HEALTH AND HUMAN SERVICES COMMISSION

VENDOR DRUG PROGRAM

FORMULARY CONTROL STATE VS. MCO

Prepared for:
Texas Health and Human Services Commission

Prepared by:
Khiem D. Ngo, F.S.A., M.A.A.A
Rudd and Wisdom, Inc.

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I. Executive Summary

The issue addressed in this report is whether it is most cost-effective to have HHSC or the MCOs be responsible for the development and management of the formulary, preferred drug list (PDL) and prior authorization (PA) requirements under the Texas Medicaid managed care pharmacy program. This report summarizes our analysis of the expected cost differences between the current mandate scenario (State control) and the no mandate scenario (MCO control).

Our analysis has modeled Texas Medicaid managed care pharmacy utilization under the no mandate scenario. This was estimated by comparing actual Texas Medicaid drug utilization by therapeutic category to utilization experience from six other states that operate pharmacy carve-in programs using a no mandate model. The other states used in our analysis were California, Kentucky, Maryland, Michigan, New Jersey and New York.

It should be noted that a number of states have recently or plan to implement a single PDL Mandate model similar to Texas for their Medicaid programs. Pennsylvania, Ohio and Illinois implemented a single PDL for all managed care plans effective January 1, 2020. Louisiana, Michigan and Kentucky implemented a single PDL on May 1, 2019, October 1, 2020 and January 1, 2021 respectively. California and New York will carve prescription drugs out of managed care effective April 1, 2021. In addition, Arizona, Massachusetts, Nebraska and Washington plan to expand the single PDL to include more drug classes.

In our analysis, we assumed that the aggregate utilization (number of prescriptions) within a therapeutic category will be the same under the mandate and no mandate scenarios. The difference in the utilization will be in the distribution of drugs within a therapeutic category. The distribution of scripts under the mandate scenario is the actual Texas Medicaid managed care pharmacy utilization. The distribution under the no mandate scenario is determined by taking the total scripts for each therapeutic category (from the mandate scenario) and re-allocating by drug based on the utilization distribution data from the no mandate states.

For each of these two utilization distributions, we applied the net cost (gross pharmacy cost less federal and supplemental rebates) per script for each of the drugs. For each individual drug, the gross cost per script and federal rebate per script are the same under the mandate and no mandate scenarios. Based on input from the MCOs, supplemental rebates were assumed to be 4.0% of gross pharmacy cost under the no mandate scenario. The total net cost was compared for the mandate and no mandate scenarios to determine the impact on net pharmacy cost.

Our analysis assumes that under the no mandate scenario, HHSC will require the MCOs to provide open access to the protected drug classes as in the case under the current mandate scenario, i.e., all protected class drugs are available without prior authorization. Based on input from VDP, we believe this is the most likely scenario.

In addition to net pharmacy claims cost, other items such as administrative expense, risk margin and premium tax were considered in order to estimate the overall financial impact to the state. Based on our assumptions, the total net pharmacy cost under the no mandate scenario is 2.0% more costly than that under the current mandate scenario. The overall cost to the state under the no mandate scenario would be approximately $15-18 million (General Revenue) more per year than that under the current mandate scenario for the FY2022 through FY2025 period.

II. Introduction

Managed Care Organizations (MCOs) in the Texas Medicaid program are financially responsible for the delivery of prescription drug services and appropriate provision for these services is included in the MCO capitation rates. However, the Vendor Drug Program (VDP) of the Health and Human Service Commission (HHSC) retains control over the formulary and responsibility for the management of federal and supplemental rebates.

Critical components of the management of any pharmacy benefit program are the development and administration of the formulary, preferred drug list (PDL) and prior authorization (PA) requirements. H.B. 1917 (of the 85th Legislature, Regular Session) required HHSC to retain the responsibility for these functions and mandated that the participating MCOs utilize the schedules and protocols developed by VDP. The responsibility for formulary management has been a topic of debate since the inclusion of pharmacy benefits in the managed care contracts in 2013. The MCOs believe that they can manage the program more cost-effectively if they are allowed to use their own formulary, PDL and PA requirements rather than those mandated by HHSC.

A key issue in the formulary control debate is the collection of rebates. Under Section 1927 of the Social Security Act, drug manufacturers participating in the Medicaid program must have a federal rebate agreement with Centers for Medicare & Medicaid Services (CMS) and the State. The federal rebate agreement does not include the MCOs. Therefore, the MCOs are not able to determine the which drug has the lowest net cost to the State. In general, federal rebates for brand drugs are much higher than those for generic drugs. The State's focus in managing the PDL is having the lowest net cost (after rebates) drugs on the PDL. On the other hand, the MCOs believe that the savings from shifting utilization to generic drugs will more than offset the reduction in federal rebates. The MCO's focus when it comes to management of the PDL is having the lowest gross cost (prior to rebates) drugs on the PDL.

The Kaiser Family Foundation (KFF) and Health Management Associates (HMA) conducted a survey in July 2019 of Medicaid officials in the 50 States and District of Columbia to determine which states operate under a mandate vs. no mandate model. Nine states had a uniform PDL for all drug class including Texas, seven states had a uniform PDL for some drug classes, 18 states didn't have a uniform PDL (i.e., allowed MCOs to control PDL under no mandate model), and 17 states didn't report, don't have a comprehensive capitated managed care program, or have pharmacy benefits carved out of managed care. Since the date of the survey in July 2019, Pennsylvania, Ohio and Illinois implemented a single PDL for all managed care plans effective January 1, 2020. Michigan and Kentucky implemented a single PDL on October 1, 2020 and January 1, 2021 respectively. California and New York will carve prescription drugs out of managed care effective April 1, 2021. In addition, Arizona, Massachusetts, Nebraska and Washington plan to expand the single PDL to include more drug classes. The results of the survey are included in Attachment 1.

In response to the formulary control issue, HHSC has requested that Rudd and Wisdom, Inc. (Rudd and Wisdom) review the current situation, evaluate the cost impact and explain the advantages and disadvantages of each option. Rudd and Wisdom has prepared similar reports for HHSC in the past. For purposes of this analysis, we will refer to the current arrangement (where HHSC dictates the formulary, PDL and PA requirements) as the "mandate" scenario and

the arrangement whereby the MCOs develop and use their own program tools as the “no mandate” scenario.

Please note that this report is intended to present a comparison of the overall expected cost difference between the mandate and no mandate scenarios and should not be used for any other purpose.

III. Definitions

This section presents a working definition or explanation for several terms used in this report.

Federal Rebates. Federal rebates are based on statutory formula and are only available to state agencies. In general, federal rebates are much higher for brand named drugs than generic drugs. Federal rebates account for over 90% of the total rebates collected by HHSC. Federal rebates differ in both concept and magnitude from prescription drug rebates in the commercial sector which are more similar to supplemental rebates. The federal rebate rate per drug will be the same under both the mandate and no mandate scenarios. However, total federal rebates will decrease under the no mandate scenario as a result of increased generic utilization. Federal rebates are not available under the CHIP program.

Formulary. A formulary is a list of drugs. Texas Medicaid/CHIP utilizes a closed formulary where drugs included on the formulary are covered by the program and those drugs not on the formulary are not covered.

Gross Pharmacy Cost. Gross pharmacy cost is equal to the total amount paid to the pharmacy. It includes ingredient cost and dispensing fee. The gross pharmacy cost is also referred to as the "gross cost" throughout this report.

Mandate Scenario. The arrangement currently utilized by HHSC where the state controls the formulary, preferred drug list (PDL) and prior authorization (PA) requirements.

National Drug Code (NDC). A universal product identifier used to uniquely identify drugs.

Net Pharmacy Cost. Net pharmacy cost is equal to gross pharmacy cost less federal and supplemental rebates. The net pharmacy cost is also referred to as "net cost" throughout this report.

No Mandate Scenario. The arrangement whereby each MCO controls the formulary, preferred drug list (PDL) and prior authorization (PA) requirements for its plan participants.

Preferred Drug List (PDL). The PDL is a list of formulary drugs separated into preferred and non-preferred categories. Preferred drugs are generally more cost-effective than non-preferred drugs. Preferred drugs are available to eligible participants without prior authorization while non-preferred drugs require prior authorization.

Prior Authorization (PA). PA is required for non-preferred drugs and drugs subject to clinical PA edits. The goal of the PA program is to ensure that the client receives treatment that is both appropriate and cost-effective. If a client presents the pharmacy with a prescription for a non-preferred drug, the pharmacy will require additional information in order for the drug to be covered. There are various levels of PA requirements depending on the drug.

Protected Drug Classes. The protected drug classes were identified in a study performed by the University of Texas at Austin and are classes used for chronic or life-threatening diseases. These drug classes include anticonvulsants, blood factors, HIV, multiple sclerosis and cancer.

Rebates. There are two types of rebates in the Medicaid pharmacy program – federal and

supplemental.

Rebate Offset Amount. Section 2501 of the Affordable Care Act (ACA) increased the minimum federal rebate amount and requires the state to remit 100 percent of the additional increase to CMS. This increased rebate established by the ACA is called the Rebate Offset Amount (ROA). For the purpose of our analysis, federal rebates are net of the ROA.

Supplemental Rebates. Supplemental rebates are obtained through direct contracts with drug manufacturers and are in addition to federal rebates. HHSC contracts directly with drug manufacturers under the current mandate scenario while the MCOs will contract with the drug manufacturers under the no mandate scenario for supplemental rebates.

IV. Advantages of Mandate and No Mandate Scenarios

Advantages of Mandate Scenario – State Control Formulary

- Consistent Protocols – Administering a single formulary will result in a consistent PDL and PA requirements across all Medicaid MCOs.

- Consistent Access – Members will have consistent access to the same drugs regardless of which plan the member is in.

- Minimize Net Cost – Federal rebates are confidential information and only available to the state. As a result, the state can determine the lowest net cost drugs.

- Increased Access to Drugs – State has the flexibility to require MCOs to cover certain drugs by their inclusion on the PDL.

Advantages of No Mandate Scenario – MCO Control Formulary

- Align PDL with Member's Needs – Allow the MCOs to align the PDL to their member's population.

- MCO Flexibility – Allow the MCOs the flexibility to design their own PDL that is similar to their other lines of business.

- Responsive to PDL Changes – MCOs can revise their PDL on short notice. HHSC can take longer to change the PDL which includes receiving recommendations from the Texas Drug Utilization Review Board and requiring approval from HHSC's Executive Commissioner.

- Increase Generic Dispensing Rate (GDR) – MCOs would shift utilization to generic drugs resulting in a reduction to gross pharmacy spend. As a result, the capitation payments to the MCOs would also be reduced compared to the current mandate scenario. However, increasing GDR doesn't necessarily result in lower net cost because rebates collected by HHSC would also be reduced.

- Coordination of Care – The MCOs have argued that clinical outcomes will improve through their coordination of care and cost management tools.

V. Overview of Methodology and Results

This report details the methodology and assumptions used to compare the gross and net pharmacy cost between the mandate and no mandate scenarios for control over the formulary and PDL used for Medicaid managed care pharmacy program. In addition to the pharmacy claims cost, other items such as administrative expense, risk margin and premium tax were considered in order to estimate the overall financial impact to the state. In performing the analysis, Rudd and Wisdom has relied on the following data sources:

- Federal and supplemental rebates by NDC provided by HHSC's subcontractor Conduent.
- Summary federal and supplemental rebates by NDC invoiced for the period January 1, 2017 through June 30, 2020, provided by HHSC's subcontractor Conduent.
- Drug therapeutic class for each NDC provided by HHSC's subcontractor Conduent.
- CMS State Drug Utilization Data for the period July 1, 2019 through June 30, 2020. CMS publishes this data quarterly separately for each state. This data includes utilization and cost data by NDC and by managed care vs. Fee-for-Service (FFS) for every Medicaid prescription filled.
- MCO responses to a HHSC request for information regarding i) list of all states where the MCOs do business with a majority of pharmacy claims carved into managed care and the MCOs have flexibility to control the PDL, ii) the MCO's expected amount of supplemental rebates as a percent of total gross pharmacy reimbursement for these states and iii) the anticipated impact on overall pharmacy utilization from the proposed change in PDL management.
- NDCs for all Protected drug classes provided by HHSC.

Although the above data was reviewed for reasonableness, Rudd and Wisdom did not audit the data.

Our pharmacy claims cost analysis modeled Texas utilization under the no mandate scenario. This was estimated by comparing actual Texas Medicaid drug utilization by therapeutic category to utilization experience from states that operate pharmacy carve-in programs using a no mandate model. The MCOs provided a list of states where they do business that operate pharmacy carve-in programs using a no mandate approach. The states used in our analysis were California, Kentucky, Maryland, Michigan, New Jersey and New York. These states were selected because they were identified by at least one of the MCOs as states that operate pharmacy carve-in programs using a no mandate approach with little or no restriction and had over $500 million of pharmacy paid claims in managed care for the period July 1, 2019 through June 30, 2020. Utilization data for these states was collected from the CMS State Drug Utilization Data. The data for both Texas and the other states included managed care claims experience for the period July 1, 2019 through June 30, 2020. This was the most recent utilization data available from CMS at the time of the study.

We have assumed that the aggregate utilization (number of prescriptions) within a therapeutic category will be the same under the mandate and no mandate scenarios. The therapeutic category for each drug class is defined using First Data Bank's first three characters of the

Hierarchical Ingredient Code (HIC3). The difference in utilization assumptions between the two scenarios will be in the distribution of drugs within a therapeutic category. The distribution of scripts under the mandate scenario is the actual Texas managed care pharmacy utilization. The distribution under the no mandate scenario is determined by taking the total scripts for each therapeutic category (from the mandate scenario) and re-allocating by drug based on utilization distribution data from the no mandate states.

To each of these two utilization distributions, we then applied the net cost (gross pharmacy cost less federal and supplemental rebates) per script for each of the drugs. For each individual drug, the gross cost per script and federal rebate per script are the same under the mandate and no mandate scenarios. Based on input from the MCOs, supplemental rebates were assumed to be 4.0% of gross pharmacy cost under the no mandate scenario. The total net cost was compared for the mandate and no mandate scenarios to determine the overall impact on net pharmacy cost.

A critical component of this study is having actual federal and supplemental rebates at the NDC level. Rebates vary significantly by drug. As a result, applying average rebate levels across the board could lead to the wrong conclusion. For example, some brand name drugs can have federal and supplemental rebates as a percentage of gross cost in excess of 95%, resulting in a lower net cost than its generic equivalent. However, if average federal and supplemental rebate levels were assumed in this case, then the generic equivalent may incorrectly appear to have a lower net cost than the brand name drug.

Attachment 4 presents a summary of our pharmacy claims cost analysis. The total pharmacy claims net cost under the no mandate scenario is 2.0% more costly than that under the current mandate scenario.

Attachment 8 presents an estimate of the overall Texas Medicaid managed care pharmacy cost for the mandate and no mandate scenarios for the period FY2022 through FY2025. The overall cost to the state under the no mandate scenario would be approximately $15-18 million (General Revenue) more per year than that under the current mandate scenario after considering the impact of all expense items.

VI. Pharmacy Claims Cost Impact Analysis - Mandate vs. No Mandate

Assumptions

The following assumptions were made for this analysis:

- The Texas no mandate scenario was estimated based on the average managed care utilization experience from California, Kentucky, Maryland, Michigan, New Jersey and New York. These states were selected because they were identified by at least one of the MCOs as states that operate pharmacy carve-in programs using a no mandate approach with little or no restriction and had over $500 million of pharmacy paid claims in managed care for the period July 1, 2019 through June 30, 2020.

- We have assumed that the drug utilization shift would occur immediately. Any transition period may impact the results of this study.

- The utilization for drug classes with fewer than 5,000 prescriptions in each state were excluded from the study. For example, the states of Michigan and Maryland do not have managed care utilization data for the antipsychotic drug class because it is carved out of managed care. As a result, the no mandate scenario utilization for the antipsychotic drug class was estimated based on the average utilization experience from the other states.

- Protected drug classes were assumed to have no cost impact. These drug class were identified in a study by the University of Texas at Austin and are classes used for chronic or life-threatening diseases. These drug classes include anticonvulsants, blood factors, HIV, multiple sclerosis and cancer. Under the current mandate scenario, protected drug classes are required to have open access, i.e., all protected class drugs are available without prior authorization. We have assumed that under the no mandate scenario, HHSC will require the MCOs to provide open access to the protected drug classes as is the case under the current mandate scenario due to the life-threatening nature of these drugs. The utilization, gross cost and net cost for these drug classes were assumed to be the same for the mandate and no mandate scenarios.

- The aggregate utilization (number of prescriptions) within a therapeutic category is assumed to be the same under the mandate and no mandate scenarios. The difference in utilization between the two scenarios is in the distribution of drugs within a therapeutic category.

- For each NDC, the gross cost per script and federal rebate per script are the same under the mandate and no mandate scenarios. Based on input from the MCOs, supplemental rebates were assumed to be 4.0% of gross pharmacy cost under the no mandate scenario.

- This analysis assumes that the state would not impose additional restrictions, other than the Protected Drug Class, that would limit the MCOs ability to control the PDL.

- Utilization of drugs currently carved out of the Texas Medicaid program, such as Hemophilia drugs, were assumed to be unchanged under the no mandate scenario.

- CHIP and the Medicaid Dual Eligible Demonstration (Dual Demo) programs were excluded from the analysis. The CHIP program was excluded from this analysis because i) federal rebates are not available under CHIP and ii) the MCOs are currently allowed PDL flexibility in the CHIP program. Dual Demo was excluded from this analysis because Medicaid is the secondary payer.

- HHSC's VDP is also responsible for formulary and rebate management for the Medicaid FFS, Clinician administered drugs (CADs), Children with Special Health Care Needs (CSHCN), Healthy Texas Women's (HTW) and Kidney Health Care (KHC) programs. These programs are excluded from this analysis because the no mandate model is expected to have minimal impact on these programs.

Utilization

Our pharmacy claims cost analysis modeled Texas utilization under the no mandate scenario. This was estimated by comparing actual Texas Medicaid managed care drug utilization by therapeutic category to utilization experience from other states that operate pharmacy carve-in programs using a no mandate model. The MCOs provided a list of states where they do business that operate pharmacy carve-in programs using a no mandate approach. The states used in our analysis were California, Kentucky, Maryland, Michigan, New Jersey and New York. These states were selected because they were identified by at least one of the MCOs as states that operate pharmacy carve-in programs using a no mandate approach with little or no restriction and had over $500 million of pharmacy paid claims in managed care for the period July 1, 2019 through June 30, 2020. Utilization data for these states was collected from the CMS State Drug Utilization Data. The data for both Texas and the other states included managed care claims experience for the period July 1, 2019 through June 30, 2020. This was the most recent utilization data available from CMS at the time of the study.

The issue addressed in this report is whether it is most cost-effective for HHSC or the MCOs to have responsibility for the development and management of the formulary, PDL and PA requirements under the Texas Medicaid managed care pharmacy program. Under either scenario, the same physicians will be writing prescriptions for the same patients treating the same conditions. What will potentially change is the drug that the pharmacy dispenses. As a result, we have assumed that the aggregate utilization (number of prescriptions) within a therapeutic category will be the same under the mandate and no mandate scenarios. The difference in the utilization assumption will be in the distribution of drugs within a therapeutic category. The distribution of scripts under the mandate scenario is the actual Texas managed care pharmacy utilization. The distribution under the no mandate scenario is determined by taking the total scripts for each therapeutic category (from the mandate scenario) and re-allocating by drug based on the utilization data from the no mandate states.

Attachment 2 presents how the no mandate utilization assumption was derived for a sample therapeutic category. This analysis was performed for each therapeutic category.

Net Pharmacy Cost Comparison

To each of the mandate and hypothetical no mandate distributions, we applied the net cost (gross cost less federal and supplemental rebates) per script for each drug. For each individual drug, the gross cost per script and federal rebate per script are the same under the mandate and no mandate scenarios. The net cost per script for the mandate scenario is determined by dividing the Texas managed care net pharmacy cost by the number of scripts for each drug. The net cost per script for the no mandate scenario assumed the same gross cost per script and federal rebate per script as the mandate scenario, for each NDC. Based on input from the MCOs, supplemental rebates were assumed to be 4.0% of gross pharmacy cost under the no mandate scenario. The total net cost was compared for the mandate and no mandate scenarios to determine the financial impact.

Attachment 3 presents the calculation of net cost for the mandate and no mandate scenarios for a sample therapeutic category. This analysis was done for every therapeutic category.

Pharmacy Cost Impact Analysis

Attachment 4 presents a summary of our pharmacy cost analysis. The total net pharmacy cost under the no mandate scenario is 2.0% more costly than that under the current mandate scenario.

Attachment 5 presents a summary of the analysis by therapeutic category for the top drug classes with the biggest net cost difference between the mandate and no mandate scenarios.

VII. Overall Cost Impact Analysis - Mandate vs. No Mandate

In addition to the net pharmacy claims cost, other expense items such as administrative expense, risk margin and premium tax were considered in order to estimate the overall financial impact to the state. Attachment 8 presents an estimate of the overall cost of the Texas Medicaid program for the mandate and no mandate scenarios for the period FY2022 through FY2025. The overall cost to the state under the no mandate scenario would be approximately $15-18 million (General Revenue) more per year than that under the current mandate scenario after considering the impact of all expense items.

Please note that projections in this report are presented to compare the overall cost between the mandate and no mandate scenarios. They should not be used for any other purpose.

VIII. Key Findings

Under the no mandate scenario, the MCOs will develop a PDL that minimizes the MCO's cost. Since federal rebates are collected by the states, the MCO's cost is the gross pharmacy cost less supplemental rebates. This strategy will increase the generic dispensing rate (GDR) and reduce the gross pharmacy cost. We estimated that, under the assumptions described in this report, the capitation rates paid to the MCOs will be reduced by approximately 17.7%. The cost impact to the state, on the other hand, must also consider other factors outside of the capitation rates such as federal rebates. Increasing the GDR will reduce total federal and supplemental rebates because the rebate per unit is higher for brand drugs than generic drugs. The reduction in gross pharmacy cost is slightly less than the reduction in total federal and supplemental rebates which results in a total net pharmacy claims cost under the no mandate scenario that is 2.0% more costly than that under the current mandate scenario.

Attachment 6 presents the utilization distribution by drug for the top four therapeutic classes in which the total net cost is less under the current mandate scenario. The current mandate scenario uses a brand name drug much more than the generic in each of the therapeutic classes listed. The high level of rebates collected for the brand drug makes it a lower net cost option than the generic drug. This may be a surprise to many. The magnitude of the federal rebate is significantly greater than rebates in the commercial sector. In these cases, the net cost of the brand drug is lower and, as a result, the current mandate scenario includes these brand name drugs on the PDL rather than their generic equivalents. The table below presents the drugs utilized for the top four therapeutic classes in which the net cost is less under the current mandate scenario.

HIC3	Lower Net Cost Drugs Utilized More Under Mandate	Higher Net Cost Drugs Utilized More Under No Mandate
C4G	Novolog, Lantus, Levemir	Basaglar, Admelog
B6W	Proair	Albuterol
B63	Advair, Symbicort	Fluticasone-Salmeterol, Wixela
B6M	Flovent	Budesonide, Qvar

Attachment 7 presents the utilization distribution by drug for the top four therapeutic classes where the net cost is higher under the current mandate scenario. The current mandate scenario's PDL management is sometimes more relaxed than that of the no mandate scenario for the therapeutic classes listed. As a result, the current mandate scenario covers more drugs and/or dispenses higher net cost drugs than that under the no mandate scenario for these therapeutic drug classes. In addition, MCOs may be more proactive in shifting utilization to lower cost formulation of a drug such as tablet or capsule as opposed to higher cost oral suspension formulation. The table below presents the drugs utilized for the top four therapeutic classes in which the net cost is higher under the current mandate scenario.

HIC3	Higher Net Cost Drugs Utilized More Under Mandate	Lower Net Cost Drugs Utilized More Under No Mandate
H7T	Invega, Seroquel, Risperdal, Zyprexa	Risperidone, Quetiapine
W5A	Oseltamivir	Acyclovir, Valacyclovir
H7X	Aristada, Rexulti	Aripiprazole
D4J	Nexium, Esomeprazole	Omeprazole

The current mandate scenario requires each participating MCO to use a single PDL. HHSC could, theoretically, operate exactly the same PDL, the same PA requirements and in the same manner as the MCOs. Even though there are therapeutic classes where the pharmacy net cost is lower under the no mandate scenario, HHSC could achieve the same level of savings by modifying the existing program to produce a utilization pattern more similar to that of the no mandate scenario for these therapeutic classes. The MCOs have argued that while HHSC could implement more aggressive PDL management tools, HHSC has been hesitant to do so in the past.

IX. Summary

At issue is whether HHSC or the MCOs will be responsible for the development and management of the formulary, preferred drug list and prior authorization requirements under the Medicaid pharmacy carve-in program. We prepared an analysis which compared actual Texas pharmacy experience to experience from other states which currently utilize a no mandate approach.

Based on our analysis, the total net pharmacy cost under the no mandate scenario is 2.0% higher than that under the current mandate scenario. In addition to the net pharmacy claims cost, other expense items such as administrative expense, risk margin and premium tax were considered in order to estimate the overall financial impact to the state. Based on our assumptions, the no mandate scenario's overall cost to the state would be approximately $15-18 million (General Revenue) more per year than that under the current mandate scenario after considering the impact of all expense items for the FY2022 through FY2025 period. Our analysis also indicates that there are modifications HHSC could make to the existing mandate arrangement which might achieve higher savings by reviewing therapeutic classes where the no mandate scenario has a lower pharmacy net cost. Rudd and Wisdom has notified VDP of the savings potentially available in these drug classes.

X. Attachments

Kaiser Family Foundation & Health Management Associates
KFF / Health Management Associates 2019 Survey of Medicaid Officials in 50 States and DC, April 2020.
State Medicaid Preferred Drug Lists
States reported policies as of July 1, 2019.

States	State Uses Uniform Preferred Drug List for MCOs[4]
Alabama	N/A
Alaska	N/A
Arizona	Uniform PDL for some classes
Arkansas	Uniform PDL for all classes
California	No uniform PDL
Colorado	NR
Connecticut	N/A
Delaware	Uniform PDL for all classes
District of Columbia	No uniform PDL
Florida	Uniform PDL for some classes
Georgia	No uniform PDL
Hawaii	No uniform PDL
Idaho	N/A
Illinois[1]	No uniform PDL
Indiana	No uniform PDL
Iowa	Uniform PDL for all classes
Kansas	Uniform PDL for all classes
Kentucky	No uniform PDL
Louisiana	Uniform PDL for all classes
Maine	N/A
Maryland	No uniform PDL
Massachusetts	Uniform PDL for some classes
Michigan	No uniform PDL
Minnesota	Uniform PDL for all classes
Mississippi	Uniform PDL for all classes
Missouri[2]	N/A
Montana	N/A
Nebraska	Uniform PDL for some classes
Nevada	No uniform PDL
New Hampshire	No uniform PDL
New Jersey	No uniform PDL
New Mexico	No uniform PDL
New York	No uniform PDL
North Carolina	N/A
North Dakota[3]	Uniform PDL for all classes
Ohio[1]	No uniform PDL
Oklahoma	N/A
Oregon	No uniform PDL
Pennsylvania[1]	No uniform PDL
Rhode Island	No uniform PDL
South Carolina	Uniform PDL for some classes
South Dakota	N/A
Tennessee[2]	N/A
Texas	Uniform PDL for all classes
Utah	NR

Kaiser Family Foundation & Health Management Associates
KFF / Health Management Associates 2019 Survey of Medicaid Officials in 50 States and DC, April 2020.
State Medicaid Preferred Drug Lists
States reported policies as of July 1, 2019.

States	State Uses Uniform Preferred Drug List for MCOs[4]
Vermont	N/A
Virginia	Uniform PDL for some classes
Washington	Uniform PDL for some classes
West Virginia[2]	N/A
Wisconsin[2]	N/A
Wyoming	N/A
United States	For all classes: 9, For some classes: 7, No uniform PDL: 18, N/A: 15, NR: 2

Footnotes:
1. IL, OH, and PA reported plans to implement a uniform PDL for all classes effective January 2020.
   NH reported plans to implement a uniform PDL for some classes in FY 2020.
2. MO, TN, WI and WV are marked as "N/A" because the pharmacy benefit is carved out of managed care in those states.
   All other states marked as N/A do not have comprehensive capitated MCOs.
3. ND reported that it will carve out pharmacy from managed care effective January 2020.
4. NR = Not Reported. N/A = State does not have comprehensive capitated managed care or has carved out the pharmacy benefit.

Sources
[KFF / Health Management Associates 2019 Survey of Medicaid Officials in 50 States and DC, April 2020]
(https://www.kff.org/medicaid/report/how-state-medicaid-programs-are-managing-prescription-drug-costs-results-from-a-state-medicaid-pharmacy-survey-for-state-fiscal-years-2019-and-2020).

Health and Human Services Commission
Mandate vs. No Mandate Study
Sample Analysis - Utilization by Therapeutic Category

Drug Class	Drug Name	Mandate (TX) Scripts	No Mandate Utilization by Drug Class						
			CA	KY	MD	MI	NJ	NY	Selected (1)
A1A	A	-	32.9%	26.9%	28.9%	31.9%	27.5%	22.9%	28.5%
A1A	B	-	34.6%	26.1%	28.1%	31.1%	29.0%	22.1%	28.5%
A1A	C	3,272	7.4%	18.4%	18.4%	13.4%	1.7%	14.4%	12.3%
A1A	D	2,070	5.3%	11.0%	13.0%	6.0%	7.8%	7.0%	8.4%
A1A	E	1,002	5.4%	5.0%	5.0%	5.0%	8.1%	7.0%	5.9%
A1A	F	585	5.0%	5.0%	3.0%	5.0%	8.1%	7.0%	5.5%
A1A	G	3,604	4.1%	0.7%	0.7%	0.7%	15.0%	2.7%	4.0%
A1A	H	2,173	0.0%	0.0%	0.0%	0.0%	0.0%	2.0%	0.3%
A1A	I	506	4.9%	4.3%	0.0%	4.3%	0.0%	6.3%	3.3%
A1A	J	-	0.1%	2.5%	0.0%	2.5%	0.0%	4.5%	1.6%
A1A	K	117	0.1%	0.0%	0.0%	0.0%	0.0%	2.0%	0.4%
A1A	L	576	0.0%	0.0%	2.3%	0.0%	0.0%	2.0%	0.7%
A1A	M	41	0.1%	0.1%	0.1%	0.1%	0.0%	0.1%	0.1%
A1A	N	-	0.0%	0.0%	0.5%	0.0%	2.7%	0.0%	0.5%
Total		13,946	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Drug Class	Drug Name	Mandate (TX) Scripts	No Mandate Projected Number of Scripts by Drug Class						
			CA	KY	LA	MI	NJ	NY	Selected
A1A	A	-	4,583	3,750	4,029	4,447	3,841	3,192	3,974
A1A	B	-	4,830	3,636	3,915	4,333	4,044	3,078	3,973
A1A	C	3,272	1,037	2,567	2,567	1,869	238	2,009	1,714
A1A	D	2,070	738	1,535	1,814	838	1,093	977	1,166
A1A	E	1,002	753	697	697	697	1,133	976	826
A1A	F	585	701	697	418	697	1,130	976	770
A1A	G	3,604	572	97	97	97	2,091	376	555
A1A	H	2,173	-	-	-	-	-	279	46
A1A	I	506	686	601	-	601	-	880	461
A1A	J	-	8	352	-	352	-	630	224
A1A	K	117	20	-	-	-	-	279	50
A1A	L	576	-	-	322	-	-	279	100
A1A	M	41	12	15	15	15	-	15	12
A1A	N	-	5	-	73	-	376	-	76
Total		13,946	13,946	13,946	13,946	13,946	13,946	13,946	13,946

(1) Notes: Selected distribution is the average distribution for all the no mandate states.

Health and Human Services Commission
Mandate vs. No Mandate Study
Net Cost by Therapeutic Category
Sample Analysis - Therapeutic Drug Class : A1A

Drug Type	Drug Name	Gross Cost per Script		Federal Rebate per Script		Supplemental Rebate per Script	
		Mandate	No-Mandate	Mandate	No-Mandate	Mandate	No-Mandate
		(1)	(2) = (1)	(3)	(4) = (3)	(5)	(6)
Generic	A	39.06	39.06	7.81	7.81	-	1.56
Generic	B	41.25	41.25	8.25	8.25	-	1.65
Brand	C	58.00	58.00	6.09	6.09	17.00	2.32
Brand	D	35.00	35.00	7.00	7.00	-	1.40
Brand	E	98.10	98.10	68.67	68.67	-	3.92
Brand	F	96.09	96.09	67.27	67.27	-	3.84
Brand	G	101.67	101.67	71.17	71.17	-	4.07
Brand	H	96.83	96.83	67.78	67.78	-	3.87
Brand	I	108.25	108.25	75.78	75.78	-	4.33
Brand	J	83.33	83.33	58.33	58.33	-	3.33
Brand	K	140.12	140.12	98.08	98.08	-	5.60
Brand	L	221.03	221.03	154.72	154.72	-	8.84
Brand	M	125.51	125.51	87.85	87.85	-	5.02
Brand	N	283.33	283.33	198.33	198.33	-	11.33
Total		1,197,195	795,799	688,894	317,938	55,624	31,832
					No Mandate Sup Rebate % Gross		4.0%

Drug Name	Drug Name	Net Cost per Script		Number of Scripts		Net Cost	
		Mandate	No-Mandate	Mandate	No-Mandate	Mandate	No-Mandate
		(7)=(1)-(3)-(5)	(8)=(2)-(4)-(6)	(9)	(10)	(11) = (9) * (7)	(12) = (10) * (8)
Generic	A	31.25	29.69	-	3,974	-	117,973
Generic	B	33.00	31.35	-	3,973	-	124,546
Brand	C	34.91	49.59	3,272	1,714	114,226	85,014
Brand	D	28.00	26.60	2,070	1,166	57,960	31,018
Brand	E	29.43	25.51	1,002	826	29,489	21,060
Brand	F	28.83	24.98	585	770	16,865	19,236
Brand	G	30.50	26.43	3,604	555	109,922	14,663
Brand	H	29.05	25.18	2,173	46	63,126	1,170
Brand	I	32.48	28.15	506	461	16,433	12,980
Brand	J	25.00	21.67	-	224	-	4,847
Brand	K	42.04	36.43	117	50	4,918	1,817
Brand	L	66.31	57.47	576	100	38,195	5,753
Brand	M	37.65	32.63	41	12	1,544	383
Brand	N	85.00	73.67	-	76	-	5,568
Total				13,946	13,946	452,676	446,029
						Net Cost Difference	-1.5%

Notes:
Cost for the mandate scenario is the average Texas managed care net cost per script.
Gross cost per script and federal rebate per script assumed to be the same for each drug under both scenarios.
Supplemental rebate assumed to be 4.0% of gross pharmacy cost under the no mandate scenario.
Utilization by therapeutic class assumed to be the same under both scenarios.
The utilization difference is the distribution of drugs within a therapeutic class.

Health and Human Services Commission
Medicaid Managed Care Prescription Drug Experience
Mandate vs. No Mandate Study
Summary of Analysis to Pharmacy Cost (1)
Experience Period - CY2019Q3-CY2020Q2

	Current Mandate Scenario (2)	No Mandate Scenario (3)	Cost Difference (4)	Percentage Difference
Number of Prescriptions				
Brand Drugs	4,831,340	2,635,769		
Generic Drugs	26,576,282	28,771,853		
Total	31,407,622	31,407,622		
Generic Dispensing Rate	84.6%	91.6%		
Gross Pharmacy Cost	3,245,881,712	2,671,951,089	-573,930,623	-17.7 %
Rebates				
Federal (less offsets)	1,761,040,768	1,235,192,009		
% Total	54.3%	46.2%		
Supplemental (5)	181,434,846	106,878,044		
% Total	5.6%	4.0%		
Total Rebates	1,942,475,613	1,342,070,052	-600,405,561	
% Total	59.8%	50.2%		
Net Pharmacy Cost	1,303,406,098	1,329,881,036	26,474,938	**2.0 %**

Footnotes:
(1) The analysis is described in the attached report. All Amounts are on an All Funds basis.
(2) The current pharmacy carve-in arrangement whereby HHSC dictates the formulary, PDL and PA requirements.
(3) An alternative arrangement where the MCOs develop and use their own formulary, PDL and PA requirements. Overall utilization by therapeutic class assumed to be the same under both scenarios. The difference is the distribution of drugs within a therapeutic class.
(4) Equals values for the No Mandate Scenario less values for the Mandate Scenario.
(5) Supplemental rebate assumed to be 4.0% of gross pharmacy cost under the no mandate scenario.

Health and Human Services Commission
Medicaid Managed Care Prescription Drug Experience
Mandate vs. No Mandate Study
Summary of Analysis by Therapeutic Drug Class
Experience Period - CY2019Q3-CY2020Q2

Class	Therapeutic Class Name	Net Pharmacy Cost		
		Mandate	No Mandate	Difference
C4G	Insulins	425,316	58,881,736	58,456,420
B6W	Beta-Adrenergic Agents, Inhaled, Short Acting	11,727,251	33,059,500	21,332,248
B63	Beta-Adrenergic And Glucocorticoid Combo, Inhaled	7,650,649	24,729,588	17,078,939
S2J	Anti-Inflammatory Tumor Necrosis Factor Inhibitor	15,623,130	22,588,261	6,965,130
C3B	Iron Replacement	847,348	6,306,683	5,459,334
B6M	Glucocorticoids, Orally Inhaled	5,328,635	9,808,236	4,479,600
Z4B	Leukotriene Receptor Antagonists	8,622,763	13,060,598	4,437,835
W1Y	Cephalosporin Antibiotics - 3Rd Generation	5,521,177	8,981,782	3,460,605
C4I	Antihypergly,Incretin Mimetic(Glp-1 Recep.Agonist)	4,251,055	7,220,944	2,969,889
C4D	Antihyperglycemc-Sod/Gluc Cotransport2(Sglt2)Inhib	(529,289)	2,379,567	2,908,856
B1D	Pulm.Anti-Htn,Sel.C-Gmp Phosphodiesterase T5 Inhib	4,137,219	1,384,664	(2,752,555)
A4D	Antihypertensives, Ace Inhibitors	5,270,433	2,392,401	(2,878,033)
C4L	Antihyperglycemic, Biguanide Type	6,141,282	2,363,772	(3,777,511)
D4J	Proton-Pump Inhibitors	8,679,674	3,923,050	(4,756,624)
P5A	Glucocorticoids	9,816,324	4,779,174	(5,037,149)
D9A	Ammonia Inhibitors	8,223,157	2,263,603	(5,959,554)
D6S	Laxatives And Cathartics	8,284,745	2,295,959	(5,988,786)
H7X	Antipsychotics, Atyp, D2 Partial Agonist/5Ht Mixed	32,453,503	26,412,688	(6,040,815)
W5A	Antivirals, General	35,452,647	19,941,075	(15,511,572)
H7T	Antipsychotic,Atypical,Dopamine,Serotonin Antagnst	62,660,311	36,553,375	(26,106,935)
	All Others	1,062,818,766	1,040,554,382	(22,264,384)
	Total	**1,303,406,098**	**1,329,881,036**	**26,474,938**
			Net Cost Difference	**2.0%**

Health and Human Services Commission
PDL Mandate Vs. No Mandate
Experience Period - CY2019Q3-CY2020Q2
Utilization Distribution by Drug for Top Drug Classes Where Current Mandate Scenario is More Cost Efficient

HIC3		Mandate	No Mandate Model						
Drug Class	Drug Name	TX	CA	KY	MD	MI	NJ	NY	Selected
C4G	Novolog	26.6%	2.8%	3.2%	7.8%	3.2%	2.2%	4.3%	3.9%
C4G	Lantus	25.9%	7.3%	2.1%	6.3%	5.2%	2.8%	1.4%	4.2%
C4G	Levemir	16.0%	0.7%	1.2%	1.3%	0.4%	2.9%	0.7%	1.2%
C4G	Humalog	9.4%	8.9%	4.7%	7.9%	4.1%	7.9%	4.0%	6.3%
C4G	Humulin	7.9%	11.8%	5.1%	6.5%	3.3%	7.0%	4.1%	6.3%
C4G	Basaglar	0.7%	45.6%	42.6%	41.2%	48.3%	42.8%	51.3%	45.3%
C4G	Admelog	0.1%	14.5%	27.5%	20.4%	31.0%	30.8%	28.3%	25.4%
C4G	All Others	13.4%	8.4%	13.6%	8.6%	4.5%	3.5%	5.8%	7.4%
C4G	Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
B6W	Proair	48.6%	0.3%	0.5%	0.4%	0.4%	0.4%	0.9%	0.5%
B6W	Albuterol	45.1%	92.3%	95.7%	94.9%	96.5%	97.6%	88.9%	94.3%
B6W	Proventil	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
B6W	Levalbuterol	2.4%	0.5%	0.8%	0.6%	0.4%	0.4%	0.5%	0.5%
B6W	Ventolin	0.5%	6.8%	3.0%	4.1%	2.6%	1.5%	9.7%	4.6%
B6W	All Others	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
B6W	Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
B63	Symbicort	41.7%	15.8%	7.5%	22.1%	10.9%	3.8%	30.2%	15.1%
B63	Advair	32.6%	9.8%	1.3%	11.7%	0.5%	3.8%	2.6%	5.0%
B63	Budesonide-Form	6.4%	8.1%	4.6%	8.7%	3.4%	1.3%	21.9%	8.0%
B63	Wixela	5.6%	22.5%	12.6%	14.6%	23.8%	8.9%	14.8%	16.2%
B63	Fluticasone-Salme	5.0%	14.5%	22.7%	23.7%	56.9%	70.4%	9.5%	33.0%
B63	Breo	2.9%	19.3%	44.7%	13.2%	1.2%	8.8%	14.9%	17.0%
B63	All Others	5.7%	9.9%	6.5%	6.0%	3.3%	3.0%	6.1%	5.8%
B63	Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
B6M	Flovent	73.1%	39.8%	25.0%	51.1%	9.5%	43.7%	65.9%	39.1%
B6M	Pulmicort	16.3%	1.2%	0.6%	1.6%	7.6%	0.2%	0.5%	2.0%
B6M	Qvar	4.5%	36.2%	32.0%	19.9%	71.6%	10.1%	7.7%	29.6%
B6M	Budesonide	4.3%	9.4%	21.4%	11.5%	11.2%	26.0%	16.4%	16.0%
B6M	Arnuity	0.2%	6.5%	19.2%	10.3%	0.1%	9.1%	6.1%	8.6%
B6M	All Others	1.6%	6.9%	1.8%	5.6%	0.1%	11.0%	3.3%	4.8%
B6M	Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Health and Human Services Commission
PDL Mandate Vs. No Mandate
Experience Period - CY2019Q3-CY2020Q2
Utilization Distribution by Drug for Top Drug Classes Where No Mandate Scenario is More Cost Efficient

HIC3		Mandate	No Mandate Model						
Drug Class	Drug Name	TX	CA	KY	MD	MI	NJ	NY	Selected
H7T	Risperidone	32.1%	21.4%	25.0%	n/a	n/a	25.2%	24.0%	23.9%
H7T	Quetiapine	30.0%	37.9%	51.2%	n/a	n/a	44.7%	42.4%	44.0%
H7T	Olanzapine	13.3%	19.3%	11.3%	n/a	n/a	13.6%	14.6%	14.7%
H7T	Latuda	8.2%	7.8%	3.3%	n/a	n/a	3.4%	4.7%	4.8%
H7T	Invega	5.1%	2.1%	1.8%	n/a	n/a	3.2%	2.9%	2.5%
H7T	Ziprasidone	4.4%	4.8%	4.7%	n/a	n/a	3.3%	3.7%	4.1%
H7T	Paliperidone	2.2%	0.9%	1.0%	n/a	n/a	2.1%	1.1%	1.3%
H7T	Clozapine	1.9%	3.9%	0.6%	n/a	n/a	2.7%	5.0%	3.0%
H7T	Risperdal	0.9%	0.0%	0.4%	n/a	n/a	0.8%	1.0%	0.5%
H7T	All Others	1.9%	2.0%	0.7%	n/a	n/a	1.1%	0.5%	1.1%
H7T	Total	100.0%	100.0%	100.0%	n/a	n/a	100.0%	100.0%	100.0%
W5A	Oseltamivir	83.8%	47.9%	57.0%	47.7%	39.0%	51.0%	42.2%	47.4%
W5A	Valacyclovir	8.1%	15.8%	25.6%	38.9%	30.7%	38.4%	48.5%	33.0%
W5A	Acyclovir	6.1%	35.3%	15.6%	12.9%	29.5%	9.3%	7.8%	18.4%
W5A	Tamiflu	1.3%	0.2%	0.3%	0.0%	0.0%	0.0%	0.0%	0.1%
W5A	All Others	0.7%	0.9%	1.5%	0.5%	0.8%	1.2%	1.6%	1.1%
W5A	Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
H7X	Aripiprazole	88.0%	92.4%	91.9%	n/a	n/a	90.6%	88.6%	90.9%
H7X	Abilify	6.1%	7.1%	2.7%	n/a	n/a	5.2%	6.4%	5.3%
H7X	Rexulti	3.6%	0.4%	4.8%	n/a	n/a	3.1%	3.6%	3.0%
H7X	Aristada	2.3%	0.2%	0.6%	n/a	n/a	1.2%	1.3%	0.8%
H7X	Total	100.0%	100.0%	100.0%	n/a	n/a	100.0%	100.0%	100.0%
D4J	Pantoprazole	39.5%	23.8%	33.7%	40.1%	21.6%	33.2%	24.1%	29.4%
D4J	Omeprazole	34.9%	69.5%	58.2%	49.4%	76.7%	58.2%	70.2%	63.7%
D4J	Nexium	13.1%	0.1%	0.2%	0.1%	0.0%	0.2%	0.1%	0.1%
D4J	Esomeprazole	7.5%	1.4%	2.1%	2.0%	0.1%	3.3%	1.3%	1.7%
D4J	All Others	5.0%	5.1%	5.8%	8.5%	1.5%	5.1%	4.3%	5.1%
D4J	Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Health and Human Services Commission
Mandate vs. No Mandate Study - Summary of Analysis to Overall Cost
Medicaid Managed Care Program - STAR, STAR Plus, STAR Health and STAR Kids[1]

Attachment 8

	All Funds				General Revenue			
	FY2022	FY2023	FY2024	FY2025	FY2022	FY2023	FY2024	FY2025
Member Months	3,593,813	3,465,928	3,484,913	3,534,620				
General Revenue %					37.9%	38.0%	38.0%	38.0%
Current Mandate Model (in $1,000,000s)	-	-	-	-				
Pharmacy Gross Cost[2]	3,865.10	3,955.48	4,136.80	4,392.17	1,465.59	1,501.36	1,570.24	1,667.44
Rebates - Federal[3]	(2,096.99)	(2,146.03)	(2,244.40)	(2,382.95)	(795.15)	(814.56)	(851.93)	(904.66)
Rebates - Supplemental[4]	(216.05)	(221.10)	(231.23)	(245.51)	(81.92)	(83.92)	(87.77)	(93.20)
Pharmacy Net Cost[5]	1,552.06	1,588.35	1,661.16	1,763.71	588.52	602.88	630.54	669.57
Administrative Expense	77.63	74.86	75.27	76.35	29.43	28.42	28.57	28.98
Risk Margin[6]	67.34	68.84	71.95	76.33	25.54	26.13	27.31	28.98
Premium Tax	71.43	73.01	76.31	80.95	27.08	27.71	28.96	30.73
MCO Capitation Premiums[7]	4,081.50	4,172.20	4,360.32	4,625.79	1,547.65	1,583.62	1,655.09	1,756.13
Total Overall Cost[8]	1,768.45	1,805.07	1,884.68	1,997.33	670.57	685.14	715.39	758.27
Total Overall Cost to State[9]					599.15	612.13	639.08	677.31
Proposed No Mandate Model (in $1,000,000s)	-	-	-	-				
Pharmacy Gross Cost[2]	3,181.68	3,256.08	3,405.34	3,615.55	1,206.45	1,235.89	1,292.60	1,372.61
Rebates - Federal[3]	(1,470.83)	(1,505.23)	(1,574.22)	(1,671.40)	(557.72)	(571.33)	(597.54)	(634.53)
Rebates - Supplemental[4]	(127.27)	(130.24)	(136.21)	(144.62)	(48.26)	(49.44)	(51.70)	(54.90)
Pharmacy Net Cost[5]	1,583.58	1,620.61	1,694.90	1,799.53	600.47	615.13	643.35	683.17
Administrative Expense	77.63	74.86	75.27	76.35	29.43	28.42	28.57	28.98
Risk Margin[6]	53.50	54.67	57.12	60.59	20.29	20.75	21.68	23.00
Premium Tax	56.74	57.98	60.59	64.26	21.51	22.01	23.00	24.40
MCO Capitation Premiums[7]	3,242.28	3,313.36	3,462.11	3,672.13	1,229.43	1,257.63	1,314.15	1,394.09
Total Overall Cost[8]	1,771.45	1,808.13	1,887.89	2,000.73	671.71	686.30	716.60	759.56
Total Overall Cost to State[9]					614.97	628.32	656.02	695.29
Difference - Proposed No Mandate less Current Mandate Model (in $1,000,000s)								
Pharmacy Gross Cost[2]					11.95	12.25	12.81	13.60
Administrative Expense					-	-	-	-
Risk Margin[6]					(5.25)	(5.38)	(5.63)	(5.97)
Premium Tax					(5.57)	(5.70)	(5.97)	(6.34)
Total Overall Cost to HHSC[8]					**1.13**	**1.16**	**1.22**	**1.29**
Total Overall Cost to State[9]					**15.82**	**16.19**	**16.93**	**17.98**

Health and Human Services Commission
Mandate vs. No Mandate Study - Summary of Analysis to Overall Cost
Medicaid Managed Care Program - STAR, STAR Plus, STAR Health and STAR Kids[1]

Attachment 8

Notes:
(1) Member Months and Current Model Capitation Projections provided by HHSC System Forecasting.
Medicaid Managed Care experience includes STAR, STAR Plus, STAR Health and STAR Kids programs.
(2) Gross pharmacy cost under No Mandate scenario assumed to be 17.7% less than the Current Model. See Attachment 4.
(3) Federal rebates were determined to be 54.3% of gross cost for mandate scenario and 46.2% of gross cost for no mandate scenario.
(4) Supplemental rebates were determined to be 5.6% of gross cost for mandate scenario and 4.0% of gross cost for no mandate scenario.
(5) Pharmacy Net Cost equals Gross Pharmacy Cost less Federal & Supplemental Rebates
Pharmacy Net Cost under No Mandate scenario assumed to be 2.0% more than the Current Model. See Attachment 4.
(6) Risk margin is 1.50% for STAR and STAR Health programs and 1.75% for STAR+PLUS and STAR Kids programs.
Weighted average risk margin of 1.65% was used for the analysis.
(7) MCO Capitation Premiums for the mandate scenario includes Pharmacy Gross Cost, Administrative Expense, Risk Margin and Premium Tax.
MCO Capitation Premiums for the no mandate scenario includes Pharmacy Gross Cost less Sup. Rebate, Administrative Expense, Risk Margin and Premium Tax.
(8) Total Overal Cost equals Pharmacy Net Cost + Admin + Risk Margin + Premium Tax
Total Overall Impact to HHSC equals Total Overal Cost Impact (All Funds) * General Revenue Percent.
(9) Total Overall Impact to State equals Total Overall Impact to HHSC (General Revenue) less Premium Tax (All Funds).