The Menges Group

Strategic Health Policy & Care Coordination Consulting

Assessment of New Jersey's Medicaid Prescription Drug Management Performance and Policy Options

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Prepared for:
New Jersey Association of Health Plans

Prepared by:
Joel Menges, Amira Mouna, and Grace Williams

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I. Executive Summary

The Menges Group has been enlisted by the New Jersey Association of Health Plans to evaluate New Jersey's Medicaid prescription drug costs to assess:

a) The performance of the Department of Human Services (DHS) and Medicaid Managed Care Organizations (MCOs) in managing the pharmacy benefits costs to date.

b) The potential impacts of a pharmacy carve-out approach, whereby the prescription drug benefit would be removed from the MCOs' responsibility and paid for in the fee-for-service (FFS) setting.

c) The impacts of two potential policy changes including maintaining MCO responsibility for the prescription drug benefit but requiring the use of the same preferred drug list (PDL), and MCOs' mandatory use of a single Pharmacy Benefits Manager (PBM) subcontractor.

Our key findings are summarized below:

1. New Jersey has achieved strong Medicaid prescription drug management results to date. During FFY2019, New Jersey had the 4th lowest Medicaid net costs per prescription in the nation. This statistic captures the key financial aspects of drug benefit management – the initial payments to the pharmacy, the mix of drugs used, and the rebates received. The rebates include those required by the Affordable Care Act and any additional rebates negotiated by MCOs and the State of New Jersey. New Jersey's net cost per Medicaid prescription during FFY2019 ($26.35) is 27.8% below the nationwide figure, 31.7% below the collective figure across the other northeastern US states and is also far below those of any other highly urbanized state. If New Jersey's FFY2019 net cost per prescription had been at the national average, its Medicaid prescription drug expenditures would have been $208 million higher than the expenditures that occurred.

2. The vast majority of New Jersey's Medicaid prescriptions (98.2% during FFY2019) were paid by the MCOs contracted by Department of Human Services – Aetna, AmeriGroup, Horizon, UnitedHealthcare, and WellCare. The strong drug management performance that has occurred is attributable to these five MCOs' efforts and processes, and for several MCOs is also attributable to their effective partnerships with PBM entities.

3. A key factor in New Jersey's successful benefits management has involved managing the mix of drugs cost-effectively. During FFY2019, 91.3% of New Jersey's Medicaid prescriptions were filled by a generic alternative, the nation's third highest generic dispensing figure. New Jersey MCOs have also managed drug mix dynamics successfully within generics and within brands.

4. New Jersey's cost-effective management of the drug benefit is not limited to FFY2019. We have assessed costs and trends from FFY2013 through FFY2019 and New Jersey has been a high-performing state throughout this timeframe, with improved results occurring

year-over-year. New Jersey had the nation's 12th lowest net cost per Medicaid prescription during 2013. New Jersey's net cost per prescription during FFY2019 ($26.35) was actually slightly lower than during FFY2013 ($26.73), despite all the dynamics pushing prescription drug costs upward during this six-year timeframe.

5. A carve-out of the drug benefit would result in significant Medicaid cost increases.

   Carving pharmacy benefits out of the MCO benefit package will cost the State of New Jersey $51 million in the first year, with cumulative state costs across the first five years of the carve-out totaling $454 million. These increased costs would occur at a particularly inopportune point in time. Public reports suggest that the COVID-19 pandemic has both diminished state revenues and increased the demand and need for social-support funding for many state governments nationwide.

   A pharmacy carve-out would also programmatically weaken the whole-person, integrated system of coverage and care that New Jersey has put in place. Removing prescription drugs from this integrated structure will undermine care coordination and ultimately diminish the quality of care offered to Medicaid members.

6. Moving to a uniform PDL would also likely increase net Medicaid costs, even after this model's additional rebates are taken into account.

   Due to a weakened ability to manage drug mix at the "front-end," moving to a uniform DHS-driven PDL will cost the State of New Jersey $3 million in the first year, with cumulative state costs across the first five years totaling $26 million. Notwithstanding these estimates, cost savings or cost neutrality could potentially occur if the Medicaid MCOs collaboratively inform the content of the uniform PDL as occurs in Michigan. This arrangement limits the degree to which New Jersey's current high level of generic prescribing would erode towards brand drugs.

7. Moving to a single PBM model is not likely to yield savings.

   We also assessed the option of DHS moving to a single PBM model, whereby the carve-in model is maintained but with all the Medicaid MCOs contracting with a PBM entity selected by DHS. We do not view this alternative as having meaningful potential to yield savings to the State. The degree to which this approach would create added costs is dependent on the degree to which the MCOs are able to maintain their existing latitude over PDL content.

Policy Recommendation

Maintain the high performing carve-in model. Our analyses demonstrate switching to a carve-out approach will significantly increase Medicaid costs and undermine quality improvements achieved through the integrated care model that the State and its MCO partners have worked to develop.

II. Assessment of New Jersey's Cost Management Performance

New Jersey's management of the Medicaid prescription drug benefit has been impressive. As shown in Exhibit 1, the state's net costs per prescription (taking into account all initial payments to pharmacies and all drug manufacturer rebates) were actually *lower in FFY2019 than in FFY2013*, notwithstanding all the dynamics pushing prescription drug costs upward as well as New Jersey's adoption of Medicaid expansion which brought into coverage an adult population that on average utilizes relatively high-cost prescription drugs (e.g., for Hepatitis C, HIV, etc.).

Exhibit 1: New Jersey's Medicaid Prescription Drug Costs, FFY 2013-2019

Federal Fiscal Year	Prescriptions	Generic Percentage of Prescriptions	Average Costs Per Prescription			Rebates as % of Pre-Rebate Cost
			Initial (Pre-Rebate) Payments	Rebates	Net (Post-Rebate) Cost	
2013	12,998,957	83.1%	$60.28	$33.56	$26.73	56%
2014	14,225,126	85.4%	$61.82	$34.27	$27.55	55%
2015	19,897,873	86.9%	$66.86	$37.46	$29.39	56%
2016	20,320,208	88.1%	$69.03	$38.82	$30.20	56%
2017	19,446,441	89.5%	$70.41	$42.49	$27.93	60%
2018	20,843,377	90.1%	$68.99	$39.86	$29.12	58%
2019	20,467,726	91.3%	$69.60	$43.25	$26.35	62%
Percent (or Percentage Point Change), 2013 - 2019	**57%**	**8.2%**	**15%**	**29%**	**-1%**	**6.5%**

Exhibit 1 also demonstrates the significant and growing degree to which generics have been used as a means to achieve relatively low Medicaid costs per prescription. Generics represented 91.3% of all Medicaid prescriptions in New Jersey in FFY2019, 8.2% above the FFY2013 figure.

Exhibit 2 conveys New Jersey's FFY2019 (the most recent available year) Medicaid prescription drug cost performance on several key metrics in context with all other states and with states in the northeastern region of the USA. These figures all demonstrate strong cost management, with New Jersey having the fourth-lowest net cost per prescription among the 50 states and the District of Columbia in FFY2019.

Exhibit 2. New Jersey's FFY2019 Medicaid Prescription Drug Management Performance Relative to Other States

Prescription Drug Management Metric	New Jersey Figure	New Jersey Rank Among All States	New Jersey Figure as Percentage of Overall USA	New Jersey Figure as Percentage of Remaining Northeastern USA States
Pre-Rebate Cost Per Prescription	$69.60	2	77.7%	75.5%
Rebates Per Prescription	$43.25	47	81.4%	80.6%
Net Cost Per Prescription	$26.35	4	72.3%	68.3%
Generic Percentage of all Prescriptions	91.3%	3	104.3%	104.5%
Percentage of Prescriptions Paid by MCOs	98.2%	6	NA	NA

New Jersey's favorable ranking has occurred despite the northeastern region of the USA generally having higher net costs per prescription than the USA overall – and this region generally experiences relatively high per capita health care costs in general. Each northeastern state's ranking on net costs per Medicaid prescription during 2019 is listed in Exhibit 3 below. A rank of 1 signifies the lowest costs per prescription in the country, and a rank of 51 represents the highest-cost state (including the District of Columbia):

Exhibit 3. Northeastern US States, Net Medicaid Cost Per Prescription Ranking, FFY2019

Northeastern State	Ranking
New Jersey	4th
Rhode Island	19th
New Hampshire	22th
Massachusetts	25th
Vermont	27th
Pennsylvania	28th
New York	33th
Maine	38th
Connecticut	46th

Exhibit 2 shows that New Jersey also ranked very favorably during FFY2019 on pre-rebate costs per prescription (2nd), generic percentage of Medicaid prescriptions (3rd), and the degree to which MCOs paid for the state's Medicaid prescriptions (6th). The metric on which New Jersey ranked poorly, rebates captured per prescription (where New Jersey ranked 47th), is actually another favorable finding, given that our analyses of Medicaid prescription drug cost dynamics over the past decade consistently demonstrate that large rebates per prescription are correlated with

relatively high net costs per prescription. For example, of the ten states receiving the largest rebates per Medicaid prescription during FFY2019, nine were among the bottom half ranking of states with regard to net cost per prescription (with five of these states ranked 40th or worse).

New Jersey's prescription drug cost performance is also uniquely favorable for a highly urban state. Health care costs are typically higher in more urban settings. The seven states with more than 90% of their overall population residing in a county categorized as "urban" are listed in Exhibit 4, along with their ranking on Medicaid cost per prescription during FFY2019. Among these seven urban states, New Jersey is the only state ranked in the top ten in net costs per prescription. The next best state, Rhode Island, is ranked 19th.

Exhibit 4. Prescription Drug Management Performance in Highly Urbanized States

State	Percent of Population in Urban County	State Rank on Net Cost Per Prescription During FFY2019
California	95.0%	29th
New Jersey	**94.7%**	**4th**
Massachusetts	92.0%	25th
Florida	91.2%	39th
Rhode Island	90.7%	19th
Utah	90.6%	36th

These achievements in New Jersey can be attributed to the foundational structure of the Medicaid managed care program and effective implementation by the DHS. The current at-risk contracting model transfers the financial exposure in managing pharmacy costs to the MCOs and creates a series of aligned incentives between the DHS and the MCOs. The New Jersey Medicaid program has historically pursued an integrated, whole person approach to the program that drives better quality outcomes for members as well as cost containment for taxpayers.

This foundation, as implemented via the MCO contract and annual managed care rate setting process, drives the prescription drug cost management acumen of the five health plans that contract with the DHS to serve New Jersey's Medicaid population – Aetna, AmeriGroup, Horizon, UnitedHealthcare, and WellCare. Nearly all (98.2%) of New Jersey's Medicaid prescriptions are paid for by these MCOs, as compared to a nationwide figure of 72.1% and 76.6% across the remaining northeastern states.

III. Cost Impacts of a Pharmacy Benefits Carve-Out Approach

Using the process described below, we estimate the cost of a pharmacy carve-out to be $51 million in State funds during the first year of implementation. We estimate that the pharmacy carve-out will increase State expenditures by $454 million across the first five years of implementation.

Step 1: Establish Baseline Costs

We used New Jersey's FFY 2019 net costs for MCO-paid prescriptions of approximately $540 million as our baseline. This figure was derived through our tabulations using the State Drug Utilization Data files for pre-rebate costs, along with an average rebate of 62.3%. Note that Medicaid prescription drug rebate data are reported by CMS for each state on a Federal Fiscal Year basis. We have therefore bracketed baseline costs into the most recent FFY year available (FFY2019).

Step 2: Trend Baseline Costs to Upcoming State Fiscal Years

We used a 4% annual trend assumption to estimate upcoming pharmacy costs under the existing carve-in model. This trend factor captures changes in the volume of prescriptions (e.g., those driven by Medicaid enrollment increases) as well as changes in Medicaid costs per prescription. This annual cost trend was used throughout the cost estimation timeframe, with a 33-month trend used to estimate cost inflation between the mid-point of FFY 2019 and SFY 2022. Cost projections were produced for each of the five New Jersey State fiscal years beginning with SFY 2022 and totaled across these five years.

Note that our projections have not specifically factored in COVID-induced increases in Medicaid enrollment or to Federal matching rates that have occurred during CY2020 – we anticipate that the carve-out were to be implemented, this would occur in a post-pandemic environment.

Step 3: Estimate Percentage Impacts of Carve-In on Pharmacy Expenditures

We have quantified the cost differential between the carve-in and carve-out approaches in three ways, taking advantage of the vast experience data available in both settings:

a. New Jersey costs in comparison with the rest of the USA's northeastern region;

b. Progression of all 2011 carve-out states; and

c. Experience of states that predominantly relied on MCOs to pay for Medicaid prescriptions as compared with states predominantly relying on the FFS setting.

Each approach considers all Medicaid prescriptions in each state, the MCOs' share of these prescriptions, initial ingredient costs, dispensing fees, statutory rebates, and supplemental rebates. All our assessments involved hundreds of millions of annual prescriptions. Our analyses focused on statewide costs per Medicaid prescription for all Medicaid prescriptions to avoid any

distortions that might be created by MCO enrollees having a different mix of health conditions than the Medicaid FFS enrollees in these same states. The three cost impact approaches are described in detail below.

a. New Jersey's Costs as Compared with Northeastern Region

New Jersey's successful performance is evident in numerous ways, as quantified in Section II. For purposes of modeling the degree to which costs would increase under a carve-out, we have estimated what New Jersey's costs could increase to if New Jersey were performing at the level occurring across the rest of the northeastern region. This differential, quantified earlier in Exhibit 2, is 31.7% (i.e., New Jersey's net costs per Medicaid prescription during FFY 2019 were 68.3% of the figure across the other seven northeastern states).

b. Progression of All CY2011 Carve-Out States

Prior to 2011, 13 states with Medicaid managed care plans used a pharmacy benefit carve-out approach. The carve-out approaches were driven by the fact that prior to passage of the Affordable Care Act (ACA), the large statutory rebates applied only to Medicaid FFS prescriptions.

Following passage of the ACA in 2011, ten states (Delaware, Illinois, Indiana, Iowa, Nebraska, New York, Ohio, Texas, Utah, and West Virginia) carved the Medicaid prescription drug benefit into their integrated, comprehensive benefit package. We compared the experiences of these states (with the exception of West Virginia, which returned to a carve-out model in 2017) to those of Missouri, Tennessee, and Wisconsin, the three states who retained the pharmacy benefit in FFS. As shown in Exhibit 5, we found significant differences in both cost savings and proportion of generics prescribed. Our analysis showed that:

- The three states that retained the pharmacy benefit carve-out between FFY 2011 and FFY 2019 saw an 18.4% *increase* in net cost (post-rebate) per prescription.

- In contrast, states that switched to a carve-in during this timeframe collectively experienced a 1.2% *decrease* in net cost per prescription.

- Similarly, states that kept the benefit carved out saw a 7.9 percentage point increase in generics as a percentage of all prescriptions as compared to an increase of twice the size - 16.7 percentage points - for those that carved the benefit in.

This analysis included all Medicaid prescriptions in each state and year, and included all Medicaid rebates in these states between FFY 2011-2019 — including the formula-driven statutory rebates mandated by the ACA as well as the "supplemental" rebates that states, MCOs, and PBM companies have negotiated with brand drug manufacturers.

Exhibit 5. Prescription Drug Cost Progression from 2011-2019 Across States Using Carve-Out Approach During 2011

State Grouping	Net Cost Per Prescription (Post-Rebate)			Generics as a Percentage of all Prescriptions			Rebates Per Prescription		
	FFY2011	FFY2019	Percent Change	FFY2011	FFY2019	Percentage Point Change	FFY2011	FFY2019	Percent Change
States with a Prescription Drug Carve-Out Throughout FFY2011 - 2019 (3 States)	$37.98	$44.97	18.4%	76.8%	84.7%	7.9	$31.19	$59.09	89.5%
States with a Prescription Drug Carve-Out During 2011, Carve-In During 2019 (9 States)	$39.31	$38.83	-1.2%	71.1%	87.8%	16.7	$37.53	$47.93	27.7%

c. Performance Comparison Between FFS-Dominant and MCO-Dominant States

In 19 states, more than 90% of Medicaid prescriptions were paid by MCOs during FFY2019. In another 18 states more than 90% of FFY2019 Medicaid prescriptions were paid in the FFS setting (due to either not using an MCO contracting model or due to implementing a pharmacy carve-out within their MCO contracting model). We compared key Medicaid prescription drug performance between these two groups of states, as shown in Exhibit 6. This analysis found net costs per Medicaid prescription to be 14.8% lower in the MCO-dominant states than in the FFS-dominant states during FFY2019.

The generic usage data conveys a similar story: the generic dispensing rate across the 19 MCO-dominant states was 5.5 percentage points higher than across the 18 FFS-dominant states during FFY2019.

Exhibit 6. FFY2019 Performance Comparison Between States Predominantly Paying for Medicaid Prescriptions in the MCO and Fee-For-Service Settings

State Grouping	Net (Post-Rebate) Cost Per Prescription, FFY2019	Generic Percentage of Medicaid Prescriptions, FFY2019	MCO % of All Prescriptions, FFY2019
States with >90% of Medicaid Prescriptions Paid in the MCO Setting (n=19)	$34.82	88.3%	95.2%
States with >90% of Medicaid Prescriptions Paid in the FFS Setting (n=18)	$40.86	82.8%	1.3%
Percent or Percentage Point Difference	14.8%	5.5%	

These three (a-c) approaches all reached similar directional outcomes – with significant savings occurring in the carve-in setting relative to the carve-out setting. The percentage magnitude of the carve-in savings did differ with each approach taken. To estimate the impacts of a carve-out in New Jersey, we averaged the cost impact differential derived from each of the three approaches, as shown in Exhibit 7.

Our aggregate finding is that the carve-in model results in pharmacy costs that are 22.12% below those in the carve-out setting. For the initial year of implementation, we estimate that the adverse impact will be only half as large (11.06%), due to an assumption that Medicaid MCO enrollees will be allowed to maintain continuity of existing drug therapies to soften the disruptions that this programmatic change will otherwise create. These assumptions result in a first-year increase in Medicaid payments to pharmacies of $66 million under the carve-out (prior to factoring in additional dynamics in the ensuing steps).

Exhibit 7. Cost Different Comparisons of States' Carve-In and Carve-Out Experience

Comparison Approach	Net Cost/Rx Difference (Carve-In Model's Savings)	MCO % of All Prescriptions	Adjusted % Difference - Net Cost Advantage of Using Carve-In Approach
Approach A: New Jersey Costs Versus Remaining Northeastern States, FFY2019	28.9%	98.2%	29.4%
Approach B: Progression of All 2011 Carve-Out States, Comparing Those Switching to Carve-In Model and Those Retaining the Carve-Out Approach	19.6%	88.5%	22.2%
Approach C: Comparison Between States Predominantly Using FFS and States Predominantly Using MCOs	14.8%	NA	14.8%
Average of Three Approaches			**22.1%**

The full 22.12% differential is applied to the second through fifth years of the implementation of a New Jersey carve-out.

As shown in Exhibit 8, we estimate that over five years, the carve-out would increase the Medicaid pharmacy payments in New Jersey by $650 million (prior to factoring in additional dynamics in the ensuing steps).

Exhibit 8. Pharmacy Expenditure Impacts of Carve-Out

Year	Net (Post-Rebate) Medicaid Costs Under Current Program Structure, MCO-Paid Prescriptions	Estimated Percentage Net Pharmacy Cost Increase of Carve-Out	Additional Medicaid Pharmacy Expenditures Due to Carve-Out
FFY2019 (baseline)	$536,228,719		
SFY 2022	$597,298,953	11.1%	$66,065,390
SFY 2023	$621,190,911	22.1%	$137,416,012
SFY 2024	$646,038,547	22.1%	$142,912,653
SFY 2025	$671,880,089	22.1%	$148,629,159
SFY 2026	$698,755,293	22.1%	$154,574,325
5-Year Total	**$3,235,163,793**	**20.1%**	**$649,597,539**

Step 4: Estimate Carve-In Savings Due to Reduced Risk Margin Payments to MCOs

Medicaid MCOs are paid a risk margin via the capitation rate-setting process to provide a reasonable opportunity for the MCOs to derive earnings from their considerable care coordination efforts and to provide a buffer against their financial risks. Under a pharmacy carve-out, DHS would not have to pay Medicaid MCOs a risk margin on the pharmacy component of health care costs. We have estimated this risk margin payment to represent 2.0% of pre-rebate pharmacy expenditures. Pre-rebate costs are used as the basis for this allocation because statutory rebates do not flow through the MCOs' books. As a result, the pharmacy costs that must be included in the MCOs' capitation rate are roughly double the ultimate net (post-rebate) pharmacy costs that occur once manufacturers pay statutory rebates to government agencies. This component of our analysis estimates a cost of approximately $30 - $35 million per year. This savings component, however, does not come close to offsetting the increased pharmacy costs derived in the previous steps.

Step 5: Administrative Cost Impacts

We do not anticipate that administrative costs will change substantially under a carve-out model – we did not include administrative cost increases nor decreases in our modeling efforts.

Other than in specialized situations, no more than 5% of the Medicaid MCOs' existing administrative functions and corresponding costs should be eliminated under a pharmacy carve-out. The vast majority of the pharmacy-related administrative costs undertaken by MCOs will need to be replicated by the state in transition to the FFS, increasing DHS' administrative costs while the cost of administering other benefits remain with the MCOs. There may be additional administrative costs incurred by the state to ensure efficient data exchanged between the MCOs and the state including:

- Reporting and operations to enable coordination with medical benefits;
- Reporting and operations to ensure management/adherence of DOH quality measures; and
- System infrastructure to share and reconcile pharmacy data with the MCOs.

The administrative services that are most at risk of evaporating altogether are some of the plans' medication access and adherence programs that benefit patients, which will be more difficult and costly for the MCOs to operate in a carve-out setting. These access and adherence supports, several of which are catalogued in Appendix A, are services that New Jersey policymakers should be highly interested in preserving and enhancing.

Quote from New Jersey Medicaid MCO Executive Regarding Carve-Out Model: "In our experience in other markets there has been no reduction in administrative costs; in fact, costs have increased to allow for coordination and data share."

Given these factors, our fiscal impact estimates have not assumed that any administrative savings (nor increased costs) will occur under a switch to a carve-out approach.

Step 6: Estimate 340B Program Impacts

Some states have estimated that savings can occur under a carve-out by restructuring 340B prescription drug program features. New York State has recently estimated that annual savings of $166 million can occur under a pharmacy carve-out model, a figure that represents 5.4% of annual net post-rebate Medicaid prescription drug costs. Lacking New Jersey 340B data, we have used this same percentage to estimate the savings that New Jersey could achieve with 340B expenses under a carve-out. This approach predicts that New Jersey 340B annual savings of $30-35 million could occur.

Note that while we have factored these savings into our projection, we have two significant reservations in doing so. First, it is not clear that a carve-out is necessary for all of these 340B savings to become achievable. Second, savings in 340B expenditures are likely to be realized predominantly through "cuts" to the payments New Jersey's safety net providers currently receive. Policymakers need to carefully assess whether such payment reductions to 340B providers represents sound policy, or if such an approach impairs these providers' ability to fulfill their mission of serving many of the state's most vulnerable subgroups.

Step 7: Calculate Overall Medicaid Impact of Carve-Out

The annual impacts of each of the above steps are shown in Exhibit 9. Across the first five years of the carve-out, New Jersey's overall Medicaid costs are projected to increase by over $300 million. The adverse impact in the first year is modest due to our assumption that pharmacy cost impacts will require two years to fully cycle into effect. We estimate that continuity of existing drug regimens will often occur at the outset (over-riding the new preferred drug list), which will prevent the drug mix from immediately becoming as cost-ineffective as will ultimately occur.

Exhibit 9. Annual Medicaid Cost Increases Created by Carve-Out Model
Note that red text denotes figures that represent favorable impacts of the carve-out, which are subtracted from the adverse impact components.

Year	Net (Post-Rebate) Medicaid Costs Under Current Program Structure, MCO-Paid Prescriptions	Estimated Percentage Net Pharmacy Cost Increase of Carve-Out	Additional Medicaid Pharmacy Expenditures Due to Carve-Out	Estimated Net Costs for Prescription Drugs Under Carve-Out Approach, MCO-Paid Prescriptions	Offsetting Carve-Out Costs -- Removing MCO Risk Margin Allocation for Rx	Offsetting Carve-Out Costs -- Reduction in 340B Program Costs	Total Medicaid Fiscal Impact (Added Cost of Carve-Out)
FFY2019 (baseline)	$536,228,719						
SFY 2022	$597,298,953	11.1%	$66,065,390	$663,364,343	-$31,712,182	-$32,233,949	$2,119,259
SFY 2023	$621,190,911	22.1%	$137,416,012	$758,606,923	-$32,980,670	-$33,523,307	$70,912,035
SFY 2024	$646,038,547	22.1%	$142,912,653	$788,951,200	-$34,299,896	-$34,864,239	$73,748,518
SFY 2025	$671,880,089	22.1%	$148,629,159	$820,509,248	-$35,671,892	-$36,258,808	$76,698,459
SFY 2026	$698,755,293	22.1%	$154,574,325	$853,329,618	-$37,098,768	-$37,709,161	$79,766,396
5-Year Total	**$3,235,163,793**	**20.1%**	**$649,597,539**	**$3,884,761,332**	**-$171,763,408**	**-$174,589,463**	**$303,244,668**

Step 8: Adjust Federal/State Share of Costs to Account for Premium Tax Impacts

New Jersey applies a 5.0 percent premium tax on MCO capitation payments, which increases federal funds for the program. The mechanics of this tax occur along the lines listed below:

a) If an MCO would normally receive a $200 monthly capitation rate from DHS, this amount would be grossed up by 5% to $210.53 ($\frac{\$200}{1-0.05} = \$210.53$).
b) The federal government would pay its matching rate on the $210.53 payment, with this matching rate being 50% for a traditional Medicaid enrollee and 90% for an enrollee in the Medicaid expansion coverage group. We estimate that the average federal match rate for all MCO enrollee prescriptions is 60%.
c) The MCOs pay the 5% premium tax ($10.53 for this hypothetical enrollee) back to the state, with the state retaining all these funds.
d) Through this process, the MCO ends up with the same $200 amount as was intended, but with the state share netting out to $73.68 instead of the $80 that would have occurred in the absence of the premium tax program, and with the federal government paying $126.32 instead of the $120 that would have been paid.

Through this process, the premium tax creates a 3% increase in the federal government's share of MCO capitation payments (and a corresponding 3% decrease in the state share of these payments).

The carve-out would considerably reduce the amount of funds paid in the MCO's capitation, removing the drug benefit and its associated claims, administration, and operating margin. In doing so, the premium tax advantages the state is currently securing would be proportionately reduced. We estimate that the premium tax would be 5% of the sum of A) existing MCO payment to pharmacies; B) a 3.5% allocation for pharmacy-related administration; and C) a 2.0% allocation for the MCOs' risk margin.

The state fund revenue loss would be 60% of this overall amount – the estimated federal share of the pharmacy benefits-related component of the premium tax program.

These figures are shown in Exhibit 10, and substantially worsen the already adverse state fund impacts the carve-out will create. While worsening the state fund impact, the premium tax impacts of the carve-out actually make this policy option favorable for the federal government.

Exhibit 10. State and Federal Cost Impacts of Carve-Out

Year	Total Medicaid Fiscal Impact (Added Cost of Carve-Out)	Premium Tax (5%)	Premium Tax Impact on State Funds	New Jersey State Fund Fiscal Impact (Added Cost of Carve-Out)	Federal Fiscal Impact (Added Cost of Carve-Out)
FFY2019 (baseline)					
SFY 2022	$2,119,260	$83,698,799	$50,219,279	$51,490,835	-$49,371,576
SFY 2023	$70,912,036	$87,046,751	$52,228,051	$94,775,272	-$23,863,236
SFY 2024	$73,748,517	$90,528,621	$54,317,173	$98,566,283	-$24,817,766
SFY 2025	$76,698,458	$94,149,766	$56,489,859	$102,508,934	-$25,810,476
SFY 2026	$79,766,396	$97,915,756	$58,749,454	$106,609,292	-$26,842,895
5-Year Total	**$303,244,667**	**$453,339,693**	**$272,003,816**	**$453,950,616**	**-$150,705,949**

While the carve-out would create a net Medicaid cost of $2 million in the first year of its implementation, *New Jersey would experience an adverse state funds impact of $51 million*, with the federal government realizing a savings of $49 million.

Collectively across the first five years of the carve-out approach, overall Medicaid costs would increase by $303 million, the state of New Jersey would experience increased costs of $454 million, and the federal government would experience a savings of $151 million.

IV. Assessment of Additional Policy Options

This section of the report describes and evaluates three additional pharmacy policy options, all of which could be implemented within the existing prescription drug carve-in framework:

- A state-determined uniform preferred drug list (PDL)
- An MCO-determined uniform PDL
- Use of the same PBM by all MCOs for their Medicaid line of business

State-Determined Uniform PDL: Several states use a uniform PDL in the Medicaid MCO program in a "top-down" model whereby the state Medicaid agency determines the PDL content and requires that all Medicaid MCOs adopt this PDL for their Medicaid prescriptions. Florida and Texas are the largest states with extensive experience using this model. Both of these states rely on MCOs extensively to pay for Medicaid prescriptions in a carve-in model – 94% of Florida's FFY2019 Medicaid prescriptions were paid by MCOs as were 97% in Texas.

However, both of these states have consistently experienced rather high net costs per prescription -- with Florida ranked 39th during FFY2019 and Texas ranked 32nd. We see no other reason for these states' cost performance to be this ineffective, other than that the state-driven PDL is forcing costs up from where they would be if the MCOs were allowed to fully use their cost-containment techniques.

We assessed the first-year impacts of Virginia's use of a state-determined PDL and found net prescription drug costs to be 2.2% higher than would have occurred under continuation of the prior model where Virginia's MCOs had latitude over their own PDL content.[1] Applying this same percentage impact to New Jersey would result in the additional costs shown in Exhibit 11.

We estimate that the total additional costs to the Medicaid program from a state-driven uniform PDL would be approximately $7 million in the initial year of implementation, and $65 million across the first five years of implementation. New Jersey's state share of these additional Medicaid costs is estimated to be 40% of these totals, which is $2.6 million in the first year and $26 million across the first five years.

[1] https://www.themengesgroup.com/upload_file/pdl_report_january_2020.pdf

Exhibit 11. Estimated Fiscal Impacts of State-Driven Uniform PDL

Year	Net (Post-Rebate) Medicaid Costs Under Current Program Structure, MCO-Paid Prescriptions	Estimated Cost of State-Driven Uniform PDL (Percentage Increase)	Estimated Cost of State-Driven Uniform PDL (Dollar Increase)
FFY2019 (baseline)	$536,228,719		
SFY 2022	$597,298,953	1.1%	$6,570,288
SFY 2023	$621,190,911	2.2%	$13,666,200
SFY 2024	$646,038,547	2.2%	$14,212,848
SFY 2025	$671,880,089	2.2%	$14,781,362
SFY 2026	$698,755,293	2.2%	$15,372,616
5-Year Total	**$3,235,163,793**		**$64,603,315**

A key administrative advantage often attributed to a uniform PDL approach involves allowing prescribers throughout the state to use the same Medicaid PDL. Note, however, that creating uniformity within Medicaid, which constitutes a small portion of most prescribers' overall prescription volume, comes at the expense of eliminating uniformity across the MCOs' multiple lines of business. A physician treating an Aetna, Horizon, or UnitedHealthcare Medicaid patient in Exam Room A will often need to prescribe a different medication than for a commercial or Medicare patient covered by the same organization that the provider is treating at the same time with the same health needs in Exam Room B. The quote below further indicates that physicians in New Jersey are accustomed to handling many different PDLs, with information technology advances making this much less challenging.

"From a Provider perspective, technology has greatly reduced or eliminated the administrative burden of working with multiple PDLs. With the advent of electronic prescribing, prescribers are able to easily view formulary status or a drug and its preferred alternatives for health plans in real-time while prescribing. This allows for seamless navigation of multiple formularies or preferred drug lists right at the prescribers' fingertips." – New Jersey MCO Executive

MCO-Determined Uniform PDL: A promising variant of the above approach is to use a common PDL across all Medicaid MCOs, with the PDL content being determined collaboratively by the MCOs. Michigan has used this approach for several years and has consistently ranked among the 10 states with the lowest Medicaid net costs per prescription. Michigan had the nation's 6th lowest costs per prescription in FFY2019.

In this model, the MCOs form a workgroup which meets regularly (and more urgently off-cycle, as-needed) to assess modifications based on drug pricing changes, introduction of new drugs,

and patent expirations. The MCOs reach a consensus around PDL changes and work to implement them, with all MCOs required to adhere to the group's consensus decisions.

With regard to expected costs if New Jersey were to implement this model, it is difficult to anticipate a significant savings nor a significant added expense. New Jersey and Michigan have both achieved favorable (and closely similar) net costs per Medicaid prescription, ranking 4th and 6th on this metric among all states during FFY2019. Between New Jersey ranking slightly higher than Michigan and being in a costlier region of the country than Michigan, we are inclined to estimate that costs would increase slightly if New Jersey were to move to this approach. However, we are not envisioning that an MCO-driven uniform PDL would have a substantial fiscal impact in New Jersey in either direction.

Use of a Single Pharmaceutical Benefits Manager (PBM): This option is another variant of the uniform PDL, requiring that Medicaid MCOs all contract with a state-determined PBM and use the state/PBM-selected PDL that the state. This would be similar to the state-determined uniform PDL approach described above. However, by requiring that each MCO contract with the state-selected PBM, most MCOs would be put in the complicated position of using one PBM to administer its Medicaid prescription drug benefit, but use other PBMs or an -in-house approach to administer pharmacy benefits for the other populations it serves (e.g., commercial and/or Medicare enrollees). This creates administrative inefficiencies for each MCO – adding to their administrative costs and creating disruption in the integrated data structure each MCO is currently using. However, if the MCOs maintain PDL latitude, we do not envision that the single PBM will yield significant net cost increases nor net savings for the State. If, conversely, the MCOs do not maintain PDL latitude, significant cost increases would be expected to occur as modeled in Section III for the carve-out approach.

If a single PBM model were to be used, it will be critical that this model not repeat the shortcomings that have occurred under the top-down, state-driven PDL as discussed above. A common theme to all the Medicaid prescription drug data analyses we have conducted over the past several years is that cost-effective management of drug mix at the "front-end" is the most important pharmacy benefits management tool. Maximizing "back-end" rebates has not yielded cost-effective outcomes overall. Medicaid MCOs in New Jersey and across the nation have demonstrated exceptional capabilities in managing drug mix cost-effectively. It is important for DHS to leverage, rather than forfeit, this strength in any program modifications that occur.

"A single PBM would result in a fragmented approach to management of the Medicaid population, just as what would exist under the carve-out model." – New Jersey MCO Executive

V. Programmatic Advantages of Retaining Existing Carve-In Model

This section of the report describes the anticipated programmatic impacts the carve-out model will have, beyond the adverse fiscal impacts quantified in Section III. There is no realistic path to avoiding diminished programmatic performance under a carve-out model. The MCOs have developed integrated staff, information systems, and care coordination processes that all function optimally under a carve-in model of all services – all with the purpose of providing the best care to Medicaid members. Pulling a benefit as central to health care and to care coordination as prescription drugs out of this integrated structure is an inherently problematic approach.

Through a survey of New Jersey's Medicaid MCOs, we have conveyed several administrative and programmatic dynamics related to the carve-in versus carve-out approaches below. All this information represents direct input from one or more of New Jersey's Medicaid MCOs. Additional case examples regarding ways in which New Jersey MCOs facilitate access and adherence to appropriate medications is presented in Appendix A.

Facilitating Versus Diminishing Value-Based Purchasing Efforts:

- Unlike in fee for service states, managed care programs can leverage value-based payment (VBP) structures to promote value, improved health outcomes, and contain costs. VBP in managed care seeks the use of generics and proper medication reconciliation to keep members healthy and decrease the likelihood of non-adherence or avoidable lapses in chronic disease management.

Quality Improvement:

- Tracking performance of HEDIS measures that involve medication utilization will become increasingly challenging under a carve-out, with MCOs losing the ability to favorably influence these quality measures.

- Several case management measures would be adversely impacted with the delay in the member claims information.

- The carve-out will be difficult for members to understand, and member complaints about pharmacy will still come to our Member Service Team causing administrative burden and a delay in service and resolution for members.

- A carve-out prevents a quick resolution of many member issues. One MCO's experience in multiple states where they do not have access to the pharmacy prior authorization systems has been challenging because they cannot determine the cause for delayed access to medications, including if the request was denied or reason for denial. Any prior authorization questions regarding status must be sent outside the organization.

Advantages of Real-Time Pharmacy Data:

- MCOs operating in multiple states indicated that most other states that use a carve-out model, such as West Virginia, do not have real time data nor does the data provided indicate the provider/prescriber. This causes a significant disconnect between the member/patient and the MCO's Care Management Team.

- In one plan's experience in other markets, claims are often delayed by a number of days, limiting the opportunity for real-time guidance and support for members and pharmacists. For example, if a member reports an urgent issue at the pharmacy, the plan is unable to see it for a few days and cannot provide real-time guidance to the plan's pharmacist.

- In states that utilize the carve-out model, plans have reported difficulty using the claims file due to errors and the inability to perform a real time review on a member's prescription history. Not having insight into pending prior authorizations and completed case reviews leaves the plan without critical information for navigating member care.

- Every day, real time pharmacy data is used to ensure members are able to access and adhere to their prescribed medications. A recent hospital discharge case was reviewed for a member who reported that she was not able to obtain her insulin due to lack of insurance. The member reported that her inability to get insulin was the cause of her hyperglycemic episode and her hospitalization. An in-depth pharmacy review determined there were no insurance issues and the medications were processed paid and then reversed. Further care management was deemed necessary to investigate this member's adherence issues. If there was, in fact, a barrier to the member receiving her medications, real time pharmacy data would help to identify this gap in care.

- Real time information helps us verify the medications were authorized and facilitates early refills if there is an issue with lost or stolen medications.

- Direct access to the pharmacy history is crucial to ascertain members adherence, barriers to receiving medications, and addressing those issues. Pharmacy claims serve as a link between the members, providers, pharmacies and the MCO to understand a member's prescription history.

- The largest systematic challenge in a carve-out environment is data sharing. Unless the MCO can maintain the same level of data exchange and transparency with FFS or the single state PBM as with the plan's current PBM, pharmacy data will not be as accurate or timely.

- Under a carve-out approach, the MCOs would need a daily claims file from the state. Once received, each plan would still need to download these files, scrub the data and then upload appropriately to ensure that they match with internal systems data fields. This would take a minimum of 2-4 weeks. If the data has errors or any kind of missing fields then the lag time would just increase trying to correct. At no point will a case manager be able to look at a member and determine their prescription history up to date.

Care Coordination for Medicaid Members:

- Integrated benefits under a carve-in model allow MCOs to improve care coordination, deliver whole person care, and have timely visibility into member needs. MCOs' staff include pharmacists and other pharmacy-focused and care management personnel who facilitate access to medications and provide adherence and other forms of support to members. The in-house pharmacy team works closely and directly with the MCO's other care coordination personnel and within the same information technology platform. That level of integration has real implications on patient care. One MCO noted that their pharmacy department staff attends weekly behavioral health and medical rounds to provide information on treatment adherence that may explain emergency department utilization or inpatient admissions. This enables staff to quickly connect with at-risk members to prevent future hospital admissions. Carving the pharmacy benefit out of managed care will reduce integration across the care continuum, and will likely have significant, negative impacts on members with complex or chronic medical conditions.

- Under the carve-in model, the MCOs are able to conduct critical and time sensitive care management activities following hospital discharge, such as medication reconciliation.

- One MCO's Patient Care Advocates (PCAs) contact members who were prescribed antipsychotic medications to ensure members understand how to take the medications, ask if there are any issues procuring medication from the pharmacy or via mail, and if non-adherence is observed, we have a discussion to identify the root cause. Depending on the outcome, the member is referred to appropriate care manager or pharmacist. In addition, it is important for the member to get their glucose A1C monitored while on anti-psychotic. Our PCAs collaborate with provider offices to ensure members receive monitoring.

- Having both medical and pharmacy data integrated will allow this plan to continue to provide members with a level of care coordination that is especially important for the management of sensitive conditions such as schizophrenia and HIV. Without the pharmacy data it would become exceptionally difficult to identify the members most in need of care coordination and could leave many at risk for treatment failure.

- Special populations such as members on BH medications, Foster Care children, members

with 2-3 chronic conditions, and members with SUD need additional support when it comes to coordinating their care. Not being able to access real time pharmacy profiles will limit the support a case manager can provide for these members.

- Especially when it comes to BH cases, many times members who have been recently discharged have trouble accessing their medications, particularly antipsychotics. Without access to claims the plan would not be aware of this barrier to receiving care or be able to perform outreach to the provider complete a prior authorization or change to a preferred medication. The plan would also be unable to inform the team about the member's compliance. This will be impactful because Care Managers will lose the ability to work directly with the member to assess compliance barriers if they cannot identify in real-time that compliance issues exist (given that poor compliance is rarely member-reported).

- The State has made significant investments in promoting an Office Based Addiction Treatment (OBAT) model for opioid use disorder and the MCO plans have played a key role in that effort including promoting this treatment model among our primary care physician network. Having integrated care coordination capabilities with the pharmacy and primary care data available in real time allows the MCO plans to better support that effort.

Responsiveness to Natural Disasters:

- During October 2012, the state encountered a major hurricane that was especially destructive along the shoreline. The plan immediately allowed emergency supplies of medications. In addition, due to pharmacy closures near the shore, the pharmacy department temporarily lifted pharmacy lock-in restrictions in certain zip codes to allow members to go to any participating pharmacy. The pharmacy department fielded calls from members that encountered obstacles to obtaining necessary medications and helped facilitate Rx transfers to operating pharmacies, and delivery of medications at alternate member locations to ensure ongoing continuity of care. Not having real-time access to pharmacy data would have impeded these efforts.

APPENDIX A
COMPILATION OF EFFORTS NEW JERSEY MCOs ARE MAKING TO FACILITATE MEMBER ACCESS AND ADHERENCE TO MEDICATIONS

The following case examples have been provided by New Jersey Medicaid MCOs conveying instances in which plans had a meaningful impact on their members through full integration of the pharmacy benefit, including **eight** specific ways plans were able to improve adherence to medications and **seven** specific ways plans were able to improve members' access.

A. Helping Members with Adherence to Prescribed Medication Regimens – Eight Case Examples

1. **Monitoring Patient Medications While on Therapy Regimen**

A retail pharmacist outreached to the plan regarding a member in a mental health and substance abuse program. Upon further review, the plan pharmacist discussed the case further with the retail pharmacist regarding the member's current medication regimen. The plan pharmacist contacted the opioid prescriber and discussed the case to ensure the prescriber was aware the member was also receiving an opioid cough/cold medication. Based on further discussion, the prescriber stated that they would consider changing to an alternative cough/cold product moving forward.

2. **Reaching out to Members to Gauge Behavioral Health Outcomes**

A plan's Patient Care Advocates (PCAs) contacted members who were prescribed antipsychotic medications. The purpose of the call is to ensure members understand how to take the medications, ask if there are any issues procuring medication from the pharmacy or via mail, and if non-adherence is observed, the PCAs and members will have a discussion to identify the root cause. Depending on the outcome, the member is referred to appropriate care manager or pharmacist. The plan's PCAs collaborated with provider offices to ensure members receive monitoring.

3. **Verifying Hepatitis C (HCV) Medication Adherence**

Members approved for HCV medications (across all lines of business) are contacted by the HIV/HCV team for counseling and to troubleshoot any barriers to care. In doing so, the HCV team routinely identifies and addresses both clinical issues (e.g., navigating through adverse effects, drug interactions, and stressing adherence) as well as administrative issues (such as ensuring medications are obtained by members if pharmacy or delivery issues are found). This leads to increased regimen completions and sustained viral responses such as a pharmacist informing a member who erroneously believed their HCV treatment length was eight weeks instead of twelve weeks, and also conveying to the member why they needed to complete an additional month's worth of medication and having the member successfully finish their treatment.

4. **Monitoring Medication Adherence for Patients with Multiple Medications**

A member with six chronic conditions and on multiple medications is served by the Managed Long-Term Services and Supports (MLTSS) program. A family member noticed them being confused and non-verbal. Their care manager was informed, with the patient's family member believing the member was having a dangerous drug interaction. The member's care manager contacted the local police department who dispatched EMS to take her to the emergency room. Following discharge from the hospital, the care manager educated the member on medication management and the patient's condition returned to normal.

In addition, the care manager used this as an opportunity to counsel the member on additional benefits that they were eligible for in the MLTSS program that she did not access. The member now has a personal care assistant coming to their home to supplement the care provided by her family and has a personal emergency device during the time periods they may be alone at home.

5. **Utilizing Advanced Analytics and Pharmacy Data to Detect Care Disparities**

A plan utilizes pharmacy data for minority groups who have not had dispensed at least 50% of their asthma controller medications in an effort to increased adherence to these important respiratory drug therapies. The targeted group was identified via a disparity analysis. Another plan used predictive modeling to identify members who are most likely to be non-compliant with medications and prioritize them for compliance promoting measures including call campaigns and case management.

6. **Providing Tailored Messages for Members with Chronic Conditions**

A plan provides members access to the CVS Pharmacy Advisor Support program, which provides tailored messages to meet the needs of the members with chronic conditions at key points in therapy. The program supports select clinical quality measures by promoting optimal adherence and by closing gaps in medication therapy.

7. **Using Targeted Medical Reviews to Address Care Gaps**

A plan uses targeted medication reviews (TMR) address gaps in care, non-Adherence, and drug interactions. Targeted medication reviews can result in comprehensive medication review which educate members on the importance of taking their medications as prescribed.

8. **Managing Prescription Overuse Through Drug Utilization Programs**

A plan has drug utilization programs in place that utilize both pharmacy and medical claim detail. The plan targets adult members with diabetes and elevated hemoglobin A1C levels that are not receiving any diabetes medications as reflected in the pharmacy data. Targeted outreach to primary care providers with a list of affected members is conducted, which ultimately leads to increased prescribing and filling of diabetes medications and improved disease management. The plan targets adult members with a diagnosis of acute bronchitis and pediatric members with a diagnosis of upper respiratory infection or acute nasopharyngitis who filled an antibiotic within a few days of the diagnosis in the absence of a confirmed group A streptococcal infection, since most of these cases have a nonbacterial cause and therefore, antibiotic therapy is not warranted. Targeted prescriber and member letters are sent to provide education on appropriate antibiotic use which ultimately leads to decreased inappropriate antibiotic utilization.

B. Helping Members Access Needed Medications – Seven Case Examples

1. **Recommending Alternative Medications Following Overdose**

A pharmacist outreached to a prescriber regarding continued opioid prescribing following possible opioid overdose. The prescriber requested additional feedback to help manage the member. The pharmacist recommended consideration of non-opioid medications to treat member's conditions, tapering benzodiazepine therapy due to increased risk of opioid overdose with concomitant therapy, and prescribing of opioid reversal agent. The prescriber was extremely receptive to the recommendations and also requested pain management assistance. The pharmacist referred the case to case management for pain management referral.

2. **Urging Additional Factor Doses for Hospitalized Member**

A specialty pharmacy reached out to the plan regarding urgent need of additional factor doses at a hospital for a hemophilia member. The pharmacy department followed the order throughout the day to ensure it was billed, paid, shipped, and received at the hospital for the member. Case management was also advised of the outcome.

3. **Providing Access to Medication for Patients Post-Discharge**

A member was hospitalized at a local hospital for hyperglycemia and muscle spasms and was later discharged to a rehabilitation center. However, the member decided to sign herself out of the rehab and did not get prescription (INSULIN, TRAMADOL, RIFAXIMIN) prior to going home. The member reached out to the case manager, who assisted with calling the PCP and GI doctor with no response. The case manager made multiple calls to the PCP and pharmacy and eventually got the PCP to evaluate the member. The PCP prescribed the above medications for member and the case manager got the pharmacy to deliver the medications to member's house.

4. **Obtaining Necessary Prior Authorizations After Rejected Claims**

A member was unable to get asthma medication Dulera, which required prior authorization (PA), after several rejected claims. The case manager reached out to prescribing provider and informed them of the need for Prior Authorization (PA). PA was approved yet the member was still unable to get the medication. The case manager referred to the plan pharmacy, which notified the member's pharmacy to process claim due to change in therapy. The member was then able to receive his Dulera. The member's OptiChamber was broken and the member has used max quantity for the year. The case manager referred to the plan's pharmacy and a one-time override was approved. The member received his OptiChamber.

5. **Facilitating Urgent Medication Access After Poisoning**

A member was discharged from a local hospital for lead poisoning. In her follow-up, the care manager was informed that the member was having issues getting medication. It was determined the medication was not a rebatable product (as required by the state contract). The plan's care manager worked with the pharmacy team to identify a resolution enabling immediate access to the medication and appropriate claim payment. The plan then worked with the state to seek an ongoing exemption to the contract requirement to avoid future issues with medication procurement and adherence.

6. **Locating Pharmacies that Have Member Medication In-Stock**

A plan received a call from the caregiver of a member diagnosed with autism and developmental disabilities. The caregiver, the member's mom, was very upset because she went to a pharmacy to pick up member's antipsychotic medication (Chlorpromazine HCL 25mg) and was given another brand of the same medication. The caregiver explained that the member has behavioral issues and only uses the brand from Sandoz—which is considered most effective in controlling his conditions. The plan's care manager worked with the plan's pharmacy to identify a local pharmacy which had the Sandoz brand of chlorpromazine in stock and available for pick up. The care manager coordinated the transfer of the prescription from member's previous pharmacy to the identified pharmacy to get filled.

7. Obtaining Needed Prescriptions Following Transitions in Insurance Coverage

A plan member had a developmental disability and had been covered by a commercial insurance plan as well as by Medicaid. In these instances, the commercial plan is the primary payer and Medicaid is considered a secondary or "payer of last resort." The member, however, had lost his commercial coverage and during his last trip to the pharmacy was denied access to his prescriptions. The commercial coverage still appeared in the system as the primary payer. The care manager was informed and able to manually override the system and align Medicaid as the payer for all of the member's services.