From:	Sisson, Karen
To:	MCD MCProcurement
Cc:	Sisson, Karen
Subject:	Walgreens Response to Ohio Department of Medicaid Request for Information
Date:	Wednesday, July 31, 2019 1:33:48 PM
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Importance:	High

Good afternoon,

Please accept the attached as our organization's response to the Ohio Department of Medicaid (ODM) recent Request for Information. We appreciate the opportunity to submit our response and appreciate the consideration of ODM to the suggestions we have put forth.

Should ODM have any questions, I serve as the lead point of contact for the attached RFI and my contact information is found below. Thank you in advance for your time and consideration.

Regards,
Karen

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PLEASE NOTE THE NEW ADDRESS and MAIL STOP NUMBER

Member of Walgreens Boots Alliance

July 31, 2019

Request for Information:

Ohio Medicaid Managed Care Program Feedback from Individuals and Providers

Presented to:

Ohio Department of Medicaid

Presented by:

Walgreen Co.

Walgreens

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COVER LETTER

Walgreen Co. (Walgreens) welcomes the opportunity to respond to the Ohio Department of Medicaid (ODM) Request for Information concerning the Ohio Medicaid Managed Care Program. We recognize that there have been a few recent announcements—such as a single state PBM and a supplemental pharmacy reimbursement fee—that will change the structure of the Ohio Medicaid program and expect there to be more changes announced in the future. Regardless of how the system is ultimately structured, we believe that our ideas present solutions to areas of concern for ODM and its patients.

Under the current model, Walgreens (as a pharmacy network provider) experiences challenges and barriers in providing care to Medicaid patients. We are excited about ODM's initial step towards pricing transparency, as displayed by its January 1, 2019, change from spread to pass-through rates. We applaud the efforts that Ohio has made towards achieving this goal.

Understanding ODM's commitment to its managed care patients, we ask ODM to consider our recommendations for systematic improvements which ultimately achieve better patient outcomes, enhance overall transparency and lead to direct cost savings for the state. We believe ODM has to address the current system's challenges in order to fundamentally change and improve outcomes not only for the patient but for ODM and pharmacy providers. We are aware of ODM's main goals for its managed care plans:

- Containment and control of costs and spend
- Elimination of bad practices
- Creation of a new system that benefits the ecosystem (e.g. state, pharmacies and patients)

We are committed to Ohio's goals, which is why Walgreens has grounded its focus on 4 core principles:

- Cut expenditures for ODM
- Achieve a transparent pricing model, with features such as clear payment for dispensing, clinical performance and intermediary roles
- Align with ODM's incentives
- Promote a cost-plus pricing model with standardized metrics for pay for performance (P4P) contracts

In order to encourage patient access, choice and medication adherence, we recommend ODM create the broadest pharmacy network possible, giving Medicaid patients more choice with access to a larger pharmacy footprint. By expanding the current network design, especially for specialty patients at retail community-based pharmacies, it would achieve greater competition on specialty medications, access to limited distribution drugs (LDDs) and patient choice for pharmacy provider. Lastly, we are supportive of ODM to create 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.

We believe that our solutions will create a new paradigm in serving Ohio's managed care population, all while lowering costs and improving patient care, outcomes and satisfaction.

Sincerely,

Walgreen Co.

Walgreen Co.

1. INTRODUCTION

The Ohio Department of Medicaid (ODM) is planning to conduct a competitive managed care procurement and is interested in hearing from individuals and providers about their experience with the current managed care system and ideas for improving member and provider experience, service quality and system accountability to inform that effort.

Through this Request for Information (RFI), ODM is seeking responses specifically from individuals who are receiving Medicaid services (individuals) and their families, advocates for individuals, providers, provider associations, partner state agencies, and other persons or organizations with relevant information about Ohio's Medicaid managed care program.

Overview of Ohio's Medicaid Managed Care Program

Approximately 90% of persons insured by Ohio Medicaid are enrolled in a managed care plan. ODM contracts with five managed care plans that were selected through a competitive procurement process seven years ago. The managed care plans are responsible for covering all medical benefits (including behavioral health services and prescription drugs) for individuals who are enrolled in the managed care plan. Managed care plans also must provide additional benefits, such as member services and care management.

In addition, other partner state agencies, including the Ohio Department of Aging, the Ohio Department of Mental Health and Addiction Services, the Ohio Department of Health, the Ohio Department of Job and Family Services, and the Ohio Department of Developmental Disabilities, help ODM with administering certain parts of the Medicaid program. Many individuals in the Medicaid program who may be enrolled with a managed care plan also receive services delivered in coordination with one or more of these agencies or their local counterparts.

2. REQUEST FOR INFORMATION

ODM is asking for your input and suggestions in the following general topic areas:

- ***Communication and engagement with individuals:*** **How easy is it for individuals to access health care and find a provider, and stay engaged in their health care efforts?**
- ***Grievances and appeals:*** **There are times an individual or provider may disagree with a decision made by the individual's managed care organization; ODM is seeking first-hand experience and ideas regarding the grievance and appeals process.**
- ***Provider support:*** **What administrative processes or functions make it easier or more difficult to do business in a managed care environment? How might sharing data be improved?**
- ***Benefits and delivery system: In*** **what ways can the managed care program improve access to services, and what unique arrangements should ODM consider in place of a one-size-fits-all model of managed care?**
- ***Care coordination and case management:*** **As ODM focuses on improving outcomes for individuals with complex health needs, how can managed care organizations and partners work to ensure appropriate care coordination and case management?**
- ***Population health:*** **How can the managed care program improve health outcomes such as infant mortality, adult smoking, and cardiovascular disease?**
- ***Performance measurement and management:*** **How should ODM be measuring the performance of the managed care program and the individual managed care plans regarding both processes and outcomes?**
- ***General feedback:*** **At the end of this RFI you have an opportunity to offer your thoughts about anything not addressed specifically in our questions.**

Specific questions for each of these general topics are below; refer to the question number with each response you submit. Also, note that while you are encouraged to submit narrative responses to any or all the following questions, you are not required to respond to every question. You may choose to respond to only those questions that are of interest to you.

For instructions on how to format and deliver your response, see Section V on the last page of this document.

Acknowledged.

Communication and Engagement with Individuals Enrolled in Managed Care Plans

Access to Care

1. **As an individual enrolled in a managed care plan, how often do you have difficulty obtaining access to services?**
    - **Less than one time a year**
    - **Approximately once a year**
    - **More frequently than once a year**
    - **More frequently than one time a month**

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2. **What kinds of difficulties do individuals enrolled in managed care plans have in being able to access health care? What would make it easier for individuals to access health care? How could managed care plans help individuals resolve problems with accessing care?**

    Individuals enrolled in managed care plans may experience difficulty accessing their desired and most conveniently located pharmacy due to an intentional, narrowed network design. The current Medicaid system in Ohio permits health plans to create a limited, narrowed pharmacy network that excludes some pharmacies. For example, if patients learn that their desired pharmacy cannot fill their prescriptions, they may become at risk for being non-adherent which can lead to an avoidable increase in healthcare costs over time (e.g. unnecessary hospitalizations, complications, ER and physician visits). The patients' pharmacy records can also become disjointed due to the various network structures currently operating in managed care plans. This can create confusion for patients, especially patients who are new to managed care plans or who switch plans and providers.

    By providing patient access to all pharmacies, the Ohio Department of Medicaid (ODM) will promote patient choice and ensure continuity of care.

    Should ODM maintain its current structure, we recommend a year-round, patient enrollment period to provide patients the ability to switch health plans and potentially pharmacies at any time during the year. In addition to the proposed year round enrollment request, we would recommend ODM give pharmacy providers a 60-day notification period to prepare for the incoming patients and promote patient coordination of care.

Communication

3. **How often do you receive communications from your managed care plan regarding your health care needs?**
    - **Less than one time a year**
    - **Approximately once a year**
    - **Monthly**
    - **Never**

    ODM should consider requiring managed care plans to send their patients ample notification about upcoming plan/network changes. These changes should be clearly and simply outlined so patients can easily understand their managed care benefits.

4. **How do you think communication with individuals enrolled in managed care plans could be improved?**

    - **Please provide any specific feedback for the following groups:**
        - **Individuals who primarily speak a non-English language**
        - **Individuals with cognitive or intellectual disabilities**
        - **Individuals with physical disabilities**
        - **Individuals who may not understand health care terminology**
    - **How could managed care plans use technology (such as web-based applications and mobile phones) to assist individuals with their health care needs?**
    - **How could managed care plans improve communication with individuals who do not have a mobile phone or computer or do not have reliable internet service?**

    Pharmacies frequently communicate with individuals enrolled in managed care plans. For pharmacies that serve Ohio's Medicaid patients, we recommend that the associated call centers have a language interpretation service in order to quickly meet the needs of all patients. In addition, when non-English speaking patients utilize the pharmacy in store, the pharmacy staff should seek other pharmacy team members who can interpret or make every effort to facilitate communication access. If all communication efforts fail, the pharmacist should have the option to call a phone interpreting service who can interpret for the two individuals.

    Individuals who are Deaf or Hard of Hearing should be encouraged to utilize Video Relay Service to communicate with call centers; in addition, a dedicated TTY line should be available. If a Deaf patient goes in store to fill a prescription, the pharmacy staff should make best efforts to communicate. If such methods fail, the pharmacy should schedule a meeting with the Deaf patient and a sign language interpreter.

Patients who are Blind or have Low Vision should be offered large print prescription labels as well as informed about pharmacy app functions such as talking pill reminders. Pharmacy staff should also ensure that patients who are Blind understand which medication is in which bottle before leaving the store.

Pharmacies should offer a mobile app which allows patients to track their prescription status, chat with a pharmacist and transfer a prescription. Individuals that do not have phone or internet service would have to travel to the nearest pharmacy in their managed care network in Ohio.

5. **What could ODM and managed care plans do to communicate with individuals enrolled in managed care plans and their families to regularly provide input and feedback?**

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Engagement

6. **What are some ways that managed care plans and providers could encourage or assist individuals to be involved in their health care and promote healthy behaviors, such as seeing a doctor regularly, quitting smoking, and eating healthier?**

   Under the current managed care system in Ohio, enrolled individuals may not experience high engagement levels with their current pharmacies. This could be due to a lack of physical pharmacy access, lack of patient choice for a desired/closest geographic proximity pharmacy and/or patient confusion over which pharmacy providers fill which medications (specialty or retail). Ideally, patients should be able to go to their pharmacy of choice and receive prescription care in a way that best fits their needs, minimizing transportation costs and barriers to care.

   Pharmacy providers should offer a rewards program for adopting and continuing healthy behaviors. In addition, patients should be able to consult with a pharmacist seven days a week, whether online or in person, to discuss adopting healthy habits.

Provider Search

7. **How could managed care plans make it easier for individuals to search for providers? In particular:**
   - **What tools and resources would be most helpful (e.g., calling member services, online provider directory, hard copy provider directory, mobile application)?**
   - **Within those resources, what type of information should be provided to help an individual choose a provider?**
   - **Are there ways to make these resources more accessible and easier to use?**

   Intentionally left blank.

Access to Information about Your Health

8. **How do individuals get information about health or medical topics (e.g., their doctor, their managed care plan, friends or family, the internet)? What could the state or managed care plans do to help individuals get the information they need to understand their health care condition and treatment options to make health care decisions?**

   Intentionally left blank.

Grievances and Appeals

9. **How can managed care plans and the state obtain feedback and be accountable for addressing member concerns over time? Is there a proactive approach (as opposed to a complaint-based system) that should be explored?**

   Intentionally left blank.

10. **How could managed care plans improve their appeal processes for individuals and providers?**

    Intentionally left blank.

11. **How could the state and managed care plans use data about appeals to improve utilization management and access to care?**

    Intentionally left blank.

12. **If you have direct experience using the appeal or grievance procedures, can you share information about your experience?**

    Intentionally left blank.

Provider Support

Standardization across Managed Care Plans

13. **Provide suggestions about how ODM could promote greater consistency of prior authorization requirements across managed care plans (e.g., requiring all managed care plans to use the same state-developed prior authorization form, or having the state establish which services can/cannot be prior authorized), including the pros and cons, potential barriers, and ideas for addressing those barriers.**

    Intentionally left blank.

14. **Are there certain other functions or processes (e.g., provider oversight, quality measures, reporting) that should be standardized across managed care plans? If so, please identify:**
    - **The function and how the function should be standardized**
    - **The pros and cons of standardizing the function**
    - **The potential barriers to standardizing the function and ideas for addressing them**

    Currently, Ohio's Medicaid structure consists of multiple and differing P4P programs among Ohio Medicaid health plans which has created confusion amongst pharmacists trying to execute and meet the needs of a particular program. As a solution, Ohio should require a standardized set of three to five metrics for P4P contracts within the managed care pharmacy network. We recommend the state focuses on three to five consistent metrics across all health plans—such as diabetes, hypertension and cholesterol (CMS triple-weighted clinical pharmacy measures for medication adherence). By creating standardized P4P metrics, ODM can track measurable improvement in medication adherence, patient health outcomes and lower overall healthcare costs amongst Medicaid population.

Communication about Policy Updates

15. **Describe your ideas for improving managed care plan communication with network providers about updates and changes to plan policies.**

    Should ODM maintain its current structure which allows narrow pharmacy networks, we would recommend that ODM improve communication with pharmacy network providers by providing a 60-day notification of any updates/changes to plans which will impact the pharmacies ability to participate in the network. This change would allow pharmacies to prepare and educate their staff. Whether it be network access alterations, new patient notifications or plan design updates, informing pharmacy networks of these changes with an ample notice period is extremely beneficial to not only pharmacies, but most importantly, patients.

Support for Administrative Requirements

16. **Describe how managed care plans could help providers navigate the plans' administrative requirements, such as submitting clean claims and resolving billing issues. Have you had any experience with a managed care plan assisting you in these areas? If so, what was most helpful?**

    Intentionally left blank.

Data Sharing

17. **How could data sharing between the state, managed care plans and providers be improved? In particular:**
    - **What data do providers want access to that they do not have access to today; how would providers use that data?**
    - **What is the most effective way of providing data to providers?**
    - **Are there barriers to providing the requested data; how could those barriers be overcome?**
    - **How could data be shared and used by providers that have limited resources and technology?**

    Pharmacy Benefit Managers (PBMs) currently administer and manage the pharmacy benefit currently for ODM. PBMs provide quarterly reports both to health plans and ODM, but these reports portray limited information in a manner not reflective of complete and full transparency. For example, the current problems pharmacy networks experience are listed below:

    1. **Problem**: PBMs report ***adjudicated*** data, not the ***contracted*** data. PBMs can adjudicate data any way they like (above or below the contracted rate with a pharmacy), which then gets adjusted at the end of the contracted period (typically annually) when compliance processes review all claims.

       Solution: In order to promote greater transparency, pharmacy providers should contract with ODM utilizing a cost-plus model (*further explained in response to Question 25*). As such, data reporting issues would be minimized and contracts would be reconciled at the end of the year with a transparent fee.

    2. **Problem**: PBMs currently report data to health plans and ODM on a ***quarterly*** basis, not annually. Since most pharmacy contracts are ***annual***, this results in data representative of a small portion of the year and does not provide a complete view.

       Solution: Quarterly data submissions can remain; however, we recommend the health plans and ODM review the quarterly data in aggregate to obtain a **complete** picture of how claims were reimbursed over the entire contracted period.

    3. **Problem**: In general, PBM reporting does not detail all fees down to the individual claim level. This results in reports that are not reflective of transparency in cost whatsoever.

       Solution: PBMs should be required to disclose all fees down to the individual claim level.

Supporting Primary Care Providers

18. **Describe how managed care plans could support primary care providers in integrating care for individuals enrolled with them. In particular:**

    - **What kind of primary care infrastructure may be needed?**

      Infrastructure would need to include: Clinical Alignment/Care Paths, shared incentives for providers (including MDs/DOs, APNs, Med Techs, etc.) to allow for better outcomes, data sharing components (e.g. shared medical records/interoperability), shared vision and mission for patient care. Please note that this is not an exhaustive list but a starting point for development.

    - **What kind of training or coaching may be needed?**

      Training should be in the form of extensive awareness/education campaigns relating to the program as well as the incentive for success. If the solution includes a shared data platform, we believe there would need to be associated training.

    - **How could the state/managed care plans incentivize primary care providers to improve access to care?**

      A combination of recognition/title, the ability to be a part of a new model of care and reimbursement/incentives for the right care would be considered appropriate.

    - **What kind of primary care models should be encouraged by the state/managed care plan?**

      Models that support population health should be encouraged because they put the patient in the middle of the equation. All things should lead to providing the right care for the patient at the right time in the right location.

      However, we recognize that not all models may work for all populations; as such, Ohio should try to test a few models in an effort to develop a continuum of solutions to serve all populations.

Workforce Development

19. **How could the state/managed care plans support workforce development for different types of providers, including dentists, pediatric psychiatrists, primary care providers, in-home providers and licensed or unlicensed behavioral health providers?**

    Intentionally left blank.

Payment Innovation

20. **What are some ways the state/managed care plans could prepare and assist providers to move through the continuum of shared accountability models that reward providers for quality and improved health care outcomes? In particular:**
    - **How could the state or managed care plans support and increase the establishment of comprehensive primary care practices and/or accountable care organizations?**
    - **Are there other payment innovations that the state should consider incorporating into the Medicaid managed care program?**

    As previously noted, the state should implement a standardized P4P program for pharmacy network providers. P4P contracts are designed to increase adherence for patients through various metrics. We recommend ODM require a standardized set three to five P4P metrics such as diabetes, hypertension and cholesterol (CMS triple-weighted and clinical pharmacy measures for medication adherence). By creating a standardized and consistent set of P4P metrics, ODM can see aligned improvement in medication adherence, patient health outcomes and lower overall healthcare costs amongst Medicaid patients and across the managed care plans. The state should also consider aligning these pharmacy metrics with the metrics that are part of MCO capitation withhold for consistency across the system. Pharmacy providers should be incentivized accordingly for meeting or exceeding the standardized and agreed upon set of P4P metrics.

Other

21. **What other suggestions do you have for ways the state/managed care plans could better support providers?**

    ODM should open access for retail and specialty pharmacy providers in order for patients to have greater options to select a pharmacy which meets their individual needs. Specialty medication definitions are often determined by the plan benefit design and frequently the most well positioned specialty medication pharmacy providers are purposefully excluded (as under the current Ohio Medicaid specialty pharmacy network design).

    Walgreens considers specialty medications to have several or all of the following characteristics:

    - May be produced through biotechnology mechanisms
    - Intended for use in unique patient populations—treats chronic, complex and/or rare conditions
    - Requires close patient monitoring/enhanced clinical support and/or REMS programs
    - The medication is high-cost
    - May be distributed through restricted or limited networks
    - May have a significant side effect profile or complex dosing requirements.

Patients new to specialty medications may not understand the complexity of coverage (narrow and closed networks) under the current structure of Ohio's Medicaid program. Maintaining continuity of care is critical for specialty care, and allowing patient choice in pharmacy is just as important for patient engagement and overall medication therapy adherence/complex disease management. By opening the retail and specialty pharmacy network access to include all interested pharmacies, this would allow unrestricted patient choice for any pharmacy to fill his or her prescription.

In addition, speed-to-therapy for specialty patient care is a critically important consideration. By opening the specialty network to ***local*** specialty pharmacy providers, a patient can more quickly initiate the therapy and receive these essential medications without delay – frequently occurring with mail order, for example.

Benefits and Delivery System

Value-Added Services

22. Managed care plans can provide services not included in the managed care benefit package as "value-added" or "extra" services, such as dental or vision services for adults. What "extra" services do you think are the most valuable to individuals enrolled in managed care plans and why?

One valuable, *extra* service for managed care patients is medication synchronization—a real-time alignment of all medications. The patient's medications should be tracked monthly to ensure the patient's medications are staying synched. The pharmacy provider should also check for any new or discontinued medications that require synchronization, helping to identify barriers to adherence and offer solutions to help a patient stay on track.

Transportation is a key challenge for Medicaid patients, especially those living in rural areas. Walgreens is supportive of managed care plans that offer this valuable, *extra* service and is working to partner with health plans in this area. Separately, Walgreens (in collaboration with FedEx) offers two-day prescription delivery at most locations. Qualified medications can be delivered to a patient's home, extremely convenient for patients who live in rural areas.

Pharmacies (such as Walgreens) also offer valuable, *extra* services to patients enrolled in managed care plans that can increase patient adherence—such as pill notifications, refill reminders, pickup alerts, refill online or by scan, safe medication disposal and more. In addition, pharmacies like Walgreens have created innovative partnerships with various companies, like Microsoft and Kroger, in order to promote patient experience, choice and positive health outcomes.

Delivery System Model

23. **The state is considering a managed care model that could uniquely administer services for a particular population (e.g., children and youth in foster care, individuals with behavioral health needs), benefit (e.g., behavioral health) or function (e.g., claims payment) from the existing managed care plan structure. Is this a good idea? For which populations, benefits or functions? Based upon your experience, what are some of the potential pros and cons of this approach?**

    Intentionally left blank.

Access to Pharmacy Benefits

24. **One area that has resulted in national attention and is of significant concern is the administration of pharmacy benefits.**
    - **What problems have individuals enrolled in managed care plans had with accessing pharmacy benefits? Has that included, for example, challenges with getting certain kinds of medications?**
    - **What challenges have providers encountered with prescribing and getting approval for certain kinds of medications?**

    Currently, the state offers differing pharmacy network designs (e.g. open networks or narrow networks) for Medicaid patients. As a result, Medicaid patients are limited in their desired and most convenient choice of pharmacies. This can cause patient care to become disjointed between pharmacies which can significantly contribute to barriers in adherence and gaps in medication therapy which is a consequential cost driver for the state.

    Under the current network structures, when patients become enrolled in Medicaid and go to their current pharmacy to fill their prescriptions, they may be surprised to learn that the pharmacy cannot fill their Medicaid prescriptions. Consequently, these patients have experienced barriers to adherence and to care.

    By expanding the Medicaid network to all pharmacies, Medicaid patients can continue to fill all of their prescriptions at their pharmacy of choice.

Pharmacy Benefit Managers

25. **What are your suggestions for ways the state/managed care plans could improve the transparency, efficiency, and accountability of pharmacy benefit managers?**

    1. In order to promote price transparency, we recommend ODM consider implementing one of the following cost-plus models in order to ensure cost transparency, performance alignment, and a better understanding of the economics:

- **NADAC + Negotiated Fee + Pay for Performance:** This model uses a transparent, national medication pricing benchmark, allowing health plans to negotiate a dispensing fee (unless the state desires to determine the set amount) and allows pharmacies to compete on three to five selected standardized P4P metrics (CMS tripled weighted metrics for medication adherence such as diabetes, hypertension and cholesterol) to drive patient outcomes.

- **Direct Pharmacy Cost + Fixed Fee + Pay for Performance:** In exchange for providing their direct costs, pharmacy providers would be granted access to all managed care lives in Ohio. Accordingly, the state can set a uniform flat fee for dispensing and encourage pharmacies to compete on three to five standard P4P metrics (diabetes, hypertension and cholesterol) to improve patient outcomes.

2. Another option that achieves greater pricing transparency is requiring carve out (from national pharmacy contracts) of pass-through rates for health plans specific to Ohio. If Ohio maintains the current model (pass-through with no state specific carve-out), then the state may be subsidizing spread model profits in other states and plans, while not obtaining actual costs. In national pharmacy contracts, Ohio would have no knowledge if it is subsidizing or being subsidized by other states under the current model. Carving out reimbursement rates ensures Ohio remunerating the true and actual economics for the state. ODM should require the PBMs to carve out the Medicaid managed care plans for Ohio out of the national pharmacy provider agreements.

3. ODM should commission a follow-up study to see if the move to pass through rates on January 1, 2019, provided any savings to the state. The study should cover the following topics:

    - Spread amounts as calculated prior to 2019 and broken down by PBM
    - Spend trend year over year broken down by utilization and per prescription trend
    - Comparison to spend trends of key players in consultants' databases
    - Spread amounts broken down between adjudicated and reconciled rates (if possible)

Integration of Behavioral Health and Physical Health Services

26. The state understands that coordination and integration of service delivery improves the experience and overall health of individuals enrolled in managed care plans, yet providing well- coordinated and holistic health care can be challenging to individuals and providers alike. Discuss any suggestions you have for improving the integration of services, particularly the delivery of behavioral health and physical health care. Include your ideas about:

- **Improving communication and consultation across providers**
- **Shared assessment and service planning**
- **Data and information exchanges**

The state should be aware that some pharmacy providers currently offer online/mobile app services for physical, behavioral and dermatological health care. Many of these services are offered at a set price for patients and can be provided during all hours of the day, especially during times when health clinics tend to be closed.

27. **How can managed care plans provide better access to evidence-based behavioral health practices, such as medication assisted treatment for opioid use disorder, multi-systemic therapy, supportive housing, and supported employment?**

Intentionally left blank.

Care Coordination/Care Management

Care Coordination/Care Management

28. **Individuals enrolled in managed care plans with chronic or complex health conditions may have multiple agencies involved in the management and coordination of their care, such as the managed care plan, the primary care provider, a behavioral health provider, or another state agency.**

    - **What are ways the state/managed care plans could improve the management and coordination of care for individuals with chronic or complex health conditions?**
    - **Who would be in the best position to help individuals with chronic or complex health conditions manage and coordinate their care:**
        - **Their managed care plan**
        - **Their primary care provider**
        - **A provider other than the primary care provider**
        - **Other (please identify)**

Intentionally left blank.

29. **What expectations should the state have for managed care plans in performing care management activities to help individuals enrolled in managed care plans and providers manage chronic and complex health conditions? Consider the following in your response:**

    - **Provider reimbursement strategies when the provider has a role in care management**
    - **Managed care plan surveillance of data (e.g., admission/discharge, utilization of crisis services) and sharing information with providers**
    - **Whether there should there be higher expectations for certain populations (if so, which ones and why)**

In order for the state to help manage complex care conditions, we would recommend the state to use pharmacy network providers that can offer complex care management through various high-touch programs in order to bolster patient adherence. These specialized pharmacy programs should dispense medications accompanied by system-driven clinical protocols that promote patient adherence and provide multiple opportunities for education, counseling and compliance monitoring. In addition, the specialty complex care programs should screen for adherence and/or barriers to adherence prior to each dispense, escalating any outreach calls to a clinician for patient-specific side-effect counseling and/or management of adherence barriers.

We also recommend that the state incorporate performance-based incentives such as P4P models for a set of three to five standardized metrics (diabetes, hypertension and cholesterol).

Special Populations

30. **Are there barriers to the delivery and coordination of care for any of the populations listed below; if so, provide suggestions on how to improve the coordination and communication among providers and systems to prevent gaps in care or duplication of services.**

    - **Children in foster care**
    - **Multi-system youth**
    - **Veterans**
    - **People with disabilities**
    - **Justice-involved individuals**
    - **Other individuals whose needs present special or unique considerations in a managed care system**

    Intentionally left blank.

Cross-System Collaboration

31. **How could coordination of services/programs managed by partner state agencies be improved? Include your recommendations for the role of the state agency, state agency case manager, managed care plan, provider, and individual enrolled in an managed care plan.**

    Intentionally left blank.

Population Health Considerations

32. **What population health measures (e.g., infant mortality, smoking, cardiovascular disease) could the state target in its procurement to have the greatest impact?**

    The state should consider targeting a standard set of three to five P4P metrics such as diabetes, hypertension and cholesterol—all designed to increase adherence. This would allow all pharmacies to compete in providing the medication care needs for patients with consistency. The current system does not have standardized P4P metrics.

33. **Which entity or entities (e.g., managed care plan, primary care provider, other providers) are best suited to work on improving performance on population health measures? Does it vary by measure?**

    Intentionally left blank.

Performance Measurement and Management

Provide your ideas about what measures should be used to evaluate the Medicaid managed care program and/or individual managed care plans. In particular:

34. **What are the most important indicators of system/managed care plan performance?**

    Intentionally left blank.

35. **What measures (current or proposed) have the highest value for measuring system/managed care plan performance? Identify the measures and why they are valuable.**

    Intentionally left blank.

36. **What measures have the least value? Identify the measures and why they have limited value.**

    Intentionally left blank.

37. **What recommendations do you have for measures that go beyond process to measure outcomes?**

    Intentionally left blank.

General Feedback

38. **If you could change one thing about the current Medicaid managed care program, what would it be?**

    We strongly believe that Ohio should transition to a more transparent pharmacy system that is based upon open pharmacy networks and creates cost savings for Ohio. We recommend a holistic approach that can be accomplished through cost-plus pricing, patient choice, performance-based reimbursement, adherence improvement, sustainable provider models and waste minimization in the middle from intermediaries.

39. **What additional suggestions do you have for the state to improve the Medicaid managed care program?**

    We recommend the state to consider all of our suggestions within this document in order to improve the Medicaid system in Ohio:

    - The state should open the retail and specialty pharmacy network to all pharmacies, allowing Medicaid patients to have improved access and choice.

- The state should consider and implement a cost-plus pricing model (*see response to Question 25*) for pharmacy providers that is based on a more transparent pricing benchmark.
- The state should implement performance-based reimbursement through a standardized set of three to five pay-for-performance metrics (e.g. diabetes, hypertension, cholesterol).
- The state should consider opening enrollment for Medicaid patients throughout the entire year (e.g. monthly).
- The state should give pharmacy providers 60-day notification of any enrollment or pharmacy changes.

We recognize that there have been a few recent announcements—such as a single state PBM and a supplemental pharmacy reimbursement fee—that will change the structure of the Ohio Medicaid program. Walgreens would provide the following recommendations:

- **Procurement of Single State PBM for Medicaid:** Walgreens believes the procurement of a single state PBM should be completed prior to the start of procurement of contracts for managed care health plans. At a later date, Walgreens would like to further discuss considerations for the structure and implementation of the single state PBM.
- **Supplemental Pharmacy Reimbursement Fee**: Walgreens supports the idea of additional reimbursement to high performing pharmacies.
- **A Single Preferred Drug List:** Walgreens supports the requirement of a single state PDL for Medicaid.

Walgreens believes that our ideas contained herein present innovative and systematic solutions to areas of concern for ODM and its patients.

3. TIMELINE INFORMATION

This RFI will be posted to the Ohio Department of Medicaid website on June 13, 2019. Responses submitted in accordance with Section V of this RFI will be accepted through July 31, 2019.

4. TRADE SECRETS PROHIBITION; PUBLIC INFORMATION DISCLAIMER

Interested parties are prohibited from including any trade secret information, as defined in the Ohio Revised Code (ORC) § 1333.61, in their submissions in response to any RFI. ODM shall consider all responses voluntarily submitted to be free of trade secrets, and such responses if opened by ODM will, in their entirety, be made a part of the public record, and shall become the property of ODM, pursuant to ORC § 149.43. Ohio law provides that information regarding recipients of Medicaid services should not be disclosed for any purpose not directly connected with the administration of programs administered by ODM. Accordingly, any information that would serve to identify an applicant for or recipient of Medicaid services will be withheld from public release.

This RFI is issued solely for information and planning purposes and does not constitute a solicitation. Respondents should note that no contract will be awarded pursuant to this RFI and that responding to, or not responding to, this RFI will neither increase nor decrease any respondent's chance of being awarded a contract from a subsequent solicitation by ODM. As noted above, ODM will not review responses from current managed care plans or potential applicants for the managed care procurement.

The State of Ohio is not liable for any costs incurred by an Interested Party in responding to this RFI.

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5. HOW TO SUBMIT YOUR RESPONSE

ODM requests responses to be submitted in electronic format and e-mailed to MCProcurement@medicaid.ohio.gov. ODM requests that all narrative responses submitted in electronic format be provided to ODM in an unprotected (i.e., no password) PDF or as a Word document. However, ODM will also accept paper responses submitted via postal mail to the following address:

Ohio Department of Medicaid
Office of Contracts and Procurement Managed Care Procurement RFI
PO Box 182709
Columbus, Ohio 43218-2709 ATTN: RFP/RLB Unit

If the response is submitted via e-mail, the respondent will receive an automatically generated confirmation e-mail from ODM upon receipt. If the response is submitted by postal mail and includes an e-mail address, ODM will send a confirmation e-mail within a reasonable timeframe of receipt. No confirmation of the receipt of mailed submissions can be provided if the response does not include an e-mail address.

If the response is submitted via email, convert the response into one single, unprotected PDF document attached to the email. If the submission's size necessitates more than the two PDF documents to contain the entire response, use the fewest separate PDF documents possible. Alternatively, you may submit your response as a Word document.

All submissions (whether paper or electronic) must be received by ODM by July 31, 2019, to allow enough time for consideration as ODM develops the managed care procurement. Materials received after the deadline will not be added to any previously received submissions. Submissions must contain the respondent's name or the name of a representative of the respondent, the organization's name (if applicable), the RFI title and number, and the submission date. Paper submissions must include an email address if the respondent would like an e-mail confirming receipt. The submission, whether paper or electronic, may be used by ODM for internal discussions, discussions with stakeholders, archiving and public records requests. See Section IV for information that is exempt from public record disclosure.

ODM will accept submissions at any time prior to the posted submission deadline in Section III. ODM cannot guarantee it will consider submissions incorrectly addressed or sent to any email other than the address specified above.

Thank you for your efforts to provide ODM with your suggestions, comments, and relevant information to assist with this project.