Medicaid Drug Utilization Review
State Comparison/Summary Report FFY 2014
Annual Report

Prescription Drug Fee-For Service-Programs

September 2015

Executive Summary of 2014 State Medicaid DUR Annual Reports

Each State Medicaid program under Section 1927(g)(3)(D) of the Social Security Act (the Act) is required to submit an annual report on the operation of its Medicaid Drug Utilization Review (DUR) program. States are required to report on their state's prescribing patterns, cost savings generated from their DUR programs and their programs' operations, including adoption of new innovative DUR practices.

DUR is a two-phase process that is conducted by the Medicaid state agencies. In the first phase, Prospective DUR (ProDUR), the state's Medicaid agency's electronic monitoring system screens prescription drug claims to identify problems such as therapeutic duplication, drug-disease contraindications, incorrect dosage or duration of treatment, drug allergy, and clinical misuse or abuse. The second phase, Retrospective DUR (RetroDUR), involves ongoing and periodic examination of claims data to identify patterns of fraud, abuse, gross overuse, or medically unnecessary care and implements corrective action when needed.

On February 18, 2015, the Centers for Medicare & Medicaid Services (CMS) sent the current Medicaid DUR Annual Report Survey to states for completion. Below is a brief summary of the findings.

I. Demographics – Page 1

All states including the District of Columbia submitted a 2014 Medicaid DUR Annual Report, with the exception of Arizona because almost all of its beneficiaries are enrolled in managed care organizations (MCOs). The information reported is focused primarily on Medicaid Fee-For-Service DUR activities. States are not currently required to submit an annual report on the specifics of MCO DUR activities.

II. Prospective DUR (ProDUR) – Page 1

ProDUR functions are done at the point-of-sale (POS) when the prescription is being filled at the pharmacy. Forty-five states (90%) contract with an outside vendor to process their POS claims. Thirty-six states (72%) use First Data Bank as their ProDUR criteria source. All states set early refill thresholds as a way of preventing prescriptions from being refilled too soon. States reported thresholds ranging from 75% to 90%, with an average of 79% of the prescription being used before a non-controlled prescription could be refilled. For controlled drugs, the range reported is 75% to 100%, with an average of 83% of the prescription being used before the prescription could be refilled.

Section 1927(g)(A) of the Act requires that the pharmacist offer patient counseling when dispensing a prescription. Forty-two states (84%) report that the Board of Pharmacy has responsibility for monitoring compliance with this requirement.

III. Retrospective DUR (RetroDUR) – Page 9

RetroDUR allows states to examine drug claims to identify patterns of abuse or misuse. These functions reside primarily with a contractor in 36 states and with an academic organization in 11 states. The DUR Board identifies those categories of prescription claims to be examined to screen for patterns of fraud, abuse, gross overuse, or medically unnecessary care and then takes corrective actions. In 43 states (86%), the DUR Board approves the RetroDUR criteria to be followed by the contracted organization.

IV. DUR Board Activity – Page 12

All states provided a summary of their DUR Board activities, which can be found in each individual state report. Six states (12%) have Medication Therapy Management (MTM) programs approved by CMS. MTM is a professional service, separate from the function of dispensing prescriptions, provided by pharmacists whose aim is to optimize drug therapy and improve therapeutic outcomes for patients.

V. Physician Administered Drugs – Page 14

To date, thirteen states (26%) have designed or redesigned their Medicaid Management Information System (MMIS) systems to incorporate Physician Administered Drugs (those drugs paid through the physicians and hospitals programs) into their DUR criteria.

VI. Generic Policy and Utilization Data – Page 15

All states reported generic utilization percentages for all covered outpatient drugs reimbursed during the 2014 reporting period. The average percentage generic utilization was 82%, which accounts for an average of 23% of the total dollars reimbursed by Medicaid for drugs during the reporting period.

VII. Program Evaluation /Cost Savings/Avoidance – Page 18

Based on states' reported estimates, DUR activities saved on the average about 18% on drug cost savings/cost avoidance compared to the total Medicaid drug spend.

VIII. Fraud, Waste and Abuse Detection – Page 21

A. Lock- In Programs – Page 21

All Medicaid agencies, except South Dakota, have a Lock-In or Restrictive Program in which the state identifies potential fraud or misuse of controlled drugs by a beneficiary. Lock-In programs restrict beneficiaries whose utilization of medical services is documented as being excessive. Beneficiaries are restricted to specific provider(s) in order to monitor services being utilized and reduce unnecessary or inappropriate utilization.

Thirty-nine states (78%) have a process to identify potential fraudulent practices by prescribers and 38 states (76%) have a process to identify potential fraudulent practices by pharmacies. These processes trigger actions such as denying claims written by that prescriber or claims submitted by that pharmacy, alerting the state Integrity or Compliance Unit to investigate, or referring to the appropriate licensing Board or another state governmental agency (e.g. Attorney General, OIG and DEA) for follow-up.

B. Prescription Drug Monitoring Programs – Page 25

Prescription Drug Monitoring Programs (PDMPs) are statewide electronic databases that collect designated data on controlled substances that are dispensed in the state. Depending on the state, physicians and pharmacists have access to these databases to identify prescribers and patients that are engaging in potential fraud or misuse of controlled substances. In 2014, 49 states (98%) reported having a PDMP in their state. Twenty-seven states (55%) have some ability to query the PDMP database, while the remaining 22 states (45%) do not have the ability to do so. Only eight states (16%) require that prescribers access the patient history in the database prior to prescribing restricted (controlled) substances. As of the close of this reporting period, Missouri remains the only state that has yet to implement a PDMP. While nine states report that they also have access to Border States PDMPs, thirty-eight states (76%) indicated that they face a range of barriers that hinder their ability to fully access and utilize the database to curb abuse.

C. Pain Management Control – Page 29

Fourteen states (28%) reported that they obtained the Drug Enforcement Administration (DEA) Active Controlled Substance Registrant's File in order to identify those prescribers not authorized to prescribe controlled drugs. Forty-five states (90%) reported having measures in place to either monitor or manage the prescribing of methadone for pain management. States report that these measures include quantity limits, prior authorization, prescriber intervention letters and pharmacist overrides at the point of sale.

D. Opioids – Page 30

Forty-two states (84%) have edits in place to limit the quantity of short-acting opioids and 43states (86%) have edits in place to limit the quantity of long-acting opioids.

E. Morphine Equivalent Daily Dose (MEDD) – Page 33

Nine states have set recommended Morphine Equivalent Daily Dose (MEDD) screens. The state limits the amount of products containing morphine or morphine derivatives that a patient may receive in a specific time frame in order to reduce potential abuse or diversion. Eleven states report that they give providers information on how to calculate the MEDD.

F. Buprenorphine – Page 34

Forty-three states (86%) set limits on the daily milligrams of buprenorphine that can be prescribed. Details on the limit amounts, length of treatment and maintenance dosing can be found in the report.

G. Psychotropic Drugs/Stimulants – Page **37**

Forty-one states (82%) have programs in place to either manage or monitor the appropriate use of psychotropic medications in children. Thirty-six states (72%) monitor all children, not just those children in foster care. These states have provided a brief synopsis of the specifics of their programs. South Dakota only monitors children in foster care. It should be noted that some states have legislation in place that prohibits any restriction being placed on the prescribing of medications used to treat mental or behavioral health conditions. Forty-two states (84%) have restrictions or special programs in place to monitor/control the use of stimulants.

IX. Innovative Practices – Page 44

Thirty-two states (64%) listed in the full report have submitted Innovative Practices that they initiated. These can be found in the individual state reports in Attachment 6.

X. E-Prescribing – Page 44

As of the end of this reporting period, 27 states (54%) have implemented e-prescribing (or electronic prescribing); 20 states (40%) have the capability to enable the prescriber to access patient data history and pharmacy coverage limitations prior to prescribing for a specific patient. Electronic prescribing helps to improve the quality of the prescribing process and helps providers identify drugs that have lower-cost generics or are more cost effective.

XI. Managed Care Organizations (MCOs) – Page 46

States are currently not required to report on the nature and scope of DUR activities in their MCOs, even though more states are moving their beneficiaries into MCOs[1]. Twenty-seven states (54%) report that prescription coverage is included (carved-in) to the capitation rate. Twenty-four (48%) states report the agency sets requirements for the MCO pharmacy benefit. Fourteen states (28%) require their MCOs to monitor or report their MCO DUR activities.

1. In the Medicaid and CHIP Managed Care NPRM (CMS-2390-P) published on June 1, 2015, CMS proposed that states require MCOs operate DUR programs that comply with Section 1927(g) of the Social Security Act as well as have the MCOs provide a detailed report of their DUR programs to the state on an annual basis.

Medicaid Fee for Service Program Drug Utilization Review Annual Report

Comparison/Summary Report FFY 2014

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I. DEMOGRAPHIC INFORMATION

49 States plus DC completed the FFY 2014 DUR Survey. AZ has the majority of its Medicaid population in Managed Care Organizations (MCOs); therefore, the state is not currently required to submit an annual DUR report.

II. PROSPECTIVE DUR (ProDUR)

II-1. Indicate the type of your pharmacy POS vendor – (Contractor, State-operated, Other).

Answer	State	Number of States (Percentage)
State-operated	IL, MN, ND, SD, WA	5 (10%)
Contractor	AK, AL, AR, CA, CO, CT, DC, DE, FL, GA, HI, IA, ID, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, TN, TX, UT, VA, VT, WI, WV, WY	45 (90%)
Other		0 (0%)

Vendor	State
Catamaran	GA, IN, NV, VT
Computer Sciences Corporation	NC, NY
Goold Health Systems	IA, ME, UT, WY
Hewlett Packard Enterprise Services	AL, AR, CT, DE, KS, OK, OR, PA, RI, WI
Magellan Medicaid Administration	AK, FL, ID, KY, MI, NE, NH, SC, TN
Molina Medicaid Solutions	LA, NJ, WV
Other	N/A
State-operated	IL, MN, ND, SD, WA
Wipro Infocrossing Healthcare Services Inc.	MO
Xerox State Healthcare, LLC	CA, CO, DC, HI, MA, MD, MS, MT, NM, OH, TX*, VA

State	Note
*TX	Prospective criteria is developed in-house via a contract with the University of Texas Health Science Center, contracted pharmacy claim services vendor, and through First Data Bank DUR modules.

II-2. If not State-operated, is the POS vendor also the MMIS Fiscal agent?

Answer	State	Number of States (Percentage)
Yes	AL, AR, CA, CO, CT, DC, DE, HI, KS, LA, MI, MO, MS, MT, NC, NJ, NM, NY, OK, PA, RI, TX, VA, WI, WV	25 (50%)
No	AK, FL, GA, IA, ID, IL, IN, KY, MA, MD, ME, MN, ND, NE, NH, NV, OH, OR, SC, SD, TN, UT, VT, WA, WY	25 (50%)

II-3. Identify the prospective DUR criteria source.

Answer	State	Number of States (Percentage)
First Data Bank	AK, AL, AR, CA, CT, DC, FL, HI, ID, IL, KS, KY, MA, MD, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NY, OH, OK, OR, RI, SC, SD, TN, TX, WI, WV	36 (72%)
Other	CO, DE, GA, IA, IN, LA, ME, NV, PA, UT, VA, VT, WA, WY	14 (28%)

If the answer to II-3 above is "Other", please specify:

State	Explanation
CO	First Data Bank as well as State DUR contractor. The contractor is University of Colorado.
DE	Micromedex
GA	Medi-Span
IA	Medispan
IN	Medi-Span
LA	In addition to FDB DUR modules, criteria are developed through collaboration of pharmacists at DHH, ULM, and Molina Medicaid Solutions, with approval of the Louisiana DUR Board.
ME	Medispan, Clinical Literature and other State programs.
NV	Medispan
PA	The Prospective DUR criteria used in Pennsylvania comes from both First Data Bank as well as criteria developed by Department staff.
UT	Medispan
VA	Xerox
VT	Medispan FDA safety alerts.
WA	Medispan prospective DUR criteria as modified by State staff.
WY	MediSpan and University of Wyoming School of Pharmacy.

II-4. Are the new prospective DUR criteria approved by the DUR Board?

Answer	State	Number of States (Percentage)
Yes	AK, AL, CO, CT, DC, DE, FL, HI, IL, IN, KS, KY, LA, MA, ME, MI, MS, MT, NC, NH, NJ, NM, NY, OH, PA, TX, UT, VA, VT, WI, WV, WY	32 (64%)
No	AR, CA, GA, IA, ID, MD, MN, MO, ND, NE, NV, OK, OR, RI, SC, SD, TN, WA	18 (36%)

If the answer to II-4 above is "No", please explain:

State	Explanation
AR	Years ago, the DUR Board approved that only the most severe alert messages would be passed on to the pharmacy providers. The ProDUR contractor was able to set that level of alert messages. However, the actual ProDUR edit criteria belong to FDB, not to the ProDUR contractor. To date the state has not received the list of new ProDUR alert criteria from FDB.
CA	The DUR Board advises and makes recommendations regarding prospective DUR criteria; however, final approval is made by DHCS.
GA	Criteria is from Medi-Span.
IA	This is a collaborative effort between the State, POS Contractor and DUR. Most new proposed criteria are reviewed by the DUR.
ID	The DUR Board reviews the vendor's criteria; however, they do not approve or disapprove any vendor criteria.
MD	Although, the DUR Board does not review and approve all prospective DUR criteria, a summary of prospective DUR alerts are reviewed and discussed at all DUR Board meetings. Individual criteria may be recommended by the Board for implementation. All new severity level 1 drug interaction criteria are automatically implemented by the POS vendor as they become available from First Data Bank.

MN	High dose and/or quantity limits which cause the claim to reject are reviewed by the DUR Board. Informational edits are not reviewed by the DUR Board.
MO	Automatic updates are made from First Data Bank which is incorporated in our DUR criteria.
ND	DUR Board only meets quarterly.
NE	The DUR Board recommends criteria; however, final approval is made by DHHS.
NV	Medispan provides the criteria; the DUR Board does not review or approve new criteria.
OK	Guidelines have been approved, and new criteria are updated as it comes from FDB as long as it meets the set parameters.
OR	ProDUR criteria are updated by FDB. There is an ability to modify how the alerts are responded to (override required or informational only) but not to change the criteria itself.
RI	The prospective DUR criteria are auto loaded from First Data Bank.
SC	Criteria is primarily provided by First Data Bank and not reviewed by the DUR board. Edits outside of those provided by FDB can be reviewed/recommended by the DUR board, but DHHS would have final approval.
SD	DUR Board does not review prospective criteria
TN	Difficult to review all new ProDUR edits. Custom or non-industry standard criteria are approved by the DUR Board when the Board has seen issues that arise.
WA	Automated prospective DUR criteria are applied automatically in the system. New prospective DUR requirements applied through prior authorization are reviewed by the DUR Board if they represent a limitation beyond adherence to FDA labeling.

II-5. When the pharmacist receives a Pro DUR message that requires a pharmacist's review, does your system allow the pharmacist to override the alert using the "conflict, intervention and outcome" codes?

Answer	State	Number of States (Percentage)
Yes	AK, AL, AR, CA, CT, DC, DE, FL, GA, ID, IN, KS, KY, LA, MA, MD, MI, MN, MO, MS, MT, NC, ND, NE, NH, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, UT, VA, VT, WA, WI, WV, WY	43 (86%)
No	CO, HI, IA, IL, ME, NJ, TX	7 (14%)

II-6. Do you receive and review periodic reports from your ProDUR contractor providing individual pharmacy provider activity in summary and in detail?

Answer	State	Number of States (Percentage)
Yes	AL, CA, DC, DE, FL, ID, KY, MI, MS, MT, NC, NE, NH, NV, OH, OK, OR, SC, TN, TX, VA, VT, WV	23 (46%)
No	AK, AR, CO, CT, GA, HI, IA, IL, IN, KS, LA, MA, MD, ME, MN, MO, ND, NJ, NM, NY, PA, RI, SD, UT, WA, WI, WY	27 (54%)

If the answer to II-6 above is "Yes", how often is the report received by the agency?

Answer	State	Number of States (Percentage)
Monthly	AL, DC, DE, ID, KY, MS, MT, NC, NE, NH, TX, VA	12 (52%)
Quarterly	FL, MI, NV, OK, OR, SC, TN, VT, WV	9 (39%)
Annually	CA, OH	2 (9%)

a) If you receive reports, do you follow-up with those providers who routinely override with interventions?

Answer	State	Number of States (Percentage)
Yes	AL, DC, DE, MI, NC, NE, WV	7 (30%)
No	CA, FL, ID, KY, MS, MT, NH, NV, OH, OK, OR, SC, TN, TX, VA, VT	16 (70%)

b) If the answer to a) above is "Yes", by what method do you follow-up?

Answer	State	Number of States (Percentage)
Contact pharmacy	DC, NE, WV	3 (43%)
Refer to Program Integrity for Review	DE, NC	2 (28.5%)
Other(explain)	AL, MI	2 (28.5%)

If the answer to b) above is "Other", please explain:

State	Explanation
AL	Alabama Medicaid has an Academic Detailing Program that provides scheduled face to face visits to providers.
MI	Both Contact Pharmacy and refer for Program Integrity Review.

II-7. Early Refill:

a) At what percentage threshold do you set your system to edit?

Category	Number of States	Percentage Threshold		
		Average	Minimum	Maximum
Non-controlled drugs:	50	79%	75%	90%
Controlled drugs:	50	83%	75%	100%

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

Answer	State	Number of States (Percentage)
Yes	AK, AL, CO, CT, DC, DE, FL, GA, HI, ID, IL, IN, KY, MA, MD, ME, MN, MO, MS, MT, NM, NV, NY, OH, OK, PA, SC, TN, TX, UT, VA, VT, WA, WV, WY	35 (70%)
No	AR, CA, IA, KS, LA, MI, NC, ND, NE, NH, NJ, OR, RI, SD, WI	15 (30%)

If the answer to (b) above is “Yes”, who obtains authorization?

Answer	State	Number of States (Percentage)
Pharmacist	MN, OK, TX, WA	4 (11.5%)
Prescriber	ID, MS, NY, TN	4 (11.5%)
Either	AK, AL, CO, CT, DC, DE, FL, GA, HI, IL, IN, KY, MA, MD, ME, MO, MT, NM, NV, OH, PA, SC, UT, VA, VT, WV, WY	27 (77%)

If the answer to (b) above is "No", can the pharmacist override at the point of service?

Answer	State	Number of States (Percentage)
Yes	AR, CA, KS, LA, MI, NC, ND, NE, OR, RI, WI	11 (73%)
No	IA, NH, NJ, SD	4 (27%)

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

Answer	State	Number of States (Percentage)
Yes	AK, AL, AR, CO, CT, DC, DE, FL, GA, HI, ID, IL, IN, KY, MA, MD, ME, MI, MN, MO, MS, MT, ND, NE, NM, NV, NY, OH, OK, PA, SC, TN, TX, UT, VA, VT, WA, WI, WV, WY	40 (80%)
No	CA, IA, KS, LA, NC, NH, NJ, OR, RI, SD	10 (20%)

If the answer to (c) above is "Yes", who obtains authorization?

Answer	State	Number of States (Percentage)
Pharmacist	MN, OK, TX, WA, WI	5 (13%)
Prescriber	CT, DE, FL, ID, IN, MS, NY, PA, TN	9 (23%)
Either	AK, AL, AR, CO, DC, GA, HI, IL, KY, MA, MD, ME, MI, MO, MT, ND, NE, NM, NV, OH, SC, UT, VA, VT, WV, WY	26 (65%)

If the answer to (c) above is "No", can the pharmacist override at the point of service?

Answer	State	Number of States (Percentage)
Yes	CA, KS, LA, NC, OR, RI, SD	7 (70%)
No	IA, NH, NJ	3 (30%)

II-8. When the pharmacist receives an early refill DUR alert message that requires the pharmacist's review, does your system allow the pharmacist to override for situations such as:

a) Lost/stolen Rx

Answer	State	Number of States (Percentage)
Yes	AL, CA, KS, LA, MD, MO, NC, NE, NH, NM, OR, RI, WA, WI	14 (28%)
No	AK, AR, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KY, MA, ME, MI, MN, MS, MT, ND, NJ, NV, NY, OH, OK, PA, SC, SD, TN, TX, UT, VA, VT, WV, WY	36 (72%)

b) Vacation

Answer	State	Number of States (Percentage)
Yes	CA, LA, MD, MO, NC, NE, NH, NM, OR, WI	10 (20%)
No	AK, AL, AR, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, MA, ME, MI, MN, MS, MT, ND, NJ, NV, NY, OH, OK, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WV, WY	40 (80%)

c) Other

Answer	State	Number of States (Percentage)
Yes	CA, DE, IL, KS, LA, ME, MI, MO, NC, ND, NE, NH, OR, SC, WA, WI	16 (32%)
No	AK, AL, AR, CO, CT, DC, FL, GA, HI, IA, ID, IN, KY, MA, MD, MN, MS, MT, NJ, NM, NV, NY, OH, OK, PA, RI, SD, TN, TX, UT, VA, VT, WV, WY	34 (68%)

If the answer to II-8 c) above is "Yes", please provide details:

State	Explanation
CA	The pharmacist can override the early refill DUR alert message for any medically necessary reason.
DE	A change in directions can be overridden by the pharmacist.
IL	Informational edits regarding duplicate therapy.
KS	Spilled medications.
LA	Other situations may be overridden using the pharmacist's professional judgment.
ME	For Nursing Home admissions.
MI	Long-Term Care (LTC) pharmacies may override using Submission Clarification Code. Point of Sale system verifies the patient has LTC enrollment.

MO	All early refill denials require the pharmacist to contact the pharmacy helpdesk for individual override each time the edit posts.
NC	Change of Therapy (This is the only override allowed for controlled substances).
ND	Overall, the pharmacy is able to override non-controlled drugs if ≥ 50% utilized. All controlled scripts require them to Call for an override for any reason.
NE	Lost or stolen controlled substance requires a prior authorization.
NH	Other early refill options include supply destroyed, increased or variable dose, transitioning into or out of nursing home, wrong days' supply on previous fill and requires two RX of same medication.
OR	Change in dose, medical necessity
SC	Therapeutic duplication may be overridden.
WA	POS system differentiates between early refills of the exact same prescription, and early refills of the same medication under a different prescription. Pharmacists have the ability to override early refills based on a difference in prescription, but must obtain PA for an early refill of the exact same prescription.
WI	Dose change, member misunderstood directions from the prescriber and natural disaster.

II-9. Does your system have an accumulation edit to prevent patients from obtaining additional refills during the calendar year?

Answer	State	Number of States (Percentage)
Yes	AK, AL, AR, DE, FL, GA, ID, IL, IN, KY, MI, MS, NC, ND, NM, NV, NY, OK, RI, SC, TN, WV, WY	23 (46%)
No	CA, CO, CT, DC, HI, IA, KS, LA, MA, MD, ME, MN, MO, MT, NE, NH, NJ, OH, OR, PA, SD, TX, UT, VA, VT, WA, WI	27 (54%)

If the answer to II-9 above is "No", do you plan to implement this edit?

Answer	State	Number of States (Percentage)
Yes	DC, IA, MA, MT, NJ, TX, VT, WA	8 (30%)
No	CA, CO, CT, HI, KS, LA, MD, ME, MN, MO, NE, NH, OH, OR, PA, SD, UT, VA, WI	19 (70%)

II-10. Has the state provided DUR criteria data requested on Table 1 – Top 10 Pro DUR Alerts by Problem Type indicating by problem type those criteria with the most significant severity level reviewed by the DUR Board?

Answer	State	Number of States (Percentage)
Yes	AK, AR, CA, CO, CT, DC, DE, FL, GA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NV, OK, OR, SC, TN, TX, UT, VA, VT, WA, WI, WV, WY	40 (80%)
No	AL, HI, IA, NM, ND, NY, OH, PA, RI, SD	10 (20%)

II-11. Section 1927(g)(A) of the Social Security Act requires that the pharmacist offer patient counseling at the time of dispensing. Who in your state has responsibility for monitoring compliance with the oral counseling requirement? Indicate all that apply:

Answer	State	Number of States (Percentage)
Medicaid agency	AK, CO, CT, FL, HI, MI, SC	7 (14%)
State Board of Pharmacy	AK, AL, AR, CA, DC, DE, GA, IA, ID, IN, KS, KY, LA, MA, MD, ME, MI, MN, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	43 (86%)
Other- please explain	DC, IL, MO, NY	4 (8%)

If the answer to II-11 above is "Other", please explain:

State	Explanation
DC	Department of Health Pharmaceutical Control Unit
IL	The Illinois Department of Financial and Professional Regulation (IDFPR) licenses pharmacists in the State of Illinois and the IDFPR pharmacy inspectors during the course of pharmacy inspections evaluate compliance with the requirement for prospective drug regimen review and counseling. IDFPR inspectors report findings to the State Board of Pharmacy which disciplines pharmacists and pharmacies.
MO	The Missouri Medicaid Audit and Compliance Unit monitor compliance with the oral counseling requirement.
NY	On-site pharmacy inspections performed by Office of Professional Discipline

II-12. Has the state included Attachment 1 – Pharmacy Oral Counseling Compliance Report, a report on state efforts to monitor pharmacy compliance with the oral counseling requirement?

Answer	State	Number of States (Percentage)
Yes	AK, AL, CA, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MS, MT, NC, ND, NE, NH, NM, NV, NY, OH, OK, OR, SC, SD, TN, TX, UT, VA, VT, WA, WV, WY	42 (84%)
No	AR, DE, MA, MO, NJ, PA, RI, WI	8 (16%)

III. RETROSPECTIVE DUR (RetroDUR)

III-1. Identify, by name and type, the vendor that performed your retrospective DUR activities during the time period covered by this report. (company, academic institution or other organization)

Answer	State	Number of States (Percentage)
Company	AK, AL, AR, CT, DC, DE, FL, GA, HI, IA, ID, IN, KS, KY, LA, MD, ME, MI, MN, MO, MT, NC, ND, NH, NJ, NM, PA, RI, SC, SD, TN, TX, VA, VT, WI, WV	36 (72%)
Academic institution	CA, CO, IL, MA, MS, NV, OH, OK, OR, UT, WY	11 (22%)
Other organization	NE, NY, WA	3 (6%)

Vendor by Name and Type

Vendor	State
Company	
Catamaran	IN,VT
Goold Health Systems	IA, ME
Health Information Design	AL, AR, CT, DE, KS, MD, ND, NY*, PA, RI, SD*, WI
Magellan	AK, FL, ID, KY, MI, NC, NH, SC, TN,
Molina Medicaid Solution	LA, NJ
Mountain Pacific Quality Health Foundation	MT
NorthStar HealthCare Consulting	GA
Xerox	DC, HI, MN, MO, NM, TX, VA, WV
SD State University College of Pharmacy	SD*
Academic Institution	
OHSU College of Pharmacy	OR
University of California, San Francisco (UCSF)	CA
University of Cincinnati College of Pharmacy	OH
University of Colorado School of Pharmacy	CO
University of Illinois College of Pharmacy Staff	IL
University of Mass	NV
University of Massachusetts Medical School	MA
University of Mississippi School of Pharmacy	MS
University of Oklahoma College of Pharmacy, Pharmacy Management Consultants	OK
University of Utah College of Pharmacy Drug Regimen Review Center (DRRC)	UT
University of Wyoming, School of Pharmacy	WY
Other Organization	
State University of NY at Buffalo	NY*
Nebraska Pharmacists Association	NE
Washington State Health Care Authority	WA

III-1. a) Is the retrospective DUR vendor also the Medicaid fiscal agent?

Answer	State	Number of States (Percentage)
Yes	DC, HI, LA, ME, MI, NJ, NM, VA, WA	9 (18%)
No	AK, AL, AR, CA, CO, CT, DE, FL, GA, IA, ID, IL, IN, KS, KY, MA, MD, MN, MO, MS, MT, NC, ND, NE, NH, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, WI, WV, WY	41 (82%)

III-1. b) Is this retrospective DUR vendor also the developer/supplier of your retrospective DUR criteria?

Answer	State	Number of States (Percentage)
Yes	AK, AL, AR, CO, CT, DC, DE, FL, GA, IA, ID, IL, IN, KS, KY, MA, MD, ME, MN, MO, MS, MT, NC, ND, NH, NJ, NM, NV, NY, OR, PA, RI, SC, SD, TN, TX, VA, VT, WA, WI, WV	41 (82%)
No	CA, HI, LA, MI, NE, OH, OK, UT, WY	9 (18%)

If the answer to III-1 (b) above is "No", please explain:

State	Explanation
CA	Retrospective DUR criteria are developed jointly by UCSF and DHCS with input and recommendation by the DUR board. Final approval of criteria is made by DHCS.
HI	The DUR Board and the DUR Coordinator develop and supply the retrospective DUR criteria.
LA	Retrospective DUR criteria are developed through collaboration of pharmacists at DHH, ULM, and Molina Medicaid Solutions, with approval of the Louisiana DUR Board.
MI	This is a joint effort between Medicaid agency staff and the vendor staff. The DUR Board identifies and defines the RetroDUR topics and the vendor operationalizes.
NE	Retrospective DUR criteria are developed jointly by DHHS, the POS Vendor and the Retro DUR vendor.
OH	Criteria are developed internally with assistance from the University of Cincinnati College of Pharmacy.
OK	The University utilizes Medi-Span drug information applications.
UT	The DRRC may or may not recommend RetroDUR criteria and Utah Medicaid may or may not accept presented or modified criteria.
WY	In FFY 2014, the School of Pharmacy used Xerox's retrospective DUR system and embedded criteria.

III-2. Does the DUR Board approve the retrospective DUR criteria?

Answer	State	Number of States (Percentage)
Yes	AK, AL, AR, CO, CT, DC, DE, FL, HI, ID, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NY, OH, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV	43 (86%)
No	CA, GA, IA, IL, NV, OK, WY	7 (14%)

If the answer to III-2 above is "No", please explain:

State	Explanation
CA	The DUR board advises and makes recommendations regarding prospective DUR criteria; however, final approval is made by DHCS.
GA	The DUR Board is advisory only; the Department of Community Health approves criteria.
IA	Goold Health Systems utilizes MediSpan for retrospective DUR criteria involving a complex screening process.

IL	The DUR Board in FY13 discussed general criteria for choosing diseases and drugs for retrospective review. In FY2014 the DUR Board identified asthma as the retrospective DUR to be conducted at each step as data was provided, they refined the criteria. For other RetroDUR activities, based on the DUR guidance we looked at criteria already in place or potential issues that may need edits put in place, staff identified the issue for discussion. Data runs were conducted by staff, and then presented to the DUR Board so they could approve prospective criteria that resulted from retrospective review of select medications, example pain, suboxone, Synagis.
NV	The DUR Board offers topics and reviews results, but does not approve before letters are sent.
OK	Guidelines have been approved, and new criteria are updated as it comes from FDB as long as it meets the set parameters.
WY	Criteria were considered to be confidential and proprietary by Xerox and were not regularly provided for review.

III-3. Has the state included Attachment 2 - Retrospective DUR Educational Outreach Summary, a year end summary of the Top 10 problem types for which educational interventions were taken?

Answer	Number of States	Percentage
Yes	50	100%

IV. DUR BOARD ACTIVITY

IV-1. State is including a summary report of DUR Board activities and meeting minutes during the time period covered by this report as Attachment 3 - Summary of DUR Board Activities

Answer	Number of States	Percentage
Yes	50	100%

IV-2. Does your State have a Disease Management Program?

Answer	State	Number of States (Percentage)
Yes	CA, DC, FL, IA, IN, MA, ME, MO, MS, ND, OK, OR, PA, UT, VT, WY	16 (32%)
No	AK, AL, AR, CO, CT, DE, GA, HI, ID, IL, KS, KY, LA, MD, MI, MN, MT, NC, NE, NH, NJ, NM, NV, NY, OH, RI, SC, SD, TN, TX, VA, WA, WI, WV	34 (68%)

If the answer to IV-2 above is "Yes", have you performed an analysis of the program's effectiveness?

Answer	State	Number of States (Percentage)
Yes	IN, MA, ME, UT, VT	5 (31%)
No	CA, DC, FL, IA, MO, MS, ND, OK, OR, PA, WY	11 (69%)

If the response is "Yes", please provide a brief summary of your findings

State	Findings
IN	The Managed Care Entities (MCEs) provide disease management programs which are monitored and evaluated through the MCE's quality improvement processes. This is accomplished at the individual health plan level and not at the state level.
MA	Educational outreach interventions to prescribers increased medication possession and demonstrated cost avoidance
ME	We were able to abate 1.5 million in inappropriate drug therapy through States PCM initiative.
UT	The hemophilia management program results in better clinical and quality of life outcomes for our patients (prevented ED visits, prevented supplemental doses, etc.). Another result is cost savings of millions per year.
VT	The Vermont Chronic Care Initiative (VCCI) has been an evolving, legislatively endorsed effort by the state of Vermont since 2007. The goal is to help Medicaid members to better manage their chronic medical conditions. During FFY2014 the VCCI engaged over 1,700 Medicaid members via face-to-face and/or telephonic case management. While this represents a decline in overall engaged members as compared to SFY 2013, the acuity of members increased significantly, and concurrently, due to changes in our contract timeline, the VCCI and our vendor both suffered a significant turnover in our RN case management staff which adversely impacted overall case load. Despite these challenges, the VCCI still positively impacted utilization as well as improved adherence to evidence based pharmacy treatment, particularly among members with a history of depression. This was an important focus of our work, given the adverse impact of depression on one's ability to manage other chronic medical conditions and thus, their overall health and wellbeing.

If the answer to IV-2 above is "Yes", is your DUR Board involved with this program?

Answer	State	Number of States (Percentage)
Yes	DC, MA, ME, MO, MS, WY	6 (37.5%)
No	CA, FL, IA, IN, ND, OK, OR, PA, UT, VT	10 (62.5%)

IV-3. Does your State have an approved CMS Medication Therapy Management Program?

Answer	State	Number of States (Percentage)
Yes	FL, IA, MN, MO, OR, WI	6 (12%)
No	AK, AL, AR, CA, CO, CT, DC, DE, GA, HI, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WV, WY	44 (88%)

If the response is "Yes" to IV-3 above, have you performed an analysis of the program's effectiveness?

Answer	State	Number of States (Percentage)
Yes	FL	1 (17)
No	IA, MN, OR, WI	4 (67 %)
No Response	MO	1 (17%)

If the response is "Yes", please provide a brief summary of your findings:

State	Findings
FL	Qualitative findings support several benefits based on the responses to open-ended questions and survey items. For example, MTM participants consistently stated that their medication adherence was positively enhanced by participation in the program. Furthermore, they also indicated greater understanding of their medications.

If the answer to IV-3 above is "Yes", is your DUR Board involved with this program?

Answer	State	Number of States (Percentage)
Yes	MO,WI	2 (33%)
No	FL, IA, MN, OR	4 (67%)

If the response is "No", are you planning to develop and implement a program?

Answer	State	Number of States (Percentage)
Yes		0 (0%)
No	FL, IA, MN, OR	4 (100%)

V. PHYSICIAN ADMINISTERED DRUGS

The Deficit Reduction Act requires collection of NDC numbers for covered outpatient physician administered drugs. These drugs are paid through the physician and hospital programs. Has your MMIS been designed to incorporate this data into your DUR criteria for both Prospective DUR and Retrospective DUR?

Answer	State	Number of States (Percentage)
Yes	CO, DE, HI, KY, MA, ME, MI, MO, PA, SC, TX, VT, WA	13 (26%)
No	AK, AL, AR, CA, CT, DC, FL, GA, IA, ID, IL, IN, KS, LA, MD, MN, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, RI, SD, TN, UT, VA, WI, WV, WY	37 (74%)

If the response is "No" to V, do you have a plan to include this information in your DUR criteria in the future?

Answer	State	Number of States (Percentage)
Yes	AK, CA, DC, FL, IA, ID, IL, MS, NC, ND, NH, NJ, NM, NV, OR, SD, UT, WV	18 (49%)
No	AL, AR, CT, GA, IN, KS, LA, MD, MN, MT, NE, NY, OH, OK, RI, TN, VA, WI, WY	19 (51%)

VI. GENERIC POLICY AND UTILIZATION DATA

VI-1. State is including a description of policies used that may affect generic utilization percentage as Attachment 4 - Generic Drug Substitution Policies:

Answer	Number of States	Percentage
Yes	50	100%

VI-2. In addition to the requirement that the prescriber write in his/her own handwriting "Brand Medically Necessary" for a brand name drug to be dispensed in lieu of the generic equivalent, does your state have a more restrictive requirement?

Answer	State	Number of States (Percentage)
Yes	AK, AL, AR, CA, CO, CT, DE, GA, IA, ID, IL, IN, KS, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NV, NY, OK, OR, PA, SD, TN, TX, UT, VT, WA, WI, WY	39 (78%)
No	DC, FL, HI, KY, LA, NM, OH, RI, SC, VA, WV	11 (22%)

If the response is "Yes" to VI-2 above, indicate all that apply:

Answer	State	Number of States (Percentage)
Require that a MedWatch Form be submitted	AK, AL, AR, DE, IA, ID, IN, KS, MD, MI, MS, NC, ND, NH, SD, TN, WY	17 (44%)
Require medical reason for override accompany prescription	AL, DE, ID, KS, MO, MS, ND, NH, OK, SD, UT	11 (28%)
Preauthorization is required	AK, AL, AR, CO, DE, GA, IA, ID, IL, IN, KS, MA, MD, MI, MN, MO, MS, MT, NC, ND, NH, NJ, NV, NY, OK, OR, PA, SD, TN, UT, VT, WI, WY	33 (85%)
Other – please explain	AR, CA, CT, ID, ME, MI, NE, TN, TX, WA	10 (26%)

If the response is "Other", please explain:

State	Explanation
AR	Prescriber is required to submit data to our program using the FDA MedWatch form to substantiate the medical necessity for receiving the brand name drug as part of the manual review PA process. In addition, there are specific criteria that must be met to determine an adverse reaction to a generic drug, an allergic reaction to a generic drug, or a therapeutic failure to a generic drug. If the information is documented and verified, the MedWatch form is submitted to the FDA and the PA for the brand name drug is approved.
CA	If a brand name drug does not appear on the Medi-Cal List of Contract Drugs, an approved Treatment Authorization Request may be required before dispensing.
CT	A BMN PA is required unless the brand name drug is on the PDL. A DAW-1 submitted on electronic prescriptions is acceptable.
ID	Failure of 2 generic products.
ME	Maine does not allow DAW 1 for Medicaid.
MI	No prior authorization for selected drug classes determined by the State legislature to be exempt from Prior Authorization.
NE	Prescriber must complete an MC-6 form, which declares that the brand name medication is medically necessary.
TN	Tennessee requires PA, and MedWatch form is included in the PA criteria.
TX	Upon monthly desk review, pharmacy must submit copies of the actual prescription showing the prescriber's

	handwriting. Payment is recouped (to the MAC price) if not provided.
WA	Brand medications will pay without authorization, but will pay at generic price. If the pharmacy accepts reimbursement as adequate, no prior authorization is needed. If the pharmacy wants to receive higher reimbursement because generic pricing is less than the cost of the medication, the pharmacy may request authorization. The prescriber is then contacted to provide medical justification (PA required).

VI-3. Indicate the generic utilization percentage for all covered outpatient drugs paid during this reporting period, using the computation instructions in Table 2 - Generic Drug Utilization Data.

State	Generic Utilization Percentage
DC	68%
MS	70%
CA	71%
TX	73%
NJ	73%
CT	74%
LA	77%
NC	77%
VT	77%
DE	77%
MT	78%
ME	78%
NV	78%
SC	78%
FL	78%
MO	79%
AL	79%
MI	79%
SD	79%
WI	79%
WY	79%
AK	79%
UT	80%
IA	80%
ID	80%
AR	80%
CO	81%
MD	81%
ND	81%
NH	81%
NY	81%
TN	81%
WV	81%
NM	82%
OK	82%
MN	82%
KS	82%
IL	83%
GA	83%
IN	83%
NE	83%
OH	84%
MA	85%
PA	86%
WA	86%
OR	86%
KY	86%
VA	87%
RI	87%
HI	93%
Average	**82%**

VI-4. Indicate the percentage dollars paid for generic covered outpatient drugs in relation to all covered outpatient drug claims paid during this reporting period using the computation instructions in Table 2 - Generic Drug Utilization Data.

State	Percentage Dollars Paid for Generics in relation to Total Drug Spend
NJ	8%
DC	11%
CA	11%
FL	16%
NY	16%
NH	17%
MI	17%
DE	18%
KS	18%
CT	19%
MT	19%
GA	19%
ND	19%
NV	19%
ME	19%
TN	20%
SC	20%
TX	20%
NC	21%
WY	21%
WI	22%
IN	22%
WV	22%
OH	23%
PA	23%
MD	23%
IA	24%
UT	24%
MS	24%
KY	25%
AL	25%
ID	25%
SD	25%
OK	25%
VT	26%
WA	26%
RI	26%
AK	26%
MN	26%
MO	26%
HI	26%
LA	26%
CO	27%
MA	27%
IL	28%
NM	29%
AR	31%
VA	32%
OR	33%
NE	39%
Average	**23%**

VII. PROGRAM EVALUATION/COST SAVINGS/COST AVOIDANCE

VII-1. Did your State conduct a DUR program evaluation of the estimated cost savings/cost avoidance?

Answer	State	Number of States (Percentage)
Yes	AK, AL, AR, CA, CO, CT, DC, FL, GA, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	48 (96%)
No	DE, HI	2 (4%)

VII-2. Who conducted your program evaluation for the cost savings estimate/cost avoidance? (company, academic institution, other institution)

Answer	State	Number of States (Percentage)
Company	AK, AL, AR, CT, DC, DE, GA, FL, HI, IA, ID, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OR, PA, RI, SC, SD, TN, TX, VA, VT, WI, WV	42 (84%)
Academic institution	CA, MA, OK, WY	4 (8%)
Other institution	CO, IL, UT, WA	4 (8%)

Organization Name and Type

Organization	States (* served by more than one organization)
Company	
Catamaran	GA, IN, NV, VT
DUR Coordinator	HI
Goold Health System	IA, ME, UT
Health Information Designs	AL, AR*, CT*, DE*, KS*, MD*, ND, NY, PA,RI, SD, TX*, WI
HP Enterprise Services	CT*, DE*, OR, KS*
Magellan Medicaid Administration	AK, AR*, FL, ID, KY, NE, NH, NC*, TN, MI, SC
Mercer	NC*
Minnesota does internally except for RetroDUR	MN
Molina Medicaid Solutions	LA, NJ, WV*
Mountain Pacific Quality Health	MT
Xerox	DC, MD*, MO, MS*, NM, OH, TX*, VA, WV*
Academic Institution	
University of California, San Francisco (UCSF)	CA
University of Massachusetts Medical School	MA
University of Oklahoma College of Pharmacy, Pharmacy Management Consultants	OK
University of Wyoming School of Pharmacy	WY
University of Massachusetts Medical School	MS*
Other Organization	
CO- Department of Health Care Policy and Financing - Colorado Medicaid	
IL- HFS of Bureau of Professional and Ancillary	

Services
UT- Both the DRRC and GHS
WA- Washington State Health Care Authority (Medicaid).

VII-3. Please provide your ProDUR and RetroDUR program cost savings/cost avoidance in the chart below.

State	ProDUR Total Estimated Avoided Costs	RetroDUR Total Estimated Avoided Costs	Other Cost Avoidance	Grand Total estimated Avoided Costs
AK	2,929,548	-	-	2,929,548
AL	-	1,456,730	-	1,456,730
AR	19,700,000	522,168	31,082,525	51,304,693
CA	193,813,195	-	-	193,813,195
CO	-	-	16,659,373	16,659,373
CT	35,435,238	5,197,734	-	40,632,972
DC	-	242,432	-	242,432
DE	2,835,000	66,240	-	2,901,240
FL	645,544,049	5,907,752	105,635,991	757,087,792
GA	52,021,172	-	-	52,021,172
HI	-	-	-	-
IA	-	621,117	-	621,117
ID	27,697,227	3,496,924	-	31,194,151
IL	-	-	762,470,788	762,470,788
IN	213,670,000	-	-	213,670,000
KS	34,207	47,923	-	82,130
KY	31,531,520	259,687	12,153,843	43,945,050
LA	117,054,780	1,291,284	-	118,346,064
MA	230,451,459	-	59,489	230,510,948
MD	28,305,585	(179,229)	-	28,126,356
ME	-	-	85,961,604	85,961,604
MI	312,975,221	2,548,821	-	315,524,042
MN	35,624,450	(9,602)	-	35,614,848
MO	32,970,159	861,213	-	33,831,372
MS	22,316,853	-	4,359,173	26,676,026
MT	13,022,428	100,504	4,238,966	17,361,898
NC	252,679,374	120,280	42,660,933	295,460,587
ND	-	530,201	-	530,201
NE	8,013,271	484,993	18,013	8,516,277
NH	4,950,621	1,286,999	3,213,822	9,451,442
NJ	14,993,566	-	-	14,993,566
NM	1,518,967	420	-	1,519,387
NV	92,862,113	-	-	92,862,113
NY	33,723,671	3,511,725	-	37,235,396
OH	36,257,934	-	-	36,257,934
OK	114,792,256	5,783,556	3,342,775	117,233,037
OR	41,259	17,654	-	58,913
PA	-	849,218	-	849,218
RI	3,153,383	236,297	-	3,389,680
SC	74,177,922	762,675	-	70,618,658
SD	-	207,488	-	207,488
TN	50,123,688	797,074	-	50,920,762
TX	32,047,548	18,462,323	-	50,509,871
UT	11,043,000	297,000	-	11,340,000
VA	14,221,352	145,051	5,974,055	20,304,458
VT	75,583,428	174,839	-	75,635,492
WA	18,971,656	-	12,932,953	31,904,609
WI	-	506,375	-	506,375
WV	20,442,333	10,927,526	-	31,369,526
WY	17,557,962	113,863	-	17,671,825
Average	**57,901,748**	**1,352,945**	**21,815,286**	**80,846,647**

VII-4. Please provide the estimated percent impact of your state's cost savings/cost avoidance program compared to total drug expenditures for covered outpatient drugs.
Grand Estimated Net Savings Amount / Total Dollar Amount X 100 = % Impact of Cost Savings /Avoidance compared to Total Drug Spend

State	Percent Impact of Cost Savings/Avoidance Compared to Total Drug Spend
HI	0%
WI	0%
DC	0%
IA	1%
ND	1%
PA	1%
SD	1%
AL	1%
OR	1%
DE	1%
KS	3%
MO	3%
CO	3%
AK	4%
CT	4%
NE	5%
NJ	5%
NY	6%
TN	6%
CA	7%
TX	7%
MD	7%
NM	8%
GA	9%
OH	9%
WV	10%
UT	10%
MS	11%
MN	15%
VA	16%
AR	18%
MT	18%
ID	20%
NC	21%
IN	22%
WA	22%
RI	23%
OK	25%
LA	25%
NH	30%
ME	39%
WY	41%
NV	42%
MA	43%
MI	43%
VT	49%
FL	62%
SC	63%
KY	66%
IL	84%
Average	**18%**

VIII. FRAUD, WASTE AND ABUSE DETECTION

VIII A. LOCK-IN or PATIENT REVIEW AND RESTRICTIVE PROGRAMS

VIII-A1. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by beneficiaries?

Answer	State	Number of States (Percentage)
Yes	AK, AL, AR, CA, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	49 (98%)
No	NH	1 (2%)

If the response to VIII-A1 above is "Yes", what action(s) does this process initiate? Indicate all that apply:

Answer	State	Number of States (Percentage)
Deny claims and require pre-authorization	AR, CO, CT, DC, FL, GA, IL, IN, KY, MA, MD, ME, MI, MO, MT, ND, NE, NJ, OK, OR, SC, TN, TX, UT, VT	25 (51%)
Refer to lock-in program	AK, AL, AR, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NJ, NM, NV, NY, OH, OK, OR, RI, SC, TN, TX, UT, VA, VT, WA, WI, WV, WY	45 (91%)
Refer to Program Integrity Unit	AK, AL, AR, CO, CT, DC, DE, FL, GA, IA, IN, KY, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NJ, OK, PA, RI, SC, SD, UT, VA, VT	31 (63%)
Other (e.g. SURS, Office of Inspector General)	AK, AL, CA, CT, GA, IN, MA, MD, MN, MS, MT, NC, NJ, NV, NY, OH, SD, TN, VA, VT, WI	21 (43%)

If the response to the above is "Other", please explain:

State	Explanation
AK	SURS, MFCU
AL	Refer to MFCU if necessary.
CA	22 CCR §50793 details available utilization restrictions when the Department has determined that a beneficiary is misusing or abusing Medi-Cal benefits. Audit & Investigations Branch (IB) is responsible for working beneficiary cases. IB has an intake process for complaints which entails an initial case review and if warranted, assignment of a case to an investigator. Subsequent actions are dependent upon the outcome of IB's investigation.
CT	Via Program Integrity/Quality Control, not Pharmacy DUR.
GA	Referral to Office of Inspector General.
IN	Submit to FSSA Bureau of Investigation for member investigation.
MA	Referral to Care Management.
MD	SURS, OIG, CDSIU (Controlled Dangerous Substance Integration Unit)
MN	Questionable utilization is referred to the SURS program and they determine the action from there.
MS	Refer to Mississippi Attorney General's Medicaid Fraud Control Unit
MT	We refer to law enforcement, the Division of Criminal Investigation.
NC	All potential beneficiary fraud and abuse leads are referred to the beneficiary's county department of social services for further investigation and disposition.
NJ	A Surveillance and Utilization Review (SURS) reporting tool is used by the Data Mining Unit within the Medicaid Fraud Division to for unusual patterns in claim reimbursement from providers and refers findings to the Audit or Investigations Units for further analysis. The reporting tool is also used by other users to identify aberrant billing practices.
NV	Refer the recipient to Welfare for eligibility verification; refer to Board of Pharmacy, or the Program Integrity Unit.
NY	Professional RetroDUR case reviewers refer potential prescriber fraud cases to the DUR program, from which they are forwarded to the Office of the Medicaid Inspector General (OMIG) for further review and/or possible investigation.
OH	SURS
SD	Medicaid Fraud Control Unit
TN	Refer to State of TN's Office of Inspector General, which is the agency that investigates and enforces Tennessee's Doctor Shopping

	and TennCare Enrollee Fraud laws
VA	Java-Server utilization Review System (JSURS) identifies members to review for enrollment in DMAS Client Medical Management Program (Lock-in program).
VT	Referrals made to law enforcement.
WI	The Office of the Inspector General (OIG) has department wide responsibilities for auditing use of department funds in support of the department's commitment to be an effective steward of the public resources DHS is entrusted to manage. OIG, which reports directly to the DHS Secretary, conducts audits of providers who receive department funds, performs internal audits of department programs and operations and investigates allegations of fraud, waste or abuse of DHS resources by contractors, providers and recipients. The OIG is responsible for working with DHS program divisions and partners to develop policies and practices to prevent fraud, waste and abuse.

VIII-A2. Do you have a "lock-in" program?

Answer	State	Number of States (Percentage)
Yes	AK, AL, AR, CA, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, TN, TX, UT, VA, VT, WA, WI, WV, WY	49 (98%)
No	SD	1 (2%)

If the response is "Yes", what criteria does your state use to identify candidates for lock-in? Indicate all that apply:

Answer	State	Number of States (Percentage)
Number of controlled substances (CS)	AK, AL, AR, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, ND, NH, NJ, NV, NY, OH, OK, OR, PA, SC, TN, TX, UT, VA, VT, WA, WI, WV, WY	41 (84%)
Different prescribers of CS	AK, AL, AR, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NV, NY, OH, OK, OR, PA, RI, SC, TN, TX, UT, VA, VT, WA, WI, WV, WY	45 (92%)
Multiple pharmacies	AK, AL, AR, CO, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, ND, NE, NH, NJ, NV, NY, OH, OK, OR, PA, RI, SC, TN, TX, UT, VA, VT, WA, WI, WV, WY	45 (92%)
Number days' supply of CS	AL, AR, CT, GA, IA, ID, KS, LA, MO, MS, ND, NV, NY, OK OR, PA, SC, TX, VT, WI, WV	21 (43%)
Exclusivity of short-acting opioids	GA, IA, KS, MI, NJ, OK, PA, SC, TX, VT, WV	11 (23%)
Multiple ER visits	AK, AL, CO, GA, HI, IA, ID, IN, KS, KY, ME, MN, MO, MS, MT, ND, NE, NH, NJ, NV, NY, OK, OR, PA, TN, TX, UT, VA, VT, WA, WI, WV	32 (65%)
Other	AL, CA, CO, IA, ID, IL, LA, MS, MT, NE, NM, NV, OR, PA, TN, VA, VT, WA, WV	19 (39%)

If the response is "Yes", do you restrict the beneficiary to?

Number of States (Percentage)	Yes	No	Total Number of States
prescriber only	17 (35%)	32 (65%)	**49**
pharmacy only	34 (69%)	15 (31%)	**49**
prescriber and pharmacy	33 (67%)	16 (33%)	**49**

If the response is “Yes”, what is the usual “lock-in” time period?

Answer	State	Number of States (Percentage)
6 months	AK	1 (2%)
12 months	AL, AR, CT, DC, FL, HI, IL, MA, MI, MS, MT, NC, NH, RI, UT, WV, WY	17 (35%)
Other	CA, CO, DE, GA, IA, ID, IN, KS, KY, LA, MD, ME, MN, MO, ND, NE, NJ, NM, NV, NY, OH, OK, OR, PA, TN, TX, VA, VT, WA, WI	31 (63%)

If the answer to above is "Other," please explain:

State	Explanation
CA	Two years according to 22 CCR§ 50793
CO	Usually the time is 12 months when someone gets locked in. Currently, Colorado is having some system issues that limit the lock-in capability. This will be fixed by our new MMIS implementation in November 2016.
DE	A client is locked in indefinitely. Lock-in removals can be requested by a client after one year, and it will then be re-evaluated.
GA	2 years
IA	24 months or longer
ID	24 Months
IN	2 years, and then re-evaluation for graduation or re-enrollment.
KS	2 years
KY	Initial Lock-In is for 24 months; annual reviews of member history/claims thereafter.
LA	24 months
MD	24 months
ME	Varies on severity and also dependent of review of urinalysis and medical charts.
MN	24 months
MO	Participant is locked in for a period of 24 months of eligibility.
ND	Until a subsequent review shows that they are properly utilizing services and their lock-in doctor agrees they should be removed from the lock-in program.
NE	Each patient enrolled in the Lock-In Program is evaluated every 24 months for necessity of Lock-in status.
NJ	Time period is decided on a case by case basis.
NM	Time period is determined on a case by case basis.
NV	Indefinite
NY	Two years for the first offense. Thereafter, for a continuation (due to continued abuse or overuse while restriction/lock-in still in place) or re-restriction/lock-in, the second term would be three years, and the third time or more would be six years.
OH	18 months
OK	24 months for new lock-in referrals, then reviewed yearly.
OR	18 months
PA	5 years as approved by CMS in 1985 audit of PA's Lock-In Program.
SC	Minimum two years initially, with periodic evaluation thereafter, at least annually.
TN	There is no time limit. 50 enrollees are re-reviewed each month for removal criteria. Also, in January each year, all enrollees who are locked into a pharmacy are queried, and those who appear to qualify are re-reviewed, giving each enrollee at least one chance per year to have the lock-in edit removed. Only exception is the enrollees who are locked into a pharmacy and subject to Prior Authorization status for all controlled substances, because of a prior conviction for TennCare Fraud or Doctor Shopping. These enrollees are never removed from the lock-in edit per TennCare Rules.
TX	First lock-in is 36 months; second lock-in is 60 months; third lock-in is lifetime. If convicted of felony, the first lock-in could be lifetime.
VA	36 months for the initial and continued lock-in period. Regulations are being promulgated to change the initial lock-in period to 24 months and the continued lock-in period to 12 months.
VT	2 years

VIII-A5. Do you have a documented process in place that identifies possible fraud or abuse of controlled drugs by prescribers?

Answer	State	Number of States (Percentage)
Yes	AL, AR, CA, CO, DC, DE, FL, GA, IA, IL, IN, KS, KY, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NJ, NM, NY, OH, OK, PA, RI, SC, SD, TN, UT, VA, VT, WA, WV, WY	39 (78%)
No	AK, CT, HI, ID, LA, MN, NH, NV, OR, TX, WI	11 (22%)

If the response is "Yes", what actions does this process initiate? Indicate all that apply:

Answer	State	Number of States (Percentage)
Deny claims written by this prescriber	CA, DC, GA, IN, KY, ME, MO, NJ, SC, TN, VT, WA, WV	13 (33%)
Refer to Program Integrity Unit	AL, AR, CA, CO, DC, DE, FL, GA, IA, IL, IN, KS, KY, MA, MD, ME, MI, MO, MS, MT, NC, ND, NJ, NM, NY, OK, PA, RI, SC, SD, TN, UT, VA, VT, WA, WV, WY	37 (95%)
Refer to the appropriate Medical Board	AL, AR, CO, DC, DE, GA, IA, IL, IN, KS, KY, MA, MD, ME, MI, MO, MS, MT, NC, ND, NJ, NM, OK, PA, SD, TN, VT, WA, WY	29 (74%)
Other - please explain:	AL, CA, GA, IL, KS, MA, MD, MI, MO, MS, MT, NC, NE, NM, NY, PA, TN, VT, WA	19 (49%)

If the response to above is "Other", please explain:

State	Explanation
AL	Refer to MFCU if necessary
CA	Propose new policy such as quantity restrictions, and further review by A&I (IB) Medical Review Branch (MRB).
GA	Referral to Office of Inspector General
IL	Also report to the Illinois Department of Financial and Professional Regulation, which issues professional licenses.
KS	Referrals are sometimes made to the Attorney General's Office.
MA	Refer to PDMP
MD	SURS, OIG, CDSIU
MI	Prescribers may be suspended from the program sanctioned and prescriptions from the prescriber would then be denied at POS.
MO	DUR Board review of provider/patient cases.
MS	Refer to DEA
MT	Referral to Medicaid Fraud Control Unit.
NC	An audit of particular claims would be performed.
NE	Program Integrity Unit is reviewing reports produced through the data warehouse of outliers for further review.
NM	Human Service Department (HSD) is allowed to impose monetary or non-monetary sanctions against any provider with misconduct. Sanctions may include prior approval before delivering services, education program, and suspension from participation and/or termination from participation in program.
NY	Professional RetroDUR case reviewers refer potential prescriber fraud cases to the DUR program, from which they are forwarded to the Office of the Medicaid Inspector General (OMIG) for further review and/or possible investigation.
PA	MFCS
TN	Refer to the DUR Board, who has the final vote on whether prescriptions are blocked from the provider.

VIII-A6. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by pharmacy providers?

Answer	State	Number of States (Percentage)
Yes	AR, CA, CO, DC, DE, FL, GA, IA, IL, IN, KS, KY, LA, MA, ME, MI, MO, MS, MT, NC, ND, NE, NJ, NM, NY, OK, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WV, WY	38 (76%)
No	AK, AL, CT, HI, ID, MD, MN, NH, NV, OH, OR, WI	12 (24%)

If the response is "Yes", what actions does this process initiate? Indicate all that apply:

Answer	State	Number of States (Percentage)
Deny claim	DC, FL, GA, IN, KY, LA, ME, MO, NJ, PA, TN, VT, WA	13 (34%)
Refer to Program Integrity Unit	AR, CA, CO, DC, DE, FL, GA, IA, IL, IN, KS, KY, MA, ME, MI, MO, MS, MT, NC, ND, NJ, NM, NY, OK, PA, RI, SC, SD, TN, UT, VA, VT, WA, WV, WY	35 (92%)
Refer to Board of Pharmacy	AR, CO, DC, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MS, NC, ND, NJ, NM, OK, PA, SD, TN, VT, WA, WV	25 (66%)
Other - please explain:	CA, GA, IL, IN, KS, KY, MI, MO, MS, MT, NC, NE, NY, TN, TX, WA	17 (45%)

If the response to above is "Other", please explain:

State	Explanation
CA	Propose new policy such as quantity restrictions, and further review by A&I (IB) Medical Review Branch (MRB).
GA	Referral to Office of Inspector General
IL	Report to the Illinois Department of Financial and Professional Regulation, which issues professional licenses.
IN	Audit recoupment, Prepayment review program
KS	Referrals are sometimes made to the Attorney General's Office
KY	Desk Audits
MI	Pharmacy providers may be suspended from the program sanctioned and prescriptions from the prescriber would then be denied at POS
MO	DUR Board review of provider/patient cases.
MS	Refer to Mississippi Attorney General's Medicaid Fraud Control Unit
MT	Medicaid Fraud Control Unit
NC	An audit of particular claims
NE	Program Integrity Unit is reviewing reports produced through the data warehouse of outliers for further review.
NY	Professional RetroDUR case reviewers refer potential prescriber fraud cases to the DUR program, from which they are forwarded to the Office of the Medicaid Inspector General (OMIG) for further review and/or possible investigation.
TN	TennCare would also terminate the pharmacy's provider contract if fraud is found. We did not take this type of action in FFY 2014.
TX	Priority Audit/ Fraud Investigation: The regional pharmacist submits a request for a priority audit for a provider that appears to be deviating from program policy. When the regional pharmacist discovers, or computerized program management reports indicate possible deviation from the standards for participation, he requests a priority audit by OIG. The regional pharmacist requests a fraud investigation when he discovers a provider's pharmaceutical practice may be in violation of the ethics adopted by the profession. Routine consultation visits, special assignments, computer reports, or continued complaints may cause the regional pharmacist to be aware of situations requiring priority audit/fraud investigation referrals. The regional pharmacist should submit a detailed written request for priority audit/fraud investigation referrals to
VT	Refer to Medicaid Fraud & Residential Abuse Unit (MFRAU)
WA	Actions above are selected on a case by case basis. All are not necessarily applicable to each pharmacy sanctioned.

VIII B. PRESCRPTION DRUG MONITORING PROGRAM (PDMP)

VIII-B1. Does your state have a Prescription Drug Monitoring Program (PDMP)?

Answer	State	Number of States (Percentage)
Yes	AK, AL, AR, CA, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	49 (98%)
No	MO	1 (2%)

If the response is “Yes”, does your agency have the ability to query the state's PDMP database?

Answer	State	Number of States (Percentage)
Yes	AL, CA, DE, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MS, MT, NC, ND, NV, OH, OK, SC, SD, TN, VT, WA, WV	27 (55%)
No	AK, AR, CO, CT, DC, FL, GA, HI, IA, NE, NH, NJ, NM, NY, OR, PA, RI, TX, UT, VA, WI, WY	22 (45%)

If the response is “Yes”, do you require prescribers (in your provider agreement with the agency) to access the PDMP patient history before prescribing restricted substances?

Answer	State	Number of States (Percentage)
Yes	DE, KS, KY, MA, NY, TN, VT, WV	8 (16%)
No	AK, AL, AR, CA, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, LA, MD, ME, MI, MN, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TX, UT, VA, WA, WI, WY	41 (84%)

If the response is "Yes", please explain how the state applies this information to control fraud and abuse.

State	Explanation
AR	The answer above to question 59 was not "yes", it was "no". The pharmacy program does not have access to the data and even if criteria "required" prescribers to check the PDMP, the pharmacy program cannot request the data from the prescriber and has no way to check if it was done. This question is non-applicable.
CA	The California Department of Justice has a Prescription Drug Monitoring Program (PDMP) system called The Controlled Substance Utilization Review and Evaluation System (CURES), which allows pre-registered users including licensed healthcare prescribers eligible to prescribe controlled substances, pharmacists authorized to dispense controlled substances, law enforcement, and regulatory boards to access timely patient controlled substance history information. Access to such information helps prescribers and pharmacists better evaluate their patients’ care, allowing them to make better prescribing and dispensing decisions, and cut down on prescription drug abuse in California. A&I (IB) uses all available information to develop and work cases, initiates audits, and assists in investigations. A&I (IB) examines PDMP information on prescribers, dispensers, and beneficiaries during the course of A&I’s usual work
DC	The District's PDMP is slated for implementation in FY16 although the legislation was passed in FY13.
DE	Since many controlled substances in our state require prior authorization, one of the questions on each prior authorization form asks the provider to verify that they checked the PDMP. These forms could be used later if there are issues around the provider's prescribing.
FL	Prescribers and dispensing pharmacists are encouraged to check PDMP. Pharmacies are required to upload dispensing records. Medicaid Program Integrity can access PDMP
GA	The state does not have access to the PDMP database.
IA	The state is unable to access this data. The PMP is only available to authorized health care practitioners (prescribers & pharmacists) to review their patients' use of controlled substances.
ID	The clinical staff at IDHW will access the PDMP in cases where it is brought to their attention if fraud/abuse is thought to be occurring. The PDMP is also accessed in RetroDUR topics that may require its usefulness in conducting the review.
IL	In adjudicating claims, staff checks PDMP to help with pertinent approvals or denials. Helps identify potential patients for narc edit. Require for Suboxone requests to ensure not filling controlled substances along with Suboxone.
IN	INSPECT Program
KS	We incorporated this into our Long-Acting Opioids criteria during FFY 2014
KY	Prescribers must attest to the fact that the PDMP has been consulted before certain drugs are approved.
LA	The additional data accessed through PDMP assists the DHH pharmacy staff in determining fraud and abuse.
MA	Database is available to prescribers on a per patient basis.
MD	We are not sure to which question the answer "yes" applies.
ME	It is suggested for review prior to prescribing but not a requirement.
MN	SURS unit has limited access in the case of a recipient under investigation for fraud and abuse.
MS	Use to review Suboxone beneficiaries for use of opioids.
MT	N/A
NC	For treatment of opioid dependence, prescribers are required to access the PDMP patient history before a PA will be granted.
ND	The answer was no
NE	Nebraska Medicaid does not have the legal authority to access PDMP data. The data that is available is incomplete, as patients may opt out. Pharmacies are not mandatorily reporting data.
NH	Answer was no, so this question is not applicable
NJ	Before issuing a prescription or dispensing a prescribed drug, qualified prescribers and pharmacists who have registered to use the

	NJPMP are able to access the NJPMP website and request the CDS and HGH prescription history of the patient. When prescribers or pharmacists identify a patient as potentially having an issue of concern regarding drug use, they are encouraged to help the patient locate assistance and take any other action the prescriber or pharmacist deems appropriate.
NV	Used for lock-in and monitoring reported cases from the community.
NY	In NYS, all prescribers writing a prescription for a Schedule II-IV controlled substance have a mandatory duty to consult the Prescription Monitoring Program Registry, with limited exceptions. The mandatory duty to consult the PDMP provision affords practitioners with current, patient-specific controlled substance prescription information intended to inform the practitioner of controlled substance utilization by their patient at the point of prescribing.
OK	N/A
PA	The current PDMP is housed in the Attorney General's office to be used by law enforcement only.
SD	Evaluate the information available to control fraud and abuse.
TN	We require that the prescriber attest that they have checked the Controlled Substance Database (PDMP) as part of the P.A. process for Long Acting Opiates and buprenorphine-containing addiction treatment drug product.
TX	This is managed by the Texas Department of Public Safety
VA	The agency does not have access and cannot use this information to control fraud and abuse.
VT	Vermont providers are required to register for the VPMS and are mandated to use it in the following circumstances. 1. At least annually for patients who are receiving ongoing treatment with an opioid Schedule II, III, or IV controlled substance; 2. When starting a patient on a Schedule II, III, or IV controlled substance for non-palliative long-term pain th3. The first time the provider prescribes an opioid Schedule II, III, or IV controlled substance written to treat chronic pain; and 4. Prior to writing a replacement prescription for a Schedule II, III, or IV controlled substance. 5. In the future, the Department of Health may promulgate rules that require health care practitioners to check the VPMS in additional circumstances Querying the VPMS allows a provider to see if a patient has been seeing multiple providers and/or prescribed large quantities of controlled substances. Mandatory registration and rules as to when a provider is mandated to use the VPMS helps to detour fraud and abuse. Therapy of 90 days or more;
WA	The state actively encourages, but does not require prescribers to access PDMP data. The state analyzes aggregate PDMP data on a regular basis to identify inappropriate utilization that may not be apparent from its own claim data alone (i.e. cash payments).
WV	We require that all prescribers access the PDMP before prescribing buprenorphine. This prevents prescribing in cases where members are obtaining benzodiazepines or opioids and results in savings for the program.
WY	The Department of Health and DUR staff has very minimal access to the PDMP. It is only applied to clinical management of lock-in patients.

If the response is "Yes", do you also have access to the border states' PDMP information?

Answer	State	Number of States (Percentage)
Yes	CT, ID, IL, IN, KS, KY, MI, OH, TN	9 (18%)
No	AK, AL, AR, CA, CO, DC, DE, FL, GA, HI, IA, LA, MA, MD, ME, MN, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OK, OR, PA, RI, SC, SD, TX, UT, VA, VT, WA, WI, WV, WY	40 (82%)

VIII-B2. Are there barriers that hinder the agency from fully accessing the PDMP that prevent the program from being utilized the way it was intended to be used to curb abuse?

Answer	State	Number of States (Percentage)
Yes	AK, AL, AR, CA, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, MA, MI, MN, NC, NE, NH, NJ, NM, NV, OK, OR, PA, RI, SC, TN, TX, UT, VA, VT, WI, WY	38 (76%)
No	DE, KY, LA, MD, ME, MO, MS, MT, ND, NY, OH, SD, WA, WV	12 (28%)

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

State	Explanation
AK	Barriers include lag time in prescription data being submitted which contributes to prescribers and pharmacy providers not having timely access to necessary information, low utilization by prescribers, inability of agency to query, thus unable to identify recipients paying cash for controlled substances.
AL	PDMP State Law prohibited Medicaid access. Prescriber/Pharmacy not accessing prior to filling/dispensing prescriptions.
AR	The AR Medicaid Pharmacy Program does not have access to the Prescription Monitoring Program (PMP) and cannot use the program for monitoring suspected fraud and abuse cases in the Medicaid Pharmacy Program. Any suspected beneficiary fraud and abuse cases will be handled in the same manner as in the past, which is to turn over

	any suspected cases to the Medicaid Fraud Investigation unit who has access to the PMP.
CA	Enrollment by California€™s prescribers and pharmacists has experienced some delays due to restructuring of the CURES program under the Department of Justice and state budgetary restrictions. Funds have been secured for personnel and upgrades to the system, but these funds will not be released until the 2015-2016 state fiscal year.
CO	We are prohibited by state legislation from accessing the PDMP data. Patient privacy issues were cited as the reason for not granting us access.
CT	There is a lag time up to a month with the data being submitted by pharmacies and when it is posted. Another barrier is blocked access to the PDMP system for DSS pharmacy operations unit employees and both DUR and MMIS contractors. Program Integrity can only view if they have an active case open on that beneficiary.
DC	Implementation of the District's PDMP is scheduled for FY15. It is not possible to report on barriers to access at this time.
FL	Legislatively prohibited from accessing PDMP unless doing actual prescribing or dispensing; not allowed to access for investigative purposes otherwise
GA	No funding, legal concerns about who can access the data.
HI	Only providers with provider numbers have access.
IA	Currently, only authorized health care practitioners (prescribers and pharmacists) are able to access the PMP information regarding their patients' use of controlled substances.
ID	Lag time in prescription data being submitted. Prescribers not accessing. Washington and Oregon - our major border states do not use.
IL	Need to view one patient at a time and re-enter data if checking neighboring state. Not all pharmacies submit data in a timely manner as evidenced by claims filled, but not visible in PDMP. Not all prescribers access prior to writing prescription.
IN	Lag time in prescription data being submitted, prescribers not accessing, pharmacists not accessing before filling script.
KS	Medicaid only has Administrative Access, which means the administrator of our PDMP has to release reports to us (as opposed to having full, real-time access).
MA	No aggregate queries and no access to border states' data.
MI	There is some lag time in prescription data being submitted, prescribers are not required by State law or Medicaid policy (yet) to access and review prior to writing a prescription. Our program is continuing discussions for more querying privileges of the PDMP database to more proactively identify potential fraud, waste, abuse of controlled substance medications.
MN	At DHS, SURS can access only for unique recipients under investigation. PDMP cannot be accessed for purpose of DUR. Pharmacy policy & Health Plan staff can't access.
NC	Many pharmacies restricted internet access, payer source not identified, lag time in data submitted.
NE	Medicaid does not have legal authority to access information. Data is incomplete, as patients may opt out. Pharmacies are not mandatorily reporting data.
NH	Legislation did not allow agency access.
NJ	Access to PDMP is controlled by each individual State and for what purpose. Currently, NJ PMP grants access to prescribers and pharmacists who are licensed by the State of New Jersey and in good standing with their respective licensing boards. Licensed pharmacy staff conducting DUR is considered unauthorized users since they are not directly delivering healthcare.
NM	Access is granted to appropriate authorities.
NV	Limited access by some health care professionals.
OK	The agency has very limited access to the PMP. Access cannot be granted to contractors who perform lock-in functions. The agency may only query one member data at a time. There is no way to access aggregated prescriber data.
OR	Payers do not have access to PDMP for our State.
PA	The current PDMP is housed in the Attorney General's office to be used by law enforcement only. Dispensing and prescribing providers do not have access to the PDMP.
RI	State law requires the user of the PDMP must have a DEA number.
SC	Prescribers not accessing the database, prescriptions paid by cash, lag in data submission (all three are currently being addressed).
TN	Cannot access the raw data, and cannot efficiently pull data for multiple patients to query against TennCare paid claims and medical data.
TX	DPS does not allow access to the agency.
UT	Utah Medicaid is limited by State Statute in how it can use data from the PDMP. Utah Medicaid can access the Utah Controlled Substance Database but pharmacy managed care providers cannot. Legislation has been proposed. Lag time also limits its usefulness.
VA	Agency does not have access to PDMP.
VT	1. Currently, the VPMS has legislation enacted to enter into a reciprocal agreement with border state. The VPMS is waiting for the vendor to provide an enhancement that will allow this to occur. 2. Although the VA is supposed to begin reporting to the VPMS, we are still waiting for this to happen in Vermont. Until then, we are missing a huge part of a critical population.
WI	Managed by a different agency.
WY	The legislation creating the PDMP in Wyoming does not allow for use by payers for general purposes.

VIII C. Pain Management Controls

VIII-C1. Does your state or your agency require that Pain Management providers be certified?

Answer	State	Number of States (Percentage)
Yes	MS, OH, SC, TN, TX, WV	6 (12%)
No	AK, AL, AR, CA, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OK, OR, PA, RI, SD, UT, VA, VT, WA, WI, WY	44 (88%)

VIII-C2. Does your program obtain the DEA Active Controlled Substance Registrant's File in order to identify prescribers not authorized to prescribe controlled drugs?

Answer	State	Number of States (Percentage)
Yes	AL, CT, HI, IA, ID, IN, MA, MI, MO, ND, NH, SC, WA, WV	14 (28%)
No	AK, AR, CA, CO, DC, DE, FL, GA, IL, KS, KY, LA, MD, ME, MN, MS, MT, NC, NE, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SD, TN, TX, UT, VA, VT , WI, WY	36 (72%)

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

Answer	State	Number of States (Percentage)
Yes	AL, CT, HI, IA, MA, MI, MO, ND, SC, WA, WV	11 (79%)
No	ID, IN, NH	3 (21%)

If the response is "Yes", please explain how the information is applied.

State	Explanation
AL	Claims are denied for controlled drugs written by a provider not on the DEA file.
CT	The information is applied at point of sale.
HI	We have not had any claims needing to be edited since 2010 due to the population demographics that FFS now covers.
IA	Claims are blocked at the point of sale for prescribers not authorized to prescribe controlled drugs.
MA	DEA Active Controlled Substance Registrant's File is entered into Pharmacy On Line Processing System
MI	The POS system has business rules that check for XDEA license eligible prescribers of office-based opioid dependency drug therapies
MO	If DEA is inactive or restricted, claims for controlled substances are denied POS.
ND	If no active DEA, claims for controlled substances are denied.
SC	Claims for unauthorized prescribers/invalid DEA are denied
WA	Association of DEA number to NPI number is required in for Schedule II drugs to be payable.
WV	If prescribers have an NPI that is has been excluded from prescribing controlled substances, the claim for that NPI does not pay.

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

Answer	State	Number of States (Percentage)
Yes		0 (0%)
No	ID, IN, NH	3 (100%)

VIII-C3. Do you apply this DEA file to your RetroDUR reviews?

Answer	State	Number of States (Percentage)
Yes	MI, NH, WA	3 (6%)
No	AK, AL, AR, CA, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, K, KY, LA, MA, MD, ME, MN, MO, MS, MT, NC, ND, NE, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WI, WV, WY	47 (94%)

If the response is "Yes", please explain how it is applied:

State	Explanation
MI	Our vendor's Retro-DUR system loads the DEA registrant file and can be queried for reports as needed, including prescribers without a valid DEA but prescribing controlled substances, etc.
NH	Used to identify prescribers not authorized to prescribe controlled drugs.
WA	DEA number is used to cross link/ associate multiple NPIs in order to analyze aggregate prescribing by a single individual and/ or clinic.

VIII-C4. Do you have measures in place to either monitor or manage the prescribing of methadone for pain management? If the response is "Yes", indicate all that apply:

Answer	State	Number of States (Percentage)
Pharmacist override	KY, MO, OH, PA	4 (9%)
Deny claim and require PA	AK, DC, DE, IN, KS, MO, NC, NJ, NM, OR, TN, VA, VT, WV	14 (31%)
Quantity limits	AK, AL, CA, DC, DE, FL, GA, ID, KS, LA, MA, ME, MI, MN, MO, MS, NC, ND, NY, OH, OK, OR, PA, SD, TN, TX, UT, VT	28 (62%)
Intervention letters	CO, CT, IA, IL, MD, MI, MT, NH, RI, SC, TN, WA, WI	13 (29%)

VIII D. OPIOIDS

VIII-D1. Do you currently have POS edits in place to limit the quantity of short-acting opioids?

Answer	State	Number of States (Percentage)
Yes	AK, AL, AR, CA, CO, DC, DE, FL, GA, IA, ID, IL, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NV, NY, OH, OK, OR, PA, SD, TN, TX, UT, VA, VT, WI, WV	42 (84%)
No	CT, HI, IN, NM, RI, SC, WA, WY	8 (16%)

If the response is “Yes”, what are your limitations?

Answer	State	Number of States (Percentage)
30 day supply	AK, AL, DC, FL, IA, ID, KY, MN, NC, NE, NH, NV, OK, SD, VA, VT, WI	17 (41%)
90 day supply	NY	1 (2%)
Other, please explain	AR, CA, CO, DE, GA, IL, KS, LA, MA, MD, ME, MI, MO, MS, MT, ND, NJ, OH, OR, PA, TN, TX, UT, WV	24 (57%)

Other, please explain:

State	Explanation
AR	Oral short-acting opioid agents have a daily quantity limit of 6 units per day, and a rolling accumulation quantity limit of 124 units per rolling 31 days. The system will add together all oral short-acting pain medications and if an incoming claim will exceed the 124 unit limit per rolling 31 days, the incoming claim will deny at point-of-sale. In addition, there is a therapeutic duplication limit that will only allow 1 short-acting pain medication with overlapping days' supply. This therapeutic duplication edit includes all short-acting pain medications (oral agents (including tramadol), transmucosal agents, injectable agents, and nasal spray agents). Only beneficiaries with a diagnosis in Medicaid history of malignant cancer can receive more than 1 short-acting opioid at a time. In addition, if beneficiary filled a buprenorphine agent, subsequent opioid medications will reject for the following 2 months.
CA	Short-acting opioids have an established maximum quantity per dispensing and a maximum of three (3) dispensings within any 75-day period.
CO	120 units per 30 days
DE	Delaware's limitations are 120 tablets per 30 days and 720 tablets per year. The expectations are for all clients with a chronic condition to be managed on two breakthrough tablets a day.
GA	30 day supply and 5 opioid fills per 30 days
IL	Only 1 short and 1 long-acting opioid allowed at a time - 186/30 days for multiple fills - Patients flagged via the Four Prescription Policy with first request receive short-term approval if appropriate. If have used opioids 3 or more months, must fill
KS	Driven by drug-specific individual quantity limits
LA	120 units per rolling 30 days for most short-acting opiates.
MA	Dose limits, Polypharmacy edits, Quantity limits
MD	Some opioids are limited by the number of dosage units per day and are included in the listing of all quantity limits at this link: https:mmcp.dhmh.maryland.gove/pap/docs/QL.pdf
ME	57 day limits before requiring a PA for continuation
MI	34 days supply with specific quantity limits on certain long acting narcotics such as fentanyl patches and ER oxycodone
MO	Quantity limits are based on the FDA approved maximum for each product.
MS	30 day supply for most agents, smaller and cumulative limits for selected agents
MT	We limit immediate release oxycodone to 8 tablets per day, and no more than 240 per month.
ND	Limit qty/day on all of them and that qty varies by drug and strength
NJ	Initial prescriptions are limited to a 34 day supply.
OH	34 days supply and dose per day limits
OR	120 morphine equivalents per day
PA	The quantity is based on dose/day limits. Additionally, recipients are limited to 4 short-acting and/or long-acting opioid prescriptions per month.
TN	Without PA, allow 1200mg per month of short-acting oxycodone and hydrocodone products, and 400mg per month of S.A. hydromorphone.
TX	Maximum quantity limits are set based on the controlled substance schedule. As well as the Opiate Overutilization clinical criteria, which checks for the number of different opiate medications prescribed within the last 60 days which may vary depending on the diagnosis of cancer or chronic non-malignant pain.
UT	180 tabs/caps per 30 days, regardless of strength(s).
WV	30 day supply: 120 units per 30 days, except for members with a diagnosis of cancer

VIII-D2. Do you currently have POS edits in place to limit the quantity of long-acting opioids?

Answer	State	Number of States (Percentage)
Yes	AK, AL, AR, CA, CO, DC, DE, FL, GA, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NV, NY, OH, OK, OR, PA, SC, SD, TN, TX, UT, VA, VT, WA, WV	43 (86%)
No	CT, HI, NJ, NM, RI, WI, WY	7 (14%)

If the response is "Yes", what are your limitations?

Answer	State	Number of States (Percentage)
30 day supply	AK, AL, DC, FL, IA, ID, KY, NC, NE, NH, OK, SD, VA	13 (30%)
90 day supply		0 (0%)
Other, please explain	AR, CA, CO, DE, GA, IL, IN, KS, LA, MA, MD, ME, MI, MN, MO, MS, MT, ND, NV, NY, OH, OR, PA, SC, TN, TX, UT, VT, WA, WV	30 (70%)

Other, please explain:

State	Explanation
AR	AR Medicaid has dose-optimization edits in place for all of the lower strengths of all long-acting opioid agents. For example if an agent is indicated for twice a day dosing, all lower strengths of that drug are limited to 2 units per day and an accumulation quantity of 62 per 31 days' supply. The single highest strength for the long-acting opioid agent does not have a quantity limitation in order to allow for those beneficiaries who may need high doses (e.g., malignant cancer patients). In addition, there is a therapeutic duplication edit that only allows beneficiaries to have one long-acting opioid at a time.
CA	Long-acting opioids have an established maximum quantity per dispensing and a maximum of three (3) dispensings within any 75-day period.
CO	These drugs are a part of the PDL, and so many claims hit for prior authorization. Also, we have quantity limits on some non-preferred products.
DE	All long-acting opioid require prior authorization. They are authorized for 6 months and then prescriber must follow up with progress and pain evaluation.
GA	30 day supply and 5 opioid fills per 30 days
IL	Only 1 short and 1 long-acting opioid allowed at a time - Patients flagged via the Four Prescription Policy with first request receive short-term approval if appropriate. If have used opioids 3 or more months, must fill out pain management program forms with medical justification and if approved, at approval expiration, must justify medical need for continued therapy.
IN	Quantity limits placed on certain long-acting opioid products for a maximum quantity of each agent per month.
KS	Driven by drug-specific individual quantity limits
LA	60 units per 30 rolling days for most long-acting opiates.
MA	Dose limits, Polypharmacy edits, Quantity limits.
MD	Some opioids are limited by the number of dosage units per day and are included in the listing of all quantity limits at this link: https:mmcp.dhmh.maryland.gove/pap/docs/QL.pdf
ME	Same as short acting opioids.
MI	34 days supply with specific quantity limits on certain long acting narcotics such as fentanyl patches and ER oxycodone.
MN	OxyContin is on PA. New formulations are always on PA until reviewed. Quantity limits on most but not all.
MO	Quantity limits are based on the FDA approved maximum for each product.
MS	30 day supply for most agents, smaller and cumulative limits for selected agents
MT	One or two per day depending on the formulation.
ND	Limit qty/day on all of them and that qty varies by drug and strength
NV	Qty limits specific to product.
NY	Point of service edit for any long acting opioid prescription for opioid patients. Absence of evidence of recent opioid use in patient's claim history or medical history will require prescriber involvement. Exemption for diagnosis of cancer or sickle cell disease. Point of service edit for any additional long acting opioid prescription for

	patients currently on long acting opioid therapy. Override will require prescriber involvement. Exemption for diagnosis of cancer or sickle cell disease.
OH	34 days supply and dose per day limits
OR	120 morphine equivalents per day
PA	The quantity is based on dose/day limits. Additionally, recipients are limited to 4 short-acting and/or long-acting opioid prescriptions per month.
SC	Two concomitant agents should not be approved, as well as 30 day supply on specified long acting agents
TN	PA required if used BID for a QD product or TID for a BID product, etc. Also PA required if the dosage form is non-preferred, or if the morphine equivalent dose is over 100mg.
TX	Maximum quantity limits are set based on the controlled substance schedule. As well as the Opiate Overutilization clinical criteria, which checks for the number of different opiate medications prescribed within the last 60 days which may vary depending on the diagnosis of cancer or chronic non-malignant pain.
UT	900 tabs/caps per 30 days, regardless of strength(s).
VT	30 day supply and daily quantity limits
WA	Dosing frequency limited to FDA indicated dosing schedule (QD, q12h, etc...)
WV	30 day supply and limit of FDA approved maximum dose at FDA approved interval.

VIII E. MORPHINE EQUIVALENT DAILY DOSE (MEDD)

VIII-E1. Have you set recommended maximum morphine equivalent daily dose measures?

Answer	State	Number of States (Percentage)
Yes	CO, DE, KS, MA, ME, MI, NC, OR, WA	9 (18%)
No	AK, AL, AR, CA, CT, DC, FL, GA, HI, IA, ID, IL, IN, KY, LA, MD, MN, MO, MS, MT, ND, NE, NH, NJ, NM, NV, NY, OH, OK, PA, RI, SC, SD, TN, TX, UT, VA, VT, WI, WV, WY	41 (82%)

If the response is "Yes", indicate the recommended maximum mg per day:

CO	DE	KS	MA	ME	MI	NC	OR	WA
300	120	200	240	30	30	750	120	120

VIII-E2. Do you provide information to your prescribers on how to calculate the morphine equivalent daily dosage?

Answer	State	Number of States (Percentage)
Yes	AR, CO, DC, ID, MA, ME, MI, NC, OR, TN, WA	11 (22%)
No	AK, AL, CA, CT, DE, FL, GA, HI, IA, IL, IN, KS, KY, LA, MD, MN, MO, MS, MT, ND, NE, NH, NJ, NM, NV, NY, OH, OK, PA, RI, SC, SD, TX, UT, VA, VT, WI, WV, WY	39 (78%)

If the response is "Yes", how is the information disseminated?

Answer	State	Number of States (Percentage)
Website	AR, CO, DC, MA, NC, OR	6 (55%)
Provider notice	ME	1 (9%)
Educational seminars		0 (0%)
Other, please explain	ID, MI, TN, WA	4 (36%)

Other, please explain:

State	Explanation
TN	Have listed the conversions on our Long Acting Opioid PA form
MI	Provider notices and the information was sent as a quantity limit via soft POS edit message and later coded as a hard denial. Oxycodone 20mg, oxycodone 30mg and meperidine 100mg require PA for any quantity
ID	Targeted letters to prescribers based on RetroDUR activities
WA	Website, and Washington State Agency Medical Director's Guidelines

VIII-E3. Do you have an algorithm in your POS system that alerts the pharmacy provider that the morphine equivalent daily dose prescribed has been exceeded?

Answer	State	Number of States (Percentage)
Yes	KS, MA, ME, MI, NC, NY, OR, SC	8 (16%)
No	AK, AL, AR, CA, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KY, LA, MD, MN, MO, MS, MT, ND, NE, NH, NJ, NM, NV, OH, OK, PA, RI, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	42 (84%)

VIII F. BUPRENORPHINE

VIII-F1. Does your agency set mg per day limits on the use of buprenorphine?

Answer	State	Number of States (Percentage)
Yes	AK, AL, AR, CA CO, CT, DC, DE, FL, GA, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NV, NY, OH, OK, OR, PA, TN, UT, VA, VT, WA, WV, WY	43 (86%)
No	HI, NM, RI, SC, SD, TX, WI	7 (14%)

If the response is "Yes", please specify the total mg/day?

Answer	State	Number of States (Percentage)
12mg	PA	1 (2%)
16mg	DC, GA, IL, IN, ME, MT, NV, VA, VT	9 (21%)
other, please explain	AK, AL, AR, CA, CO, CT, DE, FL, IA, ID, KS, KY, LA, MA, MD, MI, MN, MO, MS, NC, ND, NE, NH, NJ, NY, OH, OK, OR, TN, UT, WA, WV, WY	33 (77%)

Other, please explain:

State	Explanation
AK	24mg
AL	All buprenorphine, brand and generic, require prior authorization. Dosages above 32 mg/day are not approved.
AR	not to exceed 24 mg
CA	During FFY 2014, buprenorphine was dispensed only with an approved Treatment Authorization Request.
CO	24mg
CT	An Informational Alert is set at point of sale for any buprenorphine prescription that exceeds 24 mg per day.
DE	12mg daily max in maintenance phase
FL	24 mg
IA	24mg/day for maximum of 3 months

ID	24mg, based on Product Package Insert
KS	24 mg
KY	24 mg
LA	24mg/day
MA	32mg / day
MD	32mg, however changed in 1 QTR of 2015 to 24mg.
MI	24mg
MN	24mg
MO	The first 180 days are limited to 32mg/day. After 180 days dose is limited to 16mg/day.
MS	Step-down therapy; up to 24mg 1 month, up to 16mg 4 months, up to 8mg months 6-24.
NC	24
ND	24mg
NE	24 mg
NH	24mg
NJ	24 mg for opioid dependence
NY	Maximum daily dosage on 8 mg. units is 24 mg.
OH	24 mg/day
OK	24mg
OR	24mg
TN	16mg/day for the first 6 months of therapy, and then 8mg/day afterwards.
UT	42mg (Suboxone), 17.1mg (Zubsolv)
WA	24mg/ day
WV	24 mg/day for a sixty day induction period which is limited to once in a lifetime and then 16 mg/day or less for maintenance therapy.
WY	24 mg

VIII-F2. What are your limitations on the allowable length of treatment?

Answer	State	Number of States (Percentage)
6 months	GA	1 (2%)
12 months	IL	1 (2%)
no limit	AK, AL, CO, CT, DC, FL, HI, IA, ID, KS, KY, MA, MD, MN, MO, NC, ND, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TX, VT, WI, WV	33 (66%)
other, please explain	AR, CA, DE, IN, LA, ME, MI, MS, MT, NE, TN, UT, VA, WA, WY	15 (30%)

Other, please explain:

State	Explanation
AR	2 years
CA	During FFY 2014, buprenorphine was dispensed only with an approved Treatment Authorization Request
DE	2 year limit. Client can be referred to MAOTP if therapy is still necessary to continue.
IN	Buprenorphine/naloxone prior authorizations are granted every 6 months with a maximum 34-day supply if all criteria are met. Buprenorphine prior authorizations are granted for a 34-day supply if all criteria are met.
LA	3 months
ME	2 years
MI	12 month with option for renewal
MS	Step-down therapy; up to 24mg 1 month, up to 16mg 4 months, up to 8mg months 6-24
MT	24 months
NE	6 months for initial treatment, with an option to renew for 6 additional months if medically necessary.
TN	In FFY 2014, there was not a limit on length of treatment, a new lifetime limit of 2 years therapy has been approved by

	the Governor and State Legislature to be implemented in late 2015.
UT	18mo initial approval, 18mo reauthorization, then additional requests would be denied (recipient has the right to appeal).
VA	Approved for 3 months
WA	6 months with possible extension to 12 months depending on progress
WY	2 years

VIII-F3. Do you require that the maximum mg per day allowable be reduced after a set period of time?

Answer	State	Number of States (Percentage)
Yes	DE, FL, IA, LA, ME, MI, MO, MS, MT, TN, UT	11 (22%)
No	AK, AL, AR, CA, CO, CT, DC, GA, HI, ID, IL, IN, KS, KY, MA, MD, MN, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TX, VA, VT, WA, WI, WV, WY	39 (78%)

If the response is "Yes", what is your reduced (maintenance) dosage?

Answer	State	Number of States (Percentage)
8mg	FL, MS, TN	3 (27%)
12mg	DE	1 (9%)
other, please explain	IA, LA, ME, MI, MO, MT, UT	7 (64%)

Other, please explain:

State	Explanation
LA	16mg/day
IA	16mg/day or less
MO	After 180 days dose is limited to 16mg/day.
MT	After the first month max is 16 mg
ME	look at reductions over time at any type of dose reduction
UT	No set dose, they just have to be tapering off.
MI	Tapering is required based on individual plan of care

VIII-F4. What are your limitations on the allowable length of treatment?

Answer	State	Number of States (Percentage)
6 months	GA	1 (2%)
12 months	KS	1 (2%)
no limit	AK, AL, CO, CT, DC, FL, HI, IA, ID, KY, LA, MA, MD, MN, MO, NC, ND, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, VT, WI, WV	34 (68%)
other, please explain	AR, CA, DE, IL, IN, ME, MI, MS, MT, NE, UT, VA, WA, WY	14 (28%)

Other, please explain:

State	Explanation
AR	2 years. This is a duplicate question to VIII-F2
CA	During FFY 2014, buprenorphine was dispensed only with an approved Treatment Authorization Request
DE	2 years
IL	Case by case review for treatment extension requests beyond 12 months.
IN	Buprenorphine/naloxone prior authorizations are granted every 6 months with a maximum 34-day supply if all criteria are met. Buprenorphine prior authorizations are granted for a 34-day supply if all criteria are met.
ME	indicated above
MI	12 months with option for renewal
MS	Cumulative maximum of 24 months with 1 restart
MT	24 months
NE	6 months for initial treatment, with an option to renew for 6 additional months if medically necessary.
UT	18mo initial approval, 18mo reauthorization, then additional requests would be denied (recipient has the right to appeal).
VA	3-month authorizations may be repeated as needed.
WA	6 months which may be extended to 12 months depending on progress
WY	2 years

VIII-F5. Do you limit the type of dosage form that can be dispensed to only the **sublingual film**?

Answer	State	Number of States (Percentage)
Yes	ME, MO, MT, OH, VT, WI , WV, WY	8 (16%)
No	AK, AL, AR, CA, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, MI, MN, MS, NC, ND, NE, NH, NJ, NM, NV, NY, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, WA	42 (84%)

VIII G. PSYCHOTROPIC DRUGS/STIMULANTS

VIII-G1. Do you have a documented program in place to either manage or monitor the appropriate use of psychotropic drugs in children?

Answer	State	Number of States (Percentage)
Yes	AK, AL, AR, CA, CO, CT, DC, DE, FL, GA, ID, IL, IN, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, NE, NJ, NV, NY, OH, OK, OR, PA, RI, SC, SD, TX, VA, VT, WA, WI, WV, WY	41 (82%)
No	HI, IA, KS, MN, ND, NH, NM, TN, UT	9 (18%)

If the response is "Yes", indicate which group/groups is/are either managed or monitored:

Answer	State	Number of States (Percentage)
only children in foster care	SD	1 (2%)
all children	AK, AL, AR, CA, CO, CT, DE, FL, GA, ID, IN, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NJ, NV, NY, OK, OR, PA, RI, SC, UT, VA, VT, WA, WY	36 (88%)
other, please explain	IL, TX, WI, WV	4 (10%)

Other, please explain:

State	Explanation
IL	Prior authorization is required for all children through age 17 who have DCFS as their guardian (foster kids and those in protective custody); all children less than 6 years of age who are prescribed stimulants; all children less than 8 years of age who are prescribed atypical antipsychotic medications; adults or children prescribed long-acting atypical antipsychotics; and all long-term care residents prescribed antipsychotic medications.
TX	Children and adults
WI	7 years of age or younger for antipsychotics.
WV	A prior authorization is required for children up to six (6) years of age

If the response is "Yes", please briefly explain the specifics of your program(s):

State	Explanation
AK	Atypical antipsychotics for children less than 5 years old require PA. Therapeutic duplication edits in place.
AL	Prior authorization is required for all antipsychotics (generic, atypical and typical). Prescriptions written by psychiatrists and prescriptions for FDA-approved diagnoses are processed through electronic PA at the point-of-sale. Medical justification is required for antipsychotic polytherapy. Metabolic monitoring is required for children < 6 years of age using antipsychotics and must be indicated on PA request form.
AR	AR Medicaid requires all prescribers to submit a signed informed consent form for all new antipsychotic drug requests for all children less than 18 years of age. In addition, metabolic labs for fasting glucose and lipid panel are required every 6 months. All requests for children less than 6 years of age are a manual review by a child psychiatrist who works for the AR Medicaid Pharmacy Program. There are specific dose limits for each antipsychotic agent for four age groups: less than 6 yrs, 6-9 yrs, 10-12 yrs, and 13-17 yrs. Therapeutic duplication edits prevent more than one agent at a time from being dispensed. Any dose requests for higher than the limit, any requests for addition of 2nd agent, or any requests for a long-acting antipsychotic injectable agent require a manual review and approval from the child psychiatrist in the pharmacy program.
CA	The use of antipsychotics for Medi-Cal beneficiaries under 6 years of age requires treatment authorization approval and the use of antipsychotics for Medi-Cal beneficiaries aged 6 through 17 is restricted to use of one antipsychotic, except during titration period. Within this age group, concurrent use of two or more antipsychotics requires treatment authorization approval. In addition, DHCS Pharmacy Benefits Division, DHCS Behavioral Health Division, and California Department of Social Services (CDSS) continue to collaborate on a Quality Improvement Project entitled, "Improve Psychotropic Medication Use for Children and Youth in Foster Care." • The purpose of this program is to reduce the rate of antipsychotic polypharmacy, improve the rate of compliance with age-specific antipsychotic dose recommended guidelines, and improve the rate of children and youth in foster care with at least one psychotropic medication who have an annual metabolic risk assessment. The goals are to reduce polypharmacy to 15%, achieve 80% rate for both, compliance with dosing guidelines and annual metabolic risk assessment.
CO	Atypical antipsychotics (AAP) require a manual review of any prescription for children less than 5 years old. All AAPs are restricted to FDA approved ages. Anything outside requires a manual review. Retrospective DUR analysis focuses regularly on psychotropic utilization issues in children.
CT	HID performs 1,000 Retro DUR reviews for the pediatric population each month and the majority of the criteria used to review the pediatric population have to do with mental health drugs. An additional program exists and is administered by the Department of Children and Families for children in foster care only. The Psychotropic Medication Advisory Committee (PMAC) oversee the use of psychotropic medications in the foster care population and have specific edits, maximum doses, monitoring guidelines, etc. associated with prescribing of these medications. Some of the criteria used for the pediatric Retro DUR program have been adopted from the PMAC criteria.
DC	The District Psychotropic Monitoring Group (PMG) was formed under an information sharing MOA with the Dept of Behavioral Health and the Child and Family Services Agency to monitor the prescription of psychotropic medications to children/youth in foster care. PMG reviews cases for clinical appropriateness of 1) prescribing psychotropic medication in foster children 4 years of age or younger 2) prescribing 4 or more psychotropic medications to foster children/youth of any age.
DE	All psychotropic drugs have age limits on them. Prior authorization is required if a doctor prescribes for a client below that age.
FL	A spike in prescribing antipsychotic and psychotherapeutic medications "particularly to young children" by non-specialists, a dearth of research and testing, and reports of adverse physical effects prompted Florida to develop a Second Medical Review process (through prior authorization or PA) for children in Medicaid who are prescribed antipsychotics and antidepressants.. The Second Medical Review performed by a board-certified, child psychiatrist is required for all prescriptions to children under the age of six (6) and in some circumstances for children up to the age of eighteen (18). The Program supports the Agency's responsibility to provide access to medication balanced with measures to promote safety and effectiveness. Currently (July 2015 implementation), plans are underway to include stimulant oversight in children less than 6 years of age through Second Medical review and prior authorization. Since the inception of the Second Medical Review in 2008, fewer antipsychotics are being prescribed to children less than 6 years of age, prescribed doses have decreased, polypharmacy has decreased, and

	antipsychotic safety monitoring practices have significantly improved. Prescribers are now documenting essential monitoring information such as body mass index (BMI), increasing from limited compliance of 11% at the onset (2008) of the PA program, to 98% as of Quarter 1, 2014. Metabolic monitoring and tardive dyskinesia screens were added in 2010, and are now at 98% and 72% compliance respectively.
GA	Use of atypical antipsychotics outside of FDA approved ages and indications require prior authorization.
ID	Through the Red Flag Program
IL	Prior authorization is required for all children through age 17 who have DCFS as their guardian (foster kids and those in protective custody); all children less than 6 years of age who are prescribed stimulants; all children less than 8 years of age who are prescribed atypical antipsychotic medications; adults or children prescribed long-acting atypical antipsychotics; and all long-term care residents prescribed antipsychotic medications.
IN	Antipsychotics require prior authorization when used in duplication, low doses, or when a drug-specific quantity limit has been exceeded.
KY	A diagnosis driven prior authorization is required for all second generation antipsychotics. These products are also limited to a per day maximum dose. These edits apply to both children and adults.
LA	Psychotropic drugs are reviewed in the retrospective DUR program for concurrent use, maximum doses, and non-adherence. Prospective edits address duplication of therapy, quantity limits, and age limits.
MA	Polypharmacy edits for all members, Quantity limits
MD	In October 2011, MMPP established The Peer Review Program (PRP) for Mental Health Drugs which currently reviews antipsychotics. To ensure the safe and appropriate utilization of antipsychotics in the pediatric population, the PR team collaborates with prescribers, providing relevant clinical information when needed. The program initially addressed the use of these medications in Medicaid patients, 4 years old and younger. During fiscal year 2013, all children under the age of 10 years required prior authorization. In January 2014, the program expanded to include all Medicaid youth less than 18 years of age.
ME	PA requirements on age, length of therapy as well as metabolic monitoring
MI	We utilize a program called EnhancedMed which is operationalized through our Magellan contract. It is a monthly academic detailing mailing and face-to-face pharmacy consultant intervention with the most exceptional providers or specific educational topics.
MO	There are several Clinical Edits in place to manage the appropriate utilization of psychotropic medications in children which include an ADHD Therapy Clinical Edit, Atypical Antipsychotic Clinical Edit, SSRI Clinical Edit, SNRI Clinical Edit and a Psychotropic Medication Polypharmacy Clinical Edit. 1.) The ADHD Clinical Edit automatically sends all requests for any FDA approved stimulant/non-stimulant ADHD medication prescribed for any child under the age of 6 years to a Clinical Consultant review and requires documentation to be submitted to perform that review. Documentation required includes a confirmed diagnosis of ADHD using a standardized rating scale such as a Conners or Vanderbilt and requires yearly (at minimum) evaluation. Children ages 6-18 years require an appropriate diagnosis of ADHD and to be dosed within established dosing parameters. Any requests outside of established dosing parameters require a Clinical Consultant review. 2.) The Atypical Antipsychotic, SSRI and SNRI Edits automatically send all requests for any FDA approved Atypical Antipsychotic, SSRI or SNRI medication prescribed for any child under the age of 5 years old to a Clinical Consultant review. Children under the age of 18 require appropriate diagnosis, doses that do not exceed maximum dosing, monotherapy and use of 2 atypical psychotics, SSRI's or SNRI's for no more than 30 days to allow for cross-tapering. 3.) The Psychotropic Medications Polypharmacy Clinical Edit looks to make sure that children under the age of 5 years old are on 3 or less different psychotropic medications simultaneously within a 60 day period and that children 5 years of age and older are on 5 or less different psychotropic medications simultaneously within a 60 day period.
MS	Manual PA requiring prescriber to document age waiver, appropriate diagnosis and benefit outweighs risk
MT	We case manage children in the foster care program and require a PA for all children 6 and under who take atypicals.
NC	In April 2011 the NC Division of Medical Assistance partnered with Community Care of North Carolina to implement a registry to document the use of antipsychotic therapy in NC Medicaid and NC Health Choice beneficiaries ages 0 through 17. The registry named A+KIDS (Antipsychotics Keeping It Documented for Safety) was created due to well documented safety concerns and limited information about the efficacy of using antipsychotic agents in children. The registry encourages the use of appropriate baseline and follow up monitoring parameters to facilitate the safe and effective use of antipsychotics in the population. A+KIDS safety monitoring documentation is requested for an antipsychotic prescribed without a clinical diagnosis corresponding to an FDA approved indication; an antipsychotic prescribed in an amount differing from the FDA approved dosage for that indication; and when the prescribed antipsychotic will result in combination therapy with two or more antipsychotics prescribed outside of a 60 calendar day window allowing for cross titration when converting agents.
NE	Minimum age limits, quantity limits and a review by a board-certified child and adolescent psychiatrist is required for requests outside of label.
NJ	The Department of Children and Families have established a policy that outlines the Department's: Basic principles; Expectations regarding the development and monitoring of treatment plans; Principles for informed consent; and Principles governing medication safety.
NV	All require clinical prior authorization for psychiatric related medications. Foster children are reported monthly for psychiatric medications and diagnosis to state agency.
NY	DUR Board recommended drug-specific minimum age parameters utilized by the FFS program (Automatic bypass for established therapy). FFS diagnosis parameters* for second-generation antipsychotics in the pediatric population.*Diagnosis requirement for the initial prescription for patients between minimum age (as defined by the

	DURB for the FFS population) and 18 years of age.(Automatic bypass for established therapy.)
OH	Please see our pilot program Ohio Minds Matter located at: http://ohiomindsmatter.org/
OK	Educational mailings to prescribers of psychotropic drugs in children particularly when prescribers deviate from evidence based in this patient population.
OR	For foster children, each child is reviewed annually. For non-foster children, children meeting certain "red flags" generate a notice to the provider requesting certain clinical information.
PA	A prescription for either a preferred or non-preferred Antipsychotic regardless of quantity limit when prescribed for a child under 18 years of age requires prior authorization.
RI	HID has specific RDUR criteria that identifies use of Psychotropic Drugs and Stimulants in children. The criteria are monitored monthly during RDUR criteria review. If a reviewer identifies a recipient and he feels it is appropriate an education letter will be sent to the prescriber.
SC	Prior Authorization Criteria in place for Antipsychotics in children=6. Parameters include (but not limited to): Psych assessment, diagnosis, treatment plan, family assessment, duration 6mth/1yr requiring re-review.
SD	Child Protective Services
TX	The HHSC has a clinical prior authorization in place for both the typical and atypical antipsychotics for both adults and the children enrolled in Medicaid. The edit screens for age limits, monotherapy for insomnia or major depressive disorder, and for the concomitant use of more than two different antipsychotics. psychotropic medication utilization review (PMUR) tool developed to assist in identifying members utilizing nine criteria set forth by the 2013 version of the Psychotropic Medication Utilization Parameters for Foster Children created by the Texas Department of Family and Protective Services (DFPS), the Department of State Health Services (DSHS), and the Health and Human Services Commission (HHSC) indicating possible need for review of the child's clinical status. Some of the criteria include: 1) Four (4) or more psychotropic medication prescribed concomitantly. 2) Prescribing of: two (2) or more concomitant stimulants, two (2) or more concomitant alpha agonists, two (2) or more concomitant antidepressants, two (2) or more concomitant antipsychotics, two (2) or more concomitant mood stabilizers. 3) The psychotropic medication dose exceeds usual recommended doses (FDA and/or literature based maximum doses). 4) Psychotropic medications are prescribed for children of very young age including children receiving the following: stimulants " less than three (3) years of age, Alpha Agonists " less than four (4) years of age, Antidepressants " less than four (4) years of age, Antipsychotics " less than four (4) years of age, Mood Stabilizers " less than four (4) years of age 5) Prescribing by primary care provider who has not documented previous specialty training for a diagnosis other than the following (unless recommended by a Psychiatrist consultant): attention Deficit Hyperactive Disorder (ADHD), uncomplicated anxiety disorders, uncomplicated depression. 6) Antipsychotic medication(s) prescribed continuously without appropriate monitoring of glucose and lipids at least every 6 months. 7) Multiple psychotropic medications for a given mental disorder. 8) Inappropriate medication for patient's diagnosed mental disorder. 9) Absence of a thorough assessment of DSM-V diagnosis in the child's medical record. Finally, H.B. 915 of the 2013 83rd Texas Legislature required quarterly report on monitoring psychotropic medication by the HHSC Medicaid Vendor Drug Program and to notify the home state of any child placed in Texas under ICPC when the medication regimen is outside the parameters. The parameters mimic the PMUR parameters listed above.
VA	Service authorizations (SAs) are required for the use of antipsychotics in children under the age of 13 years. See ATT6-2014-VA-PIN for details.
VT	PA required for all antipsychotics. Limited to those with FDA approval for use in children. Certain stimulants require PA and/or quantity limits
WA	The agency, in association with its Pediatric Mental Health Workgroup and DUR Board have set quality review flags in various therapeutic classes including stratified dose by age, therapeutic duplication, and polypharmacy. When review thresholds are surpassed, authorization is required including consultation and recommendation of an agency contracted pediatric psychiatrist. Review thresholds and review process are applied universal across both the Fee-for-Service and Managed Care populations.
WI	Requires Prior Authorization (PA). Child adolescent psychiatrists review and adjudicate PA™s.
WV	WV requires a prior authorization for atypical antipsychotics for children up to six (6) years of age and review by the Medical Director. PA's are limited to six months and glucose levels and proof of monitoring for tardive dyskinesia testing is required for further approval
WY	Children who exceed set parameters (high dose, less than 5 years old, and more than 5 psychotropic medications) are identified and sent for second-opinion review by Seattle Children's Hospital.

If the response is "No", do you plan on implementing a program in the future?

Answer	State	Number of States (Percentage)
Yes	IA, KS, NH	3 (33%)
No	HI, MN, ND, NM, TN, UT	6 (67%)

VIII-G2. Do you have any documented restrictions or special program in place to monitor, manage or control the use of stimulants?

Answer	State	Number of States (Percentage)
Yes	AK, AL, AR, CA, CO, CT, DC, DE, GA, IA, ID, IL, IN, KY, LA, MA, ME, MI, MO, MS, MT, NE, NH, NJ, NM, NV, NY, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	42 (84%)
No	FL, HI, KS, MD, MN, NC, ND, OH	8 (16%)

If the response is "Yes", is your program limited to:

Answer	State	Number of States (Percentage)
children	MT, SC, VA	3 (7%)
adults	DC, GA, IA, NJ, NM, RI, WV	7 (17%)
both	AK, AL, AR, CA, CO, CT, DE, ID, IL, IN, KY, LA, MA, ME, MI, MO, MS, NE, NV, NY, OK, OR, PA, SD, TN, TX, UT, VT, WA, WI, WY	32 (76%)

If the response is "Yes", please briefly explain the specifics of your program(s):

State	Explanation
AK	Quantity limits
AL	Stimulants are included in the Preferred Drug List (PDL) and have maximum quantity limits.
AR	Provigil/Nuvigil are not allowed for use for ADD/ADHD and only allow for 1 unit per day or 31/31 days' supply if other point-of-sale diagnoses criteria are met. For C-II stimulant medications, AR Medicaid has therapeutic duplication edits, daily dose and quantity edits, and maximum monthly quantity limits for children and adults. In addition to those edits, adults require an additional manual review PA (see below). The quantity edits for long-acting C-II stimulants allow for only 1 unit per day or 31 per 31 days' supply. The quantity limit for most short-acting C-II stimulant agents is up to 2 units per day with the exception of methylphenidate 20 mg tablet, which has a quantity edit up to 3 tablets per day or 93 per 31 days' supply. However, if a prescriber writes for a "booster" dose of a short-acting C-II stimulant agent to be given with a long-acting C-II stimulant agent, the short-acting agent is then limited to 1 tablet per day. Therapeutic duplication edits prevent more than 1 short-acting C-II stimulant at a time and prevent more than one long-acting C-II stimulant at a time. In addition, the therapeutic duplication edits prevent a C-II stimulant to be given concurrently with a C-III stimulant. AR Medicaid requires a manual review PA form to be submitted for any adult age 18 years and older if a C-II stimulant is being requested for other than narcolepsy. If the beneficiary has a diagnosis of narcolepsy in Medicaid history in previous 2 years, a claim for a C-II stimulant will pay at point of sale as long as the quantity edits mentioned above and there is no therapeutic duplication with any other C-II or C-III stimulant agent in Medicaid drug profile. The manual review PA criteria for Adult ADD/ADHD for a C-II stimulant are similar to the DSM criteria for diagnosis of ADD/ADHD. A request for a C-II stimulant requires that there must be clinically significant impairment in 2 settings (home, work, or school) and prescriber must supply the work or school information and location, and must have at least 5 ADD or ADHD symptoms. Additionally, the DUR Board approved that for adults the 5 symptoms must all be in either the inattentive subtype or the hyperactive subtype, not mixed.
CA	The use of stimulants for Medi-Cal beneficiaries is restricted to use in Attention Deficit Disorder in individuals from 4 years through 16 years of age only. Any use outside of these restrictions requires treatment authorization approval.
CO	Limitations exist for children less than five years old and some products require verification of appropriate diagnosis and quantity limit.
CT	HID performs 1,000 Retro DUR reviews for the pediatric population each month and the majority of the criteria used to review the pediatric population have to do with mental health drugs, including stimulants. An additional program exists and is administered by the Department of Children and Families for children in foster care only. The Psychotropic Medication Advisory Committee (PMAC) oversee the use of psychotropic medications in the foster care population and have specific edits, maximum doses, monitoring guidelines, etc. associated with prescribing of these medications. Some of the criteria used for the pediatric Retro DUR program have been adopted from the PMAC criteria. Additionally, stimulant use is also reviewed during the monthly Retro DUR adult reviews.
DC	ProDUR edits and clinical criteria are applied to the stimulant drug class to document patient diagnosis, age

	appropriate prescribing, FDA approved product indication and possible therapeutic duplication.
DE	For children and adults, we do have maximum dosages set up for each medication. Exceeding the maximum dosage requires prior authorization. For adults, only long-acting stimulants are covered and the abuse deterrent formulations are our preferred products.
GA	Stimulants require prior authorization for adults.
IA	Require PA for members 21 years of age and older. Documentation diagnosis of ADD/ADHD meets the DSM-V criteria and is confirmed by a standardized rating scale. Symptoms must have been present before 12 years of age and there must be clear evidence of clinically significant impairment in two or more environments (social, academic, or occupational).
ID	All products have Age and Quantity Limits. Adults must have documented diagnosis of ADHD and any Adults with any substance abuse diagnosis cannot receive medication.
IL	All attention deficit hyperactivity medications (ADHD) in children less than 6 years of age require special prior authorization request form. - Medications for ADHD are allowed for clients who are 6 to 18 years of age. Adults require prior authorization for ADHD medications.
IN	Stimulants require prior authorization when used in duplication or when a drug-specific quantity limit has been exceeded.
KY	A diagnosis driven prior authorization is required for all stimulants. These products are also limited to a per day maximum dose. Members are not allowed to take more than one long-acting and one short-acting stimulant concurrently. These edits apply to both children and adults.
LA	Stimulants are reviewed in the retrospective DUR program for stimulant-induced insomnia. Prospective edits include duplication of therapy with stimulants and with narcolepsy agents.
MA	Dose limits, Quantity limits, ADHD Prescriber Education on website
ME	managing daily dose requirements
MI	Prior authorization required for members over the age of 18 and under the age of 6
MO	The ADHD Clinical Edit automatically sends all requests for any FDA approved stimulant/non-stimulant ADHD medication prescribed for any child under the age of 6 years to a Clinical Consultant review and requires documentation to be submitted to perform that review. Documentation required includes a confirmed diagnosis of ADHD using a standardized rating scale such as a Conners or Vanderbilt and requires yearly (at minimum) evaluation. Children ages 6-18 years require an appropriate diagnosis of ADHD and to be dosed within established dosing parameters. For ages 18-23 years requires Clinical Consultant review with an appropriate diagnosis of ADHD and documentation submitted that documents the goals of therapy from the provider. For adults 23 years of age and older requires a Clinical Consultant review with positive diagnosis including childhood onset, clear evidence of clinical symptoms in 2 or more environments which may require diagnostic verification using a standardized rating scale such as an ASRS or ADHD-RS, participants with psychiatric co-morbidities requires a Psychiatric Specialist consult and goals of therapy that is clearly defined by prescriber. Any requests outside of established dosing parameters require a Clinical Consultant review.
MS	Manual PA for appropriate diagnosis and appropriate age
MT	No more than 1 long acting per day,
NE	Non-preferred drugs require review for compliance and doses are monitored.
NH	Prior authorization required for all adults and for non-preferred products for children.
NJ	Prescriptions for stimulants deny and require a PA for adults older than 18 years of age.
NM	Prior Approval Criteria for CNS stimulants: age 19 years of age, diagnosis of attention deficit hyperactivity disorder (ADHD), narcolepsy, and untreated depression, or resistant to treatment by traditional antidepressant therapy. Authorization is for a period of one year for the treatment of narcolepsy, and ADHD. Authorization to treat depression resistant to traditional antidepressant therapy is granted for three months. Authorization is continued for a one year period with physician prescriber documentation of decreased symptoms of depression.
NV	Prior authorization is required for children and adults. Both require a complete evaluation.
NY	Quantity limits for patients less than 18 years of age to include: 1. Short-acting CNS stimulants, not to exceed 3 dosage units daily with a maximum of 90 days per strength (for titration). 2. Long-acting CNS stimulants, not to exceed 1 dosage unit daily with a maximum of 90 days. Quantity limits for patients 18 years of age and older to include: 1. Short-acting CNS stimulants, not to exceed 3 dosage units daily with a maximum of 30 days. 2. Long-acting CNS stimulants, not to exceed 1 dosage unit daily with a maximum of 30 days. 3. Diagnosis requirement for patients age 18 and older requesting greater than a 30-day supply.
OK	Under Age 5-psychiatrist consult, over age-21 must fill out prior authorization.
OR	Doses exceeding quantity limits require prior authorization and prescribing by a specialist.
PA	A prescription for a preferred or a non-preferred Stimulant and Related Agent for a recipient under 4 years of age or for a recipient 18 years of age or older requires prior authorization.
RI	Prior authorization program.
SC	Criteria based on FDA indications and age restrictions.
SD	Quantity limits
TN	Just approved by DUR Board and P&T committee, to be implemented in August of 2015. All adults using stimulants will be subject to PA, and all children under 21 with amphetamine use of greater than 80mg/day will be subject to PA.
TX	HHSC has a clinical prior authorization for all stimulants and non-stimulants used for treatment of ADD/ADHD. The criteria screen for age limits, ADD/ADHD diagnosis codes for adults, concomitant use of two short acting or

	two long acting products, and diagnosis of drug abuse.
UT	We have PA criteria for off-label use in children and for any use in adults.
VA	A clinical edit is used to restrict the use of stimulants to the FDA approved age for each product.
VT	Certain stimulants require PA and/or quantity limits.
WA	For children, stimulants are a subset of the program described in 114. For adults, stimulant medications are limited by diagnosis to appropriate and legal uses, and maximum doses are established which may not be exceeded without prior authorization.
WI	Documented restrictions and special programs: Diagnosis restrictions, allowable diagnoses are ADHD and narcolepsy; Prior Authorization required for non-preferred stimulants on the Preferred Drug List; System edits for early refills that can be overridden in certain circumstances by calling a specialized pharmacy call center; Children's mental health work group has focused on high dose stimulant use. Interventions have included several targeted mailings to prescribers as well as peer to peer outreach from consultant child psychiatrists.
WV	A prior authorization is required for members over 21 years of age. A diagnosis of ADD or ADHD is required and dosage is limited to FDA maximum dosing and dosing intervals.
WY	ADHD medications are limited to approved indication and maximum dosage limits are in place.

IX. INNOVATIVE PRACTICES

The 32 states listed below have initiated innovative practices during the past year. A description of their innovative practice can be found in Attachment 6 of the individual state report: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Medicaid-Drug-Programs-Data-and Resources.html?filterBy=Drug%20Utilization%20Review%20(DUR)

AL, AR, CA, CO, CT, DC, DE, FL, GA, IL, IN, KS, MA, MD, ME, MI, MO, MS, MT, NC, NH, NY, OH, OK, TN, TX, UT, VA, VT, WA, WI, WV

X. E-PRESCRIBING

X-1. Has your State implemented *e-prescribing*?

Answer	State	Number of States (Percentage)
Yes	AL, AR, CT, DC, DE, FL, GA, ID, IN, LA, MA, ME, MI, MN, MO, MT, NH, NM, NV, NY, OH, PA, SC, TX, UT, VT, WV	27 (54%)
No	AK, CA, CO, HI, IA, IL, KS, KY, MD, MS, NC, ND, NE, NJ, OK, OR, RI, SD, TN, VA, WA, WI, WY	23 (46%)

If the response is "No", are you planning to develop this capability?

Answer	State	Number of States (Percentage)
Yes	AK, CA, CO, IA, IL, MD, NC, ND, NJ, OK, SD, WA	12 (52%)
No	HI, KS, KY, MS, NE, OR, RI, TN, VA, WI, WY	11 (48%)

X-2. Does your system use the NCPDP Origin Code that indicates the prescription source?

Answer	State	Number of States (Percentage)
Yes	AR, CT, DC, DE, FL, GA, ID, IN, LA, MA, MI, MO, MT, NH, NM, NV, NY, OH, PA, SC, TX, UT, VT, WV	24 (89%)
No	AL, ME, MN	3 (11%)

X-3. Does your program system (MMIS or pharmacy vendor) have the capability to electronically provide a prescriber, upon inquiry, patient drug history data and pharmacy coverage limitations prior to prescribing?

Answer	State	Number of States (Percentage)
Yes	AL, CT, DE, FL, GA, IN, ME, MI, MN, MO, MT, NH, NM, OH, PA, SC, TX, UT, VT, WV	20 (74%)
No	AR, DC, ID, LA, MA, NV, NY	7 (26%)

a) If the response is "Yes", do you have a methodology to evaluate the effectiveness of providing drug information and medication history prior to prescribing?

Answer	State	Number of States (Percentage)
Yes	CT, DE, FL, MI, MO, NH, SC, TX, UT	9 (45%)
No	AL, GA, IN, ME, MN, MT, NM, OH, PA, VT, WV	11 (55%)

c) If the response is "No", are you planning to develop this capability?

Answer	State	Number of States (Percentage)
Yes	DC, ID, MA, NV	4 (57%)
No	AR, LA, NY	3 (43%)

XI. MANAGED CARE ORGANIZATIONS (MCOs)

XI-1. Is your pharmacy program included in the capitation rate (carved-in)?

Answer	State	Number of States (Percentage)
Yes	FL, IL, KS, KY, LA, MN, MS, ND, NJ, NM, NV, NY, OH, PA, RI, SC, TX, VA, WV	19 (38%)
No	AK, AL, AR, CO, CT, DE, GA, HI, IA, ID, IN, MA, ME, MO, MT, NC, NE, OK, SD, TN, VT, WI, WY	23 (46%)
Partial	CA, DC, MD, MI, NH, OR, UT, WA	8 (16%)

If the response is "Partial", please specify:

State	Explanation
CA	Selected HIV/AIDS treatment drugs, selected alcohol and heroin detoxification and dependency treatment drugs, selected coagulation factors and selected drugs used to treat psychiatric conditions
DC	HIV antiretrovirals
MD	Antiretroviral agents and mental health agents are carved-out of the MCO pharmacy benefit.
MI	Mental Health drugs, Substance Abuse Treatment, Hemophilia Drugs, HIV and selected drugs for rare metabolic diseases
NH	Hepatitis C agents
OR	Mental health drugs are carved out
UT	Buprenorphine/naloxone combination products, antidepressants, anticonvulsants, anxiolytics, sedatives/hypnotics and stimulants are carved-out and managed by fee-for-service Medicaid
WA	Hepatitis C treatment, Hemophilia treatment, Medication Assisted Therapy, Dental prescriptions

XI-2. Does the state set requirements for the MCO's pharmacy benefit?

Answer	State	Number of States (Percentage)
Yes	CA, DC, DE, FL, IL, KS, MA, MD, MI, MN, MO, MS, ND, NH, NJ, NY, OH, PA, RI, SC, TX, UT, WA, WV	24 (48%)
No	AK, AL, AR, CO, CT, GA, HI, IA, ID, IN, KY, LA, ME, MT, NC, NE, NM, NV, OK, OR, SD, TN, VA, VT, WI, WY	26 (52%)

If the response is "Yes", please briefly explain your policy:

State	Explanation
CA	Medi-Cal MCO's are required to provide a pharmacy benefit that is comparable to the Medi-Cal FFS pharmacy program.
DC	Managed care plans create and maintain their own individual formularies but submit them for annual review of covered therapeutic categories, product alternatives and prior authorization requirements.
DE	MCO's are required to cover injectables traditionally given in a physician's office.
FL	Single PDL, clinical edits may not be more restrictive than FFS.
IL	Managed care organizations may have medication edits in place, but may not be more restrictive than HFS. The pharmacy benefit was carved in to the 12 managed care programs by the end of FFY14. HFS Bureau of Pharmacy Services has reviewed the formularies of the managed care organizations for compliance.
KS	State has oversight of virtually all components of pharmacy program. MCOs have ability to implement quantity, gender, diagnosis, age, etc. limitations.

MA	Similar benefits must be offered.
MD	A comprehensive Drug Use Management Program has been in place for several years which evaluates each MCO pharmacy benefits including: P&T Committee procedures; formulary content and management; prior authorization criteria and procedures; generic substitution; drug use review and disease management. A review and assessment of each MCO Drug Use Management program is conducted annually.
MI	The MCO contract requires that the plans formulary include coverage available for all outpatient covered drugs identified on the Fee-For-Service Michigan Pharmaceutical Product List (MPPL).
MN	The MCO contract stated there must be comparable services.
MO	Managed care pharmacy benefits are carved out to the state. All pharmacy benefits are the same as fee for service participants.
MS	Must pay equal or higher reimbursement and must cover same drugs, but can have different preferred drugs.
ND	EHB plus we require specific early refill edits.
NH	MCOs must adhere to State PDL; also all policies must be approved by the State.
NJ	The MCO shall establish and maintain a DUR program that satisfies the minimum requirements for PDUR and RDUR as established in.
NY	Members enrolled in mainstream Medicaid managed care and Family Health Plus (FHP) plans receive pharmacy benefits directly through their MCOs. Members are issued health plan cards by their plans and are instructed to present their card at the pharmacy, rather than their Medicaid card. Network pharmacies submit claims directly to the member's managed care plan. Plans establish their own formularies and prior authorization processes. However, plan formularies must include all categories of prescription drugs on the NYS Medicaid fee-for-service list of reimbursable drugs. Plans are also be required to maintain an internal and external review process for exceptions. Managed care plans administer the enrollment and credentialing of their network providers. Reimbursement rates are set by the plan and/or their Pharmacy Benefit Manager (PBM). Plans are also responsible for managing and auditing their pharmacy networks.
OH	Managed care plans must ensure 80 percent agreement across all the preferred drug lists.
PA	Their contracts outline the coverage of outpatient covered drugs as defined in the Social Security Act as well as oversight requirements for their pharmacy related programs, formularies and prior authorization guidelines.
RI	Prescription must be written by participating MCO prescribers, benefit includes both OTC and prescription with generics first policy.
SC	The MCO may implement a PDL to encourage use of the most cost effective drugs in a class. The PDL must be approved by the P&T prior to implementation. While the MCO may employ a PDL and other mechanisms to promote cost effective , clinically appropriate medication utilization, all FDA approved medications must ultimately be covered except those listed in the Managed Care Policy and Procedure Manual.
TX	HHSC develops the Formulary and the Preferred Drug List (PDL) and requires MCOs to implement both.
UT	MCOs must cover everything that FFS covers. They are contractually able to extend coverage.
WA	Fee-for-Service program has final approval over MCO formularies to ensure comparability of coverage (as compared to the state benchmark plan). The Fee-for-Service program dictates some coverage requirements, formulary content, and limitations in specific mental health drug classes. State provides general oversight of adequacy of pharmacy benefits.
WV	The MCO's follow a state run PDL and follow PA criteria.

If the response is "No" do you plan to set standard in the future?

Answer	State	Number of States (Percentage)
Yes	IA	1 (4%)
No	AK, AL, AR, CO, CT, GA, HI, ID, IN, KY, LA, ME, MT, NC, NE, NM, NV, OK, OR, SD, TN, VA, VT, WI, WY	25 (96%)

XI-3. Does the state require the MCOs to either monitor or report their DUR activities?

Answer	State	Number of States (Percentage)
Yes	CA, DE, KS, MA, MD, MI, NH, NJ, NM, PA, RI, TX, UT, WA	14 (28%)
No	AK, AL, AR, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KY, LA, ME, MN, MO, MS, MT, NC, ND, NE, NV, NY, OH, OK, OR, SC, SD, TN, VA, VT, WI, WV, WY	36 (72%)

If the response is “No”, do you plan to develop a program to monitor or report MCO DUR activities in the future?

Answer	State	Number of States (Percentage)
Yes	DC, IA, IL, KY, ME, MS, NC, ND, OH, SC, WV	12 (33%)
No	AK, AL, AR, CO, CT, FL, GA, HI, ID, IN, MN, MO, MT, NE, NV, NY, OK, OR, SD, TN, VA, VT, WI, WY	24 (67%)

If you have any questions regarding an individual state’s report or for detailed state information, please visit the link:

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Medicaid-Drug-Programs-Data-and-Resources.html?filterBy=Drug%20Utilization%20Review%20(DUR)