At the request of the Utah Legislature, DHHS solicited a pharmacy study to assess the monetary and non-monetary cost impact of providing pharmacy services through the state-run fee-for-service (FFS) pharmacy program in lieu of the current contracted arrangements with managed care Accountable Care Organizations (ACOs). DHHS requested an assessment of pharmacy service delivery models and a summary of considerations regarding options for the Utah Medicaid's pharmacy program. The State of Utah Department of Health and Human Services (DHHS) contracted with Milliman, Inc. (Milliman) to provide actuarial and consulting services to evaluate alternate pharmacy program models. The attached report is a final draft of the evaluation and recommendations.

The study and findings highlight the following items:

- The study analyzed final paid ACO encounters and FFS pharmacy claims data with a date of service between March 1, 2022 and February 28, 2023, the most recent data available from DHHS.
- The study evaluated six (6) alternative pharmacy program models that fall under two categories, ACO Carve-in and ACO Carve-out. These are options for DHHS' consideration:

ACO Carve-In		
State Mandated FFS Reimbursement	Mandate FFS pharmacy reimbursement in the existing managed care model.	($6.5M) *cost-savings*
Single PDL	Mandate FFS PDL in the existing managed care model.	($29.6M) *cost-savings*
State Mandated FFS Reimbursement & Single PDL	Mandate FFS pharmacy reimbursement and FFS PDL in the existing managed care model.	($29.6M) cost-savings + FFS Reimbursement Impact TBD
ACO Single PBM	Procure a single PBM to provide pharmacy services for the managed care pharmacy program.	($29.6M) cost-savings, (includes admin & underwriting gains for ACOs to cover cost oft the PBM) + FFS Reimbursement Impact TBD
ACO Carve-Out		
Pharmacy Carve-Out	DHHS provides pharmacy services through the FFS pharmacy program.	($49.2M) + FFS Reimbursement Impact TBD
Prepaid Ambulatory Health Plan (PAHP)	Pharmacy services are delivered and managed by a single, state-selected PBM and operate as a managed care PAHP.	($37.8M) + FFS Reimbursement Impact TBD

- Pharmacy benefit carve-out would reduce DHHS expenses by $47.6 million
    - Reduction is driven by a decrease in admin fees and underwriting gains
    - Increase in federal and supplemental rebates
    - Over 50% of the total pharmacy expenditures are in the FFS Medicaid program due to carve out for certain therapeutic classes and drugs currently

MILLIMAN CLIENT REPORT

Evaluation of Pharmacy Service Delivery Models for the Utah Medicaid Managed Care Program

Utah Department of Health and Human Services

May 20, 2024

Prepared for:
Jennifer Strohecker, PharmD
Medicaid Director

Nate Checketts, MPA
Deputy Director, Healthcare Administration

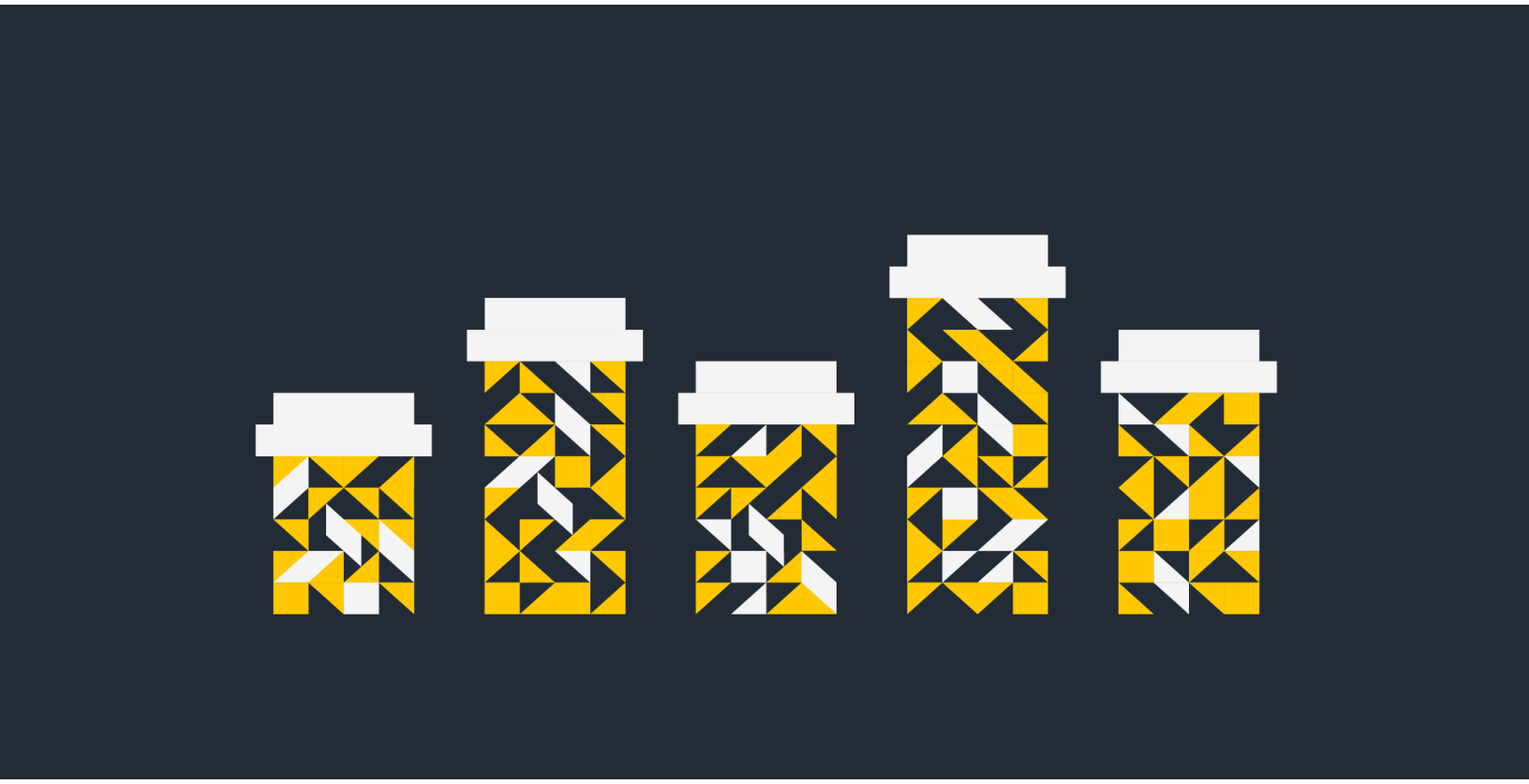
Eric Grant, MBA
Director, Financial Services

Prepared by:
Michael T. Hunter, Pharm D
Principal and Pharmacy Management Consultant

Jennifer S. Prather, PharmD
Senior Pharmacy Management Consultant

Kristin Niakan, MPH
Pharmacy Management Consultant

Brittany Schock, PharmD
Senior Managed Care Pharmacist



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Executive Summary

Milliman, Inc. (Milliman) has been retained by the State of Utah Department of Health and Human Services (DHHS) to provide actuarial and consulting services to evaluate alternate pharmacy program models for the delivery of pharmacy services in the Medicaid managed care program.[1] At the request of the Utah Legislature, DHHS solicited this pharmacy study to assess the monetary and non-monetary cost impact of providing pharmacy services through the state-run fee-for-service (FFS) pharmacy program in lieu of the current contracted arrangements with managed care Accountable Care Organizations (ACOs). DHHS also requested an assessment of pharmacy service delivery models used in Medicaid programs in other states and a summary of considerations regarding options for the transformation of Utah Medicaid's pharmacy program.

Beginning in 2012, the Utah Medicaid program began utilizing a traditional managed care model for the delivery of pharmacy benefit services through contracted arrangements between the ACOs and the state. The ACOs are paid by the State through a capitated per member per month (PMPM) rate. The ACOs, in turn, generally deliver pharmacy services through delegated Pharmacy Benefit Managers (PBMs) for the administration of formularies, reimbursement, and other pharmacy services and are at risk for pharmacy costs exceeding the capitation amounts. In most circumstances, the state does not interact with or contract directly with the PBM who is ultimately responsible for operationalizing and developing the pharmacy program as delegated by the ACO. Of note, while the Utah Medicaid program generally utilizes a traditional managed care model, they carve out nine therapeutic classes associated with significant expenditures to FFS.

When evaluating potential changes to the pharmacy program's service delivery model, DHHS' goals for the State Medicaid pharmacy program should be considered. DHHS' stated goals for the pharmacy program include:

- Develop and implement an efficient, data-driven, cost containment strategy for DHHS that will identify potential program savings, streamline operations, and improve quality of care for members enrolled in the Medicaid program.
- Establish and implement a fair and transparent reimbursement model for pharmacies within the state Medicaid program that accurately reflects the value of their services and contributions to patient care. The pharmacy reimbursement methodology should ensure equitable compensation for pharmacies and promote sustainability of pharmacies for Medicaid members to have adequate access to pharmaceutical care.
- Ensure all members have timely, equitable, and convenient access to necessary medications by eliminating barriers to medication access, improving medication adherence, and enhancing health outcomes for Medicaid members. Any program changes should aim to minimize member disruption and ensure seamless, coordinated care to reduce avoidable healthcare costs and member dissatisfaction associated with poorly managed care transitions.
- Enforce a robust managed care integrity program for DHHS that ensures compliance with all regulatory requirements, prevents fraud, waste, and abuse, and protects the interests of members, providers, and taxpayers to maintain the trust and credibility of the Medicaid program.

[1] RFSQ #MK24-29 Pharmacy Study Cost Assessment

Evaluating a potential change to the model used to deliver pharmacy services in the Utah Medicaid managed care program requires not only evaluation of the financial impact to the State, but careful consideration of the impact to stakeholders, such as members, prescribers, pharmacies, and the ACOs, and alignment with DHHS' stated goals. The three primary decisions the State must make are:

1. What plan design and payment mechanism are used for the program?
    a. What is the reimbursement methodology used to pay pharmacies for drugs?
    b. What formulary or preferred drug list (PDL) is used to manage the coverage of outpatient drugs?
2. Who is at financial risk for delivery of the program, the ACOs or the State?
3. Which operational structure best aligns with the State's goal and objectives to achieve such a change?
    a. State mandated pharmacy reimbursement and/or PDL in the existing managed care model (pharmacy benefit remains carved-in to managed care).
    b. A carve-out of the pharmacy services to the FFS Medicaid program.
    c. A State-selected single PBM, where there are options for the ACOs to be at risk for pharmacy expenditures or not.

The purpose of this evaluation was to provide DHHS with the necessary information to assist in making these primary decisions. The key objectives of the evaluation included:

- Quantitative Analysis – Estimate the fiscal impact of using the FFS pharmacy reimbursement methodology and/or FFS PDL in the Medicaid managed care program, including consideration of administrative costs for each operational structure.
- Qualitative Analysis – Identify and discuss advantages, challenges, and other considerations for each operational structure, including key stakeholder impacts.
- Characterization of state Medicaid pharmacy services delivery models – Perform an environmental scan to summarize and identify trends in pharmacy service delivery models across other state Medicaid programs.

To perform this analysis, we relied on a refined approach and methodology using our extensive experience providing consulting, analytics, and cost assessments related to management of the pharmacy benefit across multiple State Medicaid programs. We leveraged our experience as it relates to managed care capitation rate development, as well as providing fiscal impact, operational support, and implementation of single PDL, single PBM, and other pharmacy programmatic and policy changes. We utilized final paid ACO encounters and FFS pharmacy point-of-sale (POS) data, referred to as pharmacy claims throughout the report, with a date of service between March 1, 2022 and February 28, 2023. This was the most recent 12-month period of data available from DHHS to perform the quantitative analysis due to DHHS' ongoing transition to a new data system. Our scope was limited to drugs administered through the pharmacy benefit. While there are claims and expenditures for drugs[2] in the medical benefit, some of which are billed by pharmacy providers, inclusion of these claims was beyond the scope of this analysis. Additional discussion on drugs billed to the medical benefit is included in Section 7 of the report. Totals in figures within the report may not tie due to rounding. Figures shared in this analysis reflect total dollars and do not break down the federal and state share of those amounts.

[2] The term "drugs" is used generally throughout this report to represent drugs, biologics, devices, and other pharmaceutical products.

PHARMACY BENEFIT UTILIZATION AND EXPENDITURES SUMMARY

We utilized the pharmacy claims data to evaluate the pharmacy program utilization and expenditures. Figure 1 illustrates the average number of members enrolled in FFS and each managed care plan, as well as the number of members utilizing the ACO or FFS pharmacy benefit each month along with the utilization and expenditures from the study period.

FIGURE 1: FFS AND ACO PHARMACY BENEFIT UTILIZATION AND EXPENDITURE SUMMARY (MARCH 1, 2022 – FEBRUARY 28, 2023)

FFS/ACO	MONTHLY MEMBERSHIP*	MONTHLY UTILIZERS**	TOTAL CLAIM VOLUME	PERCENT OF TOTAL CLAIM VOLUME	TOTAL PAID AMOUNT ($ MILLIONS)	PERCENT OF TOTAL
FFS	108,197	59,358	1,782,660	44.6%	$ 275.1	51.6%
Health Choice Utah	44,644	6,730	200,284	5.0%	$ 23.6	4.4%
Healthy U	88,222	15,544	555,077	13.9%	$ 63.8	12.0%
Molina Healthcare of Utah	97,359	14,283	404,182	10.1%	$ 39.9	7.5%
SelectHealth Community Care	171,693	30,457	1,055,444	26.4%	$ 130.8	24.5%
Total	**510,115**	**101,557**	**3,997,647**	**100.0%**	**$ 533.3**	**100.0%**

Note: Monthly membership are members enrolled in either FFS or the respective ACO.
****Note: Monthly utilizers represent the average unique count of members with a pharmacy claim paid by FFS or the ACO plan each month. FFS utilizers are comprised of both FFS and ACO members due to the carve-out drug therapeutic classes.***

Despite approximately 80% of the membership being enrolled in managed care, over 50% of the total pharmacy POS expenditures reside in the FFS Medicaid program due to certain therapeutic classes and drugs that are carved out from ACO coverage (and capitation rates) and paid through the FFS pharmacy benefit.

FFS PHARMACY REIMBURSEMENT REPRICE ANALYSIS

A repricing of the State's ACO pharmacy encounters to the FFS pharmacy reimbursement methodology was performed to evaluate the difference in aggregate program costs of changing from the pharmacy reimbursement currently managed by ACOs to the pharmacy reimbursement used in the Utah FFS Medicaid program. We relied on the base pharmacy experience and applied certain exclusions as described in the methodology section of the report. Please note, the reimbursement methodology used in the analysis represents the approved state plan reimbursement methodology at the time of the analysis and does not reflect the increased dispensing fee of $11.56 planned to be effective July 1, 2024. It is estimated that the increased dispensing fee would result in approximately a $2.6 million increase to pharmacy providers' reimbursement, thus decreasing the savings in Figure 2 to approximately $3.3 million.

To ensure our methodology for repricing claims to the FFS reimbursement methodology produced reasonable results, we also repriced the FFS claims and compared the repriced amount to the original paid amount. The repriced FFS claims were within 0.5% of the original paid amount, therefore if the results displayed in Figure 2 varied by this percentage that would translate to $1.3 million.

The aggregate cost difference between the original amount paid by the ACOs and the amount which would have been paid using the FFS pharmacy reimbursement methodology results in a $5.9 million dollar savings to DHHS, as illustrated in Figure 2. This figure displays the original paid amount for ACOs' pharmacy claims included in the analysis, as well as the repriced amount for the same claims utilizing the FFS pharmacy reimbursement methodology by ACO.

FIGURE 2: AGGREGATE COST DIFFERENCE OF FFS PHARMACY REIMBURSEMENT BY ACO

ACO	SCRIPT COUNT	ORIGINAL ACO PAID ($ MILLIONS)	FFS REPRICED PAID ($ MILLIONS)	DIFFERENCE ($ MILLIONS)
SelectHealth Community Care	995,596	$ 128.3	$ 121.1	($ 7.3)
Healthy U	517,077	$ 62.2	$ 62.2	$ 0.0
Molina Healthcare of Utah	385,001	$ 39.3	$ 41.0	$ 1.6
Health Choice Utah	184,442	$ 22.8	$ 22.6	($ 0.3)
Total	**2,082,116**	**$ 252.7**	**$ 246.8**	**($ 5.9)**

Note: The reimbursement methodology used in the analysis represents the approved state plan reimbursement methodology at the time of the analysis and does not reflect the increased dispensing fee of $11.56 planned to be effective July 1, 2024.
Note: Numbers do not tie to Figure 1 because we excluded certain claim types to perform the reprice analysis. See methodology for detailed list of exclusions.

Repricing the pharmacy claims according to the FFS pharmacy reimbursement logic had a minimal impact on the paid amount for pharmacy claims from Healthy U and Health Choice Utah; however, there is an increased costs for Molina Healthcare of Utah and a decreased costs for Select Health Community Care. As Select Health Community Care accounted for 48% of the ACO pharmacy claims in this analysis, this contributed to an overall decrease in pharmacy costs when repriced to the FFS reimbursement logic. The main driver of decreased pharmacy costs in the FFS repricing analysis was the ACOs' higher ingredient reimbursement for brands and generics, particularly Select Health Community Care, compared to the FFS program. These savings more than offset increases caused by the higher dispensing fees paid under the FFS reimbursement methodology.

The savings to DHHS do not directly translate to the impact to pharmacy providers, as the estimated DHHS savings are based on the reported paid amount in the ACO encounter data from the pharmacy POS transaction which does not include any imposed fees or reduced payment to pharmacy providers after the POS transaction. Milliman has requested information to assess the impact to pharmacy providers from the plans and that information is still being collected at the time of this report.

SINGLE PREFERRED DRUG LIST (PDL) ANALYSIS

State Medicaid programs utilize PDLs as a strategy to contain cost and manage utilization of drugs included in the Medicaid pharmacy benefit. PDLs are designed based on therapeutic effectiveness, safety, and clinical outcomes with consideration of the drugs' net cost after federal and supplemental rebates. PDLs typically incorporate utilization management of drugs, such as prior authorization (PA), step therapies, quantity limits, and age limits, among other clinical-based requirements.

Currently, in the Utah Medicaid pharmacy program, the FFS program manages a PDL for the FFS population and ACO carve-out drugs, and each ACO manages their own PDL for drugs covered under managed care. To evaluate the fiscal impact of implementing the FFS PDL on pharmacy benefits currently managed by the ACOs, the ACO pharmacy claims distribution was "shifted" to follow the claim distribution under DHHS' FFS PDL. To complete this analysis, we relied on the base (March 1, 2022 through February 28, 2023) pharmacy experience for select therapeutic classes, with some exclusions as described in the methodology section of the report. By shifting utilization to follow the claim distribution under the FFS PDL, DHHS is able to optimize both federal and supplemental rebates, driving utilization to the lowest net cost drugs.

To evaluate the fiscal impact of the FFS PDL on the pharmacy experience currently managed by the ACOs, the ACO pharmacy encounters were shifted to a presumed claim distribution under DHHS' FFS PDL to estimate the gross cost, rebate, and net cost impacts. We used a combined ranking system based on ACO utilization and expenditures to prioritize approximately 140 PDL classes for review in the analysis. Further detail on the PDL analysis is provided in the quantitative results section of the report. Figure 3 on the following page provides a summary of the PDL analysis impact illustrating a net savings of $29.8 million.

FIGURE 3: SUMMARY OF PDL ANALYSIS IMPACTS ($ MILLIONS)

CATEGORY	PRE-SHIFT AMOUNT	POST-SHIFT AMOUNT	ESTIMATED IMPACT
Modeled PDL Classes			
Gross Expenditures	$ 102.4	$ 115.1	$ 12.7
Federal Rebates	($ 47.8)	($ 70.4)	($ 22.6)
Supplemental Rebates	$ 0.0	($ 24.3)	($ 24.3)
Net Expenditures			
Modeled PDL Classes	$ 54.6	$ 20.5	($ 34.2)
Reviewed PDL Classes	$ 34.1	$ 28.7	($ 5.5)
Remaining PDL Classes	$ 24.5	$ 23.0	($ 1.5)
Non-PDL Classes	$ 28.8	$ 28.8	$ 0.0
ACO Market Share Rebates*	($ 11.4)	$ 0.0	$ 11.4
Total Net Expenditures	**$ 130.7**	**$ 100.9**	**($ 29.8)**

Note: In capitation rate setting, capitation rates are reduced by the ACO "market share" rebate amount. Under a single PDL, the market share rebates would be eliminated, and the capitation rates would increase by this amount.

The net cost savings is largely attributable to PDL classes where the FFS PDL prefers multi-source brand drugs over their respective generic counterparts. While brand drugs may have a higher gross cost than their respective generic counterparts (resulting in $12.7 million increase in gross expenditures), the significant federal and supplemental rebates of the brand drugs (an increase of $22.6 million and $24.3 million, respectively) result in a lower net cost to the State. No shifting among different products was assumed for the top two PDL classes due to clinical consideration and potential grandfathering policies; therefore, the net cost savings is driven by the State's ability to invoice and collect supplemental rebates in these classes.

ACO ADMINISTRATIVE COSTS AND UNDERWRITING GAINS ANALYSIS

In the DHHS capitation rate development, administrative costs and underwriting gains are included in the calculation based on total gross expenditures. Depending on whether program expenditures increase or decrease, administrative costs associated with the delivery of pharmacy services will be impacted. While these numbers can vary by year, the capitation rate setting typically adds 9% of total gross expenditures for administration and 2% for underwritings. To model the impact of the FFS reprice and single PDL analyses on the ACO administrative costs and underwriting gains, we have assumed these amounts would remain unchanged as illustrated in Figure 4 below.

FIGURE 4: ACO ADMINISTRATIVE COSTS AND UNDERWRITING GAINS IMPACT – MARCH 1, 2022 – FEBRUARY 28, 2023 ($ MILLIONS)

	BASELINE	FFS REPRICE	FFS REPRICE IMPACT	SINGLE PDL	SINGLE PDL IMPACT
Gross Pharmacy Expenditures	$ 258.1	$ 252.2	($ 5.9)	$ 270.8	$ 12.7
Administrative Costs	$ 23.2	$ 22.7	($ 0.5)	$ 24.4	$ 1.1
Underwriting Gains	$ 5.2	$ 5.0	($ 0.2)	$ 5.4	$ 0.3
Total Admin and Underwriting Gains	**$ 28.4**	**$27.7**	**($ 0.7)**	**$29.8**	**$ 1.4**

Note: Baseline gross pharmacy expenditures differ from the FFS Reprice and Single PDL analyses due to exclusions as described in other sections of the report.

ACO administrative costs and underwriting gains related to gross pharmacy expenditures are estimated to be reduced by $0.7 million if the ACOs used the FFS pharmacy reimbursement methodology or increased by $1.4 million if the FFS PDL was used in the managed care program.

OPERATIONAL STRUCTURES TO ACHIEVE PHARMACY SERVICE DELIVERY MODEL CHANGES

The Utah Medicaid program currently utilizes a traditional managed care model for the delivery of pharmacy benefit services through contracted arrangements between the ACOs and the state; however, there are several therapeutic classes and drugs that are carved out from ACO coverage. The ACOs are paid by the State through a capitated PMPM rate. The ACOs, in turn, generally deliver pharmacy services through delegated PBMs for the administration of formularies, reimbursement, and other pharmacy services. In most circumstances, the state does not interact with or contract directly with the PBM who is ultimately responsible for operationalizing and developing the pharmacy program as delegated by the ACO.

The operational structures that could be leveraged for a transition to an alternate pharmacy program service delivery model fall under two categories, ACO carve-in and ACO carve-out. For the ACO carve-in models, the pharmacy expenditures are still included in the capitation rates and the ACOs are still at financial risk, whereas in the ACO carve-out models, the pharmacy expenditures are not part of the capitation rates, and the financial risk resides with the State. The following operational structures are options for DHHS' consideration to achieve a pharmacy service delivery model change:

- ACO carve-in:
  - State Mandated FFS Reimbursement: DHHS mandates implementation of the FFS pharmacy reimbursement methodology in the existing managed care model.
  - Single PDL: DHHS mandates implementation of the FFS PDL in the existing managed care model.
  - State Mandated FFS Reimbursement and Single PDL: DHHS mandates implementation of the FFS pharmacy reimbursement methodology and FFS PDL in the existing managed care model.
  - ACO Single PBM: DHHS procures a single PBM to provide pharmacy services for the managed care pharmacy program through a contracted arrangement between the PBM and each ACO. The ACO and its delegated PBM would be required to deliver the program at the direction of the State.
- ACO carve-out:
  - Pharmacy Carve-Out: DHHS provides pharmacy services for the managed care pharmacy program through the FFS pharmacy program.
  - Prepaid Ambulatory Health Plan (PAHP) Single PBM: Pharmacy benefit services are delivered and managed by a single, state-selected PBM by contracting with the state and operating as a managed care PAHP. The PBM would be required to deliver the program at the direction of the State.

Figure 5, on the following page, summarizes the qualitative and quantitative considerations, including the implementation time and level of effort, for each operational structure. In order to calculate total pharmacy program costs, the claims excluded from the FFS repricing and PDL analysis were added into the gross expenditures, including the associated rebate amounts; therefore, the numbers between the individual analyses do not reconcile with the numbers included in Figure 5. Further detail on the operational structures can be found in Section 6 of the report.

FIGURE 5: QUALITATIVE CONSIDERATIONS, IMPLEMENTATION, AND COST IMPACT SUMMARY BY OPERATIONAL STRUCTURE

OPERATIONAL STRUCTURE	KEY QUALITATIVE CONSIDERATIONS	IMPLEMENTATION TIME	IMPLEMENTATION LEVEL OF EFFORT	ESTIMATED COST IMPACT
State Mandated FFS Reimbursement	▪ Reimbursement transparency and uniformity for pharmacy providers ▪ ACO contract updates and implementation efforts ▪ Eliminates 340B ACO invoicing administration ▪ Data transfer coordination of reimbursement rates	6 to 12 months	Low - Medium	($ 6.5)
State Mandated FFS PDL (Single PDL)	▪ Centralized and consistent drug management and PA / clinical criteria for members, prescribers, and pharmacies ▪ Increased leverage for supplemental rebate negotiation – additional program savings ▪ Requires planning and strategy to mitigate member disruption upon implementation ▪ ACO contract updates and implementation efforts ▪ Data transfer coordination for PDL files ▪ May increase utilization due to consistent benefit and existing clinical criteria differences – potential reduced savings but may increase member access	12+ months	Medium	($ 29.6)
Single PDL and State Mandated FFS Reimbursement	▪ Combination of above	12+ months	Medium	($ 29.6) + FFS Reimbursement Impact TBD
ACO Single PBM	▪ Streamlined benefit administration ▪ Uniform pharmacy reimbursement / PDL ▪ May increase utilization due to consistent benefit and existing clinical criteria differences – potential reduced savings but may increase member access ▪ ACOs at financial risk but no control over pharmacy benefit ▪ Requires planning to mitigate member disruption during transition to new pharmacy model	12+ months	High	($ 29.6) (Includes admin and underwriting gains for ACOs to cover the cost of the PBM) + FFS Reimbursement TBD
Pharmacy Carve-Out	▪ Consistent reimbursement for pharmacies across the Medicaid program ▪ Consistent benefit administration for prescribers, pharmacies, and members across the Medicaid program ▪ Enhanced pharmacy network ▪ Increased administrative burden for FFS program ▪ May increase utilization due to consistent benefit and existing clinical criteria differences – potential reduced savings but may increase member access	12+ months	High	($ 49.3) + FFS Reimbursement Impact TBD
PAHP Single PBM	▪ Streamlined benefit administration ▪ Uniform pharmacy reimbursement / PDL ▪ CMS waiver approval required ▪ May increase utilization due to consistent benefit and existing clinical criteria differences – potential reduced savings but may increase member access	12+ months	High	($ 37.8) + FFS Reimbursement Impact TBD

TRENDS IN MEDICAID PHARMACY PROGRAM SERVICE DELIVERY MODELS

Over the past several years, there has been a significant increase in the oversight and management of the pharmacy benefit in Medicaid nationally, with a particular focus on state oversight and direction of the pharmacy benefit in

Medicaid managed care. While several states have implemented a single PDL across the FFS and managed care pharmacy programs or passed legislation prohibiting spread pricing, further movement has occurred resulting in even more control of the managed care pharmacy benefit by states. In recent years, four states (Ohio, Kentucky, Louisiana, and Mississippi) have procured a single PBM for the delivery of pharmacy services and three states (West Virginia[i], New York, and California) have carved the pharmacy benefit out of managed care.

CONCLUSIONS AND NEXT STEPS

Our analysis shows Medicaid could achieve cost savings while maintaining its other stated goals and objectives if it elects to change its existing pharmacy service delivery model. Many states over the past decade have made these types of decisions, with more states moving to a single PBM or carve-out recently, but there are many operational and clinical considerations when making these types of systematic changes. Figure 6 provides an illustrative framework to evaluate the pharmacy program service delivery models as they relate to the three key decision points.

FIGURE 6: PHARMACY PROGRAM SERVICE DELIVERY MODEL EVALUATION FRAMEWORK

	EXISTING MODEL	REIMBURSEMENT MANDATE	PDL MANDATE	ACO SINGLE PBM	PAHP SINGLE PBM	CARVE-OUT
Plan Design and Payment Mechanism						
Pharmacy Reimbursement Methodology	ACOs	DHHS	ACOs	DHHS	DHHS	DHHS
Drug Formulary/PDL	ACOs	ACOs	DHHS	DHHS	DHHS	DHHS
Financial Risk						
ACOs	$ $ $	$ $ $	$ $ $	$ $ $		
State	$ $	$ $	$ $	$$	$$$	$$$
DHHS Goals and Objectives						
Cost containment / program savings		+	+ +	+ +	+ + +	+ + +
Streamlined operations				+	+ +	+ + +
Fair and transparent pharmacy reimbursement		+ +		+ + +	+ + +	+ + +
Uniform pharmacy benefit and access for members			+	+ +	+ +	+ + +
Ensure program integrity of the Medicaid program		+	+	+ +	+ +	+ + +

Note: For illustrative purposes, a + symbol is used to indicate the degree to which the pharmacy program delivery model would achieve the DHHS goal and objective.

According to our analysis a pharmacy benefit carve-out would reduce DHHS expenses by $49.3 million. The reduced expenditures in a pharmacy benefit carve-out scenario are driven by:

- Decreases in expenses related to admin and underwriting gains (partially offset by increased administrative load by DHHS)
- Increase in federal and supplemental rebates resulting from use of the FFS PDL

The results of the pharmacy benefit carve-out analysis may differ from other state's pharmacy benefit carve-out analyses for the following reasons:

- Premium tax revenue: In some states the premium tax on health maintenance organizations is a source of revenue for the Medicaid program. For this reason, a pharmacy benefit carve-out may increase costs for states that have a premium tax, discouraging states from carving out their pharmacy benefit. However, the loss of premium tax revenue due to a pharmacy benefit carve-out is not applicable to Utah Medicaid because there is not a premium tax for health maintenance organizations in Utah.
- Additional costs of staffing and infrastructure: In some states carving out the pharmacy benefit to the FFS program would require additional costs for staffing and infrastructure to handle the increase in claim volume and prior authorizations. However, due to over 50% of the total pharmacy POS expenditures residing in the FFS Medicaid program due to certain therapeutic classes and drugs that are currently carved out from ACO coverage, the FFS program has existing staffing to manage a pharmacy benefit, as well as the necessary infrastructure to coordinate and exchange data with the ACOs.
- Coordination of care: Other state Medicaid programs considering a pharmacy benefit carve-out typically cite concerns related to coordination of care between managed care organizations and the FFS program, as well as fragmented care between the medical and pharmacy benefits. Additional concerns have been cited regarding increased data coordination efforts related to carving out the pharmacy benefit from managed care. While these concerns may be applicable to other state Medicaid programs, DHHS has a significant portion of the pharmacy benefit carved out from managed care which already requires coordination of care between the ACOs and FFS program, as well as data coordination.

LIMITATIONS

There are several limitations that are outlined in further detail in subsequent sections of the report. These limitations include:

- Due to the Medicaid redetermination process following the end of the COVID-19 public health emergency, it is estimated that millions of people will lose Medicaid coverage across the U.S. The data used in this analysis reflects a state of continuous coverage for the Medicaid program and the underlying data may have different utilization and/or acuity patterns than the future state.
- Effective January 1, 2024, state Medicaid rebates may exceed the AMP of a drug. While not necessarily a direct correlation to the AMP cap removal, several drugs, including many insulin products, experienced list price reductions or were discontinued. The complex effects of the AMP cap removal, including downstream effects, such as list price reductions and product discontinuations, were not taken into consideration for this analysis.
- The data relied on in this analysis is older and may not reflect current reimbursement structures for ACOs.
- The reimbursement methodology used in the analysis represents the approved state plan reimbursement methodology at the time of the analysis and does not reflect the increased dispensing fee of $11.56 planned to be effective July 1, 2024.

1 Background

Milliman, Inc. (Milliman) has been retained by the State of Utah Department of Health and Human Services (DHHS) to provide actuarial and consulting services to evaluate alternate pharmacy program models for the delivery of pharmacy services in the Medicaid managed care program.[3] At the request of the Utah Legislature, DHHS solicited this pharmacy study to assess the monetary and non-monetary cost impact of providing pharmacy services through the state-run fee-for-service (FFS) pharmacy program in lieu of the current contracted arrangements with managed care Accountable Care Organizations (ACOs). DHHS also requested an assessment of pharmacy service delivery models used in Medicaid programs in other states and a summary of considerations regarding options for the transformation of Utah Medicaid's pharmacy program.

Beginning in 2012, the Utah Medicaid program began utilizing a traditional managed care model for the delivery of pharmacy benefit services through contracted arrangements between the ACOs and the state. The ACOs are paid by the State through a capitated per member per month (PMPM) rate. The ACOs, in turn, generally deliver pharmacy services through delegated PBMs for the administration of formularies, reimbursement, and other pharmacy services and are at risk for pharmacy costs exceeding the capitation amounts. In most circumstances, the state does not interact with or contract directly with the Pharmacy Benefit Manager (PBM0 who is ultimately responsible for operationalizing and developing the pharmacy program as delegated by the ACO. Of note, while the Utah Medicaid program generally utilizes a traditional managed care model, they carve out nine therapeutic classes associated with significant expenditures to FFS.

When evaluating potential changes to the pharmacy program's service delivery model, DHHS' goals for the State Medicaid pharmacy program should be considered. DHHS' stated goals for the pharmacy program include:

- Develop and implement an efficient, data-driven, cost containment strategy for DHHS that will identify potential program savings, streamline operations, and improve quality of care for members enrolled in the Medicaid program.
- Establish and implement a fair and transparent reimbursement model for pharmacies within the state Medicaid program that accurately reflects the value of their services and contributions to patient care. The pharmacy reimbursement methodology should ensure equitable compensation for pharmacies and promote sustainability of pharmacies for Medicaid members to have adequate access to pharmaceutical care.
- Ensure all members have timely, equitable, and convenient access to necessary medications by eliminating barriers to medication access, improving medication adherence, and enhancing health outcomes for Medicaid members. Any program changes should aim to minimize member disruption and ensure seamless, coordinated care to reduce avoidable healthcare costs and member dissatisfaction associated with poorly managed care transitions.
- Enforce a robust managed care integrity program for DHHS that ensures compliance with all regulatory requirements, prevents fraud, waste, and abuse, and protects the interests of members, providers, and taxpayers to maintain the trust and credibility of the Medicaid program.

This report provides an overview of common Medicaid pharmacy service delivery models, provides background information on the Utah Medicaid pharmacy benefit, and provides a quantitative and qualitative assessment of alternative pharmacy benefit designs, such as a single preferred drug list (PDL), state mandated FFS reimbursement, a pharmacy benefit carve out, and a single PBM.

[3] RFSQ #MK24-29 Pharmacy Study Cost Assessment

2 Medicaid Managed Care Pharmacy Service Delivery Models Overview

Pharmacy benefit services in the Medicaid program can be managed and delivered to members enrolled in Medicaid managed care through different pharmacy service delivery models. We describe these models under two categories, ACO carve-in and ACO carve-out. For the ACO carve-in models, the pharmacy expenditures are still included in the capitation rates and the ACOs are still at financial risk, whereas in the ACO carve-out models the pharmacy expenditures are not part of the capitation rates and the financial risk resides with the State. These models vary by state, but typically operate within the following models:

- ACO carve-in: Pharmacy benefit services are delivered by the state's contracted managed care health plans.
  - Traditional managed care: Pharmacy benefit services are delivered by ACOs through contracted arrangements between the ACOs and the state. ACOs, in turn, generally contract with PBMs for the administration of formularies, reimbursement, and other pharmacy services and are at risk for pharmacy costs exceeding the capitation amounts. In most circumstances, the state does not interact with or contract directly with the PBM who is ultimately responsible for operationalizing and developing the pharmacy program as delegated by the ACO.
  - State mandated benefit: Pharmacy benefit services are dictated by the state in how they are created and delivered. The ACO receives capitation to deliver the benefit, and the ACO contracts with a delegated PBM to deliver the services. This may include a state FFS pharmacy reimbursement model, a state-mandated PDL, or both.
  - Single PBM: Pharmacy benefits services are delivered and managed by a single, state-selected PBM through a contracted arrangement between the PBM and each ACO. The ACO and its delegated PBM will be required to deliver the program at the direction of the state.
- ACO carve-out: Pharmacy benefit services are not delivered by the state's contracted managed care health plans.
  - PAHP Single PBM: Pharmacy benefit services are delivered and managed by a single, state-selected PBM by contracting with the state and operating as a managed care PAHP.
  - State full carve-out: The State manages and delivers the full pharmacy benefits through the FFS program.

Figure 7 below describes and compares these models as they typically relate to financial risk, drug coverage, reimbursement, and the delivery of pharmacy services for managed care health plans and the state.

FIGURE 7: HEALTH PLAN VS STATE RESPONSIBILITY BY PHARMACY PROGRAM DELIVERY MODEL

DELIVERY MODEL	FINANCIAL RISK	DRUG COVERAGE AND UM* (PDL)	PHARMACY REIMBURSEMENT METHODOLOGY	DELIVERY OF PHARMACY SERVICES
ACO carve-in:				
▪ Traditional managed care	Health plan	Health plan	Health plan	Delegated PBM
▪ State mandated benefit	Health plan	State or plan**	State or plan**	Delegated PBM
▪ Single PBM	Health plan	State	State	State-contracted PBM
ACO carve-out:				
▪ PAHP Single PBM	State	State	State	State-contracted PBM
▪ State full carve-out	State	State	State	State-contracted PBM

UM Utilization Management. UM is the list of criteria and requirements for certain drugs to be eligible to members
****State or plan coverage depending if State mandates unified PDL, FFS pharmacy reimbursement, or both.***

States have implemented and managed the pharmacy benefit through various methods and may even operate different models for different populations within the same program. Some states with a traditional managed care model have implemented a range of initiatives to coordinate and integrate pharmacy benefit services, such as requiring the use of a single PDL across managed care and FFS, use of state-mandated reimbursement methodologies, or carving out select drugs or drug classes to FFS. A PDL is a formulary, which is the list of covered drugs and the list of criteria in how those drugs are covered.

3 Background on Utah Medicaid Pharmacy Benefit

Beginning in 2012, the Utah Medicaid program began utilizing a traditional managed care model for the delivery of pharmacy benefit services through contracted arrangements between the ACOs and the state. The ACOs are paid by the State through a capitated per member per month PMPM rate. The ACOs, in turn, generally deliver pharmacy services through delegated PBMs for the administration of formularies, reimbursement, and other pharmacy services and are at risk for pharmacy costs exceeding the capitation amounts. In most circumstances, the state does not interact with or contract directly with the PBM who is ultimately responsible for operationalizing and developing the pharmacy program as delegated by the ACO.

STATE-ISSUED GOALS FOR THE MEDICAID PHARMACY PROGRAM

When evaluating potential changes to the pharmacy program's service delivery model, DHHS' goals for the State Medicaid pharmacy program should be considered to ensure alignment with the overall goals and objectives of the agency. DHHS' stated goals for the pharmacy program include:

- Develop and implement an efficient, data-driven, cost containment strategy for DHHS that will identify potential program savings, streamline operations, and improve quality of care for members enrolled in the Medicaid program.
- Establish and implement a fair and transparent reimbursement model for pharmacies within the state Medicaid program that accurately reflects the value of their services and contributions to patient care. The pharmacy reimbursement methodology should ensure equitable compensation for pharmacies and promote sustainability of pharmacies for Medicaid members to have adequate access to pharmaceutical care.
- Ensure all members have timely, equitable, and convenient access to necessary medications by eliminating barriers to medication access, improving medication adherence, and enhancing health outcomes for Medicaid members. Any program changes should aim to minimize member disruption and ensure seamless, coordinated care to reduce avoidable healthcare costs and member dissatisfaction associated with poorly managed care transitions.
- Enforce a robust managed care integrity program for DHHS that ensures compliance with all regulatory requirements, prevents fraud, waste, and abuse, and protects the interests of members, providers, and taxpayers to maintain the trust and credibility of the Medicaid program.

CURRENT PHARMACY PROGRAM MODEL

DHHS currently operates under a traditional managed care pharmacy model and contracts with four managed care ACOs to provide pharmacy benefits for roughly 400,000 Medicaid members, representing approximately 80% of the total Medicaid population.[4,5] The remainder of the Medicaid population receives its pharmacy benefits through the FFS program. Most members who live in specific counties[6] in Utah are required to select one of the currently contracted ACOs including Molina Healthcare of Utah, Health Choice Utah, Healthy U, and SelectHealth Community Care. Members who live in counties outside of these specified counties may select one of the ACOs or enroll in FFS.[ii]

[4] Throughout this report, we refer to the ACOs generically to include the ACO program covering traditional Medicaid eligibles (referred to as ACO Legacy), ACO Expansion, and the Utah Medicaid Integrated Care (UMIC) program.

[5] Certain drug classes are carved out of the ACO program and are instead managed FFS. This is discussed further in later sections of the report.

[6] The specific counties vary between the ACO Legacy and UMIC programs. The ACO Expansion program is entirely comprised of members who have the choice to enroll with either an ACO or in FFS.

The ACOs are at financial risk for the pharmacy services they provide and receive funding for these services through a capitated payment from DHHS. Each ACO utilizes a PBM to adjudicate and process pharmacy POS claims, manage pharmacy provider reimbursement and payment, create and manage prescription drug formularies, conduct PA reviews, and provide other related pharmacy administrative services on behalf of the ACOs. Figure 8 displays the ACO and PBM landscape.

FIGURE 8: UTAH MEDICAID PHARMACY FFS AND ACO PBM SUMMARY

FFS/ACO	PBM	ACO-PBM RELATIONSHIP
FFS	Change Healthcare	N/A
Health Choice Utah	RealRx	PBM owned by the University of Utah Health Plans, including Health Choice Utah
Healthy U	RealRx	PBM owned by the University of Utah Health Plans, including Healthy U
Molina Healthcare of Utah	CVS Caremark	N/A
SelectHealth Community Care	Scripius	PBM owned by Intermountain Health (Parent organization of both entities)

PREFERRED DRUG LIST

State Medicaid programs utilize PDLs as a strategy to contain cost and manage utilization of drugs included in the Medicaid pharmacy benefit. PDLs are designed based on therapeutic effectiveness, safety, and clinical outcomes with consideration of the drugs' net cost after federal and supplemental rebates. Utilization management of drugs included on PDLs is typically handled by designating a status of preferred or non-preferred to each specific drug within the therapeutic classes. In addition, PDLs typically establish quantity limits, step therapy, PA criteria, and other clinical criteria to further manage utilization. Preferred drugs are generally available to members without requiring providers to submit a PA request, whereas non-preferred drugs require providers to submit and obtain a PA approval for the pharmacy claim to be paid. Of note, not all therapeutic classes are managed through a PDL and drugs in unmanaged classes are generally not subject to PA with the exception of certain high-cost drugs. In addition to utilization management, PDLs are typically designed to drive utilization to drugs with lower net costs. The net drug cost is determined based on the reimbursement paid to pharmacy providers less any federal and supplemental rebates collected from the drug manufacturer. Federal rebates are statutorily required rebates under the Medicaid Drug Rebate Program (MDRP) and supplemental rebates refer to the voluntary rebates offered by manufacturers through a competitive bidding process as an incentive to be assigned a PDL status of preferred.

Currently, in the Utah Medicaid pharmacy program, the FFS program manages a PDL for the FFS population and ACO carve-out drugs, and each ACO manages their own PDL for drugs covered under managed care. Supplemental rebates negotiated by DHHS are only applicable to FFS claims because the ACOs, through their contracted PBMs, establish their own supplemental rebates directly with manufacturers for managed care claims. To distinguish between the two, we refer to the DHHS collected supplemental rebates as "supplemental rebates" and the ACO collected supplemental rebates as "ACO market share rebates" throughout the remainder of the report. Although DHHS does not directly receive the ACO rebates, these rebates are reported to DHHS and are reflected when developing the certified capitation rates paid to the ACOs. Statutory federal rebates, which comprise most of the total rebates, are collected directly by DHHS for both managed care and FFS claims. However, the amount of federal rebates collected under managed care is dependent on drug utilization resulting from the PDLs established by the ACOs. Since the ACO's do not receive federal rebates and primarily consider their own net cost after market share rebates negotiated for all lines of business when developing their respective PDLs, this may not result in the lowest net cost to DHHS.

PHARMACY REIMBURSEMENT

Medicaid regulations require covered outpatient drugs billed under the pharmacy benefit in FFS to be reimbursed based on actual acquisition cost (AAC) plus a professional dispensing fee, but this is not a requirement under the

managed care delivery system.[iii] As such, ACOs contract pharmacy reimbursement terms with their PBMs. The PBMs provide pricing guarantees and are often relative to a standard industry benchmark price, typically Average Wholesale Price (AWP), or the lesser of a combination of multiple pricing benchmarks. In some cases, PBMs reimburse pharmacy providers a different amount than what is paid to them by the ACO for drugs dispensed, known as "spread". At the time of writing, each ACO's PBM contract is in a pass-through pricing arrangement meaning that the paid amount from the ACO to the PBM Is the amount paid to the pharmacy for the claim. This is the amount reported by the PBM to the ACO and does not account for any reduced payment to pharmacy providers that may occur after the POS pharmacy transaction. Figure 9 provides key considerations and a comparison between managed care and FFS pharmacy reimbursement.

FIGURE 9: MANAGED CARE AND FFS PHARMACY REIMBURSEMENT COMPARISON

CONSIDERATION	MANAGED CARE REIMBURSEMENT	FFS REIMBURSEMENT
Ingredient Reimbursement	▪ Typically based on effective rate AWP discounts and/or proprietary PBM maximum allowable costs (MACs) ▪ Reimbursement varies across ACOs and may vary by pharmacy within the same health plan to meet the contracted effective rate AWP discount ▪ Potential to drive dispensations or provide more favorable reimbursement to pharmacies affiliated with the health plan's PBM, including mail-order and specialty pharmacies ▪ May have imposed fees or reduced payment to pharmacy providers after the POS transaction ▪ Less transparency	▪ Primarily based on pharmacy acquisition cost, such as the state MAC/AAC, National Average Drug Acquisition Cost (NADAC), or Wholesale Acquisition Cost (WAC) ▪ Reimbursement is uniform for all pharmacies ▪ No PBM affiliated pharmacies or directing dispensations to specific PBM preferred pharmacies, including mail-order pharmacies ▪ Prohibits imposing fees or reducing payments to pharmacy providers ▪ More transparency
Dispensing Fees	▪ $0.50 - $2 average dispensing fees that may vary between ACOs and pharmacies	▪ Utilizes a professional dispensing fee of $9.99 or $10.15 for all pharmacies
340B Reimbursement	▪ May vary based on plan specific 340B reimbursement policies and may be the same as non-340B reimbursement	▪ Based on 340B acquisition cost

Note: Effective July 1, 2024, the UT FFS Medicaid professional dispensing fee is being updated to $11.56 for all pharmacies.

Covered outpatient drugs that are dispensed and eligible for the 340B program and reimbursed under FFS are required to be submitted with their 340B acquisition cost and will be reimbursed at the lower of the 340B acquisition cost plus a dispensing fee or the pharmacy's billed charges. In the DHHS managed care program, the ACOs determine reimbursement for 340B claims which is not required to be the 340B acquisition cost; therefore, DHHS invoices each ACO on a quarterly basis for the Medicaid drug rebate equivalent associated with the 340B dispensed drugs based on the 340B indicator submitted, effectively retaining the 340B discount price in both managed care and FFS programs.[iv]

DHHS PHARMACY DEPARTMENT

DHHS's pharmacy program is managed by 13 full time employees that include a Medical Director, Pharmacy Director, five pharmacists, and a pharmacy technician manager that oversees five pharmacy technicians. The DHHS pharmacy department is responsible for the following tasks:

- Oversight of ACO coordination, communication, and compliance
- Oversight of FFS PDL maintenance
- Processing prior authorizations for drugs managed under FFS
- Developing drug utilization review criteria
- Program reporting and analytics
- Ensuring compliance with federal and state Medicaid regulations, as well as other relevant laws and regulations
- Implementing fraud, waste, and abuse prevention measure, as well as other cost containment measures
- Collaboration with healthcare providers to ensure optimal reimbursement for pharmacies and maintaining access for members
- General policy, operations, program integrity, and customer support
- Oversee the pharmacy and therapeutics (P&T) committee that selects drugs for placement on the PDL based on safety and efficacy and maximizing cost-effectiveness.
- Conduct ongoing drug utilization review (DUR) to ensure appropriate medication management according to predetermined criteria.

BASELINE PHARMACY PROGRAM UTILIZATION AND EXPENDITURES

Final paid ACO encounters and FFS pharmacy claims with a date of service between March 1, 2022 and February 28, 2023, which was the most recent year of data available from DHHS, were utilized to evaluate the pharmacy program utilization and expenditures. Figure 10 illustrates the average number of members enrolled in FFS and each managed care plan, as well as the number of members utilizing the ACO or FFS pharmacy benefit each month along with the utilization and expenditures from the study period.

FIGURE 10: FFS AND ACO PHARMACY BENEFIT UTILIZATION AND EXPENDITURE SUMMARY (MARCH 1, 2022 – FEBRUARY 28, 2023)

FFS/ACO	MONTHLY MEMBERSHIP*	MONTHLY UTILIZERS**	TOTAL CLAIM VOLUME	PERCENT OF TOTAL CLAIM VOLUME	TOTAL PAID AMOUNT ($ MILLIONS)	PERCENT OF TOTAL
FFS	108,197	59,358	1,782,660	44.6%	$ 275.1	51.6%
Health Choice Utah	44,644	6,730	200,284	5.0%	$ 23.6	4.4%
Healthy U	88,222	15,544	555,077	13.9%	$ 63.8	12.0%
Molina Healthcare of Utah	97,359	14,283	404,182	10.1%	$ 39.9	7.5%
SelectHealth Community Care	171,693	30,457	1,055,444	26.4%	$ 130.8	24.5%
Total	**510,115**	**101,557**	**3,997,647**	**100.0%**	**$ 533.3**	**100.0%**

Note: Monthly membership are members enrolled in either FFS or the respective ACO.
****Note: Monthly utilizers represent the average unique count of members with a pharmacy claim paid by FFS or the ACO plan each month. FFS utilizers are comprised of both FFS and ACO members due to the carve-out drug therapeutic classes.***

Despite approximately 80% of the membership being enrolled in managed care, over 50% of the total pharmacy POS expenditures reside in the FFS Medicaid program due to certain therapeutic classes and drugs that are carved out from ACO coverage and capitation rates. These drugs are covered and paid through the FFS benefit; therefore, ACOs are not at risk for the following carve-out expenditures[v]:

- Transplant immunosuppressive drugs
- Attention Deficit Hyperactivity Disorder (ADHD) stimulant drugs
- Antipsychotic drugs
- Antidepressant drugs
- Anti-anxiety drugs
- Anticonvulsant drugs
- Hemophilia drugs
- Opioid Use Disorder treatments
- Ultra-high cost drugs (>$1M per dose)

With the exception of the ultra-high cost drugs, which were not carved out until July 1, 2023, the above therapeutic classes and drugs have been carved out of the managed care benefit since the inception of the ACOs delivering pharmacy services beginning in 2012. The majority of the classes are for mental health drugs and the exclusion of these classes was mutually agreed upon by DHHS and the ACOs due to mental health benefits being provided through Prepaid Mental Health Plans (PMHPs). Figure 11 below illustrates the breakdown of the FFS pharmacy expenditures and claim volume by carve-in and carve-out drug status. The data provided for the pharmacy study included only the payer assignment and did not contain the member enrollment status; therefore, we were unable to differentiate the carve-out drug claim volume and paid amount associated with members enrolled in managed care from FFS.

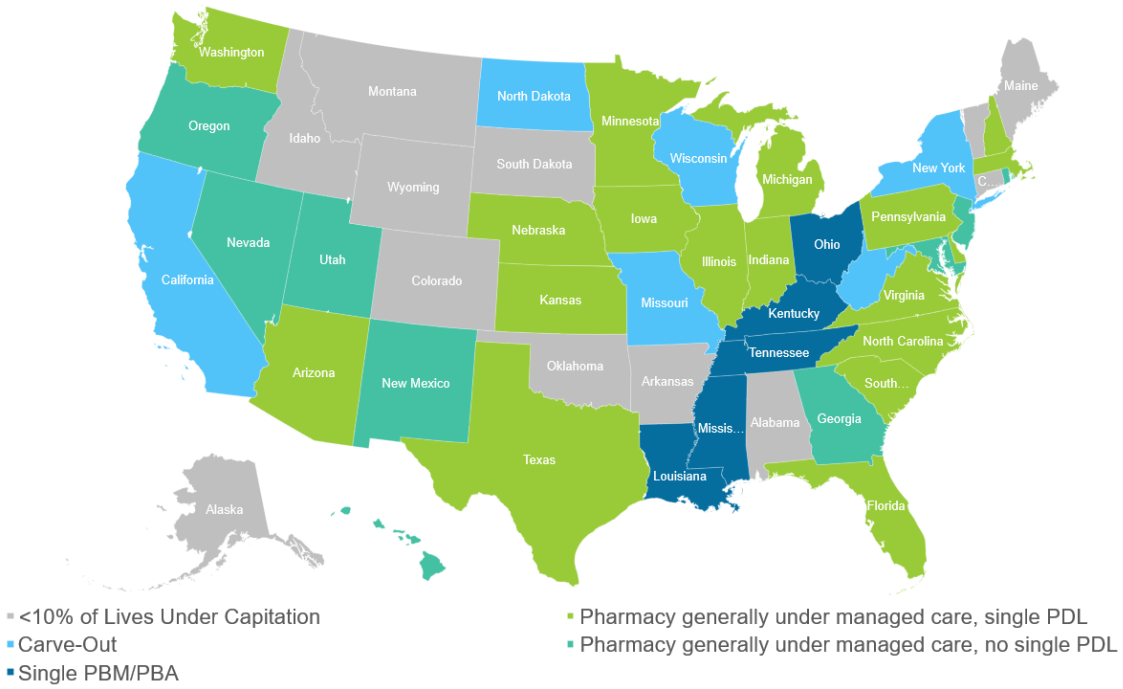
FIGURE 11: FFS DRUG EXPENDITURE AND UTILIZATION SUMMARY BY DRUG STATUS (MARCH 1, 2022 – FEBRUARY 28, 2023)

DRUG STATUS	FFS CLAIM VOLUME	PERCENT OF TOTAL	FFS PAID AMOUNT ($ MILLIONS)	PERCENT OF TOTAL
Carve-Out	1,214,757	68.1%	$ 185.7	67.5%
Carve-In	567,903	31.9%	$ 89.5	32.5%
Total	**1,782,660**	**100.0%**	**$ 275.1**	**100.0%**

4 Trends in Medicaid Pharmacy Service Delivery Models

Evaluating Medicaid pharmacy service delivery models used in Medicaid programs in other states can be leveraged to assist DHHS with evaluating a potential change to their current pharmacy service delivery model. As prescription drug costs continue to rise, Medicaid programs are under increasing pressure to control pharmacy spending. Over the past few years, there has been a significant increase in oversight and management of the pharmacy benefit in Medicaid. There is also a growing demand for transparency in drug pricing, which has led to more oversight of the pharmacy benefit, with a particular focus on PBMs and their role in the Medicaid drug supply chain.[vi,vii] Overall, these trends reflect a broader movement towards more active and stringent management of the pharmacy benefit in Medicaid managed care by the State, including prohibition of spread pricing, implementing single PDLs, requiring managed care organizations to contract with a single PBM, and / or carving out the pharmacy benefit from managed care. Figure 12 illustrates the Medicaid pharmacy service delivery models by state.

FIGURE 12: PHARMACY SERVICE DELIVERY MODEL BY STATE AS OF MAY 2024



Note: Iowa and North Carolina mandate FFS reimbursement through managed care health plans. South Carolina's pharmacy benefit design will go into effect in July 2024.

PHARMACY REIMBURSEMENT TRANSPARENCY

Spread pricing is a practice where a PBM charges a health plan a certain amount for prescription drugs and reimburses pharmacies a different amount. This practice has faced scrutiny for its lack of transparency and potential to inflate drug costs. In response, several state Medicaid programs have implemented laws and regulations to prohibit spread pricing and require PBMs to operate under a pass-through model where they charge the health plan the same amount that is reimbursed to the pharmacy for dispensed drugs. Following an audit of Ohio's Medicaid program that quantified the amount retained by PBMs in spread pricing, the Ohio Department of Medicaid directed all managed care organizations to implement pass-through pricing models with their PBMs effective January 1, 2019.[viii] Following a handful of high-profile audits of PBM practices, many states moved to prohibit spread pricing in their managed care organization contracts.[ix] In Utah, DHHS has added language in the managed care contracts to discourage spread pricing. DHHS requires that any amount retained by the PBM be excluded as a medical expense when calculating the plan's medical loss ratio (MLR). Note, solving issues related to transparency and drug pricing are multi-faceted and not achieved via the elimination of spread pricing alone.

SINGLE PDL

While many FFS Medicaid programs utilize a PDL, many states also require managed care organizations to use the FFS PDL, or a single PDL. By requiring use of a single PDL, states are able to maximize federal and supplemental drug rebates, as well as provide consistency for Medicaid enrollees and physicians who serve Medicaid patients.[x] In the last few years, there has been an increase in the number of states that have adopted a single PDL. In 2020, Illinois, Michigan, Ohio, and Pennsylvania Medicaid began requiring managed care organizations to follow the state's PDL and as recently as July 2023, Indiana implemented a single PDL.[xi,xii,xiii,xiv,xv] South Carolina is implementing a single PDL in July 2024 and New Mexico plans to implement a single PDL in fiscal year 2025.[xvi] Of states with the

pharmacy benefit carved into managed Medicaid, there are nine Medicaid programs that will not have a universal PDL as of July 2024, outlined in Figure 12 above.

PHARMACY BENEFIT CARVE OUT TO FFS

Of states that have managed care, there are currently six states (California, Missouri, New York, North Dakota, Wisconsin, and West Virginia) that do not include the delivery of pharmacy services through their contracted managed care health plans.[xvii] Notably, California and New York are two Medicaid programs that recently transitioned their pharmacy benefit from managed care to FFS. Following an Executive Order from the Governor in 2019, California carved out their pharmacy benefit from managed care effective January 1, 2022 in order to standardize the pharmacy benefit under one delivery system, improve pharmacy networks, apply uniform utilization management protocols, and strengthen California's ability to negotiate state supplemental rebates with manufacturers.[xviii] Most recently, New York implemented a pharmacy benefit carve-out effective April 1, 2023.[xix]

SINGLE PBM

Some states have implemented a single PBM as opposed to a pharmacy benefit carve-out to FFS. With a single PBM, all managed care organizations are required to use a single state-selected PBM vendor to provide streamlined benefit administration across the Medicaid program. There are two primary types of single PBMs:

- Managed care single PBM: ACOs remain at risk for pharmacy expenditures in a capitated arrangement, but all ACOs are required to contract with a single PBM.
  - Kentucky Medicaid implemented a managed care single PBM on July 1, 2021 and providers are reimbursed using the FFS pricing logic. The single PBM also uses the FFS PDL.
  - Louisiana Medicaid implemented a single PBM in October 2023. The single PBM required all ACOs to reimburse legislatively defined local pharmacies at the FFS reimbursement amount, while non-local pharmacies receive standard contract rates and the single PBM uses the FFS PDL. Note the pharmacy reimbursement and FFS PDL were already mandated in the traditional managed care model prior to transitioning to the single PBM.
- PAHP Single PBM: ACOs are not at risk for pharmacy expenditures. This model requires either a 1115 or 1915(b) waiver.
  - As of October 1, 2022, Ohio Medicaid implemented a single PBM as a PAHP and the ACOs are no longer under a capitated arrangement for pharmacy expenditures.
  - Most recently, the Mississippi Division of Medicaid announced they will implement a single pharmacy benefit administrator (PBA) during their upcoming managed care contracts. The managed care organizations will not be at risk for pharmacy expenditures; however, utilization and financial transactions will be exchanged between the PBA and ACOs.[xx]

Subsequent sections of the report discuss the qualitative considerations for implementing many of these pharmacy service delivery models.

5 Quantitative Analysis Results

We performed analyses and calculated estimated fiscal impact of key pharmacy program design changes that have the potential to have the greatest cost impact from implementation of an alternate pharmacy program model. The general methodology of each analysis can be found in section 8 of the report. A description of each analysis included in this section of the report is outlined below:

- **FFS Pharmacy Reimbursement Reprice:** Managed care pharmacy reimbursement is aligned to FFS reimbursement by repricing the State's ACO pharmacy claims to the FFS pharmacy reimbursement methodology.
- **Single PDL:** Managed care pharmacy utilization currently managed by the ACOs' PDLs is shifted to the Utah Medicaid FFS PDL.

- **Single PDL and FFS Pharmacy Reimbursement Reprice:** Managed care pharmacy utilization currently managed by the ACOs' PDLs is shifted to the FFS PDL and FFS pharmacy reimbursement methodology.
- **ACO Administrative Costs and Underwriting Gains:** ACO administrative costs and underwriting gains are estimated based on changes to gross pharmacy expenditures resulting from implementation of the FFS reimbursement methodology or single PDL in the managed care pharmacy program.

To complete these analyses, we relied on final paid ACO encounters and FFS POS pharmacy claims with a date of service between March 1, 2022 and February 28, 2023, which was the most recent 12-month period of data available from DHHS. In addition, some exclusions were applied to the pharmacy experience, and we relied upon several other data sources for the analyses as described in the methodology section of the report.

FFS PHARMACY REIMBURSEMENT REPRICE ANALYSIS

A reprice of the State's ACO pharmacy claims to the FFS pharmacy reimbursement methodology was performed to evaluate the difference in aggregate program costs of changing from the pharmacy reimbursement currently managed by ACOs to the pharmacy reimbursement used in the FFS Medicaid program. We repriced claims utilizing the FFS ingredient cost and dispensing fee methodology as approved by CMS in the DHHS State Plan in effect at the time of the analysis which does not reflect the increased dispensing fee of $11.56 planned to be effective July 1, 2024. It is estimated that the increased dispensing fee would result in approximately a $2.6 million increase to pharmacy providers' reimbursement, thus decreasing the savings in Figure 13 to approximately $3.3 million.

In addition to the ingredient cost and dispensing fee methodology, DHHS has a number of policies such as, but not limited to, monthly dispensing fee limits, member copay limits, mandatory three-month supply drugs, and quantity limits. While our analysis incorporated some aspects of DHHS' pharmacy services policies, it does not replicate the FFS claims processing system and rules. To ensure our methodology for repricing the ACO claims to the FFS reimbursement methodology produced reasonable results of the reimbursement differences between the amount paid by the ACOs and the amount paid under the FFS reimbursement methodology, we repriced the FFS claims and compared that to the original paid amount. The repriced FFS claims were within 0.5% of the original paid amount.

Figure 13 illustrates the aggregate cost difference between the original amount paid by the ACOs and the FFS pharmacy reimbursement methodology results in a $5.9 million dollar savings to DHHS. This figure displays the original paid amount for pharmacy claims included in the analysis, as well as the repriced amount for the same claims utilizing the FFS pharmacy reimbursement methodology.

FIGURE 13: AGGREGATE COST DIFFERENCE OF FFS PHARMACY REIMBURSEMENT BY ACO

ACO	CLAIM VOLUME	ORIGINAL PAID ($ MILLIONS)	FFS REPRICED PAID ($ MILLIONS)	DIFFERENCE ($ MILLIONS)
SelectHealth Community Care	995,596	$ 128.3	$ 121.1	($ 7.3)
Healthy U	517,077	$ 62.2	$ 62.2	$ 0.0
Molina Healthcare of Utah	385,001	$ 39.3	$ 41.0	$ 1.6
Health Choice Utah	184,442	$ 22.8	$ 22.6	($ 0.3)
Total	**2,082,116**	**$ 252.7**	**$ 246.8**	**($ 5.9)**

Repricing the pharmacy claims according to the FFS pharmacy reimbursement logic had a minimal impact on paid amount for pharmacy claims from Healthy U and Health Choice Utah. Repricing the pharmacy claims according to the FFS reimbursement logic would increase costs for Molina Healthcare of Utah pharmacy claims and decrease costs for Select Health Community Care pharmacy claims. As Select Health Community Care accounted for 48% of the ACO pharmacy claims included in the FFS repricing analysis, this contributed to an overall decrease in pharmacy costs when repriced to the FFS reimbursement logic.

The main driver of decreased pharmacy costs in the FFS repricing analysis was a differential in pharmacy ingredient reimbursement between the ACOs, particularly Select Health Community Care, which had higher ingredient

reimbursement for brands and generics, compared to the FFS program, which did not offset the higher dispensing fees paid under the FFS reimbursement methodology.

SINGLE PDL ANALYSIS

To evaluate the fiscal impact of the FFS PDL on the pharmacy experience currently managed by the ACOs, the ACO pharmacy encounters were shifted to a presumed claim distribution under DHHS' FFS PDL to estimate the gross cost, rebate, and net cost impacts.

We assigned each claim in the pharmacy experience with the PDL class and PDL status (i.e., preferred or non-preferred) using the FFS PDL file as of February 2023 provided by DHHS. We then used a combined ranking system based on ACO utilization and expenditures to prioritize the 140 PDL classes for review in the analysis. Beginning with the highest ranking, we grouped the PDL classes into the following categories:

- Modeled PDL Classes: Top ranked PDL classes with less than 95% of existing ACO expenditures for preferred drugs.
- Reviewed PDL Classes: PDL classes with 95% or greater of existing ACO expenditures for preferred drugs.
- Remaining PDL Classes: All other PDL classes.
- Non-PDL Classes: Drugs that are not include on the DHHS FFS PDL.

The Modeled PDL Classes, which represent over 50% of the ACO expenditures for drug on the FFS PDL, underwent a comprehensive evaluation which included clinical considerations, FFS market share distribution, and experience from other state Medicaid programs who have implemented a single PDL. Because the Reviewed PDL classes had a preferred market share of 95% or higher, claims in these classes were not shifted as it was assumed that minimal shifting would occur due to members being able to remain on their existing therapy. The Remaining PDL Classes, representing 22% of the ACO expenditures, were not analyzed. As such, these results reflect a directional impact, rather than a complete fiscal impact estimate of the FFS PDL on the ACO pharmacy experience. We note this as a directional impact because we expect a continued analysis of the remaining PDL classes would generate additional net cost savings.

The purpose of this analysis was focused on evaluating the net cost impact to DHHS of the FFS PDL on the ACO pharmacy experience. Implementation of a single PDL will increase gross cost, largely driven by preferring multi-source brand drugs over their generic counterparts. Therefore, if DHHS were to implement the single PDL within the existing managed care model or through an ACO single PBM, determination of the impact to capitation rates should include a full, comprehensive analysis of all classes on the PDL, as well as additional considerations, such as differences in the FFS PDL clinical criteria and existing ACO criteria.

Figure 14, on the following page, includes the gross cost, federal and supplemental rebate, and net cost impacts for the PDL classes included in the analysis, including the detail for the Modeled PDL Classes.

FIGURE 14: SINGLE PDL IMPACTS BY PDL CLASS

DHHS PDL CLASS	PRE- AND POST-SHIFT CLAIM VOLUME	GROSS COST IMPACT ($ MILLIONS)	FEDERAL REBATE IMPACT ($ MILLIONS)	SUPPLEMENTAL REBATE IMPACT ($ MILLIONS)	NET COST IMPACT ($ MILLIONS)
Arthritis (Anti-TNF)	7,408	$ 0.0	$ 0.0	$ 15.9	($ 15.9)
CGM / Diabetic Supply	36,439	$ 0.0	$ 0.0	$ 5.4	($ 5.4)
Insulin (Long Acting)	13,817	$ 1.3	$ 4.3	$ 0.0	($ 3.0)
Asthma Inhaled (Beta Adrenergic)	73,794	$ 1.6	$ 4.4	$ 0.0	($ 2.8)
Antidiabetic (GLP-1)	13,777	$ 0.1	($ 0.2)	$ 2.8	($ 2.5)
Asthma Inhaled (Combo)	27,715	$ 2.6	$ 4.9	$ 0.0	($ 2.3)
Insulin (Rapid Acting)	19,020	$ 6.1	$ 6.9	$ 0.0	($ 0.8)
Antidiabetic (SGLT2)	9,865	$ 0.8	$ 1.5	$ 0.0	($ 0.7)
Long-Acting Narcotic	7,854	$ 0.4	$ 0.8	$ 0.0	($ 0.4)
Acute Migraine Agent	23,174	($ 0.1)	$ 0.1	$ 0.2	($ 0.4)
Modeled PDL Classes Total	**232,863**	**$ 12.7**	**$ 22.6**	**$ 24.3**	**($ 34.2)**
Reviewed PDL Classes	723,071	$ 0.0	$ 0.0	$ 5.5	($ 5.5)
Remaining PDL Classes	374,141	$ 0.0	$ 0.0	$ 1.5	($ 1.5)
Non-PDL Classes	638,209	$ 0.0	$ 0.0	$ 0.0	$ 0.0
ACO Market Share Rebates				($ 11.4)	$ 11.4
Total	**1,968,284**	**$ 12.7**	**$ 22.6**	**$ 19.9**	**($ 29.8)**

Note: Remaining PDL classes were not shifted and only the impact of supplemental rebates based on existing ACO utilization can be included.

The net cost savings resulting from the Modeled PDL classes is largely attributable to PDL classes where the FFS PDL prefers brand drugs over their generic counterparts. While brand drugs may have a higher gross cost than their respective generic counterparts, the significant federal rebates of the brand drugs result in a lower net cost. No shifting was assumed for the top two PDL classes based on clinical considerations and potential grandfathering policies; therefore, the net cost savings is driven by the State's ability to invoice and collect supplemental rebates in these classes.

There may be additional items that have a quantitative impact that are difficult to quantify, such as differences in utilization management between the individual ACO-developed PDLs and the FFS PDL. However, the ACO's coverage of prescription drugs should demonstrate coverage consistent with the amount, duration, and scope as described by FFS and cannot have medical necessity criteria that are more stringent than FFS.[xxi]

On the following page, the impacts to gross and net costs are provided in Figure 15, while the impacts to rebates are provided in Figure 16.

FIGURE 15: SINGLE PDL GROSS AND NET PAID IMPACTS BY PDL CLASS – TOP 10 ($ MILLIONS)

DHHS PDL CLASS	PRE-SHIFT GROSS COST	POST-SHIFT GROSS COST	GROSS COST IMPACT	PRE-SHIFT NET COST	POST-SHIFT NET COST	NET COST IMPACT
Arthritis (Anti-TNF)	$ 53.9	$ 53.9	$ 0.0	$ 31.8	$ 15.9	($ 15.9)
CGM / Diabetic Supply	$ 7.4	$ 7.4	$ 0.0	$ 7.4	$ 2.0	($ 5.4)
Insulin (Long Acting)	$ 5.5	$ 6.8	$ 1.3	$ 3.1	$ 0.1	($ 3.0)
Asthma Inhaled (Beta Adrenergic)	$ 2.5	$ 4.1	$ 1.6	$ 2.1	($ 0.7)	($ 2.8)
Antidiabetic (GLP-1)	$ 12.4	$ 12.5	$ 0.1	$ 4.3	$ 1.8	($ 2.5)
Asthma Inhaled (Combo)	$ 6.2	$ 8.7	$ 2.6	$ 2.8	$ 0.5	($ 2.3)
Insulin (Rapid Acting)	$ 5.9	$ 12.0	$ 6.1	$ 0.8	($ 0.0)	($ 0.8)
Antidiabetic (SGLT2)	$ 4.9	$ 5.7	$ 0.8	$ 0.7	($ 0.1)	($ 0.7)
Long-Acting Narcotic	$ 1.4	$ 1.8	$ 0.4	$ 0.7	$ 0.3	($ 0.4)
Acute Migraine Agent	$ 2.3	$ 2.2	($ 0.1)	$ 1.1	$ 0.8	($ 0.4)
Modeled PDL Classes Total	**$ 102.4**	**$ 115.1**	**$ 12.7**	**$ 54.6**	**$ 20.5**	**($ 34.2)**
Reviewed PDL Classes	$ 55.8	$ 55.8	$ 0.0	$ 34.1	$ 28.7	($ 5.5)
Remaining PDL Classes	$ 43.5	$ 43.5	$ 0.0	$ 24.5	$ 23.0	($ 1.5)
Non-PDL Classes	$ 51.7	$ 51.7	$ 0.0	$ 28.8	$ 28.8	$ 0.0
ACO Market Share Rebates				($ 11.4)		$ 11.4
Total	**$ 253.4**	**$ 266.1**	**$ 12.7**	**$ 130.7**	**$100.9**	**($ 29.8)**
Percent Change from Baseline			**5.0%**			**(22.8%)**

Note: Remaining PDL classes were not shifted and only the impact of supplemental rebates based on existing ACO utilization can be included.

FIGURE 16: SINGLE PDL FEDERAL AND SUPPLEMENTAL REBATE IMPACTS BY PDL CLASS ($ MILLIONS)

DHHS PDL CLASS	PRE-SHIFT FEDERAL REBATES	POST-SHIFT FEDERAL REBATES	FEDERAL REBATE IMPACT	SUPPLEMENTAL REBATE IMPACT	TOTAL REBATE IMPACT
Arthritis (Anti-TNF)	$ 22.1	$ 22.1	$ 0.0	$ 15.9	$ 15.9
CGM / Diabetic Supply	$ 0.0	$ 0.0	$ 0.0	$ 5.4	$ 5.4
Insulin (Long Acting)	$ 2.3	$ 6.6	$ 4.3	$ 0.0	$ 4.3
Asthma Inhaled (Beta Adrenergic)	$ 0.4	$ 4.8	$ 4.4	$ 0.0	$ 4.4
Antidiabetic (GLP-1)	$ 8.1	$ 8.0	($ 0.2)	$ 2.8	$ 2.6
Asthma Inhaled (Combo)	$ 3.4	$ 8.3	$ 4.9	$ 0.0	$ 4.9
Insulin (Rapid Acting)	$ 5.2	$ 12.0	$ 6.9	$ 0.0	$ 6.9
Antidiabetic (SGLT2)	$ 4.2	$ 5.7	$ 1.5	$ 0.0	$ 1.5
Long-Acting Narcotic	$ 0.8	$ 1.5	$ 0.8	$ 0.0	$ 0.8
Acute Migraine Agent	$ 1.2	$ 1.3	$ 0.1	$ 0.2	$ 0.3
Modeled PDL Classes Total	**$ 47.8**	**$ 70.4**	**$ 22.6**	**$ 24.3**	**$ 46.9**
Reviewed PDL Classes	$ 21.7	$ 21.7	$ 0.0	$ 5.5	$ 5.5
Remaining PDL Classes	$ 19.0	$ 19.0	$ 0.0	$ 1.5	$ 1.5

Non-PDL Classes	$ 22.9	$ 22.9	$ 0.0	$ 0.0	$ 0.0
ACO Market Share Rebates				($ 11.4)	($ 11.4)
Total	**$ 111.3**	**$ 134.0**	**$ 22.6**	**$ 19.9**	**$ 42.5**

Note: Remaining PDL classes were not shifted and only the impact of supplemental rebates based on existing ACO utilization can be included.

SINGLE PDL AND FFS PHARMACY REIMBURSEMENT REPRICE:

The individual fiscal impacts of the FFS pharmacy reimbursement reprice and single PDL cannot be added together to estimate the fiscal impact of implementing both pharmacy program changes due to reimbursement differences based on drug mix. We did not estimate the fiscal impact of this combination due to only modeling some of the PDL classes in the single PDL analysis. It is anticipated that implementation of the FFS PDL would impact the results of the FFS reprice due to the preferred status of brand drugs over their generic counterparts on the FFS PDL and the differential.

ACO ADMINISTRATIVE COSTS AND UNDERWRITING GAINS

In the DHHS capitation rate development, administrative costs and underwriting gains are included in the calculation based on total gross expenditures. Depending on if program expenditures increase or decrease, the administrative costs associated with the pharmacy benefit will be impacted. While these numbers can vary by year, the capitation rate setting typically includes 9% for admin and 2% for underwriting gain to the DHHS capitation rates. To model the impact of the FFS reprice and single PDL analyses on the ACO administrative costs and underwriting gains, we have assumed these amounts would remain unchanged as illustrated in Figure 17.

FIGURE 17: ACO ADMINISTRATIVE COSTS AND UNDERWRITING GAINS IMPACT – MARCH 1, 2022 – FEBRUARY 28, 2023 ($ MILLIONS)

	BASELINE	FFS REPRICE IMPACT	FFS REPRICE	SINGLE PDL	SINGLE PDL IMPACT
Gross Pharmacy Expenditures	$ 258.1	($ 5.9)	$ 252.2	$ 270.8	$ 12.7
Administrative Costs	$ 23.2	($ 0.5)	$ 22.7	$ 24.4	$ 1.1
Underwriting Gains	$ 5.2	($ 0.2)	$ 5.0	$ 5.4	$ 0.3
Total Admin and Underwriting Gains	**$ 28.4**	**($ 0.7)**	**$27.7**	**$29.8**	**$ 1.4**

Note: Baseline gross pharmacy expenditures differ from the FFS Reprice and Single PDL analyses due to claim exclusions.

The impact to ACO administrative costs and underwriting gains related to gross pharmacy expenditures are estimated to be reduced by $0.7 million if the ACOs used the FFS pharmacy reimbursement methodology or increased by $1.4 million if the FFS PDL was used in the managed care program.

6 Operational Structures to Achieve Pharmacy Service Delivery Model Changes

The operational structures that can be utilized to deliver an alternate pharmacy program model fall under two financial categories, ACO carve-in and ACO carve-out. The following operational structures are options for DHHS' consideration to achieve a pharmacy service delivery model change:

ACO carve-in options:

- State Mandated FFS Reimbursement: DHHS mandates implementation of the FFS pharmacy reimbursement methodology in the existing managed care model through its existing delegated PBM.
- Single PDL: DHHS mandates implementation of the FFS PDL in the existing managed care model through its existing delegated PBM.
- State Mandated FFS Reimbursement and Single PDL: DHHS mandates implementation of the FFS pharmacy reimbursement methodology and FFS PDL in the existing managed care model through its existing delegated PBM.
- ACO Single PBM: DHHS procures a single PBM to provide pharmacy services for the managed care pharmacy program through a contracted arrangement between the PBM and each ACO. The ACO and its delegated PBM would be required to deliver the program at the direction of the State.

ACO carve-out options:

- Pharmacy Carve-Out: DHHS provides pharmacy services for the managed care pharmacy program through the FFS pharmacy program.
- PAHP Single PBM: Pharmacy benefit services are delivered and managed by a single, state-selected PBM by contracting with the state and operating as a managed care PAHP.

FFS PHARMACY REIMBURSEMENT MANDATE

Federal regulations included in the CMS Covered Outpatient Drug Rule determine how pharmacies are reimbursed under FFS. While these federal regulations do not apply to pharmacy benefits under managed care, states can create rules to determine how health plans reimburse pharmacy providers through a state-directed payment. Through a FFS pharmacy reimbursement mandate, managed care pharmacy reimbursement is aligned to FFS reimbursement. Mississippi and Iowa Medicaid are examples of states that have the same pharmacy reimbursement across FFS and managed care.[xxii] Alternately, some states have implemented state-directed pharmacy payments in managed care targeted to achieve specific goals, such as increased reimbursement for independent pharmacies. For example, prior to implementation of a single PBM, the Louisiana Department of Health required all ACOs to reimburse legislatively defined local pharmacies at the FFS reimbursement amount, while non-local pharmacies receive standard contract rates.[xxiii] This policy remains in place under the single PBM.

QUANTITATIVE IMPACT

This reimbursement model ensures that pharmacy providers are reimbursed under a transparent and uniform reimbursement methodology. The impact of a FFS reimbursement mandate in the existing managed care model is shown below in Figure 18.

FIGURE 18: FISCAL IMPACT OF FFS PHARMACY REIMBURSEMENT MANDATE ($ MILLIONS)

CAPITATITED CATEGORY	BASELINE	FFS REIMBURSEMENT MANDATE	DIFFERENCE
FFS Reprice	$ 252.7	$ 246.8	($ 5.9)
Gross Pharmacy Expenditures*	**$ 258.1**	**$ 252.2**	**($ 5.9)**
ACO Administrative Costs	$ 23.2	$ 22.7	($ 0.5)
ACO Underwriting Gains	$ 5.2	$ 5.0	($ 0.1)
Vendor Costs	$ 0.0	$ 0.0	$ 0.0
DHHS Staffing Needs	$ 0.0	$ 0.0	$ 0.0
Premium Tax	$ 0.0	$ 0.0	$ 0.0
Total Gross Cost	$ 286.5	$ 280.0	($ 6.5)
Federal Rebates	($ 115.8)	($ 115.8)	($ 0.0)
Supplemental Rebates	($ 0.0)	($ 0.0)	($ 0.0)
ACO Market Share Rebates	($ 11.4)	($ 11.4)	($ 0.0)
Net Cost to DHHS	$ 159.3	$ 152.8	($ 6.5)

Note: Baseline expenditures and rebates differ between the FFS Reprice due to inclusion of excluded claims gross cost and rebates.

QUALITATIVE CONSIDERATIONS

In addition to the change in capitation rates, mandating FFS pharmacy reimbursement in the managed care program requires the state Medicaid agency to update managed care contracts. Louisiana's State Legislature codified the managed care pharmacy reimbursement to local pharmacies in RS 46:460.36.[xxiv]

CMS governs how states may direct managed care reimbursement, known as state directed payments. CMS issued guidance for state Medicaid directors on state directed payments in Medicaid managed care that clarified states ability to direct expenditures of Medicaid managed care plans. The guidance clarifies that CMS permits state directed payment that comply with the requirements of 42 CFR § 438.6, which allows states to require managed care organizations to adopt a minimum fee schedule for particular services.[xxv,xxvi] CMS approves these state directed payments through a preprint process; however, CMS considers a change to a state plan approved reimbursement methodology to be pre-approved and waives the requirement for a preprint submission.

While mandating the ACOs to implement FFS pharmacy reimbursement results in consistent reimbursement to pharmacies in the Medicaid line of business, pharmacies that agree to an effective rate guarantee with a PBM may not experience any change in aggregate reimbursement by that PBM due to effective rate guarantees.

Effective Rate Guarantees

Pharmacies that participate in an effective rate guarantee agree to accept an aggregate reimbursement from the PBM, typically across multiple lines of business included into one (i.e., Medicaid, exchange, and commercial). Rate guarantees and reconciliations with pharmacies are typically conducted across the entire contracted network rather than for a particular Medicaid managed care organization or Medicaid program. Rate guarantees and reconciliations are typically conducted at the pharmacy chain or contract level. If the PBM has, in aggregate, reimbursed the pharmacy above the agreed upon aggregate reimbursement amount, the pharmacy may owe a reconciliation payment to the PBM over the course of the year. In other words, if DHHS increases pharmacy reimbursement through a FFS reimbursement mandate, pharmacies may still be subject to an effective rate guarantee that they have entered into with the ACO's PBM and may not experience any change in aggregate reimbursement by that PBM.

One way to ensure pharmacy providers are adequately reimbursed is to prohibit Medicaid claims from being included in reconciliation on effective rate agreements. Several states have begun prohibiting such reconciliation practices. For example, Florida is attempting to enact legislation that would prohibit financial clawbacks, reconciliation offsets, or offsets to adjudicated claims which would include effective rate adjustments through multiple network reconciliation offsets.[xxvii]

SINGLE PDL

QUANTITATIVE IMPACT

Implementing a single PDL enables states to drive utilization to the lowest net cost products while simultaneously creating a more consistent formulary experience for physicians, pharmacies, and members. Having a consistent formulary environment (one PDL and the same utilization and PA criteria across all medications for all members) could, in turn, increase utilization and reduce provider burden. While many brand drugs may have a higher gross cost than their respective generic counterparts, after taking rebates into consideration the brand drug may have a lower net cost to the Medicaid program. However, because the higher gross cost drugs may be preferred (i.e., "brand over generic"), capitation rates typically increase to reflect utilization of higher gross cost drugs. As the admin (9%) and underwriting gain (2%) are applied to total program expenditures in capitation rate development, any increase in the capitation rates due to utilization of higher gross cost drugs will increase the admin and underwriting gain that is paid to the ACOs. Additionally, "market share rebates" or supplemental rebates collected by ACOs would be prohibited and taken over by the State's rebate vendor and removed from capitation rates. Supplemental rebates collected by DHHS may increase under a single PDL if they are more favorable than the ACO market share rebates or if DHHS is able to negotiate higher supplemental rebates by leveraging increases in utilization by combining the claims volume from the FFS and managed care programs. Taken together, while the capitation rates typically increase, ultimately the state experiences a lower net cost, as outlined in Figure 19.

In addition to optimizing rebates for DHHS, the single PDL may reduce the administrative burden for prescribers and pharmacies. Given there are multiple PDLs used across the Medicaid program, the inconsistencies between each PDL may pose challenges for both providers and members. By eliminating the requirement to refer to multiple PDLs for Medicaid members it may also improve member access to medications and reduce therapy interruptions through consistent PDL status across the Medicaid program for those members who transition between ACOs and/or FFS. This allows prescribers and pharmacies to more easily understand the drug coverage and PA criteria instead of navigating different PDLs depending on the member's enrollment.

FIGURE 19: FISCAL IMPACT OF SINGLE PDL ($ MILLIONS)

CAPITATITED CATEGORY	BASELINE	FFS PDL MANDATE	DIFFERENCE
Single PDL	$ 253.4	$ 266.1	$ 12.7
Gross Pharmacy Expenditures	**$ 258.1**	**$ 270.8**	**$ 12.7**
ACO Administrative Costs	$ 23.2	$ 24.4	$ 1.1
ACO Underwriting Gains	$ 5.2	$ 5.4	$ 0.3
Vendor Costs	$ 0.0	$ 0.0	$ 0.0
DHHS Staffing Needs	$ 0.0	$ 0.0	$ 0.0
Premium Tax	$ 0.0	$ 0.0	$ 0.0
Total Gross Cost	$ 286.5	$ 300.6	$ 14.1
Federal Rebates	($ 115.8)	($ 138.5)	($ 22.6)
Supplemental Rebates	($ 0.0)	($ 32.5)	($ 32.5)
ACO Market Share Rebates	($ 11.4)	($ 0.0)	$ 11.4
Net Cost to DHHS	**$ 159.3**	**$ 129.7**	**($ 29.6)**

Note: Baseline expenditures and rebates differ between the Single PDL due to inclusion of excluded claims gross cost and rebates.

The PDL analysis was limited to the top 10 therapeutic classes on the PDL. As such, these results reflect a directional impact, rather than a comprehensive fiscal impact.

There may be additional items that have a quantitative impact that are difficult to quantify, such as differences in utilization management between the individual ACO-developed PDLs and the FFS PDL. However, the ACO's coverage of prescription drugs should demonstrate coverage consistent with the amount, duration, and scope as described by FFS and cannot have medical necessity criteria that are more stringent than FFS.

QUALITATIVE CONSIDERATIONS

By unifying the managed care population and the FFS population under one PDL, states are able to increase their leverage when negotiating supplemental rebates. The single PDL also provides centralized drug management and clinical criteria, which has the added benefit of providing more consistency for prescribers and members. As members may experience initial disruption when transitioning from an ACO PDL to the single PDL, DHHS may need to establish a plan to mitigate such disruption including the development of grandfathering guidelines by therapeutic class or communicating preferred therapeutic alternatives to ensure continuity of care for members. Despite this initial disruption, the single PDL provides consistency in formulary coverage for members moving between ACOs. Prescribers also benefit from a consistent formulary, although a single PDL does not address any concerns that pharmacy providers may have with drug reimbursement.

Implementing a single PDL requires the State to amend the ACO contracts and develop a system for communicating and transmitting PDL updates to the ACOs. DHHS may also consider monitoring the ACOs for PDL adherence and developing non-compliance penalties. The ACOs will need to work with DHHS to process and implement PDL updates according to an established cadence. As the ACO's PBM will no longer negotiate rebates for Medicaid members, it may impact their rebate negotiation power in other lines of business creating potential pushback from the ACOs.

FIGURE 20: QUALITATIVE CONSIDERATIONS – SINGLE PDL

ENTITY	QUALITATIVE CONSIDERATIONS
DHHS	▪ Increased leverage for supplemental rebate negotiation that may provide additional program savings ▪ Centralized drug management and clinical criteria which may enhance member and provider experience ▪ Requires ACO contract amendments may increase administrative burden due to re-contracting efforts ▪ Need to communicate and transmit PDL updates to ACOs and determine frequency of updates ▪ Plan to mitigate member disruption and establish continuity of care requirements and grandfathering guidelines by therapeutic class ▪ PDL adherence monitoring and potentially developing non-compliance penalties
Members	▪ Members may experience initial disruption with the formulary change but can be handled with grandfathering PAs for patients on non-preferred medications ▪ Consistent formulary for members moving between health plans ▪ Title XXI CHIP members may have higher cost sharing due to brand over generic strategy of State PDL
Prescribers and Pharmacies	▪ Consistent formulary for patients across different ACOs ▪ Does not address pharmacy provider reimbursement concerns
ACOs and PBMs	▪ Process for receiving PDL updates from DHHS ▪ May impact rebate negotiation leverage in other lines of business ▪ Potential ACO pushback due to lack of ability to manage utilization and costs

COMBINATION OF SINGLE PDL AND FFS REIMBURSEMENT MANDATE

QUANTITATIVE IMPACT

Another option is to mandate the ACOs implement both the FFS PDL and the FFS pharmacy reimbursement methodology in the existing managed care model. The individual fiscal impacts of the single PDL and the FFS reimbursement mandate (summarized in Figures 18 and 19 above) cannot be added together to estimate the fiscal impact of implementing both pharmacy program changes, due to reimbursement differences based on drug mix. We

did not estimate the fiscal impact of this combination due to only modeling some of the PDL classes in the single PDL analysis. It is anticipated that implementation of the FFS PDL would impact the fiscal impact of the FFS reprice due to the preferred status of brand drugs over their generic counterparts on the FFS PDL.

PHARMACY BENEFIT CARVE-OUT

QUANTITATIVE IMPACT

There are a multitude of fiscal considerations to consider when looking to carve a pharmacy benefit out of managed care capitation. As opposed to a fixed cost in monthly capitation payments to the ACOs, the State is fully at risk for variations in pharmacy expenditures. While some costs built into capitation payments are reduced, such as administrative costs and underwriting gains, the administrative duties are now the responsibility of the State. In this design model, the single PDL and FFS pharmacy reimbursement methodology previously outlined will apply to this delivery system. When carving-out the pharmacy benefit, DHHS may expect the following additional costs:

- Additional staffing needs
- Additional costs with claims processing vendor

Figure 21 below outlines variations in these fiscal impacts.

FIGURE 21: FISCAL IMPACT OF PHARMACY BENEFIT CARVE-OUT ($ MILLIONS)

CAPITATITED CATEGORY	BASELINE	CARVE-OUT	DIFFERENCE
FFS Reprice*	$ 252.7	$ 246.8	($ 5.9)
Single PDL	$ 253.4	$ 266.1	$ 12.7
Gross Pharmacy Expenditures	**$ 258.1**	**$ 270.8**	**$ 12.7**
ACO Administrative Costs	$ 23.2	$ 8.1**	($ 15.1)
ACO Underwriting Gains	$ 5.2	$ 0.0	($ 5.2)
Vendor Costs	$ 0.0	$ 1.0	$ 1.0
DHHS Staffing Needs	$ 0.0	$ 1.0	$ 1.0
Premium Tax	$ 0.0	$ 0.0	$ 0.0
Total Gross Cost	$ 286.5	$ 281.0	($ 5.6)
Federal Rebates	($ 115.8)	($ 138.5)	($ 22.6)
Supplemental Rebates	($ 0.0)	($ 32.5)	($ 32.5)
ACO Market Share Rebates	($ 11.4)	($ 0.0)	$ 11.4
Net Cost to DHHS	**$ 159.3**	**$ 110.0**	**($ 49.3)**

Notes: Baseline expenditures and rebates differ between the FFS Reprice and Single PDL due to analysis exclusions as outlined in the methodology section of the report.

**** FFS Reprice savings is not reflected in carve-out as the impact of the FFS reimbursement after implementation of the Single PDL is TBD.***

*****3% admin remains to account for administrative costs of coordination of care and data feeds required to manage patients.***

Admin and underwriting gain

In capitation rate development, admin and underwriting gains are included in the calculation based on total expenditures. Under a pharmacy benefit carve-out, the total program expenditure decreases and the ACOs are no longer responsible for administrative costs associated with the pharmacy benefit. As such, the admin and underwriting gain will decrease under a pharmacy benefit carve-out. While these numbers can vary by year, the capitation rate setting typically includes 9% for admin and 2% for underwriting gain. The ACOs would still need to receive pharmacy data for care coordination activities; therefore, 3% was left in the carve-out scenario for administrative costs for illustrative purposes.

Premium tax

In some states the premium tax is a source of revenue for the Medicaid program. Premium tax is built into capitation rates, which is a combination of both state and Federal funds based on a state's Federal Medical Assistance Percentage (FMAP). However, when the ACOs pay the premium tax to the state, the state does not share a portion of that with the federal government and as such, the premium tax is a source of revenue for the state. Typically, if dollars are removed from the capitation rate due to a pharmacy benefit carve-out, then the state would lose out on a portion of that premium tax revenue. For this reason, a pharmacy benefit carve-out may increases costs for states that have a premium tax, discouraging states from carving out their pharmacy benefit. However, according to Utah code 59-9-101, health maintenance organizations are not subject to premium tax.[xxviii] As such, the loss of premium tax revenue due to a pharmacy benefit carve-out is not applicable to Utah Medicaid.

QUALITATIVE CONSIDERATIONS

The operational considerations transitioning to a pharmacy benefit carve out are essential to ensure a successful program implementation. Each operational function listed below in Figure 22 will require careful planning and resources:

FIGURE 22: QUALITATIVE CONSIDERATIONS – PHARMACY BENEFIT CARVE-OUT

ENTITY	QUALITATIVE CONSIDERATIONS
Impact to DHHS	▪ May require additional staffing due to increased administrative burden associated with implementation, member and provider communication, and coordination with the ACOs ▪ FFS program can expect an increase in prior authorization reviews and other utilization management ▪ Enhanced coordination with ACOs ▪ Less budget predictability ▪ Medical vs pharmacy billing policy evaluation ▪ Potential efficiency in reporting, rebate processing, and PDL implementation ▪ System for data transmission to the ACOs
Impact to Members	▪ Members may experience initial disruption with the formulary change ▪ Consistent formulary for members moving between health plans ▪ Enhanced pharmacy network
Impact to Prescribers and Pharmacies	▪ Consistent reimbursement for pharmacies across the Medicaid program ▪ Consistent benefit administration for prescribers and pharmacies ▪ Higher professional dispensing fees under FFS ▪ Reimbursement impact/reconciliation
Impact to ACOs and PBMs	▪ Data coordination ▪ Continuity of care challenges between the pharmacy and medical benefit

Current pharmacy benefit carve-out

Utah Medicaid maintains a list of therapeutic classes that are carved out of managed care, previously listed in the *Background on Utah Medicaid Pharmacy Benefit* section. As over half of the pharmacy benefit is already covered under FFS, many of the qualitative considerations may not pose a significant barrier to implementing a full pharmacy benefit carve-out. For example, there are existing systems to support data transmission between the ACOs and DHHS for the therapies that are currently carved-out of managed care. While coordination of member care may be a concern when carving the pharmacy benefit out of managed care, these challenges exist under the current benefit design. In a pharmacy benefit carve-out states may be concerned with the predictability of their budget; however, considering that over half of the pharmacy benefit is presently carved-out of managed care, DHHS is already subject to fluctuations in their budget.

SINGLE PBM

The advantages and disadvantages of the two primary types of single PBMs are outlined below in Figure 23. There are many similarities in the advantages and disadvantages of a single PBM as a PAHP and a pharmacy benefit carve-out. While these two benefit designs are operationally very similar, with a PBM as a PAHP there may be more flexibility in provider reimbursement compared to the FFS program. 42 CFR 447.362 limits Medicaid payments to the contractor to what the state would have paid under FFS for actual utilization plus the net savings of administrative costs the state realizes through this arrangement. This could mean that rural pharmacies are reimbursed at a higher rate relative to chain pharmacies as long as the aggregate expenditures do not exceed what would have been paid in FFS. A non-risk or at-risk PBM structured as a PAHP would be permissible under a 1915(b) waiver or section 1115 demonstration. Under this arrangement, the PBM would be subject to requirements of the federal Medicaid Managed Care rule.

A managed care single PBM is also similar to a pharmacy benefit carve-out due to the streamlined benefit administration and uniform pharmacy provider payments aligned to the FFS reimbursement logic, however there may be reduced administrative costs with a single PBM and Utah would still be able to balance their risk through capitation payments.

FIGURE 23: ADVANTAGES AND DISADVANTAGES OF SINGLE PBM OPERATIONAL STRUCTURE

OPERATIONAL STRUCTURE	ADVANTAGES	DISADVANTAGES
Managed Care Single PBM	▪ Streamlined benefit administration ▪ Uniform pharmacy provider payments ▪ State budget predictability ▪ Shared risk with ACOs ▪ Retain premium tax revenue[7]	▪ FFS pricing could increase net pharmacy expenditures ▪ Potential loss of PBM pricing competitiveness ▪ Member disruption during transition
Single PBM as a PAHP	▪ Streamlined benefit administration ▪ Pharmacy provider reimbursement flexibility	▪ Potential loss of premium tax revenue (not applicable to Utah) ▪ FFS pricing could increase net pharmacy expenditures ▪ Loss of budget predictability ▪ Decrease in ACO coordination across pharmacy and medical benefit ▪ CMS waiver approval required

Figures 24 and 25 on the following page provide the estimated cost impact of each single PBM pharmacy service delivery model.

[7] Health maintenance organizations are not subject to premium tax on health care insurance in Utah, as discussed earlier in the report.

FIGURE 24: FISCAL IMPACT OF ACO SINGLE PBM ($ MILLIONS)

CAPITATITED CATEGORY	BASELINE	ACO SINGLE PBM	DIFFERENCE
FFS Reprice*	$ 252.7	$ 246.8	($ 5.9)
Single PDL	$ 253.4	$ 266.1	$ 12.7
Gross Pharmacy Expenditures	**$ 258.1**	**$ 270.8**	**$ 12.7**
ACO Administrative Costs	$ 23.2	$ 24.4**	$ 1.1
ACO Underwriting Gains	$ 5.2	$ 5.4**	$ 0.3
Vendor Costs	$ 0.0	$ 0.0	$ 0.0
DHHS Staffing Needs	$ 0.0	$ 0.0	$ 0.0
Premium Tax	$ 0.0	$ 0.0	$ 0.0
Total Gross Cost	$ 286.5	$ 300.6	$ 14.1
Federal Rebates	($ 115.8)	($ 138.5)	($ 22.6)
Supplemental Rebates	($ 0.0)	($ 32.5)	($ 32.5)
ACO Market Share Rebates	$ 11.4	$ 0.0	$ 11.4
Net Cost to DHHS	**$ 159.3**	**$ 129.7**	**($ 29.6)**

Notes: Baseline expenditures and rebates differ between the FFS Reprice and Single PDL due to analysis exclusions as outlined in the methodology section of the report.

**** FFS Reprice savings is not reflected in ACO single PBM as the impact of the FFS reimbursement after implementation of the Single PDL is TBD.***

***** Admin and Underwriting gains remain to account for the ACOs cost for the single PBM.***

FIGURE 25: FISCAL IMPACT OF PAHP SINGLE PBM ($ MILLIONS)

CAPITATITED CATEGORY	BASELINE	PAHP SINGLE PBM	DIFFERENCE
FFS Reprice*	$ 252.7	$ 246.8	($ 5.9)
Single PDL	$ 253.4	$ 266.1	$ 12.7
Gross Pharmacy Expenditures	**$ 258.1**	**$ 270.8**	**$ 12.7**
ACO Administrative Costs	$ 23.2	$ 8.1**	($ 15.1)
ACO Underwriting Gains	$ 5.2	$ 0.0	($ 5.2)
Vendor Costs	$ 0.0	$13.5***	$13.5
DHHS Staffing Needs	$ 0.0	$ 0.0	$ 0.0
Premium Tax	$ 0.0	$ 0.0	$ 0.0
Total Gross Cost	$ 286.5	$ 292.5	$ 6.0
Federal Rebates	($ 115.8)	($ 138.5)	($22.6)
Supplemental Rebates	($ 0.0)	($ 32.5)	($ 32.5)
ACO Market Share Rebates	($ 11.4)	($ 0.0)	$ 11.4
Net Cost to DHHS	**$ 159.3**	**$ 121.5**	**($ 37.8)**

Notes: Baseline expenditures and rebates differ between the FFS Reprice and Single PDL due to analysis exclusions as outlined in the methodology section of the report.

**** FFS Reprice savings is not reflected in carve-out as the impact of the FFS reimbursement after implementation of the Single PDL is TBD.***

*****3% admin remains to account for administrative costs of coordination of care and data feeds required to manage patients.***

****** 5% of gross expenditures was estimated for costs of a new PBM vendor.***

7 Discussion

This section of the report includes discussion of several items that could influence the results of our evaluation. These items should be considered when evaluating a change to the UT Medicaid pharmacy service delivery model and could be further analyzed in the future.

MEDICAL BENEFIT DRUGS

Drugs billed to the outpatient medical benefit, which may be referred to as provider administered drugs (PADs), may be billed by medical providers or pharmacy providers depending on drug coverage and billing policies. These policies determine if the drug can be billed only to the pharmacy benefit, only to the medical benefit, or can be billed to either benefit. Medical providers administering these drugs may purchase and bill for both the drug and administration (i.e., buy and bill), or may send the prescription to a specialty pharmacy who in turn, bills and ships the drug to the medical provider for administration to the member (i.e., white bagging). When drugs are covered only through the medical benefit, the pharmacy provider will bill the claim through the medical benefit. Because our evaluation only included pharmacy POS claims, not all claims from pharmacy providers are reflected in the results.

When implementing a change to the pharmacy service delivery model, coordination between DHHS and the ACOs on drug coverage and billing policies is important to mitigate variances from the anticipated outcome of the change. For example, if the financial risk for pharmacy drugs is shifted to DHHS, which would occur with a carve-out or PAHP single PBM, a change in the ACOs drug coverage and billing policy directing utilization away from the medical benefit to the pharmacy benefit could results in additional expenditures for the State. This is also an important consideration for implementation of a single PDL, if the single PDL is only applicable to drugs in the pharmacy benefit, as shifting of drugs away from the pharmacy benefit to the medical benefit could result in lower utilization of preferred drugs impacting the estimated net savings. In addition, reimbursement methodologies may differ for drugs billed through the medical versus the pharmacy benefit.

PHARMACY REIMBURSEMENT

Another goal of DHHS' pharmacy division is to establish and implement a fair and transparent reimbursement model for pharmacists within the state Medicaid program that accurately reflects the value of their services and contributions to patient care. If DHHS implements a pharmacy benefit design change that aligns pharmacy reimbursement to FFS, pharmacies may still be subject to any effective rate guarantees that they have entered into the ACO's PBM and may not experience any change in aggregate reimbursement by that PBM. For example, if a pharmacy has entered into an effective rate guarantee with a PBM, the PBM has the ability to pay more than the effective rate (typically with claims under a pass-through pricing contract) and pay the pharmacy less than the effective rate (typically with claims under a spread pricing contract), as long as the guarantee is met in aggregate across all commercial and Medicaid contracts. The following considerations vary depending on which operational structure the State ultimately chooses meaning these topics are most significant when a single PBM or delegated PBM via ACO contract is delivering the benefit on behalf of the State.

To ensure pharmacies receiving fair and transparent reimbursement, DHHS may consider:

- Prohibit offsetting the FFS mandated payments from Medicaid with Commercial claims for pharmacy reimbursement. This will provide clear line of sight into the actual payments provided to pharmacies for claims within the Medicaid program.
- Align stakeholders on a single brand / generic definition to prevent instances where the PBM pays the pharmacy a generic rate for a brand drug and charges the ACO a brand rate.
- Require PBMs to report transaction fees charged to contracted network pharmacies. This will provide pharmacies and the State greater visibility into transactional fees and payments that occur outside of the point-of-sale process.
- Require retail pharmacy reimbursement rates for specialty drugs to be at parity across all channels including mail order and specialty pharmacies. This may require DHHS to define a specialty drug list that all stakeholders must implement.

- DHHS should consider implementing audit language into both the ACO contract and any delegated PBM who delivers pharmacy services on behalf of the ACO and State. This will ensure the ACOs and respective PBMs are administering the pharmacy benefit according to State's instructions and expectations.

SINGLE PDL

DHHS's transition to a single PDL may help achieve all of its stated primary goals. A PDL is more than just the list of covered drugs that are designated as preferred or non-preferred. It also includes the set of clinical criteria that governs patients who qualify for receiving treatments. When managing a PDL, DHHS can also elect to negotiate additional discounts called supplemental rebates, which are voluntary discounts that manufacturers provide beyond federally required rebates. In implementing a single PDL, there are multiple considerations the State must evaluate to ensure the benefit is delivered according to its expectation.

- Consistency of drug coverage among ACOs including preferred and non-preferred status, PA applicability and criteria, step-therapy, quantity limit, age limit, and other clinical criteria.
- Alignment of payment policy to ensure multi-source brands are paid via the FFS reimbursement methodology consistently and paid as brands to pharmacies.
- Audit provisions to ensure that each ACO is applying the single PDL PA and other clinical criteria equally and equitably to members of the State Medicaid program.
- In the transition to single PDL, the State should consider a process to ensure any member whose drug is changing to non-preferred, a timeline this member can continue on existing treatment which allows non-preferred drug coverage to continue for existing members.

8 Methodology

DATA SOURCE

For this analysis we relied on all final paid ACO encounters and FFS pharmacy claims with a date of service between March 1, 2022 and February 28, 2023, which was the most recent year of data available from DHHS due to an ongoing transition to a new data system. In addition to the encounter data, we relied on the following data sources:

- FFS PDL as of February 28, 2023
- Carve-out drug list
- UMAC and NADAC pricing files provided by DHHS
- Urban and rural provider indicator report
- Health resource Services Administration (HRSA) Medicaid Exclusion File
- CMS Unit Rebate Amount (URA) files (3Q 2021 through 1Q 2023)
- CMS unit rebate offset amount (UROA) files (1Q2022 through 1Q 2023)
- Average manufacturer price (AMP) files
- Supplemental rebate files
- Rebate conversion factor files
- ACO pharmacy administrative costs
- Change Healthcare administrative costs
- Information through discussion with DHHS and ACOs
- ACO reported supplemental rebates

Claim level identification flags were created using information provided by DHHS to enable rules and logic to be applied to replicate the FFS reimbursement methodology and conduct the single PDL analysis. These flags were used to identify certain claim attributes such as: compounds, third-party liability (TPL), 340B, pharmacy type and location, PDL status, and carve-out drug.

FFS REPRICING

We repriced the ACO data to reflect the FFS reimbursement methodology, defined in Figure 26 below.

FIGURE 26: FFS REIMBURSEMENT METHODOLOGY

CLAIM TYPE	FFS REIMBURSEMENT METHODOLOGY
Blood glucose test strips	Lesser of the submitted cost (Submitted Ingredient Cost, U&C, Gross Amount Due) or the WAC price with no dispensing fee.
All other claims	Lesser of selected ingredient cost benchmark + professional dispensing fee or the billed charges (U&C). - Ingredient cost: WAC, FUL, NADAC, UMAC, or Ingredient Cost Submitted - Professional dispensing fee: $9.99 for urban pharmacies located in Utah; $10.15 for rural pharmacies located in Utah; $9.99 for pharmacies located in any state other than Utah

We first calculated the FFS ingredient cost allowed amount based on the claim type. The applicable ingredient cost allowed amount was then multiplied by the quantity dispensed. We then calculated the applicable professional dispensing fee based on the claim type. We did not apply a professional dispensing fee for blood glucose test trips or claims for DME supplies. All other claims received a professional dispensing fee based on the urban/rural/out-of-state indicator. Finally, we added the FFS ingredient cost allowed amount and the professional dispensing fee amount, compared that amount to U&C, and selected the lowest amount to calculate the FFS claim allowed amount.

We used a copay of $4.00 per prescription and applied copay exemptions using member, drug, and diagnosis exemption flags with information provided by DHHS.

We then calculated the FFS model paid and fiscal impact using the following calculations:

- FFS Model Paid = FFS Allowed Amount – Copay
- Fiscal Impact = FFS Model paid – Original Paid

Compounds, Title XXI CHIP, IHS, 340B, clotting factor, Paxlovid, vaccines and encounters with a reported TPL amount were excluded from this analysis.

SINGLE PDL MODELING

We assigned each claim in the pharmacy experience with the PDL class and PDL status (i.e., preferred or non-preferred) using the FFS PDL file as of February 2023 provided by DHHS. We then used a combined ranking system based on ACO utilization and expenditures to prioritize the 140 PDL classes for review in the analysis. Beginning with the highest ranking, we grouped the PDL classes into the following categories:

- Modeled PDL Classes: Top ranked PDL classes with less than 95% of existing ACO expenditures for preferred drugs.
- Reviewed PDL Classes: PDL classes with 95% or greater of existing ACO expenditures for preferred drugs.
- Remaining PDL Classes: All other PDL classes.
- Non-PDL Classes: Drugs that are not include on the DHHS FFS PDL.

The Modeled PDL Classes, which represent over 50% of the ACO expenditures for drug on the FFS PDL, underwent a comprehensive evaluation which included clinical considerations, FFS market share distribution, and experience from other state Medicaid programs who have implemented a single PDL. Because the Reviewed PDL classes had a preferred market share of 95% or higher, claims in these classes were not shifted as it was assumed that minimal shifting would occur due to members being able to remain on their existing therapy. The Remaining PDL Classes,

representing 22% of the ACO expenditures, were not analyzed. As such, these results reflect a directional impact, rather than a complete fiscal impact estimate of the FFS PDL on the ACO pharmacy experience. We note this as a directional impact because we expect a continued analysis of the remaining PDL classes would generate additional net cost savings.

In the first phase of this analysis, we included the top 10 therapeutic classes. We applied utilization shifts at the market basket level and applied the following shift assumptions:

- When shifting non-preferred generics to preferred multisource brand drugs (i.e., "brand over generic") we assumed a 97% preferred brand market share
- When shifting the remaining non-preferred products to preferred products within the same market basket we assumed a 90% market share for non-specialty products and a 50% market share for specialty products.
- In certain scenarios we allowed for a default shift override assumptions based on review of FFS distribution and clinical review.

After we applied the shift assumptions outlined above, we calculated the pharmacy encounter gross cost and the federal and supplemental rebates. We calculated the net cost by subtracting the rebates from the gross cost. To model the fiscal impact, we compared the modeled gross and net cost to the original gross and net cost.

Compounds, zero paid claims, 340B, Title XXI, CHIP, IHS, and encounters with a reported TPL amount were excluded from this analysis.

9 Limitations

AMP CAP & OTHER FEDERAL LEGISLATION

Historically, a rebate cap has been in place that prevents state Medicaid programs from collecting rebate amounts that exceed the AMP of a drug. However, that rebate cap is no longer in place effective January 1, 2024 due to provisions in the American Rescue Plan Act of 2021. As such, it is possible for states to collect rebates that are higher than the sale price of certain drugs. While not necessarily a direct correlation to the AMP cap removal, several drugs, including many insulin products, experienced list price reductions or were discontinued. The data used in this analysis reflects a point in time where the AMP cap was in place. The complex effects of the AMP cap removal, including downstream effects, such as list price reductions and product discontinuations, were not taken into consideration for this analysis. Changes in drug gross cost, drug net cost, PDL strategy changes, and changes in supplemental rebates as a direct or indirect impact of the AMP cap removal were not considered in this analysis. In addition to the AMP cap removal, other federal legislation, such as the Inflation Reduction Act (IRA) may have impacts on future drug pricing and rebates and was not accounted for in this analysis.

PHE UNWIND

In response to the COVID-19 pandemic, Congress passed legislation that provided continuous coverage for those enrolled in Medicaid during the federal public health emergency (PHE), which resulted in increased Medicaid enrollment. On May 11, 2023 the COVID-19 PHE was officially expired and states were required to begin the Medicaid redetermination process on April 1, 2023. As a result of the Medicaid redetermination process, it is estimated that millions of people will lose Medicaid coverage across the U.S.[xxix] The data used in this analysis reflects a state of continuous coverage for the Medicaid program and the underlying data may have different utilization and/or acuity patterns than the future state.

COPAY AND DISPENSING FEE LIMITATIONS

DHHS has requirements related to dispensing fees and copays that were not taken into consideration in this analysis. DHHS limits dispensing fees to one every 24 days based on the first 14 characters of a drug's generic product identifier (i.e., GPI-14). Copays are $4.00 and limited to five per month for FFS members, two per month for ACO members' carve-out drugs, and three per month for ACO members' non-carve out drugs.

DHHS also maintains a 90-day mandated drug list that was not considered in the analysis. It is possible that costs were overstated for these drugs in the repricing analysis, as they would be associated with one dispensing fee rather than three dispensing fees for three 30-day scripts.

INDIAN HEALTH SERVICES

The Utah Medicaid State Plan applies to reimbursement for services provided at Indian Health Service (IHS) facilities, Tribal 638 Programs, and Urban Indian facilities (I/T/Us). I/T/Us are reimbursed an all inclusive rate (AIR) which is based on the rates approved by the Office of Management and Budget. I/T/U pharmacy encounters are limited to one per day, per prescriber, per pharmacy.[xxx] There are very limited I/T/U claims in managed care. We excluded I/T/U claims from our analysis.

DHHS FFS PDL

Upon review the DHHS FFS PDL file, we identified anomalies in preferred and non-preferred status in some PDL classes. DHHS provided an updated PDL file which corrected several of these anomalies. During the update process, Change Healthcare experienced a system outage which resulted in DHHS not being able to fully correct the PDL file. We did perform a review for reasonability; however, the results of our analysis are based on the accuracy of the PDL file. In addition, the PDL file used for the analysis was the file effective as of February 2023 and does not account for changes to the PDL that have occurred since February 2023.

10 Conclusion

One of the goals of DHHS' pharmacy division is to develop and implement a cost containment strategy that achieves program savings, streamlines operations, and improves quality of care for members. According to our analysis, a pharmacy benefit carve-out would reduce DHHS expenses by $49.3 million. The reduced expenditures in a pharmacy benefit carve-out scenario are driven by:

- Decreases in expenses related to admin and underwriting gains: In capitation rate development, admin and underwriting gains are included in the calculation based on total expenditures. Under a pharmacy benefit carve-out, the total program expenditure decreases and the ACOs are no longer responsible for administrative costs associated with the pharmacy benefit. As such, the admin and underwriting gain will decrease under a pharmacy benefit carve-out. While these numbers can vary by year, the capitation rate setting typically includes 9% for admin and 2% for underwriting gain, translating to approximately $28.4 million. A pharmacy benefit carve out would require reconsideration of admin expenses related to potential additional staffing needs, additional costs with FFS claims processing vendor, and additional data coordination needs with the ACOs.
- Increase in federal and supplemental rebates: We estimate a pharmacy benefit carve-out would increase federal and supplemental rebates by $55.1 million. Federal rebates are confidential and paid to the state Medicaid program, regardless of if the claim was paid by an ACO or FFS. As such, ACOs may not consider federal rebates when developing their PDL. Similarly, states are able to maximize supplemental rebates with a single PDL. If the pharmacy benefit is managed under FFS, the FFS PDL will apply to all pharmacy claims and DHHS will be able to maximize rebates, driving utilization to the lowest net cost products. Note the ACOs would no longer collect ACO market share rebates; therefore, the capitation rates would no longer be reduced by this amount, which was estimated at $11.4 million in our analysis.
- Currently, over 50% of the total pharmacy POS expenditures reside in the FFS Medicaid program due to certain therapeutic classes and drugs that are carved out from ACO coverage and included as part of the FFS benefit. This indicates that the FFS program has existing staffing to manage a pharmacy benefit, as well as the necessary infrastructure to coordinate and exchange data with the ACOs.

The results of the pharmacy benefit carve-out analysis may differ from other state's pharmacy benefit carve-out analyses. One of the primary reasons for this difference is due to the lack of premium tax for health maintenance organizations in Utah. In some states the premium tax is a source of revenue for the Medicaid program. Premium tax

is built into capitation rates, which is a combination of both state and Federal funds based on a state's FMAP. However, when the ACOs pay the premium tax to the state, the state does not share a portion of that with the federal government and as such, the premium tax is a source of revenue for the state. Typically, if dollars are removed from the capitation rate due to a pharmacy benefit carve-out, then the state would lose out on a portion of that premium tax revenue. For this reason, a pharmacy benefit carve-out may increases costs for states that have a premium tax, discouraging states from carving out their pharmacy benefit. However, the loss of premium tax revenue due to a pharmacy benefit carve-out is not applicable to Utah Medicaid.

11 Next Steps

The State may achieve their stated objectives if they elect to change the existing pharmacy delivery model to one discussed in this paper. Many states over the past decade have made these types of decisions, but we caution that there are many operational and clinical aspects that should be considered in addition to the financial impacts when making these types of systematic changes. We provide the following delivery model evaluation framework as a guide to support the State's decision in how to evaluate each option and compare to how it will meet the State's objectives.

Deciding which model is the best fit for DHHS, after answering the following key questions:

- Who takes the risk for the program (is the funding Carved-in or Carved-out)
- Who delivers the care of the benefit
- The intersection of which model produces the required program goals the State wishes to achieve

Figure 27 provides a framework for the pharmacy program service delivery models as they relate to the three key decision points.

FIGURE 27: PHARMACY PROGRAM SERVICE DELIVERY MODEL EVALUATION FRAMEWORK

	EXISTING MODEL	REIMBURSEMENT MANDATE	PDL MANDATE	ACO SINGLE PBM	PAHP SINGLE PBM	CARVE-OUT
Plan Design and Payment Mechanism						
Pharmacy Reimbursement Methodology	ACOs	DHHS	ACOs	DHHS	DHHS	DHHS
Drug Formulary/PDL	ACOs	ACOs	DHHS	DHHS	DHHS	DHHS
Financial Risk						
ACOs	$ $ $	$ $ $	$ $ $	$ $ $		
State	$ $	$ $	$ $	$$	$$$	$$$
DHHS Goals and Objectives						
Cost containment / program savings		+	+ +	+ +	+ + +	+ + +
Streamlined operations				+	+ +	+ + +
Fair and transparent pharmacy reimbursement		+ +		+ + +	+ + +	+ + +
Uniform pharmacy benefit and access for members			+	+ +	+ +	+ + +
Ensure program integrity of the Medicaid program		+	+	+ +	+ +	+ + +

Note: Symbol of + illustrates the level to which the pharmacy program delivery model influences meeting the listed goal and objective. Greater strength to achieve DHHS goals and objectives.

Answering the three questions above, DHHS must also consider the impact to clinical, operational, and administrative aspects of these proposed program changes. The following list of additional considerations must be tailored specific to which of the operational structures is chosen to implement the pharmacy benefit program on behalf of the State.

These additional considerations include:

Clinical Considerations:

- Prior Authorizations and other clinical criteria
- State staffing resources to administer the clinical criteria of the program

Operational and Administrative Considerations:

- Coordination of Care Assessment
- Resource Assessment/Allocation
- Help Desk/Call Center

Additional Cost Considerations:

- Other potential costs or cost-savings, such as Indian Health Service (IHS) claims, Medicare coverage, premium savings, etc.
- Contract Assessment and Review
- 340B Drug Pricing Program
- Medical Specialty/Physician Administered

Continued analysis and evaluation of all considerations in changing program including:

- Updated analysis with current data
- Potential member disruption and alignment of the two programs

Stakeholder feedback and considerations: Pharmacies, ACOs, PBMs, and State

- Incorporation of feedback into decision-making
- Developing a flexible framework (or system) for continued analysis, stakeholder feedback and evaluation of the proposed changes from now through implementation, go-live, and post-implementation to ensure no unforeseen issues arise.
- DHHS should stay in open communication with all stakeholders and request full cooperation and transparency from all of its partnership and vendors who deliver care on behalf of DHHS.
- DHHS should gain the necessary controls, audits, and transparency to ensure all program changes are incorporated correctly and that all stakeholders are operating within the specifications of the program goals

12 Caveats and Limitations

The services provided for this project were performed under the contract signed between Milliman and the Utah Department of Health and Human Services (DHHS). The information contained in this correspondence has been prepared for DHHS and its consultants and advisors. This letter may not be distributed to any other party without the prior consent of Milliman. It is our understanding that a copy of this report will be shared with each ACO participating in the Utah ACO program. To the extent that the information contained in this correspondence is provided to any approved third parties, the correspondence should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented. Milliman recommends any recipient of the report be aided by its own actuary, pharmacist, or other qualified professional when reviewing the Milliman work product.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for the DHHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the information presented. The authors of this report have extensive experience providing consulting, analytics, and cost assessments related to management of the pharmacy benefit across multiple State Medicaid programs. The authors have experience in managed care capitation rate development, as well as providing fiscal impact, operational support and implementation of single PDL, single PBM, and other pharmacy programmatic and policy changes.

In preparing our results, we relied upon information available from various sources including: pharmacy claims data, PBM contracts, from all managed care plans, as provided by their respective PBMs. Public and internal resources including: Medi-Span Master Drug Data Base (MDDB) v2.5, National Council for Prescription Drug Programs (NCPDP) dataQ™ Pharmacy Files, DHHS provided to Milliman State Maximum Allowable Cost (SMAC) files, National Average Drug Acquisition Cost (NADAC) files, and several other data files. We did not audit or independently verify any of the information furnished, except that we did review the data for reasonableness and consistency. To the extent that any of the data or other information relied on was incorrect or inaccurate, the results of our analysis could be materially affected.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

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