Fiscal Year 2009 Drug Utilization Review (DUR)

Annual Report

Prepared by the Division of Medicaid and Health Financing

December 1, 2009

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. On May 18, 2009 was the beginning of the requirement for a Prior Authorization (PA) for non-preferred drugs. Fiscal Year 2009 (FY09) was the third 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. 298,372 eligible clients were enrolled in the program. This figure includes approximately 23,000 dual eligible clients, and represents a total increase of 30,994 from FY08. At that time, there were approximately 272,372 non-dual eligible clients enrolled in the program.

Total paid drug claims increased $1.4 million to $141,281,032. The new State Phased Down Contributions (aka "Clawback") totaled $24,111,111 bringing total program expense to $165,392,143. The average cost of a prescription decreased 4.3 percent to $63.81. The average price of a brand name drug rose 11.7 percent to $180.97. The average generic drug cost decreased 15.4 percent to $23.08. The total prescription volume was 2,213,975 up from 2,098,892 the previous year.

Mental health drugs continue to account for 36 percent of all drug expenditures. The atypical antipsychotics, the number one drug class ranked by cost, accounted for $27 million. Antidepressant medications account for another $8.3 million, and the anticonvulsant medications, with continued increase in mental health uses, totaled an additional $16 million. Direct-to-consumer marketing by the Drug Manufacturers drives market share and increases utilization 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 $2.2 million in savings for FY09 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 DRRC currently reviews 150 cases per month.

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 saving through various measures that make better use of available resources.

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I. INTRODUCTION

The Utah Department of Health, Division of Medicaid and Health Financing's Drug Program continues to show upward trends in both cost and utilization even while the impact of the Medicare Modernization Act has lowered expenditures. Effective January 1, 2006 Medicare clients 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, FY09 is the third 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 $141,281,033* for State Fiscal Year 2009 (FY09). “Clawback” payments for FY09 totaled $24,111,111 bringing total expenditures to $165,392,144. The total number of eligible clients increased from 267,378 to 298,372 or 11.5 percent. This represents a reversal from FY08 but is consistent with FY07 and FY06 where the number of eligible clients steadily increased. The Utah economy during FY09 may be responsible for some of the increase. In FY09 more new members entered the program due to decreased employment opportunities. Since the number of DE clients (~23,000) has remained about the same, the increase is mostly attributable to the non-dual population. The number of recipients receiving prescriptions increased from 169,697 to 177,030 (4.3 percent). In spite of the increase, spending declined from $824.32 per recipient per year (PRPY) to $798.06, a decrease of $26.26 (3.1 percent). Even with the PRPY decrease total expenditures continue to rise for the provision of the Medicaid prescription drug program due to increasing numbers of individuals enrolling in Medicaid each day.

Medicaid paid for 2,213,975 prescriptions up from 2,098,892 in FY08. This is an increase of 5.4 percent from FY08. The average cost per prescription decreased by $2.84, a decrease of 4.3 percent. This decrease in per prescription cost did not out-weigh the increase in number of clients and number of total prescriptions paid. This caused an increase in FY09 expenditures of $1,396,829.

The average price of a generic drug prescription decreased 15.4 percent to $23.08. Average brand name prescription prices rose 11.7 percent to $180.91, an increase of $19.07 per prescription. The Pharmacy Practice Act mandates the use of generics in the Medicaid drug program. Overall, the number of generic prescriptions increased by 3.72 percent and each 1 percent shift in generic usage equates to approximately $3.5 million in savings.

II. RETURN ON INVESTMENT

Drug Rebates

Primary Rebate

Drug rebates from the manufacturers continue to be the most significant savings to the drug program. All rebates go back into the State general fund and are shared with the Federal Government. The total primary rebate collected from 1994 through 2009 Calendar Year to Date (CYTD) approaches $414 million[1] . Including the recent billings for the third quarter of calendar year 2009 (CY09), there are approximately $13.9 million in outstanding rebates.

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 CYTD09 exceed $4.7 million[1]. There are $1.2 million in outstanding J-Code rebates through the third quarter of CY09.

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 CYTD09 is $7 million[1]. There are $550,000 in outstanding 340B rebates through the third quarter of CY09.

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 manufacturers 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

[1] All dollar amounts shown include both state and federal dollars unless otherwise noted.

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 $3.4 million[2]. There are $631,000 in outstanding uncollected supplemental rebates through the third quarter of CY09.

Table 1 shows rebates collected from 1994 through 2009.

Table 1: Drug Rebate by Calendar Year*

Calendar Year	Primary	J-code	340B Rebates	Supplemental
94-96	$25,330,631			
1997	$10,113,474	$121		
1998	$14,406,537	$2,404		
1999	$17,995,186	$5,399		
2000	$21,002,749	$15,589		
2001	$24,847,444	$13,775		
2002	$29,231,950	$54,645		
2003	$35,073,543	$127,062		
2004	$44,616,704	$178,177		
2005	$52,685,511	$526,222	$1,348,350	
2006	$32,508,989	$666,848	$1,547,501	
2007	$37,954,650	$743,317	$1,444,743	$141,272
2008	$42,217,605	$1,137,125	$1,621,478	$2,132,116
2009	$23,205,263	$1,208,517	$1,027,852	1,083,314
Totals	**$413,985,921**	**$4,679,200**	**$6,989,925**	**$3,356,702**

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

Figures since CY2006 are lower due to the exodus of dual eligible clients from the program

Figures will differ from previous years due to manufacturer adjustments

Prior Approval

The legislative mandate for the use of generics vs. brand name drugs has been cost effective. Brand name drugs for which a generic is available require a prior approval (PA). As mentioned previously each additional one percent in generic usage means approximately $3.5 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

[2] All dollar amounts shown include both state and federal dollars unless otherwise noted.

are very expensive. By legislative statute and mandate, Utah limits non-generic/brand prior authorizations to clinical applications, and excludes regulating mental health drugs via PA. In FY09, there were approximately 9,966 prior authorizations issued.

An example of the effect that prior approvals 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 prior approval was placed on Invega. After the prior authorization requirement was removed, monthly expenditures for Invega quickly rose from an average of $3,600 per month to over $24,000 per month. For the fourteen months the prior was in place, $285,600 were saved for this single drug.

Drug Regimen Review Center

The University Of Utah College of Pharmacy's Drug Regimen Review Center (DRRC) began reviewing high utilization of the Medicaid drug program in 2002. Based on paid drug claim history, the DRRC contacts physicians for identified Medicaid clients and performs educational "peer reviews" of these targeted clients. The goal is to reduce waste, duplication and unnecessary or inappropriate prescription use. The program has been well received by providers and clients. As of June 30, 2009 there have been 43,916 letters sent to 11,299 prescribers with recommendations concerning 13,905 Medicaid clients. For FY08, it appears that the DRRC program achieved at least $2.2 million savings (assuming no baseline increase in drug costs) by assisting physicians to be able to reduce the number of prescriptions that could cause potential adverse drug reactions or elimination of unnecessary or duplicate prescriptions. The DRRC is contracted with the Department for $468,000/year. Attachment 1 is the FY09 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.

The BPMS program was paid for by a grant from Eli Lilly and Company. In FY08 the BPMS program was replaced by the Utah Transformation Grant. This grant was awarded to the Utah Division of Medicaid and Health Financing by the Centers for Medicare and Medicaid Services. One hundred percent federal funding was made available through provisions of the 2005 Deficit Reduction Act. The effects of the Transformation Grant are currently being analyzed and the final report will be made available in 2010.

Co-Pay

Co-pays returned $4.5 million for FY09. 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	$8,185,931
FY 2008	$4,605,609
FY 2009	$4,530,639
Total	$41,258,131

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 recommends to the Division which drugs should be preferred or non-preferred based on that determination. Not all drug classes are candidates for a PDL.

The option to administer the PDL with a prior authorization tool was prohibited until May 18, 2009. 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 12 months the PDL was growing in FY09. These figures represent a full year for 22 drug classes, and represent partial year figures for 11 additional classes.

Table 3: Preferred Drug List Savings

Description	Total Funds
Market Shift Savings	$5,014,459
Secondary Rebates	$2,548,967
Administrative Expenses	($240,783)
PDL Savings	**$7,322,643**

III. FINANCIAL DATA FOR DRUG PROGRAM

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

Spending per Medicaid recipient per year decreased in FY09 by $26.26 (3.1 percent). Even with a decrease in the amount spent per recipient the increase in the number of recipients

and in the cost of brand name medications still resulted in an overall increase in program costs of $1,396,829 for FY09 program expenditures.

Table 4 shows a summary of the drug program.

Table 4: Drug Program Summary

Fiscal Year	FY02	FY03	FY04	FY05	FY06	FY07	FY08	FY09
Total Eligibles	249,447	249,745	276,813	286,983	287,559	274,710	267,378	298,372
Total RX Recipients	147,186	174,952	194,067	200,505	196,499	175,861	169,697	177,030
Total RX Claims	2,649,188	2,905,334	3,288,347	3,474,297	2,983,871	2,160,456	2,098,892	2,213,975
Cost (**in '000s-** Allowed Chg)	$134,495	$159,547	$183,306	$207,580	$183,029	$136,419	$139,884	$141,281
% yearly budget increase	18.30%	18.60%	14.90%	13.20%	-11.80%	-25.50%	2.54%	1.00%
Avg. Cost/RX	$50.77	$54.92	$55.74	$59.75	$61.34	$63.15	$66.65	$63.81
% increase in cost/RX	12.00%	8.20%	1.50%	7.20%	2.70%	3.00%	5.54%	-4.25%
Avg. RX/month per eligible	0.89	0.97	0.99	1.00	0.86	0.65	0.65	0.62
Avg. RX/month per recipient	1.50	1.38	1.41	1.44	1.26	1.02	1.03	1.04
% change in RX/mo. per recipient	-2.40%	-7.70%	2.00%	2.29%	-12.36%	-19.00%	1.00%	1.00%

Top Twelve Therapeutic Classes

Table 5 shows the top twelve therapeutic classes ranked by cost for FY09. 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 is not surprising that they are ranked number two. Four of the top twelve drug classes are used for mental health. Those mental health drug costs account for 40.6 percent 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 five based on cost. Only six drugs (drug classes H7T and H7X) account for $27 million.

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

Rank	Cost FY09	Cost FY08	% Change from FY08	Drug Class	Rank by RX Volume FY08	Rank by RX Volume FY09	Avg. cost/RX for FY09
1	$27,025,872	$23,825,031	13.43%	H7T/H7X ATYPICAL ANTIPSYCHOTICS	5	8	$339.06
2	$16,323,250.	$17,215,634	-5.18%	H4B ANTICONVULSANTS	2	3	$112.35
3	$9,298,882	$9,142,753	1.72%	H3A NARCOTIC ANALGESICS	1	1	$44.51
4	$8,331,235	$10,094,386.	-17.47%	H2S/H7C/H7D ANTI-DEPRESSANTS	3	2	$56.89
5	$5,722,588	$4,653,826	22.97%	H2V/J5B ADHD/ NARCOLEPSY	24	10	$122.72
6	$5,549,185	$6,311,846	-12.08%	D4J/Z2D ANTI-ULCER/PPI'S	6	6	$68.82
7	$3,599,948	$2,918,043	27.13%	M0E HEMOPHILIA FACTOR VIII	209	233	$18,749.73
8	$3,446,733	$2,831,729	21.72%	C4G INSULINS	25	26	$148.02
9	$2,410,868	$2,979,352	-19.08%	M4D/M4E/M4I/M4L/M4M LIPOTROPICS	13	11	$60.32
10	$2,084,511	$1,768,362	17.88%	J5G BETA-ADRENERGIC AND GLUCOCORTICOID COMBINATIONS	52	51	$196.23
11	$1,989,499	$1,760,108	13.03%	Z4B- LEUKOTRIENE RECEPTOR ANTAGONISTS.	30	30	$106.54
12	$1,863,631	$1,732,325	7.58%	M4A – BLOOD SUGAR DIAGNOSTICS (STRIPS)	36	41	$124.36

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 FY09, the average cost spread between the name brand price and generic was $157.89 which is an increase of $23.30. The use of generic drugs continues to be the single most important cost saving measure.

Table 6 shows the breakout of dispensing fees and also shows the brand name (B) versus generic name (G) utilization for prescriptions for FY09. The use of generics increased 3.72 percent this past year. This equates to 82,359 generic prescriptions. All brand name drugs require a prior approval if there is a generic available. Brand name drugs account for

approximately 24.8 percent of claims while generics account for approximately 65.5 percent of all claims. OTC and select I.V. drugs make up the rest. Brand name drugs still account for 70 percent of total dollars spent. Savings generated from switching to generics calculates to just over $13 million in FY 2009.

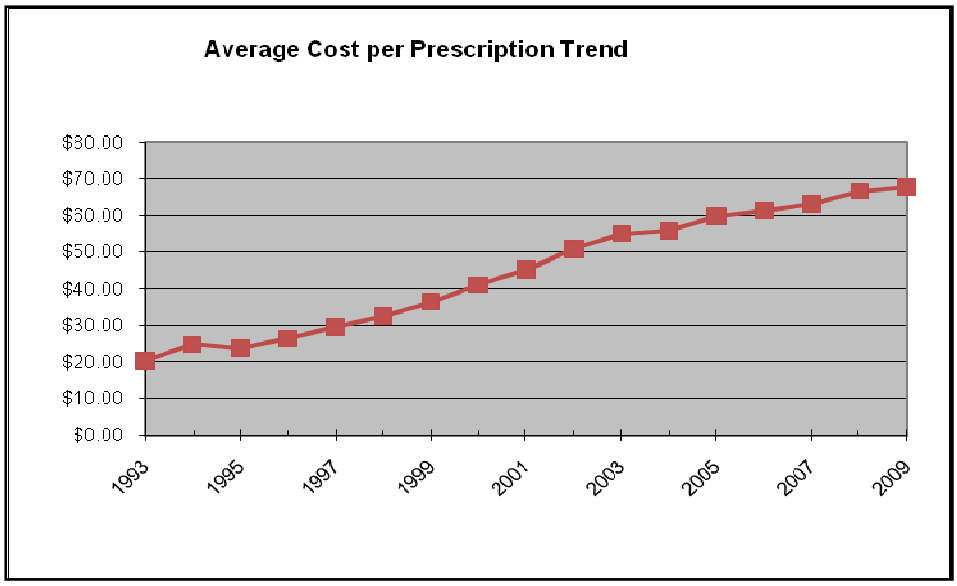
Dispensing fee indicators "F, J, K, L, M" are for select home intravenous infusion prescriptions. Dispensing fee indicator "C" is for over-the-counter products including insulin.

Table 6: Utilization by Dispensing Fee Indicator

Allowed Dispensing Source	# Rx	% of Rx's	Total Cost	Avg. cost per RX (FY09)	Avg. cost per RX (FY08)	% change for FY09 compared to FY08
Brand	548,551	24.78%	$99,270,482	$180.97	$161.90	11.78%
C	208,473	9.42%	$8,101,695	$38.86	$36.36	6.88%
F	1,174	0.05%	$3,868	$3.30	$3.02	9.11%
Generic	1,451,136	65.54%	$33,494,940	$23.08	$27.31	-15.48%
J	629	0.03%	$29,757	$47.31	$136.34	-65.30%
K	285	0.01%	$217,460	$763.02	$330.18	131.09%
L	1,574	0.07%	$44,817	$28.47	$25.89	9.98%
M	175	0.01%	$416	$2.38	$3.80	-37.36%
other	1978	0.09%	$117,595	$59.45	$85.82	-30.73%

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

Figure 1



The 4.3 percent decrease in the average price of a prescription for FY09 reflects the increase in the number of eligible clients and the increased use of generic medications. 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 decreased 4.3 percent to $63.81.)

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 FY09 Clawback amounts are added to FY09 Medicaid expenditures the total program costs are $165.4 million.

Table 7: State Phased Down Contribution "Clawback"

Period	"Clawback" Amount
Jul-08	$1,863.757
Aug-08	$1,865,990
Sep-08	$3,747,931
Oct-08	$1,947,876
Nov-08	$1,957,249
Dec-08	$1,957,179
Jan-09	$2,077,651
Feb-09	$2,044,198
Mar-09	$2,126,304
Apr-09	$2,121,581
May-09	$2,134,600
Jun-09	$2,130,548
SFY2008 Total:	**$24,111,111**

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 FY09, the Prospective Drug Utilization Review (PRODUR) program returned $1.4 million due to reversed claims. It should be recognized that in actual dollars this amount may be smaller since physicians may substitute different prescription drugs (Figures for FY09 are the result of a twelve month calculated average due to programming problems occurring for some of the months in FY2009. Corrected reports for these months are not available). The PRODUR Program ran against 2,213,975 claims for which 13,771 claims were reversed. More than 6.2 percent of submitted claims resulted in an adverse drug warning being posted to the pharmacy. Of those claims with warnings, 9.9 percent were reversed. There continues to be a gradual increase in warnings posted. Table 8 shows the trend in number of occurrences in the State's PRODUR for just one of the indicators, THERAPEUTIC DUPLICATION, over a ten-year period.

Table 8: PRODUR Therapeutic Duplication

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

For therapeutic duplication, there was a 5.5 percent increase in the number of warnings in FY09. 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 four years of the Medicaid prescription drug program, PRODUR and 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.

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 Manufacturers Association (PhRMA). The DUR Board is mandated by both state and federal law. The Board meets monthly and meetings are open to the public. Each month the DUR Board deals with several petitions from physicians seeking drug coverage outside policy and/or criteria guidelines. This past year the DUR Board approved 48 percent 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 FY09, the DUR Board considered PA recommendations for nine drugs, and placed PA on eight 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 for savings calculations. Savings from previous DUR actions maintain continuous savings benefits.

The DUR Board spent significant time reviewing PA criteria and other limits from previous Board actions. Thirty-five categories were reviewed altogether. Modifications were made to the PA criteria of nine of those categories. The DUR Board also determined to add quantity limit restrictions to three categories of drugs and to cover three drug products without PA requirements; Chantix, Hyper-sal, and Zyvox. The PA requirement was added back after an additional review for Chantix.

Quantity limits were added to Pegasys, Pristiq, and smoking cessation products, while Cymbalta was recommended to have ICD-9 code billing requirements added.

VI. CONCLUSION

The Medicaid Drug program returned more than $78.4 million to the Department when drug rebates, co-pays, preferred drug list, generic substitution, PRODUR reversals, and the College of Pharmacy's DRRC activities are factored in. In spite of this, increases in prescriptions per recipient and rising drug costs continue to offset overall savings. The brand-name prior approval initiative maintains the largest lowering effect on expenditures. Various tools are used to affect savings to the Medicaid Drug Program while at the same time providing one of the most robust and generous drug benefits in the nation.

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

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

Attachment 1 – Drug Regimen Review Center Annual Report

Drug Regimen Review Center

UTAH MEDICAID

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

ANNUAL REPORT

JULY 2008 to JUNE 2009

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

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 process. 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, between 150 and 300 patients were selected for review by a team of clinically trained pharmacists. These reviews resulted in recommendations that were made to prescribers. These recommendations are described later in this report. Recommendations are transmitted in writing either by mail or fax, are sent to all prescribers of medications related to identified drug therapy problems, 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
Benjamin Campbell, Pharm.D.
Karen Gunning, Pharm.D.
Joanne LaFleur, Pharm.D., MSPH
Bryan Larson, Pharm.D., BCPS
CarrieAnn Madden, Pharm.D., BCPS
Janet Norman, R.Ph.
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Mission

The mission of the DRRC is to review the drug therapy of Medicaid patients who are high utilizers of the Medicaid drug program or who are otherwise determined to be at high risk for drug related problems and high medical costs and to work with the individual prescribers to provide the safest and highest quality pharmacotherapy at the lowest cost possible.

Methodology

The method for identifying patients for review has undergone a revision in this year. For the months of July through October 2008, the mechanism for patient selection continued as it had in previous years. That is, patients who exceeded seven prescriptions per month were ranked by the number of prescriptions they received in that month, and the top 300 were selected after excluding children and patients who had been reviewed in the previous 12 months. Instead of doing November reviews in January, staff worked to revise and implement procedures using a new methodology. For the months of December 2008 through June 2009, the mechanism for patient selection was modified. In those months, three different mechanisms of selection were compared, as described below:

Prescription Drug Counts

An average 50 patients per month were selected on the basis of the number of prescriptions per month. This is the same mechanism that has been used in the past. In each month, patients who received any prescription were ranked according to the number of prescriptions they had received in that month, and those with the highest number of prescriptions who had not been reviewed in the previous 12 months were selected.

RxRisk Comorbidity Scores

An average 50 patients per month were selected on the basis of RxRisk comorbidity scores. RxRisk is an instrument that is used for risk adjustment based on degree of comorbidity. It is based on prescriptions filled by patients in the entire 1-year period prior to the month of the review. The RxRisk comorbidity scale is validated to identify patients at risk of having high medical expenditures in the subsequent year.

RxRisk Chronic Disease Count

An average 50 patients per month were selected on the basis of the sum of chronic diseases they had, according to the RxRisk comorbidity scale. Patients were ranked according to the number of comorbid conditions they had, and those with the highest count who had not been reviewed in the previous 12 months were selected.

We continue to provide prescribers with recommendations for changes in drug therapy as appropriate. To date, we have mailed or faxed 43,916 of these letters to 11,299 different prescribers, with recommendations concerning 13,905 Medicaid patients.

Overview

Utah Medicaid drug claim costs had been increasing 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 rising since that time. Recently, the total number of claims increased from 168,624 to 199,421 per month (18.26%) during the period from July 2008 to June 2009. Drug costs also increased from $11,947,245 to $12,948,293 per month (8.38%) 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 2008 to June 2009, and Figure 3 shows the trend in total drug claim costs during the entire project period from January 2002 to June 2009.

Figure 1 – Total Medicaid Drug Claims by Month from July 2008 to June 2009

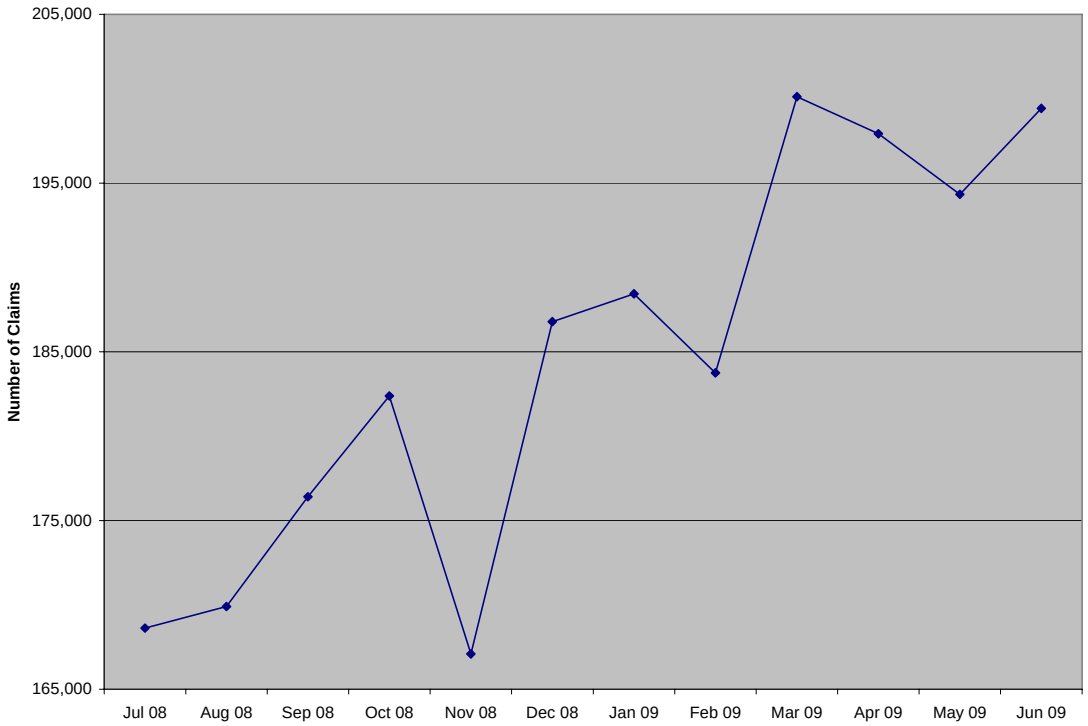


Figure 2 – Total Medicaid Drug Claim Costs by Month from July 2008 to June 2009

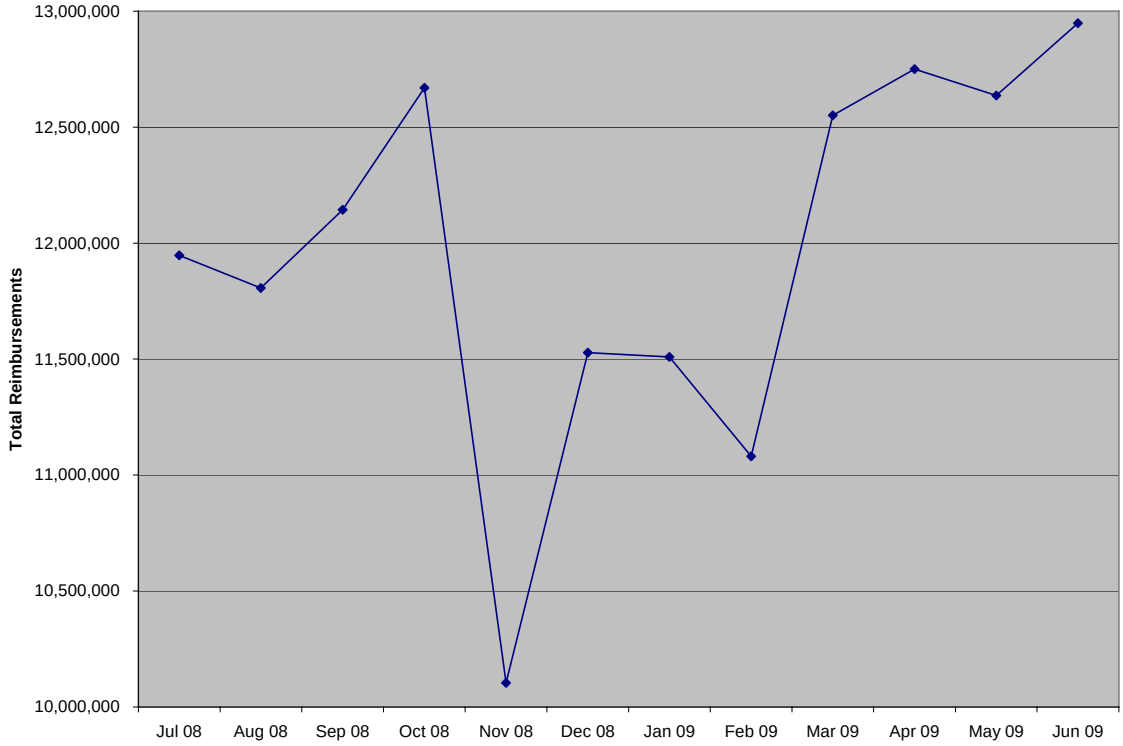
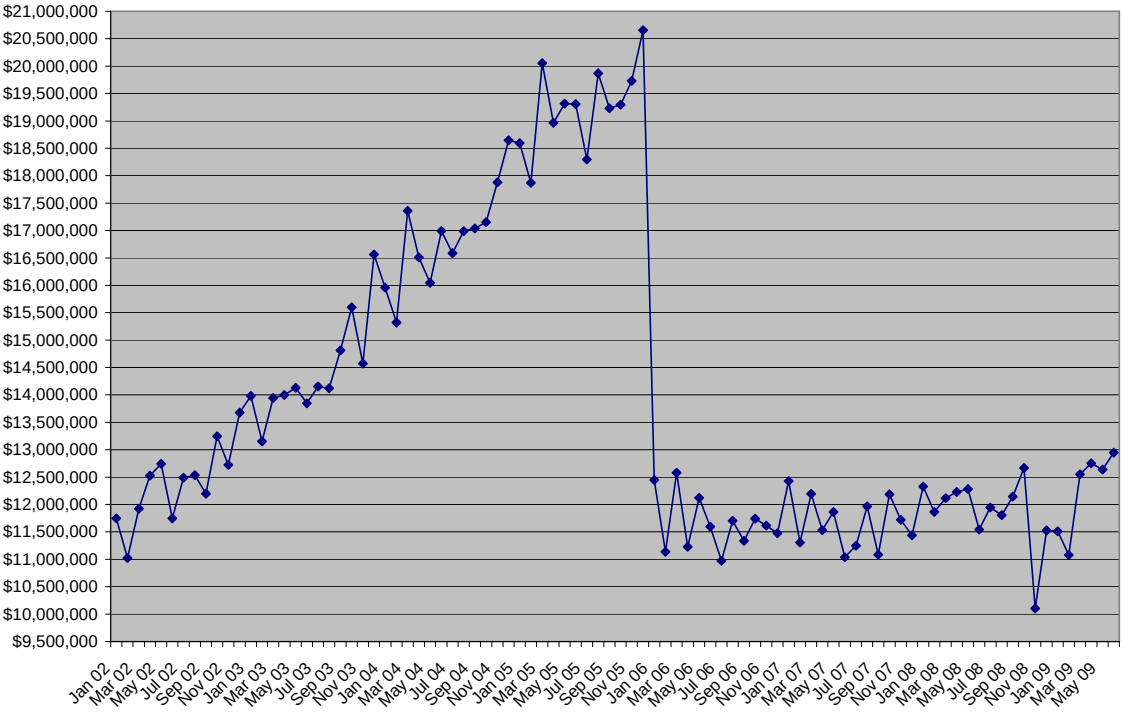


Figure 3 – Total Medicaid Drug Program Costs from January 2002 to June 2009

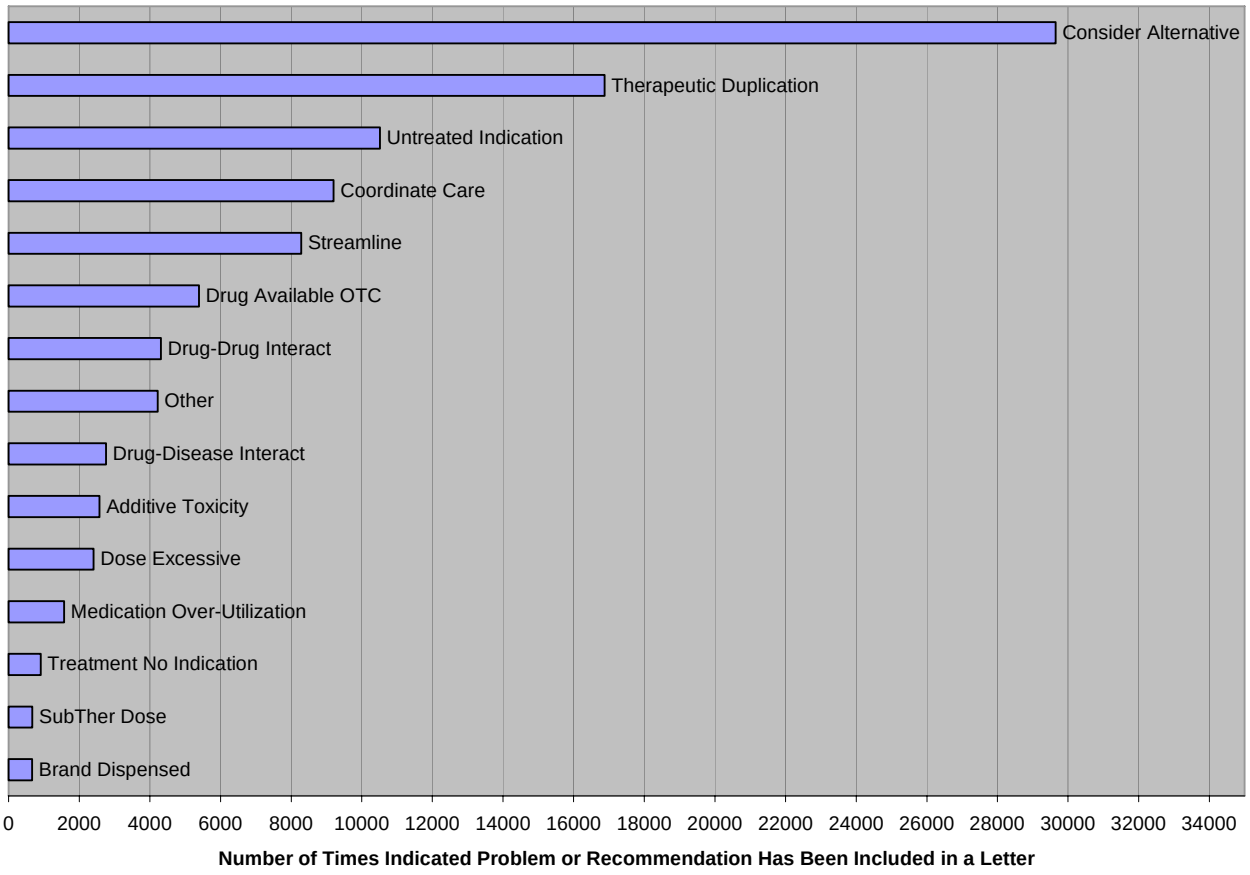


Increases in total drug spend for the past five fiscal years have been 16.4% (July 2004 to June 2005), 13.1% (July 2005 to January 2006 – when Medicare Part D went into effect), 0.6% (July 2006 to June 2007), 2.6% (July 2007 to June 2008) and recently 8.4% (July 2008 to June 2009). Several factors are responsible for increased costs, including an increase in Medicaid enrollment.

Program Summary

Figure 4 summarizes the drug related problems identified in the letters that have been sent to prescribers since the inception of the program in May 2002.

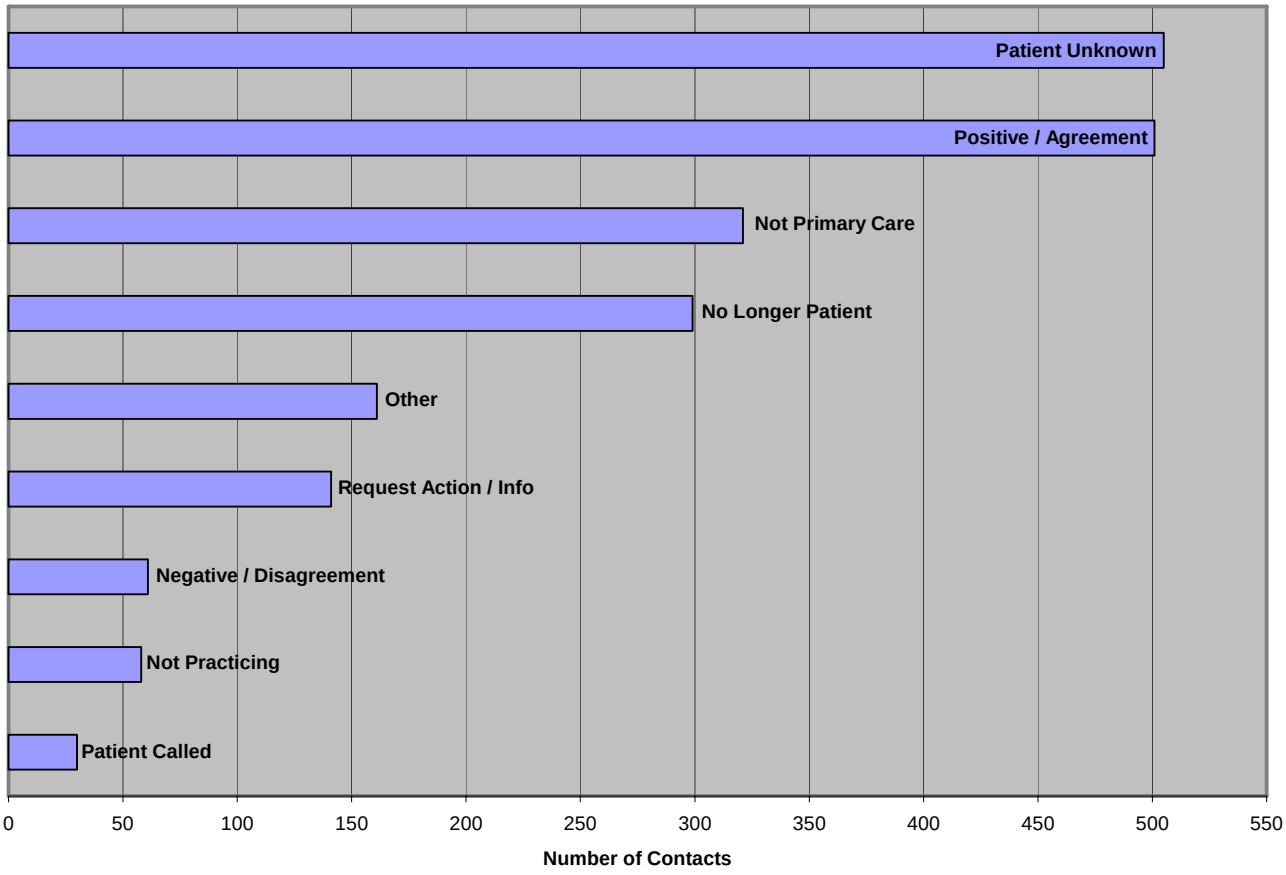
Figure 4 – Types of Drug Related Problems and Recommendations in All Letters Sent to Prescribers



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 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. Streamline therapy refers to considering changes in therapy to eliminate some of the drugs dispensed or to decrease the number of doses, where appropriate.

Figure 5 summarizes the responses of the 2,077 individuals who have contacted the DRRC after receiving an intervention letter since the program's inception in May 2002.

Figure 5 – Summary of All Responses to Letters Received

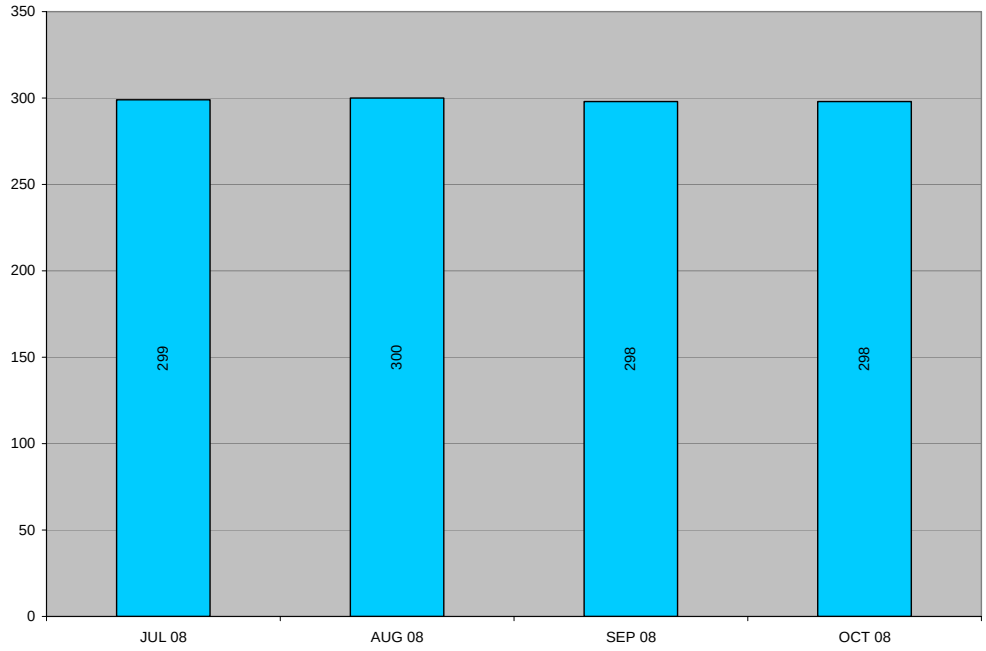


We have received a variety of comments from the prescribers, including both agreement with recommendations and some disagreement. We have also encountered some administrative problems such as pharmacy input errors, incorrect addresses on file, and patients not being treated by the prescriber identified. 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

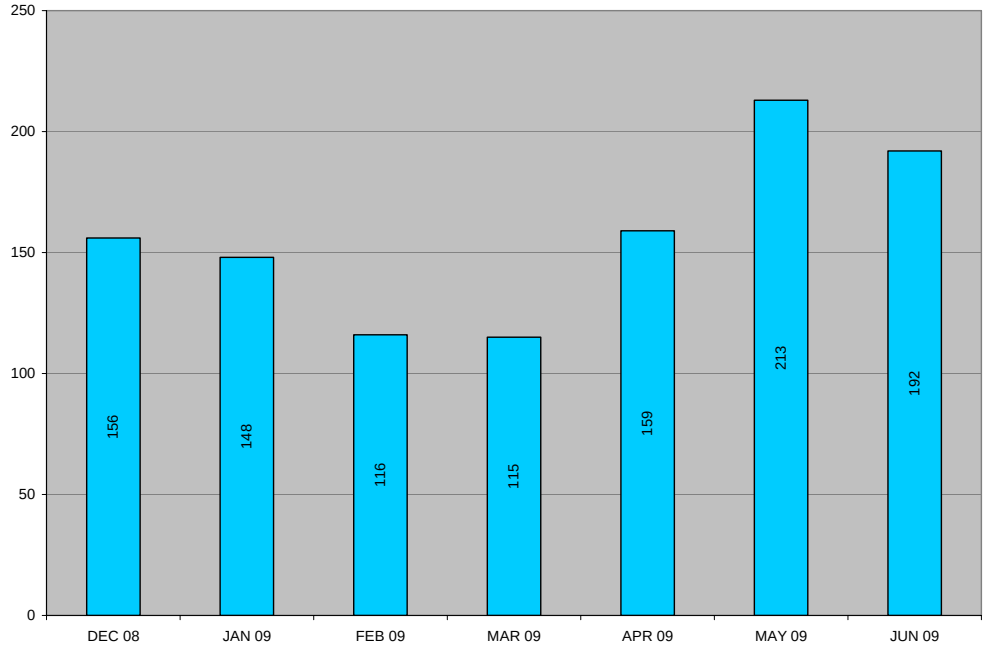
The 1,195 patients reviewed from July 2008 to October 2008 were separated into cohorts based on the month they were reviewed. Figure 6A summarizes the number of patients reviewed each month during this period. The average was 299 patients per month.

Figure 6A – Summary of Patients Reviewed Each Month from July 2008 to October 2008



The 1,089 patients reviewed from December 2008 to June 2009 were separated into cohorts based on the month they were reviewed. Figure 6B summarizes the number of patients reviewed each month during this period. The average was 156 patients per month. There is more variability per month using the new patient selection methods. This occurs primarily because the criterion of selection, such as RxRisk score, is set at a specific threshold and all patients who exceed that threshold are reviewed.

Figure 6B – Summary of Patients Reviewed Each Month from December 2008 to June 2009

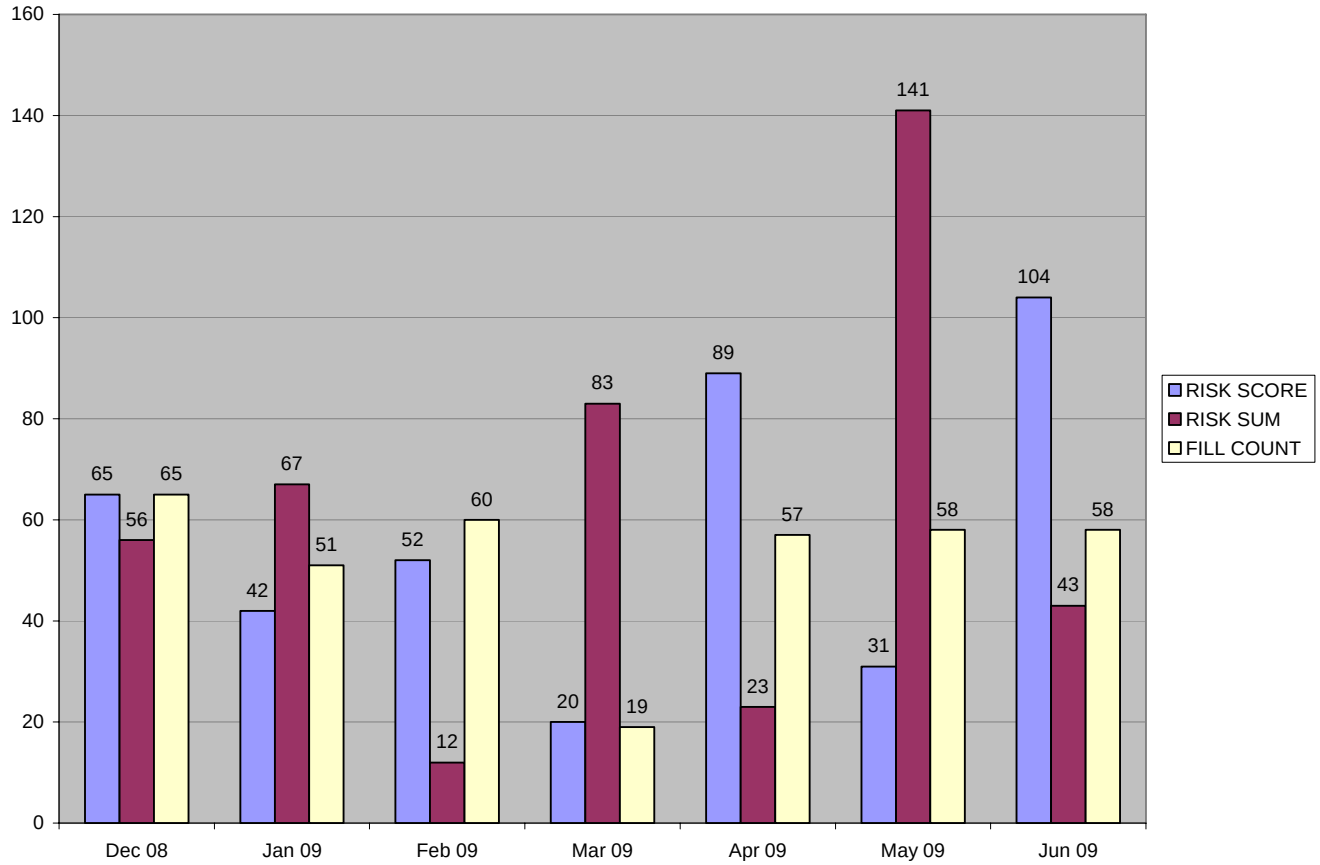


Beginning in December 2008, patients were selected for review based on three different criteria rather than simply the number of prescription fills during the month of review. Table 1 and Figure 7 summarize the patients selected each month by each of these three criteria. The total of 1,204 is less than the total from each of the methods since some patients fell under selection criteria for more than one of the method.

Table 1 – Patient Selection

	Total	Score Value	Score Count	Sum Value	Sum Count	Fills Value	Fills Count
Dec 08	156	20	65	15	56	30	65
Jan 09	148	19	42	14	67	26	51
Feb 09	116	18	52	14	12	23	60
Mar 09	115	18	20	13	83	27	19
Apr 09	159	17	89	13	23	23	57
May 09	213	17	31	12	141	22	58
Jun 09	192	16	104	12	43	22	58
TOTAL	**1109**		**403**		**425**		**376**

Figure 7 – Patients Reviewed by Selection Method



Demographics for all review cohorts are displayed in Table 2 and include gender, average age, and the average number of prescriptions dispensed. Nursing home patients are not included in this table.

Table 2 – Cohort Demographics

	Patients							
	Females				Males			
MONTH	Percent	Mean Age	Mean # Rx	Mean Cost Per RX	Percent	Mean Age	Mean # Rx	Mean Cost Per RX
Jul 08	75.9	43.5	13.3	$69.51	24.1	46.2	13.5	$82.27
Aug 08	74.9	44.9	12.7	$77.92	25.1	45.4	12.6	$100.86
Sep 08	76.9	43.3	13.2	$73.79	23.1	44.9	13.4	$83.12
Oct 08	73.0	44.0	13.2	$66.37	27.0	46.6	13.8	$89.40
Dec 08	73.4	49.0	16.8	$62.88	26.6	48.9	16.8	$78.24
Jan 09	72.2	50.7	14.9	$59.86	27.8	44.9	13.8	$73.56
Feb 09	66.0	47.4	14.2	$62.37	34.0	47.3	13.4	$55.20
Mar 09	78.1	48.3	12.8	$76.02	21.9	50.2	12.6	$73.37
Apr 09	69.5	49.1	12.8	$68.54	30.5	44.2	11.0	$91.72
May 09	72.9	46.2	11.7	$78.09	27.1	46.7	11.6	$69.38
Jun 09	63.0	44.7	10.9	$60.65	37.0	45.7	10.3	$98.99

Reviewed ambulatory patients during the reporting period were predominantly females in their 40s who filled 10 to 17 prescriptions per month.

Program Trends

The following figures show the average and range of the number of prescriptions for each of the reviewed cohorts. The mean number of prescriptions that triggered review generally ranged from 12 to 14 while the maximum number of prescriptions for a reviewed patient exceeded 35. Figures 8 and 9 represent two different methods for selecting patients for review. Data presented in Figure 8 includes only patients who were selected on the basis of a high number of prescriptions in the review month. Data in Figure 9 include patients who were selected on that basis, as well as two other methods based on patient comorbid conditions.

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

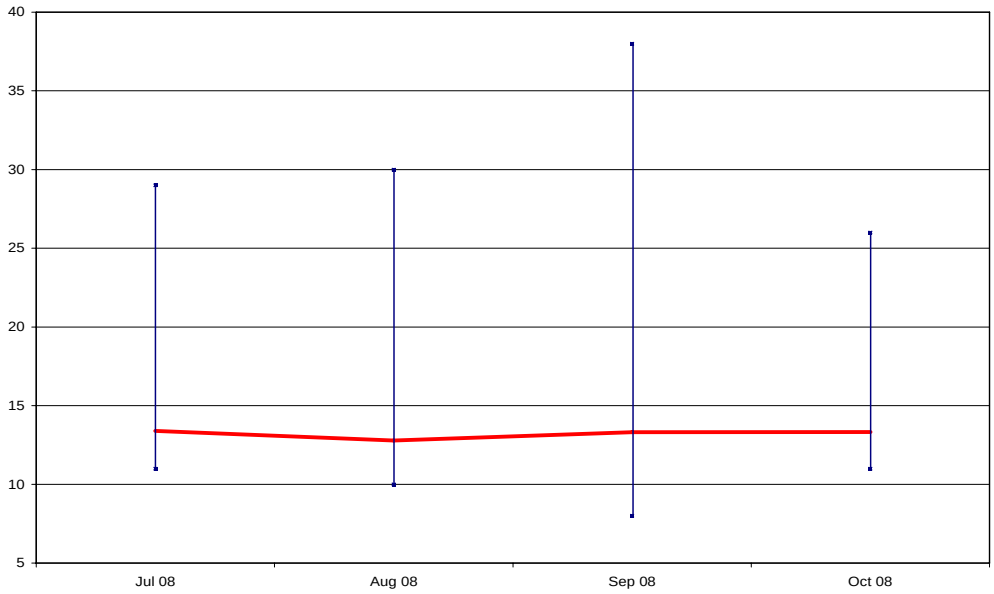
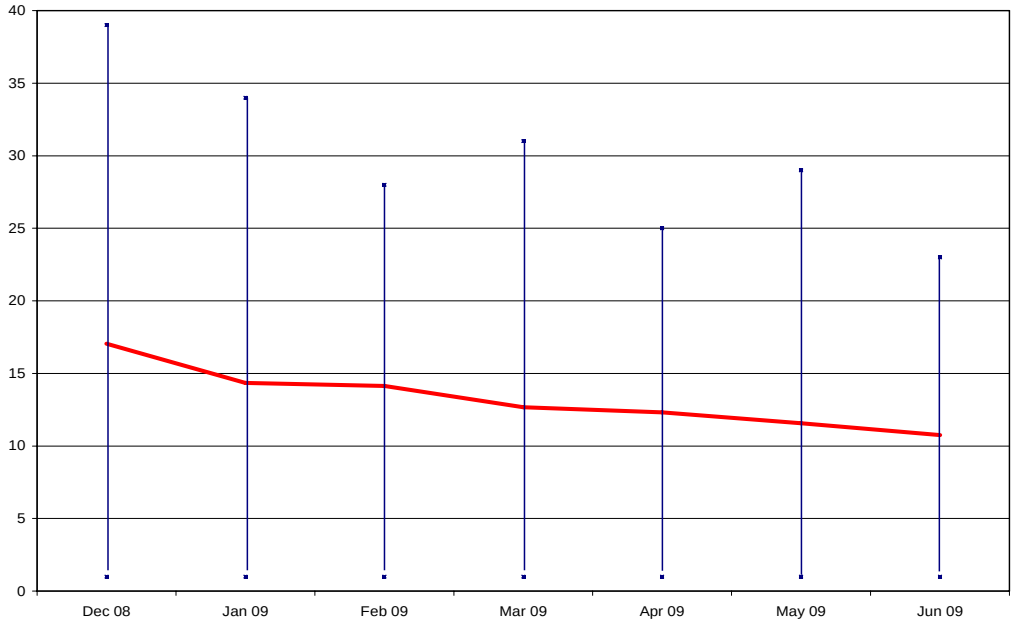


Figure 9 – Average Number of Prescriptions per Month per Reviewed Ambulatory Medicaid Patient, including Minimum and Maximum Number of Prescriptions per Review Group



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 patient presentations are representative examples of the types of patients being reviewed and the outcomes of those reviews:

PATIENT 1

In June 2009 we reviewed the drug regimen of a 27-year-old woman. We recommended several changes to her drug regimen. In October 2009, Medicaid was contacted by this patient, concerned because her physician had removed some of her medications because of the letter he had received from the Drug Regimen Review Center.

The physician had also contacted her pharmacy to cancel the remaining refills on these prescriptions. She did not understand why these medications were taken away, and did not have a good understanding of her drug regimen. We were able to explain the reasoning behind these changes to her over the phone, and ease her concerns. Below are the main changes which were made and explained to her, per our recommendations to her doctor.

She had been receiving two inhaled corticosteroids each month, Flovent and Asmanex, and a long-acting beta-2 agonist, Serevent. All of these medications were discontinued, and she was stabilized on Symbicort, a combination product with both an inhaled corticosteroid and a long-acting beta-2 agonist. This resolved the duplication in therapy, and also streamlined her drug regimen.

She was receiving cholestyramine and simvastatin, two medications used to treat hyperlipidemia, along with numerous other medications. Cholestyramine had the potential to interact with multiple medications on her drug profile by inhibiting their absorption. The simvastatin dose was increased and the cholestyramine was discontinued, streamlining her drug regimen and preventing potential drug interactions.

PATIENT 2

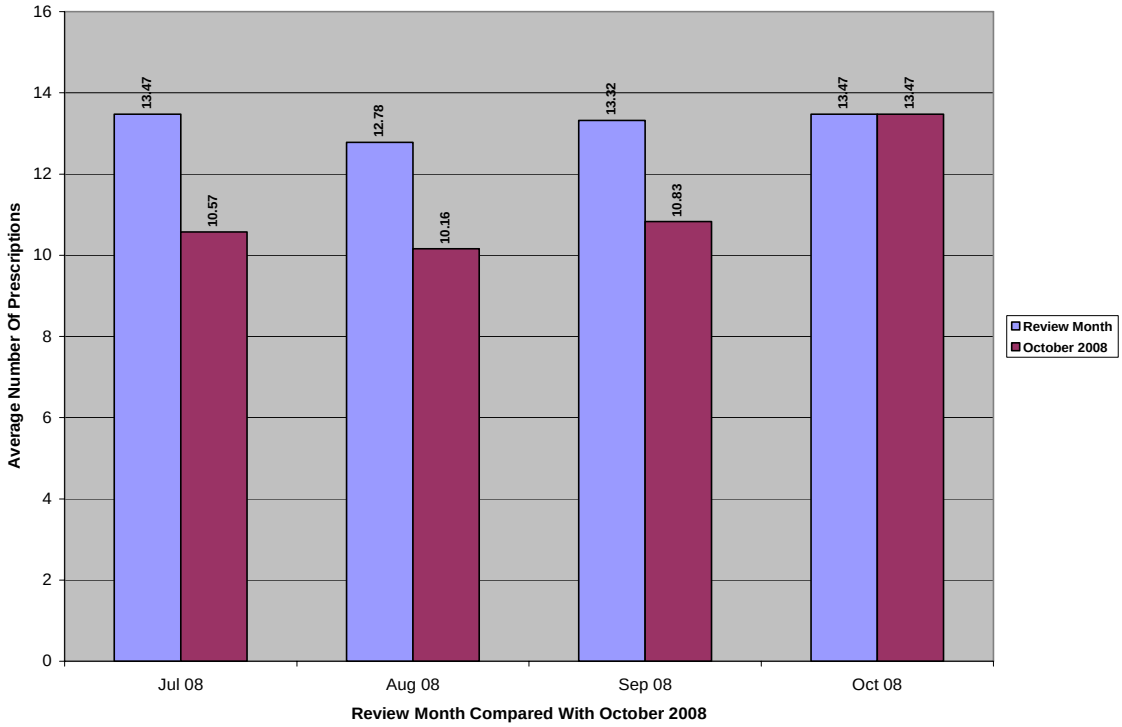
In December 2008 a 57 year old female's prescription regimen was reviewed and found to have several drug-related problems, including sub-therapeutic Seroquel in psychosis (50 mg/day), supra-therapeutic doses of Geodon (240 mg/day), a therapeutic duplication (low-dose Seroquel and high-dose Geodon), a drug that interacted with one of her diseases (metoclopramide use in epilepsy), an increased risk of experiencing extrapyramidal effects (metoclopramide and antipsychotics), two counteracting drugs from different providers (Evoxac and oxybutynin), an excessive Cymbalta dose (90 mg/day), and furosemide without a potassium supplement.

A review of the patient's regimen three months after a letter had been sent to the provider found that several of the drug-related problems had been resolved due to the discontinuation of many of the offending medications. The low-dose Seroquel had been discontinued, thus resolving both the sub-therapeutic dose and therapeutic duplication drug-related problems. In addition, the metoclopramide had been discontinued, resolving the drug-disease interaction and the increased risk of extrapyramidal effects.

The oxybutynin had been discontinued, resolving the counteracting drugs from different providers, and the furosemide was stopped, resolving the risk of the patient experiencing hypokalemia. It appears this patient's drug regimen was streamlined to discontinue unneeded and duplicative therapies, as well as decreasing the number of providers prescribing medications. Six of the eight drug-related problems resolved within a three-month time frame.

Figure 10 shows the average number of prescriptions per reviewed patient for each month from July 2008 to October 2008, compared to the average number of prescriptions per patient for the same cohort in October 2008. The number of prescriptions dispensed has decreased for all review cohorts. No change was seen for October 2008 since this report only covers data through October 2008.

Figure 10 – Average Prescriptions for Reviewed Cohort in Review Month, Compared to October 2008



Beginning in December 2008, patients were selected for review based on three different criteria rather than simply number of prescription fills during the month of review. Figures 11 through 16 show the average number of prescriptions per reviewed patient for each month from December 2008 to June 2009, compared to the average number of prescriptions per patient for the same cohort in September 2009, the most recent month with data available. The number of prescriptions dispensed has decreased for all review cohorts, regardless of selection method, but the biggest decreases are seen among patients selected for number of fills.

Figure 11 – Average Fills during Review Month Compared with September 2009 for All Patients by Selection Method

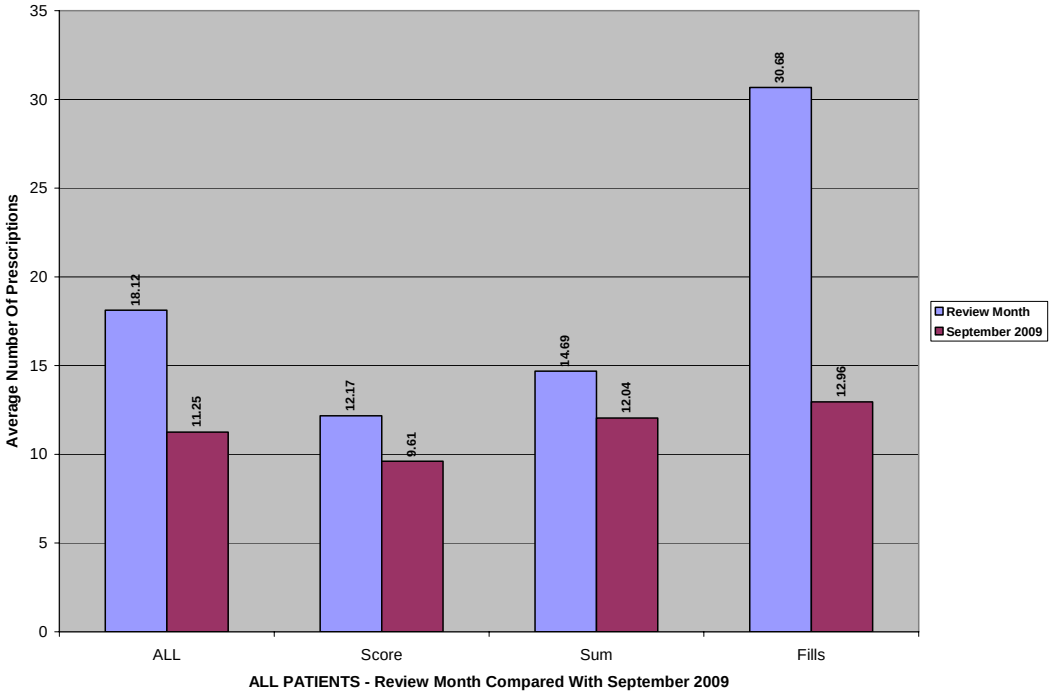


Figure 12 – Average Fills during Review Month Compared with September 2009 for All Patients by Month

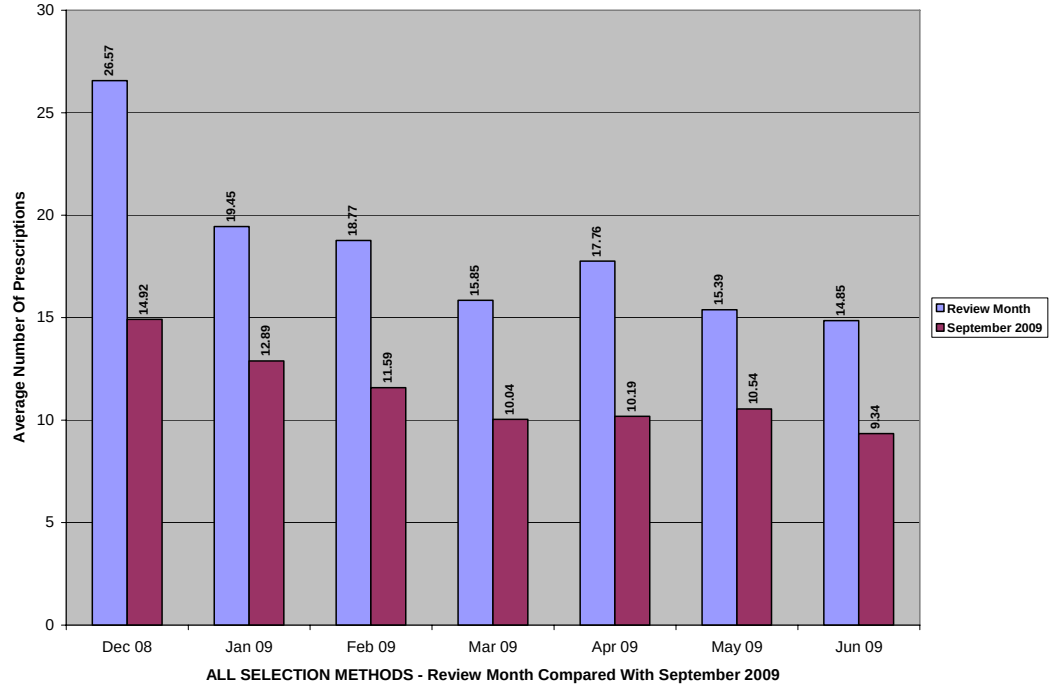


Figure 13 – Average Fills during Review Month Compared with September 2009 for Patients Selected by Risk Score

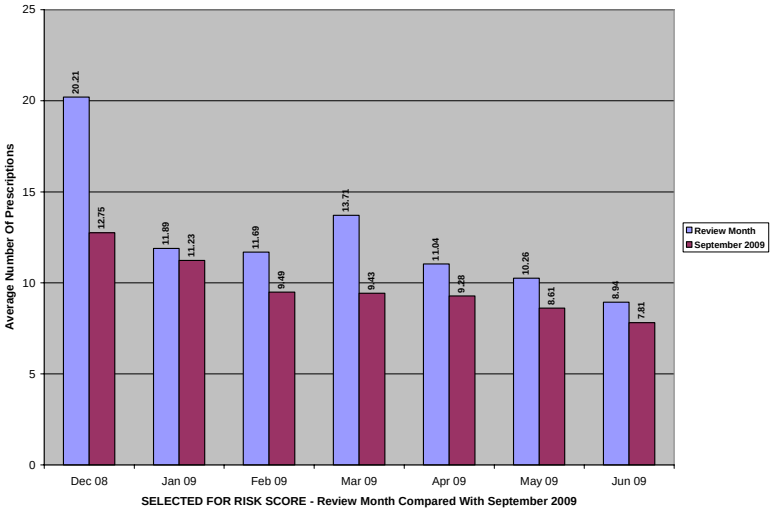


Figure 14 – Average Fills during Review Month Compared with September 2009 for Patients Selected by Risk Sum

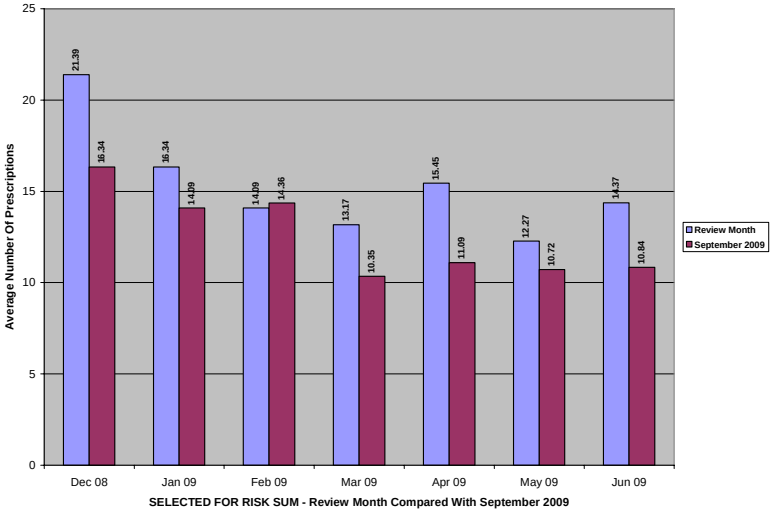
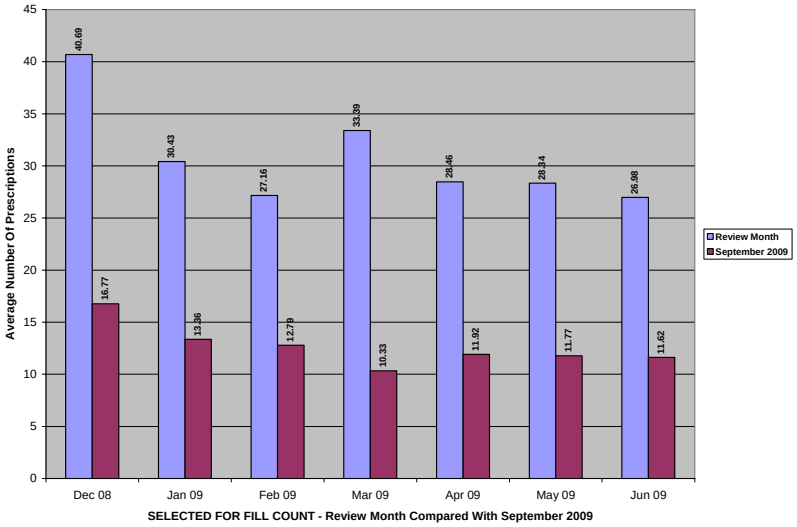


Figure 15 – Average Fills during Review Month Compared with September 2009 for Patients Selected by Fill Count



The number of prescriptions filled declined in all of the cohorts for each of the methods used to select patients. The decline was greatest, approximately 18 prescriptions per month, in patients selected for fill count; and was more modest, approximately two to three prescriptions per month, in patients selected by risk score or sum of comorbidities.

Figures 16 through 20 show the average risk score per reviewed patient for each month from December 2008 to June 2009, compared to the average risk score per patient for the same cohort in September 2009, the most recent month with data available. Patients selected for review on the basis of risk score show the largest drop in those scores over time.

Figure 16 – Average Risk Score during Review Month Compared with September 2009 for All Patients by Selection Method

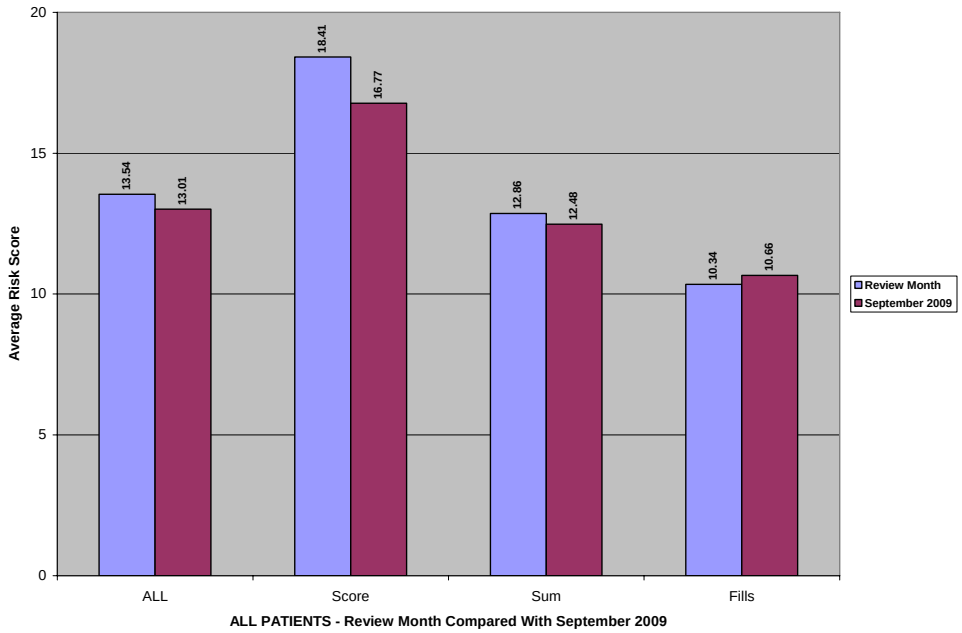


Figure 17 – Average Risk Score during Review Month Compared with September 2009 for All Patients by Month

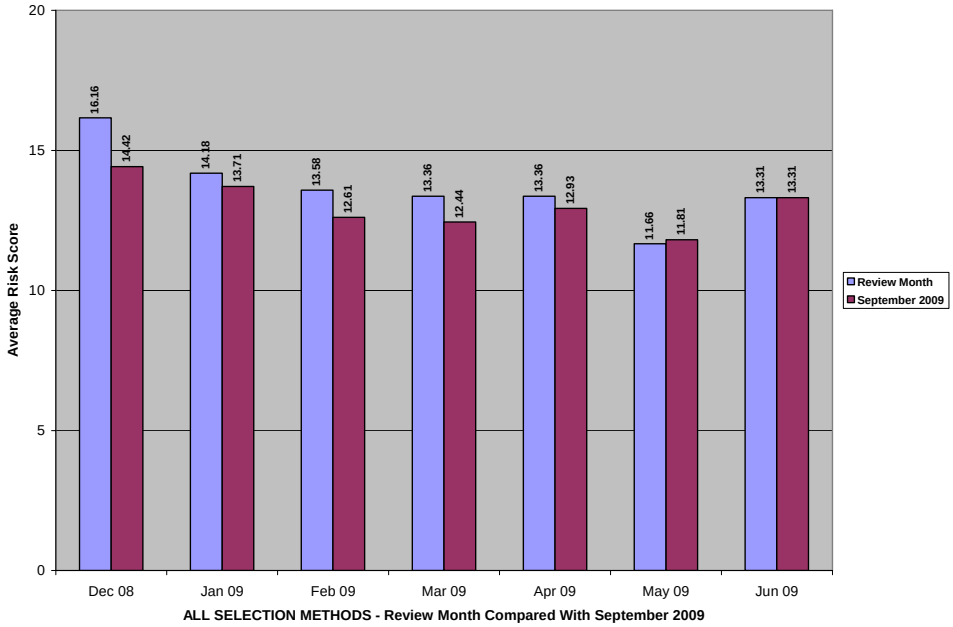


Figure 18 – Average Score during Review Month Compared with September 2009 for Patients Selected by Risk Score

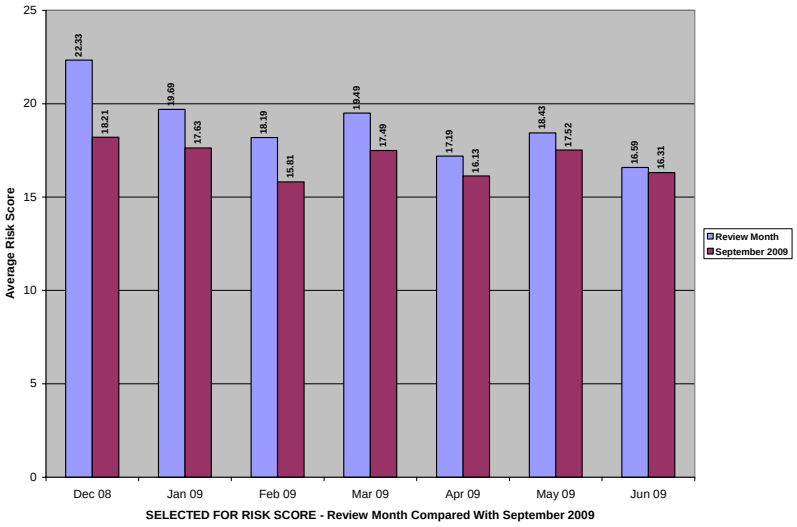


Figure 19 – Average Score during Review Month Compared with September 2009 for Patients Selected by Risk Sum

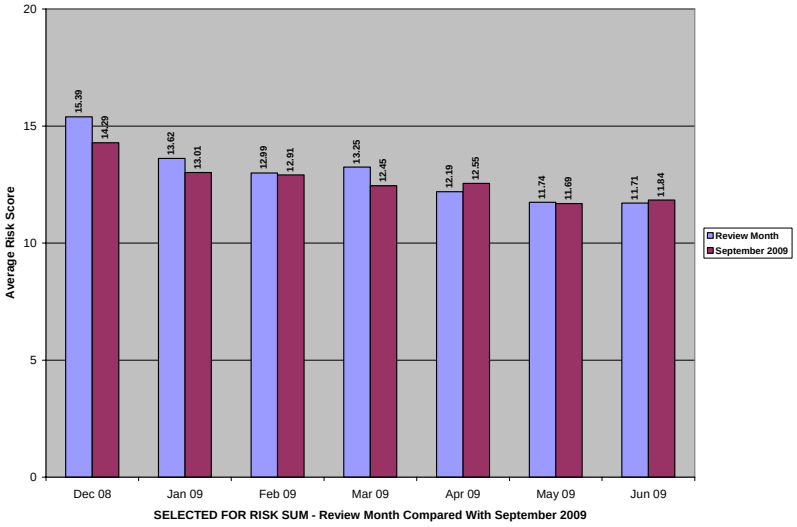
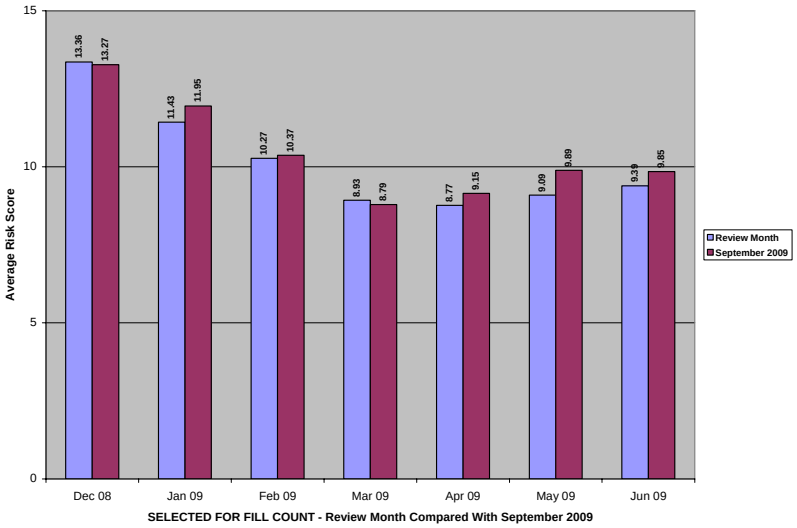


Figure 20 – Average Score during Review Month Compared with September 2009 for Patients Selected by Fill Count



Tracking Costs of Reviewed Utilizers per Month

We tracked drug cost reimbursements to review cohorts selected using all mechanisms for the remainder of the reporting period 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 months in the reporting period. Decreases in drug costs for these selected patients were seen, some significant. Because we eliminated patients who did not receive subsequent prescriptions, these estimates are conservative.

For patients reviewed from July through October 2008, the review month was used as the baseline amount for comparison. Cost savings were calculated only for patients reviewed from July 2008 to October 2008. Costs were compared for the baseline amount with the amount for June 2009. For example, costs in October 2008 and June 2009 were compared for patients reviewed during October 2008. Additional cost savings for patients reviewed before July 2008 are not included, nor are additional savings that would be expected after June 2009 for patients included in this report.

Assuming total Medicaid drug costs remain constant after the month of review, drug costs for patients reviewed in July through October, 2008 decreased by $1,767,702.

For patients reviewed from December 2008 through June 2009, the review month was again used as the baseline amount for comparison. Cost savings were calculated only for patients reviewed from December 2008 to June 2009. Costs were compared for the baseline amount with the amount for June 2009. For example, costs in February 2009 and June 2009 were compared for patients reviewed during February 2009. Additional cost savings for patients reviewed before December 2008 are not included, nor are additional savings that would be expected after June 2009 for patients included in this report.

Assuming total Medicaid drug costs remain constant after the month of review, drug costs for reviewed patients in December 2008 through June 2009 decreased by $441,988.

In considering this information it is important to understand that we cannot determine what the reviewed patients' drug costs would have been if they had not been reviewed. It is possible that without a review their costs would have increased, remained the same or declined. To effectively address this we would need to compare changes in prescription drug costs over the same period with a suitable control group. This is not possible with our current patient selection process.

Cost calculations are detailed on the following pages.

TABLE 3

Drug Cost Savings in DRRC Reviewed Patients

(vs No Change in Drug Costs in Medicaid Population)

Totals

Old Contract	$1,767,702
New Contract	$441,988
TOTAL	**$2,209,690**

New Contract

Selected by: RISK SCORE	$140,099
Selected by: RISK SUM	$55,626
Selected by: FILL COUNT	$388,028

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

	Jul 08	Aug 08	Sep 08	Oct 08	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09	Jun 09	TOTAL	PROJECTED	SAVINGS
Jul 08	**220,342**	180,048	175,650	184,165	134,210	153,932	151,295	148,850	162,230	167,301	153,855	166,573	1,998,451	2,644,104	645,653
Aug 08		**215,805**	198,510	210,971	160,521	188,427	185,754	167,602	184,299	184,835	176,227	186,898	2,059,849	2,373,855	314,006
Sep 08			**213,265**	189,630	154,088	182,715	176,175	165,087	171,796	179,173	161,266	163,689	1,756,884	2,132,650	375,766
Oct 08				**197,791**	138,701	154,362	143,743	138,558	150,042	139,263	141,274	144,108	1,347,842	1,780,119	432,277
												SUBTOTAL	**7,163,026**	**8,930,728**	**1,767,702**
Dec 08						**221,661**	174,572	164,650	172,589	187,671	180,940	180,924	1,283,007	1,551,627	268,620
Jan 09							**130,487**	109,820	117,413	114,120	116,903	132,712	721,455	782,922	61,467
Feb 09								**92,142**	107,664	95,984	85,260	88,599	469,649	460,710	-8,939
Mar 09									**89,945**	68,641	72,690	72,673	303,949	359,780	55,831
Apr 09										**117,209**	86,772	100,383	304,364	351,627	47,263
May 09											**148,433**	130,687	279,120	296,866	17,746
Jun 09												**149,673**			
												SUBTOTAL	**3,361,544**	**3,803,532**	**441,988**
												TOTAL	**10,524,570**	**12,734,260**	**2,209,690**

PATIENTS	191	175	174	180		118	105	84	76	101	141	115

*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 08	Aug 08	Sep 08	Oct 08	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09	Jun 09	TOTAL	PROJECTED	SAVINGS
Jul 08	**1,154**	943	920	964	703	806	792	779	849	876	806	872	10,463	13,843	3,380
Aug 08		**1,233**	1,134	1,206	917	1,077	1,061	958	1,053	1,056	1,007	1,068	11,771	13,565	1,794
Sep 08			**1,226**	1,090	886	1,050	1,013	949	987	1,030	927	941	10,097	12,257	2,160
Oct 08				**1,099**	771	858	799	770	834	774	785	801	7,488	9,890	2,402
												SUBTOTAL	**39,819**	**49,555**	**9,736**
Dec 08						**1,878**	1,479	1,395	1,463	1,590	1,533	1,533	10,873	13,149	2,276
Jan 09							**1,243**	1,046	1,118	1,087	1,113	1,264	6,871	7,456	585
Feb 09								**1,097**	1,282	1,143	1,015	1,055	5,591	5,485	-106
Mar 09									**1,183**	903	956	956	3,999	4,734	735
Apr 09										**1,160**	859	994	3,014	3,481	468
May 09											**1,053**	927	1,980	2,105	126
Jun 09												**1,302**			
												SUBTOTAL	**32,327**	**36,411**	**4,084**
												TOTAL	**72,146**	**85,966**	**13,820**

REVIEWED PATIENTS SELECTED FOR RISK SCORE - NO INCREASE IN COSTS ASSUMED

	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09	Jun 09	TOTAL	PROJECTED	SAVINGS
Dec 08	**75,913**	57,676	54,195	55,868	61,888	53,962	64,092	423,594	531,391	107,797
Jan 09		**29,995**	25,337	25,841	21,302	21,399	24,726	148,600	179,970	31,370
Feb 09			**32,556**	39,560	36,010	32,598	32,621	173,345	162,780	-10,565
Mar 09				**6,377**	5,779	6,255	5,551	23,962	25,508	1,546
Apr 09					**38,854**	32,517	37,454	108,825	116,562	7,737
May 09						**11,710**	9,496	21,206	23,420	2,214
Jun 09							**32,499**			
							TOTAL	**899,532**	**1,039,631**	**140,099**

PATIENTS	44	27	37	7	51	15	55

AVERAGE PER PATIENT

	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09	Jun 09	TOTAL	PROJECTED	SAVINGS
Dec 08	**1,725**	1,311	1,232	1,270	1,407	1,226	1,457	9,627	12,077	2,450
Jan 09		**1,111**	938	957	789	793	916	5,504	6,666	1,162
Feb 09			**880**	1,069	973	881	882	4,685	4,399	-286
Mar 09				**911**	826	894	793	3,423	3,644	221
Apr 09					**762**	638	734	2,134	2,286	152
May 09						**781**	633	1,414	1,561	148
Jun 09							**591**			
							TOTAL	**26,787**	**30,633**	**3,846**

REVIEWED PATIENTS SELECTED FOR RISK SUM - NO INCREASE IN COSTS ASSUMED

	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09	Jun 09	TOTAL	PROJECTED	SAVINGS
Dec 08	**70,315**	67,004	59,662	67,290	65,779	70,043	59,987	460,080	492,205	32,125
Jan 09		**51,921**	46,015	54,076	55,796	55,891	64,477	328,176	311,526	-16,650
Feb 09			**10,949**	10,771	12,158	7,722	8,603	50,203	54,745	4,542
Mar 09				**65,601**	54,635	54,652	58,460	233,348	262,404	29,056
Apr 09					**17,290**	15,074	13,834	46,198	51,870	5,672
May 09						**94,806**	93,925	188,731	189,612	881
Jun 09							**37,218**			
							TOTAL	**1,306,736**	**1,362,362**	**55,626**

PATIENTS	45	47	9	62	14	106	29

AVERAGE PER PATIENT

	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09	Jun 09	TOTAL	PROJECTED	SAVINGS
Dec 08	**1,563**	1,489	1,326	1,495	1,462	1,557	1,333	10,224	10,938	714
Jan 09		**1,105**	979	1,151	1,187	1,189	1,372	6,982	6,628	-354
Feb 09			**1,217**	1,197	1,351	858	956	5,578	6,083	505
Mar 09				**1,058**	881	881	943	3,764	4,232	469
Apr 09					**1,235**	1,077	988	3,300	3,705	405
May 09						**894**	886	1,780	1,789	8
Jun 09							**1,283**			
							TOTAL	**31,629**	**33,375**	**1,746**

REVIEWED PATIENTS SELECTED FOR FILL COUNT - NO INCREASE IN COSTS ASSUMED

	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09	Jun 09	TOTAL	PROJECTED	SAVINGS
Dec 08	**127,432**	85,815	83,451	90,525	95,618	95,232	91,221	669,294	892,024	222,730
Jan 09		**68,955**	53,390	50,988	52,533	55,074	61,017	341,957	413,730	71,773
Feb 09			**59,336**	66,262	57,280	49,876	55,145	287,899	296,680	8,781
Mar 09				**21,865**	11,566	14,761	11,305	59,497	87,460	27,963
Apr 09					**75,119**	49,868	61,295	186,282	225,357	39,075
May 09						**53,347**	35,641	88,988	106,694	17,706
Jun 09							**93,220**			
							TOTAL	**1,633,917**	**2,021,945**	**388,028**

PATIENTS	55	40	43	10	42	30	40

AVERAGE PER PATIENT

	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09	Jun 09	TOTAL	PROJECTED	SAVINGS
Dec 08	**2,317**	1,560	1,517	1,646	1,739	1,731	1,659	12,169	16,219	4,050
Jan 09		**1,724**	1,335	1,275	1,313	1,377	1,525	8,549	10,343	1,794
Feb 09			**1,380**	1,541	1,332	1,160	1,282	6,695	6,900	204
Mar 09				**2,187**	1,157	1,476	1,131	5,950	8,746	2,796
Apr 09					**1,789**	1,187	1,459	4,435	5,366	930
May 09						**1,778**	1,188	2,966	3,556	590
Jun 09							**2,331**			
							TOTAL	**40,764**	**51,130**	**10,365**