sis. This will assure that the DVA has access to all the drugs that its patients may need, and will prevent manufacturers from refusing to negotiate or give dis-
counts on particular drug products.

Second, the bill would exclude from the calculation of "best price" for determin-
ing the amount of the Medicaid rebate any prices charged under the FSS, thereby ex-
cluding all prices to the DVA. In doing so, the bill would further the economies
which the DVA-administered FSS permits such Federal health care providers as the
Department of Defense and the Bureau of Prisons, which also purchase drugs through
the FSS. In addition, the Committee bill would clarify that prices paid under State
pharmaceutical assistance *12 programs such as that operating in the State of New
York, which use DVA of FSS prices as a basis for determining rebates or discounts,
are also excluded from the calculation of "best price."

Finally, the Committee bill would also condition the availability of Federal
matching funds with respect to any covered outpatient drug of a manufacturer on the
agreement of the manufacturer to provide the DVA a minimum discount on each drug
and to comply with applicable reporting and auditing requirements. In the case of
single source drugs (outpatient or inpatient) purchased under the DVA's depot con-
tracting system or listed on the FSS, the DVA may not be charged more than 76 per-
cent of the non-Federal average manufacturer price (less an additional discount to
offset price increases in excess of inflation). The 24 percent discount represents
the median "best price" rebate under the Medicaid program for the first quarter of
1991, which was the last quarter before manufacturers began substantially increas-
ing prices to the DVA. The use of this percentage is intended to capture what the
Committee on Veteran's Affairs believes to be the level of discounts the DVA
was receiving before the Medicaid rebate program went into effect. The Committee
bill requires that an additional discount be paid on a drug when the increase in
the non-Federal AMP exceeds the increase that would have occurred if the CPI had
been applied to the non-Federal AMP (measured in the 3-month period ending one year
before the end of the 3-month period for which the discount is calculated).

The Committee bill also provides protection from drug price increases to speci-
ified Federally-funded clinics and public hospitals that provide direct clinical
care to large numbers of uninsured Americans. Like the prices charged to the DVA,
prices charged to these "covered entities" would be exempt from the calculation of
the Medicaid "best price" for purposes of determining the Medicaid rebate. The Com-
mittee expects that this exemption will remove any disincentive that the Medicaid
rebate program creates to discourage manufacturers from providing substantial vol-
tuntary or negotiated discounts to these clinics, programs, and hospitals.

In addition, manufacturers, as a condition of receiving Federal Medicaid matching
funds on their covered outpatient drugs, would have to enter into an agreement with
the Secretary of HHS to provide price reductions (whether through a discount, re-
bate, or other mechanism) to these "covered entities" on covered outpatient drugs.
These price reductions would be at least as great as those which Medicaid receives
under the rebate program. They would be implemented, at the discretion of the Sec-
cretary, either by a point-of-purchase discount, a rebate, or other mechanism. "Cov-
ered entities" receiving these price reductions would be prohibited from obtaining
payment for these drugs under Medicaid or from reselling or transferring the drugs
to individuals other than their patients, and they would be subject to audit to
verify compliance with these requirements. In giving these "covered entities" ac-
cess to price reductions the Committee intends to enable these entities to stretch
scarce Federal resources as far as possible, reaching more eligible patients and
providing more comprehensive services.

*13 The Committee bill specifies 6 types of "covered entities":

(1) Federally qualified health centers (FQHCs), a category which includes ap-