

January 15, 2018

VIA Electronic Submission at: <http://www.regulations.gov>; CMS-4182-P

Seema Verma
Administrator of the Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-4182-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Proposed Rule for 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,

H-E-B is a regional grocery chain operating over 265 pharmacies in Texas with a total employment of over 100,000 partners (employees). Thank you, for the opportunity to submit the following comments on the Proposed Rule for 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).

Request for Information (RFI) Regarding the Application of Pharmacy Price Concessions to Drug Prices at the Point of Sale

H-E-B agrees that the current framework for pharmacy price concessions does not produce the lowest overall prescription drug cost for patients and taxpayers. An overly-broad application of the “reasonably determined” exception has resulted in a dramatic rise in pharmacy DIR rebates and a number of issues from the patient and pharmacy perspective. 1.) There is a lack of transparency leading to higher beneficiary cost-sharing at the pharmacy counter and unknown reimbursement for the pharmacy. 2.) Performance or incentive programs are not always based on attainable or realistic goals. 3.) Performance programs are not always based on STAR measures.

H-E-B is generally supportive of alternative approaches for applying pharmacy price concessions including the “Lowest Possible Reimbursement” model. We believe that including a much larger share of pharmacy rebates in the negotiated price should lead to better transparency for the patient and, hopefully, pharmacy.

It is important to recognize that, on behalf of Medicare plan sponsors, community pharmacies have made a significant, positive impact on medication-use measures; however incentive payments to pharmacies pale in comparison to total pharmacy price concessions collected by plans. Tying pharmacy reimbursement to a DIR model is a poor blueprint for creating a lasting impact on patient outcomes. The vast majority of pharmacy reimbursement is used to cover the cost of the prescribed medication. H-E-B supports the concept of payment for outcomes, but performance should be managed through an incentive-based system outside the current DIR construct and also be disassociated from the product-based reimbursement model.

Performance incentives should be reasonable and attainable by most pharmacies and socioeconomic and demographic trends within a chain and/or individual pharmacy’s market should be taken into account.

Currently, many plans set performance goals so high that few pharmacies can actually achieve a fair return for the required effort. Further, we would encourage CMS to more broadly re-evaluate the role that pharmacies, as the most accessible and proximal healthcare resource to the patient, can play in improving patient outcomes. If CMS continues to allow plans to reflect pharmacy price concessions as DIR, we would recommend that these amounts not be allowed to exceed DIR “amounts paid to pharmacies.” Finally, requiring that performance incentive programs be based on current or display STAR measures would ensure that patient outcomes are the focus and lead to incentives being better aligned for beneficiaries, plans, pharmacies and other healthcare providers.

Furthermore, we would ask that any future pharmacy price concession rule be created in a manner not to, inadvertently, negatively impact patients or individual pharmacies. As noted in the RFI, reflecting pharmacy incentive payments at the point of sale could create a perverse incentive by driving beneficiaries to lower “scoring” pharmacies. Conversely, allowing plans to provide a lower copay at higher “scoring” pharmacies could negatively impact customers and regional and independent pharmacies versus national chains. Many plan performance programs calculate chain performance in aggregate yet a small chain may have most or all of their locations in a part of the country where medication measures (e.g. adherence) are generally poorer across the board. To illustrate this point, an individual large chain location may have lower adherence measures than a neighboring, regional chain location but have a better plan performance “score” thanks to the overall national distribution and diversity of the large chain.

Request for Information (RFI) Regarding the Application of Manufacturer Rebates to Drug Prices at the Point of Sale

H-E-B does not have any feedback on the calculation or application of manufacturer rebates at the point of sale but appreciates that many of our Medicare patients would see lower prices at the pharmacy counter. At the same time, we want to reiterate that pharmacies have no visibility into and are not passed PBM manufacturer rebates. As a result, any reduction in patient copay based on manufacturer rebates would reduce pharmacy reimbursement unless the plan pay amount is increased by an equal amount.

Comments on Proposed Rule CFR §423.160 to update Medicare Part-D e-prescribing standards

We appreciate the opportunity to comment on the upcoming changes for e-prescribing which would retire NCPDP SCRIPT version 10.6 on 12/31/2018 and replace with version 2017071, effective 1/1/2019. While we welcome the change, realizing that NCPDP version 2017071 offers multiple enhancements to e-prescribing including but not limited to: improved efficiency and eliminating manual transactions which currently exist within SCRIPT 10.6, improving communications between doctors and dispensers, and providing new script transactions which only enhance the pharmacy’s ability for patient care, H-E-B firmly believes the effective date of 1/1/2019 is untenable and burdensome to retailers and software vendors, alike. Such exciting, yet drastic changes within the e-prescribing environment take time to fully implement within our pharmacies. A 12-month implementation window does not allow our current IT infrastructure time to adequately assess, plan, develop, program, certify, test, and deploy to our pharmacies. We are concerned that such an aggressive effective date (counter to the customary 2 year time period of implementation) could potentially delay a patient’s ability to receive their prescriptions in a timely manner, thus ultimately impacting patient care.

Comments on Any Willing Pharmacy Standards Terms and Conditions and Better Definition of Pharmacy Types (§§ 423.100, 423.505)

H-E-B supports the updated guidance on “any willing pharmacy” and agrees with requiring plans to meet deadlines for providing requesting pharmacies with a contract containing standard terms and conditions. Furthermore, we appreciate the clarification that specific certifications or accreditations not be required to dispense specialty drugs. Community retail pharmacies are able to provide faster, local access to specialty medication and outcomes-focused and patient-centered clinical services.

We also appreciate the effort by CMS to define retail and mail-order pharmacies. It is important to recognize that pharmacy practice is evolving at a fast pace and patients expect flexible methods for obtaining medications from their local pharmacy. To meet these needs, many retail pharmacies are offering alternate delivery methods including same-day or common carrier delivery in addition to patient pick-up at the pharmacy counter. Flexibility in meeting patient needs is a critical factor in medication adherence. H-E-B would suggest that CMS revise the definitions of mail and retail pharmacy to reflect the primary method in which they serve patients.

- ***Retail pharmacy*** means any licensed pharmacy that ***primarily*** dispenses prescription drugs ~~to~~ ***for*** the walk-in general public from which Part D enrollees could purchase a covered Part D drug at retail cost sharing without being required to receive medical services from a provider or institution affiliated with that pharmacy.
- ***Mail-order pharmacy*** means a licensed pharmacy that ***primarily*** dispenses and delivers extended days' supplies of covered Part D drugs via common carrier at mail-order cost sharing.

Thank you, again for the opportunity to comment.



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