RURAL GEORGIA PHARMACY CLOSURES

OFFICE OF INSPECTOR GENERAL

OFFICE OF ANALYSIS AND INSPECTIONS

DECEMBER 1989

OFFICE OF INSPECTOR GENERAL

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The purpose of this inspection, entitled "Rural Georgia Pharmacy Closures," was to describe the extent and causes of rural pharmacy closures in Georgia.

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RURAL GEORGIA PHARMACY CLOSURES

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EXECUTIVE SUMMARY

PURPOSE

The purpose of this inspection was to examine the extent and causes of rural pharmacy closures in Georgia in Fiscal Year 1989.

BACKGROUND

The Georgia Pharmaceutical Association has expressed concern about rural pharmacies closing, and has suggested that the closures may be associated with Medicaid reimbursement.

FINDINGS

This inspection found that:

- Twelve rural pharmacies in Georgia closed in Fiscal Year 1989.
- Retirement and financial problems were the reasons for closure.
- State and local respondents reported no closures were due to Medicaid reimbursement. However, some respondents cautioned that as cost containment measures are implemented in the Medicaid program, small pharmacies with a high percentage of Medicaid prescription sales may experience financial difficulties.
- The closure of these 12 rural pharmacies did not affect access to pharmacy services for Medicaid clients in those communities.

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INTRODUCTION

PURPOSE

The purpose of this inspection was to examine the extent and causes of rural pharmacy closures in Georgia during Fiscal Year 1989. Special attention was given to the possible effect of Medicaid reimbursement on pharmacy closure.

BACKGROUND

The Georgia Pharmaceutical Association has expressed concern about rural pharmacies closing, and has suggested that these closures may be associated with Medicaid reimbursement. Because some rural communities in Georgia have high proportions of Medicaid recipients, and access to pharmacy services may be affected by pharmacy closures, the Department of Health and Human Services has an interest in this expressed concern.

The Secretary of the Department of Health and Human Services (HHS) requested this inspection.

Medicaid Reimbursement

Medicaid is a Federally aided, State-administered program which provides health care for the poor. States design, establish, and operate their Medicaid programs under the provisions of title XIX of the Social Security Act and HHS regulations. Usually, States make payments directly to health care providers, including pharmacies, for services rendered to Medicaid recipients. Within broad Federal limits, States generally are allowed to set reimbursement rates for health services covered by the program.

Federal Medicaid regulations limit reimbursement for pharmacy services to the lowest of:

- an upper limit established by HHS' Health Care Financing Administration (HCFA) for certain multi-source (generic) drugs, plus a reasonable dispensing fee set by each State;

- the estimated acquisition cost (EAC)--the price generally paid by pharmacies--for any drug, as established by the State Medicaid agency, plus a reasonable dispensing fee; or

- the pharmacy's usual and customary charge for the drug.

Dispensing fees are payments made to pharmacies to cover the cost of filling prescriptions. Federal regulations allow States to set their own dispensing fees and require only that the fees be "reasonable."

States also establish the EAC. According to the Federal requirements, the amount established should be "the price generally and currently paid" by pharmacies for the particular drug. The EAC usually applies to brand name drugs, but can be used for generic drugs if the EAC is lower than both the upper limit set for the generic drug and the pharmacy's usual and customary charge. The methodology for determining the EAC varies from State to State. Each State's formula for EAC is shown in appendix B.

Determination of Estimated Acquisition Costs (EAC)

Most pharmacies purchase drugs from a wholesaler who represents all the major drug manufacturers. Several industry publications report an "average wholesale price" (AWP) that wholesalers charge for each drug. However, wholesalers offer the pharmacies substantial discounts below the AWP as incentives for such things as high volume purchasing, timely payments, and infrequent deliveries. Virtually all pharmacies get discounts, although the amount of the discount may vary.

States use the AWP as a guide in establishing EACs; however, the AWP does not accurately reflect the price generally paid by pharmacies because it does not account for the discounts. Therefore, HCFA has aggressively encouraged States to establish EACs at an amount lower than AWP. In August 1989, HCFA revised the State Medicaid Manual to explain that, absent valid documentation to the contrary, States could no longer reimburse pharmacies using AWP without a reduction. Nationally, HCFA expects major savings from this policy change.

The HCFA's actions are supported by the findings of several studies. A 1984 Audit report issued by the HHS Inspector General[1] concluded that, on average, pharmacies actually purchase drugs for 15.9 percent below AWP. In an October 1989 update[2] of that audit, the Inspector General found no significant change in the level of discounting. The 1989 analysis showed that, on average, pharmacies now purchase drugs at 15.5 percent below AWP. Recent studies by the HCFA Region IV and VI offices provide additional support. Their studies have also found that the actual price paid by pharmacies is still significantly below AWP.

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[1]Office of Inspector General, United States Department of Health and Human Services. "Changes to the Medicaid Prescription Drug Program Could Save Millions." ACN: 06-40216. 1984.

[2]Office of Inspector General, United States Department of Health and Human Services. "Use of Average Wholesale Prices in Reimbursing Pharmacies Participating in the Medicaid and the Medicare Prescription Drug Program." CIN: A-06-89-00037. October 1989.

SCOPE

All Georgia rural pharmacies known to have closed from October 1, 1988 to September 30, 1989 and all rural pharmacies that withdrew from the Medicaid program during that period were included in the inspection. Independent pharmacies, community pharmacies, and chain pharmacies were included in the study.

For purposes of this study the following definitions were used:

> ***Closed Pharmacy:*** One that stopped dispensing prescription drugs during Fiscal Year 1989. A pharmacy that was sold and remained open was not counted as a closure. Also, a pharmacy that moved to another location in the same rural community was not counted as a closure.
>
> ***Rural:*** A city, town, or locality which is not located in a Metropolitan Statistical Area (MSA) as defined by HCFA.

Appendix A contains information on data sources and methods used in this inspection.

FINDINGS

Twelve Rural Georgia Pharmacies Closed in Fiscal Year 1989.

There are currently 1,976 licensed pharmacies in Georgia. Approximately 46 percent are in rural areas. This inspection found only 12 closures between October 1, 1988 and September 30, 1989 in the rural areas of the State.

Of the 12 stores that did close, nine were independent pharmacies and three were chain drug stores. The map on the following page shows the location of the closed pharmacies. The population of the towns where pharmacies closed ranges from 3,112 to 37,596, with the exception of one town of only 757 people. All of the closed pharmacies were Medicaid providers.

Retirement and Financial Problems Were the Reasons for Closure.

In five cases, retirement was the reason for closure. Three owners did not have a buyer, so they closed their stores. Two owners sold their businesses to nearby pharmacies who chose to close these locations. None of the former owners said financial difficulties had contributed to their decisions to retire.

In the remaining seven cases, various financial problems were cited as the reasons for closure. Two of the closures were Revco stores. These were closed by Revco D.S. Inc. as part of Chapter 11 bankruptcy proceedings, which required closing the chain's less profitable stores. Two other pharmacies closed due to competition from bigger pharmacies in town. In two other cases, the owners had more than one pharmacy in town and decided to consolidate them. Finally, one owner wanted to move out of State. His store was having cash flow problems, prompting his decision to close it and move.

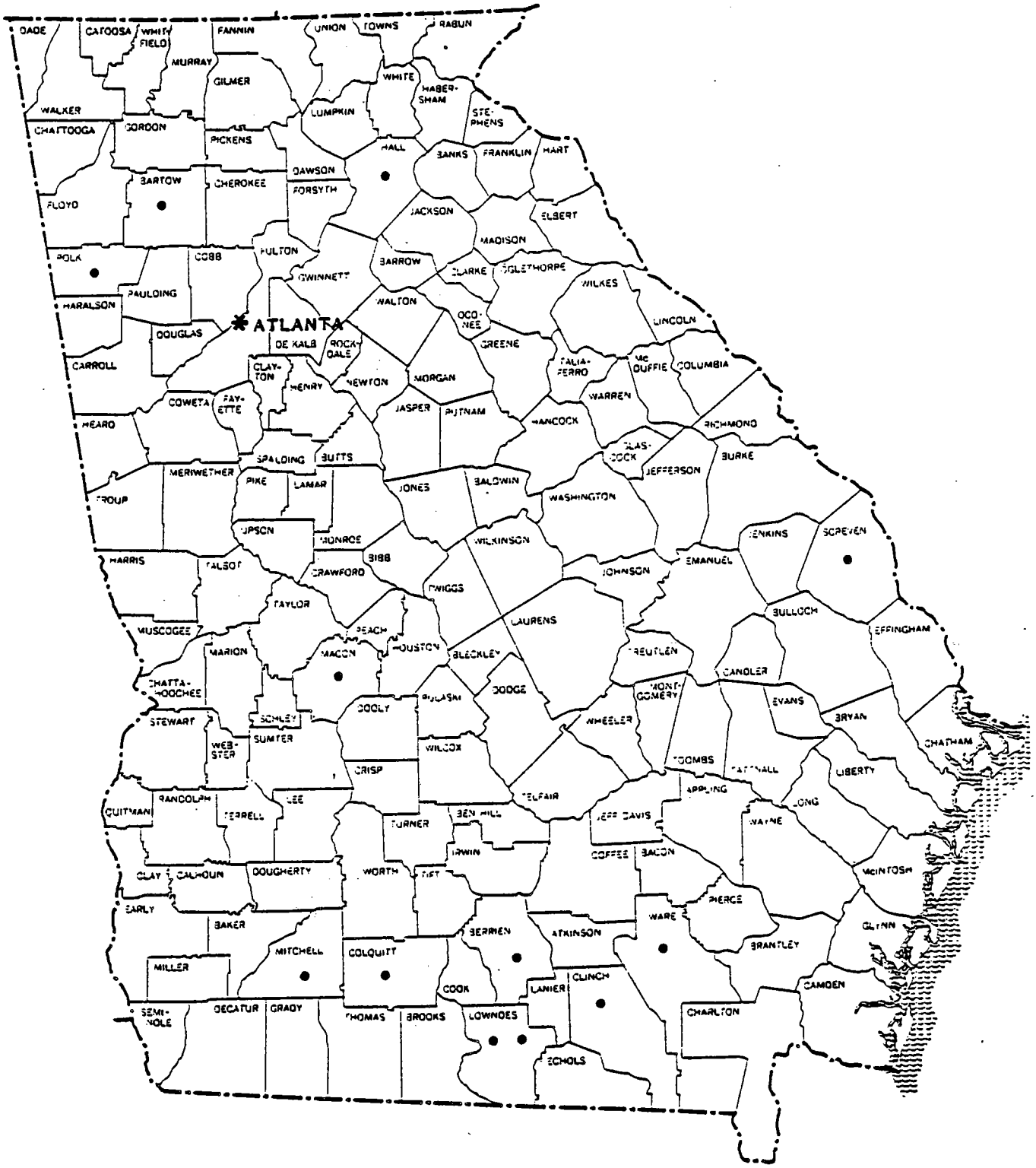
None of the respondents cited Medicaid reimbursement as the reason for closure. However, in response to specific questions about Medicaid, three former owners indicated they were experiencing cash flow problems, and that Medicaid reimbursement was a contributing factor.

Closures Did Not Disrupt Access to Pharmacy Services for Medicaid Clients.

The closure of the 12 pharmacies did not affect access to pharmacy services for Medicaid clients in those communities. In 11 of the rural towns where pharmacies closed, from 2 to 25 other drug stores still accept Medicaid.

In one case, a town with a population of 757, the closed pharmacy was the only pharmacy. Its closure means that all residents, including Medicaid clients, have to go elsewhere to get prescriptions filled. The nearest town is nine miles away. It has 12 pharmacies.

TWELVE RURAL PHARMACIES CLOSED



● RURAL PHARMACY CLOSURES

Medicaid Cost Containment Measures Reduce Pharmacy Profits.

The HCFA has been encouraging States to modify their pharmacy payment formulas so that reimbursement on the basis of EAC is below the AWP.

Most States have implemented this new HCFA policy. In August 1988, Georgia's Department of Medical Assistance (DMA) changed its pharmacy reimbursement formula. After three months' experience with the new formula, the State projected an annual savings of $7 million. The DMA has not completed its final analysis of the actual savings.

Georgia now:

- limits the pharmacies' EAC to AWP minus 10 percent; and
- pays a dispensing fee of $4.26 per prescription.

As shown in appendix B, Georgia's AWP discount is comparable to those of other States. Its dispensing fee, at $4.26, is one of the highest.

What has been the effect of Georgia's cost containment measures on Medicaid-participating pharmacies? State officials say that changes in reimbursement schedules have reduced pharmacy profits. However, they know of no pharmacies which closed in 1989 due to Medicaid payment reforms.

Most State respondents agree with the OIG Audit finding that pharmacy reimbursement should be based on a discount from the AWP. Some point out, however, that a uniform discount will affect individual pharmacies quite differently. In particular, pharmacies which are small and have high proportions of Medicaid-reimbursable sales will be more negatively affected than larger pharmacies with low Medicaid proportions. In fact, Medicaid reductions may result in financial difficulties for some small pharmacies.

The respondents explain that:

- Wholesalers give discounts for volume purchasing, quick payment, and infrequent account servicing. Small stores with low sales volumes and shallow inventories are unable to get the best wholesalers' discounts. Since the smaller stores get fewer discounts, their operating margins tend to be smaller.
- Pharmacies with a high Medicaid-to-private sales ratio have limited opportunity to "cost shift" Medicaid reductions to other private sales. The impact on operating margins is compounded, then, for pharmacies which serve high proportions of Medicaid clients.

Some respondents suggest that viable pharmacies may drop out of the Medicaid program because of low Medicaid reimbursement. However, the number of Georgia pharmacies participating in Medicaid remains very high--over 90 percent. This inspection of rural pharmacies found that, aside from those which closed, only one pharmacy withdrew from the Medicaid program in 1989.

In addition to discounts from the AWP, the State of Georgia has recently taken steps to further contain Medicaid pharmacy cost. These initiatives are described in appendix C.

Summary

This inspection found that very few rural pharmacies in Georgia closed in the past year and none of the closures were attributed to Medicaid reimbursement policies. Some respondents cautioned that as more Medicaid cost containment measures are implemented in Georgia, small pharmacies with a high percentage of Medicaid sales may encounter financial problems.

APPENDIX A

INFORMATION SOURCES AND METHODS

A. Types of Information and Sources

1. Lists of Pharmacies Closed and Withdrawn from Medicaid Program

   a. Georgia Department of Medical Assistance (State Medicaid agency)
   b. Georgia Board of Pharmacy (State licensing agency)
   c. Georgia Pharmaceutical Association

2. Reasons for Closure

   a. State Agencies/Organizations
      - Georgia Department of Medical Assistance
      - Georgia Board of Pharmacy
      - Georgia Pharmaceutical Association
      - Georgia Legislature

   b. Local Communities where Pharmacies Closed
      - Health care providers
      - Former owner(s) of closed pharmacy
      - Owner(s) of nearby pharmacies
      - Municipal officials
      - Chambers of Commerce

3. Impact on Access

   a. Georgia Business Directory
   b. Interviews with local community respondents (See above #2.b.)

B. Methods of Information Collection

1. From Existing Data Bases

   The Georgia Department of Medical Assistance (DMA) provided a list of pharmacies that have ceased to participate in the Medicaid program. These pharmacies either: a) had mail returned to DMA, b) had not submitted a

Medicaid claim within 2 years and had failed to respond to letters of inquiry, or c) had voluntarily withdrawn from the program.

The Georgia Board of Pharmacy provided a list of pharmacies which its licensing inspectors had found to be closed when they went out to conduct inspections.

From these two lists, all pharmacies which fit the following criteria were identified:

a. pharmacies located in rural areas; and
b. pharmacies whose effective date of termination from the Medicaid program was between 10/1/88 and 9/30/89, including pharmacies that the licensing inspectors discovered to be closed during that period.

A single unduplicated list was produced of 68 rural pharmacies in Georgia which the State believed to have closed or withdrawn from the Medicaid program during Fiscal Year 1989. (It should be noted that additional pharmacies may have closed during that time period, but have not yet appeared on any State list.)

2. From Contacts with Informed Persons

The inspection team attempted to contact each of the 68 pharmacies by telephone to first verify if it had closed and, if so, when. In addition, the telephone interviews were to find out:

a. the reasons for the closure;
b. if the pharmacy served Medicaid clients; and
c. the location of other nearby pharmacies that fill Medicaid prescriptions.

Telephone interviews were conducted with the current or former owner of the pharmacy whenever possible. Other local respondents were also interviewed, including nearby pharmacy owners, other health professionals in the community, municipal officials and any other knowledgeable respondents.

APPENDIX B

REIMBURSEMENT BY STATE

STATE	DISPENSING FEE	EAC
ALABAMA	$3.75	WAC plus 9.2%
ALASKA	$3.45- 11.46	AWP minus 5%
ARIZONA	State contracts with pre-paid plans	
ARKANSAS	$4.01	AWP minus 7%
CALIFORNIA	$4.05	AWP minus 5%
COLORADO	$3.78	Lower of AWP or WAC plus 18%
CONNECTICUT	$3.55	AWP minus 8%
DELAWARE	$3.65	Actual Cost to Pharmacy
DISTRICT OF COLUMBIA	$4.25 $5.10 for compound Rx	AWP minus 10%
FLORIDA	$4.23	WAC plus 7%
GEORGIA	$4.26	AWP minus 10%
HAWAII	$4.14	AWP minus 10.5%
IDAHO	$4.00 $4.15 unit dose	Actual Cost to Pharmacy
ILLINOIS	$3.58 or 10% of drug (to maximum)	Lower of State maximum or Usual & Customary

STATE	DISPENSING FEE	EAC
INDIANA	$3.00	AWP minus 10%
IOWA	$3.87	AWP
KANSAS	$2.79- $5.26 Varies by pharmacy	AWP minus 10%
KENTUCKY	$3.25	AWP minus 5%
LOUISIANA	$3.51	AWP minus 10.5%
MAINE	$3.35	AWP minus 5%
MARYLAND	$3.70	AWP
MASSACHUSETTS	$3.88	WAC plus 10%
MICHIGAN	$3.65	AWP minus 10%
MINNESOTA	$4.20	AWP minus 10%
MISSISSIPPI	$3.75	Lower of State maximum or Usual & Customary
MISSOURI	$3.10/ $3.25	AWP
MONTANA	$2.00- $4.00 +.75 for unit dose systems	AWP minus 10%
NEBRASKA	$2.84- $5.05	Lower of AWP minus 8.71% or WAC plus 12%
NEVADA	$3.95	AWP minus 10%

STATE	DISPENSING FEE	EAC
NEW HAMPSHIRE	$2.85/ $3.00	AWP
NEW JERSEY	$3.73- $4.07	AWP minus store-specific discount (0-6%)
NEW MEXICO	$3.65	AWP minus 10%
NEW YORK	$2.60	AWP
NORTH CAROLINA	$4.24	AWP
NORTH DAKOTA	$3.75	AWP
OHIO	$3.23	AWP minus 7%
OKLAHOMA	$3.55	AWP minus 10%
OREGON	$3.52 or $3.83	AWP minus 11%
PENNSYLVANIA	$2.75	AWP
RHODE ISLAND	$3.40	Lower of AWP or Usual & Customary
SOUTH CAROLINA	$3.30	AWP minus 9.5%
SOUTH DAKOTA	$4.25	AWP minus 10.5%
TENNESSEE	$4.21	AWP minus 7%
TEXAS	$3.26	Lower of AWP minus 10% or WAC plus 12%
UTAH	$3.65	AWP minus 12%
VERMONT	$2.75 or 10% of Drug	AWP

STATE	DISPENSING FEE	EAC
VIRGINIA	$3.40	Lower of AWP or Usual & Customary
WASHINGTON	$3.15, $3.60 or $4.20, based on # of Rxs.	AWP minus 11%
WEST VIRGINIA	$2.75	AWP
WISCONSIN	$3.72 (non-unit) $5.73 (unit dose)	AWP
WYOMING	$4.16	AWP

DEFINITIONS:

EAC: Estimated Acquisition Cost
WAC: Wholesale Acquisition Cost
AWP: Average Wholesale Price

SOURCES OF INFORMATION:

National Pharmaceutical Council, Inc. *Pharmaceutical Benefits Under State Medical Assistance Programs*. September 1989.

Telephone calls to State Medicaid Agencies.

APPENDIX C

GEORGIA CONTINUES TO PURSUE COST CONTAINMENT FOR MEDICAID PHARMACY SERVICES

The Georgia legislature passed a law this year (1989) which:

- permits the State's Department of Medical Assistance (DMA) to solicit competitive bids from pharmaceutical manufacturers and distributors to become the sole suppliers of specified drugs for all Medicaid clients;
- requires successful bidders to pay rebates to the State;
- stipulates for any drug on the bid list, if no acceptable bids are received, the DMA may:
  - contract with a single supplier, or
  - prohibit reimbursement to vendors who have not submitted a bid; and
- allows the DMA to set Medicaid reimbursement limits on the duration of prescriptions for selected drugs where the manufacturer claims effectiveness within a certain period of time; requires prior approval for continued coverage.

The DMA did not receive any acceptable bids under the competitive bidding provisions of the new law. In addition, manufacturers have sought a temporary restraining order to stop implementation of the law. The DMA officials contacted during this inspection indicated, however, that the bid solicitation process will be re-opened in 1990.