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Pharmacy Benefit Managers (PBMs): The Good, The Bad, and The Truth

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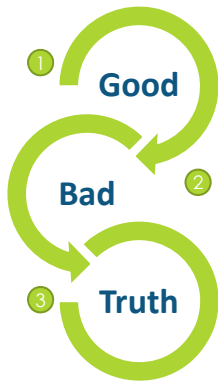
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Learning Objectives

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1. Outline the history of pharmacy benefit managers (PBMs)
2. Diagram the electronic claims adjudication process that conveys drug benefit design and transmits prescription claims data
3. Illustrate the problems and concerns associated with PBMs in today's market
4. Recognize methods utilized by PBMs to control costs and revenues
5. Design strategies to collaborate with impacted parties to diminish the negative effect of PBMs on patient care and clinical practice

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Pharmacists & Pharmacy Technicians

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Pharmacist Objectives:

- ▶ Explain the process of electronic claims adjudication
- ▶ Compare the prescription transaction and clinical services provided by PBMs
- ▶ Demonstrate how PBMs utilize contracted distribution channels and clinical management for specialty drugs

Pharmacy Technician Objectives:

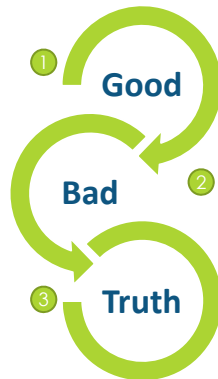
- ▶ Explain the role of a pharmacy technician for PBMs
- ▶ Describe the use of drug formularies and formulary restrictions by PBMs
- ▶ Illustrate how a patient's prescription drug benefit information is provided to pharmacies by PBMs

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Outline

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HISTORY



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History of Pharmacy Benefit Managers

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- ▶ **1968** Pharmaceutical Card System was the first Pharmacy Benefit Manager or "PBM" (PCS, later AdvancePCS). PCS invented the patient portable drug benefit card (plastic)
- ▶ **1970s** PCS was a fiscal intermediary using paper-based fiscal intermediaries by adjudicating prescription drug claims by paper
- ▶ **1980s** PBMs were hosting computer-based "electronic claims adjudication"
- ▶ **1990s** Diversified Pharmaceutical Services (DPS) was one of the earliest examples of a PBM which came from within a national health maintenance organization United HealthCare (now United Health Group)
- ▶ **1999** Express Scripts acquired Diversified in April 1999 and consolidated itself as a leading PBM for managed care organizations
- ▶ **2002** Wall Street Journal article on how PBMs had "steered doctors to cheaper drugs, low-cost generics and away big pharmaceutical companies" from 1992 through 2002
 - ▶ PBMs quietly evolved into aggressive price controls for pharmacy network contracts, marketing expensive brand name drugs, and processing specialty medications
- ▶ **2007** CVS acquired Caremark, PBMs changed "prescription claims processing and focused on trying to control pharmacy benefit design for health plans, negotiating "drug discounts with pharmaceutical manufacturers", and providing "drug utilization reviews and disease management"
- ▶ **2012** Express Scripts and CVS Caremark transitioned from using tiered formularies to models that excluded specific drugs from a formulary

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Setting the Stage

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- ▶ **Pharmacy Benefit Managers (PBMs)** are **3rd party administrators** of prescription drug programs for commercial health plans, self-insured employer plans, Medicare Part D plans, the Federal Employees Health Benefits Program, and state government employee plans.^{[1112](#)}
- ▶ According to the **American Pharmacists Association**, "PBMs are primarily responsible for developing and maintaining the formulary, contracting with pharmacies, negotiating discounts and rebates with drug manufacturers, and processing and paying prescription drug claims"
- ▶ Work directly with **health plans** to design drug benefits to maintain or reduce the pharmacy expenditures.^{[314](#)}
- ▶ PBMs operate **OUTSIDE** of integrated healthcare systems, as a "middleman" between health plans and the point of care (i.e., pharmacies or physicians)
- ▶ By 2016, PBMs were managing pharmacy benefits for **266 million** Americans
- ▶ By 2017, the largest **PBMs had higher revenue than the largest pharmaceutical manufacturers.**
- ▶ 3 major PBMs (i.e., **Express Scripts, CVS Health, and OptumRx** of UnitedHealth Group) are ~80% of market

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PBM Evolution

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- ▶ With the inception of the Medicare Part D Program in 2006, and the Affordable Care Act in 2010, insurers became more interested in outsourcing management of prescription claims and client services
- ▶ As coverage expanded, PBMs stepped in to lighten the load

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It's All About Perspective



Prescribers
Health Plans
Pharmacists
Patients
PBM
HEALTHCARE ECOSYSTEM
Wellness
TeleDoc
Price Transparency
Expert Opinion
Provider Search
Prescribing
Formulary
Prior Authorizations
Claims
Med Access

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Toll Collectors in the Prescription Drug Benefit Process
Originally to submit an Rx Claim, now multiple charges

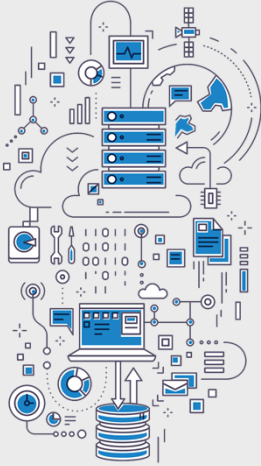
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Paper Claims / 3rd Party Administrators

1960s – 1980s



Electronic Claims Adjudicators

1980s - Present

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The Good



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PBM Scope of Services

- ▶ Real-Time Electronic Claims Processing
- ▶ Drug Utilization Review
- ▶ Drug Plan Formulary Development
- ▶ Develop Networks of Contracted Pharmacies
- ▶ Payment Policies
- ▶ Improve Medication Access
- ▶ Mail Order Medications
- ▶ Specialty Pharmacies
- ▶ Medicare Part D
- ▶ 340B

Responsibilities of a PBM



-  **Operate mail order**, so medications are delivered directly to the patient's doors.
-  **Ensure Patient Compliance** so that medication is taken as prescribed.
-  **Manage Distribution** among a network of pharmacies.
-  **Negotiating** rebates to get the most affordable options.
-  **Process Claims** from patients and pharmacies.
-  **Manage Formularies**, so individuals know what medications are covered through their health plans.

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Health Plan / Insurer ↔ **PBM** ↔ **REAL TIME**

← Prescription Claim (\$\$)

Benefit Descriptions (\$\$)

Payer, Formulary, Tier, Copay, PA, Step Therapy

Electronic Claims Adjudication

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The U.S. Pharmacy Distribution and Reimbursement System for Patient-Administered, Outpatient Prescription Drugs

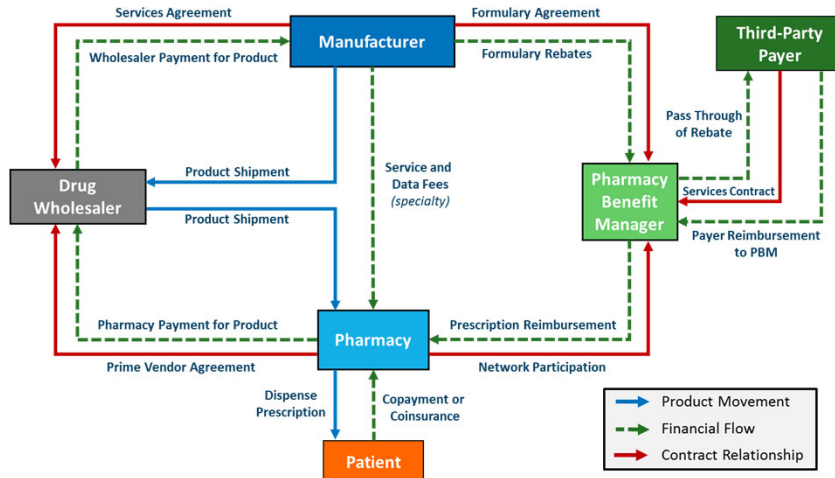


Chart illustrates flows for patient-administered, outpatient drugs. Please note that this chart is illustrative. It is not intended to be a complete representation of every type of financial, product flow, or contractual relationship in the marketplace.
 Source: Fein, Adam, J., *The 2016 Economic Report on Retail, Mail and Specialty Pharmacies*, Drug Channels Institute, January 2016.
 (Available at http://drugchannelsinstitute.com/products/industry_report/pharmacy/)

Employers feel stress over drug costs but are not standing still

#1
 Managing drug benefit trend remains the top priority for plans

83%
 are self-funded and only **51%** have stop-loss insurance that includes prescription drugs

38%
 reported four or more tiers, and **18%** have a separate tier for higher-cost generics

Use of traditional trend management tools holds steady:

- 94%** Prior authorization
- 92%** Quantity limits
- 91%** Refill too soon limits
- 86%** Step therapy

Deductibles becoming the new normal?

61% WITH HSA { A majority of employers offer a high-deductible health plan (HDHP) } **18%** WITH HRA

44%
 have a pharmacy deductible, either alone or shared with medical

Offering HDHPs with good intentions

















- 41%** see them as an effective way to manage overall drug trend and save money
- 58%** see them as an effective way to help consumers make better decisions



Prescription Drug Formulary

- ▶ List of approved drugs that a health plan covers, basis for prescription drug benefit.
- ▶ Goal is to provide high-quality care using the most cost-effective medications.
- ▶ Often includes two to five groupings of drugs ("tiers") at different levels of patient copayments.
 - ▶ Lowest tier will have the smallest patient cost-sharing, while the drugs in the highest tier will have the highest patient cost-sharing.
 - ▶ Generic drugs – medications that are essentially copies of brand name drugs with similar dosage, intended use, and side effects – are often assigned to the lowest tiers, with brand name and specialty drugs populating the higher tiers.

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Drug Formulary <small>What it Tells You... ...and What it Doesn't</small>	
What your drug formulary WILL tell you	What your drug formulary will NOT tell you
 Each medicine considered to be covered	 Actual cost of that medication when filled at a pharmacy
 "Tier" that it is placed on	 Your exact out-of-pocket responsibility related to that tier of the drug
 Indicators for use (called utilization management): • Prior Review/Prior Authorization (PA) • Quantity Limitations (QL) • Restricted Access or Step Therapy (ST) • Specialty Drugs • Specific dosage, forms and or strength limitations	 Information on your pharmacy deductible
 A "legend" to identify specific abbreviations and markers	 Brand-name alternative or generic alternatives
 Assume delivery via an in-network pharmacy provider within your plan, whether retail/local, mail order or specialty pharmacy	 Cost variance of mail order vs retail pharmacy
 Information may actually be contained on numerous "lists"	 Alternatives to your medication
 Medications considered a preventive medication when prescribed in connection with preventative benefits: no cost	 List of medicines outside of the formulary and not covered
	 Anything related to over-the-counter medications
	 Medications connected to plan exclusions (cosmetic use, sexual problems, weight loss)

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8 THINGS TO KNOW ABOUT DRUG FORMULARIES

What is a DRUG FORMULARY?

A list of medicines that your health insurance plan helps pay for. Every health plan has its own formulary or set of formularies.

A committee of doctors and pharmacists select the list, making sure it has a variety of safe, effective & affordable medicines.

Selected by: DOCTORS & PHARMACISTS

Occasional CHANGES...

...can occur when new medicines enter the market or generic versions become available. Stay up-to-date with your health plan's online drug search tool or call your member services.

A medicine might be taken off the list and replaced by a safer or better option, or a lower cost generic version. If your medicine gets taken off the list,

Your doc can help you FIND THE BEST ALTERNATIVE

Often uses the **GENERIC DRUG** over brands

RANTIDINE **ZANTAC**

You'll likely see a generic drug (like Rantidine) on the formulary instead of its brand name (like Zantac) equivalent. Generic drugs, by law, must use the same active ingredients and meet the same quality and safety standards as the brand-name drug. And good news - they are usually less expensive for you.

What you see ADVERTISED is often more expensive

Check to make sure advertised drugs are on the formulary before you get to the pharmacy counter.

Formularies don't typically include drugs that are considered cosmetic and not medically necessary.

COSMETIC DRUGS not included

EXCEPTIONS from your doctor:

If your medicine is not on the formulary but your doctor thinks it's necessary, your doctor will need to submit what's called a "prior authorization" or "pre-authorization" (PA) request to the insurance company for processing.

hphealthinsurancehelp.com

- A **drug formulary** is a list of prescription drugs (generic and brand) used to assist practitioners in selecting the **drugs that offer the greatest overall value.**
- A committee of independent, actively practicing physicians and pharmacists design & maintain the **drug formulary.**

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Pricing more transparent or not?

The use of pass-through pricing has increased slightly from last year



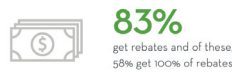
Discounts for generics and brands



Most employers use MAC



Rebates can be important



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The Bad



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The Bad

- ▶ Controversial revenue strategies
 - ▶ Fees from supply chain
 - ▶ Rebate programs with manufacturers
 - ▶ Rebate details and savings sharing is often confidential and not clear on how the savings are actually distributed amongst PBMs, payers, health plans, etc.
 - ▶ Pharmacy spreads
 - ▶ The difference between what they pay for drugs from a pharmacy and what they get paid by the insurer
- ▶ Concentrated market shares, stemming from recent mergers and acquisitions
 - ▶ Restricted pharmacy networks

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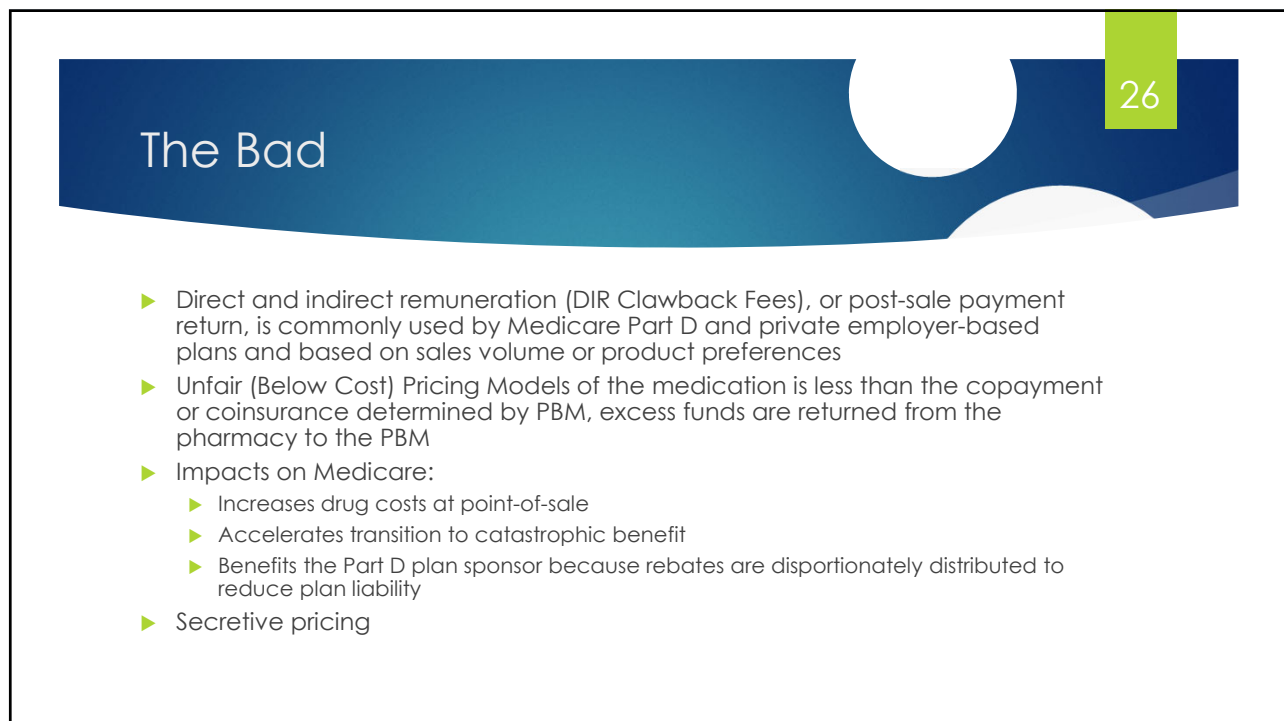


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The Bad

- ▶ Free from regulation
- ▶ Lack of transparency
 - ▶ Particularly with rebate agreements, allocation, and chargebacks
 - ▶ May not be choosing the most cost-effective drugs
 - ▶ Formulary tier priority assigned to drugs with the highest rebate
 - ▶ Profits for firms that own PBMs and distributors increased between 2011 and 2016 from \$9.9 billion to \$15.7 billion for PBMs and from \$3 billion to \$5.2 billion for distributors

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The Bad

- ▶ Direct and indirect remuneration (DIR Clawback Fees), or post-sale payment return, is commonly used by Medicare Part D and private employer-based plans and based on sales volume or product preferences
- ▶ Unfair (Below Cost) Pricing Models of the medication is less than the copayment or coinsurance determined by PBM, excess funds are returned from the pharmacy to the PBM
- ▶ Impacts on Medicare:
 - ▶ Increases drug costs at point-of-sale
 - ▶ Accelerates transition to catastrophic benefit
 - ▶ Benefits the Part D plan sponsor because rebates are disproportionately distributed to reduce plan liability
- ▶ Secretive pricing

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Different Perspectives

No One is Totally Happy









- ▶ Health Plans
- ▶ Patients
- ▶ Pharmacies
- ▶ Prescribers
- ▶ Pharmacists
- ▶ Manufacturers
- ▶ Wholesalers
- ▶ Pharmacy Benefit Managers

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Drug Benefit Design

TIER	DRUG TYPE	COST
1	Preferred Generics 	\$
2	Generics 	\$\$
3	Preferred Brands 	\$\$\$
4	Non-Preferred 	\$\$\$\$
5	Specialty 	\$\$\$\$\$



PATIENT SAFETY



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The Truth

Prescription for Change

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Truthism

AKA - Telling something like it is

We missed a critical opportunity to build the tools to serve us, instead they are being developed by others and thrust upon us...strangling pharmacists/pharmacies in an effort to a) control health plans drug benefit spend and to b) maximize PBM profits by skimming in the middle

It's time to take our profession back...This is Sparta

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Where We Are Today

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- ▶ PBMs are out of the realm of regulation and have minimal transparency and/or visibility
- ▶ DIR fees
- ▶ Prescription Discount Cards
- ▶ Controversies surrounding the potential misalignment of the financial incentives of PBMs with health plans, pharmacies, and patients
- ▶ Amazon's potential plan to forego the involvement of pharmacy benefit managers
- ▶ New Legislation: Anti-Kickback Statutes
- ▶ Passing on discount to patients

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The Truth About the Future

Our Collective Challenges

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- ▶ Discerning between Good vs Bad PBMs
- ▶ Identifying Functional PBM Alternatives
- ▶ Forcing PBMs to be regulated by State-based Insurance Commissioners
- ▶ All parties working together to hold PBMs accountable and diminish their roles
- ▶ Transparency
- ▶ Industry based alliances
- ▶ Enhanced Pharmacy Benefit Administrator (monitoring of PBM activities)
- ▶ Vertical Integration of Health Plans and PBM functions

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Examples of PBMs

- ▶ Express Scripts
- ▶ CVS Caremark
- ▶ OptumRx
- ▶ Humana
- ▶ Aetna
- ▶ RxPreferred Benefits
- ▶ Choice Rx Solutions
- ▶ True Rx Management Services

} Monopolize the Market

} PBMs who've pledged to conduct a transparent model

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The Biggest Players

PBM Market Share by 2017 Total Equivalent Prescription Claims Managed

■ Express Scripts	■ Humana Pharmacy Solutions
■ Caremark	■ Aetna
■ OptumRx	■ Others

Based on data from *The 2018 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers*, Drug Channels Institute. Available at <http://drugch.nl/pharmacy>. Percentages may not equal 100% due to rounding.

<https://openburialguide.com/top-insurers-move-to-bring-pbm-partners-in-house/>, Chad Houck & Roxanne Anderson

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PBM Growth & Consolidation









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5 Top Insurers and Their PBM Partners

Insurers	PBM Partners
UnitedHealth Group	OptumRx (in-house); CatamaranRx (purchased 2015)
Anthem	IngenioRx (launching in-house in 2020)
Aetna	CVS/Caremark (purchase under review)
Cigna	Cigna Pharmacy Management (in-house); Express Scripts (purchase under review)
Humana	Humana Pharmacy Solutions (in-house)

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Pharmacy Practice Settings



Community



Hospital



Health Plans & Mail Order




Innovative Practice Models

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Opportunities in the Profession



Develop National (non-PBM) Networks
Customized Contracts

BUSINESS PLAN	ENTERPRISE PLAN <small>Business plan features plus:</small>
View the Portfolio With Master Plans	Single Sign-On
Prioritize With the Planning Board	Security Management Tools
Payroll for PPH, PPHC and NLS	Custom TOS & Onboarding
24/7 in the Parking Lot	Centralized Tag Management
Personalized Support and Training	Personalized Support and Training
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Simplified, Fair, and Functional
Innovative Contracts & Pricing Models

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High Cost Medication Models

- ▶ Specialty Drugs
- ▶ Orphan Drugs
- ▶ Biologics
- ▶ Oncology




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Critical Concern – The Cost of Specialty Drugs

Specialty drug costs have been the top concern every year since the inception of this report, and this year is no exception.




61%

of respondents list management of specialty drug costs as their number one priority.




Large costs for small populations ...
It is estimated that specialty medications will account for **HALF** of total U.S. drug spend by 2020 even though only 1% to 2% of Americans use specialty drugs.



... with no end in sight
Specialty drug spending under the medical benefit has increased **55%** since 2011, and double-digit average specialty trend under the pharmacy benefit has been the norm since 2007.

Employers Caught in the Middle



87%

of workers report health and drug benefits as extremely or very important. Employers know that drug benefits are important to recruit and retain key talent and that healthy employees are more productive.

\$52,486

AVERAGE TREATMENT


The average annual cost of treatment with a single specialty drug was \$52,486 in 2015.¹

vs.

\$48,665

MEDIAN WAGE

Median wage in 2016 was \$48,665,² and median household income in 2016 was \$57,617.³



The average cost of healthcare in 2017 for a family of four was \$26,944. **57%** is paid by the employer.

Specialty Drugs

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Tough Choices: Tactics to Manage Specialty Trend

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Future
Tactics for
Specialty
Drugs

Balancing premiums with member out-of-pocket costs

33% The prevalence of high-deductible health plans continues to increase, rising from 28% in 2016 to 33% in 2017.


Balancing member access with network management

65%

of respondents reported that their contract requires the use of a designated specialty pharmacy.

31%


Significantly fewer reported different cost-sharing designs by site of care.




59% of employers used prior authorization to encourage use of lower-cost sites of service.

44% have reduced cost-sharing amounts at preferred sites of service.

Sharing costs and managing trend



Cost-sharing and trend management are two of the most common specialty benefit plan design strategies.



56% of respondents in 2017 reported a separate cost-sharing tier for specialty drugs under the pharmacy benefit compared to 52% in 2016.

And excluding some drugs altogether

58%

of respondents reported using formulary exclusions for specialty drugs.

62%

of all employers agree that formulary exclusions are an effective way to manage specialty trend.

41% **#1 CHALLENGE**

Member dissatisfaction is the top challenge associated with formulary exclusions, followed by clinical disruption.

24% **#2 CHALLENGE**


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Orphan Drugs: Providing Hope ... Creating Concerns


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Orphan
Drugs

Rare diseases are not so rare

 They affect nearly **30 MILLION** Americans — compare this to the 14.5 million with a history of cancer and the 1.5 million who have a stroke or heart attack annually.


 Of the new drugs approved in 2016, **41%** were orphan drugs used to treat a rare disease or condition.

 Only **5%** of rare diseases have treatments available.

 When they are available they tend to be very expensive — with average annual drug costs per patient of **\$140,000**.

Drug cost is a primary concern to employers

55% With the high price tags associated with many orphan drugs, it is unsurprising that over half (55%) of respondents rated drug costs as their top concern.

 **71%** do not feel the current prices of orphan drugs are sustainable.

But other concerns abound:

- "Lack of information on efficacy,"
- "How much we don't know about them and what's out there that could at some point devastate our healthcare cost budget."
- "Patient/provider demand — even though a drug may not be overwhelmingly effective, if it is the ONLY treatment option for that disease, patients and providers demand it and insist that the plan must cover it."
- "There is going to reach a point at which the market is not going to be able to support additional cost."

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PBM Revenue Structure

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- ▶ **Rebates:** Discount on a medication the drug manufacturer gives a PBM and in return the PBM agrees to cover their product
- ▶ **Spreads:** The dollar difference between what the PBM pays the pharmacy to dispense the medication and what the PBM charges the plan sponsor
- ▶ **Direct and Indirect Remuneration Fees:** Retrospective revenue from community pharmacies based on prescription sales

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Market Share & Encroachment

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- ▶ Due to their expanding involvement in the prescription drug industry, PBMs pull in profits from several different directions
 - ▶ Industry experts surmise that, as baby boomers age, health care and prescription drug spending will continue to rise, meaning more revenue for these claims processing giants
- ▶ According to a 2015 Applied Policy Report, the top three PBMs in the country manage the drug benefits of 78% of the U.S. population, or 180 million people
 - ▶ Pending the approval of the Aetna-Caremark and Cigna-Express Scripts deals, these giants would be linked to three colossal insurers
- ▶ When looking at prescription claims managed, OptumRx (22%), Caremark (24%), and Express Scripts (25%) dominated the market in 2017
 - ▶ The pending mergers could propel Cigna and Aetna to surpass UnitedHealthcare in PBM market share, providing the number of claims processed by each of the companies remains about the same in the future

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Vertical Integration: Health Plans & PBMS

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- ▶ October 2017, **Anthem** announced that it would not renew its contract with **Express Scripts**, but instead, launch its own PBM, **IngenioRx**, in 2020.
- ▶ December 2017 - **Aetna** stated its intention to have a PBM with its merge with CVS Health in a \$69 billion deal.
- ▶ **Cigna** disclosed its agreement to purchase **Express Scripts** for \$52 billion.

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Mergers & Acquisitions

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- ▶ A major reason why **Anthem** will allow its contract with **Express Scripts** to end at the close of 2019 is it believes Express Scripts withheld billions in savings and overcharged them for services
- ▶ Modern Healthcare reports PBMs have been criticized for keeping their rebate deals with drug makers guarded by nondisclosure agreements

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Mergers & Acquisitions

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- ▶ According to insurers, employers want drug pricing to be more transparent
- ▶ With more oversight of PBMs, insurers could provide their clients with this increased transparency and streamline and further integrate their members' care
- ▶ In turn, this could lead to lower prescription drug costs for consumers — but there's a good chance it won't

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Mergers & Acquisitions

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- ▶ If drug manufacturer rebates become more transparent, the drug manufacturers themselves could then use information about their competitors to minimize their rebate amounts
- ▶ This would make drug manufacturers more competitive, which would lead the overall price of drugs to go up, not down
- ▶ For the average joe to see lower prescription drug prices from these mergers, insurers would have to pass on the rebate savings they negotiate to beneficiaries
- ▶ Right now, it's likely companies are more interested in claiming a "rich" slice of the pie before it's gone

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Mergers & Acquisitions

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- ▶ As for Humana, at the end of March, The Wall Street Journal reported that massive retailer Walmart Inc. is “in preliminary talks” to purchase the insurer. Such a deal would be similar in nature to CVS Health’s acquisition of Aetna, Rite Aid Corp’s 2015 acquisition of PBM EnvisionRx Plus, and Albertsons Cos. proposed acquisition of Rite Aid Corp.
- ▶ Humana and Walmart already have a co-branded drug plan together, so it wouldn’t be a surprise if they chose to further their existing partnership. Creating a stronger bond with Walmart could get Humana more customers. Additionally, combining with Humana would give Walmart another way to stay competitive with Amazon. Speculation that the online retail behemoth will expand into prescription drug sales may have influenced many of the health care related merger proposals we’re seeing today.

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Mergers & Acquisitions

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- ▶ The CVS-Aetna, Cigna-Express Scripts, Albertsons-Rite Aid, and potential Walmart-Humana mergers will all need to be reviewed and approved by the Antitrust Division of the Department of Justice. If they do, insurers should have more control over drug pricing, but it’s not clear as to whether shoppers will see decreased provider options or increased savings from insurers.
- ▶ In early March, UnitedHealthcare committed to passing rebate savings on drugs to its fully insured group health members on an individual basis at the point of sale beginning in 2019. Aetna has also said it will pass negotiated drug discounts on to about three million of its members next year. Others could follow suit, but that’s anybody’s guess.
- ▶ Lawmakers in the federal and state governments are also examining PBMs and introducing regulation attempting to reform some of their more questionable practices.

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Legislation Introduced

- ▶ H.R. 1939: **Ensuring Seniors Access to Local Pharmacies Act of 2017**
 - ▶ Improves pharmacy choice for seniors and strengthens Medicare Part D through increased pharmacy competition
- ▶ H.R. 1316: **Prescription Drug Price Transparency Act**
 - ▶ Increases transparency in generic drug payments in taxpayer-funded federal health programs and preserves patient's access to local pharmacies
- ▶ H.R. 1038: **Improving Transparency and Accuracy in Medicare Part D Spending Act**
 - ▶ Prohibits pharmacy direct and indirect remuneration fees from being applied after the point-of-sale for prescriptions to Medicare beneficiaries

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Legislation – Enacted Into Law

- ▶ S. 2554: **Patient Right to Know Drug Prices Act**
 - ▶ To ensure that health insurance issuers and group health plans do not prohibit pharmacy providers from providing certain information to enrollees
 - ▶ Essentially eliminates "gag clauses"

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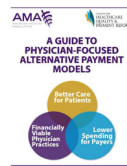
Alternatives to PBMs

- ▶ Transparent PBM Model
 - ▶ A PBM who takes a flat administrative fee for each prescription
- ▶ Pharmacy Benefit Administrator
 - ▶ Oversee administrative services for the plan sponsor such as claims processing and data reporting, while the plan sponsor handles other functions such as formulary management, rebate negotiations, and contracting with pharmacies for network participation
- ▶ Self-insured Organizations
 - ▶ Organizations create their own network
 - ▶ Example: Health Transformation Alliance

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Opportunities for Integration Into CMS & CMS Initiatives



Alternate Payment Models
(APM)

Hospital Engagement Networks
(HEN)

Transforming Clinical Practice Initiative
(TCPi)

National Opioid Crisis:
CMS Medication Management
Opioid Initiative

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P B Pharmacy Benefit
M I Management Institute

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2019 Specialty Rx Forum

September 10, 2019 | Minneapolis, MN

RESERVE YOUR SPOT NOW!

JW MARRIOTT

— Who We Are

The Pharmacy Benefit Management Institute (PBMI) is the nation's leading provider of research and education that informs, advises, and influences the industry on drug cost management. Our insights enable evidence-based, actionable decision making in a complex and evolving pharmaceuticals marketplace.

Learn More

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— President of a TPA

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The Future of Pharmacists' Reimbursement

- ▶ **Evolution of Pharmacists' Practice Models**
 - ▶ Practice Management Strategies & Tools
 - ▶ Collaborative Practice Agreements
- ▶ **Health Information Technology Resources**
 - ▶ Dynamic Patient Profiles
 - ▶ Pharmacist-specific Therapeutic Analytics
 - ▶ Practice Metrics (blending both pharmacy and medical data)
 - ▶ Practice-based Outcomes Reporting Tools (patient and organization)
 - ▶ Align Pharmacists Services "ROI" with "Value-based" Payment & Reporting Systems
- ▶ **Public & Payer Relations**
 - ▶ Enhance Market Awareness and Understanding of pharmacists impact
 - ▶ Evolve current Comprehensive Medication Management
 - ▶ Incorporation into "standard medical benefit"

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