Comments from the National Community Pharmacists Association
House Ways & Means Health Subcommittee Hearing
"Current Status of the Medicare Program, Payment Systems, and Extenders"
May 18, 2017
1100 Longworth House Office Building
Washington, DC

The National Community Pharmacists Association (NCPA) appreciates the opportunity to submit comments for the record of this hearing. We present the following observations and suggestions for action items that should be considered in order to improve and transform the Medicare Part D program. NCPA represents America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together, they represent an $81.5 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

Independent community pharmacies play a critical role in ensuring Medicare beneficiaries have immediate access to medications. They are on the front lines of health care delivery, partnering with patients and providers to help manage chronic conditions and counsel patients on proper medication use. Eighty percent of these community pharmacies are in population areas of 50,000 or less – underscoring their importance to underserved communities.

Adequate reimbursement is essential to sustaining beneficiary access to prescription drugs at the pharmacies NCPA represents. Ninety-two percent of sales revenue at an independent community pharmacy is derived from prescription drugs, and Medicare Part D accounts for 35 percent of these prescriptions[1].

Address the Growing Problem of Pharmacy "DIR fees" in the Medicare Part D program.

Pharmacy direct and indirect remuneration (DIR) fees are effectively clawback fees assessed on pharmacies retroactively months later, rather than deducted from claims on a real-time basis at the point-of-sale. This reimbursement uncertainty makes it extremely difficult for community pharmacists to forecast revenue and operate their small businesses.

Earlier this year CMS identified several concerns resulting from the rapid growth in pharmacy DIR fees[2]. First, beneficiaries face higher cost-sharing for drugs and are accelerated into the coverage gap or "donut hole" phase of their benefit. Second, more beneficiaries reach the catastrophic phase of the benefit, for which CMS incurs approximately 80 percent of the cost. (HHS Office of Inspector General has noted[3] that these catastrophic costs have tripled in recent years - from $10 billion in 2010 to $33 billion in 2015 – driven by pharmacy DIR fees.) Third, liability for Part D costs is increasingly being shifted from Part D plan sponsors to CMS.

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[1] *NCPA 2016 Digest*, sponsored by Cardinal Health, http://www.ncpanet.org/home/ncpa-digest
[2] CMS, "Medicare Part D – Direct and Indirect Remuneration," https://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2017-fact-sheet-items/2017-01-19-2.html
[3] HHS Office of Inspector General, "High-Price Drugs Are Increasing Federal Payments for Medicare Part D Catastrophic Coverage," https://oig.hhs.gov/oei/reports/oei-02-16-00270.asp

These findings were reinforced and bolstered by a report earlier this year by a leading actuarial firm commissioned by NCPA[4]. In addition, MedPAC recently warned[5] that, because of DIR, the gap between gross and net drug prices has grown 20 percent annually from 2010-2015 and that "plan incentives [are] not aligned with beneficiary and Medicare."

By utilizing tactics such as pharmacy DIR fees, the Part D plan sponsor or its pharmacy benefits manager (PBM) often receives additional compensation after the point of sale that serves to change the final cost of the drug for the payer, or the price paid to the pharmacy for the drug.

The point-of-sale price/"negotiated price" recorded on Prescription Drug Event (PDE) records is extremely significant. It is used to calculate beneficiary cost-sharing and to adjudicate the Part D benefit. Any fees or payment that are made after the point-of-sale are not reflected in the negotiated price but rather are reported to CMS separately.

Many beneficiaries and caregivers rely on the online Medicare Plan Finder to evaluate and choose a Part D plan. However, the data displayed on Medicare Plan Finder are based on point-of-sale prices. The vast proliferation of DIR and post point-of-sale price concessions have rendered this drug price information grossly inaccurate.

To address these concerns, and to help preserve access to independent community pharmacies, there are two approaches that could be employed by Congress.

1. **Enact H.R. 1038 to ban retroactive "DIR fees" on community pharmacies which increase both beneficiary out-of-pocket medication costs and CMS' Part D catastrophic costs as well as jeopardize the viability of many independent community pharmacies.**

This approach would require Medicare Part D Plan Sponsors/PBMs to utilize point of sale discounts—rather than post point of sale pharmacy price concessions. This would lower beneficiary cost-sharing and reduce Medicare program costs and liability. This approach would not prohibit the use of pay for performance arrangements but rather would encourage true quality incentive programs rather than the misaligned programs that blur the line between reimbursement for ingredient cost and pharmacist performance.

OR

2. **Encourage CMS to strengthen and finalize the concept included in 2014 proposed guidance on *Direct and Indirect Remuneration (DIR) and Pharmacy Price Concessions* that sought to implement the new definition of "negotiated price" in Medicare Part D to include all pharmacy price concessions that can be reasonably estimated based on historical data/experience.**

This approach would provide a more accurate picture of the true cost of a drug "out the door" of a pharmacy to beneficiaries, CMS and the public. In addition, this approach would provide

[4] "The Impacts of Prescription Drug Direct and Indirect Remuneration under Medicare Part D", Feb. 2017
[5] "Payment and plan incentives in Part D", April 7, 2017

pharmacists a true picture as to their total reimbursement at the time a drug is dispensed to a patient.

Request CMS review and standardize how Part D plans measure pharmacy quality and performance as community pharmacies face the impossible task of complying with a patchwork of measurements that are often disconnected from the reality of pharmacy practice.

Many large Part D plans have deeply flawed contractual requirements in place that evaluate quality at the pharmacy level using measures developed for use at the health plan level instead. Independent community pharmacists are greatly concerned about being financially penalized for circumstances that are entirely out of their control.

For example:

- Patients' who are chronically ill and on very complex medication regimens have more complex needs than patients stable on chronic medications, even though pharmacy claims could be viewed as identical

- Physicians who determine that a statin for example is not in the best interest for a diabetic patient or any physician decision that would run counter to a pharmacy level measure

- Patients' who move to another pharmacy but the original pharmacy is still being measured on a patient they no longer care for

- Low pharmacy denominators determining broad reimbursement rates

- Health plan member enrollment until death or disenrollment being used to assess pharmacies vs using the pharmacy's actual patient population

Enact H.R. 1316 to increase transparency into how generic drugs are priced by PBMs and paid for in Medicare and other federal healthcare programs.

Generic prescription drugs account for the vast majority of medications dispensed by community pharmacies, yet there is no transparency into how they are priced in federal health programs by PBMs. Through hidden maximum allowable cost (MAC) lists, PBMs can charge federal health programs at higher rates while paying much lower reimbursement rates to independent community pharmacies.

H.R. 1316, The Prescription Drug Price Transparency Act, would extend the MAC disclosure requirements currently required in Medicare Part D to TRICARE and the Federal Employee Health Benefits (FEHB) Program. As of January 1, 2016 Medicare Part D plan sponsors/PBMs must update MAC lists every seven days "to accurately reflect the market price of acquiring the drug and must also disclose prices in advance of their use for reimbursement and MAC prices must be disclosed by network pharmacies "in a manner and format that is usable by the pharmacies, so that pharmacies can validate the prices."

NCPA was very supportive of the finalization of the regulatory provision that put these requirements in place for Part D. However, even in part D there are still needed reforms.

So, in addition to passage of H.R. 1316, Congress should recommend that CMS issue guidance to Part D Plans/PBMs regarding Maximum Allowable Cost (MAC) drug pricing that would require MAC lists to be provided to pharmacies specifically in an interactive spreadsheet format and require Plans/PBMs to establish a valid MAC appeals process.

Enact H.R. 1939 to give seniors more access to discounted copays for prescription drugs at their pharmacy of choice.

Medicare beneficiary access to prescription drugs is impeded by mandates from Part D plan sponsors and PBMs that effectively dictate which pharmacy to use based on exclusionary "preferred pharmacy" arrangements between PBMs and, often, Big Box pharmacies. Independent community pharmacies are not allowed to participate in some of these arrangements, even if they offer to accept the Part D plan's same contract terms and conditions.

This situation raises patient access concerns, particularly in underserved rural and inner city areas in which many independent pharmacies are located. Indeed, this problem was noted in a recent government-funded policy brief by the RUPRI Center for Rural Health Policy Analysis, which noted, "With looming closure without replacement of many of these pharmacies, an estimated 3 million rural residents are at risk of losing the only pharmacy in their community."[6]

The Ensuring Seniors Access to Local Pharmacies Act, H.R. 1939, would allow community pharmacies that are located in medically underserved areas (MUAs), medically underserved populations (MUPs), or health professional shortage areas (HPSAs) to participate in Medicare Part D preferred pharmacy networks so long as they are willing to accept the contract terms and conditions that other in-network providers operate under.

In addition, NCPA recommends that Congress encourage CMS to implement access standards for preferred cost sharing pharmacies or require plans to disclose in all plan offerings and on the Medicare Part D Plan Finder tool, the actual number of preferred pharmacies in each individual region. In the near term, NCPA would recommend that those plans that are currently identified as "outliers" not be permitted to advertise that they offer "preferred cost sharing" in light of the fact that the lack of meaningful access renders any potential benefit or savings meaningless.

Expand access for beneficiaries in underserved areas to basic health services from a community pharmacist (H.R. 592).

Millions of Americans lack adequate access to health care due to primary care physician shortages in their communities, despite many of these patients having health insurance coverage. Enabling pharmacists to more fully utilize their education, training and expertise, and be more integrated into the patient's health care team will also improve health outcomes and greatly

[6] "Issues Confronting Rural Pharmacies after a Decade of Medicare Part D," https://www.ruralhealthresearch.org/alerts/165

benefit specific populations with chronic disease; including those with diabetes and cardiovascular disease.

H.R. 592 would enable Medicare beneficiaries access to pharmacist-provided services under Medicare Part B by amending section 1861(s)(2) of the Social Security Act to recognize pharmacists as providers.

The legislation is consistent with precedent established by the Nurse Practitioners (NPs) and Physicians' Assistants (PAs) provider status efforts. Pharmacist services would be reimbursed at 85 percent of the physician fee schedule and be consistent with each respective state's already existing scope of practice.

Conclusion

NCPA greatly appreciates the opportunity to share our thoughts and recommendations on ways in which to enhance the Medicare program and increase beneficiary access to prescription drugs and related essential health services.