Texas – Health and Human Services Commission (HHSC)
Review of Rider 60/61 Reports Findings

Rider 60/Rider 61 Evaluations | October 4, 2018

Today's Agenda

Topic	Slide Number(s)	Timing
Rider 60: Study of Potential Cost Savings in the Administration of Prescription Drug Benefits	3 – 10	20 minutes
Rider 61(a): Evaluation of Medicaid and CHIP Managed Care – Review of Managed Care System	11 – 17	20 minutes

The Rider Report 60 is posted at
https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/sb1-rider60-prescription-drug-mco-august-2018.pdf.

The Rider Report 61 is posted at
https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/sb1-rider61-evaluation-medicaid-chip-august-2018.pdf.

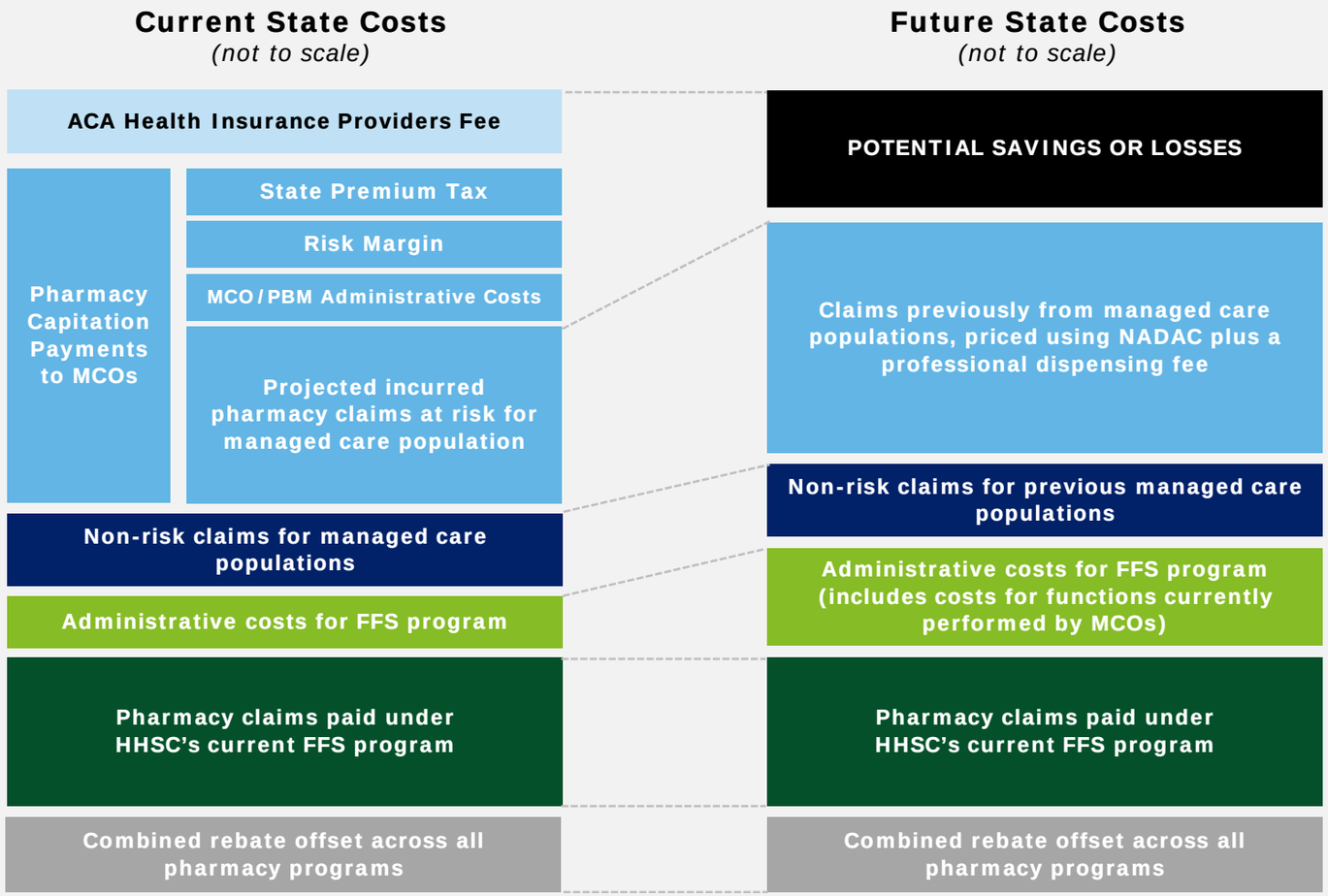
Please send your questions, comments and feedback in writing to
medicaidmanagedcare@hhsc.state.tx.us.

Rider 60: Study of Potential Cost Savings in the Administration of Prescription Drug Benefits

Rider 60: Approach

Rider 60 requires HHSC to study potential cost savings in the administration of Medicaid and CHIP prescription drug benefits by transitioning from managed care and administering them as fee-for-service (FFS).

Illustration of Approach to Quantifying Potential Costs or Savings under Rider 60[1]



- In transitioning to this model, HHSC would no longer make pharmacy capitation payments to MCOs. In estimating the impact of this transition, the following factors were considered:
  - Risk margin provision within capitation payments
  - ACA Health Insurance Providers Fees on capitation payments
  - The loss federal matching of funds on the state premium tax[2]
- FFS claim costs for pharmacy claims currently managed by the MCOs were estimated using SFY2015-2017 encounter data and the following considerations:
  - Transition to a NADAC pricing methodology
  - Potential impact on prescription drug utilization
- Administrative costs impact was considered, as HHSC would administer benefits for a larger FFS population
- Rebate impact was considered in the aggregate, as any changes in utilization would have a corresponding impact on HHSC's rebate payments[3]

[1] The graphic is for illustrative purposes only and is meant to capture some of the high-level changes that may occur in this model; other qualitative and quantitative impacts not reflected herein are also considered and incorporated in the Rider 60 study.

[2] While state premium tax is embedded in MCO capitation payments, it is later reimbursed by MCOs to the State; however, the State will lose revenue from the federal matching of funds on the tax.

[3] HHSC currently negotiates and collects rebates for all Texas pharmacy programs.

Rider 60: Key Assumptions and Limitations

The Rider 60 report outlines the key assumptions and caveats inherent in the analysis, including the following:

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

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

- Throughout the report, rebates were considered in the aggregate only, as detailed rebate experience by drug or therapeutic class was not made available. For scenarios in which the utilization is anticipated to vary, the analysis assumes total rebates as a percentage of total gross ingredient costs would remain constant after the change in utilization (implying the underlying drug mix will remain constant). **It is possible that a change in utilization might also change the mix of drugs which in turn could impact rebate levels.** The analysis does not include the impact of such changes.

- Savings associated with the risk margin were calculated based on the risk margin assumption in place for SFY2015-SFY2017. However, the risk margin assumption was reduced from 2.00% in SFY2017 for all programs except Dual Demonstration, to 1.75% for SFY2018 for STAR+PLUS and STAR Kids and 1.50% for STAR, STAR Health, and CHIP. As a result, **the future savings attributable to the risk margin for SFY2018+ will be less than the amounts calculated for SFY2015 to SFY2017.**

- **There is a moratorium expected on the ACA Health Insurance Providers Fee in 2019.** If this moratorium stands, the fee will not be assessed at the federal level for the 2019 calendar year. In this case (or if other changes are made to the structure of the fee in 2020 or later), the savings associated with the ACA Health Insurance Providers Fee may be impacted for future years.

- The **costs and savings estimates do not incorporate the upfront costs for transitioning HHSC's membership to the new statewide claims processor**, as transition-related expenses may vary based on factors including the vendor selected and the time span over which the transition is performed.

Rider 60: Key Cost or Savings Drivers (1 of 2)

The following categories represent the key drivers of potential savings (or increased costs) from carving out the Medicaid and CHIP pharmacy benefits from managed care.

Non-claim Components of Pharmacy Capitation Payments

By transitioning pharmacy benefits from managed care to FFS, HHSC would no longer be responsible for reimbursing MCOs for non-claims-related components of capitation payments, including:

- **Risk Margin:** The amount of the risk margin was estimated by multiplying the historical risk margin assumptions in the capitation rate development files by the pharmacy capitation payments for each respective Medicaid and CHIP program
- **ACA Health Insurance Providers Fee:** The amount of the fee was estimated by multiplying the actual fee as a percentage of total capitation rates from the SFY2017 capitation rate development file by the pharmacy-specific capitation payments for the MCOs subject to the fee
- **State Premium Tax:** The premium tax component of HHSC's capitation payments to MCOs is subsequently reimbursed to the State; however, by carving out pharmacy benefits, HHSC loses the federal match on state premium tax. This lost revenue was classified as a cost of carving out in the analysis, and is equal to the federal share of the state premium tax based on actual historical federal matching percentages (FMAP)

Potential Utilization Increase

In migrating HHSC's pharmacy benefits from a managed care environment to FFS, underlying costs and utilization may change if the FFS program does not manage care in the same way as MCOs:

- Recognizing that MCOs apply different prior authorizations (PAs) today than the FFS program, managed care pharmacy utilization may increase if no longer subject to these PAs. The potential change in utilization was calculated by comparing pharmacy experience between the MCOs that apply the PA and the MCOs that do not, and the variances in per member costs were extrapolated to estimate the possible impact of removing the PA in the pharmacy carve-out. The estimated impact was a 2.2% increase to gross pharmacy costs.
- An alternative scenario was also developed that reflects no increase in pharmacy utilization, which may result if HHSC implements the same PAs under the pharmacy carve-out as the MCOs use today
- A third utilization scenario was calculated wherein HHSC's utilization changes by more than expected based on the analysis above (+5% increase to gross pharmacy costs)

Rider 60: Key Cost or Savings Drivers (2 of 2)

The following categories represent the key drivers of potential savings (or increased costs) from carving out the pharmacy benefit from managed care.

Estimated Impact from Repricing

- A repricing exercise was performed to determine the amount that would be paid on a FFS basis for the claims incurred by MCOs' membership at each historical time period
- Costs for the MCOs' pharmacy encounter data were restated using the pricing methodology that would be applied under the carve-out; specifically, Rider 60 states that a pricing methodology based on NADAC should be applied, with a dispensing fee calculated according to a recent study commissioned by HHSC

Impact on Administrative Costs

- Today, HHSC pays for the administration of its pharmacy program in two ways:
  1) For the managed care population, HHSC accounts for MCOs' administrative costs in the MCO capitation rate development process
  2) For the FFS population, the VDP contracts with external vendors to help perform its administrative functions; in addition, HHSC employees help to manage and staff the FFS program pharmacy call center and perform program oversight
- Under a pharmacy carve-out, the first component will no longer be required, while the second component will increase as the FFS program expands to cover members that are currently managed by MCOs; the net impact will determine whether there are inherent costs or savings arising from administering under a unified pharmacy carve-out model
- The analysis quantifies the current administrative costs and compared them to the projected costs if the FFS program were to take on the functions the MCOs currently perform today; two scenarios were considered:
  - One scenario assumes HHSC can perform administrative services for the same costs embedded today in the MCO capitation payments ($1.80 PMPM)
  - The second scenario assumes the VDP would be able to secure pricing that is better than they receive today, but not as favorable as the scenario above ($2.20 PMPM)

Rider 60: Results by Savings Category

The results of the analysis are summarized below by savings category. In addition to the dollar impact under each scenario, the impact as a percentage of total pharmacy program costs (net of rebates and cost sharing) is included.

	Key Cost or Savings Driver	Net Cost / (Savings) Impact		
		SFY2015	SFY2016	SFY2017
Non-claim Components	Result 1: Impact from Risk Margin, ACA Fee, and Premium Tax	($85.6M)	($90.6M)	($113.6M)
	Result 2: No Savings from ACA Health Insurance Providers Fee	($26.9M)	($28.6M)	($37.1M)
Potential Utilization Increase	Result 1: 2.2% Utilization Increase from PA Impact	$26.3M	$25.2M	$29.0M
	Result 2: No Utilization Increase	-	-	-
	Result 3: 5% Utilization Increase	$60.5M	$58.0M	$66.7M
Repricing	Estimated Impact from Repricing	$33.0M	$16.6M	$28.7M
Impact on Admin Costs	Result 1: FFS Program Administrative Costs at $1.80 PMPM	($3.4M)	($5.0M)	($5.3M)
	Result 2: FFS Program Administrative Costs at $2.20 PMPM	$18.4M	$16.8M	$17.1M

Rider 60: Final Results by Scenario

The results of the analysis are summarized below by scenario. In addition to the dollar impact under each scenario, the impact as a percentage of total pharmacy program costs (net of rebates and cost sharing) is included.

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

Key Notes

- Estimates do not incorporate technology costs nor any other upfront costs for transitioning HHSC's membership to the new statewide claims processor, as transition-related expenses may vary
- The removal of the ACA Health Insurance Providers Fee presents the largest savings opportunity; however, if the moratorium expected on the fee in 2019 stands, there will be no savings associated with the fee in the future – scenarios 5 through 8 reflect this possibility

Rider 60: Other Considerations

Consideration should also be given to other qualitative factors that are not included in the savings calculation, but that may impact members' quality of care, HHSC's ability to draw conclusions from data, and other key facets of administrating Medicaid pharmacy benefits.

Upfront Transition Costs and System Capabilities	• HHSC may incur one-time technology implementation costs and costs to transition members to its new PBM under the pharmacy carve-out • HHSC's current system capabilities should be assessed, and any technology and transition costs should be considered
Ability to Integrate and Coordinate Care	• A pharmacy carve-out may present barriers for MCOs to holistically manage care across members' medical, pharmacy, and other benefits, which may increase the total cost of care • Additionally, MCOs may be reluctant to participate in quality or outcome-based incentive programs if they are no longer responsible for the full spectrum of their members' care
Data Coordination	• The carve-out model may enable HHSC to more efficiently identify outcomes and trends in pharmacy utilization across its membership • On the other hand, new costs may be incurred related to data coordination, as HHSC will be responsible for reporting pharmacy claims experience to the MCOs to enable them to manage costs at the episode, encounter, or member level
Transferred Risk from MCOs to State	• Under a pharmacy carve-out, HHSC will be at risk for fluctuations in prescription drug utilization patterns or increased costs from new drugs • However, HHSC could also benefit if utilization decreases or ingredient costs increase at a lower-than-anticipated level
Increased Preferred Drug List Adherence	• Transitioning all members to a pharmacy carve-out may increase HHSC's ability to improve adherence to its PDL • The carve-out may help improve HHSC's approach to identifying outcomes based on pharmacy data

Rider 61(a): Evaluation of Medicaid and CHIP Managed Care – Review of Managed Care System

Review of Managed Care System: Approach

Pursuant to Rider 61(a), this evaluation has assessed Texas' performance regarding cost, quality, member satisfaction, and access, while considering the impact of caseload increases and case mix changes. Further analysis was conducted to estimate the cost savings realized by continuing to expand the managed care program versus operating under the previous delivery model of fee-for-service (FFS).

Approach

Gather and Review Materials

Gather and analyze existing documentation to understand the current program, including its design, successes, and challenges

Analyze and Understand Data

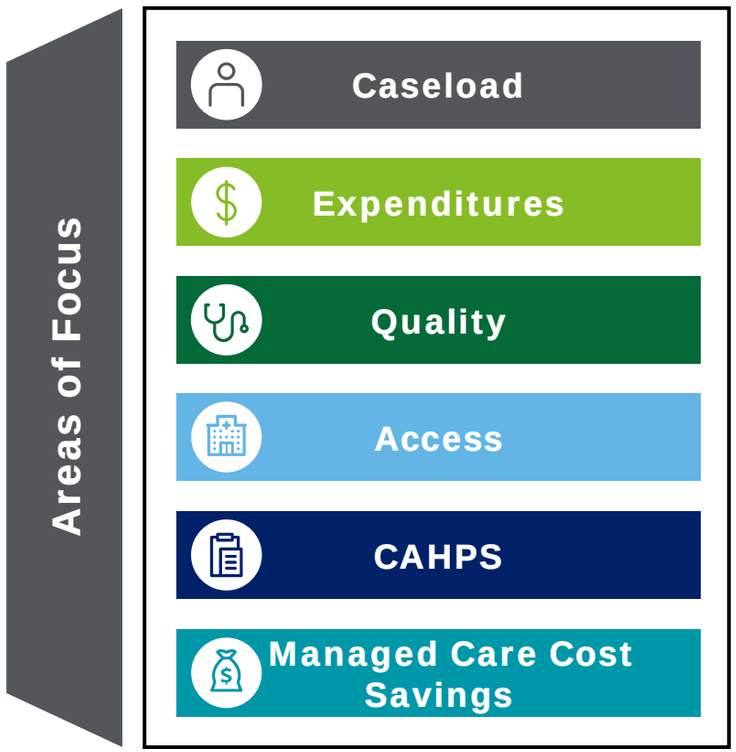
Work with HHSC to fully understand the summarized data needed to conduct the assessment. Conduct interviews with key personnel across HHSC to supplement insights gained from the data and documentation

Perform Analysis

Leverage the materials collected, the data provided, industry sources, and interviews to analyze trends, caseload growth, and savings realized within the managed care program

Compare to Other States

Leverage experience in working with other state Medicaid and CHIP programs and use nationally available data sources and industry benchmarks. Compile a summary of managed care program outcomes (cost savings, trends, and caseload changes)



Review of Managed Care System: Managed Care Savings Methodology

Rider 61(a) requires HHSC to evaluate the performance of Managed Care throughout both Medicaid and Children's Health Insurance Program (CHIP), including estimating cost savings from managed care.

Managed Care Cost Savings

High-Level Methodology

Step 1: Summarize and analyze expenditures per member per month (PMPM)

- Calculate the Medicaid and CHIP expenditures per member per month (PMPM) for the fee-for-service and managed care populations by program and risk group from SFY2009 through SFY2017
  - Expenditures were separated by program, risk group, and medical and pharmacy service categories

Step 2: Calculate adjustments that were made to the managed care program

- In order to calculate hypothetical fee-for-service expenditures that are comparable to historical managed care expenditures, any adjustments that were made to the managed care program during the analysis period that would have theoretically impacted the fee-for-service program were calculated and applied to the hypothetical fee-for-service expenditures
- Adjustments were included for managed care program expansions, managed care program changes, administrative expense changes, and population mix changes

Step 3: Calculate Savings Estimates

- To calculate savings estimates, the hypothetical fee-for-service PMPM across the analysis period of SFY2009 through SFY2017 was calculated
  - Assume that in the base year of the analysis, SFY2009, FFS PMPMs were equal to the managed care capitated rates PMPM
  - Trend the base year PMPM forward through SFY2017. A trend analysis was conducted utilizing multiple trend benchmark sources and historical Texas FFS trends
  - Apply adjustments for managed care program expansions, managed care program changes, administrative expense changes, and population mix changes
- After all adjustments to the hypothetical fee-for-service PMPMs are calculated, the difference between the hypothetical fee-for-service PMPMs and the historical managed care PMPMs are estimated to be the financial savings realized by the managed care program

Assumptions

- Note that HHSC built managed care savings assumptions into the managed care capitation rates during the initial years of managed care and during program expansions. The analysis assumes shifting from fee-for-service to managed care would have a budget neutral impact after accounting for administrative costs, taxes, risk margins, and other expenses included in managed care capitation rates.
- As with any study of this type and magnitude, the estimated savings in dollars are highly dependent on the assumptions being used, thus high- and low-end estimates of hypothetical fee-for-service expenditures have been established and are represented in the figure. The estimated range of cost savings was calculated by comparing the actual managed care expenditures over the period to the high and low ends of hypothetical fee-for-service expenditures.
- The cost savings analysis focused on savings associated with the total managed care costs across the analysis period. During this time period there were costs associated with the Affordable Care Act (ACA) Health Insurer Fee (HIF) and revenue collected via premium taxes, which the managed care expenditures where not adjusted for.

Review of Managed Care System: Managed Care Savings Results

Rider 61(a) requires HHSC to evaluate the performance of Managed Care throughout both Medicaid and Children's Health Insurance Program (CHIP), including estimating cost savings from managed care.

Managed Care Cost Savings

Trend Assumptions

Several data sources were utilized to determine a reasonable trend rate range for the hypothetical fee-for-service costs across medical and prescription drug service categories. The key data sources included:

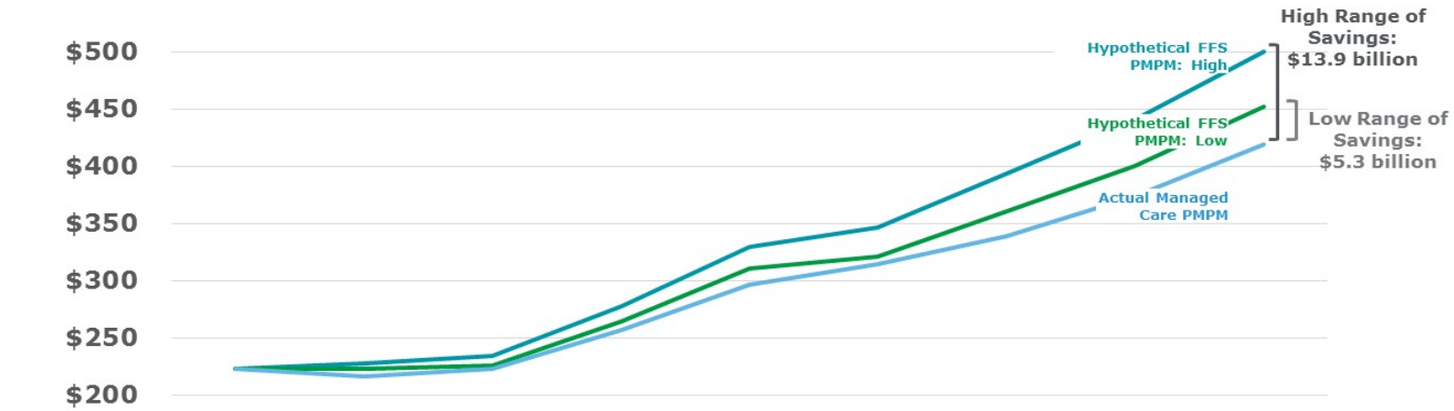
- Historical Texas fee-for-service trend rates
- CMS Health Expenditure report
- Express Scripts Annual Trend Report
- Historical Texas managed care prescription drug trend rates

The following represents the trend range used in the analysis:

Program	Low Estimate	High Estimate
All (Except STAR Plus)	3.5 %	5.5 %
Star Plus	3.0 %	5.0 %
Prescription Drug[1]	2.5 %	2.5 %

[1] While prescription drug trend benchmarks were considered when establishing the prescription drug trend rate for the hypothetical fee-for-service costs, the final prescription drug trend rate was assumed to follow the managed care trend rate over the analysis period.

Managed Care Cost Savings



	SFY09	SFY10	SFY11	SFY12	SFY13	SFY14	SFY15	SFY16	SFY17
Hypothetical FFS PMPM: High	$224	$228	$235	$278	$330	$347	$394	$440	$500
Hypothetical FFS PMPM: Low	$224	$224	$226	$265	$311	$321	$361	$400	$452
Actual Managed Care PMPM	$224	$217	$223	$257	$297	$315	$339	$374	$420
Total Saved (in billions): High		$0.28	$0.34	$0.79	$1.42	$1.35	$2.56	$3.18	$4.00
Total Saved (% of total cost): High		4.9%	5.0%	7.6%	9.9%	9.1%	13.9%	15.2%	16.1%
Total Saved (in billions): Low		$0.17	$0.08	$0.28	$0.60	$0.27	$1.01	$1.26	$1.62
Total Saved (% of total cost): Low		3.0%	1.2%	2.7%	4.2%	1.8%	5.5%	6.0%	6.5%

Review of Managed Care System: Overview of Findings

Quality Improvement

- From a quality perspective, the scores for both adult and child population Health Effectiveness Data and Information Set (HEDIS®) measures for the Medicaid and CHIP managed care programs improved slightly from calendar year 2014 through 2016.
- MCO performance exceeded the HHSC established high standards of performance for four of the 16 adult HEDIS® measures in 2016. MCO performance exceeded the HHSC high standards of performance for child-related HEDIS® measures for six of the 12 measures.
- Comparing Texas' HEDIS® results as reported in the NCQA Quality Compass® tool[(1)] to national benchmarks, Texas' results were above the national benchmark for 9 measures and below the national benchmark for 10 measures.
- Texas results as reported in the NCQA Quality Compass® tool were the highest out of all comparable states in the Pharmacotherapy Management and both the Child and Adolescent Immunizations HEDIS® measures, while Texas performed the lowest of all comparable states in Medication Management for People with Asthma, HbA1c Control, and Medical Attention for Nephropathy.
- Overall Potentially Preventable Readmission (PPR) rates increased across all programs from 2014 to 2017, apart from the STAR program, which realized an annualized decrease of 4 percent. Potentially Preventable Admission (PPA) rates improved across STAR, STAR Health, and CHIP programs, but realized a 9 percent increase in the STAR+PLUS program from 2014 to 2017.

(1) 13 of Texas' MCOs submitted HEDIS® data to the NCQA Quality Compass® tool.

Review of Managed Care System: Overview of Findings (continued)

Access

- Through an analysis of comparable states' access requirements, Texas' methodology to determine access requirements was found to be similar to the methodologies used by other states.
- Regarding the program's compliance with these requirements, the STAR, STAR+PLUS, and CHIP programs saw improvement in appointment availability metrics from 2015 to 2016.
- One area of low compliance was OB/GYN appointment availability in the STAR program, with compliance rates below 50% for third trimester and for High-Risk OB/GYN appointments.
- MCO variation was present for both OB/GYN and Behavioral Health appointment availability, while Primary Care appointments typically saw high compliance and low variation across MCOs.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

- From 2015 to 2017, Texas experienced modest improvements in member satisfaction scores for every program. Across the measures, the child populations typically had higher member satisfaction scores than the adult populations.
- Comparing Texas' CAHPS® results as reported in the NCQA Quality Compass® tool[(1)] to national benchmarks, Texas performed lower than the national 50th percentile for four out of the five CAHPS® composite measures that were reviewed: Getting Needed Care, Getting Timely Care, How Well Doctors Communicate, and Main Doctor Rating.
    - Only results for the Health Plan Rating composite measure were above the national 50th percentile.
- Reviewing Texas' CAHPS® results as reported in the NCQA Quality Compass® tool[(1)] with other comparable states, Texas' results were the lowest of the comparable states for three of the five CAHPS® composite measures that were reviewed, including Getting Needed Care, Getting Timely Care, and How Well Doctors Communicate. Texas had the third highest score of five for both the Main Doctor Rating and Health Plan Rating composite measures.

[(1)] 13 of Texas' MCOs submitted CAHPS® data to the NCQA Quality Compass® tool.

Review of Managed Care System: Opportunities for Additional Cost Containment Initiatives and Operational Efficiencies

Opportunity Area	Opportunities for HHSC to Consider
Additional Cost Containment Initiatives	• Opportunity for more aggressive efficiency adjustments in the rate setting process • Potential strengthening of the experience rebates for those MCOs deemed to have excessive administrative expenses or profits above the profit-sharing thresholds • Additional detail regarding outsourced services to compare administrative costs by FSR cost category in a more consistent manner across the MCOs • Revisions to the quality incentive program • Savings from implementing changes to the current method of administering prescription drug benefits
Operational Efficiencies	• Further incent the MCOs to develop more value-based payment models by implementing a performance incentive/withhold program with the MCOs based on achievement of the targets for value-based payment contracts with providers • Consider having the MCO's focus their provider value-based payment arrangements on improving select QOC and outcome measures that are part of the MCO Pay-For-Quality Program to further align the MCOs and providers to drive improvement on those measures

Thank You for Attending the Webinar

The Rider Report 60 is posted at https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/sb1-rider60-prescription-drug-mco-august-2018.pdf.

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