Community-Based Pharmacy: Partnering with Managed Care to Provide Value-Added Services

As pharmacy focuses more on delivering pharmaceutical care, attention is shifting to the notion of reimbursing pharmacists for providing value-added, or “cognitive” services. Although there are still roadblocks to making sure pharmacy is recognized for the value it brings, new opportunities are beginning to take hold.

As an information-based profession evolving in the budding Information Age, pharmacy is identifying a new role for itself, one that encompasses the assessment of patients, provision of relevant information, and—of course—how to get paid for the service independent of the provision of a drug product.

In this article, leaders in community, academic, and managed care pharmacy identify trends and game plans that offer promise for pharmacy in the twenty-first century as it moves further away from a cost-based reimbursement system and toward one requiring the provision of integrated value-added services to optimize care within systems.

PATIENT EDUCATION AT A PREMIUM

In upstate New York, Wellcare health plan is creating a two-tiered pharmacy program that will pay a limited number of pharmacists for patient education designed to improve compli-
ance with prescribed medication regimens. This select group of pharmacists will be paid a premium rate for the added cost of cognitive services of pharmacists care, adjusted for the number of diabetic or chronically ill patients seen. These "premium pharmacists," as Wellcare's president of administration Bill Strein called them in a recent interview, are "problem solvers, partners with physicians in working with medicine-dependent plan members."

Clearly, Wellcare has devised a payment and referral system that recognizes the value of pharmaceutical care in the total spectrum of patient services. But Wellcare's financing scheme is an exception. Around the country, few pharmacists have ventured into the uncharted waters of cognitive services reimbursement, raising questions about when, if ever, the profession will be paid more than just dispensing fees.

Bob Cipolle, director of the Peters Institute of Pharmacy Care, University of Minnesota College of Pharmacy, just shepherded a three-year study that demonstrated pharmacists can and should get paid for cognitive services. He is not reticent about the need for pharmacists to act now. "Never in the history of health care has anyone gotten paid until a service was provided. Waiting for a third-party payer to start paying pharmacists is a bad business plan," asserts Cipolle.

Today is not too soon to begin billing for cognitive services, he recommends. "Next time a patient asks for counseling about her medications, hand her a bill. Give her a flyer that explains what services are offered by the pharmacy and how much they cost," says Cipolle.

Cipolle acknowledges that many pharmacists are reluctant to assert their right to obtain payment for services rendered and may have to rethink what their professional duties encompass. "Pharmacists need to orient themselves to providing a service, not a product. This paradigm shift is so fundamental that it may be up to the next generation of pharmacists to develop it," he says.

Nevertheless, delay can be risky. Cipolle urges pharmacists not to wait too long to start billing for cognitive services. "There is a need out there for patient education and other services related to pharmaceutical care. If pharmacists don't meet that need, then other health care practitioners such as physician assistants or nurse practitioners will. The need to deliver pharmaceutical care will not go unmet in a free economy because it costs too much not to deliver it," says Cipolle.

WAITING TO CONVINCE PAYERS

While Cipolle urges immediate action to get the ball rolling on cognitive payment, other pharmacists say they first must document the value of pharmaceutical care to win third-party coverage. But they report little success in this approach.

"Perhaps pharmacy is not getting its message across. Perhaps we are just talking among ourselves and not to the people who will be paying us," reflects Gerry Mazzucca, executive director of the Philadelphia Association of Retail Druggists.

Mazzucca says managed care organizations, including pharmacy benefit management (PBM) firms, are making payment for cognitive services contingent upon demonstrating that pharmaceutical care actually improves overall treatment outcomes. This means having data sets with information on the complete episode of care—that link pharmacy services with diagnostic and outcomes data so that the effects of a pharmacist's intervention on the patient's status is documented. However, linking medical files with pharmaceutical claims is an expensive and difficult proposition, comments Mazzucca.

Paying pharmacists for cognitive services is a hard sell job for PBMs, acknowledges Lowell Sterler, PCS's assistant vice president of product management, and AMCP's president-elect. "We know intuitively that cognitive services such as counseling the patient and managing the overall disease state create value because physician office visits and emergency room visits are reduced. But no study has been able to demonstrate that value. The result is that PBMs lack the requisite empirical data to take to an employer and say, 'Here, this is how much you would pay overall for patient care if you paid pharmacists for cognitive services.'"

Sterler also emphasizes that such empirical studies will not be possible until pharmacy claims can be matched against medical claims to track expenditures along the patient-care continuum.

The short-term vision of health plan administrators who demand lower pharmacy costs even if a slight increase in pharmaceutical spending would reduce overall health care costs is lamented by several pharmacists. They complain about "silos of budgets" arrayed across the separate departments of the health plan that keep pharmacy cost savings and expenses separate from overall patient-care expenditures.

"Many managed care pharmacists are responsible for a budget and not overall patient expenditures," Sterler notes. "Plans know that most enrollees will change plans within three years of enrollment, guaranteeing that they will take their potential health problems to the next insurer. Plans need to look at overall medical spending, not just pharmacy costs."

This organizational resistance is forcing PCS to move toward payment for cognitive services at a "glacial pace," says Sterler, often frustrating pharmacists. He explains: "For a number of reasons, we can bring along our clients only very slowly. We have 60 million members all at different levels of sophistication. We work for a lot of employer groups who are simply looking for a discount off average wholesale price and limited inconvenience to their members. In addition, any program PCS implements has to work for 50,000 pharmacies, 100,000 pharmacists who have 200 different computer programs, and thousands of employer groups with differing benefit designs."

Aside from considerable administrative and philosophical hurdles, Sterler wonders if perhaps the profession has set its sights too low. "APhA has set as its goal to have only 15% of pharmacies certified in pharmaceutical care by 1997. That shows pharmacists themselves are moving at a slow pace."

PCS is inching its way to reimbursing for cognitive care. It currently pays pharmacists more than just a dispensing
fee, but the financing scheme falls short of recognizing the full value of cognitive services. Sterler explains that "PCS is using a step-wise approach" to get to the point of reimbursing for cognitive services. "Most of the added payment recognizes administrative efficiencies or increasing use of generics. We are permitting pharmacists to get as much as $12 per prescription by changing a prescription from a nonpreferred to preferred drug."

In June, PCS launched a pilot program that is paying pharmacists in four Midwest states for services that improve compliance. For example, pharmacists are getting paid for bringing in hypertensive patients monthly for blood pressure checks and cholesterol screening. "A full-blown version of the pilot won't be ready for national implementation until mid-1997," Sterler predicts. "PCS expects to be able to demonstrate that community pharmacy can drastically increase patient compliance and bring more value to total patient care," he says.

Nevertheless, the compliance program will not be an easy sell for PCS. "Can we ask groups to sign up with PCS because we will increase their drug costs but actually save on overall medical spending and hospital admissions? Now that's a difficult marketing proposition," he says.

Pharmacists interested in being paid for cognitive services represent an analogous situation to PBMs that are attempting a parallel shift from dispensing a commodity to becoming a provider organization. "That's the bottom line," explains John Jones, director, contracting and compliance for Prescription Solutions. And just as pharmacists are encountering difficulty in convincing payers to reimburse for cognitive services, PBMs are having trouble getting recognized for their sentinel effect on patient compliance and other aspects of total patient care.

PBMs continue to look for a cause-and-effect relationship between pharmaceutical care and total medical costs. "But the stumbling block remains that, while we all agree it is a good thing for pharmacists to talk to health plan members, we can't get clients to agree on the value of those services," says Jones. "We need definitive studies that show, for example, that a compliance intervention reduces overall expenses by $2.00 per member per month. But the data are not yet available. We need to be able to show that certain kinds of counseling correlate to a decrease in medical costs. But so far, we don't have any support for our belief from payers. We are frankly struggling," he admits.

A FRESH FACE FOR PHARMACISTS

The consensus is growing that business as usual is not serving the interests of pharmacists seeking payment for cognitive services and that new steps need to be taken. "Pharmacists must present themselves differently to the public. They will have to market themselves as players," ventures Mazzucca.

He cautions against pharmacists wading in too deep in the unplumbed waters of disease management: "If we narrow too much on specific disease states, we will forego taking care of the whole patient on numerous medications. Comprehensive pharmaceutical care that identifies patients who have specific disease states is needed. Pharmacists are trained in those areas and should get more involved in total patient care than in specific disease-management regimens."

Mazzucca thinks pharmacists also need to consider how automating the dispensing part of their practices will free up time to provide cognitive services. He has a vision: "A central distribution center for a particular region or state could fill and distribute to pharmacies for pick-up by patients, as Kaiser is doing now in Washington State. This pseudo mail-order operation would permit pharmacists to become more involved in patient care."

Cipolle said the three-year project run by the Peters Institute proved the hypothesis that, for "any type of pharmacy, any type of patient, and all payers, pharmacists should be paid for cognitive services." But he laments the possibility that every pharmacy group and managed care plan will feel the need to "reinvent the wheel" and prove again that cognitive services should be reimbursed. Cipolle reports health policy makers from other nations with more systematized health care delivery systems are already integrating some or all of the Peters study findings as they design ways to involve pharmacists more in total patient care.

Cipolle is currently evaluating the results of a three-year project that tested the concept of paying pharmacists for cognitive services. Minnesota Blue Cross/Blue Shield, a major health plan, two drug manufacturers, two PBMs, and an indemnity insurer participated in the pilot both through financing and a commitment of analysts. Cognitive services paid to some 50 pharmacists in the pilot study included providing initial consultations, reviewing drug histories and therapies, constructing new drug taking strategies, providing educational literature, making recommendations or referrals to other health professionals, and providing follow-up consultations.

NEED FOR DISCIPLINE

While the Peters study is being reviewed, Cipolle urged pharmacists to refocus their professional goals. "It's a matter of discipline," he insists. "Pharmacists must develop the elements of cognitive services just as every other health professional group has identified the key element of their practices. Pharmacists must provide three key services: assess a patient's pharmaceutical therapy needs; design a treatment plan that meets those needs; and evaluate the patient at follow-up. To establish this type of practice as the norm, pharmacists must be disciplined to perform certain tasks according to a deliberate thought process. It is time for pharmacists to step up to the plate and do it," Cipolle says.