OPPOSE THE S. 867, MEDICARE PRESCRIPTION DRUG PROGRAM INTEGRITY AND TRANSPARENCY ACT OF 2013

Pharmacies should be working with—not against— payors to stop prescription drug abuse and fraud.

This legislation will make it easier for bad-actor pharmacies to commit fraud and divert narcotics for street sale by limiting the tools used by pharmacy benefit managers (PBMs) to combat such occurrences. Employers and commercial payors are demanding ***MORE*** accountability for their health care dollars. Under this legislation, they would have ***fewer tools to fight fraud*** than do Medicare Parts A and B and Medicaid.

This legislation limits progress made towards reducing fraud, detecting drug abuse, and promoting safer prescribing, while increase drug costs for Medicare beneficiaries and for taxpayers.

IF ENACTED, THE MEDICARE PRESCRIPTION DRUG PROGRAM INTEGRITY AND TRANSPARENCY ACT OF 2013 WILL:

- **Shield so-called "clerical" errors, which are really fraud, from detection**
  "Clerical" errors, like missing prescriptions and date/time stamp on claims, are exactly the errors that are discovered when a patient's pharmacy shops for multiple prescriptions and fraud occurs. Currently, Part D plans work with CMS to ensure that all LEGITIMATE claims are paid in full.

- **Allow pharmacies to earn extraordinary profits from dispensing generic drugs**
  Prohibits "Maximum Allowable Cost" lists (MAC), which reimburses at a fixed limit regardless of which manufacturer is utilized. The absence of a MAC list would allow an individual pharmacy to earn a high profit by dispensing the generic drug from the manufacturer with the highest list price.

- **Limit reviews that detect fraud and drug diversion to only two most recent years**
  In establishing Medicare Part D's fraud program, CMS chose to require 10 years of pharmacy claims retention, modeled after the False Claims Act and consistent with the Medicaid drug rebate program. Limiting the time period for claims review restricts access to information needed by law enforcement officials for building a case against those committing fraud.

- **Prohibit the use of extrapolation or other statistical expansion techniques in pharmacy reviews**
  Federal and State government Medicaid and Medicare programs are seeking more accountability and expanding their own audit programs under the Affordable Care Act, including contingency fees and data methods, to calculate the amount of a recovery or penalty. These entities include: Zone Program Integrity Contractors (ZPICs), Program Safety Contractors (PSCs), Risk Adjustment Contractors (RACs), Medicaid Integrity Contractors (MICs), Medicaid Fraud Control Units (MFCUs) investigators, and Comprehensive Error Rate Testing (CERT) contractors.

- **Restrict fraud reviewers to pharmacists licensed in that state where the review occurs**
  While pharmacists are licensed in a given state, fraud does not respect state boundaries. Pharmacists may not have the expertise needed to review claims and billing patterns. Restricting clinical expertise that can be brought to bear would create an unnecessary obstacle to qualified reviewers and add unnecessary expense in efforts to root out fraud, waste and abuse.

- **Prohibit Medicare plans from discussing more affordable pharmacy options with patients**
  Under the proposed legislation, Part D plans would be prohibited from incentivizing enrollees from choosing more affordable pharmacy options, including traditional retail, mail-service, or specialty pharmacies. Restricting this ability limits savings options for enrollees and the federal government.