The Menges Group

Strategic Health Policy & Care Coordination Consulting

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

Updated Report

February 2026

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I. Executive Summary

This report updates our 2024 assessment of which prescription drug model is best suited for Washington's Apple Health (Medicaid) program. Two options have been assessed:

a) continuing the current "carve-in" prescription drug model, under which managed care organizations (MCOs) pay for members' prescriptions, or

b) transitioning to a "carve-out" model, where prescriptions are managed by a separate company using a fee-for-service (FFS) payment mechanism.

Our update focuses on the fiscal impacts of the carve-out, with our new estimates derived in Section II. Simulating the carve-out on the most recent year where data are available (FFY2024), we estimate that changing to **the carve-out approach would create additional total annual costs of $94.1 million** for Washington's Medicaid program, divided **$59.0 million in additional state outlays** and $35.1 million in additional federal outlays.

Further additional costs would be incurred at the outset to the transition to the carve-out model, and annual costs would likely increase in approximate concert with the rate of prescription drug cost inflation.

We have also provided updates on how California's costs have progressed under its carve-out approach now that early year cost impacts can be tabulated. California's carve-out had a highly concerning first year with regard to medication access, and has appeared to have significant and ongoing challenges regarding costs. Our tabulations working with California's CMS-reported data indicate that more than **$8 billion in additional costs accumulated** during the first three years of the carve-out relative to estimated costs had the carve-in model remained in use.

The remaining sections of this updated report largely address the programmatic challenges the carve-out model creates in "de-integrating" the comprehensive system of care and care coordination that the Health Care Authority and the state's Medicaid MCOs have built and operate. These sections have not been changed from the previous report.

Our recommendations also remain identical to those in the 2024 report, as described in Section VI. The key recommendation is to preserve the existing carve-in structure – both for fiscal optimization and due to the wide array of programmatic advantages that occur under an integrated model of care and care coordination.

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

The cost impacts of the carve-out model were estimated by looking in detail at known Apple Health pharmacy costs and state-reported rebates in FFY 2024, then estimating how each cost area would have changed had a carve-out model been in place. These estimates were built up component by component as shown in Exhibit 1 and summarized in narrative below.

Prescription Volume: In the Drug Utilization Files (DUF) data set that all states convey to to CMS each year, Washington reported 13.3 million Medicaid prescriptions. MCO efforts to facilitate access/adherence may diminish under a carve-out, which could create a modest decrease in prescription volume. We have assumed a 1% reduction in prescription volume under the carve-out. While this represents a prescription drug savings component in our cost modeling under the carve-out, such an outcome (driven by less adherence to needed medication regimens) would likely create an overall medical cost increase rather than a savings as well as adverse health impacts.

Drug Mix: A uniform HCA-directed PDL has been in place for several years. Apple Health MCOs are experienced in adhering to this PDL (and making appropriate clinical exceptions). For these reasons, we do not anticipate that any meaningful differences will occur with regard to drug mix under a carve-out approach. No drug mix impacts have been factored into our estimates.

Cost Per Prescription (pre-rebate): Molina Healthcare is the largest Apple Health MCO, serving roughly half of the program's statewide enrollees. Working with the known Medicaid FFS pricing practices, Molina compared its own costs for its known mix of Apple Health prescriptions with the costs for the same 700,000+ retail pharmacy prescriptions at the Medicaid FFS pricing schedule. **The results of this detailed "re-pricing" effort showed Molina's costs to be 11.5% below the FFS schedule.**

Specialty pharmacy claims are more complex to simulate, and represented 37% of Molina's Apple Health pharmacy expenditures during the same timeframe. We do not have reason to expect that MCOs (nor FFS) would have meaningfully different pricing for specialty pharmacy drugs; we have therefore assumed no differential between the carve-in and carve-out settings for these medications.

Averaging the 11.5% MCO pricing advantage for retail pharmacy (63% of overall costs) with no impact on the specialty pharmacy medications (37% of overall costs) yields an average overall unit price advantage of 7.25% for the carve-in setting.

We applied this 7.25% differential to all Apple Health pre-rebate costs, assuming that the other Apple Health MCOs' pricing practices will, on average, be similar to Molina's. In the DUF data set, Washington reported approximately $1.75 billion in Medicaid payments for Apple Health prescriptions during FFY2024, prior to taking into account manufacturer. The 7.25% differential would cause Washington's known FFY2024 average cost per Medicaid prescription to increase by more than nine dollars, from $122.25 to $131.80. This differential

Exhibit 1. Cost Comparison of Carve-In and Carve-Out Approach, FFY2024

		Actual FFY2024 Costs Under Carve-In				Estimated FFY2024 Costs If Carve-Out Model Had Been In Place		
Item #	Financial Impact Component	Total	State Share	Federal Share		Total	State Share	Federal Share
1	Prescription Volume	13,405,621	NA	NA		13,271,565	NA	NA
2	Cost Per Prescription (pre-rebate)	$122.25	$37.90	$84.35		$131.80	$40.86	$90.95
3	Total Pre-Rebate Cost	$1,638,837,167	$508,039,522	$1,130,797,645		$1,749,250,195	$542,267,560	$1,206,982,634
4	Rebates Per Prescription	$82.84	$21.54	$61.30		$82.84	$21.54	$61.30
5	Total Rebates	$1,110,521,644	$288,735,627	$821,786,016		$1,099,416,427	$285,848,271	$813,568,156
6	Net Cost Per Prescription	$39.41	$16.36	$23.05	#	$48.96	$19.32	$29.64
7	Net Pharmacy Costs	**$528,315,524**	**$219,303,895**	**$309,011,629**		$649,833,768	$256,419,289	$393,414,478
Additional Cost Components						Additional Cost Components		
8	Estimated Pharmacy Benefits Administration that would shift from MCO expense to FFS expense under carve-out	$40,970,929	$12,700,988	$28,269,941		$40,970,929	$20,485,465	$20,485,465
9	Annual 2% Premium Tax Revenue Related to Pharmacy Benefit	$0	($22,615,953)	$22,615,953		$0	$0	$0
10	1.67% Profit Margin on MCO Pharmacy Costs	$27,368,581	$8,484,260	$18,884,321		$0	$0	$0
	Total Pharmacy Benefits Related Costs	**$596,655,033**	**$217,873,190**	**$378,781,844**		**$690,804,697**	**$276,904,754**	**$413,899,943**

340-B Prescriptions: Our initial report explored 340-B pharmacy cost and participating provider dynamics in detail, as shown in Section IV. The central financial 340B issue with the carve-out is whether the state should take for itself the state share of overall Medicaid margin that the 340B program delivers to the safety net providers.

It is also important to ensure that all 340B savings estimates take into account federal matching fund dynamics. Apple Health capitation expenditures were primarily (70%) financed by the federal government during 2024. As such, any savings that occur through 340B program restructuring would accrue approximately 70% to the federal government and 30% to the state. For example, if an overall 340B savings of $20 million were accessible, only $6 million would be captured by Washington State.

Our analyses demonstrated the critical importance of the existing 340B funding to support the services Washington's FQHCs deliver. While it seems possible to restore the FQHC's revenue losses that would occur under the carve-out via a state plan amendment with CMS, this would negate much or all of the 340B savings and require taking a convoluted path to keep the FQHCS in the same position they are already in. We therefore have not factored 340B savings into our estimates, as the "downsides" of seeking savings in this place and manner are too detrimental.

Rebates Per Prescription: All states report their Medicaid drug rebates to CMS, and these figures are publicly available by state and Federal fiscal year through CMS' financial management reports (FMRs). The FMRs show both statutory and supplemental Medicaid drug rebates, which for Washington totaled just over $1.1 billion during FFY2024 (recouping 67.8% of pre-rebate prescription drug expenditures).

Given that we anticipate that drug mix will not be impacted by the carve-out, both statutory and supplemental rebates are expected to be the same in the carve-in and carve-out settings for any given prescription and across all prescriptions. We have therefore assumed no cost differential in rebates per Medicaid prescription between the carve-in and carve-out settings.

Pharmacy Administration: We have previously indicated that no meaningful changes in administrative costs are likely to occur under the carve-out. The Rx-related services performed by the MCOs still need to occur, and many of these services would still occur at the MCOs even under a carve-out (e.g., data integration with care coordination, outreach efforts to facilitate medication adherence, etc.). Those Rx-related administrative functions that shift from the MCOs to the FFS setting -- such as claims processing and payment, prior authorizations, pharmacy contracting -- are likely to occur at a similar cost in either setting.

However, moving administrative costs from the MCOs to the FFS setting has adverse federal match implications for the state. The average federal share of Washington's capitated Medicaid expenditures during FFY2014, as derived from Washington's FFY2024 FMR report, was 69%. In the FFS setting, the federal share of administrative costs is 50%. Due to this matching funds differential, we estimate that Washington's Rx-related administrative costs will increase under the carve-out (even though overall administrative spending levels are not expected to meaningfully change).

We estimate that the administrative costs that will transition from the MCOs to the FFS setting under the carve-out will represent 2.5% of pre-rebate pharmacy costs, which would be $41 million during FFY2024. The adverse annual impact in the state share of these administrative costs -- under a carve-out -- is estimated at $7.8 million.

MCO Premium Tax: Washington's MCOs pay a 2% premium tax, which is used to draw down additional federal matching funds. Under the carve-out, the existing MCO pharmacy costs (totaling more than $1.6 billion annually) would occur in the FFS rather than the MCO setting, and the premium tax would no longer apply to these expenditures. We estimate that Washington would lose $22.6 million in annual federal funds under a carve-out model.

Note that while the national Big Beautiful Bill passed during 2025 limits the degree to which states can use provider taxes (and MCO premium taxes) to draw down extra federal funds, Washington's 2% premium tax program does not appear to be affected by these new limitations. The premium tax component of the cost comparison between the carve-in and carve-out models remains applicable.

MCO Profit Margin: We have estimated a 1.67% operating margin being built into the Apple Health MCO capitation rates, which reflects the average Medicaid MCO industry operating margin reported by Milliman in its June 2025 report, "Medicaid managed care financial results for 2024."[1] This risk margin would not be applied to prescription drug costs under a pharmacy carve-out, creating a savings component for the carve-out equal to 1.67% multiplied by overall MCO pharmacy expenditures.

Overall Impacts

Taking into account all the above components, a switch to a pharmacy carve-out is expected to substantially increase Washington's Medicaid outlays. Exhibit 2 summarizes the estimated impacts. Overall annual Medicaid costs are expected to increase by $94.1 million, representing roughly a 16% cost increase.

[1] Milliman's 2024 report can be downloaded at: https://www.milliman.com/en/insight/medicaid-managed-care-financial-results-2024**Exhibit 1. Cost C**

The cost impacts will be especially adverse for Washington's own expenditures, as pharmacy-related **state fund net outlays are estimated to increase annually by $59 million (27.1%)**. The annual federal impact is also adverse, although smaller than the state fund impact in both dollar ($35 million) and percentage (9.3%) terms.

Exhibit 2. Summary Results of FFY2024 Cost Impact Simulation

Pharmacy-Related Costs	Total	State Share	Federal Share
Net Costs Under Carve-In	$596,655,033	$217,873,190	$378,781,844
Net Costs Under Carve-Out	$690,804,697	$276,904,754	$413,899,943
Carve-Out Model's Net Additional Costs	$94,149,663	$59,031,564	$35,118,099
% Additional Costs Created by Carve-Out	15.8%	27.1%	9.3%

III. Findings from Early Years of California's Pharmacy Carve-Out Model

California's Medicaid (Medi-Cal) program switched from a carve-in model to a carve-out approach effective in January of 2022. We assessed California's carve-out experience to help inform Apple Health policymakers. Our assessment compared the last three years of the carve-in with the first three years under the carve-out.

California's costs increased dramatically under the carve-out, as shown in the cost per prescription comparisons in Exhibit 3. The average net cost per Medi-Cal prescription nearly doubled between the two three-year timeframes.

Exhibit 3. California Cost Per Medi-Cal Prescription Comparison

		Costs Per Prescription			
Timeframe	Prescriptions	Pre-Rebate	Rebates	Net Cost	Rebate % of Pre-Rebate Cost
Last 3 Years of Carve-In (2019-2021)	278,610,043	$90.72	$49.62	$41.10	54.7%
First 3 Years of Carve-Out (2022-2024)	267,859,247	$147.36	$67.81	$79.55	46.0%
Percent Change	-3.9%	62.4%	36.7%	93.5%	

As context, nationwide net costs per prescription between these same two timeframes increased by "only" 15.9%.[2] **If California's net costs per prescription had increased at this 15.9% rate instead of 93.5%, its overall expenditures across the first three years of the carve-out would have been $8.5 billion lower than the net outlays that occurred.** Net Medi-Cal pharmacy costs were 67% above the level had California's costs increased at the rest of the nation's average rate.

California's implementation of its Medi-Cal pharmacy carve-out in January 2022 encountered immediate and massive medication adherence challenges. Due to a combination of the magnitude of the volume of medications that switched to a new payment setting, and the algorithms used by Magellan Health (the PBM entity enlisted by the Medicaid agency to manage the entirety of the Medi-Cal drug benefit under the carve-out), medication access plummeted on a highly concerning scale.

Tabulations using the DUF data indicate that **8.3 million fewer prescriptions were accessed** during the first six months of the carve-out model (January through June 2022) relative to the volume that would have occurred if the Q4 2021 volume had been maintained throughout the first half of 2022.

While it is encouraging that the prescription volume did come back up as of Q3 2023, this does not by any means ensure that no harm occurred while 8.3 million prescriptions were not being accessed. The initial roll-out of the Medi-Cal prescription drug carve-out model and the resulting enormous decrease in prescriptions put the covered population at risk clinically. For example, the percentage drop-off in prescription volume for insulin prescriptions was 20%, similar to what occurred overall.

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. These actions were successful in restoring Medi-Cal's prescription volume to the levels occurring under the carve-in model by the third calendar quarter.

However, these actions also at least temporarily stripped Medi-Cal of the levers needed to deliver cost-effective pharmacy benefits management. The figures shown in Exhibit 3 suggest that the carve-out has continually operated is a fiscally detrimental manner. While the carve-out was implemented in the interest of delivering fiscal savings, the opposite has occurred.

[2] Our "rest of USA" comparisons excluded California along with seven other states where the reported DUF data did not appear credible.

IV. Carve-Out Impacts for Safety Net Providers

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

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

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

The Financial Importance of 340B

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

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

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

Exhibit 3. Consolidated Financial Performance of 22 Health Centers

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

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

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

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

Programmatic Impacts of Carve-Out for FQHCs

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

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

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

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

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

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

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

- **Clinical program cuts.**

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

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

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

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

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

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

FQHC Preferences Between MCO and FFS Pharmacy Management

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attachment 4.19-B

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

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

APM: Payment in Addition to Pre-existing PPS Rate

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

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

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

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

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

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

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

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

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

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

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

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

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

model outperformed the FFS model.[3]

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

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

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

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

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

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[3] 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 (PCE), Controlling High Blood Pressure (CBP),Persistence of Beta-Blocker Treatment After a Heart Attack (PBH), Statin Therapy for Patients With Cardiovascular Disease and Diabetes (SPC, SPD), Antidepressant Medication Management (AMM), and Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA).

4. **Preventing/Detecting Adverse Drug Interactions.** MCOs have a greater ability to help members avoid adverse drug interactions when the pharmacy benefit is carved in. In a FFS carve-out model, there is a constant need for data flow between the MCO, the State, and the contracted pharmacy vendor. Even if these data delays are just one day long relative to the integrated carve-in setting's process, substantial room for error is introduced regarding identifying and preventing adverse drug interactions in a timely manner. New medication regimens are quite often prescribed and initiated on the same day.

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

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

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

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

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

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

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

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

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

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

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

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

VI. Recommendations

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

1) Preserve the Carve-In

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

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

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

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

To summarize these findings:

- We estimate that implementing a carve-out would increase overall annual Medicaid costs by $94 million. The adverse annual State Funds impact, including the lost premium tax revenue, is estimated to be $59 million.

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

- California's early year experience with its carve-out program has been highly adverse fiscally, creating an estimated $8 billion in additional Medicaid costs across the first three years of its implementation. The carve-out initially created significant and highly concerning barriers to medication access. Approximately 8 million fewer prescriptions were filled during the first six months of the carve-out's implementation and the state had to take significant remedial actions in an effort to avoid further clinical risk and detriment.

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

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

2) Preserve the Uniform PDL Program

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

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