Authorization Act (NDAA) authorized a pilot program to allow the Defense Department (DoD) to access lower pricing for Medicare Part B for medically-underserved areas.

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savings of $1.7 billion in overall healthcare costs, or a savings of $5.76 for every person in the U.S. for every one percent corresponding decrease in overall Medicare medical spending. When projected to the entire population this translates to a 1% increase in Medicaid drug spending results in a decrease in non-drug spending, saving $760 million a year. Patient access suffers when drugs are reimbursed below cost. Last year, The Centers for Medicare and Medicaid Services (CMS) issued the Covered Outpatient Drugs Final Rule, which initiated major pharmacy reimbursement changes to ensure adequate levels to help preserve patient access to prescriptions and services. The Congressional Budget Office (CBO) acknowledged that medication use reduces overall Medicare costs. In 2012, CBO revised its methodology for scoring proposals related to Medicare Part D and found that for each one percent increase in the number of prescriptions filled by beneficiaries there is a corresponding decrease in overall Medicare medical spending. When projected to the entire population this translates to a savings of $1.7 billion in overall healthcare costs, or a savings of $5.76 for every person in the U.S. for every one percent increase in the number of prescriptions filled. Reform proposals should not reimburse pharmacists below cost.

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1. As Congress examines health care reform, preserve Medicaid and Medicare access to pharmacy benefits and services. Pharmacies are not only convenient and critical access points for patient care, they generate Medicaid/Medicare savings. Many states have expanded pharmacy scope of practice and pharmacists provide lower-cost preventative services. All states cover outpatient prescription drugs, despite being an optional Medicaid benefit. A Health Affairs study found that every 1% increase in Medicaid drug spending results in a decrease in non-drug spending, saving $760 million a year. Patient access suffers when drugs are reimbursed below cost. Last year, The Centers for Medicare and Medicaid Services (CMS) issued the Covered Outpatient Drugs Final Rule, which initiated major pharmacy reimbursement changes to ensure adequate levels to help preserve patient access to prescriptions and services. The Congressional Budget Office (CBO) acknowledged that medication use reduces overall Medicare costs. In 2012, CBO revised its methodology for scoring proposals related to Medicare Part D and found that for each one percent increase in the number of prescriptions filled by beneficiaries there is a corresponding decrease in overall Medicare medical spending. When projected to the entire population this translates to a savings of $1.7 billion in overall healthcare costs, or a savings of $5.76 for every person in the U.S. for every one percent increase in the number of prescriptions filled. Reform proposals should not reimburse pharmacists below cost.

2. Support/pass provider status bills H.R. 592/S. 109 in the House and Senate to establish pharmacists as providers in Medicare Part B for medically-underserved areas. Access to affordable, quality healthcare is an issue. A national physician shortage, aging population, and rising healthcare costs are challenging U.S. health. Access, quality, cost, and efficiency in healthcare are critical factors — especially to the medically underserved, which include seniors with cultural or linguistic access barriers, public housing residents, persons with HIV/AIDS, rural populations, etc. The lack of pharmacist recognition as a provider by third party payors (Medicare/Medicaid) limits pharmacist ability to provide patient services, even though fully qualified to do so. The Pharmacy and Medically Underserved Areas Enhancement Act would provide access for Medicare beneficiaries in medically underserved communities to covered Medicare Part B services from their pharmacists, as allowed under state laws and regulations for pharmacist scope of practice.

3. MEMBER OPTION: Please sign a Congressional letter to urge the Secretary of Defense to implement the FY2017 Pilot Program to reduce TRICARE costs and expand prescription access. The FY2017 National Defense Authorization Act (NDAA) authorized a pilot program to allow the Defense Department (DoD) to access lower pricing for prescriptions dispensed at retail pharmacies. The pilot will reduce prescription costs for the DoD, expand TRICARE beneficiary choice and access to prescription drugs at retail pharmacies, and streamline DoD administrative and prescription drug rebate processes. The FY2017 NDAA gives the DoD the ability to implement the program in this fiscal year. It is critical that members of Congress tell the Defense Secretary about the need for this pilot to be implemented in this fiscal year.

4. MEMBER OPTION: Please sign a Congressional letter to urge CMS to issue much-needed guidance to improve reimbursement transparency in the Medicare Part D Program. There are growing concerns over Medicare Part D sponsor use of direct and indirect remuneration (DIR) fees in Medicare. “DIR” stands for “direct and indirect remuneration” and was initially a term used in the Medicare Part D program to address price concessions that would impact the gross prescription drug costs of Medicare Part D plans that were not captured at the point of sale, such as manufacturer rebates. However, the term has now expanded to include any number of fees that pharmacies are charged after a claim has been adjudicated. CMS reported DIR use is growing and has led to increased beneficiary cost-sharing and Medicare subsidy payments. It’s also decreased plan liability for total drug costs despite growing Part D drug costs. Pharmacies are forced to conduct business unsure if a reimbursement is final or a future fee will be assessed resulting in some pharmacies questioning their ability to participate in Part D networks, which could endanger beneficiary access to prescription drugs. The Social Security Act gives CMS the authority to regulate Medicare fees. A CMS-issued guidance to improve transparency between plans and pharmacies and reimbursement structures would provide clarity and consistency in how fees are used, applied, tracked, and reported.