including independent pharmacies, that want to survive in the face of daunting retail challenges need to create different value-adds to their service offerings. The market is there—patients like going to their pharmacies, trust their pharmacists, and will have (if not already) a need for access to primary care. The training, skills, education, and, most importantly, the pharmacists' desire to help patients is there.

Conclusions

These elements—the changing economic landscape, the patient perception of filling a prescription as a commodity, the looming primary care provider shortage, and the clinical expertise that pharmacists possess—are working together to push for a paradigm shift in how community pharmacists practice pharmacy. Community pharmacists need to practice at the height of their licensure, with less focus on order fulfillment and more focus on improving patient care.

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Employer and Plan Sponsor Views on Pharmacy Reimbursement

Michael Stull, MBA, and Cristy Gupton

Stull & Gupton's Viewpoint

For decades, employers and plan sponsors have sought to quantify the outcomes achieved for the dollars spent on health care products and services for plan participants. To date, we have

seen some progress towards this aim by progressive plan sponsors and government payers on the medical side, rewarding doctors and hospitals for achieving specific quality outcomes and cutting reimbursement and/or access to lower value providers. Still, there is ample opportunity to expand these efforts, improve results, and accelerate the uptake of outcomes-based or value-

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based purchasing strategies by employers.

One area of health care where opportunity exists to expand value-based purchasing is pharmacy. To date, employers have implemented formulary and plan design strategies aimed at aligning access and cost sharing for medications depending on their efficacy and cost, with cost historically being the determining factor. Unlike medical plans, where most payment reimburses providers for a service, pharmacy is focused primarily on reimbursing for a product and not as much concerned with the services that pharmacists provide to patients that contribute to better health outcomes and lower long-term costs.

The ultimate challenge for many self-funded plan sponsors is to balance the desire to manage long-term population health with short-term health care costs. In addition, these plans must also be able to identify appropriate metrics, accurately report those metrics, and ultimately be able to translate those metrics to business outcomes that are valued by senior leadership. While some broad-based studies have attempted to quantify the long-term benefits of, for example, patient compliance with medications to medical cost savings, few organizations are able to show the effect at an employer-specific level without using broad assumptions.

While all employers would agree that the aim of health care delivery should be to improve patient health outcomes, the price tolerance of producing such outcomes varies by employer. As previously mentioned, without clearly defined outcomes metrics that employers can track and understand, the focus often defaults to price in determining the ultimate value of a health care product or service. In pharmacy, as with the rest of health care, the true price of a product or service is often unclear and inconsistent for the patient and the plan.

Employer Pricing

In its most common form, employers negotiate pharmacy pricing using 4 primary components: discounts off the average wholesale price (AWP) of drugs, dispensing fees paid to pharmacies, administrative fees paid to pharmacy benefit managers (PBMs), and manufacturer rebates. These components are further broken out by drug type, whether brand or generic, and channel, including retail, mail, and specialty. In this model, for example, all brand claims filled at a retail pharmacy are priced independently when they occur, but they are reconciled as a group to a guaranteed discount off of AWP. It is not common for employers to know, for example, what a pharmacy was actually reimbursed, net of any postadjudication adjustments, for a particular drug or group of drugs. Said another way, employers typically negotiate a pricing guarantee for drugs across the retail channel versus individually by pharmacy chain or type.

Alternative pricing methodologies exist in the self-funded employer space, but few tie patient outcomes to medication or pharmacy reimbursement. For some biologics and specialty medications, employers, through their PBM or health plan suppliers, have negotiated rebate arrangements with manufacturers that tie reimbursement to specific patient outcomes. Under these arrangements, if a medication is shown to have not worked as intended, the manufacturer may provide additional rebates to the plan or cover the cost of retreatment, if appropriate. In addition, certain commercial and government plans provide additional reimbursement to pharmacies for meeting select quality and adherence standards.

Under the medical plan, employers have adopted outcomes-based reimbursement more readily under pay-for-performance, shared savings, or pay-for-quality initiatives. These programs deliver additional reimbursement to providers for meeting individual outcomes for an attributed patient population. Similarly, health plans and providers have contracted for episodic or bundled payments for certain procedures and have been included as part of commercial and government plans.

Some employers today pay pharmacies for medication therapy management services or adherence counseling. These are usually billed as an additional expense, typically on a per-member-per-month basis and often with a guaranteed return. Many employers, in their quest to lower pharmacy costs, forego these additional expenses performed by the pharmacy and rely instead on disease management programs or the pay-for-performance programs with medical providers to achieve the desired results. To that end, some local pharmacists have partnered with primary care practices to provide services to their patients and share in any incentive payments tied to those patients' outcomes. From an employer perspective, this type of arrangement simplifies the process, since the health plan has already contracted with the medical providers to achieve outcomes and identified metrics for evaluating results.

Employers do pay, whether knowingly or not, for patient management for specialty medications. Here, an opportunity exists for pharmacies to distinguish themselves through an enhanced service model. Many employers, however, opt for an exclusive specialty arrangement through their PBMs as part of their contracts, making patient access for other pharmacies difficult, if not impossible. Nevertheless, there is growing interest in carving out specialty and patient management for specific disease classes.

Case Example

It is true that some employers feel helpless in a health care reimbursement landscape with misaligned incentives, while

others are ready to disrupt the status quo. One employer's experience in particular offers a salient example of how pharmacy reimbursement can be reimagined when a payer, provider, and pharmacy are in alignment.

While its health plan was not in turmoil, a small restaurant group in North Carolina identified an opportunity to look at things differently as a result of concerning trends in the local health care provider landscape. To start, this employer leveraged a unique primary care delivery model in the area: direct primary care (DPC). In this model, the employer pays a per-member-per-month fee, and employees get direct access to their DPC physicians 24 hours a day, 7 days a week. They can email, text, or video chat with their physicians, discussing things such as how they feel on a new drug regimen or if they are due for a refill soon. No need to schedule, take time out of their day to go to appointments, or even pick up prescriptions in person are all benefits of having a DPC physician.

The employer also contracted with a local, independent pharmacy that serves as its own PBM. Working with a transparent, pass-through PBM is key, but the added advantage of that PBM having a brick and mortar presence in the community makes it a perfect match. The employer pays pass-through prices for medications and a dispensing fee, but they are looking to transition to a per-member-per-month pricing structure in the near future.

In designing benefits for the employer's health plan, emphasis was placed on enhancing and incentivizing the relationship between the DPC physician, the independent pharmacy/PBM, and the employee. The first step was to establish a direct contract for purchasing the drugs prescribed by the DPC physicians. This eliminated spread pricing and allowed the lowest possible cost to be accessed by the employer. Furthermore, an "internal feedback loop" exists. It starts with care originating at the DPC physician's office, a prescription sent directly to the local pharmacy partner, and then the prescription being filled and delivered to the employee's home later that day.

In addition to providing medication management and adherence support services, clinical pharmacists at the pharmacy/PBM counsel patients receiving high-cost drugs. When the employees first transitioned to this new pharmacy model, a number of those who were taking brand name drugs realized a generic equivalent is an appropriate alternative. This simple intervention saved the employer thousands of dollars per month in prescription costs while saving employees money on their copay.

Redesigning the health plan was an iterative process for this employer. First, new relationships had to be established for pharmacy benefit management and primary care. The first goal was to move to a better dispense-related reimbursement model with some enhanced pharmacy services being provided through the dispensing fee. With experience and positive employee feedback, the next step will be to move towards a per-member-per-month model for pharmacy services in addition to a dispense-related reimbursement. To start, it is not likely that the fee will be tied to outcomes, although it is something that may be considered with time.

Summary

Voluntary change is usually slow within the market. Employers typically have low levels of risk tolerance when it comes to exploring new ways to pay for pharmaceuticals and other health care services. While costs continue to grow, changing the status quo presents risks that plan administrators typically are not incentivized or positioned to take. Lean benefit staffs, conflicting expectations from leadership, and historical marketplace innovation that promised "savings" without delivering have perpetuated this risk-adverse stance. New pricing tied to affecting outcomes must be easy to understand at an individual employer level, lead to lower total costs per patient, and include the upside and downside risks for the employer and the pharmacy.

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