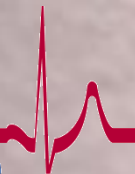


Medicaid Prescribed Drug Program

Spending Control Initiatives

**For Quarters Ended
March 31, 2011
and
June 30, 2011**

**FLORIDA
MEDICAID**



Medicaid Prescribed Drug Spending Control Program Initiatives
January 1, 2011-June 30, 2011

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**Medicaid Prescribed Drug Spending Control Program Initiatives
January 1, 2011-June 30, 2011**

Purpose of Report

Per section 409.912(37)(c), F.S., the Agency for Health Care Administration (Agency) shall submit quarterly reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives which must include, but need not be limited to, the progress made in implementing this subsection and its effect on Medicaid prescribed drug expenditures. This report includes data for the third and fourth quarters of state fiscal year 2010-2011, from January 1, 2011 through June 30, 2011. The report also includes a comparison of total expenditures to the total appropriation for the entire state fiscal year 2010-2011.

Medicaid Prescribed Drug Spending Control Program Initiatives January 1, 2011-June 30, 2011

Executive Summary

Requirements of section 409.912, F.S. (relating to cost-effective purchasing of health care, ss (37)(a) Medicaid prescribed drug spending control program) have been fully implemented, and specified spending control measures continue, including:

- Ongoing scheduled reviews of the Medicaid Preferred Drug List (PDL), with negotiated state supplemental rebates from manufacturers; continued updating of prior authorization and step therapy protocols for drugs not on the PDL; and prior authorization for Medicaid-covered prescribed drugs for compliance with clinical guidelines, for indications not approved in labeling and for prevention of potential overuse, misuse or abuse.
- Age-related prior authorization for specific drugs.
- Through a contract with the Florida Mental Health Institute (FMHI) at the University of South Florida, the Agency continues to develop and disseminate best practice guidelines, with separate specific efforts for adults and children, for coordination of care for behavioral health drug therapy management, to develop improved patient education, prescriber education, compliance with drug therapies, and improved patient outcomes.
- Medicaid Area Office pharmacists throughout the state continued pharmacist review of prior authorization requests, initiatives to support use of the Medicaid Preferred Drug List, and making initial contact with patients who are selected for high intensity case reviews.
- The Medications for Adult and Disabled High Intensity Pharmacy Case Management Program provides comprehensive prescribed drug case management for individuals with Medicaid eligibility through the Florida MEDS-AD demonstration waiver granted by the Centers for Medicare and Medicaid Services. Following a demonstration period recently extended through 12/31/2013¹, this program will measure whether maintaining health coverage for this population results in fewer institutionalizations and improved health outcomes.
- The statewide Medication Therapy Management Program continues to improve the quality of care and prescribing practices based on best practice guidelines; improve patient adherence to medication plans; reduce clinical risk; and lower prescribed drug costs including the rate of inappropriate spending on Medicaid prescription drugs.
- The contracted prescription benefit manager vendor, Magellan Medicaid Administration (Magellan)², continues to process more than one million drug claims per month for the Medicaid fee-for-service pharmacy program. The system of automated claim edits is continuously refined and improved to support safe prescribing, adherence to the Preferred Drug List, and prevention of fraud and abuse. Through a secure web portal, Magellan also collects prescription drug utilization encounter data submitted weekly by Medicaid HMOs.

¹ The state received approval for a three-year renewal of this waiver from the federal Health and Human Services Centers for Medicare and Medicaid Services on December 14, 2010.

² Formerly First Health Services, Inc.

Medicaid Prescribed Drug Spending Control Program Initiatives January 1, 2011-June 30, 2011

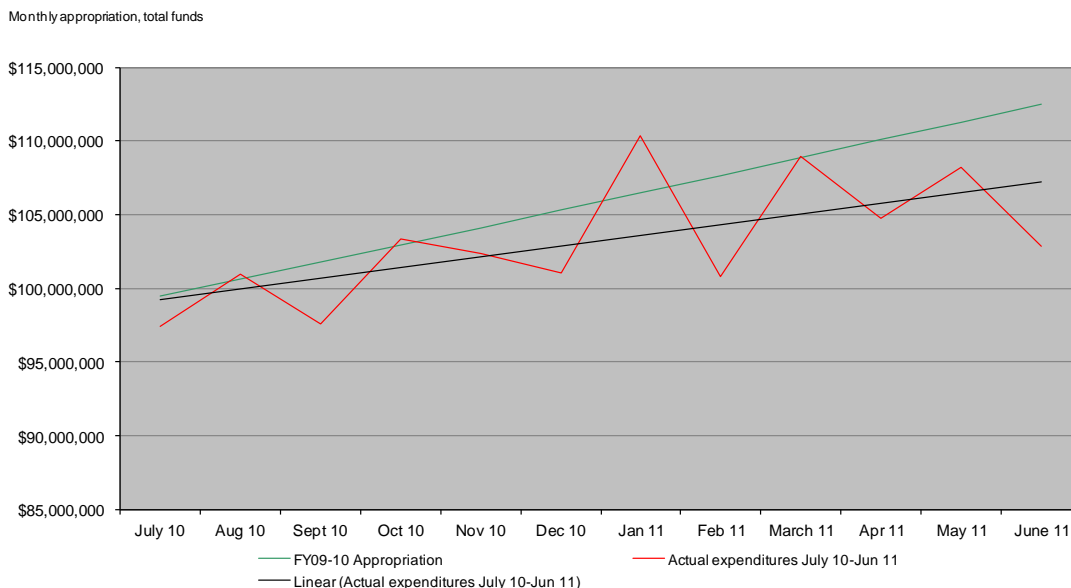
Pharmacy Appropriations and Spending for the Third and Fourth Quarters of Fiscal Year 2010-2011

Historically, the two factors that most significantly impact spending in the prescribed drug program are drug prices and the number of individuals enrolled. Prices for prescription drugs increased 4.2 percent over the twelve months ended June 30, 2011.³ Further, from January 1, 2011 through June 30, 2011, the Florida Medicaid Fee-for-Service caseload increased by 1.04 percent, from 1,186,492 to 1,198,780 individuals. During this period, the Prescribed Drug Program reimbursed more than 8.15 million prescription drug claims that totaled \$635,997,682.74. This retail reimbursement amount is prior to collection of manufacturer rebates and does not include state payments for the federal phased-down contribution for individuals now covered by Medicare Part D⁴.

The state recoups a significant part of the retail cost of prescriptions reimbursed by Florida Medicaid through rebates paid by pharmaceutical manufacturers. In addition to rebates required by the federal government, the state negotiates supplemental rebates for products included on the Medicaid Preferred Drug List. Total manufacturer rebates offset more than 48 percent of total drug costs.

The chart on this page compares pre-rebate retail spending (including a trend line for total pharmacy spending) for fee-for-service pharmacy claims to the appropriation for state fiscal year 2010-2011. Total spending in the fee-for-service prescribed drugs program for state fiscal year 2010-2011 was \$1,238,829,855.57, which was 4.71% below the appropriation of \$1,300,112,162.30.

**Pharmacy Appropriation vs. Spending
July 2010 through June 2011**



³ CPI Detailed Report-June 2011, Table 3. Consumer Price Index for all Urban Consumers (CPI-U): U.S. city average

⁴ Transfer of the cost of prescription coverage for dually eligible Medicaid/Medicare eligible individuals to the federal program on January 1, 2006 reduced direct pharmacy spending (and associated manufacturer rebates) through the Florida Medicaid prescribed drug program. However, the state is now billed for a phased-down contribution ("federal clawback") amount for the cost of this benefit for these individuals. The federal clawback paid by Florida for these quarters was \$193,168,755.20 for approximately 322,620 individuals.

Medicaid Prescribed Drug Spending Control Program Initiatives January 1, 2011-June 30, 2011

Pharmacy Appropriations and Spending, continued

Despite increases in retail drug prices and Medicaid enrollment during state fiscal year 2010-2011, spending in the fee-for-service drug program did not increase commensurately due to several actions:

- Significant savings were realized as patents expired on some relatively expensive brand drugs and use of generic alternatives was maximized.
- Pharmacy staff, the supplemental rebate negotiation vendor, and the Medicaid Pharmaceutical and Therapeutics (P&T) Committee continued an ongoing, detailed review of the PDL to consider removal of products when lower-cost alternatives are available.
- The prescribed drug program performed a comprehensive systematic review of the pharmacy claim payment process and refined controls to:
 - Achieve more timely updates of the State Maximum Allowable Cost pricing for generic drugs in the point-of-sale claims system, which allows the Agency to react quickly to price changes and competition in the wholesale drug market.
 - Implement clinical dose and quantity limits for individual drugs to ensure safety and to prevent fraud and abuse.

Medicaid Prescribed Drug Spending Control Program Initiatives January 1, 2011-June 30, 2011

Prescription Spending Trends

Fee-for-Service Caseload

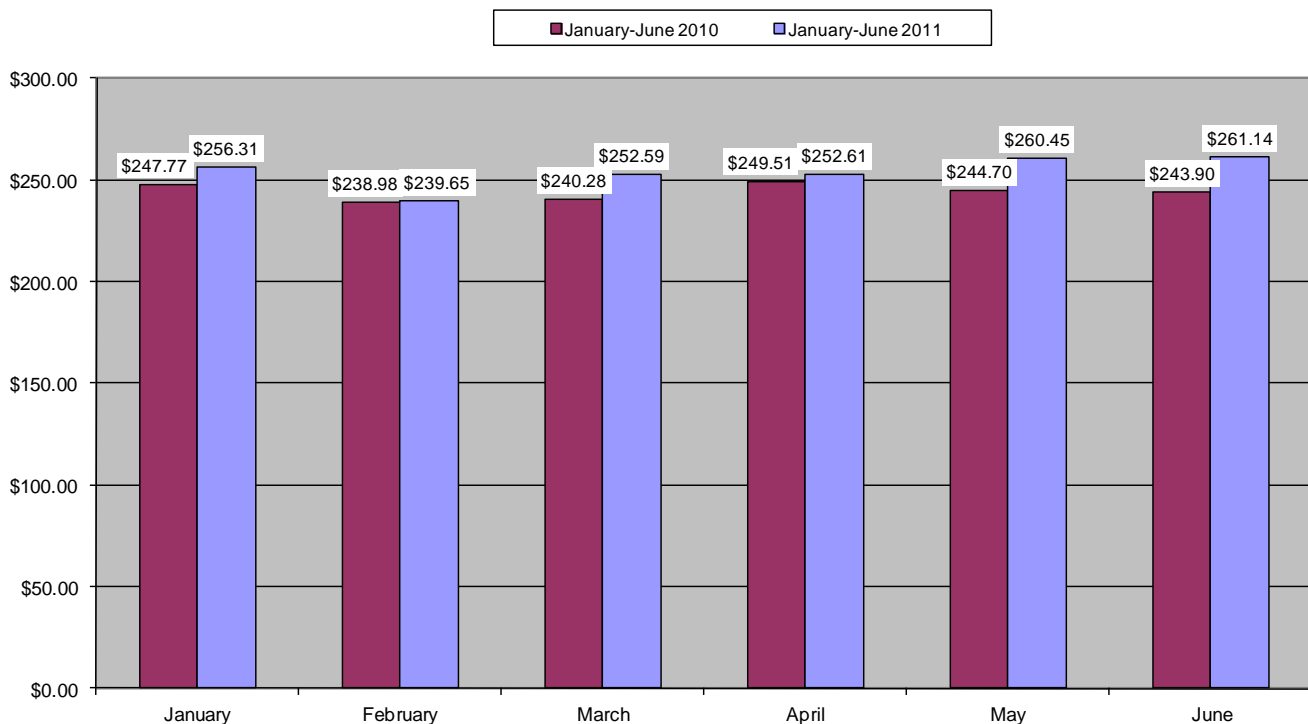
The number of individuals served through the fee-for-service program for the final two quarters of state fiscal year 2010-2011 remained relatively stable, with an increase of only 1.04% and a total of 1,198,780 individuals enrolled as of June 30, 2011.

Cost per Utilizer of Pharmacy Services

In any given month, an average of approximately 36 percent of individuals enrolled in the fee-for-service program will use prescription services. The following chart illustrates a comparison of retail pharmacy (prior to rebates) cost per utilizer from January through June of 2011 compared to January through June of 2010.

Average Monthly Pharmacy Cost Per Medicaid Fee-for-Service Prescribed Drug Service Utilizer

(Prior to Rebates, Compared by Month for January-June of 2010 and 2011)



Over the six months ended June 30, 2011, the Medicaid fee-for-service monthly average retail cost per individual who used prescribed drug services edged upward by 1.9 percent, despite an annual rate of increase in prescription drug prices of more than 4 percent during that same period⁵. Generic availability of some expensive brand drug products, Preferred Drug List (PDL) management, and ongoing refinements in claim system edits contributed to the control of costs for prescribed drugs in the fee-for-service program.

⁵ CPI Detailed Report-June 2011, Table 3. Consumer Price Index for all Urban Consumers (CPI-U): U.S. city average

Medicaid Prescribed Drug Spending Control Program Initiatives January 1, 2011-June 30, 2011

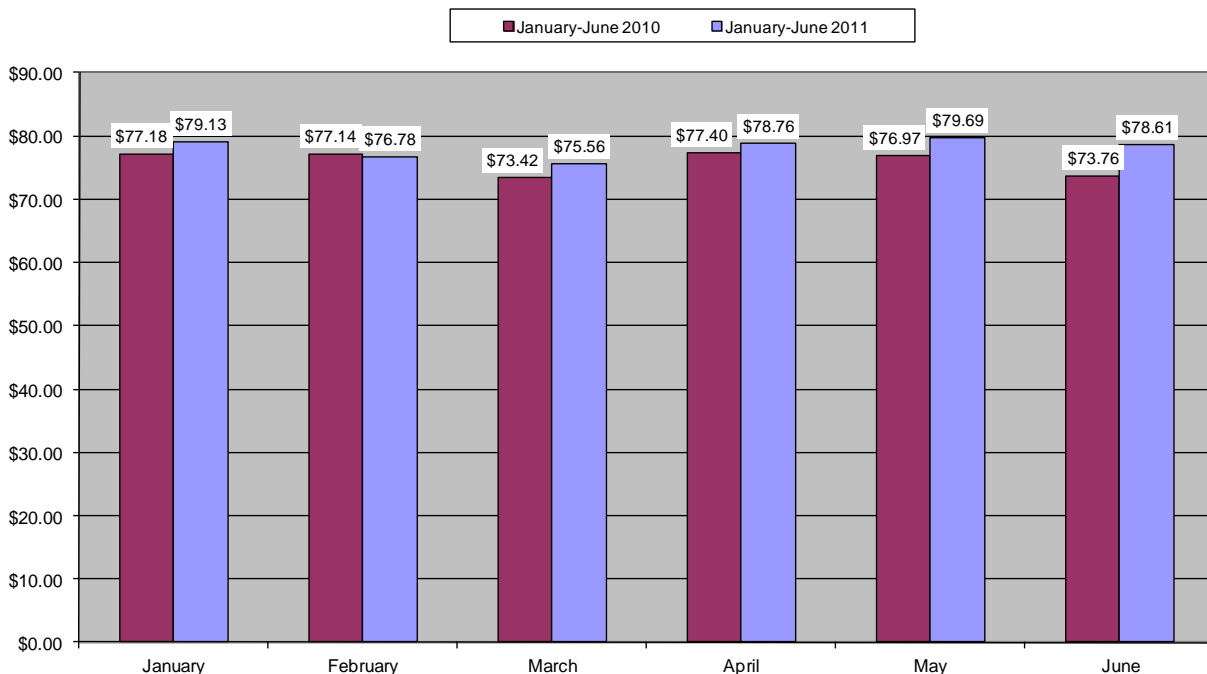
Prescription Spending Trends (continued)

Aside from the number of individuals served, two important drivers of the cost of providing pharmacy benefits are: 1) Price per prescription (varies with drug price changes and changes in the types of drugs used); and 2) The number of prescriptions dispensed per recipient (one component of utilization). The following two charts illustrate the changes in these two factors, comparing (a) the average price per prescription, prior to rebates, for January through June of 2010 compared to the same months in 2011, and (b) average number of prescriptions per recipient, for January through June of each year.

Price: Reimbursed Cost per Prescription

The price per prescription for claims reimbursed through the Medicaid fee-for-service prescribed drug program from January through June for the past two fiscal years is presented below. These amounts are the retail reimbursement paid to pharmacy providers, prior to receipt of manufacturer rebates. The chart below depicts the average retail price per prescription for claims reimbursed through the Florida Medicaid fee-for-service program each month, compared to the same month in the previous year.

Average Retail Price per Prescription, Medicaid Fee-for Service Enrollees
(Average Price per Prescription Prior to Rebates, Compared by Month for 2010 and 2011)



Comparison of the average cost per prescription reimbursed each month for January through June of 2010 to January through June of 2011 reveals an increase of 2.8 percent in the cost. The national average reported cost of prescription drugs in June of 2011 compared to June of 2010 increased by 4.2 percent.⁶

The Florida Medicaid average cost reported in the above chart is calculated prior to collection of drug manufacturer rebates, which further reduces the net cost to the state.

⁶ CPI Detailed Report-June 2011, Table 3. Consumer Price Index for all Urban Consumers (CPI-U): U.S. city average

Medicaid Prescribed Drug Spending Control Program Initiatives January 1, 2011-June 30, 2011

Prescription Spending Trends (continued)

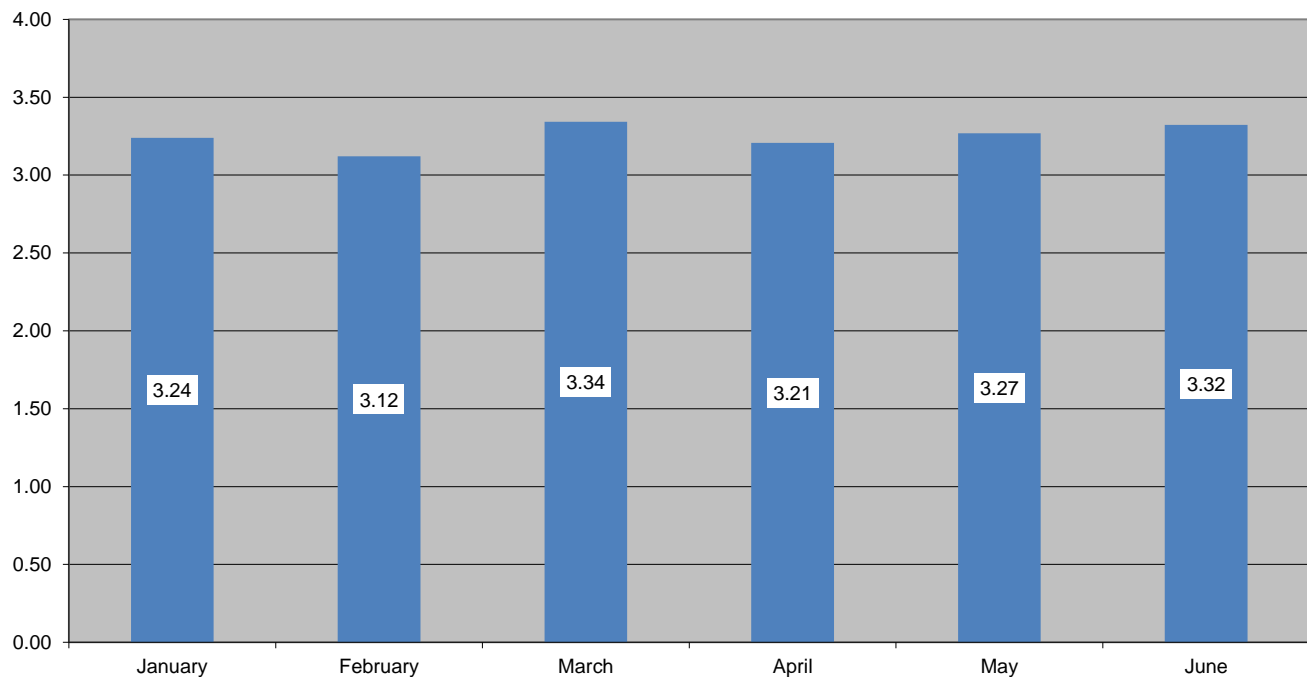
Generic Utilization

Although generic use is often more cost efficient when available, the Florida Medicaid Preferred Drug List may include brand drugs for which the state has negotiated rebates that make the net price of the brand drug lower than the generic price. As of June 2011, while only 18.2 percent of the prescriptions reimbursed by Florida Medicaid were for single-source brand products, this represented 74.4 percent of expenditures.⁷

Utilization: Number of Pharmacy Claims per Utilizer

During the months January through June of 2011, the average number of prescriptions per recipient monthly for individuals who used retail pharmacy services in the Medicaid fee-for-service program remained steady at an average of 3.3 per person. In any given month, about one third of fee-for-service recipients enrolled will use prescription services. This average has remained steady throughout the year, and is comparable to industry averages for private insurance plans.

**Average Monthly Number of Prescriptions Per Medicaid Fee-for Service
Prescribed Drug Service Utilizer**



As detailed in the preceding tables, during the last two quarters of state fiscal year 2010-2011, the fee-for-service caseload and the number of prescriptions per user remained stable, while the average retail price per prescription (prior to rebates) reimbursed by Florida Medicaid increased only 2.8 percent due to efficient management of the fee-for-service drug benefit.

⁷ Magellan Medicaid Management Monthly Generic Analysis Report for June 2011

Medicaid Prescribed Drug Spending Control Program Initiatives January 1, 2011-June 30, 2011

FY 2010-2011 Medicaid Prescribed Drug Program Ongoing Cost Controls

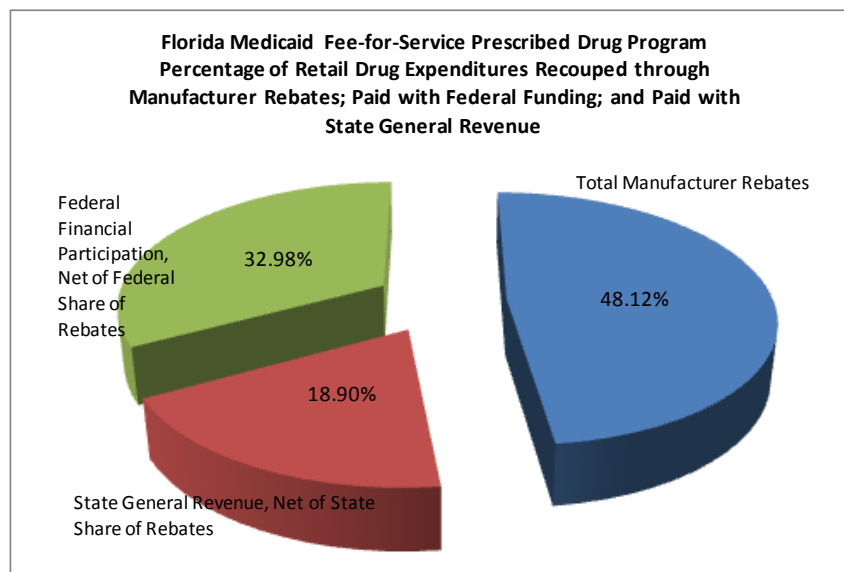
Several factors helped control expenditures, including active management of the Preferred Drug List, prompt updating of drug State Maximum Allowable Cost (SMAC) pricing based on changes in the wholesale market for drugs, systematic claim system controls to prevent overutilization or abuse, and generic substitution when appropriate.

Cost-Effective Medicaid Preferred Drug List (PDL)

The Florida Medicaid Preferred Drug List continues to produce significant savings of pharmacy costs since its implementation as a mandatory program in 2005. The savings are achieved two ways: 1) Through efficient prescribing protocols (cost avoidance through prior authorization and step therapy); and 2) Through the State Supplemental Rebate Program (negotiated cash rebates from manufacturers relating to placement on the PDL).

Despite manufacturer price increases for brand drugs of 4.2 percent for the twelve months ended June 30, 2011⁸, the average retail cost (prior to rebates) per reimbursed prescription in the Florida Medicaid fee-for-service drug program increased only 2.8 percent over the same period. This was accomplished in part due to (a) generic availability of some expensive brand products and (b) immediate updating of reimbursement pricing changes on generic drugs. Timely reaction to these changes in the marketplace contributed to control of spending in the fee-for-service drug program. Combined federal and negotiated state supplemental rebates recoup more than 48 percent of the retail prescription cost⁹. Further, since full implementation of the mandatory PDL, more than 95 percent of prescriptions reimbursed are for products on the PDL.

By taking advantage of the federal match for prescription services and aggressively negotiating and collecting manufacturer rebates, state general revenue accounts for only 18.9 percent of retail prescription expenditures in the fee-for-service drug program. The following chart illustrates the state's leveraging of resources to provide prescription drug benefits in the fee-for-service Medicaid program.



⁸ CPI Detailed Report—June 2011, Table 3. Consumer Price Index for all Urban Consumers (CPI-U): U.S. city average, detailed expenditure categories.

⁹ Average manufacturer rebate total percentage for the past four quarters is 48.12%. Source: Molina Florida Drug Rebate Project Quarterly Reports.

Medicaid Prescribed Drug Spending Control Program Initiatives January 1, 2011-June 30, 2011

Medicaid Prescribed Drug Program Ongoing Cost Controls (continued)

Pharmaceutical and Therapeutics (P&T) Committee

Background

Section 409.91195, F.S., created the Medicaid Pharmaceutical and Therapeutics (P&T) Committee to make recommendations to the Agency for the purpose of developing and maintaining the Florida Medicaid Preferred Drug List (PDL). The committee is composed of eleven members appointed by the Governor. Four members are physicians, licensed under chapter 458, F.S.; one member is licensed under chapter 459, F.S.; five members are pharmacists licensed under chapter 465, F.S.; and one member is a consumer representative. The members are appointed to serve for terms of two years from the date of appointment. Members may be appointed to more than one term. The Governor must ensure that at least some of the members of the committee represent Medicaid participating physicians and pharmacies serving all segments and diversity of the Medicaid population, and that they have experience in either developing or practicing under a preferred drug list. By statute, at least one of the members must represent the interests of pharmaceutical manufacturers. The P&T Committee meets at least quarterly and may meet at other times at the discretion of the chairperson and members. All drug classes included on the preferred drug list are routinely reviewed, and the Committee may recommend additions to and deletions from the preferred drug list, such that the preferred drug list provides for medically appropriate, cost-effective drug therapies for Medicaid patients.

The P&T Committee routinely reviews drug options within the therapeutic classes that represent a relatively large proportion of drug costs. Most of these categories include several choices of safe, efficacious drugs. In addition to the required federal rebate, the state's contracted vendor negotiates supplemental rebate offers from each brand drug manufacturer in the category. Extensive clinical and pricing information is supplied to Committee members for individual drugs in each category. Detailed analysis, including clinical and pricing information for each drug in the respective therapeutic classes, is provided to the P&T Committee. Manufacturer representatives and other stakeholders may also schedule presentations to the Committee. The Committee uses all information to develop a formal recommendation to the Agency regarding PDL status for each drug. The P&T Committee may also make recommendations to the Agency to require prior authorization before reimbursement of any prescribed drug covered by Medicaid.

For detailed information, upcoming review schedule, and the current PDL, see the website at:
www.fdhc.state.fl.us/Medicaid/Prescribed_Drug/.

Preferred Drug List Adherence—PDL Products Share of Florida Medicaid Market

Through aggressively negotiating supplemental rebates and favorable net pricing, the Florida Medicaid prescribed drug program is able to maintain an array of choices for prescribers within each therapeutic class on the Preferred Drug List. Since fully implementing the mandatory PDL in fiscal year 2005-2006, PDL products represent more than 95 percent of prescriptions reimbursed by Florida Medicaid for fee-for-service recipients.¹⁰ Approval for reimbursement of prescriptions for products not on the PDL may be obtained through prior authorization.

State Supplemental Rebate Negotiation

Prior to the scheduled review of each drug class by the P&T Committee, the state negotiates with each manufacturer (through a contracted vendor, Provider Synergies, L.L.C.) to obtain rebates supplemental to the

¹⁰ PDL compliance for quarter ended June 30, 2011 was 95.7%. Source: Provider Synergies L.L.C. PDL Compliance Report, Florida Medicaid.

Medicaid Prescribed Drug Spending Control Program Initiatives January 1, 2011-June 30, 2011

Medicaid Prescribed Drug Program Ongoing Cost Controls (continued)

federal rebate. Florida statute requires a combined (state and federal rebate) minimum of 29.1 percent for Preferred Drug List consideration. Florida consistently receives overall combined federal and state rebates of over 48 percent of its total claim reimbursement costs¹¹, which results in a substantial reduction in the cost to the state (see chart on preceding page). The objective is to obtain the best possible net price for the state while including adequate prescribing options within each drug class.

Prior to enactment of the Patient Protection and Affordable Care Act (PPACA), states shared drug manufacturer rebate revenues with the federal Centers for Medicare and Medicaid Services (CMS) at the same proportion as the federal financial participation rate for Medicaid expenditures. Enacted on March 23, 2010, PPACA changed this rebate sharing arrangement, retroactive to January 1, 2010. States must now remit a higher percentage of rebate revenue to federal CMS. The impact to Florida for fiscal year 2010-2011 is calculated to be a net reduction of \$37.3 million in rebate revenue to the state in the fee-for-service Medicaid pharmacy program.

Rebate Collection Productivity:

The rebate collection contractor performs follow-up on all unpaid or disputed invoices and has achieved an overall collection percentage of over 99 percent of invoiced rebates from manufacturers. Nonpaying labelers are reported to the federal Centers for Medicare and Medicaid Services. The contractor continues to refer providers who cannot or will not reverse billing errors and rebill correctly to the Agency for Health Care Administration Bureau of Medicaid Program Integrity.

Prior Authorization of Specific Drugs

As in all states' Medicaid programs, prior authorization for certain drugs in specific circumstances continues. Response to prior authorization requests is immediate through automatic claim system edits or by the Medicaid fiscal agent's 24-hour toll-free request line, which is staffed by pharmacists at all times. Approval of some specific medications requires clinical review by a Medicaid pharmacist. These requests are handled within 24 hours. Florida Medicaid processes over a million reimbursement claims per month for prescriptions, and the program receives about 7,000 prior authorization requests monthly.

¹¹ Source: Molina Florida Drug Rebate Project Report for Quarter Ended June 30, 2011

Medicaid Prescribed Drug Spending Control Program Initiatives January 1, 2011-June 30, 2011

Medication Therapy Management

Medication Therapy Management

Section 409.912(37), F.S., requires that the Agency for Health Care Administration “shall implement a Medicaid prescription drug management system...with a vendor that has experience in operating prescription drug management systems.” (The program will be designed)...to “improve the quality of care and prescribing practices based on best practice guidelines.”

The statewide Medication Therapy Management (MTM) Program provides interventions that help improve prescribing, dispensing, and medication usage for recipients through population-based strategies. Participating pharmacists are trained to deliver detailed medication reviews and improve coordination of medical care for patients.

Objectives of the program include:

- Instilling best-practices patterns within the prescription drug program;
- Improving quality of care and prescribing practices based on best-practices guidelines;
- Improving patient adherence to medication plans;
- Reducing clinical risk; and
- Lowering prescribed drug costs and the rate of inappropriate spending for certain drugs.

The focus of this initiative is on quality of care and adherence to drug therapy rather than specific drug cost reduction. For example, improved adherence to drug therapy for HIV may increase prescription costs, but overall costs for all services for the individual will be controlled.

The program’s original architecture hampered wide adoption by pharmacies, because many did not have the web access needed to use the program at their pharmacies at the point of sale. Further, the patient was not actively involved in the medication review process. In April 2011, the MTM program transitioned to a patient-centered review process in which recipients may choose to speak directly via telephone with pharmacists who have real-time access to the patients’ drug profiles and medical claim histories. Feedback from recipients who chose to participate has been measurably positive, and their self-reported understanding of and compliance with their drug therapies has improved. The reviews are now performed through the University of Florida Medication Therapy Management Call Center.

Behavioral Pharmacy Management Program

The Florida Medicaid Drug Therapy Management Program for Behavioral Health (MDTMP for BH) was created by the Florida Legislature in 2005. Its purpose as stated in section 409.912(37) F.S., is to accomplish the following:

- Improve the quality of behavioral health drug prescribing;
- Improve patient adherence;
- Reduce clinical risk; and
- Lower costs.

The Agency contracted with the Florida Mental Health Institute (FMHI) at the University of South Florida. Initially the focus was to slow the escalation of expenditures on mental health prescriptions. The focus of the program has broadened to include quality and safety issues, with separate specific recommendations for children and adults. As lower-cost generic versions of several drugs became available and the rate of increase in costs slowed, the Legislature faced questions about the quality and appropriateness of the use of behavioral

Medicaid Prescribed Drug Spending Control Program Initiatives

January 1, 2011-June 30, 2011

Medication Therapy Management (continued)

drugs, especially with children. During 2008, particular emphasis was put on outreach to the provider community to understand their needs, and on collaboration with a wide range of stakeholders (including mental health care providers, administrators, recipients of services, and their families) throughout the state to improve mental health care. Updated guidelines for treatment were developed for children and adults, and these are disseminated throughout the state in practitioner meetings and other stakeholder forums.

Current guidelines are on the program website at: www.flmedicaidbh.com. Guidelines for children are reviewed by the expert panel annually, and any changes adopted for the children/adolescent guidelines are distributed statewide and are used in the Florida Pediatric Consult Lines available to all prescribing physicians through call centers at the University of Florida and All Children's Hospital in St. Pete, and an additional call center is being developed at Florida International University.

Strategies to improve the quality and effectiveness of prescribing practices

Parents often first consult their family physician or pediatrician for treatment of their children for possible behavior disorders. Consistent with other insured populations in the U.S., primary care physicians prescribed approximately 65 percent of all mental health drug prescriptions reimbursed by the Florida Medicaid program.¹² Initial feedback from prescribers to determine their needs in assessing, diagnosing and treating mental health disorders revealed that these prescribers would welcome guidance since few psychotropic drugs have been rigorously evaluated for use with children.

The collaborative development of evidence-based guidelines for the treatment of and prescribing for children with mental health disorders was achieved with the help of an expert panel that included Florida psychiatric "opinion leaders" from both the community mental health and private practice spheres. Participants were selected in consultation with the Florida Psychiatric Society and the Florida Council for Community Mental Health. The panel reviewed the revised Academy of Child and Adolescent Psychiatry guidelines and the most recent and relevant research literature.

The review clearly underscored the gaps in knowledge, especially in prescribing for the under five-year old population. The panel faced the difficult task of translating limited reliable scientific evidence into specific care recommendations. As a result, the experts reached consensus based primarily on clinical experience, supplemented with scientific evidence when available. The need to constantly review and update changing information was discussed. The initial set of guidelines for children was published in 2006, and adult guidelines were first published in 2007. Both sets of guidelines and some diagnosis-specific guidelines have been reviewed and updates published annually. The program has performed extensive outreach to physician associations, community mental health centers, and medical societies to inform them of the guidelines and updated information. Presentations for prescribers are made at various locations around the state to distribute guidelines and address specific issues for adults and children.

The program pursues the following kinds of strategies to improve the quality and effectiveness of prescribing practices:

- Retrospective strategies assist in establishing performance measurement through review of pharmacy claims to identify patterns of prescribing, quality concerns, and communicating them to prescribers.

¹² "approximately 2/3 of mental health care is provided in the primary care setting" Regier et al., The Defacto US Mental and Addictive Disorders Service System: epidemiological catchment area prospective 1-year prevalence rates of disorders and services. Archives of General Psychiatry, February 1993;50:85-94.

Medicaid Prescribed Drug Spending Control Program Initiatives January 1, 2011-June 30, 2011

Medication Therapy Management (continued)

- Prospective strategies attempt to define and disseminate current information about evidence-based prescribing practices.
- Point of care strategies give physicians access to technological tools at the point of care to facilitate the application of evidence-based practices.
- Special studies look in depth at specific quality and/or effectiveness issues in order to formulate strategies for improvement.

Highlights of specific initiatives in progress through the program from January through June, 2011 include:

- Antipsychotic polypharmacy discontinuation (adults)
- Require prior authorization of antipsychotic polypharmacy for children under age 18
- Prior authorization of high dose prescribing of antipsychotics; antidepressants; and stimulants for children and adolescents under age 18
- Pediatric consultation hotline: rural community practice initiative
- Integration of mental health care and comprehensive health care initiative
- Design of behavioral health medication quality improvement programs

In addition to the public website and the toll-free Florida Pediatric Consult Lines, the MDTMP for BH website has created a secure page for mental health providers to communicate 1) concerns related to prescribing practices, 2) best practice guidelines, 3) program interventions, and 4) access the physician referral network resource.

Recipient Pharmacy Lock-in Program

In October 2002, the Agency implemented a recipient lock-in program. This program improves coordination of medical care and prevents potential fraud by ensuring that at least one medical professional, the pharmacist, is aware of all the medications the recipient is receiving. Recipients who have been identified as high users and potential abusers of prescribed drugs, or who obtain prescriptions from multiple physicians, are enrolled into the lock-in program and must obtain all of their medications from a single pharmacy. The majority of recipients originally enrolled in the program now receive their prescription drug benefits through Medicare. Further, highly efficient claim system enhancements are being designed to provide the patient's full drug profile to the prescriber, and to systematically control for overutilization and potential abuse so that the number of lock-in patients who required manual monitoring can be kept to a minimum. Consequently, fewer than 175 individuals require manual "lock-in" to a single pharmacy at any given time.

Medicaid Prescribed Drug Spending Control Program Initiatives January 1, 2011-June 30, 2011

MEDS-AD Waiver

The Florida Medicaid Medications for Aged and Disabled (MEDS-AD) demonstration waiver provides Medicaid coverage for aged or disabled residents of the State of Florida with incomes at or below 88 percent of the federal poverty level and assets at or below \$5,000 for an individual (or \$6,000 for a couple). Coverage is limited to those aged and disabled persons who are either receiving or elect to receive institutional care, hospice or home and community-based services coverage, or who are not eligible for Medicare. The current MEDS-AD Program was implemented to continue coverage for a group of individuals who would not have been eligible for Medicare Part D as of January 2006. This waiver is designed to delay the need for institutionalization of these vulnerable individuals by maintaining their level of care in the community longer through the provision of:

- Access to health care services.
- High-Intensity Pharmacy Case Management services for non-institutionalized individuals.

The continued coverage, as well as the High-Intensity Pharmacy Case Management program, is designed to avoid costs of preventable hospitalizations or institutional placement that would otherwise occur in the next five years had these vulnerable individuals been denied access to prescribed drugs and other medical services. The focus of the demonstration is to provide high-intensity pharmacy case management for enrollees who are not yet receiving institutional care.

The table below contains monthly MEDS-AD enrollment counts for January through June 2011.

1115 MEDS-AD Waiver Total Enrollment by Month, January 2011-June 2011

| January 2011 | February 2011 | March 2011 | April 2011 | May 2011 | June 2011 |
|--------------|---------------|------------|------------|----------|-----------|
| 37,721 | 37,988 | 38,376 | 38,650 | 38,725 | 38,476 |

The Agency has refined and improved the MEDS AD pharmacy case review process through a contract with the University of Florida Medication Therapy Management Call Center. Use of the call center's trained pharmacists has streamlined and improved the review process, which now involves direct patient contact and participation, and improved technology solutions allow immediate review and feedback to prescribers. This new design has overcome several limitations of the original review process. There is now real-time access to the patient's claims history for the pharmacist reviewer; patients are now involved in the communication and their understanding of their drug therapies can be assessed and improved; the primary prescriber can be more readily identified through communication with the patient; and timely feedback goes to the prescriber so that therapies can be optimized.

Expenditures reimbursed for recipients who were eligible for Medicaid through the MEDS-AD demonstration program totaled \$661,673,792 for state fiscal year 2010-2011. Annual and cumulative expenditures remain below the budget neutrality ceiling approved by CMS for this waiver. In December 2010, federal CMS approved a three-year extension of this waiver through December 31, 2013.

Report Conclusion

This concludes the report of Medicaid Prescribed Drug spending control for the third and fourth quarters of fiscal year 2010-2011.