



STATE OF UTAH
DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING
DRUG UTILIZATION REVIEW (DUR)
ANNUAL REPORT
YEAR 2006

EXECUTIVE SUMMARY

The Utah Health Care 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 was tabled last year. Implementation of the Medicare Part-D Prescription Drug Plan began in mid-year, and has had an impact on all aspects of the program. As a result, only 576 additional eligibles were enrolled on the books for a total of 287,559 total eligible clients. Total paid drug claims decreased \$24.5 million to \$183,028,972. The new State Phased Down Contributions (aka "Clawback") totaled \$ 10,047,251.95. The average cost of a prescription rose 2.7% to \$61.34. The average price of a brand name drug rose 11.9% to \$133.63. The average generic drug cost increased 8.2% to \$24.61. The total prescription volume was 2,983,871 down from 3,474,297 the previous year. Mental health drugs continue to account for over 1/4 of all drug expenditures. The atypical antipsychotics, the number one drug class, ranked by cost, accounted for \$28.8 million staying flat from \$28.3 million the previous year. Antidepressant medications account for another \$11 million, and the anticonvulsant medications with continued increase in mental health uses totaled an additional \$18 million. Intense direct-to-consumer marketing by the Drug Manufacturers drives market share and increased use of prescription and increased spending.

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 booked at least \$3.2 million dollars in savings for FY06 simply by assisting physicians to reduce the number of prescriptions that could cause potential adverse drug reactions or elimination of unnecessary and/or duplicate prescriptions. The Division contracted with the DRRC to increase the number of reviews from 200 per month to 300 per month beginning with fiscal year 2004.

A program paid for by a grant from Eli Lilly and Company is focusing on mental health drugs. The program offers physician to physician consultations as well as sending out letters to physicians whose prescribing patterns are marked by a criteria driven computer program. The program has already demonstrated significant changes in prescribing patterns with subsequently improved health care delivery.

The DUR Board continues to serve well and has been instrumental in improving both quality of care and access to medications. The DUR Board has been instrumental in improving healthcare outcomes and is directly responsible for effecting savings of over \$1.5 million dollars.

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I. INTRODUCTION

The Utah Department of Health, Division of Health Care Financing's Medicaid 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 Part D clients with eligibility in both the Medicare and the Medicaid programs (Dual Eligibles or DE) no longer have a drug benefit through Medicaid. As a result, Medicaid had expenditures for these clients only for the first six (6) months of the fiscal year. 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 \$183,028,972* for State Fiscal Year 2006 (FY06). "Clawback" payments for FY2006 totaled \$10,047,251.95, bringing total expenditures to \$ 193,076,233.95. The number of eligibles increased slightly from 286,983 to 287,559 or 0.2%. The number of recipients (those receiving prescriptions) decreased from 200,505 to 196,499 (-2%). Excluding the Part-D Dual Eligibles, there were 170,308 recipients. Factoring out the DE recipients, spending rose from \$723.32 per recipient per year (PRPY) to \$761.64. This is significant because PRPY spending for 26,197 DE clients was \$2,035, meaning that for those clients remaining in the Medicaid program, PRPY spending has increased by \$38.32. The net result: costs continue to increase for those clients which traditionally require fewer resources.

Medicaid paid for 2,983,871 prescriptions. This is a decrease of -14% compared to FY05. Factoring out the DE clients results in an adjusted decrease of -1.5%. The average cost per prescription increased by \$1.60, a rise of 2.7%. This increase in prescription costs amounts to approximately \$4,774,194.

The average price of a generic drug prescription increased 8.2% to \$24.61. Brand name prescription prices rose 11.9% to \$133.63, an increase of \$14.19 per prescription. The Pharmacy Practice Act mandates the use of generics in the Medicaid drug program. Overall generic usage increased 3.74% from FY05, and this shift to generic drugs means more than \$12,000,000.00 in savings for FY06.

II. RETURN ON INVESTMENT

Drug Rebates

Drug rebates from the manufacturers continue to be the most significant savings to the drug program. The rebate goes back into the State general fund and is shared with the Federal Government. The total rebate collected from 1994 through 2006TD exceeds \$292,000,000*. Table 1 shows rebates collected from 1994 to 2006**. A breakout of the rebate is shown in *Attachment 1*. There are approximately \$821,916 in uncollected rebates at the present time.

* All dollar amounts shown include both state and federal dollars unless otherwise noted!
**as of 06/30/06

**Table 1
Drug Rebate by Calendar Year***

Year	Dollar amount collected
'94	\$ 7,834,306
'95	\$ 8,618,615
'96	\$ 8,883,947
'97	\$ 10,111,968
'98	\$ 14,366,023
'99	\$ 17,944,267
'00	\$ 20,973,717
'01	\$ 24,857,933
'02	\$ 29,228,116
'03	\$ 35,116,747
'04	\$ 44,677,201**
'05	\$ 53,246,691
'06CYTD	\$ 16,669,796
Total	\$ 292,529,328

* All dollar amounts shown include both state and federal dollars unless otherwise noted!

** Figure decreased greatly from 2005 report due to manufacture rebate adjustments
Figures will differ from previous years due to manufacturer adjustments

Prior Approval

The mandate for the use of generics vs brand name drugs has been cost effective. Brand name drugs for which a generic is available have been placed on prior approval, and as mentioned previously the FY06 savings for this initiative amounts to over \$12,000,000 dollars. Prior authorizations are also used to control inappropriate and excessive use for very expensive medications. All totaled in FY2006, there were 10,185 prior authorizations issued, and 2,424 of those were for other than brand name prescriptions.

Drug Regimen Review Center

The University Of Utah College of Pharmacy's Drug Regimen Review Center (DRRC) began reviewing high prescription utilizers of the Medicaid drug program in 2002. The DRRC contacts physicians who prescribe for an identified Medicaid client and performs an educational 'Peer Review' of the targeted client. The selection is based on the paid drug claim history. The goal is to reduce waste, duplication and unnecessary prescription utilization, and the program has been well received by providers and clients. As of June 30, 2006 there have been 27,335 letters sent to 6,762 physicians with recommendations concerning 7,291 Medicaid clients. For

FY06, it appears that the DRRC program achieved at least a \$3,200,000 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 and/or duplicate prescriptions. The DRRC is contracted with the Department for \$468,000/yr. *Attachment 2* is the FY06 report from the DRRC.

Behavior Pharmacy Management System

The Division has been working on a program known as the Behavioral Health Pharmacy Management System (BPMS) Program which is administered by Comprehensive Neuroscience, Inc.. This Program has now been in operation since March '04 and is focused on mental health drug usage as identified in retrospective drug utilization review (RETRODUR) analysis. A total of 2,733 providers were notified in writing about the advent of this program. Utah psychiatrists provide physician to physician consultation with targeted physicians who can benefit from their expertise.

BPMS reviews and analyzes Medicaid paid drug claim history for behavioral health medication and compares these claims against a series of best practices quality indicators. Some of the key quality indicators are:

- Prescribing two or more Atypical Antipsychotics
- Children and Adolescents receiving three or more Psychotropics
- Multiple Prescribers of Any Class of Behavioral Health Drug
- Polypharmacy (e.g. patients receiving 3 or more anti-depressants)

The Division is pleased to report that there has been positive response to the program. For those prescribers to whom we have sent notification of prescribing patterns that may be at variance with the best practice guidelines, there has been noticeable changes in prescribing practices that are much more consistent with these guidelines.

A key indicator is "Multiple Prescribers of the same class of psychotropic drug for 45 days or more." All prescribers who write scripts for behavioral health drugs receive notification if their patient is also receiving prescriptions in the same class of drugs from another prescriber. From October 2005 through November 2006, approximately 3,366 letters were mailed out regarding various indicators that have been activated, for 5,934 clients. Based on the nine month period from January 2006 through September 2006, the number of multiple prescribers has been reduced by 68% (*Attachment 3*). This response indicates a strong willingness of prescribers to modify their practices when provided with feedback and information about best practices and clinical guidelines. This is particularly gratifying since minimizing the incidences of multiple prescribers can be a significant factor in reducing potential toxicity as well as increasing coordination of care. *Attachment 3* shows targeted change reports for prescribers and targeted change reports for patients in regard to mental health drugs. For example, the targeted adult patients show a 62% decrease in use of five (5) or more psychotropics for sixty (60) or more days. Targeted physicians show a 47% decrease in those using five (5) or more psychotropics in a patient for sixty (60) or more days.

The BPMS program is paid for by a grant from Eli Lilly and Company and was renewed this year. Between the BPMS and DRRC, more than 9,094 retrospective letters were mailed to physicians seeking to bring prescribing practices more in line with evidence based medicine.

Co-Pay

Co-pays returned \$5,001,665 for FY06 and \$1,498,545.04 for FY07YTD (7/1/06 - 11/17/06). Table 2 shows total co-payments collected to date:

**Table 2
Co-Payments Collected**

Fiscal year	Amount Returned
FYTD2007	\$ 1,498,545
FY 2006	\$ 5,001,665
FY 2005	\$ 5,790,175
FY 2004	\$ 5,623,221
FY 2003	\$ 3,286,039
FY 2002	\$ 1,072,334
FY 2001	\$ 992,320
FY 2000	\$ 894,260
FY 1999	\$ 833,201
FY 1998	\$ 411,472
Total	\$ 25,403,232

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 taken by Division of Finance office of fiscal operations. All FY 2006 program total figures show decreases due to one-half year of claims data without the DE clients. All direct comparisons with FY2005 data will be made with the DE clients factored out where possible.

Spending for non DE clients increased by ~ \$6,000,000 or 4.8% over FY05. Rises in spending continues to be due to increased utilization and price increases. Table 3 shows a summary of the drug program.

**Table 3
Drug Program Summary**

Fiscal Year	FY 2000	FY 2001	FY2002	FY03	FY04	FY05	FY06	FY07TD (4.5 months)
Total Eligibles	222,360	235,813	249,447	249,745	276,813	286,983	287,559	NA
Total Rx Recipients	137,936	135,947	147,186	174,952	194,067	200,505	196,499	114,395
Total Rx	2,343,126	2,508,176	2,649,188	2,905,334	3,288,347	3,474,297	2,983,871	776,779
Dollars Paid Out	96,274,017	113,651,609	134,495,292	159,546,679	183,306,089	207,580,360	183,028,972	48,621,923
% yearly budget increase	20.4%	18.1%	18.3%	18.6%	14.9%	13.2%	-11.8%	NA
Average Cost/RX	41.09	45.31	50.77	54.92	55.74	59.75	61.34	62.59
% increase in cost/RX	12.8%	10.3%	12.0%	8.2%	1.5%	7.2%	2.7%	2.0%
Ave. Rx/month per Eligible	0.88	0.89	0.89	0.97	0.99	1	0.86	NA
Ave. Rx/month per recipient	1.42	1.54	1.5	1.38	1.4115	1.4439	1.2654	0.5658
% change in RX/Mo. per recipient	1.4%	8.6%	(2.4%)	(7.7%)	2%	2.29%	(12.36%)	(55.3%)

Top Twelve Therapeutic Classes

Table 4 shows the top twelve therapeutic classes ranked by cost for FY 2006. The atypical antipsychotics remain the number one drug expenditure. Since anticonvulsants are used extensively in mental health for bi-polar and other mood disorders and in neuropathic pain treatment, it's not surprising that they are ranked at number two. Bearing that in mind, mental health drug costs account for over 1/4 of the total drug costs. Five of the top twelve drug classes are used for mental health. Two newer mental health classifications, H7X and H7C, were split off other existing mental health drug classes. The number one class, H7T, is made up of a very small group of drugs called the atypical antipsychotics. H7X is still referred to as an atypical antipsychotic and will continue to be included with H7T; by itself it would rank at number seven based on cost. Only six drugs (drug classes H7T and H7X) account for 28.8 million dollars.

Table 4
Top Twelve Therapeutic Classes By Cost, And By Volume For FY2006

	RANKED BY COST - FY2006	RANKED BY COST - FY2005	% CHANGE FROM FY05	DRUG CLASS	RANKED BY PRESCRIPTION VOLUME - 2006	RANKED BY PRESCRIPTION VOLUME - 2005	Ave. cost/RX for FY06
1	\$28,837,409	\$33,295,427	(13.38%)	H7T / H7X ATYPICAL ANTIPSYCHOTICS	7	5	\$277.91
2	\$18,303,429	\$20,004,337	(8.50%)	H4B ANTICONVULSANTS	2	2	\$114.16
3	\$10,559,530	\$13,094,101	(19.35%)	D4K ANTI-ULCER, PPIs	4	4	\$90.11
4	\$10,045,656	\$12,077,721	(16.82%)	H3A NARCOTIC ANALGESICS	1	1	\$36.38
5	\$8,541,844	\$11,799,514	(27.60%)	H2S ANTIDEPRESSANTS (SSRIs)	3	3	\$63.19
6	\$5,368,754	\$6,697,918	(19.84%)	M4E LIPOTROPICS	10	10	\$86.63
7	\$4,197,527	\$4,117,536	1.94%	M0E HEMOPHILIA FACTOR VIII	200	211	\$6,881.19
8	\$3,820,880	\$3,580,945	6.70%	H7C SEROTONIN- NOREPINEPHRINE REUPTAKE-INHIB.	25	28	\$120.77
9	\$2,831,453	\$2,936,769	(3.58%)	C4G INSULINS	24	25	\$89.12
10	\$2,663,570	\$4,366,353	(38.99%)	S2B NSAIDS, ANTI- INFLAMMATORY	6	5	\$25.13
11	\$2,649,288	\$2,379,989	11.31%	H2E SEDATIVE/HYPNOTICS	17	22	\$64.94
12	\$2,595,387	\$2,729,492	(4.91%)	H7D NOREPI / DOPAMINE REUPTAKE INHIBITORS	28	29	\$99.30

Brand Name vs. Generic

A generic drug is identical when bio-equivalent to a brand name drug 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 substantial discounts from the branded price. In FY06, the average cost spread between the name brand price and generic was \$109.02, an increase of \$12.32. The use of generic drugs continues to be the single most important cost saving measure that can be utilized.

Table 5 shows the breakout of dispensing fees and also shows the brand name (B) vs. generic name (G) utilization for traditional prescriptions for FY06. The use of generics when available has caused an additional shift of 3.74% to generics from brand name drugs this past year (this equates to 111,596 prescriptions). All brand name drugs require a prior approval if there is a generic available. Brand name drugs account for approximately 32.91% of claims while generics account for approximately 58.22% of all claims. OTC and select I.V. drugs make up the rest. Brand name drugs still account for 71.7% of total dollars spent. Savings generated from switching to generics calculates to over 12 million dollars in FY06.

Dispensing fee indicators "F, J, K, L, M" are for select home intravenous infusion

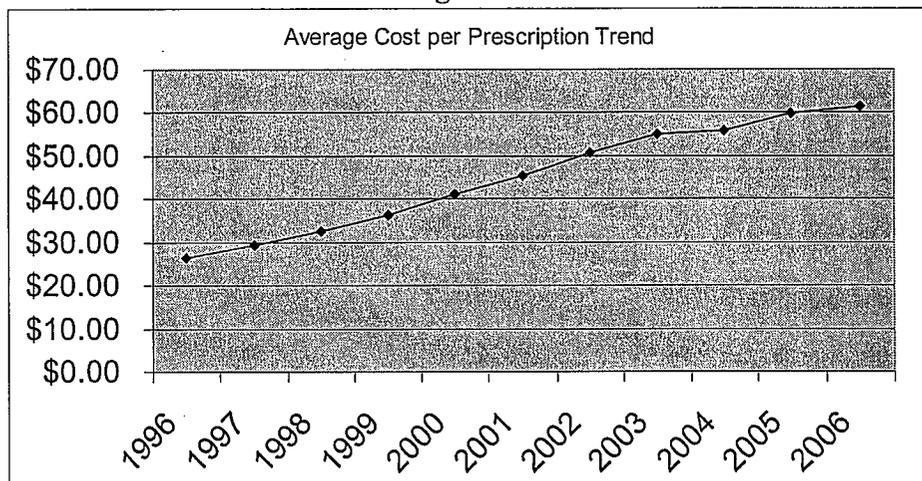
prescriptions. Dispensing fee indicator "C" is for over-the-counter products including insulins.

Table 5
Utilization By Dispensing Fee Indicator

Allowed Dispensing Source	# Rx	% of Rx's	Total Cost	ave. cost per RX (FY06)	ave. cost per RX (FY05)	% change for FY06 compared to FY05
Brand	982,253	32.91%	\$ 131,262,165.46	\$ 133.63	\$ 119.44	11.88%
C	258,557	8.66%	\$ 8,197,682.00	\$ 31.71	\$ 29.98	5.76%
F	1,682	0.0005%	\$ 7,460.42	\$ 4.44	\$ 3.01	47.36%
Generic	1,737,271	58.22%	\$ 42,756,758.19	\$ 24.61	\$ 22.75	8.18%
J	1,011	0.0003%	\$ 179,378.83	\$ 177.43	\$ 130.01	36.47%
K	941	0.0003%	\$ 564,442.90	\$ 599.83	\$ 509.37	17.76%
L	1,993	0.0006%	\$ 58,138.82	\$ 29.17	\$ 22.50	29.65%
M	138	0.00004%	\$ 1,396.30	\$ 10.12	\$ 8.12	24.61%

Figure 1 shows a graphic representation of the increase in prescription prices over the most recent ten-year period.

Figure 1



The 2.7% increase in the average price of a prescription for FY06 reflects a lower increase than customary in the past 7 years. This lower rate is mainly due to increased use of generic drugs and the migration of more expensive DE client prescriptions to the Medicare part-D program. The average price for a prescription has already increased 2.0% in the first five months of FY06.

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 FY2003 eligibility data, and factored per DE client. Table 6 contains Calendar Year totals for each months remittance since the inception of Part-D in January 2006.

When FY2006 Clawback amounts are added to FY2006 Medicaid expenditures, the total for program costs is \$ 193,076,223.95.

Table 6
State Phased Down Contribution
“Clawback”

Jan 2006	\$ 1,580,190.35
Feb 2006	\$ 1,605,404.90
Mar 2006	\$ 1,647,193.50
Apr 2006	\$ 1,637,846.05
May 2006	\$ 1,865,876.70
Jun 2006	\$ 1,710,740.45
Jul 2006	\$ 1,703,749.50
Aug 2006	\$ 1,711,368.85
Sep 2006	\$ 1,721,266.15
Oct 2006	\$ 1,758,088.91
Nov 2006	Not yet available
CY Total to date:	\$16,941,725.36

IV. PATIENT COUNSELING

The State Board of Pharmacy, under the direction of the Division of Commerce 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 July, August, September, and October of FY2006, the Prospective Drug Utilization Review (PRODUR) program returned \$1,764,573 due to reversed claims. It should be recognized that in actual dollars this amount may be smaller since physicians may substitute different prescriptive drugs for those that were discontinued (reversed) due to warnings (*Figures for the complete year are not available at this time, due to a computer programming problem. Corrected figures have not yet posted. PRODUR FY figures will be adjusted based on a partial year calculation*). The PRODUR Program ran against 1,151,259 claims for this partial year, of which 21,653 claims were reversed. More than 22 % of submitted claims resulted in an adverse drug warning being posted to the pharmacy. Of those claims with warnings, 8.5 % were reversed, an increase of 0.3% over the preceding yearly totals. Note that there continues to be a gradual increase in warnings posted to total claims generated. Table 7 shows the trend in number of occurrences in the State's PRODUR for just one of the indicators, THERAPEUTIC DUPLICATION, over an eight-year period.

Table 7
PRODUR Therapeutic Duplications

Year	Total therapeutic duplication warnings
1999	121584
2000	134596
2001	149294
2002	154441
2003	162135
2004	196356
2005	198939
2006 Calculated	154636

For therapeutic duplication, there was a 22.3% calculated decrease in the number of warnings in FY06, down from a 1.3% increase the preceding year. This decrease is largely attributable to the loss of DE clients in January. Over the previous seven year period, there was a 64% increase in therapeutic duplication warnings. 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 issue!** It is to the credit of both physicians' and pharmacists' responses to PRODUR that many probable adverse drug events are avoided. The past three years through the CNS program, RETRODUR has focused on over utilization of mental health drugs that often are therapeutic duplications. Too frequently, two or more Atypical Antipsychotics are being prescribed while other centrally acting drugs are being prescribed concomitantly. In addition, the DRRC has focused much of its work on therapeutic duplications.

DUR BOARD ACTIVITIES - RETRODUR

As discussed previously, both the Drug Regimen Review Center and the Behavioral Pharmacy Management System are retrospective drug utilization review (RETRODUR) based programs.

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 Manufactures 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 deals with several petitions from physicians seeking drug coverage outside policy and/or criteria guidelines. This past year the DUR Board approved about 28% of these petitions and denied or suspended the rest. Frequently the Board requests additional information from

the petitioner. When dealing with petitions, board members have a printout of each client's drug utilization history for several months from which to make decisions. Clients are not identified by either name or ID number, so confidentiality is maintained. All petitions that are rejected still have the option of requesting a formal hearing. To date, no DUR Board decision has been over turned by a hearing.

Last year the DUR Board placed limits or restrictions on four groups of drugs. All of these restrictions were placed in order to assure more appropriate utilization of the medications involved. Two of these groups have potential for demonstrating savings. These four limits or restrictions are as follows:

1. A limit to restrict coverage of muscle relaxants to 30 dosing units in any 30 day period. This measure saved approximately \$460,000 in 2006. Continued savings projected for FY2007 are estimated to be around \$265,000.
2. A restriction placed on benzodiazepines limiting coverage to 120 dosing units per 30 day period, and blocking duplicate therapy among this class. Placing this limit essentially flattened the 13% (21% the previous year) growth in number of prescriptions to 2.8%. While significant savings were not realized, projected savings for FY2007 should amount to around \$266,000.
3. A limit on anti-diarrheal medications to 180 units per 30 day period. Expenditures were reduced over half, saving \$25,000.
4. Medications used for the symptomatic control of cough and cold are an optional exclusion under the OBRA laws that establish Medicaid prescription coverage. The DUR Board approved coverage for a limited number of agents from this class in mid-FY2006. \$1,100,000 were spent in FY 05 and 06 for the entire range of these products. When limited to the selected products approved by the DUR Board, expenditures are anticipated to be around \$150,000.

In late FY2005, the DUR Board placed a quantity limit on narcotic analgesic, single agent medications used for the treatment of pain. Savings amounting to \$1,248,000 were realized for FY2006. Savings for FY2007 are projected to be \$1,372,000.

Throughout the year, the DUR Board passed restrictions, either through prior authorization, quantity limits, or cumulative limits on eleven other single drugs, and reviewed access of prior authorization criteria to four others. The majority were new product entries which lack historical data to compare against for savings calculations.

VI. CONSUMER PRICE INDEX (CPI)

There has been a 2.7% increase in the average cost of prescriptions for Utah Medicaid for the fiscal year 2006 while the federal government cites a 3.3% increase in the CPI for pharmaceuticals and supplies. The average price of a prescription increased 2.0% in the first four and one-half months of FY06.

The use of more generic drugs contributes to the lower CPI and lower rate of increase for drug prices. Table 8 shows CPI for prescription drugs, medical care, and all products for a thirteen year period.

Table 8
Consumer Price Index

FISCAL YEAR Jul 1-Jun 30	PRESCRIPTION DRUGS AND MEDICAL SUPPLIES	MEDICAL CARE	ALL ITEMS
1994	4	4.6	2.5
1995	1.4	4.5	3
1996	3.6	3.6	2.8
1997	3.1	2.9	2.3
1998	3.3	3.2	1.7
1999	5.7	3.4	2
2000	4.3	4.1	3.5
2001	6.2	4.6	2.1
2002	4.5	5	2.4
2003	1.9	3.5	1.8
2004	2.4	4.4	2.5
2005	2.6	4.1	4.3
2006	3.3	4	1.3

VII. CONCLUSION

The Medicaid Drug program returned more than \$50,000,000 dollars to the Department when drug rebates, co-pays, prior approvals/limits and the College of Pharmacy's DRRC activities are factored in. This year, in addition to these savings, the total drug program costs ("Clawback" included) decreased \$14.5 million to \$193,076,234 due to the departure of the Medicare Dual Eligible clients to the Medicare Part-D prescription drug plan. In spite of this, increases in prescriptions per recipient and rising drug costs continue to off-set overall savings. The brand-name prior approval initiative again returned over 12 million dollars in FY06. Various tools are used to effect 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 is not available at this time. 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 profiles and acknowledged expertise in their fields. The Division also benefits from in-house control of the entire drug program.

Attachment 1

Attachment 1

Drug Rebate by Calendar Year*

Year	Dollar amount collected
'94	\$ 7,834,306
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*** as of 06/30/06

Rebates are invoiced and totals tracked by Calendar Year. Deposited receipts are tabulated by Fiscal Year (see next three pages).

PHARMACEUTICAL REBATES
RECEIVABLE REPORT BY CALENDAR QUARTER

28-Nov-06

CALENDAR YEAR 1994

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF ADJUSTED BILLED AMT	DISPUTED AMOUNT DUE
1ST QTR. 1994	\$ 3,105,589.06	\$ 1,843,818.08	\$ 1,839,411.59	99.76%	\$ 4,406.49
2ND QTR. 1994	\$ 2,885,148.99	\$ 1,919,503.13	\$ 1,919,503.13	100.00%	\$ -
3RD QTR. 1994	\$ 2,245,488.01	\$ 1,882,544.90	\$ 1,882,544.90	100.00%	\$ -
4TH QTR. 1994	\$ 2,317,731.16	\$ 2,192,846.18	\$ 2,192,846.18	100.00%	\$ -
TOTAL CAL. 1994	\$ 10,553,957.22	\$ 7,838,712.29	\$ 7,834,305.80	99.94%	\$ 4,406.49

CALENDAR YEAR 1995

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF ADJUSTED BILLED AMT	DISPUTED AMOUNT DUE
1ST QTR. 1995	\$ 2,351,256.06	\$ 1,915,754.76	\$ 1,915,754.76	100.00%	\$ -
2ND QTR. 1995	\$ 1,999,609.38	\$ 2,063,064.91	\$ 2,063,064.91	100.00%	\$ -
3RD QTR. 1995	\$ 2,014,504.61	\$ 2,404,131.96	\$ 2,404,131.96	100.00%	\$ -
4TH QTR. 1995	\$ 2,173,643.05	\$ 2,235,663.14	\$ 2,235,663.14	100.00%	\$ -
TOTAL CAL. 1995	\$ 8,539,013.10	\$ 8,618,614.77	\$ 8,618,614.77	100.00%	\$ -

CALENDAR YEAR 1996

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF ADJUSTED BILLED AMT	DISPUTED AMOUNT DUE
1ST QTR. 1996	\$ 2,275,314.58	\$ 2,267,262.43	\$ 2,267,262.43	100.00%	\$ -
2ND QTR. 1996	\$ 2,401,796.89	\$ 2,159,095.40	\$ 2,159,095.40	100.00%	\$ -
3RD QTR. 1996	\$ 2,022,344.20	\$ 2,332,374.91	\$ 2,332,374.91	100.00%	\$ -
4TH QTR. 1996	\$ 1,968,050.11	\$ 2,126,398.36	\$ 2,125,214.48	99.94%	\$ 1,183.88
TOTAL CAL. 1996	\$ 8,667,505.78	\$ 8,885,131.10	\$ 8,883,947.22	99.99%	\$ 1,183.88

CALENDAR YEAR 1997

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF ADJUSTED BILLED AMT	DISPUTED AMOUNT DUE
1ST QTR. 1997	\$ 2,267,909.46	\$ 2,461,228.10	\$ 2,452,765.16	99.66%	\$ 8,462.94
2ND QTR. 1997	\$ 2,272,392.08	\$ 2,473,231.56	\$ 2,470,500.46	99.89%	\$ 2,731.10
3RD QTR. 1997	\$ 2,256,068.59	\$ 2,525,019.29	\$ 2,525,019.29	100.00%	\$ -
4TH QTR. 1997	\$ 2,761,901.09	\$ 2,673,075.94	\$ 2,663,683.54	99.65%	\$ 9,392.40
TOTAL CAL. 1997	\$ 9,558,271.22	\$ 10,132,554.89	\$ 10,111,968.45	99.80%	\$ 20,586.44

CALENDAR YEAR 1998

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF CURRENT BILLED AMT	DISPUTED AMOUNT DUE
1ST QTR. 1998	\$ 3,136,068.65	\$ 3,445,498.89	\$ 3,439,763.73	99.83%	\$ 5,735.16
2ND QTR. 1998	\$ 3,317,852.16	\$ 3,545,089.72	\$ 3,540,382.95	99.87%	\$ 4,706.77
3RD QTR. 1998	\$ 3,340,437.06	\$ 3,511,406.42	\$ 3,507,941.18	99.90%	\$ 3,465.24
4TH QTR. 1998	\$ 3,581,055.21	\$ 3,882,280.40	\$ 3,877,935.49	99.89%	\$ 4,344.91
TOTAL CAL. 1998	\$ 13,375,413.08	\$ 14,384,275.43	\$ 14,366,023.35	99.87%	\$ 18,252.08

DEPOSITS BY QUARTERS	
JUL/SEP 98	\$ 3,623,585.13
OCT/DEC 98	\$ 4,043,893.79
JAN/MAR 99	\$ 2,898,491.26
APR/JUN 99	\$ 3,492,770.57
TOTAL	\$ 14,058,740.75

CALENDAR YEAR 1999

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF ADJUSTED BILLED AMT	DISPUTED AMOUNT DUE
1ST QTR. 1999	\$ 4,098,810.25	\$ 4,439,350.45	\$ 4,413,517.11	99.42%	\$ 25,833.34
2ND QTR. 1999	\$ 3,971,797.68	\$ 4,348,701.68	\$ 4,347,074.16	99.96%	\$ 1,627.52
3RD QTR. 1999	\$ 3,584,477.52	\$ 4,373,790.18	\$ 4,372,295.52	99.97%	\$ 1,494.66
4TH QTR. 1999	\$ 3,950,086.89	\$ 4,817,675.97	\$ 4,811,381.15	99.87%	\$ 6,294.82
TOTAL CAL. 1999	\$ 15,605,172.34	\$ 17,979,518.28	\$ 17,944,267.94	99.80%	\$ 35,250.34

DEPOSITS BY QUARTERS	
JUL/SEP 99	\$ 4,167,622.42
OCT/DEC 99	\$ 4,752,941.22
JAN/MAR 00	\$ 4,456,129.22
APR/JUN 00	\$ 4,804,544.99
TOTAL	\$ 18,181,237.85

CALENDAR YEAR 2000

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF ADJUSTED BILLED AMT	DISPUTED AMOUNT DUE
1ST QTR. 2000	\$ 4,653,532.41	\$ 4,813,892.95	\$ 4,809,461.99	99.91%	\$ 4,430.96
2ND QTR. 2000	\$ 4,693,461.12	\$ 5,242,868.62	\$ 5,238,190.35	99.91%	\$ 4,678.27
3RD QTR. 2000	\$ 4,584,590.40	\$ 5,586,810.38	\$ 5,569,006.92	99.68%	\$ 17,803.46
4TH QTR. 2000	\$ 4,768,266.85	\$ 5,361,565.62	\$ 5,357,057.84	99.92%	\$ 4,507.78
TOTAL CAL. 2000	\$ 18,699,850.78	\$ 21,005,137.57	\$ 20,973,717.10	99.85%	\$ 31,420.47

DEPOSITS BY QUARTERS	
JUL/SEP 00	\$ 8,178,771.73
OCT/DEC 00	\$ 4,670,717.47
JAN/MAR 01	\$ 2,022,213.34
APR/JUN 01	\$ 6,355,762.22
TOTAL	\$ 21,227,464.76

TOTAL OUTSTANDING PHARMACY REBATE DUE PRIOR PERIODS - 94/00 **\$ 111,099.70**

CALENDAR YEAR 2001

28-Nov-06

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF ADJUSTED BILLED AMT	DISPUTED AMOUNT DUE
1ST QTR. 2001	\$ 5,956,760.19	\$ 6,287,990.90	\$ 6,274,282.75	99.78%	\$ 13,708.15
2ND QTR. 2001	\$ 5,707,519.93	\$ 6,248,134.25	\$ 6,237,572.46	99.83%	\$ 10,561.79
3RD QTR. 2001	\$ 5,381,010.65	\$ 6,072,162.05	\$ 6,070,006.76	99.96%	\$ 2,155.29
4TH QTR. 2001	\$ 6,104,435.76	\$ 6,293,293.30	\$ 6,276,070.68	99.73%	\$ 17,222.62
TOTAL CAL. 2001	\$ 23,149,726.53	\$ 24,901,580.50	\$ 24,857,932.65	99.82%	\$ 43,647.85

DEPOSITS BY QUARTERS	
JUL/SEP 01	\$ 8,901,272.80
OCT/DEC 01	\$ 4,881,175.52
JAN/MAR 02	\$ 4,284,280.29
APR/JUN 02	\$ 6,751,587.99
TOTAL	\$ 24,818,316.60

TOTAL OUTSTANDING PHARMACY REBATE DUE PRIOR PERIODS - 94/01 **\$ 154,747.55**

CALENDAR YEAR 2002

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF ADJUSTED BILLED AMT	DISPUTED AMOUNT DUE
1ST QTR. 2002	\$ 6,780,557.91	\$ 6,998,839.63	\$ 6,938,961.66	99.14%	\$ 59,877.97
2ND QTR. 2002	\$ 7,095,221.57	\$ 7,332,474.94	\$ 7,328,248.54	99.94%	\$ 4,226.40
3RD QTR. 2002	\$ 6,784,359.90	\$ 7,131,333.36	\$ 7,125,692.95	99.92%	\$ 5,640.41
4TH QTR. 2002	\$ 7,206,602.96	\$ 7,848,879.91	\$ 7,835,213.04	99.83%	\$ 13,666.87
TOTAL CAL. 2002	\$ 27,866,742.34	\$ 29,311,527.84	\$ 29,228,116.19	99.72%	\$ 83,411.65

DEPOSITS BY QUARTERS	
JUL/SEP 02	\$ 6,482,301.55
OCT/DEC 02	\$ 9,850,166.71
JAN/MAR 03	\$ 4,590,624.34
APR/JUN 03	\$ 7,565,968.07
TOTAL	\$ 28,489,060.67

TOTAL OUTSTANDING PHARMACY REBATE DUE PRIOR PERIODS - 94/02 **\$ 238,159.20**

CALENDAR YEAR 2003

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF ADJUSTED BILLED AMT	DISPUTED AMOUNT DUE
1ST QTR. 2003	\$ 8,292,681.95	\$ 8,555,964.60	\$ 8,551,779.04	99.95%	\$ 4,185.56
2ND QTR. 2003	\$ 8,545,644.32	\$ 8,414,572.01	\$ 8,392,086.84	99.73%	\$ 22,485.17
3RD QTR. 2003	\$ 8,851,856.67	\$ 8,533,746.14	\$ 8,516,045.70	99.79%	\$ 17,700.44
4TH QTR. 2003	\$ 9,504,983.09	\$ 9,681,913.32	\$ 9,656,835.62	99.74%	\$ 25,077.70
TOTAL CAL. 2003	\$ 35,195,166.03	\$ 35,186,196.07	\$ 35,116,747.20	99.80%	\$ 69,448.87

DEPOSITS BY QUARTERS	
JUL/SEP 03	\$ 8,722,217.90
OCT/DEC 03	\$ 12,387,001.01
JAN/MAR 04	\$ 5,403,714.10
APR/JUN 04	\$ 14,861,903.08
TOTAL	\$ 41,374,836.09

TOTAL OUTSTANDING PHARMACY REBATE DUE PRIOR PERIODS - 94/03 **\$ 307,608.07**

CALENDAR YEAR 2004

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF ADJUSTED BILLED AMT	DISPUTED AMOUNT DUE
1ST QTR. 2004	\$ 9,137,150.78	\$ 10,915,537.05	\$ 10,897,720.82	99.84%	\$ 17,816.23
2ND QTR. 2004	\$ 11,962,383.22	\$ 11,738,901.19	\$ 11,737,553.35	99.99%	\$ 1,347.84
3RD QTR. 2004	\$ 10,726,511.63	\$ 10,478,003.45	\$ 10,484,331.24	100.06%	\$ (6,327.79)
4TH QTR. 2004	\$ 11,953,479.21	\$ 11,566,975.39	\$ 11,557,595.28	99.92%	\$ 9,380.11
TOTAL CAL. 2004	\$ 43,779,524.84	\$ 44,699,417.08	\$ 44,677,200.69	99.95%	\$ 22,216.39

DEPOSITS BY QUARTERS	
JUL/SEP 04	\$ 6,102,082.71
OCT/DEC 04	\$ 12,252,445.01
JAN/MAR 05	\$ 9,753,532.45
APR/JUN 05	\$ 17,238,046.33
TOTAL	\$ 45,346,106.50

TOTAL OUTSTANDING PHARMACY REBATE DUE PRIOR PERIODS - 94/04 **\$ 329,824.46**

CALENDAR YEAR 2005

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF ADJUSTED BILLED AMT	DISPUTED AMOUNT DUE
1ST QTR. 2005	\$ 12,921,833.00	\$ 12,823,824.02	\$ 12,787,696.48	99.72%	\$ 36,127.54
2ND QTR. 2005	\$ 13,091,881.60	\$ 13,286,993.24	\$ 13,254,148.52	99.75%	\$ 32,844.72
3RD QTR. 2005	\$ 12,859,825.39	\$ 12,990,990.49	\$ 12,951,779.90	99.70%	\$ 39,210.59
4TH QTR. 2005	\$ 14,225,198.14	\$ 14,333,492.61	\$ 14,253,065.90	99.44%	\$ 80,426.71
TOTAL CAL. 2005	\$ 53,098,738.13	\$ 53,435,300.36	\$ 53,246,690.80	99.65%	\$ 188,609.56

DEPOSITS BY QUARTERS	
JUL/SEP 05	\$ 7,797,108.05
OCT/DEC 05	\$ 12,712,308.14
JAN/MAR 06	\$ 21,318,602.30
APR/JUN 06	\$ 12,205,505.44
TOTAL	\$ 54,033,523.93

TOTAL OUTSTANDING PHARMACY REBATE DUE PRIOR PERIODS - 94/05

\$ 518,434.02

CALENDAR YEAR 2006

CALENDAR QUARTERS	TOTAL QTR. BILLED AMOUNT	ADJUSTED BILLED AMOUNT	REBATES RECEIVED	% OF ADJUSTED BILLED AMT	DISPUTED AMOUNT DUE	DEPOSITS BY QUARTERS
1ST QTR. 2006	\$ 10,484,109.48	\$ 7,971,825.11	\$ 7,898,508.39	99.08%	\$ 73,316.72	JUL/SEP 06 \$ 8,831,191.71
2 nd QTR. 2006	\$ 8,998,625.14	\$ 9,001,452.12	\$ 8,771,287.30	97.44%	\$ 230,164.82	OCT/DEC 06 \$ 808,987.01
3RD QTR. 2006				#DIV/0!	\$ -	JAN/MAR 07 \$ -
4TH QTR. 2006				#DIV/0!	\$ -	APR/JUN 07 \$ -
TOTAL CAL. 2006	\$ 19,482,734.62	\$ 16,973,277.23	\$ 16,669,795.69	98.21%	\$ 303,481.54	TOTAL \$ 9,640,178.72

Attachment 2

Drug UTAH
MEDICAID
**Regimen
Review
Center**

Utah State
Department of Health
and
University of Utah
College of Pharmacy

ANNUAL REPORT

JULY 2005 to JUNE 2006



The Utah Medicaid
Drug Regimen Review Center
421 Wakara Way, Suite 208
Salt Lake City, UT 84108
www.utahdrrc.org

The University of Utah College of Pharmacy began operating the Drug Regimen Review Center (DRRC) in May 2002 to fulfill the terms of a contract with Utah Medicaid. The contract supports the Utah Medicaid prescription drug program and its drug utilization review department. The emphasis of the program is to improve drug use in Medicaid patients, to reduce the number of prescriptions and drug cost in high utilizers of the Medicaid drug program, and to educate prescribers for top utilizers of the Utah Medicaid prescription drug program.

Each month, the top drug utilizers are reviewed by a team of clinically trained pharmacists. These reviews result in recommendations that are made to prescribers. These recommendations are described later in this report. Recommendations are transmitted in writing, are sent to all prescribers, and include a list of drugs dispensed during the month of review. The DRRC also provides information and consultation by telephone with prescribers and pharmacists.

Staff

The DRRC utilizes a staff of professionals to run the program including:

Pharmacists

Karen Gunning, Pharm.D.
Joanne LaFleur, Pharm.D.
CarrieAnn McBeth, Pharm.D.
Gary M. Oderda, Pharm.D., M.P.H.
Lynda Oderda, Pharm.D.
Marianne Paul, Pharm.D.
Carin Steinvort, Pharm.D.

Data Management

Lisa Angelos
Brian Oberg
David Servatius
Yi Wen Yao

Mission

The mission of the DRRC is to review the drug therapy of Medicaid patients receiving more than seven prescriptions per month and to work with the individual prescribers to provide the safest and highest quality pharmacotherapy at the lowest cost possible.

Methodology

DRRC program methodology continues with no change from previous reports. We continue to build a cross-reference table of prescriber identification numbers, prescriber license numbers and DEA numbers that now contains 52,857 listings covering all known license addresses. We have also utilized this information to assist Utah Medicaid in preparing data and identifying prescribers as part of a contract with Comprehensive Neurosciences.

We continue to send letters to prescribers with recommendations for changes in drug therapy as appropriate. To date, we have mailed 27,335 of these letters to 6,762 different prescribers with recommendations concerning 7,291 Medicaid patients.

Overview

Utah Medicaid drug claim costs had increased substantially over the past several years. The total increase in these costs from January 2002 to January 2006, when the Medicare Part D prescription drug benefit went into effect, had been approximately 75.8%. In January 2006 these costs dropped sharply and have been fluctuating as patients moved from the Medicaid drug program into Part D Medicare program. More recently, the total number of claims increased from 278,193 to 326,228 per month (17%) during the period from July 2005 to January 2006, while drug costs increased from \$18,296,125 to \$20,655,766 per month (13%) during this same period.

Figures 1 and 2 show the total number of Medicaid pharmacy claims and the total cost of these claims for each month during the reporting period from July 2005 to June 2006, and Figure 3 shows the trend in total drug claim costs during the entire project period from January 2002 to June 2006.

Figure 1 – Total Medicaid Drug Claims by Month from July 2005 to June 2006

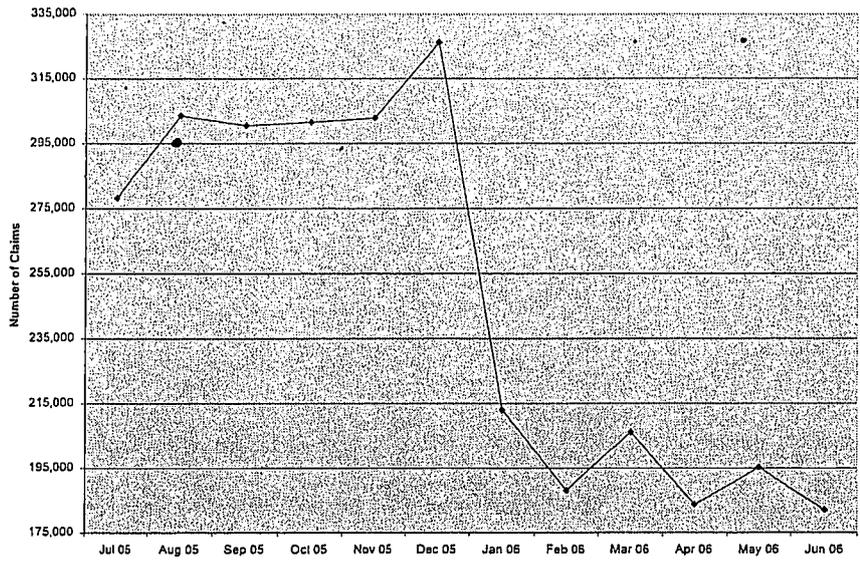


Figure 2 – Total Medicaid Drug Claim Costs by Month from July 2005 to June 2006

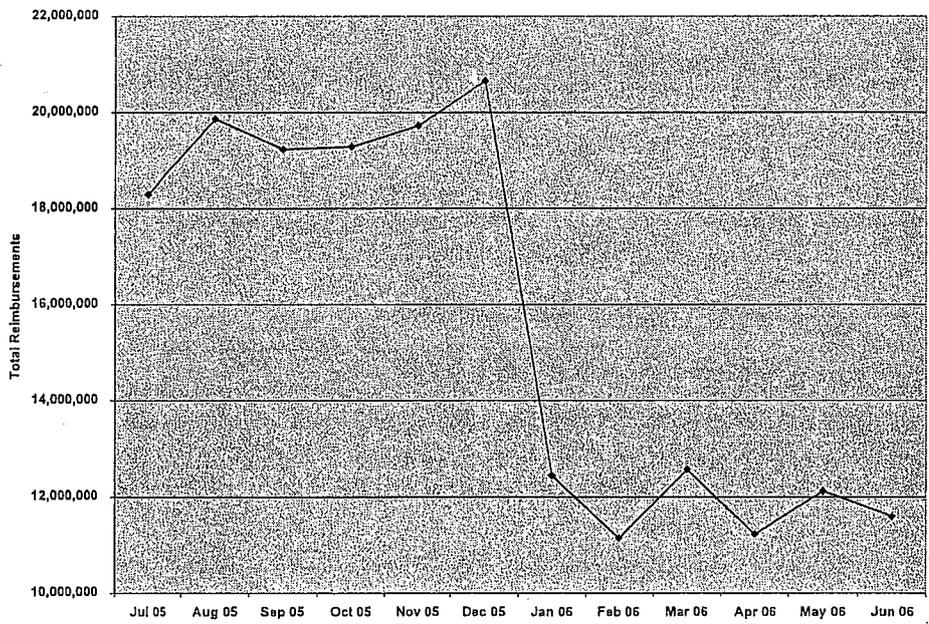
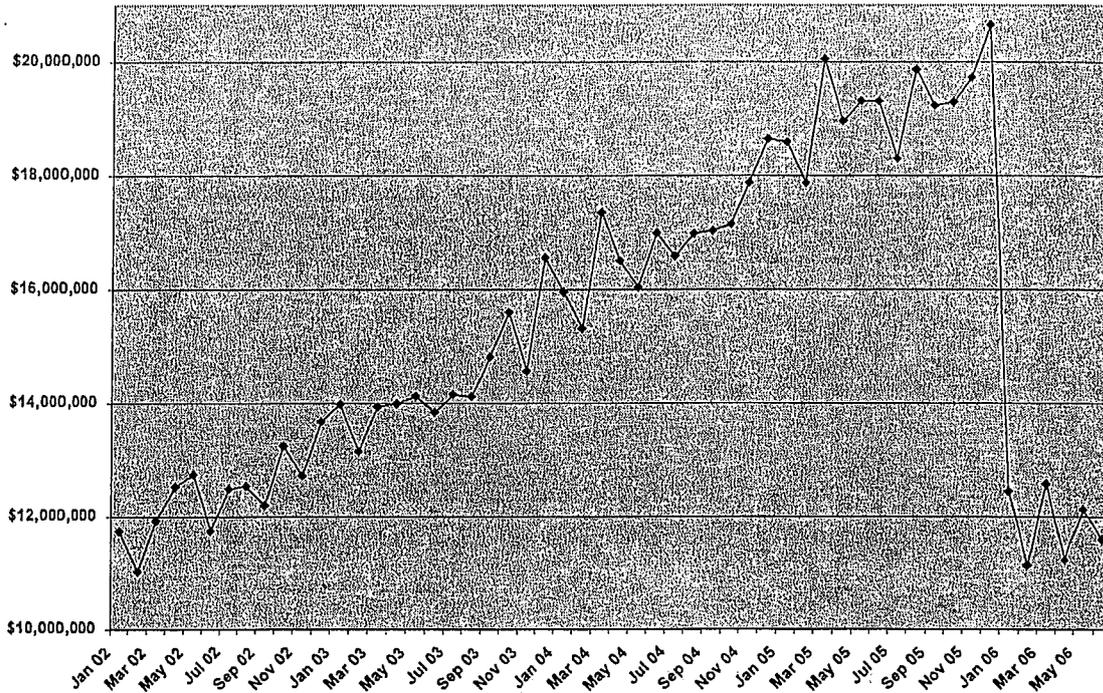


Figure 3 – Total Medicaid Drug Program Costs From January 2002 to June 2006

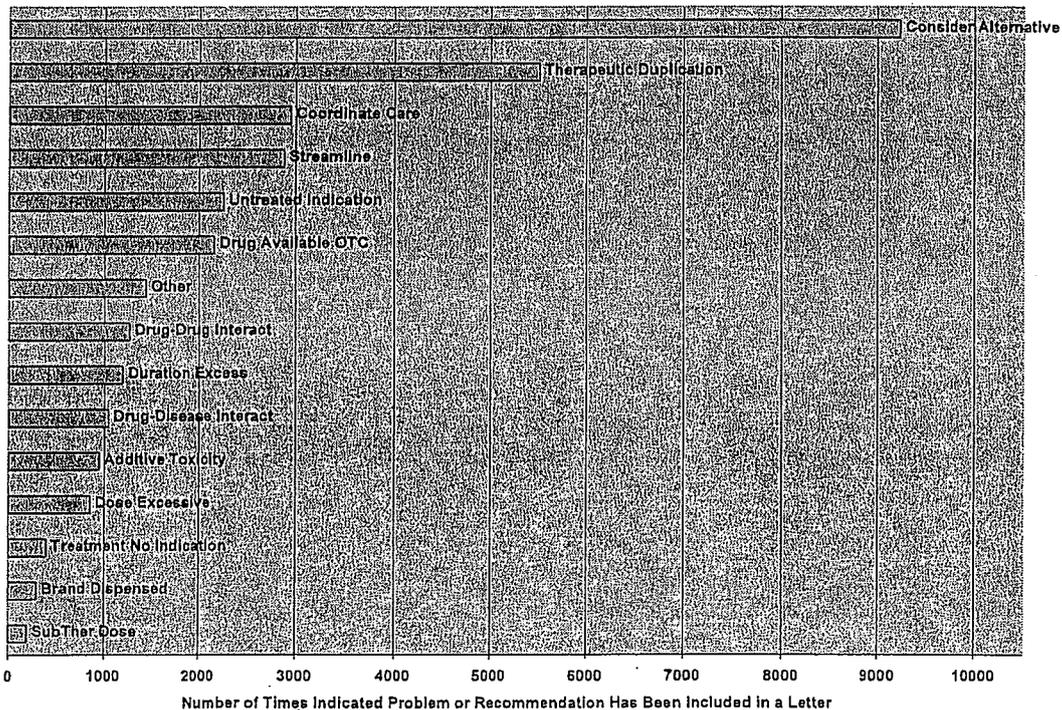


Additional figures for each fiscal year from 2001 to present are included in **Appendix A**. Increases for the previous three fiscal years were 20.1% (July 2003 to June 2004), 16.4% (July 2004 to June 2005) and 13.1% (July 2005 to January 2006 – when Medicare Part D went into effect).

Program Summary

Figure 4 summarizes the drug related problems identified in the letters that have been sent to prescribers.

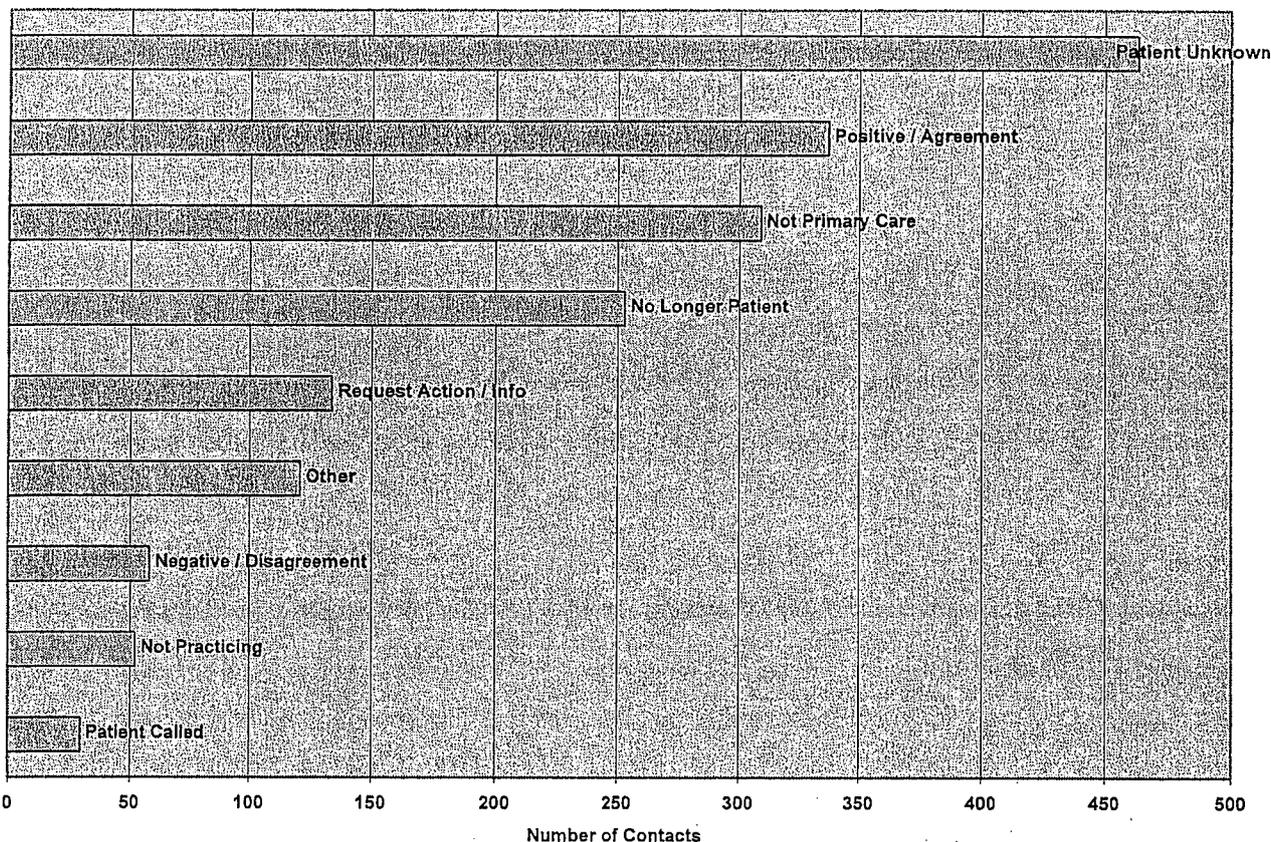
Figure 4 – Type of Drug Related Problems and Recommendations in Letters Sent to Prescribers



Recommendation categories outlined above are self-explanatory, although the top categories do deserve further description. The most common recommendation was for the prescriber to consider alternative therapy. This recommendation would have been made for a number of reasons, including considering a less costly alternative. Therapeutic duplication recommendations were made when the patient was taking multiple therapeutic agents for the same indication when there was generally no reason to include therapy with more than one agent. Coordinate care relates to situations where it appeared that multiple prescribers were ordering therapy for what appeared to be the same illness, and streamline refers to considering changes in therapy to eliminate some of the drugs dispensed. Untreated indication recommendations were made if there was an absence of a medication that appeared to be needed based on usual best practice or guidelines.

Figure 5 summarizes the responses of the 1,756 individuals who contacted the DRRC after receipt of a letter.

Figure 5 – Types of Prescriber Responses to Letters Received



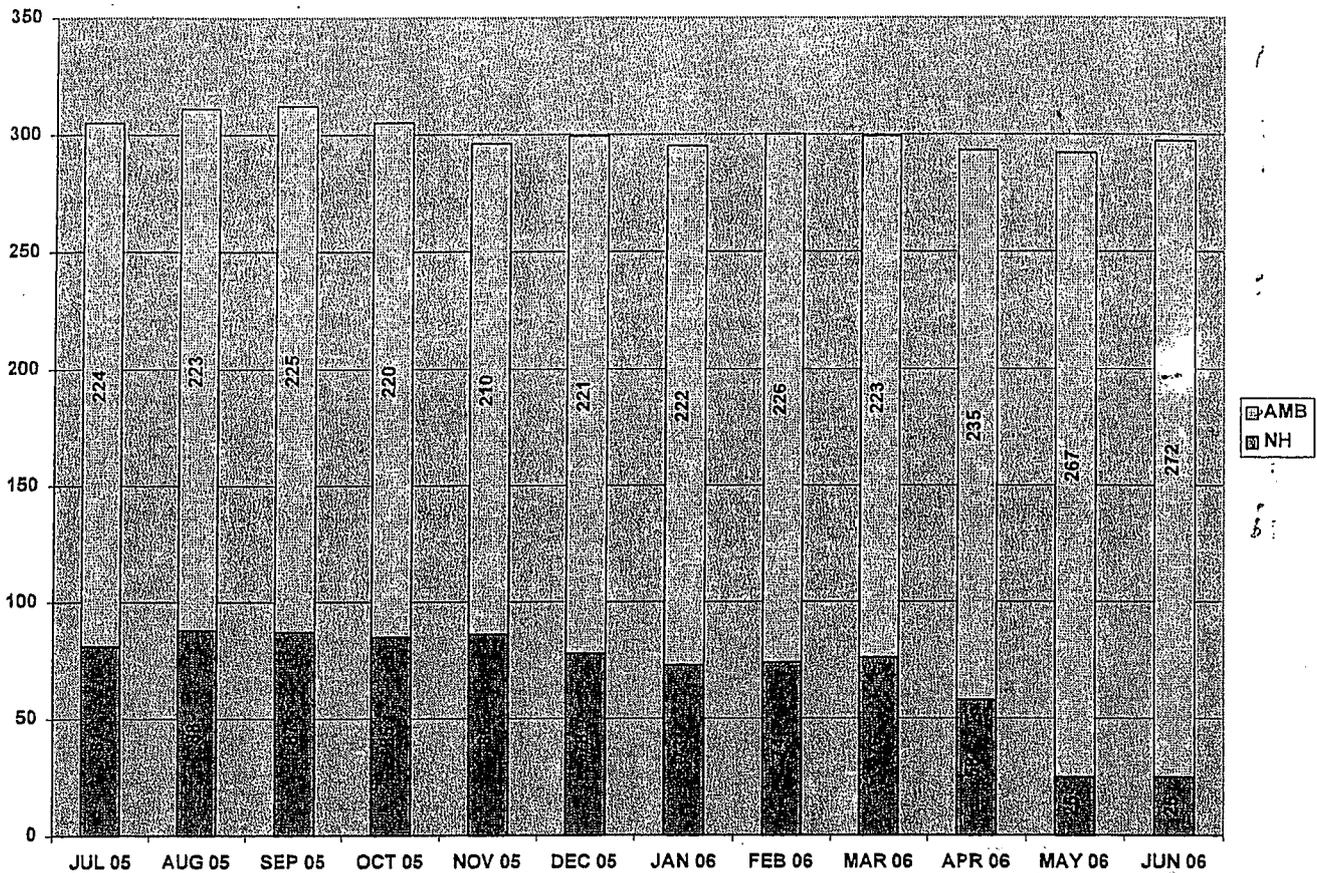
We have received a variety of comments from the prescribers, including both agreement with recommendations and some disagreement. We have also encountered some administrative problems such as pharmacy input error, incorrect addresses on file, and patients not being treated by the prescriber identified. As a result of verification procedures we have implemented, the incidence of these types of problems has gone down dramatically since the beginning of the program.

Demographics

The 3,604 patients reviewed from July 2005 to June 2006 were separated into cohorts based on the month they were reviewed.

Figure 6 summarizes the number of patients reviewed each month during this period, with the numbers of nursing home and ambulatory patients separated. The average was slightly over 300 per month. Approximately 10-30% of reviewed patients each month were nursing home patients.

Figure 6 – Summary of Nursing Home (NH) and Ambulatory (AMB) Patients Reviewed Each Month from July 2005 to June 2006



Demographics for these cohorts are displayed in Table 1 and include gender, average age, and the average number of prescriptions dispensed. Nursing home patients are not included in this table.

Table 1 – Cohort Demographics

Patients								
MONTH	Females				Males			
	Percent	Mean Age	Mean # Rx	Mean Cost Per RX	Percent	Mean Age	Mean # Rx	Mean Cost Per RX
Jul 05	74.1	49.9	19.9	\$69.77	25.9	51.0	20.2	\$68.11
Aug 05	70.4	52.5	16.0	\$57.21	29.6	53.1	15.8	\$82.50
Sep 05	76.4	51.6	15.6	\$61.16	23.6	49.4	15.5	\$75.64
Oct 05	78.2	53.7	16.0	\$62.07	21.8	50.6	16.1	\$77.37
Nov 05	75.7	52.9	16.2	\$63.43	24.3	51.4	16.0	\$76.29
Dec 05	79.6	54.0	15.6	\$63.15	20.4	53.1	15.8	\$77.48
Jan 06	78.8	46.2	15.1	\$65.17	21.2	46.8	15.2	\$85.92
Feb 06	76.1	47.0	13.5	\$68.24	23.9	43.0	13.4	\$85.52
Mar 06	81.2	44.8	14.9	\$62.55	18.8	46.7	14.8	\$71.59
Apr 06	77.0	45.6	14.6	\$66.83	23.0	45.0	13.9	\$84.87
May 06	82.0	44.5	13.7	\$68.59	18.0	46.2	13.1	\$73.05
Jun 06	79.4	44.0	12.9	\$65.23	20.6	44.2	13.2	\$76.89

Reviewed ambulatory patients during the reporting period were predominantly females in their 40s and 50s who filled on average between thirteen and twenty prescriptions per month.

Program Trends

The following figures show the number of patients exceeding seven prescriptions per month and the average number, and range, of the number of prescriptions for the reviewed cohorts. Approximately 8,000 or more patients filled seven prescriptions per month prior to Medicare Part D going into effect, and about 3,000 per month exceeded this number each month after. The mean number of prescriptions that triggered review generally ranged from 15 to 20 while the maximum number of prescriptions for a reviewed patient exceeded 30.

Figure 7 – Total Number of Ambulatory Medicaid Patients Exceeding Seven Prescriptions per Month between July 2005 and June 2006

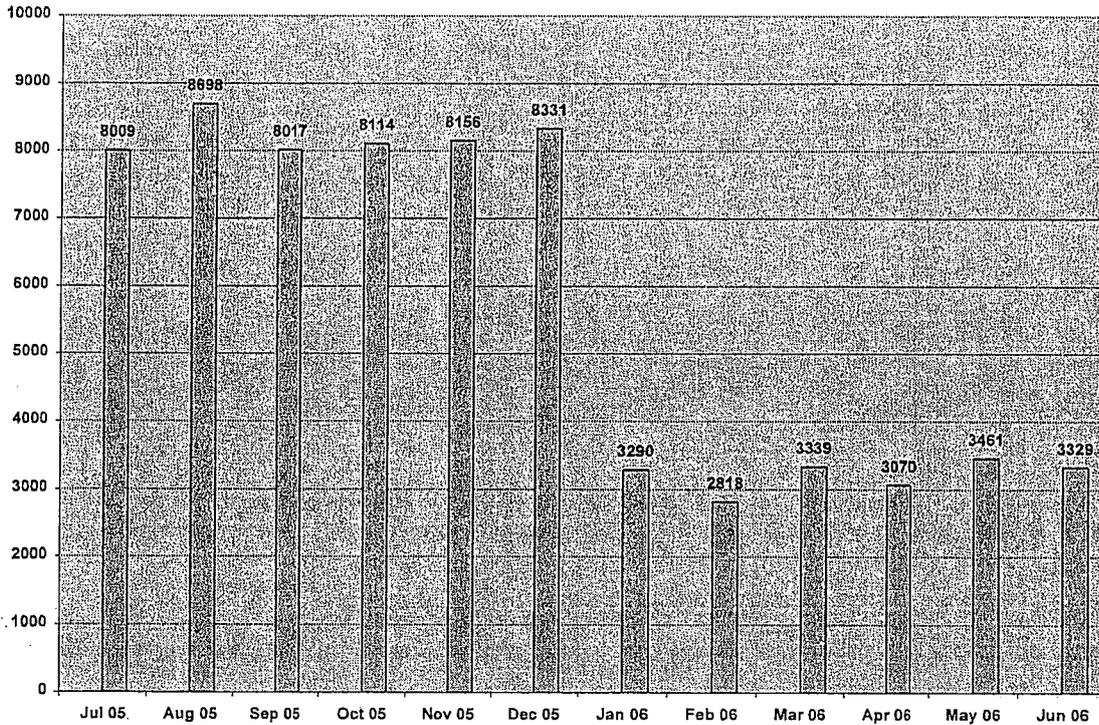
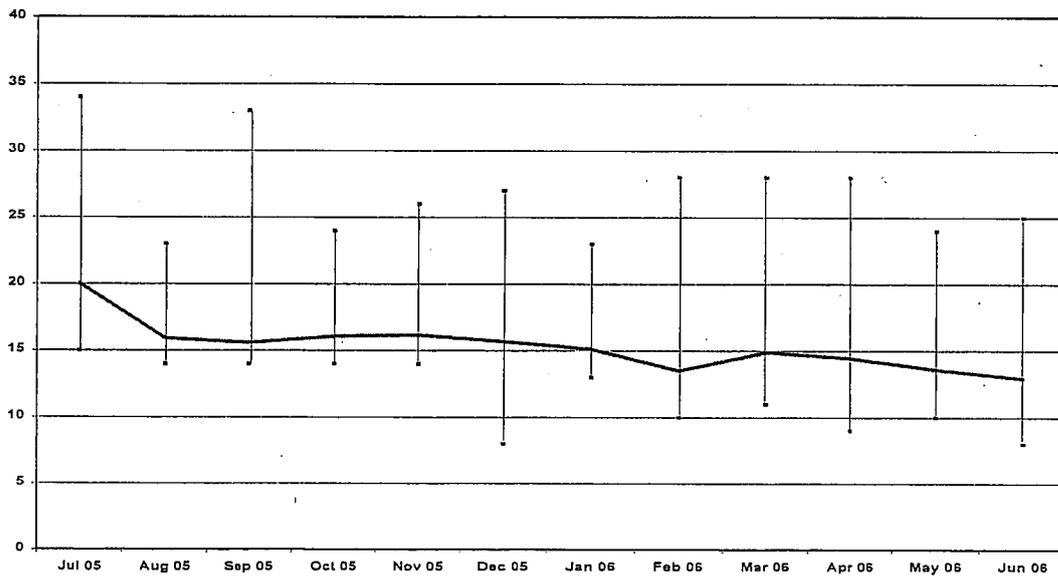


Figure 8 – Average Number of Prescriptions per Month per Reviewed Ambulatory Medicaid Patient, including Minimum and Maximum Number of Prescriptions per Review Group



Program Effectiveness

The DRRC's two major goals are to improve pharmacotherapy for Medicaid patients and to reduce health care costs by decreasing the number of prescriptions and prescription cost. As the review process has matured, we have increased the number of telephone calls to providers to discuss drug related problems. Because of that, we have more information on the impact of our reviews.

The following three patient presentations describe representative examples of the types of patients being reviewed, and the outcome of those reviews:

PATIENT 1

The medication regimen of a 39-year old male was reviewed for the month of January 2006. The review revealed that the patient had received 21 prescriptions during that month at a total cost of \$2229.17. The review identified several issues, which were described to the patient's providers in a letter. The patient had filled prescriptions from five different providers in January; these included several duplications (such as cholesterol-lowering medications from two prescribers and psychiatric medications from two prescribers). We suggested that the providers involved in the patient's care coordinate with each other to determine the most appropriate regimen for the patient to continue. The patient had been receiving anti-anxiety medications from different prescribers and had filled prescriptions for four medications used to treat anxiety. This included two intermediate-acting benzodiazepines from different providers. We requested that the patient's anxiety medication regimen be reviewed and consolidated, in order to prevent medication errors or additive effects of duplicate medications. The patient had also been receiving a Mobic, a brand-name anti-inflammatory medication. Several alternative generic anti-inflammatory medications were identified as options. Making this one change would reduce the patient's monthly medication costs significantly. Three months after the initial review, a follow-up on this patient's regimen showed that he had filled 12 prescriptions at a total cost of \$1016.89. The profile showed far less duplication among the patient's medication regimen.

PATIENT 2

A 56 year old patient was reviewed for May 2006. At that time she was receiving a total of 21 prescriptions at a monthly cost of \$1,120. Her providers were sent letters noting that she had duplicative therapies with her inhalation medications and benzodiazepines. Not only were the benzodiazepines duplicative, but given the patient's diagnosis of sleep apnea, they could have increased her risk of respiratory arrest. The final recommendation was to substitute an equivalent, yet less expensive stomach acid suppressing agent. Upon review of her pharmacy list in September, the number of prescriptions had been reduced to 12 with a total monthly cost of \$600.

PATIENT 3

A 55 year old female patient's drug regimen was reviewed for the month of March 2006. This patient received 22 medications during the month at a cost of \$1903. Issues were identified and addressed in a letter to her prescribers. She had been receiving Plavix and warfarin, both agents which increase the risk of bleeding. We suggested that this combination be reevaluated. She also received digoxin together with diazepam from different providers. We advised the providers that this combination could cause increased digoxin serum levels, possibly leading to digoxin toxicity. We also noted that she had been receiving two medications used to treat allergic rhinitis, loratadine and Nasonex. We requested that the provider evaluate whether she continued to require treatment with both agents. Three months from the time the letters were sent she received 14 medications at a cost of \$1472. Warfarin, digoxin, diazepam and loratadine were not on the prescription profile.

90-Day Followup of Top Ten Reviewed Utilizers Per Month

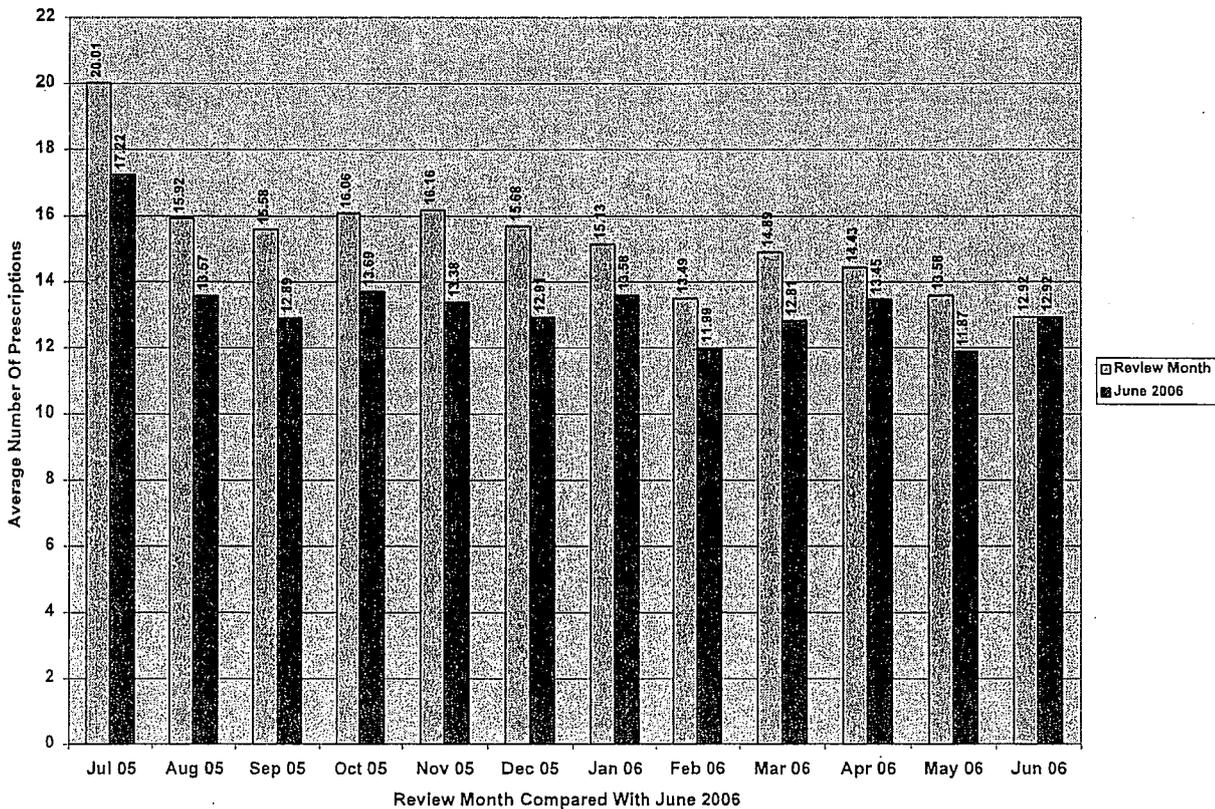
Beginning in January 2006, we have also tracked the top ten reviewed utilizers of the Medicaid prescription drug benefit for 90 days following the mailing of the recommendation letters to prescribers. We compared each patient's total drug fills, total costs and total drug related problems identified in the letters at the time of review and then again after 90 days. In all instances so far we have seen substantial to dramatic decreases in all three categories. **Appendix B** shows a more detailed analysis of the drug related problems we have tracked.

Table 2 – 90 Day Followup of Top Ten Reviewed Utilizers Per Month

	Drug Fills			Costs			Drug Related Problems			Demographics		
	Initial	Followup	Change	Initial	Followup	Change	Initial	Followup	Change	M	F	Mean Age
Jan-06	20.6	17.3	-16.0%	1506.04	1329.99	-12.5%	41	26	-36.0%	29%	71%	37.4
Feb-06	19.6	8.3	-57.0%	1095.09	453.24	-58.0%	34	11	-68.0%	29%	71%	51.4
Mar-06	23.1	19.1	-17.0%	1488.21	1282.35	-14.0%	57	30	-47.0%	14%	86%	50.1
TOTAL	21.10	14.90	-29.4%	1363.11	1021.86	-25.0%	44.00	22.33	-49.3%			

Figure 9 shows the average number of prescriptions per reviewed patient for each month from July 2005 to June 2006, compared to the average number of prescriptions per patient for the same cohort in June 2006. The average number of prescriptions per reviewed patient has decreased over the course of the year from 20.01 to 12.92 prescriptions per month. This change is probably related to implementation of Medicare Part D. The number of prescriptions dispensed has decreased for all review cohorts. No change was seen for June 2006 since this report only covers data through June 2006.

Figure 9 – Average Prescriptions for Reviewed Cohort in Review Month and Compared to June 2006



We have tracked drug cost reimbursements to review cohorts for the remainder of the reporting year following the month they were reviewed. We have only tracked costs for patients within each review cohort who remained eligible during the entire reporting period and accessed their drug benefit at least one time during each of the 12 months in the reporting period. Decreases in drug costs for these selected patients were substantial.

The review month was used as the baseline amount for comparison. Costs were compared for the baseline amount with the amount for June 2006. For example, costs in June 2006 and October 2005 were compared for patients reviewed during October 2005. Cost savings were calculated only for patients reviewed from July 2005 to June 2006. Additional cost savings for patients reviewed before July 2005 are not included, nor are additional savings that would be expected after June 2006 for patients included in this report. Overall cost savings were calculated in three ways using different assumptions for baseline costs. The most conservative assumption is that their drug costs would remain constant since the month of their review. This was used as a base case analysis. Given this assumption, a cost savings of \$3,276,615 was realized. It is unlikely that these high-utilizing patients would have no increase in costs during a period of time when significant increases in costs were being seen across the program. Cost savings were also calculated assuming that baseline costs would increase at a 10% and a 15% annual rate without intervention. Overall cost savings are shown in Table 3.

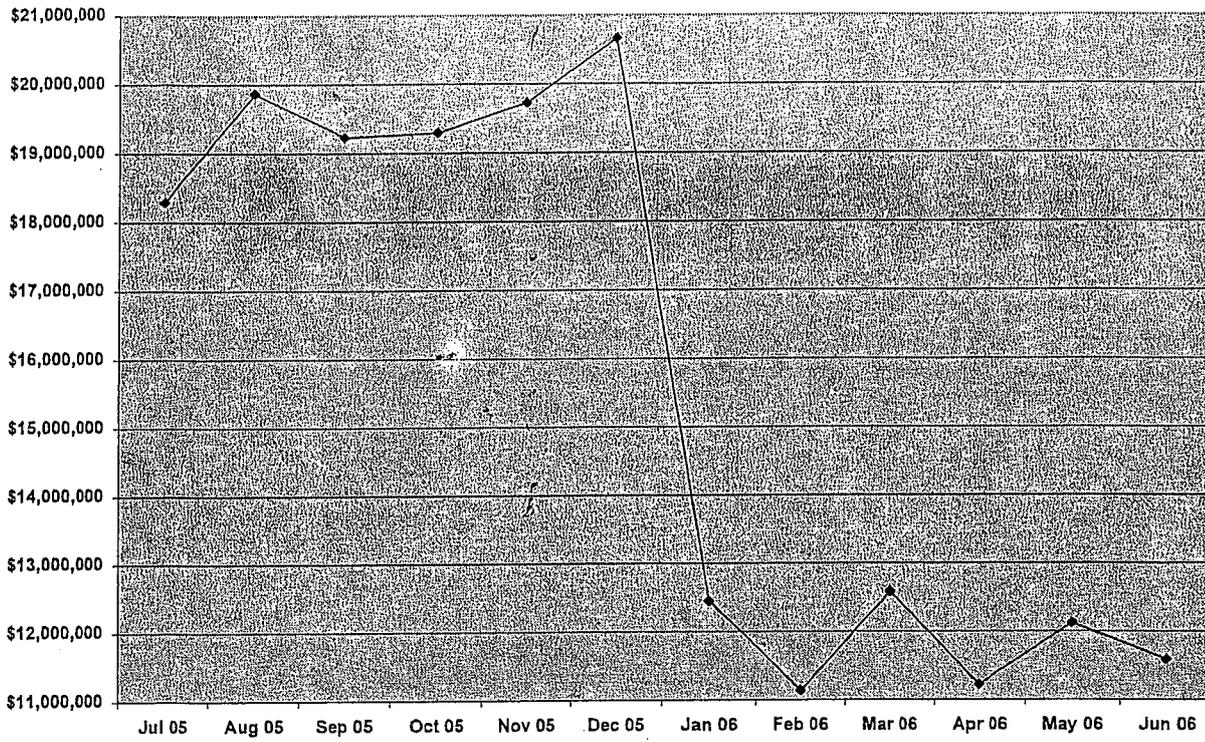
Table 3 – Cost Savings

	No Baseline Increase	10% Annual Increase	15% Annual Increase
Cost Savings	\$3,276,615	\$4,421,823	\$4,994,427

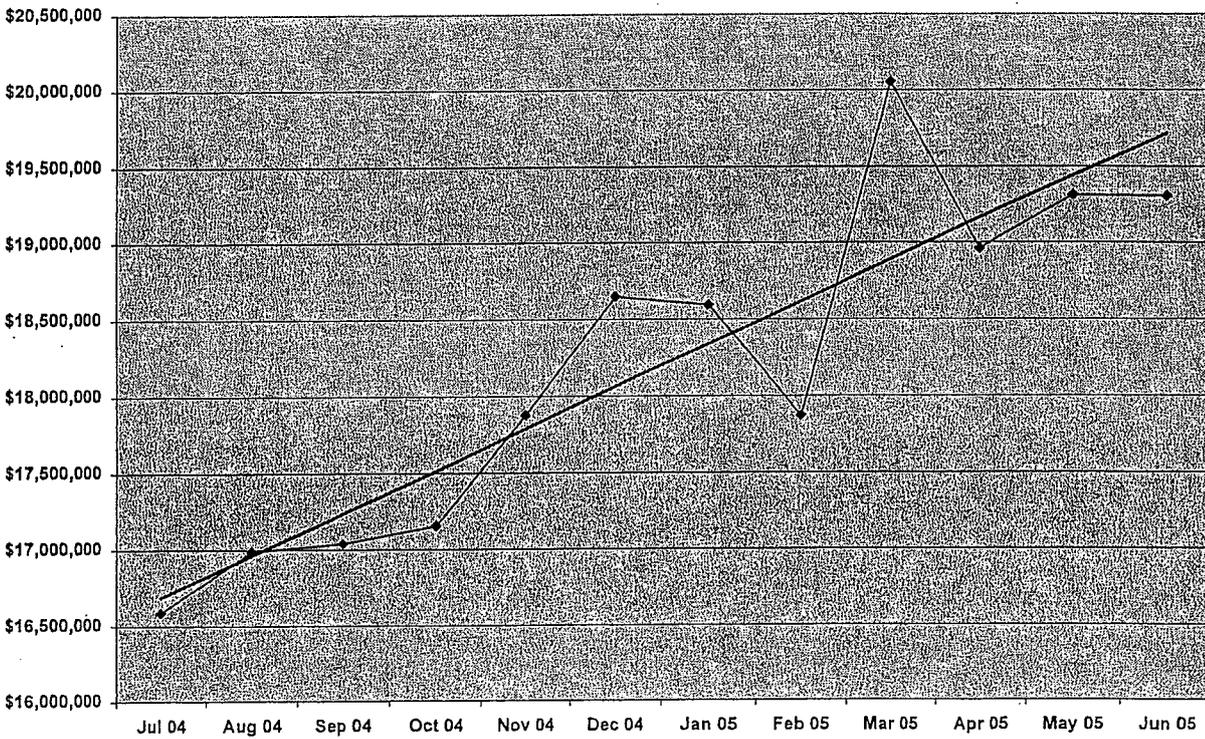
Supporting tables for the cost savings calculations are shown in **Appendix C**.

APPENDIX A

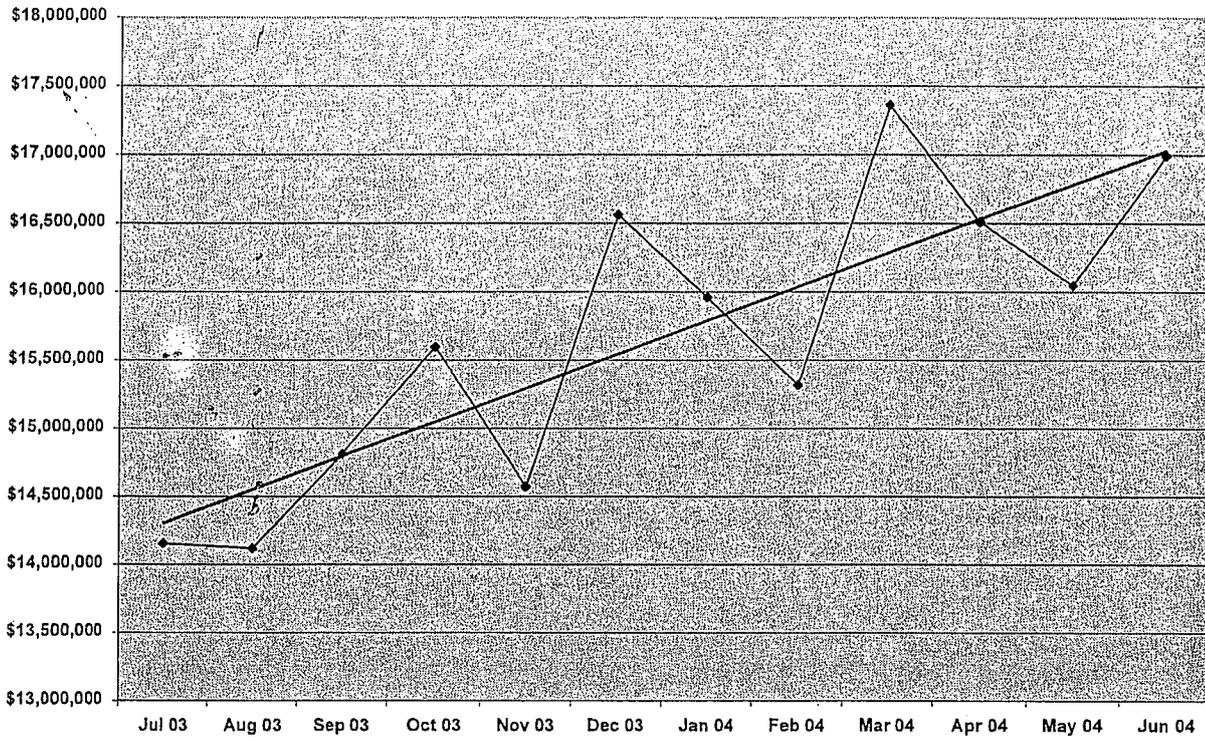
JULY 05 to JUNE 06



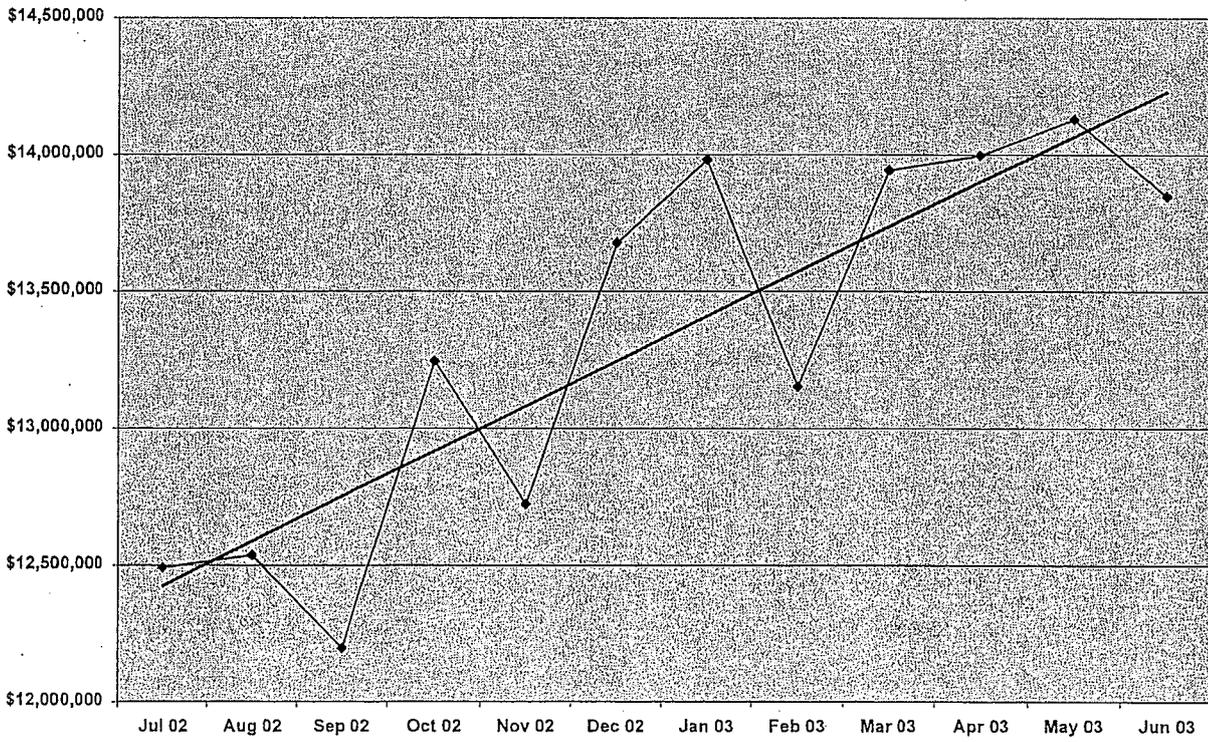
JULY 04 to JUNE 05



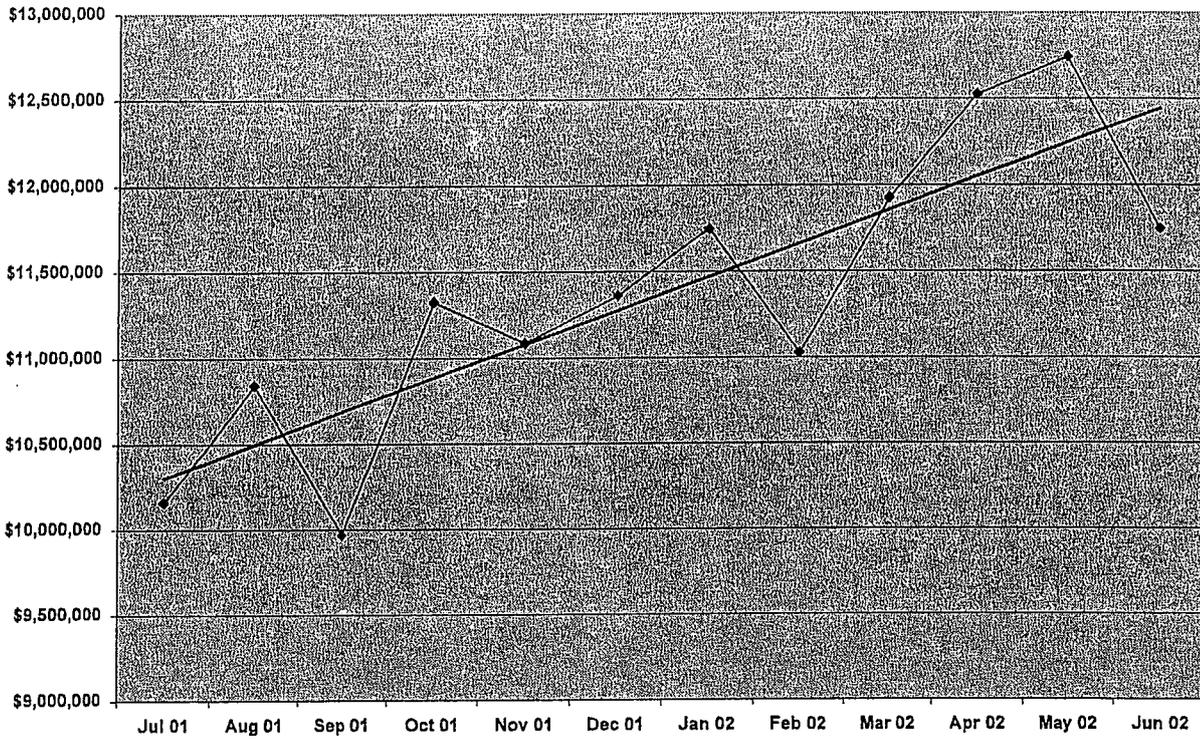
JULY 03 to JUNE 04



JULY 02 to JUNE 03



JULY 01 to JUNE 02



APPENDIX B

Utah Medicaid Drug Regimen Review Center (DRRC)
 TOP 10 Patients - 90 Day Followup Report for January 2006

DRUG RELATED PROBLEM DETAIL

Patient 1

DRUG RELATED PROBLEM	DESCRIPTION	PRESENT AT FOLLOW-UP
Consider Therapeutic Alternative	Nexium	YES
Consider Therapeutic Alternative	depakote	YES
Consider Therapeutic Alternative	Oxytrol	YES
Consider Therapeutic Alternative	Ambien	YES
Drug Interaction	Lipitor/Nexium	YES
Streamline Therapy	mirtazapine	NO
Streamline Therapy	levothyroxine	YES
Therapeutic Duplication	muscle relaxants	NO
Treatment Without Indication	multiple RX	YES

Patient 2

DRUG RELATED PROBLEM	DESCRIPTION	PRESENT AT FOLLOW-UP
Consider Therapeutic Alternative	Nexium	YES
Consider Therapeutic Alternative	Skelaxin	YES
Excessive Duration of Therapy	promethazine	YES
Treatment Without Indication	asthma medications	YES
Untreated Indication	osteoporosis/no calcium	YES

Patient 3

DRUG RELATED PROBLEM	DESCRIPTION	PRESENT AT FOLLOW-UP
Consider Therapeutic Alternative	Mobic	YES
Coordinate Care	antihyperlipidemics	NO
Coordinate Care	psych	NO
Streamline Therapy	statin plus Zetia	YES
Therapeutic Duplication	benzodiazepines	NO
Therapeutic Duplication	anxiolytics	NO

Patient 4

DRUG RELATED PROBLEM	DESCRIPTION	PRESENT AT FOLLOW-UP
Consider Therapeutic Alternative	Prevacid	NO
Coordinate Care	hydrocodone	YES
Coordinate Care	oxycodone	NO
Drug Disease Interaction	bupropion/seizures	NO
Drug Interaction	tramadol/Paxil/cyclobenzaprine	NO
Streamline Therapy	Paxil	NO

Patient 5

DRUG RELATED PROBLEM	DESCRIPTION	PRESENT AT FOLLOW-UP
Consider Therapeutic Alternative	Nasonex	NO
Consider Therapeutic Alternative	Skelaxin	YES
Consider Therapeutic Alternative	Univasc	YES

Consider Therapeutic Alternative (Superior)	senna	NO
Drug Disease Interaction	pseudoephedrine/hypertension	NO
Therapeutic Duplication	gastric acid suppressants	YES

Patient 6

DRUG RELATED PROBLEM	DESCRIPTION	PRESENT AT FOLLOW-UP
Consider Therapeutic Alternative	Prevacid	YES
Therapeutic Duplication	anxiolytics	YES
Therapeutic Duplication	antidepressants	YES
Untreated Indication	history of myocardial infarction/no beta blocker	YES

Patient 7

DRUG RELATED PROBLEM	DESCRIPTION	PRESENT AT FOLLOW-UP
Consider Therapeutic Alternative	Prevacid	NO
Consider Therapeutic Alternative	Seroquel	YES
Coordinate Care	all	YES
Streamline Therapy	albuterol/ipratropium	YES
Therapeutic Duplication	mast cell stabilizers	YES

Utah Medicaid Drug Regimen Review Center (DRRC)
 TOP 10 Patients - 90 Day Followup Report for February 2006

DRUG RELATED PROBLEM DETAIL

Patient 1

DRUG RELATED PROBLEM	DESCRIPTION	PRESENT AT F-UP
Consider Therapeutic Alternative (Equivalent)	Xopenex	NO
Consider Therapeutic Alternative (Equivalent)	omeprazole	NO
Coordinate Care	narcotic analgesics	NO
Drug-Disease Interaction	alprazolam/sleep apnea	YES

Patient 2

DRUG RELATED PROBLEM	DESCRIPTION	PRESENT AT F-UP
Consider Therapeutic Alternative (Equivalent)	Detrol LA	YES
Coordinate Care	pain medications	NO
Coordinate Care	cardiovascular medications	NO
Streamline Therapy	metformin	YES
Untreated Indication	diabetes/no asa	YES

Patient 3

DRUG RELATED PROBLEM	DESCRIPTION	PRESENT AT F-UP
Coordinate Care	antidepressants	NO
Drug-Drug Interaction	fluoxetine/amitriptyline	NO
Streamline Therapy	Seroquel	YES
Therapeutic Duplication	antineuropathic pain medications	NO
Untreated Indication	hyperlipidemia	YES
Untreated Indication	CHF	YES

Patient 4

DRUG RELATED PROBLEM	DESCRIPTION	PRESENT AT F-UP
Coordinate Care	trazodone	NO
Coordinate Care	quick-relief bronchodilators	NO
Streamline Therapy	albuterol/ipratropium	NO
Therapeutic Duplication	albuterol-containing products	NO

Patient 5

DRUG RELATED PROBLEM	DESCRIPTION	PRESENT AT F-UP
Consider Therapeutic Alternative (Equivalent)	Ambien	NO
Consider Therapeutic Alternative (Equivalent)	Prevacid	YES
Consider Therapeutic Alternative (Equivalent)	Univasc	NO
Therapeutic Duplication	Pepcid/Prevacid	YES
Untreated Indication	diabetes/no statin	NO
Untreated Indication	diabetes/no aspirin	YES

Patient 6

DRUG RELATED PROBLEM	DESCRIPTION	PRESENT AT F-UP
----------------------	-------------	-----------------

Consider Therapeutic Alternative (Equivalent)	Zocor	NO
Consider Therapeutic Alternative (Equivalent)	Flonase	NO
Consider Therapeutic Alternative (Equivalent)	omeprazole	YES
Drug-Drug Interaction	Zocor/Tricor	NO
Streamline Therapy	Lexapro	NO
Treatment Without an Indication	Lyrice	NO

Patient 7

DRUG RELATED PROBLEM	DESCRIPTION	PRESENT AT F-UP
Additive Toxicity	QT prolonging medications	NO
Therapeutic Duplication	antipsychotics	NO

Utah Medicaid Drug Regimen Review Center (DRRC)
TOP 10 Patients - 90 Day Followup Report for March 2006

DRUG RELATED PROBLEM DETAIL

Patient 1

DRUG RELATED PROBLEM	DESCRIPTION	PRESENT AT F-UP
ConsiderAlt(Equiv)	Duragesic	YES
ConsiderAlt(Equiv)	Nexium	NO
CoordCare	short-acting opiates	NO
CoordCare	muscle relaxants	NO
DrugDrug	tramadol + fluoxetine	NO
ExcessDur	cyclobenzaprine	YES
ExcessDur	guaifenesin-pseudoephedrine	YES
DupTher	alprazolam + clonazepam	YES
UntreatedIndication	unopposed estrogen	NO
UntreatedIndication	opioids, no stimulant laxative	YES
Other	fluoxetine 40mg capsule strength	NO

Patient 2

DRUG RELATED PROBLEM	DESCRIPTION	PRESENT AT F-UP
ConsiderAlt(Equiv)	Prevacid	YES
ConsiderAlt(Equiv)	Zocor	YES
ConsiderAlt(Equiv)	Mavik	YES
Streamline	gabapentin	YES
DupTher	albut+maxair	YES
DupTher	prednisone+advair	YES

Patient 3

DRUG RELATED PROBLEM	DESCRIPTION	PRESENT AT F-UP
ConsiderAlt(Equiv)	Diabetes meds (metformin, insulin)	NO
DrugDz	edema + Actos	YES
DrugDz	obesity + cyproheptadine	YES
DupTher	Starlix + glimepiride (2 secretagogues)	YES
UntreatedIndication	diabetes, no statin	YES
Other	excess diabetes test strips	YES

Patient 4

DRUG RELATED PROBLEM	DESCRIPTION	PRESENT AT F-UP
ConsiderAlt(Equiv)	lexapro	NO
DrugDrug	tramadol + multiple meds	NO
DupTher	furosemide + hydrochlorothiazide	YES
DupTher	multiple anti-psychotics	YES
UntreatedIndication	asthma / no albuterol	YES

Patient 5

DRUG RELATED PROBLEM	DESCRIPTION	PRESENT AT F-UP
AddTox	warfarin/plavix	NO
DrugDrug	digoxin/diazepam	NO
DupTher	warfarin / plavix	NO
DupTher	allergy	NO
DupTher	omeprazole [NA]	YES

UntreatedIndication	diabetes/no statin	YES
UntreatedIndication	CHF, no ACE or BB	YES

Patient 6

DRUG RELATED PROBLEM	DESCRIPTION	PRESENT AT F-UP
ConsiderAlt(Equiv)	Ambien	NO
ConsiderAlt(Equiv)	Zocor	YES
CoordCare	benzodiazepines	NO
CoordCare	warfarin	NO
CoordCare	hypnotics	NO
CoordCare	calcium-channel blockers	NO
DrugDrug	tramadol+paroxetine	NO
DrugDrug	paroxetine+trazodone	YES
DrugDrug	Effexor+tramadol	NO
DrugDrug	Zocor+verapamil	NO
Streamline	Coreg	NO
Streamline	lisinopril	NO
Streamline	paroxetine	NO
Streamline	Effexor	NO
DupTher	ACE-inhibitors	YES
DupTher	calcium channel blockers	NO
DupTher	benzodiazepines	NO
DupTher	betablockers	YES

Patient 7

DRUG RELATED PROBLEM	DESCRIPTION	PRESENT AT F-UP
AddTox	citalopram/tramadol	YES
ConsiderAlt(Equiv)	Prevacid	YES
DupTher	pain medications	YES
DupTher	gastric-acid suppressants	YES

APPENDIX C

TOTAL FOR ALL REVIEWED PATIENTS ELIGIBLE AND UTILIZING RX BENEFITS ENTIRE REPORTING PERIOD - NO INCREASE IN COSTS ASSUMED

	Jul 05	Aug 05	Sep 05	Oct 05	Nov 05	Dec 05	Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	TOTAL	PROJECTED	SAVINGS
Jul 05	243,706	244,395	217,653	204,470	219,039	226,326	153,572	130,789	131,688	125,725	131,515	130,922	2,159,800	2,924,472	764,672
Aug 05	147,241	147,241	129,686	125,350	125,654	136,084	75,152	59,476	78,080	66,592	75,169	64,740	1,083,424	1,619,651	536,227
Sep 05			117,271	103,861	106,394	110,614	66,362	62,724	65,510	58,401	61,880	56,574	809,591	1,172,710	363,119
Oct 05				142,262	124,960	129,406	76,751	71,670	76,200	65,883	75,565	68,044	830,641	1,280,358	449,717
Nov 05					145,509	124,483	68,080	61,174	58,805	59,486	56,136	52,512	626,185	1,164,072	537,887
Dec 05						112,002	63,126	64,399	66,015	60,458	71,119	64,861	501,980	784,014	282,034
Jan 06							225,107	187,588	205,712	191,163	201,799	197,824	1,209,193	1,350,642	141,449
Feb 06								249,310	238,209	234,863	238,369	231,909	1,192,660	1,246,550	53,890
Mar 06									217,519	174,168	187,804	184,530	764,021	870,076	106,055
Apr 06										219,746	213,278	211,528	644,552	659,238	14,686
May 06											199,971	173,092	373,063	399,942	26,879
Jun 06												201,863			
													10,195,110	13,471,725	3,276,615

PATIENTS 146 136 122 134 120 96 191 224 193 204 182 207
 Total number from each monthly review cohort remaining eligible for AND-utilizing prescription drug benefits during the entire 12-month reporting period.

AVERAGE PER PATIENT

	Jul 05	Aug 05	Sep 05	Oct 05	Nov 05	Dec 05	Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	TOTAL	PROJECTED	SAVINGS
Jul 05	1,669	1,674	1,491	1,400	1,500	1,550	1,052	896	902	861	901	897	14,793	20,031	5,237
Aug 05		1,083	954	922	925	1,001	553	437	574	490	553	476	7,966	11,909	3,943
Sep 05			961	851	872	907	544	514	537	479	507	464	6,636	9,612	2,976
Oct 05				1,062	932	966	573	535	569	492	564	508	6,199	9,555	3,356
Nov 05					1,213	1,037	567	510	490	496	468	438	5,218	9,701	4,482
Dec 05						1,167	658	671	688	630	741	676	5,229	8,167	2,938
Jan 06							1,179	982	1,077	1,001	1,057	1,036	6,331	7,071	741
Feb 06								1,113	1,063	1,048	1,064	1,035	5,324	5,565	241
Mar 06									1,127	902	973	956	3,959	4,508	550
Apr 06										1,077	1,045	1,037	3,160	3,232	72
May 06											1,099	951	2,050	2,197	148
Jun 06												975			
													66,865	91,548	24,683

TOTAL FOR ALL REVIEWED PATIENTS ELIGIBLE AND UTILIZING RX BENEFITS ENTIRE REPORTING PERIOD - 10% INCREASE IN COSTS ASSUMED

	Jul 05	Aug 05	Sep 05	Oct 05	Nov 05	Dec 05	Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	TOTAL	PROJECTED	SAVINGS
Jul 05	243,706	244,395	217,653	204,470	219,039	226,326	153,572	130,789	131,688	125,725	131,515	130,922	2,159,800	3,192,549	1,032,749
Aug 05		147,241	129,686	125,350	125,854	136,084	75,152	59,476	78,080	66,592	75,169	64,740	1,083,424	1,766,892	683,468
Sep 05			117,271	103,861	106,394	110,614	66,362	62,724	65,510	58,401	61,880	56,574	809,591	1,278,254	468,663
Oct 05				142,262	124,860	129,406	76,751	71,670	76,200	65,883	75,565	68,044	830,641	1,394,168	563,527
Nov 05					145,509	124,483	68,080	61,174	58,805	59,486	56,136	52,512	626,185	1,265,928	639,743
Dec 05						112,002	63,126	64,399	66,015	60,458	71,119	64,861	501,980	851,215	349,235
Jan 06							225,107	187,588	205,712	191,163	201,799	197,824	1,209,193	1,463,196	254,003
Feb 06								249,310	238,209	234,863	238,369	231,909	1,192,660	1,346,274	153,614
Mar 06									217,519	174,168	187,804	184,530	764,021	935,332	171,311
Apr 06										219,746	213,278	211,528	644,552	703,187	58,635
May 06											199,971	173,092	373,063	419,939	46,876
Jun 06												201,863			
													10,195,110	14,616,933	4,421,823

PATIENTS 146 136 122 134 120 96 191 224 193 204 182 207
 Total number from each monthly review cohort remaining eligible for AND utilizing prescription drug benefits during the entire 12-month reporting period

AVERAGE PER PATIENT

	Jul 05	Aug 05	Sep 05	Oct 05	Nov 05	Dec 05	Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	TOTAL	PROJECTED	SAVINGS
Jul 05	1,569	1,674	1,491	1,400	1,500	1,550	1,052	896	902	861	901	897	14,793	21,867	7,074
Aug 05		1,083	954	922	925	1,001	553	437	574	490	553	476	7,966	12,992	5,026
Sep 05			961	851	872	907	544	514	537	479	507	464	6,636	10,477	3,841
Oct 05				1,062	932	966	573	535	569	492	564	508	6,199	10,404	4,205
Nov 05					1,213	1,037	567	510	490	496	468	438	5,218	10,549	5,331
Dec 05						1,167	658	671	688	630	741	676	5,229	8,867	3,638
Jan 06							1,179	982	1,077	1,001	1,057	1,036	6,331	7,661	1,330
Feb 06								1,113	1,063	1,048	1,064	1,035	5,324	6,010	686
Mar 06									1,127	902	973	956	3,959	4,846	888
Apr 06										1,077	1,045	1,037	3,160	3,447	287
May 06											1,099	951	2,050	2,307	258
Jun 06												975			
													66,865	99,428	32,563

TOTAL FOR ALL REVIEWED PATIENTS ELIGIBLE AND UTILIZING RX BENEFITS ENTIRE REPORTING PERIOD - 15% INCREASE IN COSTS ASSUMED

	Jul 05	Aug 05	Sep 05	Oct 05	Nov 05	Dec 05	Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	TOTAL	PROJECTED	SAVINGS
Jul 05	243,706	244,395	217,653	204,470	219,039	226,326	153,572	130,789	131,688	125,725	131,515	130,922	2,159,800	3,326,587	1,166,787
Aug 05		147,241	129,686	125,350	125,854	136,094	75,152	59,476	78,090	66,592	75,169	64,740	1,083,424	1,840,513	757,089
Sep 05			117,271	103,861	106,394	110,614	66,362	62,724	65,510	58,401	61,880	56,574	809,591	1,331,026	521,435
Oct 05				142,262	124,860	129,406	76,751	71,670	76,200	65,883	75,565	68,044	830,641	1,451,072	620,431
Nov 05					145,509	124,493	68,080	61,174	58,805	59,486	56,136	52,512	626,185	1,316,856	690,671
Dec 05						112,002	63,126	64,399	66,015	60,458	71,119	64,861	501,980	884,816	382,836
Jan 06							225,107	187,588	205,712	191,163	201,799	197,824	1,209,193	1,519,472	310,279
Feb 06								249,310	238,209	234,863	238,369	231,909	1,192,660	1,396,136	203,476
Mar 06									217,519	174,168	187,804	184,530	764,021	967,960	203,939
Apr 06										219,746	213,278	211,528	644,552	725,162	80,610
May 06											199,971	173,092	373,063	429,938	56,875
Jun 06												201,863			
													10,195,110	15,189,537	4,994,427

PATIENTS 146 136 122 134 120 96 191 224 193 204 182 207
 Total number from each monthly review cohort remaining eligible for AND, utilizing prescription drug benefits during the entire 12 month reporting period.

AVERAGE PER PATIENT

	Jul 05	Aug 05	Sep 05	Oct 05	Nov 05	Dec 05	Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	TOTAL	PROJECTED	SAVINGS
Jul 05	1,669	1,674	1,491	1,400	1,500	1,550	1,052	896	902	861	901	897	14,793	22,785	7,992
Aug 05		1,083	954	922	925	1,001	553	437	574	490	553	476	7,966	13,533	5,567
Sep 05			961	851	872	907	544	514	537	479	507	464	6,636	10,910	4,274
Oct 05				1,062	932	966	573	535	569	492	564	508	6,199	10,829	4,630
Nov 05					1,213	1,037	567	510	490	496	468	438	5,218	10,974	5,756
Dec 05						1,167	658	671	688	630	741	676	5,229	9,217	3,988
Jan 06							1,179	982	1,077	1,001	1,057	1,036	6,331	7,955	1,624
Feb 06								1,113	1,063	1,048	1,064	1,035	5,324	6,233	908
Mar 06									1,127	902	973	956	3,959	5,015	1,057
Apr 06										1,077	1,045	1,037	3,160	3,555	395
May 06											1,099	951	2,050	2,362	312
Jun 06												975			
													66,865	103,368	36,503

Attachment 3

ATTACHMENT 3-1 FY2006 ANNUAL REPORT
Utah

 Targeted Child Patient Report by Quality Indicator
Child Interventions January 2006 - September 2006

Quality Indicator	Total Patients Targeted Prior to this Mailing	Average Number of Days Targeted for QI	Number No Longer Targeted for QI	Number Still Targeted for QI	Number No Longer Flagged for QI	Number Newly Targeted this Month	Percent Change
Use of Benzodiazepines for 60 or More Days (Under 18 Years)	127	75	84	43	73	25	66%
Use of Opiates for 45 or More Days (Under 18 Years)	20	41	16	4	14	0	80%
Use of 2 or More Atypicals and a Stimulant or ADHD Non-Stimulant for 30 or More Days (Under 18 Years)	67	76	39	28	38	8	58%
Use of 2 or More SSRIs for 60 or More Days (Under 18 Years)	1	30	1	0	1	0	100%
Use of 3 or More Psychotropics for 90 or More Days (6-12 Years)	128	67	86	42	83	27	67%
Use of 4 or More Psychotropics for 90 or More Days (6-12 Years)	28	63	23	5	23	-8	82%
Use of 3 or More Psychotropics for 90 or More Days (Under 6 Years)	1	0	0	1	0	3	0%
Use of 2 or More Antipsychotics for 45 or More Days (Under 18 Years)	157	75	80	77	71	21	51%
Multiple Prescribers of Any Psychotropic Drug for 45 or More Days (Under 18 Years)	432		329	103	329	85	
Overall Unique Count of Patients	730		481	249	442	159	76%

Note: Numbers exclude patients hitting these indicators for the first time this month



ATTACHMENT 3-2 FY2006 ANNUAL REPORT

Utah
 Targeted Child Prescriber Change Report by Quality Indicator
 Child Interventions January 2006 - September 2006

Quality Indicator	Total Prescribers Targeted Prior to this Mailing	Average Number of Days Targeted for QI	Number No Longer Targeted for QI	Number Still Targeted for QI	Number No Longer Targeted for QI	Number Newly Targeted this Month	Percent Change	Percent Change with Newly Targeted
Use of Benzodiazepines for 60 or More Days (Under 18 Years)	78	73	52	26	52	11	67%	58%
Use of Opiates for 45 or More Days (Under 18 Years)	18	41	16	2	16	0	89%	89%
Use of 2 or More Atypicals and a Stimulant or ADHD Non-Stimulant for 30 or More Days (Under 18 Years)	31	108	16	15	16	1	52%	50%
Use of 2 or More SSRIs for 60 or More Days (Under 18 Years)	1	30	1	0	1	0	100%	100%
Use of 3 or More Psychotropics for 90 or More Days (6-12 Years)	42	68	25	17	25	8	60%	50%
Use of 4 or More Psychotropics for 90 or More Days (6-12 Years)	8	42	5	3	5	3	63%	45%
Use of 3 or More Psychotropics for 90 or More Days (Under 6 Years)	1	0	0	1	0	0	0%	0%
Use of 2 or More Antipsychotics for 45 or More Days (Under 18 Years)	42	104	21	21	21	2	-50%	48%
Multiple Prescribers of Any Psychotropic Drug for 45 or More Days (Under 18 Years)	399	76	271	128	271	45		
Overall Unique Count of Prescribers	426		281	145	328	66	68%	61%

Note: Numbers exclude DNS prescribers who receive no mailings and prescribers hitting these indicators for the first time this month



Utah

Targeted Adult Patient Report by Quality Indicator
 Adult Interventions February, 2006 - August, 2006

Quality Indicator	Total Patients Targeted Prior to this Mailing	Average Number of Days Targeted for QI	Number No Longer Targeted for QI	Number Still Targeted for QI	Number No Longer Flagged for QI	Number Newly Targeted this Month	Percent Change
Use of 2 or More Benzodiazepines for 60 or More Days	101	46	75	26	68	10	74%
Use of 3 or More Opiates for 60 or More Days	8	47	7	1	7	2	88%
Use of 2 or More SSRIs for 60 or More Days	11	47	7	4	7	1	64%
Use of an ADHD Non-Stimulant and 1 or More Stimulants for 60 or More Days	2	59	2	0	2	0	100%
Use of 3 or More Antidepressants for 60 or More Days	15	43	9	6	9	1	60%
Use of 2 or More Antipsychotics for 60 or More Days	381	62	219	162	193	39	57%
Use of 2 or More Atypical Antipsychotics for 60 or More Days	307	60	186	121	165	35	61%
Use of 5 or More Psychotropics for 60 or More Days	273	55	169	104	154	24	62%
Use of 2 or More Insomnia Agents for 60 or More Days	74	54	44	30	41	19	59%
Multiple Prescribers of Any Antipsychotic for 45 Days or More	79	45	56	23	54	13	71%
Multiple Prescribers of the Same Class of Psychotropic Drug for 45 or More Days	325	51	232	93	229	73	71%
Multiple Prescribers of 1 or More Opiates for 30 or More Days	224	39	190	34	190	61	85%
Use of an Atypical Antipsychotic at a Higher Than Recommended Dose for 45 or More Days	232	57	133	99	124	27	57%
Use of 2 or More Atypicals Both at a Lower Than Recommended Dose for 60 or More Days	3	70	3	0	3	0	100%
Overall Unique Count of Patients	1246		814	432	746	246	

Note: Numbers exclude patients hitting these indicators for the first time this month



Utah

Targeted Adult Prescriber Change Report by Quality Indicator
 Adult Interventions February, 2006 - August, 2006

Quality Indicator	Total Prescribers Targeted Prior to this Mailing	Average Number of Days Targeted for QI	Number No Longer Targeted for QI	Number Still Targeted for QI	Number No Longer Flagged for QI	Number Newly Targeted this Month	Percent Change
Use of 2 or More Benzodiazepines for 60 or More Days	56	50	41	15	41	7	73%
Use of 3 or More Opiates for 60 or More Days	7	50	6	1	6	2	86%
Use of 2 or More SSRIs for 60 or More Days	11	47	7	4	7	1	64%
Use of an ADHD Non-Stimulant and 1 or More Stimulants for 60 or More Days	2	59	2	0	2	0	100%
Use of 3 or More Antidepressants for 60 or More Days	14	60	8	6	8	1	57%
Use of 2 or More Antipsychotics for 60 or More Days	89	64	36	53	36	6	40%
Use of 2 or More Atypical Antipsychotics for 60 or More Days	79	60	33	46	33	6	42%
Use of 5 or More Psychotropics for 60 or More Days	92	60	43	49	43	7	47%
Use of 2 or More Insomnia Agents for 60 or More Days	45	56	23	22	23	11	51%
Multiple Prescribers of Any Antipsychotic for 45 Days or More	79	47	49	30	49	10	62%
Multiple Prescribers of the Same Class of Psychotropic Drug for 45 or More Days	430	53	291	139	291	67	68%
Multiple Prescribers of 1 or More Opiates for 30 or More Days	386	49	296	90	296	66	77%
Use of an Atypical Antipsychotic at a Higher Than Recommended Dose for 45 or More Days	86	84	31	55	31	9	36%
Use of 2 or More Atypicals Both at a Lower Than Recommended Dose for 60 or More Days	3	70	3	0	3	0	100%
Overall Unique Count of Prescribers:	777		513	264	618	175	

Note: Numbers exclude DNS prescribers who receive no mailings and prescribers hitting these indicators for the first time this month