Utah
Medicaid Fee-For-Service (FFS)
Federal Fiscal Year (FFY) 2022
Drug Utilization Review (DUR)
Annual Report

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Section I - Number of Beneficiaries

Question	Response
1. On a monthly average, how many of your State's Medicaid beneficiaries are enrolled in your State's Medicaid Fee-For-Service (FFS) program that have a pharmacy benefit?	86,915
2. On a monthly average, how many of your State's Medicaid beneficiaries are enrolled in managed care plan(s)?	378,621

Section II - Prospective DUR (ProDUR)

Question	Response
1. Indicate the type of your pharmacy point of service (POS) vendor.	Contractor
a. Vendor Name	Change Healthcare
b. Who processes the State's National Council for Prescription Drug Programs (NCPDP) transactions?	POS vendor is a separate Pharmacy Benefits Manager (PBM)
2. Identify your ProDUR table driven criteria source. This would be initial ratings such as drug to drug interactions, dose limits based on age and pregnancy severity (multiple responses allowed).	Medi-Span
If "Other," please specify.	N/A
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 "NCPDP drug use evaluation codes" (reason for service, professional service and resolution)?	Yes
If "Yes" or "Varies by Alert Type," check all that apply.	Alerts can be overridden with standard professional codes
If "Other," please explain.	N/A
4. Does your State receive periodic reports providing individual pharmacy providers DUR alert override activity in summary and/or in detail?	No
If "No," please explain.	Reports are received on an as needed basis from the point of sale contractor.
a. How often does your State receive reports (multiple responses allowed)?	N/A
If "Other," please explain.	N/A
b. If you receive reports, does your State follow up with those providers who routinely override with interventions?	N/A
If "Yes," by what method does your State follow up (multiple responses allowed)?	N/A

Question	Response
If "Other," please explain.	N/A
5. Early Refill	
a. At what percent threshold do you set your system to edit?	
i. Non-controlled drugs:	80%
ii. Schedule II controlled drugs:	85%
iii. Schedule III through V controlled drugs:	85%
b. For non-controlled drugs, when an early refill message occurs, does your State require a PA?	Dependent on medication or situation
If "Yes" or "Dependent on medication or situation," who obtains authorization?	Pharmacist or Prescriber
If "No," can the pharmacist override at the POS?	N/A
c. For controlled drugs, when an early refill message occurs, does your State require a PA?	Yes
If "Yes," who obtains authorization?	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 State's policy allow the pharmacist to override for situations such as (multiple responses allowed):	Other
If "Other," please explain.	The pharmacies have to call Medicaid FFS to place overrides (authorized by Medicaid pharmacist) for lost/stolen Rx, and vacation.
7. Does your system have an accumulation edit to prevent patients from continuously filling prescriptions early?	No
If "Yes," please explain your edit.	N/A
If "No," does your State plan to implement this edit?	Yes

Question	Response
8. Does the State Medicaid program have any policy prohibiting the auto-refill process that occurs at the POS (i.e., must obtain beneficiary's consent prior to enrolling in the auto-refill program)?	No
9. Does your system have a diagnosis edit that can be utilized when processing a prescription?	Yes
If "Yes," please explain.	POS requires ICD-10 for cancer pain in claims that exceeds MME limits, and for antipsychotics in kids
10. For drugs not on your Preferred Drug List (PDL), does your Medicaid program have a documented process (i.e., PA) in place, so that the Medicaid beneficiary or the Medicaid beneficiary's prescriber may access any covered outpatient drug when medically necessary?	Yes
If "Yes," check all that apply.	Other
If "Other," please explain.	There are drugs that are not listed on the PDL and do not require PA. For drugs that require PA, there are two pathways. The first pathway is identified by the PDL. For these drugs, prior authorization is available for non-drug specific (Medication Coverage Exception PA Form) and drug specific. The second pathway is when a prior authorization requirement is identified at the point of sale for drugs that are not listed on the PDL for brand over generic, quantity limit, the prescriber may submit a Medication Coverage Exception Form.
If "No," please explain why not.	N/A
a. Does your program provide for the dispensing of at least a 72-hour supply of a COD in an emergency situation?	Yes
If "Yes," check all that apply.	Other process
If "Other process," please explain.	The pharmacy can place an override on the claim using PA Type Code (461-EU) = 2 and PA number: (462-EV) = 72.
If "No," please explain why not.	N/A

Question	Response
11. Please list the requested data in each category in Table 1 - Top Drug Claims Data Reviewed by the DUR Board below.	

Table 1 – Top Drug Claims Data Reviewed by the DUR Board

Column 1 Top 10 Prior Authorization (PA) Requests by Drug Name, report at generic ingredient level	Column 2 Top 10 Prior Authorization (PA) Requests by Drug Class	Column 3 Top 5 Claim Denial Reasons (i.e., Quantity Limits (QL), Early Refill (ER), PA, Therapeutic Duplications (TD) and Age Edits (AE))	Column 4 Top 10 Drug Names by Amount Paid, report at generic ingredient level	Column 5 % of Total Spent for Drugs by Amount Paid (From data in Column 4, determine the % of Total Drug Spend)	Column 6 Top 10 Drug Names by Claim Count, report at generic ingredient level	Column 7 Drugs by Claim Count % of Total Claims (From data in Column 6, determine the % of Total Claims)
DEXCOM G6 SENSOR	ANTIDEPRESSANTS	Plan Limitations Exceeded	PALIPERIDONE SUSTENNA	5.00%	GABAPENTIN	6.00%
DEXCOM G6 TRANSMITTER	ANTICONVULSANTS	Prior Authorization Required	LURASIDONE	5.00%	AMPHETAMINE/ DEXTROAMPHETAMINE	4.00%
CARIPRAZINE	ANTIPSYCHOTICS/ ANTIMANIC AGENTS	Refill Too Soon	BUPRENORPHINE/ NALOXONE	5.00%	QUETIAPINE FUMARATE	3.00%
GABAPENTIN	MEDICAL DEVICES	Claim Not Processed	PREGABALIN	4.00%	TRAZODONE HYDROCHLORIDE	3.00%
METHYLPHENIDATE HYDROCHLORIDE	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ ANOREXIANTS	Product/ Service Not Covered %u2013 Plan/ Benefit Exclusion	LISDEXAMFETAMINE	3.00%	BUPROPION HYDROCHLORIDE	2.00%
PREGABALIN	ANALGESICS - OPIOID		CARIPRAZINE	3.00%	BUPRENORPHINE/ NALOXONE	2.00%
DEXCOM G6 RECEIVER	MIGRAINE PRODUCTS		METHYLPHENIDATE	3.00%	ARIPIPRAZOLE	2.00%
ESKETAMINE 84MG DOSE	ANTIDIABETICS		ARIPIPRAZOLE MAINTENA	3.00%	CLONAZEPAM	2.00%
DESVENLAFAXINE ER	DERMATOLOGICALS		EMICIZUMAB	2.00%	ESCITALOPRAM OXALATE	2.00%
AMPHETAMINE/ DEXTROAMPHETAMINE	ANTIVIRALS, antiretroviral agents		AMPHETAMINE/ DEXTROAMPHETAMINE XR	2.00%	ALPRAZOLAM	2.00%

Question	Response
12. Section 1927(g)(A) of the Social Security Act (the Act) requires that the pharmacist offer patient counseling at the time of dispensing. Who in your State has responsibility for monitoring compliance with the oral counseling requirement (multiple responses allowed)?	Other
If "Other," please explain.	Division of Occupational and Professional Licensing (DOPL) under the Pharmacy Act Rule.

Section III - Retrospective DUR (RetroDUR)

Question	Response
1. Indicate the type of vendor that performed your RetroDUR activities during the time period covered by this report.	Other Institution
a. Identify, by name, your RetroDUR vendor.	UT Medicaid Pharmacy Team
b. Is the RetroDUR vendor the Medicaid Management Information System (MMIS) fiscal agent?	No
c. Is the RetroDUR vendor the developer/supplier of your retrospective DUR criteria?	No
Please explain "Yes" or "No" response.	The Retro-DUR criteria are developed by the Medicaid Pharmacy Team and implemented jointly by the Medicaid Pharmacy Team and the DUR Board
d. Does your State customize your RetroDUR vendor criteria?	Yes
2. How often does your State perform retrospective practitioner-based education?	Other
If "Other," please specify.	The practitioner-based education is an ongoing process. It is integrated to day-to-day Prior Authorization review work flow.
a. How often does your State perform retrospective reviews that involve communication of client-specific information to healthcare practitioners (multiple responses allowed)?	Other, Quarterly, Bi-monthly, Monthly
If "Other," please specify.	It is an ongoing process, integrated to day-to-day Prior Authorization review work flow.
b. What is the preferred mode of communication when performing RetroDUR initiatives (multiple responses allowed)?	Newsletters or other non-direct provider communications, Provider phone calls, Mailed letters
If "Other," please specify.	N/A
3. Summary 1 – RetroDUR Educational Outreach	Retrospective DUR is performed primarily through the peer-to-peer program that aims to achieve quantitative improvements through direct and focused provider engagement delivered by the Utah State Medicaid

Question	Response
RetroDUR Educational Outreach should be a year-end report on retrospective screening and educational interventions. The summary should be limited to the most prominent problems with the largest number of exceptions. The results of RetroDUR screening and interventions should be included and detailed below.	Pharmacy. All peer-to-peer work is evaluated by and receives approval from the DUR Board. 1) An update on the opioid high-dose peer-to-peer program started in FFY 2019 and is ongoing. On January 1, 2019, a threshold of 90 MME was established for opioid-naive members and 180 MME for opioid-experienced members. Over time, the higher MME threshold was reduced to achieve a common 90 MME standard for all Utah Medicaid members. In Oct 2019, 64 FFS members were receiving opioids at 90 MME or greater. The MME limit was reduced to 90 MME during FFY 2020. In Oct 2022, the number of members receiving opioids at 90 MME or greater decreased to 42. The pharmacists continue to contact the prescribers when reviewing prior authorizations for members with opioids prescriptions higher than 90 MME. Overall, despite the growth of the UT Medicaid population by 74% since 2018, the number of members on high dose opioid above 90 MME continued to decline. 2) On October 1, 2019, the UT Medicaid Pharmacy team launched a peer-to-peer intervention to monitor and manage antipsychotic medications prescribed to members 19 years of age and younger. The program has continued throughout FFY 2022 with significant results. From October 2019 to September 2022, the number of children under 6 years of age receiving antipsychotics was reduced from 16 children to 1 child. The number of more than one antipsychotic from 16 children to 1 child, and children on high dose antipsychotics exceeding literature recommendations from 61 to 39 children. The rate of metabolic screening in all children receiving antipsychotics increased from 22% in 2019 to 27% in 2021. As of September 2022, the screening rate stood at 22%, with a higher rate of 35% observed among foster kids. The pharmacists continue to outreach to providers to discuss the appropriateness of using antipsychotics in children and encourage metabolic screening when reviewing prior authorization. The UT Medicaid Pharmacy Team also contracted with the University of Utah Department of Pediatrics to provide consultation to providers to manage the use of antipsychotics in complex children. The contract has been in place in May 2021.

Question	Response
	3) In January 2020, the Utah Medicaid Pharmacy Team engaged in a peer-to-peer program for providers prescribing an opioid/benzodiazepine combination without naloxone. This program has continued through FFY 2022. A clinical pharmacist performs telephonic outreach to prescribers. During the call, the pharmacist engages the prescriber in the following topics from the CDC's Clinical Practice Guideline for Prescribing Opioids for Pain: a) Reviews with the provider cover the risks of concurrent use of opioids/benzodiazepines; b) Requests that the provider counsel patients on the risk; c) Encourages consideration of other, safer combinations; d) Encourages proactive naloxone prescribing and educates on appropriate use; e) Encourages routine use of the controlled substance database; f) Encourages the prescriber to coordinate with other co-prescribing providers. The baseline concurrent use among Medicaid Fee for Service (FFS) members is 15.38%, with 3.56% of these being prescribed naloxone. There was slight improvement at the end of September 2022: FFS members with concurrent use were 14.9%, and 3.8% of these were prescribed naloxone. 4) Beginning April 1, 2020, the UT Medicaid Pharmacy Team launched the Hepatitis C Adherence program to improve members' adherence to hepatitis C treatments. The program has continued through FFY 2022. The program's impact is reviewed per calendar year. For the calendar year of 2022, 304 prior authorizations for members enrolled in the program and the adherence rate was 84.2%, which is below the established goal of 90%. The pharmacists discussed the following points during outreach with members: Counseling members on medication direction, and adverse drug events The importance of adhering to Hepatitis C medications to "cure" hepatitis C Utilized motivational interviewing to motivate members to adhere to therapy 5) Beginning in March 2021, the UT Medicaid Pharmacy Team started an Antidepressant Medication Management (AMM) Program to improve members' adherence to antidepressant therapies. The National Committee for

Question	Response
	Quality Assurance (NCQA) AMM measure was used as the basis to identify members with newly diagnosed depression in the acute and continuation phases of treatment. Clinical pharmacists telephonically reach out to the Medicaid Fee for Service members 18 years of age or older, who have a diagnosis of major depression, and are newly treated with antidepressant medication. Clinical pharmacists use motivational interviewing to address medication non-adherence and create a strategy for change. The antidepressant medication adherence rate increased from 54.1% at baseline to 57.3% for newly treated members (acute phase) while the adherence rate dipped from a baseline of 33.4% to 32.5%, for members who had been on antidepressant medication for more than 6 months (continuation phase).

Section IV - DUR Board Activity

Question	Response
1. Does your State have an approved Medication Therapy Management (MTM) Program?	Yes

2. Summary 2 – DUR Board Activities DUR Board Activities Summary should be a brief descriptive on DUR activities during the fiscal year reported.	In FFY 2022, the Utah Medicaid DUR Board met 10 times in a rolling 12 months period. The following topics and policies were discussed at the meetings: October 2021: The DUR Board reviewed topical Lidocaine and approved removing Lidoderm prior authorization requirements, aiming to improve access to non-opioid pain treatment. The DUR Board also reviewed Rukobia for the treatment of HIV and approved to place Rukobia as a non-preferred product on the Preferred Drug List and require clinical prior authorization. November 2021: The DUR Board met to discuss the experience with newer Cystic Fibrosis treatment (particularly the Trikafta). The pharmacy team updated the DUR Board on the Early Refill Policy. With this policy, early refill requests will be evaluated based on Medicaid's definition of medical necessity as defined in the Utah Medicaid Provider Manual to expand access to medications that fall under broader circumstances. The DUR Board reviewed Acute Hereditary Angioedema (HAE) and approved utilizing the Rare Disease prior authorization to review requests for acute HAE treatments. December 2021: The DUR Board reviewed Prophylaxis Hereditary Angioedema (HAE) and approved utilizing the Rare Disease prior authorization to review requests for prophylaxis HAE treatments. The DUR Board reviewed and approved the updated Parathyroid Hormone Analogs Prior Authorization. January 2022: . The DUR Board reviewed Benlysta, and Lupkynis and approved to not place clinical prior authorization requirements for these drugs as utilization is low. The DUR Board approved changes to the PCSK9 Prior Authorization to remove requirements for ABCL-certified specialists. February 2022: The DUR Board approved restricting antitussive codeine products to adults 18 years and up and analgesics codeine products to children over 12 years of age.

	April 2022: The DUR Board reviewed the Guideline Treatment Recommendations for Nonspecific Low Back Pain with or without Radiculopathy. May 2022: The DUR Board approved the revised Anti-Asthmatic Monoclonal Antibodies Prior Authorization to accommodate newly approved and upcoming monoclonal antibodies. The DUR Board approved the revised Hetlioz Prior Authorization. June & July 2022: The DUR Board reviewed insomnia treatments in pediatric and adult patients, and approved the proposal to have coverage for OTC melatonins. The DUR Board approved the revised Intravitreal Implants & Ophthalmic Injections. August 2022: The DUR Board reviewed the drafted CDC Clinical Practice Guideline for Prescribing Opioids 2022 and the results of Utah Medicaid's high-dose opioid intervention. September 2022: The DUR Board reviewed Mounjaro (tirzepatide) and approved to place Mounjaro as a non-preferred GLP-1 product on the Preferred Drug List. The DUR Board approved the revised Calcitonin Gene-Related Peptide (CGRP) Antagonists Prior Authorization and Botox Prior Authorization. The revision allowed concurrent uses of prophylaxis CGRP and Botox. A comprehensive list of PRO-DUR edits is below: 10/13/2021 - Nayzilam (midazolam) was added to the cumulative quantity limit of benzodiazepine limit of 120 units per 30 days. 10/27/2021 - Implemented age restriction of older than 12 years of age on certain codeine products. 11/1/2021 - Removed prior authorization requirement for Lidoderm. 11/1/2021 - Added Rukobia to non-preferred on the Preferred Drug List and required clinical prior

Question	Response
	authorization. 2/3/2022 - Updated quantity limit of Vivitrol to 1 injection every 22 days. 3/1/2022 - Remove quantity limit on naltrexone tablets to improve access. 4/1/2022 - Increased quantity limit of tramadol and tramadol/acetaminophen from 6 tablets/day to 8 tablets/day. 4/1/2022 - Updated Antipsychotic Use in Children policy to only reject claims for two or more concurrent antipsychotic medications used for 45 days consecutive days or more for members 17 years of age or younger. Members 18 to 19 years of age or older will no longer be subject to concurrent use of multiple antipsychotic use restrictions. 5/25/2022 - Increased quantity limit of oxycodone, oxycodone combinations, hydrocodone, hydrocodone combinations drugs from 4 tablets/day to 6 tablets/day. The 90 MME limit remains.

Section V - Physician Administered Drugs (PAD)

The Deficit Reduction Act required collection of national drug code (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 this data into your DUR criteria for:

Question	Response
1. ProDUR?	Yes
If "No," does your State have a plan to include this information in your DUR criteria in the future?	N/A
2. RetroDUR?	Yes
If "No," does your State have a plan to include this information in your DUR criteria in the future?	N/A

Section VI - Generic Policy and Utilization Data

Question	Response
1. Summary 3 – Generic Drug Substitution Policies Generic Drug Substitution Policies should summarize factors that could affect your generic utilization percentage. In describing these factors, please explain any formulary management or cost containment measures, preferred drug list (PDL) policies, educational initiatives, technology or promotional factors, or other State-specific factors that affects your generic utilization rate.	As a result 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 products lower generic.
2. In addition to the requirement that the prescriber write in his own handwriting "Brand Medically Necessary" for a brand name drug to be dispensed in lieu of the generic equivalent, does your State have a more restrictive requirement?	Yes
If "Yes," check all that apply.	Other, Prior Authorization (PA) is required
If "Other," please explain.	DAW-1 only override for mental health medications. Other meds require prior authorization

Generic Drug Utilization Data

Computation Instructions KEY

Single Source (S) – Drugs having an FDA New Drug Application (NDA), and there are no generic alternatives available on the market.

Non-Innovator Multiple-Source (N) – Drugs that have an FDA Abbreviated New Drug Application (ANDA), and generic alternatives exist on the market

Innovator Multiple-Source (I) – Drugs which have an NDA and no longer have patent exclusivity.

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

   N ÷ (***S*** + ***N*** + ***I***) × 100 = Generic Utilization Percentage

2. **Generic Expenditure Percentage of Total Drug Expenditure:** To determine the generic expenditure percentage (rounded to the nearest $1000) for all covered outpatient drugs for this reporting period use the following formula:

   $***N*** ÷ ($***S*** + $***N*** + $***I***) × 100 = Generic Expenditure Percentage

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.

Table 2 – Generic Drug Utilization Data

	Single Source (S) Drugs	Non-Innovator (N) Drugs	Innovator Multi-Source (I) Drugs
Total Number of Claims	137,837.00	1,328,548.00	142,686.00
Total Reimbursement Amount Less Co-Pay	$152,962,954.65	$44,372,380.67	$58,326,811.83

Question	Response
3. Indicate the generic utilization percentage for all covered outpatient drugs (COD) paid during this reporting period, using the computation instructions in Table 2 – Generic Drug Utilization Data.	
Number of Generic Claims	1,328,548
Total Number of Claims	1,609,071
Generic Utilization Percentage	83%

Question	Response
4. How many innovator drugs are the preferred product instead of their multi-source counterpart based on net pricing (i.e. brand name drug is preferred over equivalent generic product on the PDL)?	185
5. Indicate the percentage dollars paid for generic CODs in relation to all COD claims paid during this reporting period using the computation instructions in Table 2 – Generic Drug Utilization Data.	
Generic Dollars	$44,372,381
Total Dollars	$255,662,147
Generic Expenditure Percentage	17%
6. Does your State have any policies related to Biosimilars? Please explain.	UT Medicaid uses the FDA's Purple Book as a reference and unless otherwise limited through the prior authorization process, the State does not mandate interchange of biosimilar, unless they are listed interchangeable.

Section VII - Program Evaluation / Cost Savings / Cost Avoidance

Question	Response
1. Did your State conduct a DUR program evaluation of the estimated cost savings/cost avoidance? If "Yes," identify, by name and type, the institution that conducted the program evaluation.	Yes
Institution Type	Academic Institution
Institution Name	University of Utah Drug Regimen Review Center / Utah Medicaid Pharmacy
2. Please provide your ProDUR and RetroDUR program cost savings/cost avoidance in the chart below.	

Cost Avoidance	Cost in Dollars
ProDUR Total Estimated Avoided Costs	$34,053,033.38
RetroDUR Total Estimated Avoided Costs	$26,728,473.21
Other Cost Avoidance	$0.00
Grand Total Estimated Avoided Costs	$60,781,506.59

Question	Response
3. The Estimated Percent Impact was generated by dividing the Grand Total Estimated Avoided Costs from Question 2 above by the Total Dollar Amount provided in Section VI, Question 5, then multiplying this value by 100.	23.77%
4. Does your Medicaid program provide coverage of over-the-counter medications when prescribed by an authorized prescriber?	Yes
If "No," please explain why not.	N/A

5. Summary 4 – Cost Savings/Cost Avoidance Methodology

Cost Savings/Cost Avoidance Methodology Summary should include program evaluations/cost savings estimates prepared by the State or contractor.

PLAN ID	CONFLICT	DUR MSG DESC	PAID CLAIMS	PAID AMT	OVERRIDE CT	DENIED CLAIMS	DENIED AMT	REV COUNT	REV AMT	TOTAL SAVINGS
NONTRAD	HD	HIGH DOSE	1832	$195,097.10	21	34	$7,311.34	537	$198,855.36	$206,166.70
NONTRAD	DD	DRUG DRUG	24890	$773,449.89	161	937	$40,126.28	5276	$292,418.12	$332,544.40
NONTRAD	LD	LOW DOSE	9996	$1,439,698.74	58	1	$219.67	2337	$756,077.22	$756,296.89
NONTRAD	TD	THER DUP	122072	$11,287,470.41	1582	45	$5,841.12	27962	$4,557,716.21	$4,563,557.33
NONTRAD	SUMMARY		1822	0	$-	36112	$5,805,066.91	$5,805,066.91		
TRAD	HD	HIGH DOSE	9172	$2,110,185.02	181	104	$38,489.20	2390	$1,284,266.75	$1,322,755.95
TRAD	DD	DRUG DRUG	105824	$4,453,359.50	2369	2530	$145,700.42	20258	$1,640,942.56	$1,786,642.98
TRAD	LD	LOW DOSE	44499	$6,100,716.83	288	0	$-	9742	$2,723,026.25	$2,723,026.25
TRAD	TD	THER DUP	564153	$61,480,030.65	10269	241	$35,470.14	116584	$21,551,420.52	$21,586,890.66
TRAD	SUMMARY			$101,343,989.48	13107	0	$-	148974	$27,199,656.08	$27,199,656.08
TRADNH	HD	HIGH DOSE	1198	$92,975.77	5	5	$1,166.99	151	$186,636.07	$187,803.06
TRADNH	LD	LOW DOSE	3559	$475,079.70	5	0	$-	386	$112,636.02	$112,636.02
TRADNH	DD	DRUG DRUG	8850	$583,158.33	104	219	$18,718.17	725	$173,261.75	

Question	Response
	$191,979.92 TRADNH TD THER DUP 44290 $2,636,929.23 484 31 $2,248.67 3416 $575,776.55 $578,025.22 TRADNH SUMMARY $4,836,453.42 598 0 $- 4678 $1,048,310.39 $1,048,310.39 SUMMARY HD HIGH DOSE 12202 $2,398,257.89 207 143 $46,967.54 3078 $1,669,758.18 $1,716,725.72 SUMMARY DD DRUG DRUG 139564 $5,809,967.72 2634 3686 $204,544.87 26259 $2,106,622.43 $2,311,167.30 SUMMARY LD LOW DOSE 58054 $8,015,495.27 351 1 $219.67 12465 $3,591,739.49 $3,591,959.16 SUMMARY TD THER DUP 730515 $75,404,430.29 12335 317 $43,559.93 147962 $26,684,913.28 $26,728,473.21 SUMMARY SUMMARY $125,681,340.51 15527 0 $- 189764 $34,053,033.38 $34,053,033.38 PLAN ID CLAIM COUNT PAID AMT REV CLAIM AMT REV AMT NONTRAD 77,802 $9,416,967.00 22,433 $3,911,452.34 TRAD 336,757 $50,515,907.58 87,631 $18,342,035.20 TRADNH 27,689 $2,736,748.21 2,535 $744,631.42

Section VIII - Fraud, Waste and Abuse Detection

A. Lock-In or Patient Review and Restriction Programs

Question	Response
1. Does your State have a documented process in place that identifies potential fraud or abuse of controlled drugs by beneficiaries?	Yes
If "Yes," what actions does this process initiate (multiple responses allowed)?	Deny claims, Other, Refer to Lock-In Program, Refer to Office of Inspector General (OIG), Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation
If "Other," please explain.	Management of Medicaid member's case in coordination with providers to bring utilization in line with Lock-in Program guidelines and criteria
If "No," please explain why not.	N/A
2. Does your State have a lock-in program for beneficiaries with potential misuse or abuse of controlled substances? If "Yes," please continue.	Yes
a. What criteria does your State use to identify candidates for lock-in (multiple responses allowed)?	Number of controlled substances (CS), Different prescribers of CS, Multiple pharmacies, Days' supply of CS, Exclusivity of short acting opioids, Multiple emergency room (ER) visits, Prescription drug monitoring program (PDMP) data, Other
If "Other," please explain.	N/A
b. Does your State have the capability to restrict the beneficiary to:	
i. Prescriber only	Yes
ii. Pharmacy only	Yes
iii. Prescriber and Pharmacy	Yes
c. What is the usual lock-in time period?	12 months
If "Other," please explain.	N/A
d. On average, what percentage of the FFS population is in lock-in status annually?	0.7000%
e. Please provide an estimate of the savings attributed to the lock-in program for the fiscal year under review.	$3,775,229.00

Question	Response
3. Does your State have a documented process in place that identifies possible FWA of controlled drugs by prescribers?	Yes
If "Yes," what actions does this process initiate (multiple responses allowed)?	Refer to the appropriate Medical Board, Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation, Deny claims written by this prescriber
If "Other," please explain.	N/A
If "No," please explain why not.	N/A
4. Does your State have a documented process in place that identifies potential FWA of controlled drugs by pharmacy providers?	Yes
If "Yes," what actions does this process initiate (multiple responses allowed)?	Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation
If "Other," please explain.	N/A
If "No," please explain why not.	N/A
5. Does your State have a documented process in place that identifies and/or prevents potential FWA of non-controlled drugs by beneficiaries, prescribers, and pharmacy providers?	Yes
If "Yes," please explain your program for FWA of non-controlled substances.	To prevent fraud, waste, or abuse of non-controlled substances utilization management edits are in place. These edits vary depending on the medication, include but are not limited to: quantity limits, day supply limits, and prior authorization.
If "No," please explain why not.	N/A

B. Prescription Drug Monitoring Program (PDMP)

Question	Response
1. Does your Medicaid program have the ability to query the State's PDMP database?	Yes
If "No," please explain.	N/A

Question	Response
If "Yes," please continue. a. How does your State access the PDMP database (multiple responses allowed)?	Direct access to the database
If "Receive PDMP data" please indicate how often (multiple responses allowed).	N/A
If "Other," please explain.	N/A
If "Direct access to the database," please specify (multiple responses allowed).	Can query by client
a. Please explain how the State applies this information to control FWA of controlled substances.	The Medicaid Pharmacy program uses the PDMP to review controlled substance use in individuals who are under prior authorization review for an opioid.
b. Does your State also have access to contiguous States' PDMP information?	Yes
c. Does your State also have PDMP data integrated into your point of sale (POS) edits?	No
2. Have you communicated to prescribers who are covered providers that as of October 1, 2021, they are required to check the PDMP before prescribing controlled substances to beneficiaries who are covered individuals?	Yes
If "Not applicable," or "No," please explain.	N/A
If "Yes," please check all that apply.	Provider bulletin, Public notice
If "Other," please explain.	N/A
If "Yes," please continue. a. Has the State specified protocols for prescribers checking the PDMP?	Yes
If "Yes," please explain.	Starting October 1, 2021 Medicaid providers must check each patient's fill history for any controlled substance through the Utah Department of Commerce Controlled Substance Database before prescribing any new controlled substances. If the provider is unable to access the patient's-controlled substance fill history they must document a reason as to why they were unable to meet this requirement. Providers must be able to provide this information to the State upon request.

Question	Response
b. Do providers have protocols for responses to information from the PDMP that is contradictory to information that the practitioner expects to receive, based on information from the client (example: when a provider prescribing pain management medication finds medications for opioid use disorder (OUD) during a PDMP check, when client denies opioid use disorder)?	No
c. If a provider is not able to conduct PDMP check, does your State require the prescriber to document a good faith effort, including the reasons why the provider was not able to conduct the check?	Yes
If "No," please explain why not.	N/A
If "Yes," does your State require the provider to submit, upon request, documentation to the State?	Yes
If "No," please explain.	N/A
3. In the State's PDMP system, which of the following beneficiary information is available to prescribers as close to real-time as possible (multiple responses allowed)?	The number and type of controlled substances prescribed to and dispensed to the beneficiary during at least the most recent 12-month period, The name, location, and contact information, or other identifying number, such as a national provider identifier, for previous beneficiary fills, Other, PDMP drug history
If "Other," please explain.	Pharmacy, and dosing
a. Are there barriers that hinder the Medicaid agency from fully accessing the PDMP that prevent the program from being utilized the way it was intended to be to curb FWA?	No
If "Yes," please explain the barriers (i.e., lag time in prescription data being submitted, prescribers not accessing, pharmacists unable to view prescription history before filling script).	N/A

Question	Response
4. Have any changes to your State's PDMP during this reporting period improved or detracted from the Medicaid program's ability to access PDMP data?	No
If "Yes," please explain.	N/A
5. In this reporting period, have there been any data or privacy breaches of the PDMP or PDMP data?	No
If "Yes," please summarize the breach, the number of individuals impacted, a description of the steps the State has taken to address each such breach, and if law enforcement or the affected individuals were notified of the breach.	N/A

C. Opioids

Question	Response
1. Does your State currently have a POS edit in place to limit the days' supply dispensed of an initial opioid prescription for opioid naïve patients?	Yes, for some opioids
If "No," please explain why not.	N/A
If the answer to question 1 is "Yes, for all opioids" or "Yes, for some opioids," please continue. If the answer to question 1 is "No," please skip to 1b. a. What is the maximum number of days allowed for an initial opioid prescription for an opioid naïve patient?	7
b. Does your State have POS edits in place to limit days' supply of subsequent opioid prescriptions? If "yes," please indicate your days' supply limit.	30-day supply
If "Other", please specify.	N/A
If "No," please explain.	N/A

Question	Response
2. Does your State have POS edits in place to limit the quantity dispensed of opioids?	Yes
If "No," please explain why not.	N/A
If "Yes," please continue. a. Does your State have POS edits in place to limit the quantity dispensed of short-acting (SA) opioids?	Yes
If "Yes," please specify limit as # of units.	6
If "No," or "Other," please explain.	N/A
b. Does your State currently have POS edits in place to limit the quantity dispensed of long-acting (LA) opioids?	Other
If "Yes," please specify limit as # of units.	N/A
If "No," or "Other," please explain.	Morphine Milligrams Equivalent (90 MME), daily quantity limit (1 to 3 units, depends on the medication), and maximum 30 days-supply
3. Does your State have measures other than restricted quantities and days' supply in place to either monitor or manage the prescribing of opioids?	Yes
If "Yes," check all that apply.	Pharmacist override, Deny claim and require PA, Require PDMP checks, Requirement that patient has a pain management contract or Patient-Provider agreement, Intervention letters, Workgroups to address opioids, Requirement that prescriber has an opioid treatment plan for patients, MME daily dose program, Step therapy or clinical criteria
If "Other," please specify.	N/A
If "No," please explain what you do in lieu of the above or why you do not have measures in place to either manage or monitor the prescribing of opioids.	N/A
4. Does your State have POS edits to monitor duplicate therapy of opioid prescriptions? This excludes regimens that include a single extended-release product and a breakthrough short acting agent?	Yes
If "No," please explain why not.	N/A

Question	Response
5. Does your State have POS edits to monitor early refills of opioid prescriptions dispensed?	Yes, both POS edits and automated retrospective claims review process
If "No," please explain why not.	N/A
6. Does your State have comprehensive automated retrospective claim reviews to monitor opioid prescriptions exceeding these State limitations (early refills, duplicate fills, quantity limits and days' supply)?	Yes
If "Yes," please explain in detail scope, nature, and frequency of these retrospective reviews.	An automatic retrospective review identifies prescriptions that exceeded the MME limit, quantity limit, and 85% refill threshold in a designated time period of 30 days. Claims are evaluated by member prescription profile and provider prescribing patterns for opioid. Next, peer-to-peer outreach is done to encourage a decrease in prescribing of high dose opioid with the following goals: 1) educate healthcare providers on the availability of non-pharmacology and non-opioid pain options and selected opioid use disorder treatment 2) Provide healthcare providers with resources on both Medicaid and CDC website 3) Educate providers on Utah Medicaid opioid policies.
If "No," please explain why not.	N/A
7. Does your State currently have POS edits in place or automated retrospective claim reviews to monitor opioids and benzodiazepines being used concurrently?	Yes, both POS edits and automated retrospective claim reviews
If "Yes," please explain above response and detail the scope and nature of these reviews and edits. Additionally, please explain any potential titration processes utilized for those patients chronically on benzodiazepines and how the State justifies pain medications, i.e., Oxycodone/APAP, for breakthrough pain without jeopardizing patient care (i.e., quantity limits/practitioner education titration programs).	When a claim for either a long-acting opioid or a benzodiazepine is submitted, the system will look back 45 days to find any paid claims for either benzodiazepines or long-acting opioid. If a paid claim for a benzodiazepine is found, the long-acting claim will reject. Likewise, if a paid claim for a long-acting opioid is found, the benzodiazepine claim will reject.
If "No," please explain why not.	N/A

Question	Response
8. Does your State currently have POS edits in place or automated retrospective claim reviews to monitor opioids and sedatives being used concurrently?	No
If "No," please explain why not.	Will implement in the future
9. Does your State currently have POS edits in place or automated retrospective claim reviews to monitor opioids and antipsychotics being used concurrently?	Yes, automated retrospective claim reviews
If "No," please explain why not.	N/A
10. Does your State have POS safety edits or perform automated retrospective claims reviews and/or provider education regarding beneficiaries with a diagnosis history of opioid use disorder (OUD) or opioid poisoning diagnosis?	No
If "No," please explain why not.	Will implement in the future
If "Yes," check all that apply.	N/A
If "Automated retrospective claim reviews" and/or "Yes, provider education," please indicate how often.	N/A
If "Other," please specify.	N/A
If "No," does your State plan on implementing POS edits, automated retrospective claim reviews and/or provider education regarding beneficiaries with a diagnosis history of OUD or opioid poisoning in the future?	Yes
If "Yes," when does your State plan on implementing?	2024
If "No," please explain why not.	N/A
11. Does your State Medicaid program develop and provide prescribers with pain management or opioid prescribing guidelines?	Yes
If "Yes," please check all that apply.	Other guidelines., Your state Medicaid program refers prescribers to the Center for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain.

Question	Response
If applicable, please identify the "other" guidelines.	N/A
If "No," please explain why no guidelines are offered.	N/A
12. Does your State have a drug utilization management strategy that supports abuse deterrent opioid use to prevent opioid misuse and abuse (i.e., presence of an abuse deterrent opioid with preferred status on your preferred drug list)?	Yes
If "Yes," please explain.	Abuse deterrent formulations have preferred status on the PDL..
If "No," please explain.	N/A
13. Were there COVID-19 ramifications on edits and reviews on controlled substances during the public health emergency?	No
If "Yes," please explain.	N/A

D. Morphine Milligram Equivalent (MME) Daily Dose

Question	Response
1. Have you set recommended maximum MME daily dose measures?	Yes
If "Yes," please continue.	
a. What is your maximum morphine equivalent daily dose limit in milligrams?	90 MME mg per day
If "Less than 50 MME," please specify the amount in mg per day.	N/A mg per day
If "Greater than 200 MME," please specify the amount in mg per day.	N/A mg per day
If "Other," please specify the amount in mg per day.	N/A mg per day

Question	Response
b. Please explain nature and scope of dose limit (i.e., Who does the edit apply to?, Does the limit apply to all opioids?, Are you in the process of tapering patients to achieve this limit?).	A Morphine Milligram Equivalents (MME) limit was implemented on January 1, 2019, for adjudication of all opioid claims for the treatment of non-cancer pain. Two sets of daily MME thresholds were established, a threshold of 90 MME for opioid-naive individuals, who have not had a claim in the last 60 days and 180 MME for opioid experience individuals who had a claim for an opioid in the last 60 days. The higher MME threshold has been reduced over time, every 6 months to achieve one common MME standard, 90 MME, for all UT Medicaid members. The MME already be reduced for opioid experience based on the timeline: January 1, 2020: MME 120; July 1, 2020: MME 90. Current MME limits are 90 for both opioid-naive and opioid-experienced.
If "No," please explain why not.	N/A
2. Does your State have an edit in your POS system that alerts the pharmacy provider that the MME daily dose prescribed has been exceeded?	Yes
If "Yes," does your State require PA if the MME limit is exceeded.	Yes
If "No," please explain why not.	N/A
3. Does your State have automated retrospective claim reviews to monitor the MME total daily dose of opioid prescriptions dispensed?	Yes
If "No," please explain why not.	N/A
4. Do you provide information to your prescribers on how to calculate the MME daily dosage or do you provide a calculator developed elsewhere? If "Yes," please continue.	Yes
a. Please name the developer of the calculator.	CDC
If "Other," please specify.	N/A
b. How is the information disseminated (multiple responses allowed)?	Website, Provider notice, Other
If "Other," please explain.	Quarterly Medicaid Information Bulletin and opioid peer to peer work.

E. Opioid Use Disorder (OUD) Treatment

Question	Response
1. Does your State have utilization controls (i.e., preferred drug list (PDL), prior authorization (PA), quantity limit (QL)) to either monitor or manage the prescribing of Medication Assisted Treatment (MAT) drugs for OUD?	Yes
If "Yes," please explain.	Preferred Drug List, Prior Authorization for buprenorphine single products that exceed the quantity limit of 24 mg/day. Prior Authorization is also required for concurrent use of opioids exceeding 7 days supply when POS identifies MAT therapy in profile with 45 days look back.
If "No," please explain.	Preferred Drug List, Prior Authorization for buprenorphine single products that exceed the quantity limit of 24 mg/day. Prior Authorization is also required for concurrent use of opioids exceeding 7 days supply when POS identifies MAT therapy in profile with 45 days look back.
2. Does your Medicaid program set total mg per day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs?	Yes
If "Yes," please specify the total mg/day.	24 mg
If "Other," please explain.	N/A
3. What are your limitations on the allowable length of this treatment?	No limit
If "Other," please explain.	N/A
4. Does your State require that the maximum mg per day allowable be reduced after a set period of time? If "Yes," please continue.	No
a. What is your reduced (maintenance) dosage?	N/A
If "Other," please explain.	N/A
b. What are your limitations on the allowable length of the reduced dosage treatment?	N/A
If "Other," please explain.	N/A

Question	Response
5. Does your State have at least one buprenorphine/naloxone combination product available without PA?	Yes
6. Does your State currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug or any form of MAT?	Yes
If "No," please explain why not.	N/A
If "Yes," can the POS pharmacist override the edit?	No
7. Is there at least one formulation of naltrexone for OUD available without PA?	Yes
8. Does your State have at least one naloxone opioid overdose product available without PA?	Yes
9. Does your State monitor and manage appropriate use of naloxone to persons at risk of overdose?	No
If "No," please explain why not.	Retrospective review and peer-to-peer education on high dose opioid and concurrent opioid/benzo monthly. Naloxone products don't require prior authorization.
10. Does your State Board of Professional Regulations/Board of Pharmacy/Board of Medicine and/or State Medicaid program allow pharmacists to dispense naloxone prescribed independently or by collaborative practice agreements, standing orders, or other predetermined protocols?	Yes, State Board of Professional Regulations/Board of Pharmacy/Board of Medicine and/or state Medicaid program under protocol

F. Outpatient Treatment Programs (OTP)

Question	Response
1. Does your State cover OTPs that provide Behavioral Health (BH) and MAT services?	Yes
If "No," please explain why not.	N/A

Question	Response
If "Yes," is a referral needed for OUD treatment through OTPs?	No
Please explain.	N/A
2. Does your State Medicaid program cover buprenorphine or buprenorphine/naloxone for diagnoses of OUD as part of a comprehensive MAT treatment plan through OTPs?	Yes
If "No," please explain.	N/A
3. Does your State Medicaid program cover naltrexone for diagnoses of OUD as part of a comprehensive MAT treatment plan?	Yes
If "No," please explain.	N/A
4. Does your State Medicaid program cover Methadone for a substance use disorder (i.e., OTPs, Methadone Clinics)?	Yes
If "No," please explain why not.	N/A

G. Psychotropic Medication For Children

Antipsychotics

Question	Response
1. Does your State currently have restrictions in place to limit the quantity of antipsychotic drugs?	Yes
Please explain restrictions or N/A.	UT Medicaid monitors the use of antipsychotics for all children under 19 years of age: high dose, under 6 years of age, concurrent use of multiple antipsychotics.
2. Does your State have a documented program in place to either manage or monitor the appropriate use of antipsychotic drugs in children? If "Yes," please continue.	Yes
a. Does your State either manage or monitor:	All children
If "Other," please explain.	N/A

Question	Response
b. Does your State have edits in place to monitor (multiple responses allowed):	Child's age, Dosage, Indication, Polypharmacy
Specify child's age limit in years.	6
If "Other," please explain.	N/A
c. Please briefly explain the specifics of your documented antipsychotic monitoring program(s).	Utah Medicaid implemented a new policy on October 1, 2019, to monitor and manage antipsychotic (AP) medications prescribed to members 19 years of age and younger. Pharmacies are required to enter the diagnosis code into the point of sale system when processing a claim for an antipsychotic. Prior Authorization is required for children who are taking high-dose antipsychotics, multiple antipsychotics, or under 6 years of age. Also, Retrospective Drug Utilization Review peer to peer educational interventions addresses the following: a. Use of other first-line services such as psychosocial counseling and safer medications. Dosing should follow the start low and go slow approach. Identification of higher than recommended doses. Careful and frequent monitoring of side effects such as metabolic screening, Body Mass Index, weight gain, movement disorders. Use of AP in children younger than 6 years old.
If "No," does your State plan on implementing an antipsychotic monitoring program in the future.	N/A
If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of antipsychotic drugs in children.	N/A
If "No," please explain why you will not be implementing a program to monitor the appropriate use of antipsychotic drugs in children.	N/A

Stimulants

Question	Response
3. Does your State currently have restrictions in place to limit the quantity of stimulant drugs?	Yes
4. Does your State have a documented program in place to either manage or monitor the appropriate use of stimulant drugs in children? If "Yes," please continue.	Yes
a. Does your State either manage or monitor:	All children
If "Other," please explain.	N/A
b. Does your State have edits in place to monitor (multiple responses allowed):	Child's age, Polypharmacy
Specify child's age limit in years.	4
If "Other," please explain.	N/A
c. Please briefly explain the specifics of your documented stimulant monitoring program(s).	Effective July 2020, age edit limitations apply when a claim for an ADHD stimulant is processed through the pharmacy point of sale: - ADHD stimulant prescriptions for children under 4 years of age. - ADHD stimulant prescriptions for Adzenys ER suspension (susp.), Dyanavel XR, Desoxyn, Adhansia XR, Jornay PM, and Cotempla XR Orally Disintegrating Tablet (ODT) for children under 6 years of age. Also, effective April 2021, a multiple agent edits, and a cross-class edit limitation will apply when claims for ADHD stimulants are processed through the pharmacy point of sale: - Three or more unique ADHD stimulant medications were prescribed concurrently for at least 30 days in the last 45 days across all ages. - Cross-class prescribing of ADHD stimulant medications from the amphetamine class and the methylphenidate class for at least 30 days in the last 45 days for children under 18 years of age.
If "No," does your State plan on implementing a stimulant monitoring program in the future?	N/A

Question	Response
If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of stimulant drugs in children.	N/A
If "No," please explain why you will not be implementing a program to monitor the appropriate use of stimulant drugs in children.	N/A

Antidepressants

Question	Response
5. Does your State have a documented program in place to either manage or monitor the appropriate use of antidepressant drugs in children? If "Yes," please continue.	No
a. Does your State either manage or monitor:	N/A
If "Other," please explain.	N/A
b. Does your State have edits in place to monitor (multiple responses allowed):	N/A
Specify child's age limit in years.	N/A
If "Other," please explain.	N/A
c. Please briefly explain the specifics of your documented antidepressant monitoring program(s).	N/A
If "No," does your State plan on implementing an antidepressant monitoring program in the future?	Yes
If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of antidepressant drugs in children.	2024
If "No," please explain why you will not be implementing a program to monitor the appropriate use of antidepressant drugs in children.	N/A

Mood Stabilizers

Question	Response
6. Does your State have a documented program in place to either manage or monitor the appropriate use of mood stabilizing drugs in children? If "Yes," please continue.	No
a. Does your State either manage or monitor:	N/A
If "Other," please explain.	N/A
b. Does your State have edits in place to monitor (multiple responses allowed):	N/A
Specify child's age limit in years.	N/A
If "Other," please explain.	N/A
c. Please briefly explain the specifics of your documented mood stabilizer monitoring program(s).	N/A
If "No," does your State plan on implementing a mood stabilizer monitoring program in the future?	Yes
If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of mood stabilizing drugs in children.	2024
If "No," please explain why you will not be implementing a program to monitor the appropriate use of mood stabilizing drugs in children.	N/A

Antianxiety/Sedatives

Question	Response
7. Does your State have a documented program in place to either manage or monitor the appropriate use of antianxiety/sedative drugs in children? If "Yes," please continue.	No
a. Does your State either manage or monitor:	N/A
If "Other," please explain.	N/A

Question	Response
b. Does your State have edits in place to monitor (multiple responses allowed):	N/A
Specify child's age limit in years.	N/A
If "Other," please explain.	N/A
c. Please briefly explain the specifics of your documented antianxiety/sedative monitoring program(s).	N/A
If "No," does your State plan on implementing an antianxiety/sedative monitoring program in the future?	Yes
If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of antianxiety/sedative drugs in children.	2024
If "No," please explain why you will not be implementing a program to monitor the appropriate use of antianxiety/sedative drugs in children.	N/A

Section IX - Innovative Practices

Question	Response
1. Does your State participate in any demonstrations or have any waivers to allow importation of certain drugs from Canada or other countries that are versions of FDA-approved drugs for dispensing to Medicaid beneficiaries?	No
If "Yes," please explain.	N/A
2. Summary 5 – Innovative Practices Innovative Practices Summary should discuss development of innovative practices during the past year (i.e., Substance Use Disorder, Hepatitis C, Cystic Fibrosis, MME, and Value Based Purchasing). Please describe in detailed narrative below 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 (i.e., disease management, academic detailing, automated PA, continuing education programs).	Beginning July 1, 2022, the UT Medicaid and our ACO partners begin to reimburse for Medication Therapy Management (MTM) services, which pharmacists provide to adults and children at outpatient pharmacies. The initial 15 minutes for new patients is reimbursed for $53.48 or $32.94 for established patients, and $16.68 for each additional 15 minutes of service. The program requires members to be Medicaid eligible and enrolled, that the assessment is performed face to face, that the member is not eligible for Medicare part D, and that the member is taking three or more medications to prevent one or more chronic conditions. In addition to the new MTM reimbursement to outpatient pharmacists, the Utah Medicaid Pharmacy Program continued to deliver impactful results with the continued peer-to-peer programs, and the medication adherence program that were started in 2019 and 2020: The Pharmacy Team continued the %u201cantipsychotics in children%u201d peer-to-peer intervention from 2019 to monitor and manage antipsychotic medications prescribed to members 19 years of age and younger. The number of children under 6 years of age receiving antipsychotics decreased from 16 in October 2019 to 1 in September 2022. The number of children on more than one antipsychotic declined from 16 children to 1 child, and the number of children on high dose antipsychotics (including exceeding literature recommendations) reduced from 61 to 39 children in this same period. Regarding the metabolic screening, in all children (foster and non-foster) receiving antipsychotics from October 2019 to September 2022, the rate of metabolic screening increased from 22% to 27% in 2021, and to 22% by 2022, with higher rates of 35% in

Question	Response
	foster kids. Beginning in May 2021, the UT Medicaid Pharmacy Team contracted with the University of Utah Department of Pediatrics (UPP) to provide consultation on certain members' cases and situations to ensure children served by UT Medicaid receive appropriate evidence-based mental health and medication therapy. The collaboration's goal is to align Medicaid's pediatric mental health care with all necessary consultation, oversight, and review as per UT Medicaid, Division of Child and Family Services, the federal SUPPORT Act, and other policies, procedures, rules, and guidance. Continued from January 2020, the UT Medicaid Pharmacy Team provided education and encouragement to prescribers with Medicaid members on concurrent use of an opioid and a benzodiazepine without naloxone. The baseline concurrent use for Medicaid Fee for Service (FFS) members is 15.38%, with 3.56% of these being prescribed naloxone. There was improvement at the end of September 2022: FFS members with concurrent use decreased to 14.9%, and 3.8% of these were prescribed naloxone. Continuing from April 1, 2020, the Hepatitis C Medication Adherence program demonstrated impactful results. In the calendar year of 2022, with 304 members enrolled in the program, the adherence rate was 84.2%, a slight decrease from 90.2% in the 2021 calendar year. The pharmacists continue to outreach to members to improve the medication adherence to hepatitis C patients. Continued from FFY 2021, the Antidepressant Medication Management outreach to non-adherent members to address and improve medication adherence . The antidepressant medication adherence rate increased from 54.1% at baseline to 57.3% for newly treated members (acute phase) while the adherence rate dipped from a baseline of 33.4% to 32.5%, for members who had been on antidepressant medication for more than 6 months (continuation phase).

Section X - Managed Care Organizations (MCOs)

Question	Response
1. How many MCOs are enrolled in your State Medicaid program? If "Zero" or "None", please skip the rest of this section.	4
2. Is your pharmacy program included in the capitation rate (carved in)?	Partial
If "Partial, "please check what categories of medications are carved out and handled by your FFS program (multiple responses allowed):	Mental Health Medications, MAT, Clotting Factors, Other
If "Other," please specify the drug categories.	Transplant Immunosuppressive Drugs, Attention Deficit Hyperactivity Disorder (ADHD) Stimulant Drugs, Anti-psychotic Drugs, Anti-depressant Drugs, Anti-anxiety Drugs, Anti-convulsant Drugs, Hemophilia Drugs, Opioid Use Disorder Treatments
3. Contract updates between State and MCOs addressing DUR provisions in Section 1004 Support for Patients and Communities Act are required based on 1902(oo). If covered outpatient drugs are included in an MCO's covered benefit package, has the State updated their MCOs' contracts for compliance with Section 1004 of the SUPPORT for Patients and Communities Act?	Yes, contracts are updated to address each provision
If "Yes," please specify effective date.	7/1/2019
If "No, contracts are not updated," please explain why not.	N/A
a. Is the State complying with Federal law and monitoring MCO compliance on SUPPORT for Patients and Communities Act provisions?	Yes, state is complying with Federal law and monitoring MCO compliance on SUPPORT for Patients and Communities Act provisions

Question	Response
If "Yes," State is complying with Federal law and monitoring MCO compliance on SUPPORT for Patients and Communities Act provisions. Please explain monitoring activities.	Monitoring activities include holding quarterly meetings with MCO pharmacy leadership to review policy updates including but not limited to the SUPPORT Act, MME/MED standards, coverage and PA changes, among other things. In these meetings the MCOs will share progress and best practices and the State inquires about specific areas of the SUPPORT Act. In the previous two years, great strides have been taken to reduce the MME/MED utilization of Medicaid members and align the MCO and FFS opioid utilization to the same MME/MED standards.
If "No," please explain why not.	N/A
4. Does the State set requirements for the MCO's pharmacy benefit (i.e., same preferred drug list, same ProDUR/RetroDUR)?	No
a. If "Yes," check all that apply.	N/A
b. Please briefly explain your policy.	N/A
If "No," does your State plan to set standards in the future?	Yes
If "No," please explain.	N/A

Question	Response
5. Is the RetroDUR program operated by the State or by the MCOs or does your State use a combination of State interventions as well as individual MCO interventions?	State uses a combination of state interventions as well as individual MCO interventions
6. Indicate how the State oversees the FFS and MCO RetroDUR programs? Please explain oversight process.	The State utilizes a data-driven approach to outreach to prescribers on trends or concerns about drug utilization through the review of FFS claims data and MCO encounter data. The MCOs are contracted to have a RetroDUR program. Because the pharmacy benefits are both carved in and carved out simultaneously, the State has set up a daily file containing pharmacy claims to allow the MCOs to perform a more reliable RetroDUR process with the latest claim data. The State also holds quarterly meetings between the State and the MCO pharmacy leadership to review policy updates including but not limited to the SUPPORT Act, MME/MED standards, coverage and PA changes, among other things.
7. How does the State ensure MCO compliance with DUR requirements described in Section 1927(g) of the Act and 42 C.F.R. § 456, subpart K?	The State ensures compliance through the inclusion of contract provisions of the specific DUR requirements as well as via regular meetings between the State and the MCO pharmacy leadership.
8. Did all of your managed care plans submit their DUR reports?	Yes
If "No," please explain why not.	N/A

Section XI - Executive Summary

Question	Response
1. Summary 6 – Executive Summary Executive Summary should provide a brief overview of your program. It should describe FFY 2021 highlights of the program, FFS initiatives, improvements, program oversight of managed care partners when applicable, and statewide (FFS and MCO) initiatives.	Utah Medicaid has been continuously implementing new pharmacy activities to improve efficiencies in cost and care for Medicaid members. Areas of focus have been improving access to COVID vaccines and treatment, improving access to care through removing certain prior authorizations, increased quantity edit in certain medications, adherence to antidepressant medications, hepatitis C therapies, and positive clinical therapy alternatives on the Preferred Drug List. The pharmacy team also continues our effort to reduce inappropriate use of opioid medications, reduce concurrent use of opioids and benzodiazepines, increase naloxone prescribing in patients on concurrent use of opioids and benzodiazepines, and antipsychotic medication use in children and adolescents. The UT Medicaid began reimbursing for MTM service performed by outpatient pharmacists. Peer-to-peer programs were continued with the primary goals of educating and providing resources to health care providers in the areas previously mentioned. For the interventions concerning inappropriate opioid use, decreasing the number of members on an opioid and a benzodiazepine combination, increasing the number of members prescribed naloxone who take a concurrent opioid/benzodiazepine, ADHD stimulants used in children under 4 years of age, concurrent use of cross-class amphetamine and methylphenidate stimulants, 3 or more inappropriate concurrent stimulants use, and antipsychotic medication use in children and adolescents, phone calls were made to providers throughout the prior authorization review process to have patient-focused discussions and educate them on Medicaid policies and procedures. Nearly all interactions were positive and well-received, and providers collaborate to improve care for the members. For adherence programs on Antidepressant Medication Adherence and hepatitis C, phone calls were made to members to counsel on treatments, provide clinical care, answer questions, and refer care to the appropriate resources if necessary. Utah Medicaid continues to enhance the prior

Question	Response
	authorization program with regular updates of all pharmacy prior authorization forms, ensuring each is supported with current and robust clinical and operational criteria and is followed by our Accountable Care Organizations. These continued efforts have improved the efficiency of the prior authorization program and team.