Subcommittee on General Government
Government Efficiency Task Force
401 Senate Office Building
May 15, 2012
8:00 a.m. – 10:00 a.m.

1) Call to Order
2) Roll Call
3) Recommendations on the Division of Real Estate
4) Discussion of Medicaid Prescription Costs
5) Public Comment
6) Adjourn

Florida Government Efficiency Task Force

Subcommittee on General Government ***Draft Recommendations***

Subject Matter: Division of Real Estate

Subcommittee Members: Pat Neal (Chair), Senator Mike Bennett, Ann Duncan, Larry Cretul, and Frances Rice

DRAFT RECOMMENDATIONS

- **State Construction:**

  The Subcommittee recommends consolidating state construction under one agency in order to create uniform practices and achieve cost savings. Currently, the Division of Real Estate and Management only manages building construction projects in DMS facilities or those projects designated as DMS managed when appropriated to agencies. Building construction staff is located in multiple agencies, there are inconsistencies in contracting, and economies of scale are not leveraged through bundling of similar projects. All agencies involved in building construction should operate through DMS, allowing for uniform standards and procedures for state construction. The state should also focus on function, in addition to form, in the design and renovation of state buildings.

- **State Leasing:**

  The Subcommittee recommends that DMS continue with current initiatives to increase the value of state leasing while reducing costs. DMS should continue its efforts to renegotiate leases statewide.[1] DMS should propose legislation that will increase its authority in leasing decisions, save time in processing, and reduce the burden on private sector landlords. DMS should continue to work with other agencies and with local governments to maximize space utilization.

- **State Building Emergency Management:**

  The Subcommittee recommends that DMS explore options for service management of state buildings and facilities in the event of a natural disaster. The state does not currently have a contracted service for management of state facilities in the case of a natural disaster (i.e. hurricanes). In order to allow for the proper functioning of state facilities, the state should address proper disaster preparedness.

[1] Since July, 2011, the state has reduced its leased footprint by more than 350,000 square feet and created more than $16 million in recurring savings.

Florida Government Efficiency Task Force

Subcommittee on General Government ***Idea Summary***

Subject Matter: PSN Prescription Drug Costs

Subcommittee Members: Pat Neal (Chair), Senator Mike Bennett, Ann Duncan, Larry Cretul, and Frances Rice

IDEA SUMMARY

Allow fee-for-service Provider Service Networks (PSNs)[1] to work with the Medicaid pharmacy benefit manager[2] to develop a Prescription Drug Listing (PDL) similar to that used by Medicaid Health Maintenance Organizations (HMOs)[3] and eliminate the requirement that all fee-for-service PSNs use the Medicaid fee-for-service PDL.

In conjunction with PDL flexibility, provide PSNs with prescriber identifying information, which will allow PSN Medicaid utilization staff to better monitor prescriptions and take action in cases of outlier prescribing patterns and suspected fraud or abuse.

Allowing PSNs to have the same flexibility as HMOs will result in savings and more efficient Medicaid drug benefits.[4]

On behalf of the fee-for-service PSNs, Magellan has developed a proposed PDL that it estimates would result in an annual savings of approximately $2 million.[5]

With access to prescriber identification, savings can be enhanced through PSNs' ability to identify outlier prescribers and take appropriate educational action or remedial/legal action in cases of suspected fraud and abuse.

In addition to the above savings, these provisions will help PSNs and their members reduce avoidable and costly ER encounters and hospitalizations resulting from inappropriate prescription drug utilization.[6]

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[1] A PSN is a managed care entity that administers Medicaid benefits through a network of providers. PSNs can either be fee-for-service or capitated.

[2] The current pharmacy benefit manager is Magellan.

[3] Each Medicaid HMO has the flexibility to develop its own plan-specific PDL.

[4] The Agency for Health Care Administration (AHCA) has required that all fee-for-service PSNs must participate in any such an arrangement.

[5] Magellan is the current Medicaid fee-for-service pharmacy benefit manager and developed this savings estimate.

[6] It is important to recognize the fact that to the extent PSNs are cost effective, the State and the PSNs both benefit. With the pharmacy benefit efficiencies described above, the State of Florida will be able to reduce Medicaid associated costs, while still providing the needed service to Medicaid recipients.

Florida Government Efficiency Task Force

Subcommittee on General Government ***Background Brief***

Subject Matter: Medicaid Managed Care

Subcommittee Members: Pat Neal (Chair), Senator Mike Bennett, Ann Duncan, Larry Cretul, and Frances Rice

ISSUE BRIEF

Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide health services coverage for eligible persons. In Florida, the program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families, the Agency for Persons with Disabilities, and the Department of Elder Affairs. Florida's Medicaid program is estimated to have 3.2 million enrolled recipients,[1] and $20.2 billion in spending, in Fiscal Year 2011-2012.[2] The projected per member cost for FY 2011-2012 is $6,382.[3]

The structure of each state's Medicaid program varies, but the portions funded by the states are largely determined by the federal government as a condition of receiving federal funds. Among other requirements, federal law sets the amount, scope, and duration of services offered in the program. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation, people and utilization, are largely predetermined for the states.

Medicaid Managed Care

Florida utilizes managed care for all Medicaid recipients. The state uses several managed care models, including Health Maintenance Organizations (HMOs), primary care case management (MediPass), provider service networks (PSNs), Minority Provider Networks (MPNs), MediPass disease management, prepaid mental health plans, and prepaid dental health plans.

The Florida Medicaid Program pays for services in three ways:

(1) Fee-for-service reimbursement based on claims from health care providers who have signed Medicaid provider agreements;

(2) Per-member, per-month payments to certain managed care organizations that bear the full risk for recipient care; and

[1] Over half the child births in Florida are paid by Medicaid. 27% of Florida children and covered by Medicaid.
[2] Information provided by the Agency for Health Care Administration (AHCA).
[3] Information provided by the AHCA.

(3) Fee-for-service reimbursement to PSNs, which must meet and share savings targets or reimburse the Medicaid program for failure to meet the target.

Medicaid uses a per-member, per-month, or capitated, payment model for HMOs, capitated PSNs, Prepaid Behavioral Health programs, and Nursing Home Diversion programs. Under capitation, contracting organizations or health plans agree to provide or accept financial liability for a broad range of Medicaid covered services. In return, the contracting organizations receive a fixed monthly payment for each individual enrolled in the organization's plan. The Florida Medicaid program has been using capitated payment systems since the early 1990s.

There are currently 1,163,410 recipients enrolled in an HMO plan and 1,054,166 recipients enrolled in fee-for-service plans. There are currently 17 HMOs and 7 PSNs (2 capitated and 5 fee-for-service).[4]

Provider Service Networks

Medicaid uses fee-for-service reimbursement for PSNs.[5] PSNs are required by contract to demonstrate savings over historic fee-for-service care.[6] Savings achieved above a set goal are shared with the PSN. Historically, the contracts have provided that failure to achieve savings goals will result in reimbursement to Medicaid of a portion of the case management payments.

One of the main cost drivers for PSNs is pharmaceutical costs. Unlike HMOs, PSNs utilize the state formulary instead of a custom formulary. The inability for the PSN to utilize a custom formulary leads to heavy use of brand prescriptions rather than generics. The PSNs also do not have the ability to track prescriber information, which can lead to the over prescription of medications, possible harmful prescription interactions, and possible fraud.

In a comparison of two managed care entities, one a PSN and the other a HMO, the PSN averaged per-member per-month drugs costs of $42.75, while the HMO averaged $22.58 per member per month.[7] The ability for a PSN to have a custom formulary and visibility into prescriber activities may reduce the overall cost to the state.

[4] Information provided by AHCA. 97,771 recipients are enrolled in capitated PSNs; 155,960 recipients are enrolled in fee-for-service PSNs; and 593,334 recipients are enrolled in Medipass.
[5] See s. 409.912(4)(d), F.S.
[6] *Id.*
[7] This is a comparison of Better Health PSN (see http://www.betterhealthflorida.com/index.html (last visited 5/14/12)) and Simply Health HMO (see http://www.simplyhealthcareplans.com/ (last visited 5/14/12)). Information on file with Government Efficiency Task Force staff.