November 27, 2017

[Submitted electronically via www.regulations.gov ]

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-9930-P
P.O. Box 8016
Baltimore, MD 21244-8013

**Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019 [Docket No. CMS-9930-P]**

Dear Administrator Verma:

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 2019 (the "Proposed Rule"). APhA, founded in 1852 as the American Pharmaceutical Association, represents 64,000 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, physicians' offices, hospitals, long-term care facilities, community health centers, managed care organizations, hospice settings and the uniformed services.

APhA is supportive of CMS's stated goal of the Proposed Rule — to increase flexibility in the individual market, improve program integrity and reduce regulatory burdens associated with the Patient Protection and Affordable Care Act (PPACA). However, APhA is uneasy with some of policies within the Proposed Rule and the possible impact they could have on pharmacists and the patients they serve.

## I. Maintaining Appropriate Prescription Drug Coverage

APhA emphasizes the need for CMS to look more broadly at health care costs and benefits, rather than viewing benefit categories in isolation. CMS, and the health care system generally, cannot continue to consider prescription drug and medical coverage, and their related costs and outcomes, separately if we are to achieve true value in health care.

Current coverage and payment policies related to prescription drugs place incentives on the short-term, focusing on cost containment for the product rather than weighing the overall clinical benefit to the patient and the impact to their medical costs. Medications are critical to disease prevention and management and changes in patients' prescription coverage can have a more costly and long-lasting impact on their health, especially for those who are the most vulnerable. Consequently, APhA strongly recommends CMS implement policies that refer to and measure overall costs, rather than continuing policies which segment care, outcomes and cost by benefit type (e.g., emergency services, hospitalization, prescription drug, etc). Breaking down the many silos within our health care system will help address the nearly $300 billion dollars spent on medication-related problems—many of which are preventable.[1,2]

While CMS is interested in obtaining feedback regarding a national prescription drug benefit standard, it is difficult to provide comments given the limited information included in the Proposed Rule. However, APhA wants to underscore the importance of maintaining robust prescription drug coverage for beneficiaries and when considering prescription drug coverage changes, long-term consequences as patients move along the care continuum must be considered in addition to any short-term benefits that may be derived from a narrow standard.

## II. Using Increased Flexibility to Enhance Network Adequacy and Essential Community Provider Standards through Recognizing Pharmacists as Participating Practitioners

APhA supports CMS's proposal to "eliminate requirements for SBE–FPs [State-based Exchanges that use the Federal Platform for Quality Health Plan (QHP) eligibility and enrollment functions], to enforce FFE standards for network adequacy at § 155.200(f)(2)(ii) and essential community providers at § 155.200(f)(2)(iii)", and, instead allow the SBE–FPs, like other SBEs, to "have the flexibility to determine how to implement the network adequacy and essential community provider standards with which issuers offering QHPs through the SBE–FP must comply."[3] 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."[4] 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's ongoing support for, and recognition of, the value of pharmacists' patient care services, including Medicare Part D medication therapy management (MTM), the enhanced MTM model, and chronic care management (CCM) and transitional care

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[1] *See* NEHI. Thinking Outside the Pillbox: A System-wide Approach to Improving Patient Adherence for Chronic Disease. *August 2009. Available at:* http://www.nehi.net/writable/publication_files/file/pa_issue_brief_final.pdf
[2] *See* Iuga, A.O. & McGuire, M. (2014). Adherence and health care costs. February 2014. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3934668/
[3] *See*, Pg. 51082
[4] *See*, 45 CFR 156.235 - Essential community providers. Available at: https://www.law.cornell.edu/cfr/text/45/156.235

management (TCM) services, affirms the benefits of using pharmacists to increase access. Thus, we strongly urge CMS, and states under this new flexibility, when adopting and enforcing network adequacy standards, to recognize the need for pharmacists' inclusion and to support policies to include pharmacists as "participating practitioners." 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 a recently-released proposed rule 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."[5]

With 91% of Americans living within five miles of a community pharmacy,[6] 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,[7] which increase patients' access to pharmacists and their services. In addition to increasing access, the inclusion of pharmacists on a patient's care team can positively impact overall quality of care,[8] 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.

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 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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[5] *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?utm_campaign=pi%20subscription%20mailing%20list&utm_source=federalregister.gov&utm_medium=email

[6] NCPDP Pharmacy File, ArcGIS Census Tract File. NACDS Economics Department.

[7] *See*, (H.R. 592/S. 109). 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

[8] *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