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The new community pharmacy model

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President Roosevelt – that's President Theodore Roosevelt – referred to Ida Tarbell as a muckraker. It was meant as a compliment, but Tarbell was affronted. Now called investigative journalists, in the early part of the last century they were called muckrakers. Moved by what they saw as inequities, corruption, and abuses at the hands of established businesses, muckrakers would investigate, report, and bring to light these abuses. Ida Tarbell was one of the best.

As the new century dawned, America was hungry for oil to fuel progress. The Standard Oil company controlled close to 90 percent of America's oil trade, from production to transportation to distribution to retail sales. It was all Standard Oil. Along the way it ran small competitors out of business. It restrained trade, mandated sweetheart deals with pipeline distributors, and

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controlled prices independent competitors paid for product, all in an attempt to drive them out of business for the benefit of its profits.

Having investigated Standard Oil, Ida Tarbell uncovered injustices and abuses and set about throwing back the curtain on such seedy practices. Her most famous work, "The History of the Standard Oil Company," published in 1904, was both an exposé and indictment. It was one of the prime factors in the 1911 Supreme Court decision to break up the monopoly due to violations of the Sherman Act, the first antitrust act passed by Congress.

Standard Oil broke the system. The competitive free market system was brought to its knees by unscrupulous, underhanded business dealings perpetrated by a large company with money and power, solely to reap large profits.

Pharmacy owners find it hard to ignore the similarities. The pharmaceutical industry is broken. Shrouded in secrecy and enveloped in complex contractual agreements designed to redirect cash flow, large companies control not only access to pharmaceuticals, but also access to care and quality of care, to the detriment of all health care professions and, most importantly, patients. The economic and political power wielded by a few large companies has led to a reimbursement breakdown within community pharmacy.

The result of this breakdown is that numerous independent pharmacies across the country are being placed at risk of closing. Access to care in those areas across the country with vulnerable populations has been adversely affected, thus threatening equitable health care for all. While contracts were put on the table with the promise of reduced spending and improved care, the large companies controlling payments within the pharmaceutical industry have failed on all counts.

CURRENT STATE OF AFFAIRS

Community pharmacy is in crisis; many would say on life support. Current below-cost product-based reimbursement models in community pharmacy have rendered the business model unsustainable. These below-cost models have led to pharmacy closures and reduced funds for important pharmacy services. Inadequate funding for vital services has brought about copious safety and workplace condition issues. Whether in the spotlight or hidden, these conditions adversely affect patient care. The direct and indirect remuneration fee/reimbursement model is unsustainable. Community pharmacies are currently defined only by the product they dispensed and not by the service provided. Arguably, the service provided is the most valuable commodity in the pharmacist-patient relationship – yet it is not recognized, measured, or compensated. Local and federal legislation has weakly attempted to react with mixed results. Several U.S. senators have sponsored bills that are under Senate Finance Committee review and markup with a call-to-action for pharmacy quality measure adoption in Medicare.

Looking only at the product reimbursement level, as investigative journalists have uncovered, why does one pharmacy get paid $300 and across the street another gets paid $10 – for the same medication? Why are patients told pharmacy X has a copay of $15 while pharmacy Z is $5? What justifies this payment differential? How should patient-centered services play into this model? Ultimately, ignoring quality weakens the whole system. The value expression is missing. Pharmacoequity is non-existent. Pharmacoequity is a relatively new term that has come to mean equitable access to drug therapies. Notably, even the best access to therapies still does not necessarily mean we are resolving poor outcomes due to suboptimal care delivery.

On May 9, 2024, Georgia Gov. Brian Kemp (R) vetoed legislation that required price parity for pharmacies with the state health benefit, despite the original bill passing the state

House and Senate with near unanimous support. Listed as supporting evidence in this legislation is the case of Bell's Family Pharmacy in Jasper, Ga., which has since gone out of business. Bell's was being reimbursed just $1.90 for a 90-day supply of generic atorvastatin, while the three closest chain pharmacies were being paid $46.87 for dispensing the same product and days' supply. This obfuscation of medication price, care, and value, is so bad that employees are now suing their employers for inadequately overseeing and lack of fiduciary responsibility on medication costs for patients. (More details at bit.ly/3XGXtO7.)

This needs to be addressed.

PERCEPTION VERSUS REALITY

As community pharmacists, we are aware of the public view that pharmacists put pills from the big bottle into the little bottle. According to Jerry Seinfeld, that's all pharmacists do. According to pharmacy benefit managers (PBMs), pharmacies just provide a commodity and cost center. According to the public, all pharmacists and pharmacies are the same. According to boards of pharmacy, pharmacists make sure the right patient gets the right medication, at the right dose, at the right time, via the right route (and for the right reason). Every time.

Unfortunately, those descriptions just aren't not accurate. What Seinfeld didn't consider was, "What happens when the wrong pill gets into the wrong bottle for the wrong person?" Data shows that half of all prescriptions have an error. This could be as minor as an inaccurate number of refills transcribed or as severe as the wrong drug or wrong dose, or even wrong patient. All pharmacists, pharmacy technicians, and pharmacies are NOT the same – better pharmacies with quality, committed pharmacy teams improve overall health care and save lives.

So, how do pharmacists express to Seinfeld, PBMs, boards of pharmacy, and ultimately patients, that our pharmacies and our pharmacist-led teams provide safer care and more value? The answer – through pharmacy network design which includes quality and safety measures, is an overhauled payment model.

A "pharmacy network" in this case is a loose collection of pharmacies working together. Pharmacy service administrative organizations, clinically integrated networks (such as CPESN® USA), shared ownership

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(chain, grocery stores, mass market merchandisers), geography (Missouri versus Kansas), or even wholesaler selection – and many more dimensions can be considered networks. These networks affect all aspects of community pharmacies – patient copay and overall reimbursement to the pharmacy, acquisition cost of a medication with the wholesaler, and even patient access. The unspoken truth of these networks is that quality is not consistent across the various categories – nor is quality used in network design.

PHARMACY NETWORK DESIGN: ARBITRARY AND CAPRICIOUS

Currently, pharmacy network design (inclusion and exclusion) is arbitrary and capricious to many stakeholders, including payers and their PBMs. Ask the vertically integrated monopoly's PBM what the preferred pharmacy network is and surely, it's the company-owned pharmacies.

"Without quality, pharmacoequity cannot be determined."

Years ago, one of the authors was told by a PBM that his pharmacy wasn't in network to dispense a refill for a patient's hepatitis C therapy – that the author's pharmacy didn't meet the quality standard despite being recognized and published as a subject matter expert on this topic and having dispensed the patient's initial fill! Instead, the PBM-owned specialty pharmacy dispensed the medication, ignoring the need to address health literacy regarding reinfection and gaps in service.

What quality measurement did the PBM use, other than, "It's our pharmacy and it's our PBM and we want money to stay in our venue?" How did they compare the local pharmacy with a national expert on staff to their "specialty" pharmacy? And what was the actual pharmacoeconomic model that reflected actual cost, outcomes, and value?

This is what pharmacy quality measures and measurement systems are solving. Care should be driven by the best medical evidence, delivery dosing, safety, and accountability. Data and measures should drive the creation and outcomes of networks on three levels:

- **"Macro" network creation – The big picture:** Network A gets reimbursed $25 for lisinopril with a $1.25 copay. Network B gets reimbursed $5 for lisinopril with a $5 copay. A pharmacy's inclusion in Network A should be based on quality, not the lowest cost denominator.
- **"Micro" network quality improvement – The practice level:** Not all pharmacists and pharmacies in Network A are the same. Quality measures can help identify lower-performing pharmacies and support quality improvement. Imagine a board of pharmacy having a report of safety quality measures and helping pharmacies transform their practice *before* an error occurs. Imagine a state Medicaid plan identifying and paying pharmacies that evaluate the pediatric antibiotic based on patient weight.
- **Patient choice – The gold standard of health care:** All patients want safe, high-quality health care. Restaurants, health systems, nursing homes, and even *movies* provide public-facing rating systems. A similar patient-facing QUALITY rating system can help empower patients to make an informed choice when choosing a pharmacy. Whether using a quality-based comparison tool to compare nursing homes for quality of service for a family member with Alzheimer's, or restaurants with the best service, quality comparator tools are a necessary function for quality decision making. Pharmacy patients deserve no less. Patients should be able to choose pharmacies based on the best health care offered, not the lowest common denominator of pricing or arbitrary network inclusion and exclusion.

A BROKEN SYSTEM

The current prescription reimbursement system is broken. It will never be the same, nor should it. Medical evidence is changing and producing better outcomes, health professionals' education is changing to allow higher standards of care, health informatics is improving patient care delivery and service outcomes. Why should these changes be ignored, and archaic transactional health care service delivery be rewarded and non-value producing participants be rewarded?

The question becomes, what is next? This is best answered by showing

how improved patient care can improve health and reduce spending. New economic modeling suggests value-based contracts reflecting increased outreach and improved care. It's used to reduce disparities, address access, and improve outcomes. This is especially true with high-cost therapies and vulnerable populations that struggle to receive care, which many times is compounded by social determinants beyond their control. Health equity is the goal and is a large part of the solution. So pharmacoequity is the goal.

THE SOLUTION: PAYING FOR VALUE, THE NEW PARADIGM

The Federal Trade Commission recently released a report condemning PBMs for the current pharmacoeconomic model and pricing referenced earlier. All reported medication prices are inconsistent – and made up. A quick fix is the realization and understanding of the bifurcation of medication spend versus medical spend targeting outcomes. Frequently, when promoting and negotiating network pharmacy services, the payers (employer, medical insurance, PBMs) ask "What is the PMPM (per member per month) savings of your pharmacy network?" This is the **wrong** question. PMPM medication savings at a pharmacy is a zero-sum game. Reducing spending at the pharmacy often reduces medication access and leads to increased overall health care spending.

Pharmacies are told by payers and PBMs to improve medication adherence, or else. Patient adherence to medication regimens takes more medication, costing the payer more for drug spend. This makes the PMPM medication spend go up – the exact opposite of what pharmacy networks are told to do! This relationship is why pharmacies are hurting. The best way to decrease PMPM medication spend is to just pay less for medications – or not at all – ignoring the downstream patient harm, increased PMPM medical cost, and inequities. A solution is needed.

First, the cost of a medication is murky and highly variable – for everyone. For example, the terms "price" and "cost" have opposite meanings depending on where you sit in the supply chain. One price/cost transparency economic viewpoint is how much a pharmacy receives from the insurance payment and from the patient copayment. This price point is determined by pharmacy networks – and is different for every network. The merging of product and service (medications and interventions) may help create a path forward for pharmacy sustainability. However, these are often contracted independently.

Table 1 provides a snapshot of how various stakeholders define the "cost" of a prescription. Ignoring the obtuse prescription financial model (Acquisition Cost + Margin = Insurance Ingredient Cost + Insurance Dispensing Fee + Insurance Incentive Fee = Total Insurance Payment + Patient Copay = Total 'Cost'), in pharmacies, our cost is the acquisition of the medication from the wholesaler evaluated against what we get paid via adjudication. Patients define cost as their copayment. Employers define cost as the total cost of the drug as stated by the insurance company.

Second, and most importantly, quality is missing from the current state of medication dispensing and access. Without quality, pharmacoequity cannot be determined. Notably, many providers, like health systems, have multiple measurement systems. Yet, there is a paucity of health equity measurement in community pharmacies. CPESN Health Equity leverages the only community pharmacy measurement system, Choose My Pharmacy. This measurement system leverages 18 quality measures and allows CPESN Health Equity to engage in value-based contracts, address disparities, and evaluate quality across the network. A quality score is applied to each pharmacy within the network and the network itself has a quality score.

Ultimately, change is needed. **Table 2** (on the next page) proposes how community pharmacies should be contracting for dispensing medications – by adding a service payment from medical. Currently, pharmacies are contracted on prescription spend only, but a new product-service contracting model would address the PMPM medication spend versus PMPM medical spend division. These payment models that account for the PMPM medication spend and *PMPM medical spend* would require a measurement system for standardized quality scores and payment. The example model is based on one hypothetical patient getting one prescription. In this example, the medical insurance and pharmacy

Table 1: Defining prescription "cost"

	Acquisition Cost	=	Patient Copay	=	Insurance Paid Copayment
Pharmacy	X				
Patient			X		
Employer					X

insurance are vertically integrated with the pharmacy chain network. Prices are proportionally valid, but attributions are categorical.

In the *Current State* a pharmacy is paid based on an abstract network rate. The pharmacy has no control, other than not signing a one-sided take-it-or-leave-it contract for product. As a result, cost savings, defined as PMPM, are only achieved with lower drug cost. This is where we are now. Even though, from a patient perspective, the pharmacy chain has the lowest "cost" (based on the copay), the vertically integrated pharmacy chain – PBM – medical insurance has the highest total accrued cost to the health care system.

In *Future State: Idea 1*, the pharmacy product (prescription spend as insurance payment and patient copayment) is based on the current model. However, a quality score is applied to pharmacies based on safety, services, and medication optimization. This provides a service payment along with the prescription payment. Pharmacies are now getting paid based on the quality of care, not just putting pills in a bottle. This service payment could even be linked to the medical insurance via the PBM – closing the bifurcated gap in medical versus medication spend. Overall, PMPM savings are now determined by reduced medical spend – which is what pharmacy has been saying since the Asheville Project decades ago. (The Asheville project was an initiative in Asheville, N.C., where pharmacists consulted with city employees to educate them about their health, with the goal of improving outcomes and reducing sick days, workers compensation claims, and overall medical costs.) This has been replicated many times and in fact the overall value contin-

Table 2

Current State					
Pharmacy network	Quality score	Prescription Spend		Medical Spend for Service	Total accrued cost
		Insurance payment	Copay		
Grocery chain	N/A	$10	$7.50	$0	$17.50
Independent	N/A	$8	$8	$0	$16
Pharmacy chain	N/A	$15	$5	$0	$20
Mass merchandiser	N/A	$11	$7.50	$0	$18.50
Future State: Idea 1					
Pharmacy network	Quality score	Prescription Spend		**Medical Spend for Service**	Total accrued cost
		Insurance payment	Copay		
Grocery chain	A	$10	$7.50	**$10**	$27.50
Independent	A	$8	$8	**$10**	$26
Pharmacy chain	C	$15	$5	**$2**	$22
Mass merchandiser	B	$11	$7.50	**$5**	$23.50
Future State: Idea 2					
Pharmacy network	Quality score	**Prescription Spend**		Medical Spend for Service	Total accrued cost
		Insurance payment	**Copay**		
Grocery chain	A	**$15**	**$5**	$10	$30
Independent	A	**$15**	**$5**	$10	$30
Pharmacy chain	C	**$8**	**$8**	$2	$18
Mass merchandiser	B	**$11**	**$7.50**	$5	$23.50

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ues to increase disproportionately (or more quickly) to the rise in total health care spending.

Finally, in *Future State: Idea 2*, a quality score is still used for service payment. However, prescription spend is also reflected in the quality score. Better quality means higher payment to the pharmacy. Better quality means a lower copayment for the patient and incentivizes patients to utilize high quality pharmacies. In other words, it is a real pharmacoequity model.

CONCLUSIONS

Unfortunately, the pharmacy product reimbursement model that is broken is not the only area for improvement in the U.S. health care system. More money is spent on the effect of non-optimized medications than on medications annually. According to the Deloitte Center for Health Solutions, the U.S. is projected to spend $1 trillion on problems associated with health inequities – three times the amount spent on medications.

While payment reform is needed within the pharmacy environment, pharmacoequity will be achieved through value-based contracting identifying health equity-focused pharmacy practices, similar to what CPESN Health Equity is implementing.

Pharmacists stand at the brink of a tipping point. As reimbursement models pivot to value-based contracting, no health care professional stands closer to the patient than the community pharmacist. No health care professional has a greater ability to monitor safe medication usage. No health care professional has a greater ability to affect social determinants of health. No health care professional has a greater ability to reach underserved populations. No health care professional has a greater ability to lower overall health care spending.

The move to value-based care brings pharmacy practice into the spotlight. No more Seinfeld big bottles to little bottles, but holistic, equitable, quality care for patients in need – pharmacoequity. ■

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