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Mr. McGinley, Jr + members of IRRC
Please utilize this material for consideration in reducing DPW Regulation #14-479
Thank you

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VALUE DRUG COMPANY SELECTS
CARMEN A. DICELLO, R.PH.
TO SERVE AS
DIRECTOR OF GOVERNMENT AND PUBLIC AFFAIRS

John L. Letizia, R.Ph., Chairman and C.E.O. of Value Drug Company, announces that Carmen A. DiCello, R.Ph., President of DiCello and Associates, Inc., has been selected by the Board of Directors, to serve as Director of Government and Public Affairs.

Known to many of you and your staff members from his 22 years as Executive Director of the Pennsylvania Pharmacists Association, Mr. DiCello will assist Value Drug Company in it's mission "to serve as a support system for all aspects of pharmacy". His reputation as a credible advocate for pharmacy has proven valuable to those who consider optimum health care availability for citizens of the Commonwealth as a priority.

Value Drug Company is a wholesale purchasing cooperative located in Altoona, Pennsylvania. Representing over 1,200 licensed pharmacists and their employees (numbering over 5,000), Value Drug Company also proudly notes that its Board of Directors is composed of eight licensed pharmacists. Their professional perspective on health care assures the formulating of policies beneficial not only to the company, but also to pharmacists and patients, your constituents.

Carmen A. DiCello, R.Ph., can be reached at the following:

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DICELLO & ASSOCIATES INC.
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November 11, 2002

Representative David G. Argall
Appropriations Chairman
Room 245, Main Capitol Building
House Box 202020
Harrisburg, PA 17120-2020

Dear Representative Argall;

Thank you for forwarding the letter you received from Secretary Feather Houstoun regarding the proposed regulation changes to pharmacy reimbursement. Listed below are relevant facts:

(1) The proposed change to the payment formula to AWP minus 15 percent is similar to that of Medicaid's HealthChoices. Following the implementation of this program in the southeast, over 300 pharmacies simply closed or were forced to sell below fair market value.

(2) The studies conducted by the Office of Inspector General have been refuted by the Center for Pharmacoeconomic Studies of the University of Texas at Austin, which legitimately questioned the accuracy of the data and the validity of the methodology. Bottom line: If Ms. Houstoun will visit my pharmacies, I will provide her with irrefutable proof that it is impossible to purchase products at AWP minus 18 percent.

(3) The PricewaterhouseCoopers PwC) study to which Ms. Houstoun refers was NOT, in fact, a bona fide study as required by Act 53-1996. Rather, it was strictly an extrapolation based on reimbursement formulas utilized by other third-party payors. Recent revelations about the practices of some accounting firms casts added doubt about the validity of their analyses.

(4) A bona fide study that was in compliance with Act 53-1996 was completed by Dr. Bruce Siecker, President of Business Research Services, Inc.--NOT an accounting firm--selected by DPW and PACE. This study was based on actual data provided by pharmacists. It concluded that with regard to the calculation of an appropriate fee, in order to just break even, providers would need $7.45. An additional $1.27 would provide some return on investment, raising the total fee to $8.72. This was in 1998. In 2002, that would be approximately $10.00. A consumer price index provision would insure that the fee kept pace with inflation. As you know, the costs of providing high quality pharmacy care

for our patients, your constituents, only ever moves in one direction: **UP**! Even our waste management service had the luxury of being able to cover the increased cost of fuel for its vehicles by simply adding a fuel surcharge to our bill. Pharmacy has no such luxury, and the token 25-cent raise in dispensing fee proposed by DPW is not adequate to compensate for the devastating reduction to AWP.

(5) Private sector prescription plans are NOT negotiated and are issued to prospective providers on a take-it-or-leave-it basis. It is occasionally necessary to refuse to participate, because the reimbursement in insufficient to even cover costs. These plans have no relevance when examining appropriate payments to pharmacy providers by the Medicaid and PACE programs.

(6) While the Department claims to have "taken a long, hard look at our reimbursement formula for pharmaceuticals," it has failed to consider a major component: for every dollar paid to pharmacy providers, **80 PERCENT** is directly returned to the pharmaceutical industry. In addition, net profit for pharmacy providers averages a mere 2 percent compared to 18.5 percent for the pharmaceutical manufacturers. Perhaps the Department could offer a revised proposal that would base cost savings on a proportionately appropriate contribution by the wealthy, powerful pharmaceutical industry.

(7) Ms. Houstoun's statement that the MA program pays more for prescription medication that the PACE program (at the current rate of AWP minus 10 percent) is false. Although this is correct with regard to the fee itself, PACE--unlike MA--has NOT implemented FUL's (federal upper limits) on generic medications, which constitute at least fifty percent of prescriptions dispensed. FUL's discount AWP by 40 to 50 percent! Too often, it is impossible for pharmacy providers to acquire generic products at these prices.

(8) The Department would have saved the Commonwealth taxpayers over $300 million ANNUALLY, on average, had it acted prudently on SB 199 (PN 206). Senator James Rhoades is the prime sponsor of this bill that carves out pharmacy services from Medicaid managed care (HealthChoices). This would allow the Commonwealth to collect MILLIONS OF DOLLARS in rebates from the pharmaceutical manufacturers THAT CAN ONLY BE COLLECTED IN THE FEE-FOR-SERVICE PROGRAM (per federal law). Consequently, the Department has essentially squandered OVER ONE BILLION DOLLARS over the last five years AND has continued to oblige the managed care organizations who have annually requested and received millions in increased payments based on claims that they cannot control the

escalating costs of prescription medications.

(9) The Department is NOT performing its duty to assure access to pharmacy services. This is evidenced by the closings of over 300 pharmacies in the southeast and was a significant factor in the decision by pharmacy providers to bring suit against the Department. MA recipients are a unique group, often requiring higher levels of service (free delivery of medication, longer consultation time, more frequent intervention with physicians, etc.) from pharmacy providers. It is imperative that the Department recognize that pharmacy services are NOT strictly a line item. Health care is an equation, and pharmacy services are the single most cost-effective factor. Properly-managed medication therapy drastically reduces the other more expensive factors in this equation such as physician office visits, hospital stays, emergency room visits, and nursing care. To view pharmacy services as simply a line item is to be penny-wise and TON FOOLISH.

(10) It is not reasonable nor is it rational to attempt to implement these ill-advised proposed regulation changes at the conclusion of a legislative session, particularly with a new in-coming administration.

(11) Several valid recommendations that are NOT punitive to pharmacy providers and their patients merit consideration. One of these is the passage of SB 199 (PN 206). The enclosed information about a carve out for pharmacy services will lend further credence to the merit of such an action. Another recommendation is to FULLY implement Act 53-1996 to finally determine the full true cost of dispensing prescriptions and providing related services as well as allowing a reasonable profit. NO REDUCTIONS TO REIMBURSEMENT SHOULD BE PERMITTED UNTIL THIS IS ACCOMPLISHED!!!

This information can be difficult to assimilate without the opportunity for dialogue. Please contact me if I can assist you with more clarification or additional information.

I can be reached by telephone at (570)-628-3268, by fax at (570)-628-5855 or by e-mail at yorkv@ioach.net.

Thank you for your consideration.

With best regards,

Carmen A. DiCello, R.Ph.
Director, government & Public Affairs, Value Drug Company

cc: John L. Letizia, R.Ph., Chairman & C.E.O., Value Drug
John McGinley, Jr., Chairman, IRRC
Governor Mark Schweiker
Lieutenant Governor Robert C. Jubelirer
Auditor General Robert P. Casey, Jr.
State Treasurer Barbara Hafer
Senator David J. Brightbill
Senator Harold F. Mowery
Senator James J. Rhoades
Senator Robert J. Mellow
Senator Allen G. Kukovich
Representative John M. Perzel
Representative Michael R. Veon
Representative George T. Kenney, Jr.
Representative Bob Allen

Why Pharmacy Should Be Carved Out of Medicaid HMO'S HealthChoices Programs!

-1-

Higher quality, more efficient pharmacist care services in a pharmacy Medicaid fee-for-service program.

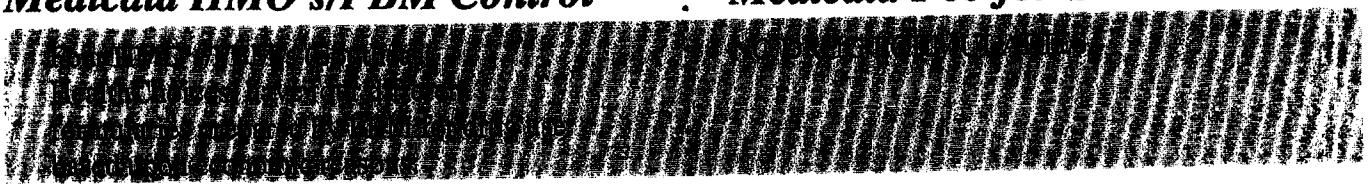
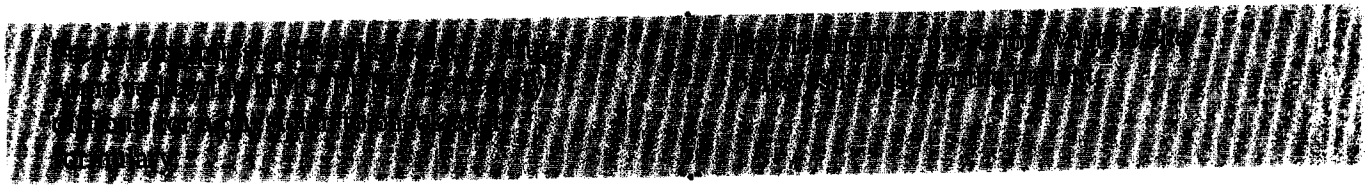
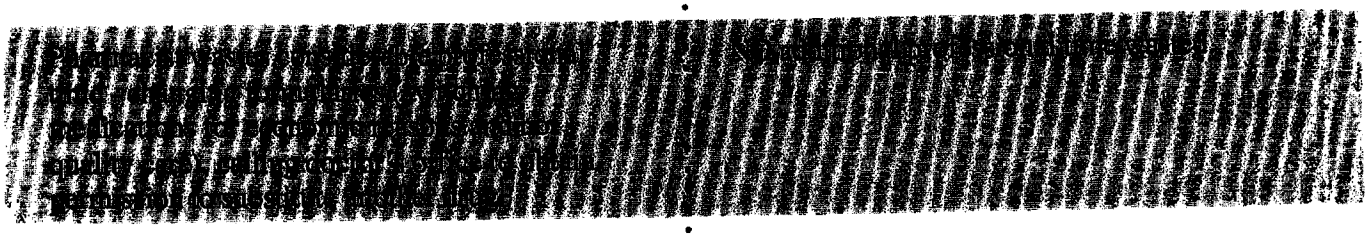
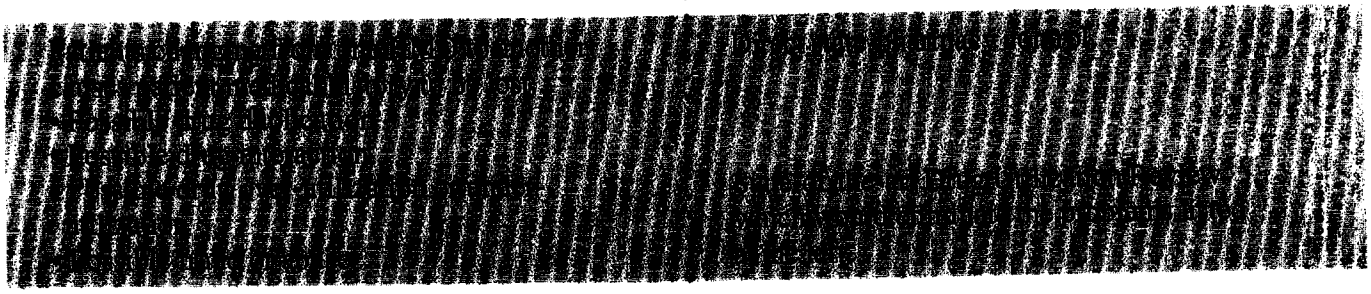
-2-

Greater cost-effectiveness in a pharmacy Medicaid fee-for-service program.

-3-

Independent pharmacies closing since Southeast Medicaid HealthChoices programs.
(Extremely detrimental to patients, since access is severly limited, especially to the elderly.)

Quality Of Pharmacist Care Services

Medicaid HMO's/PBM Control	*Medicaid Fee-for-Service*
	
Formularies exclude patient's medication that have been utilized to control disease.	**All** medications included by **all** drug manufacturers.
	
Prescribing is very retrictive.	**NO** prescribing restrictions.
	
Pharmacist must explain to patient why medication prescibed cannot be dispensed.	Pharmacist dispenses original medication prescribed by physician.
	
<u>Six players -</u> **DPW $'s HMO $'s PBM $'s pharmacies.**	
HMO's and PBM's owned by additional corporation. Wasted - administrative layers.	<u>Two players</u> - **DPW $'s direct to pharmacies.**

Cost-Effectiveness in a Medicaid Fee-For-Service Program

HMO/PBM

Manufacturer drug rebates
go to PBM (Pharmacy Benefit Manager).

HMO's	PBM
Keystone Mercy	Eagle (EMC)/Rite Aid - 100% rebate.
HMA	Eagle (EMC) Rite Aid - 100% rebate.
Health Partners	PAID/Merck - 100% rebate.
Oxford Health	PCS/Eli Lilly - 100% rebate.

No rebates (0%) go to DPW.
Federal law makes it illegal for HMO/PBM to recieve federal rebates.

Discount percentage provided by HMO's to DPW - ???
Need drug component separated.

State provided to HMO's in Southeast HealthChoices an additional $49.6 million (a 7% capitation increase) in the 1998-1999 budget.

HMO's stated they needed addtional dollars because they could not control drug cost escalations.

DPW Fee-for Service

Two drug rebates - 100% - go to DPW.

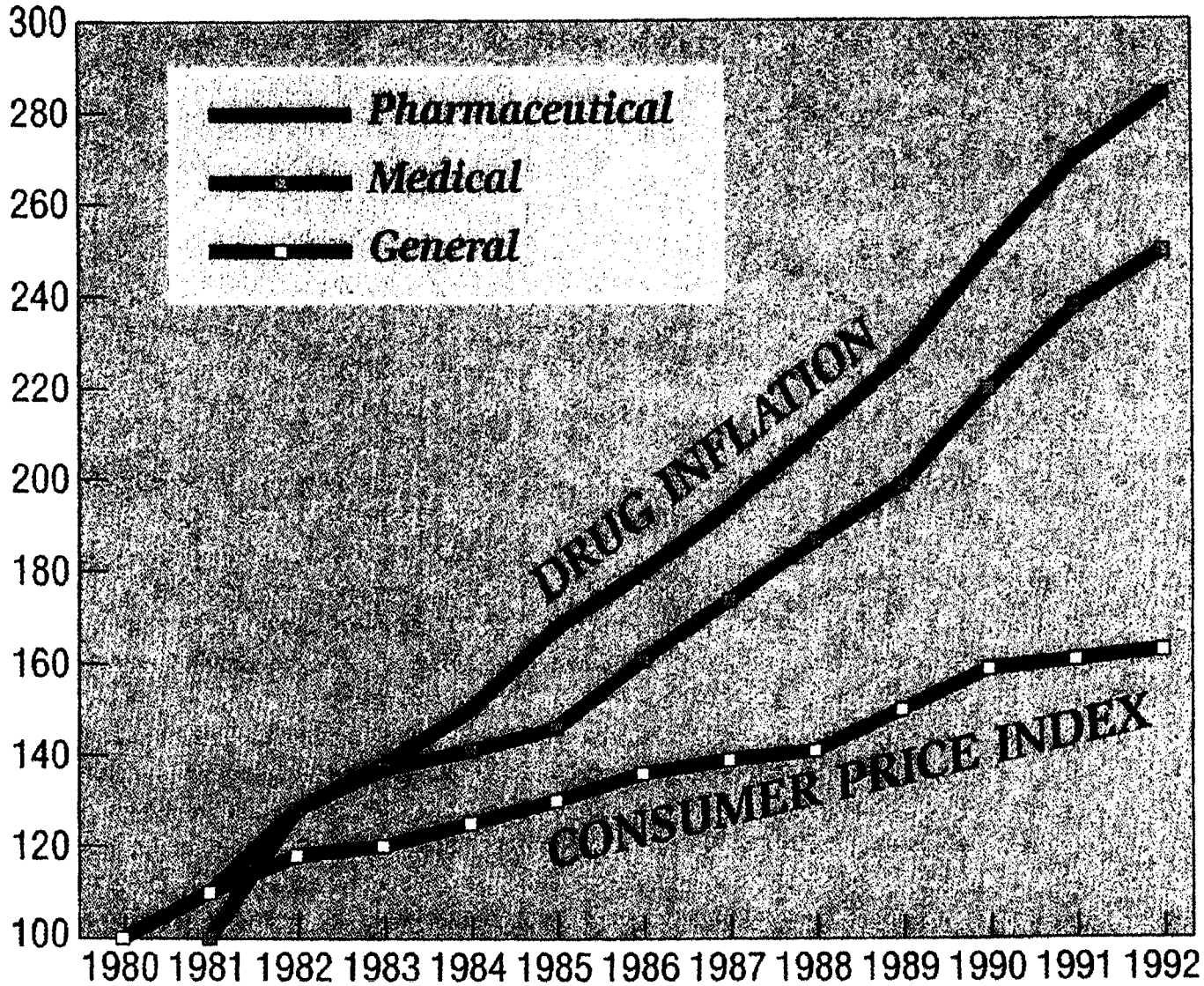
1. **Best Drug Price rebate** - approximately 18%.
2. **Consumer Price Index cap** on drug price increases (price control mechanism).

1994 DPW rebates - over $83 million;
1995 DPW rebates - over $87 million.
1991-1997 - $536 million rebate to DPW.

Average rebate amount per claim was (1995) **$4.67 per prescription.**

NO addtional pharmacy funding due to price control CPI mechanism.

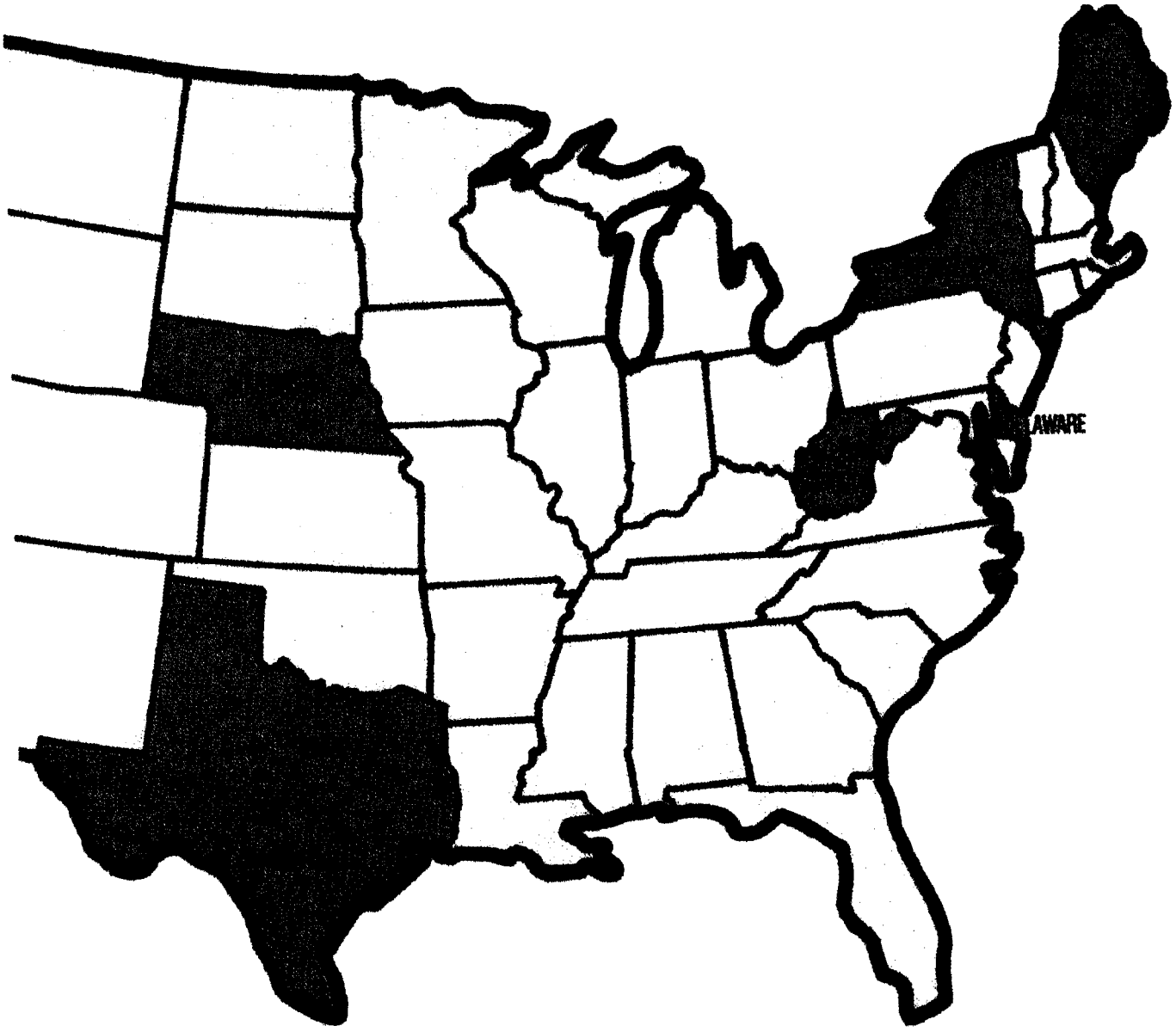
Drug Inflation Far Outpaces General Inflation 1980-1992



Why Independent Pharmacies Are Closing

Southeast HMO/PBM HealthChoices Program and Other Voluntary HMO Programs	Pharmacy Fee-for-Service Program
Lack of access to pharmacies and pharmacist care services.	Cost study survey is completed. When will it be released? Survey included pharmacist care services, overhead, and profit. Business Research did the survey and validated the results.
Serious concerns of proprietary business data going from PBM to parent corporation.	Pharmacy proprietary business information is protected.
Computer systems of PBM are frequently disabled; great difficulty calling lines that are busy. (Patient does not receive medication in a timely manner, if at all!!) Can't process for days!	DPW computer system down infrequently and more able to contact 800 number.
Medical equipment and supplies: • HMO's/PBM's have individual rules. • Patients must go to a specific supplier; accessibility problems. • Some HMO's/PBM's do not contract with any pharmacies.	All pharmacy providers can participate in selling medical equipment and supplies.

States That Have Already Carved Pharmacy Out Of Medicaid HMO Programs:



Many other states are reviewing it - i.e. New Jersey
(all pharmacies presently in a fee-for-service program).

NOTE: IN 2008 - OVER 20 STATES ARE NOT IN IN THE FEE-FOR-SERVICE PROGRAM - MEDICOID HOSPITALIZATION MANAGED CARE!

New York Governor Pataki - March 1, 1998
Texas Governor Bush - 1995

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BENEFITS OF A MEDICAID PHARMACY CARVE-OUT

Centralized Prospective Drug Utilization Review

The primary focus of pharmacy benefit managers (PBMs) prospective drug utilization review programs is to enhance the quality of patient care by encouraging appropriate drug therapy. These systems perform the detection, evaluation, and counseling components of pre-dispensing drug therapy screening. Prospective drug utilization review systems assist the pharmacist in the above functions by identifying potential therapeutic problems at the point of sale. A message describing the problem is sent to the dispensing pharmacist before the prescription is dispensed. If the pharmacist decides not to dispense the medication after receiving a prospective drug utilization review alert, a cost savings message is generated and reported.

Specific problem types detected by PBMs' prospective drug utilization review systems include:

Under-utilization	Direct drug duplication	Early refill
Over-utilization	Drug to drug interactions	Late refill
Drugs contraindicated by diagnosis	Drugs contraindicated by the presence of other drugs	Drug to age complications
Iatrogenic complications	Drug to allergy interaction	Drug to pregnancy complications
Adverse reactions	Treatment failure	Excessive quantity
Therapeutic duplication	Brand certification	Therapeutic appropriateness

Detailed reports generated by PBMs track cost avoidance, frequency of alerts by type and by drug, and identifies and isolates problems. These detailed reporting systems also identify alerts that generate a large number of "false positives." The therapeutic criteria or medical standard can subsequently be altered or deleted to alleviate this problem. The reporting systems also compute and compile the cost savings realized at the individual criterion level. As discussed later, these documented savings can be considerable.

In order to maximize the effectiveness of prospective drug utilization review systems they need to be centralized through a single PBM rather than fragmented through multiple PBMs serving several managed care organizations. A centralized prospective drug utilization review system provides critical patient prescription drug history information to dispensing pharmacists that may have been previously unavailable because it was dispensed by a different pharmacy and processed by another PBM. Centralizing PBM functions enables all Pennsylvania Medicaid pharmacy providers to review comprehensive medication histories on-line, real time and prevent potential therapeutic problems to the Commonwealth's recipients.

The benefits of centralizing prospective utilization review to a single PBM are numerous. For example, a PBM servicing the Oregon Medicaid carve-out program sent nearly 60,000 alerts to pharmacy providers in just over one month (end of December 1997 through the end of January 1998). One-third of those alerts warned of a potentially detrimental drug-drug interaction. The second and third most frequently sent alerts were for therapeutic duplications followed by early prescription refills. Excessive daily dosages and under-utilization warnings were also sent to pharmacy providers.

In addition to preventing potentially dangerous interactions or medication usage below therapeutic levels, a centralized prospective drug utilization review program saves significant money for Medicaid carve-out programs. According to an annual report issued by the State of Oregon, the Oregon Medicaid carve-out program saved more than $800,000 over the period studied. The cost savings averaged $572,000 per month of $14.7 million over the past two and a half years for that particular program. Overall, centralized prospective drug utilization review saved an average of 10.5% of total program dollars for Medicaid carve-out programs administered by a leading PBM.

In a 1994 study, the United States General Accounting Office documented a PBM saved the Maryland Medicaid carve-out program $6,782,899 in the first ten months of operating a point of sale prospective drug utilization review system. This is especially significant considering the operational costs were only

$412,000. (Each dollar spent resulted in savings of over $14.) According to the study, these savings represented over seven percent of pharmacy billings.

Even more significant that the documented drug savings were improved health outcomes gained by prospective drug utilization review preventing hospitalizations and birth defects due to adverse drug reactions. In the ten month period, the GAO documented 14,516 prescriptions with a risk of "severe drug-drug interaction" and 132 with a risk of "serious birth defects" – cancelled due to alerts sent by the PBM serving the Maryland Medicaid carve-out program.

Centralized Retrospective Drug Utilization Review

Centralized retrospective drug utilization review conducted by PBMs on behalf of Medicaid carve-out programs function to improve patient care in numerous ways. First, it may be used as a tool to augment the centralized prospective drug utilization review program by assessing a more comprehensive scope of issues within patient medical histories. A number of Medicaid programs use retrospective drug utilization review committees to evaluate various patient medication histories based on medically accepted standards of practice. Comprised of physicians and pharmacists, these committees are able to identify to identify therapeutic problem areas and pinpoint utilization trends. The committees also address patient care issues by identifying problem areas such as non-compliance, over-or-under-utilization or multiple pharmacy use.

PBMs routinely communicate retrospective drug utilization review concerns to providers through an educational letter intervention process. Special letters are sent to pharmacy providers and physicians highlighting therapeutic problems and recommending appropriate therapeutic alternatives.

Secondly, centralized retrospective drug utilization review programs can serve to compliment or support the functions of various departments and agencies within Pennsylvania. For instance, a centralized retrospective drug utilization review system for the Medicaid program will be capable of creating profiles that DPW and other Pennsylvania compliance agencies can use as a tools to investigate potential fraud, abuse or misuse by providers and recipients.

Thirdly, retrospective DUR can provide significant cost savings. The cost savings in 1997 for three state Medicaid agencies that carved-out their pharmacy program resulted in a 1:4 administrative cost to savings ratio.

Clinical Prior Authorization

PBMs have created clinical prior authorization programs to improve patient care and save considerable public money by decreasing or eliminating inappropriate drug use. In addition to its inherent therapeutic benefits, implementation of these programs results in significant cost savings to state Medicaid programs. According to the Oregon Medicaid program, the administrative cost to savings ratio can exceed 1:15 for Medicaid carve-out programs.

The table below illustrates seven-month cost savings per therapeutic class or situation based on a Medicaid carve-out program with approximately 700,000 recipients:

THERAPEUTIC CLASS/SITUATION	SEVEN MONTH COST SAVINGS
Anti-ulcer	$275,020
Non-steriodal Anti-inflammatory	$186,899
Dosage Limitation (migraine medications)	$ 66,051
Controlled Substances (opiates)	$ 33,989
Inhalers	$ 8,599
Grand Total	**$570,548**

These clinical prior authorization programs are based on medically accepted standards of practice and administered by pharmacists, nurses, pharmacy technicians and specially trained call center personnel. A

number of these programs are tailored for Medicaid carve-out programs and able to identify inappropriate utilization of certain drug classes. PBMs report documented savings in those classes between 50 to 75%.

PBMs using clinical pharmacists to promote medically accepted standards encourage FDA dosage guidelines and prevent misuse of drugs in such classes as anti-ulcers, anti-arthritics and narcotic analgesics have produced a cost:benefit ratio of 1:30 in a Medicaid carve-out population. The resulting cost savings was achieved by discouraging inappropriate drug therapy; not by denying drugs or restricting manufacturers.

Practically all PBMs offer a 24-hour call center to provide clinical pharmacists on call around the clock to ensure that all patients receive appropriate drug therapy anytime of the night or day. The ability to alert pharmacists and patients to serious drug-to-drug interactions, incorrect dosage, and therapeutic duplications can prevent potentially adverse drug reactions and subsequent hospitalizations of Pennsylvania recipients.

PHARMACEUTICAL MANUFACTURER REBATES

The process of recouping rebates is a complicated one that includes the state Medicaid agency and the various drug manufacturers, as well as the HCFA. The PBM can act as DPW's agent to calculate the monies owed, invoice the drug manufacturers and resolve any discrepancies to both parties' satisfaction.

Since there is no time limit for the resolution of disputed invoices, many outstanding claims languish in the disputed category until a state finds the resources to delve into the issue. In the interim, drugs are still dispensed creating an ever-larger backlog to invoice. Some PBMs have created automated processes for dealing with manufacturer's rebates. This enables them to resolve the outstanding backlog and streamline the process, quickly resolving past disputes.

One PBM reported that its state Medicaid clients had over $8,000,000 in outstanding rebate collections prior to having them assist in collection services. In less than one year, a PBM collected 94% of the outstanding rebate dollars for its Medicaid clients.

RELEVANT MEDICAID AND INDUSTRY EXPERIENCE

Several PBMs have extensive experience as Medicaid claims processors or fiscal agents for numerous states. They have experience with Medicaid program requirements in general and with MMIS Certification and SPR Approval practices in particular. This is of vital importance to DPW to ensure preserving maximum federal financial participation (FFP).

Some of these firms are active in policy and standards development by their participation in the Medicaid contractor's Private Sector Group, National Council for Prescription Drug Programs (NCPDP) Medicaid Subcommittee and participation in other NCPDP subcommittees. (NCPDP is the industry's standards setting organization for pharmacy claims administration.) These PBMs maintain current knowledge of HCFA policy, OBRA '90 and '93 mandates, and industry standards affecting prescription claims administration and patient care. They can assist DPW in staying abreast of industry trends and quickly evaluating emerging technologies and medical developments critical to the Pennsylvania Medicaid Program.

MEDICAID PHARMACY CARVE-OUT COST SAVINGS

Prospective Drug Utilization Review

In an annual report to the State of Maryland Department of Health & Mental Hygiene (DHMH), the contracted PBM administering the Medicaid Pharmacy Carve-out documented savings of $9,212,039 during FFY 1996. This represents a monthly average of 5.3% cost savings over the twelve month period. Overall cost savings for FFY 1995 were $9,045,653. Cost savings were calculated by tracking claims which received prospective drug utilization review alerts to determine if the prescriptions were ultimately dispensed. If a claims which generated an alerts was reversed by a pharmacist and not dispensed, the dollar amount that would have been allowed for claim payment was included as cost savings. In addition, claims which received early refill alerts were denied and counted as cost savings by the Maryland DHMH.

According to the State of Oregon Office of Medical Assistance Programs (OMAP), the Medicaid Pharmacy Carve-out prospective drug utilization review program administered by their contracted PBM has saved $7,773,258 during the period October 1997 through July 1998. Cost savings were calculated based on the number of paid claims receiving prospective drug utilization review alerts that were reversed by Oregon pharmacy providers and the number of Early Refill and Therapeutic Duplication claim denials not resubmitted. More than 71,700 prospective drug utilization review alerts were sent to 602 pharmacy providers during July 1998, saving OMAP more than $663,000 in just one month.

Clinical Prior Authorization

The State if Oregon Office of Medical Assistance Programs (OMAP) initiated a clinical prior authorization program through their PBM to improve patient care and save money spent on inappropriate or excessive drug therapies. The prior authorization program focused on six initiatives: continuing acute anti-ulcer therapy, weight reduction therapy, non-sedating antihistamines, nasal inhalers, antifungals and excessive daily dosages. The cost savings resulting from these initiatives during July 1998 was $172,036 for 1,526 prior authorization requests. The cost savings per prior authorization request was $112.74, providing OMAP with a cost:benefit ratio of 1:9. The total cost savings realized by OMAP from October 1996 through July 1998 is $4,940,968 with an average cost savings of $224,589 per month.

Manufacturers Rebate Program and Rebate Resolution

The State of Oregon Office of Medical Assistance Programs selected a PBM to assume the responsibility of their Manufacturers Rebate Program in September 1993. At that time the balance due Oregon over 12 months was $8,603,176. Over the past four years the PBM brought the balance down to $537,190 through their rebate resolution activities. The PBM's rebate resolution efforts during 1997 alone resulted in the collection of more than $443,000 in outstanding rebates.

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Pennsylvania Pharmacists Association

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Original: 2297

August 16, 2002

Robert C. Nyce
Executive Director
Independent Regulatory Review Commission
14th Floor, Harristown 2
33 3 Market Street, Harrisburg, PA 17101

Dear Mr. Nyce:

Enclosed please find a copy of a letter I sent on behalf of the Pennsylvania Pharmacists Association to Suzanne Love, of the Department of Public Welfare, regarding a proposed regulatory change.

We realize that these changes have not as yet been published in the Pennsylvania Bulletin for the IRRC process, but wanted to you to be aware of our opposition to the changes as soon as possible. We understand that they are planning to file these changes in the near future.

As you will see from my letter, we are deeply concerned that the proposed change will not help the situation but will severely impact the Commonwealth and its medication delivery system with irretrievable consequences.

Should the Department continue with its plan to publish these changes, we will follow with additional comments and concerns. Thank you for your consideration.

Sincerely,

Patricia A. Epple, CAE
Executive Director

Pennsylvania Pharmacists Association

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August 13, 2002

Suzanne Love, Director
Bureau of Policy, Budget, and Planning
Office of Medical Assistance Programs
Department of Public Welfare
P.O. Box 2675
Harrisburg, PA 17105

Dear Ms. Love:

Thank you for providing the Pennsylvania Pharmacists Association (PPA) with an advance copy of your proposal to change the regulations regarding the pharmacy reimbursement within the fee-for-service delivery system of medical assistance. (55 Pa. Code Chapter 1121)

Please know that PPA believes firmly in affordable health-care for all individuals. Furthermore, we firmly believe that in order for an affordable health system to exist, such a system must encourage and foster individual responsibility, be prevention-focused and consumer-responsive, and provide for enhanced quality of life for all.

We are obviously very alarmed by this proposed change, as it appears that Pennsylvania is once again looking to pharmacies as the sole source for additional revenues that are needed to address deficits caused by other problems. This is a very short-term, narrowly focused "solution" to ongoing problems and issues within healthcare which desperately need to be addressed. This does not get Pennsylvania any closer to having a prevention and patient focused, safe, reliable delivery system. Setting pricing so that you could be ultimately be eliminating the one area in medication delivery where quality of concern and attention to patient care is paramount is ludicrous. It seems that rather than helping a system that is floundering, everything is being done to place additional burdens and barriers on the system, by further "beating" the proverbial dead horse.

Pharmacies have been accepting, albeit reluctantly, a reimbursement system of AWP-10%, which at that rate even fails to realistically consider the very real costs involved in the delivery system. Perhaps it would be beneficial for all those proposing this change to come out and observe the actual day-to-day workings of a pharmacy. I think you would be greatly surprised. I would then ask that you compare it to a work-day in the life of a pharmaceutical sales or marketing representative or management person. Then ask the question – who is making the money here?

It is now time to also look at the price setting practices of the manufacturers. Pharmacists have absolutely no control over these prices, which continue to rise and rise. Some system cap, rebate program, or oversight as to how these prices are attributed truly needs to be reviewed. This is where the patients and health care plans are really getting hit with increases. Yet absolutely nothing is being done to address this side of the equation. Reducing the drug cost reimbursement to the very providers does not enhance quality of care.

If pharmacies continue losing money, they will not be able to stay in business and while that may not seem to be of great concern to the Commonwealth, it should be. Independent pharmacies are the backbone of medication delivery in this country and still provide a very real and very needed service, particularly in small communities and rural areas. The practical implications need to be faced. One can say that if an independent pharmacy closes, so what – a large retail chain company will come along to service that area. Well, that may or may not be true. There is even increased pressure on these large companies to deliver a profit, especially on those that are publicly traded. Can they realistically replace the many hundreds of independent pharmacies that struggle to remain in business in Pennsylvania? What happens to the Medicaid patient who no longer has convenient access to a pharmacy? Will the chains be willing to accept the ludicrous ever-rising price and reimbursement options? (CVS and Walgreen were among those who recently said " No" in Massachusetts.)

There are those who may believe mail order is an answer; but, they should consider these questions before accepting this at face value:

Who reviews the entire medication regime when mail order is involved?
What happens when certain medications are exposed to intensive temperatures and temperature shifts?
Who provides the personal dosage guidance and consultation?
Can reliable on-time delivery be expected when dosages cannot be skipped?
Is the delivery system tamper-proof?

The federal and state government have spent years and many dollars ensuring a safe and regulated environment in which pharmacies dispense medications and now many of these important guiding principles are being ignored when considering mail order alternatives.

Federal law requires that Pennsylvania pay a fair and equitable price to pharmacies for their service. Have you done a cost of dispensing study in Pennsylvania to show that this change will still meet this requirement? According to estimates, I am hearing from our pharmacists, this rate change would not meet this fair and equitable price test. If you have done such a study, we would certainly appreciate receiving a copy of this.

With profit margins diminishing, pharmacies will have no choice but to refuse to fill those prescriptions that actually cost them money. Then, where will the medical assistance program be? And more importantly, what about the patient?

On behalf of the thousands of hard-working professional pharmacists in Pennsylvania, we appreciate your need to find additional income or reduce expenses for this program and we appreciate your providing us with notice regarding your recommendation. However, this is not the solution. Please consider exploring other opportunities. Your current proposal will not ultimately benefit anyone and could in fact make matters severely worse.

Sincerely,

Patricia A. Epple, CAE
Executive Director

Cc: Senator Harold F. Mowery Jr.
Representative Dennis O'Brien
Peg Dierkers

14-479-24

Pennsylvania Pharmacy Council

1029 Mumma Road • P.O. Box 870 • Camp Hill, PA 17001-0870 • Phone: (717) 731-0600 • Fax: (717) 731-5472

November 1, 2002

Suzanne Love
Director, Bureau of Policy, Budget and Planning
Office of Medical Assistance Programs
Pennsylvania Department of Public Welfare
P.O. Box 2675
Harrisburg, Pennsylvania 17105

Original: 2297

Dear Ms. Love:

On behalf of the Pennsylvania Pharmacy Council, a non-profit organization representing community and chain pharmacies, I request that the Department of Public Welfare withdraw from further consideration of the proposed regulations reducing payments made to pharmacies for services provided to Medicaid recipients. We recommend that the proposed regulations be withdrawn until the Department complies with amendments to the Administrative Code enacted in 1996 requiring an immediate and in-depth study of the cost of dispensing medications to Medicaid patients and the evaluation of payments made to pharmacies based on the results of the study.

On October 4, 2002, the Department of Public Welfare published a notice of proposed rulemaking in the Pennsylvania Bulletin that reduced payments for ingredient costs incurred in dispensing prescriptions from a 10 percent to a 15 percent discount below published average wholesale prices. The Department accompanied this reduction with a proposed $0.25 increase in the fees paid for dispensing medications. The Department estimates that the net impact of the proposed rule will be to reduce payments to pharmacies by approximately $22.5 million in the 2002-2003 fiscal year and by more than $38.5 million in the next fiscal year.

Representatives of the pharmacy community, including the Pennsylvania Pharmacists Association, the Pennsylvania Association of Chain Drug Stores, the Long Term Care Pharmacy Alliance and the Pennsylvania Pharmacy Council, have objected to the proposed reductions in Medicaid payments because the cuts will force many pharmacies to provide services to Medicaid patients at less than actual cost. In response, the Department of Public Welfare claims that even with the payment reductions, pharmacies will receive fair, adequate and reasonable compensation. Unfortunately, because the Department has failed to comply with the General Assembly's 1996 mandate that it conduct an in-depth evaluation of the full cost of dispensing Medicaid prescriptions, information determined by the General Assembly to be necessary to evaluate the adequacy of pharmacy compensation is not available. Until the Department complies with its legal obligations, we believe the best course of action is to withdraw the proposed regulations from further consideration.

The act of June 12, 1996 (P.L.337, No. 53) (71 P.S. § 581-13) added the following provisions to the Administrative Code of 1929:

> Section 2213-A. Pharmacy Reimbursement.
>
> An immediate in-depth pharmacy service study shall be performed by the Department of Aging and the Department of Public Welfare. This pharmacy study shall determine the full cost of filling a prescription and providing pharmacy services, including reasonable profits derived, in the Pennsylvania

Medicaid and PACE programs. This study shall be considered in determining pharmacy reimbursement.

Simply stated, for more than six years the Department has failed to comply with requirements determined by the General Assembly to be necessary to evaluate pharmacy reimbursement. Instead, the Department initiated and then terminated a study that was producing results unsatisfactory to the Department and engaged PricewaterhouseCoopers to perform a study that wholly fails to satisfy the requirements of Section 2213-A.

Following the enactment of Section 2213-A, the Department of Public Welfare and the Department of Aging contracted with Dr. Bruce R. Siecker, President of Business Research Services, Inc., to conduct a detailed pharmacy cost of service study.[i] The BRS Report was based upon detailed surveys of operating costs of 90 pharmacies and follow-up field interviews with 30 of these pharmacies.[ii] The results of the BRS study revealed that the cost to break-even in dispensing Medicaid prescriptions is $7.45 per-prescription and that a reasonable profit allowance should be earned of $1.38 per-prescription. Unfortunately, at the time of the survey, the Department only paid pharmacies on average $5.99 above the cost of ingredients, thereby generating shortfalls of $1.46 per-prescription below costs and $2.84 below costs and a reasonable profit allowance.[iii]

Reacting negatively to the results of the Business Research Services Study, the Department of Public Welfare demanded that Dr. Seicker issue a written modification to his report qualifying its findings because of an allegedly inadequate survey response rate.[iv] Subsequently, the Department terminated its agreement with Business Research Services before an official final report was issued.

After terminating its contract with Business Research Services, the Department contracted with PricewaterhouseCoopers ("PwC") in an attempt to discharge its obligations under Section 2213-A of the Administrative Code. Although a report was issued by PricewaterhouseCoopers in November 1998, the report fails to even minimally satisfy the requirements of Section 2213-A.[v] Rather than conducting an actual study of costs incurred by pharmacies participating in the Pennsylvania Medicaid Program of the type provided by the BRS Report, PwC issued a report based upon gross adjustments to a prior report issued by the Federal Health Care Financing Administration in June 1994.[vi]

The 1994 HCFA Report was conducted to satisfy requirements of Section 4401(d)(4) of the Omnibus Budget Reconciliation Act of 1990 that required a study of Medicaid reimbursement rates paid to pharmacies and imposed a moratorium on rate reductions pending the completion of the study.[vii] The 1994 HCFA Report provided state-by-state estimates of the average overall cost of dispensing prescriptions, exclusive of any allowance for profit.

The 1994 HCFA Report estimated that in 1991, the average cost of dispensing a prescription in Pennsylvania was $5.65. Unfortunately, the 1994 HCFA Report itself did not measure actual state-by-state dispensing costs, but instead relied upon nationwide estimates(prepared between 1988 and 1990) of the cost of dispensing prescriptions in chain and independent pharmacies and adjusted the results based upon the number of chain versus independent pharmacies in each state and a Physician Practice Cost Index.[viii] This relatively imprecise approach was taken in the 1994 HCFA Report because the limited purpose of the HCFA Report was to provide "insight on the adequacy of State payment for pharmacy services" to be used to "provide baseline information for future studies to address in more detail access to pharmacy services by Medicaid recipients."[ix] In fact, after issuance of its 1994 Report when announcing the expiration of the moratorium imposed by the Omnibus Budget Reconciliation Act of 1990, HCFA urged individual state Medicaid Programs to conduct their own more detailed follow-up studies to justify future changes in payments for pharmacy services.[x]

Rather than using the 1994 HCFA Report to provide "baseline information" needed to support a more detailed analysis of the type mandated by Section 2213-A of the Administrative Code and as recommended by HCFA, the Department retained PwC to update the 1994 HCFA Report using two highly imprecise adjustments. First, estimated dispensing costs reported in the 1994 HCFA Report were adjusted for inflation based upon changes in

the Consumer Price Index.[xi] Second, the adequacy of overall payments was measured by subtracting from total payments made to pharmacies participating in the Medicaid Program, estimated dispensing costs (based upon the CPI adjusted results of the 1994 HCFA Report) and the cost of ingredients as estimated based upon a nationwide study prepared by the HCFA's Office of Inspector General in 1997.[xii] Based upon these calculations, PwC concluded that Pennsylvania Medicaid payments in 1997 were approximately equal to total pharmacy costs, but that pharmacies earned an average of $2.23 above costs on brand name prescriptions, but lost an average of $1.57 when dispensing generic medications.[xiii] No estimate was provided, however, regarding the appropriate allowance in excess of costs for reasonable profits.

Even a cursory review of the PwC Report illustrates that it does not provide an in-depth of study of the full cost of providing pharmacy services to Medicaid recipients, including an estimate of reasonable profits, as mandated by Section 2213-A of the Administrative Code. Because the study consists of nothing more than extrapolations on top of extrapolations of prior nationwide research (conducted between 1988 and 1990), clearly the PwC Report does not satisfy the requirement for an in-depth study of the full costs of providing services to Medicaid recipients in Pennsylvania in the late 1990s or thereafter. In particular, because it is based on the 1994 HCFA Report, it incorporates the following fundamental deficiencies of the HCFA Report:

- The 1994 HCFA Report only estimates the cost of dispensing medications, and does not include any allowance for reasonable profits.[xiv] Accordingly, the PwC Report fails to satisfy the requirement of Section 2213-A to determine a reasonable profit allowance.

- The 1994 HCFA Report estimates overall costs of dispensing all prescriptions without any adjustment to reflect actual incremental costs associated with participating in third-party payor programs and the Pennsylvania Medicaid Program. The 1994 HCFA Report acknowledges, however, that there are legitimate additional costs associated with participation in the Medicaid Program.[xv] Section 2213-A also directly requires an evaluation of the costs of participation in the Medicaid Program.

- The 1994 HCFA Report excludes receivable-carrying costs associated with the lag between the dispensing of prescriptions and the receipt of payment from the Department of Public Welfare.[xvi] These are legitimate incremental costs that should be included in the full cost of dispensing prescriptions to Medicaid patients.

- The 1994 HCFA Report does not include adjustments to reflect the inability of pharmacies to collect co-payments from Medicaid recipients.[xvii] Under Federal regulations, pharmacies are prohibited from dispensing prescriptions to Medicaid recipients who claim they are unable to satisfy co-payment obligations. The inability to collect co-payments, especially for some pharmacies serving a high volume of Medicaid patients, may represent a significant additional cost.

- The 1994 HCFA Report does not include additional costs necessary to implement mandatory drug utilization review requirements required for participation in the Medicaid Program that HCFA estimated would increase dispensing costs by up to $1.00 per-prescription.[xviii]

In addition to being based upon the 1994 HCFA Report (which itself is inadequate to satisfy the requirements of Section 2213-A), the PwC Report fundamentally fails to make reasonable adjustments for the changes in pharmacy costs between 1991 and 1997. Because of a shortage of pharmacists, labor costs for pharmacies have increased substantially over the past decade. Even if the 1994 HCFA Report accurately estimated the cost of dispensing medications in 1991, there is no reason whatsoever to conclude that a CPI Adjustment reflects a fair and reasonable modification to accounting for increasing professional labor costs.

Finally, and most significantly, no attempt has been made in the PwC Report to measure the actual costs involved in participation in the Pennsylvania Medicaid Program as mandated by Section 2213-A. Pharmacies

are not involved simply in the sale of goods from inventory, but provide a valuable professional service, the cost of which varies, based upon the needs of individual patients. Because Medicaid patients often tend to have more complicated illnesses, suffer from much higher rates of mental illness and mental disabilities than the general public, and are frequently burdened by linguistic and literacy problems, providing cognitive services to Medicaid patients can be much more expensive than dispensing prescriptions to the general public.[xix] In addition, the Department of Public Welfare imposes burdensome administrative costs on pharmacies not present in dealing with cash-paying customers or many typical health care benefit plans. The Pharmacy Medicaid Manual contains more than four inches of forms, directives, instructions and other administrative requirements that are often difficult to comprehend and confusing to follow. The Department also conducts audits and investigations, which require a dedication of pharmacy resources, far more often than other third-party prescription benefit plans.

In the proposed rulemaking published on October 4, 2002, the Department of Public Welfare attempts to justify payment reductions by comparing rates paid by Medicaid to rates paid by private health care benefit plans. As noted above, however, there are profound and fundamental differences between participation in the Medicaid Program versus private health care benefit plans. Recognizing this important distinction, in 1996 the General Assembly mandated an immediate in-depth study of the full cost of providing pharmacy services to Medicaid patients and required the consideration of the study results in determining pharmacy reimbursement. Significant cuts in the payments to pharmacies should not be considered until the Department satisfies this long over-due obligation. In addition, the Department should estimate the impact of the proposed rate reductions on estimated dispensing costs for 2003, when the proposed reductions will take effect.

Please contact me if you would like copies of the BRS Report, the 1994 HCFA Report or the PwC Report or if we can provide any further information.

Very truly yours,

Melanie Horvath

Melanie Horvath
Executive Director
Pennsylvania Pharmacy Council

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[i] *Cost of Dispensing Pennsylvania PACE and Medicaid Prescriptions,* Business Research Services, Inc., April 1998, (hereafter "BRS Report"). A copy of the BRS Report was included with the Affidavit of Stephen W. Schondelmeyer filed with the Commonwealth Court on May 20, 1999 in the matter of *Pennsylvania Pharmacists Association v. Dept. of Public Welfare,* No. 309 M.D. 1999.

[ii] BRS Report, p. 6-9.

[iii] BRS Report pp. 26-7.

[iv] BRS Report, p. 8 ("Overall, the final sample was insufficient in terms of its size (and therefore precision) and not representative of the population or initial sample of pharmacies. Therefore, the results should not be ... used as the basis for other analysis or policy").

[v] *PACE/PACENET and Medical Assistance Fee-for-Service Pharmacy Services Study,* PricewaterhouseCoopers, November 1988 (hereafter "PwC Report").

[vi] PwC Report, p. 2 ("PwC's approach ... [was] to [r]esearch and review previously published national studies in order to *estimate pharmacy drug acquisition costs ... and the costs to pharmacies for dispensing medications* ... [and] [a]pply these findings and other available data to estimate pharmacies profitability for the PACE/PACENET and Medical Assistance Fee-for-Service programs").

[vii] *Report to Congress, Pharmacy Reimbursement Rates: Their Adequacy and Impact on Medicaid Beneficiaries,* HCFA Pub. No. 03353, June 1994 (hereafter "1994 HCFA Report").

[viii] Figure 2.2, 1994 HCFA Report, p. 29.

[ix] 1994 HCFA Report, pp. ix-xi ("This study provided some insight on the adequacy of State payment for pharmacy services. However, data on actual costs and payments would allow for a better analysis of the adequacy of payment and the implementation of any alternative payment systems. Through either accounting data and/or cost surveys, States could improve their understanding of the differences in the costs of dispensing drugs .... While the lack of detailed data prevented a more definitive study, the State level

analysis presented here provide baseline information for future studies to address in more detail access to pharmacy services by Medicaid recipients").

[x] August 12, 1994 Memorandum from Sally Richardson to DHS Associate Regional Medicaid Administrators. In announcing the expiration of the OBRA 1990 Moratorium, HCFA advised that States should verify the estimated acquisition cost of medications and the reasonableness of dispensing fees by audits and surveys, compilations of data regarding professional salaries and fees; and the analysis of compiled data regarding drug acquisition costs, pharmacy overhead costs, profits and other relevant factors.

[xi] PwC Report, p. 5 ("drug dispensing costs are based on a 1998 National Association of Chain Drug Stores (NACDS) report, which estimated average dispensing costs in 1997 at $6.22 per-pharmacy"). The so-called 1998 NACDS report, however, was merely a column published in an NACDS newsletter adjusting the results of the 1994 HCFA Report using a CPI Adjustment. *See* PwC Report, p. 37.

[xii] PwC Report, p. 5.

[xiii] PwC Report, p. 30, Exhibit 2A.

[xiv] 1994 HCFA Report, p. 17 ("In our analysis of the adequacy of payment ... we focus only on the ingredient and dispensing costs. The omission of profits ... reflects the difficulties in defining or measuring 'typical' profits").

[xv] 1994 HCFA Report, pp.44-5 ("These dollar amounts ... do not include any differential in costs for prescriptions prepared under third party billing. A recent study (Kilpatrick *et al.*, 1992) concluded that third party prescriptions cost more than average and Medicaid slightly more than other third parties").

[xvi] 1994 HCFA Report, p. 20 ("No data are given in the *Lilly Digest* [the source of estimated dispensing costs for independent pharmacies] on third-party receivable carrying costs or third party bad debts. Therefore, for comparability, these two cost categories were subtracted out of the chain pharmacy figures"). The 1994 HCFA Report provides a separate "discount factor" to measure the cost of payment delays (of up to $0.30 per-prescription), but does not include the discount factor in the calculation of dispensing costs. 1994 HCFA Report, pp. 44-8.

[xvii] *Id.* The inability to collect co-payments represent one type of bad debt adjustment not reflected in the 1994 HCFA Report.

[xviii] The DUR rules were enacted in 1992 and substantially revised in 1994. *See* 57 F.R. 49408 *et seq.;* 59 F.R. 48824 *et seq.* The cost of dispensing in the 1994 HCFA Report, however, was based on independent drug store costs as reported in the 1988 through 1990 *Lilly Digests* and chain drug store costs as surveyed in 1990 by Kenneth Schafermayer. 1994 HCFA Report, p. 29.

[xix] One indication of the extent of the difference between Medicaid recipients and the general public is revealed by drug utilization profiles as documented by the 1998 *Novartis Pharmacy Benefit Report.* Although Medicaid patients only receive 11.6% of all prescriptions dispensed, they receive 46.7% of all prescriptions for anti-psychotics, 14.6% of all beta-agonists and gastrointestinal agents and 14.2% of all bronchial steroids.

SAMUEL D. BROG
R.Ph., B.S. Ph.G
EXECUTIVE DIRECTOR

PHILADELPHIA ASSOCIATION
OF RETAIL DRUGGISTS
ESTABLISHED 1898

Original: 2297

Proposed Rule Making
55 PA CODE CH 1121 Pharmaceutical Services

Comments by Samuel D. Brog, R. Ph
Executive Director
Philadelphia Association of Retail Druggist (PARD)

On June 12, 1996 Governor Thomas J. Ridge signed into law Act 1996-53.

Section 2213A Pharmacy Reimbursements. "An *immediate in depth pharmacy services study* shall be *performed by the Department of Aging and the Department of Public Welfare.* This pharmacy *study* shall determine the *full cost* of filling a prescription *and providing pharmacy services, including reasonable profits derived,* in the Pennsylvania Medicaid and Pace Programs. This *study shall* be *considered* in determining pharmacy reimbursement. " (SEE EXHIBIT A).

The Department of Public Welfare did *not* do an immediate in depth *study*. A *report* was published in Nov. 1998 by PriceWaterhouse Coopers (PWC). This study was just a review of other reports done in other States and did not review the costs of filling a prescription in Pennsylvania. This report does not meet the criteria of ACT 1996-53, and feel it should not be considered, especially in year 2003. The PWC report brought up issues such as profit for other items sold to the patients while waiting for a prescription. This has nothing to do with prescription profitability? Many of our Independent pharmacies have no front business.

As to Third Party Prescription plans and their reimbursement rates, they do not come under State and Federal regulation. They are offered as a "take it or leave it" program. More and more stores are rejecting these plans. Both Independent and Chain.

The Department of Public Welfare Health Choice programs effective Feb. 1997 in the Southeastern 5 County region was and still is in many cases reimbursing below acquisition cost, thus the reason why many pharmacies have been forced to close.

A true study done on the cost of dispensing PACE and Medicaid prescription prepared by Dr. Bruce Siecker, President Business Research Services Inc., April 1998.

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- **"Business Research Services Inc., concluded that participating pharmacies on average are presently not breaking even when dispensing Medicaid prescriptions. This conclusion is based on averages. The conclusion derives from the following calculation:**
  - **Pharmacy break even $7.45**
  - **Average pharmacy income 5.99**

  The difference, is a negative $1.46. This is the estimated average deficit per Prescription *after expenses* produced by the average Medicaid Program Prescription.

The study also stated "Total actual pharmacy income is not synonymous with TOTAL COST TO DISPENSE a THIRD PARTY PRESCRIPTION". The two are distinct concepts and should not be used interchangeably. The study recommends adding 4.5% to the net actual product cost and cost of filling a prescription to allow for a reasonable profit.

CLOSING REMARKS!

In all due respect to the Department of Public Welfare, IRRC and our legislators the various studies and reports are mind-boggling. I highly recommend that the Proposed Rule Making 55 PA Code CH 1121 Pharmaceutical Service be withdrawn for reasons outlined in my comments.

With great respect, I believe that with negotiation and discussions which include Pharmacy Representation, that the cost factor of prescription drugs as well as the fee based on overhead and a reasonable profit can be accomplished. The entire concept of Medicaid Pharmaceutical Services must be looked at, including Managed Care and the controlling of drug costs.

ADMINISTRATIVE CODE OF 1929 - OMNIBUS AMENDMENTS
Act of 1996, P.L. 337, No. 53
Session of 1996
No. 1996-53

EXHIBIT A

HB 406

AN ACT

Amending the act of April 9, 1929 (P.L.177, No.175), entitled "An act providing for and reorganizing the conduct of the executive and administrative work of the Commonwealth by the Executive Department thereof and the administrative departments, boards, commissions, and officers thereof, including the boards of trustees of State Normal Schools, or Teachers Colleges; abolishing, creating, reorganizing or authorizing the reorganization of certain administrative departments, boards, and commissions; defining the powers and duties of the Governor and other executive and administrative officers, and of the several administrative departments, boards, commissions, and officers; fixing the salaries of the Governor, Lieutenant Governor, and certain other executive and administrative officers; providing for the appointment of certain administrative officers, and of all deputies and other assistants and employes in certain departments, boards, and commissions; and prescribing the manner in which the number and compensation of the deputies and all other assistants and employes of certain departments, boards and commissions shall be determined," providing for additional duties of the Department of Corrections in relation to prison inmate medical needs, for seasonal farm labor, for powers and duties of the Department of Health relating to anatomical gifts and for a study of pharmacy prices; further providing for the duties of the Department of General Services relating to certain contracts for modular facilities; and making repeals.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. The act of April 9, 1929 (P.L.177, No.175), known as The Administrative Code of 1929, is amended by adding sections to read:

Section 903-B. Payment of Inmate Medical Needs.--(a) The Department of Corrections consistent with and as a supplement to the act of May 16, 1996 (P.L.220, No.40), known as the "Prison Medical Services Act," shall devise and implement a program whereby inmates of State correctional institutions who have medical insurance shall pay for their own medical needs through that insurance.

(b) This program shall be contained in regulations promulgated by the department.

Section 1715. Seasonal Farm Labor.--(a) The Department of Agriculture shall have the power and its duties shall be:

(1) To exercise the powers and duties and perform the duties by law heretofore vested in and imposed upon the Department of Environmental Resources under the act of June 23, 1978 (P.L.537, No.93), known as the "Seasonal Farm Labor Act."

(2) To exercise the powers and perform the duties authorized or imposed upon the Environmental Hearing Board in the "Seasonal Farm Labor Act."

(3) To enforce the provisions of 25 Pa. Code Ch. 177 (relating to seasonal farm labor camps) with the same force and

effect as though the regulations were promulgated by the Department of Agriculture under the "Seasonal Farm Labor Act."

(b) The Secretary of Agriculture shall have the power and the secretary's duty shall be:

(1) To exercise the powers and perform the duties imposed upon the Secretary of Environmental Resources in Chapter 3 of the "Seasonal Farm Labor Act."

(2) To exercise the powers and duties vested by law and imposed upon the Environmental Quality Board as specifically set forth in the "Seasonal Farm Labor Act."

Section 2125. Anatomical Gifts.--In addition to the powers and duties of the Department of Health relating to anatomical gifts, the Department of Health shall continue the rotation of referrals to tissue procurement providers started under 20 Pa.C.S. Ch. 86 (relating to anatomical gifts). Adjustments to such rotation may be made to accommodate new, quality tissue procurement providers accredited by the American Association of Tissue Banks as adjudged under the guidelines published in 26 Pa.B. 2044 (April 27, 1996), and that any hospital may discontinue such rotation for cause.

Section 2. Section 2211.1(d) and (e) of the act, added February 23, 1996 (P.L.27, No.10), are amended to read:

Section 2211.1. Investigation of State Workmen's Insurance Fund.--* * *

(d) The committee shall make a report of its investigation to the General Assembly by [June 30, 1996] **November 30, 1996.**

(e) This section shall expire [June 30, 1996] **November 30, 1996.**

Section 3. The act is amended by adding a section to read:

Section 2213-A. Pharmacy Reimbursement.--An immediate in-depth pharmacy service study shall be performed by the Department of Aging and the Department of Public Welfare. This pharmacy study shall determine the full cost of filling a prescription and providing pharmacy services, including reasonable profits derived, in the Pennsylvania Medicaid and PACE programs. This study shall be considered in determining pharmacy reimbursement.

Section 4. Section 2408(7) of the act, amended July 22, 1975 (P.L.75, No.45), is amended to read:

Section 2408. Procedure for Construction of all Capital Improvements, Repairs or Alterations under the Control of the Department of General Services.--Whenever the General Assembly has made an appropriation or authorized borrowing under the act of July 20, 1968 (P.L.550, No.217), known as the "Capital Facilities Debt Enabling Act," in any budget to the Department of General Services or to any department, board, commission, agency or State supported institution for the construction of a capital improvement, or for the repair or alteration of a capital improvement to be completed by the Department of General Services, to cost more than twenty-five thousand dollars ($25,000), the following procedure shall apply, unless the work is to be done by State employes, or by inmates or patients of a State institution or State institutions, or unless the department, board, or commission to which the General Assembly has appropriated money for the foregoing purposes is, by this act or by the act making the appropriation, authorized to erect, alter, or enlarge buildings independently of the Department of General Services, or under a different procedure:

* * *

(7) (i) The department may invite proposals, either for completely erecting, altering, or adding to any building, or separately for parts of the work, or both on all projects under twenty-five thousand dollars ($25,000) base construction cost.

[All] **Except as provided in paragraph (ii)**, all projects exceeding twenty-five thousand dollars ($25,000) shall be subject to the act of May 1, 1913 (P.L.155, No.104), entitled "An act regulating the letting of certain contracts for the erection, construction, and alteration of public buildings." Whenever the department enters into a single contract for a project, in the absence of good and sufficient reasons, the contractor shall pay each subcontractor within fifteen days of receipt of payment from the department, an amount equal to the percentage of completion allowed to the contractor on account of such subcontractor's work. The contractor shall also require such subcontractor to make similar payments to his subcontractors.

(ii) The department may invite complete proposals from a single prime contractor for the purchase and installation of modular units for:

(A) the institutions operated by the Department of Corrections; or

(B) juvenile facilities operated by the Department of Public Welfare.

* * *

Section 5. The General Assembly directs the Governor on warrant of the State Treasurer to transfer from the appropriation to the Department of Environmental Protection to the Department of Agriculture an amount equal to the amount necessary to fund one Program Specialist position and two Food Inspector positions in the Department of Agriculture for that portion of the present fiscal year beginning December 1, 1995, and ending June 30, 1996.

Section 6. (a) Section 502(c) of the act of June 28, 1995 (P.L.89, No.18), known as the Conservation and Natural Resources Act, is repealed to the extent that it is inconsistent with this act.

(b) Section 506 of the Conservation and Natural Resources Act is repealed.

Section 7. This act shall take effect immediately.

APPROVED--The 12th day of June, A. D. 1996.

THOMAS J. RIDGE

SAMUEL D. BROG
R.Ph., B.S. Ph.G
EXECUTIVE DIRECTOR

PHILADELPHIA ASSOCIATION
OF RETAIL DRUGGISTS
ESTABLISHED 1898

October 28, 2002

Response to Regulatory Analysis Form (SEE ATTACHED FORMS)

RE: REVISION TO REIMBURSEMENT FORMULA for PHARMACEUTICAL SERVICES.
IT SHOULD BE NOTED THAT ONLY 30% OF MEDICAID PRESCRIPTIONS FILLED IN PENNSYLVANIA ARE STILL UNDER THIS ACT. 70% OF ALL MEDICAID PRESCRIPTIONS ARE FILLED UNDER THE HEALTH CHOICE MANAGED CARE PROGRAM.

(11 & 12) Payment to Medicaid pharmacy providers across the United States is comparable to present rates in Pennsylvania. What ***other third-party payers*** are paying is not for **public knowledge and many incentives of these programs which increase their fees are not being taken into account by the Department of Welfare.** The **Chains are able to negotiate** and receive better rates then the ***Independents.*** **The Independents cannot negotiate as a group due to Antitrust regulations. (*SEE EXHIBIT A ATTACHED-PHARMACY PAYMENT AND PATIENT COST SHARING).***

The ***Health Choices Medicaid managed*** health care program rates are lower then Medicaid Fee-for-Service, thus the reason why many pharmacies closed. The Department of Welfare uses this information to show that lower reimbursement rates are being accepted, but does not mention the number of store closings since the initiation of Health Choices.
Most pharmacy closing were due to the fact that they were being paid lower fees that did not cover their actual expenses in the DPW manage care programs in Health Choices **(SEE EXIBIT B- PHARMACIES CLOSED 1997 THUR October 17, 2002)**

(16) If you would check the minutes of the **Medical Assistance Advisory Committee (MAAC), you would find that just an** announcement ***was made at the meeting.***. It does not look like MAAC was involved with the Revision ***prior to the*** announcement

PPA objected to revisions but **offered no** alternatives. PPA was going through a transition period, a change to a new Executive Director. PPA was **notified of the revisions on August 7, 2002, and responded on August 13, 2002.**
(20) Costs for 5 years—What plan does the Department of Public Welfare have for further waivers to **wipe out** the State **fee-for-service plan** and replace with managed care, **Health Choices? Only 30% of prescriptions are presently filled under fee-for-service now.** This would also cause a **lose** of **rebates** to the State by the Drug Manufacturers which presently average in excess of $62,000,000 per year to the State. There is no explanation on how their estimate of savings of over $10,000,000 in the first year was calculated. Taking into account the increase in Hospital & Emergency Care expenses due to a decrease in their Pharmacy Network, we feel that their figures are not accurate and are exaggerated.

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(21) **(SEE EXHIBIT A ATTACHED)** *Reimbursements in other States* - Pharmacy providers **do not willingly** accept lower reimbursements from other 3rd party plans and MCO's. In fact, many Independents and Chains are rejecting Third Party Plans that are offering lower fees than their State Medicaid Plans.
In a State or Federal Government Program the pharmacies have a voice in determining their destiny through legislation and we are exercising our concerns here.
(22 & 23) **Carving out Pharmacy** from Health Choices would generate an increase of 136 million/year in manufacturers rebates and control drug costs. Rebates mandated by OBRA 90 do not apply in managed care State Medicaid programs **(SEE EXHIBIT C ATTACHED)**
(25) This regulation **does not compare** to the reimbursement formulas in other State Agencies. The reimbursements in other states show that Pennsylvania is well within the limits and many States plans pay considerably more than paid in Pennsylvania at present.—**See sheet on Medicaid Reimbursement across the country (EXHIBIT A).**
(26) We must have hearing or informational meetings to clarify the entire concepts of Pharmacy Reimbursements. We all agree that changes must be made, but this proposed regulation is all one sided and it does not take into consideration overhead expenses and a reasonable profit. Concentrating only on the cost of product (of which Pharmacy has no control) without considering Pharmacy costs is not looking at the whole picture.
(30) **Effective date October 1, 2002. - To make this retroactive will cause great harm to Independent & Chain Pharmacy.**

FINAL PROPOSAL

I recommend that this proposed rule making 55 PA Code CH 1121 Pharmaceutical Services be withdrawn for the reasons outlined above. I do believe that with negotiation and discussions which include pharmacy representation, that the cost factor of Prescription Drugs, as well as a fee based on overhead (such as salaries, heat, electric, rent, insurance, computer costs etc.) and a reasonable profit as is required in all professions and businesses, can be accomplished. The entire concept of Medicaid Pharmaceutical services must be looked at, including managed care and the controlling of drug costs.

Sam D. Brog

Samuel D. Brog, R. Ph
Executive Director/PARD

Regulatory Analysis Form

(1) Agency Department of Public Welfare Office of Medical Assistance Program	This space for use by IRRC IRRC Number:
(2) I.D. Number (Governor=s Office Use)	

(3) Short Title

Revisions to reimbursement formula for pharmaceutical services.

(4) PA Code Cite	(5) Agency Contacts & Telephone Numbers
55 Pa. Code 1121	Primary Contact: Joseph E. Concino 772-6114 Secondary Contact: John Hummell 772-6178

(6) Type of Rule Making (Check One)	(7) Is a 120-Day Emergency Certification Attached?
_X_ Proposed Rule Making ____ Final Order Adopting Regulation ____ Final Order, Proposed Rule Making Omitted	_X_ No ____ Yes: By the Attorney General ____ Yes: By the Governor

(8) Briefly explain the regulation in clear and nontechnical language.

The proposed regulations revise the pharmacy reimbursement formula for drugs from the average wholesale price (AWP) minus 10 percent plus a $4.00 dispensing fee to the AWP minus 15 percent plus a $4.25 dispensing fee.

(9) State the statutory authority for the regulation and any relevant state or federal court decisions.

Public Welfare Code, Act of June 13, 1967, P.L. 13 (No. 21), 62 P.S. Section 201(2).

(10) Is the regulation mandated by any federal or state law or court order, or federal regulation? If yes, cite the specific law, case or regulation, and any deadlines for action.

Yes, 42 CFR 447.300 requires that Medicaid agencies' payments to providers be consistent with efficiency, economy and quality of care. In addition, federal regulations require that the drug cost component of the pharmacy reimbursement formula or the estimated acquisition cost (EAC) is the Medicaid agency's best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler in the package size of drug most frequently purchased by providers (42 CFR 447.301).

Regulatory Analysis Form

(11) Explain the compelling public interest that justifies the regulation. What is the problem it addresses?

At its current rate, the Office of Medical Assistance (MA) Programs' reimbursement formula for drugs is now one of the highest payment formulas in the Commonwealth. Other state Medicaid agencies, third-party prescription plans and managed care organizations (MCOs) pay significantly less than the MA Program. Revising the reimbursement to AWP minus 15 percent plus a $4.25 dispensing fee will make MA comparable to other states and third-party plans and MCOs in the Commonwealth. Furthermore, it assures that the pharmacy reimbursement rate is consistent with efficiency, economy and quality of care.

(12) State the public health, safety, environmental or general welfare risks associated with non-regulation.

The MA Program will remain one of the highest payers of pharmaceuticals in the Commonwealth.

(13) Describe who will benefit from the regulation. (Quantify the benefits as completely as possible and approximate the number of people who will benefit.)

The citizens of the Commonwealth will benefit from the regulation.

(14) Describe who will be adversely affected by the regulation. (Quantify the adverse effects as completely as possible and approximate the number of people who will be adversely affected.)

Approximately 3,100 pharmacy providers enrolled in the MA Program and participating in the fee-for-service delivery system will be affected by the lower reimbursement rates.

(15) List the persons, groups or entities that will be required to comply with the regulation. (Approximate the number of people who will be required to comply.)

Approximately 3,100 pharmacy providers.

(16) Describe the communications with and input from the public in the development and drafting of the regulation. List the persons and/or groups who were involved, if applicable.

The pharmacy reimbursement revisions were announced at the Medical Assistance Advisory Committee (MAAC)

on July 25, 2002. MAAC had no comments. Copies of the reimbursement revisions were also distributed to the Pennsylvania Pharmacists Association (PPA) and the Pennsylvania Association of Chain Drug Stores (PACDS). PPA objected to the revisions but offered no alternatives. PACDS submitted no comments.

(17) Provide a specific estimate of the costs and/or savings to the regulated community associated with compliance, including any legal, accounting or consulting procedures which may be required.

None.

(18) Provide a specific estimate of the costs and/or savings to local governments associated with compliance, including any legal, accounting or consulting procedures which may be required.

None.

(19) Provide a specific estimate of the costs and/or savings to state government associated with the implementation of the regulation, including any legal, accounting, or consulting procedures which may be required.

Regulatory Analysis Form

(18) Provide a specific estimate of the costs and/or savings to local governments associated with compliance, including any legal, accounting or consulting procedures which may be required.

Not applicable.

(19) Provide a specific estimate of the costs and/or savings to state government associated with the implementation of the regulation, including any legal, accounting, or consulting procedures which may be required.

The Department estimates the savings in Fiscal Year 2002-2003 for the program to be $22.538 million ($10.861 million in State funds). The annualized savings for Fiscal Year 2003-2004 is estimated at $38.540 million ($17.820 million in State funds).

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Regulatory Analysis Form

(20) In the table below, provide an estimate of the fiscal savings and costs associated with implementation and compliance for the regulated community, local government, and state government for the current year and five subsequent years.

(Dollar Amounts in Thousands)

	Current FY Year	FY +1 Year	FY +2 Year	FY +3 Year	FY +4 Year	FY +5 Year
SAVINGS:						
Regulated Community						
Local Government						
State Government						
Total Savings	$0	$0	$0	$0	$0	$0
COSTS:						
Regulated Community						
Local Government						
State Government	($10,381)	($17,820)	($20,315)	($23,159)	($26,401)	($30,097)
Total Costs	($10,381)	($17,820)	($20,315)	($23,159)	($26,401)	($30,097)
REVENUE LOSSES:						
Regulated Community						
Local Government						
State Government						
Total Revenue Losses	$0	$0	$0	$0	$0	$0

(20a) Explain how the estimates listed above were derived.

The cost estimate is based on revising the Chapter 1121 regulations governing pharmaceutical reimbursements effective October 1, 2002 in the following areas:

1) A $0.25 dispensing fee increase (from $4.00 to $4.25) for all MA prescriptions.

2) A 5 percent increase in the adjustment to the estimated acquisition cost (EAC). The current adjustment to the average wholesaler price (AWP) is AWP minus 10 percent but by the regulation change, it will increase to AWP minus 15 percent.

	FY 02-03	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08
MA-Outpatient	($10,381)	($17,820)	($20,315)	($23,159)	($26,401)	($30,097)

Regulatory Analysis Form

(20b) Provide the past three years expenditure history for programs affected by the regulation.

(Dollar Amounts In Thousands)

Program	FY -3	FY -2	FY -1	Current FY
MA-Outpatient	$622,869	$668,586	$705,750	$649,055

(21) Using the cost-benefit information provided above, explain how the benefits of the regulation outweigh the adverse effects and costs.

The MA Program cannot ignore the trends occurring in other state Medicaid programs, private third party plans, and reimbursement rates accepted by Pennsylvania pharmacies. As a prudent purchaser of medical care for its clients, the Department should be able to obtain rates similar to those of other third party payers and other Medicaid agencies. Therefore, to comply with federal regulations and to make the pharmacy payment policies for the MA Program consistent with other private and public payment policies, the Department is proposing these changes.

(22) Describe the nonregulatory alternatives considered and the costs associated with those alternatives. Provide the reasons for their dismissal.

(23) Describe alternative regulatory schemes considered and the costs associated with those schemes. Provide the reasons for their dismissal.

Regulatory Analysis Form

(20b) Provide the past three year expenditure history for programs affected by the regulation.

Program	FY -3	FY -2	FY -1	Current FY

(21) Using the cost-benefit information provided above, explain how the benefits of the regulation outweigh the adverse effects and costs.

Pharmacy providers willingly accept lower reimbursements from other third party plans and MCOs. The MA Program, with one of the largest pharmacy budgets in the Commonwealth, should be entitled to the same discounts as other providers of prescription drug benefits.

(22) Describe the nonregulatory alternatives considered and the costs associated with those alternatives. Provide the reasons for their dismissal.

None.

Regulatory Analysis Form

(23) Describe alternative regulatory schemes considered and the costs associated with those schemes. Provide the reasons for their dismissal.

None.

(24) Are there any provisions that are more stringent than federal standards? If yes, identify the specific provisions and the compelling Pennsylvania interest that demands stronger regulation.

No.

(25) How does this regulation compare with those of other states? Will the regulation put Pennsylvania at a competitive disadvantage with other states?

This regulation will be comparable to the reimbursement formulas of other state Medicaid agencies of comparable size and scope.

(26) Will the regulation affect existing or proposed regulations of the promulgating agency or other state agencies? If yes, explain and provide specific citations.

No.

(27) Will any public hearings or informational meetings be scheduled? Please provide the dates, times, and locations, if available.

Regulatory Analysis Form

No.

(28) Will the regulation change existing reporting, record keeping, or other paperwork requirements? Describe the changes and attach copies of forms or reports which will be required as a result of implementation, if available.

No.

(29) Please list any special provisions which have been developed to meet the particular needs of affected groups or persons including, but not limited to, minorities, elderly, small businesses, and farmers.

Not applicable.

(30) What is the anticipated effective date of the regulation; the date by which compliance with the regulation will be required; and the date by which any required permits, licenses or other approvals must be obtained?

October 1, 2002.

(31) Provide the schedule for continual review of the regulation.

Not applicable.

EXHIBIT A

Pharmacy Payment and Patient Cost Sharing

State	Dispensing Fee	Ingredient Reimbursement Basis	Copayment
Alabama	$5.40	AWP-10%; WAC+9.2%	$0.50 - $3.00
Alaska	$3.45	AWP-5%	$2.00
Arizona*	-	-	-
Arkansas	$5.51	AWP-10.5%	$0.50 - $3.00
California	$4.05	AWP-5%	$1.00
Colorado	$4.00	AWP-11% or WAC+18%, whichever is lowest	G: $0.75, B: $3.00
Connecticut	$4.10	AWP-12%	None
Delaware	$3.65	AWP-12.9%	None
DC	$3.75	AWP-10%	$1.00
Florida	$4.23-$4.73	AWP-13.25%; WAC+7%	None
Georgia	$4.63 + $0.50 for G or P	AWP-10%	G/P: $0.50, B/NP: $0.50 - $3.00
Hawaii	$4.67	AWP-10.5%	None
Idaho	$4.94 ($5.54 for unit dose)	AWP-12%	None
Illinois	G: $5.10, B: $4.00	AWP-11%	$1.00
Indiana	$4.00	AWP-10%	$0.50 - $3.00
Iowa	$5.17	AWP-10%	$1.00
Kansas	$4.50	AWP-10%, IV AWP-50%, blood AWP-30%	$2.00
Kentucky	$4.50	AWP-10%	None
Louisiana	$5.77	AWP-13.5% (AWP-15% for chains)	$0.50 - $3.00
Maine	$3.35 (+extra fees for compounding)	AWP-10%	$0.50 - $3.00
Maryland	$4.21	Lowest of :WAC+10%, direct+10%, AWP-10%	$1.00
Massachusetts	$3.00	WAC+10%	$0.50
Michigan	$3.72	AWP-13.5% (1-4 stores), AWP-15.1% (5+stores)	$1.00
Minnesota	$3.65	AWP-9%	None
Mississippi	$4.91	AWP-10%	$1.00
Missouri	$4.09	AWP-10.43%, WAC+10%	$0.50 - $2.00, $5.00 for some 1115 pop.
Montana	$2.00 - $4.20	AWP-10%, direct price for some labelers	G: $1.00, B: $2.00
Nebraska	$3.84 - $5.05	AWP-10%	$1.00
Nevada	$4.76	AWP-10%	None
New Hampshire	$2.50	AWP-12%	G: $0.50, B: $1.00
New Jersey	$3.73 - $4.07	AWP-10%, WAC+30%, AAC for injectables	None
New Mexico	$4.00	AWP-12.5%	None (except CHIP and working disabled)
New York	B: $3.50 G: $4.50	AWP-10%	G: $0.50, B: $2.00
North Carolina	$5.60	AWP-10%	$1.00
North Dakota	$4.60	AWP-10%	None
Ohio	$3.70	AWP-11%	None
Oklahoma	$4.15	AWP-12.0%	$1.00 - $2.00
Oregon	Retail: $3.50 Inst./NF: $3.80	AWP-13%	None
Pennsylvania	$4.00	AWP-10%	$1.00 ($2.00 for GA)
Rhode Island	OP: $3.40, LTC: $2.85	WAC+5%	None
South Carolina	$4.05	AWP-10%	$3.00
South Dakota	$4.75 ($5.55 for unit dose)	AWP-10.5%	$2.00
Tennessee*	-	-	-
Texas	(EAC+$5.27)/0.98 & delivery fee	AWP-15% or WAC+12%, whichever is lowest	None
Utah	$3.90-$4.40 (based on area)	AWP-12%	$1.00, max $5.00/mo.
Vermont	$4.25	AWP-11.9%	$1.00 - $2.00
Virginia	$4.25	AWP-9%	$1.00
Washington	$4.14-$5.12 (based on annual # of Rx)	AWP-11%	None
West Virginia	$3.90 (+ extra $1.00 for compounding)	AWP-12%	$0.50 - $2.00
Wisconsin	$4.88 (to a maximum $40.11)	AWP-11.25%	$1.00, max $5/recip/pharm/mo
Wyoming	$5.00	AWP-11%	$2.00

WAC = Wholesalers Acquisition Cost; AWP = Average Wholesale Price; EAC = Estimated Acquisition Cost; AAC= Actual Acquisition Cost; G = Generic; B = Brand Name; OP = Outpatient; LTC = Long Term Care; P = Preferred; NP = Non-Preferred.

*Within Federal and State guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.

Source: As reported by State drug program administrators in the 2001 NPC Survey.

EXHIBIT B

Southeastern 5 County region Pharmacy closures since the Inception of Health Choices- Phila., Bucks, Chester, Delaware and Montgomery Counties.

license_no	pmt_name
PM013340L	KEYSTONE DRUG STORE
PM410008L	APC PHARMACY,INC
PM410025L	AIKENS PHARMACY INC
PM410050L	ALLENS LANE PHARMACY
PM410058L	HATHAWAY PHARMACY INC
PM410078L	ARONIMINK PHARMACY
PM410108L	BALWYNNE PHARMACY
PM410117L	450 PHARMACY INC
PM410120L	BARNETT PHARMACY
PM410128L	BATTIN AND LUNGER PHARMACISTS
PM410142L	CORSONS PHARMACY INC
PM410169L	BERGMAN PHARMACY
PM410172L	BERNABEIS PHARMACY
PM410175L	RITE AID PHARMACY 831
PM410181L	BETH-PIKE PHARMACY INC
PM410182L	BETHAYRES PHARMACY
PM410210L	BLUE BELL PHARMACY INC
PM410221L	HARRY J BOMBERGER DRUGGIST
PM410269L	BROG PHARMACY,INC
PM410328L	CADILLAC PHARMACY
PM410339L	CAMPS PHARMACY
PM410341L	CANNINGS DRUG STORE
PM410354L	CARRIAGE APOTHECARY
PM410389L	CHAPEL PHARMACY
PM410395L	THE CHEMIST SHOP
PM410399L	CHESTER ARMS PHARMACY
PM410414L	CLARKS DRUG STORE
PM410422L	CLINTON PHARMACY
PM410427L	BOOKBINDER PHARMACY
PM410430L	RIOS PHARMACY
PM410431L	COHENS MASTER PHARMACY
PM410441L	COLLINGDALE DRUG STORE
PM410443L	COLONIAL PHARMACY
PM410449L	MASCIOS COLWELL ARMS PHARMACY
PM410450L	COMLY PHARMACY
PM410465L	CONNORS PHARMACY INC OF BERWYN
PM410468L	RITE AID PHARMACY 1410
PM410491L	COULSONS PHARMACY
PM410523L	CHLETCOS APOTHECARY
PM410536L	DAROSE PHARMACY
PM410538L	THE SCRIPT SHOPPE
PM410543L	DaVIDS PHARMACY
PM410556L	DAVISVILLE PHARMACY INC
PM410578L	FALLS MEDICAL CENTER PHARMACY
PM410582L	ECKERD DRUGS 6277
PM410624L	DRUG CENTER
PM410629L	DUBOWE PHARMACY CORP
PM410717L	FABIANS PHARMACY
PM410725L	ECKERD DRUGS 8668
PM410737L	MICHAEL'S PHARMACY
PM410742L	ROCCOS PHARMACY
PM410816L	FRANTZ DRUG STORE
PM410826L	QUIK-SCRIPT DRUGS
PM410841L	PENNSYLVANIA RETIRED PERSONS PHY INC
PM410845L	KENSINGTON PHARMACY
PM410855L	INNOVATIVE PHARMACY SERVICES
PM410875L	JAR PHARMACY
PM410878L	RITE AID PHARMACY 1182
PM410888L	KENSINGTON PHARMACY JR

license_no	sort_name
PP410900L	GORDONS PHARMACY
PP410920L	GREENS PHARMACY
PP410921L	THE DRUG STORE INC
PP410929L	GODSHALL PHARMACY INC
PP410930L	GROSS & PEREZ PHARMACY INC
PP410959L	HALS PHARMACY
PP410963L	CONCORDVILLE PHARMACY
PP411003L	MEDCO PHARMACY
PP411020L	THE MEDICINE SHOPPE
PP411023L	HENNESSYS PHARMACY
PP411024L	EXPRESS DRUGS
PP411041L	HIGHLAND PARK PHARMACY
PP411083L	HOLLYWOOD DRUGS INC
PP411093L	HYLINSKI PHARMACY
PP411097L	E HOWELLS PHARMACY
PP411105L	HUNSICKERS PHARMACY INC
PP411108L	GERHART PHARMACY
PP411110L	HYATT PHARMACY
PP411164L	JOHN F DETTREY PHARMACY
PP411155L	JONES PHARMACY
PP411190L	JUNIATA APOTHECARY INC
PP411245L	KIRKLYN PHARMACY
PP411292L	LONGAKER PHARMACY
PP411351L	LEEDOM AND WISSLER PHARMACY
PP411357L	ECKERD DRUGS 8634
PP411363L	LESIT PRESC PHARMACY
PP411380L	ECKERD DRUGS 6237
PP411394L	LIPSCHULTZ PHARMACY
PP411412L	LONG LANE COURT PHARMACY
PP411421L	LOVE PHARMACY INC
PP411426L	LUCKY PHARMACY INC
PP411452L	MAKEFIELD PHARMACY
PP411463L	MANIS PHARMACY
PP411469L	ECKERD DRUGS 6260
PP411480L	BRENSINGERS PHARMACY INC
PP411491L	MARTINS PHARMACY INC
PP411494L	RITE AID PHARMACY 550
PP411506L	MAXWELL DRUG STORE
PP411516L	MASCIO'S PHARMACY
PP411536L	WYOMING AVENUE APOTHECARY INC
PP411560L	ECKERD DRUGS 6321
PP411588L	MILLER PHARMACY
PP411599L	LOUIS MILNER APOTHCARY INC
PP411624L	MORGANS PHARMACY
PP411629L	MORRIS PARK PHARMACY
PP411671L	BERTOLINO PHARMACY
PP411675L	NEEDLE AND BOONIN PHARMACY INC
PP411678L	GEORGES PHARMACY
PP411681L	ECKERD DRUGS 6324
PP411698L	RITE AID PHARMACY 815
PP411704L	ECKERD DRUGS 6237
PP411711L	ZEOCK PHARMACY
PP411735L	WHITMAN PHARMACY
PP411745L	OVERBROOK PARK PHARMACY INC
PP411747L	ECKERD DRUGS 6244
PP411761L	CROSSING PHARMACY
PP411771L	PARK TOWNE PHARMACY INC
PP411777L	PARKWAY DRUGS INC
PP411781L	DIVERSIFIED PRESCRIPTION DELIVERY
PP411794L	J PAUL SHEA PHARMACY
PP411808L	PENN TOWERS PHARMACY INC

license no	soft name
PP4118161	ECKERD DRUGS 6498
PP4118331	RITE AID PHARMACY 4723
PP4118481	BUDDYS PHARMACY
PP4118521	PITCHERELLAS PHARMACY
PP4118871	THE MEDICINE SHOPPE PHARMACY 1509
PP4119281	RITE AID PHARMACY 4725
PP4119321	ECKERD DRUGS 6070
PP4119481	RADOS PHARMACY
PP4119521	RAKERS PHARMACY
PP4120441	ECKERD DRUGS 6342
PP4120521	ECKERD DRUGS 8668
PP4120611	RENZULLIS PHARMACY
PP4120821	MARIOS PARK RIDGE PHARMACY
PP4120871	RIOS PHARMACY
PP4120991	ROBBINS AVE PHARMACY
PP4121001	ALVIN DRUG CENTER
PP4121061	ROBERTS PHARMACY
PP4121431	ROSS PHARMACY
PP4121511	ROWLAND DRUG STORE
PP4121591	RUBENSTEIN PHARMACY INC
PP4121671	INDIAN VALLEY PHARMACY
PP4121901	MARIOS SANDY HILL PHARMACY
PP4122211	RITE AID PHARMACY 184
PP4122641	SHEAS PHARMACY INC
PP4122711	SHERBY PHARMACY & MEDICAL EQUIP INC
PP4123051	FRANK J SITKO INC
PP4123351	GROVE PHARMACY
PP4123651	RITE AID PHARMACY 941
PP4123781	STANOR PHARMACY
PP4123971	BRUDERS PHARMACY
PP4124501	DOCTOR AVENUE PHARMACY
PP4124851	SUN PAY DRUGS
PP4125081	SUNSET APOTHECARY,INC
PP4125151	MARIOS SWEDE SQUARE PHARMACY
PP4125281	RITE AID PHARMACY 2135
PP4125491	ECKERD DRUGS 8716
PP4125571	RITE AID PHARMACY 1145
PP4125601	WALTER O THOMAS PHARMACY
PP4125911	ECKERD DRUGS 6137
PP4126601	ECKERD DRUGS 6130
PP4126611	ECKERD DRUGS 6133
PP4126961	TILDEN PHARMACY INC
PP4127171	THE MEDICINE SHOPPE
PP4127191	AMERICAN PHARMACY
PP4127371	2601 PHARMACY
PP4127411	UNION AVENUE PHARMACY
PP4127741	VINKS PHARMACY INC
PP4128111	NORTH COVENTRY PHARMACY
PP4128211	CVS PHARMACY 624
PP4128331	WELDON PHARMACY,INC
PP4129071	WHITEHALL PHARMACY
PP4129091	RITE AID PHARMACY 1275
PP4129601	YARDLEY PHARMACY
PP4129641	WAYNE PHARMACY
PP4129811	RITE AID PHARMACY 4936
PP4129971	MED-AID PHARMACY INCORPORATED
PP4130021	RITE AID PHARMACY 829
PP4130451	ECKERD DRUGS 6165
PP4130651	ECKERD DRUGS 6181
PP4130671	AMBLER PHARMACY
PP4131121	ARROW PRESCRIPTION CENTER

license_no	esti_name
PP4131361	UNION DISCOUNT PHARMACY
PP4131421	ECKERD DRUGS 8646
PP4131461	MODEL PHARMACY PHILA COL OF PHCY SC
PP4131481	RITE AID PHARMACY 1204
PP4131501	FRANK E MORGAN & SONS INC
PP4131521	NORTH PENN PHARMACY INC
PP4131601	THE PHILADELPHIAN PHARMACY
PP4131711	MARCHWOOD PHARMACY
PP4131761	RITE AID CENTERS OF PHILA INC 559
PP4132101	WAYNE APOTHECARY
PP4132221	K AND S PRESCRIPTION CENTER INC
PP4132391	RITE AID PHARMACY 448
PP4132541	ECKERD DRUGS 6252
PP4133051	ECKERD DRUGS 6891
PP4133581	RITE AID PHARMACY 925
PP4133691	RITE AID PHARMACY 811
PP4133721	MED CTR PHCY CHESTER CO INC
PP4134091	MEDI SAVE PHARMACY
PP4134381	RICHMOND MEDICAL PHARMACY INC
PP4134591	HUNTINGDON VALLEY PHARMACY INC
PP4134621	RITE AID PHARMACY 854
PP4134901	RITE AID PHARMACY 455
PP4135061	SHOPRITE DRUGS OF BENSALEM
PP4135331	RITE AID PHARMACY 540
PP4135361	RITE AID PHCY OF ADAMS AVE INC 820
PP4135401	ALPINE DRUGS INC
PP4135441	THATCHERS DRUGS AND MED EQUIP OF
PP4135681	RITE AID PHARMACY 1356
PP4135771	ECKERD DRUGS 6221
PP4135901	NORTH PENN DRUGS
PP4135951	RITE AID PHARMACY 1039
PP4136021	SHELLYS PHARMACY #6
PP4136081	RITE AID PHARMACY 824
PP4136091	RITE AID PHARMACY 883
PP4136101	RITE AID PHARMACY OF MALVERN INC 888
PP4136151	RITE AID PHARMACY 920
PP4136451	C & B PHARMACY INC
PP4136461	ECKERD DRUGS 8776
PP4136721	THE MEDICINE SHOPPE
PP4136921	APOTHECARE INC
PP4137131	PHARMOR 525
PP4137181	THE APOTHECARY JAR
PP4137201	DRUG FAIR
PP4137551	EAGLE PHARMACY
PP4137621	ECKERD DRUGS 6532
PP4137871	SUBURBAN APOTHECARY
PP4137881	ECKERD DRUGS 6340
PP4137901	CITY AVENUE HOSPITAL APOTHECARY
PP4137991	ECKERD DRUGS 6350
PP4138011	PATHMARK PHARMACY
PP4138211	WEIS PHARMACY 124
PP4138821	RITE AID PHARMACY 2193
PP4138991	MONTGOMERY APOTHECARY
PP4139251	ECKERD DRUGS 6376
PP4139401	MARCUS FOSTER PHARMACY-LEHIGH
PP4139531	RITE AID PHARMACY 3415
PP4139621	HANAN PHARMACY
PP4139781	BANBURY PHARMACY
PP4139841	ECKERD DRUGS 6343
PP4139871	PHARMACY PLUS LTD
PP4140301	ECKERD DRUGS 6358

license no	sort_name
PP414054L	RITE AID PHARMACY 1847
PP414058L	ECKERD DRUGS 6337
PP414072L	NMC HOMECARE
PP414106L	ECKERD DRUGS 6364
PP414109L	PHARMERICA
PP414110L	ECKERD DRUGS 6361
PP414177L	PHARMOR 164
PP414222L	THE MEDICINE SHOPPE
PP414227L	ECKERD DRUGS 6390
PP414236L	ECKERD DRUGS 6651
PP414253L	RITE AID PHARMACY 2273
PP414262L	PHARMOR 223
PP414271L	LEHIGH APOTHECARY INC
PP414300L	ECKERD DRUGS 6668
PP414301L	STADTLANDERS PHARMACY
PP414330L	ECKERD DRUGS 6670
PP414338L	ECKERD DRUGS 6683
PP414362L	JOEL FAMILY PHARMACY
PP414386L	ECKERD DRUGS 6686
PP414406L	RITE AID PHARMACY 2576
PP414408L	CAPSTONE PHARMACY SERVICES
PP414428L	GERMANTOWN FAMILY PHARMACY
PP414441L	ECKERD DRUGS 6681
PP414442L	RITE AID PHARMACY 2595
PP414489L	RITE AID PHARMACY 2730
PP414508L	OMNICARE PHARMACY SVCS-PHILADELPHIA
PP414523L	NCS HEALTHCARE SOUDERTON
PP414527L	ECKERD DRUGS 6688
PP414543L	DRUG EMPORIUM 226
PP414580L	HAV MOR PHARMACY
PP414582L	MEDICAL ASSOCIATES OF N.E. PHILA INC
PP414585L	SAUNDERS PHARMACY
PP414587L	PHARMERICA
PP414597L	HOME HEALTH CORPORATION OF AMERICA
PP414606L	KMART PHARMACY 3187
PP414641L	RITE AID PHARMACY 2600
PP414664L	ECKERD DRUGS 6119
PP414699L	IMPACT CENTER OF ABINGTON
PP414704L	DURANT MEDICAL PHARMACY SERVICES
PP414717L	TENET APOTHECARY
PP414723L	RITE AID PHARMACY 2705
PP414725L	METRO PHARMACEUTICALS INC
PP414728L	CHELTEN PHARMACY INC
PP414749L	FRONT STREET PHARMACIA
PP414752L	INFUSX PHARMACY
PP414755L	DRUG EMPORIUM 235
PP414762L	MARIO'S COLLEGEVILLE PHARMACY
PP414766L	PHARMACY EXPRESS
PP414772L	ECKERD DRUGS 8661
PP414775L	BENSALEM BOULEVAD PHARMACY
PP414785L	J & L PHARMACY
PP414790L	NEIGHBORCARE
PP414791L	THE MOORE ST PHARMACY INC
PP414800L	NEIGHBORCARE
PP414806L	INFU-TECH INC
PP414808L	ECKERD DRUGS 8665
PP414828L	NEIGHBORCARE
PP414846L	DRUG EMPORIUM 236
PP414854L	TODAYS PHARMACY
PP414855L	CENTRE CITY PHARMACY
PP414862L	VN PHARMACY

61

license_no	sort_name
PP[illegible]4565L	HAGURA PHARMACY
PP[illegible]4867L	THE MEDICINE SHOPPE
PP[illegible]4872L	RX SERVICES
PP[illegible]4907L	FAMILYMEDS LTC PHARMACY
PP[illegible]4912L	UNIVERSITY SQUARE DRUG
PP[illegible]4913L	CARDIAC SOLUTIONS INC
PP[illegible]4923L	HEALTH CARE INC INFUSION SERVICES
PP[illegible]4962L	GIRARD PRESCRIPTION CENTER INC
PP[illegible]5013L	KMART OF PA LP 9539
PP[illegible]5021L	ECKERD DRUGS #717
PP[illegible]5023L	OLNEY PHARMACY
PP[illegible]5025L	BECKETT HEALTHCARE PHARMACY SERVICES
PP[illegible]5031L	RITE AID PHARMACY 3874
PP[illegible]5058L	MURRAY DRUGS INC
PP[illegible]5062L	WELSH PHARMACY
PP[illegible]5073L	INSTITUTIONAL PHARMACY
PP[illegible]5075L	ECKERD DRUGS #763
PP[illegible]5084L	ECKERD DRUGS #735
PP[illegible]5087L	PROGRESSIVE PHARMACY INC
PP[illegible]5089L	ECKERD DRUGS #863
PP[illegible]5105L	ECKERD DRUGS #751
PP[illegible]5106L	AMERICAN HOMEPATIENT
PP[illegible]5110L	OLNEY LOGAN PHARMACY,INC
PP[illegible]5136L	ECKERD DRUGS #653
PP[illegible]5140L	NEIGHBORCARE
PP[illegible]5181L	EXPRESS SCRIPTS INFUSION SERVICES
PP[illegible]5187L	SUPER FRESH PHARMACY 743
PP[illegible]5188L	SHOP N SAVE PHARMACY 62
PP[illegible]5189L	ECKERD DRUGS #766
PP[illegible]5190L	TRI-STATE INFUSION PHARMACY OF PA
PP[illegible]5215L	ECKERD DRUGS #784
PP[illegible]5218L	NEFF PRESCRIPTION CENTER
PP[illegible]5219L	ISLAND AVENUE MEDICAL CTR PHARMACY
PP[illegible]5221L	PHARMOR 600
PP[illegible]5225L	NEIGHBORCARE PROFESSIONAL PHARMACIES
PP[illegible]5229L	HEALTH SPECTRUM PHARMACY
PP[illegible]5235L	LEGEND PHARMACY
PP[illegible]5236L	HEALTH-MART PHARMACY
PP[illegible]5238L	RXPRESS PHARMACY,INC.
PP[illegible]5243L	DELAIR DRUG,INC.
PP[illegible]5250L	ECKERD DRUGS #752
PP[illegible]5264L	SUPER FRESH PHRMACY 720
PP[illegible]5266L	HEALTH-MART PHARMACY II
PP[illegible]5267L	PENZS DRUG INC
PP[illegible]5270L	NORTHEAST PHARMACY
PP[illegible]5272L	VERREE HEALTH & BEAUTY CTR PHARMACY
PP[illegible]5275L	FIRST CHOICE PHARMACY, INC.
PP[illegible]5286L	SHOP N SAVE PHARMACY 66
PP[illegible]5307L	SHOP N SAVE PHARMACY 64
PP[illegible]5323L	PPH PHARMACY
PP[illegible]5324L	MEDMAX PHARMACY
PP[illegible]5325L	MEDMAX PHARMACY
PP[illegible]5326L	MEDMAX PHARMACY
PP[illegible]5333L	VINA PHARMACY
PP[illegible]5345L	CVS PHARMACY 1930
PP[illegible]5383L	SUPER FRESH PHARMACY 245
PP[illegible]5394L	LEHIGH PHARMACY
PP[illegible]5395L	SUPER G DISCOUNT DRUG DEPT 1251
PP[illegible]5410L	RESPONSE IMPACT CENTER OF ABINGTON
PP[illegible]5411L	CVS PHARMACY 2165
PP[illegible]5425L	SUPER FRESH PHARMACY 360

license_no	sort_name
PP415430L	CPS PHARMACY SERVICES INC
PP415501L	AMBULATORY PHARMACEUTICAL SERVICES
PP415523L	AMERICAN PRESCRIPTION PROVIDERS OF
PP415525L	MARIOS COMUNITY PHARMACY
PP415540L	K & A PHARMACY
PP415577L	KMART OF PA LP 9421
PP415578L	KMART OF PA LP 9422
PP415657L	RED LION PHARMACY INC
PP415660L	CHAPEL FAMILY PHARMACY
PP415662L	BROWNS THRIFTWAY PHARMACY
PP415675L	GIANT PHARMACY 18
PP415687L	HERON PHARMACY
PP415738L	PAIN EXPERTS
PP417042L	WOODHAVEN CENTER PHARMACY
PP418014L	THE BAPTIST HOME
PP418271L	MAGEE MEM HOSP PHCY
PP481037L	THE CHILDRENS HOSP OF PHILADELPHIA
HP410002L	BURMANS PRESCRIPTIONS
HP410004L	CENTRE PLAZA PHCY
HP415246L	PENN MEDICINE AT RADNOR
HP415323L	PPH PHARMACY
HP416528L	NEIGHBORCARE
HP416567L	ST JOSEPHS VILLA PHARMACY
HP416659L	NEIGHBORCARE
HP417008L	EASTERN PA PSYCHIATRIC INST PHARMACY
HP417010L	EMBREEVILLE STATE HOSPITAL PHARMACY
HP417013L	HAVERFORD STATE HOSPITAL PHARMACY
HP418003L	ALLEGHENY UNIVERSITY HOSPS,MT SINAI
HP418086L	MERCY COMMUNITY HOSPITAL PHARMACY
HP418093L	CITY AVENUE HOSPITAL
HP418149L	KIRKBRIDE CENTER
HP418170L	CROZER CHESTER MEDICAL CENTER
HP418188L	TEMPLE EAST INC NMC
HP418253L	CHARTER FAIRMOUNT INSTITUTE
HP418274L	INGLIS HOUSE PHARMACY
HP418289L	UNION HEALTH CENTER ILGWU
HP418367L	WOODHAVEN CENTER PHARMACY

EXHIBIT C

REASON TO CARVE OUT PHARMACY FROM HEALTH CHOICE
CONTROL DRUG COSTS

	A	B	C	D	E	F	G	H
1								
2	Fiscal Year	QTR	TOTAL REBATE	PRESENT	PROJECTED	Rebates Lost	PROJECTED STATE	REBATE LOST
3			Only 30% of stores still	STATE SHARE	IF 100% ON	TOTAL	SHARE IF 100% on	TO STATE
4			on State Program	46%	State Program		State Program	
5			**Actual Figures HCFA**	**Column C X .46**	**Column C x 3.33**	**Column E - C**	**Column E X .46**	**Column G - Column D**
6	1999	1st	$ 32,356,031	$ 14,883,774	$ 107,842,651	$ 75,486,620	$ 49,607,620	$ 34,723,845
7		2nd	$ 29,515,549	$ 13,577,153	$ 98,375,325	$ 68,859,776	$ 45,252,649	$ 31,675,497
8		3rd	$ 19,551,791	$ 8,993,824	$ 65,166,119	$ 45,614,328	$ 29,976,415	$ 20,982,591
9		4th	$ 37,916,693	$ 17,441,679	$ 126,376,338	$ 88,459,645	$ 58,133,115	$ 40,691,437
10		Total	$ 119,340,064	$ 54,896,429	$ 397,760,433	$ 278,420,369	$ 182,969,799	$ 128,073,370
11	2000	1st	$ 26,939,501	$ 12,392,170	$ 89,789,357	$ 62,849,856	$ 41,303,104	$ 28,910,934
12		2nd	$ 38,114,146	$ 17,532,507	$ 127,034,449	$ 88,920,303	$ 58,435,846	$ 40,903,339
13		3rd	$ 29,013,070	$ 13,346,012	$ 96,700,562	$ 67,687,492	$ 44,482,259	$ 31,136,246
14		4th	$ 24,923,132	$ 11,464,641	$ 83,068,799	$ 58,145,667	$ 38,211,648	$ 26,747,007
15		Total	$ 118,989,849	$ 54,735,331	$ 396,593,167	$ 277,603,318	$ 182,432,857	$ 127,697,526
16	2001	1st	$ 24,566,899	$ 11,300,774	$ 81,881,474	$ 57,314,575	$ 37,665,478	$ 26,364,705
17		2nd	$ 42,153,713	$ 19,390,708	$ 140,498,325	$ 98,344,612	$ 64,629,230	$ 45,238,522
18		3rd	$ 25,532,679	$ 11,745,032	$ 85,100,419	$ 59,567,740	$ 39,146,193	$ 27,401,160
19		4th	$ 37,011,819	$ 17,025,437	$ 123,360,393	$ 86,348,574	$ 56,745,781	$ 39,720,344
20		Total	$ 129,265,110	$ 59,461,951	$ 430,840,612	$ 301,575,502	$ 198,186,681	$ 138,724,731
21	2002	1st	$ 37,057,038	$ 17,046,237	$ 123,511,108	$ 86,454,070	$ 56,815,110	$ 39,768,872
22		2nd	$ 39,319,973	$ 18,087,188	$ 131,053,470	$ 91,733,497	$ 60,284,596	$ 42,197,409
23		3rd						
24		4th	$ -	$ -	$ -	$ -	$ -	$ -
25		Total	$ -	$ -	$ -	$ -	$ -	$ -
26								$ 476,461,907
27	Column C are actual figures supplied by HCFA							TOTAL LOSS IN
28	Column H shows loss to State in Rebates from manufacturers because they are only receiving rebates on 30% of stores							3 1/2 years
29	still being paid through ACCESS - Other 70% are on Health Choices							OR
30	Rebates increase as manufacturers prices increase and also control drug costs							AN AVERAGE OF
31								$136,131,974
32								LOSS PER YEAR

PARD HCFA

ECKERD®

Ralph E. Progar
Vice President of Pharmacy Relations

2002 NOV -6 AM 9:25

INDEPENDENT REGULATORY REVIEW COMMISSION

October 31, 2002

Original: 2297

The Honorable Feather O. Houstoun
Secretary
Department of Public Welfare
Commonwealth of Pennsylvania
333 Health and Welfare Building
Harrisburg, Pennsylvania 17120

Dear Secretary Houstoun:

On behalf of the Eckerd Corporation, I would submit our strong opposition to the Department of Welfare's proposed regulations to change prescription reimbursement rates for the Medical Assistance Program. Our 8,200 associates, our 297 drug stores, and more importantly, the patients we serve will be negatively affected by this short term action to reduce the state's drug spend.

Reasons given for reducing pharmacy reimbursement rates are based on an Office of Inspector General (OIG) Report, a position that Medicaid Reimbursement Rates are out of line with other third party payors, and a determination that "payment consistent with efficiency, economy and quality of care" will be achieved. The Eckerd Corporation respectfully disagrees with this "rationale for change". As you know, the original OIG Report was disputed and subsequently revised. The replacement report was also reviewed and problems were identified that also question the results of this report. As to the second point, Medicaid **is** different from and should not be directly equated to reimbursement rates from private third party prescription payors. These differences were provided to the department verbally and in writing. Most importantly, patient care will be negatively affected when patient access to prescription services is reduced. Pharmacies that service large percentages of Medicaid patients will be forced to make business decisions. No retail pharmacy, whether a single storeowner or a multi-store chain, can afford to do business, and not generate a profit at each location. Reducing reimbursement to the proposed level will result in pharmacy closures or reduced hours for those stores that are on the low end of the 2% average net profit for a drug store in Pennsylvania.

A change in the dispensing fee from $4.00 to $4.25 will ***not*** compensate pharmacy for the reimbursement rate change. Especially, when the department's 1998 PricewaterhouseCoopers' Study had suggested a $6.22 dispensing fee (Comparable to NACDS' 2000 Study that had the cost of dispensing a Medicaid prescription at $7.14).

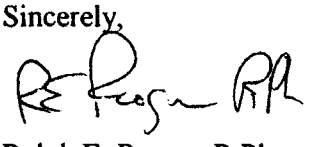
Address: 615 Alpha Drive, Pittsburgh, PA 15238
Phone: 412.967.8735 *Fax:* 412.967.8609

Implementing this regulation will result in closing unprofitable stores, will reduce patient access, and will reduce corporate taxes paid while increasing unemployment rates.

It is our opinion, based on results from states who had experienced similar drug spend problems, that viable alternatives exist for Pennsylvania to reduce the cost of their prescription benefit, and at the same time, increase the number of patients serviced. The alternatives (**Ex.**: Four Brand Limit, Preferred Drug List, Prescriber Prior Authorization) previously provided are a long term fix, and should be implemented in lieu of a reimbursement cut. Eckerd, and the pharmacy community at large, will assist the state in this endeavor.

Thank you for the opportunity to comment on this proposal.

Sincerely,



Ralph E. Progar, R.Ph.
Vice President of Pharmacy Relations
Telephone Number: (412) 967-8735

REP/dk

CC: Senator Vincent Hughes
Senator Harold Mowery
Representative George Kenney, Jr.
Representative Frank Oliver
Robert Nyce, I.R.R.C.
Brian Rider, PACDS
Neely Frye, Malady and Wooten Public Affairs

#14-479-25 ECKERD PR# 1534 176998

Due 11/29/02

Original; 2297

Ralph E. Progar
Vice President of Pharmacy Relations

Love

October 31, 2002

C. Dierken
Robert Orlowski

OFFICE OF THE SECRETARY
DEPT OF PUBLIC WELFARE
REF: Clerkers
Please Respond
2002 NOV -4 A 9:07
RECEIVED

made cc: Houstoun
Kane
Cohn

The Honorable Feather O. Houstoun
Secretary
Department of Public Welfare
Commonwealth of Pennsylvania
333 Health and Welfare Building
Harrisburg, Pennsylvania 17120

RECEIVED
NOV 07 2002
BUREAU OF POLICY, BUDGET AND PLANNING

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Thank you for the opportunity to comment on this proposal.

Sincerely,

Ralph E. Progar, R.Ph.
Vice President of Pharmacy Relations
Telephone Number: (412) 967-8735

REP/dk

CC: Senator Vincent Hughes
Senator Harold Mowery
Representative George Kenney, Jr.
Representative Frank Oliver
Robert Nyce, I.R.R.C.
Brian Rider, PACDS
Neely Frye, Malady and Wooten Public Affairs

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF GENERAL COUNSEL

Original: 2297

DATE: October 29, 2002

SUBJECT: **Public Comments**
Pharmacy Revisions - #14-479

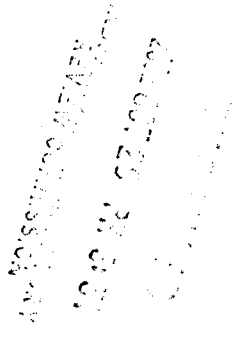
TO: Robert E. Nyce
Executive Director
Independent Regulatory Review Commission

FROM: Ruth O'Brien RO'B/r
Senior Assistant Counsel

Attached are public comments received regarding the proposed Pharmacy Revisions Regulation.

Attachments

cc: Scott Johnson
Niles Schore
Melanie Brown
Sandra Bennett



#14-479-23 176914

Pennsylvania Pharmacists Association

508 North Third Street, Harrisburg, PA 17101-1199
Telephone: 717-234-6151 • Fax: 717-236-1618
E-mail: ppa@papharmacists.com • Website: www.papharmacists.com

REF: Dierkers

cc: Dierkers
Morton
Rebert
Ridge
Delaush

2002 OCT 29 A 10:03

0141151

October 29, 2002 REFER TO: Love

RECEIVED

cc: Houstoun
Hicks
Kane

R/S Due: 11/6/02

The Honorable Feather O. Houstoun
Secretary, Department of Public Welfare
333 Health and Welfare Building
Harrisburg, PA 17105

Original: 2297

Dear Secretary Houstoun:

On behalf of the Pennsylvania Pharmacists Association, (PPA), I would like to record our strong opposition to the Department's proposed regulations affecting the Medical Assistance pharmacy reimbursement, which were published in the October 5, 2002 edition of the *Pennsylvania Bulletin.*

Of grave concern to our organization is the fact that these proposed changes are based on incorrect assumptions and misinterpretations of data that were made based on an Office of Inspector General (OIG) Study that was flawed in its data collection and analysis. PPA is also concerned about the issue of access to services for those recipients subsequent to the potential enactment of these proposed changes and the assertion that Medicaid reimbursement rates are higher than those paid by third-party private payers.

When reading and evaluating the OIG study, several confusing and contradictory statements were noted. At one point the study states that single source innovator medications are purchased at an estimated discount of 17.2% below average wholesale price (AWP). The study then states that Brand Name Prescription Drug Products are purchased at an estimated average discount of 21.8% below AWP. Equating these two figures and classes of medications is a fallacy. In effect, the Department of Public Welfare (DPW) is using the estimated discount on **all** brand name prescription drug products to justify its reimbursement amount for single source innovator medications, which are only a subset of this group. Both DPW and the OIG made an incorrect decision regarding this. You must understand that various categories of medications exist. The discount received for the subset "brand-name drugs" is greater than the discount received for the subset "single source innovator drugs", and it is simply wrong to extrapolate data from one subset to determine reimbursement for a second subset.

There are other significant deficiencies in the OIG report, as well. The most important one is the lack of any data pertaining to the percent of each invoice related to the category of medications sampled. (Example: What percent of invoice dollars was spent on single source innovator medications?) The tables show the discount **within** each group of dollar-weighted percent below AWP; but not the dollar weighted percent of the total invoice into which each medication category falls. Clearly, if this information were better delineated, it would become readily apparent how devastating a reduction in percent off AWP from 10% to 15% would be to a pharmacy's fiscal integrity.

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AND PLANNING

On the issue of access, the Department needs to look no further than its struggles with dental health to know that decreased provider participation, whatever its cause, can have far reaching negative effects on recipients' health. DPW should refer to the *Quality of Care Study: Relative Realization Value 2001* prepared on behalf of the now defunct Lancaster Community Health Plan Medicaid Primary Care Case Management (PCCM) model to understand how effective extensive provider participation in the fee-for service sector can be. Since the full implementation of Health Choices in this area, we have already seen a reduction in primary care providers willing to participate in Medicaid and there are early signs that there is even a slight increase in emergency room utilization – something that had all but been eliminated under the PCCM model.

The medical assistance recipients that remain in the fee-for-service program (special needs children, long term care residents, etc.) remain there for a reason. The Department has to acknowledge that these patients do not fall under managed care programs, because managed care programs cannot "manage them." Managed care organizations that participate in Health Choices have opted out of caring for these recipients because of the overwhelming fiscal impact that these patients would have on their case mix.

We fail to understand how DPW can allow certain providers to "walk away" from their responsibility to public health and welfare because it affects the bottom line and then turn around and impose financial penalties on those providers who have stayed at the table and delivered high quality, high service, and accessibility to these patients and residents.

It is wrong to assume that caring for Medicaid recipients is the same as caring for other patients in another generic third party program. These patients routinely have greater challenges and greater needs. By the state's own admission these clients present challenges that cannot easily be met with conventional methods.

PPA recognizes the need to reduce costs in the program **wherever possible and appropriate.** Our pharmacist members are taxpayers as well as health care providers. It is important that DPW not utilize faulty data and misassumptions to achieve cost reduction goals. We are also asking that the Department recognize that the special services required by this group of recipients cannot be ignored and that it is important to maintain quality of care. It is patently unfair and inappropriate to expect pharmacy providers to unilaterally accept an arbitrary reduction in reimbursement simply because it is expedient for the Department to do so, especially when the end result may very well harm the program recipients.

PPA would welcome the opportunity to work with the Department to explore other options for high-quality, cost-effective delivery of pharmaceutical services.

Sincerely,

Patricia A. Epple, CAE
Executive Director