



# **Medicaid Prescribed Drug Program Spending Control Initiatives**

**For the Quarter  
April 1, 2014 through  
June 30, 2014**

*Report to the Florida Legislature  
January 2015*



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## **Purpose of Report**

Per section 409.912(37)(c), Florida Statutes, 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 Medicaid prescribed drug expenditures. This report includes data for the fourth quarter of state fiscal year 2013-2014, from April 1, 2014 through June 30, 2014 as well as fiscal year totals.

## Executive Summary

Requirements of section 409.912(37)(a), F.S., relating to cost-effective purchasing of health care and the prescribed drug spending control program have been fully implemented. Generic utilization was 75.9 percent in the final quarter of state fiscal year 2013-2014, and was 75.4 percent of all Fee-for-Service prescription claims for the entire 2013-2014 fiscal year. During the fourth quarter of state fiscal year 2013-2014, approximately 22 percent of Medicaid recipients utilized the pharmacy benefit in a given month and about 25 percent used the benefit during the fiscal year. During the fourth quarter of state fiscal year 2013-2014, Average Retail Price per prescription was \$99.43 which was 16.7 percent higher than the annual estimate for retail price. The average caseload during the fourth quarter of state fiscal year 2013-2014 was trending 3.9 percent lower than the appropriation estimate for the fiscal year. The average number of claims per month during the final quarter of the fiscal year was 24.8 percent below the annual estimate. While the Average Retail Price per prescription of \$93.30 for all of state fiscal year 2013-2014 was 9.5 percent above estimates, the average monthly caseload for the year was very close to estimates made by the Social Services Estimating Conference (up 0.5 percent), the average number of prescription claims in a month was 15.9 percent below the fiscal year estimates, and the total cost for the program for the fiscal year was 7.9 percent lower than estimated for all of state fiscal year 2013-2014.

Note that the Managed Medical Assistance (MMA) portion of the Statewide Medicaid Managed Care (SMMC) program began rollout in May 2014. As the majority of Medicaid recipients move into a managed care plan, responsibility for their pharmacy claims moves to the plans as well. This means a significant number of pharmacy claims will no longer be reflected in this report and a large drop in caseload and expenditures has already been seen in the final two months of this report quarter. This drop affected many of the quarterly and yearly totals that are reported here. A more detailed discussion of the transition to SMMC, as well as the first look at costs and utilization in the post MMA rollout, fee-for-service environment will be included in next quarter's report. Note that MMA rollout was not taken into account when the appropriations estimates were generated by the Estimating Conference during 2012 or 2013. Now that it has been implemented, estimates will include MMA for future caseloads and expenditures.

The number of individuals who were eligible for the Medicaid fee-for-service drug program as of June 30, 2014 was 1,785,692, which represents a drop of 16.1 percent over the average number of eligible individuals prior to May 2014 when the MMA rollout began. The number of recipients managed by Magellan, the FFS pharmacy benefits manager, was down 25.1 percent as of June 30, 2014 compared to the average for state fiscal year 2013-2014 prior to May 2014. During the fourth quarter of state fiscal year 2013-2014, the program reimbursed a total of 3,342,795 pharmacy claims at a total of \$332,374,247. The price of brand drugs increased from an average of \$368.85 per brand claim in July 2013 to an average of \$459.89 in June 2014. The average number of brand claims per user was 0.63 for the fourth quarter and 0.66 per user for the fiscal year. The average Net Net Paid per User was up to \$155.14 in June 2014 from \$146.09 at the start of the fiscal year in July 2013. While brand claims accounted for only 20 percent of all claims (i.e., the total number of prescriptions), they accounted for 81 percent of the total cost.

Specific spending control measures include:

- 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 Preferred Drug List (PDL). The Committee performs ongoing scheduled review of the PDL, with negotiated state supplemental rebates from manufacturers and continued updating of 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. Also, Medicaid pharmacists throughout the state continue to review prior authorization requests for non-PDL approved drugs. They may make initial contact with patients who choose to receive comprehensive reviews of their drug therapies. Initiatives are in place to support the use of the Medicaid PDL.
- 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 the 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 Medicaid program including reducing the rate of inappropriate spending on Medicaid prescription drugs.

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

- Prescription Benefit Manager – The contracted prescription benefit manager vendor, Magellan Medicaid Administration (Magellan), processed an average of over 1.3 million drug claims per month for the Medicaid fee-for-service pharmacy program through April 2014. The system of automated claim edits is continuously refined and improved to support safe prescribing, adherence to the Preferred Drug List, and prevention of fraud and abuse. As of June 2014, the total number of claims was down to 790,142 due to the implementation of MMA.

Additional information related to Medicaid Pharmacy Services is available online at:  
<http://ahca.myflorida.com/medicaid/pharmacy.shtml>

## Statewide Medicaid Managed Care

The Managed Medical Assistance (MMA) portion of the Statewide Medicaid Managed Care (SMMC) program began rollout during the final quarter of State Fiscal Year 2013-2014 (in May 2014). As the majority of Medicaid recipients moved into a managed care plan, responsibility for their pharmacy claims moved to the plans as well. This means a significant number of pharmacy claims will no longer be reflected in this report. The large drop in expenditures is clear in Figure 1 below which shows a drop of 38 percent in total expenditures in June 2014 over the last month of the previous quarter. The type and number of pharmacy claims remaining in the fee-for-service population may change significantly which could affect the average prescription costs, costs per recipient, and the average number of prescriptions per recipient per month. A more detailed discussion of the transition to SMMC, as well as the first look at costs and utilization in the new fee-for-service environment will be included in next quarter's report.

### Pharmacy Appropriations and Spending for Quarter Four (April through June) of State Fiscal Year 2013-2014

Table 1 shows the state fiscal year (SFY) 2013-14 appropriations for Fee-for-Service (FFS) pharmacy services along with the appropriations from the previous state fiscal year.

**Table 1 – FFS Pharmacy Services Appropriations SFY2012-2013 and SFY2013-2014**

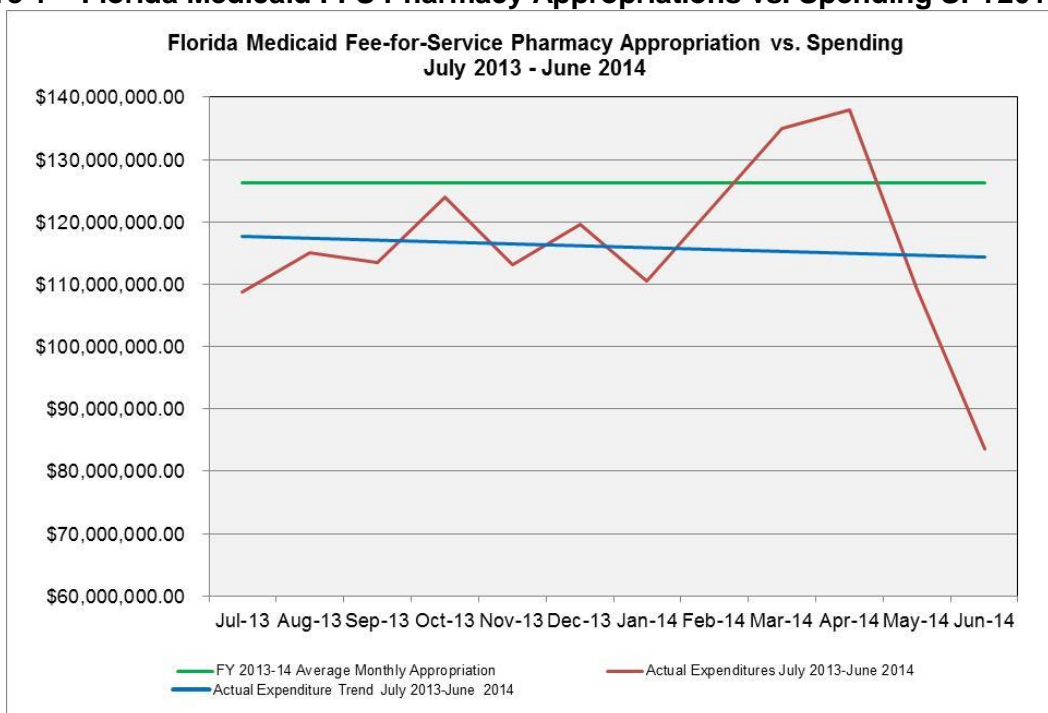
Prescribed Medicine	FY 2012-2013 Appropriation	FY 2013-2014 Appropriation
Medicaid Caseload	1,410,063	1,431,982
Medicaid Prescriptions Per Month	1,491,626	1,482,342
Medicaid Unit Cost	\$83.29	\$85.18
Medicaid Total Cost	\$1,490,904,741	\$1,515,220,381

*Source: Social Services Estimating Conference, General Appropriations Act Estimates, 2012 and 2013*

Overall it was anticipated that Medicaid Pharmacy caseload and total costs would rise 1.6 percent during state fiscal year 2013-2014 over the previous year's appropriations. The average price per prescription was expected to increase 2.3 percent while the average number of prescriptions per month was expected to decline slightly. Figure 1 shows the actual fee-for-service pharmacy expenditures for state fiscal year 2013-2014 compared to appropriations.

During state fiscal year 2013-2014, the total cost for the program was 7.9 percent lower than the Social Services Estimating conference estimate used for the General Appropriations Act. While the average cost per prescription was higher than estimated, both the average caseload and total number of the prescriptions were lower than estimated, which meant that overall costs were lower than predicted. The average retail price of \$99.43 per prescription during the fourth quarter was 16.5 percent higher than the annual estimate for retail price per prescription. For the year, the average retail price per prescription of \$93.30 was 9.5 percent higher than the annual estimate. The Average Caseload of 1,438,493 (in terms of Member Months) for state fiscal year 2013-2014 was 0.5 percent higher than estimates; and the utilization rate as measured by the total number of prescriptions was 15.9 percent lower than estimated. MMA rollout in the final part of the quarter had a significant impact on prescriptions reported during the quarter.

**Figure 1 – Florida Medicaid FFS Pharmacy Appropriations vs. Spending SFY2013-2014**



Source: Trends are calculated from the Social Services Estimating Conference estimates used for the 2013 GAA. Actual expenditures are reported in the Florida Pharmacy Report Card, Magellan Health Services, Inc., August 2014

## Claim Details

### Brand and Generic Drug Costs and Utilization

A generic utilization rate of over 75 percent (see Table 2; Figure 2), extensive application of manufacturer rebates and ongoing, detailed review of the Preferred Drug List to consider removal of products when lower-cost, equally effective alternatives are available, all helped maintain efficiency in the Medicaid prescribed drug program. Table 2 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.

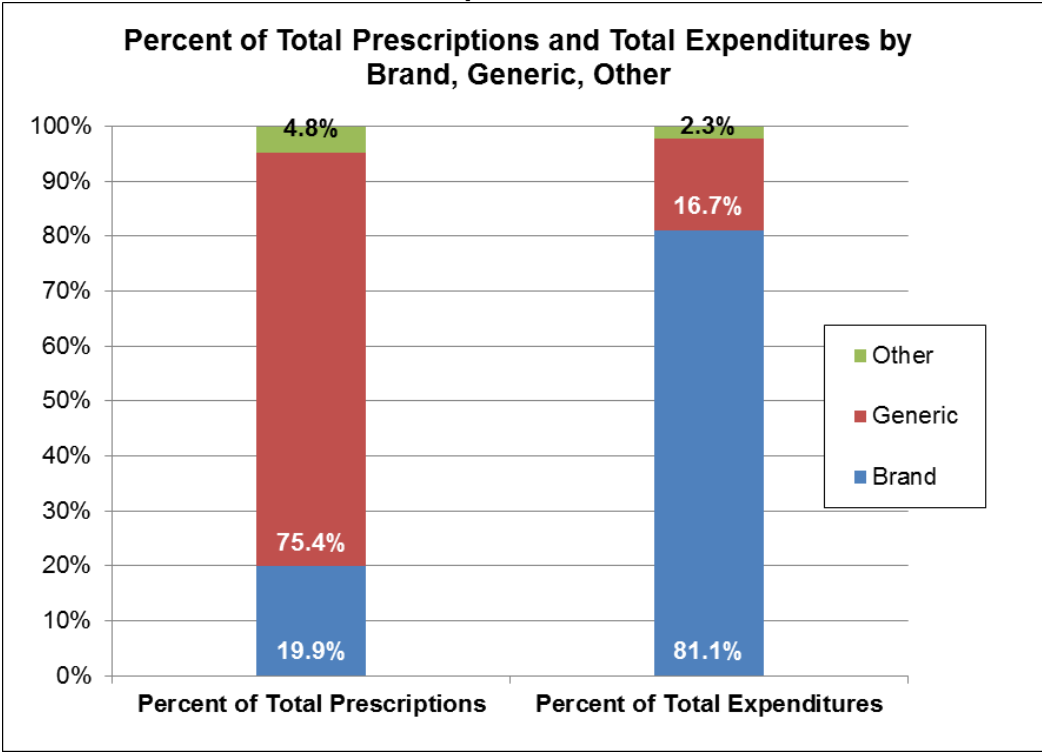
**Table 2 – Utilization and Payments by Prescription Drug Type, Medicaid FFS Pharmacy Fourth Quarter SFY2013-2014 and Fiscal Year Total**

Metric	Apr-14	May-14	Jun-14	Q4 SFY13-14	SFY Total
Generic Utilization	76.0%	76.0%	75.9%	75.9%	75.4%
Brand Paid/Claim	\$410.37	\$420.50	\$459.89	\$425.54	\$380.86
Generic Paid/Claim	\$21.44	\$21.50	\$21.78	\$21.54	\$20.64
Non-Drug/Comp Pd/Claim	\$35.14	\$24.11	\$25.78	\$29.20	\$44.02
Brand Claims	274,174	214,645	152,561	641,380	2,972,192
Generic Claims	1,085,687	850,661	602,347	2,538,695	11,276,978
Non-Drug Claims	1,612	1,184	674	3,470	16,134
Compound Claims	67,608	53,294	38,348	159,250	697,969
Brand Paid	\$112,513,319	\$90,257,368	\$70,161,455	\$272,932,141	\$1,131,980,650
Generic Paid	\$23,278,753	\$18,289,948	\$13,121,359	\$54,690,060	\$232,714,837
Non-Drug Paid	\$79,711	\$58,083	\$34,233	\$172,027	\$806,332
Compound Paid	\$2,352,921	\$1,255,503	\$971,595	\$4,580,019	\$30,627,578

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

During the fourth quarter of state fiscal year 2013-2014, 19.2 percent of claims reimbursed were for brand drug products, while these prescriptions accounted for 82.1 percent of total expenditures. For the fiscal year, 19.9 percent of the total prescriptions have been for brand name drugs which has accounted for 81.1 percent of the total expenditures (Figure 2). Revenue realized by the state through negotiation of drug manufacturer rebates offsets a significant percentage of the retail cost of drugs in the fee-for-service pharmacy benefit. The average paid per claim for a brand name prescription during the fourth quarter was \$425.54; and the average paid per claim for a generic prescription was \$21.54. For all of SFY 2013-2014, the average paid per claim was \$380.86 for brand name prescriptions and \$20.64 for generic.

**Figure 2 – Florida Medicaid FFS Pharmacy Brand Name versus Generic Utilization and Expenditures, SFY2013-2014**



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

**Prescription Spending Trends**

***Fee-for-Service Caseload and Retail Prescription Costs***

The top row of figures in the table below 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. Additional metrics record the retail reimbursement Per Member Per Month (PMPM) and Per User Per Month (PUPM). During the fourth quarter of state fiscal year 2013-2014, 22 percent of enrollees used the prescription drug benefit in any given month.



**Table 3 – Paid, Net Paid, and Net Net Paid Per Claim, Medicaid FFS Pharmacy Fourth Quarter SFY2013-2014 and Fiscal Year Total**

Metric	Apr-14	May-14	Jun-14	Q4 FY13-14	SFY Total
Paid/Claim	\$96.72	\$98.11	\$106.17	\$99.43	\$93.30
Net Paid/Claim	\$46.81	\$47.48	\$51.38	\$48.12	\$46.33
Net Net Paid/Claim	\$43.91	\$44.53	\$48.19	\$45.13	\$43.14
Paid PUPM	\$320.58	\$320.94	\$341.77	\$326.82	\$312.43
Net Paid PUPM	\$155.16	\$155.34	\$165.42	\$158.18	\$155.13
Net Net Paid PUPM	\$145.52	\$145.69	\$155.14	\$148.36	\$144.46
Paid PMPM	\$84.53	\$79.54	\$75.91	\$71.43	\$78.42
Net Paid PMPM	\$40.91	\$38.50	\$36.74	\$34.57	\$38.94
Net Net Paid PMPM	\$38.37	\$36.10	\$34.46	\$32.42	\$36.26
Claims/User	3.3	3.3	3.2	3.3	3.3

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

The number of individuals who were eligible for the Medicaid fee-for-service drug program as of June 30, 2014 was 1,785,692 of which 1,110,357 were managed by the Magellan, the Medicaid FFS pharmacy benefits manager. During the fourth quarter of state fiscal year 2013-2014, the program reimbursed a total of 3,342,795 pharmacy claims at a total of \$330,542,465. The price of brand drugs increased from an average of \$368.83 per brand claim in July 2013 to an average of \$459.89 in June 2014. The average number of brand claims per user was 0.66 per user for the fiscal year. The average Net Net Paid per User was up to \$155.14 in June 2014 from \$146.09 at the start of the fiscal year in July 2013. The following table details some basic program monthly benchmarks and overall trends for the program for the final quarter as well as the totals for state fiscal year 2013-2014.

**Table 4 – Caseload, Users, Claims, and Retail Prescription Costs, Medicaid FFS Pharmacy Fourth Quarter SFY2013-2014 and Fiscal Year Totals**

Metric	Apr-14	May-14	Jun-14	Q4 SFY13-14*	FY Totals*
Member-Months	1,650,788	1,381,259	1,621,143	1,375,639	1,438,493
Users	430,392	341,084	245,504	340,032	372,979
Claims	1,426,442	1,114,411	790,142	1,114,265	1,246,939
Paid	\$137,913,688	\$109,092,187	\$83,536,590	\$330,542,465	\$1,396,129,396

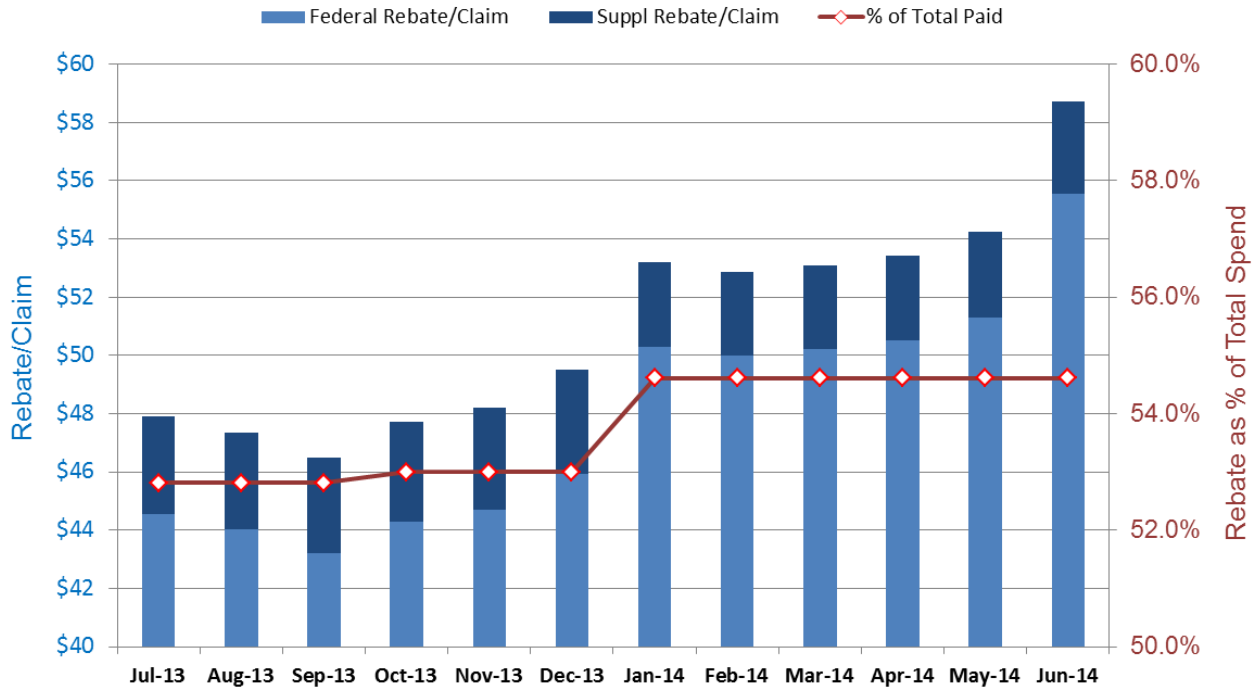
\* For Q4 SFY 2013-2014 and FY to Date, Member-Months, Users, and Claims are Average per Month, while Paid is Total Paid

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. 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 Preferred Drug List. Figure 3 illustrates the amount of the average federally required and supplemental rebates received per prescription and 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.

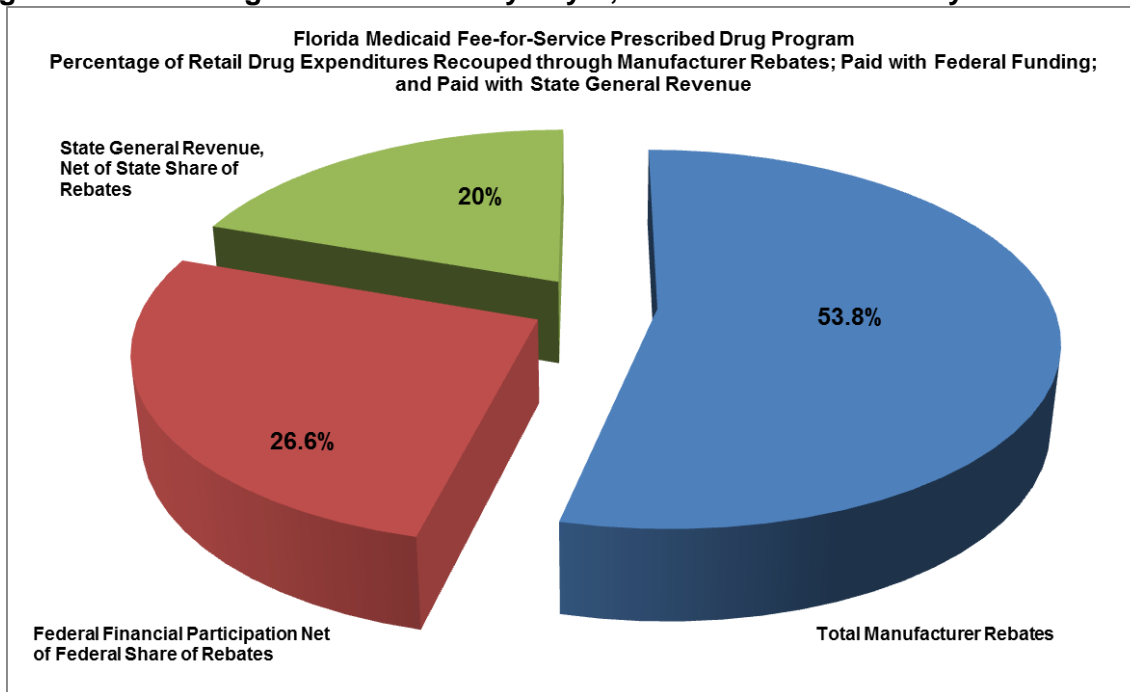
**Figure 3 – Rebates Per Claim, Medicaid FFS Pharmacy SFY 2013-2014**



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

State general revenue accounts for only 20 percent of the total retail cost of the fee-for-service drug program. The chart below illustrates the percentage of state general revenue dollars required for the state to offer the Medicaid drug benefit in the fee-for-service program after federal matching funds and manufacturer rebate revenue are received.

**Figure 4 – Percentage of Final Costs by Payer, Medicaid FFS Pharmacy SFY 2013-2014**



# Medicaid Fee-for-Service Prescribed Drug Program Ongoing Cost Controls

## Cost-Effective Medicaid Preferred Drug List (PDL)

The Florida Medicaid Preferred Drug List continues to produce significant savings of pharmacy costs since its implementation as a mandatory 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).

## Preferred Drug List Adherence – PDL Products Share of Florida Medicaid Market

Through aggressively negotiating supplemental rebates and favorable net pricing, the Florida Medicaid prescribed drug program is able to maintain an array of choices for prescribers within each therapeutic class on the Preferred Drug List. According to Magellan PDL Compliance Report (August 2014), during the final quarter of state fiscal year 2013-2014, PDL products represented 94.2 (percent of prescriptions reimbursed by Florida Medicaid for fee-for-service recipients and 83.3 percent of the total amount reimbursed. Approval for reimbursement of prescriptions for products not on the PDL may be obtained through prior authorization.

## Rebate Collection Productivity

The rebate collection contractor performs follow-up on all unpaid or disputed invoices and as of June 30, 2014, had achieved an overall collection percentage of 98 percent of invoiced rebates from manufacturers in the fee-for-service pharmacy program. Nonpaying manufacturers are reported to the federal Centers for Medicare and Medicaid Services. The contractor continues to refer providers who cannot or will not reverse billing errors and rebill correctly to the Agency for Health Care Administration’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 requests is immediate through automatic claim system edits or by the Medicaid fiscal agent’s Pharmacy Benefits Manager (Magellan Medication Administration). Magellan runs a Therapeutic Call Center which is a 24-hour toll-free request line staffed by pharmacists at all times. Approval of some specific medications requires clinical review by a 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 state fiscal year 2013-14, Florida received a total of 107,370 prior authorization requests, an average of more than 294 per day, and 8,948 per month.

The following chart details metrics related to prior authorization requests received during the final quarter of state fiscal year 2013-2014 as well as the fiscal year totals.

**Table 5 - Pharmacy Prior Authorization Requests, Medicaid FFS  
Fourth Quarter SFY2013-2014 and Fiscal Year-Totals**

Metric	Apr-14	May-14	Jun-14	Q4 SFY13-14	FY Totals
Total PA Requests	10,100	6,022	7,198	23,320	107,370
Average Per Day	336.7	194.3	239.9	256.3	294.2
Total PA Requests Approved	8,474	5,231	6,109	19,814	90,850
% PA Requests Approved	83.90%	86.86%	84.87%	84.97%	84.61%

Source: Magellan Medicaid Administration, October 2014

# 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 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 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 the following:

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

## ***Recipient Pharmacy Lock-in Program***

In October 2002, the Agency implemented a recipient lock-in program. This program improves coordination of medical care and prevents potential fraud by ensuring that at least one medical professional, the pharmacist, is aware of all the medications the recipient is receiving. Recipients who have been identified as high users and potential abusers of prescribed drugs, or who obtain prescriptions from multiple physicians, are enrolled into the lock-in program and must obtain all of their medications from a single pharmacy. The majority of recipients originally enrolled in the program now receive their prescription drug benefits through Medicare. Further, highly efficient claim system enhancements now monitor the patient's full drug profile and systematically control for overutilization and potential abuse so that the number of lock-in patients who required manual monitoring can be kept to a minimum. Due to limitations set by the Agency on controlled substances (based on number of prescriptions and their diagnoses) and the drug database for controlled substances (eForce) available to prescribers and pharmacies, the number of recipients enrolled in the lock-in program has decreased significantly. As of September 30, 2013 there were no longer any active participants in the lock-in program.

## MEDS-AD Waiver

The Florida Medicaid Medications for Aged and Disabled (MEDS-AD) demonstration waiver provides 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 limited to those aged and disabled persons who are either receiving or eligible to receive institutional care, hospice or home and community-based services coverage, or who are not eligible for Medicare. The current MEDS-AD Waiver program 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; and
- High-Intensity Pharmacy Case Management services for non-institutionalized individuals.

The continued coverage, as well as the High-Intensity Pharmacy Case Management program, is designed to avoid costs of preventable hospitalizations or institutional placement that would otherwise occur in the next five years had these vulnerable individuals been denied access to prescribed drugs and other medical services. The focus of the demonstration is to provide high-intensity pharmacy case management for enrollees who are not yet receiving institutional care.

The table below contains monthly MEDS-AD enrollment counts for the state fiscal year 2013-2014.

**Table 6: 1115 MEDS-AD Waiver Total Enrollment by Month, July 2013 – June 2014**

Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
38,364	37,668	36,969	36,544	35,894	34,336	35,093	35,241	35,028	37,893	37,817	37,056

*Source: Medicaid Data Analytics, August 2014*

Expenditures reimbursed for recipients who were eligible for Medicaid through the MEDS-AD demonstration program totaled \$78,648,234.95 for the period April through June 2014. A total of \$559,677,062 was expended for state fiscal year 2013-2014. Annual and cumulative expenditures remain well below the budget neutrality ceiling approved by federal CMS for the waiver.

## Report Conclusion

This concludes the report of Medicaid Prescribed Drug Program Spending Control Initiatives for the fourth quarter of state fiscal year 2013-14.