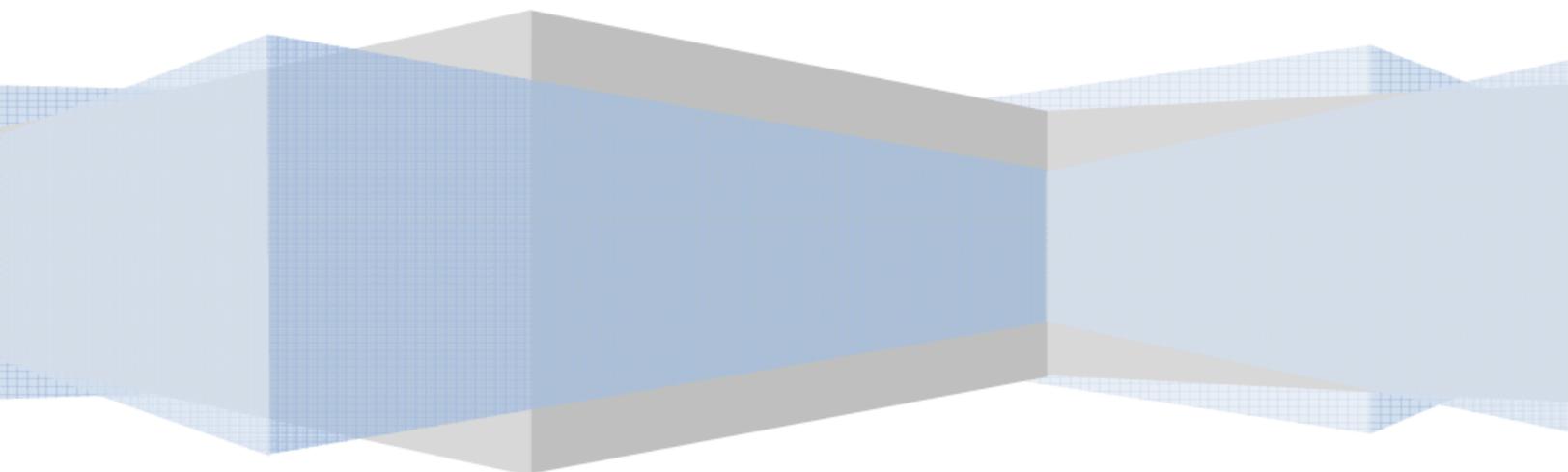


Report of the Alabama Medicaid Pharmacy Study Commission

December 2013

Produced by Optumas for
Donald E. Williamson, M.D.
Chair, Alabama Medicaid Pharmacy Study Commission



INTRODUCTION

The Alabama Medicaid program is the avenue of healthcare for a significant portion (approximately 20%) of the Alabama population. The program has seen increases in enrollment in recent years that have caused the demand for Alabama General Fund dollars to increase significantly. To address the issues arising with the Medicaid program, in October 2012, Governor Robert Bentley established the Alabama Medicaid Advisory Commission. In January 2013, the Commission recommended transforming the Alabama Medicaid program to a managed care environment by utilizing risk bearing Regional Care Organizations through an 1115 waiver from Centers for Medicare and Medicaid Services (CMS). Since January 2013, the State has been actively pursuing an 1115 waiver to put this transformation into motion.

A large component of the transformation that will create both higher quality care and decreased rate of cost growth are further improvements to management of Alabama's pharmacy benefits for its Medicaid enrollees. With this in mind, Governor Robert Bentley established the Alabama Medicaid Pharmacy Study Commission on June 06, 2013, and defined its membership (Appendix 2). The Commission is charged with conducting a study of the current Medicaid pharmacy delivery and reimbursement system and options for reform of the system. The study would include the following:

- (i) an analysis of the current system;
- (ii) a comparison of the Alabama Medicaid pharmacy program with programs in other states;
- (iii) descriptions of alternative pharmacy systems that could maintain quality and save money for the state Medicaid Agency; and
- (iv) the estimated savings and economic impact of each such described system, if implemented.

The remainder of this report provides the Commission's findings relative these four tasks.

CURRENT MEDICAID PHARMACY SYSTEM

Currently, pharmacy costs make up approximately 11% of total Alabama Medicaid medical expenditures. Alabama Medicaid pharmaceutical expenditures have two components; ingredient cost and dispensing fee. The ingredient cost for the drug is paid to pharmacies based on the lower of Federal Upper Limit (FUL), Alabama Estimated Acquisition Cost (Average Acquisition Cost (AAC) or Wholesale Acquisition Cost (if no AAC is available), Usual & Customary Charge (U&C) to the public, State Maximum

Allowable Cost (MAC), or Medicare Part B for blood clotting factor. The dispensing fee for the drug is paid to pharmacies at \$10.64 per prescription.

Pharmacy expenditures vary greatly across the various populations enrolled in Medicaid, Thus the distribution of enrollment and expenditures across aid categories compared to costs is worth noting. Pharmacy costs are driven largely by the Aged and Disabled aid categories. The Aged and Disabled population makes up just 13% of the Medicaid population, however accounts for 62% of the pharmacy expenditures. Conversely, Adults and Children make up 87% of the Medicaid population while just 38% of the pharmacy expenditures.

Over the time period from 2008 to 2012, the Medicaid program in general and specifically the pharmacy component of the program has seen significant increases in membership as well as utilization. Figure 1 provides statistics for the increases seen in overall Medicaid enrollment, enrollees eligible for total pharmaceuticals, the number of annual recipients who utilized prescription services, total Medicaid spend, and pharmacy Medicaid spend.

Figure 1 – Alabama Program Statistics from 2008 to 2012

	Medicaid Enrollment	Enrollees Eligible for Total Rx	Annual Rx Recipients	Total Medicaid Spend	Rx Medicaid Spend
FY 2008	921,000	820,000	500,000	\$ 4,400,000,000	\$ 502,600,000
FY 2012	1,100,000	1,000,000	610,000	\$ 5,630,000,000	\$ 593,100,000
Total Increase	19%	22%	22%	28%	18%
Annual Increase	5%	5%	5%	6%	4%

Along with the increases in membership and utilization, a decrease in Federal Medical Assistance Percentage (FMAP) due to the loss of Federal stimulus money increased the impact on the General Fund demand. FMAP is the amount the Federal pays of every Medicaid dollar and is based upon a Federally-defined formula that includes per capita income (as a result, FMAP percentages vary by state, although FMAP can be no lower than 50%). Overall, the General Fund demand for pharmacy increased by 44 percent, from \$110 million to \$158 million, from 2008 to 2012.

This increase would have been more severe if not for the stability in the average pharmacy Per Member Per Month (PMPM) cost and the average per Unit Cost that Alabama’s Medicaid program has been able to achieve. The pharmacy cost has been among the best in the nation due to innovative approaches that have been, and are in the process of, being implemented. Alabama’s changes to its pharmacy benefit management have been many to ensure its rate of expenditure is appropriate: the change in reimbursement formula to the average acquisition cost, a substantial increase in generic utilization mix, the preferred drug list, prior authorizations, brand name and total drug limits, 90 day supply, increased co-payments, edits and audits, dispense as written requirements, and the Drug

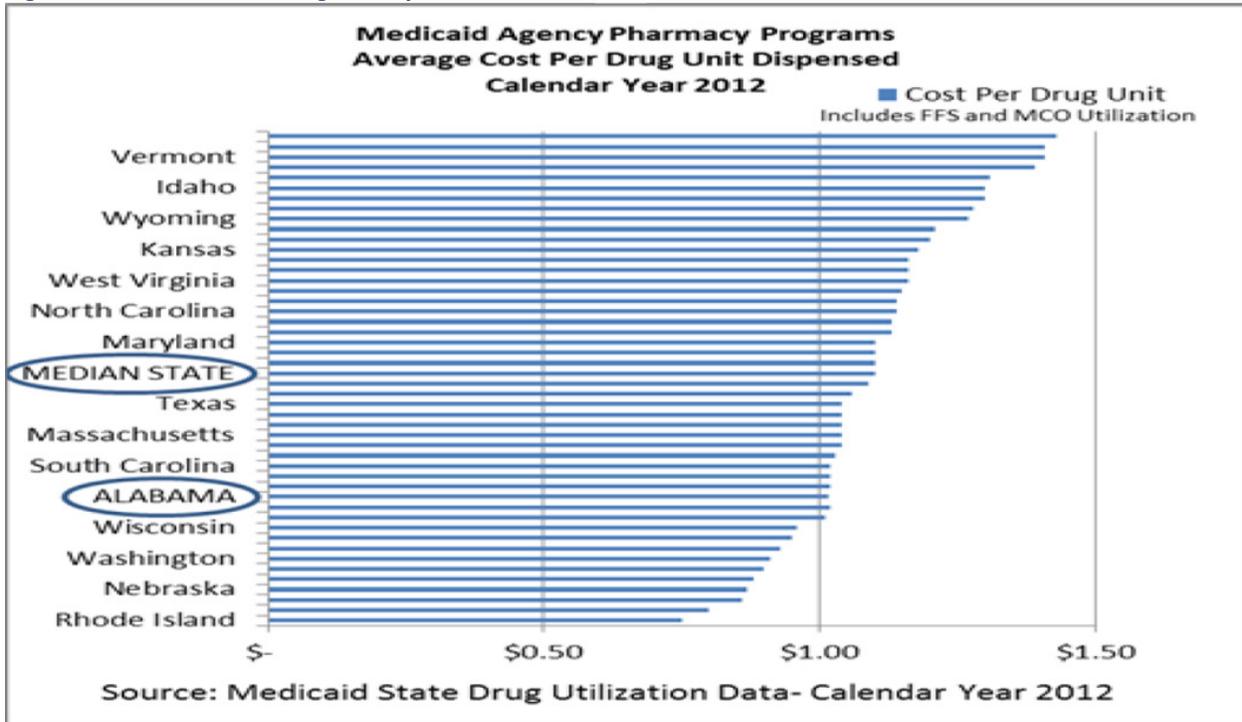
Utilization Review Board all have (and will continue to) impact pharmacy quality and cost efficiency positively. As a result of these approaches, the current structure of the Alabama Medicaid pharmacy program is considered leading edge and the overall level of spend and rate of growth is reasonable and among the lowest in the country.

COMPARISON OF PHARMACY PROGRAM TO OTHER STATES

The Commission was tasked with comparing Alabama Medicaid's pharmacy program to that of other state programs. Various approaches for making a comparison were taken including the use of Medicaid Statistical Information System (MSIS) data, Medicaid State Drug Utilization data, a report to Congress on Medicaid and the Children's Health Insurance Program (CHIP) which included pharmacy spending, as well as discussions with other state Medicaid pharmacy directors. Although these provided useful data, lack of comparability and consistency among the different data sources highlighted one of the challenges associated with this project: one consistent data source that compares pharmacy programs on a normalized basis is not readily available which makes a true comparison difficult to derive.

In order to completely normalize for each state's unique pharmacy program, accounting for things like enrollment mix, managed care programs, ingredient cost methodology, dispensing fee methodology, and monthly prescription limits, among others, would need to be incorporated into the analyses. After normalizing for as many of these factors as the data would allow, high-level state Medicaid pharmacy program comparisons were able to be made. The focal point of the comparison was the unit cost per drug, in terms of acquisition cost and dispensing fee. Alabama is among the lowest state in terms of per unit drug cost at \$1.02. See Figure 2 for a comparison of unit costs across states according to Medicaid State Drug Utilization Data for calendar year 2012. Note that the unit cost does contribute a large role in Medicaid's pharmacy spend. For each one cent decrease in unit cost, approximately \$5 million of savings are available to the Alabama Medicaid system.

Figure 2 – CY12 Per Unit Drug Cost by State



As mentioned above, other drivers that impact overall cost include utilization, program limits, and Medicaid eligibility group mix but these drivers are subject to significant variation among states that make direct comparisons among these factors difficult. The per unit cost is a standardized variable, that while not normalized for population mix, can still allow direct comparisons for one key driver of pharmacy expenditures. With that caveat, the overall conclusion when comparing Alabama’s Medicaid pharmacy program to other states across the country is that the Alabama structure is considered leading edge, the overall spend and the rate of growth is reasonable and one of the lowest across the country.

ALTERNATIVE PHARMACY SYSTEM INITIATIVES

During the October 24th, 2013 Commission meeting, representatives from three different potential alternative pharmacy management approaches made presentations on their respective reform initiatives. The presenters were tasked with identifying the most cost-effective way of reducing the rate of growth of the pharmacy benefit while maintaining or improving the current quality of care. They each had their own design that could potentially maintain quality and save money for the state Medicaid Agency’s pharmacy program. The three reform initiatives were:

- 1) A Purchasing and Network Management Cooperative presented by American Pharmacy Cooperative, Inc. (APCI),
- 2) A Pharmacy Benefit Management (PBM) presented by a coalition of three PBMs – CVS Caremark, Express Scripts, and MedImpact Healthcare Systems, Inc.
- 3) and a Preferred Pharmacy Network presented by Walmart.

Below is a more detailed description of each of the alternatives presented.

1) Purchasing and Network Management Cooperative

APCI is a purchasing cooperative and a network management service that utilizes APCI, Health Information Designs (HID), and Hewlett-Packard (HP). APCI would provide network management services from both a cost and quality perspective. HID would continue to maintain the prior authorization process and would provide clinical services. HP would provide claims processing. Their initiative reforms the current system and seeks to produce savings while maintaining quality in a way such that the current system would not be as dramatically impacted as it would with the other proposals.

Savings would be accomplished through improving care management, specifically specialty drug management. Additional savings would be seen through reimbursement management, specifically through utilization of the Predictive Acquisition Cost (PAC) model as well as through specialty reimbursement edits. Finally, additional savings could be realized through rebate improvements on generic drugs. Administratively, Alabama Medicaid already holds contracts with HID and HP and therefore, there would potentially be no additional administrative component for their services unless additional services of HID or HP were requested. The administrative efforts of APCI would require additional administrative expenditures that have been included as an offset to the savings estimates provided below. Based on conversations with APCI, it is not anticipated that the current pharmacy provider tax would sunset with this reform initiative. Unadjusted state savings estimates provided by APCI ranged from \$16 million to \$22 million. The consultants at **Optumas**, the actuary firm hired by the state Medicaid agency, reviewed the savings estimates. After adjusting for overlap with initiatives that have already been implemented by Alabama Medicaid, overall state savings are anticipated to be \$9 million to \$18 million over a one year time period.

2) Pharmacy Benefit Management (PBM) System

A PBM system is a contractor who manages the pharmacy system. The presentation to the commission included highlights of various PBM business models and management approaches, several of the components of which were used by the PBM coalition to develop their savings estimate. From a practical perspective, this approach of describing a variety of models and management approaches was very helpful in educating the Commission about the potential for PBM capabilities and how they might be applied. This approach, however, does not represent any one single PBM or one specific framework. Despite having varying management components, the various PBM models did produce similar overall savings that are discussed further below.

Per the PBM presentation, savings would be accomplished through clinical and drug management. The PBM would have the ability to decrease dispensing fee costs as well as work to cut ingredient fee costs. They would also utilize fraud, waste and abuse techniques to reduce any potential over-utilization. Per the coalition, PBMs in general have very strong analytic tools and additionally, PBM currently operate in Alabama, providing services to several large clients in Alabama, including the State Employees, as well as nationally for other state Medicaid programs. The PBM would contain an administrative component that would offset savings. The impact on the pharmacy provider tax is unknown at this time however, savings figures have assumed that the Provider tax would sunset. Unadjusted state savings estimates provided by the PBM coalition ranged from \$30 million to \$50 million. After accounting for the loss in provider tax, the **Optumas** consultants reviewed the estimates and, adjusted for overlap with initiatives already implemented by Alabama Medicaid. Overall state savings are anticipated to be \$13 million to \$35 million over a one year time period.

3) Preferred Pharmacy Network

A Preferred Pharmacy Network is a system that limits the network access to a closed subset of Pharmacies. The commission was able to see an example of this program design through a presentation from Wal-Mart. This example limited the network to Wal-Mart stores across Alabama creating the ability to use their pricing methodology which would significantly cut per

script costs. Although the reform would produce savings and promote quality, it would create a considerable change to the current system structure.

Savings would be generated through reimbursement management. In Wal-Mart’s case, they created savings through the elimination of the dispensing fees and co-payments as well as through a decreased ingredient cost. Additional savings would be realized through wellness programs. The Preferred Pharmacy Network would contain an administrative component that would offset savings. The impact on the pharmacy provider tax is unknown at this time however, savings figures have assumed that the Provider tax would sunset. Unadjusted savings estimates provided by Wal-Mart were \$40 million. After accounting for the loss in provider tax, the **Optumas** consultants reviewed the estimates and, adjusted for overlap with initiatives already implemented by Alabama Medicaid. Overall state savings are anticipated to be \$19 million to \$30 million over a one year time period.

Figure 3 below summarizes the three initiatives state savings estimates after accounting for the potential loss of the provider tax for the PBM and Preferred Pharmacy Network projections and overlap with existing initiatives already implemented by Alabama Medicaid.

Figure 3 – Alternative Pharmacy System Initiative Savings Projections: Adjusted for Provider Tax and Overlap

APCI	PBM	Preferred Rx Network
➤ \$9M – \$18M State Dollars	➤ \$13M – \$35M State Dollars	➤ \$19M – \$30M State Dollars

There are two supplementary reform approaches that should be noted as additional considerations. They include the utilization of a Most Favored Nation (MFN) reimbursement rate and an increase to the current pharmacy provider tax. Note that these are not unique initiatives and could be included in addition to, as part of, or separate from, the reform initiatives presented above.

MFN is an ingredient cost reimbursement model that pays the lesser of several options including the usual and customary charge that a provider charges or accepts from any payor. States like Georgia and Massachusetts have utilized MFN. Georgia has seen savings upwards of \$20 million per year (total

funds) compared to their previous AWP reimbursement. If Alabama were to utilize MFN, projected state savings are \$3 million to \$9 million over a one year time period.

The pharmacy provider tax currently provides approximately \$9 million in state funds for pharmacy expenditures. Pharmacy providers currently pay ten cents for each prescription filled or refilled for a citizen of Alabama. Another potential strategy for creating additional state funds would be to increase this provider tax amount. Although this is an avenue to additionally consider, it may not be feasible in the short term and a dollar impact has not estimated at this time.

Figure 4 below summarizes the two additional considerations state savings estimates.

Figure 4 – Additional Considerations State Savings Projections

Most Favored Nation	Increased Provider Tax
➤ \$3M – \$9M State Dollars	➤ Increase TBD above current \$9M

The various reform initiative options all have their own strategies for achieving the goal of producing savings for the pharmacy program while maintaining quality. It is important to note that potential state savings projections described above are estimates given the high-level information currently available. If the state of Alabama changes the pharmacy delivery system, a Request for Proposal (RFP) process would be needed in order to know the true savings potential for a given initiative.

ECONOMIC IMPACT OF DELIVERY SYSTEM REFORM

The final aspect requested of the Commission was to estimate the economic impact, specifically on Pharmacies, of a reformed pharmacy delivery system, if implemented. To approximate this impact, the Commission looked at the volume of Medicaid prescriptions by pharmacy nationally and in Alabama, reviewed published studies on how many Pharmacies in the U.S. close per year (churn), and reviewed data on the average margin per pharmacy by line of business. Using these three pieces of information, an estimated impact for change in margin and increase in churn rate given a change in the Alabama pharmacy delivery system could be derived. The above data came from multiple sources of information,

including the National Community Pharmacists Association (NCPA) dataset on independent pharmacy financial experience as well as National Health Expenditure data from the CMS Office of the Actuary.

Research shows that there are approximately 60,000 Pharmacies in the U.S. For the purposes of this study, these can be broken into two types; chain and independent (including specialty, long-term care, and other types of non-chain pharmacies). Of the 60,000 total Pharmacies, approximately 39,000 are chains. Chain pharmacies have continued to see steady increases in quantity over the years through similar shifts in pharmacy reimbursement systems much like the ones proposed above. Therefore, it is assumed that a reform to the Alabama Medicaid pharmacy system would have no significant impact on chain pharmacies. Please see Appendix 5C for additional considerations with regard to chain pharmacies. This leaves analyses on the impact a shift in the Alabama Medicaid system would have on its independent Pharmacies.

There are approximately 700 independent Pharmacies in Alabama. Studies show that nationally, approximately 90% of independent pharmacy revenues are prescription based. These prescriptions and associated revenues break into four lines of business; Medicaid, Medicare Part D, Other Third Party and Cash.

To get an estimate for the impact a shift in the Alabama Medicaid pharmacy system would have on independent Pharmacies in Alabama, research was done to see the impacts when similar shifts to the system occurred nationally, specifically the implementation of Medicare Part D. In January 2006, Medicare Part D was implemented with the intent to provide prescription drug coverage for 43 million Medicare beneficiaries. This severely shifted the pharmacy system for a large percentage of the overall business. As mentioned above, chain Pharmacies saw very little impact and continued to grow. However, studies show that independent Pharmacies were unintentionally impacted. Decreases in margins resulting in the closure of independent rural Pharmacies above normal closure rates (churn) were seen. This was a result of the implied shift from other payors to Medicare Part D average margins. Average margins by payor can be seen in figure 5 below, which depicts components of the current independent pharmacy program by line of business.

Figure 5 – Current Independent Pharmacy Picture

	% Scripts	% Revenue	Avg Gross Margin	Components of Margin	% of Margin
Medicaid	13%	10%	20%	2%	8%
Medicare Part D	30%	28%	18%	5%	21%
Other Third Party	45%	40%	20%	8%	34%
Cash	12%	22%	40%	9%	37%
TOTAL	100%	100%	24%	24%	100%

With the implementation of Medicare Part D, approximately 30% of pharmacy business shifted from cash, other third party, and/or Medicaid into the new Medicare line of business. As seen in Figure 5, the margins realized by pharmacies decreased materially with this shift. Research published in peer-reviewed journals¹ suggests that this decrease in margin may have been the primary cause for additional independent pharmacy closures. According to the study, prior to Medicare Part D, approximately 70 independent Pharmacies nationally closed per month. The study found that, after implementation of Medicare Part D, this number increased to approximately 150 independent pharmacy closures per month. Per the study findings, this potentially implies that the shift to Medicare Part D may have resulted in an additional 80 independent pharmacy closures per month. Note that these figures are for closures only and do not address the net impact due to new pharmacy additions in any given month.

Using the national findings from the Medicare Part D study and adjusting the results for the State of Alabama, projections for the impact expected with a hypothetical shift in overall Medicaid reimbursement, and therefore Medicaid margins for independent Pharmacies in Alabama, were calculated. The conclusion from **Optumas'** modeling is that minimal overall independent pharmacy margin and churn impact would be seen with a change in the Alabama Medicaid pharmacy delivery system that reduced Medicaid margins for independent Pharmacies in Alabama. Figure 5 shows that a shift in the average margin for Medicaid specifically would not be as significant as that seen from the Medicare Part D implementation. Additionally, figure 5 shows that the overall market share for Medicaid does not appear to be significant enough to materially impact the overall margin for independent Pharmacies. **Optumas'** analyses suggest that with a ten percent decrease (20% to 18%) in Medicaid margins, an additional 36 to 132 independent Pharmacies nationally would close per year (3 to 11 monthly). This translates to approximately 1 to 4 Alabama independent Pharmacies closing annually (significantly less than 1 monthly). While these figures may seem small, it should be noted that any

¹ Klepser DG, Xu L, Ullrich F, Mueller KJ. Trends in community pharmacy counts and closures before and after the implementation of Medicare Part D. *J Rural Health*. 2011 Spring;27(2):168-75.

additional closures would be materially significant for the individual Pharmacies impacted and their employees and communities. Overall, the conclusion is that changes to Medicaid reimbursement mathematically will not have a major impact on the current rate of independent Pharmacies in Alabama above what would be expected in the absence of any Alabama Medicaid pharmacy changes. This conclusion and the figures presented above are based on national data sources, adjusted for Alabama's pharmaceutical experience on average, and therefore may not be appropriate for any given independent pharmacy in Alabama. Additionally they are not specific to any one reform initiative described above. Instead, they assume non-specific reductions in Alabama Medicaid pharmacy margins for independent Pharmacies, no matter the vehicle used in accomplishing the reduction.

In addition to analyzing pharmacy closures and resulting impact on access to care, consideration has been given to impacts on pharmacy quality. An assessment on the impact to quality is not feasible given the data available; however an evaluation of quality of care would have to be a component of the reform option chosen. According to the analyses conducted by **Optumas** and described above, access to care would not be impacted.

The above impacts are calculations focused on independent Pharmacies specifically. It is important to note that there may be additional impacts in the form of economic ripple effects. If the closure rate was projected to increase materially as a result of a reduction in Alabama's independent Pharmacies' Medicaid margin, this could manifest itself in the form of fewer jobs and, as a result, fewer dollars being put back into the Alabama economy. Consistent with the conclusion above that there is no anticipated significant increase in the rate of closure of independent Pharmacies in Alabama due to a reduction in Alabama Medicaid margins, any economic ripple effects are projected to be minimal.

SUMMARY

The Alabama Medicaid Pharmacy Study Commission established by Governor Robert Bentley has worked over the past months to provide this report summarizing its findings. The current structure of the Alabama Medicaid pharmacy program is considered leading edge. Medicaid pharmacy spending and rate of growth are reasonable and among the lowest in the country. With this in mind, there remain additional changes that could be implemented to improve the program's effectiveness. The Commission was able to explore various potential initiatives and understand their design and potential state savings impacts. The potential economic impact of any potential state savings which would result in reduced

Medicaid margin for Alabama's independent Pharmacies, based on calculations by **Optumas**, appear to be minimal, specifically with regard to pharmacy closure rates. The adjusted savings estimates provided here by **Optumas** should be considered preliminary and illustrative only. If the state decides to change delivery systems, an RFP process would be needed in order to know true savings and understand full program design and capabilities.

APPENDICES

APPENDIX 1 – GOVERNORS RESOLUTION



EXECUTIVE ORDER NUMBER 40

June 6, 2013

WHEREAS, a financially sustainable Alabama Medicaid Agency is a paramount priority of this Administration;

WHEREAS, the Alabama Legislature recently passed a historic reform of Alabama Medicaid;

WHEREAS, the Alabama Medicaid Agency will begin the implementation of the reform;

WHEREAS, reform is expected to improve the quality and coordination of care and slow the growth in Medicaid costs;

WHEREAS, the Alabama Medicaid Agency provides access to critical pharmaceutical services for the elderly, the blind, the disabled, and low-income children and families in Alabama; and

WHEREAS, the continued growth in the cost of pharmaceutical services requires a review of options available to control that cost growth,

NOW, THEREFORE, based upon these considerations, and for other good and valid reasons related thereto, I Robert Bentley, Governor of the State of Alabama, by virtue of the authority vested in me by the Constitution and laws of the State of Alabama, do hereby establish the Alabama Medicaid Pharmacy Study Commission. The Commission is created to report its findings to the Governor.

The Commission shall consist of:

1. The State Health Officer, who shall serve as chair of the Commission;
2. The Acting Commissioner of the Alabama Medicaid Agency;
3. The chair of the Senate Finance and Taxation General Fund Committee;
4. Co-chair of the House Ways and Means General Fund Committee Steve Clouse;
5. The chair of the Senate Health Committee;
6. The chair of the House Health Committee;
7. A pharmacist engaged in independent private practice appointed by the Governor;
8. A hospital administrator appointed by the Governor;

9. A practicing physician appointed by the Governor;
10. Additional members as the Governor deems necessary.

All appointments by the Governor shall serve at the pleasure of the Governor.

BE IT ORDERED that the Commission shall study the current Medicaid pharmacy delivery and reimbursement system and options for reform of the system. The Commission shall provide a written report of its findings, which shall include: (i) an analysis of the current system; (ii) a comparison of the Alabama Medicaid pharmacy program with programs in other states; (iii) descriptions of alternative pharmacy systems that could maintain quality and save money for the state Medicaid agency; and (iv) the estimated savings and economic impact of each such described system, if implemented. These findings shall be presented to the Governor by December 1, 2013.

BE IT FURTHER ORDERED that the chairman of the Commission may establish an executive committee and any advisory committees he deems necessary for the effective operation of the Commission.

BE IT FURTHER ORDERED that the Commission shall adopt rules governing times and places for meetings and the manner of conducting its business. The Commission, and any committees of the Commission, may meet via teleconference. All Commission members shall serve without compensation.

BE IT FURTHER ORDERED that this Executive Order become effective immediately upon signing and shall remain in force until such time as it is modified or rescinded by the Governor.

DONE AND ORDERED this 6th day of June, 2013.

Robert Bentley

Governor

Attested

Beth Chapman

Secretary of State

APPENDIX 2 – COMMISSION MEMBERSHIP

Commission Members – 11/08/13

Alabama Medicaid Pharmacy Study Commission

State:

Dr. Don Williamson – State Health Officer, Commission Chair
Stephanie Azar – Acting Commissioner, Alabama Medicaid Agency
Senator Arthur Orr – Chair, Senate Finance and Taxation General Fund Committee
Representative Steve Clouse – Chair, House Ways and Means General Fund Committee
Senator Greg Reed – Chair, Senate Health Committee
Representative Jim McClendon – Chair, House Health Committee

Pharmacist, Independent Private Practice:

Dan McConaghy, R.Ph.

Hospital Administrator:

Barry Cochran – Fayette Medical Center

Practicing Physician:

Dr. Michael Ramsey – Dothan Pediatric Clinic

Other Appointments:

Frank Brown – USA Healthcare
Dorinda Cale – Blue Cross and Blue Shield of Alabama
Jim Carnes – Alabama Arise
Jeff Freese, R.Ph. – Turenne PharMedCo
Rhonda Harden, Pharm.D.
Spencer Holden, M.S.M., M.S.N., C.R.N.P.
Tammie Koelz, R.Ph. – Walgreens
Jim Reddoch, J.D. – Alabama Department of Mental Health

APPENDIX 3A – AUG 23, 2013 MEETING MINUTES

MINUTES OF THE ALABAMA MEDICAID PHARMACY STUDY COMMISSION AUGUST 23, 2013 MONTGOMERY COUNTY HEALTH DEPARTMENT AUDITORIUM MONTGOMERY, ALABAMA

Members Present

Donald E. Williamson, M.D., Chair	Spencer Holden
Stephanie Azar	Tammie Koelz
Frank Brown	Representative Jim McClendon
Dorinda Cale	Dan McConaghy
Jim Carnes	Senator Arthur Orr
Representative Steve Clouse	Michael Ramsey, M.D.
Barry Cochran	Tim Stone, M.D., representing Jim Reddoch
Rhonda Harden	Senator Greg Reed

Welcome by Dr. Williamson

Dr. Williamson welcomed the Commission members and stated that Governor Bentley created the Medicaid Pharmacy Study Commission by Executive Order and gave two overarching objectives: (1) to study the current Medicaid pharmacy delivery and reimbursement system and, (2) to look at options for reform. Dr. Williamson stated that Governor Bentley expected a written document from the Commission that would analyze the current system, compare Alabama's pharmacy program to pharmacy programs in other states, describe alternative delivery systems that could both maintain quality and save money, and estimate both the savings attributable to those modifications as well as any economic impact associated with implementation. The Commission will present its findings to Governor Bentley by December 1, 2013. Governor Bentley may use those findings to make decisions prior to the 2014 Legislative Session.

Introduction of Commission Members

Commission members and the organizations represented were introduced.

Status of the Current Alabama Medicaid Pharmacy Program

Dr. Williamson provided brief information on the Regional Care Organizations (RCOs) and stated that three essential things needed to occur as RCO development moved forward:

- Developing the RCO region map. The map, which would become effective mid-September, has been developed, was on display, and is available on the Medicaid Agency's Web site.
- Issuing of certification for collaboration. Emergency rules are being drafted to ensure protection against anti-trust violations. Final rules will be published around October 1 and will be released for public comment.
- Defining a probationary RCO. Dr. Williamson stated there needed to be a full understanding of what would be included in the capitated payment since it would describe the universe to be covered and the amount of funds that would be available to pull down.

Dr. Williamson then presented information on Alabama's Medicaid pharmacy program, to include total Medicaid and pharmacy enrollment, total Medicaid spending, Medicaid expenditures, Medicaid funding, the sources of the state's share, General Fund appropriations related to the federal matching rate (FMAP), pharmacy spending, pharmacy financing, pharmacy provider taxes, pharmacy drug rebates, prescription volumes and costs, pharmacy reimbursement, dispensing fees, cost controls, drug utilization, and the plan to address the shortfall in FY 2014.

The following information was brought to the attention of the Commission:

- From 2008 to 2012, annual Medicaid enrollment increased from 921,000 to 1.1 million. Enrollees eligible for total pharmaceuticals increased from 820,000 to 1 million over the four-year period. The number of annual recipients who actually received a prescription increased from 500,000 to 610,000 over the four-year period.
- The annual number of prescriptions increased from 7.3 million to almost 9 million over the four-year period. The average pharmacy cost per enrollee decreased from \$611 to \$593. The average number of prescriptions per recipient stayed constant at about 14. Medicaid's cost per prescription decreased from \$60.40 to \$58.71.
- Total Medicaid spending increased from \$4.4 billion in 2008 to \$5.6 billion in 2012. Total pharmacy spending increased from \$502 million in 2008 to \$593 million in 2012. The state's share of pharmacy spending increased from \$163.3 million to \$232.1 million over the four-year period. The state's share is funded by drug rebates, provider taxes, and the General Fund. The amount of money needed from the state to operate Medicaid is directly related to the federal match rate.

In summary, from 2008 to 2012, there was a 28 percent increase in total Medicaid spending and an 18 percent increase in pharmacy spending. There was a 42 percent increase in the state share, with a 12 percent increase in provider tax, a 44 percent increase in rebates, and a 44 percent increase in the General Fund. The increases were driven by a 22 percent growth in enrollees and a decrease in FMAP due to the loss of stimulus money. The increases were minimized by stability in the average pharmacy cost per enrollee and the average price per prescription. Despite this, the General Fund match increased by 44 percent, from \$110 million to \$158 million.

Dr. Williamson described pharmacy cost controls that were in place and those that would be implemented: a change to the average acquisition cost, an increase in generic utilization, the preferred drug list, prior authorization, brand name and total drug limits, edits and audits, dispense as written requirements, and the Drug Utilization Review Board. He also described the plan to address the shortfall for FY2014 which was projected to save the state \$12.3 million: a monthly drug limit, mandatory dispensing of a 3 month supply, end coverage of over the counter medications, ingredient cost change, expansion of Drug Utilization Review Board activities, changes to drug compounding coverage, increased co-payments for recipients, and new edits to prevent stockpiling of drugs.

Comments from Commission Members

There was discussion among Commission members regarding drug rebates and how implementation of the RCOs would affect pharmacy services.

Future Meetings of the Commission

Future meeting dates of the Commission were proposed and are as follows: September 20, 2013 at 10 a.m.; October 10 at 1 p.m.; October 24 at 1 p.m.; and November 14 at 1 p.m. All meetings will be held in the Auditorium of the Montgomery County Health Department. Dr. Williamson indicated the meetings would be available via conference call.

The focus of the September meeting will be comparing and contrasting Alabama to other states in terms of pharmacy spending (on an aggregate basis, a prescription basis, and a beneficiary basis) and funding (acquisition cost, dispensing fee, or capitated pharmacy benefits management [PBM]). The focus of the October meetings will be presentations by a PBM representative on how they would organize a pharmacy program for Alabama and by the local pharmacy community on how they could deliver a pharmacy management program. The preferred provider network option will be explored as will interesting ideas that other states may have. Medicaid's actuaries will review the data presented during the October meetings and will present the projected savings and the consequences at the November meeting.

There being no further business, the meeting was adjourned.

A handwritten signature in blue ink, appearing to read 'D. Williamson', with a long horizontal flourish extending to the right.

Donald E. Williamson, M.D.
State Health Officer
Chair, Alabama Medicaid Pharmacy Study Commission

APPENDIX 3B – OCT 10, 2013 MEETING MINUTES

MINUTES OF THE ALABAMA MEDICAID PHARMACY STUDY COMMISSION OCTOBER 10, 2013 MONTGOMERY COUNTY HEALTH DEPARTMENT AUDITORIUM MONTGOMERY, ALABAMA

Members Present

Donald E. Williamson, M.D., Chair	Spencer Holden
Stephanie Azar	Tammie Koelz
Dorinda Cale	Representative Jim McClendon
Angie Cameron, representing Frank Brown	Dan McConaghy
Jim Carnes	Senator Arthur Orr
Representative Steve Clouse	Michael Ramsey, M.D.
Barry Cochran	Jim Reddoch
Rhonda Harden	Senator Greg Reed

Consideration of Minutes

The Minutes of the Alabama Medicaid Pharmacy Study Commission Meeting held on August 23, 2013, were approved as distributed.

State Comparisons

Dr. Williamson provided a state-by-state comparison of the Medicaid pharmacy programs that were researched and compiled by Dave White, Health Policy Advisor for Governor Robert Bentley. Dr. Williamson prefaced the presentation by stating the data set was very difficult to work with since there was no single place where all of the pharmacy data for all Medicaid programs in the country resided. The data was for expenditure per beneficiary; however, the data could be skewed depending on the percentage of the beneficiaries in the fee-for-service system versus the percentage in managed care.

The following information was brought to the attention of the Commission:

- Based on 2009 data, which was the most recent data available, Alabama was significantly below the average of monthly Medicaid pharmacy reimbursement among the non dual eligible population, which is the population on which Alabama Medicaid is focused. In 2009, the cost was \$61 per member per month (PMPM) which translated to about \$720 per member per year. Since then, Alabama's costs per unit and per beneficiary have decreased.
- In 2009, disabled adults were the highest cost patients in the program. Most of Alabama's patients were children and pregnant women (\$31 PMPM and \$44 PMPM, respectively) yet over half of Alabama's drug spend was on the disabled population.
- In 2009, children and adults made up 87 percent of the beneficiaries and accounted for 38 percent of the drug spend. The disabled made up 12 percent of the beneficiaries and accounted for 60 percent of the drug spend. Alabama's distribution of spend was consistent with the rest of the country.
- Prior to the implementation of Medicare Part D, Alabama's Medicaid pharmacy reimbursement as a percentage of all costs was around 19 percent. When Part D was implemented, it fell to 10 percent. Alabama was at the national average of 10 percent.

- Based on the data available, nothing suggested pharmacy was more out of control in Alabama than anywhere else in the country or that it took a larger share of total spend. However, because of the way Alabama funded its program, a disproportionate share of the state match for pharmacy came from the General Fund.
- For Calendar Year 2012, Alabama's average cost per unit of outpatient drugs issued by pharmacies to Medicaid beneficiaries was \$1.02. Eleven states had an average cost less than Alabama; five states had the same cost; and thirty-four states had a higher cost. The costs ranged from \$.75 to \$3.49 per unit.
- Other factors should be considered, such as enrollment in managed care, the percentage of pharmacy benefits provided through managed care, the ingredient cost methodology, the dispensing fee, and monthly prescription limits. Alabama's limit is currently five total with up to four of them being name brands.
- In Calendar Year 2012, the median average cost per drug unit dispensed was \$1.10. Alabama's cost was \$1.02. Every penny difference in cost equaled \$5 million. Alabama's \$.08 below the national average equaled \$40 million less it had to spend on drugs and the state share was about \$12 to \$13 million. If Alabama could get its drug cost to Georgia's \$.88, it could save \$90 million (\$30 million state funds).
- States that had lower per unit drug costs were more likely to have their patients' drugs delivered in managed care.
- Per unit cost was only one variable in pharmacy expenditures, there were factors not controlled by per unit cost, such as utilization, program limits, and the Medicaid eligibility group mix.
- The average cost per unit of drugs for Calendar Year 2012 for the states of Georgia, South Carolina, Alabama, Arkansas, and Mississippi was discussed, as was each state's percentage of Medicaid enrollees who received drugs paid for through managed care, the ingredient cost methodology for FFS only, the dispensing fee per prescription, and the monthly limits on prescriptions for adults.

Ms. Linda Wyatt, Pharmacy Director, State of Georgia; Ms. Suzette Bridges, Pharmacy Administrator for the Arkansas Medicaid Program; and Ms. Judy Clark, Pharmacy Director, Mississippi Medicaid described their Medicaid pharmacy program and answered specific questions from Commission members. In summary:

- Georgia divided their pharmacy program into a managed care program for moms and kids and left their aged, blind, and disabled population in the fee-for-service program. Georgia has no monthly pharmacy limits, except for a limit of five prescriptions per month for narcotics. Georgia uses a "most favored nation status" which Alabama needs to research. "Most favored nation" means Georgia Medicaid will never pay more than the lowest price anyone else pays.
- Arkansas is 100 percent fee-for-service. Their monthly drug limit is three for adults; however, a physician can seek up to six if the physician deems the recipient needs more than three maintenance prescriptions per month.
- Mississippi has varying degrees of commercial managed care. Mississippi has a five drug total limit and no more than two can be brand and/or non-preferred except for those in long term care. Kids can get more drugs with medical necessity. Mississippi is precluded by statute from making any changes not mandated by federal law. They have the requirement to pay all pharmacists the same and provided Alabama with the idea of researching the multi state rebate pool to see if funds could be saved.

Mr. Carnes requested that objective data on patient outcomes (access and health measures) be gathered for the various models.

Future Meetings of the Commission

Dr. Williamson indicated that, at its next meeting, the Commission would hear information on three different delivery options: 1) a classic pharmacy benefits management (PBM) model, to include how it would work, the savings that could be expected, and the outcomes, if any, Alabama might see; 2) a community pharmacy approach presented by a representative of APCI; and 3) a preferred provider network where drugs would be available through large pharmacy chains with ideas around access, savings, and quality.

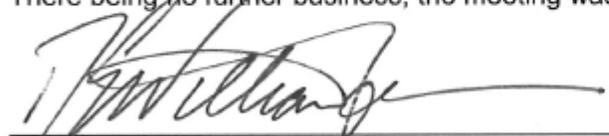
The November 14 meeting will focus on the actuary, Optumas, providing the Commission with an assessment of the amount of savings, if any, either or any of the options would provide and providing information on the economic impact in the pharmacy community due to changes in the delivery model.

A final meeting will be scheduled for the end of November for the Commission to approve the report to the Governor, which is due by December 1, 2013.

Next Meeting

The next meeting of the Alabama Medicaid Pharmacy Study Commission will be held on October 24, 2013, at 1 p.m., in the Auditorium of the Montgomery County Health Department. A conference call line will be available.

There being no further business, the meeting was adjourned.



Donald E. Williamson, M.D.
State Health Officer
Chair, Alabama Medicaid Pharmacy Study Commission

APPENDIX 3C – OCT 24, 2013 MEETING MINUTES

MINUTES OF THE ALABAMA MEDICAID PHARMACY STUDY COMMISSION OCTOBER 24, 2013 MONTGOMERY COUNTY HEALTH DEPARTMENT AUDITORIUM MONTGOMERY, ALABAMA

Members Present

Donald E. Williamson, M.D., Chair
Stephanie Azar
Frank Brown
Dorinda Cale
Jim Carnes
Representative Steve Clouse
Barry Cochran
Rhonda Harden

Spencer Holden
Tammie Koelz
Representative Jim McClendon
Dan McConaghy
Michael Ramsey, M.D.
Senator Greg Reed
Tim Stone, M.D., representing Jim Reddoch

Member Absent

Senator Arthur Orr

Opening Remarks

Dr. Williamson stated work had begun on the 2015 Medicaid budget presentation and reminded the Commission that the 2014 Medicaid budget had a projected revenue shortfall of \$100 to \$150 million in state funds. Dr. Williamson indicated nothing had changed in regard to the shortfall and the Commission's considerations around pharmacy were even more important in terms of building a budget with reasonable numbers and options for pharmacy expenditures. Dr. Williamson recapped information the Commission had heard before, that pharmacy spending in Alabama was not out of control relative to other states and that the increases in spending were driven by the same factors that increased spending in Medicaid for all providers: growth in enrollment and changes in federal matching rates. Dr. Williamson stated pharmacy was different due to the way the Medicaid funding structure was created and that costs that were not otherwise picked up by another payer (such as certified public expenditures or provider taxes) must be funded by the General Fund. While growth overall in pharmacy had been at 16 to 18 percent, all of the growth was shifted to the General Fund and the General Fund demand associated with pharmacy had grown by about 44 percent over the last 4 years. Medicaid's actions in regard to pharmacy may have a significant effect on the size of the gap between 2014 and 2015.

Consideration of Minutes

It was noted that a correction should be made to the Minutes of the Alabama Medicaid Pharmacy Study Commission Meeting held on October 10, 2013, to change "per pill" to "per unit" in all instances. The minutes were approved as corrected.

Presentations by Invited Participants

Presentations were made by representatives of Pharmacy Benefit Management (PBM) companies (CVS Caremark, Express Scripts, and MedImpact), a preferred provider network (Walmart), and community/in-state pharmacies (Alabama Prescription Services). Each

explained their organization's background, their delivery and payment models, the services they would provide, and the savings that could be expected. Each presentation was followed by discussion among and questions from Commission members.

In summary:

- The PBM would provide clinical services, analytics and reporting services, and network management. The savings were projected to be in the range of \$30 to \$50 million annual state dollars. This was based on 2011 claims data, did not include mail order pharmacy, did include 90 day supplies, was based on 79 to 80 percent generic utilization, and assumed the Medicaid Agency would maintain control of drug rebates since rebate dollars are used for match in lieu of state dollars. It was noted that an increase in generic utilization would have an impact on the overall savings. A PBM would supplement Medicaid's activities and would build upon what had already been established.
- Walmart proposed an access based network where Medicaid recipients would use Walmart pharmacies exclusively within 0 to 17 miles, with Walmart using community pharmacies to fill in coverage gaps and possibly providing transportation to pharmacies for some Medicaid recipients. In return for an increased volume of Medicaid patients, Walmart would provide very aggressive rates as well as dispensing fees. Variations in usual and customary charges would be significantly reduced by Medicaid recipients utilizing Walmart pharmacies exclusively. Medicaid would not pay more than \$4/\$10 for drugs prevalent on Walmart's \$4/\$10 drug programs (there would be no additional dispensing fee for these drugs). Over an 8 year time span, the state savings were projected to be \$40 million to \$65 or \$70 million. These savings assumed that all of the claims would go through Walmart. Alabama Medicaid would contract with a PBM, who would partner with Walmart to be the preferred provider. Choosing a preferred pharmacy network would require a change in the Regional Care Organization legislation due to the "any willing provider" requirement.
- Alabama Prescription Services (APS) proposed a unique solution that would provide comprehensive prescription benefit management services through transparent methods using state of the art systems for claim payment, network, and clinical program management. APS could also assist with rebate management. The state savings were projected to be \$16 to \$20 million, based on 2012 data. APS could provide all of the services that a PBM could provide and would be able to work quickly (about 6 months) since they have been working with the Medicaid Agency for quite some time. The fees would depend on the services selected by the Medicaid Agency.

Discussion

Dr. Williamson informed the Commission that pharmacy taxes were decided by the Alabama Legislature and stated that if there was a significant change in the reimbursement methodology, the provider assessment would cease. This should be taken into consideration as Medicaid could lose \$9 million in revenue. Dr. Williamson stated the Commission had focused on Medicaid expenditures but wondered if the Commission should also focus on Medicaid revenue. He asked the Commission to consider the practicality of contemplating adjusting the pharmacy tax rather than cutting \$20 to \$40 million from a program that was already bare bones. He noted that the pharmacy tax was different from hospital and nursing home taxes in that almost all hospitals and nursing homes have Medicaid patients while some pharmacies have almost no

Medicaid business and some have a relatively heavy Medicaid business. Dr. Williamson noted this topic could be discussed in more detail at the next meeting of the Commission.

Future Meetings of the Commission

It was noted that Medicaid's actuary, Optumas, would review the information presented at today's meeting and would provide, at the next meeting of the Commission, estimates on the savings that may be achieved from each of the three options and would give their view of experiences in other states when major changes were made to the pharmacy payment and delivery system. Dr. Williamson noted that changes had already been implemented for 2014 that would save about \$11 million.

Dr. Williamson stated a report of the findings would be written following the next meeting and a final meeting would be held before December 1 to ensure all members of the Commission concurred with the report. The report would be provided to Governor Bentley by December 1, as outlined in the Executive Order. Dr. Williamson reminded the Commission that it was charged with presenting its findings to Governor Bentley, rather than making a recommendation.

Next Meeting Date

The next meeting of the Alabama Medicaid Pharmacy Study Commission will be held on November 14, 2013, at 1 p.m., in the Auditorium of the Montgomery County Health Department.

There being no further business, the meeting was adjourned.



Donald E. Williamson, M.D.
State Health Officer
Chair, Alabama Medicaid Pharmacy Study Commission

APPENDIX 3D – NOV 14, 2013 MEETING MINUTES

MINUTES OF THE ALABAMA MEDICAID PHARMACY STUDY COMMISSION NOVEMBER 14, 2013 MONTGOMERY COUNTY HEALTH DEPARTMENT AUDITORIUM MONTGOMERY, ALABAMA

Members Present

Donald E. Williamson, M.D., Chair
Stephanie Azar
Dorinda Cale
Jim Carnes
Representative Steve Clouse
Monica Fischer, representing Frank Brown
Jeff Freese
Rhonda Harden

Spencer Holden
Tammie Koelz
Representative Jim McClendon
Dan McConaghy
Michael Ramsey, M.D.
Jim Reddoch
Senator Greg Reed

Members Absent

Barry Cochran
Senator Arthur Orr

Opening Remarks

Dr. Williamson welcomed new Commission member, Jeff Freese. Mr. Freese is employed by Turenne PharMedCo and represents organizations that serve residents in nursing homes, mental health group homes, and assisted living facilities.

Dr. Williamson stated that Optumas had synthesized the previous work of the Commission, reviewed the estimated savings, factored in the impact of changes that had already been made in the pharmacy program, factored in the potential impact of the pharmacy tax, and generated the most probable savings associated with the models. Dr. Williamson further stated that everyone recognized that money saved by changing pharmacy was only one part of the equation. What had not been addressed in the Commission's work to date was the economic impact on the state of one model versus another. Dr. Williamson had a discussion with Optumas regarding other ideas and ways to quantify the impact in other states when those states changed their pharmacy delivery model.

Dr. Williamson informed the Commission that he had spoken with the Governor's Office earlier in the day and had been given approval to extend the work of the Commission by a month, if the Commission agreed. Commission members agreed to extend their work for an additional month and provide the report to the Governor by January 1.

Consideration of Minutes

The Minutes of the Alabama Medicaid Pharmacy Study Commission Meeting held on October 24, 2013, were approved as distributed.

Presentation by Optumas

Mr. Steve Schramm, Managing Director of Optumas, stated there was no specific recommendation on how the Alabama Medicaid pharmacy program should be changed and stated the quality of services to be provided must be equal to, if not greater than, the quality of services provided by the current system. He presented information which included the goals of the Commission; a recap of previous meetings during which the delivery and reimbursement system was discussed as well as the demand on the General Fund, increases in recent spending, and Alabama's pharmacy program as compared to other states; and a recap of the reform initiatives presented by the American Pharmacy Cooperative, representatives of Pharmacy Benefit Management (PBM) companies, and representatives of a Preferred Pharmacy Network. Mr. Schramm provided detailed comparisons of the foundation, quality and cost improvement, proposed savings, and general observations regarding each of the three initiatives. Optumas' projected bottom line impact, incorporating the provider tax loss (if applicable) and removing potentially unaccounted for savings overlap, was: a savings of \$5 million to \$15 million state dollars if American Pharmacy Cooperative was selected (assumed no loss of provider tax); a savings of \$11 million to \$29 million state dollars if a PBM was selected (assumed loss of provider tax); and a savings of \$19 million to \$30 million state dollars if a Preferred Pharmacy Network was selected (assumed loss of provider tax). All of the savings were in addition to the \$11 million in savings from initiatives implemented in 2013.

Mr. Schramm indicated that the three options presented were not the only options available to the state of Alabama nor were the options themselves fixed in stone. They were meant to be options that were representative of the kind of changes that the Alabama Medicaid program could make.

Because Alabama's Medicaid pharmacy program covers a myriad of populations, services, and settings, Mr. Schramm suggested that each option be considered on a very detailed level before considering a change in the program. In order to pursue necessary information, Optumas recommended Alabama explore a sequential procurement process of the options, as most states have done. For example, Alabama would issue a Request for Proposal for Option A and would evaluate whether it could accomplish the goals. If the goals could be accomplished using Option A, Alabama would select Option A. If not, it would move on to Option B and so on.

Discussion by Commission

Mr. Freese asked the Commission to consider the residents in nursing homes, mental health group homes, and assisted living facilities that are served by a pharmacy that must provide full blown medication distribution systems and processes that are much more than just a prescription vial that can be obtained in a retail setting. These pharmacies provide services such as medication documentation for the nurses, assurance that residents are receiving medications properly, delivery of medications often with a short time frame, education of nurses, medication distributions systems, and specialized packaging. Some of these pharmacies are in rural areas. Although this is not a large population, relative to overall Medicaid spend, and it may not have a significant financial impact, Mr. Freese suggested these residents be carved out of this type of program.

Mr. Carnes expressed concern that the Commission had not seen any attempt to evaluate the human side of the equation, the relationship between the patient and the pharmacist, and the counseling that is so crucial to the Medicaid population. Mr. Schramm replied that these things

were typically seen in a more detailed specification sheet associated with the procurement process and should be added as performance standards.

Senator Reed expressed his concern that there would be the potential for pharmacies to receive less in reimbursement or their financial opportunities would be lessened as a result of these implementations and options. He stated the Commission must be careful in recognizing the economic and quality impacts as time goes along. As an example, a pharmacist in a very rural part of the state would find it easier to close the pharmacy and work for a big box store than to keep the pharmacy open in a small area. What would happen to the patient in this particular setting who depended on the pharmacist as their primary access to any kind of health care? A two-day problem for the patient could turn into a three-week problem and the state would have to pay a larger dollar amount to care for that patient in a hospital setting.

Representative McClendon requested American Pharmacy Cooperative speak on their purview of fraud, waste, and abuse since it was not specifically mentioned during their earlier presentation to the Commission. Mr. George Hiller and a representative of Health Information Designs described their processes relative to fraud, waste, and abuse.

Senator Reed questioned if there would be changes in regard to the Centers for Medicare & Medicaid Services' (CMS) guidelines for pharmacy reimbursement. Alabama adopted these guidelines in 2010 and saved significant dollars. Dr. Williamson explained that nothing would change with the guidelines and explained the process of approval by CMS if substantive changes were made to the pharmacy program. Dr. Williamson pointed out that if Alabama chose the single most aggressive option available, it would not close the funding shortfall in Medicaid by more than one-third at best. He further indicated that pharmacy, by itself, was not the solution to the funding shortfall.

Next Meeting Date

The final meeting of the Alabama Medicaid Pharmacy Study Commission was scheduled for December 13, 2013, at 1 p.m. The goal of the meeting will be to review data on the economic impact, to review data on Georgia's "most favored nation" status, to review a comparison of market basket drugs in both Alabama and Georgia, and to review the draft Commission report. If the Commission is unable to vote on the report at the December 13 meeting, another meeting will be held via conference call, prior to January 1.

There being no further business, the meeting was adjourned.



Donald E. Williamson, M.D.
State Health Officer
Chair, Alabama Medicaid Pharmacy Study Commission

APPENDIX 3E – DEC 13, 2013 MEETING MINUTES

MINUTES OF THE ALABAMA MEDICAID PHARMACY STUDY COMMISSION DECEMBER 13, 2013 MONTGOMERY COUNTY HEALTH DEPARTMENT AUDITORIUM MONTGOMERY, ALABAMA

Members Present

Donald E. Williamson, M.D., Chair
Stephanie Azar
Rhonda Harden
Tammie Koelz
Representative Jim McClendon
Dan McConaghy

Craig Miller representing Jeff Freese
John Pickens representing Jim Carnes
Michael Ramsey, M.D.
Senator Greg Reed
Tim Stone, M.D., representing Jim Reddoch

Members Participating by Telephone

Dorinda Cale
Barry Cochran
Spencer Holden

Members Absent

Frank Brown
Representative Steve Clouse
Senator Arthur Orr

Opening Remarks

Dr. Williamson informed the Commission members that the draft report of the Commission's findings would be generated and e-mailed to Commission members for review, comment, and approval. Verbal comments provided by Mr. Freese to consider excluding long-term care pharmacy from any pharmacy changes and written comments provided by Mr. Carnes would be included as addendums to the report.

Consideration of Minutes

The Minutes of the Alabama Medicaid Pharmacy Study Commission Meeting held on November 14, 2013, were approved as distributed.

Presentation by Optumas

Mr. Steve Schramm, Managing Director of Optumas, presented an outline of the contents of the Commission's report and a summary of the economic impact. He indicated the report would include the purpose of the Commission, accomplishments of previous meetings, a high-level summary of the three proposals that were presented, the economic impact on independent pharmacies in Alabama, considerations regarding the Most Favored Nation rate and an increase in the provider tax, and attachments.

After further discussions with American Pharmacy Cooperative, Inc. (APCI) and the Pharmacy Benefits Management (PBM) companies, Optumas adjusted the savings estimates of these two

groups to ensure some of the changes that had or would take place were not double counted for savings. Potential state savings of the three proposals were stated as: APCI - \$9 million to \$18 million (included the provider tax); PBM - \$13 million to \$35 million (did not include the provider tax); and for the Preferred Pharmacy Network - \$19 million to \$30 million (did not include the provider tax). Mr. Schramm stated these savings were not exact – the only way to obtain exact savings estimates would be through the procurement process, where guarantees associated with ingredient costs, dispensing fees, and network adequacy could be negotiated. Additional considerations were the Most Favored Nation rate, which could potentially save an additional \$3 to \$9 million, and the provider tax.

Mr. Schramm indicated there were 1,400 to 1,500 pharmacies in Alabama, which included independent pharmacies, chain pharmacies, and traditional retail pharmacies. Optumas' analysis focused on independent pharmacies because those are the types of pharmacies that the literature identified as being most at risk for closure when changes in government programs occurred. Of the approximately 60,000 pharmacies in the U.S., approximately 21,000 were independent pharmacies. Approximately 90 percent of pharmacy revenues for independent pharmacies were prescription based, with prescriptions being broken into four categories: Medicaid, Medicare Part D, other third party, and cash. Mr. Schramm described in detail the percentage of prescriptions, the percentage of revenue, the average gross margin, the components of margin, and the percentage of margin of the four categories for independent pharmacies. He also discussed closure rates, economic margins, and churn impacts.

If Medicaid spend was reduced (which would reduce the margin by 10 percent) it would reduce cash going into pharmacies and could result in reduced jobs in some of those pharmacies but in turns of unanticipated closures, it would not be possible to isolate the closure of any given independent pharmacy solely because of a change in Medicaid reimbursement. Increased Medicaid enrollment would not have a material impact on pharmacy closures, unless Alabama expanded Medicaid.

Dr. Williamson stated there was no good data to determine the economic impact and stated that Optumas did not suggest that the closure of one to four pharmacies in Alabama was not significant, that it would not have an economic impact on those communities, or that the reduction of reimbursement to pharmacies would not potentially cost jobs in some pharmacies. Relatively small changes in the Medicaid reimbursement (it would only be 10 to 15 percent of total pharmacy business and would constitute a relatively small percentage of the current margins) would not have cataclysmic effects on the overall pharmacy infrastructure. It could, however, be cataclysmic for an individual pharmacy.

Optumas' preliminary findings were that Alabama's Medicaid pharmacy program structure was considered leading edge and spend was reasonable and in the lowest five states across the country; there were additional changes that could be implemented to continually improve the program's effectiveness; reductions in Medicaid margin appeared to have minimal impact on the pharmacy closure rate; and if the state changed the delivery system, a Request for Proposal process would be needed in order to determine the true savings.

Discussion by Commission

Mr. Pickens referenced Mr. Carnes' written comments and asked if access to care and quality could be evaluated, possibly in another study. Optumas' analysis indicated access to care would not be materially impacted due to the very small change in closure rates. It would be very challenging to provide an estimate for quality of care.

Ms. Koelz indicated the need for chain pharmacies to be reviewed more in depth because those pharmacies filled far more prescriptions than independent pharmacies and would close if it became cost prohibitive to fill prescriptions. Further, chain pharmacies would refuse to accept prescriptions if it became a detriment to their economics. If all chain pharmacies pulled out, it would affect access to care and would affect jobs. Mr. Schramm responded that while this was true, it was not the experience nationally. Chain pharmacies grew dramatically during the Medicare Part D period, they continued to grow when the economic recession happened, and the study Optumas used commented on the location of chain pharmacies – chain and retail pharmacies tended to dominate the urban and suburban areas, which had more than adequate access. If chain pharmacies chose to pull out, it would not impact access to care in urban and suburban areas. It would, however, have an economic impact on the employees of those pharmacies. Alabama had greater than 95 percent pharmacy participation so, although possible, it would be unlikely that chain or retail pharmacies would wholesale pull out of the Medicaid market place.

Mr. McConaghy suggested adding a caveat in the report that stated Optumas used national averages adjusted for Alabama and the averages may not be applicable to every geographic region in the state or any given pharmacy.

Ms. Louise Jones, Alabama Pharmacy Association, suggested the report detail the entire economic impact, rather than just focusing on pharmacy closures. She indicated Alabama pharmacies were already at a higher susceptible level of closure due to reductions that had already been made and some pharmacies had indicated to her that they could not sustain many more cuts.

Closing Remarks

The Commission voted to allow Optumas to draft the report, which would be available the middle of next week. The report would be e-mailed to Commission members with a response date for comments. Dr. Williamson asked Commission members to focus on content rather than stylistic changes. Revisions would be made, based on comments received, and the report would be e-mailed to Commission members for approval before submission to Governor Bentley on January 1, 2014.

There being no further business, the meeting was adjourned.


Donald E. Williamson, M.D.
State Health Officer
Chair, Alabama Medicaid Pharmacy Study Commission

Alabama Medicaid Pharmacy Study Commission

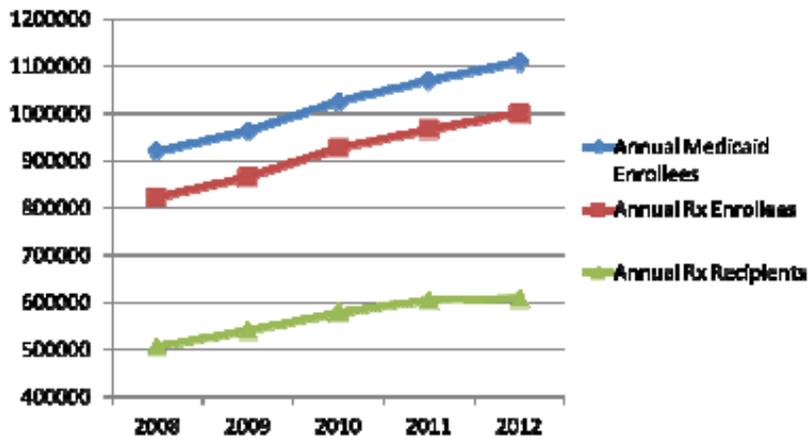
Overview of the
Alabama Medicaid
Pharmacy Program

August 23, 2013

Program Overview

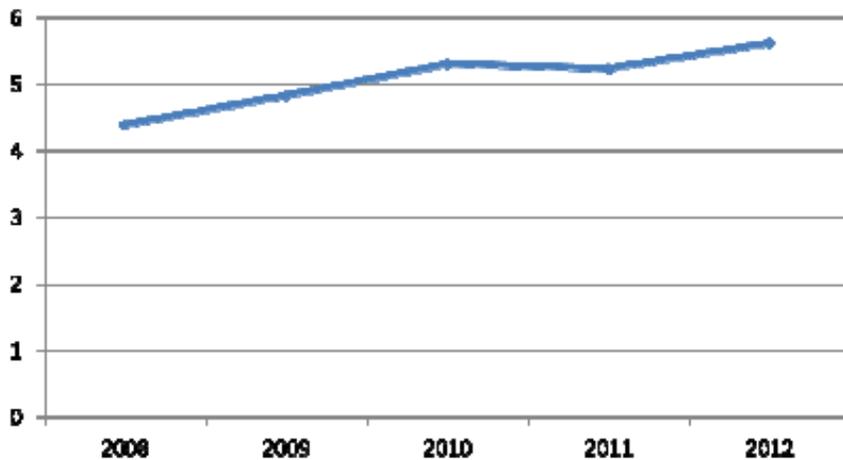
- Pharmacy Expenditure Rate vs. Overall Program Growth
- State Funding Sources
- Reimbursement
- Program Controls Now In Place
- Addressing the Shortfall in FY 2014

Total Medicaid and Pharmacy Enrollment



Total Medicaid Spending

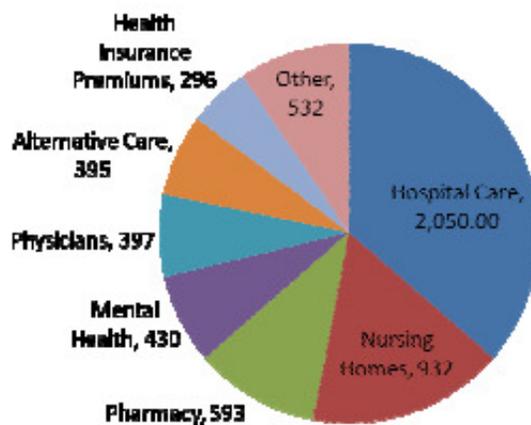
in billions



Overall Medicaid Expenditures

Service	FY 2008	FY 2012	% Rate +/-
Hospital Care	\$1.41Billion	\$2.04 Billion	30.9%
Nursing Facilities	\$768.3 Million	\$932.6 Million	17.6%
Pharmacy	\$502.6 Million	\$593.1 Million	18.0%
Physicians	\$324.6 Million	\$397.5 Million	18.3%
Total Spend for all services	\$4.40Billion	\$5.63Billion	21.8%

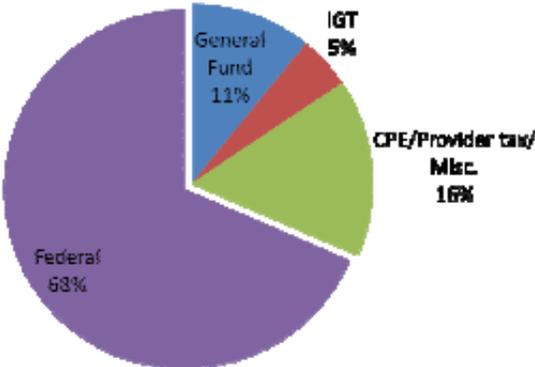
Medicaid Expenditures FY 12



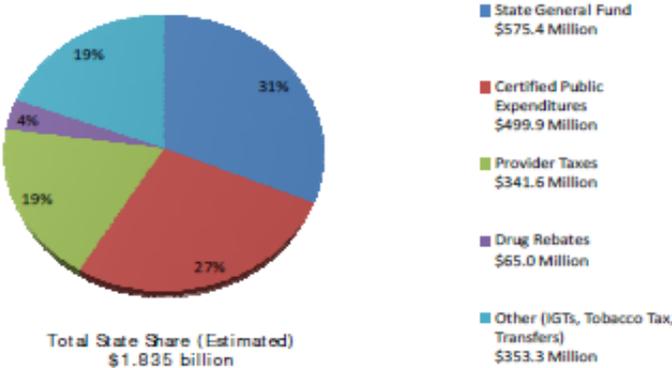
\$ 5.6 billion

Medicaid Funding

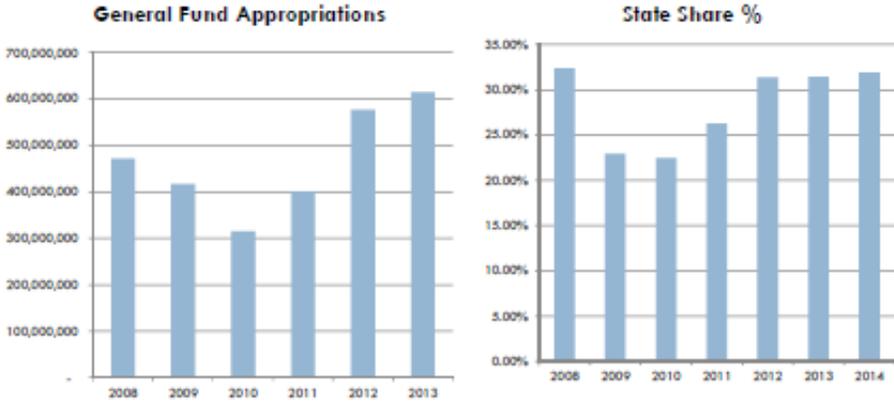
Source of Funds



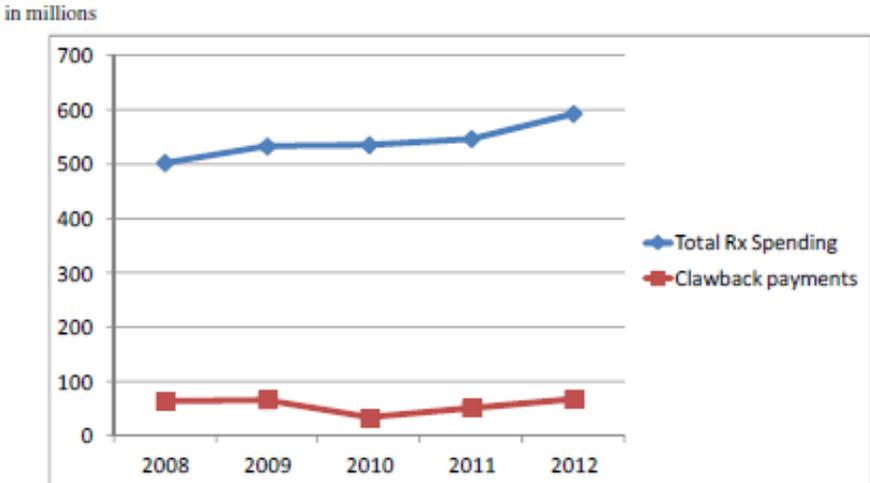
FY 2012 Budget Sources of State Share



General Fund Appropriations Related to FMAP



Pharmacy Spending

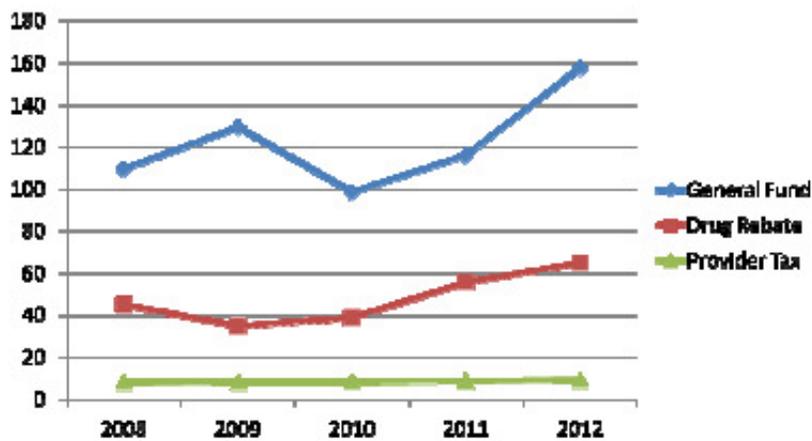


Pharmacy Program Financing FY 2008 - 2012

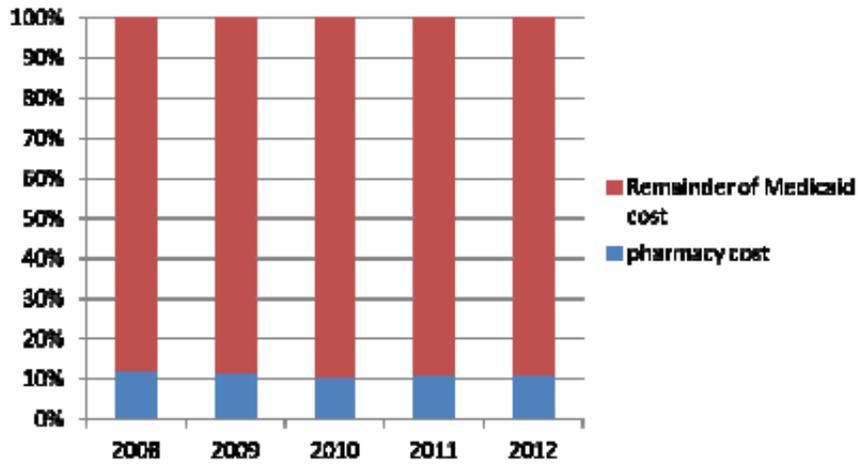
	2008	2009	2010	2011	2012	Change
# Rx enrollees	822,654	866,484	928,347	967,304	1,001,937	179,233 (22%)
Recipients as % enrollees	62%	63%	62%	63%	61%	
Total Rx Spend	\$502.6m	\$533.3m	\$535.8m	\$546.9m	\$593.1m	\$90.5m (18%)
Claw back	\$63.8m	\$65.7m	\$33.6m	\$50.8m	\$67.0m	\$3.2m (5%)
State Rx share	\$163.3m	\$172.9m	\$146.4m	\$181.0m	\$232.1m	\$68.8m (42%)
Provider Tax	\$8.3m	\$8.4m	\$8.6m	\$8.9m	\$9.3m	\$1.0M (12%)
State rebate retained	\$45.2m	\$34.9m	\$38.8m	\$55.8m	\$64.9m	\$19.7m (44%)
General Fund for Rx	\$109.8m	\$129.6m	\$98.9m	\$116.3m	\$157.9m	\$48.1m (44%)

Pharmacy Funding State Share

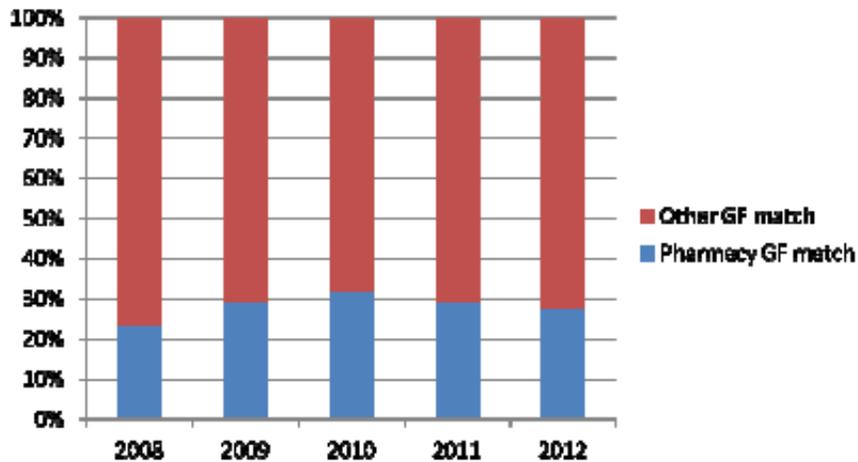
in millions



Pharmacy Cost as a Percent of Total Medicaid Expenditure



State GF Pharmacy match as Percent of Total Medicaid GF



State Funding Sources Pharmacy Provider Tax

Fiscal Year	Tax Receipts	% of State Rx Share
2008	\$8.32 Million	5.1
2009	\$8.41 Million	4.9
2010	\$8.63 Million	5.9
2011	\$8.94 Million	4.9
2012	\$9.26 Million	4.0

- 40-26B-2 requires pharmacy providers pay 10 cents for each prescription filled or refilled for a citizen of Alabama; amount self-reported directly to Alabama Dept. of Revenue

State Funding Sources Drug Rebate

Fiscal Year	Rebates Retained by state	% of State Share
2008	\$45.2 Million	27.7
2009	\$34.9 Million	20.2
2010	\$38.8 Million	26.5
2011	\$55.8 Million	30.8
2012	\$64.96 Million	28.0

- If a drug manufacturer participates in the federal rebate system, Medicaid MUST cover the drug.
- State can restrict through Prior Authorization (PA), edits/audits
- State must return federal portion

State Funding Sources General Fund

Fiscal Year	General Fund used as State share	% of Rx state share
2008	\$109.7 million	67.2
2009	\$129.6 million	74.9
2010	\$98.9 million	67.6
2011	\$116.3 million	64.3
2012	\$157.9 million	68.0

Financing Summary 2008-2012

- 21% increase in total Medicaid spending and an 18% increase in Pharmacy spending
- 42% increase in state share
 - 12% increase in provider tax
 - 44% increase in rebate
 - 44% increase in general fund
- Increase driven by
 - decrease in FMAP due to loss of stimulus
 - 22% growth in enrollees

Prescription Volume and Cost

	2008	2009	2010	2011	2012	Change
Annual # of Rx	7,263,645	7,844,949	8,603,799	8,867,049	8,961,210	1,697,565 (23%)
Average Rx cost per enrollee	\$ 611	\$ 616	\$ 577	\$ 565	\$ 593	- \$ 18 (- 2.9%)
Average # of Rx per recipient	14.3	14.5	14.9	14.6	14.7	0.4 (2.8%)
Average Cost to Medicaid per Rx	\$ 60.40	\$ 59.60	\$ 58.38	\$ 55.95	\$ 58.71	-\$ 1.69 (- 2.8%)

Pharmacy Reimbursement

- Medicaid pays pharmacies based on "Lower Of" method for drug ingredient cost (since September 2010):
 - Federal Upper Limit (FUL)
 - Alabama Estimated Acquisition Cost (AEAC)
 - Average Acquisition Cost (AAC) or
 - Wholesale Acquisition Cost+0% (after Oct 1) if no AAC available
 - Usual & Customary Charge (U&C) to the public (e.g. \$4 drugs)
 - State Maximum Allowable Cost (State MAC) – Defined in Alabama as Average Acquisition Cost (AAC)
 - Medicare Part B for Blood Clotting Factor
- Plus: Dispensing Fee of \$10.64 / prescription

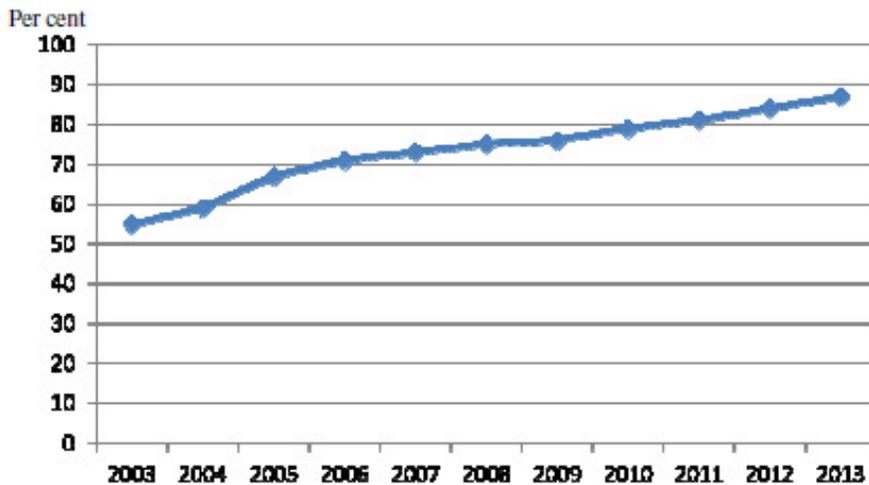
Dispensing Fee

- Includes only pharmacy costs associated with ensuring that possession of the appropriate covered outpatient drug is transferred to a Medicaid recipient. (CFR) 42 CFR 447.502
- Changed in 2010 to more accurately recognize all costs associated with dispensing drugs (in excess of the ingredient cost):
 - Personnel (pharmacists, technicians, clerks) time to check coverage, measure or mix drugs, fill container, counsel recipients, and deliver the product
 - Computers and equipment
 - Overhead cost of running a pharmacy (not entire store), maintaining inventory, etc.
- Does not include administrative costs incurred by the State in the operation of the covered outpatient drug benefit including systems costs for interfacing with pharmacies

Program Cost Controls

- Change from AWP-10% to AAC
- Increase in generic utilization
- Pharmacy & Therapeutics Committee and Preferred Drug List (PDL)
- Prior Authorization
- Brand-Name/Total drug limits
- Edits and audits (early refill, max units, therapeutic duplication, accumulation edit, and max cost)
- Dispense as Written (DAW) requirements
- Drug Utilization Review (DUR) Board

Generic & OTC Utilization



Plan to Address Shortfall in FY 14 Projected State Savings \$12.3 m

Change	Start Date	Prorated Savings to State for FY14
Monthly Drug Limit of 4 brand-name, 5 total drugs for adults; Exclusions for brand-name and generic anti-psychotic drugs and drugs for HIV or seizures, with allowances up to 10 total drugs per month for these drugs	1/1/14	\$2.85 million
Mandatory dispensing of 3 month supply for certain maintenance drugs	1/1/14	\$1 million
End coverage of OTCs for children and adults, with exception for insulin and nutritionals which remain covered	10/1/13	\$3.6 million
Ingredient cost change from WAC+9.2% to WAC+0%	10/1/13	\$2.0 million
Expansion of DUR Board activities	10/1/13	\$1.7 million
Changes to Drug Compounding coverage	7/1/13	\$0.4 million
Increased Co-Payments for Recipients	7/1/13	\$0.68 million
New edits to prevent stockpiling of drugs via early refills	7/1/13	\$0.1 million

Summary

- Increased cost driven by increase in enrollees and decrease in FMAP
- Increase mitigated by stability in average pharmacy cost per enrollee and average price per Rx
- **General Fund match has increased by 44%, from \$110 m to \$158 m**

**Alabama Medicaid
Pharmacy Study Commission**



**State-by-State
Comparison**

October 10, 2013

Objective



To compare Alabama Medicaid's
pharmacy program to other state
Medicaid programs

EXHIBIT 9
AVERAGE MONTHLY MEDICAID PHARMACY REIMBURSEMENT, BY BASIS OF ELIGIBILITY AND DUAL STATUS, 2009^{a,b,c}



Source: Medicaid Analytic eXtract (MAX), 2009. This graph is based on the information contained in Tables 4, ND.4, and D.4 of the Compendium. The Compendium was prepared for 43 states and the District of Columbia. FFS pharmacy reimbursement information for the remaining states is not included because they did not submit complete data to CMS for 2009.

^aThe Medicaid pharmacy reimbursement amount is the amount Medicaid reimbursed pharmacies, including dispensing fees minus beneficiary copayment. Reimbursement amounts are gross amounts prior to the receipt of rebates from drug manufacturers to states.

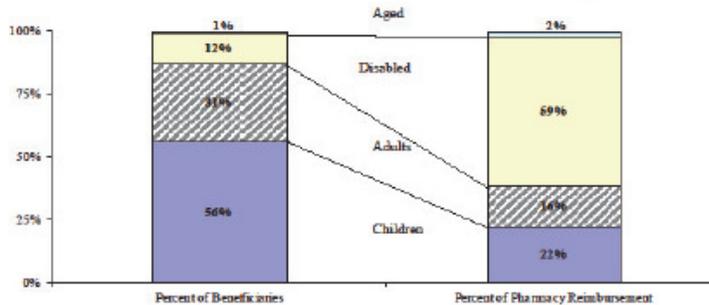
^bMonthly reimbursement amounts were calculated by dividing the total reimbursement among all beneficiaries in the study population by the total number of benefit months of those beneficiaries. Benefit months are months during which beneficiaries had FFS pharmacy benefit coverage.

^cMedicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness, and thus includes a large number of dual eligibles. The children's group includes children receiving foster care and adoptive services. The total includes some beneficiaries with unknown basis of eligibility and some whose age categories are not consistent with basis of eligibility.

^dDual eligibles are beneficiaries who had Medicare as well as Medicaid FFS pharmacy benefits during any month of Medicaid enrollment in 2009. Nondual beneficiaries include beneficiaries who were never dually eligible or were dually eligible but never had Medicaid FFS pharmacy benefits. Refer to Table 1 in the Compendium for more information about how we determined dual eligibility status.

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EXHIBIT 14
DISTRIBUTION OF MEDICAID BENEFICIARIES AND TOTAL PHARMACY REIMBURSEMENT AMONG NONDUAL BENEFICIARIES, BY BASIS OF ELIGIBILITY, 2009^{a,b,c}



Source: Medicaid Analytic eXtract (MAX), 2009. This graph is based on the information contained in Tables ND.2, ND.3, and ND.5 of the Compendium. The Compendium was prepared for 43 states and the District of Columbia. FFS pharmacy reimbursement information for the remaining states is not included because they did not submit complete data to CMS for 2009.

^aThe Medicaid pharmacy reimbursement amount is the amount Medicaid reimbursed pharmacies, including dispensing fees minus beneficiary copayment. Reimbursement amounts are gross amounts prior to the receipt of rebates from drug manufacturers to states.

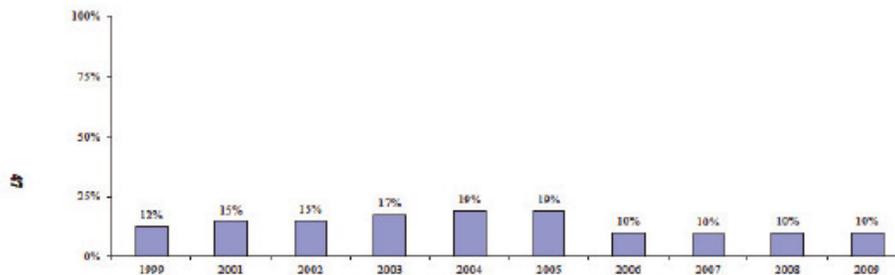
^bMedicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness, and thus includes a large number of dual eligibles. The children's group includes children receiving foster care and adoptive services.

^cDual eligibles are beneficiaries who had Medicare as well as Medicaid FFS pharmacy benefits during any month of Medicaid enrollment in 2009. Nondual beneficiaries include beneficiaries who were never dually eligible or were dually eligible but never had Medicaid FFS pharmacy benefits. Refer to Table 1 in the Compendium for more information about how we determined dual eligibility status.

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EXHIBIT 34

MEDICAID PHARMACY REIMBURSEMENT AS A PERCENTAGE OF COSTS OF ALL SERVICES, 1999 and 2001-2009^{1,2}



Source: Medicaid Analytic eXtract (MAX), 2009. This graph is based on the information contained in Table 4 of the 1999 and 2001-2009 Compendiums. The Compendium was prepared for 42 states and the District of Columbia. FFS pharmacy reimbursement information for the remaining states is not included because they did not submit complete data to CMS for 2009.

¹The Medicaid pharmacy reimbursement amount is the amount Medicaid reimbursed pharmacies, including dispensing fees minus beneficiary copayment. Reimbursement amounts are gross amounts prior to the receipt of rebates from drug manufacturers to states.

²In 7 states in 2004 (DE, IA, NE, NY, TX, UT, and WV), 8 states in 2005 (DE, IA, IL, NE, NY, TX, UT, and WV), 10 states in 2006 (DE, IA, IL, NC, NE, NY, TN, TX, UT, and WV), 8 states in 2007 (DE, IA, IL, NE, NY, TN, TX, and WV), 12 states in 2008 (CT, DE, IA, IL, NE, NJ, NY, OR, TN, TX, UT, WI, and WV), and 11 states in 2009 (CT, DE, IA, IL, NE, NJ, NY, OR, TN, TX, and WV) expenditures for Medicaid services include only Rx drug expenditures for those enrolled in capitated managed care plans, and not expenditures for other services covered by the plans or for long-term care services not covered by the plans. As a result, pharmacy reimbursement as a percentage of the costs of all Medicaid services is higher in 2004-2009 than it would otherwise be.

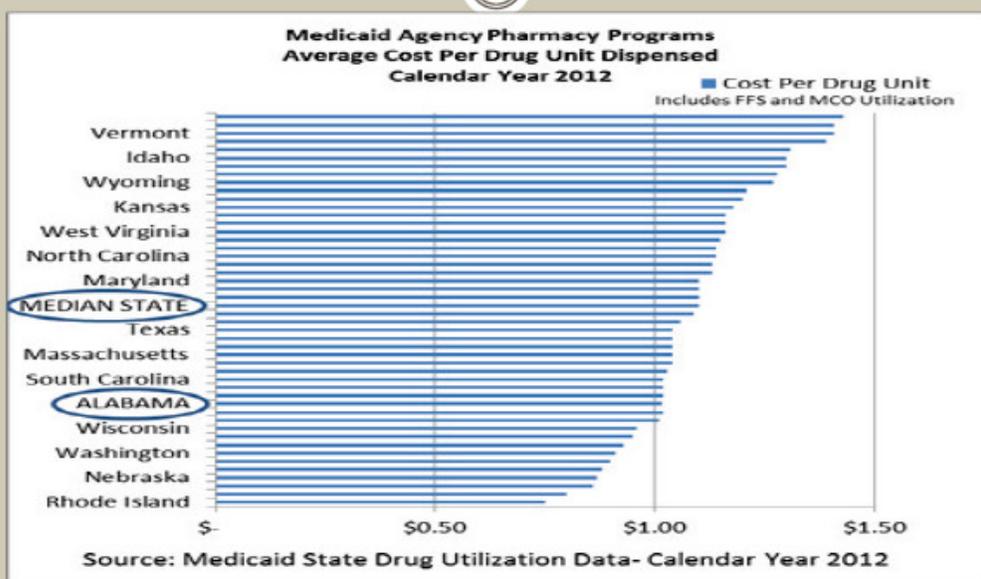
Components of Analysis

- Ranking based on average cost to state Medicaid agency per unit of outpatient drugs issued by pharmacies to Medicaid beneficiaries, calendar year 2012
 - Alabama's avg unit cost: \$1.02 per unit in CY2012
- Of 50 states analyzed, 11 states have avg cost/unit less than Alabama
 - From \$0.75 - \$3.49 per drug unit in CY2012
- Unit drug cost is average from 2012 Drug Utilization data

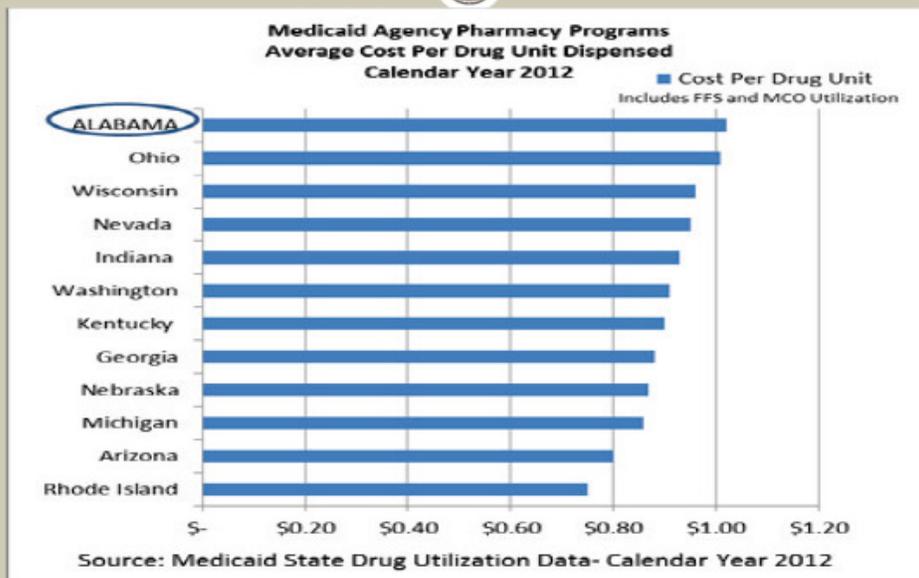
Additional Components of Analysis

- Enrollment in Managed Care
- Pharmacy from Managed Care
- Ingredient cost methodology
 - WAC – Wholesale Acquisition Cost
 - AWP – Average Wholesale Price
 - FUL – Federal Upper Limit
 - U/C – Usual and Customary
 - AAC – Actual or Average Acquisition Cost
- Dispensing fee / prescription
- Monthly prescription limits

Average Cost Per Drug Unit Dispensed



Average Cost Per Drug Unit Dispensed



Service Delivery Strategies in States By Unit Cost in 2012

- **11 states with lower per unit cost per drug**
 - RI, AZ, MI, NE, GA, KY, WA, IN, NV, WI, OH
 - 6 of 11 [55%] states have greater than 30% of drugs distributed by managed care
- **5 states with same per unit cost per drug**
 - IL, VA, IA, SC, AL
 - 2 of 5 [40%] states have greater than 30% of drugs distributed by managed care
- **34 states with greater per unit cost per drug**
 - ME, MN, MA, NM, OR, TX, AR, NJ, SD, UT, MD, ND, FL, NC, NH, OK, WV, PA, NY, KS, MS, TN, WY, CA, MN, ID, CO, MO, VT, DE, LA, CT, AK, HI
 - 8 of 34 [24%] states have greater than 30% of drugs distributed by managed care
- **Each \$0.01 difference is worth \$ 5million**

Limitations Of Unit Cost

- Per Unit Cost is only one variable in pharmacy expenditures
 - Includes reimbursement methodology (ingredient cost) and dispensing fee
- Factors not controlled by per unit cost
 - Utilization
 - Program limits
 - Medicaid eligibility group mix

Other Southern States

State	Average cost per unit of drugs CY2012 ¹	Percentage of Medicaid enrollees who get drug paid for through managed care ²	Ingredient cost methodology: FFS Only ³	Dispensing fee per prescription ⁴	Monthly limits on prescriptions for adults ⁴
GA	\$0.88	85.7%	AWP minus 11%, exceptions for drugs for rare or complex diseases; Most Favored Nation; U&C; State MAC. Specialty pharmacy pricing July, 2012	\$4.63; \$4.33 for not-for-profit pharmacies	No monthly limit except for a limit of 5 Rx's per month on narcotics.
SC	\$1.02	52.7%	Lower of AWP-16% or WAC+8%	\$3	4, with 3 overrides available for certain conditions. Some drugs not eligible for overrides.
AL	\$1.02	0.0%	Lower of Actual Acquisition Cost (AAC), Wholesaler Acquisition Cost (WAC) + 9.2%, Federal Upper Limit (FUL) or Usual and Customary (U/C).	\$10.64	4 name brands for adults with no limit on over-the-counter drugs or generics.
AR	\$1.06	0.0%	AWP minus 14% (brand); AWP minus 20% (generic)	\$5.51	3 for adults, but doctor can seek up to 6 if doctor deems recipient needs more than three maintenance prescriptions per month
MS	\$1.20	15.7%	Lower of FAWP minus 1.2% or WAC + 9% for brand drugs; AWP minus 25% for generic.	\$3.91 for brand drugs; \$4.91 for generics	No more than 5, of which no more than 2 may be non-preferred/brand for adults, exempting those in long-term care..

¹Average costs to state Medicaid agencies per unit of outpatient drugs issued by pharmacies to Medicaid beneficiaries in 2012, from an analysis of Medicaid State Drug Utilization data for 2012.

²Sources: Recent interviews with, or e-mails from, state Medicaid officials. DW

³Sources: Alabama Medicaid, Medicaid Covered Outpatient Prescription Drug Reimbursement Information by State, Quarter Ending June 2013, from CMS; also, "Managing Medicaid Pharmacy Benefits: Current Issues and Options," by the Kaiser Commission on Medicaid and the Uninsured.

⁴ Sources: Comparison by the American Medicaid Pharmacy Administrators Association

*Effective 10/1/13, percentage to WAC decreased to 0% in the formula

**Effective 1/1/14, monthly adult prescription limit is up to 4 brand/5 total, exceptions for antipsychotics, antineoplastic, antiepileptic; mandatory 3-month supply in certain drug classes

Questions?



- Analysis by David White, Gov. Robert Bentley's health policy advisor

- Next meetings:
 - October 24, 2013, 1 p.m. – 3 p.m.
 - November 14, 2013, 1 p.m. – 3 p.m.

APPENDIX 4C – OCT 24, 2013 MEETING HANDOUTS

1. PBM PRESENTATION

1

VALUE OF PHARMACY BENEFIT MANAGEMENT (PBM) TO ALABAMA MEDICAID

Danny Smith
Strategic Account Executive, CVS Caremark

Krista Ward
Senior Director - Medicaid, Express Scripts

Greg Watanabe, R.Ph.
President, MedImpact Healthcare System, Inc.

October 24, 2013

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Agenda

- PBM Background
- PBM Components
 - Clinical Services
 - Analytics/Reporting
 - Network Management
- Alabama Medicaid Savings
- Questions

PBM Background

- Well Established Industry
- 215 Million Lives Managed by the Industry
- Types of Clients Serviced
 - Employer Groups
 - Managed Care Organizations
 - Medicare and Medicaid
- Processing Claims in Alabama for more than 20 Years



PBM Components

- Clinical Services
 - Drug Utilization Management
 - Compliance/Adherence
 - Formulary Management
 - Patient Education/Information
 - Prescriber Education/Information
 - Disease Management
 - Practice Guidelines
 - Specialty Management



PBM Components

- Analytics and Reporting
 - Quality Measurement
 - Accessibility Analysis
 - Population Management Optimization
 - Utilization and Financial Forecasting



PBM Components

- Network Management
 - Contracting
 - Reimbursement
 - Fraud, Waste and Abuse



Alabama Medicaid Savings

- 2011 Claims Data Shows \$30M to \$50M Annual State Dollar Savings
- Requirements to Realize Savings
- Requirements for Capitated Arrangement



QUESTIONS?



2. PREFERRED PHAMRACY NETWORK PRESENTATION



Alabama Medicaid Pharmacy Savings Proposal

Payer Relations
October 24th, 2013



Changing the Medicaid Model

Current Environment	Walmart Environment
<ul style="list-style-type: none"> • All providers participate due to Any Willing Provider Laws creating disincentive to discount. • Copay's same at all providers. No incentive for patient to use low cost providers. • Medicaid at times can pay two pharmacies located next door to each other differently based on retailer U&C. • Limited coverage of products that incent Wellness vs. Acute need state. 	<ul style="list-style-type: none"> • Create Access Based Network that limits the number of providers in network to Walmart, which includes Sam's and other formats. Fill coverage gaps through use of Community Pharmacies. • Medicaid recipients will utilize Walmart Pharmacies Exclusively, thus significantly reducing variations in U&C pricing. • States will not pay more than \$4/\$10 for drugs prevalent on Walmart's \$4/\$10 drug programs. • Comprehensive programs offered that improve Wellness outcomes ...e.g., Text messages, Compliance Packs

2 | Alabama Medicaid



Access at a Glance

Accessibility Analysis Specifications: Average Distance

Range	0 - 10 Miles	10.1 - 17 Miles	17.1 + Miles
Percentage of Members	78.82%	13.87%	7.31%
Average Distance	3.9 Miles	13.23 Miles	20.25 Miles



8 Year Savings Projection*

Year	1	2	3	4	5	6	7	8
RX CT	8534348	8705035	8879136	9056718	9237853	9422610	9611062	9803283
Per Script	\$58.06	\$61.55	\$65.24	\$69.16	\$73.30	\$77.70	\$82.37	\$87.31
Total Spend	\$495.5M	\$535.8M	\$579.3M	\$626.3M	\$677.2M	\$732.2M	\$791.6M	\$855.9M
Projected Per Script	\$45.42	\$48.15	\$51.03	\$54.10	\$57.34	\$60.78	\$64.43	\$68.29
New Spend	\$375.6M	\$406.3M	\$439.44M	\$475.26M	\$514.07M	\$556.02M	\$601.33M	\$650.41M
Savings to Baseline	\$119.9M	\$129.49M	\$139.85M	\$151.03M	\$163.12M	\$176.17M	\$190.26M	\$205.48M

*Subject to change should growth guidance or inflation projections change
 *Simplified view using 6% overall inflation and 2% Rx Count growth

APPENDIX

Our Commitment

Alabama

Associates:

Associates in Alabama: 35,273

Average wage: \$12.57*

*For regular, full-time hourly associates in Walmart Discount Stores, Supercenters and Neighborhood Markets, as of July 31, 2013

Total Stores: 138

Suppliers:

Spent with suppliers: \$1 billion

Supplier jobs supported: 27,910

*Supplier figures provided by Dun & Bradstreet for FYE 2013

Taxes and Fees:

Collected: \$802.1 million

Paid: \$45.4 million

*Collected on behalf of the state of Alabama as part of transactional sales of taxable goods and services for FYE 2013

Community Giving to Local Organizations in 2012:

Cash and in-kind donations from stores, clubs and the Walmart Foundation: \$21.8 million

Total giving, including customer donations: \$24 million

• **Distribution Centers:**

Total number of distribution centers: 3

Data Description

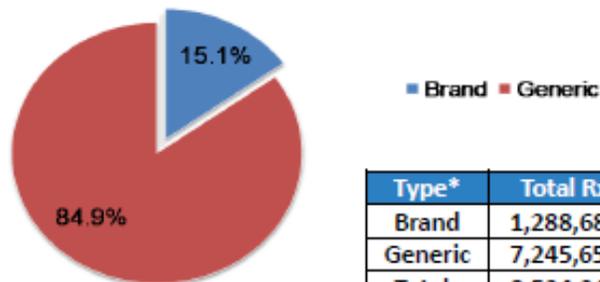
Claims file was received from Alabama Medicaid

- Claim time frame is Sept 2010 through Oct 2011
- Excluding DME and family planning
- Claims were also placed into one of the following categories (using Medispan MNOY codes):
 - Brands
 - Generic
- Savings were calculated by comparing costs of the Walmart Access Network program versus Alabama Medicaid's current spend.

Baseline Claims Summary

Total RX Count	Total Spend	Average Cost/RX
8,534,348	\$495,539,651.00	\$58.06

Brand vs. Generic Breakdown



* Brand/Generic determination is based on MSI codes per Medispan.

Baseline Claims Summary

	Per Claim	RX Count	Total Spend	Spend Share ³	Market Share ⁴
Walmart	\$40.25	686,172	\$26,816,298	5.41%	7.81%
National Drug Chains Chains	\$49.57	3,306,890	\$163,937,198	33.08%	38.75%
Independents and Regional Chains	\$46.99	5,139,370	\$241,506,690	48.74%	60.22%
Total Retail¹	\$48.01	8,446,260	\$405,443,888	81.82%	98.97%
Specialty ²	\$1,022.79	88,088	\$90,095,762	18.2%	1.0%
Total	\$58.06	8,534,348	\$495,539,651	100.0%	100.00%

¹ Includes Walmart, National Drug Store Chains, Independents, regional chains and non Specialty dispensed out of specialty facilities

² Determination to place drug in the Specialty category was made based on cost of drugs and special handling required

³ Spend Share represents the % of total Medicaid spend in the claim set

⁴ Market Share is the % of total Rx claims filed at each respective provider type divided by the number of total claims

9 | Alabama Medicaid



Projected Spend*

Year	1	2	3	4	5	6	7	8
RX CT	8,534,348	8,705,035	8,879,136	9,056,718	9,237,853	9,422,610	9,611,062	9,803,283
Per Script	\$58.06	\$61.55	\$65.24	\$69.16	\$73.30	\$77.70	\$82.37	\$87.31
Total Spend	\$495.5M	\$535.8M	\$579.3M	\$626.3M	\$677.2M	\$732.2M	\$791.5M	\$855.9M

* Simplified view using 6% overall inflation and 2% Rx Count growth; subject to adjustment per expected AL guidance

10 | Alabama Medicaid



Walmart Proposed Rates and Conditions

•These are proposed on the assumption of Access Based arrangement where Walmart would service all eligible members through its retail locations.

•Specialty items are going to be subject to separate schedule, TBD

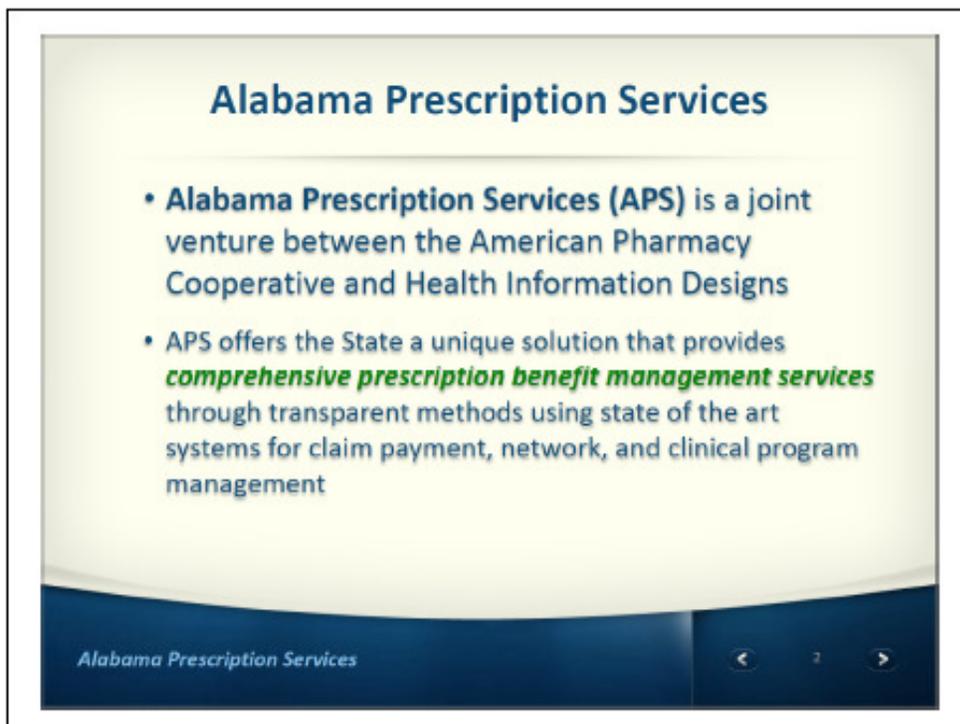
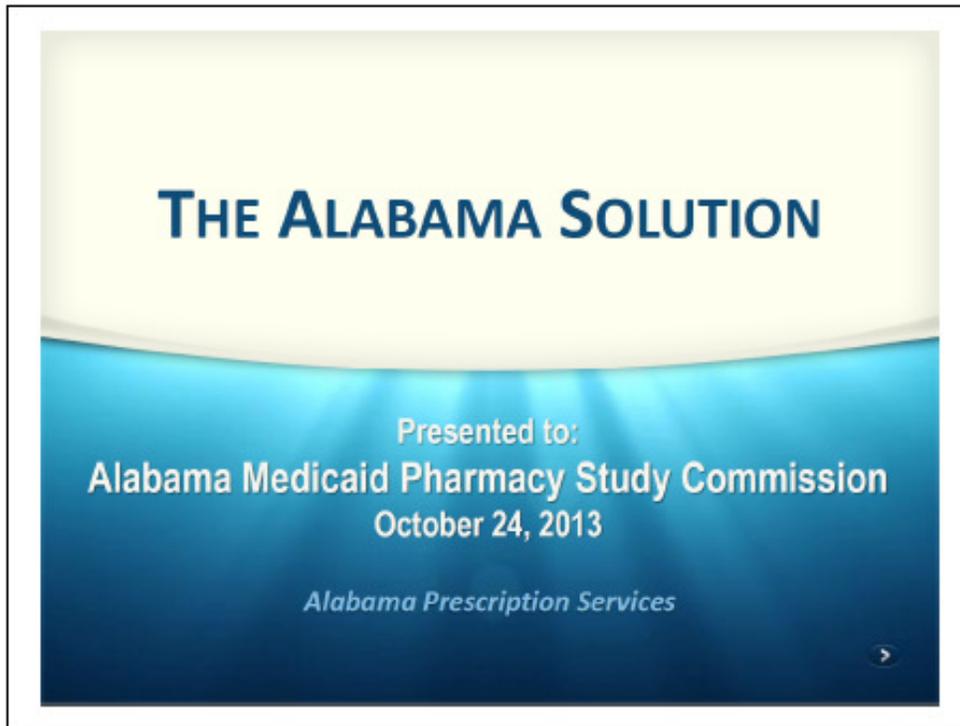
BRANDS	Dispensing FEE	GENERIC	Dispensing FEE
22.00%	\$ 1.50	85.00%	\$ 1.50

SAVINGS DATA @ YR 1

	Per Script	Up to Total \$\$	% Savings (Compared to Total Spend)
Savings to Alabama at Walmart	\$6.45	\$4,575,671	0.92%
Savings to Alabama at Walmart compared to other retail providers	\$15.22	\$50,344,680	10.16%
Total per Script Savings	\$12.64	\$64,967,984	13.11%
Total Savings	\$14.19	\$119,888,315	24.19%

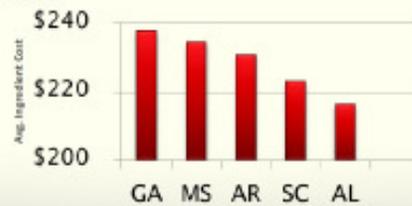
*Specialty savings are subject to additional review

3. APCI PRESENTATION



Alabama Medicaid Agency Distinctions

- AL Medicaid utilizes point-of-sale (POS) technology-based solutions that incorporate medical and pharmacy data to promote clinical and economic best practices
- AL Medicaid utilizes acquisition cost as a basis for pharmacy reimbursement with one of the lowest "net paid" amounts in the southeast



Alabama Prescription Services

PAC Predictive Acquisition Cost

- A new pricing benchmark
- Predicts acquisition cost by triangulating multiple data inputs such as MAC prices, WAC, NADAC and applying predictive logic
- PAC would compliment Alabama's current AAC reimbursement by providing an acquisition cost for those NDC's not captured by the AAC process
- PAC + AAC would provide an acquisition cost for all NDC's
- Oklahoma Medicaid is currently using PAC

Alabama Prescription Services

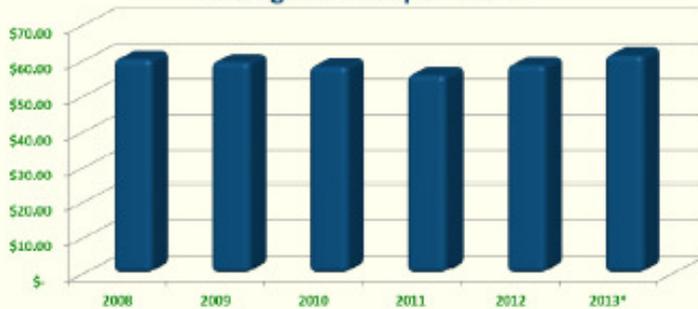
$$[(\text{Ingredient Cost} + \text{Dispensing Fee}) - \text{Co-pay}] \times \text{Utilization} = \text{Cost}$$

- Managing the Pharmacy Benefit is managing the Cost Equation, using historical data and benchmarks
 - Each component affects Cost
 - i.e., Cost is made up of “cost per unit” times “number of units”
 - Each component is managed using a unique set of tools
 - Components may affect each other is affecting Cost

Alabama Prescription Services

AL Medicaid Prescription Costs

Average Rx Cost per Claim



January-July 2013 average monthly cost per claim: \$59.80

Alabama Prescription Services

AL Medicaid PA Statistics

- **40** drug classes require PA
- **25** drug classes run through electronic PA
- **8** different override edits (require manual review)
- Monthly Statistics for AL Medicaid PA
 - **19,000-20,000** electronic PAs
 - **5,000-5,500** manual PAs
 - **3,000** manual overrides

Alabama Prescription Services

AL Medicaid Prescription Costs

Cost vs. Utilization Rates of ALMA Drugs



Alabama Prescription Services

The Alabama Prescription Services Solution

- **APS *comprehensive* solution for AL Medicaid**
 - **Leverages the clinical savings** that have provided negative trend and maintained unit cost at its current level
 - **Utilizes acquisition cost** for pharmacy reimbursement
 - **Maintains POS technology solutions** to minimize patient care disruption and optimize clinical value
 - **Positions AL Medicaid for future trend management** through formulary and rebate optimization

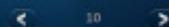
Alabama Prescription Services



Comprehensive Services

- **Claim Processing**
 - Established claim processing platform
 - Flexible plan design
 - Expanded reporting portal
 - Member portal for plan recipients
 - POS clinical PA
- **Rebate Management**
 - Maximized federally mandated and supplemental manufacturer rebates through evaluation of market share, best price, and therapeutic class optimization
 - Additional generic manufacturer rebate opportunities through APCI

Alabama Prescription Services



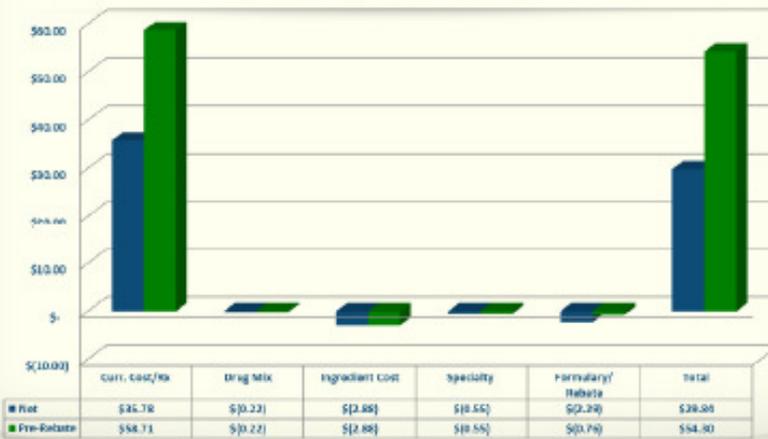
Comprehensive Services

- **Provider Network Management**
 - Comprehensive “Any Willing Provider” pharmacy network
 - Reimbursement formula for providers that support goals
 - Defined network strategy for specialty medications
- **Customer Service**
 - 24/7/365 member and provider call center services in Auburn, AL
 - Dedicated clinical pharmacists and clinical pharmacy technicians servicing AL Medicaid recipients

Alabama Prescription Services

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Cost Savings Components



Alabama Prescription Services

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Cost Savings Components

- Drug/Product Mix
- Specialty pharmacy rates
- Ingredient cost
- Formulary enhancements
- Maximization of federally mandated and subsidy rebates
- Incorporation of generic purchasing rebate incentives

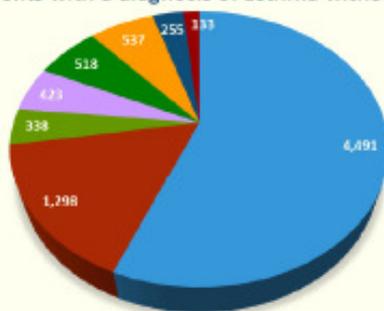
Estimated Annual Savings Opportunity: \$48-60M

Alabama Prescription Services

13

Improving Gaps in Care - Asthma

Recipients with a diagnosis of asthma without controller therapy



More than 7,900 trips to ER for inhalation therapy in 2012.

>3,685 patients on Albuterol

Only 2,500 patients on long-term controller therapy

Recipient Age
 ■ 0-9 ■ 10-19 ■ 20-29 ■ 30-39 ■ 40-49 ■ 50-59 ■ 60-69 ■ 70-99

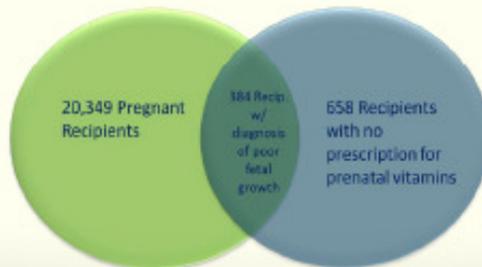
Jan. 1-Sept. 1, 2013

Alabama Prescription Services

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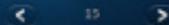
Improving Gaps in Care – Prenatal Care

- More than **20,000** females diagnosed as pregnant
- More than **600** had no prescription fill for prenatal vitamins
- More than **300** had a diagnosis of poor fetal growth at least once during their pregnancy.



Jan. 1 - Sept. 1, 2013

Alabama Prescription Services



Summary

- Current AL Medicaid expense is a direct result of unique clinical program management, which utilizes **medical and pharmacy claims history**, and acquisition-based reimbursement methodologies
- Additional savings can be attained through enhanced formulary, rebate, and network management
- **Alabama Prescription Services** offers a **comprehensive transparent solution** that ensures a singular focus on AL Medicaid interests

Alabama Prescription Services



Thank you.

Alabama Prescription Services





Alabama Medicaid Pharmacy Study Commission: Reform Options

Steve Schramm
Optumas

November 14, 2013

Discussion Outline



- Goals of Pharmacy Study Commission
- Previous Meeting Accomplishments
- Reform Initiatives
 - American Pharmacy Cooperative, Inc. (APCI)
 - Pharmacy Benefit Management (PBM)
 - Preferred Pharmacy Network
- Optumas Findings

Goals of Pharmacy Study Commission



- Review Medicaid's current Pharmacy delivery and reimbursement system
- Compare Alabama's program with other States' operations
- Evaluate options for reform that could maintain quality and save money
- Estimate savings and economic impact for each potential option

3

Previous Meeting Accomplishments



- Current delivery and reimbursement system is not out of control
- General Fund Demand
 - Pharmacy makes up a large part of the Medicaid GF demand
- Increases in recent spending due to
 - Growth in enrollment
 - Changes in FMAP

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Previous Meeting Accomplishments



- Alabama's program compared with other States'
 - Average Unit Cost among the lowest in the country
 - \$5 Million difference for each \$0.01 change in Unit Cost

- Comparing apples to apples difficult due to
 - Utilization
 - Payment Methodology
 - Population mix
 - Existence of management
 - Program limits

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Reform Initiatives



- During the October 24, 2013 meeting, we saw presentations on three different reform initiatives
 - American Pharmacy Cooperative, Inc. (APCI)
 - Pharmacy Benefit Management (PBM)
 - Preferred Pharmacy Network

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Reform Initiatives



1. Foundation

APCI	PBM	Preferred Rx Network
<ul style="list-style-type: none"> ➤ Purchasing Cooperative ➤ Network Management Service Utilizing APCI, HID and HP 	<ul style="list-style-type: none"> ➤ Clinical Mgmt ➤ Drug Mgmt ➤ Network Contracting 	<ul style="list-style-type: none"> ➤ Network Based on Limited Access ➤ Pricing Capabilities

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Reform Initiatives



2. Quality & Cost Improvements

APCI	PBM	Preferred Rx Network
<ul style="list-style-type: none"> ➤ Care Mgmt ➤ Reimbursement Mgmt (PAC) ➤ Rebate Improvements on Generics 	<ul style="list-style-type: none"> ➤ Experience (Medicaid & AL) ➤ Fraud, Waste, and Abuse ➤ Analytic Tools ➤ Ingrid. Cost and Disp. Fee Cuts 	<ul style="list-style-type: none"> ➤ Wellness programs ➤ Significant Per Script Cost Cuts (\$4/\$10 Walmart drug list) ➤ \$0.00 Copay

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Reform Initiatives



3. Proposed Savings from Initiative*

APCI	PBM	Preferred Rx Network
➤ \$48M - \$60M Year One (Total)	➤ \$91M - \$152M Year One (Total)	➤ \$120M Year One (Total)
➤ \$16M - \$22M Year One (State)	➤ \$30M - \$50M Year One (State)	➤ \$40M Year One (State)
➤ Proposal Assumes Prov Tax Remains in Place	➤ Prov Tax Impact Unknown at this Time	➤ Prov Tax Impact Unknown at this Time
<i>*Before Required Adjustments</i>		

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Optumas Findings



General Comments – APCI

- Existing AL infrastructure – HID (PA) & HP (claims)
- Savings overlap will exist for implementations since 2012 (Softer mgmt savings)
- Savings estimates gross of admin cost of purchasing cooperative and network management – reduction in estimates due to APCI admin component
- Overlap may exist for services the State already pays for through HID and HP (Softer mgmt savings)
- Pricing and rebate savings (Hard reimb savings)
- Proposal assumes no loss of Provider Tax
- Projected Bottom Line State Impact*: \$5 - \$15M

*Assumes no loss of Provider Tax

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Optumas Findings



General Comments - PBM

- Various PBM business models make an apples/apples comparison difficult – Similar overall savings
- Experience and proven in all LOB as well as in AL
- Savings net of administrative expense
- Savings largely on network cost and capabilities (Hard reimb savings)
- Savings overlap with unaccounted for implemented State programs since 2011 data source will exist (Softer mgmt savings)
- Potential for loss of Provider Tax
- Projected Bottom Line State Impact*: *\$11M - \$29M*

*Assumes loss of Provider Tax

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Optumas Findings



General Comments - Pref Rx Network

- Proposal would shift 80%-90% of network to Walmart – Large change to Pharmacy program
- Unit cost reductions to \$4/\$10 prevalent on Walmart's drug program as well as copay reductions appear firm (Hard reimb. savings)
- Savings estimates utilize trend factors across 8 years that may vary – If experienced Rx trends are lower than estimated, savings will decrease
- Savings estimates assume Walmart is full network – Savings will decrease with coverage gaps
- Potential for loss of Provider Tax
- Projected Bottom Line State Impact*: *\$19M - \$30M*

*Assumes loss of Provider Tax

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Optumas Findings



General Comments – Savings Summary

- Optumas' projected bottom line State impact incorporating provider tax loss (if applicable) and removing potentially unaccounted for savings overlap

APCI	PBM	Preferred Rx Network
>\$5M – \$15M State Dollars	>\$11M – \$29M State Dollars	>\$19M – \$30M State Dollars

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Optumas Findings



General Comments

- Three different and innovative options
- Selection remains a policy decision upon receipt of additional information
- Provided information includes industry estimates
- To know likely savings – Would need to go through an RFP process

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Questions



APPENDIX 4E – DEC 13, 2013 MEETING HANDOUTS



Optumas
EHS - Strategy - Action

Alabama Medicaid Pharmacy Study Commission Meeting

Steve Schramm
Optumas

December 13, 2013

Discussion Outline



- Purpose of Commission
- Previous Meetings
- Reform Proposals
- Economic Impacts
- Considerations
- Attachments

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Purpose of Commission



- Review Medicaid's current Pharmacy delivery and reimbursement system
- Compare Alabama's program with other States' operations
- Evaluate options for reform that could maintain quality and save money
- Estimate savings and economic impact for each potential option

3

Previous Meetings



- Status of current Alabama Medicaid Pharmacy program
- Comparisons to other States
- APCI, PBM, and Preferred Pharmacy Network proposals
- Optumas input on proposals

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Reform Proposals



- APCI – Purchasing Cooperative and Network Manager
- PBM – Managed Pharmacy Contractor
- Preferred Pharmacy Network – Closed Network

Potential Additional Considerations

- Most Favored Nation (MFN) Rate
 - Georgia has realized savings of 2%-5% by using MFN versus previous AWP reimbursement
- Increase Provider Tax
 - Increase to \$9M tax may not be feasible in short term

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Economic Impacts



Potential State Savings - Proposals

APCI	PBM	Preferred Rx Network
➢\$9M – \$18M State Dollars	➢\$13M – \$35M State Dollars	➢\$19M – \$30M State Dollars

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Economic Impacts



Potential State Savings – Additional Considerations

Most Favored Nation	Increased Provider Tax
➤ \$3M – \$9M State Dollars	➤ Increase TBD above current \$9M

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Economic Impacts



Pharmacy Implications

- How will reforming the Medicaid Pharmacy program impact Pharmacies in the State?
 - Volume of Medicaid scripts by Pharmacy in US and Alabama
 - Sense for how many Pharmacies in US close per year (Churn)
 - Sense for average margin per Pharmacy
 - Estimate change in margin and increase in churn rate with a change in AL system

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Economic Impacts



Pharmacy Implications

- Multiple sources used for analyses
- National Community Pharmacists Association (NCPA)
 - Dataset on independent Pharmacy financial experience
- National Health Expenditure Data
 - Dataset from CMS Office of the Actuary

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Economic Impacts



Pharmacy Implications

- Approximately 60,000 Pharmacies in US
- Approximately 21,000 Independent Pharmacies
- Approximately 90% of Pharmacy Revenues for Independent Pharmacies are prescription based
- Prescriptions break into four categories
 - Medicaid
 - Medicare Part D
 - Other Third Party
 - Cash

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Economic Impacts

Pharmacy Implications



Current Independent Pharmacy Picture

	% Scripts	% Revenue	Avg Gross Margin	Components of Margin	% of Margin
Medicaid	13%	10%	20%	2%	8%
Medicare Part D	30%	28%	18%	5%	21%
Other Third Party	45%	40%	20%	8%	34%
Cash	12%	22%	40%	9%	37%
TOTAL	100%	100%	24%	24%	100%

Economic Impacts

Pharmacy Implications



- Study of Medicare Part D impact suggests one unintended consequence was a decrease in margin that resulted in closure of independent rural Pharmacies
 - Shift from Other Payors to Medicare Part D average margins
- Minimal anticipated economic margin and churn impact with a change in AL system
 - Shift in average margin not as significant as Part D implementation
 - Overall market share not significant enough to impact overall Pharmacy margin

Economic Impacts



Pharmacy Implications

- National closure rate is approximately 150 independent Pharmacies per month (does not address the net impact due to adds in any given month)
- Modeling a ten percent drop (20% to 18%) in Medicaid margin:
 - An additional 36 - 132 Pharmacies nationally annually are expected to close due to a 10% reduction in Medicaid margin
 - An additional 1 - 4 Alabama Pharmacies closing annually
- Difficult to estimate the net impact due to mergers, acquisitions, and secular trends

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Pharmacy Commission



Preliminary Findings

- Alabama Medicaid Pharmacy Program Structure is Considered Leading Edge and Spend is Reasonable and among Lowest Across Country
- There are Additional Changes that Could be Implemented to Continually Improve Program's Effectiveness
- Reductions in Medicaid Margin appear to have minimal impact on pharmacy closure rate
- If State changes delivery system, an RFP process is needed in order to know true savings

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Questions



APPENDIX 5A – ADDITIONAL COMMENTS

ADDENDUM TO THE ALABAMA MEDICAID PHARMACY STUDY COMMISSION REPORT

December 2013

Mr. Jeff Freese, RPh was appointed to the Alabama Medicaid Pharmacy Study Commission by Governor Robert Bentley to represent long term care pharmacies serving Alabama long term care patients. Mr. Freese is a pharmacist with a degree from Auburn University who has 18 years of experience in delivering and managing long term care services to Alabama residents. He currently is employed as Executive Vice President with Turenne PharMedCo, a long term care pharmacy located in Montgomery.

As the only voice of long term care pharmacy on this commission, Mr. Freese noticed the Optumas report was compiled based on information up to September 2011 and therefore does not capture the savings already realized as a result of the “generic cliff” movement that occurred primarily in 2012/2013 until present. This resulted in a significant increase in lower cost generics and a decrease in higher cost brands dispensed by all pharmacies across Alabama. As equally important, the Optumas report does not include information specific to long term care pharmacies servicing Alabama Medicaid patients. Therefore, this commission has not gathered data from which to determine reasonable Medicaid reimbursement for long term care pharmacy services. Until that is done, reimbursement and other mandates/limitations for long term care should be carved out of the proposed Medicaid reform strategies.

The following paragraph is an excerpt from the Minutes of the Alabama Medicaid Pharmacy Study Commission from November 14th, 2013:

“Mr. Freese asked the Commission to consider the residents in nursing homes, mental health group homes, and assisted living facilities that are served by a pharmacy that must provide full blown medication distribution systems and processes that are much more than just a prescription vial that can be obtained in a retail setting. These pharmacies provide services such as medication documentation for the nurses, assurance that residents are receiving medications properly, delivery of medications often with a short time frame, education of nurses, medication distributions systems, and specialized packaging. Some of these pharmacies are in rural areas. Although this is not a large population, relative to overall Medicaid spend, and it may not have a significant financial impact, Mr. Freese suggested these residents be carved out of this type of program.”

To expand on the comments above, pharmacies serving residents in these settings are providing services beyond that of retail pharmacies. In most cases these services are not an option due to being mandated by CMS or other regulatory agencies. As a result of the reduction in reimbursement that was implemented in September 2010, these mandated and critical services are currently being provided at a loss. Additionally, the negative impacts of the recent Medicaid changes – 90 day supply, brand and total prescription limits – have not yet been felt. Further reimbursement cuts, or additional mandates and limitations to long term care pharmacies may force some providers to close or discontinue servicing severely compromised residents in these settings.

Until data is gathered to represent the financial and economic impact of the proposed changes, reimbursement to pharmacies serving Alabama Medicaid residents in long term care settings should be carved out of the proposed pharmacy reform initiatives.

Respectfully submitted,



Jeff Freese, RPh, Commission Member
Executive Vice President
Turenne PharMedCo, Inc.



Roger Turenne
Owner
Turenne PharMedCo, Inc.

APPENDIX 5B – ADDITIONAL COMMENTS

COMMENTS TO THE ALABAMA MEDICAID PHARMACY STUDY COMMISSION

By Alabama Arise

Dec. 13, 2013

After Gov. Robert Bentley appointed Alabama Arise policy director Jim Carnes to the only consumer advocacy seat on the Alabama Medicaid Pharmacy Study Commission, Arise recruited an advisory committee to augment consumer participation in the commission process. The committee comprised a Medicaid pharmacy consumer and pharmacists serving Medicaid consumers with special medical needs (e.g., HIV/AIDS, mental illness and conditions requiring infusion therapy). The following comments reflect the observations and concerns of this advisory committee.

General observations

Though the governor's June 6, 2013, executive order creating the Pharmacy Study Commission identified two goals for pharmacy reform – to “maintain quality and save money for the state Medicaid agency” – the bulk of the commission's work has focused on the cost factor. When questioned about quality and access concerns, Medicaid consultant Steve Schramm of Optumas noted that these issues would be more appropriately addressed in the proposal phase. The consumer advisory committee is concerned that the farther along we get in the pharmacy reform process, the harder it will be to design effective safeguards for access and quality.

On the matter of cost, one sentence in Schramm's Nov. 14 interim PowerPoint presentation calls the implied premise for Medicaid pharmacy reform into question: “Current delivery and reimbursement system is not out of control.” The presentation goes on to cite the two principal causes of recent increases in pharmacy spending: enrollment growth and changes in the federal match rate, neither of which is affected by state policy decisions.

As Dr. Williamson has reminded the commission on several occasions, the potential savings to be had from any of the pharmacy reform options under consideration are

minimal in the overall budget context. Further, these savings do not take into account the potential human – and financial – costs resulting from restricted access, compromised services and deferred care.

General recommendations

- Rather than simply defer to a later step in the process and hope for the best, the commission should recommend a thorough review of the potential impact of any proposed Medicaid pharmacy reform on patient access and quality of service.
- Restructuring Medicaid’s already well-performing pharmacy delivery and reimbursement system with the narrow aim of reducing pharmacy spending is a short-sighted and ineffectual approach to containing costs and maintaining quality. The commission should recommend that any proposed policy changes balance attention to budget trend-lines with a broader consideration of the ways pharmacy reform can reduce long-term costs by improving preventive care, care coordination, treatment of complex health needs and other qualitative factors.

Specific concerns

The pharmacy benefit management (PBM) concept figures prominently in the options the commission is considering. The consumer advisory committee has several concerns about the PBM approach. Patients on Medicaid have a pressing need for prescription counseling to help them understand their conditions, interpret symptoms and comply with medication requirements. Any restriction of pharmacy choice through a PBM system would likely increase patient volume at participating providers, thus increasing fulfillment time while reducing opportunities for consultation. Such compromises in quality have long-term cost implications that weigh against any short-term savings.

None of the three options cited mail-order prescription fulfillment as part of its plan, but Medicaid pharmacy reforms in a number of states have had a mail-order component. In addition to the obvious reduction in face-to-face encounters between patients and pharmacists, the mail-order approach creates a special risk for low-income patients who may experience frequent changes of address and phone number.

The commission heard from Georgia Medicaid's pharmacy director that her state has seen cost savings from eliminating the prescription drug limit. When questioned about this assertion, the director adamantly defended it, attributing the savings in part to a resulting increase in use of generics. The consumer advisory committee thinks this experience reported by a neighboring state warrants further investigation by Alabama Medicaid.

Even if Alabama were starting from a different baseline for generics that made additional savings unlikely, it's possible we could eliminate the drug limit without increasing costs. In so doing, we could remove both a perennial point of contention in the Medicaid budget and a major barrier for patients with complex medical needs. For example, in a state with high rates of chronic diseases, many patients require maintenance drugs for multiple conditions, leaving no room within narrow limits for treatment of acute illnesses. The problem is especially urgent for medically fragile patients who receive adequate pharmacy services under children's waivers but fall under prescription limits as they reach adulthood, often in the face of declining health. Similarly, the 10-prescription cap on antipsychotic, anti-epileptic and HIV/AIDS medications is generally adequate for the targeted illnesses, but life-prolonging treatment finds patients increasingly susceptible to chronic problems such as diabetes, high cholesterol and hypertension, which can quickly exceed the limit of six additional medications.

Two further policy matters affecting HIV/AIDS pharmacy came to the attention of the consumer advisory committee:

Under the AIDS Drug Assistance Program (ADAP, which channels federal funding through the Alabama Department of Public Health), clinics receiving medications for patients who fail to show up for treatment cannot send the medications back. Clinic physicians see ample opportunity to re-assign the unclaimed drugs to other patients, but the state pharmacy board has cracked down on unauthorized re-use. By contrast, state law allows oncologists to re-assign unclaimed oncology drugs to other patients. An equivalent law for HIV/AIDS medications would increase ADAP's cost-effectiveness and eliminate waste without affecting the state budget.

HIV treatment involves combinations of medications tailored to fit the specific medical needs of the patient. Most of the HIV medications are available only in brand-name form. Though expensive, these medications have been proven in studies

to be extremely cost-effective for the overall health care system, because they keep people healthy and out of the hospital. They are also a vital public health tool, because HIV-positive people on effective medication combinations have been shown to be far less likely to pass on the virus. Adequate treatment requires the full arsenal of FDA-approved HIV medications.

On a final note, the proposal for an exclusive Wal-Mart contract for Alabama Medicaid pharmacy led Arise to ask how many Wal-Mart employees in the state have children on Medicaid. Mobile's *Press-Register* reported in April 2005 that 4,700 children of Wal-Mart employees were enrolled in Alabama Medicaid at that time. Neither a company spokesman nor Medicaid officials provided more current data in response. The consumer advisory committee feels that such information is necessary for assessing any possible conflict of interest in the Wal-Mart proposal.

Specific recommendations

- The commission should urge the governor to order an evaluation of the potential impact of a pharmacy benefits management (PBM) system on access to and quality of pharmacy care.
- The commission should urge the governor to require a similar evaluation of mail-order prescription fulfillment if such a policy were to be proposed at a later date.
- The commission should urge the governor to order an assessment of the potential benefits and risks of eliminating Alabama Medicaid's prescription drug limits. This research should include further consultation with Georgia Medicaid officials about their no-limit policy.
- The commission should urge the governor to propose or support legislation allowing re-use of unclaimed HIV/AIDS medications, in line with existing state policy for oncology medications.
- The commission should recommend against any further limits on the number or type of HIV/AIDS medications.
- The commission should ask Alabama Medicaid to report the number of children of Wal-Mart employees who have been enrolled in Alabama Medicaid over the past five years.

Respectfully submitted,

Jim Carnes, Commission Member
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Family Voices of Alabama

APPENDIX 5C – ADDITIONAL COMMENTS

COMMENTS TO THE ALABAMA MEDICAID PHARMACY STUDY COMMISSION

By Tammie Koelz, R.Ph. - Walgreens

Dec. 26, 2013

Ms. Tammie Koelz has submitted one additional comment with regard to the following quote from page 10 of the report:

“Chain pharmacies have continued to see steady increases in quantity over the years through similar shifts in pharmacy reimbursement systems much like the ones proposed above. Therefore, it is assumed that a reform to the Alabama Medicaid pharmacy system would have no significant impact on chain pharmacies.”

Please find the additional comment from Ms. Koelz below:

“To assume that reforms to the current system would have no significant impact on Chain reimbursement is false. Taking the Most Favored Nations proposal as an example, changing from the current system to a MFN system could potentially have significantly negative impacts on both Commercial plan reimbursement (in the form of contract negotiation) and Fee for Service Medicaid reimbursement (in the form of lower reimbursement rates/dispensing fees).”