NCPA Guide to Supreme Court Ruling on Health Reform Law

NCPA staff has prepared an analysis for our members of the pharmacy impact of today’s Supreme Court ruling to uphold the Affordable Care Act (ACA), the 2010 health care reform legislation.

Most importantly: you can continue to provide discounts to Medicare Part D beneficiaries in the donut hole and you can continue to provide DME supplies if you are not accredited, as long as you've met CMS’ self-attestation criteria.

Below please find copies of NCPA's full analysis and news release in response to today's ruling. If you have any questions, please contact info@ncpanet.org. Thank you.

Impact on Community Pharmacy of Supreme Court Decision to Uphold Affordable Care Act (ACA)

Today the Supreme Court upheld the Affordable Care Act (ACA), the 2010 health care reform legislation. The ACA made broad sweeping changes in multiple areas that touch on every aspect of the health care system, including community pharmacy practice. This document provides a summary of all the provisions of the law that remain in effect and affect community pharmacy, our patients and businesses.

Of note, the Supreme Court held that the individual mandate is within Congress’s power under the Taxing Clause and is thus upheld. In addition, the Supreme Court held that the Federal government is not allowed to decrease states current Medicaid funding for not complying with the Medicaid expansion requirements.

The two most important things for pharmacists to know is you can continue to provide discounts to Medicare Part D beneficiaries in the donut hole and you can continue to provide DME supplies if you are not accredited, as long as you've met CMS’ self-attestation criteria.

MEDICAID

Medicaid AMP
The ACA sets the FULs for Medicaid drugs at no less than 175% of the weighted average of the most recently reported monthly AMP for pharmaceutically and therapeutically equivalent multiple source drug products that are available for purchase by retail community pharmacies on a nationwide basis. It requires posting of weighted average AMP data for multiple source drugs, as well as RSP data. If the Supreme Court had struck down the statute, then elimination of these requirements would have meant that CMS would have no authority to set FULs for multiple source drugs, and the existing FULs—which are sorely outdated and have been in effect since 2008—would remain in effect.

Medicaid Expansion
By 2014, the ACA expands Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (as under current law and in the House and Senate-passed bills undocumented immigrants are not eligible for Medicaid). All newly eligible adults will be guaranteed a benchmark benefit package that meets the essential health benefits available through the Exchanges.
Carve In/Out of Pharmacy Benefit in Medicaid Managed Care Plans
The ACA increases the Medicaid drug rebate percentage for brand name drugs to 23.1% (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increases the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price. The ACA extends the drug rebate to Medicaid managed care plans. States now have more of an incentive to "carve in" pharmacy into Medicaid managed care plans because the states receive higher Medicaid FFS rebates in managed care than they otherwise would have if the managed care plans were negotiating the rebates.

PBM TRANSPARENCY/EXCHANGES
The ACA requires PBMs in the State exchanges and in Part D to report: 1) PBM Retail vs. mail generic dispensing rates; 2) Aggregate PBM manufacturer rebates earned and passed through to the plan; 3) Aggregate payments from plans to PBMs and subsequent payments to pharmacies. To date, HHS has been on target in its implementation of these enhanced PBM transparency provisions.

Exchanges to Provide Marketplace for Small Biz to Purchase Insurance
By 2014, the ACA creates state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. Requires qualified health plans participating in the Exchange to meet marketing requirements, have adequate provider networks, contract with essential community providers, contract with navigators to conduct outreach and enrollment assistance, be accredited with respect to performance on quality measures, use a uniform enrollment form and standard format to present plan information. Requires qualified health plans to report information on claims payment policies, enrollment, disenrollment, number of claims denied, cost-sharing requirements, out-of-network policies, and enrollee rights in plain language.

Essential Health Benefits
By 2014, the ACA creates an essential health benefits package that requires plans in the exchanges to offer at least the essential health benefits package, which includes prescription drugs and chronic disease management.

MEDICARE PART B
Pharmacy DME Accreditation Exemption
The ACA exempts pharmacies from Part B accreditation requirements if the pharmacy has DME sales of less than 5% of total sales over the last 3 years and has been enrolled in Part B for at least 5 years without any final adverse action against the pharmacy.

Expansion of Medicare DME Competitive Bidding
Requires all Part B providers of competitively bid DME products to either competitively bid for those items or accept competitively bid prices by 2016. As of now, pharmacies that remain in the program will have to take competitively-bid prices starting in 2016.

INNOVATIVE PAYMENT SYSTEMS
Patient Care Models Such as ACOs and Bundled Payments
The ACA establishes new payment systems, which use financial incentives to encourage Medicare providers to cut costs, while delivering high quality care. It also establishes a program designed to improve the quality of care received by individuals that transition from different settings of care and includes a medication therapy management component.

MEDICARE PART D
Closing of the Donut Hole for Medicare Part D Patients
The ACA gradually phases down the Part D coverage gap coinsurance rate from 100% to 25% by 2020.

MTM Expansion
The ACA provides grants for eligible entities to expand the provision of MTM services. Within Part D, it adds a
"telehealth" option for delivery of MTM, specifies that MTM shall be furnished "by a licensed pharmacist or other qualified provider," requires automatic enrollment and requires annual CMRs and quarterly assessments. It includes pharmacist-delivered MTM services in: Medical Home Models, Transition of Care Activities and ACOs.

**SMALL BUSINESS**

**Tax Credits for Small Biz to Expand Health Insurance**
Provides small employers with no more than 25 employees and average annual wages of less than $50,000 that purchase health insurance for employees with a tax credit. The ACA also exempts employers with less than 50 full-time employees from the requirement to either provide health insurance or pay a penalty.

**FRAUD, WASTE AND ABUSE**

**Fraud, Waste and Abuse in Part B**
Risk Categorizes Part B providers according to fraud risk and assigns anti-fraud screening requirements to those providers. Requires Part B providers to pay an application fee for enrollment and revalidation as a Part B provider. Allows for moratoriums on new enrollment for provider types or geographic areas deemed to be at high risk for fraud. If the Secretary determines that a new DMEPOS supplier is in a category or geographic area of significant risk of fraud, the Secretary shall withhold payments for 90 days after the first submission of a claim. Requires the Secretary to take into account the volume of billing for a DME supplier or home health agency when determining the size of the supplier's and agency's surety bond.

CMS may indefinitely suspend payments to a Medicare provider or supplier if there is a credible allegation of fraud. Requires Medicare providers to identify and self-report overpayments within 60 days, or face potential civil monetary penalties, exclusion from Medicare and/or False Claims Act liability. Expands the RAC program to Medicare Parts C and D and Medicaid. Requires RACs to be paid through contingency fees.

**LTC Pharmacy Waste**
The ACA requires PDP sponsors to utilize specific, uniform dispensing techniques, such as weekly, daily, or automated dose dispensing, when dispensing covered part D drugs to enrollees who reside in a long-term care facility in order to reduce waste associated with 30-day fills. Short cycle will go into effect beginning January 1, 2013.

**MISCELLANEOUS**

**FSA Treatment of OTCs**
The ACA excludes the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an HSA or Archer Medical Savings Account.

**Preventative Services**
The ACA eliminates cost sharing for Medicare patients and those in qualified health plans for preventative services, such as vaccinations.

**340B**
The ACA expands the types of entities eligible to participate in the 340B program.

**Generic Biologicals**
The ACA creates a pathway for the FDA to approve lower-cost generic biologicals.

**NCPA Responds to U.S. Supreme Court Ruling on Health Care Law**

Alexandria, Va. - June 28, 2012 National Community Pharmacists Association (NCPA)CEO B. Douglas Hoey, RPh, MBA, issued the following statement regarding the U.S. Supreme Court ruling on the health care reform law—the Patient Protection and Affordable Care Act:

*America's health care system should be less costly, more efficient and drive better outcomes for patients. Pharmacists have shown, when properly utilized, that the aforementioned principles can be achieved through
the medication counseling and other services they provide to millions of patients. During the health care reform debate NCPA played a constructive role in offering recommendations for provisions that could improve the care independent community pharmacies offer, with a premium being placed on maintaining access.

“We strived for more coordination with health care providers across the spectrum; reforms that embrace the free market ethos of fairness and transparency; reimbursement levels that take into account budget constraints for payors and are financially sustainable for providers; and ensuring that successful programs are embraced further. NCPA and its members will continue to work closely with Congress and the White House, in a bipartisan fashion, to offer common-sense solutions for the challenges we face for the remainder of this year and in the future.

“The health care reform law that was upheld by the Supreme Court includes bipartisan provisions intended to achieve reasonable reimbursement for Medicaid generic prescription drugs, although the implementation process to date has been disappointing. There are also transparency requirements for pharmacy benefit managers in the health care exchanges set to launch in 2014. Medication therapy management will be expanded in Medicare. Independent community pharmacies remain exempted from the duplicative accreditation requirement for selling Medicare Part B durable medical equipment. Mechanisms have been put in place for the inclusion of pharmacies in Accountable Care Organizations and Medical Homes. In the aftermath of the Supreme Court decision and the government’s response to it, NCPA will continue to prioritize these issues because, left unaddressed in a prudent fashion, it is patients that will suffer the consequences.”

The National Community Pharmacists Association (NCPA®) represents the interests of America’s community pharmacists, including the owners of more than 23,000 independent community pharmacies. Together they represent a $93 billion health care marketplace, dispense nearly 40% of all retail prescriptions, and employ more than 315,000 people, including 62,400 pharmacists. Independent community pharmacists are readily accessible medication experts who can help lower health care spending. They are committed to maximizing the appropriate use of lower-cost generic drugs and reducing the estimated $290 billion that is wasted annually by improper medication use. To learn more go to www.ncpanet.org or read NCPA's blog, The Dose, at http://ncpanet.wordpress.com.