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Ohio Department of Medicaid
Office of Contracts and Procurement
Managed Care Procurement RFI

March 3, 2020

Director Corcoran,

On behalf of the more than 4,000 pharmacists, student pharmacists, and pharmacy professionals of the Ohio Pharmacists Association (OPA), we appreciate the opportunity to provide our responses to the Department of Medicaid's second Request for Information in regards to managed care reprocurement. We continue to be encouraged by our dialogue with you and your team, and we are excited to work with you as you transform the delivery of pharmacy benefits and overall healthcare to Medicaid beneficiaries in Ohio.

We strongly believe that the managed care reprocurement and pharmacy benefits overhauls currently underway present a significant opportunity to build a nation-leading system that transforms the role of the pharmacist and leverages their expertise to better collaborate and drive better outcomes to beneficiaries. We remain committed to be partners with you and Governor DeWine to innovate and shift the incentives at the pharmacy counter to deliver a higher standard of care at a greater value to the state.

In this response, you will see the word "incentives" a lot. This is by design. We believe that the current managed care system suffers from a litany of incentives that are working against the best interest of the state, the healthcare providers, and the Medicaid beneficiaries. We hope that in this redesign and reprocurement, a greater balance can be achieved, and that pharmacists can have greater incentives to do more than fill prescriptions, and to use their expertise and accessibility to help drive better patient outcomes.

We believe the following recommendations will help grow access to care, lower overall costs, and improve patient outcomes:

1. Person-centered care

a. How can ODM support MCOs and providers to become person-centered organizations dedicated to improving the experience of individuals they serve?

OPA believes that in order for a system to be person-centered, access to care must be as close to the person as possible. This is especially true for Medicaid beneficiaries. The more barriers that a patient encounters in order to receive care, the less likely they are to obtain it. This means that patient access to local providers is essential, and further, for some patients, it may make sense to have care brought directly to them. It also means that ensuring a proper balance of quality and choice for patients should be a guiding principle.

Things like single-source contracts – especially in the era of increased vertical integration – should be prohibited at a minimum.

Additionally, one major challenge in healthcare is the gap of knowledge that can exist between a physician and the pharmacist. During transitions and ongoing disease management, having a feedback loop between providers is essential, but the current system lacks adequate incentive for both sides to bridge those gaps. We believe the patient would be much better served if there was steady dialogue and collaboration between plans, physicians, pharmacists, and other mid-level practitioners. It's impossible to have a patient-centered system when visibility into the patient can be so fragmented and disconnected.

The pharmacist must be better integrated onto the care team and have incentive redesigns to encourage them to shift their care delivery models. OPA believes provider status and a more predictable reimbursement model can help achieve these ends.

b. *Describe strategies MCOs can use to engage members into wellness activities known to improve health outcomes.*

Pharmacists have both the expertise and accessibility to be key providers of preventive health services by providing education, conducting screenings, and making referrals to improve population health.

Specifically, research has shown that pharmacist interventions can be significant with folic acid supplementation for the prevention of neural tube defects (NTDs) in pregnancies; tobacco cessation; osteoporosis and HIV screening; and counseling and patient referrals.[i]

The relative accessibility of pharmacists lends itself well to engaging Medicaid beneficiaries on preventive health services, and research has shown that patients prefer pharmacies offer preventive care services.[ii] The problem with the current system is that a lack of financial incentives combined with long-term dispensing margin compression has driven pharmacies to dial back this level of direct patient engagement.

Beyond medication therapy management (MTM) – which pharmacists have philosophically embraced but have de-prioritized over time due to overall constrained resources, diminishing return on investment, and a lack of quality tracking – there has been limited engagement of pharmacists as it pertains to preventive care and wellness services. Further, MCOs lack their own incentives in this regard, as currently, pharmacists are not recognized as providers in the Medicaid system, thus compromising the plans' abilities to be adequately compensated when engaging pharmacists in a provider-like fashion.

When they are engaged, adequately incentivized, and have enough volume to create system and workflow changes, pharmacists have been shown to significantly impact wellness. Community pharmacy engagement with diabetes patients have demonstrated improved goal achievement, decreased sick days, decreased medical costs, and improved productivity.[iii]

c. *Describe how MCOs and providers can leverage technology to communicate with individuals about wellness activities, benefits and health care taking into consideration Ohio's geographical structure including rural vs. urban-specific needs and potential communications barriers (e.g., lack of phone and internet access)*

Leveraging technology for a patient population that has unstable phone, internet, and housing access can be extremely difficult. As such, direct-to-patient communication can be inefficient and for some, entirely ineffective.

Because Medicaid beneficiaries have challenging communication barriers, we believe that leveraging locally accessible providers to communicate physician and MCO priorities is a huge untapped opportunity. Because 90% of all patients live within five miles of a pharmacy,[iv] and because patients visit a pharmacy an average 35 times per year compared to just four visits to see medical providers; we believe that a lot more could be done to take advantage of the opportunity to engage the patient at the pharmacy level. While the patient does not interact with pharmacists at each visit, we believe that "the hook" of having the patient at the pharmacy counter in order to receive their medications is the opportunity to prompt pharmacists to communicate priority items to the patient and to close the feedback loop based on counseling and discussion.

Additionally, MCOs should communicate with community pharmacies through technology in order to identify vulnerable patient populations, patients with social determinants of health, and patients that would benefit from pharmacist-provided care services, including but not limited to, discharge records for transitions of care services.

d. *Describe how MCOs and providers can support efforts to reduce the impact of health care disparities, such as geography, race or ethnicity, or income levels.*

MCOs should leverage the pharmacist in identifying social determinants of health and health care disparities by incentivizing pharmacists and training them to identify and triage patients for additional resources.

Additionally, because healthcare disparities are at their most prevalent in high-Medicaid areas, we believe that pharmacies and other healthcare providers that invest resources in those areas are rewarded for doing so. Unfortunately, the current reimbursement system for dispensing services in the Medicaid managed care program is underfunded relative to other payers in the market. This creates a disincentive to invest in regions with the highest amounts of healthcare disparities. Anecdotally, Ohio independent pharmacy owners and chain pharmacy leadership have shared that Medicaid reimbursements are driving pharmacies out of impoverished areas and into wealthier regions with better payer mixes and less complex patient needs that can make rendering the current suite of services increasingly inefficient.

If the state wants to address healthcare disparities, we believe access standards in those areas need to be strengthened, we believe that reimbursements need to be on a more equitable scale with other payers, and we believe that pharmacists need to be adequately incentivized and compensated to offer services that can address many of the unique challenges faced by Medicaid beneficiaries.

e. *Describe how MCOs could support providers in implementing care delivery strategies that are culturally relevant and foster respect, trust, and empathy. How would this be monitored?*

In many parts of the state, pharmacists are the most known and trusted healthcare provider. Medicaid beneficiaries especially need to have trust in the system of care that is delivered to them. Often that source of trust can only be derived from a local provider that they know and trust. Regardless of whether it is fair or not, public trust in insurance

companies is weak relative to that of health care providers,[v] and MCOs should leverage the familiarity of local health providers like pharmacists to help them bridge the trust gap that may exist with their care plans.

In general, while we have seen chain pharmacies work to staff diverse patient populations with pharmacy staffs that match the local demographics, we believe that in most instances, independent, locally-owned pharmacies excel immensely at knowing, understanding, and meeting the unique needs of their communities. By their very nature, locally-owned and operated pharmacies must meet the needs of their patient population in order to be in a position to succeed. Our experience shows that local-owned means locally-focused. Ohio's independent pharmacies generally have high levels of familiarity with their patients, and they have earned significant trust from their patients.

These observations are also backed by independent research. According to the J.D. Power 2019 U.S. Pharmacy Study, patient satisfaction with independent pharmacy providers far exceeds that of chain pharmacies.[vi] Our general fear has been that if the accessibility to independent pharmacies diminishes further than it already has in our state, the competitive forces on customer service that they provide will also dissipate, leaving chain pharmacies with even less pressure to staff pharmacies appropriately and to go above on beyond to meet the complicated needs of a complicated patient population.

Maintaining access to locally-owned pharmacies throughout Ohio – but especially in high-Medicaid areas – should be a priority for our state Medicaid program.

3. Pharmacy Benefits Management

a. What suggestions do you have regarding the coordination of MCO and pharmacy benefit manager clinical programs?

OPA has significant concerns over the conflicts of interest that exist within vertically integrated PBMs that have stake in their own affiliated pharmacies. Recent revelations that show PBMs overpricing and underpricing select medications,[vii] PBMs steering overpriced medications to their own pharmacies,[viii] and PBMs using phony, self-benefitting metrics disguised as "quality measures" as a means to give their own pharmacies an anti-competitive edge over other pharmacies and to sneak hidden retroactive clawbacks from the system;[ix] are a clear indication that PBMs are not agnostic in their creation, management, and remuneration for clinical services and value-based payments.

In order to prevent PBM self-dealing in the future, either the Department of Medicaid must choose a PBM that is devoid of conflicts of interest, or they need to take an active role in setting quality metrics, establishing objective methodologies for reimbursement, ensuring network adequacy, maintaining robust competition on factors that go beyond surface-level price, and eliminating any capability for self-dealing.

With that said, ODM should maintain maximum transparency in the flow of money, contractual relationships, and incentive systems from the MCO to the PBM to the pharmacy. Additionally, the state should strive to provide maximum transparency to the public in these regards as well.

Once these above items are achieved, we believe that the state should leverage its PBM for largely transactional purposes rather than broader PBM functions. We realize that this may not sound surprising coming from our organization, but we suggest this not as a

condemnation of the utility of PBMs (even the better ones), but as an important philosophical shift for the pharmacy benefit as a whole.

The very nature of the PBM is that they manage an outsourced benefit from the MCO. We believe that while the PBM functionality has its utilities, we have always had an aversion to the idea that pharmacists would be cast off on a healthcare island, away from the other services and priorities managed under the roof of the MCO as a whole. We believe that the single PBM presents an opportunity for MCOs to focus solely on the engagement of the pharmacist, rather than using the pharmacy benefit as a means to extract non-traditional revenue out of the system or inflate medical loss ratios. Eliminating the opportunity for profiting off pharmacy transactions should create a clean slate to begin engaging the pharmacist at a higher level that is more consistent with MCO and state priorities.

The state should take an active role during this moment of disruption to ensure that the siloing of the pharmacy benefit from the medical benefit is minimized or ended. Steps should be taken to align state priorities within the pharmacy benefit. Because we feel pharmacists can have a dramatic impact on achieving state, MCO, and patient goals, this incentive realignment could significantly improve health outcomes.

b. *How could ODM better align the pharmacy and medical benefits, including physician administered drugs, to improve outcomes for individuals?*

We have always found it perplexing that drugs dispensed or administered within the walls of a physician practice or health system setting can yield significantly higher margins than when the same drugs are dispensed in a community pharmacy. We believe that reimbursements should be mostly site-agnostic, with any variances in rates coming from quality metrics, access considerations, provider size, and Medicaid market share.

The state of Colorado has recently moved to a more objective benchmark for approximating drug costs, much like is done in the Ohio Medicaid fee-for-service program. The Colorado program is moving to surveyed acquisition costs as a means to better approximate drug costs and to keep margins under control.[x]

Outside of better aligning the payment for drugs between the benefits, OPA strongly believes that pharmacy benefits and medical benefits need to be better integrated.

As we mentioned in our first RFI response, in the 132nd General Assembly, Governor Kasich signed SB 265, recognizing pharmacists as providers in the state of Ohio. Effective in April 2019, this law empowers health plans to reimburse pharmacists for clinical services that are within the pharmacist's scope of practice, such as long-acting injections, disease state management, clinical evaluations, transitions of care, and prescriptive authority within collaborative practice agreements with physicians. These pharmacist functions will add significant value into the Medicaid system.

Currently, pharmacists are not recognized as providers within the Medicaid code and MCO contracts, and we believe this needs to change. The April 11, 2019 hearing of Ohio House of Representatives Finance Subcommittee on Health and Human Services featured top leadership from UnitedHealthcare, CareSource, and Molina expressing their desire and interest in utilizing the new law to leverage the expertise of pharmacists to yield better health outcomes for their beneficiaries.[xi] We can confirm that since that hearing, each plan has moved to implement new compensation models for pharmacist-provided services. And

Buckeye Health Plan has also joined the ranks. While some are further along than others, it is clear that MCOs are ready to implement the law, but a lack of provider identification numbers and credentialing process has held up the rollout of these programs and continues to disincentivize pharmacist utilization.

We know that the Department has been working towards this end, and we look forward to full implementation of recognizing pharmacists like other healthcare professionals within the Medicaid program soon.

c. *Describe best practices for MCO exchange and integration of pharmacy data with a pharmacy benefit manager.*

Pharmacy data should be shared with medical providers through electronic medical records to ensure proper continuity of care, and medical records should be shared with pharmacy providers for the same reasons.

d. *Please describe the impact of the above model for Medicaid managed care on the provision of Medicaid and Medicare pharmacy services to MyCare members. Would you suggest that ODM use the same model for the Medicaid pharmacy benefit for MyCare members? Please explain your rationale.*

We believe that if the state can build a successful, integrated model in the Medicaid managed care program, it can and should be leveraged in the MyCare program, where interventions are arguably more needed. While typical Medicaid beneficiaries can certainly benefit from enhanced pharmacist-provided services, we believe that Medicare-eligible seniors could benefit even more. Studies have shown that pharmacists can have a significant impact on seniors' wellbeing.[xii]

6. Health and Wellness

a. *Describe ways in which MCOs serving the same region can collaborate to create and implement strategies that have a collective impact on the population within the region with specific attention to the issues identified above (i.e., reducing infant mortality and preterm births, increasing healthy behaviors, promoting tobacco cessation, and addressing healthcare inequities).*

As mentioned above, pharmacists can play a major role in promoting public health to Medicaid beneficiaries. In general, the training and expertise of the pharmacist lends itself well to assisting in meeting population health goals.[xiii] [xiv] [xv] Due to the siloed nature of the pharmacy benefit and a lack of expectations and incentives, pharmacists have historically been treated primarily as vendor access points, rather than as supplemental extensions of the healthcare team. The new managed care model should reflect a new vision that integrates the benefit as a means to improve overall population health.

Because population health ultimately serves the needs of Medicaid beneficiaries and non-Medicaid beneficiaries alike, we believe that a well-developed system of care can be extrapolated to other state benefit plans, such as OPERS, BWC, and beyond. This would help enhance the impact of successful population health strategies and create more patient volume that would qualify for this level of care management, which would increase the amount of incentive for providers to alter their business and workflow to aim toward achieving these goals.

b. *Describe how an MCO can progressively work to identify social needs and implement innovative strategies to address social determinants of health in a region including food security, housing, education, and interpersonal violence.*

In order to identify social determinants of health, the first step is actually knowing the beneficiary. This can happen a number of ways through social workers, community organizations, doctors, nurses, health plan customer service agents, and pharmacists. Recognizing that a one-size-fits-all approach will not lend itself to many beneficiaries, MCOs should be leveraging all of these resources as a means to identify and address social determinants of health.

Specifically, pharmacists can play a huge role in this space due to their accessibility, patient trust, and frequent contact points. We believe that if pharmacists are adequately incentivized, given some added training, and if there is a reasonably seamless way to provide feedback to MCOs and other providers, pharmacists could eliminate several blind spots that exist in the current system.[xvi]

7. Performance Incentives/Reimbursement Strategies

a. *Are there specific strategies that ODM should consider to support movement along the continuum of value based care/payment models and align incentives with MCOs and provider partners to achieve greater levels of integration and improved health care outcomes? What should the MCO's role be in supporting providers in value-based payment models? Are there specific alternative payment models that ODM should consider or promote?*

As mentioned above, there is significant evidence to show the positive therapeutic and economic outcomes associated with pharmacist provided care services.

There are quality metrics designed specifically for pharmacists, and there is evidence pharmacists can help patients to better meet quality metrics in practice transformation models, such as in CPC+. This was demonstrated in a collaborative program in 2020 between a patient-centered medical home (PCMH) and a grocery pharmacy chain (Kroger), where researchers evaluated the effectiveness of a community pharmacist's clinical integration in reducing hemoglobin A1c levels at clinic and patient levels.[xvii] Pharmacists were shown to significantly improve these levels.

Pharmacists need to first be empowered to engage in these ways within Medicaid managed care, and this can be accomplished through first recognizing pharmacists as billable providers. But additionally, MCOs should work to develop value-based payment programs, much like CareSource is currently developing to extract a greater value out of pharmacy than just filling prescriptions.

Additionally, as was shown by the New York Times earlier this year, the current business model of pharmacy is too reliant on compressed margins that are built on a fee-for-service system, and it is compromising outcomes and patient safety.[xviii] So long as the Department does not institute reimbursement requirements that at a minimum meet the cost of filling a prescription, measures should be put into place to ensure that pharmacy business models do not turn into a race to the bottom. Pharmacists want to be able to do more than just fill prescriptions, but the business model discourages it. By aligning pharmacists as providers like other health professionals and using objective measures for quality (not just adherence

measures that rely on prescription filling data), we believe we can begin to reward high-performing pharmacies, and drive others to do more than just cut staff and services as a means to stay afloat.[xix]

b. *MCO developed, value-based payment arrangements with providers that are not aligned with other MCOs may create additional administrative requirements for providers and dilute the underlying objectives. What level of discretion should ODM give to the MCOs to design their own value-based payment arrangements as opposed to requiring a more coordinated, statewide approach?*

Like most things, there is likely a balance that must be struck to ensure that administrative hassles for providers are minimized, while also maintaining adequate flexibility for health plans to innovate.

OPA believes that the state should work collaboratively with MCOs and providers to develop universally agreed upon standards for quality and value, and then to apply those universally across all MCOs. Then we recommend working collaboratively with each MCO and provider group to collaboratively discuss unique, sought-after additions to those metrics in a manner that seeks consensus between all parties. While consensus may not be achievable all the time, this at least provides a stakeholder process that ensures objectivity, reasonableness, and balance is considered.

We believe this allows for the development and testing of new best practices while ensuring a reasonable process for changes that can complicate care delivery.

c. *ODM is considering linking incentives to outcome metrics for MCOs, providers, or both. Describe recommended processes or capabilities to collect reliable outcome measures from network providers. Please provide examples of outcome measures and how MCOs currently use that information.*

ODM should consider a gradual transition into value-based quality metrics, especially as pharmacists transition practice responsibilities. We believe the nature of pharmacy make it highly unlikely to ever lend itself to a full value-based payment model, but we believe that it can serve as a gradual North Star. The fee-for-service element of pharmacy practice, which is the dispensing of a drug that can have widely variable costs from drug to drug needs to be accounted for in any future payment model, but we recognize the utility in tying some level of margin and profit to outcomes and quality.

We concede that quality metrics and outcome attribution models in pharmacy are still in their infancy, but as we mentioned in our first RFI response, we believe that it is extremely important for OPA, the Department, and the MCOs to work collaboratively to begin rebuilding the incentives in pharmacy. Pharmacists can – and want to – be held to a higher standard, and we believe the pharmacist's value proposition goes far beyond filling prescriptions. It is important for the payment model to reflect that.

Specifically, OPA is supportive of developing an attribution model in pharmacy to be layered over top of product distribution, where certain metrics for pharmacy quality and actual patient outcomes measurements can be combined to grade out a pharmacy's overall performance and impact. The goal would be to then tie supplemental payments to reward high-performing pharmacies to begin incentivizing a higher standard of care.

We understand this is not a simple endeavor, and that it will take time and collaboration, but we believe Ohio's moment of pharmacy benefits disruption is an incredible opportunity to begin creating a better aligned model for pharmacy and patients.

These metrics should strive to be less focused on filling more prescriptions and more focused on overlapping with broader outcomes metrics for doctors and MCOs.

8. Quality Improvement

a. *For entities that have experience in population health approaches, describe the tools and processes that were used to achieve population-level improvements. Describe dedicated staff composition and/or training required to manage these efforts, highlighting areas of success and partners crucial to that success. How might the improvements and lessons learned be integrated into MCO operations?*

In our work at OPA, we encounter pharmacists from a variety of practice settings. Notably, in health-system pharmacies like Cleveland Clinic, Nationwide Children's Hospital, Ohio State University Wexner Medical Center, OhioHealth, University of Cincinnati Medical Center, and more, pharmacists are often utilized as an integrated part of the care delivery teams. These institutions specialize in population health and have willingly boosted their pharmacist investments, even without a form of direct remuneration for the pharmacist's services.

By recognizing pharmacists as providers, we can remove the disincentives from utilizing them over other mid-level practitioners that are able to bill for their services. We believe this will open up greater opportunities to leverage the expertise and training of the pharmacist, which can help drive better outcomes. Health systems that succeed in population health management achieve their success through deployment of pharmacists onto healthcare teams. The state should encourage this deployment more broadly by enabling pharmacists to be compensated for their services within Medicaid.

11. Transportation

Describe how MCOs could improve the provision of non-emergency transportation to individuals (e.g., the quality and safety of drivers and vehicles, reducing wait and transport time, real-time monitoring, allowing siblings, providing same-day transportation, and allowing multi-stop transport), including recommendations specific to improving access in rural areas (e.g., expanding the number of qualified drivers or using ride-sharing services).

Many pharmacies offer home delivery to patients that have mobility issues in their communities. This was historically offered as a free courtesy to patients when pharmacy margins were higher. However today, due to growing trends of underpayments, many pharmacies have scaled back their delivery services. This is unfortunate, because of the added hassle and adherence gaps encountered by patients, but furthermore, because many pharmacists would check in with the patient upon delivery, many of those wellness checks are also no longer occurring.

We believe that pharmacies should be incentivized to not just deliver medications to a patient, but to actually engage them directly whether at home or at the pharmacy counter – especially when new medications are prescribed. Today, there is little incentive to do so, and as such, many prescriptions are filled without any meaningful interaction and check-in with the patient.

The state should reward those local pharmacies that follow up with patients to ensure they are taking their prescribed medications, and there should be compensation for those that help address patient mobility issues by engaging in home delivery and wellness checks.

12. Care Coordination

a. In the MCO and CCE model explained above, describe the roles, responsibilities and collaboration among involved entities that will be needed to ensure care access and continuity of care for individuals transitioning between tiers, transitioning between settings and transitioning between MCOs and/or CCEs when necessary. How should roles and responsibilities be delineated to leverage strengths of MCOs and community-based CCEs? How can duplication of effort be minimized across the entities?

MCOs and CCEs should leverage the local pharmacist as a key point of contact for care coordination. The pharmacist is the most accessible healthcare professional, and in many communities, they are trusted mainstays with more information about the patient than anyone else. Their expertise and accessibility are vital to continuity of care.

ODM should allow for and encourage the appropriate transfer of healthcare records to ensure the pharmacist has the information they need from EMRs in order to assist in clinical decision-making.

13. Services for Children Involved in Multiple State Systems or with Complex Behavioral Health Needs

a. Which subsets of children and youth may benefit from the approach outlines above?

Children in the foster system and that qualify for Medicaid have a higher incidence of being prescribed antipsychotic medications. Data from our own state shows high levels of dispensing for many behavioral health medications. There have been reports that these childrens' therapies and medications are frequently not monitored by healthcare professionals, which puts them at risk of poor therapeutic outcomes.[xx] [xxi] This phenomenon has also been found in Ohio in years past.[xxii] This is one example of where the pharmacist's expertise could be leveraged to monitor this patient population and provide feedback back to physicians and MCOs to ensure proper treatment and care.

14. Behavioral Health Services

a. Do MCOs currently require primary care clinicians to screen members for behavioral health needs (mental health or substance use disorder screens)? What screening tools would you recommend requiring or allowing primary care clinicians to use? Do they capture social determinants of health? What are recommendations for supporting and monitoring primary care clinicians to ensure screenings are being completed? What challenges keep primary care clinicians from completing these screens? How might data be shared between the primary care clinician and the MCO?

We have not seen sufficient levels of meaningful behavioral health screenings from primary care providers, and we believe more can be done to ensure that they do occur at the primary care level. However, understanding that many patients forego the needed ongoing contact with their primary care physician, more should be done to fill in the gaps that currently exist in the system.

We believe that this a great opportunity to utilize pharmacists to supplement current efforts for screening patients. As mentioned previously, adding incentives for the pharmacist to engage in screening social determinants of health and behavioral health needs could be boon to the system as a whole.

15. Opioid Use Disorder and Substance Use Disorder

a. Describe utilization management approaches that ensure individuals have access to substance use disorder services at the appropriate level of care and interventions are appropriate for the diagnosis and level of care.

As the medication experts and as the most frequent provider contact for patients, pharmacists can be a key team member is addressing the opioid epidemic. But even something as easy and seamless as providing a patient naloxone can be a challenge for pharmacies where there are minimal incentives to actually spend time with the patient, discuss the risks of drug misuse, and provide the overdose reversal medication.[xxiii]

ODM and MCOs should be building incentives into the system for pharmacists to engage on opioid prescriptions; not just fill them. The current system rewards pharmacists when they fill prescriptions, but not when they call a doctor for clarification, talk to the patient about their ailment, discuss the risks of taking too much of an opioid, or choose not to fill a prescription, when appropriate. Further, when it comes to naloxone, pharmacists have reported a history of underpayments and payments well below the cost to dispense for naloxone, which discourages them from stocking it and promoting it to patients. Instead of MCOs paying thousands of dollars in margin for single prescriptions of generic Gleevec, perhaps some added incentive could be pushed into opioid counseling, screening, follow-up, or naloxone dispensing.

Additionally, all MCOs should authorize pharmacists to administer long-acting addiction and behavioral health medications to ensure ease of access and adherence for patients. And ODM should grant pharmacists provider ID numbers so that MCOs aren't disincentivized from having pharmacists provide these needed drug administrations closer to the patient's home.

b. What efforts are necessary to develop sufficient provider capacity for each level of care, and medication-assisted treatment services in particular, for individuals with substance use disorder and opioid use disorder?

Please see comments from 15.a.

c. What are ways that the MCOs can support, shape and improve provider performance to expand access and improve outcomes for individuals with substance use disorder and opioid use disorder?

Please see comments from 15.a.

17. Centralized Credentialing

a. Please identify any potential barriers to implementing this approach and proposed solutions.

OPA supports and appreciates the move toward centralized credentialing. However, if ODM should choose not to credential all licensed pharmacists as intended through enactment of

SB 265 in the 132nd General Assembly, we would not support any program that would seek to disqualify the credentialing of pharmacists, for both pragmatic and antitrust reasons.

18. Standardizing Provider Requirements

We believe the approaches proposed for standardizing provider requirements appear to be reasonable.

22. General feedback

What other information should ODM consider as we take the next steps to achieve the goals for Ohio's Medicaid managed care program?

As we mentioned in our first RFI response, if we have learned anything from the PBM debacle in Ohio, it's that pharmacy benefits have been overlooked and misunderstood for far too long. And we've also learned that vertical integration can bring in many opportunities and many challenges. As MCOs and PBMs transition from managing care to managing and delivering care, greater scrutiny of self-dealing, patient steering, and anti-competitive behavior is essential. Furthermore, a greater focus on quality and outcomes will be needed for ensuring a high standard of care is protected in Ohio. These points are not just true in pharmacy, but across the care delivery system.

Pharmacists need to be removed from their silo in the care delivery system and integrated into the system as a whole. Through their expertise and accessibility, pharmacists present a unique, innovative way to fill care gaps, and bring services closer to the patient's home. We believe that through a more robust engagement and a realignment of payment incentives, pharmacists can help the state deliver on its goal to provide a more patient-focused system that drives greater efficiencies and better outcomes.

24. Opportunity for Interview

a. *Name of entity or organization.*

   Ohio Pharmacists Association

b. *Entity Type*

   Professional trade association representing Ohio's licensed pharmacists

c. *Point of contact, including name, telephone number, and email address, for the purpose of scheduling the interview.*

   Antonio Ciaccia
   (614) 389-3236
   aciaccia@ohiopharmacists.org

d. *Name, title and employer of proposed attendees to the interview, including any contracted lobbyists or consultants.*

   Stu Beatty
   Director of Strategy and Practice Transformation
   Ohio Pharmacists Association

e. *Brief description of the topic or topics in the entity or organization's RFI response that the entity or organization would propose to address in the interview.*

OPA would like the opportunity to discuss some of our current conversations with MCOs on how they wish to better utilize pharmacists and to provide some background on how pharmacist services can help the state achieve its goals.

Thank you for the opportunity to provide feedback on the Medicaid managed care reprocurement process. We believe this is a great opportunity to build the best program possible for Medicaid beneficiaries and the taxpayers that fund it.

Ernie Boyd, RPh, MBA, CAE
Ohio Pharmacists Association
eboyd@ohiopharmacists.org

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