UNLO

OCKING YOUR DATA

Benjamin Jolley says a wealth of valuable health care enhancement tools are at your fingertips

by Chris Linville

There are several ways you could describe Benjamin Jolley, PharmD. Meticulous, detail-oriented, data-driven. All would be accurate.

A third-generation pharmacist, Benjamin works alongside his family and team at Jolley's Compounding Pharmacy, serving patients in Salt Lake City. When asked if he was focused on details and organization from an early age, at first Benjamin pauses, but then recalls when he was about 8 years old and his dad brought him to the pharmacy.

"I was sitting there, and somebody handed me all of the prescription files and asked me to sort them (controlled substances versus regular prescriptions) and put them in order and bundle them," he says. As he did this, Benjamin says he found a medication that wasn't marked correctly and excitedly yelled out, "Oh look, I found one that doesn't match." He chuckles as he recalls the reaction. "They would say, 'Good job Benjamin, you're great, keep it up kid!' That's not all that dissimilar from being obsessed with all of the other numbers, so maybe that was one of those formative experiences."

Fast forward many years later, and Benjamin is still focused on the details. He has expertise in a variety of clinical services — including pain management, hormone balancing, and veterinary compounding — but is also knowledgeable in the business side of pharmacy, and offers insight on issues such as PBMs, PSAOs, contracting, and fair pricing and reimbursements. Benjamin is lead luminary for CPESN® Utah. He is also a frequent guest on webinars and podcasts.

DATA TROVE

Benjamin says that many pharmacists have a wealth of useful information on their computer systems but are either unsure how to find it, where to look for it, or how to use it if they do find it. Benjamin has also become something of a DIR guru and provides consulting services for other pharmacists, helping them set up DIR estimator tools that he says are available on almost all pharmacy software systems.

"There's lots of data streams that exist in pharmacy right now that pharmacists do not realize is present in their software," Benjamin says. "The concept here is that if we're deliberate about actually paying attention to what information is present and trying to find use cases for where we can actually use that information, there's a lot of opportunities to theoretically do a lot of things just using the data that we already have at our fingertips."

BASIC INFO AT THE READY

When patients see a physician, one of the first things that happens is their vital signs are recorded and documented. Seems basic, but to Benjamin it's more than just writing down numbers.

"I think at least half or more of the e-prescriptions in my area contain the patient's height, weight, and blood pressure," he says. "It doesn't sound like a big deal, but for dose verification, having that information is a big deal. You don't have to make a call to the doctor to say 'Hey, what's this patient's height and weight so I can calculate whether the dose was right?' Instead, I have it right here."

Benjamin says that theoretically a software company can automatically dose-check based on patient-specific height and weight information that is populated into the system.

"If we're giving an antibiotic that has weight-based dosing, the system — provided it had the right input — can say this dose is out of range, and not just in a general principle that this dose might be wrong with a patient of this age, but that the dose is higher than what we would expect based on the patient's weight," he says. "That's one case that we can derive from that piece of information to transmit. You can identify people who might have high blood pressure who aren't getting treatment and help them get treatment. Having pharmacists more involved in hypertension care is a priority for the CDC, so that's part of why I care about that." Benjamin says he recently identified five patients with previously undiagnosed hypertension.

Benjamin says there are lots of other bits of information that come across in transmissions that pharmacists can use.

"Another basic function is in Medicare claims," he says. "The PBMs are required to transmit a field called the benefit stage qualifier, which just identifies whether the patient is in the deductible phase, or if the patient is in the initial coverage, or they have entered the donut hole or exited the donut hole and are in the catastrophic phase."

MULTIPLE ROLES

In Benjamin's opinion, effective pharmacists in a community are playing three different roles at the same time. He says there are clinician pharmacists who get trained in pharmacy school, who know what the drug is, what it does, and what the benefits are versus potential effects.

The second role is the businessperson inventory manager who makes sure the product is actually in stock, particularly a medication the pharmacist thinks will be helpful to the patient.

"Knowing that in your head is one thing," Benjamin says. "Being able to go pull it off of your shelf when it's needed is the difference between a good pharmacist in theory and a good pharmacist in practice."

Then there's the third role, an area in which Benjamin says he has been becoming increasingly involved.

"That's the pharmacist that understands how insurance benefits work," he says. "This is a patient advocate who understands how the benefits are calculated."

Benjamin gives a hypothetical scenario where having a firm handle on benefits can demonstrate a pharmacist's value while also putting patients more at ease.

"Imagine the conversation with someone when they come to your pharmacy counter to pick up their medication and their PBM has set a cost-share for them at $527 for their Eliquis," he says. "The patient says, 'Oh my gosh I can't afford that. What is this?'"

In response, Benjamin says he can reply, "The reason that it's $527 is because you have a $480 deductible and a $47 copay after you meet your

deductible. This month it's $527, but next month it's only $47.

"That becomes a very different conversation about their adherence to the medication because they're thinking, 'Yes, once a year I can come up with $527 and just $47 once a month, I can do that.'"

EXPLAINING THINGS CLEARLY

Benjamin says that, not surprisingly, things such as copays and deductibles are rarely explained clearly to patients.

"The way that the info is transmitted to the pharmacy from the PBM, it just says benefits stage qualifier, 1,2,3, or 4. Unless you are familiar with the transmission standards from NCPDP (National Council for Prescription Drug Programs), to realize that 1 is deductible, 2 means initial coverage, 3 means donut hole and 4 means catastrophic coverage, you just don't realize what you are looking at when you see those."

Benjamin says he set his system up so that patient receipt labels have a note that clearly indicates status, whether it's deductible, initial coverage, donut hole, or something else. It makes the checkout process more helpful.

"When they ask, 'What in the world is this copay? It's usually this amount'" he says, "I can say that's because you have a deductible, or that's because you entered the donut hole. Then it's a very different conversation that makes me look a lot more competent, as opposed to me saying I don't know, call your insurance company. It saves time and hassle for the customer."

SEEING THE BIG PICTURE

Benjamin says that due to "preferred networks" you might pay less at a chain store than at Jolley's because of scale and vertical integration and a host of other factors, but he says that misses the big picture, especially with a community pharmacy that knows exactly how insurance plans work.

"They might not be realizing that they are now walking away from our quick service time at Jolley's," he says. "We can turn around a prescription in a half hour, where at some CVS' it might be two days or more. They're walking away from a pharmacy where we staff enough people that I have time to talk to you. They're walking away from a pharmacy where the pharmacist actually knows how your benefit structure works,

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so when you call me, I can say this med is Tier 3 on your benefit, but if we switched you to (another drug) it would be a Tier 1 med and the copay would drop from $40 per month to $10."

Benjamin says there are other uses for pharmacy technology if the software displays the information in a useful manner. For example, a patient can be matched to his or her exact Medicare drug plan by doing an E1 eligibility search. As background, in the early stages of development of the Medicare Part D program, the Centers for Medicare & Medicaid Services realized that the pharmacies would need a mechanism to determine eligibility for its Part D enrollees on a real-time basis at the point of sale. As a result, CMS reached out to NCPDP, which in turn developed a transaction that would allow pharmacies to submit basic demographic information on a beneficiary. In return, pharmacies would receive information that would allow them to bill the beneficiary's Part D Plan.

Other than information provided by the beneficiary, an E1 transaction is currently the only method available to pharmacies for determining Part D enrollment. As part of the E1 process, CMS contracted with the transaction facilitator (RelayHealth) to house the CMS Medicare Part A, B, and D eligibility information and respond to the real-time E1 transaction requests.

"If you transmit it (to the facilitator), they tell you exactly which plan the patient is enrolled in, and then using that information you can then correlate that to find out the exact formulary the patient is on (what drugs are preferred over others)," he says. "Using this exact software system, in this way, you can have this deep understanding of what medications are covered, how they are covered, where the pricing comes from, and what the patient's copays are going to be."

This is where a pharmacist's clinician skills can come into play, Benjamin says.

"You have the clinical effect of the drug, the sourcing of the product, knowing that you have it in stock, and then bringing in that piece where you know what their benefit design is," he says. "It just makes this pharmacist an extremely competent person in the view of their patients. It's much more valuable than someone who just knows what drug is best on a clinical basis. It's also knowing what the drugs cost and how they are covered."

WORKING THROUGH THE PBM MAZE

Benjamin readily admits that the current pharmacy reimbursement system and pharmacy data environment are extremely complex and confusing. That's why he likes to dive into the data, to make some sense of it.

Of PBMs, he says, "They are basically just a big computer system. MAC (maximum allowable cost) price lists

A pharmacy hero

Benjamin Jolley says his historical pharmacy hero is Eugene White, a Virginia pharmacist who was ahead of his time in the 1950s when he pioneered the concept of keeping patient profiles and also in redesigning his pharmacy to give it a more professional and clinical look.

"He wrote about how pharmacies should keep a profile of all of the medications a patient is taking along with any health conditions," Benjamin says of White, who died in 2011 at age 87. "At that time there weren't computers to make this process simple, so he kept everything on index cards. He had all of these prescription files, and he would keep an index card of what a patient's medications were, so he would have each patient and the patient's prescription number, and information about allergies and other medical conditions. Having these detailed, accurate records can make just an enormous difference in how well pharmacists can care for their patients. Seventy years after he invented index card profiles, I'm still maintaining the computerized equivalent of his index cards – allergies, complete medication lists, disease states, vital signs, clinical notes. That index card concept is still the basis of community pharmacy practice."

Benjamin mentioned a book White wrote in 1978 called "The Office-Based Family Pharmacist," which he read while attending pharmacy school.

"He basically collected all of the articles that he had written over the prior 20 years and added some color commentary to it," Benjamin says. "Obviously, there weren't PBMs in his time, but he thought there should be a business model in pharmacy where we charge a higher price to provide more high-touch service. Which unfortunately under the current PBM controlled system, you really can't do that. You can submit a higher price to a PBM and they don't care, they just pay you what they pay you. But his concept was that there should be varying price points for pharmacist services depending on what the pharmacist is doing. Are they just handing you pills in a bottle like these online mail-order shops, or are they additionally making sure that the medications actually work for you? Dr. White was a big influence on my thinking."

are updated into a computer system. When you submit a claim to a PBM there's no human on the other end who goes and looks at your claim who says, 'Okay, we're going to adjust it to this price.' It's all automated by a computer. They don't come up with random numbers, they come up with an algorithm and they take that percentage of that algorithm. If you pay attention to that algorithm, you can figure out where the DIR fees are coming from. A lot of times those fees are laid out in your contract with the PBM."

These days DIR consulting has essentially become a full-time job for Benjamin. He says that the way DIR fees function for most pharmacies would be akin to a wholesaler sending pharmacists an overall bill for all of the drugs they bought at the end of the year (or end of the month), as opposed to seeing a line item and cost on every single product purchased.

"Pharmacies couldn't operate if their wholesalers didn't tell them what the drugs cost," he says. "You would never know if you were in the black or not. All I'm talking about doing here is making it so you can see your line-item details of how much each of your drugs cost and the DIR cost, instead of the aggregate cost for which you bought it."

Benjamin has set up a portal for people to book time for consultations with him, and with DIR fees continuing to skyrocket, his calendar is filling up.

"The basic concept is you need to know what your costs are when you fill prescriptions, including the DIR costs," he says.

One week in the spring he spoke to 28 pharmacy owners, with one of them representing a group of 23 pharmacies. "It's busy," he says.

Benjamin says the first step in a consultation is to set up the pharmacist's software. Then he asks the pharmacist to bill a claim. Once that's done he reviews it with them. He says the first response from clients is typically along the lines of "What the hell?!" The second response is a sense of control of their destiny – now they know what the numbers are and can do something about that. "Giving pharmacy owners a sense of being in control of their destiny is extremely fulfilling," Benjamin says.

HARSH REALITY

Benjamin recalls working with a pharmacist from Colorado. She had been giving a patient medication that cost $30,000 for a month's supply. He says the PBM adjudicated a price of $32,000. She was thrilled, thinking she was making $2,000 per month.

"What she didn't realize was that the PBM was charging her 10 percent as a DIR fee every month," Benjamin says. "She wasn't making $2,000; she was losing $1,200 every single month on one prescription. That's not right."

Not surprisingly, the pharmacist agreed with that sentiment. As a result, she had to tell the patient that she couldn't buy the medication for her anymore because the patient's insurance was paying her below her cost for the medication. The pharmacist asked the patient if she could switch to another product that doesn't have such an insanely high cost.

"It turns out the patient said she needed it and went and got it from a chain pharmacy instead of from her, which is a crying shame, but the pharmacy was just bleeding money," he says. "How many prescriptions do you have to fill to make up a $1,200 loss? It's a harsh reality that the way the reimbursement is set up now, if a pharmacy wants to stay in business, in a lot of cases they have to turn some people away, which runs so counter to everything the profession stands for. But that is the way the system is designed. That is what the reimbursement system tells you to do. Which to me is just proof of how incredibly wrong the concept of direct and indirect remuneration is."

With PBM and DIR reform seemingly stuck in neutral, Benjamin doesn't mince words about his feelings.

"I really hope they resolve this so we don't have to deal with this kind of insanity, at least the not knowing what you are going to get paid without having me playing with your software until you figure out how to make it work so you can see it," he says. "It's immoral that anyone should ever have to do that. It's just wrong."

Even with the challenges and frustrations, he is still passionate about his profession.

"I've worked in independent community pharmacies since 2004, in nearly every role, from delivery driver to pharmacist," he says. "I love working with people one-on-one to help them get their pharmacy lives sorted. I believe that community pharmacy can be a powerful force to achieve positive health care outcomes for our patients." ■

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