COPE HEALTH SOLUTIONS

Medi-Cal Pharmacy Carve-out: What You Need to Know and Should Do

The State of California is "carving out" the pharmacy benefit for Medi-Cal beneficiaries from managed-care plans and transitioning to a fee-for-service (FFS) program, moving 13 million Medi-Cal beneficiaries to a new pharmacy program by January 2021. Medi-Cal is taking responsibility from the managed care organizations (MCOs) for one of the key elements of care, the pharmacy benefit, and moving its function and operation to the state under a centralized pharmacy benefit manager (PBM). The move is projected to generate "net savings" on the state's costs and will coordinate improved pharmacy access with one common drug list using the same drug utilization management protocols statewide. While the state expects to benefit from this change, health plans are warning that this could significantly impact care provided to beneficiaries across the state. With the "carve out" coming up in less than 10 months, health plans and providers who are taking on pharmacy risk should start preparing for the carve out imminently.

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The California Department of Health Care Services (DHCS) awarded the PBM benefits to a subsidiary of Magellan Health under a five-year contract. The PBM will handle:

- Claims processing for all outpatient drugs
- Pharmacy network administration
- Pharmacy drug rebate administration (Federal and State)
- Prior authorization transactions
- Drug utilization review (DUR)
- Customer service (beneficiaries and providers)
- Health plan coordination activities

Centralized drug rebates and standardization of Medi-Cal pharmacy benefits are highlights of the new program's benefits. The state promises to provide 24/7 call center service and daily data feeds to managed care plans (which they already receive today in direct contracts with PBMs).

Skeptics noted that the experience of other states carving pharmacy benefits out of Medicaid has paradoxically led to increased medication costs, not reductions in overall expenses[1]. States such as New York that have attempted to do a statewide carve out ended up moving the benefit back to health plans after the intended results were not achieved. Beneficiary confusion and customer service issues have increased under standardization and outsourcing to a single, private, for-profit PBM.

The transitional but consequential challenges of moving beneficiaries from drugs they were receiving through their health plan to those that may not be covered under the new standardized state formulary is a larger hurdle than the state likely envisions. Ensuring access to appropriate medically necessary drugs will be a critical issue the state and health plans need to continue to work through.

The biggest concern of critics regarding the new program centers on the loss of care coordination, which puts the gains made under state programs advancing whole person integrated care at risk. Care coordination under a "one-size-fits-all" model may be more difficult due to separation of the pharmacy and medical benefit where data, communication and alignment are challenged. This transfer by the State of California fundamentally alters the roles and responsibilities of both health plans and delegated medical groups. Amid the concerns regarding impact on care coordination and pharmacy management, plans should involve delegated groups in policy design and implementation.

There are a few key areas health plans and providers currently taking on pharmacy risk for Medi-Cal should focus as they prepare for this change. Delegated provider groups must begin planning for the renegotiation of division of financial responsibility (DOFR) in risk contracts. Implementation of the new policy raises concerns for delegated groups at risk for cost and payment of Part B drugs. Old DOFR templates likely do not account for the carve out and reduction in capitation so they will need to be re-evaluated. Safety net plans and hospitals should assess the financial impacts the move will have on 340B programs and associated pricing.

Health plans and delegated medical groups must continue to focus on managing total costs of care strategies, with particular focus on care coordination activities and care management approaches on high-cost beneficiaries. Data informatics remains paramount, using data analytics to identify opportunities for medical spend reductions. Health plans and delegated provider groups should continue to monitor and address pharmacy adherence and opportunities to shift the site of care (e.g. infusions in physician offices vs. outpatient centers) through appropriate pharmacy and medical utilization.

These changes are coming at a time when the State of California is proposing significant changes to the Medi-Cal benefits under Healthy California for All. The pharmacy carve out will remain a top issue for health plans to monitor and prepare for in 2020. Immediate precautions should be taken to help ensure a smooth transition and reduce the likelihood of beneficiary interruption and coordination of care concerns.

Endnotes

[1] Information from Menges Group at https://www.themengesgroup.com/.

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