

Angela Hoover, Walgreens

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?	No comment
If Medicaid were to change its current pharmacy benefit manager model, what changes would you recommend?	<p>Rising prescription drug costs continue to plague state budgets. This has been exacerbated by the pandemic as most states now expect total FY 2021 Medicaid expenditures to exceed original projections. As Louisiana looks to operate a Medicaid program of quality and efficiency, we offer the following recommendations. In order to achieve savings while promoting patient access, choice and medication adherence, we recommend LDH create the broadest pharmacy network possible, giving Medicaid patients more choice with access to a larger pharmacy footprint and more vital clinical services.</p> <p>This would be best achieved by carving out Medicaid prescription drug benefits and placing them back into the original, fee-for-service model. There are several examples of this strategy. California and New York have set this direction in motion, citing the current setup has led to the State's spending on prescription drugs increasing at an unsustainable rate. With the transition, the State now expects to generate substantial annual savings. West Virginia is the only state to have completed the transition to carve the prescription drug benefit out of Medicaid Managed Care. An actuarial study projected the carveout would save Medicaid \$30 million, but the actual savings turned out to be much greater. After one year, the carve-out saved West Virginia Medicaid \$54.4 million. Further, a report on West Virginia's program found that:</p> <ul style="list-style-type: none"> • Administrative fee-per claim-under FFS: \$1.11 • Administrative fee-per claim-under MMC: \$7.50 <p>Many in-depth studies in other states have shown that millions could be saved by carving</p>

Angela Hoover, Walgreens

	<p>pharmacy benefits away from Managed Care. For example:</p> <ul style="list-style-type: none">• Pennsylvania: Between 2013 and 2017, the amount that taxpayers paid to PBMs for Medicaid enrollees more than doubled from \$1.41 billion to \$2.86 billion.• Ohio: The State Auditor found that, of the \$2.5 billion that's spent annually through PBMs on Medicaid prescription drugs, PBMs pocketed \$224.8 million through the spread alone during a one-year period.• Michigan: Drug price manipulation allowed PBMs to overcharge Michigan Medicaid by at least \$64 million. <p>Should the state continue with the managed care structure, it is critical that the Agency evaluate the performance and transparency of the Pharmacy Benefit Managers' (PBM) administration of the drug benefit. As an industry, PBMs are virtually unregulated and their practices have contributed to skyrocketing health care spending. Central to achieving transparency are the transactions of PBMs, who, given their role as middlemen, uniquely interact with each stakeholder within the supply chain. They negotiate with drug manufacturers, perform functions on behalf of insurers, contract with and reimburse pharmacies, as well as set the benefit design and costs for patients. PBM practices have led to unfair and opaque dealings with pharmacies with respect to reimbursement, network design, audit practices, constructing artificial barriers that limit patient choice and competition, self-referring patients to their own mail-order operations, switching patients to more expensive medications to benefit the PBM, and questionable use and disclosure of sensitive patient information. Louisiana's own finding revealed that the PBMs in the State retained \$42 million that was incorrectly listed as "medical costs." The lack of transparency creates broad inefficiencies and perverse incentives that keep prices high for patients and increase program</p>
--	--

Angela Hoover, Walgreens

	<p>spending.</p> <p>Realizing greater transparency and efficiency within Managed Care can be achieved by creating an open network to any willing pharmacy, selecting a single entity to serve as the pharmacy benefits administrator (PBA) for the Managed Care Plans, and setting the reimbursement methodology to match that of the fee for service program. On this last point, this reimbursement methodology should apply to all providers, as currently, certain pharmacy providers are inexplicably reimbursed less than others for providing the same service, which overall, can limit patients access to pharmacy and clinical services. The single PBA is a pass-through transaction model, allowing the state to be in control of formularies, reimbursement methodologies, and drug rebates, and eliminates costly duplicative administrative processes for LDH and providers alike. A standard drug formulary across all Managed Care organizations allows for continuity of care, better drug pricing, and increased drug rebates. Further, as reimbursement in the fee for service program is based on an actual acquisition cost plus a professional dispensing fee, it is a truer picture of costs and accounts for the professional services provided by the pharmacy. These changes will allow the State to focus on ensuring that the incentives are properly and fairly aligned, self-dealing and steering are prevented, reimbursements are fair, and monetary loopholes are closed. This strategy has been set in motion in Kentucky in response to a state report that found PBMs keep \$123.5 million in spread annually, with the total estimated impact of this change representing a net savings of \$237.5 million per year, with the state share portion of the savings were estimated at \$44.7 million. The majority of expected savings come from expected reductions in administrative cost and, secondarily, from the removal of expenses exclusive to the managed care capitation rate-setting process.</p> <p>Lastly, as part of any of these options, LDH should consider the benefits of value-based payment models (VBPMs) that include pharmacies. VBPMs</p>
--	--

Angela Hoover, Walgreens

	<p>and other coordinated care programs promote improved healthcare outcomes by ensuring that providers work together and are reimbursed based on the value they provide to patients. Community pharmacists are uniquely qualified to improve medication management, which is the key to improved care coordination and chronic care management in VBPMs. As the nation's most accessible healthcare providers, retail pharmacies are well positioned to play a key role in care coordination. We are also supportive of LDH creating a standardized set of P4P metrics (based upon CMS triple-weighted clinical pharmacy measures for medication adherence such as diabetes, hypertension and cholesterol) in order to promote optimal patient adherence and patient care. In establishing standard pharmacy quality measures, the Department should consult with stakeholders, including pharmacies across pharmacy practice types, managed care organizations, pharmacy benefit managers, patient advocacy organizations, drug manufacturers, appropriate standard-setting organizations, professional pharmacy organizations, and other entities determined appropriate by the Department.</p>
--	---