Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

RETAIL PHARMACY PARTICIPATION IN MEDICARE PART D PRESCRIPTION DRUG PLANS IN 2006

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EXECUTIVE SUMMARY

OBJECTIVE

1. To determine the extent to which retail pharmacies participate in Medicare Part D stand-alone prescription drug plans (PDPs).
2. To determine how many Medicare Part D stand-alone PDPs are offered by participating retail pharmacies.

BACKGROUND

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) makes comprehensive prescription drug coverage under Medicare Part D available to all Medicare beneficiaries through stand-alone PDPs or Medicare Advantage plans.

Under Part D, private sponsors contract with pharmacies to create pharmacy networks that provide Part D-covered drugs to beneficiaries enrolled in their plans. To ensure that pharmacy networks offer beneficiaries access to retail pharmacies, MMA required the Centers for Medicare & Medicaid Services (CMS) to establish retail pharmacy access standards.

To provide beneficiaries with a choice of plans and sponsors, MMA requires at least two plans offered by different sponsors to be available in every region. In 2006, 1,429 PDPs were available, with beneficiaries in 29 of the 34 PDP regions having a choice of at least 40 PDPs. Additionally, beneficiaries had a choice of at least 15 different plan sponsors in every region except Alaska (11) and Hawaii (12).

To examine beneficiaries' access to retail pharmacies dispensing Part D-covered drugs, we determined the extent to which retail pharmacies participate in PDPs. To assess beneficiaries' choice of plans, we determined the number of plans offered by retail pharmacies. To determine if characteristics of pharmacies, such as location or ownership, affect participation rates, we compared rates of participation between retail pharmacies in metropolitan and nonmetropolitan counties and between independent and chain retail pharmacies.

FINDINGS

Nearly all retail pharmacies participate in Medicare Part D. Ninety-seven percent of retail pharmacies participate in at least one PDP. Moreover, most nonparticipating retail pharmacies are located within 5 miles of a participating retail pharmacy.

Retail pharmacies in metropolitan and nonmetropolitan counties participate at similarly high rates. However, there are approximately four times as many retail pharmacies in metropolitan counties as in nonmetropolitan counties. In areas where fewer retail pharmacies are located, beneficiary access to retail pharmacies that dispense Part D-covered drugs will also be more limited.

Seventy percent of participating retail pharmacies offer beneficiaries the choice of all available PDPs in their region. The majority of participating retail pharmacies offer beneficiaries the choice of every PDP available in their region. Retail pharmacies in metropolitan and nonmetropolitan counties offer beneficiaries the choice of all available PDPs at similarly high rates.

Fewer independent retail pharmacies offer beneficiaries the choice of all PDPs available in their region compared to chain pharmacies. Forty-four percent of independent retail pharmacies offer beneficiaries the choice of every PDP available in their region compared to 84 percent of chain retail pharmacies. However, most independent and chain retail pharmacies offer beneficiaries the choice of at least half of the available PDPs.

CONCLUSION

Our findings indicate that beneficiaries' access to retail pharmacies that dispense Part D-covered drugs does not appear to be limited by retail pharmacies' participation in PDPs. Nearly all retail pharmacies participate in at least one PDP and 70 percent of participating retail pharmacies offer beneficiaries the choice of all available PDPs in their region. Further, 97 percent of participating retail pharmacies offer beneficiaries the choice of at least half of available PDPs. Although having fewer retail pharmacies located in an area may limit beneficiary access to retail pharmacies, our findings suggest that Part D does not further limit beneficiary access.

AGENCY COMMENTS

CMS stated that it was pleased with our findings that beneficiary access to retail pharmacies dispensing Part D-covered drugs does not appear to be limited by retail pharmacies' participation in PDP networks. Additionally, CMS reiterated its commitment to ensuring that Part D beneficiaries have access to retail pharmacies.

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BACKGROUND

The Medicare Prescription Drug Benefit

Effective January 1, 2006, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) made comprehensive prescription drug coverage under Medicare Part D available to all 43 million Medicare beneficiaries.[1] Beneficiaries generally have the option to enroll either in a stand-alone PDP and receive all other benefits through traditional Medicare fee-for-service, or in a Medicare Advantage plan (MA plan) and receive all Medicare benefits (including drug coverage) through managed care.[2] In June 2006, the Centers for Medicare & Medicaid Services (CMS) reported that 16 million beneficiaries were enrolled in a PDP and an additional 6 million were enrolled in an MA plan.[3]

To provide Part D drug coverage, private sponsors contract with CMS to offer plans in one or more of the PDP or MA plan regions. CMS has designated 34 PDP regions and 26 MA plan regions.[4] Each region covers one State at a minimum, and some regions cover multiple States.

Within each region, sponsors may compete for beneficiary enrollment by offering several plans with a variety of features. Features may include different premiums, cost sharing, formularies, and pharmacy networks. In 2006, 1,429 PDPs were available nationwide, ranging from 27 to

[1] Pub. L. No. 108-173.

[2] 42 U.S.C. § 1395w–101.

[3] News Release, Department of Health and Human Services, "Over 38 Million People With Medicare Now Receiving Prescription Drug Coverage" (June 14, 2006). Available online at http://www.hhs.gov/news/press/2006pres/20060614.html. Accessed December 21, 2006.

[4] News Release, Department of Health and Human Services, "HHS Announces Regions To Administer New Medicare Prescription Drug Benefit and Medicare Advantage Program" (December 6, 2004). Available online at http://www.hhs.gov/news/press/2004pres/20041206.html. Accessed December 21, 2006.

52 PDPs per region. In 29 of the 34 regions, beneficiaries had a choice of at least 40 PDPs. In addition, beneficiaries had a choice of at least 15 different sponsors in every region except Alaska (11) and Hawaii (12).[5]

Although sponsors are allowed broad discretion to deliver drug coverage under Medicare Part D, the MMA established standards regarding certain program features, such as retail pharmacy access and choice of plans and sponsors.

Retail Pharmacy Access Standards

To provide Part D drug coverage, sponsors contract with pharmacies to create pharmacy networks that provide Part D-covered drugs to beneficiaries enrolled in their plans. A sponsor must offer its standard contract to any pharmacy that is willing to participate in its pharmacy network.[6] Sponsors may contract with many different types of pharmacies, such as retail, institutional, or mail-order pharmacies.

To ensure that pharmacy networks offer beneficiaries access to retail pharmacies[7] (as opposed to institutional or mail-order pharmacies) that dispense Medicare Part D-covered drugs, Federal law required CMS to establish retail pharmacy access standards based on the standards used by the Department of Defense's TRICARE Retail Pharmacy program, the health care plan for military personnel and their families.[8]

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[5] Kaiser Family Foundation, "The Growth of Private Plans in Medicare, 2006." Available online at http://www.allhealth.org/briefingmaterials/Kaiser-GrowthofPrivatePlansinMedicare-255.pdf. Accessed December 7, 2006.

[6] 42 U.S.C. § 1395w–104(b)(1)(a).

[7] As defined in the final regulation [42 CFR § 423.100], a retail pharmacy is "any licensed pharmacy that is not a mail order pharmacy from which Part D enrollees could purchase a covered Part D drug without being required to receive medical services from a provider or institution affiliated with that pharmacy."

[8] 42 U.S.C. § 1395w–104(b)(1)(C)(ii).

As such, CMS established retail pharmacy access standards[9] requiring each plan to have pharmacy networks with a sufficient number of retail pharmacies to meet the following criteria at the State level:

- At least 90 percent of Medicare beneficiaries, on average, in urban areas live within 2 miles of a network retail pharmacy;
- At least 90 percent of Medicare beneficiaries, on average, in suburban areas live within 5 miles of a network retail pharmacy; and
- At least 70 percent of Medicare beneficiaries, on average, in rural areas live within 15 miles of a network retail pharmacy.[10]

Every year, CMS reviews PDPs' compliance with the retail pharmacy access standards to ensure that beneficiaries maintain access to retail pharmacies that dispense Part D-covered drugs.

Guaranteed Choice of Plans and Sponsors

To ensure that Medicare beneficiaries have a choice of plans and sponsors, Federal law requires that at least two plans offered by different sponsors be available in every region, and at least one of those plans must be a PDP.[11]

Federal law requires the creation of a "fallback plan" whenever two plans from different sponsors are not available in a region.[12] Given that beneficiaries had a choice of between 27 and 52 PDPs in 2006, fallback plans were unnecessary.

Related Office of Inspector General Work

In addition to conducting this study, the Office of Inspector General (OIG) is conducting work that will compare reimbursements to independent and franchise retail pharmacies with the prices they pay for drugs, including dispensing fees. Additionally, OIG will explore

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[9] To meet the access standards, plans may contract with certain nonretail pharmacies, including pharmacies operated by the Indian Health Service, Indian tribes, and urban Indian Organizations (I/T/U);, Federally Qualified Health Centers (FQHC); and Rural Health Centers (RHC). 42 CFR § 423.120(a)(2). However, CMS stated its intent to "review Part D plans' proposed pharmacy networks to ensure that their inclusion of I/T/U, FQHC, and RHC pharmacies does not substitute for the inclusion in Part D plan networks of retail pharmacies." Medicare Prescription Drug Benefit, 70 Fed. Reg., 4194, 4249 (January 28, 2005).

[10] 42 CFR § 423.120(a), 42 CFR § 423.100.

[11] 42 U.S.C. §1395w–103.

[12] 42 U.S.C. § 1395w–103.

contracting provisions of PDPs that include independent and franchise retail pharmacies in their networks.

METHODOLOGY

Scope

This study assessed pharmacy participation in PDPs available in 2006. We limited our analysis to pharmacies identified as retail. We did not include types of pharmacies that serve specific populations and are not generally open to the public.[13] We did not assess retail pharmacy participation in MA plans. Additionally, we did not verify whether the PDPs met CMS's retail pharmacy access standards.

Data Collection

We obtained a comprehensive list of all State-licensed pharmacies located within the 50 States or the District of Columbia as of October 2, 2006, from the National Council for Prescription Drug Programs (NCPDP). The list included pharmacies' unique NCPDP pharmacy numbers and other descriptive information used to identify retail pharmacies and classify pharmacies as independent or chain.

For a list of all retail pharmacies that participate in each PDP's pharmacy network, we obtained the October 2006 Pharmacy Cost file from CMS. Sponsors may supply an updated list of network pharmacies as frequently as every 2 weeks. In the Pharmacy Cost file, network pharmacies are identified by their unique NCPDP pharmacy numbers.

Because of pharmacies' opening and closing and the time lag associated with reporting these events, there is some potential for pharmacies to be on one list and not the other. To limit this potential difference, we used files from the same time period, October 2006.

Data Analysis

Using each pharmacy's unique NCPDP pharmacy number, we matched retail pharmacies listed on the Pharmacy Cost file to the appropriate address and descriptive information supplied in the NCPDP file.

NCPDP categorizes pharmacies by type, such as retail, institutional, or mail-order. We limited our analysis to pharmacies identified as retail. Of the 73,398 pharmacies included in the NCPDP file, 58,768 were classified as retail.

[13] Excluded pharmacies include I/T/U, FQHC, and RHC pharmacies.

NCPDP data also indicate whether the pharmacy is independent, chain, or franchise.[14] For our analysis of pharmacy participation rates of independent and chain pharmacies, we grouped franchise pharmacies with independent pharmacies because franchise pharmacies are independently owned. Of the 58,768 retail pharmacies, 21,727 were classified as independent or franchise (hereafter referred to as independent) and 37,041 were classified as chain.

Retail Pharmacy Participation in PDPs. To examine beneficiaries' access to retail pharmacies dispensing Part D-covered drugs, we determined the extent to which retail pharmacies participate in PDPs. To accomplish this, we calculated the percentage of retail pharmacies participating in at least one PDP.

To determine the impact of nonparticipation of retail pharmacies on beneficiary access, we compared the location of retail pharmacies not participating to the location of participating retail pharmacies. Each retail pharmacy's address, as listed in the NCPDP file, was geocoded using the Geographic Information System ArcGIS 9.1 software.[15]

We improved our geocoding by replacing post office box addresses with actual street addresses, when possible. For those addresses that could not be geocoded based on the actual street address, we geocoded based on ZIP Code.[16] Of the 58,768 retail pharmacies, 77 percent were geocoded at the address level and 23 percent were geocoded at the ZIP Code level. Six retail pharmacies could not be geocoded.

For our analysis of the distance between participating and nonparticipating retail pharmacies, we determined the number of nonparticipating retail pharmacies farther than 5 miles from a participating retail pharmacy. First, we determined the number of nonparticipating retail pharmacies geocoded at the street level that

[14] As defined by NCPDP, an independent pharmacy is part of a group of fewer than three pharmacies under common ownership. A chain pharmacy is part of a group of four or more pharmacies under common ownership. A franchise pharmacy is independently owned but has a franchise agreement with another company to receive marketing, training, and/or other support.

[15] Geocoding is the process of assigning geographic coordinates (i.e., latitude and longitude) to an address. The more specific the address information used to geocode (i.e., the entire street address versus only the ZIP Code), the more accurate the geographic coordinates.

[16] We used population-weighted ZIP Code centroids from Great Data to geocode at the ZIP Code level. A population-weighted ZIP Code centroid is the center of the ZIP Code, taking into account population densities within the ZIP Code.

were farther than 5 miles from a participating retail pharmacy geocoded at the street level. Second, to be conservative, we counted nonparticipating retail pharmacies geocoded at the ZIP Code level as farther than 5 miles from a participating retail pharmacy because we were unable to precisely geocode their location. As a result, we may have overestimated the number of nonparticipating retail pharmacies farther than 5 miles from a participating retail pharmacy, given that 70 percent of nonparticipating retail pharmacies geocoded at the ZIP Code level are located in metropolitan counties.

To determine whether there are differences between rural and urban beneficiaries' access to participating retail pharmacies, we compared retail pharmacy participation rates using the Economic Research Service's urban influence codes. An urban influence code is a 12-level county classification scheme, divided into metropolitan and nonmetropolitan counties, that captures differences in population size, urbanization, and access to larger communities.

Although CMS uses TRICARE classifications of rural, suburban, and urban for Part D, as required by law, some commenters on the relevant proposed rule contended that the TRICARE classifications are broad and define as rural a number of beneficiaries who actually are not.[17] In comparison, urban influence codes provide a narrower definition of rural, capture greater variation in rural areas, and are commonly used by rural health researchers. For a comparison between retail pharmacies' TRICARE classifications and urban influence codes, see Appendix A.

We determined each retail pharmacy's urban influence code by matching its ZIP Code with the appropriate county using two files—one supplied by CMS and the other purchased from Great Data, a third-party vendor of ZIP Code data. We were unable to determine the county for four retail pharmacies.

For ease of reading, we present our analyses by metropolitan and nonmetropolitan counties in the body of the report. For a map of metropolitan and nonmetropolitan counties, see Appendix B. For greater detail, we also provide each analysis by all 12 urban influence codes in Appendix C.

[17] Medicare Prescription Drug Benefit, 70 Fed. Reg. 4194, 4247-4248 (January 28, 2005).

To determine whether beneficiary access to retail pharmacies participating in a PDP is potentially limited because of a lack of participation by independent pharmacies, we compared rates of participation between independent and chain pharmacies.

Number of PDPs offered by retail pharmacies. To assess beneficiaries' choice of plans, we determined the number of PDPs offered by retail pharmacies. As with participation rates, we also analyzed the data by urban influence codes and independent/chain classifications.

Standards

This study was conducted in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

Nearly all retail pharmacies participate in Medicare Part D

Ninety-seven percent of retail pharmacies throughout the country participate in at least one PDP. Of the 58,768 retail pharmacies in the United States, only 1,478 do not participate in any PDP. The high rate of retail pharmacy participation suggests that beneficiaries' access to retail pharmacies that dispense Part D-covered drugs is not limited by Part D.

Moreover, most nonparticipating retail pharmacies are located near a participating retail pharmacy. Of the 1,478 retail pharmacies that do not participate in a PDP, fewer than one-third are farther than 5 miles from a participating retail pharmacy. Furthermore, 80 percent of nonparticipating pharmacies are located in metropolitan counties.

Table 1, below, provides a summary of retail pharmacy participation rates by pharmacy type and county classification.

Table 1. Retail Pharmacy Participation Rates by Pharmacy Type and County Classification

County Classification	Overall Percentage of Retail Pharmacies Participating in a PDP	Percentage of Independent Retail Pharmacies Participating in a PDP	Percentage of Chain Retail Pharmacies Participating in a PDP
Metropolitan	98%	94%	99%
Nonmetropolitan	97%	96%	100%
Overall Total	**97%**	**94%**	**99%**

Source: OIG analysis of retail pharmacy participation in PDPs, 2006.

Retail pharmacies in metropolitan and nonmetropolitan counties participate at similarly high rates

Almost all retail pharmacies participate in a PDP, regardless of whether they are located in metropolitan or nonmetropolitan counties. Ninety-seven percent of retail pharmacies in nonmetropolitan counties and 98 percent of retail pharmacies in metropolitan counties participate in a PDP. Additionally, even pharmacies in the most rural areas, when broken out by urban influence codes, have high rates of participation. Table 5 in Appendix C presents a detailed analysis of retail pharmacy participation rates by urban influence codes.

Even though retail pharmacy participation rates are similar, there are approximately four times as many retail pharmacies in metropolitan counties as in nonmetropolitan counties. Additionally, 150 of 2,052 nonmetropolitan counties do not have any retail pharmacies. In areas where fewer retail pharmacies are located, beneficiary access to

retail pharmacies dispensing Part D-covered drugs will also be more limited.

Almost all independent and chain retail pharmacies in metropolitan and nonmetropolitan counties participate

Overall, independent and chain retail pharmacies participate at similarly high rates: 94 percent of independent retail pharmacies and 99 percent of chain retail pharmacies participate in a PDP.

Regardless of whether they are located in metropolitan or nonmetropolitan counties, independent and chain retail pharmacies participate at high rates. Ninety-six percent of independent retail pharmacies and 100 percent of chain retail pharmacies in nonmetropolitan counties participate in a PDP. Similarly, independent and chain retail pharmacies in metropolitan counties have high rates of participation. Table 6 in Appendix C presents a detailed analysis of independent and chain retail pharmacy participation rates by urban influence codes.

Seventy percent of participating retail pharmacies offer beneficiaries the choice of all available prescription drug plans in their region

Overall, the majority of participating retail pharmacies offer beneficiaries the choice of every PDP available in their region. In addition, 97 percent of participating retail pharmacies overall offer beneficiaries the choice of at least half of the PDPs available in their region. With 40 or more PDPs available in most regions, the majority of participating retail pharmacies offer beneficiaries the choice of a significant number of PDPs.

Table 2, below, provides a summary of beneficiary choice in PDPs overall and by participating pharmacy type and county classification.

Table 2. Beneficiary Choice in PDPs by Participating Pharmacy Type and County Classification

	Percentage of Retail Pharmacies That Participate in 100% of PDPs in Region			Percentage of Retail Pharmacies That Participate in 50% of PDPs in Region		
County Classification	**Overall**	**Independent**	**Chain**	**Overall**	**Independent**	**Chain**
Metropolitan	70%	41%	83%	97%	93%	99%
Nonmetropolitan	67%	49%	88%	97%	94%	100%
Overall Total	**70%**	**44%**	**84%**	**97%**	**93%**	**99%**

Source: OIG analysis of retail pharmacy participation in PDPs, 2006.

Retail pharmacies in metropolitan and nonmetropolitan counties offer beneficiaries the choice of all available PDPs at similarly high rates

The majority of participating retail pharmacies, regardless of whether they are located in metropolitan or nonmetropolitan counties, offer beneficiaries the choice of all available PDPs. Seventy percent of participating retail pharmacies in metropolitan counties and 67 percent of participating retail pharmacies in nonmetropolitan counties offer beneficiaries the choice of every PDP available in their region.

Moreover, almost all participating retail pharmacies, regardless of whether they are located in metropolitan or nonmetropolitan counties, offer beneficiaries the choice of at least half of available PDPs. Ninety-seven percent of participating retail pharmacies in both metropolitan and nonmetropolitan counties offer beneficiaries the choice of at least half of the PDPs available in their region. Additionally, 90 percent of participating retail pharmacies in the most rural areas, when broken out by urban influence codes, offer beneficiaries the choice of at least half of available PDPs. Table 7 in Appendix C presents a detailed analysis of beneficiary choice in PDPs by urban influence codes.

Fewer independent retail pharmacies participate in every PDP available compared to chain retail pharmacies

Forty-four percent of participating independent retail pharmacies offer beneficiaries the choice of every PDP available in their region, compared to 84 percent of participating chain retail pharmacies. This is similar to the ratio of independent to chain retail pharmacy participation rates broken out by metropolitan and nonmetropolitan counties.

However, 93 percent of participating independent retail pharmacies and 99 percent of participating chain retail pharmacies offer beneficiaries the choice of at least half of the PDPs available. Given that between 27 and 52 PDPs are available in each region, the vast majority of participating independent and chain retail pharmacies offer beneficiaries, at a minimum, a choice of between 14 to 26 PDPs, depending on the region. Table 8 in Appendix C presents a detailed analysis of beneficiary choice in PDPs by participating pharmacy type and urban influence codes.

CONCLUSION

Our findings indicate that beneficiaries' access to retail pharmacies that dispense Part D-covered drugs does not appear to be limited by retail pharmacies' participation in PDPs. Nearly all retail pharmacies participate in at least one PDP, and 70 percent of participating retail pharmacies offer beneficiaries the choice of all available PDPs in their region. Further, 97 percent of participating retail pharmacies offer beneficiaries the choice of at least half of available PDPs. Although having fewer retail pharmacies located in an area may limit beneficiary access to retail pharmacies, our findings suggest that Part D does not further limit beneficiary access.

Additionally, although independent and chain retail pharmacies have high rates of participation and offer beneficiaries a choice of plans, our analysis shows that a lower proportion of independent retail pharmacies offer beneficiaries the choice of all available plans. OIG is conducting additional work to further explore the interaction between independent retail pharmacies and the Part D prescription drug program.

AGENCY COMMENTS

CMS stated that it was pleased with our findings that beneficiary access to retail pharmacies dispensing Part D-covered drugs does not appear to be limited by retail pharmacies' participation in PDP networks. CMS also stated that it was pleased that the findings do not demonstrate significant differences in participation rates in metropolitan versus nonmetropolitan counties or between chain and independent pharmacies. Additionally, CMS reiterated its commitment to ensuring that Part D beneficiaries have access to retail pharmacies. The full text of CMS' comments is in Appendix D.

COMPARISON OF RETAIL PHARMACIES' TRICARE CLASSIFICATIONS AND URBAN INFLUENCE CODES

TRICARE classifications and urban influence codes are both used to classify areas as urban or rural. According to TRICARE, an urban area is defined as any ZIP Code with more than 3,000 persons per square mile. A suburban area is defined as any ZIP Code with between 1,000 and 3,000 persons per square mile. A rural area is defined as any ZIP Code with fewer than 1,000 persons per square mile.

In contrast, urban influence codes are a 12-level county classification system that broadly classifies counties as metropolitan or nonmetropolitan. Metropolitan counties are further divided into two groups by the size of the metropolitan area. Nonmetropolitan counties are divided into 10 groups by the size of the largest town and proximity to metropolitan counties. This allows for a more sophisticated classification of different types of rural experiences.

Table 3 provides the county description, number of counties, and population per square mile for each urban influence code. Urban influence codes are presented in order from most urban (1) to most rural (12).

Table 3. Urban Influence Codes

Urban Influence Code	County Description	Number of Counties	Population per Square Mile
Metropolitan Counties:			
1	Large metropolitan (Large metro)	414	558
2	Small metropolitan (Small metro)	676	132.4
Total		**1,089**	
Nonmetropolitan Counties:			
3	Micropolitan (micro) adjacent to large metro	92	54.7
4	Noncore adjacent to large metro	123	26.8
5	Micro adjacent to small metro	301	51.4
6	Noncore adjacent to small metro with town	358	23.5
7	Noncore adjacent to small metro with no town	185	5.6
8	Micro not adjacent to metro area	282	27
9	Noncore adjacent to micro with own town	201	16.7
10	Noncore adjacent to micro with no own town	198	6.7
11	Noncore not adjacent to metro or micro with town	138	4.6
12	Noncore not adjacent to metro or micro with no town	174	3.5
Total		**2,052**	

Source: U.S. Department of Agriculture, Economic Research Service, 2003.

We compared retail pharmacies' TRICARE classifications and urban influence codes. To classify pharmacies according to TRICARE standards, we used a file obtained from the Centers for Medicare & Medicaid Services (CMS) to classify each pharmacy based on its ZIP Code. We could not obtain the TRICARE classifications for 77 pharmacies.

TRICARE's classifications of urban and suburban match the urban influence code of metropolitan. Overall, almost all retail pharmacies classified as urban or suburban by TRICARE are also classified as metropolitan using urban influence codes.

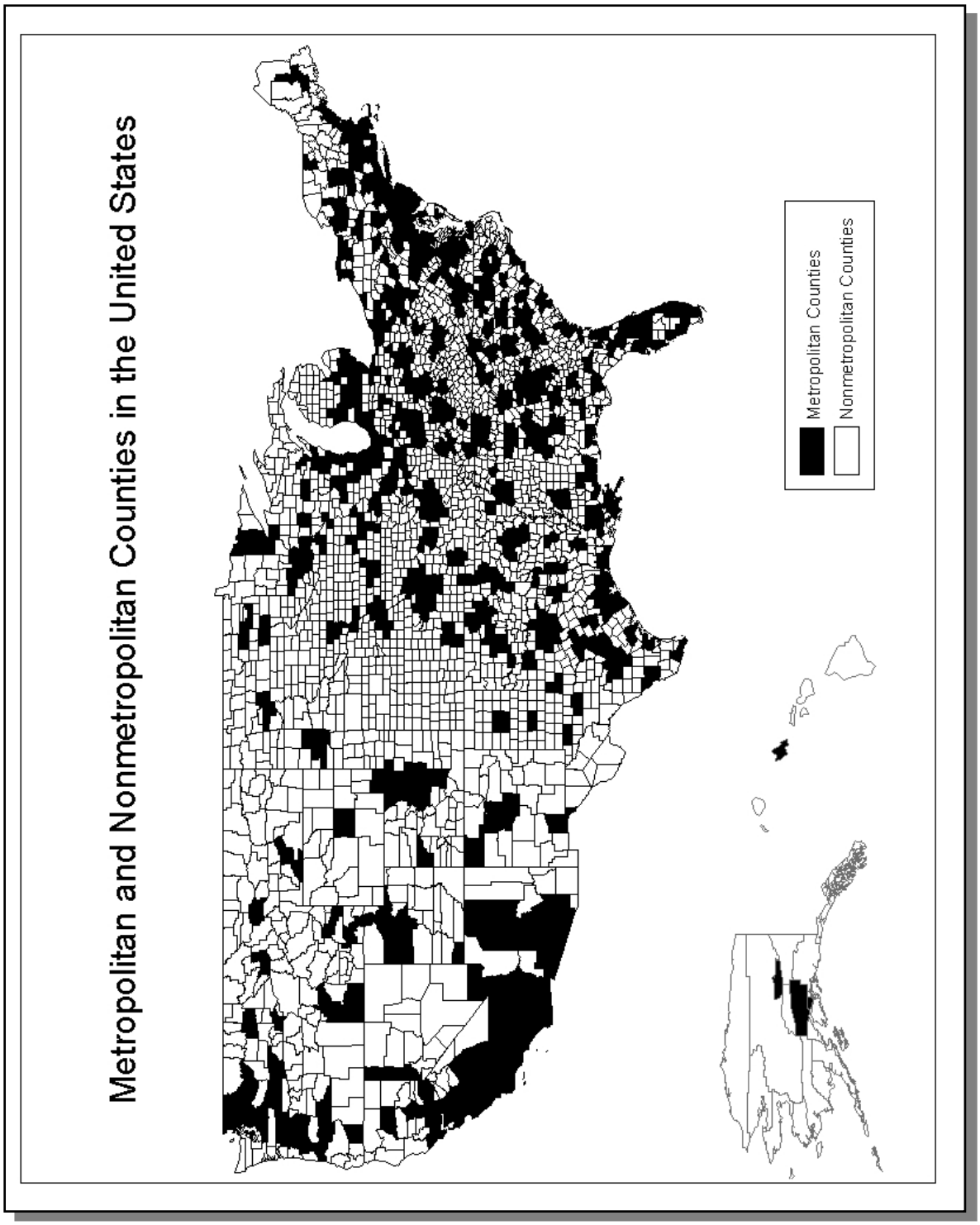
However, classifying retail pharmacies as nonmetropolitan using urban influence codes applies stricter criteria than classifying pharmacies as rural using TRICARE standards. Because of TRICARE's broad definition of rural, more retail pharmacies are classified as rural under TRICARE than are classified as nonmetropolitan by urban influence code. In fact, of the 27,216 retail pharmacies classified as rural by TRICARE, 15,686 are classified as metropolitan by urban influence code. Therefore, by using urban influence codes, we were able to more accurately target rural areas for our analyses. Table 4 gives the number of retail pharmacies defined as urban, suburban, or rural by TRICARE in each urban influence code.

Table 4. Retail Pharmacies Defined as Urban, Rural, or Suburban by TRICARE in Each Urban Influence Code

Urban Influence Code	Defined as Urban by TRICARE	Defined as Suburban by TRICARE	Designated Rural by TRICARE
Metropolitan Counties:			
1	16,772	7,157	5,902
2	2,535	4,865	9,784
Total	**19,307**	**12,022**	**15,686**
Nonmetropolitan Counties:			
3	0	20	1,077
4	0	1	547
5	5	56	3,200
6	0	3	1,955
7	0	0	431
8	20	38	2,111
9	1	2	865
10	0	0	382
11	0	0	665
12	0	0	297
Total	**26**	**120**	**11,530**
Overall Total	**19,333**	**12,142**	**27,216**

Source: OIG analysis of retail pharmacies, 2006.

MAP OF METROPOLITAN AND NONMETROPOLITAN COUNTIES



ANALYSES BY URBAN INFLUENCE CODE

The following tables provide the analyses presented in the report broken down by urban influence codes.

Urban influence codes are presented in order from most urban (1) to most rural (12).

Table 5. Retail Pharmacy Participation Rates by Urban Influence Codes

Urban Influence Code	Percentage of Retail Pharmacies Participating in at Least One Prescription Drug Plan (PDP)	Total Number of Retail Pharmacies
Metropolitan Counties:		
1	97%	29,868
2	98%	17,211
Total	**98%**	**47,079**
Nonmetropolitan Counties:		
3	98%	1,099
4	98%	548
5	98%	3,265
6	98%	1,959
7	96%	431
8	96%	2,169
9	98%	869
10	97%	382
11	99%	666
12	97%	297
Total	**97%**	**11,685**
Overall Total	**97%**	**58,768**

Source: Office of Inspector General analysis of retail pharmacy participation in PDPs, 2006.

Table 6. Independent and Chain Retail Pharmacy Participation by Urban Influence Codes

Urban Influence Code	Percentage of Independent Retail Pharmacies Participating in at Least One PDP	Number of Independent Retail Pharmacies	Percentage of Chain Retail Pharmacies Participating in at Least One PDP	Number of Chain Retail Pharmacies
Metropolitan Counties:				
1	94%	9,612	99%	20,256
2	94%	5,733	99%	11,478
Total	**93%**	**15,345**	**99%**	**31,734**
Nonmetropolitan Counties:				
3	95%	439	100%	660
4	97%	328	100%	220
5	96%	1,521	99%	1,744
6	96%	1,173	100%	786
7	95%	324	100%	107
8	93%	1,104	99%	1,065
9	96%	556	100%	313
10	97%	322	100%	60
11	97%	385	100%	281
12	97%	229	100%	68
Total	**96%**	**6,381**	**100%**	**5,304**
Overall Total	**94%**	**21,727**	**99%**	**37,041**

Source: Office of Inspector General analysis of retail pharmacy participation in PDPs, 2006.

Table 7. Beneficiary Choice in PDPs by Urban Influence Codes

Urban Influence Code	Percentage of Retail Pharmacies That Participate in 100% of PDPs in Region	Percentage of Retail Pharmacies That Participate in at Least 75% of PDPs in Region	Percentage of Retail Pharmacies That Participate in at Least 50% of PDPs in Region
Metropolitan Counties:			
1	69%	95%	97%
2	71%	95%	97%
Total	**70%**	**95%**	**97%**
Nonmetropolitan Counties:			
3	75%	97%	99%
4	68%	93%	98%
5	71%	94%	97%
6	65%	92%	97%
7	58%	89%	97%
8	69%	92%	96%
9	65%	93%	97%
10	49%	86%	92%
11	64%	91%	95%
12	45%	79%	92%
Total	**67%**	**93%**	**97%**
Overall Total	**70%**	**94%**	**97%**

Source: Office of Inspector General analysis of retail pharmacy participation in PDPs, 2006.

A P P E N D I X ~ C

Table 8. Beneficiary Choice in PDPs by Participating Pharmacy Type and Urban Influence Code

Urban Influence Code	Percentage of Retail Pharmacies That Participate in 100% of PDPs in Region		Percentage of Retail Pharmacies That Participate in at Least 75% of PDPs in Region		Percentage of Retail Pharmacies That Participate in at Least 50% of PDPs in Region	
	Independent	Chain	Independent	Chain	Independent	Chain
Metropolitan Counties:						
1	40%	83%	85%	99%	93%	99%
2	44%	84%	86%	99%	93%	99%
Total	**41%**	**83%**	**86%**	**99%**	**93%**	**99%**
Nonmetropolitan Counties:						
3	54%	88%	92%	100%	97%	100%
4	52%	91%	87%	100%	97%	100%
5	49%	89%	89%	99%	95%	100%
6	48%	90%	87%	99%	95%	100%
7	47%	87%	87%	97%	96%	100%
8	52%	86%	85%	99%	92%	100%
9	50%	90%	90%	98%	96%	98%
10	41%	87%	83%	100%	91%	100%
11	46%	89%	87%	97%	91%	100%
12	32%	88%	73%	99%	90%	99%
Total	**49%**	**88%**	**87%**	**99%**	**94%**	**100%**
Overall Total	**44%**	**84%**	**86%**	**99%**	**93%**	**99%**

Source: Office of Inspector General analysis of retail pharmacy participation in PDPs, 2006.

AGENCY COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: MAY 24 2007

TO: Daniel R. Levinson
Inspector General

FROM: Leslie V. Norwalk, Esq.
Acting Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report: "Retail Pharmacy Participation in Medicare Part D Prescription Drug Plans in 2006" (OEI-05-06-00320)

Thank you for the opportunity to review and comment on the above OIG Draft Report. The OIG's study examined beneficiaries' access to retail pharmacies that dispense covered Part D drugs, based on the extent to which retail pharmacies participate in prescription drug plans (PDPs).

The Centers for Medicare & Medicaid Services (CMS) is committed to ensuring that Part D beneficiaries have access to retail pharmacies in accordance with both the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), and our final regulations at 42 CFR 423.120(a)(1). The retail pharmacy access standards under the Medicare prescription drug benefit program, which are based on the standards used by the Department of Defense's TRICARE Retail Pharmacy program, ensure that Part D enrollees have convenient access to their covered Part D drugs at retail pharmacies participating in their Part D plans' networks.

We appreciate the OIG's thorough review of beneficiary access to retail pharmacies under the Medicare Part D program. The stringency of our retail pharmacy access standards necessitates broad contracting with retail pharmacies by Part D plans. We are, therefore, pleased with the OIG's findings that beneficiary access to retail pharmacies dispensing covered Part D drugs does not appear to be limited by retail pharmacies' participation in PDP networks. We are also pleased with the finding that any limitations in beneficiary access to retail pharmacies are due to limited retail pharmacy infrastructure, and not to limited PDP contracting with pharmacies. We are particularly pleased that the findings do not demonstrate significant differences in participation rates in metropolitan versus non-metropolitan areas, or between chain and independently-owned pharmacies.

Thank you for your efforts to study this important matter. CMS takes quite seriously its commitment to ensuring that all Part D enrollees are able to access their prescription drug benefits at the retail pharmacies that best meet their needs.

ACKNOWLEDGMENTS

This report was prepared under the direction of Ann Maxwell, Regional Inspector General for Evaluation and Inspections in the Chicago regional office, and Thomas Komaniecki, Deputy Regional Inspector General.

This report was led by Suzanne Bailey. Other principal Office of Evaluation and Inspections staff from the Chicago regional office who contributed include Melissa Hafner and Mollie Hertel. Other principal central office staff who contributed include Linda Boone Abbott, Kevin Farber, and David Graf.