FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid Prescribed Drug Program Spending Control Initiatives

For Quarters Ended
March 31, 2013
June 30, 2013

Report to the Florida Legislature
May 2014

Table of Contents

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 final two quarters of state fiscal year 2012-2013, from January 1, 2013 through June 30, 2013.

Executive Summary

Requirements of section 409.912(37)(a), F.S., relating to cost-effective purchasing of health care and the prescribed drug spending control program have been fully implemented. Generic utilization is approximately 75 percent of all Fee-for-Service prescription claims. During the final two quarters of state fiscal year 2012-2013, approximately 27 percent of Medicaid recipients utilized the pharmacy benefit in a given month. While the Average Retail Price per prescription was about 3.4 percent above estimates, and total caseload was 6.65 percent lower than estimated by the Social Services Estimating Conference, the total cost for the program was 3.66 percent lower than estimated due to several spending control measures.

The number of individuals who were eligible for the Medicaid fee-for-service drug program as of June 30, 2013 was 1,441,003. During the final two quarters of state fiscal year 2012-2013, the program reimbursed a total of 7,945,279 pharmacy claims at a total of $674,132,699. The price of brand drugs increased from an average of $327.61 per brand claim in January 2013 to an average of $353.39 per brand claim in June 2013. However, the average number of brand claims per user dropped over the same period from 0.72 brand claims per user in January, to 0.67 brand claims per user in June.

Specific spending control measures include:

- Medicaid Pharmaceutical and Therapeutics (P&T) Committee – Created by section 409.91195, F.S., the Committee makes recommendations to the Agency for the purpose of developing and maintaining the Florida Medicaid Preferred Drug List (PDL). The Committee performs ongoing scheduled review of the PDL, 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.

- Prior Authorization – Authorization prior to reimbursement for certain drugs in specific circumstances continues. Age related prior authorization has been established for certain drugs to ensure safe and appropriate prescribing. Also, Medicaid pharmacists throughout the state continue to review prior authorization requests for non-PDL approved drugs. They may make initial contact with patients who choose to receive comprehensive reviews of their drug therapies. Initiatives are in place to support the use of the Medicaid PDL.

- Behavior Health Prescribing Best Practice Guidelines – Medicaid contracts with the Florida Mental Health Institute (FMHI) at the University of South Florida to develop and disseminate best practice guidelines for behavioral health drug therapy. FMHI recommendations provide specific efforts for the different needs of adults and children, coordination of care for behavioral health drug therapy management, improved patient and provider education, compliance with drug therapies and improved outcomes.

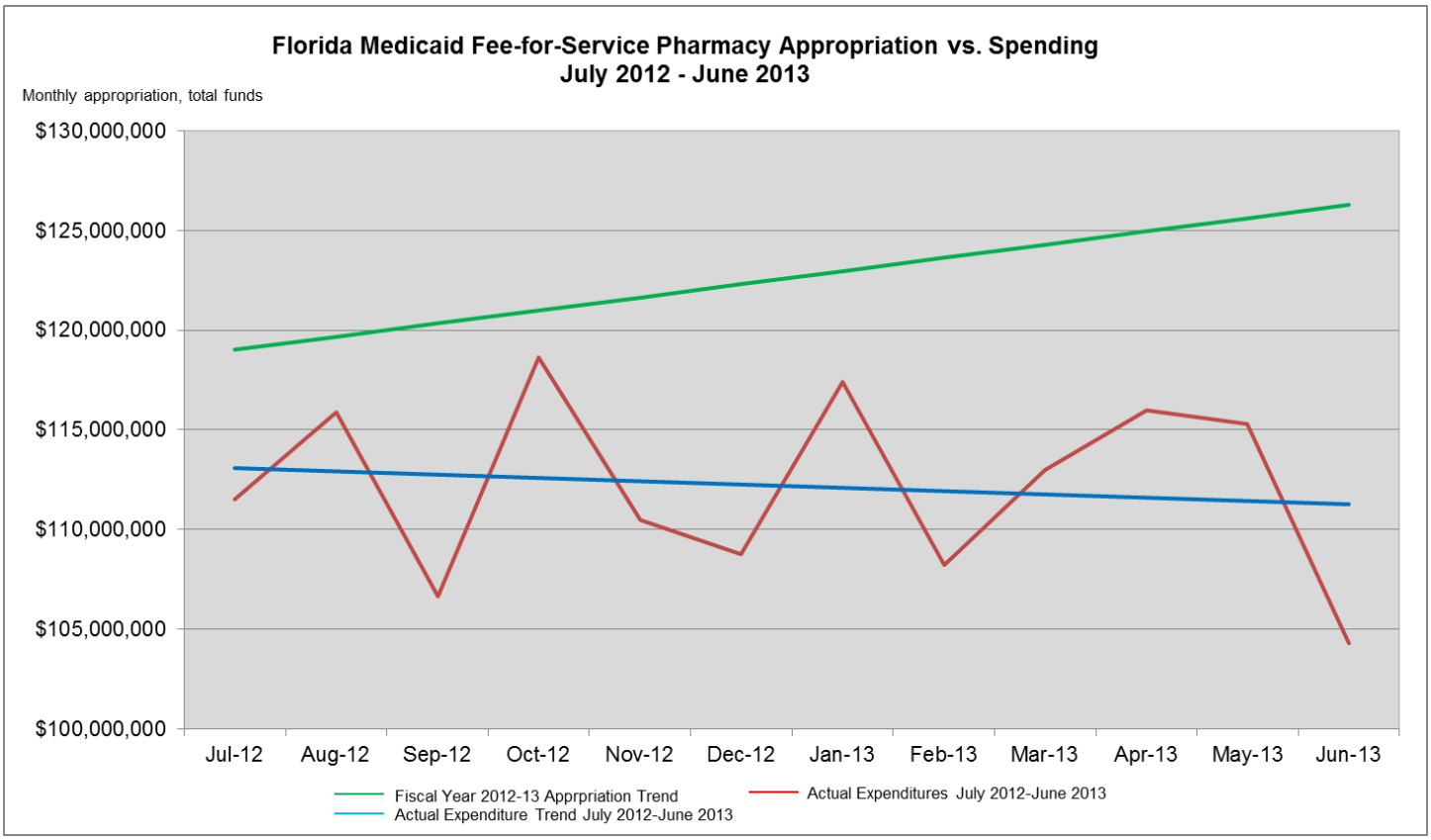
- University of Florida Medication Therapy Management Call Center (TMCC) – Through a contract with the TMCC, trained pharmacists conduct comprehensive prescribed drug case management, which involves direct patient contact if the patient chooses to participate. This statewide Medication Therapy Management Program can help resolve medication-related and health-related problems, optimize medication use for improved patient outcomes, and promote patient self-management of medication and disease states. This in turn helps reduce clinical risk and lowers prescribed drug costs to the Medicaid program including reducing the rate of inappropriate spending on Medicaid prescription drugs.

The TMCC will also measure whether maintaining health coverage for the MEDS-AD population results in fewer institutionalizations and improved health outcomes as part of the Florida MEDS-AD demonstration waiver granted by the Centers for Medicare and Medicaid Services (federal CMS).

- Prescription Benefit Manager – 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.

Additional information related to Medicaid Pharmacy Services is available online at:
http://www.fdhc.state.fl.us/Medicaid/Prescribed_Drug/index.shtml

Pharmacy Appropriations and Spending for Quarters Three and Four (January through June) of State Fiscal Year 2012-2013



For the last two quarters of state fiscal year 2012-2013, the total cost for the program was 3.66 percent lower than the Social Services Estimating conference estimate used for the General Appropriations Act. The actual average retail price per prescription of $84.46 was 3.43 percent higher than the estimate for the same period; actual caseload was 6.65 percent lower than the estimate; and the utilization rate as measured by the number of prescriptions was 6.95 percent lower than estimated. The following market factors and management actions helped to maintain efficiency in the Medicaid prescribed drug program:

- The generic substitution rate increased, partially due to the “patent cliff” effect of using relatively lower cost new generic drugs once the patent had lapsed for the more expensive brand name products.
- The State Maximum Allowable Cost team pursued aggressive pricing of generics.
- 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.

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 the months shown in the table below, 20.57 percent of claims reimbursed were for brand drug products, but these prescriptions account for 81.67 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 $336.91; and the average reimbursement for a generic prescription was $18.41.

Metric	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Total
Generic Utilization	73.7%	73.9%	74.2%	74.9%	75.0%	75.4%	74.5%
Brand Claims	294,415	268,125	277,229	278,674	273,599	242,105	1,634,147
Generic Claims	1,015,110	938,283	992,965	1,035,368	1,020,794	918,068	5,920,588
Non-Drug Claims	1,004	1,091	1,095	1,000	1,110	868	6,168
Compound Claims	67,224	62,499	66,050	66,774	65,466	56,363	384,376
Total Claims	1,377,753	1,269,998	1,337,339	1,381,816	1,360,969	1,217,404	7,945,279
Brand Paid	$96,454,408	$88,000,840	$91,766,030	$94,283,582	$94,495,875	$85,557,523	$550,558,258
Generic Paid	$17,417,312	$17,258,221	$18,500,198	$19,319,189	$19,261,416	$17,251,465	$109,007,801
Non-Drug Paid	$48,483	$51,472	$52,099	$49,103	$52,887	$40,432	$294,476
Compound Paid	$3,463,881	$2,924,383	$2,682,360	$2,316,999	$1,465,107	$1,419,433	$14,272,163
Total Paid	$117,384,084	$108,234,916	$113,000,687	$115,968,873	$115,275,285	$104,268,853	$674,132,698

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/Claims” 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). During the third and fourth quarter of state fiscal year 2012-2013, 27 percent of enrollees used the prescription drug benefit in any given month.

Metric	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Paid/Claim	$85.20	$85.22	$84.50	$83.92	$84.70	$85.65
Net Paid/Claim	$42.35	$42.36	$42.00	$34.94	$35.27	$35.66
Net Net Paid/Claim	$38.71	$38.72	$38.39	$30.49	$30.77	$31.12
Paid PUPM	$287.70	$277.37	$281.96	$283.92	$291.34	$288.60
Net Paid PUPM	$143.01	$137.87	$140.16	$118.21	$121.30	$120.16
Net Net Paid PUPM	$130.71	$126.02	$128.10	$103.15	$105.85	$104.85
Paid PMPM	$81.86	$75.83	$78.19	$77.62	$80.13	$72.36
Net Paid PMPM	$40.69	$37.69	$38.87	$32.32	$33.36	$30.13
Net Net Paid PMPM	$37.19	$34.45	$35.52	$28.20	$29.11	$26.29
Claims/User	3.4	3.3	3.3	3.4	3.4	3.4
% Users	28.5%	27.3%	27.7%	27.3%	27.5%	25.1%

Prescription Spending Trends

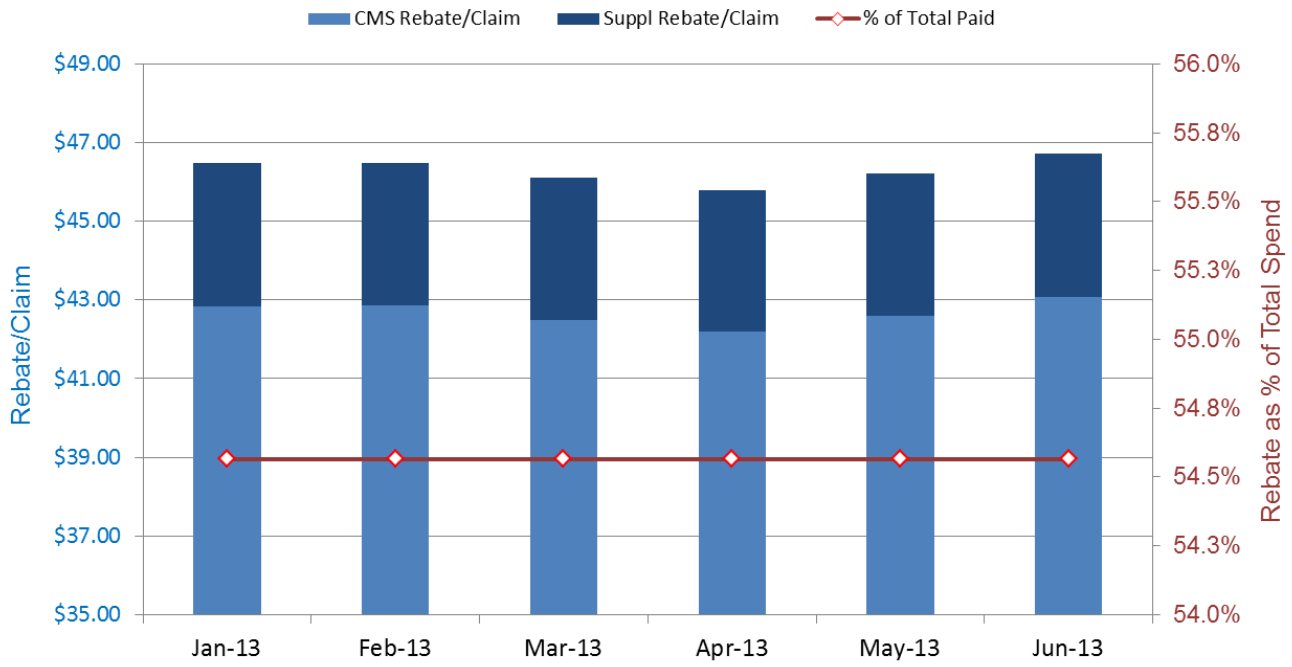
Fee-for-Service Caseload and Retail Prescription Costs

The number of individuals who were eligible for the Medicaid fee-for-service drug program as of June 30, 2013 was 1,441,003. During the final two quarters of state fiscal year 2012-2013, the program reimbursed a total of 7,945,279 pharmacy claims at a total of $674,132,699. The price of brand drugs increased from an average of $327.61 per brand claim in January 2013 to an average of $353.39 per brand claim in June 2013. However, the average number of brand claims per user dropped over the same period from 0.72 brand claims per user in January, to 0.67 brand claims per user in June. The average Net Net Paid per User dropped from $130.71 in January 2013 to just $104.85 in June. The following table details some basic program monthly benchmarks and overall trends for the program during the final two quarters of state fiscal year 2012-2013.

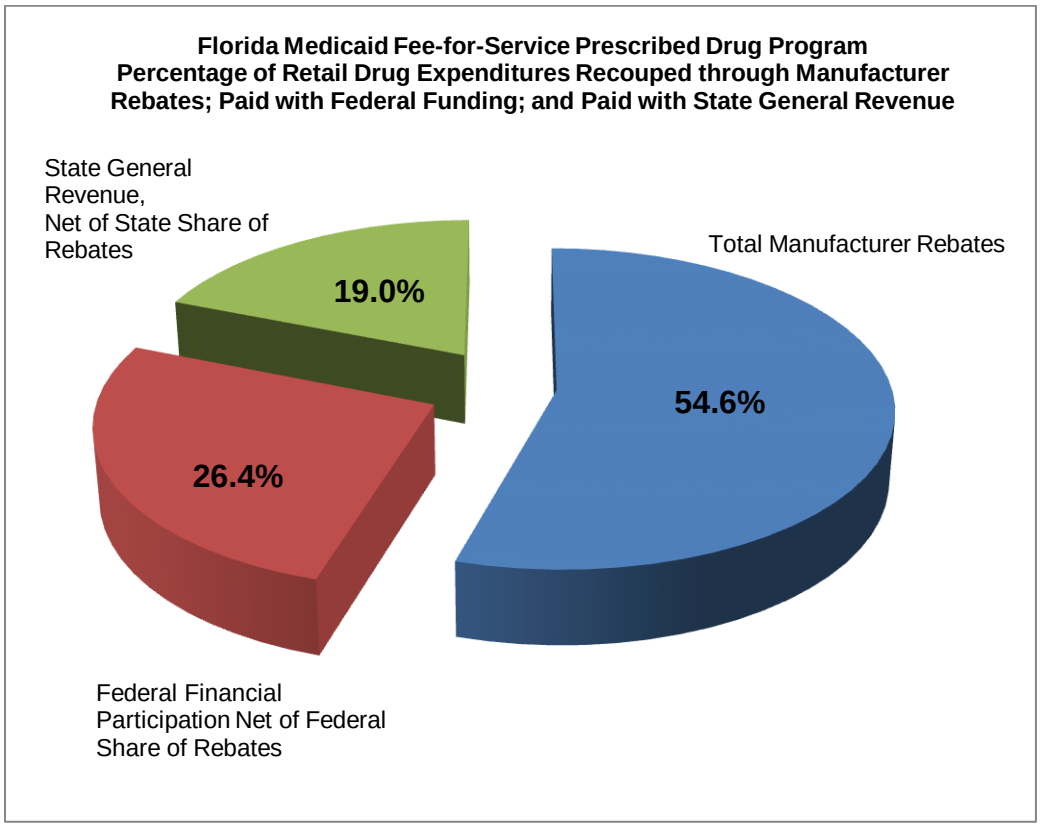
Metric	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Member-Months	1,434,003	1,427,374	1,445,198	1,493,980	1,438,544	1,441,003
Users	408,013	390,217	400,762	408,456	395,668	361,288
Claims	1,377,753	1,269,998	1,337,339	1,381,816	1,360,969	1,217,404
Paid	$117,384,084	$108,234,916	$113,000,687	$115,968,873	$115,275,285	$104,268,853

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.



State general revenue accounts for only 19.0 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 approximately 93 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.

Rebate Collection Productivity

The rebate collection contractor performs follow-up on all unpaid or disputed invoices and as of June 30, 2013, has achieved an overall collection percentage of 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. During the final two quarters of state fiscal year 2012-13, Florida Medicaid processed an average of 1.32 million reimbursement claims per month for prescriptions, and the program currently receives an average of 9,494 prior authorization requests monthly, 0.72 percent of all prescriptions.

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

Medicaid FFS Pharmacy Prior Authorization Requests, January – June 2013

Prior Authorization Requests Received	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Total
Total PA Requests	10,460	9,480	9,310	9,819	9,296	8,599	56,964
Average Per Day	337.4	338.6	300.3	327.3	299.9	286.6	314.7
Total PA Requests Approved	9,244	8,237	7,962	8,390	7,812	7,201	48,846
% PA Requests Approved	88.4%	86.9%	85.5%	85.4%	84.0%	83.7%	85.7%

Medication Therapy Management

Medication Therapy Management

Section 409.912(37)(a), F.S., requires that the Agency implement a Medicaid prescription drug management system. The management system implemented is required to rely on cooperation between physicians and pharmacists to determine appropriate practice patterns and clinical guidelines to improve the prescribing, dispensing, and use of drugs in the Medicaid program. Further, the drug management system had to be designed 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 and the rate of inappropriate spending on Medicaid prescription drugs.

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 409.921(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 to implement this program. 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, and separate specific recommendations for children and adults.

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 drug database for controlled substances (eForce) available to prescribers and pharmacies, the number of recipients enrolled in the lock-in program has decreased significantly. As of June 30, 2013 there were five patients active in the program.

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 eligible to receive institutional care, hospice or home and community-based services coverage, or who are not eligible for Medicare. The current MEDS-AD Waiver 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; and
- 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 final two quarters of state fiscal year 2012-2013.

1115 MEDS-AD Waiver Total Enrollment by Month, January – June 2013

January 2013	February 2013	March 2013	April 2013	May 2013	June 2013
42,078	42,001	40,840	40,708	39,380	37,925

Expenditures reimbursed for recipients who were eligible for Medicaid through the MEDS-AD demonstration program totaled $301,770,265 for the period January through June 2013. Annual and cumulative expenditures remain well below the budget neutrality ceiling approved by CMS for the waiver. In December 2010, federal CMS approved a three-year extension of the waiver through December 31, 2013. As of June 30, 2013 the Agency had requested a renewal of the waiver for an additional three years to run through December 31, 2016. At the time of this report, the Agency has been granted a one-year extension to the waiver through December 31, 2014.

Report Conclusion

This concludes the report of Medicaid Prescribed Drug Program Spending Control Initiatives for the final two quarters of state fiscal year 2012-13.