By electronic submission via WMOpioidSubmissions@mail.house.gov

March 13, 2018

The Honorable Peter Roskam
Chairman
Subcommittee on Health
Committee on Ways and Means
1102 Longworth House Office Building
Washington, D.C. 20515

The Honorable Sander Levin
Ranking Member
Subcommittee on Health
Committee on Ways and Means
1102 Longworth House Office Building
Washington, D.C. 20515

Re: Subcommittee on Health, Committee on Ways and Means’ Questions on Efforts to Combat the Opioid Crisis

Dear Chairman Roskam and Ranking Member Levin:

Thank you for the opportunity to submit our comments to the subcommittee regarding its ongoing efforts to respond to the opioid crisis. The National Community Pharmacists Association (NCPA) represents the interests of America’s community pharmacists, including the owners of more than 22,000 independent community pharmacies. Independent community pharmacies play a critical role in ensuring patients have immediate access to medications, including medications that help with chronic pain. In this way, our members have extensive knowledge and experience in caring for patients with chronic pain as well as those in their communities with substance use disorders.

NCPA is committed to working collaboratively with Congress, the Administration, and other stakeholders in adopting viable solutions to prevent drug abuse and diversion. We believe there are efforts in the marketplace that are currently making a difference in the battle against opioid abuse that could help inform Congress on viable options for the development of future legislation. NCPA will address many of these efforts below through answering the subcommittee’s questions.

Overprescribing/Data Tracking

1. Perverse Incentives in Medicare: The Committee seeks input on perverse incentives within Medicare that spur overprescribing of opioids across all settings of care. The Committee seeks input on best practices and policies that would modify prescribing patterns to prevent opioid abuse and misuse and reduce the use of opioids in emergency departments and other outpatient settings.
Currently, there are promising policies that would have a positive impact on mitigating or preventing abuse, without compromising legitimate patient access to needed pain medications, including establishing limits on maximum day supply for certain controlled substances. In fact, CMS’ proposed 2019 Call Letter for Part D plans included a 7-day limit for opioids for the treatment of acute pain without a daily dose maximum. NCPA supports this limitation but suggests several exceptions that CMS and Congress should consider.

First, it is important to note that federal or state-based policies to limit initial fills of opioids should be standardized for consistent implementation, taking into consideration certain patient populations such as hospice patients and those residing in skilled nursing facilities. Many of the limits in place already via state law or imposed by Pharmacy Benefit Managers (PBMs) are for 7 days. Second, any policy to limit initial fills of opioids should include a list of circumstances in which a prescriber be allowed to deviate from the mandate. In the Long Term Care (LTC) setting, limiting to a 7 or fewer day supply has proved to be a problem in states where pharmacy care is provided under a single contract with a pharmacy. Limiting the number of days for LTC patients on opioids can cause issues with patients receiving their medications on time, especially if the pharmacy must wait for an actual prescription from the physician/prescriber.

Aside from limitations on day supply, another solution is to expand electronic prescribing for controlled substances. NCPA supports expanding electronic prescribing of controlled substances where feasible.

2. Second-Fill Limits: The Committee seeks input on issues that may arise from limiting second-fill opioid prescriptions for acute pain.

As NCPA suggested in the first question, limits to days supply without certain exceptions may create an access issue to patients who are in legitimate need of their medications. Regarding second-fill limits, day supply or cumulative opioid safety edits at point-of-sale based on dosage levels may be considered.

3. Tools to Prevent Opioid Abuse: The Committee seek input on tools currently unavailable in the Medicare Program that could be used to curb opioid abuse and dependence.

Another tool that can be used to curb opioid abuse and dependence and impact “doctor shopping” and/or “pharmacy shopping” is a lock-in or drug management program. CMS is currently working on implementing such a program for Medicare Part D beneficiaries. NCPA would like to voice support for CMS’ conservative and uniform approach to implement the Comprehensive Addiction and Recovery Act of 2016 provisions in Medicare Part D. NCPA supports the frequently abused drug definition and urges CMS to finalize the proposal to designate opioids, except buprenorphine, for medication-assisted treatment (MAT) and injectables as frequently abused drugs. NCPA offers the following comments regarding any lock-in programs that may be implemented.
Lock-in programs must require a lock-in of both a prescriber and a pharmacy. The prescription drug abuse epidemic is complex and wide-ranging in nature and at the forefront of prevention efforts must be a focus on reducing the inappropriate prescribing or the overprescribing of controlled substances, as well as the prohibition of “doctor shopping.” It should be noted that similar initiatives in existing state Medicaid programs virtually always include the “lock-in” of both prescriber and pharmacy in recognition of the fact that a coordinated approach to patient care is essential to the success of any such program.

NCPA supports the exemption of hospice, cancer, and long-term care (“LTC”) patients from drug management programs. We ask that in addition to these exempted individuals, CMS also exempt residents of any facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy.

Our members are concerned that pharmacy lock-ins could be utilized to steer patients unknowingly to a pharmacy for all their drug needs, not just opioids. It is vital that any notices sent to beneficiaries regarding lock-ins do not simply offer beneficiaries a plan sponsor/PBM created list of prescribers(s) and pharmacy(ies) from which to choose. The beneficiary must be allowed to write in their prescriber and pharmacy of choice and not be limited to a list provided by the plan sponsor/PBM. The beneficiary must be able to submit pharmacy preference at any time.

With the Medicare Part D lock-in program NCPA is concerned that there is an incentive for plan sponsors and/or their PBM to simply “assign” beneficiaries to pharmacies in which they have a commercial or financial interest. This is already occurring in the Medicare Part D program where independent community pharmacies are being excluded from participation in certain pharmacy networks by plan sponsors and/or their PBM.

Since preference only is to be considered by plans/PBMs when delegating prescriber/pharmacy for purposes of the Part D lock-in program, there must be protections in place for continual access. Our members have relayed to us that a very common scenario with lock-in programs is when the lock-in pharmacy is closed, the patient has no alternative to obtain their medication. In these instances, we have learned of unfortunate hospital admissions. NCPA therefore recommends that there be a back-up plan in place for a beneficiary to obtain medications when their lock-in pharmacy is closed.

We urge this Committee to remain vigilant in ensuring appropriate patient access. We strongly recommend that plans/PBMs be required to report percentage of times when beneficiary preference is/is not considered and to track which pharmacy the plan/PBM utilizes to override patient preference.

Another tool to prevent opioid abuse is Screening, Brief, Intervention and Referral to Treatment (SBIRT) activities. NCPA supports the expansion of the pharmacists’ ability to identify individuals with substance use disorders in the Medicare Program and should be allowed to participate in SBIRT activities. Medicaid programs have already taken this important step. For example, Virginia
Medicaid’s Addiction Recovery Treatment Services (“ARTS”) is a transformative new benefit being offered for Medicaid patients. The benefit includes coverage for SBIRT provided by pharmacies. The purpose of SBIRT is to identify individuals who may have alcohol and/or other substance use problems. Following screening, a brief intervention is provided to educate individuals about their use, alert them to possible consequences and, if needed, begin to motivate them to take steps to change their behavior.

4. **Medication Therapy Management (MTM): The Committee seeks input on the value of adding beneficiaries at-risk of opioid use disorders to the list of targeted beneficiaries under the MTM program.**

NCPA believes that prevention is the best medicine, and whether it’s catching a medication error before it leads to a hospitalization or practicing effective chronic disease management, Medication Therapy Management (MTM) services present an opportunity to improve patient care while providing greater efficiencies within the healthcare system.¹ Over the years NCPA has championed for incremental changes to bring greater visibility to the MTM program, such as including it in the *Medicare & You* handbook and providing eligibility information on Medicare Plan Finder.

Recently, the Center for Medicare & Medicaid Innovation (CMMI) has recognized the importance of aligned incentives across the Medicare program to better coordinate chronic care. In doing so, CMMI has supported a demonstration model to examine enhanced changes to the MTM program within Part D. These changes are intended to maximize the value of MTM services in improving health outcomes by better aligning the financial interests of standalone PDP sponsors and creating incentives for more flexibility and innovation in designing and delivering the MTM benefit.

Increasing beneficiary access to MTM services to beneficiaries who are at-risk for opioid abuse will help achieve the triple aim of better care for patients, improved health in our communities, and reduced costs throughout the healthcare system. Further, NCPA strongly believes that more seniors, including those with chronic pain, should qualify for MTM services, as these pharmacists provided services have been shown to produce significant long-term benefits.

NCPA also contends that MTM delivered face-to-face or in an interactive telehealth method with a trusted pharmacist will yield enhanced patient understanding of their medications, improved adherence, and lower costs.

5. **Electronic Prior Authorization: The Committee seeks input on the value of standardizing the electronic prior authorization process and other improvements that could be made to improve coordination and prevent abuse.**

¹ The Community Pharmacy Enhanced Services Network (“CPESN”) is a network of clinical pharmacies across the country that seeks to empower community-based pharmacies to improve their portfolio of medication optimization activities and services, including the usage of MTM and medication synchronization services.
NCPA highlights that while there are benefits associated with electronic prior authorization, certain members of the supply chain community may attempt to use the electronic system to bypass some health care providers, such as pharmacists, from the process. NCPA is concerned that this could lead to downstream effects of rerouting the prescription altogether to be filled at a mail order facility, or other pharmacy in which a PBM has an ownership interest. NCPA urges Congress to remain vigilant in ensuring appropriate patient access to their pharmacy of choice.

6. Prescription Drug Monitoring Program (PDMPs): Currently, CMS does not have access to state PDMPs. The Committee seeks input regarding state PDMP data-sharing with CMS and other health care entities. Specifically, the Committee seeks information on potential barriers to implementation.

NCPA supports the enhancement of Prescription Drug Monitoring Programs (PDMPs) by increasing operability of robust electronic databases to track all prescriptions for controlled substances. National standards to provide timely, reliable information at point of prescribing and dispensing should also be leveraged. NCPA highlights, however, that the application of certain utilization management tools to identify patterns of abuse or overutilization at the patient and pharmacy level comes with its limitations. Therefore, NCPA recommends a cautious approach when potentially expanding data-sharing beyond state PDMP’s, the clear majority of which are already interconnected.

**Communication and Education:**

2. Prescriber Notification and Education: The Committee seeks input on the best methods for provider education on the adverse effects of prolonged opioid use, clinical guidelines for alternative pain treatments, and clinical guidelines for opioid prescribing. The Committee also seeks input on effective ways to notify providers who prescribe such medicines more than their peers.

NCPA supports an increase in healthcare provider education. NCPA believes that increasing health care provider education should be a priority. For any required prescriber education program, a verification infrastructure with minimal administrative burden should be considered. For example, automatic checks related to prescriber status on completion of educational requirements prior to transmission of impacted prescriptions and mechanisms for pharmacists to be informed about the requirements of the program must be considered. We would offer the Transmucosal Immediate Release Fentanyl (TIRF) REMS program as an example. Overall, the pharmacist’s role is to provide continuity of education and monitoring.

**Treatment**

1. Opioid Treatment Programs (OTPs) and Medication Assisted Treatment (MAT): The Committee seeks input from providers around best practices for identification and referral to OTPs, as well as how an OTP benefit could be integrated into the Medicare fee-for-service program –
whether through bundled payments or otherwise. The Committee seems input on the types of providers that are involved in the delivery of MAT, best practices to promote coordinated and managed care, and current reimbursement challenges providers face through Medicaid and commercial plans.

NCPA supports an increase in the use and access to Medication Assisted Treatment. Further, NCPA supports expanding practitioner eligibility for DATA waivers, including pharmacists. Advancement of the pharmacist’s role in MAT for opioid use disorders can help improve access and outcomes while reducing the risk of relapse. Pharmacists are already partnering with physicians to provide MAT. When such relationships form, pharmacists have taken the lead in developing treatment plans, communicating with patients, improving adherence, monitoring patients, identifying treatment options, and performing tasks to alleviate the physician’s burden. Thus, pharmacists have both the knowledge and experience to provide MAT, but treatment is limited because of barriers.

Conclusion

NCPA greatly appreciates the opportunity to share with you our comments and suggestions. NCPA stands ready to work with all stakeholders to stem the growing tide of opioid abuse and overdose.

Sincerely,

Karry K. La Violette
Vice President, Government Affairs and Advocacy

Ronna B. Hauser, Pharm.D.
Vice President, Pharmacy Affairs

cc: Chairman Kevin Brady, Committee on Ways and Means
    Ranking Member Richard Neal, Committee on Ways and Means