The Menges Group

Strategic Health Policy & Care Coordination Consulting

Medication Adherence in Medicaid

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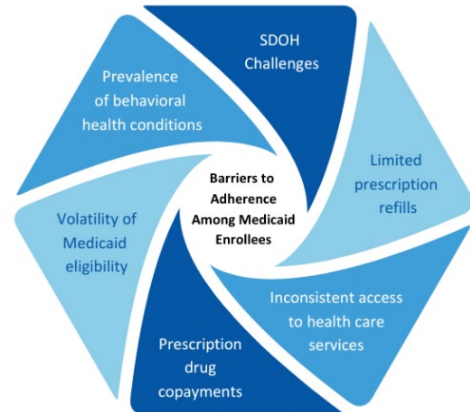
I. Introduction

Many Americans have difficulty adhering to their prescribed medication regimens due to low health literacy, financial barriers, limited access to pharmacies, and other factors. Poor medication adherence leads to approximately 125,000 deaths annually and $300 billion in annual costs to the healthcare system in additional emergency room visits and hospitalizations.[1] Achieving medication adherence in the Medicaid arena is particularly difficult due to the following dynamics:



- Medicaid enrollees disproportionately experience social determinants of health (SDOH) challenges, such as economic instability, adverse family dynamics, and health literacy, that impact their ability to consistently access health care and adhere to prescribed medication regimens.
- Medicaid enrollees have a relatively high prevalence of behavioral health conditions that often warrant consistent medication therapy. These conditions, however, may pose barriers to a person's ability to obtain and adhere to their prescribed medication regimens.
- Many Medicaid enrollees face transportation-related barriers to care, which significantly inhibits their ability to obtain prescribed medications and refills. Exacerbating this issue, the use of mail to send medications directly to a person's residence is rarely used.
- Many Medicaid beneficiaries face significant geographic, racial, cultural, and communication barriers that limit their ability to consistently access health care.
- Several states currently impose copays in their fee-for-service (FFS) and Medicaid managed care organization (MCO) programs that vary by drug type, single-source drugs, or eligibility group. These Medicaid copayments, while small relative to copayments in other coverage programs, can serve as a meaningful barrier to filling and refilling medications.
- The volatility of Medicaid eligibility in many coverage groups leads states to limit prescriptions to a 30-day supply to reduce instances of the Medicaid program paying for medications beyond coverage. These policies increase the volume of refills that Medicaid beneficiaries on a consistent medication regimen may obtain and exacerbate the potential for adherence problems (e.g., missed or delayed refills) to arise.

[1] https://www.heart.org/en/health-topics/consumer-healthcare/medication-information/medication-adherence-taking-your-meds-as-directed

- Some states impose limitations on the number of prescription refills an individual can be prescribed at one time, which most often impacts members who are living with chronic conditions.

State Medicaid agencies, Medicaid MCOs, pharmacies, pharmacists, drug manufacturers, physicians, and policymakers all share a motivation to minimize the above barriers and facilitate access and adherence to prescribed medication regimens. Extensive efforts have occurred at the state- and MCO-level to improve medication adherence among all populations, often with specific initiatives targeted toward Medicaid subgroups. The remainder of this report discusses initiatives to promote medication adherence among Medicaid enrollees.

Several developments have emerged in recent years that significantly affect medication access and adherence.

- The number of persons covered by Medicaid has grown dramatically, first due to the adoption of Medicaid expansion in most states and then, more recently, due to dynamics related to the COVID-19 public health emergency (PHE).
- The net influx of persons enrolled in Medicaid since 2014 has been largely comprised of adults in the 19-64 age cohort. Relative to enrollees under the age of 19, this subgroup has a much greater per-person usage of maintenance medications where adherence is of critical importance.[2]
- The proportion of all Medicaid prescriptions paid by MCOs (rather than through Medicaid FFS coverage) has expanded substantially, from 51.7% in 2013 to 65.8% in 2022. Medicaid MCOs' system of coverage capabilities creates enhanced opportunities to track and facilitate medication adherence among their enrolled populations.[3]
- Approvals of specialty drugs have increased in recent years. These drugs often require an even stronger focus on adherence to maintain efficacy.

This paper updates many of the analyses conducted in our prior 2014 report[4] and introduces assessments that quantify the impacts of Medicaid expansion and the COVID-19 PHE on medication access and adherence.

Sections II and III explore the chain of events that are critical precursors to achieving medication adherence. For adherence to a prescribed drug regimen to occur, access to the medication(s) via an initial prescription must be secured. In turn, for persons living in or near poverty, health insurance coverage is often needed to successfully initiate a medication regimen. In significant

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[2] https://www.kff.org/policy-watch/taking-a-closer-look-at-characteristics-of-people-in-the-coverage-gap/

[3] Note that prescriptions for persons dually eligible for Medicaid and Medicare, which represent approximately half of the prescriptions that the overall Medicaid population receives, are predominantly paid for by Medicare Part D plans and are not the focus of this report.

[4] https://themengesgroup.com/2014/10/29/prescription-drug-adherence-in-medicaid-managed-care/

but opposing ways, Medicaid expansion and the COVID-19 PHE have strongly influenced the degree to which millions of persons can adhere to a needed medication regimen.

The remainder of the report explores key state policy-shaping decisions that foster or inhibit medication adherence (Section IV), describes specific initiatives that Medicaid MCOs have implemented (Section V), and tracks the progression of Medicaid MCO scores across the past decade on HEDIS measures that involve medication adherence (Section VI).

II. Medicaid Expansion Impacts on Prescription Drug Access and Adherence

We divided states into two groupings to quantify the impacts of Medicaid expansion on Medicaid prescription drug volume. The first group includes the 21 states and the District of Columbia, which adopted Medicaid expansion in calendar year (CY) 2014 but had not previously covered the Medicaid expansion adults prior to 2014. The second group includes 18 states which had not adopted Medicaid expansion as of 2016. We tracked the progression of these groups' Medicaid prescription volume from 2013 to 2016, as summarized in Exhibit 1. Note that we exclude the five states that had been serving the Medicaid population prior to the passage of the Affordable Care Act (i.e., Arizona, Delaware, Massachusetts, New York, and Vermont) and the five states that adopted expansion in 2015 or 2016 (i.e., Alaska, Indiana, Louisiana, Montana, and Pennsylvania). We also removed 2014 and 2015 from these analyses as the Medicaid expansion population was phasing into coverage throughout these years.

Exhibit 1. Medicaid Prescription Drug Volume Comparison – All Drugs

	Timeframe	Adopted Medicaid Expansion During CY2014 (21 states + DC)	Did Not Adopt Medicaid Expansion as of CY2016 (18 states)
Prescriptions	CY 2013	216,100,574	149,826,562
	CY 2016	357,262,932	189,514,424
	Percent Increase	65.3%	26.5%
Enrollees	CY 2013	24,337,084	19,746,749
	CY 2016	35,434,988	21,949,542
	Percent Increase	45.6%	11.2%

Note: The 2014 expansion states exclude the five states that had been serving the Medicaid population prior to the passage of the Affordable Care Act and the five states that adopted expansion in 2015 or 2016.

Medicaid prescription volume increased by 27% between 2012-2013 and 2015-2016 in non-expansion states, compared to a 65% increase in the expansion states. Medicaid enrollment across the expansion states increased by 46% between these time periods. Using these figures, we estimate that the Medicaid expansion population accessed an average of 13.96 prescriptions per year, a usage rate that is 57% above the average of 8.88 for the base (non-expansion) Medicaid population. These figures are presented in Exhibit 2.

Exhibit 2. Number of Prescriptions per Enrollee in CY2016 Among States that Adopted Expansion in 2014

Population Group	Total Prescriptions, 2016	Average Enrollees, 2016	Prescriptions Per Medicaid Enrollee Per Year
Base Medicaid Population	240,207,066	27,051,939	8.88
Medicaid Expansion Enrollees	117,055,866	8,383,049	13.96
All Medicaid Enrollees	357,262,932	35,434,988	10.08

Several prior studies, including The Menges Group's own 2021 assessment of Medicaid expansion,[5] have found that the majority of persons accessing health coverage through Medicaid expansion were otherwise uninsured. Our analyses have indicated that 75% - 80% of persons enrolling in Medicaid through the Medicaid expansion eligibility category were uninsured at the point of doing so, with the remaining persons converting to Medicaid from private insurance.

Medicaid expansion coverage has been valuable in facilitating ongoing access to medication regimens. We conducted further comparisons between the two state groups' prescription drug usage in five therapeutic classes where ongoing medication regimens typically occur and are clinically optimal:

- Cardiovascular beta blockers
- Insulin
- Selective serotonin reuptake inhibitors (SSRIs)
- Statins
- Thyroid drugs

We track the progression of Medicaid prescription volume among these therapeutic classes from 2013 to 2019. For this analysis, our expansion state grouping includes states that adopted Medicaid expansion in either CY 2014 or 2015, bringing our sample size up to 24 states plus D.C. (Alaska, Indiana, and Pennsylvania adopted Medicaid expansion in 2015). Similar to our prior tabulations, we exclude the states that covered the expansion population prior to 2014 (i.e., Arizona, Delaware, Maine, Massachusetts, New York, and Vermont) as well as the states that implemented Medicaid expansion between 2016 and 2019 (i.e., Maine, Montana, Louisiana, and Virginia). These findings, summarized in Exhibit 3, suggest that Medicaid expansion has been instrumental in increasing access to maintenance medications on a large scale in terms of the size of the population being supported.

[5] https://www.themengesgroup.com/upload_file/medicaid_expansion_impacts_report_menges_group_august_2021_final.pdf

Exhibit 3. Nationwide Medicaid Prescription (Rx) Drug Volume Comparison – Five Selected Therapeutic Classes

Therapeutic Class	States Newly Covering Medicaid Expansion Population Beginning in 2014 or 2015 (24 states + DC)			States Not Expanding Medicaid as of CY2019 (17 states)		
	Medicaid Rx, CY2013	Medicaid Rx, CY2019	% Change, 2013-2019	Medicaid Rx, CY2013	Medicaid Rx, CY2019	% Change, 2013-2019
Cardioselective Beta Blockers	3,286,094	5,749,049	75%	1,330,519	1,513,413	14%
Insulin	3,190,139	5,832,729	83%	1,478,703	2,065,551	40%
SSRIs	8,992,647	14,684,098	63%	4,235,753	5,316,072	26%
Statins	5,612,526	12,402,236	121%	2,329,381	3,164,485	36%
Thyroid Drugs	3,052,244	6,074,565	99%	1,343,238	1,776,397	32%
All Medicaid Prescriptions	**253,737,498**	**400,649,829**	**58%**	**135,563,004**	**165,465,081**	**22%**

The overall Medicaid population increased by 39% from 2013-2019 across the states newly covering the Medicaid expansion population in 2014 or 2015. However, in the five therapeutic classes we assessed where the drug regimens represent maintenance medications for a chronic health condition, the volume of Medicaid prescriptions across these states jumped upwards dramatically – ranging from a low of 75% for beta blockers to a high of 121% for statins. During the same timeframe across the states that did not adopt Medicaid expansion, Medicaid prescription volume increased less sharply and more in line with Medicaid enrollment growth, with increases ranging from 14% for beta blockers to 40% for insulin.

States that have expanded Medicaid have noted increased enrollment among adults living with chronic conditions, diabetes, depression, and cardiovascular risk factors.[6] Medicaid expansion in these states provided previously uninsured populations with increased access to health services, including prescription medications. Alternatively, non-expansion states have higher rates of uninsured populations, which are less likely to receive preventive care for major health conditions and often delay prescription drug use due to high out of pocket costs.[7]

It is most common for Medicaid maintenance prescriptions used to treat chronic diseases to be dispensed as a one-month supply. Mail service and longer days' supply (e.g., 90-day prescription fills) at retail pharmacies are not used extensively in Medicaid (an issue and opportunity that is discussed further in this paper). Given these dynamics, we divide the annual prescriptions by 12 to yield an estimate of the number of Medicaid enrollees accessing a given maintenance medication in a 30-day supply. Using this approach, the calculations in Exhibit 4

[6] https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report/

[7] https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

estimate the number of people who were able to access medications in each of the five therapeutic classes we assessed due to the implementation of Medicaid expansion.

Exhibit 4. Estimated Number of Persons Accessing Maintenance Medications Due to Medicaid Expansion – Five Selected Therapeutic Classes

Therapeutic Class	States Newly Covering Medicaid Expansion Population Beginning in 2014 or 2015 (24 states + DC)	States Not Expanding Medicaid as of CY2019 (17 states)
	Estimated Additional Persons Receiving These Medications in 2019 vs. 2013	Estimated Additional Persons Receiving These Medications in 2019 vs. 2013
Cardioselective Beta Blockers	205,246	15,241
Insulin	220,216	48,904
SSRIs	474,288	90,027
Statins	565,809	69,592
Thyroid Drugs	251,860	36,097
All Medicaid Prescriptions	**12,242,694**	**2,491,840**

These tabulations indicate that approximately 474,000 additional persons are regularly receiving SSRIs due to the implementation of Medicaid expansion, along with 566,000 additional persons regularly receiving statins, and approximately 200,000 to 250,000 additional persons regularly accessing medications in each of the other three therapeutic classes assessed: insulin, cardioselective beta blockers, and thyroid drugs.

Considering the above information, Medicaid expansion's reach extends beyond the health coverage it delivers. Medicaid expansion has been a major catalyst in facilitating overall access to medications, and particularly maintenance medications, for Medicaid expansion enrollees living with chronic conditions. As described throughout the remainder of this report, enrollees' Medicaid coverage does not ensure consistent access and adherence. Across states, an array of systematic data tracking and supports are still needed to strengthen the Medicaid benefit. Nonetheless, Medicaid expansion has created the opportunity for access and adherence to occur for the millions of persons who gained eligibility and coverage. In addition, a large majority of Medicaid expansion enrollees are enrolled in Medicaid MCOs, where there may be more resources for broad access and adherence data tracking and outreach initiatives.

III. COVID-19's Impact on Prescription Drug Access and Adherence

The COVID-19 PHE appears to have substantially dampened Medicaid enrollees' medication usage, despite efforts by Congress and the Executive Branch to increase funding to states and preserve coverage for Medicaid enrollees as part of COVID-19 relief legislation.[8] Due to the

[8] https://www.cbpp.org/research/health/unwinding-the-medicaid-continuous-coverage-requirement

PHE's devastating economic impacts, the average yearly Medicaid enrollment increased from 71.4 million persons during 2019 to 83.8 million persons during 2021 – an overall increase of 17.4%. This level of enrollment growth would typically be expected to translate to a large increase in Medicaid prescription volume. However, the nationwide Medicaid prescription volume only increased from 721.7 million prescriptions in 2019 to 730.9 million prescriptions in 2021 – representing a 1.3% increase.

The number of prescriptions per Medicaid enrollee averaged 10.10 during 2019 but dropped to 9.12 during 2020 and 8.72 during 2021 – an overall decrease of 13.7% from 2019 to 2021. If prescriptions per Medicaid enrollee had remained at 10.10 throughout the pandemic, approximately 190 million additional prescriptions would have been filled during 2020 and 2021 combined. The magnitude of this drop-off is concerning as it appears to represent a significant drop in Medicaid enrollees' access and adherence to necessary medications.

Given this finding, we conducted "drill down" analyses of Medicaid prescription usage in the same five therapeutic classes assessed in the prior section. The nature of these therapeutic classes indicates that enrollees using these medications prior to the pandemic would continue to need the medications and maintain adherence throughout the PHE. Our tabulations are summarized in Exhibit 5, with the key findings described below.

Exhibit 5. Medicaid Prescription Volume Trends During COVID-19, Selected Therapeutic Classes

	Medicaid Prescriptions			Percent Change		
Therapeutic Class	**CY2019**	**CY2020**	**CY2021**	**CY2019 - CY2020**	**CY2020 - CY2021**	**CY2019 - CY2021**
Cardioselective Beta Blockers	9,418,335	9,054,342	9,004,153	-3.9%	-0.6%	-4.4%
Insulin	9,802,117	9,833,532	9,779,224	0.3%	-0.6%	-0.2%
SSRIs	25,101,621	26,075,966	28,083,931	3.9%	7.7%	11.9%
Statins	20,589,724	20,449,566	20,989,251	-0.7%	2.6%	1.9%
Thyroid Drugs	10,176,149	9,998,539	10,066,738	-1.7%	0.7%	-1.1%
All Medicaid Prescriptions	**721,653,423**	**691,596,159**	**730,862,397**	**-4.2%**	**5.7%**	**1.3%**

In three of the five therapeutic classes assessed, there was a nationwide decrease in Medicaid prescription volume from 2019 – 2021 despite the 17.4 percent increase in Medicaid enrollment that occurred across this timeframe. Thus, if *none* of the 12 million persons enrolling in Medicaid due to the pandemic needed these medications, a decrease in usage still occurred. These are therapeutic classes – beta blockers, insulin, SSRIs, statins, and thyroid drugs – where the clinical risks of non-adherence are of considerable concern.

The one category we assessed where raw Medicaid usage increased nationally from 2019 to 2021 was SSRIs, in which usage grew by 8.2%. A meaningful increase in this drug class would be expected to occur, given the social isolation, economic hardship, fear, and bereavement

dynamics that have been widely associated with the COVID-19 PHE. However, when we assess SSRIs on a per-enrollee basis, even this therapeutic class experienced decreased usage between 2019 and 2021.

As shown in Exhibit 6 below, the number of prescriptions per covered person decreased by 13.7% for all Medicaid prescriptions. Per-enrollee usage rates also dropped across the therapeutic classes we analyzed, including a decrease of 4.6% for SSRIs, 18.5% for beta blockers, 15% for insulin, 15.7% for thyroid drugs, and 13.1% for statins.

Exhibit 6. Medicaid Per-Person Prescription Volume Trends During COVID-19, Selected Therapeutic Classes

Prescriptions per Medicaid Enrollee by Year, 2019-2021				
Therapeutic Class	**CY2019**	**CY2020**	**CY2021**	**Percent Change, 2019-2021**
Cardioselective Beta Blockers	0.13	0.12	0.11	-18.5%
Insulin	0.14	0.13	0.12	-15.0%
SSRIs	0.35	0.34	0.33	-4.6%
Statins	0.29	0.27	0.25	-13.1%
Thyroid Drugs	0.14	0.13	0.12	-15.7%
All Medicaid Prescriptions	**10.10**	**9.12**	**8.72**	**-13.7%**

The COVID-19 pandemic has exposed the fragility of medication access and adherence among Medicaid enrollees. The medication access dynamics of COVID-19 may be an important issue to study in detail as part of the nation’s efforts to identify and address health inequities.

It is also worth noting that the level of excess deaths in the United States during 2020 and 2021 was well above the number of deaths directly attributed to COVID-19. It is possible that the drop-off in maintenance medication access and adherence among Medicaid-covered persons during the pandemic could have contributed to many deaths. This is another issue that may warrant closer research, as the Medicaid-covered persons who stopped accessing their medications during COVID-19 can be identified, and their health trajectory can be traced from that point forward.

IV. State Program Design Features that can Facilitate or Inhibit Medication Adherence

As of CY2021, more than 70% of the nation’s Medicaid population were enrolled in an MCO, and more than 70% of all Medicaid prescriptions were paid for by MCOs. States have significant control over the design of their Medicaid managed care programs, and these design decisions have a considerable effect on the degree to which optimal prescription drug access and adherence can occur. State “macro-level” design features that can set the table in favor of, or against, optimal medication adherence include:

- The degree to which the State Medicaid agency creates an integrated system of coverage versus a set of siloed contracts

- MCO contract requirements related to systems of care integration

Each of these state policy issues is described below:

Integrated System of Coverage and Care Coordination: A longstanding tenet in the coordinated care arena involves creating a "whole person focus" rather than having individuals self-navigate across siloed providers and health services. The degree to which each state instills accountability for whole person care at the MCO level cascades down significantly – either positively or adversely – in facilitating most aspects of care coordination, including the degree to which medication adherence is tracked and supported. Instead of including all Medicaid-covered services in an MCO's capitation payment, many states require certain services to be "carved out" of the MCO's required coverage. Common carve-out services include behavioral health services, dental services, and prescription drugs.

Inclusion of the prescription drug as part of the MCO's covered services responsibility can support adherence in the following ways:

- The MCO is regularly interacting with prescribers and pharmacies in an integrated model, as the payer of the prescription drugs. Through these interactions, the provider receives the MCO's information and context (e.g., regarding other health needs of the enrollee and services being accessed) and the MCO receives information from the prescribers and pharmacists that can be of benefit to the health plan's care coordination efforts (e.g., information about the Medicaid enrollee's adherence strengths and challenges).
- Under an integrated model, the MCO either directly "owns" the prescription drug data or, through its contract with an external pharmacy benefit manager (PBM), controls the way the drug data is provided and accessed by them. The health plan can therefore structure the data to best accommodate their overall care coordination process, and ensure their staff have access to these data in real time. Conversely, in a prescription drug benefit "carve-out" setting, the timing and nature of the prescription drug data provided to the MCOs is determined by the state or its PBM and is not tailored to each MCO's desired data structure or care coordination process. In a carve-out model, the drug data are typically slower to arrive and more difficult to work with from the perspective of the MCO and its staff.
- MCOs are more likely to invest in outreach and adherence supports when they are financially responsible for the drug benefit. Under the prescription drug carve-in model, MCOs are responsible for the pharmacy costs and must also consider prescription drug access and costs in the context of total costs of care of each enrollee.

Notwithstanding the above advantages of establishing and maintaining a fully integrated system of coverage and care coordination, state policymakers also need to be cognizant of the risks described below. It is critical that states ensure that MCOs and PBMs are held accountable through adequate contract requirements, oversight processes, and corrective actions where appropriate:

- There is a broad risk that health plans could deny needed care to save money. While it will generally be in the MCO's direct financial interest to facilitate (rather than impede) medication adherence – to avoid a more costly clinical decline – strong and ongoing monitoring of the MCOs is central to the design and operation of an optimal Medicaid coordinated care program.
- Prior authorization requirements can be "over-deployed" in a manner that prevents timely access to needed medications. MCO and PBM prior authorization requirements should themselves be closely reviewed and approved by state regulators and subjected to ongoing monitoring.
- The prescription drug benefit also needs to be managed in a cost-effective manner, which includes but is not limited to the transparency of the pricing and rebate mechanisms used by Medicaid MCOs, PBMs, state agencies, pharmacies, and drug manufacturers.

Requiring MCOs to Coordinate Care Directly: States can establish contract requirements that dictate the degree to which MCOs can and cannot "carve out" services to an external vendor. For example, in its 2021-2022 procurement of Medicaid MCO contractors, the District of Columbia no longer allowed MCOs to subcontract any case management services, although a later amendment clarified that care coordination services could still be conducted by third parties/vendors. Requirements of this nature help ensure that the State's whole person focus does not become compromised by the MCOs' own administrative structure (by including all services in the MCO capitation).

Other MCO Adherence-Related Contract Requirements and Procurement Features: In many instances, states will use the procurement process to motivate MCOs to not only meet standard medication adherence-related contract requirements but to encourage competition among bidding entities to implement innovative adherence initiatives that exceed the minimum requirements. Below, we describe several categories of procurement questions that states have used to promote medication adherence among Medicaid MCO enrollees.

1. **Promoting access to covered drugs and adherence to the preferred drug list (PDL).** States have used the procurement process to demonstrate how they are actively promoting medication access, adherence, and appropriate utilization among their covered populations. For example, Kentucky's 2019 request for proposals (RFP), North Carolina's 2020 behavioral health/intellectual and developmental disabilities (I/DD) Tailored Plan RFP, North Carolina's 2019 Prepaid Health Plan (PHP) RFP, and Illinois' 2018 HealthChoice RFP each required respondents to describe their methods to ensure members maintained sufficient access to covered drugs and adherence to the state's PDL as part of their utilization management approach.
2. **Medication therapy management (MTM) data to identify polypharmacy, medication interactions, and overutilization.** States often require MCOs to demonstrate how they will spot, monitor, and address instances of medication mismanagement. For example,

Pennsylvania's 2015 Community Health Choices RFP required plans to describe their approach to MTM, polypharmacy, and medication interactions, including programs and initiatives that have been successful at monitoring and ensuring appropriate utilization and adherence. New Hampshire's 2018 RFP asked plans to describe how their medication review will incorporate the use of pharmacy claims, provider reports, comprehensive assessments and care plans, contact with the member's provider(s), and other health information, as well as each plan's proposed approach to conducting medication review and counseling, particularly for members at risk of harm due to polypharmacy.

3. **Medication adherence for certain medication categories and subpopulations.** States have often required MCOs to focus on select quality measures. For example, Kentucky's 2019 Medicaid MCO RFP required plans to discuss strategies and interventions specific to the Pharmacy Quality Alliance's Medication Adherence for Diabetes Medications measure, and for vendors to describe their potential challenges, how those challenges will be addressed, and examples from other states of improving the quality score, as well as how those lessons could be leveraged in Kentucky. Some states have also homed in on adherence for subpopulations, such as New Hampshire's 2018 Medicaid Care Management RFP requirement that requires respondents to describe their capabilities and approach for addressing medication management among children with special health care needs.
4. **Program efficacy and improvements.** States often encourage bidding entities to submit evidence that their medication management programs are effective. For example, Florida's 2017 Medicaid Invitation to Negotiate (ITN) required a description of performance metrics used to evaluate the efficacy of plans' disease management program, including cost savings, increase in treatment adherence, and measurement of the impact on potentially preventable events. New Hampshire's 2018 RFP required plans to show improvements in their medication management initiatives in other markets. States also often ask plans to submit HEDIS scores to validate their improvements. Both Florida's 2017 ITN RFP and Washington's 2018 Apple Health Integrated Managed Care (IMC) Statewide RFP required plans to submit their HEDIS *Antidepressant Medication Management* scores. Florida also required the submission of scores for the *Adherence to Antipsychotic Medications for Individuals with Schizophrenia* HEDIS measure.
5. **Role of care coordination.** States often want to see how plans are employing their care coordination strategies to identify and treat member medical conditions. Illinois's 2018 RFP required plans to describe their process for applying evidence-based practices, such as metabolic screening to avoid medication misuse. Florida's 2017 ITN RFP required a description of plans' evidence-based guidelines utilized in the care coordination approach, including interventions targeted at improving enrollee engagement and treatment adherence.
6. **Member case scenarios.** To assess how MCOs would react to medication access or adherence issues among their enrollees, states often construct hypothetical member scenarios and ask plans to describe their comprehensive response to meeting member

needs and meeting (and often exceeding) state contract requirements. For example, Washington's 2018 Apple Health IMC RFP provided a case scenario where medication use was a factor in the member's predicament. The case scenario then asked plans to describe outreach strategies the plan would use to engage with the member (who was living with physical and behavioral health conditions), what medical services would be available to them, and how the member could receive medication management assistance.

7. **Emergency preparedness planning.** In the event of an emergency, plans must show how they will ensure continuity of member care, including maintaining access to medications. For example, North Carolina's 2018 PHP RFP required plans to describe their process and procedures to ensure medication access, and therefore adherence, during a state of emergency or disaster.

In Section V below, we show how states have used the procurement process to encourage MCOs to compete with each other to implement innovative features (which exceed the program's minimum contract requirements) that can strengthen medication access and adherence.

V. Medicaid MCO Efforts to Optimize Medication Adherence

Medicaid MCOs often implement a wide array of initiatives to identify, monitor, facilitate, and promote prescription drug adherence issues among their enrollee populations. In recent years, Medicaid MCOs have developed more integrated and comprehensive activities to identify adverse medication utilization, provide a comprehensive and integrated support system to close care gaps, communicate with members to promote adherence, and reduce costs to increase access to affordable medication. The following points include overall trends identified through an analysis of Medicaid MCO RFP responses from 2015 to 2021.

- Care management has been increasingly used as an integrated entity to communicate with members, caregivers, providers, and pharmacists to promote medication adherence.

- Medicaid MCOs are now considering SDOH as part of their assessment activities to promote targeted communication efforts that effectively promote medication adherence based on members' unique needs and circumstances.

- Medicaid MCOs have emphasized prompt communication and collaboration across all appropriate stakeholders, including members, caregivers, providers, and pharmacists, to improve adherence.

- Similar to the condition-specific educational campaigns noted prior to 2014[9], many MCO communication initiatives are targeted at promoting adherence among members diagnosed with certain conditions, such as asthma, diabetes, and Hepatitis C.

This section is categorized into the following areas:

- Data analytics to identify adherence gaps and assess the effectiveness of supports
- Importance of MTM programs to support adherence
- Integration of value-based care in medication adherence
- Member communication initiatives to promote medication adherence
- Increased use of mail service and multi-month prescriptions
- Eliminating out of pocket costs and providing adherence supports

Data Analytics to Identify Adherence Gaps and Assess the Effectiveness of Supports

Medicaid health plans and their PBM subcontractors often use pharmacy claims data to identify potential gaps in enrollee adherence. These data can serve as a primary form of "real-time" data tracking, as they provide direct insight at the point medications are filled. PBMs are often central to tracking these data and provide actional reports to MCOs, which review these data and reports to identify cases where a needed prescription was not filled or picked up by a member. In these cases, the MCO can subsequently notify the case management staff, the prescribing physician, and/or the member with the potential gap in medication adherence.

Two factors have prompted MCOs to target certain drug classes for more regular and frequent data monitoring to identify potential gaps in adherence. First, the entrance of the Medicaid expansion population brought millions of adults into the program, many of whom had significant health needs. Second, the pipeline of new, innovative drugs covered under the Medicaid pharmacy benefit requires more stringent adherence to realize medication efficacy. More focused data analytics efforts are often centered around maintenance medications (e.g., diabetes and asthma medications) and specialty medications (e.g., Hepatitis C treatment).

Beyond assessing refill gaps, MCOs will review other data sources to retroactively identify adherence challenges, such as inappropriate emergency room visits, polypharmacy, and other hospital utilization. MCOs will specifically target members upon an inpatient discharge to offer high touch, coordinated care management for members struggling to comply with their medication regimen.

Since Medicaid expansion began in 2014, some Medicaid MCOs have adopted a newer focus on addressing SDOH needs and health equity for their members. These MCOs consider SDOH data, such as members' race, ethnicity, and geographic location, as part of their care management

[9] https://www.themengesgroup.com/upload_file/medication-adherence-in-medicaid-managed-care-final-report1.pdf (Section G)

assessments to inform a holistic understanding of their members' needs. This data is often used preemptively and retrospectively to identify barriers to medication adherence and inform initiatives to support adherence.

In our review of Medicaid MCO RFP responses, SDOH assessments typically occur at the MCO level during care planning activities and new enrollee screenings and are not typically integrated with PBMs' analytical modeling efforts. Thus, there appears to be a greater opportunity for integrating SDOH data into MCO and PBM analytical efforts to identify and address barriers to medication adherence. As health insurers, providers, PBMs, and other sectors of the healthcare market continue to enhance vertical integration, states are increasingly well-positioned to demand more from their contractors in the SDOH arena. Stronger SDOH assessment efforts and programmatic initiatives to address SDOH challenges are essential components of elevating health outcomes for the Medicaid population. Elevating SDOH-focused efforts is also an important component in reducing health disparities and achieving greater health equity.

Importance of Medication Therapy Management Programs to Support Adherence

MTM programs promote optimal medication use, adherence, and health outcomes, as well as help reduce adverse events and drug interactions. These programs usually target Medicaid enrollees living with multiple chronic health problems, concurrent users of multiple medications, or individuals with abnormally high medication costs.

MTM interventions generally include a combination of comprehensive medical review, medication management action plan, patient-directed education and counseling, and care coordination among all of the patient's providers.[10] Through patient data (e.g., population health data, patient medication lists, provider service referrals, enrollment during a transition in care, high-risk patients starting a new drug regimen), pharmacists, primary care providers, and other clinicians will usually initiate routine patient outreach via telephone, by mail, or virtually, to identify patients with potential gaps in medication therapy or unusual spending or utilization trends and develop an action plan to ensure patients receive appropriate drug therapy. Prescribers and providers will often be notified of any unresolved care gaps at some interval after the initial outreach call.

Integration of Value-Based Care in Medication Adherence

Medicaid agencies and Medicaid MCOs are seeking to introduce performance-based and value-based mechanisms to move beyond a compensation system that has traditionally rewarded volume rather than health outcomes. A myriad of performance-based compensation incentives now exists between states and MCOs, and between MCOs and many of their network providers. These types of payment arrangements are used more extensively with each passing year. However, the degree to which these performance-based incentives are used to achieve optimal medication adherence is modest. Significant opportunities remain for states, MCOs,

[10] https://www.amcp.org/sites/default/files/2019-03/AHRQ-MTM-Systematic-Review_0.pdf.

PBMs, prescribing physicians, pharmacies, and perhaps even drug manufacturers to further tie compensation to medication adherence outcomes.

Many value-based payment (VBP) structures are tied to HEDIS performance measures, and seven of the 71 HEDIS measures involve medication access and adherence. Three examples of these measures are shown in Exhibit 7.

Exhibit 7. HEDIS Measure Examples Involving Medication Adherence

HEDIS Measure	Measure Definition
Antidepressant Medication Management (AMM)	Assesses adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications.
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	Assesses adults 18 years of age and older who have schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.
Statin Therapy for Patients with Diabetes	Assesses adults 40-75 years of age who have diabetes and who do not have clinical atherosclerotic cardiovascular disease (ASCVD), who received and adhered to statin therapy.

One opportunity to leverage VBP arrangements to monitor and strengthen medication adherence involves including some or all of the seven adherence-related HEDIS measures in the performance incentives that are agreed upon between states and Medicaid MCOs, and between MCOs and selected network providers. However, it is also important to not overly attach performance funds to a handful of specific HEDIS measures that, even collectively, capture a small proportion of the broad issue of how optimally medication adherence is occurring overall.

To incorporate VBP in the medication adherence arena in a larger and broader manner, it is useful to consider tracking metrics such as:

- In each month, how many situations occurred where a given Medicaid MCO's enrollee is on an ongoing prescription regimen where a refill seems warranted?
- In what percentage of these instances did the refill occur?
- In the situations where a refill did not occur, how many members (and/or caregivers) were successfully contacted within a certain number of days prior to the expiration date of the prior prescription's days' supply?
- Among those enrollees and prescribers successfully contacted, to what degree was it determined that the refill did not need to occur?

Whatever measures are used, adherence-focused incentive payments could occur between any combination of the following parties:

- Between the state Medicaid agency and each participating Medicaid MCO
- Between the state Medicaid agency and its contracted PBM (in states where prescription drugs are paid in the FFS setting rather than by MCOs)
- Between the state Medicaid agency and the drug manufacturer
- Between the MCO/PBM and selected prescribing physicians
- Between the MCO/PBM and selected pharmacies
- Between the MCO and its PBM contractor, where applicable

VBP arrangements are contractually negotiated and need to be accepted by both parties. Therefore, it is beneficial for all parties to work through these arrangements flexibly. The amount of incentive money available is an important issue in these contracting efforts, as is the degree to which the providers only have "upside" bonus opportunities versus "downside" risk when performance is below an established or expected threshold. Providers engaging in VBP contracts also need to have a reasonable opportunity to exert influence over the metrics tied to performance incentives. A potential incentive could be structured around the degree to which the percentage of refills that did not occur (plus those refills that did not occur but were found not to have been needed) has been minimized.

Notwithstanding these challenges, significant opportunities exist to utilize VBP arrangements to track medication adherence more systematically and to motivate and reward accomplishments in this area.

Member Communication Initiatives to Promote Medication Adherence

Medicaid MCOs have implemented various communication initiatives with members, providers, caregivers, and pharmacists to promote medication adherence. These efforts range from proactive general education for members to targeted efforts that directly address identified adherence concerns and gaps in care. Derived from our analysis of several Medicaid MCO RFP responses from 2015 to 2021, the ensuing section includes trends and examples of Medicaid MCO communication initiatives to promote medication adherence. These initiatives are either required by states or enacted by MCOs as value-adds to exceed minimum contract requirements.

Member Outreach and Education to Promote Medication Adherence

Medicaid MCOs often use care management to educate members about their medications and the importance of adherence. MCO care managers can be alerted to provide this education to members upon notification of a prior authorization request or a new medication fill by the member. States also require MCOs to use low-cost efforts, such as newsletters, websites, and mailings, to engage and educate members on medication management. MCOs often use these resources to notify enrollees regarding formulary changes and increase access to covered medications.

Overall, MCO educational outreach efforts regarding adherence tend to target members who are prescribed specific medications or medications within certain drug classes.[11] Plans will generate care management referrals once requests to the pharmacy for these medications are submitted, and the medical director and plan pharmacist may review these cases. In recent years, states and MCOs have also implemented a stronger focus on including SDOH as part of care management assessments to identify member needs and barriers to medication adherence and inform effective education efforts.

Furthering Medication Adherence Through Member-Initiated Communication

Medicaid MCOs typically offer designated outlets to educate and assist members with concerns about their medications to support medication adherence. This can include call centers and dedicated help desks (through the MCO or their partnering PBM) staffed with pharmacists to answer questions and address concerns related to their prescribed medications. For example, MCOs may staff their call center with pharmacists who can access members' pharmacy utilization to determine any nonadherence and identify challenges to adherence.

Text Messaging and Refill Notifications

To promote adherence, Medicaid MCOs often give members and caregivers the option to sign up for automated phone calls, texts, or email reminders to alert them when it is time for their prescription(s) to be refilled or picked up.

Some MCOs also allow members or caregivers to download a mobile application or opt into daily text messages reminding them to take or administer medications at appropriate times. Mobile applications can offer resources like adherence education, reminder notifications to take the next dose of a medication, quantity tracking, refill alerts, drug interaction warnings, and in-app incentives that reward compliance. Some apps can notify family members, caregivers, pharmacists, and other members of the Medicaid enrollee's care team of instances or trends of non-compliance.

Tracking Care Gaps and Communicating Cases of Non-Adherence or Potential Non-Adherence

In addition to automated refill notifications, Medicaid MCOs have various mechanisms to track gaps in care (e.g., missed refills), and promptly engage the appropriate stakeholders (e.g., members, caregivers, providers, and pharmacists) to address adherence gaps. For example, health plans may review claims info to identify adherence concerns and then reach out to the prescriber, member, or caregiver to identify and collaboratively address the enrollee's specific adherence challenges. Plans may use innovative strategies to streamline the medication refill process, such as integrating pharmacies and prescribers to synchronize medication refills,

[11] Based on our analysis of Medicaid MCO RFP responses, educational efforts by MCO care managers have been focused on drugs such as asthma medications, ADHD medications, antipsychotics, diabetes medications, statins, and Hepatitis-C medication.

offering options to sort and package refills for easy administration, and delivering medication to the member's home.

MCOs target adherence efforts towards members who have demonstrated a high risk for non-adherence or who already experience adherence challenges. For example, patients being discharged from a hospital setting, children with special health care needs, or members taking specific classes of drugs like antidepressants or diabetes medications may receive targeted support. One MCO, for example, described in their 2018 Health Choices Illinois proposal that they review their PBM's adherence reports to identify enrollees who are non-adherent to targeted drugs or drug classes, and their pharmacy director conducts high-cost case clinical reviews to identify any adherence issues associated with enrollees taking high-cost medications.

Collaboration Between MCOs, Pharmacies, Providers, and Members

As demonstrated by the initiatives discussed throughout this section, states and Medicaid MCOs have emphasized collaboration with pharmacies, providers, and members to more comprehensively assess enrollee medication use and health needs and to improve health and medication adherence. A Medicaid MCO's care management team is often central to these communication efforts. The MCO will coordinate with their clinical team, members, caregivers, providers, and pharmacists through care management activities. These teams communicate gaps in adherence and work together to develop person-centered interventions to address medication adherence challenges.

Increased Use of Mail Service and Multi-Month Prescriptions

Medicaid enrollees overwhelmingly fill and refill their maintenance medications on a 30-day supply basis due to traditional volatility in eligibility and enrollment. The uptake of mail-order prescriptions in Medicaid has traditionally been lower than in other markets such as Medicare Part D, which requires plans to offer members adequate access to mail-order pharmacies and at least one retail pharmacy that provides 90-day supplies.[12] Commercial carriers also commonly offer 90-day fills at mail-order pharmacies at similar rates to those at local pharmacies.[13]

Medicaid's lower usage of mail-order pharmacies is due to concern from payers (e.g., Medicaid agencies, MCOs, and PBMs) regarding the Medicaid population's eligibility volatility, housing insecurity, and lack of consistent access to technology. Payers have been averse to providing a 90-day supply for persons whose coverage may terminate within the upcoming 90 days, or those who may not have a reliable way to receive their medicines or the means to connect with the mail-order pharmacy online or by phone.

[12] https://medicareadvocacy.org/medicare-info/medicare-part-d/#_edn62

[13] https://www.goodrx.com/healthcare-access/pharmacies/5-things-to-consider-before-using-a-mail-order-pharmacy

Medicaid health plans are increasingly achieving better data capture on SDOH dynamics, which can discern where mail-order prescriptions can be used with a strong level of confidence. Beyond often involving a 90-day supply, mail service for maintenance medications eliminates the adherence gaps that occur by forcing an individual to get to and from the retail pharmacy for a refill. Between the transportation barriers, childcare challenges, pharmacy deserts, and other dynamics many Medicaid enrollees face, telepharmacies and mail-order prescriptions create significant adherence and quality-of-life advantages due to associated time savings.

Mail-service prescriptions and telepharmacies are especially important in addressing "pharmacy deserts", which are low-access communities whose residents must travel farther to the nearest pharmacy to obtain their prescription medications.[14] A 2021 study published in *Health Affairs* discovered that one in three neighborhoods throughout the 30 largest cities in the United States were considered pharmacy deserts, and these often exist in rural neighborhoods as well.[15] A lack of access to a nearby pharmacy, or a pharmacy that accepts Medicaid, can directly impact health equity for Medicaid enrollees. Decreased access may lead to increased medication non-adherence, poorer health outcomes, and increased healthcare costs.

In our consulting experience within the industry, the above concerns are valid for many enrollees but are by no means universally applicable to the Medicaid population. Our data analyses in one Medicaid MCO identified that more than one-third of Medicaid enrollees at any given point in time under the age of 65 remained continuously covered by the Medicaid program for at least three years. These enrollees accounted for more than half of all the Medicaid prescriptions that MCO paid for.

Given these dynamics, significant opportunities persist for states and MCOs to move toward 90-day prescriptions. A 90-day supply reduces by a factor of three the opportunity for a missed refill to occur, relative to the more typical 30-day supply. To optimally promote and achieve medication adherence, it is critical to look at the Medicaid population much more "surgically" than as a coverage-volatile and housing-volatile group.

MCO Initiatives to Increase the Use of Mail-Order Services

Some Medicaid MCOs use home delivery services to promote medication adherence, citing the value of using mail-order prescriptions to address pharmacy deserts and other access challenges and SDOH needs which can hinder adherence. A handful of plans are exceeding state requirements by offering same-day medication delivery and experimenting with mailed refill programs that offer members alternatives to fill prescriptions that are linked to higher rates of satisfaction.

[14] https://www.healthaffairs.org/doi/10.1377/hlthaff.2013.1397

[15] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.01699?journalCode=hlthaff

Multi-Month Prescriptions

Prior to the COVID-19 pandemic, it was not common practice for Medicaid MCOs to use increased prescription quantity supply to promote medication adherence. Of the 11 Medicaid MCO RFP responses from 2015 to 2021 that we analyzed, only one response mentioned the use of multi-month prescriptions to increase adherence.[16]

State-mandated quantity limits are often a significant contributor to the lack of multi-month prescription supplies. However, in response to the pandemic, states began lifting restrictions on quantity limits. According to an analysis by the Kaiser Family Foundation, most states are allowing enrollees to have up to a 90-day supply of maintenance medications. Since the pandemic, 32 states have either increased quantity amounts or reduced limits on prescriptions.[17] Below are some examples.

State Policy Case Studies

North Carolina

During the COVID-19 PHE, North Carolina preserved and increased access to medications by allowing up to 90 days' supply fills or refills of most non-controlled substances; allowing early refills of most non-controlled substances; allowing up to 14 days' supply of a medication waiting on prior authorization; allowing up to 14 days' supply of an emergency lock-in prescription (with limitations); and suspending behavioral health edits to lessen administrative burdens on pharmacies and prescribers, among other interventions.[18]

Louisiana

During COVID, Louisiana began to adjust for early refills, longer days of supply, pick-up services, copays, prior authorization approvals, and retrospective DUR activities. New retrospective interventions included mailings to providers on nationally recognized DM guidelines on diabetes, sleep disorders, opioid safety, asthma, sickle cell disorder, behavioral health, and heart failure.

Oklahoma

Due to COVID-19, Oklahoma’s Drug Utilization Review Board allowed for a 90-day supply of many maintenance medications. In addition, Oklahoma partnered with a telepharmacy program to allow Medicaid members to access personalized care management. A

[16] One MCO offered an expansion of medication refills supplied from 30 to 60 days for many chronic physical and mental health conditions. They also began piloting a program for 60-day refills of common generic antidepressant and antipsychotic medications and prescriptions for diabetes, asthma, blood pressure, and lipid-lowering agents.

[17] https://www.kff.org/policy-watch/states-are-shifting-how-they-cover-prescription-drugs-in-response-to-covid-19/

[18] https://www.medicaid.gov/medicaid/prescription-drugs/downloads/2020-dur-ffs-summary-report.pdf

demonstration project launched in two counties saw a 40% decrease in hospitalizations for those enrolled in Oklahoma's Medicaid program. [19]

Eliminating Out of Pocket Costs and Providing Adherence Supports

As of July 2019, 37 state FFS programs required some members to pay copayments (enrollees like children and pregnant women are exempt from cost-sharing). States may implement different copayments for drugs on a PDL or generic drugs, compared to non-preferred or brand drugs. Per federal law, Medicaid copayments are capped at $4 for preferred drugs. For non-preferred drugs, states may require copays up to $8 for most enrollees with income at or below 150% of the federal poverty level. [20] Copayments can range up to the $4 cap for prescription medications accessed during their enrollment, while some states, like Wisconsin, cap medication copays at $12 per member per provider per calendar month.[21]

For many Medicaid enrollees, the affordability of their medications is often a significant barrier to adhering to consistent medication regimens. To encourage adherence, MCOs often reduce or waive copayments entirely to eliminate member cost-sharing, even where permitted by state law. Of the 37 states that allow FFS copayments, 13 states offer MCOs the same copayment requirements as FFS plans. However, as shown in Exhibit 8, ten states and the District of Columbia have different copayment requirements for MCOs.

Exhibit 8. MCO Copayment Structure in States where MCO Copays Differ from FFS Copays

State	FFS Copays Allowed?	Difference in MCO Copayment Structure versus FFS Copayment Structure
Arkansas	Yes	MCOs may not charge copays
District of Columbia	Yes	MCOs may not charge copays
Illinois	Yes	MCOs may set their own copays, no higher than FFS copays
Iowa	Yes	MCOs may not charge copays
Kansas	Yes	MCOs may not charge copays
Maryland	Yes	MCO copays may vary, five of the seven Maryland MCOs do not have copays
Michigan	Yes	MCOs may not charge copays, except for the Healthy Michigan Plan, which employs a cost-sharing responsibility process
Mississippi	Yes	MCOs may not charge copays
Nebraska	Yes	MCOs waive some copays
Ohio	Yes	MCOs may not charge copays
Virginia	Yes	MCOs may not charge copays

[19] https://mhealthintelligence.com/news/oklahoma-medicaid-program-uses-telehealth-to-boost-medication-management

[20] https://www.kff.org/medicaid/issue-brief/management-and-delivery-of-the-medicaid-pharmacy-benefit/

[21] https://www.kff.org/other/state-indicator/state-medicaid-pharmacy-copay-requirements/?currentTimeframe=0&print=true&sortModel=%7B%22colId%22:%22MCO%20Copays%20Differ%20from%20FFS%20Copays%22,%22sort%22:%22desc%22%7D.

In addition to copays, Medicaid enrollees are often unable to afford supplemental adherence supports such as color-coded pillboxes, pill cutters, reminder charts, and multi-lingual prescription labels. While relatively low cost, these tools have proven successful in increasing appropriate adherence to their medication regimens.

In recent years, costlier interventions to support medication adherence, including smart pill dispensers and pre-dosed pill packs, have become increasingly popular. Smart pill dispensers can keep track of patients' schedules and remind them to take the proper medication, while some can even send alert notifications to caregivers.[22] New pre-dosed pill pack subscription platforms offer single-use blister packs that are tailored to each member's medication regimen and are clearly labeled with the date and time that the medications housed within the packet should be taken. These pre-packaged blister packs are recommended for adults with multiple chronic conditions to increase medication adherence.[23]

These interventions are costlier than supports like pill boxes and medication reminder charts but could prove more effective in supporting medication adherence among Medicaid enrollees with multiple chronic diseases and a history of non-compliance. Medicaid MCOs should consider offering low-cost supports to all members with one or more chronic conditions, and higher cost supports to members with a history of medication non-adherence.

VI. Medicaid MCO Industry's Quality Tracking Regarding Medication Adherence

One of the key systems of care advantages in the Medicaid managed care arena is that quality measures can be and are closely tracked by states and the federal government. MCOs have competitive incentives, contract requirements, and reporting requirements to achieve strong and improving performance on a wide range of quality measures. Fifteen of these measures involve the degree to which Medicaid enrollees with certain health conditions are accessing and adhering to clinically indicated medication regimens. The Medicaid MCO industry's performance on these measures during the past several years is summarized in Exhibit 9, which tracks the progression of nationwide Medicaid MCO median (50th percentile) performance on each measure across time.

[22] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6843901

[23] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4562676/

Exhibit 9. Progression of Nationwide Medicaid MCOs' Median Score on Each HEDIS Medication Adherence Measure

Measure	Measure Acronym	Score in Initial Measurement Year	Score in Measurement Year 2019 (Prior to COVID)	Percentage Point Increase
Medication Management for People with Asthma: Medication Compliance 75% (Total)	MMA	28.8 (2012)	38.59	9.79
Subgroup, Ages 5-11	MMA	25.7 (2012)	31.80	6.10
Subgroup, Ages 12-18	MMA	25.4 (2012)	31.44	6.04
Subgroup, Ages 19-50	MMA	33.9 (2012)	42.79	8.89
Subgroup, Ages 51-64	MMA	50.1 (2012)	55.10	5.00
Persistence of Beta-Blocker Treatment After a Heart Attack	PBH	77.4 (2010)	80.37	2.97
Pharmacotherapy Management of COPD – Bronchodilator	PCE	82.1 (2010)	84.71	2.61
Pharmacotherapy Management of COPD - Systemic Corticosteroid	PCE	65.1 (2010)	71.05	5.95
Asthma Medication Ratio - Total	AMR	62.16 (2016)	62.43	0.27
Subgroup, Ages 5-11	AMR	74.01 (2016)	73.61	-0.40
Subgroup, Ages 12-18	AMR	63.09 (2016)	62.43	0.34
Subgroup, Ages 19-50	AMR	51.00 (2016)	53.33	2.33
Subgroup, Ages 51-64	AMR	55.80 (2016)	56.23	0.43
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	SAA	60.59 (2016)	62.06	1.47
Antidepressant Medication Management - Effective Continuation Phase Treatment	AMM	36.19 (2016)	38.18	1.99
Average Improvement Across All Above Measures				**3.59**

The Medicaid MCO industry has achieved improvement in 14 of the 15 medication adherence measures when comparing the first available reporting year with the CY2019 reporting year.[24] The average level of improvement across these 15 measures was 5.04 percentage points including measurement year 2020 and 3.59 percentage points if the COVID-affected measurement year 2020 is not taken into consideration. While this may appear to be a modest

[24] The Menges Group has purchased access to the NCQA Quality Compass data set, which contains every Medicaid MCO's score on every reported measure. The earliest measurement year for which we have purchased this information is 2011, the most recent is 2021. Some measures were introduced in more recent years, and some measures did not have reported information for measurement year 2021.

improvement, these trends represent millions more people obtaining appropriate access to medications than if the scores had remained constant.

The required tracking and public release of these scores are important in promoting innovation and improvement in the medication adherence arena (and with all other quality measures). In addition, HEDIS measures are extensively used to create financial incentives both in the Medicaid agencies' payments to their Medicaid MCOs and in the MCOs' payments to their network providers.

Using Quality Metrics to Advance Health Equity

The HEDIS quality metrics, including but not limited to the medication adherence measures listed in Exhibit 9 above, present important opportunities to identify health disparities and continually track efforts to reduce or eliminate these disparities. All the above measures can be reported by race/ethnicity group, gender, age cohort, geographic area, etc. Medicaid MCOs are evolving rapidly to strengthen their efforts and ability to identify "their disparities" among their enrollee populations, to design programs to address the identified disparities, and then track the impacts these initiatives are having.

The magnitude of the health disparities can be dozens of percentage points wide, and a significant need (and opportunity) exists to invest more heavily in data analyses and in focused interventions to improve health equity.

VII. Summary and Recommendations

The prior sections' analyses and findings point to several recommendations that can improve the Medicaid population's health status through better adherence to medication regimens. Our recommendations are grouped into three categories: system-wide recommendations that apply to many different stakeholders, state policymaking recommendations, and operational recommendations for MCOs and PBMs. These recommendations are conveyed below.

A. System-Wide Recommendations

A-1. Make Medication Adherence Improvements a Stronger Priority in Medicaid

Our key recommendation is that medication adherence is worthy of greater focus and investment. States and Medicaid MCOs have full control over how they monitor and strengthen adherence to medication regimens. The health importance of adherence, the challenges Medicaid enrollees must often overcome to achieve and maintain adherence, and the technological capabilities that exist to track adherence, all justify a stronger commitment in this area. Policymakers, MCOs, PBMs, prescribers, and pharmacies should work together to elevate and optimize the Medicaid population's adherence to their medication regimens.

A-2. Study the Impacts of the COVID-19 Medicaid Prescription Drop-Off

Section III of this paper quantifies the highly concerning reduction in Medicaid prescriptions that occurred during the COVID-19 PHE – prescriptions per enrollee decreased by 13.7% from 2019 to 2021. These drop-offs were particularly large in many of the maintenance medication drug classes we assessed. Given that it is possible to discern which persons became non-adherent during this timeframe, we encourage that states and MCOs use their data to assess the degree to which persons maintained and did not maintain adherence, and close identified care gaps.

B. State Policy Recommendations

B-1. Adopt and Preserve Medicaid Expansion

The large degree to which Medicaid expansion has increased prescription drug volume, particularly for maintenance medications, is quantified in Section II of this paper. Decisions regarding whether to adopt or preserve Medicaid expansion are a state policy option and ten states have not yet adopted the Medicaid expansion as of August 2023. Focusing on this issue through a medication adherence framework, Medicaid expansion is valuable in providing the fundamental coverage for medication access and adherence to occur.

B-2. Make Permanent COVID-Initiated Policy Changes that Have Proven Successful and Effective

Many Medicaid policy and operational changes were put in place in response to the COVID-19 PHE. It is important to not simply "unwind" these changes following the pandemic, but rather to assess which COVID-driven changes can be advantageous in the post-pandemic environment. Examples of some of the COVID-enacted changes that warrant strong consideration for continuation are described below.

1. **Telehealth latitude**: The use of telehealth services, through audio and video technology increased during the COVID-19 PHE, as many regulatory barriers to the use of these approaches were lifted altogether or greatly reduced. Given the difficulties the Medicaid population disproportionately faces in accessing face-to-face health care, making telehealth access more permanently available and reducing barriers can be of value in elevating medication adherence as well as facilitating initial access to a prescription.

2. **90-day supply of medications:** As described in more detail below, significant opportunities exist in Medicaid to utilize longer days' supply as a tool to facilitate improved medication adherence to maintenance medications. Prior to COVID-19, many state policies restricted the use of longer days' supply in Medicaid, and these restrictions were typically lifted during the COVID-19 PHE. Going forward, a more data-driven approach to when a 90-day supply of medication can and cannot be used is preferable to a blunt prohibition of this approach.

3. **Coverage continuity**: During the COVID-19 PHE, states were not able to disenroll individuals or reduce Medicaid benefits. Given the importance of coverage to

medication and overall health care access, states should consider adopting policies that would provide more continuity of coverage and reduce disenrollment of eligible individuals, including those receiving maintenance medications.

B-3. Leverage MCO Procurements and MCO Contract Requirements to Elevate Adherence

MCO contract requirements have become far more extensive over the past decade as states have elevated the bar for MCO excellence. As states have transitioned their MCO procurements from transactional to strategic sourcing, states have elevated their questions and evaluation criteria to increase collaboration between their Medicaid agencies and MCOs, as well as to improve care coordination and integration across a host of holistic health and human services priorities, including medication adherence.

Despite the increased regulatory rigor and higher bar states are setting, well-qualified MCOs continue to come forward to bid for state Medicaid contracts in large numbers. Also, very few MCO voluntary market exits have occurred. These dynamics put states in a leveraged position to increase the breadth of their MCO contract requirements and the stringency of their evaluation criteria. Similarly, states are using the competitive procurement model both to identify the best qualified MCO partners and to push the health plans to make programmatic commitments above the compliance bar in their priority areas (e.g., health equity, improved birth outcomes).

We encourage states to continue advancing their MCO procurements into managed care collaboration models and to proactively define performance agendas with holistic population health priorities, rather than only on core functions and table stakes. To motivate plans to innovate and excel in achieving optimal medication access and adherence, these requirements and incentives can be directed both at how systematically medication adherence is tracked, and at what steps the MCOs take when an adherence issue appears to exist.

B-4. Create a Fully Integrated System of Care and Coverage

Competitively contracting with Medicaid MCOs allows state policymakers to put in place a system of care that reflects their evolving priorities and which creates innovation and accountability around tracking and addressing the “whole person’s” needs. States have a number of considerations when deciding how to structure their MCO contracts besides adherence concerns, including prescription drug spending and management of the pharmacy benefit.

If a state has established a goal to achieve a whole-person integrated model, benefit “carve-outs” back to the FFS setting run counter to that objective. From the perspective of optimizing medication adherence, the inclusion of the prescription drug benefit and behavioral health services establishes an optimal framework for tracking and elevating medication adherence.

An optimally integrated system of coverage needs to include a strong set of state agency contract requirements for the MCOs, regulatory oversight investments, and (when warranted) corrective actions.

C. Operational Recommendations for MCOs and PBMs

C-1. Systematically Identify and Address Missed Refills

Today's technology captures prescription drug claims and pays pharmacies in "real time." Using this technology, payers can promptly identify when a maintenance medication or other medication ***has not*** been refilled on time. MCOs and PBMs are encouraged to take advantage of this opportunity to identify missed refills and take action to facilitate the refill.

Automated text messages, reminder calls, and emails can be used to notify the member, their caregiver, the pharmacy, and the prescriber of the missed refill. These messages can be instrumental in restoring medication therapy when members have not accessed a refill that is clinically needed. MCOs and PBMs can escalate their outreach activity to increase engagement the longer a missed refill persists to reconnect the member to their medically necessary medications.

C-2. Track Adherence by Race and Ethnicity Group to Support Health Equity Objectives

We encourage states, MCOs, and PBMs to bring a health equity dimension to adherence data tracking and to initiatives designed to improve medication adherence. Medicaid MCOs can and should generate ongoing adherence data by race, geographic area, etc., to identify the nature and magnitude of the disparities that exist within their enrollee populations, and then design targeted initiatives to address these disparities.

C-3. Extend Days' Supply for Maintenance Medications Well Beyond 30 Days on a Targeted and Data-Driven Basis

The use of a 90-day supply for maintenance medications can be significantly increased in Medicaid, both at retail pharmacies and through mail-order. All other factors held constant, a 90-day supply of medication lowers the chances of missed refill *by a factor of three*. Data analyses can identify enrollees with a strong likelihood of remaining Medicaid-eligible throughout the coming year(s). This can inform which enrollees are the most promising candidates for a 90-day supply of maintenance medications.

MCOs are increasingly creating and strengthening their data capture related to housing stability as part of their broader effort to discern and favorably impact SDOH dynamics. Enrollees identified as having relatively stable housing and family dynamics are likely strong candidates for using mail service. The use of 90-day supplies and mail service can also be switched back to 30 days where evidence demonstrates that the approach is not working. As noted previously, the traditional reluctance to use 90-day supplies and/or mail service in the Medicaid arena is both a policy and an operational challenge – but also an important opportunity.

C-4. Incorporate Adherence Incentives in Medicaid VBP Programs

As the use of VBP in Medicaid increases, these performance incentives should track and reward strong medication adherence performance as well as adherence improvements. We encourage that these VBP algorithms include existing HEDIS adherence measures where possible. However, the existing HEDIS measures capture a very small share of overall maintenance medication volume. We therefore also encourage that more broad-based medication adherence incentives be put in place. Once these VBP programs are in operation, they can be expanded, modified, or curtailed as appropriate – again taking a data-driven approach.

C-5. Utilize Value-Added Benefits to Facilitate Medication Adherence

Medicaid MCOs provide enhanced benefits in many areas to elevate their system of care and attract enrollment. Several value-added benefits opportunities exist regarding medication adherence.

1. Plastic weekly or daily pillboxes are inexpensive – particularly when purchased in bulk quantities. These pillboxes are often color-coded (e.g., with different rows for the morning, noon, and evening) and can be of significant help to enrollees and their caregivers in tracking daily medication adherence.

2. More sophisticated pill boxes provide audio alerts for when the next medication dose should be taken. While much more costly than the plastic pillboxes described above, these tools are worthy of consideration for MCO investment and use for selected enrollees.

3. At the highest end of support and cost, pill packets can be delivered to a person's home daily. This tool puts together an individual's exact daily medication regimen and is worthy of consideration for persons whose circumstances warrant such a heightened level of adherence support.

4. Other tools that MCOs and PBMs can provide to facilitate adherence include pill cutters, reminder charts, and multi-lingual prescription labels.

MCOs can offer low-cost support to all members with one or more chronic conditions, and higher cost supports to members with a history of medication non-adherence.

C-6. Remove or Waive Copayments for Medications

The Medicaid population is, by definition, a low-income subgroup for which even modest copayments for medications pose a barrier to access and adherence. Prescriptions are often singled out for copayments in Medicaid policymaking and/or in MCO benefits packages, which works directly counter to placing a high value on facilitating access and adherence to needed medications.

In conclusion, the twelve recommendations above demonstrate that many avenues are available to elevate the Medicaid population's health status through improved medication

adherence. We encourage all Medicaid stakeholders to push themselves and their contracting partners in these directions, creating new initiatives, assessing their impacts, and modifying them as appropriate – all in an objective, data-driven manner.