NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

February 16, 2015

Submitted Electronically

Federal Trade Commission
Office of the Secretary
Room H-113 (Annex X)
600 Pennsylvania Avenue, N.W.
Washington, DC 20580

Re: Health Care Workshop Project No. P13-1207

The National Association of Chain Drug Stores (NACDS) appreciates the opportunity to provide overview comments to the Federal Trade Commission (FTC) and the Department of Justice (DOJ) in preparation of the second workshop in the series, "Examining Health Care Competition" to be held on February 24 - 25, 2015. NACDS intends to offer more in-depth comments in response to the workshop discussions and Federal Register Notice.

We refer the FTC and DOJ to our extensive comments offered on March 10, 2014 and April 30, 2014. In those comments, we urged the FTC to: (1) promote competition among and within innovative, quality care delivery models, which includes designating community pharmacy as providers under the Social Security Act; (2) advance efforts to secure better coordination across the medical neighborhood; and (3) encourage the implementation and public dissemination of standardized quality and patient health metrics within federal programs (ACOs, Exchanges and State Medicaid Programs) among other things. NACDS further supports efforts by FTC to create a robust health care marketplace by supporting the removal of needless and excessive state scope of practice policies that hamper innovative care delivery and chill competition and patient choice.

As FTC and DOJ seek to better understand the competitive dynamics and effects of evolving health care provider and payment models, we offer the following high-level comments on the following four topics.

1. **Accountable Care Organizations (ACOs).** The Affordable Care Act (ACA) was enacted to promote greater value in the health care system by employing a number of Medicare payment and delivery reform measures, including the establishment of the Medicare Shared Savings Program (MSSP), Advance Payment ACO Program, and the Pioneer ACO Program among others. Over 400 organizations participate in Medicare ACO programs. As anticipated, federal ACOs seem to be influencing the private sector's ACOs efforts in terms of structure, governance, programmatic actions and delivery of care.

ACOs face a myriad of significant challenges, which includes medication management.[1] According to the National Committee for Quality Assurance (NCQA), improving medication management could be a critical element of team-based care models.[2] NCQA noted that it is

[1] ACO Learning Network. 2014. Brookings –Dartmouth ACO Learning Network Webinar.
[2] Ibid.

important for data and information to be shared between pharmacies and emerging care models since pharmacies are expanding community care services (e.g., delivering accessible and affordable point of care, working on transitions of care teams to prevent hospital readmissions, and providing immunizations, health and wellness screenings, chronic medication counseling and other medication management services).[3] Innovative medication management ACO interventions may dramatically improve patient health outcomes, prevent disease state complications, and avoid preventable hospitalization and readmissions. However, few ACOs have incorporated medication management delivery approaches into their organizations even though medications are involved in 80 percent of all patient treatments.[4]

Yet, importantly, approximately 75 percent of medication problems in primary care settings can be attributed to clinician-influenced gaps in care, such as inappropriate or ineffective prescribing, lack of care coordination, or poor monitoring.[5] Pharmacists are extensively trained to conduct comprehensive medication reviews, resolve medication issues, design adherence programs for patients, and recommend cost-effective treatments.[6] However, pharmacists are "not" deemed to have "provider" status under the Social Security Act (SSA) and, thus, they are generally precluded from being compensated for clinical services rendered to Medicare Part B beneficiaries. However, "provider" status has been conferred under the SSA to an extensive list of health care professionals, including clinical social workers, dentists, physical therapists, registered dieticians and among many others.

NACDS submits that this arbitrary "provider" status omission results in federal ACOs facing a needless, policy barrier in striving to achieve the ACA's triple aim. In other words, federal ACOs that are striving to move beyond the current emerging care model to provide better care and reduce costs are precluded from incorporating pharmacists as health care "providers" into their ACO team. For those rare ACOs with an integrated medication management approach, competition is lacking among health care professionals (physicians, nurse practitioners, social workers et al) and between care settings because pharmacists are arbitrarily omitted as providers. Likewise, because commercial ACOs are influenced by federal ACOs and other federal innovative care programs, this unwarranted provider exclusion spills over to the private sector, hindering access to affordable patient care and impacting consumer choice.

Pharmacists are playing an increasingly important role in the delivery of healthcare services. NACDS submits that the arbitrary omission of pharmacists as providers within the Medicare ACOs serves to limit healthcare competition and patient choice to access quality, affordable care. We further submit that the care services provided by ACOs are needlessly restricted by state scope of practice policies, which also stifles cost-effective, innovative care delivery and chills competition and patient choice. [7]

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[3] National Committee on Quality Assurance. 2014. "The Future of Patient Centered Medical Homes: Foundation for a better health care system." Accessed July 9, 2014. https://www.ncqa.org/Portals/0/Public%20Policy/2014%20Comment%20Letters/The_Future_of_PCMH.pdf

[4] http://content.healthaffiars.org/content/32/11/1936full.

[5] Smith, M., Bates, D. & Bodenheimer, T. 2013. "Pharmacists Belong in Accountable Care Organizations and Integrated Care Teams." *Health Affairs,* 32, 1963-1970.

[6] Smith, M., Bates, D. Bodenheimer, T. et al. 2010. "Why Pharmacists Belong in the Medical Home." *Health Affairs,* 29, 906-913.

[7] NACDS Comments Submitted to the FTC, dated April 30, 2014.

2. **Alternatives to Traditional Fee-for- Service Payment Models**. Improved care coordination and chronic care management are the cornerstones of the Value-Based Payment (VBP) models and, as discussed above, medication management is central to both of these objectives. Any effort to improve quality and reduce costs in the long-term will be difficult to achieve if patients don't take their medications appropriately and/or their adherence is poor. Considering the growing evidence that pharmacists are uniquely positioned to improve medication management across the care continuum, and provide a range of health services in the community and as part of care teams, community pharmacies should play a greater role in the VBP movement.

While VBP models have primarily focused on physicians and hospitals, they are now expanding to include more providers. For example, a few large pharmacy benefits managers (PBMs) are now applying performance metrics to pharmacies in the context of Medicare Star Ratings Program. The VBP goal is to align performance and health outcomes with compensation by assess performance using quality and health metrics, and to provide tools and programs to improve patient health outcomes.

Evidence on public and commercial Pay for Performance (P4P) programs with respect to pharmacy are quite limited, but general P4P information suggests that these types of programs have the potential to improve quality and lead to more cost-effective care. To buttress this point, the ACA established the Medicare Hospital Readmissions Reductions Program (HRRP), which penalizes hospitals up to three percent of annual Medicare payments with higher than expected rates of hospitalizations. Hospitals are already experiencing penalties from the program, with CMS reporting saving $227 million in 2013 by reducing Medicare payments to 2,225 hospitals.[8] One of the best practices cited to reduce readmissions is medication reconciliation at each transition from an acute to post-acute or outpatient setting.[9] For instance, medication reconciliation is a key component of a discharge program started at Boston University. The program has shown a 30 percent decrease in readmissions and ER visits within 30 days and a 34 percent lower observed cost for program participants.[10] The contribution of community pharmacies in helping hospitals avoid costly readmission penalties is extremely promising. Accordingly, VBP reform has the potential to improve outcomes, increase better care coordination and more system efficiencies.

State scope of practice restrictions can, however, impede the ability of health care professionals to meaningfully contribute to VBP models. For example, if multi-jurisdictional plan sets forth pharmacy performance bonuses that depend on closing gaps in care, and if pharmacies in one state can not operate either autonomously or under a collaborative practice agreement to close specify gaps, those pharmacies are not only economically disadvantaged, but the VBP incentives

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[8] Kaiser Health News. 2013. "Armed with Bigger Fines, Medicare to Punish 2,225 Hospitals for Excess Readmissions". Accessed July 9, 2014. http://www.kaiserhealthnews.org/Stories/2013/August/02/readmission-penalties-medicare-hospitals-year-two.aspx

[9] Center for Healthcare Research & Transformation. 2014. "Care Transitions: Best practices and evidence-based programs". Accessed July 9, 2014. http://www.chrt.org/public-policy/policy-papers/care-transitions-best-practices-and-evidence-based-programs/

[10] Ibid.

to drive patient outcomes are clearly undermined. Hence, NACDS submits that unnecessary state scope of practice barriers can have a significant impact on the implementation of VBP models.

3. **Provider Network and Benefit Design**. NACDS believes patients should be allowed the freedom to select a provider that best fits their personal health needs and provides the most accessible care. The use of restricted or limited networks has been increasing in recent years, particularly for pharmacy benefit networks in the Part D program. NACDS has concerns that limited provider networks result in restricted patient ability to access their healthcare providers. In fact, the Centers for Medicare and Medicaid (CMS) has also expressed concerns with limited networks and in a recent study[11i] on the Part D program it found that access in urban areas was substantially below the CMS convenient access standard, with some plans providing extremely low access. CMS stated that "these findings reinforce CMS' concern that plans are offering access to pharmacies with lower cost-sharing in a way that may be misleading to beneficiaries, in violation of CMS requirements."

Reducing access to pharmacies through the use of limited pharmacy networks cuts patients off from accessing their closest and most easily accessible healthcare provider. Community pharmacists are well situated in local communities, and are often the most readily accessible healthcare provider. Research has shown that nearly all Americans (89%) live within five miles of a community retail pharmacy. From helping patients take their medications effectively and safely, to providing preventative services, pharmacist services help keep people healthier and reduce costs. Notably, millions of Americans lack adequate and timely access to primary healthcare and this is only expected to worsen as demand increases. NACDS believes open pharmacy networks foster competition amongst pharmacies and improve patient health by maintaining access to the types of services that improve medication adherence and help prevent the need for more costly healthcare services in the future. NACDS urges the FTC to examine the ability of pharmacies to improve health and reduce costs and impact that results from reducing access to pharmacy services though restrictive networks.

4. **Early Observations of Health Insurance Exchanges**. Within the health insurance exchanges, NACDS remains most concerned about the issues of transparency of drug benefit designs in plan offerings and provider network adequacy. With regard to drug benefit design transparency, we applaud CMS' requirement that exchange plans must publish an up-to-date, accurate and complete list of all covered drugs on their formulary drug lists, including any tiering structure and/or restrictions on the manner in which drugs can be obtained. However, we believe that the FTC should look at ways in which CMS can go further towards greater transparency. For example, consumers can make more meaningful decisions if CMS were to require plans to include cost sharing information in the formulary list, including the beneficiary's applicable deductible and copayment/cost sharing percentage. Additionally, to further assist prospective beneficiaries in making cost-effective plan choices, CMS should also require exchange plans' formulary information to be formatted in a manner that allows for ease in comparison shopping for exchange beneficiaries. More specifically, we support the use of a plan finder function, such as the one used in the Part D program.

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[11] http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/CMS_PCSP_Network_Study_Industry-Briefing-Slides_12-12-14.pptx

Turning to the issue of narrow provider networks, within the context of pharmacy networks, NACDS believes that there is not enough transparency regarding pharmacy networks. Unlike medical and hospital provider networks, there is little or no public information regarding pharmacy network designs within exchange plans. Without public access to such information it is not possible to determine whether the use of narrow pharmacy networks creates an anti-competitive environment that could lead to financial harm to exchange beneficiaries. Even without such transparency, we know that more open pharmacy networks promote greater competition among pharmacies, which benefits patients. Accordingly, FTC should examine the need for CMS to propose significant changes to the pharmacy network adequacy requirement, which is currently the "accessible without unreasonable delay" standard. We believe that CMS should take action to strengthen pharmacy network adequacy requirements to ensure that patients have robust access to use their prescription drug benefits.

Sincerely,
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