VIEWPOINTS

The Need to Invest in Community Pharmacy Practice

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In the United States at present, roughly 26% of health insurance coverage and 45% of all health care payments are made by government programs (state and federal). Much of the discussion surrounding the Medicare Part D drug program has centered on the profits derived from increased drug coverage, which has proven to be a wind-fall for the major US pharmaceutical manufacturers and insurers participating in plans offered by the program. Election 2008 clamor has already begun and has focused on insurance for health care and affordability of health care services. Much attention has and will be focused on the Medicare Part D drug program and costs of drugs within the program. The community pharmacy practice sites that are so valuable for our viability as schools and colleges of pharmacy are besieged with decreasing profitability and more demands to take more of our students for early and capstone practice experiences.

Our community pharmacy community is being asked to do more and more for less and less. More provision of pharmacy service and a decrease in reimbursement levels is challenging thousands of our affiliated pharmacy training and practice sites. Pharmaceutical companies and insurance programs are experiencing dramatic positive shifts in profits, while our community pharmacy practice colleagues have and are being threatened economically. Community pharmacy practice sites cannot continue to support our academic programs if we as an academy do not support their needs and growth.

I think it is time to take a close look at the insurers participating in the Medicare Part D program. Writing about the Medicare Modernization Act of 2003 (Public Law 108-173), Hogan has noted:

“The Medicare Modernization Act (MMA) included three policies to limit the financial risks that Medicare Part D prescription drug plans (PDPs) must bear. These were:

- Risk adjustment of the payments to plans, based on the demographics and health status of each plan’s enrollees, resulting in higher payments for more costly enrollees;
- Reinsurance for catastrophic costs, with the Federal government directly paying most of the cost

when an enrollee’s total drug spending exceeds \$5,100; and

- Risk corridors that limit the bottom-line profits and losses for PDPs, regardless of the reason for the profit or loss.”^{1(p7)}

In effect, participating insurers were thusly assured profitability regardless of what happened from a risk standpoint with their proffered plans. In the last quarter (3 months) of 2006, Humana, Inc.² has reported Medicare prescription drug plan (PDP) premiums of \$882 million, and an increase of 89% in Medicare Advantage (formerly Medicare Part C) premiums to a total of \$2.3 billion. Furthermore, based upon a fourth quarter profit fueled by Medicare related programs of \$155 million, the earnings per common share (EPS) for Humana, Inc. have been adjusted upward for 2007 in anticipation of further profits during the current year.² For the year 2005, the CEO of Humana, Michael B. McCallister, earned compensation of \$3.3 million, with a past 5-year compensation totaling \$15.10 million.³ Humana, Inc. has been a leader in providing Medicare Part D plans, initiating novel medication therapy management programs, and helping countless Medicare Part D enrollees with prescription drug coverage. Humana has hired many of our best and brightest pharmacy graduates. However, is it fair to have such profits derived from governmental programs borne on the backs of pharmacy practitioners and patients?

When it comes to insuring economic viability for community pharmacy, one will find no such parachute of protection against bankruptcy or practice closure. There will be minimal election-year conversations highlighting community pharmacy viability or sustainability. Pharmacists have been the standard bearer in ensuring that their patients eligible for Medicare Part D coverage have obtained necessary medications, and helping many patients and patients’ families identify insurance coverage that will be the most helpful for patients. The recently released “cost to dispense” study prepared for the Coalition for Community Pharmacy Action (CCPA) has noted an average cost of dispensing (COD) per prescription of \$10.50 for a sample of 832,000,000 prescriptions, and a COD per pharmacy of \$12.10 (reflecting the differential

in high- and low-volume prescription pharmacies).⁴ Every third-party program, whether managed care provided by private insurers or governmental Medicaid and Medicare programs, is moving in an economic, diametrically opposed vector from this payment need for pharmacy viability to providing and pushing for lower prescription costs including ratcheting down dispensing fees. The Centers for Medicare and Medicaid Services (CMS) has moved to a payment-for-product model termed the *average manufacturer price* (AMP). In the December 22, 2006 letter from the US Government Accountability Office to Congress with the subject "Medicaid Outpatient Prescription Drugs: Estimated 2007 Federal Upper Limits for Reimbursement Compared with Retail Pharmacy Acquisition Costs," it was noted that this drug pricing methodology will challenge community pharmacy viability.⁵ For 59 of the 77 drugs analyzed in the GAO study, the AMP was lower than that for which the drugs could have been purchased by community pharmacies in 2006. An AMP model cannot measure actual pharmacy or provider acquisition costs for drugs. The full measure of the effect of this shift in pricing will be a further challenging factor for community pharmacies and economic viability.

Many of our colleagues in the Association feel that too much energy is focused on the drug product within community pharmacy, and not enough attention placed on new and innovative services. The reality is that unless the economic viability of community pharmacy is stabilized, reliance on community pharmacy to provide innovative services will not come to pass. Health system pharmacies flourish because of superb management, prudent purchases through large buying groups, state of the art distribution systems, and cutting edge clinical services provided by pharmacists along side other clinicians. However, unless the economics of health system institutions are stable, these clinical services cannot be made available. The same holds true for community pharmacies.

Administrators at our universities and within our collective colleges and schools of pharmacy need to invest in the continuing viability of community pharmacy. These leaders within our universities need to be as conversant with the aforementioned COD and GAO studies as they are with National Institutes of Health (NIH) or National Science Foundation (NSF) reports that encompass research domains and basic science focus areas. Our programs cannot survive academically if the community pharmacy providers within our experiential realms fail due to inadequate reimbursement from payer programs, or from lack of support from our colleges and universities.

Deans, provosts, and college presidents need to invest in the infrastructure of community practice just as they do with major investments in the research infrastructures in our massive academic research programs. Incubators for start-up companies focusing on community pharmacy need to be state and university supported as are other basic science research start-up companies. These new companies may relate to enhanced and faculty driven and managed distribution and acquisition models, novel robotic labor-saving devices, and/or third-party adjudication or pharmacy benefit management (PBM) companies that are competitive with existing PBMs that currently are so profitable. Novel disease management programs can be franchised with developer and school or college profits shared to further support evolving research.

How to do this? Colleges and schools of pharmacy can invest in retaining faculty members who are being lured away by enhanced salaries paid to clinician practitioners. This stoppage of the brain drain of community pharmacy expertise can help our students, our community pharmacies, and our colleges and schools remain at the forefront of community pharmacy practice. Universities can start by providing seed funding for innovative pay-for-performance initiatives highlighting progressive community pharmacy practice enhancements of patient outcomes. Collectively, as an academy, we need to realize the benefits of community pharmacy practice and invest in personnel, programs, pilot projects, and practice sites with financial and human capital even more than we currently do. Community pharmacy residencies that promote disease state management, medication therapy management services, outcomes assessment, and population-based evaluation of care models need to be financially supported by universities, just as bench research programs within disciplines and program areas are financed with millions of state and privately raised endowed funds. We must continue and greatly enhance the dialogue with community pharmacy practitioners to "raise the bar" of experiential expectations for our students in training sites in community settings. Deans can use vacant lines to bring into the academy academicians who have community pharmacy as a practice focus and attendant expertise in implementing novel programs of delivery and assessment. These concepts can be shared across our experiential networks. Our curricula need to continually be refined to mirror current pharmacy practice and what it is that we project it to entail in the future.

We are at a post-crisis level with our experiential program needs and the realities of the environments of practice in the community pharmacy realm. The successes achieved in our academic pharmacy

research and health-system practice components need to be replicated with enthusiasm for and investments in our community pharmacy sites and affiliated programs.

REFERENCES

1. Hogan C. Impact of Policies to Limit drug Plan's Financial Risk. Available at: <http://aspe.hhs.gov/health/reports/06/drug06/index.htm#TOC>, November, 2005. Accessed February 6, 2007.
2. Humana Inc. Reports Financial Results for Fourth Quarter and Full Year 2006; Raises 2007 EPS Guidance. Available at www.humana.com. Accessed February 6, 2007.
3. DeCarlo S. CEO Compensation. Forbes Magazine 2006, Available at <http://www.forbes.com/lists/2006/12/AG0Q.html>. Accessed February 6, 2007.
4. Grant Thornton LLP. National Study to Determine the Cost of Dispensing Prescriptions in Community Retail Pharmacies, Washington, DC: The Coalition for Community Pharmacy Action, January 26, 2007.
5. Whitfield E. Medicaid: States' Payments for Outpatient Prescription Drugs [letter]. United States Government Accountability Office. Washington, DC; October 31, 2005. Available at: <http://www.gao.gov/new.items/d0669r.pdf>. Accessed February 7, 2007.