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Programmatic Assessment of Carve-In and Carve-Out Arrangements for Medicaid Prescription Drugs

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EXECUTIVE SUMMARY

The Lewin Group was engaged to provide a discussion of the programmatic issues involved in the use of a "carve-in" versus a "carve-out"[1] approach for pharmacy benefits within capitated Medicaid managed care programs. The engagement involved drawing upon interviews with various Medicaid managed care organizations (MCOs) and stakeholders, as well as Lewin's previous work in this arena.

The study's key findings are conveyed below.

Carve-in approaches are associated with positive utilization management and patient care practices.

- Carve-in arrangements allow for improved care coordination as pharmaceutical and other medical benefits are managed under one entity versus relying upon communication and data exchange between multiple entities to coordinate an individual's care. Carve-ins also align incentives to effectively address the "total person" from both a clinical and cost perspective.

- MCOs managing pharmacy benefits have the capability to access in-house pharmacy and medical claims data in real time, which is valuable for tailoring specific health interventions to promote improved health outcomes, managing polypharmacy issues, and positively influencing physician prescribing patterns to identify quality and cost issues.

- Pharmacy carve-in arrangements allow MCOs a unique opportunity to closely monitor all prescription drugs that members may be currently taking, which assists with identifying and engaging high utilizers, inappropriate usage, and candidates for disease and case management.

- Pharmacy carve-outs also create a range of operational challenges as Medicaid recipients, providers, MCOs, the state, and its fiscal agent must continually sort through how the various parts of the benefits package are administered. MCO enrollees in a carve-out model, for example, typically need to carry multiple health insurance cards and are often ill-positioned to keep track of which card is needed for a given type of service.

[1] By definition, a carve-out excludes certain services to which Medicaid beneficiaries are entitled from a risk contract between a state Medicaid agency and an MCO. Most often the "carve out" services will be kept out of capitation arrangements and payment for these services to Medicaid managed care enrollees will continue to occur through the traditional fee-for-service (FFS) setting.

I. INTRODUCTION AND BACKGROUND

The Lewin Group was contracted by the Association for Community Affiliated Health Plans (ACAP) to conduct a discussion of the programmatic issues involved in including pharmacy benefits in capitated Medicaid managed care programs versus carving these benefits out.[2]

To address this issue, Lewin interviewed a variety of key stakeholders including Medical Directors and Pharmacy Directors from managed care organizations (MCOs) in both carve-in and carve-out states, as well as representatives who could provide insight into the state Medicaid agency, provider, and pharmacy perspectives.

The importance of pharmaceutical drugs to the overall health of the US population has steadily increased over the past several decades, with the Medicaid population being no exception. Prescription drugs have moved from being a peripheral component of a health benefits package to being one of the highest-cost services (in terms of per capita expenditures), as medications continue to play a central role in the treatment of most health conditions.

Given this, the notion of "carving out" prescription drugs from a coordinated care program is fundamentally problematic. Medications are not a small, tangential component of health care – separating medications from an integrated care program seems almost akin to carving out physician services or any other central component of health care delivery and treatment. However, in the Medicaid arena there are special financing rules with regard to prescription drug rebates that make a pharmacy carve-out an option worthy of consideration in many state Medicaid managed care programs. While most of the 42 states with Medicaid capitation programs include (or "carve in") pharmacy, roughly 10 states fully utilize a carve-out approach.[3]

Overview of Carve-Out Arrangements in Medicaid Managed Care

Carve-out arrangements in capitated Medicaid managed care programs are fairly common for behavioral health, dental, transportation and pharmacy benefits. By definition, a carve-out excludes certain services to which Medicaid beneficiaries are entitled from a risk contract between a state Medicaid agency and an MCO. Most often the "carve out" services will be kept out of capitation arrangements and payment for these services to Medicaid managed care enrollees will continue to occur through the traditional fee-for-service (FFS) setting. However, in some instances a state Medicaid agency will contract with a separate entity to conduct management of the carve-out service(s). For example, some states (e.g., New Mexico) carve behavioral health services out of the Medicaid MCO program, but contract separately with a behavioral health management organization to administer behavioral health benefits for

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[2] ACAP's membership includes 34 safety net not-for-profit health plans. Collective Medicaid and Medicare enrollment across these MCOs exceeds more than 4 million covered lives.

[3] The source of these statistics is Lewin's project work in the Medicaid managed care arena and CMS MSIS data.

Medicaid MCO enrollees. Similarly, several states contract with a pharmacy benefits manager (PBM) entity to assist in managing Medicaid pharmacy services.

For a variety of reasons, states typically include most health benefits in their capitated programs. The greater the number of services included (or "carved in"), the better the program design to support a focus on the "whole person", with care management activities for a given enrollee coordinated by a single MCO entity. Conversely, carve-outs create "cost buckets" and can create undesired incentives as various parties strive to minimize their own costs, but not necessarily *overall* costs. Carve-out arrangements parse various benefits out to multiple entities; it is challenging for these entities to communicate and exchange data with one another to effectively coordinate care for individuals. An additional economic consideration is that the more services that are removed from the MCO capitation, the smaller the health plans' revenue base and the more difficult it is for these organizations to operate viably. Carve-outs can also create a range of operational challenges as Medicaid recipients, providers, MCOs, the state, and its fiscal agent must continually sort through how the various parts of the benefits package are administered.

Notwithstanding the general advantages of a carve-in model, carve-outs exist for several reasons. First and foremost, the package of services that is carved in (or out) typically represents a political outcome in the design and evolution of a Medicaid MCO program. A wide array of technical issues and stakeholder inputs can influence this process. In some cases where dental and/or behavioral health services have been carved out, MCOs have been deemed less able to create sufficient delivery networks as compared with the underlying Medicaid FFS or carve-out vendor programs. In some instances, states have contracted with a specialty vendor, such as a behavioral health organization, viewing such an entity to have a stronger understanding of patient needs and greater available services in a certain clinical area than a "full service" health plan. In other cases, such as non-emergency transportation, MCOs sometimes are not perceived as being able to develop the economic infrastructure needed to administer the benefit.

Carve-outs sometimes also exist due to special Medicaid financial provisions. For example, inpatient hospital services are carved out of one of Texas' capitated Medicaid managed care programs in order to preserve a special hospital financing arrangement that is tied to the FFS payment system. With regard to pharmaceuticals, carve-outs are typically implemented to allow state Medicaid agencies to maximize pharmaceutical company rebates as a result of OBRA '90.[4]

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[4] A key mechanism for curtailing rising prescription drug costs in the Medicaid program came about with the enactment of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90). This legislation established the Medicaid Drug Rebate Program, which ensures that Medicaid programs receive at least the "best price" a drug manufacturer has offered to any payer other than Federal discount programs and state pharmaceutical assistance programs. In exchange for this price, state Medicaid FFS programs must ensure that participating manufacturers' drugs are covered and reimbursable. Pharmaceutical companies must have signed rebate agreements with the Secretary of the Department of Health and Human Services in order for payment to be made for Medicaid-covered outpatient drugs. Drug manufacturers provide quarterly rebates for medications dispensed to state Medicaid recipients. One aspect of the OBRA '90

The remaining sections of this paper cover:

- Issues assessed in the study, including a discussion of our approach to interviewing key stakeholders,
- Discussion of the pros and cons associated with carve-in and carve-out arrangements, and our interview findings with state Medicaid agencies and MCOs operating in carve-in and carve-out states, and
- Key policy implications and recommendations based on our overall findings.

II. ISSUES ASSESSED IN THE STUDY

To assess pharmacy carve-in and carve-out dynamics, Lewin obtained and analyzed data through interviews with both carve-in and carve-out stakeholders.

A goal of our analysis from the outset, and one that influenced our interview and data collection methodology, was to develop a critical mass of region-specific information that included both carve-in and carve-out plan experiences. This allows us to eliminate confounding effects that could skew our data when comparing plan and member data. For the purposes of this study, we chose to use the Northeastern United States as our region of focus, as this region has a significant number of both carve-in and carve-out states. We were able to interview many MCOs in this region. Some of the MCOs interviewed were from carve-in states in other parts of the country.

Programmatic Analyses
For our qualitative analyses, we summarize the key programmatic considerations, related to Medicaid pharmacy carve-in and carve-out arrangements. In addition, Lewin developed interview guides for key stakeholders and scheduled and conducted the interviews. Focusing mainly on ACAP's member MCOs, 15 MCOs were interviewed across seven states. Some additional interviews were conducted with state Medicaid agency staff to obtain additional insight on key points of our study. In all interviews, the person (or plan) offering a specific opinion (or quote) is not disclosed. This was done to encourage candor during the interviews. The interview guides are presented in Appendix A (for carve-in MCOs) and Appendix B (for carve-out MCOs). Some of the key questions addressed included:

- In what ways does the health plan make use of pharmacy data to support and conduct care coordination activities?

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rebate provisions is that the rebates and "best price" provisions apply only to Medicaid FFS prescriptions. Medicaid MCOs responsible for pharmacy costs (through carve-in arrangements) are not eligible to access the large OBRA rebates, nor are states eligible to collect OBRA rebates on medications purchased by Medicaid MCOs.

- How do enrollees, providers and pharmacists benefit from a carve-in versus a carve-out arrangement?

- In what way (and on what timeframe) are pharmacy claims data accessed by MCO staff?

III. FINDINGS

In addition to conducting interviews with key stakeholders, Lewin examined key programmatic considerations associated with Medicaid pharmacy carve-in arrangements. Carve-in arrangements have a unique set of Medicaid programmatic characteristics. For example, they typically allow for greater care coordination because all services are managed by one entity, while carve-out arrangements must rely upon communication and data exchange between multiple entities to coordinate an individual's care.

Pharmaceutical carve-ins are associated with:

- **Higher utilization of lower-cost medications –** Carve-in MCOs rely more heavily on the use of generic drugs to achieve pharmacy cost savings. Lewin data obtained across ten carve-in MCOs shows that, as of 2006, 75% of prescriptions were filled using generic products. In the Medicaid carve-out setting, generic fill rates are much lower. Generic fill rate information in the FFS setting for available states where pharmacy carve-outs exist range from 55% to 63%. Prior Lewin work also shows that where appropriate generic alternatives are not available, MCOs have also demonstrated a strong ability to "direct utilization" towards relatively low-cost brand drugs.[5,6]

- **Increased ability to manage formularies and mix of drugs –** Our interviews with MCOs demonstrated that they have the capacity to monitor formularies more closely and make timely adjustments based upon provider and member feedback, as well as unique local

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[5] "Comparison of Medicaid Pharmacy Costs and Usage between the Fee-for-Service and Capitated Setting," Beronja et al, January 2003; "Analysis of Pharmacy Carve-Out Option for the Arizona Health Care Cost Containment System," Beronja et al, November 2003. An additional, non-published analysis was conducted for Rhode Island's disabled adult population and yielded similar results to the previous two publications.

[6] Lewin also performed analyses of the volume and mix of prescription drugs *in the same health plan* under both a carve-in and carve-out environment. This comparison is possible as a result of the way that New York structures their pharmacy benefits for children in Child Health Plus (carved-in) and TANF Medicaid (carved-out). For both demographic groups assessed (Children Age 1-5; Children Age 6-17), the generic fill rate was typically about four percentage points higher for Child Health Plus (the carve-in) than for Medicaid (where the carve-out exists). Additionally, the prescription usage rate was considerably (often more than 20%) higher for Medicaid than for Child Health Plus. Although this data was only available from one MCO, and is thus a "sample of one," it demonstrates lower usage and a less costly mix in the carve-in setting than what occurs in the carve-out setting. This is a strong comparison in that we are analyzing the same MCO in the same state, and the only difference is SCHIP vs. Medicaid (and their associated pharmacy benefits design).

needs within communities. The MCO formulary content can be driven by clinical and economic dynamics, devoid of the political pressures that can be brought to bear on a state Medicaid formulary. In addition, most MCOs do not delegate formulary changes to their respective PBMs.[7] These activities clearly impact the drug mix shifts referenced in the previous paragraph.

- **Capability to access in-house data** – MCOs managing the Medicaid pharmaceutical benefit have on-line access to pharmacy and medical claims data and therefore have the capability to examine data in real time and determine all prescription medications that a member is currently taking. While carve-in MCOs take varying approaches to drawing upon this pharmacy data, real-time access to this information is often invaluable for tailoring specific health interventions to promote improved health outcomes, for managing members who may be at risk for polypharmacy issues and adverse drug interactions, and for positively influencing physician prescribing patterns to identify issues relating quality and cost.

- **Improvement of care coordination** – Carve-in arrangements allow for the comprehensive management of care across both medical and pharmaceutical benefits and helps to coordinate medical information exchange across various provider types. It also provides an incentive for MCOs to practice comprehensive care coordination as they are financially at risk for a member's health. Carve-in MCOs have a unique opportunity to closely monitor all prescription drugs that members may be currently taking, and can more readily target high utilizers and potential needs for disease and case management. Allowing for and facilitating communication regarding both medical and pharmacy treatment is a key advantage provided by carve-in plans, as opposed to the "silo approach" associated with carve-out plans, where caregivers often operate without the benefit of knowledge regarding patients' pharmaceutical history and adherence. Carve-out approaches "de-integrate" the program back towards the unmanaged fee-for-service setting.

Overall, a carved-in pharmaceutical arrangement allows for integrated management of a person by maintaining all aspects of care under one entity.

Interview Findings

Lewin also interviewed various stakeholders to gather feedback on the advantages and disadvantages of pharmaceutical carve-in and carve-out arrangements, use and timeliness of pharmacy data, and ways in which pharmacy data is used for various quality improvement initiatives and care coordination activities. Interviews were conducted via conference call, and carve-in MCOs were asked to submit a supplemental data request. Key findings are summarized below.

[7] It is important to note that not all MCOs utilize an external PBM contractor. Most Pennsylvania Medicaid MCOs, for example, administer the prescription drug benefit "in house."

Carve-In MCOs Rely on Timely Pharmaceutical Data to Improve and Manage Care

Medicaid MCOs responsible for the pharmacy benefit indicated their reliance on real time pharmacy data aligned with other health claims data to create tailored and targeted interventions for members. Key staff within MCOs who regularly rely upon real time pharmacy claims data include pharmacy managers, medical directors, care managers, Pharmacy and Therapeutic (P&T) Committee Members, staff pharmacists, member services Representatives, utilization management and quality departments, and Information Technology (IT) staff.

Interviewees stated that they use this data to create both proactive and preventive interventions around various issues such as:

- Preventing potential drug interactions and polypharmacy (unwanted duplication of drugs) concerns,
- Identifying inappropriate use of antibiotics,
- Monitoring controlled substance usage,
- Identifying persons to contact in case of a drug recall,
- Promptly identifying newly pregnant women via use of prenatal vitamins,
- Monitoring asthma through control versus rescue inhaler medications, and
- Preventing over-utilization of ER services by "drug seekers."

> *"Online access to pharmacy claims data allows for immediate evaluation of a member's potential issues and subsequent triage to the appropriate complementary functional area. Not having this access would mean taking a step back in terms of care management."- MCO Interviewee*

Pharmacy data is also used for member education and outreach opportunities such as ensuring that non-compliant members understand the importance of picking up prescriptions in a timely manner and refilling maintenance medications on a regular basis. Education opportunities present themselves around disease management for chronic conditions such as asthma and diabetes. Several MCOs indicated that physicians are also involved in these member education and outreach efforts since they are in contact with members most frequently.

> *"Our plan's experience has been that the volume/mix of pharmaceuticals varies based on the geographic location of both providers and members. Managing the benefit in-house allows us to customize coverage decisions, member outreach, and provider education based on the experience of our own population." – MCO Interviewee*

Efforts in provider education and member outreach have provided some MCOs with valuable feedback for maintaining formularies that reflect the needs of members and the practicing habits of physicians. For example, one MCO stated that every medical community treats medical diseases differently and this demands a flexible formulary. To help meet this need, in-house P&T committees have the capacity to alter key pharmacy benefits

such as formularies or prior authorization guidelines on a monthly basis, while carve-out arrangements rely upon state Medicaid agencies and may experience lengthier delays in decision-making and may lack the capability to easily alter program specifics based on enrollees' needs.

MCOs that experience a carve-out for mental and behavioral health services in addition to pharmacy carve-outs expressed some frustrations with the lack of pharmacy claims data given the importance of prescription medications in treating individuals with behavioral health needs. These MCOs express concern at not being able to treat members "as a whole" and emphasized the importance of coordinating care across all providers and treatment options if optimal health is to be attained.

Regarding members' satisfaction with pharmacy benefits and their coordination in carve-in and carve-out environments, no specific research was found in peer-reviewed journals. Therefore, no data, other than that obtained through our interviews with MCOs, is available that addresses member satisfaction regarding the management of their pharmacy benefits. An advantage of the carve-in approach is that members have a single insurance card for both medical and pharmacy benefits. Conversely, enrollees in a carve-in may have a more limited pharmacy network and may experience greater difficulty in obtaining the drug of *their* choice (given MCO efforts to alter the mix and volume of prescriptions relative to an unmanaged setting).[8]

Carve-Out MCOs Manage Member Care Using Alternate Data Sources

Several carve-out MCO interviewees expressed concern with the lack of pharmacy data available to them in a timely manner. These MCOs were not able to view claims data in real time to determine which members are on what medications and at what time. The MCOs also faced a substantial lag time in creating rapid response interventions, with one MCO reporting, for example, that March pharmacy data is not received until May. Despite the timing issues, the majority of carve-out MCO interviewees stated that the data they do receive when it arrives is adequate for managing member care and did not seem to desire or express a need for real time claims data.

Some carve-out MCO interviewees wanted to receive additional data regarding the amounts their states pay for aggregate member medication costs, as this would assist with MCO predictive risk modeling, in addition to information regarding the prescribing physician. These MCOs report that the pharmacy data received is limited to the member identifier, filling pharmacy and prescribed drug.

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[8] The benefit management ability of the MCO is a key overall advantage of the carve-in approach. However, some patients are disappointed when they have a specific drug product in mind and find that only a substitute (e.g., generic) can be filled.

Integration of Data Systems Is Critical to Both Carve-in and Carve-out MCOs

Proper and efficient integration of an MCO's data systems with those of its PBM (carve-in) or the state's Medicaid information systems (carve-out) is critical to ensuring that data is used to the fullest extent in coordinating and providing the best care possible to members.

Carve-in MCOs that manage pharmacy benefits in-house, without the aid of a PBM, report accessing pharmacy claims data in real time and often receive claims data the same day a member receives his or her medication. Other carve-in MCOs that contract with a PBM report that interlinking systems allow MCO and PBM staff to run reports which draw upon real time data. One MCO reported weekly downloads of pharmacy claims data from its PBM with an option for MCO staff to walk over (co-located on same floor as PBM staff) or call for real time information needs.

> *"Having all of the Rx information and staff in-house, we experience no roadblocks, such as, "I need to call the other company to get the information."" – MCO Interviewee*

In one case, an MCO had never been able to utilize pharmacy data from the state due to poor system linkages and reported that this had an adverse effect on the plan's ability to tell which members are even taking needed medications. The development of interventions has also been adversely affected. This situation seemed to be an exception -- most carve-out MCOs reported receiving some pharmacy data on a regular basis from the state.

In further discussing data, carve-in MCOs also reported concern over data transferability if pharmaceutical benefits were ever to be carved out by the state. They indicated that much planning would need to take place regarding file transfers and usable formats for data to be valuable and easily manipulated. Associated costs of ensuring system compatibility were also a concern.

> *"MCOs have leaner formularies, more prior authorization requirements, and more insistence on using multi-source generic products. Physicians prefer carve-outs." - MCO Interviewee*

Perspectives of Pharmacists and Providers

Carve-in and carve-out arrangements seem to impact members more directly than pharmacists and providers. However pharmacists and providers play a key role in both programmatic scenarios.

Carve-in MCOs report that outreach and education efforts to physicians and pharmacists have generated valuable opportunities for gathering feedback on needed formulary changes based on unique member and community needs. These MCOs also feel better equipped to make formulary changes in a timely manner. It was noted that states often have difficulty incorporating formulary updates quickly in the traditional Medicaid FFS setting (including carve-outs).

Physicians, however, may experience challenges associated with carve-in arrangements. Several MCOs indicated that physicians do not always understand and appreciate the nuances of multiple formularies associated with a carve-in arrangement and that having one Medicaid formulary (as with a carve-out arrangement) may make it easier for physicians to prescribe

medications to patients. Regardless as to whether there is one formulary for Medicaid statewide, or five different Medicaid MCO formularies (under a carve-in), it was noted that most physician offices must deal with a large number of different pharmacy benefits programs across their entire patient base.

Another potential challenge facing physicians with a carve-in arrangement stems from the strict utilization controls and varying prior authorization processes across MCOs. If controls are very strict and limit prescribing patterns, they may deter some physicians from participating in carve-in MCO networks, as well as create an additional administrative burden for physicians who do participate.

With regard to physician concerns with MCO formularies, a Medicaid director indicated that states are well-positioned to establish ground rules that limit the formulary disruption that could occur under the carve-in model. For example, states can require that MCOs not change their formulary more than "x" times during a year, and/or that drugs not be removed from the formulary without a period of "y" months' advance notification/education to the physician network.

Pharmacists' information systems are typically more accustomed (relative to physician offices) to handling multiple insurers and prescription drug benefit designs. Physicians, while typically behind pharmacists in this regard, are improving their ability to work with different MCOs' benefit arrangements.[9]

Several carve-in and carve-out MCOs also stated their concerns over the influence pharmaceutical representatives have over physician prescribing patterns. Nexium and Prilosec were continually cited as a prime example of where both drugs therapeutically perform the same, but the cost associated with each are extremely different and prescribing patterns seem to be driven by the pharmaceutical industry's marketing practices.

Capitation Rate Adequacy

While MCOs predominantly prefer the pharmacy carve-in model to the carve-out approach, this preference carries the condition that the state capitation payment for the pharmacy component be adequate. If the capitation payment rate for pharmacy services under a carve-in is not sufficient to cover MCOs' net costs of administering pharmacy directly (both the costs of prescriptions themselves and the administrative costs associated with managing the pharmacy benefit), the carve-in approach will not have long-term viability in that state.

[9] For specialist physicians who administer office-based medications such as injectible drugs, one interviewee noted that carve-outs complicate physicians' administrative efforts (e.g., the office needs to bill two separate entities).

IV. POLICY IMPLICATIONS AND RECOMMENDATIONS

Whether to use the pharmacy carve-in or pharmacy carve-out approach in a capitated Medicaid managed care program is an important design issue that can have a significant impact on a wide array of stakeholders. Policy issues surrounding this debate exist at both the state and Federal levels and are described below.

State Policy Dynamics

Currently, states face a difficult decision with regard to the handling of pharmacy benefits in their Medicaid managed care programs. Financially, the carve-in approach is likely to yield substantially better management of the pharmacy benefit regarding the volume and mix of drugs used. A wide array of programmatic and care coordination issues also favor the carve-in approach, as the carve-out approach clearly compromises the integrated care management model that the MCOs provide. The carve-in model supports a focus on the "whole person", whereas under carve-outs various parties work to minimize only their own costs (but not *overall* costs). Carve-out arrangements also substantially reduce the MCOs' revenue base and make it more difficult to operate viably. Carve-outs can also create operational challenges as Medicaid recipients, providers, MCOs, the state, and its fiscal agent continually sort through how the various parts of the benefits package are administered.

The rebate advantages of the carve-out option are, however, important to consider. States need to consider whether the net pharmacy costs after rebates will be sufficiently low to justify foregoing the qualitative advantages of the carve-in approach.[10]

The logical policy recommendation resulting from this study at the state level is for states to carefully assess their own situation, financially as well as programmatically.[11] Because the carve-in approach clearly offers stronger care coordination opportunities and strongly motivates MCOs to effectively manage overall patient costs, we would suggest that there need to be clear and compelling financial savings from the carve-out approach for states to pursue this option.

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[10] If possible, the financial assessment should also consider the impact on *total* costs (medical and pharmacy), given the potential carve-out incentive for organizations to act in a cost-effective manner only for services where they are at risk.

[11] One possible "middle ground" option for states is to implement a partial pharmacy carve-out, carving out certain classes of medications (or certain specific products). While roughly ten states have taken this approach, this paper has dealt primarily with the broad issues surrounding an overall carve-in or carve-out. The pros and cons of carving out a specific drug or class of drug will generally be similar to those of adopting an overall carve-in or carve-out strategy.

Federal Policy Dynamics

Perhaps an obvious issue confronting the Federal policy-making community is "why not establish a means for the best of both worlds to occur?" Based on the information gathered for this report, carve-in arrangements provide better opportunities for care coordination and management of patient costs and care. However, because states may be influenced by increasing rebates to move away from a carve-in arrangement to carve drugs out, policymakers seeking to preserve integrated care for Medicaid managed care enrollees should consider extending the drug rebate to Medicaid MCOs. The optimal financial situation, by far, is to combine the MCOs' benefit management expertise with the rebates that currently can be accessed only in the FFS Medicaid setting. A change in Federal policy that would allow MCOs the same rebates for Medicaid prescriptions as Medicaid FFS receives would likely yield more than a 20% savings in net pharmacy costs (relative to either a carve-in or carve-out approach without the regulatory change) for Medicaid managed care enrollees.[12] Such a change would also preserve the care management advantages of the carve-in and avoid the drawbacks associated with the carve-out approach.

This change in Federal policy -- treating a Medicaid prescription equally from a rebate perspective regardless as to whether it occurs through an MCO or through FFS -- is compelling.[13] Such a change would preserve the benefits of carve-in arrangements and would yield savings to all states that have capitated Medicaid managed care programs. Those with carve-ins would realize large savings through the vastly larger rebates that would occur. Those states currently carving out pharmacy would realize savings through the lower-cost volume and mix of medications that occurs in the MCO setting.

[12] CMS actuaries have scored this proposal as saving the Federal Government $2.2 billion over five years. Additionally, CBO has scored the proposal as saving at least $1.7 billion over five years.

[13] This policy change is included in two pieces of currently proposed Federal legislation – Senate Bill #1589 (sponsored by Senator Bingaman) and House Bill #3041 (sponsored by Representative Stupak).

V. CONCLUSION

Most states with capitated Medicaid managed care programs use a pharmacy carve-in approach. This report has documented a vast array of programmatic advantages in favor of using the carve-in approach. These are delineated more fully in Section III, although a few key issues are summarized below.

- Carve-in arrangements allow for improved care coordination as pharmaceutical and other medical benefits are managed under one entity versus relying upon communication and data exchange between multiple entities to coordinate an individual's care. Carve-ins also align incentives to address the "total person" effectively from both a clinical and cost perspective.

- MCOs managing pharmacy benefits have the capability to access in-house pharmacy and medical claims data in real time, which is valuable for tailoring specific health interventions to promote improved health outcomes, managing polypharmacy issues, and positively influencing physician prescribing patterns to identify quality and cost issues.

- Pharmacy carve-in arrangements allow MCOs a unique opportunity to closely monitor all prescription drugs that members may be currently taking, which assists with identifying high utilizers, inappropriate usage, and potential needs for disease and case management.

- Pharmacy carve-outs also create a range of operational challenges as Medicaid recipients, providers, MCOs, the state, and its fiscal agent must continually sort through how the various parts of the benefits package are administered. MCO enrollees in a carve-out model, for example, typically need to carry multiple health insurance cards and are often ill-positioned to keep track of which card is needed for a given type of service.

A change in Federal policy that would treat all Medicaid prescriptions equally, from a rebate perspective, would preserve the integrated care advantages of the MCO model, and would likely yield large-scale Medicaid savings to all states that have implemented capitated Medicaid managed care programs.

APPENDIX A: CARVE-IN INTERVIEW GUIDE

ACAP INTERVIEW QUESTIONS, Rx CARVE-IN ASSESSMENT

Questions for MCO in a Carve-In State

1. Please provide the requested prescription drug cost data requested in Attachment 1. This information will be aggregated with the information provided by other MCOs and will be used for comparison against observed PMPM pharmacy costs in carve-out states.

2. Describe the advantages of a carve-in versus a carve-out of the pharmacy benefit, as you see them from your MCO's perspective. What about from your members' perspective? Your physicians? Your pharmacies?

3. Describe your use of pharmacy data. What information is accessed at what time-frames, by which staff? What pharmacy information is produced/shared with providers and others?

4. Describe the speed at which you access and use pharmacy data for overall care coordination. Do you have real-time access to your enrollees' pharmacy claims? Do you feel you want/need that despite not being financially responsible for Rx costs?

5. Describe the ways in which you use pharmacy data to identify illnesses and care management opportunities, and how this data source is used in your overall care coordination efforts.

6. Does the pharmacy carve-in enable you to better identify problems and coordinate care for your enrollees? In what ways? Is this better through your PBM than if similar services were performed under a carve-out by the state's PBM?

7. Please refer us to a few physicians and pharmacists who would be good to contact to get their input.

8. Do you think either scenario (i.e., carve-in or carve-out) is more favorable as it relates to the volume/mix of drugs?

9. Financially, would you expect the volume and mix of drugs to be more favorable under a carve-in than if the benefit were carved out? We are seeing much higher prescription volume under Medicaid FFS than in capitated MCOs – do you have any explanation as to why this might be occurring?

10. Does your MCO have Medicaid operations in states with a carve-in as well as with a carve-out? If so, who can we talk with to discern the differences in your operations between those states, with regard to:

    - Speed at which you access and use pharmacy data for overall care coordination

- Ways in which you use pharmacy data for overall care coordination
- Physician relations dynamics (e.g., to what degree is it easier to work with physicians when you don't need to review/approve their prescribing behavior?)
- Ways in which you feel carve-out operates differently (from member's perspective) than under a carve-in. For example, any "confusion differences" related to use of multiple ID cards, etc.?

APPENDIX B: CARVE-OUT INTERVIEW GUIDE

ACAP INTERVIEW QUESTIONS, Rx CARVE-OUT ASSESSMENT

Questions for MCO in a Carve-Out State

1. Please describe to us why the drugs were carved out.

2. Describe the speed at which you access and use pharmacy data for overall care coordination. Do you have real-time access to your enrollees' pharmacy claims? Do you feel you want/need that despite not being financially responsible for Rx costs?

3. What information is accessed at what time-frames, by which staff? What pharmacy information is produced/shared with providers and others?

4. Are there pharmacists and/or providers in your state who you believe would be good individuals for us to also interview?

5. Describe the ways in which you use pharmacy data to identify illnesses and care management opportunities, and how this data source is used in your overall care coordination efforts.

6. What Rx data would you like to have access to that you do not currently get?

7. Describe what your organization would do differently with the Rx data if you were at risk (i.e., under a carve-in arrangement).

8. How does the carve-out change your relationships with network physicians?

9. How does the carve-out affect beneficiaries' care coordination, either positively or negatively?

10. Does your MCO have Medicaid operations in states with a carve-in as well as with a carve-out? If so, who can we talk with to discern the differences in your operations between those states, with regard to:

    - Speed at which you access and use pharmacy data for overall care coordination – Get month down the road after claims get paid out and get monthly. Not read time. At Excellus, real time.
    - Ways in which you use pharmacy data for overall care coordination.
    - Physician relations dynamics (e.g., to what degree is it easier to work with physicians when you don't need to review/approve their prescribing behavior?)

- Ways in which you feel carve-out operates differently (from member's perspective) than under a carve-in. For example, any "confusion differences" related to use of multiple ID cards, etc.?