The Menges Group

Strategic Health Policy & Care Coordination Consulting

Assessment of the Pharmacy Carve-In Model for Utah's Medicaid Program

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 the Utah Medicaid program. Our findings and recommendations are based on what we know today, though we understand that the pharmaceutical market will continue to change. As part of our analysis, we evaluated Utah's current model in which most retail pharmacy is the responsibility of the Accountable Care Organizations (ACOs).[1] We compared this to a full carve-out model that creates a single government payer system for retail pharmacy administered by the State and their contracted national pharmacy benefit administrator using a fee for service payment methodology.

To compare these different approaches, we conducted an array of quantitative and qualitative analyses which resulted in the following findings and recommendations.

Key Findings:

1. **A single government payer system for pharmacy, or carve-out model, "silos" the prescription drug benefit and is not the best model to achieve the best outcomes for Utah Medicaid, its members and providers. This approach is incompatible with a whole-person, integrated system of care coordination and management. It is also contrary to the State statute creating the ACO model which is intended to control the overall cost of the Medicaid program in Utah.**

[1] The drugs and drug classes for which the ACOs are **not** currently financially responsible include (i) transplant immunosuppressive drugs; (ii) attention deficit hyperactivity disorder stimulant drugs; (iii) antipsychotic drugs; (iv) antidepressant drugs; (v) antianxiety drugs; (vi) anticonvulsant drugs; (vii) hemophilia drugs; and (viii) the following substance use disorder treatment drugs and their associated generics (if any) indicated for the same uses: (a) Vivitrol®; (b) Revia®; (c) Suboxone®; (d) Campral®; and (e) Antabuse®. In addition, drugs costing $1,000,000 or more for a dose (Ultra High-Cost Drugs) are paid for in the Medicaid fee-for-service setting.

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

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

2. **Carving pharmacy out of the ACO is contrary to the intent of the creation of the ACO model and shifts all the risk of retail pharmacy back to the State – doing so at a lower federal match rate for the associated administrative services.**

    - In 2011, the Utah Legislature passed legislation to create an alternative service delivery model other than fee for service. The intent of the model was to control the unsustainable increase in the Medicaid budget, to bring more predictability to quality of care for Medicaid members, and to prepare the State to handle expected growth in the program to reduce the number of uninsured Utahns. This was the full risk based Accountable Care Organization model, intended to move towards treating the whole person, through integrated care.

    - The costs of the ACO model are controlled by linking any increases in payments to the ACOs to the relative growth of the State general fund which is a reflection of the overall growth rate of the State budget.

      Pulling services out of the ACO is contrary to the intent of this model and places more risk back on the State.

3. **Most of the potential increase in Medicaid revenue (or savings) projected through the carve-out model in a recent Milliman report can be accomplished by implementing a hybrid Preferred Drug List (PDL), without the need to carve the retail pharmacy benefit out of the ACO model.**

    - Under the hybrid approach, Utah's Department of Health and Human Services (DHHS) and the ACOs would work together to identify the lowest net cost drug(s) in each therapeutic class, with DHHS stipulating the PDL content in the classes where its post-rebate pricing yields the lowest net cost. In all other drug classes, the ACOs would maintain their existing latitude to determine the lowest-cost drugs.

    - This approach is needed to align ACO drug mix decisions and incentives with those facing Utah's overall Medicaid program. Currently, the ACOs do not know what the lowest-cost drug to the Medicaid program is (due to the statutory and supplemental rebate data not being made available), and they are managing drug mix to minimize their own net cost.

    - DHHS needs to clearly identify which drug(s) or drug classes are most cost-advantageous to Utah's overall Medicaid program, share this information with the ACOs, and require the ACOs to include these drugs in their formulary for Medicaid. Due to the ways in which statutory rebates have evolved for brand name drugs, this approach will yield large-scale savings. Milliman projects these savings to be approximately $20 million annually for Medicaid overall, which would translate to an annual savings of approximately $4 - $5 million in State Funds.

    - We encourage key stakeholders, including at minimum key representatives from DHHS, each ACO, and Milliman, to collaborate on the content of the Medicaid-wide PDL. There likely remains, for example, many drug classes where maintaining ACO drug mix latitude is the most cost-effective approach.

4. **If a hybrid PDL is implemented, a pharmacy benefits carve-out of the ACO model would yield minimal additional savings, if any.**

    - Given the programmatic advantages of the integrated carve-in model, and the absence of a meaningful fiscal impact, the carve-in model with a hybrid PDL is in the best interests of DHHS and Utah's Medicaid program.

5. **Experiences in other states demonstrate that switching to a carve out model can negatively impact members, providers and the state. For example, California's recent experience in switching to a carve-out created alarming prescription access challenges for Medicaid members and resulted in a significant increase in costs.**

    - In 2022, California's Medicaid program switched from a carve-in model to a carve-out approach and the transition created a drop-off of more than 8 million prescriptions. These extremely concerning medication access challenges led to the temporary removal of most prescription drug cost containment levers. California's net costs per prescription during the first year of their switch to the pharmacy carve-out approach ($73.73) ballooned by 56% versus the last year of the carve-in model ($47.25) – resulting in roughly a $2 billion net cost increase.

6. **Milliman's report incorrectly described the relationship between the state and the ACOs and the ACO's pharmacy benefit managers (PBMs). In addition, three of the ACOs use internal PBMs—only one contracts with a national PBM.**

    - Carving out the full pharmacy benefit to the state will eliminate Utah jobs in the private sector in favor of creating more positions in state government.

7. **Utah Medicaid has many other issues and initiatives that must be addressed over the next 2 to 3 years.**

    - The implementation of PRISM did not go as well as expected. While bringing a system of this magnitude up is a significant accomplishment, the system has caused

numerous issues for members, providers, and managed care entities like the ACOs. For example:

- PRISM caused many issues with enrollment of Medicaid eligible members in their Medicaid managed care plans. There are thousands of Medicaid individuals who were incorrectly disenrolled from their managed care plan as far back as March 2021.

- As a result of the issues with disenrollments, capitation/premium payments were incorrectly taken back from Medicaid managed care plans as far back as March 2021. Due to PRISM, managed care plans have been unable to properly reconcile enrollment and capitation payments for FY 2023 and FY 2024. They have booked receivables from and payables to the State in the tens of millions of dollars in anticipation of a final true up with the State.

- Managed care plans are required to submit encounters (detailed records) for every claim paid or denied by the plan's payment system. Due to issues with PRISM, Medicaid managed care plans have had tens of thousands of encounters be rejected. Encounters are used for rate setting, calculating ARPA and Directed Payments to providers and assessing quality of care.

- Due to the issues caused by PRISM, managed care plans and the State have held off on taking back any payments to providers due to the unreliable nature of the data in PRISM. Many claims are now past the one-year timely filing period.

- PRISM has caused additional issues regarding provider Medicaid enrollment. In addition, there are defects in the provider enrollment data the State sends to managed care plans. Finally, Medicaid managed care plans do not have the same access to view provider enrollment information in PRISM as they had before.

- In addition to the need to continue to fix discrepancies and errors in PRISM, the following changes will occur over the next 2 to 3 years:
    - The State's current contract with Change Healthcare, its pharmacy administrator, will expire on March 31, 2025. The State awarded a new contract to Optum. The State will need to fix PRISM issues and ensure the successful implementation of the new vendor before the end of March 2025.
    - When the State's waiver is approved by CMS, the State will need to implement dental services for all adults. This will require modifications to PRISM.
    - In the fall of 2023, CMS released new regulations for Medicaid managed care that include significant changes for states and managed care entities. These regulations must be implemented over the next several years and some provisions will require system support and interfaces with PRISM.
    - With the approval of the Justice Involved waiver and new federal regulatory requirements regarding members in the juvenile justice system, the State must implement these provisions beginning January 2024. Full statewide implementation will take several years and again will need PRISM system support.
    - These are just a few of the challenges the State must address in the next 2 to 3 years, along with any additional federal changes or directives from the Utah Legislature.

Overall Recommendations:

1. Preserve the current carve-in pharmacy model for the Medicaid program.
2. Implement a hybrid PDL such that DHHS can effectively direct the ACOs on which drugs are most cost-effective drugs for the Medicaid program for specified drug classes (typically, those classes where a brand drug is yielding the most favorable net cost).

3. Consider changing Medicaid supplemental rebates collection such that the State collects all supplemental rebates in the specified drug classes under the hybrid PDL and the ACOs collect all supplemental rebates in other drug classes.

4. Ensure that ACO capitation rates are appropriately adjusted to reflect the greater use of brand name medications that will occur through the DHHS-determined components of the hybrid PDL, as well as the loss of most supplemental rebates the ACOs currently collect on brand drugs. States must have actuarially sound rates to obtain CMS approval.

5. Due to the changing pharmaceutical market, these changes should be made through legislation to create a three-year pilot project with a sunset date and an evaluation and report to the Social Services Appropriations committee to determine further action. The evaluator must be agreed to by the State and the ACOs to assure the most objective analysis.

These recommendations create several significant advantages for Utah's Medicaid program:

- Deliver savings and revenue to DHHS without "silo-ing" the prescription drug benefit away from the integrated system of coverage and care coordination that DHHS and the ACOs have worked to put in place.

- Keep the drug benefit managed in the private sector ACO setting that has been proven to invest most robustly in staffing and systems, and to deliver the strongest quality outcomes with regard to access and adherence.

- Avoid disrupting a mature coverage program that has been operating since 2013 and inviting transition risks such as those that California and other states have experienced when they carved-out the pharmacy benefit.

- Reinforce the partnership between DHHS and the ACOs, creating a setting where they work together more closely to achieve their shared objectives related to the prescription drug benefit.

II. Introduction

The Menges Group was enlisted to evaluate alternative policy options to manage Utah's Medicaid prescription drug costs. We were particularly focused on whether it is best to (1) continue the current pharmacy benefit "carve-in" model – whereby the ACOs pay for and manage the bulk of the prescription drug benefit for their enrollees (roughly half of Utah's Medicaid prescriptions); (2) move the entire drug benefit to a single government payer system for pharmacy on a FFS basis through a "carve-out" approach; or (3) make necessary program modifications within the carve-in model.

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

1. A review of Milliman's recent report on this same topic, which was commissioned by DHHS and published during August 2024.

2. Emerging trends in Medicaid prescription drug rebates, particularly regarding the degree to which brand name drugs have become "better than free" to the Medicaid program.

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

4. A compilation of the ACOs' programmatic efforts to manage the pharmacy benefit and integrate pharmacy services with the other components of their "whole person" system of coverage and care coordination.

The report concludes with a set of recommendations that are based on the above information and assessments.

III. Assessment of Milliman Report

The Utah Department of Health and Human Services (DHHS) commissioned Milliman to conduct an assessment of multiple Medicaid pharmacy policy options. Milliman's Report, *"Evaluation of Pharmacy Service Delivery Models for the Utah Medicaid Managed Care Program,"* was published as a final report in August 2024. The report's primary conclusion focused on the carve-out option, indicating that "a pharmacy benefits carve-out would reduce DHHS expenses by $33.5 million."

The Menges Group reviewed Milliman's report. The key findings from this review are listed below, with each of these findings then described in detail throughout the remainder of the chapter.

- The cost figures and savings projections derived in Milliman's report represent total Medicaid expenditures; Utah State Fund impacts will likely be 20-25% of the total based on a blend of the Medicaid Federal Medical Assistance Percentage (FMAP) and enhanced 90% FMAP for Adult Expansion members.

- The primary source of the projected savings, a uniform PDL, does not require establishing a single government payer system for pharmacy through a carve-out and can equally occur in the carve-in environment.

- There will be no true administrative cost savings – while there would be a reduction in administrative payments to the ACOs, these costs will move to the FFS setting (and be paid at a much lower federal percentage contribution than occurs under the carve-in model).

- The Milliman report ratings of the pharmacy benefit models were subjective and not driven by data or key performance metrics.

- A carve-out would create modest savings related to ACO operating margins.

- The identified drug claims repricing savings are limited to one of the four ACOs. It should be noted that none of the four ACOs were able to replicate or validate Milliman's analysis based on the information they provided to Milliman. If potential repricing

savings do in fact exist, the most appropriate solution to this cost savings opportunity lies in addressing that ACO's contracting practices, rather than implementing a program-wide carve-out.

- Some aspects of the Utah Legislature's request to DHSS regarding the commissioned study were not comprehensively studied in the Milliman report, including the impact on members, pharmacies, providers, and ACOs.

A. The cost figures and savings projections derived in Milliman's report represent total Medicaid expenditures. Any savings achieved by the report's recommendations would mostly accrue to the federal government.

The carve-out option is primarily under consideration by DHHS to achieve State budgetary savings for the pharmacy benefit. However, Milliman's report does not derive *State Fund* fiscal impacts but rather frames all analyses in terms of overall Medicaid costs and projected impacts.

The current Medicaid FMAP for Utah is 64.4% for most types of Utah's Medicaid costs and 90% for Utah's Adult Expansion members. In total, 75.5% of all Utah Medicaid expenditures were paid by the federal government in FFY2023 (shown in Exhibit 1).

Therefore, any savings achieved as a result of the recommendations made by Milliman or outlined in our report would predominantly accrue to the federal government. Exhibit 1 summarizes key relevant Utah figures from the FFY2023 Financial Management Reports that each state submits to CMS.

Exhibit 1. Federal and State Share of Utah Medicaid Costs, FFY2023

Utah Expenditure Category	Total	Federal Share	State Share	Federal %	State %
Medicaid ACO Payments (Capitation)	$2,249,022,794	$1,738,416,538	$510,606,256	77.3%	22.7%
Pharmacy Payments (Fee-For-Service)	$260,564,039	$208,740,741	$51,823,298	80.1%	19.9%
Overall Net Medicaid Expenditures	$4,531,351,223	$3,420,756,566	$1,110,594,657	75.5%	24.5%

Based on these figures, it is likely that only 20% to 25% of any cost savings or increased revenue from rebates represent State Funds.

In this context, all the figures in Milliman's report need to be divided by roughly four or five to ascertain the report's projected impacts on Utah's State budget. Milliman's overall annual savings estimate of $33.5 million for the carve-out, for example, would translate to a State Fund savings of $6.7 to $8.4 million.

B. PDL savings will occur equally under a carve-out or a carve-in model through a shared drug mix management model that leverages both DHHS and ACO strengths.

Milliman's report correctly identifies a significant fiscal savings opportunity in Utah: having DHHS assume responsibility for determining which drugs should be on a Medicaid-wide PDL. Most of the carve-out savings Milliman is projecting involves moving to a uniform PDL. We recommend that the State and the ACOs implement a hybrid PDL to minimize net pharmacy costs, working in collaboration to identify the lowest net cost drugs in each class and ensure that prescription volume is nimbly and aggressively steered towards these products.

In Section IV of our report, we describe in detail why such a policy change is needed, given the ways and extent to which Medicaid brand drug rebates have evolved and accumulated.

However, moving to a DHHS-driven PDL **does not require carving the pharmacy benefit out of the ACO service delivery model**. As many states have done, DHHS can identify the drugs in each class that will yield the most favorable net (post-rebate) cost for the Medicaid program. DHHS can then require, by contract, that the ACOs steer volume to these medications when it is clinically appropriate to do so. DHHS can also prohibit the ACOs from accessing supplemental rebates in drug classes where a brand drug yields the lowest net cost, ensuring that supplemental rebate funds predominantly accrue to DHHS.

Our detailed recommendations in this area are conveyed in Section VII, which we expect will yield the "double win" of delivering the same level of PDL-related savings that would occur under a carve-out, while preserving the considerable integrated care advantages of the carve-in model.

C. There will be no true administrative savings under a carve-out model.

1. *The Milliman report did not provide objective evidence that administration costs would decrease by $8.5 million through a pharmacy carveout.*

Milliman incorrectly estimates a net annual administrative savings of $8.5 million from the carve-out, derived through a $10.5 million reduction in ACO administrative costs, which is partially offset by a $1 million increase in DHHS staffing costs and a $1 million increase in DHHS vendor costs.

Milliman's administrative cost impact estimates were concerning in the following ways:

- These savings have no basis in actual ACO costs to administer the retail pharmacy benefit. Rather, these estimates appear to have been derived via general ratios, based on actuarial requirements to attribute a portion of each capitation payment to administration to create rates that are actuarially sound as required by federal regulation. There is no separate appropriation for ACO administrative costs.

- The ACOs are at dollar-for-dollar risk for their medical costs *as well as for their administrative costs*. There is no incentive for the ACOs to incur excessive administrative costs.

- Milliman's report did not acknowledge that the ACOs will continue to have administrative costs related to drugs covered under the medical benefit.

- Much of the work the ACOs and their pharmacy benefit manager (PBM) partners now conduct to administer the prescription drug benefit would move to the FFS setting under a carve-out, **but this work would not (and should not) disappear**.

2. *ACO drug benefit administration costs do not "disappear" with pharmacy carve-outs.*

There is no credible path to turning a $10.5 million administrative cost to just a $2 million cost – or even to achieving any meaningful savings by way of a carve-out. Substantial issues exist with both the (ratio-derived) $10.5 million figure and with the estimated additional DHHS cost that would occur under the carve-out.

Any administrative impacts that are being developed to inform an important policy decision should be built out on a line-item basis through close collaboration between DHHS, Milliman, and the ACOs. While there may be some savings associated with the State administering the retail pharmacy benefit in a singular manner, the net savings will be modest in scale. It is likely that Milliman has underestimated costs to the State in terms of increased staffing needs and system costs if the State assumes responsibility for the entire retail pharmacy benefit.

We are concerned that Milliman's estimates require both taking more funds out of the ACOs' capitation for pharmacy administration than is actually being expended, and then assuming far lower additional pharmacy costs in the FFS setting than will actually be incurred.

Moreover, ACOs will still need to obtain daily pharmacy data and work with this information to achieve "whole person" cost savings and health status improvements. While the drug benefit can be transitioned to a single government payer system for pharmacy, the central role medications play in the Medicaid population's health requires that the ACOs continue to remain closely attuned to which medications their enrollees are accessing, how well they are adhering to prescribed regimens, etc.

The ACOs conduct extensive drug utilization review (DUR) for all medications even those that are currently carved out to FFS, and this role would continue to occur under a full retail pharmacy carve-out.

A carve-out model also adds complexity and costs to the administration of the Medicaid restriction program.

3. *ACO administrative costs receive higher federal match rates than the fee-for-service (FFS) Medicaid program. If pharmacy services are carved out to the FFS program, Utah's net State Fund costs for pharmacy-related administration will increase.*

Milliman's report did not take into account differences in the federal match rate between capitation payments to the ACO versus administrative costs directly incurred by DHHS. ACO administrative costs are rolled into a broader capitation rate that the federal government matches at its regular rates (e.g., 64% in general and 90% for support rendered to Medicaid Adult Expansion members). Conversely, administrative costs in the FFS setting receive only a 50% federal match rate. For this reason, whenever pharmacy administrative activities shift from the ACOs to the FFS setting, Utah's net State Fund costs will increase.

4. *There are costs associated with modifying IT systems to support a full retail pharmacy carve out.*

The State will incur costs to modify their Medicaid claims system (PRISM) to facilitate this change. ACOs and their PBMs will also need to modify their pharmacy systems to accommodate a different (carve-out) model.

D. ACO administrative performance was not objectively compared with the FFS setting.

The Milliman report appears to assert or assume administrative performance advantages and efficiencies in the FFS model versus the ACO model without strong evidence. For example, on page 10 of the report in Figure 7, Milliman awarded a maximum advantage "triple plus sign" rating (+++) to the FFS carve-out setting in all five DHHS goals and objectives listed. Notwithstanding these types of assertions, there is a considerable risk that the level of direct customer support for both pharmacies and members that occurs under the carve-in will drop off under a carve-out.

As noted in the previous section, merely reducing pharmacy administrative activity and spending is not a valid goal. An administrative investment can be anywhere on the continuum from exceptionally valuable to completely unnecessary depending on what this investment is or is not achieving. The pros and cons of any given service reduction need to be closely and objectively assessed, devoid of any presumption that the ACOs' pharmacy-related administrative costs and efforts are excessive.

While the ACOs are at risk for their administrative costs, they also compete with one another for enrollees and for provider participation and have a strong incentive to deliver quality service. The same incentives do not exist in the State's FFS model. The same types of budget challenges that have prompted this overall carve-out assessment make it difficult for DHHS to make robust operational investments in staffing, information technology enhancements, etc. as more readily occur in the ACO setting.

1. *ACO Administrative performance metrics were not compared with the FFS program.*

To assess this issue objectively and in a data-driven manner, there should be a comparison of ACO administrative performance metrics with the FFS pharmacy program. While the ACOs may be tracking data the FFS program is not, there are many areas (e.g., provider authorization request response times, call center hours of operation and response times) where valid comparisons can be made.

The Milliman report assigns a rating that the carve-out FFS setting will deliver superior performance in areas such as program integrity, transparency, and streamlined operations. Yet, neither Milliman nor DHHS provide any evidence or data to support these statements.

The performance of these functions in each setting can be objectively compared. For example, the staffing resources, information technology, and outcomes of the program integrity activities occurring in each setting should be objectively compared side-by-side (and drawing upon available data in each setting) before any such assertion is made intending to inform an optimal policy decision.

2. *ACO/PBM pricing concerns were unspecified and unquantified.*

The report also cites potential and theoretical concerns with the ACO/PBM pricing (e.g., assigning a "+++" rating to "fair and transparent pharmacy reimbursement" in Figure 7), but does not identify any programmatic concerns with the ACOs' performance in this area nor acknowledge the efforts ACOs make to pay pharmacies fairly and deliver prescription drug pricing transparency. For example, some ACOs have recently implemented a targeted, enhanced payment to independent rural pharmacies to support the viability of critical access pharmacies. The ACOs are fully aligned with DHHS in ensuring pricing transparency exists "downstream" in their interactions with PBMs.

3. *Milliman's report incorrectly described the ACO-PBM relationship and administration of the pharmacy benefit.*

- ACOs are ultimately responsible for administering and complying with regulations for the pharmacy benefit, not the PBMs. These requirements are included in each ACO's contract language with DHHS and within each ACO-PBM contract.

- The Milliman report implied that the State is not currently working extensively with the ACOs, but rather mostly with the PBMs that the ACOs hire. **This is incorrect—the ACOs frequently meet with DHHS and DHHS rarely (if ever) interacts with the ACO PBMs.**
- Each PBM contract is structured differently regarding which pharmacy benefit functions are delegated to the PBM and which functions are kept with the ACOs.

- 3 of the 4 ACOs have internal PBMs with increased visibility to operations and activities.

4. *Streamlined operations were not defined or objectively measured.*

Similarly, it is by no means self-evident that a net advantage of "streamlined operations" will occur when the drug benefit is de-integrated from the ACOs' core operations (and moved from private sector management to public sector management). Medicaid health plans operating in both carve-in and carve-out states have noted that significant new administrative challenges arise under a pharmacy carve-out (e.g., data transfers, enrollees still calling the health plan about pharmacy issues, etc.).

The speed at which needed adjustments to the PDL occur in the ACO setting is also a highly valuable attribute, as is the "nimbleness" with which the ACOs are able to steer volume in a new manner within a therapeutic class. The ACOs have found the FFS PDL to be outdated at times. The ACOs welcome the opportunity to collaborate with DHHS to help ensure that both FFS-paid and ACO-paid medications promptly redirect volume within a drug class when warranted.

5. *There are challenges and risks of centralizing the pharmacy benefit for FFS Medicaid programs.*

Increasing security incidents and software outage scenarios have been an issue for states utilizing single PBMs and carved-out pharmacy benefits because all pharmacy benefits for those states rely on a single vendor to operate successfully. These technical data issues led to states being unable to process any claims for members, as all members were processing using one vendor that was out of commission due to a security incident or software outage. These scenarios required additional financial and other resources to be utilized due to the large-scale impact. In 2024 alone, there were two national scenarios including the Change Healthcare (CHC) security incident and the CrowdStrike/Microsoft data outage. The Utah FFS program contracts with CHC as its pharmacy benefits administrator and recently renewed their contract with CHC/Optum.

- During the CHC incident, pharmacies across the country were expected to provide medications without knowing when they would be reimbursed, as there were no channels for claims processing for several weeks for some of the carved-out states.
- In Utah, the State Medicaid agency asked the Medicaid managed plans to provide immediate access to critical medications. This opened members up to a significant risk of harm due to incomplete data from pharmacy systems being offline.
- To resolve these pharmacy claim and reimbursement issues, Utah Medicaid set up a separate Google billing form during the CHC outage to allow pharmacies to be reimbursed by the State for drug claims they covered while CHC systems were offline. This allowed pharmacies the opportunity to "double dip" in reimbursements from both FFS Medicaid and the ACOs.
- The FFS drug preferred drug list and other limits are still not functional since the CHC outage on 2/19/24 which increases drug costs for the Medicaid program.

States that were not carved out or did not have single PBMs, including Utah, have more agility in these scenarios due to having their drug claims redirected to Medicaid managed care plan vendors. The ability to redirect claims during critical incidents lowers access to care barriers for members and allow pharmacies to receive timely reimbursements for Medicaid claims.

E. A carve-out could create one modest savings component related to ACO operating margins, but only if drug costs don't exceed the risk margin.

Milliman identified that if the prescription drug benefit is carved out, there will be component savings in the 2% risk margin (or profit margin) that is included in the ACOs' capitation rates. This statement would hold true if the capitation rate development is aligned or lower than actual costs. However, in the event that pharmacy costs exceed actuarial drug pricing targets by 2%, Utah would save money with a carve-in since the ACOs are at risk when the costs exceed rate estimates. Medicaid drug costs have exceeded capitation pricing expectations in recent years; therefore, the State has saved money with the pharmacy benefit carved in.

Milliman projects that this risk margin component will yield an annual overall Medicaid savings of $3.6 million. **This translates to a Utah State Fund savings of less than $1 million – with 75-80% of the savings accruing to the federal government as noted previously**. **These savings would only be realized if the risk margin is not exceeded.**

This is the only savings component that we find could be attributed to moving the prescription drug benefit to a single government payer system for pharmacy. Countering this potential modest savings component, our report identifies ways that a much larger savings can be achieved through retention of the pharmacy carve-in model.

F. Utah's recent Medicaid enrollment dynamics have significant ACO capitation rate-setting implications.

1. *Utah experienced the nation's second-highest percentage loss in Medicaid enrollment after the COVID Public Health Emergency ended.*

Utah's Medicaid enrollment decreased by nearly 150,000 persons between January 2023 and April 2024 after the end of the Public Health Emergency. In percentage terms, Utah's enrollment decrease of 30.8% was the nation's second-largest (behind only Colorado). Nationwide Medicaid enrollment dropped by "only" 12% during this timeframe as states re-instituted their eligibility redetermination processes.

While Milliman's draft report did not make any adjustment for the enrollment drop-off that Utah's Medicaid program has experienced, the final report pulled all recently disenrolled persons out of their modeling. The differences between these two iterations of the Milliman report provide guidance as to the direction and magnitude of the capitation rate adjustments needed to soundly represent the expected costs of Utah's "still enrolled" Medicaid population.

2. *Medicaid members who stayed enrolled have prescription costs that are 22% higher than those who lost Medicaid coverage.*

Exhibit 2 conveys comparison information between the draft and final Milliman reports. The key finding is that PMPM pharmacy costs in the base period for Utah's "still enrolled" Medicaid ACO population costs are 22% above the costs of all persons who were enrolled in that base period. The persons losing Medicaid coverage during the redetermination process had PMPM pharmacy costs of $37 in the base period, 42% below the $64 PMPM cost of the persons who remained enrolled through April 2024.

These dynamics suggest that the overall usage and costs of the population disenrolling from Medicaid during the April 2023 to April 2024 timeframe were modest. The combination of the heightened acuity of remaining members, along with the increased costs to the ACOs under a hybrid PDL will require an appropriate adjustment to capitation rates to ensure they remain actuarially sound.

Exhibit 2. Prior Usage & Costs: Disenrolled vs. Retained Enrollees

ACO Enrollment, Usage and Costs, March 2022 – February 2023			
	Milliman Draft Report	**Milliman Final Report**	**Subsequently Disenrolled Persons in Initial Report**
ACO Prescriptions	2,082,116	1,466,401	615,715
ACO Payments (Pre-Rebate)	$252,600,000	$176,800,000	$75,800,000
Average ACO Enrollees	401,918	230,410	171,508
Prescriptions Per Enrollee	5.2	6.4	3.6
Average Payment Per ACO Prescription (Pre-Rebate)	$121	$121	$123
ACO PMPM Prescription Costs Pre-Rebate)	$52	$64	$37
% PMPM Cost Increase for Prescription Drugs, Final Report Population vs. Draft Report Population			22.1%

G. The ACOs cannot replicate Milliman's repricing of ACO pharmacy claims according to the FFS reimbursement methodology described by Milliman.

While not included in the overall carve-out savings estimate, Milliman identified that if all base period claims had been paid in the FFS setting, pharmacy payments during that 12-month timeframe would have been reduced by $4.2 million. However, it appears the savings from this repricing analysis were entirely driven by one of the four ACOs.

None of the ACOs have been able to replicate Milliman's numbers using Milliman's FFS repricing methodology, which raises question regarding Milliman's calculations. Milliman's pricing savings calculation did not incorporate the higher FFS dispensing fee the State implemented as of July 15, 2024, although Milliman's report acknowledged the pending increase in a footnote.

If Milliman had repriced claims using the higher dispensing fee of $11.57 that became effective July 2024, the projected savings stated in Milliman's report decreases to $2.3 million.

Molina and its PBM partner repriced its pharmacy claims using the methodology described in the Milliman report.

- The net increase cost to Molina pharmacy claims was 30% ($600,000) more than what Milliman reported for a total cost increase.

Based on the ACO pharmacy claim repricing results, the overall projected savings by Milliman decreases by at least 25%. For the other ACOs where there are no cost savings, such as Molina, costs could increase by 30-35%. These are large variances and suggest further analysis is needed before any policy decisions can be made.

To the extent there is an issue with one ACO's payments to Utah pharmacies being deemed overly generous by DHHS, the appropriate cost reduction solution would not be a complete carve-out of the pharmacy benefit. Rather, this should trigger a contract renegotiation effort between that one ACO, its PBM, and its network pharmacies.

Exhibit 3 shows that 42% of Utah's pharmacies are owned by companies in Fortune's Top 30. Given these dynamics, it is important to not overpay all these large corporations in order to help a few smaller Utah pharmacies.

It is also important to ensure that additional Medicaid payments made to critical access pharmacies are targeted appropriately. Providers that are struggling to compete due to scale diseconomies or other business reasons – but which are not fulfilling a critical access purpose – likely do not warrant extra compensation from the Medicaid program.

Utah's ACOs have in many ways demonstrated an ability to pay pharmacies fairly and innovatively. This includes paying most pharmacies in line with commercial and Medicare payment rates, and making additional payments available to selected pharmacies in rural areas.

Exhibit 3. Utah Pharmacies by Ownership – Tabulations Using Select Health Online Network Directory

Pharmacy Owner	Fortune 500 Rank	Salt Lake County	Statewide Total	Subtotal, Counties with ≤10 Pharmacies	Subtotal, Counties with ≤5 Pharmacies
Smiths (Kroger/Albertsons)	25	25	53	6	2
CVS	6	18	31	0	0
Walgreens	28	23	52	5	2
Costco	11	5	12	0	0
Walmart/Sam's Club	1	21	59	9	3
Harmons	N/A	9	15	0	0
All Other	N/A	85	273	70	37
Total	**N/A**	**186**	**495**	**90**	**44**
% of Pharmacies in Large National Chains (Fortune Top 30)	N/A	49.5%	41.8%	22.2%	15.9%

H. DHHS service performance assertions by Milliman were not data-driven.

- The Milliman report did not objectively measure DHHS service performance with data or key performance metrics. Further, the report never objectively compared any key performance metrics between DHHS and ACO programs.

- The ACOs cited several concerns with the FFS pharmacy data reporting due to significant data errors, delays, and ongoing reconciliation efforts for several months. These challenges have significantly increased administrative burden with FFS and ACO staff.

- The ACOs strongly disagree with the Milliman report's assumption that the current communication and processes between DHHS and ACOs are working appropriately. Additional resources will be required for DHHS in the event of a pharmacy carve-out. A key example is the transition to PRISM, which has been onerous and has presented some insurmountable (to date) challenges. PRISM was initiated 18 months ago, and many

operations tied to PRISM continuously create access to care issues for Medicaid members and providers. The ACOs are not confident that a full carve-out would be implemented smoothly without a significant disruption to members and providers

- DHHS has not demonstrated that it has the resources to address unforeseen challenges in a timely manner. Per the FFS newsletter that came out on 7/31/24, DHHS is still unable to process drug prior authorizations due to the Change Healthcare attack in February 2024. FFS pharmacy claims could not process for weeks, and the ACOs paid for both carved-in and carved-out drug claims while the Change Healthcare outage continued into March 2024 without a preferred drug list to help members access needed medications. More than five months later, problems still persist.

- The ACOs have experienced challenges receiving and working with DHHS data for the drugs that are currently carved out (e.g., behavioral health medications). One ACO noted, for example, that "Our care management team has been trying to incorporate the carved-out claim file information into a workable product, but the files we get have been very difficult to incorporate into our internal workflows."

- Incompatibility of data elements provided by DHHS has been an issue in the past that impacts workflows. DHHS has difficulty making updates to these files because all changes must be prioritized against data change requests at DHHS internally for their own systems, such as PRISM; against requests from other providers including hospitals, physicians, pharmacists, and long-term care facilities; and against reporting requirements and requests from federal agencies such as CMS.

IV. Current Rebate Dynamics

A. Description of the Challenges and Opportunities

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. We have also compared cost levels between groups of states using the carve-in approach relative to the group of carve-out states.

1. *Lower net drug costs were achieved by carving in the pharmacy benefit to Medicaid health plans compared to carving out the benefit to FFS programs.*

All these analyses indicate that the carve-in approach (including the pharmacy benefit in ACOs' 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 ACOs' 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.

---

[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/

These analyses have also demonstrated that ACO latitude over drug mix has outperformed implementing a uniform PDL across all Medicaid ACOs.

This section of our report demonstrates why the past assessments and findings may not serve as a good predictor of the effectiveness of adopting any certain approach from 2024 forward. Brand drug prices and brand rebates are evolving in a manner that appears likely to disrupt the cost-effectiveness of the "traditional" ACO 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 ACO's vantage point to be different than the drug that yields the lowest net cost to the Medicaid program (and taxpayers). This section describes the dynamics creating "perverse incentives" under the carve-in arrangement.

Due to the statutory rebate formula, many brand drugs have literally been "free" to Medicaid for the past few years, as illustrated in Exhibit 4 for a hypothetical brand drug.

Exhibit 4. Sample Brand Drug Rebate Dynamics

Row	Description	Amount	Derivation
1	Price of drug in CY2010 when introduced	$200	Hypothetical example
2	Current price in CY2024	$1,000	Hypothetical example
3	CY2024 price if increases matched Consumer Price Index (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 4 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.

2. *The American Rescue Plan Act removed the 100% rebate cap, impacting Medicaid drug rebates.*

Through the American Rescue Plan Act (ARPA) 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 Consumer Price Index (CPI) inflation factor.

The Exhibit 4 scenario is not an anomaly. According to work produced by Christopher Park and his colleagues at 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 average 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.

3. *ACO's do not collect statutory federal rebates*

A key programmatic and policymaking challenge is that the statutory (federally mandated) rebates are paid to the government and do not in any way flow to or through ACOs. As a result, ACOs typically drive volume toward drugs that minimize *their own* net cost.

This issue is illustrated in Exhibit 5 continuing the example of the hypothetical drug depicted in Exhibit 4. 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 prescribing the generic alternative drug shown.

---

[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.

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

Exhibit 5. Hypothetical Example of Current Rebate Incentives

Drug	Pre-Rebate Cost Per Prescription	Statutory Rebate %	Net Cost to ACO	Net Cost to Medicaid Program
Brand drug	$1,000	120%	$1,000	-$200
Generic alternative	$30	13%	$970	$26
Cost difference	-	-	$970	-$226

From an ACO's current perspective, the financial incentives of this drug mix choice are completely opposite those facing the State. The ACO 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 ACOs' traditional drug mix management efforts in an ever-increasing number of therapeutic drug classes. **These dynamics also eliminate the opportunity and value of negotiating**

[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.

[5] This example does not take into account any supplemental rebates that manufacturers are negotiating with the State and/or with ACOs, 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.

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 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 oddly have an incentive to minimize the degree to which their product is used by Medicaid patients.

A large set of brand drugs are now in this "better than free" situation, and many additional drugs are trending in 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 (price increase-related) 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. The remainder of this chapter describes the implications in Utah.

B. Ramifications of these changes for Utah Medicaid

The above-described recent changes in market rebates seem to require that DHHS and the ACOs manage the drug mix strategy together. The brand rebate situation for targeted drug classes requires that DHHS communicate to the ACOs which drugs need to be preferred in order for the Medicaid drug benefit to operate as cost-effectively as possible.

Milliman estimates that potential Medicaid savings of $21 million, mostly accruing to the Federal Medicaid budget, can be achieved by DHHS determining which drugs are preferred in the modeled drug classes. The potential annual State Fund savings are approximately $4-5 million. State Fund savings further decrease due to increased administrative and underwriting costs to the ACOs for administering a State-driven PDL as described in Figure 19 of the Milliman report.

Sovereign States Drug Consortium (SSDC)

Some argue that allowing Utah Medicaid to include ACO covered lives will better position the State to negotiate supplemental rebates thereby increasing potential revenue. However, Utah Medicaid already participates in an organization of 15 state Medicaid programs that collectively solicit and evaluate offers from drug manufacturers for State supplemental and DME rebates. As of March 2024, this consortium includes 15.5 million PDL lives and over $20 billion of annual drug spend. Each state is responsible for full ownership of its contracts.

Utah's covered PDL lives currently comprises only 3% of the SSDC's total PDL lives. Any net increase of PDL lives from the Utah ACO's are unlikely to make a significant difference in negotiating power for supplemental rebates with drug manufacturers.

1. *Recent market changes of rebate incentives have introduced uncertainty for how drug manufacturers will respond with drug pricing and rebates offered.*

Because Milliman did not factor in the "better than free" nature of many brand drugs beginning in January 2024, these savings could be larger than their report projects. However, we also anticipate that because more brand drugs are reaching "better than free" status with each passing year, the overall level of supplemental rebates being offered by the drug manufacturer community is likely to diminish. **The manufacturers have no reason to offer a supplemental rebate on a product they are already losing money on via the statutory rebate.** Half of the rebate savings projected by Milliman were accruing via these supplemental rebates.

Substantial uncertainty exists with how the new, "better than free" rebates are going to affect manufacturers' drug pricing behavior over time (as well as with how long such a bizarre compensation structure will remain in effect). Some manufacturers have lowered prices this year to soften their Medicaid rebate liabilities.

However, it is quite possible that the statutory rebates going forward will be larger than Milliman is projecting – with manufacturers generally continuing to take an aggressive posture with the price increases of their products (accepting that these increases will be fully rebated to Medicaid when used by Medicaid enrollees). To the extent this materializes, it is likely that supplemental rebates, in aggregate, will become smaller than Milliman has projected by looking at largely a 2022 base year.

Regardless as to whether these two types of rebates ultimately net out to be larger or smaller than Milliman is projecting in Utah, we concur with Milliman's projection that a uniform PDL may yield savings for Utah Medicaid in drug classes where the lowest net drug cost to the Medicaid program is a brand drug after all rebates have been fully and accurately taken into consideration.

2. *Medicaid PDL and rebate savings can be achieved with keeping the pharmacy benefit carved-in to the ACOs.*

A move to a uniform PDL **does not require carving out the pharmacy benefit from the ACOs' responsibility.** Milliman's report (in the map in Figure 13) shows that 19 states with Medicaid ACO/MCO programs currently implement a uniform PDL and do not carve out the drug benefit.

A key recommendation of our report, described in detail in Section VII, involves accessing the savings a hybrid PDL can deliver for Utah, but doing so within the carve-in structure that keeps the drug benefit and related data fully inside each ACO's integrated care coordination system.

V. Assessment of California's 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 the initial years of experience under the new approach can now be assessed, and due to California's large size, we assessed Medi-Cal's early experience to help inform Utah 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.

A. Programmatic Assessment of California Carve-Out

California's implementation of its Medi-Cal pharmacy carve-out in January of 2022 encountered massive access challenges – worse than those that occurred during the height of the COVID pandemic.

The combination of the claims volume that transitioned to the FFS setting, and the algorithms used by Magellan Health, the pharmacy benefit manager (PBM) entity enlisted by the Medicaid agency, had the effect of preventing medication access on a highly concerning scale. Tabulations using the quarterly data states submitted to CMS, summarized in Exhibit 5, demonstrate the degree to which a drop-off in Medi-Cal prescriptions occurred when the carve-out model went into effect.

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. People 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 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 were similar in proportion for insulin prescriptions (a 25% drop-off) and for insulin units (a 20% drop-off). Prescription volume during Q2 2022 increased, but was still 2.3 million below the carve-in's final calendar quarter.

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

Timeframe and Circumstance	Total Medi-Cal Prescriptions	% Change from Prior Quarter	Insulin Prescriptions	% Change from Prior Quarter	Insulin Units	% 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.

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 5 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)	% 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%

Taking all Medi-Cal drug rebates into account (as reported in the Financial Management Reports published by CMS), 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 Per Prescription	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 implementation are perhaps important for Utah policymakers to consider. Beyond the inherent programmatic disadvantages of the carve-out approach described in Section VII, moving the drug benefit to the FFS setting introduces significant transition risks.

California's experience also illustrates the importance of maintaining the cost containment rigor that the Utah ACOs deploy. The administrative cost savings assumptions included in the Utah Milliman report seem to create an expectation that the drug benefit can "safely" be managed with less administrative effort and rigor. California's experience under their carve-out, when the cost containment tools were temporarily relaxed, strongly refutes this.

C. Programmatic Assessment of Single Pharmacy Benefit Manager Carve-Out

Multiple issues occurred during and after a recent implementation of a single PBM carve-out which led to the State Medicaid agency delegating many State PBM oversight functions back to the Medicaid health plans such as:

- Resolving the State's pharmacy claim rejections.
- Creating workflows to remove access to care issues such as coordinating Medicaid benefits with other plan coverage, Medicare Part B drugs, emergency overrides and others.
- The health plans monitor many functions of the State's PBM including drug utilization, prior authorization key performance metrics, financial trends, drug benefit exclusions, rebates and others.
- Health plans have to complete some prior authorization reviews on behalf of the State Medicaid agency because they can't handle the drug prior authorization volume.
- During and after the implementation of the State PBM, the delegation of pharmacy benefit activities to the health plans was not timely or effective. The Medicaid health plans asked for workflows, job aids, standard operating procedures, and other detailed information on the State PBM activities and services. The State never produced these documents and as a result the pharmacy benefit structure changed significantly after moving forward with the State PBM.

VI. Programmatic Features of Utah'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 single government payer system for pharmacy "silos" the prescription drug benefit and thus represents a 180-degree turn away from all the efforts DHHS and the ACOs have made to establish and strengthen a whole-person, integrated system of Medicaid care and coverage.

Conversely, the ACOs have developed integrated staff, information systems, and care coordination processes that all function best under a carve-in model of all health services. 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.

We have presented three case examples as to how the ACOs support members and providers related to the pharmacy benefit, as well as a detailed compilation of ACO approaches and features identifying the programmatic differences between the carve-in and carve-out settings.

A. Utah Case Examples Demonstrating Value of Integrated Drug Benefit

Example 1: Educating providers to achieve savings: An ACO conducts multidisciplinary collaborations with providers to convey information on drug medication use and costs that is not readily available to providers. Recently this ACO was able to provide information to a prescriber related to Uptravi which is used to treat Pulmonary Arterial Hypertension. The pharmacy team educated the provider to prescribe a different drug dose that leads to less medication waste. The provider agreed to the change which saved at least $19,000 in monthly Medicaid spending.

Example 2: Close communication to achieve adherence: The ACO worked with a GI/liver specialist regarding a non-English speaking member who had two previous Hepatitis C

relapses of unknown cause (although not suspected to be due to "reinfection"). The member does not engage in risky behavior or IVD use. The ACO worked to help ensure a simplified therapy plan as well as pharmacy dispensing and clinic pharmacist monitoring to ensure the member understood how to take the medication correctly.

Example 3: Thoroughly assessing a seeming gap with a needed medication: For a recently hospitalized sickle cell patient, an ACO's claims did not show that the member had been filling his medications. The case management team was notified and contact was made with the family. The family confirmed that the member was taking their medications correctly.

Further research discovered that all the claims had been sent to the State and inappropriately paid by FFS. This research allowed the ACO to work on a therapy plan with the provider with the goal to prevent any further crisis and hospitalization.

B. Programmatic Comparisons Between Carve-In and Carve-Out Setting, Function by Function

The remainder of this section conveys information by operational area on the programmatic advantages of the carve-in model. A common theme to these comparisons is that the carve-out would represent a move directly opposite the integrated model of coverage and care coordination each Utah ACO operates.

1. Prescription Drug Data Timeliness, Structure, and Completeness

In the carve-out setting nationally, there is typically a delay in the transmission of prescription drug data to the ACOs (relative to the carve-in setting). Also, the pharmacy data under a carve-out are transmitted according to what is most convenient to the state (and/or its PBM), whereas in the carve-in setting, the ACO can ensure that the data structure meshes optimally with its integrated care systems.

Utah's ACOs provided input on the value of the real-time pharmacy data to their system of integrated care and timely interventions on the behalf of members. Several excerpts from their input are conveyed below.

Currently, the ACOs have access to real-time data and can view a prescription claim as soon as it is processed. This allows the ACO to immediately take into account all data components when addressing a member's situation. This is particularly important as the ACO staff are working with members daily in multiple ways:

- ACOs ensure members who are transitioning from an inpatient setting to outpatient are receiving their necessary medications.
- Many members are eligible for multiple case management programs such as the Restriction program, medication adherence, and medication reconciliation. With limited or delayed visibility to pharmacy claims used for these programs, Medicaid program costs increase due to uncoordinated care and misuse of medical services that can result in harm to members.
- Dispensing pharmacy safety edits on medications such as those that check for drug-drug interactions, duplicate drugs, and drug dosing.
- Address member and provider questions or access to care issues such as prior authorization status, pharmacy claims that aren't paying, and eligibility. All of these questions and issues would be redirected to State Medicaid staff.
- Coordinated prior authorization reviews for simultaneous treatment under the medical and pharmacy benefits such as cancer treatments.
- Quality team's immediate access to pharmacy claims data is essential since they don't get medical claims until several months after members receive treatment.
- When pharmacy benefits are carved out it creates a disconnect between medical and pharmacy data. This fragmentation results in an incomplete view of the member's health, leading to less effective care coordination. Efforts between the ACOs and DHHS staff are duplicated and become less efficient without seamless access to pharmacy data. This inefficiency can lead to duplicated efforts, increased administrative burden, and ultimately, a decrease in the quality of care provided.

2. Pharmacy-Related Quality Performance

At the national level, there is strong evidence that the carve-in setting is outperforming the carve-out setting. The Menges Group compared quality scores across 29 pharmacy-related HEDIS measures between states using carve-in and carve-out models. The quality scores were clearly and consistently superior in the carve-in setting. In 97% of the large-scale comparisons performed, the health plan-managed (carve-in) model outperformed the FFS model.[6]

These findings encompassed HEDIS measures that directly align with several of the DHHS objectives identified in the Executive Summary of Milliman's report, including:

- Improved quality of care;
- Timely, equitable, and convenient access to necessary medications;
- Improving medication adherence;
- Enhancing health outcomes for Medicaid members; and
- Reducing avoidable healthcare costs and member dissatisfaction associated with poorly managed care transitions.

Exhibit 8 summarizes one of the analyses that compared enrollment-weighted average quality scores in a carve-out state with its neighboring carve-in states – the carve-in health plans' scores were higher in 67.9% of the 533 group-to-group comparisons.

[6] The full report can be accessed at this link: https://www.elevancehealth.com/content/dam/elevance-health/articles/ppi_assets/partner-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, Controlling High Blood Pressure, Persistence of Beta-Blocker Treatment After a Heart Attack, Statin Therapy for Patients With Cardiovascular Disease and Diabetes, Antidepressant Medication Management, and Adherence to Antipsychotic Medications for Individuals With Schizophrenia.

Exhibit 8: 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' Scores	Comparisons Where Carve-Out MCOs' Weighted Average Score was Better than Carve-In MCOs' Scores	% 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%**

For this report, The Menges Group also created a weighted average score for each of the 21 pharmacy-related HEDIS measures where average MCO/ACO scores could be calculated in each of five states. We compared Utah with its four neighboring states with MCO programs – Arizona, Colorado, Nevada, and New Mexico. The state average score for each measure was calculated using each MCO/ACO's score weighted by its Medicaid enrollment level. Across these five states, Utah had the second-best average ranking – behind only New Mexico.

3. Medication Adherence

ACOs 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. Some examples are conveyed below.

- Utah's ACOs provide hands-on coordination with the dispensing pharmacy – and the member if needed – to ensure drug delivery. One ACO, for example, conducts direct provider outreach for high cost/risk members (i.e. cystic fibrosis, pulmonary hypertension).

- Currently the ACOs can quickly resolve pharmacy claim issues for members when they have challenges. This is especially important for members who are in the Restriction program. If all pharmacy claims move to the State, the ACOs will not be able to resolve

pharmacy claim issues which lead to delayed drug treatment and decrease member's medication adherence.

- Our care management helps members not only access medical and pharmaceutical resources, they also help get members signed up for additional services such as transportation, food, housing, etc. These additional services directly improve adherence to medications.

- During drug manufacturer shortages, our agents will call 2-3 pharmacies on behalf of the member to either find the drug or an alternative located near the member. This outreach ensures members' treatment is not interrupted.

- ACOs can approve services on a case-by-case basis when services are carved in. A few examples of this include single case agreements with Center for Change for our integrated members that struggle with eating disorders. For several members an ACO has arranged a special agreement on to receive home health services or private duty nursing services, including providing an increased rate for these members that would have no other option but to be admitted to a facility.

- For members who require Coordination of Benefits (COB) --commercial plan policies have different pharmacy benefit requirements than Medicaid. The ACOs work quickly to make policy exceptions to help medications process timely for these members.

4. Prescriber/Pharmacist PDL Simplification

An often-cited programmatic advantage of the carve-out model – a single Medicaid PDL – can be implemented within the carve-in model, as many states have done. This approach is one of our key report recommendations.

A. Most of Utah's population has drug coverage under commercial and Medicare plans.

Utah's Medicaid population represents approximately 10% of Utah's overall population, and there is no credible path to covering the remaining 90% of the state's residents under a uniform PDL environment. Prescribers and pharmacies need to accommodate dozens of different Utah payers' PDL structures across commercial insurance and Medicare, and these providers have

become increasingly adept (often via automated linkages) at discerning the PDL that applies to any given patient being treated.

Therefore, moving Medicaid from five PDLs (4 ACOs plus FFS) to one has the impact of reducing Utah providers' overall PDL volume from perhaps 40 to 36. This will not create significant administrative economies for Utah's providers.

B. *Drug treatments are often integrated across both the medical and pharmacy benefits—especially for medically complex individuals and persons with high-cost conditions.*

Members who have complex medical conditions require drug treatment regimens that are becoming more integrated across the pharmacy and medical benefits. For example, some members require a loading dose at a provider's office before being transitioned to self-administration under the pharmacy benefit.

Cancer treatment regimens often span across provider-administered drugs under the medical benefit and self-administered drugs under the pharmacy benefit.

- These cancer drug regimens are often dispensed together to ensure safety which is critical for the narrow dosing window of these drugs.
- With a carve-out, some parts of the cancer treatment regimen would be reviewed under the pharmacy benefit by FFS staff and part of the regimen would need to be reviewed by the ACO staff for medical benefit drugs.
- This fragmentation of drug regimens is not cost-effective since separate agencies need to review the entire treatment regimen but only dispense, approve, and/or ship a portion of it.

These scenarios require providers to submit duplicate authorization requests for the same drug or drug treatment regimen—one request to FFS for the pharmacy benefit drug or dose and another request to the ACO for medical benefit drug treatment.

- This results in disjointed reviews that can result in a denial by FFS and approval by the ACO or vice versa.
- Complex coordination between FFS and ACO staff would be required due to different prior authorization turnaround times as required by federal regulations. Pharmacy benefit prior authorizations (PAs) must be decisioned within 24 hours while medical

benefit PAs can take up to 2 weeks to be decisioned, if all information is received by the provider. PAs could be extended another two weeks if additional information is needed.

Finally, integrated or cross-benefit drug management also allows the ACOs to work with providers and members to receive drug access under the lowest cost care setting as agreed upon.

- Members can have flexibility to receive their medication in an ambulatory care suite or home infusion instead of the hospital.
- The ACOs allow providers and members the flexibility to order the drug directly or through a pharmacy.

C. Impact of Medicaid PDLs for members transitioning to other health coverage.

Due to Utah's favorable economy, many Medicaid members transition away from Medicaid to other coverage. This could be children moving to the Children's Health Insurance Program (CHIP), Marketplace or employer sponsored coverage.

D. Continuation of care policies always decrease projected savings from members switching to Medicaid preferred drugs, especially for the first few years after the State PDL. FFS Medicaid (and its ACOs) cannot force members and their providers to change drug treatment due to lowest net cost to Medicaid. They are allowed to continue their existing drug treatment as long as it works and the member is not experiencing harmful drug side effects.

5. Customer Service Challenges Between Carve-In and Carve-Out Services

The ACOs raised multiple concerns with the carve-out model's ability to navigate the "grey areas" that the carve-out model would create between medical and pharmacy benefits. Under a pharmacy benefit carve-out model, two or more different entities manage members' coverage for medical and pharmacy. This often creates confusion for members and providers. After other states carved out the pharmacy benefit, health plans' customer and provider service call centers experience a high volume of calls regarding medication access issues. Unfortunately, the health

plans cannot address these concerns and must redirect all calls to the Medicaid program and their delegated entities. Additional examples of customer service and care coordination concerns from the ACOs are outlined below.

- "A carve-out significantly decreases our ability and flexibility to coordinate care between the medical and pharmacy benefits. This lack of coordination especially impacts members with costly and high-risk conditions such as cancer or multiple sclerosis who receive drug treatment through both benefits simultaneously, or transition treatment between benefits." Based on the ACO's experience in other states, this lack of treatment coordination results in duplicate therapy and duplicate claims under both benefits. It also leads to increased costs due to the inability to manage drug treatment under a care setting that is cost effective and the best fit for members' needs.

- The ACOs have concerns with the State's ability to create processes and standard operating procedures to mitigate these benefit coordination issues based on current and historic experiences. As an example, the ACOs have been asking and waiting over a year for finalized standard operating procedure for how carved out drugs that cost at least one million per dose will be coordinated with the ACOs. Utah Medicaid covers the drug itself, but the ACOs are responsible for the hospitalization, administration, and other supportive costs. These ultra high-cost drugs require a "white-glove" approach with members and providers so they can receive treatment and be reimbursed in a timely manner. These drug treatments can only be given in a small number of very specialized treatment centers or hospitals—most of which are located outside of Utah. Extra coordination is required for:

    - Member transportation
    - Cost of meals and lodging
    - Contracting with out of state providers and treatment centers
    - Providers split billing treatment costs to ACOs and Utah Medicaid
    - The authorization process for the drug and its administration
    - Monitoring of treatment outcomes with drug manufacturers

VII. Recommendations

Based on the above analyses and findings, we offer several recommendations as described below. Taken together, these recommendations combine the best attributes that DHHS and the ACOs have to offer in terms of financial management, quality of care and care coordination, and service excellence.

Rather than choosing between "keeping the drug benefit here" or "moving it there," we encourage that Utah's Medicaid pharmacy benefit be co-managed through an enhanced partnership approach.

1) Preserve the carve-in model.

Our key recommendation is to continue keeping the drug benefit inside the set of services for which the ACOs are at risk financially and responsible for in terms of access and quality. The rationale for this recommendation is summarized below.

- The carve-in model is far superior to the carve-out approach programmatically in achieving whole-person care. Implementing a single government payer system for pharmacy through a carve-out approach represents a 180-degree turn away from the whole-person, integrated care model that DHHS and the ACOs have put in place and worked to strengthen over time.

- We estimate that the carve-in and carve-out models will yield essentially equal costs when the full set of our recommendations are taken together (particularly, a DHHS/ACO partnership model related to optimal drug mix management, where volume can nimbly be steered to Medicaid's lowest net cost drugs).

Note that this is not purely a "maintain the status quo" recommendation. The carve-in recommendation is suggested in concert with some significant modifications to the current program structure as conveyed in all the subsequent recommendations.

2) Implement a hybrid PDL program in partnership with the ACOs.

We recommend that DHHS create a partnership with the ACOs to establish PDL content and to steer volume to the most cost-effective drugs for the Medicaid program. We further recommend that the preferred drug(s) in each drug class be determined with close involvement by the ACOs.

We recommend that the ACOs and DHHS work together to discern the drug classes where the lowest net cost drug(s) are brands, versus where the lowest net cost drug is a generic. In classes where a generic drug is the Medicaid program's best option, we recommend that the ACOs maintain drug mix latitude.

In classes where a brand drug creates the lowest Medicaid net cost, DHHS will need to identify these drugs. In turn, the ACOs will need to steer volume to these brand drugs in the absence of a valid clinical justification for a different medication to be described.

We recommend that DHHS and the ACOs create a PDL Work Group that establishes an initial PDL (and determines which drug classes should remain under ACO control with regard to PDL content and drug mix management. On an ongoing basis, the PDL Work Group would meet as needed to update PDL content as needed to address manufacturer price changes, introduction of new drugs, patent expirations, new supplemental rebate negotiation outcomes, etc.

As the parties work to collaboratively design and operate the hybrid PDL in an optimal manner, we suggest the following framework:

- DHHs would dictate only the formulary status of the drugs included on the hybrid PDL.
- The ACOs would retain flexibility to apply and manage their own utilization management edits to the non-managed DHHS drugs on the PDL (prior authorization, age limits, quantity limits, etc.)
- The ACOs would manage drugs/drug classes not included on the DHHS PDL, including drug mix management and supplemental rebates.
- ACOs would retain flexibility to manage the channel through which prescriptions are covered (i.e., medical vs pharmacy).

- DHHS would deliver PDL updates to the ACOs on a regular cadence (e.g., weekly) in the form of either an updated comprehensive PDL file or as a change file (that only contains recent modifications to the previous version of the file).

3) Consider transitioning supplemental drug rebate negotiation and collection to DHHS in selected drug classes.

We recommend considering transitioning brand drug Medicaid supplemental rebate negotiation and collection from the ACOs to DHHS in the drug classes where this approach will deliver the largest net savings. DHHS is the only entity that has a full command over what the statutory rebates will be. This recommendation applies to the same drug classes where DHHS and the ACOs identify that DHHS should control the PDL content.

This change will ensure that the PDL can be developed with DHHS possessing full knowledge of each drug's net costs. This approach also avoids having the ACOs seeking to establish "steerage for rebate" arrangements on brand drugs which may not be yielding the most favorable net cost to Medicaid (even with the supplemental rebates factored in).

Note that this change will also necessitate an increase in the capitation rates paid to the ACOs at the "front end," as the ACOs would much less often be collecting "back end" rebates that reduce their own net Medicaid drug costs.

4) Work closely with the ACOs to accurately adjust capitation rates for higher use of brand drugs with a PDL as well as for the loss of supplemental rebates.

In concert with the PDL work group, it is also recommended that Milliman, DHHS, and the ACOs work in a transparent manner to identify the capitation rate changes that are needed. At the outset of the implementation of the hybrid PDL, the ACO capitation rates will need to be increased to accurately reflect the more "brand drug heavy" mix of drugs that will be prescribed. The specific types of adjustments needed are described below.

- Ensure that ACO capitation rates are adjusted appropriately to reflect the greater use of brand name medications that will occur through the DHHS-determined components of the hybrid PDL, as well as the loss of the supplemental rebates the ACOs currently collect on brand drugs in those drug classes where the rebate negotiations will be conducted by DHHS.

- State actuaries need to model generic to brand conversion rates by PDL class, then apply brand drug inflation rate assumptions and increased utilization by drug class, especially if the ACOs are required to follow the State utilization management and prior authorization strategies.

- Actuaries must consider all components on generic to brand dispensing rate, brand drug inflation, and utilization rate assumptions when setting ACO capitation rates together with the State-determined PDL content.

- Higher drug costs are incurred by ACOs when manufacturers offer larger rebates for removing prior authorization and utilization management edits on their drugs. This results in higher use of brand drugs, which requires increased capitation payments to the ACOs, and perhaps ultimately a net increase in Medicaid program costs.

5) Explore additional cost saving opportunities.

In addition to the savings a hybrid PDL will yield, the ACOs identified the following sources of potential State Fund savings.

1. Address identified health waste correction opportunities:

During 2022, 3 of the top 5 health "waste" measures for Utah Medicaid identified by Milliman (under a separate report) were due to potential overtreatment with medications:

- 2 or more antipsychotic medications;

- opiates in acute disabling lower back pain; and

- antibiotics for acute upper respiratory and ear infections.

The first item involves ACO carve-out drugs and needs to be addressed in the FFS setting. However, the Utah FFS PDL currently applies very limited utilization management edits to combat health waste such as quantity limits, and prior authorization to prevent off-label utilization.

2. **Assess cost savings opportunities within existing carve-out drugs:**

As part of the enhanced collaboration between the ACOs and DHHS that is encouraged, we recommend that DHHS solicit ACO suggestions as to how/where cost savings can be achieved within the current carve-out medications. Through their involvement with these medications in Utah for non-Medicaid subgroups, their knowledge obtained from connections to Medicaid coordinated care practices in other states, and their direct knowledge of the issues/opportunities that have arisen with their Utah Medicaid enrollees, the ACOs can compile a specific list of cost-savings opportunities.

3. **Ensure appropriate PDL updates are made for both FFS-paid and ACO-paid prescriptions:**

The ACOs welcome the opportunity to collaborate with DHHS to help ensure that both FFS-paid and ACO-paid medications promptly redirect volume within a drug class when warranted.

4. **Collaborate regarding optimal utilization management practices for FFS-paid drugs:**

Opportunities may also exist or the ACOs to collaborate with DHHS to enhance FFS pharmacy utilization management savings. A specific example cited was anti-tumor necrosis factor (TNF) inhibitors, where there do not currently appear to be strong utilization management processes to avoid exceeding FDA approved dosing limits and avoid under-age utilization.