# *Health Policy Newsletter*

**Volume 17 Number 3** **September, 2004** **Article 11**


# Assuring Individualized Pharmacotherapy for the Elderly


**Richard G. Stefanacci, DO, MGH, MBA, AGSF, CMD***

* University of the Sciences of Philadelphia





**Suggested Citation**:
Stefanacci RG. Assuring individualized pharmacotherapy for the elderly. Health Policy Newsletter 2004; 17(3): Article 11. Retrieved [date] from http://jdc.jefferson.edu/hpn/vol17/iss3/11.

# Assuring Individualized Pharmacotherapy for the Elderly

Despite the benefits shown from individualized pharmacotherapy for the elderly, the Medicare Modernization Act of 2003 (MMA) is poised to create organizations that significantly restrict formularies. While the objective of restrictive formularies is to reduce costs, there are concerns that, when applied inappropriately, the result could lead to unintended outcomes. These outcomes include lower use of essential therapies, declines in health, increased use of more expensive services, and substitution of less efficient medications.[1]

In 2000, *Why the Elderly Need Individualized Pharmaceutical Care*[2] highlighted the critical importance of access to a wide range of therapeutic classes for seniors. At the time this monograph was published, the limits on access were being placed by state Medicaid programs, so the number of elders directly affected was limited to low-income seniors. Today, with the implementation of MMA, most seniors will be affected by a move to provide a voluntary pharmacy benefit under Medicare. While this new benefit is voluntary for most, it is mandatory for the poor elderly, and those currently receiving their pharmacy benefit through Medicaid are being forced to switch to the Medicare program for their benefit. In addition, it is estimated that 85% of seniors will sign up for this voluntary benefit. The reason for this relatively high participation is based on the high level of risk adversity for seniors, as well as a significant penalty to their premium for delaying their enrollment in the program.

The Medicare pharmacy benefit will be offered through private prescription drug plans (PDPs). It is important to remember that not all PDPs are created equal. Basically, there are three types of PDPs. There are PDPs that exist for Medicare beneficiaries choosing to stay in the traditional fee-for-service (FFS) Medicare program. These FFS-PDPs are siloed in their concerns for drug expenditures, meaning that they are solo at risk for the pharmacy expenditure and not liable for other medical expenditures. As a result, FFS-PDPs have an incentive to restrict the utilization of even appropriate medication use since they are not affected by the fallout.

Opposite this group is the managed care PDP or Medicare Advantage-PDP. Medicare Advantage (MA), formerly Medicare managed care, organizations are responsible for all medical expenditures including pharmaceuticals. Obviously, MA-PDPs are concerned that the appropriate pharmacotherapy is utilized since they are affected by under-utilization. As a result, MAPDPs will most likely be very aggressive in promoting individualized pharmacotherapy for the elderly.

The last type of PDP is referred to as the fallback plan. Fallback plans are simply administrative pharmacy benefit managers that are paid an administrative fee to provide pharmacy benefit access for seniors in regions where two private plans have not entered the market. There is general consensus that few, if any, of these types of plans will be needed because of the anticipated large number of PDPs entering the marketplace.

So the question becomes how, within an FFS-PDP, can we provide for individualized pharmacotherapy for the elderly? There are actually three answers to this question. The first is to move to MA-PDPs, where the plans are motivated to provide individualized pharmacotherapy in order to reduce their overall medical expenditures. This is happening on several fronts, including the addition of several billion dollars in support of these programs. These funds are to be provided to MA plans to increase their benefits in order

to encourage greater participation in their programs. Also, the Centers for Medicare and Medicaid Services (CMS) have relaxed much of the administrative burdens on these programs, again in a move to encourage their growth.

The second answer is to mandate that FFS-PDPs have an open formulary. Unfortunately, within MMA, CMS is prohibited from forcing PDPs to have any specific formulary. In fact, CMS has been requested in MMA to have the United States Pharmacopeia identify therapeutic classes and categories that PDPs could choose to follow in order to provide a comprehensive formulary. These formularies simply need to provide for two drugs in each of these therapeutic classes. Of course, anyone looking at the formulary outline for the Medicare discount card will be quick to point out several areas where individualized pharmacotherapy for the elderly is impossible within that structure. For example, despite there being over thirty cephalosporins, only one is required on the discount card formulary. Given the language of MMA, it is unlikely that CMS will have the ability to mandate open formularies.

The third answer to our question of how to provide for individualized pharmacotherapy for the elderly rests in the conference report for MMA. It outlines a fairly liberal process for physicians to override formulary restrictions to assure that their patients receive the optimum medication. There is concern, however, that this process will look more toward the referral override process utilized by managed care organizations resulting in restrictions on access to needed medications for seniors. The exact process will be unknown until the final regulations are released in early 2005.

In answering this question, the Centers for Medicare and Medicaid Services can look to the updated edition of *Why the Elderly Need Individualized Pharmaceutical Care*, as well as other excellent research on this topic, for help in designing regulations and providing leadership to assure that seniors receive the medications that benefit them the most. Without this focus, we will witness a cost shifting from pharmaceutical expenditures to other columns in the Medicare and Medicaid ledger. This will affect more than numbers on a page. Unless we are truly able to provide for individualized pharmacotherapy for the elderly, there will be real, tangible negative outcomes for our frailest seniors.

## References

1. Soumerai SB. Benefits and risks of increasing restrictions on access to costly drugs in Medicaid. *Health Affairs* 2004;23:135-146.

2. Nash DB, Koenig JB, Chatterton ML. Why the elderly need individualized pharmaceutical care. Philadelphia, PA: Office of Health Policy and Clinical Outcomes, Thomas Jefferson University, April 2000.

## About the Author

Richard G. Stefanacci, DO, MGH, MBA, AGSF, CMD, is the Founding Executive Director of the Health Policy Institute at the University of the Sciences in Philadelphia. Please address questions and comments to r.stefan@usip.edu.