APhA
American Pharmacists Association

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Meena Seshamani, M.D., Ph.D.
Deputy Administrator and Director of the Center for Medicare
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard Baltimore, MD 21244

Dear Dr. Seshamani:

We are writing to thank you and your staff for our recent meeting the American Pharmacists Association (APhA) coordinated with eight Pharmacy Services Administration Organizations (PSAOs) on the impact of pharmacy benefit managers' (PBMs) underwater pharmacy reimbursements for the 2024 and 2025 Medicare Part D contracts on independent community pharmacy participation, dispensed medications, and federal pharmacy access requirements under § 423.120.

Underwater PBM Reimbursements

During our meeting, we shared with your staff the fact that PBM contract rates encountered by many of our members' PSAOs for the Medicare Part D National Performance Network (NPN) are typically 5% below water on average wholesale price (AWP), or the average price paid by a retailer to buy a drug from the wholesaler, for pharmacies to even break even for dispensing standard day brand medications and that all brand product medication claims are underwater, with extended day contracts that go as deep as below 10% for pharmacies that directly contracted with the large PBMs.

As we mentioned, large PBM networks cover some of the largest national Medicare Part D plan sponsors who have ignored our members' requests to negotiate more reasonable rates, which means these members will be **at a minimum 3% below cost on dispensing brand medications. This is unsustainable.**

The PSAOs have confirmed these PBM contracts clearly have room to provide relief to independent pharmacies, which raises the question if this delta is being returned to the PBMs through the practice of spread pricing.

Our group also shared that on the commercial side of reimbursements, PSAOs are being paid significantly under the contract rate without any relief on the back end with how PSAOs

manage the commercial true-up, among other factors, as many PBMs do not provide satisfactory reporting to do a store level true-up. Also, many PBMs do not work with every PSAO, which forces many pharmacies to directly contract with them and accept these rates.

These continuing underwater PBM contracts keep leading to more and more pharmacy closures, fewer pharmacies in Medicare Part D plan networks, and act as a disincentive to stock or dispense most brand medications with underwater payments.

Relief for community pharmacies is desperately needed! One option we recommended would be for CMS to consider requiring "reasonable and fair" market-based evidence that brand medications can be procured at proposed contract rates, as a temporary solution, in the short-term, and towards more reasonable PBM contracts in the future by leveraging CMS' full authorities. These efforts could likely be coupled with pending federal PBM reform legislation in the U.S. Congress.

CMS has current authority under § 423.505(b)(18) that "The contract between the Part D plan sponsor and CMS must contain…(b) Requirements for contracts. [where] The Part D plan sponsor agrees to—"

> **"(18) To agree to have a standard contract with *reasonable and relevant terms and conditions of participation* [emphasis added] whereby any willing pharmacy may access the standard contract and participate as a network pharmacy."**

APhA has also encouraged our members to submit examples of these PBM business practices and underwater payment rates to the new Federal Trade Commission's (FTC) and U.S. Department of Justice's (DOJ) portal for public reporting of anti-competitive practices in the health care sector. However, given the ongoing delay for the FTC to complete its 6(b) investigation into PBMs, and the continuing rate of pharmacy closures around the country, APhA urges CMS not to wait for these findings to leverage your current authorities to improve PBMs' federal contracting with community pharmacies.

Increased audits by CMS of the PBM and Part D plans may also be beneficial to CMS as a recent U.S. Office of Personnel Management (OPM) Office of Inspector General (OIG) audit found a large PBM overcharged the plan and federal government over $44 million by not passing through all discounts and credit related to prescription drug pricing that was required under the PBM's contract with OPM.

Pharmacy Closures and Federal Pharmacy Access Standards

Recently, CMS released the 2024 Quarter 1 Medicare Part D Retail Pharmacy Access Analysis for Prescription Drug Coverage Contracting which appears to display Part D plan compliance with federal pharmacy access standards.

Under § 423.120 "[a]t least 70 percent of Medicare beneficiaries, on average, in rural areas served by the Part D sponsor [must] live within 15 miles of a network pharmacy that is a retail pharmacy." It's 90 percent, on average, within 2 miles of a network pharmacy for urban areas and 90 percent, on average, within 5 miles for suburban areas.

Our group also shared a list of news reports on recent pharmacy closures with CMS.

Today, the Associated Press (AP) reported an updated data analysis, as of February 2024, of pharmacy access, which can be searched by the number of pharmacies per 1,000 people in a ZIP code, by building a national dataset combining state licensure records and data from the National Council for Prescription Drug Programs (NCPDP), American Community Survey 2022 5-Year Estimates, U.S. Census Bureau, Health Resources and Services Administration. Analysis of the AP data found "[r]esidents of neighborhoods that are largely Black and Latino have fewer pharmacies per capita than people who live in mostly white neighborhoods, according to an Associated Press analysis of licensing data from 44 states, data from the National Council for Prescription Drug Programs and the American Community Survey."

The University of Pittsburgh School of Pharmacy also released an updated map, utilizing NCPDP data, that illustrates closed pharmacies between January 2014 and March 2024.

APhA urges CMS to utilize this updated data on ongoing pharmacy closures to assist CMS in determining Part D plan compliance with federal pharmacy access standards. APhA requests CMS share its process for analyzing retail pharmacy access and if the pharmacy locations from the publicly available National Plan and Provider Enumeration System (NPPES) Full Replacement Monthly NPI file are up to date with real-time pharmacy participants based on newly available data sets for compliance with § 423.120. APhA also requests CMS audit Part D plans' weekly "Incremental NPI Files," to align, reflect, and conform federal pharmacy access standards under § 423.120 with ongoing data and public reports of pharmacy closures.

We also shared with CMS that APhA has recently urged our members to check their pharmacy's payment renewal notification, as soon as (4/30/2024) on ways to opt-out, in writing (potentially via fax), with a short timeframe, to avoid being locked into a year-long PBM

contract because if a pharmacy is part of a PSAO network that chooses to enroll in a PBM contract, that PSAO contract may supersede any other agreement the pharmacy has with a PBM. Our group informed CMS this is another PBM tactic that may make Part D plans appear as if they are in compliance with federal pharmacy access standards when they may not be under § 423.120.

APhA also notes that Part D plans' and PBMs' use of preferred pharmacy status should not be a mechanism coupled with anti-competitive business practices (pharmacy steering, spread pricing, etc.) by PBMs to thin down the market of participating pharmacies (mainly independents) as much as they can, force patients to use mail order for their medications (which raises medication and patient safety, waste, and other concerns), and then move the goal posts to redefine or misrepresent compliance with CMS' network adequacy standards under § 423.120.

Thank you for your prompt attention to these important matters. APhA stands ready to assist you in protecting patients' access to their trusted, local community pharmacists. We look forward to hearing from you soon. If you have any questions or would like to speak further about these requests, please contact Michael Baxter on my staff at mbaxter@aphanet.org.

Sincerely,

Michael D. Hogue, PharmD, FAPhA, FNAP, FFIP
CEO