

Medicaid Pharmacy Benefit:

Carve-Outs and Unified Formularies/Preferred Drug Lists

BACKGROUND

Prescription drugs are an optional benefit in Medicaid, yet all states currently include pharmacy as a benefit in their Medicaid programs. In states with managed care, states can either include the pharmacy benefit within Medicaid managed care organization (MCO) contracts, known as a carved-in benefit, or they can manage the pharmacy benefit separately through a fee-for-service (FFS) model administered by the state or another entity, known as a pharmacy carve-out. States that include the pharmacy benefit in MCO contracts may also require MCOs to adhere to a unified formulary and/or preferred drug list (PDL) in an effort to create uniformity in the pharmacy benefit across MCOs.

Most states that contract with MCOs carve in Medicaid pharmacy benefits to MCO contracts. Of the 42 states that contract with MCOs, only 6 states currently use a pharmacy carve-out approach, and 17 states require MCOs to adhere to a unified PDL.¹ Recently, some states have shown interest in changing the management of the pharmacy benefit either by moving to a pharmacy carve-out or by moving to a single PDL. This is due to a number of factors, including political pressure and exploring options that could potentially save states money.

MHPA POSITION

MHPA supports integrated care delivery for the Medicaid pharmacy benefit. Pharmacy benefit carve-in models delivered through comprehensive risk-based Medicaid managed care support integrated care for the whole person resulting in improved health outcomes and cost savings. MHPA appreciates the budgetary pressure on State Medicaid programs; however, we believe that carving out the Medicaid pharmacy benefit from comprehensive risk-based Medicaid managed care contracts is not in the best interest of Medicaid beneficiaries nor a prudent decision for taxpayer dollars.

States considering Medicaid pharmacy carve-outs should reflect on the following considerations that underscore the consistent lack of evidence-based beneficiary and cost enhancements from carving out pharmacy services from managed Medicaid programs.

The quality of care delivery and experience of Medicaid beneficiaries is best served through “whole person” focused integrated care delivery models.

A hallmark of an integrated care model is “whole person” care informed by the seamless integration of medical and pharmacy services that helps promote a positive beneficiary experience, supports the delivery of quality health care, and results in reduced total costs.

MHPA is concerned that states that have implemented or that are moving toward a pharmacy carve-out model for their Medicaid program may not be taking important impacts on the quality of health care delivery into consideration including Care Coordination; Data, Communication & Efficiencies; Specialized Care; Specialty Drugs; and the impact on the Beneficiary Experience.

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«« Medicaid pharmacy benefit carve-outs are costly and not fiscally responsible for states with limited budgetary considerations.

An increasing number of states are seeking to implement budgetary cuts through programmatic changes to their Medicaid program that include carving out the Medicaid pharmacy benefit from Medicaid managed care arrangements. Given the cost effectiveness of integrated care models and several recent analyses comparing the cost savings attributable to carve-in models over carve-out models, MHPA is concerned that these states may not be properly assessing the fiscal impact of a Medicaid pharmacy carve-out.

«« Carve-outs do not help states address the generally rising costs of Medicaid pharmacy benefits or provide value-focused care to beneficiaries.

Pharmacy benefit carve-outs do not overcome the principal issue they purport to solve – the rising costs of pharmacy services for states and Medicaid

¹ Kaiser Family Foundation, 50-State Medicaid Budget Survey for FY 2021 and 2022, Oct. 2021, available at: <https://www.kff.org/report-section/states-respond-to-covid-19-challenges-but-also-take-advantage-of-new-opportunities-to-address-long-standing-issues-pharmacy/>; MHPA research, July 2022.

² <https://www.express-scripts.com/corporate/drug-trend-report#2019-by-the-numbers>

³ Analysis of Pharmacy Models for Missouri Medicaid. Missouri Managed Care Organizations, June 2020.

beneficiaries. Indeed, evidence suggests that pharmacy costs have substantially increased in recent years,² and states should not risk undue budgetary pressures and fiscal volatility resulting from carving out pharmacy services.

Rather, the use of integrated models drives risk for drug price fluctuation and rising drug costs away from state budgets, generating greater state budget certainties. Through an integrated model, MCOs are equipped to effectively manage rising pharmaceutical costs with the use of cost-effective, high-quality generics in lieu of brand name drugs. As many state Medicaid agencies seek to increase the role of innovative payment structures that tie provider reimbursement closer to value, moving the pharmacy benefit to an at-risk carve-in model provides additional opportunities to build value programs that include pharmacy management. These programs can usefully incorporate metrics regarding patient drug adherence to provide a measurement to align value-based reimbursement with targeted behaviors to drive better health outcomes.³

Additional state policy considerations and recommendations

«« States should examine the broader implications of carving out pharmacy services as related to beneficiary health outcomes, including impacts to public health, avoiding adverse drug interactions, and the opioid epidemic.

ABOUT MEDICAID HEALTH PLANS OF AMERICA (MHPA)

Founded in 1995, the Medicaid Health Plans of America (MHPA) represents the interests of the Medicaid managed care industry through advocacy and research to support innovative policy solutions that enhance the delivery of comprehensive, cost-effective, and quality health care for Medicaid enrollees. MHPA is the only national trade association with a sole focus on Medicaid, representing more than 130 managed care

organizations (MCOs) serving more than 48 million Medicaid beneficiaries in 40 states, the District of Columbia and Puerto Rico.

MHPA's members include both for-profit and non-profit, national and regional, as well as single-state health plans that compete in the Medicaid market.