Submitted via email to RPS@cms.hhs.gov

August 17, 2012

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Subject: NCPA Comments on "Part I: Draft Methodology for Estimating the National Average Drug Retail Prices (NARP) for Medicaid Covered Outpatient Drugs"

Dear Barbara:

On behalf of the National Community Pharmacists Association (NCPA), I am writing regarding the recently released CMS document, "Draft Methodology for Estimating the National Average Drug Retail Prices (NARP) for Medicaid Covered Outpatient Drugs." NCPA appreciates the opportunity to review this document and to provide our comments and concerns before these data are released and states or other payers possibly use the data to set reimbursements.

NCPA represents the owners and operators of approximately 23,000 privately-held small business independent community pharmacies across the United States. Our members provide about 40 percent of all outpatient prescriptions in the United States. Moreover, more than 90% of NCPA members' business is derived from prescription revenues, and Medicaid represents an average 15% of all prescriptions filled. This percentage is higher for pharmacies in urban and rural areas. NCPA members are on the front lines of Medicaid beneficiary care, and are more significantly impacted by new methodologies than other pharmacy entities.

NCPA continues to be very concerned about CMS' haphazard approach to implementing Medicaid pharmacy reimbursement changes. This includes CMS insistence on publishing eleven, problematic draft FUL lists for Medicaid generic drugs that will devastate small business pharmacies if implemented, the development of a NADAC program for which we believe that CMS lacks authority to implement, and now a NARP program that violates the intent of the Social Security Act.

Under Section 1927(f)(1)(A)(i) of the Social Security Act, the Secretary may contract for services for… the determination on a monthly basis of retail survey prices for covered outpatient drugs that represents a nationwide average of consumer purchase prices for such drugs…" The statute is clear that the survey should consist of consumer purchase prices. Yet, CMS is including commercial third party payments, including Medicaid payments, in the calculation of the NARP, which are not consumer purchase prices.

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In addition, these are NCPA's comments on the proposed NARP methodology:

- There are too many different unidentified data files and too much estimation being used in this proposed methodology for CMS to even contend that these NARP values will be remotely credible. Releasing these data into the marketplace could have a widespread negative economic impact on small businesses – beyond the Medicaid program – if the NARP understates the amount that pharmacies receive for prescriptions, and the amounts are used as a reimbursement benchmark.

- The NARP methodology must include a mechanism to back out the millions of dollars in Medicaid copays that go unpaid every year to pharmacies. Unlike private plans, pharmacies cannot collect copays from Medicaid patients if they theoretically cannot pay or refuse to pay the required copay. States cannot and do not compensate pharmacies for such lost copays. Therefore, lack of copay collection represents a reduction in Medicaid revenues to pharmacies, which is what NARP is supposed to measure. Without this adjustment, the average revenues to pharmacies will be overstated and therefore the NARP is not an accurate methodology.

- The definition of community retail pharmacy should be adopted as part of the methodology. That is, it should be made clear that only true independent or chain pharmacies should be included. If Section 1927 is changed by a future Congress, it may create confusion as to the definition of a retail community pharmacy.

- The methodology is cryptic as to the "data suppliers" being utilized by Myers and Stauffer to determine the mean price per unit. In the interest of "full transparency" which CMS repeatedly claims it places a priority on maintaining, it must disclose the sources of the data used by the contractor to determine the NARP so that the underlying data could be validated. The use by CMS or its contractors of anonymous "data suppliers" is arbitrary and capricious.

- CMS must clarify why utilization used to calculate price for each NDC/state/payer type/pharmacy entity comes from one data source, yet the monthly utilization file used to calculate NARP at the NDC/payer type level comes from another data source.

- CMS must clarify how "data suppliers" will work together to create one master file that will then be turned over to Myers and Stauffer. Will one "data supplier" provide data on cash transactions while another "data supplier" provides data on "other" types of transactions? Will "data suppliers" be stratified by geographic region? If "data suppliers" use different methodologies to capture and measure transaction prices, how will they develop an accurate and standard measure?

- Some retail community pharmacies serve LTC facilities and 340b entities. Claims for 340B drugs and all LTC claims must also be excluded from the calculation. There will simply be no credibility to the data if such claims are included because payments to these other entities for the same drugs might be lower than the payments made to community pharmacies. The anonymous "data suppliers" must find a way to exclude these LTC claims from the data used to collect the NARP.

- The methodology states that specialty pharmacies will be excluded from the NARP at this time. Specialty pharmacies should never be included in the calculation. CMS must clarify what definition they are utilizing for specialty pharmacies.

- CMS must clarify that the Medicaid price included in the calculation is the actual price paid to the pharmacy, if the pharmacy is paid at the lower usual and customary price. The higher amount that would be paid to the pharmacy based on the state's reimbursement formula should not be included.

- CMS must clarify how they will ensure there is a representative sample across pharmacy channels *within each state/payer type calculation*. CMS states that 30 observations are necessary to calculate an average retail price, but it is unclear if 30 observations are required at the NDC level or at the pharmacy channel/state/payer type level.

- CMS must clarify if the aggregated data that CMS plans to utilize to project utilization is weighted by both chains and independents so that there is accurate representation of the amounts received by independents.

In summary, we believe that CMS is violating the statue by including prices other than consumer purchase prices in this methodology. Moreover, the sheer number of different unnamed unidentified files being used, and the various weighting and estimation processes being used, allows for the introduction of so much error in the outcomes that we question the credibility of the results. The potential economic damage to small businesses through the public release of these data is real. We hope that you will take these comments into consideration. Please contact me by email at john.coster@ncpanet.org, or at (703) 600-1184, if you have any questions.

Sincerely,

John M. Coster

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