# STATE OF TEXAS
# MEDICAID MANAGED CARE
# RATE SETTING
# PHARMACY CARVE-IN
# STATE FISCAL YEAR 2013

Prepared for:
Texas Health and Human Services Commission

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## I. Introduction

Effective March 1, 2012, the Texas Health and Human Services Commission (HHSC) implemented pharmacy carve-in for all its Medicaid and CHIP managed care programs. Prior to that date the Managed Care Organizations (MCOs) were not financially responsible for the provision of outpatient prescription drug services under the programs. Those services had been carved out and remained the financial responsibility of HHSC directly, provided under the agency's Vendor Drug Program (VDP). Effective with this change, the premium amount paid to the MCOs included provision for prescription drug services and the MCO were financially responsible for those services.

Rudd and Wisdom, Inc. has been retained by HHSC to develop the pharmacy carve-in premium rates for the period fiscal year 2013 (FY2013, September 1, 2012 through August 31, 2013) for those MCOs participating in the Texas Medicaid and CHIP managed care programs. This report presents the rating methodology and assumptions used in developing the pharmacy carve-in premium rates.

Rudd and Wisdom has provided actuarial services to the Texas Medicaid program for over 25 years. We have participated in the state's managed care rating process since its inception in 1993. This year, as in previous years, we have worked closely with HHSC in developing the premium rates documented in this report.

Rudd and Wisdom has relied on the following data sources as provided by HHSC, its subcontractors, participating MCOs and their Pharmacy Benefit Managers (PBMs):

- Monthly detailed enrollment files for the period September 2007 through March 2012. These files (provided by HHSC) include identification information, health plan code, ZIP Code, risk group and date of birth for all Medicaid and CHIP members.
- Projected monthly enrollment by program, service area and risk group for FY2013. These projections were prepared by HHSC System Forecasting staff.
- Monthly pharmacy claim files for the period September 2007 through March 2012 provided by HHSC and its subcontractor. These files included detailed claims information on all Medicaid and CHIP pharmacy claims paid during the applicable month.
- Summary pharmacy claim reports provided by HHSC and its subcontractor which included monthly paid claim amounts. These reports were used to confirm that all pharmacy claims and payments were included in our analysis.
- Pharmacy claim reports provided by the MCOs which include monthly incurred by program, service area and risk group for the period September 2007 through August 2011. These reports were used to confirm that all pharmacy claims were included in our analysis.
- Information from HHSC regarding recent changes in covered prescription drug services and pharmacy reimbursement under the VDP.
- Information from HHSC regarding anticipated future changes in pharmacy reimbursement under the VDP.

- Information from MCOs regarding administrative cost, pharmacy reimbursement and other provisions included in their PBM contracts.
- Information from HHSC, their subcontractor, several MCOs and their PBMs regarding the anticipated impact of pharmacy carve-in on prescription drug utilization and cost.

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

## II. Overview of the Rate Setting Methodology

The actuarial model used to derive the FY2013 (the rating period) MCO pharmacy carve-in premium rates relies primarily on VDP claims experience. The historical claims experience for each program, service area and risk group was analyzed and estimates for the base period (March 1, 2011 through February 29, 2012) were developed. These estimates were then projected forward to the rating period using assumed trend rates. Additional adjustments were made to the historical experience to reflect programmatic changes in covered services, member cost sharing and pharmacy reimbursement. Administrative expenses, risk margin and premium tax were added to the claims component in order to project the total rating period cost under the MCOs. These projected total cost rates were then used to produce a set of community rates for each program and service area.

The Medicaid and CHIP managed care programs included in this analysis are as follows:

- STAR
- STAR+PLUS
- STAR Health
- CHIP
- CHIP Perinatal

The managed care service areas included in the analysis were as follows:

- Bexar County Service Area– STAR, STAR+PLUS and CHIP
- Dallas County Service Area – STAR, STAR+PLUS and CHIP
- El Paso County Service Area – STAR, STAR+PLUS and CHIP
- Harris County Service Area – STAR, STAR+PLUS and CHIP
- Hidalgo County Service Area – STAR and STAR+PLUS
- Jefferson County Service Area – STAR, STAR+PLUS and CHIP
- Lubbock County Service Area – STAR, STAR+PLUS and CHIP
- Nueces County Service Area – STAR, STAR+PLUS and CHIP
- Tarrant County Service Area – STAR, STAR+PLUS and CHIP
- Travis County Service Area – STAR, STAR+PLUS and CHIP
- MRSA Central Service Area – STAR only
- MRSA Northeast Service Area – STAR only
- MRSA West Service Area – STAR only
- EPO Service Area - CHIP only

The risk groups included in the analysis are as follows:

<u>STAR Program</u>

- TANF Children Over Age One Year
- TANF Children Under Age One Year
- TANF Adults
- Pregnant Women
- Newborns
- Expansion Children Over Age One Year

- Expansion Children Under Age One Year
- Federal Mandate Children
- Disabled and Blind (MRSA service areas only)

STAR+PLUS Program

- Medicaid Only – Other Community Care (OCC)
- Medicaid Only – Community-based Alternatives (CBA)

CHIP Program

- Under Age 1
- Ages 1 through 5
- Ages 6 through 14
- Ages 15 through 18

CHIP Perinatal Program

- Perinate Under 185% FPL
- Perinate Between 185% and 200% FPL
- Newborns Under 185% FPL
- Newborns Between 185% and 200% FPL

The STAR Health program is a statewide program for foster care clients with no separately-rated service areas or risk groups.

After accumulating all of the information to be used in the rate setting process, a comparison of the various sources of claims data was performed to check for consistency. We compared (i) the detailed claim files provided by VDP, (ii) summary paid claims reports provided by HHSC and (iii) claim lag reports provided by the MCOs. There was satisfactory consistency between the three claims data sources.

We projected the rating period cost for each program, service area and risk group by estimating their base period average per-capita claims cost and then applying trend and other adjustment factors (described in Section III below). We added a reasonable provision for administrative expenses, risk margin and premium tax.

Effective September 1, 2011, several of the existing STAR and STAR+PLUS regions experienced an expansion in their service areas. Our rating analysis included the enrollment and claims experience for those clients residing in the expansion counties and expected to move to managed care. In the STAR program, the expansion area clients included in the analysis were those clients residing in the expansion counties and enrolled in PCCM. In the STAR+PLUS program, expansion area clients were assumed to come from both PCCM and FFS. An adjustment was made to the anticipated STAR+PLUS enrollment for the expansion counties to recognize that SSI children are much less likely to voluntarily enroll in STAR+PLUS as compared to their participation rates in PCCM and STAR.

Effective March 1, 2012, several new service areas were added to STAR (Hidalgo, Jefferson and the three MRSA areas) and STAR+PLUS (El Paso, Hidalgo, Jefferson and Lubbock). As discussed above for expansion counties, the rating analysis included the enrollment and claims experience for those clients residing in the new service areas and expected to move to managed care. In the STAR program, the new service area clients included in the analysis were those clients residing in the new service area counties and enrolled in PCCM. In the STAR+PLUS program, new service area clients were assumed to come from STAR (in those areas served by STAR), PCCM and FFS. An adjustment was made to the anticipated STAR+PLUS enrollment for the expansion counties to recognize that SSI children are less likely to voluntarily enroll in STAR+PLUS as compared to PCCM and STAR.

HHSC has utilized a community rating methodology in setting the initial pharmacy carve-in premium rates. The premium rates vary by program, service area and risk group but are the same for each MCO in a service area. Attachment 2 presents the summary community rating exhibit for each program and service area along with a description of the analysis.

III. Adjustment Factors

This section contains a description of the adjustment factors used in the FY2013 (rating period) pharmacy carve-in premium rate setting process.

***Trend Factors***

The rating methodology uses assumed trend factors to adjust the base period (March 1, 2011 through February 29, 2012) claims cost to the rating period. The cost trend factors used in this analysis are a combination of utilization and inflation components. The trend rate assumptions were developed by the actuary based on an analysis of recent VDP experience under the various Medicaid and CHIP programs. The trend rate assumption varied by program and risk group but was the same for all service areas.

The trend analysis included a review of MCO claims experience data paid through March 31, 2012. Based on this information, estimates of monthly incurred claims were determined through February 2012. The per-capita claims cost and trend experience was reviewed separately by program, service area and risk group. The service area trends were then combined into a statewide average using a weighted average formula with current enrollment as the weights.

The rating period trend assumptions were developed using the following formula:

Rating period trend rate equals one-eighth of the actual FY2009 trend plus two-eighths of the actual FY2010 trend plus three-eighths of the actual FY2011 trend plus two-eighths of the trend for the period September 1, 2011 through February 29, 2012. This formula was used in developing the trend assumptions for all programs and risk groups. The trend assumption for STAR Disabled and Blind clients (in the MRSA service areas only) was developed based on STAR+PLUS Medicaid Only experience. A single trend assumption was developed for the two STAR+PLUS risk groups and a single trend assumption was developed for all CHIP and CHIP Perinatal risk groups.

Attachment 3 is a summary of the cost trend analysis. The chart below presents the assumed annual trend rates for the rating period.

| | Rating Period Trend Assumption |
|---|---|
| STAR | |
| TANF Children Over Age 1 | 1.8 % |
| TANF Children Under Age 1 | 1.8 % |
| TANF Adults | 6.3 % |
| Pregnant Women | 0.0 % |
| Newborns | 3.3 % |
| Expansion Children Over Age 1 | 0.0 % |

| | |
|---|---|
| Expansion Children Under Age 1 | 0.0 % |
| Federal Mandate Children | 1.6 % |
| Disabled and Blind | 5.5 % |
| | |
| <u>STAR+PLUS</u> | |
| | |
| Medicaid Only OCC | 5.5 % |
| Medicaid Only CBA | 5.5 % |
| | |
| <u>STAR Health</u> | |
| | |
| All Clients | 2.4 % |
| | |
| <u>CHIP and CHIP Perinatal</u> | |
| | |
| All Clients | 1.8 % |

***Dispensing Fee Adjustment Factor – September 1, 2011***

Effective September 1, 2011, HHSC reduced the dispensing fee paid to pharmacies under the VDP. The fixed component of the dispensing fee is now $6.50 and the variable component is 1.96%. The experience period claims (those incurred prior to September 1, 2011) were re-processed using this revised dispensing fee formula and resulting adjustment factors developed. This issue impacted all programs, service areas and risk groups. Attachment 4 presents a summary of the dispensing fee adjustment factor analysis.

***Unlimited Prescriptions Adjustment***

Adults (clients age 21 and over) in Medicaid FFS/PCCM have a three prescription per month limit while those adult clients in STAR and STAR+PLUS have unlimited prescriptions. In order to recognize the increase in benefit (and cost) for adult clients moving from FFS/PCCM to managed care, we developed adjustment factors for adult clients in STAR (TANF Adults, Pregnant Women and Disabled and Blind adults) and STAR+PLUS (Medicaid Only adults).

Texas Medicaid Healthcare Partnership (TMHP) conducted an analysis to evaluate the historical cost of unlimited prescriptions for adults in managed care. The intent of TMHP's analysis was to determine what the prescription drug utilization and cost would have been for those adult clients had they been limited to three prescriptions per month. Their analysis considered the order of prescription purchases (in a three prescription limit scenario, the more expensive drugs would likely be among the first three purchased) and the different maximum days supply rules that apply to limited and unlimited prescription clients.

The unlimited prescriptions adjustment applied to adults in STAR and STAR+PLUS expansion counties and new service areas. The adjustment did not impact existing STAR and STAR+PLUS counties, STAR Health, CHIP or CHIP Perinatal. Attachment 5 presents a summary of the unlimited prescriptions adjustment factor analysis.

***Copayment Change Adjustment***

Effective March 1, 2012, HHSC implemented a pharmacy cost sharing increase for CHIP clients over 150% FPL. The member copayment increased from $8 to $10 for generic drugs and from $25 to $35 for brand drugs. We re-priced the base period claims (for the applicable CHIP clients) using these revised copayment amounts and determined the resulting adjustment factors. Attachment 6 presents a summary of the copayment change adjustment factor analysis.

***Family Planning Adjustment***

Some of the MCOs that participate in the STAR, CHIP and CHIP Perinatal programs are not able to provide family planning services. HHSC provided us with a listing of those drugs that are not provided by these MCOs. Using base period claims experience, we determined the percentage of claims cost expected to be represented by these family planning drugs. The pharmacy carve-in premium rates for these MCOs have been reduced to reflect the reduced services provided. Attachment 7 presents a summary of the family planning adjustment factor analysis.

***Managed Care Efficiency Factor***

The pharmacy reimbursement methodology under pharmacy carve-in is significantly different from that under the carve-out arrangement. The dispensing fee under the VDP program averages approximately $8.00 per prescription (after the September 1, 2011 dispensing fee reduction discussed above) while the dispensing fee under carve-in is expected to average around $1.50 per prescription (assumed average for all MCOs combined).

On the ingredient cost side, it is anticipated that the MCOs will pay the pharmacies more than VDP currently pays. For brand drugs we have assumed that the mean Average Wholesale Price (AWP) discount under carve-in will be 16% while the current VDP discount is around 18.3%. For generic drug ingredient cost, we have assumed that the MCOs will pay the pharmacies around 10% more than VDP. These assumptions are based on our analysis of VDP claims experience, pharmacy reimbursement information provided by the MCOs and current Maximum Allowable Cost (MAC) schedules used under several large Texas commercial plans. Please note that the above assumptions are assumed to be applicable to overall pharmacy carve-in experience, not necessarily to any one individual MCO specifically. Also, the pharmacy reimbursement assumptions are assumed to apply to all pharmacies overall, not necessarily to any one individual pharmacy or category of pharmacies.

Based on the above analysis we have established a 5% managed care discount factor for all programs and service areas except the Hidalgo service area in STAR. The 5% assumption was developed assuming that overall pharmacy reimbursement under carve-in would be 4% lower than that under VDP and that the MCOs will have a positive impact on utilization representing 1% of prescription drug cost.

Prescription drug utilization for children in the Hidalgo service area is around 80% higher than that for the remainder of the state. Based on this information it was determined that the opportunity for cost reduction under pharmacy carve-in was greater in the Hidalgo service area than in other service areas. The MCOs are expected to reduce pharmacy cost through more cost-effective professional provider contracting and increased management of both the medical and prescription drug benefit.

The managed care efficiency factors for STAR Hidalgo were determined by assuming that the MCOs would reduce the excess pharmacy cost (defined as excess of Hidalgo cost over the average of the other STAR service areas) by 25%. For example, the pharmacy claims cost for Expansion Children in the Hidalgo service area is 116% higher than that for the remainder of the state. We have assumed that the MCOs will reduce the prescription drug cost by 28.4%. It is anticipated that the opportunities for reducing cost will increase over time. However, given implementation of managed care in a new service area and the authorization of service limitations placed on the MCOs by HHSC, it is our opinion that a lower managed care efficiency factor is reasonable and appropriate.

Attachment 8 presents a summary of the managed care efficiency factor analysis for the Hidalgo service area.

***Small Sample Size Adjustments***

Both the CHIP and CHIP Perinatal programs contain risk groups that are too small to set rates on an individual service area basis. These risk groups are the Under Age One risk group in CHIP and the Perinate Between 185% and 200% FPL, Newborns Under 185% FPL and Newborns Between 185% and 200% FPL risk groups in CHIP Perinatal. In those cases we have developed a statewide premium rate which applies to all MCOs in all service areas.

***Other Adjustments***

Risk Adjustment - The current risk adjustment analysis available to HHSC was not developed for prescription drug cost. Therefore, no acuity risk adjustment has been applied to the pharmacy carve-in premium rates.

Rebates - The prescription drug cost analysis presented in this report includes the gross pharmacy cost, i.e., it has not been reduced to reflect formulary rebates. HHSC will retain the rebate management function for both federal and supplemental rebates.

## IV. Administrative Fees and Risk Margin

The pharmacy carve-in rating methodology includes an explicit provision for administrative services. The amount allocated for administrative expenses is $1.80 per member per month. This amount is intended to provide for all administrative services performed by the MCO and its subcontractors.

The premium rates also include an amount for premium tax (1.75% of premium) and a risk margin (2.0% of premium).

## V. Summary

Attachment 1 presents the results of the FY2013 pharmacy carve-in rating analysis for each of the Medicaid and CHIP managed care programs.

VI. Actuarial Certification of FY2013 Pharmacy Carve-in Premium Rates

I, David G. Wilkes, am a principal with the firm of Rudd and Wisdom, Inc., Consulting Actuaries (Rudd and Wisdom). I am a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries. I meet the Academy's qualification standards for rendering this opinion.

Rudd and Wisdom has been retained by the Texas Health and Human Services Commission (HHSC) to assist in the development of their pharmacy carve-in rate-setting methodology, assumptions and resulting premium rates and to provide the actuarial certification required under Centers for Medicare and Medicaid Services (CMS) requirements 42 CFR 438.6(c). The initial premium rates for the new pharmacy carve-in program are effective for the period fiscal year 2013 (FY2013, September 1, 2012 through August 31, 2013).

I certify that the pharmacy carve-in premium rates developed by HHSC and Rudd and Wisdom satisfy the following:

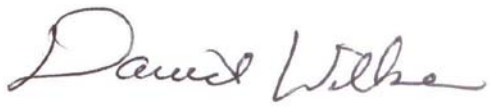
(a) The premium rates have been developed in accordance with generally accepted actuarial principals and practices;

(b) The premium rates are appropriate for the populations and services covered under the managed care contract; and

(c) The premium rates are actuarially sound as defined in the regulations.

We have relied on historical experience data and program information provided to us by HHSC. We have reviewed the data for reasonableness but have not audited the data.

Please note that actual health plan contractor experience will differ from these projections. Rudd and Wisdom has developed these rates on behalf of the State to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c). Any health plan contracting with the State should analyze its own projected premium needs before deciding whether to contract with the State.



David G. Wilkes, F.S.A., M.A.A.A.

## VII. Attachments

***Attachment 1***

Summary of Pharmacy Carve-in Rating Analysis

The attached exhibit presents the resulting FY2013 pharmacy carve-in premium rates. The exhibit includes premium rates by risk group for the STAR, STAR+PLUS STAR Health, CHIP and CHIP Perinatal programs.

***Attachment 2***

Community Experience Analysis

The following exhibits present a summary of the experience analysis performed for each Medicaid and CHIP managed care program and service area. HHSC utilizes a community rating methodology in setting the pharmacy carve-in premium rates. The community rates by risk group vary by service area but are the same for each MCO in a service area.

Below is a brief description of the exhibits contained in this attachment. The exhibits present the derivation of the FY2013 (rating period) pharmacy carve-in community premium rates for the programs listed below. Each exhibit contains the rate derivation for each service area and risk group included in the program.

Exhibit A – STAR Program
Exhibit B – STAR+PLUS Program
Exhibit C – STAR Health Program
Exhibit D – CHIP Program
Exhibit E – CHIP Perinatal Program

The actuarial model used to derive the premium rates relies primarily on VDP claims experience. The historical claims experience for each program, service area and risk group was analyzed and estimates for the base period (March 1, 2011 through February 29, 2012) were developed. The top portion of the attached exhibits show summary base period enrollment and claims experience and projected rating period enrollment. The base period per capita claims cost estimates were then projected forward to the rating period using assumed trend rates. Additional adjustments were made to the historical experience to reflect programmatic changes in covered services, member cost sharing and pharmacy reimbursement. Administrative expenses ($1.80 pmpm), risk margin (2.0%) and premium tax (1.75%) were added to the claims component in order to project the total rating period cost.

***Attachment 3***

Trend Analysis

The pharmacy carve-in rating methodology uses assumed trend factors to adjust the base period (March 1, 2011 through February 29, 2012) claims cost to the rating period (FY2013). The cost trend factors used in this analysis are a combination of utilization and inflation components. The projected trend rate assumptions were developed by the actuary based on an analysis of recent Vendor Drug Program (VDP) experience under the various Medicaid and CHIP managed care programs. The trend assumptions vary by program and risk group but are uniform for all service areas.

The trend analysis included a review of VDP claims experience data paid through March 31, 2012. Based on this information, estimates of monthly incurred claims were made through February 2012. The FY2012 trends were adjusted to recognize the dispensing fee reduction implemented by VDP on September 1, 2011. The per-capita claims cost and trend experience was reviewed separately by program, service area and risk group. The service area trends were then combined into a single statewide average (for each program and risk group) using a weighted average formula with current enrollment as the weights.

The rating period trend assumptions were developed using the following formula:

Rating period trend rate equals one-eighth of the actual FY2009 trend plus two-eights of the actual FY2010 trend plus three-eighths of the actual FY2011 trend plus two-eighths of the trend for the period September 2011 through February 2012. This formula was used in developing the trend assumptions for all programs and risk groups. The trend assumption for STAR Disabled and Blind clients (in the MRSA service areas only) was developed based on STAR+PLUS Medicaid Only experience. A single trend assumption was developed for the two STAR+PLUS risk groups and a single trend assumption was developed for all CHIP and CHIP Perinatal risk groups.

The attached exhibits present the trend assumptions for each program. Each exhibit contains the trend derivation for each program and risk.

Exhibit A – STAR Program
Exhibit B – STAR+PLUS Program
Exhibit C – STAR Health Program
Exhibit D – CHIP Program and CHIP Perinatal

***Attachment 4***

Dispensing Fee Adjustment Factor – September 1, 2011

Effective September 1, 2011, HHSC reduced the dispensing fee paid to pharmacies under the VDP. The fixed component of the dispensing fee is now $6.50 and the variable component is 1.96%. The experience period claims (those incurred prior to the reimbursement change) were re-processed using this revised dispensing fee formula and resulting adjustment factors developed. This issue impacted all programs, service areas and risk groups. Attachment 4 presents a summary of the dispensing fee adjustment factor analysis.

Exhibit A – STAR Program
Exhibit B – STAR+PLUS Program
Exhibit C – STAR Health Program
Exhibit D – CHIP Program
Exhibit E – CHIP Perinatal Program

***Attachment 5***

Unlimited Prescriptions Adjustment

Adults (clients age 21 and over) in Medicaid FFS/PCCM have a three prescription per month limit while those adults in STAR and STAR+PLUS have unlimited prescriptions. In order to recognize the increase in benefit (and cost) for adult clients moving from FFS/PCCM to managed care, we developed adjustment factors for adult clients in STAR (TANF Adults, Pregnant Women and Disabled and Blind adults) and STAR+PLUS (Medicaid Only adults).

Texas Medicaid Healthcare Partnership (TMHP) conducted an analysis to evaluate the historical cost of unlimited prescriptions for adults in managed care. The intent of TMHP's analysis was to determine what the prescription drug utilization and cost would have been for those adult clients had they been limited to three prescriptions per month. Their analysis considered the order of prescription purchases (in a three prescription limit scenario, the more expensive drugs would likely be among the first three purchased) and the differing maximum days supply rules that apply to limited and unlimited prescription clients.

The unlimited prescriptions adjustment applied to adults in STAR and STAR+PLUS expansion counties and new service areas. The adjustment did not impact existing STAR and STAR+PLUS counties, STAR Health, CHIP or CHIP Perinatal. The attached exhibits present a summary of the unlimited prescriptions adjustment factor analysis. Exhibit A is a summary of the information provided by TMHP which was used as the basis for the adjustment factors. Exhibits B and C present the derivation of the adjustment factors for STAR and STAR+PLUS, respectively.

***Attachment 6***

Copayment Change Adjustment

Effective March 1, 2012, HHSC implemented a pharmacy cost sharing increase for CHIP clients over 150% FPL. The member copayment will increase from $8 to $10 for generic drugs and from $25 to $35 for brand drugs. We re-priced the base period claims (for the applicable CHIP clients) using these revised copayment amounts and determined the resulting adjustment factors. The attached exhibit presents a summary of the copayment change adjustment factor analysis.

***Attachment 7***

Family Planning Adjustment

Some of the MCOs that participate in the STAR, CHIP and CHIP Perinatal programs are not able to provide family planning services. For these MCOs, family planning service with be provided through Fee-for-Service. HHSC provided us with a listing of those family planning drugs that will not be provided by these MCOs. Using base period claims experience, we determined the percentage of prescription drug claims cost expected to be represented by these family planning drugs. The pharmacy carve-in premium rates for those MCOs that do not provide family planning services have been reduced accordingly.

The attached exhibits present a summary of the family planning adjustment factor analysis. Exhibit A presents the analysis for the STAR program. Exhibit B presents the analysis for the CHIP program. Exhibit C presents the analysis for the CHIP Perinatal program.

***Attachment 8***

Managed Care Efficiency Factor

The pharmacy reimbursement methodology under pharmacy carve-in is significantly different from that which existed under the Vendor Drug Program. The dispensing fee under the VDP program averages approximately $8.00 per prescription (after the September 1, 2011 dispensing fee reduction discussed in a previous section) while the dispensing fee under carve-in averages around $1.50 per prescription (assumed average for all MCOs combined).

On the ingredient cost side, it is anticipated that the MCOs will pay the pharmacies more than VDP currently pays. For brand drugs we have assumed that the mean Average Wholesale Price (AWP) discount under carve-in will be 16% while the current VDP discount is around 18.3%. For generic drug ingredient cost, we have assumed that, on average, the MCOs will pay the pharmacies around 10% more than that paid under VDP. These assumptions are based on our analysis of VDP claims experience, pharmacy reimbursement information provided by the MCOs and current Maximum Allowable Cost (MAC) schedules used under several large Texas commercial plans. Please note that the above assumptions are assumed to be applicable to overall pharmacy carve-in experience, not necessarily to any one individual MCO specifically. Also, the pharmacy reimbursement assumptions are assumed to apply to all pharmacies overall, not necessarily to any one individual pharmacy or category of pharmacies.

Based on the above analysis we have established a 5% managed care discount factor for all programs and service areas except the Hidalgo service area in STAR. The 5% assumption was developed assuming that overall pharmacy reimbursement under carve-in will be 4% lower than that under VDP and that the MCOs will have a positive impact on utilization representing 1% of prescription drug cost.

Prescription drug utilization for children in the Hidalgo service area is around 80% higher than that for the remainder of the state. Based on this information it was determined that the opportunity for cost reduction under pharmacy carve-in is greater in the Hidalgo service area than in other STAR service areas. The MCOs are expected to reduce pharmacy cost through more cost-effective professional provider contracting and increased management of both the medical and prescription drug benefit.

The managed care efficiency factors for STAR Hidalgo were determined by assuming that the MCOs would reduce the excess pharmacy cost (defined as excess of Hidalgo cost over the average of the other STAR service areas) by 25%. For example, the pharmacy claims cost for Expansion Children in the Hidalgo service area is around 116% higher than that for the remainder of the state. We have assumed that the MCOs will reduce the prescription drug cost by 28.4%. It is anticipated that the opportunities for reducing cost will increase over time. However, given implementation of managed care in a new service area and the authorization of service limitations placed on the MCO by HHSC, it is our opinion that a lower managed care efficiency factor is reasonable and appropriate.

The attached exhibit presents a summary of the managed care efficiency factor analysis for the STAR Hidalgo service area.