REPORT TO THE LEGISLATURE
Pursuant to P.A. 63 of 2011
Section 813
Drug Utilization Patterns and Cost Cutting Strategies Report

Sec. 813. The department shall monitor and document drug utilization by department for prisoner health care services. As part of this effort, the department shall examine drug utilization patterns and cost-cutting strategies used by corrections systems in other states. By March 1, 2012, the department shall provide a report to the legislature detailing the department's drug utilizations and drug utilization statistics for corrections systems in other states.

Background Information

The data from ten different correctional settings is presented in three sets. The first set is from other states that are also served by the current Michigan Department of Corrections (MDOC) pharmacy vendor, Maxor Correctional Pharmacy Services. The second set of data includes two states, and data are based on the total annual dollars spent on related medications. The last set of data are from four additional states, and were extrapolated from six months of data collection to provide a per prisoner per year cost for the various medications. The reason for the different formats and tables is because each State reports their pharmacy medications and information differently. The states that report similar information using the same format were grouped together. This data and report of cost containment strategies was provided by the current pharmacy vendor, and Health Management Associates (HMA) who is functioning as the Third Party Review contractor for MDOC – Health Care.

State Level Data

First Data Set-Four States Provided by Previous and Current Pharmacy Vendor

The information below describes the per prisoner per month (PMPM) cost for the major categories of: (1) General Medicine, (2) HIV, and (3) Psychotropic. The Michigan data presented is an average PMPM cost for calendar year 2011, and was provided by the previous pharmacy vendor PharmaCorr whose contract ended December 31, 2011. The three additional regions presented are all served by the current pharmacy vendor Maxor whose contract began January 1, 2012.

Jurisdiction	General Medicine	HIV	Psychotropic	Total
Michigan	$18	$10	$9	$37
Northeastern State 1	$31	$32	$12	$75
Eastern State 2*	$37	NA	$4	$41
Western State 3	$31	$3	$2	$36

**State receives 340b pricing for HIV medications*

Second Data Set- Two States Provided by Current Pharmacy Vendor

The second table provides data on total drug cost for HIV, Psychotropic, Hepatitis and all other medications. It is not broken down by a per prisoner cost, but rather provides the overall total of the medications.

State	Hepatitis	HIV	Psychotropic	All Other	Total
Texas	$3,130,646	$18,692,137	$1,859,978	$16,271,271	$39,954,032
California	$2,809,876	$8,809,097	$12,849,114	$18,351,068	$42,819,155

Third Data Set- Four States Provided by Third Party Reviewer

The table below contains information from four different states based on a per prisoner per year cost. The four States had data that included cost related to Hepatitis, HIV, Psychotropic and all other medications, and six months of data were extrapolated to estimate a full year of experience.

State	Hepatitis	HIV	Psychotropic	All Other	Total
Connecticut	$2	$203	$96	$288	$589
Massachusetts	$57	$436	$140	$372	$1,005
Nevada	$3	$92	$73	$152	$320
Oregon	$64	$95	$224	$377	$760

Cost Containment Strategies

Provided Through Research by Maxor and Third Party Reviewer (HMA)

Through an extensive literature review and internet search of pharmacy practices cost containment strategies were found from a variety of states.

Formulary Management: Formulary management includes more than just creating a list of drugs and creating a formulary. Formulary medication decisions should be clinically based and supported by evidence relating to efficacy, safety and cost. The formulary education, implementation, evaluation, and ongoing management of the formulary are also important. Effective pharmacy utilization management is dynamic and changes with every new drug approval. To remain effective, formularies must be constantly evaluated and updated based on the changing patient population needs, the ever-changing availability of drugs, the most current research and evolving pharmacoeconomics.

The determination on whether or not to include a drug on the formulary takes into account regional standards of care, characteristics of the patient population being served, disease management evaluations, and the availability of other drugs already on the formulary. Every analysis includes an evaluation of a medication's safety, efficacy, and cost. When used in conjunction with well considered disease management guidelines, an active formulary can help provide a quality standard of care for the patients while effectively managing drug costs.

Disease Medication Management Guidelines: Evidence-based disease management guidelines provide clinical pathways for cost-effective treatment of common disease states. Such guidelines are especially effective for management of chronic diseases and typically include recommended medication therapies. Development of such guidelines typically includes a review of the medical literature, review of national treatment guidelines, and evaluation of population-specific treatment data. The goal is to develop tools that assist healthcare providers in making treatment decisions that result in improved outcomes and consistent, cost-effective care. The guidelines often include patient education information to assist providers in engaging patients in their care. Guidelines are typically reviewed and updated every three years or when new national treatment guidelines, landmark clinical studies, and/or new drug therapies become available.

Use of Generics: Most jurisdictions require the automatic use of generic medications when available unless the medical provider specifically requires the brand drug to be dispensed. An effective Pharmacy and Therapeutics (P&T) Committee process includes the monitoring of medications so that planning for immediate conversions to generic medications can occur as soon as possible. The introduction of a new medication or conversion from a branded to a generic medication may or may not translate into immediate cost savings unless a proactive conversion program is established.

Non-Formulary Approval Processes/Prior Authorizations: Implementation of a formulary system is one of the most critical components to controlling cost. However, even the most robust programs must work to improve and maintain formulary compliance. It is critical to identify non-formulary medications at the point of order entry and alert the prescriber so a formulary alternative can be considered. If a non-formulary medication is desired, then a prescribed review and approval process should be followed to ensure the non-formulary medication is required. Typically this review requires the approval of a supervising medical provider and/or a clinical pharmacist.

Disease Management Evaluation (DME): Effective P&T Committees often use a disease management evaluation program to evaluate the effectiveness of current and proposed medications. DMEs are used to assess the performance of a medication or therapeutic category, disease state or condition, medication use process or specific outcome. The goals of the DME process are to promote optimal drug use, evaluate the effectiveness of drug therapy, identify drug-related problems, identify areas where further education of providers and/or patients is needed, and to assess drug control systems, criteria and protocols. DMEs help to ensure the selected medications are producing the desired outcomes.

340B Drug Pricing Programs: The Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA) administers the 340B Drug Pricing Program which allows qualifying safety net providers to purchase pharmaceuticals at a significantly reduced price. The purpose of the Program is to improve access to medication for needy populations and help safety net providers stretch limited financial resources. 340B Programs generate savings through an upfront discount on prescription drugs that is equal to or less than the average manufacturers price (AMP) minus the federal Medicaid rebate. A few state correctional systems have implemented 340B drug pricing to reduce pharmaceutical costs. The majority of these programs use 340B pricing for inmates with HIV/AIDS and/or Hepatitis C.

In Michigan, many of the cost containment strategies discussed are already being employed. MDOC has a formulary management in process. This includes regular monthly meetings to discuss the formulary, which includes regular evaluation on its efficacy, safety and cost. Michigan requires automatic use of generics and the average fill rate is 85% generic and 15% brand name. There is a non-formulary approval process in place that requires authorization from MDOC leadership. Additionally, there is a P&T Committee that meets and discusses the use of medications including an evaluation of drug effectiveness. Michigan employed a third party to conduct a Feasibility Study related to 340B pricing for Corrections, and found there was inconclusive evidence from other state government entities that the savings achieved for *inmate* healthcare was directly correlated to the use of a 340B pricing arrangement versus other utilization and clinical management protocols.

MDOC also has implemented several other cost containment strategies:

- Selected a new pharmacy vendor through a competitive bidding process to save money in procurement costs;
- Monitoring the psychotropic costs, and through new policies those costs are decreasing;
- Improving the waste management process, which includes the development of a new operating procedure, and facility pharmacy audits; and
- Upgrading pharmacy software with bar code scanning to increase efficiency and accuracy. This also assists the provider in monitoring drug compliance and gives greater control over dispensing prescriptions and eliminating waste.