NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

February 16, 2018

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate
Washington, DC 20510-6200

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510-6200

Dear Chairman Hatch, Ranking Member Wyden, and Honorable Members of the Senate Finance Committee:

The National Association of Chain Drug Stores (NACDS) commends Chairman Hatch, Ranking Member Wyden, and the members of the Committee on Finance for your leadership in pursuing policy changes to address the opioid crisis. NACDS and our members remain committed to partnering with policymakers, law enforcement, and others to work on viable strategies to prevent prescription opioid diversion and abuse. We thank you for the opportunity to provide recommendations on policy changes that would curb opioid misuse and abuse in the Medicare and Medicaid programs in particular.

NACDS represents traditional drug stores, supermarkets and mass merchants with pharmacies. Chains operate over 40,000 pharmacies, and NACDS' nearly 100 chain member companies include regional chains, with a minimum of four stores, and national companies. Chains employ nearly 3 million individuals, including 152,000 pharmacists. They fill over 3 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative services that improve patient health and healthcare affordability. NACDS members also include more than 900 supplier partners and over 70 international members representing 20 countries. Please visit www.NACDS.org.

As public health authorities have indicated, face-to-face interactions between pharmacists and patients have made pharmacists keenly aware of the extreme challenges and complexities associated with this epidemic. Based on this first-hand experience and our commitment to the patients and communities we serve, we offer the following recommendations to help prevent opioid diversion and abuse in Medicare and Medicaid.

I. Mandatory E-Prescribing: Curb Fraud, Waste, & Abuse

Electronic controlled substance prescriptions serve to reduce the likelihood of diversion, fraud, and abuse as electronic controlled substance prescriptions cannot be altered, cannot be copied, and are electronically trackable. Importantly, the federal DEA rules for electronic controlled substance prescriptions establish strict security measures, such as two-factor authentication, that reduce the likelihood of fraudulent prescribing. Notably, the state of New York saw a 70% reduction in the rate of lost or stolen prescription forms after implementing its own mandatory e-prescribing law.[1]

Thus, for controlled substances in particular, use of this technology adds new dimensions of security as well as safety in the prescribing process. Data from self-reported drug abusers suggest that between 3% and 9% of diverted opioid prescriptions are tied to forged prescriptions.[2,3] For these reasons, NACDS supports policies that promote the mandatory use of electronic prescribing to transmit prescription information between prescribers and pharmacists.

The rate of electronic prescribing has increased significantly in recent years. In 2008, there were about 68 million electronic prescriptions.[4] As of 2016, over 1.6 billion prescriptions were issued electronically, including approximately 45.3 million controlled substance prescriptions.[5] 90% of all pharmacies are enabled to receive electronic prescriptions. Yet, today, only 17% of prescribers have systems that can send electronic prescriptions for controlled substances.[6] Accordingly, there is substantial room for improvement, particularly with controlled substance prescriptions which lag behind in overall adoption rates.

Lastly, mandatory electronic prescribing systems can be leveraged to provide timely, in-workflow analyses of real-time data with actionable point-of-care guidance for prescribers and dispensers among other entities.

To enhance healthcare providers' utilization of this technology and to foster prescriber adoption, chain pharmacy urges the adoption of policies to require that all prescriptions be issued electronically, with limited exceptions. ***We support the Every Prescription Conveyed Securely Act (H.R. 3528), legislation currently pending in the House of Representatives that requires electronic prescribing for controlled substances in Medicare Part D, and we urge lawmakers in the Senate to introduce and pass companion legislation.***

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[1] Remarks of Anita Murray, Deputy Director, New York State Department of Health at the Harold Rogers Prescription Drug Monitoring Program National Meeting (September 6, 2017)

[2] Rosenblum, Andrew, et al. "Prescription opioid abuse among enrollees into methadone maintenance treatment." Drug and Alcohol Dependence 90.1 (2007): 64-71

[3] Inciardi, James A., et al. "The "black box" of prescription drug diversion." Journal of Addictive Diseases 28.4 (2009): 332-347

[4] Surescripts National Progress Report for 2012.

[5] Surescripts National Progress Report for 2016.

[6] ibid

In addition, to accelerate the rate of electronic prescribing of controlled substances, Congress should consider providing incentives as has been done through the previous CMS demonstration program and the EHR incentive program.

II. Implement Policies Establishing a 7-day Supply Limit for Initial Opioid Prescriptions Issued for Acute Pain

NACDS supports policies establishing a 7-day supply limit for initial opioid prescriptions written for acute pain. This policy aligns with the *Guideline for Prescribing Opioids for Chronic Pain* developed by the Centers for Disease Control and Prevention (CDC) and serves to reduce the incidence of misuse, abuse, and overdose of these drugs.

A clinical evidence review performed by the CDC revealed that a greater amount of early opioid exposure is associated with a greater risk for long-term use and addiction.[7] Notably, the average day supply per opioid prescription has increased in recent years, growing from 13.3 to 18.1 days per prescription between 2006 and 2016.[8] Considering this trend and the risk of early exposure to higher amounts of opioids, it is imperative that lawmakers adopt policies to promote careful prescribing practices for prescription opioids.

So far, over 20 states have adopted laws or other policies limiting the maximum day supply that can be authorized on an initial opioid prescription for acute pain (with appropriate exemptions, such as patients with pain due to cancer, hospice, or other end-of-life care, etc.). ***Chain pharmacy encourages Congress to enact legislation that is standardized across the nation to promote consistent patient care and implementation across the country. NACDS would support federal legislation that preempts individual state variations.***

In the interim, policies are currently being considered by CMS that are aimed to limit beneficiary overutilization of opioids in the Medicare program. The 2019 Advance Notice and draft Call Letter contains a number of proposals to address the opioid crisis, including changes in Star Ratings to focus on the use of opioids and changes such as requiring plans to limit beneficiaries to a 7-day supply for new prescriptions to treat acute pain. NACDS is currently reviewing the CMS proposals and will be providing comments to the Agency.

November 2017

[7] Centers for Disease Control and Prevention, *CDC Guideline for Prescribing Opioids for Chronic Pain*. CDC.gov. https://www.cdc.gov/drugoverdose/prescribing/guideline.html

[8] Centers for Disease Control and Prevention, *Annual Surveillance Report of Drug-Related Risks and Outcomes*. United States, 2017. https://www.cdc.gov/drugoverdose/pdf/pubs/2017-cdc-drug-surveillance-report.pdf

III. Medicare & Medicaid Treatment & Prevention Incentives

An important element of any strategy to combat the opioid crisis should include policies that improve patient care, medication education, and related care services. Some states have already "engaged community pharmacy to prevent new addictions, monitor opioid medication prescriptions, improve access to naloxone (an effective treatment for opioid overdose), and implement "take-back" programs for safe disposal of unused medications."[9] As such, NACDS supports continuity of care and the expansion of community-based programs, which include retail community pharmacists helping to identify and treat those with opioid addiction and educate consumers on the dangers of opioid abuse and addiction.

Despite the ability of pharmacists to improve access and care, current law does not recognize them as a provider in the Medicare program. Medicare and Medicaid should therefore consider developing payment incentive programs that would reimburse pharmacists for prevention and treatment services related to OUD and SUD to improve patient outcomes.

Significant consideration should be given to policies and initiatives that enhance healthcare capacity and strengthen community partnerships to offset provider shortages, particularly in communities with medically-underserved populations. This can be accomplished by recognizing the value pharmacists play as a member of the healthcare team and utilizing them at the top of their training in fighting the opioid crisis. Here are some examples where Medicare and Medicaid payment incentives could be structured to support prevention and treatment programs to benefit patients and communities:

- Providing greater access to community-based Screening, Brief Intervention, and Referral to Treatment (SBIRT). SBIRT is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and substance abuse and includes a referral to treatment for those in need. ***Currently, at least one state Medicaid program recognizes pharmacists as a provider of this service; however, Medicare and Medicaid should consider reimbursement of pharmacists for this intervention across all states.***

- Providing essential screenings and immunizations related to Hepatitis B, Hepatitis C, HIV, Tuberculosis (TB), and depression to improve the population health of communities. For example, one community pharmacy partnered with a state health department to provide HIV screening in their pharmacies; the state health department gains access points to their at-risk population through the reach of pharmacies and in-turn reimburses the pharmacies per screening provided. Data from this partnership shows that pharmacy can provide these services at a lower cost than the health department, and patients find the pharmacies to be less

[9] See Johns Hopkins Report: Serving the Greater Good: Public Health & Community Pharmacy Partnerships at 11. (Oct. 2017).

stigmatizing locations than other places to receive screenings. To extend this example further, ***Medicare and Medicaid could develop a similar program based on this pilot to reimburse pharmacies for screenings***, especially since the scope of practice in many states already allows for pharmacists to conduct these services.

- Increasing access to Naloxone, a medication designed to rapidly reverse opioid overdose. Several states have recognized the importance of ensuring quick access to this life-saving medication and have employed various approaches to reimburse and make it easier for pharmacists to provide naloxone to patients.

- Assisting physicians with opioid treatment program, which provide medication-assisted treatment (MAT) for people diagnosed with an opioid-use disorder. CMS recently recognized the importance of MAT in its proposed FY2019 Call Letter, when it stated "…it is imperative to also ensure that Medicare beneficiaries have appropriate access to medication-assisted treatment (MAT)." Medicare and Medicaid could develop incentive programs that include pharmacists as a key partner in these treatment programs and reimburse for such efforts.

To help alleviate these critical issues and provide more access to providers willing and able to help battle the opioid crisis, **NACDS encourages members of Congress to support H.R. 592/S. 109, the *Pharmacy and Medically Underserved Areas Enhancement Act,*** which will allow Medicare Part B to utilize pharmacists to their full capability by providing underserved beneficiaries with services, subject to state scope of practice laws, not currently reaching them. This important legislation would lead not only to reduced overall healthcare costs, but also to increased access to healthcare services and management of medications.

IV. Prevention of Opioid Abuse in Medicaid

State Medicaid programs are currently working to adopt initiatives aimed at combatting the opioid epidemic. However, variations across state programs, such as access to services, number of accessible providers, and benefit limitations, affect how these initiatives are adopted and the level of coverage provided for affected beneficiaries.

A substantial part of fighting the opioid epidemic in the Medicaid program is the ability to provide early screening and intervention, counseling, and rehabilitative services. Nevertheless, counseling, social work services, targeted case management, screening, and preventative and rehabilitative services are all optional services under the Medicaid program, thereby limiting coverage and availability of such services in some state programs. ***Chain pharmacy encourages Congress to enact legislation that would make screening, counseling, social work services, targeted case management, preventative, and rehabilitative services mandatory services for coverage across all state Medicaid programs.*** NACDS believes that all the above-mentioned policies could effectively be adopted and implemented in the Medicaid program if there were mandatory requirements

for states to cover the needed services. This would not only increase the number and level services needed, but it would also increase the number of accessible providers that can provide these services to Medicaid beneficiaries, including retail pharmacists.

V. Pharmacy Lock-in Programs

NACDS shares the goals of policymakers to curb the incidence of abuse and diversion and believes that any potential programs aimed at "locking in" a beneficiary to a certain pharmacy or pharmacies must ensure that legitimate beneficiary access to needed medications is not impeded. Policies to reduce overutilization must maintain access to prescription medications by the beneficiaries who need them most.

CMS is currently in the process of implementing the Medicare Part D lock-in program as contained in the Comprehensive Addiction and Recovery Act of 2016 (CARA). **NACDS strongly supports the CMS proposal "*that where a pharmacy has multiple locations that share real-time electronic data, all locations of the pharmacy collectively be treated as one pharmacy under the clinical guidelines.*"** Defining a "pharmacy" in this manner does not require a beneficiary to use such a pharmacy but would provide them with the option if doing so would best meet their healthcare needs. The ability to utilize multiple store locations also protects access by allowing a beneficiary to obtain needed medication when they cannot use their usual pharmacy location due to situations such as an emergency or extended travel or when their usual pharmacy location is unable to supply the medication. The proposed definition of "pharmacy" will help ensure legitimate beneficiary access to needed prescriptions without compromising the integrity of the program and its goal to combat abuse and diversion.

VI. Nationwide Prescription Drug Monitoring Program

NACDS supports the important role of prescription drug monitoring programs (PDMPs) in helping to prevent drug abuse and diversion. Over the years, PDMPs have been established throughout the country as tools to curb diversion and abuse of controlled substance prescriptions. At this time, nearly every state has implemented their own program designed to assist in the identification and prevention of drug abuse and diversion at the prescriber, pharmacy, and patient levels. However, there are significant variances across state programs which, altogether, impede optimal use of PDMPs to their fullest extent.

NACDS is calling upon stakeholders to work together to develop and implement a nationwide PDMP solution to harmonize state requirements for reporting and accessing PDMP data. Our goal is to establish one system with unified expectations for appropriate use of PDMP data by prescribers, pharmacies, law enforcement, and others. Such a system should leverage electronic prescribing systems to provide timely, in-workflow analyses of real-time data with actionable point-of-care guidance for prescribers and dispensers. **We urge the participation of federal policymakers, healthcare providers, and other stakeholders on this important initiative to create a national PDMP solution.**

VII. Drug Take-Back and Disposal

As dedicated healthcare providers, chain pharmacies encourage patients to dispose of unneeded prescription opioids to eliminate opportunities for misuse and abuse of these medications. Patients are more likely to dispose of unused opioids when they have a variety of convenient disposal options. As a result, it is important to allow patients, pharmacies, and other stakeholders the flexibility to utilize a wide variety of disposal options. We believe that Congress should continue funding programs that help consumers dispose of their unwanted opioid medications. The Drug Enforcement Administration (DEA) periodically hosts National Prescription Drug Take-Back events, where collection sites are set up in communities nationwide for safe disposal of prescription drugs. Many local law enforcement agencies also sponsor drug take-back programs in communities across the country. Chain pharmacies play a major role in both informing their patients about these events and actively participating in and even hosting the events.

Conclusion

NACDS thanks the Committee on Finance for consideration of our comments. We look forward to working with policymakers and other stakeholders to implement policies to improve opioid prescribing practices and turn the tide in the opioid epidemic.

Sincerely,

Tom O'Donnell
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National Association of Chain Drug Stores