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Key Considerations for MassHealth Pharmacy Carve-Out

October 2026



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EXECUTIVE SUMMARY

MassHealth is evaluating changes to outpatient pharmacy financing and administration amid rapid pharmaceutical spending growth and broader fiscal pressure. For fiscal year (FY) 2026, it projects $3.36 billion in gross pharmaceutical spending before rebates—approximately $350 million more than the previous year—and $1.75 billion in rebate recovery. Prescription drug spending increased by 18% between FY 2024 and FY 2025, driven largely by high-cost drugs. Available evidence does not establish that the gross benefits attributed to a full carve-out would produce comparable incremental net savings.

MassHealth already centralizes major pharmacy policies through the Uniform Preferred Drug List, statewide coverage and prior authorization rules, utilization management, and supplemental rebate strategies. Accountable Care Partnership Plans (ACPPs) and Accountable Care Organizations (ACOs) administer benefits within this framework while retaining pharmacy expenditures in capitation, which preserves integrated accountability for pharmacy, medical, and behavioral health services.

Against this backdrop, MassHealth, supported by Marsh and the Health Policy Commission's Office of Pharmaceutical Policy and Analysis, has evaluated four pharmacy reform scenarios, two involving a single pharmacy benefit manager and two involving a full fee-for-service pharmacy carve-out. On October 26, 2026, the Health Policy Commission (HPC) released its final assessment, including Marsh's estimates of the financial effects of four pharmacy reform scenarios. The final report provides substantially more information regarding the methodology and assumptions underlying the estimates. Nonetheless, important questions remain regarding whether the modeled expenditure changes would translate into durable net savings to the Commonwealth after accounting for federal financing, provider reinvestment, transferred financial risk, implementation and ongoing administrative costs, and changes in pharmaceutical market conditions.

The Massachusetts Association of Health Plans engaged Wakely, a Health Management Associates (HMA) Company, to assess the proposals and their projected savings. Because Massachusetts already has many of the tools and authorities needed to achieve savings without removing the pharmacy benefits from the managed care organizations (MCOs) and Accountable Care Partnership Plans (ACPPs), the key question is whether a full carve-out would deliver meaningful additional savings after accounting for all costs, risks, and potential disruptions or whether those savings could be achieved more effectively through targeted reforms that preserve coordinated, integrated care.

HPC's headline savings estimates are not estimates of net savings to the Commonwealth's General Fund. The reported $10.1 million to $193.0 million represents modeled changes in state and federal program expenditures before provider reinvestments and before adjustments for federal and state shares. Accordingly, the figures should not be interpreted as equivalent reductions in Commonwealth spending or budgetary savings.

While the Commonwealth's analysis identifies potential sources of gross savings, the available evidence does not establish that a pharmacy carve-out would generate material, sustainable, incremental net savings compared with reforms available under the current integrated managed care model. The largest estimated savings depend on changes in 340B financing, while other projected savings reflect transfers of financial risk or administrative responsibilities rather than demonstrated reductions in overall spending. Many cited benefits are already available under MassHealth's structure or through targeted reforms.

Much of the policy debate surrounding pharmacy benefit reform centers on whether the projected savings represent durable reductions in Commonwealth spending or changes in how costs, revenues, and financial risk are allocated across stakeholders. **Table ES-1** summarizes the major savings categories and HMA/Wakely's assessment of each.

Table ES-1. HMA/Wakely Assessment of Major Savings Components

Savings Component	Estimated Amount	HMA/Wakely Assessment
Administrative Savings	$8.7M–$11.2	Potential administrative efficiencies, but net savings cannot be independently validated because the analysis does not fully account for retained Accountable Care Partnership Plan (ACPP) responsibilities, new administrative functions, or implementation costs.

Savings Component	Estimated Amount	HMA/Wakely Assessment
Pharmacy-Related Risk Payments	$23.3M	Removes risk-related capitation payments but omits the transfer of pharmacy risk to MassHealth. Risk is transferred not eliminated.
Incremental Manufacturer Rebates (Scenarios A–C)	$1.3M	No clear evidence that savings require structural reform or are unachievable within the existing framework.
Changes in 340B Reimbursement (Scenario C)	$115.8M	Represents a potential gross reduction in pharmacy expenditures associated with 340B claims. Net savings depend on provider impacts, replacement payments, and implementation details that have yet to be evaluated.
340B Rebate Capture (Scenario D)	$158.4M	Represents a potential gross increase in rebate revenue. Net savings depend on provider impacts, replacement payments, and implementation details that have yet to be evaluated. Savings would also be significantly reduced or eliminated if savings were reinvested into safety-net care, as the Commonwealth has stated.

Principal Findings

Administrative savings are not demonstrated on a net basis. The Commonwealth estimates $8.7 million to $11.2 million annually by replacing pharmacy benefit manager (PBM) costs currently embedded in ACPP capitation with centralized administration. Because these pharmacy functions would continue and responsibilities among MassHealth, ACPPs, and a new administrator are incompletely defined, these estimates represent potential gross savings and are not validated net savings.

Eliminating risk payments does not eliminate financial risk. Scenarios B, C, and D count $23.3 million in pharmacy-related risk payments as savings, but the underlying risk shifts to MassHealth, which would assume direct responsibility for pharmacy spending volatility. The analysis does not value this transferred risk or the financial protection that ACPPs currently provide. Consequently, the elimination of these payments cannot be equated with an equivalent reduction in the Commonwealth's financial exposure. Because state fiscal year (SFY) 2024 pharmacy costs reportedly exceeded ACPP funding, counting the payment reduction without the adverse experience MassHealth would have assumed may materially overstate net savings.

Additional manufacturer rebates may be achievable without a carve-out. Scenarios A, B, and C each project $1.3 million in additional manufacturer rebates, but the analysis neither identifies the products nor explains why MassHealth's existing Unified Pharmacy Product List (UPPL), contracting, and reconciliation tools cannot capture the value. The appropriate comparison is, therefore, a carve-out rather than targeted rebate reforms within the current model.

Declining rebate revenue raises questions about the sustainability of projected savings. Rebate revenue is eroding nationwide because of higher spending on drugs with lower rebate potential. As a result of manufacturer pricing behavior and the mix of drugs driving expense, states are seeing drug spend increase while rebate revenue as a percentage of that whole is decreasing. The analysis should account for these trends when evaluating whether projected rebate savings can be sustained over time.

Projected savings from the GENEROUS program participation cannot be independently validated. The report that HPC issued October 26, 2026, contains policy updates, including MassHealth's voluntary participation in the GENEROUS rebate program pilot with the Centers for Medicare & Medicaid Services (CMS). The report provides insufficient information regarding MassHealth's analysis or assumptions for full verification. Marsh has noted that it relied on GENEROUS derived savings estimates provided by MassHealth with no further detail. Hence, it remains unclear which GENEROUS eligible drugs are in Cohorts 1 and 2. In addition, MassHealth signals that GENEROUS derived savings could be used to make safety-net providers whole in a Scenario D model.

The analysis is unclear in which instances the existing rebates (were the drug not dispensed by a 340B provider) plus the GENEROUS rebate exceeds 340B revenue. It further appears that estimates were based on 340B ceiling prices rather than actual 340B prices, potentially inflating the differential and overstating the potential savings estimate.

Finally, the report presents savings as total funds, inclusive of the federal share, without explaining how much would be available to offset provider losses. It is unclear upon what assurance MassHealth relies, if any, that total funds could be applied to making net providers whole versus just the state share. More details about these models and their potential viability are needed so that safety-net providers can determine whether if they are to made whole for the potential loss of 340B revenue or only partially so.

The largest estimates reflect changes in 340B financing, rather than demonstrated efficiencies from pharmacy administration. Scenario C attributes $115.8 million to lower reimbursement of 340B claims, and Scenario D attributes $158.4 million to rebates on claims no longer treated as 340B. These estimates primarily reflect a redistribution of financial resources rather than demonstrated reductions in the underlying cost of prescription drugs. The analysis does not establish the net fiscal benefit after accounting for potential replacement payments to affected safety-net providers, federal financing implications, and other offsets. Given the magnitude of these estimates, even partial replacement of lost provider revenue could substantially reduce projected savings.

Implementation and transition costs are excluded. The estimates are exclusive of procurement, systems development, testing, data conversion, provider readiness, prior authorization conversion, member communication, staffing, training, or transition support. They also incompletely quantify the ongoing costs of MassHealth oversight, vendor management, data exchange, appeals administration, and coordination with ACPPs. Because these costs are excluded, the modeled amounts are not estimates of the net fiscal impact of implementing the proposed reforms. Rather, they are gross annual operating assumptions that should be reduced by implementation, transition, and ongoing costs before being compared across scenarios.

The estimates are based on a one-year retrospective snapshot. The analysis uses SFY 2024 data without applying pharmacy trend, enrollment projections, implementation timing, future rebate erosion, evolving biosimilar adoption, or other forward-looking assumptions. SFY 2024 was also the first period in which the UPPL was fully implemented, making it particularly important to distinguish a retrospective point-in-time comparison from a forward-looking savings projection. The results therefore illustrate how the scenarios would have performed under a specific set of SFY 2024 conditions. They do not establish the level of savings that would actually be realized after implementation or whether those savings would persist over time.

Other states' experiences do not establish that full pharmacy carve-outs would generate comparable net savings in Massachusetts. New York and California demonstrate that large carve-outs are operationally feasible, but publicly available evidence comprehensively validating long-term net savings remains limited. West Virginia reported significant savings, but the methodology and results were subsequently challenged. Michigan and Ohio demonstrate that states can pursue formulary alignment, administrative consistency, rebate strategies, and centralized PBM oversight through approaches short of a full fee-for-service (FFS) carve-out.

These comparisons are further limited because Massachusetts already exercises centralized control over many of the functions that motivated reforms in other states, including formulary policy, utilization management, and supplemental rebate strategies. Other state experiences, therefore, demonstrate that alternative pharmacy structures are operationally feasible but do not demonstrate the incremental financial value of adopting those structures in Massachusetts.

A full carve-out would separate pharmacy financial accountability from the ACPPs that remain accountable for medical and behavioral health care and total cost of care. ACPPs now bear integrated responsibility for medical, behavioral health, and pharmacy expenditures. Removing pharmacy from capitation would divide financial accountability between MassHealth and ACPPs and require new mechanisms to preserve pharmacy data exchange, medication management, quality measurement, and care coordination. This process entails more than a change in pharmacy administration. It changes the incentives and tools available to organizations that remain accountable for the cost and outcomes of members' overall care. The Commonwealth's analysis quantifies neither the cost of recreating or preserving these functions under a carve-out nor the potential effect of separating pharmacy risk from broader total cost of care accountability.

Conclusion and Recommended Direction

The Commonwealth's analysis identifies possible sources of gross savings, but it does not demonstrate that a full pharmacy carve-out would produce material, durable, incremental net savings beyond that MassHealth could achieve through targeted changes to the current program.

This distinction is particularly important in Massachusetts. MassHealth has already centralized many of the pharmacy functions that have motivated carve-outs in other states through the UPPL, statewide utilization management requirements, supplemental rebate strategies, and centralized pharmacy policy. What a full carve-out would also change is the financing of the benefit, the allocation of pharmacy risk, the treatment of 340B-related value, and the integration of pharmacy with ACPP total cost of care accountability.

The largest projected carve-out savings are concentrated in those structural changes. The $23.3 million attributed to risk payments reflect only underwriting margin changes while ignoring the losses ACPPs will no longer absorb and the transfer of pharmacy risk to MassHealth, whereas the $116.4 million and $135.4 million estimates under the FFS scenarios depend substantially on changes in 340B financing. At the same time, implementation costs, potential provider financing offsets, the value of transferred risk, and the effects on integrated accountability have not been fully incorporated into the analysis.

Accordingly, the analysis does not establish that a full carve-out would deliver the level of net savings projected nor that those savings would be unachievable through less disruptive reforms.

Before undertaking a structural reorganization of pharmacy financing and administration, the Commonwealth should:

- Provide replicable calculations and underlying assumptions for each savings component
- Distinguish gross payment reductions from incremental net savings
- Quantify implementation, transition, vendor, and retained ACPP costs
- Value the pharmacy risk that would transfer to MassHealth
- Incorporate anticipated 340B replacement or supplemental payments
- Evaluate savings over multiple years under alternative rebate, utilization, enrollment, and market assumptions
- Assess effects on ACPP accountability, quality, and total cost of care
- Compare a full carve-out against alternatives that address the specific policy objectives that the Commonwealth seeks to achieve

The question is not simply whether a pharmacy carve-out could generate savings, but whether it would deliver greater net savings and better outcomes than reforms that build on the existing program. If the Commonwealth's goals are greater transparency, administrative efficiency, improved rebates, better data access, or protection against high-cost drugs, those goals should be evaluated against targeted solutions that preserve integrated care and ACPP accountability.

INTRODUCTION

MassHealth Pharmacy Spending Trends

Pharmaceutical spending at MassHealth is consuming a growing share of the state budget, thereby creating fiscal pressure that is driving the organization to consider structural reforms. For fiscal year (FY) 2026, MassHealth projects spending will reach $3.36 billion on pharmaceutical utilization before rebates, an increase of approximately $350 million year-over-year, with an estimated $1.75 billion in rebate recovery. Prescription drug spending at MassHealth increased by 18% from FY 2024 to FY 2025, with high-cost drugs accounting for the bulk of growth and GLP-1 medications accounting for less than half of the increase.[1] Compounding MassHealth's financial pressures are upcoming federal funding losses, and state officials are actively seeking cost saving strategies across the program.

Review of Pharmacy Benefit Reform Scenarios

In response to these trends, the Office of Pharmaceutical Policy and Analysis (OPPA) within the Massachusetts Health Policy Commission (HPC), with support from its actuarial firm, Marsh, developed an analysis of pharmacy benefit reform scenarios and estimated savings. The analysis examined potential financial and operational impacts of different pharmacy administration models, including a fully centralized carve-out in which outpatient pharmacy benefits would be removed from ACPP capitation and administered through a state-managed or state-contracted fee-for-service (FFS) system.

This discussion follows several years of increasing centralization of MassHealth pharmacy policy, including implementation of the UPPL and statewide utilization management and rebate strategies. As a result, the policy question before Massachusetts differs from the question that confronted states that moved from decentralized managed care pharmacy programs to centralized models. Massachusetts is evaluating whether further centralization of pharmacy administration, financing, and risk would produce incremental value beyond the centralized policy tools already in place.

Independent Assessment of Reform Alternatives

The Massachusetts Association of Health Plans (MAHP) engaged Wakely, a Health Management Associates (HMA) Company, to conduct an independent assessment of the pharmacy benefit reform scenarios under consideration. This report considers the HPC's October 26, 2026, final report, its supporting analysis, and other available evidence to evaluate whether the proposed reforms would generate meaningful net savings compared with targeted improvements to the existing program.

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[1] Kuznitz A. High-Cost Drugs Push MassHealth Pharmacy Tab up $350M. State House News Service. Published by WWLP-22 News). September 3, 2026.

BACKGROUND

Overview of MassHealth's Current Pharmacy Model

MassHealth's Delivery System Structure

MassHealth provides healthcare coverage to approximately 1.97 million Massachusetts residents through multiple delivery systems tailored to different populations. The Accountable Care Organization (ACO) program, which includes both Accountable Care Partnership Plans (ACPPs) and Primary Care ACOs (PCACOs), is available to MassHealth members younger than age 65 who are eligible for coverage under various MassHealth programs (Standard, CommonHealth, CarePlus, Family Assistance, etc.). The ACO program serves approximately 1.17 million members, with ACPPs representing the larger portion (871,670 members, or 74% of the ACO population).

MassHealth's other delivery systems serve distinct populations: Senior Care Options (SCO) and One Care for individuals who are dually eligible for Medicaid and Medicare, and the Primary Care Clinician (PCC) Plan and FFS arrangements for remaining MassHealth members. In October 2025, MassHealth awarded a new pharmacy benefit administration contract to support pharmacy claims processing, rebate management, and reporting functions for members served through the PCC Plan and FFS delivery systems, with implementation scheduled for January 2027.

Capitated Payment Model

Under the capitated payment model that ACPPs use, MassHealth pays a fixed monthly amount per enrollee (capitation) that is intended to cover all medical, behavioral health, and pharmacy services. Rather than billing the state separately for each service delivered, the organization receives this predetermined capitated payment and bears financial risk if actual costs exceed the capitation amount or retains savings if costs come in below it, subject to risk corridors that establish upper and lower limits on gains and losses. This integrated payment structure means ACPPs are financially accountable for managing total cost of care across all service categories, including pharmacy, while the risk-sharing mechanisms limit MassHealth’s exposure to extreme variations in costs.

ACPPs are responsible not only for total cost of care, but also bear responsibility for overall health outcomes. Pharmacy is an important lever in managing cost and outcomes, especially for people with chronic conditions. It is unclear from the Commonwealth’s analysis whether the options identified erode ACPPs’ ability to achieve desired outcomes for enrollees. Accountable care was designed to remove fragmentation; thus, of each proposal should be assessed for the impact of newly introduced fragmentation.

Pharmacy Administration and MassHealth Oversight

Each ACPP contracts with a pharmacy benefit manager (PBM) to handle operational pharmacy functions, including claims processing, network pharmacy management, prior authorization administration, drug utilization review, appeals processing, and rebate collection and accounting. Although ACPPs delegate these administrative functions to PBMs, MassHealth maintains centralized oversight of pharmacy policy and performance across all managed care entities through a comprehensive set of policy tools and requirements:

- **Uniform Preferred Drug List (UPPL):** MassHealth maintains a centralized, standardized preferred drug list applied across all ACPPs. The UPPL designates certain drugs as "preferred" (typically with lower cost-sharing) and establishes penalty structures (such as higher copayments) for nonpreferred alternatives. This approach ensures consistent formulary coverage for MassHealth members across all ACPPs and creates concentrated purchasing power with pharmaceutical manufacturers. ACPPs cannot deviate from the UPPL without explicit MassHealth approval.
- **Centralized Drug List Administration:** The MassHealth Drug List (MHDL) infrastructure provides statewide coverage policies, clinical coverage criteria, and prior authorization requirements that all ACPPs must implement. MassHealth updates the MHDL regularly based on clinical evidence and cost considerations, and all ACPPs must apply these policies uniformly.
- **Supplemental Rebate Strategies:** Beyond the federal Medicaid Drug Rebate Program, MassHealth pursues supplemental rebate arrangements with manufacturers through strategies such as preferred product designations, value-based agreements, and volume commitments. These strategies are designed to enhance rebate recovery and are applied across all ACPPs, meaning rebate benefits accrue to the state rather than individual ACPPs.
- **Uniform Prior Authorization and Utilization Management Requirements:** All ACPPs must follow MassHealth's standardized prior authorization protocols, utilization review criteria, and clinical management guidelines for pharmacy services. MassHealth specifies which drugs require prior authorization, what clinical criteria must be met, and what appeals processes must be available to providers and beneficiaries.
- **Performance Monitoring and Compliance:** MassHealth monitors ACPP compliance with these pharmacy policies through regular audits, claims data analysis, and reporting requirements. ACPPs must submit pharmacy-related data to MassHealth regularly, and MassHealth uses this information to track formulary adherence, rebate performance, prior authorization trends, and other metrics to ensure ACPPs are following state direction.

- **Integration with Medical Management:** MassHealth requires ACPPs to coordinate pharmacy management with medical management through shared clinical policies, integrated care coordination protocols, and aligned quality measures. This process ensures that pharmacy decisions are made in the context of total care rather than in isolation.

Collectively, these mechanisms provide MassHealth with substantial control over formulary management, utilization controls, rebate strategies, and clinical pharmacy policy across the ACPP program. Hence, many key pharmacy policy decisions are established centrally and applied consistently across participating ACPPs.

Integrated Financial Accountability in the ACPP Model

A distinguishing characteristic of MassHealth ACPPs is the integration of medical, behavioral health, and pharmacy services within a single risk-bearing arrangement for the non-elderly, non-dual-eligible population. Under this model, ACPPs are financially accountable for the total cost of care across service categories rather than for pharmacy spending in isolation. This structure reflects a broader policy approach that places responsibility for care management and cost performance within organizations that are accountable for overall member outcomes and expenditures. Pharmacy benefits are therefore administered as part of a larger financing and care delivery framework rather than as a stand-alone program component.

Implications for Pharmacy Management and Care Coordination

MassHealth ACPPs place medical, behavioral health, and pharmacy services within one risk-bearing arrangement. This aligns pharmacy management with total cost of care and gives ACPPs incentives to use medication management, adherence, and clinical coordination to improve outcomes and avoid higher-cost services. A carve-out would separate pharmacy financing from that integrated framework; the implications are examined in detail later in this report.

MASSACHUSETTS POLICY CONSIDERATIONS

Assessing Reform Within the Existing MassHealth Pharmacy Framework

Massachusetts is evaluating pharmacy benefit reform from a different starting point than many states that have implemented pharmacy carve-outs. As discussed in the preceding section, the Commonwealth already combines centralized pharmacy policymaking with an integrated accountable care model. This distinction is important because several objectives commonly associated with pharmacy carve-outs, including formulary standardization, centralized utilization management, supplemental rebate strategies, and statewide pharmacy policy, already are embedded in the MassHealth framework.

Accordingly, experience from other states should be interpreted carefully. In many carve-out states, reform was undertaken to address fragmented pharmacy policies, inconsistent formularies, or limited state control over pharmacy benefit administration. Massachusetts already has many of these capabilities. As a result, **the central policy question is whether a change in pharmacy financing and administration would create meaningful value beyond the authorities, tools, and accountability structures already in place.**

This report evaluates pharmacy benefit reform through an incremental value framework. Specifically, it examines whether projected benefits are unique to a carve-out or could reasonably be achieved through modifications to existing policies, contractual arrangements, reporting requirements, or oversight mechanisms. For example, if projected savings are attributed to enhanced rebate negotiations, more aggressive formulary management, or better utilization controls, policymakers should consider whether those outcomes require a structural change to pharmacy administration. Similarly, if the anticipated benefit is greater transparency into pharmacy spending or rebate administration, the relevant question is whether those objectives necessitate a carve-out or could be accomplished through enhanced reporting, contracting, or data-sharing requirements.

Framework for Evaluating Reform Options

A pharmacy carve-out would represent more than a change in administrative structure; it would alter the allocation of financial risk, administrative responsibilities, and operational accountability that exist within the ACPP model. Accordingly, the following sections focus on the principal sources of value commonly attributed to pharmacy carve-outs, including: administrative efficiencies, rebate and manufacturer contracting opportunities, and enhanced transparency and data access. For each area, the analysis considers both the potential advantages of a carve-out and the extent to which similar outcomes may be achievable within the existing framework.

REVIEW OF THE PHARMACY BENEFIT REFORM SCENARIOS AND SAVINGS ESTIMATES

Overview of the Four Reform Scenarios

The Commonwealth's analysis evaluates four potential reforms to the administration and financing of outpatient pharmacy benefits for members enrolled in ACPPs. The scenarios vary across five primary dimensions:

- Who administers the pharmacy benefit
- Who bears pharmacy expenditure risk
- How pharmacy funding flows through the system
- Who pays retail pharmacies
- How 340B claims are treated and where the Commonwealth assumes savings would be generated

The four scenarios are summarized in **Table 1**.

Table 1. Comparison of the Commonwealth's Pharmacy Benefit Reform Scenarios

Design Feature	Scenario A Single PBM with ACPP Risk	Scenario B Single PBM with MassHealth Risk	Scenario C FFS Carve-Out with 340B Pricing	Scenario D FFS Carve-Out with Rebate Capture
Pharmacy benefit administrator	Single PBM	Single PBM	MassHealth	MassHealth
Party bearing pharmacy expenditure risk	ACPPs	MassHealth	MassHealth	MassHealth

Design Feature	Scenario A Single PBM with ACPP Risk	Scenario B Single PBM with MassHealth Risk	Scenario C FFS Carve-Out with 340B Pricing	Scenario D FFS Carve-Out with Rebate Capture
Flow of pharmacy funding	MassHealth pays ACPP capitation; ACPPs transfer pharmacy funds to the single PBM	MassHealth reimburses the single PBM for pharmacy claims and administrative fees	MassHealth pays pharmacies directly	MassHealth pays pharmacies directly

Source: Commonwealth presentation and related stakeholder discussions.

Each scenario changes elements of the current model, pharmacy administration, financial risk, and 340B financing. Scenario A changes administration while preserving ACPP risk. Scenario B transfers both administration and risk to Mass Health. Scenarios C and D change the treatment of 340B related value and financial risk.

The Commonwealth's analysis uses state fiscal year (SFY) 2024 experience as a point-in-time baseline. According to the Commonwealth, SFY 2024 was selected partly because the UPPL was fully implemented during that period and because the same underlying data were used to develop SFY 2026 capitation rates. The analysis does not apply pharmacy trend, enrollment projections, or other forward-looking assumptions, nor does it attempt to estimate how future changes in utilization, drug mix, manufacturer rebate arrangements, biosimilar adoption, coverage policies, or broader market conditions may affect costs over time. The analysis also excludes implementation and transition costs.

Accordingly, the estimates should be interpreted as a retrospective comparison of how the four reform scenarios would have performed if applied to SFY 2024 experience rather than as projected future savings over multiple years. This distinction is important because SFY 2024 reflected a unique set of market conditions, benefit policies, rebate arrangements, and utilization patterns, including the significant pharmacy cost pressures that prompted the current policy discussion. The analysis therefore provides a useful framework for understanding the financial mechanisms affected by each reform option, but it does not establish whether the estimated savings would persist, increase, or diminish over time as market conditions evolve.

Scenario A: Single PBM with ACPPs Retaining Risk

Under Scenario A, MassHealth would contract with a single PBM to administer pharmacy claims for ACPP members, but pharmacy expenditures would remain within ACPP capitation. MassHealth would continue to pay ACPPs a capitated rate that includes pharmacy expenditures, and ACPPs would transfer the pharmacy portion of those payments to the single PBM, which would reimburse retail pharmacies. Because ACPPs would continue to bear financial risk for pharmacy expenditures, the analysis assumes no reduction in pharmacy-related risk payments. It also assumes no change in gross drug expenditures. Estimated savings are limited to $1.3 million in additional manufacturer rebates and $8.7 million in administrative expenses, for total estimated savings of $10.1 million.

Scenario B: Single PBM with MassHealth Retaining Risk

Scenario B would also establish a single PBM, but pharmacy expenditures would be removed from ACPP capitation. The single PBM would pay pharmacies, and MassHealth would reimburse the PBM for pharmacy claims and administrative fees. MassHealth, rather than the ACPPs, would bear the financial risk associated with actual pharmacy expenditures. The analysis assumes no change in gross drug expenditures. It estimates $1.3 million in additional rebates, $10.2 million in administrative savings, and $23.3 million from removal of pharmacy-related risk payments from capitation for total estimated savings of $34.9 million.

Scenario C: FFS Carve-Out with 340B Allowed

Under Scenario C, pharmacy benefits would be removed from ACPP capitation. Instead, MassHealth would retain pharmacy risk and would pay pharmacies directly through an FFS structure. The scenario would continue to allow 340B claims. The analysis assumes that applicable 340B claims would be reimbursed at no more than the 340B ceiling price. It estimates $115.8 million in reduced gross drug expenditures, reflecting the difference between current reimbursement and 340B ceiling prices, adjusted for the effects of selected biosimilars. The analysis also estimates $1.3 million in additional rebates, $11.2 million in administrative savings, and $23.3 million from removal of risk payments, for total estimated savings of $151.7 million.

Scenario D: FFS Carve-Out with 340B Disallowed

Scenario D would similarly remove pharmacy benefits from ACPP capitation, place pharmacy risk with MassHealth, and have MassHealth pay pharmacies directly; however, 340B claims would be disallowed. The analysis assumes no reduction in gross ingredient costs because affected claims would be reimbursed under the applicable non-340B methodology. Instead, claims that were previously ineligible for manufacturer rebates because of their 340B status would become rebate-eligible. HPC and Marsh estimate $158.4 million in additional federal and supplemental manufacturer rebates, adjusted for selected biosimilar changes. The analysis also estimates $11.2 million in administrative savings and $23.3 million from removal of risk payments, for total estimated savings of $193.9 million.

Composition of the Estimated Savings

The estimates vary considerably across the four scenarios, both in total amount and in the source of the projected savings.

Table 2. Estimated Annual Savings by Component

Savings Component	Scenario A Single PBM with ACPP Risk	Scenario B Single PBM with MassHealth Risk	Scenario C FFS Carve-Out with 340B Pricing	Scenario D FFS Carve-Out with Rebate Capture
Gross drug expenditures	$0.0M	$0.0M	$115.8M	$0.0M
Manufacturer rebates	$1.3M	$1.3M	$1.3M	$158.4M
Administrative expenses	$8.7M	$10.2M	$11.2M	$11.2M
Risk payments	$0.0M	$23.3M	$23.3M	$23.3M
Total estimated savings	$10.1M	$34.9M	$151.6M	$193M

Source: The Commonwealth's presentation and related stakeholder discussions. Totals may reflect rounding.

Although the four scenarios differ structurally, the Commonwealth's estimated savings are concentrated in a relatively small number of assumptions. All four scenarios include administrative savings associated with replacing PBM administrative costs now embedded in ACPP capitation with a centralized PBM or pharmacy benefit administration arrangement.

Scenarios B, C, and D also include the same $23.3 million reduction in pharmacy-related risk payments associated with removing pharmacy expenditures from ACPP capitation and shifting financial risk to MassHealth.

The FFS carve-out estimates should not be interpreted as net state budget savings. The HPC's estimated $151.7 million to $193.0 million in annual savings does not fully reconcile implementation and transition costs, ongoing MassHealth administrative costs, potential provider reinvestment or stabilization payments, federal versus state shares, the actuarial value of pharmacy risk transferred to MassHealth, potential medical and behavioral health spillover effects, or multiyear changes in rebate and 340B economics. These factors could materially reduce the net fiscal benefit ultimately realized by the Commonwealth.

As a result, much of the variation in projected savings across the scenarios is driven by differences in how the Commonwealth handles 340B claims and manufacturer rebates. Scenario C attributes significant savings to reduced reimbursement of 340B claims, while Scenario D attributes significant savings to additional manufacturer rebates on claims that would no longer be treated as 340B claims. The majority of the difference between the two FFS carve-out scenarios is, therefore, attributable to alternative assumptions regarding 340B-related financing rather than differences in administration, risk allocation, or pharmacy operations.

Savings estimates are highly sensitive to 340B policy assumptions. Whether savings are realized through reduced 340B reimbursement or increased manufacturer rebates accounts for most of the difference between the fee-for-service carve-out scenarios.

The following analysis evaluates each major savings component separately, including administrative expenses, pharmacy-related risk payments, manufacturer rebates, and 340B-related assumptions. For each category, we identify the Commonwealth's underlying assumption, the amount attributed to that assumption, whether the estimate represents incremental savings or a transfer of costs or risk, potentially excluded costs and offsets, and the extent to which the estimate can be validated based on the information available.

Framework for Assessing the Savings Estimates

The Commonwealth's analysis estimates savings from several distinct sources, including administrative expenses, pharmacy-related risk payments, manufacturer rebates, and changes in treatment of 340B claims. Each category represents a different type of financial assumption and therefore requires a different analytical lens.

For each major savings component, this report evaluates:

- The Commonwealth's underlying methodology and assumptions
- The amount of savings attributed to the assumption
- Whether the estimate reflects a true reduction in spending, consolidation of existing expenditures, or a transfer of costs, revenue, or financial risk
- Material costs, obligations, or offsets that do not appear to be reflected in the estimate
- The extent to which the estimate can be validated based on the available information

This framework distinguishes between gross savings, net savings, and transfers of financial responsibility. A reduction in a particular payment category does not necessarily mean that the underlying cost has been eliminated. In some instances, the cost may be assumed elsewhere in the system, transferred to another stakeholder, or replaced through a different financing mechanism.

Accordingly, the analysis does not attempt to predict the precise savings that would be realized under any scenario. Rather, it evaluates whether the projected savings appear to represent durable, incremental reductions in Commonwealth spending and identifies areas where additional information would be necessary to fully assess the financial impact of the proposed reforms.

Administrative Expense Savings

The Commonwealth estimates administrative savings by replacing PBM costs embedded in ACPP capitation with a centralized administration fee. Pharmacy functions—including claims processing, utilization management, prior authorization, network management, rebate administration, appeals, reporting, and care coordination—would continue; only responsibility and financing would shift. The key question is whether a centralized model can perform these functions at lower net cost after retained ACPP duties, MassHealth oversight, vendor fees, and implementation expenses are included. Those details are not fully developed.

Table 3. Illustrative Administrative Function Crosswalk

Function	Current ACPP Model	Single PBM Model (Scenarios A & B)	FFS Carve-out (Scenarios C & D)	Likely Financial Effect
Claims processing	ACPP-contracted PBMs	Single statewide PBM	MassHealth/PBA or FFS administrator	Consolidated, not eliminated
Pharmacy network administration	Individual PBMs	Single statewide PBM	State contractor or administrator	Consolidated
Pharmacy reimbursement	ACPP PBMs	Single statewide PBM	MassHealth directly	Transferred
Prior authorization administration	PBMs operating under MassHealth policy	PBM operating under MassHealth policy	State administrator operating under MassHealth policy	Retained
Utilization management	ACPPs and PBMs under MassHealth requirements	ACPPs and PBM under MassHealth requirements	MassHealth, administrator, and potentially ACPPs	Retained and reallocated
Rebate administration and invoicing	MassHealth with PBM support	MassHealth with PBM support	MassHealth with administrator support	Consolidated or transferred
Provider support and issue resolution	ACPPs and PBMs	ACPPs and PBM	MassHealth, administrator, and potentially ACPPs	Retained
Member support and call center activities	ACPPs and PBMs	ACPPs and PBM	MassHealth, administrator, and potentially ACPPs	Retained

As **Table 3** illustrates, many pharmacy management activities would continue under any scenario. The principal difference is which organization performs the function and how it is financed.

Potentially Excluded Costs and Operational Considerations

Beyond the allocation of current responsibilities shown above, several categories of cost do not appear to be explicitly quantified in the Commonwealth's estimate. These costs are relevant because they would affect whether the projected administrative savings represent gross efficiencies or net reductions in administrative spending.

Several categories of cost also do not appear to be explicitly quantified, including:

- Procurement and contracting activities
- Systems development, testing, and integration
- Data exchange between ACPPs, MassHealth, pharmacies, and a centralized administrator
- Additional MassHealth staffing and oversight functions
- Provider and member communications
- Transition and implementation costs
- Ongoing contract management and vendor oversight
- Administrative functions that may continue to reside within the ACPPs

The analysis also does not clearly address whether ACPPs would incur incremental costs associated with maintaining separate pharmacy administrative arrangements across Medicaid and non-Medicaid lines of business or how ongoing UPPL implementation activities, utilization management operations, and prior authorization workloads were treated.

Even under a centralized model, ACPPs may continue to require timely pharmacy data and operational capacity to support medication reconciliation, identify adherence gaps, coordinate behavioral health medications, monitor quality measures, respond to provider questions, and integrate pharmacy information into broader care management activities. To the extent those responsibilities remain, the associated costs are transferred or retained rather than eliminated.

Assessment

Administrative consolidation may create legitimate efficiencies. A centralized administrator could reduce certain duplicative PBM functions, streamline contracting arrangements, improve consistency, and simplify some reporting and claims processing activities. The Commonwealth's estimate therefore identifies a plausible area of potential savings.

The information available at present, however, is insufficient to independently validate the projected savings as reductions in total administrative spending. The analysis identifies expenditures removed from ACPP capitation but provides an incomplete accounting of the costs assumed by MassHealth, the centralized administrator, and the ACPPs under the alternative models. It also does not identify the extent to which functions are eliminated versus retained, transferred, or duplicated.

Accordingly, the estimated administrative savings of $8.7 million to $11.2 million are best understood as potential gross efficiencies associated with administrative consolidation rather than demonstrated net savings to the Commonwealth. A more complete analysis would reconcile all current pharmacy-related administrative expenditures with all administrative expenditures expected under each proposed scenario and identify the specific functions responsible for the projected savings.

Pharmacy-Related Risk Payments

Basis for the Estimate

Scenarios B, C, and D attribute $23.3 million in annual savings to the removal of pharmacy-related underwriting margin and other risk payments from ACPP capitation when pharmacy responsibility shifts to MassHealth. The available materials do not clearly separate compensation for risk from broader rate-setting adjustments, so the amount cannot yet be classified fully as savings, redistribution, or risk transfer.

What the Estimate Represents

The $23.3 million reflects both removal of payments for bearing pharmacy risk and transfer of that risk to MassHealth. A net savings analysis must value both: lower capitation payments and MassHealth's new exposure to favorable or adverse pharmacy experience.

State fiscal year (SFY) 2024 data illustrate the issue. Pharmacy expenditures reportedly exceeded ACPP funding, partly because of GLP-1 growth and other pressures. Although risk corridors and reconciliation may limit ACPP losses, MassHealth would have borne the adverse experience directly under a carve-out. Counting the removed payment without this downside produces an asymmetrical comparison.

Potentially Excluded Costs and Offsets

Several aspects of the risk payment estimate remain unclear based on the information now available.

Additional information would be useful regarding:

- The pharmacy-specific portion of underwriting margin
- Treatment of Model A and other ACO risk arrangements
- Operation of risk corridors and retrospective reconciliation
- The amount of SFY 2024 pharmacy losses ultimately retained by ACPPs
- Financing and carrying costs associated with delayed reconciliation
- Sensitivity of the estimate to favorable and unfavorable pharmacy experience
- Changes to quality incentive payments and other payment methodologies tied to total cost of care
- The value of the risk protection currently provided to the Commonwealth through the ACPP structure

Further limiting the analysis is its reliance on a single year of experience. Pharmacy financial risk can vary significantly over time due to new therapies, specialty drug growth, utilization shifts, coverage policy changes, manufacturer pricing actions, and changes in rebate arrangements.

A point-in-time estimate cannot demonstrate whether the payments removed from capitation exceed the long-term cost of the pharmacy risk that would be assumed by MassHealth.

Assessment

It is reasonable to remove pharmacy-related underwriting margin and other risk-related payments if ACPPs no longer bear pharmacy risk. To the extent those payments are intended to compensate ACPPs for accepting financial exposure, they would no longer be necessary if the Commonwealth were to assume that exposure directly. The full $23.3 million, however, should not be interpreted as net savings without evaluating the corresponding value of the risk transferred to MassHealth.

The SFY 2024 experience provides an especially important test. If the Commonwealth had retained pharmacy risk during that year, it would have absorbed pharmacy losses that were instead borne or financed, at least in part, by ACPPs. The absence of that downside experience from the estimate materially affects interpretation of the projected savings.

Accordingly, the $23.3 million is more accurately characterized as a reduction in capitation expenditures associated with transfer of pharmacy risk from ACPPs to the Commonwealth. Demonstrating net savings would require a broader assessment that compares the payments removed from capitation with the expected cost, volatility, and actual experience associated with the pharmacy risk assumed by MassHealth. A multiyear analysis incorporating both favorable and unfavorable experience would provide a more complete assessment of the net financial impact of this policy change.

Incremental Manufacturer Rebates

Basis and Interpretation

Scenarios A, B, and C attribute about $1.3 million annually to additional manufacturer rebates, but the materials identify neither the products, rebate categories, nor contracting changes involved. The opportunity could be incremental, yet MassHealth already controls the UPPL, supplemental rebates, utilization management, and reconciliation. The central question is whether a new administrative model is necessary or targeted changes could capture the same value.

- Which drugs, manufacturers, or rebate categories generate the additional $1.3 million
- Why the Commonwealth is unable to collect those amounts under the existing model
- Whether the estimate assumes changes in preferred product selections, utilization management policies, or manufacturer contracting strategies
- Whether current UPPL-related financial reconciliation and penalty mechanisms were netted against the estimate
- Whether providers or ACPPs would incur implementation costs associated with achieving the additional rebate value
- Whether the estimate represents gross rebate collections or net financial savings after related changes in utilization, ingredient costs, and administration

The durability of the estimate also is uncertain. Rebate collections are affected by manufacturer pricing decisions, product mix, brand and generic utilization, preferred drug strategies, biosimilar adoption, and supplemental rebate negotiations. Although the Commonwealth adjusted the analysis for certain known biosimilar changes, the estimate remains based on SFY 2024 utilization patterns and reflects neither future changes in pharmacy utilization nor coverage policy. Consequently, the rebate opportunity observed in SFY 2024 may not be replicated under future program conditions.

Assessment

The estimated $1.3 million appears plausible as a modest incremental rebate opportunity. The information available at present, however, does not establish that the savings depend on implementation of a single PBM model or pharmacy carve-out.

Because MassHealth already maintains centralized authority over pharmacy policy and rebate strategy, additional information is needed to demonstrate why the projected rebate value cannot be achieved under the current framework. A complete analysis would identify the specific rebate opportunities, the operational changes required to realize them, and the interaction between those opportunities and existing UPPL-related reconciliation mechanisms.

Accordingly, the $1.3 million should be viewed as a potential rebate opportunity rather than a demonstrated benefit unique to the proposed reform scenarios.

340B-Related Savings

Basis and Interpretation. The two fee-for-service scenarios derive most projected savings from 340B value. Scenario C estimates $115.8 million from reimbursing qualifying claims at or below 340B ceiling prices; Scenario D estimates $158.4 million from federal and supplemental rebates on claims no longer treated as 340B. Both redirect value from participating providers to the Commonwealth, so the figures are gross fiscal effects rather than established net savings. Importantly, a substantial portion of the estimated savings under the FFS carve-out scenarios does not arise from lower manufacturer prices, reduced utilization, improved clinical management, or lower underlying drug costs. Rather, it results from changing how 340B-related value is allocated among MassHealth, manufacturers, and participating safety-net providers. Characterizing these amounts as savings without separately identifying the underlying financial transfer risks conflating reductions in the cost of pharmacy services with a redistribution of existing pharmacy-related revenue.

Potentially Excluded Costs and Offsets. Several aspects of the 340B estimates require additional clarification.

Under Scenario C, the materials provided lack sufficient detail regarding the following:

- Identification of the claims included in the estimate
- Current reimbursement amounts
- Application of 340B ceiling prices
- Treatment of Medicaid rebates and duplicate-discount requirements
- Differences between current managed care reimbursement and MassHealth FFS reimbursement
- National Average Drug Acquisition Cost-plus reimbursement assumptions

- Treatment of contract pharmacies and different purchasing arrangements
- Product-specific biosimilar adjustments

Without this information, stakeholders can neither independently reproduce the $115.8 million calculation nor assess its sensitivity to changes in utilization and market conditions.

Perhaps more importantly, neither estimate fully accounts for potential replacement funding for affected providers to offset lost 340B revenue. The Commonwealth is seeking authority through its next Section 1115 demonstration waiver to provide funding to safety-net providers to replace reduced 340B revenue. The details of this proposal including the amount of funding, eligible providers, payment methodology, and availability of federal matching funds, however, remain unclear. To the extent the Commonwealth provides hospitals or other safety-net providers supplemental payments to offset some or all of the lost 340B value, those expenditures could substantially offset the projected savings under Scenarios C and D. Without accounting for those potential payments, the analysis does not establish how much of the projected 340B savings would ultimately be retained by the Commonwealth.

This issue is particularly important because the projected savings in both scenarios are large relative to all other modeled savings categories. The Commonwealth should quantify the anticipated cost of offsetting provider revenue, including both state and federal shares, before classifying these estimates as true net savings. Even partial replacement of lost provider revenue could materially reduce the net fiscal effect of the policy change.

Assessment

The Commonwealth's analysis identifies a potentially significant financial opportunity associated with alternative treatment of 340B claims; however, the estimates should be interpreted as gross financial impacts rather than demonstrated net savings.

For Scenario C, the $115.8 million may be supportable as a reduction in MassHealth pharmacy reimbursement if the underlying claim-level assumptions, reimbursement methodologies, and biosimilar adjustments can be validated. For Scenario D, the $158.4 million may be supportable as a measure of potential additional rebate collections if the rebate-eligibility assumptions are accurate. Neither estimate, however, fully addresses what happens after that financial value is removed from participating providers.

If MassHealth ultimately provides supplemental payments or other financial support to offset lost 340B revenue, some portion of the projected savings would be replaced by new expenditures elsewhere in the program. In that circumstance, the policy change may alter how funds flow through the system without producing equivalent reductions in overall Commonwealth spending.

Accordingly, the 340B estimates are best viewed as potential gross fiscal opportunities rather than demonstrated net savings. A complete analysis should identify the extent to which affected providers are expected to lose revenue, whether replacement funding will be provided, the mechanism through which such funding would be distributed, and the resulting net fiscal impact after those offsets are considered.

Additional Considerations Beyond the Modeled Savings Estimates

The Commonwealth's analysis focuses primarily on projected changes in pharmacy expenditures, manufacturer rebates, administrative costs, and pharmacy-related capitation payments. Although these estimates capture the principal sources of projected savings under the modeled scenarios, they do not appear to quantify several potentially important operational, financial, and policy considerations that could affect the net impact of reform.

Several material financial and operational effects are omitted from the modeled savings estimates and therefore should be considered in assessing the net impact of reform.

Implementation and Transition Costs

The Commonwealth's estimates reflect ongoing operating assumptions but exclude the costs associated with implementing the proposed reforms. This distinction is important because each scenario would require meaningful changes to contractual arrangements, administrative processes, information systems, and organizational responsibilities.

Potential implementation activities include:

- Procurement of a single PBM or pharmacy benefit administrator
- Development and modification of contracts among MassHealth, vendors, pharmacies, and ACPPs
- Systems development, testing, and integration
- Data migration and validation
- Conversion of current prior authorizations and clinical programs
- Provider enrollment and readiness activities
- Member and provider communications
- Staffing, training, and operational support
- Ongoing oversight, auditing, and performance monitoring

Some of these costs would likely be one-time expenditures, while others may create ongoing administrative obligations. The Commonwealth's estimated savings therefore should be interpreted as annual operating estimates rather than implementation-adjusted net savings.

Implementation complexity may also vary considerably across scenarios. Scenario A would retain pharmacy risk within ACPP capitation while changing the pharmacy administration structure, whereas Scenarios B, C, and D would require removal of pharmacy expenditures from capitation and reallocation of associated financial and operational responsibilities. The FFS carve-out scenarios would require the most substantial operational changes because MassHealth would assume direct responsibility for pharmacy reimbursement and associated program administration.

Total Cost of Care, Quality, and Accountability

The Commonwealth's analysis focuses on pharmacy expenditures and selected capitation payments but does not quantify effects on medical spending, quality, health equity incentives, or accountability for total cost of care. Under the current model, ACPPs can connect pharmacy data and interventions to medication adherence, chronic disease management, behavioral health medication monitoring, transitions of care, and provider outreach.

A carve-out would not necessarily end these activities, but it would change who finances them, how quickly ACPPs receive pharmacy data, and which entity is accountable for medication-related outcomes. The cost of preserving equivalent data exchange and care coordination should therefore be included in the evaluation. The report addresses these issues fully in the section on ACPP accountability and total cost of care.

Broader Market and Operational Considerations

The analysis similarly appears to focus on impacts within the MassHealth pharmacy benefit and does not evaluate broader market implications that could result from changes in pharmacy administration.

Many ACPP sponsors participate in multiple lines of business, including commercial, Medicare, Connector, and other public programs. Removing MassHealth pharmacy membership from existing PBM arrangements could affect contracting scale, administrative operations, and pharmacy purchasing relationships beyond the Medicaid program.

Potential areas for additional evaluation include:

- Effects on PBM contracting scale
- Administrative efficiencies or inefficiencies across multiple product lines
- Commercial and Medicare pharmacy contracting arrangements
- Provider contracting considerations
- Potential cost-shifting among payers or providers

These factors may have no direct impact on the MassHealth budget, but they could influence the broader economic effects of reform and may be relevant when assessing overall market implications.

Limitations of the Current Analysis

Finally, the Commonwealth's estimates should be interpreted in the context of the analytical approach used to develop them.

HPC appropriately presents a sensitivity analysis incorporating certain trends in CY2026 enrollment, acuity, utilization, and unit cost. This sensitivity analysis, however, does not resolve the more fundamental question of durability because it remains a short-term projection and does not model multiyear changes in manufacturer pricing, rebate dynamics, product mix, new drug launches, biosimilar competition, utilization response, or future 340B policy. According to the Commonwealth, this approach was intentionally selected to evaluate reform options using actual MassHealth experience rather than assumptions about future market conditions.

Although this methodology provides a useful point-in-time comparison, it does not establish whether the estimated savings would persist over time. Pharmacy expenditures, manufacturer rebates, biosimilar utilization, coverage policies, and provider behavior continue to evolve. The Commonwealth's estimates therefore illustrate how the modeled reforms would have performed under a specific set of SFY 2024 conditions rather than how they would necessarily perform in future years.

A more complete assessment would evaluate the sensitivity of the estimated savings to changes in enrollment, pharmacy trend, utilization patterns, rebate arrangements, biosimilar adoption, 340B participation, and future high-cost therapies. Such analysis would provide additional insight into the durability and sustainability of the projected savings over time.

WHAT CAN MASSACHUSETTS LEARN FROM OTHER STATES?

Other states have pursued a range of pharmacy reform strategies, including full FFS pharmacy carve-outs, centralized PBM arrangements, unified preferred drug lists, and other hybrid models. These experiences provide useful context for Massachusetts, but direct comparisons should be made cautiously because states differ substantially in their Medicaid delivery systems, rebate strategies, 340B policies, managed care structures, provider financing arrangements, and baseline pharmacy capabilities.

Several themes emerge from the state experience. First, pharmacy reform can be implemented operationally under a variety of models. Second, states have reported benefits related to transparency, standardization, and centralized oversight. Third, publicly available evidence regarding realized net savings remains more limited than evidence regarding projected savings. Finally, an increasing number of states are pursuing reforms that fall between a traditional pharmacy carve-in and a full carve-out model. See **Table 4** for details.

Table 4. Selected State Pharmacy Reform Approaches

State	Reform Model	Primary Objectives	Key Observations	Massachusetts Relevance
New York	Full pharmacy carve-out (NYRx)	Centralize pharmacy policy, rebate administration, and utilization management	Demonstrated operational feasibility; limited public evidence regarding validated net savings	Illustrates implementation considerations for large-scale carve-outs
California	Full pharmacy carve-out (Medi-Cal Rx)	Standardization, rebate leverage, transparency, and oversight	Savings difficult to validate; state assumes direct pharmacy spending risk	Highlights implementation complexity and budget-risk transfer

State	Reform Model	Primary Objectives	Key Observations	Massachusetts Relevance
West Virginia	Full pharmacy carve-out	Administrative savings, rebate optimization, transparency	State-reported savings later challenged by independent analyses	Demonstrates methodological challenges associated with validating savings
Michigan	Single Preferred Drug List (no carve-out)	Formulary alignment and rebate optimization	Preserved managed care accountability while standardizing pharmacy policy	Particularly relevant alternative to a carve-out

Full Pharmacy Carve-Out States

New York: NYRx Pharmacy Carve-Out

New York implemented NYRx in 2023, moving most Medicaid outpatient pharmacy benefits to a state-administered FFS model to centralize formulary policy, utilization management, rebates, and oversight. The transition demonstrates operational feasibility and greater uniformity, but public evidence does not comprehensively reconcile realized savings, administrative costs, capitation changes, 340B effects, and impacts on managed care medication management.

Takeaway for Massachusetts

New York demonstrates the confusion that a pharmacy carve-out can create for enrollees and prescribers alike without demonstrable savings.

California: Medi-Cal Rx

California implemented Medi-Cal Rx in 2022, shifting outpatient pharmacy to a centralized FFS model. The state projected substantial savings, including 340B effects, but returned significant funding to affected clinics. Subsequent oversight found that savings remain difficult to isolate, pharmacy spending rose around implementation, and the state assumed greater budget volatility. Public evaluations have yet to establish effects on care coordination, adherence, or population health.

Takeaway for Massachusetts

California demonstrates the logistic challenges of such an undertaking while having difficulty showing return on investment. California has not demonstrated how the carve-out from its ACOs has affected care coordination, medication adherence, and population health outcomes in publicly available evaluations.

West Virginia: Full Pharmacy Carve-Out

West Virginia carved pharmacy benefits out of managed care in 2017 to improve oversight, transparency, rebates, and administrative efficiency. The state reported $54.4 million in first-year savings, but a later industry-sponsored review disputed the methods and magnitude of the study. The unresolved debate underscores the difficulty of validating net savings and the stricter governance demands placed on a state administering claims, rebates, data, and program integrity.

Takeaway for Massachusetts

The experience suggests that projected savings should be carefully scrutinized and that robust governance structures are essential to support claims management, rebate administration, and program integrity activities.

States Using Alternatives to Full Carve-Outs

Michigan: Formulary Alignment Without a Full Carve-Out

Michigan adopted a Single Preferred Drug List in 2020 while retaining managed care responsibility for pharmacy. The model standardized coverage and strengthened rebate leverage without removing integrated accountability. Reported rebate gains alone do not establish total savings, but the approach shows that formulary consistency and administrative simplification can be achieved without a full carve-out.

Takeaway for Massachusetts

Michigan may provide one of the most relevant models for Massachusetts. The state demonstrates that formulary alignment, administrative simplification, and enhanced rebate leverage are achievable without fully removing pharmacy from managed care risk arrangements. If Massachusetts seeks greater consistency and transparency while preserving ACPP accountability, Michigan's approach warrants particular consideration.

Ohio and Other Hybrid Pharmacy Models

Ohio and several other states use hybrid models that centralize selected pharmacy functions while preserving broader managed care structures. Ohio combined a single PBM with a unified preferred drug list. A 2025 actuarial review estimated savings, although the results reflect multiple reforms rather than PBM centralization alone. Kentucky, Louisiana, Mississippi, and Tennessee similarly illustrate options between the status quo and a full fee-for-service carve-out.

Takeaway for Massachusetts

Hybrid models may be particularly relevant to Massachusetts because they offer opportunities to improve consistency, transparency, and purchasing leverage while preserving ACPP accountability for total cost of care, care coordination, medication adherence, and clinical outcomes.

Collectively, these states illustrate that pharmacy reform exists along a continuum rather than as a binary choice between full carve-in and full carve-out models. States increasingly are pursuing strategies that centralize formulary management, standardize clinical policies, strengthen PBM oversight, and improve transparency while preserving integration between pharmacy management and broader population health objectives.

Key Lessons for Massachusetts

The following themes emerge consistently across the states reviewed:

- **Operational Feasibility and Financial Performance Are Different Questions.** States have demonstrated that pharmacy carve-outs, centralized PBM arrangements, and other pharmacy reforms can be implemented successfully; however, successful implementation does not necessarily demonstrate that projected savings were realized. Publicly available evaluations frequently focus on projected savings, while relatively few comprehensively reconcile changes in pharmacy expenditures, rebate collections, capitation payments, administrative costs, implementation expenses, and provider financing or patient outcomes.
- **State Starting Points Matter.** Many states implemented pharmacy reforms to obtain capabilities that Massachusetts already possesses. These capabilities include formulary standardization, centralized utilization management, supplemental rebate

administration, statewide pharmacy policy authority, and PBM oversight. As discussed earlier in this report, MassHealth already operates under a Uniform Preferred Drug List, negotiates supplemental rebates, administers centralized pharmacy policy, and maintains integrated accountability through the ACPP model. Consequently, savings reported in other states may not be fully transferable to Massachusetts if those states were able to capture opportunities that already exist within the current MassHealth framework.

- **Pharmacy Reform Exists on a Continuum.** The experience in Michigan, Ohio, Kentucky, Tennessee, and other states demonstrates that pharmacy reform is not a binary choice between maintaining the status quo and implementing a full fee-for-service carve-out. States are increasingly pursuing targeted reforms that centralize selected pharmacy functions while preserving managed care accountability.

These approaches include unified preferred drug lists, single PBM arrangements, enhanced rebate strategies, transparency initiatives, targeted risk-sharing approaches, and other efforts designed to improve pharmacy governance without fundamentally restructuring care accountability relationships.

Implications for Massachusetts

The peer state evidence demonstrates that centralized pharmacy administration can improve oversight, policy consistency, and transparency. It also demonstrates that pharmacy reform can be pursued through a variety of structures, not solely through a full pharmacy carve-out.

At the same time, the evidence regarding validated long-term net savings remains considerably more limited than the evidence regarding projected savings. Many publicly cited savings estimates rely on assumptions regarding rebates, administrative costs, provider financing, or risk allocation that are difficult to validate independently and are subject to market shifts.

For Massachusetts, the most important lesson may be that state experience should be evaluated through the lens of the present MassHealth framework. Because Massachusetts already possesses many of the policy tools and administrative authorities that other states sought to create through pharmacy reform, the relevant policy question is more than whether another state-reported savings. Rather, it is whether those savings represent opportunities that remain available within the current MassHealth and ACPP structure or whether similar outcomes could be achieved through targeted reforms that preserve current accountability arrangements.

WHAT MASSACHUSETTS GIVES UP: ACPP ACCOUNTABILITY AND TOTAL COST OF CARE

Massachusetts deliberately structured the ACPP program around integrated accountability for medical, behavioral health, and pharmacy services. Pharmacy, therefore, is more than another category of claims within the current financing model. Medications are clinical interventions that influence chronic disease management, behavioral health outcomes, avoidable utilization, quality performance, and total cost of care. As a result, changes to pharmacy financing affect more than pharmacy spending alone.

Under scenarios B and C, ACPPs would remain accountable for medical, and behavioral health spending while MassHealth would assume responsibility for pharmacy expenditures. This would not eliminate pharmacy-related care management activities, but it would change the incentives, information flows, operational responsibilities, and accountability structures that support them.

Pharmacy Differs from Other Cost Categories

Pharmacy spending often functions as an investment in broader health outcomes rather than a stand-alone cost center. Appropriate medication use can prevent avoidable emergency department visits, hospitalizations, disease progression, and complications associated with chronic illness. Conversely, barriers to medication access or adherence may reduce near-term pharmacy spending but increase medical spending elsewhere in the system. An analysis limited to pharmacy expenditures cannot by itself establish the net total cost of care effect of removing pharmacy risk from an integrated risk arrangement.

Under the existing ACPP structure, organizations can evaluate these tradeoffs across the full continuum of care. Investments in pharmacy-related interventions may increase pharmacy expenditures while reducing medical expenditures, improving quality performance, or advancing health equity goals.

Examples include:

- Medication adherence programs for members with chronic conditions
- Medication reconciliation following hospitalization or transitions of care
- Coordination of behavioral health and physical health medications
- Monitoring and management of specialty therapies
- Identification of refill gaps and interrupted therapy
- Clinical outreach to prescribers and members
- Management of medication-related quality measures
- Integration of pharmacy data into broader care management activities

Because ACPPs are accountable for total cost of care, they can assess pharmacy interventions based on their overall effect on member outcomes and program performance rather than on pharmacy expenditures in isolation.

Changes in Financial Accountability

Under the current structure, the same organization is accountable for both pharmacy expenditures and many of the resulting medical outcomes, which creates a direct financial incentive to manage pharmacy and medical spending together.

Under Scenarios B, C, and D, that relationship would change. MassHealth would bear pharmacy expenditure risk, while ACPPs would remain accountable for medical and behavioral health costs. Financial responsibility for related services would therefore be divided among different entities.

For example:

- An intervention that increases medication adherence may increase pharmacy expenditures but reduce hospitalizations and emergency department (ED) utilization.
- A medication management initiative may require pharmacy investments while generating savings through reduced medical utilization.
- A new high-cost therapy may increase pharmacy expenditures while reducing costs associated with disease progression.

Under an integrated model, these effects are evaluated within a common accountability framework. Under a carve-out, pharmacy spending and medical spending would be financed through separate structures, which does not mean that ACPPs would stop supporting medication management. Quality measures, contractual obligations, provider relationships, and medical risk would continue to create incentives for engagement. The direct financial alignment between pharmacy expenditures and total cost of care, however, would be reduced and would need to be replaced through explicit contractual mechanisms, performance measures, reporting requirements, or incentive arrangements.

Data Access and Care Coordination

Integrated care management depends on access to pharmacy information. Pharmacy claims support activities such as medication reconciliation, adherence monitoring, transitions of care management, quality reporting, provider outreach, and member engagement.

Under the current model, pharmacy information is available through the ACPP and PBM administrative structure. Under a centralized model, pharmacy information would originate from a state-selected PBM, pharmacy benefit administrator, or MassHealth FFS system.

Maintaining the current level of integration would therefore require robust data exchange among MassHealth, pharmacy administrators, and ACPPs. Relevant questions include:

- How quickly pharmacy claims information would be available to ACPPs
- Whether ACPPs would have access to authorization and utilization review information
- How pharmacy data would be integrated into clinical and care management systems
- Which entity would be responsible for identifying medication-related care gaps
- How errors, delays, and missing information would be addressed
- What systems and staffing would be required to support ongoing coordination

The Commonwealth's analysis neither addresses these questions in detail nor quantifies the cost of maintaining equivalent information flows under a centralized model.

Behavioral Health and Medication Management

Behavioral health medications illustrate the importance of integrated accountability. Members often receive medications from multiple providers across primary care, specialty care, behavioral health, EDs, and inpatient settings. Effective management requires coordination among providers and visibility into medication histories, adherence patterns, and potential interactions.

A carve-out would not necessarily prevent behavioral health medication coordination, but preserving the current level of coordination could require additional infrastructure, data-sharing arrangements, operational processes, and accountability mechanisms. These considerations are unaddressed in the Commonwealth's savings estimates.

Perspectives from ACPPs

Several ACPPs have argued that opportunities remain to improve pharmacy performance within the existing MassHealth framework. Stakeholders have described opportunities related to enhanced medication management programs, improved adherence initiatives, specialty drug oversight, provider engagement, and more sophisticated integration between pharmacy and medical management.

MAHP's analysis showed that the 7% trend was driven primarily by price (5.5%) and new drugs (1.9%), while utilization was flat (−0.2%), suggesting that ACPPs are managing utilization effectively and that benefits management, not administrative restructuring, is a high-value lever. Suggestions include expanding ACPP formulary authority beyond floor formulary including generics, biosimilars, prior authorization and step therapy; and delaying coverage of new drugs until efficacy is evaluated and no covered alternative exists. Another concept is modifying the UPPL to operate prospectively rather than retrospectively, limiting changes to no more than every 6–12 months, and eliminating penalties when plans demonstrate net savings.

Assessment

The Commonwealth's analysis evaluates pharmacy expenditures, rebates, administrative costs, and pharmacy-related capitation payments. It does not evaluate how removing pharmacy from ACPP accountability could affect total cost of care, quality performance, health equity initiatives, provider incentives, or care management activities.

The appropriate conclusion is not that a pharmacy carve-out would necessarily increase medical spending or worsen outcomes. Rather, it is that a carve-out would alter financial incentives, accountability relationships, and information flows that are central to Massachusetts' ACPP model, and the Commonwealth has not yet evaluated those effects.

Because Massachusetts intentionally designed the ACPP program around integrated accountability for the whole person and total cost of care, these considerations are not peripheral to the policy discussion. They are a core component of the evaluation.

340B AND SAFETY-NET FINANCING

The 340B Drug Pricing Program plays a key role in the financing of many hospitals, health centers, and other safety-net providers. As discussed previously, the Commonwealth's two FFS carve-out scenarios derive a substantial share of projected savings from changes in how 340B claims are treated. This section focuses on the provider financing implications of those changes and the extent to which projected savings may be offset by future provider support payments.

Why 340B Matters. Under current arrangements, participating 340B covered entities may retain financial value associated with eligible prescriptions. The Commonwealth's scenarios would redirect a portion of that value. Under Scenario C, the Commonwealth would reimburse qualifying claims at or below the applicable 340B ceiling price. Under Scenario D, claims would no longer be treated as 340B claims and would instead become eligible for federal and supplemental rebates. Although these mechanisms differ, both scenarios ultimately shift financial value away from participating providers and toward MassHealth.

Key 340B Questions

1. Are the projected savings technically achievable?
2. How much represents incremental Commonwealth value versus redistribution of existing value?
3. What portion, if any, would be offset through replacement/supplemental provider financing?

Safety-Net Financing Implications. The projected savings estimates do not appear to evaluate provider financing consequences. Key questions center on:

- Which providers would experience the largest reductions in 340B-related revenue
- The extent to which hospitals, community health centers, and other safety-net providers rely on that revenue
- Whether replacement or supplemental payments would be provided
- The amount of any replacement funding
- How replacement funding would be financed
- Whether replacement payments would be distributed in the same manner as existing 340B value

These concerns are especially important because the projected 340B-related savings are substantially larger than any other savings component identified in the Commonwealth's analysis.

Net Savings Versus Redistribution of Funding. A central policy question is whether the projected savings represent reductions in total Commonwealth spending or redistribution of financial value within the healthcare system. If MassHealth captures additional rebate revenue or reduces pharmacy reimbursement but subsequently creates supplemental payment arrangements to offset provider losses, the net fiscal effect will differ from the gross pharmacy or rebate estimate. Accordingly, the appropriate evaluation should distinguish:

- Gross reductions in pharmacy expenditures
- Gross increases in rebate revenue
- Provider revenue reductions
- Supplemental or replacement payments
- Administrative costs associated with revised payment arrangements
- State and federal financing implications

Without this information, neither Scenario C nor Scenario D can be evaluated on a net basis.

Program Integrity and Duplicate Discounts. Federal requirements prohibit manufacturers from providing both a Medicaid rebate and a 340B discount on the same claim. Any revised model would therefore require clear processes for identifying 340B claims, preventing duplicate discounts, and supporting rebate administration.

MassHealth would need to address:

- Claim identification requirements
- Contract pharmacy treatment
- Audit and reconciliation responsibilities
- Data-sharing requirements
- Rebate invoicing processes
- Compliance oversight
- Resolution of disputed claims

These operational requirements may be manageable, but they also carry implementation, administrative, and compliance costs that should be considered when evaluating the projected savings.

Assessment. The Commonwealth's 340B-related estimates identify substantial gross financial value; however, they do not yet establish the amount of net savings that would remain after accounting for provider financing impacts and any replacement payments.

A reduction in provider revenue is not equivalent to a reduction in system costs, particularly if some of that value must later be restored through another payment mechanism.

Consequently, policymakers should evaluate the net budget effect of the proposed changes rather than relying solely on reductions in pharmacy reimbursement or increases in rebate collections.

Before moving forward with either 340B scenario, the Commonwealth should provide a transparent assessment of provider impacts, replacement-payment assumptions, financing implications, and net fiscal effects.

LOWER-RISK ALTERNATIVES

The evidence reviewed in this report suggests that many of the policy objectives associated with a pharmacy carve-out may be achievable through targeted reforms that involve less disruption to the existing ACPP structure.

MassHealth already maintains substantial authority over pharmacy policy through the UPPL, centralized prior authorization requirements, supplemental rebate strategies, utilization management policies, and statewide oversight mechanisms. As a result, policymakers should consider whether the specific objectives motivating the current discussion can be achieved without removing pharmacy from integrated accountability arrangements.

Table 5. Alternative Approaches to a Full Pharmacy Carve-Out

Alternative	Primary Objective	Preserves ACPP Accountability	Implementation Complexity	Savings Potential	Key Considerations and Risks
Enhanced UPPL and Formulary Governance	Consistency and rebate leverage	Yes	Low	Yes	Provider and patient disruption; administrative burden
Single PBM or Pharmacy Benefit Administrator	Administrative consistency and transparency	Generally, yes	Moderate	Yes, but offset by start-up investment	Operational dependency on single vendor; lack of competition; reduced care management opportunities
Enhanced PBM Governance and Reporting	Transparency and accountability	Yes	Low	No	Administrative burden

Alternative	Primary Objective	Preserves ACPP Accountability	Implementation Complexity	Savings Potential	Key Considerations and Risks
Enhanced Rebate Optimization	Increased manufacturer revenue	Yes	Low to moderate	Yes	Further distance between pharmacy coverage decisions and medical outcomes/total cost of care
Targeted High-Cost Drug Carve-Outs or Risk Corridors	Volatility management	Largely yes	Moderate	Yes	Med/Pharm fragmentation; disconnection from total cost of care; state budget volatility

Enhanced UPPL and Pharmacy Governance. MassHealth already operates a statewide preferred drug structure and centralized utilization management framework. Additional refinements to preferred product strategies, clinical policies, and formulary governance may provide incremental opportunities without restructuring pharmacy financing. This approach would preserve integrated accountability while building on tools that MassHealth already uses.

Single PBM or Pharmacy Benefit Administrator. Among the scenarios modeled by the Commonwealth, Scenario A demonstrates that administrative consistency can be pursued without removing pharmacy risk from ACPP capitation. A single PBM or pharmacy benefit administrator could create greater consistency in claims administration, reporting, and contracting while preserving the financial relationship between pharmacy management and total cost of care. This model would still involve implementation costs and operational change, but it may avoid many of the accountability concerns associated with a full carve-out.

Enhanced PBM Governance and Transparency. If transparency is the primary concern, MassHealth could strengthen oversight of pharmacy benefit administration through enhanced reporting requirements, audit rights, rebate transparency provisions, network reporting, pricing disclosures, and performance requirements. Such changes would target identified concerns directly without fundamentally restructuring pharmacy financing.

Enhanced Rebate Optimization. The Commonwealth already possesses substantial authority to pursue supplemental rebates, preferred product strategies, and value-based purchasing arrangements. Additional opportunities may exist within the current framework. Importantly, the Commonwealth's own analysis identifies only a modest incremental rebate opportunity associated with structural reform. This raises the question of whether additional rebate value could be captured without implementing a full carve-out.

Targeted Approaches for High-Cost Drugs. If high-cost therapies or the volatility associated with specific drug categories are driving concerns, more targeted approaches may be appropriate. Potential options include:

- Risk corridors
- Stop-loss arrangements
- Shared-risk models
- Drug-specific carve-outs
- Alternative funding arrangements for select high-cost therapies

These approaches may address volatility without requiring complete restructuring of pharmacy accountability.

Assessment. No alternative eliminates every challenge associated with pharmacy management, nor does any alternative offer guaranteed savings. Nonetheless, the alternatives reviewed suggest that transparency, administrative consistency, rebate optimization, and risk management can be pursued through multiple pathways.

The appropriate policy question is not whether a full carve-out can produce any benefits. Rather, it is whether the Commonwealth's objectives require a full carve-out and whether the incremental benefit justifies the financial, operational, safety-net, and accountability risks associated with structural reorganization.

The available evidence suggests that policymakers should evaluate targeted alternatives carefully before concluding that a full carve-out is necessary.

CONCLUSION: THE EVIDENCE DOES NOT SUPPORT A FULL PHARMACY CARVE-OUT AT THIS TIME

The Commonwealth's preliminary analysis identifies potential savings, but the available evidence does not establish that a full pharmacy carve-out would generate material incremental net savings. The central findings follow.

Finding 1. Savings Estimates Cannot Be Independently Validated at Present

Key assumptions for administrative savings, risk payments, rebates, and 340B changes cannot yet be independently replicated, and several estimates reflect transfers of cost, revenue, or risk rather than reductions in underlying spending.

Finding 2. Not Every Reduction in Spending Represents Net Savings

Removing costs from ACPP capitation does not eliminate pharmacy administration or expenditure risk, and capturing 340B value may require replacement payments. Gross payment reductions therefore should not be presented as net savings without accounting for continuing obligations and offsets.

Finding 3. Massachusetts Already Possesses Many of the Capabilities Associated with Carve-Outs

Massachusetts already has formulary standardization, centralized utilization management, statewide policy authority, supplemental rebate strategies, and PBM oversight. The relevant test is whether a full carve-out adds material value beyond targeted reforms using these existing tools.

Finding 4. Other States' Experience Provides Limited Evidence Regarding Long-Term Net Savings

Peer states show that centralized models are feasible, but publicly available evidence of durable net savings is limited and often does not reconcile expenditures, rebates, capitation, implementation costs, provider financing, and risk transfer. Their experience offers implementation lessons, not proof of comparable Massachusetts savings.

Finding 5. A Full Carve-Out Would Introduce Meaningful Risks

A full carve-out would shift financial risk, provider financing, operational responsibilities, and accountability. The analysis does not fully quantify implementation costs, 340B and provider impacts, transferred risk, effects on total cost of care and coordination, or the durability of rebate savings.

Recommended Path Forward

The evidence available at this time does not establish that a full pharmacy carve-out would generate material incremental net savings for Massachusetts. Before undertaking a structural reorganization of pharmacy financing and administration, the Commonwealth should:

- Provide transparent and replicable calculations supporting each major savings component
- Distinguish gross savings, net savings, and transfers of costs, revenue, or risk
- Quantify implementation and transition costs
- Evaluate provider financing and 340B-related impacts on a net basis
- Assess implications for ACPP accountability and total cost of care
- Evaluate the durability of projected rebate-related savings over multiple years
- Compare a full carve-out against targeted alternatives designed to address the specific policy objectives under consideration.

If the primary goals are transparency, administrative consistency, rebate optimization, or management of high-cost pharmacy trends, those goals should first be pursued through reforms targeted to those objectives and designed to preserve integrated accountability wherever possible.

The evidence reviewed in this report supports continued evaluation of pharmacy reform opportunities. It does not, however, demonstrate that a full pharmacy carve-out currently represents the most effective or least disruptive path forward for Massachusetts.

APPENDIX A. SOURCE INVENTORY AND DETAILED REFERENCES

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