



# Choppy Seas Persist for Medicare Outpatient Drug Plan: PBMs and Community Drugstores Fight over Medication Management Programs

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The Medicare drug benefit has encountered rough seas since it was launched at the beginning of the year, and the waves are only getting higher. The turbulence threatens to upset the proverbial stomachs of a lot of pharmacy benefit managers (PBMs) and insurance companies, who are offering the new Part D benefit. They are on the defensive because of allegations that they are riding roughshod over community pharmacies, which are being short-changed because Part D plans funnel most of the prescription business to mail-order and big-name chain pharmacies.

Those complaints have already found the ear of influential Republicans on Capitol Hill, including Senator Thad Cochran (R-Mississippi), chairman of the Senate Appropriations Committee. At the end of April, he introduced a bill (S. 2563) that has attracted an influential group of bipartisan cosponsors; this has spawned a similar bill in the House (H.R. 5182), sponsored by Representative Walter Jones (R-North Carolina).

The bill does three things:

- It forces Part D plans to pay pharmacies on a fixed schedule.
- It dictates the kind of medication-management programs that the Part D plans must use.
- It outlaws the practice of Part D plans—when they are partners with a chain drugstore—of putting the name of the chain on Part D cards that are sent to the Medicare recip-

ient. Leslie Norwalk, Esquire, Deputy Administrator of the Centers for Medicare & Medicaid Services (CMS), has already stated that Part D cards with drugstore names on them are on the way out.

However, the CMS has been much more hesitant to authorize changes in the medication therapy management (MTM) program. The program's general outlines were "sketched in" by the Medicare Modernization Act of 2003 (MMA), which established the outpatient drug benefit. *Sketched* is the operative word, because that legislation did not provide heavy details and the MTM programs that the Part D plans have deployed, according to critics, have been conducted via telephone by the PBMs.

The MMA did not indicate who should provide MTM services. Oren Harden, Jr., RPh, Executive Vice President of the Georgia Pharmacy Association, says that community pharmacists should be working directly with patients, face to face, to manage their medications.

Some Medicare Part D plans do follow that game plan. MemberHealth, Inc., the fourth largest stand-alone Part D plan in the U.S., has set up its Community Care Rx (CCR<sub>x</sub>) program, whereby the local pharmacist is enlisted specifically to help steer consumers to generic drugs. MemberHealth's generic incentive program provides higher dispensing rates to pharmacies that meet generic dispensing-rate goals. The CCR<sub>x</sub> generic dispensing rate is about 60%, well above industry averages.

Mark Merritt, president of the Pharmaceutical Care Management Association (PCMA), the PBM industry trade group, has been working overtime to ward off the Cochran and Jones bills, the latter of which had about 110 cosponsors

one month after they were introduced. On MTM programs, the Jones bill states:

"To the extent feasible, face-to-face interaction shall be the preferred method of delivery of medication therapy management services."

Mr. Merritt points out that the average senior adult takes five or more medications each day and sees at least two physicians at any one time. He or she may use any number of pharmacies.

"A complete drug history is critical to an effective MTM program," he emphasizes. "Individual pharmacies often do not have this history, but the drug plan does—and therefore can ensure patients are not taking drugs which cause interactions."

CMS's Ms. Norwalk and her boss, Mark McClellan, MD, PhD, can probably read the tea leaves. Medicare already made one significant PBM change a few months ago, when it told Part D plans to continue providing members with medications that had been taken off the plan's formulary if the patient's condition had been stabilized with that drug—that is, unless the brand name was taken off the formulary for one of three reasons:

- A new generic product became available.
- There was a safety warning.
- New clinical guidelines that affected that drug were published.

On the other hand, Medicare probably understands that it makes no sense to tie the hands of Part D plans too tightly concerning MTM or anything else. After all, even the CMS actuaries have said that PBMs are achieving deeper discounts than previously anticipated. Reductions have achieved an average of 27% off the normal retail price, much better than the 15% discount that had been expected. ■