Assessing Trends in Enhanced Services and Medication Support with Value-Based Payment Models in Medicaid

Prepared for the
NCPA Innovation Center

This initiative was made possible by the **NCPA Innovation Center** with support from **Pfizer**

October 2019

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Executive Summary

In an effort to generate learnings about emerging pharmacy enhanced services delivery and trends in value-based payment models within Medicaid programs, a project team set out to observe the activities of a newly formed nationwide network of community-based pharmacies (CPESN), applying population health management concepts.

While not an Accountable Care Organization as that term is defined by statute, the network is most easily conceptualized as an "accountable pharmacy organization" (APO). CPESN is clinically integrated network, meaning the members collaborate on patient care, apply quality improvement initiatives including best-practice clinical pathways (Service Sets), share clinical data flows to measure outcomes and monitor quality and cost through data analytics. The clinical practices and quality measurement capabilities allow the APO to enter into service and performance contracting with healthcare payers. At the time of project completion, the nationwide network maintained more than 2,300 participating community-based pharmacies across 43 states.

Medicaid subject matter experts from a well-known nationwide consultancy were contracted to engage local Medicaid stakeholders as well as Medicaid Managed Care executives and program directors about their emerging need(s), if any, including obtaining a competitive advantage for themselves, by contracting with community-based pharmacies for enhanced services that support optimizing medication use.

Because of higher than anticipated interest from state administrators and Managed Care Organizations (MCOs), including states in the process of Medicaid managed care plan procurements, the original project goal of approaching Medicaid stakeholders in ten states was revised half-way through the project. Ultimately, Medicaid administrators and/or MCO plans from 27 different states interested in payment and performance contracting with community-based pharmacies were successfully engaged (AR, CA, FL, GA, HI, IA, IL, KS, KY, LA, MA, MI, MN, MS, NC, NE, NY, OH, OK, PA, SC, TN, TX, UT, VA, WI, WY).

Partnerships aligned with managed care plan interests, such as optimizing medication use and pharmacy-provided care management supports, were easier to establish than anticipated. In addition to the need for more conventional enhanced services, MCOs also expressed a need for novel pharmacy-based activities, such as partnerships with substance abuse disorder clinics and local community health worker networks.

The project team successfully engaged Medicaid administrators from 21 states. Thirteen of those states engaged as payers in for Fee-for-Service contracts on behalf of enrollees, while the other eight facilitated MCO relationship-building. In total, the project team engaged with MCOs operating in 25 of the 27 states, comprising a total of 36 different state-MCO combinations, 25 of whom represent regional or national plans, with the remainder of engagements comprising Integrated Delivery Network (IDN-health system) (6) and physician-run Accountable Care Organizations (ACOs) (4).

While engaging with Medicaid stakeholders was more easily accomplished than anticipated, the contracting process for the APO was a more lengthy and challenging endeavor. Many initial discussions (with MCO plans in particular) required buy in from medical, finance, business development, and care management leads. Additionally, several MCOs terminated discussions because of in-house or contracted Pharmacy Benefit Managers who resisted engagements with pharmacy networks that provide both dispensing and clinical services outside of their in-house programs. Nevertheless, during the time period of this project, the APO and/or local APO chapters entered into several payer contracts.

Key Learnings Included:

- ***Medicaid Has Become an Important Laboratory***
- ***MCO Bidding Drives the Preponderance of Innovation***
- ***Legislatures and Personalities Also Drive Innovation***
- ***Discussion of Pharmacy Enhanced Services is Noticeably Absent with Medicaid Pharmacy Benefit Managers***
- ***Medicaid Health Plan Care Management and Population Health Priorities are Driving Medication Management Services Discussions***
- ***Outcome-Based Reimbursement Programs and Value-Based Purchasing Arrangements with Pharmaceutical Manufacturers Remain Nascent and are Complex to Implement***
- ***Specialty Pharmacy Is Prominent in Medicaid but Not Top of Mind as It Is for Non-Medicaid***
- ***340b Contracting is Beginning to Expand as Medicaid becomes a New Avenue for Growth***

Notable Excerpts:

"For pharmacies, the historical retailing business model has recently suffered as product reimbursement margins have approached acquisition costs, or in some situations, now produce negative margins. This occurred within the larger arc of retail moving away from community-based storefronts. This has led some pharmacies who are services capable and want to follow the medical model of accountable care to form their own pharmacy versions of accountable care models – accountable pharmacy organizations (APOs). Clinically integrated, accountable care is appealing to pharmacies because it allows pharmacy providers to self-organize and choose with whom they want to organize with and be held accountable. The ability to offer higher value services and be accountable for service delivery, these networks can collectively express value and enter into payer contracts for healthcare services, similar to how physicians and health systems contract and obtain reimbursement."

"Most of our engagements with MCOs involved positive discussions about the Pharmacist electronic Care Plan (PeCP) and when community pharmacy care management was involved, became a required element for payment to the pharmacy. The PeCP emerged as a popular way to accomplish three ends simultaneously: 1) quality assurance of the intervention 2) adjudication for payment and 3) care coordination."

"There is a remarkable divergence and oftentimes lack off alignment between stakeholders' outcomes of interest. This may help policymakers better understand why pharmacy quality improvement and integration with stakeholders and care team members outside of the pharmacy sector has been so difficult. Divergent goals coming from divergent business models continues to plague forward progress."

"The project team had a near one hundred percent success rate in generating interest in working with community pharmacies from plan executives. Once presented with the idea, in almost all cases the non-pharmacist staff expressed great interest. Generally speaking, if pharmacists who were engaged worked under the medical director or other non-PBM staff, they were amenable to the idea of working with APOs. If the pharmacists reported up through the PBM, or worked in another building separate from the medical, care management, or quality team, the pharmacist(s) were generally a barrier to moving forward."

"We encountered a surprising level of skepticism among the health plans of the fidelity of their contracted PBM to the plans' interests. Lack of financial transparency within manufacturers rebate agreements and plan member self-channeling have generated concerns among the health plans. Most recently, concerns have emerged about PBM use of pharmacy data to compete with the health plan who has contracted with them to provide PBM services. With all three major PBMs now merged with major medical insurers, the distrust between plans and PBMs seems to be growing."

"There wasn't a single payer, purchaser or partner engagement that directed the project team to contemplate how to submit claims or clinical data through conventional pharmacy claims routes using MTM or other codes in the NCPDP standards. This demonstrates the level of disconnect on provider and payment reform between the non-pharmacy and pharmacy sides of the current healthcare system of financing and delivery."

Pharmacy and the Current Medicaid Environment

Medicaid Enrollment and Expansion

Medicaid enrollment continues to grow in Medicaid expansion and non-expansion states. Medicaid now covers more than 65 million people, or approximately 20 percent of the US population, a nearly 15 million person increase since passage and implementation of the Affordable Care Acts.[1] For many pharmacies, especially those in rural areas of the country, Medicaid is a critical reimbursement source. *"In some states, the population percentage served by Medicaid is higher. As an example, Medi-Cal, California's Medicaid program, is the state's health insurance program for low-income Californians, including 40% of all children, half of all people with disabilities, over a million seniors, and nearly 4 million adults. It also pays for more than 50% of all births in the state and 58% of all patient days in long-term care facilities. In total, 13 million, or one in three, Californians rely on the program for health coverage. Medi-Cal pays for essential primary, specialty, acute, behavioral health, and long-term care services."*[2]

Medicaid Drug Rebate Program

As a result of the 1990 creation of the Medicaid Drug Rebate Program and the high proportion of healthy women and children enrollees, Medicaid outpatient pharmacy spend is relatively small. After the federal and state rebates, pharmacy spending represents between just 4%-8% of global Medicaid spending in most states.[3] However, the Medicaid Aged, Blind and Disabled (ABD) population (inclusive of the disabled and those "dually eligible" for inclusion in both Medicare and Medicaid programs) has the highest rate of prescription drug utilization of any category of patients in the United States. This duality of healthy women and children and complex aged and disabled within Medicaid enrollment creates unique challenges for state Medicaid programs. *"Although outpatient drugs account for a small share of Medicaid spending, spending on this service before rebates increased by 21% in 2015 and grew an additional 11% in 2016. Though it grew more slowly in 2017, it is expected to grow faster than most other Medicaid services in the next 10 years. Because states must balance their budgets, ongoing increased spending on Medicaid prescription drugs is a policy concern, prompting states to consider ways to reduce drug spending."*[4] Notably, as pre-rebate cost has risen, post-rebate costs have not risen as sharply, and in at least one state (North Carolina), outpatient pharmacy costs as a percentage of overall Medicaid budget have actually decreased steadily over the past decade, from greater than 10% to approximately 6% of total state Medicaid expenditure.[4,5]

Medicaid Disproportionally Utilized in Rural Settings of Care

Pharmacies in rural areas serve high numbers Medicaid eligible patients. Medicaid is a critical third-party payer for these pharmacies, and any changes to Medicaid Outpatient Pharmacy Program reimbursement can have a large effect. Rural, community-based pharmacies act as an important access point for health care providers and offer an avenue for primary care and chronic disease management services that are locally provided. Rural pharmacies also have a disproportionate level of political capital to engage state legislators and MCO business development executives during the RFP-bid cycle.

Financing of the Dually-Eligible

As the population ages, the dually-eligible population continues to grow. For those who are dually-eligible, Medicare is the primary payer for most services; Medicaid covers benefits not offered by Medicare. Under the current system of financing for medications, the dually-eligible are covered almost entirely by the Medicare Part D program and trust fund. The dually-eligible, and in particular the disabled dually-eligible offer a unique opportunity for community-based pharmacies, and APOs since they tend to require a lot of in person or relationship-oriented encounters:

> *"Dual Eligible Special Needs Plans (D-SNPs), a type of Medicare Advantage (MA) managed care plan, are a readily available platform for increasing the number of people in integrated care and better aligning Medicare and Medicaid policies. D-SNPs enroll only individuals dual eligible for Medicare and Medicaid; are required to have an approved care management model describing how each plan will meet the needs of its enrollees; and arrange for or provide enrollees with a coordinated Medicare and Medicaid benefit package Now, at a minimum, D-SNPs must either: (1) include Medicaid benefits in their capitated benefit package; or (2) arrange for Medicaid benefits to be provided in some other way such as through a companion Medicaid managed long-term services and supports (MLTSS) program, a Medicaid managed care plan, or through Medicaid fee-for-service providers, depending on the state. D-SNPs have the potential to deliver a coordinated Medicare and Medicaid benefit package that offers more integrated care than regular MA plans or traditional Medicare fee-for-service."*[6]

This complex dual-eligible coverage environment splits payment sources for these patients, separating drug product reimbursement from medical services reimbursement, thus complicating individual pharmacists' efforts to provide and fund medication synchronization, medication reconciliation, and enhanced services delivery. Additionally, conflicts of interest between the plan's desire to contract with APOs and their contracted or owned PBM, and that PBM's desire to maximize rebates, direct and indirect remuneration fees, clawbacks and self-channeling were frequently identified as barriers to contracting with community-based pharmacies for enhanced services.

Growth of Managed Care

Though Medicaid Managed Care Organizations (MCOs) have been operating for decades now, they are still expanding their members and reach. Growth areas include Medicaid Expansion and the aged, blind and disabled (ABD) populations. Previously focused on those eligible for, and enrolled in, Medicaid through the Temporary Assistance for Needy Families (TANF) program consisting of generally healthier women and children, the MCOs are now aggressively entering the ABD and Dual Special Needs Plan (D-SNP) populations. This represents an opportunity to provide enhanced services to MCOs as these patient populations need intensive supports to coordinate care and optimize medication use.

MCO penetration in more complex patient populations introduces and intersects care management with population health workforces, and aligns with community-based pharmacies' desire to support those workforces with pharmacy-provided enhanced services.

Effects of Part D, MA and MCO Pharmacy Benefit Managers on Pharmacy Providers

Fee-For-Service Medicaid has historically been a favorable payer for community-based pharmacies. Prior to Medicare Part D programs, Medicare-eligible patients paid out of pocket for their medications, creating similarly favorable margins for product reimbursement. However, the entry of Part D, growth of Medicare Advantage (MA) and expansion of MCOs into high medication-taking populations in Medicaid have placed great strain on community-based pharmacies through narrow networks, lower reimbursements, claw backs (i.e., taking money back), and delayed payment or cross-class rate setting strategies employed by the PBMs. These strategies were nearly non-existent prior to Part D and MCO entries into complex populations. Further complicating these factors is the escalating pre-rebate cost trends of prescription drugs, resulting in initiatives which often negatively impact community-based pharmacies' revenues.

Vertical Integration is Causing Horizontal Disruption

Financially co-dependent relationships between the PBMs and the MCOs, expressed through pharmaceutical manufacturer rebates in both Medicare and Medicaid, has created an uneasy tension among MCOs who do not own their PBM. We encountered a surprising level of skepticism among the health plans of the fidelity of their contracted PBM to the plans' interests. Lack of financial transparency within manufacturers rebate agreements and PBM pharmacy self-channeling have generated conflict of interest concerns among the health plans. Most recently, concerns have emerged about PBM use of pharmacy data to compete with health plans who have contracted with them to provide PBM services. With all three major PBMs now merged with major medical insurers, the distrust between plans and PBMs seems to be growing. There is an emerging belief these vertically aligned entities are using their relationship to advantage themselves against their competitor MCOs who may be their PBM clients.

Growth of 340b "Carve-In" and "Carve-Out" Discussions

With widespread dissatisfaction in reimbursement rates and claw backs, pharmacies of all types (community-based, health system-based, FQHC-based, specialty) are all looking for means of reimbursement and revenue strategies that do not emanate from the PBM. The 340b program offers a widely-available means to participate in alternative pricing and reimbursement. The growth of 340b programs came both from health systems themselves becoming pharmacy providers and from the expansion of eligible participant pharmacies through "contract" pharmacy relationships. A significant number of pharmacies, both chain and independent, federally-qualified, or specialty would go out of business without access to 340b pricing. Greater utilization of 340b in Medicaid programs has accelerated greatly over the past decade, and is now starting to include Medicaid MCOs who want to share in the "savings" with pharmacy providers, health systems and other qualified entities.

Project Description and Implementation

Emergence of Accountable *Pharmacy* Organizations

The push for Pharmaceutical Care started in the 1980s,[7] yet the practice model languished as the business of pharmacy remained dominated by buying product from wholesalers and selling it with a product reimbursement margin to patients and/or their third party intermediaries. Much like the Patient Centered Medical Home movement for primary care providers, pharmacy practice transformation orienting toward clinical outcomes and population management has been a hard sell to a successful business enjoying a profitable fee-for-service environment. Since the ACA's push toward cost-containment through improved outcomes, providers have undertaken the steps to implement accountable care, including making investments in practice transformation and operationalizing the patient centered medical home. The practice model has followed the business model.

For pharmacies, the historical retailing business model has recently suffered as product reimbursement margins have approached acquisition costs, or in some situations, now produce negative margins. This occurred within the larger arc of retail moving away from community-based storefronts. This has led some pharmacies, who are services-capable and want to follow the medical model of accountable care, to form their own pharmacy versions of accountable care models – APOs. Clinically-integrated, accountable care is appealing to pharmacies because it allows pharmacy providers to self-organize and choose with whom they want to organize and be held accountable with the ability to offer higher value services and be accountable for service delivery, these networks can collectively express value and enter into payer contracts for healthcare services, similar to how physicians and health systems contract and obtain reimbursement.

Project Goals

The project team sought to utilize a learning laboratory of more than 40 community-based, clinically-integrated pharmacy provider groupings that are within a nationwide APO framework. The members of this APO provide for an excellent testing ground as they commit to service sets (similar to what health care providers refer to as care pathways), data collection and transmission, quality assurance and minimum service standards that include medication synchronization, medication reconciliation, comprehensive medication reviews, immunizations, face-to-face counseling, adherence packaging and a number of screening, care management, population health, performance measurement, disease management and social supports screening services.

Key questions to be answered were as follows:

1. What are the Emerging Service Models Addressing Suboptimal Medication Use in Medicaid?
2. What are the Outcomes of Interest Expressed by Medicaid Plans and Stakeholders?
3. How can MCO's leverage community-based pharmacies longstanding community and patient relationships and operational infrastructures?
4. What is the Enhanced Services Posture of Pharmacy Sector Stakeholders in Medicaid?
5. What is the Role of Standards and Technology Solutions for Enhanced Services Delivery?

6. What are Opportunities and Barriers for community pharmacies that want to Provide Enhanced Services?
7. What is the Role and Relationship between Specialty Pharmacy and Community Pharmacy for Medicaid Recipients?
8. What is the re-emerging role of the 340b program in Medicaid and what are the latest trends in health care providers and provider-led health plans utilization of 340B programs in partnering with mail order, and perhaps community-based pharmacies?

Project Construction

CPESN, as the shared services entity for the more than 40 local APO chapters, contracted with a large and well-established consultancy with deep expertise in Managed Medicaid who maintained strong and varied relationships in multiple states. These consultants then worked with CPESN staff to engage the local APO chapters and strategize about approaching state administrators, MCO personnel, integrated delivery networks and physician ACOs around Medicaid opportunities to provide community-based pharmacy enhanced services.

Project Team

The Executive Director of the nationwide, clinically integrated APO with experience in Patient Centered Medical Homes, care management and population management was paired up with a Consultant who was previously a Chief Medical Officer in a large Medicaid MCO to engage Medicaid Administrators, MCO staff and other Medicaid stakeholders over a 6 month period. Consultants with relationships in their resident geography from time to time were also tasked with engaging Medicaid stakeholders in their catchment or responsibility areas. Additionally, local APO personnel were tasked from time to time to initiate engagements with payers, purchasers or partners of the APO.

Non-PBM Payer, Purchaser and Partner Engagements

The project team was specifically charged with generating medical side, care management payer, purchaser and partner engagements. These engagements were independent of existing Pharmacy/PBM/MCO relationships and conventional drug product reimbursement and contracting. The APO is specifically focused on delivering enhanced services offerings that are measured on clinical outcomes and provide care team supports. Often these services are focused on areas of activity which are challenging for MCOs to have meaningful impacts using their own personnel and systems of care.

Emerging Service Models Addressing Suboptimal Medication Use

Care Management is a Mature Construct in Medicaid Programs

Generally speaking, most Medicaid programs spend significant time and resources attempting to improve population health through care management supports. Care management services may range from discharge coordination, to in-home assessments, to personal care services, to health home[a] services, to behavioral supports, to medication reconciliation and adherence coaching. Care managers, patient navigators and community health workers constitute a considerable investment for most MCOs.

Optimizing Medication Use Remains a Challenge

Care management resources, though, are often not adequately trained in recognizing sub-optimal drug use nor accessible for face-to-face encounters with MCOs enrollees. A high proportion of MCO-provided care management personnel weave medication reconciliation or integrate adherence coaching into their care management activities, yet those interventions are often limited in depth and intensity. When MCOs do place personnel in the community, they tend to have a more limited knowledge base and experience, applying clinical judgment to drug regimen reviews and side effect recognition compared to their call-center based pharmacist colleagues. Currently, very few Medicaid-supported, pharmacist-provided services are delivered in the community.

Pharmacy-Provided Medication Therapy Management Less Prominent in Medicaid

Medication Therapy Management (MTM) is provided for, and required by, Medicare for Part D Plans and Medicare Advantage Plans. However, MTM is almost non-existent or minimally effective as currently administered in Medicaid programs due to a number of factors.

During the project, state administrators sometimes expressed an initial concern that pharmacy-provided services could be redundant to medication coordination services provided by nurses, social workers and other care management personnel. Medicaid programs most commonly view the management of the pharmacy network as contained entirely within the pharmacy benefit manager and believe that adequate services are provided through Drug Utilization Review or formulary enforcement opportunities. Importantly, these activities allow limited opportunity for enhanced services-providing pharmacies to differentiate themselves from other pharmacies. One of the goals of this project was to broaden the plans' expectations of the range and depth of services provided by pharmacies.

Historically, it has been uncommon for PBMs or health plans to view the community-based pharmacy as a healthcare service provider that transcends the prescription fill. Existing, conventional pharmacy programs are largely driven by the pharmacy administrator or pharmacy benefit manager, who typically derives no benefit from better clinical outcomes or economic outcomes produced by pharmacy-provided enhanced

a Health Home is a CMS-funded care coordination model.

services. This creates a misalignment between the PBMs' outcomes of interest and the community-based pharmacies' expression of value. This was the main reason the project team chose to approach non-PBM stakeholders about considering purchase of pharmacy-provided enhanced services, with a focus on physician and care management executive engagements.

Clinical Pharmacist Models Are Present but Remain Nascent

A few states' pharmacy advocates have been successful in passing state laws, submitting 1115b Medicaid waivers, or making rule changes to allow the pharmacist to be a "provider" who can charge for their services. Tennessee, Michigan, Minnesota, and Wisconsin maintain billable opportunities with Medicaid programs, with Washington and California soon to follow. Also emerging are health system pharmacists' ability to bill for clinical or enhanced services. Unfortunately, these opportunities are often limited to narrow billing and credentialing privileges that advantage those with proximity to physicians and common employment to a practice. Broadly speaking, the accessibility of these billable services among Medicaid programs for pharmacists who practice in community pharmacies remains small in number, though growing.

Community Pharmacies Becoming Recognized for Their High Touch Environment

As health reform, population management and medical model ACOs grow and health system reform begins to put providers partially or completely at risk, ACOs have looked to care management or care management-like staff and infrastructure to "fill the interstitial space" by engaging, tracking, coordinating care and filling care gaps. This is typically achieved either through call centers or, less frequently with personnel embedded in the clinic or at the hospital during patient discharge.

However, as time passed, ACOs, Integrated Delivery Networks (IDNs/health systems) and even MCOs began to realize that a high-touch, engaging environment with an interventionist who has broad knowledge of medication use is essential to program performance and meeting contractual deliverables. Indeed, 27 of the 33 original Medicare ACO measures are either directly or indirectly influenced by optimizing medication use.

The Rise of Community Pharmacy Care Management

During the project team's engagements, ACOs, IDNs, MCOs, and State Administrators acknowledged the high cost of "new stack" divisions of care managers and other population management personnel that were created in response to accountable care and at-risk contracting. They were open to the notion of utilizing community-based pharmacy for care management or care management-like services both as stand-alone offerings as well as in support of existing care management personnel. Some stakeholders and executives were enamored with the idea of using community pharmacies as a "force multiplier" for their care management teams. Many qualities of a community-based pharmacy are appealing to the cost-effective execution of care management:

- Pharmacies encounter complex patients up to 10 times more often than care managers or primary care
- Pharmacists and their staff have broad knowledge of medications, common misuse, and pragmatic and cost-effective solutioning capabilities

- Pharmacies tend to have much higher engagement rates and more accurate banks of phone numbers
- Some pharmacists and their staff are becoming ever more willing to practice more like care managers with special medication and mediation use knowledge
- Pharmacies have ready access to homes and established travel logistics as many of them have been home delivering medications for decades

Hybrid Mail Order, Call Center and Care Management Services

Just as community pharmacies contemplate providing care management services, some care management entities are considering providing pharmacy services. Care management entities are now realizing the structural advantage of community-based pharmacies' high-touch, medication-centric environment to providing cost and time-efficient care management services. This realization has stimulated a number of start-up companies that blend mail order, community social determinants supports, and care management operations into a single business. The marketplace is at an odd juncture where pharmacies are now wanting to get into the care management space at the same time care management wants to get into the pharmacy space, all with an eye on improving performance metrics related to medication use in a manner and performance not previously achieved by conventional approaches.

Outcomes of Interest Expressed by Plans and Stakeholders

Stakeholders in Medicaid are More Varied

Unlike commercial group, self-insured, and non-dual Medicare populations who are more homogenous in their respective enrollment and medical complexity, Medicaid has patient populations of all ages, conditions and disabilities. This results in varied and diverse outcomes of interest that reflect Medicaid's diverse charge, from mostly healthy women and children in the TANF population, whose quality of care may be reflected by well-child checks, screenings and childhood immunizations and pregnancy outcomes, to the Aged, Blind and Disabled (ABD) enrollees, who range from the elderly poor to homebound to the severely mentally ill with a focus on emergency room visits, polypharmacy or readmission rates. Medicaid's diversity of patient populations generates an even more diverse set of stakeholders with diverse sets of outcomes of interest.

Providers of Care in Medicaid are More Varied

Diverse populations with diverse needs require diverse sets of providers, para-professionals, housing needs and structures to address social determinants of health, necessitating multiple forms and types of care management. With respect to medication management services, nearly all of these types of patients need some version and level of intensity of medication optimization through regimen reviews by nurses and physicians to coaching by social workers and patient navigators. Community-based pharmacies are well positioned to support all of these care team actors.

Outcomes of Interest in Medicaid are More Varied

Outcomes of interest vary by state and are often reflected in revenue withhold percentages or membership allocation within MCO contracts. Financial withhold or membership assignment incentive outcome targets are generally HEDIS or HEDIS-like-aligning with an individual state's priority areas. Topics most often focus on clinical or financial areas, however more focus has been seen recently on consumer satisfaction. Some common examples of Medicaid outcomes of interest include:

- Heart Failure Readmission Rate
- Reduce the Percent of Asthma-Related Emergency Department Visits
- Asthma in Young Adults Admission Rate
- Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate
- Use of Opioids at High Dose
- Tobacco Use – Screening and Cessation
- Controlling High Blood Pressure
- Therapy for Patients with Diabetes or Cardiovascular Disease
- Comprehensive Diabetes Care
- Medication Management for People with Asthma

- Antidepressant Medication Management
- LDL-C Control (<100 mg/dl)
- Depression Screening and Follow-Up for Adolescents and Adults
- Depression Remission or Response for Adolescents or Adults
- Concurrent Use of Opioids and Benzodiazepines
- Medication Adherence
- Consumer satisfaction (CAHPS)
- Medical Assistance with Smoking and Tobacco Use Cessation
- Adherence to Antipsychotic Medication
- Antidepressant Medication Management
- Follow-Up After Hospitalization for Mental Illness
- Use of Multiple Concurrent Antipsychotics in Children
- Childhood and Adolescent Immunizations
- Medication Reconciliation Post Discharge

Payer Engagements Avoided Conventional Pharmacy Measures, Plans Interested in Clinical Data from the Pharmacy

During the MCO engagements, most plans were interested in utilizing the APO's clinical data as a means to ensure quality and demonstrate effectiveness rather than rely on conventional claims-based pharmacy measures, such as Proportion of Days Covered, that are mandated in Medicare Part D and Medicare Advantage programs. Plans also expressed an interest in using APO clinical and care plan data to enhance coordination of care supports within their in-house care management teams. Plans consistently sought provider clinical data to demonstrate value and social determinants, health status, disposition and telecommunications contact data to improve their care management delivery efficiency and, ultimately, its cost-effectiveness. In addition to APO clinical data, plans also expressed a desire to utilize pharmacies to improve HEDIS and HEDIS-like measures.

APOs unique data collection practices and utilization of the Pharmacist electronic Care Plan (PeCP) HL7 standard includes data not previously collected or accessible by State's and MCOs including:

- Health Concerns
- Patient Goals
- Drug Therapy Problems
- Active Medication List (regardless of where filled)
- Plan of Care
- Vitals
- Laboratory Results

The HL7 standard utilizes SNOMED CT codes which are non-proprietary but easily used for adjudication of claims and/or invoicing.

Plans Avoided Using Pharmacy Systems of Adjudication, Have Low Interest in Current NCPDP Standards

There wasn't a single payer, purchaser or partner engagement that directed the project team to contemplate how to submit claims or clinical data through conventional pharmacy claims routes using MTM or other codes in the NCPDP standards. This demonstrates the level of disconnect on provider and payment reform between the non-pharmacy (medical) and pharmacy domains within the current healthcare system of financing and delivery.

As time passes, and the community pharmacy care management and enhanced services marketplace matures, the types of data collected within the Pharmacist electronic Care Plan (PeCP) should closer align with types of information MCOs have to report to state Medicaid departments and accreditation entities, such as NCQA, to demonstrate meaningful outcome improvement in the areas the health plans are measured and financially rewarded.

National Consensus and Consolidation of Outcome Measures will be Difficult

Owed to the diversity of providers and outcomes of interest expressed by the states, national consensus and consolidation of outcomes measures will be difficult. In all of the project's payer engagements, very little convergence of outcomes of interest occurred, and often there was disparate, even grossly conflicted outcomes of interest within the same plan, expressed separately in different divisions within the company.

Not surprisingly, the pharmacy benefit side of the company (or contracted PBM) is mostly motivated by manufacturer rebates, self-channeling for dispensing market share, generic efficiency rate and using internal call centers to provide remote engagement services (and in the case of the dually-eligible, to address Comprehensive Medication Review (CMR) completion rates). The majority of state administrators or MCO staff had a limited working knowledge or interest to engage quality outcomes from the pharmacy benefit. Within the plans, non-pharmacy staff seem to have an entirely different set of outcomes of interest than their counterpart executives operating the pharmacy benefit.

Pharmacy Benefit Manager Outcomes of Interest

- Percent Mail Order In-House
- Generic Efficiency Rate
- Formulary Compliance
- Rebates Maximization
- Star Ratings (PDC, CMR completion) – Dually Eligible-Only

State Administrator Outcomes of Interest (non-Outpatient Pharmacy)

- Total Cost of Care (Fee-For-Service Model)
- Preventable Readmissions
- Access to Certain Services (Medication Assisted Treatment, Behavioral Health)
- Avoid Newspaper and Poor Coverage related to Budget and Poor Access
- Standardized Measures
- "Pet" or Advocacy Driven Measures from Political Appointee

MCO/Plan Outcomes of Interest

- Regulatory, Provider Agreement and State Contract Requirements
- Revenue or Membership Incentives or Penalties. These may reflect 1-5% of Capitation Payment
- Compliance
- Meaningful Access to Membership
- Care Manager Productivity
- Integration with Health Care System and Community
- Increasing Enrollment
- Good Press, Goodwill

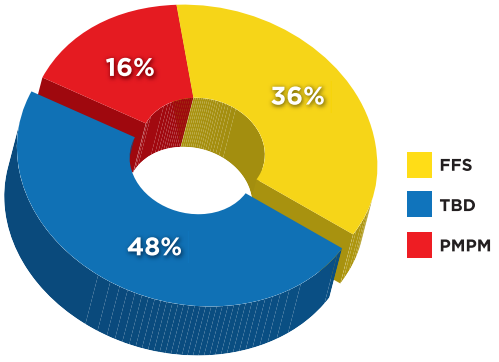
IDN/ACO Outcomes of Interest

- Maximizing 340b Pricing and Contracting
- Clinical Outcomes
- Reduce "Seepage" of Patients to Non-IDN, Non-ACO Providers

Divergent and Misaligned Outcomes of Interest and Business Models

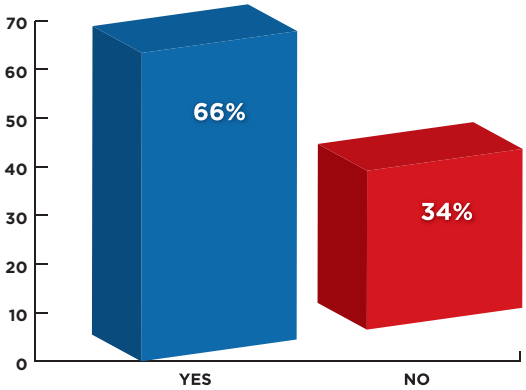
When interacting with Medicaid stakeholders, there was a remarkable divergence and oftentimes lack of alignment between the above stakeholders' outcomes of interest. This may help policymakers better understand why pharmacy quality improvement and integration with care team members outside of the pharmacy sector has been so difficult. Divergent goals emanating from divergent business models continues to plague forward progress.

Chart 1. Type of Payment Model Utilized



FFS: Fee For Service; TBD: To Be Determined, Not Yet Decided or Contracted
PMPM: Per Member or Per Engaged Per Month

Chart 2. Are there Contract Measures and Pay for Performance Components?



Enhanced Services Posture of Some Pharmacy Benefit Managers

Initially, Pharmacy Benefit Managers were disinterested in community-pharmacy provided enhanced services, and they expressed a skepticism that APOs could impact their network-building business posture. Frequently, a challenging dynamic emerged wherein an APO pitching a PBM on services would be met with "we do that internally," again expressing a perception that APOs and PBMs are competing for the same space.

Interestingly, toward the end of the Project, many pass-through PBMs ("transparent PBMs") began to reach out to the APO and its local APO chapters about building-in enhanced services delivery into their offerings with states. This was the result of a number of MCOs who were leery of, or in outright legal fights, with their currently contracted non pass-through or vertically integrated PBMs. These MCOs were looking for alternatives to their currently contracted PBM. There seems to be a large divide emerging in PBM go-to-market and business plans between the historical approach of rebate-oriented business and revenue strategies versus services-oriented business and revenue strategies.

Enhanced Services Posture of the Medical Plan and Care Management Structures

MCOs and their Care Management infrastructures continue to receive increasing scrutiny on cost-effectiveness and connectedness to the communities they are contracted to serve, even in the case of IDNs and non-IDN ACOs. Recognizing community-based pharmacies as high-touch, care management-oriented, patient-engaging "eyes and ears" for the plans grew in appeal dramatically over the course of this project.

The project team had a near one hundred percent success rate in generating interest in working with community pharmacies from plan executives. It was the sense of the team that nobody had presented most of these MCO executives (and even state administrators) the notion of accountable pharmacy-based enhanced services and working with pharmacy providers outside of conventional outpatient pharmacy programs. Once presented with the idea, in almost all cases, the non-pharmacist staff expressed great interest. Generally speaking, if pharmacists who were engaged worked under the medical director or other non-PBM staff, they were amenable to the idea of working with APOs. If the pharmacists reported up through the PBM, or worked in another building separate from the medical, care management, or quality team, the pharmacists generally became a barrier to moving forward.

Since MCOs/IDNs/ACOs all are subject to performance measures, relating those measures to community pharmacy enhanced services was a successful means of generating APO program interest and contracting discussions. MCO executives acknowledged that plan measures would be improved by more optimal and continuously monitored medication use. For many of the plans the project team discussions were educational and triggered many "aha" moments for them as they suddenly realized the opportunity to partner with APOs to achieve their ends.

The APO concept was important to them, since low belief exists among most executives and plan personnel that community-pharmacies can actually deliver the services in a consistent and effective manner. APOs allow for scalable accountability of pharmacy providers. Interestingly, the same was said of the patient centered primary care medical home movement, yet that effort spurned the idea of ACOs forming on the medical side. Executives and state administrators who were being presented with the same approach expressed both praise and intrigue at the notion of accountable care on the pharmacy side (for the subset of pharmacy providers willing to go at risk and be held accountable).

While promising, the relationship between APO and Medicaid MCOs on the plan side remains early and ill-defined. There remain many barriers to scaling services and administrative economies of scale, including internal and external conflicts of interest between the plan's desire to engage APOs and the current PBM business model.

Enhanced Services Posture of the Pharmaceutical Manufacturer

Manufacturers are largely unaware of the APO movement. Often as large and complex organizations, there are multiple divisions and reporting verticals. One division or department within a manufacturer may be aware of emerging community-based pharmacy enhanced services and care models, while other divisions may be completely unaware.

Manufacturers will inevitably need to join in the accountable care and risk-sharing movement, and community-based pharmacy enhanced services would no doubt play a positive role. However, since 90% (and rising) of prescription fills are for generic medications, it isn't clear if manufacturers will elect to work with specialty pharmacies exclusively, as the relationship between manufacturers and community pharmacies continues to wane.

Role of Standards and Technology Solutions for Enhanced Services Delivery

Building out a Clinical Record "Owned" by the Pharmacy Provider

The emergence of clinical documentation in the community pharmacy user interface has been the most important evolution in community-based pharmacy practice in the past 5 years. Co-mingling dispensing workflows and information technology solutions with clinical documentation solutions is enabling community pharmacies for the first time to develop scalable and reliable health care services and supports.

Conjoint, community-based medication dispensing and health care service delivery is a unique capability that only community-based pharmacies can provide. Yet that potential is only realized when health information technology solutions that are designed for dispensing throughput become married with user interfaces and data stores that represent clinical throughput, such as scheduling patients and charting enhanced clinical and care managements services delivery.

Many APO stakeholders and pharmacy providers expressed a high level of frustration with existing Part D MTM program platforms and existing Medicaid program vendors where interventions and payment are part of IT systems that are not native to the pharmacy. Separate systems cause separate dispensing and clinical workflows. Lack of integrated dispensing and clinical IT solutions was identified by pharmacies as the single biggest barrier to performing enhanced services in all four states where Medicaid Fee-for-Service MTM programs exist.

HL7 eCare Plan Standard

The Pharmacist electronic Care Plan (PeCP) Standard is a Health Level 7 (HL7) international standard that is now on par with Continuity of Care Document (CCD). The CCD remains at the core of medical informatics, interoperability and health information exchange. The CCD is endorsed by United Stated Department of Health and Human Services through many meaningful use provisions and payment reform legislation and innovations models. The PeCP standard may become the core of pharmacy informatics related to clinical and enhanced pharmacy services. The PeCP is emerging as the pharmacy-side contemporary to the medical side CCD standard. Since the PeCP contains health concerns, patient goals, drug therapy problems, vitals, labs and plan of care (among many other fields), it has the requisite clinical data payload to facilitate coordinated care. It also contains payer identification fields and utilizes SNOMED CT (also HHS endorsed) to identify with precision the interventions and activities of the provider submitting the PeCP.

Most of our engagements with MCOs involved positive discussions about the PeCP. When community pharmacy care management was involved, it emerged as the desired vehicle for adjudicating payment to the pharmacy. The PeCP became a popular means by which to accomplish three ends simultaneously:
1) quality assurance of the intervention, 2) adjudication for payment, and 3) care coordination.

CPT 2 Codes

Current Procedural Terminology 2 codes have been developed on the medical side to bridge the gap on lab and quality metrics reporting to plans under pay for performance models on the medical side. Specific codes have been created to report specific lab results such as, "Patient has a HgA1c <7.0." CPT 2 codes hold promise for community-based pharmacies when participating in pay for performance related to biometrics including vitals and laboratory results.

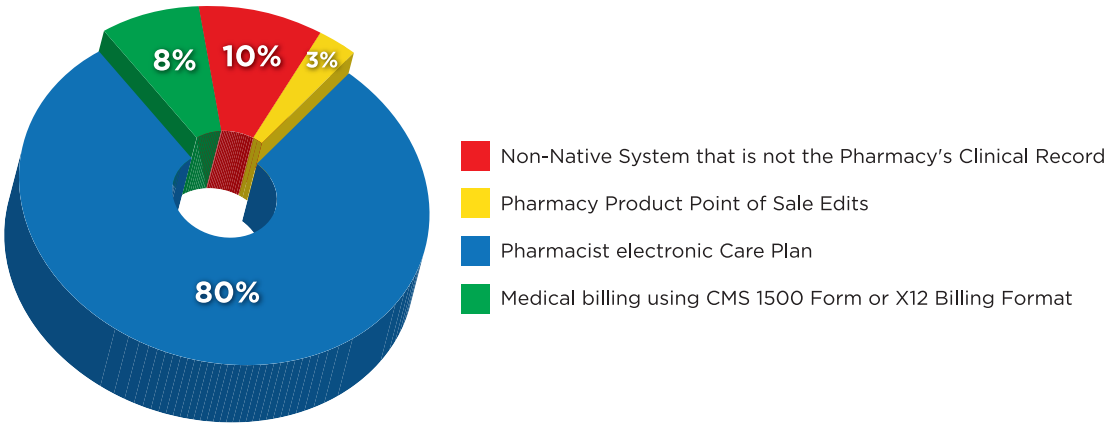
X12/HCFA 1500 Billing

A few of the plan and state administrator engagements favored the use of standard medical claims to adjudicate and administer payment for community pharmacies. Some of the PeCP solution providers have the ability to submit these types of claims, whereas some vendors do not, but allow for a faxed paper billing that gets converted to an electronic claim as an alternative.

Remote Care Delivery and Enhanced Services

Many of the plan engagements inquired about the ability for the pharmacy's delivery driver to digitally engage the pharmacist in the pharmacy in real time after a screening of the patient or otherwise happenstance discovery of a drug-related problem. Currently, none of the pharmacy technology solutions providers maintain an elegant video telepresence for pharmacy staff who are engaging patients outside of the physical walls of the pharmacy in the community. With this capability void, pharmacies are currently using a number of workarounds, including FaceTime and other non-native applications to accomplish this end. This is an area of health information technology that will no doubt grow and mature over time.

Chart 3. Type of Technology Deployed to Document Interventions and/or Bill for Services



Key Opportunities for Community-Based Pharmacy Enhanced Services Delivery

High Touch

Complex patients with multiple co-morbidities visit their primary care provider 3.5 times a year, on average generate 35 visits to the pharmacy in the same timeframe. Most care management encounters result in medication-oriented problem solving, while care and disease state management infrastructures often lack advanced training in pharmacy and therapeutics. As more APOs form, an increasingly willing and available workforce becomes capable of engaging the patient using the dispensing event as a prompt for other activities.

Relationship-Oriented

Arguably the single largest selling point among MCOs, when considered in combination with high touch environment, is the strong relationships that exist between community-based pharmacies and the patients in the communities they serve. The relationships are most prominent with sicker and more elderly patients that have longstanding trust with local pharmacies. It was widely acknowledged among the Medicaid stakeholders that community-based pharmacies have the largest and most accurate banks of phone numbers among health care team members, and enrollees tend to answer the phone when the pharmacy calls them.

Cost-Effective on Information Gathering, Social Determinants and Coaching

Through a convenience sample of pharmacies participating in the APO and extrapolating the findings across almost 2,000 pharmacies that participate, the project team estimates that the APO engages in roughly 1.7 million home encounters per month.

To better leverage these encounters, the APO has created community health worker training for pharmacy staff, including delivery drivers, and has engaged in general education about social determinants of health. The logistics of home encounters are well-suited for community-based pharmacies who provide enhanced services locally. Plans were interested in community-based pharmacies as cost-effective screeners and information gatherers. Medicaid stakeholders consistently expressed positive views of community-based pharmacy staff engaging in community health worker training and activities.

Growing Medical-Side Interest in Medication Expertise Related to Provider Performance Contracting

The project team's initial MCO encounters and, to a lesser extent state, IDN and ACO encounters, were often met with initial confusion about the role of community-based pharmacies outside of outpatient pharmacy programs and PBM networks. Yet without fail, as the project team educated the plans about the high-touch, trusted, relationship-oriented, care plan driven activities of the APO's participating pharmacies, increasing levels of interest were expressed in community-based pharmacies helping the plan

meet its contracted performance measures and care management obligations. Cost-effectiveness emerged as a common theme for care management supports.

Most often, the chief medical officer (CMO) was the plan executive with the greatest readiness and willingness to work with community-based pharmacies. The project team believed that this was owed to Medicaid stakeholders hiring CMOs with primary care practice experience, especially in family medicine, where there is often a greater appreciation for the important role of the local pharmacy than in other physician specialties. The team would often encounter CMOs and Medical Directors that would mention certain community-based pharmacies they used to work with when they trained or practiced, especially if that training or practice was in a rural area prior to their executive and state administrator positions.

Separating product reimbursement programming from enhanced services programming was another barrier that abated over time as the Medicaid stakeholder had more time to absorb the concept of an APO. Initially, many executives and stakeholders couldn't wrap their heads around how APOs could interact with PBMs and narrow pharmacy networks. The project team could often see a visible "aha" moment when they realized that the APO pharmacies would continue to participate in the PBM Network as they are now, and would simultaneously contract directly with the APO for accountable care oriented services. This realization was the single greatest accelerator to the contracting life cycle.

Locally Politically Active

Community-based pharmacies are connected to state and local politics and elected officials. Quite often the local pharmacy owner(s) are members of the Boards of the Chambers of Commerce, local Hospital, or School Board. One APO's state group organized a legislative educational campaign around community-based pharmacies and their provision of enhanced services with flyers and meetings with the theme *"Did you know?,"* educating and promoting the often unknown and un-recognized services that are delivered every day by APO participants. The strategy was much more successful than originally envisioned, with more than 15% of the legislature engaged for in-person meetings within 2 months of launching in their home districts.

Community-Based Pharmacist Willingness to Change Continues to Grow

As product reimbursement margins continue to decline and the need for highly engaging medication optimization services grows, an increasing number of community-based pharmacies have become more willing to engage in practice transformation efforts and enhanced services delivery. Not to support, but rather to supplant product reimbursement, a surprising number of APO pharmacy participants consistently expressed a willingness (and desire) to give up product reimbursement in favor of moving to services reimbursement strategies.

It was common for an APO pharmacy member to exclaim, "please get me out of this business. I want to keep dispensing, but without owning inventory or dealing with purchasing or selling drugs." This sentiment is reinforced by the now aggressive push by pharmacies of all types to engage in 340b contracting, which effectively eliminates buy-sell spread. The principal motivation among APO participants to provide enhanced services outside of their PBM contract was to avoid being subject to conventional PBM product reimbursement. One pharmacy summed it up well when describing reimbursement from a Medicare program of lifestyle management with patients. After her pharmacy received their first check for the services, she noted, "I received my first thousand dollar check today and there were no DIR fees," followed by "I loved working with the patients – I was meant to do this."

Key Barriers for Community-Based Pharmacy Enhanced Services Delivery

Building (Scalable) Practice and Information Technology Model from Scratch

The pharmacy sector has a long history of interoperability on product procurement and sale of medications and now near ubiquity with medication ordering (electronic prescribing). However, it is in its early stages of building and maintains a pharmacy-based clinical record. As an essential part of any healthcare service provider recognition, medical-legal and accountable care contracts, scalable APO engagements will languish as a set of one-off demonstrations without the continued evolution of pharmacy user interfaces that provide workflow at the patient-level, with the ability to send and receive clinical information for accountable care contracting. The PeCP holds promise with more than 10k submissions to the APO per month, but the industry must accelerate the use of scalable tools, such as the PeCP standard, to build a $100 billion pharmacy services industry from a $100 million Part D MTM industry that is mostly served by call centers.

Lack of Scaled Succession Planning

Community-based pharmacy owners are generally aging. The energy and forward-leaning entrepreneurship that comes with building-out and delivering enhanced services now includes younger men and women with socioeconomically and culturally diverse workforce. APOs are only relevant if there are enough community pharmacies providing enhanced services to cover large geographies and populations of interest for payers and insurance captives. A nationally-scaled succession plan is necessary to prevent the degradation of pharmacies that are rooted in their communities. The continued presence of these pharmacies and passing of the brand and community goodwill (community pharmacies' greatest asset) is essential for the survival of community-based pharmacy practice. Without succession planning, future APOs may not include pharmacies based in the community.

A Bottleneck in Community Pharmacy Residency Training Process and Sites

As the project team worked with more than 27 different APO chapters, it stumbled across a clearly observable trend. Nearly all of the pharmacist leadership within these APOs (numbering in the hundreds) were associated with community-pharmacy residencies. The current ASHP accreditation and operation of community-pharmacy residencies is cumbersome and unpopular among pharmacy sites and academicians alike. For community-based pharmacy to thrive and enhanced services delivery to become ubiquitous, hundreds more community-pharmacy residencies, with lower overhead and programming that is aligned with community-based pharmacy practice and business ownership skills, will need to be created.

Constrained Expression of Value Beyond the Pharmacy Benefit

"If 65,000 pharmacies cannot do it, no pharmacies are allowed to do it" has become the rallying cry for the APOs. Part D MTM and other prior efforts at pharmacy services marketplaces have been anything but marketplaces, often requiring a monolithic approach to program qualifications and deployment. This has led to a watering down of interventions, expectations and unwieldy documentation systems that represent the lowest common denominator of care delivery to be provided by all pharmacies, regardless of desire or capability. Absent the use of clinical data standards and data sharing, these programs will use IT systems that are out of community pharmacy workflow and disconnected from the community.

The expression of value in producing clinical outcomes via personalized, relationship-oriented, high-touch services is completely unrealized in the pharmacy benefit at current. As the outcomes of interest section above illustrates, different pharmacy stakeholders are asking for different points of value, with the health care services portion of that value being absent in the pharmacy benefit. Unless PBMs are asked to take on medical risk and clinical outcomes, community-based pharmacies must continue to seek value expression beyond the pharmacy benefit to survive. This project sought to learn from such explorations within Medicaid programs and populations.

Continued Growth in Conflicted Relationships in the Sector

Without question, the single biggest barrier to pharmacy services growth and community-based pharmacy sustainability is the complex web of conflicts of interest, mostly borne through rebates and other monikers of the same (sharebacks, clawbacks, service fees and other names) for money reverting back to a trading partner after the purchasing transaction to avoid disclosure of pricing and business relationships. The project team frequently observed examples of plans being frustrated with their contracted PBM, or even their wholly owned or merged PBMs. The most commonly observed conflict of interest was the plan's desire to work with an APO on enhanced services, wherein the plan's contracted PBM stepped in to block the progression of the enhanced services program relationship and contracting to favor their in-house programs. The second most common conflict of interest were special revenue deals co-mingled with rebates that required the plan to channel patients and programs to the PBM's in-house pharmacy.

Specialty Pharmacy and Its Relationship with Community-Based Pharmacy

Two Percent of Fills but 50% of Medication Spend

Specialty pharmacy will comprise roughly 2% of this year's prescription fills, yet eclipse more than 50% of the costs across all plans of all types. Community-based pharmacies, despite their local presence and advantages enumerated prior, are largely locked out from specialty pharmacy participation with PBM-operated pharmacies and health systems pharmacies taking most of the business. Specialty pharmacy in Medicaid programs offers slightly more flexibility in some states for community-based pharmacies to participate, but that opportunity continues to shrink as MCO contracted PBMs delve further into becoming the dominant specialty pharmacy provider for their plan clients.

Filling "The Last Mile" Services Gap

On at least two occasions, specialty pharmacies that were not community-based approached the project team proposing a relationship with APO pharmacies wherein the specialty pharmacy becomes the dispensing pharmacy of record, but utilizes local pharmacies for counseling, monitoring, follow-up and information gathering.

In Desperate Need of a Manufacturer Outcomes-Based Contracting Model

The rebates-fueled relationships between various supply chain and third-party actors and manufacturers is having a devastating effect on community-based pharmacies downstream. If community pharmacies, through APOs, could establish direct contracting relationships with manufacturers for fair market value or, in combination with insurers or employers or other purchasers, could establish performance-based services contracts, it may ameliorate or otherwise set aside the ill effects of the rebates since the progenitor of them can adjust them based on, and motivated by, outcomes based contracting with purchasers (employers, insurers, taxpayer-public insurance).

What's Next?
Enhanced Services and Value-Based Payments in 2025

Product Reimbursement Continues to Decline, Becomes Unsustainable

Community-based pharmacy, despite great potential value expression, will ultimately yield to unsustainable product reimbursement. PSAO facilitated contracts for 2021 are suspected to be even worse than 2020, which were much worse than in 2019. Despite this unsustainable trajectory, there was a clear and present interest and belief in the potential value of community-based pharmacy expressed by Medicaid stakeholders and plans. However, the opportunity remains difficult to deploy with significant scale at this early stage in the market for pharmacy-provided enhanced services. It appears that there is a two to five year window to transform community-based pharmacy practice and reimbursement. Without this evolution, community based pharmacy practice will struggle to survive.

Pressure to Create Alternative Contracting Grows

All pharmacies not owned by a PBM and/or a Plan are looking for alternative contracting, and Medicaid has become a supple environment for experimenting with such opportunites. Very few conversations came to light that discussed product reimbursement during the project teams' interactions with Medicaid plans and non-PBM stakeholders. There was a clear desire to collaborate with, and pay community pharmacies for, non-dispensing services, but a lack of clarity on how to proceed to contracting. There was a remarkable openness to alternative contracting, despite the unconventional nature of MCOs contracting directly with pharmacies through the APO and lack of established means by which to do that contracting.

Pressure to Move Beyond Pharmacy Claims-Based Outcomes Measures Grows

There is growing anxiety about the pharmacy sector's current inability to measure community pharmacy quality in terms the medical benefit and health care purchasers generally consider important. A recent Pharmacy Quality Alliance (PQA) emergency meeting was convened to discuss the development and deployment of pharmacy-level measures. The Project team would agree with PQA's haste in moving forward on developing clinical measures, such as mmHg and A1c.

Aside from some select Medicare Advantage programs with dually-eligible Medicaid enrollees, none of our engagements with payers and purchasers of Medicaid services were interested in using the existing pharmacy-claims based quality measures used by Medicare Part D and Medicare advantage for their performance contracting with pharmacies. Clinical measures and process measures were most commonly desired. Humanistic and economic were the second most common group.

Pharmacy-Operated Accountable Networks Grow

As more pharmacies continue to operate businesses with an unsustainable product reimbursement model, the only alternative to sale or closure may be to join an APO, or, become an APO in the case of a chain of

pharmacies with common ownership. Pharmacies will need to follow the medical model and aggregate themselves to be able to execute single-signature contracts based on population management services and performance guarantees with their peer pharmacies. In the absence of an APO, there is no ability for smaller, community-based pharmacies to express their value.

Corporately-Owned and Operated Service Networks Grow

Startup mail order pharmacies, through aggressive marketing, 340b contracting and other PBM work arounds or creative business relationships, are looking for accelerated means of growing for exit (company sale) opportunities. The Project team observed three startups during the project period focused specifically on Medicaid enrollees, all focused on 340b contracts as a means of alternative contracting and penetrating markets across the United States.

Technology solutions providers (both startup and established) have developed call-center based services that utilize community-based pharmacy data to develop services for sale, including those seeking better star ratings or manufacturer-sponsored adherence programs. It's too early to tell if these solutions will buttress community-based pharmacy's ability to establish better and more efficient enhanced services solutions, or create dependencies and PBM-middlemen-like relationships by having the technology solution provider sit between the provider (pharmacy) and the purchaser (payer, plan, partner). All indications are that this space continues to accelerate with growing venture capital investments in start-ups that directly or indirectly compete with community-based pharmacies.

Key Learnings

Medicaid Has Become an Important Laboratory

Medicaid has become a popular testing ground for new and emerging models of enhanced services delivery, medication use supports, community partnering and alternative payment models. Unlike Medicare policy, Medicaid policy is generally built at the state level with federal approval, so local legislators and state administrators have a high level of influence on services and payment, allowing for locally conceived innovations. MCOs are often given considerable latitude from state Medicaid departments and MCOs are rewarded by state Medicaid agencies for being innovative. This has resulted in a diverse set of approaches to addressing sub-optimal medication use, differing from state to state and in some situations, county by county.

Medicaid programs also have a disproportionate number of highly complex patients with multiple medications complicated often by living within difficult social environments in need of support services compared to their commercial and employed plan counterparts, fueling the demand for innovations that address optimal medication use through enhanced services. In addition, people living in these situations often have significant unmet population health and complex care needs. Most states also have some mix of fee-for-service and managed care that further encourages experimentation.

MCO Bidding Drives the Preponderance of Innovation

MCOs, both locally and nationally organized and operated, devote exceptionally high levels of time and resources to bidding cycles to procure and re-procure Medicaid business. It is during the Request for Proposals (RFPs) cycle of RFP anticipation, creation, announcement, bidding, and awarding that offers the greatest opportunity for pharmacy-provided enhanced services innovation and MCO responsiveness. In particular, the time period after a health plan becomes aware of an upcoming state Medicaid health plan RFP until the time health plans are drafting their RFP proposal response is generally the time when health plans are most interested in identifying capabilities to meet a known or anticipated RFP requirement or meeting a key priority of the state (e.g., opioid epidemic, infant mortality). States are generally more interested in a health plan's *actual* experience with an innovative process as compared with their *intention* to innovate by implementing a new program. Hence, MCOs having a history of enhanced services implementation and outcomes data to include in their RFP response provides a competitive advantage for the MCOs.

Legislatures and Personalities Also Drive Innovation

Individual legislators and state administrators can greatly influence RFP priority areas, construction bid cycles, waivers and Medicaid budgeting. The degree of individual influence versus a more collective influence varies considerably state-by-state. During the project, it was commonplace to encounter an advocacy-driven legislator, secretary, medical director or more quietly, a pharmacy director who may drive pharmacy-based enhanced services and value-based payment discussions. Though advocacy does properly occur outside of the Medicaid managed care procurement process, these individual expressions of support for community pharmacy-provided enhanced services often influence the RFP itself prior to the bidding process, as well as post-award implementation of these programs.

Pharmacy Enhanced Services Discussion is Noticeably Absent with Medicaid Pharmacy Benefit Managers

PBM mistrust and fatigue has clearly set in with state administrators, and even with executives and program managers within the MCOs who contract with, or own, their own PBMs. With an increasing trend for vertical integration between national health plans and PBMs, small to mid-sized community-based pharmacies are often financially and programmatically disadvantaged, despite large potential value expression to the MCO on the health plan side. There is a growing sentiment that these larger PBMs are misaligned with the overall goals of health plans and state Medicaid departments, especially as relates to health plan-side medical benefit and care management priorities. Oftentimes, Pharmacy directors on the PBM side of the business have a wholly different set of objectives and deliverables which do not align with the health plan's pharmacy Care Management, business development, performance improvement, population health and quality priorities.

Notably, the health plan priorities are often different state-to-state based on individual state Medicaid-directed programs with financial (e.g., pay-for-performance) and/or membership impacts for health plans (e.g., unassigned member auto-assignment). This further exacerbates the disconnect between the Plans and their PBMs since the PBMs tend to favor national-level measures. These misaligned priorities and allocation of resources may increasingly inhibit health plans' ability to successfully bid and procure business in competitive managed Medicaid environments. It isn't unusual for these entities to have different reporting structures and even residing in different buildings and cities. This has created palpable and occasionally overt tensions.

Medicaid Health Plan Care Management and Population Health Priorities is Driving Medication Management Services Discussions

A vacuum of meaningful, pharmacy-based medication management services has been created as a result of PBM mis-alignment with Medicaid health plans. This has resulted in health plans, and to a lesser extent, state Medicaid administrations, desiring to develop innovative medication management programs that successfully engage their membership. The breadth of activities and funding for medication management activities within population health, care management and care coordination sections of RFPs and State Medicaid Plan contracts far outpaces those found within the Pharmacy sections. This has resulted in both an opportunity for community-based pharmacies who are connected locally to members and enrollees, but also a challenge as these pharmacies have historically been ill-equipped to interact with traditional care management activities.

Notably, care management and care-management-like activities represent a more than $2:1 funding gap over outpatient pharmacy program budget lines after federal and supplemental rebates are considered. A plethora of services and supports by a variety of ancillary and para-professional services providers make upwards of a third of a given state's Medicaid expenditures (e.g., personal care services, adult care homes, care management). Care management and population health services are an entirely untapped marketplace for community-pharmacies and importantly, they are wholly outside the purview of the PBMs.

Outcome-Based Reimbursement Programs and Value-Based Purchasing Arrangements with Pharmaceutical Manufacturers Remains Nascent and Complex to Implement

Despite engagements across 27 states, only once did a conversation arise with the project team about outcome-based reimbursement arrangements with pharmaceutical manufacturers related to Hepatitis C courses of therapy. Another in a Midwest state came about with one of the APO chapters involving immunizations.

While arrangements between payers and manufacturers continues to grow slowly among commercial plans, they are nearly absent from public payers such as Medicaid. This may be owed to the relative contributions of cost borne by medications against other types of healthcare utilization. Medicaid programs generally spend less than 7% of their budget on outpatient pharmacy programs after rebates, whereas commercial plans can have upwards of 20-30% of their claims' expenditure emanating from medications after rebates. Regulatory limitations also become a barrier for publicly funded insurance such as Medicaid.

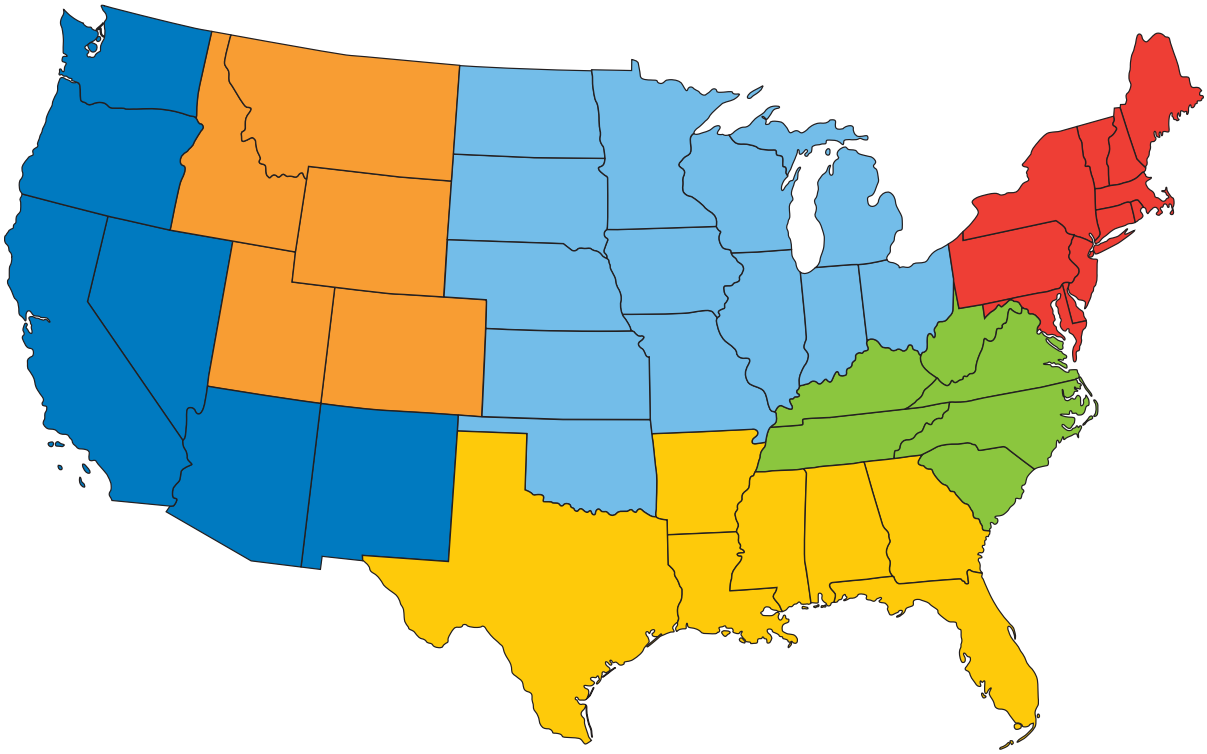
Specialty Pharmacy Is Prominent in Medicaid but Not Top of Mind as It Is for Non-Medicaid Payers

For complex children needing enzymes, gene therapies and other niche therapies for rare conditions, Medicaid continues to be the main utilizer for manufacturers, wholesalers and specialty pharmacies. Other conditions such as Hepatitis C, hemophilia, HIV and behavioral health (e.g., long-acting injectables) do have a strong presence in Medicaid. However, the proportion of dollars and administrative effort afforded to specialty pharmacy policy and network-building is much less in Medicaid than in Medicare, commercial/group or self-insured employers, where specialty pharmacy is top of mind every hour of every day for insurers, purchasers and/or their contracted administrators. The physicians drug program (the Medicaid equivalent of Part B for Medicaid) continues to grow but remains a small portion of the overall Medicaid budget spend. For community-based pharmacies, they are largely left out of the Specialty Pharmacy provider space either through PBM narrow networking, limited distribution channels, or competition with health system specialty prescribers seeking 340b savings. The project team did encounter a few emerging strategies for community-based pharmacies to participate in "last-mile" services on behalf of the specialty pharmacy provider.

340b Contracting is Beginning to Expand Again, and Medicaid has become the New Avenue for Growth

Later in the project, the team experienced a marked change in 340b activity with aggressive movement of 340b strategies into the Medicaid space. A number of central fill or mail order entities, some of whom utilize a local care manager-like workforce, are aggressively marketing 340b savings back to the qualified entity, and now the state administrator or MCO executives. This is a rapidly emerging trend that warrants close monitoring and additional discovery.

Appendix A:
Map of Medicaid Engagements by State and MCO Type



Region	State	Leg	NMCO	CP	IDN	ACO
South	□□□□		☆☆☆☆☆☆	◇		△
Southeast	□□□	⬡	☆☆☆☆☆☆☆		○	△△
Midwest	□□□□		☆☆☆☆☆☆☆☆	◇◇	○	△
Northeast	□□		☆☆☆	◇◇◇◇◇	○○	△
West			☆	◇◇		
Mountain				◇	○○	

□ **State** State Administrators
⬡ **Leg** State Legislature
☆ **NMCO** National Managed Care Organizations
◇ **CP** Community Plans
○ **IDN** Integrated Delivery Networks
△ **ACO** Accountable Care Organizations

Appendix B:
Case Studies: State Administrators and Legislators

State Administrators

CASE STUDY #1 *(Southeast)*

Population: Medicaid Enrollees

Intervention: Comprehensive Medication Review

Care Team Members: Pharmacy staff and physician office staff

Payment Model: Fee-for-Service

Performance Model: None

Technology: Pharmacies must log-in to a state purchased program for medication management documentation

Time Horizon: Program began in 2018 and has no end date

Important Insight: The state is paying a vendor to administer the program for both documentation as well as payment. This, in combination with the burdens of collaborative practice agreement requirements and low pay, are inhibiting program growth.

CASE STUDY #2 *(Midwest)*

Population: Medicaid Enrollees

Intervention: Medication Therapy Management

Care Team Members: None

Payment Model: Fee-for-Service

Performance Model: None

Technology: Pharmacies must log-in to a state purchased program for medication management documentation

Time Horizon: Program began in 2018 and has no end date

Important Insight: Much like the Southeastern state, the requirement to log into an external vendor versus using the care plan is a large program inhibitor.

CASE STUDY #3 *(Midwest)*

Population: Medicaid Enrollees with Hospital Discharge, two or more chronic conditions, or four or more medications

Intervention: Comprehensive Medication Review, with three follow ups

Care Team Members: Pharmacy staff only

Payment Model: Fee-for-Service

Performance Model: None

Technology: Much like the Southeastern state and Midwestern states, the requirement to log into an external vendor versus using the care plan, is a large program inhibitor.

Time Horizon: Program has been in place since 2008

Important Insight: This program, like others, has suffered from uptake by the pharmacy community. They cite the vendor-based platform as a big inhibitor of growth much like three other states.

CASE STUDY #4 *(Midwest)*

Population: Medicaid Enrollees

Intervention: Comprehensive Medication Review and follow-up

Care Team Members: Pharmacy staff only

Payment Model: Fee-for-Service

Performance Model: None

Technology: Pharmacies must log-in to a state purchased program for medication management documentation

Time Horizon: Program has been in place for more than three years

Important Insight: This is probably the best and easiest program for community-based pharmacies to participate in across the country and there is low participation on the part of the pharmacies. The APOs practice transformation effort will focus on increasing participation.

CASE STUDY #5 *(Midwest)*

Population: Female Medicaid Enrollees

Intervention: Screening and active intervention for HPV vaccination administration

Care Team Members: Follow up with state registry and primary care provider

Payment Model: Fee-for-Service

Performance Model: Passive, increase in rates of immunizations

Technology: Enhanced screening and point of sale edits to prompt pharmacy to action

Time Horizon: Begins this quarter

Important Insight: States may look to pharmacies to help solve quality care gaps after trying every other available avenue. The state is frustrated with lack of uptake in immunizations and is now looking to APO to partner to be a demonstration of success.

***CASE STUDY #6** (South)*

Population: Fee-for-Service Medicaid

Intervention: Community Pharmacy Care Coordination, Enhanced Medication Synchronization, home encounters

Care Team Members: Pharmacy staff only

Payment Model: Fee-for-Service

Performance Model: Clinical outcomes measures, proportion of days covered

Technology: eCare Plans

Time Horizon: The state has had two stakeholder meetings with very positive reception from the state administration

Important Insight: Fee-for-Service Medicaid is an area of opportunity for enhanced services experimentation since many states are very frustrated with their inability to have outpatient pharmacy programs that interact with the rest of the Medicaid program or produce and meaningful services. There is a desire to "do something different with pharmacy." However, Fee-for-Service Medicaid requires a lot of waiver, rulemaking and public stakeholder involvement which leads to very long sales cycles and time to contract/opportunity realization.

***CASE STUDY #7** (South)*

Population: Fee-for-Service Medicaid, MCOs

Intervention: Community Pharmacy Care Coordination, Disease State Management

Care Team Members: Pharmacy Staff

Payment Model: TBD

Performance Model: TBD

Technology: eCare Plans and others considered

Time Horizon: The state has engaged APO multiple times but has not been specific about next steps.

Important Insight: The APO lacks the experience and wherewithal to precipitate or compel the state administrators to specific program constructs and directives.

***CASE STUDY #8** (Northeast)*

Population: Fee-for-Service Medicaid, MCOs

Intervention: Community Pharmacy Care Coordination, Disease State Management

Care Team Members: Pharmacy staff, Home Health staff, eProvider-Plan and IDN-Plan entities

Payment Model: TBD

Performance Model: TBD

Technology: eCare Plans and others considered

Time Horizon: The state has engaged APO, a single encouraging meeting, but has not been specific about next steps.

Important Insight: The APO lacks the experience and wherewithal to precipitate or compel the state administrators to specific program constructs and directives. The most promising follow up from the meeting was an interest in rural health and access to community pharmacy enhanced services.

CASE STUDY #9 *(South)*

Population: Fee-for-Service Medicaid

Intervention: Community Pharmacy Care Coordination

Care Team Members: TBD

Payment Model: TBD

Performance Model: TBD

Technology: TBD

Time Horizon: The state has discussed with APO, but lost to follow-up

Important Insight: This state is a good example where the engagement with the state was promising until the RFP cycle was complete and awards had been sent. Now the APOs that are not engaged with the state are left to court the MCOs who received the award bid, but without any preparation or interaction with the APOs during the bidding process.

CASE STUDY #10 *(Southeast)*

Population: MCO Aged, Blind and Disabled

Intervention: Community Pharmacy Care Management, Social Determinants Screening

Care Team Members: Pharmacy Staff and Community Based Organizations

Payment Model: TBD

Performance Model: TBD

Technology: eCare Plan

Time Horizon: The state has discussed new programs with APO multiple times and is interested in coordinating with other states, is awaiting RFP cycle.

Important Insight: This state's APO has focused on Community Health Worker training with its participating pharmacies. That was appealing to the state as it broadened the enhanced services discussion well beyond the outpatient pharmacy program and thus engendered more meaningful cross departmental engagements, increasing the appeal for the pharmacy group to pursue a program. This dynamic is the opposite of the PBM-plan dynamic wherein pharmacy doesn't typically want other divisions involved in their work with pharmacies.

CASE STUDY #11 *(South)*

Population: MCO Aged, Blind and Disabled Fee-for-Service

Intervention: Community Pharmacy Care Management, Social Determinants Screening

Care Team Members: Pharmacy staff

Payment Model: Fee-for-Service

Performance Model: TBD

Technology: eCare Plan

Time Horizon: The state is going through an RFP MCO procurement and will re-visit the opportunity following the procurement

Important Insight: The Medical Director for the state sent an email to the MCOs saying "this is the most exciting thing I've seen in my time working for Medicaid."

CASE STUDY #12 *(Southeast)*

Population: Fee-for-Service Aged, Blind and Disabled

Intervention: Community Pharmacy Care Management, Social Determinants Screening

Care Team Members: Pharmacy Staff and Physician ACO

Payment Model: Risk Adjusted Performance, Adjusted Per Member Per Month

Performance Model: TBD

Technology: eCare Plan, Care Management System log in

Time Horizon: The state has discussed new programs with APO multiple time, is awaiting RFP cycle to revisit with FFS population. Is encouraging APO to contract with physician ACO.

Important Insight: The state enlisted a separate consultancy a few years ago and they discovered that the state was one of 41 states with PCCM Care Management payments still in their state plans and pharmacies could be eligible providers.

CASE STUDY #13 *(Northeast)*

Population: The state has three different MCO types

Intervention: Community Pharmacy Care Management

Care Team Members: Pharmacy staff

Payment Model: TBD

Performance Model: TBD

Technology: eCare Plan

Time Horizon: The state has discussed new programs with APO twice now and encouraged the APO to work with IDN MCOs, and their own managed care that the state is responsible for administering. Those discussions are ongoing.

Important Insight: This state has long-established multi-payer and pay for performance programs with MCOs, IDNs, and ACOs. That presents opportunities for community-based pharmacy value expression but creates a great deal of complexity for the APO to navigate.

State Legislators

CASE STUDY #1 *(Southeast)*

Population: Medicaid Aged, Blind and Disabled and TANF

Intervention: Multiple Enhanced Services (>30)

Care Team Members: Care Managers, Behavioral Health, Medication Assisted Treatment providers, Others

Payment Model: Unspecified

Performance Model: Accountable Care Organization Contracting

Technology: Unspecified

Time Horizon: Implement Enhanced services in the non-MCO population

Important Insight: Community-based pharmacies are exceptionally effective at local state legislator engagement. Every state legislator was contacted in this state for an in person meeting and over 50 engagements were promised and occurred within two months of the request. The focus was not on preventing anything from occurring (change in payment, new administrator, etc.) but rather a positive focus on "did you know" that local pharmacies provided enhanced services and explaining the care planning process and coordination with other care team members with de-identified case studies from their pharmacies in their local districts. The APOs believed it went so well that it is being planned in other states.

Appendix C:
Case Studies: Managed Care Organizations

National MCOs with Care Management Integration

CASE STUDY #1 *(Southeast)*

Population: Complex, mostly Aged, Blind and Disabled members identified by Medicaid MCO OR members identified by pharmacy with MCO approval

Intervention: Comprehensive assessment and care planning, to include medication synchronization, adherence packaging, home delivery and referral to MCO care management for social determinants of health when needed

Care Team Members: Pharmacy staff, MCO care managers, MCO pharmacy director

Payment Model: Per targeted and engaged patient per month

Performance Model: Performance payments based on rates of engagement of target members, patient satisfaction scores, quality reports, and MCO staff satisfaction scores

Technology: Use of HL7 Pharmacist Care Plan to convert to human-readable output and share with MCO care managers for quality and care coordination

Time Horizon: Contracted 12 month program which began in January 2019

Important Insight: While care planning (and related documentation) is a relatively new activity for community pharmacies, physicians and care managers have been care planning for years. This can create high standards for robust care plans beginning on day one of a new program. This requires pharmacies to very quickly progress through the learning curve.

CASE STUDY #2 *(Midwest)*

Population: Complex, high-risk members of a Medicaid MCO

Intervention: CPESN Community Pharmacy Care Management service set

Care Team Members: Pharmacy staff

Payment Model: Not yet known

Performance Model: Not yet known

Technology: HL7 Pharmacist Care Plan

Time Horizon: Plan recently went live; hope to implement CPESN program within 3-6 months

Important Insight: Medicaid MCOs coming into states with a recent history of MCOs leaving their contracts early are looking for unique strategies to manage the population and CPESN enhanced services are perceived to fill at least part of this need.

***CASE STUDY #3** (South)*

Population: Medicaid MCO members with a diagnosis of asthma and are either complex/high-risk or have history of asthma-related ED visits

Intervention: CPESN Asthma service set, medication synchronization, social determinants of health assessment, care planning

Care Team Members: Pharmacy staff with potential referral to health plan care management for social determinants of health concerns

Payment Model: Per targeted and engaged patient per quarter plus shared savings

Performance Model: Shared savings model based on reduction in asthma-related ED visits

Technology: HL7 Pharmacist Care Plan

Time Horizon: Contract awaiting state approval; program 12-18 months in duration

Important Insight: Not all Medicaid MCOs care about the same thing. Some want to understand the pharmacy intervention(s) involved in the program and monitor fidelity to that model. Others, like this one, simply want to see outcomes and are comfortable allowing the pharmacies to design and deploy an effective intervention.

***CASE STUDY #4** (Southeast)*

Population: Medicaid and D-SNP

Intervention: CPESN Diabetes Management, Community Pharmacy Care Management service sets

Care Team Members: Pharmacy staff

Payment Model: Not yet known

Performance Model: Not yet known

Technology: HL7 Pharmacist Care Plan

Time Horizon: Currently on hold awaiting the announcement of Medicaid MCO bid winners.

Important Insight: Traditional pharmacy interventions have centered around the PBM and "vendors." Some managed care plans have trouble figuring out how a pharmacy provider services network fits in with their other in-house, PBM, and vendor programs.

***CASE STUDY #5** (Midwest)*

Population: Medicaid and D-SNP

Intervention: CPESN Diabetes Management, Community Pharmacy Care Management service sets

Care Team Members: Pharmacy staff

Payment Model: Not yet known

Performance Model: Not yet known

Technology: HL7 Pharmacist Care Plan

Time Horizon: Currently on hold awaiting the announcement of Medicaid MCO bid winners.

Important Insight: Traditional pharmacy interventions have centered around the PBM and "vendors." Some managed care plans have trouble figuring out how a pharmacy provider services network fits in with their other in-house, PBM, and vendor programs.

***CASE STUDY #6** (Midwest)*

Population: D-SNP members

Intervention: CPESN Community Pharmacy Care Management

Care Team Members: Pharmacy staff

Payment Model: Not yet known

Performance Model: Not yet known

Technology: HL7 Pharmacist Care Plan

Time Horizon: Discussions on hold due to a recent departure of a key staff member and program advocate within the plan

Important Insight: Medicaid MCOs that also have D-SNP plans may find CPESN enhanced services even more valuable to D-SNP population than Medicaid ABD.

***CASE STUDY #7** (West)*

Population: TBD

Intervention: Community Pharmacy Care Management

Care Team Members: Care Managers

Payment Model: TBD

Performance Model: TBD

Technology: TBD

Time Horizon: Engagement is on hold owed to internal management changes and lack of Network adequacy/good member coverage on the part of the ACO Network.

Important Insight: No matter the value of the product and readiness to begin on the part of the provider(s), if there is internal unrest or key people are missing, forward progress is difficult.

***CASE STUDY #8** (Midwest)*

Population: Complex, mostly Aged, Blind and Disabled members identified by Medicaid MCO OR members identified by pharmacy with MCO approval

Intervention: Comprehensive assessment and care planning, to include medication synchronization, adherence packaging, home delivery and referral to MCO care management for social determinants of health when needed

Care Team Members: Pharmacy staff, MCO care managers, MCO pharmacy director

Payment Model: Per targeted and engaged patient per month

Performance Model: Performance payments based on rates of engagement of target members, patient satisfaction scores, quality reports, and MCO staff satisfaction scores

Technology: Use of HL7 Pharmacist Care Plan to convert to human-readable output and share with MCO care managers for quality and care coordination

Time Horizon: Contracted 12 month program to begin in this quarter.

Important Insight: This engagement was the first to achieve contracting that was replicated from another program in another state within the same National MCO. In order for APOs and the pharmacy healthcare services industry to flourish, more replicability and reproducibility of contracting and service standards like this engagement will need to grow and mature.

CASE STUDY #9 *(Midwest)*

Population: TBD

Intervention: Community Pharmacy Care Management

Care Team Members: Care Managers

Payment Model: TBD

Performance Model: TBD

Technology: TBD

Time Horizon: Engagement resulted in positive meetings but ceased after RPF awards released

Important Insight: Engagement was promising with care management and medical director leads engaged prior to the RFP submission and awarding process. Lesson learned is to have a solid Letter of Intent or something more binding or politically painful as a consequence for using APO to generate positive scoring and relationships with state government with no apparent intention to follow through after the Plan received the award/bid.

CASE STUDY #10 *(South)*

Population: TBD

Intervention: Community Pharmacy Care Management, MAT Supports

Care Team Members: Care Managers

Payment Model: Fee-for-Service

Performance Model: TBD

Technology: TBD

Time Horizon: Engagement resulted in positive meetings but ceased after RPF awards released.

Important Insight: Engagement was promising with care management and medical director leads engaged prior to the RFP submission and awarding process. Lesson learned is to have a solid Letter of Intent or something more binding or politically painful as a consequence for using APO to generate positive scoring and relationships with state government with no apparent intention to follow through after the Plan received the award/bid.

CASE STUDY #11 *(South)*

Population: Complex, mostly Aged, Blind and Disabled members identified by Medicaid MCO OR members identified by pharmacy with MCO approval

Intervention: Comprehensive assessment and care planning, to include medication synchronization, adherence packaging, home delivery and referral to MCO care management for social determinants of health when needed

Care Team Members: Pharmacy staff, MCO care managers, MCO pharmacy director

Payment Model: Per targeted and engaged patient per month

Performance Model: Performance payments based on rates of engagement of target members, patient satisfaction scores, quality reports, and MCO staff satisfaction scores

Technology: Use of HL7 Pharmacist Care Plan to convert to human-readable output and share with MCO care managers for quality and care coordination

Time Horizon: Waiting for appeals process to complete to start new performance cycles for MCOs

Important Insight: This is the third engagement with this national plan that has attempted to mimic prior program implementations in other states. While the plan is attempting to roll out in new states with consistency, the complexity and pace of rollout of this model is slow given the nascency of pharmacy and care manager coordination from a process and data and technology perspective.

CASE STUDY #12 *(Southeast)*

Population: Dual Special Needs (D-SNP)

Intervention: Community Pharmacy Care Management

Care Team Members: Care Managers

Payment Model: Per Member Per Month

Performance Model: Star Ratings based, Successful Engagements

Technology: TBD

Time Horizon: First quarter 2020 for MAPD plan year.

Important Insight: The local plan wants to move forward, and chief medical officer and care management leads have a strong belief in the value of community-based pharmacies being integrated into care their deployments. Pharmacy personnel have been noticeably absent, and the project team believes perhaps purposefully absent from the discussion to avoid conflicts or adding complexity and conflicts.

National MCO Models Without Care Management Integration

CASE STUDY #1 *(Southeast)*

Population: Diabetes management for patients with an A1c greater than 9.0

Intervention: Diabetes disease state management, medication synchronization, care planning and laboratory reporting

Care Team Members: Pharmacy staff and referrals to other MCO programs focused on high-risk members with diabetes

Payment Model: Per targeted and engaged patient per month with a performance guarantee.

Performance Model: Performance guarantee focused on the following measures: engagement of the target population, A1c reporting for target population, and achievement of A1c reduction

Technology: Use of HL7 eCare Plan Standard to document pharmacy care planning efforts

Time Horizon: In final contract negotiations, program scheduled to begin February 2020

Important Insight: Performance guarantee structure is very important to plan based on studies that show people try harder to keep what they have as compared to working to get something new or extra.

CASE STUDY #2 *(Southeast)*

Population: Medicaid MCO population

Intervention: CPESN Diabetes service set or other enhanced service aimed at improving clinical outcomes

Care Team Members: Pharmacy staff

Payment Model: Not yet known

Performance Model: The payer has a strong interest in a performance guarantee of some kind, but the program is not sufficiently scoped to have these details at this time

Technology: HL7 Pharmacist Care Plan

Time Horizon: Awaiting announcement of Medicaid MCO RFP in the state; still in discussion phases

Important Insight: The predominant proportion of Medicaid MCO members reside in urban areas but CPESN pharmacies are disproportionately rural in this state. The MCO requested that CPESN do a recruiting campaign in two metropolitan areas of this state.

CASE STUDY #3 *(Northeast)*

Population: Medicaid members who use tobacco but are open to cessation

Intervention: Tobacco cessation support

Care Team Members: Pharmacy staff

Payment Model: Unknown

Performance Model: Unknown

Technology: Care plan documentation and medical claims billing

Time Horizon: Currently contracted with one pharmacy as a pilot; plans to expand to rest of network upon successful completion of pilot

Important Insight: State Medicaid requirements or a focus on specific quality measures can create opportunity for pharmacy networks that are willing to be held accountable for performance and quality and/or fill a niche role like tobacco cessation.

CASE STUDY #4 *(Northeast)*

Population: Medicaid MCO members who meet certain criteria (poor adherence, asthma, complex/high risk)

Intervention: CPESN Asthma service set, medication synchronization, patient education and monitoring, motivational interviewing, comprehensive medication therapy review with care planning

Care Team Members: Pharmacy staff

Payment Model: Multiple payment models were considered

Performance Model: TBD

Technology: Unknown

Time Horizon: Discussions with this plan are currently stalled in one state due to inability to identify a performance-based program for the right disease state at the right price point for the plan; however, dialogue continues with this plan's Medicaid programs in at least 2 other states. Three different proposals have been vetted to date: an adherence program, an asthma program, and a comprehensive care planning program for complex, high-risk members.

Important Insight: TBD

CASE STUDY #5 *(Southeast)*

Population: Medicaid MCO members with poor adherence to medications, high-risk opioid use, or social determinants of health

Intervention: CPESN Opioid Patient Support service set; medication synchronization, adherence packaging, and home delivery bundled with social determinants of health assessment and referral

Care Team Members: Pharmacy staff

Payment Model: Not yet known

Performance Model: Not yet known, but likely based on medication adherence or utilization measures

Technology: Not yet known

Time Horizon: Program is in early discussion phases

Important Insight: Particularly with Medicaid populations, MCOs realize the potential limitations associated with PBM, vendor, or call center-based adherence initiatives.

***CASE STUDY #6** (Midwest)*

Population: Medicaid MCO members with suboptimal medication adherence

Intervention: Medication synchronization with adherence packaging

Care Team Members: Pharmacy staff

Payment Model: Fee-for-Service for each month of completed packaging

Performance Model: Not known

Technology: Medical-side billing (either manual CMS-1500 form or X12 electronic billing)

Time Horizon: Not known

Important Insight: This program was close to being contracted when the plan leadership thought it would be beneficial to pause and check in with their national representatives about potential CPESN relationships in other states (which number 10+ at the latest count).

***CASE STUDY #7** (Southeast)*

Population: Medicaid MCO members with high-risk opioid use or opioid use disorder

Intervention: To be determined, but likely similar to CPESN Opioid Patient Support service set

Care Team Members: Pharmacy staff

Payment Model: Not yet known

Performance Model: Not yet known

Technology: HL7 Pharmacist Care Plan

Time Horizon: Being scoped to go live at the same time the plan is implemented in this state (recently won managed care bid)

Important Insight: Support from the office of the CMO is critical for Medicaid MCO engagements.

***CASE STUDY #8** (Midwest)*

Population: Dually Eligible Part D Enrollees

Intervention: Enhanced Medication Therapy Management

Care Team Members: None

Payment Model: Fee-for-Service

Performance Model: Targeted Patients Completed (but no payment for performance)

Technology: Use of vendor technology platform

Time Horizon: Engagement is on hold owed to internal management changes and lack of Network adequacy/good member coverage on the part of the ACO Network.

Important Insight: No matter the value of the product and readiness to begin on the part of the provider(s), if there is internal unrest or key people are missing, forward progress is difficult.

***CASE STUDY #9** (Midwest)*

Population: Medicaid MAPD/Dually Eligible members who meet certain criteria (poor adherence, asthma, complex/high risk)

Intervention: CPESN Asthma service set, medication synchronization, patient education and monitoring, motivational interviewing, comprehensive medication therapy review with care planning

Care Team Members: Pharmacy staff

Payment Model: Multiple payment models were considered

Performance Model: TBD

Technology: Unknown

Time Horizon: Initial engagement ensued, but no follow up planned.

Important Insight: Discussions were promising with the quality director and the medical director but were derailed by an objection from their wholly owned PBM pharmacy director who announced during a planning call that the APO was competitive to their PBM business model.

***CASE STUDY #10** (South)*

Population: Medicaid MAPD/Dually Eligible members who meet certain criteria (poor adherence, asthma, complex/high risk)

Intervention: CPESN Asthma service set, medication synchronization, patient education and monitoring, motivational interviewing, comprehensive medication therapy review with care planning

Care Team Members: Pharmacy staff

Payment Model: Multiple payment models were considered

Performance Model: TBD

Technology: Unknown

Time Horizon: Initial engagement ensued, but no follow up planned

Important Insight: This experience followed a Midwest state that borders this state. Discussions were promising with the quality director and the medical director but were derailed by an objection from their wholly owned PBM pharmacy director who announced during a planning call that the APO was competitive to their PBM business model.

***CASE STUDY #11** (South)*

Population: Medicaid ABD

Intervention: Multiple service sets considered

Care Team Members: Multiple models were considered

Payment Model: Multiple payment models were considered

Performance Model: Multiple Performance models were considered

Technology: Not discussed

Time Horizon: Initial engagement ensued but follow up lost

Important Insight: This was a unique engagement in that the pharmacy director was very interested in contracting with the APO, even prior to this project as a new employee coming from a state that had Medicaid payment for enhanced services at his prior employment. However, after two weeks into the job, the project team never heard from him again.

CASE STUDY #12 *(South)*

Population: Medicare Advantage Dually Eligible

Intervention: Community Pharmacy Care Management

Care Team Members: Pharmacy staff

Payment Model: Fee-for-Service

Performance Model: Not yet known, but likely based on medication adherence or utilization measures

Technology: Not yet known

Time Horizon: Program was in contracting phases, but lost to follow up

Important Insight: This payer was engaged initially as a promise to pharmacies for past transgressions of the plan. The promise looked to be promising until the engagement stopped responding even though it has gotten to a final draft contract. The project team believes they contacted their parent company about the engagement and a conflict with the contracted PBM and rebate and channel incentives is inhibiting ongoing contracting discussions with this plan in multiple states.

CASE STUDY #13 *(Northeast)*

Population: Medicaid

Intervention: CPESN Diabetes Management, Community Pharmacy Care Management service sets

Care Team Members: Pharmacy staff

Payment Model: Fee-for-Service

Performance Model: Clinical Outcomes – Blood Pressure and A1c

Technology: eCare Plan

Time Horizon: On second contract with MCO for services

Important Insight: Even though the MCO is not integrating the pharmacy services with its own MCO care management staff, it is using dollars to fund the contracts from a care management pool of monies and considers the pharmacy activities care management.

Community Plans with Care Management Integration

CASE STUDY #1 *(Northeast)*

Population: Medicaid MCO members in 1 of 2 target populations: asthma and transitional care

Intervention: CPESN Asthma service set or transitional care

Care Team Members: Pharmacy staff and for transitional care program, collaboration with Medicaid MCO care managers that are based in hospitals

Payment Model: Not yet known

Performance Model: Not yet known

Technology: HL7 Pharmacist Care Plan; regional HIE

Time Horizon: Still in discussion phases

Important Insight: Individuals within payer organizations can be very enthusiastic about new provider engagements and contracts, but inevitably require a lot of vetting through nearly all divisions within the payer organization.

CASE STUDY #2 *(Midwest)*

Population: Medicaid MCO members in a regional geography

Intervention: Community Pharmacy Care Management

Care Team Members: Pharmacy staff and for transitional care program, collaboration with Medicaid MCO care managers

Payment Model: Not yet known

Performance Model: Not yet known

Technology: Not yet discussed

Time Horizon: Still in discussion phases as RFP cycle is upcoming

Important Insight: This is a state that has had MCOs for many years but a version that doesn't invite competition from out of state or region of state. That will change substantially with the new RFP and that has stimulated discussions with the MCO that were not existent prior to help the MCO be better positioned in the bid.

CASE STUDY #3 *(South)*

Population: Medicaid MCO members enrolled in plan

Intervention: Multiple service sets possible, none specifically discussed

Care Team Members: Multiple options, none specifically discussed

Payment Model: Not yet known

Performance Model: Not yet known

Technology: Not yet discussed

Time Horizon: None

Important Insight: The APO is actually a part of the joint venture with other provider types and has a seat on the Board. Despite that, the remarkably high level of consternation over product reimbursement has sidelined and delayed any forward movement on enhanced services. Top of mind for the APO with Medicaid is unseating existing PBM incumbents and passing legislation that prevents spread and self-dealing on the part of the PBM.

Community Plans Without Care Management Integration

CASE STUDY #1 *(Midwest)*

Population: Medicaid MCO members with uncontrolled diabetes

Intervention: CPESN Diabetes Management service set

Care Team Members: Pharmacy staff, potentially in conjunction with health plan care management

Payment Model: Not yet determined

Performance Model: Performance guarantee related to clinical outcomes

Technology: HL7 Pharmacist Care Plan

Time Horizon: Discussions recently resumed after a two month hiatus while the plan dealt with requirements and changes from the state. The plan has mentioned a potential program start date of January 2020.

Important Insight: Although CPESN programs are related to pharmacy service and not prescription fulfillment, bandwidth at the plan for any type of pharmacy-related item can be easily overtaken by prescription fulfillment changes (e.g., new state requirements for PBMs, extensive preferred drug list changes).

CASE STUDY #2 *(West)*

Population: Non-Institutionalized Medicaid with Chronic Disease

Intervention: Medication Reviews, Disease Management

Care Team Members: None identified

Payment Model: Fee-for-Service

Performance Model: Bonus for closing gaps

Technology: Desire for x12 standard claim to bill

Time Horizon: Sometime in 2021

Important Insight: This community plan has tried pharmacy networks in the past twice without good success. This time around they are interested in the idea of Accountable Pharmacy Organizations because of quality assurance increase and ability to single signature with a group of pharmacies or corporation willing to be measured as one. They also want to add/ensure a training component to entry into the program.

***CASE STUDY #3** (West)*

Population: Medicaid enrollees with Diabetes

Intervention: Disease State Management

Care Team Members: None identified

Payment Model: Fee-for-Service

Performance Model: Reduction in A1c

Technology: Medical claims billing

Time Horizon: Pilot by end of 2019

Important Insight: The pharmacy director didn't understand the concept of an APO and what it brought to the plan. This is juxtaposed to the typical Medical Director who consistently picked up on the concept of APOs in nearly every project team engagement.

***CASE STUDY #4** (Mountain)*

Population: TBD

Intervention: TBD

Care Team Members: TBD

Payment Model: TBD

Performance Model: TBD

Technology: TBD

Time Horizon: Legislature in disruption with current waiver and tabled engagement after expressing interest

Important Insight: Both RFP cycles as well as 1115b waivers generally can be both opportunities and distractions and delays for innovative programs.

***CASE STUDY #5** (Northeast)*

Population: Medicaid Demonstration Project Members

Intervention: CPESN Mental Health, Disease State and Medication Synchronization service sets

Care Team Members: Pharmacy Staff

Payment Model: Performance Based Payments on clinical outcomes

Performance Model: Performance guarantee related to clinical outcomes

Technology: HL7 Pharmacist Care Plan

Time Horizon: Two contracts completed

Important Insight: Community-based plans have a high level of appreciation for local provider relationships and partnerships.

***CASE STUDY #6** (Northeast)*

Population: Dually

Intervention: Activate Patients for medication adherence

Payment Model: Performance Based Payments on Proportion of Days Covered

Performance Model: Bonus model for positive PDC

Technology: None

Time Horizon: Pilot to launch in a month. Scale for 2020.

Important Insight: Plans have "unreachable" populations for their call centers and need assistance with "boots on the ground."

***CASE STUDY #7** (Northeast)*

Population: Complex Medicaid/Aged, Blind and Disabled

Intervention: Medication Synchronization plus clinical revive and adherence coaching

Payment Model: Referral model only

Performance Model: None identified

Technology: None identified

Time Horizon: Relationship exists but being disrupted

Important Insight: Large national mail order pharmacies who synchronize and offer compliance packaging are offering 340b savings to the MCO in order to generate referrals from the plan.

***CASE STUDY #8** (Northeast)*

Population: Patients at risk for Opioid Use Disorder

Intervention: Medication Assisted Treatment supports

Payment Model: Fee-for-Service

Performance Model: None identified

Technology: eCare Plan

Time Horizon: Two initial meetings to discuss but lost to follow up

Important Insight: The community plan was interested in the OUD program, but the project team believes that other providers the plan works with are sensitive to pharmacies getting into their provider space.

Appendix D:
Case Studies: Integrated Delivery Networks and Physician ACOs

Integrated Delivery Networks

CASE STUDY #1 *(Mountain)*

Population: All Medicaid enrollees

Intervention: Opioid use disorder, Rural Community Pharmacy Care Management

Care Team Members: TBD

Payment Model: TBD

Performance Model: TBD

Technology: eCare Plan

Time Horizon: IDN is waiting to rely on state value-based purchasing committee to take up pharmacy enhanced services for their next agenda item. Additionally, the IDN would like to see more pharmacies participating prior to contracting.

Important Insight: This IDN is a health system, a payer, and has more than 20 outpatient pharmacy sites. Yet it wants them to participate in the APO with non IDN sites as the system views local care delivery, even if potentially competitive to be positive and a better alternative to vertically integrated pharmacy solutions/companies.

CASE STUDY #2 *(Mountain)*

Population: All Medicaid enrollees

Intervention: Opioid use disorder, Rural Community Pharmacy Care Management

Care Team Members: Pharmacy staff in the IDN as well as the pharmacies, some potential for IDN care managers

Payment Model: Fee-for-Service

Performance Model: Hospital admissions, others considered

Technology: Not discussed

Time Horizon: Initial engagement lost to follow up

Important Insight: This IDN is a health system, a payer began to write the APO into its Medicaid RFP as care management, business development and medical were favorable of the partnership. Pharmacy was brought in two weeks prior to the RFP due date and engagement was lost. They mentioned troubles with community pharmacies in the past, but the project team suspects there were 340b motives for keeping pharmacy dispensing in house as much as possible.

***CASE STUDY #3** (Midwest)*

Population: Complex, high-risk members of a Medicaid MCO

Intervention: CPESN Community Pharmacy Care Management service set

Care Team Members: Pharmacy staff

Payment Model: Not yet known

Performance Model: Not yet known

Technology: HL7 Pharmacist Care Plan

Time Horizon: Initial engagement lost to follow up owed to inability to recruit sufficient participating pharmacies to cover their enrollees.

Important Insight: This was the first community pharmacy APO desert the project team encountered but proved fatal to the payer engagement as far too few pharmacies that provide enhanced services were in the Plans catchment area. This speaks to the need for APO network adequacy.

***CASE STUDY #4** (Southeast)*

Population: Patients being discharged, Disease State Management – Medicaid Included

Intervention: CPESN Disease State Management and Transitions of Care service sets

Care Team Members: Pharmacy staff in Community and in Primary Care Clinics

Payment Model: 340b funding for Fee-for-Service with Pay for Performance

Performance Model: IDN Metrics on Clinical, Economic and Hospitalization Outcomes

Technology: HL7 Pharmacist Care Plan

Time Horizon: First Quarter of 2020, but must have pharmacies get qualified

Important Insight: 340b was identified as the way to pay for services in the absence of a budget, inclusive of Medicaid plan (of their own)

***CASE STUDY #5** (Northeast)*

Population: Patients being discharged, Disease State Management – Medicaid Included

Intervention: CPESN Disease State Management and Transitions of Care service sets

Care Team Members: Pharmacy staff in Community and in Primary Care Clinics

Payment Model: 340b funding for Fee-for-Service with Pay for Performance

Performance Model: IDN Metrics on Clinical, Economic and Hospitalization Outcomes

Technology: HL7 Pharmacist Care Plan

Time Horizon: Unknown, third meeting scheduled

Important Insight: 340b has been identified as the way to pay for services as it is appealing to the health systems

***CASE STUDY #6** (Northeast)*

Population: Patients being discharged from hospital

Intervention: Transitions of Care service set

Care Team Members: Pharmacy staff in Community receiving referral from Care Managers at IDN

Payment Model: Fee-for-Service

Performance Model: None identified

Technology: None identified

Time Horizon: Project underway

Important Insight: IDNs are complex entities and getting to contract took many months and even when contracted, the roll out can be slow and laborious

Accountable Care Organizations

***CASE STUDY #1** (Southeast, Midwest)*

Population: Multi-Payer Type including Dually Eligible

Intervention: Five core service sets with advanced scope of practice activities

Care Team Members: Pharmacy staff, Clinical Pharmacist Staff, Primary Care Providers

Payment Model: Fee-for-Service

Performance Model: Not yet determined

Technology: eCare Plan with SNOMED coding and an ACO-Information Exchange with portal

Time Horizon: Pilot underway, contracting discussions ongoing for 2020

Important Insight: ACOs that are not IDN-based are good targets for community-based pharmacies to partner with culturally and neighborhood centric entities. However, they typically do not have the working capital or appetite to be a payer to other care team members. This ACO was atypical in that it is very aggressive and has built confidence in the APO owed to its comprehensive practice transformation project.

***CASE STUDY #2** (South)*

Population: Medicaid enrollees in Primary Care ACO

Intervention: Disease State Management, Care Management, Care Coordination

Care Team Members: Pharmacy staff, Primary Care, Plan Care Managers

Payment Model: Fee-for-Service with Pay for Performance

Performance Model: Mimic Primary Care ACO

Technology: eCare Plan, facsimile, Electronic Medical Record

Time Horizon: Deploy by first quarter 2020 if plan wins appeal after losing bid

Important Insight: This was a very unique program driven by a National MCO to help enhance their RFP bid. It would have a statewide independent PCP network working with and contracted with the Plan and the APO to deliver patient and plan outcomes as a dyad with shared revenue and shared savings.

CASE STUDY #3 *(Southeast)*

Population: Medicaid MCO Enrollees, Medicaid FFS, D-SNP

Intervention: Community Pharmacy Care Management, Social Determinants Screening, Patient Activation and Engagement

Care Team Members: Pharmacy staff, Clinical Pharmacist Staff, Primary Care Providers, ACO Care Managers

Payment Model: Fee-for-Service and Per Member Per Month

Performance Model: Not yet determined

Technology: eCare Plan, use of ACO care management system

Time Horizon: Q1 2020 launch concurrent with Medicaid Reform

Important Insight: ACO has expressed that it knows it will have trouble hitting patient activation and engagement targets and pharmacies can help their care management structures meet their contracted deliverables with up to six MCOs.

CASE STUDY #4 *(Northeast)*

Population: Medicaid MCO Enrollees as Part of ACO-Risk Capitation

Intervention: Community Pharmacy Care Management, Social Determinants Screening, Patient Activation and Engagement, MAT and Diabetes and Hypertension and Asthma Disease Management

Care Team Members: Pharmacy staff, Clinical Pharmacist Staff, Primary Care Providers, ACO Care Managers

Payment Model: Fee-for-Service and Per Member Per Month

Performance Model: Aligned with ACO performance measures, clinical and engagement oriented

Technology: eCare Plan, use of ACO care management system

Time Horizon: Concurrent with ACO-Capitation Program rollout

Important Insight: ACO has expressed desire to work with community-based pharmacies as it has aggregated community-based primary care providers and is culturally equivalent. ACO has little comparative care management infrastructure against National Plan call centers and locally based care management personnel as the IDNs maintain and sees pharmacies as a way to fill the void.

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