Medicaid Drug Utilization Review
State Comparison/Summary Report FFY 2015
Annual Report

Prescription Drug Fee-For-Service Programs

December 2016

Executive Summary of 2015 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 states' 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 at least quarterly examination of claims data to identify patterns of fraud, abuse, gross overuse, or medically unnecessary care and implements corrective action when needed.

On July 1, 2016, the Centers for Medicare & Medicaid Services (CMS) sent the FFY 2015 Medicaid DUR Annual Reporting tool 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 2015 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. Forty states (80%) 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 70% 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 70% to 100%, with an average of 84% 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-three states (86%) report that the Board of Pharmacy has responsibility for monitoring compliance with this requirement.

III. Retrospective DUR (RetroDUR) – Page 10

RetroDUR allows states to examine drug claims to identify patterns of abuse or misuse. These functions reside primarily with a contractor in 37 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 13

All states provided a summary of their DUR Board activities, which can be found in each individual state report. Six states (12%) reported that they 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 15

To date, 11 states (22%) for the Prospective DUR and 20 states (40%) for the Retrospective DUR 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 16

All states reported generic utilization percentages for all covered outpatient drugs reimbursed during the 2015 reporting period. The average percentage generic utilization was 81%, 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 19

Based on states' reported estimates, DUR activities saved on the average about 22% on drug cost savings/cost avoidance compared to the total Medicaid drug spend.

VIII. Fraud, Waste and Abuse Detection – Page 23

A. Lock- In Programs – Page 23

Almost all Medicaid agencies, except Florida and South Dakota, have a Lock-In or Patient Review and Restriction 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. In addition, 23 states (46%) have a documented process in place that identifies potential fraud or misuse of non-controlled drugs by a beneficiary.

Forty states (80%) have a process to identify potential fraudulent practices by prescribers and forty states (80%) 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 30

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 2015, forty-eight states (96%) reported having a PDMP in their state. Twenty-eight states (58%) have some ability to query the PDMP database, while the remaining twenty states (42%) do not have the ability to do so. Only nine states (19%) 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 and DC report to be states that are not implementing a PDMP. While 9 states (19%) report that they also have access to Border States PDMPs, thirty-seven states (77%) 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 **35**

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. Thirty-nine states (78%) reported having measures in place to either monitor or manage the prescribing of methadone for pain management.

D. Opioids – Page 38

Thirty-five states (70%) have edits in place to limit the quantity of short-acting opioids and thirty-nine states (78%) have edits in place to limit the quantity of long-acting opioids.

E. Morphine Equivalent Daily Dose (MEDD) – Page 41

Thirteen states (26%) 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 (22%) report that they give providers information on how to calculate the MEDD.

F. Buprenorphine and Buprenorphine/naloxone combinations – Page 44

Forty-one states (82%) 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. Antipsychotics/Stimulants – Page 47

Forty-one states (82%) have programs in place to either manage or monitor the appropriate use of antipsychotic medications in children. Thirty-eight of these states (93%) monitor all children, not just those children in foster care or a subset of children specified by a young age limit. The 41 states have provided a brief synopsis of the specifics of their programs. Delaware 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-seven states (94%) have restrictions or special programs in place to monitor/control the use of stimulants.

IX. Innovative Practices – Page 54

Thirty-seven states (74%) 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 55

Twenty-one states (42%) 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 56

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]. Thirty-seven states (74%) have MCOs. Twenty-one states (57%) report that prescription coverage is included (carved-in) to the capitation rate. Seventeen states (46%) report the agency sets requirements for the MCO pharmacy benefit. Twenty-eight states (76%) require their MCOs to have a targeted intervention program (i.e. CMC/ Lock-In) for the misuse or abuse of controlled substances. Lastly, only 10 states (27%) require their MCOs to monitor or report their MCO DUR activities.

1. In the Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) published on May 6, 2016, CMS finalized that states require MCOs to 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 program activities to the state on an annual basis.

Comparison/Summary Report FFY 2015

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I. DEMOGRAPHIC INFORMATION

49 States plus DC completed the FFY 2015 Medicaid DUR Annual Report. 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
Change Healthcare	IA*, ME, WY*
Computer Sciences Corporation	NY
CSRA	NC
Goold Health Systems	UT, VT*
Hewlett Packard Enterprise Services	AL, CT, DE, KS, OK, OR*, PA, RI, WI
Magellan	AK, AR,FL, ID, KY, MI, NE, NH, SC, TN
Molina	LA, NJ, WV
OptumRx	GA, IN, NV
Other	N/A
State-operated	IL, MN, ND, SD, WA
Wipro Infocrossing Healthcare Services Inc.	MO
Xerox	CA, CO, DC, HI, MA, MD, MS, MT, NM, OH, TX*, VA

State	Note
*IA	Formerly Goold Health Systems
*OR	Hewlett Packard Enterprise Services operates the POS claims system and Prospective DUR services. Oregon Health Sciences University (OHSU) College of Pharmacy is subcontracted to operate the Retrospective DUR services.
*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.
*VT	Goold Health System/Change Healthcare
*WY	Previously Emdeon

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

Answer	State	Number of States (Percentage)
Yes	AL, CA, CO, CT, DE, HI, KS, LA, MO, MS, MT, NC, NJ, NM, NY, OK, PA, RI, TX, VA, WI, WV	22 (49%)
No	AK, AR, DC, FL, GA, IA, ID, IN, KY, MA, MD, ME, MI, NE, NH, NV, OH, OR, SC, TN, UT, VT, WY	23 (51%)

II-3. Identify the prospective DUR criteria source.

Answer	State	Number of States (Percentage)
First Data Bank	AK, AL, AR, CA, CO, CT, DC, FL, HI, ID, IL, KS, KY, LA, MA, MD, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NY, OH, OK, OR, PA*, RI, SC, SD, TN, TX, VA, WI, WV	40 (80%)
Medi-Span	GA, IA, IN, ME*, NV, UT, VT*, WA, WY	9 (18%)
Other	DE	1 (2 %)

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

State	Explanation
DE	Micromedex
*ME	Medispan, Clinical Literature and other State programs.
*PA	The Prospective DUR criteria used in Pennsylvania comes from both First Data Bank as well as criteria developed by Department staff.
*VT	Medispan FDA Safety Alerts Clinical Literature.

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, MS, MT, NC, NH, NJ, NM, NY, OH, PA, TX, UT, VA, VT, WI, WV, WY	31 (62%)
No	AR, CA, GA, IA, ID, MD, MI, MN, MO, ND, NE, NV, OK, OR, RI, SC, SD, TN, WA	19 (38%)

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

State	Explanation
AR	Pro-DUR criteria are not presented to the DUR Board.
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; however, they do not approve or disapprove any vendor criteria.
MD	Although the DUR Board does not review and approve all new prospective DUR criteria, a summary of prospective DUR alerts is reviewed and discussed at all DUR meetings. Individual criteria may be recommended by the Board for implementation. All new severity level 1 drug intervention criteria is automatically implemented by the point-of-sale (POS) vendor as it becomes available from First Data Bank.

MI	The Michigan Department of Health and Human Services (MDHHS) and the DUR Board reviewed the ProDUR criteria when the First Data Bank (FDB) criteria was first implemented. After that, the Board felt comfortable with the completeness of the FDB criteria.
MN	Informational edits are not reviewed by the DUR Board. High dose or quantity limits edits which cause the claim to reject are reviewed by the DUR Board.
MO	Automatic updates are made from First Databank which are incorporated in our DUR criteria.
ND	The DUR Board meets quarterly so their responsibility is to review all new retrospective DUR criteria.
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	DUR 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 is auto loaded from First Data Bank.
SC	Criteria is primarily provided by FDB (First Data Bank) and not reviewed by the DUR Board. Edits outside of those provided by FDB or existing edits may be reviewed/recommended by the DUR Board, but DHHS would have the final approval.
SD	DUR reviews retrospective claims data
TN	Difficult to review all new ProDUR edits. Custom or non-industry standard criteria are approved by the DUR Board when the
WA	Board has seen issues that arise. Passive automated DUR criteria provided as part of the Medispan drug file as applied by the OptumRx claim processing system which are overridable by pharmacists with the use of submitted DUR codes are not reviewed by the DUR Board. Active DUR criteria in the form of prior authorization requirements (including quantity and dosing limits, step therapy, etc..) applied by the state which are based strictly on the definitions of medically accepted indications are also not reviewed by the DUR Board, as federal rule already requires the state to use medically accepted indications as a standard. The DUR Board reviews those active Prospective DUR criteria which represent predetermined standards which are more stringent than medically accepted indication alone.

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, TX, UT, VA, VT, WA, WI, WV, WY	44 (88%)
No	CO, HI, IA, IL, ME, NJ	6 (12%)

II-6. How often do you receive and review periodic reports providing individual pharmacy provider activity in summary and in detail?

Answer	State	Number of States (Percentage)
Monthly	AL, CT, DC, KY, MA, MS, MT, NC, ND, NE, NH, NM, TX, VA	14 (28%)
Quarterly	AK, DE, GA, HI, MI, NV, NY, OK, OR, SC, VT, WA	12 (24%)
Annually	CA, LA, OH, RI, SD, TN	6 (12%)
Never	AR, CO, FL, IA, ID, IL, IN, KS, MD, ME, MN, MO, NJ, PA, UT, WI, WV, WY	18 (36%)

a) If the answer to II-6 above is “Never”, please explain why you do not receive and review the reports.

State	Explanation
AR	Individual pharmacy reporting on ProDUR edits are not provided for review.
CO	In the current system, there are only a couple of these ProDUR edits set to deny, and the pharmacy must call to obtain a PA. This process may change in the new system.
FL	The Agency for Healthcare Administration (AHCA) Bureau of Pharmacy Policy globally reviews pharmacy provider activity and brings any concerns to the DUR Board. Medicaid Program Integrity (MPI) reviews individual pharmacy providers
IA	We do not allow overrides at the pharmacy level. Individual pharmacy claim activity is reviewed bimonthly, by the top 100 pharmacies by prescription count and top 100 pharmacies by dollar amount. From this, a sampling of pharmacies are then selected for a more detailed review.
ID	The individual pharmacy provider level report is not being generated at this time.
IL	Our current MMIS does not have this capability
IN	The claims processing system has logic in place to determine appropriate pharmacy provider submissions of conflict, intervention, and outcome codes. We continue to evaluate the utility of this type of reporting.
KS	Looking into possibility of receiving reports.
MD	Reports are generated and reviewed adhoc or as necessary.
ME	Current do not allow pharmacies to override conflict interventions as they are soft messaging back to the pharmacies.
MN	We do not have plans to use them. If the concern is large enough, then we require the claim to reject, then it cannot be overridden.
MO	Reports are requested on an as needed basis.
NJ	ProDUR alert messages cannot be overridden by pharmacists.
PA	Pharmacy provider activity is monitored by the Bureau of Program Integrity.
UT	We do not receive regularly scheduled reports, but can request them when needed.
WI	Wisconsin is currently in the process of modifying the DUR alerts. After completion of this work, Wisconsin will need to evaluate and revise the prospective DUR alert reports.
WV	They are received on request.
WY	We have reviewed them in the past and they were not found to be valuable.

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

Answer	State	Number of States (Percentage)
Yes	AK, AL, DC, DE, FL, KY, LA, MA, MD, MI, NC, ND, NM, SD, WV	15 (43%)
No	CA, CT, GA, HI, MS, MT, NE, NH, NV, NY, OH, OK, OR, RI, SC, TN, TX, VA, VT, WA	20 (57%)

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

Answer	State	Number of States (Percentage)
Contact pharmacy	AK, DC, KY, LA, MA, ND, SD, WV	8 (53%)
Refer to Program Integrity for Review	DE, FL, NC	3 (20%)
Other(explain)	AL, MD, MI, NM	4 (27%)

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

State	Explanation
AL	Alabama has an Academic Detailing Program that provides scheduled face-to-face visits to providers.
MD	Any concern related to ProDUR submissions from the individual pharmacy providers is referred to the Maryland Office of Inspector General (OIG).
MI	Contact Pharmacy and Refer to Program Integrity for Review.
NM	These are referred to the Program Policy Bureau Utilization Unit.

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%	70%	90%
Controlled drugs:	50	84%	70%	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%)
Prescriber	ID, MS, NY	3 (9 %)
Either	AK, AL, CO, CT, DC, DE, FL, GA, HI, IL, IN, KY, MA, MD, ME, MO, MT, NM, NV, OH, PA, SC, TN, UT, VA, VT, WV, WY	28 (80%)

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, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	41 (82%)
No	CA, IA, KS, LA, NC, NH, NJ, OR, RI	9 (18%)

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

Answer	State	Number of States (Percentage)
Pharmacist	MN, OK, TX, WA, WI	5 (12%)
Prescriber	CT, DE, FL, HI, ID, IN, MS, NY, PA	9 (22%)
Either	AK, AL, AR, CO, DC, GA, IL, KY, MA, MD, ME, MI, MO, MT, ND, NE, NM, NV, OH, SC, SD,TN, UT, VA, VT, WV, WY	27 (66%)

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	6 (67%)
No	IA, NH, NJ	3 (33%)

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

a) Lost/stolen Rx

Answer	State	Number of States (Percentage)
Yes	CA, KS, LA, MD, MO, NC, NE, NH, NM, OR, RI, SD, WA, WI	14 (28%)
No	AK, AL, 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, 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, SD, WI	11 (22%)
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, TN, TX, UT, VA, VT, WA, WV, WY	39 (78%)

c) Other

Answer	State	Number of States (Percentage)
Yes	AK, AR, CA, DE, KS, LA, ME, MO, NC, ND, NE, NH, NM, OH, OR, SC, SD, WA, WI	19 (38%)
No	AL, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KY, MA, MD, MI, MN, MS, MT, NJ, NV, NY, OK, PA, RI, TN, TX, UT, VA, VT, WV, WY	31 (62%)

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

State	Explanation
AK	Lost/stolen only in the event a police report has been filed and upon coordination/approval from prescriber.
AR	During SFY 2015, pharmacists could override all early refill alerts for any reason for non-controlled drugs. Controlled drugs require a prior approval from the state and approvals are not approved for lost/stolen Rx, vacation, etc. for controlled drugs.
CA	The pharmacist can override the early refill DUR alert message if medically necessary.
DE	Change in directions can have a pharmacist override
KS	Spilled Medications
LA	Other situations may be overridden using the pharmacist's professional judgment.
ME	Nursing Home admissions
MO	All early refill denials require the pharmacist to contact the helpdesk for individual override ach time the edit posts.
NC	Change of Therapy (this is the only override allowed for controlled substances).
ND	Prescription must be 60% utilized. Will make exceptions for seizure medication.
NE	Lost or stolen controlled substances require a prior authorization.
NH	Other early refill options include increased or change in dose, transitioned to nursing home, requires two prescriptions of the same medication, wrong days supply on previous claim.
NM	The pharmacy can override after contacting the State for approval.
OH	Pharmacy may call for an override for early refill for vacation/travel, multiple supplies needed, or lost/stolen/destroyed medications.
OR	Change in therapy, medically necessary, LTC leave are among other accepted clarifications.
SC	Therapeutic duplication may be overridden
SD	Situational
WA	Washington State has two levels of early refill rejections, one of which is a 'hard' edit requiring authorization, the other being a 'soft' DUR edit overridable by pharmacists. 'Soft' early refill edits occur at an ingredient level and are primarily information regarding what a client has filled at other pharmacies than the one submitting the current claim. 'Hard' early refill edits are specific to the particular pharmacy and prescription being filled, and require authorization. Pharmacists can self-authorize some early refill situations. They may use an override for lost or stolen prescriptions once per drug per six month period. Additional instances of loss require an active request of authorization from the state. The state does not allow early refill overrides for vacations. Pharmacists may also self-authorize early refills for situations where separate supplies are needed for separate locations, such as a home supply and a school supply.
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 continuously filling prescriptions early?

Answer	State	Number of States (Percentage)
Yes	AK, AL, FL, GA, ID, IL, IN, KY, LA, ND, NM, NY, OK, RI, SC, WV, WY	17 (34%)
No	AR, CA, CO, CT, DC, DE, HI, IA, KS, MA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NV, OH, OR, PA, SD, TN, TX, UT, VA, VT, WA, WI	33 (66%)

If the answer to II-9 above is “Yes”, please explain your edit.

State	Explanation
AK	Allows for 7 day accumulation over a 120 day look-back period
AL	Claims that exceed, or result in, the accumulation of more than 7 days' worth of medication within a 120-day time period will deny at the point-of-sale (POS).
FL	Certain specific drug classes (examples include proton pump inhibitors, skeletal muscle relaxants) have accumulation limits; all medications have an 80% threshold to prevent early refills
GA	Refill-too-soon edit, which allows patients to only obtain next fill if 75% of previous fill would be completed by that time.
ID	The pharmacy claims system is set to look at a maximum quantity per day as well as it is set up with a rolling accumulation edit to not allow for early refills
IL	Refill too soon carryover days accumulate from month to month
IN	The claims processing system will evaluate the days supply for historical claims against the days supply of new claims. If the new claim's daily dose has increased, the system will calculate the next date of fill automatically based on remaining supply. If

	the new daily dose has not increased, the system will calculate the next date of fill based on the remaining supply from all historical claims.
KY	The system has the capability, KY also utilizes a three (3) day tolerance edit.
LA	We have an accumulation edit on hydrocodone which requires clinical override from our prior authorization center.
ND	Max 15 days accumulation in 180 days for non-controlled. Max 10 days accumulation in 180 days for controlled.
NM	An exception code posts to the pharmacy indicating the date when the medication can be refilled.
NY	The enhanced edit denies a claim if more than a 10 day supply of medication is remaining of the cumulative amount that has been dispensed over the previous 90 days, and will augment current editing where claims are denied when less than 75% of the previously dispensed amount has been used (the more stringent rule will apply). Beneficiaries will still have the ability to refill their prescription(s) early, allowing for ample supply of their medication(s) on hand.
OK	Cumulative early refill edit is triggered when the member has received early fills for the medication in the past 240 days. The combined extra days' supply of the early fills is equal to 110% or more of the days' supply on the current claim being submitted. The edit is set up for stimulant medications only at this time.
RI	Edit allows one original and 5 refills per script.
SC	None
WV	The edit keeps members from getting a thirteen month supply in 12 months by not allowing them to refill their prescriptions early each month, based on the total number of units obtained during a rolling 12-month period.
WY	Scheduled drugs II-V require 90% of the days supply to be used and no more than seven (7) days accumulation over a one hundred eighty (180) day look back period before a refill or new claim for the same medication will be allowed. ï,· All other medications require 80% of the days supply be used and no more than fifteen (15) days of accumulated medication over a one hundred eighty (180) day look back period before a refill or a claim for the same medication will be allowed.

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

Answer	State	Number of States (Percentage)
Yes	AR, CO, DC, DE, MA, MS, MT, NE, SD, VT, WA	11 (33%)
No	CA, CT, HI, IA, KS, MD, ME, MI, MN, MO, NC, NH, NJ, NV, OH, OR, PA, TN, TX, UT, VA, WI	22 (66%)

II-10. Does the state or the state's Board of Pharmacy have any policy prohibiting the auto-refill process that occurs at the POS?

Answer	State	Number of States (Percentage)
Yes	DE, FL, GA, IL, MA, MD, MS, NC, NE, NY, OK, SC, SD, TN, TX, UT, VA, WV, WY	19 (38%)
No	AK, AL, AR, CA, CO, CT, DC, HI, IA, ID, IN, KS, KY, LA, ME, MI, MN, MO, MT, ND, NH, NJ, NM, NV, OH, OR, PA, RI, VT, WA, WI	31 (62%)

II-11. Has the state provided DUR data requested on Table 1 – Top 10 Drug Claims Data reviewed by the DUR Board?

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, OK, OR, SC, SD, TN, TX, UT, VA, VT, WA, WV	45 (90%)
No	OH, PA, RI, WI, WY	5 (10%)

II-12. 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? Check 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	IL, MO, NY	3 (6 %)

If the answer to II-12 above is "Other", please explain:

State	Explanation
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 monitors compliance with the oral counseling requirement.
NY	On-site pharmacy inspections performed by Office of Professional Discipline

II-13. 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, DE, FL, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NM, NV, NY, OH, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, WA, WV	43 (86%)
No	AR, GA, MA, NJ, PA, WI, WY	7 (14%)

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, NY, PA, RI, SC, SD, TN, TX, VA, VT, WI, WV	37 (74%)
Academic institution	CA, CO, IL, MA, MS, NV, OH, OK, OR, UT, WY	11 (22%)
Other organization	NE, WA	2 (4 %)

Organization by Name and Type

Organization	State (* served by more than one organization)
Company	
Change HealthCare	IA, ME, VT*
Goold Health System	VT*
Health Information Design	AL, AR, CT, DE, KS, MD, ND, NY*, PA, RI, SD*, WI, WV
Magellan	AK, FL, ID, KY, MI, NC, NH, SC, TN
Molina Medicaid Solution	LA, NJ
Mountain Pacific Quality Health	MT
NorthStar HealthCare Consulting	GA
OptumRx Administrative Services	IN
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 Medicaid	WA
Goold Health Systems/Change HealthCare	VT*

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

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

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, IL, IN, KS, KY, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NH, NJ, NM, NV, NY, OR, PA, RI, SC, SD, TN, TX, VA, VT, WA, WI, WV, WY	42 (84%)
No	CA, HI, ID, LA, NE, OH, OK, UT	8 (16%)

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	Developed in-house by Hawaii Medicaid.
ID	Medicaid pharmacy program clinical pharmacists develop the Retro-DUR criteria
LA	Retrospective DUR criteria are developed through collaboration of pharmacists at DHH, Molina Medicaid Solutions, and the University of Louisiana-Monroe.
NE	Retrospective DUR criteria are developed jointly by DHHS, the POS vendor and the RetroDUR 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 Retrospective DUR criteria, and Utah Medicaid may or may not accept presented or modified 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, IL, 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, WI, WV	43 (86%)
No	CA, GA, IA, NV, OK, WA, 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	Change Healthcare utilizes MediSpan for retrospective DUR criteria involving a complex screening process.
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 Medi-Span as long as it meets the set parameters.
WA	Washington State Medicaid performs ongoing periodic retrospective review of pharmacy claims at least quarterly to identify areas of clinical concern. In general these activities are performed for the purpose of identifying potential problems for presentation to the DUR Board, prior to the Board's involvement. In most instances these retrospective review results are used by the Board to recommend Prospective DUR interventions, which the State wraps educational components into. It is rare that the board determines the appropriate intervention is Retrospective DUR resulting in outreach to prescribers based specifically on that analysis.
WY	Retrospective reviews are now done in the form of provider reports. A DUR issue is identified and the DUR Contractor determines how to pull the data and present the issue to providers.

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, ND, NY, OK, OR, PA, UT, VT, WA, WY	17 (34%)
No	AK, AL, AR, CO, CT, DE, GA, HI, ID, IL, KS, KY, LA, MD, MI, MN, MS, MT, NC, NE, NH, NJ, NM, NV, OH, RI, SC, SD, TN, TX, VA, WI, WV	33 (66%)

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 (29%)
No	CA, DC, FL, IA, MO, ND, NY, OK, OR, PA, WA, WY	12 (71%)

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 the State Pharmacy Care Management program PCM
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 (current savings calculations are not available).
VT	The Vermont Chronic Initiative has been an evolving, legislatively endorsed effort by the State of Vermont since 2007. The goal is to help Medicaid Members to better manage the chronic conditions.VCCI 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 well-being.

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,	4 (24%)
No	CA, FL, IA, IN, ND, NY, OK, OR, PA, UT, VT, WA, WY	13 (76%)

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

Answer	State	Number of States (Percentage)
Yes	FL, IA, ME, MN, MO, WI	6 (12%)
No	AK, AL, AR, CA, CO, CT, DC, DE, GA, HI, ID, IL, IN, KS, KY, LA, MA, MD, MI, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, 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, ME, MN, MO WI	5 (83 %)

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, ME, MN	4 (67%)

If answer to IV-3 above is "No”, are you planning to develop and implement a program?

Answer	State	Number of States (Percentage)
Yes	CA, CO, DC, ID, IL, MA, MS, ND, OK, SC, TN, TX, VT, WA, WV, WY	16 (36%)
No	AK, AL, AR, CT, DE, GA, HI, IN, KS, KY, LA, MD, MI, MT, NC, NE, NH, NJ, NM, NV, NY, OH, OR, PA, RI, SD, UT, VA	28 (64%)

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.

V-1. Has your MMIS been designed to incorporate this data into your DUR criteria for Prospective DUR?

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

If answer to V-1 above is "No", 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, CO, DC, DE, IA, ID, IL, MS, NC, ND, NH, NV, OR, SD, TX, VA, VT, WV, WY	20 (51%)
No	AL, AR, FL, GA, IN, KS, LA, MD, MN, MT, NE, NM, NY, OH, OK, RI, TN, UT, WI	19 (49%)

V-2. Has your MMIS been designed to incorporate this data into your DUR criteria for Retrospective DUR

Answer	State	Number of States (Percentage)
Yes	AK, CA, CT, FL, HI, KY, LA, MA, ME, MI, MN, MO, ND, NH, NV, PA, SC, SD, VT, WA	20 (40%)
No	AL, AR, CO, DC, DE, GA, IA, ID, IL, IN, KS, MD, MS, MT, NC, NE, NJ, NM, NY, OH, OK, OR, RI, TN, TX, UT, VA, WI, WV, WY	30 (60%)

If answer to V-2 above is "No", do you have a plan to include this information in your DUR criteria in the future?

Answer	State	Number of States (Percentage)
Yes	CO, DC, IA, ID, IL, MS, NC, OR, TX, VA, WY	11 (37%)
No	AL, AR, DE, GA, IN, KS, MD, MT, NE, NJ, NM, NY, OH, OK, RI, TN, UT, WI, WV	19 (63%)

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, OH, OK, OR, PA, SD, TN, TX, UT, VT, WA, WI, WV, WY	41 (82%)
No	DC, FL, HI, KY, LA, NM, RI, SC, VA	9 (18%)

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, CT, DE, IA, ID, IN, KS, MD, MI, MS, NC, ND, NH, NV, SD, WV, WY	19 (46%)
Require medical reason for override accompany prescription	AL, DE, ID, KS, MO, MS, MT, ND, NH, NV, OK, SD, WV	13 (32%)
Preauthorization is required	AK, AL, AR, CO, DE, GA, IA, ID, IL, IN, KS, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NH, NJ, NV, OH, OK, OR, PA, SD, TN, TX, UT, VT, WI, WV, WY	36 (88%)
Other – please explain	AR, CA, CT, ID, ME, MI, NE, NY, WA	9 (22%)

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. 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 DAW1 submitted on electronic prescriptions is acceptable.
ID	Failure of 2 generic products
ME	Maine does not allow DAW 1 for prescriptions as everything is driven by the MaineCare PDL
MI	Selected drug classes determined by the state legislature are exempt from prior authorization
NE	Prescriber must complete an MC-6 Form, which declares that the brand name medication is medically necessary.

NY	On April 26, 2010, New York Medicaid implemented a cost containment initiative which promotes the use of certain multi-source brand name drugs when the cost of the brand name drug is less expensive than the generic equivalent.
WA	Washington Medicaid allows a brand to be dispensed without authorization when prescribed 'Dispense as Written', but will only reimburse the dispensing pharmacy the same amount it would for the generic equivalent. If the pharmacy wishes to receive higher reimbursement for the brand, they must request authorization. When authorization is requested the State contacts the prescriber to review the medical necessity for the branded agent.

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
CA	67%
DC	69%
MS	70%
TX	71%
NJ	74%
CT	75%
FL	75%
NE	75%
VT	75%
NC	76%
NM	77%
LA	77%
MD	78%
ME	78%
MT	79%
DE	79%
AL	79%
MO	79%
WY	80%
WI	80%
SD	80%
ID	80%
AK	80%
OK	81%
CO	81%
UT	81%
MI	81%
IA	81%
TN	82%
IN	82%
MN	82%
ND	82%
NV	82%
OH	83%
GA	83%
NY	83%
IL	83%
WV	83%
RI	84%
KS	85%
NH	85%
AR	85%
MA	86%
WA	87%
OR	88%
VA	88%
SC	89%
PA	90%
KY	91%
HI	95%
Average	**81%**

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	7%
DC	9%
CA	10%
FL	11%
TX	17%
NH	18%
NV	18%
GA	18%
WA	18%
ME	18%
NC	19%
SC	19%
NY	19%
MT	20%
CT	20%
NE	20%
MI	20%
TN	20%
DE	20%
WY	21%
MD	21%
KS	22%
WI	22%
OK	22%
PA	23%
ID	23%
OH	23%
WV	23%
IN	23%
IA	24%
MA	24%
AL	24%
UT	24%
MN	25%
VT	25%
MS	25%
SD	26%
LA	26%
RI	26%
CO	27%
AK	27%
MO	27%
IL	28%
HI	29%
NM	30%
KY	30%
OR	30%
VA	32%
ND	37%
AR	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, DE, 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	49 (98%)
No	HI	1 (2%)

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, FL, GA, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, ND, NE, NH, NJ, NM, NV, NY, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WI, WV	40 (80%)
Academic institution	CA, MA, OK, WY	4 (8%)
Other institution	CO, HI, MD, NC, OH, WA	6 (12%)

Organization Name and Type

Organization	State (* served by more than one organization)
Company	
Change HealthCare	IA, WY*
Goold Health System	IL*, ME, UT*, VT*
Health Information Design	AL, CT*, DE*, KS*, ND, NY*, PA, RI, SD, TX*, WI, WV*
Hewlet Packard Enterprise Services	CT*, DE*, KS*, OR,
Magellan	AK, AR, FL, ID, KY, MI, NE, NH, SC, TN
Minnesota does internally except for RetroDUR	MN
Molina Medicaid Solution	LA, NJ, WV*
Mountain Pacific Quality Health	MT
OptumRx Administrative Services	GA, IN, NV
Xerox	DC, MO, MS, NM, OH*, TX*, VA
Academic Institution	
University of California, San Francisco (UCSF)	CA
University of Cincinnati College of Pharmacy	OH*
University of Massachusetts Medical Center	MA
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	
NYS Dept. of Health calculates ProDUR and Health Information Designs, LLC calculates RetroDUR	NY*
Washington State Medicaid	WA
Goold Health Systems/Change HealthCare	VT*
Molina Healthcare (ProDUR) and Health Information Designs (RetroDUR)	WV*
Pro-DUR is HPE; Retro-DUR is HID	DE*
Prospective DUR cost savings estimate was conducted by HPE. Retrospective DUR cost savings estimate was conducted by HID.	CT*
Xerox Heritage for retroDUR and Health Information Design (HID) for prospective clinical prior authorization edits.	TX*
ProDUR: Xerox State Healthcare, LLC RetroDUR: University of Cincinnati College of Pharmacy	OH*

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	5,670,573	-	-	5,670,573
AL	-	685,960	-	685,960
AR	20,770,350	947,924	51,958,704	73,676,978
CA	217,545,867	-	-	217,545,867
CO	-	-	9,296,892	9,296,892
CT	52,593,853	5,360,342	-	57,954,195
DC	-	1,131,591	-	1,131,591
DE	1,042,000	964,000	-	2,006,000
FL	1,141,675,979	4,688,120	33,641,915	1,180,006,014
GA	65,252,216	-	-	65,252,216
HI	-	-	-	-
IA	-	7,075,103	-	7,075,103
ID	31,637,921	9,564,098	-	41,202,018
IL	-	-	584,464,012	584,464,012
IN	230,390,000	(544)	-	230,390,000
KS	28,928	75,669	-	104,597
KY	32,212,643	443,447	15,920,765	48,576,855
LA	80,058,674	381,446	-	80,440,120
MA	195,743,138	-	3,300,034	199,043,172
MD	34,448,945	(112,065)	-	34,336,880
ME	-	-	81,403,455	81,403,455
MI	300,339,874	499,395	-	300,839,269
MN	41,232,465	1,864,822	-	43,097,287
MO	43,204,537	162,735	-	43,367,272
MS	20,296,837	-	-	20,296,837
MT	114,747,275	412,127	29,413,819	144,573,221
NC	455,100,000	179,000	54,942,137	510,221,137
ND	-	478,818	-	478,818
NE	5,689,493	250,492	22,120	5,962,106
NH	4,190,017	497,406	1,663,776	6,351,199
NJ	12,713,684	-	-	12,713,684
NM	2,390,241	2,775	-	2,393,016
NV	113,773,859	-	-	113,773,859
NY	29,746,674	2,105,819	-	31,852,493
OH	42,251,307	175,826	-	42,427,133
OK	130,238,851	161,989	(3,943,846)	126,456,994
OR	67,163	-	-	67,163

PA	-	712,766	-	712,766
RI	3,229,449	917,301	-	4,146,750
SC	6,780,518	630,125	-	7,410,643
SD	-	69,641	-	69,641
TN	23,983,102	1,392,391	532,814	25,908,307
TX	46,932,428	10,195,383	-	57,127,810
UT	14,761,510	393,739	-	15,155,249
VA	18,842,740	580,251	5,905,421	25,328,412
VT	2,671,024	-	6,402,362	9,073,386
WA	30,865,099	-	15,179,826	46,044,925
WI	-	802,354	-	802,354
WV	38,650,360	1,385,369	90,969	40,126,698
WY	20,463,895	1,029,082	-	21,492,977
Average	**74,127,214**	**1,122,094**	**17,803,904**	**91,570,678**

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%
SD	0%
WI	0%
OR	0%
AL	1%
DC	1%
ND	1%
PA	1%
CO	1%
IA	2%
DE	3%
NE	3%
TN	3%
MO	3%
NY	4%
KS	5%
VT	5%
NJ	5%
CT	5%
MD	6%
CA	6%
AK	7%
SC	7%
MS	8%
TX	8%
NM	9%
WV	10%
OH	10%
GA	10%
UT	11%
MN	18%
AR	23%
ID	23%
WA	24%
VA	25%
OK	26%
IN	28%
RI	29%
NC	30%
LA	32%
MI	32%

ME	34%
MA	34%
NH	39%
WY	45%
NV	50%
KY	63%
IL	83%
MT	120%
FL	183%
Average	**22%**

VII-5. State is providing the Medicaid Cost Savings/Cost Avoidance Evaluation as Attachment 5 "Cost Savings/Cost Avoidance Methodology".

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, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	49 (98%)
No	HI	1 (2%)

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, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	50 (100%)
No		0 (0%)

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	CO, CT, DC, DE, FL, GA, ID, IL, IN, KY, MA, MD, ME, MI, MO, MT, ND, NE, NJ, OR, SC, TN, TX, UT, VT, WV	26 (52%)
Refer to lock-in program	AK, AL, AR, CO, CT, DC, DE, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NJ, NM, NV, OH, OK, OR, RI, SC, TN, TX, UT, VA, VT, WA, WI, WV, WY	43 (86%)
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, NV, OK, PA, RI, SC, SD, UT, VA, VT, WV, WY	34 (68%)
Other (e.g. SURS, Office of Inspector General)	AK, AL, CA, GA, IN, KY, MD, MI, MN, MS, MT, NC, NH, NJ, NY, OH, PA, SD, TN, UT, VA, VT, WI	23 (46%)

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

State	Explanation
AK	SURS, MFCU
AL	Refer to MFCU if necessary.
CA	22CCR 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.
GA	Referral to Office of Inspector General
IN	Submit to FSSA Bureau of Investigation for member investigation
KY	When possible fraud or abuse is detected, the information is shared with the KY Board of Pharmacy as well as the Commonwealth's audit vendor for further research/investigation.
MD	SURS, OIG, CDSIU
MI	The Office of Inspector General performs SURS for both providers and beneficiaries.
MN	Questionable utilization is referred to the SURS program and they determine the action from there.
MS	Depends on situation. Could refer to Mississippi Attorney General's Medicaid Fraud Control Unit
MT	Following a Fraud review of a member and the determination that the member is doing something illegal, we refer the member to 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.
NH	The Program Integrity Unit performs this function and maintains the lock-in program.
NJ	A Surveillance and Utilization Review (SURS) reporting tool is used by the Data Mining Unit within the Medicaid Fraud Division to look 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.

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
PA	Refer to OIG for criminal investigation.
SD	Medicaid Fraud Control Unit
TN	Those enrollees who fit the criteria for the State of TN for Doctor Shopping are referred to the State's Office of Inspector General, which is the agency that investigates and enforces TN's Doctor Shopping and TennCare enrollee fraud laws.
UT	Medicaid Fraud Control Unit (MFCU)
VA	Java-Server Utilization Review System (JSURS) identifies member to review for Enrollment in DMAS Client Medical Management Program (lock0in program).
VT	referrals made to law enforcement
WI	The Office of the Inspector General (OIG) has department wide responsibility for auditing the use of department funds in support of the department's commitment to be an effective steward of the public resources DHS is instructed to manage. OIG, which reports directly to the DSH Secretary, conducts audits of providers who receive department funds, performs internal audits of department programs and operations and investigates allegations of fraud, waste and abuse of DHS resources by contractors, providers and members. OIG is responsible for working with DHS programs, divisions and partners to develop policies and practices to prevent fraud, waste and abuse.

VIII-A2. Do you have a "lock-in" program for beneficiaries who misuse or abuse controlled substances?

Answer	State	Number of States (Percentage)
Yes	AK, AL, AR, CA, CO, CT, DC, DE, 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	48 (96%)
No	FL, SD	2 (4 %)

If answer to VIII-A2 above is “Yes”, what criteria does your state use to identify candidates for lock-in? Check all that apply:

Answer	State	Number of States (Percentage)
Number of controlled substances (CS)	AK, AL, AR, CA, DC, DE, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, NC, ND, NH, NJ, NM, NV, NY, OH, OK, OR, PA, SC, TN, TX, VA, VT, WA, WI, WV, WY	41 (85%)
Different prescribers of CS	AK, AL, AR, CA, CO, DC, DE, 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	47 (98%)
Multiple pharmacies	AK, AL, AR, CA, DE, 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	44 (92%)
Number days’ supply of CS	AL, AR, CA, CT, GA, IA, KS, LA, MD, MO, MS, ND, NM, NY, OK OR, PA, SC, TX, VT, WI, WV	22 (46%)
Exclusivity of short-acting opioids	AR, CA, GA, IA, KS, NM, NY, OK, PA, SC, TX, VT	12 (25%)
Multiple ER visits	AK, AL, CA, CO, GA, IA, ID, IN, KS, KY, ME, MI, MN, MO, MS, MT, ND, NE, NH, NJ, NY, OK, OR, PA, TN, UT, VA, VT, WA, WI, WV	31 (65%)
Other	AL, CA, CT, IA, IL, IN, LA, MI, MS, NE, NV, OR, PA, TN, UT, VA, VT, WA	18 (38%)

If answer to VIII-A2 above is “Yes”, do you restrict the beneficiary to?

Answer	State	Number of States (Percentage)
prescriber only		0 (0 %)
pharmacy only	AR, CO, CT, DC, DE, MD, NH, NJ, NV, OR, RI, SC, TN, WV, WY	15 (31%)
Both prescriber and pharmacy	AK, AL, CA, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, ME, MI, MN, MO, MS, MT, NC, ND, NE, NM, NY, OH, OK, PA, TX, UT, VA, VT, WA, WI	33 (69%)

If answer to VIII-A2 above is “Yes”, what is the usual “lock-in” time period?

Answer	State	Number of States (Percentage)
6 months	AK	1 (2%)
12 months	AL, CT, DC, ID, IL, MA, MS, MT, NC, NH, RI, WV, WY	13 (27%)
Other	AR, CA, CO, DE, GA, HI, IA, IN, KS, KY, LA, MD, ME, MI, MN, MO, ND, NE, NJ, NM, NV, NY, OH, OK, OR, PA, SC, TN, TX, UT, VA, VT, WA, WI	34 (71%)

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

State	Explanation
AR	Re-review after 12 months to determine the need of continued lock-in; if lock-in was "for cause" and requested by the Medicaid Pharmacy Program, e.g., an adult filling his/her controlled drugs on the child's Medicaid ID number, beneficiary will remain locked-in until approved by the state to unlock from the pharmacy.
CA	Two years according to 22CCR 50793.
CO	This program is still being re-designed. Currently, members are identified as potential over-utilizers and referred to or enrolled in care coordination. We are in the process of finalizing the "lock-in" portion of the program.
DE	Lock-in does not have an end-date, but can be reviewed at the client's request.
GA	9-12 months
HI	There has been no usual "lock-in" time period since 2009 when ABD moved into managed care in 2009. No one has been "lock-in" since 2009.
IA	24 months or longer
IN	2 years, and then re-evaluation for graduation or re-enrollment.
KS	2 years
KY	The Commonwealth of Kentucky has a twenty-four (24) month initial lock-in period, followed by annual review of member's claims for appropriateness of continuance in the lock-in program.
LA	24 months
MD	24 months
ME	Varies on the severity and also dependent of review of urinalysis and medical charts
MI	2 years
MN	24 months
MO	Participants are locked in for a period of 24 months of eligibility
ND	Until a subsequent review shows that the patient is properly utilizing services and their lock-in doctor agrees the patient 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	Case by case situations
NV	Indefinite, we do not have a process for review to remove from lock-in.
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 2 years initially, with periodic evaluation, at least annually.
TN	Indefinite. All enrollees are given at least one chance per year to be unlocked.

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.
UT	Open-ended, reviewed after 12 months
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
WA	Clients are placed on 'lock-in' for three years. Periodic interim reviews are performed which may release them earlier.
WI	2 years.

VIII-A3. On the average, what percentage of the FFS population is in lock-in status annually?

State	Percentage of the FFS population in lock-in status annually
CO	0%
HI	0%
KY	0%
MO	0.00%
NH	0%
NM	0%
OH	0%
OR	0%
AR	0.01%
TX	0.01%
WY	0.01%
LA	0.02%
SC	0.02%
AL	0.04%
IL	0.04%
IN	0.05%
CT	0.06%
MI	0.06%
NE	0.06%
PA	0.06%
DC	0.10%
KS	0.10%
MA	0.10%
AK	0.20%
DE	0.20%
GA	0.20%
ID	0.20%
NC	0.20%
UT	0.21%
NY	0.25%
OK	0.47%
IA	0.50%
ME	0.50%
MT	0.50%
ND	0.50%
RI	0.50%
WI	0.50%
NV	0.54%
CA	1%
MD	1%
MS	1%
NJ	1%
TN	1%
VA	1%
VT	1%
WV	1.42%
WA	1.50%
MN	1.80%
Average	**0.37%**

VIII-A4. Please provide an estimate of the savings attributed to the lock-in program for the fiscal year under review.

State	Estimate of the savings attributed to the lock-in program for the fiscal year under review
AK	$-
CA	$-
CO	$-
DE	$-
GA	$-
HI	$-
IA	$-
ID	$-
IN	$-
KS	$-
KY	$-
MA	$-
ME	$-
MI	$-
MN	$-
MS	$-
ND	$-
NE	$-
NH	$-
NM	$-
OH	$-
RI	$-
VA	$-
WA	$-
WI	$-
NC	$1
IL	$2
DC	$100
OR	$5,934
MD	$27,841
WY	$42,917
AR	$45,201
AL	$75,823
WV	$90,969
SC	$100,000
LA	$100,278
VT	$109,050
TX	$112,161
NJ	$113,456
OK	$242,400
UT	$248,415
MT	$252,868
CT	$484,334
TN	$532,814
NV	$3,666,631
MO	$7,381,492
PA	$53,600,000
NY	$114,000,000
Average	**$3,775,681**

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

If answer to VIII-A5 above is "Yes", what actions does this process initiate? Check all that apply.

Answer	State	Number of States (Percentage)
Deny claims written by this prescriber	CA, GA, IN, MI, MO, NJ, SC, TN, VT, WA, WV	11 (28%)
Refer to Program Integrity Unit	AL, AR, CA, CO, CT, DC, DE, FL, GA, IA, IL, IN, KS, KY, MD, ME, MI, MO, MS, NC, ND, NJ, NY, OH, OK, PA, RI, SC, SD, TX, VA, VT, WA, WV, WY	35 (88%)
Refer to the appropriate Medical Board	AL, CO, DC, DE, GA, IA, IL, IN, KS, KY, MD, ME, MI, MO, MS, NC, ND, NJ, OK, PA, SD, TN, VT, WA, WV, WY	26 (65%)
Other - please explain:	CA, GA, IL, KS, MD, MI, MN, MO, MS, NC, NE, NH, NY, PA, TN, UT, VT, WA	18 (45%)

If (d) "Other" above is selected, please explain:

State	Explanation
CA	Propose new policy such as quantity restrictions and further review by Audit & Investigations Branch (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
MD	SURS, OIG, CDSIU
MI	Prescribers may be suspended or sanctioned and prescriptions written by this prescriber would then be denied at point-of-sale.
MN	Refer to DHS's Office of Inspector General.
MO	DUR board review of provider/patient cases.
MS	Refer to DEA
NC	An audit of specific claims would be performed.
NE	Program Integrity Unit is reviewing reports produced through the data warehouse of outliers for further review.
NH	The Program Integrity Unit performs this function and will refer as needed.
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	Refer to MFCS and initiate payment suspension if appropriate.
TN	Referred to TennCare's Provider Review Committee, which is the body that reviews and has the authority to terminate a provider's medicaid ID.
UT	Refer to MFCU or UOIG.
VT	refer to Medicaid Fraud and Residential Abuse Unit
WA	Washington Medicaid maintains a Medical and Dental Advisory Committee which performs ongoing active review of prescribers and their prescribing practices. Practitioners found to have aberrant prescribing practices or other issues with quality of care may have sanctions against them which can range from not allowing prescribing of Schedule II medications for Medicaid patients, to terminating the provider's relationship with Medicaid and working with the Department of Health to have their license revoked.

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

If answer to VIII-A6 above is "Yes," what actions does this process initiate? Check all that apply.

Answer	State	Number of States (Percentage)
Deny claim	GA, IN, KY, LA, ME, MI, MO, NJ, TN, VT, WV	11 (28%)
Refer to Program Integrity Unit	AL, AR, CA, CO, CT, DC, DE, GA, IA, IL, IN, KS, KY, ME, MI, MO, MS, NC, ND, NJ, OH, OK, PA, RI, SD, TN, TX, UT, VA, VT, WA, WV	32 (80%)
Refer to Board of Pharmacy	AL, CO, DC, DE, GA, IA, IL, IN, KS, KY, ME, MI, MO, MS, NC, ND, NJ, OK, PA, SD, TN, VT, WV	23 (58%)
Other - please explain:	CA, FL, GA, IL, IN, KS, KY, MD, MI, MN, MO, MS, NC, NE, NH, NY, PA, SC, TN, UT, VT	21 (53%)

If (d) "Other" above is selected, please explain.

State	Explanation
CA	Propose new policy such as quantity restrictions and further review by Audit & Investigations Branch (IB) Medical Review Branch (MRB).
FL	Medicaid Program Integrity conducts pharmacy provider's desktop and on-site audits
GA	Referral to Office of Inspector General
IL	Also 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	If fraud or abuse is suspected, that information is shared with the Commonwealth's audit vendor for further research/investigation.
MD	OIG conducts audits of Maryland pharmacies to ensure compliance with regulations for all medications for Medicaid.
MI	Pharmacies may be suspended or sanctioned which results in the denial of claims submitted by the pharmacy at point-of-sale
MN	Refer to DHS's Office of Inspector General.
MO	DUR Board review of provider/patient cases.
MS	Refer to Mississippi Attorney General's Medicaid Fraud Control Unit
NC	An audit of specific claims would be performed.
NE	Program Integrity Unit is reviewing reports produced through the data warehouse of outliers for further review.
NH	The Program Integrity Unit performs this function and will refer as needed.
NY	Professional RetroDUR case reviewers refer potential 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	Refer to MFCS
SC	Yes. We have developed ranking reports for pharmacy providers based on composite scores to several algorithms and using numerous measures.
TN	Contracts are held by the PBM vendor, and they may decide to terminate the pharmacy's provider contract.
UT	Refer to MFCU or Utah Office of Inspector General (UIOG) for Medicaid Services.
VT	refer to Medicaid Fraud and Residential Abuse Unit

VIII-A7. Do you have a documented process in place that identifies potential fraud or abuse of non-controlled drugs by beneficiaries?

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

If answer to VIII-A7 above is "Yes," please explain your program for fraud or abuse of non-controlled substances.

State	Explanation
AL	Through eligibility and URC, recipients are referred to MCFU.
CA	Audit & Investigations Branch (IB) uses all available information to develop and work cases, initiates audits, and assists in investigations, including review of claims data and trends of non-controlled drugs.
CO	Retrospective DUR analysis can identify potential fraud or abuse, and also prior authorizations can identify these issues. If identified, these members are given attention where necessary.
CT	The quality assurance program at DSS performs random claims samples of controlled and non-controlled drugs to identify anomalies in payment and claims processing.
FL	Quantity limits, appropriate age and gender restrictions in place for many non-controlled medications, requests to override these limits may indicate fraud, waste or abuse
GA	Retrospective analyses of potential fraud/abuse on a case-by-case basis
KY	The Commonwealth of Kentucky utilizes edits such as; refill too soon, ProDUR checks, RetroDUR checks, quantity limits, accumulation edits and desk audits to detect cases of possible fraud and/or abuse of non-controlled substances.
LA	Point of Sale edits.
ME	Review and referral system to identify over use and internal clinical review for placement within the lock-in program
MI	Beneficiaries with high utilization of emergency room prescribers and pharmacies including those that paid with cash are subject to review.
MN	Questionable utilization is referred to the SURS program and they determine the action from there.
MT	We run a statistical algorithm to review usage, for controlled and some non-controlled substances.
NH	Program Integrity Unit has fraud and abuse reports available.
NJ	Lock into pharmacy and negative PA. Negative PA is designed to block payment of a prescription service. This interruption in payment can be time limited and based on a drug's National Drug Code (NDC), drug class or patient identity.
NY	Professional RetroDUR case reviewers refer potential 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.
OK	Muscle relaxants claims are considered when locking in members.
PA	Review for the Lock-In Program includes all medications. Recipients may be restricted for fraud, waste or abuse of non-controlled substances.
SC	Yes. We have developed twenty criteria that are then applied to a recent six month period of claims data and scores each of the criteria for the beneficiary. The twenty scores are added together to reach a composite score. If that score exceeds a certain value, the beneficiary is automatically enrolled in a pharmacy lock-in period for two years.
UT	The DRRC has algorithms to identify recipients who may be mis-using or abusing non-controlled drugs.
VA	Java-Server Utilization System (JSURS) identifies member to review for enrollment in DMAS Client Medical Management Program.
WA	Washington Medicaid does not differentiate between controlled and non-controlled substances for its lock-in program. Although it is usually controlled substances which most easily land a client on Restriction, any documentable fraud, abuse, or even unintentional misuse of the prescription drug benefit can lead to placement in the lock-in program.
WI	Fraud and abuse must be reported regardless if the drug is a controlled drug or a non-controlled drug. Providers may report fraud and abuse by going to the OIG fraud and abuse website or by calling the fraud and abuse hotline.
WV	Our early refill edit and quantity limit edit protect against a member obtaining more than 12 months supply of any drug in a year. Drugs requiring a PA typically require at minimum an approved diagnosis.

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, 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	48 (96%)
No	DC, MO	2 (4%)

If answer to VIII-B1 above is "Yes," does your agency have the ability to query the state's PDMP database?

Answer	State	Number of States (Percentage)
Yes	AL, CA, CT, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MS, MT, NC, ND, NV, OH, OK, SC, SD, TN, VT, WA, WV, WY	28 (58%)
No	AK, AR, CO, DE, FL, GA, HI, IA, NE, NH, NJ, NM, NY, OR, PA, RI, TX, UT, VA, WI	20 (42%)

If answer to VIII-B1 above 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, ND, NY, SC, TN, VT, WV	9 (19%)
No	AK, AL, AR, CA, CO, CT, FL, GA, HI, IA, ID, IL, IN, LA, MA, MD, ME, MI, MN, MS, MT, NC, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SD, TX, UT, VA, WA, WI, WY	39 (81%)

If answer to VIII-B1 above is "Yes," please explain how the state applies this information to control fraud and abuse.

State	Explanation
AK	Note: Changes to PDMP access rules occurred in 2016
AL	n/a
AR	Medicaid Pharmacy Program does not have access to the PDMP.
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. Audit & Investigations Branch (IB) uses all available information to develop and work cases, initiates audits, and assists in investigations. Audit & Investigations Branch (IB) examines PDMP information on prescribers, dispensers, and beneficiaries during the course of A&I's usual work.
CO	Our agency cannot access.
CT	No, however, state law requires all prescribers to review a patient's controlled substance history report if writing for more than a 72 hour supply.
DE	For prior authorizations on controlled substances, the prescriber must indicate on the prior authorization form that the PDMP was checked.
FL	Pharmacies and dispensing pharmacists are encouraged to check PDMP. Pharmacies are required to upload dispensing records
GA	The State does not have access to the PDMP database.
HI	At present the agency does not have access to the state PDMP.
IA	The state is unable to access this data. The PMP is only available to authorized health care practitioners to review their patents' 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	Prescribers are asked to check ILPMP for Suboxone, hepatitis C medications, and chronic opioid use. HFS checks ILPMP as well and information helps in determining Prior authorization approval as well as identifying patients for lock-in
IN	INSPECT Program
KS	We incorporated this into our Long-Acting Opioids criteria during FFY 2014
KY	Prescribers in Kentucky must attest to the fact that the PDMP has been consulted prior to particular drugs being approved.
LA	The additional data accessed through PDMP assists the DHH pharmacy staff in determining fraud and abuse.
MA	N/A

MD	Information obtained from the PDMP is used for the Corrective Managed Care (CMC) program through the FFS program if a formal investigation is being conducted.
ME	providers are suggested to review prior to dispensing and prescribing
MI	MDHHS requires prescribers of medication assisted therapy (MAT) agents to be registered and access the PDMP. In addition, the MI Dept of Licensing and Regulatory Affairs (LARA) monitors prescribing patterns and investigates. MDHHS also works closely with the OIG and the AG offices.
MN	There is very strict criteria where SURS can access the PDMP in the case of a recipient under investigation for fraud and abuse.
MS	Use to review Suboxone beneficiaries for use of opioids.
MT	We review utilization for a single member to look for cash payments on covered drugs.
NC	For treatment of opioid dependence, prescribers are required to access the PDMP patient history before a PA will be granted.
ND	Require prescribers to access PDMP before approving prior authorizations on narcotics.
NE	Nebraska Medicaid does not have the legal authority to access PDMP data.
NH	Responded with No above for FFY 2015.
NJ	It currently does not.
NM	The PDMP is monitored by the State Board of Pharmacy.
NV	The State Board of Pharmacy has this requirement.
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.
OH	Reviewed based on referrals
OK	Evaluate members for the lock-in program and individual review of members to prevent excess abuse.
OR	VIII-B1 = No.
PA	The current PDMP is housed in the Attorney General's office to be used by law enforcement only.
RI	Prescribers and pharmacists have access to the PDMP when writing and dispensing scripts.
SC	State will begin to monitor. Audits may provide method for recouping of payment for office visit if PDMP was not checked
SD	The answer was no
TN	Providers are required to check the CSMDB (Controlled Substance Monitoring DB) as part of PA criteria for specific medications in an effort to control fraud and abuse.
TX	This is managed by the Texas Department of Public Safety.
UT	Utah Medicaid is limited by State Statute in how it may access and use data from the PDMP.
VA	The Prescription Monitoring Program collects prescription data for Schedule II-IV drugs into a central database which can then be used by limited authorized users to assist in deterring the illegitimate use of prescription drugs. The information collected in this program is maintained by the Department of Health Professions, and strict security and confidentiality measures are enforced. Only those persons authorized by law can be provided information from the database, and the list of authorized persons is very limited. Prescribers and dispensers may query the database to assist in determining treatment history and to rule out the possibility that a patient is "doctor shopping" or "scamming" in order to obtain controlled substances.
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, IV. 2. When starting a patient on a Schedule II, III, IV for non palliative long term therapy. 3. The first time the provider prescribes to treat chronic pain. 4. Prior to writing a replacement prescription for a Schedule II, III, IV 5. In the future, the Department of Health may promulgate rules that require practitioners to check the VPMS in additional circumstances. The Vermont Statutes Online Title 18 : Health Chapter 084A : Vermont Prescription Monitoring System 4289. Standards and guidelines for health care providers and dispensers (a) Each professional licensing authority for health care providers shall develop evidence-based standards to guide health care providers in the appropriate prescription of Schedules II, III, and IV controlled substances for treatment of chronic pain and for other medical conditions to be determined by the licensing authority. The standards developed by the licensing authorities shall be consistent with rules adopted by the Department of Health. (b)(1) Each health care provider who prescribes any Schedule II, III, or IV controlled substances shall register with the VPMS by November 15, 2013. (2) If the VPMS shows that a patient has filled a prescription for a controlled substance written by a health care provider who is not a registered user of VPMS, the Commissioner of Health shall notify the applicable licensing authority and the provider by mail of the provider's registration requirement pursuant to subdivision (1) of this subsection. (3) The Commissioner of Health shall develop additional procedures to ensure that all health care providers who prescribe controlled substances are registered in compliance with subdivision (1) of this subsection. (c) Each dispenser who dispenses any Schedule II, III, or IV controlled substances shall register with the VPMS. (d) Health care providers shall query the VPMS with respect to an individual patient 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 nonpalliative long-term pain therapy of 90 days or more; (3) 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 pursuant to section 4290 of this title. (e) The Commissioner of Health shall, after consultation with the Unified Pain Management System Advisory Council,

	adopt rules necessary to effect the purposes of this section. The Commissioner and the Council shall consider additional circumstances under which health care providers should be required to query the VPMS, including whether health care providers should be required to query the VPMS when a patient requests renewal of a prescription for an opioid Schedule II, III, or IV controlled substance written to treat acute pain. (f) Each professional licensing authority for dispensers shall adopt standards, consistent with rules adopted by the Department of Health under this section, regarding the frequency and circumstances under which its respective licensees shall: (1) query the VPMS; and (2) report to the VPMS, which shall be no less than once every seven days. (g) Each professional licensing authority for health care providers and dispensers shall consider the statutory requirements, rules, and standards adopted pursuant to this section in disciplinary proceedings when determining whether a licensee has complied with the applicable standard of care. (Added 2013, No. 75, Â§ 11.)
WA	The agency has regularly engaged in multiple projects to utilize PDMP data in controlling fraud and abuse. The agency supplies its MCOs with PDMP data for their use as well, primarily in identify clients for possible restriction. PDMP data is also used by clinical staff performing clinical review of authorization requests. The agency regularly partners with DOH on projects to promote and improve use of the PDMP, and in FFY 2015 participated with them in a grant project to further that use. PDMP data was used to identify clients who were paying cash for prescriptions which had been denied by Medicaid. Medicaid providers are not allowed to accept cash from clients. 37 clients were identified as paying cash for 10 or more scheduled drug prescriptions in a 12 month period. 1784 instances of Medicaid clients paying cash after receiving refill too soon rejections were identified in the 12 month review period, and intervention letters were sent to the pharmacies who were accepting cash payments detailing the clients and cash transactions in question.
WI	The Department of Health Services does not have access to the PDMP data.
WV	If the PDMP indicates that a member is obtaining a controlled substance by more than one payer source the matter is referred to the Medicaid Fraud unit. Information obtained through this query may also be used when evaluating a request for prior authorization.
WY	The PDMP can be accessed by the Medicaid program for program integrity purposes only. It is used to clinically evaluate patients who appear to be abusing or misusing controlled medications.

If answer to VIII-B1 above is "Yes," do you also have access to border-states' PDMP information?

Answer	State	Number of States (Percentage)
Yes	CT, ID, IL, IN, KS, KY, MI, ND, NJ, OH, TN, VA	12 (25%)
No	AK, AL, AR, CA, CO, DE, FL, GA, HI, IA, LA, MA, MD, ME, MN, MS, MT, NC, NE, NH, NM, NV, NY, OK, OR, PA, RI, SC, SD, TX, UT, VT, WA, WI, WV, WY	36 (75%)

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, FL, GA, HI, IA, ID, IL, IN, KS, MA, MD, MI, MN, NC, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, TN, TX, UT, VA, WA, WI, WV, WY	37 (77%)
No	DE, KY, LA, ME, MS, MT, ND, NY, SC, SD, VT	11 (33%)

If answer to VIII-B2 above 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	During FFY2015, the agency did not have access to the PDMP. New laws in 2016 have made advancements in decreasing barriers.
AL	The Agency has limited access. Prescribers/pharmacies are not required to access prior to writing/dispensing prescriptions.
AR	The Medicaid Pharmacy Program was specifically excluded from access to the PDMP when the Act was legislated several years ago.
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. A streamlined application and

	approval process for access to the Controlled Substance Utilization Review and Evaluation System (CURES) 2.0 is nearing completion and should be fully operational in FFY 2016.
CO	Our agency is prohibited by state legislation from accessing PDMP data.
CT	Access is restricted to our Medicaid Fraud Unit only.
FL	Legislatively prohibited from accessing PDMP unless doing actual prescribing or dispensing
GA	No access to PDMP for State Medicaid programs. No funding and legal concerns about who can access the data. Prescribers and pharmacies also do not access like they should.
HI	No time resources within the agency to utilize PDMP. Agency is not a provider and only providers have access at this time.
IA	Medicaid agency is not granted access to the PMP. The PMP is only available to authorized healthcare practitioners to review their patients' use of controlled substances.
ID	The lag time that can be seen with prescription data being submitted to the PDMP by other states. No rules requiring that prescribers access the system prior to prescribing. Only 2 of the 6 states bordering Idaho are part of national PDMP.
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 yet visible in PDMP. No way to verify if prescriber checked ILPMP prior to writing prescription.
IN	Lag time in prescription data being submitted, prescribers not accessing, pharmacists not accessing before filling script.
KS	Ours SURS team at our fiscal agents only has administrative access (they must submit report requests to the agency that administers our PDMP, and are not able to pull reports real-time).
MA	No aggregate data
MD	The FFS program must have a bona fide formal investigation to access the PDMP. Requests must be approved by the DHMH Secretary. Information is obtained through DHMH office. This may lead to a lag time between request and receipt of information. Also, technical issues include system downtime maintenance and delay of claims submission by providers.
MI	Discussions have been ongoing to increase the Agency's ability to access the PDMP. System improvements are improving lag and data availability.
MN	SURS can access only for unique recipients under investigation. PDPM cannot be accessed for the purpose of DUR. Pharmacy policy and Health Plan staff cannot access.
NC	Many pharmacies have restricted internet access, payer source not identified, delay in data submitted.
NE	Nebraska Medicaid does not have legal authority to access PDMP data. The data are incomplete, as patients may opt out. Pharmacies are not mandatorily reporting data.
NH	Legislation as written does not allow State Medicaid Program staff access to data.
NJ	Access to PDMP is controlled by each individual State and for what purpose. Currently, NJ PDMP 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 only available at pharmacy and prescriber offices
NV	Only the State staff have access to the data, contractors for the State are not allowed to access the PMP unless they have responsibility for direct patient care. Unable to query by prescriber.
OH	Only able to use for individual patient reviews, not data mining or analytics.
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 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.
TN	We are only able to pull data for one patient at a time, and are unable to query the database directly.
TX	The Department of Public Safety does not allow Medicaid program access to PDMP.
UT	Utah Medicaid is limited by State statute in how it may access and use data from the PDMP.
VA	Agency does not have access to PDMP
WA	Washington State continues to struggle with uptake of PDMP usage by providers.
WI	The PDMP is managed by a different agency.
WV	Access to the PDMP is limited to one person at our department and queries are capable of only pulling up one member at a time.
WY	Medicaid does not have full access to the PDMP for all purposes, including consideration and review of prior authorization requests. Lags that have existed with the PDMP in the past have been improved immensely with online access for providers.

VIII-B3. Have you had any changes to your state's Prescription Drug Monitoring Program during this reporting period that have improved the agency's ability to access PDMP data?

Answer	State	Number of States (Percentage)
Yes	ID, IL, MI, NV, SC	5 (10%)
No	AK, AL, AR, CA, CO, CT, DE, FL, GA, HI, IA, IN, KS, KY, LA, MA, MD, ME, MN, MS, MT, NC, ND, NE, NH, NJ, NM, NY, OH, OK, OR, PA, RI, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	43 (90%)

If answer to VIII-B3 above is "Yes," please explain.

State	Explanation
ID	Pharmacies are required to transmit prescription information daily.
IL	ILPMP expansion to view some of our neighboring states' data.
MI	The PDMP servers have been upgraded to improve data availability.
NV	They system has improved in response time making queries faster.
SC	April 1, 2015- requirement implemented to check PDMP

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, TX	4 (8 %)
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, TN, UT, VA, VT, WA, WI, WV, WY	46 (92%)

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

If answer to VIII-C2 above 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, IA, MI, MO, ND, SC, WA	8 (57%)
No	AK, ID, MS. NH, TN, WV	6 (43%)

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

State	Explanation
AL	Claims are denied for controlled drugs prescribed by a provider not on the DEA file.
CT	The information is applied at POS.
IA	Claims are blocked at the point of sale for prescribers not authorized to prescribe controlled drugs.
MI	The Point-Of-Sale (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	During automated prescriber file loads, providers without DEA numbers are identified an added to restricted prescriber networks which do not allow the filling of Schedule II medications written by the provider.

If answer to VIII-C2 above 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	CO, DC, MA, ME, SD, VA	6 (17%)
No	AR, CA, DE, FL, GA, HI, IL, IN, KS, KY, LA, MD, MN, MT, NC, NE, NJ, NM, NV, NY, OH, OK, OR, PA, RI, TX, UT, VT, WI, WY	30 (83%)

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

Answer	State	Number of States (Percentage)
Yes	MI, NH	2 (4 %)
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, WA, WI, WV, WY	48 (96%)

If answer to VIII-C3 above is "Yes," please explain how it is applied.

State	Explanation
MI	Our vendor's RetroDUR 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 substance medications.

VIII-C4. Do you have measures in place to either monitor or manage the prescribing of methadone for pain management?

Answer	State	Number of States (Percentage)
Yes	AK, AL, CA, CO, CT, DC, DE, GA, IA, ID, IL, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, NC, ND, NJ, NY, OH, OK, OR, PA, SC, TN, TX, UT, VA, VT, WA, WI, WV, WY	39 (78 %)
No	AR, HI, MT, NE, NH, NM, NV, RI, SD	9 (18%)
Other	FL, IN	2 (4 %)

If answer to VIII-C4 above is "Yes," please check all that apply.

Answer	State	Number of States (Percentage)
Pharmacist override	ID, KY, MO	3 (8%)
Deny claim and require PA	AK, AL, DC, DE, ID, KS, KY, MA, ME, MI, MO, NC, ND, NJ, OR, PA, TN, UT, VA, VT, WA, WV	22 (56%)
Quantity limits	AK, AL, CA, DC, DE, GA, ID, KS, LA, MA, ME, MI, MN, MO, MS, NC, ND, NY, OH, OK, OR, PA, TN, TX, UT, VT, WA, WV, WY	29 (74%)
Intervention letters	CT, DE, IA, ID, IL, MD, MI, ND, SC, WA, WI	11 (28%)
morphine equivalent daily dose program	AK, CA, CO, ID, MA, ME, MN, OR, WY	9 (23%)
step therapy or clinical criteria	AL, DC, DE, ID, KY, MA, MI, MO, ND, NY, OR, PA, TN, TX, WA	15 (39%)

If answer to VIII-C4 above is either " No or Other," please explain what you do in lieu of the above or why you do not have measures in place to either manage or monitor the prescribing of methadone for pain management.

State	Explanation
NH	Clinical edit implemented in 2016.
AR	In FFY 2015, methadone was still listed as "preferred" on the PDL under long-acting opioids. The PA criteria for the single highest strength of the LA opioid did not have a limit so that terminal pain patients would have access to the dose prescribed, methadone 10 mg tablet did not have a quantity limit. In FFY 2016, methadone has moved to non-preferred status for chronic pain patients; cancer patients still have access without a PA required.
NV	Methadone is non-preferred on our PDL. We are looking at ways to better control its use.
NM	Nothing in lieu of at this time, but the topic is under consideration.
RI	Pharmacy and Therapeutic Committee determined methadone would be a preferred agent. FFS is routinely secondary. The primary insurance will make that determination.
NE	Quantity limits, 30 day supply and refill threshold of 90% are applied to all methadone claims.
SD	Reviewing as a part of a broader opioid management program
HI	This is a managed care issue. No FFS recipient since 2009 has been in need of a pain management program.
MT	We will begin monitoring methadone by prior authorization in FFY 17.
FL	All recipients (except those with a diagnosis of cancer or sickle cell disease) are limited to 4 controlled substance Rx per month; cancer and sickle cell patients are limited to 6 controlled substance Rx per month
IN	Indiana law requires methadone to be dispensed only for the treatment of pain in an outpatient setting. Prior authorization is required if the member is over the established dosing limit or has greater than four prescribers of opiates.

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

a) If answer to VIII-D1 above is "Yes," what is your maximum daily limit in terms of numbers of units (i.e. tablets, capsules)? Please indicate the number of unit(s) per day.

State	Number of unit(s) per day
AK	varies; nmt 8 for some
AL	2
AR	6
CA	Short-acting opioids have an established maximum quantity per dispensing and a maximum of three (3) dispensings within any 75-day period.
CO	4
DE	4 units for acute period, and then 2 units a day for chronic pain
FL	12
GA	Varies; 5 opioid fills per 30 days
IA	varies by drug
ID	It depends on the specific drug.
IL	Dosage form/strength specific
KS	other - drug specific
KY	xx
LA	4
MD	see section b) below for explanation
ME	15 day limit with continuation requiring PA for additional units and clinical rationale for long term use
MI	6
MO	Varies from drug to drug.
MS	186
MT	8
ND	Limit qty/day on all short-acting opioids and the quantity varies by drug and strength
NH	N/A
NY	N/A
OH	dependent on product
OK	4
OR	120 MME
PA	Varies by drug and all short acting opioids require prior authorization
SD	30 day supply
TN	1200mg/mo of oxycodone/hydrocodone, 300mg/mo hydromorphone
UT	90 tablets (regardless of specific product or strength) per 30 days
VA	Depends on the drug
VT	dependent on the medication
WI	16
WV	4
WY	6

b) If answer to VIII-D1 above is "Yes," what is your maximum days supply per prescription limitation?

Answer	State	Number of States (Percentage)
30 day supply	AL, CO, DE, FL, GA, ID, KY, LA, ME, MO, MT, NH, OK, OR, SD, TN, UT, VA, VT, WI, WY	21 (60%)
90 day supply		0 (0%)
Other, please explain	AK, AR, CA, IA, IL, KS, MD, MI, MS, ND, NY, OH, PA, WV	14 (40%)

If answer to (b) above is "Other," please explain.

State	Explanation
AK	34 days
AR	Although 6 units of SA opioids allowed per day for acute pain situations, during FFY 2015 the maximum allowed per month was 124 units for all short-acting opioids a beneficiary received during the previous 31 calendar days. The edit counted the units dispensed of every short-acting opioid dispensed so it was an accumulation of all that was dispensed up to 124 units in the previous 31 days. In addition, for chronic pain patients there is a therapeutic duplication edit in effect that does not allow chronic pain patients to have more than one short-acting opioid medication at a time. Since that time we have decreased the quantity allowed for short-acting opioids to 93 units in previous 31 calendar days.
CA	Short-acting opioids have an established maximum quantity per dispensing and a maximum of three (3) dispensings within any 75-day period.
IA	Up to a 31 day supply
IL	- 30 days - Only 1 short and 1 long-acting opioid allowed at a time - Patients flagged via the Four Rx 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
KS	driven by drug-specific individual quantity limits
MD	Some opioid are limited by number of dosage units per day and are included in the listing of all quantity limits. See website: https://mmcp.dhmh.maryland.gov/pap/docs/QL.pdf
MI	34 days supply
MS	30 day supply for most agents. Smaller monthly and cumulative quantity limits for selected agents.
ND	34 days max for all products unless primary insurance allows > 34 days.
NY	90 day supply limit; Limited to a total of four (4) opioid prescriptions every 30 days; Exemption for diagnosis of cancer or sickle cell disease CLINICAL CRITERIA (CC); For opioid: Naive patients - limited to a 15 days supply for all initial opioid prescriptions, except for patients with diagnosis of sickle cell disease or cancer; Medical necessity rationale for opioid therapy is required for patients on established buprenorphine opioid dependence therapy; PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy
OH	34 days supply and dose per day limits
PA	All short acting opioids require prior authorization. Children under 21 can get one 7 day supply within 365 days without prior auth. Adults 21 and older can get a 14 day supply within 180 days without prior auth.
WV	34 day supply

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

a) If answer to VIII-D2 above is “Yes,” what is your maximum daily limit in terms of numbers of units (i.e. tablets, capsules)?

Answer	State	Number of States (Percentage)
2 units/day	AL, AR, GA, IA, ID, KY, LA, MD, ME, MI, MS, MT, ND, OR, PA, SC, TN, VT, WA, WV	20 (51%)
3 units/day	AK, CA, DE, FL, IL IN, KS, MA, NE, NH, NJ, NV, NY, OH, OK, SD, TX, UT, VA	19 (49%)

b) If answer to VIII-D2 above is “Yes,” what is your maximum days supply per prescription limitation?

Answer	State	Number of States (Percentage)
30 day supply	AL, FL, GA, IA, ID, IL, KY, LA, MA, MD, NE, NH, NV, OK, OR, SC, SD, TX, UT, VA, VT	21 (54%)
90 day supply	PA	1 (3%)
Other, please explain	AK, AR, CA, DE, IN, KS, ME, MI, MS, MT, ND, NJ, NY, OH, TN, WA, WV	17 (44%)

If answer to (b) above is "Other," please explain.

State	Explanation
AK	34 days
AR	Although 2 units per day is marked above, actually the quantity edit for the LA opioid drugs is a dose-optimization edit that is based on the FDA approved frequency of the drug. For example, if a drug is FDA approved for a once daily dosing and it is available in several strengths (10 mg, 20 mg, 30 mg, etc.), only one unit per day is allowed for the 10 mg and 20 mg strengths because there is a 30 mg strength available. If the drug is approved as a twice daily dose, the quantity allowed for the 10 mg and 20 mg strengths is 2 units per day because there is a 30 mg strength available. In addition, there is a therapeutic duplication edit in effect so that beneficiaries cannot receive more than 1 LA 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.
DE	All long acting opioids are prior authorized. Specific clinical reviews allow for individual entry. Routinely the authorization is for 1 year. IF there is any concerns the authorized quantities are for a month a t a time.
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
ME	15 day limit similar to short acting opioids
MI	34 days supply
MS	30 day supply for most agents. Smaller monthly and cumulative quantity limits for selected agents.
MT	34 days supply
ND	VIII-D2 is yes, but 97a doesn't give proper choices. We limit all long acting products to no more than FDA approved dosing. 34 days max is our entire program max (unless primary insurance allows > 34 days)
NJ	30 day or 100 units whichever is greater.
NY	90 day supply: Hydromorphone ER, oxymorphone ER- Maximum 4 (four) units per day, 120 units per 30 days: Morphine ER (MS Contin 100mg only) - Maximum 4 units per day, up to 3 times a day, maximum 120 units per 30 days: All other long acting opioids are either 2 or 3 times a day.
OH	34 days supply. Maximum daily limit on long-acting units dependent on product.
TN	30 days. Fentanyl - 10 patches/30 days, Embeda- 2 capsules/day, Kadian - 130mg, 150mg, 200mg: 1/day, all others 2/day.
WA	The agency limits all long-acting opioids to dosage frequency according to FDA labeling. For some products this is a limit of 3 per day, 2 per day, or 1 per day. The maximum days supply is no more limited than that for any other medication (34-days).
WV	34 day supply

VIII-D3. Do you currently have edits in place to monitor opioids and benzodiazepines being used concurrently?

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

If answer to VIII-D3 above is "Yes," please explain.

State	Explanation
CT	Retrospectively we have criteria to identify the concurrent use of opioids and benzodiazepines together but there is nothing at POS to identify and monitor the use of these medications concurrently.
DE	Prior authorization for all long-acting and high dose opiates can only be approved if the client is not receiving a benzodiazepine.
IN	Retrospective DUR established to monitor concurrent claims for opioids and benzodiazepines. A near real-time letter is faxed to the prescriber notifying them of the combination therapy and risks associated with this therapy.
KY	The Commonwealth utilizes the standard ProDUR edits within First Data Bank (FDB) and does require pharmacist intervention before this combination of drugs can be processed.
NH	Part of the clinical criteria questions being asked.
NY	PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy
OR	Prior Authorization criteria for benzodiazepine and opioids restrict the use of concurrent use.
TN	BNZ all require PA, and are denied if enrollee is using chronic opioid.
TX	Alprazolam/ Carisoprodol/ Hydrocodone Combination clinical prior authorization has been in place since 2013 through which concurrent use of these three drugs with overlap of greater than 35 days will be denied.
VA	FDB AlertSpace edits
WY	Concurrent use of opiates and benzodiazepines requires prior authorization.

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

If answer to VIII-E1 above is "Yes", indicate the recommended maximum mg per day:

CO	DE	ID	KS	MA	ME	MI	MN	NC	ND	OR	WA	WY
300	120	120	200	240	30	120	120	750	90	120	120	180

If answer to VIII-E1 above is "No," please explain the measure or program you utilize.

State	Explanation
AK	A formal policy has not defined the limit; guidance recommends MED below 100mg
AL	Placed maximum units manually.
AR	For FFY 2015, see questions above that answer the dose for the SA opioids and the LA opioids above that limit the quantizes allowed and that do not allow therapeutic duplications among the SA opioids or among the LA opioids edits . In addition, beneficiaries are allowed to have 1 SA and 1 LA agent. During FFY 2016, the DUR Board approved limits using the MEDD program (we call it MME), however we pushed the implementation date back a month so it will not start until beginning of FFY 2017 (Nov. 8, 2016).
CA	All opioids have an established maximum quantity per dispensing and a maximum of three (3) dispensings within any 75-day period.
CT	During FFY 2015 we did not have a MEDD in place, however, effective 9/1/2016 we implemented a MEDD informational alert message at POS.
DC	FDA approved maximum daily dosing limits from the First Data Bank weekly file are edited at POS and are implemented prospectively during claims adjudication.
FL	The DUR Board is currently reviewing MEDD recommendations
GA	We are moving in the direction of implementing a max MED in the future. Currently, our QLLs vary not based on MED.
HI	FDA-approved quantity edit for excessive quantity per First Data Bank.
IA	Currently, individual opioids have set quantity limits.
IL	Pain management Program for Long-term Opioid Use
IN	Indiana Medicaid is planning on implementing a program for new-to-therapy opiate utilizers and current opiate utilizers. This program will restrict the dosage for new utilizers based on a maximum morphine equivalent dose and will restrict the duration of therapy. Current utilizers will be evaluated in conjunction with prescriber education.
KY	Kentucky is considering moving to maximum morphine equivalent daily dosing, but currently the Commonwealth utilizes the maximum dosing guidelines found in package inserts.
LA	Dose limits are applied to opiate products with established maximum doses.
MD	During FFY 2015, quantity limits were used to limit opioid doses.
MO	We are currently working on a MEDD policy.
MS	Monthly quantity limits.
MT	We use quantity limits for opioids.
NE	Quantity and day supply limit, with a 90% refill threshold.
NH	MED implemented in 2016.
NJ	ProDUR editing in place
NM	Topic is under consideration.
NV	The DUR Board reviews utilization of these products at nearly all quarterly meetings.
NY	Limited to a total of four (4) opioid prescriptions every 30 days; Exemption for diagnosis of cancer or sickle cell disease. PA required for initiation of long-acting opioid therapy in opioid-patients. Exemption for diagnosis of cancer or sickle cell disease. PA required for any additional long-acting opioid prescription for patients currently on long-acting opioid therapy. Exemption for diagnosis of cancer or sickle cell disease.
OH	State has issued guidelines on opioid prescribing for emergency department/urgent care, chronic pain, and acute care. Chronic pain guideline recommends the prescriber review doses greater than 80 MED.
OK	Quantity limits 3 tablets a day for long-acting 4 tablets a day for short-acting Ingredient duplication
PA	Dose/day is based on package labeling specific to each drug.
RI	The prescriber makes that determination.
SC	State plans to implement an MED program by 1st quarter 2017
SD	No MED measures
TN	During this year, in 2016, we are moving towards, over a period of 1 year, limiting the use of opioids to the CDC recommendations of 90mg/day
TX	In addition to the maximum quantity limits per prescription for all opioids, Vendor Drug Program has multiple clinical prior authorizations criteria in place such as: Opioid Overutilization criteria that check for total opiate claims per month or total number of opioid medications per month, as well as, total number of opioid prescribers (doctor shoppers) and total number of dispensing pharmacies (pharmacy shoppers). OxyContin clinical prior authorization criteria check for the number of units per day of OxyContin /generics. VDP also has placed prior authorization criteria for multiple fentanyl products that check for quantity per day of those products.
UT	Tablet quantity limits
VA	The DUR Board has been reviewing Morphine Equivalent Dose Utilization at 120 meq per day.
VT	Currently none are being utilized
WI	Wisconsin monitors these drugs through edits such as quantity limits and early refill alerts. Wisconsin has also looked at specific drugs through retroDUR and targeted interventions. Prescribers identified during these processes receive a letter which alerts them to the clinical concern.
WV	Drug edits are in place on each drug based on the number of units allowed. It is anticipated that we will soon be ready to begin implementing a MME edit in October 2016.

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	AK, AR, CA, CO, CT, DC, ID, IN, MA, ME, MI, NC, ND, NH, OH, OR, TN, VA, WA	19 (38%)
No	AL, DE, FL, GA, HI, IA, IL, KS, KY, LA, MD, MN, MO, MS, MT, NE, NJ, NM, NV, NY, OK, PA, RI, SC, SD, TX, UT, VT, WI, WV, WY	31 (62%)

If answer to VIII-E2 above is "Yes," how is the information disseminated?

Answer	State	Number of States (Percentage)
Website	CO, CT, DC, MA, ME, NC, NH, OR, WA	9 (47.5%)
Provider notice	MI	1 (5%)
Educational seminars		0 (0%)
Other, please explain	AK, AR, CA, ID, IN, ND, OH, TN, VA	9 (47.5%)

If answer to above is "Other," please explain.

State	Explanation
AK	Website, prior authorization criteria and form
AR	In FFY 2015, no, we did not. In FFY 2016, we have letter and memo posted on Medicaid website and mailed letters to prescribers with patients who were receiving MEDD greater than 300. Beginning Nov. 8, 2016, the POS system will calculate the MEDD and will reject claims greater than 300 MEDD.
CA	The Medi-Cal DUR program published an educational bulletin entitled, "Clinical Review: Morphine Equivalent Daily Dose to Prevent Opioid Overuse" to the Medi-Cal DUR website. This bulletin defined morphine equivalent daily dose (MEDD) and provided evidence to support using MEDD as an indicator of potential dose-related risk for prescription opioid overdose. The bulletin provided links to several online MEDD calculators, as well as additional resources to providers. The bulletin was also emailed to all providers who subscribe to the Medi-Cal Subscription Service.
ID	Targeted letters to prescribers based on RetroDur Activity
IN	Drug Utilization Review Board Newsletter, posted electronically, provides opiate conversion charts.
ND	Limit of 90 is for immediate release products only. PRN doses limited to 15% of current extended release narcotic dosage.
OH	PDMP includes MED for each opioid Rx.
TN	There is a conversion table on the PA form for Long Acting Opioids
VA	On the Service Authorization (SA) form

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

VIII F. BUPRENORPHINE and BUPRENORPHINE/NALOXONE COMBINATIONS

VIII-F1. Does your agency set total mg/ day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs?

Answer	State	Number of States (Percentage)
Yes	AK, AL, AR, 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, PA, TN, UT, VA, VT, WA, WV, WY	41 (82%)
No	CA, HI, NM, OR, RI, SC, SD, TX, WI	9 (18%)

If answer to VIII-F1 above is "Yes," please specify the total mg/day?

Answer	State	Number of States (Percentage)
12mg	DE, PA	2 (5%)
16mg	GA, IL, ME, VA, VT, WV	6 (15%)
24mg	AK, AL, AR, CO, DC, FL, IA, ID, IN, KS, KY, LA, MD, MI, MN, MT, NC, ND, NE, NH, NV, NY, OK, OR, TN, UT, WA, WY	26 (63%)
other, please explain	CT, MA, MO, MS, NJ, OH, TN	7 (17%)

If answer to above is "Other," please explain.

State	Explanation
CT	An informational alert is set at POS for any buprenorphine prescription that exceeds 24mg per day.
MA	32mg
MO	First 180 days, 32mg buprenorphine limit. After 180 days, 16mg buprenorphine limit.
MS	Step down therapy; up to 24mg for month 1, up to 16mg for months 2-5, up to 8mg for months 6-24. There is a prior authorization process in place that allows the prescriber to go beyond dosing limits when needed.
NJ	32 mg
OH	16mg/day with exceptions up to 24mg/day consistent with Ohio Medical Board rules
TN	16mg/day for the first 6 months of treatment, 8mg/day after 6 months of treatment

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, DE, FL, ID, KS, KY, MA, MD, MN, MO, ND, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, VT, WI, WV	32 (64%)
other, please explain	AR, CA, HI, IA, IN, LA, ME, MI, MS, MT, NC, NE, UT, VA, WA, WY	16 (32%)

If “Other”, please explain.

State	Explanation
AR	The PA criteria for buprenorphine-containing agents is not set up as a "lifetime limit". The standard PA is approved for 1 month or up to 3 months at a time during a 2 year time period for the drug dispensed from a retail pharmacy. This is reviewed through a manual review PA process and prescriber is required to submit specific documentation with each PA request. Prescribers can request an exception, or reconsideration, to the established criteria to any PA denied, or can request a fair hearing if the reconsideration is denied or can request the fair hearing for a denied PA without requesting a reconsideration. In addition, if a patient needs additional opioid-addiction treatment beyond the 2 years on the standard PA form used in our program, the prescriber can refer the patient to a certified Opioid Treatment Program.
CA	Until June 1, 2015, buprenorphine was dispensed only with an approved Treatment Authorization Request. For the remainder of FFY 2015, it was restricted to 120 dosage units (regardless of strength) and a 30 day supply per dispensing. Exceptions to this rule continue to require an approved Treatment Authorization Request.
HI	Have not had to do pain management since 2009.
IA	24mg/d for maximum of 3 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.
LA	3 months
ME	2 years without PA requirements
MI	The initial authorization is for 12 months, then renewal requests are evaluated on a case by case basis.
MS	Cumulative maximum of 24 months with 1 restart. There is a prior authorization process in place that allows the prescriber to go beyond the length of therapy limit when needed.
MT	We ask for a plan of care after two years and may grant the use.
NC	Authorization for 12 months initially but then renewed with treatment plan
NE	6 months for initial treatment, with an option to renew for an additional 6 months if medically necessary.
UT	Authorization and reauthorization are based on medical necessity
VA	Approved for 3 months
WA	Limitations were removed during FFY 2015. Previously they were limited to a single course of treatment in association with enrollment in a treatment program (six months to a year). Effective July 1, 2015 the agency allows ongoing use as a maintenance medication in treating substance use disorders.
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, IL, LA, ME, MI, MO, MS, MT, TN, UT, WY	13 (26%)
No	AK, AL, AR, CA, CO, CT, DC, GA, HI, ID, 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	37 (74%)

a) If answer to VIII-F3 above is "Yes," what is your reduced (maintenance) dosage?

Answer	State	Number of States (Percentage)
8mg	FL, MS, MT, TN, WY	5 (38%)
12mg	DE	1 (8%)
16mg	IA, LA, MO	3 (23%)
other, please explain	IL, ME, MI, UT	4 (31%)

If answer to (a) above is "Other," please explain.

State	Explanation
IL	We look for dose maintenance and tapering plan but do not require a set decrease in mg at a set period of time. Approvals are at 2 months, 3 months, 3 months and if no taper, the prescriber is contacted.
ME	look at a reduction in mg over a time period and PA submissions
MI	Tapering required based on individualized care plan
UT	No set dose, taper required for re-authorization

b) If answer to VIII-F3 above is “Yes,” what are your limitations on the allowable length of reduced dosage treatment?

Answer	State	Number of States (Percentage)
6 months	MT	1 (4.5%)
no limit	DE, FL, IA, LA, MO, TN, WY	7 (54%)
other, please explain	IL, ME, MI, MS, UT	5 (38.5%)

If answer to (a) above is "Other," please explain.

State	Explanation
IL	Case by case review for treatment extension requests beyond the original total 12 months.
ME	Indicated above
MI	These are reviewed on a case by case basis.
MS	Step down therapy; up to 24mg for month 1, up to 16mg for months 2-5, up to 8mg for months 6-24. There is a prior authorization process in place that allows the prescriber to go beyond dosing limits when needed.
UT	Authorization and reauthorization are based on medical necessity

VIII-F4. Do you have at least one preferred buprenorphine/naloxone combination product available on your PDL?

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

VIII-F5.Do you currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug?

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

If answer to VIII-F5 above is "Yes," can the POS pharmacist override the edit?

Answer	State	Number of States (Percentage)
Yes	MD, RI, VA	3 (11%)
No	AK, AR, DC, DE, GA, ID, IL, IN, KS, KY, LA, MA, ME, MO, MS, MT, ND, NH, NJ, NY, PA, TN, TX, WY	24 (89%)

VIII G. ANTIPSYCHOTICS/STIMULANTS

VIII-G1. ANTIPSYCHOTICS

VIII-G1-1. Do you have a documented program in place to either manage or monitor the appropriate use of antipsychotic drugs in children?

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

a) If answer to VIII-G1-1 above is "Yes," indicate which group/groups is/are either managed or monitored:

Answer	State	Number of States (Percentage)
only children in foster care	DE	1 (2%)
all children	AK, AL, CA, CO, CT, FL, GA, ID, IN, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NV, NY, OH, OK, OR, PA, RI, SC, SD, VA, VT, WA, WV, WY	35 (86%)
other, please explain	AR, IL, TN, TX, WI	5 (12%)

If answer to (a) above is "Other," please explain

State	Explanation
AR	The edits apply to all children less than 18 years of age.
IL	Prior authorization is required for all children under DCFS care; all children less than 8 years of age who are prescribed atypical antipsychotic medications; and all children prescribed long-acting atypical antipsychotics.
TN	Adults and children under age 21 are required via PA to meet clinical criteria to be eligible for coverage
TX	Both children and adults
WI	7 years of age or younger.

b) If answer to VIII-G1-1 above is "Yes," do you have edits in place to monitor? Check all that apply.

Answer	State	Number of States (Percentage)
Child' Age	AK, AL, AR, CA, CO, CT, DE, FL, GA, ID, IL, IN, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NV, NY, OH, OK, OR, PA, RI, SC, SD, TX, VA, VT, WA, WI, WV, WY	40 (98%)
Dosage	AR, CA, CO, CT, FL, GA, ID, IN, KY, LA, MA, MD, ME, MI, MO, NE, OK, OR, RI, SD, TX, VT, WA, WI, WV, WY	26 (63%)
Polypharmacy	AK, AL, AR, CA, CO, CT, GA, ID, IN, KY, LA, MA, MD, ME, MI, MN, MO, MT, NV, OH, OK, OR, RI, SD, TN, TX, WA, WI, WV	29 (71%)

c) Please briefly explain the specifics of your antipsychotic monitoring program(s).

State	Explanation
AK	Atypical antipsychotics for children < 5yrs require prior authorization; therapeutic duplications (regardless of age) require prior authorization
AL	PA is required for all antipsychotics (brand; atypical and typical). Prescriptions written by a psychiatrists and prescriptions for FDA-approved diagnoses are processed through electronic PA at the POS. Medical justification is required for polytherapy. Metabolic monitoring is required for children < 6 years of age and must be documented on the PA request form.
AR	The short version is no therapeutic duplication among antipsychotic agents is allowed without prior approval from our Medicaid child psychiatrist; the dose edits are based on specific age groups (< 6, 6-9 yrs, 10-12 yrs, 13-17 yrs) and no exceptions to the established dose edits without approval from our Medicaid child psychiatrist; and manual review for all new starts for all children less than 7 years old for any antipsychotic;
CA	An approved Treatment Authorization Request is required for any antipsychotic medication for all Medi-Cal beneficiaries 0 ~17 years of age. 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, "Improving the Use of Psychotropic Medication among 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 and improve compliance with dosing guidelines and annual metabolic risk assessment.
CO	All prescriptions for antipsychotics for children under 5 years old require a manual review. All requests for antipsychotics outside of their FDA approved ages/indications require a PA. Polypharmacy and other odd PA requests are referred to a child psychiatrist for a peer to peer consult.
CT	HID performs 1,000 RetroDUR 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 RetroDUR program have been adopted from the PMAC criteria.
DE	Ages on the atypical antipsychotic agents are set to the FDA approved indications. Synergy is also achieved in Delaware by the Department of Family Service working with Medicaid on foster children to reduce unnecessary therapies.
FL	Florida continues to perform second medical review. The second medical review performed by a board-certified, child psychiatrist is required for all prescriptions to children under the age of six and in some circumstances for children up to the age of 18
GA	Require the use of an atypical antipsychotic form, which delineates important parameters such as use of psychiatrist, age of patient, off-label use of atypical agents, how long patient has been on therapy, medical necessity of medication, etc.
ID	Targeted DUR interventions for foster children and children < or = 5 years.
IL	Atypical antipsychotics in children < 8: ensuring appropriate use in schizophrenia, bipolar disorder, other requested conditions. Check indication and comorbidities. Behavioral/psychosocial interventions before or with drug therapy. Preferred mood stabilizer used alone or in combination before atypical is used. In some cases atypical may be first line therapy: Risperidone first-line-preferred. Polypharmacy not just kids: latuda different doses used at same time.

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 and there are maximum daily dosing edits and checks for therapeutic duplication as well.
LA	Requirements for antipsychotics include appropriate diagnosis, therapeutic duplication (3rd agent), dose and age limit, and clinical preauthorization for age < 6 years.
MA	*Behavioral health medication polypharmacy: pharmacy claims for 4 or more behavioral health medications (i.e., alpha2 agonists, antidepressants, antipsychotics, atomoxetine, benzodiazepines, buspirone, cerebral stimulants, hypnotics, and mood stabilizers) filled within a 60 day period *Antipsychotic polypharmacy: overlapping pharmacy claims for 2 or more antipsychotics for 60 days within a 90 day period *Any pharmacy claim for an antipsychotic, antidepressant, atomoxetine, benzodiazepine, buspirone, or mood stabilizer for members less than 6 years old
MD	In October 2011, MMPP established the peer review program for mental health drugs. This peer reviewed authorization process informs clinicians of relevant pharmacologic and non-pharmacologic clinical information for decision-making and ensures the appropriate use while limiting adverse sequelae in Medicaid's valuable pediatric population. The program initially addressed the use of antipsychotics in recipients < 5 years of age. During FFY 2013, all recipients < 10 years of age required prior authorization. As of January 2014, the program was expanded to include all recipients < 18 years of age.
ME	PA requirements limiting age, length of therapy as well metabolic monitoring
MI	We utilize a program called WholeHealthRx 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 or specific educational topics.
MN	Monthly the DHS Children's Division receives reports that identifies children on 4 or more psychotropic drugs in 53/60 days.
MO	For children 0 to 5 years old, atypical antipsychotics deny at point of sale and must be reviewed by a clinical consultant for approval or denial. For children 5 to 9 years old, all new and non-adherent requests for atypical antipsychotics will deny at point of sale and must be reviewed by a clinical consultant for approval or denial. For children 5 to 9 years old, that are already established along with children 9 to 18 years old atypical antipsychotics will approve as long as they are on only 1 atypical, have appropriate diagnosis, dose does not exceed recommended maximum doses and are adherent to therapy 60 of the most recent 90 days. Requests that are reviewed by a clinical consultant require submission of at least the past 6 months of progress notes from the prescribing provider, results of a baseline fasting lipid profile and fasting glucose, BMI %tile and notation of any evidence-based behavioral therapy that the participant is or will be participating in.
MS	Electronic PA to check age limits; if under age limit, manual PA requiring prescriber to document age waiver, appropriate diagnosis and benefit outweighs risk.
MT	We have an edit that requires a PA for those 6 and under who are prescribed an atypical antipsychotic and we case manage those taking these to verify labs are done.
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 for cross titration when converting agents.
NE	Maximum daily dose limits and minimum age limits have been applied. All requests outside of the limits are referred to a Board Certified Child and Adolescent psychiatrist for peer to peer review prior to approval or denial.
NV	Children age 7 to 17 are allowed one drug from each class (antidepressant, antianxiety, antipsychotic, anticonvulsant) without PA up to three medications total. The fourth class requires PA. Age six and under all require PA.
NY	DUR Board recommended drug-specific minimum age parameters have been established. (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 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 norms in patient population.
OR	Please note. Question 112 is required to complete the form because we have a "monitoring" program. We do not have any edits in place. As discussed below, our state uses education, not edits. 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. See ATT3-2013-OR-SDBA.docx for complete details.
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	Health Information Design has specific RDUR criteria that identifies use of psychotropic drugs and stimulants in children. Criteria monitored monthly. If reviewer identifies an issue a letter is sent to the prescriber.
SC	PA requirements in place for all antipsychotics for < 6 years of age- additional clinical edits: MD consult with psychiatrist/informed consent/psychosocial tx in place for 12 weeks without adequate clinical response/only one anti psych agent approved at one time (exception: tapering one agent while titrating another);comprehensive psychiatric assessment with diagnosis, impairments, treatment targets and treatment plans clearly identified and documented
SD	Child Protective Services
TN	During this 2016 calendar year, we have implemented a polypharmacy in Intellectual/Developmental Delay (IDD) edit. Not available during the reporting period of FFY15
TX	The HHSC has a clinical prior authorization edit 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 patients 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 (SA) are required for the use of antipsychotics in children under the age of 18. See ATT6-2015-VA-IPN for details
VT	a) PA process for all antipsychotics for children; b) 18 years or less PA for diagnosis and max daily dose; c) less than 5 years of age PA is reviewed by Medical Director. d) Non-specialists have access to Psychiatrists at University of Vermont for psychiatric consultation
WA	The agency maintains a Pediatric Mental Health Advisory Committee that provides recommendations to the DUR Board. Based on these recommendations, Washington Medicaid currently has dose limits stratified by patient age, limitations against ongoing therapeutic duplication, and polypharmacy. Any of these review thresholds will cause a case to be referred to our Second Opinion Network program, in which pediatric mental health experts engage in a one on one consultation with the prescriber.
WI	Wisconsin monitors the use of antipsychotic drugs in young children through prior authorization (PA). The PA process is intended to scrutinize the prescribing of antipsychotic drugs for mood disorders and the monitoring of metabolic effects of this class of drugs.
WV	A prior authorization is required for all children < 18 years of age.
WY	Age limits and dosage limits are set on ADHD medications and antipsychotics. Polypharmacy is reviewed retrospectively and cases can be referred to Seattle Children's Hospital for further review.

d) If you do not have antipsychotic monitoring program, do you plan on implementing a program in the future?

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

If answer to (d) above is “No,” please explain why you will not be implementing a program to monitor the appropriate use of antipsychotic drugs in children.

State	Explanation
CA	We will not be implementing a program because as of FFY 2015 we already have an antipsychotic monitoring program.
GA	Currently have a program in place at the moment. Plan on continuing current program.
HI	FFS is not in need of one because other programs cover antipsychotropic drugs in children (DOH/CAMHD and Medicaid managed care). These programs are very successful.
ND	Legislation prevents managing antipsychotic medications in North Dakota
NJ	There are current guidelines provided by the New Jersey Department of Children and Families for the use of psychotropic medications in children.
NM	A DUR intervention is in preparation to identify children who require metabolic monitoring of atypical antipsychotics.
WI	The State of Wisconsin already has a program in place to monitor the appropriate use of antipsychotic drugs in children.

VIII-G2. STIMULANTS

VIII-G2-1 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, FL, GA, HI, IA, ID, IL, IN, KY, LA, MA, ME, MI, MN, MO, MS, MT, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	47 (94%)
No	KS, MD, NC	3 (6%)

a) If answer to VIII-G2-1 above is "Yes," is your program limited to:

Answer	State	Number of States (Percentage)
children	MT, SC	2 (4%)
adults	DE, GA, IA, NJ, NM, RI	6 (13%)
both	AK, AL, AR, CA, CO, CT, DC, FL, HI, ID, IL, IN, KY, LA, MA, ME, MI, MN, MO, MS, ND, NE, NH, NV, NY, OH, OK, OR, PA, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	39 (83%)

b) Please briefly explain your program.

State	Explanation
AK	quantity limits
AL	Stimulants are included in the Preferred Drug List (PDL) and have max quantity limits.
AR	Adult use of a C-II stimulant requires manual review for ADHD, and if for narcolepsy requires documentation of test results submitted; all beneficiaries must conform to the dose edits and the therapeutic duplication edits; the C-II stimulants are also on the PDL so any requests for non-preferred drug require additional manual review, and any requests for higher dose than established edits require additional manual review.

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 an approved Treatment Authorization Request.
CO	Stimulants are managed on our PDL, and so prior authorizations control utilization of all non-preferred and some preferred prescriptions. There are also minimum age requirements.
CT	HID performs 1,000 RetroDUR reviews for the adult and pediatric populations 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 RetroDUR program have been adopted from the PMAC criteria. Additionally, stimulant use is also reviewed during the monthly RetroDUR adult reviews.
DC	Clinical criteria is in place for all stimulants with requirements for diagnosis, age appropriate use, expected length of therapy and days supply limits. Prior authorization can be set for up to 1 year.
DE	Adults must be on the less abuse potential long-acting agents of generic Concerta and Vyvanse first and fail before approval of any other agent will be considered.
FL	Quantity limits for adults (18 and older); prior authorization required on long-acting stimulants for children under 6 years of age
GA	Stimulants require prior authorization for adults
HI	IDC-10 and age requirements are drug specific.
IA	Require PA for members 21 years of age and older. Documentation diagnosis of 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 on all stimulants, there are also maximum dosing per day edits as well as therapeutic duplication edits in place.
LA	Stimulants are reviewed in the retrospective DUR program for stimulant-induced insomnia and use in young children. Prospective edits include duplication of therapy with stimulants and with narcolepsy agents, diagnosis requirement, and clinical preauthorization for young children.
MA	*Behavioral health medication polypharmacy: pharmacy claims for 4 or more behavioral health medications (i.e., alpha2 agonists, antidepressants, antipsychotics, atomoxetine, benzodiazepines, buspirone, cerebral stimulants, hypnotics, and mood stabilizers) filled within a 60 day period *Cerebral stimulant polypharmacy: overlapping pharmacy claims for 2 or more cerebral stimulants (immediate-release and extended-release formulations of the same chemical entity are counted as one) for 60 days within a 90 day period
ME	managing daily dosing requirements
MI	Prior authorization required for members over the age of 18 years and under the age of 6 years.
MN	We have quantity limits in place.
MO	Under 6 years old requires prior authorization. 6 to 18 years old requires appropriate diagnosis on file and within approved dosage limitations for it to approve transparently. Greater than 23 years of age requires prior authorization.
MS	Electronic PA age edits and quantity limits for all beneficiaries and diagnosis edit for adults.
MT	These are part of our fraud review.
ND	First fill limitation (14 days initial supply), only one long acting and one short acting allowed concurrently and they must be the same molecule (e.g. they can't be on dexmethylphenidate extended release and methylphenidate immediate release concurrently), FDA max doses and age limits
NE	Maximum daily dose limits and minimum age limits have been applied. All requests outside of the limits are referred to a Board Certified Child and Adolescent psychiatrist for peer to peer review prior to approval or denial.
NH	Prior authorization required for all adults preferred or non-preferred and for non-preferred medications in children.
NJ	A prior authorization is required to obtain an approved diagnosis from the prescriber.
NM	Stimulants require prior authorization for those 18 years of age or older.
NV	PA criteria for both adults and children established by the DUR Board.
NY	Quantity limits for patients less than 18 years of age to include: Short-acting CNS stimulants: not to exceed 3 dosage units daily with maximum of 90 days per strength (for titration) Long-acting CNS stimulants: not to exceed 1 dosage unit daily with maximum of 90 days. Concerta 36mg not to exceed 2 units daily. Quantity limits for patients 18 years of age and older to include: Short-acting CNS stimulants: not to exceed 3 dosage units daily with maximum of 30 days Long-acting CNS stimulants: not to exceed 1 dosage unit daily with maximum of 30 days. Concerta 36mg not to exceed 2 units daily. For patients 18 years of age and older: a 90 day supply may be obtained with confirmation of FDA approved, Compendia supported or Medicaid covered diagnosis

OH	Quantity per day and duplicate therapy limits.
OK	Under Age of 5-psychiatrist control, over age of 21 must fill out P.A. Quantity limits in placed based on FDA approved dosing.
OR	Doses exceeding quantity limits require prior authorization and prescribing by a specialist.
PA	A prescription for a preferred or non-preferred Stimulant and Related Agents 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	edits for indication/age < 6 (several products including Strattera/vyvanse/methylphenidate/Adderall XR not indicated); Narcolepsy products- diagnosis confirmed by sleep study (documented)
SD	Quantity limits
TN	This was not available in FFY15, and was implemented October 1, 2015. Criteria for PA for adults and children under 21 taken from DSM-V, along with quantity limits.
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	Utah has 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	Program for children is largely similar to that described for antipsychotics above. Adults have maximum dose limits established as well as expedited authorization requirements for validation of diagnosis.
WI	Wisconsin had both documented restrictions and special programs to monitor, manager or control the use of stimulants. Diagnosis restrictions: allowable diagnoses are ADHD and narcolepsy; Prior authorization required for non-preferred stimulants on the Preferred Drug List; System edits for early refill 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	Members are limited to 1 short-acting + 1 long-acting stimulant and these must be composed of the same chemical entity.
WY	Children between the ages of 3 and 18 are allowed preferred stimulants with no prior authorization. Adults must have a diagnosis of ADHD on file as well. Dosage limits apply to children and adults.

IX. INNOVATIVE PRACTICES

The 37 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: Drug Utilization Review Annual Report | Medicaid.gov

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

X. E-PRESCRIBING

X-1. Does your MMIS or pharmacy vendor have a portal to electronically provide, patient drug history data and pharmacy coverage limitations to a prescriber prior to prescribing, upon inquiry?

Answer	State	Number of States (Percentage)
Yes	AL, AR, CT, DE, FL, GA, ID, IN, KY, LA, ME, MI, MN, MO, MT, NH, NM, OK, TX, UT, WV	21 (42%)
No	AK, CA, CO, DC, HI, IA, IL, KS, MA, MD, MS, NC, ND, NE, NJ, NV, NY, OH, OR, PA, RI, SC, SD, TN, VA, VT, WA, WI, WY	29 (58%)

a) If answer to X-1 above 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	AR, CT, DE, FL, MI, MO, NM, TX	8 (38%)
No	AL, GA, ID, IN, KY, LA, ME, MN, MT, NH, OK, UT, WV	13 (62%)

b) The 11 states listed below explain the evaluation methodology in Attachment 7 “E-Prescribing Activity Summary” and can be found in Attachment 6 of the individual state report: Drug Utilization Review Annual Report | Medicaid.gov

AR, CT, DE, FL, LA, MI, MN, MO, NM, OK, TX

c) If answer to X-1 above is "No," are you planning to develop this capability?

Answer	State	Number of States (Percentage)
Yes	CO, DC, IA, IL, MA, ND, NJ, NV, OH, SD, VT, WA	12 (41%)
No	AK, CA, HI, KS, MD, MS, NC, NE, NY, OR, PA, RI, SC, TN, VA, WI, WY	17 (59%)

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

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

XI. MANAGED CARE ORGANIZATIONS (MCOs)

XI-1. Does your state have MCOs?

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

XI-2. Is your pharmacy program included in the capitation rate (carved-in)?

Answer	State	Number of States (Percentage)
Yes	DC, DE, HI, IL, KS, KY, LA, MA, MN, MS, ND, NH, NJ, NM, NV, NY, OH, PA, SC, VA, WV	21 (57%)
No	CO, GA, MO, NE, TN	5 (13%)
Partial	CA, FL, IN, MD, MI, OR, RI, TX, UT, WA, WI	11 (30%)

If answer to XI-2 above is "partial," please specify the drug-categories that are carved out.

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
FL	Hemophilia is carved out
IN	Healthy Indiana Plan (HIP) 2.0 and Hoosier Care Connect (HCC) are carved-in. Fee-for-service members are carved-out (Hoosier Healthwise).
MD	During FFY 2015, antiretrovirals for the treatment of HIV/AIDS, mental health medications and substance use disorder medications were included in the carve-out program.
MI	Mental Health drugs, Substance abuse Treatment, Hemophilia Drugs, HIV and selected drugs for rare metabolic diseases
OR	mental health as per http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_121.html
RI	There is a stop loss arrangement for Hepatitis C Drugs
TX	Hepatitis C and Orkambi are carved out.
UT	Anti-convulsants, antidepressants, antipsychotics, stimulants for ADD/ADHD, substance abuse treatments, and anti-rejection medications for organ transplants
WA	Currently hemophilia factor products for maintenance use in the home, and HCV treatment are carved out.
WI	Managed Care Organizations care-out in Wisconsin occurs by specific program, rather than drug category. In FFY 2015 the carve-out program was Family Care. Family Care is a long-term care program which helps frail elders and adults with disabilities get the services they need to remain in their homes.

XI-3. Does the state set requirements for the MCO's pharmacy benefit? (e.g. same PDL, same ProDUR/Retro DUR)?

Answer	State	Number of States (Percentage)
Yes	CA, DE, FL, IL, KS, MD, MI, MS, NH, NJ, NY, PA, SC, TX, UT, WA, WV	17 (46%)
No	CO, DC, GA, HI, IN, KY, LA, MA, MN, MO, ND, NE, NM, NV, OH, OR, RI, TN, VA, WI	20 (54%)

If answer to XI-3 above is “Yes," please check all requirements that apply below.

Answer	State	Number of States (Percentage)
Formulary Reviews	CA, DE, IL, MD, MI, NH, NJ, NY, PA, SC, TX, UT, WA	13 (77%)
same PDL	DE, FL, KS, MS, NH, TX, WV	7 (41%)
same RetroDUR	KS, NJ	2 (12%)
same ProDUR	FL, KS, MS, NJ	4 (24%)

If answer to XI-3 above 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.
DE	MCOs must follow the state Medicaid PDL to a 95% compliance rate
FL	MCOs must follow the fee-for-service (FFS) preferred drug list (PDL); MCOs may be no more restrictive than FFS
IL	MCO formularies must have the same drug classes available and may not be more restrictive than HFS. The pharmacy benefit is carved in to the 12 voluntary managed programs from Oct 1, 2014 to Sept 30, 2015. HFS has reviewed the formularies of the managed care organizations for compliance.
KS	Same PDL & DUR criteria
MD	A comprehensive drug use management program has been in place for several years which evaluates each MCO drug benefits, including: P&T Committee management and procedure, formulary content/management, prior authorization procedures and criteria, 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 include coverage available for all outpatient covered drugs identified on the Fee-For-Service Michigan Pharmaceutical Product List (MPPL).
MS	MCOs have been required to reimburse at same amount or higher than FFS. As of January 1, 2015, MCOs were required to use Universal Preferred Drug List and same clinical criteria.
NH	MCO's had to follow FFS PDL until 9/30/15
NJ	MCOs contractually required to comply with NJ DURB standards
NY	Managed care plans maintain a similar formulary to fee-for-service Medicaid with ability to provide the same drug when necessary. The New York State Department of Health (NYSDOH) obtains drug formulary information from Medicaid participating managed care plans on a quarterly basis. The formulary unit conducts meetings with managed care plans to review policies and discuss potential formulary modifications. The DUR board makes recommendations to the managed care plans regarding potential clinical editing.
PA	The requirements for the outpatient drug services provided by the Medicaid Managed Care Organizations are defined in Exhibit BBB of the HealthChoices Agreement. The amount, duration, and scope of covered outpatient drugs must be consistent with coverage under the Fee-For-Service program. The Department reviews and approves all MCO formularies, prior authorization policies and drug utilization management programs prior to implementation.
SC	The MCO may implement a PDL to encourage the 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	Formulary and PDL requirements are enforced through Provider Contract Management team. The RetroDUR policies are in place for certain classes of drugs such as antipsychotics. The MCOs are also required to adopt a few of clinical prior authorizations edits that are implemented by Vendor Drug Program, such as PA criteria for Antipsychotics, promethazine dose-per-day, and for Hepatitis C treatment. Of the PA criteria that are not required by Vendor Drug Program, the MCOs may still choose to implement exactly as approved by the DUR Board or they may modify to a less stringent version
UT	MCO requirements are detailed in contract.
WA	The state selectively limits the pharmacy benefit. The state must review and approve of MCO formularies according to standards of adequacy outlined in contract. Generally, MCOs are allowed to manage their own formularies after approval, but the state does dictate some specific areas of coverage to ensure consistent quality of care for all clients.
WV	The MCOs must follow our state run PDL criteria.

If answer to XI-3 above is "No," do you plan to set standard in the future?

Answer	State	Number of States (Percentage)
Yes	DC, HI, LA, MA, ND, NE, NV, VA	8 (40%)
No	CO, GA, IN, KY, MN, MO, NM, OH, OR, RI, TN, WI	12 (60%)

XI-4. Does the state require the MCOs to report their DUR activities?

Answer	State	Number of States (Percentage)
Yes	CA, DE, KS, LA, MD, MI, OH, PA, TX, UT	10 (27%)
No	CO, DC, FL, GA, HI, IL, IN, KY, MA, MN, MO, MS, ND, NE, NH, NJ, NM, NV, NY, OR, RI, SC, TN, VA, WA, WI, WV	27 (73%)

a) If answer to XI-4 above is "Yes," please explain your review process.

State	Explanation
CA	MCOs submit DUR reports to both the Managed Care Division and the Audit & Investigations branch for review.
DE	The MCOs report their activities as part of their state specific P&T meetings. There is also an exchange of informal reports.
KS	The MCOs submit monthly reports regarding PDL and DUR approved criteria adherence. In addition, the MCOs present an annual report to the Kansas Medicaid DUR board.
LA	We have a monthly report that addresses DUR activities initiated by MCOs.
MD	Through the annual MCO Drug Use Management Program survey, each MCO is required to report all DUR policies and procedures, as well as specific documents related to oversight of the drug use evaluation process and maintenance of patient confidentiality. The survey also requires reporting of types of prospective or retrospective programs, including any program specifically related to the use of controlled substances by recipients.
MI	MCOs are contractually required to provide details about their DUR activities upon request.
OH	MCOs submit a version of the CMS annual DUR report to the agency.
PA	The MCOs are required to submit an annual DUR Report to the Department.
TX	The managed care organizations (MCO) report to the Contract Performance Management team on the number and the nature of their retroDUR activities. They are not required to report on the financial outcomes of those activities. The MCOs must seek the DUR Board's approval before implementing a retroDUR intervention. Otherwise, they must be presented to the DUR and Formulary team at Vendor Drug Program for approval.
UT	See Appendix for MCO DUR reports

b) If answer to XI-4 above is "No," do you plan to develop a program to have MCOs report their DUR activities in the future?

Answer	State	Number of States (Percentage)
Yes	CO, DC, FL, HI, IL, KY, MA, MS, ND, NE, NH, NJ, NM, NV, NY, OR, RI, SC, VA, WA, WI, WV	22 (82%)
No	GA, IN, MN, MO, TN	5 (18%)

c) If answer to (b) above is "No," please explain.

State	Explanation
GA	The State does not plan to develop a program requiring MCOs to report their DUR activities in the future. The MCOs operate independently and report their DUR activities in ways they see fit without intervention from the State.
IN	The office continues to evaluate the effectiveness of this type of reporting.
MN	Minnesota does not have concrete plans yet.
MO	Our MCOs do not provide pharmacy benefits.
TN	Pharmacy is carved out, so the MCO's do not currently administer pharmacy benefits for TennCare.

XI-5. Does all of the Medicaid MCOs in your state have a targeted intervention program (i.e. CMC/ Lock In) for the misuse or abuse of controlled substances?

Answer	State	Number of States (Percentage)
Yes	CO, DC, DE, GA, IL, IN, KS, KY, MA, MI, MN, MO, MS, ND, NH, NJ, NM, NV, OH, OR, PA, RI, SC, TX, UT, VA, WA, WV	28 (76%)
No	CA, FL, HI, LA, MD, NE, NY, TN, WI	9 (24%)

If answer to XI-5 above is “No,” please explain.

State	Explanation
CA	Not a requirement of the MCO contracts.
FL	MCOs may implement lock-in programs but they are not required to do so
HI	Not all 5 managed care plans have implemented. All are at least in the process of implementing.
LA	4 of the 5 existing MCO plans have a Lock-in Program. The other plan intends to create a Lock-in Program in the near future.
MD	During FFY 2015 not all MCOs participated in a corrective managed care or lock-in program. Any recipient identified under the FFS coverage was referred to the MCO CMC program or information related to lock-in status was provided as coverage changed. A comprehensive CMC program has been developed and will be reported for FFY 2016.
NE	Pharmacy is currently carved out of managed care.
NY	In New York, the Office of the Medicaid Inspector General (OMIG) is the organizational component dedicated to anti-fraud and abuse activities. The OMIG is an independent entity within the New York State Department of Health. New York has implemented a rigorous lock-in program for beneficiaries with a demonstrated pattern of abusive utilization of Medicaid services. These primary providers may include a primary medical provider, pharmacy, hospital, durable medical equipment provider, dentist, and podiatrist. In addition, restricted beneficiaries who are eligible for managed care are transitioned into managed care. The MCOs also have their own restriction programs, which are monitored by OMIG.
TN	Pharmacy is carved out, so the MCO's do not currently administer pharmacy benefits for TennCare.
WI	The Family Care Partnership contract does not establish requirements for a Lock-In program or CMC program.

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

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