

■ Unprecedented Opportunities for Managed Care Organizations and Community Pharmacies to Work Together

Over the years, a considerable amount of discontent and distrust has been expressed between community pharmacies and managed care organizations (MCOs), especially between community pharmacies and pharmacy benefit managers (PBMs). In fact, one can deduce from the pharmacy press that the discontent between the 2 industry groups continues to grow. Most of the friction between MCOs/PBMs and community pharmacies has revolved around the MCO/PBM business model with transparency issues and lack of a “level playing field” for PBM-owned mail-service pharmacies. Some of these fairness issues are being addressed by state legislatures.

Despite the troublesome issues, one would expect the rift between these groups to diminish as common ground became more obvious with the advent of the Medicare Part D prescription drug program. In fact, some groups are working together to improve patient care and deliver medication management programs. For example, Community Care Rx, which provides patient care services with its network pharmacies, and Maryland BlueCross BlueShield’s Medi-CareFirst Part D plan are paying pharmacists for pharmacist-patient drug consultations.¹ MemberHealth, a PBM, just recently honored Medicine Shoppe International, Inc., for patient care services provided to beneficiaries.² Surprisingly, however, not many patient care-focused partnerships have evolved between community pharmacies and MCOs/PBMs.

Early signs indicate that community pharmacies are not the principal providers of medication therapy management (MTM). A 2005 survey of 97 Medicare Advantage and stand-alone prescription drug plans (PDPs) revealed that only 8.2% planned on using community, long-term care, hospital, or clinic pharmacies to deliver MTM. The majority indicated they were going to use pharmacists employed by the MCOs.³ A 2006 survey of 21 distinct MTM programs from 70 health insurance plans representing 50 PDP and 221 Medicare Advantage plans and covering 12.1 million beneficiaries found that only 4 MTM programs had service contracts with community pharmacies.⁴

Centers for Medicare & Medicaid Services Requirements

The Centers for Medicare & Medicaid Services (CMS) has mandated MTM services for all Part D plans. It is hoped that this mandate will be the stimulus for community pharmacies and MCOs to work together. In fact, the patient care goals of both groups and CMS are very similar in that they want to offer cost-effective medications coupled with patient care services. Community pharmacies and MCOs need to realign their goals and especially their strategies so that both groups can tap each others’ strengths and deliver value-added, high-quality, cost-effective patient care services.

The managed care/PBM industry is missing an important opportunity if it does not work with community pharmacies to

develop meaningful patient care and MTM programs. Likewise, community pharmacists are missing important opportunities if they believe they can do MTM alone without the expertise, leverage, computer infrastructure, and networking capabilities of the MCOs. It is important for the two to respect each other and start working effectively as a team. Large strides could be made in reducing medication errors, improving drug use by patients, and reducing health care and medication therapy costs. Medicare Part D is the force to bring and tie these “adversaries” together; however, cooperation requires a change in attitudes and respect for each other. Working together requires each group to step forward, find common ground, and seek a new future.

Currently, the standards for MTM programs are vague and very open; it is up to the plans, pharmacies, and other health care providers to develop effective MTM programs. However, the Medicare Modernization Act does mandate that CMS work with quality improvement organizations (QIOs) nationwide to improve quality of care for Medicare beneficiaries.⁶ Every state has a QIO that will work with health plans, pharmacies, and health care providers. As an example, the Florida QIO is working with 2 Part D plans to measure the impact of MTM programs.⁷ Furthermore, the Pharmacy Quality Alliance, which started in April 2006, has selected the National Committee for Quality Assurance to develop and test measures for assessing the quality of pharmacy services. Nine therapeutic and patient service areas have been selected: diabetes, respiratory disorders, hypertension, heart problems, hyperlipidemia, generic drug use, formulary management, patient satisfaction, and patient safety. The plan is to have validated measures ready by November 2007 and testing of measures by early 2008.⁸ We can be assured that CMS, with the help of QIOs, will continue to monitor and evaluate MTM programs provided by Part D plans and by community pharmacies.

With QIO involvement, it is possible that the best MTM programs will be identified and some kind of CMS “report card” will be developed for MTM programs, Part D plans, and community pharmacies. In other words, CMS will create a public “report card” for the MTM programs provided by Part D plans and community pharmacies. These “report cards” will be based on outcomes measurements so that CMS can compare plans, programs, and pharmacies. Since CMS has medical as well as prescription drug data, the capability exists to examine a variety of outcome measures, including rates and length of hospitalizations, emergency room visits, physician visits, diagnoses, adherence rates for prescription drugs, adverse effects of drug therapy, and drug and health care costs. The appropriate measure(s) will be calculated by health plans, MTM programs, specific drug therapy, and health care providers, including community pharmacies. Furthermore, much of this research will not be conducted by the Part D plan but by the QIOs, CMS researchers, and independent or academic-based researchers.

The MTM programs and pharmacies that demonstrate the best clinical and cost outcomes will receive the highest grades. These grades for MTM programs, plans, and pharmacies will most likely be posted for public viewing on the CMS Web pages and in print. Components that have the highest grades will survive; plans and pharmacies with failing or low grades will probably be dropped by CMS or by their patients at the time of reenrollment. In other words, the apparent effectiveness of past consumer marketing campaigns trumpeting low copayments and low premiums will be replaced by more readily identifiable total health care value provided to patients. Therefore, market differentiation through value of cost-effective patient services will drive patient demand for providers and health plans.

The implications for MCOs/PBMs and for community pharmacies in the new total value measuring stick are enormous. Both groups need to work together to develop and deliver programs that provide the best value. A common belief held by many MCOs and PBMs is that MTM can be delivered solely through sophisticated data analysis programs and with a bank of telephones staffed by pharmacists. Admittedly, large database computer information systems are excellent tools and telephones and mailings can be very useful, but both fall short of direct patient care and interaction. The situation brings to mind some of the miscalculations made by this nation's intelligence-gathering community when they decided to rely increasingly on sophisticated electronic surveillance systems instead of on the personal contacts and instincts of their own people stationed around the world. After a few disasters, the limitations of electronic surveillance became evident, and the U.S. intelligence community has invested in people on the ground to collect and confirm critical electronic intelligence information.

For managed care, community pharmacists are the "people on the ground." They observe, listen to, talk to, touch, and, most important, understand and evaluate their patients. Many understand the economic, social, emotional, and mental characteristics of their patients and their families as well as their health issues. Few people in MCOs have tapped this strength in the pharmacy provider networks. It is time for MCOs to reevaluate their strategies and use and reward pharmacists as resources to build effective MTM programs.

Underused Resources and Opportunities

The relationship between MCOs and community pharmacists can be improved in many ways. The following lists opportunities for both groups:

1. MCOs and PBMs can create advisory panels composed of community pharmacists and other health care providers so that they can assess opportunities for working together more closely. They can also discuss problems or weaknesses that need to be addressed. For example, open discussions can be used to improve prior-authorization programs so that the systems are more responsive to the needs of pharmacists and

their patients who are the members of the MCOs and PBMs. Avoiding waste in pharmacy personnel time and frustration can reduce the costs of undesirable service outcomes for pharmacists and MCO members.

2. Similarly, MCOs and PBMs can appoint community pharmacists to advisory committees committed specifically to the development and continuous quality improvement of MTM programs.
3. MCOs and PBMs can appoint community pharmacists to MCO and PBM formulary committees.
4. MCOs and PBMs can work with community pharmacists to deliver live educational programs designed to better engage community pharmacists to understand the rationale for benefit plan designs, which will enable community pharmacists to better inform patients.
5. Some PBMs employ many pharmacists who work in telephone-based call centers, and these telephone systems can be used to assist community pharmacists. For example, telephone-based service centers can distribute drug and health information to community pharmacy patients as well as mail-service patients. In other words, MCO and PBM call centers can be employed to assist all plan beneficiaries, not just mail-service patients.
6. MCOs/PBMs and pharmacies can assist each other with missing, incomplete, or new patient drug and health information.
7. A huge opportunity exists for PBMs that work closely with health plans and have integrated pharmacy and medical claims data to assist community pharmacists in counseling patients regarding drug-disease interactions and in improving compliance with medical office visits and adherence to medications.
8. Some PBMs and all MCOs will increasingly use sophisticated computer systems to store and integrate pharmacy and medical information from many providers. When these systems are combined with the knowledge of the clinical experts who work for PBMs and health plans, community pharmacists can target patients for intervention to attain goal therapeutic values in blood pressure, lipid profile, fasting blood glucose, and glycosylated hemoglobin. Many may say that these systems are used today, but talks with community pharmacists reveal that these systems are typically imperfect or entirely ineffective.
9. With the increase in electronic prescribing, not only will pharmacists receive more legible prescriptions, but physicians and pharmacists likely will also be sharing more patient information. New electronic data transfer standards are now being developed in which prescription drug information will be passed on to physicians, and patient information from physician offices will be passed on directly to pharmacies. In other words, physicians will receive information electronically, notifying them if their patients picked up their prescriptions,

and pharmacists will have access to diagnosis and laboratory values from physicians. This will improve the capabilities and functions of community pharmacists in the areas of patient care, especially in MTM programs.

10. Community pharmacy residency programs with the emphasis on MTM services need to be developed and expanded between MCOs/PBMs and community pharmacies. Such joint programs may include college of pharmacy faculty.^{9,10} This is an excellent value for both managed care and community pharmacies, plus the program educates and trains future pharmacists to provide patient care services. Funding for such projects and programs could be sought from the pharmaceutical industry, especially for those MTM programs dedicated to improving drug adherence and/or reducing medication adverse events.

Conclusion

Many approaches can be employed for community pharmacies and MCOs to work together, especially in the area of patient care programs. The point is to tap the strengths of each group, be fair to each other, and reward success. Developing a strong working relationship between both groups is essential to improve patient care, including better service and clinical outcomes at lower cost. It is time for community pharmacies and MCOs to work together to develop meaningful, innovative, and cost-effective pharmaceutical and patient care programs. The window of opportunity is *now*, so let's start constructive dialogue and build patient care successes together.

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DISCLOSURES

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