



March 1, 2021

[Submitted electronically via [michael.ashworth@opm.gov](mailto:michael.ashworth@opm.gov)]

Mr. Michael Ashworth  
Contracting Officer  
U.S. Office of Personnel Management (OPM)  
1900 E Street, NW  
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**Re: Notice ID 24322621R0004: Request for Public Comment on the Pharmacy Benefits Landscape in the U.S. and Specific Strategies to Enhance the Federal Employees Health Benefits (FEHB) Program Pharmacy Benefit and Its Administration**

Dear Mr. Ashworth:

The American Pharmacists Association (APhA) is pleased to submit these comments in response to OPM’s “Request for Public Comments,” regarding the pharmacy benefits landscape in the U.S. and specific strategies to enhance the FEHB pharmacy benefit and its administration.

APhA is the largest association of pharmacists in the United States advancing the entire pharmacy profession. APhA represents pharmacists in all practice settings, including community pharmacies, hospitals, long-term care facilities, physician offices, clinics, hospice settings, and government facilities. Our members strive to improve medication use, advance patient care, and enhance public health.

OPM’s request for information (RFI) states “In broad terms, OPM is looking for additional information regarding the pricing, delivery, and management of prescription drug benefits in order to provide the best value for enrollees, the government, and taxpayers.”

As OPM has previously stated to the U.S. Congress:

*“The FEHB negotiates annually with its plans to provide benefits, rates, and administrative actions that are beneficial to our enrollees. To improve the administration of the drug benefits, OPM issued regulations in August 2003 that established requirements for FEHB experience-rated carriers’ large provider agreements, including agreements with pharmacy benefit managers. The regulations became final July 1, 2005, and provide the OPM’s Office of Inspector General (OIG) all the authority needed to conduct complete reviews of carriers’ PBM arrangements. Also in 2005, OPM issued new contract requirements that included standards for FEHB carriers to use in contracts with*

*vendors for retail and mail order pharmacy. The carriers are required to use these standards which provide for PBM transparency, integrity and performance.”<sup>1</sup>*

Thus, OPM possesses strong tools to require PBMs and health plans to enhance pharmacy benefits for federal employees. Accordingly, APhA’s comments will focus on a few specific areas in the request, including: PBM relationships with health insurance carriers, pharmacists and pharmacies; coverage of drugs under the medical benefit; and tools, programs, and strategies that would allow for an improved and innovative pharmacy benefits program while reducing costs.

### Strengthening OPM’s PBM Standards

Within this context, we offer the following recommendations to strengthen the “Standards for Pharmacy Benefit Management Company (PBM),” included in the publicly available language included in the “Proposed Changes to Standard 2017 Fee-For-Service Health Benefits Contract,”<sup>2</sup> based on pharmacists’ experience in contracting with PBMs.

Recommended Improvements to the Standards for PBMs (based on the 2017 FFS Health Benefits Contract):

- **Section (1)(a)(2)(i):**  
There is no guarantee that the Carrier is due “lower of” pricing. If the provider’s “usual and customary,” (U&C) charge (a provider’s charge for a service less than or equal to a charge percentile threshold for that service in the medical market where the service was delivered) would result in savings (e.g., a pharmacy with a \$4 generic list), the Carrier may be charged higher than the U&C charge even if passed onto pharmacy at higher cost. Similarly, there is no requirement regarding the basis of reimbursement for pharmacy outside of the mail order pharmacy. This creates potential problems for FEHB plans regarding appropriate payments of pharmaceuticals, as payments to pharmacies could be higher within the network without violating this contract term.
- **Section (1)(a)(2)(ii):**  
There is no guarantee that payment to pharmacy will be above acquisition cost; however, the contract requires such payment within PBM owned mail pharmacies. For example, Section 2(ii) requires that the PBM pay at acquisition cost plus a dispensing fee, which despite best intentions, may create an unfair competitive advantage via a PBM-owned pharmacy vs. retail pharmacies.
- **Section (1)(a)(3):**  
Suggest altering requirement to “sources of revenue,” as opposed to profit, as profitability is a metric that can be manipulated by PBMs.
- **Section (1)(a)(4):**

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<sup>1</sup>Kichak, Nancy. OPM. Statement before the Subcommittee on Federal Workforce, Postal Service and the District of Columbia. U.S. House of Representatives on FEHBP'S Prescription Drug Benefits. June 24, 2009, available at: <https://www.opm.gov/news/testimony/111th-congress/fehbps-prescription-drug-benefits/>

<sup>2</sup> OPM. Proposed Changes to Standard 2017 Fee-For-Service Health Benefits Contract, available at: <https://www.opm.gov/healthcare-insurance/healthcare/carriers/2016/2016-12c1/>

Suggest requiring inclusion of incentive fees (such as what exists within vaccine administration) in addition to administrative fees.

The contract language states “OPM reserves the right to review and receive any information and/or documents the Carrier receives from the PBM, including a copy of its contract with the PBM. A PBM providing information to a Carrier under this subsection may designate mark that information as confidential commercial information.” In addition, “OPM shall handle the information in accordance with 5 CFR 294.”

- **Recommendation:** Conform FEHB plans with the recent final rule on price transparency<sup>3</sup> from the Department of Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury. Specifically, require health plans/carriers and PBMs to publicly release the in-network negotiated rates and “historical net prices,” or the retrospective average amount a plan or issuer paid an in-network provider. This includes any in-network pharmacy or other prescription drug dispenser, for a prescription drug with any reasonably allocated rebates, discounts, chargebacks, fees, and any additional price concessions received by the plan or issuer with respect to the prescription drug or prescription drug services. OPM can strengthen this requirement by removing or defining the term, “reasonably allocated.” It is vital for OPM to provide a clear manner with which the “historical net price” is to be calculated to prevent PBMs from manipulating historical net pricing data differently, which will make comparisons meaningless. In addition, publicly releasing the information will help ensure OPM enrollees know how much medications will cost in advance and allow them to make more informed and value-conscious decisions.

### Damaging PBM Practices

The PBM marketplace is highly concentrated, whereby roughly three-quarters of all equivalent prescription claims are processed by only three vertically merged companies: CVS Health (including Caremark and Aetna), Express Scripts (Cigna), and the OptumRx (UnitedHealth). This has increased barriers to market entry, raised prescription drug costs, and reduced choice for consumers and purchasers. For clarification, the top six PBMs handle more than 95% of total U.S. equivalent prescription claims (76% to the top 3 vertically merged PBMs).<sup>5</sup> Ample and growing data analysis clearly shows increasing evidence that consolidation of PBMs with pharmacies and vertical integration in the healthcare space has led to increases in purchasers’ and patients’ drug prices through use of list prices, price discrimination, spread pricing, and patient steering for brand, generic and specialty drugs and to PBM-affiliated pharmacies.

- **Recommendation:** Ban harmful PBM practices in all OPM contracts with FEHB plans, as described below.

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<sup>3</sup> IRS/DOL/HHS. Transparency in Coverage. Final Rule. 85 FR 72158. November 12, 2020, available at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-Transparency-in-Coverage-9915F.pdf>

<sup>5</sup> Drug Topics. CVS, Express Scripts, and the Evolution of the PBM Business Model. May 29, 2019, available at: <https://www.drugchannels.net/2019/05/cvs-express-scripts-and-evolution-of.html>

List Prices: For pharmacies, “list prices,” for prescription drugs are significantly overinflated relative to their actual cost (for a markup of about 20% or more).<sup>6</sup> PBMs use those list prices or average wholesale price (“AWP”), as the basis for their pricing guarantees to pharmacies and plan sponsors. AWP does not include buyer volume discounts or rebates often involved in prescription drug sales, and is subject to manipulation by manufacturers or even wholesalers.<sup>7</sup> Brand name drugs have high AWP that are offset by negotiated rebates and discounts that make those net prices much lower. Generic drugs have high AWP (derived from brand drugs) that in no way reflect the actual prices pharmacies pay to acquire those drugs.<sup>8</sup> In both regards, the “actual” prices of both brand and generic drugs are hidden by PBMs from the plan sponsor and patient.

Price discrimination: This is a strategy that charges customers different prices for the same product based on what the seller thinks they can get the customer to agree to. PBM and drug manufacturers negotiate a “net price,” but the extent to which that true net price is captured by the payer depends on the payer’s access to information and negotiating leverage. This results in a system riddled with inequities that often disadvantages smaller, less sophisticated plan sponsors in favor of large, well-resourced ones. Hidden rebates are the key enabler allowing the drug supply chain to capture benefits of drug price discrimination.

Spread pricing: This is the difference between the reimbursements paid to pharmacies and the rates reported back to the payer where the PBM retains the difference. Numerous studies and audits have found spread pricing amounts ballooning to excessive amounts, reaching more than \$8 per prescription in some instances. While spread pricing adds unnecessary costs for plan sponsors, it also raises anti-competitive issues, as PBMs (who often have pharmacies of their own) can directly profit off underpayments to network pharmacies. As more states eliminate spread behavior from their Medicaid managed care programs, APhA believes other plan sponsors should follow suit.<sup>9</sup>

Drug Steering: This is the pushing of particular medications by vertically merged PBMs to their owned pharmacies. For example, analysis of the brand drug claims from a 2018 small commercial dataset, divided into drugs above and below \$2,000, found PBM-owned pharmacies filled an overwhelming number of the expensive medications greater than \$2,000 per claim (total 76%), but only a small fraction of the cheaper brand medications with cost less than \$2,000 per

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<sup>6</sup> Thomson Reuters MicroMedex. Website. AWP Policy. Accessed October 30, 2020 at [https://www.micromedexsolutions.com/micromedex2/4.31.0/WebHelp/RED\\_BOOK/AWP\\_Policy/AWP\\_Policy.htm](https://www.micromedexsolutions.com/micromedex2/4.31.0/WebHelp/RED_BOOK/AWP_Policy/AWP_Policy.htm)

<sup>7</sup> Gecarelli GM. Average Wholesale Price for Prescription Drugs: Is There a More Appropriate Mechanism? National Health Policy Forum. Issue Brief. No. 775. Accessed Sept. 20, 2020 at [https://www.nhpf.org/library/issue-briefs/IB775\\_AWP\\_6-7-02.pdf](https://www.nhpf.org/library/issue-briefs/IB775_AWP_6-7-02.pdf)

<sup>8</sup> 46Brooklyn. Inside AWP: The arbitrary pricing benchmark used to pay for prescription drugs. November 8, 2018, available at: <https://www.46brooklyn.com/research/2018/11/7/visualizing-how-aint-whats-paid-awp-really-is>

<sup>9</sup> Milliman. Florida Agency for Health Care Administration. Pharmacy Benefit Manager Pricing Practices Affecting Statewide Medicaid Managed Care Program. December 2020, available at: [https://cdn.ymaws.com/www.floridapharmacy.org/resource/resmgr/docs\\_2021\\_legislative\\_session/milliman\\_report.pdf](https://cdn.ymaws.com/www.floridapharmacy.org/resource/resmgr/docs_2021_legislative_session/milliman_report.pdf)

claim (total 16%).<sup>10</sup> An additional analysis of the same small commercial payer dataset also found steering to vertically merged PBM-affiliated pharmacies with specialty generics. With generics, the PBM can set the price it chooses to pay its affiliated pharmacy with no oversight due to opacity of price. In 2018, vertically-merged PBMs in this data set directed more than half of \$1,000+ generic claims to affiliated pharmacies and paid themselves a weighted average margin of \$3,448 per claim.<sup>11</sup>

**Specialty Steering:** Utilization distortions of the prescription drug marketplace are all about getting lucrative specialty drugs into pharmacies owned by the vertically merged insurer and/or PBM. In commercial plans, this is accomplished by directly specifying the specialty pharmacy that will fill all “specialty” drugs – where specialty is defined by the insurer/PBM.

As an example, a 2020 analysis of the Florida Medicaid program uncovered specialty drug steering issues. For pharmacy claims dispensed at retail pharmacy groups, the reported weighted average margin was \$2-4 per prescription. Meanwhile, claims dispensed at PBM/MCO-owned specialty pharmacies had a reported weighted average margin of up to \$200 per prescription. The study also found growing trends of expensive brand prescriptions being steered to PBM/MCO-affiliated pharmacies, and once dispensed at those affiliated pharmacies, the claims appeared to be more expensive than those filled at other pharmacies. The same study found that despite only accounting for 0.4% of the prescription claim volume, specialty pharmacies affiliated with MCOs and/or PBMs captured 28% of the available pharmacy dispensing margin in 2018, suggesting the growing pressure on non-MCO/PBM-affiliated pharmacy providers, as well as the lack of incentives that exist for affiliated pharmacies to contain costs to the state on specialty drugs – the biggest cost driver in the state’s drug program.<sup>12</sup>

PBMs price generic maintenance drugs very cheaply for patients at preferred and/or PBM-owned pharmacies to pull patients over from standard pharmacies and then charge inflated prices on specialty drugs after patients have been lured in with cheap generics. As a result of this practice, many OPM enrollees could face decreased pharmacy choices and increased drug costs.

### Current State of Pharmacy Pricing

**Net Payments:** For additional context on pharmacy pricing, the effective rate guarantees obfuscate the actual net payments to pharmacies. Much of this is handled through intermediaries between PBMs and Pharmacy Services Administrative Organizations (PSAOs)<sup>13</sup>, making claim reconciliation extremely difficult, as the contractual terms of “true up,” (between a target reimbursement rate in a participating pharmacy agreement and the aggregated effective rate actually realized by a pharmacy) and “net” cost differs from one PBM-PSAO relationship to the next.

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<sup>10</sup> 3AA. Small commercial payer data set/Ohio Pharmacists Association presentation. 2018, available at: <https://das.ohio.gov/Portals/0/DASDivisions/AdministrativeSupport/Ohio%20Pharmacists%20Association%20presentation.pptx?ver=2020-08-25-170926-980>

<sup>11</sup> Ibid.

<sup>12</sup> 3AA. 2020 Florida Medicaid analysis.

<sup>13</sup> Over 75% of independent and small chain pharmacies contract with PSAOs. PSAOs contract with pharmacies to perform many of the pharmacies’ core operations, such as negotiating reimbursement and tracking remittances.

- **Recommendation:** Require “net” payment to pharmacies be predicated on a cost-plus model, such as that already within the mail order pharmacy relationship of the FEHB contract may improve this difficulty.

Gap Between True Acquisition Cost: There is a growing knowledge gap within true acquisition cost information for the most expensive brand name medications. Limited distribution networks of medications between drug manufacturers and PBM-owned specialty pharmacies conceals true cost information for many payers, including cost after all manufacturer income / revenue is accounted for as the current FEHB contract attempts to do.

Differential Pricing within Pharmacy Networks: Research has detailed how limited access via closed networks to specialty drugs can result in payers incurring higher than needed costs relative to a more open network and competitive approach. Because PBMs control payment rate settings, and nothing within the existing FEHB contract prevents them from paying their own pharmacies a higher network rate than competitor pharmacies, they can self-enrich through network arrangements which restrict drug dispensation to affiliated pharmacies, even within a pass-through arrangement, at increased costs to patients, employers and taxpayers.

### Current State of the Delivery of Prescription Drugs

Mail Order Concerns: Within the context of broken mechanisms to pay for prescription drugs, payers are subjected to a broken delivery model of drugs. Over the last 4 years, the rate of one-time mail delivery of packages has declined via the USPS (high of 89.6% on time in 2017 to 85.8% in 2020).<sup>14</sup> During this same time, particularly during the pandemic, the upkeep of mail order pharmacy has increased, potentially jeopardizing the safety and efficacy of medications delivered via mail. As the PBM industry has moved to shift high dollar prescriptions (i.e., specialty) to mail, the risks have increased. New programs designed to white bag delivery of what would otherwise be provider administered drugs from the PBM-owned pharmacy to facilities only increases this risk within the healthcare system.<sup>15</sup>

Impact of Cost Sharing: The goal of prescription drug benefits should be the right patient, receiving the right drug, at the right time. Unfortunately, PBM benefit design choices, which shift more costs to patients, risk the ability to meet this metric. For example, structuring benefit design around the lowest net cost to the payer, without also ensuring that those therapies are the lowest net cost for the patient, creates conflicts within the prescription delivery model. Data has shown for years that patients are most adherent to medications when cost share is small,<sup>16</sup>

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<sup>14</sup> USPS. Quarterly Performance for Package Services. Quarter 1. FY 2021, available at: <https://about.usps.com/what/performance/service-performance/fy2021-q1-package-services-quarterly-performance.pdf>

<sup>15</sup> White bagging is the practice of disallowing a provider from procuring and managing the handling of a drug used in patient care. Instead, a third-party specialty pharmacy dispenses the drug and sends it to a hospital or physician office on a one-time basis.

<sup>16</sup> Chernew, Michael. Et. al. Impact Of Decreasing Copayments On Medication Adherence Within A Disease Management Environment. Health Affairs. January/February 2008, available at: <https://www.healthaffairs.org/doi/10.1377/hlthaff.27.1.103>

however, plans often deliver drugs to patients without consideration of keeping their cost share low.

**Impact of Cash Prices:** These points are compounded when pharmacies are expected to help patients adhere to medications via benefit designs they have no say in. For example, consider a claim a pharmacy cashes out for the patient because their cash price is cheaper than the patient's copay (a situation which may occur in a FEHB plan given the lack of a lower pricing guarantee discussed earlier). The pharmacy may later be monetarily penalized because the patient appears non-adherent with therapy because the insurance does not see a paid claim for that drug in their system (since it was paid via cash).

### Current State of Drug Benefits

Drug benefits are increasingly not designed with the patient's best interest in mind. Such poorly designed systems have the inevitable effect of not being in the payer's best interest either. Prescription drug benefits remain one of the most successful healthcare tools, outside of lifestyle modifications and exercise, for the management of disease and yet are increasingly unattainable for patients to access.

To remove sources of potential conflict, APhA proposes the following recommendations:

- **Recommendation:** Independently bid FEHB rebate and net revenues from manufacturers from the entity responsible for claim adjudication, formulary management and prior authorization determination.
  - Having an independent party negotiate rebates for the FEHB removes a source of conflict from the existing PBM model whereby the person responsible for collecting rebate information has a conflicted role in determining which drugs are preferred and which prior authorizations are approved (which ultimately determines rebate payments).
- **Recommendation:** Have an independent board review net cost information from the FEHB rebate provider to set the formulary for the claim's adjudicator in an unconflicted manner.
- **Recommendation:** Institute greater oversight of the prior authorization (PA) program including service level agreements<sup>17</sup> (SLAs) regarding response time (no greater than 24 hours post receipt of PA), tracking of approval and denial of PA by drug category and type, and requirements that denied approvals be followed up with to ensure the covered member gets a therapy necessary for controlling their medical condition (which they otherwise would not get due to the denied PA).
- **Recommendation:** Require PBMs to configure rejection messages for prior authorizations at the point-of-sale to include the reason for denial and the preferred

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<sup>17</sup> SLAs are contractual agreements between the parties that specify the services to be provided and the costs associated with them.

formulary medication such that pharmacies can attempt to get patients the preferred formulary medication when appropriate.

- **Recommendation:** Require PBMs to configure electronic prescribing to inform the pharmacy when a PA has been approved.
- **Recommendation:** Require PBMs to incentivize programs to support medication adherence such as medication synchronization which enables all medications to be filled for a patient on the same day, thereby potentially increasing proper adherence to chronic therapies.
- **Recommendation:** Require a clear delineation of drug coverage by medical or pharmacy benefit. Ensure reconciliation between pharmacy and medical claims does not occur due to double billing.

### Medication Management Programs under the Pharmacy Benefit and the Medical Benefit

APhA appreciates the opportunity to comment on the types of medication management programs, their advantages and disadvantages under both the pharmacy benefit and the medical benefit, as well as how transitions of care, polypharmacy, adherence, and optimal medication management are currently handled. Because of the broad reach of OPM's FEHB program across multiple health plans nationwide, there is a significant opportunity to optimize the medication management programs that are required of all plans.

In 2018, the Joint Commission of Pharmacy Practitioners (JCPP), a coalition of 13 national pharmacy organizations approved a definition of Medication Management Services (MMS)<sup>18</sup> that can be used to guide medication management programs in the benefit design for services delivered. There are many different terms used in the marketplace for MMS, and a goal of the JCPP definition is to define the key elements of MMS:

*“Medication Management Services are a spectrum of patient-centered, pharmacist-provided, collaborative services that focus on medication appropriateness, effectiveness, safety, and adherence with the goal of improving health outcomes.”*

Key considerations from this definition that guide optimal medication management service delivery are:

- MMS includes a spectrum of services that meet the key elements in the definition based on individual patient need and level of complexity. These elements serve as the guide for determining whether a specific service meets the definition, regardless of the term used. There are many medication-related services; only those services that meet the elements of the definition fall under the umbrella of MMS.

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<sup>18</sup> Joint Commission of Pharmacy Practitioners. Medication management services (MMS) definition and key points. March 14, 2018. Available at: <https://jcphp.net/wp-content/uploads/2018/05/Medication-Management-Services-Definition-and-Key-Points-Version-1.pdf>.

- Patient-centered approach to care – the service is individualized for a specific patient, focuses on the patient’s needs and concerns, and involves the patient in the care process.
- Assessment of medication appropriateness, effectiveness, safety, and adherence.
- Consideration should be given to accessibility and cost of medications.
- Collaborative approach to care that involves the patient, caregiver(s), pharmacists, and other healthcare providers.
- Focus on health outcomes.

Pharmacists have unique expertise in the appropriate use of medications and play a significant role in optimizing medication outcomes. This definition recognizes that the management of medications can include contributions from various members of the healthcare team.

*Pharmacy Benefit Programs and Tools - Question #12: Medication management programs under the pharmacy benefit*

Since the introduction of Medication Therapy Management (MTM) programs in the Medicare Part D benefit in 2006,<sup>19</sup> various types of medication management programs have been implemented in Medicaid and private sector health plans. Many, but not all, of these programs are administered by PBMs, either stand-alone or under contracts with health plans. Like the Part D MTM program, medication management programs under the pharmacy benefit primarily use prescription claims data and pre-specified enrollment criteria to identify patients who qualify for medication management services. APhA’s observations on MTM program structure under the pharmacy benefit based on environmental scans since 2006 are detailed below.

- *Medication Management Program Patient Enrollment:* Enrollment criteria can include the number of medications the patient is taking, the number and sometimes type, of chronic conditions, and/or the patient’s anticipated drug spend. Other criteria often seen could include patients taking high risk medications, those with recent hospitalizations, or identified gaps in therapy. This identification of patients for medication management services takes a population health management approach where the plan/PBM is identifying patients who can receive the service.
- *Medication Management Service Delivery:* Once patients are identified, the services may be delivered by “in-house” pharmacists or other healthcare professionals who work within the health plan or PBM, or by pharmacists who are often part of an MTM vendor network. For medication management service providers outside of the health plan, dashboards and other web portals may be used to alert the pharmacist that a patient needs a medication-related service. Many of the medication management services under the

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<sup>19</sup> CMS. Medication Therapy Management. Last Modified: 02/05/2021, available at: <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM>

pharmacy benefit are delivered telephonically, but they can also be delivered face-to-face, especially in cases where frontline pharmacists are contracted to deliver the service.

- *Types of Services:* Across the spectrum of MMS, common types of services conforming to the pharmacy profession definition include comprehensive medication reviews (CMRs) where all medications are assessed for medication appropriateness, effectiveness, safety, and adherence, and opportunities to optimize medications are identified and acted upon; follow-up visits for medication monitoring are permitted in some programs; medication adherence programs where medication assessment is a component, as well as targeted medication interventions can be part of a medication management program. Transitions of care services, with medication reconciliation and assessment, can be a component of some MMS, and often involves a community pharmacist working with the hospital discharge program and the patient's primary care provider to address medication discrepancies and ensure that the patient is on an appropriate medication regimen.

A potential benefit of medication management programs under the pharmacy benefit is integration of prescription claims and cost data that can help to inform solutions to medication access issues and potential safety problems and identify potential medication adherence problems. Also, pharmacies participating as network providers for prescription drugs can serve as a network of providers of MMS if the incentives are aligned.

Several challenges with medication management programs under the pharmacy benefit include:

- Misaligned incentives to offer a robust medication management program since most benefits recognized by optimized medication regimens occur in the hospital and medical benefit (pharmacy benefit is primarily incentivized to keep prescription drug costs low).
- The siloed nature of the prescription drug benefit separates medication management services from most of the other healthcare services the patient receives in the medical benefit, thus causing potential coordination of care issues.
- Most programs do not permit frontline healthcare providers, including pharmacists to identify patients who could benefit from MMS. Using solely a population health approach without verification that patients actually need a service could cause waste in the system by paying for services that may not be needed and omitting patients who could be costing the system from consideration for the service.
- Pharmacists can experience significant administrative burden in accessing key medical data such as diagnoses, prescriber goals of therapy, and laboratory values that are often needed in providing medication management services to the patient.
- Patient care services are generally provided in communities where patients have relationships with their providers, and providers are integrated into the community with collegial connections with each other. Positioning frontline pharmacists to provide medication management services and better connections with local providers is a focus

of a Center for Medicare and Medicaid Innovation (CMMI) program, the Enhanced MTM Program and should be considered in MTM program construct.<sup>20</sup>

*Drugs Administered Under the Medical Benefit - Question #36: Medication management programs under the medical benefit*

Medication management programs under the medical benefit are often integrated into team-based care models where the pharmacist works with the rest of the patient's healthcare team toward the patient's individual clinical goals and improved health outcomes. In many of these models, the pharmacist is embedded in a physician practice or clinic and is responsible for comprehensive management of the patient's medications that involves longitudinal care of the patient. Because medications are a primary treatment modality for chronic diseases, pharmacists' medication management services may also include chronic disease management. As technology continues to facilitate sharing of health information and virtual collaboration between providers, expanded opportunities for pharmacists to collaborate with physicians and other providers are emerging. Medication management program structure under the medical benefit often consists of:

- *Medication Management Program Patient Enrollment:* Patients are often identified by the prescriber for referral to a pharmacist for medication management. Under some programs like the Minnesota Medicaid Program, the pharmacist can identify patients and patients can self-refer. In this program, patient eligibility consists of taking a minimum of one prescription medication to treat or prevent one or more chronic conditions.<sup>21</sup>
- *Medication Management Service Delivery:* Payer parameters may dictate the number of visits and the type of services the pharmacist provides, but in general, medication management services delivered are individualized to the needs of the patient. Most services are delivered in a face-to-face format scheduled visit, but during the pandemic, many of the visits converted to telehealth delivery, and its anticipated that telehealth delivery will play an important role moving forward.
- *Types of Services:* Medication management services delivered under the medical benefit are often referred to as comprehensive medication management (CMM) services. Comprehensive assessment of the patient's medication regimen and ongoing follow-up to optimize the regimen, including the addition of medications for untreated conditions is a key focus of the service. Pharmacists in these practices may also be responsible for patients who are undergoing transitions of care, including hospital discharge, and coordinating their medications between providers.

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<sup>20</sup> CMS. Part D Enhanced Medication Therapy Management Model. Last updated on: 11/05/2020, available at: <https://innovation.cms.gov/innovation-models/enhancedmtm>

<sup>21</sup>MN Department of Health and Human Services. Revised: 03-08-2018, available at: [https://www.dhs.mn.gov/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LATESTRELEASED&dDocName=DHS16\\_136889#er](https://www.dhs.mn.gov/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LATESTRELEASED&dDocName=DHS16_136889#er)

Advantages of medication management programs under the medical benefit include:

- Better aligned incentives for medication-related decisions that may increase the drug spend but can reduce medical and hospital expenditures.
- Integration of MMS with the care provided by the patient's other healthcare team members for more coordinated and potentially efficient care.
- In team-based care models under the medical benefit, better access to clinical data to inform pharmacists' recommendations and decisions.
- Based on the design of medication management programs, patient care that is individualized to the patient and may identify patients who could benefit from the service who may not be identified in a population health approach.

Challenges for medication management programs under the medical benefit include implementing a network of pharmacists to deliver the benefit to achieve network adequacy, identifying the optimal benefit design for the medication management program, and lack of recognition and payment for pharmacists to provide medication management services under the medical benefit.

#### Medication Management Recommendations

- **Recommendation:** APhA recommends that OPM conduct an evaluation of FEHB medication management programs across all health plans to better understand the types of services being delivered, how well they align with the MMS definition, and the impact of the programs on beneficiary health and outcomes.
- **Recommendation:** Incentives may be better aligned to offer medication management programs under the medical benefit than the pharmacy benefit, and APhA requests that OPM consider that requirement. Pharmacists are increasingly being recognized and credentialed as providers in various payer programs, and networks of pharmacies are also available for the provision of robust MMS.
- **Recommendation:** APhA recommends that OPM support and advocate for, as feasible, sharing of healthcare information between hospitals, healthcare providers, including pharmacists and pharmacies, and plans that facilitate better coordination of care.
- **Recommendation:** As the healthcare system moves to value-based models to improve the quality and outcomes of care, APhA recommends that OPM encourage health plans to add value-based components to their medication management programs to more effectively measure the outcomes of the program. A recent report from Pharmacy Quality Solutions provides excellent insight into patient, pharmacist, and payer perceptions about outcomes-based measurement, and various resources exist that highlight how pharmacists

are contributing to value-based programs.<sup>22-23</sup> Plans should have the following parameters for medication management programs in place to facilitate value-based contracting:

- A pharmacist/pharmacy network;
- The capability and systems in place to collect robust measures; and
- Inclusion of meaningful measures for medication optimization.

Thank you for the opportunity to provide feedback on the RFI. APhA welcomes the opportunity to serve as a resource to OPM, and also to identify pharmacists delivering various types of MMS to inform OPM's efforts to improve medication management programs as a critical health plan benefit. If you have any questions or require additional information, please contact Michael Baxter, Senior Director of Regulatory Policy, at [mbaxter@aphanet.org](mailto:mbaxter@aphanet.org).

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<sup>22</sup> PQS. 2020 Industry Quality Report in Pharmacy Quality. 2020, available at:

<https://www.pharmacyquality.com/wp-content/uploads/2020/11/PQStrendreportinPharmacyQuality2020.pdf>

<sup>23</sup> American Pharmacists Association. Successful Integration of Pharmacists in Accountable Care Organizations and Medical Home Models: Case Studies. March 2020, available at:

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