NPSC
STRONGER Rx TOGETHER

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2017-0156-0046
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS-2017-0156-0046 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

January 11, 2018

Dear Administrator,

My name is Dave Benoit; Vice President of Patient Care Services for Northeast Pharmacy Service Corporation. We are a pharmacy services administrative organization (PSAO) that represents over 300 independently owned community pharmacies located in MA, CT, RI and ME. The pharmacies in each state provide prescription drugs and related pharmacy services to urban, suburban and rural service areas. Our participating pharmacies offer home delivery to house-bound patients, deliveries to residential care facilities, special packaging for medications in group homes and assisted living, hospice care, compounding and specialty drugs that are essential to the patients' care and are not generally otherwise available.

As an interested stakeholder, we would like to submit our comments on **CMS-2017-0156-0046 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.** We would like to voice our support for several provisions in the proposed rule and we urge CMS that this rule be finalized for several reasons.

First, we urge action via this rule requiring all pharmacy price concessions, or DIR fees to be reflected at the point of sale instead of being applied retroactively (which is what the proposal suggests). Doing this would provide our participating pharmacies with accounting predictability as to their minimum reimbursement amounts. This would also allow for our participating pharmacies to have improved business planning operations.

Moreover, pharmacy benefit managers (PBMs) and Part D plan sponsors (PDPs) would still be able to offer performance incentives to pharmacies that achieve contractual goals. We have seen this through the star ratings program. We do wish that CMS would put out

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some clarifying standards around the star ratings incentives. The way this is currently constructed has it where our member pharmacies have been presented with the lion's share of responsibility for ensuring that plan standards are met, yet PDPs and PBMs do not share any incentives with their pharmacy partners. Pharmacies experience performance programs as punitive financial programs. We don't believe that CMS' intent was to pass along a plan's risk to the pharmacies for patient care, nor do we believe it was CMS' intent to incentivize only a select portion of those responsible for lowering patient risks.

Furthermore, CMS has determined that accounting for pharmacy DIR at point of sale would create significant net savings for Medicare beneficiaries and would make vital prescription medication more affordable overall, even after considering any potential increase in monthly premiums.

We also commend the proposed rule for creating a definition of mail-order pharmacy. Retail pharmacies that mail a prescription to a patient who may be living 20 or 30 miles away risk being classified as a mail order pharmacy by some PBMs, even if the patient is paying the retail, and not the mail order, cost-sharing amounts. This can lead to pharmacies being removed from networks. The proposal would bring greater clarity as to what constitutes a mail order pharmacy. This would also be consistent with state pharmacy regulations that allow in-state mailing of prescription medications.

The proposed rule also reinforces existing "any willing pharmacy" regulations as they pertain to base pharmacy networks. We strongly support this reinforcement. Many independent pharmacies offer services such as compounding or care for patients on specialty medications in addition to retail offerings, but, because of these additional services, PBMs sometimes preclude our these pharmacies from participating in base networks.

Moreover, the proposed rule establishes a date when the terms and conditions of the base network must be readily available and would require they be promptly provided at the request of a pharmacy. Thus the rule provides necessary clarifications to the "any willing pharmacy" provisions. While the proposed rule did not expand "any willing pharmacy" provisions to preferred pharmacy networks, we are hopeful future rulemaking will address this.

CMS in its proposed rule also expressed disapproval of current PDP sponsor or PBM-specific credentialing criteria in order to participate in a network or dispense certain medications. We echo this. PBM-specific credentialing is both costly and duplicative of other recognized credentials, and we strongly support CMS' efforts to ban this extra credentialing. Furthermore, NCPDP offers a standardized credentialing database, which is available to the industry.

Finally, we would like to voice support for CMS' conservative and uniform approach to implement the Comprehensive Addiction and Recovery Act of 2016 provisions in Medicare Part D. We support the exemption of Hospice, Cancer, and LTC patients from

drug management programs and also that any notices sent from plan sponsors or PBMs be approved by the Secretary. We ask that in addition to these exempted individuals, CMS also exempt residents of any facility for which frequently abused drugs are dispensed for residents through a service contract with a single pharmacy. I also want to make sure that any notice sent to patients makes very clear that any lock-in program applies only to frequently abused drugs. We also strongly support prescriber agreement to implement a pharmacy lock-in.

In conclusion, we believe that bringing greater transparency to DIR fees to help both beneficiaries and pharmacies; creating a sound definition of mail order pharmacy; bringing greater clarity to the "any willing pharmacy" provisions of standard networks, and proposing a common sense, uniform approach when establishing drug management programs for beneficiaries will improve the Medicare Part D program. For these reasons, we urge that the rule be quickly finalized with these provisions remain intact.

Sincerely,

David G Benoit

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