

# **ASSESSING THE IMPACT OF MASSHEALTH MANAGED CARE PHARMACY BENEFIT REFORMS**

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## ABOUT THE HEALTH POLICY COMMISSION AND THE OFFICE OF PHARMACEUTICAL POLICY AND ANALYSIS

The **Massachusetts Health Policy Commission** (HPC), established in 2012, is an independent state agency charged with monitoring health care cost trends and making policy recommendations to improve the affordability of health care for all residents of the Commonwealth. Through data-driven analysis, actionable policy insights, public accountability, and innovative investments, the HPC seeks to improve health care delivery, lower costs, and reduce health disparities. The HPC is committed to better health and better care – at a lower cost – for all residents of the Commonwealth.

The HPC's **Office of Pharmaceutical Policy and Analysis** (OPPA) was established in 2025, a component of [historic legislation](#) that also limited out-of-pocket costs for certain high-value drugs and expanded oversight of pharmaceutical companies and pharmacy benefit managers (PBMs).

The main function of OPPA is to serve as the hub of expertise on pharmaceutical drug policy in Massachusetts by collecting and analyzing pharmaceutical data, conducting cutting-edge analyses related to access, affordability, and spending on pharmaceutical drugs in the Commonwealth, and developing recommendations on pivotal matters related to pharmaceutical policy. For more information, visit <https://masshpc.gov>.

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## EXECUTIVE SUMMARY

MassHealth, the Medicaid and Children's Health Insurance Program agency serving Massachusetts, provides critical health benefits for low- and middle-income families, children, seniors, and people with disabilities in the Commonwealth.<sup>1</sup> Due to major changes in federal policy that will meaningfully reduce Medicaid funding and overall unsustainable cost growth, MassHealth is facing significant budgetary challenges.<sup>2</sup> Policymakers have been focused on health care affordability generally, and MassHealth sustainability in particular.<sup>3</sup>

Recognizing the urgency and severity of these challenges, the Healey-Driscoll Administration recently established a new Health Care Affordability Working Group charged with developing recommendations for addressing drivers of health care spending growth.<sup>4</sup> The working group made an initial set of 12 recommendations to the Governor in August 2026, providing a roadmap to target some of the biggest drivers of health care costs, including rising prescription drug costs. Specific to this topic, the Governor announced and directed the Executive Office of Health and Human Services, Health Connector Authority, Group Insurance Commission, and Health Policy Commission ("HPC") to work together to develop a coordinated strategy to leverage the state's purchasing power to lower drug costs and improve access to medications.<sup>5</sup> Additionally, and directly relevant to this report, the Healey-Driscoll Administration's annual budget recommendation called for the creation of "a workgroup to discuss carving out pharmacy benefits" to "simplify operations and generate savings" and set MassHealth on "a more sustainable path."<sup>6</sup> The MassHealth Pharmacy Benefit Workgroup was subsequently formed, consisting of payer, provider, pharmacy, patient advocacy, and legislative stakeholders.<sup>7</sup>

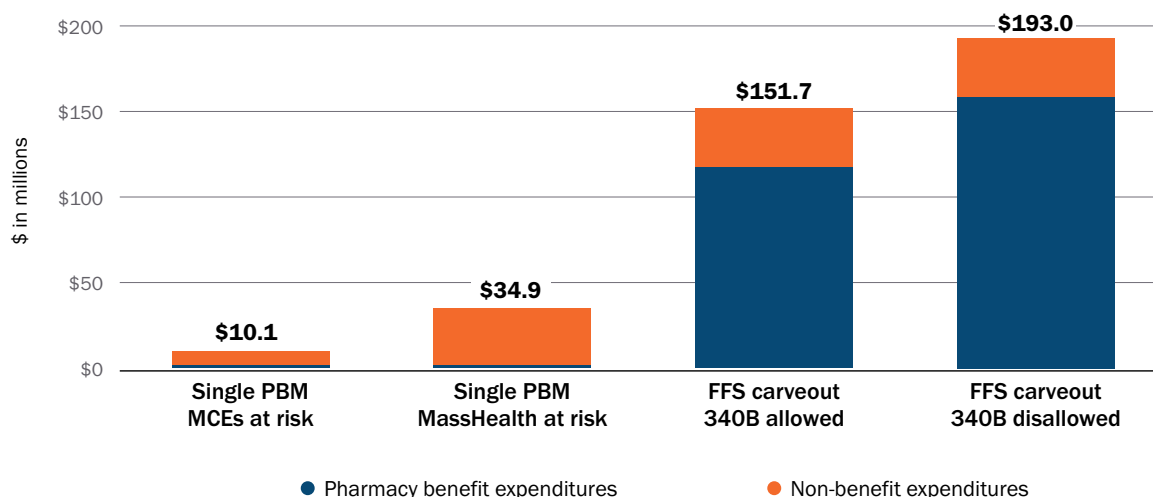
To support these efforts with objective, data-driven analyses, the HPC's Office of Pharmaceutical Policy and Analysis ("OPPA") engaged the actuarial firm Marsh Government Health Consulting ("Marsh"), formerly named Mercer Government Human Services Consulting, to evaluate the potential effects of reforming MassHealth's managed care pharmacy benefit on pharmacy spending. Specifically, four models of reform were considered; as described in detail below, the reform scenarios vary based on which entity administers the pharmacy benefit (one pharmacy benefit manager ("PBM") for all managed care entities ("MCEs") through a single PBM model or MassHealth through a fee-for-service ("FFS") carveout model), which entity bears financial risk if costs are higher or lower than expected (MCEs or MassHealth), and whether drugs may be dispensed through the 340B Drug Pricing Program ("340B program").<sup>8</sup> Each of the reforms evaluated in this report have been implemented in some form by other states.

Key findings in this report include:

- **Changes in federal policy are expected to severely cut MassHealth funding and increase rates of uninsurance.**<sup>9</sup> The Massachusetts Taxpayers Foundation estimates that provisions of the One Big Beautiful Bill Act, H.R.1, will reduce MassHealth funding by \$24 billion over the 2025-2034 period, and the Blue Cross Blue Shield of Massachusetts Foundation and the Urban Institute estimate that roughly 110,000-180,000 MassHealth members will become uninsured as a result of the law.
- **MassHealth pharmacy spending has been growing at an unsustainable rate.**<sup>10</sup> In recent years, pharmacy spending has been a key driver of health care cost growth. Over the 2022-2024 period, net pharmacy spending by MassHealth managed care plans increased at an annual average rate of 17.2 percent compared with medical spending growth of 9.1 percent.
- **Over the past decade, more than a dozen state Medicaid agencies have reformed their managed care pharmacy benefit program designs.**<sup>11</sup> Since 2017, over one-third of state Medicaid agencies with pharmacy benefits administered by managed care entities and their PBMs (13 states) have enacted major reforms to their pharmacy benefit programs based on single PBM, FFS carveout, and 340B disallowed models considered in this report. Various states evaluated the impact of their reforms and found material savings.
- **Reforming MassHealth's managed care pharmacy benefit could generate over \$190 million in savings annually.**<sup>12</sup> Savings estimates are based on presently available information, including the most recent data available that has been validated, with adjustments so that the results provide reasonable estimates of the financial impacts

of the reforms as of calendar year (“CY”) 2026. Each of the reform scenarios is estimated to generate savings for MassHealth, though the magnitudes of savings differ by reform: the single PBM reforms are estimated to save from \$10.1 million to \$34.9 million, less than the FFS carveout reforms’ savings of \$151.7 million to \$193.0 million. See **Exhibit 1**.

**Exhibit 1.** Summary of estimated annual savings from MassHealth managed care pharmacy benefit reforms



**Notes:** Pharmacy benefit expenditure and non-benefit expenditure savings analyses are described in Section IV.A. Results reflect savings before any reinvestments MassHealth may make in Massachusetts providers or adjustments for federal and state shares. See Sec. IV.B (discussing potential MassHealth reinvestments in providers); *infra* notes 165-167 and accompanying text (discussing federal and state shares of savings and potential new federal matching funds and other available federal funding resources for reinvestments and new administrative expenditures, including MassHealth’s recent draft 1115 Demonstration Project Extension Request that has been published for public comment, which requests funding to support hospitals).

**Source:** Marsh analysis.

- **The number of local retail pharmacies available to MCE plan members would increase under the FFS carveout reforms.**<sup>13</sup> Because “any willing pharmacy” in the state may participate in MassHealth’s pharmacy network, the number of local retail and specialty pharmacies available to MassHealth MCE plan members would increase under the FFS carveout reforms.
- **Higher pharmacy reimbursement rates under the single PBM and FFS carveout reforms may help preserve access to local retail pharmacies.**<sup>14</sup> The managed care pharmacy benefit reforms evaluated in this report would likely increase reimbursements to pharmacies, which could help mitigate closures. Moreover, these increased pharmacy reimbursements would not materially impact MassHealth’s pharmacy spending.
- **MassHealth could strategically deploy savings from the reforms, including by reinvesting in Massachusetts hospitals and other providers serving vulnerable and underserved populations.**<sup>15</sup> Given that the uncompensated care burden on providers is likely to increase under H.R.1, MassHealth could strategically reinvest a portion of the savings from these reforms in Massachusetts providers caring for vulnerable and underserved populations, including hospitals that may face reductions in 340B revenue under the FFS carveout reforms. To the extent this occurs, MassHealth could leverage new federal matching funds and other available federal funding resources for these reinvestments. In its recent draft Section 1115 Demonstration Project Extension Request that has been published for public comment, MassHealth requested funds for the Safety Net Care Pool that supports safety net providers, including for uncompensated care for uninsured patients, as well as “expenditure authority to make hospital access stabilization payments to enable hospitals to stop relying on 340B retail pharmacy margin.”<sup>16</sup> The state share of savings in each reform scenario, as well as any reinvestments in providers and availability of federal funds, would affect the state budget impact of the scenarios.

## REFERENCES

- 1 See Sec. I and App'x C.
- 2 See Sec. I and App'x D.
- 3 See *infra* notes 29-31 and accompanying text.
- 4 See Healey-Driscoll Administration. Governor Healey takes nation-leading action to make it easier, more affordable for people to get health care. Jan 14, 2026. <https://www.mass.gov/news/governor-healey-takes-nation-leading-action-to-make-it-easier-more-affordable-for-people-to-get-health-care>.
- 5 See Healey-Driscoll Administration. Governor Healey Announces Health Care Affordability Working Group Recommendations to Lower Health Care Costs. Aug. 3, 2026. <https://www.mass.gov/news/governor-healey-announces-health-care-affordability-working-group-recommendations-to-lower-health-care-costs>.
- 6 Healey-Driscoll Administration. Governor's Budget Recommendation, Budget Briefs, House 2, Fiscal Year 2027. Jan. 28, 2026. [https://budget.digital.mass.gov/govbudget/fy27/budbriefpdf/fy2027h2\\_budget\\_briefs.pdf](https://budget.digital.mass.gov/govbudget/fy27/budbriefpdf/fy2027h2_budget_briefs.pdf), at 74.
- 7 Preliminary findings from this report were presented to the workgroup in July and September 2026. The HPC thanks workgroup members for their constructive comments and feedback in the development of this report.
- 8 Specifically, the four models of reform assessed in this report include: (1) single PBM with MCEs at risk and 340B drug claims allowed (the "single PBM with MCEs at risk" scenario); (2) single PBM with MassHealth at risk and 340B drug claims allowed (the "single PBM with MassHealth at risk" scenario); (3) FFS carveout with 340B drug claims allowed and MassHealth at risk (the "FFS carveout with 340B allowed" scenario); and (4) FFS carveout with 340B drug claims disallowed and MassHealth at risk (the "FFS carveout with 340B disallowed" scenario). See Sec. IV.A.
- 9 See Sec. I; App'x D (discussing One Big Beautiful Bill Act, H.R.1, Pub. L. No. 119-21, and its projected impacts); Massachusetts Taxpayers Foundation. The changing landscape: Impacts of federal action on Massachusetts. Sep. 10, 2025. <https://www.masstaxpayers.org/sites/default/files/publications/2025-09/MTF%20Federal%20Impacts%203%20-%20Federal%20Reconciliation%20%20Health%20Care.pdf>, at 2; Buettgens M, Carter J, Banthin J. Six-month redetermination and work requirements: Impacts on health coverage in Massachusetts. Blue Cross Blue Shield of Massachusetts Foundation and Urban Institute. Sep. 2025. [https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/acquiadam-assets/90325\\_SixMonth\\_Redetermination\\_and\\_Work\\_Requirements\\_Impact\\_on\\_Massachusetts.pdf](https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/acquiadam-assets/90325_SixMonth_Redetermination_and_Work_Requirements_Impact_on_Massachusetts.pdf), at 4.
- 10 See Sec. I.
- 11 See Sec. III.
- 12 Based on Marsh analysis; see Sec. IV.A.
- 13 See Sec. IV.B.
- 14 See *id.*
- 15 See *id.*
- 16 Massachusetts Executive Office of Health and Human Services. Medicaid Section 1115 Demonstration Project Extension Request. Sept. 14, 2026. <https://www.mass.gov/doc/demonstration-extension-request-2/download>, at 24, 53.

## I. INTRODUCTION

MassHealth, the Medicaid and Children’s Health Insurance Program agency serving Massachusetts, provides health benefits for low- and middle-income families, children, seniors, and people with disabilities.<sup>17</sup> In 2024, MassHealth covered approximately 2 million people, representing over 25 percent of Massachusetts residents, including 46 percent of children, 19 percent of seniors, and 60 percent of individuals with disabilities.<sup>18</sup>

The critical health insurance coverage provided by MassHealth, however, is under pressure – both from major changes in federal policy and from unsustainable cost growth, driven in large part by spending on pharmaceuticals.

**Changes in federal policy.** On July 4, 2025, the One Big Beautiful Bill Act, H.R.1, was signed into law.<sup>19</sup> The Congressional Budget Office projects that H.R.1’s Medicaid provisions will severely cut program funding by \$900 billion and result in 7.8 million Americans becoming uninsured over the next ten years.<sup>20</sup> In Massachusetts, the Massachusetts Taxpayers Foundation estimates that H.R.1 policies will reduce MassHealth funding by \$532 million in Federal Fiscal Year (“FFY”) 2026, \$1.4 billion in FFY 2027, and \$1.7 billion in FFY 2028, increasing in later years and totaling \$24 billion over the 2025-2034 period.<sup>21</sup> The Blue Cross Blue Shield of Massachusetts Foundation and the Urban Institute estimate that roughly 110,000-180,000 MassHealth members will become uninsured due to H.R.1 provisions.<sup>22</sup>

**Unsustainable pharmacy spending growth.** In recent years, pharmacy spending has been a key driver of health care cost growth in the Commonwealth, including for MassHealth. Over the 2022-2024 period, net pharmacy spending by MassHealth managed care health plans increased at an average annual rate of 17.2 percent compared with medical spending growth of 9.1 percent.<sup>23</sup>

One notable trend affecting MassHealth pharmacy spending relates to the 340B Drug Pricing Program.<sup>24</sup> Among the MassHealth managed care health plans for which pharmacy benefits are administered by MCE/PBMs (ACO-A and MCO plans),<sup>25</sup> spending on 340B drugs grew on average by more than 55 percent per year over the 6-year period from state fiscal year (“SFY”) 2019 (\$29.7 million) to SFY 2024 (\$268.9 million).<sup>26</sup> See **Exhibit 2**. These amounts do not reflect

<sup>17</sup> To be eligible for MassHealth coverage, members must satisfy certain requirements, including income limits that differ by age and health status but generally range from 133-250 percent of the federal poverty level. See App’x C.

<sup>18</sup> Children include individuals under age 21; seniors include individuals age 65 and older. See Blue Cross Blue Shield of Massachusetts Foundation, et al. MassHealth: The Basics, Facts and Trends. Oct. 2025. [https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/acquiadam-assets/2025\\_MassHealthTheBasics\\_PPT\\_FINAL.pdf](https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/acquiadam-assets/2025_MassHealthTheBasics_PPT_FINAL.pdf), at 4, 13 (citing enrollment as of SFY-end 2024) [hereinafter, “Basics”].

<sup>19</sup> One Big Beautiful Bill Act, H.R.1, Pub. L. No. 119-21. The provisions and projected impacts of H.R.1 are discussed further in App’x D.

<sup>20</sup> See Congressional Budget Office. Estimated budgetary effects of Public Law 119-21, to provide for reconciliation pursuant to Title II of H. Con. Res. 14, relative to CBO’s January 2025 baseline. July 21, 2025. <https://www.cbo.gov/publication/61570>; Congressional Budget Office. Estimated effects on the number of uninsured people in 2034 resulting from policies incorporated within CBO’s baseline projections and H.R.1, the One Big Beautiful Bill Act. June 4, 2025. <https://www.cbo.gov/publication/61463>, at 6.

<sup>21</sup> Massachusetts Taxpayers Foundation. The changing landscape: Impacts of federal action on Massachusetts. Sep. 10, 2025. <https://www.masstaxpayers.org/sites/default/files/publications/2025-09/MTF%20Federal%20Impacts%203%20-%20Federal%20Reconciliation%20%20Health%20Care.pdf>, at 2.

<sup>22</sup> See Buettgens M, Carter J, Banthin J. Six-month redetermination and work requirements: Impacts on health coverage in Massachusetts. Blue Cross Blue Shield of Massachusetts Foundation and Urban Institute. Sep. 2025. [https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/acquiadam-assets/90325\\_SixMonth\\_Redetermination\\_and\\_Work\\_Requirements\\_Impact\\_on\\_Massachusetts.pdf](https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/acquiadam-assets/90325_SixMonth_Redetermination_and_Work_Requirements_Impact_on_Massachusetts.pdf), at 4.

<sup>23</sup> HPC analysis of Center for Health Information & Analysis (“CHIA”) Total Health Care Expenditure Data, Feb. 2025 and Feb. 2026. Net pharmacy spending is adjusted for drug manufacturer rebates. See Sec. II.D.3. Medical spending includes hospital inpatient, hospital outpatient, and professional services. Growth rates reflect all MassHealth managed care health plans, including ACO-A (Accountable Care Partnership Plans), MCO (Managed Care Organization plans), ACO-B (Primary Care Accountable Care Organizations), and PCC (Primary Care Clinician Plan) plans. See Sec. II.A and App’x B. During the 2022-2024 period, the HPC also observed higher spending growth among plans with pharmacy benefits administered by managed care entities and their PBMs (ACO-A and MCO plans) compared to plans with pharmacy benefits administered by MassHealth (ACO-B and PCC plans). However, due to data limitations it was not possible to adjust for various enrollment and program changes that occurred during the period, which limits the interpretability of these results.

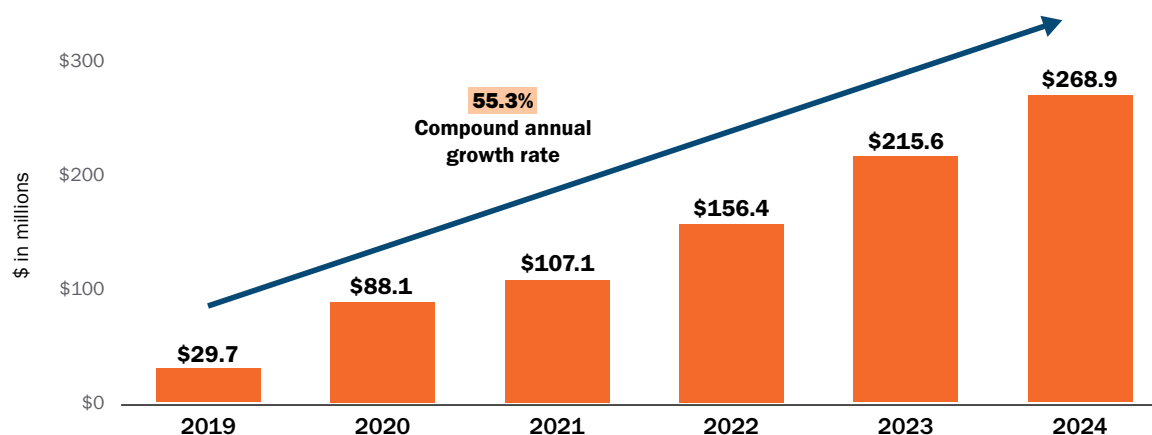
<sup>24</sup> The 340B program is notoriously technical and complex. An overview of how the program works and how it may affect the managed care pharmacy benefit reforms assessed in this report are included in Sec’s II.D and IV.A.

<sup>25</sup> MassHealth delivery systems, including ACO-A and MCO plans, are described in Sec. II.A and App’x B.

<sup>26</sup> On a per-member basis, pharmacy spending on 340B drugs grew at an annual average rate of 43.9 percent during the period. On April 1, 2023, a sizeable managed care health plan switched from ACO-B to ACO-A (Mass General Brigham Health Plan), which likely contributed to the spending growth between 2022 and 2023.

spending on 340B clinician-administered drugs covered under MassHealth’s medical benefit, which likely account for additional spending on drugs dispensed through the 340B program.<sup>27</sup>

**Exhibit 2.** MassHealth ACO-A and MCO managed care plan 340B pharmacy spending, SFY 2019-2024



**Notes:** Includes total amounts paid for drugs covered under the pharmacy benefit with a reported wholesale acquisition cost and Submission Classification Code of 20 or a Basis of Cost Code of 08.

**Source:** MassHealth information request. Jan. 2026.

Under the 340B program, which was established to support health care providers serving vulnerable and underserved populations, eligible providers (known as 340B covered entities) are reimbursed at the MCE/PBM’s contracted rate but acquire drugs at a significant discount, retaining the difference as a source of revenue. However, increases in 340B spending translate into reduced rebates collected by MassHealth because MassHealth is prohibited from collecting rebates on drugs for which a 340B discount has been provided.<sup>28</sup> Consequently, this high growth in 340B spending has contributed to lower rebate collections and higher net pharmacy spending for MassHealth.

**Seeking a “more sustainable path” for MassHealth.** Recognizing the increasing burden of health care costs on Massachusetts patients, families, and employers, the Healey-Driscoll Administration recently created a new Health Care Affordability Working Group charged with developing recommendations for addressing drivers of health care spending growth.<sup>29</sup> The group released an initial set of 12 recommendations in August 2026, providing a roadmap to target some of the biggest drivers of health care costs, including rising prescription drug costs. Specific to this topic, the Governor announced and directed the Executive Office of Health and Human Services, Health Connector, Group Insurance Commission, and HPC to work together to develop a coordinated strategy to leverage the state’s purchasing power to lower drug costs and improve access to medications.<sup>30</sup> Additionally, and directly relevant to this report, the Healey-Driscoll Administration’s annual budget recommendation published in January 2026 called for the creation of “a workgroup to discuss carving out pharmacy benefits” to “simplify operations and generate savings” and set MassHealth on “a more sustainable path.”<sup>31</sup> The MassHealth Pharmacy Benefit Workgroup was subsequently formed, consisting of

<sup>27</sup> See, e.g., Minnesota Department of Health. 340B covered entity report: Report to the legislature. Feb. 27, 2026. <https://www.health.state.mn.us/data/340b/docs/2025report.pdf>, at 7 (discussing substantial contribution of clinician-administered drugs to total 340B spending in the state).

<sup>28</sup> This tradeoff is reflected in federal law, which protects drug manufacturers from providing a 340B discount and a Medicaid rebate on the same drug. See *infra* note 86 and accompanying text.

<sup>29</sup> See Healey-Driscoll Administration. Governor Healey takes nation-leading action to make it easier, more affordable for people to get health care. Jan. 14, 2026. <https://www.mass.gov/news/governor-healey-takes-nation-leading-action-to-make-it-easier-more-affordable-for-people-to-get-health-care>.

<sup>30</sup> See Healey-Driscoll Administration. Governor Healey Announces Health Care Affordability Working Group Recommendations to Lower Health Care Costs. Aug. 3, 2026. <https://www.mass.gov/news/governor-healey-announces-health-care-affordability-working-group-recommendations-to-lower-health-care-costs>.

<sup>31</sup> Healey-Driscoll Administration. Governor’s Budget Recommendation, Budget Briefs, House 2, Fiscal Year 2027. Jan. 28, 2026. [https://budget.digital.mass.gov/govbudget/fy27/budbriefpdf/fy2027h2\\_budget\\_briefs.pdf](https://budget.digital.mass.gov/govbudget/fy27/budbriefpdf/fy2027h2_budget_briefs.pdf), at 74.

payer, provider, pharmacy, patient advocacy, and legislative stakeholders. Preliminary findings from this report were presented to the workgroup in July and September 2026.<sup>32</sup>

Given the interest among policymakers, the growth in MassHealth pharmacy spending, and H.R.1's severe funding cuts to Medicaid, the HPC has prepared an assessment of the effects of reforming MassHealth's managed care pharmacy benefit. The analyses presented in this report examine how the managed care pharmacy benefit reforms would affect MassHealth pharmacy spending and other considerations. The HPC engaged the actuarial firm Marsh Government Health Consulting to assess the potential financial impact of the reforms on MassHealth pharmacy spending.<sup>33</sup> Marsh currently serves as MassHealth's actuarial firm. HPC staff prepared the analyses relating to other considerations.<sup>34</sup>

The report evaluates four pharmacy benefit reform models that vary based on which entity administers the pharmacy benefit, which entity bears financial risk if costs are higher or lower than expected, and whether drugs may be dispensed through the 340B program, including:

1. Single PBM with MCEs at risk and 340B drug claims allowed (the "single PBM with MCEs at risk" scenario);
2. Single PBM with MassHealth at risk and 340B drug claims allowed (the "single PBM with MassHealth at risk" scenario);
3. FFS carveout with 340B drug claims allowed and MassHealth at risk (the "FFS carveout with 340B allowed" scenario); and
4. FFS carveout with 340B drug claims disallowed and MassHealth at risk (the "FFS carveout with 340B disallowed" scenario).

Over the past decade, more than a dozen states have enacted variations on each of these reforms, including single PBM (6 states), FFS carveout (5 states), and the disallowance of 340B drug claims (2 states disallow 340B dispensing for most drugs) reforms.<sup>35</sup>

The report proceeds as follows. Section II provides an overview of MassHealth's pharmacy benefit coverage, enrollment and spending trends, administration processes, and payment methods; Section III reviews major Medicaid managed care pharmacy benefit reforms implemented by other states; Section IV evaluates how the reforms considered in this report would affect MassHealth pharmacy spending and other considerations; and Section V concludes.

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<sup>32</sup> The HPC thanks workgroup members for their constructive comments and feedback in the development of this report.

<sup>33</sup> See Sec. IV.A.

<sup>34</sup> See Sec. IV.B.

<sup>35</sup> States that have enacted single PBM reforms include Kentucky, Ohio, Mississippi, Minnesota, Virginia, and Nevada; states that have enacted FFS carveout reforms include West Virginia, North Dakota, California, New York, and Iowa; and states that have enacted 340B disallowed reforms include New Hampshire and Indiana. See Sec. III.

## II. MASSHEALTH PHARMACY BENEFITS OVERVIEW

MassHealth provides primary coverage for eligible members who do not have other insurance and secondary, or wrap-around, coverage for members who are also covered by Medicare, an employer-sponsored plan, or other insurance. In this background section, the HPC provides a summary of MassHealth's pharmacy benefit coverage (Section II.A), presents enrollment and spending trends related to the pharmacy benefit (Section II.B), and describes how pharmacy benefits are administered (Section II.C) and paid for (Section II.D), which differs for MassHealth fee-for-service and managed care health plans.

### A. SUMMARY OF COVERAGE

The MassHealth pharmacy benefit covers thousands of prescription drugs, over-the-counter drugs, and non-drug pharmacy products, as well as vaccines.<sup>36</sup> Under federal law, MassHealth is required to cover all drugs in the Medicaid Drug Rebate Program ("MDRP").<sup>37</sup>

MassHealth's formulary – the MassHealth Drug List ("MHDL") – specifies which drugs are managed with prior authorization and clinical criteria requirements.<sup>38</sup> In April 2023, MassHealth unified its formulary, requiring all delivery systems, including FFS and managed care health plans, to use the MHDL for drugs administered through the pharmacy benefit.<sup>39</sup> See the sidebar "MassHealth Delivery Systems."

#### MASSHEALTH DELIVERY SYSTEMS<sup>40</sup>

**Delivery systems with pharmacy benefits administered by an MCE/PBM (ACO-A and MCO).** Managed care entities and their contracted PBMs administer the pharmacy benefit for MassHealth members enrolled in Accountable Care Partnership ("ACO-A") and Managed Care Organization ("MCO") plans. Under the ACO-A model, managed care health plans partner with provider organizations to coordinate care for members. MassHealth pays ACO-A plans a fixed per-member-per-month capitation rate to cover the health care costs of their members. ACO-As are at risk for their members' total cost of care, sharing financial gains from any savings they may generate but also facing financial losses if costs are higher than expected. Like ACO-As, MCO plans are paid a fixed per-member-per-month capitation rate. However, MCOs do not enter partnerships with provider organizations to coordinate care delivery. In SFY 2024, 68% of members with MassHealth as their primary insurer were enrolled in ACO-A and MCO plans.

**Delivery systems with pharmacy benefits administered by MassHealth (ACO-B, PCC, and FFS primary).** MassHealth administers the pharmacy benefit for members enrolled in Primary Care Accountable Care Organization ("ACO-B") and Primary Care Clinician ("PCC") plans, and for members with FFS primary coverage.<sup>41</sup> Under the ACO-B model, MassHealth pays provider groups a fixed per-member-per-month capitation rate for primary care and care coordination services, while other services – including pharmacy – are reimbursed on a FFS basis. ACO-B plans are at risk for their members' medical spending, sharing in financial savings or losses relative to a total cost of care benchmark. In the PCC plan, a member's primary care provider is responsible for providing primary care and care coordination services, while members may utilize MassHealth's provider network for other services (e.g., hospital and specialty care). The PCC plan is reimbursed for most services on a FFS basis. In SFY 2024, ACO-B and PCC plans covered 26% of members with MassHealth as their primary insurer, while FFS primary coverage accounted for 6% of members.

MassHealth does not permit cost-sharing requirements to be imposed by FFS or managed care health plans, so members do not pay deductibles, copayments, or coinsurance.<sup>42</sup>

The pharmacy networks available to MassHealth members differ by delivery system and MCE. MassHealth allows "any willing pharmacy" in the state to join its network and thus maintains a broad network that may be used by members with MassHealth-administered pharmacy benefits (ACO-B and PCC plans and FFS primary). By contrast, MCE/PBM

<sup>36</sup> Non-drug pharmacy products include items such as diabetic test strips and glucose monitoring systems.

<sup>37</sup> See CMS. Medicaid Drug Rebate Program (MDRP). <https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program>.

<sup>38</sup> See MassHealth. MassHealth drug list. <https://mhdl.pharmacy.services.conduent.com/MHDL>.

<sup>39</sup> See MassHealth. The prescriber e-letter, vol. 13(1). Apr. 2023. <https://www.mass.gov/doc/issue-1-april-2023-0/download>, at 1.

<sup>40</sup> For more information on MassHealth's delivery systems, see App'x B.

<sup>41</sup> FFS primary refers to members with FFS coverage and MassHealth as their primary insurer.

<sup>42</sup> See Levine M. All Provider Bulletin 388. MassHealth. Apr. 2024. <https://www.mass.gov/doc/all-provider-bulletin-388-masshealth-and-health-safety-net-hsn-copayments-eliminated-0/download>, at 1. While H.R.1 imposes new cost-sharing requirements on selected services for certain Medicaid members, prescription drugs are excluded from these new requirements. See, e.g., Cliff BQ, Hirth R. New cost-sharing requirements in Medicaid: Considerations for state implementation. Health Affairs Forefront. Feb. 12, 2026.

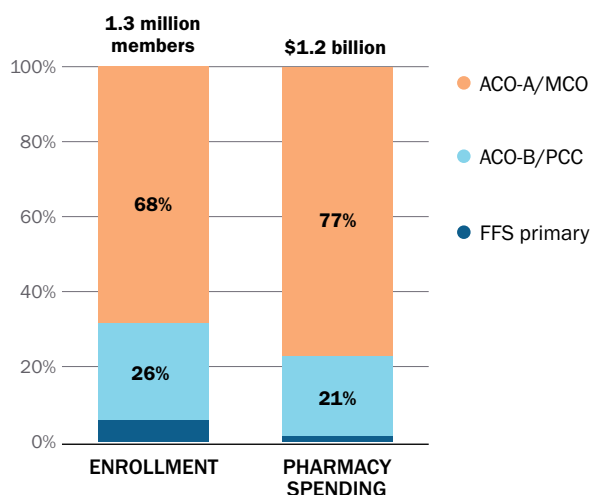
pharmacy networks (for ACO-A and MCO plans) generally have fewer in-state local retail pharmacies but may include mail order and out-of-state pharmacies in their networks.<sup>43</sup>

## B. ENROLLMENT AND SPENDING

In SFY 2024, MassHealth spent \$1.2 billion on prescription drugs, net of drug manufacturer rebates, to help manage chronic conditions and treat acute illnesses for 1.3 million Massachusetts residents with MassHealth as their primary insurer.<sup>44</sup> As shown in **Exhibit 3**, 68 percent of these members were enrolled in ACO-A and MCO plans, accounting for 77 percent of pharmaceutical spending. The pharmacy benefits for these plans are administered by MCEs and their subcontracted PBMs. The remaining members (32 percent) were covered by ACO-B and PCC plans (26 percent) and FFS primary (6 percent). MassHealth administers the pharmacy benefit for these plans. The reforms assessed in this report focus on ACO-A and MCO plans with MCE/PBM-administered pharmacy benefits.

MassHealth ACO-A and MCO plans all currently contract with either Express Scripts or OptumRx – two of the “Big 3 PBMs” – for pharmacy benefit management services.<sup>45</sup> In SFY 2024, Express Scripts managed 56 percent of ACO-A/MCO members representing 50 percent of pharmacy spending, and OptumRx managed 44 percent of members representing 50 percent of pharmacy spending. See **Exhibit 4**. While these two PBMs manage the pharmacy benefit for all ACO-A and MCO plans, the MCEs and their PBMs handle various functions differently (e.g., prior authorization review and specialty drug management), requiring MassHealth to coordinate these functions separately with each MCE.

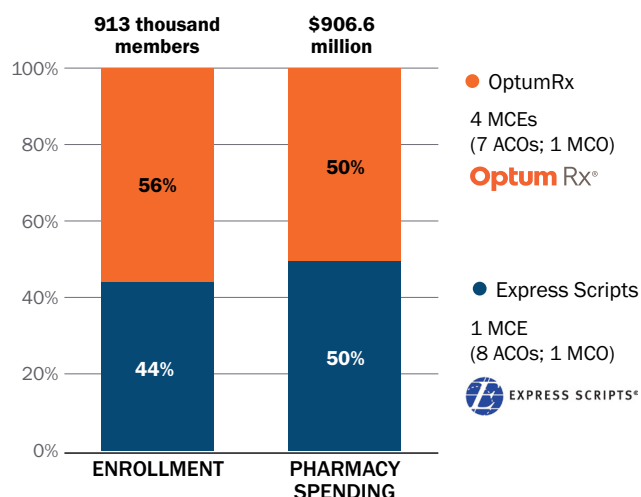
**Exhibit 3. MassHealth primary coverage enrollment and pharmacy spending by delivery system, 2024**  
(% of total)



**Notes:** Enrollment as of the end of SFY 2024 and spending for 2024. Pharmacy spending is net of drug manufacturer rebates.

**Sources:** HPC analysis of CHIA Enrollment Trends Databook, Mar. 2025 and CHIA Total Health Care Expenditure Data, Feb. 2025.

**Exhibit 4. MassHealth ACO-A and MCO managed care enrollment and pharmacy spending by pharmacy benefit manager, 2024**  
(% of total)



**Notes:** Enrollment as of the end of SFY 2024 and spending for 2024. Pharmacy spending is net of drug manufacturer rebates.

**Sources:** HPC analysis of CHIA Enrollment Trends Databook, Mar. 2025; CHIA Total Health Care Expenditure Data, Feb. 2025; and Anderson E, et al. Pharmacy Facts, No. 217. MassHealth. Dec 15, 2023 (MCE-PBM contracting information).

<sup>43</sup> Pharmacy networks are discussed in Sec’s I.I.C and IV.B.

<sup>44</sup> See Exhibit 3. Given that Medicaid is a joint federal/state program, the cost of funding MassHealth is shared with the federal government. The Federal Medical Assistance Percentage, or FMAP, rate for Massachusetts is 50 percent for most members and services, i.e., the federal government and the state each pay 50 percent of the cost, though the FMAP rate is higher for certain services and covered populations. See KFF. Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier. <https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier>; Basics, *supra* note 18, at 27 (noting, for example, that the federal government pays 65 percent of the cost for services provided to Children’s Health Insurance Program members).

<sup>45</sup> Specifically, WellSense contracts with Express Scripts and Fallon Health, Health New England, Mass General Brigham Health Plan, and Tufts Health contract with OptumRx. See also Federal Trade Commission, Office of Policy Planning. Pharmacy benefit managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies. July 2024. [https://www.ftc.gov/system/files/ftc\\_gov/pdf/pharmacy-benefit-managers-staff-report.pdf](https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf), at Sec. II (describing the Big 3 PBMs and the increasing consolidation and vertical integration within the industry).

## C. PHARMACY BENEFIT ADMINISTRATION

MassHealth administers the pharmacy benefit for its FFS members and for ACO-B and PCC plans and oversees the MCEs that subcontract with PBMs to administer the pharmacy benefit for ACO-A and MCO plans.<sup>46</sup> This section describes the main operational areas and functions needed to administer the pharmacy benefit. Aspects of pharmacy benefit administration are useful to understand because the analyses presented later in the report consider how responsibilities may shift under different reforms and the fiscal implications of these shifts.

The MassHealth pharmacy team is comprised of approximately 20 staff, including pharmacists, operations staff, and data analysts. MassHealth also engages contractors to provide selected services, including pharmacy benefit administrator Conduent State Healthcare LLC (“Conduent”),<sup>47</sup> drug utilization review services provider ForHealth Consulting (“ForHealth”),<sup>48</sup> and actuarial firm Marsh.

**Exhibit 5** lists core pharmacy benefit operational areas, identifies select functions within each area, and indicates the entity primarily responsible when the pharmacy benefit is managed by MassHealth versus an MCE/PBM. Note that MassHealth and its contractors are responsible for selected operational areas even when the pharmacy benefit is managed by an MCE/PBM.

**Exhibit 5. Pharmacy benefit operational areas and responsible entity**

| Operational area                                              | Selected functions                                                                                                                                                                                        | Entity responsible when pharmacy benefits administered by: MassHealth | Entity responsible when pharmacy benefits administered by: MCE/PBM |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--------------------------------------------------------------------|
| <b>Formulary design and management</b>                        | <ul style="list-style-type: none"> <li>Maintain MassHealth’s preferred drug list</li> <li>Develop utilization management requirements</li> <li>Conduct new drug and clinical guideline reviews</li> </ul> | ForHealth                                                             | ForHealth                                                          |
| <b>Utilization management</b>                                 | <ul style="list-style-type: none"> <li>Process prior authorizations and other utilization management requirements</li> <li>Conduct prospective and retrospective drug utilization review</li> </ul>       | ForHealth & MassHealth PBA                                            | MCE & PBM                                                          |
| <b>Pharmacy network design and contracting</b>                | <ul style="list-style-type: none"> <li>Design, construct, and maintain adequate pharmacy network</li> <li>Negotiate pharmacy contracts, including reimbursement rates and other terms</li> </ul>          | MassHealth                                                            | MCE & PBM                                                          |
| <b>Manufacturer rebate and value-based contracting</b>        | <ul style="list-style-type: none"> <li>Negotiate supplemental drug manufacturer rebates</li> <li>Negotiate value-based contracts</li> </ul>                                                               | MassHealth                                                            | MassHealth                                                         |
| <b>Manufacturer rebate invoicing and cash reconciliations</b> | <ul style="list-style-type: none"> <li>Invoice, collect, and reconcile rebates from drug manufacturers</li> </ul>                                                                                         | MassHealth & MassHealth PBA                                           | MassHealth & MassHealth PBA                                        |
| <b>Pharmacy and provider services</b>                         | <ul style="list-style-type: none"> <li>Maintain pharmacy and provider call centers</li> </ul>                                                                                                             | ForHealth & MassHealth PBA                                            | MCE & PBM                                                          |
| <b>Claims processing</b>                                      | <ul style="list-style-type: none"> <li>Route prescription information between pharmacies and PBM/payers</li> <li>Process reimbursements</li> </ul>                                                        | MassHealth PBA                                                        | PBM                                                                |
| <b>Clinical drug programs</b>                                 | <ul style="list-style-type: none"> <li>Maintain clinical drug programs (e.g., medication therapy management)</li> </ul>                                                                                   | ForHealth & MassHealth                                                | MCE & PBM                                                          |
| <b>PBM/PBA oversight</b>                                      | <ul style="list-style-type: none"> <li>Oversight of PBM or PBA</li> <li>Auditing of PBM or PBA</li> </ul>                                                                                                 | MassHealth                                                            | MCE                                                                |
| <b>Actuarial support</b>                                      | <ul style="list-style-type: none"> <li>Analyze pharmacy claims data to support medical rate-setting and clinical analyses</li> </ul>                                                                      | Marsh                                                                 | MCE Actuary                                                        |
| <b>Analytics and reporting</b>                                | <ul style="list-style-type: none"> <li>Conduct analyses and prepare reports to support clinical and operational functions</li> <li>Conduct fraud, waste, and abuse audits</li> </ul>                      | MassHealth, ForHealth & MassHealth PBA                                | MCE, PBM, MassHealth & ForHealth                                   |

Notes: Table is illustrative and does not capture all pharmacy benefit operational areas and functions.

<sup>46</sup> See Sec. II.A and App’x B.

<sup>47</sup> The term of Conduent’s contract ends on June 30, 2027. MedImpact will assume responsibility for MassHealth’s pharmacy benefit administration on July 1, 2027.

<sup>48</sup> ForHealth is affiliated with the University of Massachusetts Chan Medical School.

Select operational areas are described further below.

**Formulary management.** MassHealth’s unified drug formulary – the MassHealth Drug List, or MHDL – covers thousands of prescription drugs and other pharmacy products, and specifies coverage requirements, such as which drugs require prior authorization when prescribed.<sup>49</sup> To keep the MHDL up-to-date, MassHealth’s clinical pharmacy team meets weekly with ForHealth to review new drugs and clinical proposals and make decisions on any MHDL changes. Selected changes are presented for review at MassHealth’s drug utilization review (“DUR”) board meetings.<sup>50</sup>

**Utilization management.** Utilization management involves a set of techniques and tools used by payers and PBMs to ensure medication safety, appropriateness and cost-effectiveness. One common utilization management tool is prior authorization, which requires a health care provider to obtain prior approval before a medication is dispensed. Additional utilization management tools include prospective and retrospective drug utilization review. Prospective DUR aims to identify and resolve potential issues before a medication is dispensed, such as issues relating to potential drug interactions, improper dosages, and inappropriate durations. Retrospective DUR involves periodically examining pharmacy claims data to identify patterns of overuse or medically inappropriate use of prescription drugs.<sup>51</sup>

**Pharmacy network design and contracting.** MassHealth and MCE/PBMs must maintain adequate pharmacy networks where their members can fill prescriptions. By law, “any willing pharmacy” located in Massachusetts may participate in MassHealth’s pharmacy network,<sup>52</sup> and in-network pharmacies are reimbursed at a statutory rate.<sup>53</sup> By contrast, MCE/PBMs are permitted to construct limited pharmacy networks (with a defined set of pharmacies available to members), and negotiate separate contracts with reimbursement rates that differ by pharmacy.<sup>54</sup> Because limited networks include fewer pharmacies, in-network pharmacies generally agree to accept lower reimbursement rates in exchange for higher prescription volume.

**Drug manufacturer rebate and value-based contracting.** MassHealth negotiates with drug manufacturers for supplemental rebates (in addition to the rebates that are required by federal law) to further reduce net drug spending. When negotiating supplemental rebates, MassHealth considers factors such as efficacy, cost, demand, and therapeutic competition.<sup>55</sup> MassHealth also negotiates value-based contracts with drug manufacturers, which link reimbursements to outcomes (e.g., based on clinical, adherence, or safety measures) rather than volume alone. Value-based contracting may be employed in different scenarios, such as when the use of a high-cost drug is supported by only limited safety and efficacy evidence.<sup>56</sup> As of February 2026, MassHealth collected supplemental rebates on 97 drugs with an annual value of approximately \$650 million.<sup>57</sup>

**Pharmacy and provider services.** ForHealth and MassHealth’s PBA host call centers to answer pharmacy and provider questions, including questions about prior authorization requests.<sup>58</sup> MCE/PBMs maintain their own call centers.

**Claims processing.** When a patient fills a prescription at a pharmacy, the claim is processed in real-time via an electronic communications system. The PBA or PBM and pharmacy communicate information regarding drug coverage and any utilization management requirements. The PBA or PBM also processes the payment to the pharmacy.

**Clinical drug programs.** Clinical drug programs can encompass a range of clinical outreach programs. Medication therapy management, for example, involves pharmacists and providers collaborating to improve drug therapy regimens for members. Other programs may focus on assisting members that require drug procurement assistance or monitoring

<sup>49</sup> See Sec. II.A.

<sup>50</sup> See Lenz K. Health Policy: Massachusetts Medicaid Pharmacy Overview. Presented at Harvard School of Public Health. Nov. 5, 2024, at 13.

<sup>51</sup> See Commonwealth of Massachusetts Executive Office of Health & Human Services and University of Massachusetts Chan Medical School. Intra-departmental Service Agreement. MMARS Doc. ID ISA CT EHS 19UMMSHSNDURPHARMASW. SFY 2025, at 6 [hereinafter “ForHealth ISA”].

<sup>52</sup> See 130 CMR 406.404.

<sup>53</sup> See Sec. II.D.4.

<sup>54</sup> Generally, MCEs subcontract with PBMs to perform these functions. See Sec. II.D.4.

<sup>55</sup> See Lenz, *supra* note 50, at 23.

<sup>56</sup> See *id.*

<sup>57</sup> Levine M. Letter to House Ways and Means Committee on MassHealth Pharmaceutical Utilization 2026. June 9, 2026. <https://malegislature.gov/Bills/194/SD3981.pdf>, at 2.

<sup>58</sup> See Lenz, *supra* note 50, at 8.

clinical outcomes.<sup>59</sup> ForHealth manages various clinical outreach programs on behalf of MassHealth.<sup>60</sup> MCE/PBMs oversee their own clinical drug programs.

**Additional operational areas.** Several other operational areas that are a core part of administering pharmacy benefits include oversight and auditing of PBMs and PBAs, actuarial support, and analytics and reporting. The entities that manage these areas for MassHealth and the MCEs are listed in **Exhibit 5** above.

## D. PHARMACY BENEFIT PAYMENTS

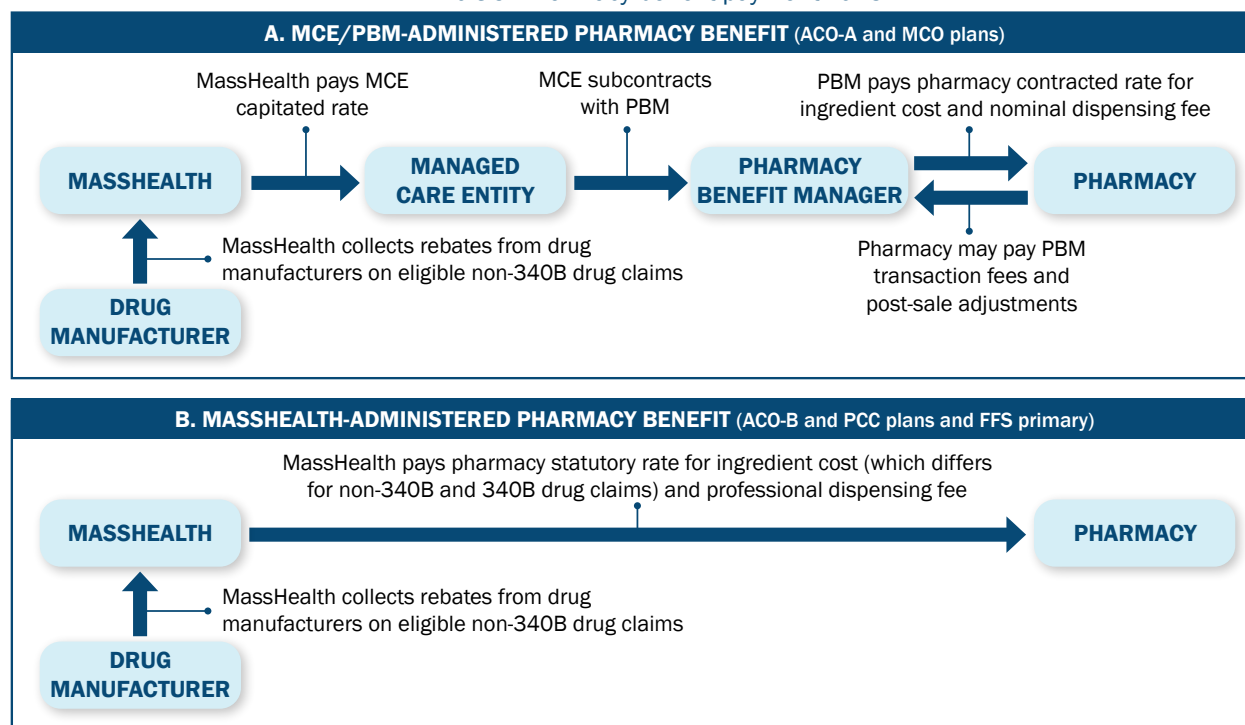
While all MassHealth members receive the same coverage for drugs on the MassHealth Drug List, MassHealth pays differently for drugs depending on the delivery system of a member’s plan and the 340B status of a drug claim. The methods for determining pharmacy benefit payments are technical and complex but important to understand because the differences between payment methods affect the managed care pharmacy benefit reforms assessed in this report.

This section begins by providing an overview of pharmacy benefit payments, how payments differ by delivery system and 340B drug status, and the implications for MassHealth pharmacy spending (Section II.D.1). Then the components of pharmacy benefit payments are described, including capitated payments (Section II.D.2), drug manufacturer rebates (Section II.D.3), and pharmacy reimbursements (Section II.D.4).

### 1. Overview of pharmacy benefit payments

For pharmacy benefits administered by MCE/PBMs (ACO-A and MCO plans), MassHealth pays a fixed per-member-per-month capitated payment to MCEs, and then the MCEs and their contracted PBMs reimburse pharmacies for the prescriptions. For pharmacy benefits administered by MassHealth (ACO-B and PCC plans and FFS primary), MassHealth pays pharmacies directly for prescriptions. For all delivery systems, MassHealth also collects rebates from drug manufacturers on eligible non-340B drug claims, but not on 340B drug claims. Pharmacy benefit payment flows are illustrated in **Exhibit 6**. Selected related technical terms are defined in the sidebar “Pharmacy Benefit Payment Terms” and an overview of the 340B program is provided in the sidebar “About the 340B Drug Pricing Program.”

**Exhibit 6. Pharmacy benefit payment flows**



**Notes:** Figure is illustrative and does not capture all entities, fund flows, and contractual relationships, and different payment methods may be employed for selected claims.

<sup>59</sup> See *id.* at 16.

<sup>60</sup> See ForHealth ISA, *supra* note 51, at 12.

## PHARMACY BENEFIT PAYMENT TERMS

**340B actual acquisition cost:** The amount a 340B covered entity pays a drug manufacturer for a drug purchased through the 340B program, which is equal to the 340B ceiling price, net of discounts, rebates, charge backs, and other adjustments (if any).<sup>61</sup>

**340B ceiling price:** The maximum price that drug manufacturers may charge 340B covered entities for a drug purchased through the 340B program.<sup>62</sup>

**340B covered entity:** A health care facility that is eligible to purchase drugs through the 340B program.<sup>63</sup>

**340B margin:** The difference between the 340B actual acquisition cost a covered entity pays to purchase the drug and the reimbursement amount it receives from the payer.

**Average Wholesale Price (“AWP”):** A benchmark for the ingredient cost of a drug. AWP does not reflect the actual price paid to pharmacies,<sup>64</sup> though PBMs commonly reimburse pharmacies for brand drugs based on a negotiated discount from AWP.

**Capitated payment:** A fixed per-member-per-month amount paid by MassHealth to MCEs to cover expected medical and pharmacy benefit expenses and non-benefit expenses, including administrative expenses, care management costs, incentive payments, taxes, and other non-medical costs.

**Dispensing fee:** The amount paid to a pharmacy, over and above the ingredient cost, for dispensing drugs. For claims paid directly by MassHealth, pharmacies receive a professional dispensing fee, which is set based on a survey of pharmacies in the state regarding their operating costs for staffing, rent, utilities, and other expenses.<sup>65</sup> Currently, MassHealth pays a professional dispensing fee of \$10.02 for most drugs. For claims paid by MCE/PBMs, pharmacies are often paid a nominal dispensing fee (which averaged \$0.50 in 2023).<sup>66</sup>

**Drug manufacturer rebates:** The amounts paid by a drug manufacturer to a PBM or payer when a drug is dispensed, including but not limited to base rebates tied to formulary

placement and utilization metrics, price or inflation protection rebates, and performance-based rebates.

**Federal Upper Limit:** The maximum amount Medicaid agencies may reimburse for certain multisource drugs, as determined by the Centers for Medicare & Medicaid Services (“CMS”).<sup>67</sup>

**Ingredient cost:** The amount paid to a pharmacy for the drug itself, excluding the dispensing fee.

**Maximum Allowable Cost (“MAC”):** The maximum amount that a PBM will reimburse a pharmacy for the ingredient cost of a drug. There is no standard definition for MAC. PBMs develop and maintain proprietary MAC lists, which are nonpublic and can change frequently (e.g., weekly).<sup>68</sup>

**National Average Drug Acquisition Cost (“NADAC”):** A benchmark representing the average price paid by pharmacies to acquire drugs based on a voluntary CMS survey of primarily community pharmacies.<sup>69</sup> CMS has approved MassHealth’s use of NADAC for approximating pharmacy acquisition costs.<sup>70</sup> The benchmark, however, likely overestimates large pharmacies’ acquisition costs because most survey respondents (community pharmacies) generally pay more than large pharmacies for the same drugs.<sup>71</sup>

**Post-sale adjustments:** An exchange of funds between a PBM and a pharmacy occurring after the point-of-sale that affects the pharmacy’s reimbursement, such as brand and generic effective rate reconciliations, performance-based incentives, and audit adjustments.

**Transaction fee:** A per-claim fee paid by a pharmacy to a PBM for claims processing and administration.

**Usual and customary price:** As defined by MassHealth, the “lowest price that a provider [pharmacy] charges or accepts from any payer for the same quantity of a drug on the same date of service, in Massachusetts.”<sup>72</sup>

**Wholesale Acquisition Cost (“WAC”):** The list price for a drug reported by drug manufacturers to wholesalers and direct purchasers, not including discounts or rebates.<sup>73</sup>

<sup>61</sup> 101 CMR 331.02.

<sup>62</sup> 42 U.S.C. § 256b(a)(1).

<sup>63</sup> 42 U.S.C. § 256b(a)(4).

<sup>64</sup> See Fein A. The 2025 economic report on U.S. pharmacies and pharmacy benefit managers. Drug Channels Institute. Mar. 2025, at 282 (“There is no formal national legislative definition of AWP. Despite its name, the AWP does not represent actual marketplace transactions and does not accurately measure average prices from wholesalers to pharmacies.”).

<sup>65</sup> See 101 CMR 331.06; see also Mercer. Pharmacy reimbursement: Cost of dispensing survey results. Oct 11, 2024, <https://www.mass.gov/doc/pharmacy-reimbursement-cost-of-dispensing-survey-results-october-11-2024-0/download>, at 1.

<sup>66</sup> HPC analysis of MassHealth pharmacy claims in the CHIA Massachusetts All-Payer Claims Database v2023. Includes in-state retail pharmacies except for federally qualified health centers, which receive directed payments. See *infra* note 92 and accompanying text.

<sup>67</sup> See Fein, *supra* note 64, at 290. Note that the Federal Upper Limit requirement only needs to be satisfied in the aggregate, so states may pay more for some drugs and less for others.

<sup>68</sup> See Federal Trade Commission, *supra* note 45, at 57-58.

<sup>69</sup> See CMS. Retail Price Survey. Last updated Apr 6, 2026. <https://www.medicaid.gov/medicaid/prescription-drugs/retail-price-survey>

<sup>70</sup> See, e.g., Massachusetts State Plan Amendment No. 17-006, Apr 2017, at 1e.

<sup>71</sup> See Federal Trade Commission, Office of Policy Planning. Specialty generic drugs: A growing profit center for vertically integrated pharmacy benefit managers, January 2025. [https://www.ftc.gov/system/files/ftc\\_gov/pdf/PBM-6b-Second-Interim-Staff-Report.pdf](https://www.ftc.gov/system/files/ftc_gov/pdf/PBM-6b-Second-Interim-Staff-Report.pdf), at 7.

<sup>72</sup> 101 CMR 331.02. Note that MassHealth’s definition differs from the common definition of a usual and customary price, which is the retail price a pharmacy charges cash-paying patients. See Fein, *supra* note 64, at 134.

<sup>73</sup> See 42 U.S.C. § 1395w-3a(c)(6).

## ABOUT THE 340B DRUG PRICING PROGRAM

Established in 1992 to support health care providers serving vulnerable and underserved populations, the 340B Drug Pricing Program requires drug manufacturers to sell outpatient drugs to eligible providers, known as 340B covered entities, at significantly reduced prices.<sup>74</sup> Public hospitals, non-profit hospitals, and federal grantees, such as federally qualified health centers (“FQHC”), may be eligible to participate in the 340B program.

Covered entities benefit from dispensing 340B drugs because they are reimbursed at the MCE/PBM’s contracted rate but acquire the drugs at a significant discount.<sup>75</sup> Data from MassHealth ACO-As and MCOs suggests an estimated average margin of 58 percent in SFY 2024, e.g., a covered entity that is reimbursed \$1,000 for a drug could retain roughly \$580 in 340B margin before accounting for associated administrative expenses.<sup>76</sup>

In Massachusetts, 29 hospitals and 55 federal grantees were covered entities in 2024.<sup>77</sup> While federally qualified health centers are disallowed from dispensing 340B drugs for MassHealth ACO-A and MCO members<sup>78</sup> and MassHealth disallows certain high-cost drugs from the 340B program altogether,<sup>79</sup> non-profit hospital covered entities can benefit from the majority of 340B drugs dispensed to these members.

Given the different methods employed to determine and incorporate capitated payments, pharmacy reimbursements, and drug manufacturer rebates, the net prices paid by MassHealth for the same drug can differ substantially when non-340B and 340B drug claims are filled by members with pharmacy benefits administered by MCE/PBMs and MassHealth.

**Exhibit 7** presents a stylized example illustrating how MassHealth payments may differ. The example considers a hypothetical drug with an ingredient cost of \$1,000 and a rebate of \$400 (resulting in a net price of \$600), which also equals the 340B actual acquisition cost of this drug for covered entities. In Panel A, which depicts non-340B drug claims, MassHealth’s gross price for the drug is \$1,000 regardless of whether the claim is processed by an MCE/PBM or MassHealth,<sup>80</sup> and MassHealth collects \$400 in drug manufacturer rebates, resulting in a net price of \$600. However, for 340B drug claims shown in Panel B, MassHealth pays a significantly higher net price when the claim is processed by an MCE/PBM. Under this scenario, MassHealth cannot claim any drug manufacturer rebates, so MassHealth’s net price is \$1,000 (while the 340B covered entity retains most of the \$400 in 340B margin). When the 340B claim is processed by MassHealth directly, MassHealth still cannot claim any drug manufacturer rebates but the loss in rebates is offset by MassHealth paying the lower 340B actual acquisition cost (\$600) for the drug.

<sup>74</sup> See Congressional Budget Office. Growth in the 340B drug pricing program. Sep. 2025. <https://www.cbo.gov/publication/60661>, at 3-11.

<sup>75</sup> MCE/PBM contracted rates are discussed in Sec. II.D.4. The maximum amount a manufacturer can charge a covered entity is the 340B ceiling price set by statute, and covered entities can negotiate additional discounts to achieve prices below the 340B ceiling price. See Congressional Budget Office, *supra* note 74, at 1.

<sup>76</sup> HPC analysis of MassHealth 340B pharmacy spending data. See MassHealth information request. Jan. 2026. Margin is estimated based on ACO-A and MCO pharmacy claims. This margin does not account for 340B entities’ associated administrative expenses, such as payments to 340B contract pharmacies and third-party administrators, among other expenses. Minnesota found that such expenses accounted for roughly 12 percent of 340B covered entity margin. See Minnesota Department of Health, *supra* note 27, at 8.

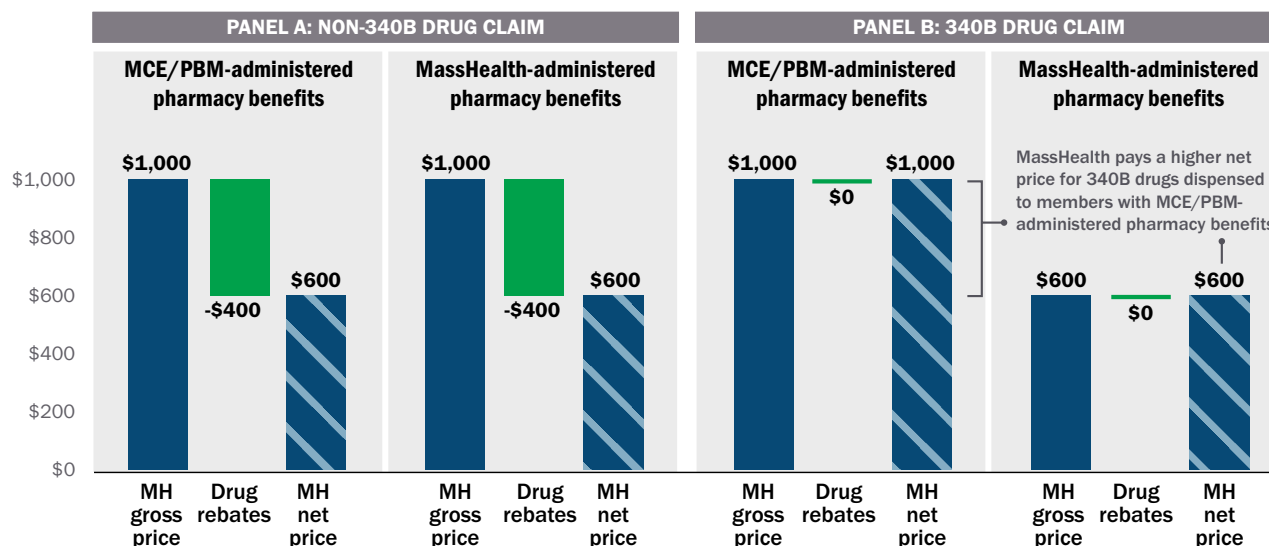
<sup>77</sup> HPC analysis of HRSA Office of Pharmacy Affairs 340B Covered Entity Database, as of Dec. 10, 2024. <https://340bopais.hrsa.gov/SearchCe>. Entities with multiple sites are counted once.

<sup>78</sup> See, e.g., Commonwealth of Massachusetts. Third amended and restated accountable care partnership plan contract for the MassHealth Accountable Care Organization Program. Jan. 1, 2021. <https://www.mass.gov/doc/3rd-amended-and-restated-acpp-contract/download>, at Sec. 2.6.B.1.d.2, p. 131 [hereinafter, “MassHealth ACPP Contract”]; see also Anderson E, et al. Pharmacy Facts, No. 217. MassHealth. Dec. 15, 2023. <https://www.mass.gov/doc/pharmacy-facts-217-december-15-2023-0/download>, at 2.

<sup>79</sup> MassHealth currently prohibits hepatitis C virus drugs and certain glucagon-like peptide-1 (GLP-1) agonists from being dispensed as 340B drugs by managed care entities. See Levine M. Managed Care Entity Bulletin 112. MassHealth. Mar. 2024. <https://www.mass.gov/doc/managed-care-entity-bulletin-112-obesity-drugs-and-the-340b-drug-pricing-program-change-in-effective-date-0/download>; Tsai D. Managed care organization bulletin 6. MassHealth. Jul. 2016. <https://www.mass.gov/doc/managed-care-organization-bulletin-6-masshealth-contracted-managed-care-organization-mco/download>. MassHealth also excludes from the 340B program 24 clinician-administered drugs covered under the medical benefit that cost more than \$100,000 per-member-per-year. See MassHealth. MassHealth acute hospital carve-out drugs list. Feb. 2026. <https://mhd1.pharmacy.services.conduent.com/MHDL/pubdownloadpdfcurrent.do?id=9945>; Evers A, et al. Pharmacy Facts, No. 178. MassHealth. Jan. 24, 2022. <https://www.mass.gov/doc/pharmacy-facts-178-january-24-2022-0/download>, at 1.

<sup>80</sup> Reflecting the statutory rate of the ingredient cost used to determine MassHealth’s capitation payments.

**Exhibit 7.** Stylized example of MassHealth payments for non-340B and 340B drug claims filled by members with pharmacy benefits administered by MCE/PBMs and MassHealth



A summary of the components of MassHealth’s payments to MCEs and pharmacies, and how these payments differ by MassHealth delivery system and 340B drug claim status, is presented in **Exhibit 8**. Then the balance of this section further describes the methods used for determining the components of pharmacy benefit payments, including capitated payments, drug manufacturer rebates, and pharmacy reimbursements.

**Exhibit 8.** Summary of MassHealth payments to MCEs and pharmacies

| Entity administering pharmacy benefit: | MCE/PBM<br>(paid by MassHealth to ACO-A and MCO plans in capitation rate) |                             |                                                                   | MassHealth<br>(paid by MassHealth to pharmacies for ACO-B and PCC plans and FFS primary claims) |                             |                                                                        |
|----------------------------------------|---------------------------------------------------------------------------|-----------------------------|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------|------------------------------------------------------------------------|
| Payment components:                    | Ingredient costs                                                          | Drug rebates                | Dispensing fees                                                   | Ingredient costs                                                                                | Drug rebates                | Dispensing fees                                                        |
| <b>Non-340B drug claims</b>            | Capitated rate paid to MCE (statutory rate, often NADAC or WAC)           | MassHealth collects         | Capitated rate paid to MCE (professional dispensing fee, \$10.02) | Statutory rate paid to pharmacy (often NADAC or WAC)                                            | MassHealth collects         | Statutory rate paid to pharmacy (professional dispensing fee, \$10.02) |
| <b>340B drug claims</b>                | Capitated rate paid to MCE (statutory rate, often NADAC or WAC)           | MassHealth does not collect | Capitated rate paid to MCE (professional dispensing fee, \$10.02) | Statutory rate paid to pharmacy (no more than 340B ceiling price)                               | MassHealth does not collect | Statutory rate paid to pharmacy (professional dispensing fee, \$10.02) |

## 2. Capitated payments

The fixed per-member-per-month capitated rates paid by MassHealth to MCEs are based on medical/pharmacy benefit expenses and non-benefit expenses. The benefit expense component is intended to cover MCE members’ medical and pharmacy costs. It is calculated using historical cost and utilization data and adjusted for expected program changes, reimbursement changes, population changes, differences in member acuity and utilization, and changes in provider mix in an MCE’s provider network, among other factors.<sup>81</sup> To estimate the pharmacy component of benefit expenses, drug utilization is repriced assuming pharmacy reimbursement parity based on the statutory rate for ingredient costs plus the

81 See MassHealth. ACO Bidder’s Conference #2: Pricing, Payment, and Finance. Apr. 28, 2022, at 11-15.

professional dispensing fee (as described in Section II.D.4 below).<sup>82</sup> The capitation rate’s non-benefit expense component covers administrative expenses, care management costs, incentive payments, taxes, and other non-medical costs.<sup>83</sup>

### 3. Drug manufacturer rebates

Most drugs covered by MassHealth are part of the Medicaid Drug Rebate Program (“MDRP”). Drug manufacturers must enter into an agreement with the federal government to participate in the MDRP, which requires drug manufacturers to pay rebates to Medicaid agencies in exchange for guaranteed coverage of the manufacturers’ drugs under Medicaid.

Minimum rebate amounts are determined quarterly by a statutory formula, though states may also negotiate additional “supplemental” rebates with drug manufacturers. The statutory rebate includes two components: a base rebate and an inflationary rebate. For most brand drugs, the base rebate is the greater of 23.1% of the average manufacturer price (“AMP”) or the difference between AMP and the Medicaid “best price” (defined as the lowest available price to any wholesaler, retailer, or provider, excluding certain government programs).<sup>84</sup> For multisource generic drugs, the base rebate is 13% of AMP. The inflationary rebate, which is added to the base rebate when applicable, is the growth in the AMP that exceeds the rate of overall inflation as measured by the Consumer Price Index.<sup>85</sup> As noted earlier, MassHealth negotiates and processes rebates for FFS and managed care health plans.

The 340B program and the MDRP both require manufacturers to provide discounts on their drugs, but federal law prohibits duplicate discounts on the same drug unit. Medicaid agencies, therefore, are prohibited from collecting a manufacturer rebate on a drug if it is sold to a covered entity at the 340B actual acquisition cost.<sup>86</sup> As the 340B program has expanded in recent years, so has its impact on the rebates MassHealth may collect.

### 4. Pharmacy reimbursements

When prescriptions are dispensed to MassHealth members, pharmacies are reimbursed for drug ingredient costs and for professional services and other costs associated with filling prescriptions that are covered in whole or in part by dispensing fees. The amounts pharmacies are paid, however, vary depending on the delivery system of a member’s plan and whether the drug is being dispensed through the 340B program, as summarized in **Exhibit 9** and discussed further below.

**Exhibit 9. Summary of pharmacy reimbursement components**

| Reimbursement components:          | Ingredient costs                               |                                               | Dispensing fees        |                                       |
|------------------------------------|------------------------------------------------|-----------------------------------------------|------------------------|---------------------------------------|
| Pharmacy benefits administered by: | MCE/PBM                                        | MassHealth                                    | MCE/PBM                | MassHealth                            |
| <b>Non-340B drug claims</b>        | Contracted rate (AWP discount, MAC, etc.)      | Statutory rate (often NADAC or WAC)           | Nominal dispensing fee | Professional dispensing fee (\$10.02) |
| <b>340B drug claims</b>            | Contracted rate (AWP discount, MAC list, etc.) | Statutory rate (340B actual acquisition cost) | Nominal dispensing fee | Professional dispensing fee (\$10.02) |

Notes: Reimbursements on selected claims may be based on different payment methods.

82 For selected services, including high-cost drugs, payments are calculated separately, with MassHealth covering the majority of the cost for providing these services. See MassHealth, *supra* note 81, at 19; see also MassHealth information request. Jan. 2026 (noting high-cost drugs generally “defined as prescription drugs that have a typical treatment cost in excess of \$200,000 per member per year and treat an applicable condition that affects fewer than 20,000 individuals nationwide”).

83 See MassHealth, *supra* note 81, at 20. Incentive payments, which are capped at 5 percent of total capitation payments, reflect the amounts MCEs may receive for meeting certain quality and health equity benchmarks, and MCEs offering ACO-A plans may also receive payments for achieving “pharmacy utilization targets . . . to support MassHealth’s collection of rebates.” Seifert RW. What to know now about MassHealth ACOs. Blue Cross Blue Shield of Massachusetts Foundation and Massachusetts Medicaid Policy Institute. Oct. 2023. [https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/2023-10/ACO%20Primer\\_2023\\_FINAL.pdf](https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/2023-10/ACO%20Primer_2023_FINAL.pdf), at 5 [hereinafter, “What to Know About ACOs”].

84 As defined in 42 U.S.C. § 1396r-8 (k)(1), the average manufacturer price, or AMP, is the average price paid to a manufacturer for a drug, excluding prices paid by certain federal payers and providers and certain discounts to wholesalers.

85 42 U.S.C. § 1396r-8(c).

86 42 U.S.C. § 256b(a)(5)(A)(i).

**MCE/PBM pharmacy reimbursements.** When an ACO-A or MCO plan member fills a prescription, the MCE's contracted PBM reimburses the pharmacy for the ingredient cost and dispensing fee. PBMs negotiate separate pharmacy contracts and generally do not reimburse all pharmacies in their network at the same rate.<sup>87</sup> Ingredient costs for brand drugs are often reimbursed based on a negotiated discount from a drug pricing benchmark, such as the Average Wholesale Price or Wholesale Acquisition Cost.<sup>88</sup> Ingredient costs for generic drugs are most commonly reimbursed based on a PBM's proprietary maximum allowable cost, or MAC, list.<sup>89</sup> PBMs also pay pharmacies a nominal dispensing fee, which for ACO-A and MCO plans averaged \$0.50 per claim in 2023.<sup>90</sup> Pharmacy reimbursements may also be offset by transaction fees and post-sale adjustments imposed by PBMs.<sup>91</sup> MCE/PBMs generally reimburse pharmacies the same for non-340B and 340B drug claims.

There are exceptions to the reimbursement methods described above. Since 2021, MassHealth has required ACO-A and MCO plans to reimburse federally qualified health centers at the MassHealth FFS level or higher.<sup>92</sup> This requirement was expanded to independent pharmacies in January 2025.<sup>93</sup> Additionally, MassHealth disallows FQHCs from dispensing 340B drugs to ACO-A and MCO members.<sup>94</sup> For all other pharmacy types, the managed care reimbursement methods described above apply.

**MassHealth pharmacy reimbursements.** When an ACO-B, PCC, or FFS primary member fills a prescription, MassHealth reimburses the pharmacy directly at a statutory rate for the ingredient cost. For non-340B drugs, ingredient cost reimbursements are determined by a "lesser of" methodology. Specifically, MassHealth pays the lesser of (i) NADAC, (ii) WAC, (iii) the Federal Upper Limit, and (iv) the "usual and customary" price as defined by MassHealth.<sup>95</sup> Most of the time, ingredient costs for non-340B drugs are reimbursed at NADAC or WAC. For drugs purchased through the 340B program, federal regulations mandate that MassHealth reimburse for ingredient costs at no more than the 340B ceiling price.<sup>96</sup> MassHealth pays the same professional dispensing fee for non-340B and 340B drug claims, which is currently \$10.02 per claim for most drug types.<sup>97</sup> MassHealth does not collect transaction fees or post-sale adjustments when pharmacies follow the statutory rate requirements.

87 PBMs negotiate either directly with pharmacies or through a pharmacy's pharmacy services administrative organization, or PSAO.

88 See Fein, *supra* note 64, at 282.

89 One study, for example, found that over 80 percent of generic prescriptions dispensed by retail pharmacies were paid based on a MAC list. See Three Axis Advisors. Unravelling the drug pricing blame game. Sept. 2023. [https://static1.squarespace.com/static/5c326d5596e76f58ee234632/t/650924780b6b9c590edfa2b4/1695097983750/Unravelling\\_the\\_Drug\\_Pricing\\_Blame\\_Game\\_3AA\\_APCI\\_0923.pdf](https://static1.squarespace.com/static/5c326d5596e76f58ee234632/t/650924780b6b9c590edfa2b4/1695097983750/Unravelling_the_Drug_Pricing_Blame_Game_3AA_APCI_0923.pdf), at 40.

90 See *supra* note 66.

91 Historically, PBMs could also profit from spread pricing (i.e., billing their MCE clients more than they reimburse pharmacies for drugs), but MassHealth prohibited this practice in 2021. See, e.g., Fallon Community Health Plan, Inc. and MassHealth. Accountable care partnership plan contract for the MassHealth Accountable Care Organization Program. Dec. 19, 2025. <https://www.mass.gov/doc/3rd-amended-and-restated-acpp-contract-fallon-atrius/download>, at Sec. 2.7.B.1.d ("The Contractor shall ensure its contract with its PBM utilizes a pass-through contract model, consistent with applicable state law, where the PBM is only permitted to charge administrative fees for services it provides under the PBM contract") [hereinafter "Fallon ACPP Contract"].

92 See, e.g., MassHealth ACPP Contract, *supra* note 78, at Sec. 2.6.B.1.d.6, p. 132.

93 See, e.g., Fallon ACPP Contract, *supra* note 91, at Sec. 2.8.D.9.h., p. 174. MassHealth defines independent pharmacies as having "three or fewer pharmacies under common ownership." Anderson E, et al. Pharmacy Facts, No. 232. Oct. 7, 2024. <https://www.mass.gov/doc/pharmacy-facts-232-october-7-2024-0/download>, at 1.

94 See MassHealth ACPP Contract, *supra* note 78, at Sec. 2.6.B.1.d.2., p. 131; Anderson, *supra* note 78, at 2.

95 See 101 CMR 331.04.

96 Specifically, MassHealth reimburses pharmacies at actual acquisition cost for 340B drugs, which is equal to or lower than the 340B ceiling price. See 101 CMR 331.07 (1)(a).

97 101 CMR 331.06.

### III. MEDICAID MANAGED CARE PHARMACY BENEFIT REFORMS IN OTHER STATES

Over the past decade, numerous states have implemented major reforms to their Medicaid managed care pharmacy benefits, prompted by the rapid growth of pharmacy benefit costs<sup>98</sup> and concerns about PBM practices.<sup>99</sup>

In 2017, 35 out of 39 states with Medicaid managed care programs allowed managed care entities and their PBMs to administer pharmacy benefits, i.e., pharmacy benefits were “carved in” to managed care.<sup>100</sup> Since that time, over one-third of these states have reformed their pharmacy benefit program designs. Some states commissioned studies to evaluate the impacts of their reforms and found material savings, including West Virginia (\$54 million in a single year)<sup>101</sup> and Ohio (\$140 million over two years),<sup>102</sup> while other states prepared less formal assessments of their estimated savings.<sup>103</sup> Ohio’s evaluation also reported that its reform resulted in increased pharmacy reimbursements and improved patient access to local retail pharmacies.<sup>104</sup> As of 2026, at least 16 state Medicaid agencies have enacted major reforms to their managed care pharmacy benefit programs. See **Exhibit 10**.

The balance of this section describes different types of pharmacy benefit reforms implemented by various states, including the single PBM, FFS carveout, and 340B disallowed models.

**Single PBM.** Seven states have implemented, or will be implementing, a single PBM model in which one PBM serves as the sole administrator of Medicaid managed care pharmacy benefits in the state to achieve administrative efficiencies.<sup>105</sup> While program designs vary by state, there are two main versions of the single PBM model. In one version, states select a single PBM to serve as a third-party administrator and require all managed care entities to contract with this PBM to oversee various aspects of their Medicaid pharmacy benefits.<sup>106</sup> Typically, the managed care entities remain at financial risk for members’ pharmaceutical spending under this model.<sup>107</sup> In another version, the single PBM provides various pharmacy benefit administrative services and the state assumes the financial risk for members’ pharmaceutical spending.<sup>108</sup>

98 Williams E. Recent trends in Medicaid outpatient prescription drugs and spending. KFF. Mar. 12, 2026. <https://www.kff.org/medicaid/recent-trends-in-medicaid-outpatient-prescription-drugs-and-spending> (finding that overall Medicaid pharmacy spending increased 46 percent from \$31 billion in 2019 to \$46 billion in 2024). Part of the growth in managed care pharmacy costs may be driven by misaligned incentives. While MCEs are incentivized to control spending to the extent they bear financial risk, empirical evidence suggests that this incentive can be limited by the capitation rate setting methods used to pay MCEs because past spending dictates future payments, so “in the long run, when insurers reduce costs, their payments are decreased (aka the ‘ratchet effect’).” See Layton T, Politzer E. The dynamic fiscal costs of outsourcing health insurance—evidence from Medicaid. National Bureau of Economic Research, Working Paper No. 33302. Dec. 2024. [https://www.nber.org/system/files/working\\_papers/w33302/w33302.pdf](https://www.nber.org/system/files/working_papers/w33302/w33302.pdf), at 1.

99 For example, Ohio reformed its Medicaid managed care pharmacy benefit after the state auditor found that PBMs captured \$224.8 million from spread pricing from 2017 to 2018. See Yost D. Ohio’s Medicaid managed care pharmacy services. Ohio Auditor of State. Aug. 16, 2018. [https://ohioauditor.gov/auditsearch/Reports/2018/Medicaid\\_Pharmacy\\_Services\\_2018\\_Franklin.pdf](https://ohioauditor.gov/auditsearch/Reports/2018/Medicaid_Pharmacy_Services_2018_Franklin.pdf), at 2.

100 Gifford K, et al. Medicaid moving ahead in uncertain times: Results from a 50-state Medicaid budget survey for state fiscal years 2017 and 2018. KFF. Oct. 19, 2017. <https://www.kff.org/medicaid/medicaid-moving-ahead-in-uncertain-times-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2017-and-2018>, at 3.

101 Navigant. Pharmacy savings report: West Virginia Medicaid. Feb. 25, 2019. <https://www.ncpa.co/pdf/state-advoc/west-virginia-report.pdf>, at 5.

102 Clarkson J, Schulze T, Kruse S. Ohio single pharmacy benefit manager experience analysis. Milliman. Mar. 28, 2025. [https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/About%20Us/PublicNotices/Ohio\\_SPBM\\_Experience\\_Analysis\\_20250328.pdf](https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/About%20Us/PublicNotices/Ohio_SPBM_Experience_Analysis_20250328.pdf), at 4. (including savings from the “Higher Managed Care” scenario, which the state identified as its best estimate).

103 See, e.g., Garden-Monheit H, Haydell T. Cutting out the middleman: How states can save Medicaid dollars by firing pharmacy benefit managers. Institute for Responsive Government. Nov. 14, 2025. [https://responsivegov.org/wp-content/uploads/2025/11/IRG\\_MedicaidPBM\\_FINAL.pdf](https://responsivegov.org/wp-content/uploads/2025/11/IRG_MedicaidPBM_FINAL.pdf), at 4 (listing savings estimates prepared by several states).

104 See Eckard S, Corcoran M. SPBM Program Review/Experience Analysis. Ohio Dep’t of Medicaid. Apr. 9, 2025. <https://acrobat.adobe.com/id/urn:aaid:sc:us:9e7a9930-022d-42a0-b3c5-73a702cc00c5>, at 1.

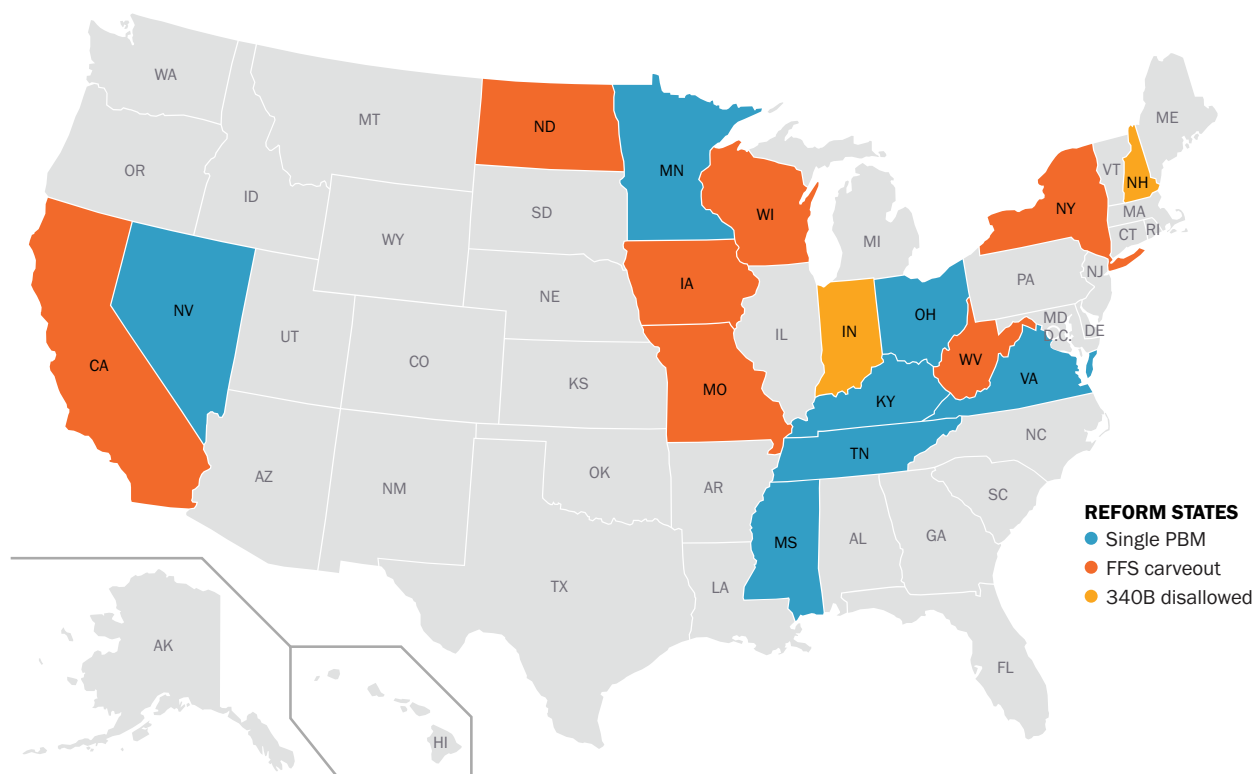
105 See Gifford K, Lashbrook A, Payne C. State approaches to managing the Medicaid pharmacy benefit: Insights from a national survey for state fiscal year 2023 and 2024. Health Management Associates. Aug. 2024. [https://www.healthmanagement.com/wp-content/uploads/2024-Medicaid-Rx-Survey-Rpt\\_FINAL.pdf](https://www.healthmanagement.com/wp-content/uploads/2024-Medicaid-Rx-Survey-Rpt_FINAL.pdf), at 9.

106 States that have implemented this model include Kentucky and Mississippi. See Kentucky R.S. § 205.5512 (mandating that all managed care entities contract with a single, state-selected PBM); Mississippi Division of Medicaid. Medicaid to implement single pharmacy benefit administrator July 1, 2024. <https://medicaid.ms.gov/medicaid-to-implement-single-pharmacy-benefit-administrator-july-1>.

107 See Hinton E, Raphael J. 10 things to know about Medicaid managed care. KFF. Feb. 27, 2025. <https://web.archive.org/web/20260218215403/https://www.kff.org/medicaid/10-things-to-know-about-medicaid-managed-care>.

108 See CMS. Managed care entities. <https://www.medicaid.gov/medicaid/managed-care/managed-care-entities>; Hansen A, Courtney B, Ranck A. State strategies for PBM oversight in Medicaid managed care: Navigating complexity and transparency. Myers & Stauffer LC. <https://myersandstauffer.com/insights/state-strategies-for-pbm-oversight-in-medicaid-managed-care-navigating-complexity-and-transparency>.

**Exhibit 10.** States with major Medicaid managed care pharmacy benefit reforms



| State         | Pharmacy benefit reform type | Year enacted | Year implemented |
|---------------|------------------------------|--------------|------------------|
| Tennessee     | Single PBM                   | 2002         | 2003             |
| Wisconsin     | FFS carveout                 | 2007         | 2008             |
| Missouri      | FFS carveout                 | 2009         | 2009             |
| New Hampshire | 340B disallowed              | 2017         | 2017             |
| West Virginia | FFS carveout                 | 2017         | 2017             |
| North Dakota  | FFS carveout                 | 2019         | 2020             |
| Kentucky      | Single PBM                   | 2020         | 2021             |
| California    | FFS carveout                 | 2019         | 2022             |
| Ohio          | Single PBM                   | 2019         | 2022             |
| New York      | FFS carveout                 | 2020         | 2023             |
| Mississippi   | Single PBM                   | 2024         | 2024             |
| Indiana       | 340B disallowed              | 2026         | 2026             |
| Iowa          | FFS carveout                 | 2026         | 2026             |
| Minnesota     | Single PBM                   | 2025         | 2028             |
| Virginia      | Single PBM                   | 2025         | 2028             |
| Nevada        | Single PBM                   | 2025         | 2030             |

**Sources:** Dates of enactment and implementation were identified by HPC analysis of literature, state laws, regulations, Medicaid State Plan Amendments, and other Medicaid documentation, including Hinton E, et al. A view of Medicaid today and a look ahead: Balancing access, budgets and upcoming changes. KFF. Nov. 13, 2025. <https://www.kff.org/medicaid/50-state-medicaid-budget-survey-fy-2025-2026>, at 50 (summarizing reforms); Gifford K, Lashbrook A, Payne C. State approaches to managing the Medicaid pharmacy benefit: Insights from a national survey for state fiscal year 2023 and 2024. Health Management Associates. Aug. 2024. [https://www.healthmanagement.com/wp-content/uploads/2024-Medicaid-Rx-Survey-Rpt\\_FINAL.pdf](https://www.healthmanagement.com/wp-content/uploads/2024-Medicaid-Rx-Survey-Rpt_FINAL.pdf), at 10 (summarizing reforms); Tenn. Comp. R. & Regs. 1200-13-13-03; BadgerCare+. Update No. 2007-108. Dec. 2007. <https://www.forwardhealth.wi.gov/kw/pdf/2007-108.pdf>, at 4 (Wisconsin); Missouri Department of Social Services. Managed Care Pharmacy Carve-Out-Billing Notification. <https://dss.mo.gov/mhd/cs/pharmacy/pages/mcpharmacob.htm>; NH State Plan Amendment #17-0003 (but certain family planning providers are exempt); West Virginia Department of Human Services. Pharmacy Benefits Changes for Medicaid Managed Care Members. May 31, 2017. <https://bms.wv.gov/pharmacy-benefits-changes-medicaid-managed-care-members>; North Dakota SB 2012 (2019); Kentucky SB 50 (2020); California EO N-01-19; Ohio HB 166 (2019); New York S7506B (2020); Amendment Number One to the Mississippi Medicaid Coordinated Care Contract Between the Mississippi Division of Medicaid in the Office of the Governor and Mississippi True D/B/A True Care. June 2025 [https://medicaid.ms.gov/wp-content/uploads/2025/08/MS-True-dba-TrueCare\\_Coordinated-Care-Services\\_20240812\\_Amend1\\_FULLY-EXECUTED.pdf](https://medicaid.ms.gov/wp-content/uploads/2025/08/MS-True-dba-TrueCare_Coordinated-Care-Services_20240812_Amend1_FULLY-EXECUTED.pdf); Indiana Family and Social Services Administration. Notice of Update to the 340B Drug Program. Feb. 25, 2026. <https://iar.iga.in.gov/register/20260225-IR-4052600590NA> (but FQHCs are exempt); Iowa Health & Human Services. Pharmacy Benefit Carveout. Aug. 6, 2026. <https://hhs.iowa.gov/medicaid/provider-services/medicaid-pharmacy>; Minnesota HF2 (2025); Virginia H 2610 (2025); and Nevada SB 389 (2025).

Under the single PBM model, 340B covered entities typically retain the 340B margin on drugs dispensed through the 340B program.<sup>109</sup> However, this is not always the case. Last year, for example, Ohio changed its reimbursement methods in response to the significant growth in 340B drug claims, resulting in the state recapturing 340B margin from certain covered entities.<sup>110</sup> As discussed below, Ohio also implemented policies to partially offset the financial impact of its new reimbursement methods on covered entities.

**FFS carveout.** Seven state Medicaid agencies have shifted the pharmacy benefit from managed care entirely, returning to a FFS model administered by the state. Because FFS plans reimburse 340B drug claims at no more than the 340B ceiling price (rather than a higher amount often based on WAC or NADAC), states realize savings on these drug claims.<sup>111</sup> California and New York implemented FFS carveouts in recent years, in part to recapture 340B margin from covered entities and realize budgetary savings.<sup>112</sup> At the same time, both states committed to reinvesting funds in certain 340B covered entities to partially offset the financial impacts of their FFS carveouts.<sup>113</sup>

**340B disallowed.** Rather than altering the delivery system that administers the pharmacy benefit, some states disallow the dispensing of 340B drugs in their Medicaid managed care programs. Currently, New Hampshire and Indiana prohibit Medicaid managed care entities from covering most drugs dispensed through the 340B program.<sup>114</sup> Other states limit the dispensing of 340B drugs under certain conditions. For example, 13 states prohibit the use of 340B contract pharmacies in Medicaid managed care, so the only 340B drugs permitted are those dispensed through a provider-owned in-house pharmacy or administered by a clinician in a physician office or hospital outpatient department.<sup>115</sup> Moreover, some states disallow the dispensing of selected high-cost drugs through the 340B program.<sup>116</sup>

In Massachusetts, MassHealth recently disallowed the dispensing of 340B drugs for ACO-B, PCC, and FFS members whose pharmacy benefits are administered by MassHealth.<sup>117</sup> MassHealth also currently disallows federally qualified health centers from dispensing 340B drugs to ACO-A and MCO plan members<sup>118</sup> and prohibits 340B dispensing of certain high-cost drugs.<sup>119</sup>

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<sup>109</sup> 340B payments are described in Sec. II.D.

<sup>110</sup> See Ohio Channel. Ohio House Medicaid Committee – 3-4-2025. Mar. 4, 2025, <https://ohiochannel.org/programs/ohio-house-medicaid-committee-3-4-2025>, at 31:30 (noting number of 340B claims had doubled after the single PBM model was implemented resulting in estimated rebate losses to the state of more than \$323 million); Ohio R.C. § 5167.01; Ohio R.C. § 5167.123.

<sup>111</sup> See Sec. II.D.

<sup>112</sup> See Gabriel Petek, The 2020-21 budget: Analysis of the Medi-Cal budget. California Legislative Analyst's Office. Feb. 14, 2020. <https://lao.ca.gov/reports/2020/4161/Medi-Cal-Budget-021420.pdf>, at 18 (highlighting that the FFS carve-out proposal would allow the state to reclaim 340B savings and increase supplemental rebate revenue); see also New York Department of Health. Transition (carve-out) of the pharmacy benefit from managed care to fee-for-service (FFS): Implementation update & strategy. July 13, 2020. [https://www.health.ny.gov/health\\_care/medicaid/redesign/mrt2/meetings/docs/2020-07-13\\_phcy\\_carve-out\\_stake\\_meet.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/meetings/docs/2020-07-13_phcy_carve-out_stake_meet.pdf), at 4 (describing the goals for the pharmacy carve out, including visibility into drug costs, greater negotiating power with manufacturers, and recouping state rebate revenue following growth in the 340B program).

<sup>113</sup> See, e.g., Sheppard. Medi-Cal Rx: California to transition Medi-Cal pharmacy benefits to fee-for-service. Jan 11, 2021. <https://www.sheppard.com/insights/blogs/california-to-transition-medi-cal-pharmacy-benefits-to-fee-for-service> (highlighting supplemental payments to certain non-hospital 340B covered entities in the California state budget); New York Governor's Office. Governor Hochul launches new statewide Medicaid pharmacy benefit program. Governor's Press Office. Apr. 1, 2023. <https://www.governor.ny.gov/news/governor-hochul-launches-new-statewide-medic-aid-pharmacy-benefit-program> (highlighting \$705 million in direct investments to covered entities to accompany implementation of the FFS carve out).

<sup>114</sup> See Health Management Associates. 340B duplicate discounts: enforcement inconsistent and weak due to lack of data transparency and despite federal prohibition. Feb. 2025. [https://www.healthmanagement.com/wp-content/uploads/HMA\\_340BDuplicateDiscounts\\_Feb2025v2.pdf](https://www.healthmanagement.com/wp-content/uploads/HMA_340BDuplicateDiscounts_Feb2025v2.pdf), at 4; Indiana Family and Social Services Administration. Notice of Update to the 340B Drug Program. Feb. 25, 2026. <https://iar.iga.in.gov/register/20260225-IR-405260059ONA>; Newton W. Indiana to exempt health centers from new policy ending 340B savings under Medicaid. 340B Report. Apr. 28, 2026 (noting FQHCs exempt from the policy).

<sup>115</sup> See Gifford, *supra* note 105, at 30.

<sup>116</sup> See, e.g., Oklahoma Health Care Authority. 340B drug discount program. Dec. 12, 2025. <https://oklahoma.gov/ohca/providers/types/pharmacy/340b-drug-discount-program.html>.

<sup>117</sup> Levine M. All Provider Bulletin 414. MassHealth. Apr. 2026, at 1. <https://www.mass.gov/doc/all-provider-bulletin-414-changes-in-exclusion-of-designated-340b-drugs-for-masshealth-fee-for-service-coverage-corrected-0/download>.

<sup>118</sup> See MassHealth ACPP Contract, *supra* note 78, at Sec. 2.6.B.1.d.2., p. 131; Anderson, *supra* note 78, at 2.

<sup>119</sup> See *supra* note 79.

Given the financial implications that certain Medicaid managed care pharmacy benefit reforms may have on 340B covered entities, states implementing these reforms have strived to address the impact on affected 340B covered entities that care for vulnerable and underserved populations. For example, when New York implemented its FFS carveout reform (which shifted 340B margin to the state), Governor Hochul committed to reinvest funds for 340B entities – a commitment codified in a State Plan Amendment approved by CMS.<sup>120</sup> Similarly, Ohio’s recent change to 340B reimbursement (which shifted 340B margin from hospitals to the state) was accompanied by an increase in state-directed payments and extensions of other policies that benefit hospitals.<sup>121</sup>

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<sup>120</sup> See NY State Plan Amendment NY-23-0039; New York Governor’s Office, *supra* note 113.

<sup>121</sup> See Goodman A, Kramer E, et al. H.B. 96: Final analysis. Ohio Legislative Service Commission. Nov. 25, 2025. <https://www.lsc.ohio.gov/assets/legislation/136/hb96/en0/files/hb96-bill-analysis-as-enacted-136th-general-assembly.pdf>, at 378-385.

## IV. EFFECTS OF MASSHEALTH MANAGED CARE PHARMACY BENEFIT REFORMS

To assess the potential impact of reforming MassHealth’s managed care pharmacy benefit, the HPC considered four models of reform, which vary based on selected design elements. First, **which entity administers the pharmacy benefit**. Pharmacy benefits for ACO-A and MCO plans are currently administered by MCEs and their subcontracted PBMs. The reform scenarios assess the effects of requiring all MCEs to contract with the same PBM to administer the pharmacy benefit (the single PBM model) and of shifting pharmacy benefit administration from MCE/PBMs to MassHealth (the FFS carveout model). Second, **which entity is at financial risk**. Under the current managed care carve-in model, ACO-A and MCO plans are paid a fixed capitation rate to cover their members’ total cost of care but face two-sided risk (bounded by risk corridors<sup>122</sup>), i.e., they may incur financial losses if costs are higher than expected or share financial gains if savings are generated. Several of the reform scenarios model the impact of shifting this risk from MCEs to the state. Third, **whether drugs may be dispensed through the 340B program**. The dispensing of 340B drugs by eligible providers is currently allowed under the managed care pharmacy benefit model. One of the reform scenarios disallows the dispensing of 340B drugs, which has implications for MassHealth’s ability to collect rebates from drug manufacturers and for the covered entities that would otherwise retain the 340B margin.

Specifically, the reforms evaluated in this report are listed below, and the design elements of each reform scenario are summarized in **Exhibit 11**.

1. Single PBM with MCEs at risk and 340B drug claims allowed (the “single PBM with MCEs at risk” scenario);
2. Single PBM with MassHealth at risk and 340B drug claims allowed (the “single PBM with MassHealth at risk” scenario);
3. FFS carveout with 340B drug claims allowed and MassHealth at risk (the “FFS carveout with 340B allowed” scenario); and
4. FFS carveout with 340B drug claims disallowed and MassHealth at risk (the “FFS carveout with 340B disallowed” scenario).

**Exhibit 11.** Design elements of each reform scenario

|                                         | (A)<br>Single PBM<br>MCEs at risk | (B)<br>Single PBM<br>MassHealth at risk | (C)<br>FFS carveout<br>340B allowed | (D)<br>FFS carveout<br>340B disallowed |
|-----------------------------------------|-----------------------------------|-----------------------------------------|-------------------------------------|----------------------------------------|
| <b>Reform type</b>                      | Single PBM                        | Single PBM                              | FFS carveout                        | FFS carveout                           |
| <b>Pharmacy benefit administered by</b> | MCE/<br>single PBM                | Single PBM                              | MassHealth                          | MassHealth                             |
| <b>Entity at risk</b>                   | MCEs                              | MassHealth                              | MassHealth                          | MassHealth                             |
| <b>340B drug claims</b>                 | Allowed                           | Allowed                                 | Allowed                             | Disallowed                             |

These reforms would apply to ACO-A and MCO plans for which the pharmacy benefit is currently managed by MCEs and their contracted PBMs. Each of the reforms have been implemented in some form by other states.<sup>123</sup> As modeled in this report, the single PBM with MCEs at risk scenario is similar to Kentucky’s program,<sup>124</sup> the single PBM with MassHealth

<sup>122</sup> See *infra* notes 150-152 and accompanying text.

<sup>123</sup> See generally Sec. III.

<sup>124</sup> See, e.g., Houchens P, et al. Evaluation of Senate Bill 50 on the Kentucky Medicaid Managed Care Pharmacy Benefit. Milliman. Sept. 12, 2023. <https://www.scribd.com/document/759325566/SB50Evaluationon-the-Kentucky-Medicaid-Managed-Care-Pharmacy-Benefit-9-12-2023>.

at risk is similar to Ohio’s program;<sup>125</sup> the FFS carveout scenarios are similar to New York’s program,<sup>126</sup> though the 340B disallowed scenario also incorporates aspects of New Hampshire’s program.<sup>127</sup> Some of the reforms may require CMS approval and/or amendments to state regulations.<sup>128</sup>

The following sections describe the estimated impacts of the managed care pharmacy benefit reforms on MassHealth pharmacy spending (Section IV.A) and considerations relating to access (Section IV.B).

## A. MASSHEALTH SPENDING ON PHARMACY BENEFITS

To assess the potential financial impact of the reforms on MassHealth pharmacy spending, the HPC engaged the actuarial firm Marsh Government Health Consulting (“Marsh”), formerly named Mercer Government Human Services Consulting, in February 2026.<sup>129</sup> As MassHealth’s actuarial firm, Marsh is responsible for developing capitation rates for MassHealth managed care entities, including ACO-A and MCO plans.

The analyses presented in this section estimate the effects of the reforms on MassHealth’s annual prescription drug spending and non-benefit expenditures for ACO-A and MCO plans. The analyses are based on presently available information, including the most recent data available that has been validated, with adjustments so that the results provide reasonable estimates of the financial impacts of the reforms as of CY 2026. Actual experience may vary in future years due to unforeseen events. The analyses assume the reforms are fully implemented.<sup>130</sup>

This section proceeds as follows: an overview of the methods employed is provided in Section IV.A.1; results are presented in Section IV.A.2; and various dynamics that have been occurring in the market that may affect the reforms are discussed in Section IV.A.3.

### 1. Methods

The analyses in this section estimate the savings that MassHealth could potentially achieve by implementing the managed care pharmacy benefit reforms. The analyses rely on the most recent data available that has been validated, with adjustments so that the results provide reasonable estimates of the financial impacts of the reforms as of CY 2026. The savings are calculated by comparing MassHealth’s estimated pharmacy spending under its current carve-in model with estimated spending for each reform. The analyses consider changes across two categories of spending:

- Pharmacy benefit expenditures, including MassHealth’s gross drug expenditures and drug manufacturer rebates (federal and supplemental), as applicable.<sup>131</sup>
- Non-benefit expenditures, including PBM administrative fees, risk payments, and new single PBM and/or MassHealth administrative expenses resulting from the reforms.<sup>132</sup>

The methods employed to assess changes in pharmacy benefit expenditures and non-benefit expenditures, as well as a sensitivity analysis relating to market trend considerations, are described below.

#### a. Pharmacy benefit expenditures

For the pharmacy benefit expenditure analyses, baseline spending under the current carve-in model was derived from rate year 2026 ACO-A and MCO capitation rates,<sup>133</sup> which Marsh developed using SFY 2024 retail pharmacy claims. This is the most recent data available that has been validated. Marsh then estimated changes to gross drug expenditures

<sup>125</sup> See, e.g., Clarkson, *supra* note 102.

<sup>126</sup> See, e.g., New York State Department of Health. Medicaid Update: NYRx Pharmacy Benefit Transition: Special Edition – Part One. October 2022. [https://www.health.ny.gov/health\\_care/medicaid/program/update/2022/docs/mu\\_no11\\_oct22\\_speced\\_pr.pdf](https://www.health.ny.gov/health_care/medicaid/program/update/2022/docs/mu_no11_oct22_speced_pr.pdf).

<sup>127</sup> See Health Management Associates, *supra* note 114, at 4.

<sup>128</sup> While an assessment of specific legal requirements is outside the scope of this report, MassHealth may need to obtain a CMS-approved 1115 or 1915(b) waiver or State Plan Amendment and/or amend certain state regulations prior to implementing certain scenarios.

<sup>129</sup> The HPC defined the objectives for the engagement and developed an analytic plan, while Marsh provided guidance to refine the analytic plan based on its subject matter expertise and then conducted the analyses. The engagement was limited to the analyses presented in this section.

<sup>130</sup> If MassHealth pursues any of these reforms, the budget implications during the implementation period may vary by reform model.

<sup>131</sup> See Sec’s IV.A.1.a and IV.A.2.a.

<sup>132</sup> See Sec’s IV.A.1.b and IV.A.2.b.

<sup>133</sup> Rate year 2026 covers the CY 2026 period.

and drug manufacturer rebates under each of the reform scenarios and made adjustments so that the results provide reasonable estimates of the financial impacts as of CY 2026.<sup>134</sup>

**Baseline gross drug expenditures.** The baseline gross drug expenditures employed in these analyses were used for the development of rate year 2026 ACO-A and MCO capitation rates. Marsh developed these rates by repricing actual SFY 2024 prescription drug utilization for ACO-A and MCO members based on the MassHealth fee schedule for both ingredient cost and dispensing fee reimbursement.<sup>135</sup> This approach removes variation attributable to differences in ACO-A and MCO reimbursement methodologies and aligns costs to what MassHealth would have paid. The resulting repriced experience serves as the basis for 2026 capitation rates before trend and program changes are applied. As described below, Marsh made adjustments when evaluating reform scenarios so the results reflect reasonable estimates of the reforms' financial impacts as of CY 2026.

**Changes in gross drug expenditures.** The FFS carveout with 340B allowed reform (scenario (C)) would generate savings for MassHealth by reducing gross drug expenditures because MassHealth would be required to reimburse for 340B drug claims at no more than the 340B ceiling price.<sup>136</sup> Marsh repriced the ACO-A and MCO claims accordingly to estimate MassHealth's savings from changes in gross drug expenditures under scenario (C). Because MassHealth maintains a unified formulary (the MassHealth Drug List), the analysis assumes no changes in drug coverage and member utilization. No changes to gross drug expenditures are expected for the single PBM reforms (scenarios (A) and (B))<sup>137</sup> or for the FFS carveout with 340B disallowed reform (scenario (D))<sup>138</sup> because MassHealth would continue to reimburse claims at the statutory rate (often NADAC or WAC) under these scenarios.

**Changes in drug manufacturer rebates.** Under the FFS carveout with 340B disallowed reform (scenario (D)), MassHealth would be able to collect drug manufacturer rebates on claims previously dispensed through the 340B program (including both federal and supplemental rebates). Using MassHealth rebate data, Marsh calculated the savings MassHealth would achieve from increased rebate collections on claims that would be reclassified from 340B to non-340B under scenario (D).<sup>139</sup> Scenario (D) generates more savings than scenario (C) because the supplemental rebates MassHealth negotiates with drug manufacturers under scenario (D), taken together with the federal rebates it would collect, result in greater savings than MassHealth would achieve in scenario (C) from reimbursing 340B drug claims at no more than the 340B ceiling price. In addition to the supplemental rebates negotiated by MassHealth, the rebates in scenario (D) include the supplemental rebates MassHealth estimates it will receive through the CMS GENEROUS Model on drugs that were previously dispensed through the 340B program (as discussed Section IV.A.1.c below). Marsh also assessed how process efficiencies from having all pharmacy claims managed by one program administrator (either a single PBM or MassHealth) would modestly enhance rebate collections across all reform scenarios.<sup>140</sup>

<sup>134</sup> See Sec. IV.A.1.c.

<sup>135</sup> See *supra* notes 95 and 97 and accompanying text.

<sup>136</sup> MassHealth would pay no more than the 340B ceiling price under scenario (C). In this analysis, Marsh utilized 340B ceiling prices as a conservative estimate of what MassHealth would reimburse for 340B drugs. Federal regulations require Medicaid FFS programs to pay no more than the ceiling price for a 340B drug and also require 340B entities to bill at 340B actual acquisition cost, which may be lower than the 340B ceiling price due to discounts or rebates received by the pharmacy. Therefore, MassHealth might generate additional savings under scenario (C) when it reimburses pharmacies at their 340B actual acquisition cost.

<sup>137</sup> The single PBM scenarios modeled in this report assume that 340B margins are retained by 340B covered entities. Some states, however, have started to require that certain providers remit at least part of their 340B margins to the state. For example, Ohio implemented such a policy last year with respect to its single PBM. See *supra* note 110 and accompanying text. Oklahoma also generally requires covered entities to remit a portion of 340B margins to the state through its "shared savings" program. See Oklahoma Health Care Authority, *supra* note 116; OK Admin. Code § 317:30-5-87.

<sup>138</sup> Though MassHealth would pay the statutory rate directly to pharmacies rather than in capitation payments.

<sup>139</sup> Marsh multiplied the total quarterly rebate per unit by drug (inclusive of both federal and supplemental rebates), provided by MassHealth, by the quarterly quantities dispensed for the 340B drug claims to estimate the total rebate impact for scenario (D).

<sup>140</sup> Each year MassHealth assesses ACO-A and MCO plan compliance with its preferred drug list by reconciling expected rebate amounts against actual rebates invoiced for 15 categories of drugs with the largest drug expenditures. If actual rebates invoiced are below expected rebate amounts, MassHealth imposes a financial penalty on the plans. If actual rebates invoiced are above expected rebate amounts, MassHealth pays the plans a financial reward. Because MassHealth would manage preferred drug list compliance and realize all rebates under the single PBM and FFS carveout reforms, the rebate efficiencies amount included in this analysis reflects the incremental increase in financial penalties that MassHealth would collect if all drugs (not just the top 15 categories) were reconciled. Penalties collected from plans and/or rewards paid to plans may vary by year.

## b. Non-benefit expenditures

For the non-benefit expenditure analyses, Marsh utilized data on ACO-A and MCO per-member PBM administrative fees as reported by the MCEs, 2026 projected enrollment, and baseline spending under the current carve-in model derived from 2026 ACO-A and MCO capitation rate data (developed using SFY 2024 retail pharmacy claims). This is the most recent data available that has been validated. Then Marsh estimated changes to non-benefit expenditures informed by single PBM contract materials from other states' Medicaid agencies<sup>141</sup> and contract materials and estimates from MassHealth's pharmacy benefit administrator and DUR services contractor.<sup>142</sup> Marsh also made adjustments so that the results provide reasonable estimates of the financial impacts as of CY 2026.<sup>143</sup>

**Changes in administrative expenses.** The components of administrative expenses include the following:

- **PBM administrative fees (existing).** These fees are included in the capitation rate development to cover the MCEs' cost of subcontracting with PBMs to provide services such as pharmacy network design, utilization management, and claims processing.
- **Single PBM administrative fees (new).** These fees include the estimated single PBM fees that MassHealth would pay under the single PBM scenarios.
- **MassHealth administrative expenses (new).** These expenses reflect the estimated expenses that MassHealth would incur to expand its internal staff and for contractor services relating to managing pharmacy benefit operations under the FFS carveout scenarios.

To assess changes in administrative expenses, Marsh first removed existing PBM administrative expenses (based on ACO-A and MCO per-member PBM administrative fees, as reported by the MCEs, and applied to 2026 projected enrollment) across all reform scenarios, which resulted in estimated savings to MassHealth. These savings were then offset by new administrative expenses that MassHealth would incur, which differ by scenario. For scenario (A), the MCEs would be required to contract with a single PBM selected by MassHealth to provide and coordinate services aligned with managed care regulations as the MCEs would remain at-risk for the drug expenditures under this scenario. Marsh estimated single PBM administrative fees for scenario (A) based on Kentucky's single PBM contract.<sup>144</sup> Under scenario (B), the MCEs would not be at-risk for drug expenditures. While the single PBM would still be required to provide services aligned with managed care regulations, it is assumed that some clinical drug program support services would transition to MassHealth's DUR services provider. Marsh estimated single PBM administrative fees for scenario

<sup>141</sup> For the single PBM with MCEs at risk scenario, see Contract between Commonwealth of Kentucky, Office of the Comptroller, and MedImpact Healthcare. Contract no. MA 758 2100000556 and subsequent modifications, Jan. 1, 2021; Kentucky Cabinet for Health and Family Services, Department for Medicaid Services. Monthly Managed Care Member Counts. Jan. 2026. <https://www.chfs.ky.gov/agencies/dms/stats/MCMMC20260101.pdf>; Kentucky Finance and Administration Cabinet, Exported Ledger.csv, <https://transparency.ky.gov/search/Pages/spendingsearch.aspx#/spending> (summarizing payments to MedImpact); Houchens, *supra* note 124. For the single PBM with MassHealth at risk scenario, the assessment of non-benefit expenditures relied on Tennessee contracts. While the scenario in this report is generally modeled on Ohio's reform, Ohio provides some services internally and uses multiple contracts in addition to its single PBM contract. Tennessee's single PBM covers a more comprehensive set of services, making its contract an appropriate reference for the administrative fees component of non-benefit expenditures under this scenario. See State of Tennessee, Department of Finance and Administration, Division of TennCare and OptumRx, Inc. Contract no. 61494, Amendment no. 4. Feb. 22, 2019; Contract between State of Tennessee, Department of Finance and Administration, Division of TennCare and Mercer Health and Benefits LLC. Contract no. 76738, Amendment no. Jan. 1, 2022; Contract between State of Tennessee, Department of Finance and Administration, Division of TennCare and Myers and Stauffer, LLC. Contract no. 81047. Nov. 15, 2023; TennCare. CoverKids Enrollment Data. Jan. 2026. <https://www.tn.gov/coverkids/enrollment-data.html>; TennCare. Enrollment Data. Jan. 2026. <https://www.tn.gov/tenncare/information-statistics/enrollment-data.html>.

<sup>142</sup> For the FFS carveout scenarios, see ForHealth ISA, *supra* note 51 (MassHealth's DUR services contractor); Commonwealth of Massachusetts Executive Office of Health & Human Services and Conduent State Healthcare LLC. Fourth-Generation Pharmacy Online Processing System Contract. MMARS Doc. ID CT-EHS-20MH416CONDUENTSTAKA. Mar. 31, 2020, and Amendments 1-3. (Conduent is MassHealth's PBA; the term of Conduent's contract ends on June 30, 2027); MedImpact. Response to Commonwealth of Massachusetts Executive Office of Health & Human Services Bid No. BD-25-1039-EHS01-ASHWA-111426. Attachment B—Cost Response Workbook. Apr. 10, 2025 (MedImpact will assume PBA responsibilities for MassHealth on July 1, 2027); MassHealth Information Request. Jan. 2026 (providing estimates on internal pharmacy staffing costs).

<sup>143</sup> See Sec. IV.A.1.c.

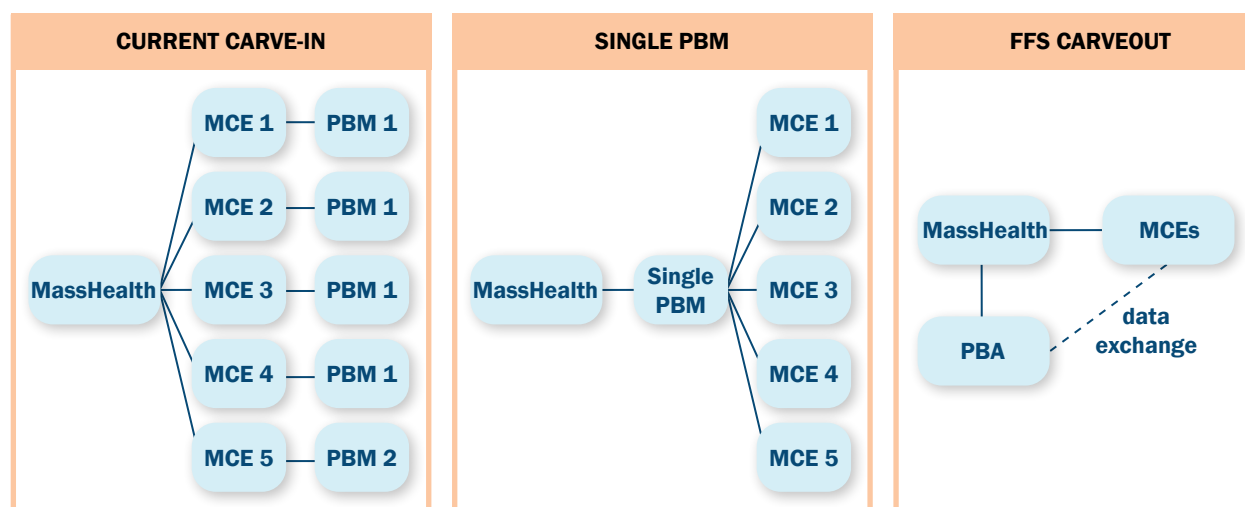
<sup>144</sup> Specifically, Marsh applied per-member administrative expenses from Kentucky's single PBM contract to MassHealth's ACO-A and MCO 2026 projected enrollment. See *supra* note 141 (listing Kentucky's single PBM contract materials). Under scenario (A), the single PBM administrative fees would be included in the capitation rate development, and the MCEs would pay the single PBM this contracted amount.

(B) based on Tennessee’s single PBM contract.<sup>145</sup> At the same time, MassHealth’s costs for actuarial services would decrease in scenario (B) because prescription drug expenditures would no longer be included in the capitation rate development.<sup>146</sup> For scenarios (C) and (D), MassHealth would incur new expenses for pharmacy benefit administration and DUR services<sup>147</sup> and additional internal staff,<sup>148</sup> partially offset by a reduction in costs for actuarial services related to prescription drug expenditures.<sup>149</sup>

### Changes in pharmacy benefit operational roles and responsibilities

To provide additional context for how the changes in administrative expenses would occur in practice, this section discusses the ways in which the reforms would consolidate and shift operational roles and responsibilities relative to the current carve-in model, streamlining processes and resulting in lower non-benefit expenditures. Selected operational relationships between MassHealth and other entities in the current carve-in model compared with the single PBM and FFS carveout reforms are illustrated in **Exhibit 12** and described further below.

**Exhibit 12.** Selected operational relationships between MassHealth and other entities under the current carve-in model and the single PBM and FFS carveout reforms



**Notes:** Figure is illustrative and does not capture all entities and relationships. MCE is managed care entity; currently, five MCEs offer ACO-A and MCO plans. PBM is pharmacy benefit manager; the MCEs currently contract with two PBMs. PBA is pharmacy benefit administrator. See Exh. 4 and App’x B (describing MassHealth delivery systems).

More specifically, **Exhibit 13** summarizes changes that would be implemented within MassHealth’s managed care pharmacy operations for each of the operational areas listed in **Exhibit 5** above due to the reforms. The cells shaded in blue reflect operational areas managed by MCEs and their subcontracted PBMs; the cells shaded in orange reflect operational areas managed by MassHealth and its contractors. Note that MassHealth’s operational responsibilities would be impacted in some but not all areas, since certain operational areas are already unified across delivery systems and overseen by MassHealth, such as formulary management and drug manufacturer rebate contracting.

<sup>145</sup> Specifically, Marsh applied per-member administrative expenses from Tennessee’s single PBM contract to MassHealth’s ACO-A and MCO 2026 projected enrollment. See *supra* note 141 (listing Tennessee’s single PBM contract materials).

<sup>146</sup> Estimate provided by Marsh, which serves as MassHealth’s actuarial firm and is responsible for developing capitation rates for MassHealth managed care entities, including ACO-A and MCO plans.

<sup>147</sup> Marsh estimated these costs based on current and pending contract materials and estimates provided by MassHealth’s contractors, ForHealth and MedImpact. See *supra* note 142 (listing MassHealth’s contract materials).

<sup>148</sup> Estimate provided by MassHealth. See *supra* note 142.

<sup>149</sup> See *supra* note 146.

**Exhibit 13.** Changes in MassHealth managed care pharmacy benefit operations

Operational area managed by: ● MassHealth and its contractors ● MCE/PBMs

| Operational area                                                   | Current carve-in                       | (A)<br>Single PBM<br>MCEs at risk             | (B)<br>Single PBM<br>MassHealth at risk       | (C)<br>FFS carveout<br>340B allowed          | (D)<br>FFS carveout<br>340B disallowed       |
|--------------------------------------------------------------------|----------------------------------------|-----------------------------------------------|-----------------------------------------------|----------------------------------------------|----------------------------------------------|
| <b>Formulary design and management</b>                             | ForHealth                              | ForHealth                                     | ForHealth                                     | ForHealth                                    | ForHealth                                    |
| <b>Utilization management</b>                                      | MCE & PBM                              | Single PBM<br>ForHealth                       | Single PBM<br>ForHealth                       | ForHealth &<br>MassHealth PBA                | ForHealth &<br>MassHealth PBA                |
| <b>Pharmacy network design and contracting</b>                     | MCE & PBM                              | MCE & Single PBM                              | Single PBM<br>MassHealth                      | MassHealth                                   | MassHealth                                   |
| <b>Drug manufacturer rebate and value-based contracting</b>        | MassHealth                             | MassHealth                                    | MassHealth                                    | MassHealth                                   | MassHealth                                   |
| <b>Drug manufacturer rebate invoicing and cash reconciliations</b> | MassHealth &<br>MassHealth PBA         | MassHealth &<br>MassHealth PBA                | MassHealth &<br>MassHealth PBA                | MassHealth &<br>MassHealth PBA               | MassHealth &<br>MassHealth PBA               |
| <b>Pharmacy and provider services</b>                              | MCE & PBM                              | MCE & Single PBM                              | MCE & Single PBM                              | ForHealth &<br>MassHealth PBA                | ForHealth &<br>MassHealth PBA                |
| <b>Claims processing</b>                                           | PBM                                    | Single PBM                                    | Single PBM                                    | MassHealth PBA                               | MassHealth PBA                               |
| <b>Clinical drug programs</b>                                      | MCE & PBM                              | MCE & Single PBM                              | MCE & Single PBM<br>ForHealth &<br>MassHealth | ForHealth &<br>MassHealth                    | ForHealth &<br>MassHealth                    |
| <b>PBM/PBA oversight</b>                                           | MCE                                    | MCE<br>MassHealth                             | MassHealth                                    | MassHealth                                   | MassHealth                                   |
| <b>Actuarial support</b>                                           | Marsh                                  | Marsh                                         | Marsh                                         | —                                            | —                                            |
| <b>Analytics and reporting</b>                                     | MCE & PBM<br>MassHealth &<br>ForHealth | MCE & Single PBM<br>MassHealth &<br>ForHealth | MCE & Single PBM<br>MassHealth &<br>ForHealth | MassHealth,<br>ForHealth &<br>MassHealth PBA | MassHealth,<br>ForHealth &<br>MassHealth PBA |

Notes: Table is illustrative and does not capture all pharmacy benefit operational areas and functions.

Source: Based on review of Kentucky, Ohio, and Tennessee single PBM contracts, and MassHealth's contracts with ForHealth and Conduent and pending contract with MedImpact.

Under the single PBM scenarios, most pharmacy benefit operations would continue to be handled by the MCEs and/or the single PBM, though MassHealth could expand its role in setting certain policies. For example, under the single PBM with MCEs at risk reform (scenario (A)), MassHealth and its contractors could direct utilization management policies, while under the single PBM with MassHealth at risk reform (scenario (B)), MassHealth could also set pharmacy contracting policies and support clinical drug programs and the analytics and reporting functions.

By contrast, under the FFS carveout scenarios, pharmacy benefit operations would shift entirely to MassHealth and its contractors (e.g., for PBA and DUR services). MassHealth would therefore be responsible for processing a higher volume of claims and providing services to more members within various operational areas, such as utilization management, pharmacy and provider call center services, and claims processing.

**Changes in risk payments.** Changes in the risk payment category of non-benefit expenditures derive from the MCE underwriting gain, which is a cost included in the capitation rate to cover the cost of capital (i.e., the amount of

reserves a health plan holds for risks assumed) and a contingency margin against losses. The MCE underwriting gain associated with pharmacy services is calculated as a percentage of total pharmacy expenditures and administration fees (1.25 percent). For scenario (A), the MCEs would continue to be at risk for pharmacy expenditures but due to the change in PBM administration costs, there would be a slight reduction in underwriting gain. For scenarios (B), (C), and (D), the entire MCE underwriting gain for pharmacy services would be removed from capitation rate development. The effect of this change is calculated by applying the MCE underwriting gain percentage to the total pharmacy expenditures and administrative fees removed from the capitation rate when risk is shifted from MCEs to MassHealth.

With the reduction in risk payments, MassHealth would take on a larger share of financial risk for the pharmacy benefit. However, MassHealth already bears most of the risk through several risk-sharing provisions in the ACO-A and MCO contracts, including:

- The Market-Wide Risk Sharing Arrangement (the “Market Corridor”) provision: MCEs retain 100 percent of any market-wide gain or loss up to 0.75 percent of Market Corridor revenue (as defined in the MCE contracts).<sup>150</sup> For the balance 99.25 percent of Market Corridor revenue, MassHealth assumes 95 percent of the risk and MCEs assume 5 percent. Market-wide gains or losses are allocated to each MCE proportionally by each MCE’s share of Market Corridor revenue. Market Corridor revenue includes most revenue received by MCEs to cover benefit expenses (both medical and pharmacy), but does not include non-benefit revenue for administrative costs and risk provisions. In 2025, Market Corridor revenue for ACO-As and MCOs totaled \$7.2 billion.
- The Contract-Wide Risk Sharing Arrangement (the “Plan Corridor”) provision: MCEs retain 100 percent of any plan-specific gain or loss up to 5 percent of Plan Corridor revenue, which is a part of the medical/pharmacy benefit component of the plan’s capitation rate (as defined in the MCE contracts).<sup>151</sup> For the balance 95 percent of Plan Corridor revenue, MassHealth assumes 95 percent of the risk and the MCEs assume 5 percent.
- The High-Cost Drugs Add-On Risk Sharing provision: High-cost drugs are risk-shared separately from regular pharmacy. MassHealth assumes 99 percent of any gain or loss up to \$100,000 of High-Cost Drug Add-On revenue (as defined in the MCE contracts) as compared to actual expenditures in aggregate for the year that meet the High-Cost Drug criteria, while the MCE retains 1 percent of risk on the first \$100,000.<sup>152</sup> Beyond that, MassHealth assumes 100 percent of risk on expenditures above \$100,000.

While MassHealth already assumes the majority of risk under these mechanisms, some additional risk would shift to MassHealth under the reform scenarios modeled in this report. Comparing the pharmacy funding built into the 2026 capitation rates with MCE-reported pharmacy spending for the first quarter of 2026, the capitation rates paid to MCEs exceeded spending by 1.3 percent, or \$7.0 million.<sup>153</sup> At the end of 2026, the market and plan-specific performance will be compared and recoupments or repayments will be made according to the risk sharing arrangements described above.

Marsh, however, did not attempt to project year-end market and plan performance based on first quarter results to include as additional savings (or costs) in the analysis. Reconciliation amounts are not included in the change in risk payments because over the long run, pharmacy funding built into capitation rates is expected to be sufficient to cover benefit costs. From 2020 through 2025, plans experienced financial gains in four of the six years after accounting for all reconciliation impacts (i.e., pharmacy capitation rate funding including any reconciliation payments exceeded plan-reported costs during these years). The estimated percentage gain or loss attributed to the pharmacy benefit after adjusting for the risk sharing arrangements ranged from a high of a 1.3 percent gain in 2020 to a low of a 2.1 percent

<sup>150</sup> See, e.g., Boston Medical Center Health Plan, Inc. and MassHealth. Eighth amended and restated accountable care partnership plan contract for the MassHealth Accountable Care Organization Program. Jan. 1, 2026. <https://www.mass.gov/doc/8th-amended-and-restated-mco-contract-wellsense/download>, at Sec. 4.5.C, p. 289.

<sup>151</sup> See *id.* at Sec. 4.5.D, p. 290.

<sup>152</sup> See *id.* at Sec. 4.5.E, p. 291. Unless otherwise specified by MassHealth, High-Cost Drugs are defined as prescription drugs that have a typical treatment cost in excess of \$200,000 per member per year and treat an applicable condition that affects fewer than 20,000 individuals nationwide. MassHealth information request. Jan. 2026.

<sup>153</sup> Marsh analysis of originally certified rate year (“RY”) 2026 capitation rates multiplied by actual enrollment, compared to plan-reported expenditures in Q1 F-40 reports provided to MassHealth. Originally certified capitation rates reflect the inclusion of GLP-1 drugs for weight loss.

loss in 2025.<sup>154</sup> These results demonstrate the year by year fluctuations in gains and losses, though aggregate payments over the 2020 to 2025 period were close to breakeven (-0.4 percent) even with the outlier losses related to GLP-1 drug expenditures in 2024 and 2025. Additionally, these financial results do not consider the revenue plans received for MCE underwriting gain, which cover the cost of capital (i.e., the amount of reserves a health plan holds for risks assumed) and a contingency margin against losses. From 2020 to 2025, the pharmacy component of underwriting gain paid to MCEs averaged an estimated \$20 million per year.

### c. Recent policy changes and market trend considerations

To provide reasonable estimates of the financial impacts of the reform scenarios as of CY 2026, Marsh adjusted results for three recent policy changes that were expected to have a potentially material effect on drug expenditures and rebates and for which data were available to model the change. First, MassHealth began preferring Humira and Stelara biosimilars (with lower gross costs and rebates) over the brand products with a soft launch in January 2026 and a full rollout in April 2026.<sup>155</sup> Marsh adjusted for this policy change using Humira and Stelara biosimilar drug expenditure and rebate data from first quarter 2026.<sup>156</sup> Second, MassHealth discontinued coverage of GLP-1 drugs for weight loss in July 2026.<sup>157</sup> To account for this policy change, Marsh removed the contribution of these drugs from its savings estimates.<sup>158</sup> Third, Marsh adjusted for the effects of MassHealth's participation in the CMS GENEROUS Model, as estimated by MassHealth.

The CMS GENEROUS Model is a 5-year demonstration program designed to lower Medicaid drug spending by aligning Medicaid net prices with international reference prices for selected drugs.<sup>159</sup> To reduce Medicaid net prices to the relevant international reference price levels, drug manufacturers will provide additional supplemental rebates on GENEROUS drugs.<sup>160</sup> These supplemental rebates will be paid retrospectively for some drugs back to January 1, 2026 (cohort 1) and for other drugs back to April 1, 2026 (cohort 2) if states are in compliance with key terms. MassHealth recently agreed to participate in the program, and it expects to execute contracts for several dozen GENEROUS drugs.<sup>161</sup> MassHealth has estimated the amount of additional GENEROUS supplemental rebates it would receive from cohort 1 drugs in 2026;<sup>162</sup> as noted above, Marsh incorporated these estimates into its analyses.

Marsh also assessed the potential impacts on the savings analyses of market trends occurring between SFY 2024 and CY 2026, including trends relating to changes in ACO-A and MCO plan enrollment, member acuity, pharmacy utilization,

<sup>154</sup> Based on Marsh's estimate of the pharmacy benefit's risk sharing gain/loss across all ACO-A and MCO plans from 2020 through 2025. For 2020-2024, Marsh used actual plan-share results and estimated the pharmacy share based on pharmacy-related expenditures. For 2025, Marsh used MassHealth's RY 2025 Q4 Market Corridor file to estimate the risk sharing gain/loss assuming pharmacy spend is approximately 30% of total spend.

<sup>155</sup> See Bettencourt R, et al. Pharmacy Facts, No. 272. Apr. 10, 2026. <https://www.mass.gov/doc/pharmacy-facts-272-april-10-2026-0/download>, at 2.

<sup>156</sup> To adjust for this formulary change under scenario (C), Marsh removed the estimated drug expenditure change due to brand Humira and Stelara claims and replaced it with the estimated drug expenditure change expected for the biosimilar products based on first quarter 2026 pricing and 340B ceiling price data. Similarly, to adjust for this formulary change under scenario (D), Marsh removed the estimated rebates from brand Humira and Stelara claims and replaced these with the estimated rebates expected for the biosimilar products based on first quarter 2026 rebate information.

<sup>157</sup> See Bettencourt R, et al. Pharmacy Facts, No. 276. May 13, 2026. <https://www.mass.gov/doc/pharmacy-facts-276-may-13-2026-corrected-0/download>, at 1.

<sup>158</sup> To adjust for this coverage change, Mercer identified and removed claims for GLP-1 drugs for weight loss from the baseline capitation rate data. Mercer also removed the impact of these drugs from the drug expenditure change and rebate change estimates.

<sup>159</sup> CMS. GENEROUS (GENERating cost Reductions fOr U.S. Medicaid) Model. Sept. 2026. <https://www.cms.gov/priorities/innovation/innovation-models/generous>. Participation in the program is voluntary for both drug manufacturers and Medicaid agencies, and states may choose which drugs to include. The international reference prices are determined based on each drug's second lowest adjusted net price from among eight countries, including the G7 (excluding the U.S.) plus Denmark and Switzerland.

<sup>160</sup> *Id.*

<sup>161</sup> See CMS. CMS Announces Participants in Landmark Medicaid Drug Payment Model to Bring Down Drug Costs for Most Vulnerable Americans. Sept. 18, 2026. <https://www.cms.gov/newsroom/press-releases/cms-announces-participants-landmark-medicaid-drug-payment-model-bring-down-drug-costs-most>.

<sup>162</sup> MassHealth will receive GENEROUS supplemental rebates on non-340B claims for these drugs under its current carve-in model as well as under all the reform scenarios. However, MassHealth will not receive the supplemental rebates on 340B claims under its current carve-in model or reform scenarios (A), (B), or (C) because states are prohibited from collecting rebates on drugs dispensed through the 340B program. See Sec. II.D.3. Under the FFS carveout with 340B disallowed reform (scenario (D)), MassHealth would be permitted to collect the additional supplemental rebates on GENEROUS drugs previously dispensed through the 340B program. MassHealth estimated the value of these rebates for cohort 1 drugs as the difference between spending on the drugs dispensed through the 340B program based on 2025 utilization priced at NADAC or WAC (if there was no NADAC price) versus the GENEROUS international reference prices. MassHealth did not estimate the value of additional supplemental rebates for cohort 2 drugs because the international reference prices of these drugs have not yet been made available.

and reimbursements (unit costs). The results of these trend estimates are included as a sensitivity analysis below<sup>163</sup> but not incorporated in the main analysis in order to be conservative (adjusting for these trends would increase MassHealth's savings across the reform scenarios).

Marsh did not evaluate and adjust for other considerations that may affect MassHealth's pharmaceutical benefit spending or the potential savings that could be achieved by the reforms.<sup>164</sup>

\* \* \*

**Federal and state shares.** The savings results presented for each scenario include the impact on total MassHealth spending, including the federal and state share. MassHealth's Federal Medical Assistance Percentage, or FMAP, is 50 percent for most members and services, though the FMAP rate is higher for certain services and covered populations.<sup>165</sup> For the changes in pharmacy benefit expenditures, the state would share a portion of the savings from the reforms with the federal government, but if MassHealth reinvests some of the savings in Massachusetts providers, it would likely receive new federal matching funds. To the extent reinvestments are made, MassHealth could leverage new federal matching funds and other available federal funding resources. Some approaches may require CMS approval and/or amendments to state regulations.<sup>166</sup> In its recent draft Section 1115 Demonstration Project Extension Request that has been published for public comment, MassHealth requested funds for the Safety Net Care Pool that supports safety net providers, including for uncompensated care for uninsured patients, as well as "expenditure authority to make hospital access stabilization payments to enable hospitals to stop relying on 340B retail pharmacy margin."<sup>167</sup> For the changes in non-benefit expenditures, the state similarly would share a portion of the savings with the federal government, but it would also likely receive federal matching funds on the new administrative expenses incurred by MassHealth under the reform scenarios. The state share of savings in each reform scenario, as well as any federal funding available for reinvestment in hospitals and new administrative expenses, would affect the state budget impact of the scenarios.

**Exhibit 14** summarizes how key design elements of each reform would affect MassHealth's spending relative to spending under the current carve-in model.

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<sup>163</sup> See Sec. IV.A.2.c.

<sup>164</sup> See Sec. IV.A.3.

<sup>165</sup> See *supra* note 44.

<sup>166</sup> See *supra* note 128.

<sup>167</sup> Massachusetts Executive Office of Health and Human Services. Medicaid Section 1115 Demonstration Project Extension Request. Sept. 14, 2026. <https://www.mass.gov/doc/demonstration-extension-request-2/download>, at 24, 53.

**Exhibit 14.** Comparison of reform elements relative to current carve-in model

● Contributes to MassHealth savings    ● Contributes to MassHealth expenses

|                                                | (A)<br>Single PBM<br>MCEs at risk                                                                   | (B)<br>Single PBM<br>MassHealth at risk                      | (C)<br>FFS carveout<br>340B allowed                                                    | (D)<br>FFS carveout<br>340B disallowed                                                          |
|------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------|----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| <b>Payment flows</b>                           | MassHealth pays MCEs capitation rate; MCEs transfer funds to single PBM; single PBM pays pharmacies | Single PBM pays pharmacies; MassHealth reimburses single PBM | MassHealth directly pays pharmacies                                                    | MassHealth directly pays pharmacies                                                             |
| <b>PHARMACY BENEFIT EXPENDITURES</b>           |                                                                                                     |                                                              |                                                                                        |                                                                                                 |
| <b>Ingredient costs – Non-340B drug claims</b> | No change                                                                                           | No change                                                    | No change                                                                              | No change                                                                                       |
| <b>Ingredient costs – 340B drug claims</b>     | No change                                                                                           | No change                                                    | Significant decrease as 340B drug claims reimbursed at no more than 340B ceiling price | Not applicable because 340B drug claims disallowed                                              |
| <b>Rebates</b>                                 | Small increase due to process efficiencies                                                          | Small increase due to process efficiencies                   | Small increase due to process efficiencies                                             | Significant increase as MassHealth can now collect rebates on previously ineligible 340B claims |
| <b>NON-BENEFIT EXPENDITURES</b>                |                                                                                                     |                                                              |                                                                                        |                                                                                                 |
| <b>Current PBM administrative fees</b>         | Significant decrease (reduced to 0)                                                                 | Significant decrease (reduced to 0)                          | Significant decrease (reduced to 0)                                                    | Significant decrease (reduced to 0)                                                             |
| <b>Single PBM administrative fees</b>          | Moderate increase                                                                                   | Moderate increase                                            | —                                                                                      | —                                                                                               |
| <b>MassHealth administrative expenses</b>      | No change                                                                                           | No change                                                    | Moderate increase                                                                      | Moderate increase                                                                               |
| <b>Risk payments</b>                           | No change                                                                                           | Significant decrease (reduced to 0)                          | Significant decrease (reduced to 0)                                                    | Significant decrease (reduced to 0)                                                             |

Notes: These changes and adjustments for recent policy changes and market trend considerations are described further in the text.

## 2. Results

Each of the MassHealth managed care pharmacy benefit reforms evaluated are estimated to result in savings, with the magnitude of savings varying by reform. As shown in **Exhibit 15**, the single PBM with MCEs at risk reform could save an estimated \$10.1 million (column (A), row (7)), the single PBM with MassHealth at risk reform could save \$34.9 million (column (B), row (7)), the FFS carveout with 340B drug claims allowed reform could save \$151.7 million (column (C), row (7)), and the FFS carveout with 340B drug claims disallowed reform could save \$193.0 million (column (D), row (7)). These savings resulted from decreases in pharmacy benefit expenditures (row (3)) and non-benefit expenditures (row (6)).

**Exhibit 15.** Estimated annual savings from MassHealth managed care pharmacy benefit reforms

| \$ in millions                                     | (A)<br>Single PBM<br>MCEs at risk | (B)<br>Single PBM<br>MassHealth at risk | (C)<br>FFS carveout<br>340B allowed | (D)<br>FFS carveout<br>340B disallowed |
|----------------------------------------------------|-----------------------------------|-----------------------------------------|-------------------------------------|----------------------------------------|
| <b>CHANGES IN PHARMACY BENEFIT EXPENDITURES</b>    |                                   |                                         |                                     |                                        |
| (1) Gross drug expenditures                        | \$0.0                             | \$0.0                                   | (\$115.8)                           | \$0.0                                  |
| (2) Drug manufacturer rebates                      | (\$1.3)                           | (\$1.3)                                 | (\$1.3)                             | (\$158.4)                              |
| (3) Total changes in pharmacy benefit expenditures | <b>(\$1.3)</b>                    | <b>(\$1.3)</b>                          | <b>(\$117.1)</b>                    | <b>(\$158.4)</b>                       |
| <b>CHANGES IN NON-BENEFIT EXPENDITURES</b>         |                                   |                                         |                                     |                                        |
| (4) Administrative expenses                        | (\$8.7)                           | (\$10.2)                                | (\$11.2)                            | (\$11.2)                               |
| (5) Risk payments                                  | \$0.0                             | (\$23.3)                                | (\$23.3)                            | (\$23.3)                               |
| (6) Total changes in non-benefit expenditures      | <b>(\$8.7)</b>                    | <b>(\$33.5)</b>                         | <b>(\$34.6)</b>                     | <b>(\$34.6)</b>                        |
| <b>TOTAL CHANGES</b>                               |                                   |                                         |                                     |                                        |
| (7) Total changes                                  | <b>(\$10.1)</b>                   | <b>(\$34.9)</b>                         | <b>(\$151.7)</b>                    | <b>(\$193.0)</b>                       |

**Note:** Parentheses indicate decreases in expenditures and increases in rebate collections, both of which reflect positive savings. Results reflect savings before any reinvestments MassHealth may make in Massachusetts providers or adjustments for federal and state shares. See Sec. IV.B (discussing potential MassHealth reinvestments in providers); *supra* notes 165-167 and accompanying text (discussing federal and state shares of savings and potential new federal matching funds and other available federal funding resources for reinvestments and new administrative expenditures, including MassHealth's recent draft 1115 Demonstration Project Extension Request that has been published for public comment, which requests funding to support hospitals).

Source: Marsh analysis.

The following sections provide further details on each spending category.

**a. Pharmacy benefit expenditures**

Savings from pharmacy benefit expenditures under the reforms relative to MassHealth's current carve-in model derive from changes to gross drug expenditures and drug manufacturer rebates.<sup>168</sup> In the current carve-in model, ACO-A and MCO members' gross drug expenditures used for CY 2026 capitation rate development totaled an estimated \$1.9 billion.<sup>169</sup> After accounting for \$1.1 billion in drug manufacturer rebates, net drug expenditures totaled approximately \$0.9 billion.<sup>170</sup>

As summarized in **Exhibit 15**, no changes to gross drug expenditures are expected for the single PBM scenarios (scenarios (A) and (B), row (1)).<sup>171</sup> Drug manufacturer rebates are estimated to increase modestly by \$1.3 million (row (2)) due to process efficiencies from having all pharmacy claims under a single PBM program<sup>172</sup> – which represents the total pharmacy benefit expenditure savings for the single PBM scenarios (row (3)).

Under the FFS carveout scenarios (scenarios (C) and (D)), there would be no changes to gross drug expenditures for non-340B drugs. However, the FFS carveout with 340B allowed reform (scenario (C)) would lead to an estimated reduction in gross drug expenditures of \$115.8 million (row (1)). This amount was calculated by repricing the 340B drug

<sup>168</sup> Note that drug expenditures include a small amount of spending on durable medical equipment (2.1 percent of gross expenditures).

<sup>169</sup> These gross drug expenditures reflect repriced amounts based on ACO-A and MCO members' actual utilization. The analysis assumes that MassHealth spending (through capitation payments) are equal to these amounts. Capitation payments, however, are calculated using historical cost and utilization data and adjusted for expected changes in trends and other factors, and so may differ from the repriced amounts based on actual utilization. See Sec. II.D.2.

<sup>170</sup> Marsh analysis of MassHealth data.

<sup>171</sup> See *supra* note 137 and accompanying text.

<sup>172</sup> See *supra* note 140 and accompanying text.

claims from the statutory rate (often NADAC or WAC) to the 340B ceiling price,<sup>173</sup> which generated estimated savings of \$151.7 million, and then adjusting these savings to account for MassHealth's recent shift to preferring Humira and Stelara biosimilars over the brand products and discontinuation of coverage of GLP-1s for weight loss, which reduced the amount MassHealth would save by \$35.3 million and \$0.6 million, respectively.<sup>174</sup> As with the single PBM scenarios, manufacturer rebates are estimated to increase modestly by \$1.3 million due to efficiencies (row (2)).<sup>175</sup> Taken together, changes in pharmacy benefit expenditures under scenario (C) would total \$117.1 million (row (3)).

Under the FFS carveout with 340B disallowed reform (scenario (D)), MassHealth would continue to reimburse claims for drugs previously dispensed through the 340B program at the statutory rate, so gross drug expenditures would remain stable relative to the current carve-in model (row (1)). However, MassHealth would be able to collect additional rebates on these claims (including both statutory and supplemental rebates). Overall, drug manufacturer rebates are estimated to increase \$158.4 million under scenario (D) (row (2)). This amount includes increased rebates collected on previously ineligible 340B drug claims (\$181.0 million),<sup>176</sup> increased rebates due to process efficiencies (\$1.3 million),<sup>177</sup> and additional supplemental rebates on CMS GENEROUS drugs previously dispensed through the 340B program (\$24.0 million),<sup>178</sup> which are offset by lower rebates relating to MassHealth's recent shift to preferring Humira and Stelara biosimilars over the brand products (\$46.9 million) and discontinuation of coverage of GLP-1s for weight loss (\$1.0 million).<sup>179</sup> A key reason the savings in Scenario (D) are greater than in scenario (C) is that MassHealth can collect supplemental rebates on drugs previously dispensed through the 340B program under scenario (D), including rebates that it negotiates with drug manufacturers and additional rebates on drugs included in the CMS GENEROUS program. The savings from these supplemental rebates in addition to the federal rebates that MassHealth collects are greater than the savings MassHealth could achieve under scenario (C) from reimbursing 340B drug claims at no more than the 340B ceiling price.

## **b. Non-benefit expenditures**

Non-benefit expenditures include two main components, administrative expenses and risk payments. Changes in administrative expenses relate to operational changes that would occur under the reforms, while changes in risk payments relate to changes in which entity bears the financial risk for pharmacy spending. As summarized in **Exhibit 15**, row (6), non-benefit expenditures relative to the current carve-in model are estimated to decrease by \$8.7 million under the single PBM with MCEs at risk reform (scenario (A)), by \$33.5 million under the single PBM with MassHealth at risk reform (scenario (B)), and by \$34.6 million under the FFS carveout reforms (scenarios (C) and (D)).

Savings from changes in administrative expenses are presented in row (4) of **Exhibit 15**. As described in Section IV.A.1.b, the components of administrative expenses include existing PBM administrative fees, new single PBM administrative fees (under scenarios (A) and (B)), and new MassHealth administrative expenses (under scenarios (C) and (D)). For all scenarios, the existing PBM administrative fees that are currently included in the capitation rate development as part of the non-medical expenses are first removed since the MCEs would no longer be responsible for contracting with their own PBMs,<sup>180</sup> resulting in savings of \$21.1 million under each scenario. These savings, however, are offset by new administrative expenses that MassHealth would incur, which differ by scenario. For scenario (A), the MCEs would be required to contract with a single PBM selected by MassHealth to provide services aligned with managed care regulations and support the MCE's clinical drug management programs. The new administrative fees for the single

<sup>173</sup> See *supra* note 136 and accompanying text.

<sup>174</sup> See *supra* notes 155-158 and accompanying text. The drug expenditure and rebate adjustment relating to GLP-1 drugs for weight loss was relatively modest because MassHealth started covering GLP-1 drugs for weight loss on January 1, 2024, so the contribution of these drugs to gross drug expenditures was limited to only the second half of the SFY 2024 (the data used to develop RY 2026 capitation rates), utilization was ramping up during this period, and only GLP-1 drugs for weight loss dispensed through the 340B program impact the drug expenditure and rebate savings estimates.

<sup>175</sup> See *supra* note 140 and accompanying text.

<sup>176</sup> See *supra* note 139 and accompanying text.

<sup>177</sup> See *supra* note 140 and accompanying text.

<sup>178</sup> See *supra* notes 159-162 and accompanying text. Further, the amount of additional supplemental rebates on GENEROUS drugs that MassHealth would collect under scenario (D) is expected to increase when the second cohort of 2026 drugs are included as well as when new drugs are added to the program in 2027.

<sup>179</sup> See *supra* notes 155-158 and accompanying text.

<sup>180</sup> See Sec. IV.A.1.b.

PBM are estimated at \$12.4 million.<sup>181</sup> Administrative expense savings would therefore total \$8.7 million for scenario (A) (\$12.4 million – \$21.1 million = \$8.7 million in savings). For scenario (B), MassHealth would select and contract directly with a single PBM that would provide services aligned with managed care regulations. The administrative fees for the single PBM in scenario (B) are estimated at \$11.8 million (less than in scenario (A) because it is assumed that the single PBM in scenario (B) would transition some clinical drug management support services to MassHealth’s DUR services provider).<sup>182</sup> These new expenses would be partially offset by a \$0.9 million reduction in costs for no longer needed actuarial services.<sup>183</sup> Administrative expense savings for scenario (B) would therefore total \$10.2 million (\$11.8 million – \$0.9 million – \$21.1 million = \$10.2 million in savings). For scenarios (C) and (D), MassHealth would incur new expenses for pharmacy benefit administration and DUR services (\$9.3 million) and for additional internal staff (\$1.5 million), partially offset by a reduction in costs for actuarial services (\$0.9 million).<sup>184</sup> Administrative expense savings for scenarios (C) and (D) would therefore total \$11.2 million (\$9.3 million + \$1.5 million – \$0.9 million – \$21.1 million = \$11.2 million in savings).

Savings from changes in risk payments are presented in **Exhibit 15**, row (5). As discussed in Section IV.A.1 above, the risk payment category of non-benefit expenditures includes the MCE underwriting gain associated with pharmacy services, which is calculated as a percentage of total pharmacy expenditures and administration fees. For scenarios (B), (C), and (D), the entire MCE underwriting gain for pharmacy services would be removed from capitation rate development, resulting in estimated savings of \$23.3 million. For scenario (A), there is a slight change in the underwriting gain (\$0.1 million) due to the reduced administrative expenses; this amount has been reported with administrative expenses (row (4)).

### c. Sensitivity analyses related to market trend considerations

In addition to adjusting for recent policy changes (i.e., the shift to Humira/Stelara biosimilars, the discontinuation of coverage of GLP-1 drugs for weight loss, and MassHealth’s participation in the CMS GENEROUS program), Marsh assessed the potential impacts of market trends between SFY 2024 and CY 2026 on the savings analyses by projecting trends related to changes in ACO-A and MCO plan enrollment, member acuity, pharmacy utilization, and reimbursements (unit costs).<sup>185</sup> While ACO-A and MCO enrollment declined by 13.7 percent over the period, a greater share of high-acuity members remained enrolled. Combined with continued growth in prescription drug spending among enrolled members, this resulted in a 20.3 percent increase in per-member-per-month spending on pharmacy benefits. Overall, the offsetting enrollment and utilization trends resulted in a 3.8 percent increase in gross pharmacy expenditures from SFY 2024 to CY 2026. Applying these trends to the MassHealth savings models would increase the amount of funding removed from capitation, thereby increasing the savings associated with MCE risk provisions. It would also increase estimated spending through the 340B program, and therefore the savings associated with those changes in scenarios (C) and (D).

After adjusting for market trend considerations, changes in estimated savings compared with the results presented above would be as follows: savings from the single PBM with MCEs at risk reform (scenario (A)) and the single PBM with MassHealth at risk reform (scenario (B)) would increase slightly by \$50,000 since only the rebate efficiencies changes are incrementally impacted due to gross drug cost trends. The other two reform scenarios would be more affected due to the changes in drug expenditures and rebates. The FFS carveout with 340B drug claims allowed reform (scenario (C)) savings would increase from \$151.7 million to \$156.1 million, and the FFS carveout with 340B drug claims disallowed reform (scenario (D)) savings would increase from \$193.0 million to \$198.1 million. These results are included here as a sensitivity analysis but not incorporated in the main analysis presented above in order to be conservative.

## 3. Changing market dynamics and other considerations

The analyses presented in this report reflect a snapshot in time based on the most recent validated data available. The analyses, however, cannot reliably account for certain recent and future market dynamics and other considerations that

<sup>181</sup> See *supra* note 144 and accompanying text.

<sup>182</sup> See *supra* note 145 and accompanying text.

<sup>183</sup> See *supra* note 146 and accompanying text.

<sup>184</sup> See *supra* notes 147-149 and accompanying text.

<sup>185</sup> Trend developed based on actual experience through August 2026, projected through rest of year. See Sec. IV.A.1.c.

may affect MassHealth's pharmacy benefit expenditures and the potential savings that could be achieved by the reforms. Selected considerations and their potential impacts are discussed below.

**Enrollment changes.** MassHealth enrollment is expected to decline in the coming years as members become uninsured due to provisions in H.R.1 (the One Big Beautiful Bill Act).<sup>186</sup> Enrollment declines may result in lower pharmacy benefit expenditures overall (as fewer members are filling prescriptions), which in turn would reduce the savings that could be generated overall – though savings on a per-member basis would likely still be similar. Enrollment declines could also result in lower administrative expenses under the single PBM scenarios if part of the PBM's compensation is determined on a per-member or per-claim basis.

**New drug entries.** The entry of new, high-priced drugs on the market could increase MassHealth's pharmacy benefit expenditures in future years.<sup>187</sup> Such increases, however, may be offset by new generic drug entries as well as greater uptake of biosimilars.<sup>188</sup> If overall pharmacy benefit expenditures increase, the savings that may be achieved from the reforms could also increase.

**The 340B program.** MassHealth spending on drugs dispensed through the 340B program has increased significantly in recent years. If spending on 340B drugs continues to grow, the savings achieved from the FFS carveout reforms in future years would increase. However, several recent federal drug pricing policies and programs may constrain 340B spending growth and margins. These pricing policies and programs include the Average Manufacturer Price ("AMP") cap<sup>189</sup> and Medicare Maximum Fair Price negotiations,<sup>190</sup> and others that are scheduled to take effect in the months ahead, including CMS's GLOBE and GUARD models.<sup>191</sup> Some drug manufacturers have responded, or may respond, to these federal initiatives by lowering their list prices, which could indirectly affect Medicaid pharmacy spending. Lower list prices reduce Medicaid's gross expenditures, which in turn reduces margins on 340B drug claims and could also result in reduced Medicaid rebates on non-340B drug claims. To the extent 340B margins and Medicaid rebates are reduced due to these federal pricing policies and programs, the savings from the FFS carveout reforms could also be moderated.

**Drug manufacturer rebate disputes.** Some MCEs and their subcontracted PBMs have reported issues with identifying and reporting 340B drug claims to MassHealth, resulting in drug manufacturer rebate disputes. Under the reform scenarios, the number of claims in dispute may decrease, resulting in operational efficiencies and increased rebate collections.

**Cash flow considerations.** The analyses in this report estimate administrative savings assuming the reforms are fully implemented and operating in a steady state. During the implementation period, MassHealth would likely experience a one-time, temporary increases in administrative spending as it transitions from existing to new systems. In addition, under the FFS carveout with 340B disallowed scenario, there would be a lag in invoicing and collections of rebates for claims on drugs previously eligible under the 340B program. These considerations would affect the timing of when MassHealth may realize savings from the reforms.

<sup>186</sup> See App'x D.

<sup>187</sup> See Ferguson R, et al. Drug Trend & Pipeline–2026 and Beyond. Mercer. Feb. 10, 2026. <https://www.mercer-government.mercer.com/our-insights/2026-drug-trend-and-pipeline.html>.

<sup>188</sup> See *id.*

<sup>189</sup> The American Rescue Plan Act removed the AMP cap on Medicaid rebates effective January 1, 2024, allowing Medicaid agencies to collect rebates above the AMP when a drug's list price growth outpaces inflation. While this policy, all else being equal, would increase Medicaid rebate collections, some drug manufacturers have responded by lowering their list prices. See KFF. What Are the Implications of the Recent Elimination of the Medicaid Prescription Drug Rebate Cap? Jan. 16, 2024. <https://www.kff.org/medicaid/what-are-the-implications-of-the-recent-elimination-of-the-medicaid-prescription-drug-rebate-cap>.

<sup>190</sup> Established by the Inflation Reduction Act of 2022, the Medicare Drug Pricing Negotiation Program negotiates maximum fair prices that Medicare will reimburse for selected high-expenditure, single-source drugs and biological products for seniors. See KFF. Key Facts About Medicare Drug Price Negotiation. Mar. 11, 2026. <https://www.kff.org/medicare/key-facts-about-medicare-drug-price-negotiation>. These negotiations do not directly impact Medicaid but some drug manufacturers of selected products have responded by lowering their list prices.

<sup>191</sup> GLOBE refers to the Global Benchmark for Efficient Drug Pricing model and applies to certain drugs filled under Medicare Part B. GUARD refers to the Guarding U.S. Medicare Against Rising Drug Costs model and applies to certain drugs filled under Medicare Part D. Under the GLOBE and GUARD models, manufacturers will be required to pay rebates for selected single source drugs and biologics that exceed certain spending thresholds if the prices paid for those drugs exceed prices in selected comparable countries. See Federal Register. Global Benchmark for Efficient Drug Pricing (GLOBE) Model. Dec. 2025. <https://www.federalregister.gov/documents/2025/12/23/2025-23702/global-benchmark-for-efficient-drug-pricing-globe-model>; Federal Register. Guarding U.S. Medicare Against Rising Drug Costs (GUARD) Model. Dec. 2025. <https://www.federalregister.gov/documents/2025/12/23/2025-23705/guarding-us-medicare-against-rising-drug-costs-guard-model>.

## B. CONSIDERATIONS RELATING TO ACCESS

In addition to generating savings to the state, the MassHealth managed care pharmacy benefit reforms considered in this report would also have implications for access to local retail pharmacies and the provision of hospital care for vulnerable and underserved populations.

### **The number of local retail pharmacies available to ACO-A and MCO plan members would increase under the FFS carveout reforms**

Both MassHealth and MCE/PBMs must maintain adequate pharmacy networks where their members can fill prescriptions. However, “any willing pharmacy” located in Massachusetts may participate in the MassHealth pharmacy network, while MCE/PBMs are permitted to construct limited pharmacy networks that specify the pharmacies available to members in order to control costs through reimbursement rate negotiations.<sup>192</sup> In addition, MCE/PBMs may require members to fill prescriptions for specialty drugs at designated specialty pharmacies, some of which may exclusively dispense drugs through mail order.

Using the MassHealth files from CHIA’s Massachusetts All Payer Claims Database (“APCD”) for 2023 (the latest data available), the HPC assessed the difference in the number of local retail pharmacies that dispensed prescriptions for ACO-A and MCO plan members compared to members with MassHealth-administered pharmacy benefits (ACO-B, PCC, and FFS primary).<sup>193</sup> The dispensing of all drugs and specialty drugs were examined separately. ACO-A and MCO plan members had fewer local retail pharmacies in-network than members with access to MassHealth’s pharmacy network across all regions, ranging from 1.9 to 11.2 percent fewer for all drugs and 12.5 to 59.5 percent fewer for specialty drugs.<sup>194</sup> Under the reforms considered in this report, the single PBM would still be allowed to maintain a limited pharmacy network, subject to MassHealth oversight,<sup>195</sup> while all members would be shifted to MassHealth’s broader pharmacy network under the FFS carveout scenarios.

### **Higher pharmacy reimbursement rates under the single PBM and FFS carveout reforms evaluated in this report may help preserve access to local retail pharmacies**

In a recent survey of Massachusetts’ pharmacies, two-thirds of respondents identified low reimbursements as a concern.<sup>196</sup> Low reimbursements may materially impact the financial viability of pharmacies.<sup>197</sup> Last year, the HPC assessed trends in pharmacy closures in Massachusetts and found that the number of pharmacies decreased by 17 percent (with nearly 200 net closings) over the 2019-2025 period.<sup>198</sup>

Under the reforms evaluated in this report, the FFS carveout scenarios would shift pharmacy reimbursements from MCE/PBM contracted rates to MassHealth FFS statutory rates, and the single PBM scenarios could also be structured to do so. The MassHealth FFS rate includes a statutory rate for ingredient costs (often NADAC or WAC) plus a professional dispensing fee (currently \$10.02).<sup>199</sup>

<sup>192</sup> See Sec. II.C (discussing pharmacy network design and contracting).

<sup>193</sup> A pharmacy was designated as being in-network for ACO-A and MCO plan members if the pharmacy filled more than 10 claims for the MCE’s members during the year. The analytic sample for the all-drugs analysis included 14.1 million drug claims dispensed by 1,148 pharmacies for members with MassHealth-administered pharmacy benefits and 1,128 pharmacies for members in ACO-A and MCO plans. The sample for the specialty drugs analysis included approximately 67,000 drug claims dispensed by 926 pharmacies for members with MassHealth-administered pharmacy benefits and 769 pharmacies for members in ACO-A and MCO plans. To account for variation in where ACO-A and MCO plan members reside, the HPC identified by region the number of local retail pharmacies that dispensed drugs to members of each MCE and then calculated the average number of pharmacies across MCEs in a region weighted by MCE membership in the region.

<sup>194</sup> For the all-drugs analysis, the largest differences were observed in the Cape and Islands (11.1 percent) and Western Massachusetts (11.2 percent) regions. For the specialty drugs analysis, the largest differences were observed in the Central Massachusetts (59.5 percent), Cape and Islands (59.1 percent), and South Coast (56.5 percent) regions.

<sup>195</sup> For example, MassHealth could impose certain rules such as prohibiting the PBM from steering prescriptions to its affiliated pharmacies.

<sup>196</sup> See Three Axis Advisors. Massachusetts Pharmacy Survey. Mar. 2026 (unpublished).

<sup>197</sup> See, e.g., Guadamuz J, et al. More US pharmacies closed than opened in 2018-21; Independent pharmacies, those in Black, Latinx communities most at risk. Health Affairs. Dec. 2024, at 1703-04 (“Low reimbursement rates by state Medicaid programs and PBMs . . . may affect pharmacies’ profitability and lead to disparate closure rates.”).

<sup>198</sup> Massachusetts Health Policy Commission. DataPoints issue 31: When the closest pharmacy is too far: Mapping pharmacy deserts in Massachusetts. Oct. 2025. <https://masshpc.gov/publications/datapoints-series/issue-31-when-closest-pharmacy-too-far-mapping-pharmacy-deserts>, at 3.

<sup>199</sup> See Sec. II.D.

Using 2023 APCD MassHealth data (the latest data available), the HPC found that ACO-A and MCO plans reimbursed pharmacies less than the estimated MassHealth FFS reimbursement rate on 76 percent of claims.<sup>200</sup> The reforms considered in this report would likely increase payments to pharmacies,<sup>201</sup> which could help mitigate closures and preserve pharmacy access. Such reforms could be implemented without materially impacting MassHealth’s overall pharmacy spending because MassHealth would shift from paying drug acquisition costs and professional dispensing fees in the MCE capitation rates to reimbursing pharmacies for these amounts.

**The FFS carveout reforms would reduce 340B revenue for hospitals participating in the 340B program; MassHealth savings could be strategically reinvested in Massachusetts hospitals and other providers serving vulnerable and underserved populations**

The FFS carveout reforms considered in this report would result in savings for MassHealth but reduce 340B revenue for hospitals participating in the 340B program, which was established to support health care providers serving vulnerable and underserved populations. The law, however, does not specify how 340B hospitals must use 340B revenue,<sup>202</sup> and participating hospitals vary widely in the amount of uncompensated care they provide. In 2024 (the latest data available), uncompensated care costs as a percentage of net patient service revenue ranged across 340B hospitals from less than 1 percent on the low end to over 8 percent for the hospitals with the highest proportion of uncompensated care costs, with the median 340B hospital reporting 1.7 percent.<sup>203</sup> While hospital uncompensated care costs as a percentage of net patient service revenue have been flat over the past five years, the burden of uncompensated care is anticipated to increase as individuals become uninsured as a result of H.R.1 (the One Big Beautiful Bill Act).<sup>204</sup> If one of the FFS carveout reforms is implemented, MassHealth could strategically reinvest savings in Massachusetts hospitals and other providers that are providing care for vulnerable and underserved populations. To the extent this occurs, MassHealth could leverage new federal matching funds and other available federal funding resources on these reinvestments.<sup>205</sup> In its recent draft Section 1115 Demonstration Project Extension Request that has been published for public comment, MassHealth requested funds for the Safety Net Care Pool that supports safety net providers, including for uncompensated care for uninsured patients, as well as “expenditure authority to make hospital access stabilization payments to enable hospitals to stop relying on 340B retail pharmacy margin.”<sup>206</sup>

<sup>200</sup> The HPC compared the amount that pharmacies were reimbursed by ACO-A and MCO plans for ingredient costs and dispensing fees with estimated MassHealth FFS reimbursement rates for the claims based on NADAC drug acquisition costs and professional dispensing fees. The sample included approximately 6.9 million claims dispensed at 1,061 local retail pharmacies. The following pharmacy types were included in the sample: mass merchant (e.g., Costco and Walmart), chain (e.g., CVS and Walgreens), independent (with three or fewer locations), grocery, and provider-based pharmacies. Out-of-state, mail order, specialty, and FQHC pharmacies were excluded (the latter are already reimbursed based on MassHealth FFS methodology). By pharmacy type, the proportion of claims for which ACO-A and MCO reimbursements were below estimated MassHealth FFS reimbursements ranged from 75-84 percent. The dispensing fee paid by ACO-A and MCO plans averaged \$0.50 per claim, which is lower than the \$10.02 professional dispensing fee typically paid by MassHealth FFS.

<sup>201</sup> This analysis identifies claims for which pharmacies are reimbursed less than MassHealth FFS reimbursements. The financial impact of these claims on pharmacies are offset by claims paid above MassHealth FFS reimbursements. After accounting for these offsets, pharmacies were still reimbursed less by ACO-A and MCO plans than they would have been paid based on MassHealth FFS reimbursements for the claims in the sample. The HPC’s sample, however, does not include all claims (notably, claims without a NADAC are excluded), so the full financial impact on pharmacies cannot be assessed.

<sup>202</sup> Under the law, however, 340B federal grantees (i.e., non-hospital 340B covered entities that qualify for the 340B program through federal grant funding, such as FQHCs and Ryan White Clinics) are subject to their grant requirements, which generally specify that their funding be used to provide high-quality, affordable care to underserved patients. See Congressional Budget Office, *supra* note 74, at 6.

<sup>203</sup> 340B participation was identified from HRSA’s Office of Pharmacy Information Systems data. Uncompensated care costs include two components, charity care and bad debt. Uncompensated care costs and net patient service revenue data were derived from the National Academy for State Health Policy (“NASHP”) Hospital Cost Tool, which sources its data from the CMS hospital cost reports. Uncompensated care metrics are commonly assessed in the academic literature. See, e.g., Levengood TW, et al. Assessing the impact of the 340B Drug Pricing Program: a scoping review of the empirical, peer-reviewed literature. *Milbank Quarterly*. Jun. 2024; 102(2):429-62; Desai S, McWilliams JM. The 340B Drug Pricing Program and hospital provision of uncompensated care. *American Journal of Managed Care*. Oct. 2021; 27(10):432.

<sup>204</sup> See App’x D.

<sup>205</sup> See *supra* notes 165-167 and accompanying text.

<sup>206</sup> Massachusetts Executive Office of Health and Human Services. Medicaid Section 1115 Demonstration Project Extension Request. Sept. 14, 2026. <https://www.mass.gov/doc/demonstration-extension-request-2/download>, at 24, 53.

## V. CONCLUSION

The HPC engaged the actuarial firm Marsh Government Health Consulting to support policymakers, the Healey-Driscoll Administration, and MassHealth in assessing the impact of four managed care pharmacy benefit reforms on MassHealth's pharmacy spending, including (1) the single PBM with MCEs at risk scenario, (2) the single PBM with MassHealth at risk scenario, (3) the FFS carveout with 340B allowed scenario, and (4) the FFS carveout with 340B drug claims disallowed scenario. Each of the scenarios is estimated to generate savings, though the magnitudes of savings differ by reform: the single PBM reforms are estimated to save from \$10.1 million to \$34.9 million, while the FFS carveout reforms are estimated to save from \$151.7 million to \$193.0 million. These results reflect savings of state and federal funds before MassHealth deploys savings from the reforms. MassHealth could strategically deploy the savings from the reforms in various ways, including by reinvesting a portion of the savings in Massachusetts hospitals and other providers serving vulnerable and underserved populations, for which it would likely receive new federal matching funds. The HPC also found that the reforms could enhance access to local retail pharmacies.

As the Commonwealth considers these and other potential reforms to the MassHealth pharmacy benefit to advance program sustainability, the HPC and the Office of Pharmaceutical Policy and Analysis stand ready to support these efforts with additional objective data insights and independent policy leadership.

# APPENDIX

## APPENDIX A: GLOSSARY OF ABBREVIATIONS

| TERM             | DEFINITION                                                                                     |
|------------------|------------------------------------------------------------------------------------------------|
| <b>AAC</b>       | Actual Acquisition Cost                                                                        |
| <b>ACO-A</b>     | Accountable Care Partnership Plans or ACPP (MassHealth delivery system type)                   |
| <b>ACO-B</b>     | Primary Care ACO Plan or PCACO (MassHealth delivery system type)                               |
| <b>AMP</b>       | Average Manufacturer Price (ingredient cost price benchmark)                                   |
| <b>AWP</b>       | Average Wholesale Price (ingredient cost price benchmark)                                      |
| <b>CHIA</b>      | Center for Health Information & Analysis                                                       |
| <b>CMS</b>       | Centers for Medicare & Medicaid Services                                                       |
| <b>Conduent</b>  | Conduent Business Services, LLC (pharmacy benefit administrator)                               |
| <b>CY</b>        | Calendar year                                                                                  |
| <b>ForHealth</b> | University of Massachusetts Chan Medical School, ForHealth Consulting                          |
| <b>FFS</b>       | Fee-for-service (MassHealth delivery system type)                                              |
| <b>FFY</b>       | Federal fiscal year (October 1 to September 30)                                                |
| <b>FMAP</b>      | Federal Medical Assistance Percentage                                                          |
| <b>FQHC</b>      | Federally Qualified Health Center                                                              |
| <b>HPC</b>       | Massachusetts Health Policy Commission                                                         |
| <b>H.R.1</b>     | One Big Beautiful Bill Act, H.R.1, Pub. L. No. 119-21                                          |
| <b>MAC</b>       | Maximum allowable cost (PBM proprietary ingredient cost price)                                 |
| <b>Marsh</b>     | Marsh Government Health Consulting, formerly named Mercer Government Human Services Consulting |
| <b>MCE</b>       | Managed care entity                                                                            |
| <b>MCO</b>       | Managed Care Organization (MassHealth delivery system type)                                    |
| <b>NADAC</b>     | National Average Drug Acquisition Cost (pharmacy acquisition cost price benchmark)             |
| <b>NASHP</b>     | National Academy for State Health Policy                                                       |
| <b>PBA</b>       | Pharmacy benefit administrator                                                                 |
| <b>PBM</b>       | Pharmacy benefit manager                                                                       |
| <b>PCC</b>       | Primary Care Clinician Plan (MassHealth delivery system type)                                  |
| <b>RY</b>        | Rate year                                                                                      |
| <b>SFY</b>       | State fiscal year (July 1 to June 30)                                                          |
| <b>WAC</b>       | Wholesale Acquisition Cost (ingredient cost price benchmark)                                   |

## APPENDIX B: MASSHEALTH DELIVERY SYSTEMS

This section describes the delivery systems through which MassHealth provides benefits to members. MassHealth benefits are either managed by a managed care entity through a variety of managed care health plans or directly by MassHealth through FFS coverage. MassHealth provides primary coverage for members who do not have other insurance and secondary, or wrap-around, coverage for members who are also covered by Medicare, an employer-sponsored plan, or other insurance. In general, members with MassHealth as their primary insurer who are under age 65 and living in a community setting (rather than an institution) are required to enroll in a managed care health plan.<sup>207</sup> In SFY 2024, two-thirds of MassHealth members were enrolled in managed care health plans, including 94 percent of members with MassHealth as their primary source of coverage.<sup>208</sup> MassHealth’s different managed care and FFS offerings are described in this section.

### 1. Primary managed care coverage

MassHealth contracts with MCEs to offer managed care health plans. In general, MCEs bear the financial risk of coverage and MassHealth pays the MCEs a capitation payment, which is a fixed per-member-per-month amount designed to cover the expected cost of member care and non-benefit expenses.<sup>209</sup> Two types of accountable care organizations (“ACOs”) and two other types of MCEs currently provide primary coverage for MassHealth members. Established in 2018 under a Section 1115 Demonstration Waiver, MassHealth’s two ACO programs includes Accountable Care Partnership Plans (“ACO-As”) and Primary Care ACOs (“ACO-Bs”). The two other managed care options are Managed Care Organizations (“MCOs”) and the Primary Care Clinician Plan (“PCC”).

These four types of MassHealth managed care delivery systems are described further below. Two types of MCEs (ACO-As and MCOs) contract with PBMs to manage the pharmacy benefit for their members. The managed care pharmacy benefit reforms assessed in this report focus on these MCEs. By contrast, MassHealth itself administers the pharmacy benefit for the two other types of MCEs (ACO-Bs and PCC). See **Exhibit A-1**.

**Exhibit A-1.** Types of primary managed care delivery systems

| Pharmacy benefits administered by | Abbreviation | Delivery system                            | Number of managed care health plans |
|-----------------------------------|--------------|--------------------------------------------|-------------------------------------|
| <b>MCE/PBM</b>                    | ACO-A        | Accountable Care Partnership Plan          | 15                                  |
| <b>MCE/PBM</b>                    | MCO          | Managed Care Organization                  | 2                                   |
| <b>MassHealth</b>                 | ACO-B        | Primary Care Accountable Care Organization | 2                                   |
| <b>MassHealth</b>                 | PCC          | Primary Care Clinician Plan                | 1                                   |

Notes: MCE is managed care entity; PBM is pharmacy benefit manager.

**Accountable Care Partnership (ACO-A) Plans.** Under this delivery system model, managed care health plans partner with provider organizations to form Accountable Care Partnership Plans, or ACO-As. MassHealth pays ACO-As a fixed per-member-per-month capitation rate to cover the health care costs of their members, including medical and pharmacy benefits and administrative expenses.<sup>210</sup> ACO-As are at risk for their members’ total cost of care, sharing financial gains

<sup>207</sup> What to Know About ACOs, *supra* note 83, at 6.

<sup>208</sup> HPC analysis of CHIA Enrollment Trends Databook. Mar. 2025.

<sup>209</sup> Capitation rate setting is described in Sec. II.D.2.

<sup>210</sup> *Id.*

from any savings they may generate, but also facing financial losses if their costs are higher than expected.<sup>211</sup> These arrangements seek to promote care coordination and control spending. As of the end of SFY 2024, five managed care health plans had partnered with 15 provider organizations to form 15 ACO-As covering approximately 860,000 members.<sup>212</sup>

**Managed Care Organization (MCO) Plans.** A small but declining number of MassHealth members are enrolled in Managed Care Organization plans. MCOs are paid a fixed per-member-per-month capitation rate to cover their members' health care costs, including medical and pharmacy benefits and administrative expenses.<sup>213</sup> Unlike ACO-As, MCOs do not enter into partnerships with provider organizations to coordinate care delivery.<sup>214</sup> As of the end of SFY 2024, two MCOs covered approximately 54,000 MassHealth members.<sup>215</sup> This delivery system is being phased out and MCO plans will no longer be offered in 2028.<sup>216</sup>

**Primary Care ACO (ACO-B) Plans.** Primary Care ACO plans, or ACO-Bs, consist of groups of physicians that deliver primary care services while relying on MassHealth's provider network to deliver other services including hospital and specialty care. MassHealth pays ACO-Bs a fixed per-member-per-month capitation rate for primary care and care coordination services, while other providers are paid on a FFS basis. MassHealth manages the pharmacy benefit for ACO-Bs. Similar to ACO-As, ACO-Bs are at risk for their members' spending, sharing in financial savings or losses relative to a total cost of care benchmark.<sup>217</sup> As of the end of SFY 2024, MassHealth offered two ACO-Bs covering approximately 293,000 members.<sup>218</sup>

**The Primary Care Clinician (PCC) Plan.** Under this delivery system model, a member's primary care provider is responsible for providing primary care and care coordination services, while members may utilize MassHealth's provider network for hospital, specialty care, and other services. MassHealth manages the pharmacy benefit for the PCC plan. Most services, including pharmacy services, are reimbursed on a FFS basis.<sup>219</sup> In SFY 2024, approximately 52,000 MassHealth members were enrolled in the PCC plan.<sup>220</sup>

## 2. Fee-for-service primary coverage

While most members with MassHealth as their primary source of coverage are enrolled in a managed care health plan, selected members are eligible for FFS coverage.<sup>221</sup> Approximately 77,000 MassHealth members had FFS primary coverage as of the end of SFY 2024.<sup>222</sup> MassHealth manages the pharmacy benefit for these members, but they do not receive care coordination services.

<sup>211</sup> See What to Know About ACOs, *supra* note 83, at 3-4.

<sup>212</sup> HPC analysis of CHIA Enrollment Trends Databook, Mar. 2025. The five managed care health plans include Fallon Health, Health New England, Mass General Brigham Health Plan, Tufts Health, and WellSense, and the 15 ACO-As include Fallon Health-Atrius Health Care Collaborative, Berkshire Fallon Health Collaborative, Fallon 365 Care, BeHealthy Partnership Plan, Mass General Brigham, Tufts Health Together with Cambridge Health Alliance, Tufts Health Together with UMass Memorial Health, East Boston Neighborhood Health WellSense Alliance, WellSense Beth Israel Lahey Health Performance Network ACO, WellSense Boston Children's ACO, WellSense Care Alliance, WellSense Community Alliance, WellSense Mercy Alliance, WellSense Signature Alliance, and WellSense Suncoast Alliance. See What to Know About ACOs, *supra* note 83, at 3.

<sup>213</sup> Capitation rate setting is described further in Sec. II.D.2. MCOs are not accountable care organizations and do not share financial gains or losses relative to total cost of care.

<sup>214</sup> See What to Know About ACOs, *supra* note 83, at 6.

<sup>215</sup> The two MCOs are WellSense Essential MCO and Tufts Health Together.

<sup>216</sup> See Basics, *supra* note 18, at 20.

<sup>217</sup> See What to Know About ACOs, *supra* note 83, at 3.

<sup>218</sup> HPC analysis of CHIA Enrollment Trends Databook, Mar. 2025. The two ACO-Bs were Community Care Cooperative and Revere Health Choice (previously Steward Health Choice).

<sup>219</sup> See Basics, *supra* note 18, at 34.

<sup>220</sup> HPC analysis of CHIA Enrollment Trends Databook, Mar. 2025.

<sup>221</sup> This population includes, for example, members under age 65 who are receiving services from the Department of Children and Families or Department of Youth Services; members under age 65 who are enrolled in a home- and community based services waiver; members over age 65 who do not have another form of insurance; members living in a nursing facility, chronic disease or rehabilitation hospital, intermediate care facility for individuals with intellectual disabilities, or a state psychiatric hospital for other than a short-term rehabilitative stay; members who are receiving hospice care or are terminally ill.

<sup>222</sup> HPC analysis of CHIA Enrollment Trends Databook, Mar. 2025.

### 3. Secondary coverage

MassHealth provides secondary coverage to approximately 750,000 members. The majority of these members' benefits, including the pharmacy benefit, are covered by their primary insurer (e.g., Medicare or an employer-sponsored plan). Most secondary coverage is provided through MassHealth FFS (598,000 members).<sup>223</sup> Secondary coverage is also provided through specific managed care programs, including the Program of All-inclusive Care for the Elderly (PACE), Senior Care Options (SCO), and One Care (127,000 member).<sup>224</sup> These managed care programs combine Medicare and Medicaid benefit for older adults and those with disabilities.

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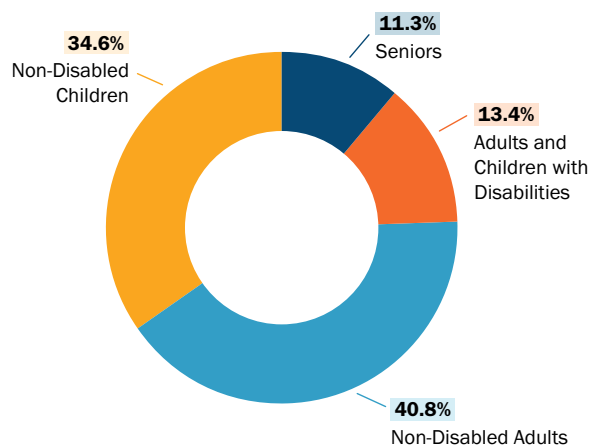
<sup>223</sup> *Id.* Enrollment as of SFY-end 2024.

<sup>224</sup> *Id.* Enrollment as of SFY-end 2024.

## APPENDIX C: MASSHEALTH TOTAL ENROLLMENT AND SPENDING

In 2024, MassHealth covered approximately 2 million people, representing over 25 percent of Massachusetts residents.<sup>225</sup> To be eligible for MassHealth coverage, members must satisfy certain requirements, including income limits that differ by age and health status but generally range from 150-200 percent of the federal poverty level for children and 133-250 percent for adults with selected medical conditions.<sup>226</sup> The shares of MassHealth members by age and disability status are shown in **Exhibit A-2**.

**Exhibit A-2. MassHealth Enrollment by Populations Served, SFY 2024**  
(% of total)



Source: HPC analysis of MassHealth Snapshot Enrollment Summary of June 2025 Caseload.

**Exhibit A-3** presents MassHealth enrollment trends over the SFY 2019-2024 period. During the COVID-19 Public Health Emergency from SFY 2020-2023, enrollment grew by approximately 35 percent to over 2.4 million members as state Medicaid agencies were required to maintain eligibility for most enrollees in exchange for enhanced federal funding.<sup>227</sup> After the Public Health Emergency ended, states started performing eligibility redeterminations and enrollment declined; this period is sometimes referred to as “the unwinding.”<sup>228</sup> During SFY 2024, MassHealth enrollment declined by 15 percent to just over 2 million members. While most of these individuals were able to obtain insurance through the Massachusetts Health Connector,<sup>229</sup> enrollment is projected to continue to decline as various new policies imposed by H.R.1 (the One Big Beautiful Bill Act) take effect.<sup>230</sup>

MassHealth total service spending is presented in **Exhibit A-4**. Overall, service spending grew at a compound annual growth rate of 7.6 percent during the SFY 2019 (\$14.3 billion) to SFY 2024 (\$20.6 billion) period.<sup>231</sup> On an

<sup>225</sup> See Basics, *supra* note 18, at 4.

<sup>226</sup> In 2025, the federal poverty level for a family of four (100 percent) was \$32,150. See U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. 2025 poverty guidelines: 48 contiguous states (all states except Alaska and Hawaii). <https://aspe.hhs.gov/sites/default/files/documents/dd73d4f00d8a819d10b2fdb70d254f7b/detailed-guidelines-2025.pdf>, at 1. Eligibility requirements differ for seniors with MassHealth as secondary coverage. See Basics, *supra* note 18, at 8-9. Eligibility criteria also determine coverage type placements; MassHealth has five coverage types, including Standard (the most comprehensive benefit, covering about 57 percent of MassHealth members), CommonHealth (for higher-income children and adults with disabilities), CarePlus (for childless adults who do not qualify for other types of benefits), Family Assistance (for children with higher family incomes, higher-income adults with HIV-AIDs, and certain people who do not qualify for Standard due to immigration status), and Limited (for people that do not qualify for other benefits due to immigration status). See Basics, *supra* note 18, at 19.

<sup>227</sup> See Basics, *supra* note 18, at 11.

<sup>228</sup> See, e.g., CMS. Unwinding and Returning to Regular Operations after COVID-19. <https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/archived-unwinding-and-returning-regular-operations-after-covid-19>.

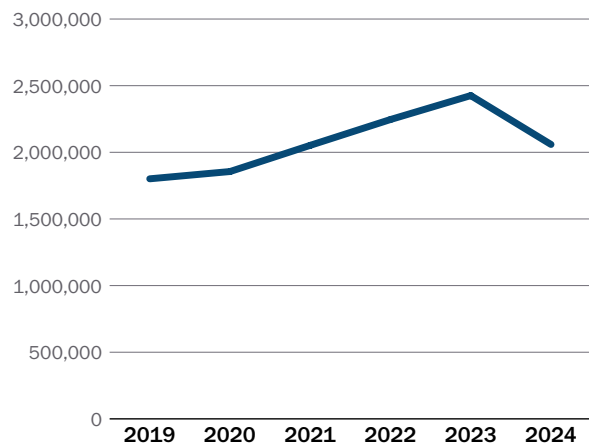
<sup>229</sup> CHIA. Annual Report 2026: Performance of the Massachusetts Health Care System. Pub. No. 26-071-CHIA-01. Mar. 2026, at 8. The Massachusetts Health Connector offers subsidized insurance coverage through its state-based marketplace. See Massachusetts Health Connector. Who we are. <https://www.mahealthconnector.org/about/who-we-are>.

<sup>230</sup> See App’x D.

<sup>231</sup> See Basics, *supra* note 18, at 30.

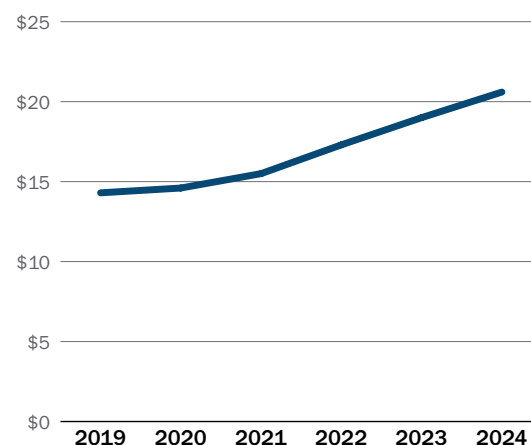
inflation-adjusted basis, spending increased at a compound annual growth rate of 5.5 percent over this period.<sup>232</sup> Although enrollment declined in SFY 2024, spending continued to rise due to increased investments in selected service areas (e.g., in primary care, behavioral health, and long-term services and supports) and selection bias (members who remained enrolled in MassHealth after the unwinding had higher health care costs, on average).<sup>233</sup>

**Exhibit A-3. MassHealth Total Enrollment, SFY 2019-2024**  
(number of enrollees)



Source: HPC analysis of CHIA Enrollment Trends Databook, Mar. 2025.

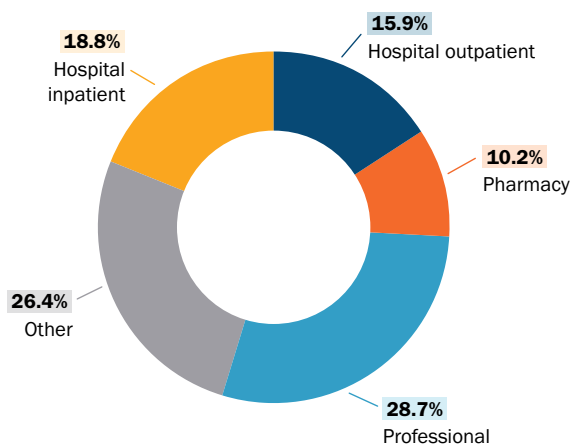
**Exhibit A-4. MassHealth Total Service Spending, SFY 2019-2024**  
(\$ in billions)



Source: Basics, *supra* note 18, at 30.

MassHealth service spending by category during 2024 is presented in **Exhibit A-5**. Pharmacy spending, net of drug manufacturer rebates, accounted for 10.2 percent of all claims-based spending.

**Exhibit A-5. MassHealth Service Spending by Category, 2024**  
(% of total)



**Notes:** Pharmacy spending is net of drug manufacturer rebates. Hospital inpatient and outpatient spending includes facility spending only. Professional spending includes physician and other provider types. Other primarily includes spending for dental, home health, and long-term care. Non-claims-based payments are excluded.

Source: HPC analysis of CHIA Total Health Care Expenditure Data, Feb. 2026.

<sup>232</sup> See *id.*

<sup>233</sup> See *id.* at 31.

## APPENDIX D: H.R.1 AND ITS PROJECTED IMPACTS ON MASSHEALTH

On July 4, 2025, the One Big Beautiful Bill Act, H.R.1, was signed into law.<sup>234</sup> H.R.1 reduces Medicaid program funding by \$900 billion over the 2025-2034 period, according to the Congressional Budget Office.<sup>235</sup> These funding cuts to Medicaid partially offset H.R.1's estimated \$3.4 trillion in tax cuts.<sup>236</sup> Changes to the Medicaid program imposed by H.R.1 are projected to result in 7.8 million Americans becoming uninsured over the next ten years.<sup>237</sup>

In Massachusetts, the Massachusetts Taxpayers Foundation estimates that H.R.1 policies will reduce MassHealth funding by \$532 million in Federal Fiscal Year (FFY) 2026, \$1.4 billion in FFY 2027, and \$1.7 billion in FFY 2028, increasing in later years and totaling \$24 billion over the 2025-2034 period.<sup>238</sup> The Blue Cross Blue Shield of Massachusetts Foundation and the Urban Institute estimate that roughly 140,000-203,000 MassHealth members will lose coverage due to selected H.R.1 provisions, with 110,000-180,000 members becoming uninsured as a result.<sup>239</sup>

H.R.1's projected fiscal impacts on MassHealth are driven by the changes to Medicaid financing structures included in the law, as well as by provisions that will likely cause significant reductions in coverage. First, H.R.1 imposes new restrictions on state-directed payments, limiting these payments to 100 or 110 percent of Medicare rates.<sup>240</sup> Historically, state-directed payments allowed Medicaid programs to provide higher reimbursements on selected services. Because standard Medicaid reimbursement rates are commonly below Medicare rates, and sometimes far below commercial rates, many Medicaid programs (including MassHealth) have used state-directed payments to support safety net providers who treat a large share of Medicaid patients.<sup>241</sup> H.R.1 hinders MassHealth's ability to provide these payments, which also affects MassHealth's funding as lower state-directed payments also result in reduced federal matching funds.<sup>242</sup> Second, H.R.1 places a moratorium on the use of provider taxes. Most states employ provider taxes to draw down additional federal matching funds.<sup>243</sup> H.R.1 prohibits new provider taxes and phases down current provider tax rates from as high as 6 percent to a cap of 3.5 percent in Medicaid expansion states beginning in FFY 2028.<sup>244</sup> Third, and relatedly, H.R.1 requires that provider taxes be uniform across provider types. This provision will affect taxes that Massachusetts levies on Medicaid managed care organizations, resulting in a projected loss to the state budget of \$70 million annually.<sup>245</sup>

The projected loss of coverage for MassHealth members is mainly driven by two H.R.1 policies. First, H.R.1 imposes a work requirement (effective in 2027), which requires most individuals age 19 to 64 to demonstrate that they work,

<sup>234</sup> One Big Beautiful Bill Act, H.R.1, Pub. L. No. 119-21.

<sup>235</sup> H.R.1 also eliminates coverage for certain Affordable Care Act exchange plan enrollees and is expected to reduce enrollment by tightening eligibility requirements and verification processes. Combined with the Medicaid funding cuts, H.R.1 cuts over \$1 trillion in health care. See Congressional Budget Office. Estimated budgetary effects of Public Law 119-21, to provide for reconciliation pursuant to Title II of H. Con. Res. 14, relative to CBO's January 2025 baseline. July 21, 2025. <https://www.cbo.gov/publication/61570>.

<sup>236</sup> See *id.*

<sup>237</sup> Additionally, over 2 million Americans with exchange plan coverage are projected to become uninsured due to H.R.1's funding cuts. See Congressional Budget Office. Estimated effects on the number of uninsured people in 2034 resulting from policies incorporated within CBO's baseline projections and H.R.1, the One Big Beautiful Bill Act. June 4, 2025. <https://www.cbo.gov/publication/61463>, at 3.

<sup>238</sup> Massachusetts Taxpayers Foundation, *supra* note 21, at 2.

<sup>239</sup> These loss of coverage estimates relate to H.R.1's new work requirements, which are discussed below. See Buettgens, *supra* note 22, at 4; see also Buettgens M, et al. Millions could lose Medicaid coverage due to new rules. Robert Wood Johnson Foundation. Mar. 2026. <https://www.rwjf.org/en/insights/our-research/2026/03/millions-could-lose-health-coverage-due-to-new-rules.html>, at 28 (estimating 99,000-202,000 MassHealth members will lose coverage due to work requirements and six-month redeterminations).

<sup>240</sup> These restrictions apply to all new state state-directed payments, while existing state-directed payments will be reduced by 10 percentage points per year starting in January 2028 until reaching compliance with the new caps. See KFF. Implementation dates for 2025 budget reconciliation law. <https://www.kff.org/medicaid/implementation-dates-for-2025-budget-reconciliation-law>.

<sup>241</sup> See Joyce D, Marceno L. How new limits on state provider taxes will affect Medicaid funding. Commonwealth Fund. Dec. 19, 2025. <https://www.commonwealthfund.org/publications/explainer/2025/dec/how-new-limits-state-provider-taxes-will-affect-medicare-funding>.

<sup>242</sup> KFF. Health provisions in the 2025 federal budget reconciliation law. Aug. 22, 2025. <https://www.kff.org/medicaid/health-provisions-in-the-2025-federal-budget-reconciliation-law/> [hereinafter, "KFF Summary of H.R.1"].

<sup>243</sup> In general, provider taxes work as follows: a state sets a provider tax rate; the capitation rate paid to MCEs includes funding for the provider tax; both state and federal government payments cover the capitation rate's funding for the provider tax, but the state retains the entire tax; hence, states are able to draw additional federal matching funds through provider taxes. See KFF Summary of H.R.1, *supra* note 242.

<sup>244</sup> See KFF Summary of H.R.1, *supra* note 242.

<sup>245</sup> See Massachusetts Taxpayers Foundation, *supra* note 21, at 9.

participate in qualified community engagement activities for 80 hours per month, or attend school at least half-time.<sup>246</sup> The majority of Medicaid members, however, already work or qualify for an exemption.<sup>247</sup> Further, evidence from states that have implemented Medicaid work requirements suggests that many eligible individuals will lose coverage because they are unaware of the requirements or related exemptions or unable to comply with the administrative burdens of consistently documenting and submitting proof of hours worked.<sup>248</sup> Second, H.R.1 requires eligibility redeterminations every six months (rather than annually), adding new administrative burdens that are projected to further reduce coverage.<sup>249</sup>

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<sup>246</sup> Limited exceptions to the Medicaid work requirement are provided for medically frail individuals, parents of children 13 and under, and individuals participating in a substance use disorder program. Limited exceptions to the Medicaid work requirement are provided for medically frail individuals, parents of children 13 and under, and individuals participating in a substance use disorder program. See KFF Summary of H.R.1, *supra* note 242.

<sup>247</sup> See KFF. Understanding the intersection of Medicaid and work: An update. May 30, 2025. <https://www.kff.org/medicaid/understanding-the-intersection-of-medicaid-and-work-an-update> (finding the following employment statuses among Medicaid adults in 2023: 64 percent working, 11 percent caregivers, 10 percent disabled, 7 percent in school, and 8 percent retired, unable to find work, or other).

<sup>248</sup> See Coleman A, Federman A. Work requirements for Medicaid enrollees. Commonwealth Fund. Sep 30, 2025. <https://www.commonwealthfund.org/publications/explainer/2025/sep/work-requirements-medicaid-enrollees>; Wagner J, Schubel J. States' experiences confirm harmful effects of Medicaid work requirements. Center on Budget and Policy Priorities. Nov. 18, 2020. <https://www.cbpp.org/health/states-experiences-confirming-harmful-effects-of-medicaid-work-requirements>.

<sup>249</sup> KFF Summary of H.R.1, *supra* note 242.

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