

The Menges Group

Strategic Health Policy & Care Coordination Consulting

Assessment of Medi-Cal Pharmacy Benefits Policy Options

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I. Executive Summary and Introduction

A. Overview

Currently, California’s Managed Care Organizations (MCOs) coordinate the pharmacy benefit as part of comprehensive health care coverage for nearly 11 million Medicaid (“Medi-Cal” in California) enrollees. This integrated model of pharmacy benefit administration is known as a “carve-in”.

Recently, some policymakers have expressed an interest in moving to a pharmacy “carve-out”, whereby the state would instead manage the pharmacy benefit for MCO enrollees, including paying directly for drugs made available in the program.

We have been engaged to estimate the fiscal impacts of Medi-Cal switching to a carve-out as well as the programmatic advantages and disadvantages of this potential change. We have also estimated the impacts of alternatives that may better achieve the carve-out’s purported objectives. These include retaining the carve-in but moving to a uniform formulary/preferred drug list (PDL) across all MCOs and/or modifying pharmacy benefit managers’ (PBMs) current contracting model.

This report details our findings on the impacts of a pharmacy carve-out, alternatives that can be considered, and potential next steps for policymakers.

An optimal Medi-Cal prescription drug policy should achieve four objectives:

1. Sound management of the *mix* of drugs prescribed.
2. Sound management of the *net price* of each drug.
3. Integration of prescription drugs and Rx data with medical care and medical data.
4. Extensive efforts to assist beneficiaries in accessing and adhering to an optimal medication regimen.

The carve-out focuses almost entirely on the second component – drug prices. However, the evidence is compelling that the carve-out model is detrimental to the other three critical components.

B. Recommendations

Based on the analysis detailed in this report, we offer the following recommendations:

- 1) Programmatically, a pharmacy carve-out diminishes Medi-Cal’s ability to deliver whole-person integrated care. Available data and other states’ carve-out experiences also demonstrate that a carve-out will result in a substantial increase in net pharmacy expenditures relative to a carve-in. The pharmacy benefit should remain carved in unless and until there is compelling, objective evidence that a carve-out will produce large scale savings without eroding access, care management resources and enrollees’ clinical outcomes.¹

¹ The published information available specifically analyzing the carve-out approach’s impacts is primarily contained in the Legislative Analyst Office’s (LAO) report, “Analysis of the Carve-Out of Medi-Cal Pharmacy Services from Managed Care,” April 5, 2019. The report is available at <https://lao.ca.gov/reports/2019/3997/medi-cal-pharm-services-040519.pdf>. Unfortunately, while the report makes directional statements, (e.g., “We find that the carve

- 2) It has been assumed that the carve-out will produce significant savings for the state. These assumptions have not been supported with data or information and are at odds with carve-out states' experiences and what publicly available data demonstrate. Further analytical efforts should be undertaken, disclosed and discussed prior to implementing a carve-out.
- 3) While the carve-out option is being more thoroughly assessed, we encourage California to take steps to achieve near-term fiscal savings under the existing carve-in model. These steps include full disclosure of all pharmacy-related costs (e.g., including the amounts PBMs are being paid and what *their* benefits and administrative costs have been), supplemental rebate levels, etc. This information will allow policymakers to identify specific problems and opportunities and devise tailored solutions. These solutions, for example, could involve creating a Medi-Cal administrative cost and operating margin ceiling on PBMs, requiring that certain MCO/PBM contract terms be renegotiated, and establishing a minimum supplemental rebate percentage to be built into each Medi-Cal MCO's capitation rate.

All of our analyses indicate that California's best pharmacy benefits policy option involves retaining the integrated pharmacy carve-in and establishing cost savings enhancements within this model.

C. Key Findings

The most significant findings from our analyses are summarized below.

1. **A change to a pharmacy carve-out would result in a 19.4% increase in net Medi-Cal pharmacy expenditures across the five year timeframe SFY2020 - 2024, increasing state fund costs by \$51 million in SFY2020 and \$757 million over five years.**
 - Based on our analyses, transitioning pharmacy benefits management responsibility from Medi-Cal MCOs to fee-for-service (FFS) would represent a significant and costly step backwards for the Medi-Cal program. This study has tabulated the experience of ten states moving from a carve-out to a carve-in during the past several years, and compares these results with findings from the three carve-out states that retained their carve-out approach through the same time period. These comparisons take into account all Medicaid prescriptions in all 13 states, the initial payments to pharmacies for these prescriptions (including dispensing fees and ingredient costs), the mix of drugs delivered to Medicaid beneficiaries, and all statutory and supplemental rebates. Based on this experience, we estimate that by adopting a

out of the Medi-Cal pharmacy benefit from managed care is likely to generate *net* savings for the state.”), no specific fiscal estimates are provided, nor is any methodology for deriving estimates. As a result, the LAO report provides others with no means of assessing the validity of its stated findings. The LAO report does acknowledge and emphasize that a lack of evidence exists regarding the carve-out's impacts.

pharmacy carve-out in Medi-Cal, California would experience an overall net cost increase of approximately \$149 million during SFY2020, representing an added cost of \$50.7 million in state funds. This policy change would increase Medi-Cal pharmacy expenditures by 7.95% in SFY2020. In Year 3 and beyond, the estimated annual net cost increase of the carve-out model is 23.85%, which captures the long-term differential experienced across the 13 states we were able to fully compare. Our phase-in estimates are driven by an expectation that continuity of care requirements will preserve, albeit only in the short term, much of the drug mix accomplishments the MCOs have achieved.

- Across the five-year timeframe (SFY2020 – SFY2024), the added cost of a pharmacy carve-out is estimated at \$2.2 billion for the Medi-Cal program, with \$757 million of these additional costs being state funds.
- The net cost increase of a pharmacy carve-out is attributable to the state’s increased reliance on brand-name and other costlier drugs in order to secure more rebates, higher dispensing fees, and decreased ability to promptly make needed modifications to the PDL to address emerging dynamics such as price changes, patent expirations, and new drug introductions.

2. We also assessed an alternative whereby the carve-in would be retained but all Medi-Cal MCOs would be required to utilize a uniform, state-run PDL. A change to a uniform PDL could have modest programmatic benefits but is expected to also result in increased Medi-Cal pharmacy expenditures relative to the current carve-in. We estimate that requiring a uniform PDL would result in a 15% increase in pharmacy expenditures from Year 3 forward. This approach would increase state fund costs by \$39 million in SFY2020 and \$515 million over five years.

- A uniform PDL could provide modest administrative simplification for enrollees and, to a lesser extent, providers.
- However, under a uniform PDL, we estimate that California would experience an overall net Medi-Cal cost increase of approximately \$114 million during SFY2020, representing an added cost of \$39 million in state funds. This policy change would increase Medi-Cal pharmacy expenditures by 5% in SFY2020 increasing to 10% in Year 2 and 15% in Year 3.
- Across the five-year timeframe SFY2020 – SFY2024, the added cost of a uniform PDL is estimated at \$1.5 billion for the Medi-Cal program, with \$515 million of this additional cost being financed through state funds.

- Like the carve-out, the cost increase associated with a uniform PDL is primarily attributable to increased use of costlier and brand-name drugs, which would be placed on the PDL to secure greater back-end rebates.

3. National tabulations of each state’s Medicaid prescriptions demonstrate the importance of focusing on optimizing front-end drug mix rather than securing back-end rebates.

- Increased drug rebates occur in the carve-out setting and under a uniform PDL, but these rebates do not offset the higher costs that occur by forfeiting optimal “front-end” drug mix management.
- States that have adopted a pharmacy carve-out and/or control the Medicaid PDL entirely are not performing well in terms of net cost per prescription and generic dispensing rates.
- Our analyses demonstrate that the states that are faring the best on net (post-rebate) cost per prescription are predominantly those that have the highest generic dispensing rates and lowest initial (pre-rebate) costs.
- ***The states most successful in garnering rebates are least successful at lowering net costs.*** During FFY2017, the three states with the highest rebates per Medicaid prescription – Connecticut, South Dakota, and Vermont – are the three states with the nation’s *highest* net costs per Medicaid prescription in that year.
- National aggregate figures for FFY2017, shown in Exhibit 1, demonstrate that Medicaid MCOs are managing the mix of drugs between generics and brands far more effectively than is occurring in the FFS setting. Given that the average net cost of a brand drug is ***8.9 times higher*** than the average generic, the 4.8 percentage point difference in generic usage between the MCO and FFS settings has an enormous financial impact. Exhibit 1 also shows that MCOs are achieving lower net costs *within* generics and *within* brands. Taking all of these impacts together ***the national average net cost per prescription was 27.2% lower in the Medicaid MCO setting than the Medicaid FFS setting.*** These net figures take into account all statutory and supplemental rebates paid by manufacturers in both settings.

Exhibit 1. Net (Post-Rebate) Costs Per Prescription Across All USA Medicaid Prescriptions, MCO vs FFS Settings, FFY2017

	MCO	FFS	Medicaid Total	MCO Cost as % of FFS Cost
Brand	\$160.81	\$183.80	\$168.79	87.5%
Generic	\$17.99	\$21.96	\$19.07	81.9%
Total	\$34.80	\$47.82	\$38.47	72.8%
Generic Percentage of All Prescriptions	88.1%	83.8%	86.9%	

4. Programatically, a pharmacy carve-out would be detrimental to the whole-person care coordination model Medi-Cal has embraced.

- Pulling the pharmacy benefit out of the capitated benefits package – and into a fiscal silo – is antithetical to the goals of care integration and coordination. Prescription drug treatments are central to the health services Medi-Cal beneficiaries receive, and prescription drug data are essential to discerning individuals’ health needs and comorbidities, new diagnoses, and treatment adherence patterns.

- Medi-Cal MCOs were invited to provide both process examples and case examples regarding how their direct management of the drug benefit is supporting their efforts to identify and address their enrollees’ overall health needs, as well as information as to how their health plan facilitates access and adherence to appropriate medication regimens. Several of these examples are conveyed in text boxes throughout the report, and [Appendix A](#) presents a lengthy set of these case examples.

MCO Care Management

While in the field, Care Management nurse was asked by enrollee which medications are safe to crush and mix with food. The nurse consults with our pharmacist and immediately relays that information to member.

-- MCO Pharmacy Director

5. Programatically, the uniform PDL would be an improvement over a carve-out but potentially detrimental relative to the carve-in.

- Relative to a carve-out, a uniform PDL across MCOs has significant programmatic advantages. These include preserving the real-time pharmacy data within the MCO’s desired information technology framework, supporting care coordination and whole person integration, as well as preserving the health plans’ ability and to deliver their medication access and adherence programs.

- With regard to the carve-out and/or a uniform PDL approach that has been taken in other states, programmatic advantages have been overstated or are unlikely to materialize at all..
- For example, the purchasing power of combining all Medi-Cal pharmacy spending together would work against the program’s interests, as the PBMs used by the Medi-Cal MCOs typically have much more purchasing power already than the state can amass.
- Similarly, the administrative simplicity of having a single statewide PDL will have unclear value in an environment where Medi-Cal represents approximately 21% of all California prescriptions. Prescribers and pharmacies must work with dozens of PDLs regardless of Medi-Cal’s approach, and information systems technologies have evolved to make it much easier for them to do so.
- MCOs across the nation (and within Medi-Cal) have proven to be much more nimble than the state-administered FFS setting in updating PDLs and processing exceptions.

Taking all of our analyses into account, we encourage California’s policymakers to maintain the carve-in and retain the PDL latitude the Medi-Cal MCOs currently are afforded.

This does not – and should not – preclude the state and the MCOs from developing initiatives (and new program requirements) that will yield further savings on net prescription drug expenditures. However, our findings indicate that these savings will be maximized *within* the full-risk, highly coordinated and integrated system of care that the MCO capitation contracting environment delivers.

II. States’ Experiences with a Medicaid Pharmacy Carve-Out

A. Analysis of Progression of 13 States Using Pharmacy Carve-Out

During 2011, 13 states used a pharmacy carve-out model in their Medicaid MCO programs. With the passage of the Affordable Care Act (ACA), the large statutory rebates – which had previously been payable only for Medicaid prescriptions paid in the fee-for-service (FFS) setting – were extended to all Medicaid prescriptions, including those paid by MCOs. As a result, 10 of these 13 states moved to a pharmacy carve-in approach (Delaware, Illinois, Indiana, Iowa, Nebraska, New York, Ohio, Texas, Utah, and West Virginia) during the ensuing years.² Three of the 2011 carve-out states – Missouri, Tennessee, and Wisconsin – retained their carve-out approach throughout the 2011-2017 timeframe.

These dynamics permit a comparison of the progression of key Medicaid prescription drug costs and metrics between these two groups of states. Our tabulations include all Medicaid prescriptions between FFY2011-FFY2017, including all Medicaid prescriptions in each of these states, as well as all associated rebates. Even the smaller group of three states provides a large statistical volume of data – nearly 40 million prescriptions during FFY2017, for example. A summary of these tabulations is presented in [Exhibit 2](#).

Exhibit 2. Comparison of Costs and Usage Between States that Retained Carve-Out Model and States that Switched to Carve-in Model

Federal Fiscal Year	Net Cost/Rx		Generic Dispensing Rate		Rebates Per Rx	
	3 Carve-Out States throughout 2011-2017	10 States with 2011 Carve-Out that Used Carve-In Model in 2017	3 Carve-Out States throughout 2011-2017	10 States with 2011 Carve-Out that Used Carve-In Model in 2017	3 Carve-Out States throughout 2011-2017	10 States with 2011 Carve-Out that Used Carve-In Model in 2017
2011	\$37.98	\$38.62	76.8%	71.1%	\$31.19	\$37.55
2017	\$43.40	\$38.12	84.5%	86.6%	\$50.93	\$44.20
Percent Change from 2011-2017	14.3%	-1.3%	7.7%	15.5%	63.3%	17.7%

The states that switched to a carve-in model have collectively outperformed those that retained their carve-out approach. A key metric demonstrating this performance is that the states that carved-in the drug benefit as a group experienced a 1.3% *decrease* in net cost per prescription across the entire FFY2011-FFY2017 timeframe (after factoring in rebates). States that continued to carve out the pharmacy benefit experienced an 14.3% cost increase. This 15.6 percentage point difference in net cost per prescription between these two state groupings provides strong evidence of the MCOs’ favorable impact on drug spending.

² West Virginia recently switched to a carve-out model; their cost progression since doing so is described later in this section. However, West Virginia used a carve-in model during FFY2017 and is therefore included in the carve-in group of states for this section of the analysis.

Two Important Adjustments

Two factors need to be taken into consideration to more appropriately estimate the cost difference between the carve-in and carve-out settings. The first is Medicaid expansion. States adopting Medicaid expansion experience higher costs per prescription due to the demographics of the expansion population and their associated medication needs (e.g., much higher incidence of cancer, hepatitis C, and HIV infection than the underlying Medicaid population experiences).

To estimate the impact Medicaid expansion is having on net cost per prescription, we assessed FFY2011 and FFY2016 net cost per prescription data in 13 states that have always had 100% of prescriptions paid in the FFS setting (in order to control for impacts of MCO management on pharmacy benefit management). Among these 13 states, eight states did not adopt Medicaid expansion and these states collectively experienced a 17% increase in net cost per Medicaid prescription from FFY2011-FFY2016. Among the five states (within the 13 continuous FFS states) that did adopt Medicaid expansion, net cost per prescription increased by 22% from FFY2011-FFY2016.

This suggests that Medicaid expansion has a 5 percentage point upward impact on net cost per prescription, which requires adjustment to the figures in [Exhibit 1](#). All three states that retained the carve-out model are non-expansion states, whereas seven of the ten states that switched to a carve-in have adopted Medicaid expansion and can be expected to have higher per prescription costs as a result.

A second adjustment is needed because the comparisons in [Exhibit 1](#) include all prescriptions, whereas the states switching to a carve-in model continued to have some FFS Medicaid prescription volume (which the MCOs can not impact). During FFY2017, Medicaid MCOs paid for 85.6% of all Medicaid prescriptions across the 10 states that switched to a carve-in.

[Exhibit 3](#) (next page) presents the adjustments to the net cost per prescription figures to both account for these dynamics and create a more accurate estimate of the relative costs between the carve-in and carve-out models. The adjustments for the Medicaid expansion and the fact that states switching to a carve-in model still have some FFS prescriptions increase the carve-out model's estimated percentage savings from carve-in from 15.6 % to 23.85%.

Note that the additional statistics presented in [Exhibit 2](#) are also important in conveying the different cost management approaches that occur in the MCO and FFS settings. Under the carve-in, the MCOs have been highly effective at managing the "front-end" mix of drugs, whereas the carve-out states have been highly effective at obtaining large "back-end" rebates. The states switching to a carve-in approach have achieved greater use of generics than has occurred in the carve-out states, with the states retaining the carve-out approach obtaining much larger rebates per prescription.

Exhibit 3. Adjustments to Create Accurate Comparison of Costs and Usage Between States that Retained the Carve-Out and Those That Switched to a Carve-In

	3 States That Maintained Carve-Out Model Throughout 2011-2017	10 States with Carve-Out Model in 2011 that Switched to the Carve-In Model as of 2017
Percentage of Group's 2017 Prescriptions In Non-Expansion States	100.0%	18.0%
Cost Per Prescription Impact of Medicaid Expansion	5.0%	5.0%
Cost Per Prescription Adjustment	5.00%	0.90%
Initial 2017 Net Cost/Rx	\$43.40	\$38.12
Parity-Adjusted 2017 Net Cost/Rx	\$45.57	\$38.46
Percent Change from 2011	20.0%	-0.4%
Overall Differential		20.4%
Percentage of 2017 Prescriptions Paid by MCOs in 10 States That Switched to Carve-In Model		85.6%
Estimated Percentage Savings in Net Costs Attributable to Switch to a Carve-In Approach		23.85%

Our data analyses across all states strongly indicate that managing drug mix effectively – as is done in carve-in states – is most likely to yield the most favorable net costs. During FFY2017, the average net cost per prescription among the 10 states with the largest rebates per Medicaid prescription(\$43.73) was **34% above** the corresponding net cost per prescription across the 10 states that had the most favorable generic dispensing rate (\$32.63). The 10 states with the highest generic usage rank an average of 10th in net costs per prescription, but average 44th on rebates per prescription.

Conversely, the states most successful in garnering rebates have been least successful at

controlling net costs. The 10 states with the highest rebates per prescription rank an average of 41st across all states in net costs per prescription and an average of 45th across all states in their generic usage rates. During FFY2017, the three states with the highest rebates per Medicaid prescription – Connecticut, South Dakota, and Vermont – were the three states with the nation’s *highest* net costs per Medicaid prescription in that year.

B. West Virginia’s Initial Experience Since Adopting a Medicaid Pharmacy Carve-Out Model

The above analyses focus on states moving from a carve-out to a carve-in approach. Only one state in recent years – West Virginia – has moved in the direction California is considering, changing from a pharmacy carve-in to a carve-out. This section of the report briefly summarizes West Virginia’s early experience with the Medicaid pharmacy carve-out.

The CMS State Drug Utilization data files now contain five calendar quarters of West Virginia data since the carve-out took effect (July 2017 through September 2018). We calculated average Medicaid costs per prescription during this timeframe as well as the same statistic for the last five calendar quarters of the carve-in model (April 2016 through June 2017). We calculated the same information for the overall USA Medicaid program. *West Virginia’s pre-rebate costs per Medicaid prescription rose sharply after the carve-out was implemented, increasing 12.6% between the pre-post comparison timeframes described above.* During this same timeframe, nationwide Medicaid costs per prescription increased by 4.1%.

This outcome is directionally similar to the multi-state experience described previously, with the carve-out resulting in increased pharmacy expenditures. The magnitude of this difference is smaller in West Virginia, where roughly an 8.5 percentage point increase in costs per

prescription occurred across the first 15 months of the carve-out. A potential explanation for this reduced impact, given the vast evidence of the importance of front-end drug mix, is that MCO enrollees have continued their existing drug therapies during the first year of the carve-out. Over time, the larger shift away from generics and other lower-cost drugs that have occurred in other states may well occur in West Virginia as the carve-out’s initial continuity of treatment regimens becomes a smaller proportion of overall Medicaid prescriptions.

III. Cost Impact Modeling

A. California’s Baseline Pharmacy Costs

During FFY2017, California’s net (post-rebate) Medi-Cal drug spending totaled more than \$4 billion, the largest expenditure of any state. California contracts and partners extensively with Medi-Cal MCOs, which cover over 80% of Medi-Cal enrollees. For example, MCOs paid for 74.1% of Medi-Cal’s prescriptions and 50.9% of Medi-Cal’s net prescription drug expenditures during FFY2017. Policies related to the Medicaid managed care program’s prescription drug benefit therefore have a determinative impact on overall Medi-Cal spending on prescription drugs as well as the degree to which Medi-Cal pharmacy benefits are optimally integrated with other covered services. [Exhibit 4](#) summarizes California’s statistics and rankings among all states on various key Medicaid prescription drug metrics.

Exhibit 4. Overview of Medi-Cal Prescription Drug Costs – FFY2017

Statistical Measure	FFY2017 Base Data			Ranking Among States (51 States including DC for FFS and Total, 37 states including DC for MCO)		
	MCO	FFS	Total	MCO	FFS	Total
Prescriptions	75,950,956	26,527,018	102,477,974			
Pre-Rebate Expenditures	\$3,962,019,914	\$4,419,659,311	\$8,381,679,225			
Rebates	\$1,906,055,706	\$2,438,280,718	\$4,344,336,425			
Net Expenditures	\$2,055,964,207	\$1,981,378,593	\$4,037,342,800			
Costs Per Prescription						
Pre-Rebate (state with lowest cost is ranked 1st)	\$52.17	\$166.61	\$81.79	2nd	48th	21st
Rebates (state with largest rebates is ranked 1st)	\$25.10	\$91.92	\$42.39	35th	4th	31st
Net Costs (state with lowest cost is ranked 1st)	\$27.07	\$74.69	\$39.40	3rd	49th	31st
Generic Percentage of Prescriptions (state with highest percentage is ranked 1st)	89.8%	82.4%	87.8%	12th	38th	16th

Across the 37 states where MCOs are responsible for the pharmacy benefit for their Medicaid enrollees, California has among the nation’s lowest costs per prescription. California ranks second-lowest in FFY2017 initial (pre-rebate) costs per prescription and third-lowest in net (post-rebate) costs per prescription. Several high-cost medications have already been “carved-out” of the Medi-Cal managed care program (e.g., anti-psychotics, cancer drugs, and HIV medications). These carve-outs skew the Medi-Cal MCO average cost figures downward to some degree relative to states where the MCOs pay for these high-cost medications.

Nonetheless, California’s #2 ranking on net costs per prescription demonstrates strong cost management performance.

Rebates per prescription for Medi-Cal MCO prescriptions rank ahead of only two other states (35 out of 37), indicating that net cost outcomes are not driven by large rebates. California’s MCOs ranked fairly high (12th) in the generic percentage of all FFY2017 MCO prescriptions.

“Placing emphasis on maximizing supplemental rebates contrasts with the fundamental concept of cost-effective formulary management. Placing priority on the rebate itself incentivizes the wrong approach by commoditizing the pricing aspect of a drug in front of a drug’s cost effectiveness, its potential impacts on overall healthcare costs, and its therapeutic value.”

– Medi-Cal MCO Pharmacy Director

Conversely, California’s FFS costs per prescription are among the nation’s highest, below only two states in terms of FFY2017 net costs per Medicaid FFS prescription. California is securing the 4th largest rebates per prescription in the FFS setting.

B. Cost Impact Modeling of the Proposed Carve-Out

Our approach to estimating the carve-out model’s cost impacts included the following steps.

First, we used the Medi-Cal MCOs’ net FFY2017 pharmacy costs, \$2.1 billion, as a base. These costs were trended forward by an annual trend factor of 4.0% to estimate net Medi-Cal MCO pharmacy costs in each state fiscal year from 2020-2024. These figures are shown in the second column of Exhibit 5.

Second, we applied the 23.85% cost factor derived earlier in this report, reflecting the average savings the ten carve-out states experienced when they moved to the carve-in model. This savings factor takes into account all initial ingredient costs, dispensing fees, the mix of drugs prescribed, statutory rebates, and supplemental negotiated rebates in both the carve-in and carve-out settings.

We have phased this impact in evenly across the first three years of the carve-out, taking into account West Virginia’s initial experience with the carve-out but relying primarily on the larger volume and longer-term evidence across the ten states moving to the carve-in approach. The phase-in also assumes that the detrimental effects of weaker front-end management of drug mix will be softened initially by continuity of care (and continuity of medication regimens) that preserves, for many Medi-Cal beneficiaries, the more cost-effective PDLs the MCOs have used.

The phase-in assumptions estimate a 7.95% net pharmacy cost increase in the first year of the carve-out, a 15.9% increase in Year 2, and a 23.85% increase from Year 3 forward. As shown in Exhibit 4, this factor yields an estimated increase in Medi-Cal’s net pharmacy expenditures (attributable to the switch to a carve-out model) of \$182 million in SFY2020, accumulating to \$2.4 billion across the five-year timeframe SFY2020 – SFY2024.

The two right-hand columns of Exhibit 5 convey the distribution of these increased Medi-Cal costs between federal and state funds, respectively. The proposed carve-out is projected to create increased pharmacy expenditures of \$62 million in state funds during FFY2020 and a total additional state fund cost of approximately \$818 million across SFY2020 – SFY2024.

Exhibit 5. Pharmacy Carve-out Impacts on Total Pharmacy Expenditures

Year	Net Medi-Cal Pharmacy Costs Under Current Program Structure, MCO-Paid Prescriptions (4% Annual Increase Assumed)	Estimated Percentage Net Cost Increase of Carve-Out	Estimated Net Costs Under Carve-Out Approach, MCO-Paid Prescriptions	Additional Medi-Cal Pharmacy Expenditures Due to Carve-Out	Additional Federal Cost of Carve-Out	Additional State Fund Cost of Carve-Out
FFY2017 actual	\$2,055,964,207					
SFY2020	\$2,290,114,691	7.95%	\$2,472,178,809	\$182,064,118	\$120,162,318	\$61,901,800
SFY2021	\$2,381,719,279	15.90%	\$2,760,412,644	\$378,693,365	\$249,937,621	\$128,755,744
SFY2022	\$2,476,988,050	23.85%	\$3,067,749,700	\$590,761,650	\$389,902,689	\$200,858,961
SFY2023	\$2,576,067,572	23.85%	\$3,190,459,688	\$614,392,116	\$405,498,796	\$208,893,319
SFY2024	\$2,679,110,275	23.85%	\$3,318,078,075	\$638,967,800	\$421,718,748	\$217,249,052
5 Year Total	\$12,403,999,865	19.39%	\$14,808,878,915	\$2,404,879,049	\$1,587,220,173	\$817,658,877

Note: Federal share assumes 90% match on Medicaid expansion prescriptions, which are assumed to represent 40% of all Medi-Cal prescriptions, and 50.0% Federal share of all other Medicaid prescription drug costs.

The next step in the process involves factoring in additional dynamics that will impact Medi-Cal costs. This includes projecting net administrative cost impacts and MCO risk margins (which would not have to be paid for the prescription drug benefit if the health plans are no longer placed at risk). The projected costs for each of these components are presented in Exhibit 6 and discussed in the following narrative. Exhibit 7 presents the same information but focused on state fund impacts.

Exhibit 6. Estimated Overall Impacts of a Pharmacy Carve-Out

Year	Net Pharmacy Cost Impact	Administrative Cost Impact	Risk Margin Impact (1% of base pharmacy expenditures)	Net Impacts
SFY2020	\$182,064,118	-\$10,000,000	-\$22,901,147	\$149,162,971
SFY2021	\$378,693,365	-\$10,400,000	-\$23,817,193	\$344,476,173
SFY2022	\$590,761,650	-\$10,816,000	-\$24,769,880	\$555,175,769
SFY2023	\$614,392,116	-\$11,248,640	-\$25,760,676	\$577,382,800
SFY2024	\$638,967,800	-\$11,698,586	-\$26,791,103	\$600,478,112
5 Year Total	\$2,404,879,049	-\$54,163,226	-\$124,039,999	\$2,226,675,825

Exhibit 7. Pharmacy Carve-Out Impacts on State Funds

Year	Pharmacy Cost Impact	Administrative Cost Impact	Risk Margin Impact (2% of base pharmacy expenditures)	Net Impacts
SFY2020	\$61,901,800	-\$3,400,000	-\$7,786,390	\$50,715,410
SFY2021	\$128,755,744	-\$3,536,000	-\$8,097,846	\$117,121,899
SFY2022	\$200,858,961	-\$3,677,440	-\$8,421,759	\$188,759,762
SFY2023	\$208,893,319	-\$3,824,538	-\$8,758,630	\$196,310,152
SFY2024	\$217,249,052	-\$3,977,519	-\$9,108,975	\$204,162,558
5 Year Total	\$817,658,877	-\$18,415,497	-\$42,173,600	\$757,069,781

Carve-Out Administrative Cost Impacts: We analyzed the SFY2018 financial statements of 14 Medi-Cal health plans, which collectively serve approximately 60% of all Medi-Cal MCO enrollees. After adjusting premium taxes out of the revenues, these plans' collective Medi-Cal administrative expenses represented 4.7% of Medi-Cal premium revenues. Overall SFY2018 administrative costs across all the Medi-Cal MCOs, based on this percentage, are projected to be approximately \$2.0 billion. Administrative cost impacts for the carve-out require estimating two dynamics:

- 1) How much of these overall Medi-Cal MCO administrative costs would disappear in a pharmacy carve-out environment?
- 2) To what extent would the reduction in Medi-Cal MCO administrative costs be offset by increased state costs in managing the Medi-Cal managed care pharmacy benefit?

Most pharmacy-related administrative costs will move from the MCOs to the state under the carve-out, with the volume of these costs not likely to be significantly reduced nor increased. Examples of these functions include:

- *Pharmacy claims processing:* The volume of Medi-Cal prescriptions – and the corresponding claims processing costs – are not expected to materially change under the carve-out model (although this administrative work would shift from the MCOs to the state).
- *Prior authorizations:* The volume of prior authorization requests – and the corresponding costs of handling these requests – are not expected to materially change under the carve-out model.
- *Member and provider calls regarding prescription drug benefit:* The volume of pharmacy-related issues the members will experience is not expected to significantly change under the carve-out model. However, many of these calls will continue to be directed to the MCOs as beneficiaries will often not know whom to contact.

The administrative activities and costs that will be reduced overall under the carve-out include the following areas:

- MCO pharmacy staff primarily managing others' work will be reduced as all pharmacy management is housed at DHCS.
- Pharmacy work regarding compliance with regulatory requirements will largely be eliminated.

The MCO administrative costs that will *not* be reduced under the carve-out model are described below:

- *Rebate Negotiation Costs:* Most Medi-Cal MCOs operate lines of business beyond serving Medi-Cal enrollees, and thus will continue to manage pharmacy benefits for these

other populations under a Medi-Cal carve-out. The health plans will continue to contract with PBMs, for example, and these PBMs will continue to negotiate supplemental rebates with manufacturers as currently occurs.

- *Pharmacy Data Integration:* These MCO costs will likely increase under the carve-out due to needing to work with the data in the state's standardized format. Currently, data integration at each MCO is tailored to each MCO through its relationship with its PBM. The timing and level of detail available will also be diminished, which is discussed in the report's programmatic section.

In the aggregate, based on our analysis of numerous health plan financial statements (encompassing approximately 60% of all Medi-Cal MCO enrollees during 2018), we estimate that Medi-Cal MCOs are collectively expending approximately \$2 billion annually for administrative functions. Information provided to us by the MCOs suggests that approximately 5% of their administrative spending is tied to pharmacy benefits management activities. This leads to an estimate that approximately \$50 million in annual administrative spending occurs across the Medi-Cal MCOs attributable to pharmacy benefits management. Our assessment of the nature of these administrative functions indicates that at most 10% of these costs will disappear under the carve-out model, with most of the costs being transferred from the MCOs to DHCS and a sizable portion (roughly one-fourth) continuing to occur at the MCO level (e.g., utilizing pharmacy data for overall care coordination activities, processing member calls about medications, etc.). ***The net annual administrative savings from the carve-out are estimated to be approximately \$10 million.***

Risk Margin Impacts: Under a carve-out, it would no longer be necessary to pay the Medi-Cal health plans a risk margin for the pharmacy portion of the Medi-Cal premiums (given that the health plans would no longer be at risk for these costs). Working with the same financial statement data described earlier, the 14 Medi-Cal plans' collective net (post-tax) operating income in SFY2018 for their Medi-Cal line of business was 0.4%. We have assumed a target 1% after-tax net income for the Medi-Cal MCOs, and factored this figure into our estimates of the carve-out impacts as shown in Exhibits 6 and 7. We estimate an overall cost reduction to Medi-Cal of \$23 million in SFY2020 due to the removal of a risk margin for pharmacy costs under a carve-out approach, with these cost reductions totaling \$144 million across the five-year timeframe SFY2020 – SFY2024. The state fund reductions for this component, shown in Exhibit 6, are estimated at \$8 million in SFY2020 and \$49 million across the five-year timeframe SFY2020 – SFY2024.

340B Pricing Impacts: It has been argued that under a Medi-Cal pharmacy carve-out additional savings opportunities will occur related to the 340B drug purchasing program. Estimating the savings from this approach require assessing the following components:

- Within the existing volume of Medi-Cal MCO paid prescriptions, what percentage of these prescriptions would be newly converted towards or away from the 340B pricing model?

- What would the net savings of the conversion to 340B pricing be for these medications if the mix of drugs remains constant under the carve-out?
- Would there be offsets to these 340B-related savings, such as higher dispensing fees under the Actual Acquisition Cost (AAC) pricing methodology, relatively greater use of brand drugs under the carve-out, etc. that need to be taken into account?

We are not aware that data have been provided to accurately quantify the impacts of these components. Our understanding is that a modest percentage of Medi-Cal MCO prescriptions qualifies for 340B pricing, that the carve-out will have no impact on 340B pricing for members while hospitalized, and that the carve-out has no mechanism that would re-direct prescription volume towards or away from 340B providers.

The high dispensing fees paid in FFS pose challenges when prescriptions are transferred into this environment. During the most recent nine month timeframe where all Medi-Cal prescription volume is available in the State Drug Utilization files (October 2017 through June 2018), 79% of Medi-Cal MCO prescriptions had an average pre-rebate cost below \$30, with the overall average cost of these prescriptions being only \$8.35 (including the dispensing fee and ingredient costs). California's FFS Medicaid program pays a dispensing fee of \$10.05 to pharmacies with a volume of 90,000 or more annual fee-for-service Medi-Cal prescriptions, and a dispensing fee of \$13.20 to all other pharmacies. Therefore, for 79% of the MCO volume the FFS payment will typically be \$4.85 per prescription above the MCOs' total payment before any ingredient costs are paid whatsoever. A relatively favorable ingredient cost differential for 340B drugs will simply push this cost disadvantage up further, dollar-for-dollar. It is possible that the 340B ingredient savings differential on costlier drugs will offset the added amounts paid on the lower-cost drugs, but in our view there is not yet evidence that allows anyone to responsibly make such an assertion.

We have not been able to model 340B pricing impacts due to the lack of available information upon which the direction and magnitude of these impacts can be assessed.

MCO Tax: California uses an MCO tax mechanism to draw in additional federal funds for Medi-Cal. Typically, removing a covered benefit such as pharmacy would reduce the level of taxes being levied and in turn reduce the net federal fund advantages the tax mechanism is yielding. However, California's MCO tax is currently structured as a fixed PMPM amount for each MCO based on its membership mix and enrollment volume. We have therefore not modeled any advantageous or disadvantageous aspects of the carve-out related to this tax program. However, if the current PMPM tax levels were to exceed a CMS percentage ceiling due to the carve-out, these PMPM taxes would need to be reduced and a further adverse state fund impact would be created by the carve-out model.

Overall Fiscal Impacts of Carve-Out Model

Taking all of the above factors into account, the estimated fiscal impacts of a pharmacy carve-out in the Medi-Cal managed care programs are shown in [Exhibits 6 and 7](#). [Exhibit 6](#) presents overall Medi-Cal impact estimates, with [Exhibit 7](#) conveying state fund impacts.

Our analyses indicate that the carve-out model will impose considerable additional costs on the Medi-Cal program. During the initial year of the carve-out (SFY2020), these additional costs are projected at \$149 million overall of which \$51 million would be the adverse impact on state funds. The net costs are projected to increase substantially in Years 2 and 3 of the carve-out as the mix of drugs becomes less and less cost-effective.

Continuity of care efforts are expected to initially help preserve the cost-effective drug mix the MCOs have achieved under the carve-out, but over time a rebate-driven uniform Medi-Cal PDL will more fully (and more adversely) affect drug mix. By Year 3 (SFY2022), the additional costs of the carve-out approach are projected to be \$555 million for Medi-Cal overall of which \$189 million would be the adverse state fund impact. *Across the five year timeframe SFY2020-2024, additional costs are projected to total \$2.2 billion for Medi-Cal overall including a \$757 million state fund impact.*

C. Cost Impact Modeling of Requiring a Uniform PDL Within the Carve-In

A possible alternative to the carve-out would involve retaining the existing carve-in but requiring all Medi-Cal MCOs to use a single, uniform PDL. The estimated cost impacts of California moving to a uniform Medi-Cal PDL were derived using the methodology described below.

- 1) We quantified FFY2017 costs per prescription in California, Florida, and Texas. Florida and Texas are the two large states that have used the uniform PDL model in their Medicaid managed care programs throughout the past several years. Exhibit 8 presents these cost per prescription figures:

Exhibit 8. Net Costs Per Prescription in Large States, FFY2017

State	FFY2017 Net Cost Per Prescription	5% Parity Adjustment for Medicaid Expansion in FL and TX
California	\$39.40	\$39.40
Florida	\$43.44	\$45.61
Texas	\$39.27	\$41.23
Florida/Texas Average	\$41.36	\$43.42
California Difference vs. FL/TX Average	\$1.96	\$4.03

The CMS Financial Management Reports (FMR) include both the ACA's statutory rebates as well as supplemental rebates the state negotiates with manufacturers. Together, these data sources permit tabulation of each state's Medicaid initial (pre-rebate) cost per prescription, rebates per prescription, and the net (post-rebate) cost per prescription.³

- 2) Given that California has adopted Medicaid expansion and Florida and Texas have not, we applied a 5% factor to Florida's and Texas' base year costs to create eligibility parity between California and these two states. These figures are shown in the right hand column of Exhibit 8. The derivation of the 5% factor was described in Section II.
- 3) Florida's and Texas' costs per prescription figures were averaged together, creating a differential of \$4.03 per prescription in FFY2017 (after adjusting for Medicaid expansion). In other words, net costs per prescription are \$4.03 lower in California than the average for Texas and Florida. This per prescription figure represents a 10.2% estimated cost increase in California's net Medi-Cal pharmacy expenditures should a uniform PDL be implemented. Note that the cost differentials are driven by drug mix management outcomes. For example, during FFY2017 87.8% of Medi-Cal prescriptions were generics versus 82.0% in Texas and 85.1% in Florida.
- 4) This \$4.03 figure was trended upward annually by 4% to account for typical cost per prescription escalation. Annual per prescription costs of the uniform Medi-Cal PDL are shown in Exhibit 8. We estimated that due to medication continuity expectations, the detrimental drug mix impacts of the uniform PDL will be muted initially. We estimate that the Year 1 impact will be only 1/3 of the full long-term percentage impact, with Year 2 impacts being two-thirds of the long-term impacts. From Year 3 forward, the full per prescription impacts shown in Exhibit 9 are projected to occur.
- 5) These cost per prescription differentials are multiplied by the annual volume of prescriptions paid by California's Medi-Cal MCOs. The actual FFY2017 prescription volume (75.95 million) was used throughout the five-year projection period. The resulting figures, shown in the fifth column of Exhibit 9, represent our annual estimate of the overall cost increases the uniform Medi-Cal PDL model would create. These annual adverse impacts are estimated at more than \$200 million, totaling over \$1.5 billion across the five-year timeframe FFY2020 – FFY2024.

³ Medicaid MCO supplemental rebates are published in the FMR reports for several states, and these percentage rebates are used to estimate the Medicaid MCOs' supplemental rebate levels in all other states with Medicaid MCO programs.

Exhibit 8. Projected Cost of Uniform Medi-Cal PDL, SFY2020 – SFY2024

Year	California Per Prescription Difference vs. FL/TX Average (4% Annual Increase Assumed)	Estimated Percentage Phase-In of Full Long-Term Impact	Medicaid MCO Prescription Volume (FFY2017 Level Used Throughout)	Estimated Additional Cost of Uniform Medi-Cal PDL	Additional Federal Cost of Uniform PDL	Additional State Fund Cost of Uniform PDL
FFY2020	\$4.53	33.333%	75,950,956	\$114,640,954	\$75,663,030	\$38,977,924
FFY2021	\$4.71	66.667%	75,950,956	\$238,453,185	\$157,379,102	\$81,074,083
FFY2022	\$4.90	100.000%	75,950,956	\$371,986,968	\$245,511,399	\$126,475,569
FFY2023	\$5.09	100.000%	75,950,956	\$386,866,447	\$255,331,855	\$131,534,592
FFY2024	\$5.30	100.000%	75,950,956	\$402,341,104	\$265,545,129	\$136,795,976
5 Year Total				\$1,514,288,657	\$999,430,514	\$514,858,144

Note: Federal share assumes 90% match on Medicaid expansion prescriptions, which are assumed to represent 40% of all Medi-Cal prescriptions, and 50.00% of all other Medi-Cal prescription drug costs.

- 6) Overall Medi-Cal cost impacts were broken out between the federal and state share. We assumed that 40% of California’s Medicaid prescription drug costs are for the expansion population’s medications (at a 90% Federal match rate), with the remaining costs paid by the federal government at California’s 50% match rate. Adverse annual California state fund impacts are estimated at \$39 million during SFY2020, increasing to \$137 million as of SFY2024, and totaling over \$500 million across the five-year timeframe SFY2020 – SFY2024.

A variation of the uniform PDL within the existing carve-in structure would involve the state dictating both the formulary content and the prices to be paid to pharmacies. The cost impacts of this variation could not be modeled due to a lack of long-term data or any year-over-year results of this model.

IV. Programmatic Impacts of Alternative Medi-Cal Pharmacy Benefits Management Approaches

In addition to the financial impacts the carve-out will have, it is critical to consider the programmatic dynamics of the carve-in versus carve-out policy decisions. These programmatic impacts overwhelmingly favor the carve-in model. At a fundamental level, the integrated carve-in creates a whole-person focused, well-coordinated system of care and coverage. Pulling the pharmacy benefit out of this system – and into a fiscal silo – is antithetical to the goals of care integration and coordination. Prescription drug treatments are central to the health services Medi-Cal beneficiaries receive, and prescription drug data are essential to discerning individuals’ health needs and comorbidities, new diagnoses, and treatment adherence patterns.

Medi-Cal MCOs have two significant care coordination advantages in the carve-in environment. First, the prescription drug data are available on their own terms, integrated with their staff and information systems in the manner they deem to be most effective. Second, the prescription drug claims information is available to the MCO immediately. Unlike other health services, prescription drugs have no claims submission/payment lag time. These transactions are visible

immediately and can flag issues (a pregnancy vitamin, an opioid medication, etc.) that trigger prompt and valuable care coordination actions. MCOs' ability to coordinate care is supported by a pharmacy carve-in and is compromised by a carve-out.

Several specific programmatic aspects of a pharmacy carve-out are conveyed below, capturing the "lived experience" input from numerous Medi-Cal MCOs through quotes from their pharmacy directors.

There is widespread value of maintaining in-house pharmacy staff expertise in delivering whole person care coordination. Some examples include:

- The UM team that reviews medical coverage requests relies heavily on pharmacy support, such as for physician-administered drugs. Losing access to these in-house resources could result in unnecessary delays in care in many situations.
- Care coordination and case management staff rely on our pharmacy team to facilitate medication reconciliation, provide clinical expertise as needed, remove barriers to access, and support transitions in care.
- Our Quality Improvement staff rely on our pharmacy staff to ensure proper clinical design of initiatives and programs related to pharmacy, as well as for collaboration on interventions. Pharmacy staff are instrumental in developing clinical programs where medication treatment is a factor, such as chronic disease management, opioid substance use disorder, maternal health, mental health, and many other areas.

"We have yet to enjoy any real time data from DHCS. The data we have received for the medications that have been carved out (e.g., psychotropics) have often arrived months later than the fill dates. Real time data is critical for population-based diseases such as diabetes and asthma in order for timely interaction and avoidance of preventable high-cost resource utilization."

"[The state has indicated it] would be providing "daily" pharmacy claims data to the plans. This is not real-time data, this is a daily flat file. Pharmacy claims are often processed, reversed, reprocessed, re-reversed, until they are dispensed and picked up. It is possible to write the programming logic to deal with the daily claim noise, but this will not come near matching what we are able to accomplish where we control the data flows under the carve-in. Daily data feeds, even if they occur, will fall far short of real-time access."

“We utilize real-time pharmacy claims data on a daily basis for several programs. We provide access to claims data to prescribers so they can see medications their patients are receiving that were prescribed by other providers. We utilize data for several programs, including tobacco cessation, opioid overutilization, polypharmacy reviews, disease management, case management, whole person care, the whole child model, interdisciplinary care teams, HEDIS quality measures, risk assessment, identifying target populations, and FWA. Not having access to real-time pharmacy claims data will significantly hinder all of the above programs and reduce quality of care as well as HEDIS scores.”

“We also utilize real-time pharmacy data for pharmacy-related Customer Service inquiries. Oftentimes when members call, they do not have the information needed to address their issues. We are able to look into the pharmacy claims system for both paid and rejected claims to ascertain the necessary information. Without this access, we will lose the ability to assist members in these kinds of situations.”

Medication Access and Adherence Support

The Medi-Cal MCOs deliver a compelling level and mix of support to their members regarding accessing needed medications and adhering to prescribed regimens. A lengthy list of examples of efforts the health plans are making in these areas is provided in [Appendix A](#). A few of these examples and programs are conveyed below. A pharmacy carve-out model compromises the MCOs technical ability to deliver these supports, as well as the financial viability of doing so.

Real-time pharmacy data are:

- used to identify the presence of pharmacy utilization and certain medical conditions;
- crucial in informing a member’s current medication profile during time-sensitive transitions of care situations;
- necessary to allow health plan staff to effectively resolve issues preventing access to prescription drugs;
- important in supporting interventions to improve quality such as within over a dozen pharmacy-related HEDIS measures;
- shared with other partners in care, such as county behavioral health services to support common initiatives and goals;
- imperative to establish a full picture of a patient’s condition or overall utilization trends to offset the absence of information and general claims lag challenges that occur with medical data;
- valuable in identifying and managing FWA within the medical benefit and the pharmacy benefit.

“We know by name many of the pharmacists working in [our county]. In times of drug shortages, we work together to identify which pharmacies have supplies (e.g., Epipen and Shingrix shortages) and the pharmacists transfer prescriptions to wherever supply is available. Pharmacists also call us when a formulary drug is in short supply so we can open access to an alternative medication until the supply problem is corrected.” -- Medi-Cal MCO Pharmacy Director

“A member living in a single room occupancy situation reported that she has had her medications stolen by her roommates when she leaves. We supplied this member with a fanny pack so she can take her medications with her when she leaves.” -- Medi-Cal MCO Pharmacy Director

“We have several members who were lost to follow-up but who we have been able to reach through the pharmacist because the pharmacist was the healthcare professional most recently in touch with the member.” -- Medi-Cal MCO Pharmacy Director

“Our pharmacy team was notified late in the afternoon of a child having difficulty obtaining a specialty medication that had complicated billing issues and could only be dispensed by one pharmacy. The child was in jeopardy of not continuing his therapy. Our Pharmacy Supervisor stayed on the phone with the specialty pharmacy for over 60 minutes to resolve the billing issue and got the medication to the member the next day.” -- Medi-Cal MCO Pharmacy Director

“A member called while on travel because his medications rejected at the pharmacy and he was told they were not covered. Our member services representative (MSR) quickly diffused the situation by letting the member know the medication is covered and placed an out-of-state override. The MSR then called the pharmacy, which reprocessed the claims. The MSR then called the member to let him know the medications were ready for pick-up.” -- Medi-Cal MCO Pharmacy Director

“During a post-discharge reconciliation, our pharmacist reviewed medication claims and noticed the member had received Glipizide 5 mg refills since 2017 but this medication was not on the patient’s list. After discussing this with the PCP, the Glipizide prescription was cancelled.” -- Medi-Cal MCO Pharmacy Director

“A member had trouble filling Suboxone. Our pharmacist clarified with the network pharmacist to use the attending’s license (rather than the resident’s) to reprocess the claim. The member was then able to promptly obtain the medication.” -- Medi-Cal MCO Pharmacy Director

“A member with dementia was getting worse, breaking windows, disrobing, etc. We determined that he was on a anticholinergic medication and an anticholinesterase inhibitor, which were essentially cancelling one another out. Our pharmacist noticed the interaction and suggested a change. The anticholinergic was discontinued and the member improved dramatically the next day.” -- Medi-Cal MCO Pharmacy Director

“A member with breast cancer was filling both anastrozole and exemestane. Member was supposed to discontinue anastrozole three months ago, when starting on exemestane. The dispensing pharmacy continued to fill anastrozole without checking with the prescriber, and the prescriber was under the impression that anastrozole had been discontinued. We called both the prescriber and the pharmacy regarding the duplication and harm risk, and then notified the member to discontinue the anastrozole.” -- Medi-Cal MCO Pharmacy Director

“A five year old boy received a kidney transplant, requiring medications to prevent organ transplant rejection. The hospital notified us after 3 pm to request coverage of a non-formulary brand instead of the available generic. Our pharmacy staff worked immediately to make an exception for the brand. In leveraging our relationship with the local pharmacy, we were able to confirm the medication was ready the same day in less than two hours from the hospital’s request, ensuring timely discharge.” -- Medi-Cal MCO Pharmacy Director

“To support a 62 year old member with adherence challenges, our staff coordinated with a community social worker and with the neighborhood pharmacy to repackage his medications in bubble-packs sorted by time of day.” -- Medi-Cal MCO Pharmacy Director

Programmatic Impact of a Uniform Preferred Drug List (PDL)

The use of a uniform PDL is promoted both for fiscal and programmatic advantages. The prior section of the report indicates that a change to a uniform PDL will create large-scale increases in Medi-Cal expenditures relative to the formulary latitude that exists in the current carve-in. This section assesses the programmatic arguments made in favor of and against a uniform PDL, and also assesses the programmatic aspects of a uniform PDL relative to a carve-out.

1) Administrative Simplification: The key argument made for a uniform PDL is the administrative simplification it may offer enrollees and prescribers. Currently, for one-fifth of Medi-Cal MCO enrollees, there is only one Medi-Cal MCO in operation via the County Organized Health System (COHS) model. In the most common Medi-Cal model, two MCOs serve the county along with the FFS program. While current MCO formularies are based on the FFS PDL, there is variation across plan formularies. A uniform PDL across all MCOs and FFS could simplify the program for enrollees. The same programmatic advantage would exist to some extent for prescribers – there would be one Medi-Cal program PDL in lieu of multiple current PDLs – one for each Medi-Cal MCO and one for FFS.

The uniform PDL may offer limited administrative simplification for providers, however. The administrative simplification argument looks at PDLs only through a Medicaid lens, whereas the provider community faces a much broader set of dynamics. Medi-Cal pays for only approximately 21% of population-wide prescriptions in California, based on Kaiser Family Foundation website data. Creating “uniformity” for the Medi-Cal PDL does not change the number of PDLs that are in use for other managed care plans (such as commercial or Medicare Part D) which pay for more than three quarters of all California prescriptions. Medicare Part D and private insurance do not have PDL uniformity. Thus, the prescriber and pharmacy community will need to work with dozens of PDLs regardless of California’s Medi-Cal PDL policies.

“It is also important to note that advancing technologies are making multiple PDLs much easier to work with for the prescriber community. One Medi-Cal MCO pharmacy director noted that “With e-prescribing occurring for the vast majority (more than 70%) of our member prescriptions written, the e-prescribing systems assist the prescriber with differences from formulary to formulary across all commercial and government pharmacy benefits. For the remaining prescriptions not written via e-prescribing, simple and free formulary tools like Epocrates help prescribers quickly look up formulary and drug dosing guidelines.”

Medi-Cal MCO Pharmacy Director

Creating Medicaid PDL “oneness” comes at the expense of maintaining consistent PDL content for any given health plan. Many Medi-Cal health plans serve other populations in addition to Medicaid. A uniform PDL seeks to force-fit prescribing activity into a “Medicaid silo” that does not exist in California.

”Since there are a myriad of commercial and Medicare Part D plans, prescribers and pharmacies are accustomed to working with multiple payors each with their own unique PDL and benefit design. Carving out and consolidating Medi-Cal pharmacy benefits into a uniform state-administered PDL will not simplify nor reduce the administrative work for physicians and pharmacies to the extent predicted by the carve-out model.”

– Medi-Cal MCO Pharmacy Administrative Contractor

California providers currently have relatively modest Medi-Cal FFS prescription volume, but routinely serve patients of the same plan across the health plan’s multiple products. For example, a Medi-Cal enrollee is more likely to be viewed as an “Inland Empire patient” or a “Molina patient” rather than as a Medi-Cal patient. Forcing providers to look up different formularies within the same payer entity adds to their administrative burden. California’s Medi-Cal program has been restructured to be managed by various MCOs, with the express objective of creating a more mainstream system of coverage for impoverished Californians than Medi-Cal can achieve on its own. Any effort to create Medi-Cal uniformity across these health

plans risks creating more provider confusion and burden than it will alleviate.

2) PDL Updating: One key cost management advantage of the PDL latitude model is the speed at which MCOs can make appropriate modifications to their PDL to accommodate the introduction of new drugs, pricing changes, etc.

Medi-Cal health plans provided numerous examples to us regarding how they are more nimbly able to modify their PDLs than the state is able to modify its Medi-Cal PDL, a few of which are conveyed below.

- Recent examples include Proventil, Ventolin, Viread, generic Reyataz, generic Adcirca, generic Albenz, generic Epclusa, and more minor drugs such as generic ophthalmic drops, Cosopt.
- In the diabetes area, preference of alogliptin, Admelog, and Basaglar
- Identifying generics, authorized generics, and biosimilars as has occurred with Mavyret, Glatopa, glatiramer acetate, albuterol sulfate HFA, Respliclick, and Advair Diskus with Wixela Inhub and Retacrit.

“A local Medi-Cal managed care formulary can be nimble and can be adjusted based on community needs and/or to align with other payers in an area. A universal PDL would not allow for this flexibility.” -- Pharmacy Director in a County Organized Health System Medi-Cal MCO

3) Supplemental Rebates: The uniform PDL will lead to enhanced supplemental rebate revenues, as the State of California will be able to negotiate with manufactures with the leverage of all Medi-Cal prescription volume in each therapeutic drug class.

The cost impact estimates in Section III factor in the additional supplemental rebates states using the uniform PDL approach (e.g. Florida and Texas) are obtaining. These additional rebates are helpful in and of themselves. However, the comprehensive data analyses we are able to conduct

demonstrate that these additional rebates do not come close to offsetting the increased costs that occur at the “front end” when the drug mix moves to costlier drugs (e.g. fewer generics).

Of perhaps greater concern is the psychological attractiveness rebates seem to enjoy among many state purchasers and policymakers. The rebate revenues that arrive have a “bonus money” aura. In addition, the negotiation of supplemental rebates creates a vivid “savings” figure that can be touted, notwithstanding that the placement of these brand drugs are often creating net costs rather than savings. As shown in Section II, the preponderance of the states’ Medicaid experience with rebate-focused approaches has been that overall net costs are much higher than when a front-end drug-mix management strategy is deployed.

Nationwide the average net cost of a brand drug (after rebates) is nine times the average generic. It is critical that California not get caught up in “playing the wrong game” in its effort to manage Medi-Cal prescription drug costs.

“Any ‘consistency’ benefits to the providers and pharmacies are vastly overshadowed by the potential loss of local provider input into the formulary, the loss of professional relationships between the health plan clinicians and the network care givers. Similar to the Kaiser system, we often consult with local clinical experts on formulary drug placement and prior authorization criteria. Our network providers asked for local access for specialty pharmacy to serve members with housing challenges who can’t have medications delivered to a home mailbox. Our providers asked for pharmacy benefit coverage for home blood pressure monitoring to help members improve compliance and self-management. Our providers asked for 90-day coverage of chronic brand medications to improve medication compliance for diabetes, asthma, hypertension, cholesterol, etc. Our providers tend to evaluate whole person care and understand the importance of reducing access barriers to medications as critical to preventing illness, hospitalizations, ER visits, etc. In addition, the provider community supports the Knox-Keene protections including the standard CA PA form, PA TATs, accessible Formulary and PA criteria, clear NOAs, appeal rights, mandated local provider input into formularies, mandated clinical-decisions by plans, etc.”
-- Pharmacy Director in a Two-Plan Model County’s Medi-Cal MCO

“The state shouldn’t concentrate on optimizing rebates, but instead should concentrate on managing the front-end cost of drugs. -- Medi-Cal MCO Pharmacy Director

“Our PBM, which is midsized, represents more than 50 million lives currently.”

-- Medi-Cal MCO Pharmacy Director

“DHCS is now basing all FFS pharmacy reimbursement on NADAC (national average drug acquisition cost) for all pharmacies. A health plan or PBM would generally not pay a large pharmacy chain the same average acquisition price as a small independent because the chain is not paying the average cost to acquire the medication. Generally, standardization may make things easier but rarely does is lead to cost management.” -- Medi-Cal MCO Pharmacy Director

- 4) **Purchasing Power:** Another issue related to the supplemental rebates is that policymakers often feel they are acquiring better purchasing power through a uniform PDL. With all Medicaid volume behind them, states feel uniquely positioned to negotiate more favorable rebates with manufacturers. What is typically missed in this calculation, however, is that the MCOs are typically contracting with pharmaceutical benefits management (PBM) entities that have far more covered lives of purchasing power than the California Medi-Cal population represents (even if combined with other state health coverage programs such as state employees, correctional health, etc.). In this context, the uniform PDL can only diminish the baseline level of prescription drug purchasing power the Medi-Cal program is currently accessing through its MCO partners.

Programmatic Advantages Of Uniform PDL Relative to Carve-Out

While our assessment indicates that the programmatic aspects of a uniform PDL are inferior to the current model of affording the MCOs latitude over their own PDL configurations, there are several reasons why a uniform PDL is programmatically advantageous relative to a complete carve-out of the drug benefit. These are briefly described below.

- *Real-Time Data:* By maintaining the carve-in model with a uniform PDL, the MCOs would continue to capture pharmacy transaction data in real-time, on the information technology platform they are accustomed to using. This would be of significant benefit to the health plans' care coordination efforts relative to a carve-out model. As described previously, the carve-out model would at best disrupt and weaken the existing integrated programs and data flows, and at worst force a discontinuation of many of these care coordination activities and techniques.
- *Preservation of Access and Adherence Initiatives:* The uniform PDL would not jeopardize the vast array of access and adherence programs and activities the health plans undertake. The processes described in this report (in the above section and in Appendix A) would be impaired or eliminated under a carve-out, but not by a uniform PDL within the carve-in structure.
- *Preservation of Integrated Member Services:* Under a uniform PDL, member services calls regarding the pharmacy benefits would continue to come to the MCO and the handling of these calls can be integrated with other health services. For example, during a call about a prescription refill the health plans can often become aware, in real time, that the member (and/or other members residing in the same household) are overdue for a preventive service. The member services call can address the refill issue but also address the other gap(s) in care – such as by placing three-way call to the PCP to schedule an appointment. Under the carve-out model, members will extensively continue to contact the MCO about pharmacy-related issues, but the MCO will need to refer these members to the state-operated call center. When members contact the state-operated call center for their medication-related needs, there will be no ability on the state's part to deliver the types of integrated support described above.

V. Concluding Observations

Moving to a pharmacy carve-out model for the Medi-Cal managed care programs inherently diminishes the integrated system of health coverage that is being delivered to California's impoverished residents. Medications are a central component of health treatment. Access and adherence to an optimal medication regimen are essential to this population's health.

Effective administration of the pharmacy benefit involves four major components:

- (1) Sound management of the mix of drugs prescribed.
- (2) Sound management of the net price of each drug.
- (3) Integration of prescription drugs and data with medical care and data.
- (4) Extensive efforts to assist beneficiaries in accessing and adhering to an optimal medication regimen.

The carve-out model is focused almost entirely on the second of these components – securing the lowest possible net price for the medications prescribed. While the extent to which these unit price advantages will materialize for the Medi-Cal program is debatable, overwhelming evidence exists that the pharmacy carve-out will diminish Medi-Cal's ability to achieve the other three critical components – effective drug mix management, optimal integration and coordination across pharmacy and medical services, and robust access and adherence support mechanisms.

The traditional FFS Medicaid setting has always been effective at minimizing unit prices to providers. However, controlling *only* this lever led Medicaid to become an increasingly substandard payer, with providers unwilling to accept Medicaid thwarting the very access to care the Medicaid program is seeking to deliver. California has been a pioneer state in moving away from this traditional model to a system of coverage focused on identifying and addressing the beneficiary's needs through full-risk contracting with MCOs. Decades later, more than 70 percent of the nation's Medicaid prescription drugs are paid by MCOs and the cost-effectiveness of these efforts is well documented. It is concerning that California's policymakers are considering moving backwards – pursuing a price-centered and siloed strategy at the expense of other critical program objectives.

Our financial impact analyses indicate that the state would incur significant costs if it adopts a carve-out. California's state fund costs of the carve-out approach are estimated at \$51 million in the first year (SFY2020) and \$757 million across the five-year timeframe SFY2020 – SFY2024. Even more concerning are the carve-out's adverse programmatic impacts on care coordination, as conveyed throughout Section IV.

We encourage California policymakers to preserve the carve-in and focus instead on available options for cost savings and administrative improvements within this integrated structure.

APPENDIX A

**EXAMPLES OF MEDI-CAL MCOs' EFFORTS TO ANALYZE
AND FACILITATE MEMBER ACCESS AND ADHERENCE TO
NEEDED MEDICATIONS**

Helping a Member Access a Needed Drug

1. Access: Medication Storage

Many members report having significant issues with medication storage. Working with the community and care team, a health plan's pharmacy team took the following steps to ensure that members could store medications safely and efficiently: funded lockers at needle exchange centers for Hepatitis C medication storage; contracted with a local specialty pharmacy that dispense smaller medication quantities as needed; identified all our pharmacies that Blister-Pak daily doses; have medications delivered to clinics for storage, and provide fanny packs (see image) for secure, discrete on-person medication storage.

2. Access: Marginal Housing and Fanny Packs

A member reported to his care coordinator that he is marginally housed and is storing medications with a friend. This friend has a history of then withholding the member's medication. The health plan supplied this member with a fanny pack as an option for keeping his medications with him, rather than relying on his friend.

3. Access: Single Room Occupancy

A member living in a single room occupancy reported that she has had her medications stolen by her roommates when she leaves. The health plan supplied this member with a fanny pack so she can take her medications with her when she leaves.

4. Access: Establishing Strong Relationships with Local Pharmacists

A health plan has established relationships (first-name basis) with many pharmacists working in local independent and chain pharmacies. In times of drug shortages, the plan works together to identify which pharmacies have supplies (i.e. Epipen and Shingrix shortages) and the pharmacists transfer prescriptions wherever supply is available.

5. Access: Working with Pharmacies to Find Members

Health plans partner with pharmacies to find members who are lost to follow-up through their relationship with a pharmacy. Several members became eligible for housing but were lost-to-follow-up—the health plan was able to reach out to these members through their pharmacist. The health plan prepared a housing notice for the member and gave a copy to the pharmacist to give to the member, as the pharmacist was the healthcare professional most recently in touch with the member.

6. Access: Compound Medication Access

Sterile eye drops compound medication prescribed by a tertiary Specialist for chronic use— No compounding pharmacy was capable of filling this prescription was willing to become a Medical provider. The member was paying cash for the prescription, which the pharmacy discovered when the member asked for reimbursement. A health plan identified a qualified compounding pharmacy that would fill the prescription monthly and bill the plan directly.

7. Access: Formulary Management

A health plan covers a 90-day supply of chronic, non-specialty medications and formulary agents to promote compliance including pen-needles, insulin pens, inhalers with high compliance rates,

and many combination medications for hypertension and asthma for example. Formulary changes can be based on direct provider feedback during a prior authorization case.

For example, Orencia® was requested by a local expert physician based on a just published trial which he provided with the request. The plan updated our criteria with this new indication within 10 business days. Furthermore, the Formulary covers OTC medications and supplies that are often safer than prescription options and facilitate self-management for minor conditions. Examples include OTC heat pads for muscle pain, melatonin for sleep, adult diapers for incontinence, chewable aspirin, condoms, home blood pressure monitors and large cuffs. The formulary is often adjusted to fit the needs of an individual member.

8. Access: Efficient Authorization Process

Authorizations for chronic medications (brand and generic) are placed as indefinite authorizations- annual renewal is not required and there is no 6 Treatment Authorization Request (TAR) limit. Urgent authorizations are available immediately— there is no delay of 24 to 48 hours for an urgent authorization. Our pharmacy staff are often on the phone with the pharmacy to ensure the authorization is entered correctly and the claim can process. Members can pick up a small partial fill supply and refill as much as needed (based on storage issues for example) with no concerns about the 6 TAR limit.

9. Access: Establishing Constructive Partnerships with Local Prescribers

Prior to implementing a 7-day supply limit on initial prescriptions for short acting opioid medications, the pharmacist and the Chief Medical Officer (CMO) attended provider meetings with all our major medical groups to discuss the clinical problem, the evidence and the proposed intervention. During these meetings, providers were both informed of the planned 7-day limit and asked for input regarding concerns. As a result of these meetings, a list of exempted providers was created. These providers would routinely have clinical reason to initiate a longer day supply of opioid medications: oncologists, palliative care specialist, etc. Member focused materials on the initial day supply limit for short acting opioids were also created at the behest of providers.

10. Access: Transition of Care Program

A Transition of Care plan has been established where health plan and provider office staff will communicate any changes in medications, gaps in therapy, compliance issues, and inappropriate drug. Our team talks with the hospital, clinic provider, nurses and pharmacist to come up with a recommended treatment plan that will most benefit the patient.

- Reviewing daily prior authorizations requests
- UM medication requests (J-codes)
- Providing very significant daily support to member services when members call with questions regarding why their medications are not available/troubleshoot,
- Work with G&A to ensure appeals are dealt with appropriately (providing necessary documentation for decisions and access to updates)
- Provide recommendations/background information as needed to MDs as they review appeals
- Outreach letters to members and providers regarding negative formulary changes
- Work with provider relations to ensure that members are receiving appropriate medication management (e.g. with inappropriate medication prior authorizations)

11. Access: Child Having Difficulty Obtaining Specialty Medication

The health plan's pharmacy staff was notified by Care Coordination late in the afternoon of a CCS child having difficulty obtaining a specialty medication that had complicated billing issues and could only be dispensed by one pharmacy. The child had been using this medication for several months and was in jeopardy of not being able to continue his scheduled therapy. Using the pharmacy processing platform, our Pharmacy Supervisor stayed on the phone for over 60 minutes with the pharmacist from the specialty pharmacy to resolve the claim billing issue and got the medication shipped to the member the next day. Access to the pharmacy processing platform and cross-departmental efforts allowed the issue to be resolved in real time and prevented delay and disruption of care to the member.

12. Access: Difficulty Finding Medication at Local Pharmacy

A Member's family could not find a pharmacy with Fycompa in stock for a member who needed to be discharged. To ensure a safe discharge home, the facility would not discharge the member until family could get Fycompa prescription filled. The plan's pharmacist called multiple pharmacies and was able to locate a pharmacy with the medication in stock that day. Family was able to obtain medication timely, and member was scheduled for discharge.

13. Access: Overcoming Medication Supply Shortage

Member had difficulty obtaining Lonsurf. The Pharmacy Coordinator called the plan's preferred limited distribution drug (LDD) pharmacies to check availability. Preferred pharmacies were unable to order Lonsurf. Coordinator called other pharmacies and was able to find an LDD pharmacy that could order the drug. Coordinator facilitated prescription transfer process with pharmacies and worked with Customer Service to keep the member updated throughout the process.

14. Access: Member's Inability to Obtain Prescription Refills

Member was unable to obtain prescription refills and expressed frustration that the pharmacy had contacted the doctor's office multiple times without success. Our Pharmacy Coordinator assisted by calling the doctor's office to initiate a request for a new prescriptions to be sent to the member's pharmacy. This occurs with new requests as well as expired prior authorizations.

15. Access: Customer Service Interactions

When members contact Customer Service about the status of their prior authorization submitted by their provider and request it to be urgently reviewed, the plan's pharmacists are able to find the request in the queue for prompt review. Upon approval, our pharmacy staff outreach to the pharmacy to process the claims successfully and notify the member.

16. Access: Culturally Tailored Support

A member of the Native American community was interested in holistic remedies for his conditions. The health plan discussed which medications he "had" to take to address high blood pressure, but the member shared that he had worked with his Primary Care Physician to add more homeopathic remedies as well. A Case Manager was able to look up his pharmacy utilization history to review what medications he had filled across the previous 12 months. The member further reported to have chronic back pain and while discussing the natural remedies he had tried and his preference to avoid the use of pain medications, his Case Manager offered the Silver and Fit Tai Chi home kit. The member was thrilled to have an option that was in line with his cultural

values and expressed gratitude that an insurance representative honored his wishes to address medical issues as holistically as possible. Without having access to his prescribed medication profile, his care coordination and self-directed individualized care plan development would have been less successful.

17. Access: Culturally Tailored Support

There have been multiple instances where our Spanish speaking technicians identified that a member didn't understand a medication such as insulin was covered by their plan, and so they were paying hundreds of dollars and countless hours making the commute to Mexico to pay cash for their medication. These examples are able to be identified by pharmacy technicians who are culturally aware of the needs of the members who come in and because the technicians understand the pharmacy benefit. Thus, they were able to explain the matter so that members could truly understand their benefits at hand.

18. Access: Complex Case Management Support

The plan assisted a Member who was identified to meet complex case management program enrollment due to uncontrolled chronic conditions, multiple hospitalization and multiple ED visits. One of her uncontrolled chronic conditions was hyponatremia which resulted in 2 acute inpatient hospital admissions. As part of her post discharge plan, Member was given a prescription for sodium chloride tablets to continue outpatient treatment initiated during her inpatient course, to maintain an optimal electrolyte balance. Her PCP had to complete a pharmacy prior authorization request form for sodium chloride tablets, however this request was denied at the pharmacy review level and an appeal was upheld because drug is considered to be OTC and non-FDA approved. Member's sodium level was also getting closer to normal range, which contributed to the denial. The Member began having side effects of headaches and very high blood pressure (which could have been due to the sodium chloride medication she had been receiving during her inpatient stay). The health plan collaborated with our medical director and coordinated/facilitated referral to [provider] for a second opinion and to assess further work up to find root cause of symptoms. Nephrologist submitted a new Prior Authorization request for both a diuretic and continued sodium chloride tablets, which were approved while the dosage of oral sodium chloride was being monitored and adjusted until an optimal level had been maintained. Subsequently, the member adhered to appropriate regimen prescribed by Nephrologist and her condition was managed effectively, no longer requiring sodium tablets.

19. Access: Advair Call for a Nebulization Mask

Team member followed up with patient by contacting UM department regarding status of approval of nebulization mask. After talking to UM contact, this approval was complete but not submitted. Once the fax was submitted for approval, the team member ensured that the patient would receive the nebulizer mask via the medical supply pharmacy. The member was very pleased with excellent customer service. It took her days to figure out the status of her approval for her nebulization mask and was possibly non-adherent with medications due to improper administration. Because of the team member's follow up, patient was able to get the needed device within 24 hours.

20. Access: Difficulty Receiving Seizure Medication for Daughter

A team member received a call asking for assistance with a member that was having a hard time trying to receive her daughter's seizure medication (PHENOBARB TAB 64.8MG) and asked what the process for a member was to get reimbursed if they were to pay for the medication out of pocket. After checking NaviClaims, it seemed that the member was able to receive the medication in the past at lower quantities (#42tabs/14 days) so there was no reason why this medication shouldn't go through if they are due for it. A mock claim was processed by the technician who took the call before me to prove PHENOBARB 64.8MG #90tabs/30 Days will go through without an issue. The team member called the pharmacy and spoke directly to a pharmacist who stated that the rejection was "Plan limitations exceeded." The reason it was rejecting this time, as opposed to the last couple times, was because this is a controlled substance and it can only have a set number of refills before a new Rx is needed & the prescription is only good for 5 months or 120 days (whichever is less). Understanding all this, the member would only need a new Rx to be able to process through the health plan. The member's mother mentioned that they only see a physician twice a year and have had great difficulty getting hold of the physician's office. The team member called the physician's office a couple times but kept getting the round around until they were finally transferred to the nurse advise line who was only able to send a message to the physician. However, because of the timing of the call, the patient would not get a response until the next day, soonest. Unfortunately, the member only had a night and morning dose before being completely out. Our team member called the physician's office the next morning and after some light badgering, another message was sent out. The team member was assured by the physician's office that this issue would be resolved, and before calling the office again, they called the pharmacy an hour later. Per the pharmacist technician, the prescription was received for a full month's supply. Our team member called the member's mother (to inform her about all this and how the medication will be ready by 1pm for pick up. She was ecstatic by the news and couldn't say enough good things about the plan. She stated that the pharmacy quoted her a price of \$50 for a 2-week supply of the medication and couldn't imagine having to pay that every couple of weeks to keep her daughter from seizing. The team member informed the mother that if she has any more issues or questions on the medication to give us a call back and definitely never pay for anything out of pocket before contacting us.

21. Access: Continuation of Pain Management Medication

A team member received a call from) asking for assistance with a member that was not able to receive his Oxycodone/Apap 10-325mg & Oxycotin 20mg CR through his mail order services. Per NaviClaims, the member last filled these medications for a 30-day supply and would not be due until the next month. Per mock claims, the next fill date would be 4/11. The pharmacy representative forwarded this to the member who would not accept this, saying he needs his medication to be filled even though he should have more than a couple weeks' worth of medications. The team member asked the representative to forward the call to them directly to explain to the member why the next fill date is not until the next month. Per the member, he was out of medication for 2 weeks due to pharmacies in his location not being able to fill it and being turned away at the ER when he tried to receive it there. Stating "they laughed in my face when I tried to fill it with them." The team member advised them that based on when the claims were processed and when he received them, he should still have enough medication for at least 20 days and his next fill is the following month. The Member went on to say that if he doesn't fill his medication when his provider writes his Rx, he will get in trouble and it will look like he is not

taking the medications as prescribed (he went on to say, he's been on these meds for 9 years and the problem is to just keep the medications away from children and there will not be any issues, among other comments). The team member advised the member that they would talk to both the physician's office and our mail order service to explain and resolve the issue. The member reluctantly agreed.

The team member called to inquire when the member got his medication shipped and received and if they have a new Rx for next month's fills which was confirmed. If the member needs medications shipped quicker that he would need to pay for them (Overnight=\$32, 2 day=\$13, & USPS Priority 3 days=\$7). Due to the member being upset as to when the medication gets filled and when the member actually received them, the Team Member asked that they just make a note to process the medications and ship them a week early— this way the member would have about a week's worth of medications while the new shipment is in the mail and he wouldn't need to pay any extra to get them there on time. The Team Member followed up with the member and explained that if he runs into any more issues to call the health plan first and ask for them to resolve his issues. The Team Member provided the member with their direct phone number and a schedule of when he would need to call PPS to get the next fill shipped out. The Team Member was able to calm the member down and help establish the proper avenues for going forward and preventing similar situations in the future.

22. Access: Difficulty Receiving Baby Formula

At the appeal level a member was having a difficult time obtaining an authorization for her baby's formula. The Social Services team reached out to us and informed us that her car was stolen and the formula was inside. The pharmacy team reviewed the authorization request in a timely manner and identified the steps quickly to allow the member immediate access to the formula for her baby. The member was extremely grateful, and her baby was able to obtain immediate care and attention.

23. Access: Plan Limitations Exceeded for a Number of Refills

A member contacted the Health Plan to inquire on a claim for CIII medication Acetaminophen/Codeine tab that was being denied at the pharmacy. The pharmacy stated that the plan limitations had been exceeded as the maximum number of refills had been met. After review of the member's pharmacy claim history, it was discovered the member had not exhausted the total number of refills allowed for CIII medications (5 refills) and therefore the claim rejected inappropriately. The issue was escalated to the health plan's PBM for proper system configuration. Follow-up outreach was made to the member the following day to inform her that the issue had been resolved and her pharmacy had been notified and was able to process a successful paid claim for her medication.

24. Access: Health Plan Pharmacists Working with Manufacturer

A health plan pharmacist worked with a manufacturer to increase availability of certain diabetic supplies to pharmacies in our network so our members would have improved access.

25. Access: Obtaining Medications While Out of State

A member called to say that he is in Las Vegas, went to the emergency room, and was released with a few prescriptions. He called in because his medications were rejected at the pharmacy and he was told they were not covered. The Team Member let the member know that the medication is covered and that the plan can place an Out Of State override for him so that he can get his medications. Our Team Member placed the override then made a call to the pharmacy so they could process the prescriptions just so the member would definitely get his medications. The pharmacy reprocessed the claims and our Team Member reached out to the member to let him know his medication was ready.

Facilitating Adherence to Medication Regimen

26. Adherence: Misunderstanding of Medication Indication

During Institutional Care Pharmacy (ICP) outreach, our case manager discovered that the member had a misunderstanding of his medication indication. The member didn't know the names of medications that he had been taking for years. A review of his prescribed pharmacy utilization history revealed that he was using "loratidine" for his "pain" and was taking "naproxen" for his "excessive mucous secretions." Our Nurse Case Manager intervened and provided education as to the names and appearances of his prescribed medications and clarified to the member that that naproxen is for pain and loratidine is an antihistimine.

27. Adherence: Appeal for a Medication Denied by Member's Primary Insurance

Normally, denials are supposed to go through the primary insurance appeals process instead of the health plan. The member's provider was having difficulty getting in touch with the correct people at the member's primary insurance. The health plan's pharmacists called the primary insurance and after many transfers was finally able to get in touch with one of their medical directors. She then conferenced in the provider who was able to explain the need for the medication to the insurer's medical director and it was then approved.

28. Adherence: Transitions of Care

Health Plan Pharmacist established collaborative relationship to support transitions of care with inpatient pharmacists. When members are admitted to hospital, hospital can receive medication changes or additions through reconciled medication list or paid pharmacy claims. Upon discharge, the new medication regimen is clarified for all involved.

29. Adherence: Post-Discharge Medication Recommendation

During post-discharge medication reconciliation, pharmacist reviewed medication claims and noticed client was receiving Glipizide 5mg refills since 2017 but was not on the hospital's medication list. Pharmacist contacted the nurse practitioner managing client's diabetes and informed them that client was taking Glipizide. NP stated " Glipizide had been discontinued before working with patient in summer 2017" and called the client to not continue taking Glipizide. Pharmacist called the pharmacy and cancelled the Glipizide prescription.

30. Adherence: Switching Medications

After a post-discharge medication reconciliation, our pharmacist recommended PCP to switch client's Metformin from immediate release (IR) to extended release (ER) formulation for adherence benefits. At the next PCP visit, client was switched from IR to ER and client reported less pill burden taking once daily.

31. Adherence: Post-Discharge Medication for a Member who had Suffered a Stroke

Pharmacist was completing post-discharge medication reconciliation for member who had a recent stroke and was discharged to the daughter's home. Pharmacist reviewed pharmacy claims and noticed member attempted to pick up medications at the local pharmacy but was denied due to out-of-network. Pharmacist placed override code and called the pharmacy to process the claim. Pharmacist communicated with Care Coordinator who called member that needed medications are ready for pick-up. Member/Caregiver were grateful they did not need to drive to a distant pharmacy to pick up medications.

32. Adherence: Reconciled Medication Lists

A health plan pharmacist provided a reconciled medication list to a patient that did not show up to medication review appointments. A client had been taken off Xarelto and Keppra by their PCP but re-started while inpatient because hospital had an old medication list. Notification was sent to the Ambulatory Service Pharmacy manager who forwarded information to Inpatient Pharmacist working with the client. Both medications were discontinued during the hospital stay.

33. Adherence: Pharmacist Communication with Specialist

Our Pharmacist reviewed medication claims history and noticed paid claims for Losartan and Entresto. Our Pharmacist contacted the PCP and Cardiologist regarding the duplication. Cardiologist acknowledged the discontinuation of Losartan in electronic medical record and not the pharmacy. Pharmacist called pharmacy to inactivate the prescription and notified the Care Coordinator. Care Coordinator visited the client in the afternoon and informed client of the duplicative medication and recommended safe disposal of medications.

34. Adherence: Pharmacist Communication with PCP

A member reported to a CM RN that he takes furosemide three times daily, but our Pharmacist noted that his most recent discharge instructions were to take furosemide once daily. This confusion was reported to the PCP who clarified the dose with the patient.

35. Adherence: Comfort in Hospice Care

A member was put on comfort care measures at a hospice care facility and the family subsequently requested that she be released home. Our Pharmacist completing a medication reconciliation for this member noted that she was still taking all of her chronic medications. Our Pharmacist recommended that all chronic medications be discontinued, and that the member be moved to only the appropriate comfort care related medications.

36. Adherence: Medication Therapy Management (MTM)

A Member had trouble getting Suboxone from his usual pharmacy. The health plan Pharmacist clarified with the network pharmacy to use the attending's license, and to reprocess the claim, not use the resident's. Member was able to pick up the medication.

37. Adherence: Approval of a Continuous Glucose Monitor

The continuous glucose monitor is currently Prior Authorization required. A young adult with type 1 diabetes engaged with our Transitions of Care team with an extremely elevated A1C expressed that he did not like checking his blood sugar and generally avoided the task. Our Pharmacist involved in the case noted that we would approve a continuous glucose monitor for this member, placed an authorization, and informed the care team.

38. Adherence: Care Management

While in the field, a member asks the Care Management nurse a question of which medications are safe to crush and mix with food. The RN consults with our pharmacist and immediately relays that information to the member.

39. Adherence: Case Conference at Medical Respite

Our pharmacist accompanied Care Coordinator to case conference at Medical Respite with client, RN and Housing Manager. Pharmacist clarified medication regimen that client is supposed to be on and recommended clarification on potential unnecessary medications since client had complained of pill burden.

40. Adherence: Medication Consolidation

A member was prescribed Metformin 1000mg BID but reported only taking the morning dose and expressed that he would rather not take medications multiple times a day if possible. As a result, our Pharmacist recommended the patient be switched to Metformin ER tablets to be taken only in the morning. The PCP agreed with the assessment and wrote a new script.

41. Adherence: Difficulty with Transportation to/from Pharmacy and/or Appointments

A member reported that his medication adherence difficulties involved his needing to travel to the pharmacy multiple times in a month. Once completing medication reconciliation, our Care Coordination Pharmacist was able to outreach to the provider and send medications to a pharmacy that both bubble packs medications and delivers. In order to align the bubble pack and delivery, our care coordination pharmacist also placed "med sync" overrides.

42. Adherence: Difficulty with Transportation to/from Pharmacy

A member with multiple chronic conditions (i.e. diabetes, COPD) requiring numerous medications was traveling numerous times to pharmacy to pick up her medications. The member also had limited mobility which made traveling to the pharmacy difficult. Our pharmacist was able to place overrides so that all of her medications could be picked up on the same day, limiting her pharmacy trips to once a month and we provided a medication calendar in the member's preferred language, Spanish.

43. Adherence: Difficulty with Transportation to/from Pharmacy

Our pharmacist saw in chart notes that patient was unable to get to appointments due to lack of reliable transportation. The provider didn't reach out to plan with a referral for transportation. The pharmacist referred these patients to Case Management to ensure patient can get transportation arranged through us.

44. Adherence: Compounded Drug for Infants

We have aided members who needed a compounded drug for infants with tuberculosis. We polled the pharmacy network to see who had the ability and was willing to do so. We then paired the member and pharmacy together to get the needed medication. The health plan will often assist in a similar fashion, members who need drugs that are not routinely stocked, recalled, etc. We will search the network and help the member obtain the therapy.

45. Adherence: Interdisciplinary Case Management Rounds and Patient with Dementia

This is seen both at the transition of care level (hospital SNF, or hospital/SNF ambulatory) and in the outpatient setting identifying members with a high complexity of care. We have various clinics such as a diabetic clinic and MTM clinics which help the member optimally use their medications, look for therapeutic duplications, avoid drug interactions, etc. An example identified in complex case management rounds: A member with dementia was getting worse. Literally breaking out the windows at night, disrobing, etc. The issue was he was on an anticholinergic medication and an anticholinesterase inhibitor, essentially cancelling each other out. At rounds, the doctors, nurses, and social workers were relaying the issues and trying to determine the next steps. The pharmacist noticed the interaction and suggested a change. They discontinued the anticholinergic and the member improved dramatically the next day.

46. Adherence: Interdisciplinary Case Management of Chemotherapy

Multiple instances regarding high cost drugs such as chemotherapy and Soliris where the dispensing pharmacy continued to fill the medication, despite MD stopping it. Error was caught after thorough review of chart notes for the new regimen. Call was made to pharmacy regarding the switch and to confirm with the physician before dispensing.

47. Adherence: Educating Members on Potential Complications

Provider requested a medication for a pediatric patient that can cause blindness. There were no baseline tests done prior to initiating the medication. Involved case management to set up an appointment/referral with an ophthalmologist, speak to the provider regarding regular vision tests and speak to the caregiver regarding the role of remaining compliant with ophthalmology appointments given member's intellectual abilities.

48. Adherence: Provider education on Safe Prescribing

A Member with migraine headaches for months has been consistently filling butalbital products. Provider never addressed the possible connection of butalbital with migraines (medication overuse headaches). We brought this to the provider's attention.

49. Adherence: Provider Trainings

In-service trainings conducted for over 10 clinics regarding insulin initiation and titration. Health plan team members meet with clinicians and hear of their daily shortcomings when it comes to best insulin regimen, formulary coverage, and navigating our provider resources.

50. Adherence: Smoking Cessation Management

A member had been on nicotine replacement therapy (NRT) non-stop for at least the past 3 years. The member was still continuing to smoke as well (individuals should ideally stop smoking when they start NRT). NRT should ideally be used as a bridge on the path to complete cessation of nicotine. We had case management reach out to the member to assess if they are actually ready to quit, and inform them of how a quitting plan works (and that they should stick to the timeline in their plan to achieve success). CM also provided relevant counseling resources and education on how to create a plan for quitting smoking and ideas on how to get around potential barriers to quitting.

51. Adherence: Hepatic Encephalopathy Management

A member was using Lactulose in combination with Xifaxan, but their adherence to Lactulose had not been very good. The member's hepatic encephalopathy was worsening, likely in part due to the member not using their lactulose as prescribed. They were on a large med regimen, so we reached out to case management (CM) to speak with the member. We instructed them to inform the member that the lactulose was used to help their liver, and explain the importance of using it to help with their hepatic encephalopathy. Also informed CM that the med has a side effect of diarrhea, so if the member is hesitant to use it due to this side effect, they should mention that to their doctor.

52. Adherence: Medication Errors

- a) Xarelto was continued at high dose of 15mg BID from hospital, when the dose was supposed to be reduced to 20mg daily after 3 weeks. PCP and dispensing pharmacist continued the high dose, which could have led to fatal bleeding. Multiple calls were made to dispensing pharmacy and PCP office on Friday afternoon, trying to reach someone to prescribe 20mg tablets to prevent gap in therapy to prevent stroke/PE, while not continuing 15mg BID which may lead to bleeding. Was able to reach the Medical Director at the PCP office to prescribe the correct dose of 20mg daily.
- b) When reviewing for a different drug Ibrance, noticed that member was filling both anastrozole and exemestane for breast cancer. Member was supposed to stop anastrozole 3 months ago, when starting on exemestane. Dispensing pharmacy continued to fill without checking with prescriber, and physician was under the impression that one was stopped. Member continued to take both, as pharmacy continued to fill both medications. Called both MDO and pharmacy regarding the duplication and high risk for harm for duplication in therapy. Notified case management to alert the member to confirm with prescriber for clarification. As both anastrozole and exemestane are on formulary, it would not have been caught unless we had access to the whole profile and medication history.
- c) Pharmacy requesting authorization for Keflex 750mg BID as hospital discharge medication, no chart notes submitted. Upon reviewing hospital authorization request from UM department,

noticed that member had recent hospitalization for seizures and started on Keppra 750mg BID. Called the dispensing pharmacy to verify the hard copy, and the pharmacy confirmed that it was supposed to be for antiseizure med Keppra, not antibiotic Keflex. Member received the correct seizure medication on same day.

- d) Infusion pharmacy was processing Entyvio weekly loading dose, instead of maintenance dose every 6 weeks as indicated on chart notes. Called MDO and notified infusion pharmacy regarding change in direction. Also helped set up with Diplomat infusion pharmacy so the member can receive medication at home, instead of driving 3 hours for infusion at Option Care.

53. Adherence: Urgent Request for Synagis for Twins

An urgent request for Synagis was received for twins prior to traveling for a funeral abroad. After approval, our pharmacy technician called the specialty pharmacy regarding the approval and to expedite the process. She also called the pharmacy to confirm the delivery for the next day.

54. Adherence: Access to FDA-approved nitrofurantoin solution instead of compounded

Request from compounding pharmacy for liquid nitrofurantoin compound, due to shortage of FDA-approved nitrofurantoin solution. The health plan asked the pharmacy tech to call local pharmacies regarding availability of nitrofurantoin solution. Found a local pharmacy that carries the product within minutes away from member's home. Confirmed billing through primary insurance for commercially available product. This was also a safety issue as compounded products create a sterility issue for the high-risk member with recent transplant. The Care Manager was notified to ensure that member's caretakers were aware at each step of the process and confirm access to local pharmacy.

55. Adherence: Lidocaine Injection for a Child

A member on a biologic Limited Distribution Drug (LDD) for a 'fever disorder', and the child needed lidocaine to be provided to avoid the sting with the biologic injection. The prescribing MD kept calling in the auto-injectors of lidocaine, no one carries those in local pharmacies plus there is a storage issue. We needed to get the script changed. The script had to be called into a pharmacy that the member could access before the pending weekend – and the child was overdue for the injection. Our pharmacy technician orchestrated the syringes as well, since the original pharmacy for the lidocaine only had certain syringes in-stock vs. the pharmacy that ended up filling the lidocaine vial.

56. Adherence: rejections at point-of-sale due to not having an active pharmacy profile

A newly enrolled member was receiving rejections at point-of-sale due to not having an active pharmacy profile. After review and verification of member eligibility with the plan, a pharmacy profile was created manually and the member was able to obtain medications without further delay.

57. Adherence: alternative to birth control medication that was not covered

A member requested to speak with Clinical Pharmacist in regard to finding an alternative to her birth control medication that was not covered. She was close to running out of her medications and did not want to interrupt her hormone therapy. She was having a hard time finding an alternative through her provider and her local pharmacy. Due to the accessibility of the health plan's pharmacy team, the member was guided to an appropriate medication and through the steps of obtaining the new prescription.

58. Adherence: special needs and inability access rare drug due to shortage

A member with special needs was unable to find and refill an uncommonly used medication that was experiencing a backorder and shortage. The member's primary caretaker, his mother, had tried for a long time and was unable to find any local pharmacy in their area that had the medication; pharmacies had mentioned that very few patients use the medication and therefore they don't keep it in stock. When plan pharmacy staff found out about the situation, the following steps occurred:

- Determined the drug was on backorder locally, despite absence from the FDA drug shortage list.
- Attempted to authorize the brand name product and learned it was no longer manufactured.
- Called additional pharmacies in an expanded area with no success.
- Leverage patterns in historical pharmacy claims data to improve our chances of identifying any pharmacy within the region that had the medication; were able to locate one pharmacy on the other end of the county with the medication in stock.
- Plan pharmacy staff coordinated with member services staff to provide a taxi ride for the member's mother, allowing her to get the medication on the same day.

59. Adherence: Patient Awaiting Discharge with Prescriptions from a Sanctioned Provider

Health plan was notified that a pharmacy was unable to fill all prescriptions for a patient awaiting discharge because one of their behavioral health prescriptions was written by a state sanctioned provider. Coordination with county behavioral health staff resulted in the arrangement for another physician to prescribe the medication and see the patient at an appointment. The pharmacy was notified to ensure discharge would not be delayed.

60. Adherence: Patient with Special Needs and Primary Coverage

Although not her primary insurance, plan pharmacy staff reached out to several pharmacies to identify Out of Pharmacy (OOP) costs under her primary insurance and the cost of special packaging. Through our relationship with a nearby pharmacy, plan staff was able to arrange for special packaging for her medications and even get the pharmacy to agree to waive the member cost-share and the packaging fee due to the member's age and special needs.

61. Adherence: Member with Transient Primary and Medi-Cal Coverage

Due to fluctuations in employment status, a member experienced transient coverage through primary insurance and Medi-Cal, which caused issues with filling a specialty medication. Frustrated with the

pharmacies who were unable to fill his medication, the member found it more convenient to go to the ED every day to get his medications filled. Upon learning of the situation, plan care coordination staff intervened and worked with member services to resolve his eligibility issue. Through multiple efforts including 3-way calls with stakeholders such as both pharmacies and the member, plan staff were able to ensure his medications were filled, ready, and delivered to the member. This immediately resolved the ED utilization issue.

62. Adherence: Ensuring compliance in member going through hardships

A Member with COPD, bipolar disease and epilepsy experienced recent hospitalizations due to wildfires and increasing shortness of breath. The Member was not taking any medications for her COPD. For her condition the member should be on 3-4 different inhalers but due to other co-morbid conditions and lack of compliance, Health Plan team member approved one medication that is the combination of 3 different medications to reduce pill burden and improve compliance. Otherwise, the member would have continued with hospitalizations. Also referred to case management so a nurse can speak to member regarding the role of compliance.

63. Adherence: Medication Adherence Outreach to Patient with End-Stage Renal Disease

For a Member with End Stage Renal Disease and metabolic disorders, the provider requested an 'add on' phosphate binder to member's current regimen (sevelamer and Sensipar). Provider did not know that the rising phosphate levels are due to non-compliance. Health plan team member spoke with the provider regarding addressing non-compliance and enrolled member in case management to help her understand the role of compliance and consequences given her current condition.

64. Adherence: Difficulty Obtaining Inhaler and Lantus

During an Outbound Call (OBC) to a patient to inform her of formulary changes related to her inhaler, the patient informed the health plan team member that she was having trouble obtaining another inhaler and Lantus. The patient had mentioned she has used our formulary alternative in the past (Basaglar) but said she doesn't like it because "it doesn't work the same as Lantus". She also stated she had a few incidents where she felt nauseas, light headed and even collapse and attributes it to the Basaglar. Fearing the patient doesn't really understand that the medication is similar, a pharmacist talked to the member for consultation. After several attempts made by the pharmacist to get a hold of the member with no luck, the team member tried calling and got ahold of the Member's daughter. After getting consent from the member, the Pharmacist was able to speak to the daughter and explain everything to her. The pharmacist decided that due to the member's extended history and familiarity of Lantus, concerns the patient might not be adherent to alternatives due to fear of adverse effects, he decided that the patient continuing Lantus is the best course of action for the member. The Health Plan team member called the physician's office the next day to have them get started on the prior authorization (PA) process for the member.

65. Adherence: Patient using Insulin from Tijuana and Proper Pharmacy Utilization

A Health Plan Team Member was making adherence calls and came across a member who gave the team member consent to speak with her husband about her medication because "she doesn't know about them and her husband is in charge of them all." Initially the reason for the call was to ask about her wife's Glimepiride 4mg which was a couple of weeks over due since her last fill. He mentioned

that her physician had discontinued this medication a while ago and is strictly on Insulin to control her diabetes. The Team Member found this odd since the member does not have any paid claims for insulin or syringes in the past couple months. Regardless he gave consent to s/w her current physician to confirm this information. Per the MA at her doctor's office, the member was not to discontinue her Glimepiride per the physician's most current progress notes in April 2018. She also confirmed that there is no mention that the physician prescribed her insulin recently, the last time being in 2016. The Team Member contacted the member's pharmacy and per the clerk, the member had not received insulin from them, either by the insurance or paying cash. The Team Member called the member's husband back where he finally confessed that he bought Basaglar Pens on a trip to Tijuana a couple months ago since he could get them over there for a fraction of the price, around \$200/box instead of \$400+/box here. After the Team Member asked him how much he would inject her, he said her previous doctor had given her a signature to follow but doesn't follow a specific schedule, only injects her when she "feels" like she needs it. The Team Member asked if her current PCP knows about the insulin use which he says he does but per the MA, the MD does not have any record of this. The Team Member ran a 3D report to reveal that the last time member received insulin through the plan was two years ago for a 90-day supply from her old PCP.

The Team Member had the husband pick up the Glimepiride and await instructions from the physician's office. After relaying all this information to Viviana, they called the member to set up an appointment for the member the next Friday to get the member back under control since there has not been any labs drawn to see how her A1C levels might be. The Team Member feared was that the member's husband might be doing more harm than good with insulin the PCP does not know about and unable to adjust the doses incase the member is not responding to the insulin. The husband had mentioned her sugars have been rather high lately. The Team Member called the member's husband one last time to confirm the appointment, make sure they go to it and educate the importance of adherence to her medication and the danger of self-medicating. The patient was also informed that after the physician reevaluates her and writes a new Rx with a current sig, that we would be more than happy to cover the insulin and supplies so they won't have to buy it themselves no matter how inexpensive it might be in Tijuana. After the appointment, a Follow up call was made to the Member & physician's office to see what the doctor had decided to do. Per the MA, the prescriber reviewed her blood sugars, she received a blood glucose machine and her Basaglar insulin was reviewed to check the dose. The physician talked to the member and her husband about the medication, the importance of adherence and what's the proper way to request/receive medication.

66. Adherence: Patient Unable to Obtain Shingles Shot

Team Member reached out to the member as part of Adherence calls, to assist with his medication and adherence. As Team Member was talking to the member about this, Team Member brought up the fact that we cover the Shingles and Pneumonia vaccines along with the Flu vaccine. The member was very interested in this information since, per him, he has been trying to get the Shingles vaccine since May 2018 when his physician first prescribed it to him. He states that his local pharmacy has been telling him they are out of stock every time he goes in and it has been very frustrating to be told this for multiple months. Team Member offered to call his pharmacy to see what they had to say about it and also try to find a solution. Team Member called pharmacy and shared with the pharmacist there who confirmed they have been out of the vaccine for a couple months now and have not been able to get any. They also mentioned their other store in the area is out of the vaccine so that's why they couldn't refer the member out to another pharmacy for it. Team Member called around and found another pharmacy that was only a mile from his home and had the vaccine in stock. Team

Member gave the new pharmacy the old pharmacy's phone number to get the Rx transferred over and get the vaccine ready for the member. Team Member called the member back later that day to let him know everything was taken care of and all he had to do is go down to the new pharmacy to get the vaccine. He was delighted at this news and impressed it was just that easy. He said it was a struggle and getting the run around from his regular pharmacy for months was getting frustrating. He said he would go down the following Monday to get the injection since he was busy at the moment. Team Member received a follow up call from the member telling them how he just received his vaccine, he only had to pay \$3.70 (his copay). He was just very grateful for the help and wanted to thank Team Member personally, not just with the vaccines but also with his medication refills. Team Member assured him he could always just call us back if he had any questions or issues with anything pharmacy related and ask for me if he'd liked. It took no time for the member to call back on the same week just to ask about more drug related questions. Member was glad to be able to speak with Team Member again and said he will keep the health plan and Team Member's name handy, "it's hard to find someone to s/w in my own language that knows what I'm going through and willing to go the extra mile to help".

67. Adherence: Member Robbed of Medications

A health plan care transitions coach was conducting a routine check-in with the member, who notified the coach that he was robbed of all 11 of his medications he had recently filled. Unable to fill his medications, the member had planned to visit the emergency department to get his medications refilled. The care transitions coach immediately reached out to pharmacy services staff, who was able to respond in less than 30 minutes to authorize overrides for claim payment and then contact pharmacies to transfer the prescriptions to a location near the member. This level of coordination resulted in both the avoidance of an unnecessary ED visit and ensured the member received his medications.

68. Adherence: Leveraging Local Relationships to Coordinate Care

Local pharmacy that agrees to stock supplies and ingredients necessary to compound an alternative in place of an FDA-approved medication that is no longer available, even when the reimbursement did not incentivize them to do so. Another local pharmacy was willing to offer blister and unit dose packaging for members that reside in facilities or are a part of special community programs. They often reach out to plan staff directly to coordinate requests, providing special arrangements and delivery to members. Examples of how individuals have benefited are below:

- A 63-year-old male patient who was homeless and moving between cities - Plan staff worked with the doctor and the local pharmacy to provide the patient with bubble packs and synchronize early fills to promote adherence before he relocated.
- A 62-year-old male who was participating in a community program - Plan staff coordinated with the social worker and neighborhood pharmacy to repackage his medications in bubble-packs and sorted by time of day for him.

69. Adherence: SNF Placement Challenges due to Medication Needs

A complex member with a viral infection required SNF placement in order to transition out of the hospital inpatient setting. Due to his condition and the high cost non-formulary medications he was receiving, SNFs were unwilling to take him. Plan staff understood the importance of assessing the overall healthcare picture when reviewing medication coverage requests. We were able to review the requests quickly to authorize the medications and successfully get the member discharged to the SNF within the same day and avoid unnecessary medical utilization.