Texas Health and Human Services Commission (HHSC)

Deliverable 2 – Rider 60 Report

Final Report on the Study of Potential Cost Savings in the Administration of Prescription Drug Benefits

Rider 60: Prescription Drug Benefit Administration in Medicaid, CHIP, and Other Health-Related Services

August 17, 2018

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1. Executive Summary

The Texas Legislature commissioned Rider 60 to study the potential savings from implementing certain changes to HHSC's current method of administering prescription drug benefits for Medicaid and the Children's Health Insurance Program (CHIP). HHSC engaged Deloitte Consulting LLP[1] to develop the Rider 60 study in response to this request. The changes contemplated under Rider 60 for HHSC's pharmacy program include the following:

1. Moving to a single, statewide claims processor model to deliver prescription drug benefits to all of Texas's Medicaid and general revenue programs;
2. Reducing or eliminating the Affordable Care Act (ACA) Health Insurance Providers Fee, risk margin, and administrative services costs under the capitation program related to HHSC's pharmacy benefits; and
3. For prescription drug claims currently managed by Managed Care Organizations (MCOs) in Texas, transitioning to a prescription drug pricing methodology based on National Average Drug Acquisition Cost (NADAC), with a professional dispensing fee commensurate with a recent study commissioned by HHSC.

To accomplish these changes, HHSC's prescription drug benefits for all Medicaid and CHIP members would need to be carved out from Texas MCOs and paid by HHSC through its fee-for-service (FFS) program.

This report quantifies the potential impact of a transition to a pharmacy carve-out model based on HHSC's historical costs from State Fiscal Year 2015 (SFY2015) through SFY2017. In doing so, the following steps were applied:

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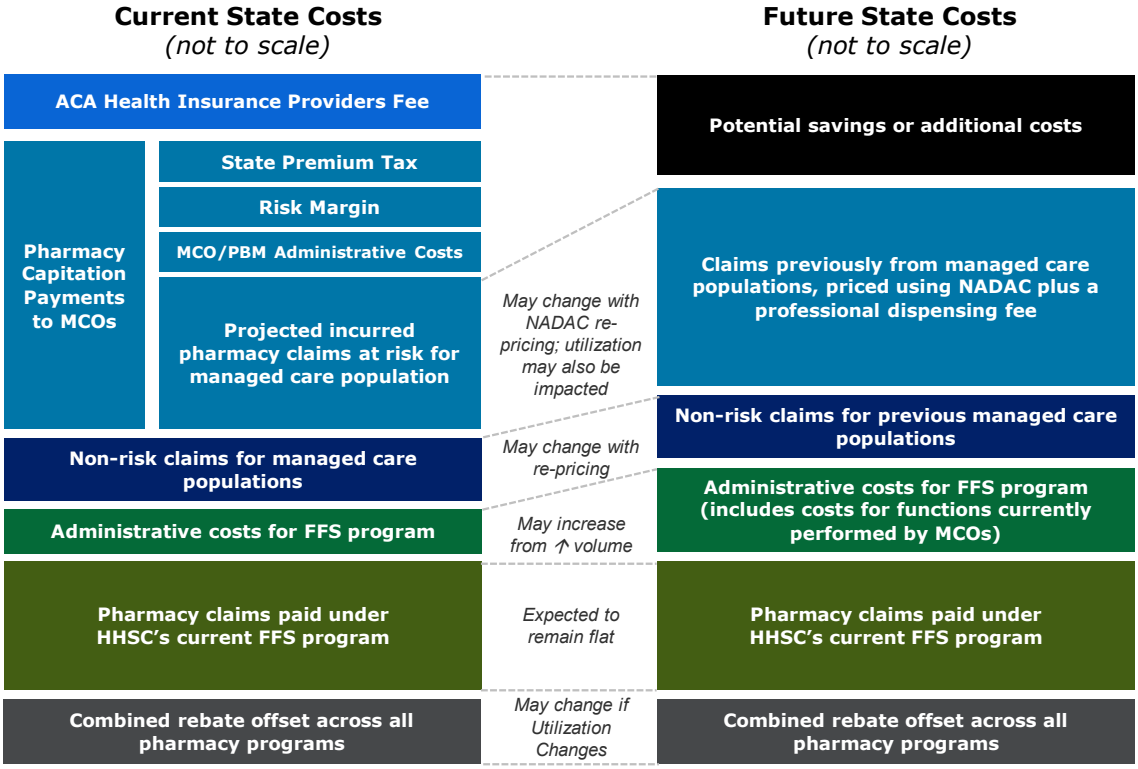
1. Repriced HHSC's managed care pharmacy encounter data using a NADAC pricing methodology for ingredient costs and a professional dispensing fee commensurate with the study referenced by Rider 60;
2. Evaluated the potential impact of transitioning to a FFS model on drug utilization for Medicaid and CHIP members currently managed by MCOs;
3. Quantified the impact of reducing certain non-claims-related components of HHSC's capitation payments to MCOs, including the ACA Health Insurance Providers fee, risk margin, and state premium tax;
4. Calculated the potential impact of a pharmacy carve-out model on HHSC's total pharmacy administrative costs; and
5. Considered other potential qualitative and quantitative impacts that may result from a transition to a pharmacy carve-out model.

Figure 1 represents a simplified view of how HHSC's costs may change in carving out HHSC's pharmacy benefits. The graphic illustrates some of the significant cost components that may be impacted by the carve-out and are quantified in this report; however, there may be many other additional costs that could shift, be eliminated, or require new investment from HHSC. As mentioned above, considerations around these potential costs are also addressed in this report but may not be depicted below.

Figure 1. Illustration of Approach to Quantifying Future Costs or Savings under Rider 60.



At the same time Rider 60 was commissioned, a second Rider 61 (Conference Committee Report Rider 220) was also approved. Since the two Riders are related, it is necessary to delineate the topics addressed in this report developed for Rider 60 from those contained in the separate report for Rider 61.

Rider 60 compares HHSC's actual historical pharmacy costs from SFY2015 through SFY2017 incurred under a managed care delivery model to the costs developed under a number of scenarios that may have occurred under a pharmacy carve-out model. The findings documented in this report for Rider 60 do not constitute an evaluation of Texas MCOs' effectiveness in administering pharmacy benefits. Rider 61 includes an assessment of the performance of Medicaid and CHIP managed care including an analysis of costs, cost savings, cost trends, caseload growth, and cost containment initiatives. The results and findings from Rider 61 are documented in a separate report.

Additionally, this report for Rider 60 only studies the impact to HHSC of carving out the pharmacy benefits currently administered under managed

care; it does not address the potential cost impact of carving in the programs currently administered on a FFS basis to Texas's MCOs.

The costs and savings estimates that appear in this report do not incorporate the upfront costs for transitioning HHSC's membership to the new statewide claims processor, as transition-related expenses may vary based on factors including the vendor selected and the time span over which the transition is performed. The estimates are presented on an all-funds basis, inclusive of both the state and federal impact from the transition to a pharmacy carve-out.

To reflect that there is uncertainty in how costs may be impacted by the transition to a pharmacy carve-out model, several scenarios are analyzed. As shown in **Figure 2**, the results of these scenarios indicate that had the carve-out been in place in SFY2017, the potential impact ranges from an estimated savings of $90.3 million (a 4.9% decrease in total net pharmacy costs) to an estimated cost increase of $75.3 million (a 4.1% increase in total net pharmacy costs).

Figure 2. Summary of Potential Cost/(Savings) Impact from Transitioning to a Pharmacy Carve-Out Model.

Current State Experience	SFY2015	SFY2016	SFY2017
Managed Care Capitation Payments	$2,735.2M	$2,867.4M	$3,654.4M
ACA Health Insurance Providers Fee	$58.7M	$62.0M	$76.5M
FFS Claims and Non-Risk Claims for Managed Care Population, Net of Cost Sharing	$714.4M	$797.0M	$351.1M
FFS Administrative Costs	$21.9M	$32.6M	$23.6M
Total Rebate Offset	($1,858.7M)	($2,144.7M)	($2,251.6M)
Total Net Pharmacy Program Costs	**$1,671.6M**	**$1,614.4M**	**$1,854.0M**

Scenario	*Assumption Selected:* Impact of Utilization Increase on Gross Costs	*Assumption Selected:* ACA Health Insurance Providers Fee Savings	*Assumption Selected:* Administrative Costs Per Member Per Month (PMPM)	SFY2015 Carve-Out Net Cost/ (Savings) Impact	SFY2016 Carve-Out Net Cost/ (Savings) Impact	SFY2017 Carve-Out Net Cost/ (Savings) Impact
Scenario 1	2.2%	Yes	$1.80	($29.7M) (1.8%)	($53.8M) (3.3%)	($61.3M) (3.3%)
Scenario 2	0%	Yes	$1.80	($56.0M) (3.4%)	($79.1M) (4.9%)	($90.3M) (4.9%)
Scenario 3	5%	Yes	$1.80	$4.5M 0.9%	($21.1M) (1.3%)	($23.6M) (1.3%)
Scenario 4	2.2%	Yes	$2.20	($7.9M) (0.5%)	($31.9M) (2.0%)	($38.9M) (2.1%)
Scenario 5	2.2%	No	$1.80	$29.0M 1.7%	$8.2M 0.5%	$15.3M 0.8%
Scenario 6	0%	No	$1.80	$2.7M 0.9%	($17.0M) (1.1%)	($13.7M) (0.7%)
Scenario 7	5%	No	$1.80	$63.2M 3.8%	$41.0M 2.5%	$52.9M 2.9%
Scenario 8	5%	No	$2.20	$85.0M 5.1%	$62.9M 3.9%	$75.3M 4.1%

The key drivers of the calculated cost/(savings) impact under the pharmacy carve-out include the following:

- **Risk Margin and ACA Health Insurance Providers Fee:** Eliminating the need for the risk margin and the ACA Health Insurance Providers Fee under the carve-out present the largest savings opportunities, contributing $73.0 million (3.9% of total net program costs) and $76.5 million (4.1% of total net program costs) in savings, respectively. However, in evaluating these results on a forward-looking basis, it is important to consider there is uncertainty around the continuation of the ACA Health Insurance Providers Fee for SFY2019 and beyond. Specifically, there is a moratorium expected on the fee in 2019[2]; if this moratorium stands, the fee will not be assessed at the federal level for the 2019 calendar year. Because the fee might not be assessed, the savings attributed to the fee historically under the carve-out would not exist in 2019. To reflect that there is uncertainty around whether the ACA Health Insurance Providers Fee will be assessed in the future, scenarios 5 through 8 presented above remove the savings attributable to this fee.

  Additionally, the scenarios above were calculated using the historical risk margin assumptions used in developing MCO capitation payments for SFY2015 through SFY2017. However, HHSC's risk margin assumption was reduced from 2.00% in SFY2017 for all programs except for the Texas Dual-Eligible Integrated Care Demonstration Project (known as Dual Demonstration), to 1.75% in SFY2018 for STAR+PLUS and STAR Kids and 1.50% in SFY2018 for STAR, STAR Health, and CHIP. As a result, the potential savings attributable to the risk margin for SFY2018 and beyond may be less than the historical amounts estimated for SFY2015 to SFY2017 in the figure above.

- **State Premium Tax:** The premium tax component of HHSC's capitation payments to MCOs is subsequently reimbursed to the State; however, by carving out pharmacy benefits, HHSC loses the federal match on state premium tax. This lost revenue was classified as a cost of carving out in the analysis, and is equal to the federal share of the state premium tax based on actual historical federal matching percentages (FMAP). For SFY2017, this cost is $36.0 million (1.9% of total net program costs).
- **Utilization Change:** The cost savings estimates may be also influenced by assumptions as to how the pharmacy carve-out will impact managed care members' drug utilization. Today, HHSC places multiple restrictions on how MCOs can administer their members' prescription drug benefits,

[2] H.R. 195, Division D – Suspension of Certain Health-Related Taxes, §4003

and so the MCOs in Texas may not use preferred drug list (PDL) management and certain other techniques to direct and manage drug utilization as they do in other states. The analysis considers multiple scenarios as to how drug utilization may change under the carve-out in light of these restrictions. These scenarios were developed by analyzing the areas for which MCOs do have discretion in managing their members' prescription drug benefits and quantifying how these areas may influence overall utilization after the transition to a carve-out. The first scenario reflects that prescription drug utilization may increase by 2.2% under the pharmacy carve-out, increasing costs by $29.0 million (1.6% of total net program costs). This scenario recognizes that MCOs apply certain optional clinical prior authorizations (PAs) today that the FFS program does not apply, and managed care pharmacy utilization may increase if no longer subject to these PAs. Another scenario reflects no increase in pharmacy utilization, which may result if HHSC implements the same PAs under the pharmacy carve-out as the MCOs use today. Finally, a third utilization scenario is considered wherein the impact is greater than expected and HHSC's utilization increases by 5% following the transition, increasing costs by $66.7 million. HHSC should consider which scenario it believes is most likely based on its ability under the carve-out to manage costs.

Under the scenarios in which utilization is anticipated to change under the pharmacy carve-out, the impact of the change on HHSC's rebate levels is also considered in the analysis. Rebate data was provided for this analysis at the aggregate level and not by drug or therapeutic class. As such, the impact on rebates of any changes in utilization is calculated at an aggregate level, where it is assumed the historical ratios of total rebates as a percentage of total gross ingredient costs would remain constant after any change in utilization. Using this methodology, an assumed increase in utilization would also drive an increase in rebates. The nature of this assumption implies that the drug and therapeutic class mix would remain the same after a change in utilization. While it is possible a change in utilization could be accompanied by a change in drug mix, data was not made available to perform a more detailed analysis on the rebate impact by drug.

- **Fee Schedule:** Adopting the new pricing methodology increased total pharmacy costs by $28.7 million (1.5% of total net program costs) in SFY2017 in all scenarios. The change in professional dispensing fee methodology increased costs, while transitioning to a NADAC ingredient cost pricing methodology decreased costs but not by enough to offset the increase in dispensing fees. No change is assumed in total rebates collected as a result of the new pricing methodology.

- **Administrative Costs:** Two administrative cost scenarios are considered in the analysis. The first scenario reflects that HHSC's total administrative costs are anticipated to decrease on a per unit basis under the pharmacy carve-out, reflecting the economies of scale inherent in HHSC's ability to contract for administrative services using a larger volume. In this scenario, the costs for administrative functions that may scale with the addition of new FFS membership are assumed to be $1.80 per member per month (PMPM), on par with the MCO's current administrative costs. This assumption decreases total costs under the pharmacy carve-out by $5.3 million (0.3% of total net program costs).

  However, it may take time for HHSC to be able to efficiently deliver administrative services under the carve-out model. As a result, an alternative scenario is also considered that incorporates a higher estimate of HHSC's potential administrative costs. Under this scenario, the costs for administrative functions that may scale with the addition of new FFS membership are assumed to be $2.20 PMPM. This scenario increases total costs under the pharmacy carve-out by $17.1 million (0.9% of total net program costs). The savings calculated in this analysis are based on administrative costs incurred by HHSC for Medicaid, CHIP, and the other programs in the State of Texas (Healthy Texas Women, Children with Special Health Care Needs Services, and Kidney Health Care) for which HHSC performs administrative functions on their behalf. HHSC will use the pooled membership across all programs for which it performs these functions to negotiate pricing with vendors. Any administrative functions that the other programs perform today on their own, without the help of HHSC, are not included in the analysis and these costs are not anticipated to be impacted by the carve-out.

Additionally, there are other potential costs that should be evaluated in deciding whether to carve out the pharmacy benefit from managed care. These potential costs have not been incorporated in the costs and savings estimates presented in this report, as they may vary based on the vendor with which HHSC selects to partner under the carve-out, the timing of the transition, and other factors. These types of potential costs include:

- **Upfront Transition Costs and System Capabilities:** HHSC may incur one-time technology implementation costs and costs to transition members to its new pharmacy benefit manager (PBM) under the pharmacy carve-out. HHSC's current system capabilities should be assessed and any technology and transition costs should be considered as part of the discussion around carving pharmacy out of the managed care programs.

- **Data Coordination:** Costs related to data coordination may increase under the pharmacy carve-out, as HHSC will be responsible for reporting pharmacy claims experience to the MCOs to enable them to track and manage costs at the episode, encounter, or member level.
- **Transferred Risk from MCO to the State:** Under a carve-out, HHSC will also be at risk for fluctuations in prescription drug utilization patterns or increased costs from new drugs. However, HHSC could benefit if utilization decreased or ingredient costs increased at a lower than anticipated level.

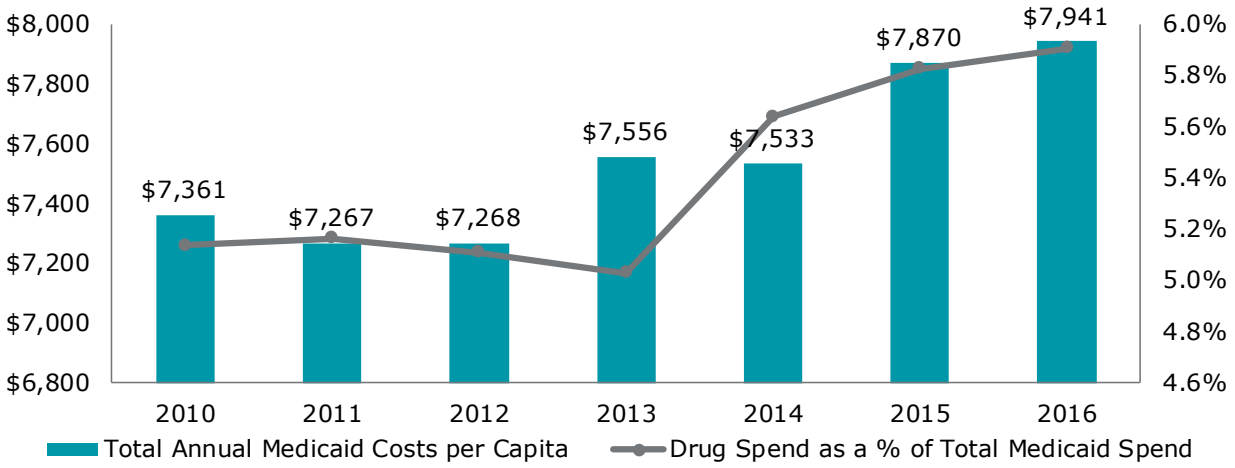
The changes in pharmacy delivery models contemplated under Rider 60 also have the potential to impact certain aspects of members' care. Any savings that may be achieved in carving the pharmacy benefit out of managed care should be assessed against the opportunities, risks, and other considerations posed herein. These include:

- **Integrated Care Management:** A pharmacy carve-out model may present barriers for MCOs to holistically manage care across members' medical, pharmacy, and other benefits. This could not only increase the total cost of care, it could discourage some MCOs from participating in quality or outcome-based incentive programs if they are no longer responsible for the full spectrum of their members' care.
- **Data Coordination:** The pharmacy carve-out model may enable HHSC to more efficiently identify outcomes and trends in pharmacy utilization across its membership.
- **Increased PDL Adherence:** Transitioning all members to a pharmacy carve-out may increase HHSC's ability to improve adherence to its PDL, and help HHSC identify outcomes based on pharmacy data.

2. Introduction

In recent years, prescription drugs have become increasingly known for their high costs and rising trends. Across Medicaid programs nationwide, between 2011 and 2016, prescription drug spend grew annually by an average rate of 9.7%. By comparison, total Medicaid health care costs grew by only 6.8% annually over the same time period.[3,4] Given the rising costs of prescription drugs and their impact on the nation's overall health care expenditures, effectively managing pharmacy costs and trends has become a critical concern for most US health care payers.

Figure 3. US Drug Spend for Medicaid Programs.



Year	Total Annual Medicaid Costs Per Capita	Drug Spend as a Percent of Total Medicaid Spend
2010	$7,361	5.1%
2011	$7,267	5.2%
2012	$7,268	5.1%
2013	$7,556	5.0%
2014	$7,533	5.6%
2015	$7,870	5.8%
2016	$7,941	5.9%

[3] CMS, "NHE Fact Sheet," https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html
[4] CMS, "National Health Expenditure Data," https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html

As prescription drug costs increase across the nation, there is a growing need for effective management of these benefits. Recognizing this need, the Texas Legislature commissioned a study and report to help with the State's approach and strategy for administering pharmacy benefits for Texas's Medicaid members.

2.1. Background and Purpose of Rider 60

In the State of Texas, MCOs administer prescription drug benefits for approximately 92% of Texas Medicaid members[5], as well as for the entire CHIP program. For these populations, HHSC makes a monthly capitation payment to the MCOs for each of its members and the MCO in turn pays for and manages the health care costs, including pharmacy costs, for those members. Capitation rates are developed to cover the expected costs of the members' pharmacy claims[6], as well as provisions for administrative expenses, taxes, licensing and regulatory fees, and other operational costs for the MCOs to manage the benefits. The MCOs are at risk for any costs that may exceed the capitation payment from HHSC. Conversely, if their members' actual pharmacy costs plus the MCOs' costs to administer their benefits are less than the capitation rate payment from HHSC, the MCOs may retain the extra amount.[7]

For the remaining 8% of Texas Medicaid members, as well as for other general revenue programs administered in Texas (described further in **Section 3 Background on HHSC's Current Pharmacy Program**), the prescription drug benefit is managed by HHSC on a FFS basis. In this FFS delivery model, pharmacy claims are paid directly by HHSC as they are incurred by enrollees.

Pursuant to Rider 60, a study on HHSC's approach for administering prescription drug benefits has been performed. The nature of the study performed and documented in this report is summarized in the following section.

[5] As of SFY2017
[6] Excludes certain high cost drugs for which the MCOs are not at risk. Further detail on non-risk drugs is included in **Section 3.4 Description of HHSC's Current Approach to Pharmacy Administration**.
[7] An experience rebate provision requires the MCOs to pay back part of any profit margin greater than 3% when comparing their actual medical, prescription drug, and administrative costs to the final capitation payments received.

2.2. Proposed Changes Studied under Rider 60

Rider 60 was commissioned to study and quantify the potential savings from implementing certain changes to HHSC's current method of administering prescription drug benefits. The changes contemplated under Rider 60 for HHSC's pharmacy program include the following:

1. Moving to a single, statewide claims processor model to deliver prescription drug benefits to all of Texas's Medicaid and general revenue programs;
2. Reducing or eliminating the ACA Health Insurance Providers Fee, risk margin, and administrative services costs under the capitation program related to HHSC's pharmacy benefits; and
3. For prescription drug claims currently managed by MCOs in Texas, transitioning to a prescription drug pricing methodology based on NADAC with a professional dispensing fee commensurate with the most recent study commissioned by HHSC.

To accomplish these three potential changes, HHSC's prescription drug benefits for all Medicaid and CHIP members would need to be carved out from the Texas MCOs and paid through the FFS program.

The first change contemplated is moving to a "single statewide claims processor." This single, statewide claims processor would likely function similar to a statewide pharmacy benefit manager or PBM. PBMs serve in various capacities in the health care industry to provide administrative services related to prescription drug benefits. A PBM may perform pharmacy claims adjudication, drug reimbursement negotiation with pharmacies, or rebate negotiation with drug manufacturers; it may operate mail order and specialty pharmacies; perform drug utilization review; or a combination of these and other functions. In this study, it is assumed that a PBM-like entity would provide administrative functions for HHSC's pharmacy program under the carve-out model and would be reimbursed by HHSC for its services retrospectively on a non-risk basis. Unlike the Texas MCOs, the PBM would not be at financial risk for any changes in HHSC's pharmacy utilization or ingredient costs or dispensing fees.

The second change considered under Rider 60 is that by administering pharmacy benefits through a statewide PBM on a non-risk basis, HHSC may be able reduce the impact of certain fees and provisions it pays today under its managed care model. For example, MCOs are subject today to the ACA

Health Insurance Providers Fee[8], for which HHSC reimburses the MCOs. However, a PBM paid on a non-risk basis would not be subject to this fee. In addition, other provisions are embedded today in HHSC's capitation payments to MCOs that would no longer be required under a FFS model.

The third change contemplated by Rider 60, transitioning to NADAC pricing with a professional dispensing fee commensurate with the most recent study commissioned by HHSC, would also not be possible under a managed care model, as MCOs negotiate their own drug pricing. In order to facilitate a transition to a uniform prescription drug pricing methodology based on NADAC, HHSC would need to carve out its MCO pharmacy benefit into the FFS program.

In addition to the three changes described above, a transition to a pharmacy carve-out model may impact HHSC's program costs in other ways. For example, PBMs' pricing for their administrative services are often dependent on volume, where health care payers with larger populations may receive preferable pricing per unit compared to payers with small volume. By administering pharmacy benefits for all HHSC's population through a single PBM, HHSC's purchasing power would likely increase and administrative costs may be reduced through economies of scale. Additionally, depending on the methods the MCOs use to manage their members' benefits today, different patterns in members' drug utilization, such as higher or lower brand drug utilization, may emerge following the transition to a pharmacy carve-out. These potential shifts are also considered and incorporated into the cost and savings estimates.

This report considers various ways in which costs may change under a pharmacy carve-out scenario to ultimately present an estimate of the costs or savings inherent in the proposed changes to HHSC's pharmacy benefits. This report only addresses the impact of carving out the pharmacy benefits currently administered under a managed care model. It does not address the potential impact of carving into managed care the Medicaid and CHIP populations currently administered by the FFS Program.

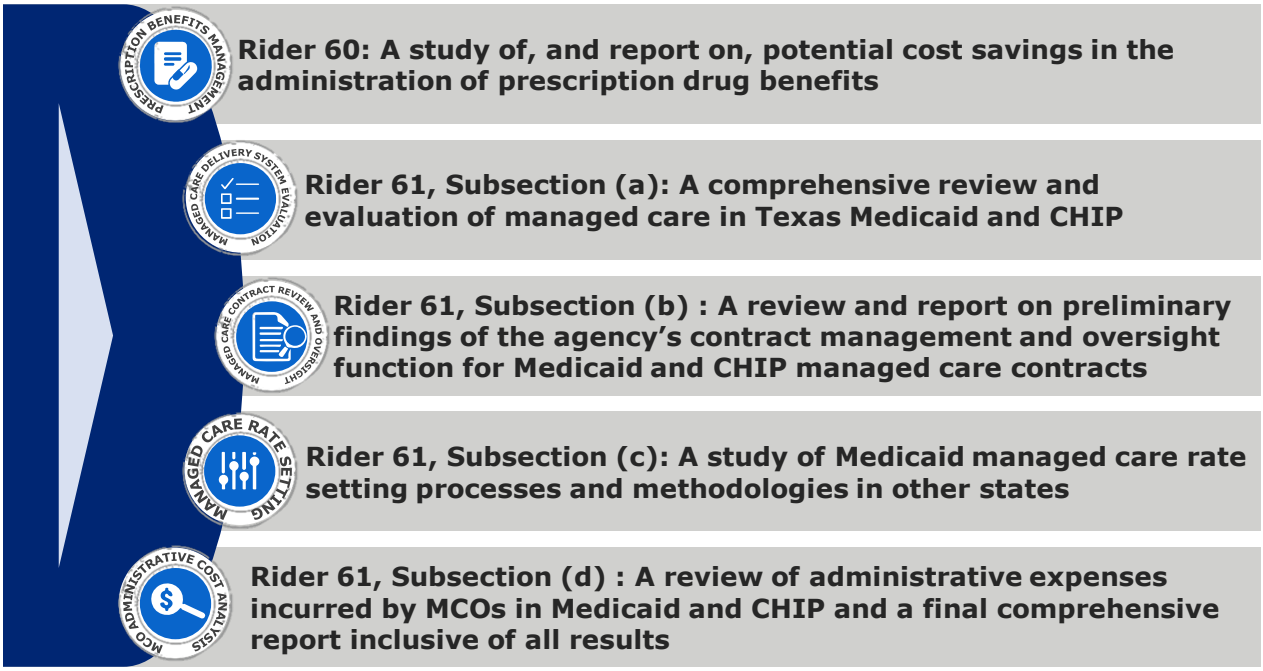
2.3. Distinctions between Riders 60 and 61

At the same time Rider 60 was commissioned, a second Rider 61 (Conference Committee Report Rider 220) was also approved. Through Rider 61, the Texas Legislature commissioned a four-part study of costs and operations of the managed care program in Texas, as delineated in **Figure**

[8] Per Section 9010 of the ACA

4. HHSC included Riders 60 and 61 in a single request due to the overlap in their topics of review.

Figure 4. Focus of Riders 60 and 61.



Rider 61(a) includes an assessment of the performance of Medicaid and CHIP managed care including the analysis of costs, cost savings, cost trends, caseload growth, and cost containment initiatives. Since the two Riders are related in terms of estimating potential cost savings associated with the managed care programs, it is necessary to delineate the topics addressed in Rider 60 from those contained in the separate report developed for Rider 61.

This report, which addresses only Rider 60, does not constitute an evaluation of Texas MCOs' effectiveness in administering pharmacy benefits. The Rider 60 study compares HHSC's actual historical pharmacy costs from SFY2015 through SFY2017 incurred under a managed care delivery model to the costs developed under a number of scenarios that may have occurred under a pharmacy carve-out model. Other than the potential impact on prescription drug utilization of carving out pharmacy benefits from managed care, the Rider 60 study does not incorporate potential upfront transition costs or the potential impact from changes in the coordination of care or data reporting.

The Rider 61(a) assessment of Medicaid and CHIP managed care costs and savings studies the actual managed care program trends over SFY2009 through SFY2017 (inclusive of medical, pharmacy, administrative, and risk margin costs) compared to hypothetical FFS trend levels estimated based on

historical Texas FFS experience, industry reports, and national benchmarks. The assessment then calculates a range of potential savings observed through the managed care program by comparing the actual historical managed care trends to the hypothetical FFS trend range. As noted in the Rider 61(a) report, during transition years within the managed care program (including years in which new managed care programs were introduced or existing programs were expanded), the assumed savings in shifting from FFS to managed care incorporated into the premium were at least budget neutral to, if not greater than, any additional costs associated under a managed care arrangement.

Finally, while this report does not evaluate the effectiveness of the MCOs, **Section 9 Other Costs and Considerations** highlights potential impacts to the pharmacy program and the populations covered by MCOs today if HHSC were to carve out its pharmacy benefits.

3. Background on HHSC's Current Pharmacy Program

This section provides an overview of HHSC's Medicaid programs, its prescription drug benefits, and HHSC's current methods for administering pharmacy benefits for its members today.

3.1. Prescription Drug Coverage and Pricing under Medicaid

Medicaid provides health care services for low-income adults, children, pregnant women, elderly adults, and people with disabilities. The program is jointly funded by states and the federal government and is administered by states according to federal requirements.

Outpatient prescription drugs are an important benefit covered by Medicaid. Each state has flexibility in how it administers prescription drug benefits, subject to federal regulations. In practice, some states rely on a managed care model, in which prescription drug benefits are managed by MCOs in exchange for a capitation payment from the state, while others use a FFS model, in which the state pays for members' pharmacy claims as they are incurred. States that administer pharmacy benefits on a FFS basis establish their own pricing methodologies for reimbursing pharmacies for their members' claims. The methodology must be based on one of several accepted pricing schedules that reflect the actual cost of each drug (see **Section 5.1 Description of Current FFS Pricing Methodology** for further details on prescription drug pricing requirements). The amounts paid by the state to pharmacies for members' pharmacy claims are referred to in this report as gross drug costs.

Regardless of whether a state administers prescription drug benefits using a managed care or FFS model, rebates from drug manufacturers are an important mechanism for managing program costs. Further detail on how rebates are contracted and reimbursed under Medicaid is contained in **Section 3.3 Background on Medicaid Drug Rebate Program**. This report refers to the costs of prescription drugs after rebates as net drug costs.

A central goal for maintaining the affordability of state Medicaid programs is to manage Medicaid members' net drug costs. Various levers exist for states to direct their members' utilization towards drugs with lower net costs. These mechanisms are discussed in subsequent sections of this report.

3.2. Covered Pharmacy Benefits under the Texas Medicaid Program

Texas's Medicaid program has covered prescription drug benefits since 1971, when HHSC first implemented an optional Medicaid drug benefit program. As of 2018, the Texas Medicaid program has evolved to provide pharmacy benefits to multiple unique populations.

The following Texas Medicaid programs exist today:

- **State of Texas Access Reform (STAR):** Provides services for low-income families, pregnant women and newborns, most children that are not otherwise receiving Social Security income, and some former foster care youth.
- **STAR+PLUS:** Provides services for individuals who are age 65 or older, as well as adults with disabilities.
- **STAR Health:** Provides services for children in state conservatorship (young adults up to 22 years of age with voluntary foster care placement agreements), as well as for young adults under age 21 who were previously in foster care and continue to receive Medicaid services.
- **STAR Kids:** Provides services to children and young adults with disabilities. This program began on November 1, 2016.
- **Dual Demonstration:** Also known as the Dual-Eligible Integrated Care Demonstration Project, this program provides services to individuals age 21 and over who are dually eligible for Medicare and Medicaid benefits.

All Texas Medicaid programs provide outpatient prescription drug benefits to their members. To be covered by Medicaid, a drug must be prescribed by a member's health care professional and dispensed through a Medicaid-eligible pharmacy. Some vitamins, minerals, home health supply products, and Zika prevention products are also covered. Some adults enrolled in the FFS program are limited to three prescription drugs per month, while there is no limit to the number of prescriptions other Medicaid-eligible individuals may receive. Family planning drugs, smoking cessation drugs, and insulin syringes do not contribute toward this monthly limit.

In addition to Medicaid, there are several other programs in the State of Texas that also provide pharmacy benefits. These programs serve certain at-risk populations who do not otherwise meet the eligibility requirements for Medicaid:

- **CHIP and CHIP Perinatal:** CHIP is a jointly funded state-federal program that provides services to low-income, uninsured children up to age 19 with household incomes up to 201% of the federal poverty limit (FPL) who do not qualify for Medicaid. In addition, the CHIP Perinatal program is available to unborn children with household incomes up to 202% of the FPL and who do not qualify for Medicaid.
- **Healthy Texas Women:** This program provides family planning services and other women's health services that contribute to preconception care and better birth outcomes. The program launched on July 1, 2016, and is a consolidation of the legacy Texas Women's Health Program and the Expanded Primary Health Care Program.
- **Children with Special Health Care Needs Services (CSHCN):** This program provides services to individuals under age 21 with special health care needs that meet certain requirements, or individuals of any age with cystic fibrosis.
- **Kidney Health Care:** The Kidney Health Care program is available to certain individuals with End Stage Renal Disorder (ESRD).

The changes proposed by Rider 60 involve carving out the pharmacy benefits from managed care for the Medicaid and CHIP programs only, and are not anticipated to directly impact costs for Healthy Texas Women, CSHCN, or Kidney Health Care. Throughout this report, references to the FFS program refer specifically to the FFS populations within Medicaid only, unless it is otherwise specified.

The average annual enrollment for each Texas program is summarized in **Figure 5**. [9,10,11,12]

[9] Unless otherwise specified, all years in this report represent state fiscal years.
[10] Medicaid represents members enrolled in managed care and those in the FFS program combined.
[11] CSHCN represents number of clients served.
[12] Kidney Health Care represents number of clients provided drug benefits.

Figure 5. Average Annual Enrollment by HHSC Program.

Program	SFY2015	SFY2016	SFY2017
Medicaid	4,056,702	4,060,564	4,067,408
CHIP (including CHIP Perinatal)	376,366	395,859	425,082
Healthy Texas Women	103,700	94,851	167,177
CSHCN	1,752	1,797	1,685
Kidney Health Care	6,615	6,668	5,687

3.3. Background on Medicaid Drug Rebate Program

In providing prescription drug benefits to nearly 4.7 million members in the State of Texas, a key component of managing costs is collecting rebates from pharmaceutical manufacturers. The requirements for how Medicaid agencies collect rebates from drug manufacturers and share them with the federal government are determined by the Medicaid Drug Rebate Program.[13]

Under the Medicaid Drug Rebate Program, for a manufacturer's outpatient drug products to be covered by state Medicaid programs, the manufacturer must enter into a national rebate agreement with the U.S. Department of Health and Human Services (HHS). In exchange for coverage by state Medicaid programs, the manufacturer must pay a rebate on a per unit basis for drugs dispensed to Medicaid members. These rebate amounts are shared between the states and the federal government to offset the overall cost of prescription drugs under the Medicaid program. The rebates paid through the Medicaid Drug Rebate Program are also known as federal rebates. The amount of federal rebate due for each unit of a drug is based on statutory formulas, which vary by drug type.

Prior to the passage of the ACA, state Medicaid agencies could only collect federal rebates on prescription drugs that were administered by the state under a FFS program, and not on any prescription drugs managed by MCOs for their members. Section 2501(c) of the ACA expanded the Medicaid Drug Rebate Program to allow states to collect federal rebates on covered outpatient drugs dispensed to beneficiaries who receive pharmacy benefits from Medicaid MCOs.

In addition to federal rebates, state Medicaid agencies may also negotiate supplemental rebate agreements with drug manufacturers. These

[13] CMS, "Medicaid Drug Rebate Program," https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/index.html

agreements are negotiated at the discretion of each state to provide rebates above and beyond the federal rebate amounts. In exchange for receiving additional rebate amounts from the manufacturer, a state Medicaid agency may agree to place the manufacturer's drug on its PDL. As with federal rebates, supplemental rebates received by the state Medicaid agencies are shared with the federal government. **Section 3.5 Roles of the Vendor Drug Program and MCOs** contains further detail on how HHSC manages the PDL and negotiates supplemental rebates with drug manufacturers.

3.4. Description of HHSC's Current Approach to Pharmacy Administration

3.4.1. Managed Care Population

As mentioned previously, pharmacy benefits for most Medicaid members and all CHIP members in Texas are administered today by MCOs. In total, as of August 2018, 18 different MCOs serve the State of Texas's Medicaid and CHIP populations. Certain MCOs serve only specific programs; while other MCOs serve multiple programs. MCOs also manage the medical costs for their enrolled members, which allows MCOs to coordinate care holistically across both medical and pharmacy benefits.

The capitation payments made to MCOs to manage the pharmacy benefits for each program are summarized in **Figure 6** on the following page. [14,15]

[14] The STAR Kids program began on November 1, 2016, and so enrollment does not exist for SFY2015 and SFY2016.
[15] The Grand Total does not reflect the impact of rebates which are collected directly by HHSC.

Figure 6. Annual Pharmacy Capitation Payments to MCOs by HHSC Program (in Millions).

Program Type	SFY2015	SFY2016	SFY2017
STAR	$1,323M	$1,369M	$1,479M
STAR+PLUS	$1,220M	$1,292M	$1,405M
STAR Health	$59M	$59M	$62M
STAR Kids	N/A	N/A	$522M
Dual Demonstration	$1M	$2M	$2M
CHIP	$133M	$145M	$184M
Grand Total	**$2,735M**	**$2,867M**	**$3,654M**

The pharmacy capitation payments to MCOs were developed to cover the expected gross costs for prescription drugs incurred by each population during the given period, with two exceptions:

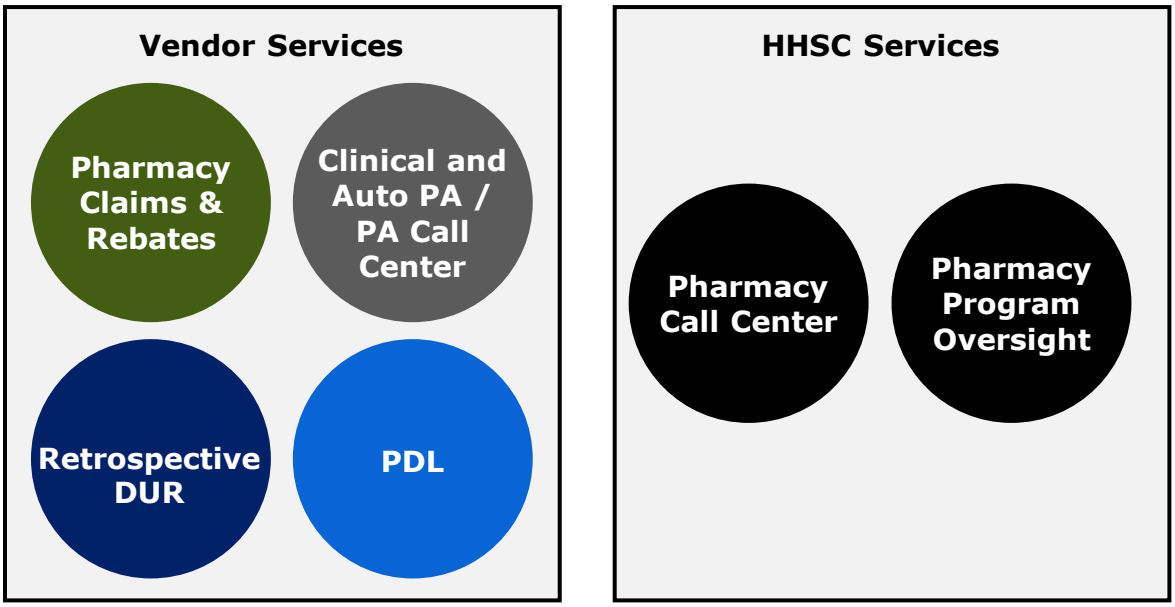
- Federal and supplemental rebate offsets are not reflected in the capitation payments, as rebates are collected directly by HHSC (this will be discussed further in **Section 3.5 Roles of the Vendor Drug Program and MCOs**).
- The capitation payments in **Figure 6** do not provide for certain drugs used to treat Hepatitis C (second generation direct acting antivirals) or Orkambi, a drug used to treat cystic fibrosis. Additionally, they do not include the costs of Medicaid wrap-around services for outpatient drugs and biological products for STAR+PLUS members. Instead, MCOs are paid for these drugs on a non-risk, cost settlement basis. HHSC reimburses the MCOs for the actual amounts paid to pharmacy providers, up to the FFS reimbursement amount. Starting September 1, 2018, the Hepatitis C drugs and Orkambi will be incorporated into the MCO capitation rates.

3.4.2. FFS Population

For the portion of Texas's Medicaid population not enrolled in managed care, as well as for the Healthy Texas Women, CSHCN, and Kidney Health Care programs, outpatient pharmacy benefits are administered on a FFS basis through HHSC's Vendor Drug Program (VDP). In the FFS model, the VDP contracts with pharmacies to dispense drugs for its members. The VDP then reimburses the contracted pharmacies directly for the cost of its members' prescription drugs.

Currently, the VDP contracts with four separate external vendors to help perform the pharmacy administrative functions for the FFS population. HHSC staff also perform certain functions in-house.

Figure 7. Current Landscape of Administrative Services Providers for FFS Program.



As will be further discussed in **Section 3.5 Roles of the Vendor Drug Program and MCOs**, some of the functions performed by the VDP and its vendors are specific to administering benefits for the FFS population; while other functions are handled centrally by the VDP across both the FFS and managed care populations.

Figure 7 represents the current state of the VDP's vendor contracting structure as of August 2018. In the future, HHSC plans to transition to a single vendor for all pharmacy administrative functions. Since the transition to a single vendor is still pending, in this report it is assumed that the current vendor structure in place represents the costs for performing administrative functions for the FFS program.

3.5. Roles of the Vendor Drug Program and MCOs

While MCOs are responsible for managing the prescription drug benefits for their members, the VDP maintains control of certain aspects of the MCOs' pharmacy administration, and participating MCOs are required to adhere to certain protocols developed by the VDP:

- **Formulary Development and Management:** The formulary is a list of covered drugs. Medicaid programs must cover drugs for which the manufacturer holds a national rebate agreement with HHS, but the VDP may design a more limited formulary for CHIP and other programs. The VDP develops and maintains the Texas Drug Code Index, which is composed of program-specific formularies for Medicaid, CHIP, CSHCN, Healthy Texas Women, and the Kidney Health Care programs. All MCOs are required to adhere to the VDP-developed Texas Drug Code Index.
- **Supplemental Rebate Negotiation and PDL Development:** The VDP is also responsible for maintaining the PDL for Medicaid and CHIP. HHSC may add or remove drugs from its PDL based on clinical efficacy, cost effectiveness, and safety. Drugs with preferred status on the PDL are available without PA, while those that are identified as nonpreferred on the PDL require a PA in order to be dispensed. As discussed in **Section 3.3 Background on Medicaid Drug Rebate Program**, the VDP and its vendors negotiate with manufacturers for supplemental rebates in exchange for a preferred status on the PDL.

  Currently, the VDP and its vendors perform supplemental rebate negotiation with manufacturers and manage the PDL centrally across all Medicaid and CHIP programs. The MCOs must use the VDP-developed PDL in administering pharmacy benefits for their members.[16]
- **Rebate Administration:** In addition, the VDP invoices, collects, and reconciles federal and supplemental rebates across the FFS and MCO populations on a combined basis. MCOs provide the VDP with the pharmacy encounter records that detail the drug utilization of their members. The VDP's vendor then combines this data with the pharmacy claims records from HHSC's FFS programs and processes the rebates for the combined utilization across all programs.
- **Prior Authorization Development and Management:** Clinical PAs may be required before dispensing a drug to ensure clinical appropriateness based on factors such as age, availability of alternative medications, or possible drug interactions. Such clinical PAs can be applied for certain drugs or for entire classes of drugs. With the assistance of the Texas Drug Utilization Review (DUR) Board, the VDP and its vendors develop, manage, and review clinical PAs across both the FFS and managed care programs. Further details on the DUR Board can be found in the following section.

[16] Texas Health and Human Services, "Vendor Drug Program Preferred Drugs," https://www.txvendordrug.com/formulary/prior-authorization/preferred-drugs

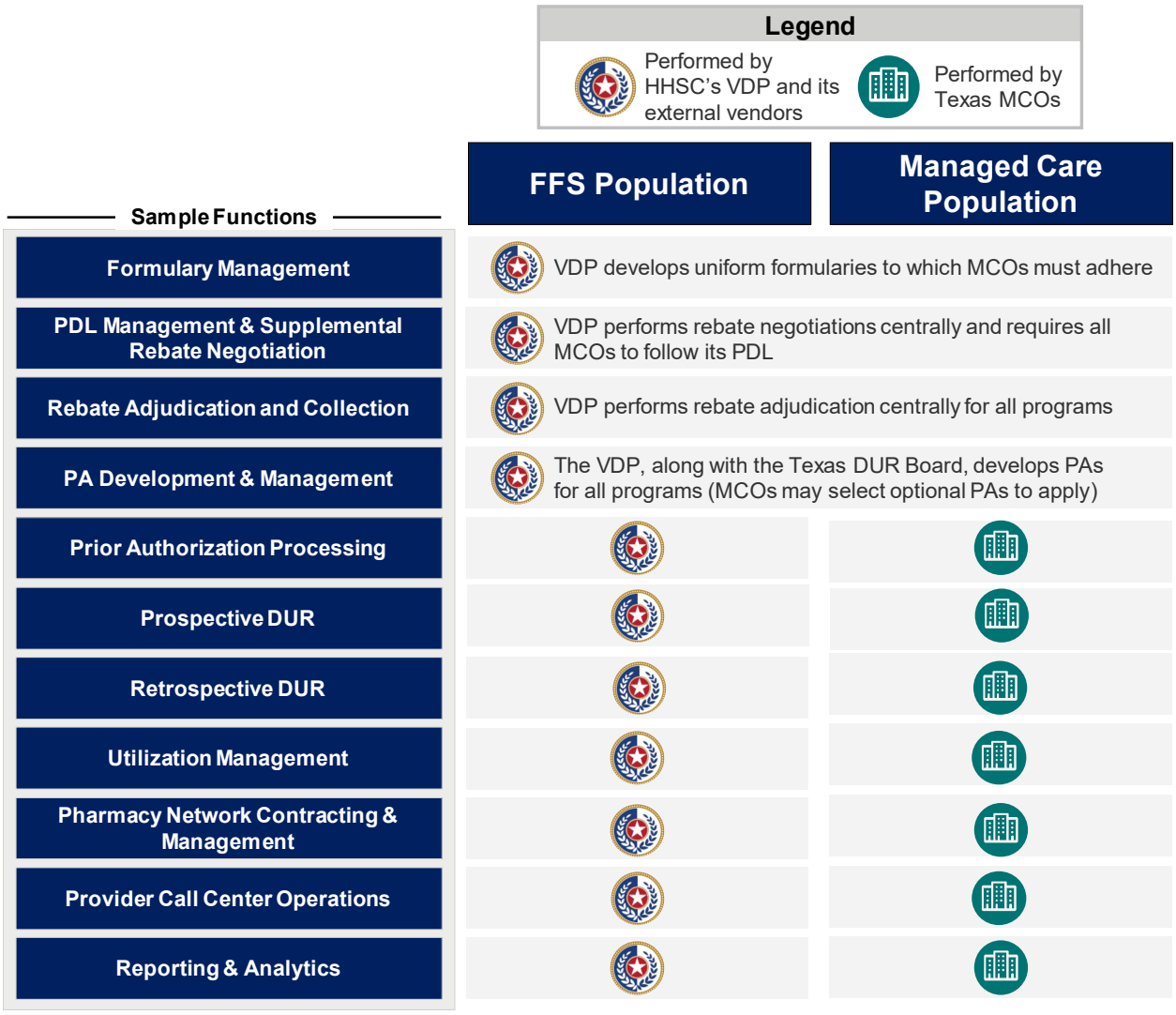
- **Specialty Drug List Development:** The specialty drug list defines the prescription drugs that are permitted to be exclusively provided through a specialty pharmacy network. The VDP develops the specialty drug list that must be adhered to across the FFS program and by Texas MCOs.

While the VDP requires MCOs to follow many of its practices and protocols, there are a few areas where MCOs are permitted to alter their pharmacy administrative approach from the FFS program:

- **Optional Clinical Prior Authorizations:** As of the publishing of this report, the Texas DUR board requires MCOs to perform five clinical PAs. However, MCOs also have the option to select from a menu of 73 additional, board-approved clinical PAs to require for their populations. MCOs may not perform any PAs that are not on this list. In practice, there is some variance in the optional PAs elected by each of the MCOs, as well as by the VDP, in their administration of the FFS program. Each MCO also has the option to develop their own algorithms for performing clinical PAs, so long as their algorithms are no more stringent than the board-approved criteria.
- **Utilization Management (UM):** MCOs may also apply different strategies in attempting to drive their members' utilization to different drugs on the PDL through UM. For example, because MCOs do not receive rebates, they manage prescription drug costs on a gross basis (before rebates). On the other hand, HHSC's goal is to manage the net prescription drug costs to the program after rebates. These varying goals may result in different patterns of how each program drives and manages its program's drug utilization.

Figure 8 summarizes the functions performed by the VDP versus the MCOs in today's managed care model in Texas.

Figure 8. Summary of Pharmacy Administrative Functions Performed by the VDP and Texas MCOs.



3.6. Role of the Texas DUR Board and MCOs' DUR Boards

Federal regulations require state Medicaid agencies to perform drug utilization reviews for their outpatient drug programs. DUR programs are intended to develop policies that encourage safe and appropriate use of drug therapies and help contain costs, as well as to evaluate the effectiveness of such policies. In practice, DUR programs often help educate physicians on how to identify and reduce fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and members.

There are two broad approaches to DUR. The first, prospective DUR, is performed prior to or at the point of dispensing a medication to a member through a review of the patient's medication record and prescription drug orders. Prospective DUR helps a health care provider understand whether the drug is clinically appropriate, or whether potential drug therapy problems, drug-disease contraindications, allergies, interactions between drugs, or potential drug misuse may exist.

Retrospective DUR, on the other hand, is an examination of claims data and other records to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among health care professionals, pharmacists, and members. It is performed after the point of sale in a review of members' pharmacy and medical claims experience.[17]

The Texas DUR Board was established under the authority of Section 1927(g)(3) of the Social Security Act and Section 531.0736 of the Texas Government Code. The objective of the Texas DUR Board is to develop criteria and standards for DUR for the Texas Medicaid program, as well as to perform the functions of a Pharmaceutical and Therapeutics (P&T) committee.[18] The board is composed of physicians and pharmacists who provide services across the Medicaid population and represent a variety of different specialties. In addition, two representatives (one physician and one pharmacist) from MCOs and one consumer advocate for Texas's Medicaid members are included on the Texas DUR Board. The two representatives from MCOs serve as nonvoting members.

[17] Texas Health and Human Services, "Vendor Drug Pharmacy Provider Procedure Manual" (see link for Drug Utilization Review), https://www.txvendordrug.com/about/policy/manual
[18] Prior to 2015, a separate P&T Committee existed in Texas to make recommendations to HHSC concerning the implementation of the PDL; however, in 2015 the P&T Committee was eliminated and its responsibilities were transferred to the Texas DUR Board.

The duties of the Texas DUR Board include developing and submitting recommendations to HHSC for the PDL; suggesting to HHSC restrictions or PAs on prescription drugs; developing, recommending, and reviewing educational interventions for Medicaid providers; and reviewing drug utilization across the Medicaid program. Other duties may arise on an ad-hoc basis or as specified by law. The Texas DUR Board meets quarterly and is supported by various external vendors as described in **Section 3.4 Description of HHSC's Current Approach to Pharmacy Administration**.

In addition, MCOs have their own P&T Committees, DUR Boards, or other equivalent bodies that provide recommendations on clinical policies and procedures. Based on the recommendation of their P&T Committees, MCOs may submit clinical prior authorizations to the Texas DUR board for review and consideration.

3.7. MCOs' Pricing with Providers

Each of the MCOs that provide pharmacy benefits to Texas Medicaid and CHIP members contracts with PBMs to process prescription claims for their members. In turn, the PBMs contract with individual pharmacies to negotiate pricing for prescription drugs. In effect, each of the 18 MCOs negotiates different ingredient cost and dispensing fee terms for providing pharmacy benefits to the State's members, to the extent member access is not negatively affected by such pricing schedules.

Each MCO also develops its own participating pharmacy network for delivery of services. However, the MCO must allow any enrolled pharmacy provider willing to accept the financial terms and conditions of the contract to enroll in the MCO's network.

4. Approach and Methodology

This section describes the approach to quantifying costs or savings under Rider 60, as well as the data sources and key assumptions used in the analysis.

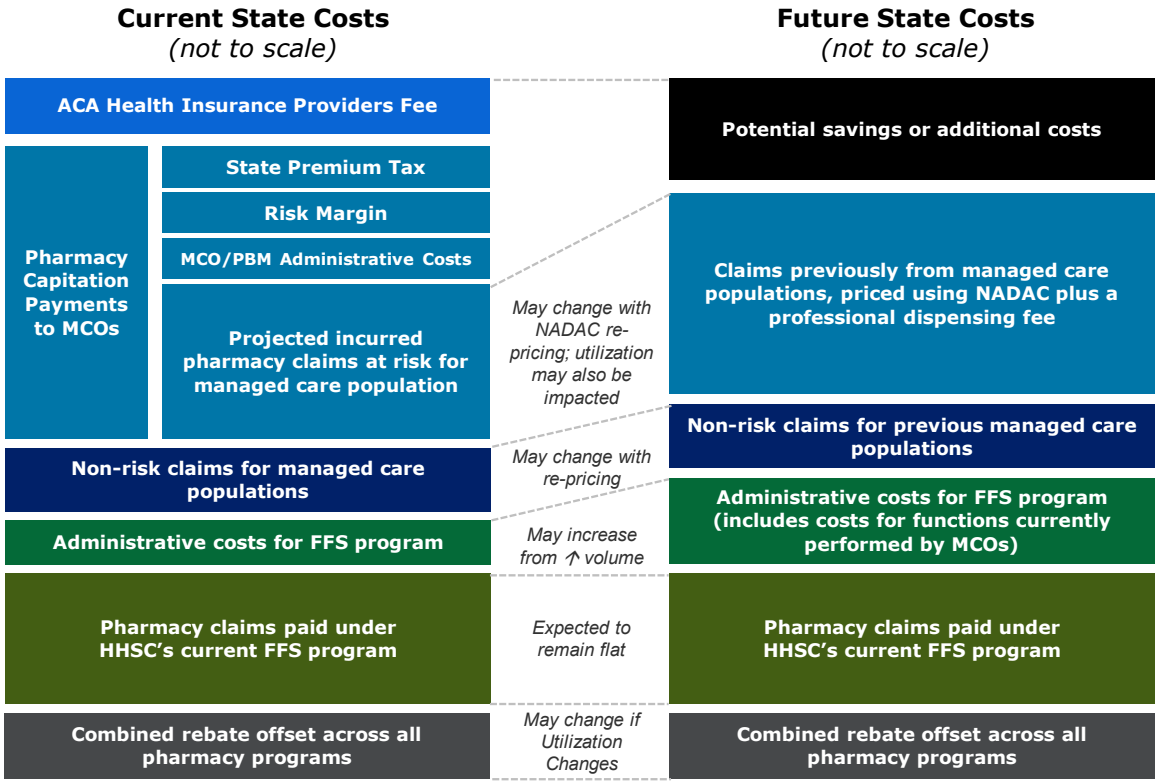
4.1. Overview of Approach

To quantify the potential costs or savings resulting from moving prescription drug benefits from managed care to a single statewide claims processor model (carving out pharmacy from the managed care programs to FFS), this report contains a detailed evaluation of how current pharmacy costs may change under the new delivery model.

To help frame the analysis, **Figure 9** represents a simplified view of how costs may change in carving out HHSC's Medicaid and CHIP pharmacy benefits from managed care. The graphic is not to scale but is intended to help visualize the potential impacts.

For simplicity, the graphic captures some of the significant cost components that may be impacted by the carve-out; however, there may be other additional costs that could shift, be eliminated, or require new investment from HHSC. Considerations around these potential costs or savings are also addressed in this report but are not necessarily pictured.

Figure 9. Illustration of Approach to Quantifying Future Costs or Savings under Rider 60.



In transitioning to a pharmacy carve-out, the prescription drug costs for today's FFS membership can be assumed to remain the same. Pharmacy claims for the FFS program are already administered by the VDP, as they will be under the carve-out. Additionally, as addressed further in subsequent sections, prescription drug costs for FFS members are already priced according to a NADAC pricing methodology, plus a professional dispensing fee commensurate with that expected to be applied under the carve-out scenario.

However, the total administrative costs for operating the Medicaid and CHIP programs under the pharmacy carve-out may change. Under the carve-out, the total administrative costs or savings will depend on how the expenses for operating the new FFS pharmacy carve-out compare to the VDP's current administrative costs, plus the administrative cost provision paid to MCOs today in their capitation rates. In quantifying this change, it is necessary to consider the impact from economies of scale; where HHSC may be able to use its larger membership under the carve-out to negotiate better administrative costs per unit with a statewide PBM. Administrative costs incurred directly by the other FFS programs (Healthy Texas Women, CSHCN,

and Kidney Health Care) will not be affected by the carve-out, but costs for functions the VDP performs across all programs may change as they are spread across a larger population.

This report also considers the impact on claims from members whose prescription drug benefits are managed today by MCOs and who would transition to FFS administration under the carve-out:

1. **Non-risk-based claims:** The underlying costs for pharmacy claims reimbursed by HHSC on a non-risk basis will change. Today, the MCOs' costs for non-risk-based drugs and wrap-around coverage for outpatient drugs and biological products for STAR+PLUS members are calculated using the MCOs' negotiated pricing methodology with pharmacies.[19] Under the carve-out, all claims would be reimbursed using a NADAC pricing methodology, plus a professional dispensing fee calculated according to a study recently commissioned by HHSC.
2. **At-risk pharmacy claims:** Similarly, the expected claims for prescription drugs managed by the MCOs on an at-risk basis would also change. Currently, the expected pharmacy claims costs embedded in the capitation payments are based on the MCOs' actual costs using their negotiated pricing. Under the carve-out, all pharmacy claims would be priced using the methodology described above.

If HHSC were to carve out its pharmacy benefits, it would also no longer be required to pay several other fees and costs which are embedded in the capitation rates paid to MCOs under a managed care model. This includes the risk margin embedded in the MCOs' capitation payments, as well as the ACA Health Insurance Providers Fee. In addition, today a provision for state premium taxes is embedded in the capitation payments from HHSC to the MCOs, then later reimbursed from the MCOs to the State. However, a portion of the premium tax reimbursement is funded by the federal government, and under a pharmacy carve-out model this additional revenue will be lost. This impact is categorized as a cost to the State of carving out HHSC's pharmacy benefits and will be discussed in detail in a subsequent section.

The final row in **Figure 9** represents the impact on rebates from the potential pharmacy carve-out. As HHSC today is already responsible for negotiating and collecting rebates for all claims across both the FFS and managed care populations, the carve-out is not anticipated to change the

[19] While this is true at the date this report was published, as of September 1, 2018, Hepatitis C drugs and Orkambi will be incorporated into the MCO capitation rates.

underlying rebate contracts or composition. However, if utilization changes the mix of drugs under the pharmacy carve-out, the rebate amounts may change commensurately. In calculating potential costs or savings in this report, it is assumed that under the pharmacy carve-out, there would be no changes to the formularies in place at each historical period for Medicaid, CHIP, or any other Texas programs.

To quantify the impact resulting from the framework above, the following steps were conducted. The section in this report where each component is addressed is listed alongside the description.

Figure 10. Steps to Quantifying Future Costs or Savings under Rider 60.

Step	Description	Section of Report Addressed
Step 1	Collect and review data from HHSC	Section 4.2
Step 2	Perform repricing of managed care claims experience using NADAC pricing methodology, plus professional dispensing fee	Section 5
Step 3	Consider and quantify potential impacts on the current managed care population's utilization from carving out prescription drug benefits	Section 6
Step 4	Quantify non-claims related components of the managed care capitation payments, including the ACA Health Insurance Providers fee, risk margin, and the loss of the federal match on the state premium tax	Section 7
Step 5	Quantify current and future administrative costs for the FFS program	Section 8
Step 6	Consider other potential qualitative and quantitative impacts resulting from a pharmacy carve-out	Section 9
Step 7	Synthesize cost components into a comprehensive estimate of costs or savings from the carve-out model	Section 10

4.2. Data Used in the Analysis

The analysis in this report relied on data provided by HHSC. Some of these data sources were developed by HHSC, while others were prepared or created by third parties and delivered to HHSC.

As part of the analysis, all data was reviewed for reasonableness, but an audit of the data was not performed. To the extent the data contains errors

or anomalies that were unknown at the time the data was provided, the analysis may be impacted by those issues. In certain cases, the data was audited or reviewed by other sources, and the results and any conclusions from those reviews were used to determine whether the data was reasonable for use in this report.

The following is a summary of key data items received and used in the study performed for Rider 60:

1. **FFS Pharmacy Claims Data:** HHSC provided its outpatient prescription drug claims data for the Medicaid, CHIP, Healthy Texas Women, CSHCN, and Kidney Health Care members whose benefits were administered on a FFS basis over the study period. Specifically, claims data for all prescription drugs filled between SFY2015 and SFY2017 was provided. **Figure 11** shows a summary of the gross drug costs from the FFS pharmacy claims data used in the analysis.[20,21]

Figure 11. FFS Program Annual Pharmacy Utilization and Gross Costs.

FFS Program Annual Pharmacy Utilization and Gross Costs	SFY2015	SFY2016	SFY2017
Claim Count	4.7M	4.2M	2.1M
Total Gross Drug Costs	$733.4M	$763.8M	$286.4M

2. **MCO Encounter Data:** HHSC also provided the MCOs' pharmacy encounter records for Medicaid and CHIP members enrolled in managed care over the study period. This data set captured all outpatient prescription drug encounters with fill dates between SFY2015 and SFY2017.

   HHSC collects pharmacy encounter data from MCOs to perform rebate negotiation and collection.[20,21] The MCOs transfer their encounter data to HHSC, where the data is stored in a central repository. As a reasonableness check, the encounter data has been compared to the MCOs' self-reported annual Financial Statistical Report (FSR) packages, and the two data sources were found to be consistent.

[20] The FFS claim count and gross drug spend decreased from SFY2016 to SFY2017, and the managed care experience increased, as STAR Kids was carved in to managed care between these two years.
[21] Gross drug costs exclude the impact of member cost sharing and rebates, and the managed care encounter experience includes the costs of drugs reimbursed on a non-risk basis

Figure 12. Managed Care Program Annual Pharmacy Utilization and Gross Costs.

Managed Care Program Annual Pharmacy Utilization and Gross Costs	SFY2015	SFY2016	SFY2017
Claim Count	34.4M	33.7M	35.7M
Total Gross Drug Costs	$2,650.7M	$2,844.2M	$3,398.6M

3. **Claims and Encounter Data Mappings and Tables:** HHSC also provided tables, reports, and mappings that contain additional information required to interpret the FFS claims and managed care encounter data. These sources include, but are not limited to, the current (and historical, where applicable) PDL, lists of drugs currently reimbursed on a non-risk basis to MCOs, and a mapping of pharmacy National Provider Identifier (NPI) to pharmacy type.
4. **Rebate Summary by Fiscal Year:** HHSC provided a file documenting its federal and supplemental rebate experience in total for the combined FFS and managed care populations by state fiscal year.
5. **Capitation Rate Development Files:** HHSC's external actuarial consultant develops pharmacy capitation rates for each program and fiscal year. The capitation rate development files present the assumptions and data sources used by HHSC's external actuary to develop the final capitation rates paid to MCOs. These files are posted publicly on the HHSC website.
6. **HHSC Forecasting Files:** HHSC provided its forecasting files that detail the actual enrollment and pharmacy component of the capitation payments by program and MCO from SFY2015 through SFY2017. These files are developed, updated, and maintained by HHSC's forecasting department. To review these files for reasonableness, the data from these files was compared to other forecasting files produced by HHSC at an aggregated level and any variances were reconciled through conversations with HHSC.
7. **Pricing Methodology Documentation:** HHSC provided files to document its current prescription drug pricing methodology under the FFS program. Many of these documents are available on the State of Texas Health and Human Services website for reference by pharmacies, other providers, and the public. The pricing methodologies enumerated in these documents are in line with the reimbursement approach contemplated by Rider 60 under the pharmacy carve-out. As such, this documentation was used to develop the pricing methodology applied to the managed care encounter data.

8. **Administrative Contracts with External Vendors:** HHSC provided the VDP's contracts with its external vendors. These contracts delineate the administrative functions provided today by each vendor and the costs paid by HHSC for those services.
9. **Payment Summaries of External Vendor Costs:** HHSC also provided a summary of its payments to each external vendor that provides administrative services for the FFS program today. These were used to validate the administrative costs from the VDP's contracts.
10. **Prior Authorization Summaries:** HHSC's VDP website contains a list of current optional PAs approved by the Texas DUR Board, as well as a summary of the PAs elected by each MCO and by the VDP in administering FFS benefits. This information was used to quantify the potential impact of key prior authorizations that are elected by the majority of MCOs but not by the current FFS program.
11. **Public NADAC Price History Data:** To perform the repricing of the managed care encounter data, the full historical NADAC pricing database was used. This dataset is publicly available on the Medicaid website.[22]
12. **HHSC Correspondence:** Throughout the analysis, questions were communicated to HHSC through email and over the phone. Their responses were relied upon to supplement and clarify the information from the files above.

4.3. Key Assumptions and Limitations

This report recalculates pharmacy costs under the hypothetical pharmacy carve-out scenario contemplated by Rider 60. These calculations were performed with the benefit of hindsight in how pharmacy costs and utilization materialized over the study period. Actual experience could be different in the future as new drugs come to market or as other trends in pharmacy administration evolve. The savings estimates presented in this report should not be construed as a statement of how experience will develop in the future if HHSC is to change its approach to pharmacy administration, but rather as a retrospective study of what costs may have been over the study period had the carve-out been in place.

In quantifying the costs or savings under the hypothetical scenario presented by Rider 60, it was assumed that the prescription drug benefit

[22] CMS, "Pharmacy Pricing," https://www.medicaid.gov/medicaid/prescription-drugs/pharmacy-pricing/index.html

design in place at each historical time period would have remained the same under the pharmacy carve-out model.

In quantifying how administrative costs may change under the pharmacy carve-out, knowledge of current market trends and pricing was used. However, pricing quotes were not requested on HHSC's behalf from external vendors. HHSC would need to request those quotes to secure actual pricing and evaluate costs for SFY2018 and beyond.

Throughout the report, rebates have been considered in the aggregate only, as detailed rebate experience by drug or therapeutic class was not made available. For scenarios that incorporate a change in prescription drug utilization from the levels historically incurred by members under HHSC's managed care model, a corresponding adjustment was also made to HHSC's aggregate rebate offset amount. This adjustment reflects that when drug utilization changes, rebates are anticipated to change as well.

Specifically, the analysis assumes that the actual historical ratio of total rebates to total gross ingredient costs would remain constant after a change in utilization, and rebates are adjusted up or down following a change in assumed utilization to hold this ratio constant. This approach implies that the underlying drug mix would remain the same after the change in utilization.

The costs and savings estimates in this report are presented on an all-funds basis, inclusive of both the state and federal impact from the transition to a pharmacy carve-out.

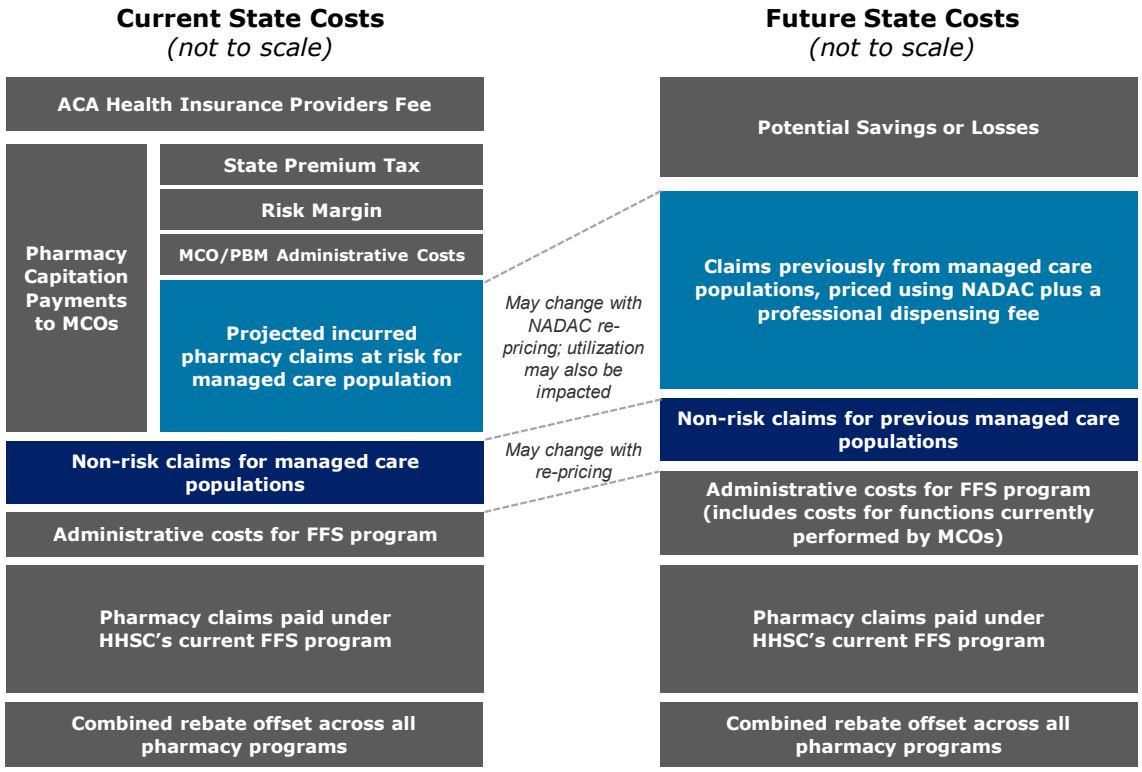
Other assumptions and limitations may be detailed in subsequent sections of this report.

5. Estimated Impact from Repricing

The first step to quantifying the changes contemplated by Rider 60 was to determine the amount that would be paid on a FFS basis for the claims incurred by MCOs' membership today. This step requires restating the costs for the MCOs' pharmacy encounter data using the pricing methodology that would be applied under the carve-out. Specifically, Rider 60 states that a pricing methodology based on NADAC should be applied, with a dispensing fee calculated according to a recent study commissioned by HHSC.

Relating back to the graphic presented in **Section 4 Approach and Methodology** to visualize the savings under Rider 60, this section focuses on the segments highlighted below. Claims paid today on an at-risk basis to MCOs, as well as claims that are reimbursed on a non-risk basis, are impacted by the repricing.

Figure 13. Focus of Analysis Performed in Sections 5 and 6.



5.1. Description of Current FFS Pricing Methodology

This section outlines HHSC's current approach to calculating pharmacy prices for its Medicaid FFS program. This pricing methodology is largely in line with the approach stipulated by Rider 60 for use in the potential pharmacy carve-out. As such, this methodology is applied to the managed care encounter data in the repricing analysis.

State Medicaid agencies reimburse pharmacies for the cost of their members' outpatient drugs in two components: (1) reimbursement for the ingredient costs of the drugs and (2) reimbursement for their cost to dispense the drug (referred to as a dispensing fee). The subsequent sections discuss the FFS pricing methodology for each of these two components.

5.1.1. FFS Program Ingredient Cost Reimbursement Methodology

Federal regulations require that state Medicaid agencies reimburse pharmacies for their members' ingredient costs using a best estimate of the actual acquisition cost for the pharmacy to provide the drug.[23] Various benchmarks exist for determining the estimated acquisition cost, and state Medicaid agencies may vary in which benchmark they select. NADAC is one appropriate benchmark used by state agencies for calculating their reimbursements to pharmacies. NADAC was developed on behalf of the Centers for Medicare & Medicaid Services (CMS) and represents the average acquisition costs for covered outpatient drugs purchased by retail community pharmacies.[24] CMS maintains the NADAC pricing compendium on its website, where it is updated on a weekly basis to reflect changes in average drug prices.[25]

NADAC pricing varies at the drug level by National Drug Code (NDC). An NDC is a unique, numerical indicator for a drug that contains information on the manufacturer, product, and package size. The NADAC price per unit for

[23] CMS, "Implementation of the Covered Outpatient Drug Final Regulation Provisions Regarding Reimbursement for Covered Outpatient Drugs in the Medicaid Program," https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16001.pdf
[24] CMS, "Methodology for Calculating the National Average Drug Acquisition (NADAC) for Medicaid Covered Outpatient Drugs," https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/ful-nadac-downloads/nadacmethodology.pdf
[25] CMS, "Pharmacy Pricing," https://www.medicaid.gov/medicaid/prescription-drugs/pharmacy-pricing/index.html

an NDC may be multiplied by the quantity of the drug dispensed to calculate the total ingredient cost to be reimbursed to the dispensing pharmacy.

The Texas Medicaid FFS program began using NADAC as its primary ingredient cost reimbursement benchmark beginning on June 1, 2016. For drugs that are not contained in the NADAC pricing list (which may be the case for new drugs or for specialty drugs that are only available from specialty pharmacies), HHSC uses a reimbursement methodology based on a drug's wholesale acquisition cost (WAC) price. WAC is another widely accepted drug pricing benchmark that represents an estimate of the drug manufacturer's reported list price to its wholesalers.

As of 2018, NADAC prices are only studied and published by CMS for retail community pharmacy entities. Prices from specialty pharmacies are specifically excluded. Variance likely exists in the average ingredient costs for drugs dispensed from specialty and long-term care (LTC) pharmacies compared to retail pharmacies, as the entities may dispense different drug types and require different operating models. Recognizing these differences, HHSC applies different pricing methodologies for each pharmacy type in calculating the reimbursement amounts for its current FFS program.

HHSC's ingredient cost reimbursement methodologies by pharmacy type are as follows[26]:

- **Retail Pharmacies:** The ingredient cost is equal to the NADAC price, or WAC minus 2 percent if NADAC pricing is not available.
- **Specialty Pharmacies:** The ingredient cost is equal to NADAC minus 1.7 percent, or WAC minus 8 percent if NADAC pricing is not available.
- **LTC Pharmacies:** The ingredient cost is equal to NADAC minus 2.4 percent, or WAC minus 3.4 percent if NADAC pricing is not available.

The Medicaid FFS program's pricing methodology varies from NADAC pricing for certain claim types. These categories include the following, which each represent a small portion of the total program costs (see **Figure 14** for details):

- **340B Claims:** Certain eligible health care organizations participate in the 340B Drug Pricing Program, which allows covered entities to purchase drugs at a highly discounted price. For pharmacy claims that qualify for 340B pricing in Texas, HHSC's FFS program reimburses ingredient costs

[26] Texas Health and Human Services, "Vendor Drug Pharmacy Provider Procedure Manual" (see link for Pricing and Reimbursement), https://www.txvendordrug.com/about/policy/manual

at a discounted percentage of the WAC price. The discount applied may range from 23.1% to 57.0% and varies based on the NDC.

- **VDP Acquisition Cost (VAC):** Certain NDCs are priced based on the VAC when there is no price for NADAC or WAC, or when there is newer pricing than what is available. The VAC price is established by HHSC using invoices from pharmacies.
- **Limited Home Health Supplies (LHHS):** Certain product groupings, such as LHHS, vitamins and minerals, and mosquito repellent, are reimbursed at a fixed amount which varies by NDC. Pharmacies are not paid a dispensing fee or delivery incentive for these claims.
- **NADAC Generic Equivalent (NGR):** For brand drugs where there is a generic equivalent available and the price for that generic drug is lower than the NADAC price for the brand drug dispensed, the generic's NADAC price is reimbursed. However, there may be certain circumstances in which the full price is reimbursed, including when a claim is submitted with a dispense as written (DAW) indicator or if the NDC is on HHSC's preferred NADAC price list.

Additionally, the total ingredient cost reimbursement amount is limited for all claims to the minimum of the Usual & Customary (U&C) amount and Gross Amount Due (GAD) submitted by the pharmacy. The U&C price reflects the cost of the drug to the consumer at the retail level without the use of insurance, and the GAD price is the amount requested by the pharmacy. In cases where the calculated ingredient cost is greater than the U&C or GAD, the VDP only reimburses the minimum of the U&C and GAD.

The table below summarizes the percentage of scripts and total ingredient costs for the FFS program in SFY2017 that were subject to each limit or criteria from the VDP's pricing methodology. The table displays gross costs before rebates.

Figure 14. SFY2017 Gross FFS Program Ingredient Costs by Pricing Methodology.

Reimbursement Methodology Applied	Claim Count	% of Total Claims	Total Ingredient Cost	% of Total Ingredient Cost	Average Ingredient Cost per Claim
NADAC	1.71M	82.7%	$175.44M	65.8%	$102.76
WAC	0.03M	1.3%	$69.09M	25.9%	$2,585.96
VAC	0.01M	0.3%	$10.35M	3.9%	$1,848.64
Limited to U&C/GAD	0.26M	12.5%	$7.00M	2.6%	$27.11
340B	0.02M	1.0%	$2.87M	1.1%	$144.09
NGR	0.01M	0.6%	$1.15M	0.4%	$86.16
LHHS	0.03M	1.6%	$0.73M	0.3%	$22.65
Other	0.00M	0.0%	$0.04M	0.0%	$54.68
Grand Total	**2.06M**	**100.0%**	**$266.68M**	**100.0%**	**$129.18**

5.1.2. FFS Program Dispensing Fee Reimbursement Methodology

The FFS program reimburses the professional dispensing fee to pharmacies using a formula based on the ingredient cost of each claim. There is both a "fixed" and a "variable" component of the dispensing fee calculation. The fixed component represents a reimbursement to cover the pharmacies' fixed costs per claim, while the variable component varies with costs that may change commensurately with ingredient costs:

Dispensing Fee = (Fixed Component + Ingredient Cost) / Variable Component – Ingredient Cost

Prior to June 1, 2016, HHSC's fixed component of the dispensing fee calculation was set at $6.50 and the variable component was 0.9804. In June 2014, HHSC commissioned a study[27] of the average actual dispensing costs incurred by pharmacies serving Medicaid beneficiaries. The study found the average cost to pharmacies to dispense an outpatient prescription drug was equal to $10.12.[28] The report suggested HHSC update the $6.50 fixed

[27] Texas Health and Human Services, "Survey of the Average Cost of Dispensing a Medicaid Prescription in the State of Texas," https://www.txvendordrug.com/sites/txvendordrug/files/docs/reports/2014-06-cost-of-dispensing-study.pdf

[28] The average dispensing fee from the study was weighted by Medicaid volume and excludes drugs dispensed through specialty pharmacies.

component of its dispensing fee formula to result in an average dispensing fee more closely aligned with the actual costs incurred by pharmacies.

As of June 1, 2016, HHSC adopted formula modifications to reflect dispensing fees closer to actual costs. The resulting formula for calculating the base dispensing fee, which is still in place as of SFY2018, is to add a $7.93 fixed component to a drug's total ingredient cost, divide the resulting sum by 0.9804, and then subtract the drug's ingredient cost.

In addition, other amounts may be added to the base dispensing fee if the dispensing pharmacy meets certain criteria. An additional $0.15 per claim is reimbursed if the pharmacy has been certified as providing free delivery service to members enrolled in Medicaid. In addition, $0.50 is added if the pharmacy dispenses a premium preferred generic (PPG) product, as defined by HHSC on its PDL.

As with the ingredient cost pricing methodology, certain limits and exclusions apply:

- The dispensing fee is capped at $200 for a single claim.
- The total amount of the claim (ingredient cost + dispensing fee) is limited to the minimum of the U&C and GAD price submitted on the claim; thus:
  - If the minimum of the U&C and GAD is lower than the (ingredient cost + dispensing fee) but higher than the ingredient cost, then the dispensing fee is limited to the minimum of the U&C and GAD minus the ingredient cost.
  - If the minimum of the U&C and GAD is lower than the ingredient cost, then no dispensing fee is paid.
- LHHS claims do not receive a dispensing fee.

The table below in **Figure 15** summarizes the total dispensing fees for the FFS program based on the categories described above. [29]

[29] The total percentage does not sum to 100%; this is due to rounding. Other tables in this report may also reflect differences between the sum of the rows and the total. In all cases, these differences are due to rounding.

Figure 15. SFY2017 FFS Program Dispensing Fees by Pricing Methodology.

Dispensing Fee Methodology	% Total Claims	Average Dispensing Fee per Claim
Standard methodology ($7.93 fixed + 0.9804 variable)	86%	$10.35
Fee limited to U&C/GAD minus ingredient cost	10%	$4.09
U&C/GAD is less than ingredient cost	1%	$0.00
LHHS claims with no dispensing fee	2%	$0.00
Standard methodology, but capped by $200 limit	0%	$200.00
Grand Total	**100%**	**$9.56**

5.1.3. Checks Performed to Validate FFS Pricing Methodology

The FFS pricing methodology described in this section was compared and consistent with actual costs coded on each FFS claim record for prescription drugs dispensed after June 1, 2016 (where before this date, a different reimbursement methodology was used). The comparison was conducted by recalculating the costs for the FFS program data using the methodology described above and comparing to the costs coded on the claim records.

During this process, variances between the recalculated amounts and the actual costs coded on the FFS claims data were reconciled through communication with HHSC. As **Figure 16** shows, the final pricing algorithm produced variances of less than 0.2% in total ingredient costs and less than 0.1% in total dispensing fees when compared to the calculated amounts to the costs coded in the FFS data.

Figure 16. Results of SFY2017 FFS Pricing Methodology Validation.

Cost Component	Actual Cost Reimbursed under FFS Program	Repriced Cost	% Difference
Gross Ingredient Costs	$266.7M	$267.0M	0.12%
Dispensing Fees	$19.7M	$19.8M	0.04%
Grand Total	**$286.4M**	**$286.7M**	**0.11%**

Some amount of variance may be expected in such an exercise due to data inconsistencies or overrides made to the costs on specific claim lines. The remaining variances were considered nominal enough to indicate the drugs were priced using the intended methodology.

5.2. Description of Encounter Data Repricing Approach

Rider 60 does not explicitly state that reimbursement under the pharmacy carve-out model should include all of the caveats, exclusions, and stipulations applied for the FFS program today. However, given the similarities between the Rider text and the current reimbursement approach used under the FFS program, it was assumed the intention of the Rider was to quantify the costs assuming today's FFS program pricing methodology was applied to the managed care encounter data. As such, the FFS methodology described above was applied to the managed care encounter drug utilization to calculate the repriced ingredient cost and dispensing fees.

Prior to June 1, 2016, the VDP applied a different ingredient cost pricing methodology from the one described in the prior section and one that was not based on NADAC. This old methodology was not replicated in the repricing exercise, but rather the methodology currently in place was applied across all historical years. This decision was made because only the current pricing methodology is consistent with the intention of the Rider, which is to use an algorithm based on NADAC.

In repricing the dispensing fee, however, the fixed component of the dispensing fee formula in place at each historical period was applied ($6.50 prior to June 1, 2016, and $7.93 thereafter). The actual historical fixed components were incorporated because HHSC's dispensing fee formula is intended to help index the dispensing fee payment to pharmacies' actual costs for dispensing prescription drugs, which are expected to increase over time. Using the actual fixed component in place at each time reflects these increases in the analysis.

The key inputs used in repricing the managed care encounter data were the following:

- **NDC:** This represents the drug type dispensed and was used to calculate the ingredient costs according to the pricing methodology delineated in **Section 5.1 Description of Current FFS Pricing Methodology**.
- **Pharmacy type:** HHSC provided a mapping from the NPI coded on each encounter data record, which identifies the pharmacy from which the script was dispensed, to the pharmacy type used in ingredient cost pricing. This was used to determine the discount from NADAC or WAC that should be applied in calculating the ingredient cost for each claim.
- **U&C and GAD amounts:** As described in **Section 5.1**, the U&C and GAD amounts are submitted by the pharmacy on each pharmacy encounter

record. The total reimbursement for each claim was capped at the minimum of the U&C and GAD amounts.

- **Basis of reimbursement indicator:** This is included on each managed care pharmacy encounter record and was used to identify 340B claims.
- **PPG indicator:** An indicator of whether the claim constitutes a PPG drug was mapped onto each encounter data record based on its status in the Texas PDL. This indicator was used to determine whether the $0.50 incentive fee component of the delivery fee should apply.
- **Delivery fee indicator:** HHSC provided a list of pharmacy NPIs that should receive the $0.15 delivery incentive component of the dispensing fee. This mapping was added to the managed care encounter data records and used in the calculation.

In performing the analysis, there were several categories of claims that could not be repriced according to the FFS pricing methodology:

- **Noncovered NDCs for compound drugs:** In the encounter data, compound drugs may have multiple records to represent the various NDCs that are included in the compound. NDCs that were included in a compound drug but that are not covered by the Medicaid program are represented as an encounter record with $0 costs. These constitute only about 0.6% of claims from the managed care encounter data in SFY2017. These claims were excluded from the analysis as they are not covered by the Medicaid program.
- **Compound drugs with no NDC:** Additionally, 0.4% of ingredient costs in the managed care encounter data are attributable to compound claims coded without an NDC. The ingredient costs for these claims cannot be repriced, as the NDC is critical for determining the NADAC or WAC price per unit. For these records, it was assumed that ingredient costs would remain the same as the amount coded directly on the encounter record. However, the dispensing fee was repriced, as it is not dependent on drug type. It is not expected that the small amount of these claims would impact the cost or savings estimates materially.
- **Claims with invalid NDCs:** A small portion of claims had an NDC that did not map to any of the pricing files. These instances constituted less than 0.1% of managed care claims and ingredient costs. For these claims, it was assumed that ingredient costs would remain the same as the amount coded directly on the encounter data record, but the dispensing fee was repriced. As per the above, it is not expected that these claims would materially impact the cost or savings estimates.

The following section documents the outcomes of the managed care encounter data repricing to align the pricing methodology with the current FFS program.

5.3. Summary of Repricing Impact

Figure 17 on the next page shows a comparison of the gross drug costs from the managed care population before and after the repricing to align the pricing methodology with the current FFS program.[30]

[30] All costs in this section represent gross costs before rebates. The experience includes the costs of drugs reimbursed on a non-risk basis.

Figure 17. Gross Pharmacy Costs for Managed Care Population Before and After Repricing.

Repricing Impact	SFY	Total Scripts	Total Drug Costs (before Rebates) for Ingredient Costs	Total Drug Costs (before Rebates) for Dispensing Fees	Total Drug Costs (before Rebates) for Total Costs	Average Cost per Script for Ingredient Cost	Average Cost per Script for Dispensing Fee	Average Cost per Script for Total Cost/ Script
SFY2015 Managed Care Experience	2015	34.4M	$2,602.3M	$48.4M	$2,650.7M	$75.63	$1.41	$77.04
SFY2015 Repriced using FFS Methodology	2015	34.4M	$2,437.9M	$245.8M	$2,683.7M	$70.85	$7.14	$78.00
SFY2015 Gross Costs/(Savings) Impact	**2015**	**34.4M**	**($164.4M)**	**$197.4M**	**$33.0M**	**($4.78)**	**$5.74**	**$0.96**
SFY2015 Gross Cost/(Savings) % Impact			**-6.3%**	**408.0%**	**1.2%**			
SFY2016 Managed Care Experience	2016	33.7M	$2,803.9M	$40.2M	$2,844.2M	$83.08	$1.19	$84.28
SFY2016 Repriced using FFS Methodology	2016	33.7M	$2,623.5M	$237.3M	$2,860.8M	$77.74	$7.03	$84.77
SFY2016 Gross Costs/(Savings) Impact	**2016**	**33.7M**	**($180.4M)**	**$197.1M**	**$16.6M**	**($5.24)**	**$5.73**	**$0.48**
SFY2016 Gross Cost/(Savings) % Impact			**-6.4%**	**489.6%**	**0.6%**			
SFY2017 Managed Care Experience	2017	35.7M	$3,360.0M	$38.6M	$3,398.6M	$94.05	$1.08	$95.13
SFY2017 Repriced using FFS Methodology	2017	35.7M	$3,144.5M	$282.8M	$3,427.3M	$88.02	$7.92	$95.94
SFY2017 Gross Costs/(Savings) Impact	**2017**	**35.7M**	**($215.6M)**	**$244.2M**	**$28.7M**	**($6.27)**	**$7.10**	**$0.83**
SFY2017 Gross Cost/(Savings) % Impact			**-6.4%**	**632.5%**	**0.8%**			

After the repricing, average dispensing fees increased compared to the amounts historically paid by MCOs. Specifically, in SFY2017, the average dispensing fee rose from $1.08 per script to $7.92 per script based on the revised methodology. On the other hand, the average ingredient cost decreased from $94.05 to $88.02 per script in SFY2017. In total, the overall gross drug costs increased slightly by $0.83 per script in SFY2017 (0.8% of gross drug costs).

The overall increase in costs from the repricing varies slightly by fiscal year (from $0.96 per script in SFY2015 to $0.83 in SFY2017); however, the change in ingredient cost remains consistent as a percentage of total ingredient costs. The change in the dispensing fee fluctuates between SFY2016 and SFY2017 due to the increase in fixed cost component from $6.50 to $7.93 starting on June 1, 2016.

One note is that the average repriced dispensing fee per claim in SFY2017 of $7.92 is lower than the average cost of $10.12 suggested by the dispensing fee study. This is due to the existence of claims for which the FFS program's pricing logic limits the total cost to the U&C or GAD, and thus, the dispensing fee is capped. To illustrate, **Figure 18** shows a breakdown of the repriced dispensing fees for HHSC's SFY2017 managed care experience, split by how the pricing logic impacted the dispensing fee repriced on the claim.

For the 69% of managed care encounter claims that were not limited by the U&C or GAD criteria and repriced according to the typical dispensing fee logic, the average dispensing fee is $10.14 per claim, in line with the average cost suggested by the dispensing fee study. However, 23% of all managed care encounter claims are subject to the limits inherent in the FFS program's pricing logic, decreasing the average dispensing fee to $7.92.

Figure 18. SFY2017 Managed Care Repriced Dispensing Fee Breakdown.

Dispensing Fee Methodology	% of Total Claims	Average Dispensing Fee per Claim
Standard methodology ($7.93 fixed + 0.9804 variable)	69%	$10.14
Fee limited to U&C/GAD minus ingredient cost	23%	$3.75
U&C/GAD is less than ingredient cost	5%	$0.00
LHHS claims with no dispensing fee	4%	$0.00
Standard methodology, but capped by $200 limit	0%	$200.00
Grand Total	**100%**	**$7.92**

To summarize the discussion in this section, **Figure 19** below shows the total impact of the repricing on the managed care encounter data. Positive numbers indicate additional costs to HHSC, rather than savings.

Figure 19. Costs/(Savings) Impact from Repricing Managed Care Encounter Data.

Cost Component	SFY2015	SFY2016	SFY2017
Total Impact from Repricing	**$33.0M**	**$16.6M**	**$28.7M**

6. Estimated Impact on Utilization

The prior section assumed that the prescription drug utilization for the current managed care population would not change under the pharmacy carve-out. In migrating HHSC's pharmacy benefits from a managed care environment to a FFS delivery model, there may be a change in the underlying costs and utilization if the FFS program does not manage care in the same way as its MCOs. In estimating the savings pursuant to carving out HHSC's pharmacy benefits, it was necessary to consider how pharmacy utilization may shift following the transition.

6.1. Background

A key objective of a managed care payment model is to create a more efficient delivery system than a traditional FFS model. To help accomplish that goal, in administering pharmacy benefits, an MCO may perform UM to determine the appropriateness of drugs, require PA before a medication is dispensed, and use other techniques and strategies intended to lower costs and ensure the clinical appropriateness of prescription drug benefits. Transitioning from a managed care model to a FFS program may generate a shift in members' drug utilization and drug mix if members are no longer limited by MCOs' formulary restrictions, prior authorization rules, or UM programs. This shift in drug use could materialize as an increase in overall drug utilization as members receive more prescription drugs or as a shift to more expensive drugs. Both scenarios may cause an increase in total program pharmacy costs.

However, some state Medicaid agencies already have strong protocols in place that restrict and direct members' drug use as effectively as MCOs under a managed care model. If a state-run Medicaid program manages its members' utilization as effectively as an MCO, no increase in utilization under a carve-out scenario may be expected. As discussed in **Section 3 Background on HHSC's Current Pharmacy Program**, today HHSC places multiple restrictions on how MCOs may administer their members' prescription drug benefits. These restrictions include defining a uniform PDL to which all MCOs must adhere, defining the prior authorizations that must be applied by both the FFS program and by MCOs, and performing rebate negotiation and collection centrally. In effect, because of the restrictions enforced by HHSC, MCOs in Texas today may not be able to use formulary management and UM to direct and manage drug utilization to the extent they may be able to in other states.

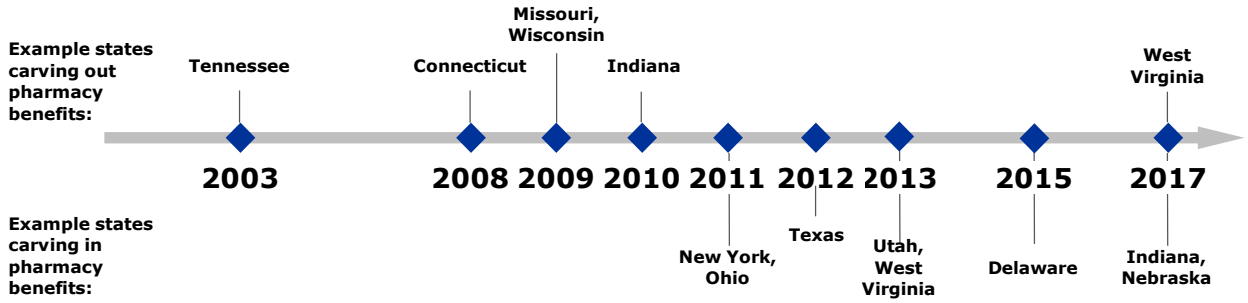
With these principles in mind, the following section discusses the results of recent carve-out programs in other Medicaid states.

6.2. Current Landscape in Other States

When Medicaid was first enacted in 1965, states administered their members' health care benefits on a FFS basis. Beginning in the mid-1980s, however, the use of managed care as a delivery system for Medicaid programs began to grow in popularity. Today, MCOs cover nearly two-thirds of Medicaid beneficiaries nationwide.[31] Some states use MCOs to holistically manage both their medical and pharmacy benefits, while others "carve-in" only their medical benefits to MCOs and continue to administer their pharmacy benefit on a FFS basis.

Over the past 20 years, there have been several trends of states carving in or carving out their pharmacy benefits from managed care (see **Figure 20** below).

Figure 20. Selected History of Pharmacy Benefit Administration Changes by State.



In the 2000s, several states carved out their pharmacy benefits from managed care, including Tennessee, Connecticut, Missouri, Wisconsin, and Indiana. However, after the passage of the ACA, which permitted state Medicaid agencies to receive rebates on the drug utilization from both their FFS and managed care programs, the trend reversed and a number of states that had previously administered their pharmacy benefits under a FFS delivery model transitioned back to managed care. These states included New York, Ohio, Texas, Utah, West Virginia, Delaware, Indiana, and Nebraska. Most recently, in 2017, West Virginia elected to carve out its

[31] Kaiser Family Foundation, "Medicaid Managed Care Plans and Access to Care: Results from the Kaiser Family Foundation 2017 Survey of Medicaid Managed Care Plans," https://www.kff.org/medicaid/report/medicaid-managed-care-plans-and-access-to-care-results-from-the-kaiser-family-foundation-2017-survey-of-medicaid-managed-care-plans/

pharmacy benefits, though it is too soon to tell whether this decision will represent a new trend in prescription drug benefit administration.

States' decisions to carve in their pharmacy benefits during the 2010s came in the wake of studies that indicated administering pharmacy benefits on a FFS basis may increase overall prescription drug costs. One such study, published in April 2015[32] on behalf of America's Health Insurance Plans, concluded that the states that rely on MCOs to manage their pharmacy benefits generally make use of less expensive generic drugs and have lower average costs per prescription than states that administer prescription drug benefits on a FFS basis.

That study did recognize that programmatic differences between state agencies may vary the extent to which MCOs in a pharmacy carve-in are able to influence costs. The impact of such programmatic differences is important in the case of Rider 60, since under the current pharmacy carve-in model in Texas, HHSC restricts how MCOs administer prescription drug benefits. These restrictions may decrease the differential in costs and utilization between today's managed care environment and a future-state pharmacy carve-out.

Therefore, to gauge how the transition from managed care to FFS may influence members' drug use in Texas, an analysis of the primary areas where the Texas MCOs today may vary from the FFS program's protocols was performed. The areas of difference today include:

1. MCOs may elect from a menu of optional clinical PAs defined by the Texas DUR Board in administering benefits for their members. As of February 2018, when the analysis in this section was performed, the VDP elected 57 of the optional PAs in place at the time for use in its FFS program, while each MCO elected between 40 and 66 of the optional PAs. To the extent MCOs select different PAs from this list than the FFS program, different utilization patterns may result.
2. MCOs each operate their own UM programs (subject to some limitations by the VDP). Variances in UM between the FFS program and the MCOs may lead to differences in how each program directs utilization to covered prescription drugs.

[32] America's Health Insurance Plans, "Comparison of Medicaid Pharmacy Costs and Usage in Carve-in Versus Carve-out States," https://www.ahip.org/wp-content/uploads/2015/11/Medicaid-Pharmacy-Carve-In-Final-Paper-The-Menges-Group-April-2015.pdf

The following sections discuss and analyze these programmatic differences between the FFS program and the MCOs and quantify how the differences may affect the underlying utilization in transitioning to a single-payer model.

6.3. Potential Impact from Prior Authorization Variances

Clinical PAs must be approved by the Texas DUR Board. Once approved, a PA is available for use by the VDP for administering the FFS program, as well as by MCOs in administering pharmacy benefits for their populations. As of the publishing of this report, there are five clinical PAs that all MCOs and the VDP are required to perform and 73 optional clinical PAs that may be elected for use at the discretion of each MCO.

The VDP publishes a table to demonstrate which optional PAs are elected by each MCO and by the VDP[33], as well as whether each MCO applies all or only some steps of the PA. For the optional PAs elected by a large number of MCOs today, but not by the VDP for use in the FFS program, utilization for the drugs subject to the PAs may potentially change in a transition to a carve-out model if the PAs are no longer enforced.

As of February 2018, when this analysis was performed, there were nine optional PAs that were elected and used by five or more of the MCOs. **Figure 21** on the following page displays the managed care utilization and repriced costs for the drugs affected by these PAs in SFY2017 for the STAR program. [34,35,36] Some of the PAs affect therapeutic classes or drugs for which only a small number of scripts were dispensed in SFY2017, while others affect a larger volume of scripts.

[33] Texas Health and Human Services, "Pharmacy Clinical Prior Authorization Assistance Chart," https://www.txvendordrug.com/sites/txvendordrug/files/docs/prior-authorization/cpa-assistance-chart.pdf
[34] During SFY2017, there were 19 total MCOs.
[35] Managed Care Scripts represent all scripts dispensed for drugs in the PA category, not necessarily all of which were subject to the PA.
[36] Repriced Managed Care Drug Costs uses repriced costs to reflect the impact of NADAC pricing methodology.

Figure 21. SFY2017 STAR Experience for Drugs with PAs Elected by Most MCOs and Not by the VDP.

Optional Clinical PA Description (As of February 2018)	Number of Texas MCOs Electing PA	Managed Care Scripts	% of Total Managed Care Scripts	Repriced Managed Care Drug Costs	% of Total Managed Care Costs
Cytokine and Cell Adhesion Molecule (CAM) Antagonists	17	7,432	0.04%	$34.1M	2.50%
Topical Acne Agents	15	96,055	0.50%	$18.8M	1.38%
Hereditary Angioedema (HAE) Agents	15	53	0.00%	$1.6M	0.12%
Gaucher's Disease Agents	16	69	0.00%	$1.0M	0.08%
Xenazine	18	51	0.00%	$0.5M	0.04%
Lidoderm (Lidocaine) Patch	18	916	0.00%	$0.2M	0.01%
Savella (Milnacipran)	17	502	0.00%	$0.1M	0.01%
Nuplazid	14	0	0.00%	$0.0M	0.00%
Zelboraf (Vemurafenib)	17	0	0.00%	$0.0M	0.00%
Grand Total	**N/A**	**105,078**	**0.55%**	**$56.3M**	**4.13%**

To understand the potential impact of enforcing the above optional PAs, one may compare the experience of the MCOs who elected the PA to a similar benchmark population for which the PAs were not applied. The differences in utilization patterns may be due to the differences in whether each group enforces the PAs. While the VDP's FFS program is one such population for which these optional PAs are not applied today, the underlying composition of members in the FFS program varies substantially from the MCOs and includes children, ESRD patients, and other groups that have meaningfully different drug use patterns than Medicaid members. For that reason, the MCOs' experience was not compared to the FFS program to ascertain the impact from optional PAs.

However, for each PA above, the total managed care experience can be split between MCOs that apply each optional PA versus those that do not. The following table compares the cost and utilization of these two cohorts for the STAR program. Performing this comparison for only the STAR program allows for a like comparison across a cohesive population, whereas comparing experiences of STAR and STAR+PLUS members, for example,

may inherently capture different utilization patterns not attributable to the PA variances.

The comparison suggests that for some PAs, utilization and costs are higher for the populations where MCOs do not apply the PA criteria than for those that enforce the PA. [37]

[37] Gross costs represent the repriced costs following the pricing methodology described in **Section 5 Estimated Impact from Repricing**, before rebates.

Figure 22. Anticipated Impact of Optional PA Variances for STAR Program.

Optional Clinical PA Description	*Experience for MCOs that Apply PA:* Annual Scripts per 1,000	*Experience for MCOs that Apply PA:* Gross Costs PMPY	*Experience for MCOs that Do Not Apply PA:* Annual Scripts per 1,000	*Experience for MCOs that Do Not Apply PA:* Gross Costs PMPY	*Impact from Applying Difference in PMPY:* Estimated Impact	*Impact from Applying Difference in PMPY:* Impact as a % of MCO Costs
Cytokine and CAM Antagonists	2.29	$10.58	6.90	$29.43	$53.8M	3.9%
Topical Acne Agents	31.05	$5.32	35.14	$8.86	$7.7M	0.6%
HAE Agents	0.00	$0.00	0.06	$1.69	$3.4M	0.3%
Gauchers Disease Agents	0.02	$0.22	0.03	$0.68	$1.0M	0.1%
Xenazine	0.02	$0.18	0.02	$0.20	$0.1M	0.0%
Lidocaine Patches	0.33	$0.06	0.23	$0.03	$0.0M	0.0%
Savella	0.15	$0.04	0.24	$0.07	$0.1M	0.0%
Nuplazid	0.00	$0.00	0.00	$0.00	$0.0M	0.0%
Zelboraf	0.00	$0.00	0.00	$0.00	$0.0M	0.0%
Grand Total					**$66.0M**	**4.8%**

As an example of how to interpret the table above, the first row indicates that for the MCOs that do not apply the PA for "Cytokine and CAM Antagonists," utilization of these drugs is approximately three times higher than for populations where the MCOs do elect the PA (6.90 versus 2.29 scripts per 1,000 members). For these drugs, this leads to an average annual cost per member approximately three times higher where the PA is not applied ($29.43 per member per year (PMPY) versus $10.58). This difference in the two populations suggests that in moving from an environment in which this PA is enforced to one in which the PA is no longer used, the underlying utilization and costs of the population may increase.

In the rightmost columns of the above table, the impact on costs from this potential shift was estimated by applying the difference in per member costs between the two groups to the average annual membership that would no longer have each PA applied under the pharmacy carve-out. Extending the example for PA for Cytokine and CAM Antagonists, the difference in annual per member costs of $18.85 ($29.43–$10.58) was applied to the approximately 2.9 million members enrolled today in MCOs that apply the PA. These are the members for which the utilization may be subject to an increase in a model where the VDP no longer enforces the PA requirement. This calculation assumes that the populations covered by MCOs that apply the PA, versus those that do not apply the PA, have similar incidence rates of conditions that require the drugs in the categories above.

For some of the PAs in **Figure 22**, the variance in utilization between MCOs that do and do not apply the PA is small. In other cases, the population that does not apply the PA already has the same or slightly less utilization of these drugs. In those cases, no cost or utilization changes may be anticipated.

It is possible there may be other drivers of the differences in utilization between the two groups of MCOs in the table above. For example, the populations covered by MCOs that do not apply the PA may have different underlying disease profiles that inherently drive higher utilization than the MCOs that apply the PA (and the numbers in the table above have not been risk-adjusted). However, patterns in the analysis above may still be used to draw high-level inferences about how the differences in PAs may be expected to shift utilization.

The analysis above was repeated for each of the managed care Medicaid and CHIP populations. Pharmacy experience between the MCOs that apply the PA and the MCOs that do not was compared, and the variances in per member costs were extrapolated to estimate the possible impact of removing the PA

in the pharmacy carve-out. The resulting impact for each population varied based on the composition of its members and their drug use patterns. These results are documented in **Appendix A**.

In total, across all managed care Medicaid and CHIP populations, the calculated impact of removing the PAs equates to 2.2% of gross drug costs in SFY2017. This represents the potential increase in gross costs for the managed care population if it were to transition to a delivery model in which the same optional PAs are not applied.

This 2.2% increase in gross pharmacy costs, driven largely by utilization of certain drugs for which PAs are applied today, would also have a corresponding impact on rebates (rebates increase when utilization increases, and vice versa).

As previously mentioned, the VDP collects federal and supplemental rebates for all pharmacy utilization across the FFS and managed care programs. As such, rebate experience is only available in aggregate across both programs. This aggregated rebate data was used to approximate the increase in rebates that might accompany a 2.2% increase in gross pharmacy costs. The total rebate experience is presented in **Figure 23** below, and from this data the ratio of total rebates as a percentage of total gross ingredient costs was calculated.

Figure 23. Total Annual Rebate Experience across HHSC's Pharmacy Program (in Millions).

Combined FFS and MCO Experience	SFY2015	SFY2016	SFY2017
Total Gross Pharmacy Costs	$3,384.1M	$3,608.0M	$3,685.1M
Combined Federal and Supplemental Rebate Offset	$1,858.7M	$2,144.7M	$2,251.6M
Rebates as Percentage of Gross Pharmacy Ingredient Costs	**54.9%**	**59.4%**	**61.1%**

The ratio of rebates to gross ingredient costs from **Figure 23** was then applied to the estimated change in gross pharmacy costs under the pharmacy carve-out to calculate the impact on HHSC's rebate offset in **Figure 24** below. The net cost impact from the anticipated change in utilization under the pharmacy carve-out is equal to the increase in gross pharmacy costs, less the estimated increase in HHSC's rebates:

Figure 24. Net Cost Impact of +2.2% Utilization Change after Rebates (in Millions).

Cost Impact	SFY2015	SFY2016	SFY2017
+2.2% Gross Pharmacy Cost Increase	$58.4M	$62.3M	$74.6M
Rebates as % of Gross Costs	54.9%	59.4%	61.1%
Rebate Increase	($32.1M)	($37.0M)	($45.6M)
Net Impact	**$26.3M**	**$25.2M**	**$29.0M**

This methodology holds the historical ratio of rebates to gross pharmacy costs steady, implying that the underlying drug mix would not change if utilization increases under the pharmacy carve-out. This assumption was made because detailed rebate data at the therapeutic class or drug level was not available to enable a more granular analysis. It is possible that the drug and therapeutic class mix could change with an increase in utilization, in which case the historical rebate ratios would change.

6.4. Potential Impact from Utilization Management Variances

MCOs in Texas are also permitted to deviate to some extent from the VDP's administration techniques in the strategies they use to direct members to different preferred drugs on the PDL. MCOs may employ different strategies to limit and direct members' utilization of clinically appropriate drugs, including:

- Quantity limits may be used to dictate the maximum amount of a drug that a member can have dispensed to him or her at one time. MCOs have some discretion in how they apply and enforce quantity limits in the Medicaid and CHIP programs today.
- Days' supply edits may also be applied at the discretion of the MCOs. For example, MCOs may elect to enforce a 30, 60, or 90 days' supply of a certain drug.

It is possible that these and other UM strategies employed by MCOs may result in different utilization patterns for members enrolled in managed care compared to the FFS program. If this is the case, it may be appropriate to reflect an adjustment for the anticipated shift in utilization under a pharmacy carve-out.

To verify if MCOs' UM programs drive meaningful shifts in their members' drug use patterns compared to the FFS population, an analysis of historical drug utilization in the managed care encounter data and FFS pharmacy

claims data was conducted. This assessment compared the drug utilization patterns at the therapeutic class level. Drugs in a common therapeutic class are designed to treat the same conditions. As such, any differences in utilization patterns between drugs on the same therapeutic class are more meaningful than differences in drug use across classes, which could be more heavily impacted by overall disease mix.

For each therapeutic class, the percentage of utilization directed to each drug was compared between each MCO, all MCOs in total, and the FFS program. In this type of assessment, some degree of variance is expected across populations and between drugs (where some classes contain hundreds of unique drugs). Since some variance is expected, the assessment focused on the following two questions:

- Does the pattern of utilization between drugs in a common therapeutic class exhibit large variances between the managed care population and the FFS program? For example, if the most highly utilized drug in a therapeutic class is a high-cost brand drug for the MCO population, but a low-cost generic for FFS (or vice versa), this may be indicative of patterns driven by one program or the other.
- Are these types of utilization patterns consistently witnessed across therapeutic classes? If the scenario in the prior bullet exists for multiple classes, for example, the results would be more meaningful than if it was only witnessed for a single therapeutic class.

In performing this analysis, the drug utilization patterns across most therapeutic classes were largely consistent between the MCOs and the FFS program. No consistent patterns emerged that indicated MCOs direct or steer their membership toward a different set of covered drugs compared to the FFS program.

As the results of the exercise did not bring to light any systemic differences between the MCO and FFS populations' utilization, no explicit adjustment was made to the underlying pharmacy utilization to reflect the UM variances between the two populations.

6.5. Estimated Utilization Impact

Overall, the degree to which utilization and drug mix for the current managed care population may shift following a transition to a pharmacy carve-out is difficult to predict. It is dependent on how actively MCOs today manage their populations' prescription drug benefits and how that may compare to the management performed by the VDP under the carve-out.

Currently, HHSC places restrictions on how Texas MCOs operate their pharmacy programs. It is possible that the VDP, with the help of its PBM vendor, can implement techniques under the pharmacy carve-out that align the rest of its program with today's MCOs. In that case, utilization may not be impacted at all.

As discussed in **Section 6.3 Potential Impact from Prior Authorization Variances**, the utilization analysis assumes that in administering the pharmacy carve-out, the VDP would maintain the same set of optional PAs as it applies today in its FFS program, which leads to a potential increase in gross drug costs (before rebates) of approximately 2.2%.

However, it is also possible for the VDP to elect and apply PAs commensurate with those used by the MCO population today. In that case, the utilization of the managed care population may not shift in the transition to a pharmacy carve-out due to differences in PAs. As such, a scenario is presented to reflect the possibility that the FFS program could implement the same PA categories as the MCOs do today and, thus, experience no utilization changes.

Finally, in moving to a carve-out model, it is also possible that utilization could increase more than predicted by the data based on programmatic differences between the FFS and MCO programs that were not anticipated. In the current environment, there is variation between the MCOs in overall prescription drug utilization per member. By this same principle, there could also be variation in the utilization for the FFS program under the pharmacy carve-out compared to today's MCOs. To present another alternative view of how utilization may change and how savings would be affected, a scenario is considered that assumes a flat 5% gross cost increase resulting from such fluctuations in utilization. The impact of this possible scenario will also be shown on the final cost or savings quantification. In quantifying the 5% increase to gross pharmacy costs scenario, rebates were considered in the same way as described in **Section 6.3**, by assuming that the aggregate rebate offset would also increase commensurately with the increase in gross costs. The net cost increase is reflected in **Figure 25**.

In summary, the three alternative sets of assumptions for anticipated utilization changes in moving to a pharmacy carve-out are presented below:

Figure 25. Cost/(Savings) Impact from Potential Utilization Shift for Managed Care Members (in Millions).

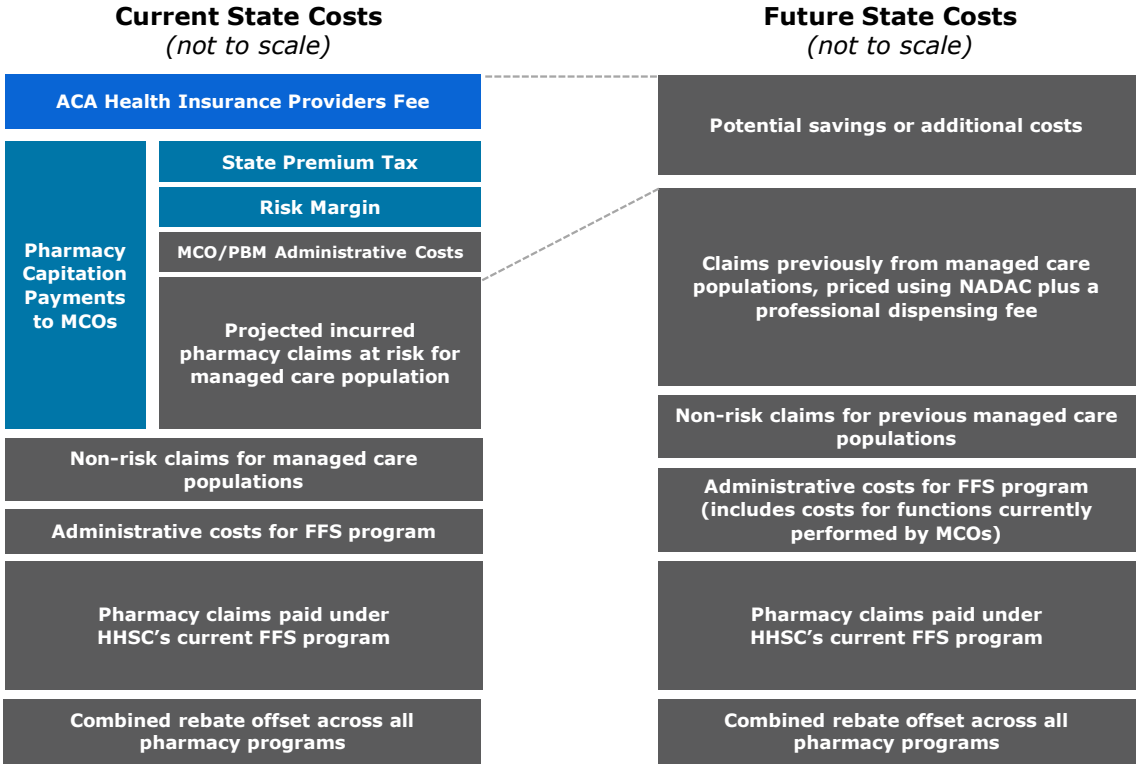
Scenario	SFY2015	SFY2016	SFY2017
+2.2% Gross Cost Increase	$26.3M	$25.2M	$29.0M
No Cost Increase	$0.0	$0.0	$0.0
+5% Gross Cost Increase	$60.5M	$58.0M	$66.7M

7. Estimated Impact on Capitated Amounts and Fees

In addition to the changes in pharmacy claims costs contemplated in **Section 5 Estimated Impact from Repricing** and **Section 6 Estimated Impact on Utilization**, the transition from managed care to a pharmacy carve-out may also reduce certain non-claims-related cost components that are embedded in HHSC's current capitation payments to MCOs. Similarly, other fees HHSC incurs today as a result of providing pharmacy benefits through a managed care model may be eliminated. This section describes these costs and quantifies their potential impact.

Relating back to the graphic introduced in **Section 4 Approach and Methodology**, this section focuses on the segments highlighted below, which will no longer be required under a FFS delivery model.

Figure 26. Focus of Analysis Performed in Section 7.



While MCO capitation rates also contain a provision for administrative expenses, as pictured in the graphic, their impact is not addressed in this section. These administrative costs will not be eliminated under the pharmacy carve-out. Rather, it is assumed that HHSC will need to provide

administrative functions for a larger, unified FFS program, and the amount embedded in MCO capitation rates today for administrative expenses will need to be repurposed in the future state. The administrative costs across the current FFS and managed care programs are addressed in **Section 8 Changes in Administrative Expenses Under the Carve-out**.

7.1. Overview of Capitation Rate Development and Related Fees

Capitation payments to MCOs participating in the Texas Medicaid and CHIP programs are currently developed by HHSC and its external actuarial consultant. The total capitation rates are analyzed separately for the medical, prescription drug, and other benefit types provided by the Medicaid and CHIP programs in Texas. Calculating the capitation rates involves projecting actual historical claims experience from a base period forward to the period for which the capitation rate payment will apply. For example, the pharmacy component of the total capitation rate for SFY2017 is developed using actual prescription drug claims for the managed care population from calendar year 2015, trended forward to the 2017 plan year.

To project the claims experience from the base period to the projection period, trend rate assumptions are developed based on an analysis of recent pharmacy claims experience under each program and the actuary's professional judgment for anticipated future cost changes. Consideration is also given for any new benefit types or program changes that may have occurred or are planned between the base period and the projection period. After the expected claims are trended forward and any such adjustments for benefit changes are made, provisions for premium tax, risk margin, and administrative expense are loaded into the rates to provide for other non-claims costs that the MCO may incur in managing the members' benefits.

The pharmacy component of the capitation payments to MCOs under HHSC's managed care model can be grouped into the following components:

- **Projected Pharmacy Claim Costs:** This represents the amount HHSC expects will be required to pay prescription drug claims for the MCOs' members during the coverage period. This is the largest component of the capitation payment.
- **Provision for Administrative Expenses:** This is an amount added to the projected benefit component of the capitation payment to help cover the MCOs' costs for administering their members' pharmacy benefits. The provision for administrative expense embedded in the Medicaid and CHIP pharmacy capitation rates in SFY2017 is $1.80 per member per month

(PMPM) for all programs except for the Dual Demonstration. The provision for Dual Demonstration members is $0.29 PMPM.

- **Provision for Risk Margin:** CMS regulations and actuarial standards of practice require that MCO capitation payments also include a provision for risk margin. This contingency allows MCOs to cover excess costs if trends or unexpected events cause actual benefit costs to be higher than anticipated at the time capitation rates were developed. The risk margin provision embedded in HHSC's prescription drug capitation payments from SFY2015 through SFY2017 was 2% of the capitation rate for most programs. The capitation payments for Dual Demonstration members do not include a provision for risk margin in the rate for the prescription drug benefit.
- **State Premium Tax:** The capitation rate also includes a provision for the state premium tax that the MCOs are required to pay to operate in Texas. The premium tax payable is equal to 1.75% of the total capitation rate for all years and programs. Again, the Dual Demonstration program is an exception, as no provision for premium tax is included in the prescription drug capitation payment.

Section 7.2 Potential Impact on Capitated Fees will quantify the impact of each of these components and discuss how they may change under a pharmacy carve-out model. **Appendix B** also contains a summary of the administrative expense, risk margin, and premium tax assumptions embedded in the capitation payments for SFY2015 through SFY2017.

Another fee paid by HHSC today under managed care that would be impacted by a move to a FFS delivery model is the ACA Health Insurance Providers Fee. Section 9010 of the ACA imposes a fee on each covered entity engaged in the business of providing health insurance. The United States Internal Revenue Service calculates the fee based on the amount of net premiums the covered entity wrote for health insurance during the applicable year. Most Medicaid MCOs in Texas are subject to the ACA Health Insurance Providers Fee. Nonprofit corporations that receive more than 80% of their revenue from government-sponsored poverty programs, along with governmental entities and insurance organizations owned by governmental entities (including MCOs owned by county hospital districts), are exempt.

HHSC's MCO capitation payments do not include a provision for the MCO's payment of the ACA Health Insurance Providers Fee. Rather, HHSC reimburses MCOs separately for the amounts the MCOs are assessed, along with any applicable federal income tax or state premium tax resulting from the payment of the fee. The reimbursement amounts to MCOs for the ACA

Health Insurance Providers Fee are also developed by HHSC's external actuary.

7.2. Potential Impact on Capitated Fees

By transitioning its pharmacy benefit from managed care to FFS, HHSC would no longer be responsible for reimbursing MCOs for the non-claims-related components described in the prior section, including the risk margin, state premium tax, and ACA Health Insurance Providers Fee.[38]

The methodology for quantifying the savings associated with each component under a pharmacy carve-out was as follows:

1. **Risk Margin**

   To calculate the costs attributable to the risk margin under today's managed care model, HHSC provided its total, historical pharmacy capitation payments to MCOs by program and fiscal year. The risk margin assumptions embedded in the publicly available capitation rate development files were also extracted and summarized by program and fiscal year. Applying the pharmacy risk margin assumptions to the pharmacy capitation payments for each program yielded the total amount of the capitation payments attributable to the risk margin. The results across all programs are summarized in **Figure 28**.

   In evaluating the results of **Figure 28** on a forward-looking basis, it should be noted that the risk margin assumption embedded in the MCO capitation payments was reduced from 2.00% in SFY2017 for all programs except Dual Demonstration, to 1.75% for SFY2018 for STAR+PLUS and STAR Kids and 1.50% for SFY2018 for STAR, STAR Health, and CHIP. As a result, the future savings attributable to the risk margin may be less than the amounts shown for SFY2017 in **Figure 28**.

2. **State Premium Tax**

   A provision for state premium tax is embedded in the capitation payments from HHSC to the MCOs, which is ultimately paid by the MCOs to the State as a tax for operating as a health insurance entity. However, a portion of the adjustment to MCO capitation payments related to the premium tax is funded by the federal government. In effect, because HHSC only funds a portion of the premium tax provision in the capitation rates, but the state receives the full amount of the tax from the MCOs,

[38] See **Section 8 Changes in Administrative Expenses under the Carve-out** for a discussion of the administrative component of the capitation rate, for which costs will not be eliminated but will rather shift to the VDP.

the premium tax represents net revenue to the state under a managed care model. The amount of this revenue is equal to the federal matching percentage on the state premium tax embedded in the capitation rates. Under a pharmacy carve-out model, the premium tax would be removed and this revenue would be lost. The savings quantification in this report reflects this lost federal revenue as a net new cost under the pharmacy carve-out. The impact is calculated in **Figure 27** below:

Figure 27. Calculation of Lost Revenue from Federal Match on State Premium Tax.

Cost Impact	SFY2015	SFY2016	SFY2017
Total State Premium Tax	$47.9M	$50.1M	$63.9M
Actual Historical FMAP	58.10%	57.21%	56.26%
Net Impact of Carve-Out	**$27.8M**	**$28.7M**	**$36.0M**

3. ACA Health Insurance Providers Fee

The amounts reimbursable to MCOs for the ACA Health Insurance Providers Fee are presented in the annual capitation rate development files. There is no explicit breakdown of the fee between medical, pharmacy, and the other benefit types managed by MCOs; however, under a pharmacy carve-out, HHSC would still be required to pay the portion of the fee related to its non-pharmacy capitation rates. As such, an approach was developed to approximate the amount of the fee attributable to HHSC's prescription drug benefits.

The SFY2017 capitation rate development file[39] presents a summary of the ACA Health Insurance Providers fee attributable to each MCO. To estimate the amount of the fee allocable to HHSC's pharmacy benefits, the impact of MCOs that only manage dental and behavioral health benefits was removed from the rate development calculation.[40] For the remaining MCOs that provide pharmacy benefits in Texas and are subject to the fee, it was calculated that the total fee (after adjustment for federal income taxes) equals 2.75% of their aggregate capitation payments. This estimate is corroborated by a recent report[41] that estimated the impact of the ACA Health Insurance Providers Fee,

[39] Texas Health and Human Services, "FY2017 Rate Amendment for STAR, STAR+PLUS, STAR Health, NorthSTAR, Medicaid Dental and CHIP," https://rad.hhs.texas.gov/sites/rad/files/documents/managed-care/2016/2016-09-acahipf.pdf

[40] Specifically, DentaQuest, MCNA, and ValueOptions were excluded.

[41] Milliman, "ACA Health Insurer Fee: Estimated Impact on the U.S. Health Insurance Industry," http://us.milliman.com/uploadedFiles/insight/healthreform/pdfs/ACA-health-insurer-fee.pdf

including taxes, to be between 2.7% and 3.0% of premium between 2015 and 2018 across all states and payer types.

To calculate the impact from carving out HHSC's pharmacy benefits, the 2.75% estimate was multiplied by HHSC's pharmacy-specific capitation payments for the MCOs subject to the fee. This approach assumes that the MCOs subject to the fee remain the same over time, but to the extent changes are made in the future to the list of applicable MCOs, savings associated with this fee may change. **Appendix C** contains the list of MCOs subject to the ACA Health Insurance Providers Fee today, as incorporated in the analysis.

Additionally, there is a moratorium expected on the ACA Health Insurance Providers Fee in 2019. If this moratorium stands, the fee will not be assessed at the federal level for the 2019 calendar year. In this case (or if other changes are made to the structure of the fee in 2020 or later), the savings associated with this fee may be impacted for future years. The analysis quantifies the impact of the potential pharmacy carve-out on historical costs, but HHSC may want to consider the moratorium on the fee when extrapolating the results of this study on a forward-looking basis. For this reason, in presenting savings from the pharmacy carve-out, an alternative scenario is included to remove the impact from the ACA Health Insurance Providers Fee.

Figure 28 below summarizes the total savings by year for each component described above.

Figure 28. Cost/(Savings) Impact from Non-claims Components of Capitation Payments (in Millions)

Impact from Cost Component	SFY2015	SFY2016	SFY2017
Risk Margin	($54.7M)	($57.3M)	($73.0M)
State Premium Tax	$27.8M	$28.7M	$36.0M
ACA Health Insurance Providers Fee	($58.7M)	($62.0M)	($76.5M)
Impact from All Components	**($85.6M)**	**($90.6M)**	**($113.6M)**
Impact Excluding ACA Health Insurance Providers Fee	**($26.9M)**	**($28.6M)**	**($37.1M)**

8. Changes in Administrative Expenses Under the Carve-out

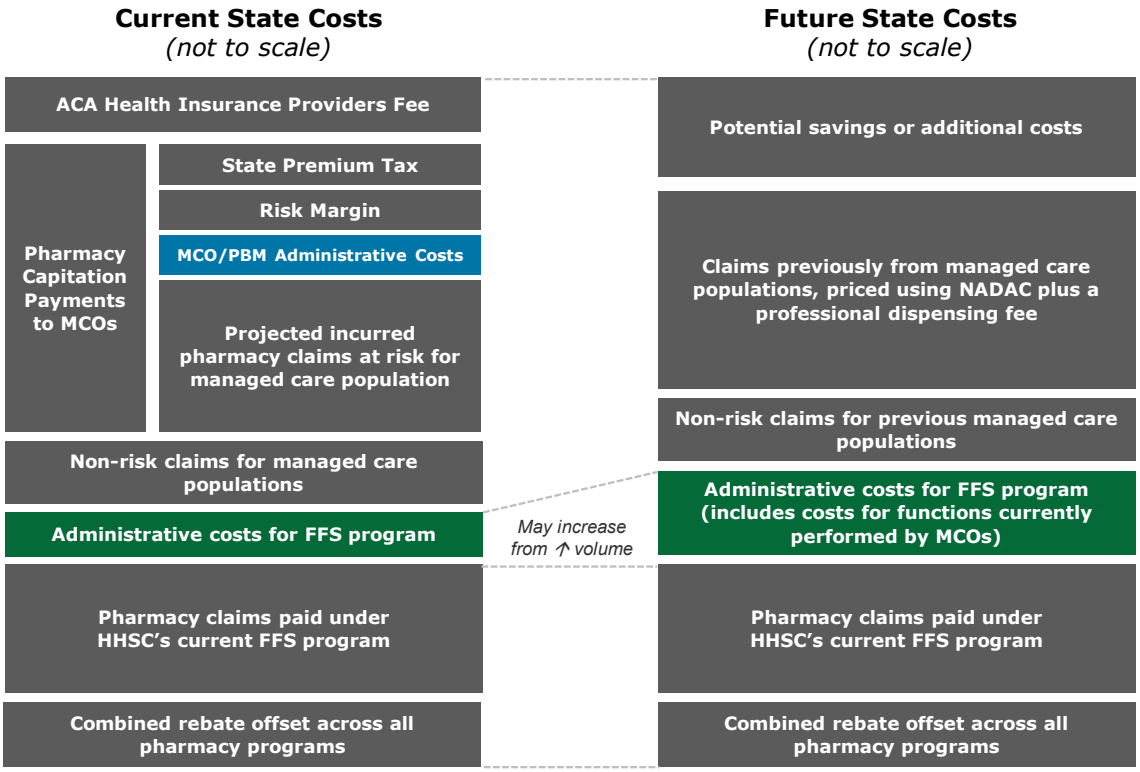
This section discusses how administrative costs may change if HHSC were to carve out its pharmacy benefits. Today, HHSC pays for the administration of its pharmacy program in two ways:

1. For the managed care population, HHSC accounts for MCOs' administrative costs in the MCO capitation rate development process (as discussed in **Section 7.1 Overview of Capitation Rate Development and Related Fees**).
2. For its FFS population, the VDP contracts with external vendors to help perform its administrative functions, including PDL development, PA management, DUR management, and other services. In addition, HHSC employees from its Managed Care Compliance and Operations department help to manage and staff the pharmacy call center and perform program oversight.

Under a pharmacy carve-out model, the first component will no longer be required. However, the second component will increase as the FFS program expands to cover the members that are currently managed by MCOs. The net impact of these two components will determine whether there are inherent costs or savings arising from administering HHSC's entire population under a unified pharmacy carve-out model.

This section will quantify the changes in the highlighted cost components in **Figure 29**.

Figure 29. Focus of Analysis Performed in Section 8.



8.1. Current-State Administrative Costs

HHSC's approach to paying for pharmacy administration today varies for the managed care and FFS populations.

8.1.1. Current Administrative Costs Embedded in MCOs' Capitation Payments

As described in **Section 7.1 Overview of Capitation Rate Development and Related Fees**, a provision for MCOs' pharmacy-related administrative expenses is embedded in HHSC's capitation payments for members enrolled in managed care. HHSC currently values MCO pharmacy-related administrative costs at $1.80 PMPM for most Medicaid and CHIP programs and $0.29 PMPM for Dual Demonstration program members.

To calculate the total amount paid to MCOs for administering pharmacy benefits, the PMPM administrative expense assumption embedded in HHSC's capitation rates is multiplied by the number of months members were enrolled in each program by fiscal year. The results are documented in **Figure 30**.

Figure 30. Total Administrative Costs for HHSC's Managed Care Population (in Millions).

Cost	SFY2015	SFY2016	SFY2017
Administrative Costs Embedded in Pharmacy MCO Capitation Payments	$84.0M	$84.8M	$88.8M

8.1.2. Current FFS Program Administrative Costs

As discussed in **Section 3 Background on HHSC's Current Pharmacy Program**, HHSC contracts today with several external vendors to provide administrative services to the FFS program. HHSC provided its contracts with these external vendors and summaries of the payments made to each vendor by fiscal year. The administrative costs summarized from these sources are presented in **Figure 31**. [42,43,44,45]

To supplement the contracts and summaries, HHSC also provided estimates of its full-time equivalents (FTEs) that perform provider call center administration and oversight for the FFS program. These FTE counts were multiplied by estimates of fully loaded costs per FTE (inclusive of costs to the VDP for salaries, benefits, and other personnel-related expenses) to produce the costs shown below.

In some cases, the VDP's administrative functions listed in **Figure 31** may cover the Healthy Texas Women, CSHCN, and Kidney Health Care programs in addition to Medicaid and CHIP. Healthy Texas Women, CSHCN, and Kidney Health Care may also incur additional costs to perform administrative functions specific to their own programs; these additional costs were not considered in the analysis. Finally, certain functions are not necessary for some programs; for example, the Healthy Texas Women, CSHCN, and

[42] In SFY2019, HHSC plans to consolidate all its administrative contracts and functions to a single, unified vendor. However, since the analysis represents a historical view, the costs represented in **Figure 31** are the actual payments from HHSC by fiscal year using its vendors in place today.

[43] This figure includes costs for all administrative functions performed by the VDP and its vendors on behalf of the Medicaid, CHIP, Healthy Texas Women, CSHCN, and Kidney Health Care programs. It does not include costs for any functions the Healthy Texas Women, CSHCN, and Kidney Health Care programs may perform on their own without the assistance of the VDP. For example, the Kidney Health Care program performs PA processing and management using its own staff.

[44] SFY2015 costs are representative of the vendor in place prior to the transition; and costs for SFY2016 and SFY2017 are those paid to the new vendor.

[45] Not all functions in this figure apply to all FFS programs; for example, the Kidney Health Care, CSHCN, and Healthy Texas Women do not utilize a PDL.

Kidney Health Care programs do not utilize a PDL and so they do not require PDL development and management functions. It is assumed that the VDP and each program will continue performing the same functions they do today under the carve-out and that there would be no change in the functions required for each program.

Figure 31. Historical Administrative Costs for FFS Program (in Millions).

Administrative Function Performed	SFY2015	SFY2016	SFY2017
Claims/rebate adjudication and encounter extract processing	$7.4M	$7.6M	$7.9M
Pharmacy front-end services and related tools	$7.6M	$8.7M	$7.8M
Transition of pharmacy front-end services to a new vendor	$0.2M	$9.7M	$2.0M
PA processing and management	$3.4M	$3.4M	$2.6M
PDL development and management	$1.2M	$1.2M	$1.2M
Use of electronic prescribing system (Surescripts)	$1.2M	$1.1M	$1.1M
Provider call center administration and oversight	$0.6M	$0.6M	$0.6M
Retrospective DUR interventions	$0.4M	$0.3M	$0.3M
Grand total FFS program administrative costs	**$21.9M**	**$32.6M**	**$23.6M**

As shown in **Figure 31**, total costs were approximately $23.6 million in SFY2017. Costs in SFY2016 were higher than in SFY2015 and SFY2017 because the VDP in SFY2016 transitioned between vendors performing its pharmacy front-end services. The change in vendors required investments for training, system changes, and other transition-related expenses, which are delineated as a separate line item in the table above to help illustrate their impact on the SFY2016 costs.

In addition to studying total costs, the analysis examines administrative costs on a PMPM basis. This allows for the ability to compare the $1.80 PMPM provision embedded in the MCOs' capitation rate payments to the costs incurred by the VDP in administering the FFS program on an equitable basis.

Before comparing costs between the two programs, the analysis normalizes for the functions that the VDP performs centrally for the Medicaid program. For example, the VDP and its vendors perform all functions for the Medicaid and CHIP programs related to PDL management, supplemental rebate negotiation, and PA development and management so that the MCOs do not incur these costs. In addition, the VDP's one-time cost to transition to a new front-end service vendor might distort HHSC's PMPM costs compared to the MCOs.

The analysis also makes an adjustment for the first line item in **Figure 31**. Today, the VDP pays one fixed annual cost to a vendor to perform its claims adjudication, rebate adjudication, and encounter extract processing. MCOs, on the other hand, do not perform rebate adjudication (as the VDP performs this function centrally) or encounter extract processing. It is assumed that claims adjudication constitutes 50% of the administrative payments to the vendor for this basket of services, rebate adjudication represents 35%, and encounter extract processing represents the remaining 15% of costs.

The impact of removing these costs is reflected in **Figure 32** below. [46,47]

[46] The VDP's contract for PA processing includes a small provision (<$0.1 million per year) for the vendor to develop data extracts for MCOs. These costs would no longer be required under a pharmacy carve-out, but because they are de minimis and for simplicity they have not been removed.

[47] While MCOs perform retrospective DUR for their own membership, it is anticipated that the VDP's current retrospective DUR costs will remain stable, or not increase meaningfully, under the carve-out despite the larger population size. See **Section 8.2 Projected Administrative Cost under the Pharmacy Carve-out** for further details. As such, retrospective DUR costs are excluded from the final row of **Figure 32**, since costs incurred historically by the VDP should not be scaled by the additional membership under the carve-out.

Figure 32. Per Member Per Month Administrative Costs for FFS Program.

FFS Program Administrative Function Performed	SFY 2015	SFY 2016	SFY 2017	Do MCOs perform this function for managed care?
Claims adjudication	*$0.48*	*$0.53*	*$0.63*	**Yes**
Rebate adjudication	*$0.34*	*$0.37*	*$0.44*	No
Encounter extract processing	*$0.14*	*$0.16*	*$0.19*	No
Subtotal for claim and rebate adjudication and encounter extract processing	$0.96	$1.06	$1.26	
Pharmacy front-end services and related tools	$0.98	$1.22	$1.24	**Yes**
Transition of pharmacy front-end services to new vendor	$0.03	$1.37	$0.33	No
PA processing and management	$0.44	$0.48	$0.42	**Yes**
PDL development and management	$0.15	$0.17	$0.19	No
Use of electronic prescribing system (Surescripts)	$0.15	$0.15	$0.18	**Yes**
Provider call center administration and oversight by VDP	$0.08	$0.09	$0.10	**Yes**
Retrospective DUR interventions	*$0.05*	*$0.05*	*$0.05*	See Figure's footnote
Grand total administrative costs PMPM	**$2.84**	**$4.58**	**$3.78**	
Costs PMPM for functions also performed by MCOs, less retrospective DUR	***$2.13***	***$2.47***	***$2.58***	**All with "Yes"**

Per the table above, the total administrative cost for operating the FFS program was $3.78 PMPM in SFY2017. However, this amount includes costs the VDP handles centrally for all MCOs and the FFS program. For the functions that MCOs perform today for their managed care populations, the VDP's comparable costs were $2.58 PMPM for the FFS program.

Economies of scale may be one cause of the FFS program's higher PMPM costs compared to the $1.80 PMPM provided to MCOs. Pricing for pharmacy administrative functions often varies based on population size and volume of claims activity. PBMs may provide certain services on a lower per unit basis to a large population because their own costs per unit decrease as volume

increases. For example, claim adjudication may require a large up-front investment by the PBM for technological systems, labor costs for coding, and other implementation costs. However, once the systems have been developed, the vendor can process claims for incrementally larger populations with lower relative unit costs. In general, the MCOs have larger membership than the current FFS program and, therefore, may be able to secure lower costs with PBMs.

The FFS program's PMPM costs for the functions MCOs provide for the managed care population correlate with changes in its membership. The FFS program costs are lowest in SFY2015 when the FFS membership was highest (approximately 650,000 members), and highest in SFY2017 after average annual membership decreased to approximately 520,000 members.

8.2. Projected Administrative Costs under the Pharmacy Carve-out

Under the carve-out, certain costs paid by the VDP today in administering benefits for the FFS program may remain stable; some may be eliminated because they are not required under a carve-out model; and some may change with the change in pharmacy claims and membership volume. The analysis considers and estimates the costs separately for each category under the pharmacy carve-out.

For the functions the VDP performs across the entire Medicaid and CHIP pharmacy programs today, including rebate adjudication and PDL management, administrative costs may not change under the carve-out model. The VDP's external vendors already perform these processes for HHSC's combined FFS and managed care membership, and so the pharmacy carve-out would not provide additional economies of scale for the VDP to use in contract negotiation. The amounts that HHSC paid for these services between SFY2015 and SFY2017 are documented in **Figure 33**. It is assumed that these amounts would remain stable under the potential pharmacy carve-out.

In addition, while today MCOs perform retrospective DUR for their own Medicaid and CHIP populations, it is anticipated that the VDP's historical retrospective DUR costs would remain stable, or not increase meaningfully, under the carve-out. Today the VDP's retrospective DUR vendor develops and performs a fixed number of DUR interventions per year. The number of interventions would not need to increase for an increase in membership. Further, once a DUR intervention is developed, it can be applied to an increasingly large population size with less incremental effort. As such, VDP's

costs for retrospective DUR are not expected to vary proportionately with membership. Instead, it is assumed the VDP's historical retrospective DUR costs would remain static under the carve-out despite the larger population size. These costs are captured in **Figure 33** below.

The VDP's costs to transition to the new front-end services vendor are also included in **Figure 33**. These costs would not be required on a recurring or ongoing basis. However, excluding these historical costs under the pharmacy carve-out would make it appear that these represent additional savings under the new delivery model, which is not the case.

Finally, under the carve-out, the pharmacy extract encounter processing performed by the VDP's external vendor today will no longer be necessary. In the table below, these costs are reduced to $0.

Figure 33. Administrative Functions with Costs Not Expected to Change under Pharmacy Carve-out (in Millions).

Administrative Function Performed	SFY2015	SFY2016	SFY2017
Rebate adjudication	$2.6M	$2.7M	$2.8M
PDL development and management	$1.2M	$1.2M	$1.2M
Retrospective DUR intervention	$0.4M	$0.3M	$0.3M
Transition of pharmacy front-end services to new vendor	$0.2M	$9.7M	$2.0M
Encounter extract processing	N/A	N/A	N/A
Grand total costs	**$4.4M**	**$13.9M**	**$6.3M**

Costs must also be estimated for the pharmacy administrative functions that MCOs perform today and that the VDP would assume responsibility for performing under the carve-out. These services include pharmacy claims adjudication, front-end services, PA processing and management, use of an electronic prescribing system, provider call center services, and program oversight. The total costs for these functions would increase with an increase in membership, but may decrease on a per unit basis as economies of scale are realized. A key consideration in moving to a carve-out model is whether the VDP will be able to provide these functions as cost effectively as MCOs.

Per **Section 8.1 Current-State Administrative Costs**, in SFY2017, the VDP paid $2.58 PMPM for these functions for its FFS population. For the managed care population, HHSC provides MCOs with $1.80 PMPM to perform the same functions. MCOs self-report their administrative expenses, including pharmacy administrative costs, to HHSC as part of their annual FSR package. For a majority of MCOs, actual pharmacy administrative costs are reasonably aligned with the $1.80 PMPM provision embedded in MCO

capitation payments. As the $1.80 PMPM provision is in line with actual MCO administrative costs, it is assumed that the VDP may also negotiate a contract with a PBM at this level.

This assumption was made with several considerations in mind. The size of HHSC's potential pharmacy carve-out was compared to the membership the MCOs have today in procuring their PBM contracts. MCOs use the volume across their multiple clients to negotiate pricing with PBMs. For example, MCOs that operate across more than one state might use their combined membership across the Medicaid agencies, as well as their Commercial and Medicare membership, as negotiating power. Some of these national MCOs have larger combined membership than HHSC's 4.7 million members and, therefore, may be able to secure better pricing than the VDP. However, not all MCOs that serve HHSC's Medicaid and CHIP members operate nationally; several are regional health plans with membership that is likely smaller than the volume the VDP would have under the carve-out. As the $1.80 PMPM administrative cost provision was found to be reasonable across MCOs, and not just for the national health plans with larger membership than HHSC, the $1.80 assumption is believed to be reasonable for projecting costs to the VDP under the pharmacy carve-out.

To estimate the administrative costs under the carve-out, the $1.80 PMPM assumption was multiplied by HHSC's combined FFS and managed care programs' membership. The costs for the functions that are not expected to increase with an increase in membership under the carve-out (as documented in **Figure 33**) are added to calculate the total administrative costs. The results are documented in **Figure 34**.[48]

[48] It is assumed the $1.80 PMPM applies for all Medicaid members, including those enrolled in the Dual Demonstration program; whereas, in the MCO capitation payments today, the MCOs only receive $0.29 PMPM for administrative costs for this population. This leads to a slight discrepancy between this table and **Figure 30** from **Section 8.1 Current-State Administrative Costs**.

Figure 34. Total Administrative Costs under Pharmacy Carve-out using $1.80 PMPM Assumption (in Millions).

Administrative Function Performed	SFY2015	SFY2016	SFY2017
Costs for Administrative Functions Not Expected to Change under Pharmacy Carve-out (from **Figure 33**)	$4.4M	$13.9M	$6.3M
Costs for Administering Benefits for Current FFS Members at $1.80 PMPM	$13.9M	$12.8M	$11.2M
Costs for Administering Benefits for Current Managed Care Members at $1.80 PMPM	$84.3M	$85.7M	$89.6M
Grand Total Projected Administrative Costs	**$102.5M**	**$112.4M**	**$107.1M**
Total Administrative Costs PMPM	**$1.88**	**$2.05**	**$1.91**

Again, the SFY2016 costs in the table above are slightly higher than SFY2015 or SFY2017 due to the front-end services vendor transition in SFY2016.

8.2.1. Alternative Scenario

However, it is possible the VDP would not be able to secure pricing with its new PBM that is as favorable as the MCOs, or that other circumstances may exist at least in the first few years of the pharmacy carve-out that result in higher administrative costs in the short term.

To reflect this possibility, an alternative estimate of administrative costs has been developed that assumes the VDP would be able to secure pricing that is better than they receive today for their FFS program, but not as favorable as the MCOs' average of $1.80 PMPM. There is some variance in the actual costs for MCOs to administer their members' pharmacy benefits, but based on the administrative cost levels self-reported in their FSRs, a majority of MCOs are able to secure pricing with their PBM for under $2.20 PMPM. As such, it is assumed that the high end of the range for the VDP's FFS program administrative costs was $2.20 PMPM.

As in the first scenario, the total cost for the VDP to provide the services currently performed by MCOs was calculated at $2.20 PMPM across all FFS

and managed care members. The costs for the functions that are not expected to increase with an increase in membership were added to this amount. The resulting administrative costs are summarized in **Figure 35**.

Figure 35. Total Administrative Costs under Pharmacy Carve-Out using $2.20 PMPM Assumption (in Millions).

Administrative Function Performed	SFY2015	SFY2016	SFY2017
Costs for Administrative Functions Not Expected to Change under Pharmacy Carve-out (from **Figure 33**)	$4.4M	$13.9M	$6.3M
Costs for Administering Benefits for Current FFS Members at $2.20 PMPM	$17.0M	$15.7M	$13.7M
Costs for Administering Benefits for Current Managed Care Members at $2.20 PMPM	$103.0M	$104.7M	$109.5M
Grand Total Projected Administrative Costs	**$124.3M**	**$134.3M**	**$129.5M**
Total Administrative Costs PMPM	**$2.28**	**$2.45**	**$2.31**

8.3. Total Impact on Administrative Cost

The potential changes in pharmacy administrative expenses from the prior sections are synthesized into an estimate of the impact on costs in **Figure 36** below.[49]

[49] Savings listed are for Medicaid and CHIP. The administrative costs incurred by the non-Medicaid and CHIP programs (Healthy Texas Women, CSHCN, and Kidney Health Care) will not be affected by the carve-out.

Figure 36. Cost/(Savings) Impact from Administrative Cost Changes (in Millions).

Cost Component	SFY2015	SFY2016	SFY2017
Provision in MCO capitation rates	$84.0M	$84.8M	$88.8M
FFS program expenses	$21.9M	$32.6M	$23.6M
A. Administrative costs in current delivery model *(Subtotal of Provision in MCO capitation rates and FFS program expenses)*	$105.9 M	$117.5M	$112.4M
B. Estimated Costs under Carve-out ($1.80 PMPM)	$102.5M	$112.4M	$107.1M
A – B = $1.80 PMPM Scenario Cost/(Savings) Impact	**($3.4M)**	**($5.0M)**	**($5.3M)**
C. Estimated Costs under Carve-out ($2.20 PMPM)	$124.3M	$134.3M	$129.5M
A – C = $2.20 PMPM Scenario Cost/(Savings) Impact	**$18.4M**	**$16.8M**	**$17.1M**

In the $1.80 PMPM scenario, the SFY2017 administrative costs estimated under the pharmacy carve-out decreased by $5.3 million compared to HHSC's historical payments. This implies that the VDP could potentially use the combined purchasing power of HHSC's nearly 4.7 million members under the carve-out to negotiate better pricing than the VDP receives today.

However, pricing quotes have not been collected on behalf of HHSC so the analysis is based on historical studies. HHSC's true administrative costs will depend on the pricing quotes it can secure with vendors, which may be better or worse than those shown here. The $2.20 PMPM scenario presents a view of how costs may look if HHSC was not able to negotiate pricing with its PBM as cost effectively as the MCOs provide these services today. Under this scenario, the pharmacy carve-out generates an additional $17.1 million in administrative costs in SFY2017.

The costs discussed in this section represent administrative expenses that HHSC may incur on an ongoing basis for administrating pharmacy benefits under a carve-out. The following section addresses some of the one-time or implementation costs HHSC may also incur upon the transition.

9. Other Costs and Considerations

In addition to the cost elements quantified in **Section 5** through **Section 8**, consideration should also be given to factors that may not have a quantifiable financial impact under a pharmacy carve-out, but may impact the quality of care for members, as well as HHSC's ability to manage and draw conclusions from data and other key facets of administrating Medicaid pharmacy benefits. This section presents a discussion of a number of these potential costs and considerations.

9.1. Ability to Integrate and Coordinate Care Across Benefits

Central to the goals of a managed care delivery model is the principle that care should be integrated and coordinated across the medical and pharmacy benefits. This type of coordinated approach to delivering care may help reduce costs in total. For example, if members adhere to a specified prescription drug regimen, it may help them avoid costly hospital visits and reduce their total health care costs overall. A pharmacy carve-out model may present a barrier for MCOs to understand and manage the total cost of care across their members' coverage. They may be less able to detect drug non-adherence, drug abuse, or other prescription drug patterns that indicate an underlying medical condition. This is likely to have the largest impact on the most complex and high-cost patients who require the most engagement from the MCO. Additionally, under a pharmacy carve-out, MCOs may be reluctant to participate in quality or outcome-based incentive programs if they are no longer responsible for the full spectrum of members' care.

It is difficult to quantify the impact that MCOs' effective management of Medicaid pharmacy benefits may have on medical costs (or vice versa), and few industry studies attempt this quantification. However, recognizing the value of integrating care, many state Medicaid agencies have recently carved in their pharmacy benefits to MCOs. Further, recent mergers and acquisitions in the health care industry may indicate that the focus on coordinating care across medical and pharmacy benefits could continue to grow. In March 2018, CVS Health, a large PBM, announced it planned to acquire Aetna, one of the largest health care insurers in the United States. Cigna, another health care insurer, also indicated interest in acquiring PBM Express Scripts Holdings (ESI). If the proposed mergers are approved by regulators, the resulting organizations may have the tools to coordinate data and care across benefits in new ways.

HHSC and the MCOs do have certain protocols in place under the current managed care delivery model that, if continued under a pharmacy carve-out, may help mitigate some of the barriers to coordinating care. For example, when a member moves to a new MCO, HHSC provides three years of historical claims data to the new MCO. This and other approaches to coordinating data and care across the delivery model can help enable better integrated care.

In contemplating the decision to carve out its pharmacy benefits, HHSC should consider how the carve-out model may impact an MCO's ability to coordinate care and manage costs holistically for HHSC's members. Consideration should also be given to the current market dynamics and which delivery model will best enable HHSC to implement any new tools, trends, or methods of coordinating care that the changing health care landscape may introduce. Additionally, HHSC should consider the impact of separating the relationship between medication adherence and overall health status. For example, a decrease in adherence to a prescribed drug regimen may increase the likelihood of emergency room visits and inpatient stays which will increase MCO costs, while an increase in adherence may reduce those events. In a carve-out model, an MCO's ability to directly influence member adherence may be reduced, and as a result the MCO may be subject to additional risk.

9.2. Technological System Implementation or Improvements

The VDP's current contractual arrangements with vendors and its technological systems and capabilities were constructed to serve the current FFS population of less than 1 million members. A transition to a pharmacy carve-out, and the addition of approximately 4 million Medicaid and CHIP members, would likely require the VDP to alter its existing vendor contracts and modify or upgrade its current systems. Both items represent additional costs HHSC would likely incur. The extent of these costs may vary and will depend on factors, including the vendor selected by HHSC, the vendor's technological capabilities and bandwidth, and the time it will take to amend these contracts. In addition, system changes and new vendor relationships would also have to be coordinated and integrated into HHSC's overall Medicaid Management Information System modernization strategy. Finally, if the transition to carve-out happens, but is later reversed, new costs would need to be incurred to revert to the original contractual arrangements.

9.3. Data Coordination

As mentioned previously, in today's pharmacy delivery model, HHSC already maintains a central repository to collect and house pharmacy encounter records from MCOs, as well as the pharmacy claims data from HHSC's FFS programs. As such, HHSC already has access to the pharmacy data across its program that allows it to track and understand prescription drug utilization centrally.

However, a pharmacy carve-out model may enable HHSC to more quickly identify outcomes and trends across its membership, and removing the extra step of collecting encounter data from MCOs may allow for real-time processing. On the other hand, costs related to data coordination may increase or shift under the pharmacy carve-out. To enable the MCOs to understand their members' conditions across the spectrum of care, HHSC will be responsible for reporting the pharmacy claims experience back to the MCOs. There may be additional costs associated with this reporting, particularly if it involves tracking costs at the episodic or member level, or it is possible that the costs currently incurred by HHSC for processing MCO encounter extracts may be repurposed.

9.4. Managing Uncertainty

HHSC's capitation payments to MCOs are fixed throughout the course of the year, regardless of how pharmacy costs materialize. This approach places the MCOs at risk for any unexpected trends or events that may cause pharmacy costs to increase above the levels anticipated in the capitation rates. In effect, a capitated model may help HHSC avoid some risk inherent in the fluctuation in prescription drug prices.

By this same principle, however, if actual pharmacy trends evolve to be lower than the expected pharmacy costs used in developing the capitation payments, MCOs receive the same fixed capitated payment amount over the course of the plan year. So, while the pharmacy managed care model allows HHSC to avoid risk in unfavorable trend environments, it may penalize HHSC in a favorable trend environment. In this instance, the trade-offs and benefits of the pharmacy carve-out model may depend on HHSC's risk tolerance and expectations for future trends.

To illustrate, **Figure 37** on the following page summarizes the total MCO experience compared to the total expected claims component of the MCO's capitation payments by fiscal year across all programs. [50,51]

Figure 37. Actual Versus Expected Managed Care Pharmacy Claims Experience (in Millions).

Impact from Cost Component	SFY2015	SFY2016	SFY2017
A. Expected Claims Component of Capitation Rate	$2,548.6M	$2,675.2M	$3,428.5M
B. Total Cost to MCOs	$2,586.2M	$2,716.5M	$3,238.1M
A - B = Margin in Capitation Payments Retained by MCOs	**($37.5M)**	**($41.3M)**	**$190.4M**

In SFY2015 and SFY2016, the managed care members' drug experience was higher than the expected levels predicted by the capitation payments; thus, by using a managed care model, HHSC paid less than if it had been at risk for the claims experience itself. Conversely, in SFY2017, the managed care members' costs were lower than expected so the capitation payments were higher than HHSC would have likely paid under a FFS model.

Additionally, if HHSC were to carve out its prescription drug benefits, HHSC and the VDP would assume responsibility for managing pharmacy trend. In recent years the trend in HHSC's pharmacy capitation payments to MCOs has been lower than the national average growth in prescription drug spend for Medicaid programs. Between 2011 and 2016, Medicaid prescription drug spend nationwide grew by an average annual rate of 9.7%[52], while between 2014 and 2017, HHSC's pharmacy capitation rates PMPM increased on average by only 2.8% per year.[53] HHSC should consider the trend rate risk inherent in the transition to a pharmacy carve-out and whether it may be able to manage trend as effectively as under its current managed care model.

[50] Expected Claims Component of Capitation Rate represents total pharmacy capitation payments with the impact from administrative expense, state premium tax, and risk margin provisions removed

[51] Total Cost to MCOs includes impact from member cost sharing; as such, these numbers reflect a slight difference from other numbers stated previously in the report, which were gross of cost sharing

[52] CMS, "NHE Fact Sheet," https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html

[53] Represents the average annual growth rate in capitation payments for the Medicaid and CHIP programs that were in place each year since 2014

9.5. Minimizing Net Costs After Supplemental Rebates

In today's delivery model in Texas, HHSC collects federal and supplemental rebates on all Medicaid and CHIP members' drug utilization. HHSC's goal is to minimize its population's net pharmacy costs after rebates. To this end, the VDP constructs the PDL in a way that is intended to maximize rebates and minimize net costs to the program. However, since Texas MCOs do not receive prescription drug rebates and do not have insight into the supplemental rebate contracts the VDP has secured with manufacturers, they may manage their programs to drive their members' utilization to drugs with the lowest gross ingredient costs before rebates. This can result in a greater use of nonpreferred drugs, which may reduce total rebates for the pharmacy program overall. Under a pharmacy carve-out, the FFS program may be able to better manage the benefit on a net cost basis across all its members, which could produce savings.

9.6. One-time Member Transition Costs

When a population migrates from one PBM to another, there are typically costs associated with the transition. These costs may come in the form of issuing new ID cards to members, communicating the transition to members (which may incur printing and postage costs), or consultancy fees to help perform the transition. The actual costs to transition may vary based on the population size and complexity, the sophistication of the PBM vendor elected in the carve-out, and the time period over which the transition will occur (where performing a "big bang" transition on a single date for all members may be more costly and complex than transitioning to the new PBM over time).

Based on industry benchmarks, it is estimated that typical transition costs may range between $8 and $12 per member, though depending on the situation, the costs could be higher or lower. For HHSC's SFY2017 population size, these benchmarks would suggest HHSC may incur approximately $30 to $50 million in one-time transition costs in moving to a pharmacy carve-out. Additionally, during the transition period members may experience disruptions in their process for filling prescriptions, which could negatively impact care, particularly for the most complex patients. Transition planning should be performed prior to a change in delivery models to minimize the potential disruption to members.

9.7. Third-party Reports and Studies

Under a pharmacy carve-out, the nature of the third-party reports and studies HHSC commissions under today's delivery model may change. For example, under its current managed care model, HHSC commissions its external actuary to set capitation rates for HHSC's medical, pharmacy, and other benefit types. Under the carve-out, pharmacy-specific capitation rates would no longer be required. Since the external actuary would still be required to set capitation rates for the medical benefit, however, the decrease in costs from this savings element is estimated to be less than $1 million.

9.8. Time Value of Money

In today's pharmacy delivery model, HHSC makes capitation payments to MCOs at the beginning of a month for MCOs to manage the cost of members' prescription drugs over that period. However, in a pharmacy carve-out model, HHSC would pay claims directly as they are incurred. The difference in the timing of these payments between these two models could present an opportunity for HHSC to earn interest by deferring the payments to when claims are made. However, given the current low-interest rate environment, the impact from this cash float is likely to be nominal.

10. Summary and Conclusion

The results of the analysis quantifying the impact to each component are summarized in the tables below:[54]

Figure 38a. Components in the Comprehensive Estimate of Cost/(Savings) Impact from Pharmacy Carve-out.

Current State Experience	SFY2015	SFY2016	SFY2017
Total Pharmacy Program Costs, Net of Rebates & Cost Sharing (Managed Care + FFS + Administrative Costs)	**$1,671.6M**	**$1,614.4M**	**$1,854.0M**

Component of Estimated Impact from Repricing from Section 5	SFY2015 Cost/ (Savings) Impact	SFY2016 Cost/ (Savings) Impact	SFY2017 Cost/ (Savings) Impact
Impact of Moving to NADAC Pricing for Ingredient Costs	($164.4M)	($180.4M)	($215.6M)
Impact of Moving to Professional Dispensing Fee Based on HHSC Study	$197.4M	$197.1M	$244.2M
Total Impact from New Pricing Methodology	**$33.0M**	**$16.6M**	**$28.7M**

Component of Estimated Impact on Utilization from Section 6	SFY2015 Cost/ (Savings) Impact	SFY2016 Cost/ (Savings) Impact	SFY2017 Cost/ (Savings) Impact
Result 1: 2.2% Utilization Increase	$26.3M	$25.2M	$29.0M
Result 2: No Utilization Increase	-	-	-
Result 3: 5% Utilization Increase	$60.5M	$58.0M	$66.7M

[54] Risk margin savings are calculated using the 2% risk margin assumption that was in place during SFY2015-SFY2017. The risk margin assumption was reduced for SFY2018 and beyond for all programs, except Dual Demonstration, to 1.75% for STAR+PLUS and STAR Kids and 1.50% for STAR, STAR Health, and CHIP.

Component of Estimated Impact on Capitated Amounts and Fees from Section 7	SFY2015 Cost/ (Savings) Impact	SFY2016 Cost/ (Savings) Impact	SFY2017 Cost/ (Savings) Impact
Risk Margin	($54.7M)	($57.3M)	($73.0M)
Loss of Federal Match on State Premium Tax	$27.8M	$28.7M	$36.0M
ACA Health Insurance Providers Fee	($58.7M)	($62.0M)	($76.5M)
Result 1: Impact from All Categories	**($85.6M)**	**($90.6M)**	**($113.6M)**
Result 2: No Savings from ACA Health Insurance Providers Fee	**($26.9M)**	**($28.6M)**	**($37.1M)**

Component of Changes in Administrative Expenses under the Carve-out from Section 8	SFY2015 Cost/ (Savings) Impact	SFY2016 Cost/ (Savings) Impact	SFY2017 Cost/ (Savings) Impact
Result 1: FFS Administrative Costs on Par with MCOs ($1.80 PMPM)	**($3.4M)**	**($5.0M)**	**($5.3M)**
Result 2: FFS Administrative Costs Exceed MCOs ($2.20 PMPM)	**$18.4M**	**$16.8M**	**$17.1M**

Figure 38b. Comprehensive Estimate of Cost/(Savings) Impact from Pharmacy Carve-out.

Summary of Scenarios and Assumptions Selected	Impact of Utilization on Gross Costs	ACA Health Insurance Providers Fee	Administrative Costs PMPM	SFY2015 Cost/ (Savings) Impact in Millions and as Percent	SFY2016 Cost/ (Savings) Impact in Millions and as Percent	SFY2017 Cost/ (Savings) Impact in Millions and as Percent
Scenario 1	+2.2%	Yes	$1.80	**($29.7M)** (1.8%)	**($53.8M)** (3.3%)	**($61.3M)** (3.3%)
Scenario 2	0%	Yes	$1.80	**($56.0M)** (3.4%)	**($79.1M)** (4.9%)	**($90.3M)** (4.9%)
Scenario 3	+5%	Yes	$1.80	**$4.5M** 0.9%	**($21.1M)** (1.3%)	**($23.6M)** (1.3%)
Scenario 4	+2.2%	Yes	$2.20	**($7.9M)** (0.5%)	**($31.9M)** (2.0%)	**($38.9M)** (2.0%)
Scenario 5	+2.2%	No	$1.80	**$29.0M** 1.7%	**$8.2M** 0.5%	**$15.3M** 0.8%
Scenario 6	0%	No	$1.80	**$2.7M** 0.9%	**($17.0M)** (1.1%)	**($13.7M)** (0.7%)
Scenario 7	+5%	No	$1.80	**$63.2M** 3.8%	**$41.0M** 2.5%	**$52.9M** 2.9%
Scenario 8	+5%	No	$2.20	**$85.0M** 5.1%	**$62.9M** 3.9%	**$75.3M** 4.1%

The scenarios analyzed indicate that had the carve-out been in place in SFY2017, the cost impact ranged from an estimated savings of $90.3 million (a 4.9% decrease in total net pharmacy costs) to an estimated cost increase of $75.3 million (a 4.1% increase in total net pharmacy costs). All costs and savings estimates are presented on an all-funds basis.

A summary of the key drivers of the change follows:

- **Risk Margin and ACA Health Insurance Providers Fee:** The removal of the risk margin and the ACA Health Insurance Providers Fee present the largest savings opportunities, contributing $73.0 million (3.9% of total net program costs) and $76.5 million (4.1% of total net program costs) in savings, respectively. However, in evaluating these results on a forward-looking basis, it is important to consider there is uncertainty around the continuation of the ACA Health Insurance Providers Fee for SFY2019 and beyond. Specifically, there is a moratorium expected on the ACA Health Insurance Providers Fee in 2019[55]; if this moratorium stands, the fee will not be assessed at the federal level for the 2019 calendar year. To reflect that there is uncertainty around whether the ACA Health Insurance Providers Fee will be assessed in the future, two of the scenarios presented above remove the $76.5 million in savings attributable to this fee.

  Additionally, the scenarios above were calculated using the historical risk margin assumptions used in developing MCO capitation payments for SFY2015 through SFY2017. However, it is understood the risk margin assumption was reduced from 2.00% in SFY2017 for all programs except Dual Demonstration, to 1.75% in SFY2018 for STAR+PLUS and STAR Kids and 1.50% in SFY2018 for STAR, STAR Health, and CHIP. As a result, the potential savings attributable to the risk margin for SFY2018 and beyond may be less than the historical amounts estimated for SFY2015 to SFY2017 in **Figure 38**.

- **State Premium Tax:** The premium tax component of HHSC's capitation payments to MCOs is subsequently reimbursed to the State; however, by carving out pharmacy benefits, HHSC loses the federal match on state premium tax. This lost revenue was classified as a cost of carving out in the analysis, and is equal to the federal share of the state premium tax based on actual historical federal matching percentages. For SFY2017 this cost is $36.0 million (1.9% of total net program costs).

- **Utilization Change:** The cost and savings estimates may be also influenced by assumptions as to how the pharmacy carve-out will impact

[55] H.R. 195, Division D – Suspension of Certain Health-Related Taxes, §4003

managed care members' drug utilization. Today, HHSC places multiple restrictions on how MCOs can administer their members' prescription drug benefits, and so the MCOs in Texas may not use PDL management and certain other techniques to direct and manage drug utilization as they do in other states. The analysis considers multiple scenarios as to how drug utilization may change under the carve-out in light of these restrictions. These scenarios were developed by analyzing the areas for which MCOs do have discretion in managing their members' prescription drug benefits and quantifying how these areas may influence overall utilization after the transition to a carve-out. The first scenario reflects that prescription drug utilization may increase gross costs by 2.2% under the pharmacy carve-out, increasing costs by $29.0 million (1.6% of total net program costs). This scenario recognizes that MCOs apply certain optional clinical PAs today that the FFS program does not apply, and managed care pharmacy utilization may increase if no longer subject to these PAs. Another scenario reflects no increase in pharmacy utilization, which may result if HHSC implements the same PAs under the pharmacy carve-out as the MCOs use today. Finally, a third utilization scenario is considered wherein the impact is greater than expected and HHSC's utilization increases by 5% following the transition, increasing costs by $66.7 million. HHSC should consider which scenario it believes is most likely based on its ability under the carve-out to manage costs.

Under the scenarios in which utilization is anticipated to change under the pharmacy carve-out, the impact of the change on HHSC's rebate levels is also considered in the analysis. Rebate data was provided for this analysis at the aggregate level and not by drug or therapeutic class. As such, the impact on rebates of any changes in utilization is calculated at an aggregate level, where it is assumed the historical ratios of total rebates as a percentage of total gross ingredient costs would remain constant after any change in utilization. Using this methodology, an assumed increase in utilization would also drive an increase in rebates. The nature of this assumption implies that the drug and therapeutic class mix would remain the same after a change in utilization; while in reality it is possible a change in utilization could be accompanied by a change in drug mix, data was not made available to perform a more detailed analysis on the rebate impact by drug.

- **Fee Schedule:** Adopting the new pricing methodology increased total pharmacy costs by $28.7 million (1.5% of total net program costs) in SFY2017 in all scenarios. The change in professional dispensing fee methodology increased costs, while transitioning to a NADAC ingredient cost pricing methodology decreased costs but not by enough to offset the

increase in dispensing fees. No change is assumed in total rebates collected as a result of the new pricing methodology.

- **Administrative Costs:** Two administrative cost scenarios are considered in the analysis. The first scenario reflects that HHSC's total administrative costs are anticipated to decrease on a per unit basis under the pharmacy carve-out, reflecting the economies of scale inherent in HHSC's ability to contract for administrative services using a larger volume. In this scenario, the costs for administrative functions that may scale with the addition of new FFS membership are assumed to be $1.80 PMPM, on par with the MCO's current administrative costs. This assumption decreases total costs under the pharmacy carve-out by $5.3 million (0.3% of total net program costs).

  However, it may take time for HHSC to be able to efficiently deliver administrative services under the carve-out model. As a result, an alternative scenario is also considered that incorporates a higher estimate of HHSC's potential administrative costs. Under this scenario, the costs for administrative functions that may scale with the addition of new FFS membership are assumed to be $2.20 PMPM. This scenario increases total costs under the pharmacy carve-out by $17.1 million (0.9% of total net program costs). The savings calculated in this analysis are based on administrative costs incurred by HHSC for Medicaid, CHIP, and the other programs in the State of Texas (Healthy Texas Women, CSHCN, and Kidney Health Care) for which HHSC performs administrative functions on their behalf. HHSC will use the pooled membership across all programs for which it performs these functions to negotiate pricing with vendors. Any administrative functions that the other programs perform today on their own, without the help of HHSC, are not included in the analysis and these costs are not anticipated to be impacted by the carve-out.

- **Scenario 8**: Scenario 8 incorporates the largest cost increase or least cost savings scenario from each cost component. Under this scenario, the pharmacy carve-out increases HHSC's pharmacy costs by $75.3 million (4.1% of total net program costs).

As discussed in **Section 9 Other Costs and Considerations**, there are other potential costs that should be evaluated in deciding whether to carve out the pharmacy benefit from managed care. They are not included in the net cost impact calculation above, but should be considered if deciding whether to carve out the pharmacy benefit from managed care. These include:

- **Upfront Transition Costs and System Capabilities:** HHSC may incur one-time technology implementation costs and costs to transition members to its new PBM under the pharmacy carve-out. HHSC's current system capabilities should be assessed and any technology and transition costs should be considered as part of the discussion around carving pharmacy out of the managed care programs.
- **Data Coordination:** Costs related to data coordination may increase under the pharmacy carve-out, as HHSC will be responsible for reporting pharmacy claims experience to the MCOs to enable them to track and manage costs at the episode, encounter, or member level.
- **Transferred Risk from MCO to the State:** Under a carve-out, HHSC will also be at risk for fluctuations in prescription drug utilization patterns or increased costs from new drugs. However, HHSC could realize savings if utilization decreased or ingredient costs increased at a lower than anticipated level.

The changes in pharmacy delivery models contemplated under Rider 60 also have the potential to impact certain aspects of members' care. Any savings that may be achieved in carving the pharmacy benefit out of managed care should be assessed against the opportunities, risks, and other considerations posed herein. These include:

- **Integrated Care Management:** A pharmacy carve-out model may present barriers for MCOs to holistically manage care across members' medical, pharmacy, and other benefits. This may not only increase the total cost of care, it could discourage some MCOs from participating in quality or outcome-based incentive programs if they are no longer responsible for the full spectrum of their members' care.
- **Data Coordination:** The pharmacy carve-out model may enable HHSC to more efficiently identify outcomes and trends in pharmacy utilization across its membership.
- **Increased PDL Adherence:** Transitioning all members to a pharmacy carve-out may increase HHSC's ability to improve adherence to its PDL, and help HHSC identify outcomes based on pharmacy data.

11. Appendices

11.1. Appendix A – Prior Authorization Impact for SFY2017 for Other Medicaid and CHIP Programs

11.1.1. Detail for STAR+PLUS

Figure 39. Prior Authorization Impact for SFY2017 for the STAR+PLUS Program.

Optional Clinical PA Description	*Experience for MCOs that Apply PA:* Annual Scripts per 1,000	*Experience for MCOs that Apply PA:* Gross Costs PMPY	*Experience for MCOs that Do Not Apply PA:* Annual Scripts per 1,000	*Experience for MCOs that Do Not Apply PA:* Gross Costs PMPY	*Impact from Applying Difference in PMPY:* Estimated Impact	Impact from Applying Difference in PMPY: Impact as a % of MCO Costs
Cytokine and CAM Antagonists	24.61	$109.53	27.68	$123.31	$5.0M	0.36%
Topical Acne Agents	15.61	$2.36	20.96	$3.89	$0.5M	0.04%
HAE Agents	0.00	$0.00	0.02	$0.57	$0.1M	0.01%
Gauchers Disease Agents	0.02	$0.99	0.00	$0.18	$0.0M	0.00%
Xenazine	0.57	$8.20	0.73	$10.36	$0.8M	0.06%
Lidocaine Patches	15.45	$2.30	7.36	$0.79	$0.0M	0.00%
Savella	2.81	$0.77	2.80	$0.83	$0.0M	0.00%
Nuplazid	0.02	$0.02	0.06	$0.06	$0.0M	0.00%
Zelboraf	0.03	$0.26	0.00	$0.00	$0.0M	0.00%
Grand Total					**$6.4M**	**0.47%**

11.1.2. Detail for STAR Kids

Figure 40. Prior Authorization Impact for SFY2017 for the STAR Kids Program.

Optional Clinical PA Description	*Experience for MCOs that Apply PA:* Annual Scripts per 1,000	*Experience for MCOs that Apply PA:* Gross Costs PMPY	*Experience for MCOs that Do Not Apply PA:* Annual Scripts per 1,000	*Experience for MCOs that Do Not Apply PA:* Gross Costs PMPY	*Impact from Applying Difference in PMPY:* Estimated Impact	Impact from Applying Difference in PMPY: Impact as a % of MCO Costs
Cytokine and CAM Antagonists	7.36	$38.29	8.30	$37.55	$0.0M	0.00%
Topical Acne Agents	59.41	$10.76	57.22	$12.79	$0.2M	0.04%
HAE Agents	0.17	$6.08	0.13	$6.07	$0.0M	0.00%
Gauchers Disease Agents	0.32	$5.93	0.34	$16.97	$1.2M	0.25%
Xenazine	1.06	$16.22	0.65	$8.14	$0.0M	0.00%
Lidocaine Patches	1.72	$0.44	1.37	$0.14	$0.0M	0.00%
Savella	0.03	$0.01	0.00	$0.00	$0.0M	0.00%
Nuplazid	0.00	$0.00	0.00	$0.00	$0.0M	0.00%
Zelboraf	0.00	$0.00	0.02	$0.08	$0.0M	0.00%
Grand Total					**$1.4M**	**0.30%**

11.1.3. Detail for CHIP

Figure 41. Prior Authorization Impact for SFY2017 for the CHIP Program.

Optional Clinical PA Description	*Experience for MCOs that Apply PA:* Annual Scripts per 1,000	*Experience for MCOs that Apply PA:* Gross Costs PMPY	*Experience for MCOs that Do Not Apply PA:* Annual Scripts per 1,000	*Experience for MCOs that Do Not Apply PA:* Gross Costs PMPY	*Impact from Applying Difference in PMPY:* Estimated Impact	Impact from Applying Difference in PMPY: Impact as a % of MCO Costs
Cytokine and CAM Antagonists	1.43	$7.23	2.00	$7.67	$0.2M	0.15%
Topical Acne Agents	20.32	$4.10	25.36	$5.69	$0.5M	0.41%
HAE Agents	0.00	$0.00	0.00	$0.00	$0.0M	0.00%
Gauchers Disease Agents	0.02	$0.34	0.00	$0.00	$0.0M	0.00%
Xenazine	0.00	$0.00	0.01	$0.10	$0.0M	0.03%
Lidocaine Patches	0.07	$0.01	0.14	$0.01	$0.0M	0.00%
Savella	0.00	$0.00	0.00	$0.00	$0.0M	0.00%
Nuplazid	0.00	$0.00	0.00	$0.00	$0.0M	0.00%
Zelboraf	0.00	$0.00	0.00	$0.00	$0.0M	0.00%
Grand Total					**$0.7M**	**0.59%**

11.2. Appendix B – Non-claims Provisions in SFY2015 to SFY2017 Pharmacy Capitation Rates, by Fiscal Year and Program

Figure 42. Non-claims Provisions in SFY2015 to SFY2017 Pharmacy Capitation Rates, by Fiscal Year and Program.

Program	SFY2015 Pharmacy Administrative Costs	SFY2015 Risk Margin	SFY2015 State Premium Tax
STAR	$1.80 PMPM	2.00%	1.75%
STAR+PLUS	$1.80 PMPM	2.00%	1.75%
STAR Health	$1.80 PMPM	2.00%	1.75%
STAR Kids	$1.80 PMPM	N/A	N/A
Dual Demonstration	$0.29 PMPM	0.00%	0.00%
CHIP	$1.80 PMPM	2.00%	1.75%

Program	SFY2016 Pharmacy Administrative Costs	SFY2016 Risk Margin	SFY2016 State Premium Tax
STAR	$1.80 PMPM	2.00%	1.75%
STAR+PLUS	$1.80 PMPM	2.00%	1.75%
STAR Health	$1.80 PMPM	2.00%	1.75%
STAR Kids	$1.80 PMPM	N/A	N/A
Dual Demonstration	$0.29 PMPM	0.00%	0.00%
CHIP	$1.80 PMPM	2.00%	1.75%

Program	SFY2017 Pharmacy Administrative Costs	SFY2017 Risk Margin	SFY2017 State Premium Tax
STAR	$1.80 PMPM	2.00%	1.75%
STAR+PLUS	$1.80 PMPM	2.00%	1.75%
STAR Health	$1.80 PMPM	2.00%	1.75%
STAR Kids	$1.80 PMPM	2.00%	1.75%
Dual Demonstration	$0.29 PMPM	0.00%	0.00%
CHIP	$1.80 PMPM	2.00%	1.75%

11.3. Appendix C – MCOs Subject to ACA Health Insurance Providers Fee for SFY2017

Figure 43. MCOs Subject to ACA Health Insurance Providers Fee for SFY2017.

MCO	ACA Health Insurance Providers Fee Applies?
Aetna	Yes
Amerigroup	Yes
Blue Cross Blue Shield	Yes
Children's Medical	No
Christus	No
Cigna	Yes
Community First	No
Community Health	No
Cook	No
Driscoll	No
El Paso First	No
First Care	Yes
Molina	Yes
Parkland Community	No
Scott and White	Yes
Sendero	No
Seton	Yes
Superior	Yes
Texas Children's	No
United	Yes