 1-A

The Kentucky Pharmaceutical Association believes that the following schedule of dispensing fees would be acceptable for the Medicaid Program:

FY 1978-79	\$2.58
FY 1979-80	\$2.79
FY 1980-81	\$3.01
FY 1981-82	\$3.25

These figures are based upon the most reliable data presently available. It is our understanding that the Department for Human Resources will undertake another cost of dispensing survey in 1979, and we would respectfully submit that data developed as a result of that process might modify our response for FY 1980 and beyond.

DHR Response to LRC Staff Inquiry No. 1-A

During the 1978 Legislative Session, representatives of the Kentucky Pharmaceutical Association conveyed the impression to DHR staff that the dispensing fees of \$2.22 for FY 1978-79 and \$2.35 for FY 1979-80, which were ultimately adopted, were acceptable fees for pharmacists participating in the KMAP.

During the meeting of the Pharmacy TAC (Technical Advisory Committee) on October 5, 1978, (also attended by LRC staff), the comment was made in reference to the preparation of a pharmacy-related report for the Governor's Task Force on Welfare Reform that "most pharmacists are satisfied with the way things are going (in the Medicaid Program)."

Since participation in the Medicaid Program is entirely voluntary, it is to be expected that interacting market forces would preclude any pharmacy from participating in a program which has an inequitable economic impact as a result of such participation. It follows that if a program experiences a high rate of participation by a particular provider group, that group is unlikely to be disadvantaged economically by such participation. The rate of participation in the KMAP by pharmacies (approximately 95%) is among the highest of any provider groups.

LRC Staff Inquiry No. 1-B

How were the figures stated in "1-A" above derived?

K.Ph.A. Response to LRC Staff Inquiry No. 1-B

The above figures are obtained from the comprehensive cost of dispensing survey undertaken by the Department in 1977-78, and are based upon 1976-77 operational data. The figures derived by the Department fully justified a \$2.39 fee for FY 1977-78, as has been pointed out in previous K.Ph.A. statements. This basic figure (\$2.39) has, therefore, been modified by an 8% inflation factor for FY 1978-79.

DHR Response to LRC Staff Inquiry No. 1-B

The statement that "the figures derived by the DHR fully justified a \$2.39 fee for FY 1977-78 is questionable for several reasons.

First, the \$2.39 figure was an unweighted mean of the average operational costs adjusted for inflation plus a return on investment costs, as reported by 149 pharmacies, and as such was merely one informational figure included in the referenced DHR survey.

This unweighted mean did not eliminate extremes of reported data, e.g., the 10 and 20 percent extremes, a statistical procedure customarily employed to improve the quality of reported data.

Also, the \$2.39 figure was an unadjusted figure which does not take into consideration the results of data verification audits. Such audits indicated that pharmacies reported data that resulted in a computed dispensing fee which was on the average 10.6 cents higher than the fee computed utilizing audit verified data.

Finally, the mean figure of \$2.39 was higher than the average usual and customary gross margin, or the fee usually charged to the general public, for 79 of the 149 pharmacies included in the survey analysis. Since the KMAP is precluded from paying more than any provider's usual and customary charge for a covered service (in order to qualify for Federal Financial Participation), the \$2.39 figure would have been an unacceptable fee for approximately 46% of the 149 pharmacies included in the survey.

LRC Staff Inquiry No. 1-C

Do the figures stated in "1-A" above include an adjustment for inflation? If so, please explain the method used to determine the inflation factor. If not, cite reasons.

K.Ph.A. Response to LRC Staff Inquiry No. 1-C

The figures for FY 1979-80 and beyond are further adjustments to the initial DHR figure by use of a constant 8% rate of inflation. The annual 8% rate is a recent, and a viable anticipated, norm for the pharmaceutical industry. You will note that this figure is actually below the traditional cost of living increase expected for the economy as a whole.

DHR Response to LRC Staff Inquiry No. 1-C

The Fiscal Year 1979 and Fiscal Year 1980 dispensing fee figures include adjustments for inflation. Inflation figures were obtained from the Bureau of Labor Statistics (BLS) and the Lilly Digest.

According to the Lilly Digest, the nationwide average prescription charge went up 7.8% (44 cents) during 1977 to \$6.10 from \$5.66. However, it is important to realize that the increase in the average prescription charge is largely the result of a 38.3% increase in the average prescription size. The U. S. Department of Labor's Bureau of Labor Statistics (BLS) holds the prescription size constant when compiling the consumer price index (CPI) for prescriptions. It is interesting to note that the BLS-CPI reports a 22.1% increase in prescription charges since 1967 and some of that increase is related to a 25.4% wholesale price increase (WPI) of pharmaceuticals. Since the Department routinely adjusts drug costs to reflect price changes, a percentage of the CPI increase is addressed in that manner; the remaining has been covered by periodic adjustments to the dispensing fee.

LRC Staff Comment Upon the Responses to Inquiry No. 1-C

See Chapter VII for additional discussion of the inflation factor as it relates to dispensing fee reimbursement under the KMAP.

LRC Staff Inquiry to DHR No. 1-D

Pharmacists seem to feel that the dispensing fee should be adjusted on an annual basis to reflect inflationary costs. Does the DHR concur with this position? If not, why?

DHR Response to LRC Staff Inquiry No. 1-D

Reimbursement for prescribed drugs can be broken down into two components; the drug cost component and the dispensing fee component.

The Department has routinely revised the KMAP Outpatient Drug List to reflect changes in drug costs to participating pharmacies. For over two years the Department has monitored the cost of some 2,600 drug products and the KMAP Drug List has been revised monthly to reflect any changes. This Drug List, composed of approximately 100 pages, has been mailed to each pharmacy participating in the Program on a monthly basis.

Beginning under the Kerr-Mills Program in 1961, the KMAP employed a sliding fee scale based on drug cost in establishing the professional fee per prescription.

In January, 1962, the KMAP adopted a flat dispensing fee reimbursement system. A dispensing fee of \$1.10 was paid for prescriptions on all covered drugs dispensed to eligible recipients by participating pharmacies. In July of 1966, the KMAP (under Title XIX of the Social Security Act) increased the dispensing fee to \$1.20 per prescription. The dispensing fee was adjusted upward again in July of 1967 to \$1.40. The dispensing fee was adjusted upward again in July, 1972 to \$1.65 for those pharmacies which were exempt from the then imposed Wage/Price Freeze of 1972. In May of 1974, all pharmacies received the dispensing fee of \$1.65 retroactive to February, 1974. On July 1, 1974, the dispensing fee was increased to \$1.80 per prescription. The current dispensing fee of \$2.22 became effective as of July 1, 1978 and will be adjusted upward again on July 1, 1979 to \$2.35 per prescription.

The dispensing fee has not been adjusted annually to reflect inflationary changes in the cost of dispensing a prescription. Historically, the dispensing fee paid by the Department has reflected available funds. The Program has utilized studies conducted by the University of Kentucky College of Pharmacy in evaluating dispensing fees; however, reimbursement levels have never been based on these studies, which actually involve average gross margins per prescription rather than an analysis of operating costs.

The dispensing fee levels established for Fiscal Years 1979 and 1980 are based on a 1977 KMAP dispensing fee study which involved both operating costs and average gross margins.

The Department does support the concept of a reimbursement method which is cognizant of the inflationary changes in the cost of dispensing a prescription. It is hoped that during future studies the Department will be in a position to identify an appropriate methodology to equitably identify and apply inflationary adjustments to the dispensing fee.

B. COST CONTAINMENT PROPOSALS

LRC Staff Notation to the K.Ph.A.

Please state the Kentucky Pharmaceutical Association's position regarding the following proposals by the Department for Human Resources to modify the dispensing fee reimbursement in order to identify more funds to increase the dispensing fee.

LRC Staff Inquiry No. 2

Implementation of a 50 cent recipient co-pay per prescription.

K.Ph.A. Response to LRC Staff Inquiry No. 2

Although the Association has supported this proposition in the past, we recognize that there are several potential problems with implementation of such a system. First, this places an increased burden on individuals who, by their very definition, are hardest pressed to provide for their own support. The plan would, quite possibly, be politically unwise for introduction in the near future. Such systems do require the recipient to make a health care decision based upon financial considerations. However, co-payment programs have been found to be effective cost containment procedures. K.Ph.A. would only be able to fully support a co-payment system if it could be proven to not be detrimental to patient care, would not present an undue financial burden to the recipient, and if collection of the co-payment were mandated by the state.

DHR Response to LRC Staff Inquiry No. 2.

The most reliable information and assessment of a recipient co-pay on prescriptions should be available from those states which have had actual experience with this cost containment measure.

As of December 4, 1978, thirteen states utilized the co-pay on prescriptions, and in the limited time which was available for the preparation of this response, DHR staff contacted four of these states, which are in HEW Regions IV and VI, to obtain information regarding experience with the co-pay.

The four states contacted were: Alabama, Georgia, Arkansas, and Mississippi. The Medicaid Program representatives contacted in each of the four states indicated that the recipient co-pay has had a very positive impact on their respective programs with regard to stemming inappropriate use of pharmacy benefits. Alabama indicated that over a two-year period, the 50 cents per prescription co-pay had resulted in a \$3,250,000 savings to the Program. Approximately 60% of this savings resulted from an interruption of prescriptions—i.e., no prescription being dispensed, and approximately 40% of the savings was due to the monies generated by the co-pay replacing the expenditure of State/Federal monies.

The Alabama representative indicated that a better utilization of drugs occurred with the co-pay, with a resultant improvement in patient health status.

The Georgia representative indicated that the co-pay in that state had "really put the brakes on the pharmacy program." During the first month after the implementation of the co-pay, the number of prescriptions paid by the Program decreased by 180,000. (Note [DHR]: The Georgia Program usually pays for approximately 500,000 prescriptions per month.)

The Georgia representatives indicated that it has been estimated that the co-pay has resulted in savings of approximately \$6,000,000 per year.

The Mississippi representatives indicated that the co-pay in that state had reduced pharmacy expenditures by approximately \$5,000,000 per year when it was in effect.

The co-pay has been discontinued for what the Mississippi representative termed were "political reasons." Efforts are underway to reestablish this feature of the Mississippi Program.

The Arkansas representative indicated that the Title XIX Program in that State had been implemented with the co-pay, and there was no experience without a co-pay to use in making comparisons of savings.

The Alabama, Georgia, and Mississippi representatives indicated that initially a few complaints regarding the co-pay had been received from Program recipients; however, this now occurs very infrequently.

The only problem area referenced by the four states' spokesmen concerned patients in long-term care facilities. Such patients frequently are maintained on multiple prescriptions, which sometimes creates a financial hardship when the co-pay is collected on each prescription. Arkansas is considering the exemption of nursing home patients from the co-pay.

Note [DHR]: If a co-pay per prescription program were implemented in Kentucky, the above-referenced problem would not be encountered, since drugs prescribed for and provided to such patients (in long-term care facilities) are not included within the outpatient drug program and would not be subject to the co-pay.

The four states' spokesmen indicated that initially the state pharmaceutical associations within their respective states had opposed the imposition of the co-pay. The primary reason cited for the opposition was the concern that many pharmacists would refuse to collect the co-pay, and it was felt that this would tend to undercut those pharmacists who did collect the co-pay. It was perceived that this would reflect adversely on pharmacy as a whole and would give the impression that the fifty cents was unnecessary and was not justified since some pharmacists would not collect it.

The co-pay programs in three of these states are now well received by the state pharmacists, as the waste and unnecessary use of the drug programs have decreased. One state's spokesman commented that the pharmacists realize that their tax dollars support this program, and they support efforts to use those dollars wisely.

Also, the Arkansas spokesman noted that the system tends to monitor itself in that if one pharmacist within a community does not collect the co-pay, this is reported to the program by other community pharmacists. Most of the states consider it grounds for termination of program participation if a pharmacy establishes a pattern of refusing to collect the co-pay.

None of the states' spokesmen could provide any documentation that the co-pay had proved detrimental to patient health care or had contributed to patients making medical decisions in deciding which prescriptions to have filled. Rather, as cited by the Alabama representative, it was felt that the co-pay had contributed to an improvement in care in that many unnecessary refills of drugs were avoided and that the likelihood of drug interactions was decreased as the numbers of prescriptions dispensed decreased.

LRC Staff Comment Upon the Response to Inquiry No. 2

Co-payment may reduce expenditures in the pharmacy component of state medical assistance programs, but there is some evidence that suggests that such reductions result in increased costs in other medical assistance program areas, such as hospitalization and physician services. See Chapter IX for a detailed explanation.

LRC Staff Inquiry No. 3

Limitation of the number of prescriptions to three or four per recipient per month. Monies saved by implementation of this proposal would be used to increase the dispensing fee.

K.Ph.A. Response to LRC Staff Inquiry No. 3

This system of cost containment would be totally unacceptable to the Association. Such a system is only "cost effective" through penalizing the most acutely ill and older recipient. The present system of patient lock-in effectively controls any abuse potential of the "unrestricted" system.

DHR Response to LRC Staff Inquiry No. 3

The same precept as outlined in the response to Inquiry No. 2 would apply here in that the most reliable assessment should come from states having actual experience with the monthly prescription limitation.

Among the four states contacted regarding the co-pay, only Arkansas also utilizes a limit on the number of prescriptions per recipient per month. Arkansas presently employs a limit of four prescriptions. The Arkansas spokesman characterized this as a very successful cost-savings measure.

Two problem areas were cited by the Arkansas representative. The first concerned patients in long-term care facilities who, as referenced above, are often maintained on multiple drugs. As with the co-pay, Arkansas is considering the exemption of such patients from the monthly prescription limitation.

Note [DHR]: As with the co-pay, this would not be a problem in Kentucky because of the different coverage of drugs for patients in facilities. Such patients would be exempt from a monthly prescription limitation, should this measure be imposed on the outpatient drug program.

The second problem referenced by the Arkansas spokesman concerned situations where one pharmacist would fill four prescriptions within one month for a specific patient, but would neglect to notate this on the patient's medical assistance I.D. card. As a result, pharmacists filling and submitting subsequent prescriptions for the same patient within the month would experience rejections of payment.

Note [DHR]: At least two states which utilize the monthly prescription limitation, Texas and Florida, have developed systems to cope with this problem. Texas utilizes a medical record/I.D. book for each recipient. If a pharmacist neglects to notate the dispensing of a prescription in the medical record book, thereby misleading another pharmacist who subsequently dispenses an extra prescription to the patient, the Texas system deducts payment from the first pharmacist's claim and makes payment to the second pharmacist.

Florida utilizes a monthly pharmacy "lock-in" program whereby the patient selects a pharmacy each month, and that pharmacy removes a peel-off MAID (Medical Assistance Identification) number from the patient's monthly ID card. The pharmacist cannot bill without the MAID number label—i.e., the label must be attached to the claim for that recipient in order for payment to be made.

With regard to the K.Ph.A. response to Inquiry No. 3, it should be noted that the KMAP Lock-In program only "controls" the approximately 300 recipients (less than 1% of

total eligible recipients) per month who are included in the Lock-In procedures. [Author's Note: The KMAP Lock-In Program restricts recipients who have inappropriately used the program to one physician and one pharmacy.]

Note [DHR]: The Florida program utilizes a monthly lock-in program for drug benefits for *all* eligible Program recipients.

LRC Staff Comment Upon the Responses to Inquiry No. 3

Limiting the number of prescriptions to three or four per month may pose a very real hardship on many elderly persons and others whose health care is maintained by more prescriptions than would be allowed under such a cost containment measure. As in the case of co-payment, limiting the number of prescriptions may result in decreased expenditures for the pharmacy component of a medical assistance program and increased costs in hospitalization and physician services.

LRC Staff Inquiry No. 4

Reimbursement on non-legend drugs according to one of the following proposals:

- (1) cost plus 50 %
- (2) cost plus 50 % plus 50 cents co-pay

Savings realized through implementation of one of these methods would be used to increase the dispensing fee on legend drugs.

K.Ph.A. Response to LRC Inquiry No. 4

Neither system would be acceptable since, in either case, the cost of dispensing and billing of typical non-legend drugs is identical to the dispensing of legend-only items. Also, HEW regulations prohibit mark-up systems of reimbursement for Medicaid pre-prescription claims, which would obviate this approach. If cost reduction in the area of OTC (Over the Counter) items is sought, complete elimination of this category of drugs would be the most expeditious route.

DHR Response to LRC Staff Inquiry No. 4

The statement that the cost of dispensing typical non-legend drugs is identical to the dispensing of legend-only items is somewhat misleading. Many of the most frequently dispensed non-legend drugs, e.g., insulin, cough mixtures, and liquid antacids, are dispensed in the trade packages with the manufacturer's label attached. Therefore, container costs, label costs, and professional time in terms of package preparation are not involved in the dispensing of these non-legend items.

A representative from the Georgia Title XIX Program indicated that that state has attempted to address the problem of paying a dispensing fee on non-legend drugs by restricting payment for such drugs to specific diagnoses. For example, Georgia will pay for an antacid drug only when there is a diagnosis of peptic ulcer, and for aspirin only when there is a diagnosis of rheumatoid arthritis. Although diagnosis is not coded on the Georgia pharmacy claim form, the state agency holds the pharmacist responsible to ascertain from the physician the specific diagnoses for which all non-legend drugs are prescribed.

LRC Staff Comment Upon the Response to Inquiry No. 4

There is a difference in the cost to a pharmacist to dispense a legend drug and a non-legend drug. The DHR comment is correct in stating that many non-legend drugs are pre-packaged, thereby eliminating container, label and professional time in package preparation costs. Non-legend drugs should not be eliminated from the list of reimbursable drugs, as many of these drugs, such as insulin and antacids, are crucial to the health maintenance of many medical assistance program recipients.

LRC Staff Inquiry No. 5

If the K.Ph.A. does not support any of the aforementioned cost containment proposals, please specify how additional funds might be obtained to increase the dispensing fee.

K.Ph.A. Response to LRC Staff Inquiry No. 5

In light of our only limited support of the above proposals, we would suggest that increased funds for fee increases could best be accomplished by adequate legislative funding and a re-institution of quantity limitations within the program. In the first instance, it should be pointed out that an across-the-board increase of 50 cents in the dispensing fee would only result in an increased expenditure of less than \$800,000 for the state (due to the availability of federal matching funds), which is a nominal amount in view of the total Departmental budget for administration of the Medicaid program. The re-introduction of quantity limitations would also be an effective mechanism, as can be witnessed by the fact that traditionally—and today—the average Medicaid claim within the Commonwealth is the lowest of any state in the nation.

DHR Response to LRC Staff Inquiry No. 5

The K.Ph.A. response to this inquiry reiterates the somewhat unimaginative and fiscally unsound approach of simply “throwing more money at a problem” and justifying this by claiming that the resultant increased expenditures are “nominal” in view of the total DHR budget for the Medicaid program.

It is disappointing that the K.Ph.A., while able to give only limited support to cost containment proposals suggested by the DHR, has no real cost containment measures of its own to offer.

The proposals made by the DHR in no way exhaust alternatives and options in this area.

Examples of other drug cost containment measures which are under consideration or have been implemented in other states include: capitation payments for drugs, payment of fees (less than the dispensing fee) to pharmacists to not dispense drugs when such drugs are contraindicated, unnecessary, or inappropriate; volume purchase drug plans whereby the State purchases drugs, under a bid-contract procedure, directly from drug manufacturers and provides such drugs to participating pharmacies for distribution, as prescribed, to patients in return for a dispensing fee only.

At a time when there is growing concern over high taxes and the appropriate expenditure of tax dollars, it would seem to be an irresponsible guardianship of public funds to endorse the spending of \$2,000,000 to increase the dispensing fee by fifty cents without first

assuring beyond doubt that the expenditure was indeed warranted and secondly assuring that every possible cost control measure would be considered first and implemented when feasible.

With regard to the K.Ph.A suggestion that the re-introduction of quantity limitations would be an effective mechanism to increase the dispensing fee, attention is directed to a Staff Report (dated August 25, 1978) regarding this subject. (See Appendix No. 5, available through the LRC Library.)

It is interesting to note that one of the primary reasons that Kentucky has had a comparatively low average prescription cost (and a comparatively high percentage of drug expenditures due to dispensing fees) has been the practice of Kentucky pharmacists to dispense multiple small quantity prescriptions. As the Staff Report documents, it is a less than appropriate expenditure of public funds to pay a pharmacist \$11.10 in dispensing fees (at \$2.22 per prescription) to dispense five prescriptions within one month of a cough preparation, such as Triaminic Expectorant, which can be purchased without a prescription and at a much lower cost. A pint of this preparation costs the pharmacist approximately \$7.95 and is sold over-the-counter at a 33 ⅓ markup on cost, or approximately \$10.60.

The rationale behind the K.Ph.A. effort to have the quantity per prescription limits reimposed is further illustrated by the copy of a letter which appeared in the October 24, 1978 issue of *Drug Topics*, from a pharmacist in Nashua, New Hampshire (See Appendix No. 6, available through the LRC Library).

LRC Staff Comment Upon the Response to Inquiry No. 5

As pointed out in Chapter XI of this report, any increases in the dispensing fee under the KMAP should be based upon documented costs. Chapter V of this study points out that many pharmacists do not know their costs. Until pharmacists can document their costs with some degree of accuracy, no increases under the KMAP should be granted. The KMAP removed all quantity limitations effective July 1, 1978. This was a prudent decision which will result in decreased program expenditures, not only for drugs, but for physician consultations. Re-introduction of quantity limitations would serve to increase pharmacists benefits while increasing overall program expenditures, inconveniencing recipients and needlessly burdening physicians.

C. CLAIMS SUBMISSION

LRC Staff Inquiry No. 6

It is the understanding of LRC staff that pharmacists are now receiving reimbursement in a timely manner in seven to ten days for error-free claims and ten to fourteen days for other claims. Is this the experience of the membership of the Kentucky Pharmaceutical Association who are providers in the KMAP?

K.Ph.A. Response to LRC Staff Inquiry No. 6

Membership experience of time reimbursement under the present system is somewhat variable. We have found that, generally, claims are being paid more promptly than in the past, but not within the seven to ten days mentioned. It appears that most "clean" claims are being paid within 14 to 21 days, which is a considerably more acceptable tolerance. There are continu-

ing problems on the receipt of payment for prior-authorized claims in particular, and of prompt price updating of the computer in instances of individual drug product prices.

DHR Response to LRC Staff Inquiry No. 6

A recent survey by the KMAP showed that the average turnabout time for a pharmacy claim is 19 days. This is the number of days from the time the claim is received in the pharmacy section until the day the check is mailed. The total time frame runs from three to five days for clean claims (claims with no scanner read errors) to four weeks for provider number errors, which must be verified and reprocessed. All rejected claims must be resubmitted by the pharmacy with corrected data.

LRC Staff Inquiry No. 7

During the 1978 session of the General Assembly, pharmacists complained of excessive and cumbersome paperwork requirements for receiving reimbursement under the medicaid program.

A. Is this still a problem? Explain response.

B. Would the installation of a WATS line in all participating pharmacies for the purpose of transmitting claims represent a significant improvement over the utilization of the present claim forms?

K.Ph.A. Response to LRC Staff Inquiry No. 7

A. This (excessive and cumbersome paperwork requirements) does present a problem to many practitioners. The Department's willingness to allow alternate claims submission procedures, such as the WATS-submission program and computer tape submissions, has eliminated much of the original problem caused by the "hard copy" submission. However, we do not believe that it should be necessary for a pharmacist to purchase or lease a computer in order to submit claims to a governmentally funded program. There also continue to be some time delays involved in payment and unnecessary paperwork in the form of occasional claim resubmissions. A specific example of one problem commonly encountered is that of the claim form itself. When it is necessary to submit claims for quantities of over "999" units the three-digit "quantity" space does not allow for proper claims submission.

B. The uniform use of a WATS-type claim submission procedure would potentially go a long way towards solution of the paperwork burden, depending upon the specific requirements of such a system. We would like to reserve a final decision on this item until completion of the pilot program now in process.

DHR Response to LRC Staff Inquiry No. 7

7-A. In the opinion of DHR staff, the excessive and cumbersome paperwork requirements to receive reimbursement are created, to a large degree, by illegible submissions on the MAP-20 and the MAP-21 billing forms. When a figure is misread by the optic scanner, this produces an incorrect MAID (Medical Assistance Identification) number, N.D.C. (National Drug Code) number, service date or quantity dispensed, resulting in a rejection of that claim. This rejection requires a resubmission, which is costly in time and money to the pharmacy.

A solution to the problem of only space for three digits in the quantity dispensed column is being researched at this time with several possible solutions being considered. This problem reflects only a fraction of 1% of all claims submitted.

As a temporary measure, pharmacists have been advised to enter quantities in excess of "999" on two lines of the claim form.

7-B. In the opinion of DHR staff, the implementation of the Pharmacy Touch Tone System (PTTS) should significantly reduce the paperwork for participating pharmacies. It appears that the error and rejection rate would also drop, once the person, or persons, inputting the data became adept at using the equipment. It is felt that the PTTS claims submission option would be particularly effective for pharmacies filling up to 25 KMAP prescriptions per day.

[Author's Note: Because questions No. 8-14 relate to information which could only be supplied by the Department for Human Resources, these questions were not directed to the Kentucky Pharmaceutical Association.]

LRC Staff Notation to DHR:

It seems apparent that the use of magnetic tapes by some pharmacists has been a key factor in alleviating an overload on the present system of processing claims, thereby facilitating more expeditious reimbursement for all pharmacists than previously was possible.

LRC Staff Inquiry No. 8

What percent of the total number of pharmacists participating in the KMAP program are using magnetic tapes prepared by private organizations at a cost to pharmacists as a means to submit claims to the KMAP?

DHR Response to LRC Staff Inquiry No. 8

Approximately 13.9% (130) of the pharmacies participating in the KMAP submit claims via computer tapes. Annually, an estimated 500,000 line items are processed via computer tape claim submissions.

LRC Staff Inquiry No. 9

How much would it cost the DHR to reimburse pharmacists for their costs incurred in the preparation of their claims on magnetic tapes?

DHR Response to LRC Staff Inquiry No. 9

Based on reports made to the Department, pharmacies pay 17 cents for each new prescription billed via computer tape and 11 cents for each refilled prescription billed. According to nationwide data, new prescriptions constitute approximately 48.5% of all prescriptions filled, while refills constitute 51.5% of all prescriptions filled. Reimbursing the 130 pharmacies for their costs of submitting approximately 500,000 claims would cost the Department approximately \$70,000 per year. Such a reimbursement system would cost the Department \$556,400 annually if all pharmacies submitted claims via computer tapes.

LRC Staff Inquiry No. 10

How much would it cost the DHR to improve its system of claims management and simultaneously eliminate the need for pharmacists to use an independent organization to prepare their claims for submission to the KMAP, without increasing the time lapse between the submitting of claims and the sending of reimbursement to pharmacists?

DHR Response to LRC Staff Inquiry No. 10

The Department is currently involved in evaluating the feasibility of utilizing a touch tone transmission of claims from pharmacies to the Department. The results of this study should be available within the next few months.

LRC Staff Notation to DHR:

The KMAP has initiated a WATS line program to facilitate the submission of claims. If this project is fully implemented:

LRC Staff Inquiry No. 11

How much will it cost to install and operate such a system in a pharmacy?

DHR Response to LRC Staff Inquiry No. 11:

The cost of a touch tone apparatus to a pharmacy should be relatively low. In most areas of the Commonwealth, consumers should have an option of the touch tone type of telephone. In such cases the only cost to pharmacies would be the touch tone telephone installation charge and applicable monthly telephone charges from the telephone company. Some areas of the Commonwealth do not have access to touch tone telephones from their respective telephone company. However, in such cases, they can rent a portable touch tone coupler which can be easily attached and removed from a standard telephone. The touch tone couplers can be leased for about \$2.00 a month or purchased for around \$75.

LRC Staff Inquiry No. 12

Who will pay for the installation and operation of the WATS line—the DHR or each pharmacist who chooses to use this system?

DHR Response to LRC Staff Inquiry No. 12

This aspect will be included in the evaluations of the touch tone claims transmission project.

LRC Staff Inquiry No. 13

Does the KMAP envision the WATS line method of claims submission as a feasible substitute for either claims submitted on hard copy or claims submitted on magnetic tapes?

DHR Response to LRC Staff Inquiry No. 13

The KMAP is currently evaluating the feasibility of touch tone transmission system as an option to the hard copy and/or computer tape claim submission methods. The results of the touch tone pilot project should be available within the next few months.

LRC Staff Comment Upon the Responses to Inquiries No. 6-13:

The optic scanner used to process the claim forms can only read numbers formed in a specific manner. Illegible numbers or those not formed in the proper manner are rejected, which, in turn, results in a delay in reimbursement. This situation has prompted some pharmacists to pay a private organization to have their claims "pre-processed" or "cleaned up," put on magnetic tapes and sent to the KMAP, where such claims can be rapidly processed. Even though only 13.9% or 130 participating pharmacies use magnetic tapes, they create an expense which participating pharmacists should not have to incur. With the large number of transactions involved in large volume pharmacies today, it is unrealistic to expect that the numbers on a claims form be precisely drawn. Legibility is a realistic requirement; precision drawing is not. The DHR should either revise its system of processing claims or reimburse pharmacists who use magnetic tapes for costs involved in the preparation of the magnetic tapes, since the tapes would be unnecessary if the DHR had a more sophisticated system for processing claims. The high cost of reimbursing pharmacists for magnetic tape claim submissions suggests that it would be more economical for the DHR to improve its system of claims processing, whether this be accomplished by the Pharmacy Touch Tone System or by another system which accomplishes the same end.

**D. REIMBURSEMENT RATE FOR PHARMACISTS
COMPARED TO OTHER KMAP PROVIDERS**

LRC Staff notation to DHR:

Please respond to *each* of the following issues which have been raised by several pharmacists:

LRC Staff Inquiry to DHR No. 14

Some pharmacists contend that the rate of reimbursement for other providers has increased more rapidly over the years than for pharmacists; that pharmacists, compared to other providers, receive a disproportionately low reimbursement rate for the services they render. They say they cannot understand why the DHR continues to oppose their proposals for increasing the dispensing fee, pointing out "that an across-the-board increase of 50 cents in the dispensing fee would only result in an increased expenditure of less than \$800,000 for the state (due to the availability of federal matching funds), which is a nominal amount in view of the total Departmental budget for administration of the Medicaid program." Some pharmacists point to the fact that reimbursement for prescribed drugs comprised only nine percent of all Medicaid expenditures for FY 1976 as evidence that the pharmacy component of the KMAP maintains a low priority in the KMAP budget.

DHR Response to LRC Staff Inquiry No. 14

Limitations exist throughout the Program in terms of covered services and in the amounts of reimbursement.

For example: Hospital benefits extend only for the first 21 days of care a recipient receives within the hospital per admission. The result is that less than 90% of the total days of

care a recipient receives is covered by Medicaid. The hospital must seek reimbursement for any days above 21 from other sources.

Hospitals are not reimbursed on a usual and customary charge basis. The system of payment is based upon reasonable allowable cost as determined on an annual basis. Very intricate cost reporting is required of the hospitals. Detailed audits of the hospitals' records are undertaken by the Department to ensure that the costs reported are accurate and reasonable.

In the final analysis, the cost allowed by the Department may in effect be less than the actual total cost incurred by the hospital.

Payments to skilled nursing homes and intermediate care facilities are subject to the same kind of scrutiny applied to hospitals. In the case of intermediate care facilities, payments are made on the basis of prospectively determined rates which the facility must agree to in advance of actually providing the care. The efficiency with which the facility is operated during the year determines whether or not the pre-established prospective rate will cover their cost of providing services to Title XIX recipients. An upper limit of payment also exists for intermediate care facilities. If their cost is greater than either their pre-established rate or the upper limit, no additional payment is made by the Department.

Payments to physicians under Medicaid is made on the basis of the principle of usual and customary reimbursement. However, the system currently in effect in no way reimburses all physicians at 100% of their current charges.

Payments to physicians for outpatient services are presently made on the basis of the charges that were established, by the physician, under Medicare during calendar year 1976. The net effect is that the charges a physician submits to the Program today are subject to reduction based upon their 1976 charges.

This allowable payment to physicians is defined as the lowest of the following five parameters:

1. The billed charge on the claim form.
2. The title XVIII (Medicare) charge for the respective procedure for the respective physician.
3. The Title XVIII (Medicare) charge for all physicians' billing for the respective procedure by area.
4. The KMAP charge for the procedure for the physician (based on 1976 data).
5. The KMAP charge for the procedure for all physicians in the area (based on 1976 data).

Payments to physicians for in-hospital services are reduced to 65% of the allowable 1976 fee after the initial \$50.00 is paid in full, on a by-service basis.

Optometrists are reimbursed in accordance with the concept of usual and customary charges. However, their charges are presently based upon the "going rate" in effect during 1972. Optometrists have never received an increase in fees since the Program initiated coverage of vision services in 1972.

Medicaid payments to dentists are subject to similar limitations with even more restrictions placed upon their charges for in-hospital services.

In addition, reimbursement restrictions are placed upon many other health care providers participating in the KMAP, such as ambulance services, audiologists, home health agencies, laboratories, and community mental health centers.

The Advisory Council for Medical Assistance has continuously recommended improvements in the Program in accordance with available funds. During fiscal year 1978, the improvements recommended by the Council totaled more than fifty (50) million dollars. The Council being acutely aware, both that available resources are not sufficient to meet all needs, and that implementation of one item must mean that another is at least delayed in coverage, has traditionally established priorities for expansion.

In the case of pharmacy services, the Council, in 1976, assigned a low priority to the recommendation of increasing the dispensing fee. The Council assigned a relatively high priority to the pharmacy fee increase included in its 1978 recommendations.

An across-the-board increase of 50 cents on the pharmacy dispensing fee would result in an estimated two million dollar increase in Program expenditures. The state share of such an across-the-board increase would be approximately \$600,000.

National reports indicate that in 1976, Kentucky was above the national average in terms of the percent of total Medicaid benefit expenditures attributed to pharmacy payments. The national average for 52 reporting states and territories was 6.7% while in Kentucky it was 8.6%. Only seventeen of the reporting states and territories paid a larger percentage of their benefit payments for prescribed drugs, while thirty-two paid a lower percentage than did Kentucky. Two states, Wyoming and Alaska, did not cover prescribed drugs in their state Title XIX programs.

In total dollars, only twenty-three states and territories paid more for prescribed drugs than Kentucky did.

E. ALTERNATIVE FEE STRUCTURE (VARIABLE FEE SYSTEM)

LRC Staff Inquiry No. 15

Would the Kentucky Pharmaceutical Association support a variable fee system in Kentucky similar to the one in the state of Kansas? If not, give reasons and offer a *feasible* alternative arrangement.

K.Ph.A. Response to LRC Inquiry No. 15

The Association would support a variable fee system, and would welcome the opportunity of working with the Department and/or Legislative Research Commission on such a plan. While the system of reference (Kansas) is an outstanding approach, we believe that additional study should be given to any such system before attempted implementation.

DHR Response to LRC Staff Inquiry No. 15

KMAP staff is in full agreement with the K.Ph.A. on this issue.

LRC Staff Inquiry to DHR No. 16

Approximately how much money would be required to adapt the present system to implement a variable fee system similar to the one used by the Medicaid program in Kansas? Itemize these costs by specifying the type and cost of each modification.

DHR Response to LRC Staff Inquiry No. 16

Appendix No. 6, available through the LRC Library, is a copy of an Application for Federal Assistance titled: *Pharmacy Cost-Related Reimbursement System*, which Department staff initiated for the development of a pharmacy cost-related reimbursement system applicable to federally-funded drug reimbursement programs. The proposed project includes a primary objective of analyzing a variable fee reimbursement system for pharmacies. (See Appendix No. 7 for the text of the proposal, available through the LRC Library.) [Author's Note: This project proposal has subsequently been rejected by the federal funding agent, the Health Care Financing Administration.]

LRC Staff Inquiry No. 17

How much time would be required to complete the conversion process?

DHR Response to LRC Staff Inquiry No. 17

The projected cost for the development and implementation of a variable fee system is currently estimated at \$96,404 encompassing an 18-month period.

[Please refer to the grant application in Appendix No. 7 for detailed descriptions of developmental costs and milestone dates.]

F. SUMMARY OF MAJOR CONCERNS OF PHARMACISTS

LRC Staff Inquiry No. 18

If the membership of the Kentucky Pharmaceutical Association is dissatisfied with any aspect of the pharmacy dispensing fee component of the Kentucky medicaid program, please list these concerns below in order of their importance:

K.Ph.A. Response to LRC Staff Inquiry No 18

The Association views the dispensing fee component of the Medicaid program with a few remaining areas of dissatisfaction. These include, in order of importance, the facts that: 1) the present fee, as mentioned in the K.Ph.A. response to LRC Staff Inquiry No. 1, is not current with actual costs of dispensing; 2) the system does not assure cost-of-living or other periodic adjustments, and historically it has been shown that such increases are not favorably viewed; 3) the fee does not include a factor recognizing a pharmacist's investment in his practice; 4) there are areas of the current fee which have skyrocketed in comparison with any measure of inflation, such as container costs, which should be separately identified in order to be properly compensated; and 5) the system should be re-designed around a variable fee approach.

DHR Response to LRC Staff Inquiry No. 18

The KMAP is planning to pursue an evaluation of a variable fee reimbursement system during 1979 and 1980.

G. ENFORCEMENT OF MAXIMUM ALLOWABLE COST (MAC) REGULATIONS

Some pharmacists who dispense prescriptions on an outpatient basis and other pharmacists who dispense prescriptions in both outpatient and institutional settings have stated that

they would be very content to receive the fees paid to pharmacists who dispense drugs in institutional settings. According to these pharmacists, the MAC regulations are not strictly enforced in regard to the dispensing of prescriptions in institutional settings because of the difficulty in monitoring payments. This difficulty is attributed to the indirect system in which pharmacists receive reimbursement for their services; i.e., the pharmacist bills the institution, which bills the KMAP; the KMAP reimburses the institution; which in turn reimburses the pharmacist.

Some pharmacists allege that it is a common practice for pharmacists who dispense prescriptions in an institutional setting to be reimbursed on the basis of the "usual and customary" charges they submit to the institution, with no MAC adjustment; thus, the MAC regulations are NOT being applied to pharmacy services within an institutional setting, but are being applied to outpatient pharmacy services.

LRC Staff Inquiry To DHR No. 19

Does the DHR have a system which can determine with certainty whether pharmacists serving institutions are being reimbursed according to the mark-up system? Explain answer.

DHR Response to LRC Staff Inquiry No. 19

Under the present cost reimbursement system, facilities are reimbursed for drugs dispensed to Medicaid patients on a cost basis which is subject to the MAC and Estimated Acquisition Cost (EAC) limitation. It is the responsibility of the facilities to utilize the prudent buyer concept in obtaining their drugs at the lowest possible price.

The Audit Branch is presently conducting an analysis of the charges (whether based on mark-up or dispensing fee) paid to the facilities for drugs. The analysis includes an evaluation of the facilities' compliance with the MAC Regulations. Approximate adjustments in payment will be made in accordance with the findings of the audit.

LRC Staff Inquiry to DHR No. 20

Are pharmacists who service institutions being reimbursed according to the charges they submit, without adjustment for the MAC regulations? If yes, explain. If no, provide the following documentation:

(a) A signed statement from the audit manager(s) in charge of audits for Intermediate Care Facilities (ICF's), and hospitals that an annual audit was conducted in each ICF, SNF and hospital facility for FY 1977-78; and that

(b) The amount of money paid by the KMAP to each facility for pharmacists' fees in FY 1977-78 reflected the application of the MAC regulations.

DHR Response to LRC Staff Inquiry No. 20

Supplying pharmacies are reimbursed by the facilities according to each pharmacy's charge; however, as previously stated, the facilities must observe the MAC and EAC regulations in billing the KMAP. The hospitals and skilled nursing facilities are audited by the Medicare Part A intermediary (an insurance company which contracts with the federal government) according to the Medicare Principles of Reimbursement. The intermediate care facilities are audited primarily by DHR staff with the exception of some audit work performed by outside audit firms.

At the present time, the intermediate care facilities are requested to complete a drug information form which will enable the program to compare drug expenses on a facility by facility basis. Also, the DHR Audit Branch is conducting a drug survey of certain facilities that filed costs reports for fiscal year ending 12/31/77. After this survey has been completed, the Kentucky Medical Assistance Program will formalize its drug audit procedures.

LRC Staff Inquiry to DHR No. 21

It is my understanding that the reimbursement provisions for hospitals, skilled nursing facilities and intermediate care facilities, although different in some ways, all require that reimbursement be based upon "reasonable costs." I cannot find a written program definition of "reasonable costs." Does one exist? If so, please send me a copy. If this terminology has not been defined, then how can the DHR or anyone else determine if pharmacists providing services in institutions are receiving excess reimbursement for their services?

DHR Response to LRC Inquiry No. 21

When an audit is conducted in an institution, the auditor compares certain costs to see if they are in line with costs of other institutions of like size, location, etc. This effort enables the auditor to verify whether certain costs in question are reasonable. [Appendix No. 8 is a copy of a section in the Intermediate Care Policy Manual, Part II, which defines reasonable cost and is available through the LRC Library.] The Title XIX Program utilizes the Title XVIII Principles of Reimbursement for Hospitals to Skilled Nursing Homes. [Appendix No. 9 is a copy of Section 2101 of HIM-15 (Medicare Reimbursement Manual), which defines reasonable cost as it related to Title XIX reimbursement for Skilled Nursing Facilities and Hospitals and is also available through the LRC Library.]

At the present time, the DHR has entered into a contract with Arthur Young and Co., a CPA firm, to develop screens of reasonableness. One of the objectives of this contract is to assist the Department in more clearly defining reasonable cost.

LRC Staff Comment Upon the Response to Inquiry No. 21

The author of this report questions the need for the DHR to contract with a certified public accountant firm for the purpose of developing "screens of reasonableness."

**H. THE 1977 KMAP PRESCRIPTION DEPARTMENT
OPERATIONAL COST SURVEY REPORT**

LRC Staff Inquiry to DHR No. 22

Pharmacists have expressed the following criticisms of the 1977 KMAP Dispensing Fee Survey:

A. The survey identified two fees. "Method A" identified the operational cost of dispensing a prescription in Kentucky to be \$2.39. "Method B" identified the pharmacies' usual and customary gross margin per prescription at \$2.18

(According to pharmacists, the most likely explanation for the "Method A" results being higher than "Method B" is that—given run-away inflation immediately preceding and

during the 1975 period from which data was collected—the actual cost of operating and dispensing a prescription was higher than many pharmacists fully realized.)

In the analysis of the survey data, KMAP officials created a “Method C” procedure which provided a downward bias to the survey, resulting in a final dispensing fee of \$2.04. This “Method C” is absolutely without statistical validity or practical meaning. DHR was unable to present a single guideline from HEW or anyone else to justify this approach.

B. The KMAP survey did not take into consideration the appreciable extra cost of filling a medicaid prescription. Both the Kentucky Medical Assistance Act and DHEW policies would recognize such expenses as overhead costs, which should be reimbursed. Thus, the KMAP dispensing fee survey does not comply with state or federal laws.

C. The \$2.15 dispensing fee proposed by DHR was unreasonable. The KMAP Dispensing Fee Survey showed that as of June 30, 1976 the average dispensing fee paid by non-Medicaid customers was \$2.18. Applying a conservative 6% per year inflation factor to DHR’s own data indicates that, by June 30, 1978, the average dispensing fee in Kentucky for paying customers will be *at least* \$2.44.

D. The Study erred in not including an adjustment for inflation to the final dispensing fee of \$2.04 derived by “Method C.”

DHR Response to LRC Staff Inquiry No 22

A. The Code of Federal Regulations (CFR 450:30) mandated that: “States shall periodically conduct such surveys of pharmacy operational data including such components as overhead, professional services and profits.”

Federal Regulations did not outline any specific criteria or methodology to be utilized by states in conducting dispensing fee studies.

The methodology of assigning each pharmacy participating in the study the lower of two identified fees is felt to be an appropriate and valid procedure.

The procedure has been utilized by the state of Kansas in a variable fee reimbursement system for pharmacies. However, the application of such a methodology is also valid when applied to a sample population.

The methodology is equitable in that it reflects the cost of dispensing prescriptions with a profit factor yet not in excess of usual and customary gross margins.

It should be noted that the Method A fee (Cost of Dispensing or COD) includes an average return on investment factor of \$.45, as identified from the responding pharmacies’ cost reports. The actual cost of dispensing a prescription was \$1.94. There have been numerous speculative explanations for the variance between the two identified fees. It is felt that the accounting techniques employed by many pharmacies did not lend themselves to the identification of certain crucial items and therefore resulted in reporting difficulties.

In the survey analysis, 54% of the reporting pharmacies indicated average operational costs (Method A) were higher than the average usual and customary gross margin (Method B) per prescription. On an average, the Method A (COD) dispensing fee was \$.21 higher than the Method B (Gross Margin or GM) figure. Overall 98% of the pharmacies’ surveys identified a variance between the two identified fees.

Theoretically, the cost of dispensing a prescription should be relatively close to the average usual and customary gross margin per pharmacy.

With a continuing effort to meet the objectives of the study, it was necessary to identify a single representative figure which was reasonable and fair to both the pharmacy providers and the state.

A reasonable dispensing fee is one which is both reflective of costs and yet not in excess of average usual and customary gross margins.

It was determined that the most equitable methodology would be to compare the two fees from each of the responding pharmacies and assign the lower of the two as a pharmacy's dispensing fee.

Thus, the Department for Human Resources had taken into account the pharmacy operational cost data in determining the dispensing fee. By assigning the lower of Method A and Method B, the Department has insured that the resultant fee is both reasonable and not in excess of the average usual and customary gross margin paid by the general public.

The statewide average cost-of-dispensing figure of \$2.39 (Method A) represented approximately the 85th percentile of all reasonable fees. The statewide average of usual and customary figure of \$2.18 (Method B) represented approximately the 75th percentile of the reasonable fee. The most equitable fee identified by the state represents the median or 50th percentile of the reasonable fees. The reasonable fee insures that the reimbursement level is in balance between all pharmacies participating in the Program.

B. The KMAP survey did recognize all those costs of dispensing a perscription, including any costs associated with dispensing a Title XIX prescription, i.e., personnel expense, delivery costs, telephones, vials, utilities, and numerous other direct and indirect expenses.

C. The KMAP applied appropriate inflation factors to the final reasonable dispensing fee identified through the study. The reasonable dispensing fee, labeled Method C, represents the lower of the average gross margin and cost of dispensing. Therefore, an inflation adjustment to the average margin (\$2.18) was not conducted.

D. The dispensing fee figure of \$2.04 included inflationary adjustments through June 30, 1977, as outlined in the June 1, 1977, addendum to the KMAP Study.

LRC Staff Inquiry to DHR No. 23

Some pharmacists have made the following statements regarding the dispensing fee under the KMAP: Pharmacists are subsidizing the KMAP because the dispensing fee is inadequate; it fails to cover the actual cost of dispensing a prescription and a reasonable return on investment. The KMAP dispensing fee fails to take into account the extra effort required to fill a medicaid prescription, as opposed to those filled for private pay patients or those covered by other third-party programs (insurance companies). In order for a pharmacist to continue to provide services for medicaid recipients, he must either take a loss or charge his private pay patients more in order to compensate for his losses under medicaid. The latter alternative is undesirable because increased prices to the general public decrease the pharmacists' ability to successfully compete in the marketplace.

DHR Response to LRC Staff Inquiry No. 23

It is not the Program's intent for pharmacies to subsidize the Kentucky Medicaid Program. However, through the application of a flat fee reimbursement system, some pharmacies may receive payment which is above or below their cost-of-dispensing level. The results of the

KMAP study identified the inequities of flat fee reimbursement systems and stressed the importance of assessing the feasibility of a variable fee reimbursement system. However, the KMAP study did recognize both usual and customary gross margin and cost-of-dispensing figures (both including profit factors) for every pharmacy responding to the study. As a result, the dispensing fee is reflective of the conditions in over 50% of the pharmacies participating in the Kentucky Medical Assistance Program (KMAP) study.

LRC Staff Inquiry to DHR No. 24

According to some pharmacists, neither the present dispensing fee of \$2.22 nor the \$2.35 fee for FY 1979-80 includes an adjustment for inflation.

DHR Response to LRC Staff Inquiry No. 24

Both the Fiscal Year 1979 dispensing fee of \$2.22 and \$2.35 dispensing fee for the Fiscal Year 1980 reflect projected inflationary changes. The Fiscal Year 1980 dispensing fee of \$2.35 is \$0.13 or 5.86% above the current \$2.22 dispensing fee.

LRC Staff Inquiry to DHR No. 25

According to some pharmacists, the present dispensing fee, which reimburses all pharmacies at the fixed rate of \$2.22 (\$2.35 effective July 1, 1979 to July 1, 1980) does not adequately compensate "full service" pharmacies.

DHR Response to LRC Staff Inquiry No. 25

The KMAP dispensing fee study compared pharmacies providing professional services with those that did not; on the average, those pharmacies providing professional services had higher dispensing fees than those not providing such services. For example, of the 149 responding pharmacies, 136 provided for prescription charge services, 112 delivered prescriptions, 120 provided 24 hour emergency service, 95 utilized patient profiling systems, 95 incurred continuing education expenses, and 10 provided unit dose dispensing system. Therefore, the KMAP study was reflective of "full service" pharmacies and the resultant dispensing fees for Fiscal Years 1979 and 1980 are representative within the scope of a flat fee reimbursement system.

LRC Staff Inquiry to DHR No. 26

Dr. Norman F. Billups, a former faculty member of the University of Kentucky College of Pharmacy, conducted a study of dispensing fees in the state of Kentucky in 1976. His study reported an average dispensing fee of \$2.34. Some pharmacists want to know why the KMAP doesn't use Dr. Billups' report rather than its own fee survey, as a basis for determination of a dispensing fee.

DHR Response to LRC Staff Inquiry No. 26

The survey conducted by Doctor Billups measured average gross margins per prescription rather than the cost of dispensing a prescription, thus Doctor Billups' study did not meet the DHEW regulations for a survey to determine a pharmacy dispensing fee. HEW regulations required the study to include operational cost data. The technique employed by Doctor Billups consisted of subtracting the average ingredient cost from the average prescription charge and

labeling the difference as the average professional fee. The KMAP study included an analysis of both the average gross margin per prescription and the average cost of dispensing a prescription.

LRC Staff Inquiry to DHR No. 27

Legal Counsel for the Kentucky Pharmaceutical Association contended during the 1978 session of the Kentucky General Assembly that the \$1.80 dispensing fee was not in compliance with the legal intent of KRS 205.560 or of the MAC regulations. Counsel asserted that KRS 205.560 is specific and explicit in mandating a cost-related payment basis for hospital benefits, drug benefits and nursing home benefits.

DHR Response to LRC Staff Inquiry No. 27

In view of the extensive communications and coordination which involved the Division for Medical Assistance, the Pharmacy Technical Advisory Committee (TAC), the Formulary Subcommittee, the Center for Program Development, the Office of the Counsel, the HEW Region IV Office, and the HEW Division of Policy and Standards regarding the KMAP implementation of the MAC Regulations, it seems unlikely that the KMAP is out of compliance with either State or Federal regulations regarding reimbursement for covered outpatient drugs. The Department has not received notification of any alleged non-compliance from either State or Federal agencies.

The KMAP is in compliance with all State and Federal regulations with regard to established dispensing fees.

LRC Staff Inquiry to DHR No. 28

According to a statement by the past President of the K.Ph.A., which appeared in the February, 1978 edition of the *Kentucky Pharmacist*, DHR officials erroneously have contended that pharmacists rejected various options (e.g., co-pay) for freeing up funds for more equitable dispensing fee reimbursement. The position of the Kentucky Pharmaceutical Association, as explicitly stated to the Commissioner of Social Insurance during the 1978 session of the General Assembly, was that "such decisions about options were the responsibility of DHR officials, and that . . . the state should fully and fairly reimburse pharmacists for whatever services it decides to include in the Program."³¹

DHR Response to LRC Staff Inquiry No. 28

The Division for Medical Assistance staff attended numerous meetings with the Pharmacy Technical Advisory Committee and with the K.Ph.A. Medicaid Legal Defense Committee.

The Pharmacy Technical Advisory Committee (TAC) recommended, during May 4, 1977, that "the Formulary Subcommittee be instructed to review the Drug List and to delete those drugs they deemed necessary in order to free funds to implement an increase in the dispensing fee." However, the Pharmacy TAC later withdrew the recommendation after conferring with the Formulary Subcommittee on June 8, 1977.

DMA staff discussed with the K.Ph.A. Legal Defense Group various methods by which funds could be made available, within the existing budget, for an increase in the dispensing fee. However, the Group did not recommend any of the various options and indicated that such decisions should be the responsibility of the Department.

LRC Staff Inquiry to DHR No. 29

Some pharmacists have complained that doctors and dentists participating in the medicaid program are not required to complete fee survey forms. Why must pharmacists?

DHR Response to LRC Staff Inquiry No. 29

The code of Federal Regulations 450.30 mandates that states conduct dispensing fee studies; therefore, the KMAP responded to that mandate by conducting a study as required by Federal regulations. The KMAP follows all applicable State and Federal Regulations in establishing reimbursement systems and levels for all Program benefits including physicians and dentists.

LRC Staff Inquiry to DHR No. 30

Some pharmacists claim that physicians and dentists are reimbursed by the State on the basis of usual and customary charges to the public and ask why pharmacists cannot be repaid on the same basis.

DHR Response to LRC Staff Inquiry No. 30

It is not accurate to state flatly that other professionals in the Medicaid Program are reimbursed at "usual and customary charge." For example, physicians bill at their usual and customary charges and are reimbursed at the allowable charges for the calendar year preceding the fiscal year on outpatient procedures. "Allowable charge" is defined as the lowest of the following five parameters:

1. the billed charge on the claim form;
2. the Title XVIII (Medicare) charge for the respective procedure for the respective physician;
3. the Title XVIII (Medicare) charge for all physicians billing for the respective procedure in that area;
4. the KMAP charge for that procedure for the physician (based on 1976 data);
5. the KMAP charge for the procedure for all physicians in the area (based on 1976 data).

For in-hospital procedures, physicians bill at their usual and customary charges and are reimbursed at 65% of the allowable fee after the first fifty dollars is paid in full on a by service basis.

The "usual and customary" charge only provides an upper limit for the purpose of payment. Intermediate care and skilled nursing facilities as well as inpatient hospital benefits are paid according to costs. These institutions must meet established review criteria and complete extensive cost information reports. Each facility is audited annually to verify reported costs and adjust payments, if necessary.

Individual providers are required to bill the Program for covered benefits at their usual and customary charges. The Program does not necessarily pay the amount billed but utilizes the usual and customary fees in establishing payment schedules and parameters.

It is evident that pharmacists are not the only professionals to be confronted with the complex requirements of a Federally-approved reimbursement system.

The Maximum Allowable Cost (MAC) regulations require reimbursement to pharmacies to be the lowest of the following three parameters:

1. usual and customary charge;
2. drug cost plus a dispensing fee;
3. federal maximum allowable drug cost (if any), plus a dispensing fee. (Note: A physician may override number three if the physician indicates in his own handwriting that in his/her medical judgment a specific brand is medically necessary for the patient.)

CHAPTER XI

CONCLUSIONS AND RECOMMENDATIONS

The basic difficulty involved in the determination of dispensing fees is that there presently is no universally acceptable standard which can be used to identify the dispensing costs of a pharmacy. There is little evidence available to suggest that reimbursement formulas possess the capability to assess accurately the actual costs of providing pharmacy services. This situation is the direct result of the existing conditions set forth below:

1. The limitations inherent in cost studies attempting to ascertain pharmacist dispensing fees.

2. Poor record-keeping practices on the part of many pharmacists, resulting in the reporting of inaccurate data in cost studies.

3. The refusal of a significant number of pharmacists to participate in cost studies developed by state medicaid programs or their contractual agents for the purpose of determining an equitable dispensing fee. Federal guidelines specify that state medicaid programs must conduct these studies.

4. Most schools of pharmacy generally do not include instruction in business accounting procedures relating to the operation of a pharmacy, which results in pharmacists going into practice ill-equipped to generate reliable financial information.

5. Lack of initiative at the federal level.

Officials of the KMAP have stated that the amount of the dispensing fee has historically reflected available funds. Pharmacists contend that funds do not become available unless they launch a major lobbying effort.

It is true that in recent years the dispensing fee was increased only after pharmacists brought their concerns to the attention of various individuals and committees of the Kentucky General Assembly.

However, it does not seem reasonable to increase the dispensing fee either because funds may be available or because of lobbying efforts on the part of some pharmacists. Increases in the dispensing fee should be based upon documented costs incurred by pharmacists in the filling of prescriptions.

The KMAP dispensing fee survey published in 1977 and the next survey, planned for publication in 1980, represent attempts to delineate actual costs. However, because the methodology for conducting cost studies directed toward the analysis of dispensing fee costs is far from being honed to perfection, the results of such studies will remain targets for criticism until the advent of a universally acceptable methodology. The absence of such a universal methodology means dispensing fees under the KMAP will be determined by either (1) data gathered from the KMAP dispensing fee surveys and by "available funds," both of which will be challenged continually by pharmacists seeking a greater return for their services, or by (2) lobbying activities of pharmacists, or by (3) a combination of (1) and (2).

However, the fact remains that, at present, neither the Department for Human Resources nor the pharmacists can present irrefutable evidence to substantiate their positions.

State legislators should also be aware that pharmacists throughout the United States have shifted their emphasis from negotiating with medicaid program administrators to lobbying legislators. An article in the October 15, 1977 issue of *Drug Topics* illustrates the point. Referring to chain and large independent drug stores, the article states that,

Politically, this group has become more adept at using the system to its advantage. Case in point: Over the last year or so, they've been shifting the focus of their efforts to the folks who appropriate the money—legislators—and away from state administrators.³²

As long as pharmacists can achieve dispensing fee increases through political pressure, there will be little incentive for either medicaid officials or participating pharmacists to work together to devise a more equitable system for all concerned—one which is based upon documented costs, as opposed to an arbitrary "negotiated" figure which will bear no relation to actual cost. It is not an unlikely hypothesis to suggest that if pharmacists continue to effect fee increases in the KMAP through legislative efforts, other providers participating in the program will be encouraged to lay their demands for increased reimbursement at the doorsteps of their legislators. There are 19 categories of providers and 7,000 individual providers participating in the KMAP.

This is not to suggest that pharmacists or any other individual or group of providers should not feel free to address their concerns to members of the Kentucky General Assembly when they feel they have been treated unfairly, because certainly such a right is inherent in a democratic system of government, in that it provides a mechanism to balance the needs of the providers with the responsibility of officials of the medicaid program to ensure that taxpayer monies are expended on a cost-related basis. However, in order to prevent the breakdown of established administrative procedures, and thereby prevent chaos within the KMAP, legislative involvement in the establishment of reimbursement rates for KMAP providers should occur only when extensive research into a provider's grievance clearly demonstrates unfair treatment of the grievance by KMAP officials.

It would not be unrealistic to anticipate that increasing economic pressures may prompt provider groups to attempt to recoup reduced income by exerting pressure upon legislators and administrators of the KMAP to increase their fees, whether their losses are due to inappropriate reimbursement through the KMAP, inefficient management of their businesses, or other economic factors which affect their total profit factor.

The most constructive role legislators can serve is to support measures which will improve the existing system to ensure that pharmacists receive the most equitable treatment possible within reasonable fiscal bounds.

This study emphasizes the point that a universally acceptable method for the determination of pharmacist dispensing fees presently does not exist. Chapter V discusses this problem in detail.

It seems reasonable to accept the conclusion that a fair dispensing fee cannot be definitively ascertained, but there are several measures which can be taken to *improve* significantly the quality of the pharmacy component of the Kentucky Medical Assistance Program (KMAP). Set forth below are several recommendations which will ensure the fairest treat-

ment presently feasible for pharmacists participating in the program, KMAP officials, and the taxpayers, who, it must be remembered, support this program in its entirety.

1-a. *The Kentucky Department for Human Resources should implement a variable fee reimbursement mechanism for pharmacists dispensing fees under the Kentucky Medical Assistance Program by June 30, 1981.*

1-b. *The 1980 regular session of the Kentucky General Assembly should appropriate for fiscal years 1980-82 sufficient funds to accomplish the conversion of the present fixed fee system to a variable one under the KMAP.* In January of 1979, officials of the Department for Human Resources estimated the projected cost for implementation of a variable fee system (over an eighteen-month period) at \$96,404.

2. *If the KMAP implements a variable fee system, the Department for Human Resources should promulgate a regulation requiring an annual review of the pharmacist dispensing fee under the KMAP.* The regulation also should provide for special annual meetings of the KMAP staff with members of the Pharmacy Technical Advisory Committee of the Advisory Council for Medical Assistance for the exclusive purpose of reviewing the existing dispensing fee in relation to the results of the annual cost survey.

3. *If the Department for Human Resources elects to retain the fixed fee system, the Department should take immediate steps to promulgate regulations and revise provider agreements to require mandatory participation by all KMAP participating pharmacists in the KMAP Prescription Department Operational Cost Survey and specify that a failure to respond to the Survey or the submission of an inadequate response will result in a penalty of suspension from participation in the program until these requirements are met.*

4. *Pharmacists participating in the KMAP should make a concerted effort to apply basic business accounting principles to the operation of their pharmacies.* Relevant cost information can thus be easily accessed. The implementation of the Uniform Cost Accounting System in each participating pharmacy is the suggested vehicle for accomplishing this goal.

5. *The University of Kentucky College of Pharmacy should devote serious consideration to including a required course in business accounting principles in the pharmacy curriculum.* The course should address the accounting needs unique to the operation of a pharmacy. *It should also be offered in the pharmacy continuing education program so practicing pharmacists can take it.*

6-a. The 1977 KMAP Prescription Department Operational Cost Survey Report accepted all reported data without placing any limitations on the reported amounts of such items as supplies, delivery services, salaries and return on investment. Failure to impose such restrictions can produce a serious distortion of data, resulting in an upward bias in the derivation of the final dispensing fee. Therefore, *the methodology developed for the analysis of the 1980 KMAP Prescription Department Operational Cost Survey Report should include the application of upper limits to such items as salaries, delivery expenses, supplies, and return on investment.*

6-b. An addendum published six weeks after the distribution of the 1977 KMAP Prescription Department Operational Cost Survey Report described the methodology used in the Survey to compute return on investment and inflationary adjustment. *The body of the 1980 report should include a clear statement of the specific method used to address these factors.*

6-c. *KMAP officials, participating pharmacists and the Pharmacy Technical Advisory Committee should all work together on the development of the methodology to be used*

in the 1980 KMAP Prescription Department Operational Cost Survey Report. In order to avert the kind of misunderstanding which occurred over the 1977 KMAP Prescription Department Operational Cost Survey Report, it is essential that all parties involved clearly understand the method of analysis that ultimately will be used to devise the final dispensing fee(s).

6-d. If the compliance audit for the 1980 KMAP Prescription Department Operational Survey Report reveals an audit exception rate (the degree of error identified by auditors in the data reported on the survey forms) which exceeds .15, the Department for Human Resources should refrain from publishing it, as the results would be invalid. If such a situation should occur, the Department for Human Resources should reject any proposals from participating pharmacists to increase the dispensing fee until such time as pharmacists take the measures necessary to equip themselves with the capability to submit accurate data.

6-e. The Department for Human Resources should promulgate regulations which provide DHR auditors access to audit any and all participating pharmacies for the purpose of verifying data reported in the KMAP Prescription Department Operational Surveys and specify that provider failure to allow such audits shall result in suspension from participation in the program until the provider allows DHR auditors access to his records.

7. The Department for Human Resources should improve its system for processing provider claims in order that pharmacists would no longer feel the need to submit magnetic tapes prepared by private organizations and paid for by the pharmacists. Approximately 13.9% or 130 pharmacists participating in the KMAP presently send their claims to a private organization which, for a fee, makes any necessary corrections and puts the claims on a computer tape, which is then sent to the KMAP. These computer tapes facilitate the processing of claims by the KMAP, which results in more rapid reimbursement to the pharmacists who use this system.

8. The Department for Human Resources should collaborate with the University of Kentucky College of Pharmacy and the Kentucky Pharmaceutical Association in submitting a grant application to the Health Care Financing Administration for the purpose of securing funding for the demonstration and evaluation of alternatives to the current method of reimbursing for pharmacy services under the KMAP.

FOOTNOTES

1 Kentucky Medical Assistance Program, "Prescription Department Operational Cost Survey Report" (April 15, 1977), p. 2.

2 U. S. Dept. of Health, Education and Welfare, Social and Rehabilitation Service, Medical Services Administration, (SRS-MSA-196-1971), "Medicaid Guidelines: Payment of Reasonable Charges for Prescribed Durgs," p. 4, citing excerpts from the *Compilation of the Social Security Laws Including the Social Security Act, As Amended, and Related Enactments through January 2, 1968*.

3 Gregory J. Ahart, "Cost to Dispense A Prescription: A Critique of Four Methods," (Paper presented at the Annual Meeting of the American Pharmaceutical Association, New York, May 16, 1977), p. 3.

4 S. E. Berki, J. W. Richrds and H. A. Weeks, *Prescription Dispensing in 20 Pharmacies: Characteristics, Utilizers, Services and Costs, Final Report*, Washington, D.C., 1971), p. 9.

5 R. Keith Campbell and Larry A. Dixon, "Prescription Pricing Needs Pharmacists' Attention," *The Washington Pharmacist* (May-June, 1975), p. 1.

6 Bruce R. Siecker, "The Uniform Cost Accounting Approach for Pharmacy Pricing Decisions," *Journal of the American Pharmaceutical Association*, Vol. NS 17, No. 4 (April, 1977), p. 208.

7 Bruce R. Siecker, *Valid Economic Measurement in a Pharmacy Through Prudent Accounting System Design* (Northeast Louisiana University, May, 1977), p. 3, quoting T. D. Rucker, "Possible Impact of Government Drug Program on Community Pharmacies," *Journal of the American Pharmaceutical Association*, Vol. 11, 1971, p. 336.

8 Ibid.

9 Ibid., citing R. H. Garrison, *Managerial Accounting* (Business Publications, Inc., Dallas, Texas, 1976), p. 339 and G. Shillinglaw, *Cost Accounting*, 3rd Edition (Richard D. Irwin, Inc., 1972), p. 233.

10 Ibid.

11 Ahart, p. 6.

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APPENDIX NO. 1



**GENERAL ASSEMBLY
COMMONWEALTH OF KENTUCKY**

REGULAR SESSION 1978

SENATE RESOLUTION NO. 45

WEDNESDAY, MARCH 8, 1978

The following bill was reported to the House from the Senate and
ordered to be printed.

A CONCURRENT RESOLUTION directing the Legislative Research Commission to conduct an independent study on the costs to Kentucky pharmacists to dispense prescriptions paid for by the medicaid program.

WHEREAS, the costs to pharmacists to dispense prescriptions paid for by medicaid was a subject of great controversy during the 1978 General Assembly; and

WHEREAS, during the 1978 General Assembly, several different surveys and studies were cited by both the Department for Human Resources and the Kentucky Pharmaceutical Association regarding the costs of dispensing drugs;

NOW, THEREFORE,

Be it resolved by the Senate of the General Assembly of the Commonwealth of Kentucky, the House of Representatives concurring therein:

1 Section 1. The Legislative Research Commission
2 shall conduct an independent study and survey on the
3 costs to Kentucky pharmacists to dispense prescriptions
4 paid for by the medicaid program.

5 Section 2. The findings and recommendations shall
6 be reported to the Interim Joint Committee on Health and
7 Welfare no later than June 1, 1979.

8 Section 3. Staff services to be utilized in

1 completing this study are estimated to cost \$12,000.
2 These staff services shall be provided from the regular
3 Commission budget and are subject to the limitations and
4 other research responsibilities of the Commission.

APPENDIX NO. 2

THE FEDERAL MEDICAID GUIDELINES

Payment of Reasonable Charges For Prescribed Drugs

Set forth below are selected portions of the federal medicaid guidelines which relate to the issues addressed in this report:

I. AUTHORIZATION: REGULATIONS, AND OTHER FACTORS

(B) The Regulations

The regulations require that payments for prescribed drugs not exceed "upper limits" and offer two methods of establishing these limits whether the drugs prescribed be legend or non-legend items.

1. "Cost as defined by the State agency plus a dispensing fee. The dispensing fee should be ascertained by analysis of pharmacy operational data which includes such components as overhead, professional services, and profit. Indices to be considered should include payment practices of other third-party organizations, including other Federal programs. Both the cost and the dispensing fee may vary according to the size and location of the pharmacy and according to whether the dispensing is done by a physician or by an outpatient drug department of an institution, and according to whether the drug is a legend or a non-legend item. In evaluating a dispensing fee by analysis of operational data, the objective of the State agency should be to insure that the average prescription price paid by the State agency does not exceed the average prescription price paid by the general public."

2. Customary charges which are reasonable. The prevailing charges in the locality for comparable services under comparable circumstances shall set the upper limit of payments. In reviewing prevailing charges for reasonableness, the State agency should consider the combined payments received by providers (for furnishing comparable services under comparable circumstances) from the carriers under title XVIII and beneficiaries under title XVIII of the Social Security Act and the combined payments received from other third-party insuring organizations and their regular policy holders and subscribers, using whichever of these criteria or other criteria are appropriate to the specific provider service."

These methods for establishing upper limits do not apply to payment for drugs in institutions where drugs are included in a reimbursement formula, or where a public agency makes bulk purchases of drugs. In the latter instance, payment will be made in accordance with the Governmental statutes and regulations governing such purchases.

The regulations provide that the use of a formulary is optional, as are provisions for use of generic drugs. Where either is employed, there must be standards for quality, safety, and effectiveness under the supervision of professional personnel.

(C) Other Relevant Policies

1. Freedom of Choice: Section 249.11, Title 45, Chapter II of the Code of Federal Regulations, published in the Federal Register June 5, 1970, and issued simultaneously as SRS Program Regulation 40-18, implements the requirement of Section 1902(a)(23) of the Social Security Act. State plans

for medical assistance under title XIX "must provide that any individual eligible for medical assistance under the plan may obtain the services available under the plan from any institution, agency pharmacy, or practitioner ... qualified to perform such services. This provision does not prohibit the State agency from establishing the fees which will be paid to providers ... or from setting reasonable standards relating to the qualifications of providers of such care." Nor does it require an institution to allow a recipient a choice of drug provider if the institution (e.g., hospital or nursing home) customarily includes pharmaceuticals as part of its total package of services, just as it includes, for example, nursing services.

It is recommended that State brochures describing medical assistance programs clearly advise recipients of their right to select any qualified source that is prepared to provide pharmaceutical services to them.

2. Documentation: Section 250.21, Title 45, Chapter II of the Code of Federal regulations, published in the Federal Register on September 20, 1969 and issued simultaneously as SRS Program Regulation 40-13, implements section 1902(a)(27) of the Social Security Act. A State plan for medical assistance under title XIX must provide for agreements in which providers of services undertake "to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan; and to furnish the State agency with such information, regarding any payments claimed by such person or institution for

providing services under the State plan, as the State agency may from time to time request."

All provider claims for reimbursement of prescribed drugs should be supported by written records maintained as a prescription file independent of patients' case records in the practitioner's file.

3. Fraud or violation of lawful dispensing: Fraud regulations published in the Federal Register on March 27, 1971 as Section 250.80, Title 45, Chapter 11 of the Code of Federal Regulations and issued simultaneously as SRS Program Regulation 40-14, require that all provider claim forms used in the program include language indication that Federal and State funds are involved, and that false claims or statements can be prosecuted under Federal and State law. The regulations also require the State agency administering the title XIX program to report to the SRS every case of suspected fraud (by Provider number) that has been referred to law enforcement officials for appropriate action. The regulation also requires a system to verify that services billed were received by clients. Section 250.71, Title 45, Chapter 11 of the Code of Federal Regulations, published March 27, 1971 and issued simultaneously as SRS Program Regulation 40-15, provides for (1) identifying providers of services; and (2) complying with Internal Revenue Service information-reporting requirements.

a. Rebates, Discounts, Commissions, or Other Valuable Considerations:

In those States where practitioners are not prohibited from paying and receiving rebates or other valuable

considerations, it is recommended that proper action be taken by the State agency to prevent practitioners from paying to or receiving from other practitioners, directly or indirectly, and rebate, refund, discount, commission, or other valuable consideration on income received or resulting from furnishing prescribed drugs to another practitioner's patients.

b. Proper Dispensing of Prescribed Drugs:

State regulations should be issued to provide for the dispensing of prescribed drugs in accordance with the best medical and pharmacological practices, and consistent with economy. The following points may be covered: (1) in acute illnesses, prescribed drugs should be limited to the quantity needed for treatment; (2) maintenance drugs for chronic illnesses should be prescribed in quantities sufficient to effect optimum economy in dispensing; (3) refills should be checked periodically; and (4) prescribed drugs should be dispensed in suitable containers, properly labeled with instructions for the patient.

4. Civil Rights Act Compliance or Certification: Each pharmacy must provide the State agency a written assurance of compliance with title VI of the Civil Rights Act of 1964 which prohibits discrimination on the basis of race, color, or national origin; or each claim submitted for payment must contain a legend certifying that services provided are in compliance with that Federal statute.

II. PRESCRIPTION PRICING METHODS AND OPTIONS

(A) Policy Objectives

It is essential that any drug reimbursement plan a State adopts should be reviewed periodically (at least annually) to assure fair treatment for both the State and the provider of services. The ideal reimbursement formula has been described by the Chief of the Drug Studies Branch, Division of Health Insurance Studies, Office of Research and Statistics, Social Security Administration, as "simultaneously simple, responsive, neutral, adequate, valid, discriminative, effective, precise, inclusive, and, of course, practical."

Achieving a formula that is highly successful in all these areas is difficult. Nevertheless, such goals may help establish a method, which if not the best, is likely to be the least objectionable.

Simplicity - This objective is essential; every vendor must understand the basis on which he is being paid. In addition, the vendor should not be required to maintain such extensive records that he spends as much time keeping books as he does dispensing prescriptions.

Responsiveness - The reimbursement formula should be able to reflect changes in the costs of operating a prescription department. This can be facilitated by asking vendors to report, semiannually, on three or four cost items that are both significant and dynamic, together with the average number of prescriptions dispensed daily. That information, combined with the remaining annual data, may permit interim adjustments to be made in the reimbursement level. The

formula should also provide incentives for efficient management performance. The level of remuneration should be reevaluated at least once a year.

Neutrality - The reimbursement formula should manifest a prudent neutrality among various types of retail drug outlets by permitting the prevalence of various types of retail drug outlets to be governed by the overall competitive forces in the economy. It should not favor, for example, discount houses over community outlets.

Adequacy - Compensation provided by the formula must cover those overhead expenses directly associated with dispensing prescribed drugs, and yield a rate of return, i.e., profit, on invested capital consistent with competitive standards established by reasonably efficient retailers. The level of remuneration should induce enough vendors to participate in the program to assure patients an ample supply of pharmacy services through the nation. Indeed, the concept of adequacy recognizes a level of compensation sufficient to encourage establishment of new retail outlets in any area where a genuine shortage exists.

Validity - The formula should measure realistically and consistently the dispensing expenses of many different types of retail drug outlets in many different areas.

Discrimination - The formula should be able to differentiate between vendors whose necessary costs of dispensing vary because of regional, economic, and management differences.

Effectiveness The pharmacist should be stimulated continually to seek more efficient ways of rendering dispensing

services. The primary means of accomplishing this is to pay a bonus to vendors whose performances meet professional standards and whose expenses fall below the cutoff level. Maximum incentives can be achieved by varying the bonus in direct proportion to the savings generated by a given pharmacy.

Precision - An ideal formula would measure precisely those overhead expenses associated with the dispensing function. Without a reasonable precise formula, neither the program administrator nor the vendors can judge the effectiveness of reimbursement policy.

Inclusiveness - An ideal reimbursement formula would reflect and support the performance of necessary professional services beyond those directly related to the dispensing function itself, but at least three requirements must be fulfilled before this goal can be achieved. First, professional services such as patient consultation or review of medical record must make a significant contribution to improve drug usage. Second, a mechanism for measuring the expenses associated with these related services must be worked out. Finally, the marginal cost of additional professional services must not exceed the marginal benefits provided by such professional activities.

Practicality - This characteristic embraces all of the qualities previously described, plus the ingredients of vendor acceptance on the one hand and administrative feasibility on the other. Of particular significance is vendor acceptance, since a pharmacist who has major reservations concerning the reimbursement mechanism is not likely to provide the con-

tinuous cooperation necessary for the program to achieve its goal. Administrative feasibility is required to give the drug program a reimbursement method that is not in excess of reasonable charges, consistent with efficiency, economy, and quality of care.

(B) Legal Implications Involved in Reimbursement

State agencies should approach the adoption of prescription-pricing schedules with due regard for the legal implications involved under the Federal antitrust laws. The schedule must be unilaterally determined by the State agency. State pharmaceutical associations or groups cannot legally fix prescription prices. While the State may canvass the providers, it cannot seek suggested fees from the group. Also, any group rejection or boycott of the program due to fees may constitute a violation of the Federal antitrust laws.

(C) Authorized Options in Methods of Reimbursement

1. Cost of the drug as defined by the State agency plus a straightforward of all systems of reimbursement for pharmacy services. The program pays the defined acquisition cost plus a stipulated amount for pharmacy services for each prescription dispensed. This method offers potential advantages of automatic data processing, simplicity of administration, and incentives for efficiency.

This method requires a degree of precision in determining the dispensing fee. If the fee is set too high, pharmacies will have excess profits at the expense of the program. If the fee is set too low, pharmacies may not participate, and thus defeat program objectives.

In August 1970, the Kansas Medicaid Program introduced a variable dispensing fee for participating pharmacies. Each pharmacy must justify its fee by submitting to the State a detailed report of prescription experience during the previous year. Similarly, in other states each pharmacist must decide whether the dispensing fee proposed to him by the State is sufficient compensation for his services. He can get the benefit of advice from the type of survey performed in Kansas or from his pharmacy association as to what factors should be taken into account in testing whether a fee will be adequate.

In addition to defining the cost of the drug, it may be advisable for a State agency to define the level of pharmaceutical services for which it is willing or able to pay. For example, the State may consider delivery service, maintenance of patients' drug record, or consultation services. At least one private prescription payment program offers two plans to participating pharmacists, based on the type of service to be available to the patient. In essence, the State, in conjunction with its medical advisory committees and perhaps the State Board of Pharmacy, should determine and define what should be provided under pharmaceutical services, and make payment accordingly.

Cost of the drug may be defined by the State in various manners. One method most commonly used is the cost of the drug product as listed in a standard reference book, i.e., the Red Book or the Blue Book (including supplements). Since such listings may reflect more than the actual cost to

the community pharmacist, a State establishing cost on this basis should recognize it may be paying an inflated price for drugs. States should also frequently review and adjust drug costs to reflect price advances or declines.

Some States that use formularies, or drug lists, establish a unit cost for each drug product. Each product has an identification code which lends itself to electronic data processing, thereby reducing administrative costs and vendor payment time. Periodic updatings are required for price changes.

The June 1970 edition of the National Drug Code Directory, published by the Food and Drug Administration (FDA), identifies more than 18,000 prescription and over-the-counter products. States are encouraged to utilize the Directory for payment purposes, usage analysis, and the preparation of authorized drug listings. California has established Maximum Allowable Wholesale Costs (M.A.W.C.) for some high-cost and high-usage products listed in the Medi-Cal Drug Formulary by "established name." Special billing instructions are ordinarily included for items requiring extemporaneous compounding.

Some State programs reimburse for the drug product on the basis of "actual acquisition cost" to the dispensing pharmacist. Under the best of circumstances, it is nearly impossible to determine the actual cost at the time of dispensing. This method is also far more expensive to administer under title XIX than "average wholesale price."

It is recommended that the State set the wholesale price for each drug on the basis of the quantity in which

the item is most frequently purchased. However, when the quantity of medication prescribed equals or exceeds the manufacturer's largest consumer package size, the maximum allowable payment should be set accordingly.

It should be emphasized that the purpose of pricing regulations is to establish an upper limit for payments under the Medical Assistance plan. The State agency may pay less than the upper limit.

Non-legend drugs are a special situation under a dispensing fee system. Since a prescription is required for a Medicaid patient to participate in the drug program, the vendor perhaps has some justification for the expense of his participation in processing such a claim. Prescribers should be encouraged to order non-legend items in the original packages. When the prescriber orders quantities other than the original package size, or changes the directions, the item ceases to be an over-the-counter item and begins to resemble a legend drug prescription.

Another option is for the State to establish cost for all non-legend items as the "shelf price" or posted price and set the dispensing fee at zero. Acceptance of this option might be a condition of participation in the drug program. Shelf price is suggested as the "cost as determined by the State" because it is relatively simple and inexpensive to establish, vis-à-vis the expense of determining true cost of a relatively few infrequently prescribed items. Appropriate modifications can be applied if the utilization review process discloses significant deviations from anticipated patterns of use.

Some states exclude non-legend items from their drug programs. The patient is expected to obtain such items from the allowance in his direct money payment. Where excluding non-legend items may cause exceptional hardship, the State may provide them upon proper justification by the physician.

2. Reimbursement for Drugs under Customary Charges which are Reasonable. Federal policy permits States to reimburse drug vendors on the basis of "customary charges which are reasonable." For States using this system the upper limit of payments for prescribed drugs is the prevailing charge in the locality for a comparable prescription dispensed under comparable circumstances. In determining what is reasonable (and above which it will not pay) the State must consider what the general public is charged. It is clearly against policy to pay more than this, but the State may pay less. However, the reimbursement structure must be designed to enlist the participation of enough pharmacists to ensure that prescriptions from eligible persons will be filled as readily as those from the general public.

A program administrator would be well advised to study this system very carefully before adopting or rejecting it. In theory, it meets the test of equating the price of a program prescription with the price paid by the general public. However, it tends to be inflationary. One of the main problems with reimbursement based on customary charges is the great difficulty in maintaining proper administrative controls over costs. Necessary extensive profile data on each vendor are expensive to develop as well as expensive and difficult to manage and to maintain in a current status.

Some drug stores accept credit cards issued by commercial organizations. For the pharmacist the net result is a payment of a sum discounted from the amount he would have received in a cash sale, and a wait for payment, but a high degree of assurance that the transaction will not result in a bad debt. Similarly, in a Medicaid drug program, the prescription is both a unique medical document, and evidence of credit pledge by the State on behalf of the patient. Policy permits the State to discount the reimbursement to an appropriate level. However, if this plan is used, the State should ensure the payment of claims on a current basis, so that the vendor is not disadvantaged by unwarranted delay in receiving money legitimately due him. In setting an appropriate discount level, the State should consider its financial resources, discount practices of commercial credit-card organizations, and the need to keep an adequate number of drug vendors in the program. Some opposition may be expected from vendors, no matter what the discount, although one might anticipate less protest from chain drug operators with credit care experience. Discounting gives a State a measure of protection against a price spiral, if the State increases the discount percentage as the dollar price rises. States with a good capability in automated claims processing may wish to explore this system.

With the exception of the discount feature mentioned above, a reasonable charge reimbursement system will be welcomed by most vendors. This factor may be the overriding practical consideration in a State's selection of a

reimbursement system. States need to be aware that the reasonable charge reimbursement system is both difficult and costly to administer.

Moreover, at some point the State must define what is "reasonable" and reject claims beyond this level. Inherently, this method of reimbursement may generate administrative expenses in excess of savings sought by the administrative process.

(D) Alternate Methods of Reimbursement

1. Reimbursement on the Basis of The Lower of Customary Charges or Cost Plus Dispensing Fee. We have described the two methods of establishing upper limits permitted under the policy: (a) cost plus dispensing fee, and (b) customary charges which are reasonable. Most States will elect to use one of these options. Another possibility is to employ the two methods in combination, as some States now do. These States pay for prescribed drugs as follows: cost plus dispensing fee, but not to exceed the charge made to the general public for the same medication. Another way of expressing the same concept would be: the lower of (1) the cost plus dispensing fee or (2) the charge made to the general public. One criticism of the exclusive use of the cost plus dispensing fee method is that the State is charged more for low-cost items than the general public pays. The combination of methods described here solves the problem.
2. Reimbursement Based on an Established Percentage Markup. This system relates pharmacy services to the acquisition cost of the drug product and thus, encourages the use of

high-cost drug products when lower-cost items are available. To determine the final consumer price, many pharmacists add a percentage markup to the cost of a drug. The difference between the acquisition cost of all products dispensed and the aggregate prescription prices received must be large enough to cover overhead expenses and provide a profit. Most vendors have a minimum prescription price, charged when the calculated price is less than the minimum. This practice results from recognition that very low-cost items are dispensed at a loss when a percentage markup is used.

The U. S. General Accounting Office opposes the use of this system. State agencies may use this method only if the results fall within the range of customary charges which are reasonable, up to the prevailing charge in the locality for comparable services under comparable circumstances. The State plan should indicate the method of reimbursement as "customary charges which are reasonable," and include a description of the necessary measures or methods that the single State agency will use to ensure appropriate audit of reimbursement records. The State plan should certify that any payment made for prescribed drugs will not exceed the customary charge which is reasonable, and the agency should be prepared to furnish documentation to that effect. If the method of payment used by the State results in payments in excess of the ceiling, a conformity issue might be raised. Moreover, Section 250.30(d) of the Code of Federal Regulations, Title 45, Chapter II, limits Federal matching to payments within the ceiling limit. Thus, payments in excess thereof would be subject to audit exception.

III. VARIATIONS IN REIMBURSEMENT FOR PRESCRIBED DRUGS BY
DIFFERENT TYPES OF LICENSED AUTHORIZED PRACTITIONERS

(A) Federal Policy

Federal policy permits States to vary the cost of the drug and the dispensing fee according to (1) the size and location of the pharmacy, (2) whether the dispensing is done by a physician or by an outpatient drug department of an institution, and (3) whether the drug is a legend or a non-legend item.

Section 249.10(b) (12)(i), Title 45, Chapter II, of the Code of Federal Regulations states: "Prescribed drugs are any simple or compounded substance or mixture of substances prescribed as such or in other acceptable dosage forms for the cure, mitigation, or prevention of disease, or for health maintenance, by a physician or other licensed practitioner of the healing arts within the scope of his professional practice as defined and limited by Federal and State law. With respect to prescribed drugs, Federal financial participation is available in expenditures for drugs dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act. When dispensing, the practitioner must do so on his written prescription and maintain records thereof."

(B) Priority of State Laws and Regulations

State laws and regulations with respect to licensed authorized practitioners' dispensing of prescribed drugs shall prevail. Single State agencies responsible for administering or supervising medical assistance program may impose such regulations governing dispensing by practitioners

as is consistent with efficiency, economy, and quality of care.

(C) Provider Agreements (Under the provisions of Section 250.21, Title 45, Chapter II, of the Code of Federal Regulations)

"A State plan for medical assistance under title XIX of the Social Security Act must provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees:

- (a) To keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan; and
- (b) To furnish the State agency with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency may from time to time request."

1. Methods of Reimbursement to Physicians - It is recommended that payment for drugs dispensed by physicians be limited to not more than the cost of the drug. One State will reimburse the physician for the cost of the drug only when it is two dollars or more. Reimbursement for the cost of drugs which are less costly is not considered by this State to be administratively feasible. Physicians are professionals who gain their livelihood from the practice of medicine. Accordingly, it may be held that they should not also profit from a pharmacy practice, particularly when the drugs they sell are also prescribed by them.

2. Methods of Reimbursement to Skilled Nursing Homes - "Standards for Skilled Nursing Home Care" were published as Federal regulations on April 29, 1970. Section 249.33, Title 45, Chapter II, of the Code of Federal Regulations (SRS-PR 40-12 (C-1)), requires that skilled nursing homes have satisfactory policies and procedures relating to the dispensing and administering of drugs and biologicals, which means that they must meet the standards pertaining to extended care facilities under title XVIII of the Social Security Act. (See Section 405.1127, Title 20, Code of Federal Regulations.)

Although the conditions of participation for skilled nursing homes are similar to those of extended care facilities, the method of reimbursement for prescribed drugs may differ. Under title XVIII (Medicare), payment for drugs is included in the payment made to the extended care facility pursuant to the reasonable cost formula. Under title XIX, prescribed drugs is usually a separate service for which reimbursement is made directly to the community pharmacy providing the service. The reimbursement is made according to the payment schedule specified in the State's title XIX plan for prescribed drugs.

However, in States which reimburse skilled nursing homes under title XIX on the same basis as extended care facilities under title XVIII, payment for drugs provided by the facility may be made to the facility as an item of allowable cost under the reasonable cost formula. Even where the reasonable cost formula is not used, moreover, if

drugs are included as part of the nursing home package of services, the payment for nursing home services may include reimbursement for drugs.

Skilled nursing homes which have their own pharmacy, licensed under State laws, may furnish prescribed drugs to the patients in the nursing home under the reimbursement schedule specified in the State's title XIX plan.

3. Methods of Reimbursement to Hospital Pharmacies with Outpatient Services, Neighborhood Health Centers and OEO Clinics - Nonprofit hospital pharmacies with outpatient services, Neighborhood Health Centers, and OEO clinics that have pharmacies licensed under State law, and provider agreements with the single State agency, may be paid for prescribed drugs under the reimbursement schedules for non-profit institutions as specified in the State's title XIX plan.

* MEDICAID GUIDELINES

Payment of Reasonable Charges for Prescribed Drugs

U. S. Department of Health, Education and Welfare

Social and Rehabilitation Service

Medical Services Administration p.4-15

APPENDIX NO. 3

FEDERAL GUIDELINES ON SURVEY OF PHARMACY DISPENSING COSTS

OBJECTIVES OF THE DISPENSING FEE

A dispensing fee should cover the operating costs of an efficient pharmacy and provide the pharmacist a reasonable return on his investment. If the fee is set too high, the public will be over-paying for services, while if the fee is too low, there may be inadequate pharmacy participation in the program. The fees established by the State should compensate pharmacies for providing all professional pharmacy services deemed necessary by the program.

Fees compensate pharmacies for providing specific professional and dispensing services. There is no economic rationale for the fee to fluctuate according to the value of each prescription. The identical amount of professional time and overhead cost is used in dispensing prescriptions of dissimilar ingredient cost, except for the rare instance when a product is compounded. As a result, fees based on the mark-up system are not permitted in Medicaid programs.

The growth of third party payment systems has increased the need to establish fees that reflect actual dispensing costs. Many pharmacy organizations are concerned about fees established on the basis of what other programs are paying, and not on actual cost information. The Department is aware of these concerns and is requiring States to conduct surveys of operating costs. The surveys must provide a measure of actual dispensing costs, and cannot be limited to usual and customary charges or estimated costs.

ACCEPTABLE TYPES OF FEES

Only two types of dispensing fees are allowed in the Medicaid program:

- (1) fixed fee, which is identical for all pharmacies,
or
- (2) variable fee, which varies among pharmacies.

The fixed fee is currently used by most Medicaid programs because it is the easiest to administer, but it has several flaws in its application.

The fixed fee tends to overpay large pharmacies, which normally have lower per unit dispensing costs, and underpay smaller pharmacies, which may have relatively high costs even though they are providing necessary pharmacy services at an efficient level. Differences in the cost of operating pharmacies in particular locations or in providing specific services are not recognized by a fixed fee system. In addition, the economic incentive is for pharmacies to reduce the total level of pharmacy services provided to Medicaid patients in an effort to increase their earnings per prescription. Under a fixed fee system, the pharmacy providing complete professional services is actually being penalized.

Variable fee systems have been introduced by several Medicaid programs to overcome some of the problems associated with the fixed fee. The Kansas Medicaid Program was the first to introduce a variable dispensing fee in August, 1970, and has continued to use the system.

Two drawbacks to the variable fee have been the difficulty in measuring dispensing costs and the need to modify computer

programming to handle this type of fee. Several pharmacy organizations and Medicaid programs have conducted considerable research into dispensing costs, and results from these efforts should provide needed guidance. The regulations mandate the survey; consequently, the States may find it feasible to examine the merits of a variable fee. The programming required to introduce a variable fee could be undertaken at the same time volume adjustments for the EAC prices are prepared.

COST ELEMENTS INVOLVED IN DISPENSING A PRESCRIPTION

The regulations require States to conduct "surveys of pharmacy operational data including such components as overhead, professional services and profits." A detailed listing of the cost items associated with a pharmacy's operation is contained in the "Uniform Accounting Manual for Pharmacies" prepared by the National Pharmacy Insurance Council.¹ The major cost groupings normally identified in a cost survey include:

Personnel Costs. Approximately 60% of the dispensing costs are for personnel expenses, which include salary or wage, social security contributions, unemployment benefits, workman's compensation taxes, health insurance benefits, and other benefits. Personnel costs attributable to the pharmacy may come from the pharmacists, interns, pharmacy technicians, clerks, delivery personnel and janitorial personnel. Only the hours the employee directly works in the pharmacy department should be charged to dispensing expenses.

Direct Prescription Expenses. Many direct expenses are entirely chargeable to the pharmacy department. Included in this category of costs would be patient profile expenses, continuing education expenses paid by the store, advertising or promotion of the prescription department, container and label costs, professional druggist liability insurance, dues to professional associations paid by the store, and other pharmacy related costs.

Direct Store Expenses. Some expenses associated with the entire store operations are necessary for the proper functioning of the pharmacy department. As a result, a portion of these direct store expenses should be allocated to the pharmacy department. Included in this category are bookkeeping and accounting expenses, legal fees, bad debts, collection agency, telephone bills, advertising of total store, and other direct expenses that have an influence on the pharmacy's operating costs.

Direct expenses not affecting the pharmacy should not be included (i.e., advertising expenses for non-pharmacy items). Direct store expenses could be allocated to the pharmacy on the basis of pharmacy sales as percent of total store sales.

Overhead Expenses. Overhead would include items such as rent for the entire store, heat, electricity, taxes, insurance, depreciation, and interest on notes. These expenses might be allocated to the pharmacy department according to floor space, inventory, sales value, or a combination of these measures.

Delivery Expenses. Since delivery expenses are outside the normal operating expenses of many pharmacies, a Medicaid program might examine delivery costs as a separate grouping. Included in this category would be personnel costs, depreciation of vehicle, insurance, gasoline and oil costs, maintenance and repairs, and taxi expenses, if used.

In developing and/or selecting a survey form and cost calculating technique, the Medicaid program will want to evaluate the types of services it requires and expects from pharmacies. The final list of services chosen as desirable will affect the cost groupings used in the Medicaid program's survey.

PROFITS AND INFLATION

Results from the surveys should provide information on the cost of dispensing a prescription, but might not address the question of profit. The Department recognizes the need to provide efficient pharmacies with a profit level that adequately compensates the owner for his investment and risk. Establishing the level of profit will be the function of each State. Currently, there is no best method for establishing the profit level. Results from work being conducted in standardized accounting methods may provide some insight into the adequate level, but definitive information will not be available for at least another year.

Two alternative methods for calculating the profit level might be used by the State during the first survey:

- (1) Apply the pharmacy's ratio of gross profit to operating costs (less costs of goods sold) to the pharmacy's operating costs. The measure

obtained from this method reflects the return afforded from the market place, but does have the disadvantages of reflecting profitability of the entire store, rather than just the pharmacy department. National ratios or information collected from the survey can be used to develop the profit percentage.

- (2) Audit several pharmacies and determine the actual equity in the stores. Once the equity values for varying size stores is determined, the national average of profit as a percent of equity (or invested capital) could be used to determine the profit level. Without standardized accounting methods this technique is extremely difficult.

Results from any survey will reflect the costs associated with dispensing a prescription in the previous year. Fees based on survey results should include an inflation adjustment, which can be derived from either a spot survey of current pharmacy costs or from specific price indices published by the Bureau of Labor Statistics. Rather than conduct a complete survey of pharmacy operating costs every year, the Medicaid program may examine annual increases in pharmacy operating costs and adjust the fee accordingly.

ALTERNATIVE FEE SURVEYS

The survey form and data gathering techniques will be chosen by the individual Medicaid program. The survey must be an examination of pharmacy operating costs, and cannot merely

identify the usual and customary charges of pharmacies according to demographic characteristics.

Timetable for Conducting Surveys

States must "conduct periodic surveys of pharmacy operational data." In this case, the Department defines periodic as meaning at least once every three years, as long as inflation factors are considered every year. An annual survey can be conducted, but it is probably unnecessary because of the relatively stable composition of cost elements involved in dispensing a prescription. Annual adjustments for inflation combined with a survey every three years should provide an adequate data base for establishing the fee.

Criteria for Evaluating Surveys

The States should examine the strengths and weaknesses of alternative cost determination techniques before selecting or developing the survey form. Questions the program might ask when evaluating surveys include:

- (1) Will the results fully reflect actual operating costs?
- (2) Is the survey form easy to understand and complete?
- (3) Is adequate auditing provided to ensure accurate reporting of costs?
- (4) Are services and cost elements deemed important by the program (such as patient profiles, pharmacy location, 24 hour emergency service, type of pharmacy, etc.) adequately reflected by the survey?

- (5) Will the resultant fee encourage efficiency?
- (6) Is there a method for identifying inappropriate cost items?
- (7) Can special circumstances be accommodated by the survey technique?

Partial List of Fee Surveys

Several fee survey forms and techniques have been developed during the past five years by pharmacy-oriented organizations. States may want to review the techniques developed by these groups and individuals. In addition, the State pharmaceutical association and nearby pharmacy schools may have information on the survey techniques that are most appropriate for the specific Medicaid program.

Below is a list of survey forms and techniques that recently have come to the attention of the Department. The list is being offered to the States as a reference of alternative surveys designed to measure pharmacy operating costs:

American College of Apothecary Survey

D. C. Huffman, Ph. D.
Executive Secretary
American College of Apothecaries
874 Union Avenue
Memphis, Tennessee 38102

Kansas Survey

William A. Newman
Director of Medical Services
Department of Social and
Rehabilitation Services
64 State Office Building
Topeka, Kansas 66612

PAID Prescription Survey:

Marc Laventurier
Senior Vice President
PAID Prescriptions, Inc.
1633 Old Bayshore
Burlingame, California 94010

Washington Survey:

Keith Campbell
Assistant Professor
College of Pharmacy
Washington State University
Pullman, Washington 99163

Wisconsin Survey:

R. W. Hammel
Professor of Pharmacy Administration
Center of Health Sciences
University of Wisconsin
Madison, Wisconsin

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