



NATIONAL ASSOCIATION OF
CHAIN DRUG STORES

Statement
Of
The National Association of Chain Drug Stores
For
United States House of Representatives
Committee on Ways and Means
On
Department of Health and
Human Services' Fiscal Year 2018 Budget Request

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Introduction

The National Association of Chain Drug Stores (NACDS) thanks Chairman Brady, Ranking Member Neal, and the Members of the Committee on Ways and Means for the opportunity to submit a statement for the hearing on “Department of Health and Human Services’ (HHS) Fiscal Year 2018 Budget Request.”

NACDS and the chain pharmacy industry are committed to partnering with Congress, HHS, patients, and other healthcare providers to improve the quality and affordability of health care services. NACDS represents traditional drug stores, supermarkets, and mass merchants with pharmacies. Chains operate 40,000 pharmacies, and NACDS’ more than 100 chain member companies include regional chains, with a minimum of four stores, and national companies. Chains employ more than 3.2 million individuals, including 178,000 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 850 supplier partners and over 60 international members representing 21 countries. Please visit nacds.org.

As the face of neighborhood health care, chain pharmacies and pharmacists work on a daily basis to provide the best possible care and the greatest value to their patients with respect to access to critical medications and pharmacy services. We help to assure that patients are able to access their medications and take them properly. NACDS believes retail pharmacists can play a vital role in improving and sustaining the Medicare and Medicaid programs by greatly improving beneficiary health while reducing program spending including better health through improved medication adherence, and through improving access for underserved beneficiaries with chronic conditions in the Medicare Part B Program. As this Committee examines the HHS budget request for 2018 we offer the following for its consideration.

Pharmacist Provider Status

As the U.S. healthcare system continues to evolve, a prevailing issue will be the adequacy of access to affordable, quality healthcare. The national physician shortage coupled with the evolution of health insurance coverage will have serious implications for the nation’s healthcare system. Access, quality, cost, and efficiency in healthcare are all critical factors—especially to the medically underserved. The medically-underserved population includes 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.

Pharmacists play an increasingly important role in the delivery of services, including key roles in new models of care beyond the traditional fee-for-service structure. In addition to medication adherence services such as medication therapy management (MTM), pharmacists are capable of providing many other cost-saving services, subject to state scope of practice laws. Examples include access to health tests, helping to manage chronic conditions such as diabetes and heart disease, and expanded immunization services. However, the lack of pharmacist recognition as a provider by third-party payors, including Medicare and Medicaid, limits the number and types of services pharmacists can provide, even though they are fully qualified to do so. Retail pharmacies are often the most readily accessible healthcare provider. Research shows that nearly all Americans (91 percent) live within five miles of a retail pharmacy. Such access is vital in reaching the medically underserved.

We urge you to increase access to much-needed services for underserved Medicare beneficiaries by supporting 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 those 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 improved healthcare quality, all of which are vital to ensuring a strong Medicare program.

Value of Medication Adherence and MTM

Medications are the primary intervention to treat chronic disease and are involved in 80% of all treatment regimens.¹ Medicare beneficiaries with multiple chronic illnesses see an average of 13 different physicians, have 50 different prescriptions filled per year, account for 76% of all hospital admissions, and are 100 times more likely to have a preventable hospitalization.² Yet medication management services are poorly integrated into existing healthcare systems. Poor medication adherence alone costs the nation approximately \$290 billion annually—13% of total healthcare expenditures—and results in avoidable and costly health complications.³ Thus, given the importance of medications in achieving patient care outcomes and lowering overall healthcare costs, it is critical that policies are implemented to encourage greater care integration across the healthcare continuum and promote financial accountability for safe and appropriate medication use.

¹ <http://www.pcpcc.org/sites/default/files/media/medmanagement.pdf>

² Ibid.

³ “Thinking Outside the Pillbox: A System-wide Approach to Improving Patient Medication Adherence for Chronic Disease;” New England Healthcare Institute, Cambridge, MA, 2009.

A growing body of evidence suggests that when physicians, nurses, pharmacists, and other healthcare professionals work collaboratively, better health outcomes are achieved. Pharmacies in particular provide access to highly-trained and highly-trusted health professionals. The unique reach and access points of pharmacy provide a means of continuous care and oversight between scheduled visits. Medication related services provided by community pharmacists improve patient care, enhance communication between providers and patients, improve collaboration among providers, optimize medication use for improved patient outcomes, contribute to medication error prevention, assist with hospital readmission cost avoidance goals, and enable patients to be more actively involved in medication self-management. Examples of the value of these services include:

- A 2013 CMS report found that Medicare Part D MTM programs consistently and substantially improved medication adherence for beneficiaries with chronic diseases. This included savings of nearly \$400 to \$525 in lower overall hospitalization costs.⁴
- A study of published research on medication adherence conducted by Avalere Health in 2013 concluded that the evidence largely shows that patients who are adherent to their medications have more favorable health outcomes such as reduced mortality and use fewer healthcare services, especially hospital readmissions and ER visits. Such outcomes lead to less expensive healthcare costs, relative to non-adherent patients.⁵
- How and where MTM services are provided also impact its effectiveness. A study published in the January 2012 edition of *Health Affairs* found that a pharmacy-based intervention program increased adherence for patients with diabetes and that the benefits were greater for those who received counseling in a retail, face-to-face setting as opposed to a phone call from a mail-order pharmacist. The interventions were cost-effective, with a return on investment of approximately \$3 for every \$1 spent. These findings highlight the central role that pharmacists can play in promoting the appropriate initiation of and adherence to therapy for chronic diseases.⁶

⁴ “Medication Therapy Management in Chronically Ill Populations: Final Report;” Centers for Medicare and Medicaid Services (CMS); August 2013
(http://innovation.cms.gov/Files/reports/MTM_Final_Report.pdf).

⁵ “The Role of Medication Adherence in the U.S. Healthcare System;” Avalere Health; June 2013
(http://www.avalerehealth.net/research/docs/20130612_NACDS_Medication_Adherence.pdf).

⁶ “An Integrated Pharmacy-Based Program Improved Medication Prescription and Adherence Rates in Diabetes Patients;” *Health Affairs*, January 2012 (<http://content.healthaffairs.org/content/31/1/120.full>).

Despite the proven value of medication adherence and MTM, the Medicare Part D MTM Program historically has seen low enrollment and utilization rates. Over the years, CMS has made programmatic changes they believed would increase eligibility and enrollment. However, these changes have not led to increased MTM eligibility and utilization. In 2012, there were approximately 27.2 million people enrolled in either a MA-PD (9.9 million) or a PDP (17.3 million). Of the more than 27 million beneficiaries, only 3.1 million were enrolled in an MTM program (11.4%). These figures fall well short of the CMS estimate that approximately 25% of the beneficiaries would be eligible for MTM.

NACDS has long been supportive of exploring new and innovative approaches to improve the Part D MTM program. One of the approaches we believe can be successful is the Enhanced MTM Model pilot being conducted by the Center for Medicare and Medicaid Innovation. This pilot gives Part D plans the opportunity to utilize new and innovative approaches to MTM, such as more efficient outreach and targeting strategies and tailoring the level of services to the beneficiary's needs. NACDS believes the Enhanced MTM Pilot program presents an opportunity to create better alignment of program incentives and has the potential to lead to improved access to MTM services for beneficiaries and greater medication adherence.

To ensure the success of the Enhanced MTM model, NACDS believes retail pharmacists must be included in the Enhanced Model Pilot programs. As preparations are made for the second year of the pilot, ways to maximize utilization of retail community pharmacists and their unique ability to improve medication adherence should be considered.

Transparency in Use of Fees in the Part D Program

NACDS supports transparency between Medicare Part D plans and retail pharmacies in the use of direct and indirect remuneration (DIR) fees, post-adjudication fees, and quality and performance-based network fees by prescription drug plans in the Medicare program.

The Centers for Medicare and Medicaid Services (CMS) recently released a fact sheet on the use and impact of DIR fees by plan sponsors in the Medicare Part D program. The fact sheet reported that the use of DIR by Part D sponsors has been "growing significantly in recent years" and has led to an increase in beneficiary cost-sharing and an increase in subsidy payments made by Medicare.

The increasing use of fees in the Part D program is also a growing problem for retail pharmacies. Retail pharmacies have to conduct business in an environment where they are unsure if a reimbursement they received is the "final reimbursement" or if a fee will be applied at some future point. This may lead some pharmacies to question their ability to continue to participate in certain Part D networks, which ultimately endangers beneficiary access to prescription drugs.

The Social Security Act clearly gives CMS the authority to regulate the use of fees in the Medicare program. We believe that CMS should issue guidance clarifying the appropriate use, submission, and approximation of fees in the Medicare program, including in quality and performance-based payment structures. Such guidance should also clarify the components of DIR fees, such as direct product and service reimbursement, as well as quality and performance-based program reimbursement. DIR fees must be separately tracked and reported by plans to ensure their transparent use. In seeking guidance, NACDS is not asking CMS to regulate the types of fees plans can use, how or when plans can use fees, or the dollar amounts for such fees. Rather, we are seeking guidance that would require clarity and consistency in how fees are used and applied.

We urge Congress to advise CMS on the importance of issuing guidance to improve transparency between plans and pharmacies in prescription drug reimbursement structures. Specifically, we urge Congress to advise CMS on the importance of issuing guidance to improve consistency in disclosures to pharmacies on how fees are defined, how they will be calculated, the timing for fee collection, how fees will be reported to pharmacies at the claim level detail (thus allowing reconciliation of reimbursement), and the parameters for pharmacies to “earn” back the fee post reconciliation. Increased transparency in the Medicare program will benefit CMS, participating pharmacies, and beneficiaries alike.

Lowering Prescription Drug Costs

NACDS shares the goal of reducing the cost of prescription drugs and believes community pharmacies are ideally situated to help through services designed to improve medication adherence and the promotion of generic drugs as safe, cost-effective alternatives. Retail community pharmacies are the closest healthcare providers to patients with respect to prescription medications. A March 2017 survey of registered voters conducted by *Morning Consult* and commissioned by NACDS found that eight-in-ten respondents believe that pharmacists are credible sources of information about how to save money on prescription drugs—the highest rating of healthcare professionals tested. In addition to the ability of improved adherence and increased transparency (as detailed above) to impact drug costs, NACDS recommends other beneficial changes, such as:

- **Generic Utilization:** Pharmacies have long promoted generic drugs as safe, cost-effective alternatives. Increasing the use of generic drugs is one of the most effective ways to reduce prescription costs. For every one percent increase in generic utilization, the Medicaid program could save \$558 million. For example, if all other states could match the generic utilization rate of Hawaii (82.7%), the Medicaid program could save \$6.56 billion annually. Community pharmacies have a higher generic dispensing rate (71%) than any other practice setting.

- **Risk Evaluation and Mitigation Strategy (REMS)**: The REMS program requires manufacturers to ensure the benefits of a drug or biological product outweigh its risks. However, some manufacturers unfortunately are using the REMS Elements to Assure Safe Use (ETASU) requirements to prevent competition for products. Specifically, certain companies are employing restricted distribution networks to deny manufacturers of generics and biosimilars access to product samples they need to compete. An analysis by Matrix Global Advisors found that utilizing these networks to prevent generic competition costs the health care system \$5.4 billion annually, including \$1.8 billion to the federal government. Also, it could result in approximately \$140 million in lost savings for every \$1 billion in biologics sales. NACDS supports closing loopholes to boost generic-medication access and lower costs.
- **Biosimilars**: NACDS supports policies that promote confidence in and encourage increased use of more cost-effective biosimilar medications. FDA should adopt naming policies for biosimilar drugs and biologics that are consistent with the naming conventions for brand and generic small molecule drugs, that is assigning the same individual nonproprietary name (“INN”) to a biosimilar drug product that is assigned to the reference biologic drug counterpart. Special naming policies for biosimilar drugs (and other biological drugs) that deviate from the traditional naming scheme can undermine prescriber and patient confidence in biosimilar products, thereby discouraging their use and jeopardizing the savings that could otherwise be achieved through increased use of more cost-effective biosimilar products. Without robust generic competition, brand biological products could cost the United States healthcare system \$120 billion by 2024, according to projections from Express Scripts. However, a 2014 report published by the Rand Corporation found that the use of biosimilars could provide a \$44.2 billion reduction in direct spending on biologic medications over the next ten years.

Conclusion

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