



December 28, 2017

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: CMS-4182-P 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 Programs

To whom it may concern:

I am writing to you today as the CEO of Kansas Independent Pharmacy Service Corporation (KPSC), which has provided a wide range of services for independent pharmacies throughout Kansas since 1985. Each fall, KPSC asks its stockholder pharmacies to rate a variety of federal and state level legislative and regulatory issues that impact their practice. The allowance for Medicare Part D plans to charge retail network pharmacies direct or indirect remuneration (DIR) fees was rated as the leading concern (out of 24 total issues) and actually has been the highest rated issue for the past three years.

We strongly support the CMS proposed Medicare Part D Rule re: Contract Year 2019 as it regards revising the definition of negotiated prices to make all price concessions from pharmacies (i.e., DIR fees) be reflected in prices made available to beneficiaries at the point of sale and reported to CMS on a PDE record.

We agree with CMS that this change would result in significant cost sharing savings for plan beneficiaries beginning in plan year 2019. In doing so, this change also will give plan pharmacies more certainty in net pricing at the point of sale. Currently, DIR fees are charged well after each point of sale transaction (with great variance across Part D plans) and are a major hindrance in assessing actual per prescription revenue and costs. In addition to savings for beneficiaries, this change will save the federal government billions of dollars in payments to plan sponsors, for reinsurance and for low-income patient subsidies.

It is our understanding that pay for performance for plan pharmacies would not be included in this change. In doing so, it is KPSC's hope that such pay for performance will involve true incentive payments and not be paid out as smaller penalties/lower DIRs as has happened too often.

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The proposed rule includes ways that manufacturer rebates may be reflected at the point of sale, which also can benefit plan beneficiaries. We also support this as it provides further savings for those Part D plan members.

There are other parts of this proposed rule for which we wish to express support. There is a clarification of what constitutes "any willing pharmacy", noting that retail pharmacies may need to engage in other lines of business for their patients (e.g., compounding, specialty prescriptions) and that such pharmacies must still be offered standard terms and conditions to participate in a Part D pharmacy network. We have a number of stockholder pharmacies that offer varied services, in addition to traditional retail prescription drug dispensing, as a necessity for patients in their service areas.

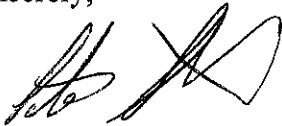
Plans and their PBMs also have tried to have retail pharmacies, that must engage in limited home delivery for their retail patients, redefined as mail order pharmacies and have them be licensed in all states. CMS's proposed clarifications in defining mail order and retail pharmacies are appropriate and reflect the reality of how retail pharmacies must operate to meet patient needs and expectations.

In the area of specialty pharmacy, certain retail pharmacies serving Part D plans must provide some of these medications to their patients based on patient need. CMS is correct in noting concern about having Part D plans require retail pharmacies to meet credentialing criteria (including sometimes using criteria set by the plan/PBM themselves). Trying to box out these retail pharmacies only allows plans to transfer more business to their own specialty pharmacies.

In review, KPSC strongly supports these changes in the above reference proposed rule and encourages CMS to maintain these changes in its final rule for plans in contract year 2019. The net patient savings of \$10.4 billion over a ten year period speaks plainly and positively to the need to change when DIRs are figured.

If there any questions about this letter, please contact me at the email, phone or address indicated below.

Sincerely,

A handwritten signature in black ink, appearing to read "Peter E. Stern", with a stylized flourish at the end.

Peter E. Stern
CEO

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