and the taxpayer, but it also places the government in the position of providing operating capital which can be used to wipe out the competitive presence of lower volume independent pharmacies.

Any claim that providers should be rewarded for large volume buying practices is met by the provision of Section 19.3(b) which would award any pharmacy 25 percent of the difference between a MAC and the price at which the pharmacy is able to purchase a particular drug product. This concession should not be increased for what in practice is one class of pharmacies—large volume purchasers —by awarding additional "gravy" above actual acquisition cost.

A related matter involves the proposed reimbursement for so-called "warehousing" costs to "a provider who maintains a warehouse separate from his retail place of business." This proposed warehousing allowance is discriminatory in that it primarily benefits large volume drug chains, while failing to take into account the fact that all providers, including independent pharmacies, have costs associated with getting a drug product from their source of supply to their stock shelves. These costs are not attributable to the drug product itself, however, but represent operational costs and overhead which would properly be accounted for in the determination of all providers' professional fees. If the regulations in final form award what is really merely a special "handling" allowance only to large volume purchasers, they would be discriminatory on their face and, in the view of APhA subject to legal challenge.

All providers must be treated the same and any possible drug product handling costs should be limited to the actual costs of handling the drug products themselves (eliminating costs of handling unrelated merchandise) with an established upper cost limit.

APhA comments regarding the drug product cost component of pharmaceutical service, save one, have already been made with regard to the proposed Departmental regulations. The remaining comment is applicable to all of the proposed regulations, which would authorize the payment of actual acquisition cost for a drug product, without regard to any MAC limitation which may be established for that drug, if the prescriber has certified in writing that the specific drug product prescribed is the only one which can be tolerated or which will be effective for the patient involved.

Beyond stating that certification by the prescriber would be required in writing, the proposed regulations do not specify the precise form of certification, to whom the certification would be made, or the means by which the pharmacist would establish the fact of certification to obtain actual acquisition cost reimbursement in such situations. The lack of specificity in the proposed regulations may be aimed at permitting each program to establish its own requirements for prescriber certification. It would be far better, however, were all of the program regulations themselves to specify with regard to prescriber certification at least the following elements:

1. A form which would identify the patient and the drug product, such information to be provided in the prescriber's own handwriting and signed by him.
2. Transmittal of the certification in duplicate to the pharmacist (along with a written prescription order), one copy to be retained in the pharmacist's files and one copy to be transmitted to the state agency as support for the pharmacist's claim for reimbursement. This procedure should not be available for oral prescription orders.

The certification provisions of all of the proposed regulations are also deficient in that they fail to provide for "actual acquisition cost" reimbursement when the pharmacist, in the exercise of his professional judgment, determines that the patient requires a particular drug product. In several states, whose number will be increasing rapidly, pharmacists have the right of drug product selection even though the prescriber may have ordered a drug by a particular brand name. The pharmacist should be able to dispense a more expensive brand as a matter of professional judgment in the same manner as the physician. Since reimbursement is based on actual drug product cost there can be no claim that such pharmacist discretion will be influenced by economic incentives.

If, for example, a prescriber orders a particular drug product for a diabetic patient not realizing that sugar is included in the formulation, the pharmacist would be able to dispense the same drug in a formulation containing an artificial sweetener which could be tolerated by the patient. Such a product might fall outside the MAC limitation for the drug, and the regulations should provide for actual acquisition cost reimbursement on the basis of the pharmacist's certification rather than the physician's.

PHARMACIST PROFESSIONAL FEES

Comments which follow address themselves primarily to the Medical Assistance Program "reasonable charges" regulations in Section 250.30 and PHS regulations in Section 50.504.

The most vigorous disagreement APhA has with regard to the proposed Medicaid "reasonable charges" and Public Health Service regulations is the fact that Sections 250.30(b) (2) (i) and 50.504, respectively, do little more than repeat the language of present provider reimbursement regulations. Although officials of HEW have assured APhA that it is their intention that state Medicaid and other programs move to a professional fee structure which would terminate the present almost universal "uniform fixed fee" situation, the proposed regulations clearly do not require such action by any state or Public Health Service program. Thus, the proposed regulations are inadequate and unacceptable because they are neither adequately specific nor explicitly mandatory.

In Sections 250.30(b) (2) (i) and 50.504(a) (2), all of the specified criteria for professional fee determination could continue to be used to establish a "uniform fixed fee" on an "average" pharmacy basis. A perpetuation of this fee structure would represent an absolute breach of faith by the Department and its component agencies with the nation's pharmacists.

In the above referenced sections, the continued suggestion that states should consider the payment practices of other third party organizations is a clear signal that the present "uniform fixed fee" will continue to be tolerated since virtually all existing third party payment programs have established professional fees on this basis. APhA must again point out, as it has so many times previously, that a uniform fixed fee results in the unfair overpayment of some pharmacists and the unfair underpayment of others, while a third group is appropriately compensated on the basis of operating costs related to services provided. The final regulations must make "crystal clear" the Department's intention that this gross inequity be terminated.

The feasibility of establishing professional fees on an individual pharmacy basis is no longer in question since this approach has been demonstrated successfully in the state of Kansas since 1970, a fact which is brought to the attention of all states by the Medical Assistance Program in the Medical Assistance Program Manual (see CCH Medicare and Medicaid Guide, Vol. 2, p. 6387). Texas now utilizes a similar approach.

The time has long since passed for the Department to demonstrate its good faith and interest in equitable treatment for pharmacists by requiring a variable professional fee for phar-