
**One Year In:
Sole Community Rural Independent Pharmacies and Medicare Part D**

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Executive Summary

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established funding to allow up to 43 million Medicare beneficiaries to enroll in plans providing outpatient prescription drug coverage, beginning in January 2006.¹ The new Medicare Part D program has changed the means by which beneficiaries purchase prescription drugs, which is likely to affect the business operations of pharmacies. This paper describes the experiences of 51 rural independently-owned pharmacies that are the sole providers of pharmacy services in their community one year after implementation of Medicare Part D. All of the pharmacies in the study were located ten miles or more from the next closest pharmacy (either chain or independent). Issues are identified that may affect the ability of rural Medicare beneficiaries to continue to have full access to pharmaceuticals in their local communities. These issues warrant attention within the context of the current laws and regulations governing the Part D program.

Following implementation of Medicare Part D, it was not known whether the initial financial and administrative problems faced by sole community pharmacists would resolve over time. We find that one year after implementation, the sole community pharmacists interviewed continue to face administrative and financial challenges directly related to Medicare Part D. Three conclusions are apparent from the data collected:

- One year following implementation, dealing with Part D plans (PDPs) and working with patients during enrollment periods remains administratively burdensome;
- Areas of concern identified by pharmacists following program implementation in 2006, such as reimbursement levels, complexity of dealing with multiple plans, and timeliness of payments, continue to be cited as problem areas; and
- Opportunities to generate additional revenue through Medication Therapy Management (MTM) may be more limited for sole community providers due to a variety of factors, including limited time available for pharmacists to spend on MTM, relatively small numbers of eligible patients, and program requirements perceived as barriers to participation.

Other important findings from the study include the following:

- During open enrollment pharmacists and their staff spend approximately four and a half hours per day dealing with Part D enrollment and formulary issues.
- For 29 percent (n=15) of respondents, administrative activities during open enrollment decreased the time spent in patient counseling and other clinical activities.
- Twenty of the 23 respondents (87%) who were able to report their gross margin per prescription for Medicare Part D said it was lower than the gross margin they needed to stay in business.
- Although most respondents had not dropped any PDP plan contracts, for those who had, low reimbursement rates were the primary reason.

- For 78 percent of respondents, revenue from prescription sales accounted for at least 85 percent of total retail revenue; PDPs were consistently identified as one of the two lowest payers along with other third-party/commercial insurers.
- Almost all respondents were familiar with the MTM option under Part D, but only 51 percent reported offering this service and to only a small number of patients.
- Thirteen respondents raised concerns about their ability to sell their stores upon retirement.

The findings from this study, along with specific suggestions made by pharmacists during the interviews, suggest actions that can be taken to address the challenges faced by rural independent pharmacies who are the sole provider in their communities. To ease the administrative burden they face in working with multiple PDPs, technical and perhaps financial assistance (to purchase appropriate information systems and train in their use) could be provided to improve efficiencies in dealing with multiple plans. To ensure full choice for rural Medicare beneficiaries and full access to pharmaceuticals through the ongoing presence of a local pharmacy, a mechanism ensuring that reimbursement for prescriptions covers drug acquisition costs, related overhead and a reasonable profit margin could be developed. Such a policy could be targeted towards a subset of pharmacies that are essential for local access. Additional research into how existing policies and regulations can be modified to ensure reasonable access to pharmaceuticals for rural Medicare and Medicaid beneficiaries is also needed.

Introduction and Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established funding to allow up to 43 million Medicare beneficiaries to enroll in plans providing comprehensive outpatient prescription drug coverage, beginning in January 2006.² The new Medicare Part D program has changed the means by which Medicare beneficiaries purchase prescription drugs, which is likely to affect the business operations of pharmacies. Very little is known, though, about the effects of this new program on rural independent pharmacies.

This paper describes the experiences of rural independently-owned pharmacies one year after implementation of Medicare Part D, focusing on those that are the sole providers of pharmacy services in their community. Independently-owned pharmacies are known to have unique characteristics that make them especially vulnerable to major changes in reimbursement.³ These pharmacies typically have lower prescription volume than urban and chain retail pharmacies and may consequently have less leverage to negotiate prices with wholesalers. Further, independently-owned pharmacies are highly dependent on drug sales as their major source of revenue. There is concern that such pharmacies might be especially sensitive to policy changes that substantially alter payer mix and reimbursement. In rural areas, independents represent approximately half of all retail pharmacies. Thus it is of particular importance to understand the strain Part D might be placing on these important providers, especially those whose closure would leave their communities without a source of pharmaceutical care.⁴

Methods

This study was conducted by researchers from the North Carolina Rural Health Research & Policy Analysis Center and the RUPRI Center for Rural Policy Analysis. A semi-structured interview protocol was developed by the research team and informed by responses from pharmacists and representatives from state pharmacy associations who participated in a 2006 study of rural independent pharmacies, with additional input from academic experts.¹ The final interview protocol included questions regarding the pharmacist-owners' administrative efforts during the most recent enrollment period in the fourth quarter of 2006, Part D reimbursement, and the pharmacies' financial position; experiences with Part D contracting; and participation in Medication Therapy Management (MTM) programs.

To be included in our study, pharmacies had to be independently owned, located ten miles or more from the next closest pharmacy, and the owner could not own more than three pharmacies. A subset of pharmacies likely to meet these study criteria were identified using data from the National Council for Prescription Drug Programs, Inc. (NCPDP)⁵, which contain information about the 74,756 pharmacies in the U.S. with active provider numbers (used for payment). Using this dataset, pharmacies with the

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following characteristics were identified: the only pharmacy within its ZIP code; independently owned (including franchise licenses); operating as a community retail pharmacy; and physically located in a non-metropolitan ZIP code. Application of these criteria resulted in the identification of 1,422 rural independent pharmacies. This group was randomly ordered, and an initial sample of 250 pharmacies was generated. The final determination of whether or not a pharmacy was eligible to participate in our study was made during the initial telephone contact by use of screening questions. Potential respondents were asked if the pharmacy was independently owned, the number of pharmacies owned, and the distance to the next closest pharmacy.

The study goal was to complete 50 interviews. No attempt was made to contact 47 pharmacies. An attempt was made but no contact was made with 90 pharmacies (no answer or busy signal). Of the remaining 113, two were confirmed closed and eight are likely to have closed (phone disconnected, no listing on the world wide web), further reducing the sample to 103. For the 103 pharmacies in which we spoke with pharmacy personnel, 27 did not meet the study criteria. Of the remaining 76, 25 declined to participate and 51 participated, for a response rate of 67% (51/76). For those who declined to participate, the primary reasons given were lack of time and being short staffed.

Respondents were located in 27 of the 50 states and in eight of the nine census divisions (see Table 1).

Table 1: Geographic distribution of respondents (n=51)

Census Division	Number of Respondents	States Represented
NORTHEAST		
New England	0	
Middle Atlantic	3	NY, PA
MIDWEST		
East North Central	9	IL, IN, MI, OH
West North Central	11	IA, KS, MN, MO
SOUTH		
South Atlantic	8	GA, MD, SC, VA, WV
East South Central	3	AL, MS
West South Central	9	AR, LA, OK, TX
WEST		
Mountain	2	CO, ID
Pacific	6	AK, CA, OR, WA

Pharmacist-owners who were contacted were given the option to complete the interview at the time of the initial call or schedule a time that was more convenient for them. Participants who scheduled for a later date were provided a copy of the interview questions prior the scheduled interview time. Following each telephone interview, the entire research team reviewed notes taken by the interviewer to ensure clarity of responses and thoroughness of the interview. Responses to each question were aggregated and analyzed both separately and in conjunction with other questions.

Findings

Respondent Characteristics

A total of 51 pharmacist-owners of sole-community pharmacies were interviewed. For the purpose of this study, the term sole-community pharmacy was defined as any independently owned pharmacy located 10 or more miles from another pharmacy. On average, the self-reported proximity to the next closest pharmacy was 18 miles, with a range of 10 to 50 miles.

Seventy-six percent (n=39) of respondents reported owning only one pharmacy, while the remaining 24 percent (n=12) reported owning two or three stores.ⁱⁱ Staff size was generally small (Table 2). Fifty-eight percent (n=30) of the pharmacies in the study employed only one pharmacist (the pharmacist-owner), and the average number of full time equivalent (FTE) employees, including all pharmacists, technicians, and other employees, was 5.6.

Table 2: Pharmacy staffing levels (n = 51)

Position	Average Number of Full Time Equivalents*	Range Reported
Pharmacist	1.20	1.0 – 1.6
Pharmacy technician	1.80	0.0 – 3.5
Non-pharmacy staff	2.60	0.0 – 10.5

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

Twenty-two percent (n=11) of the respondents reported that someone regularly worked in an unpaid capacity in their store, and that person was typically a family member of the pharmacist-owner. Some of the volunteers' reported activities included bookkeeping, paying bills, stocking shelves, merchandising, and general store maintenance. We also learned that sometimes the unpaid worker was functioning as a pharmacy technician.

ⁱⁱ One respondent co-owned four stores with three other pharmacists in his region. All were independents who chose a co-ownership model to improve discounts available through bulk purchasing.

Administrative Effort During Open Enrollment

Respondents to our survey were asked questions regarding the time that their pharmacy's staff spent dealing with administrative issues related to Part D open enrollment and the burden these administrative issues placed on the pharmacist-owners and their business operations. During the most recent enrollment period, November 5 through December 31 of 2006, pharmacists and other staff averaged approximately four and a half hours per day dealing with Medicare Part D enrollment or formulary issues, though responses for total staff time per day ranged from 30 minutes to 13 hours. In half of the pharmacies surveyed (n=25), the pharmacist-owners took on the majority of this administrative work themselves. Other pharmacies relied more heavily upon paid staff to manage the new administrative work associated with Medicare Part D. Overall, the average amount of time per day reported for paid staff was two and a half hours and approximately two hours for pharmacists.

In many pharmacies, this administrative work was incorporated into the normal workday and did not require the pharmacist or staff to work additional hours. However, others found that the responsibilities of administering the Medicare drug benefit extended their typical workdays. Forty-seven percent (n=24) of the respondents reported personally working extra hours (7.3 hours per week on average), and 32 percent (n=16) indicated that their staff worked a few extra hours as a result of Part D enrollment activities.

Most pharmacists found their existing staff to be sufficient for the increased workload. Two reported hiring temporary staff to assist during the enrollment period. Unpaid volunteers such as family members or insurance representatives also assisted during the enrollment period in seven of the pharmacies surveyed. However, after the initial implementation of Part D in January 2006, two respondents found it necessary to hire an additional pharmacy technician on a permanent basis to manage the extra administrative work.

Because most of the additional hours were worked by the pharmacists, volunteers, or other salaried staff, few respondents indicated that Part D enrollment activities had a financial impact on their business in terms of additional payroll. Most respondents were unable to quantify the payroll increase if there was one; however, those who could generally reported increases of less than \$175 per week. Respondents did, however, identify other ways in which their businesses' finances were negatively affected by the increased administrative work related to Medicare Part D. For example, one pharmacist told us that during the enrollment period he was unable to spend time comparing drug prices and may have unnecessarily overpaid for his inventory.

Eighty percent (n=41) of respondents described ways in which administrative activities associated with Medicare Part D open enrollment displaced their usual work. Pharmacists talked about having less time in their workday for patient counseling and reading information about new medications (n=15). They also reported having less time for activities such as filling prescriptions, ordering, stocking shelves, merchandising, removing out-of-date merchandise, and cleaning. Many pharmacists were also unable to

keep up with bookkeeping and got behind in making bank deposits, reconciling payments, and paying bills. Repeatedly, pharmacists told us that the new workload interfered with their personal lives because they had to work late. In addition to sacrificing family time, many said they regularly gave up their lunch break in order to get all of the work done.

Talking with pharmacists, it became apparent that part of the challenge they face during enrollment periods is a limited availability of resources for their patients who have questions or who need guidance in selecting a drug plan. Approximately 63 percent (n=32) of respondents indicated that someone not affiliated with their pharmacy was available to help Medicare patients with enrollment questions during the most recent enrollment period. However, in 20 of the 32 communities where some external resource was available, the assistance was provided by representatives of the PDPs. For some pharmacists, this created concern about the impartiality and integrity of the advice that patients received, while in other communities these drug representatives were made available at the pharmacist's request. In 16 communities, counseling was made available by local organizations for the aged (senior citizen centers or area agencies for aging), nursing homes, hospitals, or community members.

We heard from the pharmacist-owners that they were one of the main sources of assistance for their patients who changed plans after initial enrollment. Sixty-one percent (n=31) reported that at least 10 percent of their Medicare customers changed plans for 2007, and one respondent noted that he believed many of his patients did not switch because they feared more problems and confusion would result. In some cases, pharmacists reported that patients switched plans because they were dissatisfied with their coverage. Respondents also reported that autoassignment has been a problem for a portion of patients dually eligible for Medicaid and Medicare. One pharmacist said that some of his patients were automatically assigned to plans that weren't even offered in his area; some of the plans were from other states. Another explained that patients were auto-assigned without consideration for their particular drug regimen. One pharmacist told us that some patients are getting lost in the system, and their coverage is accidentally being dropped completely.

An issue that came up repeatedly during our interviews was frustration over dealing with multiple drug plans' formularies and the resulting need to obtain prior authorization for Medicare Part D patients. Pharmacists talked about the challenges of working with physicians to identify the most appropriate drug for their patients given the formulary limitations of particular drug plans, and that both physicians and pharmacists spend a substantial amount of time on prior authorizations. One pharmacist told us that because of the volume of requests physicians now receive for prior authorizations, getting responses back takes days where it used to take just a few minutes.

Several respondents commented that there should be some consolidation of Part D drug plans. These pharmacists explained that the multitude of options makes it unnecessarily confusing to patients and labor-intensive for pharmacists who have to deal with each plan's reimbursement, prior-authorization, and coverage issues. One respondent said he

has patients who were enrolled in as many as four plans at a time, leaving him with the responsibility of determining which one to bill.

When asked to compare the burden of this year's open enrollment to last year's, 75 percent (n=38) of respondents said this year was less burdensome than last. However, they were quick to point out that even though the situation is improving, the administration of Part D still requires a lot of resources, and there is some anxiety about the future because of the changing array of PDPs. Finally, a majority of the respondents (73 percent) said that the general administration of Part D is more burdensome than for other payers.

Financial Profile and Part D Reimbursement

Respondents were asked to describe their pharmacy's overall financial position at the time of the interview. Thirty-one percent (n = 16) described their financial position as good, strong, or excellent. Forty-seven percent (n = 24) described their pharmacy's financial position as stable, average, or fair, while the remaining 22 percent (n = 11) described their financial position as poor, declining, or unstable. The pharmacists interviewed were also asked if their pharmacy's financial position had improved, stayed the same, or gotten worse compared to six months ago. For just over half (53%), their pharmacy's financial position was reported to be the same as six months prior to the interview (n = 27). Thirty-seven percent (n = 19) said their store's financial position declined over this time period while 10 percent (n = 5) saw an improvement. Reasons given for worsening financial positions included low reimbursement rates from Medicare PDPs and third-party/commercial insurers resulting in decreased margins and the increased time it takes to receive payments. Those with an improved financial position attributed it to cost cutting strategies and expansions in their non-pharmacy retail sales.

We found that the primary source of revenue for the rural independent pharmacies in our study is prescription sales. An overwhelming majority, 78 percent (n=40), of the pharmacists interviewed reported that revenue from prescription sales accounted for at least 85 percent of total retail revenue. For 31 percent (n = 16) of the respondents, sales of prescriptions accounted for 95 percent or more of their total retail revenue. Several respondents noted that while the volume of prescriptions filled had increased, total revenue had remained constant or had dropped due to decreases in payment per prescription.

Respondents were asked what percentage of their prescription revenue came from various payer types. For 51 percent (n=26) of respondents, Medicare Part D accounted for the largest portion of their total prescription revenue; 43 percent (n=22) of respondents reported that their largest source of revenue came from third-party/commercial insurers. For the remaining three pharmacies, their largest source of revenue was cash sales. The median percentage of total revenue by payer type across the full sample is summarized in Table 3 below.

Table 3: Percentage of total patient revenue by payer type*

	Part D (n=48)	Third Party / Commercial (n=46)	Medicaid (n=49)	Cash (n=47)
Median	35%	31%	16%	10%
Minimum	8%	0%	3%	1%
Maximum	83%	66%	35%	60%

*Other payers were reported by some respondents; however percentages were very small and are not reported here.

Respondents were also asked to rank the different payer types from highest/best payer to the lowest/worst payer. For all but one of the 49 respondents who answered this question, cash was ranked as the best payer, followed by Medicaid as the second best payer. With the exception of that same pharmacy, Medicare PDPs were consistently identified as one of the two lowest payers along with third-party/commercial insurers.

Respondents were asked about their Part D gross margin per prescription, and what level of gross margin they needed to remain financially viable. Gross margins were reported in a variety of formats from absolute dollars to percentages, so a direct data comparison was not possible.ⁱⁱⁱ However, comparisons between Part D gross margin and the gross margin needed to remain viable could be made for each individual respondent. For the 23 respondents who were able to report their gross margin per prescription for Medicare Part D, 87 percent (n=20) indicated that it was lower than the gross margin they needed to stay in business.

To understand other financial stressors on these rural independent pharmacies, respondents were asked if they had any outstanding business loans and, if so, whether or not these loans were taken out before or after the implementation of Part D in January 2006. Just over half of the respondents, 59 percent, (n = 30) reported having no outstanding business debt. Among the 21 respondents who did report having business loans, 49 percent of these (n = 10) had taken out the loans prior to Part D, 29 percent (n = 6) incurred loans since the implementation of Part D, and 24 percent (n = 5) had taken out loans both before and after program implementation.

Respondents reported that loans taken out prior to the implementation of Part D were generally to start, purchase, or improve their pharmacies. Most of the loans taken out since program implementation were to shore up cash flow and to purchase prescription

ⁱⁱⁱ An objective assessment of the financial performance of rural independent pharmacies is difficult because unlike hospitals, home health agencies, or other institutional providers, there is no standardized financial reporting required of pharmacies (such as a Medicare cost report). This lack of standardized reporting and a common data set along with the multiple financial reporting options available to independent pharmacies, as small privately-owned businesses, makes a comprehensive analysis of financial performance challenging.

drugs from wholesalers. Respondents who incurred loans following the implementation of Part D were asked whether or not their decision to take out these loans was the result of Part D. Eight of the 11 respondents attributed Part D, specifically the impact of low reimbursement and delays in receiving payments, as the primary reason for their loans.

Part D Contracts

We queried the respondents about whether they had made any changes in the number of PDPs they contracted with during the year since program implementation. Of the 51 pharmacist-owners interviewed, 84 percent (n=43) had not dropped any plans with whom they had previously contracted. Eleven of these respondents stated that they had been very selective when signing contracts initially. One respondent who reported being selective during the initial contract signing is now threatening to drop certain plans because of changes made to the original contract terms. An additional five of those respondents who had not dropped plans said they are strongly considering doing so in the future. Some (n=5) respondents reported that it would not be fair to their patients if they dropped a plan.

Among the 16 percent (n=8) of respondents who had dropped plans, six reported low reimbursement rates as the primary reason. Other reasons for ending contracts included difficulties working with the plan, slow payment, and changes in contract terms. Those that had dropped plans all reported that fewer than 10 percent of their patients were affected by this change. Most commonly, less than 2 percent of their patients were affected.

90-Day Prescriptions

Fifty-five percent (n=28) of the pharmacist-owners reported offering a 90-day supply of medications. The most common reasons respondents gave for offering a 90-day supply were that patients requested it and that it was necessary in order to be competitive with mail-order pharmacies. Respondents also said it was a service that makes getting medications more convenient for patients. Six respondents told us they fill 90-day prescriptions only because it was in their initial contract. A few respondents stated that they had agreed to fill prescriptions for 90 days only with contracts that offered reasonable reimbursement rates (i.e. the same as or only slightly lower than what would be received by filling three 30-day prescriptions).

Eighteen of the 28 respondents who offer 90-day prescriptions were unable to report the specific reimbursement rate for these prescriptions; however, 19 reported that it was lower than their average rate for 30-day supplies. Only one pharmacist-owner reported a higher average reimbursement rate for 90-day prescriptions when compared to 30-day. Among the 10 respondents who could report specific reimbursement levels, average reimbursement rates for 90-day prescriptions ranged from average wholesale price (AWP) less 22 percent to AWP less 5 percent.

Among the 45 percent (n=23) of respondents who said they do not offer 90-day prescriptions, 19 cited low reimbursement rates as a major reason for not offering this service. Others reported little patient demand for filling 90-day supplies. Two pharmacist-owners felt that 90-day supplies were wasteful because in their experience, unless a medication is used for long-term maintenance, dosing frequently changes within a 90-day period and the full prescription is not used. One respondent explained that he did not offer 90-day supplies because he felt it was important to have regular face-to-face interaction with his patients in order to make sure they are staying healthy and seeing their doctors—in some cases 90 days without seeing a patient may be too long. Fifteen of the 23 respondents who did not offer a 90-day supply of medications believed they have lost patients as a result and that some of this loss may also be attributed to patients being redirected to mail-order pharmacies by their PDP.

Medication Therapy Management

Medication therapy management (MTM) is a reimbursable service in Medicare Part D meant to optimize therapeutic outcomes for individual patients. The types of services involved in MTM can include (but are not limited to) formulating medication treatment plans; monitoring and evaluating responses to therapy; performing comprehensive medication reviews to identify, resolve, and prevent medication-related problems; and providing verbal education and training to improve understanding and appropriate use of medications.⁶

Ninety-three percent (n=47) of respondents were familiar with the MTM option under Part D. When asked approximately what percentage of their Part D contracts provided the option to participate in MTM, many were either unable to answer or gave rough estimates. According to the 39 pharmacists who were able to provide a specific answer to the question, on average, one out of five Part D contracts provided the option for MTM. Three of the participants were not offered any Part D contracts that included MTM programs.

When asked whether they had chosen to participate in any MTM programs, 51 percent of respondents (n=26) reported that they were offering this service to some of their Medicare Part D patients. Among those 26 pharmacists, 19 were involved in only one program, four were involved in two programs, one was involved in four programs, one was involved in 18 programs, and one did not answer the question. Pharmacists participating in MTM had a median of six patients enrolled; however, responses ranged widely from zero to 90 patients.

We also asked the 26 pharmacists participating in MTM whether they had joined all of the MTM programs available to them through Medicare Part D contracts. Over three quarters (n=20) of the respondents reported having joined all available programs. Of the remaining pharmacists, three did not join all available programs, two were not sure whether or not they had joined all of the programs available, and one did not answer.

Pharmacists who offered MTM were asked whether they felt MTM programs were profitable from a business perspective, given the resources it took to provide the service. Nine respondents thought that MTM made a profit, 10 respondents thought it broke even, two thought it lost money, three were unsure, and two did not answer the question.

For respondents that did not participate in all of the MTM plans offered to them, three provided a number of reasons for their decision. One chose not to participate in some plans due to low reimbursement rates, and another said the need to have a second pharmacist available to interact with customers during an MTM session was a barrier to participation. Two of these pharmacists noted that they had to limit the number of MTM programs they signed up for because providing the service was so time-consuming. One pharmacist who was offered two MTM plans only chose to participate in one and promoted it over the other because it had a higher reimbursement rate.

The 45 percent (n=23) of respondents who reported not participating in any MTM programs listed a wide range of reasons for their decision.^{iv} Most often, pharmacists were unable to offer MTM because of time or staffing constraints. Sixty-five percent of these (n=15) felt that it was too time consuming to provide the service, and 14 respondents cited that the need to have another pharmacist solely to provide MTM while the store was open was reason for not participating. Other reasons included a lack of a private space to conduct MTM as required by the Part D providers (7); that the mandatory training/certification was too time-consuming (6); that Part D reimbursements for MTM was too low (2); and that the expense of purchasing a separate computer system, which was required by one MTM plan, was too high (1).

Several pharmacists explained that, although they do not participate in formal MTM programs, they already provide these services to many of their patients. Respondents also expressed interest and intention to begin offering MTM in the future. However, a few pharmacists commented that they do not have enough patients who would qualify for the service to make it worthwhile to provide MTM.

Both participating and non-participating pharmacists discussed other issues they had with MTM. One of the respondents expressed concern that patients would no longer be able to receive advice outside of paying for MTM and added that many people would be unable or unwilling to pay for the service. This respondent felt that dangerous levels of neglect would result. Similarly, another respondent noted MTM would not work unless patients saw it as a benefit and that patients would resist having to pay for a service they were used to getting for free. However, one respondent believed that as pharmacists are paid less for doing more work, paying for MTM would become the only way for customers to receive advice. Another respondent commented that the only future for pharmacists would be getting into the management of healthcare, and that healthcare companies needed to offer more MTM programs.

^{iv} Two respondents did not answer the question regarding participation in MTM programs.

Respondents' Additional Comments and Suggestions

At the conclusion of the interview, pharmacists were asked if they had any other thoughts regarding their experiences with Medicare Part D that they would like to share. Many of the respondents provided additional comments and recommendations. While the comments varied broadly, several key areas of concern emerged. These key areas include future plans to retire and sell the business, concerns over the implementation of the new Medicaid drug payment rule, frustration with low reimbursement rates and the slow reimbursement process, and the need to simplify plans and improve communication.

Future Plans to Retire and Sell the Business

One topic of conversation that was introduced by 13 of the respondents was concern about their ability to sell their stores upon retirement. Respondents felt that their decreasing profit margin might make the idea of owning an independent pharmacy less enticing to potential buyers. One pharmacist stated that he believes owning a rural independent pharmacy is no longer financially viable and that “he would discourage anybody from going into the field.” Two other pharmacists felt that they could not, in good conscience, sell their struggling businesses to another individual. Finally, several respondents who are currently trying to sell their stores mentioned that they have not had any interested buyers. One is considering trying to sell both his physical location and book of business to a chain, while the other is considering selling only her book of business to the nearest chain located 25 miles away (physical location would close). Both pharmacists were very concerned that these alternatives would be detrimental to their customers' wellbeing.

Implementation of the New Medicaid Drug Payment Rule

Repeatedly, respondents expressed anxiety about the potential effect that new Medicaid drug payment rules may have on their pharmacies. As part of the Deficit Reduction Act of 2005, state Medicaid agencies will be subject to new federal reimbursement limits for prescription drug payments. Following the implementation of this new policy, states will use Average Manufacturer's Price (AMP) information as the basis for setting drug reimbursement rates for their participating pharmacy providers. Six of the survey respondents mentioned concern that the proposed change will negatively affect their profitability by lowering the reimbursement they receive from their state Medicaid agencies.

For many of the rural independent pharmacies surveyed, Medicaid is the second best payer after cash and provides a significant source of revenue. Four respondents felt that the new Medicaid drug payment rule will decrease their profit margin to the point where they will be forced to close their businesses. One pharmacist said that if the new Medicaid reimbursement rate is enacted as currently proposed, he did not see how independent pharmacies would be able to take Medicaid patients and stay in business. Another pharmacist called the potential change in Medicaid reimbursement “the final nail in the coffin.”

Low and Slow Reimbursement

A key area of concern that was frequently mentioned by respondents was low reimbursement rates and slow reimbursement times by the Part D plans. Nine pharmacists reported that their Medicare Part D reimbursement rates were too low to be profitable. One pharmacist mentioned that the Part D maximum allowable cost (MAC) is so low that he only makes two dollars to three dollars per prescription, instead of the 10 dollars he needs to stay in business. Two other respondents said that Medicare Part D reimbursement rates would have to increase for them to stay in business. Pharmacists' recommendations to improve reimbursement rates include allowing pharmacists to purchase medication at the same cost as mail order companies and paying pharmacists higher reimbursements fees when they save money for the PBMs by catching mistakes, such as unnecessarily prescribed or expensive medications.

Nine respondents reported that it takes excessive amounts of time to receive reimbursement from the various Medicare Part D plans, noting that it takes between 30 and 90 days to get reimbursed for Medicare prescriptions. Such lengthy payment delays have caused cash flow problems for some pharmacies. In order to improve reimbursement times, one pharmacist recommended that "Part D should be set up like a food stamp system where they have a card with a certain amount of points to use towards meds and payment only takes a matter of days." Two other pharmacists recommended that all Part D plans initiate direct deposit of reimbursements.

Need for Better Communication

Five pharmacists mentioned difficulty in communicating with PDPs about formulary and benefit issues. One pharmacist complained that help desks for the Part D plans are inaccessible and unresponsive compared to other commercial third party plans. Another pharmacist mentioned long waits on the phone in order to reach a customer support representative. Seven respondents also mentioned the need for better communication between Part D plans and their beneficiaries, recommending that plans better inform their enrollees about benefit levels and the amount of money remaining in their accounts before the beneficiary reached their coverage gap. One noted that while many Part D plans have established online customer support services, they have failed to consider that a large portion of the population they are serving often does not have or know how to use computers.

Need to Simplify Part D Program

Respondents also brought up the current complexity of the Medicare Part D program. Thirteen pharmacists noted that Medicare Part D is too complex, confusing, and time consuming. Respondents stated that they were having difficulty keeping track of the different Part D plans and their various reimbursement rates, formulary restrictions, and required paperwork. They reported that dealing with the various Part D plans was very time consuming and took away from time spent with their customers. Several

pharmacists also noted that Part D was too confusing for the beneficiaries. Respondents recommended that the plans that participate in Part D be streamlined and standardized in order to simplify the program for both pharmacists and beneficiaries. One pharmacist specifically recommended that all plans be required to use the same source for MAC prices and that a universal price guide be created and used by everyone for all medications.

Discussion

The implementation of Medicare Part D in 2006 resulted in a significant change in payer mix for rural independent pharmacies. Previous interviews with sole community pharmacists found a large decrease in the percentage of patients who were covered by Medicaid or were non-covered cash pay following program implementation.⁷ Administrative burdens also increased as the number of payers pharmacists dealt with grew substantially as multiple plan options became available to patients who formerly had no coverage or were covered by Medicaid. Immediately following implementation it was unknown whether the initial financial and administrative problems faced by sole-community pharmacists would resolve over time. We find that one year after Part D's implementation, the sole-community pharmacists interviewed continue to face administrative and financial challenges directly related to Medicare Part D. Three conclusions are apparent from the data collected:

- One year following implementation, dealing with PDPs and working with patients during enrollment periods remains administratively burdensome;
- Areas of concern identified by pharmacists following program implementation in 2006, such as reimbursement levels, complexity of dealing with multiple plans, and timeliness of payments, continue to be cited as problem areas; and
- Opportunities to generate additional revenue through MTM may be more limited for sole community providers due to a variety of factors including limited pharmacist time available to spend on MTM, relatively small numbers of eligible patients, and program requirements perceived as barriers to participation.

For independently owned pharmacies in rural communities the administrative tasks necessary to deal with multiple PDPs instead of the relatively few payment sources available prior to Part D (Medicaid, supplemental insurance, and cash transactions) can divert time and money from other tasks, resulting in both a clinical and financial impact. Open enrollment periods increase this administrative workload as pharmacists assist patients with enrollment decisions. Almost a third of respondents (29 percent) noted that administrative tasks associated with open enrollment decreased the time they were able to spend in clinical activities such as patient counseling. Given that participation in MTM is currently not widespread, this decreased time available for patient interactions could have quality implications. This is an area that requires additional study and monitoring over time to ensure that quality is not unintentionally compromised.

The pharmacists interviewed reported administrative tasks during open enrollment also took time away from revenue generating activities such as filling prescriptions and other tasks necessary to managing cash flow. Direct impact of this increase in administrative tasks on a pharmacy's bottom line is difficult to estimate, and this study draws no conclusion regarding the size of this financial impact. While Part D was identified as more administratively burdensome than other payers, it is not known specifically how the administrative burden of Part D compares to the administrative efforts required by non-Part D commercial plans. To ease the administrative burden of working with multiple PDPs, technical and perhaps financial assistance (to purchase appropriate information systems and train in their use) is warranted to improve efficiencies in dealing with multiple plans. Since public policy created the multiple plan environment, there could be a role for public policy to assist pharmacists that are essential providers in rural communities in adjusting to the new operating realities.

The administrative burden on sole community pharmacists could be lessened during the open enrollment period by increasing patients' access to other community resources that provide assistance in sorting through plan options. This study found that in some communities rural beneficiaries turn to their local pharmacist for enrollment assistance, while in others, although assistance is available from someone other than the pharmacist, it is not always originating from reliable sources. This indicates the need for CMS to continue its efforts to enlist "partners," especially in isolated rural communities, to help seniors work through their Part D options. Additional research into the ability of patients served by sole community pharmacies to access these potential community partners is needed.

With revenue from prescription sales being the primary source of operating income for the pharmacists interviewed, Medicare Part D has clearly affected their businesses' financial position. While Part D and third party commercial insurers constitute the largest percentages of these pharmacists' payor mix, they were also identified as the two lowest payers. Some pharmacists reported that their businesses were at risk of financial failure, and concerns were raised regarding the ability to sell the business upon retirement. Medicare Part D, however, cannot be identified as the sole reason for potential financial difficulties; private contracts and Medicaid changes also contribute. Since payment for Medicare beneficiaries moved from the best sources (cash and Medicaid) prior to Part D to one of the worst, there is prima facie evidence that to remain financially solvent pharmacies must respond by developing other sources of revenue, finding administrative savings, or lowering operating costs (e.g., attempting to negotiate lower prices from manufacturers, trying to shift prescriptions to alternatives with reasonable margins per prescription). However, due to a lack of purchasing power as compared to large chains, it is difficult for sole community pharmacies to negotiate lower acquisition costs with manufacturers. When strategies to develop other sources of revenue or to cut costs are not available or sufficient, pharmacies are at risk.

Until modifications are made to the Part D program or resources are made available for safety net pharmacies, sole community pharmacists should explore additional strategies for dealing with Part D plans. One strategy includes being selective in signing contracts

and not participating with the lowest reimbursing PDPs, a strategy adopted by many of the pharmacists interviewed for this study. A second strategy is to explore all other revenue sources available from PDP plans, such as MTM. However, these strategies will have varying levels of success for rural pharmacies. For a subset of sole community pharmacies, these strategies will not be effective, either due to low reimbursement options from all area PDPs, an unwillingness of PDPs to negotiate higher reimbursement levels, an inability to meet all conditions necessary to deliver MTM services, or the presence of only a small number of patients who qualify for MTM plans under Part D, thus limiting potential revenue.

A rural Medicare beneficiary's ability to choose from a variety of PDPs can directly conflict with a sole-community pharmacist's need to be selective and only participate with the plans whose reimbursement levels provide a reasonable margin. Also, the convenience and cost savings rural Medicare beneficiaries may experience by purchasing their maintenance medications for chronic conditions through 90-day mail order can conflict with a sole-community pharmacy's financial need to fill prescriptions at a higher 30-day rate. If, however, sole-community pharmacies lose so much business to mail order that it causes them to close, rural Medicare beneficiaries lose local access for acute/urgent prescriptions.

To maintain full choice for rural Medicare beneficiaries, as well as full access to pharmaceuticals through the on-going presence of a local pharmacy, a mechanism needs to be created which ensures that reimbursement for pharmaceutical services covers drug acquisition costs, related overhead, and a reasonable profit margin. Such a policy could be targeted towards a subset of pharmacies that are essential for local access. Additional research into how existing policies and regulations can be modified to ensure reasonable access to pharmaceuticals for rural Medicare and Medicaid beneficiaries is also needed.

¹ Office of the Inspector General. Retail Pharmacy Participation in Medicare Part D Prescription Drug Plans in 2006. June 2007. OEI-05-06-00320

² Office of the Inspector General. Retail Pharmacy Participation in Medicare Part D Prescription Drug Plans in 2006. June 2007. OEI-05-06-00320

³ Fraher et al. How might the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 affect the financial viability of rural pharmacies? An analysis of preimplementation prescription volume and payment sources in rural and urban areas. *Journal of Rural Health*. Vol 21, no.3; 114-121.

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⁵ The National Council For Prescription Drug Programs, Inc. (2005). Pharmacy database. Available from the National Council for Prescription Drug Programs Web site, <http://www.ncdp.org/provider.asp>

⁶ Bluml, B. Definition of medication therapy management: development of professionwide consensus. *Journal of the American Pharmacists Association*. Vol 45, No. 5; 566-572.

⁷ Radford A, Slifkin R, Fraser, R, et al. The Experience of Sole Community Rural Independent Pharmacies with Medicare Part D: Reports from the Field. *Journal of Rural Health*. Vol. 23, No. 4, 286-293.