

# **Medicaid Prescribed Drug Program**

## **Spending Control Initiatives**

**For Quarters Ended  
September 30, 2012  
December 31, 2012**

**FLORIDA**  
**MEDICAID**



**Medicaid Prescribed Drug Spending Control Program Initiatives**  
**July 1, 2012-December 31, 2012**

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**Table of Contents**

Purpose of Report.....	1
Executive Summary.....	2
Pharmacy Appropriations and Spending for the First and Second Quarters of Fiscal Year 2012-2013..	3
Claim Details .....	4
<i>BRAND AND GENERIC DRUG COSTS AND UTILIZATION</i> .....	4
Prescription Spending Trends.....	5
<i>FEE-FOR-SERVICE CASELOAD AND RETAIL PRESCRIPTION COSTS</i> .....	5
Manufacturer Rebates Reduce Net Cost of Drugs to State.....	5
Medicaid Fee-for Service Prescribed Drug Program Ongoing Cost Controls.....	6
<i>COST-EFFECTIVE MEDICAID PREFERRED DRUG LIST (PDL)</i> .....	6
<i>PREFERRED DRUG LIST ADHERENCE—PDL PRODUCTS SHARE OF FLORIDA MEDICAID MARKET</i> .....	6
<i>REBATE COLLECTION PRODUCTIVITY</i> .....	7
<i>PRIOR AUTHORIZATION OF SPECIFIC DRUGS</i> .....	7
Medication Therapy Management.....	8
<i>MEDICATION THERAPY MANAGEMENT</i> .....	8
<i>BEHAVIORAL PHARMACY MANAGEMENT PROGRAM</i> .....	8
<i>RECIPIENT PHARMACY LOCK-IN PROGRAM</i> .....	8
MEDS-AD Waiver .....	9

**Medicaid Prescribed Drug Spending Control Program Initiatives  
July 1, 2012-December 31, 2012**

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**Purpose of Report**

Per section 409.912(37)(c), Florida Statutes, 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 first two quarters of state fiscal year 2012-2013, from July 1, 2012 through December 31, 2012.

# Medicaid Prescribed Drug Spending Control Program Initiatives

## July 1, 2012-December 31, 2012

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### 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:

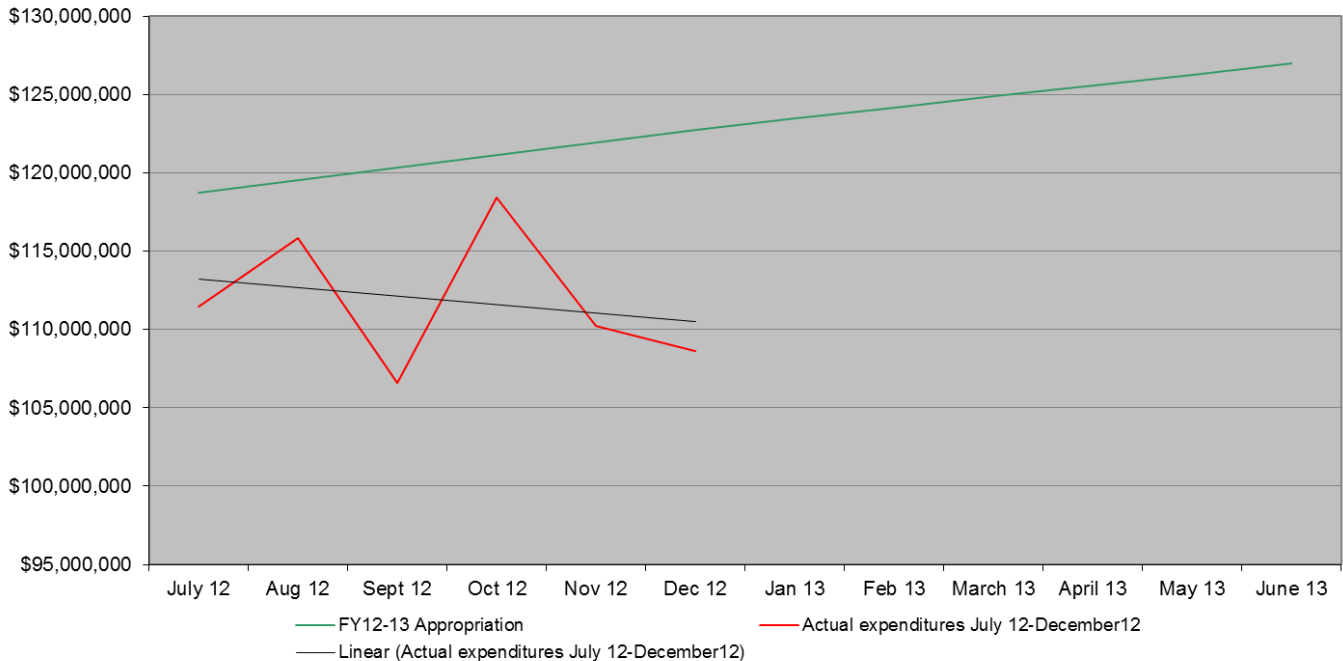
- Section 409.91195, F.S., created the Medicaid Pharmaceutical and Therapeutics (P&T) Committee to make recommendations to the Agency for the purpose of developing and maintaining the Florida Medicaid Preferred Drug List (PDL). The Committee performs ongoing scheduled reviews of the Medicaid Preferred Drug List, with negotiated state supplemental rebates from manufacturers and continued updating of prior authorization and step therapy protocols for drugs not on the PDL. The Committee may also recommend prior authorization protocols for Medicaid-covered prescribed drugs to ensure compliance with clinical guidelines, for indications not approved in labeling, and for prevention of potential overuse, misuse or abuse. For detailed information, upcoming review schedule and the current PDL, see the website at: [http://ahca.myflorida.com/Medicaid/Prescribed\\_Drug/](http://ahca.myflorida.com/Medicaid/Prescribed_Drug/).
- Age-related prior authorization for specific drugs, to ensure safe and appropriate prescribing.
- 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. Current guidelines and links to resources available for prescribers are on the program website at: [www.flmedicaidbh.com](http://www.flmedicaidbh.com).
- Medicaid pharmacists throughout the state continued review of prior authorization requests, initiatives to support use of the Medicaid Preferred Drug List, and making initial contact with patients who may choose to receive comprehensive reviews of their drug therapies.
- Through a contract with the University of Florida Medication Therapy Management Call Center, trained pharmacists conduct comprehensive prescribed drug case management, which involves direct patient contact if the patient chooses to participate. This 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. As part of the Florida MEDS-AD demonstration waiver granted by the Centers for Medicare and Medicaid Services, this statewide program will measure whether maintaining health coverage for this population results in fewer institutionalizations and improved health outcomes.
- The contracted prescription benefit manager vendor, Magellan Medicaid Administration (Magellan), continues to process more than 1.3 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.

# Medicaid Prescribed Drug Spending Control Program Initiatives July 1, 2012-December 31, 2012

## Pharmacy Appropriations and Spending for the First and Second Quarters of Fiscal Year 2012-2013

### Florida Medicaid Fee-for-Service Pharmacy Appropriation vs. Spending July 2012 through December 2012

Monthly appropriation, total funds



For the first six months of state fiscal year 2012-2013, the total cost for the program was 7.36 percent lower than the Social Services Estimating Conference estimate used for the General Appropriations Act. The actual average retail price per prescription was only .91 percent higher than the estimate for the same period; actual caseload was 3.19 percent greater than the estimate; and the utilization rate as measured by number of prescriptions was 8.16 percent lower than estimated. The following market factors and management actions helped to maintain efficiency in the Medicaid prescribed drug program:

- Significant savings were realized as patents expired on some relatively expensive brand drugs and use of generic alternatives was maximized.
- The State Maximum Allowable Cost team pursued aggressive pricing of generics.
- The generic substitution rate increased, partially due to the “patent cliff” effect of the relatively lower cost of new generic drugs once the patent has expired for the brand product.
- Pharmacy staff, the supplemental rebate negotiation vendor, and the Medicaid Pharmaceutical and Therapeutics Committee continued an ongoing, detailed review of the Preferred Drug List to consider removal of products when lower-cost, equally effective alternatives are available.

## Medicaid Prescribed Drug Spending Control Program Initiatives July 1, 2012-December 31, 2012

### Claim Details

#### ***Brand and Generic Drug Costs and Utilization***

The following table details monthly metrics related to efficient utilization of generic products, the average cost of a brand and a generic prescription, and the number of brand and generic prescriptions reimbursed.

For months shown in the table below, 22.79 percent of claims reimbursed were for brand drug products, but these prescriptions account for 85.47 percent of total expenditures. Revenue realized by the state through negotiation of drug manufacturer rebates offsets a significant percentage of the retail cost of drugs in the fee-for-service pharmacy benefit. The average reimbursement for a brand prescription during the time period was \$306.14; and the average reimbursement for a generic prescription was \$15.34.

Metric	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
Generic Utilization	75.3%	75.7%	76.9%	77.8%	78.1%	77.9%
Brand Claims	316,542	324,419	299,315	316,728	295,685	291,890
Generic Claims	974,259	1,024,073	1,009,315	1,127,613	1,071,643	1,043,708
Non-Drug Claims	464	709	730	938	1,066	1,056
Compound Claims	3,361	3,438	3,316	3,819	3,667	3,759
Brand Paid	\$96,133,743	\$98,862,493	\$89,613,853	\$98,807,902	\$91,223,523	\$90,062,727
Generic Paid	\$14,095,397	\$15,589,599	\$15,405,303	\$17,592,581	\$16,854,857	\$16,457,259
Non-Drug Paid	\$21,394	\$32,900	\$33,994	\$44,303	\$50,763	\$49,305
Compound Paid	\$1,201,004	\$1,350,377	\$1,513,786	\$1,991,510	\$2,088,964	\$2,060,760

Note: Compound claims show a seasonal variation in drug utilized for respiratory syncytial virus (RSV) prophylaxis.

The top row of figures in the table below report the overall average retail reimbursement paid for a prescription claim, prior to any rebates received from manufacturers. The "Net Paid/Claim" row is the reimbursed amount less rebates received from manufacturers based on their federal rebate agreements. The row titled "Net Net Paid/Claim" shows the reimbursed amount net of federal and state supplemental rebates paid back to the state by pharmaceutical manufacturers. Additional metrics record the retail reimbursement Per Member Per Month (PMPM), and Per User Per Month (PUPM). Approximately 29.91 percent of enrollees use the prescription drug benefit in any given month.

Metric	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
Paid/Claim	\$86.09	\$85.64	\$81.18	\$81.73	\$80.33	\$81.04
Net Paid/Claim	\$45.36	\$45.12	\$42.77	\$43.34	\$42.60	\$42.98
Net Net Paid/Claim	\$40.77	\$40.56	\$38.45	\$38.69	\$38.03	\$38.37
Paid PUPM	\$284.99	\$283.58	\$257.18	\$268.08	\$257.72	\$258.57
Net Paid PUPM	\$150.16	\$149.41	\$135.50	\$142.16	\$136.67	\$137.12
Net Net Paid PUPM	\$134.98	\$134.31	\$121.80	\$126.91	\$122.01	\$122.41
Paid PMPM	\$77.58	\$80.84	\$74.06	\$81.24	\$76.47	\$74.96
Net Paid PMPM	\$40.87	\$42.59	\$39.02	\$43.08	\$40.55	\$39.75
Net Net Paid PMPM	\$36.74	\$38.29	\$35.07	\$38.46	\$36.20	\$35.49
Claims/User	3.3	3.3	3.2	3.3	3.2	3.2
% Users	27.2%	28.5%	28.8%	30.3%	29.7%	29.0%

# Medicaid Prescribed Drug Spending Control Program Initiatives July 1, 2012-December 31, 2012

## Prescription Spending Trends

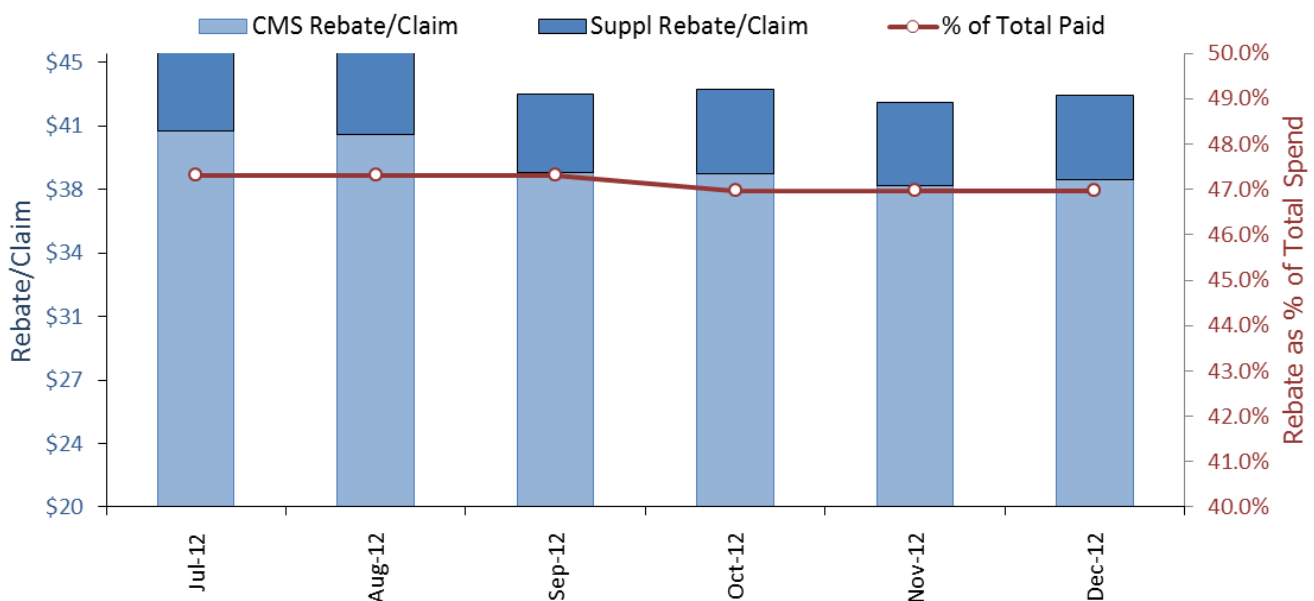
### *Fee-for-Service Caseload and Retail Prescription Costs*

The number of individuals who were eligible for the Medicaid fee-for-service drug program as of December 31, 2012 was 1,449,146. During the first two quarters of state fiscal year 2012-2013, the program reimbursed 8,121,513 community pharmacy claims at a total expenditure of \$671,138,298. While the price of brand drug products increased over the period, the program maintained cost efficiency through appropriate use of available generic products. The following table details some basic program monthly benchmarks and overall trends for the program during the first two quarters of state fiscal year 2012-2013.

Metric	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
Member-Months	1,436,634	1,432,957	1,439,004	1,457,843	1,441,403	1,449,146
Users	391,068	408,472	414,367	441,792	427,663	420,113
Claims	1,294,626	1,352,639	1,312,676	1,449,098	1,372,061	1,340,413
Paid	\$111,451,539	\$115,835,368	\$106,566,936	\$118,436,297	\$110,218,106	\$108,630,050

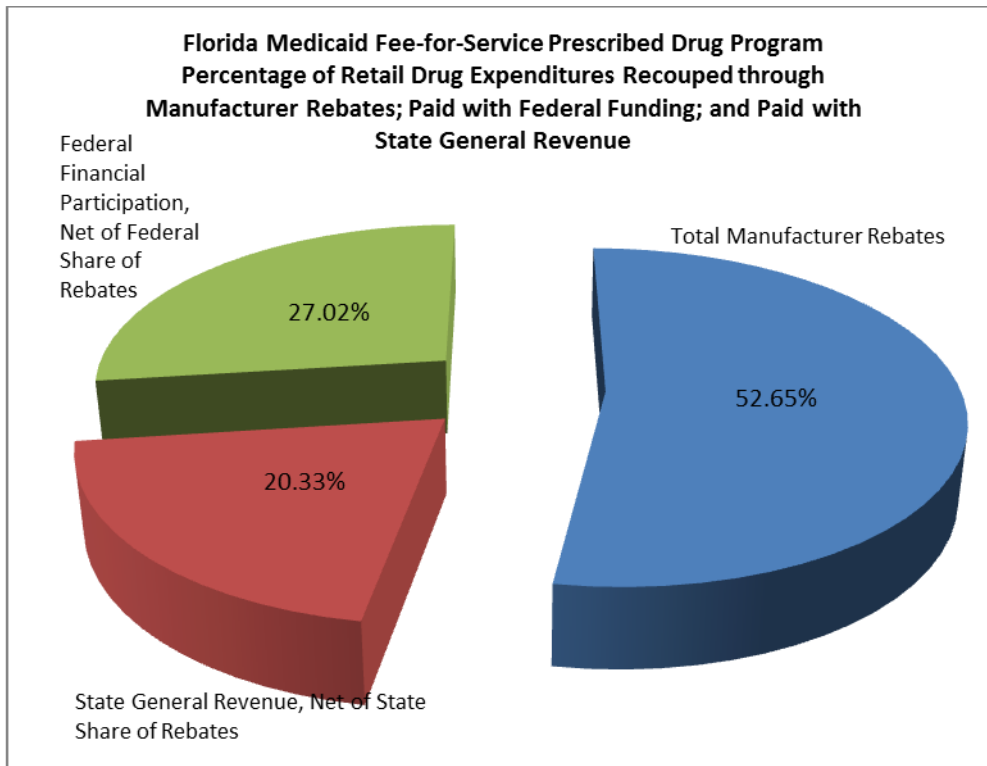
## Manufacturer Rebates Reduce Net Cost of Drugs to State

Pharmaceutical manufacturer rebate revenue paid to the state is a significant offset to the retail cost of prescription reimbursement. The program continues to negotiate agreements for manufacturers to provide supplemental rebates, in addition to required federal rebates, for their brand drug products. These rebates reduce the total retail cost of reimbursement to community pharmacy providers and allow prescribers more choices of preferred products within therapeutic classes on the Preferred Drug List. The following chart illustrates the amount of the average federal and supplemental rebates received per prescription, and the proportion of the total retail drug cost that the Florida Medicaid program is able to recoup through federal rebates and additional negotiated supplemental rebates.



## Medicaid Prescribed Drug Spending Control Program Initiatives July 1, 2012-December 31, 2012

State general revenue accounts for only 20.33 percent of the total retail cost of the fee-for-service drug program. The chart below illustrates the percentage of state general revenue dollars required for the state to offer the Medicaid drug benefit in the fee-for-service program after federal matching funds and manufacturer rebate revenue are received.



### Medicaid Fee-for Service Prescribed Drug Program Ongoing Cost Controls

#### ***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).

#### ***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. Approval for reimbursement of prescriptions for products not on the PDL may be obtained through prior authorization.



**Medicaid Prescribed Drug Spending Control Program Initiatives  
July 1, 2012-December 31, 2012**

***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 in the fee-for-service pharmacy program. 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's Bureau of Medicaid Program Integrity.

***Prior Authorization of Specific Drugs***

As in all states' Medicaid programs, authorization prior to reimbursement 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 Pharmacy Benefits Manager (Magellan Medication Administration) 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 staff clinical pharmacist. These requests are handled within 24 hours. Florida Medicaid processes over 1.35 million reimbursement claims per month for prescriptions, and the program currently receives an average of 17,303 prior authorization requests monthly, approximately 1.28 percent of prescriptions.

The following chart details metrics related to prior authorization requests received during the first two quarters of state fiscal year 2012-2013:

Florida Therapeutic Consultation Call Center	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
Clinical Calls Received	5,922	6,292	5,943	6,419	5,464	4,759
Faxes Received	10,710	12,109	11,241	13,043	12,852	9,062
Faxes worked by Magellan Staff	8,021	9,355	8,535	9,978	8,662	6,667
Faxes worked by Agency staff	2,689	2,754	2,706	3,065	4,190	2,395
Total Calls/Faxes	16,632	18,401	17,184	19,462	18,316	13,821

# Medicaid Prescribed Drug Spending Control Program Initiatives

## July 1, 2012-December 31, 2012

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### **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. 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 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 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. Detailed information, including current guidelines and links to resources available for prescribers are on the program website at: [www.flmedicaidbh.com](http://www.flmedicaidbh.com).

#### ***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 now monitor the patient’s full drug profile and 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. Due to limitations set by the Agency on controlled substances (based on number of prescriptions and their diagnoses) and the new drug database for controlled substances (eForce) available to prescribers and pharmacies, the number of recipients currently enrolled in the lock in program has decreased significantly. Currently 11 patients are active in the program.

# Medicaid Prescribed Drug Spending Control Program Initiatives

## July 1, 2012-December 31, 2012

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### 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 the first two quarters of state fiscal year 2012-2013.

#### 1115 MEDS-AD Waiver Total Enrollment by Month, July 2012-December 2012

July 2012	Aug 2012	Sept 2012	Oct 2012	Nov 2012	Dec 2012
42,814	42,793	43,190	42,964	42,384	41,954

Expenditures reimbursed for recipients who were eligible for Medicaid through the MEDS-AD demonstration program totaled \$333,985,849 for the first two quarters of state fiscal year 2012-2013. 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. The Agency anticipates submission of a request to renew the waiver for an additional three years, through December 31, 2016.

#### ***Report Conclusion***

This concludes the report of Medicaid Prescribed Drug spending control for the first two quarters of state fiscal year 2012-2013.