AmeriHealth Caritas Louisiana, Inc. d/b/a AmeriHealth Caritas Louisiana

Non-Emergency Medical Transportation (NEMT) and Pharmacy Benefits Manager (PBM) Request for Comment	
RFI Question	Response
If Medicaid were to change its current broker model for non-emergency medical transportation (NEMT), what changes would you recommend?	AmeriHealth Caritas Louisiana recommends not changing the broker model currently in place for non-emergency medical transportation (NEMT). Based on our observations in the states where the AmeriHealth Caritas Family of Companies operates, we believe it to be the most efficient and enrollee-friendly means for Louisiana MCOs to provide NEMT services for their respective enrollees. Stakeholders have expressed concerns with the current NEMT model, including inconsistent reporting among the brokers, the availability and affordability of insurance, and the adequacy of reimbursement. To address inconsistent reporting across brokers, definitions and terminology should be standardized and regularly reviewed by MCOs, providers, and the Louisiana Department of Health (LDH). We support clear and regular communication among LDH, MCOs, and providers; to that end, we support quarterly meetings with standing agendas to discuss unresolved issues that are common across providers. We support the continuation of small workgroups to address accountability on the part of enrollees, brokers, and providers. As to the availability and affordability of provider insurance and adequacy of reimbursement, we support LDH's flexibility in interpreting insurance guidelines, as well as its regular study of the adequacy of reimbursement and the potential means of financing. While we recognize that deficiencies in the current model exist, they can be remedied and are not sufficiently disadvantageous as to warrant moving away from the broker model.
If Medicaid were to change its current pharmacy benefit manager model, what changes would you recommend?	Based on AmeriHealth Caritas Louisiana's experience in (and publicly available research on) pharmacy benefit management, we recommend continuing the use of an integrated model. Integrated pharmacy benefit management allows MCOs to better identify enrollee diagnoses and facilitate treatment adherence, improving

	enrollee outcomes. Using an integrated model can reduce provider abrasion by combining medical and pharmacy coverage through a common entity. This simplifies communication for both the provider and the enrollee when trying to determine who to contact regarding services. From a coordination-of-care perspective, providers can access shared quality platforms to identify care gaps and have access to real-time pharmacy utilization. In October 2019, The Menges Group, a strategic health policy and care coordination consultancy, published a study on the impact of an integrated pharmacy benefit titled "Value of Managed Care Organizations and Pharmacy Benefit Managers in Managing the Medicaid Prescription Drug Benefit." The researchers looked at the benefits that were derived from integrating the prescription drug benefit into a whole-person, coordinated care model. These advantages, discussed in further detail below, provide additional tools for both the MCO and the pharmacy benefit manager (PBM) that lead to improved patient care. An integrated model allows access to real-time data, which confers significant advantages. With no claims submission or payment lag time for prescription drug data, MCOs can monitor filled medications as they occur, promptly flag potential utilization issues, and identify certain medical conditions to help inform providers' medical decisions. An integrated model also facilitates strong communication and systems that contribute to whole-person health care. By closely tracking prescription drug use, MCOs can discern the enrollee's health needs, comorbidities, and treatment adherence, as well as the accuracy of their diagnoses. When MCOs integrate real-time prescription drug data (using internally designed information systems and contracts with their PBMs), it allows:

	• Utilization Management teams to review medical coverage requests based on pharmacy data, helping to ensure enrollees have access to the prescription drugs they need, when appropriate. • Care Coordination and Case Management staff to use pharmacy data to facilitate medication reconciliation and support transitions in care. • Quality Improvement staff to use pharmacy data to help ensure the proper clinical design of initiatives and programs and to collaborate on interventions — including for chronic disease management, opioid and substance use disorder, maternal health, and mental health. • Enrollee Services staff to handle calls and other outreach tasks with full prescription drug use information and help address care gaps. • Data to be shared with other partners in care, such as behavioral health providers, to help improve overall health outcomes. For all of the reasons stated, we recommend retaining the integrated pharmacy benefit management model.