



CONNECTICUT PHARMACISTS ASSOCIATION

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Testimony before the Human Services Committee
March 13, 2007

Re: HB 7324: An Act Concerning Medicaid Reimbursement Rates to Pharmacists

Good Morning Senator Harris and Representative Villano. My name is Margherita R. Giuliano. I am a pharmacist and the Executive Vice President of the Connecticut Pharmacists Association. The Connecticut Pharmacists Association is a professional organization representing more than 1,000 pharmacists in the state.

I am here today to ask for your support of HB 7324: AAC Medicaid Reimbursement Rates to Pharmacists. In 2005 the federal government passed the Deficit Reduction Act which included huge cuts to Medicaid. Specifically, the federal government will no longer be reimbursing pharmacies based on the controversial method of Average Wholesale Price or AWP for generic drugs. The new method of reimbursement to pharmacies will be based on the Average Manufacturers Price or AMP. It is critical that the legislature understands that pharmacies do not purchase drugs at AMP. At this time, the federal government is still making a final determination on how AMP will be calculated.

CPA has been working closely with DSS to try to determine the impact that AMP will have on community pharmacies and patient access to pharmacy services. A recent analysis comparing cost of claims as they are currently reimbursed to pharmacies and cost of claims using the federal government's current definition of AMP pricing reveals a gap of more than \$18.00 in ingredient cost. According to DSS, some of the drugs have a differential of \$100.00. Again it is important for legislators to understand that pharmacies do not purchase drugs at AMP. Most pharmacies purchase medications from wholesalers – who purchase medications from the manufacturers. Pharmacies are at the end of the distribution system.

We recognize that the state of Connecticut has no ability to influence the definition of AMP. However, the state does have the ability to change the dispensing fee to pharmacies to keep them viable. Historically, pharmacies are reimbursed with a formula of “cost of drug” plus “dispensing fee”. Any good business person understands that to be viable a business must make a return on investment. Pharmacies were able to realize a ROI by discounts off AWP. With ingredient cost now less than actual acquisition cost, new strategies will need to be adopted to keep pharmacies viable. This legislation asks that the state keep pharmacies “whole” when AMP is implemented this spring or summer. It then asks that the state calculate the pharmacies' actual cost of dispensing of multiple source drugs to Medicaid patients and implements this adjusted fee by April 1, 2008. A recent national survey on the cost of dispensing shows that Connecticut's Median Average per pharmacy to dispense a prescription is \$11.59. This is the fee



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that covers just the cost to dispense – not allowing for profits. Currently the Medicaid dispensing fee is \$3.15. Pharmacies have not had a fee increase since 1991.

Putting all that into perspective, come Spring 2007 when reimbursement for Medicaid is based on AMP pharmacies will need adequate reimbursement to remain accessible to Medicaid patients. It is also critical when budgeting for this increase that language is added to increase fees each year to keep pace with the cost of living. Pharmacists are the only providers whose fees decline as the cost of doing business in the state increases.

I want to praise the Department and the hard work of Sheila Dorval and Evelyn Dudley in providing us with the information used to evaluate the AMP impact. DSS has been our biggest supporter since they recognized what pharmacists did in Medicare Part D. The state was able to realize savings by using intelligent selection when placing patients in the appropriate plans. We ask you to invest in the professionals that helped you in the past. We look forward to ongoing discussions with the department in looking at new strategies to reimburse pharmacies and pharmacists appropriately while providing new ways to improve patient care.

Track chronologically:

Changes in reimbursement from the state

July 13, 1978	\$2.52 walk-in; \$2.10 nursing home
September 12, 1980	\$2.77 walk-in; \$2.31 nursing home
December 3, 1981	\$3.11 walk-in; \$2.59 nursing home
November 1, 1985	\$3.55 walk-in; \$3.11 nursing home
August 8, 1989	AWP – 8%
January 1, 1991	AWP – 8% + \$4.10* (*first time for a universal fee)
1/1/91 – 12/31/94	OBRA freeze on pharmacy reimbursements
August 1, 1995	AFDC moved to Managed Care (fees decreased)
November 1, 1995	AWP -12% + \$4.10
November 15, 1997	\$1.00 Co-pay
September 1, 2002	AWP – 12% + \$3.85
2003 Legislative Session	AWP – 12% + \$3.60 & \$1.00 co-pay
October 1, 2003	AWP – 12% + \$3.30
November 1, 2003	Medicaid Co-pay increased to \$1.50
July 1, 2004	AWP -12% + \$3.15

Additional duties to pharmacists from the state

2001 Legislative Session Prior Authorization Legislation Passed
Generic Substitution Mandatory (Brand Medically Necessary)

July 1, 2002

- Quality Assurance
- State MAC list established
- Voluntary Mail-order for state assistance patients (not yet implemented)
- State may contract with “an established entity” to purchase drugs through the lowest price available (not yet implemented)

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| February 4, 2003 | - MAC list implemented |
| June 18, 2003 | - Prior Authorization for prescriptions over \$500 |
| July 16, 2003 | - Prior Authorization for Brand Medically Necessary prescriptions
with a Class-A generic alternative |
| | - Prior Authorization for early refills (<75%) |
| December 2004 | - Preferred Drug List Implemented (PPIs) |

Changes in cost of filling prescriptions