State of Utah
Department of Health
Division of Health Care Financing

Fiscal Year 2008 Drug Utilization Review (DUR) Annual Report

December 1, 2008

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 began shortly after passage of the legislation in the 2007 session, and actual implementation began October 1, 2008. Fiscal Year 2008 (FY08) was the second complete year of the Medicare Part D program operation of prescription benefits to the dual eligible population. This has had an impact on all aspects of the program. 267,378 eligible clients were enrolled in the program. This figure includes approximately 23,000 dual eligible clients, and represents a total decrease of 7,332 from FY07. There were approximately 244,378 non-dual clients enrolled in the program.

Total paid drug claims increased $3.5 million to $139,884,203. The new State Phased Down Contributions (aka "Clawback") totaled $21,992,207 bringing total program expense to $161,876,410. The average cost of a prescription rose 5.5% to $66.65. The average price of a brand name drug rose 5.67% to $161.90. The average generic drug cost increased 1.25% to $27.31. The total prescription volume was 2,098,892 down from 2,160,456 the previous year.

Mental health drugs continue to account for over 36% of all drug expenditures. The atypical antipsychotics, the number one drug class ranked by cost, accounted for $23.8 million. Antidepressant medications account for another $10 million, and the anticonvulsant medications, with continued increase in mental health uses, totaled an additional $17 million. Direct-to-consumer marketing by the Drug Manufacturers drives market share and increases use and 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 achieved at least $1.04 million in savings for FY08 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 focused on mental health drugs through the first half of FY2008. The program offered physician-to-physician consultations and sent out letters to physicians whose prescribing patterns were monitored by a criteria driven computer program. The program demonstrated small changes in prescribing patterns with commensurate improvements in 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 also been instrumental in improving healthcare outcomes and is directly responsible for influencing savings through various measures that make better use of available resources.

TABLE OF CONTENTS

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 clients with eligibility in both the Medicare and the Medicaid programs, the so-called Dual Eligible (DE) clients, obtain their medications through the Medicare Part-D program. As a result, FY08 is the second complete year without DE expenditures. Consequently due to Part-D, all aggregate totals have decreased, yet the Federal Government still requires the State to pay a portion of the costs associated with the DE clients that now receive drug benefits through the new Part-D Medicare Drug Plan. This portion has come to be known as the "Clawback."

Total drug spending totaled $139,884,203* for State Fiscal Year 2008 (FY08). "Clawback" payments for FY08 totaled $21,992,207, bringing total expenditures to $161,876,410. The total number of eligible clients decreased from 274,710 to 267,378 or 2.7%. This represents a reversal from recent years where the number of eligible clients has steadily increased. The Utah economy during FY08 may be responsible for some of the decline. The good economy meant that some members left the program with improving employment opportunities. Since the number of DE clients (~23,000) has remained about the same, the declines are mostly attributable to the non-dual population. The number of recipients (those receiving prescriptions) decreased from 175,861 to 169,697 (3.5%). In spite of these declines, spending rose from $775.72 per recipient per year (PRPY) to $824.32, an increase of $48.60 (6.3%). Costs continue to increase for those Medicaid clients using prescription drugs.

Medicaid paid for 2,098,892 prescriptions. This is a decrease of 2.8% compared to FY07. The average cost per prescription increased by $3.50, a rise of 5.5%. This increase in per prescription cost amounts to $7,394,032 and accounts for all of the expenditure increase from FY07.

The average price of a generic drug prescription increased 1.25% to $27.31. Average brand name prescription prices rose 5.67% to $161.90, an increase of $8.69 per prescription. The Pharmacy Practice Act mandates the use of generics in the Medicaid drug program. Overall the number of generic prescriptions decreased 3.3%, while the percentage of generic use among all prescriptions decreased 0.3% to 61.8% from FY07. Each 1% shift in generic usage equates to approximately $1.4 million.

II. RETURN ON INVESTMENT

Drug Rebates

A. **Primary Rebate -** Drug rebates from the manufacturers continue to be the most significant savings to the drug program. All rebates go back into the State general fund and are shared with the Federal Government. The total primary rebate collected from 1994 through 2008 Calendar Year to Date (CYTD) exceeds $380,000,000*. Including the recent billings for the third quarter of calendar year 2008 (CY08), there are approximately $11,732,298 in outstanding uncollected rebates.

B. **J-Code Rebates**- Since 2005, the Division has retroactively billed manufacturers back to 1997 for J-Code rebates to comply with CMS directives. J-codes are Health Care Procedure Coding System (HCPCS) codes used by providers in the office setting to bill for drugs administered in the physician's office. The total J-Code rebates collected for years 1997 through CYTD08 exceed $1,066,000*. There is $319,503 in outstanding uncollected J-Code rebates through the third quarter of CY08.

C. **340B Rebates**- The Division has had an arrangement with the 340B covered entities under the University of Utah Hospital System whereby the covered pharmacies remit back to the State a rebate equivalent to the difference between amounts reimbursed and their 340B price. Since it is illegal for the State to collect a rebate on drugs reimbursed at 340B prices, this system was set up to take advantage of 340B pricing and avoid duplicate savings. Primary rebates are not invoiced for drugs reimbursed under this system. The total 340B rebate collected from 2005 through CYTD08 is $4,700,409*.

D. **Supplemental rebates**- The 2007 Utah legislature authorized the Division to begin using a Preferred Drug List tool in its program. Utah joined the Sovereign States Drug Consortium (SSDC) in order to negotiate with drug manufactures for Supplemental Rebates. These rebates are in addition to the primary rebate that drug manufacturer's offer. After safety and efficacy are established through a Pharmacy and Therapeutics Committee (P&T), equally safe and effective drugs in a drug class are categorized as "preferred" or "non-preferred." Manufacturers offer a supplemental rebate to leverage a favorable position in the "preferred" class in exchange for increased market share potential. The total supplemental rebate collected since implementation of the PDL in October, 2007 is $944,069*. There is $850,808 in outstanding uncollected supplemental rebates through the third quarter of CY08.

Table 1 shows rebates collected from 1994 through 2008.

Table 1: Drug Rebate by Calendar Year*

Calendar Year	Primary	J-code	340B Rebates	Supplemental
94 - 96	$28,132,819.95			
1997	$10,110,798.78	$121.05		
1998	$14,373,330.30	$2,403.68		
1999	$17,945,046.43	$5,398.62		
2000	$20,985,756.25	$15,577.31		
2001	$24,844,881.66	$13,751.20		
2002	$29,282,179.41	$54,705.52		
2003	$35,140,270.65	$127,097.35		
2004	$44,699,248.29	$176,054.90		
2005	$52,680,651.08	$188,957.55	$1,301,963.03	
2006	$32,531,917.61	$190,704.24	$1,558,105.65	
2007	$38,213,411.70	$193,278.16	$1,437,433.18	$141,446.96
2008YTD	$21,249,674.62	$98,602.97	$402,907.21	$802,622.10
Totals	**$370,189,986.73**	**$1,066,652.55**	**$4,700,409.07**	**$944,069.06**

* All dollar amounts shown include both state and federal dollars unless otherwise noted!
Figures since FY2006 are lower due to the exodus of dual eligible clients from the program
Figures will differ from previous years due to manufacturer adjustments

Prior Authorization

The legislative mandate for the use of generic vs. brand name drugs has been cost effective. Brand name drugs for which a generic is available require prior authorization (PA). As mentioned previously each additional 1% in generic usage means approximately $1.4 million in savings.

Prior authorizations are also used to control duplicate therapies, or inappropriate and excessive use of medications. The Omnibus Budget Reconciliation Act (OBRA) laws give states the authority to use a prior authorization with any covered medication. Often these medications are very expensive. By legislative statute and legislative mandate, Utah limits non-generic/brand prior authorizations to clinical applications, and excludes mental health drugs from regulation by a PA. In FY08, there were approximately 10,700 prior authorizations issued.

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

Drug Regimen Review Center

The University Of Utah, College of Pharmacy's Drug Regimen Review Center (DRRC) began reviewing high utililizers of the Medicaid drug program in 2002. Based on paid drug claim history, the DRRC contacts physicians for identified Medicaid clients and performs educational "peer reviews" of these targeted clients. The goal is to reduce waste, duplication and unnecessary, inappropriate prescription utilization. The program has been well received by providers and clients. As of June 30, 2008 there have been 39,691 letters sent to 9,729 prescribers with recommendations concerning 12,306 Medicaid clients. For FY08, it appears that the DRRC program achieved at least $1,039,457 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/year. ***Attachment 1*** is the FY08 report from the DRRC.

Behavior Pharmacy Management System

The Division ended a program known as the Behavioral Health Pharmacy Management System (BPMS) Program which was administered by Comprehensive Neuroscience, Inc. in December 2007. This program began operation in March 2004 and 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 provided physician to physician consultation with targeted physicians to provide benefit from their expertise.

BPMS reviewed and analyzed Medicaid paid drug claim history for behavioral health medications and compared these claims against a series of best practices quality indicators. Some of the key quality indicators were:

- 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 achieved an overall positive response to the program. For those prescribers receiving notification of prescribing patterns that were at variance with best practice guidelines, there were some changes in prescribing practices that were more consistent with these guidelines.

One key indicator was "Multiple Prescribers of the same class of psychotropic drug for 45 days or more." All prescribers who wrote scripts for behavioral health drugs received notification if their patient was also receiving prescriptions in the same class of drugs from another prescriber. For example, during February 2007, 1,219 letters were mailed out regarding various indicators that had been activated for adult and child clients. Mailings were temporarily halted after that time due to a federally commissioned analysis of the program to determine its effectiveness, and change data were not immediately updated. Mailings were later

undertaken anew with an improved methodology. Reductions in the number of outliers for this indicator suggest a willingness of prescribers to modify their practices when provided with feedback and information about best practices and clinical guidelines. This is important since minimizing the incidences of multiple prescribers is a significant factor in reducing potential toxicity as well as increasing coordination of care. ***Attachment 2*** is the draft summary report for the federal analysis of the program as of July 17, 2008. The final report has not yet been issued.

The BPMS program was paid for by a grant from Eli Lilly and Company. Between the BPMS and DRRC, more than 9,000 retrospective letters were mailed to physicians in an effort to bring prescribing practices more in line with evidence based medicine.

Co-Pay

Co-pays returned $4,605,609 for FY08. Co-pays are collected on prescriptions for recipients in the Primary Care Network program and the Non-traditional Medicaid Program. No co-pays are collected in the traditional program for certain exempt categories of recipients, e.g. children under age 18, pregnant women, some nursing home residents, and family planning prescriptions. **Table 2** shows total co-payments collected to date:

Table 2: Co-Payments Collected

Fiscal year	Amount Returned
FY 1998	$411,472
FY 1999	$833,201
FY 2000	$894,260
FY 2001	$992,320
FY 2002	$1,072,334
FY 2003	$3,286,039
FY 2004	$5,582,844
FY 2005	$5,862,754
FY 2006	$5,000,728
FY 2007	$4,185,931
FY 2008	$4,605,609
Total	$32,727,492

Figures since FY2006 are lower due to the exodus of dual eligible clients from the program

Preferred Drug List

The 2007 Legislature passed a directive authorizing the Division to implement a preferred drug list (PDL) in the Medicaid program. In order to operate a credible, responsible program, the Division created the Pharmacy and Therapeutics Committee (P&T) consisting of competent Pharmacists and Physicians familiar with issues surrounding the use of a PDL. This panel of professional experts was seated and began operation in August, 2007. The P&T committee meets monthly to consider drug classes that favor use in a PDL setting. The committee utilizes the University of Utah, Drug Information Service to screen and summarize data for use in the monthly meeting, and draws heavily upon the work of the Oregon Health & Sciences University evidence-based medicine center for concurrent conclusions.

The charge of the P&T committee is to evaluate the members of a drug class for equivalency in efficacy and safety. Cost is not part of their evaluation. The committee determines whether or not the various drugs in a class are equally safe and effective and then makes recommendations to the Division for PDL implementation. Not all drug classes are candidates for a PDL.

The option to administer the PDL with a prior authorization tool is prohibited. Implementation began with two classes of drugs – the Proton Pump Inhibitor stomach acid reducers and the cholesterol lowering Statins. Additional classes are added each month as the P&T committee deliberates. **Table 3** shows the results of the nine months the PDL was operating in FY08. These figures do not represent a full year for any drug class, and except for the Statins and Proton Pump Inhibitors none represent the full nine months of activity.

Table 3: Preferred Drug List Savings – Nine Months

	Total Funds		
Description	**Actuals**	**Annualized Projections**	**FY 08 Projections**
Market Shift Savings	$756,038	$1,090,032	$756,038
Secondary Rebates	$1,400,329	$2,218,355	$1,400,329
Administrative Expenses	($213,503)	($284,671)	($213,503)
PDL Savings	**$1,942,864**	**$3,023,716**	**$1,942,864**

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 the Division of Health Care Financing office of fiscal operations.

Spending per Medicaid recipient per year increased by $48.60 (6.3%). Even with a decrease in overall recipients, this increase in cost per recipient represents $8,247,274. Rises in spending continue to be due to increased utilization and price increases. **Table 4** shows a summary of the drug program.

Table 4: Drug Program Summary

Fiscal Year	**FY02**	**FY03**	**FY04**	**FY05**	**FY06**	**FY07**	**FY08**
Total Eligibles	249,447	249,745	276,813	286,983	287,559	274,710	267,378
Total Rx Recipients	147,186	174,952	194,067	200,505	196,499	175,861	169,697
Total Rx Claims	2,649,188	2,905,334	3,288,347	3,474,297	2,983,871	2,160,456	2,098,892
Dollars Paid **(in '000s)** (Allwd Chg)	$134,495	$159,547	$183,306	$207,580	$183,029	$136,419	$139,884
% yearly budget increase	18.30%	18.60%	14.90%	13.20%	-11.80%	-25.50%	2.54%
Average Cost/RX	$50.77	$54.92	$55.74	$59.75	$61.34	$63.15	$66.65
% increase in cost/RX	12.00%	8.20%	1.50%	7.20%	2.70%	3.00%	5.54%
Ave. Rx/month per Eligible	0.89	0.97	0.99	1	0.86	0.65	0.65
Ave. Rx/month per recipient	1.5	1.38	1.41	1.44	1.26	1.02	1.03
% change in Rx/Mo. per recipient	-2.40%	-7.70%	2%	2.29%	-12.36%	-19%	1%

Top Twelve Therapeutic Classes

Table 5 shows the top twelve therapeutic classes ranked by cost for FY08. The newest mental health classification, atypical antipsychotics, remains 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 number two. Five of the top twelve drug classes are used for mental health. Bearing that in mind, mental health drug costs account for 36.5% of the total drug costs. The number one class in the atypical antipsychotics, H7T, is made up of a very small group of five drugs. H7X is a single drug category still referred to as an atypical antipsychotic and will continue to be included with H7T. By itself this single drug would rank number eight based on cost. Only six drugs (drug classes H7T and H7X) account for $23.8 million.

Table 5: Top 12 Therapeutic Classes by Cost, and by Volume for FY08

Rank	Cost - FY08	Cost - FY07	% Change from FY07	Drug Class	Rank by Rx Volume FY08	Rank by Rx Volume FY08	Avg. cost/RX for FY08
1	$23,825,031	$20,846,927	14.29%	H7T / H7X ATYPICAL ANTIPSYCHOTICS	8	5	$327.11
2	$17,215,634	$15,418,762	11.65%	H4B ANTICONVULSANTS	2	2	$127.73
3	$9,142,753	$7,740,370	18.12%	H3A NARCOTIC ANALGESICS	1	1	$47.03
4	$6,311,846	$7,219,816	-12.58%	D4J/Z2D ANTI-ULCER/PPI'S	6	6	$82.80
5	$4,653,826	$2,262,752	105.67%	H2V / J5B ADHD / NARCOLEPSY	10	24	$111.37
6	$4,366,208	$5,405,630	-19.23%	H2S ANTIDEPRESSANTS (SSRIs)	3	4	$47.33
7	$3,708,514	$3,354,617	10.55%	H7C SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB.	20	19	$134.68
8	$2,979,352	$2,991,549	-0.41%	M4D/M4E/M4I/M4L/M4M LIPOTROPICS	11	13	$81.00
9	$2,918,043	$3,368,095	-13.36%	M0E HEMOPHILIA FACTOR VIII	209	209	$13,203.82
10	$2,831,729	$2,348,721	20.56%	C4G INSULINS	25	25	$127.72
11	$2,042,653	$2,448,313	-16.57%	H2E SEDATIVE/HYPNOTICS	16	16	$60.99
12	$2,022,707	$2,103,175	-3.83%	H7D NOREPI / DOPAMINE REUPTAKE INHIBITORS	27	26	$103.54

Brand Name vs. Generic

A generic drug is identical to a brand name drug when bio-equivalent in dosage form, safety, strength, route of administration, quality, performance, characteristics and intended use. Although generic drugs are chemically identical to their branded counterparts, they are typically sold at discounts from the branded price. In FY08, the average cost spread between the name brand price and generic was $134.59, an increase of $8.35. The use of generic drugs continues to be the single most important cost saving measure that can be utilized.

Table 6 shows the breakout of dispensing fees and also shows the brand name (B) vs. generic name (G) utilization for prescriptions for FY08. The use of generics decreased 0.28% this past year. This equates to 5,877 prescriptions. All brand name drugs require a PA if there is a generic available. Brand name drugs account for approximately 28.5% of claims while generics account for approximately 61.8% of all claims. OTC and select I.V. drugs make up the rest. Brand name drugs still account for 69.21% of total dollars spent. This small decrease in generic usage cost $790,985.

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

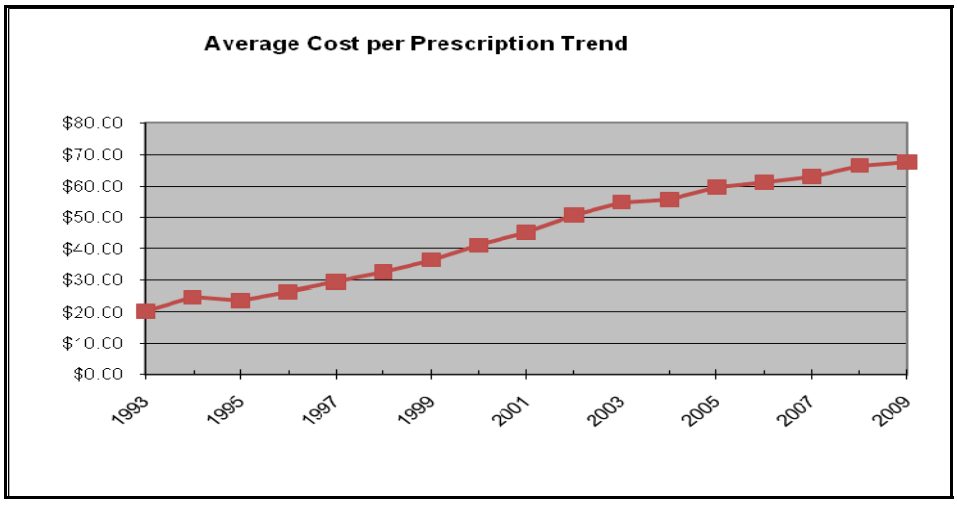
prescriptions. Dispensing fee indicator "C" is for over-the-counter products including insulin.

Table 6: Utilization By Dispensing Fee Indicator

Allowed Dispensing Source	# Rx	% of Rx's	Total Cost	Avg. cost per RX (FY08)	Avg. cost per RX (FY07)	% change for FY08 compared to FY07
Brand	597,997	28.49%	$96,817,946.82	$161.90	$153.21	5.67%
C	197,367	9.40%	$7,177,087.40	$36.36	$33.71	7.88%
F	1,225	0.06%	$3,698.98	$3.02	$3.52	-14.27%
Generic	1,297,511	61.82%	$35,434,579.24	$27.31	$26.97	1.25%
J	671	0.03%	$91,484.52	$136.34	$117.05	16.48%
K	417	0.02%	$137,682.99	$330.18	$976.19	-66.18%
L	1,373	0.07%	$35,543.24	$25.89	$30.14	-14.10%
M	169	0.01%	$642.87	$3.80	$10.86	-64.97%
Other	2162	0.10%	$185,536.97	$85.82	$77.93	10.12%

Figure 1 shows a graphic representation of the increase in prescription prices over the most recent 16 year period.

Figure 1



The 5.5% increase in the average price of a prescription for FY08 continues to reflect a lower increase than customary in past years. This lower rate is mainly to 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 1.7% in the first five months of FY09.)

Clawback

With the Medicare Part-D prescription drug plan, the Federal government requires that the States continue to pay a portion of the costs associated with the prescriptions that are now provided through Medicare Part-D. This portion, called the "State Phased Down Contribution," is remitted on a monthly basis to the Federal Government by what has come to be known as the "Clawback" payment. This payment is calculated monthly based on FY03 eligibility data, and factored per DE clients. **Table 7** contains Calendar Year totals for each month's remittance for the fiscal year. When FY08 Clawback amounts are added to FY08 Medicaid expenditures the total program costs are $161,876,410.

Table 7: State Phased Down Contribution "Clawback"

Period	"Clawback" Amount
Jul 2007	$1,856,745.08
Aug 2007	$1,841,120.20
Sep 2007	$1,838,920.86
Oct 2007	$1,795,139.36
Nov 2007	$1,786,453.66
Dec 2007	$1,784,909.39
Jan 2008	$1,801,573.79
Feb 2008	$1,809,775.62
Mar 2008	$1,806,449.43
Apr 2008	$1,893,766.30
May 2008	$1,890,064.58
Jun 2008	$1,887,288.29
SFY2008 Total	**$21,992,206.56**

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 FY08, the Prospective Drug Utilization Review (PRODUR) program returned $5,454,580 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 than were discontinued (reversed) due to warnings (*Figures for FY08 are the result*

of a twelve month calculated average due to programming problems occurring for some of the months of FY2008. Corrected reports for these months are not available). The PRODUR Program ran against 2,098,892 claims for which 63,402 claims were reversed. More than 27.9% of submitted claims resulted in an adverse drug warning being posted to the pharmacy. Of those claims with warnings, 10.8% were reversed, an increase of 0.6% over the previous year. There continues to be a gradual increase in warnings posted to total claims generated. **Table 8** shows the trend in number of occurrences in the State's PRODUR for just one of the indicators, THERAPEUTIC DUPLICATION, over a ten-year period.

Table 8: PRODUR Therapeutic Duplications

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

Figures since FY2006 are lower due to the exodus of dual eligible clients from the program.

For therapeutic duplication, there was an 8.3% increase in the number of warnings in FY08. Over the seven year period from 1999 through 2005, there was a 64% increase in therapeutic duplication warnings. The departure of the dual eligible Part-D clients accounts for the decrease seen beginning in 2006 and extending through 2007. 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.

In the last three years of the CNS program, RETRODUR 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 41% 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 twelve 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 an appeal option of requesting a formal hearing. To date, only one DUR Board decision has been overturned by a hearing.

During FY08, the DUR Board considered PA recommendations for 12 new drugs, and placed a PA on 8 of those drugs or drug groups. All of these restrictions were placed in order to assure more appropriate utilization of the medications involved. The majority were new product entries which lack historical data to compare against for savings calculations. Savings from previous DUR actions maintain continuous savings benefits.

The DUR Board spent significant time reviewing PA criteria from previous Board actions. Eleven categories were reviewed altogether. Modifications were made to the PA criteria of 9 of those categories; 3 were unchanged. The DUR Board also undertook a review of eleven existing categories including Synagis®, flu medications, wake promoting agents, erythropoetins, opiate analgesics, antiemetics, 2nd generation antihistamines, bladder drugs, Invega®, immunomodulators, and pulmonary hypertensive drugs. Modifications to the PA criteria were made for eight of these, while the Board determined to maintain the current controls in place for 3 of these groups. Policy discussions were held for age limit restrictions, conflict of interest, and pro-drug/metabolic "me-too" drugs.

VI. CONSUMER PRICE INDEX (CPI)

There has been a 5.5% increase in the average cost of prescriptions for Utah Medicaid for the fiscal year 2008 while the federal government cites a 2.9% increase in the CPI for prescription drugs as of July 2008. (The average price of a prescription increased 1.73% in the first five months of FY09 for the Medicaid program.)

The use of more generic drugs contributes to a lower rate of increase for drug

prices. **Table 9** shows CPI for prescription drugs, medical care, and all products for an eleven year period.

Table 9: Consumer Price Index

FISCAL YEAR Jul 1-Jun 30	PRESCRIPTION DRUGS	MEDICAL CARE	ALL ITEMS
1997	2.8	2.7	2.2
1998	3.8	3.4	1.7
1999	5.8	3.3	2
2000	4.2	4.4	3.7
2001	5.7	4.6	2.7
2002	5.3	5.3	1.5
2003	2.7	4.3	2.1
2004	3.5	5.2	3.0
2005	3.5	4.8	3.2
2006	4.3	4.0	4.1
2007	1.4	5.4	2.4
2008YTD	2.9	2.8	3.7

VII. CONCLUSION

The Medicaid Drug program returned more than $30.3 million to the Department when drug rebates, co-pays, preferred drug list, and the College of Pharmacy's DRRC activities are factored in. 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 maintains the largest lowering effect on expenditures. Various tools are used to affect savings to the Medicaid Drug Program while at the same time providing one of the most robust and generous drug benefits in the Nation.

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

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.