DISPENSING OF DRUGS BY LOCAL HEALTH DEPARTMENTS

REPORT OF THE

VIRGINIA ADVISORY LEGISLATIVE COUNCIL

TO

The Governor

And

The General Assembly of Virginia

SENATE DOCUMENT NO. 9

COMMONWEALTH OF VIRGINIA

Department of Purchases and Supply

Richmond

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REPORT OF THE

VIRGINIA ADVISORY LEGISLATIVE COUNCIL

COMMITTEE ON THE

DISPENSING OF DRUGS BY LOCAL HEALTH DEPARTMENTS

Richmond, Virginia

August 24, 1976

TO: The Governor and the General Assembly

At its 1975 Session, the General Assembly, in Senate Joint Resolution No. 134, requested the Virginia Advisory Legislative Council to study certain aspects of the dispensing of prescription drugs under the Medicaid program by health departments. The text of that resolution is as follows:

SENATE JOINT RESOLUTION NO. 134

Requesting the Virginia Advisory Legislative Council to conduct a study on the dispensing of drugs by local health departments.

WHEREAS, although the federal Medicaid program, which the Commonwealth of Virginia participates in, requires the expenditure of large amounts of both federal and State funds, it provides many needed medical services to thousands of deserving citizens of very limited economic ability; and

WHEREAS, as presently administered, this program allows great volumes of prescription drugs to be dispensed directly to Medicaid recipients by the various county and city health departments throughout the Commonwealth; and

WHEREAS, this procedure within this worthy program gives a great deal of concern to many citizens of whether sufficient control is being exercised over the dispensing of these drugs that will insure that public funds are being expended for the purposes for which they were appropriated and whether this deviation from the normal legal methods of dispensing controlled substances gives sufficient assurances that they will not be diverted for illegal uses; now, therefore, be it

RESOLVED by the Senate of Virginia, the House of Delegates concurring, That the Virginia Advisory Legislative Council is requested to conduct a study of the policies and practices of dispensing prescription drugs throughout the Commonwealth under the Medicaid program. The Council is further requested to complete this study and submit its report, including suggested legislative

changes if found necessary, to the Governor and General Assembly no later than December one, nineteen hundred seventy-five.

All agencies and political subdivisions of the Commonwealth shall assist the Council in the conduct of this study upon request.

To conduct the study, the Council appointed a committee to be chaired by Senator Edward E. Willey of Richmond, a member of the Council. Other members of the Committee were Dr. Raymond Brown of Gloucester, Senator John C. Buchanan of Wise, Mr. Charlie Green of Bedford, Dr. William Grossman of Franklin, Delegate Evelyn M. Hailey of Norfolk, Dr. William R. Hill of Richmond, Mr. Curt Nottingham of Williamsburg, Mrs. Sophie Ann Salley, of Richmond, Delegate Eva Scott of Church Road, and Mrs. Anne Shortell of New Castle.

Officials of the Virginia Pharmaceutical Association, the Department of Health, the Department of Mental Health and Mental Retardation, the Department of Corrections, and the Board of Pharmacy provided information and assistance to the Committee.

I.

The study revealed several problem areas in the Medicaid drug program. The first is the amount of reimbursement to pharmacists for drugs dispensed to Medicaid clients. Under the present regulations, pharmacists are, in the case of almost every drug, reimbursed the cost of the drug and a fixed dispensing fee. That fee was fixed at $1.80 in 1969 and raised to $1.95 in 1971 and has not been raised since. According to studies of the Virginia Pharmaceutical Association, this fee is lower than the actual cost to the pharmacists of dispensing the drug. Thus a pharmacist could lose money on each Medicaid prescription that he fills although, once in the store, the client could spend money on non-drug items sold in "the front end" of the store. Furthermore, many third-part payment schedules are based on the Medicaid rates. All of these factors result in higher charges to non-Medicaid customers or loss of reasonable and necessary profits or both.

The Health Department in its budget request to the General Assembly will ask for a sufficient appropriation to increase this fee paid to pharmacists to $2.25. This will alleviate the problem temporarily. However, because of the unfairness to pharmacists and to non-Medicaid drug purchasers when the pharmacist does not recover his costs from Medicaid-covered prescriptions, it is recommended that the Department of Health monitor this fee more closely and revise it when necessary.

II.

Another problem, albeit small, is that some local health departments operate pharmacies which dispense drugs directly to

Medicaid patients. In fiscal year 1975, participating health department pharmacies dispensed 45,313 prescriptions to Medicaid patients for which they were paid $162,514. This represented only 1.2 percent of the total Medicaid pharmacy services consisting of 3,030,450 prescriptions at a cost of $13,976,000. Because the State can purchase drugs from the manufacturers at a lower cost than can private pharmacists, the Virginia Pharmaceutical Association believes that the State is competing with private businesses. It is recommended that the Department of Health take steps to ensure that private pharmacies are utilized to provide drug services to Medicaid recipients whenever possible.

III.

The study also revealed that there have been instances involving the dispensing of drugs by unlicensed persons, poor security and storage, improper record keeping, and improper labelling in local health departments, the State departments of Corrections and Mental Health and Mental Retardation, and State college infirmaries.

The Department of Health has recognized the existence of these infractions and has been working with local departments to correct the situation. The Department of Corrections and the Department of Mental Health and Mental Retardation have taken steps to ensure proper control over the dispensing of drugs by establishing central pharmacies which will dispense drugs for the entire system. The State Board of Pharmacy is also working to correct these practices. Adequate laws currently exist to prevent these problems; thus only continued action to assure compliance is recommended.

IV.

The final problem addressed in the study, and one that causes a great deal of concern, is the dispensing of large quantities of powerful drugs to Medicaid patients. There have been cases where one patient was given prescriptions for several hundred tranquilizers, for example, by each of several doctors. The problem seems to occur most often in large clinics and has two causes. One is doctors' writing long-term prescriptions and the second is failure, on the part of the clinic pharmacies, to keep adequate records on each patient. To help alleviate this situation, it is recommended that the Department of Health amend its policies so as to discourage rather than encourage physicians participating in the Medicaid program, either in private practice or in clinics, from writing prescriptions whereby patients can obtain at one time more than a thirty-day supply of drugs which have a potential for abuse. This recommendation is not intended to apply to maintenance drugs for which it is desirable to dispense a long-term supply. Birth control pills are the prime example of this latter category. It is intended to apply primarily to drugs which have a potential for abuse and which, if not carefully controlled, may be sold illegally in the streets.

Summary

There have been, and still are, some potentially serious problems in the dispensation of drugs by health departments and State agencies and in the drug component of the Medicaid program. However, these problems can be dealt with through changes in regulations and policies and through corrective measures by State agencies to assure compliance with existing laws. The Department of Health and other involved State agencies are making efforts to rectify the problems. It is hoped that these efforts will continue.

Respectfully submitted,

Edward E. Lane, Chairman

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Dissenting Statement of Anne Shortell, Committee member

I do not approve of Section II of the report of the VALC Committee to study the dispensing of drugs.

1.2% of total Medicaid pharmacy services provided by the State Health Department is only a so called "drop in the bucket' compared to the remaining 98.8% which private pharmacies collected during fiscal year 1975.

What kind of competition is that?

Why should the Virginia Pharmaceutical Association attempt to dictate to State Health Department pharmacies by recommending that Medicaid patients utilize private pharmacies?

It's obvious that the majority of patients go to private physicians and private pharmacies.

It's only reasonable that if a patient is treated at a Health Department clinic and a pharmacy is available through them that the prescription be filled there for the convenience of the patient.

I doubt seriously that if all Medicaid prescriptions were filled by private pharmacies that it would result in any lower charges to non-Medicaid patients. In the case of Medicaid, the usual feeling is if the government is paying, charge what traffic will bear, resulting in higher costs to the taxpayer while filling the businessman's pocketbook.

This recommendation is a step in the direction of eliminating Health Department pharmacies. For the sake of health care delivery to the indigent and low income group, I feel that I must speak up.

Supplemental Statement of S.A. Salley, Committee Member

Background:

The health care industry has to be considered differently from the other components of the national economy because, in Fiscal Year 1975, 42.2% ($49.9 billion) of all health care expenditures came from the governmental sector. Federal payments for Medicare and Medicaid totaled $21.8 billion. Total Federal payments, including Veterans Administration and Department of Defense hospitals and various construction and research programs, were $33.8 billion. State and local outlays for health were $16.1 billion, including $6.0 billion in State Medicaid payments and $4.4 billion for public hospitals.

Health Expenditures in 1975

	Billions of dollars	Percent
Private sector	68.5	57.8
Public sector	49.9	42.2
Federal	33.8	
State, local	16.1	
Total	118.4	100%

The health care industry cannot be analyzed by the same criteria as non-subsidized industries (i.e. machine tool or soft-goods ilndustries). Rather it has to be considered perhaps as a public utility. It is heavily subsidized by direct governmental involvement and by a favorable tax structure. It has been estimated by the U.S. Office of Management and Budget that about $8 billion in tax subsidies are received in form of tax deductions for health insurance premiums, medical expenses and foregone social security tax revenues. Additional public support comes from Federal, state and local tax exemptions provided to nonprofit hospitals and Blue Cross/Blue Shield plans.

Other characteristics of the health care industry also put it in a different category. Competitive forces that regulate the steel industry, for example, in terms of cost and efficiency are absent in the health care industry. The health care industry has its own characteristics which are explained succinctly in a recently published report by the Council on Wage and Price Stability, Executive Office of the President, The Problem of Rising Health Care Costs. (Staff Report, April 1976) The report points out four special characteristics of the industry as follows:

1. The reimbursement system of the industry has contributed to an increase in the cost of health care.

In the last decade the rapid growth of third party payments in the private sector has been dwarfed by the growth in the public

expenditures through Medicare (i.e. health care for the aged), kidney dialysis and Medicaid. This insurance system obscures the impact of health care costs on the household budget.

2. The central role played by the physician. The nature and extent of the services provided are usually determined by the physician with the patient usually accepting the advice without being able to compare and analyze services offered and determine the level of services.

3. Stress on cost effectiveness and managerial efficiency seems to be not as strong as in other sectors of the economy.

4. Increasilng governmental support creates new conditions as to the evaluation of the health care industry.

The following six points further underscore the strong inflationary pressures that exist in the health care industry:

1. Price increases for medical care services over the last decade (1966-75) have significantly outpaced increases in other consumer service prices, with the disparity accelerating more rapidly in the past year;

2. The cost of an average hospital stay is up from $311 in 1965 to $1017 in 1975;

3. The medical care services component of the Consumer Price Index (CPI) rose 10.3 percent and physician fees by 11.8 percent, compared to 7.7 percent for the CPI's overall service component less medical services;

4. The drugs and prescriptions component of the Consumer Price Index rose 7.4 percent in 1975, a highly unusual rate since in the past these prices have rarely ilncreased more than 1 percent annually;

5. Health expenditures as a percentage of our Gross National Product rose to an unprecedented level of 8.3 percent in 1975, up 41 percent from the 5.9 level in 1965;

6. Health care expenditues have tripled since 1965, up from $39 billion to $119 billion; the 1974 to 1975 increase of $15 billion was the biggest in our history.

Recommendation:

Therefore, if one looks at Senate Joint Resolution No. 134 in the context of the rising health care costs, limited inherent competition within the industry, a consensus on the part of the public that health care is an essential public service, and heavy subsidization by the government and preferential tax structure support, then it would seem to me to be cost effective to have high risk patients receive prescription drugs at the health department clinic sites. Furthermore, if the health department clinics can save the taxpayer some money by buying drugs at lower rates and dispensing them to

high risk patients, it would also aid in balancing the Medicaid component of the health department budget. In the long run the cost of maintaining high risk patients under observation and instruction at a clinic site might prevent medical complications to the patients and might prevent further expenditure of public funds on their behalf. It is in this grey area that the Health Department should consider the cost effectiveness factor in deciding whether to send a patient to a Medicaid participating pharmacy or to administer the medication at a clinic site.