

March 1, 2006

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: 2007 Prescription Drug Plan (PDP) Call Letter

Dear Centers for Medicare & Medicaid Services (CMS):

The National Community Pharmacists Association (NCPA) respectfully submits the following comments regarding the 2007 Prescription Drug Plan (PDP) Call Letter. NCPA represents the nation's community pharmacists, including the owners of more than 24,000 pharmacies. The nation's independent pharmacies, independent pharmacy franchises, and independent chains dispense nearly half of the nation's retail prescription medicines.

Reporting of Manufacturer Rebates (pages 7-10)

NCPA supports the full and required transparency of all PDP financial components contained within the Medicare Part D program. This includes financial transactions associated with Part D plans and all subcontractors (including pharmacy benefit managers and pharmacies). We remind CMS that several large PBMs, who often serve either as Part D plans or subcontractors, including Medco Health Solutions, Express Scripts and Caremark/Advance PCS, have been the subject of federal/state investigations and prosecutions due, in part, to discrepancies with financial transparency.

Long Term Care Pharmacies

CMS has consistently recognized the need for specialized pharmacy services in the long term care (LTC) population. The performance guidelines mandated by CMS in the March 16, 2005 program memorandum require pharmacies to provide additional LTC services under Medicare Part D that go well beyond usual retail dispensing guidelines. While the performance guidelines are appropriate recognition that managing the special needs of this population is critically important, it is not without additional expense to pharmacists. CMS has maintained that this additional cost should be contained within the LTC dispensing fee. However, the reality is that LTC pharmacy dispensing fees adopted by Part D plan sponsors do not fully address the financial impact to pharmacies diligently providing these LTC services.

By limiting or eliminating the “access/performance rebates” to LTC pharmacies, additional financial burden will fall onto community pharmacies. This will be especially problematic in rural settings. According to the 2005 NCPA-Pfizer Digest, over 50 percent of community

pharmacies are located in areas with populations of less than 20,000. Increases in overhead due to the performance guidelines without adequate compensation in the form of dispensing fees and rebates will cause a significant and undue burden on community LTC pharmacies. This could lead to substantial gaps in health care for the elderly underserved—the most fragile population in the health care sector today.

NCPA requests that CMS strongly advise Part D plan sponsors to provide adequate dispensing fees to community LTC pharmacies in recognition of the unique, critical services provided by LTC pharmacies over and above retail dispensing. Furthermore, any changes to LTC pharmacy “access/performance rebates” under Medicare Part D must be implemented universally so all entities purchasing pharmaceuticals for LTC patients or facilities are subject to the same rules to ensure a level playing field.

Reassignment of Full-Benefit Duals in 2007

Given the experience of 2006, NCPA believes that it is important to try and limit the amount of re-assignment of full benefit duals among PDPs. The change from Medicaid to Medicare coverage in 2006 posed significant challenges for both beneficiaries and pharmacists, and the prospect of another round of large numbers of random assignments and related disruption and burden associated with additional need to change drug regimens is a concern to community pharmacy. We urge CMS to consider looking at additional approaches that might be used to minimize the numbers of beneficiaries that get automatically randomly re-assigned. It is likely that moving beneficiaries among plans for what may be very minimal differences in premium costs will be more disruptive to the patients and more burdensome to pharmacy providers, while also increasing administrative costs to PDPs and CMS.

Co-Branding Requirements (pages 21-22)

NCPA applauds the recognition by CMS that co-branding may “unintentionally convey a message that beneficiaries can only use the co-branded providers, rather than all participating providers listed in the plan’s provider or pharmacy directory.” However, we believe that the current solution, while a step in the right direction, is inadequate to the problems presented by co-branded identification cards.

As the association representing independently owned and operated community pharmacies, our members have found that many of their patients have been confused about their pharmacy choices under Medicare especially if enrolled in co-branded Part D plans. This has been a serious problem for independent pharmacies as long-term customers have transferred to co-branded chain and mass merchant pharmacies simply because the member identification card has misled them.

Member identification cards transcend normal marketing materials. Given the level of information contained in identification cards, these cards often are seen as instructional cards with vital information about the insurance plan. Including co-branded chain and mass merchant pharmacies on identification cards naturally directs and steers beneficiaries to these pharmacies—similar to how customer service numbers contained on the back of cards direct

members to the customer service hotline. A card with advertising is in clear conflict with the anti-steering provisions that were posited in CMS's marketing guidelines.

NCPA contends that member identification cards are not marketing materials in the classic sense of marketing. In fact, precedent set in other federal programs does not view identification cards as marketing material. An example is the Social Security card. The Social Security card serves as an admission vehicle into the Social Security program. There is no advertising on that card. As mentioned above, the identification card for Part D serves the same purpose. It is the admission vehicle for the program. The Part D member identification cards should not present an advertising opportunity primarily because it confuses seniors.

Because of the nature of member identification cards specified above, NCPA requests that cards be removed from consideration as "marketing" items. Consequently, co-branded pharmacy logos should be removed from member identification cards. NCPA does think that CMS should continue to review the identification cards as plan information subject to CMS review as is done with other plan information under the CMS's marketing guidelines.

Specialty Pharmacy (page 27)

NCPA supports the new guidelines established by CMS regarding pharmacy access for certain "specialty" Part D drugs. This will be a positive step forward for beneficiaries to access "specialty" pharmaceuticals at their local pharmacy.

NCPA would like to thank CMS for the opportunity to submit these comments on behalf of community pharmacists. We look forward to continuing to work with CMS to help ensure that the Medicare Part D program is successful in 2007 and beyond. For additional information or questions about these comments, please contact Stacey Swartz, Pharm.D., Director of Management & Educational Affairs, on my staff at Stacey.swartz@ncpanet.org.

Sincerely,

A handwritten signature in black ink, appearing to read 'B. Roberts', with a long horizontal flourish extending to the right.

Bruce T. Roberts, R.Ph.
Executive Vice President and CEO
National Community Pharmacists Association