COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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Bill Ritter, Jr., Governor • Joan Henneberry, Executive Director

December 1, 2007

The Honorable Anne McGihon, Chairman
House Health & Human Service Committee
200 East Colfax
Denver, CO 80203

Dear Representative McGihon:

Enclosed please find a legislative report to the House Health & Human Services Committee on the Department of Health Care Policy and Financing's (Department) Pharmacy Utilization Plan FY 07-08.

C.R.S. § 25.5-5-506(3)(b) (2006) requires the Department to provide the Pharmacy Utilization Plan on an annual basis to the General Assembly.

The Pharmacy Utilization Plan describes the drug utilization mechanisms implemented by the Department and the estimated savings generated by those mechanisms.

Questions regarding the Pharmacy Utilization Plan can be addressed to Cathy Traugott, Pharmacy Section Manager. Her telephone number is 303-866-2468 and her email address is Catherine.Traugott@state.co.us.

Sincerely,

Joan Henneberry
Executive Director

JH:ke

Enclosure

Cc: Representative Jerry Frangas, Vice-Chairman, House Health and Human Services Committee
Representative Sara Gagliardi, House Health and Human Services Committee
Representative Gwyn Green, House Health and Human Services Committee
Representative John Kefalas, House Health and Human Services Committee
Representative Jim Kerr, House Health and Human Services Committee
Representative Dianne Primavera, House Health and Human Services Committee
Representative Jim Riesberg, House Health and Human Services Committee
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COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REPORT TO THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE, THE SENATE HEALTH AND HUMAN SERVICES COMMITTEE AND THE JOINT BUDGET COMMITTEE

ON

PHARMACY UTILIZATION PLAN FY 07-08

DECEMBER 1, 2007

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INTRODUCTION

The Pharmacy Utilization Plan FY 07-08 is required by C.R.S. § 25.5-5-506(3)(b) (2006) as stated below.

> (b) The state department shall report to the health and human services committees for the house of representatives and the senate, or any successor committees, and the joint budget committee no later than December 1, 2003, and each December 1 thereafter, on plan utilization mechanisms that have been implemented or that will be implemented by the state department, the time frames for implementation, the expected savings associated with each utilization mechanism, and any other information deemed appropriate by the health and human services committees, or any successor committees, or the joint budget committee.

The Department of Health Care Policy and Financing (the Department) has continued to pursue reductions in pharmaceutical expenditures as outlined in SB 03-294 and SB 03-011. The Department has implemented several utilization mechanisms to control costs while allowing access to medications for clients who need them. Such mechanisms include limits and prior authorizations on certain drugs. The Department is also considering other utilization mechanisms to determine if they would result in any reduction in expenditure. The Drug Utilization Review (DUR) Board established by the Department continues to review drug utilization issues and make recommendations to the Department to optimize appropriate prescription drug use. The DUR Board findings are used by the Department to review identified drugs and to achieve expenditure reduction in pharmaceuticals. The Business Research Division of the Leeds School of Business at the University of Colorado (the BRD) also continued to assist the Department until the end of their contract in June 2007. In addition, the Department continued to work with Comprehensive Neuroscience, Inc. to run the Behavioral Pharmacy Educational (BPE) Program, which identifies misutilization issues regarding mental health drugs and opioids and works with prescribers to change their prescribing habits. The Department is also in the process of developing a Preferred Drug List (PDL). Finally, the Department will continue to monitor monthly drug expenditures and provider/client utilization patterns.

Throughout this report, the Department identifies the utilization mechanisms that have been implemented to generate a reduction in expenditures to a specific prescription drug class, rather than attempting to identify a savings to the overall Department's pharmaceutical budget. The amounts reported for a specific drug or drug class does not capture the possible increased utilization of another prescription drug, which may act as a substitute. As an example, the reduction in expenditure from the implementation of prior authorizations on certain drugs in a drug class may have caused clients to shift to another drug in that drug class which is not subject to prior authorization. The reported reductions in expenditures detailed in this report are not offset by the possible increase in expenditure for other drugs. The increase in the utilization for other drugs directly related to the implementation of prior authorizations is not measurable.

PLAN UTILIZATION MECHANISMS PREVIOUSLY IMPLEMENTED

The following calculations contain FY 06-07 measures of the reductions in expenditure for each of the Department's utilization control initiatives. As FY 07-08 is not yet complete, the FY 07-08 figures below are forecasts. In certain categories, the FY 06-07 data below varies from last year's Pharmacy Utilization Plan (FY 06-07 Report) as the data is now complete and also because the calculations were refined and improved.

The Department believes that it is important to note that unmeasurable market factors may affect the reductions in expenditures realized by the implementation of these prior authorizations. This is particularly true for the prior authorizations that were implemented more than a year ago. The Department does not believe it is possible to accurately predict the potential reduction in expenditure after a prior authorization has been implemented for more than a year. There are potential methodologies but many factors make these methodologies unreliable. Those factors include the introduction of new drugs in the drug class, withdrawal of drugs from the market, new drugs in different drug classes that treat the same condition, new studies regarding the effectiveness of the drug, and the addition of more than 40,000 clients to Fee-for-Service Medicaid after the withdrawal of Colorado Access from Medicaid managed care. The loss of Colorado Access particularly makes it difficult to accurately assess the reduction in expenditure for prior authorizations created more than a year ago. Effective September 1, 2006, approximately 60,000 clients needed to be reassigned to either Fee-for-Service Medicaid or Denver Health, the only remaining managed care program. Approximately 20,000 clients chose to enroll in Denver Health leaving 40,000 additional clients in Fee-for Service Medicaid. The Department has not analyzed the effect from the increase in clients but it can only be assumed that the client increase affected the reductions in expenditures.

PHASE IV: Implemented March 1, 2007

The Department has implemented a number of limits and prior authorizations in phases over the past few fiscal years. Phase I, II and III have been analyzed in earlier Reports. While the Department believes that the limits and prior authorizations implemented in those Phases are still useful for utilization control, any savings calculations would be difficult given the significant time that has passed and the multiple market factors that could affect those calculations. Thus, no calculations are included in this Report for Phase I, II and III.

In Phase IV, prior authorizations were implemented for stimulant medications, Zantac liquid, Tramadol, narcotic analgesics, injectable medications, Methadone, Provigil and Fentora. Not all of the prior authorizations were implemented for cost savings. The injectable medications were placed on prior authorization because medications given in a physician's office are considered a medical benefit and not a pharmacy benefit by Colorado Medicaid. Other categories, such as the narcotic analgesics and Tramadol, were placed on prior authorization for safety reasons. The Department removed the prior authorization requirements from Methadone because of changes to the substance abuse policy. The details and reasoning for the prior authorization changes for Phase IV are described in the following sections.

Stimulants

Stimulant medications were placed on prior authorization for clients who are under 5 years of age and for clients 18 years of age and older. Some older stimulant medications were already on prior authorization but the newer medications were not included. To be consistent and fair for all drugs in this therapeutic class, a prior authorization was put into place for all stimulant medications.

FY 06-07 estimated reduction in expenditure within this drug class: $28,899

Zantac liquid

Zantac liquid was also placed on prior authorization because the liquid formulation is more expensive than other formulations that can be used by most clients. The utilization of this formulation of the drug has dropped significantly since the implementation of the prior authorization, which has resulted in a larger estimated reduction in expenditure than originally projected.

FY 06-07 estimated reduction in expenditure within this drug class: $57,499

Tramadol

Tramadol was placed on prior authorization to limit the quantity dispensed to the maximum safe dosage. Severe side effects are possible when this medication is taken at higher than recommended dosages. The prior authorization has stopped more than 200 claims per month that exceeded the maximum safe dose. Even with the implementation of the prior authorization, the expenditures on this drug increased primarily due to the increase in utilization within the safe dosage guidelines that keeps growing for this medication.

FY 06-07 estimated increase in expenditure within this drug class: $7,444

Narcotic analgesics

Similarly, acetaminophen containing products require a prior authorization when the dosage exceeds the maximum safe dosage. Acetaminophen is toxic when taken at high doses. The prior authorization limits the quantity to prevent over-utilization. The prior authorization has stopped over 3,000 claims per month that exceeded the maximum safe dose. Even with the implementation of the prior authorization, the expenditures on these drugs increased because of the continual increase in utilization within the safe dosage guidelines for narcotic pain medications.

FY 06-07 estimated increase in expenditure within this drug class: $8,091

Injectable medications

Medications administered in a physician's office are a medical benefit and not a pharmacy benefit with Colorado Medicaid. Several injectable medications were placed on prior authorization to make sure claims were being processed according to Department policy. The

resulting expenditures on these drugs through the pharmacy benefit dropped significantly but many of these claims were then paid by the Department as medical claims.

FY 06-07 estimated reduction in expenditure as a pharmacy benefit within this drug class: $634,507

Provigil
Provigil was placed on prior authorization to ensure the proper utilization of this product. The utilization of this drug has dropped significantly since the implementation of the prior authorization which has resulted in a large reduction in expenditure.

FY 06-07 estimated reduction in expenditure within this drug class: $100,951

Fentora
Fentora was placed on prior authorization because of the specific FDA safety restrictions associated with this narcotic medication. This medication should only be given to individuals who have cancer and are tolerant to opioid drugs.

FY 06-07 estimated reduction in expenditure within this drug class: $79,379

Methadone
Methadone was taken off of prior authorization because of the change in substance abuse policy. Historically, Methadone was not covered for substance abuse treatment because such treatment was not a Medicaid benefit. However, effective July 1, 2006, the Department provided a substance abuse treatment program as a benefit and thus the Department believed that this drug should be covered as a part of that treatment program.

FY 06-07 estimated increase in expenditure within this drug class: $5,344

PLAN UTILIZATION MECHANISMS TO BE IMPLEMENTED IN FY 07-08

The Department is continuing to monitor drug utilization and trends to determine if additional drugs should be placed on prior authorization. In addition, the Department will continue to update existing prior authorization criteria based on drug utilization and trends as well as new medical information.

PHASE V: Scheduled to be implemented early 2008

Preferred Drug List (PDL)
In January 2007, Governor Ritter signed Executive Order D 004 07 establishing a PDL for Colorado's Medicaid program. The purpose of this program is to provide needed medications to Medicaid clients while decreasing expenditures on pharmaceuticals. This Executive Order gives the Department the authority to implement a PDL. The Department engaged in significant

research about PDLs and obtained many comments from the public in order to determine the best way in which to implement the PDL. The Department recently passed rules regarding the PDL and the Pharmacy and Therapeutics Committee. The Department is responsible for forming a Pharmacy and Therapeutics Committee which will evaluate clinical data and evidence on all drugs under consideration for inclusion to the PDL. The Department will also evaluate and pursue supplemental rebates to further facilitate providing pharmaceuticals for Medicaid clients at the lowest possible cost. The Department will not join a purchasing pool to obtain such rebates but will pursue them independently.

Taking into account various factors, the Department estimates a reduction in expenditures of $20,758 per drug class per month in FY 07-08. The Department anticipates the implementation of the first three drug class by April 1, 2008 leading to an estimated reduction in expenditure of $186,820 for FY 07-08 (November 1, 2007 Budget Request, Base Reduction Item 2, Page G-23).

As FY 07-08 is not yet complete, these FY 07-08 figures are forecasts. For these forecasts, the Department assumed the proposed PDL would be implemented on April 1, 2008. Thus, the estimated reductions in expenditure are prorated for that portion of FY 07-08. Again, it is important to note that these are only estimates and that many immeasurable market factors may affect the reductions in expenditures actually realized by the Department.

OTHER ACTIVITIES

DUR Board Activities

In accordance with Federal law, the DUR Board performs various drug utilization review functions including retrospective drug utilization review and education to providers. The DUR Board also reviews certain policies of the Department and provides recommendations with regard to those policies.

The DUR Board is currently comprised of the following members:

Jeffrey Almony, M.D.
James R. Kant, R.Ph.
Robert D. McCartney, M.D., F.A.C.P.
Mary Newell, R.Ph.
Robert Lee Page II, Pharm. D.
James Regan, M.D.
Terrie A. Sajbel, Pharm. D.
Edra B. Weiss, M.D., F.A.A.P.
Kristin Andrews (pharmaceutical representative).

Kimberly Eggert, R.Ph., attends the Board's meetings as the Department's representative but does not hold a voting position on the Board. Health Information Designs, Inc. (HID), the Department's contractor, continues to provide assistance with the DUR Board. A HID representative, Candace Rieth, R.Ph., attends the DUR Board meetings.

The Board meets on a quarterly basis and holds special meetings when deemed necessary. During FY 06-07, the Board considered a number of issues including the review of the prior authorization criteria for the above-mentioned medications; a review of the length of the existing prior authorizations; and review of the retrospective drug utilization review criteria that is used to create client profiles and identify any potential misutilization issues (discussed below). The Department has considered all of the recommendations of the DUR Board and in many cases, has implemented the recommendations.

The Board and HID also review client drug profiles to determine if there are any utilization issues that need to be addressed. Educational letters are sent to providers regarding prescribing practices that could be deemed inappropriate. The goal of the program is to inform providers of potential drug utilization problems and change prescribing habits toward better utilization protocols.

HID provides a quarterly and biennial report of its activities and the activities of the DUR Board. The most recent biennial report was for the first six months of FY 06-07. During that time, HID and the DUR Board looked at the therapeutic appropriateness of topical steroids in the pediatric population, statin drug interactions, drug abuse issues, maximum dosage of acetaminophen, drug-drug interactions, drug-disease interactions, general overutilization and duplicate therapy, sedative/stimulant concurrent therapy and skeletal muscle relaxant duplication/overutilization. There were 1,538 clients identified with potential drug therapy issues. Letters were sent to physicians in 1,529 of those cases. The categories of drug therapy problems and percentage of cases in each category identified were as follows: 27% drug-disease interactions, 41% drug-drug conflict, 17% overutilization, 1% underutilization and 14% clinical appropriateness. About 43% of the prescribers voluntarily replied to the educational letters. There were a variety of responses from the physicians, including modification or discontinuance of therapy, several who scheduled appointments to discuss the issue with the clients and several who tried to modify therapy but the symptoms recurred. HID determined that the changes to appropriate therapy resulted in a reduction in expenditure of $330,835 to the Department during the first six months of FY 06-07. They also estimated that the Department's return on investment was $7.63 for every dollar spent on the contract with HID. Thus, although the primary goal of the DUR program is provider education and appropriate drug therapy, the program did result in a reduction of expenditures to the Department.

Behavioral Pharmacy Educational (BPE) Program

Starting June 1, 2006, the Department engaged in a two-year project with Comprehensive NeuroScience (CNS) to run the BPE Program. Through this Program, the Department is able to provide information to prescribers about the psychiatric and opioid medication utilization of their patients. The program is entirely funded by a grant from Eli Lilly and thus results in no cost to the Department.

The BPE program is designed to help ensure that the Department's clients receive the best care possible through more appropriate utilization of these medications. CNS has extensive experience in evidence-based and consensus-based standards for psychiatric medication prescribing and has administrated several similar projects for a number of other Medicaid programs. Twenty-five other states have also entered into similar agreements with CNS. Missouri, one of the first states, received the 2006 Bronze Achievement Award from the American Psychiatric Association for success in improving the quality of prescribing practices for psychiatric medications and patient outcomes.

During the span of the BPE Program, educational alerts/letters will be sent to prescribers to inform them if the medication dosing for their patients is in line with FDA guidelines and, for children, research and consensus-based guidelines. The messages are advisory and intended to be supportive. Prescribers are asked to review each case in the context of the guidelines and decide individually what is best for the patient. The program is also designed to notify prescribers about forgotten refills and when a patient obtains the same class of drug from multiple prescribers. If prescribing patterns do not change, follow-up letters are sent to the prescribers. When deemed necessary, peer consultants meet with prescribers to discuss their prescribing habits and current clinical information regarding the drugs.

The program is designed to be educational to providers and to improve the quality of care for the Department's clients. Through better quality of care and utilization, the program provides cost savings.

Since the program was implemented in June of 2006, CNS has reported a reduction in expenditure of $496,683 in behavioral pharmacy costs. It is not known how much of this savings occurred in FY 07-08. The BPE program will continue until the end of FY 07-08. The total savings from this program will be reported in the FY 08-09 report.

Utilization Research by the Business Research Division of the Leeds School of Business at the University of Colorado (the BRD)

The BRD performed a variety of research and analytical projects as directed by the Department to facilitate retrospective review of and reporting on the appropriateness of prescription drug use, provider prescribing habits, and the potential fiscal impact of drug utilization issues such as drug-drug interactions, drug-disease interactions and therapeutic duplication. In FY 06-07, the BRD performed analysis for previously implemented prior authorizations and limits and the impact of those initiatives on the Department's budget.

The BRD also produced a "Top 25 Drugs" report, which dissects Colorado Medicaid drug expenditures by gender, age, county, expenditure concentration[1], side-effects, utilization rates, and a cross-tabulation of linked drugs (so-called poly-pharmaceutical medications).

The contract with the BRD ended in June 2007 and was not renewed in order to direct the drug utilization review funding to the contractor needed to assist with the implementation of the PDL.

CONCLUSION

The Department has implemented a number of drug utilization mechanisms to control costs. Throughout this report, the Department identifies the utilization mechanisms that have been implemented to generate a reduction in expenditures to a specific prescription drug class, rather than attempting to identify a savings to the overall Department's pharmaceutical budget. Some mechanisms to control costs involve certain restrictions on drugs while others involve obtaining utilization reports and information from contractors which can be used to determine other mechanisms to achieve reduction in expenditures. A summary of the estimated reduction in expenditures by drug class or by contractor realized from these mechanisms is listed below.

FY 06-07 estimated reduction in expenditure by drug utilization mechanism:

Zantac Liquid..... $57,499
Provigil..... $100,951
ADHD drug class..... $28,899
Fentora..... $79,379
DUR Contract (annualized)..... $661,670
BPE Program..... $496,683

SUBTOTAL..... $1,425,081

FY 06-07 estimated increase in expenditure even with drug utilization mechanism:

Tramadol..... $7,444
Narcotic Analgesics..... $8,091
Methadone..... $5,344

TOTAL SAVINGS..... $1,404,202

FY 06-07 estimated reduction in expenditure for the pharmacy benefit for Injectables..... $634,507

[1] Expenditure concentration is a percentage measure that divides the number of clients by the total expenditures. A high expenditure concentration indicates, for example, that 5% of the clients account for 40% of the total drug cost. This concentration indicator provides a focus for Departmental cost-containing strategies.

FY 07-08 estimated reduction in expenditure by drug utilization mechanism:

PDL..... $186,280
BPE program (will be reported in FY 08-09)..... $0.00
Zantac Liquid.....$308,510
Provigil..... $279,061
ADHD drug class..... .....$543,959
Fentora.....$237,926

SUBTOTAL.....$1,555,736

FY 07-08 estimated increase in expenditure even with drug utilization mechanism:

Tramadol..... $40,562
Narcotic Analgesics..... $160,713
Methadone.....$5,593

TOTAL SAVINGS.....$1,348,868

FY 07-08 estimated reduction in expenditure for the pharmacy benefit for Injectables..... $2,351,484