Minnesota Medical Assistance Reform

MN MA should transition from a traditional PBM system to a single PBM model for drug benefit management.

Frustrated by rising pharmacy costs and seeking a simpler system, eight states in recent years have decided to "carve out" retail pharmacy benefits management from their contracts with Medicaid managed care organizations. Direct fee-for-service carve out management models have shown to greatly reduce the costs for the state, but may have unintended consequences related to 340B discounts that manufacturers must give to covered entities.

A "middle ground" single PBM approach first tested by Kentucky is gaining steam, as three states, Ohio, Louisiana and Mississippi, followed in Kentucky's footsteps after the state implemented such a program in July 2021. With that approach, Medicaid MCOs still get paid for providing pharmacy benefits but must contract with a single PBM and use a preferred drug list (PDL) selected by the state.

The SPBM also has constraints on the management of the drug benefit and essentially acts as a Pharmacy Benefits Administrator (PBA) that prohibits the SPBM's use of spread pricing, claw-backs, below cost pharmacy reimbursement, formulary fees and reduces by 100+% the amount paid per claim to manage adjudication of claims. Kentucky Medicaid switched to a transparent payment model with a single PBM. By 2023, the state saved nearly $283 million, exceeding its projected $200 million savings.

- Ohio Medicaid implemented a transparent payment model where Medicaid contracts with a single PBM and sets pharmacy reimbursement rates under a "drug cost plus model." Net savings have exceeded $100 million each year ($186.1M in 2022 and $230M in 2023).

- Louisiana in late 2019, Louisiana consolidated its Medicaid prescription drug benefits under a single PBM. Over the first couple of years, state officials reported more than $50 million in cost reductions compared to prior projections under multiple PBMs.

- Mississippi similarly implemented a single PBM arrangement for its Division of Medicaid. Initial estimates indicated $30–$40 million in annual savings, although the exact figure can differ by source and timeframe.

- Virginia recently enacted a single PBM model realignment that will save the state an estimated $39 million a year. The bill requires the Department of Medical Assistance Services to appoint a single third-party administrator for all pharmacy benefits for Medicaid recipients by the end of 2027.

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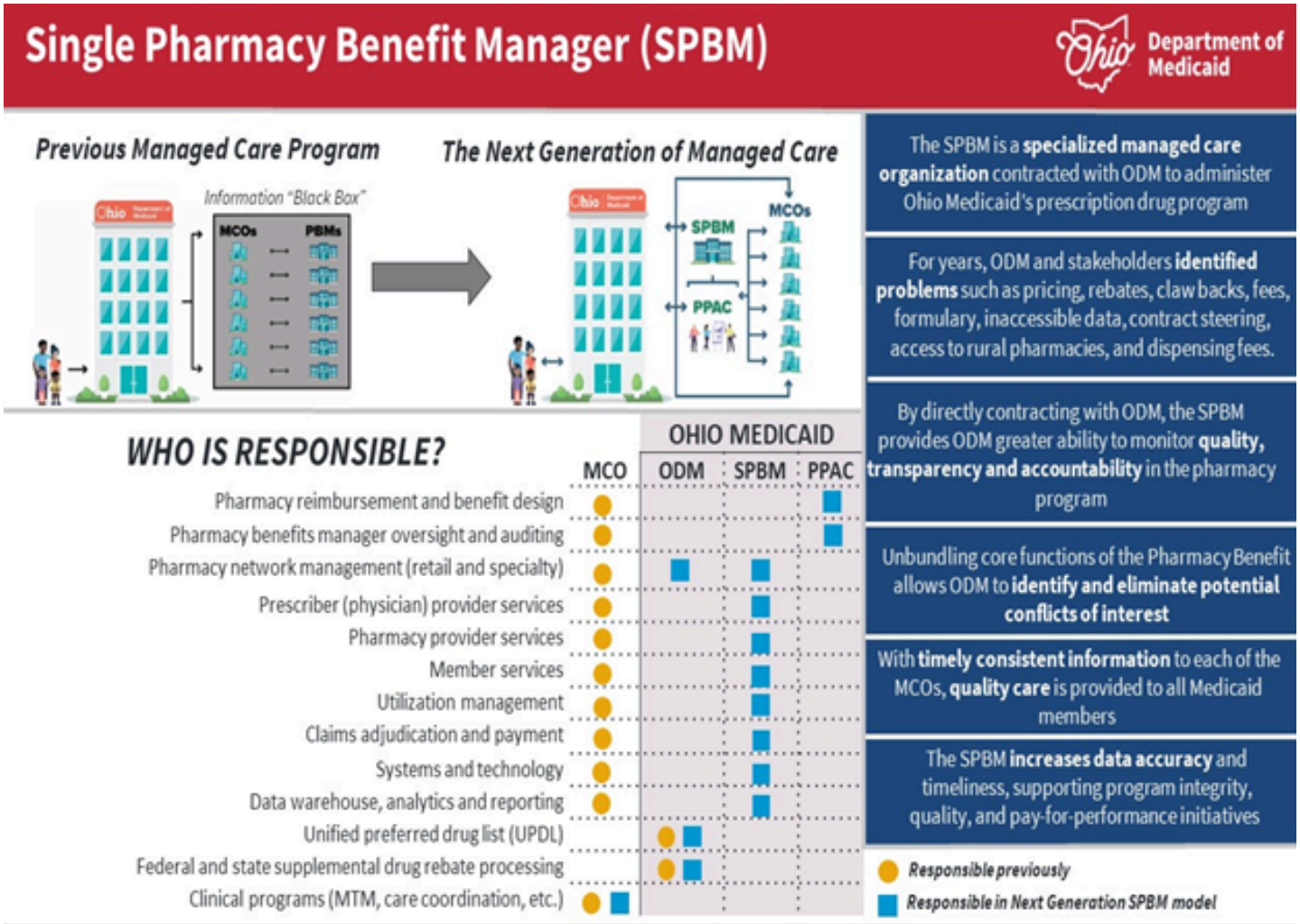
MPhA Minnesota Pharmacists Association
MSHP Minnesota Society of Health-System Pharmacists
College of Pharmacy, University of Minnesota, Driven to Discover℠
Minnesota Pharmacists Association
4248 Park Glen Rd, Minneapolis, MN 55416
(952) 928-7463 - info@mpha.org
www.mpha.org

2025 is the year to make a change to the MN-MA drug benefit management model. MN-MA managed care procurements are on a 5 year cycle though they can be re-procured sooner or extended upon Department of Admin approval. Here is the current MA contracts status for the approximately 1.2 million Minnesotans insured by the state's MA-Medicaid program:

- Metro-area Families and Children (PMAP and MinnesotaCare) began in 2022. A new procurement would be held in 2026 for contracts effective January 1, 2027
- Greater MN Families and children (PMAP and MinnesotaCare) began in 2023. A new procurement would be held in 2027 for contracts effective January 1, 2028
- Seniors (MSC+ and MSHO) and SNBC statewide began in 2023. A new procurement would be held in 2027 for contracts effective January 1, 2028.

Changing Minnesota to a SPBM model for contracts being procured in 2026 and 2027 would not incur costs to get out of the current capitated rate contracts. Savings realized by the state's MA budget, as well as the improved, fair reimbursement for pharmacies, would begin in 2027.



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