Medicaid Managed Care Reform

States must reform their Medicaid managed care prescription drug benefits to protect Medicaid beneficiaries, taxpayers, and local community pharmacy businesses. Too much control over the Medicaid drug benefit has been ceded to managed care organizations (MCOs) and their pharmacy benefit managers (PBMs), who have been found to "employ controversial utilization and management tools to generate revenue for themselves in a way that is detrimental to health plan sponsors, patients, and pharmacies."

MCOs and PBMs work for their own best interests, instead of the beneficiaries' or taxpayers' best interests. They engage in spread pricing, which "is inflating prescription drug costs that are borne by beneficiaries and by taxpayers." In Ohio and Kentucky, spread pricing allowed PBMs to pocket $224.8 million and $123.5 million respectively in one year. They create drug formularies and negotiate rebates that lead to the greatest value for themselves, instead of the state, leading one state to unnecessarily pay $605 million to its MCOs and PBMs over a four-year period. State investigations into MCO and PBM practices have led one MCO to set aside $1.1 billion to settle lawsuits alleging mismanagement of public funds paid to administer the Medicaid managed care prescription drug benefit.

The solution: Increase PBM Transparency/Accountability and Ensure State Oversight of Medicaid prescription drug benefits

Carve pharmacy benefits out of the Medicaid managed care program and administer the benefits through the fee-for-service program

California, Missouri, North Dakota, Tennessee, West Virginia, and Wisconsin have carved their pharmacy benefits out of the Medicaid managed care program, and Nevada plans to do the same for fiscal year 2023. This moved helped West Virginia save over $54.4 million and North Dakota save $17 million in Medicaid spending in one year. by carving its Medicaid pharmacy benefits out of the managed care program. California estimates that its carve out will save at least $150 million a year.

Require MCOs and PBMs to reimburse at the transparent fee-for-service rates

Fee-for-service Medicaid programs reimbursement rates are transparent and evidence-based. Recognizing the value to taxpayers of requiring transparent reimbursements in their Medicaid managed care programs, Iowa, Kansas, Kentucky, Louisiana, Mississippi, Arkansas, and North Carolina require MCOs and PBMs to reimburse pharmacies at the same rates established under the fee-for-service program. If such transparent reimbursement methodologies were adopted nationwide, federal Medicaid spending would drop by almost $1 billion over 10 years.

Increasing regulatory oversight over PBMs in the Medicaid managed care program

Some states have passed legislation giving Medicaid officials greater oversight over the PBM Medicaid managed care contracts.

- Single PBM: Kentucky and Ohio have decided to contract with a single PBM to administer their Medicaid managed care prescription drug benefits, giving the states greater authority to oversee the administration of those benefits.
- Single PDL: adopting a single preferred drug list (PDL) would ensure that MCOs and their PBMs establish formularies that create the most value for taxpayers.
- Pass-through pricing model: Arkansas, Georgia, Kentucky, Louisiana, Maryland, New Hampshire, New York, Ohio, Pennsylvania, and Virginia do not allow MCOs or PBMs to engage in the costly practice of spread pricing.

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