



# American Pharmacists Association<sup>®</sup>

Improving medication use. Advancing patient care.

October 6, 2016

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Centers for Medicare & Medicaid Services (CMS)  
Department of Health and Human Services  
Attention: CMS-9934-P  
P.O. Box 8016  
Baltimore, MD 21244-8013

**Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018 [Docket No. CMS-9934-P]**

The American Pharmacists Association (APhA) is pleased to submit these comments regarding the Centers for Medicare & Medicaid Services (CMS's) proposed rule on benefit and payment parameters for the exchange plans for 2018 (the "Proposed Rule"). Founded in 1852 as the American Pharmaceutical Association, APhA represents more than 62,000 pharmacists, pharmaceutical scientists, student pharmacists, pharmacy technicians, and others interested in improving medication use and advancing patient care. APhA members provide care in all practice settings, including community pharmacies, hospitals, long-term care facilities, physicians' offices, community health centers, managed care organizations, hospice settings, and the uniformed services.

We thank CMS for the opportunity to comment on the Proposed Rule. APhA was pleased to see CMS continue its efforts to improve patients' access to necessary medications as well as recommend the use of prescription drug utilization data to help improve the predictive ability of the public health insurance exchanges' risk-adjustment program to more accurately reflect enrollees' health care costs.

**I. Prescription Drug Hybrid Model (Pgs. 61468-61473)**

APhA supports, in concept, CMS's proposal to incorporate prescription drug utilization indicators into the HHS risk adjustment model, beginning for the 2018 benefit year, to create a "hybrid" drug-diagnosis risk adjustment model to more accurately reflect the cost of marketplace plan enrollees. However, while the Proposed Rule states that CMS "worked with clinician consultants" on the policy, it is unclear if these "consultants" included pharmacists—the medication experts on patient care teams. APhA strongly urges CMS and the marketplace plans to consult with pharmacists for any proposed medications for the prescription drug categories (RXC) and drug-diagnosis pairs (RXC-HCC<sup>1</sup>) under the hybrid model. APhA also requests that CMS provide more transparency regarding

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<sup>1</sup> CMS currently uses Hierarchical Condition Categories (HCCs) as the risk adjustment model to prospectively estimate future year's predicted costs for enrollees.

stakeholder interactions and input on its policies, in particular, who or which organizations participated. Additionally, APhA urges CMS to require marketplace plans to offer medication management programs to leverage pharmacists and their medication expertise in order to avoid medication-related problems, optimize medications, create practice efficiencies and increase patients' access to health care. Finally, APhA cautions against CMS implementing policy that affects patient care and forces clinical decisions based on coverage and costs instead of a health care professional's judgment.

## **II. Network Adequacy Standards (Pgs. 61512-61513)**

45 CFR § 156.230 establishes the minimum criteria for network adequacy that issuers must meet to have plans certified as Qualified Health Plans (QHPs). Furthermore, § 156.235 states that QHPs must "include in its provider network a sufficient number and geographic distribution of essential community providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income individuals or individuals residing in Health Professional Shortage Areas [HPSAs] within the QHP's service area, in accordance with the Exchange's network adequacy standards."<sup>2</sup> APhA, like CMS, recognizes the need to increase patient access to health care. To address access issues across the country and provide care to millions of medically-underserved individuals, APhA encourages the adoption of strategies to increase patient access to pharmacists and their services. CMS's ongoing support for, and recognition of, the value of pharmacists' patient care services, including Medicare Part D medication therapy management (MTM) and chronic and transitional care management services, highlights the benefits of providing access to these services. Thus, we strongly urge CMS, when adopting and enforcing network adequacy standards, to recognize the need for pharmacists' inclusion and to support policies to include pharmacists as essential providers. Furthermore, to help meet adequacy standards and allow for patient choice, APhA recommends CMS incorporate "any willing pharmacy" requirements that would require plans to contract with any pharmacy willing to accept the plan's terms and conditions for network participation.

With nearly 86% of Americans live within five miles of a community pharmacy,<sup>3</sup> CMS and other state and federal policymakers are aware that the inclusion of pharmacists as part of patients' health care teams can have a profound impact on access, quality, health outcomes and costs, particularly in medically underserved communities. Accordingly, APhA urges CMS to work with Congress on Medicare improvements that require legislative changes,<sup>4</sup> which should serve as a model for the exchange plans to follow, especially as the lack of health care access has become more prevalent across the country. In addition to being medication experts, pharmacists also provide a broad array of services beyond dispensing medications, including disease state and medication management, smoking cessation counseling, health and wellness screenings, preventative services, immunizations, and, in some states, women's health services. The inclusion of pharmacists on a patient's care team can have a profound impact on overall quality of care,<sup>5</sup> while increasing patient satisfaction and access to essential services, particularly in HPSAs and medically underserved areas (MUAs). In contracting with community pharmacies, plans create opportunities for patients to interact with providers in a way

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<sup>2</sup> See 45 CFR 156.235 - Essential community providers. Available at: <https://www.law.cornell.edu/cfr/text/45/156.235>

<sup>3</sup> NCPDP Pharmacy File, ArcGIS Census Tract File. NACDS Economics Department.

<sup>4</sup> See (H.R. 592/S. 314). The Pharmacy and Medically Underserved Areas Enhancement Act. Introduced January 28, 2015. Available at: <https://www.congress.gov/bill/114th-congress/house-bill/592/text?q=%7B%22search%22%3A%5B%22%5C%22hr592%5C%22%22%5D%7D&resultIndex=1> : <https://www.congress.gov/bill/114th-congress/senate-bill/314/text>

<sup>5</sup> See Avalere Health. Exploring Pharmacists' Role in a Changing Healthcare Environment. May 2014. Available at: <http://avalere.com/expertise/life-sciences/insights/exploring-pharmacists-role-in-a-changing-healthcare-environment>

that maximizes coordinated and team-based care. In addition, including pharmacists and pharmacies in networks benefits patients and plans—the geographic positioning and hours of operation of community pharmacies would contribute to improved outcomes, access, and patient satisfaction and help plans control costs and meet reasonable access and network adequacy standards.

### **III. Recommending a Separate Prescription Drug Deductible under the Standardized Silver and Gold Plans (Pg. 61492-61495)**

While CMS refrained from requiring marketplace plans to offer standardized products<sup>6</sup> in what will be their second year on Healthcare.gov, it recommended separate medical and prescription drug deductibles under its silver and gold standardized policies.<sup>7</sup> A number of state exchanges, like California and Connecticut, already have separate drug deductibles in their standardized plans. APhA appreciates CMS recognizing that for many patients, insurance coverage does not always equate to affordability, particularly when medications may comprise a large share of a beneficiary's out-of-pocket cost sharing. Research indicates that financial incentives such as low or no cost sharing on certain medications, particularly medications for chronic conditions, may increase patient adherence to medication regimens—this can translate to improved health outcomes and reduced costs to the health care system. Accordingly, APhA continues to encourage CMS to develop medication cost-sharing policies that, to the extent possible, minimize financial barriers to medications.

Thank you for the opportunity to provide feedback on the Proposed Rule and for your consideration of our comments. If you have any questions or require additional information, please contact, Michael Baxter, Director of Regulatory Affairs, at [mbaxter@aphanet.org](mailto:mbaxter@aphanet.org) or by phone at (202) 429-7538.

Sincerely,



Thomas E. Menighan, BSPHarm, MBA, ScD (Hon), FAPhA  
Executive Vice President and CEO

cc: Stacie S. Maass, RPh, JD, Senior Vice President, Pharmacy Practice and Government Affairs

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<sup>6</sup> While CMS requires the separate prescription drug deductible under its standardized options for gold and silver plans, the policy does not restrict issuers' ability to offer nonstandardized options.

<sup>7</sup> For example, the proposed standardized options for the silver standard plan has a drug deductible of \$500 with a \$200 prescription drug deductible for the silver 73% cost sharing reduction plan. In addition, the silver 87 percent cost sharing reduction plan variation, silver 94 percent cost-sharing reduction plan variation, and gold levels of coverage have a drug deductible equal to \$0, meaning no deductible applies to the drugs.