Submitted electronically to Rural_Urban@mail.house.gov

November 29, 2019

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

The Honorable Kevin Brady
Ranking Member, Ways & Means Committee
United States House of Representatives
1139 Longworth House Office Building
Washington, DC 20515

Re: House Committee on Ways and Means, Rural and Underserved Communities Health Task Force Request for Information

Dear Chairman Neal, Ranking Member Brady, and members of the Rural and Underserved Communities Health Task Force:

The National Community Pharmacists Association ("NCPA") appreciates the opportunity to provide comments on the *Rural and Underserved Communities Health Task Force* (the "Task Force") Request for Information on the delivery and financing of healthcare and related social determinants in urban and rural underserved areas. NCPA represents American's community pharmacists, including roughly 22,000 independent community pharmacies. Almost half of all community pharmacies provide long-term care services and play a critical role in ensuring patients have immediate access to medications in both community and long-term care settings. Together, our members represent a $75.8 billion healthcare marketplace, employ 250,000 individuals, and provide pharmacy services to millions of patients every day. Our members are small business owners who are among America's most accessible healthcare providers.

NCPA offers the following responses to the Task Force's questions.

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?

Access to pharmacies is a main factor related to patient outcomes in underserved areas. Community pharmacies tend to be in rural and urban underserved areas. Due to reimbursement pressures, however, pharmacies are closing at an alarming rate.[1] These closures mean patients will

[1] From 2009 to 2018, 1,350 community pharmacies have closed. *Compare* NCPA 2019 Digest by Cardinal Health, *available at* https://www.ncpanet.org/newsroom/news-releases/2019/10/29/ncpa-releases-2019-digest *with* NCPA 2010 Digest by Cardinal Health, *available at* https://www.ncpanet.org/pdf/digest/2010/2010digestexecsum.pdf.

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have to travel farther and longer to obtain their needed medications and may lead to patients not picking up their medications at all. A recent study published by the Journal of the American Medical Association found that pharmacy closures are associated with patient adherence to cardiovascular medications among US adults 50 years or older. The study found that patients in communities where pharmacies had closed experienced "an immediate statistically and clinically significant decline in adherence during the first 3 months after closure."[2] More so, "this difference persisted over 12 months and was greater among older adults living in neighborhoods with fewer pharmacies."[3]

Even if a pharmacy is in an underserved area, patients may not have access to those pharmacies because their local community pharmacy is not allowed to participate in a health plan's network. Thus, NCPA supports H.R. 4946, *The Ensuring Seniors Access to Local Pharmacies Act*, introduced by Reps. Peter Welch (D-Vt.) and Morgan Griffith (R-Va.) as a way to allow pharmacies that are in medically underserved areas, medically underserved populations, health professional shortage areas, or Federal Office of Rural Health Policy's designated rural areas to participate in Medicare Part D preferred pharmacy networks so long as they are willing to accept the contract terms and conditions.

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?

NCPA supports the usage of various value-based arrangements that incorporate community pharmacies located in rural and urban underserved areas into care teams. For example, many NCPA members are a part of the Community Pharmacy Enhanced Services Network ("CPESN"), a clinically integrated network of community pharmacies that coordinates patient care with physicians, care managers, and other patient care teams to provide medication optimization activities and enhanced services for high-risk patients. CPESN now has 43 networks in 40 states across the United States.[4] CPESN pharmacy providers see their complex patients 35 times a year, while physicians only see their patients 3.5 times a year. NCPA member pharmacies in this network work directly with payers to add enhanced services into contracts and lower drug costs.[5] NCPA supports CPESN as a model for value-based payment programs and arrangements for both commercial and federal insurance programs.

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[2] Dima M. Qato, PharmD, MPH, PHD, et al., *Association Between Pharmacy Closure and Adherence to Cardiovascular Medications Among Older Adults* (Apr. 19, 2019), a*vailable at* https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2730785.
[3] *Id.*
[4] CPESN, *available at* https://www.cpesn.com/.
[5] *Id.*

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

Unlike their chain counterparts, independent community pharmacies exist in rural and urban areas where patient volume may not always be concentrated. Thus, it is more important that these rural and urban patients have access to their local community pharmacy than for community pharmacies to have access to a high concentration of patients. One such way to ensure access is to require preferred networks include local community pharmacies so long as the pharmacy is willing to accept the terms and conditions of that preferred network. For Medicare patients, NCPA supports the previously mentioned H.R. 4946, *The Ensuring Seniors Access to Local Pharmacies Act,* to ensure vulnerable senior populations have access to their local community pharmacy.

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?

NCPA argues the lack of flexibility in healthcare delivery and payment is a major contributor to the reduction of providers that serve underserved communities. In the drug benefit space, reimbursement to pharmacies continues to blur the line between the cost of a drug, payment for pharmacy services and quality/performance, and pharmacy price concessions (in Medicare Part D referred to as "pharmacy DIR fees"). NCPA has long advocated that reimbursement for the cost of a drug and pharmacy price concessions should be decoupled from the payment for pharmacy services and quality/performance in any reimbursement arrangement.

In Medicare Part D, NCPA continues to advocate that pharmacy DIR fee relief means that Part D plan sponsors and their pharmacy benefit managers ("PBMs") must assess all pharmacy DIR fees at the point of sale, instead of retroactively clawing back monies from pharmacies. Then current retroactive assessment of pharmacy DIR in the Part D program is arbitrary, unpredictable, and leads to a pharmacy's inability to manage business operations.[6] NCPA also argues that any reimbursements for services and quality/performance be based on standardized measures recognized by industry stakeholders. To address retroactive pharmacy DIR fees and unstandardized quality/performance measures, NCPA 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. Without these changes, reimbursements to pharmacies will

[6] In fact, a recent NCPA member survey conducted in October shows that 58% of independent pharmacies are somewhat or very likely to close their doors in the next two years without relief from pharmacy DIR fees. NCPA Survey: Health of Independent Pharmacy (Oct. 2019), *available at* http://www.ncpa.co/pdf/survey-health-cp.pdf.

continue to diminish, making it impossible to provide medication and services to patients in underserved communities.

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?

As previously noted above, health plans continue to recognize that pharmacists can lower the overall spend for both the patient and plan. One such way to do this is for payers to engage with CPESN, a network of clinically integrated pharmacies that contract directly with payers to add enhanced services into contracts and lower drug costs of care. CPESN now has 43 networks in 40 states across the United States.[7] NCPA supports the CPESN model as a blueprint to incorporate community pharmacies into various payer models. Most notably, NCPA has recently encouraged policymakers to consider integrating established networks of community pharmacies into Medicare ACOs to maintain access to critical community pharmacies in rural and underserved areas.

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?

Community pharmacies play an important role in substance use needs. It is for this reason, NCPA continues to advocate for the advancement of the pharmacist's role in Medication Assistance Treatment ("MAT") to improve patient access and outcomes to such treatment while reducing the risk of relapse. NCPA supports MAT to be covered by commercial and federal insurance programs.

Pharmacists are already partnering with physicians to provide MAT. For example, 48 states and the District of Columbia allow pharmacists to enter into collaborative practice agreements with physicians and other prescribers to provide MAT. When such relationships form, pharmacists have taken the lead in developing treatment plans, communicating with patients, improving adherence, monitoring patients, and identifying treatment options.

[7] CPESN, *available at* https://www.cpesn.com/.

Pharmacies providing MAT are aiding city governments by partnering with local rehabilitation centers, physicians, and drug courts. For example, Alps Specialty Pharmacy in Missouri provides several services for patients receiving MAT including: 1) streamlining access to Vivitrol through insurance and financial support resources; 2) adherence support (timely refill/appointment reminders to ensure the injection is given on time); and 3) monthly Clinical Pharmacist Assessments to evaluate efficacy, safety, and adherence. Although this program has shown to be successful for patients in Missouri, some insurance companies mandate that Vivitrol be filled under a "medical benefit," which limits pharmacists to assisting with billing/filling and forces prescriber offices to "buy and bill." Further, some insurance companies mandate that Vivitrol be filled through a specific mail-order pharmacy which prevents pharmacies from assisting with patient management.

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?

With an increasing elderly population requiring assistance with activities of daily living, finding the appropriate care for this population is essential. Many community and long-term care pharmacies service patients in their home that might otherwise be in a nursing home due to their need for extra clinical services. Some of these services include medication management services, such as specialized packaging, medication reconciliation, hand-delivery, and consulting services, as well as review of any unnecessary drugs, duplication of therapies, or adverse reactions.

Currently, there are multiple states that offer a waiver program in the 1915C Medicaid program to allow healthcare professionals, such as long-term care and community pharmacists, to provide nursing home services in a patients home, including occupational and physical therapy, and help with activities of daily life ("ADLs") (toileting, transferring, eating, bathing, and dressing). These medical at home services, among others, can decrease errors and increase patient compliance.

For Medicare patients, long-term care pharmacists work with homebound patients and their core interdisciplinary team to help to limit hospital readmissions, contain health care costs, and respond to the shifting paradigm of value over volume services. However, until policymakers recognize medical at home pharmacy services, PBMs will not change their payment structures for these services for Medicare Part D patients, Therefore, NCPA continues to urge CMS to formally recognize and promote medical at home pharmacy services to help improve value-based patient care, increase savings to the health care system, and ensure pharmacy providers are fairly and properly reimbursed for their services.

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?

NCPA supports the sharing of clinical and pharmacy dispensing data that may be necessary to support improved medication use for all patients and would highlight the Pharmacy Health Information Technology Collaborative's work to advance the Pharmacist eCare Plan to accomplish sharing of data amongst providers, especially in federal programs.[8] In recent years, there has been momentum in the community pharmacy sector away from proprietary documentation platforms to standards-based documentation using the Pharmacist eCare Plan. This effort uses existing standards adopted by medical providers in electronic medical records ("HL7") to develop an electronic Pharmacist eCare Plan, which is a shared document detailing a patient's current medication regimen and health concerns, including drug therapy problems and medication support needs, in addition to the pharmacy's interventions and the patient's health outcomes over time. Other data components include patient demographics, payer information, health concern information (allergies and medication therapy problems), medication history, interventions, care coordination, referral information, patient centric medication related goals, and outcomes. Right now, pharmacy partners are participating in the Pharmacist eCare Plan initiative in CPESN clinically integrated networks. CMS should consider the Pharmacist eCare Plan as a standard way of sharing pharmacist-provided clinical data that will give pharmacists a way to validate their services for these new emerging quality-based payment models and move to new payment models in parallel with the same movement for physician groups.

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?

As previously mentioned, reimbursement to pharmacies continues to blur the line between the cost of a drug, payment for pharmacy services and quality/performance, and pharmacy price concessions. The blurring of the line results in pharmacies not being paid for services that contribute to positive patient outcomes, especially those provided to underserved communities. NCPA argues that reimbursement for the cost of a drug and pharmacy price concessions should be decoupled from the payment for pharmacy services and quality/performance in any reimbursement arrangement. More so, NCPA argues that pharmacies should be incentivized to achieve certain performance metrics via positive payments, not by penalizing high performers via reduced pharmacy DIR fees or other retroactive claw backs.

[8] CPESN, *Empowering Community Pharmacies to Improve Care Coordination and Health Outcomes with Use of Electronic Care Plans*, *available at* https://cpesn.com/ecare-plan/.

Additionally, NCPA continues to argue that any reimbursements for services and quality/performance be based on standardized measures recognized by industry stakeholders. Specifically, NCPA supports the alignment of quality measurements and reporting requirements under value-based payment programs (Medicare Shared Savings Program, etc.) with quality measurements and reporting requirements in other Medicare programs as a way to improve the value of care provided in such programs and arrangements. Doing so would minimize the need for providers to devote excessive resources to understand and achieve the different measures.

Finally, to ensure transparency of payment for rural and urban pharmacies, NCPA supports H.R. 1035, *The Prescription Drug Price Transparency Act*, introduced by Reps. Doug Collins (R-Ga.) and David Loebsack (D-Iowa), which seeks to bring clarity to generic drug payments in Medicare Part D and the Federal Employee Health Benefits program.[9]

Conclusion

NCPA appreciates the opportunity to respond to the Task Force's questions on the delivery and financing of healthcare and related social determinants in urban and rural underserved areas. We look forward to additional collaborative efforts to identify strategies to address the challenges that contribute to health inequities.

Sincerely,

Karry K. La Violette
Senior Vice President of Government Affairs & Director of the Advocacy Center
National Community Pharmacists Association

[9] By way of background, PBMs in these programs can currently overcharge federal health programs while paying much lower reimbursement rates to community pharmacies via hidden and varying maximum allowable cost ("MAC") lists. What's more, these lists often include MAC reimbursement rates that are at times below-cost or fail to keep up with inflation. H.R. 1035 would enhance program integrity and establish MAC as a drug pricing standard, which would give community pharmacies insight into the basis for MAC reimbursement rates, certainty that they are updated to reflect real-world prices (at least every seven days), and an effective appeals process to contest below-cost payments.