APhA
American Pharmacists Association

January 30, 2023

Jeff Wu, JD, MBA
Deputy Director for Policy
Center for Consumer Information & Insurance Oversight (CCIIO)
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services (HHS)
Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024, Proposed Rule

Dear Mr. Wu:

The American Pharmacists Association is pleased to submit our comments HHS Notice of Benefit and Payment Parameters for 2024, Proposed Rule.

APhA is the largest association of pharmacists in the United States advancing the entire pharmacy profession. APhA represents pharmacists in all practice settings, including community pharmacies, hospitals, long-term care facilities, specialty pharmacies, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and government facilities. Our members strive to improve medication use, advance patient care, and enhance public health.

CMS' proposed rule also includes requirements related to updating standardized plan options, essential community providers (ECPs) and network adequacy where we will focus our comments.

Standardized Plan Options (§ 156.201) (87 FR 78277)

CMS is proposing that issuers of standardized plan options must place all covered generic drugs in the standardized plan options' generic drug cost-sharing tier, or the specialty drug tier if there is an appropriate and nondiscriminatory basis; and place

brand name drugs in either the standardized plan options' preferred brand or non-preferred brand tiers, or specialty drug tier if there is an appropriate and non-discriminatory basis.

APhA strongly supports these proposals to encourage generic drug use. As CMS states "it is reasonable to assume that consumers expect that only generic drugs are covered at the cost-sharing amount in the generic drug cost-sharing tier." This is an important step forward to protect enrollees in exchange plans from overpaying for low-cost generic medications.

For reference and comparison, Avalere Health conducted an analysis of CMS' Part D 30-day-supply negotiated price that found when generics in Part D are placed on the preferred brand tier some patients pay the full cost for their drugs. "The analysis indicated that in cases where the generic is covered on the preferred-brand tier nearly 45% of Medicare Part D beneficiaries paid the full cost of their generic drug at least once while in the initial coverage phase. Since the generic drug cost less than the copay assigned to the preferred brand tier during the initial coverage phase, some beneficiaries in these cases paid the full price of the generic drug at the pharmacy."[1]

Plans That Do Not Use a Provider Network: Network Adequacy (§ 156.230) and Essential Community Providers (§ 156.235) (87 FR 78285-26)

CMS is proposing "to revise the network adequacy and [Essential Community Providers [ECP]] standards at §§ 156.230 and 156.235 to state that all individual market [Qualified Health Plans] QHPs and SADPs and all SHOP QHPs across all Exchanges must use a network of providers that complies with the standards described in those sections, and to remove the exception that these sections do not apply to plans that do not use a provider network."

APhA supports CMS' proposal as only a single plan since 2016 has sought a certification on an FFE for a plan that does not use a network.

[1] Avalere. Some Part D Beneficiaries May Pay Full Price for Certain Generic Drugs. July 20, 2021. Available at: https://avalere.com/insights/some-part-d-beneficiaries-may-pay-full-price-for-certain-generic-drugs#:~:text=Avalere%20identified%20generic%20products%20on%20a%20preferred-brand%20tier,chemical%20entities%20at%20the%20National%20Drug%20Code%20level.

The statutory requirement under section 1311(c)(1)(C) of the Affordable Care Act (ACA) that "a plan shall, at a minimum . . . include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals."

As CMS understands, § 156.235 states 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."[2] APhA, like CMS, recognizes the need to increase patients' 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 patients' access to pharmacists and their services. CMS' ongoing support for, and recognition of, the value of pharmacists' patient care services, including testing, treating and immunizations during the COVID-19 pandemic,[3] Medicare Part D medication therapy management (MTM), chronic care management (CCM) and transitional care management (TCM) services, affirms the benefits of using pharmacists to increase access. Thus, we strongly urge CMS, and states when adopting and enforcing network adequacy standards, to recognize the need for pharmacists' inclusion and to support policies to include pharmacists as "participating providers." Furthermore, to help meet adequacy standards and allow for patient choice, APhA recommends CMS require QHPs to contract with any pharmacy willing to accept their terms and conditions for network participation. Accordingly, APhA appreciates CMS stating in 2019 stating that "Part D plan sponsors may not exclude pharmacies with unique or innovative business or care delivery models from participating in their contracted pharmacy network on the basis of not fitting in the correct pharmacy type classification."[4]

---

[2] *See,* 45 CFR 156.235 - Essential community providers.
[3] Grabenstein JD. Essential services: Quantifying the contributions of America's pharmacists in COVID-19 clinical interventions. JAPhA. 2022;62(6):1929–1945.
[4] *See,* CMS. 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 Program. November 17, 2017. Available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-25068.pdf

With over 90% of Americans living within five miles of a community pharmacy,[5] the inclusion of pharmacists as part of patients' health care teams can have a profound impact on patients' access to health care, particularly those who are underserved. 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, and preventive services. Accordingly, APhA urges CMS to continue to implement policies, as well as work with Congress on Medicare improvements that require legislative changes, which increase patients' access to pharmacists and their services. For example, CMS should implement the best practices established by the Office of Personnel Management's (OPM) Federal Employee Health Benefits (FEHB) Program Carrier Letter (Letter Number 2022-21) requiring all QHPs to provide reimbursement for state licensed pharmacists for the necessary patient assessment and prescribing of Paxlovid for enrollees infected with COVID-19,[6] particularly in underserved areas to promote health equity.

In addition to increasing access, the inclusion of pharmacists on a patient's care team can positively impact overall quality of care,[7] while increasing patient satisfaction and health outcomes. By better utilizing the medication expertise of pharmacists, QHPs could improve health care delivery by maximizing coordinated and team-based care and better meeting reasonable access and network adequacy standards.

PBM oversight

While not mentioned in the proposed rule, APhA also recommends increasing CMS oversight of the pharmacy benefit managers (PBMs) utilized by QHPs. The PBM marketplace is highly concentrated, whereby roughly three-quarters of all equivalent prescription claims are processed by only three vertically merged companies. This has increased barriers to market entry, raised prescription drug costs, and reduced choice

[5] Berenbrok, Lucas A., et al. "Access to Community Pharmacies: A Nation-Wide Geographic Information Systems Cross-sectional Analysis." Journal of the American Pharmacists Association (July 12, 2022). Available at: https://www.japha.org/article/S1544-3191(22)00233-3/fulltext

[6] OPM. FEHB Program Carrier Letter. Letter Number 2022-21. December 8, 2022, https://www.opm.gov/healthcare-insurance/healthcare/carriers/2022/2022-21.pdf

[7] *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

for consumers and purchasers. For clarification, the top six PBMs handle more than 95% of total U.S. equivalent prescription claims (76% to the top 3 vertically merged PBMs). Ample and growing data analysis clearly shows increasing evidence that consolidation of PBMs with pharmacies and vertical integration in the healthcare space has led to increases in purchasers' and patients' drug prices through use of list prices, price discrimination, spread pricing, and patient steering for brand, generic and specialty drugs and to PBM-affiliated pharmacies. CMS possesses strong tools to require PBMs and health plans to enhance pharmacy benefits. Accordingly, APhA urges CMS to ban these harmful PBM practices in all QHP contracts.

If you have any questions or require additional information, please contact APhA at mbaxter@aphanet.org.

Sincerely,

Michael Baxter

Michael Baxter
Acting Head of Government Affairs