

## **EXECUTIVE SUMMARY - FFY 2011 DUR REPORT**

### **FOR FEE FOR SERVICE (FFS) PHARMACY PROGRAMS - STATE BY STATE**

#### **ALASKA**

The Alaska Medicaid Drug Utilization Review (DUR) committee had six scheduled meetings for FFY 2011, but last minute scheduling conflicts with members resulted in the cancellation of one meeting. As part of the mission of the Alaska DUR to improve quality of pharmaceutical care by ensuring that prescriptions are appropriate, medically necessary and not likely to result in adverse medical results, the Committee will continue to focus on maintaining medication access, promoting cost saving initiatives, educating providers through the point of sale system and providing intervention letters to pharmacies and physicians. Prospective Drug Utilization Review (ProDUR) The generic utilization from FFY 2010 (67%) to FFY 2011 (70.1%) had a 3.1% increase. The generic expenditure, as a percent of total costs, for FFY 2010 was 23% and for FFY 2011 rose to 25.5%. The influencing factors can be attributed to the constant focus on new edits and diligence to promote less expensive therapies while maintaining standards of care. While the increases seem small, they are good positive trends to maintain for FFY2012. Current point of sale edits and prior authorizations have had continued success, and Alaska has implemented a number of edits or quantity limits on medications for narcolepsy, sleep disturbance, and pain in FFY 2011. Quantity limit edits help ensure medications are used at appropriate doses and enables the Department to realize cost savings as well as reduce waste and diversion. Retrospective Drug Utilization (RetroDUR) The RetroDUR program primarily consists of the committee reviewing patient profiles for selected criteria, but other aspects of their recipient's profile was eligible to be reviewed for potential interventions. Examples of some clinical issues the committee found relevant to initiate provider outreach were drug-drug interactions, poly-providers (both physicians and pharmacies), lock-in candidates, therapeutic duplication, and inappropriate duration of therapy. As a part of the intervention letters the DUR committee has added website links to educate practitioners about new drug interactions, drug dosing, and the prescription drug monitoring program. CONCLUSION In FFY2011 the DUR committee addressed many issues of unnecessary care, continued diligence against waste, and implemented prior authorizations on therapies to maintain proper drug use or to promote use of less expensive therapies, such as generic products. In FFY2012 the committee will continue to monitor and improve drug regimens for any issues that may impact our Alaskan citizens.

**ALABAMA** - Summary not submitted

#### **ARKANSAS**

The Arkansas Medicaid Pharmacy Program utilizes a variety of strategies to try to maintain a flat growth pattern in pharmacy expenditures from one year to the next. Excluding pharmacy

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program contract costs for each year, the Medicaid Pharmacy Program finished FFY 11 with an overall decrease in pharmacy expenditures (approximately -2.5%) when compared to FFY 10. The Pharmacy Program attributes the decrease in expenditures to avoided costs by utilizing preferred agents in the PDL, in addition to utilizing clinical prior approval (PA) criteria edits and claim (fiscal integrity) edits that have been applied to various drugs or drug classes throughout the year. Every quarter, the Pharmacy Program staff continues to identify various aspects of inappropriate utilization, from billing errors, to excessive quantities & doses written for and dispensed, to over-utilization of medications in a drug class, to new drugs that have the potential for inappropriate use. The Pharmacy Program staff uses an evidence-based approach for developing proposals for the DUR Board to review and approve at the quarterly meetings for clinical PA criteria edits or claim edits (quantity edits, dose edits, cumulative quantity edits, age, or gender edits) as preventive measures of inappropriate utilization. Although it is important for the Pharmacy Program to conserve program funds using these types of edits or PA criteria, the success of the AR Medicaid Pharmacy Program is not measured by cost savings or cost avoidance alone. The evidence-based approach for developing the clinical edits and claim edits ensure that AR Medicaid beneficiaries are receiving prescription drug benefits through the AR Medicaid Pharmacy Program that are therapeutically appropriate and medically appropriate. The Pharmacy Program has found that when the beneficiaries receive therapeutically appropriate and medically appropriate care, the program costs decrease.

#### **CALIFORNIA**

California's Medi-Cal DUR is a dynamic program designed to optimize recipients' medical and pharmaceutical care, and to reduce the costs of this care. The program objective is to educate physicians and pharmacists on ways to improve the quality of patient care by increasing awareness of therapeutic issues. Medi-Cal DUR reviews outpatient prescribing patterns, alerts pharmacists to potential prescribing hazards and educates all providers, enabling them to render the best possible care to recipients. Medi-Cal DUR uses a broad array of tools that allow real-time evaluation of recipient medical and pharmaceutical care. Central to the DUR program is the DUR Board, comprised of volunteer pharmacists and physicians with active practices in California. The DUR Board acts in an advisory role to the State on drug use considerations, develops criteria to evaluate drug therapy, regularly reviews resulting evaluations, and recommends educational interventions to the providers. The enclosed California 2011 Medicaid Drug Utilization Review Annual Report Survey highlights the quality program provided to the recipients. By using the best tools, maintaining a high quality staff, and building and customizing a powerful decision-making process, Medi-Cal DUR continues to improve programs to support the provider with an interactive information environment and provide recipients with an optimal care environment.

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**COLORADO** - Summary not submitted

#### **CONNECTICUT**

EXECUTIVE SUMMARY Objectives for the operations of the Connecticut Medical Assistance Drug Utilization Review (DUR) Board during federal fiscal year 2011 include: (1) maintain a DUR Board with membership that meets OBRA 1990 requirements; (2) continue prospective DUR criteria review and evaluation, (3) conduct focused retrospective analyses of claims data to study drug utilization in the Connecticut Medical Assistance Program; in the fee-for-service population (also known as HUSKY C), HUSKY A (T19 eligible kids), HUSKY D (Medicaid for Low-Income Adults or MLIA, formerly SAGA) as well as in HUSKY B (our SCHIP), the ConnPACE and the Charter Oak populations; and to (4) guide the development and implementation of educational interventions to improve drug use in these populations. From 10/01/2010 to 9/30/2011 the DUR Board was comprised of six pharmacists and three physicians. Four DUR Board meetings were held during FFY 2011. Prospective DUR was performed on-line during FFY 2011 for all Connecticut Medical Assistance recipients. Thirteen prospective DUR analyses existed from 10/1/10 to 9/30/11 and are as follows: Early Refill by Therapeutic Class, Therapeutic Duplication by Therapeutic Class, Drug-Drug Interactions, High Dose by Therapeutic Class, Pregnancy by Therapeutic Class, Pediatric (Drug-Age) by Therapeutic Class, Low Dose by Therapeutic Class, Late Refill by Therapeutic Class, Geriatric (Drug-Age) by Therapeutic Class, Ingredient Duplication by Therapeutic Class, Minimum Duration by Therapeutic Class, Maximum Duration by Therapeutic Class, and Drug Disease Interaction by Therapeutic Class. Low Dose, Late Refill, Minimum Duration, and Maximum Duration are informational alerts only and do not require an override, however, they are reported on in attachment 2 in order to illustrate the top therapeutic classes that make each alert hit. Geriatric Age is an alert which requires override, however when the number of overrides are recorded for this alert, they are combined with the Pediatric Age alert. Twelve retrospective analyses were reviewed and approved by the DUR Board and conducted during FFY 2011. All of the retrospective evaluations included mailing of recipient specific educational intervention letters to prescribers. Recipient specific educational intervention letters highlight a drug therapy concern and are sent to prescribers with a complete recipient drug and diagnosis history profile along with a response form. The Pharmacy Restriction Program (also known as the Pharmacy Lock-In Program) is ongoing and the State's contractor, Health Information Designs, Inc. (HID) was required to review 800 lock-in profiles monthly. A summary report of the activities of the regular DUR and Lock-In Program during FFY 2011 is included below. For the future, the DUR Board aims to accomplish the following: (1) provide recommendations to help improve drug therapy in the Connecticut Medical Assistance Program (CMAP) populations, with more emphasis on the pediatric recipients (2) analyze the utility and effectiveness of existing prospective DUR criteria and retrospective interventions for these CMAP service populations

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and patients taking medications reimbursed by CMAP, (3) recommend and review prescriber interventions and educational programs and (4) serve in an advisory role for the development and management of a Pharmacy Restriction Program. Cost Savings analyses of both prospective and retrospective DUR are reported and can be found in Attachment 6 of the CMS Report. The reported cost savings for Retrospective DUR during FFY 2011 from HID was \$2,405,071. The reported cost savings for Prospective DUR during FFY 2011 was \$16,442,637.

#### **DISTRICT OF COLUMBIA**

The District of Columbia Drug Utilization Review Board has worked diligently during FY11 to address potential medication safety and adherence issues in a more proactive systematic manner. The preparation for completion of the revised annual report has prompted the Board to reprioritize its long term goals to more closely align with new reporting requirements and interim reports from the Contractor will be requested and reviewed. The Board has made plans to collaborate with the DC Department of Health in a recently approved and funded academic detailing program targeting prescribers of drugs with proven abuse potential, adherence concerns and complex treatment regimens.

#### **DELAWARE**

Each quarterly DUR meeting is divided up into four sections: 1) pro-DUR, e-prescribing, and call center statistics; 2) retro-DUR interventions; 3) old business and follow-ups; and 4) new business. Pro-DUR: Step-edits determine if they had a first-line medication or a diagnosis code that would preclude the doctor from using another therapy. This year 35% of our edits processed electronically. 13% of our drug claim submissions hit for a pro-DUR alerts. This was a 1% increase from last year primarily due the duplicate therapy alert implementation on short-acting narcotics, and low dose alert on Seroquel. Retro-DUR: Retro-DUR interventions occur every 2 months with 3 sets of client profile reviews and 3 provider education topic mailings. In 19% of the cases evaluated for this report, prescribers responded to alert letters. Many physicians responded by discontinuing unnecessary prescriptions, reducing the quantities of medications prescribed, or switching to safer drug therapies. The most mailings to physicians concern clinical appropriateness (45%) and drug-drug interactions (37%). Non-compliance is often targeted in the disease states of asthma and diabetes. Cost Savings: Delaware's cost savings for the 2011 federal fiscal year were estimated at \$3.4 million or 2.27% of the pre-rebate expenditure of \$152 million. \$247,000 can be attributed to the retro-DUR mailings and provider education, while the other \$3.2 million comes from pro-DUR therapeutic duplication and dose optimization interventions. The \$3.2 million is a conservative estimate as Delaware only takes into account true cost savings, not deferred payments. Generic Utilization: The generic utilization percentage in Delaware is 74% on the 2.2 million prescriptions dispensed, while the

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pre-rebate expenditure was 19% of the \$152 million pre-rebate drug expenditure. E-prescribing: Delaware's e-prescribing program began in November 2008. From October 2010 to September 2011 the percentage of Delaware Medicaid providers using an e-prescribing device increased from 24% to 50%. The percentage on prescriptions that were e-prescribed increased from 11.6% to 17.45% over that same period. Innovation: Delaware has watched its ranking amongst states for stimulant and narcotic prescribing. In order to curb misuse and abuse, Delaware worked to implement policies that took effect at the end of the fiscal year or had start dates in federal fiscal year 2012. Adult ADHD prescribing and possible abuse or misuse of stimulants is a nationwide problem. Prior to any changes, 61% percent of the DMMA adult population taking medication for ADHD used short acting stimulants. DMMA, on the recommendation of the DUR Board, began to require adult patients to try and fail with a long-acting ADHD medication before use of a shorter acting one would be approved. Within two months the percentage of ADHD clients prescribed a short acting stimulant dropped to 42%. Delaware's second policy revision centered on the management of chronic pain. While prior authorizations have been in place for some time with a total quantity limit of 200 units per month, no prior authorization or pain contract was needed for short-acting narcotics that were under the quantity limit. An increasing number of patients were being treated long term with only high dose, high quantity, short-acting medications. New quantity limits were placed on highly abusable short acting medications. For clients currently getting greater quantities, titration to a long-acting narcotic or a rotation to a different short-acting narcotic for breakthrough pain was required. DMMA recommended further restrictions on short acting narcotics and actions to ensure abuse will not shift to other drugs.

**FLORIDA** - Summary not submitted

#### **GEORGIA**

The Drug Utilization Review Board (DURB) continued its service to the Department of Community of Health in an advisory capacity. In this role, the DURB made recommendations related to the safe and effective use of medications for our citizens to the Department. The DURB is comprised of 20 members from a variety of backgrounds located throughout the state of Georgia. Gary Williams, MD, served as chair during this period and was assisted by Laurel Ashworth, PharmD, as vice chair. The primary responsibility and charge to the Board was the continuing development and modification of the State of Georgia's Preferred Drug List for the Medicaid Fee for Service program. The Board, after careful thought and much deliberation believes the PDL has matured to the point that it can be monitored annually leaving 3 meetings per year to concentrate on utilization review activities. Hence, the Board has initiated an enhanced meeting schedule that will allow for adequate time to maintain the PDL as well as additional time to further concentrate on utilization review. Additionally, the board offered its

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expertise to assist the state with development of prior authorization criteria, increasing generic utilization, and advising on conditions for claims processing. Further, the DURB has continued to be vigilant in its review and inclusion of mental health medications on the Preferred Drug List and subsequent monitoring of these efforts. Board Meetings follow parliamentary procedures and have a standing order of business, specifically: Call to Order Approval of Minutes Comments from the Department Clinical Review of Therapeutic Classes Future Agenda Items Future Meeting Dates Consumer Comments Session Executive Session Boards' Recommendations Announcements Adjournment The clinical review of information includes input from several sources: NorthStar HealthCare Consulting (NHC) (review of medical literature including controlled clinical trials as well as clinical guidelines, drug safety alerts, generic availability report, new medication pipeline report); the pharmaceutical manufacturers (verbal presentations via the manufacturers' forum and written materials via electronic submission); consumers' comments at the meetings; and the DURB members through their independent research and clinical expertise. Additionally, the Board sought clinical input from practicing clinical experts when supplemental information was needed. Drug classes previously reviewed by the Board are reconsidered on an annual basis. New market entrants that are subject to the outpatient drug benefit are reviewed after 6 months of market availability at which time the full therapeutic class is reviewed. During Federal Fiscal Year 2010, the DURB researched, reviewed and made Preferred Drug List recommendations. The Board continues to be impressed with the quality of the support staff and professionals within the Department of Community Health including: Linda Wiant, Turkesia Roberts-Jones, Lori Garner, Gilletta Gray, and Rose Marie Duncan. The Board appreciates their hard work and dedication in facilitating the Board's efforts. Additionally, the Board has been very pleased with the clinical support provided by NorthStar HealthCare Consulting.

#### **HAWAII**

The Hawaii Medicaid DUR Board continues to meet for the needs of the Fee-For-Service (FFS) population and CMS' requirements. Although the FFS population demographics continue to change, the number of eligible recipients is consistently less than 1.5% of the total Hawaii Medicaid population. The eligible recipients are predominantly from the QUEST window and they remain in the FFS program for one to three months (as new to the Medicaid program) before transferring into the QUEST program. This program services the younger, healthier individuals and families. Their drug needs differ greatly from the former FFS population demographics of aged, blind and disabled. The DUR Board focus has shifted to meet the needs of the population. Also in FFS are State of Hawaii Organ and Tissue Transplant (SHOTT) program eligibles that remain in FFS for up to one year prior to and post- transplant. Their numbers are less than 100. Past DUR Board recommendations have been support to current

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issues being addressed by the Hawaii Medicaid managed care programs QUEST and QUEST Expanded Access.

#### **IOWA**

The Commission had a successful year with overall direct total cost savings of \$3.28 for every dollar spent on the program administratively. Overall, the program produced a net cost savings of \$615,600.07. Patient-focused review saw a savings of \$275,771.07 versus a savings of \$292,030.24 in FFYE 2010. Total dollars saved per patient evaluated was \$252.31. This decrease is due in part to only seven patient-focused reviews this past federal fiscal year versus eight the year prior. Beginning in July 2010, the number of meetings was reduced to six meetings per year versus eight meetings the prior years. Total cost savings for the problem-focused studies for FFYE 2011 is \$609,829.00 versus \$139,669.24 in FFYE 2009. This increase is due to a larger number of focused studies this past federal fiscal year versus the year prior. Fourteen focus studies were evaluated in FFYE 2011 compared to six in FFYE 2010. Twelve of these focus studies were designed to promote appropriate therapy and optimize patient outcomes and two of the focus studies addressed inappropriate use of medication.

#### **IDAHO**

During Federal Fiscal Year 2011, the activities of the Idaho DUR Board were coordinated by Magellan Medicaid Administration. This has developed into a great partnership between Magellan and the staff clinical pharmacists at Idaho State Medicaid. The staff is able to identify areas of concern and quality improvement opportunities. Magellan is able to pull data and profiles and the state staff is able to complete the profile reviews. Generic utilization for the Idaho Medicaid Pharmacy Program is currently at 74%. Our program is a strong believer in using therapeutically equivalent drugs that have the least net price which in some cases may be Brand over generic, particularly when a drug first goes generic or when there are supplemental rebates involved. Net Cost Savings for Prospective DUR was \$5,283,596 and for Retrospective DUR was \$ 815,633. During the time period of this report, 16 unique RetroDUR Studies were completed with follow-up. These studies were strongly correlated with Pharmacy and Therapeutics Committee current focus and included educational interventions to both prescribers and pharmacies. Studies included insufficient dose, incorrect duration, over utilization, underutilization, therapeutic duplication, drug/drug interaction and drug disease contraindications. Idaho Medicaid ensures appropriate drug utilization through the Drug Utilization Review Board, the Pharmacy and Therapeutics Committee and an extensive prior authorization system including an automated PA system at point of sale. The Department puts emphasis on evidence based drug information and utilizes that information for the 80 plus drug classes in the preferred drug list as well as the development of therapeutic prior authorization.

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The Department operates its own internal call center to manage the prior authorization program. The DUR Board is involved in outcome studies to review PDL changes and impact of prior authorization criteria. Probably the most significant change during this time period was the switch from an AWP based reimbursement model to an acquisition cost model. Although this was implemented at the end of this reporting federal fiscal year (September 28, 2011), the work of development and all initial implementation steps occurred during the 6-9 months prior to this.

#### **ILLINOIS**

Throughout FFY11, Illinois Medicaid continued to strive to ensure the efficient operation of the Pharmacy Program, in part, by protecting against reimbursement for unnecessary or inappropriate services. During FY11, the program primarily focused on reducing the overutilization of narcotic agents and mental health agents. Illinois employed a variety of claims editing strategies, including duration of therapy edits, daily dose edits, maximum quantity edits by drug and by class, and prior approval for specific populations where overutilization or inappropriate utilization patterns are more prevalent.

#### **INDIANA**

State of Indiana Medicaid DUR Annual Report For Federal Fiscal Year 2011 (October 1, 2010 through September 30, 2011) Executive Summary The State of Indiana is committed to operating a Medicaid DUR program that has a positive impact upon quality of care as well as upon pharmacy and medical expenditures. Prospective DUR (pro-DUR) and retrospective DUR (retro-DUR) each serve a unique purpose in alerting practitioners and pharmacists with specific, focused, and comprehensive drug information available from no other source. For FFY 2011, the total estimated net savings for pro-DUR and retro-DUR programs for Indiana Medicaid is \$45.43 million. The retro-DUR estimated savings were \$479,661\* while the pro-DUR estimated savings were \$45.58 million. The total savings was estimated at \$46.06 million. The cost to administer both programs is \$0.63 million which results in a net savings of approximately \$45.43 million. The Indiana Medicaid DUR program remains beneficial to the State, provider community, and beneficiary population served. The Office of Medicaid Policy and Planning (OMPP) will continue to improve the retro-DUR and pro-DUR program.

**KANSAS** - No Summary submitted

**KENTUCKY** - No Summary submitted

#### **LOUISIANA**

This annual report represents a summary of the Louisiana Medicaid Pharmacy Benefits Management (LMPBM) program's activities under the direction of the Louisiana Department of

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Health and Hospitals (DHH). A commitment to improving the quality of patient health care was demonstrated during the federal fiscal year from October 1, 2010 through September 30, 2011. Education Under the direction of the DHH, the University of Louisiana at Monroe (ULM) College of Pharmacy compiles disease state management (DSM) materials for the recipient and provider populations. • Brochures addressing quality of care issues relating to diabetes management were mailed to 3,650 recipients. • A series of educational articles are published in the Provider Update newsletters. This bimonthly newsletter is sent to every provider in the Louisiana Medicaid program. Prospective DUR Interventions Prospective drug utilization review (DUR) screening occurs every time a pharmacist processes a prescription, before the prescription is dispensed to the patient, to assure safe and medically necessary drug use. • Clinical alerts and edits address current disease-focused categories such as behavioral health and pain disorders. • Pharmacy cost avoidance attributed to the use of the prospective interventions during federal fiscal year 2011 is \$70,155,574. Retrospective DUR Interventions Retrospective clinical interventions, in the form of mailings or phone-calls to prescribers and pharmacists, occur after prescriptions are dispensed. • The Louisiana Drug Utilization Review (LADUR) program is outstanding and unique in that throughout the year important clinical interventions in eight disease-specific categories are made concerning the health care of individual recipients. • These clinical interventions potentially improve the recipients' disease management and quality of life. • Pharmacy cost avoidance attributed to LADUR interventions during federal fiscal year 2011 projected to \$1,266,690 in the targeted drug classes. Drug expenditure reductions averaged 9 percent in the drug classes in which discontinuation or reduction of drug use was recommended. Drug expenditure increases were reflected for disease management drug initiation recommendations, indicating successful clinical interventions. The cost analysis does not include potential savings in other categories such as hospitalizations or physician visits. • LADUR program acceptance and approval by the provider community is evident by numerous positive responses along with a response rate of 36 percent. The retrospective LADUR Program is increasingly deriving clinical interventions from nationally-recognized disease management principles, providing current pertinent information to the provider concerning his patient. Current LADUR clinical interventions address issues in the following categories: Heart failure management Hypertension management Diabetes management Asthma management Pain disorders Behavioral health Sleep disorders Gastrointestinal disorders Depressive disorders

**HIGHLIGHTS OF SUCCESSFUL CLINICAL INTERVENTION EXAMPLES IN THE RETROSPECTIVE LADUR PROGRAM** Successful clinical interventions in asthma management were demonstrated in federal fiscal year 2011. • It is known that good asthma management can reduce or halt the progression of the disease and improve symptoms and quality of life in patients with asthma. • Nationally-recognized clinical guidelines for the management of asthma recommend routine use of a steroid inhaler for patients with persistent asthma. • Patients who initiated steroid inhalers (FFY10 DUR) showed reductions in hospital visits. 5 Successful

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clinical interventions were also demonstrated in diabetes management, heart failure management and hypertension management, as prescribers ordered the following based on LADUR recommendations: Diabetes management interventions • 104 patients (43%) had A1C laboratory testing post-intervention. • 58 patients (29%) added an ACE inhibitor or AR blocking agent prescription. Heart failure management interventions • 14 patients (21%) added beta-blocker therapy. • 53 patients (35%) added ACE inhibitor therapy. Hypertension management interventions • 29 patients (26%) added an anti-hypertension agent prescription.

#### **MASSACHUSETTS**

Introduction and Overview: The University of Massachusetts Medical School administers the Massachusetts Drug Utilization Review Program for MassHealth (Massachusetts Medicaid). The Massachusetts Drug Utilization Review (DUR) program was established in response to the requirements of the Omnibus Budget and Reconciliation Act of 1990 (OBRA90). The main goal of the DUR program is to ensure that Medicaid recipients are receiving appropriate, medically necessary, prescription drug therapy. To achieve this goal, three programs have been implemented. Prospective DUR (pDUR): Prior to dispensing prescription medication, the pharmacist is required to screen for possible drug therapy problems including incorrect dosing, over/under utilization, drug-drug interactions, drug-disease interactions, duplicate therapy, and possible abuse. The process of a drug requiring a prior authorization approval prior to dispensing of the drug is also part of pDUR. Retrospective DUR (rDUR): This program occurs after the prescription is dispensed and targets patterns involving the prescriber, pharmacists, and Medicaid recipients. Under advice of the DUR Board and MassHealth, educational interventions are executed to promote proper use of prescription medications. Such interventions are including providing education material to pharmacists, providers, and recipients. The Drug Utilization Review (DUR) Board: The Massachusetts DUR Board was established in response to OBRA90 regulations. Its responsibilities include advising MassHealth on clinical guidelines for medications and case reviews. The DUR Board is made up of physicians and pharmacists currently practicing in Massachusetts.

#### **MARYLAND**

Executive Summary FFY 2011 Objectives for the operations of the Maryland Medicaid Drug Use Review (DUR) Board during Federal Fiscal Year (FFY) include: 1) maintain a DUR Board with membership that meets OBRA 1990 requirements; 2) continue prospective DUR criteria review and evaluation; 3) conduct focused retrospective analyses of claims data to study drug utilization in the Maryland Medicaid fee-for-service population; and 4) to guide the development and implementation of educational interventions to improve drug use in this population. During FFY 2011, the DUR Board was comprised of six (6) pharmacists and five (5) physicians. Four

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(4) DUR Board meetings were held during FFY 2011. Since July 1997, approximately 93% of Maryland State Medicaid recipients have transferred from the fee-for-service program to a managed care program known as HealthChoice. However, mental health drugs and antiretroviral agents are carved out of the managed care pharmacy benefit and are paid fee-for-service. As a result of this, the transition to managed care resulted in the need to integrate all prescription claims through a common source. The Department of Health and Mental Hygiene (DHMH) implemented and continues to maintain an electronic claims management pharmacy processing system which includes Coordinated Prospective Drug Utilization Review (ProDUR). Beginning on July 1, 2006, a new Primary Adult Care (PAC) Program was initiated. Patients enrolled in the PAC Program are those not eligible for full Medicaid benefits based on their incomes and assets. Physician visits and medications are covered by the PAC Program. Mental health drugs and antiretroviral agents are also carved out of the PAC benefit and are paid fee-for-service. The contract for maintaining the electronic claims management pharmacy processing system, along with Coordinated ProDUR, is administered by Xerox Government Healthcare Solutions. Xerox continues to enhance and maintain Coordinated ProDUR and provides the DUR Board with quarterly prospective DUR message summary reports for prescription claims reimbursed by the Maryland Medicaid Pharmacy Program. For FFY 2011, these reports include all claims for fee-for-service recipients, claims for medications included on the Specialty Mental Health System Formulary (SMHSF) and antiretroviral therapy for HealthChoice and PAC recipients. The Maryland Medicaid Pharmacy Program (MMPP) is responsible for conducting focused retrospective DUR analyses. Data evaluations, educational interventions and clinical support services are provided by Health Information Designs, LLC. (HID). MMPP, with recommendations from the DUR Board, implement educational and administrative interventions with the objective of improving drug use and outcomes among Maryland Medicaid recipients. Five (5) retrospective analyses were conducted during FFY 2011. All of these retrospective evaluations included the mailing of recipient specific educational intervention letters to prescribers or pharmacy providers. Recipient specific educational intervention letters highlight a drug therapy concern and are sent to prescribers and pharmacy providers with a complete recipient drug and diagnosis history profile along with a response form. One of the five retrospective analyses presented in this report is a summary of the Recipient Corrective Managed Care (Pharmacy Lock-In) Program, which was initiated at the end of FFY 2006 and has been ongoing since that time. After detailed review of the drugs categorized as innovator multiple-source, as referenced in Section VII, Generic Policy and Utilization Data, Subsection 2, many of these were found to be listed as generic drug products, including several highly utilized mental health agents. Since mental health drugs are carved out of the Maryland Managed Care benefit and paid fee-for-service, an accurate generic utilization rate could not be calculated. In an effort to report the most accurate generic utilization rate possible, we have recalculated the generic utilization rate by including all drugs categorized as innovator multisource listed by generic

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name as generic agents. A generic utilization rate of 72.9% (1, 2) was then calculated. During FFY 2011 there was increased public scrutiny, controversy and debate regarding the increasing use of antipsychotic agents in children. As a response to this, MMPP established a new program—The Peer Review Program for Mental Health Drugs. The program began in October 2011 and initially addressed the use of antipsychotics in Medicaid patients under five years of age. In partnership with the Mental Hygiene Administration (MHA) and the University of Maryland (UMD) Division of Child and Adolescent Psychiatry and School of Pharmacy, the program's goal is to ensure that members of this vulnerable population receive optimal treatment in concert with appropriate non-pharmacologic measures in the safest manner possible. For the future, the DUR Board aims to accomplish the following: (1) provide recommendations to MMPP to improve drug therapy in the Maryland Medicaid population, (2) analyze the utility and effectiveness of existing prospective DUR criteria and retrospective interventions for the fee-for-service population and patients taking medications reimbursed fee-for-service, (3) recommend and review prescriber interventions and educational programs, and (4) serve in an advisory role for MMPP in the continued management of a Recipient Corrective Managed Care (Pharmacy Lock-In) Program. (1) Since antiretroviral agents are carved out fee-for-service and since most antiretroviral agents are brand name drugs, this has the impact of disproportionately increasing the percentage of brand named drugs utilized. (2) Some highly utilized brand drugs are preferred over their generic counterparts due to the availability of supplemental rebates and lower net cost. Taking into account the preferred brands, an alternate generic use rate of 73.9% was calculated.

#### MAINE

The Maine Medicaid program, known as MaineCare, oversees the pharmacy benefit program and the Drug Utilization Review Committee (DUR). The DUR was formed in accordance with the Omnibus Budget Reconciliation Act of 1990. The purpose is to review drugs that will become part of the preferred drug list (PDL) and assist the Department to make decisions on the structure of the PDL based on clinical and financial reviews. For federal fiscal year 2011, the DUR reviewed narcotic, statin and atypical antipsychotic prescribing records of Maine providers. The committee focused the reviews on monitoring of the patients care, such as testing lipids, monitoring metabolic changes, testing for over use or underutilization. The DUR did a variety of surveys, working with the Department, medical records were collected and the Department provided multiple analyses to the DUR for review. As a result of the reviews mentioned above the DUR has recommended changes to PA requirements for these categories of drugs and in some cases have added a PA requirement. The DUR will continue to monitor these classes of drugs and provide recommendations to the department to improve and education prescribers. The DUR will continue to monitor these classes of drugs and provide recommendations to the department to improve patient care and to educate prescribers.

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#### MICHIGAN

This DUR program annual report encompasses the drug utilization review activities and outcomes that have occurred during FFY 2011. Included are ProDUR alerts and intervention statistics, RetroDUR alerts and intervention statistics. The Medicaid enrollment continues to grow, with an average total enrollment of 1,930,414 for FFY 2011, a 3.82% increase over FFY 2010. Presently, 65% of the Medicaid patients are enrolled in Managed Care Organizations (MCOs). The remaining 35% are in Fee for Service (FFS). The DUR Board reviews prescribing patterns for primarily the FFS patient population. In April 2010, full coverage of Medicaid Health Plan (MHP) Carve-Out medications was transferred to FFS. Prior to this change, FFS covered 60% of the cost of these medications and the MCOs covered 40%. The MHP Carve-Out medications include antidepressants, antipsychotics, CNS stimulants, anticonvulsants and antiretroviral agents. The costs of the carve-out medications are tremendous. The Michigan Public Acts 248 and 250 that currently prohibit Michigan Medicaid from prior authorization of psychotropic medications. To help contain the cost of these medications and ensure safe prescribing for the beneficiaries, Michigan Medicaid is developing a new academic detailing program, called EnhanceMed, which will begin as a pilot in May 2012. While the DUR Program addresses patient safety, Michigan believes safe and effective pharmaceutical prescribing results in cost effective medicine. The Michigan Medicaid program has aggressively addressed pharmacy expenditures. Other initiatives of our pharmacy program include daily Maximum Allowable Cost (MAC) pricing review, use of quantity limits, dose optimization (dose consolidation), e-prescribing and the multi-state pooling initiative. In 2011, Michigan Medicaid began the development of a specialty drug program to control costs of these medications paid under the medical benefit. The program was implemented in January 2012. The full impact will not be realized until the end of FFY 2012. It is through these efforts Michigan continues to provide safe and effective treatment of citizens served by the Medicaid program. E-prescribing was initiated for Michigan Medicaid in September 2008. Utilization of electronic prescriptions continues to grow among Michigan Medicaid prescribers. This on-going program increases prescription drug safety by reducing errors due to handwriting issues and by giving prescribers the opportunity to review a patient's medication history prior to ordering a new drug. This report was prepared by Donna P. Johnson, PharmD, Clinical Account Manager at Magellan Medicaid Administration, Inc. Questions regarding this report should be directed to Trish M. O'Keefe, Director, Pharmacy Management Division, Medicaid Program Operations and Quality Assurance, Michigan Department of Community Health at (517) 335-5442.

MINNESOTA - No Summary submitted

## EXECUTIVE SUMMARY - FFY 2011 DUR REPORT

### FOR FEE FOR SERVICE (FFS) PHARMACY PROGRAMS – STATE BY STATE

#### MISSOURI

Incorporating increasing levels of technology throughout Missouri's health care system increases efficiency, coordination and transparency; decreases errors and reduces administrative costs. CyberAccessSM is a web-based HIPAA-compliant tool providing health care providers with access to MO HealthNet patient data. It is the first step toward a comprehensive electronic health record for MO HealthNet participants and allows access to medical, procedural and pharmacy paid claims data for participants for the past two years. In addition to the participant health information, a health care provider with prescribing privileges can submit an electronic prescription and access the clinical rules engine to request precertification of medical procedures and prior authorization for prescription drugs when needed. CyberAccessSM allows providers to view the MO HealthNet participant's claims history from all providers to determine the most appropriate course of treatment. MO HealthNet participants, health care providers, Missourians and the state of Missouri benefit from the use of this tool. More than 17,000 MO HealthNet providers and allied health professionals use this web-based portal to access electronic health records for MO HealthNet patients. Treating providers can view a patient's medical history including diagnoses, procedures and prescribed medications. Providers can electronically submit prescriptions, request pre-certification for imaging procedures, durable medical equipment, inpatient hospital stays and optical services within the tool. CyberAccessSM improves the efficiency of health care delivery by using a rules-based engine to determine if a requested drug or procedure meets the appropriate clinical criteria. All of these tasks are performed in a secure environment and the entire system is Health Insurance Portability and Accountability Act (HIPAA) compliant. The tool now includes lab and clinical trait data imported from provider medical records, as well as increased functionality to allow physicians to input notes. Recent pharmacy program initiatives include protecting patient safety by assessing utilization of psychotropic medications. Four psychotropic clinic edits (atypical antipsychotics, selective serotonin reuptake inhibitors, selective norepinephrine reuptake inhibitors and polypharmacy) were implemented to reduce the inappropriate use of these medications and to improve patient outcomes and quality of care. Additionally, effective February 2011, MO HealthNet Division covers smoking cessation for all eligible participants. MO HealthNet covers 2 quit attempts of up to 12 weeks of intervention per lifetime, including behavioral and pharmacologic interventions. The MO HealthNet Pharmacy Program's goal is the continued provision of quality, cost-effective health care for Missouri's most vulnerable citizens.

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#### MISSISSIPPI

The Mississippi Division of Medicaid 2011 Annual Report for the Drug Utilization Program was prepared through a collaborative effort between the Division of Medicaid, the Drug Utilization Review Board, Xerox, Inc. (formerly known as ACS, Inc.), Shared Health, Inc., and the Mississippi Evidence-Based DUR Initiative (MS-DUR). The Mississippi Division of Medicaid underwent several changes during and after the 2011 federal fiscal year which are reflected in this report, including a change in the retrospective DUR vendor from Health Information Designs (HID), Inc. to MS-DUR, which is based out of the University of Mississippi School of Pharmacy. HID, Inc. performed the retrospective drug utilization review activities during the first quarter of the reporting period until MS-DUR began on January 1, 2011. As a result, some information required for the report was not provided upon request from the previous retrospective DUR vendor, Health Information Designs, Inc. for the period covering October 1, 2010 to December 31, 2010. Throughout the 2011 federal fiscal year, the Mississippi Division of Medicaid has several noteworthy accomplishments and initiatives worth mentioning. The Division of Medicaid implemented a more robust electronic prior authorization system, including automation of pharmacy benefits for children (EPSDT) as determined by qualifying diagnoses and claims history and the automation of the 72 hour emergency supply. This electronic prior authorization system maintained by the fiscal agent, Xerox Inc. (formerly known as ACS, Inc.), is continuously updated with updated criteria using feedback from the P&T Committee, the DUR Board, the preferred drug list and drug utilization vendors. In addition to the improved electronic prior authorization system, Mississippi Medicaid is following the lead of CMS and increasing focus on quality-based initiatives and exploring the use of more education-based interventions to improve quality prescribing practices. The Mississippi Division of Medicaid takes great care in reviewing and implementing prospective and retrospective DUR criteria to ensure that each of the criteria are clinically sound and economically justifiable. DUR Board reviews certain criteria that the Division of Medicaid requests feedback on before implementing. The DUR Board is also involved in the educational outreach efforts of the Division of Medicaid, providing insight and recommendations for the content of educational newsletters. While valuable information can be gleaned from metrics like the generic utilization percentage, some background information may be helpful to support the numbers provided. Mississippi law requires that Medicaid shall not reimburse for a brand name drug if an equally effective generic equivalent is available and the generic equivalent is the least expensive. The only exceptions to this policy are: observed allergy to a component of the generic drug; or an attributable adverse event; or drugs generally accepted as narrow therapeutic index (NTI) drugs. The Division of Medicaid does not have a state maximum allowable costs (MAC) program for multisource generic drugs. However, DOM does have a robust preferred drug list (PDL) with associated supplemental rebates. For some agents,

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### **FOR FEE FOR SERVICE (FFS) PHARMACY PROGRAMS – STATE BY STATE**

the combination of federal and supplemental rebates results in the branded agents being the least expensive to both the state and to the federal government. State law limits the adult non-institutionalized beneficiary to 5 drugs monthly of which no more than 2 may be branded. There are some situations where a more expensive generic drug is co-preferred with the branded agent in order for beneficiary access. If there are questions or if additional information is needed regarding this report, please contact Vicky Donaho at (601) 359-6398.

#### **MONTANA**

Executive Summary: The Montana Medicaid FFY 2011 Annual Drug Utilization Report contains the following tables and attachments. The DUR Program survey has been completed as provided throughout the report. Montana has completed the following Tables and Attachments as outlined below: Table 1 as placed into the online table format; Attachment 1 (Produr Review Summary), Named: MT-2011-ATT.1-PRS.xlsx; Attachment 2, (Produr Pharmacy Compliance Report) Named: MT-2011-ATT.2-PPCR.xlsx; Attachment 3, (Retrodur Screening & Intervention Summary) Named: MT-2011-ATT.3-RSIS.docx Table 2 as placed into the online table format; Attachment 4, (Summary of DUR Board Activities) Named: MT-2011-ATT.4-SDBA; The answer to question under attachment 4, does MT have a disease management program – No; Does your state have a medication therapy management program? No; Attachment 5, (Generic Drug Substitution Policies) Named: MT-2011-ATT.5-GDSP.docx; Attachment 6, (Cost Savings Estimate) named: MT-2011-ATT.6-CSE.docx; Attachment 7, (Prescription Drug Monitoring Program) named MT-2011-ATT.7-PDMP.docx Attachment 8, (Innovative Practices Narrative) named MT-2011-ATT.8-IPN.docx Attachment 9, (E-prescribing Activity Summary) named MT-2011-ATT.9-EAS.docx The Executive Summary is completed with this.

#### **NORTH CAROLINA**

Executive Summary: The Drug Utilization Review Board is advisory to the Division of Medical Assistance and is comprised of six physicians and six pharmacists. The fiscal agent, HP Enterprise Services, provides Prospective DUR reporting. Magellan Health Services, through a contract with Computer Sciences Corporation, provides Retrospective DUR reporting. In this advisory role, the Board meets quarterly, reviews Prospective DUR and Retrospective DUR data and makes recommendations related to the safe and effective use of medications for the Medicaid beneficiaries in North Carolina. Noteworthy items included in this annual report are the minutes and meeting packets from each of the quarterly meetings, a list of the Board approved interventions, cost savings analysis performed by Mercer Government Human Services Consulting at the request of the Division and innovative practices and policies developed for the Federal Fiscal Year 2011. These documents provide detailed information for the topics covered

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briefly below. At the October 28, 2010 meeting, the Board discussed changes to the Pro-DUR alerts. There were no recommended changes to the current low dose alerts. There were 15 GC3 deletions for the high dose alerts and 17 GC3 additions. For the therapeutic duplication Pro-DUR alert, there were 3 GC3s deleted and 30 GC3s added to this alert. Deletions were made where there was low alerting of a particular GC3 and additions were made where the Board felt it was clinically appropriate and there were many claims for a particular category. For example, additional antipsychotic GC3s were added for the therapeutic duplication Pro-DUR alert. The complete list of recommended changes is noted in Attachment 1. Another component of the Board activity is reviewing data retroactively and making recommendations for lettering prescribers and pharmacies that provide services to beneficiaries. A complete description of the activities is listed in Attachment 3. The following utilization interventions were performed during the FFY 2011 at the request of the Board: 1. Utilization of short-acting beta agonists 2. Utilization of more than four grams of acetaminophen per day 3. Concurrent utilization of clopidogrel and CYP2C19 inhibitors 4. Duplication of therapy-SSRI 5. Duplication of therapy-skeletal muscle relaxants 6. Benzodiazepines-high dose and duplication of therapy 7. Tramadol overutilization 8. Propylthiouracil utilization-FDA warning letter 9. Drug interaction-tizanidine and oral contraceptives. As previously mentioned, Mercer conducts reviews of the programs and policies implemented by the Outpatient Pharmacy Program and tracks cost savings and cost avoidance using Medicaid data. These reports are included in Attachment 6. Please note these are comprehensive programmatic reviews and not limited to activities within the scope of the DUR Board. Additionally, HP provided information regarding savings from the Pro-DUR edits for FFY2011. Another highlight of the annual report is Attachment 8 that details some of the articles published in the monthly Pharmacy Newsletters. This section of the annual report gives insight into some of the recent and most notable developments in the Outpatient Pharmacy Program for FFY 2011 and describes innovative practices. Some of the topics include the implementation of the off label antipsychotic monitoring program for children through age 17, clinical PA criteria for Synagis and utilization of vacation supplies for medications. For access to a complete listing of the Pharmacy Newsletters, go to <http://www.ncdhhs.gov/dma/pharmnews/index.htm>. The DUR Board continues to meet quarterly and develop new initiatives and make recommendations to the Division of Medical Assistance.

### **NORTH DAKOTA**

North Dakota continues to work towards maximum efficiencies given the limitation of no PDL and no prior authorization of six drug classes that account for 45%+ of overall drug spend. For instance, the overall generic share (not SNI calculation, but one that takes into account OTC's and other products not included on the SNI file) is > 82%, the rebate collection percent is almost 53%, and the average prescription cost is \$51.14 (Jul 11 - Jun 12). Some important areas that

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will be addressed in the coming months include narcotic duplication, asthma treatment guidelines, and continued prescriber education. It is hoped that all efficiencies are retained as we transition to a new claims system in the near future.

#### **NEBRASKA**

The Nebraska Medicaid DUR Program continues to accomplish its goals to improve the quality of pharmacy services and to ensure rational, cost-effective medication therapy for Nebraska Medicaid recipients. DUR Board members assess the utilization, quality, medical appropriateness and cost of prescribed medication through the evaluation of claims data and make recommendations regarding the pharmacy benefit to Nebraska Medicaid. The Board conducts monthly profile reviews which are either patient specific or problem/therapy focused. Providers are informed of their patient's drug use by intervention letters. Provider intervention letters are designed for educational purposes and are meant to assist the provider in the further assessment of the patient's drug therapy requirements. Education is also communicated via the quarterly DUR newsletter, DUR Matters. A variety of topics are addressed in the newsletter, including guidelines for treatment and information regarding the coverage of items for Medicaid patients. The DUR Board met six times in FFY 2011. Agenda items included: new drug reviews, retrospective DUR ideas, discussions of prospective DUR edits, annual review of PA Criteria and development of new criteria as requested by DHHS. The DUR program has demonstrated cost avoidance of over \$9,000,000 in FFY 2011.

#### **NEW HAMPSHIRE**

The NH Medicaid program continues to focus on drugs and drug classes demonstrating a significant percentage of prescription drug expenditures, with an emphasis on clinical interventions involving potentially dangerous drug interactions, adverse reactions, overutilization, underutilization, misuse or abuse. As new drugs are approved by the FDA it will be essential to manage the rising costs through clinically appropriate and cost-effective prospective and retrospective DUR criteria.

#### **NEW JERSEY**

The New Jersey Division of Medical Assistance and Health Services (NJDMAHS) is pleased to provide this Medicaid Drug Utilization Review Annual Report for Federal Fiscal Year 2011. This Annual Summary details the activities and accomplishments of the New Jersey Drug Utilization Review Board (NJDURB), as well as the outcome of prospective drug utilization review (PDUR) and retrospective drug utilization review (RDUR) activities conducted by Molina Medicaid Solutions, the State's fiscal agent. The Division is pleased to be able to illustrate through this report, the outstanding performances of both the Board and the fiscal agent

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in effectively monitoring and cost-avoiding inappropriate payment of pharmacy claims based on the principles of drug utilization review (DUR). The Division is proud to acknowledge the contributions of the Board in their continuing efforts to recommend essential building blocks for administering a cost-effective drug utilization review program. At the same time, the Division acknowledges the dedication of Molina programming staff that provides the technical knowledge to develop programming changes for the POS system to reflect the Board's recommendations. During FFY 2011, Molina Medicaid Solutions adjudicated 23,493,334 Medicaid pharmacy claims totaling \$859,092,112. During this fiscal period, pharmaceutical services for both Medicaid fee-for-service (FFS) and managed care beneficiaries were processed by Molina Medicaid Solutions. In general terms, the claim adjudication process monitored PDUR conflicts including, but not limited to severe drug-drug interactions, therapeutic duplication, duration of therapy and maximum daily dosage. For FFY 2011, the estimated DUR savings was \$24,829,811. Critical to our PDUR program is the State's Medical Exception Process (MEP). The MEP is a prior authorization process which functions within the framework of DUR standards recommended by the NJDURB and approved by the New Jersey Department of Human Services and the New Jersey Department of Health and Senior Services. The MEP is truly a clinically-based DUR process that does not influence in any way the product selection decisions made by prescribers. Instead, the MEP utilizes prior authorization as a tool to determine if medications are being prescribed properly and derives cost savings by ensuring that prescribed medications are clinically appropriate and properly utilized. In FFY 2011, the MEP prior authorization process continued to benefit from those innovative authorization procedures implemented in FFY 2010 to effectively monitor drug utilization. The 'negative PA' procedure has proven to be an effective tool to minimize potential fraud, waste and abuse. The 'first fill' procedure also implemented in FFY2010 provided opportunities to confirm diagnostic information and the appropriateness of medication therapy prior to treatment being initiated. The NJDURB is a 13 member board consisting of practicing physicians and pharmacists representing several major specialties. The Board meets quarterly in an open public forum. Updated information regarding the Board members, meeting schedule, DURB educational newsletters and annual reports may be found at [www.nj.gov/humanservices/dmahs/boards/durb/](http://www.nj.gov/humanservices/dmahs/boards/durb/) Continuing to expand the framework for the State's PDUR program, the Board recommended several clinically significant DUR protocols during FFY 2011, including antipsychotics, non-steroidal anti-inflammatory drugs (NSAIDs), long-acting oxycodone, rheumatoid arthritis drugs, Egrifta®, Victrelis®, and short-acting opioids. The NJDURB was also requested by Pfizer Pharmaceuticals, the manufacturer of Advil® and Arthrotec®, to present their argument concerning the adoption of a DUR protocol for NSAIDs. During FFY 2011, the Board gained experience with the implementation of a new protocol for NSAID drugs that relied on 'step therapy.' This was a significant development for the Board since New Jersey maintains an open formulary in its FFS Medicaid program. This new protocol provided opportunities for the Board

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to assess the impact of step therapy on utilization that did not mandate product selection for prescribers. Clinicians were educated through the MEP regarding alternative, more cost-effective drug treatments. After considering Pfizer's concerns, the Board recommended that the NSAID protocol presented to the Board by the Department of Human Services and the Department of Health and Senior Services remain unchanged. The State also implemented two RDUR screens and interventions in FFY 2011. Anti-hyperglycemic compliance interventions were initiated in November 2010 and HIV compliance interventions were on-going during the fiscal year. Due to the efforts of our Medical Exception Process Unit, the response rates for interventions conducted by Molina Medicaid Solutions exceeded 30 percent for the anti-hyperglycemic compliance project and 45 percent for the HIV compliance intervention project. The Board also approved a NJDURB Newsletter (Vol.01, No.07) providing practitioners useful clinical information regarding the safe and appropriate use of oxycodone. This Newsletter was distributed in response to the national outcry concerning the abuse of prescription pain medications. Approximately 95 percent of New Jersey Medicaid beneficiaries are now enrolled in managed care. Managed care members receive services from four HMOs. In contrast to the Medicaid FFS program, HMOs have closed formulary systems and prior authorization protocols designed to manage product selection by prescribers. Although the design of HMO prescription drug policies is remarkably different from that of FFS Medicaid, the State is working closely with our HMO partners to not only understand operational aspects of their clinical programs, but to also appreciate their potential benefits to the State's FFS program. HMO encounter claims will also provide valuable opportunities to monitor drug utilization and base these reviews on State-approved DUR standards.

**NEW MEXICO** – No Summary submitted

#### **NEVADA**

Nevada Medicaid switched pharmacy benefit management vendors beginning December 2, 2011. Magellan Medicaid Administration was the vendor during FFY2011. Catamaran (previously SXC Health Solutions) is now the PBM vendor. As a result of this transition, some data on the report is incomplete or not available. Most of the data included in this report was gathered from DUR Meeting minutes and material.

#### **NEW YORK**

The New York State Medicaid Drug Utilization Review (DUR) Program has two separate but complementary components, namely the Retrospective Drug Utilization Review (RetroDUR) Program and the Prospective Drug Utilization Review (ProDUR) Program. The ProDUR Program is designed such that a pharmacy provider may enter information pertinent to a prescription at the point of sale, and that information is automatically compared against

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previously processed claim data such as dispensed drugs, duplicate prescriptions, drug-to-drug interactions, over and under dosage and drug-to-disease alerts. If the verification process detects a potential problem, the pharmacist receives an on-line warning or rejection message. The pharmacist can then take the appropriate action, such as contacting the prescriber to discuss the matter. The outcome may be that the drug is not dispensed, the dosage is reduced, or a change is made to a different medication. The cost of drugs not dispensed averaged \$647,778 in gross drug savings per week due to the avoidance of therapeutic duplications and drug-to-drug interactions. For 2011, there were 929,739 on-line claim rejects resulting in annual savings of \$33,684,444. These results demonstrate the success of the DUR Program in improving quality of care and patient safety and in helping to avoid prescription drug and medical costs associated with adverse drug events. As reported in the past, there were significant savings in the program's early refill edit as well. However, these savings were reported as part of the NYS Medicaid Redesign Team initiative and therefore will not be reported as a factor in cost avoidance for DUR for FFY2011. Through RetroDUR, predetermined criteria are used to generate case reviews of selected Medicaid patients from paid prescription drug claim data. The patient's most recent drug utilization is examined for safety and appropriateness of therapy. If it is suspected that the patient has received inappropriate drug therapy, an alert is sent to prescribers and pharmacists detailing potential drug therapy problems due to the therapeutic duplication, drug-to-disease contraindications, drug-to-drug interactions, incorrect drug dosage or duration of drug treatment, drug allergy reactions and/or clinical abuse/misuse. The RetroDUR Program is designed to improve prescribing trends by educating providers and alerting them to potential problems. The Department continues to use alert letters based on DUR Board approved criteria to inform prescribers of potential drug-related problems among their patients. FFY 2011 RDUR review volume is 2,000 cases per month, and cases are reviewed by pharmacist staff from the State University at Buffalo. The Department's RetroDUR vendor, Health Information Designs, Inc. (HID), created 11,649 confirmed cases for clinical review resulting in 18,267 alert letters sent to providers. Approximately 24% of these providers voluntarily replied to our alert letters. In 2011, the RetroDUR Program saved an estimated \$16,085,629 as a direct result of reduced drug costs and an additional \$9,354,502 from avoiding medical costs associated with adverse drug events. In 2011, total cost avoidance from prospective drug utilization review (ProDUR) (\$33,684,444), retrospective drug utilization review (RetroDUR) (\$16,085,629) and medical claims resulting from the Drug Utilization Review program (\$9,354,502) is estimated at \$59,124,575\*\*. Educational letters are sent to targeted providers by the Medicaid Drug Utilization Review (DUR) Program in order to address specific clinical matters or to share relevant clinical information. The chart below lists the number and type(s) of clinical letters that were distributed to providers during the reporting period.

Education Letters sent to providers	Topic	Quantity	Date Distributed	Vusion
380				
July 13, 2010	Regranex	794	August 16, 2010	Oxycontin 1,576
			August 31, 2010	Solaraze 469

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October 31, 2010 Suboxone 396 February 4, 2011 Early Refill 440 March 24, 2011 Triptans 3,496 April 15, 2011 PPIs 1,639 June 6, 2011 Interferon 358 July 13, 2011 \*\* In previous years, these results were calculated in accordance with guidelines issued by the U.S. Department of Health and Human Services. In order to more closely estimate cost avoidance for the DUR Program, this annual report is using an average prescription cost calculated by using the net-net cost of medications rather than the previously used gross value. In other words, the cost of medications for this report is calculated with the inclusion of manufacturer rebates.

**OHIO** – No summary submitted

#### **OKLAHOMA**

DUR Board Activities The Oklahoma Health Care Authority Drug Utilization Review Board met ten times in fiscal year 2011. Highlights of these meetings include: • 34 speakers addressed the Board during public comment periods. • 17 products or categories added or updated for criteria based prior authorization • 28 products or categories were added or updated for product based prior authorization • Annual reviews were conducted on 22 prior authorization categories Cost Savings Estimates • Total DUR Program Savings: \$121,516,577 • State Maximum Allowable Cost Savings: \$108,968,670 • Prior Authorization Program Savings: \$13,998,072 • ProDUR Savings: \$2,317,368 ProDUR Enhancements Due to technical constraints, the ProDUR information included in Table 1 of the 2011 annual report was incomplete. A new ProDUR system was implemented in July 2012. A new ProDUR system was implemented in July 2012. New reports are also being developed by OHCA's fiscal agent that may provide additional data for the fiscal year 2012 annual report.

#### **OREGON**

Drug Use Review (DUR) within the Division of Medical Assistance Programs is a program designed to measure and assess the proper utilization, quality, therapy, medical appropriateness, appropriate selection and cost of prescribed medication through evaluation of claims data. This is done on both a retrospective and prospective basis. This program includes, but is not limited to, education in relation to over-utilization, under-utilization, therapeutic duplication, drug-to-disease and drug-to-drug interactions, incorrect drug dosage, duration of treatment and clinical abuse or misuse. Due to legislative changes, the DUR board was reorganized and had limited meetings during FY 2011. The DUR Board's priorities focused on prior authorization criteria, drug use evaluations, etc.

#### **PENNSYLVANIA**

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The emphasis of Pennsylvania's drug utilization review (DUR) program is to promote patient safety through an increased review and awareness of outpatient prescribed drugs to assure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results. Pennsylvania employs a combination of prospective and retrospective DUR initiatives for a comprehensive approach to pharmacy utilization management. The prospective DUR component includes a combination of alerts transmitted to the dispensing pharmacist at the point of sale and clinical prior authorization required at the point of sale which is reviewed by the Pennsylvania clinical staff for medical necessity determination. The retrospective DUR component supports the overarching goal of patient health and safety by focusing on a retrospective review of patients' drug claims against specific criteria, identifying common drug therapy concerns such as inappropriate use of drugs, medically unnecessary care, and increased risk for drug interactions, and providing for educational interventions that promote effective prescribing practices in a factual and unobtrusive manner. Through the RetroDUR, the Department provides prescribing providers with a comprehensive drug history profile for their patient and specific recommendations which enable them to consider medically appropriate actions such as identifying and discontinuing unnecessary prescriptions, reducing quantities of medications prescribed, or switching to safer drug therapies. Outcomes include enhanced therapy compliance and reductions in utilization of other medical services like emergency rooms and hospital stays, combined with reductions in drug abuse and diversions, all of which contribute to cost savings without compromising access or quality of care.

#### **RHODE ISLAND**

Rhode Island Medical Assistance Retrospective DUR Program Federal Fiscal Year 2011 Executive Summary Introduction Retrospective Drug Utilization Review (DUR) seeks to assist prescribers by calling their attention to potential concerns with individual recipient's drug therapy that could lead to possible adverse effects or undesirable outcomes. Pharmacy claims data are evaluated on an ongoing basis and run against criteria to generate educational intervention letters that are then sent to prescribers. The specific potential therapy issue is noted in the letter and the letter is sent along with a complete drug history and available diagnosis history for the prescriber to review. Rhode Island DUR Program Description Rhode Island has an active retrospective DUR program which alerts prescribers of potential drug therapy issues for the Medical Assistance (Medicaid) population. The Rhode Island retrospective DUR program alerts prescribers to potential issues related to the following: • drug-disease conflicts • drug-drug interactions • over-utilization • under-utilization (non-adherence) • clinical or therapeutic appropriateness • therapeutic duplication Each month pharmacy claims data and available diagnosis data are evaluated against a database of several thousand criteria which look for potential drug therapy concerns. Approximately 1,000 drug and diagnosis history profiles for individual recipients are reviewed by a clinical pharmacist. An additional 200-300 recipients are

## **EXECUTIVE SUMMARY - FFY 2011 DUR REPORT**

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screened each month specifically to evaluate for potential overutilization of controlled substances. Specific recipients are selected for intervention based on the clinical review. Educational intervention letters are then generated and mailed to their prescribers along with a complete drug history and a response form which asks the prescriber to indicate any action taken in response to the letter. Responses to the letters are voluntary and give feedback to the program as to how prescribers may be adjusting therapy if required, based on the intervention letters. A response rate of approximately 30% has been observed from prescribers who have received educational intervention letters. Approximately 75% of prescribers who responded found the letters to be useful. If a prescriber receives a letter addressing a specific drug therapy issue for a recipient, the same letter for that prescriber will not be sent again for an additional 6 months. However, prescribers may receive additional letters within that 6 month time period for the same recipient if other drug therapy concerns are noted. After the 6 month period, the same criteria may be evaluated against the recipient's data and a second letter may be mailed. Changes in utilization and criteria exceptions are evaluated on an ongoing basis and are discussed at DUR Board meetings. For example, for those recipients who are selected for overuse of controlled substances each case is reviewed again after 6 months to determine if the initial letter had an impact on reducing overutilization. The Rhode Island Drug Utilization Review Board works closely with the Rhode Island Department of Human Services and their contracted vendors to develop criteria and focus on specific areas of concern with regard to recipient drug therapy. For federal fiscal year 2011 (FFY 2011) the DUR Board raised concerns over recipient adherence to maintenance drug therapy and to alerting prescribers to potential drug interactions. In addition, overutilization of controlled substances and therapeutic duplication are others areas that were targeted by the DUR program during FFY 2011.

#### **SOUTH CAROLINA**

South Carolina Department of Health & Human Services Annual Drug Utilization Review Program Executive Summary September 2012 South Carolina Department of Health & Human Services strives to provide beneficiaries with access to medications necessary to achieve an optimum level of health, while concurrently managing both the utilization and clinically appropriate pharmaceutical products. The Pharmacy services program works to result in ensuring access, controlling unit cost, and managing utilization. The Prescription Drug List is a cornerstone of managing the pharmacy program, by driving utilization to clinically viable cost savings alternatives, as well as by garnering rebate revenues. Utilization control measures have been incorporated to ensure processes are in place to steer providers to evidence-based, cost effective and outcomes based pharmaceutical use. In addition to the methods listed above, the Prospective and Retrospective DUR Interventions programs assist in a more active role in the management of beneficiaries' medication regimens. In concert with prescribers, problems of non-adherence medication errors and avoidable adverse effects can be addressed via these programs.

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Future focus is being directed toward investigating alternative solutions to address such instances, including MTM (Medication Therapy Management) in coordination with these valuable programs.

#### **SOUTH DAKOTA**

The Drug Utilization Review activities in South Dakota for Federal Fiscal Year 2011 were essentially the same as for previous fiscal years.

#### **TENNESSEE**

Throughout FY2011, TennCare's DUR Board continued its service to the State of Tennessee in an advisory capacity. In this role, the Board made recommendations related to the safe and effective use of medications for our citizens to the Bureau. During FY2011, there was some transition in the membership of the DUR Board, as two pharmacist members resigned due to conflicts of interest. Further transition included lack of attendance/interest from one physician member and our mid-level practitioner level. Effective with the June 2012 quarterly DUR Board meeting, both pharmacists have been replaced with the help of recommendations from the Tennessee Pharmacists Association. A new mid-level practitioner also began to serve on the Board effective June, 2012. We are still looking to replace a physician on the Board. TennCare's DUR Board is comprised of 11 individuals with considerable experience and expertise in the medical and pharmacy fields, among them being five Tennessee-licensed physicians and 5 Tennessee- licensed pharmacists. Medical specialties currently represented among our Board physicians include Psychiatry, Pediatrics, Internal Medicine, and Emergency Medicine. Among the pharmacist Board members, we have one individual who is a Representative in the Tennessee State Legislature. Four of the five pharmacists practice in independent pharmacies, and one pharmacist member practices in a large grocery chain. Our new mid-level practitioner is a cancer pain specialist at the Sarah Canon Cancer Center at Vanderbilt University. The chairperson of the TennCare DUR Board is Dr. Toie Alston, PharmD, who is employed by Catamaran, TennCare's PBM vendor. Ray McIntire, DPh, TennCare's Director of Pharmacy Operations is the individual at TennCare with overall DUR responsibility. Dr. Alston and Dr. McIntire work collaboratively with Dr. David Collier, M.D., TennCare's Associate Medical Director, Dr. Bryan Leibowitz, PharmD, TennCare's Pharmacy Director, Dr. Michael Polson, PharmD, TennCare's Clinical Pharmacy Director and Dr. Bill Hudson, PharmD, Catamaran's overall Project Manager for the TennCare account. The primary responsibility and charge to the DUR Board is to review trends in TennCare's pharmacy utilization, and to advise TennCare on the addition, deletion, and ongoing management of DUR edits and activities, to encourage proper and safe use of prescription medications by TennCare recipients. As stated previously within the enclosed yearly CMS report, the DUR Board is also

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involved in several aspects of fraud and abuse monitoring of TennCare recipients and prescribers, and are of great importance in assisting the TennCare Pharmacy team with our program integrity efforts. Board Meetings follow parliamentary procedures and have a standing order of business, specifically: • Call to Order • Approval of Minutes • TennCare Update presented by Dr. David Collier • TennCare Pharmacy Update presented by a TennCare Pharmacy team associate • Follow Up on Old Business • New Business • Review of TennCare Population Trends • Review of TennCare Drug Utilization Trends • Review of Pharmacy Lock-In • Review of DUR Activities • Review of Provider Practice Activities • Future Meeting Dates • Adjournment Throughout FY 2011, the DUR Board has focused on ways to promote more appropriate prescribing within the TennCare program. Specific emphasis has been placed on reducing overprescribing of narcotic analgesics, the blocking of prescriptions written by non-participating prescribers whose prescribing patterns appear to be outliers compared with their peers, and implementing select high-level severity drug-gender edits. The pharmacy team at TennCare has recently transitioned, as the former Pharmacy Director left the Bureau in March of 2012. Two new associates were added to the Bureau's pharmacy management team: Dr. Bryan Leibowitz as the new Pharmacy Director and Dr. Michael Polson as the new Pharmacy Clinical Director. Many of our processes and day-to-day activities are being analyzed for new opportunity, among these being the TennCare DUR Board and DUR program. At the most recent DUR Board meeting in September of 2012, the Board was re-focused on core responsibilities, as 21 CFR 456.700 through 456.725 was part of the agenda, and the core responsibilities were presented and discussed. At the same time, the pharmacy PBM vendor (also serving as our DUR vendor) was challenged to innovate and bring new and meaningful topics to the DUR Board for discussion and direction. Among the topics that we will focus on during FY2012 and beyond are: • High incidence of Neonatal Abstinence Syndrome in the TennCare population • High incidence of antipsychotic medication in children (with a special emphasis on Foster Children) • High incidence of adult stimulant use, and high incidence of doses over recommended maximum doses The Bureau of TennCare continues to appreciate the time and efforts of the DUR Board members. The Bureau appreciates their support, and with some of the new initiatives included in this report, we can also expect to see much more success from their support and efforts in the years to come.

### TEXAS

The Texas Medicaid Drug Use Review program was established in October 1992 in response to the Omnibus Reconciliation Act of 1990 (OBRA 90). OBRA 90 requires states to implement both retrospective and prospective Medicaid Drug Use Review programs. Prospective DUR: Involves screening for any drug therapy problems or any significant drug related issues before each prescription is dispensed at the point of sale. The prospective Clinical Edits services were provided by Health Information Design Inc. (HID) beginning January 1st, 2011. and the savings

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indicated in this paragraph include the period between 1/1/2011 through 9/30/2011. The total savings from the Prospective DUR included in this report are associated with both clinical edits as well as Preferred Drug List (PDL) prior approvals (PAs). The prospective program outcomes provided by HID indicates a total of \$75,236,699.30 overall savings. Retrospective DUR: Involves using existing patients' drug claims data to monitor for therapeutic appropriateness and specific problems specified based on the guidelines established by the DUR Board. A total of nine retrospective interventions conducted during FFY 2011 by Texas Medicaid vendor, Xerox. One of those interventions, "Caring for Your Patient with Hypertension", was a new intervention that was proposed and approved in November 2010 and implemented in April of 2011. The savings from Retrospective DUR program reported by Xerox for the FFY 2011 amounts to \$21,552,661. Educational Programs: Is a component of Retrospective DUR and is conducted through DUR Board guidance. The information communicated with the prescribing providers are to improve prescribing and dispensing practices, and educate practitioners on common and serious drug therapy problems. This is done by Xerox in the form of letters that include patient-specific information extracted from the Medicaid encounter data. In addition to the letters, and as an added value to the program, the vendor assesses the responses from providers who received these educational letters and if necessary, face-to-face meetings are scheduled with certain prescribers whose prescribing patterns remain unchanged. In FFY 2011 the academic detailing on Diabetes Mellitus was provided to those prescribers in 1/13/2011. The savings from total of all academic detailing is \$47,947.04. DUR Board: Is an advisory board and its members are appointed and must have expertise as specified in the state statute, and must include licensed actively practicing physicians and pharmacists. Texas Medicaid Drug Use Review Board consists of six practicing physicians and six practicing pharmacists who develop the criteria and standards used in the program and make recommendations on educational interventions for the purpose of promoting appropriate use of prescription drugs. The sum of all savings reported for FFY 2011 is over \$96,789,360, or 3.77% of total drug spend.

**UTAH** – No Summary submitted

### **VIRGINIA**

This DUR program analysis and report encompasses the drug utilization review activities and outcomes that have occurred during FFY 2011. Included are ProDUR alerts and intervention statistics and RetroDUR alerts and intervention statistics. There is an analysis of drug costs that looks at the increases in drug spending, population statistics and offers recommendations for maximizing cost savings. Another contributor to the ProDUR savings for FFY 2011 was the addition of numerous ProDUR criteria that included criteria for twenty seven new drugs. Also,

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there was an overall 7.41% increase of alerts in FFY11 when compared to FFY10. The number of history and non-criteria (ER2) based alerts increased by 9.65% and 3.47%, respectively from FFY10 to FFY11 while the non-history alerts decreased by 1.38%. Cost containment measures are essential to combat the rising prices and to change prescribing patterns. Virginia's mandatory generic, MAC and PDL programs have had a significant impact on controlling the rising drug costs. The incorporation of service authorizations and step therapy has guided prescribing practices to control drug spending. During FFY 2011, the DUR board implemented a service authorization requirement for the use of atypical antipsychotics in children under the age of six years. In addition, the board implemented a service authorization requirement for the use of Synagis. Dose optimization and quantity limits continue to aid in the management of drug costs in FFY 2011.

#### **VERMONT**

During FFY 2011 Vermont's DUR programs focused on the prescribing of buprenorphine and improving the treatment oversight of beneficiaries with substance abuse problems. In addition to modifying the clinical criteria for buprenorphine to assure appropriate use, the Department of Vermont Health Access (DVHA) and the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (VDH-ADAP) collaborated in an Agency-wide initiative with community substance abuse treatment providers and organizations to develop a Hub and Spoke style health care system for patients who require medication-assisted treatment (buprenorphine and methadone) for opiate dependency. The objective is to provide a coordinated approach to substance abuse treatment and strengthen the use of evidence-based treatment guidelines. In addition, the DVHA restructured the beneficiary lock-in program for buprenorphine and other controlled substances, in addition to the approval process for beneficiaries and physicians who appeal clinical decisions related to controlled substances to provide a centralized and consistent approach to management of drugs of abuse. In addition, Vermont's DUR programs continue to be focused on the prescribing of atypical antipsychotics and psychotherapeutic drugs in general. The DVHA addressed the overuse of low doses of quetiapine (Seroquel®) for insomnia and anxiety, and is currently participating in a Center for Health Care Strategies technical assistance grant to support other initiatives such as creating evidence-based prior authorization criteria for the use of anti-psychotics in children, improving the informed consent process for foster families, and providing psychiatric consultations for primary care providers and pediatricians caring for children in custody. In addition, we continue to focus on psychotherapeutic drug use in adults. For example, during SFY2011, the Vermont Academic Detailing Program, which promotes high quality, evidence-based treatment decisions by healthcare professionals through interactive visits between prescribers and pharmacists, presented an educational module on the appropriate use of antipsychotics in adults that was met with much enthusiasm by the provider community. Our efforts in controlling drug costs improved with the continued expansion of our

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340B drug discount program. Vermont has put in place an innovative methodology to maximize Medicaid participation in 340B pricing for Medicaid beneficiaries served by eligible prescribers at 340B enrolled covered entities. This methodology has enabled growth in 340B program participation by covered entities, and has demonstrated proven savings to the Vermont Medicaid programs. The Vermont pharmacy best practices and cost control program was authorized in 2000 and established in SFY 2002 by Act 127. This program, as the Vermont Health Access Pharmacy Benefits Management (PBM) Program, is administered by the DVHA. Central to this program is the Drug Utilization Review Board (composed of physicians and pharmacists), which also serves as the program's Pharmacy and Therapeutics (P&T) Committee. The goal of the program and the DUR Board is to ensure that clinically appropriate, cost-effective drug therapy is provided to the beneficiaries of the State of Vermont's publicly funded programs. In difficult economic times, this is particularly important, so that these same benefits can be provided to an increasingly larger number of beneficiaries. The DUR Board focused on high-cost, high volume medications during FFY 2011 and was once again particularly active in the areas of buprenorphine and antipsychotic prescribing as explained earlier in this summary. In addition to the ProDUR and RetroDUR review activities of the DUR Board and the establishment of clinical criteria and quantity limits for newly reviewed medications, the MedMetrics Clinical Call Center is responsible for issuing prior authorization (PA) approval and quantity limit (QL) approval prior to the dispensing of a drug. The MedMetrics Clinical Call Center processed a total of 34,829 (28,699 FFY2010) work volume requests October 2010 through September 2011 for DVHA. There were 27,986 clinical requests and 6,843 help desk/informational type requests. Of the 27,986 clinical requests, 21,562 were approved, 5,783 were denied and 641 were denied with a change in therapy resulting in an overall approval rate of 79 % (same percentage as FFY2010). The breakdown of clinical requests was 24,360 PA requests and 3,626 QL requests. The Drug Utilization Review Board met 7 (seven) times in FFY2011. Results of Prospective and Retrospective Drug Utilization reviews are outlined in earlier sections of this report. Further discussion of many of these initiatives appears in the Innovative Practices section of this report.

#### **WASHINGTON**

Washington State Medicaid's Prescription Drug Program incorporates multiple components in order to ensure clinically appropriate, efficacious, and cost-effective utilization of pharmaceutical therapies for Medicaid Patients. Prospective DUR: The State maintains an automated Prospective Drug Utilization Review system which alerts pharmacies to potentially inappropriate therapies while allowing a client's licensed healthcare professionals to determine the best course of therapy for the client by either making changes to therapy or entering Conflict, Intervention, and Outcome codes to verify that the prescription in question is in fact appropriate for the treatment of the client as written. Retrospective DUR: The Medicaid program of the Washington State Health Care Authority engages in the ongoing periodic examination of claims

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data and other records in order to identify patterns of fraud, abuse, gross overuse, and inappropriate or medically unnecessary care. Within the Washington Medicaid Prescription Drug Program, this ongoing examination of claims data is generally performed on a systematic basis for the purpose of identifying aberrant prescribing trends that represent unsupported off-label utilization and opportunities to enforce appropriate prescribing through Prior Authorization requirements. Drug Utilization Review Board / Pharmacy and Therapeutics committee: In accordance with federal requirements, Washington State meets regularly with its DUR Board for the purpose of obtaining outside guidance from actively practicing unbiased clinical experts who have recognized knowledge and expertise in the clinically appropriate prescribing, dispensing, and/or monitoring of covered outpatient drugs, as well as drug use review, evaluation, intervention and medical quality assurance. This Board provides guidance to the State in regard to Prospective and Retrospective DUR, Prior Authorization requirements, educational interventions for Medicaid providers, and ensuring appropriate access to an adequate scope of therapeutic alternatives on the Preferred Drug List. Prescriber Education: The Prescription Drug Program regularly provides Medicaid prescribers with education and guidance in regard to appropriate prescribing through newsletters, numbered memoranda, targeted retrospective DUR correspondence, and requests for clinical information within the prior authorization program that provide prescribers with detailed information on criteria for appropriate medication use. Preferred Drug List and Supplemental Rebates: Washington Medicaid maintains a PDL for the purpose of ensuring cost effective utilization of therapeutic and generic alternatives within specific drug classes, and leveraging the lowest possible cost to the State for preferred products through contracting for rebates from pharmaceutical manufacturers above and beyond rebates mandated by federal law. State Maximum Allowable Cost: Washington Medicaid aggressively pursues cost containment by setting Maximum Allowable Costs for products based on actual invoiced prices from pharmacies for generic drugs, and requiring clinical prior authorization to justify the need for any branded multisource product. Prior Authorization: Washington State's Prior Authorization program exists to ensure that prescription drug utilization is both evidence-based and cost-effective by limiting utilization to FDA labeled indications and/or indications supported in the officially recognized compendia. Prior Authorization ensures appropriate care for patients while avoiding unnecessary costs associated with treatments that have not been proven effective when more appropriate therapeutic alternatives exist. Washington State's aggressive management of the prescription drug benefit for Medicaid patients has proven an effective tool to for ensuring a high quality of care while still containing growth in expenditures to a rate below the national rate of healthcare inflation.

### WISCONSIN

**BACKGROUND** The Omnibus Budget Reconciliation Act (OBRA) of 1990 requires that, effective January 1, 1993, each State establishes a Medicaid Drug Utilization Review (DUR)

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Program. The program must include both prospective and retrospective DUR to assure that prescriptions are appropriate, medically necessary, and are not likely to result in adverse medical results. To accomplish this objective, the law requires Medicaid DUR programs to screen, based upon explicit criteria, for therapeutic problems specified in the law (for example, drug-drug interactions, incorrect dosage and duration of therapy, therapeutic duplication), to develop and implement interventions to change drug use behavior, and to assess the outcome of the intervention. 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.

**HISTORY OF WISCONSIN DRUG UTILIZATION REVIEW PROGRAM** The state agency in the Wisconsin Department of Health Services responsible for benefits administration is the Division of Health Care Access and Accountability (DHCAA). The DHCAA established a Medicaid Evaluation and Decision Support Drug Utilization Review (DUR) Project. Since September 1996, the primary contractor for the DUR Project has been Hewlett Packard (HP), formerly Electronic Data Systems (EDS). From September 1994 through June 1, 2009, HP administered the Wisconsin retrospective DUR activities through a subcontract with APS Healthcare in partnership with Health Information Designs, Inc. Effective July 1, 2009 HID assumed full responsibility for retrospective DUR activities.

**SUMMARY OF PROSPECTIVE DUR ACTIVITIES** The State of Wisconsin utilizes an on-line real-time prospective DUR program that began in the second quarter of FFY 2002. Prior to this time, Wisconsin relied on pharmacists to provide these services.

**SUMMARY OF RETROSPECTIVE DUR ACTIVITIES** Monthly DUR reviews are performed following receipt of paid claims tape. Interrogation of drug claims against DUR Board-approved criteria generates patient profiles that are individually reviewed for clinical significance by the pharmacy staff of HID. Criteria are developed jointly by HID and are reviewed and approved by the DUR Board and recommended to DHCAA for approval. If a potential drug problem is discovered, intervention letters are sent to all providers who prescribed a drug relevant to the identified problem. Retrospective DUR criteria and interventions are tabulated in Table 2 and Attachment 3 of this report.

**DUR BOARD ACTIVITIES** The DUR Board meets four times annually. Additional materials are sent to Board members between meetings for review and action. Activities of the DUR Board included review and approval of DUR criteria, review and approval of educational material and interventions, and other recommendations to the DHCAA on drug-related issues.

**COST SAVINGS** A cost savings analysis of member's drug costs before and after a retrospective DUR letter intervention are reflected in Attachment 6 prepared by Health Information Designs, Inc.

**CONCLUSION**

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The State of Wisconsin is in compliance with the DUR program requirements specified in OBRA '90 and the FFY 2011 reporting requirements established by CMS.

#### **WEST VIRGINIA**

During FFY 2011, the West Virginia Medicaid Drug Utilization Review Board focus on two primary areas for prescriber education and intervention: Overutilization of Opioids and Atypical Antipsychotics in Children. Evaluation of the outcomes for intervention in opioid prescribing show a modest decrease in the number prescriptions for short-acting opioids after six months. There were a number of comments about provider profiling to the Medical Director and we plan to continue working on this issue. The number of children on atypical antipsychotics decrease by 30% with our interventions directed toward the use of atypical antipsychotic agents in children under six (6) years of age. The number of requests for prior authorization has declined dramatically since the prior authorization program began. We did find that prescribing of atypical antipsychotics for foster children was very close in percentage to the Medicaid general population of this age. The Preferred Drug List continues to expand and the Drug Utilization Review Committee plays a significant role in developing prior authorization criteria for non-preferred drugs. One of the DUR Board members also serves as a Pharmaceutical and Therapeutics Committee member and acts as the liaison between these two groups and their activities have dovetailed nicely to benefit the program and Medicaid members. The RetroDUR Program is an important component of the Drug Utilization Review Program, both for monitoring inappropriate clinical prescribing and the MMIS system. Monthly review of 250 profiles for therapeutic criteria (early refill, drug duplication, therapeutic duplication, quantity limits, and inappropriate utilization of controlled substances) greatly strengthens the clinical components of the WV Medicaid Pharmacy Program, but also reduces waste, abuse and fraud. DUR savings for this year are calculated at approximately \$17,000,000. The majority of these savings can be attributed to the early refill edit. The Pharmacy Services Program has managed to minimize rising costs by maintaining and expanding a broad Preferred Drug List with supplemental rebates, utilizing an aggressive State Maximum Allowable Cost Program which saves an average of \$4,000,000 per month, monitoring the utilization of covered drugs as closely as possible through DUR prospective edits, retrospective reviews, and implementing policies to encourage generic utilization where ever possible. The compliance rate for the Preferred Drug List varies between 95-97% and a large part of the compliance can be attributed to prior authorization criteria developed and approved by the DUR Board. The Pharmaceutical and Therapeutics Committee and the Drug Utilization Review Board work closely to insure the success of the PDL both clinically and for cost effectiveness. The use of the electronic prior authorization application, Smart PA, has been very helpful in maintaining efficiency for processing of drugs for which there are not supplemental rebates or are non-preferred for other reasons. During this year, we have also written a Request for Proposal for a new MMIS and are

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now evaluating bids for this proposal. The new system requested will be very helpful in enforcing limits established by the program and coordinating medications administered in the physicians' office with those dispensed in our-patient pharmacies. We continue to work closely with our Drug Utilization Review Board, Retrospective Drug Utilization Review Committee and staff members working with medical/dental claims. Coordination of our efforts toward payment for services that are clinically appropriate and cost effective continues to grow, as does the number of prescriptions transmitted electronically by our prescribers. We believe that our investment in e-prescribing will contribute to even better coordination of care for our members and saving for the West Virginia Medicaid Program.

#### **WYOMING**

The Wyoming Drug Utilization Review Program completed significant prospective review and retrospective review resulting in an estimated cost avoidance of \$12,543,681 (29% of the total pharmacy spend) to the Wyoming Medicaid program. As expected, most of the cost avoidance is attributed to prospective DUR edits (not including prior authorization or preferred drug list edits). Retrospective savings are calculated based on 709 profile reviews resulting in 465 prescriber alert letters regarding 355 unique recipients. Savings attributed to larger, more generalized education mailings are not included as savings from these mailings are very difficult to ascertain.