According to a study conducted by the Kaiser Commission on Medicaid and the Uninsured, across all 50 states, only three (Alaska, New Hampshire, and Wyoming) have no form of managed care operating within their Medicaid system. In addition, as of June 2009, 71.7% of Medicaid beneficiaries were to some degree involved in managed care. However, this statistic is somewhat misleading when one looks at the individual state coverage because many of these are not full-risk managed care programs. Many states claim to provide an MCO when in fact they are offering a primary care case management (PCCM) program, administrative service organization (ASO) or similar partial risk option programs. In spite of the growth in the use of managed care and its promotion as a cost containment strategy, health care costs continue to rise and Medicaid budgets continue to skyrocket. If managed care is utilized, then policy and decision makers must find more effective ways to monitor and administer these services.

If the state decides to contract the management of the pharmacy program to a private sector entity or entities, there are best practices that should be followed—the most valuable are set out in this document. It is essential that the state maintain program oversight and pharmacy program integration with other health care services. The state must also ensure that protections are set in place to provide for fair treatment of pharmacy. Failure to do so will jeopardize pharmacy provider retention, overall health outcomes, cost, and safety.

The following states found that the use of managed care in their Medicaid pharmacy program did NOT result in discernable cost savings or improved coordination of care.

### Florida 2011

Insufficient evidence to verify claims of potential cost savings and also very serious concerns with regard to patient access to care, particularly with turnover among private plans that disrupt sustainable patient-provider relationships.

*(Georgetown University Health Policy Institute study, hpi.georgetown.edu/floridamedicaid)*

### Missouri 2009

- No significant difference in access to, or quality of, care between fee-for-service and managed care.
- Pharmacy is frequently, if not always, best delivered through a consolidated, **state controlled** program.
- Regardless of the degree of risk a state decides to offset to a vendor, and regardless of the method of delivering services, it is clear that careful consideration should be given to pharmacy services. Pharmacy is frequently, if not always, best delivered through a consolidated, **state controlled** program. This provides the state with the most control, the most integrated benefit and the most cost-effective benefit.

*(Alicia Smith and Associates, Missouri Oversight Committee Presentation, October 27, 2009)*

### Oklahoma 2009

- States with *in-house* managed care programs could produce results equal to the MCOs if Medicaid agencies have

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**Arkansas 2001-2009**

- Even with successful implementation of new programs and notable decreases in emergency room visits, the state observed increased costs per participant and increased overall caseloads.

**Contracting Principles for Medicaid MCOs and PBMs**

When a state chooses to outsource its pharmacy benefit programs to MCOs the following are best practices that should be in place in contracts between the PBM/pharmacy to provide a fair and reasonable marketplace for pharmacy.
Proper provider reimbursement

As was stated in previous sections of this document, proper reimbursement is vital to ensuring provider retention and fair and reasonable provider compensation. Currently there are vast discrepancies between pharmacy reimbursement and the true cost of the services provided. Therefore, it is essential that both reimbursement and pharmacy dispensing fees are reasonable and accurately reflect the true costs of the product as well as the operation. A 2011 cost of dispensing study conducted by the Texas Health and Human Services Commission found that it costs a pharmacy $11.27 to dispense a medication in Texas. This does not include the cost of the drug but simply incorporates administrative costs such as company overhead and packaging. Currently in most cases, dispensing fees do not come close to reflecting the cost of pharmacy operations. States must reasonably compensate a pharmacy for the services they provide as well as monitor these reimbursements if contracting with managed care organizations if they expect to have adequate pharmacist participation and corresponding beneficiary access to services.

Fair and timely pharmacy reimbursement standards

PBMs and MCOs should outline the requirements for prompt pay/reimbursement to a pharmacy. Generally, pharmacies should expect to be reimbursed no less than biweekly. For example, section 162 of Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires the sponsors to pay all clean claims submitted by network retail pharmacies within 14 days for electronic claims.

An ideal program would state that this time begins to toll once a complete and correct claim is transmitted and accepted by the payer. Detail should be provided indicating how quickly claims are returned to the provider for any corrections and how quickly corrections need to be resubmitted. If this is not defined, abusive practices may occur whereby a pharmacy enters into a period of comment and correction while not being reimbursed.

If a pharmacy does not receive reimbursement within the contractually agreed upon “prompt pay” time frame, interest should immediately begin to accrue at that time and continue to do so until payment is made. The rate of interest should be established in contractual terms between the pharmacy and PBM/MCO.

Consistent and protected co-pays

Generally, a federally approved State Plan Amendment (SPA) sets out the terms and conditions of implementing the Medicaid program within the given state and all co-pays should be consistent with this established framework. For the average Medicaid recipient, the co-pay must not exceed a certain amount as determined by the Centers for Medicare and Medicaid Services. Currently, $3 is the maximum co-pay that CMS has approved and it is important that the co-pay relationship to the total reimbursement amount be clearly stipulated. If it is a true co-pay, it will be a deduction from the aggregate reimbursement submitted consisting of the aggregate of the cost of the medication and the dispensing fee.

Generally, CMS has held that the failure to pay co-pays by the recipient cannot be the sole basis for withholding services. This is a measure to protect health care accessibility for the truly needy population that cannot afford such co-pays. Legitimate reasons for being unable to pay co-pays do exist and pharmacists understand this. However, states should implement measures to protect pharmacy against fraudulent activities regarding co-pays.

Transparent “any willing provider” provisions

Many states have some type of “any willing provider” statute guaranteeing a provider the opportunity to be offered a contract to participate in a third-party program. This is applicable as the provider willingly accepts all of the terms and conditions of the contract that the MCO makes available to any other like provider in the state. States should only contract with MCOs that ensure that there will be no variations in the terms and conditions applicable to providers.

In some cases, smaller pharmacy operations are at a contractual disadvantage in
comparison to larger chain operations and PBM mail order facilities. This is due to the size of the pharmacy operations in gross sales, physical facility size, and the volume (in dollars or prescription volume) that the pharmacy expects to provide for the MCO. This does not provide a level playing field, especially for independent pharmacies that compete with these corporate PBM giants or large chains. If “any willing provider” language is incorporated into a program, then it must be fair and transparent for all parties.

Required PBM disclosures to the state Medicaid agency
Properly contractually implemented transparency measures will result in MCOs and PBMs passing the proper cost savings measures through to plans and the state itself. At a minimum, PBMs should be required to disclose to the MCO and to the state the same information that PBMs that will serve the State Health Insurance Exchanges must disclose to the U.S. Health and Human Services Secretary and the health plans under the Affordable Care Act (ACA). Under Title VI Section 6005 of PPACA, PBMs that serve the health plans in the exchange will be required to confidentially disclose to the Secretary and the plans information on:

• The percent of all prescriptions provided through retail pharmacies compared to mail order and the generic dispensing rate and substitution rates of each;

• The aggregate amount and types of rebates, discounts and price concessions that the PBM negotiates on behalf of the plan and the aggregate amount of these passed on to the plan sponsor;

• The average aggregate difference between the amount the plan pays the PBM and the amount that the PBM pays the retail and mail order pharmacy.

The disclosure of this data will enable the state to determine whether or not the PBM is in fact doing its job by acting in the best interests of the state and maximizing cost savings opportunities.

Fair and uniform pharmacy auditing standards
Any contract offered by an MCO or PBM payer to a pharmacy should have set out within the contract clear definition of the requirements of any auditing process that is anticipated to occur to enforce the individual contract. Also set out should be the requirements between the individual contracting third-party (MCO or PBM) and the Medicaid agency. Specifically, it should be noted in the contract if any of the terms and conditions associated with the primary contract is relevant to this secondary provider contract. In other words, it should be clearly set out who the auditing agency will be to alleviate any confusion and to assure that the pharmacy will not be audited by multiple parties under the same criteria.

“Fair audit” provisions should be required to be included in contracts between the MCO/PBM and the pharmacy and at a minimum should include the following provisions:

• The entity conducting the audit shall not use extrapolation in calculating the recoupments or penalties for the audits.

• Interest may not accrue during the audit period.

• Clerical or record-keeping errors may not be the basis for the recoupment of funds by the PBM—unless the PBM can provide proof of intent to commit fraud or such error results in actual financial harm to the PBM, the state or a consumer.

• Any legal prescription that complies with the State Board of Pharmacy requirements may be used to validate claims in connection with prescriptions, refills or changes in prescriptions.

In addition, contracts between the PBM and the pharmacy should also include the methodology and resources utilized for maximum allowable cost (MAC) pricing as well include details on how often these files will be updated and how pharmacies will be notified of such changes. The PBM should also include provisions in which they agree to pay pharmacies promptly for clean claims and not require that a pharmacy or pharmacist participate in a pharmacy network managed by such PBM as a condition for the pharmacy to participate in another network managed by such PBM.