

November 4, 2022

Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

Subject: Make Your Voice Heard Request for Information
To Whom it May Concern,

We thank you for the opportunity to provide evidence for the Request for Information: Make your Voice Heard on efforts to increase health equity and access to care. The National Community Pharmacists Association (NCPA) represents over 19,400 independent pharmacies across the country. Independent pharmacies provide services beyond dispensing, such as immunizations, point-of-care testing, lifestyle and weight management, chronic disease management, diabetes prevention and education, and contraceptive prescribing. Pharmacists are widely accessible healthcare professionals ready and trusted by the public to provide care. Pharmacy benefit manager (PBM) anticompetitive practices and patient steering to affiliate pharmacies are leading to a decreased access to care.

Inadequate or restricted pharmacy networks offered by third-party payers create challenges to accessing prescription drugs and pharmacy services. Payer networks that include independent pharmacies, whether in health insurance marketplace plans, Medicaid, Medicare Part D, or Medicare Advantage, increase patient access to pharmacy care as well as pharmacy services.

In order to identify inadequate networks caused by actual pharmacy shortage, NCPA has partnered with the University of Southern California to create a tool to determine pharmacy shortage areas at the neighborhood level.¹ Payer networks may create their own shortage areas by exclusion of a pharmacy that could be included in said network, such as an independent pharmacy. Pharmacy shortage areas, under our definition, also created by total absence of pharmacies within a census tract. We have identified that **25% of the U.S. population, or 81,203,948 people, live in a pharmacy shortage area in either an urban, suburban, or rural area.**² Our research found that 27.5% of urban census tracts, 22.7% of suburban census tracts, and 22.6% of rural census tracts are pharmacy shortage areas where there is no pharmacy within 0.5 miles (urban tracts), 2 miles (suburban tracts), or 5 miles (rural tracts) of the neighborhood, or block group/census tract*.² NCPA and USC have verified these thresholds through comparison with

*A 'census tract' is generally regarded as a small geographic entity or 'neighborhood' within a county, comprised of roughly 2,500 to 8,000 residents with boundaries that follows visible features like roads or rivers.

1. <https://ncpa.org/newsroom/news-releases/2022/10/24/ncpa-collaborates-usc-groundbreaking-pharmacy-mapping-project>
2. See the USC-NCPA Pharmacy Initiative's Pharmacy Shortage Areas tool.

shortage areas are also designated as medically underserved areas (MUAs) and these areas recent peer-reviewed studies.³ Additionally, findings showed that only one third of pharmacy disproportionately affect low-income (36.7% of pharmacy shortage areas), Medicaid (33.2% of pharmacy shortage areas), and black (37.1% of pharmacy shortage areas) populations.² Previous peer-reviewed studies on pharmacy access have similarly demonstrated this disproportionate division of pharmacy shortage areas.⁴

Our tool not only identifies if the area is a pharmacy shortage area but shows statistics about the area such as racial/ethnic composition, percentage of urban/suburban/rural neighborhoods, and which pharmacy shortage areas are newly created based on pharmacy closures. **Our work shows that pharmacy shortage areas are created, it is likely due to an independent pharmacy closing. Payers that exclude independent pharmacies limit the effect of an oasis, and payers that delay or slow walk credentialing have the same effect.** To discuss these findings in detail or view the tool in detail, please contact me at Jessica.satterfield@ncpa.org or media@ncpa.org.

To address pharmacy access challenges, we encourage CMS to consider updating current pharmacy access standards used in Medicare Part D and in marketplace plans. Current pharmacy access standards used in Medicare Part D show a dramatically lower number of lives living in pharmacy shortage areas compared to the work that the USC-NCPA Pharmacy Access Initiative has shown in its pharmacy shortage areas identification tool.

During the COVID-19 PHE, flexibilities issued to pharmacists, pharmacy interns, and pharmacy technicians increased uptake of immunizations. However, lack of provider status prevented pharmacists from maximizing their test to treat efforts. Under PHE, CMS may consider direction to Medicare Part D plans to pay pharmacists a dispensing fee for oral antivirals treatment.

Prior to the COVID-19 PHE, the impact of pharmacist-given immunizations was estimated but relatively unknown. Community pharmacies administered influenza vaccines the most, but studies also showed that herpes zoster, pneumococcal, Tdap, hepatitis A and B, MMR, varicella, meningococcal, and human papillomavirus vaccines were prevalent.⁵ CMS waivers allowed for increase in immunizations in skilled nursing facilities (SNFs) via waived enrollment fee and ability for direct billing to Medicare Part B.

3. Guadamuz JS, Alexander GC, Zenk SN, Kanter GP, Wilder JR, Qato DM. Access to pharmacies and pharmacy services in New York City, Los Angeles, Chicago, and Houston, 2015-2020. *J Am Pharm Assoc* (2003). 2021 Nov-Dec;61(6):e32-e41. doi: 10.1016/j.japh.2021.07.009. Epub 2021 Jul 19. PMID: 34366287.

4. Guadamuz JS, Wilder JR, Mouslim MC, Zenk SN, Alexander GC, Qato DM. Fewer Pharmacies In Black And Hispanic/Latino Neighborhoods Compared With White Or Diverse Neighborhoods, 2007-15. *Health Aff (Millwood)*. 2021 May;40(5):802-811. doi: 10.1377/hlthaff.2020.01699. PMID: 33939507.

5. Baroy J, Chung D, Frisch R, Apgar D, Slack MK. The impact of pharmacist immunization programs on adult immunization rates: A systematic review and meta-analysis. *J Am Pharm Assoc* (2003). 2016 Jul-Aug;56(4):418-26. doi: 10.1016/j.japh.2016.03.006. PMID: 27450138.

Pharmacists have been able to provide point-of-care testing after obtaining a Clinical

Laboratory Improvement Amendments (CLIA) waiver to test for influenza, Strep A, HIV, Hepatitis C, as well as monitor lipids, A1c, and INR. PREP Act flexibilities authorized licensed pharmacists to order and administer FDA-authorized COVID-19 tests, including serology.⁶ These flexibilities increased the number of sites offering COVID-19 testing dramatically by eliminating financial and regulatory barriers. In turn, patient awareness of pharmacy services increased during the COVID-19 pandemic.⁷

Adaptation and maintaining of PREP Act flexibilities increases patient access to immunizations, point of care testing, and enhanced pharmacy services. To increase care in SNFs, maintaining of SNF immunization flexibilities and waived enrollment fees would encourage further pharmacist uptake. We thank CMS for the opportunity to provide information and welcome any opportunities to collaborate on these efforts in the future. Please do not hesitate to contact me at Jessica.satterfield@ncpa.org with any questions or concerns.

Sincerely,

A handwritten signature in cursive script that reads "Jessica Satterfield".

Jessica Satterfield

Associate Director, Policy and Pharmacy Affairs
National Community Pharmacists Association

6. <https://cca.hawaii.gov/pvl/files/2020/10/PHadministeringCOVIDtest202101.pdf>

7. Klepser DG, Klepser NS, Adams JL, Adams AJ, Klepser ME. The impact of the COVID-19 pandemic on addressing common barriers to pharmacy-based point-of-care testing. *Expert Rev Mol Diagn.* 2021 Aug;21(8):751-755. doi: 10.1080/14737159.2021.1944105. Epub 2021 Jun 23. PMID: 34130575.

