

**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
Stephanie Azar
Dorinda Cale
Angie Cameron, representing Frank Brown
Jim Carnes
Representative Steve Clouse
Barry Cochran
Rhonda Harden

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