SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based only on the provisions contained in the legislation as of the latest date listed below.)

BILL: HB 2151

SPONSOR: General Appropriations and Representative Sanderson

SUBJECT: Medicaid; Drug Spending Control

DATE: April 26, 2000 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Liem	Wilson	HC	Fav/1 amendment
2.			GO	Withdrawn
3.	Peters	Hadi	FP	Fav/1 amendments
4.				
5.				

I. Summary:

House Bill 2151 modifies Medicaid requirements relating to cost-effective purchasing of health care in order to implement a spending reduction in the proposed 2000-2001 General Appropriations Act. Because the reductions made within this program are recurring in nature and affect the base upon which future budgets will be built, permanent changes to the law are necessary.

The bill requires the Agency for Health Care Administration (AHCA) to implement a Medicaid prescribed drug spending control program. Under the program, adult Medicaid beneficiaries not residing in nursing homes or other institutions will be limited to four brand-name prescription drugs. Children, institutionalized adults, anti-retroviral agents, and certain medications used to treat mental illnesses are exempt from this restriction. The bill requires the reimbursement level to pharmacies for Medicaid prescribed drugs to be set at the average wholesale price minus 14 percent. The bill also requires manufacturers of generic drugs prescribed to Medicaid patients to guarantee the state a rebate of at least 15.1 percent of the total Medicaid payment for their generic products.

The bill requires AHCA to establish a process to manage the drug therapies of Medicaid recipients who require a significant number of prescribed medications each month.

The bill authorizes AHCA to limit the size of its pharmacy network and requires AHCA to establish a program that requires Medicaid practitioners prescribing drugs to use a counterfeit-proof prescription pad for Medicaid prescriptions. The agency may contract for any or all portions of the program.

This bill amends s. 409.912, F.S.

II. Present Situation:

Medicaid

Medicaid is a medical assistance program that pays for health care for the poor and disabled. The program is jointly funded by the federal government, the state, and the counties. The federal government, through law and regulations, has established extensive requirements for the Medicaid program. Under the Florida Medicaid program the match rate is 56 percent federal and 44 percent state funding. The Title XXI program established an enhanced federal match of 69 percent federal and 31 percent state funding. The Agency for Health Care Administration (AHCA or agency) is the single state agency responsible for the Florida Medicaid program. The statutory provisions for the Medicaid program appear in ss. 409.901 through 409.9205, F.S.

Currently, Florida Medicaid's prescription drug program operates within an open formulary, covering all medically necessary drugs for patients under twenty-one, and most drugs for adults. In total, over 300,000 drugs are covered by the program. Nearly 98 percent of the Medicaid pharmacy budget is spent on approximately 6,000 drugs, whereas over 20 percent of the total pharmacy budget is spent on just 12 drugs.

The current program limits monthly drugs to six prescriptions (with exceptions) for community patients, and eight prescriptions (with exceptions) for institutional patients; allowing for a 30- to 100-day supply of each prescription.

Medicaid Drug Rebate Program

The Omnibus Budget Reconciliation Act of 1990 requires a pharmaceutical company to pay a rebate on its drug products in order to receive reimbursement by the Medicaid program. This law requires drug manufacturers that participate in the Medicaid program to enter into a national rebate contract with the Secretary of the Department of Health and Human Services for states to receive federal funding for outpatient drugs dispensed to Medicaid patients. The rebate program requires drug manufacturers to pay state Medicaid programs, for each of a manufacturer's pharmaceutical products, the higher of a basic percentage rebate or a rebate equivalent to the best price the manufacturer offers a non-government customer. Manufacturers must pay an additional rebate if the price of any product has increased faster than the Consumer Price Index since the fourth quarter of 1990. These rebates apply only to state Medicaid programs and are not available to the general public.

Medicaid Pharmacy Pricing

Medicaid uses a complex algorithm to determine the price it will pay for a specific drug at a given time. The maximum Medicaid will pay is the lesser of the average wholesale price (AWP) of the drug less 11.5 percent, the wholesale acquisition cost of the drug plus 7 percent, the Federal maximum allowable cost, the state maximum cost, or the amount billed. The pricing system edits a claim which has been billed to Medicaid, and therefore does not apply to non-Medicaid transactions. The state employee group insurance program pays at a rate of AWP less 18 percent. Many commercial insurers pay between AWP less 13 percent and AWP less 18 percent.

Forty-two state Medicaid programs pay higher ingredient prices than Florida Medicaid.

Medicaid Provider Enrollment

Section 1902 (a) (23) of the Social Security Act requires that (with the exception of programs under s. 1915 of the Act) Medicaid recipients must be allowed to receive services from any institution, agency or person qualified to perform the service who undertakes to provide the service. Implementing federal regulations at 42 CFR 431.51(b)(1)(i) and (ii) require that, absent a waiver, the state plan for Medicaid must provide that a recipient may obtain services from any provider that is qualified to furnish the services and is willing to furnish them to that recipient. 42 CFR 431.51(c) clarifies that these requirements do not prohibit the Medicaid agency from establishing fees, setting reasonable standards for providers, or restricting free choice under a waiver or, under certain conditions, for the purchase of medical devices, laboratory and x-ray services, or for the purpose of "locking-in" recipients who over utilize services of designated providers, or to "lock-out" providers who have abused the program. According to the Health Care Financing Administration, the state is allowed to determine its own provider standards, so long as such standards are reasonably related to the provider's ability to render care to recipients.

Subsection (9) of s. 409.907, F.S., requires the agency to either enroll a qualified provider, or deny a prospective provider's application if enrollment is not in the best interests of the program. The determination that enrollment is not in the best interests of the program must be based on grounds specified in subsection (10) of s. 409.907, F.S., which include:

- making false statements on the application;
- having been involuntarily excluded or terminated from participation in a Medicaid or insurance program;
- conviction of an offense related to delivery of goods or services under Medicaid or other health care or insurance program;
- conviction of offenses related to neglect or abuse of a patient;
- drug-related convictions;
- conviction of any crime punishable by imprisonment of a year or more which involves moral turpitude;
- conviction of obstructing or interfering with the investigation of any of the offenses listed in the subsection;
- violation of laws or rules governing Medicaid or any other health care or insurance program which resulted in sanctions;
- previous violations of standards related to professional licensure; and
- failure to pay a fine or overpayment by Medicaid.

III. Effect of Proposed Changes:

The bill requires the Agency for Health Care Administration to limit adult Medicaid beneficiaries not residing in nursing homes or other institutions to four brand name drugs. Children, institutionalized adults, anti-retroviral agents, and certain medications used to treat mental illnesses would remain exempt from this restriction. Unlimited generics, contraceptive supplies and drugs, and diabetic supply items remain available to all Medicaid patients. The agency is required to limit the supply of prescribed drugs to no more than 34 day supplies.

Exceptions to the brand-name drug restriction are allowed when the exceptions are based on prior consultation provided by the agency or an agency contractor. The bill requires that the agency establish procedures which ensure: a response to a request for prior authorization within 24 hours; provision of a 72 hour supply of a drug in an emergency or when the agency does not provide a response within 24 hours to a request for prior authorization; and an expedited appeal process of a decision to decline coverage for a medically necessary drug.

The bill sets a reimbursement level to pharmacies for Medicaid prescribed drugs at the average wholesale price minus 14 percent.

The bill requires the agency to develop and implement a process for managing drug therapies of Medicaid recipients who are using significant numbers of prescribed drugs each month. The management may include, but is not limited to: comprehensive, physician-directed medical record review, claims analysis, and case evaluation to determine the medical necessity and appropriateness of the treatment plan. The agency is allowed to contract with a private organization to provide these services.

The bill allows the agency to limit the size of its network of providers, based on need, competitive bidding, price negotiations, credentialling, or other criteria. The agency is required to give special consideration to rural areas in determining the size and location of pharmacies included in the network. The credentialling process may include a variety of criteria. Th agency may impose a moratorium when it has determined it has sufficient participating providers.

The bill requires that manufacturers of generic drugs prescribed to Medicaid recipients guarantee the state a rebate of at least 15.1 percent of the Medicaid payment for their generic products. In the instance that a generic manufacturer raises prices in excess of the Consumer Price Index, the amount in excess shall be included in the supplemental rebate to the state.

The agency is directed to implement the provisions of the subsection regarding generic rebates to the extent that funds are appropriated to administer the program, and is allowed to contract all or part of the program to private organizations. The agency is required to submit a report to the Governor and the Legislature by January 15 of each year on the progress made in implementing the program and the effect of the measures on Medicaid prescribed drug expenditures. Requiring physicians to use a sequentially numbered, counterfeit - proof prescription pad for their Medicaid prescriptions, will result in a substantial reduction of fraud, thereby providing a cost savings of nearly $18 million.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Subsections 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The provisions in the bill will reduce pharmacy manufacturers' revenues. Reduction of ingredient prices will reduce pharmacy revenues. In some cases, the reduction may result in reimbursements which are less than some pharmacies' costs, having a disproportionate effect on small pharmacies, potentially reducing access in areas where recipients do not have access to chain pharmacies. The counterfeit-proof prescription pad program may increase administrative burden and costs to physicians.

C. Government Sector Impact:

The Medicaid prescribed drug program reductions that were included in the conference agreement for FY 2000-2001 are as follows:

Voluntary Preferred Drug List	($25,000,000)
Monthly Limit on Recipient Drugs:	($70,000,000)
Reduction of Ingredient Prices	($24,126,993)
Drug Benefit Management	($41,000,000)
Pharmacy Network Controls	($22,585,849)
Generic Rebates	($2,996 082)
Counterfeit Prescription Pads	($18,000,000)
Total:	**($203,708,924)**

VI. Technical Deficiencies:

The bill requires the agency to develop and implement a process for managing drug therapies of Medicaid beneficiaries who are using significant numbers of prescribed drugs each month. The term “significant” is not defined in the bill.

VII. Related Issues:

The contents of this bill are substantive changes related to implementation of reductions taken in the budget proposed by the House of Representatives. Differences between the House and Senate versions of the budget will be resolved in conference committee. This bill will require amendment prior to passage to reflect the consensus budget.

VIII. Amendments:

#1 by Health, Aging and Long-Term Care:
Changes the term “prior authorization” to “prior consultation; requires the program to have a process to provide medically necessary drugs in excess of the four drug limit; deletes language in the bill giving the agency broad authority to restrict its pharmacy network and replaces it with authorization to control the size of the network only to reduce fraud; allows a pharmacist who receives a prescription not written on a counterfeit-proof form to call the doctor to verify authorization, and, if verification is not possible, to dispense a limited supply of the medication under certain circumstances; establishes a 7 member Medicaid Pharmaceutical and Therapeutics Committee, which is to develop and implement a voluntary Medicaid preferred drug list to educate practitioners; and requires the agency to establish the voluntary preferred drug list by rule, which becomes effective 60 days after it is filed with the Secretary of State, notwithstanding provisions of ch. 120, F.S..

#1 by Fiscal Policy:
Deletes language relating to persons with Alzheimer’s disease that were previously exempted from the limitation of four brand-name drugs per month; deletes language that authorized exceptions to the four brand-name drug limit for medically necessary drugs; revises reimbursement to pharmacies for Medicaid drugs to be set at the average wholesale price less 13.25 percent; deletes language that authorized the agency to establish pharmacy network controls directed at reducing fraud, such as establishing minimum initial pharmacy drug inventories; allows the agency to limit the size of its pharmacy network based on certain criteria; adds language that allows the agency to give special consideration to rural areas in determining the size and location of pharmacies to be included in the Medicaid pharmacy network; adds specific pharmacy credentialing criteria to include a pharmacy’s full-service status, location, size, patient educational programs, patient consultation and disease management services and other characteristics; adds language that allows the agency to impose moratoriums on Medicaid pharmacy enrollment based on certain criteria; deletes language that allowed a pharmacist who receives a prescription not written on a counterfeit-proof form to call the doctor to verify authorization, and, if verification is not possible, to dispense a limited supply of the medication under certain circumstances; revises language that requires manufacturers of generic drugs prescribed to Medicaid recipients to provide rebates of at least 15.1 percent of the average

manufacturer price; provides that members of the Medicaid and Pharmaceutical and Therapeutics Committee may serve more than one term; increases the number of members to the committee from seven to nine and adds one practicing podiatric physician and one trauma surgeon; revises the composition of the committee members to include one health care professional with expertise in clinical pharmacology appointed by the Governor from a list of recommendations from the Pharmaceutical Research and Manufacturers Association; and deletes the requirement that the agency establish the voluntary Medicaid preferred prescribed drug list by rule, associated changes, and 60 day requirement to file with the Secretary of State.