

Aligning Incentives



Pharmacist





LISA HELFERT

How one Medicare plan's incentive program rewards pharmacies for helping patients and lowering plan costs

By Jennifer Bruckart

Pharmacy owner Neil Leikach, RPh, admits one of the toughest challenges he faces as a business owner is balancing patient needs with the pharmacy's bottom line.

Leikach and his wife, Dixie, also a pharmacist, own Catonsville Pharmacy and Finksburg Pharmacy in suburban Baltimore, along with a closed-door pharmacy that services several assisted living facilities and mental health clinics in the area.

"Some things we've had to look at and say we'd like to do that but it doesn't make sense to the bottom line," he says.

Medicare Part D has intensified the challenges Leikach and his wife face, especially with a patient base nearly 70 percent of which is in the 65-plus age bracket.

"It's definitely changed the way we do things and look at things now," Leikach says. Part of that change includes taking on the role of financial advisor to his patients as he helps them find lower-cost therapies. This is particularly important for patients facing Medicare's infamous "donut hole," which is scheduled to be phased out as a result of the recently enacted health care reform law.

"More people are going into the donut hole because some of the drugs they take are very expensive," Leikach says. "We try to help them."

Leikach talks to patients, particularly those on statins or other classes that have lower-cost generics available.

"If the patient asks or if we point out there's another



drug in the same class that may work as well, we offer to call the doctor to switch to another medication that will do the same thing,” he says.

The Concept of a Win-Win-Win

Community CCRxSM PDP, which is offered through the Universal American family of companies and is one of the largest Part D plans nationwide, wanted to leverage the expertise of pharmacists such as Leikach to help lower patients’ out-of-pocket costs while also reducing the plan’s costs. In 2006, the plan launched the first pharmacy-based incentive program. The concept was to reward pharmacies for actively working with patients and their physicians to move to lower-cost generics, where appropriate. The end result was a lower cost to the patient, decreased drug costs for the plan, and additional payment to the pharmacy.

“The program was originally designed to improve our generic dispensing rate (GDR) in relation to other Part D plans and to reward pharmacies for helping their patients and us as the plan realize that cost savings,” says Mike Bukach, senior vice president of pharmacy network and clinical operations for MemberHealth®, LLC, a Universal American company and the PBM for the Community CCRx plans.

Higher generic use leads to lower patient and plan costs—two key ingredients for success in the Part D program, which uses an annual bidding process to determine plan payments and regional low-income subsidy benchmarks, which are used to assign dual-eligible patients.

The incentive program, available to all MemberHealth-contracted pharmacies, pays pharmacies higher

dispensing fees at the point of sale for reaching certain preset benchmarks.

“It rewards pharmacies that are doing things to encourage generic utilization and give us, as the plan, a competitive edge in the marketplace,” Bukach says.

From Leikach’s perspective, moving a patient from a brand to a generic helps the patient, but it also helps his pharmacy.

“It saves the patient money, and it also helps us with the incentive program,” he says.

Moving the Needle

To ensure that the program is achieving its goal of keeping the plan’s generic use above the industry average, MemberHealth each year evaluates the marketplace to determine the benchmarks and associated incentives for the upcoming year.

In 2010, the generic incentives range from 40 cents (72 percent GDR) to \$1.50 (82 percent GDR) with several levels in between. Pharmacies are evaluated quarterly and paid these incentives for each generic prescription they fill at the contract rate.

The program is based on generic dispensing rate (number of generics filled divided by total prescriptions filled). By basing it on generic dispensing rate instead of a generic efficiency rating (number of generics filled divided by number of prescriptions with a generic form available), it encourages pharmacists to look for therapeutic substitutions that require involvement from the patient’s physician.

“When a prescription is changed from a brand to a generic as the result of a therapeutic substitution that a pharmacist has done with a patient and his or her physician, we believe that extra effort should be rewarded,” Bukach says.

Competing With Mail Order

Community CCRx remains one of the few Part D plans that does not utilize mail order, a characteristic that has kept it popular for many pharmacists and patients who value the face-to-face service they receive from their community pharmacy.

“From the beginning, one of our cornerstone principles has been no mail order,” Bukach says. “We believe it’s important for patients in our plan to stay connected to their community pharmacies, and mail order does not promote that interaction.”



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A patient, concerned about the rising cost of her medications, asks Neil Leikach about lower-cost generic alternatives.

Doug Perine, RPh, owner of Doug's Pharmacy in Rossville, Kan. (population: 1,000), admits that Community CCRx was the only plan he accepted when Medicare Part D first came out. Perine, who opened his pharmacy in 1977 and specializes in round-the-clock service and delivery to several nursing homes in the area, liked Community CCRx's "no mail order" policy and strong formulary.

"CCRx advertised itself as a company that paid a fair fee for filling prescriptions and offered compensation for pharmaceutical services that could lower their overall operating costs," Perine says.

One of the ways that some plans have lowered their costs is by aggressively promoting 90-day supplies and mail order prescriptions, which are dispensed at a much deeper discount than those filled in a retail setting, Bukach explains. By doing so, plans can lower their cost of goods significantly.

"When those plans go to calculate their bid, they're able to do so with a lower cost per prescription and potentially able to have lower premiums compared with ours, since we don't have mail order and don't have the same volume of prescriptions being filled at the deeper discount," Bukach says.

In response to the competition from mail order plans, MemberHealth in 2009 added a new performance category to the incentive program as a way to encourage greater patient use of maintenance supplies. While maintenance fills are not for everyone, Bukach explains that, in cases where patients are stabilized on a specific therapy to treat a chronic condition, pharmacists should talk to them about maintenance supplies.

Unlike the generic incentive that is applied only to generics dispensed at the contract rate, the maintenance supply incentives, which range from 5 cents to 25 cents in 2010, are applied to each prescription the pharmacy dispenses (brand or generic).

“We want to be proactive in trying to move our patients, where appropriate, to the maintenance schedule and reward the pharmacies appropriately for their efforts,” Bukach says.

Adding it All Up

While an additional dime here or quarter there may not look like much, pharmacies across the country have benefited from the program since its debut. In 2009 alone, the program paid out slightly more than \$16 million in incentives to community pharmacies.

Initially, MemberHealth issued paper checks to pharmacies each quarter, but in 2007 made the switch to electronic payments at the point of sale, allowing pharmacies to receive their incentive payments much faster.

“While it’s not as glamorous as a check, they are effectively getting the money faster,” Bukach says. “They’re getting that money along with each weekly payment from us.”

The downside with the electronic payments is that many pharmacies cannot readily see how much they

are receiving from the program, Bukach says. To address this drawback, in 2007 MemberHealth launched an online scorecard feature (see sidebar) that allows pharmacies to see how they are performing against the program benchmarks and how much they earned in the previous quarter.

The scorecard also uses actual claims data from the previous quarter to identify top opportunities for generic substitutions/therapeutic interchanges and potential maintenance supplies.

Perine says he watches his pharmacy’s scorecard online to make sure his pharmacy is exceeding the generic percentage needed to get maximum reimbursement incentives.

Rewarding Proactive Pharmacies

The concept behind the pharmacy incentive program is simple—but according to Bukach, the implementation is more challenging. One of the biggest criticisms by pharmacists is that the benchmarks required to earn the incentives have increased each year, a fact that Bukach does not contest.

Scorecard for MAIN STREET PHARMACY (9999999)

Generic Fill Performance
Incentive Payment for Q-1 2010 (1/1/2010 - 3/31/2010)

Total Claims	Generic Claims	Generic Rate	Generic Incentive	Earned Incentive

Evaluation for Q-2 2010 Incentive (12/16/2009 - 3/15/2010)

Total Claims	Generic Claims	Generic Rate	Generic Incentive
1487	1098	73%	\$0.40

Maintenance Fill Performance
Incentive Payment for Q-1 2010 (1/1/2010 - 3/31/2010)


Total Claims	Maintenance Claims	Maintenance Rate	Maintenance Incentive	Earned Incentive

Evaluation for Q-2 2010 Incentive* (12/16/2009 - 3/15/2010)


Total Claims	Maintenance Claims	Maintenance Rate	Maintenance Incentive
1487	41	2%	\$0.00

Top Opportunities: Maintenance Drugs at 30 Day Supply		Fills in this Quarter
Simvastatin		129
Furosemide		111
Lisinopril		90

*Fills under LTC contracts are excluded from Total Claims.




Generic Performance



0%-71.99%	\$0.00
72%-76.99%	\$0.40
77%-81.99%	\$0.80
82%-100%	\$1.50

Maintenance Performance



0%-5.99%	\$0.00
6%-7.99%	\$0.05
8%-9.99%	\$0.10
10%-11.99%	\$0.15
12%-13.99%	\$0.20
14%-100%	\$0.25

The information presented on this scorecard is for reference only. Final incentive payments are calculated based on official audit results.

How Does Your Pharmacy Measure Up?

Community CCRxSM Medicare Prescription Drug Plans were founded on a pillar of aligning incentives between the patient, plan and pharmacist. As a result, Community CCRx was the first Medicare plan to include a pharmacy-based incentive program in 2006 that rewarded pharmacists for controlling drug spend through the appropriate use of generics. In 2009, a second performance category was added to encourage the use of maintenance supplies.

Pharmacies are tracked and evaluated on a quarterly basis, and incentives are paid to qualifying pharmacies in the form of higher dispensing fees at the point of sale.

Scorecards like the one shown here allow you to:

- Track where your pharmacy stands compared to

current program benchmarks

- Calculate what incentives your pharmacy is currently receiving
- Identify top opportunities for improving your pharmacy's generic dispensing rate or maintenance dispensing rate based on actual claims history
- View total incentive payment amounts received in the previous quarter

You can monitor your pharmacy's performance by viewing your scorecard at www.mhrx.com. You will be asked to enter your pharmacy's NCPDP and password. If you do not know your password, you may call the Community CCRx pharmacy help desk at 866-684-5395.

While an additional dime here or quarter there may not look like much, pharmacies across the country have benefited from the program since its debut. In 2009 alone, the program paid out slightly more than **\$16 million in incentives to community pharmacies.**

“The goal of the program is to improve our generic dispensing rate in relation to other Part D plans,” Bukach says. “As a result of aggressive promotion of generics throughout the Medicare program, the average generic utilization in the Medicare population continues to rise, and we have to adjust our program to keep pace.”

The benchmarks are adjusted annually based on two key factors—average dispensing rate across all Part D plans and the availability of new generics entering the market.

“We have to account for these types of marketplace changes,” Bukach says. “Without it, pharmacies are benefiting from marketplace activities and not as a result of proactively engaging with patients, which is the primary intent of the program.”

The second challenge is designing a program that rewards pharmacies, like Perine's, that are truly taking an active role in managing drug spend.

“The average pharmacy will use cephalexin for Keflex, but may not recommend lovastatin, pravastatin, or simvastatin for Lipitor,” Perine says. “The CCRx program can save huge amounts of money by offering pharmacists incentives for looking for reasonable alternatives.” **ap**

Jennifer Bruckart is NCPA's director of program outreach for Community CCRx and can be reached at jennifer.bruckart@ncpanet.org and 800-544-7447.