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Rural Policy Brief

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Issues Confronting Rural Pharmacies after a Decade of Medicare Part D

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Purpose

The RUPRI Center for Rural Health Policy Analysis has been monitoring the status of rural independent pharmacies since the implementation of Medicare Part D in 2005. After a decade of Part D, we reassess in this brief the issues that concern rural pharmacies and may ultimately challenge their provision of services. This reassessment is based on survey responses from rural pharmacists.

Key Findings

- Rural pharmacists indicated that two challenges—direct and indirect remuneration (DIR) fees, and delayed maximum allowable cost (MAC) adjustment—ranked highest on scales of both magnitude and immediacy. Nearly eighty (79.8) percent of respondents reported DIR fees as a very large magnitude challenge, with 83.3 percent reporting this as a very immediate challenge. Seventy-eight percent of respondents reported MACs not being updated quickly enough to reflect changes in wholesale drug costs as a very large magnitude challenge, with 79.7 percent indicating it as a very immediate challenge.
- Medicare Part D continues to be a concern for rural pharmacies—58.8 percent of pharmacists said being an out-of-network pharmacy for Part D plans was a very large magnitude challenge (an additional 29.0 percent said large magnitude) and 60.5 percent said it was a very immediate challenge (an additional 28.1 percent said moderately immediate).
- Pharmacy staffing, competition from pharmacy chains, and contracts for services for Medicaid patients were less likely to be reported as significant or immediate challenges.

Background

We previously reported the annual number of rural sole independent pharmacy closures (total of 924 from March 2003 to December 2013),[1] which peaked in 2008.[2] The advent of Medicare Part D raised questions about the financial viability of small rural pharmacies that had received payment directly from Medicare beneficiaries based on charges, and would now be reimbursed by private insurance plans per the terms of contracts offered by those plans.[3] The dramatic increase in closures of rural sole independent pharmacies has slowed in recent years, but the financial viability of such pharmacies as the sole provider in many rural communities remains a concern.[1] However, after ten years' experience with Part D plans, the challenge of agreeable terms under those contracts may not be the most serious or immediate challenge facing rural pharmacies. Previous work shows that low reimbursement rates, delayed payments, and inability to find someone to take over upon retirement are also posing serious challenges to these pharmacies.[1,3,4]

A pharmacy in a rural community is more than a place to fill prescriptions. Local pharmacists are part of the health care system, providing essential services such as counseling residents as prescriptions are filled (including medication therapy management), attending to residents with mild illnesses that can be treated

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with over-the-counter medications, providing immunizations, and supporting other local providers (e.g., hospitals, skilled nursing facilities, and hospices).[1,3] With all that is at stake in maintaining local access to pharmaceutical services, understanding these challenges is critical to developing policies focused on this essential element of local health services.

Methods

National Council for Prescription Drug Programs data for June 2014 and data on Primary Care Service Areas[5,6] were used to identify pharmacies that were the only retail outlet (including community, retail, grocery, and clinic pharmacies) in their Primary Care Service Area. A total of 643 such independent pharmacies were identified.

Key informants were interviewed to develop a questionnaire about the top 10 issues perceived to be a threat to pharmacy sustainability. The survey instrument sought responses on the magnitude and immediacy of the threat posed by each issue. The survey also contained open-ended questions that asked respondents to provide any additional information. Following a pilot test of the survey with local, rural pharmacists, a final web-based instrument was developed. E-mail addresses for 430 of the independent pharmacies were obtained from the National Community Pharmacists Association. Initial survey participation invitations were e-mailed on June 28, 2016, and follow-ups were sent on July 12, 2016. Responses were received from 118 pharmacies (27.4 percent).

Results

Two of the 10 survey items focused directly on payment per prescription: the timeliness of changes to MACs, and the use/size of DIR fees. Those items were identified as the most challenging of any item on the survey, as is clearly shown in Figure 1, and in the data presented in Table 1.

All respondents rated delayed MAC adjustment as a large or very large challenge, and 79.8 percent said it is a very immediate challenge. Similarly, all but two respondents (98.2 percent) rated DIR fees as a large or very large challenge and a moderately immediate or very immediate challenge. The next-highest-rated challenge was competition from mail order pharmacies (91.5 percent large or very large challenge, 88.8 percent moderately or very immediate challenge). Somewhat related and consistent with our previous findings related to pharmacy closure and significant challenges to rural pharmacies,[3,7] the next-highest-rated challenge was exclusion from Medicare Part D Plan preferred networks, with 87.8 percent of respondents rating that as a large or very large challenge and 88.6 percent saying the challenge was either very immediate or moderately immediate.

Other potential challenges were less impactful and immediate (see Table 1), but in the context of providing pharmacy services directly to local residents, including Medicare beneficiaries, two stand out. One challenge was handling the needs of more complex patients resulting from the growth in the elderly population—rated as a large or very large challenge by 76.1 percent and a very or moderately immediate challenge by 63.2 percent. The other challenge was not being reimbursed for providing clinical services, said to be a very large or large challenge by 63.7 percent and a very or moderately immediate challenge by 57.6 percent.

Many respondents provided answers to the open-ended questions asking for additional information on the challenges facing their pharmacies. Although the responses to these questions varied, two key areas emerged: challenges posed by payer practices (plan/Pharmacy Benefit Manager [PBM]), and reimbursements.

Payer practices: Respondents cited the "unfair competition" from payer-owned/affiliated mail order and chain stores as a major challenge. PBM practices such as restricting their preferred networks to chain stores and mail order companies, charging patients higher co-pays for using an independent pharmacy rather than mail order, and requiring patients to switch to mail order (among other "aggressive" practices) were perceived as creating an uneven playing field that gives mail order and chain stores an unfair competitive edge. This uneven playing field was reported as having contributed significantly to the declining finances of rural independent pharmacies. Respondents also mentioned that mail order was "a real detriment to patients' health" as it splinters care and serves "as a source of confusion" to many patients. One respondent also mentioned that the mail order pharmacy practice of auto-refilling prescriptions often leads to waste, as many patients end up with medications that have been changed or discontinued.

Figure 1 – Pharmacy Issues: Magnitude and Immediacy

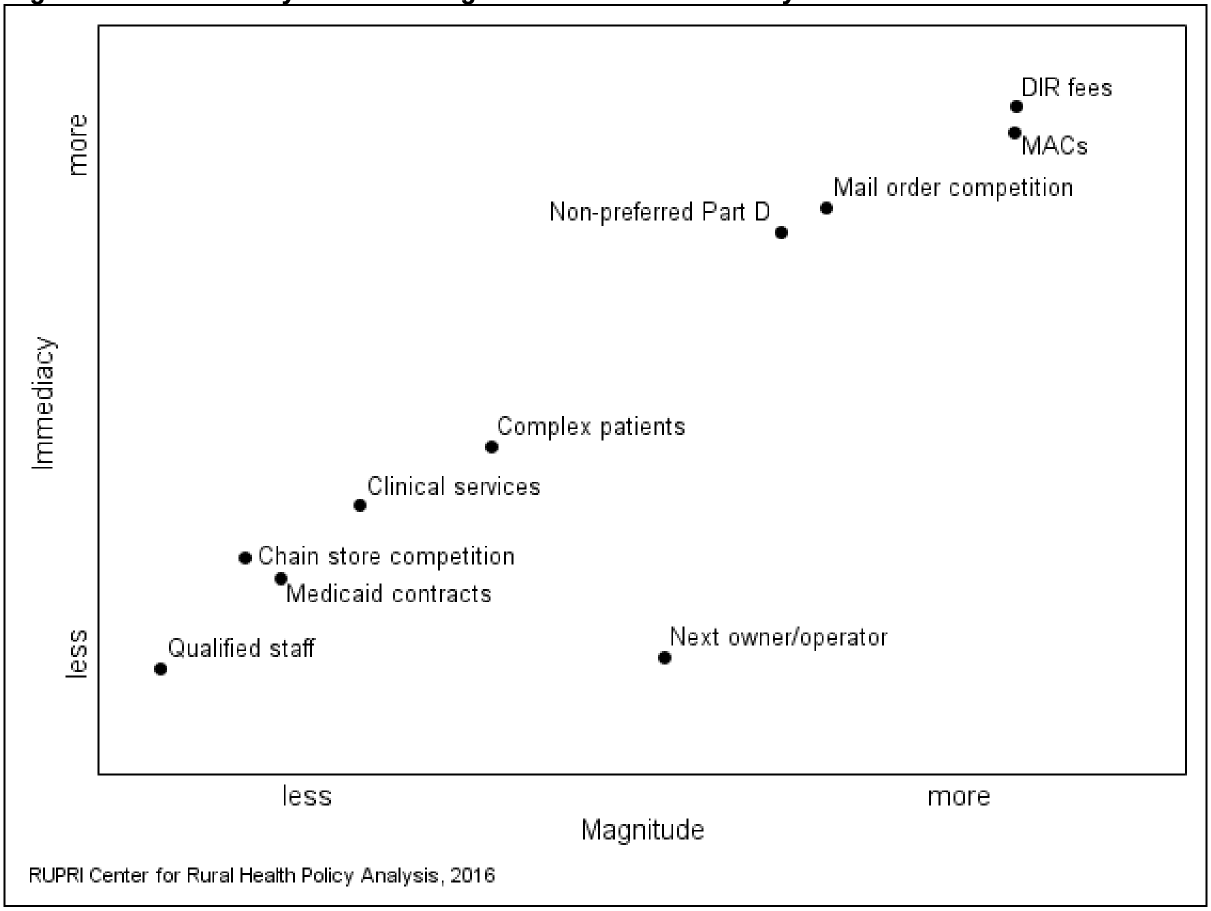

Table 1 – Pharmacy Issues: Magnitude and Immediacy

Pharmacy Challenge	Magnitude		Immediacy	
	Large	Very Large	Moderately Immediate	Very Immediate
Maximum allowable costs (MACs) are not updated quickly enough to reflect changes in wholesale drug costs	22.0%	78.0%	15.3%	79.7%
Being charged direct and indirect remuneration fees (sometimes known as "DIR fees," "true-up fees," "pay-to-play fees," or "administrative fees") by preferred network drug plans	18.4%	79.8%	14.9%	83.3%
Greater competition from mail order pharmacies	30.8%	60.7%	22.7%	66.1%
Being a non-preferred pharmacy for Medicare Part D plans	29.0%	58.8%	28.1%	60.5%
Finding someone to continue operating the pharmacy if I decide to retire or sell the pharmacy	43.6%	43.6%	20.9%	22.7%
Handling the needs of more complex patients resulting from the growth in the elderly population	46.0%	30.1%	30.7%	32.5%
Not being reimbursed for providing clinical services (e.g., blood pressure monitoring)	36.3%	27.4%	25.7%	31.9%
Greater competition from chain store pharmacies	50.0%	15.3%	34.8%	21.2%
Contracting with private entities to receive payment for providing services to Medicaid participants	29.8%	27.2%	23.9%	27.4%
Employing a sufficient number of qualified staff	40.7%	12.7%	27.1%	14.4%

Other PBM practices that respondents felt were posing a challenge to their pharmacies included “predatory audits,” excessive “number of prior authorizations required” before filling prescriptions, and withholding reimbursements based on a patient’s non-compliance with medications. One respondent felt that such withholding was unfair since they could only ensure that patients got their prescriptions but had very little control over whether they took their medications. This respondent also indicated that “patients are beginning to feel intimidated by PBMs and pharmacies calling them and telling them they aren't taking their meds appropriately." Respondents also viewed DIR fees charged by PBMs as a major challenge to the financial sustainability of their pharmacies. They cited the upward trend in these fees, the “undefined” nature, and lack of “transparency” in the determination of these fees.

Reimbursements: MAC pricing was a major source of concern for respondents as it was “hurting” their “bottom line every day.” Respondents noted that MACs were often below the actual cost incurred in purchasing and dispensing the drug. One respondent stated that “nearly 10 percent of my prescriptions are reimbursed from PBM's under my actual cost to buy the medication, and nearly 80 percent are under my cost to dispense the prescription.” Respondents also reported that MAC pricing “is not updated often enough” and even when updated, the adjustment is not retroactive and the price is still “set too low.” Respondents were also concerned about the MAC appeals process. They reported that these processes were slow and changed frequently and that appeals were frequently denied. One respondent said that “PBMs deny 99 percent of all appeals.” Respondents also expressed concern that payment of reimbursements was often slow. In addition, they expressed concern about the low, and in many cases lack of, reimbursement for clinical services rendered by their pharmacies, such as blood pressure checks and medication therapy management.

Discussion and Implications

The major challenges facing rural pharmacies responding to this survey affect their ability to generate net revenue from the sale of prescription medications. The combination of delayed MAC adjustment and DIR fees results in pharmacies losing money on many of the prescriptions filled. Comments from respondents further buttressed these fiscal difficulties. These financial difficulties have made it difficult for many of these pharmacies to remain open, and many are on the verge of closure. As one respondent put it, “I am afraid it is too late to be conducting this study. Our fate is already set, and it is just a matter of time before we all go under.” Many also expressed concerns about the future of their pharmacies, as declining profitability was making it difficult to find buyers or successors willing to take over their pharmacies upon retirement.

With looming closure without replacement of many of these pharmacies, an estimated 3 million rural residents are at risk of losing the only pharmacy in their community.[7] For many of these individuals, the nearest pharmacy is over 10 miles away.[7] This geographical barrier to accessing pharmacy services is exacerbated for individuals who are unable to travel that distance (e.g., low-income and elderly).[7] Such individuals’ only choice may be to use mail order, which lacks the face-to-face consultation that is important to providing quality pharmacy services.

Closures of rural independent pharmacies would significantly limit access to services for rural residents, especially those most vulnerable and likely to need the services. Public policies could ameliorate fiscal stress for rural independent pharmacies by focusing on MAC and DIR, adjusting costs and payments for at least this group of vulnerable pharmacies. Another, not mutually exclusive, policy consideration would be to facilitate alternative means of delivering quality pharmacy services to these rural communities, such as tele-pharmacy.

References

1. Ullrich F, Mueller KJ. *Update: Independently Owned Pharmacy Closures in Rural America, 2003-2013* (Rural Policy Brief No. 2014-7). Iowa City, IA: RUPRI Center for Rural Health Policy Analysis; 2014:1-4.
2. Klepser DG, Xu L, Ullrich F, Mueller KJ. Trends in community pharmacy counts and closures before and after the implementation of Medicare part D. *J Rural Health* 2011;27:168-75.
3. Radford A, Mason M, Richardson I, et al. Continuing effects of Medicare Part D on rural independent pharmacies who are the sole retail provider in their community. *Res Social Adm Pharm* 2009;5:17-30.
4. Todd K, Westfall K, Doucette B, Ullrich F, Mueller K. *Causes and Consequences of Rural Pharmacy Closures: A Multi-Case Study* (Rural Policy Brief No. 2013-11). Iowa City, IA: RUPRI Center for Rural Health Policy Analysis; 2013:1-4.
5. For an overview of Primary Care Service Areas (PCSAs), see Goodman D, Chang C, Shipman, S. *Primary Care Service Areas.* https://www.hrsa.gov/advisorycommittees/shortage/Meetings/20110118/MeetingMaterials/primarycare.pdf (accessed 2/21/2017)
6. "Health Workforce Data | Bureau Of Health Workforce". *Bhw.hrsa.gov*. N.p., 2017. (accessed 2/21/2017).
7. Nattinger M, Ullrich F, Mueller KJ. *Characteristics of Rural Communities with a Sole, Independently Owned Pharmacy* (Rural Policy Brief 2015-6). Iowa City, IA: RUPRI Center for Rural Health Policy Analysis; 2015:1-4.