August 15, 2012

Alan P. Spielman, MBA
President and CEO
URAC
1220 L Street, NW, Suite 400
Washington, D.C. 20005

Dear Alan:

Thank you for the opportunity to comment on the community pharmacy draft practice standards recently released by URAC. NCPA would like to take this opportunity to offer comments regarding URAC's community pharmacy accreditation (CPA) efforts. Though we recognize the hard work done to promote quality of patient care in community pharmacies, we do not believe that the current draft standards would lead to such results. Instead, we remain cautious of the potential implications that would result from accrediting individual pharmacies.

NCPA General Concerns and Comments Surrounding Community Pharmacy Accreditation

Since 1998, NCPA's official position has been to support individual state boards of pharmacy as the regulating bodies for pharmacy, rather than another entity providing national oversight. The fact that neither community pharmacies, patients, nor payers are currently demanding community pharmacy accreditation is of concern to NCPA.

NCPA questions whether CPA will become a truly voluntary option in the current market environment. Though CPA may seem voluntary, our collective experience tells us that payers will likely justify creating reimbursement tier structures or, even worse, exclusion from networks based on CPA requirements. Such punitive networks would, instead of encouraging participation, force community pharmacies to choose between costly accreditation and keeping their doors open.

Even after being accredited, the significant upfront and long term costs of accreditation will not only create additional financial burdens to pharmacy owners, but also result in little likely return on their investment. Though the goal of CPA is to improve patient care, NCPA questions the prudency of diverting already scarce resources away from actually providing better patient care. Instead, we should be working collaboratively to prevent the creation of a perverse incentive to further decrease community pharmacy reimbursement rates. Ultimately, NCPA is concerned that CPA would become a "carrot" for larger entities but a "stick" for smaller independent businesses.

100 Daingerfield Road
Alexandria, VA 22314-2888
(703) 683-8200 PHONE
(703) 683-3619 FAX

However, NCPA does acknowledge the quality recognition that can be associated with an accreditation or certification program, especially when called for by practitioners in a specialized area. For example, NCPA supports compounding pharmacy accreditation through the Pharmacy Compounding Accreditation Board (PCAB). Pharmacies that specialize in compounding are a vital subset of community pharmacies and currently utilize PCAB accreditation as a badge of skill and quality. Likewise, NCPA recommends that any community pharmacy accreditation or certification efforts focus on a smaller subset of community pharmacy practitioners. Standards should be strengthened to ensure that any accreditation or certification program is a badge of quality and not just a name-tag. For any program to be an effective and supportive process, it should go beyond a "pay to play" model.

In the alternative, the certification of community practitioners instead of site accreditation may yield better results in improving the quality of patient care. For example, APhA currently certifies practitioners as Ambulatory Care and Pharmacology specialists; these certifications or even a newly tailored specialty for community pharmacists could be utilized to ensure a high quality of care. Since the pharmacist, and not the site, is the one providing the actual care, improving the quality at the point of service may be a more appropriate approach. This may be an approach that could prevent the creation of restrictive or tiered PBM networks, ultimately restricting patient access.

Community Pharmacy Accreditation Offers No Return on Investment at This Time

From a different perspective, NCPA is concerned over the inherent proposal being offered by URAC. As a private, non-government accrediting organization, URAC is essentially offering a business proposal to pharmacy owners through the release of the draft CPA standards; for a large fee, the pharmacy can become accredited by a private, non-government entity. A business owner is being asked to invest his or her scarce and hard earned resources, including money, time and staff, to become accredited. When analyzing his or her returns on this investment, he or she is likely to conclude the following:

- First, there are no likely immediate returns from CPA. As community pharmacies rely on the hard earned, trusting relationship with their patients to retain and gain business, accreditation would likely have no immediate benefits.
- Second, there are likely no long term benefits for his or her business either. As URAC seeks to accredit most community pharmacies, a small business owner may question whether they need accreditation for what is already being done and whether CPA would separate their business from others.
- Third, he or she would likely see little value in participating in an eventual "pay to play" reimbursement structure. Exclusion from a network based on CPA non-compliance would be detrimental for community pharmacies, which are already fighting with reimbursement cuts, restrictive networks and capricious audits to keep their doors open. A pharmacy owner would likely come to these conclusions when offered this deal and refuse to "pay to play," but our market is not as simple as that.

Even though most community pharmacies would likely refuse CPA at first, incorporation of URAC's program into a PBM network or tier structure will eventually mandate that a community pharmacy undergo this costly procedure just to retain current reimbursement levels; they will essentially be forced to "pay to stay." NCPA questions whether the low return on an investment in CPA compared to the financial burden it places on community pharmacies can be associated with a prudent and objective measure of quality. In fact, URAC's CPA standards do suffer from a lack of objective measurements, a heavy reliance on documentation requirements, and a duplication of state regulatory requirements and current pharmacy practices.

Community Pharmacy Practice Draft Standards Are Duplicative and Subjective

NCPA is concerned over the substance of the draft standards. First, most of the draft standards are duplicative of existing federal and state laws. For example, many of the Patient Medication Management standards (PMM 1 through PMM 10) are duplicative of the current practice of medication therapy management, which is already regulated by the Code of Federal Regulations, volume 42, section 423.153(d). These include requirements for comprehensive medication review, medication management services to be conducted by a qualified healthcare professional and the capability to conduct medication therapy management services. In addition, the organization structure and oversight standards are already addressed by state laws and regulations.

Second, many of the draft standards are duplicative of existing practices, often dwelling on documentation of policies and procedures. For example, having adequate and sufficient resources to provide services would be already addressed by requirements to participate in certain programs or own and operate a business. In addition, documentation of pharmacist communication with health care providers and patients is a common practice, often aided by already present technology. Also, there are many requirements pharmacies must attest to meeting in order to participate in Medicare Part D prescription drug plan networks, most of which are duplicative of requirements in the URAC draft standards.

Third, the language used in the draft standards is subjective, yielding standards that are difficult to measure objectively. For example, how would URAC objectively measure how much a pharmacy is acknowledging and reinforcing favorable behaviors?

Lastly, NCPA believes that URAC has not taken into consideration that community pharmacies in different localities and regions often use unique strategies when implementing medication management for their population. We question whether the draft CPA standards can be compatible with this nationwide diversity. For example, a rural community pharmacy would not find the strategies used in a densely populated area as effective, and vice versa.

Given that localities differ greatly in their population, factors such as age, gender, literacy, English proficiency and education level suggest that having a single set of patient medication management standards for the whole nation might be unrealistic. The simple fact is that once you've seen one community pharmacy practice, you've seen one community pharmacy practice. NCPA is adamantly opposed to accreditation arrangements that allow certain entities to be sampled and not others. Ultimately, when dealing with all types of community pharmacies on a national level, they should be allowed to utilize innovative techniques and strategies that work best for them.

Conclusion

In conclusion, NCPA is concerned that the URAC draft standards are duplicative of current state and federal laws and regulations and of generally accepted and already widely used pharmacy practice standards, are focused on subjective procedures and goals and are not results oriented, in part, by relying mostly on documentation of policy and procedures instead of actual practice improvements. NCPA also has concerns about how compliance with the draft standards will be measured. Lastly, we believe that CPA will become a conveniently-used stick to penalize independents, not offered as a carrot. NCPA would like to thank you for your hard work at trying to promote better patient care, but we cannot recommend that the current draft standards be finalized at this time.

Sincerely,

Douglas Hoey, Pharmacist, MBA
Chief Executive Officer
National Community Pharmacists Association