Statement of Tim Tucker of the American Pharmacists Association (APhA)
House Committee on Government Reform on the Medicare Drug Benefit
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Good morning. I am Tim Tucker, a pharmacist and owner of City Drug Company Pharmacy, in Huntingdon, Tennessee. I am here today representing the American Pharmacists Association (APhA), of which I am also a member of the Board of Trustees.

The American Pharmacists Association (APhA) welcomes the opportunity to present the pharmacist's perspective on the implementation of the new Medicare prescription drug benefit, Medicare Part D. As the medication experts on the health care team, and the front-line health professionals dedicated to partnering with patients to improve medication use, pharmacists have a unique perspective on the benefit. APhA, founded in 1852 as the American Pharmaceutical Association, represents more than 53,000 pharmacist practitioners, pharmaceutical scientists, student pharmacists, pharmacy technicians, and others interested in advancing the profession. APhA members provide care in all practice settings such as community pharmacies, hospitals, long-term care facilities, managed care organizations, hospice settings, and the military.

Pharmacists' recent efforts to implement Part D highlight the fact that they are the most important health care professional to successful implementation of Medicare drug benefit. We are the glue that holds the health care system together when it comes to medication use. Pharmacists have worked hard to ensure that the challenges with this benefit do not disrupt patient care, and that patients who were previously unable to afford their medications now can. The Medicare program needs to include coverage for prescription drugs, and it is imperative that we make this benefit work.

A Rocky Start

Unfortunately, the start of the new Medicare prescription drug benefit would be described by many patients and pharmacists as a nightmare. Community pharmacists, bearing the brunt of implementing the new benefit, discovered that the 'choice' Congress required in the benefit led to a cumbersome number of plans, yielding chaos. Some of those plans were well-prepared to implement the benefit. Many were not. Simple steps were unnecessarily challenging. For the last few weeks, my pharmacy has been more of an eligibility verification center and insurance navigator than a health care facility. Many of my patients were confused about their new coverage, many simply did not know the name of their new plan, or in some cases, that their medication coverage changed from the Medicaid to the Medicare program. Because prescription drug coverage programs are often navigated at the pharmacy counter, I and other pharmacists endured (and in some cases, continue to endure,) the following:

- Calling plan's customer service lines and being placed on hold for hours. When the call was answered, I was often told to call back when the plan was less busy, or, worse, was provided with incorrect information. Some calls were simply terminated by the plans—they hung up on us.

- Plans that confirmed enrollment with beneficiaries yet had not yet entered the beneficiary's information into their system—so our pharmacy's claims for that patient were rejected because the patient was 'not in the plan'.
- Calling the dedicated pharmacy line established by the Centers for Medicare & Medicaid Services (CMS) only to find out that the customer service representatives are unable to answer my question because I needed more information from the patient, who may have already left my practice or may not have had the additional, necessary information with them.
- Wide variation in plan procedures to authorize the CMS-mandated transition supplies of medications.
- Finally completing the process to secure billing information and submitting claims for my patient's prescriptions, only to have the plans return the wrong co-pay and deductible information—particularly for my patients moving from the Medicaid to the Medicare program.
- Dual eligibles were auto-enrolled in plans that do not have in-network pharmacies in their area. The options the plans offered these beneficiaries were to pay cash or drive a long distance — neither of which is a likely option for this patient population.

Pharmacists Answered the Call

Pharmacists' commitment to helping patients access their necessary medications has never been more evident than in the last few weeks. Even amidst all the chaos, pharmacists answered the call and patients were served. While our efforts were not always 100% successful, many more patients would have gone without their medications during this implementation phase without a concerted effort by pharmacists. It is not often that one hears reports of health care providers giving away care for free, yet pharmacists were because of our belief that patient care should take precedence over insurance red tape. But in some situations, the price of the medication—and the uncertainty of insurance coverage—precluded me and my colleagues from simply handing out medications. If I had some assurance that insurance coverage was indeed available, it was easier to provide a few days supply of medication and work through the challenges. But in some situations I was unable to find any information, and only able to provide so many medications on blind faith. At the end of the day, I want to care of my patients, but I also have to be able to keep the doors open and the lights on. Recent statements by the Secretary of Health and Humans Services that 'no one should leave the pharmacy without their medications' are not helpful, particularly when some pharmacies have reported up to $40,000 in outstanding receipts.

I am proud of my profession's efforts. And many patients have expressed great appreciation to me and my colleague pharmacists for the efforts we have undertaken on their behalf. Without pharmacists' efforts, patient care would have been greatly damaged. Unfortunately, pharmacy's efforts were met with negative consequences to the practice of pharmacy — both economic and clinical. Because of the size of the program and the realization that implementing a benefit of

this magnitude would likely have its challenges, CMS required plans to provide patients with a transition supply of their current medications— most often a 30 day supply—regardless of plan formularies or other drug coverage policy. The purpose of this supply was to ensure that administrative glitches didn't result in patients going without necessary medications. A transitional supply could be used when a patient's current medication is not included on the plan's drug formulary. Transitional supplies are critical to ensuring that patient care is not disrupted. Unfortunately, the procedure for securing the transition supply for one plan differed from the next, so the red-tape burden continued to mount.

The humanitarian response of pharmacy was similar to pharmacy's response to the hurricane crises. Patient care trumped red tape. But that red tape must be addressed. Requiring pharmacists to provide free drugs or face hours of telephone calls to secure insurance information or secure authorization for a month's supply of medications should not be considered a viable option. Such protocols are system flaws that cannot be sustained on the backs of pharmacy. Administration of the benefit should not take pharmacists away from their primary role of taking care of patients. The solutions to the problems, such as State efforts to cover medication supplies until transition issues are addressed, are welcome but only helpful if the associated red tape with those safety net programs is minimal.

Thankfully, pharmacists were not alone in their efforts. CMS worked closely with interested parties, including APhA and our members, to identify and resolve issues as they arose. Many of CMS' efforts prior to implementation were also helpful, such as the computer communication system that allowed pharmacists to request information about a patient's eligibility. When this system worked, it was great. Throughout implementation, CMS has been a good partner. As a result, improvements to the system were made daily. For example, CMS' dedicated pharmacy line's availability changed from 'normal business hours' to twenty-four hours a day/seven days a week and staffing increased dramatically; eligibility query response time was reduced from minutes to seconds; and CMS instructed plans to increase the number of customer service representatives available to assist pharmacists and to be sure those people were prepared to answer my questions and those of my colleagues. While problems remain, CMS' efforts should be commended.

The Weakest Link

So who is to blame for this fiasco? A primary culprit was those prescription drug plans that weren't prepared. Some plans were ready for January 1st, others simply were not. Some plans improved their operations, others have yet to show improvement. Some of their challenges were created by the structure of the program — it really wasn't realistic to assure beneficiaries that they could sign up for a plan on December 31st and use that plan at their local pharmacy on January 1st. But the 'choice' directive from Congress compounds the challenges of implementing this benefit. For example, in Tennessee there are eighteen companies providing over 40 different prescription drug plans and that doesn't take into account the many managed

care plans also serving Medicare beneficiaries in the state. Each of these plans has a different formulary, a different system for processing claims, and different capacities for addressing problems. Multiply this scenario by the total number of states and territories each with their own multitude of plans and it quickly becomes clear why administrating this benefit has been chaotic.

Maintaining the current level of choice and supporting that level of inconsistency creates a heightened demand for plans to take ownership of their role in making the benefit work and fix their structural flaws. The next potential for chaos — formulary management — will soon raise its ugly head. Transition supplies that have been provided to patients will soon run out. In order to prevent disruption of patient care, prescribers must begin working through each plans' formulary management procedures (such as prior authorization requests). The first few weeks provided many 'lessons learned'. Identified program flaws must be addressed to ensure the benefit is a success. Plans that are unable to meet their contractual obligations should face stiff penalties. This market-based system is reliant upon the market for success, and to date, some elements of that market have failed.

In the end, it is patients who suffer from these system flaws. To better ensure that Congress is getting what it paid for, there must be greater assurances that we are receiving a fair return on investment in the new program. If patients are unable to get the medications that they were prescribed and pharmacists are unable to help patients make the best use of those medications because the pharmacist is busy trying to process claims, can we claim success at having added drug coverage to Medicare? Pharmacy's ability to navigate administrative duties or to be 'emergency responders', providing medications and care without payment, is sustainable for only a limited amount of time. Not addressing these issues, which place the economic burden of implementing the Medicare drug benefit onto pharmacy, will have a negative impact on patient care by limiting patient access to pharmacists — either limiting a pharmacist's time to provide patient care or eventually damaging pharmacy's economic infrastructure to a degree that results in limited access to pharmacies. If nothing else, the last three weeks suggest that it is time to re-examine our infrastructure.

Re-evaluating the Infrastructure

Pharmacists are distinguishable from other health care providers. We can only give away so many medications before they must close their doors. The heroic efforts of most pharmacists over the last few weeks to implement Medicare Part D resulted in economic losses that may not be recoverable, because much of their practice's income is in medications. Unfortunately, these expenses are soon to be compounded by pending changes in the Medicaid program. Despite extensive outreach by the pharmacy community, Congress retained significant Medicaid cuts to pharmacy in their final budget package. The potential for serious patient harm from these cuts is real. Trusting that pharmacists will be available in the future to provide services is misplaced if Congress proceeds with these payment cuts.

It is imprudent to damage the infrastructure on which one relies to implement the largest change to Medicare since the program's inception. But that is what Congress is about to do. It is time for policymakers to ask, how would patients have been served during implementation of the Medicare drug benefit with reduced access to pharmacies or pharmacists? Clearly, far more problems with the new benefit would have harmed far more patients.

A fundamental flaw in the private sector infrastructure, on which this benefit relies, puts the private sector in everyone's medicine cabinet. Pharmacy is one part of health care where the payor is intimately involved in what the patient receives. It is not like physician services, where perhaps a health insurer requires a second opinion before a procedure is 'covered'. That evaluation is completed before the point of service. Drug coverage decisions, however, are rarely addressed until the patient is facing the pharmacist, and the red tape clouds patient care.

We don't debate what will be covered — anesthesia or cesarean sections — in the delivery room. It is time to stop having those debates at the pharmacy counter, when the patient is trying to understand medication regimens that are critical to their health care needs. As we have moved to more outpatient care that relies heavily upon medications and patients' ability to manage those medication regimens, we have removed health care providers from the mix and inserted insurance companies. Pharmacy benefit management can be helpful — it can yield savings to the health care system and promote the use of effective, lower-cost interventions. But those savings should not come about because patients are denied necessary therapy. We must improve the system.

Conclusion

Amidst the chaos and confusion, there is some good news. The new prescription drug benefit was a success for many patients. Medicare beneficiaries are finally receiving financial relief for their medication costs. Some of my patients are returning to my practice because they are now able to afford their medications.

To the degree the program has and will be a success is reflective of pharmacists, as well as the efforts of CMS and other agencies. We applaud those who have recognized the critical role pharmacists play in assisting patients with the new drug benefit. Efforts by CMS, state Governors, and Members of Congress to address the issues raised during the transition to the new drug benefit were essential as well.

However, we must also recognize the absurdity of undercutting the very infrastructure responsible for making the Medicare drug benefit work. Congress' cuts to pharmacy are misguided; they will not 'reform' the infrastructure as Congress' portends, and do not include assurances that pharmacy can cover their costs for providing care to patients. Without such assurances, pharmacists cannot serve any patients — Medicaid or Medicare. Policymakers must begin reflecting that reality in their decisions.

Thank you for your consideration of the views of the nation's pharmacists. APhA looks forward to working with interested parties to develop a more effective system of providing prescription medications to Medicare beneficiaries.