FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid Prescribed Drug Program Spending Control Initiatives

For Quarters Ended
September 30, 2013
December 31, 2013

Report to the Florida Legislature
June 2014

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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 2013-2014, from July 1, 2013 through December 31, 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 first two quarters of state fiscal year 2013-2014, approximately 26 percent of Medicaid recipients utilized the pharmacy benefit in a given month. While the Average Retail Price per prescription was about 4.8 percent above estimates, and total caseload was trending 1.52 percent less than estimated by the Social Services Estimating Conference, the total cost for the program was 10.67 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 December 31, 2013 was 1,473,126. During the first two quarters of state fiscal year 2013-2014, the program reimbursed a total of 7,758,893 pharmacy claims at a total of $692,918,969. The price of brand drugs increased from an average of $353.39 per brand claim in June 2013 to $358.60 per brand claim in December 2013. The average number of brand claims per user was 0.69 per user. While brand claims accounted for only 20 percent of all claims, they accounted for 81 percent of the total cost.

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 almost 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 One and Two (July through December) of State Fiscal Year 2013-2014

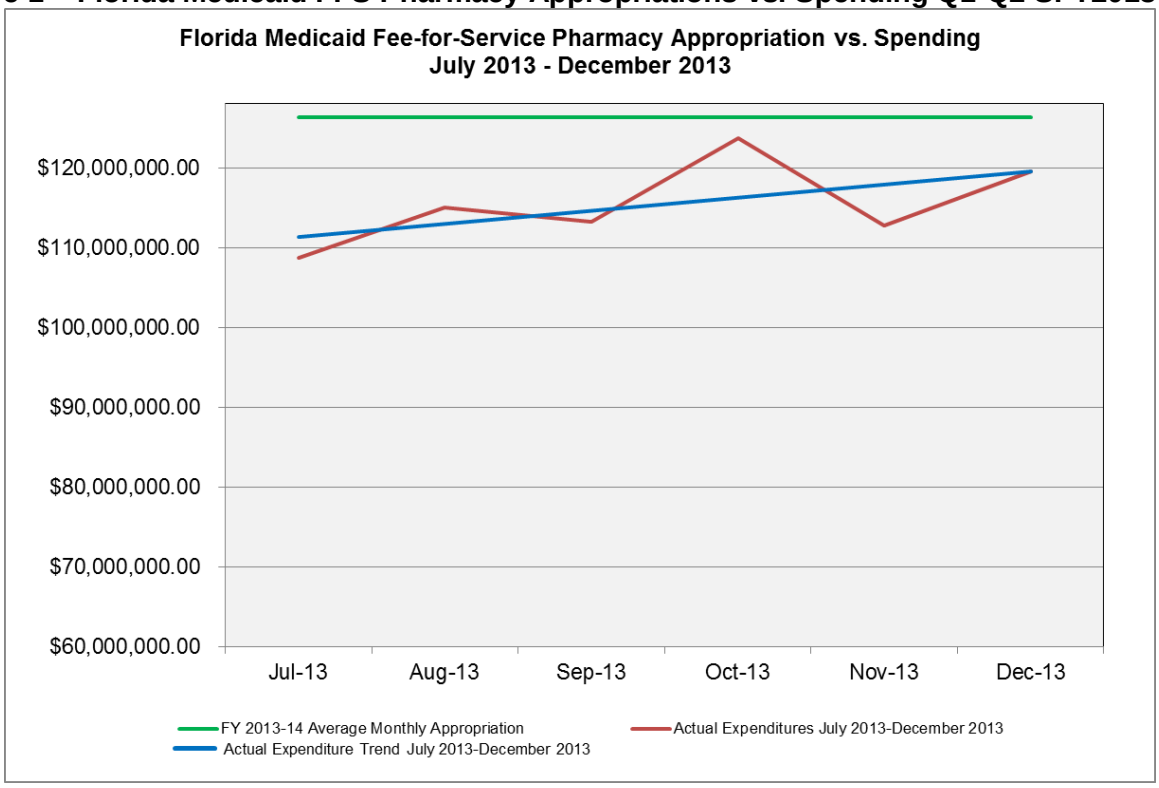
Table 1 shows the state fiscal year 2013-14 appropriations for Fee-for-Service (FFS) pharmacy services along with the appropriations from the previous state fiscal year.

Table 1 – FFS Pharmacy Services Appropriations SFY2012-2013 and 2013-2014

Prescribed Medicine	FY 12-13 Appropriation	FY13-14 Appropriation
Medicaid Caseload	1,410,063	1,431,982
Medicaid Prescriptions Per Month	1,491,626	1,482,342
Medicaid Unit Cost	$83.29	$85.18
Medicaid Total Cost	$1,490,904,741	$1,515,220,381

Overall it is anticipated that Medicaid Pharmacy caseload and total costs will rise 1.6 percent over the previous year's appropriations. The average price per prescription is expected to increase 2.3 percent while the average number of prescriptions per month is expected to decline slightly. Figure 1 below shows the actual pharmacy expenditures for the first two quarters of state fiscal year 2013-2014 compared to appropriations.

Figure 1 – Florida Medicaid FFS Pharmacy Appropriations vs. Spending Q1-Q2 SFY2013-2014



For the first two quarters of state fiscal year 2013-2014, the total cost for the program was on track to be 8.54 percent lower than the Social Services Estimating conference estimate used for the General Appropriations Act. The weighted average retail price per prescription of $89.31 was 4.84 percent higher than the estimate for the same period; actual caseload was trending to be 1.52 percent lower than the estimate; and the utilization rate as measured by the number of prescriptions was 10.67 percent lower than estimated. A generic utilization

rate over 75 percent, extensive application of manufacturer rebates and ongoing, detailed review of the Preferred Drug List to consider removal of products when lower-cost, equally effective alternatives are available all helped maintain efficiency in the Medicaid prescribed drug program.

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, the number of brand and generic prescriptions reimbursed, and the total amounts reimbursed for drug claims.

During the first two quarters of state fiscal year 2013-2014, 20.15 percent of claims reimbursed were for brand drug products, while these prescriptions account for 80.92 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 $358.60; and the average reimbursement for a generic prescription was $19.85.

Table 2 – Utilization and Payments by Prescription Drug Type, Medicaid FFS Pharmacy SFY 2013-2014

Metric	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Total
Generic Utilization	75.4%	75.0%	75.1%	75.1%	75.1%	75.2%	75.1%
Brand Claims	241,366	263,553	262,814	280,432	253,949	261,555	1,563,669
Generic Claims	915,089	973,979	978,962	1,045,585	943,147	972,827	5,829,589
Non-Drug Claims	810	1,199	1,380	1,644	1,521	1,411	7,965
Compound Claims	55,922	60,419	60,707	64,868	57,483	58,271	357,670
Total Claims	1,213,187	1,299,150	1,303,863	1,392,529	1,256,100	1,294,064	7,758,893
Brand Paid	$89,049,247	$94,080,130	$92,265,875	$99,635,889	$90,209,466	$95,492,909	$560,733,516
Generic Paid	$17,741,822	$18,555,686	$18,504,666	$20,770,611	$19,456,587	$20,674,219	$115,703,591
Non-Drug Paid	$38,465	$57,465	$65,617	$77,954	$75,273	$66,428	$381,202
Compound Paid	$1,896,215	$2,294,976	$2,392,534	$3,220,542	$3,055,913	$3,240,480	$16,100,660
Total Paid	$108,725,749	$114,988,257	$113,228,692	$123,704,996	$112,797,239	$119,474,036	$692,918,969

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 first and second quarter of state fiscal year 2013-2014, 26 percent of enrollees used the prescription drug benefit in any given month.

Table 3 – Paid, Net Paid, and Net Net Paid Per Claim, Medicaid FFS Pharmacy SFY 2013-2014

Metric	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Paid/Claim	$89.62	$88.51	$86.84	$88.83	$89.80	$92.32
Net Paid/Claim	$44.55	$44.00	$43.17	$44.16	$44.64	$45.89
Net Net Paid/Claim	$40.72	$40.22	$39.46	$40.36	$40.80	$41.95
Paid PUPM	$309.68	$305.67	$291.41	$305.85	$298.43	$316.68
Net Paid PUPM	$153.94	$151.95	$144.86	$152.04	$148.35	$157.42
Net Net Paid PUPM	$140.70	$138.88	$132.40	$138.97	$135.59	$143.88
Paid PMPM	$75.06	$79.64	$77.73	$84.64	$78.40	$81.10
Net Paid PMPM	$37.31	$39.59	$38.64	$42.08	$38.97	$40.32
Net Net Paid PMPM	$34.10	$36.18	$35.32	$38.46	$35.62	$36.85
Claims/User	3.5	3.5	3.4	3.4	3.3	3.4
% Users	24.2%	26.1%	26.7%	27.7%	26.3%	25.6%

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, 2013 was 1,473,126. During the first two quarters of state fiscal year 2013-2014, the program reimbursed a total of 7,758,893 pharmacy claims at a total of $692,918,969. The price of brand drugs increased from an average of $353.39 per brand claim at the end of state fiscal year 2012-2013 to an average of $358.60 per brand claim in December 2013. The average number of brand claims per rose slightly to an average of 0.69 brand claims per user over the period July 2013 to December 2013. The average Net Net Paid per User was up to $143.88 in December 2013 from $104.85 in June 2013. The following table details some basic program monthly benchmarks and overall trends for the program during the first two quarters of state fiscal year 2013-2014.

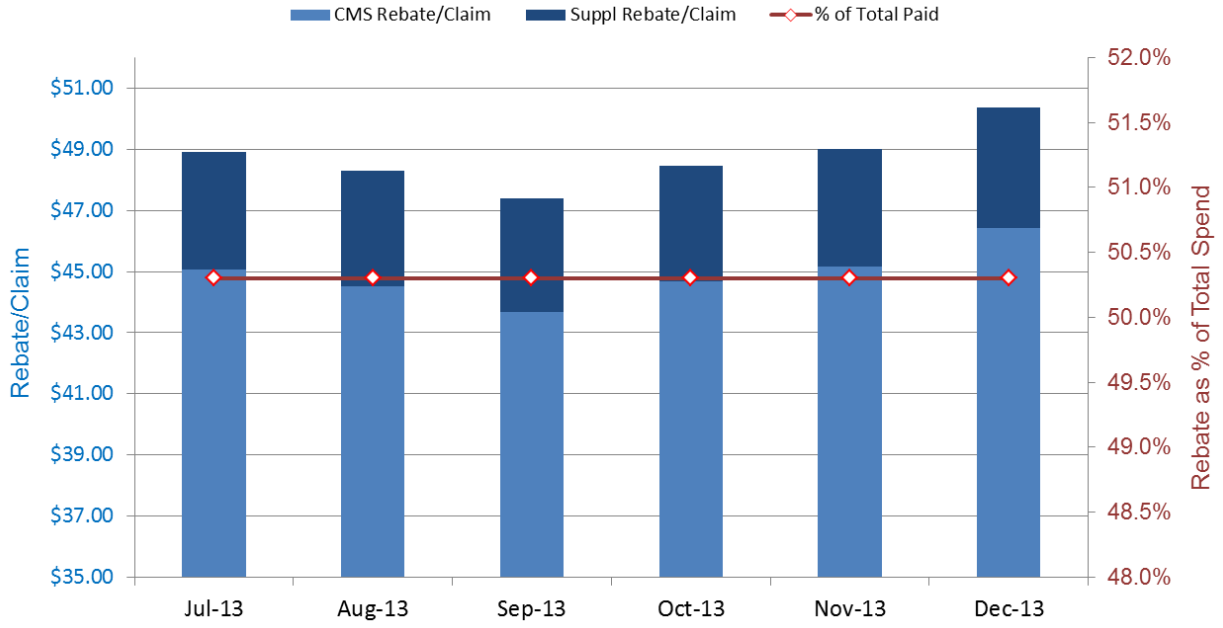
Table 4: Caseload and Retail Prescription Costs, Medicaid FFS Pharmacy SFY 2013-2014

	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Member-Months	1,448,511	1,443,876	1,456,623	1,461,510	1,438,814	1,473,126
Users	351,094	376,185	388,559	404,459	377,965	377,273
Claims	1,213,187	1,299,150	1,303,863	1,392,529	1,256,100	1,294,064
Paid	$108,725,748	$114,988,257	$113,228,691	$123,704,996	$112,797,238	$119,474,036

Manufacturer Rebates Reduce Net Cost of Drugs to State

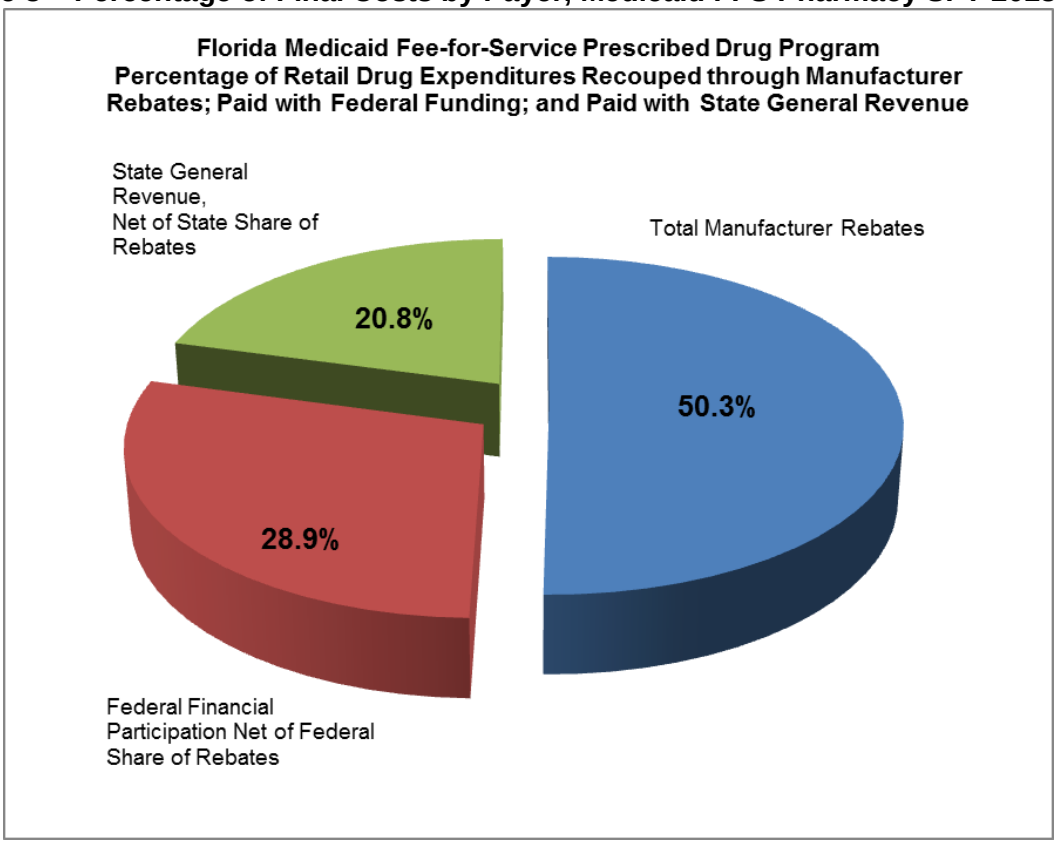
Pharmaceutical Manufacturer rebate revenue paid to the state is a significant offset to the retail cost of prescription reimbursement. The program continues to negotiate agreements for manufacturers to provide supplemental rebates, in addition to required federal rebates, for their brand drug products. 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.

Figure 2 – Rebates Per Claim, Medicaid FFS Pharmacy SFY 2013-2014



State general revenue accounts for only 20.8 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.

Figure 3 – Percentage of Final Costs by Payer, Medicaid FFS Pharmacy SFY 2013-2014



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 December 31, 2013, has achieved an overall collection percentage of 98 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 first two quarters of state fiscal year 2013-14, Florida Medicaid processed an average of 1.29 million reimbursement claims per month for prescriptions, and the program currently receives an average of 9,183 prior authorization requests monthly, 0.71 percent of all prescriptions.

The following chart details metrics related to prior authorization requests received during the first two quarters of state fiscal year 2013-2014.

Table 5: Pharmacy Prior Authorization Requests Medicaid FFS Pharmacy SFY 2013-2014

Prior Authorization Requests Received	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Total
Total PA Requests	8,917	9,667	8,962	10,399	8,494	8,659	55,098
Average Per Day	287.6	311.8	298.7	335.5	283.1	279.3	299.4
Total PA Requests Approved	7,493	8,087	7,466	8,717	7,093	7,417	46,273
% PA Requests Approved	84.0%	83.7%	83.3%	83.8%	83.5%	85.7%	84.0%

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 September 30, 2013 there were no longer any active participants in the lock-in 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 first two quarters of state fiscal year 2013-2014.

Table 6: 1115 MEDS-AD Waiver Total Enrollment by Month, July – December 2013

July 2013	August 2013	September 2013	October 2013	November 2013	December 2013
38,364	37,668	36,969	36,544	35,894	34,336

Expenditures reimbursed for recipients who were eligible for Medicaid through the MEDS-AD demonstration program totaled $322,240,428.44 for the period July through December 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. A temporary extension was granted through December 2014. The Agency anticipates meeting with CMS in June 2014 for further discussion.

Report Conclusion

This concludes the report of Medicaid Prescribed Drug Program Spending Control Initiatives for the first two quarters of state fiscal year 2013-14.