MINUTES OF THE MEETING
BUSINESS & INDUSTRY COMMITTEE
MONTANA STATE SENATE

February 4, 1987

The fourteenth meeting of the Business and Industry Committee met on Wednesday, February 4, 1987, in Room 410 of the Capitol at 10 a.m. The meeting was called to order by Chairman Allen C. Kolstad.

ROLL CALL: All committee members were present. Senator Mike Halligan was also present.

CONSIDERATION OF SENATE BILL NO. 205: Sen. Mike Halligan, Senate District 29, of Missoula, stated that the bill is the product of a lot of frustration. The bill sets up a voucher system for the reimbursement of pharmacists when they fill prescriptions for people who are on Medicaid. He said there are severe problems with pharmacists that submit claims for prescriptions, then do not get paid for months, sometimes for several years and in some cases not at all. A pharmacist in Butte has been submitting claims for years and the claims have still not been paid. Some businesses have lost from $10-30,000 which is a loss of cash flow and a tremendous impact on a small business. This bill is designed for pharmacists only. We are giving vouchers to pharmacists who are licensed with the State. These would not be in the hands of welfare recipients. An individual would go to a welfare office where it would be determined if they were eligible; after that determination is made they would be given a form, then see a physician if they have a medical problem and if that physician writes them a prescription a pharmacist could then fill it. Presently under the law, when that prescription is filled, the pharmacist has to send a copy of that form plus some additional data into the State and many times it takes months for them to get paid. Sen. Halligan said the State ought to pay its bills on time. He said that under the system proposed in SB 205, the whole first part of that system stays in place. The only change is the way in which the pharmacist makes his claim. With this bill, the pharmacist would fill out a voucher that includes the recipient's ID number, the identification number of the drug, the cost of the drug, the fee that is added for each prescription and then would sign it. (It has a statement included that says it's a fraud if he submits anything that is above what he is supposed to receive and there is a criminal penalty associated with any fraudulent activity involving the use of the voucher.)

The pharmacist deposits the voucher in his commercial account at his bank - he can't get cash for it. The bank simply pays it - the pharmacist's account is credited for that amount. In essence, he gets paid immediately. The bank then sends the voucher to Social and Rehabilitation Services where it would be verified and a record kept of that account. Sen. Halligan then explained the fiscal note. According to the information gathered, the Department of SRS believes they will need four more full time employees to

administer the program which will cost about a half million dollars for 1988 and about $163,000 for 1989. Sen. Halligan stated that he questioned the amount, feeling that if they are verifying existing claims in the system and if they are administering the paper work with all the same information only on a different form, it should not cost that much more. Initially, only pharmacists would be using the voucher system.

PROPONENTS: Mr. Robert H. Likewise, Executive Director of the Montana State Pharmaceutical Association, testified in support of SB 205. (EXHIBIT 1) (EXHIBIT 2) (EXHIBIT 3)

Mr. Byron E. Dodd, Pharmacist and owner of Smith Drug in Missoula, spoke in support of SB 205. He also supplied the committee members with a number of suggestions for inclusion in a Medicaid Reform Bill and proposals for modification of the Medicaid payment plan. (EXHIBIT 4)

Mr. Don Whitman of Eastgate Drug in Missoula, stated that he also supports SB 205 and wished to help identify some of the problems that the pharmacists are having in dealing with the chronic eligibility problems that occur almost constantly. These problems arise when paper work must pass back and forth between county people, state people, plus the individual store personnel before it ever reaches the computers. Presently, they are having to wait two weeks to six months for authorizations to be processed on new and reinstated recipients. In a case where errors must be corrected, it takes more than 30 days and after 30 days it is virtually impossible to get paid. He told how often times, after they invest the time and the medication, they get the reply, "Bill the recipient." They are prevented from asking for an address of a recipient and don't know where to bill them. In most cases they have left the county. He feels his pharmacy has all the problems mentioned by Mr. Dodd and Mr. Likewise, but his main purpose in supporting SB 205 was to show that helping the pharmacists get paid would also help give better service to the recipients and help the pharmacists survive.

Mr. Herman Schrader of Great Falls who recently sold his store said that he had visited the present owner and had gathered a few figures which indicated that since the new owner had been in business (3 months), the payments from Medicaid, or SRS, had been running about 80% in the 30 day period. From the 60-90 day period, it has been running about 3%; over 90 days almost 7%; 31-60 days 11%. He said this was too much for a business to be running behind and there is a constant reshuffling of bills. A tie-up of information from the county to the state level can cause another 30-60 days delay and he said that the waiting period for these claims to be processed is entirely too long. He urged the committee to give SB 205 a Do Pass.

Mr. Carl Sivage who runs the Medicine Shoppe in Missoula and a pharmacist for 17 years testified in support of SB 205. (EXHIBIT 5)

Mr. Phillip B. Johnson, Director for the Montana Bankers Association stated that the Association wished to be on record as supporting SB 205. He requested the committee consider amending the bill in such a way that the items clearing the check processing systems in banks of Montana be MICR encoded (Micro encoding - magnetic ink encoding on bottom of checks, deposits, drafts, etc.). He said this would expedite the handling of the items because if they are not encoded it adds to the cost of the processing and they become special items at an exorbitant cost to SRS and the banks. One other amendment they would like to see would eliminate the responsibility of the bank for monitoring the checks for fraudulency, etc. He expressed the view of the banks that this bill, and its purpose, as analagous to a system which is now in effect, namely the WIC Program (Women, Infants and Children), a federal program that is administered by the State. The WIC Program is presently on a voucher system that is MICR encoded and items are clearing the system efficiently. Mr. Johnson introduced Mrs. Terri Platters, Assistant Vice-President and Transaction Processing Manager for the First Bank System Transaction Processing Center and stated that she could testify as an expert witness or answer questions if the Committee wished. Mr. Johnson also agreed, as an experienced lender and banker for 17 years, that the length of time that providers have to wait to be paid is appalling.

Mr. Frank Davis, pharmacist from Great Falls, testified that he previously had held the position of Mr. Bob Likewise as Executive Director for the State Pharmaceutical Association. He recalled there was a cash flow problem at that time and it has not gotten any better. He said the problem gets worse as the cost of medication rises and offered the following example: The pharmacist is paid the cost of the product based on the average wholesale price, less 10%. Added to that is a fee which averages $3.25 in Montana at this time. That has been the amount since 1981. There is about $6.75 worth of merchandise in a $10 prescription but most prescriptions are much more. For a $50 prescription he still just gets $3.25 for filling the prescription but he pays $46.75 for the merchandise. If he doesn't get paid for that in a short time that has to be made up for by something else in his business. He has to pay the wholesaler within 15 days of the time he receives the merchandise. He orders the merchandise when he fills the prescription but he has to pay for it long before he is paid by Medicaid which causes a cash flow problem which he would like the Committee to recognize. He feels the voucher system would straighten this out and urged the Committee's support of SB 205.

Mr. Lee Saucier, retired pharmacist after 25 years with a pharmaceutical business, testified that there must be a better method of reimbursement than that which is presently being used and that the voucher method would not be a panacea but would be an improvement. He said that the company which he worked for had both direct and non-direct buyers; in other words, the pharmacist was allowed to buy through the wholesaler or if his business was such that he could afford to buy direct at a further savings, he was allowed

to do that. Because of credit problems, this company, as of January 26, went strictly to the wholesale process where the pharmacist has to pay his bills every 15 days. Previously he had many pharmacists who never missed getting that extra one or two percent discount by paying on time. In the past year he had pink slips in his mail that said "Holding Order. Your Order Will Be Shipped When We Receive Part of The Payment, Please Pay Attention To This." He said his company was not hard to deal with but when pharmacists are waiting for a $14,000 payment from SRS, it means $10,000 out of his pocket for merchandise that is gone. In order for pharmacists to serve their customers, this problem must be solved for the good of the businessman, the customer and the State and urged passage of SB 205.

Mr. Bill Moody, pharmacist and former owner of a successful pharmacy in Missoula, noted that one of the problems that pharmacists face is the fact that the data base that is decisive in the prices pharmacists receive does not have accurate or up-to-date information as to the cost of those drugs to the pharmacist. He said that the computer paid the pharmacist whatever it thought was the cost plus the $3 mark-up. A prescription might cost the pharmacist $56; the data bank (being behind) might allow a cost of perhaps $50, therefore, the pharmacist would lose $3 on the transaction, even with the $3 prescription fee that is paid. A pharmacist who accepts Medicaid cannot refuse a customer because of a loss factor involved in that particular case. The pharmacist is faced with a situation of lost dollars before they even add business costs. This does not happen with Medicaid alone. Mr. Moody feels that it is important that SB 205 receives a Do Pass recommendation.

Sen. Elmer Severson, Stevensville, appeared on behalf of his son, Dan and his wife Darlene, who own a family pharmacy in Stevensville. He said he has heard all of the same stories told in the previous testimony. He said these pharmacies want to do business with Medicaid recipients but the circumstances make it very difficult. He said that SB 205 is a good pro-business bill and urged the committee to take a good look at the bill and consider a Do Pass recommendation.

Calvin Lindberg, owner of the Lindberg Pharmacy, Ronan, stated he was appearing in support of SB 205. He cited the many frustrations he, and other pharmacists, experience in collecting from Medicaid. He included the lists he receives each month of unpaid claims stating one reason or another why they can't be paid; the cost of resubmitting those claims, payments that are denied after being submitted three or four times and then finally coming back stating that the 180 days in which to submit a claim is now past and the claim cannot be paid. Many times the pharmacist is told to bill the recipient but Mr. Lindberg said if they were able to pay the bill they wouldn't be on welfare. He said they have a mark-up of between 7-80%, the 7% being the expensive

prescriptions for which a pharmacist pays maybe $50 and can collect back about $53. He explained that there are very few prescriptions that a pharmacist can mark up 80%. He said if he combined all the programs, including Workers' Comp, Indian Health Service, Medicaid, Medicare and Veterans' Administration and totaled what they owe him for past due bills it would total nearly $30,000. As a consequence, he had to secure a bank loan where he was charged 11 1/2% interest. He said that the situation should be corrected in the quickest manner possible and believes that the voucher payment system would be an answer to some of the problems. He also cited an incident in which he was overpaid by SRS for an oxygen concentrator; he received a letter from SRS on January 10 stating that they wanted their money back by January 20 and if not received he would be charged interest. On January 22 he received another letter wanting to know why he hadn't returned the money and that he now owed $400 plus interest. His check was already in the mail and as of this date (2/4/87) he already has his cancelled check.

OPPONENTS: Jack Nielson, Bureau Chief of the Medicaid Services Section, SRS, testified that his bureau has been in contact with other states and federal authorities who are responsible for administering the the federal financial participation on Medicaid and have quite a bit to say about how these systems work because the federal participation is from 67-90% of the cost. They found that no other states really have a voucher system they are using at the present time; Alabama did at one time. In later years these Medicaid systems became more and more automated and they found that the voucher system would no longer work for them with the electronic claims processing. Other reasons for not using the voucher system is the cost of the system. Montana Medicaid processes about $6.6 million per year for drugs for approximately 360 providers. The Department feels they would need another four full time employees to verify the vouchers, to make sure they are correct and to collect the overpayments. Mr. Nielson said that the voucher system would necessitate doing all the prescription claims in a manner different from all other claims. The claims would be paid and then would be entered into the MMIS (Medicaid Management Information System) after the fact. This is the data processing system that is approved by the federal government. Mr. Nielson said if his bureau gets into the situation where federal reviewers are not satisfied with the system being used as it was intended, Montana could lose significant financial participation in the neighborhood of a quarter of a million dollars in reimbursement. He also noted there would be other costs such as revising the rules, printing and distributing the voucher, modifying the MMIS system and obtaining advance approval from the federal government. He said the state would be breaking new ground in setting up a voucher system and they would have to be sure it would fit in in accordance with federal regulations.

Another concern of his department is the overpayments; they have been historically difficult to collect, sometimes requiring litigation. The MMIS is designed to do all steps with the claims preauthorized. He said he was surprised and disappointed to see the lists of some of the claims that have been denied. He noted that the reports indicated that 3% of the claims that were submitted for drugs had been rejected and that the average number of days from receipt of the claim until the date of payment is actually 20 days. He agreed there have been problems with eligibility but they are in the process of trying to update that with a new electronic FAMOUS system to improve the eligibility picture and hopefully solve these problems. His staff said that some of the problems and rejection of claims was due to numbers not being included on the claim, a missing signature, provider number not being included on the claim, etc. He expressed his willingness to work with the providers to do whatever they can to take care of these long lists of unpaid claims and to try to determine what the real problems of the system are.

DISCUSSION OF SENATE BILL NUMBER 205:

Chairman Kolstad then called for questions from the Committee. Sen. Walker asked why the SRS Medicaid Bureau felt they would need four FTE's to implement this system. Sen. Halligan answered that he could see the collection aspect of it concerning overpayments as being the only increased duty. The review and clarification still takes place. He felt that four FTE's may be a little high. Sen. Walker felt that the fiscal note may not be correct and he did not understand how other vendors wanting in on the system would create a problem. He said that if the number of vendors wanting to provide service to Medicaid customers increased, it would not affect the number of prescriptions being filled. Sen. Halligan said they were referring to vendors other than pharmacists, to which Mr. Nielson agreed.

Sen. Kolstad asked Mr. Nielson if his bureau had any plans to speed up the processing of these claims. Mr. Nielson replied that his department is working with a new eligibility system that he hopes will help alleviate the problems they have in that area and they are constantly working with the firm that runs the MMIS, Counsel Tech, to make the changes that the providers are interested in to make the processing of the claims more economical and efficient.

Sen. Halligan cited the preliminary determination of eligibility as one of the most frequent problems faced by providers. He stated that a person goes in and applies for welfare, they are given a preliminary determination of eligibility and he can then go and get his prescription filled. It then takes about 30 days at the local level in the county welfare office to get that determination and paperwork done. The pharmacist fills the

prescription, completes the claim and submits it. The recipient's eligibility is not in the computer for 30 days so it is automatically rejected. The pharmacist resubmits the claim 30 days later and if the eligibility tech misses a number and it doesn't go into the computer or sent back again for verification and review another 30 days goes by for a total of 60 days. Sen. Halligan felt there ought to be some way to have some preliminary determination of eligibility in the computer so some kind of payment could be made. He felt that the program Counsel Tech is using is inefficient.

Sen. Boylan asked Sen. Halligan if the problem was before or after the person getting his number. Sen. Halligan replied that much of the problem seemed to be with just getting numbers transposed, leaving them out or having them entered into the computer incorrectly.

Sen. Thayer asked Mr. Likewise if he felt that the pharmacists believed the eligibility aspect was a problem. Mr. Likewise replied that they do feel that to be a serious problem because each time an eligibility is determined (and that may be for only one day, one week or for several months) that eligibility must be on the state computer before the claim can be paid. Also, new people coming on the system causes a very serious problem. The computer system at the state level has an excess of 500 edits that will kick a claim back or reject it and it must then be sent back to the county for reevaluation. Some of these turn-around documents go back and forth through the mail a half dozen times before they get on the computer.

Sen. Hager asked Sen. Halligan what the additional $270,000 (Item 2) listed on the Fiscal Note is for. Sen. Halligan and Mr. Nielson agreed that it would be for a cash fund in the bank to pay those vouchers as they came in and that the total amount of money would not have to be deposited all at one time.

Sen. McLane asked if there was any vendor or provider in the state, at this time, who was being reimbursed through the voucher system. Mr. Nielson replied that the WIC program utilizes the voucher system; however, it is outside the Medicaid program and does not relate to the federal regulations involved in Medicaid. Sen. McLane then asked Mr. Nielson if he felt other vendors such as dentists, chiropractors and optometrists would also want to use the voucher system. Mr. Nielson answered that there are a certain number of complaints in all the provider areas with respect to the timeliness of payment and the amount of time required to complete the forms, etc. From the standpoint of the vendor it would be like writing out a check and being able to cash it right away. The concern of the department is that other vendors will want to start doing the same thing.

Sen. McLane asked if the four FTE's listed on the fiscal note were solely for the pharmacists' voucher program or for other vendors who wished to have the same program as well. Mr. Nielson answered that they estimated four additional FTE's for the pharmacists' voucher program only. Sen. McLane asked what the percentage of chance would be that the state could lose federal participation in the program if the voucher program is initiated. Mr. Nielson said they would have to put together a program, have it approved by the federal government and then try it. If at any time it appeared not to work or if they could not come up with a suitable plan, a large percentage of the federal funding would be lost and that would amount to about $250,000. Sen. McLane wanted to know how that would compare to what has been estimated as a possible savings by use of the voucher program. Mr. Nielson stated that he had not seen the fiscal note and would have to study it further in order to reply to that question.

Sen. Walker asked Mr. Nielson how many claims are processed to which Mr. Nielson replied that they process approximately 100,000 per month. Sen. Walker then asked Mr. Schrader if the general public was paying more because of the present situation with the pharmacists not getting paid promptly. Mr. Schrader answered that they probably are.

Sen. Weeding asked Mr. Likewise if he understood comments of several of the druggists that they were selling some of their drugs at less than wholesale cost and he wondered how they could keep from going broke if that was the case. Mr. Likewise replied that the pharmacist receives a discount from the wholesaler for being a prudent businessman. The discount depends upon the volume of business. Some stores receive virtually no discount; others receive up to 10% or greater. This discount is what is being taken off the average wholesale price and that is what they are being reimbursed for as the average cost of the goods regardless of the gross total cost of the goods, they still only receive a maximum fee of $3.75 per prescription. The smaller stores may receive no discount depending on their volume and some may receive up to 13% or more. The very small stores are, of course, subsidizing the program and the extra cost of the program has to be passed on to the private paying consumer.

Sen. Williams asked who was going to issue the vouchers. Sen. Halligan replied that the State would print and distribute them to the pharmacists. They would have them in their stores, fill them out and deposit them in the bank. Sen. Williams then asked how the pharmacist would know who was eligible, to which Sen. Halligan replied that the pharmacist would have to see the recipient's eligibility form or proof of eligibility before filling the prescription.

Sen. Thayer asked how many people in the SRS Medicaid Bureau work with the drug reimbursement program. Counsel Tech, mentioned previously, does all the major work with these claims, according to Mr. Nielson, and they contract with the State for this service. Sen. Thayer felt that the voucher system might help solve some of the current problems of incorrect numbers, etc. Mr. Nielson said that one person in their bureau was their representative and was responsible for coordination of the pharmacist portion of the Medicaid program with the Counsel Tech firm, answering questions of providers and trying to keep the problems at a minimum.

Sen. Walker asked Mr. Nielson what the cost is to the State to contract with Counsel Tech. Mr. Nielson replied that the operational costs for processing all Medicaid claims is approximately $80,000 per month. The total Medicaid disbursements are in excess of $10 million per month so the $80,000 is only a small part of the total cost.

Sen. Kolstad noted in Mr. Dodd's testimony he had indicated that in Delaware and Alabama it has been demonstrated that a savings of 50% or more was attained in the area of claims handling but Mr. Nielson testified that there were no other states operating under the voucher system, and he asked Mr. Dodd to explain that difference in testimony. Mr. Dodd explained that the programs were instituted in these other states but were later discontinued. The federal system is being pushed in the direction of establishing this whole system as a nationwide program. The National Association of Retail Druggists has been really pushing toward this type of program as it would save a considerable amount of money.

Sen. Weeding asked Mr. Nielson if there might be some off-setting savings if the four FTE's were placed in the department to do some of the work that is presently contracted out. Mr. Nielson answered that after the vouchers were paid, these people would have to review them individually to see that everything was done properly; then they would still have to go through the MMIS portion of the program. Sen. Weeding then asked if the MMIS could be programmed to accommodate the voucher system and Mr. Nielson answered that that is what part of the cost of initiating the voucher system would be for.

Sen. Williams wondered how SRS is presently billed by the pharmacists. Mr. Likewise told the committee that some firms bill weekly and some monthly. For each prescription they fill out a form called a MA5 with all the information necessary plus their "usual and customary fee". They are then mailed or delivered to Counsel Tech in Helena where they are sorted, reviewed and processed on a weekly basis. Sen. Williams then asked if the voucher system would cause them to handle many more pieces of paper every day but Mr. Likewise felt it would not cause a lot more work because each claim must be handled individually now.

Sen. Neuman asked Mr. Nielson what percentage of claims was ultimately determined to be ineligible for payment and Mr. Nielson said his latest report indicated that approximately 3% of the claims had been returned for one reason or another. Sen. Neuman then asked how long it took for the State to receive the reimbursement from the federal government. Mr. Nielson said he would have to check that out.

Sen. Thayer asked why the pharmacists billed the State at their normal prescription rate rather than at the reimbursement rate. Mr. Nielson told the committee that the reimbursement rate is the result of comparison of several figures. Those prices would be the direct price from the manufacturer, average wholesale price assigned by the manufacturer, maximum allowable cost established by the federal government, plus the store's specific dispensing fee. The lower of those, or the amount that they are actually billed by the pharmacy, is then used to determine the payment.

There were no further opponents.

Sen. Halligan closed the hearing on SB 205 by stating that this is an important piece of legislation for a lot of people and the problem is statewide. He urged the committee to attempt to make this a workable bill and to consider it very seriously. He said he was happy to see the bankers in support of the bill and asked if the Committee Researcher, Mary McCue, would work with the Bankers' Association on amendments that would take care of their concerns. He said the program is fundamentally flawed and if the problem is the computer than perhaps the claims could be handled in a better way. He cited an article in the Federal Register, August, 1986 which stated that the federal government is encouraging the use of vouchers and other innovative systems in the processing of Medicaid claims to make the program more efficient and simplified. Vouchers would be only in the hands of the pharmacists and stiff penalties have been added for any misuse or fraud. When the voucher system was tried in other states it proved to be too efficient because the payments were made promptly thus denying the interest earned by the State when claims were not paid promptly. This bill puts the money into the hands of the small business person where it belongs. Sen. Halligan suggested that Mr. Nielson get together with Counsel Tech to work out some of the problems as the program has to be dealt with. Sen. Halligan said he would be happy to work with the Committee and Ms. McCue to make this a workable bill. The hearing was closed on SB 205.

Following a short break, Vice Chairman Ted Neuman called the meeting back to order.

CONSIDERATION OF SENATE BILL NO. 218: Sen. Darryl Meyer, District 17, Great Falls, stated that SB 218 is designed to provide continued

insurance protection for Medicare supplement insureds in Montana. Sen. Meyer said, like most other businesses, most insurers try to maintain a positive relationship with their insureds and take into account the impact of certain decisions on their policy holders. Section I addresses companies who discontinue a product and offer to transfer a product to their clients and then require them to meet a new pre-existing waiting period. Section II applies only to Medicare supplement insureds that is fronted by one insurance company for another, such as when a company that is licensed to do business in this state and a number of other states, fronts a product developed by another company that is not licensed. An unlicensed company reinsures the businesses, accepts all the risk thus, insuring Montana residents without authority to do so and handles all the product development. Section III deals with general problems experienced by a number of Senior Citizens when buying Medicare supplement coverage. Sen. Meyer said that many of these people are vulnerable to high pressure tactics and are subject to constant replacement of their coverage. Under SB 218 if an individual has coverage in one company and the company replaces it, the insured will get credit for the pre-existing waiting period for the time they have under the existing contract. Section IV does two things; it codifies a general concept that the company will not discontinue an individual's coverage merely because of poor claim experience, and it requires companies to offer some sort of replacement coverage if they discontinue a product or offer a conversion option.

PROPONENTS: Andrea Bennett, State Auditor and Ex Officio Commissioner of Insurance, testified that SB 218 addresses what has become a serious problem for many of our Senior Citizens. She stated that over the past two years the Insurance Department has received a number of complaints from people concerning companies not renewing, changing, cancelling, or otherwise abusing Medicare insurance supplements and said this has created extremely difficult problems for Senior Citizens of the state. Over 30% of the consumer complaints that her department receives involves Medicare supplemental insurance. She said that Senior Citizens are often considered easy prey when it comes to Medicare supplements and felt this bill would allow the Insurance Department to address the problems in this area. She explained the reason insurance companies discontinue a product and do not renew all policies is they feel they are not making enough money. They then offer similar policies at an increased price which requires that all policy holders must meet a newly created waiting period. She cited the case of the Reserve Life Company. In 1984 that company undertook such action affecting nearly 1,000 policy holders in Montana. The Insurance Department, along with five other states, took administrative action against the company but they were found not to be in violation of any statutes in any of these states. She said the second part of the bill addresses the problem of one company fronting for an unlicensed company. She noted that twice in the past three years, companies have used this type of arrangement to sell Medicare supplemental insurance. One company,

Eagle Life, first marketed its Medicare supplement through an admitted company, Arcadia, and then later through Central National. When the admitted companies became aware of Eagle's poor claim handling practices and found the insurance products were not adequately priced, both Arcadia and Central National withdrew the agreement they had with Eagle and then cancelled all policies. This meant that, at best, our Senior Citizens were required to buy new coverage, meet a new waiting period and at worst, they found themselves unable to obtain any insurance at all.

She said the third area will eliminate problems where Senior Citizens are often taken advantage of by many offers for supplemental insurance. Because of their very real worries and concerns, Senior Citizens are often pressured into considering a new, improved Medicare policy and are subject to constant replacement of their policies. She said that SB 218 provides if an individual has an existing policy in place, they would not be required to meet another pre-existing waiting period on a new policy. She testified that the fourth and final provision of the bill provides that companies do not discontinue an individual's policy simply for the claims experience of that individual. That is the reason for health insurance - to take care of health problems. She then explained that companies who do wish to nonrenew a particular coverage must nonrenew all policies of that type. The bill also provides that if all policies of a certain type are not renewed, the company must offer some type of replacement policy so those affected will not be left without coverage. She said it is important that the bill does not inhibit companies from charging reasonable costs for coverage because Senior Citizens are willing to pay more if they are assured that the policy would remain in force. Further, she feels that the Senior Citizens have the right to feel comfortably secure that the Medicare supplement they are buying is going to be there when they need it and they should not be subjected to fears that the policy will not be renewed or that they will be required to meet yet another waiting period.

Jerome Loendorf, representing the Montana Medical Association, stated that he feels Senior Citizens need added protection from unfair insurance sales practices because they are vulnerable and often, like many of us, do not fully understand insurance and pretty much rely on what they are told by the agent who sells them the coverage. He urged the Committee's favorable support of the bill and feels it would solve many of the aforementioned problems.

Bonnie Tippy, speaking on behalf of the Montana Association of Life Underwriters, said that many life underwriters also sell health insurance and are aware that there are a lot of abuses in this area, particularly mailing campaigns where Senior Citizens buy from fly-by-night companies. Because the MALU sell for legitimate companies and are very professional agents, they want the disreputable people kept in line. They feel that SB 218 will help do that and strongly supported offering Senior Citizens the

fairness which would result from passage of SB 218.

OPPONENTS: There were no opponents to SB 218.

DISCUSSION OF SENATE BILL NO. 218: Vice Chairman Neuman called for questions from the Committee. There were none.

Sen. Meyer closed the hearing on SB 218 stating that he feels it is a very good bill and explained that he takes care of two 74 year old people who are constantly dogged by insurance people trying to change their health coverage. He said that several times his mother-in-law was just about ready to sign a check and buy another policy which would have been a big mistake as she would have had a long waiting period and would, therefore, been without coverage for a considerable length of time. He feels that the state really does need a bill like SB 218.

Executive action on SB 218 will be taken at a later date.

FURTHER CONSIDERATION OF HOUSE BILL NO. 68: Vice Chairman Neuman announced that there were several people who had come from Kalispell to give additional testimony on House Bill 68. They had stayed in Helena an additional day to give this testimony and the testimony is as follows:

Clayton Bayne, Chairman of the Board of Private Security and Investigators stated that he had come to oppose any amendment to HB 68 to exclude proprietary people from the code which HB 68 refers to. His reason for opposing such an amendment was that when that particular code was drafted in 1983 by a task force comprised of both proprietary and contract security people, they decided that because the duties, the responsibilities and problems were quite similar between the two, they should both be licensed. He said he had contacted the Board members and they are all in agreement that he take this stand and asked to withdraw his amendment which was proposed when the bill was initially heard. He said the amendment would really leave everything wide open and would not accomplish what they had had in mind. He stated he had talked with the Board attorney who feels that people employed by retail merchants who do not have any responsibility for the private security of a firm, are actually exempt from the law and would not be licensed, however, the way the bill presently reads, people who are actually assigned to specifically do security work for the firm would have to be licensed.

Robert B. Evans, Kalispell, who runs a business there and is past president of the State of Montana Private Investigators and Security Operators, stated he had appeared before the Committee at the initial hearing to urge the Committee to pass the bill as it came from the House. He said that over a year of work had been put into the bill and to amend it as Mr. Bayne previously

suggested would change the purpose of the law which is to protect the public from illegal, improper or incompetent actions. He said that exempting the proprietory personnel or in-house security does not protect the public and it lets each individual, local owner or operator determine his own training standards. He urged the Committee to pass the bill as it was transmitted from the House.

Mr. Craig Christie, Billings, owner of Legal Investigation Bureau, a private investigating firm and a contract security company, and Secretary-Treasurer of the Montana Association of Private Investigators and Security Operators, stated that since 1983 when the initial bill governing security operators and private investigators was enacted, they have run into several problems. Some of those problems have to do specifically with exemptions. He feels they have, over the past several years, upgraded the qualifications in the services provided by private entities, and that for the first time since the inception of the licensing board, the board, the state association and private industry, coupled with the Montana Sheriffs and Peace Officers Association, is in total agreement with regard to the specific issue addressed in HB 68. He feels if the bill is passed as it came from the House, they will not have to come back next session to try to overcome problems. He urged the Committee to pass the bill as written without amendments.

Mr. Fred Valiton of Helena with the Valco Security Service Company, stood in support of HB 68 and urged that the Committee give the bill a Do pass recommendation without amendments.

FURTHER DISCUSSION OF HOUSE BILL NO. 68: Vice Chairman Neuman called for questions from the Committee.

Sen. Walker asked Mr. Bayne about stores that have security programs and in-house training and if they are able to meet the training specifications of the Board if they would be able to get the license without further training. Mr. Bayne answered that the Board recognizes programs that meet the training criteria which the Board has set and they have authorized various agencies to go ahead and use these programs to train their people. The Board does have certified instructors out in the field who are available to train personnel from companies who do not have a training program.

Sen. Boylan wanted to know if the uniformed security students at MSU in Bozeman are undergoing training. Mr. Bayne stated they are under the supervision of the security police who are certified. The security students are exempt under the code because they are working for a governmental entity.

Sen. Thayer asked Mr. Bayne how much the fee would be if a store had its own security system. Mr. Bayne answered the license for the store, would cost $75. For each individual that is hired an additional fee of $75 is charged for processing which includes an examination, finger printing, etc.

Vice Chairman Neuman asked Chuck O'Reilly, Lewis and Clark County Sheriff if he had anything to add. Mr. O'Reilly said he wanted to express his support of HB 68 and wanted the record to show that he does not support the amendment that is being withdrawn by Mr. Bayne.

Sen. Walker asked Mr. O'Reilly if he had seen any problems with arrests made by persons who were not licensed. Mr. O'Reilly said that those people do not have good training, in a number of cases, and perhaps no training whatsoever and an 18 year old could be turned loose with a badge and a gun to handle security for a business. This could prompt lawsuits by citizens who, perhaps, had his rights abused or was physically abused, as has been the case. He said they have heard story after story about this type of circumstance, on a national level, because of untrained store security.

The next meeting of the Business and Industry Committee will be held on Thursday, February 5, 1987.

There being no further business, Vice Chairman Newman adjourned the meeting at 12:03 p.m.

ALLEN C. KOLSTAD, CHAIRMAN

TED NEUMAN, VICE CHAIRMAN

cal/ls

ROLL CALL

Business & Industry COMMITTEE

50th LEGISLATIVE SESSION -- 1987 Date 2/4/87

NAME	PRESENT	ABSENT	EXCUSED
ALLEN C. KOLSTAD, CHAIRMAN	✓		
TED NEUMAN, VICE CHAIRMAN	✓		
PAUL BOYLAN	✓		
TOM HAGER	✓		
HARRY H. McLANE	✓		
DARRYL MEYER	✓		
GENE THAYER	✓		
MIKE WALKER	✓		
CECIL WEEDING	✓		
BOB WILLIAMS	✓		

Each day attach to minutes.

DATE 2/4/87

COMMITTEE ON Business & Industry

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One: Support	Check One: Oppose
Phillip D. Johnson	Montana Bankers Assn	205	X	
Neysa A. Humphreys	Montana Bankers Assoc.	205	X	
Terri Blatters	Montana Bankers	205	X	
Jim Lynch	M.A.G.A.	218	X	
Jack Nielson	SRS	205		X
Herb Swanson	Self	205	X	
Herman Schneider	self	205	X	
Lee Saucier	Self	205	X	
Frank J. Davis R. Ph.	Self	205	X	
Robert Holmes	MSPA	205	X	
Bryson G. Nordell	Smith Drug	205	X	
Carl Lange	Medicine Shoppe	205	X	
Mon Wilkinson	East Helena	205	X	
James W. Brady	Health Ass'n	205	X	
Edwin Lindley	Lindley Drug	205	X	

(Please leave prepared statement with Secretary)

DATE 2/4/87

COMMITTEE ON Business & Industry BILL NO. HB 68

VISITOR'S REGISTER

NAME	REPRESENTING	Check One: Support	Check One: Oppose
Robert B. Crane	M.A.P.I.S.O.	w/o Amnd	
Clayton Varian	Board of Private Security	w/o Amnd	
Craig Christie	M.A.P.I.S.O.	w/o amendments	
Fred D. Clifton	MAPISO	w/o Amend	
Chuck O'Reilly	Mt. Sheriffs + Peace Officers Assoc.	w/o Amendments	

(Please leave prepared statement with Secretary)

DATE 2/4/91

COMMITTEE ON Business & Industry BILL NO. SB 218

VISITOR'S REGISTER

NAME	REPRESENTING	Check One Support	Oppose
[illegible] Bennett	State Auditor	X	
[illegible]	MT. Ins. Dept	X	

(Please leave prepared statement with Secretary)

Montana State Pharmaceutical Association

Incorporated
P.O. BOX 4718
HELENA, MONTANA 59604
TELEPHONE 406-449-3843

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 1
DATE 2/4/87
BILL NO. SB 205

SB 205

February 4, 1987

Testimony

Montana State Pharmaceutical Association

Mr. Chairman, Members of the committee, for the record I am Robert H. Likewise, the Executive Director of the Montana State Pharmaceutical Association. The Pharmacists of Montana support this bill and ask that you give it every consideration. This bill has been presented in an effort to help the pharmacists of Montana receive timely pay and improved cash flow on those claims that are problem free and can be paid immediately.

This morning before coming to this hearing I stopped at the store in which I do relief work and found that the prescriptions billed medicaid for the past several weeks are still unpaid. Since we are required to pay our wholesale drug bill every two weeks, the product used to fill these prescriptions has been paid on all but the last couple of weeks. I testified before the Joint Appropriations Committee some time back concerning the problem of stores discontinuing to accept portions of medicaid. I feel this has become worse in some areas. Butte has nine store and only three accept medicaid and of these three only two accept state medical. Helena has seven stores that accept medicaid and only two will accept state medical. We also have one pharmacy that has given up rebilling on rejected claims and finally wrote off $2600.00 of these claims.

The July 31, 1986 issue of the Washington Bulletin contains the following statement concerning the voucher program: "During hearings on the FY 1987 budget request several witnesses testified regarding the complexity and

cost of administering the prescription drug program under Medicaid. According to this testimony, drug claims, which account for only 8% of program dollars, account for more that 50% of all Medicaid paperwork. Given the need to reduce the portions of Medicaid's budget which is expended for administrative costs, the Committee believes that Health Care Financing Administration should aggressively address the problem. Prior to its hearing on the FY 1988 budgetrequest the committee will expect to receive a report on the extent of the problem and on alternatives which might be tried in the area. These alternatives should include further expansion of electronic claims handling as well as drug vouchers if cost effective." I am submitting this copy of the bulletin in my testimony.

The Federal Register of Tuesday, August 19, 1986 also carried the following statement: "Although not a subject of these proposal regulations, the Department has received a number of suggestons regarding administrative mechanisms for medicaid prescriptions drug reimbursement. The thrust of these suggestions is to simplify administration of the payment process through the use of vouchers or other innovative mechanisms such as smart cards. We would encourage States to use the flexibility accorded to them to develop payment mechanisms with the potentions to simplify the administrative process, while reducing potential fraud and abuse. We also encourage others to further develop promising new technologies for these purposes." I am also

submitting this as part of my testimony.

Delaware Blue Cross/Blue Shield is currently utilizing the voucher method of reimbursement in the drug claims they process. In talking to Mrs. Negri concerning this method of reimbursement she indicated that they handle claims for several large corporations including the teachers union, Chrysler and General Motors.

I am submitting the above articles as well as a study supplied to me by the National Association of Retail Druggists concerning Voucher Reimbursement. This study not only explains the Alabama medicaid program of several years back but also the Blue Cross/Blue Shield of Delaware program. Cost savings projections are outlined in the article for your review. It is my understanding that New Jersey has just let a contract for a system which will allow the pharmacies to instantly determine the patients eligibility and at the same time will provide a guaranteed payment authorization number. This is another step toward timely reimbursement.

From the above we would ask that this Committee consider this proposal and utilize the local bank in the reimbursement mechanism since they are already set up to handle large volumes of transactions accurately and efficiently.

8-19-86
Vol. 51 No. 160
Pages 29545-29628

federal register

Tuesday
August 19, 1986

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 2
DATE 2/4/87
BILL NO. SB 205

Briefings on How to Use the Federal Register—
For information on briefings in Washington, DC, see announcement on the inside cover of this issue.

Compliments of
The National Association
of Retail Druggists
GOVERNMENT AFFAIRS DEPARTMENT

methodology for determining upper limits for drug reimbursement. The alternative proposed policies would enable the Federal and State governments to take advantage of savings that are currently available in the marketplace for multiple source drugs. They also would maintain State flexibility in the administration of the Medicaid program.

DATE: To be considered, comments must be mailed or delivered to the appropriate address, as provided below, and must be received by 5:00 p.m. on September 18, 1986.

ADDRESSES: Mail comments in writing to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: BERC-356-P, P.O. Box 26676, Baltimore, Maryland 21207.

Please address a copy of comments on information collection requirements to: Fay Iudicello, Office of Information and Regulatory Affairs, Room 3208, New Executive Office Building, Washington, DC 20503.

In commenting, please refer to file code BERC-356-P.

If your prefer, you may deliver your comments to one of the following addresses:

Room 309-G, Hubert H. Humphrey Building, 200 Independence Ave., SW., Washington, DC, or

Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland.

Comments received timely will be available for public inspection as they are received, beginning approximately three weeks after publication of this document, in Room 309-G of the Department's offices at 200 Independence Ave., SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (phone: 202-245-7890).

FOR FURTHER INFORMATION:

For issues related to PhIP or MAC, contact: Anthony Lovecchio, (301) 594-4010.

For issues related to CIP, contact: Walton Francis, (202) 245-0291.

SUPPLEMENTARY INFORMATION:

I. Background

A. Existing System

In 1976, the Department implemented drug reimbursement rules at 45 CFR Part 19 under the authority of statutes pertaining to upper payment limits for Medicaid and other programs. The authority to set an upper payment limit for services available under the Medicaid program is provided under section 1902(a)(30)(A) of the Social Security Act.

The Department rules are intended to ensure that the Federal government acts as a prudent buyer of drugs under certain Federal health programs. The rules set limits on payments for drugs supplied under Medicaid and other programs. Of the Federal programs involved, these rules have the greatest impact on the Medicaid program. Specifically, these regulations provide that the amount the Department recognizes for drug reimbursement or payment purposes will not exceed the lowest of—

- The maximum allowable cost (MAC) of the drug, as established by HCFA's Pharmaceutical Reimbursement Board for certain multiple source drugs (generic drugs), plus a reasonable dispensing fee;
- The estimated acquisition cost (EAC) of the drug (the price generally and currently paid by providers for a particular drug in the package size most frequently purchased by providers, as determined by the program agency), plus a reasonable dispensing fee; or
- The provider's usual and customary charge to the public for the drug.

The regulations provide that the MAC will not apply if the prescriber has certified in his own handwriting that a specific brand of that drug is medically necessary for the patient.

The regulation at 45 CFR Part 19 also establishes within HCFA a Pharmaceutical Reimbursement Board (PRB). The PRB identifies multiple source drugs for which significant amounts of Federal funds are or may be expended and is responsible for establishing the MAC for those drugs. The process by which a MAC is established includes PRB consultation with the Food and Drug Administration (FDA), opportunity for public comment on a proposed notice of the MAC limit published in the Federal Register, a public hearing, and publication of the final MAC determination in the Federal Register. The PRB sets the MAC at the lowest unit price at which the drug is widely and consistently available. In addition to limitating the level of payment for multiple source drugs, the MAC program tends to promote substitution of lower cost (generic) drug products for brand-name drugs, since the latter are frequently available only at prices higher than the MAC limits.

Similar to the Department regulations (45 CFR Part 19) that set limits to Federal payments for drugs are the Medicaid regulations at 42 CFR 447.331 through 447.334. The regulations at §§ 447.331 through 447.334 limit the

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 405 and 447

45 CFR Parts 1 and 19

[BERC-356-P]

Medicare and Medicaid Programs; Limits on Payments for Drugs

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would: (1) Eliminate current Departmental procedures for setting limits on payments for drugs supplied under certain Federal health programs; and (2) set forth three alternative approaches to revise Medicaid rules concerning the

the survey results. State Medicaid agencies have contended that the requirement is both burdensome and costly. On the other hand, it has been contended by pharmacy groups that dispensing fees should be established at levels which specifically reflect costs. Although we have not included a proposal to remove the requirement for the surveys, we specifically invite comments on this issue and on alternative approaches.

Although not a subject of these proposal regulations, the Department has received a number of suggestions regarding administrative mechanisms for Medicaid prescription drug reimbursement. The thrust of these suggestions is to simplify administration of the payment process through the use of vouchers or other innovative mechanisms such as "smart cards." We would encourage States to use the flexibility accorded to them to develop payment mechanisms with the potential to simplify the administrative process, while reducing potential fraud and abuse. We also encourage others to further develop promising new technologies for these purposes.

Discussion of Alternatives

A. Pharmacists' Incentive Program Alternative

The Pharmacists' Incentive Program (PhIP) would replace the Federal MAC program. It is designed to encourage pharmacists to be prudent purchasers of drugs and to substitute less costly, therapeutically equivalent drug products (as determined by the FDA) for more costly brand name drug products. PhIP would accomplish this objective by providing an economic incentive to pharmacists to engage in product selection.

Under PhIP, upper limits would apply to multiple source drugs which meet the following requirements:

- All of the formulations of the drug approved by FDA have been evaluated as therapeutically equivalent in the most current edition of their publication, *Approved Drug Products with Therapeutic Equivalence Evaluations* (including supplements or any successor publications).
- At least three suppliers advertise the drug (which has been classified by the FDA as category "A" in the FDA's *Approved Drug Products with Therapeutic Equivalence Evaluations*, including supplements or any successor publications) in the most current edition of the *Red Book* or *Blue Book*. The purpose of the three supplier requirement is to ensure that the drug equivalents are in fact widely available, thereby avoiding one of the major criticisms of the MAC program.

We would include the requirement that drugs be therapeutically equivalent as evaluated by the FDA. Specifically, we would require that the FDA has rated the drug in one of the "A" categories representing therapeutic equivalence. Such findings are currently included in its publication, *Approved Drug Products with Therapeutic Equivalence Evaluations* (including supplements). We would use the FDA's evaluations of therapeutic equivalency (category "A") because the FDA has the experience and expertise to make these determinations. The FDA prepares these evaluations to promote public education in the area of drug product selection, to advise State health agencies and pharmacists in the administration of drug product selection laws, and to foster containment of health care costs. The publication is available on a subscription basis (stock #917-001-00000-8) from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

In a State using the PhIP upper limits, pharmacists would be encouraged to purchase as prudently as possible because, in addition to the dispensing fee they receive under existing regulations, they would retain the difference between what they pay for the drug product and the upper limit of payment established by HCFA for the particular drug. In essence, this would be a prospective pricing system for multiple source drugs.

The PhIP upper limit of payment for a multiple source drug would be set at a percentage of the least costly multiple source drug advertised in a specific quantity or volume. The specific advertised quantity we would use is 100 tablets or capsules, or the smallest package size commonly advertised. In the case of liquids, we would use the commonly advertised size. We would use these measures because we recognize that small pharmacies are unable to stock large quantities of many drugs. If a provider dispenses a drug in a quantity smaller than 100 tablets or the specific quantity upon which the PhIP calcualtion was based, payment would be made on a proportionate basis.

In determining the advertised price and commonly advertised size of a drug, we are proposing to use the *Red Book* and *Blue Book*. The *Red Book* and *Blue Book* are annual publications that list drugs and their wholesale prices. We would use the *Red Book* and *Blue Book* as our sources of drug costs because they are widely recognized and available nationally. (These publications are available from Drug Topics *Red Book*, P.O. Box 553, Oradell, New Jersey 07649 and from American Druggist *Blue Book*, Hearst Corporation, 555 W 57th Street, New York, New York 10019). Although we have referred to the *Red Book* and *Blue Book* in our discussions, we specifically invite comments and suggestions on the use of other nationally available sources of drug costs.

Initially, we are proposing to set the PhIP upper limits at 150 percent of the lower of the *Red Book* or *Blue Book* price for the least costly multiple-source drug. We would set the mark-up to 150 percent (or a slight different amount, depending on public comment and further analysis) in order to meet the following two objectives: (1) That the mark-up be high enough to assure that pharmacists can normally obtain and stock and equivalent product without losing money on acquisition costs of incurring the expense of department from normal purchasing channels, and (2) that the mark-up not be so high as to cost the Medicaid program unnecessary money. In other words, the 150 percent (or some alternative such as 140 percent of the average of the three lowest priced therapeutically equivalent multiple source drugs) is intended to balance the interests of both pharmacists and the government in achieving effeciency, economy and quality of care as specified in section 1902(a)(30) of the Act. When the PhIP formula is applied to the lowest price products in the *Red Book* or *Blue Book*, the pharmacist can choose among numerous supplier for a drug. Further, we believe the use of advertised prices in either the *Red Book* or *Blue book* would assure an adequate payment amount because a range of discounts are frequently available to pharmacists to purchasse drug products at prices lower than the advertised price. Also, most of the multiple source drugs under consideration for PhIP limits are high volume drugs which many pharmacists purchase in larger package sizes (for example, bottles of 500's, 1000's or larger). When pharmacists purcahse in these larger package sizes, the per unit drug product cost in lower, further providing the pharmacist and even greater financial incentive.

At the proposed upper limits for multiple source drugs, pharmacists would have the opportunity to select among the products of several suppliers. Based on a review of pricing patterns among suppliers of multiple source drugs using *Red Book* entries for drugs for which there are three or more therapeutically equivalent products, we found that there is a sizeable number of

the survey results. State Medicaid agencies have contended that the requirement is both burdensome and costly. On the other hand, it has been contended by pharmacy groups that dispensing fees should be established at levels which specifically reflect costs. Although we have not included a proposal to remove the requirement for the surveys, we specifically invite comments on this issue and on alternative approaches.

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The National Association of RETAIL DRUGGISTS

NATIONAL HEADQUARTERS
205 DAINGERFIELD ROAD
ALEXANDRIA, VIRGINIA 22314
(703) 683-8200

WASHINGTON BULLETIN

July 31, 1986

HOUSE VOTES TO SUPPORT ITS APPROPRIATIONS COMMITTEE'S REQUEST FOR MEDICAID DRUG VOUCHER

"*Federal administration.*—The bill includes $215,177,000 to support Federal administrative activities related to the Medicare and Medicaid programs. This is the same amount as the President's budget request and an increase of $9,357,000 over the amount available for FY 1986. The funds recommended by the Committee will support a staffing level of 3,757 full-time-equivalents for fiscal year 1987, a reduction of 124 FTE's from the number funded in FY 1986. The Committee has accepted this proposal based on the convincing testimony of the Acting Administrator that this would allow sufficient staff for program operations. This reduction will be accomplished through attrition.

During hearings on the FY 1987 budget request several witnesses testified regarding the complexity and cost of administering the prescription drug program under Medicaid. According to this testimony, drug claims, which account for only 8 percent of program dollars, account for more than 50 percent of all Medicaid paperwork. Given the need to reduce the portion of Medicaid's budget which is expended for administrative costs, the Committee believes that HCFA should aggressively address this problem. Prior to its hearing on the FY 1988 budget request, the Committee will expect to receive a report on the extent of the problem and on alternatives which might be tried in this area. These alternatives should include further expansion of electronic claims handling as well as drug vouchers if cost effective. "

House Rept. 99-711, p. 106; H.R. 5233, making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies, for the fiscal year ending September 30, 1987. July 24, 1986

John Neeth
as requested

quately reflect current experience, the rate adjustments should be delayed until this information can be obtained.

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Social Security Administration

The following table displays the amounts recommended by the Committee for programs administered by the Social Security Administration with appropriate comparisons. The Committee has deferred consideration of the budget requests for Refugee and Entrant Assistance and the Low Income Energy Assistance Programs. The basic laws authorizing these activities have not yet been extended for fiscal year 1987. Appropriations for these programs will be considered as soon as possible after the enactment of new authorizing legislation.

	Fiscal year 1986		Fiscal year 1987 estimates	Recommendation
	Enacted	Post sequestration		
SOCIAL SECURITY ADMINISTRATION	$497,608,000	$497,008,000	$500,555,000	$500,555,000
Payments to Social Security trust funds				
SPECIAL BENEFITS FOR DISABLED COAL MINERS				
Benefit payments	991,389,000	991,389,000	957,000,000	957,000,000
Administration	6,519,000	6,239,000	6,437,000	6,437,000
Subtotal, black lung, program level	997,908,000	997,628,000	963,437,000	963,437,000
Less funds advanced in prior year	−270,660,000	−270,000,000	−270,000,000	−270,000,000
Unobligated balances available under such sums	12,341,000	12,341,000		
Appropriation available in prior year	−11,730,000	−11,730,000		
Total, black lung current request	728,519,000	728,239,000	693,437,000	693,437,000
Subsequent year advance appropriation	270,000,000	270,000,000	252,450,000	252,450,000
SUPPLEMENTAL SECURITY INCOME				
Federal benefit payments	9,040,551,000	9,040,551,000	9,589,000,000	9,589,000,000
Beneficiary services	6,600,000	6,800,000	8,200,000	8,200,000
Administration	1,010,507,000	977,838,000	972,118,000	972,118,000
	10,057,658,000	10,025,189,000	10,569,318,000	10,569,318,000
	2,345,769,000	2,345,769,000	2,339,250,000	2,339,250,000
Subtotal, supplemental security income, program				

VI. Medicaid Prescription Drug Draft (Voucher) Program *

In an era of staggering deficits and tightening budget constraints, the need for containing government program costs is essential. Many initiatives are being undertaken to reduce health care expenditures. These initiatives include proposals to set further limits on the reimbursement paid to pharmacists for providing their services to Medicaid recipients. Other mechanisms for containing costs should be explored in order to reduce other program costs related to maintaining the Medicaid program. The use of a Medicaid prescription drug draft (voucher) system is one proposal which, based on a conservative estimate related to claims processing, can save taxpayers greater than $420 million in administrative expenses over a five year period. In addition, this system also achieves prompt payment, which meets current government initiatives.

Administrative costs include the amount of money paid to a vendor to process claims, printing of the claim forms, and the salaries of the program's staff pharmacists, investigators, clerical personnel and program administrator. Cost reductions in this area are possible through the use of claims processing systems which are much more efficient and substantially less expensive than the current systems. A drug draft or voucher system can provide greater efficiencies and lower costs by utilizing the existing structure and proven expertise of the national banking system. A program which results in a 66 percent reduction in administrative expenses, and is much more acceptable to the pharmacist in terms of reimbursement, is one which deserves serious consideration.

A prescription drug draft program to reimburse pharmacy services was first used in the Alabama Medicaid program and is currently being used by Blue Cross/Blue Shield in the state of Delaware. It is proposed that a Medicaid Prescription Drug Draft (Voucher)

* Part of PraCon study presented to NARD entitled "Marketplace Economics: Alternatives in Medicaid Prescription Reimbursement"

Program should be initiated which benefits taxpayers by preventing their tax dollars from being needlessly wasted; benefits the government by meeting cost reduction initiatives and operational efficiencies; and benefits pharmacists by providing them with fair and timely reimbursement for their services. The analysis of these programs which follows provides greater insight into this proposed system.

Alabama Pharmacy Bank Draft Program

The Alabama bank draft program which was introduced in 1970, received a citation in 1976 from the Department of Health, Education and Welfare, which was presented, "...in recognition of demonstrating extraordinary awareness and front-end management of an innovative bank draft system of drug payments that has significantly reduced many problems experienced by other states."

This system used a two-part draft which was provided by the state to the pharmacy participants. Unlike food stamps, potential fraud was limited since it was only the pharmacist who had access to the draft. When a patient, enrolled in the Medicaid program, brought a prescription to the pharmacy, a plastic ID card was presented to validate eligibility. This card was then used like a credit card to imprint patient and program information directly on the draft. The remaining information was then completed by the pharmacist. Information on the draft included the National Drug Code (NDC) number, prescription number, refill status, physician ID number, and pricing information. The form was signed by both the pharmacist and the patient. Pricing information included the cost of ingredients, including earned discounts, the fee, and the deducted copay, if any.

Once the information was completed, the draft was deposited in the pharmacy's bank and credited immediately. The draft could only be deposited to the pharmacy's bank account and could not be

cashed as a check. The bank then sent the draft with other checks, drafts, and negotiable instruments to a central clearing bank which separated them and encoded them with machine-readable data.

Once processed, the drafts were sent to the state Medicaid office to be audited. Initially, if a form was in error or if too large a claim had been made, a bill or corrective notice would be sent to the pharmacy on a monthly basis. Due to concerns that Medicaid would not be reimbursed promptly by the pharmacists, it was decided to treat the drafts in error as checks with insufficient funds. In this case, the pharmacy's bank account would be debited the sum of the draft, immediately transferring the funds back to Medicaid. If an error was present on the draft, it could be resubmitted. Any overpayment would have to be returned to the state by the pharmacy after receiving the bill. Other information was also readily retrievable from the draft. Drug utilization review was easily done by using the NDC number. Statistical reports were generated which were used for the Medicaid Management Information System (MMIS) and provided marketing data to the Medicaid program director indicating drug usage and dispensing patterns by provider and recipient. Problems could be identified quickly, allowing pharmacists to be informed immediately of claims to be returned. If a Medicaid recipient was violating the law by using multiple pharmacies for the same prescription, this abuse of the system could be identified within 24 hours. In this way, fraud and abuse were readily identified and halted. Inspector General Kusserow pointed out that traditional audits may be reviewed "...for months, before being passed on to interested parties..." The point of this comment is the long lag time to identify potential system abusers, thereby delaying a process which could halt fraud and prevent Medicaid dollars from erroneously being paid. The reports generated as a result of the draft system may help

expedite this auditing process assuring that corrections which save expenses can readily be made.

Administrative program expenses were kept to a minimum. The state's cost for processing claims was 15 cents per draft. When other administrative expenses were added to the figure, the total administrative cost was 20 cents per draft. These administrative expenses included five clerical people, one administrative accountant, two pharmacists, the program administrators (5 percent of the time) and three investigators (70 percent of the time). Prior to this, Alabama was paying 45 cents to process each claim. Currently, state Medicaid programs pay approximately 60 cents to more than $1.00 per claim.

Problems which lead to the eventual demise of Alabama's program included a dislike of the "pay first" system by auditors. The "pay first" system meant that pharmacists would receive payment for their services first, followed by a review and audit of the claims being submitted through the pharmacy's bank. Other problems which troubled the draft system included complaints by other health care providers, including physicians and hospitals, who had to wait for their payment. Perhaps the major contributing problem was cash flow which resulted from insufficient funds available to pay for prescription services in such an immediate fashion. The end result of dismantling the drug draft system was to place the problem of cash flow back on the provider by delaying payments several weeks after the service and product had been delivered.

Delaware Prescription Drug Draft Program

The Delaware Prescription Drug Draft Program was started by Blue Cross/Blue Shield in 1973 and is currently in operation. The program mechanics are similar to those described in the former Alabama program. Once again, a two-part form is used which

gathers all pertinent information. One major difference is that the Delaware system provides an option for computer, pin-fed copies of the draft which can be run at the end of a business day on the pharmacy computer. Once completed, the pharmacist signs the drafts and deposits them in the bank. For those who do not have the available computer software or hardware, the manual system of filing the forms may be done as usual.

If the draft is properly filled out and patient eligibility is properly determined, the draft is deposited directly into the pharmacy's bank. Any drafts which are not complete will be returned as a check with insufficient information.

After payment, Blue Cross and Blue Shield of Delaware audits the drafts to verify eligibility, correct pricing and other submitted information. In the event of a discrepancy, the pharmacy is mailed a monthly notice. If the data is incorrect, the pharmacy can return accurate information to clarify the problem. If the pricing is in error or the patient is deemed ineligible, the pharmacy is billed for the difference and must make payment within 30 days.

Professional Relations Representative Juana Negri has stated that since she has been working with the pharmacy program she has "never had a problem receiving funds from the pharmacists. This is because they want to make sure the system works so they don't lose the program."

Shortly after the program was implemented, significant dollar savings comparable to those seen with the Alabama program were realized related to the cost of claims processing and paperwork was reduced by at least 50 percent. Ms. Negri estimates that the current cost of running their prescription draft program runs about 20 cents per claim.

Concerns with the Delaware program are similar to those experienced by Alabama. Frequently people in the accounting department complain about paying first and auditing later. She argues that, "with pharmacy, a product is involved that the pharmacy must pay for. A surgeon can take out an appendix and it won't cost him anything other than his professional time. A pharmacist not only has the cost of his professional time, but the cost of the drug as well." She believes that it would not be equitable for a pharmacist to cover the cost of a product when payment may not be received for six to eight weeks.

Ms. Negri also predicts that as the technology becomes available, the Delaware system will be able to be operated entirely by electronic transfer of information without having to generate the actual hard copy. When this system is implemented, those pharmacies unable to afford the necessary computer equipment will still be able to utilize the program in its original format and maintain the integrity of the information in the system.

Benefit to Pharmacists

The current reimbursement mechanisms cause significant hardships on pharmacies providing services to Medicaid recipients. Based on information reported by the National Pharmaceutical Council, in 1984 Medicaid paid a mean average of $164,485,166 per month for prescribed drugs. While considering the number of pharmacies participating in Medicaid and an average 6 to 8 week turnaround time for claims processing, pharmacists were forced to carry an average of $3,712 to $4,950 in unpaid Medicaid claims at any given time during 1984.

Independent retail pharmacies process 80 percent of the prescriptions received by Medicaid recipients. It is particularly this group of independent businessmen who are forced to bare the brunt of expenses related to filling Medicaid

prescriptions. By adopting a Medicaid Prescription Drug Draft (Voucher) Program, this money could be allocated to other business expenses and cost-effective pharmacy services and other business expenses.

Freeing this money, in some cases, may allow pharmacists to remain in the Medicaid program. It has been documented, that, in many instances, pharmacies have had to halt their participation in the program due to excessive late payments by Medicaid. This may be necessary even in the face of losing the business of other members of the recipient's family who are not receiving Medicaid benefits. Pharmacists may also be forced to make business decisions that will require dropping professional services in an effort to continue providing their Medicaid patients. The resulting loss will not only be felt by the Medicaid patients, but those non-Medicaid patients who previously benefitted from the lost service. The draft (voucher) system may prove to be a major factor in preserving the ability of the independent retail pharmacist to continue to serve the Medicaid population.

Benefit to the Taxpayers and the Government

One of the major benefits of a Medicaid Prescription Drug Draft (Voucher) Program would be the substantial monetary savings in claims processing costs (see Table F). Had this program been in use during 1985, the estimated potential savings would have surpassed $73 million for the entire Medicaid program. A straight line trend analysis for the number of prescription claims was performed to determine the number of claims over the next five years, considering trends in the number of Medicaid recipients receiving prescription drug benefits. Assuming no changes in eligibility and a zero percent inflation rate, the estimated five year savings could be as much as $420 million (see Table G and Exhibit IX). This calculation was done based on a $0.60 per claim fee for the current system compared with a charge of $0.20 per claim under the drug draft (voucher) system. It

TABLE F

Potential Savings in Administrative Costs

1985

Total Number of Medicaid Prescription Claims Processed for 1985	184,583,099
Current Service Charge ($0.60 per claim)	$110,749,859
Projected Drug Draft Service Charge ($0.20 per claim)	$36,916,620
Potential Savings	$73,833,240

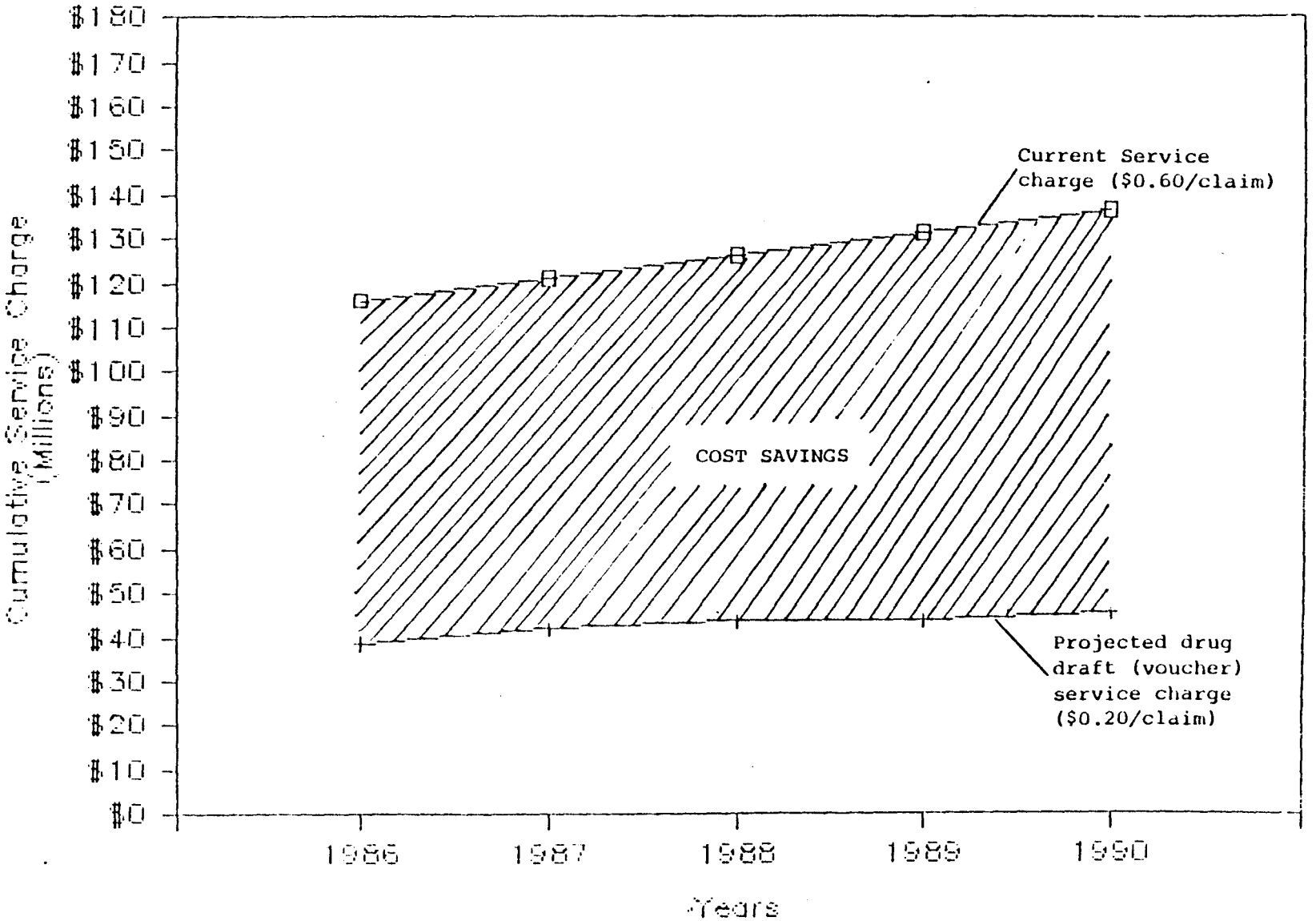
TABLE G

Five Year Projected Savings

	1986	1987	1988	1989	1990	Total
Projected Number of Prescription Claims	193,062,895	201,642,194	210,221,494	218,800,793	227,380,092	1,051,107,468
Current Service Charge ($.060 per claim)	$115,837,737	$120,985,316	$126,132,896	$131,280,476	$136,428,055	$630,664,480
Projected Drug Draft Service Charge ($0.20 per claim)	$ 38,612,579	$ 40,328,439	$ 42,044,299	$ 43,760,159	$ 45,476,018	$210,221,494
Projected Savings	$ 77,225,158	$ 80,656,878	$ 84,088,598	$ 87,520,317	$ 90,952,037	$420,442,987

EXHIBIT IX

FIVE YEAR PROJECTED SAVINGS



should be noted that in all cases, these are in fact conservative estimates; actual savings could be much higher based on the range of administrative costs from $0.60 to greater than $1.00 per claim. To complement these savings, based on the Delaware Blues' success, the program would have the potential of decreasing the paperwork related to Medicaid prescription drug reimbursement by 50 percent, decreasing the total Medicaid paper volume by 25 percent. This paperwork reduction results from taking advantage of the national banking system with its built-in efficiencies for handling financial procedures of this magnitude.

The amount of tax dollars spent on claims processing is clearly illustrated in information obtained from one state Medicaid program. The claims processing vendor will receive approximately $1.5 million in profits over a three year period beginning in 1987 which amounts to a 12 percent profit margin. Generally, most vendors realize a profit ranging between 12 and 15 percent. Reducing this profit margin would result in saving the Medicaid program added money. It is interesting to note that according to the 1985 Lilly Digest, pharmacies on the whole made a net profit of 3.1 percent. This same source indicates that only 11 percent of the pharmacies reporting had a profit margin of 10 percent or over, while 36 percent of the pharmacies either operated at less than a 2 percent profit margin or operated at a loss. These data suggest that there are other areas of expense to be reduced which have not been addressed before attacking the limited profit margin of pharmacies. Operating with such small margins makes it necessary to have as much available money freed for other purposes as possible. Instead of making it more difficult for pharmacies to operate, there should be more parity in profit allowances for all participants in the Medicaid program including vendors and pharmacists alike.

The Medicaid Drug Draft (Voucher) Program can be implemented in conjunction with any reimbursement mechanism set by HCFA and

still meet the drug draft programs's objectives to reduce administrative costs. The mechanism for determining the reimbursement rate is independent of the claims processing function. As technologies change, the drug draft (voucher) system would also be easily transferrable to a computer program which will still be compatible with the paper draft system.

It should also be considered that filling Medicaid prescriptions for less than the pharmacy's cost often results in shifting of those costs to the private sector. Many of those people in the private sector include older people on a fixed income. Although their financial situations do not allow them to be eligible for Medicaid benefits, they are in effect helping to subsidize the Medicaid patient. This is particularly significant because this segment of the population uses a higher number of prescription drugs. This essentially results in an added taxation on a non-Medicaid patient population which can ill afford added expenses.

Finally, the system provides for drug utilization reviews (DURs) to be easily done by all state Medicaid programs. This is an important aspect of cost containment, as seen with the DUR program reported by the Virginia Medicaid program which estimated an annual savings of $409,000 per year from the prevention of 452 patients hospitalization. Currently, DUR is not performed in all state Medicaid programs since the necessary information is unavailable from MMIS. It is this type of quality information that would allow states, at a local level, to determine prescribing trends and identify other areas for potential cost savings.

Recommendation and Conclusion

It is recommended that a Medicaid Prescription Drug Draft (Voucher) Program be adopted by the state Medicaid programs on a national basis. The federal government should set a mandate that

state governments implement this program as soon as possible to assure that pharmacists receive prompt payment for their services as directed by current initiatives. Ideally the system should provide a standard form or Universal Draft which collects the same basic information for each program. Use of a Universal Draft would allow all data to be easily compiled on a national basis for evaluation and review. This information could allow for a national DUR to allow states to compare their progress in areas of cost control with other states. Information could also provide valuable post-marketing surveillance data. This can be used to identify trends signalling potentially new adverse drug reactions or interactions which could be readily communicated to both pharmacists and physicians to provide them with information to prevent further adverse reaction. To allow for these benefits, information on a two-part form should minimally include the National Drug Code, drug quantity and prescription number, pricing information, a pharmacy code, a physician code, the date dispensed and other patient and program specific information.

Start-up costs will be a one time investment in a program that has the potential to save a significant amount of money for many years. Initial costs should be minimal since the system takes advantage of a claims processing technology already existing in the banking industry. Production of the new draft forms and plastic recipient ID cards would comprise most of the initial costs.

Other variations of the system and their related costs may best be addressed during a pilot program. Options may include the use of direct electronic transfer and payment of drafts or immediate verification of a recipient's eligibility for service just as a person's credit card is checked for payment authorizations.

The Medicaid Prescription Drug Draft (Voucher) Program can be equitable to pharmacists, cost effective to taxpayers and allow

streamlined operations for both the federal and state governments. This program takes advantage of the sophisticated claims processing system already in use by the banking industry, a system which has excellent proven capability. Prompt payment for services is an additional benefit of this system. By using the business expertise of private enterprise, the government's Medicaid program can dramatically improve its efficiency as the data presented here has shown. It is strongly encouraged that action be taken in this direction to effectively deal with the Medicaid program which grows more difficult to administer as time passes.

PATIENT'S COPY

DRUG PROGRAM NO. 808651

IDENTIFICATION NO	GROUP NO	PHYSICIAN CODE	PHARMACY CODE	DATE DISPENSED (MONTH / DAY / YEAR)

PATIENT NAME (LAST NAME)	INITIALS	BIRTH YR	SEX	CARDHOLDER'S NAME (LAST, FIRST, INITIAL)

	NATIONAL DRUG CODE	METRIC QTY	NUMBER	TOTAL REIMBURSEMENT DOLLARS	CENTS	OUT OF STATE BC/BS PLAN CODE
1						
2						

Blue Cross. Blue Shield.

DATE: _____

PAY TO THE ORDER OF: THE PHARMACY ENDORSEMENT APPEARS ON THE REVERSE SIDE

TOTAL REIMBURSEMENT DOLLARS | CENTS

NOT OVER $99.99

DELAWARE TRUST COMPANY
WILMINGTON, DELAWARE
52-13
311

NON-NEGOTIABLE

SIGNATURE OF DISPENSING PHARMACIST INDICATES APPROVAL OF CERTIFICATION ON REVERSE SIDE

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 3
DATE 2/4/87
BILL NO. S.B. 205

SOCIAL AND REHABILITATION SERVICES IDENTIFICATION CARD

No. 916986

THIS ID CARD IS VALID DURING THE PERIOD 01MAR86 TO 31MAR86 FOR MEDICAID SERVICES FOR COUNTY 32. MISSOULA COUNTY

NOT TO BE USED FOR CHECK CASHING PURPOSES

NAME	CLIENT ID.	BIRTHDATE	SEX	INSURANCE	RACE	AFDC
WILLIAM J BUTTERFLY	3119782IT1	07 01 83	M	NO	INDIAN	YES
JOANNE RACINE	4434822241	11 29 48	F	NO	INDIAN	YES
BILLIE J MYO	5177833489	05 24 79	F	NO	INDIAN	YES

STATE OF MONTANA

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 4
DATE 2 4 87
BILL NO. S.B. 205

Testimony of Byron E. Dodd
Pharmacist and Owner of
Smith Drug Co., Missoula

PRESENTATION TO MONTANA SENATE COMMITTEE ON BILL S205

This presentation is being made in support of bill S 205, which is before you, because of the failure of the present system to adequately care for the welfare recipient and compensate the providers of service in a fair and economical manner.

We have suggested to S.R.S. on several ocassions that the type of program outlined in S205 be installed. Copies of these suggestions and the reasons for them are included in the handouts to you. I will highlight only a few of these now, in the interest of time.

The number one reason for switching to the voucher system is to save money. It has been demonstrated in two other states, Alabama and Delaware, that saving of 50%, and more were attained in the area of claims handling. We are not talking about nickels and dimes savings of tax dollars.

The second reason for working for this program reform is to correct the State's failure to properly pay for services rendered in good faith. It is my contention that the pharmacies of this state should not be expected to subsidize the welfare program out of their own pockets. That is the situation now. I have here an example from the files of Smith Drug Co. This is a print-out of the prescriptions of the SRS (or State of Montana) has not paid us for since June 15, 1985. It comes to $14,614. This is money owed to us that undoubtedly will never be paid. We cannot afford this kind of loss and should not have to sustain it. Other stores have similar and worse situations.

The suggestions we have proposed to SRS contain many administrative points which are not included in the legislation before you and should not be there, as they might tie the hands of the administrators and miss some new innovations that would help. One such new practice has just come to our attention this week. It has recently been contracted for in New Jersey to combat some of the same problems we face here. Bob Likewise has just testified concerning this.

I suggest that the Senate and/or House appoint an oversight committee to work with SRS in implementing this program to obtain the most savings possible.

The current payment system loses too many prescriptions thru a variety of errors. Keypunch errors,errors in elegibility files, errors in national drug codes in the state computer system, computer errors in issuing cards to inelegible patients, and the error of not knowing whether a prescription is a duplicate submission or not are just some of the myria of examples. Some of the problems have been alleviated by training programs for keypunch operators. Very much remains to be done and, quite frankly, I can not wait forever for help.

If you have questions, please call me at my store in Missoula, or contact Bob Likewise here in Helena.

I ask you to vote " DO PASS " on this legislation.

Thank You.

SMITH DRUG CO.
MISSOULA MONTANA
MARCH 1986

PROPOSED MODIFICATION OF MEDICAID PAYMENT PLAN

This suggestion is being made due to the total inadequacy of the present system. The pharmacy reimbursement program is unable to track prescriptions and patients to allow compensation for medications and supplies provided to patients.

This is not submitted as a completed program, but rather as a starting point. Modifications and additions are necessary to meet many situations, however I am sure the basic plan can be used with startling savings of money, and elimination of abuses.

Basically the program would operate similarly to the food stamp program in that chits (or some other name applied) would be issued to patients at the county level by a health nurse or other professional in amounts to cover their routine maintainence medications. Additional and emergency needs for chits would be reviewed by the nurse and issued in necessary amounts. This nurse would be attached to the county health department with SRS designated authorities and duties.

The chits obtained in the above manner would be taken to the pharmacy of the clients choice and exchanged for medication in dollar amounts. No refunds or change would be allowed. The pharmacy would then deposit the chits with their daily bank deposits as are food stamps.

This concept would eliminate many of the faults and abuses of the present system.Some of the corrections are as follows:

1) The intake technicians would process 2 areas of coverage at one time instead of 3 separate operations as at present. Opening general assistance and medical coverage with the food stamp optional coverage at the technicians decision would reduce the paper work by approximately half. This would also automatically cause the TAD's to be issued at appropriate times.

2) A professional would evaluate the patient and thus avoid unnecessary and especially inappropriate apointments to doctors and dentists. Many patients seen in the pharmacies are unaware of the seriousness or meaning of some of the symptoms they have. This has resulted in referring them for further treatment when it should have all been taken care of in one appointment.This observation has been verified by Ms. Healy in conversations concerning individual patients. The professional evaluation would also make recommendations on possible drug abusers and alcoholics to move them towards or into corrective programsand restrict their medicaid and state medical spending. These two groups are involved in about 25% of all case loads. Except in Missoula county, there is no one on site to intercept and

evaluate these problem people. A report that is forth-coming from this Missoula group should be considered along with this proposal as the extensive work done supports the need for changes.

3) Prescriptions would be paid for on an immediate basis and it is possible this program can be expanded to include the doctors and dentists as well. I am sure their need is as great as ours in pharmacy. This would aleviate the problems: ineligible patient, " lost in system", duplicate and lost prescription,and ad infinitum, with the present system which must include key-punch errors that are not pharmacist errors.

Doctor and dentist peer review programs would not be interferred with since adequate time is involved to allow patients to obtain the necessary chits to cover the further treatments these programs cover.

The immediate payment for prescriptions would immeasurably help the cash flow problem that is so much a part of the current system. It would also remove most of the serious difficulties now encountered.

4) Elimination of the computer processing of medicaid forms and the reprocessing would save many thousands of dollars. While the program could be put into effect with minimum problem for the state medical funds, it would take more effort to obtain the agreement from the federal program. The proof of operational savings from state operations should make the plan acceptable to others.

The savings from the processing costs can help to offset the added professional staff at the county level needed to oversee and procoss the clients. The professionals at this level will also up-grade the quality of care these patients need and deserve. The proper screening of applicants would reduce operating expenses by an estimated 10%. The costs in the pharmacies of submitting, resubmitting, and resubmitting again of claims for payment would be substantially reduced; and as such these can be applied to savings in the program.

5) As a check at the state level, the chits could have on them the name of the drug dispensed and/or the quantity without all the other information now required on medicaid forms. This added information is of no value to anyone but the pharmacist filling the prescription, this is obvious from the errors that are returned to us.

The careful control of the paper work is a necessary part of the legislative groups work in establishing a program such as this. A legislative oversite committee is probably necessary to maintain this minimum level. The reason for this is that every time information is transcribed it increases the potential for error. This is our basic problem today. We have mountains of information being transcribed several times by people who do not know when they are making errors, and these errors multiply.

6) A staff of perhaps 3 investigators needs to be present in the state offices to do routine field examinations of pharmacies and county offices. Inspections

should include family record systems (which should be mandatory) and be compared to county records. Discrepancies should be explained to everyone's satisfaction or penalties assessed.

7) The elimination of payments for laxatives, antiacids, and weight control medications,except in emergency situations, would substantially reduce cost with low risk to patients. Additionally the limitation of pain medications to 10 days supply per month, except on the review of the professional health care person, would help to control drug dependency problems.

Drug and alcohol abusers should be required to participate in restorative programs as a prerequisite for medical benefits. These programs should utilize blood and urine testing to document problem clients preformance.

8) Statistics have shown that medicaid clients have higher overall prescription size as well as dollar cost type of medication,(eg. Keflex use instead of Ampicillin) than the general population. This can be partially offset by the professional reviewer referring the client to the proper specialty service on the first visit. The second saving would be the supervision of compliance and utilization of medications. An example of misuse I am talking about is the purchase on medicaid of Nicorette every week for months, an impossible use pattern. Other patients are unable due to age or other incompetence to follow directions and therefore do not recover as expected. Substantial savings can be affected by this upgrading of supervision and patient counseling by professionals.

9) The method of calculation of fees is an area of great concern to everyone. It is an area of many possible answers and much savings to both provider and Medicaid. I am suggesting the following plan only if the chit system is used, as the most equitable, in my opinion.

The use of the chit with NO paper work, immediate redemption for cash, and no losses due to eligibility etc. to contend with would make it possible to use a standard fee for everyone of $3.75 plus the acquisition cost of the medication. This plan would apply equally to independent, chain store, hospital, nursing homes, Planned Parenthood or others who supply prescriptions to Medicaid patients.

The supplier would be expected to supply invoices to investigators upon request to reasonably substantiate any charges made. Prices do not fluctuate so violently that it would be necessary or practical to use invoice numbers or lot numbers on chits.

Everyone would save many thousands of dollars by this method. The proposed system would generate enough savings from paper work, and other losses and expenses to offset the reduction in charges and still have an acceptable cash flow. An acceptable cash flow is something we do not have under the present system.

Doctors and dentists fees could be modified under some similar system where they are guaranteed no losses, tho I

would not presume to try to tell them exactly how to organize their pay schedules since I'm not familiar with their problems. Equally I'm sure major savings could be accomplished if no losses are foreseen and cash flow is improved dramatically.

10) An area that needs much attention in the area of abuse of the present system, is the misuse of the emergency room service by medicaid patients. It has been my observationthat people use the emergency room when no bonified emergency exists but for the sole purpose of avoiding waiting in an MD's office for a standard appointment time. The loss to Medicaid for each such visit is approximately $60.00. The screening by the professionals at health centers would eliminate this abuse yet allow bonofied emergencies be taken care of. I do not object to proper ER use, just the blatant abuse thereof.

Other professions and organizations can, I am sure, suggest other areas of abuse, misuse, and redundancies which if eliminated, would save importnat tax dollars. I have not begun to cover all of the areas that are suggestable from pharmacists and would welcome involvement by others to put together the best possible program for everyone.

A suggestion was made to me in conversations with others during the production of this proposal that a task group covering many of those involved, Health department,SRS, Pharmacists, Doctors, Dentists etc.,be organized to install such a program as this in the Missoula area where we have most of the personnel already in place, and use it as a trial program. Final modifications could be developed from this group and possibly then applied to the whole medicaid program.

SUGGESTION FOR INCLUSIONS IN MEDICAID REFORM BILL;

1. Eliminate contract processor of claims.

Reason: a) divided responsibility - constant passing of buck as to why payments are not made or not made on time. b) not feasible to have - computer to access to state computer, therefore when patient files are missing or in error, it is impossible for contractor to obtain information. One network of computers with county terminals and access could eliminate several problems we experience daily.

2. Eliminate duplicate effort in county and state levels that are merely reviews of paperwork which cost time and serve little purpose. Either a caseworker is competent or is not. If the worker is competent give responsibility and fire those that are not able to use discretion.

3. Review all requests for medications and professional services by a professional before issuing authorization for assistance. Eliminate (90%) of all emergence room calls only bonified emergency room situations being paid for. Routine medical services must be through a medical practitioner during regular office hours.

4. Adopt a policy of voucher payment of claims as the fastest and least expensive method of payment. Approximate overall saving of 50% have been achieved.

5. Eliminate payments for diet medications.

6. Eliminae payments for OTC products.

7. Products such as ostomy products (durable goods) would be processed on the same form and pattern as prescription merchandise. If it is necessary for budgetary purposes to separate items this can be done on the computer at state level. If filling for Medicare was proper then transfer to Medicare at state level directly eliminating current delays.

8. Vouchers need to be dated and redeemable at local banks (as are food stamps). We are suggesting that these vouchers should be presented to the bank for deposit rather than submitted to the state for redemption.

9. Review via computer input on individual patient-basis for improper drug utilization. eg. multiple purchases from several drugstores of controlled substances or other medications for possible sale or abuse.

10. Installation of a negative formulary which would list unapproved medications, otc products and diet pills as not being paid for.

11. Establishment of a peer review committee as arbitrator when SRS has declined payment and contesting is in order.

12. Same peer review committee to be empowered to examine delays in dealing with other problems that arise and be able to communicate with legislative committees that are established to watch the function of this expensive operation.

13. All claims remain active until decided for specific reason to be accepted or denied.

14. All claims not paid in 60 days bear interest at prevailing rate for commercial loans. This would include

such items as vouchers returned or questioned or contested, and claims for durable equipment that would necessitate special handling(wheelchairs etc.).
15. Obtain a complete listing of NDC numbers instead of an abreviated list as at present and be required to update the price on at a maximum time basis of 6 weeks after manufacturer announces price change.
16. A pharmacist must be on hand to act as consultant for work in progress.

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 5
DATE 2-4-87
BILL NO. S.B. 205

Testimony of Mr. Carl Sivage
Pharmacist and Operator of the
Medicine Shoppe, Missoula, MT

SENATE 3

Mr. Chairman, and Members of the Committee,

I am here to support S.B.-205 before you.

As a pharmacist with welfare patients accounting for approximately ~~one fifth~~ 1/8th of my business, I am vitally interested in improving a situation that is presently intolerable. Historically Medicaid was less of a problem, but since the current operators have taken over the program, the situation has seriously deteriorated. Substantial losses occur with each new submission of claims.

The price paid by Medicaid for medications is well below what the general public pays. Medicaid pays on a basis of minimum cost available plus a dispensing fee which does not cover the actual costs of Medicaid prescriptions due to the extra paperwork involved. An additional price discrepancy occurs because the State requires an 11% price increase in our cost before being adjusted in the system. When this fact is added to the slow turn around time involved, it places a severe strain on accounts receivable in any store. The use of vouchers will make enough difference in cash flow to make it a practical account to service. Without the initiation of vouchers it is impractical to provide service to our Medicaid clients.

Many elderly as well as handicapped patients need the knowledge acquired by the pharmacist from long term familiarity with that patients problems. This is a part of the pharmacy picture that is not considered in compensation figures, and is ignored in most considerations of value received. Personal involvement with the individual is a vital factor to properly regulate the patient's medication. Therefore it is important to their health that we be able to continue to serve these patients. With the voucher system, we are sure this is possible. Without it , many of us will be forced to drop Medicaid patients.