

Community Pharmacy Recommendations for Health Care Reform - April 2009

The National Community Pharmacists Association (NCPA) is dedicated to health care reforms that improve the quality of health for patients but also reduce overall health care expenditures. Our members represent the owners and operators of more than 23,000 independent community pharmacies.

Enhanced utilization by the health care system of patient care services provided by pharmacists can help reduce the estimated \$177.4 billion spent each year to treat hospital admissions, physician visits, and other health care expenditures resulting from inappropriate medication use. In fact, for every dollar spent on prescription medications, at least one dollar is also spent to treat mostly-preventable adverse drug events from prescription drugs.¹ Pharmacists can often prevent potential adverse drug events and encourage higher medication adherence rates by working with patients and physicians to promote the most appropriate, cost-effective medication regimen given a patient's medical history.

Community pharmacies represent the most accessible point in patient centered health care, with 92 percent of Americans located within 5 miles of a retail pharmacy. Pharmacists are highly-trained health professionals that are licensed in the individual states where they practice. The expertise, knowledge, and accessibility of community pharmacists means that health care reform initiatives will be greatly enhanced by increasing access to the patient care services of the community-based pharmacist and by giving them sufficient information and resources to do their jobs.

This document describes how patient care can be improved through an enhanced utilization of pharmacist-delivered patient care services in a reformed health care delivery system.

I. Reforming the Health Care System

Recommendation: Incorporate Pharmacy Services into "Standard Benefits" and "Medical Home" Concept

Prescription medications have a central role in the treatment of chronic disease. However, their success in improving health depends on their appropriate use by patients. Pharmacists have repeatedly demonstrated that the medication therapy management (MTM) services they provide are able to improve the outcomes from medications, as well as save money for both patients and health plans. Pharmacists achieve these goals by helping patients understand how to manage and use their medications and working with physicians to assure the most appropriate drugs are used, including lower-cost generics. Such actions help to contribute to lower overall health care costs by increasing medication adherence, and reducing the number of physician visits and hospitalizations due to inappropriate drug use.²

¹ Ernst F, Grizzle A. "Drug Related Morbidity and Mortality: Updating the Cost-Of-Illness Model." *J Am Pharm Assoc.* 2001; 41:192-9

² Barnett MJ, Frank J, Wehring H, Newland B, VonMuenster S, Kumbera P, Talterman T, Perry PJ. "Analysis of Pharmacist-Provided Medication Therapy Management (MTM) Services in Community Pharmacies Over 7 Years." *J Manag care Pharm.* 2009; 15(1) 18-31.

Health care reform should require that patients have access to pharmacist-delivered medication therapy management services as part of any standard health care benefit package that is developed, and that these services be incorporated into the medical home approach.

Recommendation: Reform Medicaid Payment System for Multiple Source Drugs

Access to pharmacists' services depends upon a strong, viable community pharmacy infrastructure. However, retail pharmacies operate on a slim net 2 percent profit margin, making it important that pharmacists receive sufficient reimbursement for the products and services they provide.

Assuring adequate payment for generic medications is especially important, since the average generic drug cost (about \$25) is one-fifth that of a brand-name drug. However, implementation of the DRA-mandated Average Manufacturer's Price (AMP)-based system for Medicaid generic drug reimbursement – currently under legislative moratorium until October, as well as a Federal court injunction – would be devastating to retail pharmacies, especially small community pharmacies.

We support proposed legislative changes to the DRA's Medicaid generic drug reimbursement methodology that would assure that only prices paid by retail pharmacies are included in the calculation of AMP; that the Federal Upper Limits (FULs) for generics are set at 300 percent of the weighted average AMP; and that AMPs are not made public so that the market place is not distorted by reporting of inaccurate or misunderstood AMP data. Related to Medicaid, we also ask Congress to take action to assure that pharmacies are paid adequately by states to dispense prescriptions, as well as to provide pharmacy services.

Recommendation: Create Mechanism to Federally Regulate Pharmacy Benefit Managers (PBMs)

There is no consistent regulatory structure or oversight in the United States for pharmacy benefit managers (PBMs). Yet, these unregulated entities "manage" prescription drug benefits for tens of millions of patients in the United States, including Medicare Part D enrollees. PBMs act as a middleman between the pharmacist, the physician, the plan sponsor (such as an employer) and the patient. The PBM influences every part of the relationship between these individuals, such as determining the medications to which patients will have access, determining the rates that pharmacists are paid for services rendered, and limiting the ability of patients to use their community pharmacy to obtain their prescriptions. Ironically, PBMs self refer patients to their own mail order facilities, even in federal government programs.

PBMs have been subject to numerous federal and state enforcement actions because of inappropriate behavior that is harmful to patients and payers. For example, studies have documented that PBMs engage in spread pricing, where, unbeknownst to the plan sponsor, they pay pharmacies one price for prescription drugs dispensed but charge the plan sponsor a much higher price, thereby pocketing the difference.³

³ Siracuse M, Clark B, Garis R. "Undocumented source of pharmacy benefit manager revenue," Am J Health-Syst Pharm – Vol 65 Mar 15, 2008.

Recently, there have been numerous cases of PBMs illegally switching patients onto more expensive medications in order to maximize their revenue through rebates from pharmaceutical manufacturers,⁴ ultimately making health care more expensive.

Health care reform legislation should create a formal Federal structure for the regulation of PBMs that requires PBMs to have a fiduciary responsibility to plan sponsors, as well as allows for greater transparency of financial relationships. This will help assure that the interests of plans, patients and pharmacists are served in reducing costs and assuring the most appropriate drug therapy is used, rather than PBMs' financial interests.

Recommendation: Assure Medicare Beneficiaries Can Continue to Access Diabetes Supplies

Recent policies adopted by the Centers for Medicare and Medicaid Services (CMS) will significantly reduce access to community pharmacy services to Medicare beneficiaries with diabetes. That is because pharmacies are among the only state-licensed, state-regulated health care providers now required by CMS to obtain costly and redundant "accreditation", as well as a \$50,000 annual "surety bond" to continue to sell diabetes testing supplies. Millions of Medicare beneficiaries regularly obtain their testing supplies (such as test strips and lancets) as well as their prescription medications from retail pharmacies, helping to promote a "coordinated care" approach to treating diabetes.

However, these new, onerous, and costly CMS policies will force many pharmacies to stop providing diabetes testing supplies, thereby dramatically limiting the access of Medicare beneficiaries to these products and services. These policies create a situation which is inconsistent with the "coordinated care" approach to individuals with chronic disease, which is desperately needed by the health care system and patients. Congress should specify that state-licensed retail pharmacies are not subject to these unnecessary new requirements in order to provide services to Medicare beneficiaries.

II. Improving Quality of Care

Recommendation: Use Validated Outcomes-Based Pharmacy Measures to Enhance Medication Use

Health care reform should provide patients and payers with better data and information on the overall contributions made by various providers to quality of care and health care outcomes. Like other health care providers, pharmacists' contribution to overall quality should be based on a validated set of pharmacy outcomes measures. The Pharmacy Quality Alliance (PQA), which was initiated by CMS in 2006, has already taken the lead in developing validated pharmacy quality measures that help to determine whether a pharmacist made a difference in improving the use of prescription medications.

Measures have been developed to determine whether pharmacists "improve medication adherence", "enhance the care of individuals with diabetes", and "improve medication safety." These current and future

⁴ Gloria Gonzalez, "PBM Express Scripts reaches multistate pact to end switching probes; Joins other PBMs in agreeing to alter business practices", Business Insurance, June 2, 2008. MEDICARE AND MEDICAID; CVS Caremark Corp. to Pay \$36.7 Million to U.S., 23 States, & D.C. to Settle Medicaid Prescription Drug Fraud Allegations" Drug Week, April 4th 2008.

PQA measures can be incorporated into Medicare Part D Medication Therapy Management (MTM) programs, and can also be used by health insurance plans and other payers to differentiate among pharmacies based on quality and outcomes. They can also be used to pay pharmacies differently for achieving different outcomes with patients.

Recommendation: Make Pharmacists Part of Interoperable Health Care System and Enhance E-Prescribing

Health care reform should provide the infrastructure and the financial incentives to connect retail pharmacies to the interoperable health care system. Reform should also include a way for pharmacy information to be included in personal health records, and should allow pharmacists access to electronic medical records. For example, providing pharmacists with information such as patient diagnosis and laboratory values will enhance the value that pharmacists can provide to the health care system.

With respect to e-prescribing, it is currently estimated that implementing electronic prescribing can provide national savings of \$27 billion per year,⁵ increase medication compliance through easier prescription refills,⁶ and can help prevent over 2 million adverse drug events.⁷ Currently, aggressive efforts are being undertaken by Medicare Part D to facilitate the adoption of e-prescribing among physicians. However, physicians do not pay any transaction charges to send the e-prescription to the pharmacy. In contrast, the pharmacy pays a transaction charge for the e-prescription coming into the pharmacy, and a charge to send the prescription to the PBM or plan for payment.

Many independent community pharmacies cannot afford the charges for connecting to the e-prescribing network or the per-prescription transaction charges. Only about 50 percent of independents are currently enabled to receive e-prescriptions. Similar to the incentive program developed in MIPPA for physicians to e-prescribe under Medicare Part D, a temporary incentive program for independent community pharmacies should be established to defray part of the transaction costs to receive Medicare Part D e-prescriptions.

Recommendation: Build on Medicare Part D Medication Therapy Management Program

Since it began in 2006, the Medicare Part D Medication Therapy Management (MTM) program has helped to improve health outcomes for Medicare beneficiaries. Now is the time to build on this program's success so that Medicare beneficiaries can expect a more uniform level of MTM-related services from Medicare Part D plans, and more beneficiaries can have access to these programs.

We support CMS's requirements for 2010 that Part D plans enroll eligible Medicare beneficiaries in Part D MTM programs (opt out) unless they decline to be included in the program. We also support a standard

⁵ Leavitt MO. "Pilot testing of Initial Electronic Prescribing Standards – Cooperative Agreements Required Under Section 1860D-(4) (e) of the Social Security Act as Amended by the Medicare Prescription Drug, Improvement, and Modernization Action (MMA) of 2003."

http://healthit.ahrq.gov/portal/server.pt/gateway/PTARGS_0_1248_227312_0_0_18/eRxReport_041607.pdf

⁶ "Electronic Prescribing: Building, Deploying and Using E-Prescribing to Save Lives and Money." Center for Health Transformation, 2008.

⁷ Leavitt MO. "Pilot testing of Initial Electronic Prescribing Standards – Cooperative Agreements Required Under Section 1860D-(4) (e) of the Social Security Act as Amended by the Medicare Prescription Drug, Improvement, and Modernization Action (MMA) of 2003."

package of MTM services that would include a yearly comprehensive medication review, as well as targeted quarterly medication reviews for Medicare beneficiaries that may be at risk for certain potential medication-related issues. We also believe that the MTM program should be provided to individuals taking multiple medications for a single chronic condition (such as diabetes), those that are transitioning between levels of care (such as from a hospital to the community setting) and those transitioning from Medicaid to Medicare Part D. We also believe that the program should require that pharmacists deliver the MTM program services, ideally, in a personal encounter with the patient.

New research will be released soon that will demonstrate that community pharmacies are able to provide annual prescription drug savings of more than \$408 per patient through MTM interventions to Medicare Part D beneficiaries. These savings are due to the ability of pharmacists to increase generic utilization rates, reduce the number of prescriptions dispensed from duplication of therapies, and prevent potential adverse drug events. Such success can provide tremendous savings to Medicare Part D through the development of the correct incentives to reward pharmacists for their performance and to encourage the use of MTM programs in an expanded number of Medicare beneficiaries.

III. Enhancing Prevention and Public Health

Recommendation: Enhance Role of Pharmacists in Immunization Programs

There are 49 states that permit pharmacists to immunize based on various criteria and conditions. As a result, many Medicare beneficiaries receive their annual flu and pneumonia vaccinations each year from a pharmacist under Medicare Part B and other vaccinations under Medicare Part D. Pharmacists can have an enhanced role in the delivery of vaccinations for both Medicare beneficiaries and non-Medicare beneficiaries, and can reduce the costs to the health care system in providing these vaccinations.

Recommendations: Enhance Role of Pharmacists in Disease Prevention and Wellness Programs

Many pharmacists offer programs that help patients manage a particular medical or disease condition. Pharmacists offer smoking cessation programs, obesity management programs, cholesterol management programs, and diabetes self-management programs. Health reform proposals should enhance the accessibility of these programs to patients through pharmacies and help support and expand them.

Recommendation: Create a Realistic Pathway for Generic Biologicals

We support legislation that creates a regulatory pathway for the approval of generic biological medications that maximizes the ability of pharmacists to provide such medications consistent with current state generic substitution laws.

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