

Submitter : Mr. Lawrence Irene R.Ph
Organization : Armada Health Care
Category : Other Health Care Professional

Date: 02/16/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attached

CMS-2238-P-736-Attach-1.DOC

ARMADA

Health Care

February 16, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2238-P
P.O. Box 8015
Baltimore, MD 21244-8015

Re: Docket: CMS-2238-P - Prescription Drugs

To Whom It May Concern;

Please accept for consideration this letter pertaining to an announcement by the Centers for Medicare & Medicaid Services (CMS) on December 22, 2006 that requires the imposition of a new methodology to establish reimbursement under CMS program(s) and referred to as "Average Manufacturer Pricing" (AMP). As noted in that announcement, CMS has established a comment period and has invited interested parties to provide their input on the promulgation of specific rules, regulations and specifically on the definition of AMP as it will be utilized in the development of pricing and reimbursement formulae that will set reimbursement rates for prescription drugs.

This comment is provided by Armada Health Care, Inc. on behalf of our pharmacy membership. We serve our members by securing contracts with pharmaceutical manufacturers for a broad array of prescription drugs and we focus specifically on the specialty pharmacy segment and working with specialty pharmacies nationally to provide them access to group discounts. Our manufacturer negotiations specifically target high-cost injectables, infusible, and other select biotech class medications. Our member pharmacies include the majority of independent specialty pharmacies operating in the US. Additionally, our membership also includes the top largest chain pharmacies in the country. In the aggregate, Armada membership now represents more than 7,000 retail pharmacy locations, billions of dollars in specialty pharmacy spend, and millions of patients.

CMS has publicly stated that the proposed rules and introduction of AMP methodology will impact independent retail pharmacies. All of the pharmacies associated with our organization are classified / licensed as retail pharmacies and often dispense traditional drugs in conjunction with specialty medications. Since our membership will be impacted by this action we are offering this comment to provide CMS with information to assist in developing an equitable methodology, one that does not disproportionately impact the sub-class of specialty pharmacy or try to insert it into a 'one size fits all' formula.

Pricing Component Inequities for Specialty Pharmacies –

The cost of an average prescription in a retail pharmacy currently averages ~\$100.00 for a brand name drug and ~\$40.00 for a generic prescription. By contrast, the average prescription dispensed in a specialty pharmacy easily exceeds \$1,500.00 per month. This pricing disparity naturally magnifies the financial impact that any change in reimbursement, such as proposed under AMP methodology, may have on net

reimbursement. While the effect may only be a dollar on a routine brand name prescription and perhaps pennies on a routine generic drug, the magnified effect to reimbursement for a specialty drug may be ten (10) or more times greater in real dollars.

Specialty pharmacies also have significantly greater dispensing costs than a retail pharmacy and routinely serve patients requiring express overnight delivery and special handling. While gross margins may appear larger for a specialty transaction, associated costs are disproportionately large and significantly erode profit even under current reimbursement methods. This disparity should be accounted for in factoring in 'dispensing fees' as they are a stated component of the proposed AMP methodology rule.

Pharmacy associations nationally suggest that the average cost to dispense a traditional prescription is as high as \$10.00. By contrast, specialty pharmacies incur dispensing expense per prescription well in excess of that figure. These incremental costs typically include taking a thorough patient medical history, comprehensive patient counseling on the drug regimen and disease state, training on administration of injectables, obtaining medical records required for pre-authorizations, and compliance tracking and other cognitive services. We estimate that these costs easily double the average cost to dispense a prescription – or more, based on the complexity of the patient's disease state. Additionally, delivery costs are considered a part of the 'dispensing fee' under AMP. While a traditional prescription might only cost \$1-\$3.00 to deliver by mail, specialty pharmacy medications, many of which require temperature control, require express shipping with an average delivery cost of \$15.00 or more per prescription.

Independent specialty pharmacies are not able to routinely contract directly with manufacturers. As such, National Purchasing Organizations represents the only viable discount opportunity available to them for high-cost specialty pharmacy medications and biologics. However, only within the past year have pharmaceutical manufacturers begun to even consider incentives for specialty products for the independent specialty class of trade and rarely offer our pharmacies direct incentives such as rebates or free goods for specialty medications. This disparity becomes significant when one considers that specialty medications now represent s much as 35% of all pharmacy spend in the US.

However, it is well known that very large customers, such as hospitals and PBM-owned mail service pharmacies, use their leverage to garner significant discounts, preferred terms, rebates, and pricing concessions on specialty pharmacy medications through direct manufacturer contracts. Since these customers represent the majority of total specialty pharmacy expenditures, they move the mean in a direction that creates even greater disparity for small independent specialty pharmacies. Some weighting of this effect in the AMP formula will be critical to mitigate the adverse impact to independent specialty pharmacies.

This issue may be particularly evident when defining "Best Price" for single source or innovator multiple source products. Specialty pharmacy is unique as this category includes many single source and innovator products. A strict definition of "Best Price" would almost inevitably exclude independent specialty pharmacies from providing these products since their acquisition costs will be significantly higher than other trade classes (e.g., hospitals, mail order pharmacies included in the AMP calculation) and would predictably result in a loss on each transaction. These pharmacies would be unable to fill these prescriptions as a result. Since the new methodology will be initially applied to

Medicaid programs, the impact to patients would be severe. These patients commonly obtain their specialty pharmacy medications through local independent specialty pharmacies, not through mail order. If their local pharmacies can no longer viably serve this population, these patients will either go without medication or will be forced to more costly sites of service, such as hospital outpatient departments.

Lastly, we wish to express concern over how establishment of the Federal Upper Limit (FUL) will impact specialty pharmacy. FUL understandably applies to multiple source drugs (e.g., generics with therapeutic equivalents). At this time, the number of therapeutic equivalents in the specialty pharmacy category is very small. However, this issue is currently at the heart of pending legislation in Congress relating to the approval of generics in biologics. We believe that this issue is highly complex as evidenced by the FDA's stance and inability to set scientific standards that clearly differentiate equivalency between/among specialty medications. As such we strongly suggest that all specialty medications be exempt from FUL definition/calculations until this critical issue is resolved in law and in the marketplace.

We would be pleased to provide CMS with specific information or clarifications on the points that we have raised on behalf of the specialty pharmacy industry. You may contact me directly at the address noted herein. Thank you for this opportunity to comment.

Sincerely,

A handwritten signature in black ink, appearing to read 'L. Irene', with a long horizontal flourish extending to the right.

Lawrence S. Irene, RPh
Chief Executive Officer
Armada Health Care

Submitter : Mrs. jennifer valentine

Date: 02/16/2007

Organization : medicap pharmacy

Category : Other Technician

Issue Areas/Comments

GENERAL

GENERAL

I would like to send a comment about the Deficit Reduction Act. I do not agree with this proposed act. If the pharmacy is getting reimbursed less for the medications that we fill, then we will not have enough profit to cover payroll or good customer service. The pharamcy will no longer be able to pay the costs for more employees, our raises will be less causing technicians to eventually find another profession that can pay better.

Submitter : Miss. Teri Belcher

Date: 02/16/2007

Organization : Medicap Pharmacy

Category : Other Technician

Issue Areas/Comments

GENERAL

GENERAL

If this bill passes, the custom service you expect at a pharmacy, will no longer be available and resulting in not enough money to cover payroll and supplies.

Submitter : Mr. Jozef Beckley

Date: 02/16/2007

Organization : APhA

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

February 14, 2007

<p>Centers for Medicare and Medicaid Services</p>

Attention CMS 2238-P Mail Stop C4-26-05

7500 Security Blvd

<p>Baltimore, Maryland 21244-1850

<p>Subject: Medicaid Program: Prescription Drugs; AMP Regulation

<p>CMS 2238-P RIN 0938-AO20

<p>I am pleased to submit these comments to the Centers for Medicare and Medicaid Services (CMS) regarding CMS December 20, 2006 proposed regulation that would provide a regulatory definition of AMP as well as implement the new Medicaid Federal upper limit (FUL) program for generic drugs. I am a pharmacy student attending Wilkes University and I also work at Minnich's Colonial Pharmacy in York, PA.

<p>1. Remove PBM and Mail Order from the Retail Class of Trade

<p>(i) Creates consistency in the Regulation

<p>(ii) Conforms definition with market reality

<p>2. Implement a Trigger Mechanism

<p>(i) Addresses severe price fluctuations

<p>(ii) Reduces risk of Market Manipulation

<p>(iii) Mitigates Risk of Pricing Lag

<p>3. Use of 11-Digit NDC versus 9-Digit NDC

<p>(i) Represents the most common package size dispensed by retail pharmacies

<p>I support the more extensive comments that are being filed by Pennsylvania Pharmacists Association regarding this proposed regulation. I appreciate your consideration of these comments and ask that you please contact us with any questions.

<p>Sincerely,

<p><p>Jozef R. Beckley

Submitter : Dr. Jennifer Askew
Organization : NC Association of Pharmacists
Category : Pharmacist

Date: 02/16/2007

Issue Areas/Comments

GENERAL

GENERAL

February 16, 2007

Centers for Medicare and Medicaid Services
Attention CMS 2238-P Mail Stop C4-26-05
7500 Security Blvd
Baltimore, Maryland 21244-1850

Subject: Medicaid Program: Prescription Drugs; AMP Regulation
CMS 2238-P RIN 0938-AO20

I am pleased to submit these comments to the Centers for Medicare and Medicaid Services (CMS) regarding CMS December 20, 2006 proposed regulation that would provide a regulatory definition of AMP as well as implement the new Medicaid Federal upper limit (FUL) program for generic drugs. My pharmacy(s) is located in Wilmington, NC. We are a major provider of pharmacy services in the community and your consideration of these comments is essential.

1. Remove PBM and Mail Order from Retail Class of Trade
 - (i) Creates consistency in the Regulation
 - (ii) Conforms definition with market reality
2. Implement a Trigger Mechanism
 - (i) Addresses severe price fluctuations
 - (ii) Reduces risk of Market Manipulation
 - (iii) Mitigates Risk of Pricing Lag
3. Use of 11-Digit NDC versus 9-Digit NDC
 - (i) Represents the most common package size dispensed by retail pharmacies

I support the more extensive comments that are being filed by the North Carolina Association of Pharmacists regarding this proposed regulation. I appreciate your consideration of these comments and ask that you please contact us with any questions.

Sincerely,

Jennifer P. Askew, BS, PharmD, CPP

cc. Members of Congress (Senator Elizabeth Dole, Senator Richard Burr, Representative Mike McIntyre)

Submitter : Mr. dale smith

Date: 02/16/2007

Organization : PBA Health d/b/a TrueCare Pharmacy

Category : Pharmacist

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-2238-P-741-Attach-1.TXT

From: Dale Smith

Sent: Friday, February 16, 2007 1:40 PM

To: Dale Smith

Subject: More than half of all prescriptions dispensed by retail pharmacies are for generic medications, so losing money on every one d

Submitter : Mr. Russ Jensen
Organization : Dean Pharmacy
Category : Pharmacist

Date: 02/16/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2238-P-742-Attach-1.DOC



February 16, 2007

Centers for Medicare and Medicaid Services
Attention CMS 2238-P Mail Stop C4-26-05
7500 Security Blvd
Baltimore, Maryland 21244-1850

**Subject: Medicaid Program: Prescription Drugs; AMP Regulation
CMS 2238-P RIN 0938-AO20**

Dean Pharmacy is writing to provide our views on CMS' December 20th proposed regulation that would provide a regulatory definition of AMP as well as implement the new Medicaid Federal Upper Limit (FUL) program for generic drugs.

Our Corporation operates eight pharmacies in Southern Wisconsin. We are a major provider of pharmacy services in the communities in which our pharmacies are located.

This proposed regulation, if adopted, would have a significant negative economic impact on my pharmacies. It could jeopardize my ability to provide pharmacy services to Medicaid beneficiaries and the general public. This regulation should not move forward unless substantial revisions are made. Incentives need to be retained for pharmacies to dispense low-cost generic medications. I ask that CMS please do the following:

- **Delay Public Release of AMP Data:** The Centers for Medicare and Medicaid Services (CMS) should not make Average Manufacturers Price (AMP) data public until a final regulatory definition of AMP is released. This definition should reflect the prices at which traditional retail pharmacies purchase medications. CMS indicates that it will start putting these data on a public website this spring. However, release of flawed AMP data could adversely affect community retail pharmacies if used for reimbursement purposes. CMS has already delayed release of these data, and we urge that release of these data be delayed again.
- **Define AMP to Reflect Retail Pharmacy Purchasing Costs:** CMS' proposed regulatory definition of AMP is problematic because it would result in AMP values that would not reflect the prices at which retail pharmacies purchase medications. Only manufacturers' sales to wholesalers for drugs sold to traditional community retail pharmacies should be included in the AMP definition. This is what the law requires.

Mail order pharmacy and nursing home pharmacy sales should be excluded because these are not traditional retail pharmacies. Pharmacies do not have access to the special prices offered to these classes of trade.

In addition, manufacturers should not be allowed to deduct rebates and discounts paid to PBMs when calculating the AMP. Retail pharmacies do not benefit from these rebates and discounts, so the resulting AMP would be lower than the prices paid by retail pharmacies for medications. This proposed definition needs to be significantly modified.

- **Delay New Generic Rates that Would Significantly Underpay Pharmacies:** The new Federal Upper Limits (FULs) for generic drugs would be calculated as 250% of the lowest average AMP for all versions of a generic drug. This will reduce Medicaid generic payments to pharmacies by \$8 billion over the next 5 years. These cuts will be devastating to many retail pharmacies, especially in urban and rural areas. We ask that the implementation of these FULs be suspended because it is now documented that these new generic reimbursement rates will be well below pharmacy's acquisition costs. A recent report from the Government Accountability Office found that pharmacies would be reimbursed, on average, 36 percent less for generics than their acquisition costs under the new proposed AMP-based FUL system.
- **Require that States Increase Pharmacy Dispensing Fees:** CMS should direct states to make appropriate adjustments to pharmacy dispensing fees to offset potential losses on generic drug reimbursement. Fees should be increased to cover pharmacy's cost of dispensing, including a reasonable return. Without these increases in fees, many prescriptions may be dispensed at a loss, and pharmacies may have reduced incentives to dispense lower-cost generic drugs.

I support the more extensive comments that are being filed by the National Association of Chain Drug Stores (NACDS) regarding this proposed regulation. We appreciate your consideration of these comments and ask that you please contact us with any questions. Thank you.

Sincerely,

Russell J Jensen, RPh, MS
Director of Pharmacy

Submitter :

Date: 02/16/2007

Organization :

Category : Pharmacist

Issue Areas/Comments

GENERAL

GENERAL

February 16, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2238-P
P.O. Box 8015
Baltimore, MD 21244-8015

Ms. Norwalk,

The purpose of this letter is to comment on the proposed rule (CMS-2238-P) regarding the reimbursement of pharmacy providers based on the AMP model as set forth in the Deficit Reduction Act of 2005.

As I am sure you are well aware, pharmacy services are an integral part of the health care of all Americans, but especially important to the health care of the poor, indigent, or others who qualify for state Medicaid assistance. This population may be at an increased risk of poor health care due to various influences, and often, pharmacy services, such as prescriptions, may be one of the most efficient and influential accesses for the recipient.

Unfortunately, quality health care does come with a cost, and the pharmacy piece is no different. If CMS-2238-P is implemented in its current form, my pharmacy will be reimbursed below the cost of acquisition for the medication. This does not consider the recently released report from the accounting firm Grant Thornton LLP National Study to Determine the Cost of Dispensing Prescriptions in Community Retail Pharmacies in which it is reported that the median cost of dispensing a prescription for a pharmacy is \$10.51.

My concerns are further supported by the GAO's report that states that community pharmacies, such as mine, will lose an average of 36% on each generic prescription filled for Medicaid recipients. My pharmacy will not be able to fill Medicaid prescriptions under such an environment.

Pharmacists save money for state Medicaid agencies, CMS, and this country. If the AMP is not defined fairly, from a retail pharmacy perspective, and if the GAO report is accurate, many pharmacies, including my pharmacy, will be unable to fill Medicaid prescriptions or will cease to exist. This in turn will decrease access for the Medicaid recipient and will increase the costs for Medicaid and this country far above any savings that are to be realized through AMP pricing for generic prescriptions.

Sincerely,

Hal Densman

Submitter : Mrs. Suzanne DeMott

Date: 02/16/2007

Organization : Mrs. Suzanne DeMott

Category : Pharmacist

Issue Areas/Comments

GENERAL

GENERAL

The formula for AMP based FULs in the proposed rule will not cover our costs and will cause many pharmacies to close. We should get paid what the drugs actually cost us plus a fee to cover overhead costs plus a reasonable profit. The AMP, AWP should be done away with and we should be able to use our AAC (the actual cost).

Submitter : Mr. Neldon McCort, Jr.
Organization : Brookside Discount Pharmacy
Category : Pharmacist

Date: 02/16/2007

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2238-P-745-Attach-1.TXT

February 15, 2007

Centers for Medicare and Medicaid Services
Attention CMS 2238-P Mail Stop C4-26-05
7500 Security Blvd
Baltimore, Maryland 21244-1850

**Subject: Medicaid Program: Prescription Drugs; AMP Regulation
CMS 2238-P RIN 0938-AO20**

I am pleased to have the opportunity to submit these comments to the Centers for Medicare and Medicaid Services (CMS) regarding CMS' December 20, 2006, proposed regulation that would provide a regulatory definition of AMP as well as implement the new Medicaid Federal Upper Limit (FUL) program for generic drugs. I am a pharmacist and owner of Brookside Discount Pharmacy, a community retail pharmacy located at 1901 Brookside Drive, Kingsport, TN 37660. We are a major provider of pharmacy services in the community, and your consideration of these comments is essential.

1. Definition of "Retail Class of Trade" – Removal of PBMs and Mail Order Pharmacies

CMS is proposing an overly broad inclusive definition of "retail class of trade" for use in determining the AMP used in calculating the FULs. The proposed regulatory definition of AMP would not reflect the prices at which retail pharmacies can purchase medications. Only manufacturers' sales to wholesalers for drugs sold to traditional retail pharmacies should be included in the AMP definition. Excluding PBMs and mail order pharmacies from the AMP determination recognizes that these are not community pharmacies, where the vast majority of Medicaid clients have prescriptions dispensed. Mail order pharmacies do not meet the "open to the public" distinction, as they require unique contractual relationships for service to be provided to patients. PBMs do not purchase prescription drugs from a manufacturer or wholesaler or dispense drugs to the general public. Both these types of organizations do not dispense to the "general public" and, therefore, should be excluded from the information used in the calculation of the AMP to be used for determining an FUL. The more extensive comments submitted by the Tennessee Pharmacists Association have addressed differentiation, consistency with federal policy, and the benefits of excluding these data elements.

2. Calculation of AMP – Removal of Rebates, Concessions to PBMs and Mail Order Pharmacies

AMP should reflect prices paid by retail pharmacies. Including the elements defined in the proposed regulations is counter to Congressional intent. Rebates and other concessions paid by manufacturers to entities such as mail order pharmacies and PBMs are not shared with community retail pharmacies and, thus, do not reduce the prices pharmacies pay for drugs and are not available to the "general public." These rebates and concessions must be excluded from the calculation of the AMP used to determine the FULs.

While the AMP data is not currently publicly available, so that retail pharmacies can actually determine what the relationship will be between the proposed AMP-based FULs and the prices retail pharmacies pay to acquire the drugs, the GAO has conducted an analysis of this relationship. The GAO used the highest expenditure and the highest use drugs for Medicaid in the analysis. The GAO reported that retail pharmacies will be reimbursed, on average, 36% less than their costs to purchase the drugs included in the analysis. A business can not be sustained if it is forced to continuously sell its products below its actual acquisition costs.

The CMS claims that almost all stores sell goods other than prescription drugs, and that overall sales average more than twice as much as prescription drug sales. This is not the case in my pharmacy, where the majority of our business comes from prescription drugs. What the “other sales” in the pharmacy are should not be used in any decision regarding determination of the FULs. FUL pricing should be based solely on the prices retail pharmacies pay for drugs.

3. Removal of Medicaid Data

Medicaid pricing is heavily regulated by the state and federal governments. Medicaid should be treated consistently with other federal payor programs, and also be excluded from AMP in the proposed regulation.

4. Manufacturer Data Reporting for Price Determination – Address Market Lag and Potential for Manipulation

The actual implementation of the AMP Regulation could create an avenue for market manipulation. The risk of both price fluctuations and market manipulation, due to timing of manufacturer reporting and the extended ability to revise reported data, are amplified under the proposed structure. In order to address these concerns, the Tennessee Pharmacists Association (TPA) proposes a “trigger mechanism” whereby severe price fluctuations are promptly addressed by CMS. Furthermore, the TPA comments on the lack of clarity on “claw back” from manufacturer reporting error.

5. Use of 11-Digit NDC versus 9-Digit NDC

We believe that CMS should use the 11-digit AMP value for the most commonly-dispensed package size by retail pharmacies to calculate the FUL for a particular dosage form and strength of a drug. Some drug products are sold in extremely large drums or package sizes (e.g., 5,000, 10,000, 25,000 or even 40,000 tablets or capsules) that are not practical for a typical retail pharmacy to purchase due to the excess amount of product and carrying cost that would result from holding this large quantity in inventory for a much longer than usual time. In some community retail pharmacies, the product would go out of date before it could be dispensed. It simply would not be feasible or practical to purchase in these quantities. The prices used to set the limits should be based on the most common package size dispensed by retail pharmacies. Current regulations specify that the FUL should be set on package sizes of 100 tablets or capsules or the package size most commonly dispensed by retail pharmacies. These entities can only be captured if the 11-digit package size is used.

In conclusion, I support the more extensive comments that are being filed by the Tennessee Pharmacists Association regarding this proposed regulation. I appreciate your consideration of these comments and ask that you please contact me with any questions.

Sincerely,

Neldon C. McCort, Jr.
1048 Amersham Road
Kingsport, TN 37660

cc: Senator Lamar Alexander
Senator Bob Corker
U.S. Representative David Davis

Submitter :

Date: 02/16/2007

Organization :

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2238-P-746-Attach-1.TXT

Submitter : Mr. David Machlowitz
Organization : Medco Health Solutions, Inc.
Category : Health Care Industry

Date: 02/16/2007

Issue Areas/Comments

Background

Background

See attachment.

Collection of Information Requirements

Collection of Information Requirements

See attachment.

GENERAL

GENERAL

See attachment.

Provisions of the Proposed Regulations

Provisions of the Proposed Regulations

See attachment.

Regulatory Impact Analysis

Regulatory Impact Analysis

See attachment.

Response to Comments

Response to Comments

See attachment.

Submitter : Ms. Teri Miller

Date: 02/16/2007

Organization : Planned Parenthood of Greater Cleveland

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-2238-P-748-Attach-1.DOC

February 16, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-2238-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: File Code CMS-2238-P

Dear Administrator Norwalk:

I am the Vice President of Health Services and Operations for Planned Parenthood of Greater Cleveland (PPGC), which operates five non-profit outpatient health centers in Northeast Ohio. We provide a broad range of health care services including birth control methods, cancer screenings, pregnancy testing, testing and treatment for sexually transmitted infections, HIV counseling and testing, urinary tract infection diagnosis and treatment, cervical cancer diagnosis and treatment, and HPV vaccinations to uninsured and underinsured women. PPGC serves more than 22,000 unduplicated patients each year, many of whom could not otherwise afford the health services—particularly oral contraceptives—that we provide. We have served the community for more than 78 years.

Nominal drug pricing is essential to our ability to serve women in the Greater Cleveland community. Consider:

- Ohio currently ranks 48th in the states for access to birth control, and the loss of safety net providers like Planned Parenthood would be devastating to the community.
- The vast majority of our clients are poor women. We make every attempt to accommodate patients who are not covered by insurance by offering a sliding fee scale. This chart illustrates the poverty status of our clients.

As a major provider of family planning services, losing the ability to purchase drugs at a discount will put a severe burden on the agency and our ability to survive, as well as on our clients, and ultimately will result in more unplanned pregnancies and untreated sexually transmitted diseases, thereby increasing medical costs for the state of Ohio and the nation.

Respectfully submitted by,

Teri Miller, M.S.N., C.N.P
Vice President of Health Services and Operations
Planned Parenthood of Greater Cleveland