



NATIONAL ASSOCIATION OF  
CHAIN DRUG STORES

Statement  
Of  
The National Association of Chain Drug Stores  
For  
United States House of Representatives  
Committee on Energy and Commerce  
Subcommittee on Health  
On  
“Combating the Opioid Crisis:  
Improving the Ability of Medicare and Medicaid  
to Provide Care for Patients”

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## **Introduction**

The National Association of Chain Drug Stores (NACDS) thanks Chairman Burgess, Ranking Member Green, and the members of the Subcommittee on Health for your continued commitment to implementing strategies to curb prescription opioid abuse and diversion. The chain pharmacy community welcomes the opportunity to partner with lawmakers and other stakeholders for this purpose. NACDS and our members are focusing our energies on real, workable solutions that will address the problem of prescription drug abuse while also ensuring that legitimate patients are able to receive their prescription pain medications.

Chain pharmacies engage daily in activities with the goal of preventing drug diversion and abuse. Since chain pharmacies operate in almost every community in the U.S., we support policies and initiatives to combat the prescription drug abuse problem nationwide. We believe that holistic approaches must be implemented at the federal level.

Pharmacists take very seriously their role in helping to ensure safe use of medications – but they cannot do it alone. We support a collaborative approach to curb prescription drug abuse and preserve patient access to their medically-necessary pain medications. We believe that there are a variety of ways to help curb prescription drug diversion, and chain pharmacies actively work on many initiatives to reduce this problem. We thank you for the opportunity to provide recommendations on policy changes to prevent the abuse and diversion of prescription opioid medications.

NACDS represents traditional drug stores and 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. For more information, visit [www.NACDS.org](http://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 the opioid abuse epidemic.

Pharmacists and pharmacies fully understand that controlled substances are subject to abuse by a minority of individuals who improperly obtain controlled substance prescriptions from physicians and other prescribers. Pharmacists and pharmacies strive to treat medical conditions and ease patients' pain while simultaneously guarding against the abuse of controlled substances. The key is to guard against abuse without impeding our primary goal of assisting patients who need pharmacy services.

Based on our experiences, NACDS is pursuing a number of policy solutions to complement pharmacy's collaboration with other stakeholders including healthcare professionals and law enforcement to address prescription opioid abuse in communities across the country.

### **Utilizing Pharmacists to Combat the Opioid Crisis**

Retail community pharmacists are an underutilized component in helping to identify and treat those with opioid addiction as well as educating consumers on the dangers of opioid abuse and addiction. Recognizing the value pharmacists play as a member of the healthcare team and utilizing them at the top of their training would greatly benefit the battle against the opioid crisis.

Access, quality, cost, and efficiency in healthcare are critical, especially for those who are medically underserved and/or are at-risk for substance abuse disorders. These may include seniors with cultural or linguistic access barriers, residents of public housing, persons with HIV/AIDS, as well as rural populations and many others. Many of these beneficiaries suffer from multiple chronic conditions. 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.

Retail pharmacies are often the most readily accessible healthcare provider. Research shows that nearly all Americans (89%) live within five miles of a retail pharmacy.

Despite the ability of pharmacists to improve access and care, current law does not recognize them as a provider in the Medicare program. H.R. 592/S. 109, the *Pharmacy and Medically Underserved Areas Enhancement Act*, would change this to recognize pharmacists as providers in medically underserved areas, thus creating better access to services for these vulnerable populations. Not only would recognition of pharmacists improve access, but it would lead to reduced healthcare costs as pharmacists would provide already-covered Medicare services at 85% of the physician fee schedule.

Pharmacists have advanced education and training that equips them to provide many services in addition to their role in providing patients with access to information about their prescription medications. These services include:

- Health Tests and Screening
- Management of Chronic Conditions and Related Medications
- Immunization Screening and Administration
- Point of Care Testing (e.g. Flu, Strep)
- Transition of Care Services

In addition to these vital services, pharmacists are also trained and equipped to help in the battle against opioid abuse. Examples of ways pharmacists could help include:

- Assisting physicians with opioid treatment programs, which provide medication assisted treatment (MAT) for people diagnosed with an opioid-use disorder. CMS recently recognized the importance of MAT in its final FY2019 Call Letter, when it stated "...it is imperative to also ensure that Medicare beneficiaries have appropriate access to medication-assisted treatment (MAT)."

- 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.
- 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. In this model, 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 stigmatizing locations than other places to receive screenings.
- Increased 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. Notably, the U.S. Surgeon General recently issued an advisory urging all Americans to learn how to use naloxone and keep it within reach.<sup>1</sup>
- Increased use of pharmacogenomic testing to determine the right pain medication and dosing. By performing pharmacogenetic testing, personalized medicine allows patients to be prescribed with the right drug to be administered for adequate pain control – to avoid experiencing dose-dependent side effects or lack of drug efficacy. A pain medication may alleviate pain for one patient while providing no relief for another. Pharmacogenetic testing can help alleviate this problem.

***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.***

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<sup>1</sup> <https://www.surgeongeneral.gov/priorities/opioid-overdose-prevention/naloxone-advisory.html>; accessed April 10, 2018.

***592/S. 109, the Pharmacy and Medically Underserved Areas Enhancement Act.***

**Electronic Prescribing of Controlled Substances**

Chain pharmacy supports policies that promote the use of electronic prescribing to transmit prescription information between prescribers and pharmacists. For controlled substances in particular, use of this technology adds new dimensions of safety and security 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.<sup>2,3</sup> Electronic controlled substance prescriptions serve to reduce the likelihood of diversion in this manner, as electronic controlled substance prescriptions cannot be altered, cannot be copied, and are electronically trackable. Furthermore, the federal DEA rules for electronic controlled substances 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 electronic prescribing law.<sup>4</sup>

The rate of electronic prescribing has increased significantly in recent years. In 2008, there were about 68 million electronic prescriptions.<sup>5</sup> As of 2016, over 1.6 billion prescriptions were issued electronically, including approximately 45.3 million controlled substance prescriptions.<sup>6</sup> Still, there is room for further improvement, particularly with controlled substances prescriptions which lag behind in overall adoption rates. While 90% of all pharmacies are enabled to receive electronic prescriptions, only 17% of prescribers have systems that can send electronic prescriptions for controlled substances.<sup>7</sup>

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<sup>2</sup> Rosenblum, Andrew, et al., "Prescription Opioid Abuse Among Enrollees into Methadone Maintenance Treatment," *Drug and Alcohol Dependence*, 90.1 (2007): 64-71.

<sup>3</sup> Inciardi, James A., et al., "The 'Black Box' of Prescription Drug Diversion," *Journal of Addictive Diseases*, 28.4 (2009): 332-347.

<sup>4</sup> 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).

<sup>5</sup> Surescripts National Progress Report for 2012.

<sup>6</sup> Surescripts National Progress Report for 2016.

<sup>7</sup> Ibid.

To enhance healthcare providers' utilization of this technology and to foster prescriber adoption, chain pharmacy urges the adoption of policies that encourage all prescriptions be issued electronically, with limited exceptions for situations in which issuing an electronic prescription may not be feasible. ***We support the Every Prescription Conveyed Securely Act (H.R. 3528), legislation that requires electronic prescribing for controlled substances in Medicare Part D. We thank Representative Mullin as an original cosponsor of this legislation and we ask that the Subcommittee work to pass this necessary legislation.***

### **Nationwide Prescription Drug Monitoring Program**

NACDS continues to support the important role of prescription drug monitoring programs (PDMPs) to help prevent drug abuse and diversion. Over the years, states have established PDMPs as a tool to provide critical information to prescribers and dispensers. However, many states have implemented their own approaches to designing and managing PDMPs, resulting in disparate data and access requirements. These challenges are compounded by the lack of interconnectivity and complete data sets among many PDMPs, impeding their optimal use.

PDMP databases are populated when pharmacies contribute records of dispensed controlled substance prescriptions to the state PDMP data repository. Pharmacies are required by state law to report dispensing information that identifies the patient, the drug and quantity received by the patient, the prescriber, and the pharmacy where the medication was dispensed. However, specific data reporting requirements vary by state.

Unfortunately, the state PDMPs are difficult to access and utilize. It can take an average of 2 to 6 minutes to access and run an individual report from states' PDMP web portals. Given that there were approximately 492 million<sup>8</sup> controlled substances prescriptions dispensed in 2016, if healthcare providers were to run a PDMP report for each patient who received a controlled substance prescription, this would require approximately 16 to 49 million

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<sup>8</sup> PHAST® Prescription Monthly, data drawn November 2017.

additional hours per year to access PDMP data for all dispensed controlled substances prescriptions.

Evidence suggests that physicians do not use PDMPs consistently, or at all, due to a lack of data timeliness to show real-time prescribing data in their workflow and lack of health IT integration with electronic health records (EHRs). NACDS supports health IT initiatives that equip providers with real-time data within EHRs. Improvement of health IT integration to combat the opioid crisis also would be facilitated through the use of electronic controlled substance prescriptions.

The experience of the state of New York – which enacted the I-STOP Law to enhance the PDMP and mandate use of electronic prescriptions – illustrates how PDMPs and e-prescribing, when used together, can improve opioid prescribing practices and reduce opportunities for prescription opioid abuse and diversion. According to data from the New York State Department of Health, increased use of PDMP data by prescribers led to an 8.7% reduction in the number of opioid prescriptions and a 10.4% reduction in the total number of patients who received an opioid prescription in the first year alone.<sup>9</sup> *Furthermore, following implementation of the e-prescribing mandate, the state saw a 70% reduction in the rate of lost or stolen prescription forms.<sup>10</sup> Altogether, these policies contributed to a 98% reduction in the rate of doctor shopping.<sup>11</sup>*

As a result of the present functionality and interoperability challenges, NACDS is calling on stakeholders to work together to develop and implement a nationwide PDMP solution to harmonize state PDMPs. *Such a system should be built in tandem with efforts that encourage e-prescribing for controlled substances in an effort to provide timely, in-*

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<sup>9</sup> Terence O’Leary, Bureau of Narcotic Enforcement. New York’s I-STOP Law. Available at: [http://www.pdmpassist.org/pdf/PPTs/National2014/1-04\\_OLeary.pdf](http://www.pdmpassist.org/pdf/PPTs/National2014/1-04_OLeary.pdf)

<sup>10</sup> 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).

<sup>11</sup> After initially enacting the I-STOP law, the New York Bureau of Narcotics and Enforcement initially saw a 91.2% reduction in the rate of doctor shopping. Now that the e-prescribing mandate has been implemented, Feb. 2018 data shows that there has been a 98.8% reduction in incidence of doctor shopping since before I-STOP. BNE estimates that the additional decrease was, in part, due to e-prescribing. Data provided by Anita Murray, Deputy Director, New York State Department of Health (February 26, 2018).



***workflow analyses of real time data with actionable point of care guidance for prescribers and dispensers.***

Working in tandem with e-prescribing technology would help ensure that prescribers receive immediate, in-workflow information at the point-of-prescribing, thus eliminating the need to access another system or database. Moreover, this would help ensure that any federal or state opioid prescribing limits are followed.

A nationwide PDMP solution could take many forms, pulling information from several data sources, including: clinical data extracted from insurers, PBMs, and state PDMPs; and aggregated data via a commercial market solution. Additionally, controlled substances prescribing information could be included within EHRs. NACDS would support a nationwide solution through any of those vehicles, provided that the solution includes the following principles:

- The most effective use of PDMP data is in ensuring appropriateness of controlled substance use when the prescriber is issuing a prescription for a patient. To that end, prescribers should have real-time, actionable data at the point of care to better inform their prescribing decisions. We recommend that a nation-wide data solution be utilized by pharmacies as a secondary safeguard, in addition to the prescriber's review. In exercise of their professional judgment, pharmacists can take necessary actions to investigate and attempt to resolve any concerns identified as a result of a query, as part of the process of determining whether or not to fill controlled substance prescriptions.
- Data is accessible to prescribers, dispensers, and supporting staff (e.g. automatic and free registration into PDMP).
- Compile data exclusively on controlled substances; stay focused on main mission.
- Sufficiently protect proprietary data rights of participating stakeholders.

NACDS strongly supports the development of a nationwide PDMP solution that includes the previously mentioned principles; however, we are agnostic to the specific format of the solution. In other words, this solution could be supported and housed within a federal agency (e.g. ONC, ONDCP) or it could be built and delivered entirely outside government through commercial market forces. Depending on the solution that moves forward, it could build upon existing state PDMP data or pull data from other sources – we are open to the most reasonable solution that harmonizes existing gaps and inconsistencies.

We were interested upon learning that at today’s hearing the Subcommittee will be considering a discussion draft of “Medicaid Providers and Pharmacists Required to Note Experiences in Record Systems to Help In-need Patients (PARTNERSHIP) Act,” which would allow the Medicaid program in each state to integrate PDMP usage into pharmacists’ workflow. Although we have concerns with specific parts of the legislation, we are encouraged by the effort to work toward a nationwide PDMP solution that would modernize and strengthen existing programs and provide timely information in the workflow of health care providers. We welcome the opportunity to work with lawmakers to advance legislation that would include the concepts in alignment with the important principles for a nationwide PDMP solution outlined above. We look forward to working with key stakeholders to discuss the development and implementation of a nationwide PDMP.

### **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.<sup>12</sup>

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<sup>12</sup> Centers for Disease Control and Prevention, *CDC Guideline for Prescribing Opioids for Chronic Pain*. CDC.gov. <https://www.cdc.gov/drugoverdose/prescribing/guideline.html>.

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.<sup>13</sup> 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.<sup>14</sup> 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.***

***Moreover, this legislation should provide liability protection for pharmacists to ensure that pharmacists do not have to second-guess a prescriber and determine whether a prescriber appropriately issued a prescription for a days supply that exceeds the 7-day limit.***

### **Pharmacy “Lock-In”**

NACDS shares the goals of policymakers to curb the incidence of fraud and abuse and are interested in the Subcommittee’s consideration in today’s hearing of the “Medicaid Pharmacy Home Act,” which would create a Medicaid “lock-in” program through federal law. We have seen such programs implemented by commercial payers, as well as Medicare and state Medicaid programs, and believe they can be beneficial in helping prescribers ensure that patients are not being overprescribed opioids. However, any potential Medicaid program 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.

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<sup>13</sup> Ibid.

<sup>14</sup> 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>

While the use of limited pharmacies could lower the incidence of fraud and abuse, as well as provide the potential for better care coordination, a lock-in provision could raise barriers to care and cause patient harm. For example, a patient could suffer harm to their health if their “locked in” pharmacy is unable to obtain their medication. Also, patients often legitimately see multiple doctors representing different specialties in different locations. In addition, there are instances, due to location and/or services offered (e.g. compounded or specialty drugs) in which a single pharmacy may not meet all of the needs of a specific patient.

In order to protect legitimate patient access while combatting prescription drug abuse and diversion, NACDS suggests the following definition of a pharmacy be included in the legislation:

*In the case of a pharmacy that has multiple locations that share real-time electronic data, all such locations of the pharmacy shall collectively be treated as one pharmacy.*

This definition is used in the recently adopted Medicare Drug Management Program for At-Risk Beneficiaries (as contained in the Comprehensive Addiction and Recovery Act of 2016 (CARA)). With respect to combatting abuse and diversion, pharmacies sharing real-time data will ensure that beneficiaries are only obtaining the necessary prescriptions while protecting beneficiary access and health without compromising the integrity of the management program.

Additionally, NACDS recommends revision to the pharmacy selection process. Currently, the language requires the State to provide a process to allow affected individuals to submit a request to use a particular pharmacy. However, the legislative language is silent on whether the State would be required to honor that request. To ensure adequate access, NACDS suggests adding language to the bill to "require the State to use beneficiary preferences unless such selection would contribute to prescription drug abuse or drug diversion by the beneficiary." This language mirrors that used in Medicare Part D lock-in program.

Finally, the current language requires the State to provide notice to the patient before enrollment in the drug management program. NACDS strongly encourages the legislation be changed to require two notices before enrollment. Not only would this mirror requirements under the Medicare Part D program, but multiple notices are especially important for the Medicaid population. The Medicaid population is more transient and often patients tend to change primary addresses and location due to living condition or financial needs. Including requirements for two notices, like those required under the Medicare Part D program, would ensure that beneficiaries are adequately notified in the event of a primary address change as well as further ensure that identified individuals receive proper monitoring and care.

### **Conclusion**

NACDS thanks the Subcommittee for consideration of our comments. We look forward to working with policymakers and stakeholders on these important issues.