Drug Utilization Review (DUR)

Annual Report

Prepared by
Division of Medicaid and Health Financing

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EXECUTIVE SUMMARY

The Utah Medicaid and Health Financing DUR Program Managers continue to deal with complex medical and drug issues. There have been multiple challenges this past year. The initiative to implement a preferred drug list began shortly after passage of the legislation in the 2007 session, and actual implementation began October 1, 2008. A requirement, passed in the 2009 legislative session, for Prior Authorization (PA) for non-preferred drugs was implemented on May 18, 2009. Fiscal Year 2010 (FY10) was the fourth complete year of the Medicare Part D program operation of prescription benefits to the dual eligible population. This has had an impact on all aspects of the program. 326,535 eligible clients were enrolled in the program. This figure includes approximately 23,850 dual eligible clients, and represents a total increase of 28,163 from FY09. There were approximately 302,685 non-dual eligible clients enrolled in the program.

Total paid drug claims increased $13.5 million to $154,845,911[1]. The State Phased Down Contributions (aka "Clawback") totaled $16,522,847 bringing total program expense to $174,779,958. The average cost of a prescription decreased by 0.4 percent to $63.55. The average price of a brand name drug rose 8.9 percent to $196.99. The average generic drug cost increased 4.7 percent to $24.16. The total prescription volume was 2,436,438 up from 2,213,975 the previous year. All drug products do not fall within brand or generic categories. Some drugs are considered branded generics and some brands are multi-source drugs.

Mental health drugs account for $60.2 million, or 38.9 percent of all drug expenditures. The atypical antipsychotics, the number one drug class ranked by cost, accounted for $30.7 million, or 19.9 percent of drug expenditures. Antidepressant medications account for another $8.9 million, and the anticonvulsant medications, with continued increase in mental health uses, totaled an additional $11.6 million.

Efforts to control spending are aggressively being pursued. The contract with the University of Utah College of Pharmacy's Drug Regimen Review Center (DRRC) has achieved at least $1.3 million in savings for FY10. These savings were gained simply by assisting physicians to reduce the number of prescriptions that could cause potential adverse drug reactions, and to eliminate unnecessary and/or duplicate prescriptions. The DRRC currently reviews 150 cases per month.

The DUR Board continues to be instrumental in improving both quality of care and access to medications. The DUR Board has also been instrumental in improving healthcare outcomes and is directly responsible for influencing savings through various measures that make

[1] All data presented at DUR Board meetings and in this report are referenced to gross paid claims from the data-warehouse. Final year-end dollar and unit amounts may be different due to ledger adjustments.

better use of available resources. During the 2010 General Session of the Utah Legislature, Utah Code 26-18-105 was amended. This change allowed the DUR Board to consider drug therapy costs in determining clinical utilization criteria.

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I. INTRODUCTION

The Utah Department of Health, Division of Medicaid and Health Financing's Drug Program continues to show upward trends in both cost and utilization, even while the impact of the Medicare Modernization Act has lowered expenditures. Effective January 1, 2006, Medicare clients eligible for both the Medicare and the Medicaid programs (so-called Dual Eligible or DE clients), obtain their medications through the Medicare Part-D program. As a result, FY10 is the fourth complete year without DE expenditures. Consequently due to Part-D, all aggregate totals have decreased, yet the Federal Government still requires the State to pay a portion of the costs associated with the DE clients that now receive drug benefits through the new Part-D Medicare Drug Plan. This portion has come to be known as the "Clawback."

Total drug spending totaled $154,845,911 for State Fiscal Year 2010 (FY10). "Clawback" payments for FY10 totaled $16,522,547 bringing total expenditures to $174,779,658. The total number of eligible clients increased from 298,372 to 326,535, a 9.4 percent increase. The Utah economy during FY09 and FY10 may be responsible for some of the increase in the Medicaid population. In both of these years more new members entered the program due to decreased employment opportunities. Since the number of DE clients has remained about the same, the increase is mostly attributable to the non-dual population. The number of recipients receiving prescriptions increased from 187,156 to 207,948, an 11 percent increase. In spite of the increase, spending declined from $754.88 per recipient per year (PRPY) to $744.64, a decrease of $10.24 (1.4 percent). Even with the PRPY decrease, total expenditures continue to rise for the provision of prescription drugs due to increasing numbers of individuals enrolling in Medicaid.

Medicaid paid for 2,436,438 prescriptions up from 2,213,975 in FY09, a 10 percent increase. The average cost per prescription decreased $0.26, a decrease of 0.4 percent. This decrease in per prescription cost did not out-weigh the increase in number of clients and number of total prescriptions paid. This caused an increase in FY10 expenditures of $13.5 million dollars.

The average price of a generic drug prescription increased 4.7 percent to $24.16. Average brand name prescription prices rose 8.9 percent to $196.99. The Pharmacy Practice Act mandates the use of generics in the Medicaid drug program. Overall, the number of generic prescriptions increased by 14.9 percent and each one percent shift in generic usage equates to approximately 2.5 million in savings.

II. RETURN ON INVESTMENT

Drug Rebates

Primary Rebate

Drug rebates from the manufacturers continue to be the most significant savings to the drug program. All rebates go back into the State general fund and are shared with the Federal Government. The total primary rebate collected from 1994 through 2010 Calendar Year to Date (CYTD) approaches $468 million[2]. Including the recent billings for the second quarter of calendar year 2010 (CY10), there are approximately $1.6 million in outstanding rebates[3].

J-Code Rebates

In 2005, the Division retroactively billed manufacturers back to 1997 for J-code rebates to comply with CMS directives. J-codes are Healthcare Common Procedure Coding System (HCPCS) codes used by providers in the office setting to bill for drugs administered in the physician's office. J-code rebate billings have continued forward since 2005. The total J-code rebates collected for years 1997 through CYTD10 exceed $ 9.3 million[1]. There are $425,000 in outstanding J-code rebates through the second quarter of CY10.

340B Rebates

The Division has had an arrangement with the 340B covered entities under the University of Utah Hospital System, whereby the covered pharmacies remit back to the State a rebate equivalent to the primary rebate. Since the state is not allowed to collect a rebate from drug manufacturers on drugs reimbursed at 340B prices, this system was set up to take advantage of 340B pricing and avoids duplicate savings. Primary rebates are not invoiced to the manufacturers for drugs reimbursed under this system. The total 340B rebate collected from 2005 through CYTD10 is $8.8 million[1]. There remains $758,000 in outstanding 340B rebates through the second quarter of CY10.

Supplemental rebates

The 2007 Utah legislature authorized the Division to begin using a Preferred Drug List tool in its program. Utah joined the Sovereign States Drug Consortium (SSDC) in order

[2] All dollar amounts shown include both state and federal dollars unless otherwise noted.
[3] Health Care Reform legislation created new minimums for primary rebates which affect the way rebates are shared with the Federal Government. While CMS guidance is not yet complete, the overall impact of these changes is estimated to increase Utah's sharing of rebate amounts with the federal government in excess of $6 million per year.

to negotiate with drug manufactures for Supplemental Rebates. These rebates are in addition to the primary rebate that drug manufacturers offer. After safety and efficacy are established through a Pharmacy and Therapeutics (P&T) Committee, equally safe and effective drugs in a drug class are categorized as "preferred" or "non-preferred". Manufacturers offer a supplemental rebate to leverage a favorable position in the "preferred" class in exchange for increased market share potential. The total supplemental rebate collected since implementation of the PDL in October, 2007 is $5.9 million[4]. There are $17,000 in outstanding uncollected supplemental rebates through the second quarter of CY10. Table 1 presents rebates collected from 1994 through 2010.

Table 1: Drug Rebate by Calendar Year[2,5]

Calendar Year	Primary Adjusted	J-code Adjusted	340B Rebates Adjusted	Supplemental Adjusted
1994 – 1997	$38,212,093	$121	—	—
1998	$14,406,738	$2,404	—	—
1999	$18,008,705	$5,399	—	—
2000	$21,004,520	$15,589	—	—
2001	$24,869,395	$13,775	—	—
2002	$29,236,933	$54,645	—	—
2003	$35,077,187	$127,062	—	—
2004	$44,654,500	$178,177	—	—
2005	$52,713,234	$515,412	$1,348,350	—
2006	$32,564,708	$696,112	$1,547,501	—
2007	$37,976,992	$810,416	$1,444,743	$139,753
2008	$42,415,265	$1,198,717	$1,621,478	$1,982,326
2009	$48,806,409	$3,296,357	$2,189,402	$2,536,773
2010	$29,362,276*	$2,418,358*	$1,365,000*	$1,269,613*
Totals	**$469,310,954***	**$9,332,543***	**$9,156,475***	**$5,928,465***

Prior Approval

The legislative mandate for the use of generics versus brand name drugs has been cost effective. Brand name drugs for which a generic is available require a prior approval (PA). As

[4] All dollar amounts shown include both state and federal dollars unless otherwise noted.
[5] Figures since Fiscal Year 2006 are lower due to the exodus of dual eligible clients from the program. Figures will differ from previous year due to manufacturer adjustments.

mentioned previously each additional one percent in increased generic usage means approximately $2.5 million in savings.

Prior authorizations are also used to control duplicate therapies, and inappropriate or excessive use of medications. The Omnibus Budget Reconciliation Act (OBRA) laws give states the authority to use a prior authorization with any covered medication. Often these medications are very expensive. By legislative statute and mandate, Utah limits non-generic/brand prior authorizations to clinical applications, and excludes regulating mental health drugs via PA. In FY10, there were approximately 38,700 prior authorizations issued.

An example of the effect that prior approvals can have on the drug program is exemplified by the medication Invega, a drug that treats a condition for which lower cost, safe, and effective duplicate therapies exist. Prior to the legislative mandate excluding antipsychotic medications from PA regulation, a prior approval was in place for Invega. After the prior authorization requirement was removed, monthly expenditures for Invega quickly rose from an average of $3,600 per month to over $24,000 per month. For the fourteen months the prior was in place, $285,600 was saved for this single drug.

Drug Regimen Review Center

The University Of Utah College of Pharmacy's Drug Regimen Review Center (DRRC) began reviewing high utilization of the Medicaid drug program in 2002. Based on paid drug claim history, the DRRC contacts physicians for identified Medicaid clients and performs educational "peer reviews" of these targeted clients. The goal is to reduce waste, duplication, and unnecessary or inappropriate prescription use. The program has been well received by providers and clients. As of June 30, 2010 there have been 46,251 letters sent to 12,570 prescribers with recommendations concerning 15,201 Medicaid clients. For FY10, it appears that the DRRC program achieved at least $1.4 million savings (assuming no baseline increase in drug costs) by assisting physicians to be able to reduce the number of prescriptions that could cause potential adverse drug reactions or elimination of unnecessary or duplicate prescriptions. The DRRC is contracted with the Department for $468,000 per year. Attachment 1 presents the FY10 report from the DRRC.

Co-Pay

Co-pays returned $4.4 million for FY10. Co-pays are collected on prescriptions for recipients in the Primary Care Network program and the Non-traditional Medicaid Program. No co-pays are collected in the traditional program for certain exempt categories of recipients (e.g., children under age 18, pregnant women, some nursing home residents, and family planning prescriptions). Table 2 presents total co-payments collected to date. Note that figures since FY06 are lower due to the exodus of dual eligible clients from the program.

Table 2: Co-Payments Collected

Fiscal year	Amount Returned
1998	$411,472
1999	$833,201
2000	$894,260
2001	$992,320
2002	$1,072,334
2003	$3,286,039
2004	$5,582,844
2005	$5,862,754
2006	$5,000,728
2007	$4,185,931
2008	$4,605,609
2009	$4,530,639
2010	$4,431,349
Total	**$45,689,480**

Preferred Drug List

The 2007 Legislature passed a directive authorizing the Division to implement a preferred drug list (PDL) in the Medicaid program. In order to operate a credible, responsible program, the Division created the Pharmacy and Therapeutics (P&T) Committee. The Committee consists of pharmacists and physicians familiar with issues surrounding the use of a PDL. This professional panel of experts was seated and began operation in August 2007. Implementation began with two classes of drugs – those that reduce stomach acid (the Proton Pump Inhibitors), and those that lower cholesterol (the Statins). Additional classes are added as the P&T committee deliberates classes that favor use in a PDL setting. The committee utilizes the University of Utah, College of Pharmacy to screen and summarize data for use in its monthly meeting, and draws heavily upon the work of the Oregon Health & Sciences University evidence-based medicine center for concurrent conclusions.

The charge of the P&T Committee is to evaluate the members of a drug class for equivalency in efficacy and safety. Cost is not part of their evaluation. The Committee determines whether or not the various drugs in a class are equally safe and effective, then recommends to the Division which drugs should be preferred or non-preferred based on that determination. Not all drug classes are candidates for a PDL.

The option to administer the PDL with a prior authorization tool was prohibited until May 18, 2009. Table 3 shows the combined savings results of the 12 months the PDL was growing in FY10. These figures represent a full year for 22 drug classes, and represent partial year figures for 11 additional classes.

Table 3: Preferred Drug List Savings

Description	Total Funds
Market Shift Savings	$13,72,731
Secondary Rebates	$ 3,137,863
Administrative Expenses	($193,021)
PDL Savings	**$16,647,572**

III. FINANCIAL DATA FOR DRUG PROGRAM

All data presented at DUR Board meetings and in this report are referenced to gross paid claims from the data-warehouse. Final year-end dollar and unit amounts may be different due to ledger adjustments made by the Division.

Spending per Medicaid recipient per year decreased in FY10 by $10.24, a 1.4 percent decrease. Even with a decrease in the amount spent per recipient, the increase in the number of recipients and in the cost of brand name medications still resulted in an overall increase in program costs of $13,564,879 for FY10 program expenditures. Table 4 presents a summary of the drug program.

Table 4: Drug Program Summary

	FY03	FY04	FY05	FY06	FY07	FY08	FY09	FY10
Total Eligibles	249,745	276,813	286,983	287,559	274,710	267,378	298,372	326,535
Total Rx Recipients	174,952	194,067	200,505	196,499	175,861	169,697	177,030	207,948
Total Rx Claims	2,905,334	3,288,347	3,474,297	2,983,871	2,160,456	2,098,892	2,213,975	2,436,438
Cost (Allowed Charge, (in '000s)	$159,547	$183,306	$207,580	$183,029	$136,419	$139,884	$141,281	$155,143
Percent yearly expense increase	18.60%	14.90%	13.20%	-11.80%	-25.50%	2.54%	1.00%	9.6%
Average Cost per Rx	$54.92	$55.74	$59.75	$61.34	$63.15	$66.65	$63.81	$63.55
Percent increase in cost per Rx	8.20%	1.50%	7.20%	2.70%	3.00%	5.54%	-4.25%	-0.4%
Average Rx per month per eligible	0.97	0.99	1.00	0.86	0.65	0.65	0.62	0.62
Average Rx per month per recipient	1.38	1.41	1.44	1.26	1.02	1.03	1.04	0.98
Percent change in Rx per month per recipient	-7.70%	2.00%	2.29%	-12.36%	-19.00%	1.00%	1.00%	-5.7%

Top Twelve Therapeutic Classes

Table 5 shows the top twelve therapeutic classes ranked by cost for FY09 and FY10. Therapeutic classes divide drug agents into groups that reflect their physiologic action. The newest mental health classification, atypical antipsychotics, comprised of two subgroups – H7T and H7X – remains the number one drug expenditure. The subgroup H7X consists of only one drug and accounts for $9 million in expenditures. Anticonvulsants are used extensively in the treatment of mental health disorders (e.g., bi-polar, mood, and other disorders), and in neuropathic pain treatment. They are ranked number two. Four of the top twelve drug classes are used to treat mental health disorders. Mental health drugs account for 38.9 percent of total Medicaid drug costs.

Table 5: Top 12 Therapeutic Classes by Cost and by Volume for FY10

Rank	Cost FY09	Cost FY10	% Change, FY09 to FY10	Drug Class	Rank by RX Volume FY10	Avg. Cost per Rx FY10
1	$27,018,525	$30,769,317	13.9%	Atypical Antipsychotics **H7T, H7X**	6	$359.00
2	$16,317,953	$11,590,664	–29.0	Anticonvulsants **H4B**	2	$73.08
3	$9,297,325	$9,975,826	7.3%	Narcotic Analgesics **H3A**	1	$45.78
4	$8,329,834	$6,984,168	–16.2%	Antidepressants **H2S, H7C, H7D**	3	$43.98
5	$5,548,286	$5,496,955	–0.9%	Proton Pump Inhibitors (anti-ulcer) **D4J, Z2D**	7	$63.02
6	$3,534,369	$4,109,577	16.3%	Hemophilia factor VIII **M0E**	243	$21,743.79
7	$3,446,377	$4,035,477	17.1%	Insulins **C4G**	22	$156.26
8	$2,968,006	$3,740,936	26.0%	Adrenergics (aromatic, non-catacholamine) **J5B**	47	$129.58
9	$2,752,099	$3,354,861	21.9%	Narcolepsy & ADHD **H2V**	29	$130.72
10	$1,989,175	$2,529,270	27.2%	Leukotriene receptor agonists **Z4B**	25	$115.90
11	$2,084,010	$2,490,541	19.5%	β-adrenergic & glucocorticoids **J5G**	9	$202.37
12	$2,410,539	$2,227,645	–7.6%	Lipotrophics **M4D, M4E, M4I, M4L, M4M**	12	$48.81

Brand Name vs. Generic

A generic drug is identical to a brand name drug when bio-equivalent in dosage form, safety, strength, route of administration, quality, performance, characteristics, and intended use. Although generic drugs are chemically identical to their branded counterparts, they are typically sold at discounts from the branded price. In FY10, the average cost difference between the name brand and generic prices was $172.82, an increase of $14.93 from FY09. The use of generic drugs continues to be Utah Medicaid's single most important cost saving measure.

Table 6 presents the breakout of dispensing source and also shows the brand name versus generic agent utilization for prescriptions for FY10. The use of generics increased 215,575, or 14.9 percent this year. All brand name drugs require a prior approval if there is a generic available. Brand name drugs account for 21.5 percent of claims while generics account for approximately 68.4 percent of all claims. Over-the-counter and select intravenous drugs make up the rest. Brand name drugs still account for 67 percent of total dollars spent. Savings generated from switching to generics is just over $37 million.

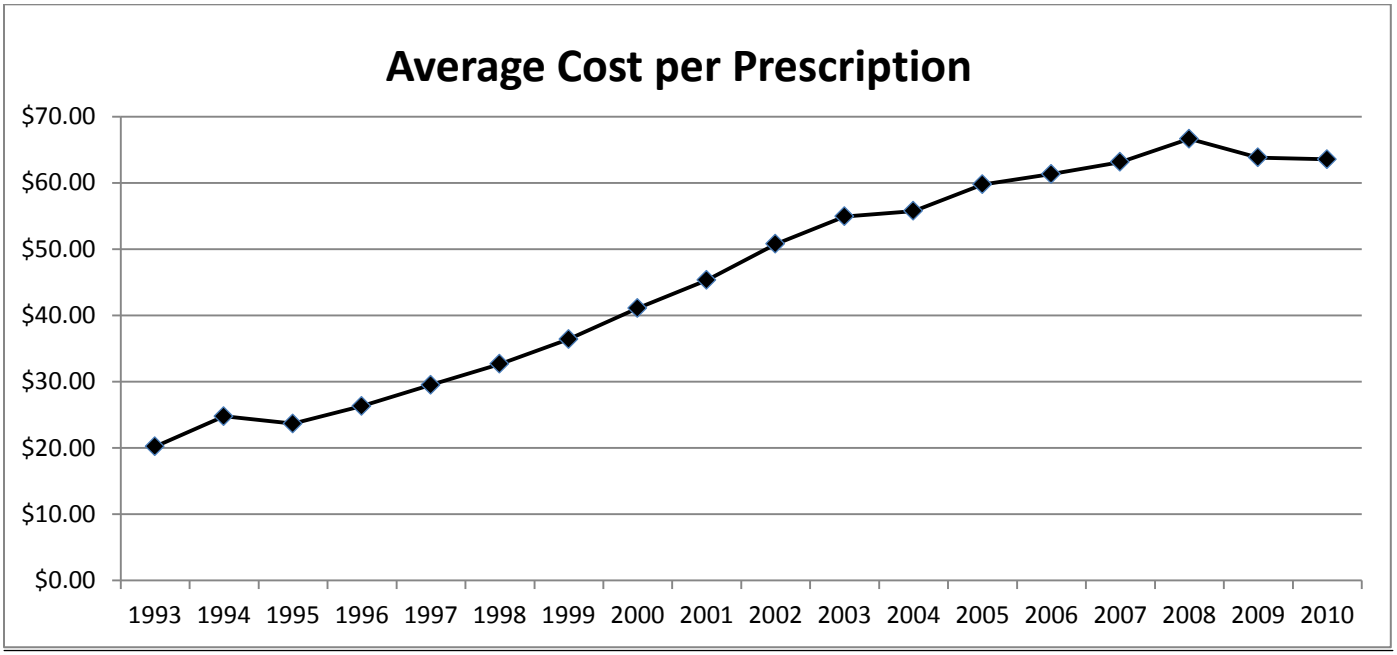
Dispensing fee indicators "F, J, K, L, M" are for select home intravenous infusion prescriptions. Dispensing fee indicator "C" is for over-the-counter products including insulin.

Table 6: Utilization by Dispensing Fee Indicator

Allowed Dispensing Source	Number of Rx (FY10)	Percent of Rx (FY10)	Total Cost (FY10)	Average Cost per Rx (FY10)	Average Cost per Rx (FY09)	Percent Change (FY10 vs. FY09)
Brand	524,711	21.54%	$103,361,903	$196.99	$180.97	8.85%
C	230,657	9.47%	$9,951,643	$43.14	$38.86	11.03%
D	9,208	0.38%	$806,959	$87.64	$59.45	47.41%
F	1,283	0.05%	$7,450	$5.81	$3.30	75.95%
Generic	1,666,711	68.41%	$40,274,784	$24.16	$23.08	4.70%
J	1,603	0.07%	$32,756	$20.43	$47.31	-56.81%
K	414	0.02%	$348,800	$842.51	$763.02	10.42%
L	1,608	0.07%	$60,595	$37.68	$28.47	32.36%
M	243	0.01%	$1,022	$4.21	$2.38	76.71%
Total	2,436,438	100.00%	$154,845,911	$63.55	$63.81	-0.40%

Figure 1 presents a graphic representation of the increase in prescription prices over the most recent 17 year period.

Figure 1: Average Cost per Prescription, 1993 through 2010



For FY10 the average price of a prescription decreased by $0.26, a 0.4 percent decrease. FY10 saw an increase in the number of eligible clients and an increased use of generic medications.

Clawback

With the Medicare Part-D prescription drug plan, the Federal government requires that the States continue to pay a portion of the costs associated with the prescriptions that are now provided through Medicare Part-D. This portion, called the "State Phased Down Contribution," is remitted on a monthly basis to the Federal Government by what has come to be known as the "Clawback" payment. This payment is calculated monthly based on FY03 eligibility data, and factored per DE clients. Table 7 presents Calendar Year totals for each month's remittance for the fiscal year. When FY10 Clawback amounts are added to FY10 Medicaid expenditures the total program costs are $175 million. Note that the "Clawback" amounts due for March, May, and June 2010 are zero. December 2009's "Clawback" is also significantly lower than the other months. This is due to the American Recovery and Reinvestment Act, which allows accumulation of credits for prior payments.

Table 7: State Phased Down Contribution - "Clawback"

Period	"Clawback" Amount
Jul-09	$2,130,548
Aug-09	$2,133,137
Sep-09	$2,365,358
Oct-09	$2,152,812
Nov-09	$1,999,802
Dec-09	$1,695
Jan-10	$2,104,623
Feb-10	$2,157,877
Mar-10	$0
Apr-10	$1,476,996
May-10	$0
Jun-10	$0
Total FY 2010	**$16,522,847**

IV. PATIENT COUNSELING

The State Board of Pharmacy, under the direction of the Division of Occupational and Professional Licensing is responsible for identifying pharmacists who do not counsel. Last year, no pharmacists were cited for failure to counsel Medicaid Clients.

V. DRUG UTILIZATION REVIEW

PRODUR

For FY10, the Prospective Drug Utilization Review (PRODUR) program returned approximately $1.4 million from reversed claims. It should be recognized that the actual dollar amount may be smaller because physicians may substitute different prescription drugs. The PRODUR Program examined 4,677,524 claims. Of that total there were 350,107 claims reversed and 138,361 adverse drug warnings posted to the pharmacy for 3 percent of submitted claims. Of those claims with warnings, 10.6 percent were reversed. There continues to be a gradual increase in warnings posted. Table 8 shows the trend in number of occurrences in the State's PRODUR over a ten-year period.

Table 8: PRODUR

Year	Total Warnings
1999	121,584
2000	134,596
2001	149,294
2002	154,441
2003	162,135
2004	196,356
2005	198,939
2006	154,636
2007	117,941
2008	127,738
2009	134,826
2010	138,361

There was a 2.6 percent increase in the number of warnings in FY10. As more complex new drugs come to market and more prescriptions are used per recipient per year, the chances for serious adverse drug events continue to increase. Therapeutic duplication continues to be a major concern. It is to the credit of both physicians' and pharmacists' responses to PRODUR that many probable adverse drug events are avoided.

In the last four years of the Medicaid prescription drug program, PRODUR and RETRODUR focused on over-utilization of mental health drugs that are often therapeutic duplications. Too frequently, two or more atypical antipsychotics are being prescribed concomitantly with other centrally acting drugs. In addition, the DRRC has focused much of its work on therapeutic duplications.

RETRODUR

As discussed previously, the Drug Regimen Review Center is a retrospective drug utilization review (RETRODUR) based program.

The DUR Board is a group of volunteers, nominated by their respective professional organizations, whose charge it is to monitor the Medicaid Drug Program and look for opportunities to eliminate waste, adverse drug reactions, drug over-utilization, and fraud. The Board consists of physicians, pharmacists, a dentist, a community advocate, and a representative from the Pharmaceutical Research and Manufacturers Association (PhRMA). The DUR Board is

mandated by both state and federal law. The Board meets monthly and meetings are open to the public. Each month the DUR Board reviews several petitions from physicians seeking drug coverage outside policy and/or criteria guidelines. This past year the DUR Board approved 21 of 28, or 75 percent of these petitions, and denied or suspended 7. Frequently the Board requests additional information from the petitioner. When evaluating petitions, board members review the client's drug utilization history for twelve months. Clients are not identified by name, ID number, or any other information, so confidentiality is maintained. All petitions that are rejected are provided with the option to appeal by requesting a formal hearing. To date, only one DUR Board decision has been overturned by a hearing.

During FY10, the DUR Board considered prior authorization (PA) recommendations for 15 drugs, and placed a PA on 9 of those drugs. All of these restrictions were placed in order to assure more appropriate utilization of the medications involved.

The DUR Board spent significant time reviewing PA criteria and other limits from previous Board actions. Twenty-three categories were reviewed. Modifications were made to the PA criteria of 11 of those categories. Criteria changes included expanding or restricting coverage, imposing maximum daily doses or quantity limits, consideration of new FDA-approved indications, and requirement of ongoing patient monitoring (e.g., lab values). Savings from DUR actions continue to be significant.

VI. DRUG UTILIZATION PROGRAM REPORTING MODIFICATIONS

New practices will be implemented in order to make better use of the Division's limited resources. The State DUR Report will be re-formatted over the next year to match the Federal DUR Report. As part of this re-formatting, the reporting period will change from July 1st through June 30th, to October 1st through September 30th. The State DUR report released in the summer of 2011 will include data covering federal fiscal year 2010 which covers October 2009 through September 2010. Because of the change, the FY11 report will include 9 months of data already presented in this report. Each year's report will be submitted soon after submission of the Federal report (i.e., late summer).

VII. CONCLUSION

The Medicaid Drug program avoided or returned more than $61 million to the Department when drug rebates, co-pays, preferred drug list, generic substitution, PRODUR reversals, and the College of Pharmacy's DRRC activities are taken into account. In spite of this, increases in prescriptions per recipient and rising drug costs continue to offset overall savings. The brand-name prior approval initiative maintains the largest lowering effect on

expenditures. Various tools are used to affect savings to the Medicaid Drug Program, while at the same time providing one of the most robust and generous drug benefits in the nation.

A preferred drug list was implemented in FY08. Other initiatives that are not part of Drug Utilization Review such as the Hemophilia program and 340B pricing are not reported here. Both programs currently operate within the Medicaid program and are growing.

The DUR Board continues to play an active role in the Medicaid Drug Program, and the Division is fortunate to have DUR Board members with high community standing and acknowledged expertise in their fields. The Division also benefits from in-house control of the entire drug program.

Attachment 1 – Drug Regimen Review Center Annual Report