

A Payment Paradigm for Pharmaceutical Care

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The implementation of pharmaceutical care is changing the practice of pharmacy. Often the most trusted healthcare professionals, pharmacists have made great strides in changing direction from a drug to a patient orientation. Furthermore, pharmaceutical care appears to be a successful patient-centered paradigm for providing population-based prescription medication management. Yet pharmacists may still be largely unrecognized as medication therapy experts by health systems, other healthcare professionals, patients, and themselves.¹ Third-party payers continue to reduce payments for drugs often without corresponding reimbursements for any pharmaceutical care provided. In addition, while still benefiting from the sales of double-digit increases in prescriptions filled, the gross margins of pharmacies are declining as a percentage of sales.² Yet pharmacists still cling to their economic reliance on reimbursement for the dispensing of a prescription medication. Perhaps more importantly, universal acceptance of economically viable pharmaceutical care continues to evade the profession of pharmacy. Pharmacists are searching for ways to secure that viability. Even the most optimistic data sources, however, only refer to the slow increases in pharmacists charging separate fees for providing disease management services.³ Nevertheless, pharmaceutical care's continued growth may depend on its ability to survive as a viable economic paradigm.

Unless the patient recognizes the value of pharmaceutical care and is willing to pay for it, the pharmacist may be searching in vain. It has been suggested that what is needed is to motivate and create patient and employer demand. In this way, the healthcare market will pay for required and valuable pharmaceutical care services. According to John Gans of the American Pharmaceutical Association, however, we have a problem! "Our current business model does not pay pharmacists to address society's needs." Referring to pharmacy's mission to carry out pharmaceutical care, he states, "Pharmacists . . . are being paid for dispensing prescriptions, not for even the most basic aspects of the services embodied in this mission. We need business models that rely on something other than the margin on a drug

product as an incentive to modify the pharmacist's activities and behavior."⁴

Thus, new approaches to paying pharmacists for their professional services may be needed. The basic problem is whether the societal value of pharmaceutical care can be reconciled with the means to pay for it in an already costly prescription drug distribution environment. If not, continued implementation of pharmaceutical care is in danger and may eventually fail. If so, this concept has reached an impasse, a crossroads, and may be unable to progress without changes in the pharmaceutical environment.

The Values of Pharmaceutical Care

By now, the concept of pharmaceutical care has been well disseminated throughout the pharmacy profession. Some of its basic tenets, however, may need to be better understood. The fundamental relationship in pharmaceutical care is a covenant, "a mutually beneficial exchange in which a patient promises to grant authority to the provider, and the provider promises competence and commitment to the patient."⁵ This covenantal relationship requires fidelity in both promise and truth telling; safeguarding the preservation of self as conceived by the patient; freedom from pain, fear, and abandonment; and encouragement of realistic hope for improvement or cure.⁶

A business relationship (e.g., merchant/customer) does not rely on a covenant; rather, it uses a more concrete and legally enforceable agreement, the contract. When the covenant is washed away, what remains is a businessman's contract. These distinctions may confuse pharmacists about their roles as professionals and/or businessmen. Furthermore, mixing business with a professional relationship may narrow and limit the professional relationship. The professional takes care of his client; the businessman takes care of his business.⁷ The pharmaceutical care relationship between pharmacist and patient is based on a covenant of authority and commitment and not on a businessperson's contract of mutual exchange.⁸

A pharmacy is a business. It relies on the sale of products to remain viable. Traditionally, pharmacies charge for dispensing a product (drugs) while not charging for services that accompany the product's sale. In addition, there is overwhelming evidence that pharmacists spend the largest part of the workday on product selling (dispensing).

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Arguably, dispensing is a minor step in the provision of pharmaceutical care. For example, the word *dispense* is not mentioned anywhere in *The Principles of Practice for Pharmaceutical Care* of the American Pharmaceutical Association. The document refers to “initiate, and modify medication use” (Preamble), “assuring that his/her patient has been able to obtain, and is appropriately using, any drugs” (Part D), “initiating drug therapy . . . coordinating the acquisition of medications” (Implementing the Plan, 4.1), “that the patient receives . . . all necessary medications” (Implementing the Plan, 4.2), “that appropriate mechanisms are in place to ensure that the proper medications . . . are received by the patient in a timely fashion” (Implementing the Plan, 4.3), and finally, “efficient work flow processes” and “resources” (Appendix).⁹

Some have even questioned the link of pharmaceutical care to dispensing. For example, the provision of pharmaceutical care in New Zealand was quickly dissociated from the dispensing process.¹⁰ In that country, pharmaceutical care activities are considered fundamentally different from dispensing-related counseling duties. There, the pharmacist takes a holistic view of the patient, “which is rarely the case during a patient–pharmacist dispensing intervention.”¹¹

Under the business of pharmaceutical care, the pharmacist focuses on the selling of services that may even preclude the sale of a product. When the focus shifts too often from the service to the product, we may have a problem. This can stress the sensitive covenantal relationship of pharmaceutical care. Fortunately, this has not been a serious problem until now. In particular, the financial viability (exchange value) of product dispensing has supported the utility of pharmaceutical care, while the search for pharmaceutical care exchange value goes on. Unfortunately, changes in the marketplace are threatening this precarious balance.

An Economic Prescription for Disaster

The machinations of the prescription drug marketplace may be becoming hazardous to the health of the pharmacy profession. Someone once characterized managed care as being subject to a drug utilization minimization bias (DUMB), noting that reduction in medication use can and often does result in an increase in the use of other, often more expensive, health services.¹² In that regard, managed care and the rest of the healthcare system may still be “DUMB” when it comes to the use of drugs. Today it may be more appropriate, however, to translate the acronym DUMB as drug utilization maximum bias, in which increases in medication use suddenly make us concerned only with drug costs and not with the “other, more expensive health services” (e.g., hospitals, nursing homes).

Perhaps there are good reasons for this phenomenon. While medical costs in general are rising at approximately 6% per year, prescription drug costs rose almost 19% during this past year and are expected to rise an average of 12% per year in the coming decade. One source¹³ estimates that drug spending rose 40% from 1998 to 2000.

According to the National Institute for Health Care Management Foundation,¹³ the increases occurred not just because drugs are becoming more expensive but because doctors are writing many more prescriptions for higher-cost drugs. Their report stated that 42% of last year’s increase in retail spending on prescription drugs was attributable to an increase in the number of prescriptions written by doctors and filled by pharmacists. Retail pharmacies filled 2.9 billion prescriptions in 2000, an increase of 7.5% over the 2.7 billion filled in 1999.

Meanwhile, states are grappling with drug costs that are growing at a rate of 18% annually, almost double the rate of overall Medicaid spending. Overwhelmed by this explosive growth in prescription drug costs, a number of states are actively pursuing cost-cutting strategies to tame medication expenses.¹⁴ According to Tom Susman,¹³ director of the state Public Employees Insurance Agency (PEIA) in West Virginia, 2000–2001 Medicaid expenditures for prescription drugs will be greater than spending on nursing homes and hospitals. State Medicaid programs are literally going berserk over these increasing drug costs (the irony is particularly fascinating, as prescription drugs are not a required covered service under Medicaid!). At least 19 states have cut or are considering cuts in reimbursements to participating Medicaid pharmacies.

Unfortunately, Medicaid programs and others are looking for someone on whom to vent their drug cost frustrations. West Virginia’s PEIA has issued a request for proposal (RFP) to solicit bids from pharmacy benefit managers (PBMs) to provide discounts through a network of pharmacies to residents aged 60 and older. They are also working on a similar RFP for a 15-multistate coalition.¹⁵

President Bush is proposing the use of pharmacy discount cards to Medicare beneficiaries. His plan would rely on PBMs to negotiate discounts on prescription drugs and issue cards that would entitle seniors to buy drugs at discounts of reportedly 10–40%.¹⁶ The National Association of Chain Drug Stores (NACDS) has identified similar proposals in 44 states. It suggests that the states “undoubtedly will rely on community pharmacies to support the lion’s share of this cost.”¹⁷ Many pharmacy organizations are opposed to discount prescription card programs because they believe it “unfair to ask pharmacies to shoulder the entire burden of cost savings when they are not responsible for high prescription drug costs.”¹⁸ Sensing frustration with the apparent inability to stem this tide, NACDS and the National Community Pharmacists Association (NCPA) filed a lawsuit questioning the legality of the President’s discount drug card initiative.

Meanwhile, PBMs are gearing up for their own assault on the drug margins of the community pharmacy. The 3 major PBMs already manage approximately 50% of the 2.5 billion or more prescriptions written annually in the US.¹⁹ Community pharmacies are not the sole receivers of reimbursements from prescription plans managed by PBMs. Many practitioners believe that mail-order pharmacies are receiving better terms and opportunities from these PBMs. Indeed, PBMs may consider retail pharmacies to

be just another distribution channel. Turning from the traditional 2-tiered approach to the reimbursement of drugs (generic drugs vs. brand-name drugs), Express Scripts, a PBM, recently unveiled a 5-tiered drug plan. The first tier would include cheaper generic drugs, and the second tier is for more expensive generics. The third tier would encompass preferred brands (higher-value classes). Nonpreferred products of higher value as well as preferred products of lower value would make up the fourth tier, and the final tier would include nonpreferred, lower-value drugs.²⁰

E-prescribing holds enormous promise for improving practice efficiencies, particularly in prescription-related messaging. Yet PBMs are about to use e-prescribing to take an additional bite out of prescription reimbursements. Rx-Hub, the new e-prescribing PBM, is planning to charge pharmacies \$0.25–1.00 per prescription received from a physician through the Internet.¹⁹

Third-party plans, not patients, represent the major source of reimbursement to pharmacies. This phenomenon has grown so that, today, >70% of all retail prescriptions are paid by third parties.²¹ It is conceivable that this number will continue to increase until virtually all prescriptions are reimbursed this way. These plans are literally forcing pharmacies to accept less and less in reimbursement above the medication costs, thereby gradually squeezing pharmacies' profits. Third-party programs are barely providing adequate reimbursement for the drug product and the dispensing fee. There often is not enough remaining to reimburse for pharmaceutical care services.

Such economic pressures, increasingly being placed on pharmacies, are fueling the demand for increased dispensing volume to make up for these reductions. Large prescription volumes, however, tend to interfere with the provision of pharmaceutical care. Specifically, many pharmacists indicate that the lack of time, due mostly to filling large numbers of prescriptions, contributes greatly to providing inadequate pharmaceutical care. It has been estimated that 73% of pharmacy staffs' time may be spent processing orders and prescriptions, while <2% is spent providing disease management and other health-related services.²² There is simply too much of the pharmacist's time spent on dispensing activities and tedious administrative duties. Indeed, to some healthcare observers, large prescription volumes strongly suggest that significant portions of medications dispensed are inappropriate, not needed, or worse, potentially harmful.

The Pharmacist, Not the Pharmacy

Pharmacists, not pharmacies, provide pharmaceutical care. In other words, independent pharmacies dispense drugs while independent pharmacists provide pharmaceutical care. Ideally, these 2 activities should coexist compatibly. It now appears, however, that the pharmacy business may be interfering with pharmacists' ability to solve medication problems. Consider that now, and for the foreseeable future, there is a pharmacist manpower shortage. Two major contributors to this shortage are the expansion of

pharmacy practice (into pharmaceutical care?) and increased use of prescription drugs.²³ Can both contributors be satisfied? Is there a need for more dispensers or pharmaceutical care providers? Perhaps we need pharmacies to dispense fewer medications and pharmacists to provide more pharmaceutical care.

Too often, the needs of the pharmacy (to dispense more prescriptions) are put first or get in the way of the patient's need for pharmaceutical care. Eventually, the ability to provide pharmaceutical care may be eroded. As a result, the discharge of its mandate of commitment to the patient would become increasingly more difficult. Pharmacists cannot continue to provide these services without some reasonable compensation or remain dependent on reimbursement that is tied solely to the dispensing of the medication.

Certain other burdensome disincentives that are found in many pharmacies also can undermine support for pharmaceutical care. For example, the use of a single pharmacy for all of a patient's pharmaceutical needs is seen as a means to cement and maintain long-lasting relationships. Yet this is often criticized as being impractical or is even deemed anticompetitive. This certainly does not mean that pharmacies are no longer important or necessary. It means that pharmacists may need a better work environment (i.e., better business model) adaptable to suit the needs of the patient under pharmaceutical care. Pharmacies as we know them may be unable to supply the sufficient support needed for pharmaceutical care activities. As Gans observes,⁴ "One fact is painfully obvious, insurers and third party payers will not change their benefit schemes until either employers or patients demand that they do. The healthcare market will pay only for those services that it is either required to cover or that it deems valuable."

Establishing the Pharmaceutical Care Practice

Only through extraordinary changes can pharmacies continue to support pharmaceutical care in the unfolding economic marketplace. One logical step in that direction is to reduce the pharmacy's reliance on the sale of a medication and reemphasize the legitimate role of the pharmacist as pharmaceutical care provider. Pharmacists should have a viable capability to offer patients more than just the dispensing of a medication. A clear distinction between the pharmacy's dispensing and the pharmacist's pharmaceutical care roles must be made. The basic payment mechanism of this new kind of pharmaceutical care practice would include (1) reimbursement of pharmacists for providing pharmaceutical care and (2) reimbursement of medication costs only.

Changes in both the pharmacist and the pharmacy would be required. The pharmacy would serve primarily as a medication-dispensing site. Pharmacists could establish a pharmaceutical care practice either with or away from an established pharmacy site. Pharmaceutical care consultations could take place in any number of settings such as a private consultation place within a pharmacy, in a

nursing home or hospital, in the patient's home, or in a physician's office.¹¹ This helps define pharmaceutical care as a different pharmacist role, and the patient's perception may be less confused with that of the dispensing role. Appropriate mechanisms would have to be established to efficiently and safely provide access to correctly dispensed medications. No doubt, PBMs will be well suited to take on that job. However, PBM could now stand for *pharmacist* benefit management. Presumably, pharmacists would make excellent benefit managers, having no conflict of interest as retail dispensers of drugs.

Pharmacists would still have to balance professional and financial obligations. The need for a new approach to pharmacy payment was validated by the inspector general of the Department of Health and Human Services (DHHS) in 1991. He clearly stated that an increased clinical role for community pharmacists was not possible on the existing reimbursement framework based solely on dispensing activities. The Joint Commission of Pharmacy Practitioners (JCPP) has suggested the following formula as the components of a pharmacy's reimbursement:

$$\text{product cost} + \text{overhead} + \text{compounding/dispensing fee} + \text{professional service fee} = \text{pharmacy payment}^4$$

The payment emphasis, however, is on the dispensing of a product! Obviously, there is a need for specific reimbursement mechanisms based on securing payment for providing pharmaceutical care. For example, the JCPP suggests seeking recognition of pharmacists as providers through the use of pharmacist-specific current procedural terminology (CPT) codes, thus securing payment for pharmacist medication therapy management services under Medicare, managed care organizations, etc.⁴ The NCPA is already looking into the development of a Pharmacy Companion Guide to the X12N 837 Professional Implementation Guide. This implementation guide will set the standards and the process by which payors and health plans can receive and pay claims for professional pharmacist services.²⁴

The Patient's Advocate

Why should the pharmacy profession or any other pharmaceutical care stakeholder accept such changes? In this new era, the pharmacist would provide pharmaceutical care services without the burden that it must always include the dispensing of a drug. When dispensed, the cost of the medication would be just another cost. Healthcare decision makers would more likely appreciate the financial value of pharmaceutical care if pharmacists had interest only in actual medication cost reimbursement. Without that burden, pharmacists could more easily promote its benefits to all stakeholder groups, thereby creating greater demand for pharmaceutical care. Pharmacists would be freer to engage in strong marketing initiatives to develop the demand for this service.

As a result, pharmaceutical care providers would be more likely to be included in medication management programs by Medicare and other drug benefit programs. The

Pharmacy Benefits All Coalition, 2 of whose member organizations had sued the government over discount cards, asked the secretary of the DHHS to create a Medicare pharmacy benefit, not simply a prescription drug benefit.¹⁷ Calling for a limited administrative role for PBMs, they suggested that patients should select their own pharmacist. The pharmacist would be adequately compensated for providing medication therapy management services. Once again, the acronym PBM could more appropriately stand for pharmacist benefit manager.

Reimbursement for only the medication cost provides disincentives to dispense a medication unnecessarily. It also creates disincentives to dispense increasingly larger volumes of medications to remain competitive. Certain petty annoyances may no longer frustrate pharmacists. For example, in 1 prescription drug plan, patients receiving >2 vials of insulin per month create an audit flag that often results in an on-site audit of the pharmacy.²⁵ This type of annoyance may cease if reimbursements were made for only the actual cost of the insulin (or other drugs).

Pharmacies also would have no vested economic interest in their legal drug sources. Instead, pharmacies would have incentives to control both the volume of medications dispensed and the cost of drugs obtained from these sources. Responsibility for unnecessary medication costs and the focus of its criticisms would fall primarily on those sources. Pharmacists will become less subject to the whims of legal drug sources and freer to become better patient advocates. While competing to provide medication management services to patients, pharmacists would be more likely to work together in controlling drug costs.

If pharmacists could obtain favorable reimbursement for medication management services, pharmacies would no longer feel compelled to participate in prescription plans with unfavorable medication reimbursement terms. The nation's pharmacies would no longer continue to bear the financial burden for drug transactions placed on them by discounted third-party prescription plans. Problems concerning the nature of medication cost reimbursements, their fairness, and the burden they place on all pharmacies would be virtually eliminated. For example, it would eliminate such controversial reimbursements as percent of average wholesale price (AWP) versus actual costs.

Inefficiencies in prescription processing, which detract from the pharmacist's efficiency and productivity in the workplace, could be reduced. Such reductions could provide pharmacists with more time to concentrate on medication management. Meanwhile, appropriately supervised pharmacy technicians and robotic systems would be allowed to perform dispensing duties safely and effectively.

Reimbursements for medication management that include the medication as just another cost can resolve several other issues of concern to the profession. Pharmacists could make lower-cost drug-purchasing decisions for themselves and payers. Discount prescription cards would become meaningless or their discounting burden would fall elsewhere (i.e., manufacturers, distributors). Substitution and any number of other generic versus brand drug is-

sues could be better clarified. Prescription benefit drug cards and drug reimbursement forms might be reduced, eliminated, or less time consuming. Finally, these reimbursement changes could lower barriers that have kept pharmacists from becoming more actively involved in nonconflicting formulary management decisions and in associated professional services such as therapeutic substitution or collaborative prescriptive activities.

Perhaps most importantly, real benefits to the public would be associated with such a change in professional behavior. Having no vested economic interest in how many prescriptions are filled, pharmaceutical care services might be better given by pharmacists and best received by their patients. Pharmacists would be more believable and trusted if not obliged to overemphasize drug costs at the expense of correct medication use. Consumer groups would more likely refrain from blaming pharmacists for expensive drugs and support the pharmacist's role in the provision of pharmaceutical care. Pharmacists would be more likely to be recognized as health professionals, not merchants. The pharmacist could truly become the patient's advocate.

Today, pharmacies are less beholden to their patients than to physicians, third-party payers, and drug manufacturers. How prescriptions are paid should not interfere with patient confidence in the knowledge that safe and effective access to their medications and to appropriate medication use has been ensured. Subsequently, patients may prefer their pharmacists to be providers of healthcare services that may include the dispensing of a medication rather than drug dispensers who may provide healthcare services.

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