The Menges Group

Strategic Health Policy & Care Coordination Consulting

Assessment of Medicaid MCO Preferred Drug List Management Impacts

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I. Executive Summary and Introduction

Overview:

There are opportunities for Texas to achieve significant Medicaid prescription drug savings by allowing its managed care organizations (MCOs) to fully administer the Medicaid prescription drug program, including giving MCOs the flexibility (latitude) to manage the mix of drugs cost-effectively through their own preferred drug lists (PDL), also referred to as formularies. Texas Medicaid can adopt the PDL latitude approach that has worked successfully in many other state Medicaid programs, as well as private, individual, and employer-sponsored insurance, Medicare Advantage, and other state health insurance programs (TRS and ERS) to fully leverage its investment in managed care and achieve these savings without adverse impacts to quality or access. We estimate that by pursuing such an approach, Texas will realize total annual Medicaid savings of more than $230 million and annual general revenue savings of nearly $100 million. The value of implementing this change is substantial and is likely to accrue immediately – *the current uniform PDL policy is costing Texas taxpayers over $1 million for every four days it remains in effect.*

Background:

Texas' Medicaid program relies heavily on the capitation contracts with managed care organizations (MCOs) to facilitate access to needed services, measure and improve quality, and achieve available cost savings. As part of this effort to transition the Medicaid program to a highly integrated system of coverage, Texas included prescription drugs as part of the MCOs' set of capitated, at-risk services during 2012. Our tabulations indicate that Texas is now one of nine states with more than 80% of Medicaid prescriptions paid for by Medicaid MCOs.

However, while Texas has given its Medicaid MCOs financial responsibility for the prescription drug benefit, Texas' Medicaid managed care program policies significantly restrict the MCOs' flexibility to manage the pharmacy benefit. The key restrictions are that all MCOs must use the same preferred drug list (PDL) developed and utilized by the Health and Human Services Commission (HHSC) for Medicaid fee-for-service prescriptions, that the MCOs have no authority to develop their own prior authorization requirements or clinical and safety edits, and that "step therapy" is generally not permitted. (Step therapy involves prescribing the lowest-cost product initially among those that are deemed likely to be clinically effective, then switching to higher cost drugs only if the initial product is not clinically successful.) Step therapy is commonly used in other health insurance markets.

Summary of Approach:

Our assessment of Texas' Medicaid prescription drug costs has three major components:

a) Statewide Cost Per Prescription: Data were available that allowed for an accurate comparison between Texas' average costs per Medicaid prescription on a net (post-rebate) basis and every other state. These analyses, presented in Section II, allow for comparisons of Texas with states where MCOs have PDL latitude. We are also able to quantify the degree to which a drug mix focus (e.g., extensive use of generics) versus a rebate-focused strategy is yielding the most favorable net costs. PDL latitude is particularly needed in Texas to increase the use of generic medications. The average post-rebate cost for brand prescriptions in Texas was more than *five times* higher than the corresponding average for generics during 2014. Texas ranked 45th among states in its use of generics as a percentage of all Medicaid prescriptions.

b) Therapeutic Class Assessments: Data were tabulated in Section III at the therapeutic class level to permit a more detailed assessment of where Texas' drug mix can be managed more cost-effectively.

c) Input from MCOs: Texas Medicaid MCOs either manage the Medicaid drug benefit directly in several other states, or contract with a pharmacy benefits management (PBM) organization that has Medicaid benefits management experience in other states. These health plans and PBMs are therefore well-positioned to describe what they are able to achieve in other states where they have PDL latitude relative to what they can achieve in Texas – as well as provide comparison data. This information is compiled in Section IV and demonstrates many qualitative, programmatic advantages to PDL latitude as well as providing further evidence of the cost-effectiveness this policy change would create in Texas.

All the analyses and findings in this report point in the same direction: Texas will be best-served by enlisting the full capabilities of its MCO partners in managing the Medicaid prescription drug benefit for each health plan's enrollees. The health plans are currently unnecessarily constrained by the uniform PDL requirement, and a policy change is needed to allow the prescription drug benefit to be administered in an optimal manner. Texas Medicaid PDL latitude, as implemented in dozens of other states, is projected to yield more than $230 million in annual Medicaid savings, the State share of which will be nearly $100 million.

II. Aggregate Cost Per Prescription Analyses

A. Analytical Approach and Data Sources

The cost per prescription for every state's Medicaid program was assessed for federal fiscal year (FFY) 2014, on both a pre-rebate and a post-rebate basis. This statistic was derived for the entirety of each state's Medicaid population with the exception of dual eligibles, for whom Medicare Part D serves as the primary payer for prescriptions. CMS publishes the State Drug Utilization Files, quarterly data by national drug code (NDC) for each state and for every Medicaid prescription. This source conveys the volume of prescriptions and the corresponding Medicaid amount paid. The data rows include an indicator for drugs paid in the fee-for-service setting and those paid by managed care organizations (MCOs). A separate CMS data source, the CMS 64 Reports, captures the Medicaid prescription drug rebates each state receives in each federal fiscal year. The reported rebates include both the ACA's statutory rebates as well as any supplemental rebates the state and its MCOs negotiate with drug manufacturers. Together, these two data sources allow for tabulating each state's Medicaid initial (pre-rebate) costs per prescription, rebates per prescription, and the net (post-rebate) cost per prescription.

The net cost per prescription statistic serves as a useful measure of how cost-effectively the pharmacy benefit is being managed within each state's Medicaid program by reflecting the mix of medications being filled.[1] This is important because within a given health condition there can be significant price variations between many different clinically effective drugs. This statistic also captures all statutory rebates required for each drug, as well as the outcomes of states' and Medicaid MCOs' efforts to negotiate supplemental rebates from drug manufacturers.

B. Summary of Findings

In FFY 2014, Texas ranked 22nd in the country in its net Medicaid cost per prescription, with its cost slightly below the nationwide average. Texas' statistics and national ranking on a variety of measures are shown in Exhibit 1.

[1] Given that multiple medications are often clinically effective, but that these alternative drugs often have significantly different costs, managing the "mix of medications" successfully involves steering volume towards the lowest-cost, clinically effective product through the preferred drug list (PDL) and related utilization management processes. This includes using generics in lieu of brands where appropriate, but also includes using relatively low-cost brands (when a brand drug is most cost-effective) and relatively low-cost generics (when a generic drug is most cost-effective).

Exhibit 1. Medicaid Prescription Drug Statistical Overview, Texas & USA, FFY 2014

Medicaid Statistic, FFY 2014	Texas	USA	Texas' Rank Among 50 States Plus DC
Net Cost Per Prescription	$36.21	$37.37	22
Initial Cost Per Prescription	$79.60	$72.38	33
Rebates Per Prescription	$43.39	$35.00	9
Generics as % of All Prescriptions	77.0%	80.7%	45
Percentage of Prescriptions Paid by MCOs	82.5%	55.3%	9
Volume of Prescriptions	35,150,055	589,160,908	3

Notes: The market entry of two high-cost Hepatitis C drugs, Sovaldi and Harvoni, increased national Medicaid net costs per prescription by approximately $2.00 during 2014 for states that approved the use of these medications in their Medicaid programs. Texas did not approve use of these medications in its Medicaid program during 2014, so Texas' net cost per prescription does not include the cost of these medications and is slightly below the national average. Texas' costs per prescription for all non-Hepatitis C Medicaid medications are actually slightly above (rather than slightly below) the national average.

Also, the State Drug Utilization data indicated that Texas had 10% more units per Medicaid prescription than the national average during FFY2014. We have not assessed the validity of the "units" data, but to the extent Texas averages more pills per Medicaid prescription than the nation overall, the above figures would put Texas in a less favorable ranking than is warranted.

The Hepatitis C issue and the units per prescription dynamics would move Texas' ranking in opposite directions. We anticipate that these dynamics, if fully accounted for, would closely offset one another.

While the figures in Exhibit 1 indicate that Texas' prescription drug costs are in line with national averages, opportunities exist to achieve cost savings in Texas' mix of drugs. Despite the fact that Texas' Medicaid prescriptions are predominantly purchased by Medicaid MCOs (82.5%), Texas ranks 45th in the degree to which generics are used as a percentage of all Medicaid prescriptions. Greater savings can be achieved by focusing on lowering overall drug spending by maximizing the use of generics through Medicaid managed care. Twenty-one other states fare better than Texas on net spending per prescription (post-rebates).

As shown in Exhibit 2, Medicaid MCOs have demonstrated strong acumen nationally at steering volume to generic therapies. In Texas, the usage of generics within MCO-paid medications is 4.6 percentage points lower than the nationwide figure. These percentage point differences translate to large dollar spending differences, given that brand drugs' average costs are more than five times higher than generics on a post-rebate basis in Texas (and 6.5 times higher nationally). The greater use of brand name drugs over generics is not offset by the increased rebate revenue.

Exhibit 2. Generic Usage Within MCO-Paid Medications, FFY 2014

	% Generics Within Prescriptions Paid by Medicaid MCOs	MCO Average Cost Per Generic Prescription (Post-Rebate)
Texas	78.2%	$17.25
USA	82.8%	$16.48
17 States in Top Third of Country Regarding % Generics	83.4%	$15.94

To assess Texas' savings opportunities more closely, the degree to which different state attributes are yielding favorable net costs per prescription was assessed for a variety of statistical measures. These analyses are conveyed in Exhibit 3 and the ensuing narrative.

Exhibit 3. Medicaid Prescription Drug Cost Management Outcomes, FFY 2014

State Group	Net Post-Rebate Cost Per Prescription	Initial Cost Per Prescription	Rebates Per Prescription	Rebates as % of Initial Cost	Generics as % of Total Prescriptions	% of Medicaid Prescriptions Paid by MCOs
Texas	**$36.21**	**$79.60**	**$43.39**	**54.5%**	**77.0%**	**82.5%**
States in Top Third, Generic % of All Prescriptions	$32.72	$63.71	$30.99	48.6%	82.8%	67.8%
States in Top Third, Rebate Per Prescription	$43.09	$86.64	$43.55	50.3%	77.4%	35.2%
States in Top Third, % of Prescriptions Paid by MCOs	$34.48	$67.36	$32.88	48.8%	81.6%	82.1%
States in Top Third, Medicaid Prescription Volume	$36.01	$70.66	$34.64	49.0%	81.2%	65.6%
USA Total	**$37.37**	**$72.38**	**$35.00**	**48.4%**	**80.7%**	**55.3%**
States in Top Third, Net Cost Per Prescription	$29.42	$58.95	$29.53	50.1%	82.5%	64.5%
16 States With No MCO Paid Drugs	$45.80	$87.42	$41.62	47.6%	77.0%	0.0%
34 States (plus District of Columbia) with MCO Paid Drugs	$36.08	$70.06	$33.98	48.5%	81.3%	65.2%
4 States Requiring Uniform PDL of Medicaid MCOs	$39.26	$79.70	$40.44	50.7%	78.5%	65.8%
30 States (plus District of Columbia) with MCO Paid Drugs and where PDL Latitude Exists	$35.53	$68.39	$32.87	48.1%	81.8%	65.1%

Green shading denotes comparison state groupings with lower net, post-rebate costs per prescription than Texas. Red shading denotes state groupings with higher net costs than Texas.

The figures in Exhibit 3 demonstrate which attributes of states' Medicaid pharmacy cost management efforts are proving to be most effective – as well as those that have not been important or effective.

- **Securing relatively large rebates was not an effective strategy in achieving optimal net costs.** The "top third" of states that achieved the highest rebates per prescription fared poorly in their net cost per prescription drug. Despite obtaining average rebates of $43.55 per prescription, which were 24.4% above the USA average ($35.00), the average net cost per prescription across these 17 states ($43.09) was 15.3% above the USA average ($37.37). The 17 states with the highest generic dispensing rate and the 17 states with the largest rebates per prescription are entirely separate groups of states. ***Maximizing rebates and optimally managing drug mix are two separate strategies that are in conflict with each other, with managing drug mix producing lower overall prescription drug spending for state Medicaid programs.*** Net costs in the top third of states with regard to generic mix are 24.1% below the net costs per prescription in the top third of states with regard to rebates per prescription.

- **Use of generics was strongly correlated with achieving relatively low net costs.** The states in the "top third" with regard to generic dispensing rate (generics as a percentage of all Medicaid prescriptions) consistently achieved highly favorable net costs per prescription. This group of 17 states collectively had a net cost of $32.72 per prescription (post-rebate) during FFY2014, which was 12.5 percent lower than the national average and 9.6% lower than Texas. Of the 17 states in the top third with regard to generic dispensing rate, 13 were also in the top third of states in terms of lowest net costs per prescription; 10 were among the top third in terms of the degree to which Medicaid prescriptions were paid by MCOs.

- **Volume purchasing was *not* a key driver in achieving relatively low net costs**. The status of being a particularly large state (and thus having relatively large purchasing power) does not appear to be of significant value, in and of itself, in achieving favorable net costs per prescription. The largest 17 states (with regard to the volume of Medicaid prescriptions) collectively averaged $36.01 in net costs per prescription, slightly (3.6%) below the USA average. While it appears that having particularly large purchasing power may be of some benefit, leveraging purchasing power tends to be a **price-focused** strategy. As shown above with the rebates, this general approach is not as effective as managing the **mix of drugs** effectively – which smaller states appear to be equally positioned to do as larger states.

- **States with no MCO involvement in Medicaid drug purchasing experienced higher net costs per prescription**. Enlisting MCOs to manage the pharmacy benefit is clearly yielding favorable net costs per prescription. During 2014, ten states engaged in no MCO contracting and another six states used a pharmacy carve-out model within their capitated MCO program. Across these 16 states where 100% of Medicaid drugs were paid in the Medicaid fee-for-service setting, net costs per prescription were $45.80, 22.5% above the USA average of $37.37 and 27% above the net cost across the 34 states with at least some MCO-paid Medicaid prescriptions ($36.08).

Generics comprised 77.0% of Medicaid prescriptions across the 16 states with no MCO-paid drugs, versus 81.3% in the 34 states (plus the District of Columbia) using MCOs to some degree.[2]

- **States with MCO involvement that allow MCOs to have PDL latitude experienced lower net costs per prescription than Texas and the national average.** During FFY2014, collective net costs in the 30 states (plus the District of Columbia) where MCOs have PDL latitude were 10% below the net costs in the four states where the MCOs must work within a uniform PDL.

- **The four states requiring Medicaid MCOs to utilize uniform PDLs were collectively above the national average in net cost per prescription.** Florida, Kansas, Texas and West Virginia require MCOs to utilize a uniform statewide PDL. Average net costs per prescription across these states during FFY2014 were $39.26, 5% above the USA total and 20% above the average net per prescription cost across the 17 states in the "top third" in terms of the generic dispensing rate.

C. Savings Estimates

While Texas' net Medicaid costs per prescription were near the national average during 2014, the State can achieve significant savings by allowing MCOs to more fully manage Medicaid pharmacy costs. Texas ranks ninth in the nation in the percentage of Medicaid prescriptions paid by MCOs, and is thus well-positioned to achieve generic utilization rates and net cost per prescription outcomes in line with the nation's top-performing states. Three states (Kentucky, Michigan and Rhode Island) with very high Medicaid MCO involvement and where PDL latitude exists achieved net costs per prescription more than $10 below Texas during FFY 2014, for example.

With Texas ranking 45th in the nation in the Medicaid generic dispensing rate, it is clear from the aggregate comparative analyses with other states that the Texas health plans' ability to manage the mix of drugs has been significantly constrained. Given that many of Texas' MCOs serve Medicaid populations in other states where they have been able to achieve significantly more favorable net cost outcomes (as will be conveyed in Section IV), Texas' improvement opportunity appears to be dependent on its policymaking. To facilitate optimal net costs, MCO latitude to manage drug mix needs to be on a par with what occurs in most other states. This requires removal of Texas' current uniform PDL policy and related drug mix management constraints (e.g., a general disallowance of step therapy).

In terms of the level of savings that is achievable, Exhibit 4 presents four savings scenarios. These figures estimate that by removing barriers to management of the mix of drugs prescribed in Texas' Medicaid program, annual Medicaid savings of $119 million to $392 million would occur. The top row of Exhibit 4 estimates savings based on the difference between Texas' FFY 2014 net cost per prescription and the collective average costs across the 17 states with the lowest net costs. The per-prescription difference of $6.79 is multiplied by Texas' prescription volume (35,150,055) to yield the total annual Medicaid savings of approximately $240 million. The second row assumes that Texas will only achieve

[2] The value of using the MCO carve-in approach was documented in detail in our April 2015 report, "Comparison of Medicaid Pharmacy Costs and Usage in Carve-In Versus Carve-Out States," sponsored by America's Health Insurance Plans (AHIP).

half this level of cost reduction. The third row estimates the savings if Texas reaches the same cost levels occurring in Michigan, another large state with high Medicaid MCO penetration but where the health plans had wide PDL latitude during FFY 2014. This per-prescription cost difference of $11.16 translates to a $392 million annual savings.

Texas is well-positioned to achieve these statewide Medicaid reductions in cost per prescription given the large proportion of Medicaid prescriptions paid by Texas Medicaid MCOs (82.5% during FFY2014).

Exhibit 4. Texas Medicaid Savings Estimates Based on Aggregate Net Cost Per Prescription Analyses

Cost Reduction Scenario (Texas net cost per prescription averaged $36.21 during FFY2014)	Net Cost Per Prescription In This Scenario	Total Annual Medicaid Savings (Federal and State Funds)	State Fund Savings	Premium Tax Adjusted State Fund Savings
Texas Reaches Same Net Cost Per Rx as Occurred Across Top Third of States	$29.42	$238,750,554	$98,627,854	$94,449,719
Texas Moves Halfway to Net Cost of "Top Third of States" in Prior Row	$32.82	$119,375,277	$49,313,927	$47,224,860
Texas Reaches Same Net Cost Per Rx as Michigan	$25.05	$392,000,000	$161,935,200	$155,075,200
Texas Moves Halfway to Michigan's Net Cost	$30.63	$196,000,000	$80,967,600	$77,537,600
Average of Above Four Scenarios	**$29.48**	**$236,531,458**	**$97,711,145**	**$93,571,845**

The right-hand columns of Exhibit 4 shows the state fund savings that correspond with each scenario. The federal match rate in Texas is currently 58.69%. State fund savings are therefore estimated to be 41.31% of total Medicaid savings. The state fund savings figures range from $49.3 million to $161.9 million.[3] Another dynamic in Texas that needs to be factored in is the State's Medicaid MCO premium tax, which draws in additional Federal revenues and represents 1.75% of the base payment. The State Fund savings from PDL latitude remove, in the last column of Exhibit 4, the premium tax revenue that will be foregone due to the savings achieved.

Taking a straight average of the four scenarios in the right-hand column, ***the uniform PDL is costing Texas taxpayers $93.6 million per year and $256,361 per day. Thus, for every four days that the uniform PDL policy remains in effect, we estimate that over $1 million in excess costs are borne by Texas' taxpayers.***

[3] The net savings from a policy change to PDL latitude will achieve large savings under any reasonable scenario. The multiple scenarios shown in Exhibit 4 exist because the savings level cannot be precisely pinpointed in advance. The level of the MCO capitation rate adjustments for prescription drugs will have to be estimated during the initial year of the policy change. The savings estimate calculated from averaging the four scenarios can be used as a reasonable estimate for this premium calculation for the initial year. Due to the real-time nature of pharmacy claims and the likelihood that the MCOs will be able to achieve their net cost impacts fairly quickly, capitation rate-setting based on direct experience within the PDL latitude policy will be able to occur from the second year of implementation forward.

III. Therapeutic Class Analyses

The prior section focused on statistics across all Medicaid prescriptions in each state. In this section, we conduct an array of "drill-down" analyses at the therapeutic class level (e.g., contraceptives, ophthalmic anti-infectives, vitamin and mineral combinations, laxatives). We examined the cost per prescription, the generic percentage rate, Texas' net cost per prescription as a percentage of other states, and the potential for savings in Texas' top 20 therapeutic classes where the largest cost savings opportunities appear to exist.

A. Analytical Approach and Data Sources

The Menges Group mapped each NDC code, a unique code assigned by the FDA as a product identifier for drugs, to therapeutic classes during 2015, relying primarily on publicly reported information.

We continue to focus on net (post-rebate) costs per prescription. At the therapeutic class level, these figures need to be estimated because Medicaid drug rebates are published only at the aggregate level and are not available at the individual drug level (or therapeutic class level). To compute the post-rebate amount reimbursed, we used FY2014 aggregate rebate data (the most recent year in which rebate data were publically available) as compiled in the CMS-64 reports.

Because the Affordable Care Act mandates at least a 13% rebate on generic drugs, and generics rarely command higher rebates than the statutory minimum, we are able to closely estimate average percentage brand rebate levels in each state.[4] Knowing what the total rebates were in each state and assuming that generic rebates remained at 13%, we are able to closely estimate brand percentage rebates. Exhibit 5 conveys the average derived brand rebates in Texas, and in three states where, like Texas, a large portion of Medicaid prescriptions are paid by Medicaid MCOs but where, unlike Texas, wide PDL latitude exists. These selected states included Michigan, New Mexico, and Kentucky. Figures were also tabulated for the United States overall.

Exhibit 5. Average Rebates for Medicaid and Brand Drugs, CY2014

State	% Brand Rebate	% Generic Rebate
Texas	67%	13%
Michigan	70%	13%
Kentucky	64%	13%
New Mexico	70%	13%
USA Total	59%	13%

[4] Note that by applying the 13% generic rebate to the full initial pharmacy payment, which includes both the ingredient cost and the dispensing fee, we are factoring in an assumption that some negotiated rebates are occurring on generics above the 13% statutory minimum.

Using the CMS State Drug Utilization data files, we tabulated the CY2014 pre-rebate costs and prescriptions within each therapeutic class for brand and generic drugs in each state. The rebate percentages in Exhibit 5 were then applied to the pre-rebate costs so that an estimate of post-rebate costs per prescription could be calculated in each state and for each therapeutic class.

An estimated value for Texas' potential annual savings in each therapeutic class was calculated by multiplying the cost per prescription differences in each class (between Texas and each comparison state) by Texas' corresponding 2014 Medicaid prescription volume in each class. From this information, we were able to determine which therapeutic classes offered the greatest opportunity for savings. Through these calculations, we identified the top 20 therapeutic classes in Texas where the most significant total dollar cost savings opportunities appear to exist through strengthened management of drug mix.

B. Data Findings

As conveyed in Exhibits 6 and 7, Texas' costs per prescription are *far* above the identified well-managed comparison states that utilize Medicaid managed care – as well as the national average – in many therapeutic classes. Exhibit 6 presents net costs per prescription and Exhibit 7 shows Texas' average cost in each therapeutic class as a percentage of each comparison state (and the USA overall). The Exhibit 7 figures show that it is not uncommon for Texas' estimated net costs per prescription to be more than double the corresponding comparison states' figures. For example, within the proton pump inhibitor therapeutic class, Texas' estimated net cost per prescription was *four to five times* higher than the cost in other states.

The aggregate analyses in Section III demonstrate that the generic percent of prescriptions in comparison with the other states is highly correlated with the achievement of optimal net costs per prescription. Our analyses in this section demonstrate this dynamic at the therapeutic class level, as conveyed in Exhibit 8. In many of the therapeutic classes identified as representing large-scale savings opportunities in Texas, the proportion of prescriptions filled with a generic in Texas is dozens of percentage points below the comparison states. Examples of this are proton pump inhibitors, ophthalmic anti-infectives, contraceptives, and purine nucleosides.

Exhibit 8 also shows the importance of managing drug mix effectively within generics and within brands. There are several therapeutic classes where significant cost-savings opportunities appear to exist in Texas where a large percentage of generics is being prescribed (e.g., vitamin and mineral combinations, upper respiratory combinations, cephalosporins, and otic anesthetics). For example, even though Texas has a comparable large generic use to the comparison states for vitamin and mineral combinations, Texas' costs for this therapeutic class are seven to ten times higher than these other states, showing that there is opportunity for additional savings by increased management within generics.

Exhibit 6: Texas Net Cost Per Prescription (Post-Rebate) Comparison with States with Wide PDL Latitude, Within 20 Therapeutic Classes Where Largest Savings Opportunity Appears to Exists, CY2014

Clinical Area	Texas Medicaid Scripts, CY 2014	Estimated Per Prescription (Post-Rebate)				
Therapeutic Class - 3rd Tier		Texas	Kentucky	Michigan	New Mexico	USA Total
Proton pump inhibitors	658,972	$63	$16	$13	$14	$22
Third generation cephalosporins	585,490	$83	$42	$35	$35	$56
Antiadrenergic agents, centrally acting	580,696	$46	$37	$48	$7	$34
Vitamin and mineral combinations	192,724	$51	$5	$4	$7	$18
Topical acne agents	137,656	$109	$49	$38	$39	$71
Upper respiratory combinations	1,188,691	$22	$9	$5	$14	$18
Selective serotonin reuptake inhibitors	770,131	$17	$8	$6	$6	$11
Laxatives	277,018	$30	$16	$13	$13	$19
Dibenzazepine anticonvulsants	210,762	$79	$55	$51	$46	$66
Triazine anticonvulsants	89,775	$60	$30	$17	$14	$33
Heparins	20,906	$312	$134	$277	$178	$207
Fatty acid derivative anticonvulsants	201,505	$86	$69	$74	$68	$76
Ophthalmic anti-infectives	272,068	$24	$10	$10	$11	$17
Carbonic anhydrase inhibitor anticonvulsants	134,318	$36	$22	$16	$12	$23
Second generation cephalosporins	42,336	$86	$33	$32	$34	$45
Contraceptives	225,847	$44	$20	$17	$23	$37
Purine nucleosides	65,061	$70	$39	$23	$36	$49
Antidiuretic hormones	40,899	$117	$73	$67	$94	$84
Pyrrolidine anticonvulsants	141,132	$51	$40	$30	$33	$42
Otic anesthetics	131,865	$22	$8	$8	$10	$13

Exhibit 7: Texas' Net Cost Per Prescription as a Percentage of the Comparison States for the Top 20 Therapeutic Classes, CY2014

Clinical Area	Texas Medicaid Scripts, CY 2014	Texas' 2014 Net Cost/Rx as % of Comparison State			
Therapeutic Class - 3rd Tier		Kentucky	Michigan	New Mexico	USA Total
Proton pump inhibitors	658,972	402%	506%	463%	152%
Third generation cephalosporins	585,490	198%	235%	239%	306%
Antiadrenergic agents, centrally acting	580,696	124%	96%	618%	370%
Vitamin and mineral combinations	192,724	996%	1125%	759%	156%
Topical acne agents	137,656	221%	284%	283%	283%
Upper respiratory combinations	1,188,691	254%	429%	160%	549%
Selective serotonin reuptake inhibitors	770,131	218%	277%	293%	278%
Laxatives	277,018	182%	224%	222%	263%
Dibenzazepine anticonvulsants	210,762	145%	154%	172%	586%
Triazine anticonvulsants	89,775	200%	353%	444%	226%
Heparins	20,906	233%	113%	175%	298%
Fatty acid derivative anticonvulsants	201,505	124%	116%	126%	910%
Ophthalmic anti-infectives	272,068	238%	248%	220%	350%
Carbonic anhydrase inhibitor anticonvulsants	134,318	164%	227%	309%	267%
Second generation cephalosporins	42,336	262%	265%	251%	210%
Contraceptives	225,847	224%	261%	190%	646%
Purine nucleosides	65,061	180%	311%	195%	336%
Antidiuretic hormones	40,899	161%	175%	125%	354%
Pyrrolidine anticonvulsants	141,132	127%	174%	155%	561%
Otic anesthetics	131,865	261%	286%	209%	258%

Exhibit 8: Generic Percent of Prescriptions within Texas, Comparison States, and USA Overall, CY2014

Clinical Area	Texas Medicaid Scripts, CY 2014	Generic Percent of Prescription				
Therapeutic Class - 3rd Tier		Texas	Kentucky	Michigan	New Mexico	USA Total
Proton pump inhibitors	658,972	21%	89%	93%	97%	85%
Third generation cephalosporins	585,490	96%	98%	100%	98%	98%
Antiadrenergic agents, centrally acting	580,696	62%	91%	68%	99%	79%
Vitamin and mineral combinations	192,724	100%	86%	90%	100%	96%
Topical acne agents	137,656	31%	50%	39%	52%	45%
Upper respiratory combinations	1,188,691	99%	96%	99%	99%	99%
Selective serotonin reuptake inhibitors	770,131	74%	90%	89%	80%	86%
Laxatives	277,018	97%	94%	93%	93%	92%
Dibenzazepine anticonvulsants	210,762	80%	92%	87%	88%	83%
Triazine anticonvulsants	89,775	85%	97%	95%	99%	95%
Heparins	20,906	81%	69%	59%	87%	66%
Fatty acid derivative anticonvulsants	201,505	88%	89%	91%	90%	87%
Ophthalmic anti-infectives	272,068	50%	96%	95%	98%	84%
Carbonic anhydrase inhibitor anticonvulsants	134,318	91%	99%	97%	99%	97%
Second generation cephalosporins	42,336	97%	99%	90%	97%	96%
Contraceptives	225,847	34%	66%	70%	58%	54%
Purine nucleosides	65,061	58%	99%	99%	98%	95%
Antidiuretic hormones	40,899	95%	99%	98%	97%	98%
Pyrrolidine anticonvulsants	141,132	90%	98%	96%	98%	95%
Otic anesthetics	131,865	100%	100%	100%	100%	100%

C. Savings Estimates

Significant cost savings opportunities exist in Texas by focusing on changing the current drug mix in the therapeutic classes identified in this section.

Exhibit 9 quantifies Texas' potential annual savings in each of the 20 identified therapeutic classes, based on the difference in estimated net costs per prescription in each class and each state. Significant annual savings to Texas' Medicaid program are available within each of the 20 classes shown, ranging from approximately a $30 million savings for proton pump inhibitors to $1 million - $2 million in several of the classes towards the bottom of the table. Note that while the classes are ordered by the level of savings Texas can achieve relative to the USA average cost per prescription, the state comparisons demonstrate that savings are available far in excess of merely reaching the USA average cost, if drug mix is managed optimally.

The figures in Exhibit 9 also show that Texas' overall savings opportunities involve managing drug mix differently across a wide range of therapeutic classes and drugs. This will require a fundamental change in the existing PDL approach and content, by allowing MCOs to fully administer the prescription benefit including PDL, rather than modifications to the existing PDL in a few therapeutic classes.

Exhibit 9: Texas' Potential Annual Savings at Other States' Costs Per Prescription for the Top 20 Therapeutic Classes

Clinical Area	Texas Medicaid Scripts, CY 2014	Annual Medicaid Savings if Texas Cost/Rx Were at Comparison State's Level			
Therapeutic Class - 3rd Tier		Kentucky	Michigan	New Mexico	USA Total
Proton pump inhibitors	658,972	$31,441,129	$33,564,611	$32,793,855	$27,447,678
Third generation cephalosporins	585,490	$24,034,652	$27,913,462	$28,238,798	$15,862,648
Antiadrenergic agents, centrally acting	580,696	$5,097,618	-$1,046,047	$22,362,584	$7,214,874
Vitamin and mineral combinations	192,724	$8,767,908	$8,880,257	$8,461,657	$6,242,083
Topical acne agents	137,656	$8,247,878	$9,744,823	$9,714,143	$5,317,431
Upper respiratory combinations	1,188,691	$15,814,076	$19,999,541	$9,750,510	$4,748,164
Selective serotonin reuptake inhibitors	770,131	$6,950,862	$8,220,119	$8,468,956	$4,615,037
Laxatives	277,018	$3,718,431	$4,580,503	$4,554,814	$3,142,512
Dibenzazepine anticonvulsants	210,762	$5,145,684	$5,860,288	$6,956,920	$2,844,315
Triazine anticonvulsants	89,775	$2,694,430	$3,857,509	$4,167,055	$2,385,156
Heparins	20,906	$3,715,674	$728,247	$2,788,986	$2,188,881
Fatty acid derivative anticonvulsants	201,505	$3,368,858	$2,373,484	$3,546,309	$1,902,061
Ophthalmic anti-infectives	272,068	$3,766,689	$3,871,065	$3,532,770	$1,855,326
Carbonic anhydrase inhibitor anticonvulsants	134,318	$1,914,288	$2,738,632	$3,310,736	$1,830,526
Second generation cephalosporins	42,336	$2,237,255	$2,257,383	$2,178,569	$1,727,071
Contraceptives	225,847	$5,494,101	$6,130,766	$4,704,847	$1,536,575
Purine nucleosides	65,061	$2,030,977	$3,096,801	$2,225,007	$1,357,437
Antidiuretic hormones	40,899	$1,826,513	$2,054,322	$946,117	$1,355,858
Pyrrolidine anticonvulsants	141,132	$1,539,042	$3,069,392	$2,582,272	$1,291,015
Otic anesthetics	131,865	$1,748,859	$1,845,437	$1,476,745	$1,100,240
Total Across Above 20 Therapeutic Classes	**5,967,852**	**$139,554,924**	**$149,740,597**	**$162,761,651**	**$95,964,890**

IV. Information from Texas' Medicaid Health Plans

A. Introduction

The analyses conducted in the previous sections were based entirely on data files compiled by CMS and made publicly available. While these analyses appear to compellingly demonstrate the value of allowing MCOs to develop and administer their own PDLs (PDL latitude) – rather than using Texas' current uniform PDL – it is important to obtain both data and insights from Texas' Medicaid MCOs on this issue as well. The health plans have a direct, "street level" appreciation for what is working optimally in their partnership with HHSC and where mutually beneficial improvements can occur. With regard to PDL latitude, many of Texas' Medicaid health plans also have the significant advantage of operating Medicaid lines of business in other states where PDL latitude exists. They can therefore provide comparison data and programmatic information contrasting their cost experience with the uniform PDL in Texas with their experience where PDL latitude exists (which collectively exists across many states). In addition, most of the Medicaid MCOs that only operate within Texas have contracted with Navitus as their pharmacy benefits management (PBM) partner, and information was also therefore sought from (and provided by) Navitus about its experience in Texas versus states with PDL latitude.

The Menges Group sought comparative cost data from the Texas MCOs conveying per member per month (PMPM) costs and other statistics between Texas and other states they serve, as well as programmatic data regarding the functioning of the existing uniform PDL relative to what occurs in other markets where PDL latitude exists (and what would occur in Texas under a policy change to a PDL latitude model).

B. Financial and Usage Comparison Information

Several of the Texas MCOs serving other states provided data in a consistent requested format comparing their PMPM costs and generic usage by eligibility category between their Texas Medicaid business and other states in which they operate Medicaid lines of business. Pharmacy cost data were provided for six comparison states, seeking to compare Texas' PMPM costs within a given eligibility group with similar information from another state where PDL latitude exists. Once the data were obtained, some of the comparison information was dropped from the analysis because the comparison state had significant differences in the capitated benefits package (e.g., behavioral health medicine carve-out) that distorted the comparisons to Texas' performance statistics. As summarized in Exhibit 10, 17 appropriate comparison points of information (full PMPM cost comparison for same eligibility group) were retained, and these results were averaged together to ensure the anonymity of the reporting plans and their reported data. The results of these comparisons, presented in Exhibit 10, are entirely consistent with the analyses in the prior two sections. In every one of the 17 comparison situations, the Medicaid MCOs have achieved far lower PMPM pharmacy costs in their other Medicaid states than in Texas, as well as far higher generic usage (as a percentage of all prescriptions). These two findings are closely related, given the importance of shifting the drug mix towards generics in achieving optimal costs per prescription.

Exhibit 10. Comparisons of Medicaid MCOs' Texas Pharmacy Costs and Usage with Other States in Which They Operate, January 2014 – June 2015

Eligibility Category	Number of Comparison Points	Texas PMPM Rx Cost as % of Comparison State Cost	Generics as % of Prescriptions, Texas	Generics as % of Prescriptions, Comparison State
TANF Child	4	158%	77.1%	87.5%
TANF Adult	6	149%	76.0%	89.5%
SSI Child	3	174%	66.4%	84.2%
SSI Adult	4	147%	78.5%	86.4%
Total	**17**	**155%**	**75.2%**	**87.4%**
Range of Values		**114% to 213%**	**66.0% to 79.3%**	**82.6% to 90.7%**

A weakness in the above analyses is that the cost comparisons were made on a pre-rebate basis (since the MCOs do not collect the statutory ACA rebates directly, they cannot precisely tabulate the State's net post-rebate costs for their prescriptions). Nonetheless, the relatively high rebates that occur in Texas cannot offset an average 55 percent unfavorable differential in the Texas pre-rebate PMPM costs. The information in Exhibit 10 further validates the concern that the health plans are significantly constrained by the uniform PDL in Texas from achieving the cost-effectiveness results that they are clearly able to achieve when PDL latitude is made available by state policymakers.

C. Concerns With Uniform PDL and Related Processes

The programmatic issues raised by the MCOs fell into two categories – general concerns with the Texas Medicaid/CHIP Vendor Drug Program's (VDP) processes, and specific concerns with the PDL content. The concerns with the VDP's process encompassed an array of areas. Many of these situations inhibit quality of care; many others "only" result in excess costs.

Responsiveness to Needed Changes: Numerous concerns were raised with the speed at which the VDP modifies the PDL. The Pharmacy and Therapeutics (P&T) Committee and Drug Utilization Review (DUR) Board meetings typically occur quarterly, and this somewhat arbitrary schedule does not keep pace with the stream of PDL issues which warrant attention.[5] Examples of situations where VDP's processes are not sufficiently nimble are conveyed below.

- It took more than a year for the new Hepatitis C medications to be added to the formulary. The Texas Medicaid population was essentially denied access to a curative therapy.

- Typically, it is only during the first 6 months of a new generic launch that the brand is lower cost. After this, the generic can suddenly become a dramatically lower cost alternative. The fact that

[5] These two committees are being combined into a single body effective March 2016 through the provisions of Texas Senate Bill 200, 84th Legislative Session.

VDP only updates their PDL twice annually means that they are unable to react quickly to these types of market shifts and are at risk of losing potential cost savings.

- The uniform PDL is not always in line or up-to-date with the clinical evidence and national guidelines available. Suprax is listed as a preferred antibiotic even though it is clinically suggested and accepted to be a third line antibiotic treatment. This creates greater opportunity for antibiotic resistance patterns to occur in the Medicaid population. Edits were suggested for Suprax in 2013 by MCOs; however, Suprax remains on the formulary. Exhibit 11 conveys several specific situations where the PDL is not consistent with clinical best practices.

Exhibit 11. Examples of Uniform PDL Not Capturing Clinical Best Practices

Drug Category	Drug Name	Issue
Antimetic-Antivertigo agents	Granisetron Emend	The National Comprehensive Cancer Network (NCCN) recommends the use of these medications as first line agents in highly emetogenic chemotherapy regimens; however, the formulary does not provide a similar first line agent in these clinical situations.
Antifungals, Oral	Vfend (voriconazole), Sporanox, noxafil	The currently preferred drugs fail to treat highly resistant fungus infections, such as aspergillosis.
Antivirals, topical	Abreva Acyclovir ointment Denavir	In clinical evidence, topical antivirals have a limited role in the treatment of viral infections; however these are preferred in Texas. The national guidelines consider oral antivirals to be the first line therapy.
Bronchodilators	Albuterol syrup	Oral beta agonists have limited efficacy in the treatment of acute asthma attacks and bronchospasms. The inhaled formulation is clinically preferred over the oral beta agonists. However, by including the oral drugs on the formulary, there is inappropriate prescribing occurring.
Cephalosporins – 3rd generation	Suprax	Several bacterial strains have become highly resistant to Suprax, and this drug should be considered a third line antibiotic treatment.
Leukotriene modifiers	Accolate	Montelukast has several advantages (e.g. dosing regimen and side effects) over Accolate.

- The brand drug Amicar was removed from the formulary so only the generic was covered; however, generic aminocapriotic acid is not available from the manufacturer. In a similar example, the manufacturer of Somatuline reformulated all the doses of its medication and issued new NDC codes for the drug. The PDL did not reflect these changes in a timely manner causing a delay in treatment as a result. Both examples resulted in the interruption in treatment of patients' care.

NDC Specific Level Drug Coverage: The current PDL has on occasion covered a specific drug but may not cover all the NDC codes associated with the drug—and changes on the NDC level on the uniform PDL have occurred on a frequent basis. Texas MCOs have encountered situations in which the pharmacy from which a beneficiary is seeking to obtain their medication has ordered the previously covered NDC code of a drug but does not carry the currently covered NDC code. This scenario delays the ability for a beneficiary to fill their prescription and can directly lead to access of care issues. Another example occurred in the past year when an NDC was removed from the formulary resulting in no inhaled corticosteroid metered dose inhalers being available for the treatment of asthma.

Drug Shortages and Pharmacy Confusion: When MCOs manage their own PDLs, the MCOs are able to work with the pharmacies to make coverage decisions quickly and easily to ensure members are able to fill their prescription needs. In the current uniform PDL, there are several drugs in which the brand drug is covered and the generic form of the drug is not covered. Frequently, pharmacies switch their inventory to generic drugs when they are available. There have been occurrences when a brand product is not available and the generic drug is not allowed to be substituted. Further, pharmacies are often confused when a brand is preferred over the generic drug as they try to automatically process generic prescriptions, which are typically the preferred drug in other insurance markets. There have been instances when pharmacies have informed the providers that a generic is being denied coverage and the provider has to go through an appeal process with the health plan, further delaying access to the drug. Also, because brand drugs are frequently preferred over generic drugs on the current uniform PDL, the physician must write "Brand Name Medically Necessary" on the prescription, causing further confusion because the brand name is not medically preferred (just preferred for Medicaid coverage purposes).

Provider Dissatisfaction with Inability to Prescribe the Clinically Appropriate Drug: As described throughout this section, there have been several occurrences when the clinically appropriate drug is not on Texas' preferred drug list. Providers have expressed their dissatisfaction with not being able to prescribe what is clinically evident to be the best drug to prescribe to the beneficiary---and to not have a means around this. MCOs have experienced providers threatening to stop participating in Medicaid if they are unable to prescribe the clinically appropriate drug.

Transition of Care Issues: The preference of brand name drugs over generic drugs can also impact transitions of care, such as the transition of a patient from inpatient care to ambulatory care. Two specific examples are provided below.

- A hospital routinely prescribes the antibiotic clindamycin for their patients at discharge; however, the hospital pharmacy does not regularly stock the NDCs allowed on the uniform Medicaid PDL. Medicaid beneficiaries being discharged have to seek the appropriate NDC code and pick up the prescription from another pharmacy. This creates an additional burden on the beneficiary and could hinder medication adherence.

- A pediatric patient was hospitalized for a decompensated psychotic episode. Upon discharge, the patient was given a supply of aripiprazole to start at home, and a prescription for aripiprazole was sent electronically to the caregiver's pharmacy of choice. The supply of aripiprazole from the hospital was labeled and the directions for use were on the supply properly. However, the caregiver also went to the pharmacy to pick up the electronically

prescribed drug which was written as Abilify and labeled as Abilify. The caregiver did not recognize (nor should they have been expected to know) that the supply of aripiprazole that they were given from the hospital and the Abilify prescription that they then picked up at the community pharmacy were the same drug. The caregiver gave both the generic aripiprazole and the brand name Abilify to the patient, doubling the daily dose and potentially putting the patient at risk of serotonin syndrome, a serious and possibly life threatening condition. The situation was only noticed because the caregiver called the pharmacy complaining that the patient was experiencing confusion and sweating, and the pharmacist was able to ascertain that the patient was simultaneously taking both aripiprazole and Abilify.

Generic alternatives would be more likely to be available if the Medicaid PDL was more aligned with hospital formularies as well as commercial managed care organizations. This change would significantly decrease the likelihood of scenarios such as that described above from occurring in Texas hospitals.

Disconnectedness to the Provider Community: Many of the above challenges may be related to the fact that the State and VDP are not in constant communication with the provider community as occurs with each Texas MCO. The quote below summarizes this dynamic:

> "The state doesn't have a relationship with the prescribers. Texas MCOs have ongoing interactions with their network physicians and understand what the physicians' prescribing issues and needs are. Our plans have provider services representatives who regularly and proactively meet with the physicians, for example." -- Mary Dale Peterson, MD, MSHCA, President/CEO of Driscoll Children's Health Plan

Specific Cost-Effectiveness Concerns with the Texas PDL. The MCOs provided extensive input on areas where the State's PDL is not functioning optimally. Exhibit 12 presents specific excerpted examples of the information provided.

In many instances, the uniform PDL unnecessarily favors brand name drugs over generic drugs—even when it is clear the rebate may not be high enough to offset the cost-savings of using the generic drug. For example, Nexium, a brand drug and proton pump inhibitor, remains a covered preferred drug. The average cost per 30 day prescription of Nexium is $249.36. The average cost of 30 days of the generic alternatives, omeprazole or pantoprazole, are $18.30 and $15.17, respectively. While the State has likely negotiated significant supplemental rebates for Nexium, it would take a rebate of approximately 94% for Nexium to be equally cost-effective to pantoprazole on a net cost basis.

The uniform PDL frequently lists preferred status for both the brand and generic of a specific drug, creating no differentiation between the drugs. By having a brand name and generic name in preferred status on the formulary, there is no ability to manage cost or encourage providers to prescribe the lower cost alternative, particularly when the products have similar clinical usage. Further, the State has not approved outbound communications by the MCOs to providers educating them on less costly formulary alternatives. This has significantly hindered the cost management ability of MCOs, and provided no corresponding benefits.

Exhibit 12. Examples of Specific Cost-Effectiveness Concerns Raised With Existing PDL

Drug Category	Drug names	Issue
Acne agents, topical	Benzaclin	Separate ingredients are generically available, but brand name product is preferred.
Angiotensin modulators	Benicar, Diovan Benicar-HCT, Exforge, Exforge HCT,Tarka	Therapeutic class has several generics that are not preferred; while brand name products are preferred.
Antibiotics, gastrointestinal	Tindamax	Brand preferred while generic formulation is not preferred.
Anticholinergic, Antihistamine, Dopamine Antagonists	Diclegis	Separate ingredients are available over the counter to purchase, but brand product is preferred. Generic ondansetron is available and more cost effective for nausea and vomiting due to pregnancy.
Triptans	Relpax	Brand products preferred while several generic alternatives are non-preferred.
Antiherpetic	Valtrex	Brand Valtrex is preferred while generic formulation (valacyclovir) is non-preferred
Antivirals, Topical	Abreva, Acyclovir ointment, Denavir	Topical antivirals have a limited role in the treatment of viral infections. Oral antivirals are considered first line therapy and are more cost effective.
Bladder Relaxant Preparations	Toviaz, Vesicare	Brand products preferred while several generic alternatives are non-preferred.
Cephalosporins – 3rd generation	Suprax	Several bacterial strains have become highly resistant to Suprax. Generic cefdinir is available and is more cost effective.
Intranasal, glucocorticoids	Nasonex	Brand Nasonex is available over the counter and several generic alternatives are not preferred.
Intranasal Rhinitis Agents, others	Patanase	Brand Patanase is preferred while its generic formulation is non-preferred.
Ophthalmics, antibiotics – Steroid Combinations	Tobradex	Brand Tobradex is preferred while its generic formulation is non-preferred.
Proton pump inhibitors	Nexium	Brand Nexium is preferred while its generic formulation is non-preferred.
Stimulants	Adderall XR, Focalin XR	Brand products are preferred while its generic formulations are non-preferred.

Topical compounds for already approved drugs is another area of waste cited by the MCOs. Compound pharmacies are mixing multiple products, and the state has no control over the use of these compounded drugs due to a lack of criteria edits. Compounds can cost thousands of dollars per prescription for pain treatment. Solaraze (a nonsteroidal anti-inflammatory drug), diclofenac gels, and Flector are a few examples, and other topical muscle relaxants and pain medications have been used in a multi-drug compound. VDP has been informed of this issue, but no corrective action has yet occurred.

It was also noted that reformulations of older drugs are expensive and do not provide much additional efficacy. An optimal PDL should have strict edits in place, including clinical edits, step edits, and quantity limits on these drugs.

V. Conclusions and Policy Recommendations

This report assessed Texas' current uniform PDL approach in three major ways, and the findings point to the same conclusion:

The uniform PDL approach does not permit optimal management of Texas' Medicaid prescription drug benefit. A policy change is warranted that provides the State's Medicaid MCOs with the PDL latitude and corresponding utilization management processes that have proven to be highly effective in numerous other states.

Texas has implemented a prescription drug carve-in model that places financial responsibility for pharmacy costs with the Medicaid MCOs (through capitated risk), but significantly limits the ability of MCOs to effectively manage the benefit. Because Texas requires MCOs to use the uniform PDL and generally prohibits use of step therapy and other tools commonly used by health plans to manage the benefit, Texas is left in the position of posting "average" Medicaid prescription drug costs (in relation to nationwide experience). The extent to which the Medicaid population is enrolled in MCOs should place Texas among the nation's leaders with regard to the cost-effectiveness of the pharmacy benefit.

Our comparisons and analyses have focused on post-rebate costs, as this represents Medicaid's cost once large prescription drug rebates are appropriately taken into account. We estimate that the recommended policy change to a "PDL latitude model" will yield annual net Medicaid savings of $236 million, including annual State General Revenue savings of $98 million.

Texas should implement the proposed policy change as quickly as possible so that savings may be realized. Significant transition time is not needed for MCOs to implement the PDL latitude approach, given that this model is used in nearly all other states and for all other populations these health plans serve. ***For every four days in which the uniform PDL approach remains in effect, Texas' taxpayers collectively will pay over $1 million more than under a switch to a PDL latitude model.*** There are also many programmatic advantages to implementing the recommended policy change, as delineated in Section IV.

Because the two strategies are in conflict with each other, states need to choose between a strategy that maximizes rebates or a strategy that manages drug mix in an optimally cost-effective manner. Maximizing rebates leverages the state's purchasing power to negotiate the largest possible rebates. Managing drug mix cost-effectively steers prescription volume to the lowest net cost drug that is clinically effective. One of the most important findings in this report is that the top third of states in terms of achieving the highest rebates per Medicaid prescription (those focusing primarily on price) are *an entirely different group of states* than the top third of states in terms of highest generic drug use as a percentage of Medicaid prescriptions (those focusing primarily on drug mix). As shown in Exhibit 13, the focus on drug mix is yielding far lower net costs per prescription than a focus on rebates.

Exhibit 13. Net Cost Per Prescription Summary

Geographic Area	2014 Net Post Rebate Cost Per Prescription	Texas' Rank Among 51 Medicaid Programs (50 States + DC)
States in Top Third, Percentage of Prescriptions Filled with Generic Drug	$32.72	45
States in Top Third, Rebates Received Per Medicaid Prescription	$43.09	9
Texas	$36.21	22

The figures in Exhibit 13 demonstrate that within its group of states achieving relatively large rebates per prescription, Texas has been successful in also achieving a relatively low net cost per prescription.

However, Texas finds itself in the position of playing the wrong game well. The State needs to focus on optimal management of the *mix* of drugs, and the Medicaid MCOs have resoundingly demonstrated the ability to accomplish that objective when given the opportunity. Conversely, while Texas' Medicaid/CHIP Vendor Drug Program (VDP) has demonstrated an ability to successfully negotiate rebates, Texas sits 45th among state Medicaid programs on the more important metric – steering volume towards generics.[6] Additionally, 21 other states outperform Texas in regards to net cost per prescription drug. The recommended policy change to PDL latitude should, almost immediately upon enactment, yield improved performance outcomes.

State policymakers did the right thing in 2011 when the decision was made to pursue a managed care drug carve-in model. Since the program was implemented in 2012, savings have been achieved without any negative unintended consequences. However, the manner in which the prescription drug carve-in was implemented is not optimal. By restricting the ability of MCOs to manage their own PDLs, the opportunity to achieve more than $1 billion dollars in total Medicaid savings since the 2012 carve-in has been lost. (The lost savings assumption assumes the total annual savings of $230 million identified in this report is applied across the SFY 2012 – 2016 timeframe.) This savings opportunity continues to exist and, as noted above, maintaining the uniform PDL imposes an ever-accumulating burden on Texas' taxpayers.

Texas can take advantage of this savings opportunity by allowing the MCOs to have PDL latitude and removing restrictions on MCOs that inhibit their ability to apply commonly used commercial utilization management principles to the administration of the Medicaid prescription drug benefit.

[6] Managing drug mix optimally also requires steering volume towards lower-cost drugs *within* generics and *within* brands. Medicaid MCOs have demonstrated their capability in these areas as well, as summarized in "Comparison of Medicaid Pharmacy Usage and Costs in Carve-in Versus Carve-Out States," April 2015, available at following link: https://www.themengesgroup.com/upload_file/medicaid_pharmacy_carve-in_final_paper_the_menges_group_april_2015.pdf

Appendix 1. State Medicaid Costs Per Prescription and Related Statistics, FFY2014

State	Cost Per Rx, Initial Payment	Rebate Per Rx	Cost Per Rx Net Payment	Generic Percent of Prescriptions	% of Scripts MCO	% of $$ MCO
Rhode Island	$43.79	$19.57	$24.22	82.7%	77.6%	88.7%
Kentucky	$48.25	$23.34	$24.91	84.5%	90.8%	89.4%
Michigan	$58.30	$33.25	$25.05	82.7%	63.4%	39.1%
New Mexico	$55.29	$29.04	$26.25	82.2%	100.0%	93.0%
Washington	$49.34	$23.06	$26.28	83.8%	57.3%	51.2%
Arizona	$48.13	$21.26	$26.88	85.4%	99.6%	99.0%
Nebraska	$72.49	$44.49	$28.00	82.2%	2.5%	2.7%
Iowa	$62.51	$34.19	$28.32	79.3%	0.0%	0.0%
Oregon	$57.61	$28.57	$29.05	85.0%	73.6%	66.6%
Maryland	$66.21	$36.58	$29.62	80.9%	70.1%	47.1%
Illinois	$61.22	$31.31	$29.91	82.8%	23.1%	22.4%
West Virginia	$58.65	$28.52	$30.13	79.9%	23.6%	19.5%
Ohio	$58.98	$27.03	$31.95	80.8%	71.6%	69.0%
District of Columbia	$61.59	$29.26	$32.33	82.3%	58.6%	48.2%
Georgia	$59.77	$26.62	$33.15	81.8%	51.5%	37.6%
Minnesota	$71.43	$37.77	$33.67	83.3%	72.0%	67.0%
New Jersey	$68.84	$34.81	$34.04	82.0%	91.8%	91.6%
Utah	$67.43	$32.83	$34.60	80.3%	55.1%	42.4%
Wisconsin	$77.65	$42.88	$34.77	77.8%	0.9%	0.7%
Tennessee	$68.19	$33.42	$34.77	81.6%	2.7%	3.7%
Maine	$76.62	$41.66	$34.96	75.0%	0.0%	0.0%
Texas	$79.60	$43.39	$36.21	77.0%	82.1%	73.3%
Idaho	$78.38	$42.04	$36.35	79.5%	0.0%	0.0%
South Carolina	$65.87	$28.72	$37.15	80.6%	76.3%	70.9%
Massachusetts	$74.91	$37.07	$37.84	81.8%	45.9%	48.3%
Wyoming	$85.88	$47.69	$38.19	78.9%	0.0%	0.0%
New York	$71.73	$32.48	$39.25	82.4%	84.7%	85.1%
Delaware	$89.85	$50.58	$39.27	76.5%	6.8%	13.0%
Hawaii	$81.13	$41.70	$39.43	83.8%	99.7%	99.7%
North Dakota	$73.47	$33.89	$39.58	80.3%	15.0%	15.1%
California	$78.15	$37.70	$40.46	81.4%	58.7%	28.0%
Louisiana	$73.14	$32.68	$40.46	78.6%	42.8%	36.5%
Nevada	$69.77	$28.87	$40.90	80.2%	36.9%	23.3%
Pennsylvania	$75.33	$34.42	$40.91	81.5%	92.7%	96.5%
North Carolina	$91.10	$49.56	$41.54	73.2%	0.0%	0.0%
Arkansas	$71.80	$30.03	$41.77	79.6%	0.0%	0.0%
Alabama	$78.29	$36.22	$42.07	77.9%	0.0%	0.0%
Oklahoma	$80.93	$38.00	$42.92	81.0%	0.0%	0.0%
Kansas	$83.66	$40.47	$43.19	77.7%	99.7%	99.7%
Montana	$93.48	$49.51	$43.97	77.9%	0.0%	0.0%
New Hampshire	$89.41	$44.93	$44.48	76.8%	0.0%	0.0%
Florida	$85.08	$40.04	$45.04	80.2%	51.1%	40.5%
Alaska	$79.94	$34.76	$45.19	77.7%	0.0%	0.0%
Virginia	$81.52	$35.74	$45.78	80.1%	74.7%	81.5%
Mississippi	$81.69	$34.83	$46.86	78.8%	50.4%	44.8%
South Dakota	$80.93	$32.81	$48.12	78.2%	0.0%	0.0%
Indiana	$91.46	$41.68	$49.77	77.2%	1.3%	1.2%
Colorado	$85.43	$34.91	$50.52	81.0%	0.0%	0.0%
Missouri	$97.69	$40.55	$57.14	78.5%	0.0%	0.0%
Vermont	$114.71	$56.93	$57.78	72.0%	0.0%	0.0%
Connecticut	$109.80	$49.28	$60.52	73.2%	0.0%	0.0%
USA TOTAL	**$72.40**	**$35.09**	**$37.32**	**80.7%**	**55.2%**	**46.3%**

Appendix 2. State Rankings in Medicaid Costs Per Prescription and Related Statistics, FFY2014

State	Rank, Initial Cost/Rx (lowest cost is #1)	Rank, Rebates Per Rx (highest rebate is #1)	Rank, Net Cost Per Rx (lowest cost is #1)	Rank, Generic % of Scripts (highest % is #1)	Rank, MCO % of Scripts (highest % is #1)	State Size Rank (most Medicaid prescriptions is #1)
Rhode Island	1	51	1	9	10	37
Kentucky	3	48	2	3	7	11
Michigan	7	33	3	8	17	7
New Mexico	5	41	4	13	1	33
Washington	4	49	5	5	20	23
Arizona	2	50	6	1	4	12
Nebraska	23	8	7	12	33	41
Iowa	13	30	8	33	36	32
Oregon	6	44	9	2	13	27
Maryland	15	22	10	22	16	17
Illinois	11	38	11	7	29	8
West Virginia	8	45	12	30	28	25
Ohio	9	46	13	23	15	4
District of Columbia	12	40	14	11	19	43
Georgia	10	47	15	16	22	10
Minnesota	20	19	16	6	14	15
New Jersey	18	27	17	14	6	13
Utah	16	34	18	26	21	38
Wisconsin	29	10	19	41	35	20
Tennessee	17	32	20	17	32	16
Maine	28	14	21	48	36	39
Texas	33	9	22	45	9	3
Idaho	32	11	23	32	36	44
South Carolina	14	43	24	24	11	28
Massachusetts	26	21	25	15	25	14
Wyoming	43	6	26	34	36	51
New York	21	37	27	10	8	1
Delaware	45	2	28	47	31	42
Hawaii	37	12	29	4	2	40
North Dakota	25	31	30	25	30	50
California	30	20	31	19	18	2
Louisiana	24	36	32	36	26	21
Nevada	19	42	33	27	27	36
Pennsylvania	27	29	34	18	5	6
North Carolina	46	3	35	49	36	9
Arkansas	22	39	36	31	36	34
Alabama	31	23	37	40	36	26
Oklahoma	35	18	38	21	36	30
Kansas	40	16	39	42	3	35
Montana	48	4	40	39	36	47
New Hampshire	44	7	41	46	36	45
Florida	41	17	42	28	23	5
Alaska	34	28	43	43	36	48
Virginia	38	24	44	29	12	22
Mississippi	39	26	45	35	24	31
South Dakota	36	35	46	38	36	49
Indiana	47	13	47	44	34	18
Colorado	42	25	48	20	36	29
Missouri	49	15	49	37	36	19
Vermont	51	1	50	51	36	46
Connecticut	50	5	51	50	36	24