COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax • (303) 866-3883 TTY

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

December 1, 2008

The Honorable Moe Keller, Chairman
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Senator Keller:

Enclosed please find a legislative report to the Joint Budget Committee on the Department of Health Care Policy and Financing's (Department) Pharmacy Utilization Plan FY 08-09.

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 Kim Eggert, Clinical Pharmacy Supervisor. Her telephone number is 303-866-3176 and her email address is kimberly.eggert@state.co.us.

Sincerely,

Joan Henneberry
Executive Director

JH:ke

Enclosure

Cc: Representative Jack Pommer, Vice-Chairman, Joint Budget Committee
Senator Abel Tapia, Joint Budget Committee
Senator Al White, Joint Budget Committee
Representative Mark Ferrandino, Joint Budget Committee
Representative Don Marostica, Joint Budget Committee
Senator Peter Groff, President of the Senate
Senator Ken Gordon, Senate Majority Leader
Senator Andy McElhany, Senate Minority Leader
Representative Andrew Romanoff, Speaker of the House
Representative Alice Madden, House Majority Leader
Representative Mike May, House Minority Leader
John Ziegler, JBC Staff Director
Melodie Beck, JBC Analyst
Todd Saliman, Director, Office of State Planning and Budgeting
Luke Huwar, Budget Analyst OSPB
Legislative Council Library (4 copies)
State Library (4 copies)
HCPF Executive Director's Office
Joan Henneberry, Executive Director
John Bartholomew, Budget and Finance Office Director
Sue Williamson, Director, Client & Community Relations Office
Jennifer Evans, Director, Administration and Operations Office
Sandeep Wadhwa, M. D., Director, Medical and CHP+ Program Administration Office
Ginny Brown, Legislative Liaison
Joanne Lindsay, Public Information Officer
HCPF Budget Library, HCPF Budget Division

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 2008-09

DECEMBER 1, 2008

TABLE OF CONTENTS

INTRODUCTION

The Pharmacy Utilization Plan FY 2008-09 is required by C.R.S. § 25.5-5-506(3)(b) (2008) 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 on certain drugs, prior authorizations and selecting drug classes for the Preferred Drug List (PDL). 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. Until the program ended on June 30, 2008, the Department continued to work with Comprehensive Neuroscience, Inc. to run the Behavioral Pharmacy Educational (BPE) Program, which identified misutilization issues regarding mental health drugs and opioids and works with prescribers to change their prescribing habits. Finally, the Department will continue to monitor monthly drug expenditures and provider/client utilization patterns.

In most cases, 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. As an example, the reduction in expenditure from the implementation of a prior authorization on certain drugs in a drug class may have caused clients to shift to another drug in a different therapeutic drug class, which may act as a substitute. The increase in the utilization for drugs in other therapeutic classes is not measurable, since there are many drugs that have multiple indications and many medications that are used for off-label indications. However in one case, the Department was able to estimate the reduction in expenditure not only to the Department's pharmaceutical budget but the Department's overall budget. This class will be explained in detail later in this report.

PLAN UTILIZATION MECHANISMS PREVIOUSLY IMPLEMENTED

The following calculations contain FY 2007-08 measures of the reductions in expenditure for each of the Department's utilization control initiatives. As FY 2008-09 is not yet complete, the FY 2008-09 figures below are forecasts. In certain categories, the FY 2007-08 data below varies from last year's Pharmacy Utilization Plan (FY 2007-08 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 and new studies regarding the effectiveness of the drug.

PHASE IV Implemented March 1, 2007

In Phase IV, prior authorizations were implemented for stimulant medications, Zantac liquid, Tramadol, narcotic analgesics containing acetaminophen, certain injectable medications, Methadone, Provigil and Fentora. Not all of the prior authorizations were implemented for cost savings. The Department removed the prior authorization requirements from Methadone because of changes to the substance abuse policy. Some categories, such as the narcotic analgesics and Tramadol, were placed on prior authorization for safety reasons. Certain injectable medications were placed on prior authorization because they are commonly administered in a physician's office, which is considered a medical benefit and not a pharmacy benefit by Colorado Medicaid. To prevent these medications from being double-billed as a medical and pharmacy claim, the Department implemented a prior authorization on the pharmacy side. The details and reasoning for the prior authorization changes for Phase IV are described further in the following sections. 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.

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 2007-08 estimated reduction in expenditure within this drug class: $927,251

Zantac liquid

Zantac liquid was placed on prior authorization because the liquid formulation is much more expensive than the tablet formulation, which can be used by most clients. The utilization of the liquid formulation has dropped significantly since the implementation of the prior authorization.

FY 2007-08 estimated reduction in expenditure for Zantac liquid: $178,236

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 estimate from last year's report showed an increase in expenditure even with the implementation of the prior authorization because the utilization of this drug kept growing. However, that estimate was a forecast. After running the data query this year, FY 2007-08 shows a decrease in expenditure for Tramadol.

FY 2007-08 estimated decrease in expenditure for Tramadol: $55,411

Narcotic analgesics containing acetaminophen

Similarly to Tramadol, narcotic analgesics containing acetaminophen 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 previous estimate from last year showed an increase in expenditure even with the implementation of the prior authorization because the utilization of this drug class kept growing. However, that estimate was a forecast. After running the data query this year, FY 2007-08 shows a decrease in expenditure for narcotic analgesics containing acetaminophen.

FY 2007-08 estimated reduction in expenditure for narcotic analgesics containing acetaminophen: $56,790

Injectable medications

Medications administered in a physician's office are a medical benefit and not a pharmacy benefit by Colorado Medicaid. Several injectable medications were placed on prior authorization to make sure claims were being processed according to Department policy. The pharmacy budget estimated a reduction in expenditure of $2,403,470. The medical budget estimated an increase of $1,337,282. Therefore, the Department realized an overall estimated reduction in expenditure.

FY 2007-08 estimated reduction in expenditure for the Department's overall budget for injectable medications: $1,066,188

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 an even larger reduction in expenditure than reported in the FY 2007-08 report.

FY 2007-08 estimated reduction in expenditure for Provigil: $328,387

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 2007-08 estimated reduction in expenditure for Fentora: $229,842

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 2007-08 estimated increase in expenditure within this drug class: $5,379

PHASE V: Implemented the Preferred Drug List (PDL) February 1, 2008

As stated in last year's report, Governor Ritter signed Executive Order D 004 07 in January 2007 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 gave 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 passed rules regarding the Pharmacy and Therapeutics Committee in October 2007 and rules regarding the PDL in November 2007. The Department formed a Pharmacy and Therapeutics Committee which evaluates clinical data and evidence on all drugs under consideration for inclusion to the PDL. The Department has also evaluated and pursued supplemental rebates to further facilitate providing pharmaceuticals for Medicaid clients at the lowest possible cost.

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

Since the PDL was not fully implemented by the time of last year's report, the FY 2007-08 figures were forecasts. The three drug classes that were added to the PDL in FY 2007-08 were Proton Pump Inhibitors (PPIs), Statins and Sedative/Hypnotics. PPIs were added to the PDL on February 1, 2008. Statins and Sedative/Hypnotics were added to the PDL on April 1, 2008. The estimated reduction in expenditure for FY 2007-08 covers the implementation date until June 30, 2008.

PPIs
Prevacid capsules and solutabs and Nexium capsules were selected as the Preferred drugs for this class. Aciphex, Nexium packets, Prevacid suspension, Prevpac, Prilosec OTC, Protonix and Zegerid were selected as Non-preferred products.

FY 2007-08 estimated reduction in expenditure within this drug class: $531,745

Statins
Lipitor, Crestor and Pravachol were selected as the Preferred drugs for this class. Altoprev, Lescol, Lescol XL, lovastatin, Mevacor, Pravachol, simvastatin, Caduet, Vytorin, Advicor and Zocor were selected as Non-preferred products.

FY 2007-08 estimated reduction in expenditure within this drug class: $445,231

Sedative/Hypnotics
Rozerem, Lunesta and Zolpidem were selected as the Preferred drugs for this class. Ambien and Sonata were selected as Non-preferred products.

FY 2007-08 estimated reduction in expenditure within this drug class: $84,721

Total FY 2007-08 estimated reduction in expenditure for the PDL.....$1,061,697

PLAN UTILIZATION MECHANISMS TO BE IMPLEMENTED IN FY 2008-09

The Department's main focus will continue to be on adding classes to the PDL. In addition, the Department will continue to monitor drug utilization, trends and safety information to determine if additional drugs should be placed on prior authorization.

PHASE VI: Continue Adding Classes to the PDL

The Department originally estimated savings of $670,376 for six months and $1,340,752 for twelve months from FY 2003-04 pharmaceutical data for Legislative Council's May 3, 2005 fiscal note for SB 05-022. This estimate was used to calculate the appropriation received by the Department during Figure Setting for FY 2006-07 (Figure Setting, February 14, 2007, page 14-15). This estimate was updated using FY 2006-07 data due to legislative changes impacting pharmacy expenditures including the impact of the Medicare Modernization Act of 2003. The Department also estimated implementing 2-3 drug classes quarterly, for a total of 12 drug classes

by the end of FY 2008-09. Further, the savings estimate was revised to account for the staggered drug class implementation dates and inflation due to the anticipated increase in drug utilization across fiscal years. As a result, the Department estimates a total potential savings of $2,438,677 in savings in FY 2008-09 for classes added to the PDL in FY 2007-08; this is $1,097,925 more than the $1,340,752 in savings in the Medical Services Premiums from the Figure Setting, March 8, 2007, page 52. These calculations are available in Table 4 in the Calculations for Request section in BRI-2, November 1, 2007 page G-14.

During FY 2008-09, the Department will add several more classes to the PDL. So far, newer generation antihistamines, angiotensin receptor blockers (ARBs), ARB combinations, renin inhibitors, renin inhibitor combinations, long-acting oral opioids, inhaled anticholinergics, anticholinergic combinations, short-acting inhaled beta2 agonists, long-acting inhaled beta2 agonists, inhaled corticosteroids, inhaled corticosteroid combinations, skeletal muscle relaxants and stimulants have been added to the PDL and several more classes will be added by the end of FY 2008-09. It is too soon to have estimates for reductions in cost for these classes. The total savings from the FY 2008-09 classes will be reported in the FY 2009-10 report.

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.
Lisa Sanchez, Pharm.D., (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 2007-08, the Board considered a number of issues including the review of the prior authorization criteria for the above-mentioned medications and classes 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 2007-08. During that time, HID and the DUR Board looked at the therapeutic appropriateness of topical immunomodulators, suicidality associated with antidepressants, diabetes management, drug-drug interactions, drug-disease interactions, drug-disease interactions with Pregabalin and interactions of triptans with SSRIs. There were 1842 clients identified with potential drug therapy issues. Letters were sent to physicians in 1457 of those cases. The categories of drug therapy problems and percentage of cases in each category identified were as follows: 22% drug-disease interactions, 43% drug-drug conflict, 12% overutilization, 2% underutilization and 21% clinical appropriateness. About 34% 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 $358,503 to the Department during the first six months of FY 2007-08. They also estimated that the Department's return on investment was $6.79 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 was able to provide information to prescribers about the psychiatric and opioid medication utilization of their patients. The program was entirely funded by a grant from Eli Lilly and thus resulted in no cost to the Department.

The BPE program was designed to help ensure that the Department's clients received 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 were sent to prescribers to inform them if the medication dosing for their patients were in line with FDA guidelines and, for children, research and consensus-based guidelines. The messages were advisory and intended to be supportive. Prescribers were asked to review each case in the context of the guidelines and decide individually what was best for the patient. The program was also designed to notify prescribers about forgotten refills and when a patient obtained the same class of drug from multiple prescribers. If prescribing patterns did not change, follow-up letters were sent to the prescribers. When deemed necessary, peer consultants met with prescribers to discuss their prescribing habits and current clinical information regarding the drugs.

The program was 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 provided cost savings.

The savings from the program was not given in the FY 2007-08 report because the final analysis from CNS was not completed. Since last year's report, CNS has been able to provide the cost avoidance information to the Department. CNS determined that the total cost avoidance for FY 2006-07 was estimated at $800,000 for adults and $1,100,000 for children. This measure takes in account the full twelve months of the intervention in addition to the results that were observed in FY 2007-08 on the population that was intervened in FY 2007. The total cost avoidance for FY 2007-08 was estimated at $20,000 for adults and $20,000 for children. The FY 2007-08 results were based on data from three mailing periods for both adult and child populations and followed through the end of the program.

CONCLUSION

The Department has implemented a number of drug utilization mechanisms to control costs. In most sections of 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.

In addition to the estimated reduction in expenditure reported in the FY 2007-08 report, the estimated reduction in expenditure for FY 2006-07:

BPE Program.....$1,900,000

FY 2007-08 estimated reduction in expenditure by drug utilization mechanism:

Zantac Liquid	$178,236
Provigil	$328,387
Stimulants	$927,251
Fentora	$229,842
Tramadol	$55,411
Narcotic Analgesics containing acetaminophen	$56,790
Injectables	$1,066,188
Statins	$445,231
PPIs	$531,744
Sedative/Hypnotics	$84,720
DUR Contract (annualized)	$717,006
BPE Program	$40,000
PDL	$1,061,697
SUBTOTAL	$5,722,503

FY 2007-08 estimated increase in expenditure by drug utilization mechanism:

Methadone	$5,379
TOTAL SAVINGS FY 2007-08	$5,717,124

FY 2008-09 estimated reduction in expenditure by drug utilization mechanism:

PDL	$2,438,677
TOTAL SAVINGS FY 2008-09	$2,438,677