Moreau-Johnson, Gennifer L (HSS)

From: Rodney Gordon [rgordon@NSHCORP.ORG]
Sent: Monday, August 05, 2013 1:29 PM
To: Moreau-Johnson, Gennifer L (HSS)
Subject: New Medicaid SPA

Ms. Moreau-Johnson,

I am writing to respond to the new proposed SPA for modifying our reimbursement for Medicaid prescriptions, as the pharmacy director at Norton Sound Health Corporation, a tribal organization which handles the medication needs of IHS beneficiaries in the northwest region of Alaska.

Norton Sound Health Corporation does NOT participate in the 340B program, so according to this new SPA we would be required to submit a charge for the "actual acquisition cost" of all medications for Medicaid claims, rather than AWP or MAC, or any widely published pricing schedule for drugs. I can foresee several problems with this new pricing approach.

First, we are not unique in how we calculate U&C pricing for medications, which is a process driven by the current method for billing most private insurance payers that involves AWP or MAC pricing for drugs, minus a percentage, plus a dispensing fee. The systems which support this billing process are well established, since it relies on publically published pricing schedules for drugs (AWP or MAC), which is automatically updated in most pharmacy computer programs by the software vendor.

If we transition to a cost basis for reimbursement, that will require our software vendor to have access to the FSS pricing data, as well as our "open-market" pricing rates, something that is not possible, due to the protected and private nature of that pricing information. To accurately bill cost for prescriptions processed we will therefore need to devote a person to manually review all 4000+ drugs that we have in our inventory on a biweekly basis, at least, in order to keep our costs updated and current. That would be an overly burdensome task to expect to be sustained indefinitely.

Also, if our reimbursement is reduced according to the SPA, based on the cost of drug + off the road system fee, we will have to start deciding which treatments we can afford to handle, and which we cannot. A perfect example is the patient [redacted] reimbursement is reduced as projected in this SPA, will may have to stop providing this treatment, which would have life threatening consequences for this patient.

A better way to approach this SPA would be to stay with AWP or MAC for the basis for reimbursement, but define a deeper discount than is commonly used by private plans. An example might be AWP – 40% or 45% plus a dispensing fee for IHS programs. I think this approach will provide significant savings for the state Medicaid program, and make Medicaid more fiscally sound, and at the same time will facilitate the implementation of the change, since most pharmacies throughout the state could easily adapt to this new pricing structure, and it would also simplify the process needed to sustain the program from the pharmacy's perspective, since most software vendors already provide AWP and MAC. This would also give local tribal facilities like ours, the small margins needed to sustain vital services to our beneficiaries.

Thank you for considering these comments.

Rod Gordon

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