Sent via Email
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Mr. Demetrios Kouzoukas
Principal Deputy Administrator for Medicare and Director
Centers for Medicare & Medicaid Services
200 Independence Ave SW
Mailstop: 301H
Washington, DC 20201

RE: Community Pharmacy Recommendations for Measuring Quality at the Pharmacy Level in the Medicare Part D Program

Dear Mr. Kouzoukas:

On behalf of community pharmacies, the National Community Pharmacists Association (NCPA) and the National Association of Chain Drug Stores (NACDS) are writing to express our concerns with direct and indirect remuneration (DIR) and pharmacy price concessions in the Medicare Part D program and the need for the development of pharmacy quality measures. In this letter we outline the impact of DIR fees on community pharmacies, the primary concerns with the way in which pharmacy quality is currently being measured in the Part D program, and we provide recommendations for measuring quality at the pharmacy level.

NCPA represents the interests of America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $81.5 billion health care marketplace, dispense nearly half of all retail prescriptions, and employ more than 250,000 individuals on a full or part-time basis.

NACDS represents traditional drug stores, supermarkets and mass merchants with pharmacies. Chains operate 40,000 pharmacies, and NACDS' more than 100 chain member companies include regional chains, with a minimum of four stores, and national companies. Chains employ more than 3 million individuals, including 152,000 pharmacists. They fill over 3 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative services that improve patient health and healthcare affordability. NACDS members also include more than 900 supplier partners and over 70 international members representing 20 countries.

Impact on Community Pharmacies: Community pharmacy providers have experienced a skyrocketing increase in the amount of post point-of-sale price concessions (often referred to as direct and indirect remuneration fees) extracted from their businesses by Part D plan sponsors and pharmacy benefit managers (PBMs) in the past few years. The increase in these retroactive fees continues to have a detrimental effect on Part D beneficiaries, the Medicare program, pharmacies, and taxpayers, and the trend is not slowing. These fees blur the line among the cost of a prescription drug, payment for pharmacy services, quality measures, and pharmacy price concessions. Many of these retroactive fees are marketed by Medicare Part

D plan sponsors as "quality based." However, these retroactive fees are based on a payment methodology consisting of a withhold of a certain amount with the opportunity for the pharmacy to either “earn back” or have the retroactive fees decreased based on achieving certain arbitrary quality measures.

Our primary concerns with the way in which pharmacy quality is currently being measured in the Part D program include the following:

- The "quality based" measures often being used were developed for use in population health measurement at a health plan level, not developed for use in pharmacies with much smaller numbers of patients.
- Plan sponsors are receiving significant bonus payments for their performance, yet bonus payments are not being passed down to providers to drive performance. Pharmacies and other healthcare providers are driving performance through their services and relationships directly with patients yet are being paid less and penalized for their efforts that contribute to a plan’s quality rating.
- The use of health plan level measures at the pharmacy level are likely not reflective of an individual pharmacy’s overall quality. There is wide variance and lack of standardization among PBMs and plans with respect to terminology, metrics, timing, and calculation methods.
- PBMs and plans regularly do not adhere to the measure specifications when using endorsed measures to determine pharmacy level quality. PBMs and plans will oftentimes alter the list of drugs used to capture a metric during the evaluation period.
- There is a lack of transparency as to how PBMs and health plans are implementing and/or altering defined measure specifications. Moreover, the frequency of changes makes it challenging for pharmacies to consistently track their performance.
- There is a lack of consistency in attribution methods or number of patients required to capture a metric. PBMs and plans often utilize a measure to determine the entire pharmacy’s quality based on as few as one patient.
- Pharmacies experience systematic arbitrary payment reductions based on ambiguous contract terms.
- No consistency exists among withhold or reconciliation time periods.
- Under the Part D program, plans have clear and consistent quality measurement rules that are not suitable for pharmacies. Community pharmacies have no such rules. In addition, as pharmacies serve patients from multiple health plans and PBMs, there is an inconsistent and untenable application of the definition of “quality” applied to pharmacies among the various payors.
- Pharmacies face disincentives to care for the sickest patients (i.e. lower quality scores equal increased retroactive pharmacy price concessions).
- Pharmacy performance “goals” are oftentimes unattainable due to unrealistic thresholds and cut points.
- Pharmacy chains and independents sometimes have no insight into their individual pharmacy’s quality standing in any given PBM network. A pharmacy may not be given access to a dashboard or data/metrics showing where it stands in relation to other pharmacies in the PBM “quality” network.

Proposed Solutions/Recommendations: As highlighted above, there are numerous industry-wide concerns regarding how pharmacies are evaluated in the Part D program. Therefore, community pharmacy offers the following recommendations for measuring quality at the pharmacy level:

- Define pharmacy quality within the Medicare Part D program. Any pharmacy quality program should be calculated separate and apart from the negotiated price to ensure such incentives do not increase costs for beneficiaries. This will ensure pharmacy quality metrics accurately reflect pharmacy quality, the impact on the Medicare program, and ultimately the impact on Medicare beneficiaries.
- Plans should be held accountable by CMS for determining performance-based payments based on standardized, achievable, and proven criteria that measure individual pharmacy performance, at a Medicare regional level, as opposed to criteria that focus on measuring plan performance or criteria which pharmacies may have little to no opportunity to influence. Such standardized, achievable, and proven criteria should relate to patient minimums, consistent use of endorsed measure specifications, consistent setting of thresholds and cut points and should be based on overall pharmacy performance for all plans and payers, and not be measured on a plan by plan basis.
- We reiterate that performance should be bonused/penalized separate from the cost of the medication; however, at a minimum, CMS should cap performance-based fees on a per script basis, limiting the amount of performance fees that can be collected related to a specific drug. This would facilitate greater transparency and predictability for pharmacies. Patients would benefit because cost variability would be minimized from drug to drug, as only a limited amount of fees could be subject to performance and outside of the negotiated price.
- Providers (e.g. pharmacists/pharmacies, physicians, and other prescribers) should be rewarded for efforts to drive performance and not solely penalized, especially when plan sponsors are receiving bonus payments.

NCPA and NACDS thank you for accepting these comments and concerns and we look forward to working with CMS to find a solution to the issues stated above based on the provided recommendations.

Sincerely,

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Vice President
Pharmacy Affairs
NCPA

Christie R. Boutte, PharmD
Senior Director
Federal and State Public Policy
NACDS

cc: Cheri Rice, Acting Deputy Director
Amy Larrick, Director, Medicare Drug Benefit and C and D Data Group
Jennifer Harlow, Acting Director, Medicare Plan Payment Group