
**The Experience of Sole Community Rural Independent Pharmacies
with Medicare Part D: Reports from the Field**

A Joint Publication of
The North Carolina Rural Health Research & Policy Analysis Center ⁽¹⁾
Working Paper No. 87

And
The RUPRI Center for Rural Health Policy Analysis ⁽²⁾
Policy Paper P2006-3

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November, 2006

This study was funded under a cooperative agreement with the Federal Office of Rural Health Policy (ORHP), Health Resources and Services Administration, U.S. Department of Health and Human Services, Grant Numbers U1 CRH03714 -01-00 (North Carolina Center) and 5 UICRH037-02-00 (RUPRI Center). The conclusions and opinions expressed in this paper are the authors' alone; no endorsement by RUPRI, the University of North Carolina, ORHP, or other sources of information is intended or should be inferred.

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Executive Summary

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) created prescription drug coverage for Medicare beneficiaries through the Medicare Part D program. The program's intent is to expand access to outpatient prescription medications, and for many beneficiaries it has done so; approximately 22.5 million beneficiaries are enrolled in Part D plans (PDPs), with an additional 15.8 million covered by other plans. The new drug benefit relies on competing PDPs, which enroll beneficiaries, set premiums, establish formularies, and contract directly with pharmacies for reimbursement purposes. This case study describes first-hand reports from 12 rural independent pharmacists in seven states about their experiences with Medicare PDPs in the first seven months of 2006. All 12 respondents operate pharmacies that are located 10 miles or more from the next closest pharmacy. Findings for this case study are taken from a larger survey of rural independent pharmacists. The study examines unintended impacts of the Medicare Part D program on independent pharmacies in rural areas. Issues are identified that may affect future geographic access to outpatient pharmaceuticals for some rural residents, and so may warrant immediate attention within the context of the current law and regulations governing the Part D program.

The rural independent pharmacists interviewed are experiencing major changes in payment, administrative burden, and interaction with patients as a result of the shift of patients into Medicare Part D plans. Previously, these patients were mostly non-covered cash or Medicaid-covered clients. Two consequences are apparent in the data collected:

- Payment per prescription is lower from Medicare PDPs than from either non-covered cash or Medicaid, and in some instances payment from PDPs is less than the combined cost of stocking the medications and dispensing them, representing a reduction in revenue; and

- The number of plans that provide Part D benefits greatly exceeds the two payment sources pharmacists previously dealt with, representing an increase in administrative burden for independent pharmacies.

Other important findings from the study include the following:

- One respondent felt financially prepared for Medicare Part D; however, most respondents interviewed were apprehensive about the long-term effects of Medicare Part D and expressed concern about the long-term viability of their businesses.
- Respondents were offered from 10 to 43 Medicare PDP contracts/plans. Only one respondent accepted all contracts offered, with the others citing low reimbursement rates as the reason for rejecting contracts.
- There have been very few opportunities to negotiate payment rates with PDPs, and the negotiations that were reported involved local pharmacies that the PDPs felt to be necessary providers to meet access standards.
- Some respondents contacted Medicare PDPs about providing 90-day supplies of medications, but few chose to do so due to the very low reimbursement rates offered.
- The pharmacists interviewed cited difficulty in communicating with Medicare PDPs, including excessive amounts of time on hold and an inability to reach someone knowledgeable about their problem.
- Time from service to payment received is longer when PDPs are involved than is true for that of Medicaid and most commercial plans, and limited improvement has been seen in the last six months.
- Most respondents lost some patients because they did not contract with patients' plans. They also reported losing patients to mail-order pharmacies even though they participated in the patient's plan of choice.
- Nine of the 12 respondents cited a significant increase in workload during program implementation. Many respondents worked extra unpaid hours educating Medicare beneficiaries and helping them to enroll. Some paid their staff to work additional hours and/or hired more staff. Concern was expressed that many of these problems will be repeated during the annual open enrollment periods.

- Some of the pharmacists interviewed noted that the increased complexity of managing their pharmacies is forcing them to spend more time dealing with insurance plans and financial pressures; this has decreased the time they have available to work as clinicians in counseling and managing their patients' medications.

The findings from this study, along with specific suggestions made by pharmacists during the interviews, suggest short-term actions that can be taken to address the challenges faced by rural independent pharmacies who are the sole providers in their communities. These actions include providing technical assistance to pharmacists who need to adopt new business practices; developing a grant program to provide financial assistance to small independent pharmacies who need to implement new information systems; and creating regional networks of counselors to assist Medicare beneficiaries, thereby relieving some of the burden on pharmacists.

The study findings also support a set of long-term actions that focus on adapting the Part D program to the circumstances confronting rural independent pharmacies to ensure that sole providers of pharmacy services can remain open. These actions include creating a category of safety-net rural pharmacies and requiring that payment to these pharmacies equals, or exceeds by a small percent, their actual costs; requiring development and adoption of common reporting forms and procedures for prior authorizations and other routine interactions between pharmacies and Medicare PDPs to decrease administrative burden; and supporting information systems that include more efficient means of communications between pharmacies, physicians, and Medicare PDPs.

The implementation of the Medicare Part D program has undoubtedly provided important prescription drug insurance coverage for many rural Medicare enrollees who were previously without such insurance. However, adequate access to health care requires both the means to pay

for, and physical access to, services. If the financial stress on sole community pharmacies that is observed in our case study is representative of conditions facing others in similar circumstances across the country, protections for these providers will need to be put in place in order to realize the full benefit of the Part D program.

Introduction

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) created prescription drug coverage for Medicare beneficiaries through a new Medicare Part D program. The program's intent is to expand access to outpatient prescription medications, and for many beneficiaries it has done so; approximately 22.5 million beneficiaries are enrolled in Medicare Part D, with an additional 15.8 million receiving prescription drug coverage through other plans.¹ Unlike Parts A and B, the new drug benefit relies exclusively on competing Medicare prescription drug plans (PDPs), which, under broad guidance from the federal government, enroll beneficiaries, set premiums, establish formularies, and contract directly with pharmacies for reimbursement purposes. Part D is the single largest addition to Medicare since its creation in 1965 and the most expansive use of an insurance market to serve beneficiaries (peak enrollment in private Medicare+Choice plans was 6.3 million in 2000). Implementation of such a large entitlement program is not easy and involves meeting both predictable challenges and some associated unpredicted challenges.

Prior to program implementation in January 2006, concerns had been voiced as to how independent pharmacies, which represent a higher proportion of all retail pharmacies in rural areas,² would fare under the new program. Independent pharmacies tend to earn a higher-than-average portion of their revenues from prescription drug sales, making them vulnerable to decreases in reimbursement.³ They also have less bargaining power than do large chain pharmacies and so face higher wholesale prices from drug manufacturers. In addition, in many states pharmacies were already experiencing financial pressure due to tightening reimbursement from Medicaid and the move to pharmacy benefit managers by private insurers.⁴⁻⁶

This study describes first-hand reports from rural pharmacist-owners about their experiences with Medicare PDPs in the first seven months of 2006, focusing on pharmacies that are the sole provider of pharmacy services in their community. The study has two goals; the primary goal is to gain a more thorough understanding of the challenges faced by rural independent pharmacies as a result of working with Medicare PDPs, especially those that contribute to financial stress. The second goal is to provide a context for these difficulties, including such factors as pharmacy size, dependence on payments from Medicare beneficiaries, and ability to negotiate payment terms with Medicare PDPs. Unintended effects of the Medicare Part D program on sole community independent pharmacies are examined to identify issues that may affect future geographic access to outpatient pharmaceuticals for some rural residents. This study seeks to identify areas that may warrant immediate attention within the context of the current law and regulations governing the Part D program. As such, the findings will inform public policy makers, administrative and legislative, of the difficulties rural community pharmacies are encountering that may be remediable in the near term.

Methodology

This study was conducted by staff from the North Carolina Rural Health Research & Policy Analysis Center and the RUPRI Center for Rural Health Policy Analysis. Project staff worked collaboratively to develop a semi-structured interview protocol for use in telephone interviews with the pharmacist-owners of rural independent pharmacies. State pharmacy associations located in various regions of the country were contacted for help in identifying pharmacies that met the following criteria: the business was located in a rural area and was independently owned, it was experiencing financial challenges, the pharmacy was still operating

at the time of the interview, and the pharmacist-owner was willing to share his or her experiences with the research team. State licensure data were used to identify the sub-set of identified pharmacies that are at least 10 miles from the next closest pharmacy. Not all contacts with state pharmacy associations were successful, but the desired regional balance was achieved through participation by 12 pharmacists in the following states: Kansas, Minnesota, Montana, Nebraska, New Mexico, North Carolina, and South Carolina.

After identification by the state pharmacy association, up to three pharmacists in each state were contacted by the research team to assess their willingness to participate and to provide more information on the study. Those who expressed interest in participating were provided a copy of the interview instrument prior to a scheduled interview time.

After completion of telephone interviews, notes kept by members of the study team were reviewed by other team members not participating in the interview to be sure that all important details were included in the interview data set. The questions used were derived from statements of concerns expressed by pharmacists and their associations during the early months of 2006. In order to isolate the particular challenges of working with Medicare PDPs and PDP payment levels, similar information was requested for commercial insurance and Medicaid (e.g., payment formula, profit margin, prompt payment). Opportunities were provided for respondents to share general observations, which most of them did. Analysis was completed by aggregating responses for each question and by comparing some of the responses among pharmacies with different characteristics.

The sampling frame for this study was purposive, contacting pharmacies thought to be experiencing financial difficulty, as the study's goal was to investigate the claims made as to why rural independent pharmacies in particular are vulnerable to certain behaviors of Medicare

PDPs (e.g., delayed payment, reduced payment as compared to Medicaid and private pay). Because of the nature of case studies, while the research *suggests* issues that warrant further policy attention and research focus, it does not *confirm* any research hypotheses regarding impacts on all pharmacies.

Results

Respondent Characteristics

Pharmacists from 12 independently owned sole community rural pharmacies in seven states were interviewed. Of the 12 pharmacists interviewed, 9 owned a single store; the remainder owned two stores. All 12 respondents operated pharmacies located 10 miles or more from the next closest pharmacy.

Many of the pharmacists interviewed operated apothecary-type stores (primarily dispensing, with little to no other retail) with limited staffing. Two respondents characterized their pharmacy as a compounding pharmacy, and four others noted that they compounded occasionally. Some respondents operated more extensive businesses that also sold home oxygen equipment and/or other merchandise. Table 1 summarizes reported staffing levels for the pharmacies represented in this study.

Table 1: Pharmacy staffing levels (n = 12)

Position	Average Number of Full Time Equivalents*	Range Reported
Pharmacist	1.43	1.0 – 2.5
Pharmacy technician	1.92	0.0 – 5.0
Non-pharmacy staff	2.48	0.0 – 9.0

* Forty hours of staff time represents an FTE, whether it is worked by one individual or by several working part-time.

Contracting with Part D Plans

Medicare beneficiaries have a wide variety of Medicare PDPs from which to choose. For the states represented, the number of companies offering Medicare PDPs ranged from 15 in Kansas to 19 in South Carolina at the time of our interviews.⁷ Companies offer multiple plans, and the number of plans available ranged from 38 to 45.⁸ Respondents were asked about the number of contracts they were offered and the number they chose to accept. Based on their responses, not all pharmacists were offered contracts covering every available plan in their state. The reported range of contracts (a respondent could have been referring to either companies or plans) offered was from 10 to 43. One of the pharmacists reported being offered all contracts and plans available in his state; this pharmacist signed all contracts offered. Another pharmacist interviewed accepted all contracts offered because he felt he had to.

In three instances the difference between the number of contracts offered and the number of contracts accepted showed that the respondents were being highly selective; for example, 30 were offered and 11 accepted or 40 were offered and 15 accepted. A low reimbursement rate was the most commonly reported reason for rejecting contracts.

Four pharmacists interviewed reported receiving assistance from a third-party negotiating group. These third-party groups assume the responsibility of reviewing and negotiating the contracts offered. Two respondents did not know the number of contracts they were offered or the number of contracts they had accepted because a third-party negotiator handled the entire process, including enrolling the pharmacies in Medicare PDPs deemed acceptable by the third-party negotiator. Two respondents reported handling some contracts on their own and accepting some plans their third-party negotiator advised against.

Most of the pharmacists interviewed had no influence on the terms of the Medicare PDPs offered to them. Respondents also believed that use of a third-party negotiator had little to no effect on the contract terms offered. For most of the respondents, their only two options were to either accept or decline specific contracts. However, 3 of the 12 pharmacists surveyed were able to negotiate enhanced reimbursement rates for some of their Medicare PDP contracts. Due to their rural or remote location, these three were able to increase their reimbursement rates because the plan believed they were needed to meet access/coverage requirements.

Pharmacists were also asked if and how their Medicare PDP contracts had changed since signing the original contracts. Most had not experienced any contract changes, but one did know of changes to existing contracts.

Other Communication with Plans

The pharmacists interviewed were asked about their communication with Medicare PDPs regarding compensation levels, payment delays, medication therapy management, and the potential to provide 90-day supplies of medication. As noted above, three of the respondents were able to improve their compensation levels, but most contacts with Medicare PDPs about compensation levels yielded no effect, even when reimbursement rates were lower than the cost of the medication dispensed. Contact by the pharmacists interviewed with Medicare PDPs regarding payment delays and medication therapy management was limited. Four of the pharmacists did contact Medicare PDPs about providing 90-day supplies of medications, but because of the very low reimbursement rates offered, few chose to do this. In general, the pharmacists interviewed cited the difficulty of communicating with Medicare PDPs, including excessive amounts of time on hold and the inability to reach someone knowledgeable about their

problem. A few of the pharmacists interviewed did comment that on-hold times had improved since the beginning of the year but noted that they still experienced frustrations when trying to resolve problems.

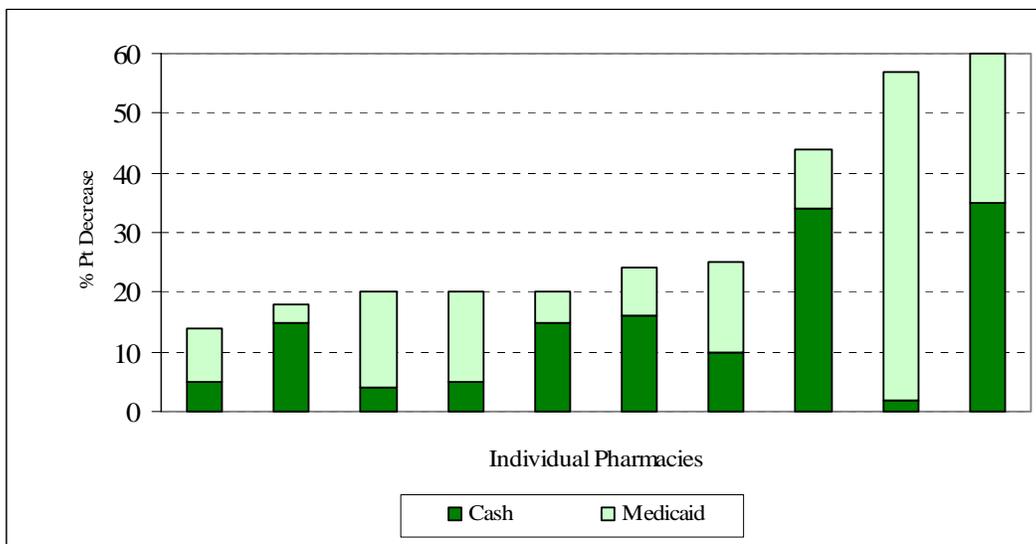
Pharmacy Revenue and Part D Reimbursement

Prescription sales were the primary source of revenue for the rural independent pharmacies contacted. Revenue from prescription sales accounted for at least 85% of total retail revenue for 9 of the 12 pharmacists interviewed. Other reported sources of revenue included sales of over-the-counter medications and oxygen and related supplies. Implementation of Medicare Part D has had little to no effect on the percent of revenue accounted for by prescription sales. While some respondents noted an increase in their overall volume of prescriptions filled, this did not change the percent of total revenue accounted for by prescription sales because of a decrease in what they were paid per prescription. The decrease in payment per prescription, attributed to the implementation of Medicare Part D, was due to patients shifting from a payer type that pays more to a payer type that pays less.

The pharmacists interviewed were asked what percentage of their prescription sales were made to individuals covered by the different payer types both before and after the implementation of Medicare Part D. Third-party/commercial insurers (excluding Medicare PDPs) were the primary payer both before and after the implementation of Medicare Part D for over half of the pharmacists surveyed (7 of 12). In contrast, the percentage of patients who were covered by Medicaid or were non-covered cash patients decreased markedly after the implementation of Medicare Part D. (Non-covered cash patients are either patients with no health insurance or patients whose insurance plan does not include a prescription benefit.) Elderly

patients with no prior prescription coverage gained coverage under Medicare Part D, while Medicare-Medicaid dual-eligible patients were switched from Medicaid to Medicare PDPs. Figure 1 illustrates the percentage point decrease in patients who were covered by Medicaid or were non-covered cash patients following the implementation of Medicare Part D among the 10 pharmacists who could supply these data. For example, if 25% of a pharmacy's prescription sales were to Medicaid patients before Part D, and after Part D Medicaid prescription sales accounted for 15% of total sales, their Medicaid percentage decreased by 10 percentage points. Respondents saw percentage point decreases of 3 to 55 for Medicaid prescription sales and 2 to 35 for non-covered cash prescription sales after Part D was implemented. Patients covered by Medicare PDPs represented from 18% to 67% of the total prescription sales for the pharmacists at the time of our interviews. The shift in payer mix from non-covered cash and Medicaid to Medicare Part D is a shift from the two highest payers to the lowest payer.¹

Figure 1: Percentage point decrease in Medicaid and non-covered cash prescriptions sales as a percent of total prescription sales after the implementation of Medicare Part D (n=10)



¹ Respondents were queried as to changes in Medicaid payment methodologies for their states since January 2006 and they reported no changes.

The pharmacists interviewed were asked about their gross profit or loss for dispensing prescription medications to non-covered cash patients and patients covered by third-party/commercial (non-Medicare PDPs) payers, Medicaid, and Medicare Part D. Gross profit or loss values were reported in a variety of formats from absolute dollars to percentages, so a direct data comparison was not possible. However, the trends of highest and lowest payers were consistent despite the varied reporting formats used. Non-covered cash patients were the best payers, with Medicaid the second highest payer. Medicare PDPs were consistently identified as the lowest payer, with third-party/commercial plans the next lowest.

In order to gather more information about their Medicare Part D and third-party/commercial reimbursement, respondents were asked to describe how reimbursement rates for these plans were determined. As noted above, payments from Medicare PDPs for prescription medications were generally lower than payments from third-party/commercial plans. Most third-party/commercial plans set their payment amounts based on average wholesale price (AWP) less 12% to 15% plus a dispensing fee. Some third-party/commercial plans paid as much as AWP less 10% or as little as AWP less 17%. Most Medicare PDPs set their payment amounts at AWP less 14% to 16%, with some plans reimbursing AWP less 18%. Some of the pharmacists interviewed noted that third-party/commercial payers were beginning to drop their reimbursement rates to match the lower Medicare PDP reimbursements.

Business Operation Implications

Implementation of Medicare Part D has highlighted some of the administrative and financial challenges of managing a rural independent pharmacy. Only one respondent felt financially prepared for Medicare Part D; most respondents interviewed were apprehensive about

the long-term affects of Medicare Part D. Half of the pharmacists surveyed expressed concern about the long-term viability of their business. Three voiced doubts about whether they would be able to keep their stores open in the short-term. When asked whether they knew if any pharmacies in their area had closed recently, nine answered affirmatively. When asked why the closures occurred, seven of the nine mentioned Part D, either as a direct factor or in combination with multiple causes. Other reasons provided included retirement of the pharmacist-owner and unspecified legal problems.

Almost all pharmacists interviewed have attempted to minimize their cost of purchasing pharmaceuticals. Nine of the 12 belonged to a group purchasing organization (GPO), such as Pace Alliance, McKesson, or Rx Plus, and received discounts on generics and high-volume purchases and rebates. Some of those who did not belong to a GPO reported that they kept their purchase costs down by negotiating discounts directly with wholesalers and by making bulk purchases prior to anticipated price increases.

In addition to keeping acquisition costs down, timeliness of payments from insurers is also an important factor in managing a pharmacy's cash flow. The promptness with which payments are received is influenced by several factors, including method of claims transmission (hard copy or electronic), mandated payment ceilings or floors, and method of claims payment (paper check or direct deposit). Respondents were queried as to their method of claims transmission as well as the average amount of time it took to receive payment from third-party/commercial plans, Medicaid, and Medicare PDPs, and how payments were received. All respondents reported that they filed claims electronically.

Medicaid was the most timely payer for the pharmacists interviewed, usually providing payment within 14 days for a clean claim. Ten respondents reported receiving payment from

Medicaid in 14 days or less, and two reported around 20 days. Third-party/commercial payers were reported to provide payment within 14 to 28 days for a clean claim. Four respondents reported receiving payment from some third-party/commercial payers in as few as 15 days, three receive payments at approximately 21 days, and five are paid after 30 days or more. According to the pharmacists interviewed, the amount of time it took to receive payment from a Medicare PDP varied widely, with some paying in 14 days and others taking as long as 60 days. Delays in payment from Medicare PDPs in the early months of 2006 caused at least one of the pharmacists interviewed to take out loans to deal with cash flow problems. When asked if the timeliness of payment had changed within the last six months, the majority of respondents reported they had noticed little, if any, difference in the amount of time it took to receive payment. Five pharmacists did report that some Medicare PDPs had made small improvements. The majority of respondents did not believe payment time would improve in the future; however, some remained hopeful.

Most of the pharmacists interviewed receive payments via both direct deposit and paper check; however, three respondents receive paper checks as their only method of payment. They reported that some commercial plans and many Medicare PDPs provide payment only in the form of paper check. Direct deposit appeared to be the preferred method of payment among the respondents, but this payment method was not always offered as an option, especially among Medicare PDPs. Some pharmacists reported using a third-party group to manage payment reconciliation, and these third party groups sometimes directly deposited payments when the option was not otherwise available.

The Medicare Part D contracts a pharmacist chooses to accept can also affect his or her overall patient base. Most of the pharmacists interviewed, 10 of 12, had lost patients from their

practice because they did not contract with patients' enrolled plans. A similar number reported losing patients to mail-order pharmacies even though they participated in the patient's plan of choice. The respondents also lost patients due to confusion caused by co-branding. Co-branding occurs when Medicare PDPs print the logos of preferred chain pharmacies on the Medicare Part D benefit card. Medicare PDPs are no longer permitted to do this. Patients thought they had to use the pharmacy whose logo appeared on their PDP card. Several pharmacists noted that these individuals did return once they knew they were not required to use the pharmacy shown on their card.

As has been widely noted elsewhere, the Part D implementation period in early 2006 strained the business operations of many pharmacies.^{7,9-12} Some of those interviewed felt pharmacists unfairly carried the burden of many Part D implementation problems. Nine of the 12 respondents cited a significant increase in workload during the implementation period. Many of the pharmacists worked extra hours unpaid, spending a large portion of their time educating Medicare beneficiaries about Part D and helping them to enroll. To handle the increased workload, pharmacy staff were paid to work additional hours, or more staff were hired either permanently or on a contract basis. Some of the pharmacists interviewed expressed concern that many of the problems experienced during the original implementation period will be repeated during the annual open enrollment periods.

Some respondents reported difficulty in determining how they were doing financially for different plans or payer types. Other respondents were frustrated by the wide variability in drug pricing and reimbursement and the inability to know their reimbursement rate for different medications prior to receiving the actual payment.

Respondents' Suggestions for Change

After describing their experiences with Medicare Part D, the pharmacists interviewed were asked to list the top three things they believed needed to change in order for their pharmacy and other rural independent pharmacies to have a solid financial footing. A number of suggestions were made by multiple respondents and include the following:

- Require minimum reimbursement rates;
- Require payment to pharmacists within 15 days of a clean claim being received, and require that payment be made by direct deposit;
- Limit the number of Medicare PDPs;
- Protect rural independent pharmacies from reduced Medicaid reimbursement when the change is made in Medicaid payment (in 2007) to using average manufacturer's price; and
- Pay pharmacists for medication therapy management services through Part B of Medicare, which would enable rural independent pharmacists to continue their clinical services to patients regardless of the source of medications.

Discussion

The rural independent pharmacists interviewed are experiencing major changes in payment, administrative burden, and interaction with patients as a result of the shift of patients into Medicare Part D plans. Previously these patients were mostly non-covered cash or Medicaid-covered clients. A small percentage was insured by commercial carriers (persons with supplemental insurance who switched into Part D plans, and a small number who switched out of employer-sponsored retiree coverage). Two consequences are apparent in the data collected:

- Payment per prescription is lower from Medicare PDPs than from either non-covered cash or Medicaid, representing a reduction in revenue; and
- The number of plans that provide Part D benefits greatly exceeds the payment sources pharmacists previously dealt with, representing an increase in administrative burden.

Both of these consequences were anticipated prior to January 1, 2006. Medicare PDPs are paying slightly less than commercial plans (which would have been the benchmark).

Commercial plans were already paying less than Medicaid, and non-covered cash was, and remains, the highest payer. Commercial plans also offered different levels of benefits for their enrollees and used different formularies that could change during an enrollment year, two practices cited by interviewees as creating administrative burdens.

With the implementation of Medicare Part D, the rural independent pharmacy has become a more complicated business to manage. Billing and reimbursement from Medicaid and non-covered cash patients are relatively straightforward procedures. Cash patients pay up-front, and with Medicaid, there is usually only one set of billing requirements to master, one payer to track for accounts receivable, and one formulary to monitor. Medicare Part D substantially increased the number of insurance companies and plans with whom rural independent pharmacists have to interact, increasing the complexity of managing their accounts receivable and their overall financial position. Pharmacists without a strong business background may have difficulties operating a viable rural independent pharmacy in the future. Conversely, those who are set up with information systems and business practices to work with multiple commercial plans will experience far less difficulty.

The potential impact of Medicare Part D on business operations places pharmacist-owners who are, after all, clinical health care providers, in a difficult position. A patient's ability

to choose from a wide variety of plans may conflict with the financially prudent course of action for an independent pharmacist. While it is often financially advantageous for a pharmacist to limit the contracts he or she accepts to only those that provide the opportunity to cover the cost of the medication and overhead, and to make a margin, some of the pharmacists interviewed chose to accept all plans, even those under which they lost money, because they did not want to limit patients' access to care. Other pharmacists did limit the number of plans they accepted and worked with patients to enroll and/or switch them to these plans.

Independent community pharmacies are more likely to be vulnerable to the problems identified and described by the 12 pharmacists interviewed and by those responding to national surveys.¹⁰ The increased vulnerability is due to the relationships between volume purchasing by pharmacies and the reimbursement rates from Medicare PDPs, size of the pharmacies and their ability to purchase and support information systems to deal with complexities inherent in billing multiple plans, and capitalization of the pharmacies and the ability to carry the cost of an inventory while waiting for reimbursement.

The implementation of the Medicare Part D program has undoubtedly provided important prescription drug insurance coverage for many rural Medicare enrollees who previously lacked this benefit. However, adequate access to health care requires both the means to pay for and physical access to services. If the financial stress on sole community pharmacies that is observed in our case study is representative of conditions across the country, protections for these providers will need to be put in place to realize the full benefit of the Part D program.

Short-term actions can be taken to address the challenges faced by rural independent pharmacies that would help pharmacists adjust to the new circumstances of having Medicare

patients mirror, for administrative and payment purposes, commercially insured patients. These include the following:

- Provide technical assistance to pharmacists who need to adopt new business practices, including contract negotiations, information systems to accommodate multiple plans and formularies, communications with physicians and plans, and cash flow management;
- Develop a grant program to provide financial assistance to small independent pharmacies who need to implement new information systems (similar to the grant program created by the MMA for physician offices); and
- Create regional networks of counselors to assist Medicare beneficiaries in understanding the details of available plans and the implications for pharmacist-patient interactions (for example, using Area Agencies on Aging), thereby relieving some of the burden on pharmacists.

The study findings also support a set of long-term actions that focus on adapting the Part D program to the circumstances confronting rural independent pharmacies. These include the following:

- Create a category of safety-net rural pharmacies who are identified based on dependence on public sources of reimbursement and their need to ensure population access, similar to categories created for hospitals (e.g., critical access hospitals, disproportionate share), and require that payment to these pharmacies equals or exceeds by a small percent their actual costs (including costs for dispensing);
 - Require development and adoption of common reporting forms and procedures for prior authorizations and other routine interactions between pharmacies and Medicare PDPs;
- and

- Support information systems that include more efficient means of communications between pharmacies, physicians, and Medicare PDPs for the purposes of appealing disallowances of medications and for changing prescriptions to meet formulary requirements.

Conclusion

Responses from the 12 pharmacists interviewed illustrate the financial and operational challenges faced by rural independent pharmacies in adapting to the Medicare Part D program. These challenges include decreased reimbursement per prescription and the complexities of dealing with multiple carriers and plans. Identification of safety-net pharmacies and modification of existing policies and regulations may be necessary to ensure reasonable access to pharmaceuticals for rural populations. Further study in this area is needed.

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