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## PDL FORMULARY CONTROL – STATE VS. MCO



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## TABLE OF CONTENTS

I.	Executive Summary .....	1
II.	Introduction.....	2
III.	Definition .....	4
IV.	Advantages of State Control and MCO Control Scenarios .....	6
V.	Overview of Methodology .....	7
VI.	Pharmacy Claims Cost Impact Analysis – State Control vs. MCO Control.....	9
VII.	Overall Cost Impact Analysis - State Control vs. MCO Control.....	12
VIII.	Key Findings.....	13
IX.	Summary .....	17
X.	Attachments .....	18

## 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. Under the current State control model, HHSC develops a single PDL to be used by all MCOs for all Medicaid managed care programs. Under the MCO control model, each MCO has the flexibility to develop their own PDL. This report summarizes our analysis of the expected cost differences between the current State control and the MCO control models.

The experience period used in the analysis includes actual Texas Medicaid managed care prescription drug experience for the period January 1, 2021 through December 31, 2021 (CY2021). Our analysis is based on a comparison of drug utilization under the State control scenario (actual Texas Medicaid experience) to an estimate of that under the MCO control scenario. Pharmacy utilization under the MCO control scenario was modeled by assuming the distribution of drugs by therapeutic class will be equal to utilization experience from six other states that operated pharmacy carve-in programs using the MCO control model for the CY2021 period. The other states used in our analysis were California, Indiana, Maryland, New Jersey, New York and Oregon.

In our analysis, we assumed that the aggregate drug utilization (number of prescriptions) within a therapeutic category will be the same under the State control and MCO control scenarios. The difference in the utilization will be in the distribution of drugs within a therapeutic category. The distribution of prescriptions (scripts) under the current State control model is the actual Texas Medicaid managed care pharmacy utilization experience. The assumed distribution under the MCO control scenario is determined by taking the total scripts for each therapeutic category (from the actual State control experience) and re-allocating by drug based on the utilization distribution data from the MCO control 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 State control and MCO control scenarios. Based on input from the MCOs, supplemental rebates were assumed to be 4.0% of gross pharmacy cost under the MCO control scenario. The total net cost was compared for the current State control and projected MCO control scenarios to determine the impact on net pharmacy cost.

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 MCO control scenario is 6.5% higher than that under the current State control scenario. The overall cost to the state under the MCO control scenario would be approximately \$35-40 million (General Revenue) more per year than that under the current State control scenario for the FY2024 through FY2028 periods.

## II. INTRODUCTION

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. 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, H.B. 1917 (of the 85<sup>th</sup> 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 HHSC through August 31, 2023. Effective September 1, 2023, these functions will transfer to the MCOs without a change in legislation. 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 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 applies to state governments only. Any federal rebate amounts are payable to the states, regardless of whether the state or MCO is responsible for the PDL. As a result, MCOs have no financial incentive to consider federal rebates in developing their PDL. 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 federal 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 State control vs. MCO control models. 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. The results of the survey are included in Attachment 1.

It should be noted that since the date of the last KFF and HMA survey in July 2019, a number of states have or plan to implement a single PDL model similar to Texas for their Medicaid managed care programs. 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 carved-out prescription drugs out of managed care effective January 1, 2022. New York will carve-out prescription drugs out of managed care effective April 1, 2023. In addition, Arizona, Massachusetts, Nebraska and Washington plan to expand their state control PDL to include more drug classes.

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. The methodology used in this analysis is the same as what was used for prior reports. The only difference is using the most recent utilization and rebate data available. For purposes of this analysis, we will refer to the

current arrangement (where HHSC dictates the formulary, PDL and PA requirements) as the “State control” scenario and the arrangement whereby the MCOs develop and use their own program tools as the “MCO control” scenario.

Please note that this report is intended to present a comparison of the overall expected cost difference between the State control and MCO control 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 available only 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 specific drug will be the same under both the State control and MCO control scenarios. However, total federal rebates will decrease under the MCO control 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.

**MCO Control Scenario.** The arrangement whereby each MCO controls the formulary, preferred drug list (PDL) and prior authorization (PA) requirements for its plan participants.

**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.

**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 rebate amounts have been reduced by the ROA.

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

***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 State control scenario while the MCOs will contract with the drug manufacturers under the MCO control scenario for supplemental rebates.

#### IV. ADVANTAGES OF STATE CONTROL AND MCO CONTROL SCENARIOS

##### Advantages of 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 including smooth continuity of care for members who move between managed care plans.
- 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 MCO Control Formulary

- Align PDL with Member's Needs – Allow the MCOs to align the PDL to their member population.
- MCO Flexibility – Allow the MCOs flexibility to design their own PDL that is similar to their other lines of business.
- Responsive to PDL Changes – MCOs may be able to revise their PDL more quickly. 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 State control scenario. 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 section of the report details the methodology and assumptions used to compare the gross and net pharmacy cost between the State control and MCO control scenarios for control over the formulary, PDL and PA requirements used for the Texas 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:

- Detailed gross pharmacy cost, federal and supplemental rebates by NDC for the period January 1, 2021 through December 31, 2021, 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 January 1, 2021 through December 31, 2021. CMS publishes this data quarterly for each state. This information includes utilization and cost data by NDC and by managed care vs. Fee-for-Service (FFS) for every Medicaid prescription filled.
- NDCs for all Protected Drug Classes provided by HHSC.
- List of brand name drugs preferred over its generic equivalent provided by HHSC.

After accumulating all of the information to be used in the analysis, a comparison of the various sources of data was performed to check for consistency. We compared (i) the gross pharmacy cost to claim amounts reported in the Financial Statistical Report (FSR) and (ii) rebates collected by quarter to the information included in HHSC’s Performance Reporting for the Prescription Drug Program Report required by S.B. 1 (of the 87<sup>th</sup> Legislature, Regular Session, Article II, HHSC, Rider 107.e). Based on the review of the data provided to us by HHSC and its subcontractor Conduent, we have concluded that all data sources are consistent, complete and accurate. Although the above data was reviewed for reasonableness, Rudd and Wisdom did not audit the data.

The experience period used in the analysis includes actual Texas Medicaid managed care prescription drug experience for the period January 1, 2021 through December 31, 2021 (CY2021). Our analysis is based on a comparison of drug utilization under the State control scenario (actual Texas Medicaid experience) to an estimate of that under the MCO control scenario. Pharmacy utilization under the MCO control scenario was modeled by assuming the distribution of drugs by therapeutic class will be equal to utilization experience from six other states that operated pharmacy carve-in programs using the MCO control model for the CY2021 period. The other states used in our analysis were California, Indiana, Maryland, New Jersey, New York and Oregon. These states were selected because they operate pharmacy carve-in programs using a no mandate approach with little or no restriction and had over \$500 million of pharmacy paid claims per year in managed care. Utilization data for these states was collected from the CMS State Drug Utilization Data. 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 State control and MCO control 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 State control scenario is the actual Texas Medicaid managed care pharmacy utilization. The distribution under the MCO control scenario is determined by taking the total scripts for each therapeutic category (from the State control scenario) and re-allocating by drug based on utilization distribution data from the MCO control 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 specific drug, the gross cost per script and federal rebate per script are the same under the State control and MCO control scenarios. Based on input from the MCOs, supplemental rebates were assumed to be 4.0% of gross pharmacy cost under the MCO control scenario. The total net cost was compared for the State control and MCO control 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 incorrect conclusions. For example, some brand name drugs can have federal and supplemental rebates as a percentage of gross cost in excess of 99%, 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 MCO control scenario is 6.5% higher than that under the current State control scenario.

Attachment 8 presents an estimate of the overall Texas Medicaid managed care pharmacy cost for the current State control and MCO control scenarios. The overall cost to the state under the MCO control scenario would be approximately \$35-40 million (General Revenue) more per year than under the current State control scenario for the FY2024 through FY2028 period. The overall cost to the state considers all expense-related items such as pharmacy claims cost, administrative expense, risk margin and premium tax.

## VI. PHARMACY CLAIMS COST IMPACT ANALYSIS – STATE CONTROL VS. MCO CONTROL

### ASSUMPTIONS

The following assumptions were made for this analysis:

- Texas utilization data for the period January 1, 2021 through December 31, 2021 (CY2021) was used as the baseline experience period. This data includes detailed gross pharmacy cost, federal and supplemental rebate by NDC drug level and was provided to us by HHSC’s subcontractor Conduent.
- Utilization under the MCO control scenario was developed based on the average managed care utilization experience from California, Indiana, Maryland, New Jersey, New York and Oregon for the period January 1, 2021 through December 31, 2021. These states were selected because they operated pharmacy carve-in programs using a no mandate approach with little or no restriction and had over \$500 million of pharmacy paid claims per year in managed care.
- We have assumed that the drug utilization shift would occur immediately. Any transition period such as grandfathering will 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, Maryland does not have managed care utilization data for the antipsychotic drug class because it is carved out of managed care. As a result, the MCO control 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 difference between the two scenarios. These drugs 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 State control 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 MCO control scenario, HHSC will require the MCOs to continue to provide open access to the Protected Drug Classes as is the case under the current mandate scenario. The utilization, gross cost and net cost for these drug classes were assumed to be the same for the State control and MCO control scenarios.
- The aggregate utilization within a therapeutic category is assumed to be the same under the State control and MCO control scenarios. The difference in utilization between the two scenarios is in the distribution of specific drugs within a therapeutic category.
- For each NDC, the gross cost per script and federal rebate per script are the same under the State control and MCO control scenarios. Based on input from the MCOs, supplemental rebates were assumed to be 4.0% of gross pharmacy cost under the MCO control scenario.

- This analysis assumes that the state would not impose additional restrictions, other than the Protected Drug Classes, that would limit the MCOs ability to control the PDL.
- Utilization of drugs currently carved out of the Texas Medicaid program, such as Hemophilia and Hepatitis C drugs, were assumed to be unchanged under the MCO control scenario.
- This analysis is a point-in-time estimate based on utilization distribution during the experience period. The results of the study may change over time due to i) changes in federal and supplement rebates, (ii) changes to utilization distribution under the State control model such periodic changes to the PDL implemented by VDP and (iii) new drugs entering the market.
- 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 MCO control model only impacts Medicaid managed care and is expected to have minimal impact on these programs.

## UTILIZATION

The experience period used in the analysis includes actual Texas Medicaid managed care prescription drug experience for the period January 1, 2021 through December 31, 2021 (CY2021). Our analysis is based on a comparison of drug utilization under the State control scenario (actual Texas Medicaid experience) to an estimate of that under the MCO control scenario. Pharmacy utilization under the MCO control scenario was modeled by assuming the distribution of drugs by therapeutic class will be equal to utilization experience from six other states that operated pharmacy carve-in programs using the MCO control model for the CY2021 period. The other states used in our analysis were California, Indiana, Maryland, New Jersey, New York and Oregon. These states were selected because they operated pharmacy carve-in programs using a no mandate approach with little or no restriction and had over \$500 million of pharmacy paid claims per year in managed care. Utilization data for these states was collected from the CMS State Drug Utilization Data. 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 both scenarios. The difference in the utilization assumption will be in the distribution of drugs within a therapeutic category. The distribution of scripts under the State control scenario is the actual Texas managed care pharmacy utilization. The distribution under the MCO control scenario is determined by taking the total scripts for each therapeutic category (from the State control scenario) and re-allocating by drug based on the utilization data from the MCO control states.

Attachment 2 presents how the MCO control 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 current State control and hypothetical MCO control utilization distributions, we applied the net cost (gross cost less federal and supplemental rebates) per script for each drug. For each specific drug, the gross cost per script and federal rebate per script are the same under the State control and MCO control scenarios. The net cost per script for the State control scenario is determined by dividing the Texas Medicaid managed care net pharmacy cost by the number of scripts for each drug. For each NDC, the net cost per script for the MCO control scenario assumed the same gross cost per script and federal rebate per script as the State control scenario. Based on input from the MCOs, supplemental rebates were assumed to be 4.0% of gross pharmacy cost under the MCO control scenario. The total net cost was compared for the State control and MCO control scenarios to determine the net cost impact.

Attachment 3 presents the calculation of net cost for the State control and MCO control 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 MCO control scenario is 6.5% higher than that under the current State control scenario.

Attachment 5 presents a summary of the analysis by therapeutic category for the top drug classes with the largest net cost differential between the State control and MCO control scenarios. The two main reasons why the net pharmacy cost under the MCO control scenario is higher than the current State control scenario is due to (a) the Insulin category and (b) the Brand-Over-Generic program. Additional information about these two groups is presented in Section VIII below.

## VII. OVERALL COST IMPACT ANALYSIS – STATE CONTROL VS. MCO CONTROL

The total net pharmacy cost under the MCO control scenario is 6.5% higher than that under the current State control 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. Attachment 8 presents an estimate of the overall Texas Medicaid managed care pharmacy cost for the current State control and MCO control scenarios. The overall cost to the state under the MCO control scenario would be approximately \$35-40 million (General Revenue) more per year than under the current State control scenario for the FY2024 through FY2028 period.

This analysis is a point-in-time estimate based on utilization distribution during the experience period. The results of the study may change over time due to i) changes in federal and supplement rebates, (ii) changes to utilization distribution under the State control model such periodic changes to the PDL implemented by VDP and (iii) new drugs entering the market.

Rudd and Wisdom has conducted this study several times in the past. The first study titled “State of Texas Vendor Drug Program Formulary Control State vs. MCO” and dated January 9, 2017 determined that the overall cost to the state under the MCO control scenario would be approximately \$20M less than the current State control scenario. Since the time of the first study, several new drugs have entered the market such as Admelog, Basaglar, Fluticasone-Salmeterol (Advair), Budesonide-Formoterol (Symbicort), Ciprofloxacin / Dexamethasone (Ciprodex) and dextroamphetamine/amphetamine (Adderall). MCOs are assumed to utilize these drugs under the MCO control scenario since they have a lower gross pharmacy cost than the alternative drug treatment. However, these drugs have a significantly higher net pharmacy cost than drugs currently utilized under the current State control scenario. The addition of these new drugs to the market is the main reason why the overall cost to the state under the MCO control scenario is now estimated to be more than the current State control scenario.

## VIII. KEY FINDINGS

Under the MCO control scenario, the MCOs will develop a PDL that minimizes the MCO's cost. Since federal rebates are collected by the state and not the MCOs, 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 12.3%. 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 supplemental and federal rebates will exceed the reduction in gross pharmacy cost resulting in a total net pharmacy claims cost under the MCO control scenario that is 6.5% higher than that under the current State control scenario.

### MCO CONTROL NET COST HIGHER THAN STATE CONTROL

The two main reasons why the net pharmacy cost under the MCO control scenario is more costly than the current State control scenario is due to Insulin and Brand-Over-Generic.

- Insulin. Ademlog and Basaglar are two new insulins that entered the market in 2017 and 2018 respectively. Compared to insulins that are preferred under the current State control scenario, these two new insulins have a lower gross pharmacy cost but after rebates, a significantly higher net pharmacy cost. Based on utilization data from other states, the MCOs are expected to shift about 65% of insulin utilization to higher net cost Ademlog and Basaglar under the MCO control scenario.
- Brand-Over-Generic. Under the current State control scenario, VDP identifies a list of brand drugs where the net cost is less than its generic equivalent. These brand name drugs are included in the Brand-Over-Generic program and are preferred over the generic equivalent. Under the MCO control scenario, MCOs will shift utilization to higher net cost generic drugs. The reason why the net cost for certain brand drugs is less than its generic equivalent is due to federal rebates, which are only available to the state. As a result, GDR for Medicaid programs utilizing a State control model will tend to be lower than commercial prescription drug plans because of the Brand-Over-Generic strategy that results in lower net cost to the state.

Attachment 6 presents the utilization distribution by drug for Insulin and top Brand-Over-Generic drugs in which the total net cost is less under the current State control scenario. The current State Control scenario uses brand name drugs more than the generic in each of the therapeutic classes listed. The table below presents the drugs utilized for which the net cost is less under the current State control scenario.

HIC3	Lower Net Cost Drugs Utilized Under State Control	Higher Net Cost Drugs Utilized Under MCO Control
C4G (Insulin)	Novolog, Lantus, Levemir, Humalog	Basaglar, Admelog
BOG-B6W	Proair	Albuterol Sulfate
BOG-B63	Symbicort	Budesonide-Formoterol
BOG-B63	Advair Diskus	Fluticasone-Salmeterol
BOG-Q8F	Ciprodex	Ciproflox-Dexameth
BOG-J5B	Adderall	Dextroamp-Amphetamine

The chart below presents the CY2021 utilization distribution by drug for Insulin and top Brand-Over-Generic drugs under the current State control and projected MCO control scenarios.

HIC3	Drug Name	State Control (Current)	MCO Control (Projected)
<b>Insulins</b>			
C4G	Novolog	26.0%	2.1%
C4G	Lantus	27.5%	3.6%
C4G	Levemir	13.6%	1.1%
C4G	Humalog	12.7%	3.9%
C4G	Humulin	7.1%	6.8%
C4G	Basaglar	1.0%	40.0%
C4G	Admelog	0.2%	23.9%
C4G	All Others	12.0%	18.6%
C4G	Total	100.0%	100.0%
<b>Brand over Generic (BOG) Program</b>			
BOG - B6W	Albuterol	56.7%	98.5%
BOG - B6W	Proair	40.0%	0.6%
BOG - B6W	Proventil	1.5%	0.0%
BOG - B6W	Ventolin	1.8%	0.9%
BOG - B6W	Total	100.0%	100.0%



HIC3	Drug Name	State Control (Current)	MCO Control (Projected)
<b>Brand over Generic (BOG) Program</b>			
BOG - B6W	Albuterol	56.7%	98.5%
BOG - B6W	Proair	40.0%	0.6%
BOG - B6W	Proventil	1.5%	0.0%
<u>BOG - B6W</u>	<u>Ventolin</u>	<u>1.8%</u>	<u>0.9%</u>
BOG - B6W	Total	100.0%	100.0%
BOG - B63	Budesonide-Formoterol	47.6%	94.1%
<u>BOG - B63</u>	<u>Symbicort</u>	<u>52.4%</u>	<u>5.9%</u>
BOG - B63	Total	100.0%	100.0%
BOG - B63	Advair	74.8%	8.1%
BOG - B63	Fluticasone-Salmeterol	12.6%	53.8%
<u>BOG - B63</u>	<u>Wixela</u>	<u>12.6%</u>	<u>38.1%</u>
BOG - B63	Total	100.0%	100.0%
BOG - Q8F	Ciprodex	79.8%	0.1%
<u>BOG - Q8F</u>	<u>Ciproflox-Dexameth</u>	<u>20.2%</u>	<u>99.9%</u>
BOG - Q8F	Total	100.0%	100.0%
BOG - J5B	Adderall	25.2%	0.5%
<u>BOG - J5B</u>	<u>Dextroamp-Amphetamine</u>	<u>74.8%</u>	<u>99.5%</u>
BOG - J5B	Total	100.0%	100.0%

#### MCO CONTROL NET COST LOWER THAN STATE CONTROL

Attachment 7 presents the utilization distribution by drug for the top therapeutic classes where the net cost is higher under the current State control scenario. The current State control scenario's PDL management may be more relaxed than that of the MCO control scenario for the therapeutic classes listed. As a result, the current State control scenario covers more drugs and/or dispenses higher net cost drugs than that under the MCO control 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 therapeutic classes in which the net cost is higher under the current State control scenario.

HIC3	Higher Net Cost Drugs Utilized Under State Control	Lower Net Cost Drugs Utilized Under MCO Control
H7T	Invega, Seroquel, Risperdal, Zyprexa	Risperidone, Quetiapine
P5A	Emflaza	Kenalog-40
D6S	Kristalose	Constulose, Lactulose
H7X	Abilify, Rexulti, Aristada	Aripiprazole

The current State control scenario requires each participating MCO to use a single PDL mandated by HHSC. 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 MCO control 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 MCO control 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 under the current State control scenario to experience from other states which utilize a MCO control scenario.

Based on our analysis, the total net pharmacy cost under the MCO control scenario is 6.5% higher than that under the current State control 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 MCO control scenario's overall cost to the state would be approximately \$35-40 million (General Revenue) more per year than that under the current State control scenario after considering the impact of all expense items for the FY2024 through FY2028 period.

The two main reasons why the net pharmacy cost under the MCO control scenario is more costly than the current State control scenario is due to Insulin and Brand-Over-Generic.

- Insulin. Ademlog and Basaglar are two new insulins that entered the market in 2017 and 2018 respectively. Compared to insulins that are preferred under the current State control scenario, these two new insulins have a lower gross pharmacy cost but after rebates, have significantly higher net pharmacy cost. Based on utilization data from other states, the MCOs are expected to shift about 65% of insulin utilization to higher net cost Ademlog and Basaglar under the MCO control scenario.
- Brand-Over-Generic. Under the current State control scenario, VDP identifies a list of brand drugs where the net cost is less than its generic equivalent. These brand name drugs are included in the Brand-Over-Generic program and are preferred over the generic equivalent. Under the MCO control scenario, MCOs will shift utilization to higher net cost generic drugs. The reason why the net cost for certain brand drugs is less than its generic equivalent is due to federal rebates, which are only available to the state. As a result, GDR for Medicaid programs utilizing a State control model tend to be lower than commercial prescription drug plans because of the Brand-Over-Generic strategy that results in lower net cost to the state.

The current State control scenario requires each participating MCO to use a single PDL mandated by HHSC. 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 MCO control 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.

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.

<b>States</b>	<b>State Uses Uniform Preferred Drug List for MCOs<sup>4</sup></b>
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 <sup>1</sup>	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 <sup>2</sup>	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 <sup>3</sup>	Uniform PDL for all classes
Ohio <sup>1</sup>	No uniform PDL
Oklahoma	N/A
Oregon	No uniform PDL
Pennsylvania <sup>1</sup>	No uniform PDL
Rhode Island	No uniform PDL
South Carolina	Uniform PDL for some classes
South Dakota	N/A
Tennessee <sup>2</sup>	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.

<b>States</b>	<b>State Uses Uniform Preferred Drug List for MCOs<sup>4</sup></b>
Vermont	N/A
Virginia	Uniform PDL for some classes
Washington	Uniform PDL for some classes
West Virginia <sup>2</sup>	N/A
Wisconsin <sup>2</sup>	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  
 State Control vs. MCO Control Study  
 Sample Analysis - Utilization by Therapeutic Category

Drug Class	Drug Name	Current (TX) Scripts	MCO Control Utilization by Drug Class						Selected (1)
			CA	IN	MD	NJ	NY	OR	
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	Current (TX) Scripts	MCO Control Projected Number of Scripts by Drug Class						Selected
			CA	IN	MD	NJ	NY	OR	
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 MCO control states.

Drug Type	Drug Name	Gross Cost per Script		Federal Rebate per Script		Supplemental Rebate per Script	
		State Control (1)	MCO Control (2) = (1)	State Control (3)	MCO Control (4) = (3)	State Control (5)	MCO Control (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	
		State Control (7)=(1)-(3)-(5)	MCO Control (8)=(2)-(4)-(6)	State Control (9)	MCO Control (10)	State Control (11) = (9) * (7)	MCO Control (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 State control 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 MCO control 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  
 State Control vs. MCO Control Study  
 Summary of Analysis to Pharmacy Cost (1)  
 Experience Period - January 1, 2021 through December 31, 2021 (CY2021)

	Current			
	State Control Scenario (2)	MCO Control Scenario (3)	Cost Difference (4)	Percentage Difference
Number of Prescriptions				
Brand Drugs	4,226,085	2,399,474		
Generic Drugs	25,540,732	27,367,343		
Total	29,766,817	29,766,817		
Generic Dispensing Rate	85.8%	91.9%		
Gross Pharmacy Cost	3,337,280,701	2,927,713,675	-409,567,026	-12.3 %
Rebates				
Federal (less offsets)	1,770,472,519	1,310,326,941		
% Total	53.1%	44.8%		
Supplemental (5)	156,990,567	116,309,808		
% Total	4.7%	4.0%		
Total Rebates	1,927,463,086	1,426,636,749	-500,826,337	
% Total	57.8%	48.7%		
Net Pharmacy Cost	1,409,817,615	1,501,076,926	91,259,310	<b>6.5 %</b>

## 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 MCO control scenario less values for the State control scenario.  
 (5) Supplemental rebate assumed to be 4.0% of gross pharmacy cost under the MCO control scenario.

Health and Human Services Commission  
 Medicaid Managed Care Prescription Drug Experience  
 State Control vs. MCO Control Study  
 Summary of Analysis by Therapeutic Drug Class  
 Experience Period - January 1, 2021 through December 31, 2021 (CY2021)

Class	Therapeutic Class Name	Net Pharmacy Cost		
		State Control	MCO Control	Difference
C4G	Insulins			55,693,290
BOG	Brand over Generic Program			54,739,920
P4L	Bone Resorption Inhibitors			6,903,984
S2J	Anti-Inflammatory Tumor Necrosis Factor Inhibitor			6,819,079
C4D	Antihyperglycemic-Sod/Gluc Cotransport2(Sglt2) Inh			5,346,449
Q5P	Topical Anti-Inflammatory Steroidal			3,014,709
B6M	Glucocorticoids, Orally Inhaled			2,910,324
C4J	Antihyperglycemic, Dpp-4 Inhibitors			2,590,478
Q5W	Topical Antibiotics			2,500,329
W1Y	Cephalosporin Antibiotics - 3Rd Generation			2,174,113
J5B	Adrenergics, Aromatic, Non-Catecholamine			(1,281,319)
J2B	Anticholinergics,Quaternary Ammonium			(1,694,706)
W5A	Antivirals, General			(1,696,243)
W1D	Macrolide Antibiotics			(2,333,697)
Z2P	Antihistamines - 1St Generation			(2,638,756)
H7X	Antipsychotics, Atyp, D2 Partial Agonist/5Ht Mixed			(4,614,551)
H2V	Tx For Attention Deficit-Hyperact(Adhd)/Narcolepsy			(4,732,325)
D6S	Laxatives And Cathartics			(5,678,550)
P5A	Glucocorticoids			(8,735,781)
H7T	Antipsychotic,Atypical,Dopamine,Serotonin Antagnst			(17,579,991)
	All Others			(447,446)
	<b>Total</b>	<b>1,409,817,615</b>	<b>1,501,076,926</b>	<b>91,259,310</b>
			<b>Net Cost Difference</b>	<b>6.5%</b>

## Health and Human Services Commission

## State Control vs. MCO Control Study

Experience Period - January 1, 2021 through December 31, 2021 (CY2021)

Utilization Distribution by Drug for Top Drug Classes Where Current Mandate Scenario is More Cost Efficient

HIC3		State Control TX	MCO Control Model						Selected
Drug Class	Drug Name		CA	IN	MD	NJ	NY	OR	
<b>Insulins</b>									
C4G	Novolog	26.0%	1.2%	1.3%	4.6%	1.5%	1.9%	1.9%	2.1%
C4G	Lantus	27.5%	7.3%	2.7%	5.2%	2.7%	1.0%	2.6%	3.6%
C4G	Levemir	13.6%	0.7%	1.6%	1.0%	2.0%	0.5%	0.8%	1.1%
C4G	Humalog	12.7%	6.6%	2.3%	4.7%	5.4%	1.8%	2.8%	3.9%
C4G	Humulin	7.1%	12.0%	3.7%	8.1%	6.4%	3.7%	7.2%	6.8%
C4G	Basaglar	1.0%	41.8%	42.6%	40.9%	42.8%	35.3%	36.6%	40.0%
C4G	Admelog	0.2%	15.5%	23.7%	22.6%	32.9%	31.0%	17.5%	23.9%
C4G	All Others	12.0%	14.9%	22.0%	13.0%	6.4%	24.9%	30.6%	18.6%
C4G	Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
<b>Brand over Generic (BOG) Program</b>									
BOG - B6W	Albuterol	56.7%	98.6%	98.1%	99.2%	99.7%	97.8%	97.7%	98.5%
BOG - B6W	Proair	40.0%	0.6%	1.1%	0.2%	0.1%	0.7%	0.8%	0.6%
BOG - B6W	Proventil	1.5%	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%
BOG - B6W	Ventolin	1.8%	0.8%	0.8%	0.6%	0.3%	1.5%	1.4%	0.9%
BOG - B6W	Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
BOG - B63	Budesonide-Form	47.6%	97.9%	98.8%	88.7%	83.6%	98.5%	97.4%	94.1%
BOG - B63	Symbicort	52.4%	2.1%	1.2%	11.3%	16.4%	1.5%	2.6%	5.9%
BOG - B63	Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
BOG - B63	Advair	74.8%	5.5%	16.6%	9.6%	3.9%	4.0%	9.2%	8.1%
BOG - B63	Fluticasone-Salme	12.6%	35.1%	34.3%	54.7%	86.3%	43.3%	68.9%	53.8%
BOG - B63	Wixela	12.6%	59.4%	49.1%	35.6%	9.8%	52.7%	21.9%	38.1%
BOG - B63	Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
BOG - Q8F	Ciprodex	79.8%	0.3%	n/a	n/a	n/a	0.0%	n/a	0.1%
BOG - Q8F	Ciproflox-Dexam	20.2%	99.7%	n/a	n/a	n/a	100.0%	n/a	99.9%
BOG - Q8F	Total	100.0%	100.0%	n/a	n/a	n/a	100.0%	n/a	100.0%
BOG - J5B	Adderall	25.2%	0.9%	0.2%	n/a	1.0%	0.5%	0.1%	0.5%
BOG - J5B	Dextroamp-Amph	74.8%	99.1%	99.8%	n/a	99.0%	99.5%	99.9%	99.5%
BOG - J5B	Total	100.0%	100.0%	100.0%	n/a	100.0%	100.0%	100.0%	100.0%

Health and Human Services Commission  
 State Control vs. MCO Control Study  
 Experience Period - January 1, 2021 through December 31, 2021 (CY2021)  
 Utilization Distribution by Drug for Top Drug Classes Where No Mandate Scenario is More Cost Efficient

HIC3 Drug Class	Drug Name	State Control	MCO Control						Selected
		TX	CA	IN	MD	NJ	NY	OR	
H7T	Risperidone	31.1%	20.5%	n/a	n/a	23.5%	23.2%	n/a	22.4%
H7T	Quetiapine	31.3%	36.2%	n/a	n/a	46.0%	41.7%	n/a	41.3%
H7T	Olanzapine	14.0%	20.7%	n/a	n/a	14.6%	16.1%	n/a	17.1%
H7T	Latuda	8.0%	8.0%	n/a	n/a	3.0%	4.7%	n/a	5.2%
H7T	Invega	5.3%	3.0%	n/a	n/a	3.1%	3.2%	n/a	3.1%
H7T	Ziprasidone	4.0%	4.1%	n/a	n/a	3.1%	3.5%	n/a	3.6%
H7T	Paliperidone	2.2%	0.9%	n/a	n/a	2.1%	1.3%	n/a	1.4%
H7T	Clozapine	2.0%	3.9%	n/a	n/a	2.9%	5.0%	n/a	3.9%
H7T	Risperdal	0.7%	0.5%	n/a	n/a	0.7%	0.8%	n/a	0.6%
H7T	All Others	1.5%	2.3%	n/a	n/a	1.0%	0.6%	n/a	1.3%
H7T	Total	100.0%	100.0%	n/a	n/a	100.0%	100.0%	n/a	100.0%
P5A	Dexamethasone	6.9%	18.6%	7.9%	9.0%	15.1%	12.0%	18.6%	13.5%
P5A	Methylprednisolone	10.9%	10.8%	20.0%	21.3%	22.3%	13.7%	8.9%	16.2%
P5A	Prednisolone	45.9%	9.3%	11.2%	10.0%	11.8%	9.7%	1.9%	9.0%
P5A	Prednisone	33.3%	47.3%	43.8%	44.5%	35.5%	40.4%	45.1%	42.8%
P5A	Kenalog-40	0.1%	3.6%	3.6%	4.3%	4.7%	10.4%	6.3%	5.5%
P5A	Emflaza	0.3%	0.0%	0.1%	0.0%	0.0%	0.1%	0.1%	0.1%
P5A	All Others	2.6%	10.4%	13.4%	10.9%	10.5%	13.8%	19.1%	13.0%
P5A	Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
D6S	Docusate	2.7%	34.8%	23.5%	18.9%	17.1%	15.4%	20.4%	21.7%
D6S	Dok 1	2.4%	10.5%	5.0%	8.6%	7.5%	8.6%	7.3%	7.9%
D6S	Stool	7.2%	5.0%	3.0%	2.3%	6.0%	8.7%	4.4%	4.9%
D6S	Constulose	5.8%	0.9%	1.1%	1.4%	0.7%	0.6%	1.3%	1.0%
D6S	Kristalose	9.6%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%
D6S	Lactulose	11.7%	3.8%	6.9%	10.1%	8.7%	4.1%	3.0%	6.1%
D6S	Polyethylene	50.3%	21.6%	37.0%	29.6%	28.2%	23.1%	26.8%	27.7%
D6S	Senna	0.1%	4.1%	2.4%	5.0%	4.6%	8.8%	9.0%	5.7%
D6S	All Others	10.2%	19.3%	21.0%	24.2%	27.0%	30.5%	27.8%	25.0%
D6S	Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Health and Human Services Commission  
 State Control vs. MCO Control Study  
 Experience Period - January 1, 2021 through December 31, 2021 (CY2021)  
 Utilization Distribution by Drug for Top Drug Classes Where No Mandate Scenario is More Cost Efficient

HIC3 Drug Class	Drug Name	State Control	MCO Control						Selected
		TX	CA	IN	MD	NJ	NY	OR	
H7X	Aripiprazole	88.8%	93.5%	n/a	n/a	91.2%	88.8%	n/a	91.2%
H7X	Abilify	5.4%	3.0%	n/a	n/a	4.5%	6.2%	n/a	4.6%
H7X	Rexulti	3.5%	1.0%	n/a	n/a	3.0%	3.6%	n/a	2.5%
H7X	Aristada	2.3%	2.5%	n/a	n/a	1.3%	1.5%	n/a	1.8%
H7X	Total	100.0%	100.0%	n/a	n/a	100.0%	100.0%	n/a	100.0%
H2V	Dexmethylphenidate	32.9%	15.6%	26.9%	n/a	19.1%	15.4%	7.3%	16.8%
H2V	Focalin	4.7%	0.1%	0.0%	n/a	0.0%	0.1%	0.0%	0.0%
H2V	Concerta	8.0%	0.5%	0.1%	n/a	0.9%	0.2%	0.2%	0.4%
H2V	Methylphenidate	38.5%	82.1%	60.1%	n/a	77.7%	83.1%	91.9%	79.0%
H2V	Quillichew	4.7%	0.2%	4.0%	n/a	0.4%	0.2%	0.0%	1.0%
H2V	Quillivant	5.1%	0.7%	3.8%	n/a	0.5%	0.4%	0.1%	1.1%
H2V	All Others	6.0%	0.8%	5.2%	n/a	1.4%	0.7%	0.5%	1.7%
H2V	Total	100.0%	100.0%	100.0%	n/a	100.0%	100.0%	100.0%	100.0%

Medicaid Managed Care Program - STAR, STAR Plus, STAR Health and STAR Kids<sup>(1)</sup>

	All Funds					General Revenue				
	FY2024	FY2025	FY2026	FY2027	FY2028	FY2024	FY2025	FY2026	FY2027	FY2028
Member Months	3,930,343	3,526,530	3,533,437	3,581,004	3,629,235					
General Revenue %						38.5297%	39.1229%	39.1319%	39.1388%	39.1453%
	-	-	-	-	-					
<b>Current State Control Model (in \$1,000,000s)</b>										
Pharmacy Gross Cost <sup>(2)</sup>	3,175.81	3,102.73	3,237.84	3,407.14	3,587.13	1,223.63	1,213.88	1,267.03	1,333.51	1,404.19
Rebates - Federal <sup>(3)</sup>	(1,684.81)	(1,646.04)	(1,717.72)	(1,807.53)	(1,903.02)	(649.15)	(643.98)	(672.18)	(707.45)	(744.94)
Rebates - Supplemental <sup>(4)</sup>	(149.39)	(145.96)	(152.31)	(160.28)	(168.74)	(57.56)	(57.10)	(59.60)	(62.73)	(66.06)
Pharmacy Net Cost <sup>(5)</sup>	1,341.60	1,310.73	1,367.81	1,439.33	1,515.37	516.92	512.80	535.25	563.33	593.19
Administrative Expense	84.90	76.17	76.32	77.35	78.39	32.71	29.80	29.87	30.27	30.69
Risk Margin <sup>(6)</sup>	55.70	54.30	56.61	59.52	62.61	21.46	21.24	22.15	23.29	24.51
Premium Tax	59.07	57.59	60.04	63.12	66.40	22.76	22.53	23.49	24.71	25.99
MCO Capitation Premiums <sup>(7)</sup>	3,375.47	3,290.79	3,430.81	3,607.13	3,794.54	1,300.56	1,287.45	1,342.54	1,411.78	1,485.38
Total Overall Cost <sup>(8)</sup>	1,541.27	1,498.79	1,560.78	1,639.32	1,722.77	593.85	586.37	610.76	641.61	674.38
Total Overall Cost to State <sup>(9)</sup>	-	-	-	-	-	534.77	528.78	550.72	578.48	607.98
<b>Proposed MCO Control Model (in \$1,000,000s)</b>										
Pharmacy Gross Cost <sup>(2)</sup>	2,786.06	2,721.95	2,840.48	2,989.00	3,146.90	1,073.46	1,064.90	1,111.53	1,169.86	1,231.86
Rebates - Federal <sup>(3)</sup>	(1,246.93)	(1,218.23)	(1,271.28)	(1,337.75)	(1,408.43)	(480.44)	(476.61)	(497.48)	(523.58)	(551.33)
Rebates - Supplemental <sup>(4)</sup>	(110.68)	(108.14)	(112.84)	(118.74)	(125.02)	(42.65)	(42.31)	(44.16)	(46.48)	(48.94)
Pharmacy Net Cost <sup>(5)</sup>	1,428.45	1,395.58	1,456.35	1,532.50	1,613.46	550.38	545.99	569.90	599.80	631.59
Administrative Expense	84.90	76.17	76.32	77.35	78.39	32.71	29.80	29.87	30.27	30.69
Risk Margin <sup>(6)</sup>	47.15	45.95	47.89	50.35	52.96	18.17	17.98	18.74	19.71	20.73
Premium Tax	50.00	48.73	50.80	53.40	56.16	19.27	19.07	19.88	20.90	21.99
MCO Capitation Premiums <sup>(7)</sup>	2,857.42	2,784.66	2,902.64	3,051.35	3,209.39	1,100.96	1,089.44	1,135.86	1,194.26	1,256.33
Total Overall Cost <sup>(8)</sup>	1,610.50	1,566.43	1,631.36	1,713.59	1,800.97	620.52	612.83	638.38	670.68	704.99
Total Overall Cost to State <sup>(9)</sup>						570.51	564.10	587.59	617.28	648.83
<b>Difference - Proposed MCO Control less Current State Model (in \$1,000,000s)</b>										
Pharmacy Gross Cost <sup>(2)</sup>						33.46	33.19	34.65	36.47	38.40
Administrative Expense						-	-	-	-	-
Risk Margin <sup>(6)</sup>						(3.29)	(3.27)	(3.41)	(3.59)	(3.78)
Premium Tax						(3.49)	(3.47)	(3.62)	(3.81)	(4.01)
<b>Total Overall Cost to HHSC<sup>(8)</sup></b>						<b>26.67</b>	<b>26.46</b>	<b>27.62</b>	<b>29.07</b>	<b>30.61</b>
<b>Total Overall Cost to State<sup>(9)</sup></b>						<b>35.74</b>	<b>35.32</b>	<b>36.86</b>	<b>38.80</b>	<b>40.85</b>

State Control vs. MCO Control Study - Summary of Analysis to Overall Cost

Medicaid Managed Care Program - STAR, STAR Plus, STAR Health and STAR Kids<sup>(1)</sup>

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 MCO control scenario assumed to be 12.3% less than the current State control model. See Attachment 4.
- (3) Federal rebates were determined to be 53.1% of gross cost for current State control scenario and 44.8% of gross cost for MCO control scenario.
- (4) Supplemental rebates were determined to be 4.7% of gross cost for current State control scenario and 4.0% of gross cost for MCO control scenario.
- (5) Pharmacy Net Cost equals Gross Pharmacy Cost less Federal & Supplemental Rebates  
Pharmacy Net Cost under MCO control scenario assumed to be 6.5% more than the current State control 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 current State control scenario includes Pharmacy Gross Cost, Administrative Expense, Risk Margin and Premium Tax.  
MCO Capitation Premiums for the MCO control scenario includes Pharmacy Gross Cost less Sup. Rebate, Administrative Expense, Risk Margin and Premium Tax.
- (8) Total Overall Cost equals Pharmacy Net Cost + Admin + Risk Margin + Premium Tax  
Total Overall Impact to HHSC equals All Funds Total Overall Cost Impact \* General Revenue Percent.
- (9) Total Overall Impact to State equals Total Overall Cost Impact less Premium Tax All Funds.