

November 29, 2019

The Honorable Richard E. Neal
Chairman, House Ways & Means Committee
United States House of Representatives
1102 Longworth Hob
Washington, DC 20515

The Honorable Kevin Brady
Ranking Member, House Ways & Means Committee
United States House of Representatives
1102 Longworth Hob
Washington, DC 20515

RE: RURAL AND UNDERSERVED COMMUNITIES HEALTH TASK FORCE REQUEST FOR INFORMATION

Dear Chairman Neal and Ranking Member Brady,

On behalf of McKesson Corporation (“McKesson”), I am pleased to submit comments on Rural and Underserved Communities Health Task Force Request for Information. We appreciate the House Ways and Means Committee’s commitment to advancing commonsense legislation to improve healthcare outcomes within rural and underserved communities.

About McKesson

McKesson is a mission driven company, focused on working with our customers and partners to create a sustainable future for healthcare. Together, we are charting a course to better health. For over 180 years, McKesson has led the industry in the delivery of medicines and healthcare products. We deliver vital medicines, medical supplies, care management services and health information technology (IT) solutions that touch the lives of over 100 million patients in healthcare settings that include more than 50,000 retail pharmacies, 5,000 hospitals, 200,000 physician offices, nearly 12,000 long-term care facilities and 2,400 home care agencies.

McKesson is also a leader in pharmacy solutions. Our Health Mart franchise is the fourth largest pharmacy network in the U.S. with more than 5,000 independent pharmacies. Our RelayHealth Pharmacy Solutions manage the nation’s most reliable pharmacy connectivity network, executing more than 18 billion pharmacy transactions annually and connecting more than 50,000 retail pharmacies with key healthcare stakeholders. In addition, CoverMyMeds is a leader in electronic prior authorization (PA) solutions that automate the PA process for more than 500 electronic health records systems, 49,000 pharmacies, 700,000 providers and most health plans and pharmacy benefit managers (PBMs). Our RxBenefit Clarity solution provides patient-centric data that empowers providers and their patients with prescription price transparency data that goes above and beyond the patient’s benefit, and leverages cash options as well as patient

assistance programs. McKesson also develops and administers custom patient assistance programs to help patients overcome barriers to medication adherence.

Our unique role in the supply chain of the healthcare system provides us a distinctive vantage point. We monitor and engage in regulatory activities that present both opportunities and challenges for our company, our customers and the patients they serve. Our company strives to ensure that our views on better healthcare prioritize what is best for the patient. Our public policy platform is driven by the core belief that the *Patient Comes First*.

We are pleased to offer the following comments and recommendations:

1. What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional, systems or factors outside of the health care industry that influence health outcomes within these communities?

All patients deserve access to affordable medicine and healthcare services as these services are essential for positive health outcomes and quality of life. In the United States, rural and underserved communities face the same (or greater) growing cost pressures as other communities as these burdens are contributing to increasing financial toxicity and barriers to high quality care. Additionally, patients in rural and underserved communities often face additional access barriers due to workforce shortages, a lack of diverse healthcare ecosystem, transportation scarcity, and language barriers. While all communities are unique, at a minimum, all patients must be able to conveniently and confidently access services such as primary care, pharmacy services, dental care, behavioral health, emergency care, and public health services. To address the significant growing cost pressures and access barriers faced by patients in rural and underserved communities, solutions should target the foundational healthcare infrastructure and include:

- Patients need increased access to high quality healthcare providers- Primary Care Providers (PCP) & Specialists
- Patients deserve access to a diverse healthcare ecosystem and lower cost sites of care
- Patients need increased access to new technologies including telemedicine and tele pharmacy
- Improved funding for providers to be able to provide high quality, face to face health services
- Patients deserve to be served by healthcare providers that are able to understand as well as respond to the unique community and population dynamics to provide tailored solutions to unique problems as trusted providers

Barriers to healthcare result in unmet healthcare needs, including a lack of preventive and screening services and treatment of illness. A vital community is dependent on health of its population and it's essential to promote positive health outcomes across all communities in the United States.¹ This committee should consider opportunities to leverage both existing resources and new technologies to address barriers to care in rural and underserved communities across our nation.

¹ A. Clinton MacKinney, MD, MS. 2014. Access to Rural Health Care- A Literature Review and New Synthesis. *Rural Policy Research Institute*. http://www.rupri.org/Forms/HealthPanel_Access_August2014.pdf

2. What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?

Independent community pharmacies have great potential to deliver services aimed at promoting health and preventing disease in rural and Medically Underserved Areas across the US given their unique relationship driven approach to providing pharmacy services. Given McKesson's unique relationship with community independent pharmacies that fall under the Health Mart franchise, we can offer unique insight into the current pharmacy landscape in rural and underserved communities. Some 500 of our Health Mart pharmacies operate in Medically Underserved Areas (MUA) across the United States and even more serve rural communities in the United States. As an organization we are committed to supporting the viability of independent pharmacies given their critical role in driving positive outcomes for patients.

Independent pharmacies are more likely to be the sole source of pharmaceutical services in rural and other areas facing poor access to care. They are essential to the health of these communities given they offer a unique added value to patients as they provide more personalized, dedicated care and offer enhanced services to promote positive outcomes. Pharmacists are exceptionally positioned in rural and underserved communities to provide positive interventions on health outcomes in areas such as disease prevention, inoculation services, chronic condition management services, and medication management.² Medication nonadherence alone is estimated to cost the health care system some \$300B annually.³ Additionally, many community pharmacists offer invaluable services such as drug delivery, nutrition counseling, and point of care testing.

Despite the many benefits detailed above, independent community pharmacies' business model is under serious threat as more than 16% of independently owned rural pharmacies have closed their doors between March 2003 and March 2018. Strikingly, there are some 630+ rural communities that had at least one in 2003 that now have no retail pharmacy in 2019. While the dramatic increase in closure of rural sole independent pharmacies has slowed in recent years, the financial viability of such pharmacies as the sole provider in many rural communities remains a major concern given their limited negotiating power and greater reliance on drug sales as a primary source of income.⁴ Given the range of services that community pharmacies provide, the shuttering of pharmacies in rural and Medically Underserved Areas can have grave implications for the population's access to health services. With all that is at stake in maintaining local access to pharmacy services, it's critical that this committee work to develop policies that will strengthen this essential element of local health services.

3. What should the Committee consider with respect to patient volume adequacy in rural

² K Thompson, F Hillier-Brown, N Walton, M Bilaj, C Bamba, Adam Todd. 2019. The Effects of Community Pharmacy- Delivered Public Health and Health Inequalities. *Preventive Medicine*.

³ J Lagasse. 2018. Patients who skip medications cost healthcare \$300 billion annually <https://www.healthcarefinancenews.com/news/patients-who-skip-medications-cost-healthcare-300-billion-annually>

⁴ <https://rupri.public-health.uiowa.edu/publications/policybriefs/2018/2018%20Pharmacy%20Closures.pdf>

areas?

Rural providers have always faced a unique set of challenges including a challenging payer and patient mix, low population density, and geographic isolation. New solutions should be considered to provide greater access to high quality services in areas that face declining number of providers. Many providers struggle to cover high fixed operational costs in rural areas which has resulted in consolidation, practice closure, and a shortage of specialists in low population density areas.⁵ This has reduced the set healthcare of services available in these areas and forced many practices and hospitals to go out of business altogether. It is now critically important to consider policies that leverage and strengthen existing health care assets, such as the community pharmacist, to address treatment gaps in our healthcare system. For one, it's essential to provide adequate economic incentives to preserve the viability of the local healthcare ecosystem and enable the delivery of the full range of services needed in a community. Second, plans and payers like Medicare and Medicaid should leverage pharmacists to address workforce shortages as they do much more than count pills. In such rural areas, we recommend that this committee advocate for an exception process that enables patients to receive access to opioid treatment programs through willing community pharmacists as permitted under state statutes and regulations.

4. What lessons can we glean from service line reduction or elimination in hospitals that serve underserved communities where —a. patients have the option to transition to alternative care sites, including community health centers and federally qualified health centers? b. there is broader investment in primary care or public health? c. the cause is related to a lack of flexibility in health care delivery or payment?

The lack of flexibility in healthcare delivery and payment is a significant driving force behind the many pharmacy closures facing rural and underserved communities across the United States. In the Medicare Part D space, DIR fee relief is essential to promote the financial health and viability of community pharmacies around the nation. The current retroactive assessment of DIR in the Part D program is arbitrary, unpredictable, and leads to a pharmacy's inability to manage business operations. We support legislation that ends retroactive fees levied on pharmacies after the point of sale and suggest that any fees levied on pharmacies are tied to a standardized, independent set of quality measure established by HHS. To address retroactive pharmacy DIR fees and unstandardized quality/performance measures, McKesson supports The Phair Pricing Act, introduced by Sen. John Kennedy (R-La.) as S. 640 in the Senate and by Reps. Doug Collins (R-Ga.) and Vicente Gonzales (D-Texas) as H.R. 1034 in the House.

5. If states or health systems have formed regional networks of care, leveraging for example systems of transport or the use of telehealth/telemedicine, what states or entities are these, what approaches did they use to form these networks, what challenges did they overcome, and what challenges persist?

⁵ American Hospital Association. 2019. *Rural Report: Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-Quality, Affordable Care*. <https://www.aha.org/system/files/2019-02/rural-report-2019.pdf>

N/A

6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

N/A

7. Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?

There is ample evidence to suggest that Americans in rural and other underserved communities face increased obstacles in receiving care that addresses their oral, behavioral, and substance use needs. Lack of access to quality care is one contributing factor that explains why rural communities have been hit particularly hard by the opioid crisis. Given the lack of accessible facilities, patients should be able to choose to receive these treatments from their pharmacist. McKesson believes that pharmacists can play an effective role in treating Substance Use Disorder (SUD).

There are several promising examples of state programs that are leveraging pharmacists to address this critical need in fighting the opioid epidemic. Currently, pharmacy-based SBIRT services are being rolled out in Pennsylvania, Virginia, Massachusetts, Rhode Island, and Ohio. In Virginia, pharmacist-provided SBIRT services are reimbursed by Medicaid. While the expansion of pharmacist-provided SBIRT under Medicaid in Virginia is a positive step, further expansion in other states would improve access to SUD care. We have been urging other states to implement these types of programs in their Medicaid programs so that Medicaid beneficiaries can access this important pharmacist-provided service across the country. In Rhode Island, a MAT program is funded by a \$1.6 million NIDA grant. Under this initiative, the Rhode Island Hospital is conducting a pilot program involving six pharmacies working with 125 patients to manage their MAT. In the pilot, patients receive their initial MAT prescription from a physician.⁶ In order to successfully address the substance abuse crisis facing our country and seniors, McKesson believes that Medicare should explore a bundled payment that provides maximum flexibility in provider/supplier enrollment while ensuring compliance with an evidence-based treatment program or protocol. McKesson believes that limiting participation to recognized Part B providers or those meeting Substance Abuse and Mental Health Services Administration (SAMHSA) accreditation alone could hinder patient access, particularly in areas where these providers are in short supply.

8. The availability of post-acute care and long-term services and supports is limited across the nation but can be particularly challenging in rural and underserved areas facing disproportionately large burdens of chronic and disabling conditions. What approaches have communities taken to address these gaps in care delivery and the associated challenges of social isolation?

⁶ Felive J. Freyer. 2019. *In Rhode Island. Some get addiction care at the pharmacy.* <https://www.bostonglobe.com/metro/2019/03/12/getting-addiction-care-pharmacy/m1mcceVILRXX1W9X3WdeOP/story.html>

N/A

9. There are known, longstanding issues with the availability and integrity of data related to rural and urban community health. What data definitions or data elements are needed to help researchers better identify the causes of health disparities in rural and underserved areas, but are unavailable or lack uniformity?

N/A

10. Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

In addition to the policies and programs mentioned above, McKesson believes that the federal government should also address three important policy issues that will strengthen independent community pharmacies and thus access to care in rural and underserved areas across the United States:

Improved Pharmacy Reimbursement- Direct and Indirect Remuneration (DIR) fees have evolved in such a way that action is needed to limit practices that are burdensome to beneficiaries and may lead to reduced beneficiary access to pharmacy services. While DIR fees can adversely impact all retail pharmacies, they disproportionately affect independent community pharmacies which are often located in underserved or urban rural areas. It's imperative that pharmacies have access to an estimated DIR at point of sale and that quality metrics used to evaluate pharmacy performance are established at the national level by an unbiased, independent third party. Additionally, this committee should explore additional avenues for improved pharmacy reimbursement for clinical services that will provide additional revenue streams for independent pharmacies.

Network Adequacy Standards- McKesson believes there should be uniform pharmacy access standards and require Medicaid managed care plans to follow federal standards, such as those required for Medicaid fee-for-service, Medicare Advantage (MA) and Medicare Part D. We are concerned that the Trump Administration's recent move away from the time and distance standard requirement in their revision of network adequacy standards will further disadvantage beneficiaries from rural and underserved areas who are less mobile due to their age, management of health conditions, reliance on public transportation, or any combination of these and other factors.

Maximum Allowable Cost Adjustment- MAC prices are the upper limits that a pharmacy manager or prescription drug benefit plan will pay a pharmacy for generic drugs and brand name drugs that have generic versions available. In recent years, MAC reimbursement amounts have not been updated quickly enough to reflect changes in wholesale drug costs. For many rural pharmacies to remain financially viable, it is critical that MAC reimbursement rates are updated to keep pace with inflation.

Conclusion

McKesson appreciates the opportunity to comment on this request for information. We look forward to continuing our partnership with Congress to promote a robust, patient-centered healthcare ecosystem that works for patients. If you have questions or need further information, please contact Fauzea Hussain, Vice President of Public Policy, at Fauzea.Hussain@McKesson.com.

Sincerely,

A handwritten signature in black ink, appearing to read "Pete Slone", written in a cursive style.

Pete Slone