The Challenge of Medicare Part D for Community Pharmacies

To the editor:

A commentary by Spooner, published in the November/December 2008 issue of JMCP, highlighted many of the issues faced by independent community pharmacies under Medicare Part D. The relatively lower reimbursement and delay in payment under Medicare Part D creates a dilemma that is keenly described by the author—that the “closure of an independent pharmacy not only affects the business owner and his or her staff, but can also mean the end of convenient access to pharmacy services for patients, including the very Medicare beneficiaries for whom Part D was created.” Such a viewpoint needs further emphasis; an unpublished analysis conducted by the National Community Pharmacists Association (NCPA) found that between December 2007 and December 2008, 200 retail pharmacies serving as the sole provider within their neighborhood closed their doors without a single retail pharmacy taking their place in the community. Of these sole providers, 160 were independent community pharmacies operating as the most accessible pharmacy for an aggregate population of over 780,000 people, approximately 101,000 of whom are over the age of 65. In short, the viability of independent community pharmacy is a story about patient accessibility.

The importance of this dynamic was missing from a commentary by Benner and Kocot, published in the January/February 2009 issue of JMCP. Pharmacists provide value. Pharmacists do so by improving health while minimizing overall long term health care costs; they do this by promoting the optimal use of prescription drugs while working to prevent adverse drug effects. The success of medication therapy management programs have in fact, been documented, from the initial Asheville studies performed in North Carolina, to a more recent analysis by Barnett et al., published in the January/February 2009 issue of JMCP.

Additionally, Mirixa, an NCPA subsidiary dedicated to helping pharmacists provide medication therapy management to patients, has made great strides in developing contracts with over 46,000 pharmacies. As of August 2008, Mirixa had delivered its 500,000th patient care intervention since the company’s launch in June of 2006. These developments have helped to reduce health care costs and improve health as pharmacists, using the company’s secure web-based technology designed to promote and help patient education and intervention programs, have been able to identify and prevent potential drug safety issues for over 70% of patients served.

It must be put in context that the ability of a patient to benefit from these services, by definition, is greatly limited when patients no longer have adequate access to a community pharmacy. Community pharmacists dedicated to providing patient-centered care are curtailed when government reimbursement programs and analysts choose to make pharmacy a commodity by evaluating success primarily based upon prescription drug expenditures. Helping community pharmacists better serve their patients means working to address the main political and economic issues faced by community pharmacies.

The NCPA understands this important role played by pharmacy, and has seen recent success in protecting the interests of community pharmacies. One such accomplishment is H.R. 6331, enacted July 15, 2008 over a presidential veto to become PL 110-275. The provisions of this law delay until October 1, 2009 the implementation of reimbursement cuts for cost-saving generic drugs in the Medicaid program that the Government Accountability Office reported would average at least 36% of a pharmacy’s acquisition cost; postpone for 18 to 24 months a Medicare competitive bidding program likely to stop smaller pharmacies from selling diabetes testing strips and other non-prescription supplies to elderly patients with diabetes; and require product reimbursement payments under Medicare Part D within 14 days—the same cycle on which wholesalers require pharmacies to pay their bills—beginning January 1, 2010.

The next step to help independent community pharmacy is to gain collective business negotiation rights through legislation similar to that of the Community Pharmacy Fairness Act of 2007. Independent community pharmacies currently are at a disadvantage when negotiating contract terms with pharmacy benefits management companies (PBMs), largely because federal antitrust laws bar local groups of independents from joint bargaining. Publicly held pharmacy chains, on the other hand, are not prevented from negotiating contracts with PBMs for all of their thousands of pharmacies across the country. Therefore independent community pharmacies have less bargaining power than the large chain pharmacies which command a bigger market share.

One 2008 report from the Office of Inspector General found that 90% of independent community pharmacies and all pharmacy service administration organizations expressed concerns in a survey regarding limited or no ability to negotiate with Medicare Part D Prescription Drug Plan (PDP) sponsors, with 76% of community pharmacies expressing that PDP sponsors had described negotiations as a “take it or leave it” process. The limited bargaining power that independents have allows for many PBMs to create contracts that allow for “spread pricing” and mandatory mail order. Allowing for collective business negotiations would therefore allow independents to compete on an even playing field with the chain pharmacies, while allowing independents to be in a better position to negotiate for contracts that provide the right incentives for patient centered care that rewards pharmacists for their performance.

Attempts at reforming health care will be limited without sufficient access to a community pharmacist that can educate and help patients optimize the use of their prescription drugs. Independents have always been committed to a mission of patient-centered care, and have remained competitive by offering various niche services that are less likely to be available at the larger chain pharmacies. For these reasons, I would argue that
the future is not “bleak” but is merely a challenge. Many independent community pharmacy owners would agree, as this past year an average of 98 independent community pharmacies have opened their doors each month, despite the problems faced in the pharmacy marketplace.

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DISCLOSURES

The author is an economist employed by the National Community Pharmacists Association.

REFERENCES

2. National Community Pharmacists Association, unpublished internal analysis of National Council for Prescription Drug Programs data and 2000 U.S. Census data. “Neighborhood” and “community” are used interchangeably, and are defined at the zip code level.
14. Doucette WR, Kreling DH, Schommer JC, Gaither CA, Mott DA, Pedersen CA. Evaluation of community pharmacy service mix: evidence from the 2004 National Pharmacist Workforce Study. J Am Pharm Assoc (2003). 2006;46(3):348-55. In this study, the percentage of independents offering patient care services was higher than the percentage of chains, supermarkets, or mass merchandisers for 9 of the 16 categories, and for 5 of the 8 disease state management services.
15. National Community Pharmacy Association internal analysis of National Council for Prescription Drug Programs data. No new retail pharmacies (either chain or independent) have opened in the 200 communities mentioned earlier to replace the sole providers that have been lost.