

**Testimony of  
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of the  
Committee on Energy and Commerce**

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Chairman Deal, Representative Brown, I thank you for inviting me here this morning to talk about how the Centers for Medicare & Medicaid Services (CMS) has worked with pharmacists to implement the Medicare prescription drug benefit. CMS has fully engaged with the pharmacy community in this effort and they have been key partners in the success of this benefit so far. We greatly appreciate their efforts and appreciate receiving their feedback and input on how to improve our operations. We look forward to continuing to work with them in meeting the needs of people with Medicare.

The Secretary, the Administrator and I have all traveled the country and listened to the concerns that pharmacists have about the Medicare prescription drug program. To this point, among other things, CMS has improved its data systems, provided extensive education and outreach, hired pharmacists and worked with the prescription drug plans to simplify business processes between them and the pharmacists who actually serve our Medicare beneficiaries. Before the benefit began, we worked with pharmacy associations to inform their members about what was coming, and we established electronic systems to assist them in verifying eligibility of enrolled beneficiaries. Since the benefit became available in January, we have issued multiple guidance letters to Medicare prescription drug plans on topics ranging from the need to improve their customer service to pharmacists, to allowing the pharmacists to submit bills for a longer than typical period, many of which have been aimed at streamlining plan/pharmacist/beneficiary interactions – so that pharmacists can continue with the outstanding job they have been doing. We are continuing to work closely with pharmacists to address further issues as they arise.

## **Pre-Implementation Work with Pharmacists**

We knew early on that pharmacists would be key players to the success of the Medicare Prescription Drug benefit. As front-line providers, pharmacists are the health care professionals to whom many patients turn to for advice and counseling on a broad range of issues, from minor aches and ailments, to medication therapy management, to decisions on what drug plans may be best for them. Interaction and a strong partnership with the pharmacists and the pharmacy community has been a top priority for CMS.

In preparing for implementation of the Medicare Drug benefit, CMS made a point of hiring pharmacists. We hired at least one pharmacist in each of our ten regional offices. And we added ten more pharmacists in our central office, including pharmacists in senior leadership positions inside the Center for Beneficiary Choices and a pharmacy expert within the immediate office of the Administrator. They effectively brought the pharmacy perspectives to bear throughout CMS during our preparation and implementation phases. We also contracted with 125 additional pharmacists to review plan formularies for the 2006 benefit year, and to ensure that plans continued compliance with our regulations and formulary guidance after the drug benefit went into effect.

From the beginning of our implementation efforts, we have engaged in rigorous outreach to the pharmacy community. This included an effort beginning in May of 2005 when we partnered with chain and independent pharmacies in an education and outreach program for beneficiaries likely to qualify for the low income subsidy. The effort reached over 30,000 stores. Those communications between CMS and pharmacies marked the beginning of an extensive and lasting effort to exchange information with the pharmacy community. We continued our regular communications with pharmacies through the Medicare Rx Update. Since last May, we have sent 42 updates to pharmacists and pharmacy associations. With over 2,700 subscribers and its known multiplying effect (state and national organizations distribute it as well) these updates have gone a long way toward informing the pharmacy community about the procedures surrounding Part D. Indeed, we have provided outreach through national, state and local pharmacy

organizations and their newsletters and email lists, as well as their standards-setting organization and technical societies.

CMS' regional office pharmacists traveled the country and presented to tens of thousands of pharmacists in 2005 – and they remain in constant contact with pharmacists all over the nation. One part of these outreach efforts involved hundreds of town hall and state pharmacy association meetings around the country – including our participation in 27 National Community Pharmacists Association (NCPA) Part D town hall events, with attendance approaching 7,000 independent pharmacists. We have held numerous national conference calls and posted extensive information on a page of the CMS web site dedicated to pharmacists.

All of our efforts are in addition to the tremendous work that pharmacy associations and individual pharmacies have done with our support. These efforts have resulted in over 50,000 pharmacists and pharmacy technicians receiving continuing education related to Part D, several Part D centered websites with millions of hits, numerous conferences, and in-store efforts that have educated thousands of pharmacists and engaged millions of people. These efforts to provide outreach to pharmacists continue through the present day, and we are grateful to the pharmacy community for doing so much to make a difference for Medicare beneficiaries.

Recognizing some of the difficulties that pharmacists have in administering private third party programs, CMS collaborated with pharmacists starting in 2004 to create a system that would help them identify beneficiary plan information through their existing pharmacy systems. This collaboration has yielded an electronic eligibility and enrollment query system that has now become part of most pharmacies' work flow. If a Medicare enrollee does not have a card or proof of enrollment in a prescription drug plan, pharmacists can use this eligibility system (the E1 system) to obtain information needed to determine the beneficiary's Part D plan and fill the prescription. Retail pharmacists now generally have the ability to perform real-time eligibility determinations for

Medicare beneficiaries on their existing computer systems, which has resulted in new efficiencies at the pharmacy counter.

To assist pharmacists in learning to use this tool, CMS produced a CD-ROM that was distributed to national associations and placed on our Pharmacy website. We also held special training events conducted by CMS pharmacists from our ten regions in connection with that tool.

The E1 system is working as designed, providing rapid responses to pharmacists' queries. Response times since January 2 have consistently been less than one second. In addition, the number of queries is decreasing, because more people with Medicare are enrolling early in the month and have accurate billing information with them when they go to the pharmacy. Pharmacies have also been able to obtain that information from the individual's plan, in most cases. As a result, inquiries to the system have declined markedly from the opening days of the benefit. For example, on January 4, the E1 system received nearly 1.5 million inquiries. On January 31<sup>st</sup>, it dropped to around 300,000 and then to just over 120,000 on May 1<sup>st</sup>. While the need for the E1 system has been reduced remarkably, it nevertheless has provided many pharmacies with critical information to ensure that beneficiaries received drug coverage from the appropriate plan. Since January 1, using the E1 system, pharmacists have been able to identify plan information for beneficiaries more than 14 million times.

### **Post-Implementation Work with Pharmacists**

CMS has taken many steps in order to ensure that accurate enrollment and payment information was available when people with Medicare prescription drug coverage went to the pharmacy to obtain their medications. However, during the first weeks of January, it became apparent that certain beneficiaries, particularly some dual-eligible beneficiaries who switched or joined plans late in the month, had difficulty accessing their coverage when they went to the pharmacy. Working with an independent experts and the drug plans and states, CMS refined data quality and availability to enhance system

performance. For example, CMS has made available twice-monthly summaries on eligibility and copay status for all enrollees in the limited income subsidy in each plan, and is monitoring plan use of these data to assure their coverage records are up to date. As a result of these steps, more complete, accurate, and timely information has been available to pharmacists when they fill prescriptions for people with Medicare drug coverage.

In addition to refining data systems related to coverage, we also provided expanded, direct customer support to pharmacists by modifying our call centers to include dedicated lines for pharmacists. We provided a toll-free number exclusively for pharmacists and worked to ensure that answer times were well under a minute. Pharmacists could call that line to obtain beneficiary enrollment information if they were unable to access it through the E1 system. We also increased funding for customer service representatives (CSR) to assist our beneficiaries and the professionals who serve them.

In addition to this significant strengthening of our 1-800-MEDICARE capabilities, we have issued guidance to the plans, instructing them to increase the numbers of CSRs in their own call centers, expand call center hours, and take other necessary steps to provide timely and effective responses to inquiries from enrollees and health professionals, including pharmacists. Plans have responded and as a result, call handling and wait times have improved significantly.

In addition to bolstering customer service efforts on our own part and through the plans, on February 2, we issued guidance calling on plans to extend the length of time during which they supplied a transitional supply of off-formulary medications from 30 days, to 90 days to ensure that pharmacists were able to readily help beneficiaries access their medically necessary prescription drugs during the initial transition period. We then encouraged plans to aggressively work to identify their enrollees who needed assistance to transition to on-formulary medications, or obtain an exception with the help of their provider. These steps made it possible for pharmacists to more easily fill prescriptions during the initial startup of the benefit and helped ease the burden of the transition on

beneficiaries and pharmacists. Additionally, we issued guidance to plans on formulary changes, specifying that patients who had been stabilized on a medication that was covered by a plan when they enrolled could continue to be covered for that medication, even if the plan took their drug off of the formulary, unless the change was made because of a new generic coming on the market, an FDA safety warning, or new clinical guidelines becoming available. This move reduced concerns and confusion for both patients and pharmacists.

We also asked the Part D plans to work with pharmacists to resolve claims for medications dispensed when the pharmacist could not obtain adequate information on coverage for an enrolled beneficiary. Many pharmacists did provide medications to their patients, even when they could not verify coverage through a plan, and we are grateful to them for being willing to support their patients in this difficult position. We expect plans to appropriately compensate pharmacists for medications the pharmacists properly dispensed to plan enrollees, but due to systems issues were not initially covered by the plan.

Because implementation challenges delayed payment of claims or verification of beneficiary eligibility for a percentage of Medicare enrollees, CMS has instructed plans that their typical window for submission of claims by pharmacies must be expanded. Ordinarily plans have a time period of between 30 and 90 days during which a pharmacy can submit claims. We have required plans to expand that to 180 days for claims incurred during the first half of the year in recognition of the fact that pharmacies may not have been able to obtain appropriate or adequate billing information even though they have dispensed medications to meet their patients' needs.

For beneficiaries who were for any time covered by two different plans, CMS is facilitating plan-to-plan reconciliation of claims paid, so that pharmacists will not have to resubmit claims or sort out issues of coverage once the beneficiary's coverage status is resolved. CMS has also developed a process for state-to-plan reconciliation for claims incurred by States and State Pharmaceutical Assistance Programs between January 1 and

March 31, 2006 which provided coverage to dual eligible and other low-income subsidy eligible individuals through state payment systems — again providing an alternative process for recouping costs that avoids pharmacies having to reverse and re-bill claims.

To ensure that quality service by plans to their network pharmacists is a continuing part of the Medicare prescription drug program, in addition to the various pieces of guidance we have issued during 2006, we have indicated to plans that their customer service to pharmacies will be used as a measure of their effectiveness and compliance with contractual requirements.

In its 2006 marketing guidelines, CMS permitted Part D plans to co-brand. Many plans took advantage of this opportunity and have co-branded with a number of organizations, including state pharmaceutical assistance programs and the AARP. Some plans co-branded with pharmacies, and placed the name or logo of the pharmacy on the prescription drug insurance card. CMS and the plans are providing complete information on participating pharmacies. This is available through plan pharmacy network directories provided to plan enrollees, through our respective websites, and also by calling plan phone numbers. Nonetheless, to assure that beneficiaries do not conclude that they could only get their prescriptions covered at co-branded pharmacies, for 2007 and beyond CMS will prohibit plans from placing pharmacy logos on beneficiary cards. Doing so should alleviate any potential for beneficiary confusion over which pharmacies they can use, and better ensure that they know they are able to access all pharmacies that participate in their plan's pharmacy network.

### **Working with Long Term Care Pharmacies**

Early in preparations for implementation of the prescription drug benefit, CMS identified long-term care residents as a particularly vulnerable population, and created a long-term care "campaign within a campaign" to address their special needs. In the LTC population, 70 percent are full-benefit dual eligibles, beneficiaries that are entitled to Medicare Part A and/or Part B, and are also eligible for Medicaid benefits. The Medicare

Modernization Act required that all dual eligible beneficiaries receive prescription drug coverage from Medicare, rather than Medicaid. CMS needed to ensure that nearly six million dual eligibles would continue to be covered under the new program.

Adding to the challenge of switching coverage for so many beneficiaries, many nursing home residents have cognitive and/or other impairments which make communication a challenge. To address this issue, CMS worked with the nursing home industry and related advocacy associations to get information to their members and caregivers. We communicated directly to the staffs of the more than 16,800 nursing homes throughout the nation. Further, since January 2006, CMS has kept nursing homes up-to-date on policy clarifications and recommendations that directly impact nursing home patient care and participation in Part D. These include:

- Continuation of a dedicated fax/express mail program that allowed nursing homes to obtain residents' Part D enrollment data from Medicare, with more than 500,000 records processed, to ensure continuity of care;
- Continuation of Part D auto-enrollment of full-benefit dual eligibles in nursing homes;
- Weekly calls with industry representatives to help troubleshoot individual Part D cases, fine-tune our procedures, address anticipated questions and concerns, and receive feedback;
- Identification of CMS Regional Office long-term care leads to troubleshoot Part D nursing home cases in their respective regions;
- Providing industry groups with Part D plan contacts for the exceptions and appeals processes;

- Issuing written guidance for differentiating Part B and Part D drugs in the LTC setting, thereby eliminating confusion, speeding prescription fulfillment and reducing physician call backs on transitions, exceptions and appeals;
- Distribution of a model Part D Exception & Prior Authorization trigger form to assist with exceptions requests;
- Distribution of mid-year Part D formulary request information;
- Issuing guidance to plans charging them with using best available information to adjust subsidy levels in the event that data received from CMS does not yet reflect full dual eligible institutionalized status and the corresponding \$0 co-payments for beneficiaries in this population. This guidance also advised plans to reimburse LTC pharmacies directly for underpaid cost sharing subsidies when those pharmacies have refrained from billing their residents.
- Clarifying that \$0 co-payments for full benefit dual eligibles are effective the first day of the first month that the individual is expected to remain in a LTC facility for the entire calendar month; and
- Allowing those entering a nursing home as a resident after May 15 to enroll in a prescription drug plan without having to wait until the next open enrollment in November 2006.

### **Standardizing Business Procedures and Practices**

Efforts to reduce administrative burdens associated with health insurance coverage and payments have the potential to reduce pharmacists' costs by shortening the amounts of time they have to spend in resolving problems at the pharmacy counter. CMS has strongly supported collaborative efforts undertaken by the plans and pharmacists to reduce the day-to-day costs of working with different health insurance plans. This is one

of many examples of how various parties are working together not only to improve the Medicare drug benefit for pharmacists, but also to use this opportunity to reduce administrative costs more generally for pharmacists.

In January we heard concerns from pharmacists about different claims processing and administrative systems and protocols used by the various Medicare prescription drug plans. While pharmacists have long had to deal with multiple health insurance plans, the new drug benefit provided an opportunity to streamline administrative procedures across insurance plans. We have made plans aware of the challenges posed by their varying requirements, and supported external industry discussions involving both plan and pharmacy representatives. As a result, in early April, a group of pharmacy and plan organizations, including America's Health Insurance Plans (AHIP), the NCPA, and the National Association of Chain Drug Stores (NACDS), announced an unprecedented joint effort to simplify and standardize the steps that most affect service for Medicare beneficiaries filling prescriptions at pharmacies.

NACDS, NCPA, and AHIP worked together, along with the American Pharmacists Association (APhA) and the Pharmaceutical Care Management Association (PCMA) and others, to simplify and standardize the electronic claims processing messages going from Medicare Part D drug plans to pharmacies. The initial step in this effort was to provide pharmacists electronic message clarity regarding the coverage status of certain drugs.

Coverage denials can be grouped into many categories: drugs that are denied because they are excluded from Part D coverage as mandated by the Medicare Modernization Act, and drugs that are denied because they are covered under Medicare Part B, the drug is not on a plan formulary, or requires some prior authorization. Pharmacists need clarity about why a particular drug is not covered, and they need it in a format that is recognized and consistent between plans. This information will help the pharmacist guide the beneficiary to the appropriate next step, whether that is contacting his or her physician for an alternative prescription, billing Medicare Part B, or paying out of pocket.

To alleviate some of this concern, AHIP, NACDS, and NCPA developed and presented joint recommendations to a Work Group of the National Council for Prescription Drug Programs (NCPDP), the organization that creates and promotes standards for transferring data to and from pharmacies. NCPDP then approved a process for using standardized coding and electronic messages notifying pharmacists of claims rejections when the prescription is excluded from Medicare, or may be covered under Medicare Part B.

AHIP, NACDS, and NCPA have transmitted to CMS and NCPDP a second set of recommendations to further improve service to Medicare beneficiaries filling prescriptions at community pharmacies. That proposal for additional standardized electronic claims processing messages to pharmacists addresses prior authorization requirements, daily dose limitations, quantities that may be dispensed for a given prescription, and age and gender contraindications.

On February 7, CMS posted to its website a model form for beneficiaries to use in requesting a coverage determination. The form was developed with input from the American Medical Association (AMA), AHIP and others and is accompanied by instructions. Cooperation between the plans and physician organizations led to a form that will receive wider adoption and use and will help reduce confusion for providers, plans and our beneficiaries.

CMS has also posted contact information on our web site for every drug plan for those wishing to pursue an appeal. To facilitate communications between pharmacists and physicians, we recently posted a form for pharmacists to use to inform physicians that their patient's plan is requiring use of another drug, step therapy, or prior authorization. To ensure access to these forms and other important exceptions and appeals information, we required plans to create exceptions and appeals web pages with this information. We have also encouraged plans to accept prior approval requests by fax, rather than requiring phone calls from physicians, since that is less time consuming for the physicians.

CMS also sent information to plans which will expedite their processes for making sure they are not inappropriately paying for drugs that should be covered under Medicare Part

B, and we have worked with Epocrates, an electronic prescribing software company, to ensure that their product provides accurate and easy access to plan formularies. We've also held weekly prescribers' conference calls and bi-weekly meetings with the AMA and other organizations to find out what prescribers are experiencing, to supply them with information on our activities and answer their specific questions.

### **Current Conditions**

Many pharmacists expressed concerns that they are not being paid in a timely fashion. Interruptions in cash flow occurred as pharmacies switched from the system used by their respective state Medicaid payment systems to those of the Medicare prescription drug plans. However, a clear majority of PDPs are paying pharmacies well within the industry standard of 30 days from the time a clean electronic claim is submitted to the time a pharmacy receives payment. A recent CMS survey found that up to 18 out of the top 20 PDPs pay pharmacy claims on a twice-a-month billing cycle of 15 days or less. A 15-day billing cycle generally provides pharmacies with payment within 21-25 days. These top plans account for more than 90 percent of the drug coverage for Medicare beneficiaries.

Because resolving specific pharmacy complaints is a top priority for CMS, we have investigated a number of complaints from pharmacists that they have not been paid in a timely manner. The result of the vast majority of these investigations has been that the plan has paid the pharmacy in accordance with the terms of its contract. In some cases, a plan sent a check to the wrong address or to the pharmacy's claims payment representative (e.g., a pharmacy buying group or Group Purchasing Organization (GPO), etc.). Additionally, we discovered situations where plans may have printed checks that were held several days before mailing. In these cases, the plans quickly remedied any problems to ensure pharmacies are paid as expeditiously as possible.

The Medicare prescription drug benefit represents a new line of business for the pharmacies, but it does not differ substantially from the private commercial market with which they are already familiar. Thus, the contract terms require that claims for

medications dispensed to people with coverage under the Medicare prescription drug benefit are being paid in a timeframe with which pharmacies are accustomed and within which they know how to operate.

In addition to expressing concerns about prompt payment and cash flow issues, smaller pharmacies have complained to CMS that low Medicare payment rates may threaten access to a robust pharmacy network for Medicare beneficiaries. We are very sympathetic to the concerns of small pharmacies. In particular, the MMA creates a competitive environment that provides constraints on how aggressive plans can be in negotiating pharmacy rates. CMS will not approve a plan for participation in the Medicare program unless it can demonstrate that it can meet the TriCare access standards for pharmacy network participation. This provides small independent pharmacies, particularly those in underserved areas, with bargaining power that they can use to negotiate favorable rates with the plans. Plans are also required to accept into their network any pharmacy that is willing to participate and hence, cannot selectively exclude specific pharmacies.

Congress specifically included these provisions to assure beneficiary access to pharmacies in the Medicare program. However, a corollary benefit to pharmacies is that these standards assure that pharmacy payment rates remain acceptable to pharmacies. For example, if a plan is overly aggressive in its contracting, and enough pharmacies independently decide not to accept the network rate, the plan will not be able to participate in the program because it does not meet the TriCare Access standards. On the other hand, if a plan can meet the TriCare Access standard because a sufficient number of pharmacies accept the plan's network contract rate, this is a strong indication that pharmacy network rates are acceptable to most pharmacies and that competition is working to keep premiums and prices low for beneficiaries while preserving access to an adequate number of pharmacies for the beneficiary. Aggressive contracting by plans, while meeting the TriCare Access requirements, has contributed to more affordable prescription drug costs for Medicare beneficiaries and taxpayers while preserving convenient access to pharmacies.

## **Supporting Quality in the Pharmacy Environment**

While the new drug benefit has led to greater access to needed prescription medicines for our beneficiaries, CMS believes that further steps can be taken to support high-quality pharmacy care, that may result in better health and lower overall health care costs. In line with CMS' extensive efforts to improve and promote quality across the health care settings we serve, in April we announced the formation of the Pharmacy Quality Alliance (PQA). The goal of the PQA will be to agree on a strategy for measuring and reporting data that will help consumers make informed choices and appropriate healthcare decisions. The founding members of the PQA include leading pharmacy organizations, health plans, consumer and employer groups.

CMS has implemented quality measurement programs in other payment systems within Medicare, and now it is time for a similar consensus effort to support pharmacy services in order to promote higher quality care and lower overall costs. We would like to like to place more emphasis on providing better support for high quality innovative healthcare. The PQA is the vehicle that can help us do this. We cannot do it by ourselves at CMS, but we will assuredly support and promote a collaborative effort across the healthcare system.

While the primary goal of the PQA is to develop strategies for defining and measuring pharmacy performance, CMS expects that this will lead to greater interest in plans that promote high-quality pharmacy services and potentially new pharmacy payment models to help improve patient outcomes at a lower cost. We are very interested in supporting the testing and development of those payment models. Private sector expertise, working in collaboration with the other key stakeholders in our program, is absolutely essential for making this happen soon.

Thanks to the Ambulatory Care Quality Alliance and to the leadership and hard work of the health plans and many physician organizations involved in ambulatory care, we have

made substantial progress in creating consensus around meaningful measures of quality of physician care. We are now in the process of implementing physician payment demonstration programs that tests whether we can obtain higher quality care at a lower overall cost to our healthcare system.

We believe that through the PQA we can make a similar kind of progress in the development of pharmacy-care quality measures and the development of better support for high quality pharmacy care. Encouraging higher quality and less costly care is a critical priority for us at CMS, just as providing high quality care and avoiding preventable complications is a top priority for our nation's health professionals.

Pharmacists and other health professionals want to do everything in their power to provide the best care for their patients. When we provide consumers with better information about quality and when our payment systems encourage better quality, we enable health professionals to focus on what they do best.

This is part of a fundamental strategy in Medicare and Medicaid today. For 40 years, our programs have focused on paying the bills without really taking into account as much as we should, whether what we are buying really improves beneficiary outcomes, at the lowest possible cost.

Pharmacists and pharmacies have already demonstrated the tremendous value they provide in their work through the implementation of the Medicare drug benefit. They have shown that they can add much more as well, including helping people find lower cost drugs like generic medicine.

They can help people who have multiple illnesses understand how to use their medication thus improving patient compliance with treatment plans and preventing complications. All of these things can improve quality and reduce overall healthcare costs, to achieve a healthcare system that provides the right care for each patient every time.

A recent CMS analysis indicated that a beneficiary with common chronic conditions who enrolls in a Medicare prescription drug plan can save, on average, more than 55 percent compared to what they would pay without drug coverage. If they switch to lower-cost generic medications, which have exactly the same active ingredients as the brand-name medicines they had been taking, they could achieve savings of up to 70 percent over what they would pay without drug coverage.

Even larger savings are possible on a very broad range of drug plans for beneficiaries who also switch to lower-cost “therapeutically equivalent” drugs – drugs in the same drug class that have very similar effects. Those who switch to less expensive brand-name therapeutic equivalents can save even more— with savings of up to 83 percent for the plan with the lowest cost.

Pharmacists can provide a valuable service through coordination of care with respect to prescription medications. This could help reduce adverse drug interactions and the accompanying expenses and risks to beneficiaries. Their participation in medication therapy management programs has the potential to help patients better understand how their medications work and what to expect. Promoting continuity and coordination of care and medication therapy management may lead to appropriate utilization of prescription drugs and better health for Medicare beneficiaries at a lower cost.

### **Deficit Reduction Act of 2005 (DRA)**

In conjunction with concerns about payment rates in the Medicare drug benefit, pharmacists have also raised concerns about reimbursement rates in state Medicaid and other programs. Specifically, they cite recent changes in the Deficit Reduction Act (DRA) that will affect the way the Medicaid program calculates the Federal Upper Limit (FUL), which is used by many states to determine the maximum level of reimbursement at which a state will reimburse a pharmacy for multiple source drugs, including generic drugs. The goal of these DRA provisions is to capture the most accurate pricing data

possible to assure that the Federal government and State Medicaid programs are not overpaying pharmacies for generic drugs.

While the DRA represents an opportunity for state and the federal governments to save money on generic product costs, actual savings will be dependent upon the actions that states take in implementing the new FUL. For example, if states do not maintain the right incentives for encouraging generic utilization, potential savings on generic reimbursement will be lost to higher and more expensive brand name utilization. For this reason, CMS has consistently encouraged states to align incentives for optimizing generic utilization and consider paying pharmacists more in dispensing fees if they can assist the state in saving money through greater generic utilization.

In its “Road Map to Medicaid Reform”, CMS also encourages states to “Re-align Medicaid prices on prescriptions drugs with other purchasers and protect community pharmacists.” Specifically, CMS said:

*... States retain the overall authority for pharmacy reimbursement and may target reimbursement to providers, for example, through higher dispensing fees for independent pharmacies, pharmacies serving a large share of low-income beneficiaries, or pharmacies in rural areas to assure access. States can also adjust payments to provide more financial support to pharmacists that improve quality and reduce costs of drug coverage and chronic disease management...*

Private and public payers, including Medicaid, do not want to pay more for products and supplies than is reasonable or necessary. They are, however, willing to pay for a high level of service that promotes quality and the very best health outcomes. We believe that the states should have the tools and options to promote a value-based approach to the delivery of health care, and specifically the delivery of prescription drug benefits, and CMS intends to continue to support the implementation of such steps in pharmacy care.

## **Conclusion**

CMS worked hard to resolve the early challenges of implementing the Medicare prescription drug benefit. We greatly appreciate the way in which the pharmacy community has stepped up to the challenge and how they have worked with us and the plans to identify and resolve these issues. Plans are now paying for millions of prescriptions every day, and pharmacies are receiving those payments in a timely fashion. Competition among plans has resulted in prices for beneficiaries and the government that are substantially lower than originally expected, and we have already seen important improvements in the delivery of the drug benefit to reduce costs for pharmacists and to promote more effective use of prescription drugs. We look forward to continuing to work closely with the pharmacy community to ensure that our beneficiaries receive the highest quality of care at the lowest cost, and that pharmacies are able to operate freely in a market setting, running their businesses as they see fit, without the necessity of complying with a cumbersome regulatory structure.

I thank the Committee for its time and look forward to answering any questions you may have.