

America's Affordable Health Choices Act of 2009 (H.R. 3200)

Summary of Pharmacy Provisions

Medicaid Pharmacy Reimbursement (AMP Fix):

- The generic reimbursement is set at 130% of the weighted average AMP—a change from 250% of the lowest AMP.
- AMP definition is redefined to more accurately reflect retail acquisition costs.
 - Prices which are excluded from the AMP calculation include:
 - 1) Customary prompt pay discounts to wholesalers
 - 2) Bona fide service fees paid by manufacturers
 - 3) Reimbursements for recalled, damaged, expired or otherwise unsalable returned goods, including reimbursement for the cost of the goods and any reimbursement of costs associated with return goods handling and processing, reverse logistics, and drug destruction
 - 4) Sales directly to, or rebates, discounts, or other price concessions provided to, pharmacy benefit managers, managed care organizations, health maintenance organizations, insurers, mail order pharmacies that are not open to all members of the public, or long term care providers, provided that these rebates, discounts, or price concessions are not passed through to retail pharmacies
 - 5) Sales directly to, or rebates, discounts, or other price concessions provided to, hospitals, clinics, and physicians, unless the drug is an inhalation, infusion, or injectable drug, or unless the Secretary determines, as allowed for in Agency administrative procedures, that it is necessary to include such sales, rebates, discounts, and price concessions in order to obtain an accurate AMP for the drug.
- Weighted average of brand and generic AMP data will be posted on a public website.
- The new Medicaid FUL benchmark will not be implemented until January 2011—the current (pre-DRA) benchmark (150% of the lowest published price) will be used until that date. This is important because we need to have time to focus on increasing state dispensing fees.

Exemptions from Medicare DME Accreditation and Surety Bond Requirements

- New accreditation requirements will not apply to pharmacies supplying **diabetic testing supplies, canes and crutches**.
- Includes an extension of the Oct 1st, 2009 accreditation deadline for any Part B supplier of DMEPOS if they have submitted an application for accreditation by August 1, 2009.

- This extension will be effective until such time as the accreditation organization has completed the accreditation process- no hard deadline for completing the process.
- Exemption of surety bond requirements for pharmacies who provide Part B DMEPOS products if that pharmacy has held a provider number for at least 5 years and a final adverse action has never been imposed on that pharmacy.
- 0.5% payment reduction in DMEPOS reimbursement that was included in the bill as a “pay for” for another Medicare item-especially problematic due to the current accreditation requirements.

Public Health Insurance Plan Option

- Legislation gives the Secretary complete discretion to set reimbursement rates for prescription drugs under the option. This concerns us because of the problems pharmacy has had with CMS setting adequate payment rates under Medicaid. CMS has also been unresponsive to situation where payment rates are too low.
- The legislation does not clarify how the drug benefit will be administered, although it does indicate that the Secretary should contract with “administrators” to operate the benefit. We continue to advocate for the drug benefit to be administered by pharmacy benefit administrator (PBA) rather than a PBM.
- Conditions for provider participation in the public plan network would be up to standards developed by the Secretary of HHS. We support an “any willing pharmacy” provision so that any pharmacy that is willing to participate in the plan and accepts the payment rates can do so. This would be consistent with both the policies of the state Medicaid programs, as well as Medicare Part D prescription drug benefit as it relates to pharmacy participation in networks.
- PBM transparency- requires transparency for pharmacy benefit managers (PBMs) if they are used by health insurance plans that operate in the exchange, including the public plan option. The requirements included:
 - require that PBMs disclose their generic dispensing rates in retail pharmacies compared to mail order;
 - disclose the amount of the rebates and discounts they obtain from drug manufacturers that are actually passed through to the plan sponsors;
 - disclose the amount they are paid by the plan versus the amount the PBM actually pays the pharmacy for that prescription.

MTM and Pharmacists’ Involvement in Medical Home Pilot Project

- MTM-establishes a grant program that would test new and innovative methods to deliver medication therapy management services by pharmacists, especially in the treatment of chronic medical conditions.

- The bill includes non-physician practitioners – such as pharmacists – as part of the medical home concept in the delivery of medication therapy management services for which they can be reimbursed.

Requirements on Businesses to Provide Health Insurance

- Sets a minimum benefits healthcare package which employers must provide.
- “Play or pay” provision would mandate that employers provide health insurance for employees or pay a penalty. The rates set in the bill are as follows:
 - Employers with payroll below \$500,00 annually are exempted from the mandate (up from \$250,000)
- Provides a tax credit to assist small employers who want to offer coverage.