

January 16, 2018

The Honorable Seema Verma Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health & Human Services 7500 Security Boulevard  
Baltimore, MD 21244

Re: Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program (CMS-4182-P)

Dear Administrator Verma:

On behalf of OC Pharmacy

I am pleased to submit comments and recommendations on the proposed rule, “Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program (CMS-4182-P).”

Part D plan sponsors and Pharmacy Benefit Managers (PBMs) extract DIR (Direct and Indirect Remuneration) fees from community pharmacies. Nearly all pharmacy DIR fees are clawed back retroactively months later rather than deducted from claims on a real-time basis. This reimbursement uncertainty makes it extremely difficult for community pharmacists to operate their small businesses. The current DIR model may also increase costs to patients at the point of sale and ultimately increase cost to CMS as patients enter the “donut hole” and catastrophic phases of coverage.

Additionally, it is extremely important to note that PBMs and Part D plans do not allow for network pharmacies or the network pharmacy sponsors to negotiate payment terms, including the negotiation of DIR fees. It is our belief that your understanding is there is some sort of negotiation that takes place between network pharmacies and their sponsors, and PBMs and PDPs. The reality is quite the opposite; PBMs and PDPs force network pharmacies and their sponsors to sign the contract “as-is” without any offer or potential for negotiation of the terms set forth. There isn’t even an entity, department, or individual at the PBM or PDP that we could approach for negotiating contract terms. PBMs and PDPs operate as a racket, using their patient base as leverage. If the pharmacy or their sponsor does not sign the contract as provided by the PBM or PDP, then the pharmacy loses access to the patients subscribed to that PDP.

To give you an example, most DIR Fees and prescription audit practices result in clawbacks of payments made to the pharmacy. We have lost so much money on Medicare plans that we may be forced to terminate our Medicare contract, forcing our Medicare patients to find care elsewhere, effectively restricting the patients choice of where to fill their prescriptions. Patients come to our pharmacy because our pharmacists set aside ample time to help patients with their questions. We’re never compensated for the amount of time, like physicians are, that we set aside for a patient to help explain lengthy and complicated topics like diabetes.

Moreover, PBMs and PDPs have passed on their responsibilities to the STAR ratings program to network pharmacies without providing any additional compensation. They expect us to maintain their star rating for them, and financially punish us when the patient doesn’t comply with the instruction and direction provided by the pharmacy and the physician.

For example, if we do not regularly fill a patient's diabetes medication, we are punished by the PBM with lower payments, and the threat of sending the patient to a different pharmacy. We can only explain to the patient the importance of taking their diabetes medication, and urge them to fill it on time; but often times this is a battle with the patient and they often ask, "are you forcing me to fill this? I don't have the money to do that right now". What are we supposed to say or do? The pharmacy requires working capital to purchase over-priced drugs to provide to the patient. If the patient is unable to pay, then we cannot maintain financial viability. If the patient doesn't fill, then the PBM and PDP punish us with lower reimbursements (something that they will not allow us to negotiate at the time of network enrollment). At the end of the day the network pharmacy loses – it loses money and it loses the patient due to medicare's misguided policies as influenced by PBMs and PDPs that have a financial incentive to not lower premiums and instead lower reimbursements to the provider. If providers aren't paid properly, eventually they will refuse to participate in the program. What will CMS do then?

I write to voice my organization's strong support for the proposed change to require that all pharmacy price concessions be reflected in price at the point of sale. Additionally we urge you to incorporate a requirement that PBMs and PDPs have a contract negotiation procedure, whereby PBMs and PDPs are able to look at the actual acquired cost (AAC) of the dispensed drug, and pay at minimum 80% over cost so that the pharmacy is able to adequately pay its employees, its vendors, and so that pharmacists can spend the necessary amount of time with patients. 80% is just a suggestion but that is the typical amount over cost that will cover all overhead expenses. To be clear, our request is that PBMs and PDPs agree to pay, at minimum, the cost to fill a given prescription for a patient. We are not asking to make a major profit, only that we are paid for what it costs us to do business. At this time, PBMs and PDP contracts will only pay towards the cost of the medication, and they restrict the pharmacy from charging anything additional for materials and labor. How is any business supposed to maintain fiscal viability if it is required to give products and services away for free?

This approach will bring much needed transparency, improve the predictability of business operations for community pharmacists, and most importantly, lead to significant beneficiary savings.

Thank you for your consideration.

Sincerely, Omeed Askari  
Owner  
OC Pharmacy