

**National Community Pharmacists Association (NCPA)
Advocacy Center Update
Week Ending July 9th, 2011**

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Please Contact your Members of Congress to support:

**H.R. 1971/S. 1058 (PBM Reform/McMorris Rodgers; Pryor-Moran),
H.R. 1946 (PBM Negotiations/Marino) and
H.R. 1936 (DME/Schock-Welch)**

Medicaid Cuts on the Table at Debt Ceiling Talks: As debt ceiling discussions continue in Washington, rumors are circulating about those programs that may be cut, and by how much. Cuts to Medicare and Medicaid are on the table, but it's not clear which policy approach may be adopted. For the Medicaid program, "block granting" appears to be off the table, but a new proposal called a "blended rate" appears to be gaining favor.

Here's how a blended rate might work. States receive Federal matching funds for their Medicaid and Childrens Health Insurance Program (CHIP) costs based on a specific matching formula for EACH program. However, under this blended rate approach, a state would receive a single new matching Federal percentage rate to pay for costs for its combined existing Medicaid population, its CHIP population and its Medicaid expansion populations which come on line in 2014. Currently, Federal Medicaid matching rates for states' costs range from 50 to 75%, with a 57% average; CHIP matching rates are 70% on average; while the new Medicaid expansion populations will be covered initially at 100% by the Federal government, and then in the 90% to 95 % range after the first few years of the expansion.

Concerns exist that a new single blended matching rate would result in states receiving fewer Federal funds to pay for health care costs for these populations. That would result in a shift of some of the program costs from the Federal government to the states, which could mean provider cuts or benefit reductions. The Obama Administration is advocating for this "blended rate" proposal. Another option would require drug manufacturers to pay Medicaid rebates for drugs dispensed to Medicare Part D dual eligibles. Providers groups are gearing up to oppose proposals that would shift Medicaid costs back to cash-strapped states.

NCPA Supports Eliminating the Rx Requirement for FSA-reimbursed OTCs: NCPA expects U.S. Senators Pat Roberts (R-KS) and Ben Nelson (D-NE) to introduce legislation repealing the restrictions placed on tax-preferred accounts which reimburse over-the-counter ("OTC")

medications without a doctor's prescription. NCPA is working with the Health Choice Coalition of physicians, consumers, retailers, manufacturers, patients, insurers, small businesses and employers on this important legislation. We plan to sign on to the coalition letter supporting the legislation in the Senate.

Preserving Our Hometown Independent Pharmacies Act of 2011 (HR. 1946): NCPA continues to meet with Members of the Subcommittee on Intellectual Property, Competition, and the Internet, to urge Chairman Goodlatte (R-VA) to hold a hearing and markup of HR.1946 within the committee. The legislation would provide more leverage to independent pharmacies against PBM contracts. We intend to circulate letters in the states of Texas and Virginia for NCPA members to sign that would urge the Chairman of the Judiciary Committee (Rep. Lamar Smith-TX) and Subcommittee Chairman Goodlatte to support a hearing for this bill. If you live in one of these states please keep on the look out for the request for a signature in the coming weeks.

Medicare Access to Diabetes Supplies Act of 2011 (H.R. 1936): There are concerns that Congress may be considering including all retail pharmacies in the Medicare competitive bidding program for diabetes test supplies as part of the debt ceiling talks. NCPA submitted a letter this week to congressional leaders opposing any effort to move independent community pharmacies into competitive bidding for diabetic testing supplies or to reduce the fee schedule for diabetic testing supplies. We indicated our support for H.R. 1936, which would exclude smaller community pharmacies from the bidding program or from having to accept the competitively-bid price.

We will be asking you to reach out to your Member of Congress to oppose the inclusion of independent pharmacies once we get all the details. We are working the Reps. Schock and Welch on a Dear Colleague letter to circulate with other Congressional offices to gain co-sponsors.

Debit Card Interchange Fees (swipe fees): Earlier this week, the Federal Reserve issued the new regulations for debit card interchange fees. Below is a summary of main points:

- The regulation increased the fee cap from the 12-cents-per-transaction cap contained in the draft regulation to between 21 and 24 cents in the final version-twice the fee which was included in the draft reg. Currently the current average swipe fee is 44 cents;
- The regulation delays implementation to Oct. 1, 2011. Under the draft regulations the debit card restrictions would have begun on July 21, 2011;
- Merchant and consumer groups are both unhappy because the fees are higher than expected and there is no prohibition on raising other banking service fees so there is the likely threat that the banks and credit card companies will raise other fees to make up for the cuts to the swipe fees.

NCPA continues to review the new regulations and will determine if we will respond to the final regulations.

Political Activities: This week, NCPA met with Rep. Austin Scott (R-GA), President of the Freshmen class of the 112th Congress, Rep. Tom Marino (R-PA), Rep. Mike Rogers (R-MI), Rep. Eliot Engel (D-NY), Rep. Michael Grimm (R-NY), Rep. Bill Cassidy (R-LA), Rep. Devin Nunes (R-CA) and Rep. Mike Ross (D-AR).

CMS Awards Pricing Survey Contract to Myers and Stauffer: CMS announced that the accounting firm Myers and Stauffer has been awarded a contract to survey retail pharmacy prices and pharmacy drug acquisition cost information. The contract is titled “Survey of Retail Prices: Payment and Utilization Rates, and Performance Rankings.” Get ready for new alphabet soup in pharmacy reimbursement. The survey will produce two new sets of publicly-available pharmacy pricing information:

- Retail Survey Price (RSP) which will be a compilation of the prices (reimbursement) received by pharmacies for covered outpatient drugs, known as “consumer purchase prices.” In theory, this is the average “out the door” price the pharmacy receives for a particular drug. As we understand, the price would be a blend of commercial payers, Medicaid (maybe), and cash prices, with only retail pharmacy prices included. Mail order and LTC prices would be excluded. This would give states a sense of how much a pharmacy is receiving from non-Medicaid payers as compared to Medicaid.
- Actual Acquisition Cost (AAC) is supposed to be based on a “voluntary” survey of pharmacies to determine retail pharmacy purchasing costs for drugs. It is assumed that the contractor will ask pharmacies to provide their invoices so it can determine an AAC. However, it is not clear how granular this survey will be. It sounds like the contractor will publish AACs for brands and generics, but will it publish an AAC for each manufacturer’s generic or a weighted average across all manufacturers of that particular generic drug? It is not clear whether or how CMS will treat LTC pharmacies in this survey, although the information provided so far indicates that AAC will be based on independent, chain and specialty pharmacies. It is also not clear if CMS will publish an AAC for each separate class of pharmacy. Finally, it is not clear that CMS has the actual legislative authority to publish an AAC file. NCPA has sent several communications to CMS since the concept of a survey was floated to question the agency’s ability to publish these data. CMS has made it clear they want stakeholder input in design of the survey, however.

According to CMS, the purpose of the Survey of Retail Prices is to develop a monthly survey of retail community pharmacy prescription drug prices and the generation of publicly available pricing files. CMS anticipates that the files will give State Medicaid agencies an array of covered outpatient drug information, regarding retail prices for the ingredient costs of prescription drugs

and consumer purchase prices for such drugs. CMS expects Medicaid agencies will use this information to compare their own pricing methodologies and payments to those derived from the survey. Additionally, on an annual basis, CMS will obtain from the State Medicaid agencies information on their prescription drug payment and utilization rates and prepare a comparative report regarding the performance of the States' reimbursement prices and the national retail price data collected in the survey.

In addition to RSP and AAC data, states will also receive weighted average AMP data for multiple source drugs. CMS has not indicated when such data will be made public, although it is likely tied to the publication of the final rule on AMP, which has not yet even been published as a proposed regulation. Weighted AMP is the average price (based on utilization) paid to the generic manufacturers by wholesalers (including chain warehouses) for a particular dosage form and strength of a multiple source drug distributed to community retail pharmacies. Weighted AMPs will only be made public for multiple source drugs. Weighted AMP will be used to set FULs when a final CMS regulation is published.

CMS Delays Implementation of Infusion Drug Policy Change: CMS released a notice on July 1 that delays implementation of the policy clarification surrounding billing of drugs furnished incident to a physician service to August 15, 2011. The notice clarifies that pharmacies may not bill Medicare Part B for drugs dispensed directly to a beneficiary for administration "incident to" a physician service, such as refilling an implanted drug pump. When drugs are administered in the physician's office to a beneficiary, the only way these drugs can be billed to Medicare is if the physician purchases the drugs from the pharmacy. NCPA understands that some pharmacies are billing the Part B carrier directly for the drugs and the physician bills for the service of refilling the pump. NCPA has been coordinating with both the National Home Infusion Association and the International Academy of Compounding Pharmacists and will continue to gain feedback from our membership about the impact of this policy clarification on their daily practice and the needs of their patients.

GAO Report on Competitive Bidding at Manufacturer Level: The GAO released a report outlining options for Congress to consider if it wanted to do competitive bidding for DME at the manufacturer level instead of the supplier level. CMS would leverage its purchasing power at the manufacturer level to reduce prices, instead of at the supplier level. The report looked at how the VA, Medicaid and some group purchasing organizations operate in negotiating prices with manufacturers. The GAO found that CMS would have to address some of the same issues it faces with the supplier level CBP, plus some new ones. There do not appear to be any plans in place to implement this proposal.

CMS Announces Changes to DME Billing Practices: Starting August 2, 2011, DME supplies provided on a recurring basis must be billed prospectively, not retrospectively. This means that a supplier cannot deliver a supply, wait to see how much is used and then bill for the used portion at the end of the month. The supplier must bill for the full amount supplied and must bill at the beginning of the month. Moreover, for refilled DME supplies, the supplier must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. Contact with the beneficiary must occur 14 days or fewer

before the delivery date. Delivery of the refill must occur 10 days or fewer before the end usage of the current product.

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