Florida Medicaid
Prescribed Drug Service
Spending Control Initiatives

For the Quarter
July 1, 2014 through
September 30, 2014

Report to the Florida Legislature
September 2015

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Purpose of Report

Per section 409.912(37)(c), Florida Statutes (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 Florida Medicaid prescribed drug expenditures. This report includes data for the first quarter of state fiscal year (SFY) 2014-2015, July 1, 2014 through September 30, 2014.

Executive Summary

Transitioning to Statewide Medicaid Managed Care

The Managed Medical Assistance (MMA) component of the Statewide Medicaid Managed Care (SMMC) program began rollout during the final quarter of SFY 2013-2014 (in May 2014) and completed rollout during the first quarter of SFY 2014-15 (in August 2014). A majority of Florida Medicaid recipients are now enrolled in managed care and going forward the health plans are responsible for all facets of care including reimbursement for the Medicaid pharmacy benefit. This means there will be significantly fewer pharmacy claims reimbursed under fee-for-service (FFS).

In addition to there being fewer FFS claims, those recipients remaining in FFS will no longer include recipients from virtually all eligibility groups. Most of the Florida Medicaid recipients remaining in FFS are enrolled in waivers or are receiving special services, and have services and benefits that are specific to their unique needs. These benefits can often include specific or unique drug requirements. The change in FFS pharmacy population will likely mean that the costs and utilization patterns seen in FFS pharmacy will be different than in previous years when the recipient population was more diverse. As more time elapses, and the FFS and managed care populations stabilize, this report will track changes over time and make note of differences where they appear significant.

As Florida Medicaid moved toward a predominantly managed care environment, special emphasis was placed on transitioning the pharmacy benefit of recipients as seamlessly as possible. The Agency realized that filling a prescription could be the first encounter many recipients would experience with their new health plan. The Agency identified and met several goals related to pharmacy services and the transitioning of the Florida Medicaid population to managed care.

FFS Pharmacy Cost Controls

While the population remaining in Florida Medicaid FFS pharmacy will likely look different than in the past, many of the same cost control measures will remain in place and should still be effective at controlling costs in the FFS population. Specific spending control measures in place for the FFS population include:

- Pharmacy Rebates – 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 federally required 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 Florida Medicaid Preferred Drug List (PDL). During the first quarter of SFY 2014-2015, the average retail price for a prescription reimbursed under FFS was $132.48. After accounting for rebates received from manufacturers based on their federal rebate agreements, the average amount reimbursed per prescription was $58.38. The average amount reimbursed during the quarter after taking into account both federal rebates and state supplemental rebates was $53.94.

- 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 PDL. The committee performs ongoing scheduled review of the PDL, with negotiated state supplemental rebates from manufacturers, and continuously updates 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.

- 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 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 Florida Medicaid program including reducing the rate of inappropriate spending on Medicaid prescription drugs.

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

- Prescription Benefit Manager – The contracted prescription benefit manager vendor, Magellan Medicaid Administration (Magellan), managed a caseload of more than 715,000 persons per month and processed an average of almost 370,000 drug claims per month for the Florida Medicaid FFS pharmacy service during the first quarter of SFY 2014-2015. The system of automated claim edits is continuously refined and improved to support safe prescribing, adherence to the PDL, and prevention of fraud and abuse. There has been a steady downward trend in the total number of claims each month since the implementation of the MMA program. The total number of FFS pharmacy claims reached 302,305 as of September 2014, down from 790,142 at the end of the previous quarter (June 2014), and down from just over 1.3 million at the end of September 2013.

FFS Caseload and Retail Prescription Costs

During the first quarter of SFY 2014-2015, a total of more than 2.1 million pharmacy claims totaling almost $147 million was reimbursed. The number of users averaged almost 116,000 per month, but decreased each month during the quarter. Total claims averaged almost 370,000 per month and the amount paid averaged almost $49 million per month over the quarter. The average number of claims per user was 3.2 claims per user, per month. During the first quarter, just over 16 percent of eligible recipients used the pharmacy benefit in a given month. Finally, during the first quarter of SFY 2014-2015, just over 20 percent of claims reimbursed were for brand drug products, which accounted for almost 84 percent of total expenditures.

Additional information related to Florida Medicaid's pharmacy services is available on the Florida Medicaid Pharmacy Policy webpage at:

http://ahca.myflorida.com/Medicaid/Policy_and_Quality/Policy/pharmacy_policy/index.shtml

Medicaid Fee-for-Service Pharmacy in Transition

Statewide Medicaid Managed Care

The Managed Medical Assistance (MMA) component of the Statewide Medicaid Managed Care (SMMC) program was implemented between May and August 2014. Most recipients are now enrolled managed care and the health plans have taken over responsibility for virtually all of the medical care needs of their enrollees, including the Medicaid pharmacy benefit. As a result, those pharmacy claims reimbursed by health plans will not be included in this report. The number of pharmacy claims reflected here will be significantly lower than in the past. Also, due to the nature of the population that is remaining in FFS, they will likely have different claims histories than has been previously seen in this report as well. The following populations are excluded from enrollment in a MMA plan and will continue to receive pharmacy benefits under FFS:

- Family Planning Waiver
- Emergency Services for Aliens
- Women with Breast or Cervical Cancer
- Medically Needy
- Qualified Medicare Beneficiary (QMB)/ Specified Low-Income Medicare Beneficiary (SLMB) Only

In addition, the following populations have the option of enrolling in a MMA plan but may choose to remain in FFS:

- Medicaid recipients who have other creditable health care coverage, excluding Medicare
- Persons eligible for refugee assistance
- Medicaid recipients who are residents of a developmental disability center
- Medicaid recipients enrolled in the developmental disabilities home and community based services waiver or Medicaid recipients waiting for waiver services
- Children receiving services in a prescribed pediatric extended care center
- Medicaid recipients residing in a group home facility licensed under chapter 393.

The change in FFS pharmacy population will likely mean that the costs and utilization patterns seen in FFS pharmacy will be different than in previous years when the FFS recipient population represented a more diverse cross-section of Florida Medicaid enrollees. As more time elapses, and the FFS and managed care populations stabilize, this report will track changes over time and make note of differences where they appear significant.

Transitioning to Managed Care

As Florida Medicaid moved toward a predominantly managed care environment, special emphasis was placed on transitioning the pharmacy benefit of recipients as seamlessly as possible. The Agency realized that filling a prescription could be the first encounter many recipients would experience with their new health plan and had several goals related to pharmacy services and the transitioning of the Florida Medicaid population to managed care:

- Support plans' efforts to provide continuity of care for the pharmacy benefit for all enrollees (without delay, on day one for each region)
- Provide a way for enrollees' plan enrollment and pharmacy billing information to be available electronically at the pharmacy point of sale (without need for telephone calls, even if the enrollee does not know they are enrolled in a managed care plan or which plan)
- Ensure that claims could be adjudicated and pharmacies paid without delay for providing services to plan enrollees

- Communicate with all stakeholders (health plans, Florida Association of Health Plans, large retail pharmacy chains, independent pharmacies, Prescription Benefit Managers (PBM), advocates, and recipients) about ways they could prepare for the transition

Through scheduled all-plan calls and written policy guidance, the Agency communicated to health plans that they would be required to allow open pharmacy networks (rather than contract-only limited networks) for the first 60 days of operation in each region. This meant that enrollees could still go to their usual pharmacy and not be required to use a pharmacy that is in the plan's network during this transition period. A list of all Florida Medicaid pharmacy providers was provided to PBMs. Additionally, the Agency communicated that existing approved prescriptions must be allowed without prior authorization during the transition period. A series of webinars continued throughout the transition period regarding prescription services and managed care. The Magellan PBM call center staff was trained and prepared to handle large volumes of calls.

Agency staff assembled a network of technical contacts from health plans, their PBMs, retail pharmacy payer relations representatives, and retail pharmacies. Each contact was invited to participate in testing the point of sale messaging function.

The full Florida Medicaid covered drug file was updated weekly and posted to a secure FTP site so health plans can provide the file to their PBMs. Plan readiness testing included pharmacy claim test cases to ensure that plans' PBMs will adjudicate claims according to contract requirements or that they use the single Florida Medicaid PDL.

The Agency took some of the following additional actions to assist health plans during the transition:

- Provided updates of the full covered drug file and all prior authorization or step therapy criteria
- Provided a year of pharmacy claims history for plan enrollees
- Provided a listing of active prior authorizations for their enrollees who transitioned from FFS
- Designed and implemented a point of sale messaging system (coordinated effort by the Agency, HP, and Magellan PBM)
- Test cases for PBM adherence to the single Florida Medicaid PDL were provided and all issues resolved prior to go-live for each plan
- Communicated to recipients, through Webinars, plan communications, and through retail pharmacies to provide guidance on what they could do to help make a smooth transition (e.g., get a printout of all medications from their current pharmacy prior to the transition; bring all medication packages to the pharmacy; or, get refills prior to the first of the month, if needed)

Florida Medicaid FFS Pharmacy Caseload and Expenditures

Table 1 shows the SFY 2014-15 estimated expenditures and utilization for FFS pharmacy services along with the appropriations from the previous SFY.

Table 1 – FFS Pharmacy Services Appropriations SFY 2013-2014 and SFY 2014-2015

Prescribed Medicine	SFY 2013-2014 Appropriation	SFY 2014-2015 Estimates*	Expected % Change from SFY2013-14
Medicaid Caseload	1,431,982	512,796	-64.2%
Medicaid Prescriptions Per Month	1,482,342	516,751	-65.1%
Medicaid Unit Cost	$85.18	$92.01	8.0%
Medicaid Total Cost	$1,515,220,381	$379,792,597	-74.9%

*Source: SFY 2013-2014 Appropriation data are from the 2013 Social Services Estimating Conference (SSEC) General Appropriations Act Estimates. *SFY2014-15 Estimates reflects amended expenditure and caseload estimates from the March 2015 SSEC. Initial appropriation estimates were calculated without accounting for SMMC and the revised estimates more accurately reflect expected expenditures and utilization.*

Overall, it is anticipated that Florida Medicaid FFS pharmacy caseload and monthly prescription claims will fall by approximately 65 percent. The average price per prescription is expected to rise by 8.0 percent, but with the significant drop in caseload and number of prescriptions expected, the total cost of FFS pharmacy claims is expected to fall by almost 75 percent during the year. Table 2 compares the first quarter performance with the fiscal year estimates from the March 2015 SSEC.

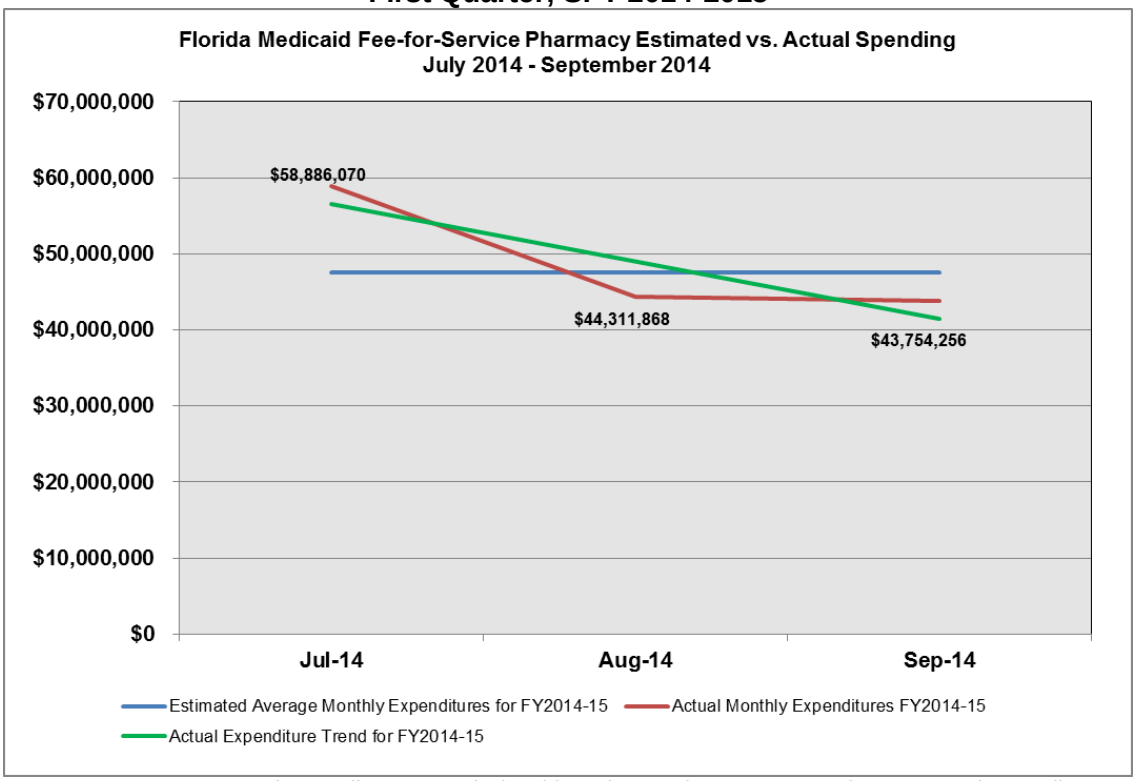
Table 2 – FFS Pharmacy Services Expenditures and Utilization Estimates vs. Actual First Quarter, SFY 2014-2015

Prescribed Medicine	SFY 2014-2015 Estimates	Q1 SFY 2014-2015 Actual	% Difference Estimates vs. Actual
Average Caseload (Member Months)	512,796	715,351	39.50%
Average Prescriptions Per Month	516,751	369,735	-28.45%
Average Paid/Claim	$92.01	$132.48	43.98%
Average Total Cost Per Month	$47,547,600	$48,984,065	3.02%

Source: SFY 2014-15 Estimates are based on the March 2015 SSEC. Actual data are reported in the Florida Pharmacy Report Card, Magellan Health Services, Inc., December 2014

During the first quarter of SFY 2014-2015, the average caseload was 39.5 percent higher than the SSEC estimate. The average number of prescriptions per month was more than 28 percent below estimates, average amount paid per claim (prior to rebates) was just under 45 percent higher, and the average total cost per month was about 3 percent higher than estimated. However, the total costs per month were trending downward throughout the quarter. Figure 1 shows the actual FFS pharmacy expenditures for the first quarter of SFY 2014-2015 compared to the average expected expenditures.

Figure 1 – Florida Medicaid FFS Pharmacy Expenditures Estimates vs. Actual Spending First Quarter, SFY 2014-2015



Source: Average expected expenditures are calculated from the March 2015 SSEC estimates. Actual expenditures are reported in the Florida Pharmacy Report Card, Magellan Health Services, Inc., December 2014

Claims Details

Brand and Generic Drug Costs and Utilization

Generic utilization plays a significant role in controlling pharmacy costs. During the first quarter, the generic utilization rate was over 75 percent (see Table 3; Figure 2). Coupled with the extensive application of manufacturer rebates (see Table 4) and ongoing, detailed review of the Florida Medicaid PDL to consider removal of products when lower-cost, equally effective alternatives are available, helps maintain efficiency in the Florida Medicaid prescribed drug services. Table 3 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.

Table 3 – Utilization and Payments by Prescription Drug Type, Medicaid FFS Pharmacy First Quarter SFY2014-2015

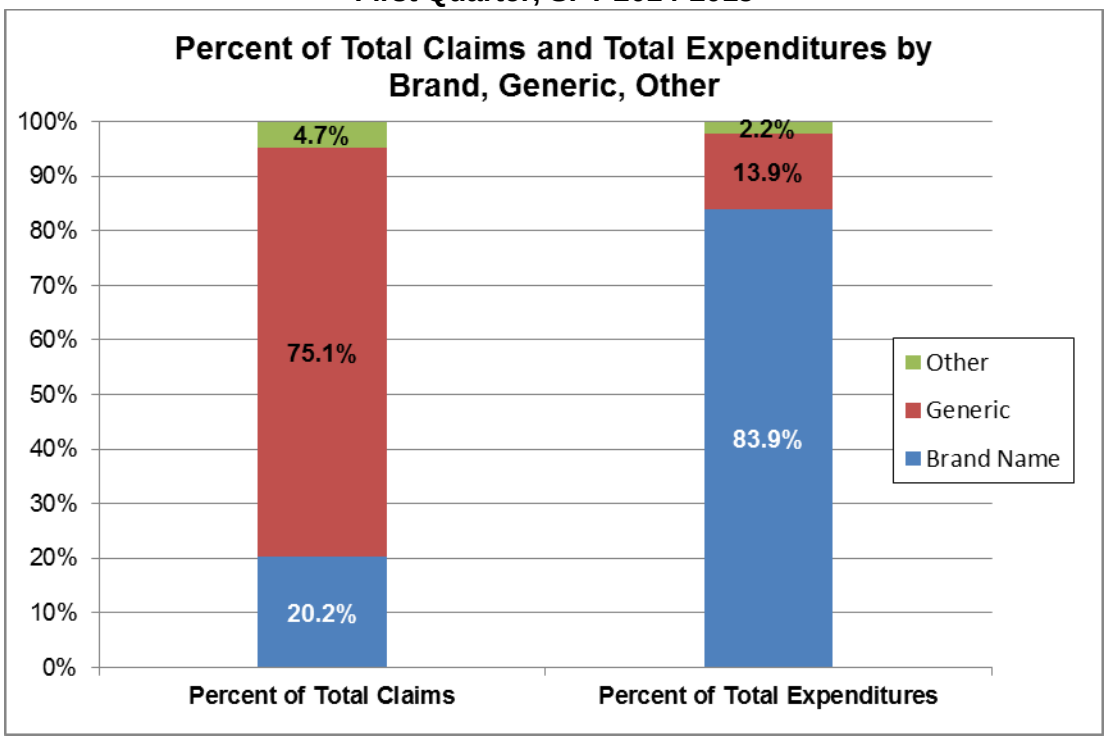
Metric	July 2014	August 2014	September 2014	Q1 SFY 2014-2015
Generic Utilization	76.2%	74.1%	74.3%	75.1%
Brand Paid/Claim	$518.22	$557.91	$587.32	$549.40
Generic Paid/Claim	$23.49	$25.33	$25.59	$24.58
Non-Drug/Comp Paid/Claim	$50.49	$63.86	$76.39	$61.85
Brand Claims	94,608	66,989	62,763	224,360
Generic Claims	372,613	235,567	224,531	832,711
Non-Drug Claims	418	402	359	1,179
Compound Claims	21,500	14,804	14,652	50,956
Brand Paid	$49,027,974	$37,373,694	$36,861,789	$123,263,457
Generic Paid	$8,751,419	$5,967,157	$5,745,801	$20,464,377
Non-Drug Paid	$25,213	$22,610	$16,464	$64,287
Compound Paid	$1,081,464	$948,407	$1,130,202	$3,160,073

Source: Florida Pharmacy Report Card, Magellan Health Services, Inc., December 2014.
Utilization and amounts Paid/Claim for the Quarter are averages, all other figures are Quarter totals.

The average paid per claim for a brand name prescription during the first quarter was $549.40 for 224,360 prescriptions and the average paid per claim for a generic prescription was $24.58 for 832,711 prescriptions. This means that during the first quarter of SFY 2014-2015, while 20.2 percent of claims reimbursed were for brand drug products, these prescriptions accounted for 83.9 percent of total expenditures.

The higher drug prices are likely attributable to higher priced and newly introduced drugs (such as Sovaldi used for treating hepatitis C). After transition to SMMC, the majority of Medicaid recipients are enrolled in a health plan and much of the population remaining in Florida Medicaid FFS is enrolled in special programs and have special needs. This means utilization patterns will be different and drug prices will likely be higher for the higher need population.

Figure 2 – Florida Medicaid FFS Pharmacy Brand Name versus Generic Utilization and Expenditures
First Quarter, SFY 2014-2015



Source: Calculated based on data provided in the Florida Pharmacy Report Card, Magellan Health Services, Inc., December 2014

FFS Caseload and Retail Prescription Costs

During the first quarter of SFY 2014-2015, a total of 2,146,054 pharmacy claims totaling $146,952,194 was reimbursed. The number of users averaged 115,574 per month, but decreased each month during the quarter. Total claims averaged 369,735 per month and the amount paid averaged $48,984,065 per month over the quarter. There was a downward trend in all metrics over the span of the quarter except for the average number of claims per user which held steady at 3.2 claims per user, per month. During the first quarter, an average of 16.2 percent of eligible recipients used the pharmacy benefit in a given month.

Table 4 – Caseload, Users, Claims, and Retail Prescription Costs, Medicaid FFS Pharmacy
First Quarter SFY2014-2015

Metric	July 2014	August 2014	September 2014	Q1 SFY 2014 2015 Total	Q1 SFY 2014 2015 Average
Member-Months	705,607	723,872	716,575	2,146,054	715,351
Users	152,706	98,846	95,171	346,723	115,574
Claims	489,139	317,762	302,305	1,109,206	369,735
Paid	$58,886,070	$44,311,868	$43,754,256	$146,952,194	$48,984,065
Claims/User	3.2	3.2	3.2	3.2	3.2

Source: Florida Pharmacy Report Card, Magellan Health Services, Inc., December 2014

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. Florida Medicaid continues to negotiate agreements for manufacturers to provide supplemental rebates, in addition to federally required 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 Florida Medicaid PDL.

The impact of rebates on overall pharmacy costs can be seen in Table 5. The top row of figures in the table reports 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. Reimbursement amounts are shown per Claim; per user, per month (PUPM), and per member (i.e., eligible recipient), per month (PMPM).

Table 5 – Paid, Net Paid, and Net Net Paid Per Claim, Medicaid FFS Pharmacy First Quarter, SFY 2014-2015

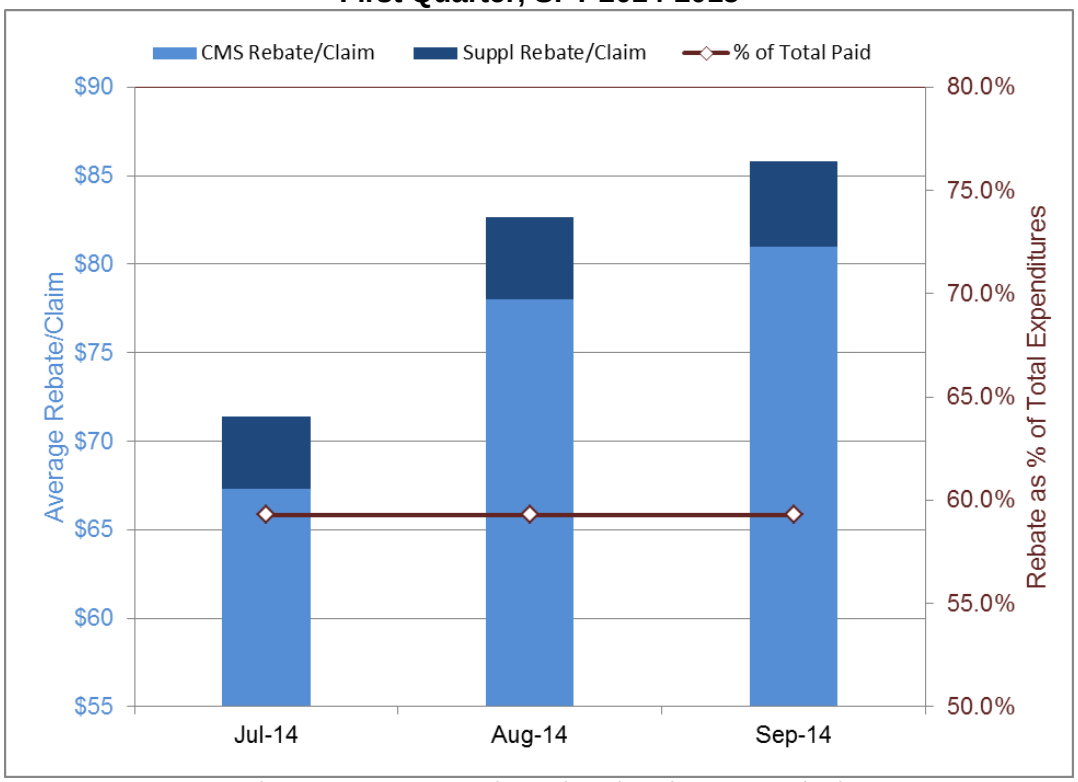
Metric	July 2014	August 2014	September 2014	Q1 SFY 2014-2015
Paid/Claim	$120.39	$139.45	$144.74	$132.48
Net Paid/Claim	$53.05	$61.45	$63.78	$58.38
Net Net Paid/Claim	$49.01	$56.78	$58.93	$53.94
Paid PUPM	$385.62	$448.29	$459.74	$423.83
Net Paid PUPM	$169.92	$197.54	$202.59	$186.76
Net Net Paid PUPM	$157.00	$182.52	$187.18	$172.56
Paid PMPM	$83.45	$61.22	$61.06	$68.48
Net Paid PMPM	$36.77	$26.97	$26.91	$30.17
Net Net Paid PMPM	$33.98	$24.92	$24.86	$27.88

Source: Florida Pharmacy Report Card, Magellan Health Services, Inc., December 2014

Figure 3 illustrates the amount of the average federally required and supplemental rebates received per prescription as well as 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. The average percentage of total pharmacy expenditures attributable to rebates was 59.3 percent for the quarter. While the percentage was the same for each month in the quarter, it does represent an increase from the previous quarter and reflects an upward trend in the rebate percentage over the last year. This is likely the direct result of higher drug prices. Higher drug prices mean the rebate percentages and amounts per claim will increase, on average. This is particularly true when drug prices rise faster than the overall rate of the Consumer Price Index (CPI). Due to the formula for calculating federal rebates, the federal rebate percentage increases more rapidly when the price of drugs rises faster than overall inflation.

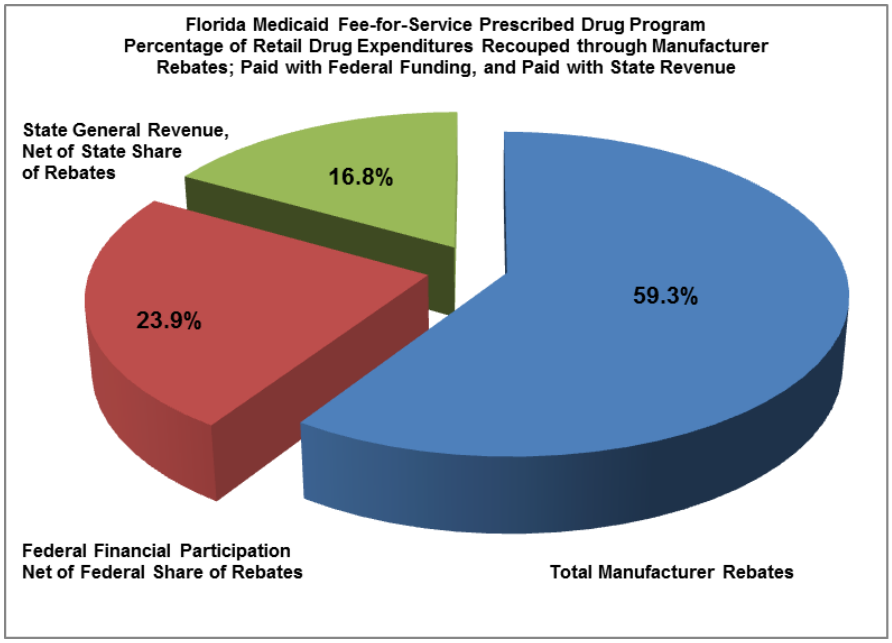
Figure 4 shows the distribution of the final cost of a prescription drug between the state, the federal government, and the manufacturers' rebates. It illustrates the percentage of state general revenue dollars required for the state to offer the Florida Medicaid FFS drug benefit after federal matching funds and manufacturer rebate revenue are received. State general revenue accounts for only 16.8 percent of the total retail cost of FFS pharmacy services.

Figure 3 – Rebates Per Claim, Medicaid FFS Pharmacy
First Quarter, SFY 2014-2015



Rebate percentages are estimates based on pharmacy caseload.
Source: Florida Pharmacy Report Card, Magellan Health Services, Inc., December 2014

Figure 4 – Estimated Percentage of Final Costs by Payer, Florida Medicaid FFS Pharmacy
SFY 2014-2015 Year-to-Date



Source: Calculated from rebate information provided in Florida Pharmacy Report Card, Magellan Health Services, Inc., December 2014
Federal Financial Participation Rates reported by http://aspe.hhs.gov

Florida Medicaid FFS Prescribed Drug Services Ongoing Cost Controls

Cost-Effective Florida Medicaid PDL

The Florida Medicaid PDL continues to produce significant savings of pharmacy costs since its implementation as a mandatory component of the Florida Medicaid 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).

PDL Adherence – PDL Products Share of Florida Medicaid Market

Through aggressively negotiating supplemental rebates and favorable net pricing, the Florida Medicaid prescribed drug service is able to maintain an array of choices for prescribers within each therapeutic class on the Florida Medicaid PDL. Approval for reimbursement of prescriptions for products not on the PDL may be obtained through prior authorization. According to Magellan's PDL Compliance Report (January 2015), during the first quarter of SFY 2014-2015, PDL products represented 93.8 percent of prescriptions reimbursed by Florida Medicaid for FFS recipients and 72.9 percent of the total amount reimbursed.

While the percentage of PDL drugs remained consistent, the amount of total FFS pharmacy reimbursement attributable to PDL drugs fell by 10.4 percent. This is likely a combination of factors including the nature of the population remaining in FFS which affects drug usage patterns, increases in the overall price of drugs, and the price of recent market entrants that are not on the PDL (such as the recent introduction of Sovaldi for hepatitis C).

Rebate Collection Productivity

Molina Medicaid Solutions, the rebate collection contractor, performs follow-up on all unpaid or disputed invoices. In their report dated October 30, 2014, they show that as of September 30, 2014, they had achieved an overall collection percentage of 98 percent of FFS invoiced rebates from manufacturers for the first quarter of SFY 2014-2015. Nonpaying manufacturers are reported to federal CMS. The contractor continues to refer providers who cannot or will not reverse billing errors and rebill correctly to the Agency'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 (PA) requests is immediate through automatic claim system edits or by the Florida Medicaid fiscal agent's Pharmacy Benefits Manager (Magellan). Magellan's Therapeutic Call Center is a 24-hour, toll-free request line, staffed by pharmacists and pharmacy technicians at all times. Approval of some specific medications requires clinical review by a Florida Medicaid staff clinical pharmacist. These requests are handled within 24 hours. Requests are either approved, denied, or can result in a change in therapy. During the first quarter of SFY 2014-2015, Florida received a total of 17,012 PA requests through the call center, an average of almost 185 per day, and more than 5,670 per month.

The following chart details metrics related to PA requests received during the first quarter of SFY 2014-2015. There was a roughly 3 percent increase in the percentage of PA requests that were approved over the previous quarter and the average for SFY 2013-2014. This could possibly be attributable to efforts at maintaining existing treatment programs as recipients transitioned into Medicaid and between health plans. Trends in PA approvals will be monitored as the Florida Medicaid FFS recipient population stabilizes over time after SMMC transition.

Table 6 – Pharmacy Therapeutic Call Center Prior Authorization Requests, Florida Medicaid FFS First Quarter, SFY2014-2015

Metric	July 2014	August 2014	September 2014	Q1 SFY 2014-2015
Total PA Requests	6,910	5,336	4,766	17,012
Average Per Day	222.9	172.1	158.9	184.9
Total PA Requests Approved	5,692	4,735	4,212	14,909
% PA Requests Approved	86.3%	88.7%	88.4%	87.6%

Source: Magellan Medicaid Administration, January 2015

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 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 Florida 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 Florida 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 all of the following:

- Improve the quality of behavioral health drug prescribing
- Improve patient adherence
- Reduce clinical risk
- 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.

MEDS-AD Waiver

The Florida MEDS-AD demonstration waiver provides Florida 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 available to those aged

and disabled persons who are either receiving or eligible to receive institutional care, hospice or home and community-based services, or who are not eligible for Medicare. The current MEDS-AD Waiver 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, along with High-Intensity Pharmacy Case Management services, is designed to avoid costs of preventable hospitalizations or institutional placement that would otherwise occur in the next five years had these vulnerable recipients been denied access to prescribed drugs and other medical services. The focus of the demonstration is to provide high-intensity pharmacy case management for recipients who are not yet receiving institutional care.

The table below contains monthly MEDS-AD enrollment counts for the first quarter of SFY 2014-2015.

Table 7 – 1115 MEDS-AD Waiver Total Enrollment by Month, July 2014-September 2014

July 2014	August 2014	September 2014
39,014	39,053	38,500

Source: Medicaid Data Analytics, August 2014

Expenditures reimbursed for recipients who were eligible for Florida Medicaid through the MEDS-AD demonstration waiver totaled $56,437,124 for the period July through September 2014. Cumulative expenditures remain well below the budget neutrality ceiling approved by federal CMS for the waiver.

Report Conclusion

This concludes the report of the Florida Medicaid Prescribed Drug Services Spending Control Initiatives for the first quarter of SFY 2014-2015.