



Benchmark pricing system created by Congress in 1990 for calculation of Medicaid rebates. Methodology for calculation has been revised, to consider current market dynamics.

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AMP Timeline-

- 10/1/07 Regulation effective
- 10/1-10/31 1st monthly AMP reporting period under new regs.
- 11/30/07 Mfgr's report 10/07 AMP's
- 12/30/07 FUL's issued based on Oct AMP's; Mfgr's report Nov. AMP's.
- 10/1-12/30/07 First Quarterly AMP reporting period under new Regs.
- 1/30/08 FULS based on Oct. AMP take effect after 30 day period for states to implement; FULS Issued Based on Nov. AMPs; Manufacturers report Quarterly AMP, 10-12/2007 Mfgrs Report December AMPs
- 3/1/2008 November FULS take effect; FULS issued based on December AMPs; Mfgrs report 1/2008 AMPs

Tamper Resistant Rx Pads

A CMS directive defines state obligations for complying with the October 1, 2007, deadline requiring tamper evident prescription pads for Medicaid recipients. The new law seeks to generate government savings by decreasing forgery. Rx pads possessing characteristics that prevent use of counterfeit Rx forms, prevent alteration, and prevent duplication of blank or completed Rx's are required. Exclusions include; refills of Rx's written prior to October 1, phoned, faxed, or electronic prescriptions. States are responsible for plans and implementation. Non-enforcement may result in loss of Federal financial participation. The law, eliciting response from pharmacy groups for its short notice, impacts about 55 million Medicaid recipients. These guidelines, while not applicable to managed care prescriptions, will undoubtedly accelerate e-prescribing initiatives throughout the health care system.

AMP Re-Defined

After 17 years, CMS, the Center for Medicaid and Medicare Services is redefining average manufacturer price (AMP) and in the process creating potentially major changes in the health care environment.

As part of a 1990 effort to stretch health care dollars, Congress created AMP, a new benchmark pricing system for calculating Medicaid Rebates. AMP was based on the average price paid by wholesalers for drugs distributed to retail pharmacies and was not publicized. In fact, CMS the Center for Medicaid and Medicare Services was prohibited by law from disclosing AMP's. Then, in 2004, reports by the Government Accountability Office (GAO) and the HHS Office of the Inspector General (OIG) showed Medicaid payment to pharmacies for multi-source or generic drugs were much higher than what pharmacies were actually paying for them. Use of inflated commercial drug pricing guides as the basis for setting state reimbursement levels resulted in overpayment, and the playing field began to change.

The Deficit Reduction Act of 2005 (DRA) encouraged appropriate payment to states for the estimated acquisition costs of multi-source drugs. CMS is now required to establish a new federal upper limit (FUL) for generic drugs, (set at 250% of AMP). This is the maximum the federal government will pay to states in federal matching funds or federal financial participation (FFP) for generic drugs dispensed through state Medicaid programs. States may pay above or below the FUL for individual drug classes and still receive the full FFP as long as overall payment for generic drugs subject to FUL are under the annual aggregate cap. AMP is made available to the states to consider in determining their methods for setting reimbursement for drugs under the Medicaid Program. According to the final rule, sales to PBM's and long term care pharmacies are excluded from the determination of AMP. Home infusion, specialty pharmacy, and mail order sales are included, reflecting today's market trends.



Individual states retain the authority to set reimbursement levels and establish fees to be paid to pharmacies. Because the new FUL's will likely reduce drug ingredient payments to pharmacies, CMS has encouraged states to evaluate whether fees paid to pharmacies are adequate to compensate them for their costs. Included in the final rule, is a definition of dispensing fees, which includes overhead and profit. Dispensing fees are anticipated to increase since they receive a full federal match and are not limited by the new FUL's. To adjust fees, state Medicaid programs submit a state plan amendment for federal approval. These changes will potentially impact fees as the marketplace responds to these dynamics.

E-Prescribing

SureScripts, formed in 2001 by the pharmacy industry has developed a network allowing physicians to electronically transmit prescriptions to almost all U.S. pharmacies. Earlier this year, Allscripts & Dell Inc. joined forces to form a coalition, the National ePrescribing patient Safety Initiative. Efforts will get a boost from the recent Rx pad ruling ("*Tamper Resistant Rx Pads*") and the July ruling by the

Centers for Medicare & Medicaid services (CMS), which amends the 2003 Medicare Modernization act (MMA.) The act mandated use of standards for electronic prescribing by participants in the Medicare Part D Program. The new ruling eliminates the "fax exception" and when adopted would require all electronic prescriptions to comply with the NCPDP Script Standard. The proposed rule sets a deadline for elimination of computer generated faxes by

January 1, 2009. Allscripts expects to ramp-up its programs in September. They project that health plans will see improved patient safety, and cost savings.

Did you Know: The national average cost of dispensing prescription medication for retail pharmacies is \$10.50 per Rx, according to the coalition for Community Pharmacy Action study done March to August '06.