Medicare’s recently announced changes to its Part D drug-reimbursement program are sure to have a major impact on pharmacists and pharmacies. The key modifications concern the way in which long-term care (LTC) pharmacies will be serving nursing homes and which nursing-home patients should receive expanded medication therapy management (MTM) services. LTC pharmacies such as Omnicare, PharMerica, Inc., and Managed Health Care Associates, Inc., currently control about 90% of the market.

The big change entails what nursing homes can demand of LTC pharmacies; this in turn affects the pharmacies’ distributors, namely companies such as McKesson, AmeriSource Bergen, and Cardinal. For years, Medicare directors were concerned that their health insurance program was being billed by nursing homes for drugs that their residents never used. To fix this financial and environmental problem, specifically the improper disposal of unused toxic drugs, the Centers for Medicare and Medicaid Services (CMS) late last year proposed that LTC pharmacies provide prescriptions for medications in amounts of no more than seven days’ duration to all nursing-home patients served by Part D. That idea didn’t go over well with anyone—not the Part D plans, the nursing homes, or the LTC pharmacies.

In the final CMS rule, issued on April 15, 2011, the agency made several concessions. It postponed the deadline for implementing the provisions from January 1, 2012, to January 1, 2013. Instead of calling for Part D plans to require their nursing-home pharmacy suppliers to provide all brand-name drugs in quantities of seven days’ use or less, the CMS decided to require a 14-day supply or less. Typically, LTC pharmacies deliver 30-day drug supplies to nursing-home residents.

The final rule also allows nursing homes to dictate to their pharmacy suppliers how the pharmacy must provide drug supplies of 14 days or less to residents. The LTC facility may choose to have one dispensing method for brand-name Part D drugs, another technique for generic Part D drugs, and a third procedure for drugs dispensed to non-Part D enrollees (Part A participants). The facility, not the Part D sponsor (who actually contracts with the pharmacy provider), chooses the method. Clearly, the CMS would like to see nursing homes move toward automated dose dispensing as a way to reduce medication errors as well as drug waste, but the final rule does not mandate the use of that procedure.

The CMS also backed off from its proposal requiring nursing homes to send all unused drugs back to the pharmacy from whence they came. Instead, nursing homes will have to communicate to their Part D plans which drugs and how many drugs went unused. The CMS will use that information to fine-tune these new requirements at some future time.

In the end, the one-year delay of the 14-day supply of brand-name drugs effectively erases most LTC pharmacy concerns, as several major brand-name drugs are set to go off patent soon. According to Bill Daniel, Executive Director of the Long Term Care Pharmacy Alliance, his members are reporting that about 4% of their drug sales to nursing homes will be affected by the 14-day supply rule.

The changes to MTM requirements apply to all Medicare recipients in Part D plans, both within and outside of nursing homes. These changes are a bit less radical than those having to do with nursing-home patients, in part because the CMS has already implemented a number of administrative changes. In April 2010, the CMS requested that Part D plans perform a quarterly assessment of all “at-risk” individuals who were not already enrolled in an MTM program, to establish opt-out enrollment procedures for MTM, and to offer MTM services to targeted beneficiaries. These services must include, at a minimum, an annual comprehensive patient medication review that could be conducted person-to-person or via telehealth technologies. These evaluations may result in the creation of a recommended medication action plan, and the patient would receive a written or printed summary of the results.

For pharmacists in general, the most objectionable point about the April final rule is this: The CMS says that Part D plans do not have to use only pharmacists to perform the annual comprehensive drug review; “any qualified provider” can do the review. However, the CMS indicated that it might establish qualifications for health care providers in the future and “welcomes” input in that regard.

Consultant pharmacists working at nursing homes have a separate concern. Medicare had initially said that nursing-home residents who currently receive monthly drug regimen reviews from consultant pharmacists under nursing-home rules should also receive MTM services that Part D plans are required to offer most Medicare patients, regardless of the patients’ place of residence. However, the CMS believes that the full range of MTM services is not being provided to some of these location. As a result, Part D plans would have to develop contracts with consulting pharmacists to provide the full panoply of MTM services to qualified residents.

Lynne Batshon, Director of Policy and Advocacy for the American Society of Consultant Pharmacists, says some nursing-home patients would benefit from additional MTM services, but she adds that the patient population should be identified first—which Medicare agreed to do in the final rule. The fly in the ointment, not surprisingly, will be figuring out how Medicare will pay for those additional MTM services.