Since the early 1980s, a growing national trend has been for states to use managed care organizations (MCOs) to deliver and finance care for Medicaid beneficiaries. With the implementation of health care reform this trend is expected to substantially increase. The stated goal of this approach is to increase access to care, improve quality, and reduce overall cost. However, as some Medicaid directors agree, this result is not easily achieved. If not implemented cautiously with the appropriate level of oversight, an MCO program can actually result in higher overall costs. However, if a state chooses to take this approach, there are certain guidelines and principles that should be implemented to protect valuable pharmacy services.

What Does an MCO Do?
States contract with MCOs to provide a comprehensive package of benefits to Medicaid beneficiaries primarily on a capitation basis (the state pays a per-member-per-month premium). MCOs may be commercial HMOs that also serve persons with employer-sponsored insurance, or they may be Medicaid-only. Each state develops its own MCO standards. Usually these standards include: adherence to specified protocols, member support, requirements to ensure adequate access to care, benchmarks for quality, data collection, and submission requirements. Medicaid MCOs may be licensed by the state, or operate under contract with the Medicaid agency, regardless of licensure.

Snapshot of Medicaid MCOs
(data from 2011 Kaiser Commissions on Medicaid and Uninsured)

- As of June 2009 71.9% of Medicaid beneficiaries were enrolled in some level of managed care.
- Only three states have no form of managed care operating in their state.
- Over two-thirds of states utilizing MCOs in Medicaid report beneficiary access problems
- Sixteen states carve out prescription drug services from their MCO program.
- The Accountable Care Act is causing many states to implement, or consider implementing, “carve ins” of pharmacy benefits to their MCO programs due to perceived cost savings and the new ability to collect Medicaid pharmacy rebates on purchased drugs.

Key Guidelines If Managed Care Is Utilized for Medicaid Pharmacy Services
- Pharmacy providers must be reasonably reimbursed for the services they provide. Reasonable reimbursement must include both drug cost and a dispensing fee. Reimbursement must represent the true cost of the medication and the true cost of dispensing that medication to a beneficiary.
- Medicaid beneficiaries are not required to pay a co-pay if they are truly unable to do so. Reasonable protections must be implemented regarding recoupment of such lost co-pays to protect pharmacies from being forced to absorb this cost.
- All providers must be treated fairly and on an equal basis. If a contract contains “any willing provider” language, than it must treat all providers equally and not base participation criteria on business size or number of patients served.
- Proper transparency must be incorporated into contracts between the MCO and the pharmacy benefit manager (PBM) retained to administer the pharmacy benefit AND contracts between the PBM and participating pharmacies. Properly implemented transparency measures will result in PBMs passing the proper cost savings through to the state.