# FEDERAL FISCAL YEAR 2012
# MEDICAID DRUG UTILIZATION REVIEW
# ANNUAL REPORT

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Section 1927(g)(3)(D) of the Social security Act requires each State to submit an annual report on the operation of its Medicaid Drug Utilization Review (DUR) program. Such reports are to include: descriptions of the nature and scope of the prospective and retrospective DUR programs; a summary of the interventions used in retrospective DUR and an assessment of the education program; a description of DUR Board activities; and an assessment of the DUR program's impact on quality of care as well as any cost savings generated by the program.

This report is to cover the period October 1, 2011 to September 30, 2012 and is due for submission to CMS by no later than June 28, 2013. Answering the attached questions and returning the requested materials as attachments to the report will constitute full compliance with the above-mentioned statutory requirement.

*Note: this is a true copy of data submitted online to the Centers for Medicare and Medicaid Services.*

## I. State

1. State Name Abbreviation: UT

## II. Medicaid Agency Information

2. Identify State person responsible for DUR Annual report preparation.
   First Name: Dr. Robyn M.
   Last Name: Seely, R.Ph., Pharm.D.
3. Address: 288 North 1460 West P.O. Box 143102
   City: Salt Lake City
4. State: UT
5. Zip Code: 84114
6. Email: rmseely@utah.gov
7. Phone: 801-538-6841

8. Identify pharmacy POS vendor – (Contractor, State-operated, Other).
   Contractor

9. Please enter the vendor name of explain –
   Goold Health Systems (GHS)

10. If not State-operated, is the POS vendor also the MMIS Fiscal agent?
    No

## III. Prospective DUR

11. Identify prospective DUR criteria source (First Data Bank, Other) –
    Other

12. If answer is "Other", please specify here –
    Medispan

13. Are new prospective DUR criteria approved by the DUR board (Yes, No)?
    Yes

14. When the pharmacist receives prospective DUR messages that deny the claim, does your system:
    a) Require preauthorization
    b) Allow the pharmacist to override with the correct "conflict", "intervention", and "outcome" codes?
    c) a and/or b above – depending on the situation
    c

15. If the answer is "c)", please explain –
    No claim is currently denied based upon prospective DUR messages. Claims are denied for early refill, duplication edits, lock-in (the patient is restricted to one pharmacy/physician), preferred drug list (PDL) and/or clinical prior authorizations (PAs).

16. Early refill: At what percent threshold do you set your system to edit?
    Non-controlled drugs: 80%
    Controlled drugs: 100%

17. When an early refill message occurs, does the State require prior authorization for non-controlled drugs (Yes, No)?
    Yes

18. Who obtains authorization (Pharmacist, Prescriber, Either)?
    Either

19. When an early refill message occurs, does the State require prior authorization for controlled drugs (Yes, No)?
    Yes

20. Who obtains the authorization (Pharmacist, Prescriber, Either)?
    Either

21. Therapeutic Duplication: When there is therapeutic duplication, does the State require prior authorization for non-controlled drugs (Yes, No, Sometimes)?
    Sometimes.

22. If the answer is "Sometimes", please explain –
    Multiple medications within a class are used frequently for a synergistic approach to disease management. For example, it is not uncommon to use more than one type of insulin.

23. When there is therapeutic duplication, does the State require prior authorization for controlled drugs (Yes, No, Sometimes)?
    Sometimes.

24. If the answer is "Sometimes", please explain –
    A cumulative edit is set to deny for therapeutic duplication that occurs over a set amount. For example, the system accumulates and tracks all hydrocodone + acetaminophen dosages and limits the total quantity that can be obtained without prior authorization.

25. State is providing DUR criteria data requested in Table 1 – Prospective DUR Criteria Reviewed by DUR Board, indicating by problem type those criteria with the most significant severity levels that were reviewed in-depth by the DUR Board in this reporting period (Yes, No).

Yes

## 26. Table 1 – Prospective DUR Criteria Reviewed by DUR Board

| Problem Type | AHFS Therapeutic Category Level 2 | AHFS Therapeutic Category Level 4 | Drug Name |
|---|---|---|---|
| Inappropriate Dose | Central Nervous System Agents | Anxiolytics | citalopram |
| | Blood Formation, Coagulation & Thrombosis | Hemorrheologic Agents | rivaroxaban |
| | Central Nervous System Agents | Analgesics and Antipyretics | fentanyl |
| Therapeutic Duplication | Central Nervous System Agents | Anxiolytics | citalopram, escitalopram |
| | Central Nervous System Agents | Psychotherapeutic Agents | modafinil, armodafinil |
| Inappropriate Duration | Gastrointestinal Drugs | Prokinetic Agents | metoclopramide |
| | Hormones and Synthetic Substitutes | - | mecasermine |
| | Respiratory Tract Agents | Antivirals | palivizumab |
| Drug-Disease Interaction | Respiratory Tract Agents | Vasodilating Agents | treprostinil |
| | Respiratory Tract Agents | Vasodilating Agents | ambrisentan |

27. State has included Attachment 1 – Prospective DUR Review Summary (Yes, No).
    Yes

28. Attachment 1 File Name –
    UT-2012-ATT.1-PRS

29. Attachment 1, see attached

## ATTACHMENT 1: PRODUR REVIEW SUMMMARY
## TOP 20 PROBLEM TYPES AND DRUG ALERTS

| DUR MESSAGE | DRUG NAME | # MESSAGES GENERATED | # OVERRIDES | # REVERSED | DENOMINATOR |
|---|---|---|---|---|---|
| DUPLICATE THERAPY Beta-Adrenergic Blockers/Statins | SIMVASTATIN | 2,355 | 2,609 | 228 | 90.3% |
| DUPLICATE THERAPY ACE Inhibitors/Capsaicin | LISINOPRIL | 2,183 | 3,220 | 299 | 67.8% |
| DUPLICATE THERAPY Sympathomimetics/Corticosteroids | VENTOLIN HFA | 2,165 | 2,759 | 377 | 78.5% |
| DUPLICATE THERAPY Acetaminophen/Estrogens | HYDROCODONE/ACETAMINOPHEN | 1,927 | 2,042 | 209 | 94.4% |
| DUPLICATE THERAPY Penicillins/Erythromycin | HYDROCODONE/ACETAMINOPHEN | 1,772 | 1,898 | 191 | 93.4% |
| DUPLICATE THERAPY Penicillins/Erythromycin | AMOXICILLIN | 1,677 | 1,825 | 219 | 91.9% |
| DUPLICATE THERAPY Acetaminophen/Anticholinergics | HYDROCODONE/ACETAMINOPHEN | 1,672 | 1,921 | 244 | 87.0% |
| DUPLICATE THERAPY Serotonin Reuptake Blockers/Benzodiazepines | ALPRAZOLAM | 1,661 | 1,937 | 244 | 85.8% |
| DUPLICATE THERAPY Sympathomimetics/Corticosteroids | ALBUTEROL SULFATE | 1,640 | 1,856 | 389 | 88.4% |
| DUPLICATE THERAPY Sympathomimetics/Corticosteroids | PREDNISONE | 1,575 | 2,329 | 373 | 67.6% |
| DUPLICATE THERAPY ACE Inhibitors/Capsaicin | HYDROCODONE/ACETAMINOPHEN | 1,510 | 1,697 | 226 | 89.0% |
| DUPLICATE THERAPY Beta-Adrenergic Blockers/Benzodiazepines | CLONAZEPAM | 1,195 | 1,416 | 180 | 84.4% |

| DUR MESSAGE | DRUG NAME | # MESSAGES GENERATED | # OVERRIDES | # REVERSED | DENOMINATOR |
|---|---|---|---|---|---|
| DUPLICATE THERAPY<br>Nifedipine & Derivatives/Diltiazem | FUROSEMIDE | 1,135 | 1,470 | 154 | 77.2% |
| DUPLICATE THERAPY<br>ACE Inhibitors/Capsaicin | METFORMIN HCL | 1,099 | 1,220 | 138 | 90.1% |
| DUPLICATE THERAPY<br>Serotonin Reuptake Blockers/Benzodiazepines | FLUOXETINE HCL | 1,094 | 1,177 | 241 | 92.9% |
| DUPLICATE THERAPY<br>Beta-Adrenergic Blockers/Statins | CARVEDILOL | 957 | 1,075 | 140 | 89.0% |
| DUPLICATE THERAPY<br>Oral Contraceptives/Benzodiazepines | CLONAZEPAM | 950 | 1,035 | 123 | 91.8% |
| DUPLICATE THERAPY<br>Topiramate/Lamotrigine | TOPIRAMATE | 940 | 1,144 | 125 | 82.2% |
| DUPLICATE THERAPY<br>Oral Contraceptives/Benzodiazepines | ALPRAZOLAM | 918 | 990 | 112 | 92.7% |
| DUPLICATE THERAPY<br>Topiramate/Lamotrigine | LAMOTRIGINE | 908 | 1,027 | 115 | 88.4% |

30. State has included Attachment 2 – Prospective DUR Pharmacy Compliance Report, a report on State efforts to monitor pharmacy compliance with oral counseling requirement (Yes, No).

    Yes

31. Attachment 2 File Name –

    UT-2012-ATT.2-PPCR

32. Attachment 2, see attached

# ATTACHMENT 2 - PRODUR PHARMACY COMPLIANCE REPORT

*(This attachment reports the monitoring of pharmacy compliance with all prospective DUR requirements performed by the State Medicaid agency, the State Board of Pharmacy, or other entity responsible for monitoring pharmacy activities. If the State Medicaid agency itself monitors compliance with these requirements, it may provide a survey of a random sample of pharmacies with regard to compliance with the OBRA 1990 prospective DUR requirement. This report details State efforts to monitor pharmacy compliance with the oral counseling requirement. This attachment should describe in detail the monitoring efforts that were performed and how effective these efforts were in the fiscal year reported.)*

The Utah State Board of Pharmacy, under the direction of the Department of Commerce, Division of Occupational and Professional Licensing, is responsible for administering and policing all aspects of the State Pharmacy Practice Act which has a provision mandating Patient Counseling on prescription drugs.

By statute, the Board of Pharmacy investigates all allegations against pharmacists. The Board monitors all pharmacists and claims, whether the claim is through Medicaid or through a different payer. While the Board researchd various allegations in Federal fiscal year 2012, failure to counsel was sometimes discovered and acted upon appropriately. Utah Medicaid does not maintain a record of how many or how often those failures to counsel occur as separate citations.

**Utah Code 58-17b-613. Patient counseling.**

(1) Every pharmacy facility shall orally offer to counsel a patient or a patient's agent in a personal face-to-face discussion with respect to each prescription drug dispensed, if the patient or patient's agent:
   (a) delivers the prescription in person to the pharmacist or pharmacy intern; or
   (b) receives the drug in person at the time it is dispensed at the pharmacy facility.

(2) A pharmacist or pharmacy intern shall provide counseling to each patient, and shall provide the patient with a toll-free telephone number by which the patient may contact a pharmacist at the dispensing pharmacy during normal business hours and receive oral counseling, with respect to each prescription drug dispensed if the patient provides or the prescription is otherwise provided to the pharmacy facility by a means other than personal delivery, and the dispensed prescription drug is mailed or otherwise delivered to the patient outside of the pharmacy facility.

(3) (a) The provisions of Subsections (1) and (2) do not apply to incarcerated patients or persons otherwise under the jurisdiction of the Utah Department of Corrections or a county detention facility.
   (b) A written communication with a person described in Subsection (3)(a) shall be used by a pharmacist or pharmacy intern in lieu of a face to face or telephonic communication for the purpose of counseling the patient.

## ATTACHMENT 2 – CONT'D.

**Utah Pharmacy Practice Administrative Rule R156-17b-610. Operating Standards – Patient Counseling.**
In accordance with Subsection 58-17b-601(1), guideline for providing patient counseling established in Section 58-17b-613 must include the following . . .

(3) A pharmacist shall not be required to counsel a patient or patient's agent when the patient of patient's agent refuses such consultation.
(4) The offer to counsel shall be documented and said documentation shall be available to the Division [of Administrative Rules]. These records must be maintained for a period of five years and be available for inspection within 7-10 business days.

## IV. Retrospective DUR

33. Identify the vendor that performed your retrospective DUR activities during the time period covered by this report (Company, Academic institution or Other organization) –
    Academic Institution.

34. Organization Name –
    University of Utah College of Pharmacy Drug Regimen Review Center.

35. Is the retrospective DUR vendor also the Medicaid fiscal agent (Yes, No)?
    No

36. Is this retrospective DUR vendor also the developer/supplier of your retrospective DUR Criteria?
    No

37. If the answer is "no", please explain –
    RetroDUR criteria are recommended by the DURB after careful review. Information is supplied by leading experts, studies, and other validated sources. Both the Utah Medicaid staff and the University of Utah College of Pharmacy recommend RetroDUR criteria to the DURB.

38. Does the DUR Board approve the retrospective DUR criteria supplied by the criteria source (Yes, No).
    Yes

39. State has provided the DUR Board approved criteria data requested on Table 2 – Retrospective DUR Approved Criteria (Yes, No).
    Yes

## 40. Table 2 – Retrospective DUR Approved Criteria

| AHFS Therapeutic Category Level 2 | AHFS Therapeutic Category Level 4 | Problem Type |
|---|---|---|
| Blood Formation, Coagulation & Thrombosis | Antithrombotic Agents | Inappropriate dose, over-utilization, therapeutic duplications and/or drug/disease contraindication |
| Gastrointestinal Drugs | Prokinetic Agents | Inappropriate duration and/or over-utilization |
| Central Nervous System Agents | Anticonvulsants, analgesics and/or anxiolytics | Inappropriate dose, over-utilization, and/or under-utilization |
| Hormones and Synthetic Substitutes | - | Incorrect duration and/or over-utilization |
| Respiratory Tract Agents | Antivirals and vasodilating agents | Inappropriate duration, over-utilization, and/or drug-drug interaction |

41. State has included Attachment 3 – Retrospective DUR Screening and Intervention Summary Report (Yes, No)
    Yes

42. Attachment 3 File Name –
    UT-2012-ATT.3-RSIS

43. Attachment 3, see attached

# ATTACHMENT 3 - RETRODUR SCREENING AND INTERVENTION SUMMARY REPORT

*This is a year-end summary report on retrospective DUR screening and interventions. Separate reports on the results of retrospective DUR screening and on interventions are acceptable at the option of the State. The report(s) should:*

*• Report the level of criteria exceptions by drug class (or drugs within the class) and problem type. (An exception is an instance where a prescription submitted for adjudication does not meet the DUR Board-approved criteria for one or more problem types within a drug class.)*

*NOTE: a) Reporting levels of criteria exceptions by only drug class (or drugs within the class) or problem type is not acceptable.*
Utah Medicaid's retrospective review program reports criteria exceptions by many means including drug class, specific drug, and problem type. Goold Health Systems and the University of Utah Pharmacy Department are also contracted to aid in identifying, reporting, and managing DUR activities.

*b) Year end summary reports should be limited to the Top 20 problem types with the largest number of exceptions.*
Please see Attachment 1.

- *Include a denominator for each drug class/problem type for which criteria exceptions are reported. A denominator is the number of prescription claims adjudicated for a drug class (or individual drugs in the class) during a given time period compared to the number of criteria exceptions for the drug class (or individual drugs in the class) during that time period.*
  A summary of all problem types reported for the full Federal fiscal year 2012 time frame is included in Attachment 1.

- *Also report, for each drug class/drug and problem type included in this summary report, the number of interventions (letters, face-to-face visits, etc.) undertaken during the reporting period.*

Utah Medicaid has a contract with the University of Utah's Drug Regimen Review Center (DRRC). The DRRC reviews Utah Medicaid clients who have high drug utilization and drug costs. These reviews began in 2002, and have proved advantageous for Utah Medicaid, prescribers, and clients. The DRRC contacts physicians who are prescribers for identified Medicaid clients and performs educational "peer reviews" of targeted clients. Client (and therefore prescriber) election is based on paid drug claim history. The goal is to reduce waste, duplication, and unnecessary prescription utilization. A report is composed and submitted to Utah Medicaid each year. The most recent report includes data from July 01, 2011 through June 30, 2012 attached as (Appendix 1). The table below summarizes the letters that the DRRC sent to prescribers in that time period. Each letter clearly stated one or more recommendations concerning specific Utah Medicaid patients, and included a voluntary feedback form. For the State fiscal year 2012, the DRRC program achieved over $958,108 in savings by assisting physicians to reduce the number of prescriptions that could cause potential adverse drug reactions, or eliminate unnecessary and/or duplicate prescriptions. Voluntary feedback indicates

that more than 50% of prescribers learned valuable information regarding specific medications, and that over 25% made changes to their patients' drug regimens as a result of the review.

| Problem Type | Number of Interventions |
|---|---|
| Untreated Indication | 459 |
| Therapeutic Duplication | 452 |
| Medication Over-Utilization | 408 |
| Additive Toxicity | 401 |
| Consider Alternative | 328 |
| Drug-Drug Interaction | 299 |
| Coordinate Care | 285 |
| Streamline Drug Treatment | 138 |
| Drug-Disease Interaction | 130 |
| Adherence | 126 |
| Excessive Dose | 109 |
| Subtherapeutic Dose | 42 |
| Treatment without indication | 41 |
| Other | 26 |
| Encourage Generic Use | 10 |

## V. Physician Administered Drugs

44. The Deficit Reduction Act requires collection of NDC numbers for covered outpatient physician administered drugs. These drugs are paid through the physician and hospital programs. Has your MMIS been designed to incorporate the data into your DUR criteria for both Prospective DUR and Retrospective DUR (Yes, No)?

    No.

45. Please explain –

    Goold Health Systems (GHS) became Utah's Point Of Sale vendor during Federal Fiscal Year 2011. Utah's MMIS system is midway into an approximately 9-year planning and programming phase. Interfaces between the GHS and MMIS continue to be evaluated and established.

## VI. DUR Board Activity

46. State is including a summary report of DUR activities and meeting minutes during the time period covered by this report as Attachment 4 – Summary of DUR Activities (Yes, No)?

    Yes.

47. Attachment 4 File Name –

    UT-2012-ATT.4-SDBA

48. Attachment 4, see attached

# ATTACHMENT 4 - SUMMARY OF DUR BOARD ACTIVITES

*This summary should be a brief descriptive report on DUR Board activities during the fiscal year reported.*

• *Indicate the number of DUR Board meetings held.*
During Federal fiscal year 2012 Utah Medicaid's DUR Board held nine meetings**.**

• *List additions/deletions to DUR Board approved criteria.*

a. *For prospective DUR, list problem type/drug combinations added or deleted.*
This information is summarized in Table 1.

b. *For retrospective DUR, list therapeutic categories added or deleted.*
This information is summarized in Table 2.

• *Describe Board policies that establish whether and how results of prospective DUR screening are used to adjust retrospective DUR screens. Also, describe policies that establish whether and how results of retrospective DUR screening are used to adjust prospective DUR screens.*

Findings from Prospective and Retrospective Drug Utilization Review directly affect each other. Anticipation of intentional or unintentional misuse of a drug give reason for a prospective review of the drug. Prior authorization (PA), quantity limits, mutual exclusivity with other drugs, or other measures may be recommended in order to guide use along FDA-approved indications. Retrospective review of a drug may be initiated as a follow-up to PA placement, in response to inside or outside interest, upon entry of new product(s) into a drug class, or for other reasons. For example, after a PA has been in place for approximately nine months, drug utilization, quantity and qualities of PA requests, and numbers of PA approvals are considered. If the current PA criteria effectively manage use of the drug, no change is made. PA criteria may be modified or removed if prior authorization causes unnecessarily narrow access to the drug. Inquiries received from providers, the University of Utah College of Pharmacy's Drug Regimen Review Center (DRRC), or generated internally as to potential drug therapy related issues may also initiate a retrospective review.

• *Describe DUR Board involvement in the DUR education program (e.g., newsletters, continuing education, etc.) Also, describe policies adopted to determine mix of patient or provider specific intervention types (e.g., letters, face to face visits, increased monitoring).*

The Utah DUR Board often recommends education information that is included in Medicaid's Amber Sheet newsletter. Example topics from Federal fiscal year 2012 include changes, addition, or removal of PA criteria, national drug recalls, use of generic or preferred drugs, use of drugs only for FDA-approved indications, and education regarding drug-specific dosing guidelines. Patient profiling is the primary method of monitoring used in Utah's DUR program. However, prescriber profiling is often included in the review of controlled substances.

## ATTACHMENT 4, CONT'D.

## DUR Board Activities

The Utah 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 Utah DUR Board is mandated by both state and federal law. The Board meets monthly and meetings are open to the public, except for patient-specific petitions from physicians seeking drug coverage outside policy and/or criteria guidelines.

This past year the DUR Board considered eight of these petitions. Frequently the Board requests additional information from the petitioner. Clients are not identified by name or ID number, so confidentiality is maintained. All petitions that are rejected still have the option of requesting a formal hearing. To date, no DUR Board decision has been overturned by a hearing.

In Federal fiscal year 2012 the DUR Board discussed fourteen issues over nine meetings, placing new prior authorization requirements on two different drugs, removing prior authorization requirements from three different drugs, altering prior authorization criteria for two different drugs, and adding quantity limits on two different drug products

49. Does your State have a Disease Management Program (Yes, No)?
Yes.

50. If the answer is "Yes", is your DUR Board involved with this program (Yes, No)?
No.

51. Does your State have a Medication Therapy Management Program (Yes, No)?
No.

## VII. Generic Policy and Utilization Data

52. State is including a description of new policies used to encourage the use of therapeutically equivalent generic drugs as Attachment 5 – Generic Drug Substitution Policies (Yes, No).
Yes.

53. Attachment 5 File Name –
UT-2012-ATT.5-GDSP

54. Attachment 5, see attached

# ATTACHMENT 5 – GENERIC DRUG SUBSTITUTION POLICIES

*Describe any policies used to encourage the use of generic drugs such as State maximum/minimum allowable cost (pricing, higher dispensing fee for generic and/or lower co-pay for generics). Include relevant documentation.*

**Utah Code 58-17b-606.**
**Title 58-Occupations and Professions**

(4) When a multisource legend drug is available in the generic form, the Department of Health may only reimburse for the generic form of the drug unless the treating physician demonstrates to the Department of Health a medical necessity for dispensing the nongeneric, brand-name legend drug.
(5) The Department of Health pharmacists may override the generic mandate provisions of Subsection (4) if a financial benefit will accrue to the state
(6) This section does not affect the state's ability to exercise the exclusion options available under the Federal Omnibus Budget Reconciliation Act of 1990.

As a result of this part of the Pharmacy Practice Act, Medicaid has placed all name brand products on prior approval if a generic is available, except when allowed rebates bring the cost of the brand name product lower than the generic. The mandate for the use of generics versus brand name drugs, along with the rebate program, has been cost effective. In Federal fiscal year 2012, the savings for this initiative has amounted to more than $490 million when the calculation is based on the average cost of multisource generic medications being priced at the average cost of a multisource brand name drug 100 percent of the time.

**PHARMACY GENERIC SAVINGS**

**Assumes 100% Brand**

| Drug Type | Claims | Reimbursement | Per Script |
|---|---|---|---|
| Generic (N) at Brand (S) | 2,015,163 | $542,401,273 | $269.16 |
| Brand (S) | 370,678 | $99,771,704 | $269.16 |
| Brand (I) | 190,678 | $25,917,132 | $135.92 |

**Actual**

| Drug Type | Claims | Reimbursement | Per Script |
|---|---|---|---|
| Generic (N) | 2,015,163 | $52,090,258 | $25.85 |
| Brand (S) | 370,678 | $99,771,704 | $269.16 |
| Brand (I) | 190,678 | $25,917,132 | $135.92 |

**GENERIC SAVINGS: $490,311,015.25**

## 55. Table 3 – Generic Utilization Data

| | Total Number of Claims | Total Reimbursement Amount Less Co-Pay |
|---|---|---|
| Single Source Drugs (S) | 370,678 | $99,771,703 |
| Non-Innovator Drugs (N) | 2,015,163 | $52,090,258 |
| Innovator Multi-Source Drugs (I) | 190,678 | $25,917,132 |

Key:
(S) Single-Source Drugs: have an FDA New Drug Application (NDA) approval for which there are no generic alternative available on the market.
(N) Non-Innovator Multiple-Source Drugs: have an FDA Abbreviated New Drug Application (ANDA) approval, and for which there exists generic alternatives on the market.
(I) Innovator (I) Multiple-Source Drugs: have an NDA and no longer have patent exclusivity.

Indicate the generic utilization percentage for all covered outpatient drugs paid during this reporting period:

56. Number of Generic (N) Claims: 2,015,163

57. Total Number of Claims (S, N, I): 2,576,519

58. Generic Utilization Percentage: 78%

Indicate the percentage dollars paid for generic covered outpatient drugs in relation to all covered outpatient drug claims paid during this reporting period:

59. Generic Dollars: $52,090,258

60. Total Dollars: $177,779,093

61. Generic Expenditure Percentage: 29%

## VIII. Program Evaluation / Cost Savings

62. Did your State conduct a DUR program evaluation/cost savings estimate (Yes, No)?
    Yes

63. Who conducted your program evaluation/cost savings estimate (Company, Academic institution, Other) –
    Company

64. Organization name –
    Goold Health Systems (GHS)

65. State is providing the Medicaid program evaluations/cost savings estimates as Attachment 6 – Cost Savings Estimate (Yes, No).
    Yes

66. Attachment 6 File Name
    UT-2012-ATT.6-CSE

67. Attachment 6, see attached

# ATTACHMENT 6 – COST SAVINGS ESTIMATES

**Preferred Drug List**
The actions that the DUR Board adopted for Federal fiscal year 2012 involved new product entries coming to market which lack historical data for comparison.

As a strategy for managing Medicaid pharmaceutical expenditure the Utah State Legislature passed Senate Bill 42 during the 2007 legislative session. This Bill allowed Medicaid to create a Preferred Drug List (PDL).

Utah Medicaid's PDL is designed to control spending growth by increasing the use of preferred drugs. Drug class reviews are performed by Utah Medicaid, public boards, and our contracted colleagues at the University of Utah. After thorough review, many drugs within a given class are found to be equally safe and effective. Of these equally safe and effective drugs, consideration is given to utilization and cost data, resulting in the identification of preferred drugs. These preferred drugs may be generic or branded agents. (Please note that while this Federal DUR report focuses on use of generic rather than branded drugs as the major source of cost savings, Utah Medicaid often gains cost savings through rebate programs. See Attachment 8 for a discussion of these cost savings.)

Utah Medicaid's PDL program became operational in October 2007 without the requirement of Prior Authorization (PA) for non-preferred drugs. Although it was a voluntary program, it was still able to reduce Medicaid claim expenses by approximately $1.9 million in total funds its first State fiscal year. Prior authorization requirements were introduced in the second, third and fourth years, which saw $7.3 million, $16.6 million and $26.7 million, respectively. This State fiscal year (2012) is the fifth year of the PDL program, and Utah Medicaid has enjoyed a reduction in claim expenses of over $34.0 million. Note that these savings include rebate savings in addition to generic substitution savings. It is clear that rebate savings contribute greatly to reduced claim expenses.

**Prospective Drug Utilization Review**

Attachment 1 provides information regarding the top 20 drugs generating the most ProDUR alerts in Federal fiscal year 2012. Total monies captured from claims that were reversed as a result of ProDUR alerts were added for the twelve months. Pro-DUR reversals resulted in over $12.0 million total savings in Federal fiscal year 2012.

**Retrospective Drug Utilization Review**

The University of Utah's Drug Regimen Review Center generates an annual report for Utah Medicaid. The latest report includes information from July 1, 2011 to June 30, 2012. During this period it is conservatively estimated that Retrospective Drug Utilization Review has saved more than $958,000 total funds for Utah Medicaid (see Attachment 3).

68. Please state the estimated net savings amount.
    $13,053,275

69. Please provide the estimated percent impact of your State's cost savings program compared to total drug expenditures for covered outpatient drugs. Divide the estimated net savings amount provided in Section VII, Question 4, above, by the total dollar amount provided in Section VII, Question 3. Then multiply this number by 100.
    7%

## IX. Fraud, Waste, and Abuse Detection

70. Do you have a process in place that identifies potential fraud or abuse of controlled substances by recipients (Yes, No)?
    Yes

71. If Yes, what action(s) do you initiate?
    Deny the claim and/or refer the recipient to lock-in program and/or refer to Medicaid Fraud Control Unit (MFCU) or Program Integrity

72. Do you have a process in place that identifies potential fraud or abuse of controlled substances by prescribers (Yes, No)?
    Yes

73. If Yes, what action(s) do you initiate?
    Refer to Medicaid Fraud Control Unit (MFCU) or Program Integrity

74. Do you have a process in place that identifies potential fraud or abuse of controlled substances by pharmacy providers (Yes, No)?
    Yes

75. If Yes, what action(s) do you initiate?
    Refer to Medicaid Fraud Control Unit (MFCU) or Program Integrity

76. Does your State have a Prescription Drug Monitoring Program (PDMP) (Yes, No)?
    Yes.

77. State is providing the Medicaid program evaluations/cost savings estimates as Attachment 7 – Prescription Drug Monitoring Program (Yes, No).
    Yes, Attachment 7 File Name = UT-2012-ATT.7-PDMP

78. Attachment 7, see attached

# ATTACHMENT 7 – PRESCRIPTION DRUG MONITORING PROGRAM

In fiscal year 2002, Congress appropriated funding to the U.S. Department of Justice to support Prescription Drug Monitoring Programs (PDMPs). These programs help prevent and detect the diversion and abuse of pharmaceutical controlled substances, particularly at the retail level where no other automated information collections system exists. States that have implemented PDMPs have the capability to collect and analyze data on filled and paid prescriptions more efficiently than those without such programs, where the collection of prescription information can require a time-consuming manual review of pharmacy files. If used properly, PDMPs are an effective way to identify and prevent diversion of the drugs by health care providers, pharmacies, and patients.

## Utah Controlled Substance Database

See Utah Code 58-37F, Controlled Substance Database Act. A summary of pertinent information is presented below.

**The Program**

The Utah Controlled Substance Database Program was legislatively created and put into effect on July 1, 1995. It is used to track and collect data on the dispensing of Schedule II-V drugs by all retail, institutional, and outpatient hospital pharmacies, and by both in-state and out-of-state mail order pharmacies. The data is disseminated to authorized individuals and used to identify potential cases of over-utilization, misuse, and over-prescribing of controlled substances throughout the state.

**The Requirement**

All retail, institutional, outpatient hospital pharmacies, and mail order pharmacies in Utah that dispense prescriptions for Schedule II-V drugs are required to report. Controlled substances dispensed (administered) to an inpatient at a licensed health care facility are exempt from reporting. A file containing records of each Schedule II-V drugs dispensed must be completed and submitted by the pharmacist-in-charge to the program manager once a week for the previous seven days.

**Collection of Data**

The required data may be reported by modem, an encrypted attachment to e-mail, or paper. Generally, the media used is dependent on the pharmacy software. Data must be submitted monthly, but many pharmacies submit it weekly or bi-weekly. All submissions are required to include a Data Transmission Form.

## X. Innovative Practices

79. Have you developed any innovative practices during the past year which you have included in Attachment 8 – Innovative Practices (Yes, No)?
    Yes

80. Attachment 8 File Name –
    UT-2012-ATT.8-IPN

81. Attachment 8, see attached

# ATTACHMENT 8 - INNOVATIVE PRACTICES NARRATIVE

*Please describe in detailed narrative form any innovative practices that you believe have improved the administration of your DUR program, the appropriateness of prescription drug use and/or have helped to control costs. (e.g., disease management, academic detailing, automated pre-authorizations, continuing education programs).*

## Re-examination of Cost Savings Calculations

Although not new to Utah Medicaid, an important cost-savings method has been overlooked in the annual Drug Utilization Review Report. Many of the questions and data requested in this Report address cost savings acquired by encouraging use of generic drug products over their branded counterparts. While such generic substitution policies can afford important up-front savings, some of Utah Medicaid's savings actually come from both the federal and supplemental rebate programs as managed through our Preferred Drug List (PDL). The PDL guides medication use to those drugs offering the best rebates. Once rebates are taken into account many older brand name products cost less than their generic counterparts. Please see Section VIII, Attachment 6. ProDUR and RetroDUR activities resulted in an estimated percent impact upon Utah's cost savings program of 7%. Preferred Drug List activities resulted in an estimated impact of over 25%. Note that the Preferred Drug List

## Streamlining Annual Drug Utilization Review Reports

Each year the state of Utah prepares extensive Drug Utilization Review (DUR) reports for both the Federal and State governments. Each report is time consuming, taking resources from DUR activities in order to report on DUR activities. In order to streamline these efforts, the State report has adapted the format and covered timeline of the Federal report. Both now report on the Federal fiscal year. This, in effect, allows the Federal DUR report to also serve as the State DUR report, allowing those involved in the preparation more time to perform daily DUR activities. Last year's report for Federal fiscal year 2011 was presented and accepted by all interested state and private entities. This report for Federal fiscal year 2012 is anticipated to be likewise submitted and accepted.

## Utah Medicaid Hemophilia Disease Management Program

Utah implemented its Medicaid Hemophilia Disease Management program in July 1998. This was done under a Modification to Utah's Choice Of Health Care Delivery Program 1915(B) Waiver. It allowed for the development of a Hemophilia Disease management and medication therapy program that allowed for reduced errors of duplication, less medication waste, and increased monitoring and education for hemophilia patients. Under this program Case Managers must be a LPN or RN with at least one year hemophilia experience. They must also visit patients in their home at least monthly. The Case Managers also work with the patients and their treating physicians to develop disease management plans and teach patients to keep monthly logs of all bleeds, medication use, histories of injuries, and completed education modules.

Under this program outdated quantities of factor over one percent per year are unacceptable. All clients must receive service from their case manager within 12 hours of a bleed. Medicaid receives quarterly reports regarding number of visits each patient received per month and treatment program efficacy. The Hemophilia Case Management program provides each patient

with a device for the duration of their participation in the program. The device has the capability to electronically record their monthly bleeds, medication use (antihemophilic and other), histories of injuries, and completed education modules. These records are sent regularly to treating physicians and case workers. Annual savings for drug product and dispensing fees alone average approximately $2 million per State fiscal year for about 25 patients (enrollment can vary monthly due to patients' Medicaid eligibility).

## Contracting an Outside Point of Sale Vendor

In Federal fiscal year 2010, a Request for Proposal (RFP) was issued inviting any interested vendors to submit a proposal for managing Utah Medicaid's Point of Sale (POS) system. Significant costs, both monetary and administrative, were required of Utah Medicaid in order to choose and initiate a vendor, but many processes, including many pertaining to DUR, are more efficient, and information more readily accessible. Goold Health System, Inc. was selected, and preparations for the change to the new POS system began in Federal fiscal year 2011. The new POS system has been in production since February 20, 2012, and has dramatically affected how Utah Medicaid staff perform day-to-day tasks. Utah Medicaid and GHS continue to work together to optimize the system. GHS has been a great help in providing the data for this report.

## Contracting an Outside MMIS Vendor

Utah Medicaid is midway through a decade-long migration to a new MMIS system. The Pharmacy department and GHS will work closely with the vendor, CNSI, to ensure that the new MMIS will serve the department's needs and that it will integrate as seamlessly as possible with the GHS POS system.

## XI. E-Prescribing

82. Has your State implemented e-prescribing (Yes, No)?
No

83. If "No", please skip to question 91.

91. If "No", are you developing this capability?
Yes

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