maceutical service. Even "consumer leaders" with whom the Association has discussed the existing professional fee situation have recognized its inherent unfairness and irrationality.

If correspondence addressed to the Association is any indication, pharmacists will no longer tolerate situations in which professional fees in state Medicaid programs remain static for several years in the face of spiraling inflation. Pharmacists cannot understand why manufacturers have been permitted unlimited "pass-through" of price increases at their expense. In several states, there has been an effort to reduce fees rather than increase them in order to compensate for increased drug product costs resulting from higher manufacturer prices.

At the same time, pharmacists have been expected to continue financing these programs with their own capital because of inordinate delays in claims payment in many states—when interest rates have skyrocketed. Members are telling APhA that they can no longer tolerate or absorb such financing costs, even if they were willing to do so—which they are not.

The simple fact is that the present Medical Assistance Program regulations permit, and administration of the program has condoned, the payment of a professional fee of $1.25 in the state of Missouri and at the same time, a professional fee of $2.42 in the state of California. The close to 100 percent difference among state Medicaid professional fees is ample argument for mandatory federal regulation. In all candor, APhA is beyond the point of even trying to explain to the nation's pharmacists how the government can permit such gross disparities in the treatment of pharmacists by the states.

Present HEW regulations require the payment of a "reasonable dispensing fee" for the professional services provided by the pharmacist. If fees actually paid in 1969 were then "reasonable," the same, or only minimally increased fees are clearly unreasonable in 1975 when inflation during this period has accumulated to 34.5 percent according to the Bureau of Labor Statistics. It is clear that HEW has failed to observe and enforce its own regulations.

The following table shows the fees paid in 26 state Medicaid programs which utilized a uniform fee for pharmacist professional services during the 1969-73 period. In 1969 the average fee for these 26 states was $1.77; in 1973 the average fee was $1.87—a 5.8 percent accumulative increase in five years. In twelve states the fee was not increased one cent. Just to keep pace with the CPI measure of inflation, the average fee for the 26 states should have been increased $.61 to $2.38.

These facts taken individually and collectively reflect a gross abuse of pharmacists which APhA regards as a national disgrace.

State Medicaid Professional Fees 1969 and 1973

	1969	1973
Alabama	$1.50	$1.50
California	2.30	2.42
Colorado	1.85	1.85
Connecticut	1.75	2.00
Delaware	2.00	2.00
Dist. of C.	1.50	1.60
Georgia	1.85	1.95
Indiana	1.85	1.85
Iowa	2.00	2.00
Kentucky	1.40	1.65
Louisiana	1.80	1.80
Maine	1.75	2.00
Maryland	1.75	1.75
Massachusetts	1.80	1.85
Michigan	2.00	2.00
Mississippi	1.50	1.50
Missouri	1.10	1.25
New Hampshire	1.85	2.20
New Jersey	1.85	2.05
New Mexico	2.00	2.00
New York	1.80	1.80
North Carolina	1.75	2.00
Rhode Island	1.50	1.90
South Carolina	1.90	1.90
Tennessee	1.85	1.95
Vermont	1.75	1.85

There can be little question that if the Department can establish mandatory requirements for "state-plan" programs with regard to reimbursement for drug product cost, the Department can likewise establish a mandatory requirement that states adopt a variable fee system which reflects the differences in professional service provided by individual pharmacies and which also adequately compensates individual pharmacies for such service. Certainly, the Department can establish such requirements for its own "in-house" programs.

APhA wishes to voice its support for the "unit dose" system provisions of Section 250.30(b) (2) (i) (b) of the proposed Medical Assistance Plan regulations, but believes they should be expanded. The Association would note, however, that administration of this provision should effectively require the establishment of a unit dose *system* for dispensing and not merely the obtaining and dispensing of drug products in unit dose packaging. Unfortunately, the provisions of this subsection are inadequate in that they do not require payment for non-drug dispensing professional services provided by pharmacists in long-term care facilities, although such services are required under the Medical Assistance Program for the facility to qualify as a recipient of federal funds.

The Commissioner of the Medical Services Administration has recently stated his view, that the failure of a facility to pay for such professional services provided by a pharmacist separate and apart from payment for the dispensing of drug products, is, in effect, a "kickback" situation and a violation of federal law. While APhA might concur in this assessment, it would also have to point out that the situation is one which has been created by the fact that states do not generally reimburse long-term care facilities for such services because federal regulations and program guidelines do not require the states to pay for them. "Unit Dose" provisions should also be included in the Public Health Service regulations whether or not such systems are currently employed in those programs.

Section 250.30(b) (2) (i) (c) of the proposed Medical Assistance Program regulations setting a provider reimbursement limit is, in its present form, an open invitation to take advantage and divert federal Medical Assistance Program funds for the benefit of persons not entitled to participate in the program. This is because the regulation would continue to permit state agencies to evaluate the appropriateness of a particular pharmacy's professional fee by testing that the *average* prescription price paid the pharmacy by the state agency does not exceed the *average* prescription price paid by the general public. To enforce this requirement, a state agency would have to audit every charge for all the prescriptions dispensed by a particular pharmacy. Unless the word "average" is stricken from this provision, the government and taxpayers will continue to overpay in the fashion reported recently by the General Accounting Office in its review of the District of Columbia Medicaid program.

It can be documented virtually nationwide that some pharmacies, usually chains and so-called "discounters" have been collecting from Medicaid programs drug product cost (often on a catalog price basis) plus full professional fee for prescriptions which they are dispensing to the general public at "loss leader" prices. Not only have these pharmacies not extended to the government their usual pricing policies, but the windfalls received from federal funds reimbursed on a full cost plus fee basis have been used to subsidize "giveaway" prices to patients who do not qualify as Medicaid participants. The only way for the government to put a stop to these abusive and unlawful practices is to