The Menges Group

Strategic Health Policy & Care Coordination Consulting

Assessment of Washington State's Medicaid Prescription Drug Management Performance and Policy Options

October 2024

The Menges Group

Strategic Health Policy & Care Coordination Consulting

Table of Contents

The Menges Group

Strategic Health Policy & Care Coordination Consulting

I. Executive Summary

This report explores which prescription drug model is best suited for Washington's Apple Health (Medicaid) program: the current carve-in prescription drug model, under which managed care organizations (MCOs) pay for members' prescriptions, or a carve-out model, where prescriptions are managed by a separate company using a fee-for-service (FFS) payment mechanism.

To compare these different approaches, we conducted an array of quantitative and qualitative analyses. Our key findings include:

1. **The carve-out model "silos" the prescription drug benefit, which is incompatible with a whole-person, integrated system of care coordination and management.**

    - MCOs have integrated staff and information systems that function optimally under a carve-in model encompassing all health services.

    - A carve-in pharmacy benefit leads to higher scores on pharmacy-related HEDIS quality measures, increased ability to influence medication adherence, enhanced detection of potential adverse drug interactions or opioid abuse, real-time data integration, and increased member outreach.

    - For MCOs to optimally coordinate their members' care and deliver quality outcomes, they need the ability to manage all components of care delivered to their members (including physical, behavioral, and pharmacy services).

2. **A pharmacy carve-out would likely have an adverse fiscal impact on Washington's Federally Qualified Health Centers (FQHCs) due to the 340B Drug Pricing Program's requirements that will impact efforts to expand capacity and increase access to services.**

    - The federal 340B program requires drug companies that participate in the Medicaid program to provide discounted drugs to FQHCs. Safety-net providers delivering pharmacy services can generate significant savings through reimbursement from Medicaid managed care programs, which are, by federal statute, required to be reinvested into the FQHC's health services and other care coordination programs, which increase access to care. Several examples of these investments are conveyed in the report – two in the pharmacy arena are free mail and home delivery services and free convenience packaging that supports medication adherence.

- Of the 22 FQHCs' financial outcomes analyzed, all relied on 340B savings to make significant investments to expand capacity and increase access to critical services. A carve-out could cause substantial cuts to FQHC's pharmacy programs, staffing, clinical programs, and capital facilities projects.

3. **We estimate that implementing a carve-out would increase overall annual Medicaid costs in Washington by $36 million.**

   - The adverse annual General Fund impact, including the lost premium tax revenue, is estimated to be $22 million. The remaining $14 million in additional carve-out costs would be borne by the Federal Government.

   - We derived the above figures by assessing each component of the Medicaid program that would experience a meaningful cost difference between the carve-in and carve-out settings, and estimating each component's impact.

4. **Other State Medicaid Programs that have carved-out their pharmacy benefit have experienced cost increases, unintended consequences, and challenges.**

   - In 2022, California's Medicaid program switched from a carve-in model to a carve-out approach and experienced major issues related to medication access and payer confusion around the dual eligible population.

   - The access challenges led to temporary removal of most prescription drug cost containment levers resulting in a $2 billion net cost increase. For example, California's net costs per prescription during the first year of their switch to the pharmacy carve-out approach ballooned by 56% compared to the prior year of the carve-in model (from $47.25 per prescription cost to $73.73 per prescription).

5. **The Medicaid Drug Rebate Program has evolved in a manner that requires states and MCOs to work together to steer volume to the drugs that have the lowest net cost.**

   - Brand drug manufacturers are often now literally paying Medicaid when their products are used. In some situations where the brand drug is "better than free," using a low-cost generic can create an adverse net cost to Medicaid.

- States need to clearly identify to the MCOs which drug(s) are most cost-advantageous and partner with the MCOs to achieve savings on both brand and generic drugs.

6. **Washington Medicaid's most favorable net costs for prescription drugs occurred during periods when MCOs paid for a majority of prescriptions and managed the drug formulary.**

    - Washington State has managed Medicaid prescription costs well. Since 2011, Washington has often been among the Top 10 states with regard to lowest net costs per prescription, including some years in the Top 5.

    - Washington and Oregon, the two northwest states with the lowest net costs per Medicaid prescription, are the two northwest states with the highest share of MCO-paid prescriptions.

With these key findings in mind, our **overall recommendation is that Washington should preserve the carve-in pharmacy model for the Medicaid program**.

II. Introduction

The Menges Group has been enlisted to evaluate alternative policy options to manage Washington State's Medicaid prescription drug costs. We were particularly focused on whether it is best to continue the current model – whereby the Apple Health MCOs are paying for and managing the prescription drug benefit – or if it is best to move the drug benefit to the FFS setting through a "carve-out" approach.

Our report conveys an array of quantitative and qualitative analyses assessing the following dynamics:

a) The performance of the Health Care Authority (HCA) and Medicaid MCOs in managing the pharmacy benefit costs to date.

b) The estimated cost and programmatic impacts of a pharmacy carve-out approach, whereby the prescription drug benefit would be removed from the MCOs' responsibility and paid for by a separate organization operating in the FFS setting.

c) Delineation of the importance of the 340B Program in supporting the full range of FQHC activities, the degree to which these programs would face reduction or elimination under a pharmacy carve-out, and options for preserving safety net providers' financial well-being under the carve-out.

d) A summary of California's early-year experience with its pharmacy carve-out program.

e) Emerging trends in Medicaid prescription drug rebates, particularly regarding the degree to which brand drugs have become increasingly cost effective to the Medicaid program.

III. Assessment of Washington's Prescription Drug Cost Management Performance

A. Historical Overview

Washington's Medicaid program has consistently demonstrated sound management of the prescription drug benefit, particularly during the timeframe when the state's health plans paid for the vast majority of Medicaid prescriptions, and had latitude to manage the mix of drugs (brand name versus generics) and which drugs in a therapeutic class would be included on a formulary.

Exhibit 1 conveys the progression of Washington's net costs per Medicaid prescription from federal fiscal year (FFY) 2011 through 2022. During FFY2011, less than 30% of Medicaid prescriptions were paid by the MCOs, with the majority (72.1%) paid in the FFS setting. During that year, Washington's net cost per prescription ($28.65) ranked 13th lowest in the nation.

Between 2011 and 2015, the share of Washington's Medicaid prescriptions paid by MCOs jumped to 85.5%, and its cost management performance strengthened. Washington's 2015 net cost per prescription was 4.7% *below* its 2011 figure. Even though Washington's costs increased from 2013 to 2015, nationwide costs increased at a similar rate which kept Washington's ranking both high and stable.

Exhibit 1. Progression of Net Costs Per Prescription in Washington State

Federal Fiscal Year	Total Medicaid Prescriptions	Net Cost Per Medicaid Prescription	Rank out of 50 states + DC (1 = least expensive)	MCO % of Prescriptions
2011	9,012,157	$28.65	13	27.9%
2012	9,115,385	$28.54	8	35.3%
2013	7,337,717	$24.60	4	55.0%
2014	11,442,527	$25.22	4	79.1%
2015	15,665,153	$27.30	5	85.5%
2016	16,472,284	$32.01	11	87.6%
2017	16,863,536	$33.25	12	91.2%
2018	15,618,546	$33.43	12	91.2%
2019	15,283,836	$30.82	2	91.4%
2020	15,023,298	$42.37	30	92.5%
2021	14,693,591	$38.24	8	92.9%
2022	14,682,092	$33.16	10	93.2%

Washington's improved ranking between 2011 and 2015 occurred despite Washington's 2014 adoption of the Affordable Care Act (ACA) Medicaid expansion – even though this adult population utilizes relatively high-cost prescription drugs on average. Throughout the 2013-2015 period, Washington was among the top five states in terms of net costs per prescription.

Since 2015, Washington has experienced a slight decline in its ranking for net costs per prescription but remains a high-performing state, ranking 10th in FFY2022. Some of the reduction in Washington's ranking involves other states significantly increasing the degree to which their MCOs are managing the Medicaid drug benefit. For example, Louisiana's ranking jumped from 23rd in 2015 to 8th in 2016 -- which occurred in concert with a large increase in the percentage of its Medicaid prescriptions paid by MCOs.

Meanwhile, beginning in 2018, Washington implemented a uniform PDL program, which significantly restricted the health plans' ability to manage the drug mix.

FFY2019 and FFY2020 were aberrant years in opposite directions, with Washington's national ranking on net costs per prescription moving up to 2nd and then down to 30th. These fluctuations were perhaps due to the timing of drug rebate payments between 2018 and 2020 along with the unique impacts of the COVID-19 pandemic during 2020.

During the most recent two years, FFY2021 and FFY2022, Washington's net costs per prescription rankings were 8th and 10th, closely resembling the levels seen in the pre-COVID-19 years. For FFY2023, only pre-rebate costs are available, and pre-rebate costs per prescription increased by approximately 5% versus FFY2022. These recent figures demonstrate effective management of the drug benefit, although not as strong as typically occurred during the years when the MCOs had wider latitude over the PDL.

B. Regional Comparison

Washington's net cost per prescription rank among states is also favorable within the northwest USA, as shown in Exhibit 2. The two northwest states with the lowest net costs Washington and Oregon, respectively, are also the two states in the region with the highest percentage of prescriptions paid by MCOs. These data further demonstrate that delegating management to MCOs – rather than paying for Medicaid prescriptions in the FFS setting – has been an optimal cost management approach.

Exhibit 2: Northwest State Comparison of Medicaid Costs, FFY2022

Stat	Rank in Net Cost Per Medicaid Prescription, FFY2022	Percentage of FFY2022 Medicaid Prescriptions Paid by MCOs
Idaho	24th	0%
Montana	23rd	0%
Oregon	15th	77%
Washington	10th	93%
Wyoming	41st	0%

IV. Carve-Out Impacts for Safety Net Providers

A pharmacy carve-out could have a significant adverse fiscal and programmatic impact on Washington's Federally Qualified Health Centers (FQHCs) due to the 340B Drug Pricing Program's rules and requirements. This section explores these threats along with the opportunities to mitigate them should an Apple Health pharmacy carve-out occur.

FQHCs are non-profit entities chartered by the federal government to provide primary medical, dental, and behavioral health services to Medically Underserved Areas or Medically Underserved Populations. FQHCs provide services regardless of a patient's ability to pay and, therefore, attract and serve a disproportionately large share of uninsured and underinsured subgroups – along with those covered by Medicaid.

The federal 340B program, created in 1992, requires drug companies that participate in the Medicaid program to provide substantially discounted drugs to certain healthcare entities (such as FQHCs) that serve vulnerable populations. These discounts are often dozens of percentage points below standard prices paid in the pharmacy setting. Safety-net providers delivering pharmacy services can generate savings through reimbursement from Medicaid managed care programs, which are reinvested into health and wraparound social services to better fulfill their broader mission.

The Financial Importance of 340B

The central importance of 340B to the Washington FQHCs' ability to support their communities is shown in Exhibit 3. This exhibit consolidates 22 FQHCs' collective financial outcomes from January 2023 through September 2023, showing overall revenues and expenses, 340B revenues and expenses, and these organizations' collective finances across all remaining (non-340B) programs and activities.

While the FQHCs' pharmacy line of business represented "only" 21% of overall revenue, it accounted for more than these organizations' entire collective operating margins across the January – September 2023 timeframe.

The FQHCs collectively lost money on all their non-340B operations, which represent 90% of the expenditures and collectively constitute their core mission. These services include primary medical care, dental care, and behavioral health care, along with care coordination and an array of services that address adverse social drivers of health.

Exhibit 3. Consolidated Financial Performance of 22 Health Centers

CONSOLIDATED TOTAL ACROSS 22 HEALTH CENTERS	2023 (Jan-Sep)
Organization-Wide Financials	
Revenue	$1,681,133,319
Operating Expenses	$1,609,037,009
Operating Margin	$72,096,310
Operating Margin %	4.3%
340B Program Financials	
Revenue	$328,900,407
Operating Expenses	$160,600,592
Operating Margin	$168,299,815
Operating Margin %	51.2%
All Other Business Functions (except 340B)	
Revenue	$1,352,232,912
Operating Expenses	$1,448,436,417
Operating Margin	-$96,203,505
Operating Margin %	-7.1%

With regard to a potential Medicaid managed care carve-out of the pharmacy benefit, approximately half of these health centers' 340B revenue is paid by Medicaid MCOs. The central financial 340B issue with the carve-out is whether the state should take for itself the state share of overall Medicaid margin that the 340B program delivers to the safety net providers.

When drugs are carved out of managed care (and covered under the state FFS program), the state is expected to reimburse the covered entities no more than the 340B ceiling price, depriving covered entities of any significant savings from the steep price discounts on these drugs.

A carve-out allows the state Medicaid program to internalize a portion of the savings (the state share of these Medicaid dollars) from the 340B program. In addition, because federal law prohibits states from collecting duplicate discounts on 340B drugs, states are unable to collect rebates through the Medicaid Drug Rebate Program when the covered entity uses 340B drugs for Medicaid patients, irrespective of whether they are covered by FFS or managed care.

Programmatic Impacts of Carve-Out for FQHCs

It is clear from the figures in Exhibit 3 that the 340B program is playing a critical role in these organizations' ability to invest in and deliver on their full spectrum activities. To assess this in a different manner, Washington's FQHCs were surveyed regarding what programmatic adjustments would need to occur if their 340B margins were no longer accessible for medications prescribed to Apple Health enrollees under an Apple Health pharmacy carve-out. The list below partially conveys these organizations' collective input and demonstrates the widespread threat the carve-out poses to the services FQHCs currently provide.

- **Pharmacy program cuts.** Most FQHCs indicated that they would strive to continue to offer pharmacy services given the importance of medications to their patients' health and the risks that their patients would often be unable to access these medications without the support the FQHCs provide. However, many FQHCs indicated that they would need to significantly reduce their pharmacy programs. An example of this input is conveyed below.

"We would try to continue to provide pharmacy services but would need to close two of our three locations and reduce hours for the remaining location. The gross margin on non-340b drugs is so low that it wouldn't cover our staff salaries & other fixed costs for operating multiple locations."

  Specific pharmacy programs that would be at risk for closure or reduction include:

  - Free mail and home delivery services
  - Free convenience packaging that supports medication adherence
  - Discounted vaccines
  - Free blood pressure monitors
  - Continuous glucose monitoring (CGM)
  - HIV PrEP (pre-exposure prophylaxis)
  - Certain pharmacies would need to be closed (for one FQHC, six pharmacies potentially affecting 80,000 patients)

- **Staffing reductions.** In addition to the many types of staffing reductions listed below that the FQHCs would need to at least consider implementing, the health centers indicated that the significant fiscal constraints that would occur if 340B margins were not accessible would put them in a much more disadvantageous position to provide competitive wages and salaries for *all* positions, compromising their ability to attract and retain talent. Staffing hours would need to be reduced in several operational areas:

- Most or all pharmacy staff would be "let go" at many FQHCs
- Mobile medicine teams
- Health equity personnel
- Quality personnel
- Dental staff
- Behavioral health staff
- Utilization management personnel
- Care management personnel
- Transitions of care personnel
- Population health personnel
- Education and training personnel
- Some administrative staff supporting the above services would need to be laid off

- **Clinical program cuts.**

  - School-based health and wellness programs
  - Substance use disorder counseling
  - Behavioral health counseling and other programs
  - Medication Assisted Treatment (MAT) program
  - Diabetes, hyperlipidemia, and hypertension management services
  - Dental program (particularly adult dental services)
  - Inpatient midwifery services, which serves a large proportion of minority enrollees and persons for whom English is not their primary language
  - An anticoagulation clinic
  - Tobacco cessation
  - Hepatitis C monitoring
  - A primary care clinic serving distressed psychiatric patients
  - Housing and homeless outreach team nurses

- **Additional programs that were cited as those that would be curtailed/reduced include:**

  - Programs tailored to address social determinants of health (e.g., those supporting homeless individuals)
  - Community outreach
  - Expanded care teams (nursing, community health workers, fellowships, apprentice programs)
  - Subsidized health services and support for unreimbursed services – patient fee write-offs and adjustments; one FQHC noted that "*Many uninsured/underinsured patients in our community would no longer*

be able to afford their much-needed medications."
  - Community health improvement services

- **Capital facilities projects:**
  - Facility closures (especially in rural areas where fiscal viability is particularly dependent on cross-subsidization)
  - Cancellation or delay of future expansion

The FQHCs also emphasized that overhead and staffing costs financed through 340B program margins would need to be included in the overall encounter visit rate, reducing any savings the state might expect to achieve by "taking the 340B margins for itself."

FQHC Preferences Between MCO and FFS Pharmacy Management

Beyond the financial dynamics, FQHCs strongly prefer working with the Apple Health MCOs relative to the Medicaid FFS program with regard to the pharmacy benefit. Several examples of their rationale are conveyed below.

- The health centers prefer working with the MCOs to assess, facilitate, achieve, and maintain medication adherence.

- The health centers collaborate with the health plans on quality and outcome measures.

- An FQHC noted that *"FFS often under reimburses pharmacies, it would be more beneficial to see the prescription drug benefit administered by the Apple Health MCOs."*

- Another FQHC noted that *"Currently, the majority of our patients in the Medicaid population have prescriptions paid for by Medicaid MCOs. This payment model provides us with a fair reimbursement and revenue to reinvest right back to these same Medicaid patients through our expanded services."*

- When compared to the state, MCOs are much more responsive and available with regard to patient needs, prior authorizations, and emergency overrides.

- Working with FFS for prior authorizations has been extremely challenging due to reliance on antiquated systems (manual faxing, not interfacing with common prior authorization platforms such as CoverMyMeds, etc.) and workflows.

- A health center's staff team indicated that MCOs have better systems in place to administer the prior authorization process. The FFS program requires its staff to submit a particular fax cover sheet, and its pharmacy must call to initiate the process (which often does not happen or does not happen in a necessarily timely manner).

- The FFS setting has created extended wait times for the patient when prior authorization is required.

- Because there is business competition between the MCOs, there is an incentive to create better access to information and claims.

The lone FQHC comment in favor of the FFS setting is that "The pharmacy help desk for FFS, at least in Washington State, is generally good because they only have to administer one program and are very knowledgeable about that one program. MCOs have many different plans to administer, making it more challenging for their helpdesk to provide appropriate guidance when requested." The organization providing this input still preferred the carve-in model overall, noting "Given the MCOs' broader adoption of technologies and processes that facilitate day to day operations, paired with the enhanced reimbursement currently provided that allows organizations like ours to open more pharmacies and provide more and diverse services, prescription benefits should continue to be administered by the MCOs."

Mitigation of FQHC 340B Losses If a Carve-Out is Implemented

While the above dynamics indicate that an Apple Health pharmacy carve-out will be both fiscally and programmatically detrimental to Washington's FQHCs, it does appear that an opportunity exists to mitigate the fiscal issues if a carve-out is implemented.

New York's FQHCs faced similar financial concerns when their Medicaid agency, the Department of Health (DOH), implemented a Medicaid managed care pharmacy carve out in 2023. The DOH crafted a unique payment structure to ascertain each FQHC's financial impact under the carve-out, and to make a tailored payment to each entity to "keep them whole."

Exhibit 4 presents an excerpt from the New York State Plan Amendment document conveying the specific annual payment derived for several of the state's 340B providers.

Exhibit 4. Except from New York State Plan Amendment to "Keep 340B Providers Whole" Under Medicaid Managed Care Pharmacy Carve-Out

Attachment 4.19-B

New York
2(c)(iv)(f)

1905(a)(2)(B) Rural Health Clinic (RHC) Services and 1905(a)(2)(C) Federally Qualified Health Centers(FQHC)

APM: Payment in Addition to Pre-existing PPS Rate

Effective April 1, 2023, eligible Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) will be designated as eligible by the Department to receive the additional payment under this section in order to preserve and improve beneficiary access to care and avoid loss of services in areas of concern.

The Department will routinely review eligible providers under this section and obtain information as it deems necessary to evaluate and determine need and effectiveness of previous payments.

For eligible providers, the annual amount of the additional payment that will be paid each state fiscal year, which runs April 1st through March 31st, on or before June 30th will be listed in the table which follows and will not be subject to subsequent adjustment or reconciliation. Furthermore, the FQHC/RHC payments made pursuant to this section are considered an alternative payment methodology (APM) and will be made in addition to the FQHC/RHC Prospective Payment System (PPS) rate. The APM will be agreed to by the Department of Health and the FQHC/RHC and will result in payment to the FQHC/RHC of an amount that is at least equal to the PPS rate. FQHCs/RHCs that do not choose an APM will be paid at their PPS per visit rate.

Additional payments have been approved for the following providers for the amounts listed:

Provider Name	Gross APM Payment Amount
Anthony L Jordan Health Ctr	$6,515,434.43
Apicha Comm Hlth Ctr	$9,800,000.00
Beacon Christian	$50,000.00
Beacon Christian Community Health Center	$100,000.00

This payment mechanism was submitted to the Center for Medicare and Medicaid Services (CMS) as a State Plan Amendment, and New York received approval from CMS to implement this payment program during December 2023. If a carve-out were to be implemented in Washington, a similar separate payment approach seems available to HCA to preserve the FQHCs' programmatic efforts. This would likely involve submitting a State Plan Amendment similar to New York's and a similar allocation of state funding to FQHCs.

V. Programmatic Features of Washington's Current Medicaid Prescription Drug Management Approach

This section describes the anticipated programmatic impacts of a carve-out model.

There is no realistic path to avoiding diminished programmatic performance under a carve-out model. At the broadest level, the key disadvantage of a carve-out is that it treats prescription drugs as separate from the rest of health services. The carve-out model "silos" the prescription drug benefit and thus represents a 180-degree turn away from all the efforts HCA and the MCOs have made to establish and strengthen a whole-person, integrated system of care and coverage under Apple Health.

Conversely, the MCOs have developed integrated staff, information systems, and care coordination processes that all function optimally under a carve-in model of all health services. MCOs recognize that optimal management of prescription drugs will lead to the avoidance of flare-ups and complications for people with chronic medical conditions, in both physical and behavioral health. This leads to a reduction in emergency department visits and inpatient admissions and readmissions, resulting in better health and lower total spending.

In order to avoid diminished program performance, the HCA would have to take on a greater role in aggressively managing the care of all Apple Health enrollees. HCA does not have the staffing, infrastructure, or expertise to replicate the role that managed care plays in the Medicaid prescription drug program. This would entail building out the MCOs' extensive suite of tools. Even if the agency were able to do so, it would represent an inefficient duplication of efforts - MCOs would still need to manage the overall health of their members, but would be forced to do so in constant, non-integrated communication with the Medicaid fee-for-service prescription drug program.

The programmatic advantages of the pharmacy carve-in model are compelling. Specific comparative advantages of the carve-in approach are described below.

1. **Quality.** Quality scores across pharmacy-related HEDIS measures (29 measures were assessed) have been superior in the carve-in setting. In a recent Elevance Public Policy Institute report, large-scale comparisons of HEDIS quality scores were made between the MCO and FFS settings, each considering a broad set of relevant measures and reporting years. In 97% of these instances, the fully MCO-managed model outperformed the FFS model.[1]

[1] The full report can be accessed at this link: https://www.elevancehealth.com/content/dam/elevance-health/articles/ppi_assets/partner-

Exhibit 5 summarizes one of the analyses that compared enrollment-weighted average quality scores in a carve-out state with its neighboring carve-in states, with the carve-in MCOs' score being higher in 67.9% of the 533 group-to-group comparisons tabulated.

Exhibit 5: Regional Cluster Comparisons of Average Scores Across 29 Pharmacy-Related HEDIS Measures and Across the 2014-2022 Timeframe

Carve Out State	Comparisons Where Carve-In MCOs' Weighted Average Score was Better than Carve-Out MCOs' Score	Comparisons Where Carve-Out MCOs' Weighted Average Score was Better than Carve-In MCOs' Score	% Of Comparisons Where Carve-In MCOs' Score was More Favorable
Missouri	139	29	82.7%
Tennessee	120	67	64.2%
Wisconsin	103	75	57.9%
Total	**362**	**171**	**67.9%**

2. **Innovation.** Health plans are incentivized to drive innovations in technology, care coordination, and benefit management that improve outcomes and lower the total cost of care. These innovations are often costly to implement and require a high level of technical capabilities that are often unavailable to Medicaid FFS programs.

3. **Medication Adherence.** MCOs often have advanced technology to inform prescribers of adherence patterns – integrating medical, behavioral health, and pharmacy data in a real-time manner that cannot occur under a carve-out.

4. **Preventing/Detecting Adverse Drug Interactions.** MCOs have a greater ability to help members avoid adverse drug interactions when the pharmacy benefit is carved in. In a FFS carve-out model, there is a constant need for data flow between the MCO, the State, and the contracted pharmacy vendor. Even if these data delays

papers/Elevance_Pharmacy_Quality_Policy_Paper_October_2023.pdf. Seven examples of the 29 measures included in the study include: Pharmacotherapy Management of COPD Exacerbation (PCE), Controlling High Blood Pressure (CBP),Persistence of Beta-Blocker Treatment After a Heart Attack (PBH), Statin Therapy for Patients With Cardiovascular Disease and Diabetes (SPC, SPD), Antidepressant Medication Management (AMM), and Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA).

are just one day long relative to the integrated carve-in setting's process, substantial room for error is introduced regarding identifying and preventing adverse drug interactions in a timely manner. New medication regimens are quite often prescribed and initiated on the same day.

5. **Prescription Drug Data Timeliness, Structure, and Completeness.** In the carve-out setting, there is typically a delay in the transmission of prescription drug data to the MCOs (relative to the carve-in setting). The information conveyed in the carve-out is transmitted in a standardized manner across all the health plans – and this data feed typically includes only the final disposition of each claim.

Input from Apple Health MCOs Regarding Data Advantages of Carve-in Setting

We receive real-time data from our current PBM, which are directly integrated into a number of downstream clinical and reporting tools. For example, our integrated coordination program relies heavily on pharmacy claims data to stratify members' clinical acuity, emerging risk, and likeliness to respond to a wide range of available clinical interventions. These models are updated daily for each health plan, and pharmacy claims data are typically the most timely resource to identify new and emerging medical conditions/concerns for our members.

We also employ a complex suite of concurrent (point of care) and retrospective drug utilization review (DUR) programs, all of which rely heavily on the availability of timely, reliably formatted pharmacy claims data. These programs identify cases of drug-drug or drug-disease interactions and alert the dispensing pharmacist of the concern in real-time. This allows the pharmacist to evaluate the concern, communicate with the prescriber(s) and our staff when appropriate, and proceed with the course of action in the best interest of the member. These real-time DUR features go well beyond the basic services typically used by Medicaid carve-out programs.

Data provided to MCOs from FFS PBMs is typically delayed, inconsistent, and partially redacted, all of which greatly inhibit the ability of health plans to integrate their benefits and respond to emerging needs in a timely manner. The frequency and quality of prescription claims data extracts provided to MCOs in a carve-out model vary widely, but even in the best case, are still a significantly less usable resource than under the carve-in model.

Even if a carve-out claim file is provided daily to MCOs for their covered members, the data are typically provided in a delimited text file, which must be formatted, uploaded, control tested, and mapped to MCO data warehouses. This process often takes several days, which significantly delays the utility of the claims data. This delay of even a few days can make a significant difference for MCOs and their care management/coordination efforts. For example, a 5-7 day delay in data availability for a member who initiates treatment with a drug contraindicated with their health conditions or with other active medications could mean the difference between a real-time intervention and a serious adverse health event for the member.

In the carve-in setting, pharmacy data are captured immediately by the MCO in a tailored manner that best supports their integrated care model. The more detailed information obtained in the carve-in setting tracks through medication reconciliation and pharmacy point-of-sale rejections and can be coordinated with

medication adherence programs.

6. **Opioid Abuse**. A carved-in pharmacy benefit provides an enhanced ability to detect opioid abuse and implement harm reduction measures. MCOs have the tools to identify higher-risk members and implement practices such as education, improving prescribing practices, and providing alternative pain management strategies in order to prevent opioid-related harm.

7. **Outreach.** Taking the above issues together, it is likely that under a carve-out model, Apple Health members would receive less outreach from care coordinators, and pharmacy providers would be less connected to real-time data exchanges with health plans that manage both medical and pharmacy benefits for their members. This decreased integration and lower member engagement could well result in lower medication adherence, more adverse drug events, increased medication errors, and higher utilization of preventable emergency department (ED) and inpatient hospital services.

8. **Prescriber/Pharmacist PDL Simplification.** An often-cited programmatic advantage of the carve-out model -- a single Medicaid PDL -- already exists under the carve-in model. The Health Care Authority moved to a uniform PDL across all the Apple Health MCOs in 2018.

9. **Customer Service.** Under the carve-out model, two (or more) different entities manage members' medical and pharmacy coverage. This can create confusion for members and providers. Health plans in the carve-out setting note that their customer service and provider service centers receive a high volume of medication-related calls that they cannot address but rather need to refer to the organization administering the carve-out. This is usually a frustrating and unwelcome call outcome from the perspective of the caller.

The above content represents a small subset and summary of the extensive information received from a variety of stakeholders regarding the programmatic differences between the pharmacy carve-in and carve-out settings. The carve-out model has been deployed in many states. At a national level, many of the Apple Health MCOs have strong familiarity with both settings and are well-positioned to convey the experience of the pros and cons. In many ways, however, the programmatic differences represent a straightforward comparison between the carve-in setting's integrated approach versus the carve-out setting's siloed approach.

VI. Findings from California's Recent Pharmacy Carve-Out

California's Medicaid (Medi-Cal) program switched from a carve-in model to a carve-out approach effective in January of 2022. Because there is now roughly two years of experience under the new approach, and due to California's large size and geographic proximity to Washington, we assessed Medi-Cal's early experience to help inform Apple Health policymakers.

Our assessment included data comparisons of the last stages of the carve-in with available information under the carve-out, as well as interviews with several Medi-Cal health plan pharmacy directors.

In summary, the switch to a carve-out model caused an extraordinarily disturbing drop-off in prescription access. The initial solutions implemented to address these carve-out induced access barriers then resulted in a massive net overall cost increase in the first year of the carve-out relative to the last year of the carve-in model.

A. Programmatic Assessment

California's implementation of its Medi-Cal pharmacy carve-out in January of 2022 encountered immediate and massive challenges.

Due to a combination of the magnitude of the volume of medications that switched to a new payment setting, and the algorithms used by Magellan Health, the PBM entity enlisted by the Medicaid agency, medication access plummeted on a highly concerning scale. Tabulations using the quarterly data states submitted to CMS, summarized in Exhibit 6, demonstrate the degree to which a drop-off in Medi-Cal prescriptions occurred when the carve-out model went into effect.

Table 6 also demonstrates that California's carve-out implementation drop-off was much larger than the prescription access drop-off that occurred during the height of the COVID-19 pandemic. The top rows of Exhibit 6 demonstrate that Medi-Cal prescriptions decreased by 14% in the second quarter of CY2020, when the COVID-19 pandemic swung into full effect, and no vaccines existed. Persons were sheltering in place and particularly avoiding going to health care facilities (e.g., pharmacies) to avoid the risk of infection.

We also tabulated insulin prescriptions and units (milliliters) during this timeframe. During the second quarter of 2020, insulin prescriptions decreased by 3% although insulin units actually increased. These insulin figures suggest that the COVID-19 pandemic may not have diminished access to important maintenance medications.

The COVID-induced drop-off in Medi-Cal prescription volume, while highly concerning, was much *smaller* than the drop-off that occurred in the first quarter of CY2022, when the pharmacy carve-out took effect. Medi-Cal's overall prescription volume decreased by six million in Q1 2022 versus Q4 2021, a 26% drop-off.

These decreases at the outset of the carve-out were similar in proportion for insulin prescriptions (a 25% drop-off) and for insulin units (a 20% drop-off). These insulin statistics are deeply concerning, both with regard to what that loss of medication access could have meant to those beneficiaries, and in terms of signaling that access to other important maintenance medications was likely compromised on a large scale as well. Prescription volume during Q2 2022 increased, but was still 2.3 million below the last calendar quarter of the carve-in.

Exhibit 6. Medi-Cal Prescription Volume Trends During Selected Time Periods

Timeframe and Circumstance	Total Medi-Cal Prescriptions	Percent Change from Prior Quarter	Insulin Prescriptions	Percent Change from Prior Quarter	Insulin Units	Percent Change from Prior Quarter
COVID-19 Drop-Off						
Q4 2019	23,926,454		375,818		5,693,333	
Q1 2020	25,093,075	5%	385,776	3%	5,889,368	3%
Q2 2020	21,550,696	-14%	375,036	-3%	6,021,419	2%
Pharmacy Carve-Out Drop-Off						
Q4 2021	23,114,700		367,648		6,253,442	
Q1 2022	17,104,563	-26%	275,619	-25%	4,974,029	-20%
Q2 2022	20,815,825	22%	322,181	17%	5,963,785	20%
Q3 2022	24,540,853	18%	369,736	15%	7,103,211	19%

Exhibit 6 also demonstrates that there was a "course correction" that restored the carve-in model's prescription volume as of Q3 of 2022. By that point, however, the Medi-Cal population had accessed ***8.3 million fewer prescriptions*** than would have occurred if the Q4 2021 volume had been maintained throughout the first half of 2022.

While it is encouraging that the prescription volume did come back up as of Q3 2023, this does not by any means ensure that no harm occurred while 8.3 million prescriptions were not being accessed. The initial roll-out of the Medi-Cal prescription drug carve-out model and the resulting enormous decrease in prescriptions put the covered population at risk clinically. We encourage that further research be conducted regarding the adverse morbidity and mortality impacts that may have occurred during this timeframe.

Another issue that arose in California (and which still persists) is confusion around who is responsible for dual-eligible enrollees' medications, particularly regarding certain physician-administered drugs delivered outside of the pharmacy setting. Throughout the tenure of the carve-out model Medi-Cal enrollees, prescribers, and MCOs have been repeatedly navigating situations where Medi-Cal Rx, Medicare Part B, and Medicare Part D are not approving payment for a covered drug.

The quote below is indicative of the need for improved handling of this issue under the Medi-Cal carve-out – but also of the value of the integrated carve-in model where these types of problems were not regularly occurring.

"In many of these instances we've decided to just pay for the drug, even though it is clearly the responsibility of Medi-Cal Rx, to break through the logjam and get our enrollee access to the needed medication. But this isn't the correct solution."
-- Medi-Cal MCO Pharmacy Director

B. Financial Assessment

In response to the clinical endangerment and large-scale frustration that was occurring at the outset of the carve-out, California's Medicaid agency removed all barriers to prescription access. A moratorium was placed on deploying prior authorizations, requirements were lifted related to PDL compliance, and the practice of denying "too soon" refills was curtailed. As shown in Exhibit 6 above, these actions were successful in restoring – by the third calendar quarter – Medi-Cal's prescription volume to the levels occurring under the carve-in model.

However, these actions also temporarily stripped Medi-Cal of the levers needed to deliver cost-effective pharmacy benefits management. As shown in Exhibit 7, Medi-Cal costs per prescription (pre-rebate) were between $97 and $101 throughout the last carve-in year (CY2021). These figures jumped to $128 in the first quarter of the carve-out and rose further to $142 by the carve-out model's third calendar quarter.

Exhibit 7. Quarterly Medi-Cal Costs Per Prescription (Pre-Rebate)

Calendar Quarter	Average Cost Per Medi-Cal Prescription (pre-rebate)	Percent Change from Prior Quarter
Q1 2021	$97.63	
Q2 2021	$98.40	0.8%
Q3 2021	$98.23	-0.2%
Q4 2021	$100.64	2.5%
Q1 2022 (carve-out begins)	$128.48	27.7%
Q2 2022	$131.42	2.3%
Q3 2022	$142.49	8.4%

Exhibit 8 also takes all Medi-Cal prescription drug rebates into account (as reported in the Financial Management Reports published by CMS). California's net costs per prescription were $47.25 in FFY2021 and jumped to $73.73 in FFY2022 – **a 56% increase**. Medi-Cal's net pharmacy costs during FFY2022 were ***$2.07 billion above the prior year***. These figures are presented in Exhibit 8.

Even if one were to assume that Medi-Cal's net costs per prescription would have increased by 10% in FFY2022 under the continuation of the carve-in model, the carve-out's actual results would have produced a cost increase of $1.86 billion in its initial year.

Exhibit 8. Medi-Cal's Net Pharmacy Costs, 2021-2022

Federal Fiscal Year	Net Cost/Rx	Medi-Cal Prescriptions	Net Cost
FFY2021	$47.25	89,682,896	$4,237,516,836
FFY2022	$73.73	85,575,941	$6,309,514,130

These adverse cost outcomes occurred despite the sharp reduction in prescription volume and access that the carve-out's implementation caused. The increased costs also demonstrate the importance and value of deploying the cost containment tools that were temporarily "shelved" – the increased costs were both massive and immediate.

The significant clinical, fiscal, and administrative challenges that California has experienced at the outset of the carve-out approach are perhaps important for Washington policymakers to consider. Beyond the inherent programmatic disadvantages of the carve-out approach described in Section III, moving the drug benefit to the FFS setting introduces significant transition risks.

VII. Emerging Rebate Dynamics for Policymakers to Consider

We have analyzed the cost-effectiveness performance of carve-in and carve-out policy options in numerous states and on a national level. Links to several of these assessments are provided in the footnote below.[2] These analyses have tabulated comparative data on all Medicaid prescriptions in each setting and included all initial ingredient costs, dispensing fees, and rebates. We have conducted "pre versus post" comparisons when a state switches (in either direction) between a carve-in and carve-out approach, and we have compared groups of states using the carve-in approach with carve-out states.

All of these analyses have indicated that the carve-in approach (including the pharmacy benefit in MCOs' capitation payments) has consistently delivered lower net prescription drug costs than by relying on the FFS setting through the carve-out approach. A driver in the carve-in model's overall cost-effectiveness has been the MCOs' drug mix management, steering volume to generics and to lower-cost brands at the "front-end." This approach has proven more effective than focusing more on "back-end" rebate maximization as occurs under FFS. These analyses have also demonstrated that MCO latitude over drug mix has outperformed implementing a uniform PDL across all Medicaid MCOs.

Notwithstanding the prior findings, brand drug prices and brand rebates are evolving in a manner that appears likely to disrupt the cost-effectiveness of the "traditional" MCO strength in managing pharmacy costs – steering prescription volume towards the drugs that yield their own lowest net cost.

It has become increasingly common for the lowest-cost drug from an MCO's vantage point to be different than the drug that yields the lowest net cost to the Medicaid program (and taxpayer). This section describes the dynamics creating "perverse incentives" under the carve-in arrangement.

[2] Links to several analyses assessing the carve-in and carve-out models are provided below:

1) Medicaid Prescription Drug Benefit Management: Performance Comparison Across Different State Policy Approaches: https://themengesgroup.com/wp-content/uploads/2022/06/menges_group_rx_paper_march_2022.pdf
2) Assessment of New Jersey's Medicaid Prescription Drug Management Performance and Policy Options: https://themengesgroup.com/wp-content/uploads/2022/06/rx_carve_out_report_njahp_february_11_2021-1.pdf
3) Assessment of Virginia Medicaid Pharmacy Benefits Carve-Out Impacts: https://themengesgroup.com/wp-content/uploads/2022/06/virginia_pharmacy_carve-out_assessment_january_2020.pdf
4) Assessment of Medi-Cal Pharmacy Benefits Policy Options: https://themengesgroup.com/2019/05/15/assessment-of-medi-cal-pharmacy-benefits-policy-options/

Medicaid's prescription drug rebate structure, codified in the federal Affordable Care Act, delivers enormous discounts on brand drugs. As shown in Exhibit 9, while brand drugs represented only 10% of Washington's Medicaid prescriptions during FFY2021, these drugs represented approximately 86% of pre-rebate costs, 97% of Medicaid prescription drug rebates, and 67% of net (post-rebate) prescription drug costs.

Exhibit 9. Brand and Generic Drugs' Share of Washington Medicaid's Prescriptions and Costs, FFY2021

	Brand	Generic	Brand % of Total
Prescriptions	1,531,847	13,483,074	10.2%
Pre-Rebate Costs	$1,318,281,972	$219,531,258	85.7%
Rebates	$934,581,487	$28,539,064	97.0%
Net Costs	$383,700,485	$190,992,195	66.8%
Per Prescription Cost			
Pre-Rebate	$861	$16	
Rebates	$610	$2	
Net	$250	$14	

On a cost-per-prescription basis in FFY2021, brand drugs were *53 times* costlier than generics on a pre-rebate basis, and *18 times* costlier on a post-rebate basis.

Washington's brand rebates per prescription in FFY2021 were *288 times larger* than generics. These rebates reached the point where many brand drugs have literally been "free" to Medicaid for the past few years. Exhibit 10 illustrates these dynamics for a hypothetical brand drug.

Exhibit 10. Sample Brand Drug Rebate Dynamics

Row	Description	Amount	Derivation
1	Price of Drug in CY2010 When Introduced	$200	Hypothetical Example
2	Current Price (CY2024)	$1,000	Hypothetical Example
3	2024 Price if Increases Matched CPI (since CY2010)	$400	Hypothetical Example
4	Rebate Owed by Manufacturer Due to Price Increases	$600	Row 2 - Row 3
5	Best Price Currently Offered	$400	Hypothetical Example
6	Rebate Owed by Manufacturer Due to Best Price	$600	Row 2 - Row 5
7	Total Rebate Owed by Manufacturer	$1,200	Row 4 + Row 6

In the Exhibit 10 situation, the rebate owed of $1,200 would actually exceed the drug's current price of $1,000. Until January 2024, the Medicaid rebate for this drug was capped at 100% of the drug's initial price, meaning this drug was essentially "free" to the Medicaid program when used.

Through the American Rescue Plan (ARP) Act of 2021, from January 2024 forward, the 100% rebate cap is no longer in effect. In the above example, this drug would create a *net revenue* of $200 per prescription for the Medicaid program. This will increase further whenever the manufacturer increases the price beyond the CPI inflation factor.

The Exhibit 10 scenario is not an anomaly. According to work produced by Christopher Park and his colleagues at the Medicaid and CHIP Policy and Access Commission (MACPAC),[3] 18.2% of Medicaid pre-rebate drug spending during FFY2020 was on brand drugs that had already reached a "free to Medicaid" situation. If the cap had been lifted on these drugs, the additional "better than free" rebate owed on these drugs would have been 30.7%. Since 2020, due to the ongoing pricing behavior of brand manufacturers, a steadily increasing set of brand drugs have entered the "beyond free zone" and the percentage by which many drugs' rebates are beyond free has also increased.

A key programmatic and policymaking challenge is that the statutory rebates are paid to the government and do not in any way flow to or through MCOs. As a result, MCOs are typically driving volume toward drugs that minimize their own net cost. This issue is illustrated in Exhibit 11 continuing the example of the hypothetical drug depicted in Exhibit 10. In this example, the Medicaid rebate formula takes the brand drug 20% "beyond free" for the state, with the Medicaid program realizing a $200 surplus every time a prescription for this drug is filled. This surplus grows to $226 relative to filling the prescription with the generic alternative drug shown.

Note that for drugmakers whose products are primarily used by the Medicare and commercial populations, where lucrative profit margins often occur, "taking a loss" in Medicaid at this level is acceptable, and further price increases will often continue to net out in the manufacturer's favor.[4]

Exhibit 11. Hypothetical Example of Current Rebate Incentives

Drug	Pre-Rebate Cost Per Prescription	Statutory Rebate Percentage	Net Cost to MCO	Net Cost to Medicaid Program
Brand Drug	$1,000	120%	$1,000	-$200
Generic Alternative	$30	13%	$30	$26
Cost Difference			$970	-$226

[3] https://www.macpac.gov/wp-content/uploads/2022/10/07_Trends-in-Medicaid-Drug-Spending-and-Rebates-Chris.pdf The data referenced above are on Slide 28. The full document explains Medicaid drug price and rebate regulatory parameters extremely well.

[4] While an ongoing incentive to increase prices appears to persist, the magnitude of the additional rebates some manufacturers will owe Medicaid in 2024 (when the rebate cap of 100% is lifted) does appear to be motivating some manufacturers to reduce prices on drugs that have otherwise become "better than free" to Medicaid. This Reuters article describes recent manufacturer price increase and decrease actions: Exclusive: Drugmakers set to raise US prices on at least 500 drugs in January | Reuters

From the MCO's current perspective, the financial incentives of this drug mix choice are completely opposite those facing the state. The MCO faces a cost of $1,000 for the brand drug and just $30 for the generic alternative – and thus has a strong incentive to utilize the generic (saving $970 each time it does so).[5]

The proliferation of "better than free" brand drugs for Medicaid upends the value of the health plans' traditional drug mix management efforts in an ever-increasing number of therapeutic drug classes. These dynamics also eliminate the opportunity and value of negotiating supplemental rebates on brand drugs in a considerable and growing number of drug classes. For example, brand drug manufacturers whose cost to produce a pill is $1.00 have some incentive to offer enhanced rebates all the way to the point where their net revenue will be above $1.00 per pill – if these rebates are perceived to be needed to get their product used in Medicaid in lieu of alternative drugs.

However, manufacturers have no reason whatsoever to agree to any supplemental rebate amount once the statutory rebates have put them in the position of literally paying Medicaid each time their drug is used. Manufacturers in this situation will, unfortunately, have an incentive to minimize the degree to which their product is used by Medicaid patients. Between FFY2021 and FFY2022, reported supplemental rebates in Washington decreased by 14.6%. This also suggests that supplemental rebates are playing a declining role in the effort to minimize the state's Medicaid pharmacy costs.

Early reports from Washington stakeholders have been that the prices for several brand drugs have dropped considerably in concert with the January 1, 2024 removal of the Medicaid rebate cap. However, a large set of brand drugs are now in this "better than free" situation, and many additional drugs are trending into the same situation. While each drug's pricing dynamics will be its own "sample of one," we expect that price increases that are sharper than the CPI will continue to commonly occur. Being in a loss position with Medicaid will not likely prevent manufacturers from continuing to aggressively raise drug prices. The marginal revenue they receive from Medicaid will be "rebated" back, but the marginal revenue they receive from other payers will be retained.

These rebate dynamics represent the current realities of Medicaid prescription drug finances and can profoundly affect which Medicaid drug policies make sense for states to implement.

[5] This example does not take into account any supplemental rebates that manufacturers are negotiating with the State and/or with MCOs, in addition to the statutory rebates. These supplemental rebates often represent several percentage points of additional rebates, but will not likely significantly "change the story" being depicted. Manufacturers will not offer supplemental Medicaid rebates for drugs where the statutory rebates already put them in a loss position.

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

This section models the costs of two policy options:

1. Keeping the *pharmacy carve-in approach* in place, with HCA providing strong ongoing guidance regarding which drug in each class is yielding the most favorable net cost to Washington's Medicaid program.

2. Implementing a *pharmacy carve-out* whereby the Apple Health MCOs would no longer have financial responsibility for the prescription drug benefit.

We estimate the implementation of a carve-out will increase Apple Health's overall net costs by $36 million annually (including Premium Tax revenue reduction impacts), with the adverse annual State Fund impact estimated at $22 million. The key components of these estimates are shown in Exhibit 12 and are summarized in the ensuing narrative.

Exhibit 12. Annual Cost Impact Summary

Note: Positive figures represent fiscal advantages to preserving the carve-in model; negative figures represent fiscal advantages to switching to a carve-out approach. All figures are based on FFY2022 base year's expenditure levels.

Financial Impact Component	Total	State Share	Federal Share
Annual 2% Premium Tax Revenue Related to Pharmacy Benefit	$28,597,924	$20,247,330	$8,350,594
Initial Cost Per Prescription (2.5% difference in favor of MCO setting)	$35,747,405	$10,438,242	$25,309,163
2% Profit Margin on MCO Pharmacy Costs	($28,597,924)	($8,350,594)	($20,247,330)
Total Carve-Out Annual Cost Impact	**$35,747,405**	**$22,334,979**	**$13,412,426**

All ten components we assessed are conveyed in Exhibit 13, along with our estimated annual cost impacts of each component and the rationale for our impact estimate.

Note that in most of these areas (seven of the ten), we do not envision that a meaningful cost difference exists between the carve-in and carve-out settings. These "no impact" expectations are primarily due to the uniform PDL that HCA has implemented within the carve-in model. With HCA controlling the mix of drugs used by the MCOs, there is already a mechanism in place to ensure that the MCOs steer volume towards the drugs that have the most advantageous net cost to the Medicaid program.

Exhibit 13. Cost Impact Components Assessed

Cost Impact Area	Expected Cost Impact of a Carve-Out	Rationale
Drug Mix	No cost difference is anticipated.	A uniform HCA-directed PDL has been in place for several years. Apple Health MCOs are experienced in adhering to this PDL (and making appropriate clinical exceptions).
Prescription Volume	No major difference is anticipated.	MCO efforts to facilitate access/adherence may diminish under a carve-out, which could create a modest decrease in prescription volume. Such an outcome would likely create an overall medical cost increase rather than savings.
Dispensing Fees and Ingredient Costs	We estimate a $36 million increase in annual pharmacy payments under a carve-out model, $10 million of which would reflect new State Fund costs.	We compared FFS and MCO costs per prescription, lining up high-volume NDC codes to assess overall cost/prescription dynamics. 44 NDC codes were identified which ranked among the top 500 NDCs in all four of the following categories: MCO prescriptions, FFS prescriptions, MCO amount paid, and FFS amount paid. We calculated costs per prescription for each code in the MCO and FFS settings, and compared overall costs once the drug mix was equalized across the 44 NDCs. This comparison showed costs per prescription (pre-rebate) in the MCO setting to be 2.5% below Washington's corresponding FFS figure. These comparisons captured both the ingredient cost and dispensing fee differences.
Statutory Rebates	No cost difference is anticipated.	If the drug mix is not being impacted by the carve-out, statutory rebates will be the same in each setting.
Supplemental Rebates	No cost difference is anticipated.	If the drug mix is not being impacted by the carve-out, statutory rebates will be the same in each setting.
Prescription Benefits Administration	No cost difference is anticipated.	We do not have grounds to assume a cost difference if administrative functions are transferred from the MCOs to the FFS setting in a carve-out.
340B Program	No cost difference is anticipated.	Per Section V, we do not envision that Apple Health policymakers will want to extract 340B savings "off the backs of" Washington's safety net providers. If a carve-out does occur, a CMS State Plan Amendment process (as used in New York) holds the safety net providers harmless, which Washington should be able to deploy.
MCO Risk Margin	We estimate a $29 million annual reduction in risk margin payments to MCOs under a carve-out, with $8 million accruing to the State.	Collective FFY2022 pre-rebate pharmacy costs across the Apple Health MCOs were $1.43 billion. Assuming a 2.0% risk margin for the MCOs in the capitation rates, a pharmacy carve-out would reduce the MCOs' collective annual risk margin by $28.6 million.
MCO Premium Tax	We estimate a $29 million loss in annual premium tax revenue under a carve-out, with State revenues reduced by $20 million.	The 2% premium tax creates the same $29 million impact as in the above row, although the State Fund impact would be much larger (as the Federal share of the premium tax represents the State's revenue loss).

IX. Recommendations

Based on the above analyses and findings, we offer the following overall recommendations:

1) Preserve the Carve-In

All of our assessments and findings support preserving the existing program structure whereby the Apple Health MCOs are:

a) financially responsible for the prescription drug benefit while taking direction from HCA via the uniform PDL;

b) are programmatically responsible for meeting enrollees' medication needs; and

c) are also responsible for integrating the drug benefit with all other aspects of their whole-person-focused system of care.

To summarize these findings:

- We estimate that implementing a carve-out would increase overall annual Medicaid costs by $36 million. The adverse annual State Funds impact, including the lost premium tax revenue, is estimated to be $22 million.

- The carve-in model is also far superior to the carve-out approach programmatically, given that a carve-out represents a 180-degree turn away from the whole-person, integrated care model that HCA and the MCOs have put in place and worked to strengthen over time. A few specific examples are described below.
  - Recent research demonstrates that MCO scores on pharmacy-related HEDIS quality measures are higher in the carve-in setting than in the carve-out setting.
  - The timeliness, structure, and completeness of pharmacy data are all better tailored to each MCO's needs under the carve-in.
  - The health plan's pharmacy team is typically much more robust in the carve-in setting. These staff interact extensively with each other and with all other MCO care coordination staff (and other departments) to address challenges and take advantage of opportunities.
  - Programs to support medication adherence are also more robust in the carve-in setting.

- California's initial experience with its carve-out program has been highly adverse fiscally and created significant barriers to medication access. While California's issues can likely be attributed to a poorly implemented roll-out, it is important for HCA to avoid taking significant transition/disruption risks within a program design that is currently (and consistently) performing well.

- A carve-out also imposes significant fiscal and programmatic risks and threats for Washington's FQHCs. The health centers face the loss of the 340B Program's operating margins, which play a critical role in the viability of a wide array of their programs to support Washington's Medicaid, uninsured, and under-insured subgroups. While it appears that a path will exist via a State Plan Amendment to protect the FQHCs' funding under a carve-out model, the sustainability of this solution is not assured (e.g., there is no legislative statute even in New York where the precedent for this approach is in place).

- The State Plan Amendment process also takes the State down a convoluted path to seek a remedy to a problem that it would be creating in the first place via the carve-out. Even if the FQHCs can be "kept whole" financially, these organizations have indicated that they prefer working with the MCOs than with the FFS program with regard to the drug benefit's administration (having worked extensively with both).

2) Preserve the Uniform PDL Program

Due to the convoluted rebate dynamics described in Section VI, it is important for HCA to maintain its role in establishing PDL content and directing the MCOs to which the most cost-effective drugs to the Medicaid program. The MCOs are otherwise not currently in a position to know which drugs offer the most advantageous net cost to the overall Medicaid program.

MCOs have demonstrated -- both in Washington and throughout the nation across many years -- a very strong capability to nimbly and optimally steer drug volume to the preferred medications. Accordingly, the carve-in model operating in conjunction with and HCA-driven uniform PDL is highly likely to be the optimal approach.