March 7, 2014

Jonathan Blum, Principal Deputy Administrator and Director
Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244


Dear Mr. Blum:

Thank you for the opportunity to submit our comments on CMS’ 2015 Medicare Part C and Part D Draft Call Letter. As CMS considers finalizing the 2015 Draft Call Letter, the National Community Pharmacists Association (NCPA) appreciates the opportunity to share our perspectives.

NCPA represents the interests of America’s community pharmacists, including the owners of more than 23,000 independent community pharmacies, pharmacy franchises, and chains. Together they represent a $93 billion health-care marketplace, have more than 315,000 employees including 62,400 pharmacists, and dispense over 41% of all retail prescriptions. In addition, 34% of our members serve an LTC facility and 48% serve an Assisted Daily Living facility. In sum, approximately 40% of the long-term care market is serviced by an independent community pharmacy.

Independent community pharmacies are proud to play a vital role in the Medicare Part D program and have been on the front lines of providing medications, related counseling, and assistance with plans since the inception of the Part D program. More than any other segment of the pharmacy industry, independent community pharmacies are often located in the underserved and rural areas that are home to many Medicare recipients. In fact, independent community pharmacies represent 52% of all rural retail pharmacies and there are over 1,800 independent community pharmacies operating as the only retail pharmacy within their rural communities.

Proposed Enhancements to the 2015 Star Ratings and Beyond

NCPA was pleased to see that the Agency added the MTM completion rate for Comprehensive Medication Reviews (CMRs) as a display measure for the 2014 Star Ratings, and concurs with the proposal to maintain as a display measure in 2015, and deferring the addition of this measure until the 2016 or 2017 Star Ratings.

While it is important for plans to track success in engaging patients in MTM services, there are still areas of improvement for greater consistency among plans in terms of MTM program eligibility criteria. We applaud CMS for providing proposed revisions to such eligibility parameters in the CY2015 Proposed Rule, and
believe that the industry will need some time to adjust to any new requirements. However in the meantime, we hope that the Agency will continue to provide robust oversight of the MTM programs offered to ensure that they are being conducted in an interactive, person-to-person or telehealth manner and performed in real-time with the beneficiary, caregiver or other authorized representative.

MTM and adherence go hand-in-hand, as the provision of MTM services to targeted beneficiaries is intended to increase adherence to medications and other health or lifestyle goals. While NCPA recognizes the importance of measuring medication use, we have also shared our concerns that the current use of Proportion of Days Covered (PDC) as a proxy for beneficiary adherence to prescribed medications is a potentially faulty measurement as it is calculated using claims-based information, without accounting for whether patients are actually taking their medications.

We commend CMS for wanting to incorporate more outcomes-based measures into the Star Ratings, and for recognizing the limitations associated with the current methodology for the three Part D adherence measures. This is certainly a step in the right direction towards quality improvement, and eventually we could envision the adherence measures based on PDC considered as an access and process measure, not an outcomes measure.

Given our concerns with the PDC measure calculation, NCPA urges CMS, along with stakeholders, to take care in developing new clinical-based measures for adherence and MTM. NCPA also recommends that CMS continue to work closely with the Pharmacy Quality Alliance, as it is in the process of developing additional measures related to MTM that can further demonstrate the impact of the CMR and MTM program on improving medication use and achieving true outcomes.

Access to Preferred Cost Sharing

NCPA greatly appreciates the attentiveness of CMS regarding beneficiary access to preferred cost sharing, and for listening to the concerns of community pharmacists and their patients. For several years, NCPA has raised our on-going concern about this issue to the Agency on behalf of pharmacists and patients alike. We have heard from numerous pharmacists who expressed interest in participating in these preferred networks and their willingness to accept the stated contractual terms and conditions only to be informed that participation in these networks was “by invitation only.” NCPA is strongly supportive of the provisions included in the proposed CY2015 Part D rule that would shift away from the current “preferred pharmacy” structure and instead move to a preferred cost sharing model that would allow “any willing pharmacy” to participate. NCPA feels that this will afford more seniors access to these potential cost savings and provide them with additional choices in terms of where they would prefer to access their pharmacy services.

Studies on network adequacy should be aligned with provisions on preferred cost sharing model in the proposed Part D Rule

We applaud CMS for examining the issue of beneficiary access to preferred cost sharing, and are pleased to see that the Agency has awarded a contract to study this further. However we would urge CMS to consider network adequacy standards in conjunction to what is discussed in the proposed rule with regard to preferred cost sharing so there is more coordination and the timing is aligned for plan years. As outlined in the 2015 Call Letter, we support CMS’ intent to conduct studies on beneficiary access to preferred sharing but feel strongly that these activities or studies should not be seen as a substitute or alternative to the proposed cost sharing model as proposed in the Part D rule. The preferred cost sharing model in conjunction with the proposed inclusion of pharmacy price concessions in negotiated prices will significantly expand access and ensure that the federal government is not charged more money for these models—in sharp contrast to what is occurring today in many cases. Also, the Call letter provides that CMS is not considering network adequacy
standards at this time—but rather for the 2014 and 2015 plan years CMS will continue to examine the issue. The changes proposed in the Part D rule to address the issue of beneficiary access are ones that need to be implemented as soon as possible.

Beneficiaries cannot afford to wait another year or two for these strengthened access protections. For at least three years, we have been contacted by multiple Part D beneficiaries who did not realize that when they signed up for a “preferred pharmacy” plan that this would effectively mean that in order to realize any cost savings, they would no longer be able to utilize their local community pharmacy that was convenient to their residence. Other patients have reported having to travel significant distances (in some cases – close to 40 miles each way) in order to reach a “preferred pharmacy” in their plan.

These anecdotes were most recently confirmed when NCPA conducted a geo-access analysis for two rural towns in Oregon. For example, seniors enrolled in the Humana Preferred Rx plan, and residing in Florence, OR, have the option to choose between forty network pharmacies to fill their prescriptions, yet only two of these pharmacies are part of the preferred network. Relying on GPS coordinate data, NCPA was able to identify the precise location of each participating network pharmacy. NCPA went on to calculate the distance a senior residing by a network pharmacy would have to travel to reach a preferred pharmacy. In many cases the distance was more than thirty miles. As an example, seniors living in Florence, Oregon, with either Humana Enhanced OR Humana Preferred Rx have access to five pharmacies within one mile of their house, none of which are preferred by either plan. Those seniors must travel more than forty miles to reach the nearest preferred pharmacy. Seniors with Humana Preferred Rx residing in Rockaway Beach, Oregon, must travel more than thirty miles to reach their nearest preferred pharmacy. [Please see Attachment 1 for more detailed information]

While NCPA believes there is still significant value in assessing beneficiary access under the current “preferred pharmacy” structure, we would strongly recommend that CMS move forward with the changes outlined in the proposed Part D rule that will allow “any willing pharmacy” to offer preferred cost sharing as long as they are willing to meet the applicable terms and conditions.

**Medication Therapy Management**

NCPA appreciates the Agency’s efforts to both strengthen the MTM benefit by expanding eligibility requirements, and heighten the awareness for beneficiaries who qualify through the “Medicare & You” handbook and enhanced information presented on Medicare Plan Finder. NCPA also commends CMS for requiring plans to enroll targeted beneficiaries on an opt-out basis when they meet the eligibility criteria as a means to increase program participation. In the past, many Medicare beneficiaries became eligible for MTM services, but may not have received these important medication reviews. We are also very supportive of the proposed changes to MTM eligibility criteria in the CY2015 Part D proposed rule, which will expand beneficiary access to MTM services under Medicare Part D.

CMS notes in the Call Letter that the Agency considers MTM program services as an administrative cost included in the plan bid. We would caution that given the competitiveness of the bid process and Star Ratings, maintaining MTM as an administrative cost may not align interests and incentives for Plan Sponsors to provide high quality services, negating the intent of CMS to improve medication use through MTM.

While we are in full support of broadening the population eligible for MTM services, Plan Sponsors may see this as an added administrative cost, when their priority is to keep their bids low. If plans have to account for a greater number of beneficiaries to offer MTM services to while maintaining a competitive plan offering, we are concerned they will choose to accomplish this in the least expensive manner possible. We’ve received feedback from pharmacists that plans today already appear to employ a “check-the-box” approach
to MTM, which allows essential CMR elements to be completed at a call center by plan staff that may never have had an existing relationship or any contact with the patient. While this may seem to be a more cost-effective way to complete CMRs and enhance Star Ratings, without meaningful patient engagement, patient behavior is unlikely to change, and despite the efforts to expand access to such services, health outcomes and cost savings realized from MTM may not reach their full potential. [Please see Attachment 2 for NCPA MTM Survey]

NCPA recommends that CMS closely monitor the MTM benefit being presented by plan sponsors as part of their bid, and also report the percentage of beneficiaries in the plan that qualify for a CMR. This would provide feedback on the effectiveness of plan outreach efforts and the extent to which the medication reviews are interactive. Therefore we fully support CMS’ consideration of the development of new audit performance elements for MTM programs, and the possibility that the findings from these audits could impact Part D Star Ratings for MTM. In the future we hope CMS will consider innovative payment structure for MTM in the Part D program that aligns interests and provides meaningful quality improvement.

**Antipsychotic Drug Use Data**

NCPA is committed to working with CMS to further ways in which pharmacists can impact the use of atypical antipsychotic use. NCPA supports the National Partnership to Improve Dementia Care, an initiative launched by CMS in partnership with industry stakeholders to reduce unnecessary utilization of antipsychotics in the SNF setting. We also support efforts of the Pharmacy Quality Alliance that have focused on using the Minimum Data Set (MDS) as a data source versus only relying on PDE data. We would like to see efforts to reduce unnecessary antipsychotic utilization more aligned, especially regarding quality measurement parameters.

**Conclusion**

As you finalize plans for release of the 2015 Call Letter, NCPA respectfully urges you to consider these issues. We appreciate the opportunity to share our concerns and recommendations with you.

Sincerely,

Steve Pfister
Senior Vice President, Government Affairs

Attachment(s)
1. NCPA analysis on beneficiary access to preferred network locations
2. NCPA Survey on MTM, conducted February 2014
Attachment 1: NCPA analysis on beneficiary access to preferred network locations

Rockaway Beach, Oregon
Zip Code: 97136
Population: 1,312 (2010 consensus)

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<tr>
<th>Humana Enhanced (PDP) Summary</th>
<th>Total Pharmacies</th>
<th>Total Non-Preferred</th>
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<tr>
<td>Within 46 miles</td>
<td>39</td>
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Findings:
- A Medicare Part D beneficiary with Humana Enhanced living in Rockaway beach, Oregon has access to 6 pharmacies within 27 miles of his or her house, none of which are preferred by the plan. He or she must travel more than 30 miles (within 38 miles) to find a preferred pharmacy. He or she must travel an additional dozen miles (within 46 miles) to have a choice of pharmacy between 6 that are preferred.
- A Medicare Part D beneficiary with Humana Preferred Rx Plan living in Rockaway beach, Oregon has access to 12 pharmacies within 38 miles of his house, none of which are preferred by the plan. He or she must travel more than 40 miles (within 46 miles) to find a preferred pharmacy.
Florence, Oregon  
Zip Code: 97439  
Population: 8,466 (2010 consensus)

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<tr>
<td>Within 46 miles</td>
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Findings:
- A Medicare Part D beneficiary with either Humana Enhanced OR Humana Preferred Rx living in Florence, Oregon has access to 5 pharmacies within 1 mile of his or her house, none of which are preferred by either plan. There are 7 pharmacies located within 28 miles and 11 pharmacies within 39 miles, none of which are preferred. He or she must travel more than 40 miles (within 46 miles) to find a preferred pharmacy.
Attachment 2: NCPA Member Survey on Medication Therapy Management (MTM)

The survey was conducted in February 2014, and received a total of 539 responses. The second half of the survey focused specifically on MTM conducted in long-term care settings.

Do you have contracts to provide MTM for Part D beneficiaries?

83% (448 out of 539) of survey respondents have contracts to provide MTM for Part D beneficiaries.

Why do you choose not to provide MTM for Part D beneficiaries?

Of those who indicated they do NOT offer MTM for Part D beneficiaries, 78% (71 out of 91) say it is due to lack of opportunity from plans or another reason.

22% (20 out of 91) do not offer MTM because of lack of patient population or caseload opportunities.

How long have you been a Part D MTM provider?

57% (309 out of 538) of respondents have been a Part D MTM provider for 3 or more years.
On average how many Part D CMRs are being conducted by your pharmacy per year?

69% conduct less than 25 CMRs annually

31% conduct more than 25 CMRs per year

Have you noticed any changes in the volume of MTM cases you’ve received?

54% of respondents noticed changes in the volume of MTM cases they have received.

Do you feel plan sponsors are providing adequate outreach to beneficiaries regarding their MTM benefit?

84% do NOT feel plan sponsors are providing adequate outreach to beneficiaries regarding their MTM benefit.
Long-Term Care Specific Questions

On a scale of 1-5, how well do you feel Part D plan sponsors have communicated and/or implemented the new CMR requirements for LTC since January 1, 2013?

Of the 182 respondents who offer long-term care, 77% do NOT feel plan sponsors have communicated and/or implemented the new CMR requirements for LTC, while only 3% feel they have.

Have you seen CMRs being completed at the facilities you service?

68% have NOT seen CMRs being completed at the facilities they service, while only 32% have.

If not seeing cases, do you feel your ability to provide CMR services is being prevented by any third party offering these services (i.e. sponsor call centers)?

55% feel their ability to provide CMR services is being prevented by any third party offering these services (i.e. sponsor call centers), while 35% were not sure. 10% do not feel their ability is being prevented.
How many cases would you estimate have been completed in the LTC setting in 2013?

90% estimate that less than 25 cases have been completed in the LTC setting in 2013.

Who have you generally observed providing the CMR to residents?

52% (81 out of 156) observe a consultant pharmacist with relationship to the facility provide CMR to residents.

24% observe other third parties, and 24% observe pharmacists who are NOT the facility’s consultant, providing the CMR.

Have you observed coordination amongst MTM providers and other health professionals in the facility in relation to the results and recommendations from the CMR and the monthly drug regimen reviews (DRR)?

29% have observed coordination amongst MTM providers and other health professionals in the facility in relation to the results and recommendations from the CMR and the monthly drug regimen reviews (DRR), while 71% have not.