

Annual Drug Utilization Review Report Federal Fiscal Year 2013

Utah Medicaid

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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 between October 01, 2012 and September 30, 2013 and is due for submission to the Centers for Medicare and Medicaid Services no later than September 30, 2014. Answering the attached questions and returning the requested materials as attachments to the report will constitute full compliance with the above-mentioned statutory requirement.

I. Demographic Information

State Name Abbreviation: UT

Medicaid Agency Information: Identify State person responsible for DUR
Annual Report Preparation

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II. Prospective DUR

1. Identify pharmacy POS vendor – (Contractor, Utah Medicaid-Operated, Other).
Goold Health Systems (GHS)
2. Identify prospective DUR criteria source – (First Data Bank, Other).
Medispan
3. Are new prospective DUR criteria approved by the DUR board?
Yes
3. When the pharmacist receives a ProDUR alert message that requires a pharmacist’s review, does your system allow the pharmacist to override the alert using the “conflict, intervention and outcome” codes?
Yes.
4. Do you receive and review periodic reports from your ProDUR contractor providing individual pharmacy provider activity in summary and in detail?
No. These reports can be provided upon request.

If you receive reports, how often is the report received by the agency?
Per request

If you receive reports, do you follow up with those providers who routinely override with interventions?
Follow-up is determined post review

If you follow up, by what method do you do so?
Contact method is review-dependent

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

b) When an early refill message occurs, does Utah Medicaid require prior authorization for non-controlled drugs?

Yes

If Yes, who obtains authorization?

Either the pharmacy or the prescriber

If No, can the pharmacist override at the POS?

n/a

c) When an early refill message occurs, does Utah Medicaid require prior authorization for controlled drugs?

Yes

If Yes, who obtains the authorization?

Either the pharmacy or the prescriber

If No, can the pharmacist override at the POS?

n/a

6. When the pharmacist receives an early refill DUR alert message that requires the pharmacist's review, does your system allow the pharmacist to override for such situations as:

Lost or Stolen prescription/Vacation/Other.

No

7. Does your system have an accumulation edit to prevent patients from obtaining additional refills during the calendar year?

No

If No, do you plan to implement this edit?

No

8. Utah Medicaid has included [Table 1 – Top 10 ProDUR Alerts by Problem Type](#), indicating by problem type those criteria with the most significant severity level reviewed by the DUR Board?

Yes, see Appendix

9. Section 1927(g)(A) of the Social Security Act requires that the pharmacist offer patient counseling at the time of dispensing. Who in Utah Medicaid has responsibility for monitoring compliance with the oral counseling requirement? Utah Medicaid relies upon the State Board of Pharmacy, whose responsibility it is to monitor compliance with State Code and Administrative Rules that requires counseling.

10. Utah Medicaid has included **Attachment 1 – Prospective DUR Pharmacy Compliance Report**, a report on Utah Medicaid efforts to monitor pharmacy compliance with oral counseling requirement?
Yes, see Appendix

III. Retrospective DUR

1. Identify, by name and type, the vendor that performed your retrospective DUR activities during the time period covered by this report.
University of Utah College of Pharmacy Drug Regimen Review Center (DRRC)
2. Does the DUR Board approve the Retrospective DUR criteria supplied by the criteria source?
Yes
3. Utah Medicaid has included **Attachment 2 – Retrospective DUR Educational Outreach Summary**, a year-end summary of the top 10 problem types for which educational interventions were taken?
Yes, see Appendix

v. DUR Board Activity

1. Utah Medicaid is including a brief summary report of DUR activities and meeting minutes from the time period covered by this report as **Attachment 3 – Summary of DUR Activities?**

Yes, see Appendix

2. Does Utah Medicaid have a Disease Management Program?

Yes

If Yes, have you performed an analysis of the program's effectiveness?

Yes

If Yes, please provide a brief summary of your findings.

The hemophilia management program results in better outcomes for our patients (prevented ED visits, prevented supplemental doses, etc). Another result is cost savings of millions per year (current savings calculations are not available).

If Yes, is your DUR Board involved with this program?

No

3. Does Utah Medicaid have an approved CMS Medication Therapy Management Program?

No

4. If No, are you planning to develop and implement a program?

n/a

VI. Physician Administered Drugs

1. 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 system been designed to incorporate the data into your DUR criteria for both Prospective DUR and Retrospective DUR?
No
2. If No, do you plan to include this information in your DUR criteria in the future?
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 systems continue to be evaluated and established. When the new MMIS system is operational, we plan to expand the use of NDC data for covered outpatient physician-administered drugs.

VII. Generic Policy and Utilization Data

1. Utah Medicaid is including a description of policies that may affect generic utilization percentage as **Attachment 4 – Generic Drug Substitution Policies**
Yes, see appendix
2. In addition to the requirement that the prescriber write in his/her own handwriting “Brand Medically Necessary” for a brand name drug to be dispensed in lieu of the generic equivalent, does Utah Medicaid have a more restrictive requirement?
Yes

If Yes, indicate if any or all of the following apply:

Utah Medicaid requires preauthorization, including a medical reason, for override of non-preferred drugs. NOTE: Utah Medicaid does prefer some branded drugs because of favorable primary rebate positions.

3. Utah Medicaid has included **Table 2 – Generic Utilization Data?**
Yes, see Appendix
4. Indicate the generic utilization percentage for all covered outpatient drugs paid during this reporting period.

Number of Generic (N) Claims:	1,294,481
Total Number of Claims (S, N & I):	1,633,207
Generic Utilization Percentage:	79.26%

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

Generic Dollars:	\$28,537,823
Total Dollars:	\$118,251,071
Generic Expenditure Percentage:	24.13%

VIII. Program Evaluation / Cost Savings

1. Did Utah Medicaid conduct a DUR program evaluation of the estimated cost savings/cost avoidance?

Yes

If Yes, who conducted your program evaluation for the cost savings estimate/cost avoidance?

GHS and DRRC

3. Please provide your ProDUR and RetroDUR program cost savings/cost avoidance below.

ProDUR Total Estimated Avoided Costs:	\$11,031,639
<u>RetroDUR Total Estimated Avoided Costs:</u>	<u>\$934,776</u>
Total Estimated Avoided Costs:	\$11,966,415

4. Please provide the estimated percent impact of Utah Medicaid's cost savings/cost avoidance program compared to total drug expenditures for covered outpatient drugs. Divide the Grand Total Estimated Avoided Costs (immediately above) by the Total Dollars (above, in Section VII, Question 5). Then multiply this number by 100.

$$(\$11,966,415 / \$118,251,071) * 100 = 15.33\%$$

5. Utah Medicaid has provided the Medicaid cost savings/cost avoidance evaluation as [Attachment 5 – Cost Savings/Cost Avoidance Methodology](#)?

Yes, see Appendix

IX. Fraud, Waste, and Abuse Detection

1. Do you have a documented process in place that identifies potential fraud or abuse of controlled substances by recipients?

Yes

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

2. Do you have a “lock-in” program?

Yes

If Yes, what criteria does Utah Medicaid use to identify candidates for lock-in?

- 4 or more PCPs in 12 months
- 4 or more Pharmacies in 12 months
- 3 or more different providers prescribing controlled substances
- 5 or more non-emergent ER visits in 12 months

If Yes, do you restrict the member regarding
Both Prescriber and Pharmacy

3. What is the usual lock-in period?

Open-ended, reviewed after 12 months

4. On average, what percentage of Utah Medicaid’s population is in lock-in status annually?

0.35%

5. Please provide an estimate of the savings attributed to the lock-in program for the time period under review.

\$6.2 million

6. Do you have a process in place that identifies potential fraud or abuse of controlled substances by prescribers?

Yes

If Yes, what action/s do you initiate?

Refer to Medicaid Fraud Control Unit (MFCU) or Medicaid Office of Inspector General (OIG)

7. Do you have a process in place that identifies potential fraud or abuse of controlled substances by pharmacy providers?

Yes

If Yes, what action/s do you initiate?

Refer to Medicaid Fraud Control Unit (MFCU) or Program Integrity

8. Does Utah Medicaid have a Prescription Drug Monitoring Program (PDMP)?
Yes

If Yes, does Utah Medicaid have the ability to query the Utah Medicaid PDMD database?

No

If Yes, do you require prescribers (in your provider agreement with the Utah Medicaid) to access the PDMP patient history before prescribing restricted substances?

No

If Yes, please explain how Utah Medicaid applies this information to control fraud and abuse.

Utah Medicaid is limited by State Statute in how it may access and use data from the PDMP.

If Yes, do you also have access to border states' PDMP information?

No

9. Are there barriers that hinder the Utah Medicaid from fully accessing the PDMP that prevent the program from being utilized that was it was intended to be, to curb abuse?

Yes.

If Yes, please explain the barriers (e.g. lag time in prescription data being submitted, prescribers not accessing, pharmacists unable to view prescription history before filling script).

Utah Medicaid is limited by State Statute in how it may access and use data from the PDMP. Utah Medicaid can access the Utah Controlled Substance Database, but pharmacy managed care providers cannot. Legislation has been proposed. Lag time also limits its usefulness.

10. Does Utah Medicaid require that pain management providers be certified?
No

Does Utah Medicaid obtain DEA Active Controlled Substance Registrants' files in order to identify prescribers not authorized to prescribe controlled drugs?

No

If Yes, do you apply this DEA file to your ProDUR POS edits to prevent unauthorized prescribing?

n/a

If Yes, please explain how the information is applied.

n/a

If No, do you plan to obtain this DEA Active Controlled Substance Registrant's file and apply it to your POS edits?

Programs from our POS vendor allow us to look up a provider's DEA status, but these queries are only done ad hoc, not for every fill.

Do you apply this DEA file to your RetroDUR review?

No

If Yes, please explain how it is applied.

n/a

11. Do you have measures in place to monitor/manage the prescribing of methadone for pain management?

Yes

If Yes, indicate if any or all of the following apply:

Quantity limits; 150 tablets or 2,000mL (regardless of strength) per 30 days

12. Do you currently have POS edits in place to limit the quantity of short-acting opioids?

Yes

If Yes, what are your limitations?

180 tablets (regardless of specific product or strength) per 30 days

Do you currently have POS edits in place to limit the quantity of long-acting opioids?

Yes

If Yes, what are your limitations?

90 tablets (regardless of specific product or strength) per 30 days

13. Have you set recommended maximum morphine equivalent daily dose (MEDD) measures?

No

If Yes, what is your maximum MEDD limit in milligrams?

n/a

Do you provide information to your prescribers on how to calculate the MEDD?

No

If Yes, how is this information disseminated? Indicate if any or all of the following apply:

n/a

Do you have an algorithm in your POS system that alerts the pharmacy provider that the MEDD prescribed has been exceeded?

No

14. Does your agency set mg per day limits on the use of buprenorphine?

Yes

If Yes, specify

24mg / day (Suboxone) and 17.1mg / day (Zubsolv)

What are your limitations on the allowable length of treatment?

18 month initial approval, 18 month reauthorization, then no more under any other circumstances.

Do you require that the max per day be reduced after a set period of time?

Yes

If Yes, what is your reduce (maintenance) dosage?

No set dose, taper required for re-authorization

What are your limitations of the allowable length of treatment?

36 months total

Do you limit the type of dosage form that can be dispensed to only the sublingual film?

No, Utah Medicaid allows Suboxone film and tablets, and Zubsolv tablets (the only dosage form available)

15. Psychotropic drugs / Stimulants

Do you have a documented program in place to manage/monitor the appropriate use of psychotropic drugs in children?

No

If "Yes", do manage/monitor...

n/a

Do you have any documented restrictions or special programs in place to monitor/manage or control the use of stimulants?

Yes. We have PA criteria for off-label use in children, and for any use in adults.

X. Innovative Practices

1. Have you developed any innovative practices during the past year which you have included in [Attachment 6 – Innovative Practices](#)?
Yes, see Appendix

XI. E-Prescribing

1. Has your State implemented e-prescribing?

Yes

If Yes, does your system use the NCPDP Origin Code that indicates the prescription source?

Yes

If Yes, does your program system (MMIS or pharmacy vendor) have the capability to electronically provide a prescriber, upon inquiry, patient drug history data and pharmacy coverage limitations prior to prescribing?

Yes, on the GHS provider portal

Do you have a methodology to evaluate the effectiveness of providing drug information and medication history prior to prescribing?

Yes, see Appendix

If Yes, please explain the evaluation methodology in [Attachment 7 – E-Prescribing Activity Summary](#)

If No, are you planning to develop this capability?

n/a

XII. Managed Care Organizations

Is your pharmacy program included in the capitation rate (carved-in)?

Partially. Suboxone, antidepressants, anticonvulsants, anxiolytics, sedatives/hypnotics and stimulants are “carved-out” and managed by fee-for service.

Does the state set requirements for the MCO’s pharmacy benefit?

Yes, MCOs must cover everything that Utah Medicaid covers. They are contractually able to extend coverage and can develop their own PDLs.

Does the state require the MCOs to monitor or report their DUR activities?

Yes

XIII. Executive Summary

Please include an Executive Summary as [Attachment 8](#)

See Appendix

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Appendix 1

Attachments and Tables

Table 1 – Top 10 ProDUR Alerts by Problem Type

Indicate by problem type those criteria with the most significant severity levels that were reviewed in-depth by the DUR Board. For each problem type below in the first column list the drugs/drug category/disease combinations for which the DUR Board conducted in-depth reviews.

Accepted Problem Types:

IA Dose = Inappropriate Dose

IA Duration = Inappropriate Duration

TC Duplication = Therapeutic Duplication

D/D Interaction = Drug/Drug Interaction

D/A Interaction = Drug/Allergy Interaction

D/Dx Interaction = Drug Disease Interaction

Other

Your Top 10 ProDUR Alerts may include any or all of the Problem Types.

*AHFS TC = American Society of Health-System Pharmacists Therapeutic Category. For identification of drug classifications, the Centers for Medicare and Medicaid (CMS) has forwarded a file named **AHFS TC.pdf** to Utah Medicaid. The full file is readily available upon request.*

Table 1 – Top 10 ProDUR Alerts by Problem Type

Problem Type	AHFS TC Level 2	AHFS TC Level 4	AHFS TC Level 6	AHFS TC Level 8	Drug Name	Disease	Criteria Implemented
D/D	28 central nervous system agents	28:16 psychotherapeutic agents	28:16.04 antidepressants	28:16.04.20 selective serotonin reuptake inhibitors	citalopram	depression	None – legislatively mandated not to control mental health drugs
D/D	28 central nervous system agents	28:80 analgesics and antipyretics	28:80.08 opiate agonists	28:80.08 opiate agonists	tramadol	moderate to severe pain	quantity limits
D/D	56 gastrointestinal drugs	56:28 antiulcer agents and acid suppressants	56:28.36 proton pump inhibitors	56:28.36 proton pump inhibitors	omeprazole	ulcer, GERD, esophagitis, etc	quantity limits
D/D	28 central nervous system agents	28:16 psychotherapeutic agents	28:16.08 antipsychotics	28:16.08.04 atypical antipsychotics	quetiapine	bipolar, depression, schizophrenia etc	None – legislatively mandated not to control mental health drugs
D/D	28 central nervous system agents	28:32 antimigraine agents	28:32.28 selective serotonin agonists	28:32.28 selective serotonin agonists	sumatriptan	migraine	quantity limits
D/D	28 central nervous system agents	28:16 psychotherapeutic agents	28:16.04 antidepressants	28:16.04.20 selective serotonin reuptake inhibitors	trazodone	depression	None – legislatively mandated not to control mental health drugs
D/D	56 gastrointestinal drugs	56:22 antiemetics	56:22.20 5-HT3 receptor antagonists	56:22.20 5-HT3 receptor antagonists	ondansetron	antiemetic	none
D/D	28 central nervous system agents	28:12 anticonvulsants	28:12.08 benzodiazepines	28:12.08 benzodiazepines	clonazepam	seizure disorders, panic disorders, etc	None – legislatively mandated not to control mental health drugs
D/D	28 central nervous system agents	28:16 psychotherapeutic agents	28:16.04 antidepressants	28:16.04.20 selective serotonin reuptake inhibitors	escitalopram	depression	None – legislatively mandated not to control mental health drugs
D/D	28 central nervous system agents	28:16 psychotherapeutic agents	28:16.08 antipsychotics	28:16.08.04 atypical antipsychotics	risperidone	bipolar, schizophrenia etc	None – legislatively mandated not to control mental health drugs

Attachment 1 – Prospective DUR Pharmacy Compliance Report

This attachment reports the monitoring of pharmacy compliance with all prospective DUR requirements performed by Utah Medicaid or other entity responsible for monitoring pharmacy activities. If Utah Medicaid 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 Utah Medicaid's 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 reporting time period. Include relevant documentation, including any written policies. It may be useful to refer to Utah Code 58-17b-613 and Utah Pharmacy Practice Administrative Rule R156-17b-610.

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 enforcing 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 researching various allegations in Federal fiscal year 2013, 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.

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 or 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.

Attachment 2 – Retrospective DUR Educational Outreach Summary

This is a summary of retrospective DUR screening and educational interventions. The year-end summary report should be limited to the Top 10 problems with the largest number of exceptions. The results of RetroDUR screening and interventions should be included.

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 October 01, 2012 through September 30, 2013. 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 Federal fiscal year 2013, the DRRC program achieved over \$935,000 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.

Top 10 Problem Types	Number of Interventions
Medication Over-Utilization	602
Untreated Indication	511
Consider Alternative	459
Additive Toxicity	401
Therapeutic Duplication	322
Adherence	187
Excessive Dose	157
Streamline	153
Coordinate Care	148
Drug-Drug Interaction	144

Attachment 3 – Summary of DUR Activities

This summary should be a brief descriptive report on DUR Board activities during the reporting period. This summary should:

- *Indicate the number of DUR Board meetings held.*
- *List additions/deletions to DUR Board approved criteria.*
 - *For prospective DUR, list problem type/drug combinations added or deleted*
 - *For retrospective DUR, list therapeutic categories added or deleted*
- *Describe Board policies that establish whether and how results of prospective DUR screening are used to adjust retrospective DUR screens. Also describe (and provide the text of) policies that establish whether and how results of retrospective DUR screening are used to adjust prospective DUR screens.*
- *Describe DUR Board involvement in the DUR education program (e.g., newsletters, provider education, etc.) Also describe (and provide the text of) policies adopted to determine mix of patient or provider specific intervention types (e.g., letters, face to face visits, increased monitoring).*

During Federal fiscal year 2013 Utah Medicaid's DUR Board held ten meetings

ProDUR: Tramadol quantity limits, proton-pump inhibitor quantity limits, sumatriptan quantity limits.

RetroDUR: PA on androgens, loosen PA criteria on insulin pens, require step-through ≥ 2 alternatives before prescribing a dipeptidyl peptidase IV inhibitor, PA on rifaximin.

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 limited 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.

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. Provider education consists largely of the letters sent from the University of Utah College of Pharmacy's Drug Regimen Review Center (DRRC). The details of new policies suggested by the Board and adopted by Utah Medicaid are published in the quarterly Medicaid Information Bulletin (MIB).

Attachment 4 – Generic Drug Substitution Policies

Please report any factors that could affect your generic utilization percentage and include any relevant documentation, including any written policies.

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 non-generic, 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 very cost effective. In Federal fiscal year 2013, the savings for this initiative has amounted to more than \$525 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.

Table 2 – Generic Utilization Data

Please provide the following utilization data for this reporting period for all covered outpatient drugs paid. Exclude Third Party Liability.

Drugs are classified as follows:

- (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.*

Generic Utilization Percentage: To determine the generic utilization percentage of all covered outpatient drugs paid during the reporting period, use the following formula:

$$\text{Generic Utilization Savings} = 100 \times N \div (S + N + I) = 79\%$$

Generic Expenditures Percentage of Total Drug Expenditures: To determine the generic expenditure percentage for all covered outpatient drugs for this reporting period, use the following formula, rounding to the nearest \$1,000:

$$\text{Generic Expenditures Percentage of Total Drug Expenditures} = 100 \times \$N \div (\$S + \$N + \$I) = 24\%$$

Table 2 – Generic Utilization Data					
Single-Source (S) Drugs		Non-Innovator (N) Drugs		Innovator Multi-Source (I) Drugs	
Total Number of Claims	Total Reimbursement Amount, Less Co-Pay	Total Number of Claims	Total Reimbursement Amount, Less Co-Pay	Total Number of Claims	Total Reimbursement Amount, Less Co-Pay
227,000	\$75,466,000	1,295,000	\$28,538,000	111,000	\$14,247,000

*CMS has developed an extract file from the Medicaid Drug Rebate Program Drug Product Data File, identifying each NDC along with sourcing status of each drug: S, N or I. CMS has forwarded this file, named **Drug Product Data File.xlsx** to Utah Medicaid. The full file is readily available upon request.*

Attachment 5 – Cost Savings/Cost Avoidance Methodology

Include a copy of program evaluations/cost savings estimates prepared by Utah Medicaid or contractor, noting methodology used

Generic Drug Substitution Policies and Preferred Drug List

The actions that the DUR Board adopted for Federal fiscal year 2013 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 gains significant cost savings through rebate programs. See Attachment 4). 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. In 2008 prior authorization became a requirement, and in Federal fiscal year 2013 Utah Medicaid has enjoyed savings and cost avoidances of over \$101 million (including rebate savings).

Lock-In Program

One of the tools that Utah Medicaid uses to reduce fraud, waste and abuse is the lock-in program. For Federal fiscal year 2013, the program afforded almost \$6,200,000 in savings/cost avoidance.

Prospective Drug Utilization Review

Attachment 1 provides information regarding the top 10 ProDUR alerts in Federal fiscal year 2013. 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 \$11 million total savings/cost avoidance in Federal fiscal year 2013.

Retrospective Drug Utilization Review

The University of Utah's Drug Regimen Review Center generates an annual report for Utah Medicaid. For Federal fiscal year 2013, the DRRC program achieved almost \$935,000 in savings.

Total Cost Savings

The four methodologies mentioned above have resulted in a grand total of more than \$538 million in cost savings and avoidance in Federal fiscal year 2013.

Attachment 6 – Innovative Practices

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). Please include any written policies, if applicable.

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, an appreciable portion of Utah Medicaid's savings 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.

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 2011, in order to streamline these efforts, the State report 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.

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 results in fewer 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 an electronic 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 fiscal year for about 25 patients (enrollment can vary monthly due to patients' Medicaid eligibility).

Contracting an Outside MMIS Vendor

Utah Medicaid is midway through a decade-long migration to a new MMIS system. The Pharmacy department and GHS are working 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.

Attachment 7 – E-Prescribing Activity Summary

Please describe all development and implantation plans/accomplishments in the area of e-prescribing. Include any evaluation of the effectiveness of this technology (e.g. number of prescribers e-prescribing, percent e-prescriptions to total prescriptions, relative cost savings).). Please include any written policies, if applicable.

The Utah Health Information Network (UHIN) provides a low cost solution for exchanging administrative and clinical data through a secure internet gateway. Additionally, the UHIN supports the exchange of images. Utah Medicaid, most of Utah's commercial payers, most Utah Healthcare Providers, and thousands of National payers participate. Through the UHIN providers and payers can participate in the Clinical Health Information Exchange (cHIE).

The cHIE provides medical professionals with a way to share and view patient information in a secure electronic manner. This information is accessible, with patient consent, to authorized users while maintaining the highest standards of patient privacy. Also available is e-prescribing, Electronic Health Records (EHR) and e-prescriptions. This program began on May 10, 2010.

Another avenue for e-prescribing is Utah Medicaid's Provider Portal. Among other functionalities, prescribers can write and submit prescriptions through the Portal, and pharmacies can retrieve the prescriptions through the Portal. Providers must register and their professional status must be validated before Portal use. The Portal became available January 01, 2013. Use is very limited due to low provider awareness and training, although Utah Medicaid routinely notifies providers of its existence and many functions.

Utah Medicaid currently does not have the data necessary to approximate the percentage of primary care clinics that have adopted use of an EHR or the Medicaid Provider Portal in their practice. Most EHR have e-prescribing functionality. However, information on actual use and performance evaluation is not yet available. Data are not yet available for the number of prescribers who use e-prescribing (including the Portal), percent e-prescriptions to total prescriptions, or relative cost savings at this time.

Attachment 8 – Executive Summary

Utah Medicaid is pleased to report cost savings and avoidances totaling more than \$543 million during Federal fiscal year (FFY) 2013 (October 01, 2012 through September 30, 2013). Savings and avoidances have improved from year to year through the efforts of Utah’s Division of Medicaid and Health Financing and its contractors. A summary of Cost Savings/Avoidances (rounded to the nearest \$1,000) for FFY 2013 is below:

Generic Substitution Policies	\$423,692,000
Preferred Drug List/Rebate Policies	\$101,723,000
Prospective Drug Utilization Reviews	\$11,032,000
Lock-in Program	\$6,164,000
<u>Retrospective Drug Utilization Reviews</u>	<u>\$935,000</u>
Total	\$543,546,000

Note that the greatest contributor to cost savings and avoidances was garnered by the generic substitution policy described in Utah Code 58-17b-606. Although 79% of all prescriptions reimbursed by Utah Medicaid were for generic products, only 24% of the total prescription expenditures were for those generic products.

One arena in which Utah Medicaid seeks to control costs is that of pain and substance abuse treatments. In addition to generic substitution and rebate programs, quantity limits and prior authorizations are in place to discourage inappropriate use. Although limits on opiate drugs have been in place for years and are generally accepted by Utah prescribers, limits on buprenorphine – naloxone combination products (Suboxone and Zubsolv) are more controversial and sometimes overridden during the hearing process.

Suboxone and Zubsolv are two of the drugs that have been “carved out” of Utah Medicaid’s pharmacy managed care program. The entities with which Utah Medicaid contracts to manage the pharmacy benefit are called Accountable Care Organizations (ACOs). Utah Medicaid currently has contracts with four ACOS: Health Choice Utah, Healthy U, Molina and SelectHealth. The other “carved-out” drugs are antidepressants, anticonvulsants, anxiolytics, sedatives/hypnotics and stimulants. Interestingly, like many States, Utah legislation does not allow Medicaid to regulate use of most of the “carved-out” drugs (excepting Suboxone and sedatives/hypnotics).

Utah’s ACOs cannot currently access the Utah Controlled Substance Database, although Utah Medicaid can. However, legislation to allow access has been proposed. Other legislation has been passed that requires each ACO’s preferred drug list (PDL) to include the same drugs as does Utah Medicaid’s. Each ACO is free to expand upon the PDL as they see fit.

ACOs are at-risk entities which are charged with using a fixed amount of dollars to garner the greatest possible cost savings and avoidances without sacrificing optimal patient care. Each ACO is required to submit an annual report to Utah Medicaid.

Appendix 2

Utah Medicaid Drug Regimen Review Center Annual Report

Appendix 3

Annual Reports from Utah's Accountable Care Organizations

**Molina
Health Choice
Healthy U
Select Health**