



November 8, 2023

The Honorable Chairman Ron Wyden
Senate Finance Committee
United State Senate
219 Dirksen Senate Office Building
Washington, DC 20510-6200

The Honorable Ranking Member Mike Crapo
Senate Finance Committee
United State Senate
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Re: Better Mental Health Care, Lower-Cost Drugs, and Extenders Act

Dear Chairman Wyden and Ranking Member Crapo:

We applaud the Senate Finance Committee for marking up the Better Mental Health Care, Lower-Cost Drugs, and Extenders Act, which will address concerns around Pharmacy Benefit Managers' (PBM) practices in Medicare Part C and D, as well as Medicare and Medicaid coverage of mental health services. Some PBM practices have put participants, beneficiaries, and enrollees' health and safety at risk, and restricted individuals' access to safe and affordable prescription drugs. ASHP is the largest association of pharmacy professionals in the United States, representing over 60,000 pharmacists, student pharmacists, and pharmacy technicians in all patient care settings, including hospitals, ambulatory clinics, and health-system community pharmacies. Our members have seen firsthand how PBM practices put patients at risk.

Site Neutrality: We applaud the exclusion of harmful site neutrality provisions from the bill. Hospitals provide a higher level of care to patients suffering from chronic conditions than physician offices and infusion centers do. Proposals considered this year would drastically reduce reimbursements for drug administration services in hospital outpatient departments inappropriately equate care provided in these hospital clinics with less complex care provided at freestanding physician offices. The care is not equivalent, and current payment rates take into account important differences. Hospitals are required to take many additional measures to make certain that medications are prepared and administered safely while also providing important care coordination services for their patients. In addition, hospitals must remain compliant with important safety standards such as those required by the Food and Drug Administration (FDA), U.S. Pharmacopeia, and The Joint Commission. These proposed policies would force hospitals and pharmacists to scale back some of the critical services they are able to provide to their patients. We appreciate their exclusion from the bill and oppose any amendments which would add them to the legislation and harm patient care, including Hassan Amendment #2.

Substance Use Disorder: We support efforts to expand Medicare beneficiary access and coverage to mental health and substance use disorder (SUD) treatment in title Title I of the Better Mental Health Care, Lower-Cost Drugs, and Extenders Act, but recommend the bill be expanded to fully utilizing pharmacists to provide this care. In 2021, more than 46 million U.S. patients met the criteria for substance use disorder. Ninety-four percent did not receive any treatment, even though many states have expanded their scopes of practice to allow pharmacists to increase access and ensure adherence to medications for opioid use disorder (MOUDs),

historically referred to as medication assisted treatment.¹ The Mainstreaming Addiction Treatment (MAT) Act of 2022 eliminated the X-waiver required under the Controlled Substances Act which streamlined the prescribing of medications, like buprenorphine, for the treatment of SUD/OD. Already, 11 states allow pharmacists to manage MOUDs in collaboration with physicians.² This was an important step in expanding the number of providers able to prescribe buprenorphine for patients with SUD/OD. CMS has also urged participation of pharmacists in opioid treatment programs to dispense MOUDs to Medicare beneficiaries. We recommend the Better Mental Health Care, Lower-Cost Drugs, and Extenders Act add a mechanism to pay for OUD services provided by pharmacists, whether through direct payment or incident to a physician.

Any Willing Provider: With revisions to clarify and recognize the importance of hospital outpatient pharmacy services, we would support 201 of the bill, but it must be expanded to clearly encompass outpatient hospital pharmacy services that benefit medically underserved areas (MUAs). Specifically, we support section 201 requiring Medicare Part D plan sponsors contract with any willing pharmacy that meets their standard contract terms and conditions. However, section 201 should be clarified to ensure that its requirement that Part D plans pay essential retail pharmacies no lower than a drug's average National Average Drug Acquisition Cost explicitly encompasses outpatient pharmacy services. Hospital pharmacies are a critical source of drugs for MUAs, so we recommend that the four-pharmacy cap be lifted for hospital-owned pharmacies. Further, for hospitals in a MUA, all hospital-owned pharmacies should be considered eligible, regardless of whether the pharmacy itself is in an MUA, since it will be serving the hospital's patients located in the MUA. Finally, for a hospital not in an MUA, hospital-owned pharmacies in an MUA should be eligible for entail retail pharmacy status to benefit beneficiaries in the MUA. With these changes, section 201 will protect hospital outpatient pharmacies from discriminatory activities by PBMs and ensure that Medicare beneficiaries receive access to these life-saving prescription drugs.

Coinsurance Limits: We support section 203 of the bill that increases patient affordability and drug pricing transparency by Medicare Part D plans. The provision limits Part D plans' post-deductible enrollee coinsurance to net prices, rather than list-prices. The section also provides greater transparency of coinsurance.

Ensuring Access to Pharmacists' Services: We appreciate the Committee's focus on ensuring Medicare beneficiaries have untethered access to prescription drugs without PBM interference. However, additional action should be taken to ensure beneficiaries also have access to pharmacists' services. Studies have shown that pharmacists improve patient outcomes, expand access to care, and contribute to cost savings.³ Recognizing their value, states are already calling on pharmacists to provide patients with access to essential healthcare services — from diagnostic testing to patient counseling and administration of certain drugs. Forty-three state Medicaid programs reimburse pharmacists for some clinical services, and all 50 states have expanded pharmacists' authority to provide care. Unfortunately, Medicare has not kept pace with advances in state scope of practice and does not reimburse pharmacists for providing eligible enrollees access to these services. Senators John Thune and Mark Warner introduced the Equitable Community Access to Pharmacists Services Act

¹ Substance Abuse and Mental Health Services Administration. Key Substance Use and Mental Health Indicators in the United States; 2023.

² CA, ID, MA, MT, NV, NM, NC, OH, UT, TN, WA.

³ McFarland, MS, Nelson J, Ourth H, Groppi J and Morreale A. Optimizing the primary care clinical pharmacy specialist: Increasing patient access and quality of care within the Veterans Health Administration. *J Am Coll Clin Pharm.* 2020;3:494-50; Funk, K., Pestka, D., McClurg, M., Carroll, J., Sorensen, T. Primary Care Providers Believe That Comprehensive Medication Management Improves Their Work-Life. *Journal of American Board of Family Medicine.* 2019; 32(4): 462-473. doi: 10.3122/ jabfm.2019.04.180376.

([S. 2477](#)), or ECAPS, to ensure Medicare enrollees have access to testing and treatment for services that pharmacists are licensed to provide. Senators Chuck Grassley, Sherrod Brown, Bob Casey, and Cindy Hyde-Smith introduced the Pharmacy and Medically Underserved Areas Enhancement Act ([S. 1491](#)), or PMUAEA, which will expand access to pharmacists' services for Medicare beneficiaries in MUAs. We recommend the Committee adopt Thune/Warner/Daines/Brown Amendment #3 (ECAPS) and Grassley/Casey/Brown #5 (PMUAEA) .

High-Discount Biosimilars: We support greater parity between reference biologics and biosimilars. We also support the classification of high and low discount biosimilars because it provides greater transparency and true net cost of these products. Specifically, we support requiring a Medicare Part D plans which covers a reference biologic include a less costly biosimilar on a tier with lower cost-sharing. We also support extending these requirements to high-cost small molecule specialty drugs as well. This will incentivize beneficiaries to utilize the most cost-effective therapies and increase patient access. We recommend the Committee adopt Lankford/Menendez/Cornyn/Bennet/Hassan Amendment #1 and Amendment # 2.

White Bagging: We appreciate the Committee's focus on concerning PBM activities, and ask that PBM mandated white and brown bagging be prohibited in Medicare. White bagging occurs when a PBM requires patient medications be distributed through a narrow network of specialty pharmacies that are often affiliated with the PBM before the pharmaceuticals are then sent to a site of care, such as a hospital, where they will be dispensed by a provider. Hospitals have strict quality controls and by circumventing the traditional and regulated hospital supply chain, white bagging raises patient safety risks by enabling diversion and heightening the possibility of drug spoilage/wastage. Brown bagging occurs when a PBM ships medications to a patient, who then must take the pharmaceutical to the provider for administration. These medications typically require special storage and handling. White bagging and brown bagging put pharmaceuticals at risk of spoilage, contamination, and diversion, putting patients' health at risk. We recommend Congress prohibit Medicare Advantage Plans from imposing white and brown bagging. Relatedly, we support and request the committee adopt Blackburn Amendment #2 that will look into Medicare Advantage plan vertical integration.

ASHP thanks you for your work to address abusive PBM practices. We look forward to continuing to work with you on this issue. If you have questions or if ASHP can assist in any way, please contact Frank Kolb at fkolb@ashp.org.

Sincerely,



Tom Kraus
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