# A Primer on Health Center Pharmacy Operations

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## INTRODUCTION

Many Community Health Centers (including Federally-Qualified Health Centers and Federally-Qualified Health Center Look-Alike programs) choose to integrate pharmacy services into their current operations model. Some have in-house pharmacies, other use contract pharmacies, and some use a combination of both.

In addition to simplified medication access, pharmacists can quickly become an integral part of a health center's care team. They collaborate on patients' medication plans, administer vaccines, evaluate the effectiveness of treatment, provide patient education, improve access to reimbursement, etc. One of the many benefits experienced by health centers engaging in direct pharmacy services is access to the **Federal 340B Drug Discount Program**.

With new manufacturers' restricting shipments to contract pharmacies (only) for certain discounted 340B drugs, health centers are even more interested in opening an in-house or entity-owned pharmacy to care for their patients.

In this paper we outline a variety of topics associated with pharmacy operations for health centers, including: the role of the pharmacy in the patient care model (in-house and entity-owned); the 340B program; the intersection of the 330 Grant requirements and the 340B program; patient assistance programs; prescription capture rates; and growth.

## THE ROLE OF THE PHARMACY IN THE PATIENT CARE MODEL

### IN-HOUSE PHARMACY AND CLINICAL PHARMACY SERVICES

The terms "in-house" or "entity-owned" pharmacy are used to describe a situation where the health center owns the pharmacy license and the insurance contracts. The pharmacy can be staffed and

operated by the health center, or an outsourced management company that specializes in operating pharmacies can be hired.

In-house pharmacies come in all shapes and sizes. From 350 to 2,000 square feet. The size is based on state pharmacy requirements and business potential. Most CHCs chose not to open a pharmacy "dispensary" because this model doesn't allow for billing insurances and gaining the financial benefits of the 340B program.

Health centers that established in-house pharmacies generally have no regrets and wish it was established sooner. When health centers are unfamiliar with pharmacy operations and the pharmacy business in general, they are hesitant to take this step. However, once leadership can move past the "unknowns," the possibilities are endless.

One of the keys to a successful in-house pharmacy is location. If your pharmacy is visible to your patients within the clinic, they'll be more likely to establish their prescription business with you. An in-house pharmacy does not need to be co-located within the medical practice, though it should be a place your patients can easily see and find, like in a nearby shopping area. That is why the term "entity-owned" is the most descriptive. Overall, your pharmacy can provide access to higher quality care for patients – and delighted patients are the best advertisers your pharmacy can get.

Appropriate staffing is also essential to a successful and sustainable in-house pharmacy. In many cases, a patient comes to an in-house pharmacy after spending 1-2 hours in the clinic for their medical visit. Filling prescriptions quickly and accurately is critical for growing your business. Since in-house pharmacies don't have large areas to wander and shop (unlike chain or grocery store pharmacies), the speed at which an in-house pharmacy can safely fill the prescriptions will be a huge selling point. To process prescriptions quickly, you'll need to staff appropriately.

The number of staff hired for an in-house pharmacy will be dependent on the other duties you expect from your pharmacist. If you want a pharmacist to spend time in patient rooms counseling new diabetics or other patients (clinical pharmacy work), for example, you would need to staff at a higher level. It is not legal to operate a pharmacy when the pharmacist is not present.

As a rough estimate, a pharmacist and a pharmacy technician can handle 75-100 prescriptions each day. As the business grows, adding pharmacy technicians is the common first step. By the time a pharmacy is filling 150 or more prescriptions per day, you will be ready to add an additional pharmacist.

### IN-HOUSE PHARMACY ADVANTAGES

## AN IN-HOUSE PHARMACY HAS MUCH TO OFFER YOUR PATIENTS:

- The ability to see a provider and fill a prescription in the same location
- Direct access to the medical provider, often through instant messaging, giving patients immediate access to their medications
  - Provider can prescribe an alternative while the patient is still in the building if a drug is not covered by a patient's insurance or it is too costly
  - Refill requests can be expedited when a patient is out of medication
  - Pharmacists can offer patient education and support
- Access to discounted medication prices are available for eligible patients
- Generally, the pharmacy contracts with all insurance plans so patients benefit by not having to shop around for a pharmacy that accepts their insurance
- Most importantly, friendly, knowledgeable staff work in the health centers

## AN IN-HOUSE PHARMACY HAS MUCH TO OFFER YOUR PROVIDERS:

- Providers will see their patients adhere with and comply to pharmaceutical regimens more often
- Providers will see improved clinical outcomes, especially for Medicare patients
- Providers can easily consult with pharmacy staff on patient medication plans
- Pharmacy staff become essential members of the care team, with far more contact with patients on a weekly/monthly basis, providing encouragement and education

Some health centers provide **clinical pharmacy** or **advanced practice services** in conjunction with their in-house pharmacy. This can be a stand-alone service, or a hybrid. Clinical pharmacy can take many forms and implementing clinical pharmacy services can be straight forward. Most health centers start with a few patients, like diabetics with A1Cs above 12. For these patients, they can set up an education and monitoring program to reduce their A1Cs by 4 points over a period of time. Some health centers employ designated pharmacists to work with providers and patients to achieve improved health outcomes, while others utilize their dispensing pharmacist staff to provide these services.

Clinical pharmacy services can be utilized in person or offered virtually, opening additional opportunities. How the program is set-up is dependent on the financial and staffing resources available.

At a minimum, your in-house pharmacy can impact outcomes for your Medicare patients by providing Medication Therapy Management (MTM). The Medicare plans will pay a stipend for the pharmacy to perform a comprehensive review of their patient's medications and provide them with a personal medication record and related action plan. The pharmacist documents the encounter and provides recommendations to the patient's provider. MTM can be done for any patient, but Medicare is generally the only organization that pays for the service.

### CONTRACT PHARMACY

Contract Pharmacies (CPs), as the name suggests, are nearby pharmacies that serve health centers under a contract to provide medications to health center patients. These contracts can be with independent and/or chain pharmacies. Sometimes they are with Specialty Pharmacies (which provide unique or "special" drugs to patients).

Under this model the health center can obtain 340B savings when insured patients fill their medications at a contract pharmacy. The 340B revenue paid to the health centers by the CP is based on what the insurance paid for the prescription plus the patient co-pay, less the pharmacy service fee and other administrative fees. Health centers must then purchase the drug at 340B prices to replenish the product dispensed by the pharmacy to the patient.

With this arrangement, the pharmacy can replenish their stock and the CP obtains the service fee based on the contract agreement. (see chart below)

Contract pharmacy arrangements are beneficial for health centers that either have a small patient population or patients that live throughout a broad geographic range, so operating an in-house pharmacy is not feasible. Many health centers use a hybrid model of in-house and contract pharmacies as the preferred way to provide prescription care for patients to maximize the 340B savings available.

## THE 340B DRUG DISCOUNT PROGRAM

In 1992, part of the Public Health Service Act (Section 340B) established a drug discount program to help safety net organizations stretch their scarce federal resources to reach more eligible patients and provide more comprehensive services. This legislation is known as the 340B Drug Discount Program (or 340B).

The 340B program requires pharmaceutical manufacturers to sell their drugs to health centers at the discounted rate they charge Medicaid (30-50% less than a retail pharmacy would pay). 340B purchased medications can only be used for health center patients and for prescriptions written by

health center providers. Under certain conditions, specialist/referral prescriptions can apply as well.

Health centers, including FQHC Look-Alikes can use these discounted rates for patients with in-house pharmacies or at contract pharmacies. When a prescription is filled at an in-house pharmacy for an insured patient, the pharmacy bills the insurance company the contracted 340B rate for the medication. With prices ranging 30%-50% less than a retail pharmacy, health centers benefit from the savings.

### IN-HOUSE 340B PHARMACY EXAMPLE

| Retail | | | 340B | | |
|---|---|---|---|---|---|
| 3rd party reimbursement | $150 | | 3rd party reimbursement | $150 | |
| Dispensing fee | $5 | | Dispensing fee | $5 | |
| Total reimbursement | | $155 | Total reimbursement | | $155 |
| Cost of drug | | $125 | Cost of drug | | $50 |
| Total savings to the retail pharmacy | | $30 | Total savings to the health center | | $105 |

### CONTRACT PHARMACY 340B EXAMPLE

| Retail | | | 340B | | |
|---|---|---|---|---|---|
| 3rd party reimbursement | $150 | | 3rd party reimbursement | $125 | |
| Dispensing fee | $5 | | Dispensing fee | $5 | |
| Total reimbursement | | $155 | Total reimbursement | | $155 |
| Cost of drug | | $125 | Cost of drug | | $50 |
| Retained savings | | $30 | Retained savings | | $105 |
| | | | Contract pharmacy fees | | ($45) |
| | | | Total savings to the health center | | $70 |

## THE SLIDING FEE SCALE (SFS) AND ELIGIBLE PATIENT PRESCRIPTION ASSISTANCE PROGRAM (EPPAP)

### HOW DOES THE SLIDING FEE SCALE (SFS) WORK IN PHARMACY?

Health centers are obligated to ensure eligible patient have access to affordable medications. This is based on the health center mission, the 330 grant/**compliance manual**, and the spirit of the 340B program.

Many health centers choose to view prescriptions as supplies and, as such, are not bound to the strict payment tiers established by the Bureau of Primary Health Care which requires four distinct payment tiers based on income for patients under 200% of the federal poverty level (FPL). Health centers can choose to set up an EPPAP (Eligible Patient Prescription Assistance Program) which offers discounted medications to any patient under 200% FPL at a flat rate, such as $4.00/prescription and actual acquisition cost, plus $1.00 (whichever is more). This provides significant discounts for

eligible patients under 200% FPL, while not over-pricing medication.

A traditional 4-tiered SFS can end up charging patients double the price they for generic drugs sold at most chains and many independent pharmacies. At no time do we want our health center's discounted medications for eligible patients to be higher than the prevailing rate in the community.

### HOW TO WORK WITH PATIENTS OVER 200% OF THE FEDERAL POVERTY LEVEL (FPL)?

Despite having income over 200% FPL, many patients have high deductible plans which come with high prescription co-pays. This places the pharmacy in a difficult position. Health center contracts with the companies that manage patient prescription benefits (PPBs) place restrictions on waiving or discounting co-pays for patients.

A SFS/EPPAP program can be built in a "safe harbor" based on the requirements of our 330 grant, the health center mission, and the spirit of the 340 B program. There really is no safe harbor for those patients over 200% FPL.

Co-pays for Medicare Part D patients may be waved, but only in certain situations and not as a matter of course in the pharmacy. There are limits to waiving the co-pays for some prescriptions, for example, and patients must show financial need prior to the discount occurring. Because Medicare Part D patients still need access to medications, the pharmacy staff can work with medical providers to find alternative, covered medications. These are great opportunities for providers to tap into extensive education of pharmacists, and provide suggestions to ensure patient's needs are met

Unfortunately, there are no documented waivers for commercially insured patients. Commercially insured patients may qualify for co-pay discount cards provided by the drug manufacturers that can drastically reduce the "out of pocket" expenses for brand name medication.

Some health centers have foundations that can contribute money to assist in patient care. This would be a good resource for patients over 200% FPL who need assistance with medication copays, and it would not violate any contract agreements. Some health centers have used United Way funds and even asked their employees to select their health center as the recipient of their weekly Unite Way contributions to assist patients with copays.

## PATIENT ASSISTANCE PROGRAMS

Pharmaceutical manufacturers offer significant discounts to commercially insured and uninsured patients on most of their brand products. Often the PAP programs allow patients with incomes of 300-500% FPL to access free or discounted medications. This is a great alternative for those patients who do not meet the SFS/EPPAP requirements for being under 200% FPL. The best way to locate the PAP programs is to Google the drug name and the words "patient assistance." Some health centers have saved literally millions of dollars for their patients by maximizing patient assistance programs (PAPs).

These programs are not available for patients covered by Medicare or Medicaid. There are foundations and other organizations that will assist Medicare patient, but there is a lot of 'leg work" involved in finding those sources of assistance.

## MAXIMIZING YOUR IN-HOUSE PHARMACY

Many health centers have in-house pharmacies but have not maximized that resource.

Capture rates are the percentage of prescriptions filled at the pharmacy, divided by the total number of prescriptions written. These rates can vary for health centers from 15% - 75%, though most capture between 25% and 40% of the prescriptions written. A good capture rate would be around 50%.

Since patients cannot be forced to use a specific pharmacy ("pharmacy of choice" rules), there are various techniques we can use to encourage patients to use an in-house pharmacy. When no in-house pharmacy is available, promotions to contract pharmacies can alert patients about benefits and 340B savings.

For both avenues, posters in exam rooms and waiting rooms can be effective tools to highlight the benefits of your in-house or contract pharmacies, and they can be used to attract clients. Mention that the contract pharmacies support the mission of the health center and list addresses to help direct patients to locations where 340B savings are available. In a poster for in-house pharmacies, highlight the advantages the patient will experience when they use your pharmacy. (see advantages above)

If possible, promote beneficial services, like delivery and compliance packaging where the patient receives their prescription in a "bubble pack" organized by the day and time they should take their medication.

There is also a program called Med Synch which helps patients by filling all maintenance medications once per month, saving the patient time and reducing the number of pharmacy visits needed each month.

## FINAL THOUGHTS

Health centers are expected to utilize the 340B Drug Discount program to reduce costs for both patients and health centers and expand access to health center services more broadly. Because pharmacy programs bring many benefits to health centers and their patients, it is important for health center administrators to consider developing a pharmacy program (either in-house or through contract pharmacies) that can tap into the 340B benefits.

Health center-based pharmacy programs do not need to be complicated or difficult to achieve. The first step is to determine the best way for your health center to implement or grow a pharmacy program; and the key to success to assertively promote the many advantages of pharmacy services for your patients.

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