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Bristol Bay Area Health Corporation is a tribal organization representing 34 villages in Southwest Alaska:

- Aleknagik
- Chignik Bay
- Chignik Lagoon
- Chignik Lake
- Clark's Point
- Dillingham
- Egegik
- Ekuk
- Ekwok
- Goodnews Bay
- Igiugig
- Iliamna
- Ivanof Bay
- Kanatak
- King Salmon
- Knugank
- Kokhanok
- Koliganek
- Levelock
- Manokotak
- Naknek
- New Stuyahok
- Newhalen
- Nondalton
- Pedro Bay
- Perryville
- Pilot Point
- Platinum
- Port Heiden
- Portage Creek
- South Naknek
- Togiak
- Twin Hills
- Ugashik

Our mission is to provide health care with competence and sensitivity

September 4, 2013

Delivered by email to:
gennifer.moreau-johnson@alaska.gov

Ms. Gennifer Moreau-Johnson
State Plan Coordinator
Alaska Department of Health and Social Services
4501 Business Park Blvd., Building L
Anchorage, Alaska 99503

Re: Proposed Medicaid State Plan Amendment (SPA)
Regarding Coverage and Payment for Outpatient and Physician-Administered Drugs

Dear Ms. Moreau-Johnson:

I am the President and CEO of Bristol Bay Area Health Corporation and write to express our strong objection to the proposed Medicaid State Plan Amendments (SPA) regarding coverage and reimbursement for outpatient and physician-administered drugs.

In the recent "Mega Meeting" with tribal health organizations on August 14, 2013, Commissioner Streur committed to sitting down with tribal providers to work through the proposal and address our concerns. Consistent with that commitment, I respectfully call for a high-level meeting between the Department and affected tribal health organizations, at the earliest possible date, where we can discuss the proposal's adverse fiscal, operative, and public health impacts and agree how they can be prevented or mitigated.

As our leadership explained to the Commissioner, in its current form the Department's proposal would fall far short of covering the true costs of tribal pharmacy programs. Despite our access to discounted "federal supply source" and other federally-discounted medications (hereafter, "Federally-Discounted Drug Sources" (FDDS)), tribal programs incur much higher costs than most other pharmacies. This is not only because so many of our programs serve remote areas, but also because of the extra time we take with our patients – many of whom speak no English or have limited English proficiency – to ensure they understand what medications they are taking, how and when they should be taken, what their potential side effects are, and whether they may interact adversely with other medications.

Extending this extra degree of culturally competent care to our American Indian and Alaska Native (AI/AN) patients is essential, given that they are members of the most medically underserved population group in the Nation. We and the entire Alaska tribal health system are deeply committed and constantly

striving to change that deplorable statistic, and we are sure you and the Commissioner share that goal. But the current proposal would work against us all, by drastically reducing Medicaid reimbursement to tribal programs for essential pharmacy services.

Further, and as we also briefly discussed with the Commissioner, because the federal government reimburses Alaska at a 100% Federal Medical Assistance Percentage (FMAP) rate for the services tribal programs provide our AI/AN patients, because nothing in federal law compels the reimbursement changes the Department has proposed for tribal programs, and because the federal Centers for Medicare and Medicaid Services (CMS) has indicated it will allow States discretion in setting tribal pharmacy reimbursement rates, there is simply no sound fiscal or policy reason to cap reimbursement at levels that would fail to cover our costs and be detrimental to our patients. The proposal should be abandoned until the Department and tribal health programs can agree on a more fitting, fair, and adequate reimbursement methodology.

As you may know, the current proposal is similar to (and we assume, replaces) one made last year, which we and other tribal health organizations vehemently opposed. Although this year's proposed SPA (and corresponding proposed regulation changes) has been revised to mitigate some of the concerns we expressed last year, other proposed changes would make matters even worse for tribal providers than under the earlier proposal. In particular, the withdrawal of last year's proposed $2 extra dispensing fee for providers who procure drugs from a federally-discounted source means there would be *no offsetting payment* to help cover the double-blow of proposed much *lower* drug acquisition cost reimbursement coupled with much *higher* administrative and professional costs for tracking and reporting those costs. Overall, we anticipate the changes proposed this year would result in a sudden, dramatic, and crippling revenue drop for tribal health programs – a reduction that, given the 100% FMAP for tribal programs, would yield no State savings at all.

We also strenuously object to the singling out of FDDS-supplied programs for an "actual acquisition drug cost" (AADC) methodology. It is premature, for a host of reasons, to impose such a methodology on *any* pharmacy. But we simply cannot comprehend why the Department would impose it *only* on tribal and other pharmacies that qualify for federally-discounted drugs, when the fact is many other pharmacies – including well-heeled, for-profit, big-box pharmacies like Walgreens and Wal-Mart – acquire their drugs at deeply discounted commercial prices that rival FDDS rates.

FDDS-qualified providers, by definition, are those that care for the most medically underserved segments of the population and thus rely most on Medicaid reimbursement. As non-profit entities serving high-needs patients, as a group we are the least able to bear the burdens and lost revenue that would attend the proposed AADC methodology. Yet only we would be subjected to it, while commercial pharmacies would continue to be paid at rates tied to the "Wholesale Acquisition Cost" (WAC), an arbitrary metric that bears little connection to true acquisition costs and would potentially allow those pharmacies to make a margin on their drug costs at public expense. No tribal program should be limited to reimbursement at its "actual acquisition drug cost" until all pharmacies are. Even then, tribal programs should not be subject

to an AADC methodology until CMS endorses a cost-effective metric for determining them and dispensing fees are increased enough to cover tribal pharmacies' higher dispensing costs.

Beyond these fundamental concerns, the proposal suffers from many of the same shortcomings we identified last year. Among other problems, the proposed changes to ingredient cost reimbursement are not supported by *any data*. They thus would not satisfy standards CMS proposed in 2012 or the "reasonable basis" test Alaska courts apply to regulatory action. Although the proposed higher dispensing fees for pharmacies located off the road system are promising in some respects, they are not refined or high enough to cover higher-than-average costs for tribal and low-volume pharmacies; especially without the $2 extra fee that was part of last year's proposal. Indeed, because dispensing fees would be set at the median "average" cost reported by pharmacies in a 2012 cost survey, they are *guaranteed* to under-compensate roughly half of all Medicaid-participating pharmacies (more if costs have gone up since the survey was conducted).

We are separately submitting our comments on the proposed state Medicaid regulation changes that would implement the proposed SPA. Those comments also apply to the proposed SPA, so we attach them here and, by this reference, incorporate them into these comments.

For all the reasons explained above and in the attached comments, we urge the Department to withdraw the current proposal, await further developments on the federal level, and work closely with tribal health programs to devise a reimbursement methodology that will meet any final federal requirements, fairly and adequately compensate all pharmacy programs for their true costs, and ensure continued Statewide access to this vital health care service.

Thank you for the opportunity to comment. We will continue a comprehensive internal review of the proposed changes and look forward to discussing this further in the promised meetings with the Commissioner.

Robert J. Clark, President / CEO
Bristol Bay Area Health Corporation

cc: Commissioner William Streur, Commissioner, william.streur@alaska.gov
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