***Protecting Pharmacies in Medicaid Act* Summary**

Topline Summary

The *Protecting Pharmacies in Medicaid Act* would prohibit the use of spread pricing arrangements in Medicaid programs. Pharmacy benefit managers (PBMs) would be required to pass through to pharmacies the full amount of the money paid to the PBMs by Medicaid programs, except for a fixed administrative fee. The total reimbursement amount will be determined by a survey of national average drug acquisition costs administered by the Department of Health & Human Services.

Section-by-Section Summary

Section 1. Short Title.

- *Protecting Pharmacies in Medicaid Act*

Section 2. Ensuring Accurate Payments to Pharmacies Under Medicaid.

- Directs the Department of Health & Human Services (HHS) to conduct a survey of "retail community pharmacy" drug prices and "applicable non-retail pharmacy" drug prices to determine the national average drug acquisition cost for both categories, which will be used to establish payment benchmarks.
  - "Retail community pharmacy" uses the existing statutory definition, meaning an independent pharmacy, a chain pharmacy, a supermarket pharmacy, or a mass merchandiser pharmacy that is licensed as a pharmacy by the State and that dispenses medications to the general public at retail prices. It does not include nursing home pharmacies, long-term care facility pharmacies, hospital pharmacies, clinics, charitable or not-for-profit pharmacies, government pharmacies, or pharmacy benefit managers.
  - "Applicable non-retail pharmacy" is newly defined as a pharmacy that is licensed as a pharmacy by a state and is not otherwise a retail community pharmacy, mainly specialty pharmacies and mail-order pharmacies. This definition also excludes nursing home pharmacies, long-term care facility pharmacies, hospital

pharmacies, clinics, charitable or not-for-profit pharmacies, government pharmacies, or “low dispensing pharmacies” as defined at the discretion of HHS.
    - Pricing for applicable non-retail pharmacies cannot be applied to retail community pharmacies.

- Survey results and design information must be made public in a form and manner determined by HHS but must include the monthly response rate, the sampling methodology, the number of pharmacies sampled monthly, and information on price concessions.

- HHS is authorized to contract with a vendor to conduct the NADAC survey.

- If HHS contracts with a vendor, the vendor must provide a monthly update to HHS on the survey prices for covered outpatient drugs. The vendor must differentiate, in both collecting and reporting, between retail community pharmacies, applicable non-retail pharmacy, and whether such pharmacy is affiliated with a PBM or other managed care entity.
    - HHS is directed to create unique pharmacy type indicators for applicable non-retail pharmacies and include those indicators in its monthly reports.

- All pharmacies covered by the survey that receive any payment from a state or managed care organization (MCO) contracted to perform Medicaid pharmacy benefit services are required to accurately respond to the survey or be subject to financial penalties.
    - Penalties may be up to $100,000 per violation per pharmacy. Individual chain pharmacy locations are treated as separate pharmacies for the purpose of levying penalties.

- Oversight authority is granted to the Inspector General of HHS, and funds are appropriated to carry out such oversight.

- The effective date for this section is the first day of the first full quarter occurring at least six months after enactment for HHS and retail community pharmacies. The effective date is the first day of the first full quarter occurring at least 18 months after enactment for applicable non-retail pharmacies.
    - Surveys and reports for retail community pharmacies will begin before applicable non-retail pharmacies.

Section 3. Preventing the Use of Abusive Spread Pricing in Medicaid.

- Contracts between states and PBMs or other type of MCO for the administration of pharmacy benefits are required to use a "transparent prescription drug pass-through pricing model." All spread pricing arrangements are prohibited for purposes of claiming Federal matching payments.

- Payments made by the state to the PBM are limited to the ingredient cost of the drug, a professional dispensing fee, and a reasonable administrative payment to be retained by the PBM or MCO.
    - Payments made to a 340B covered entity may exceed the ingredient cost as long as the amount is not higher than the ingredient cost would be if they were not a covered entity.

- A PBM must inform the state of all costs and payments related to covered outpatient drugs and related administrative service incurred, received, or made by the PBM. This information includes the ingredient cost of each drug, professional dispensing fees, discounts or other price adjustments, post-sale and post-invoice fees, and any other type of remuneration. This information must also be made available to HHS upon request.
    - HHS must publish an annual report of this information that breaks it down by category of 340B covered entity. This report must not disclose identified information of any covered entity.

- PBM is defined by the Act as any person or entity that performs, directly or through an intermediary, at least one of the following services pursuant to contract with a state Medicaid program:
    - Acts as a price negotiatior or group purchaser on behalf of the state;
    - Manages the prescription drug benefits provided by a state Medicaid program, including the processing and payment of claims for prescription drugs;
    - Performance of drug utilization review;
    - Process prior authorization requests and utilization management appeals or grievances;
    - Contracting with pharmacies; and
    - Controlling the cost of covered outpatient drugs and related services.

- The effective date for this section is 18 months after the enactment of the Act.