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A Critical Access Pharmacy Program

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Commonwealth Policy Institute 2023 Congressional Summit

Center for Health Disparities

A Critical Access Pharmacy Program

By Julia Mattingly, Senior Fellow; Jack Reynolds, Fellow

Summit Background

This policy brief - which recommends new development of federal, state, and local policy measures - is derived from the 2022 and 2023 Congressional Summit meetings of the Commonwealth Policy Institute think tank, and meetings with elected state government officials immediately prior. The Commonwealth Policy Institute (CPI) is nonpartisan, evidence-based policy think tank, founded with its first chapter at the University of Louisville, and is acknowledged as resource for tailored policymaking in Kentucky under bicameral resolutions of the KY General Assembly. Under its stream of work conducted as public service, CPI forms policy centers combining university level research of faculty and university community members with input of stakeholder groups, businesses, and policymakers to create tailored policy solutions to needs faced across the Commonwealth of Kentucky. As many issues we address are common to other states, and as discussion across the states at a federal level may incubate new ideas which may be tailorable to Kentucky, each year CPI conducts an annual Congressional Summit for the purpose of leveraging the federal system for policy diffusion -- rapidly “trickling up” ideas from our state-level policy design into a federal context, or, “trickling down” new policy approaches that may be re-designed for implementation in the Commonwealth.

This briefing is the result of trickling up a state-level proposal and recommends a national critical access pharmacy program to the federal government.

Introduction

With much light on rural hospital closures and healthcare workforce shortages, a sect of rural healthcare rarely discussed is the availability and accessibility of rural independent pharmacies. Pharmacies are a vital part of healthcare delivery in rural communities, with many not only supplying medications but also offering clinical services such as immunizations, blood pressure and glucose monitoring, medication counseling, and more.

According to the RUPRI Center for Rural Health Policy Analysis, nearly half of rural pharmacies in the United States are independently-owned retail stores unaffiliated to a larger chain or franchise.[1]

[1] Lazaro, E., Ullrich, F., & Mueller, K. (2022). Update on Rural Independently Owned Pharmacy Closures in the United States, 2003-2021. *Policy File*, *2022*.

However, independent pharmacies face particular financial challenges—such as low reimbursements stemming from limited negotiating power and a greater reliance on drug sales as a primary source of revenue—that make them especially susceptible to closure. Between 2003 and 2021, approximately 1,231 independently owned rural pharmacies (16.1 percent) in the United States closed.

The most drastic rate of rural independent pharmacy closures occurred between 2007 and 2009, which coincided with the implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).[2] The 2003 MMA was a crucial bill establishing Medicare Part D and providing 3.4 million American seniors with prescription drug insurance. Unfortunately, though, Medicare Part D plans have consistently reimbursed pharmacies at lower rates than the actual costs and previous out-of-pocket payments. Rural independent pharmacies also face financial pressures from outdated maximum allowable cost (MAC) pricing for wholesale costs to pharmacies, DIR fees charged to rural pharmacies by pharmacy benefit managers, and competition from mail order companies and chain store pharmacies who often can purchase prescription drugs in large volume at a reduced cost.[3]

Recommendations

As funds are available, Congress should designate the Centers for Medicare & Medicaid Services to establish a Critical Access Pharmacy Care Program to ensure the sustainability of critical access pharmacies throughout the United States. To qualify as a "Critical access care pharmacy," a pharmacy must be:

- A United States-based brick-and mortar-pharmacy;
- Located in a county having fewer than fifty thousand (50,000) residents according to the most recent federal decennial census
- Located in an area designated as a Medically Underserved Area by the Health Resources & Services Administration (HRSA)
- Owned by an entity that owns fewer than ten (10) United States-based brick-and-mortar pharmacies

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[2] Salako, A., Ullrich, F., & Mueller, K. J. (2018). Update: Independently Owned Pharmacy Closures in Rural America, 2003-2018. *Rural Policy Brief*, *2018*(2), 1-6.

[3] *Rural Pharmacy and prescription drugs overview - rural health information hub*. Overview - Rural Health Information Hub. (2023, January 26). https://www.ruralhealthinfo.org/topics/pharmacy-and-prescription-drugs#challenges

On a quarterly basis, the Centers for Medicare & Medicaid Services shall determine the number of prescriptions filled by Critical Access Care Pharmacies reimbursed by Medicaid managed care organizations utilizing encounter data available to CMS. CMS shall determine the individual payment amount per prescription by dividing 1/4 of the annual amount appropriated for the Critical Access Care Pharmacy Program by the number of prescriptions filled by all critical access care pharmacies reimbursed by Medicaid managed care organizations that quarter. Individual payment amounts per prescription shall not exceed the dispensing rate that the department would have reimbursed under the state's medical assistance program as of July 1 of the same year.

CMS shall distribute a critical access care pharmacy program payment quarterly to critical access care pharmacies. The first payment shall be calculated utilizing the encounter data from the last quarter of the fiscal year 2022.