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"Physicians see this as one more health plan, as an annoyance. Ninety-nine out of 100 will say don't bother me if they're asked about reconsideration or drug coverage."

—[Joel Brill, MD, MRAW](#) advisor



Question corner

PDPs should be able to flag double-rebate dipping

Under plan contracts, manufacturers will have to pay rebates based on utilization. But if a government low-income network pharmacy reimbursed via the 340B program carries and then dispenses a product to a Part D beneficiary, should the manufacturer have to pay a second rebate? Prescription drug plans (PDP) should be able to identify when these pharmacies seek a rebate after dispensing a drug to a Part D beneficiary. "Our system can definitely flag this," says [David Clark](#), Regence's pharmacy director. "I can understand why manufacturers would be concerned about this."

Manufacturers are already required to pay their best price to the government's 340B low-income network pharmacies, so the issue lies in whether the plans will be able to detect when one of these pharmacies seeks an additional rebate for Part D dispensing. "It would be tough to flag if, for example, we don't know the pharmacy is 340B," Clark says. "If the pharmacy bills us at the normal rate and paid pennies on the dollar [for the drug], they double-dip." All plans should have that capability to flag these rebates, but whether they will is another story, adds Clark. [T](#)

Physician apathy about CAP, Part D won't last

On January 9, [Joel Brill, MD](#), shared the following opinions with MRAW.

PART D BUMP

A patient has rheumatoid arthritis and receives Remicade through Medicare B. But Part B forces the patient to pay full cost for all of his or her other medications, such as anti-inflammatory medicines or Methotrexate injections. The cost of these drugs under Part D is now calculated as part of true out-of-pocket costs, or TrOOP. The takeaway: Expect to

see another bump in enrollment from March to April as more seniors who need high-cost medications start to understand the lure of the catastrophic cap. Patients with inflammatory bowel syndrome, multiple sclerosis, and other conditions—not just cancer and HIV—will benefit.

2008

If you're a prescription drug plan (PDP), the government is reinsuring your benefits. You can't lose if you're a Part D plan in the first year, but [> p. 2](#)

Survey snapshot

45% of family practice doctors and internists revealed that they would strongly consider adding a pharmacy dispensing option to their practice because of revenue/reimbursement challenges. "We consider all new potential revenue areas," says **Becky Hollister**, practice manager for six physician practices in west Texas. Twenty-seven percent say their practices already dispense, whereas 18% refuse to take on dispensing. In a side note, five of those who will consider dispensing are orthopedists.

Physician apathy


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don't be surprised if some D plans try to enter the competitive acquisition program (CAP), especially if CAP starts to look like a better deal for a pharmacy benefit manager. In the future, Medicare beneficiaries may have just two choices for drugs: Obtain their medicines through either Part D or CAP. I don't think many doctors have considered this and how they would respond.

For example, suppose that a beneficiary has a Part D plan and needs Enbrel, a high-cost drug that treats rheumatoid arthritis. Your physician customers will have two choices: Give the patient the script and tell him or her to go to Walgreen's, for example, and bring it back (i.e., the brown-bag method) or obtain a prescription for a different drug (e.g., Avastin or Remicade). Brown-bagging

certain drugs becomes attractive for everyone. Physicians have complex decisions ahead of them, and the pharmaceutical industry might be able to play a part in helping providers determine how to structure their business for the future.

CAP

Doctors who provide infusions as a one-off type of service rather than a product line are interested in the CAP as an appealing business model. The question is whether they understand it and know about it. CAP would eliminate wastage, copayment, and inventory concerns. But for high-volume physicians (e.g., oncology, urology and infectious disease providers), CAP will pull revenue out of practices. Help your sales force communicate these messages to doctors between now and CAP enrollment. 

Pharmacists, not PDPs, to take on MTM financial planning role

There may be thousands of people like **Dan Buffington, PharmD**, for you to pitch to or partner with in the near future. Don't recognize the name? Think of Buffington as one of Medicare's first medication management financial services advisors. Buffington, a clinical pharmacist at Clinical Pharmacology Services in Tampa, FL, says CMS has underfunded and undefined the medication therapy

management (MTM) program to such an extent that there's a need to help pharmacists develop a service model and consultant role to assist patients. "People need help navigating prior authorizations, therapeutic equivalency, and formulary structure," he says. The candidate for doing that: pharmacists.

Savvy patients who need high-cost medicines > p. 3



MTM

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will start to ask questions about the advantages of Part D and how to navigate the program. Consider beneficiaries who take a drug that costs \$24,000 per year, such as the injectable Enbrel. At \$2,000 out of pocket, these patients will pay about \$400 per month under some Part D plans and will consequently hit the catastrophic cap (at \$5,100) much sooner than most. After the cap, the patients will pay a small 5% copay.

“It’s impossible for CMS at this stage to ensure any continuity from plan to plan and patient to patient so that such services will make an impact,” says Buffington about the MTM program. “Without clear boundaries in terms of the goals, a PDP [prescription drug plan] may not be compelled to deliver a face-to-face meeting with a patient. CMS realizes that.”

As a result, pharmacists have been forced to become the purveyors of information under Part D. And with pharmacy benefit managers (PBM) and PDPs likely to utilize the full spectrum of blocks and formulary games used by major managed care plans, Buffington anticipates a high level of consumer dissatisfaction. Some PDPs will offer a premium and basic MTM service. At least one plan will charge an extra copay for its premium, or “pro,” offering, while another will conduct internal utilization


research and send a letter to members with the findings. “Not everything about MTM has to be face-to-face patient communication, but [the letter approach above is] inadequate,” Buffington says.

WHAT'S BEING ADVISED?

Buffington tells pharmacists in the retail, independent, and other settings to advertise their Part D planning and assistance advocacy services. However, expect pharmacists to charge a fee because this is not a one-minute intervention.

He recommends an initial intake visit, during which the pharmacist will identify the patient’s prescribers, meds, and how he or she tracks TrOOP. Then he or she will create a system based on the patient’s PDP to help him or her make it through the donut hole and derive some benefit from Part D.

TAKEAWAY

Look at where your products are positioned and the mechanisms available to you from a patient advocacy perspective. Buffington is open to partnerships. Your mission: Help patients who need to be on your products to navigate Part D. “Medicare may not agree, but if a patient benefits from your agent, then it’s extremely appropriate for you to look out for that marketplace, because what CMS has created will, in fact, do the opposite.” 



Reporter's notebook

"Think of it as our specialist formulary."

—**Rita Bubar**, human resources and wellness manager at Cianbro, which is urging its employees to choose the best specialists at reduced copays

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Productivity

Employers use health data to shape programs, provider choice

A new quality-initiative, productivity-driven program at East Coast construction giant Cianbro is having a positive effect on where employees go for care, how much they pay, and how quickly they return to work. Insurer Cigna developed a list of hospitals and medical centers of excellence and **Rita Bubar**, corporate human resources and wellness manager, says all Cianbro employees receive the list (e-mail the editor at bcote@hcpro.com for a copy). "We encourage them to schedule their procedures at the centers with a 5 rating," she says. "Some hospitals aren't too happy that they were left off."

Cianbro also developed a list of network physician specialists. "Think of it as our specialist formulary," Bubar says. All doctors on the list completed Cigna's credentialing process. If an employee meets with one of these physicians, they pay a \$15-per-visit copay, rather than the standard \$25. Outcomes and productivity have improved across the board due to the incentive program, Bubar says. "This usually means lower costs for us."

At Quad Graphics, a Sussex, WI-based company with 12,000 employees worldwide, the company's Lean You employee wellness and productivity program appears to be a success after one year. "We found that a lot of our people have discovered a

condition, and sometimes a chronic one," reports spokesperson **Claire Ho**. The on-site incentive program gives employees tools to control diabetes and blood pressure, learn about their conditions, and exercise. "You get a \$250 reward if you meet the top criteria," Ho says. An interview with Quad's medical division chief will appear in a future issue of **MRAW**.

Health educators meet with Cianbro employees and their spouses for a health appraisals. During this meeting, the educator identifies controllable risk behavior such as high cholesterol and blood pressure and sets goals to help employees reduce these behaviors. Participating employees receive \$1,600 off of their family medical plan premium.

FILLING IN THE HOLES

Cianbro has seen an increase in multiskeletal injuries, its employer studies reveal. The response: a new ergonomics program rolling out this year to teach employees proper body techniques. "It's our biggest medical claims area," Bubar says. However, Bubar says there's no good way that she knows of yet to manage or even know which depression medications people are on and what effects they have. "We know from pharmacy data that depression meds are our highest use," she says. 