Pharmacy Benefits Managers Workgroup

Meeting #4

Tuesday, August 25, 2026

Co-Chairs: Mary Kwei, MIA, Associate Commissioner, Market Regulation and Professional Licensing

Athos Alexandrou, MDH, Director, Office of Pharmacy Services

First - A Few Words

Bonnie Cullison
Delegate, Montgomery County
Vice Chair of the Health Committee

Steve Johnson
Delegate, Harford County
Chair of the Health Committee's
Pharmaceuticals Subcommittee

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First - A Few Words

Marie Grant
MIA, Commissioner
Maryland Insurance Administration

Perrie Briskin
MDH, Deputy Secretary for Health Care Financing & Maryland Medicaid Director

Workgroup Members

Entity Required to be Represented	Representative Name	Representative's Organization
community pharmacies - chain setting	Jill McCormack	National Association of Chain Drug Stores
community pharmacies - independent setting	Steve Wienner	Mt. Vernon Pharmacy
pharmacy services administrative organizations	Brian Hose	EPIC Pharmacy Network
health insurance carriers	Kim Robinson	CareFirst
plan sponsor representatives	Beverly Churchill	Queen Anne's County
drug wholesalers and distributors	Leah Lindahl	Healthcare Distribution Alliance
non–pharmacy benefit manager–owned mail order pharmacies	Scott Glasscock	Walmart

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Workgroup Members

Entity Required to be Represented	Representative Name	Representative's Organization
brand name drug manufacturers	Jay Eberle	AstraZeneca
generic drug manufacturers	VACANT	
pharmacists	Aliyah Horton	Maryland Pharmacists Association
pharmacy benefit managers	Heather Cascone	PCMA
third party experts in the field of drug pricing in Medicaid	Allan Hansen	Myers and Stauffer
managed care organizations	Meredith Fleming	WellPoint
Maryland Board of Pharmacy (*not a required entity)	Deena Speights-Napata	Maryland Board of Pharmacy

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Today's Discussion

I. Presentation on Independent Specialty Pharmacies and Pharmacy Accreditation
   A. Sheila Arquette, National Association of Specialty Pharmacy (NASP)
II. Presentation on Transparency within PBM Reimbursement Arrangements
   A. Benjamin Link, 3 Axis Advisors
III. Continued Overview of Charge #2, Pharmacy Reimbursement
   A. Athos Alexandrou, MDH, Director, Office of Pharmacy Services
   B. Laura Spicer & Morgane Mouslim, The Hilltop Institute at UMBC
   C. Allan Hansen, Myers and Stauffer, LC
IV. Topics for Group Discussion
V. Comments from Workgroup Members
VI. Comments from Public Stakeholders, as time allows
VII. Closing Remarks

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Specialty Pharmacy Accreditation

Maryland PBM Workgroup

Sheila Arquette, RPh
President & CEO, National Association of Specialty Pharmacy

August 25, 2026

NASP
NATIONAL ASSOCIATION OF SPECIALTY PHARMACY

National Association of Specialty Pharmacy (NASP)

The mission of the National Association of Specialty Pharmacy (NASP) is to empower specialty pharmacy stakeholders to advance the standard of patient care.

What is a Specialty Drug – Thinking Beyond Drug Cost

Cost-based definitions blur the line between high-cost and true specialty drugs

- More complex than most other prescription medications
- Special or complex administration requirements
- Special access conditions required by manufacturers to ensure pharmacy capabilities
- Treat patients with complex, sometimes life-threatening conditions
- Require management of side effect profile
- Extensive payer authorization or benefit requirements
- Require comprehensive patient care clinical management & product support
- May be taken orally, but often injected or infused
- Treat patients with rare diseases/ conditions
- Affordability/ patient financial hardship to begin and maintain treatment

NASP

NASP Definition of a Specialty Pharmacy

- Pharmacies that solely or largely provide only medications for people with serious health conditions requiring complex therapies
- State-licensed and regulated Specialty Pharmacies (and DEA licensed/regulated if dispensing controlled substances) that are accredited by an independent third party, nationally recognized specialty pharmacy accreditor.
- Specialty pharmacies function in the following ways:
  - Connect patients who are seriously ill with the medications that are prescribed for their conditions
  - Provide intensive patient care services that these medications require
  - Support patients who are facing reimbursement challenges for these highly needed but costly medications

Specialty Pharmacy Staffing Differs from Traditional Retail or Mail Order Pharmacy

- Intake / Enrollment
- Insurance and Billing
- Patient Financial Assistance
- Patient Care Specialists
- 24/7 Call Center
- Specialty Pharmacists
- Specialty Pharmacy Technicians
- Nurses
- Dietitians (at some specialty pharmacies)

Conditions Historically Managed by a Specialty Pharmacy	Conditions That Have Transitioned from Retail Pharmacy Management to Specialty Management
Crohn's Disease	Asthma/ COPD
Cystic Fibrosis	Diabetes
Hemophilia and other Bleeding Disorders	Atopic Dermatitis
Hepatitis C virus	Osteoporosis
Human Growth Hormone Deficiency	Anemia
Multiple Sclerosis	Retinal Diseases
Oncology (cancer)	Hypercholesteremia
Organ Transplantation	Rare Lipid Disorders
Psoriatic Arthritis	Immunology
Psoriasis	
Rare and Orphan Diseases	
Rheumatoid Arthritis	

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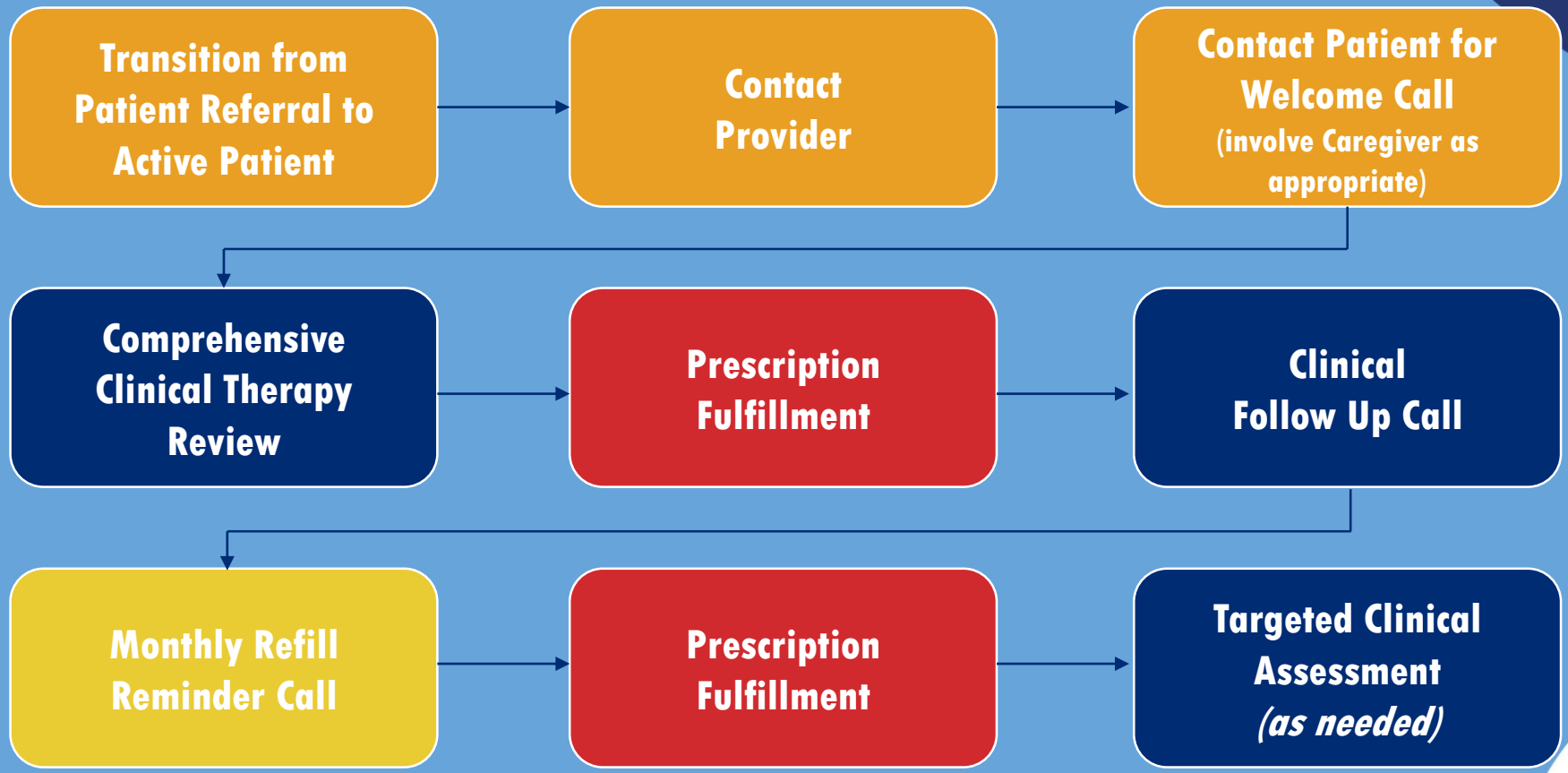
Specialty Pharmacy Practice	
	Specialty Pharmacy
Conditions Managed	Chronic, complex, life threatening, rare diseases
Medications Stocked	Specialty medications that are disease specific and readily available
Insurance/benefits and onboarding	Complex benefits investigation and prior-authorization support for frequently denied drugs
Clinical Support. Knowledge	Disease state expertise and focus, available 24/7
Dispensing	High patient interaction, temperature-controlled shipping when needed, tracking of patient and refill coordination, follow up on missed doses to identify areas of concerns
Disease Management	Condition-specific expertise, promotes adherence, mitigates side effects and enhances clinical outcomes
Clinical monitoring	Ongoing monitoring for effectiveness, adverse events, adherence, labs, disease progression, and treatment issues
Care Coordination	Communicate regularly with prescribers, nurses, case managers, health plans, pharmaceutical manufacturers and FDA when necessary
Escalation	Can identify adherence, adverse-event, affordability, or clinical and social problems and intervene

Specialty Pharmacy Patient Journey



Specialty Accreditation

- Specialty Pharmacy accreditation demonstrates a commitment to consistency, quality, and safety for the management of a patient treated with a specialty drug
- Any accreditation standard or process should be fair and used to measure quality, not punitive or intended to decrease pharmacy market competition
- Some payer organizations have established accreditation requirements that are overly onerous and intended to decrease network participation and restrict patient and provider choice
- Accreditation standards must be specific to specialty pharmacy performance and not so stringent that more time is spent on accreditation than on patient care
- Pharmacy cost and staffing levels required to receive and maintain accreditations are factors that should be considered

About Specialty Pharmacy Accreditation

WHY IT MATTERS

Specialty accreditation evaluates the full specialty pharmacy operating model, not just dispensing.

Specialty accreditation creates a framework for longitudinal patient management, measurable quality, compliance readiness and medication safety.

WHO IS ELIGIBLE?

Any state licensed pharmacy that demonstrates the clinical capabilities necessary to safely and effectively manage patients receiving specialty drugs and the operational and technological infrastructure required to support their proper storage, dispensing, fulfillment, and delivery to the patient.

Comprehensive Third-Party Specialty Pharmacy Accreditation

Pharmacy Operations

- Prescription processing and dispensing
- Dispensing accuracy and adherence monitoring
- Product management (temperature, hazardous materials, manufacturer requirements

Medication Distribution

- Distribution management (qualification testing, packing and shipping procedures, distribution auditing)
- Shipping logistics
- Distribution accuracy monitoring

Patient Services/ Communications

- Patient information and support
- Measuring complaints and satisfaction
- Communication process and monitoring

Patient Management

- Patient management, program structure and overview
- Clinical assessments and interventions
- Education and support
- Care team collaboration

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North Carolina Definitions

- The North Carolina definition of specialty pharmacy was supported by the state pharmacy association
- **NC Definition of Specialty Drug – Any of the following prescription medications:**
  a) **A medication that is subject to restricted distribution by the United States Food and Drug Administration.**
  b) **A medication used to treat complex or chronic conditions that requires special handling, provider coordination, or patient education.**
  c) **A medication classified as a specialty drug as determined by a health benefit plan.**

- **NC Definition of Specialty Pharmacy –** A pharmacy accredited as a specialty pharmacy by a nationally recognized, independent accrediting organization that evaluates a pharmacy's compliance with quality, safety, and service standards for handling, dispensing, and managing specialty drugs. The accreditation may be issued by the Utilization Review Accreditation Commission (URAC), Accreditation Commission for Health Care (ACHC), the National Association of Boards of Pharmacy (NABP), the Joint Commission, or their successors.

Bottom Line…

Ensure the Highest Standards in Quality and Care for Specialty Patients and a Fair and Competitive Landscape for Pharmacies Qualified to Dispense to AND Manage Specialty Patients.

THREE AXIS ADVISORS

Transparency in Pharmacy Reimbursement

Benjamin Link

August 2026

About Me

Benjamin Link, PharmD
President – 46Brooklyn | Vice President – 3 Axis Advisors

- After years of work in retail pharmacy, got the opportunity to work for a traditional PBM.
- Consolidation within PBM space led me to work for a pharmacy benefit administrator (PBA) within Ohio's Medicaid system.
- Years of learning and digging led to the uncovering of hundreds of millions of dollars in hidden drug costs and a nationwide reckoning for drug pricing reform.
- Joined 46brooklyn Research in 2019 to publish and translate publicly-available drug pricing data for free.
- Joined 3 Axis Advisors in 2019 to help others solve drug pricing riddles using more extensive data research and analysis. Clients include Medicaid Fraud Control Units, provider groups, research firms, technology companies, law firms, investment analysts, employers, benefit consultants, and private foundations.

Goals for today

Identify Why Transparency Matters

Review and Identify Core Reimbursement Terms

Transparency: Regulatory & Contractual

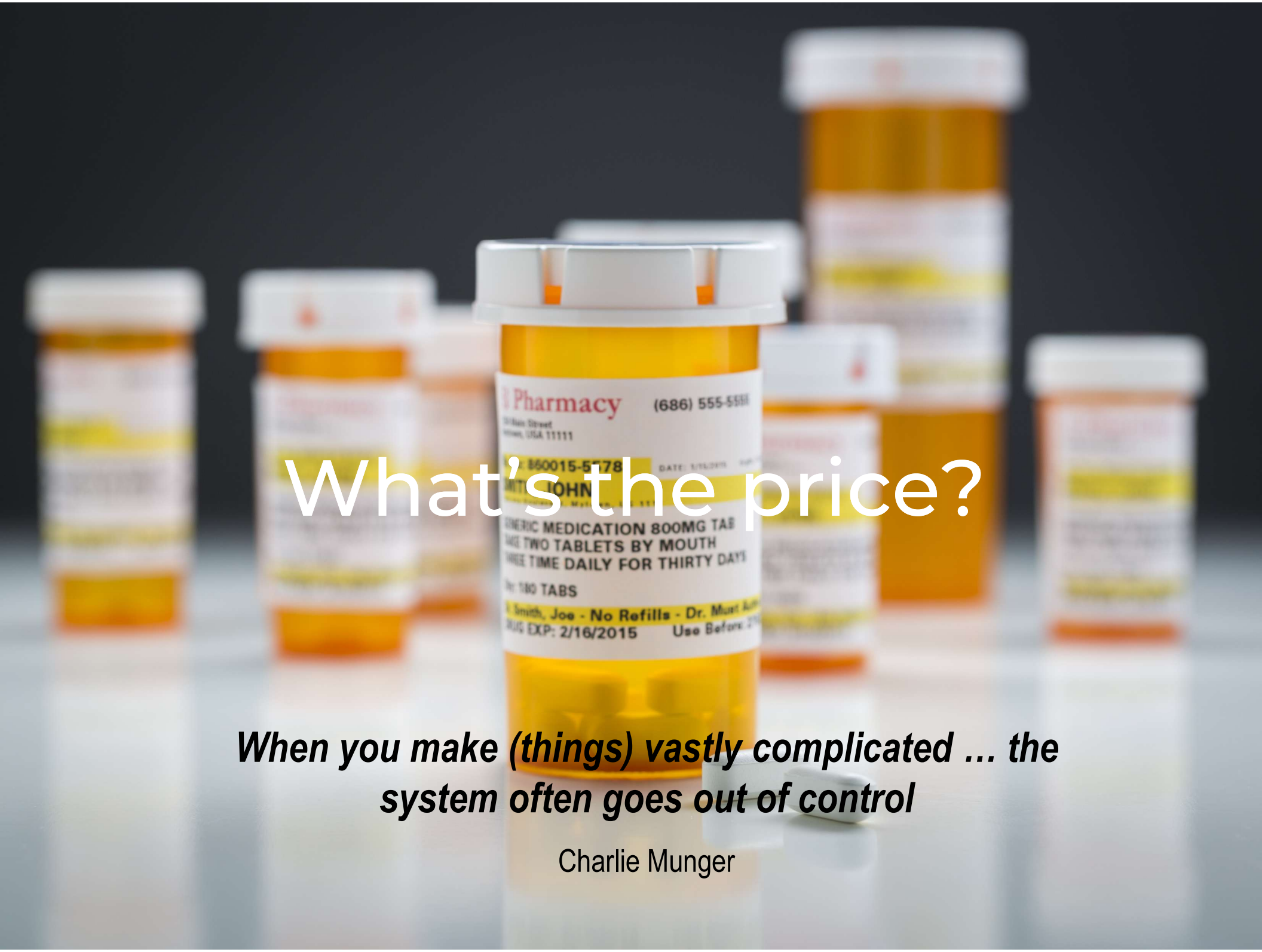
Why Transparency Matters?

Transparency is fundamentally a communication problem.

For example:

- A **plan** wants to understand what it is paying and what the PBM is retaining.
- A **pharmacy** wants to understand how its reimbursement was calculated.
- A **PBM** needs contract terms that are operationally definable and capable of being administered consistently.

Can all three parties look at the same reimbursement arrangement and reach the same understanding of the economics?



What's the price?

When you make (things) vastly complicated … the system often goes out of control

Charlie Munger

Efficient Marketplace Overview

- We must first start with the basics of any transaction that involves a buyer, a seller, and an intermediary whose role is to facilitate the transaction between the two parties.

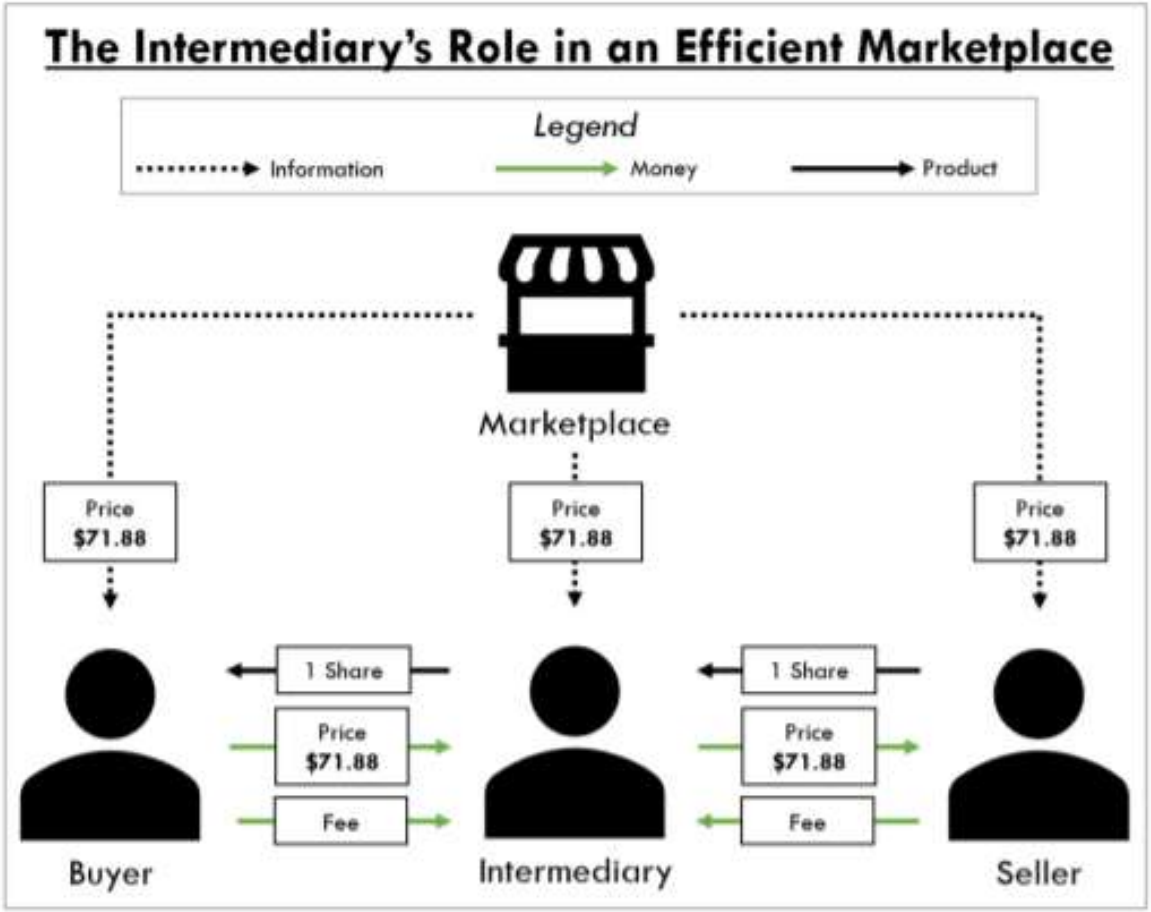


Figure 1: The Intermediary's Role in an Efficient Marketplace

Source: https://www.3axisadvisors.com/projects/2019/1/17/analysis-of-pbm-spread-pricing-in-new-york-medicaid-managed-care

Energy prices are…

Transparent

+

Set by the marketplace

=

Trustworthy

Which price are you talking about?

MANY PRICES AVAILABLE FOR DRUGS IN THE U.S.

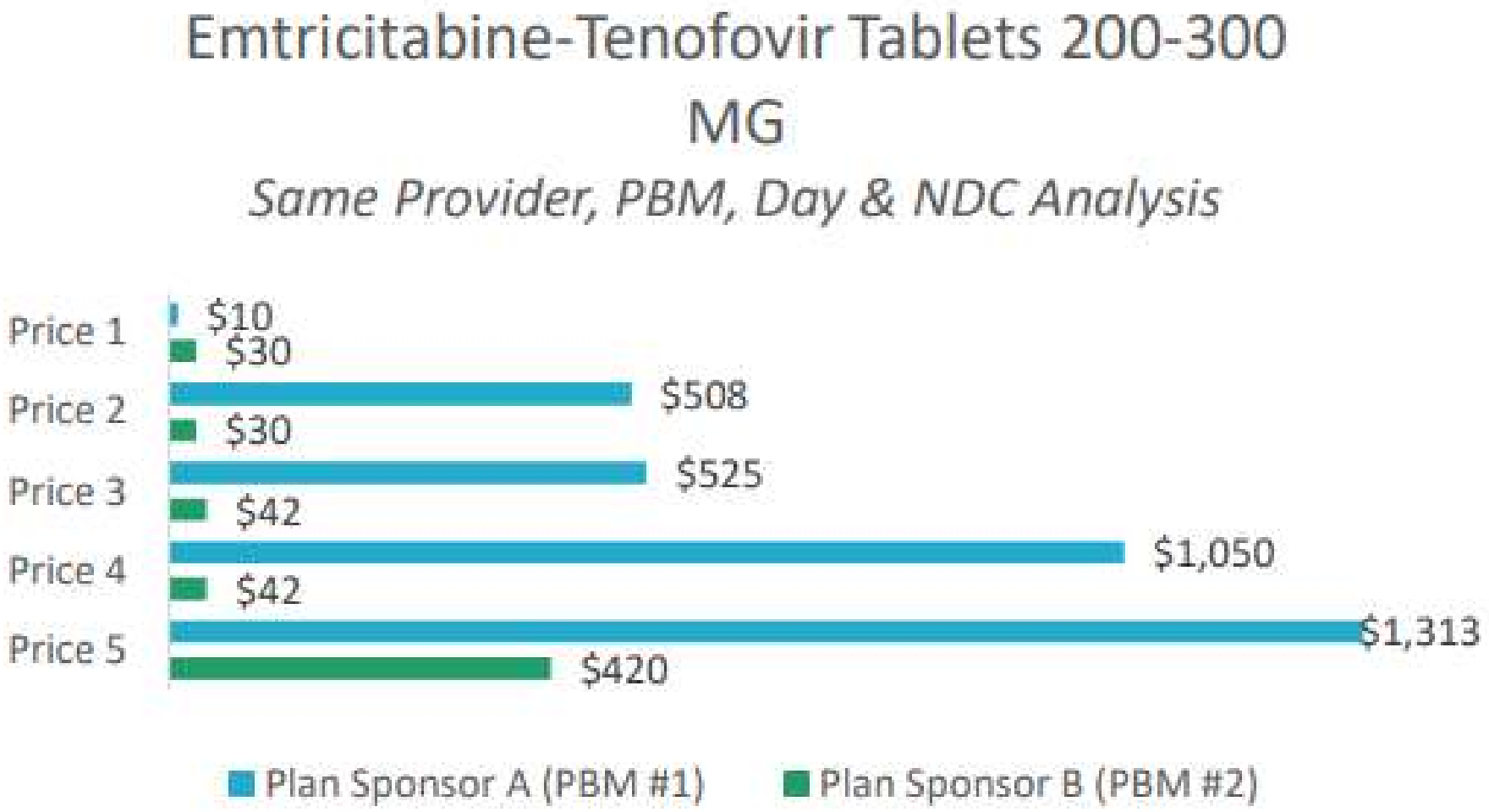
Drug prices are…

Hidden

Set by contracts – not efficient market

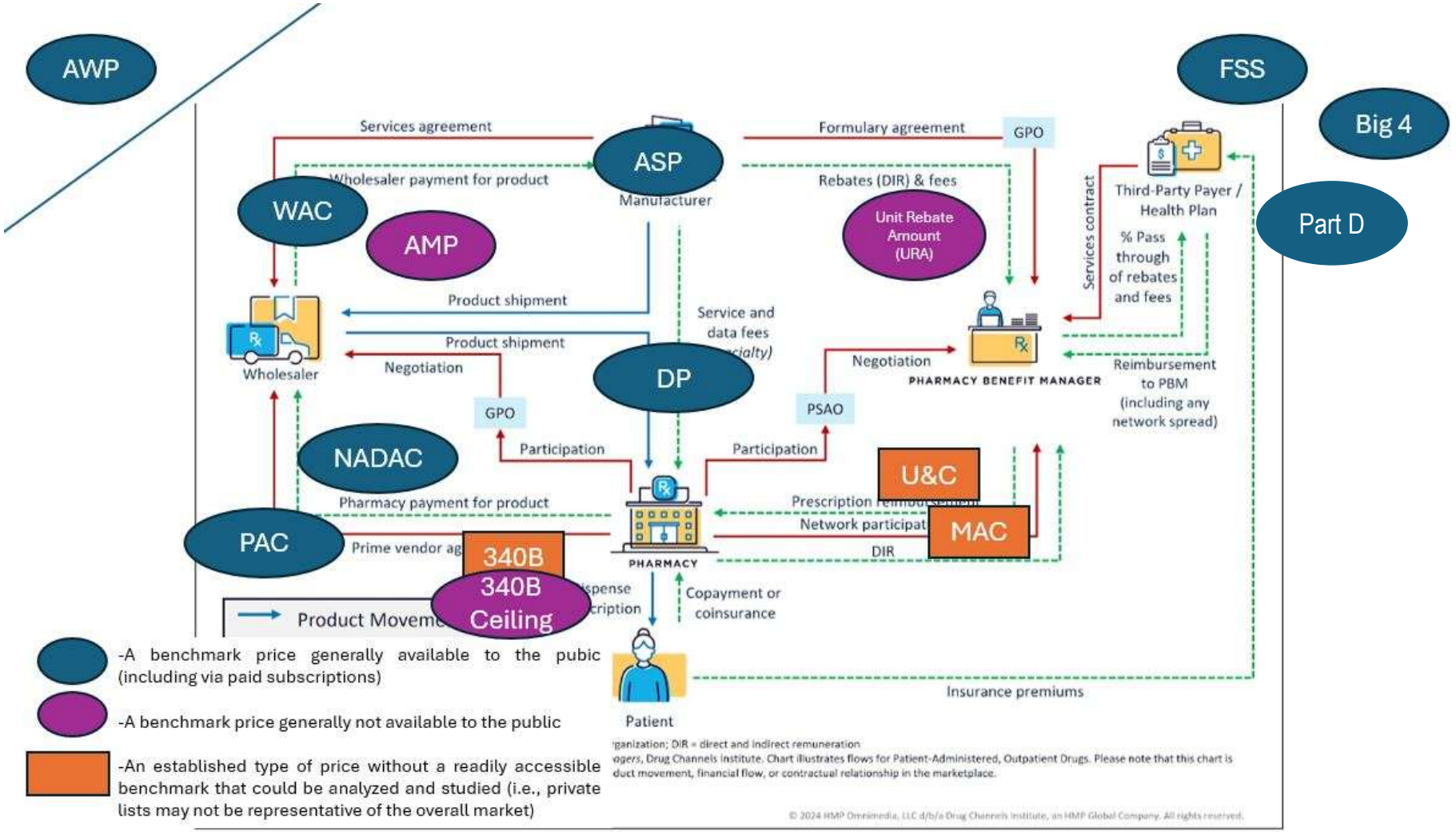
Prone to manipulation

Same Drug, Same Day, Different Price

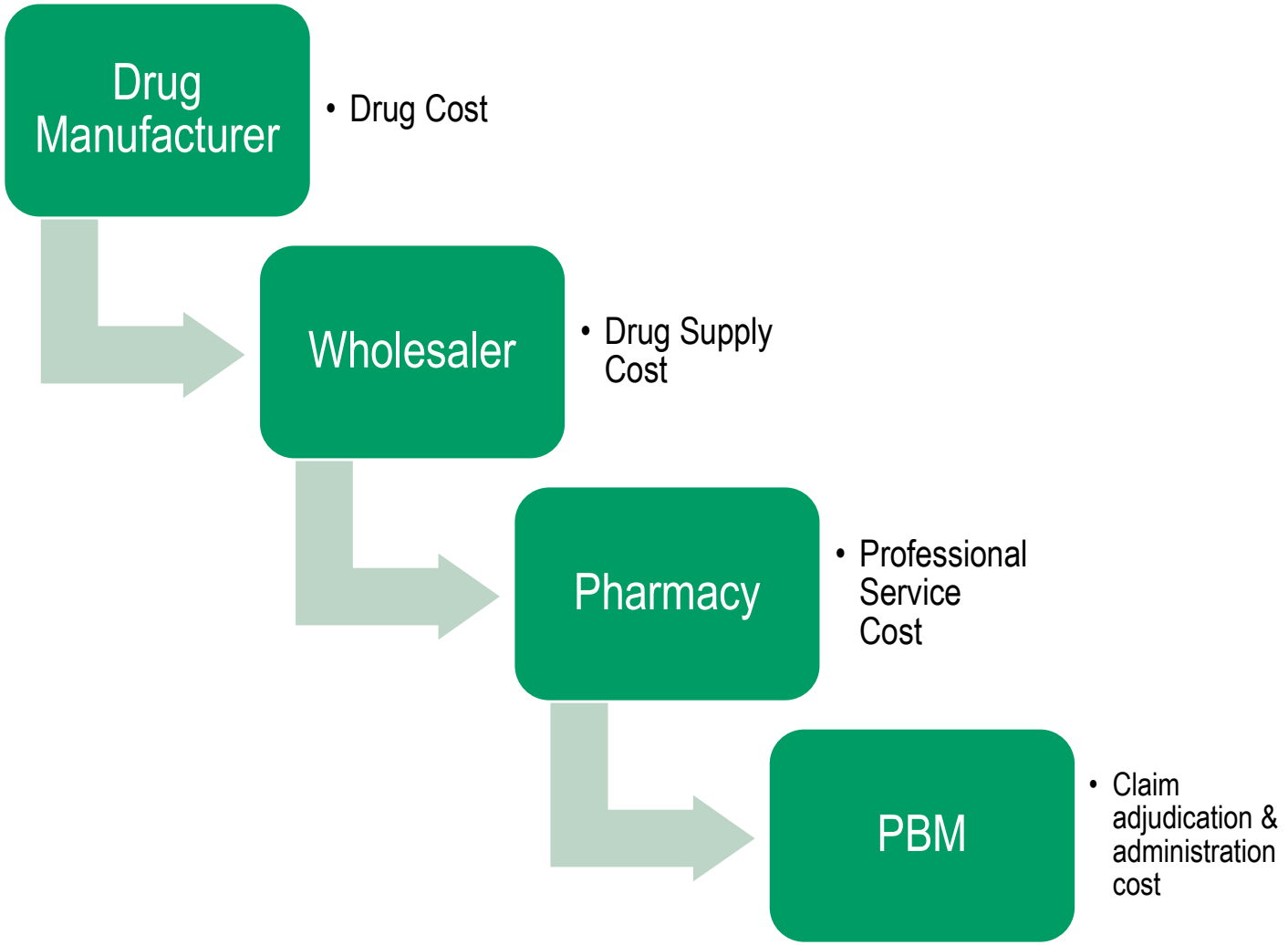


https://static1.squarespace.com/static/5c326d5596e76f58ee234632/t/667a03dc16a9fb18a1b13614/1719272422304/3AA_Washington_Report_20240620.pdf

Drug Prices Attempt to Capture Certain Business Activities…



Pieces of Drug Reimbursement



PBM-to-Plan Sponsor Contract

Vendor	Current - Regence
PBM Model	Traditional
Network Access	65,000
Formulary	Standard Formulary
Pharmacy Administration Fee	$0
Retail Pricing:	
Brand Discounts	AWP - 17.20%
Brand Dispensing Fee	$0.95
Generic Discounts	AWP - 77.90%
Generic Dispensing Fee	$0.95
Estimated Rebate/Claim	$108 per Brand Claim

Plan Cost/Savings Estimates (6 Months)	
Total Plan Ingredient Cost (+ dispensing fees)	$341,197
ANNUALIZED	**$682,395**
Total Administration Fees (claims fees)	$0
ANNUALIZED	**$0**
Carve Out Costs (Regence carve out cost - $4.00 PEPM)	$0
ANNUALIZED	**$0**
Rebates (Estimated Rebate or Admin Credit)	$35,132
ANNUALIZED	**$70,264**
TOTAL NET Rx COSTS	**$612,131**
Est Total Savings (increase)	**$0**
Percent Savings (neg = % increase in cost)	**0%**
Clinical Prior Authorizations	$55
Total Employees	136
Total Members	466
Number of Claims Included in File	1,495
Estimated Cost/claim	$204.73

Alternative Funding Prog Savings Ests (Annualized)	
Copay Assistance/Max Program	
Percent Savings	
Patient Assistance Programs	
Percent Savings	
Clinical/Redirect Programs	
Percent Savings	
PAP Fees	
Estimated Rebate Reduction	
Total Estimated Savings ($)	
Total Estimated Percentage	

Source: https://www.utah.gov/pmn/files/901597.pdf

PBM-to-Pharmacy Contract

1. **Pharmacy Reimbursement Rates For Covered Medications**. For Covered Medications dispensed to Members, Provider shall receive reimbursement equal to the lowest of the following, at the rates in the Contract Rates table below:

   (1) For Single-Source and Multi-Source Brands and Generic Drugs without an ESI MAC:

   (a) the Provider's Usual and Customary Retail Price;

   (b) not less than the applicable AWP discount plus dispensing fee;

   (c) the Provider's submitted ingredient cost plus dispensing fee; or

   (d) the state fee schedule (if applicable).

   (2) For Generic Drugs and Multi-Source Brands with an ESI MAC:

   (a) the Provider's Usual and Customary Retail Price;

   (b) not less than the applicable AWP discount plus dispensing fee (as listed under the "BRANDS" column or the "GENERICS - A" column);

   (c) an ESI MAC plus dispensing fee;

   (d) the Provider's submitted ingredient cost plus dispensing fee; or

   (e) the state fee schedule (if applicable).

	BRANDS Single-Source & Multi-Source(2.1) Brands not paid on ESI MAC(2.2)	**GENERICS - A** Generic Drugs not paid on ESI MAC
30 Day	**AWP - % + $**	**AWP - % + $**
90 Day	**AWP- % + $**	**AWP - % + $**

2. **Notes**.

   2.1 Multi-Source pricing depends on the DAW Code utilized and design of the specific Prescription Drug Program.

   2.2 "ESI MAC" means the maximum allowable cost for such drugs as determined by ESI. The items and their prices will be updated by ESI from time to time at its sole discretion.

   2.3 All payments shall be net of the applicable Copayment.

3. **Schedule Effective Date**. The reimbursement rates set forth herein shall become effective (INSERT DATE] (the "Schedule Effective Date").

Source: https://www.sec.gov/Archives/edgar/data/1402479/000162828020013237/exhibit1023-sx4xpharma.html (image modified to fit screen)

Concepts of Reimbursement Terms

Category	Description
Ingredient Cost	An amount that compensates for the underlying product dispensed. A discount is not a price. Compensates Drug Manufacturer and Wholesaler within the drug supply chain.
Dispensing Fee	An amount that compensates for the pharmacy's professional service activities related to dispensing. Cost of Dispensing surveys identify cost of approximately $12 per prescription. Compensates the pharmacy within the drug supply chain.
PBM Compensation	An amount that compensates the PBM for adjudication services as well as any other services the plan selects. Compensates the PBM within the drug supply chain.
Plan Costs	The total cost to administer pharmacy benefits to plan members.

Concepts of Reimbursement Terms (Continued)

Category	Descriptions
Drug Categories	Products are generally classified as brand, generic, or specialty. Brand and generic status reflects patent/exclusivity status and drives ingredient cost; specialty status reflects clinical complexity and cost, and typically requires special handling or monitoring. To the extent that costs are differentiated by a category, definitions should clearly identify how and allow for independent identification of the category.
Pharmacy Channels	The setting through which a prescription is dispensed (e.g. retail, mail, or specialty.) Channel can affect which pharmacies are eligible to fill a claim, and supply duration. To the extent that the channel impacts reimbursement terms then the contract should clearly identify how and allow for independent verification of the channel.
Rebate Guarantees	A contractual commitment from the PBM to the plan regarding the amount of manufacturer rebate value that will be passed through. Rebates are generally paid after the fact and should have clear definitions that allow independent verification.
Formulary	The PBM's list of covered drugs, organized into cost-sharing tiers. Formulary placement affects both member cost-sharing and rebate eligibility. As multiple drug channel participants can benefit from formulary knowledge, clear descriptions and identifiers (e.g., NDCs) should be available for independent formulary status identification.

Teriflunomide Tablet 14 mg (NDC: 70710-1115-03), Two Separate Claims Dispensed on 10/24/2023, PBM-Reported WV Claims Dataset

	Claim 1	Claim 2
Ingredient Cost Paid	$7,605.78	$58.74
Dispensing Fee Paid	$0.16	$0
Plan Paid	$7,305.94	$0
Member OOP	$300	$58.74
AWP	$9,752.09	$9,752.09
AWP Discount	AWP – 22%	AWP – 99.4%
NADAC	$20.80	$20.80
Margin Over NADAC	+$7,584.98	+$37.94

Disclosed ≠ Understood

Pharmacies

- Should understand what they will be paid for the services rendered

Plans

- Should understand what they will pay for services

PBMs

- Should explain how the two connect

Transparency = Common Definitions + Clear Calculations + Independent Reconciliation

Transparency Test

- Can all parties independently identify the reimbursement numbers from the contract?
  - What does the term mean?
  - How is it calculated?
  - What data is used?
  - Who receives or pays the resulting amount?
  - Can another party independently reconcile it?

Transparency Regulations

- The Consolidated Appropriations Act of 2026 now treats PBMs as covered service providers under ERISA, subject to compensation disclosure requirements, with 100% rebate and remuneration pass-through to plans required with only limited exceptions for bona fide service fees
  - The law requires PBMs to receive flat administrative fees instead of compensation tied to list prices and rebates, reducing the incentive to favor higher-priced drugs
- Proposed FTC settlements with PBMs impose structural changes to pricing and transparency
- California's SB 41 bans PBMs from keeping the spread on contracts written or renewed after January 1, 2026

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ben@3axisadvisors.com

Continued Discussion of HB 813 Charge #2 – Pharmacy Reimbursement

Presented by Athos Alexandrou, Maryland Medicaid, The Hilltop Institute at UMBC, and Myers and Stauffer, LC

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HB 813 Charge #2

"(2) review reimbursement for pharmacists, including:

(i) existing Maryland Medical Assistance Program requirements for pharmacy benefits managers and managed care organizations related to dispensing fee reimbursement, pharmacy benefits managers fees charged to pharmacies and the Maryland Medical Assistance Program, transparency in pricing and reimbursement data, specialty drug designations, and appeals processes;

(ii) how other states' pharmacy benefits services operate in Medicaid, including in Ohio, Kentucky, New York, California, and West Virginia;

(iii) measures that offset the Department's costs to fund the Medicaid Managed Care Program and adopt NADAC plus the Fee–for–Service Professional Dispensing, including:

1. savings associated with NADAC ingredient cost pricing and managed care organizations; and

2. pharmacy benefits managers administrative fee consolidation and rebate allocations; and

(iv) strategies for adopting pharmacy reimbursement parity and drug pricing transparency"

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Overview of Other States' Pharmacy Benefits Services

Comparative approaches in Ohio, Kentucky, New York, California, and West Virginia

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HB 813 – Charge #(2)(ii)

"(2) review reimbursement for pharmacists, including:

(ii) how other states' pharmacy benefits services operate in Medicaid, including in Ohio, Kentucky, New York, California, and West Virginia"

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Requested Follow-Up with Other States

At the Workgroup's request, we contacted the five states to participate in interviews.

- **Kentucky:** Interview completed.
- **California:** Interview scheduled for August 24th.
- **New York:** Interview scheduled for August 27th.
- **Ohio** and **West Virginia:** Scheduling in progress.

A summary of the follow-up findings for <u>all five states</u> will be presented at the September PBM Workgroup meeting.

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HB 813 – Charge #(2)(iv)

"(2) review reimbursement for pharmacists, including:

(iv) strategies for adopting pharmacy reimbursement parity and drug pricing transparency"

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Comparison of Three Delivery Models for Medicaid Pharmacy Benefits

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Background

- Although it is an optional benefit under federal Medicaid law, all state Medicaid programs currently provide pharmacy coverage but take different approaches to administering it.
- Managed care is the primary payment and delivery system in Medicaid, used in **42** states, covering about **75%** of enrollees and **52%** of program spending.
- Within managed care states, all or part of the pharmacy benefit may be carved in or carved out of the managed care organization (MCO) benefit package.
- In the last Workgroup meeting, we reviewed Maryland's current requirements and approaches in **5** other states.
- Today, we will review considerations for **3** pharmacy benefit delivery models.

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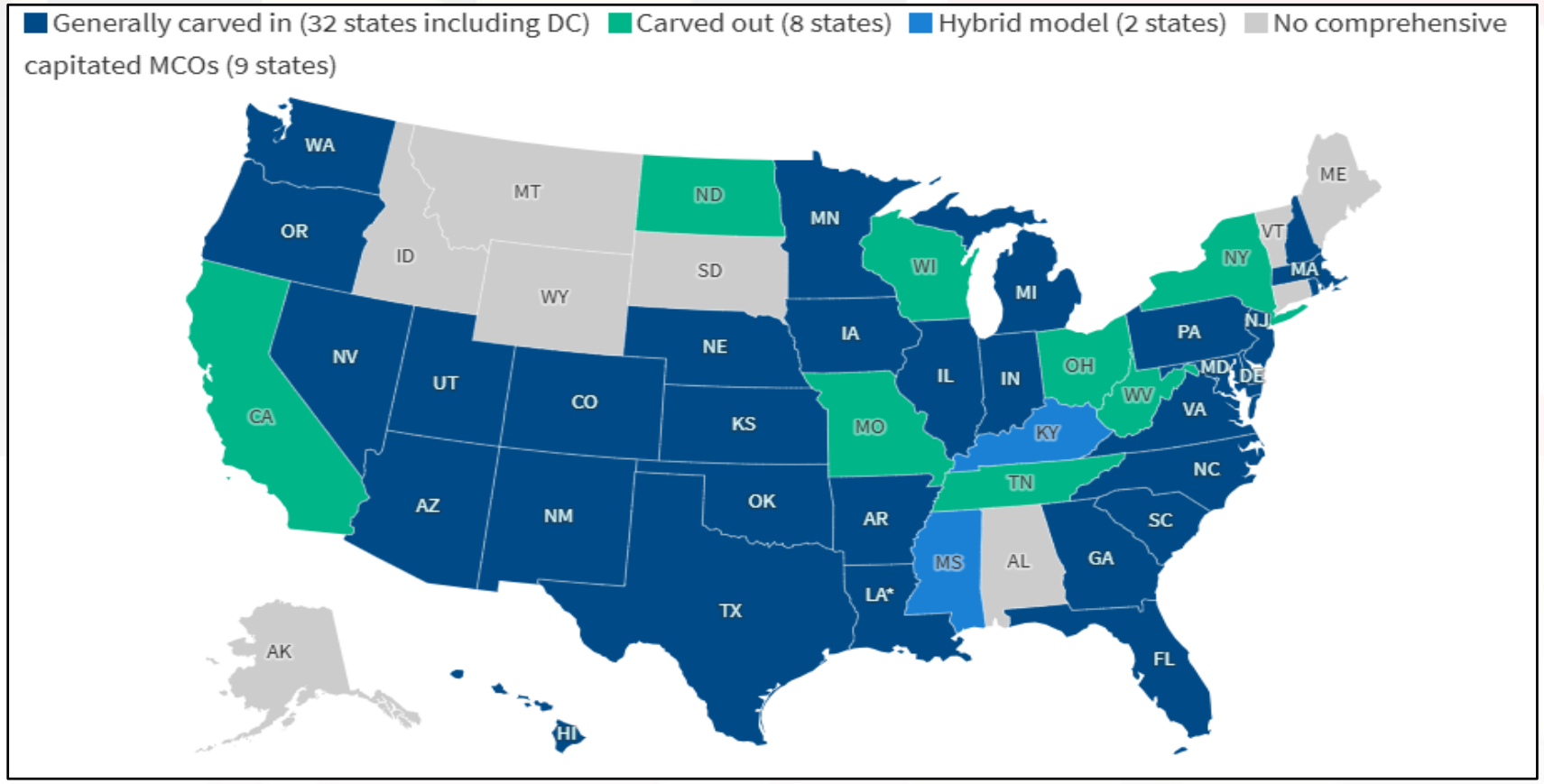
Background *cont.*



Notes: MCO = managed care organization. ID's Medicaid-Medicare Coordinated Plan and Medicaid Plus programs have been recategorized by CMS as MCO programs but are not counted here as such since they are secondary to Medicare. Publicly available data used to verify status of states that did not respond to the 2025 survey or this survey question (FL, KS, MN, MS). *LA discontinued its single PBM "hybrid model" on October 1, 2025, allowing each MCO to utilize their own PBM.

Data Source: Annual KFF survey of state Medicaid officials conducted by Health Management Associates, November 2025
Infographic Source: https://www.kff.org/medicaid/5-key-facts-about-medicaid-prescription-drugs/

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Three Delivery Models for Medicaid Pharmacy Benefits

1 Current MCO Carve-In Model

- Pharmacy remains within the MCO benefit package; certain drugs are carved out
- MCOs contract with their own PBMs and independently contract with network pharmacies
- MDH oversight focuses on MCOs and their PBMs

2 Single PBM (SPBM) Model

Managed Care + SPBM

- Pharmacy remains in managed care, but all MCOs use a single state-selected PBM
- MDH would have increased control over reimbursement methodology, PDL strategy, and SPBM oversight
- Model design may vary, including whether MCOs remain at risk for pharmacy claims

3 FFS Carve-Out Model

- Pharmacy is removed from the MCO benefit package and administered through FFS.
- MDH would use a single FFS PDL and FFS reimbursement framework.
- State/vendor responsibilities and costs would expand, and the state would bear pharmacy cost risk.

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Factors to Consider for Assessing Cost Differences in the Three Delivery Models

1) Pharmacy Claims Cost / Reimbursement Methodology Impact
2) Pharmacy Benefit Administrative Cost
3) Preferred Drug List (PDL) Structure and Rebate Impact
4) Other Factors Impacting Capitation Rate-Setting

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Pharmacy Claims Cost / Reimbursement Methodology Impact

Current MCO Carve-In Model: Currently, PBMs for each MCO independently contract with network pharmacies at negotiated rates. Some states have required managed care plans to reimburse pharmacy claims using the fee-for-service (FFS) reimbursement methodology. The potential impact of implementing FFS reimbursement within Maryland HealthChoice was presented in a previous meeting. The net impact to pharmacy reimbursements was modeled as an increase in claim cost in excess of $80 million per year.

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Pharmacy Claims Cost /Reimbursement Methodology Impact *cont.*

Single PBM (SPBM) Model: Under a Single PBM (SPBM) model for Medicaid pharmacy benefits, MDH could have significantly increased control to standardize the reimbursement methodology applied to pharmacies. While the reimbursement methodology could mirror that of FFS, since the pharmacy benefit is still being delivered under managed care, there could also be flexibility to design a benefit that incorporates some, but not all features of the FFS reimbursement methodology.

Pharmacy Claims Cost /Reimbursement Methodology Impact *cont.*

FFS Carve-Out Model: Under the FFS carve-out model, MDH would be required to reimburse pharmacies in accordance with federal regulatory requirements including those implemented under the 2016 CMS Final Rule on Covered Outpatient Drugs (CMS-2345-FC). The reimbursement methodology would include ingredient reimbursements according to an actual acquisition cost model and professional dispensing fees (PDFs) supported by survey data.

Pharmacy Claims Cost /Reimbursement Methodology Impact *cont.*

340B Impact: Currently, MCOs are allowed to reimburse pharmacies associated with 340B covered entities, or their contract pharmacies, at standard commercial rates. MDH cannot collect Medicaid rebates for these 340B claims. Under an FFS carve-out model, MDH would be required to pay 340B claims at actual acquisition cost, plus a PDF. Under an SPBM model, MDH would have the flexibility to consider reimbursing 340B claims at actual acquisition cost but would not be required to do so. While changes to 340B reimbursement could result in savings for MDH, there will be a corresponding impact to 340B covered entities.

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Pharmacy Benefit Administrative Cost

Current MCO Carve-In Model: Currently, MCO's incur administrative expenditures for maintaining the pharmacy benefit. This includes administrative fees paid to PBMs and internal MCO costs relating to PBM oversight and other internal pharmacy benefit management. A presentation in a previous workgroup session shared results of an analysis of PBM costs incurred by HealthChoice MCOs. While some costs were fees paid to PBMs, other costs relate to the MCOs internal management of the pharmacy benefit. In addition to MCO cost, MDH currently incurs administrative costs to perform oversight activities of MCOs, including monitoring the delivery of the pharmacy benefit by MCOs and PBMs.

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Pharmacy Benefit Administrative Cost *cont.*

SPBM Model: Under an SPBM model, MDH would incur costs for a SPBM vendor to perform various functions (e.g., claims processing, prior authorization management, member and provider call centers, etc.). Additionally, the state would incur cost for oversight of the SPBM vendor and would require greater involvement in decisions relating to pharmacy network management, reimbursement methodology, handling of clinical edits and handling of prior authorizations. A comprehensive cost assessment would need to consider vendor costs as well as additional costs for state staffing.

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Pharmacy Benefit Administrative Cost *cont.*

FFS Carve-Out Model: Under an FFS carve-out model, MDH will incur cost for a significant expansion of the FFS pharmacy claims vendor role to perform various functions (e.g., claims processing, prior authorization management, member and provider call centers, etc.). Additionally, the state would incur increased cost for oversight of the FFS claims processor given the significant increase in volume. The level of state involvement may increase for decisions relating to pharmacy network management, reimbursement methodology, handling of clinical edits and handling of prior authorizations. A comprehensive cost assessment would need to consider vendor costs as well as additional costs for state staffing.

PDL Structure and Rebate Impact

Current MCO Carve-In Model: Under the current MCO carve-in model of pharmacy reimbursement, each MCO and PBM within the HealthChoice program has flexibility to determine its PDL, independent of the preferred drug list maintained by the FFS pharmacy program. To the extent that MCO/PBM incentives for specific PDL choices do not align with state incentives for reduced cost and/or maximizing opportunities for either federal or supplemental rebates, this lack of alignment may lead to higher net costs for the program. Some states use the carve-in model of pharmacy benefits delivery but implement a unified PDL and require MCOs and their PBMs to adopt that PDL.

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PDL Structure and Rebate Impact *cont.*

SPBM Model: Under an SPBM model, the state would most likely use a unified PDL. This approach would offer an opportunity for MDH to move toward a cohesive clinical and financial strategy and leverage its full purchasing power. Choices within the PDL strategy can be optimized to meet overall state goals with respect to lowest net cost, including impact of federal and supplemental rebate opportunities. Centralizing the PDL generally reduces administrative burdens for providers who currently navigate multiple, differing drug lists across various MCOs. As the Centers for Medicare & Medicaid Services (CMS) introduces complex new pricing and value-based models drug pricing for Medicaid programs (e.g., Cell & Gene Therapy Model, GENEROUS, BALANCE, etc.), a unified PDL may provide a better framework to implement these changes.

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PDL Structure and Rebate Impact *cont.*

FFS Carve-Out Model: An FFS carve-out model would also include the use of a unified PDL, with similar potential advantages as described for the SPBM model.

Of note, implementation of a uniform PDL (UPDL) from a system in which the **9** individual MCOs manage their own lists would require careful planning, cost analysis and extended implementation timelines to avoid disruptions to patient care and medication access. It does place some immediate burdens on providers relating to potential therapy conversions and prior authorizations. Sufficient communication and timing coordination are required so that enrolled pharmacies can properly manage potential shifts in inventory.

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Other Factors Impacting Capitation Rate-Setting

Current MCO Carve-In Model: Assessments to consider shifts from a carve-in model of reimbursement usually consider potential implications to premium taxes. To the extent that HealthChoice MCOs are subject to a health insurance premium tax assessed by the state of Maryland, the cost for such tax assessments would be included within the capitation rate and would impact federal funds received by MDH for payment of capitation rates to MCOs. Since the premium taxes paid by HealthChoice MCOs are revenues to the state, they represent a net gain to the state due to the drawdown of federal funds.

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Other Factors Impacting Capitation Rate-Setting *cont.*

Current MCO Carve-In Model ***(cont.)*****:** Additionally, within the capitation rate-setting processing process, actuarial calculations typically include a factor for "underwriting gain" to compensate MCOs for the financial risks associated with covering patient medical/pharmacy costs. To the extent that pharmacy costs are included within the capitation rates, some amount of the imputed underwriting gain would be associated with those pharmacy costs.

Other Factors Impacting Capitation Rate-Setting *cont.*

SPBM Model: There are various approaches for establishing an SPBM model which may or may not continue to place MCOs at risk for the cost incurred for pharmacy claims. Whether there is any impact to premium taxes and cost associated with underwriting gain would depend on the specific SPBM model applied and whether MCOs would be at risk for pharmacy claims or not.

Other Factors Impacting Capitation Rate-Setting *cont.*

FFS Carve-Out Model: A removal of the pharmacy portion of capitation rates would occur under an FFS carve-out model. This would remove premium taxes and the underwriting gain cost for the portion of the capitation rate associated with pharmacy cost. The removal of premium taxes could result in a net loss to the state given federal matching funds received for capitation rates paid to MCOs. Removal of the underwriting gain component of the portion of the capitation rate associated with pharmacy claims cost could result in savings for MDH. Notably, the state would bear the risk for pharmacy costs as opposed to sharing that risk with MCOs.

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Delivery Model Cross-Option Comparison

Policy Dimension	1. Current MCO Carve-In Model	2. Single PBM (SPBM) Model	3. FFS Carve-Out Model
Claims / Reimbursement	PBMs independently contract with network pharmacies at negotiated rates. FFS reimbursement within HealthChoice was modeled as a claim cost increase more than $80M/year.	MDH could have significantly increased control to standardize reimbursement; methodology could mirror FFS or incorporate some FFS features.	MDH would be required to reimburse under federal requirements: actual acquisition cost model + professional dispensing fees supported by survey data.
340B Treatment	MCOs may reimburse pharmacies associated with 340B covered entities, or their contract pharmacies, at standard commercial rates; MDH cannot collect Medicaid rebates for these 340B claims.	MDH would have flexibility to consider actual acquisition cost reimbursement for 340B claims but would not be required to do so.	MDH would be required to pay 340B claims at actual acquisition cost + PDF.
Admin/Oversight	MCOs incur PBM fees and internal pharmacy benefit management costs; MDH oversees MCOs and PBMs.	MDH incurs SPBM vendor and oversight costs; greater state involvement in network management, reimbursement, clinical edits, and prior authorizations.	FFS claims vendor role would significantly expand; MDH incurs increased oversight costs due to higher volume.
PDL/Rebates	Each MCO/PBM has PDL flexibility; lack of alignment with state incentives may lead to higher net costs.	State would most likely use a unified PDL; could support cohesive clinical and financial strategy and leverage full purchasing power.	FFS carve-out would also include a unified PDL; implementation requires careful planning, cost analysis, and extended timelines.
Capitation/Risk	Pharmacy costs remain in capitation, including premium-tax and underwriting-gain components.	Premium tax and underwriting gain impacts depend on the specific SPBM model and whether MCOs remain at risk for pharmacy claims.	The pharmacy portion of capitation rates would be removed; removal of premium taxes could result in a net loss to the state; the underwriting gain component associated with pharmacy costs would be removed; the state would bear pharmacy cost risk.

Discussion Questions: Current MCO Carve-In Model

- What operational challenges do pharmacies experience when contracting with multiple MCOs and PBMs?

- How do differences across MCOs and PBMs affect patient access?

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Discussion Questions: Single PBM (SPBM) Model

- Which differences across PBMs create the greatest burden, particularly related claims payment?

- Are there current PBM or MCO practices that stakeholders believe should be standardized regardless of which delivery model Maryland uses?

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Discussion Questions: FFS Carve-Out Model

- What are the biggest advantages and disadvantages of carving pharmacy benefits out of managed care and administering them through FFS?

- What implementation issues would Maryland anticipate if claims processing, prior authorization, provider support, and pharmacy operations shifted to an expanded FFS vendor role?

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Questions and/or Comments from Workgroup Members

Questions and/or Comments from Public Stakeholders

Written Comments

Written comments will be accepted though **EOD Tuesday, September 8, 2026**, on the topics covered in today's meeting.

Those can be submitted via email to:

pharmacyservicesworkgroup.mia@maryland.gov

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Contact Information

Maryland Insurance Administration

800-492-6116 (toll-free)

410-468-2000 (local)

800-735-2258 (TTY)

insurance.maryland.gov

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