NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

March 20, 2023

Senate Committee on Health, Education, Labor and Pensions (HELP)
United States Senate
28 Senate Dirksen Office Building
Washington, DC 20510

Submitted via email to HealthWorkforceComments@help.senate.gov

Re: Senate HELP Committee RFI on Solutions to Health Care Workforce Shortages

Dear Chairman Sanders and Ranking Member Cassidy,

The National Association of Chain Drug Stores (NACDS) applauds the commitment of the Senate Committee on Health, Education, Labor and Pensions (HELP Committee) to identify and advance solutions that address the ongoing shortage of health care workers impacting communities across the nation. With approximately 65 million people living in regions without adequate primary care and an estimated shortage of up to 122,000 physicians by 2032,[1][2] pharmacists and their pharmacy teams are poised to help fill gaps in care and provide a growing number of essential health care services to the public. As Congress works to construct legislation to augment the health care workforce and implement strategies to meet patient demand for needed care, we appreciate the opportunity to make recommendations for needed policy changes that better leverage pharmacy providers' ability to help alleviate the workforce shortages and strains across the broader healthcare system.

Discussed in detail below, we urge lawmakers' support for the following:

1. **Support modernization of disparate state pharmacy practice laws to align with allowances for pharmacy personnel authorized under the federal PREP Act, which will enable pharmacies to continue to optimize the roles and contributions of the full pharmacy team – including pharmacy technicians – to meet public demand for the important health care services available in pharmacies;**

2. **Urge the Administration to provide needed clarification that the pharmacy-related flexibilities authorized under the PREP Act following the COVID-19 public health emergency declaration will continue to be extended in alignment with other public health emergencies such as Zika virus where the PREP Act declaration remains in place until December 2027 and mpox where the corresponding PREP Act declaration remains in place until 2032 or at minimum until October 2024;**

[1] State and Federal Efforts to Enhance Access to Basic Health Care. The Commonwealth Fund. https://www.commonwealthfund.org/publications/newsletter-article/state-and-federal-efforts-enhance-accethe ss-basic-health-care
[2] Association of American Medical Colleges. New Findings Confirm Predictions on Physician Shortage. April 2019. https://www.aamc.org/newsinsights/press-releases/new-findings-confirm-predictions-physician-shortage

3. **Support legislation expected to be introduced soon and based on the Equitable Community Access to Pharmacist Services Act (H.R. 7213 from the 117th Congress) that would help sustain access to pharmacy care by creating a dependable, direct payment pathway in Medicare for clinical care services provided by pharmacists such as vaccinations, testing and treatment; and**

4. **Support legislation expected to be introduced soon that would require the U.S. Department of Health and Human Services (HHS) to evaluate whether pharmacy measures are relevant to the type of drugs dispensed and managed by the pharmacy and would require plan sponsors to use standardized performance measures that are tethered to star ratings. The new bill would require HHS to reform direct and indirect remuneration (DIR) fees by requiring reasonable pharmacy reimbursement and ensure Part D DIR fees are based on fair and achievable pharmacy performance measures.**

Together, these needed policy changes will help enhance health care provider capacity across the broader health care system and help to ensure that patients can continue to receive the level of care they now expect at neighborhood pharmacies. We thank the HELP Committee for considering our perspectives on this important matter.

I. Leveraging the Full Pharmacy Team – Including Pharmacy Technicians – Bolsters Pharmacies' Capacity to Meet Public Demand for Essential Healthcare Services

The ability to leverage highly capable pharmacy technicians to assist pharmacists in performing technical tasks that do not require a pharmacist's professional judgement bolsters pharmacies' capacity to connect millions of patients – especially those in medically underserved areas – with needed basic healthcare services. With 90 percent of Americans living within 5 miles of a pharmacy, pharmacies are an important access point for millions of Americans seeking needed healthcare services. More and more, people now rely on their local pharmacy for clinical care services such as vaccinations, testing services, health screenings, and other important preventive and chronic care. Meeting patient demand for these clinical services, while simultaneously meeting their prescription dispensing needs, is greatly enhanced when each pharmacy team member is authorized to contribute at the top of their skills and training. Doing so enables pharmacy providers to deploy care models that remove inefficiencies and focus the pharmacist on patient care activities.

The COVID-19 pandemic amplified the vital role that pharmacies play in delivering healthcare services to the public, further demonstrating the importance of leveraging the full pharmacy team at the top of their skills and training. Recognizing the unparalleled access and high-quality care available at pharmacies, the federal government took action under the Public Readiness and Emergency Preparedness Act (PREP Act) to remedy the regional disparities in care resulting from the patchwork of state pharmacy practice laws. Under the PREP Act, pharmacies across the country were allowed to optimize the roles and contributions of the full pharmacy team – including pharmacy technicians – to deliver a broad portfolio of vaccine services, testing, and treatment access. As a result, pharmacies played a central role in public health

initiatives to get more than 300 million "shots in arms" and to connect millions of Americans with essential COVID-19 testing services and treatment access, and pharmacy technicians helped to make this possible. With the support of pharmacy technicians, pharmacies were able to stand up and staff the 20,000 COVID-19 testing sites nationwide – 70% of which were in areas with moderate to severe social vulnerability; and to provide more two out of every three COVID vaccinations.[3] In fact, an internal survey of NACDS members conducted in March 2022 found that up to 38% of all COVID vaccine doses provided by pharmacies were administered by pharmacy technicians.[4]

Pharmacists have made clear that they appreciate the option of being able to delegate technical tasks like vaccine administration and collecting specimens for testing to pharmacy technicians. One study found that community pharmacists who supervise pharmacy technicians trained to administer immunizations were receptive to technicians taking on this new role, and that utilizing technicians in this way positively affects the morale of the pharmacy team, while helping to increase the number of vaccinations given by the pharmacy.[5]

For the last two and a half years, pharmacy technicians have demonstrated their ability to assist pharmacists safely and effectively with administering vaccines and testing. Unfortunately, many states have been slow to act to modernize outdated laws to permanently allow these practices, even though the temporary PREP Act allowances for pharmacy technicians will soon expire. Permanent codification of PREP Act allowances for pharmacy technicians at the state level is both necessary and warranted to help ensure that pharmacies can continue to provide the level of patient care services that the public has come to expect from neighborhood pharmacies in recent times. **To ensure that pharmacy care capacity is not interrupted, we encourage members of Congress to work with state lawmakers to advance needed changes to state pharmacy practice laws that will enable pharmacy technicians to continue to assist pharmacists with administering immunizations and testing. Additionally, we ask members of Congress to urge the Administration to provide needed clarification that the pharmacy-related flexibilities authorized under the PREP Act will continue to be extended in alignment with other public health emergencies such as Zika virus where the PREP Act declaration remains in place until December 2027 and mpox where the corresponding PREP Act declaration remains in place until 2032 *or at minimum until October 2024.*** Extending the PREP Act flexibilities will help ensure that states are afforded the time to make needed changes to their different laws and regulations. Otherwise, and without such action, pharmacies in most states will again be limited by the labyrinth of outdated states that otherwise limit pharmacists' ability to delegate to pharmacy technicians the technical acts of administering vaccines and testing. (See Appendix 1 detailing the states that do not expressly authorize pharmacists to delegate administration of vaccines and/or administration of testing to pharmacy technicians.)

II. Promoting Access to Pharmacist Care for Seniors in Medicare Part B

[3] https://www.cdc.gov/vaccines/covid-19/retail-pharmacy-program/index.html
[4] NACDS conducted a survey of their chain pharmacy membership via an established workgroup in late March 2022. The workgroup is comprised of more than 60 individuals representing about 30 chain pharmacy organizations. The purpose of the survey was to begin estimating pharmacies' impact in responding to the COVID-19 pandemic in topic areas where data was not readily available. The survey response rate was 40%.
[5] https://pubmed.ncbi.nlm.nih.gov/31036525/

As the most accessible healthcare provider, pharmacists are well-positioned to fill health care workforce shortages. The number of pharmacists in the United States continues to grow, with an excess of around 50,000 pharmacists expected in 2030.[6] Patients are already visiting their pharmacies more than other healthcare providers – with data from a high-risk Medicaid population showing that patients visit pharmacies ten times more frequently than they see other healthcare providers[7] – so it is critical to leverage the untapped potential of pharmacists to provide care for patients, especially in rural areas and medically underserved areas. Multiple studies have also shown that when patients visit pharmacists for chronic disease management, vaccinations, or minor ailments care, they often do so outside of normal clinic hours, and many of these patients do not have a primary care provider.[8,9,10,11,12] Therefore, by promoting models of care that support access to and reimbursement for clinical care services provided by pharmacists, patients – especially those living in areas where there is a shortage of other health care providers – will have increased opportunities and options to access quality healthcare services that best meet their unique needs. NACDS urges the HELP Committee to promote models of care that serve this purpose, supporting pharmacists' ability to provide direct patient care services and corresponding reimbursement.

To this end, NACDS continues to vigorously encourage legislative efforts to promote Medicare beneficiary access to pharmacist-provided clinical care. Unfortunately, pharmacies continue to face numerous payment barriers and gaps in working to serve Medicare patients because there is no reimbursement mechanism or pathway for pharmacies or pharmacists to bill for clinical care services for Medicare Part B patients. In other words, pharmacists providing clinical services – testing, vaccine administration, and antiviral assessments – have limited ability to be paid by Medicare for those services. This puts pharmacists in an untenable position because they are clinically trained to provide these services which are needed by their communities, but they struggle to sustain the provision of care in their communities. In fact, today this gap is continuing to have real-word consequences, as pharmacists were afforded prescribing authority for Paxlovid without a corresponding billing mechanism for patient assessments. The role of pharmacies and pharmacists was, therefore, effectively discouraged from being fully leveraged in resolving the Paxlovid equity gap.

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[6] HRSA. National Center for Health Workforce Analysis. Allied Health Workforce Projections, 2016-2030: Pharmacists. 2016. https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/pharmacists-2016-2030.pdf

[7] Hemberg N, Huggins D, et al. Innovative Community Pharmacy Practice Models in North Carolina. North Carolina Medical Journal. June 2017. http://www.ncmedicaljournal.com/content/78/3/198.full

[8] Klepser ME, Adams AJ, Klepser DG. Antimicrobial Stewardship in Outpatient Settings: Leveraging Innovative Physician-Pharmacist Collaborations to Reduce Antibiotic Resistance. Health Security. 2015;13(3):166-173. doi:10.1089/hs.2014.0083

[9] Klepser DG, Klepser ME, Smith JK, Dering-Anderson AM, Nelson M, Pohren LE. Utilization of influenza and streptococcal pharyngitis point-of-care testing in the community pharmacy practice setting. Research in Social and Administrative Pharmacy. 2018;14(4):356-359. doi:10.1016/j.sapharm.2017.04.012

[10] Klepser DG, Klepser ME, Dering-Anderson AM, Morse JA, Smith JK, Klepser SA. Community pharmacist–physician collaborative streptococcal pharyngitis management program. Journal of the American Pharmacists Association. 2016;56(3):323-329.e1. doi:10.1016/j.japh.2015.11.013

[11] Klepser ME, Klepser DG, Dering-Anderson AM, Morse JA, Smith JK, Klepser SA. Effectiveness of a pharmacist-physician collaborative program to manage influenzalike illness. Journal of the American Pharmacists Association. 2016;56(1):14-21. doi:10.1016/j.japh.2015.11.008

[12] Goad JA, Taitel MS, Fensterheim LE, Cannon AE. Vaccinations administered during off-clinic hours at a national community pharmacy: implications for increasing patient access and convenience. Ann Fam Med. 2013 Sep-Oct;11(5):429-36. doi: 10.1370/afm.1542. https://www.ncbi.nlm.nih.gov/pubmed/24019274

To mitigate these undue barriers, NACDS looks forward to the reintroduction of legislation introduced in the 117th Congress as the "Equitable Community Access to Pharmacist Services Act" (H.R. 7213). This important legislation would create a dependable, direct payment pathway in Medicare allowing pharmacy providers to bill Medicare Part B for clinical care services that are within the pharmacist's scope of practice. By including pharmacists as eligible Medicare Part B providers for certain services, this legislation would help alleviate the noticeable gap in seniors' access to care and strengthen their ability to fill workforce gaps across the healthcare system. **Upon its reintroduction, we would greatly appreciate the leadership and support of the HELP Committee to help ensure this legislation is successful in the 118th Congress.**

III. Protecting the Pharmacy Workforce and Public Access to Pharmacies Through Comprehensive DIR and PBM Reform

Community pharmacies and their staff continue to support and strengthen the nation's healthcare infrastructure and capacity to deliver needed healthcare services to the public across diverse communities. The strength of the pharmacy workforce has continued to be called upon to address the nation's various public health challenges and a healthy pharmacy workforce is essential to promoting better health outcomes, access, and health equity. Consider the role of pharmacies during the COVID-19 pandemic to extend public health as described above.

However, the relentless manipulation of Pharmacy Benefit Managers (PBMs) threatens the ability of the pharmacy workforce to continue filling critical capacity and access gaps across our healthcare system. PBMs continue to inhibit community pharmacies' viability, threatening public access to pharmacies and jeopardizing the pharmacy workforce. As PBMs continue to undermine the ability of pharmacies to serve the nation, they are also driving up drug prices, limiting patient access to certain medications and forcing some pharmacies to close, especially in rural and underserved communities. Consider, that the PBM market is expected to reach $740 billion by 2029,[13] that pharmacy payments to PBMS have increased more than 107,400% in just a decade,[14] and Medicare and patients have overpaid PBMs by $2.6 billion when those payments should have instead yielded cost savings to patients.[15]

Oftentimes, PBMs deflect policy changes by simply leveraging new, aberrant mechanisms to boost revenue at the expense of patients and community pharmacies, in particular. Comprehensive PBM reform that eliminates those divergent opportunities is critically needed and long overdue. Policymakers can take immediate action to help put a stop to the persistent drain on healthcare dollars that PBMs continue to rack up.

NACDS continues to urge state and federal policymakers to take critically important and overdue action to stop harmful PBM practices. (*See Appendix 2 NACDS' Principles for PBM Reform)* Policymakers should hold PBMs accountable and support comprehensive PBM reform to provide reasonable oversight, prohibit

[13] Fortune Business Insights, March 2022
[14] CMS Federal Register, January 2022
[15] USC Schaeffer, May 2022

unfair pricing schemes that drive up healthcare costs, ensure reasonable reimbursements to pharmacies, and preserve robust patient access at neighborhood pharmacies for essential medications and healthcare services to improve overall health outcomes. Implementation of comprehensive PBM reform can also help protect the strength of the nation's pharmacy workforce to respond to Americans' needs.

Congressional action is urgently needed to promote better drug costs for patients, maintain pharmacy access for the public, and ensure a healthy pharmacy workforce. **NACDS urges Congress to support legislation expected to be introduced soon that would require the U.S. Department of Health and Human Services (HHS) to evaluate whether pharmacy measures are relevant to the type of drugs dispensed and managed by the pharmacy and would require plan sponsors to use standardized performance measures that are tethered to star ratings. The new bill would require HHS to reform direct and indirect remuneration (DIR) fees by requiring reasonable pharmacy reimbursement and ensure Part D DIR fees are based on fair and achievable pharmacy performance measures.**

IV. Conclusion

Thank you for considering our recommendations for needed policy changes that better leverage pharmacy providers' ability to help alleviate the workforce shortages and strains across the broader healthcare system. We welcome the ongoing opportunity to work with members of Congress on these and other important matters that impact patient access to care. If we can provide further information to assist the Senate HELP Committee with its work, please do not hesitate to contact Sara Roszak, Senior Vice President, Health and Wellness Strategy and Policy at sroszak@nacds.org or 703-837-4251.

Sincerely,

Steven C. Anderson, FASAE, CAE, IOM
President and Chief Executive Officer
National Association of Chain Drug Stores

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NACDS represents traditional drug stores, supermarkets and mass merchants with pharmacies. Chains operate nearly 40,000 pharmacies, and NACDS' chain member companies include regional chains, with a minimum of four stores, and national companies. Chains employ nearly 3 million individuals, including 155,000 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 21 countries. Please visit NACDS.org.

Appendix 1

Many states still do not expressly authorize pharmacists to delegate administration of vaccines and/or administration of testing to pharmacy technicians.		
	Administering vaccines	**Administering testing**
Alabama		• No express authority to administer testing
Alaska		• No express authority to administer testing
Arizona	• No express authority to administer vaccines	• No express authority to administer testing
California	• No express authority to administer vaccines	• No express authority to administer testing
Colorado		• No express authority to administer testing
Connecticut	• No express authority to administer vaccines	• No express authority to administer testing
District of Columbia	• No express authority to administer vaccines	• No express authority to administer testing
Florida	• Authority to administer adult vaccines only	• No express authority to administer testing
Georgia	• No express authority to administer vaccines	• No express authority to administer testing
Hawaii	• No express authority to administer vaccines	• No express authority to administer testing
Illinois	• No express authority to administer vaccines	• No express authority to administer testing
Indiana		• No express authority to administer testing
Kansas	• No express authority to administer vaccines	• No express authority to administer testing
Kentucky		• No express authority to administer testing
Maine	• No express authority to administer vaccines	• No express authority to administer testing
Maryland	• No express authority to administer vaccines	• No express authority to administer testing
Massachusetts	• No express authority to administer vaccines	• No express authority to administer testing
Michigan	• No express authority to administer vaccines	• No express authority to administer testing
Minnesota	• No express authority to administer vaccines	• No express authority to administer testing

Many states still do not expressly authorize pharmacists to delegate administration of vaccines and/or administration of testing to pharmacy technicians.		
Mississippi	• No express authority to administer vaccines	• No express authority to administer testing
Missouri		• No express authority to administer testing
Montana	• No express authority to administer vaccines	• No express authority to administer testing
Nebraska	• No express authority to administer vaccines	• No express authority to administer testing
Nevada		• No express authority to administer testing
New Hampshire	• Authority to administer COVID vaccines only	• No express authority to administer testing
New Jersey	• No express authority to administer vaccines	• No express authority to administer testing
New Mexico		• No express authority to administer testing
New York	• No express authority to administer vaccines	• No express authority to administer testing
North Carolina	• Authority to administer flu & COVID vaccines only	• No express authority to administer testing
North Dakota		• No express authority to administer testing
Ohio	• No express authority to administer vaccines (note: rulemaking is to allow is pending)	
Oklahoma	• No express authority to administer vaccines	• No express authority to administer testing
Oregon	• No express authority to administer vaccines	• No express authority to administer testing
Pennsylvania	• No express authority to administer vaccines	• No express authority to administer testing
Rhode Island		• No express authority to administer testing
South Carolina	• No express authority to administer vaccines	• No express authority to administer testing
South Dakota	• No express authority to administer vaccines	• No express authority to administer testing
Tennessee		• No express authority to administer testing
Texas	• No express authority to administer vaccines	• No express authority to administer testing
Utah		• No express authority to administer testing

Many states still do not expressly authorize pharmacists to delegate administration of vaccines and/or administration of testing to pharmacy technicians.		
Vermont	• No express authority to administer vaccines	• No express authority to administer testing
Washington		• No express authority to administer testing
West Virginia	• No express authority to administer vaccines (note: legislation to allow pending Gov's signature)	• No express authority to administer testing
Wisconsin		• No express authority to administer testing
Wyoming	• Authority to administer vaccines only 13 yrs + only	• No express authority to administer testing

Appendix 2

STOP PHARMACEUTICAL BENEFIT MANIPULATION
PRINCIPLES FOR PBM REFORM

I. Help to Preserve Patient Access to Pharmacies by Addressing PBMs' Retroactive Pharmacy Fees

Retroactive DIR Fees/Claw backs – **Retroactive DIR Fees/Claw backs** – Pharmacy access can be undermined when health plans and their middlemen, PBMs, arbitrarily "claw back" fees retroactively from pharmacies weeks or months after a claim has been adjudicated/processed. This manipulation of pharmacy reimbursement may diminish access to care *(e.g., pharmacies being forced to close their doors or pare back hours and healthcare services)* when PBMs are unpredictable and not transparent, and when payment falls below a pharmacy's costs to acquire and dispense prescription drugs. Policymakers should prohibit payers or PBMs from retroactively reducing and/or denying a processed pharmacy drug claim payment, and obligate them to offer predictable and transparent pharmacy reimbursement to better protect pharmacies as viable and reliable access points for care.

II. Provide Fair and Adequate Payment for Pharmacy Patient Care Services

Reasonable Reimbursement & Rate Floor – Pharmacy access remains at risk when PBMs reimburse pharmacies below the cost to acquire and dispense prescription drugs. Pharmacy reimbursement that falls below the costs to acquire and dispense prescription drugs threatens future sustainability for pharmacies to provide valuable medication and pharmacy care services to communities. To help maintain robust public access to pharmacies, policymakers should adopt a reimbursement rate floor that requires PBMs to use comprehensive reimbursement models that are no less than the true cost to purchase and dispense prescription drugs.

Standardized Performance Measures – A crucial part of comprehensive DIR fee reform is advancing pharmacy quality that improves outcomes for beneficiaries and drives value in care – which are essential to controlling costs in the healthcare system. Arbitrary performance measures developed by PBMs assess the performance of the pharmacy without pharmacies' input, and they create a moving target for pharmacies to show value and improve health outcomes. Measures vary across the various plans and dictate DIR fees (or claw backs at the state level) imposed on pharmacies, as well as help create substantial system dysfunction and unnecessary spending in the Part D program. Policymakers should standardize PBMs' performance measures for pharmacies to help set achievable goals for pharmacies before signing a contract, and to promote harmonization in the healthcare system and improvements in health outcomes.

III. Protect Patient Choice of Pharmacies

Specialty – Some PBMs require patients with rare and/or complex diseases to obtain medications deemed "specialty drugs" from designated "specialty pharmacies" or mail-order pharmacies. This impedes patients' access to their convenient local pharmacies where specialty drugs are filled as well. Prescription drugs should not be classified as "specialty drugs" based solely on the cost of the drug or other criteria used to limit patient access and choice—instead, definitions should focus on clinical aspects such as requiring intensive clinical monitoring. Policymakers should establish appropriate standards for defining and categorizing specialty drugs to ensure comprehensive and pragmatic patient care and access. Policymakers should prohibit PBMs from steering patients to only specialty pharmacies, including those owned by the PBMs, for their prescription needs.

Mail Order – Medication access and care can be weakened when PBMs manipulate the system by requiring patients to use mail-order pharmacies only. Some plans impose penalties such as higher copays or other financial disincentives for choosing a retail pharmacy instead of a mail-order pharmacy which is often owned by the PBM. Policymakers should support patient choice and access by enacting laws to prohibit PBMs from requiring or steering patients to use mail-order pharmacies.

Any Willing Pharmacy - Due to PBMs' network and contract barriers, pharmacies willing and ready to serve patients may be ineligible to provide important pharmacy services, and patients may experience unnecessary delays and interruptions in patient care. Patients should have the choice and flexibility to utilize the pharmacy that best meets their healthcare needs. Policymakers should require PBMs and plans to include any pharmacies in their networks if the pharmacy is willing to accept the terms and conditions established by the PBM. This will help to maximize patient outcomes and cost savings.

IV. Enforce Laws to Stop PBM Manipulation and Protect Pharmacies and Patients

Audits – PBMs routinely conduct audits to monitor a pharmacy's performance and reverse or claw back pharmacy payments when there are alleged issues with a particular pharmacy claim. PBM audits interrupt the pharmacy workflow, can extend wait times, and detract attention from the quality of care patients receive. Policymakers should support fair pharmacy audit practices to ensure timely patient care delivery at community pharmacies and bring efficiency, transparency, and standardization to the PBM audit process.

Oversight Authority – There are growing concerns that pro-patient, pro-pharmacy public policy successes might be undercut if PBMs fail to comply with new laws and regulations – and/or if states fail to fully enforce them. Such failure could significantly impact pharmacy reimbursement and overall patient access. Policymakers should establish and enforce laws already on the books to regulate harmful PBM reimbursement practices that may harm patients and the healthcare system as we know it, especially at the pharmacy counter, and empower state regulators to do the same to enforce PBM transparency and fair and adequate pharmacy reimbursement.