National Medicaid Managed Care Organization (MCO) FFY 2022 Drug Utilization Review (DUR) Annual Report

Executive Summary
National Medicaid Drug Utilization Review (DUR)
Managed Care Organization (MCO)
Federal Fiscal Year (FFY) 2022 Annual Report
(FFY 2022 Data: October 2021-September 2022)

Consistent with 42 C.F.R. § 438.3(s)(4) and (5), the Centers for Medicare & Medicaid Services (CMS) requires any Medicaid Managed Care Organization (MCO) that includes covered outpatient drugs as a benefit to operate a Drug Utilization Review (DUR) program that complies with section 1927(g)(3)(D) of the Social Security Act (the Act) and 42 C.F.R. § 456, subpart K. MCOs are required to report on the nature and scope of their prospective and retrospective DUR programs. The reports must include a summary and assessment of the interventions used in prospective and retrospective DUR, educational programs, DUR board activities, and the DUR program's overall impact on quality of care. A description of the cost savings generated from their DUR programs, including adoption of new innovative DUR practices, is also required.

A high-level comparison of States' DUR MCO survey responses can be found in this aggregate report summary. Detailed MCO responses, including this aggregate national summary, can also be found on Medicaid.gov.[1]

I. Demographic Information
Thirty-four States (this reference includes the District of Columbia hereafter) have submitted 205 MCO DUR Annual Surveys encompassing FFY 2022 reported responses.[2,3] The information in this report is focused on national MCO DUR activities based on these 205 Surveys.

- MCO data includes 49,853,837 beneficiaries enrolled in MCOs that include covered outpatient drugs as a benefit. This represents an 8% decrease from FFY 2021.[4]

II. Prospective DUR (ProDUR)
ProDUR functions are performed at the point-of-sale (POS) when the prescription is being processed at the pharmacy. MCOs employ a variety of ProDUR alert messages, including duplicate therapy, high dose alerts, and subtherapeutic alerts. FFY 2022 reported responses show 200 MCOs (98%) allow the pharmacist to override ProDUR alert messages, a 20% increase from FFY 2021.

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[1] All data presented within these reports originate from MCO responses to the FFY 2022 DUR MCO Survey.
[2] The MCO DUR survey was not submitted by Arizona because of the State's existing waiver of these DUR requirements included in their approved 1115 Demonstration, which is valid until September 2022.
[3] California, Ohio (1 out of six of their MCOs), Missouri, North Dakota, Tennessee, West Virginia and Wisconsin have pharmacy benefits carved out of their managed care program and covered through their FFS pharmacy benefit. Each of these States submitted an abbreviated MCO survey for these programs. These reports can be accessed on Medicaid.gov.
[4] The decrease of managed care enrollees in FFY 2022 is directly related to the California and Ohio MCO programs having their pharmacy benefits carved out of their managed care program and covered through their FFS pharmacy benefit.

Additionally:

- FFY 2022 reported responses confirm all MCOs set early prescription refill thresholds as a way of preventing prescriptions from being overutilized:
  - Non-controlled substances: MCOs reported thresholds range from 67% to 90% of the prescription being used, with a national average of 80% of the prescription being used before a subsequent prescription could be refilled, a 1% decrease from FFY 2021.
  - Controlled substances (CII)[5]: MCO reported thresholds range from 81% to 90% of the prescription being used, with a national average of 86% of a prescription being used before a subsequent prescription could be dispensed. This is consistent with FFY 2021.
  - Controlled substances (CIII to CV)[6,7,8]: MCO reported thresholds range from 80% to 90% of the prescription being used, with a national average of 86% of the prescription being used before a subsequent prescription could be refilled, a 1% increase from FFY 2021.
- FFY 2022 reported responses show 125 MCOs (61%) utilize an accumulation edit that reviews multiple refills and sums the total number of days by which each refill is dispensed early to ensure refill thresholds are not exceeded as another way to prevent excessive early prescription refills, a 9% increase from FFY 2021. Additionally, 15 MCOs (19%) plan to implement this type of edit in the future.

III. Retrospective DUR (RetroDUR)

Through the RetroDUR process, MCOs screen literature, clinical data, and existing guidelines, and then evaluate claims to identify patterns of clinical concern. MCOs then engage in various activities to address those clinical concerns, including notifications to providers. Based on FFY 2022 reported responses, 61 MCOs (30%) utilize either their MCO DUR board or their Pharmacy Benefit Manager (PBM) to review/approve RetroDUR criteria, a 3% decrease from FFY 2021. Responses also indicate 8 MCOs (4%) utilize their State's Medicaid DUR board, a 1% increase from FFY 2021. Additionally, 135 MCOs (66%) utilize other internal and external resources for review/approval of RetroDUR criteria, a 4% increase from FFY 2021.

IV. DUR Board Activity

Each State is required to have a DUR board that meets the requirements of 42 C.F.R. § 447.716. DUR boards are comprised of physicians and pharmacists and may include other members. These boards typically meet quarterly and are open to the public pursuant to applicable State open meeting laws. Most MCOs establish their own DUR board, use the State Medicaid DUR board, or use the PBM board for application, review, evaluation, and re-evaluation of DUR standards, and the clinical information and interventions are reviewed on an ongoing basis. All MCOs submitted a summary of their DUR board activities for FFY 2022 describing prospective, and retrospective interventions. MCO DUR board summaries can be found on Medicaid.gov listed by State. Additionally, based on FFY 2022 reported

[5] Schedule II drugs, substances, or chemicals are defined as drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence. Additional drugs may be also considered Schedule II as defined by State specific law.
[6] Schedule III drugs, substances, or chemicals are defined as drugs with a moderate to low potential for physical and psychological dependence. Additional drugs may be also considered Schedule III as defined by State specific law.
[7] Schedule IV drugs, substances, or chemicals are defined as drugs with a low potential for abuse and low risk of dependence. Additional drugs may be also considered Schedule IV as defined by State specific law.
[8] Schedule V drugs, substances, or chemicals are defined as drugs with lower potential for abuse than Schedule IV and consist of preparations containing limited quantities of certain narcotics. Additional drugs may be also considered Schedule V as defined by State specific law.

responses, 91 MCOs (44%) reported utilization of a Medication Therapy Management (MTM) program, a professional service provided by pharmacists, a 3% increase from FFY 2021.

V. Physician-Administered Drugs

Physician-administered drugs (PAD) are drugs that are covered outpatient drugs under section 1927(k)(2) of the Act and are administered by a medical professional in a physician's office or other outpatient clinical setting. Based on FFY 2022 reported responses, 43 MCOs (21%) have incorporated PAD into DUR criteria for ProDUR, a 3% increase from FFY 2021, and 30 MCOs (19%) plan to incorporate PAD in the future, a 4% increase from FFY 2021. Additionally, 60 MCOs (30%) have incorporated PAD into their DUR criteria for RetroDUR, a 2% increase from FFY 2021, and 40 MCOs (28%) plan to incorporate PADin the future, a 2% increase from FFY 2021.

VI. Generic Policy and Utilization Data

In an ongoing effort to reduce spending on prescription drugs, States continue to encourage the use of lower cost generic drugs. The average generic percentage utilization rate across all MCOs was 87%, a 1% increase from FFY 2021. FFY 2022 reported responses confirm the majority of MCOs base coverage decisions of brand or generic drugs on the respective net prices, taking into consideration federal and supplemental rebate dollars on brand and generic drugs.

VII. Fraud, Waste and Abuse Detection

A. Lock- In or Patient Review and Restriction Programs

Lock-In or Patient Review and Restriction Programs are often used to restrict beneficiaries to specific practitioners or pharmacies, when their utilization of medical services is documented as being potentially unsafe, excessive, or who could benefit from increased coordination of care. In some instances, beneficiaries are restricted to specific prescribers and/or pharmacies in order to monitor services being utilized and reduce unnecessary or inappropriate utilization. Based on FFY 2022 reported responses, 197 MCOs (96%) institute a Lock-In program for beneficiaries with potential abuse of controlled substances, a 5% increase from FFY 2021. Additionally, 167 MCOs (85%) restrict beneficiaries to a specific prescriber, a 2% decrease from FFY 2021, and 192 MCOs (97%) restrict beneficiaries to a specific pharmacy, a 1% increase from FFY 2021.

While the title of this subsection refers to Lock-In and Patient Review and Restriction Programs, the survey includes questions related to the processes used by MCOs to identify potential fraud, waste and abuse. Based on FFY 2022 responses, all MCOs have processes in place to identify potential fraudulent practices by prescribers and 204 MCOs (99%) have processes in place to identify potential fraudulent practices by pharmacies; both instances show a 1% increase from FFY 2021. MCO fraud, waste and abuse reviews initiate actions such as denying claims written by that prescriber or claims submitted by that pharmacy, alerting the State integrity or compliance program to investigate, and/or referring the providers to the appropriate licensing board for additional follow-up. In addition, based on FFY 2022 reported responses, all MCOs have a documented process in place which identifies potential fraud or misuse of controlled drugs by a beneficiary, a 1% increase from FFY 2021.

B. Prescription Drug Monitoring Program (PDMP)

PDMPs are Statewide electronic databases that collect designated data on controlled substances that are dispensed in the State. Depending on the State, MCOs have access to these databases and can review claims to identify patients that are engaging in potential fraud or misuse of controlled substances. Based on FFY 2022 MCO reported responses:

- 67 MCOs (33%) have the ability to directly query the State's PDMP database and 10 MCOs (5%) receive PDMP data from the State PDMP administrator upon request.
- 128 MCOs (62%) are unable to access their State's PDMP data in any form.
- 145 MCOs (71%) responded that they face barriers that hinder their ability to fully access and utilize the PDMP database, a 2% increase from FFY 2021. Responses indicate the MCOs do not have the authority to access the PDMP database or receive the data.

C. Opioids

In reference to opioid naïve patients, most MCOs have POS edits in place to limit the quantity dispensed of an initial opioid prescription. Based on FFY 2022 reported responses, 168 MCOs (82%) apply this POS edit to all opioid prescriptions, a 7% increase from FFY 2021, and 33 MCOs (16%) apply this edit to some opioids, a respective 7% decrease from FFY 2021.

Additionally:

- 203 MCOs (99%) have prospective edits in place to monitor duplicate therapy of opioid prescriptions, a 2% increase from FFY 2021.
- 189 MCOs (93%) have an automated retrospective claims review process to monitor opioid prescriptions exceeding program limitations, a 23% increase from FFY 2021.
- 196 MCOs (96%) have prospective edits or a retrospective claims review process to monitor opioids and benzodiazepines being used concurrently, a 5% increase from FFY 2021.
- 173 MCOs (85%) have prospective edits or a retrospective claims review process to monitor opioids and sedatives being used concurrently, a 10% increase from FFY 2021.
- 194 MCOs (95%) have prospective edits or a retrospective claims review process to monitor opioids and antipsychotics being used concurrently, a 9% increase from FFY 2021.
- 193 MCOs (95%) develop and/or provide prescribers with pain management or opioid prescribing guidelines, a 1% increase from FFY 2021.
- 128 MCOs (63%) have a drug utilization management strategy that supports abuse deterrent opioid use to prevent opioid misuse and abuse, a 9% increase from FFY 2021.

D. Morphine Milligram Equivalent (MME) Daily Dose

MME is the amount of morphine, in milligrams, equivalent to the strength of the opioid dose prescribed. Using an MME approach allows comparison between the strength of different types of opioids. A total of 203 MCOs (99%) limit maximum MME daily doses, consistent with FFY 2021.

FFY 2022 reported responses also confirm 204 MCOs (99%) have an edit in their POS system that alerts the pharmacy provider that the MME daily dose prescribed has been exceeded, a 1% increase from FFY 2021. Additionally, 192 MCOs (94%) have an automated retrospective claim review process to monitor the total daily dose of MMEs for opioid prescriptions dispensed, a 7% increase from FFY 2021.

E. Opioid Use Disorder (OUD) Treatment

Naltrexone, methadone, buprenorphine and buprenorphine/naloxone combination drugs, in conjunction with behavioral health counseling, are used to treat OUD. Based on FFY 2022 reported responses, 175 MCOs (85%) have utilization controls to monitor or manage prescribing of medication-assisted treatment (MAT) drugs for OUD, a 9% increase from FFY 2021. Further, FFY 2022 reported responses confirm 156 MCOs (76%) set total milligrams per day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs, a 9% increase from FFY 2021.

Additionally, 173 MCOs (84%) provide at least one buprenorphine and buprenorphine/naloxone combination drug without a prior authorization requirement, an 8% increase from FFY 2021. 177 MCOs (86%) have system edits in place to monitor opioids being used concurrently with any buprenorphine drug or any form of MAT, a 10% increase from FFY 2021.

Naloxone is a medication designed to rapidly reverse opioid overdose. It is an opioid antagonist and can reverse and block the effects of opioids. Naloxone is available without prior authorization in 193 MCOs (94%), a 7% increase from FFY 2021. Additionally:

- 194 MCOs (95%) allow pharmacists to dispense naloxone prescribed independently or by collaborative practice agreements, standing orders, or other predetermined protocols, a 9% increase from FFY 2021.
- 143 MCOs (70%) monitor and manage appropriate use of naloxone to persons at risk of overdose, a 14% increase from FFY 2021.

F. Outpatient Treatment Programs (OTP)

Methadone is a drug that is indicated for both chronic pain and/or as part of an Opioid Treatment Program (OTP) (formerly referred to as a methadone treatment center). The FDA has approved methadone as one of three drugs for treatment of OUD within an OTP. Based on FFY 2022 reported responses, 179 MCOs (87%) provide coverage for methadone for OUD through an OTP, a 10% increase from FFY 2021, and 26 MCOs (13%) provide no methadone coverage for OUD, a respective 10% decrease from FFY 2021.

G. Psychotropic Medication for Children

It is important to note that several MCOs have psychotropic drug benefits carved out of their managed care program, and, therefore, are covered under their States' FFS program or have no pediatric population enrolled.

Antipsychotic Medication

Based on FFY 2022 reported responses, 180 MCOs (88%) have a program in place for managing or monitoring appropriate use of antipsychotic drugs in children, an 8% increase from FFY 2021. Additionally, 174 (97%) of these 180 MCOs manage or monitor antipsychotic medication for all children, including children in foster care, a 12% increase from FFY 2021.

Stimulant Medication

Based on FFY 2022 reported responses, 176 MCOs (86%) have a program in place for managing or monitoring appropriate use of stimulant drugs in children, a 6% increase from FFY 2021. Additionally, 168 (95%) of these 176 MCOs manage or monitor stimulant medication for all children, including children in foster care, a 9% increase from FFY 2021. Of the 29 MCOs not having a program in place for managing or monitoring appropriate use of stimulant drugs in children, 7 MCOs (24%) have plans to implement this program in the future.

Antidepressant Medication

According to FFY 2022 reported responses, 142 MCOs (69%) have a program in place for managing or monitoring appropriate use of antidepressant medication in children, a 10% increase from FFY 2021. Additionally, 132 (93%) of these 142 MCOs manage or monitor antidepressant medication for

all children, including children in foster care, a 15% increase from FFY 2021. Of the 63 MCOs not having a program in place for managing or monitoring appropriate use of antidepressant drugs in children, 18 MCOs (29%) have plans to implement this program in the future.

Mood Stabilizer Medication

According to FFY 2022 reported responses, 128 MCOs (62%) have a program in place for managing or monitoring appropriate use of mood stabilizing medication in children, a 10% increase from FFY 2021. Additionally, 117 (91%) of these 128 MCOs manage or monitor mood stabilizer medication for all children, including children in foster care, an 11% increase from FFY 2021. Of the 77 MCOs not having a program in place for managing or monitoring appropriate use of mood stabilizer drugs in children, 23 MCOs (30%) have plans to implement this program in the future.

Antianxiety/Sedative Medication

According to FFY 2022 reported responses, 134 MCOs (65%) have a program in place for managing or monitoring appropriate use of antianxiety/sedative medication in children, a 9% increase from FFY 2021. Additionally, 124 (93%) of these 134 MCOs manage or monitor antianxiety/sedative medication for all children, including children in foster care, a 14% increase from FFY 2021. Of the 71 MCOs not having a program in place for managing or monitoring appropriate use of antianxiety/sedative drugs in children, 26 MCOs (37%) have plans to implement this program in the future.

VIII. Innovative Practices

Sharing of new ideas and best practices is an invaluable resource for both States and MCOs. MCO innovative practices can be found on Medicaid.gov listed by State.

IX. Executive Summary

All MCOs have submitted Executive Summaries. MCO executive summaries can be found on Medicaid.gov listed by State.

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PLEASE NOTE:
This is an aggregate standalone report. MCOs responses to survey questions throughout the report are identified as the representative State and total MCOs responding as follows: State (Count of MCOs), i.e. MA (3) represents 3 MCOs in the State of Massachusetts responding to a particular question. Individual State MCO reports, attachments, and responses throughout the report can be found on Medicaid.gov.

Detailed summaries, select responses including Yes, No, other explanations, and narratives, pertaining to responses in this report can be found on Medicaid.gov in the MCO State Report table.

List of Figures

List of Tables

Number of Managed Care Organizations by State

Table 1 - Number of MCOs per State

State*	Total Number of MCOs
Arkansas	4
Colorado	2
Delaware	2
District of Columbia	4
Florida	11
Georgia	3
Hawaii	6
Illinois	6
Indiana	5
Iowa	2
Kansas	3
Kentucky	6
Louisiana	5
Maryland	9
Massachusetts	5
Michigan	9
Minnesota	9
Mississippi	3
Nebraska	3
Nevada	4
New Hampshire	3
New Jersey	5
New Mexico	3
New York	15
North Carolina	5
Ohio	5
Oregon	21
Pennsylvania	8
Rhode Island	3
South Carolina	5
Texas	16
Utah	4
Virginia	6
Washington	5
Totals	**205**

*Only States that have MCOs with pharmacy benefits are shown. California, Ohio (1 out of 6 of their MCOs), Missouri, North Dakota, Tennessee, West Virginia and Wisconsin have pharmacy benefits carved out of their managed care program and covered through their FFS program and have submitted the MCO Abbreviated Survey.

Section I - Demographic Information

1. On average, how many Medicaid beneficiaries are enrolled monthly in your MCO for this Federal Fiscal Year?

Figure 1 - Number of Beneficiaries Enrolled in MCO (Total by State)

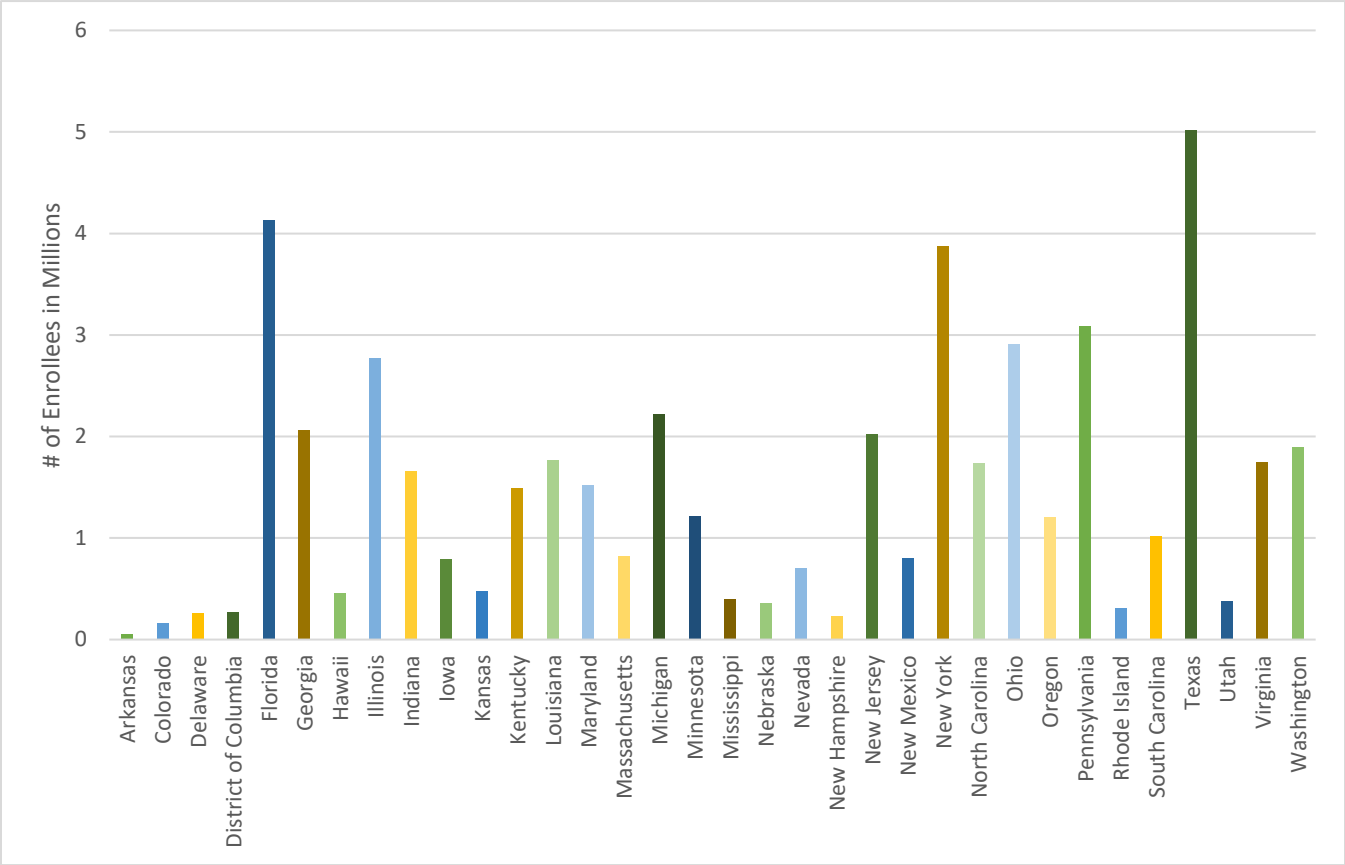

Table 2 - Number of Beneficiaries Enrolled in MCO (Total by State)

State	Number of Beneficiaries Enrolled in MCO by State
Arkansas	54,527
Colorado	159,074
Delaware	260,178
District of Columbia	268,602
Florida	4,133,216
Georgia	2,066,150
Hawaii	462,529
Illinois	2,768,587
Indiana	1,663,819
Iowa	789,564
Kansas	478,138
Kentucky	1,489,393
Louisiana	1,769,944
Maryland	1,519,318
Massachusetts	821,393
Michigan	2,219,321
Minnesota	1,211,865
Mississippi	398,919
Nebraska	360,378
Nevada	702,968
New Hampshire	233,188
New Jersey	2,020,650
New Mexico	801,598
New York	3,880,702
North Carolina	1,734,325
Ohio	2,915,306
Oregon	1,208,142
Pennsylvania	3,086,904
Rhode Island	306,336
South Carolina	1,022,577
Texas	5,019,885
Utah	383,482
Virginia	1,748,589
Washington	1,894,270
National Totals	**49,853,837**

Section II - Prospective DUR (ProDUR)

1. Indicate the type of your pharmacy point of service (POS) vendor and identify by name.

Figure 2 - Pharmacy POS Type of Vendor

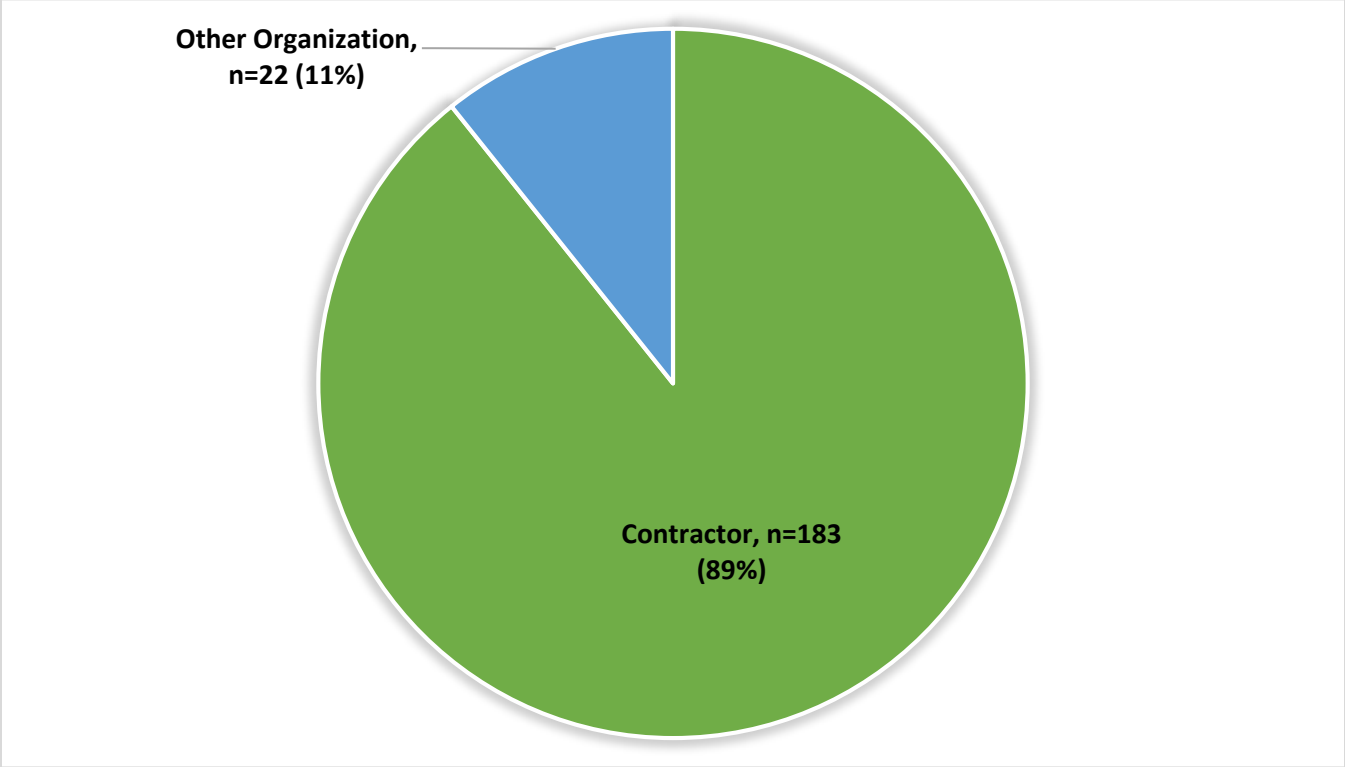

Table 3 - Pharmacy POS Type of Vendor

Response	States (Count of MCOs)	Count	Percentage
Contractor	Arkansas (3), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (2), Hawaii (5), Illinois (5), Indiana (5), Iowa (2), Kansas (2), Kentucky (6), Louisiana (4), Maryland (9), Massachusetts (5), Michigan (8), Minnesota (8), Mississippi (3), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (4), New Mexico (3), New York (14), North Carolina (4), Ohio (5), Oregon (19), Pennsylvania (6), Rhode Island (3), South Carolina (3), Texas (14), Utah (2), Virginia (6), Washington (5)	183	89.27%
Other Organization	Arkansas (1), Georgia (1), Hawaii (1), Illinois (1), Kansas (1), Louisiana (1), Michigan (1), Minnesota (1), Nevada (1), New Jersey (1), New York (1), North Carolina (1), Oregon (2), Pennsylvania (2), South Carolina (2), Texas (2), Utah (2)	22	10.73%
National Totals		**205**	**100%**

If “Contractor” or “Other organization”, please identify by name your pharmacy POS vendor.

Table 4 - Pharmacy POS Vendor Name

Response	State (Count of MCOs)	Count	Percentage
CVS/Caremark	Arkansas (2), Delaware (1), District of Columbia (2), Florida (5), Georgia (1), Hawaii (3), Illinois (2), Indiana (2), Kansas (2), Louisiana (2), Maryland (4), Massachusetts (2), Michigan (3), Minnesota (1), Mississippi (1), Nebraska (1), Nevada (2), New Hampshire (1), New Jersey (2), New York (6), North Carolina (2), Ohio (2), Oregon (7), Pennsylvania (4), Rhode Island (2), South Carolina (2), Texas (3), Utah (1), Virginia (2), Washington (2)	72	35.12%
DST Pharmacy Solutions	Michigan (1), Oregon (1)	2	0.98%
EnvisionRx Options	Virginia (1)	1	0.49%
Envolve Pharmacy Solutions	Illinois (2), Iowa (1), New Mexico (1), Ohio (1)	5	2.44%
Express Scripts	Arkansas (1), Georgia (1), Indiana (1), Maryland (1), Massachusetts (1), Michigan (2), Minnesota (2), New Hampshire (1), New York (4), Ohio (1), Pennsylvania (1), Washington (1)	17	8.29%
Magellan Rx Management	Michigan (1)	1	0.49%
MCO’s PBM	South Carolina (1)	1	0.49%
MedImpact Healthcare Services, Inc.	Colorado (1), Hawaii (1), Illinois (1), Indiana (1), Kentucky (6), Maryland (1), Michigan (1), Minnesota (2), New York (1), Oregon (6)	21	10.24%
Navitus Health Solutions	Minnesota (1), Oregon (1), Texas (10)	12	5.85%
OptumRx	Colorado (1), Florida (1), Hawaii (1), Indiana (1), Kansas (1), Louisiana (1), Maryland (1), Massachusetts (2), Michigan (1), Minnesota (1), Mississippi (1), Nebraska (1), Nevada (1), New Jersey (2), New Mexico (1), New York (2), North Carolina (1), Ohio (1), Oregon (4), Pennsylvania (1), Rhode Island (1), Texas (1), Virginia (2), Washington (1)	31	15.12%
PerformRx	Delaware (1), District of Columbia (1), Florida (1), New Hampshire (1), North Carolina (1), Pennsylvania (1)	6	2.93%
Prime Therapeutics, LLC	Illinois (1), Minnesota (1), New Mexico (1), Texas (1)	4	1.95%
ProcareRx	Maryland (1)	1	0.49%
Prospective Health Services (PHS) from RelayHealth	Utah (1)	1	0.49%
Providence Health Assurance Pharmacy Solutions	Oregon (2)	2	0.98%

Response	State (Count of MCOs)	Count	Percentage
Other	Arkansas (1), District of Columbia (1), Florida (4), Georgia (1), Hawaii (1), Iowa (1), Louisiana (2), Maryland (1), Minnesota (1), Mississippi (1), Nebraska (1), Nevada (1), New Jersey (1), New York (2), North Carolina (1), Pennsylvania (1), South Carolina (2), Texas (1), Utah (2), Virginia (1), Washington (1)	28	13.66%
National Totals		**205**	**100%**

2. Identify ProDUR table driven criteria source (multiple responses allowed).

Figure 3 - Prospective DUR Criteria Source

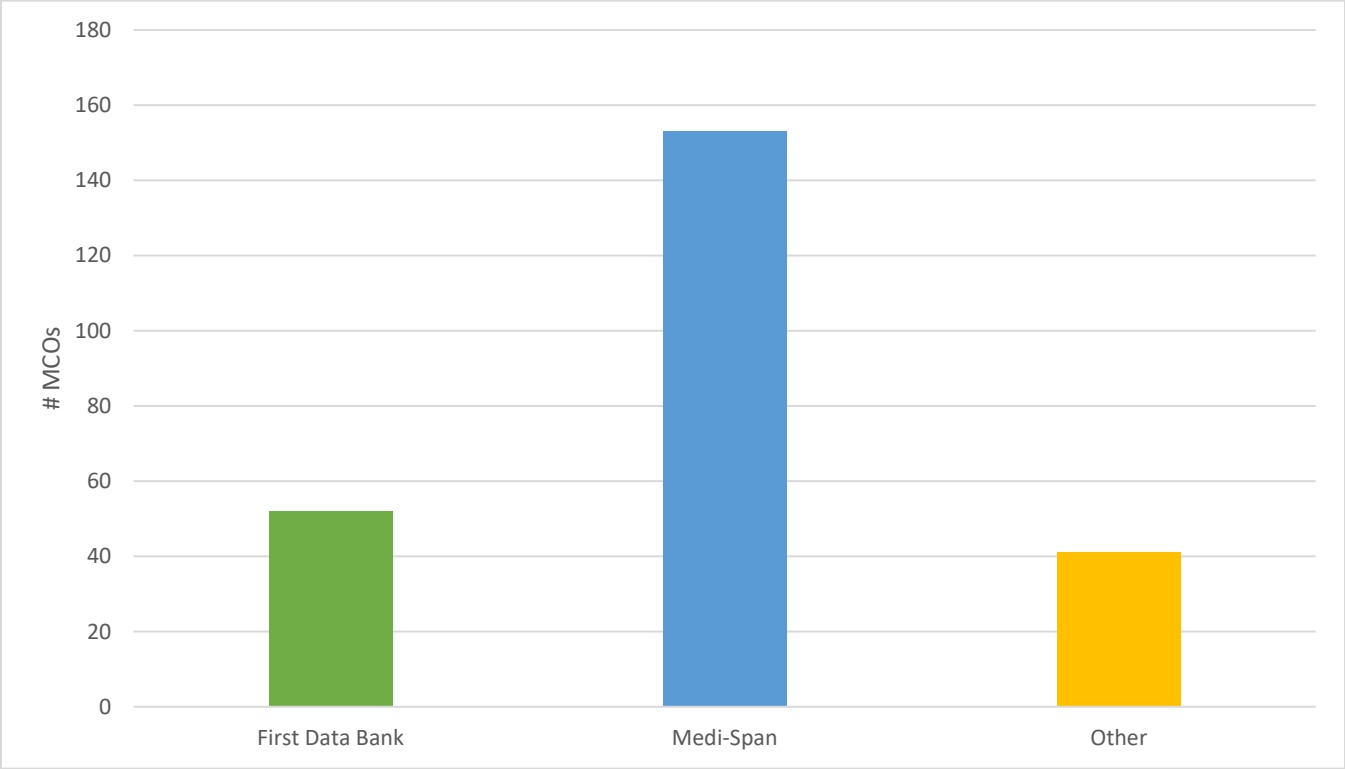

Table 5 - Prospective DUR Criteria Source

Response	States (Count of MCOs)	Count	Percentage
First Data Bank	Arkansas (1), Colorado (1), Delaware (1), Florida (3), Georgia (1), Hawaii (1), Illinois (2), Indiana (2), Iowa (1), Kentucky (6), Maryland (3), Massachusetts (1), Michigan (5), Minnesota (4), Mississippi (1), New Hampshire (1), New York (4), Ohio (1), Oregon (9), Pennsylvania (1), South Carolina (2), Washington (1)	52	21.14%
Medi-Span	Arkansas (3), Colorado (1), Delaware (1), District of Columbia (4), Florida (9), Georgia (2), Hawaii (5), Illinois (4), Indiana (3), Iowa (1), Kansas (3), Louisiana (5), Maryland (6), Massachusetts (4), Michigan (4), Minnesota (5), Mississippi (2), Nebraska (3), Nevada (4), New Hampshire (2), New Jersey (5), New Mexico (3), New York (10), North Carolina (5), Ohio (4), Oregon (12), Pennsylvania (7), Rhode Island (3), South Carolina (3), Texas (16), Utah (4), Virginia (6), Washington (4)	153	62.20%

Response	States (Count of MCOs)	Count	Percentage
Other	Arkansas (1), Delaware (1), Florida (5), Georgia (1), Hawaii (2), Kansas (1), Louisiana (1), Maryland (2), Michigan (2), Nebraska (1), Nevada (1), New Jersey (1), New York (5), North Carolina (2), Ohio (1), Oregon (2), Pennsylvania (4), South Carolina (2), Texas (2), Utah (1), Virginia (1), Washington (2)	41	16.67%
National Totals		**246**	**100%**

3. When the pharmacist receives a ProDUR alert message that requires a pharmacist's review, does your system allow the pharmacist to override the alert using the National Council for Prescription Drug Program (NCPDP) drug use evaluation codes (reason for service, professional service and resolution)?

Figure 4 - ProDUR Alert Message for Pharmacist Override using NCPDP Drug Use Evaluation Codes

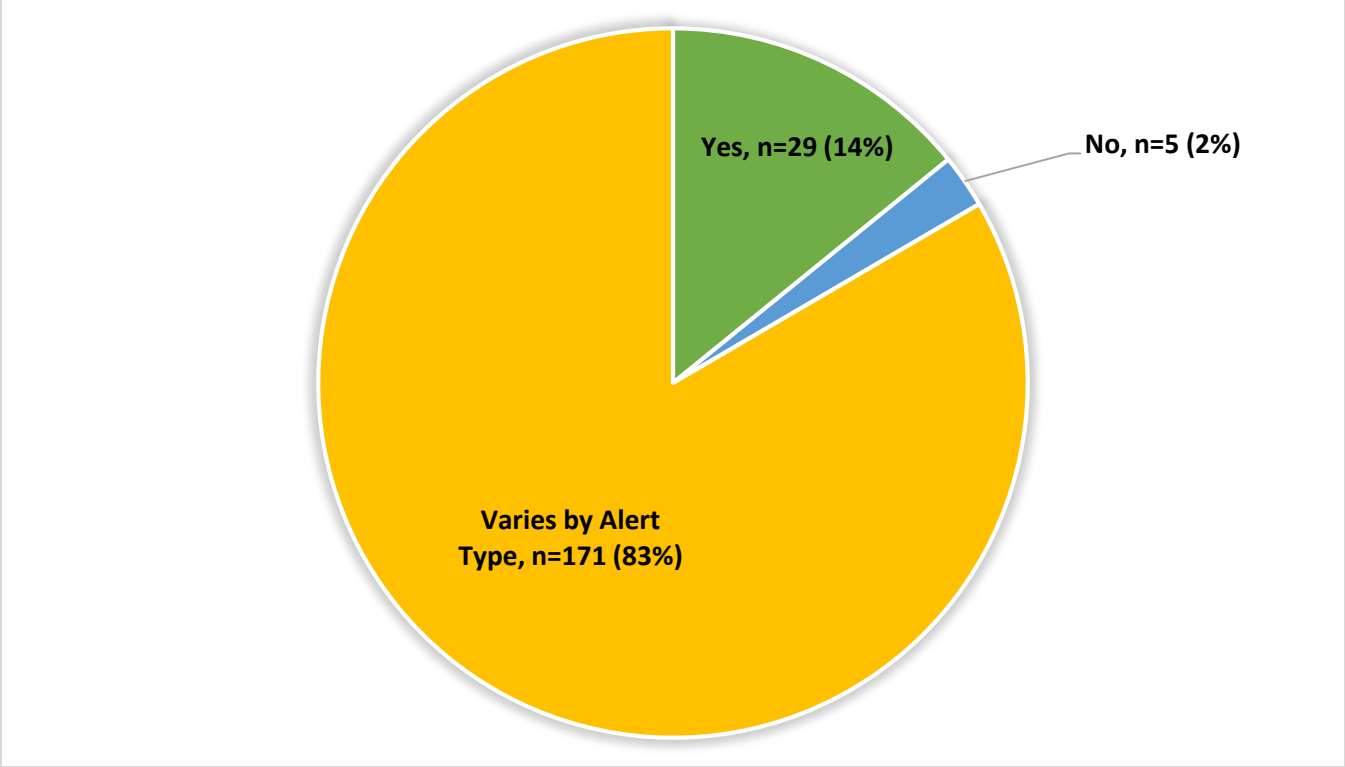

Table 6 - ProDUR Alert Message for Pharmacist Override using NCPDP Drug Use Evaluation Codes

Response	States (Count of MCOs)	Count	Percentage
Yes	District of Columbia (1), Hawaii (2), Illinois (1), Indiana (2), Louisiana (1), Maryland (1), Massachusetts (1), Nebraska (1), Nevada (2), New Jersey (2), New Mexico (1), New York (3), Oregon (2), Pennsylvania (2), Rhode Island (1), South Carolina (1), Texas (3), Washington (2)	29	14.15%
No	District of Columbia (1), Iowa (2), Pennsylvania (2)	5	2.44%

Response	States (Count of MCOs)	Count	Percentage
Varies by Alert Type	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (2), Florida (11), Georgia (3), Hawaii (4), Illinois (5), Indiana (3), Kansas (3), Kentucky (6), Louisiana (4), Maryland (8), Massachusetts (4), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (2), Nevada (2), New Hampshire (3), New Jersey (3), New Mexico (2), New York (12), North Carolina (5), Ohio (5), Oregon (19), Pennsylvania (4), Rhode Island (2), South Carolina (4), Texas (13), Utah (4), Virginia (6), Washington (3)	171	83.41%
National Totals		**205**	**100%**

If “Yes” or “Varies by Alert Type,” check all that apply.

Figure 5 - ProDUR Alert Types for Pharmacist Override

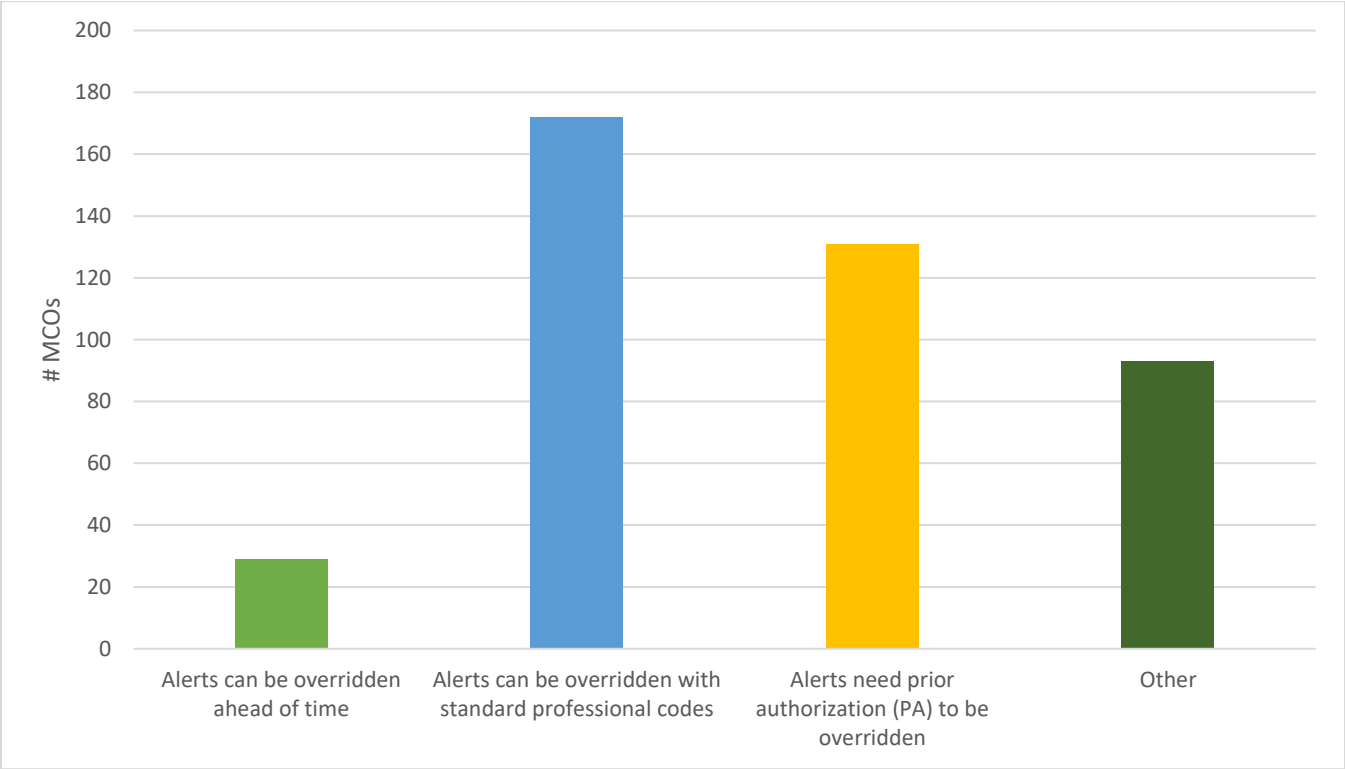

Table 7 - ProDUR Alert Types for Pharmacist Override

Response	States (Count of MCOs)	Count	Percentage
Alerts can be overridden ahead of time	Arkansas (1), District of Columbia (1), Florida (1), Illinois (2), Maryland (1), Massachusetts (2), Michigan (2), Mississippi (1), Nevada (1), New Hampshire (2), New York (2), North Carolina (1), Ohio (1), Oregon (5), South Carolina (1), Texas (1), Utah (1), Washington (3)	29	6.82%

Response	States (Count of MCOs)	Count	Percentage
Alerts can be overridden with standard professional codes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (3), Florida (10), Georgia (2), Hawaii (4), Illinois (6), Indiana (5), Kansas (3), Kentucky (6), Louisiana (5), Maryland (7), Massachusetts (4), Michigan (8), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (4), New Mexico (3), New York (11), North Carolina (4), Ohio (3), Oregon (20), Pennsylvania (6), Rhode Island (3), South Carolina (4), Texas (9), Utah (1), Virginia (6), Washington (5)	172	40.47%
Alerts need prior authorization (PA) to be overridden	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (2), Florida (9), Georgia (1), Hawaii (2), Illinois (5), Indiana (4), Kansas (3), Kentucky (6), Louisiana (3), Maryland (6), Massachusetts (1), Michigan (8), Minnesota (8), Mississippi (3), Nebraska (3), Nevada (2), New Hampshire (2), New Jersey (3), New Mexico (2), New York (6), North Carolina (2), Ohio (3), Oregon (14), Pennsylvania (4), Rhode Island (1), South Carolina (3), Texas (5), Utah (3), Virginia (5), Washington (4)	131	30.82%
Other	Arkansas (2), Colorado (1), Florida (5), Georgia (1), Hawaii (2), Illinois (2), Indiana (1), Kansas (1), Kentucky (6), Louisiana (2), Maryland (4), Massachusetts (3), Michigan (6), Minnesota (4), Nebraska (1), Nevada (1), New Hampshire (1), New Jersey (3), New York (6), North Carolina (2), Ohio (2), Oregon (15), Pennsylvania (1), Rhode Island (1), South Carolina (2), Texas (12), Utah (4), Virginia (1), Washington (1)	93	21.88%
National Totals		**425**	**100%**

4. Does your MCO receive periodic reports providing individual pharmacy providers DUR alert override activity in summary and/or in detail?

Figure 6 - Receive Periodic Reports Providing Individual Pharmacy Providers DUR Alert Override Activity

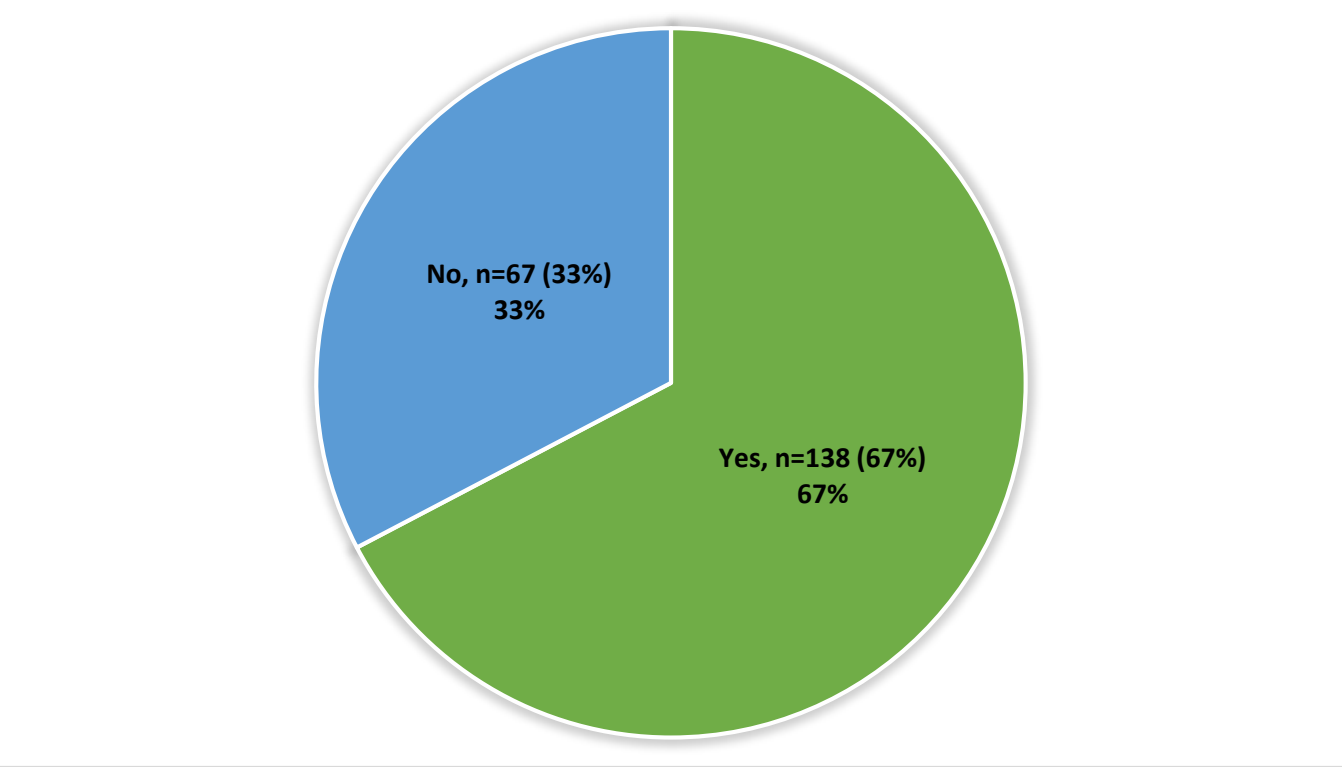

Table 8 - Receive Periodic Reports Providing Individual Pharmacy Providers DUR Alert Override Activity

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (3), Colorado (2), Delaware (1), District of Columbia (3), Florida (8), Georgia (1), Hawaii (2), Illinois (4), Indiana (5), Kansas (3), Kentucky (6), Louisiana (5), Maryland (6), Massachusetts (4), Michigan (8), Minnesota (7), Mississippi (3), Nebraska (3), Nevada (3), New Hampshire (1), New Jersey (4), New Mexico (1), New York (13), North Carolina (3), Ohio (4), Oregon (8), Pennsylvania (6), Rhode Island (3), South Carolina (3), Texas (5), Utah (1), Virginia (4), Washington (5)	138	67.32%
No	Arkansas (1), Delaware (1), District of Columbia (1), Florida (3), Georgia (2), Hawaii (4), Illinois (2), Iowa (2), Maryland (3), Massachusetts (1), Michigan (1), Minnesota (2), Nevada (1), New Hampshire (2), New Jersey (1), New Mexico (2), New York (2), North Carolina (2), Ohio (1), Oregon (13), Pennsylvania (2), South Carolina (2), Texas (11), Utah (3), Virginia (2)	67	32.68%
National Totals		**205**	**100%**

a. If "Yes," how often does your MCO receive reports (multiple responses allowed)?

Figure 7 - Frequency of Reports Providing Individual Pharmacy Providers DUR Alert Override Activity

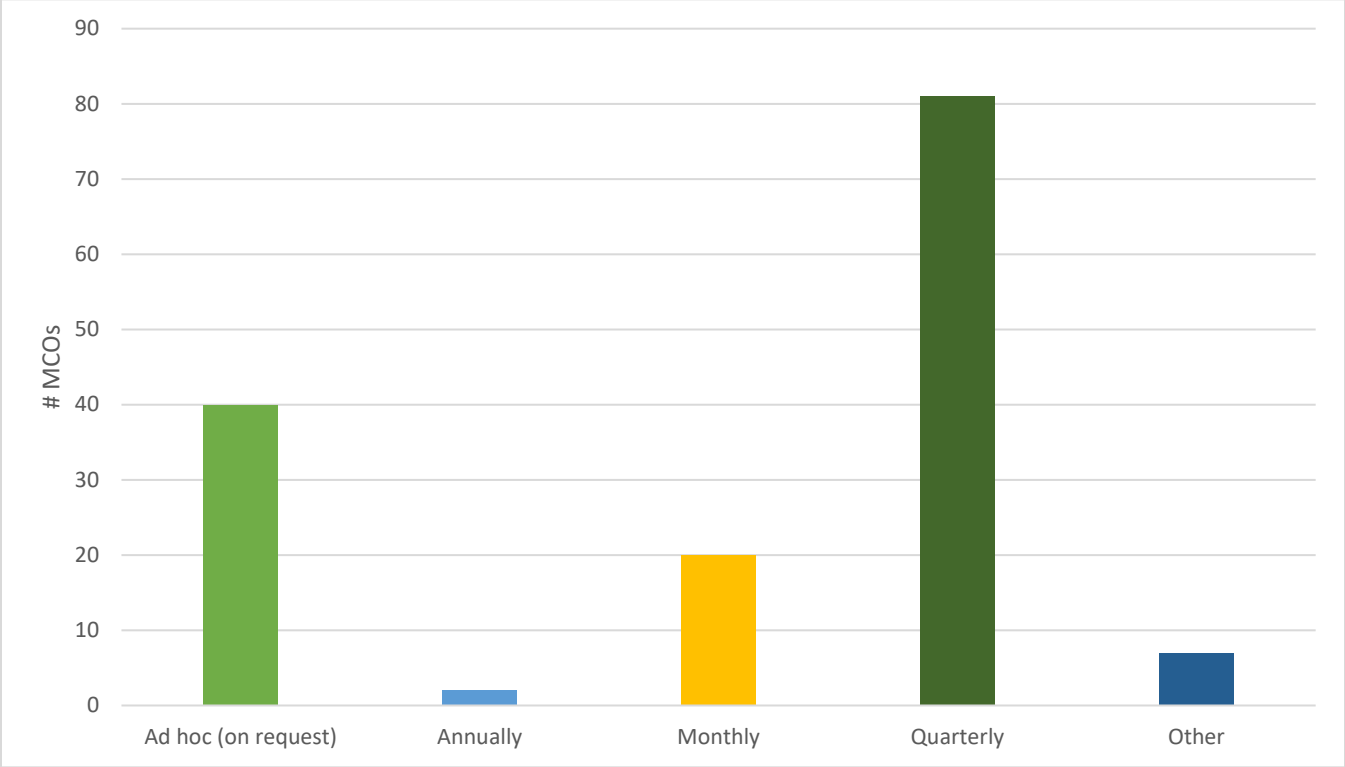

Table 9 - Frequency of Reports Providing Individual Pharmacy Providers DUR Alert Override Activity

Response	States (Count of MCOs)	Count	Percentage
Ad hoc (on request)	Arkansas (1), Colorado (1), District of Columbia (2), Florida (4), Kansas (1), Kentucky (5), Louisiana (2), Maryland (1), Massachusetts (2), Michigan (4), Minnesota (2), New Hampshire (1), New Jersey (1), New York (7), North Carolina (1), Oregon (1), Pennsylvania (1), South Carolina (1), Texas (1), Washington (1)	40	26.67%
Annually	Minnesota (1), New York (1)	2	1.33%
Monthly	Arkansas (2), District of Columbia (1), Illinois (2), Indiana (1), Louisiana (3), Minnesota (1), Mississippi (1), Nebraska (2), Nevada (1), New Mexico (1), Pennsylvania (1), Texas (1), Virginia (2), Washington (1)	20	13.33%
Quarterly	Arkansas (1), Colorado (1), Delaware (1), District of Columbia (2), Florida (4), Georgia (1), Hawaii (2), Illinois (3), Indiana (4), Kansas (2), Kentucky (1), Maryland (5), Massachusetts (3), Michigan (5), Minnesota (3), Mississippi (2), Nebraska (1), Nevada (2), New Jersey (3), New York (4), North Carolina (3), Ohio (4), Oregon (7), Pennsylvania (4), Rhode Island (3), South Carolina (2), Texas (3), Utah (1), Virginia (2), Washington (2)	81	54.00%
Other	Indiana (1), Louisiana (1), Minnesota (1), New York (2), Rhode Island (1), Washington (1)	7	4.67%
National Totals		**150**	**100%**

b. If "Yes," does your MCO follow up with those providers who routinely override with interventions?

Figure 8 - Follow up with Providers who Routinely Override with Interventions

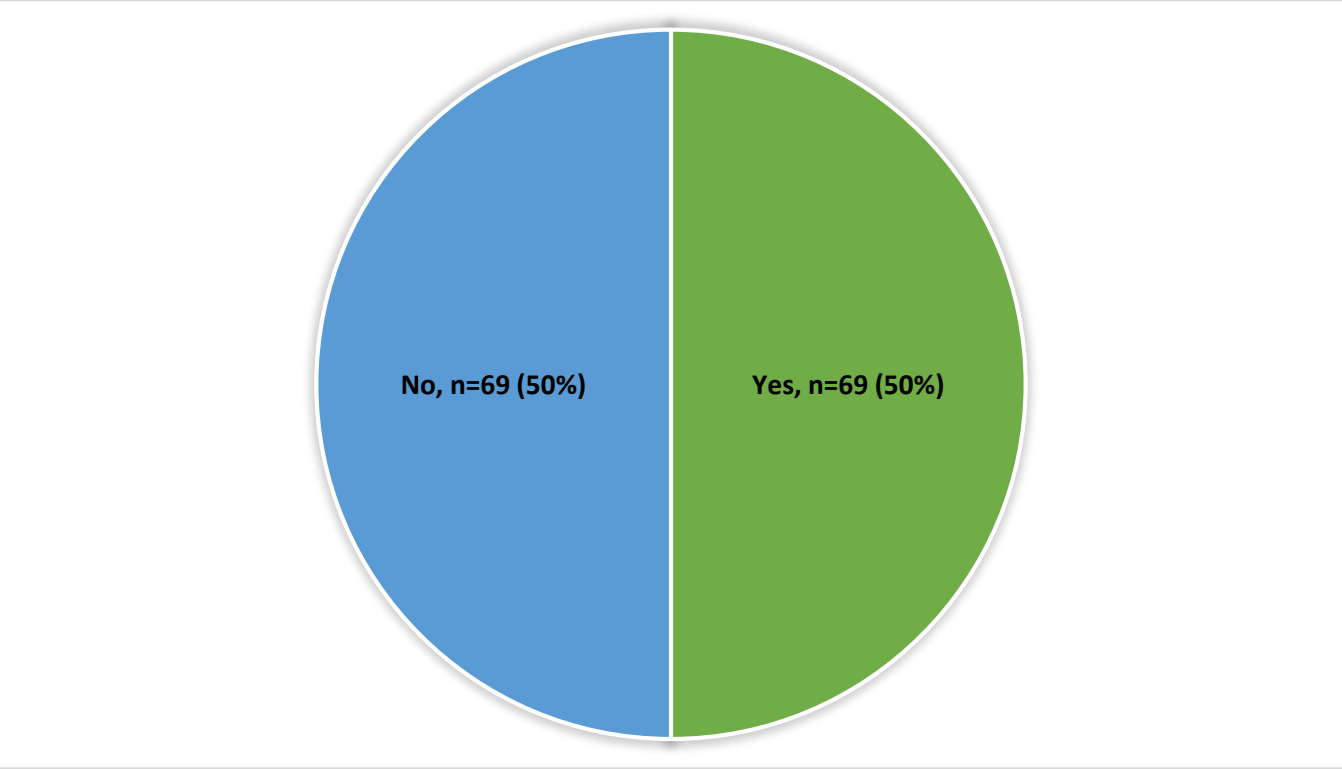

Table 10 - Follow up with Providers who Routinely Override with Interventions

Response	States (Count of MCOs)	Count	Percentage
Yes	Colorado (1), District of Columbia (2), Florida (3), Hawaii (2), Illinois (1), Indiana (4), Kansas (2), Kentucky (1), Louisiana (3), Maryland (5), Massachusetts (3), Michigan (5), Minnesota (4), Mississippi (2), Nebraska (2), Nevada (1), New Hampshire (1), New Jersey (3), New Mexico (1), New York (4), North Carolina (1), Ohio (2), Oregon (2), Pennsylvania (2), Rhode Island (3), Texas (3), Utah (1), Virginia (2), Washington (3)	69	50.00%
No	Arkansas (3), Colorado (1), Delaware (1), District of Columbia (1), Florida (5), Georgia (1), Illinois (3), Indiana (1), Kansas (1), Kentucky (5), Louisiana (2), Maryland (1), Massachusetts (1), Michigan (3), Minnesota (3), Mississippi (1), Nebraska (1), Nevada (2), New Jersey (1), New York (9), North Carolina (2), Ohio (2), Oregon (6), Pennsylvania (4), South Carolina (3), Texas (2), Virginia (2), Washington (2)	69	50.00%
National Totals		**138**	**100%**

If "Yes," by what method does your MCO follow up (multiple responses allowed)?

Figure 9 - Follow-up Methods with Providers who Routinely Override with Interventions

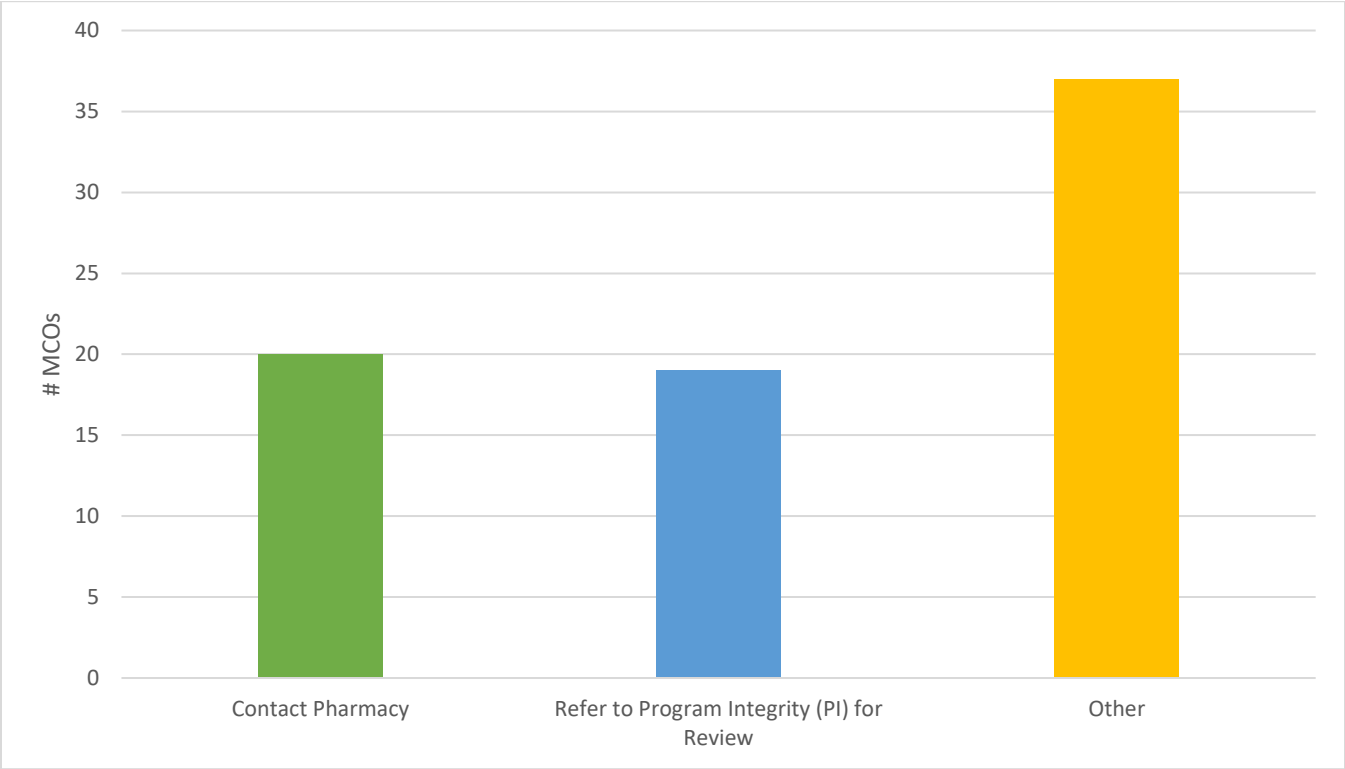

Table 11 - Follow-up Methods with Providers who Routinely Override with Interventions

Response	States (Count of MCOs)	Count	Percentage
Contact Pharmacy	District of Columbia (1), Florida (2), Hawaii (1), Maryland (4), Michigan (1), Minnesota (1), Nebraska (1), New Jersey (2), New York (3), Oregon (2), Pennsylvania (1), Rhode Island (1)	20	26.32%
Refer to Program Integrity (PI) for Review	Indiana (3), Kansas (1), Louisiana (1), Maryland (1), Massachusetts (1), Michigan (3), Minnesota (1), Mississippi (1), New Hampshire (1), New York (1), Ohio (1), Oregon (1), Rhode Island (1), Virginia (1), Washington (1)	19	25.00%
Other	Colorado (1), District of Columbia (1), Florida (1), Hawaii (1), Illinois (1), Indiana (1), Kansas (1), Kentucky (1), Louisiana (2), Maryland (2), Massachusetts (2), Michigan (3), Minnesota (2), Mississippi (1), Nebraska (1), Nevada (1), New Jersey (1), New Mexico (1), New York (1), North Carolina (1), Ohio (1), Pennsylvania (1), Rhode Island (2), Texas (3), Utah (1), Virginia (1), Washington (2)	37	48.68%
National Totals		**76**	**100%**

5. Early Refill

a. At what percent threshold does your MCO set your system to edit?

Figure 10 - Non-Controlled Drugs Early Refill Percent Edit Threshold (Average by State)

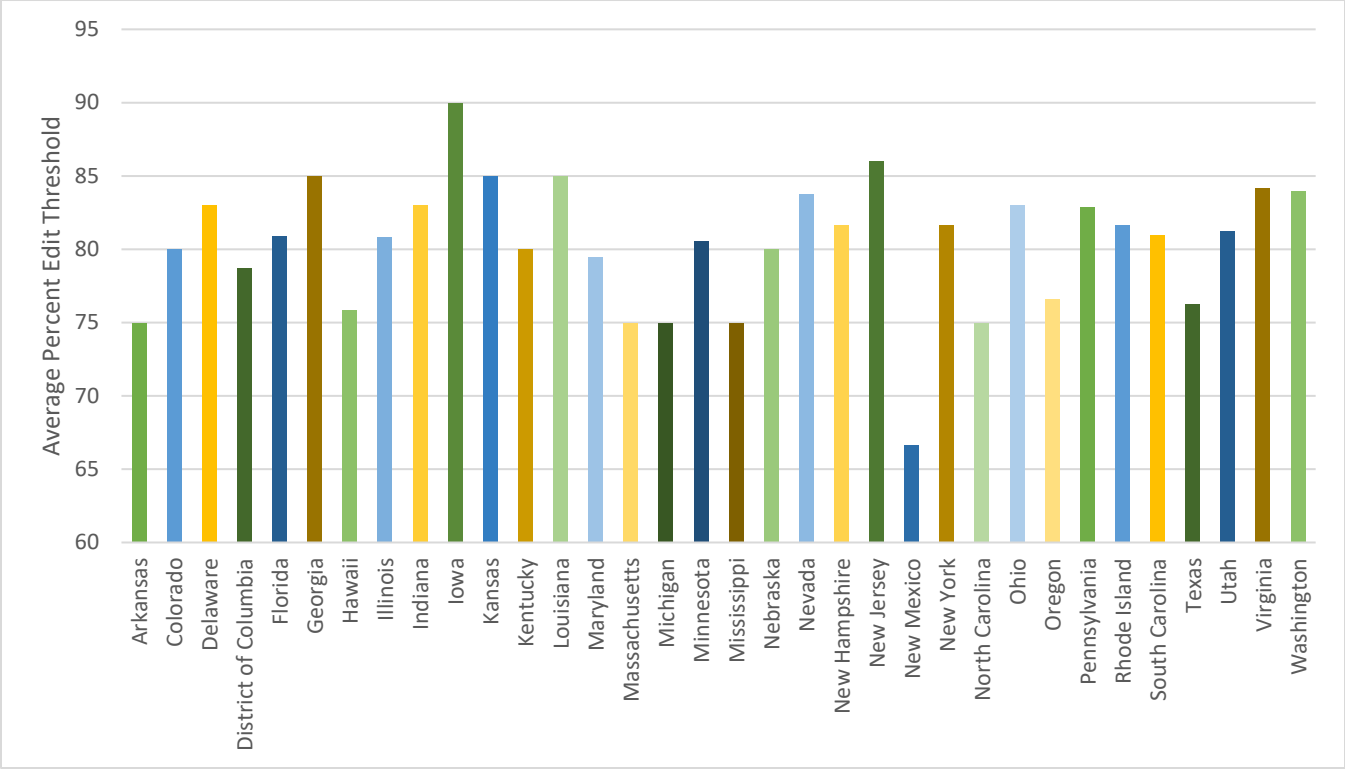

Figure 11 - Schedule II Controlled Drugs Early Refill Percent Edit Threshold (Average by State)

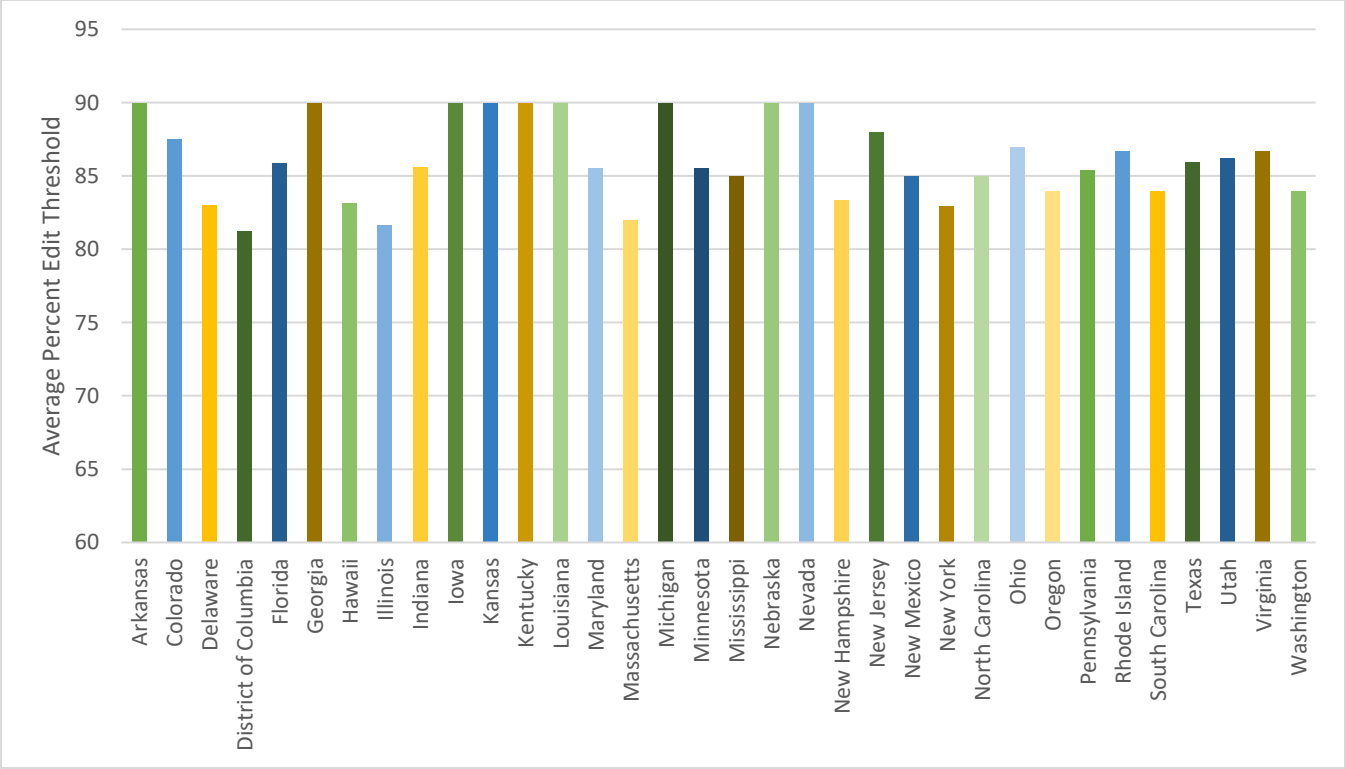

Figure 12 - Schedule III through V Controlled Drugs Early Refill Percent Edit Threshold (Average by State)

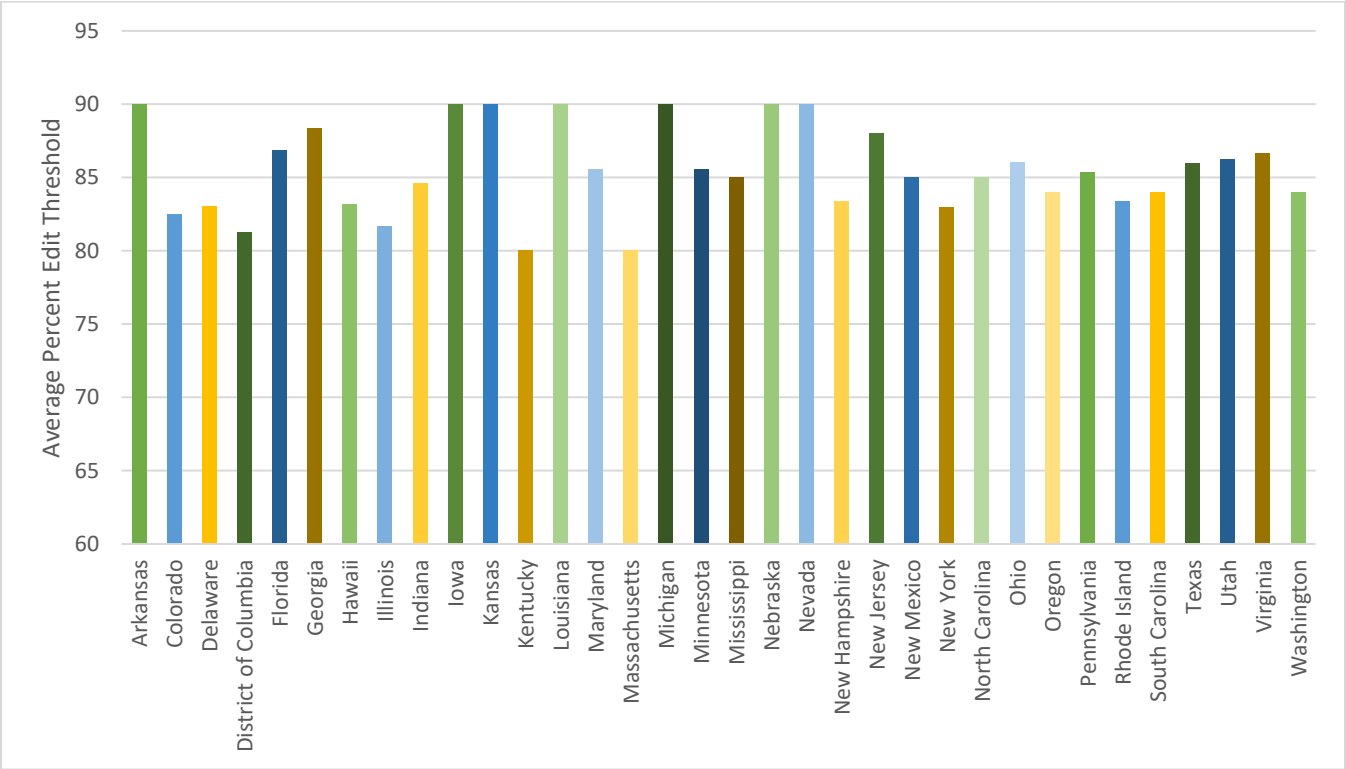

Table 12 - Early Refill Percent Threshold for Non-controlled and Controlled Drugs (Average by State)

State	Non-controlled Drugs	Schedule II Controlled Drugs	Schedule III through V Controlled Drugs
Arkansas	75%	90%	90%
Colorado	80%	88%	83%
Delaware	83%	83%	83%
District of Columbia	79%	81%	81%
Florida	81%	86%	87%
Georgia	85%	90%	88%
Hawaii	76%	83%	83%
Illinois	81%	82%	82%
Indiana	83%	86%	85%
Iowa	90%	90%	90%
Kansas	85%	90%	90%
Kentucky	80%	90%	80%
Louisiana	85%	90%	90%
Maryland	79%	86%	86%
Massachusetts	75%	82%	80%
Michigan	75%	90%	90%
Minnesota	81%	86%	86%
Mississippi	75%	85%	85%
Nebraska	80%	90%	90%
Nevada	84%	90%	90%
New Hampshire	82%	83%	83%
New Jersey	86%	88%	88%
New Mexico	67%	85%	85%
New York	82%	83%	83%
North Carolina	75%	85%	85%
Ohio	83%	87%	86%
Oregon	77%	84%	84%
Pennsylvania	83%	85%	85%
Rhode Island	82%	87%	83%
South Carolina	81%	84%	84%
Texas	76%	86%	86%
Utah	81%	86%	86%
Virginia	84%	87%	87%
Washington	84%	84%	84%
National Average	**80%**	**86%**	**86%**

b. For non-controlled drugs, when an early refill message occurs, does your MCO require PA?

Figure 13 - Non-Controlled Drugs, Early Refill Requirement for Prior Authorization

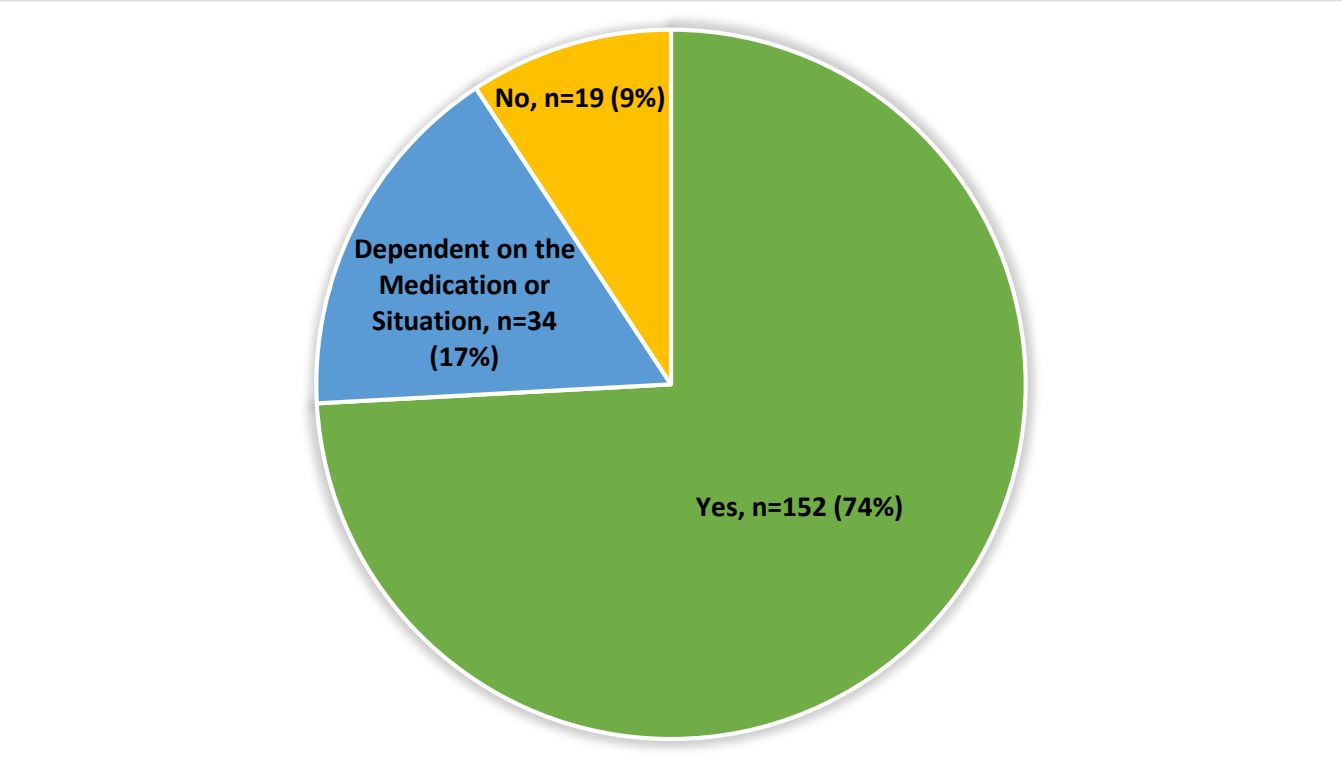

Table 13 - Non-Controlled Drugs, Early Refill Requirement for Prior Authorization

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (3), Colorado (2), Delaware (2), District of Columbia (3), Florida (8), Georgia (3), Hawaii (5), Illinois (5), Indiana (4), Iowa (2), Kansas (2), Kentucky (6), Louisiana (4), Maryland (7), Massachusetts (1), Michigan (6), Minnesota (7), Mississippi (1), Nebraska (1), Nevada (2), New Hampshire (1), New Jersey (5), New York (13), North Carolina (3), Ohio (3), Oregon (18), Pennsylvania (6), Rhode Island (3), South Carolina (2), Texas (13), Utah (3), Virginia (5), Washington (3)	152	74.15%
Dependent on the medication or situation	Arkansas (1), Florida (2), Illinois (1), Indiana (1), Kansas (1), Maryland (1), Massachusetts (2), Michigan (2), Mississippi (2), Nebraska (2), Nevada (1), New Hampshire (1), New Mexico (3), New York (2), North Carolina (1), Ohio (2), Pennsylvania (1), South Carolina (3), Texas (2), Utah (1), Virginia (1), Washington (1)	34	16.59%
No	District of Columbia (1), Florida (1), Hawaii (1), Louisiana (1), Maryland (1), Massachusetts (2), Michigan (1), Minnesota (2), Nevada (1), New Hampshire (1), North Carolina (1), Oregon (3), Pennsylvania (1), Texas (1), Washington (1)	19	9.27%
National Totals		**205**	**100%**

If "Yes," or "Dependent on medication or situation," who obtains authorization?

Figure 14 - Non-Controlled Drugs Early Refill Authorization Sources

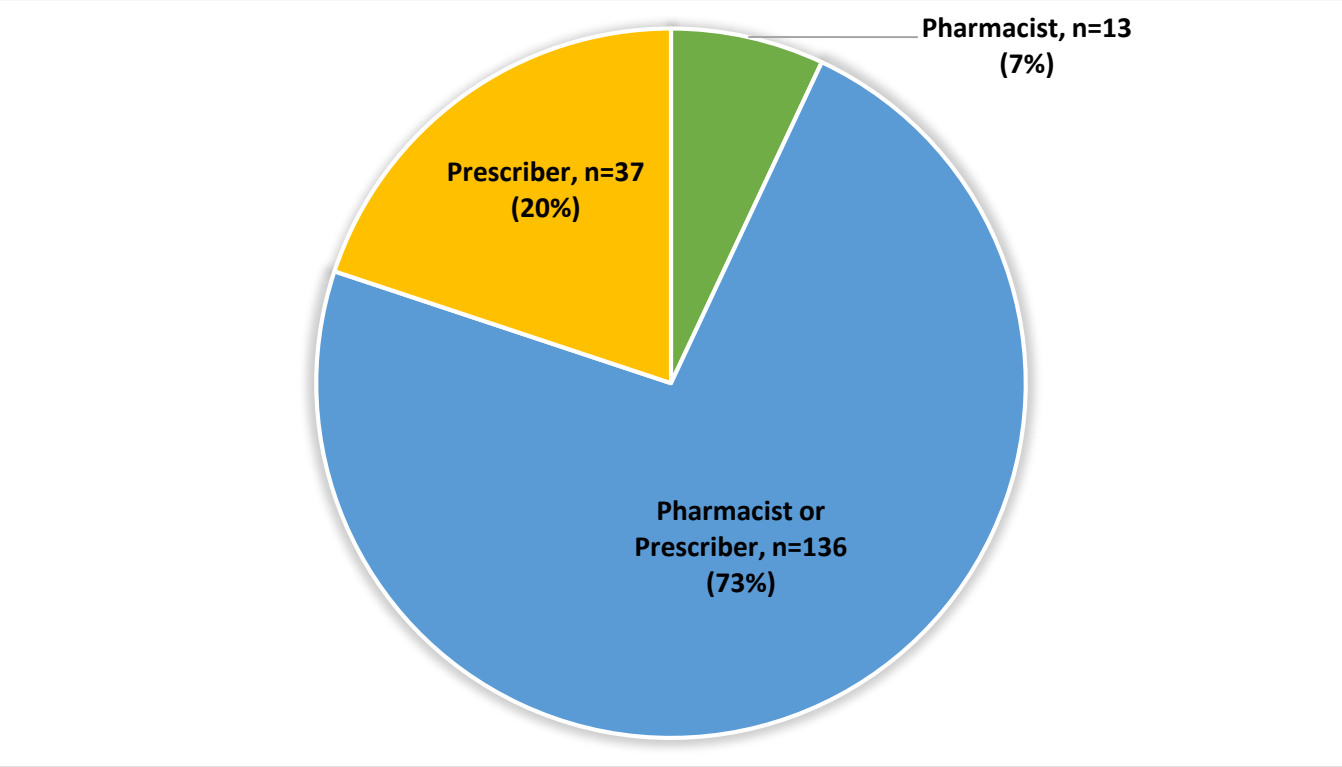

Table 14 - Non-Controlled Drugs Early Refill Authorization Sources

Response	States (Count of MCOs)	Count	Percentage
Pharmacist	Arkansas (1), District of Columbia (1), Florida (1), Maryland (1), Massachusetts (1), Minnesota (3), Nebraska (1), New York (2), North Carolina (1), South Carolina (1)	13	6.99%
Pharmacist or Prescriber	Arkansas (3), Colorado (2), Delaware (1), District of Columbia (2), Florida (6), Georgia (2), Hawaii (5), Illinois (5), Indiana (4), Kansas (1), Kentucky (6), Louisiana (2), Maryland (5), Massachusetts (2), Michigan (7), Minnesota (3), Mississippi (2), Nebraska (2), Nevada (2), New Hampshire (2), New Jersey (3), New Mexico (3), New York (9), North Carolina (1), Ohio (3), Oregon (18), Pennsylvania (4), Rhode Island (2), South Carolina (4), Texas (14), Utah (4), Virginia (3), Washington (4)	136	73.12%
Prescriber	Delaware (1), Florida (3), Georgia (1), Illinois (1), Indiana (1), Iowa (2), Kansas (2), Louisiana (2), Maryland (2), Michigan (1), Minnesota (1), Mississippi (1), Nevada (1), New Jersey (2), New York (4), North Carolina (2), Ohio (2), Pennsylvania (3), Rhode Island (1), Texas (1), Virginia (3)	37	19.89%
National Totals		**186**	**100%**

If "No," can the pharmacist override at the point of service?

Figure 15 - Non-Controlled Drugs, Pharmacist May Override at Point of Service

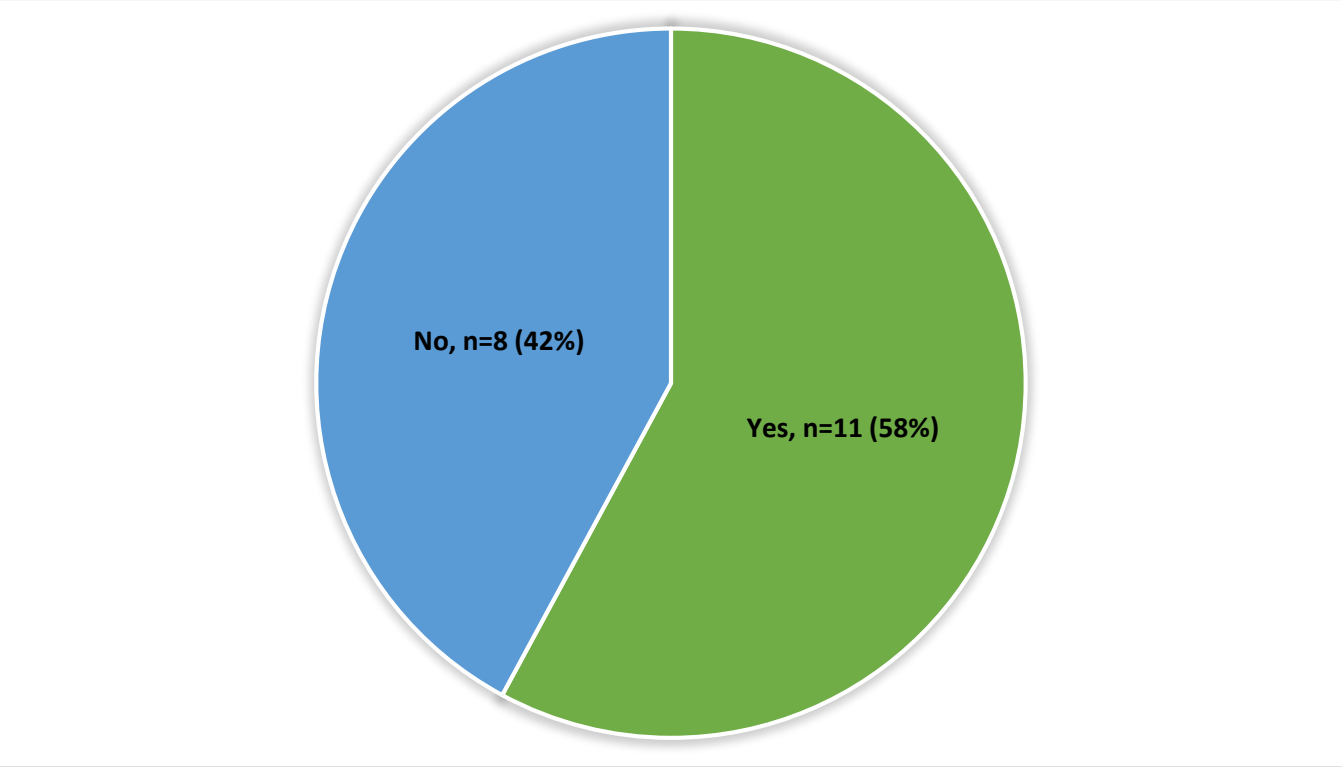

Table 15 - Non-Controlled Drugs, Pharmacist May Override at Point of Service

Response	States (Count of MCOs)	Count	Percentage
Yes	District of Columbia (1), Hawaii (1), Massachusetts (2), Michigan (1), North Carolina (1), Oregon (2), Pennsylvania (1), Texas (1), Washington (1)	11	57.89%
No	Florida (1), Louisiana (1), Maryland (1), Minnesota (2), Nevada (1), New Hampshire (1), Oregon (1)	8	42.11%
National Totals		**19**	**100%**

c. For controlled drugs, when an early refill message occurs, does your MCO require PA?

Figure 16 - Controlled Drugs, Early Refill Requirement for MCO Prior Authorization

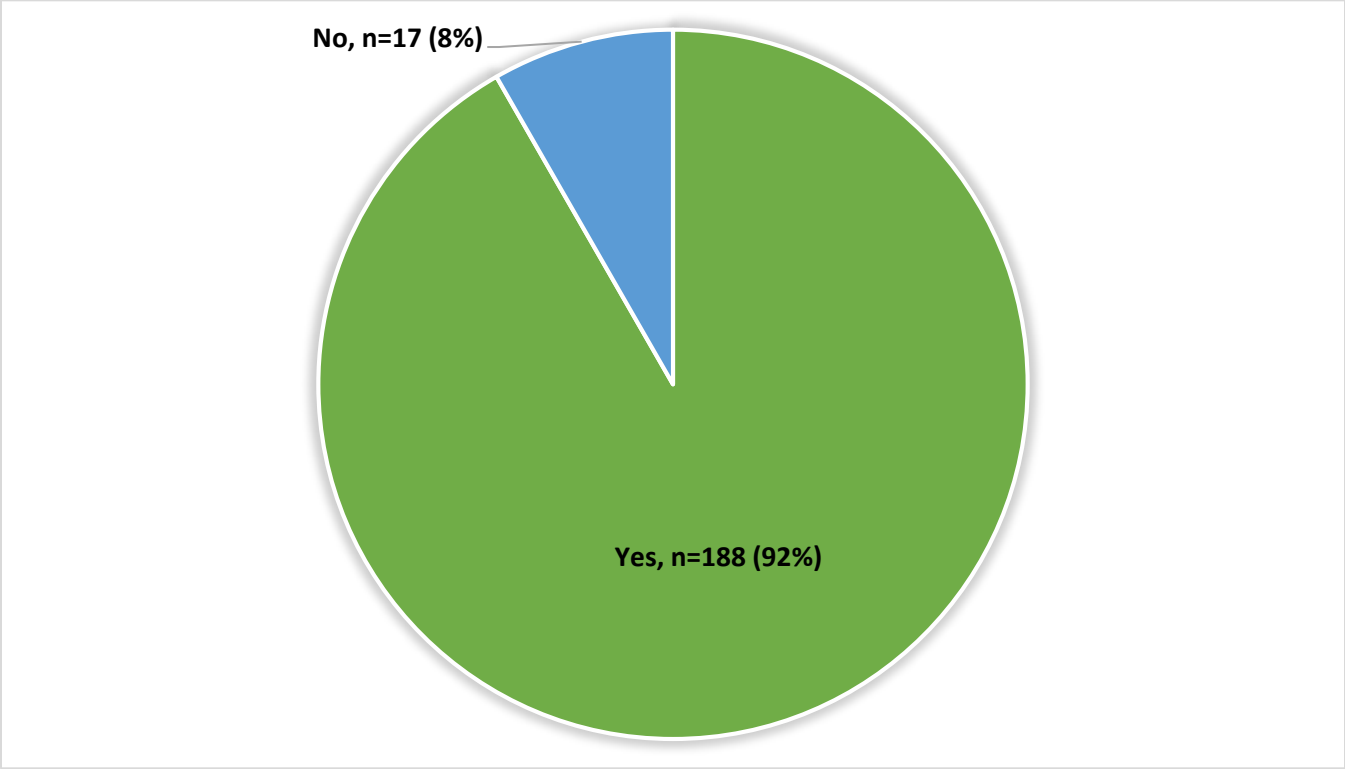

Table 16 - Controlled Drugs, Early Refill Requirement for MCO Prior Authorization

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (10), Georgia (3), Hawaii (5), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (4), Maryland (8), Massachusetts (4), Michigan (8), Minnesota (7), Mississippi (3), Nebraska (3), Nevada (3), New Hampshire (2), New Jersey (5), New Mexico (3), New York (14), North Carolina (4), Ohio (5), Oregon (18), Pennsylvania (7), Rhode Island (3), South Carolina (5), Texas (15), Utah (4), Virginia (6), Washington (5)	188	91.71%
No	Florida (1), Hawaii (1), Louisiana (1), Maryland (1), Massachusetts (1), Michigan (1), Minnesota (2), Nevada (1), New Hampshire (1), New York (1), North Carolina (1), Oregon (3), Pennsylvania (1), Texas (1)	17	8.29%
National Totals		**205**	**100%**

If "Yes," who obtains authorization?

Figure 17 - Controlled Drugs Early Refill Authorization Source

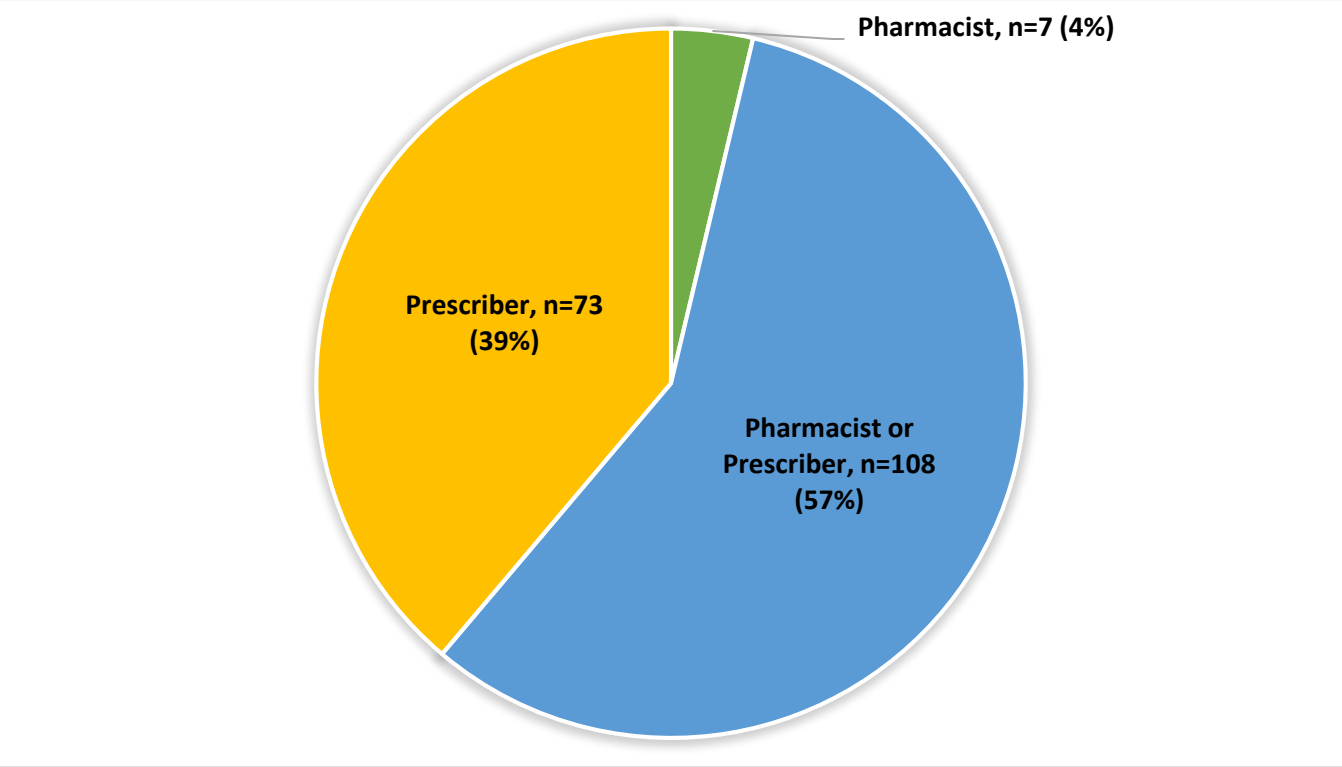

Table 17 - Controlled Drugs Early Refill Authorization Source

Response	States (Count of MCOs)	Count	Percentage
Pharmacist	Arkansas (1), Maryland (1), Minnesota (2), New York (2), South Carolina (1)	7	3.72%
Pharmacist or Prescriber	Arkansas (3), Colorado (2), District of Columbia (3), Florida (5), Georgia (1), Hawaii (4), Illinois (4), Indiana (1), Kansas (1), Kentucky (1), Louisiana (2), Maryland (3), Massachusetts (4), Michigan (4), Minnesota (3), Mississippi (2), Nebraska (1), New Hampshire (2), New Jersey (2), New Mexico (3), New York (7), North Carolina (1), Ohio (3), Oregon (16), Pennsylvania (3), Rhode Island (1), South Carolina (3), Texas (13), Utah (2), Virginia (3), Washington (5)	108	57.45%
Prescriber	Delaware (2), District of Columbia (1), Florida (5), Georgia (2), Hawaii (1), Illinois (2), Indiana (4), Iowa (2), Kansas (2), Kentucky (5), Louisiana (2), Maryland (4), Michigan (4), Minnesota (2), Mississippi (1), Nebraska (2), Nevada (3), New Jersey (3), New York (5), North Carolina (3), Ohio (2), Oregon (2), Pennsylvania (4), Rhode Island (2), South Carolina (1), Texas (2), Utah (2), Virginia (3)	73	38.83%
National Totals		**188**	**100%**

If "No," can the pharmacist override at the point of service?

Figure 18 - Controlled Drugs, Pharmacist May Override at Point of Service

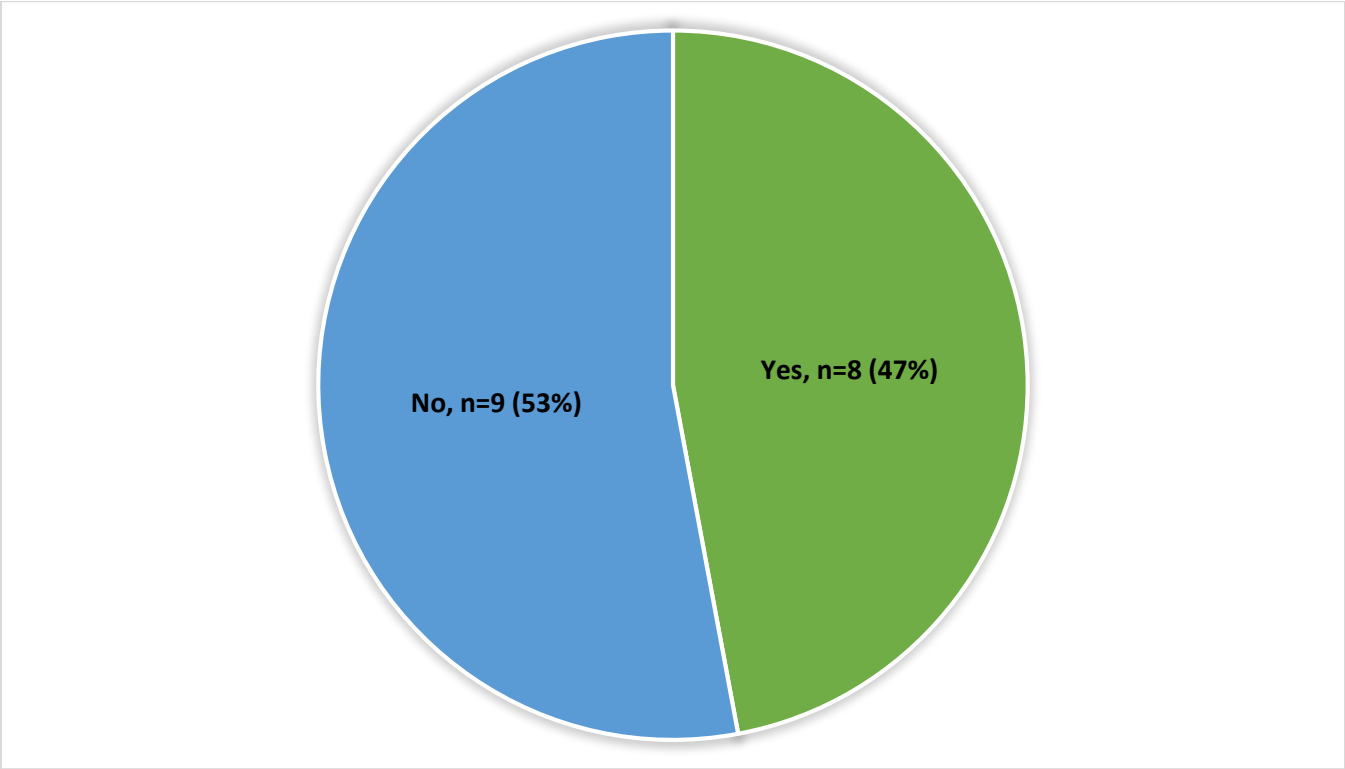

Table 18 - Controlled Drugs, Pharmacist May Override at Point of Service

Response	States (Count of MCOs)	Count	Percentage
Yes	Hawaii (1), Massachusetts (1), Michigan (1), North Carolina (1), Oregon (2), Pennsylvania (1), Texas (1)	8	47.06%
No	Florida (1), Louisiana (1), Maryland (1), Minnesota (2), Nevada (1), New Hampshire (1), New York (1), Oregon (1)	9	52.94%
National Totals		**17**	**100%**

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

Figure 19 - Allow Pharmacist Overrides for an Early Refill

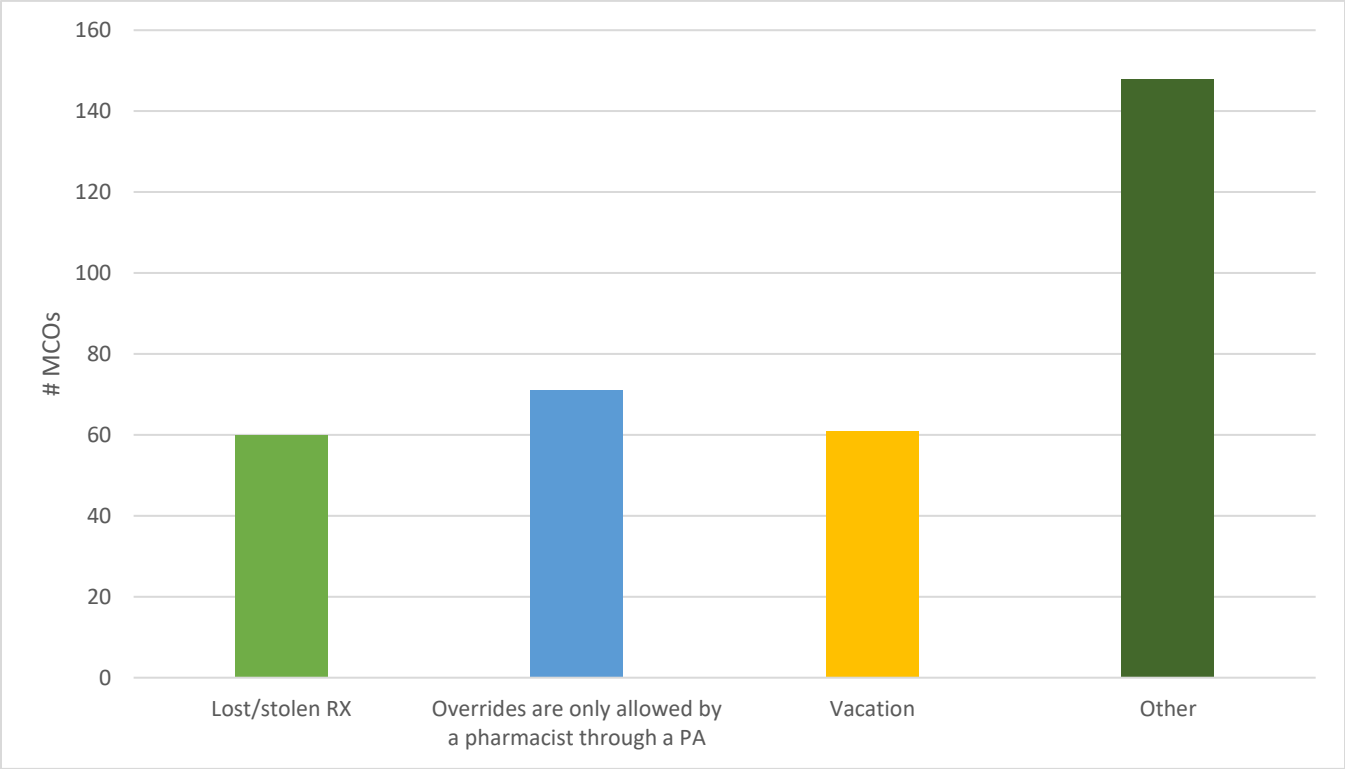

Table 19 - Allow Pharmacist Overrides for an Early Refill

Response	States (Count of MCOs)	Count	Percentage
Lost/stolen RX	Arkansas (2), Delaware (1), District of Columbia (2), Florida (5), Georgia (1), Hawaii (1), Illinois (2), Indiana (2), Maryland (2), Massachusetts (3), Michigan (3), Minnesota (2), Mississippi (1), Nevada (1), New Hampshire (2), New York (1), North Carolina (3), Ohio (2), Oregon (10), Pennsylvania (3), Rhode Island (1), South Carolina (2), Texas (3), Utah (1), Virginia (1), Washington (3)	60	17.65%
Overrides are only allowed by a pharmacist through a PA	Arkansas (1), Colorado (2), District of Columbia (2), Florida (4), Hawaii (3), Illinois (3), Indiana (2), Kansas (2), Kentucky (6), Louisiana (2), Maryland (4), Massachusetts (1), Michigan (2), Minnesota (4), Mississippi (2), Nebraska (1), Nevada (2), New Jersey (3), New Mexico (1), New York (4), Ohio (2), Oregon (10), Pennsylvania (1), Rhode Island (1), South Carolina (1), Texas (2), Virginia (3)	71	20.88%
Vacation	Arkansas (2), Delaware (1), District of Columbia (2), Florida (6), Georgia (1), Hawaii (1), Illinois (2), Indiana (2), Kansas (1), Maryland (3), Massachusetts (3), Michigan (4), Minnesota (2), New Hampshire (2), New Jersey (1), New York (1), North Carolina (3), Ohio (2), Oregon (7), Pennsylvania (3), Rhode Island (1), South Carolina (2), Texas (4), Utah (1), Virginia (1), Washington (3)	61	17.94%

Response	States (Count of MCOs)	Count	Percentage
Other	Arkansas (4), Colorado (1), Delaware (2), District of Columbia (2), Florida (6), Georgia (3), Hawaii (3), Illinois (4), Indiana (3), Iowa (2), Kansas (2), Louisiana (3), Maryland (5), Massachusetts (4), Michigan (8), Minnesota (7), Mississippi (1), Nebraska (2), Nevada (3), New Hampshire (2), New Jersey (1), New Mexico (3), New York (12), North Carolina (3), Ohio (5), Oregon (18), Pennsylvania (7), Rhode Island (3), South Carolina (3), Texas (14), Utah (4), Virginia (4), Washington (4)	148	43.53%
National Totals		**340**	**100%**

7. Does your system have an accumulation edit to prevent patients from continuously filling prescriptions early?

Figure 20 - System Accumulation Edit for Prevention of Early Prescription Filling

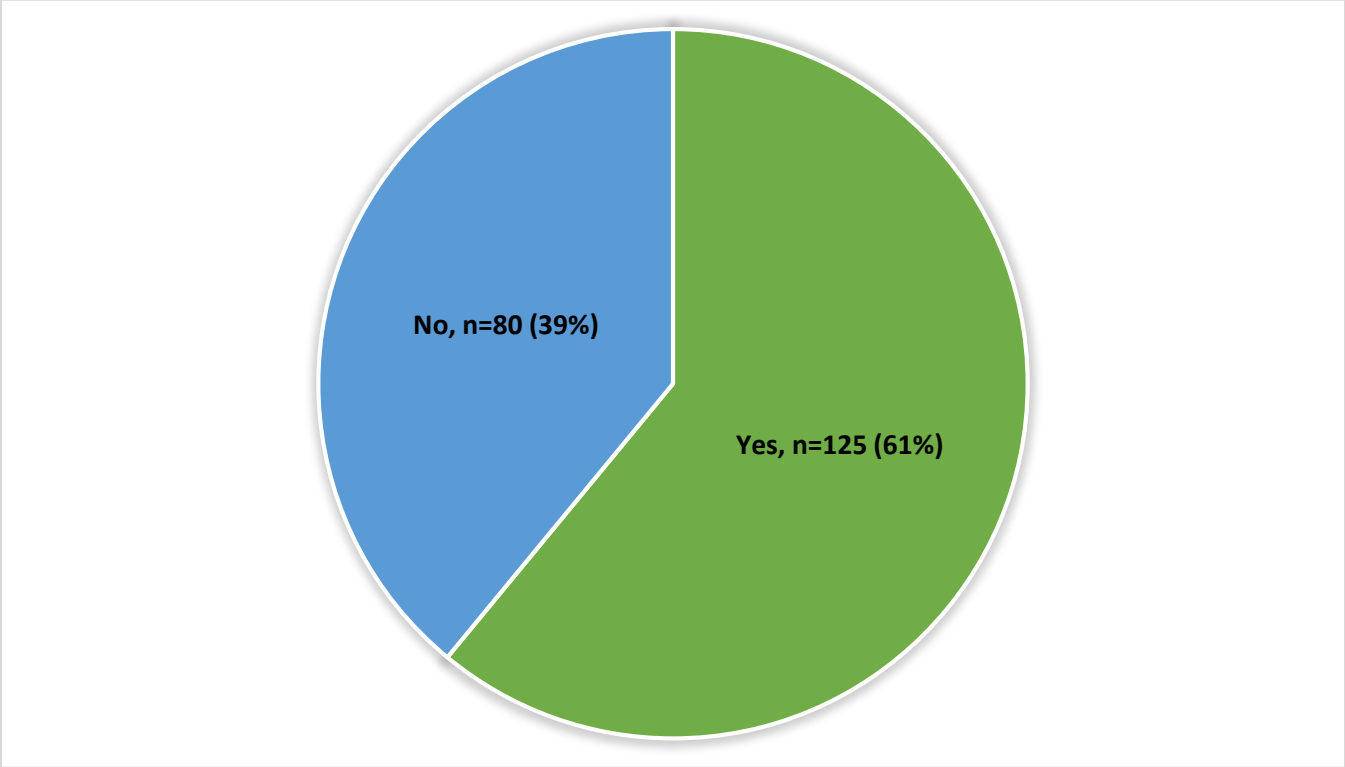

Table 20 - System Accumulation Edit for Prevention of Early Prescription Filling

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), District of Columbia (4), Florida (9), Georgia (2), Hawaii (3), Illinois (6), Indiana (3), Kansas (1), Kentucky (6), Louisiana (3), Maryland (7), Massachusetts (2), Michigan (5), Minnesota (5), Mississippi (2), Nebraska (1), Nevada (2), New Hampshire (3), New Jersey (4), New Mexico (2), New York (11), North Carolina (1), Ohio (4), Oregon (15), Pennsylvania (4), Rhode Island (1), South Carolina (2), Texas (3), Utah (3), Virginia (3), Washington (4)	125	60.98%

Response	States (Count of MCOs)	Count	Percentage
No	Colorado (2), Delaware (2), Florida (2), Georgia (1), Hawaii (3), Indiana (2), Iowa (2), Kansas (2), Louisiana (2), Maryland (2), Massachusetts (3), Michigan (4), Minnesota (4), Mississippi (1), Nebraska (2), Nevada (2), New Jersey (1), New Mexico (1), New York (4), North Carolina (4), Ohio (1), Oregon (6), Pennsylvania (4), Rhode Island (2), South Carolina (3), Texas (13), Utah (1), Virginia (3), Washington (1)	80	39.02%
National Totals		**205**	**100%**

If “Yes”, please explain your edit.

Please reference individual State MCO reports on Medicaid.gov for more information.

If “No”, does your MCO plan to implement this edit?

Figure 21 - Plans to Implement a System Accumulation Edit

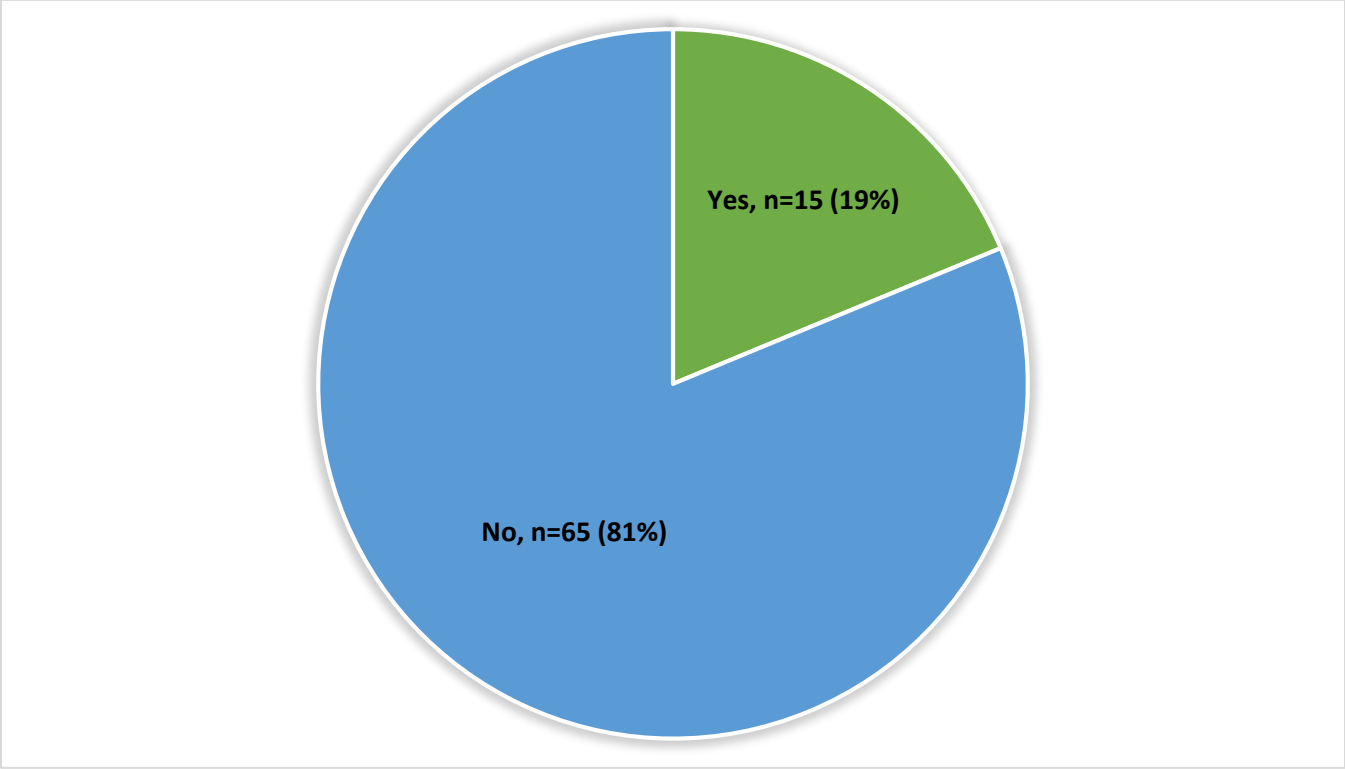

Table 21 - Plans to Implement a System Accumulation Edit

Response	States (Count of MCOs)	Count	Percentage
Yes	Delaware (1), Georgia (1), Hawaii (2), Indiana (1), Iowa (2), Massachusetts (1), New York (1), North Carolina (1), Pennsylvania (1), South Carolina (2), Texas (1), Virginia (1)	15	18.75%

Response	States (Count of MCOs)	Count	Percentage
No	Colorado (2), Delaware (1), Florida (2), Hawaii (1), Indiana (1), Kansas (2), Louisiana (2), Maryland (2), Massachusetts (2), Michigan (4), Minnesota (4), Mississippi (1), Nebraska (2), Nevada (2), New Jersey (1), New Mexico (1), New York (3), North Carolina (3), Ohio (1), Oregon (6), Pennsylvania (3), Rhode Island (2), South Carolina (1), Texas (12), Utah (1), Virginia (2), Washington (1)	65	81.25%
National Totals		**80**	**100%**

8. Does your MCO have any policy prohibiting the auto-refill process that occurs at the POS (i.e., must obtain beneficiary's consent prior to enrolling in the auto-refill program)?

Figure 22 - MCO Policy Prohibiting Auto-Refill at the POS

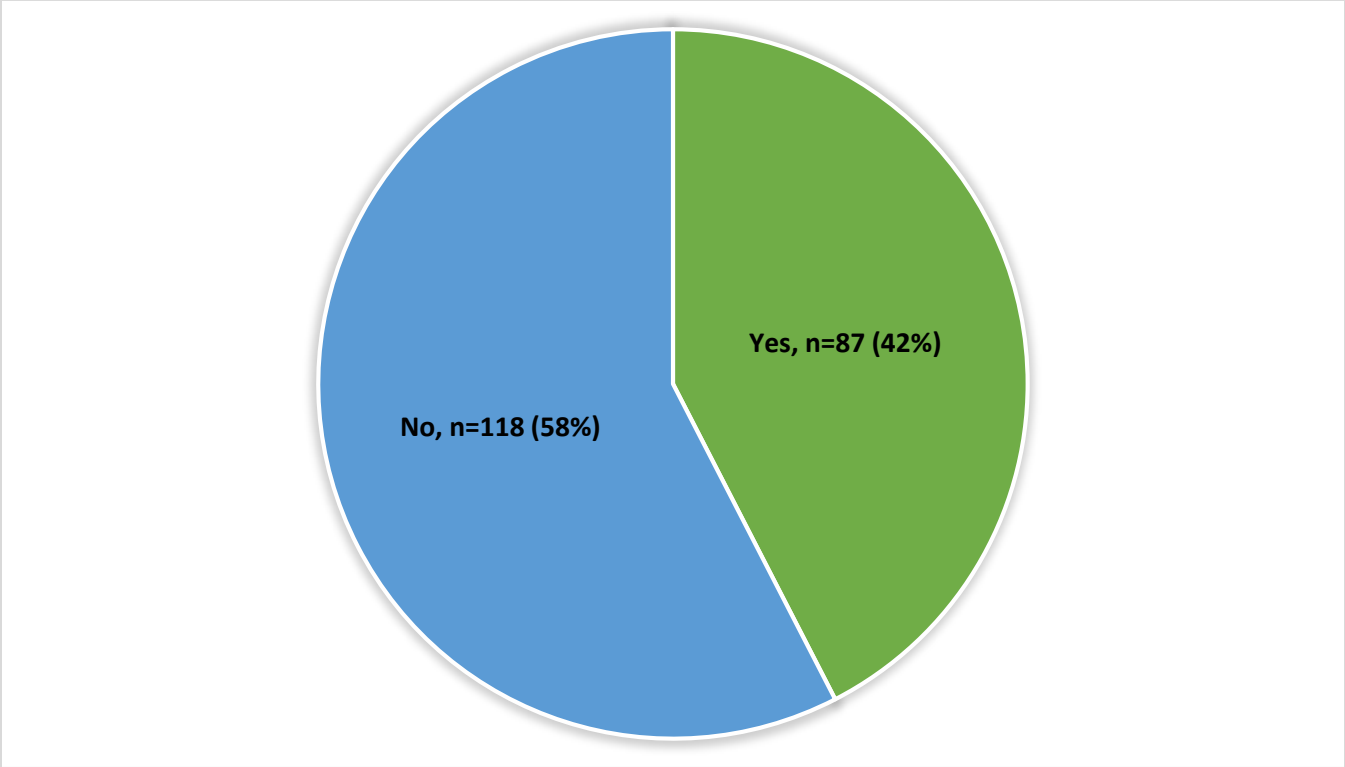

Table 22 - MCO Policy Prohibiting Auto-Refill at the POS

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (1), Colorado (1), Delaware (1), District of Columbia (1), Florida (3), Georgia (1), Hawaii (1), Illinois (1), Indiana (3), Louisiana (1), Maryland (2), Massachusetts (1), Michigan (3), Minnesota (8), Mississippi (2), Nevada (1), New Hampshire (1), New Jersey (5), New Mexico (1), New York (11), North Carolina (4), Ohio (2), Oregon (10), Rhode Island (1), South Carolina (2), Texas (13), Utah (2), Virginia (2), Washington (2)	87	42.44%

Response	States (Count of MCOs)	Count	Percentage
No	Arkansas (3), Colorado (1), Delaware (1), District of Columbia (3), Florida (8), Georgia (2), Hawaii (5), Illinois (5), Indiana (2), Iowa (2), Kansas (3), Kentucky (6), Louisiana (4), Maryland (7), Massachusetts (4), Michigan (6), Minnesota (1), Mississippi (1), Nebraska (3), Nevada (3), New Hampshire (2), New Mexico (2), New York (4), North Carolina (1), Ohio (3), Oregon (11), Pennsylvania (8), Rhode Island (2), South Carolina (3), Texas (3), Utah (2), Virginia (4), Washington (3)	118	57.56%
National Totals		**205**	**100%**

9. Does your system have a diagnosis edit that can be utilized when processing a prescription?

Figure 23 - System Having a Diagnosis Edit That Can be Utilized When Processing Prescription

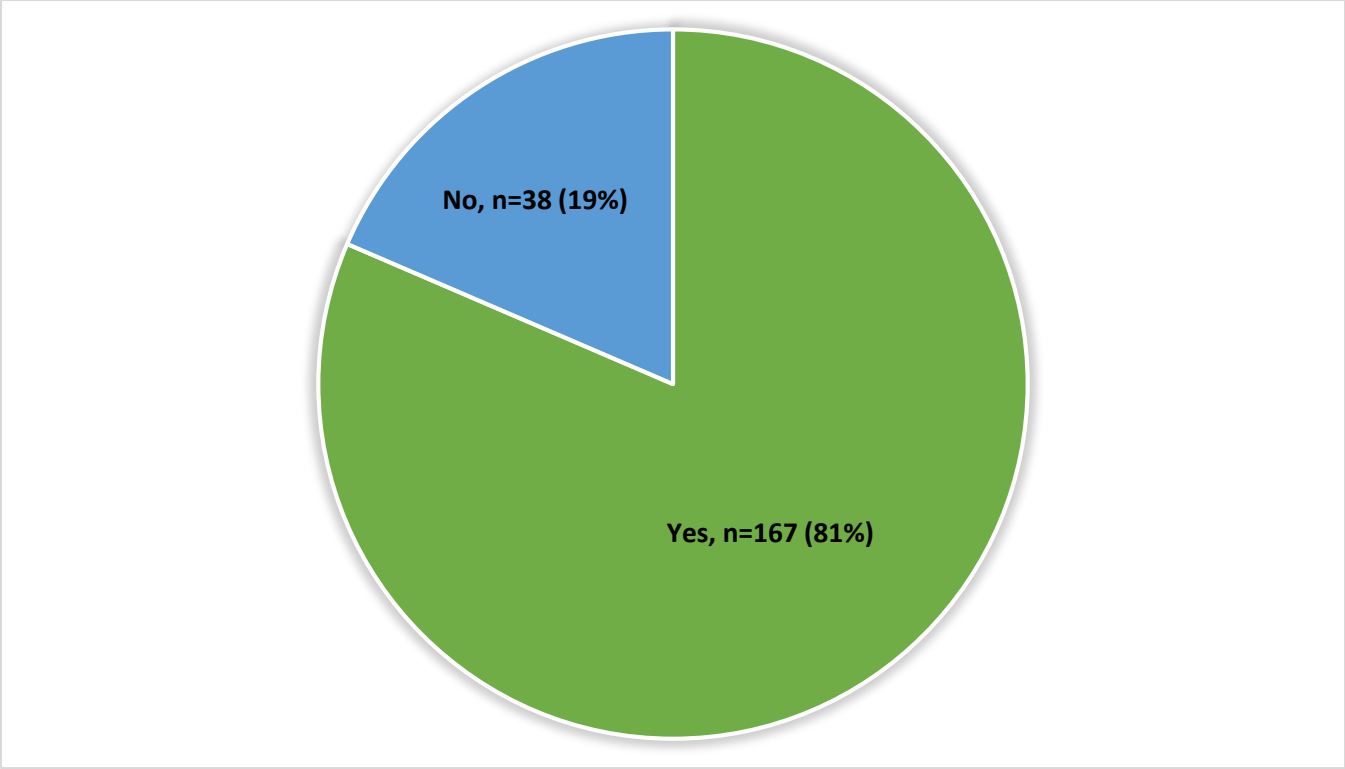

Table 23 - System Having a Diagnosis Edit That Can be Utilized When Processing Prescription

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (3), Colorado (1), Delaware (2), District of Columbia (2), Florida (11), Georgia (3), Hawaii (6), Illinois (5), Indiana (5), Kansas (3), Kentucky (6), Louisiana (5), Maryland (6), Massachusetts (1), Michigan (7), Minnesota (5), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (2), New Jersey (5), New Mexico (2), New York (11), North Carolina (5), Ohio (5), Oregon (14), Pennsylvania (7), Rhode Island (2), South Carolina (5), Texas (15), Utah (4), Virginia (4), Washington (5)	167	81.46%

Response	States (Count of MCOs)	Count	Percentage
No	Arkansas (1), Colorado (1), District of Columbia (2), Illinois (1), Iowa (2), Maryland (3), Massachusetts (4), Michigan (2), Minnesota (4), New Hampshire (1), New Mexico (1), New York (4), Oregon (7), Pennsylvania (1), Rhode Island (1), Texas (1), Virginia (2)	38	18.54%
National Totals		**205**	**100%**

If “Yes,” please explain.

Table 24 - Explanations for System Having a Diagnosis Edit That Can be Utilized When Processing Prescription

State	MCO Name	Explanation
AR	Arkansas_Total_Care_Inc.	We have the ability to require a diagnosis code as part of a Smart PA to allow the claim to pay. Certain drugs have this edit in place.
AR	CareSource	PBM ingests diagnosis codes when prescription is submitted at retail.
AR	Summit_Community_Care	The system has the capability to utilize an ICD-10 code from medical claims or a pharmacist may enter an ICD-10 code at the pharmacy point-of-sale.
CO	Rocky Mountain Health Plans	A diagnosis code using ICD-10 may be entered into the claims system to allow payment when a drug requires a diagnosis check to ensure it is a coverable indication or for a drug that may have off-label uses that are not compendia supported. When an FDA approved or compendia supported ICD-10 code is entered, the claim will pay normally. If a non-supported ICD-10 code is entered, an approved PA would be required before the drug could be covered.
DC	AmeriHealth Caritas DC	YES A diagnosis code can be submitted on certain prescriptions to allow the prescription to process without a prior authorization requirement
DC	MedStar Family Choice - District of Columbia	The DUR Diagnosis edit "messages" the pharmacist if a contraindication based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary.
DE	AmeriHealth Caritas Delaware	The processing system requires ICD-10 codes be submitted for certain products to ensure that off-label prescribing is not occurring.
DE	HighmarkHealthOptions	There is coding in place for a subset of edits that require diagnosis upon claim submission per State of DE requirements. Additionally, there are clinical edits in place that require the diagnosis to be submitted to allow claims to be paid at time of sale.
FL	Aetna Better Health	Some medications and DUR edits also automatic coding in place that searches for the presence of a diagnosis code in the member's medication history. If certain diagnoses codes are found, then those medications will automatically pay through smart PA edits. There is also coding in place for some medications that allows the pharmacist to enter a diagnosis code at point of sale to allow a prescription claim to process if appropriate (e.g., MAT therapy).
FL	Amerihealth Caritas Florida	YES A diagnosis code can be submitted on certain prescriptions to allow the prescription to process without a prior authorization requirement or to override certain DUR edits
FL	Children's Medical Services	Adjudication system is able to systematically review for diagnosis codes programmed to allow for successfully paying a claim without any human intervention.

State	MCO Name	Explanation
FL	Clear Health Alliance	Our system has the capability to review a diagnosis code and pay a claim according to AHCA automated prior authorization and bypass list requirements.
FL	Community Care Plan	Diagnosis codes are sent to the PBM daily and this information is on the members file in advance in most cases. At POS if the prescribing physician wrote the diagnosis on the script, then the PBM will accept the pharmacist/provided information and allow an override. AHCA POS diagnosis edits are also
FL	Florida Community Care	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary."
FL	Humana Medical Plan	Yes - Drug-disease interaction edits utilize ICD-10 codes from medical history, Opioid edits infer exclusions for sickle cell, cancer based on medical claims, ICD-10 and pharmacy claims drug lists. Custom functionality to utilize medical claims and pharmacy claims to apply exclusions across all duplicate therapy, drug-drug interaction edits.
FL	Molina Healthcare	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary."
FL	Simply Healthcare	Our system has the capability to review a diagnosis code and pay a claim according to AHCA automated prior authorization and bypass list requirements.
FL	Sunshine	Adjudication system is able to systematically review for diagnosis codes programmed to allow for successfully paying a claim without any human intervention.
FL	United Healthcare	UnitedHealthcare Community Plan aligns required diagnosis edits on products/drug classes as outlined by the State Medicaid Prescription program specified by the Agency for Healthcare Administration (AHCA) Examples of medications where this is utilized are : HIV agents, ADHD and specific Diabetic Agents (GLP-1 class). Appropriate diagnosis per ICD-10 codes must be included on the prescription for the prescription to process by the pharmacist- otherwise a prior authorization is required.
GA	Amerigroup GA	Pharmacist can enter ICD-10 code to allow claim to pay or ICD-10 is found with the diagnosis in the medical claim.
GA	CareSource	CareSource sends medical diagnosis information to our PBM. Our PBM also ingests diagnosis codes when the prescription is submitted at retail.
GA	Peach State Health Plan	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary
HI	AlohaCare	We allow automatic PA override based medical encounter data looking at diagnosis and pharmacy claims history to by-pass PA requirements from the provider. For some drugs, a diagnosis is required for the claim to pay at the point of sale.

State	MCO Name	Explanation
HI	HMSAQI	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary."
HI	Kaiser	Prescription orders generated from the electronic medical record require a diagnosis code.
HI	UnitedHealthcare	UnitedHealthcare utilizes a Diagnosis to Drug Match edit that verifies that the member has an approved FDA diagnosis for the prescribed medication at the point of sale. At the point of sale, the pharmacist verifies the member's diagnosis for the identified medication. A prompt appears in the Rx system to indicate diagnosis requirement. The pharmacist can contact the provider to check on the diagnosis. The medication is rejected if the diagnosis does not match and moves to the prior authorization process. An emergency supply may be dispensed when required.
HI	WellCareHealthPlans	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary.
HI	WellCareHealthPlansCCS	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary.
IL	Aetna_Better_Health_of_Illinois	Diagnosis edits are applied for specific drug classes, and allow the health plan to enforce prior authorization and/or DUR criteria for a predetermined diagnosis code. Diagnosis codes can be entered at the POS, as well as obtained automatically from health plan records. Use of the diagnosis code is not mandatory for claim adjudication.
IL	CountyCare_Health_Plan	CountyCare's opioid edits can infer a cancer, sickle cell, and/or Opioid Use Disorder diagnosis based on claims history and drug lists. Depending on the inferred diagnosis the edit will be skipped, or claim will deny. For Substance use disorder (SUD) and Seizure disorders, we have custom edits that allow for MAT and seizure medications to process without prior authorization.
IL	MeridianHealth	There is a smartPA feature in place that can review medical diagnosis and adjudicate a claim based on rules for diagnosis. For example, if a member has a seizure/epilepsy diagnosis in medical claims history, any seizure medication will adjudicate, regardless of PA status.
IL	Molina_Healthcare_of_Illinois,_Inc	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The drug/disease combinations to which the edit is applied is maintained within the Medispan Database. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary."
IL	YouthCare_HealthChoice	A smartPA can be programmed to review medical claim diagnosis when a pharmacy claim is being processed. If rules are met, the pharmacy claim will adjudicate. For example, if a member has a medical claim diagnosis for seizure/epilepsy, a non-preferred seizure medication pharmacy claim will adjudicate at the point of sale, even without a prior authorization.
IN	Anthem, Inc.	Automatic PA based on diagnosis code.
IN	CareSource	CareSource sends medical diagnosis information to our PBM. Our PBM also ingests diagnosis codes when the prescription is submitted at retail.

State	MCO Name	Explanation
IN	Managed Health Services Indiana (MHS)	If a diagnosis code enters into the PBM, this will allow some medications to process with no prior authorization from the provider. i.e.: cancer diagnosis in the PBM system allows a dispensation of a longer days supply for that member.
IN	MDwise, Inc.	MCO sends medical diagnosis information to our PBM, which is utilized in the prescription claims processing system to eliminate Prior Authorization requirements. i.e. If a patient has a multiple sclerosis diagnosis on a medical claim, preferred medications can bypass the need for prior authorization since the medical claim confirms an appropriate diagnosis.
IN	UnitedHealthcare Community Plan, Inc.	On eligible drugs, system checks will review data to determine whether an automated approval can be granted at the point of sale. This can be done with diagnosis codes, claims history, or other information needed to assist in review.
KS	Aetna Better Health of Kansas	We can program smart edits that allow certain diagnosis codes to be entered at point of sale. These smart edits can be set up to allow the diagnosis code to bypass PA, and we can also remap the rejection to 39 for Missing/Invalid Diagnosis Code if we want to ensure the pharmacy is entering an appropriate diagnosis at point of sale before the medication will pay.
KS	Sunflower Health Plan	The pharmacy prescription system is linked to a database of medical diagnoses for our members and can edit claims against the available diagnoses.
KS	UnitedHealthcare	We can load diagnosis edits from our medical claims system that can assist adjudication for pharmacy claims at Point of Sale for automatic claim acceptance or allow the pharmacy to type a diagnosis code for adjudication, or we can require a diagnosis within a Prior Authorization for acceptance. Diagnosis edits can also be used for exclusions such as cancer.
KY	Aetna Better Health of Kentucky	For Drug-Disease Contraindication: MCO's ProDUR Drug-Disease Contraindication edit utilizes ICD-10 codes submitted on the incoming claim and (if applicable) retrieved from stored ICD-10 codes from member medical history. ï¿½ For Opioid edits: MCO's opioid edits can infer a cancer, sickle cell, and/or Opioid Use Disorder diagnosis based on claims history and drug lists. Depending on the inferred diagnosis the edit will be skipped, or claim will deny. ï¿½ Custom edits: Auto-PA for various drug classes.
KY	Anthem Inc. Kentucky	Custom edits for Kentucky include: Auto-PA for various drug classes.
KY	Humana Healthy Horizons in Kentucky	Drug-disease interaction edits utilize ICD-10 codes from medical history, Opioid edits infer exclusions for sickle cell, cancer based on medical claims, ICD-10 and pharmacy claims drug lists. Custom functionality to utilize medical claims and pharmacy claims to apply exclusions across all duplicate therapy, drug-drug interaction edits.
KY	Passport Health Plan By Molina Healthcare	For Drug-Disease Contraindication: MCO's ProDUR Drug-Disease Contraindication edit utilizes ICD-10 codes submitted on the incoming claim and (if applicable) retrieved from stored ICD-10 codes from member medical history. ï¿½ For Opioid edits: MCO's opioid edits can infer a cancer, sickle cell, and/or Opioid Use Disorder diagnosis based on claims history and drug lists. Depending on the inferred diagnosis the edit will be skipped, or claim will deny. ï¿½ Custom edits: none

State	MCO Name	Explanation
KY	United Healthcare Community Plan of Kentucky	Custom edits: Auto-PA for various Drug Classes
KY	WellCare Health Plans	For Drug-Disease Contraindication, this edit utilizes ICD-10 cods submitted on the incoming claims and (if applicable) retrieved from stored ICD-10 codes from member medical history. For Opioids, this edit can infer a cancer, sickle cell, and/or Opioid Use Disorder diagnosis based on claims history and drug lists. Depending on the inferred diagnosis the edit will be skipped, or the claim will deny. In addition, we also have Auto PA for various drug classes
LA	Aetna Better Health of Louisiana	A Point-of-Sale (POS) edit allows the claim to automatically bypassed when then appropriate diagnosis code is entered on the claim at the pharmacy.
LA	AmeriHealth Caritas Louisiana	Multiple medications require the pharmacist to submit the appropriate ICD-10 code for the claim to process.
LA	Healthy Blue Louisiana	The pharmacist can enter a diagnosis code at POS to be utilized when processing a prescription. Also, our auto PA rules can look for diagnosis in member history.
LA	Louisiana Healthcare Connections	LDH requires MCOs to have a diagnosis submitted on the pharmacy claim on select drugs or drug categories.
LA	UnitedHealthcare Community Plan	Our claims system has the capability for capturing and storing a Dx as verified with the prescriber and written on the prescription. Our system has the capability to capture and validate State-mandated Dx codes for specific medications prior to POS processing.
MA	AllWays Health Partners	The DUR diagnosis edit "messages" the pharmacist when contraindications based upon diagnosis are identified. The edit notes contraindications based on member diagnosis. These contraindications are classified as absolute, potential or precautionary.
MD	Aetna Better Health of Maryland	Yes, we can code so that DX code in members med history permits a script be filled (Smart PA edit) or to require the entry of a dx code at POS for a prescription claims to process.
MD	Amerigroup Community Care	The pharmacist can enter a diagnosis code at POS to be utilized when processing a prescription. Also, our auto PA rules can look for diagnosis in member history.
MD	Kaiser Foundation Health Plan of the Mid-Atlantic States	Drug-Disease Contraindication: ProDUR Drug-Disease Contraindication edit utilizes ICD-10 codes submitted on the incoming claim and (if applicable) retrieved from stored ICD-10 codes from the member's medical history. Opioid edits: Opioid edits can infer cancer, sickle cell, and/or Opioid Use Disorder diagnosis based on claims history and drug lists. Depending on the inferred diagnosis, the edit will be skipped, or the claim will deny.
MD	MedStar Family Choice	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary.
MD	Priority Partners MCO	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis are identified. These contraindications are classified as either absolute, potential or precautionary.

State	MCO Name	Explanation
MD	United Healthcare	For drugs that require or will adjudicate with a diagnosis (dx) submission, a prompt in the point of sale (pos) system will require the dispensing pharmacist to submit diagnosis information which is documented on the prescription. This is utilized to ensure the diagnosis will match FDA-approved indication or a use supported by current published evidence.
MI	Blue Cross Complete of Michigan	Although we don't have any current edits for diagnosis related data at this time, ICD-10 codes are able to be utilized for overrides in the NCPDP claim format if MDHHS and our Common Formulary Workgroup decided to pursue that option.
MI	HAP Empowered	Yes, the pharmacy claims processing system can leverage medical claims data and use ICD-10 codes for claims adjudication.
MI	McLaren Health Plan	Primary and Secondary Diagnosis Codes on claims with a Date of Service within a year will be reviewed for PA at POS (point of sale) to reduce PA requests/reviews. Not active yet.
MI	Meridian Health Plan	The DUR diagnosis edit messages the pharmacist when contraindication based on the diagnosis are identified. The edit identifies contraindications based on the member diagnosis. These contraindications are classified as either absolute, potential, or precautionary.
MI	Molina Healthcare of Michigan	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary.
MI	Priority Health Choice	The PBM has smart logic that will bypass certain utilization management rules when the plan has the target ICD-10 code on file or the pharmacy submits a qualifying ICD-10 code on the claim.
MI	UnitedHealthcare Community Plan	We can load diagnosis edits from our medical claims system that can assist adjudication for pharmacy claims at Point of Sale for automatic claim acceptance or allow the pharmacy to type a diagnosis code for adjudication, or we can require a diagnosis within a Prior Authorization for acceptance.
MN	HealthPartners	Opioid edits can infer a cancer, sickle cell, and/or opioid use disorder diagnosis based on claims history and drug lists. Depending on the inferred diagnosis the edit will be skipped, or claim will deny.
MN	IMCare	Yes, our system has the option to require a diagnosis code be submitted in order for the claim to process.
MN	PrimeWest	PrimeWest's ProDUR Drug-Disease contraindication edit utilizes ICD10 codes submitted on the incoming claim and retrieved from stored ICD10 codes from the member history. PrimeWest's opioid edits can infer a cancer cell, sickle cell and/or opioid use disorder diagnosis based on claims history and drug lists. Depending on the inferred diagnosis the edit will be skipped, or the claim will deny.
MN	UCare	There are systematic smart rules in place that leverage ICD-10 diagnosis codes to be used within smart logic.
MN	UnitedHealthcare	We can load diagnosis edits from our medical claims system that can assist adjudication for pharmacy claims at Point of Sale for automatic claim acceptance or allow the pharmacy to type a diagnosis code for adjudication, or we can require a diagnosis within a Prior Authorization for acceptance.
MS	MS-MAGNOLIA	Pharmacies can enter an ICD-10 diagnosis code in the NCPDP field 424-DO at POS to capture a diagnosis code on a claim.

State	MCO Name	Explanation
MS	MS-MOLINA	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary.
MS	MS-UNITED	We can load diagnosis edits from our medical claims system that can assist adjudication for pharmacy claims at Point of Sale for automatic claim acceptance or allow the pharmacy to type a diagnosis code for adjudication, or we can require a diagnosis within a Prior Authorization for acceptance.
NC	AMHC FFY22	Per the contract with NC Medicaid, AMHC is required to follow NCDHB pharmacy policies. A diagnosis edit is utilized for specific drugs and specific drug categories to process a prescription in alignment with NCDHB policy. Example a seizure diagnosis can be entered on a point of sale claim for a non-preferred anticonvulsant to bypass trial and failure edits.
NC	CCH FFY22	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary
NC	HB FFY22	ICD-10 diagnosis codes are shared with the pharmacy claims processing system from the member's medical claims history to be utilized within smartPA functionality and/or a pharmacist may enter an ICD-10 diagnosis code in the appropriate NCPDP field at the point-of-sale.
NC	UHC FFY22	We can load diagnosis edits from our medical claims system that can assist adjudication for pharmacy claims at Point of Sale for automatic claim acceptance or allow the pharmacy to type a diagnosis code for adjudication, or we can require a diagnosis within a Prior Authorization for acceptance.
NC	WC FFY22	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary
NE	HealthyBlueNebraska	A diagnosis can be entered to obtain authorization at point of sale for certain drugs.
NE	Nebraska Total Care	The Dur Diagnosis edit sends messages to the pharmacist when contraindications based on diagnosis are identified. These contraindications are classified as either absolute, potential, or precautionary.
NE	United Healthcare	Diagnosis edit is utilized for HIV, antipsychotics and various medications as defined in the NE Medicaid Preferred Drug List
NH	AmeriHealth Caritas NH	Our system does allow a diagnosis code to override a prior authorization requirement in some scenarios.
NH	NH Healthy Families	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary
NJ	Aetna Better Health of New Jersey	It is coded so that DX code in member's medication history permits a script be filled (Smart PA edit) or to require the entry of a dx code at POS for a prescription claims to process
NJ	Amerigroup Community Care	The pharmacist can enter a diagnosis code at POS to be utilized when processing a prescription. Additionally, our system also has the capability to utilize a diagnosis code from medical claims.

State	MCO Name	Explanation
NJ	Horizon NJ Health	The plan can either enter an acceptable diagnosis code in the system to allow certain medications to pay or the plan can allow certain medications to pay if an acceptable diagnosis code is entered by the retail pharmacist.
NJ	NJ United	We can load diagnosis edits from our medical claims system that can assist adjudication for pharmacy claims at Point of Sale for automatic claim acceptance or allow the pharmacy to type a diagnosis code for adjudication, or we can require a diagnosis within a Prior Authorization for acceptance.
NJ	Wellcare health plans	yes- The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary
NM	Presbyterian Health Plan	PHP developed an innovative process that bypassed the PA barrier and allowed pregnant mothers in need of treatment to have immediate access to their medication. The process enabled the dispensing pharmacy to enter the members diagnosis code into the pharmacy claims billing system. This was also configured in the electronic prescribing (ePrescribe) system so prescribers could include the member diagnosis code with their electronic prescriptions. This allowed for real-time adjudication at the Pharmacy that resulted in a paid Rx claim if the appropriate diagnosis code was entered, and it removed the need to submit a PA request. As a result of this program, potentially disenfranchised members in urgent need of treatment for opioid addiction experienced no delays in care. PHP is expanding the diagnoses that can be utilized when processing prescriptions.
NM	Western Sky Community Care	Some medications have a smart PA so the medication will pay when the appropriate diagnosis code is entered. Ex: opioids for cancer patients and increased quantities allowed for diabetic test strips for pregnant members.
NV	Anthem Blue Cross Blue Shield	The pharmacy POS system can be configured to edit based on diagnosis codes sent by the member eligibility system.
NV	Health Plan of Nevada	We can load diagnosis edits from our medical claims system that can assist adjudication for pharmacy claims at Point of Sale for automatic claim acceptance or allow the pharmacy to type a diagnosis code for adjudication, or we can require a diagnosis within a Prior Authorization for acceptance.
NV	Molina	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary.
NV	Silver Summit Health Plan	Clinical criteria is built into the point of sale system which allows the dispensing pharmacy to enter a qualifying diagnosis code in order to bypass prior authorization requirements for opioid medications when a member has a diagnosis of cancer, sickle cell, palliative care or chronic nonmalignant pain.
NY	Empire Blue Cross Blue Shield HealthPlus	The pharmacist can enter a diagnosis code at POS to be utilized when processing a prescription. Additionally, our system also has the capability to utilize a diagnosis code from medical claims.
NY	Excellus Health Plan	Our PBM Claims processing system can utilize medical claims diagnosis info to use for UM edits, but we do not currently have any in place.
NY	Fidelis Care	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary."

State	MCO Name	Explanation
NY	Highmark Blue Cross Blue Shield of Western New York	The pharmacist can enter a diagnosis code at POS to be utilized when processing a prescription. Additionally, our system also has the capability to utilize a diagnosis code from medical claims.
NY	Independent Health	Drugs can be built to require a diagnosis to be present in order for a claim to process without requiring a prior authorization. This diagnosis can either be entered by the MCO into the patient's profile in the claims processing system (these are typically batch-loaded) or entered by a pharmacy while processing the claim.
NY	MetroPlus Health Plan	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary.
NY	Molina Healthcare of New York	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary.
NY	MVP Health Care	Through the plan's PBM, we have the capability to process a diagnosis code when provided.
NY	United HealthCare	UHC can load diagnosis edits from our medical claims system that can assist adjudication for pharmacy claims at Point of Sale for automatic claim acceptance or allow the pharmacy to type a diagnosis code for adjudication, or we can require a diagnosis within a Prior Authorization for acceptance.
NY	Univera Healthcare	Our PBM Claims processing system can utilize medical claims diagnosis info to use for UM edits, but we do not currently have any in place.
NY	VNSNY CHOICE SelectHealth	SelectHealth from VNS Health's opioid edits can infer a cancer, sickle cell, and/or Opioid Use Disorder diagnosis based on claims history and drug lists. Depending on the inferred diagnosis the edit will be skipped, or claim will deny. SelectHealth from VNS Health ProDUR Drug-Disease Contraindication edit utilizes ICD-10 diagnosis codes submitted on the incoming claim.
OH	Buckeye Health Plan	The DUR diagnosis edit messages the pharmacist when contraindications based on diagnosis identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential, or precautionary.
OH	CareSource	CareSource sends medical diagnosis information to ESI. ESI also ingests diagnosis codes when a prescription is submitted at retail.
OH	Molina Healthcare of Ohio	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary."
OH	Paramount	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary.
OH	UnitedHealthcare Community Plan of Ohio	United Healthcare Community Plan can load diagnosis edits from our medical claims system that can assist adjudication for pharmacy claims at Point of Sale for automatic claim acceptance or allow the pharmacy to type an override code for acceptance.

State	MCO Name	Explanation
OR	Advanced Health	Advanced Health's opioid edits can infer cancer, sickle cell, and/or opioid use disorder diagnosis based on claims history and drug lists. Depending on the inferred diagnosis the edit will be skipped, or claim will deny.
OR	Cascade Health Alliance	For Drug-Disease Contraindication: CHA's ProDUR Drug-Disease Contraindication edit utilizes ICD-10 codes submitted on the incoming claim and (if applicable) retrieved from stored ICD-10 codes from member medical history. For Opioid edits: CHA's opioid edits can infer a cancer, palliative care, long term care, hospice, sickle cell, and/or Opioid Use Disorder diagnosis based on claims history and drug lists. Depending on the inferred diagnosis the edit will be skipped or the claim will deny.
OR	Columbia Pacific CCO	The system has an ability to adjust PA or DUR requirements off the presence of certain diagnoses (such as for pain drugs in cancer). The system does not require a diagnosis code to adjudicate claims.
OR	Health Share of Oregon-CareOregon RAE	The system has an ability to adjust PA or DUR requirements off the presence of certain diagnoses (such as for pain drugs in cancer). The system does not require a diagnosis code to adjudicate claims.
OR	Health Share of Oregon - Legacy Health/PacificSource	Some medications can have an edit that require a diagnosis code which allows an override of the need for prior authorization at the point of sale.
OR	Health Share of Oregon - OHSU	The claims processing system has the capability to apply diagnosis code edits to guide claims processing.
OR	InterCommunity Health Network	We have the ability to accept diagnosis codes and based on previous meds can do an inferred diagnosis edit on the pro-DUR.
OR	Jackson Care Connect	The system has an ability to adjust PA or DUR requirements off the presence of certain diagnoses (such as for pain drugs in cancer). The system does not require a diagnosis code to adjudicate claims.
OR	PacificSource Community Solutions- Central Oregon	Some medications can have an edit that require a diagnosis code which allows an override of the need for prior authorization at the point of sale.
OR	PacificSource Community Solutions- Columbia Gorge	Some medications can have an edit that require a diagnosis code which allows an override of the need for prior authorization at the point of sale.
OR	PacificSource Community Solutions - Lane	Some medications can have an edit that require a diagnosis code which allows an override of the need for prior authorization at the point of sale.
OR	PacificSource Community Solutions - Marion/Polk	Some medications can have an edit that require a diagnosis code which allows an override of the need for prior authorization at the point of sale.
OR	Trillium Community Health Plan - North	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary
OR	Trillium Community Health Plan - South	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary
PA	Aetna Better Health of Pennsylvania	Coding can be set up for diagnosis code in members medical history to permit a script to be filled (Smart PA edit) or to require the entry of a diagnosis code for a prescription claim to process.
PA	Geisinger	Defined drugs will process at $0 copay if claim contains a COVID diagnosis code

State	MCO Name	Explanation
PA	Highmark Wholecare	There are clinical edits in place that require the diagnosis to be submitted to allow claims to be paid at point of sale.
PA	PA Health and Wellness	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary
PA	United Healthcare	For drugs that require or will adjudicate with a diagnosis (dx) submission, a prompt in the point of sale (pos) system will require the dispensing pharmacist to submit diagnosis information which is documented on the prescription. This is utilized to ensure the diagnosis will match FDA-approved indication or a use supported by current published evidence.
PA	UPMC	There is a drug-disease module that takes into account actual ICD-10 codes or infers the diagnosis. Other modules may take into account diagnosis codes or prescription history to bypass certain edits.
PA	Vista	Pharmacist can enter diagnosis code upon submission of claim. If logic is in place for the given drug and code is consistent with logic for payment, it will allow the claim to pay at Point of Service.
RI	NHPRI	If a prescription requires a prior authorization, and all that is required for the prior authorization is a diagnosis code and the member has that diagnosis, the claim may have the ability to process at point of sale without a rejection.
RI	UHCCP	UnitedHealthcare Community Plan provides diagnosis edits from the medical claims system to the PBM. The diagnosis edits can assist with adjudication of pharmacy claims at Point of Sale. If there is a diagnosis match, the claim is automatically accepted. The pharmacy can also manually submit a diagnosis code and if there is a match, the claim will adjudicate.
SC	Absolute Total Care	The DUR Diagnosis edit messages the pharmacist when contraindications based on diagnosis are identified. These contraindications are classified as either absolute, potential, or precautionary.
SC	Healthy Blue South Carolina	Pharmacists may enter a ICD-10 diagnosis code at point of sale. We have SMART PA logic in place that can recognize those diagnosis codes.
SC	Humana	Drug-disease interaction edits utilize ICD-10 codes from medical history, Opioid edits infer exclusions for sickle cell, cancer based on medical claims, ICD-10 and pharmacy claims drug lists. Custom functionality to utilize medical claims and pharmacy claims to apply exclusions across all duplicate therapy, drug-drug interaction edits.
SC	Molina Healthcare	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis.
SC	Select Health of South Carolina, Inc.	Yes the system has the capability of accepting a diagnosis code for some medications.
TX	Aetna Better Health of Texas	We can code so that a diagnosis code in a member's medication history permits a script be filled (Smart PA edit) or to require the entry of a diagnosis code at POS for a prescription claim to process.
TX	Amerigroup	Our autoPA rules can look for diagnoses in member history.
TX	Community First Health Plans	The system is able to accept and read a diagnosis code submission from the pharmacy. A diagnosis can be required for paid claims.
TX	Community Health Choice	The system is able to accept and read a diagnosis code submission from the pharmacy; a diagnosis can be required for paid claims

State	MCO Name	Explanation
TX	Cook Children's Health Plan	The system is able to accept and read a diagnosis code submission from the pharmacy; a diagnosis can be required for paid claims
TX	Dell Children's Health Plan	The system is able to accept and read a diagnosis code submission from the pharmacy; a diagnosis code can be required for paid claims.
TX	Driscoll Health Plan	The claims adjudication system is able to accept and read a diagnosis code submission from the pharmacy.
TX	El Paso Health	The system is able to accept and read a diagnosis code submission from the pharmacy; a diagnosis can be required for paid claims
TX	FirstCare Health Plans	The system is able to accept and read a diagnosis code submission from the pharmacy; a diagnosis can be required for paid claims.
TX	Molina Healthcare of Texas	Members' diagnoses file is loaded into the pharmacy claims adjudication system. Claims with required diagnoses pay at point of sale for members with record of required diagnoses. Claims for members without required diagnoses reject for manual prior authorization review.
TX	Parkland Community Health Plan	The system is able to accept and read a diagnosis code submission from the pharmacy; a diagnosis can be required for paid claims
TX	Scott and White Health Plan	The system is able to accept and read a diagnosis code submission from the pharmacy; a diagnosis can be required for paid claims.
TX	Superior HealthPlan	Yes, the MCO's PBM claim's system has the capability to require diagnosis codes on the pharmacy claim.
TX	Texas Children's Health Plan	The system is able to accept and read a diagnosis code submission from the pharmacy. A diagnosis can be required for paid claims.
TX	UnitedHealthcare Community Plan	A prescription can require a diagnosis code at point-of-sale before it will pay. The dispensing pharmacist can enter or edit this information when processing a prescription.
UT	Healthy U	We have the capability to attach a diagnosis or condition to the member's profile and allow different coverage and edits based upon the condition or diagnosis. This is not currently being utilized. Accepting a diagnosis on the claim is not currently a capability of our claims processing system.
UT	Molina Healthcare of Utah	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary.
UT	SelectHealth	Our system allows for utilization management edits to be bypassed with specified diagnosis codes.
UT	Steward Health Choice Utah	- We have the capability to attach a diagnosis or condition to the member's profile to allow different coverage and edits based upon the condition or diagnosis. This is not currently being utilized. - Accepting a diagnosis on the claim is currently not a capability of our claims processing system.
VA	AetnaBetterHealthofVirginia	We can code so that DX code in members med history permits a script be filled (Smart PA edit) or to require the entry of a dx code at point of sale (POS) for a prescription claim to process.
VA	Anthem	Yes - the pharmacist can enter a diagnosis code at POS to be utilized when processing a prescription. Also, our autoPA rules can look for diagnosis in member history.
VA	MolinaCompleteCareofVirginia	Molina Complete Care of Virginia (MCC of VA) uses CVS/Caremark's SmartPA technology that can use an ICD-10 diagnosis codes either submitted on the pharmacy claim or stored in an integrated medical claims database.

State	MCO Name	Explanation
VA	UnitedHealthCare	We can load diagnosis edits from our medical claims system that can assist adjudication for pharmacy claims at Point of Sale for automatic claim acceptance or allow the pharmacy to type a diagnosis code for adjudication, or we can require a diagnosis within a Prior Authorization for acceptance.
WA	Amerigroup Washington Inc.	The system has the capability to utilize diagnosis codes submitted by the pharmacy AND/OR diagnosis codes within the member's medical record to check if a claim meets the criteria of a specific smart PA.
WA	Community Health Plan of Washington	CHPW provides medical data and diagnosis codes to the PBM which are used to adjudicate claims at point of sale.
WA	Coordinated Care Corporation	The diagnosis edit was not implemented during this fiscal year for this reporting period.
WA	Molina Healthcare of Washington, Inc.	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary.
WA	UnitedHealthcare Community Plan	Coverage of ADHD stimulants for adults requires confirmation of the diagnosis (ADHD) or prior authorization (PA) to establish medical necessity for other diagnoses. When a claim is submitted, the claims system checks to see if the patient has a diagnosis of ADHD associated with the patient's profile (this information may come from either medical claims or previous pharmacy claims). If our records include an ADHD diagnosis, the claim will pay at POS. If not, the claim will reject at the POS with messaging directing the pharmacist to enter the diagnosis code (ICD-10). If diagnosis entered is ADHD, the claim will pay. If not, the claim will reject with messaging stating that prior authorization is required.

10. For drugs not on your MCO's Preferred Drug List (PDL), does your MCO have a documented process (i.e. PA) in place, so that the Medicaid beneficiary or the Medicaid beneficiary's prescriber may access any covered outpatient drug when medically necessary?

Figure 24 - Documented Process for Beneficiaries or their Prescribers to Access Any Covered Outpatient Drug (COD) when Medically Necessary

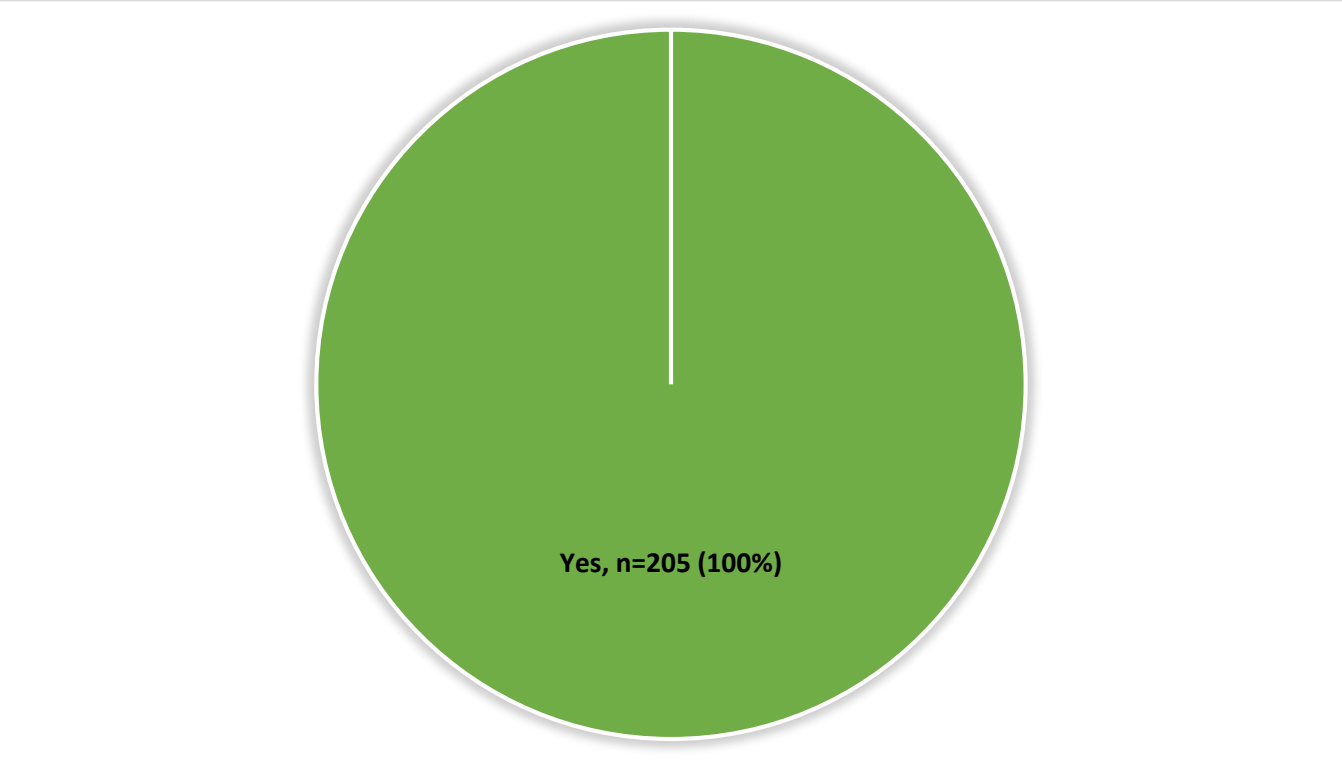

Table 25 - Documented Process for Beneficiaries or their Prescribers to Access Any Covered Outpatient Drug (COD) when Medically Necessary

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	205	100.00%
National Totals		**205**	**100%**

If "Yes," check all that apply.

Figure 25 - Documented Process in Place for Beneficiaries or their Prescribers to Access Any Covered Outpatient Drug (COD) When Medically Necessary

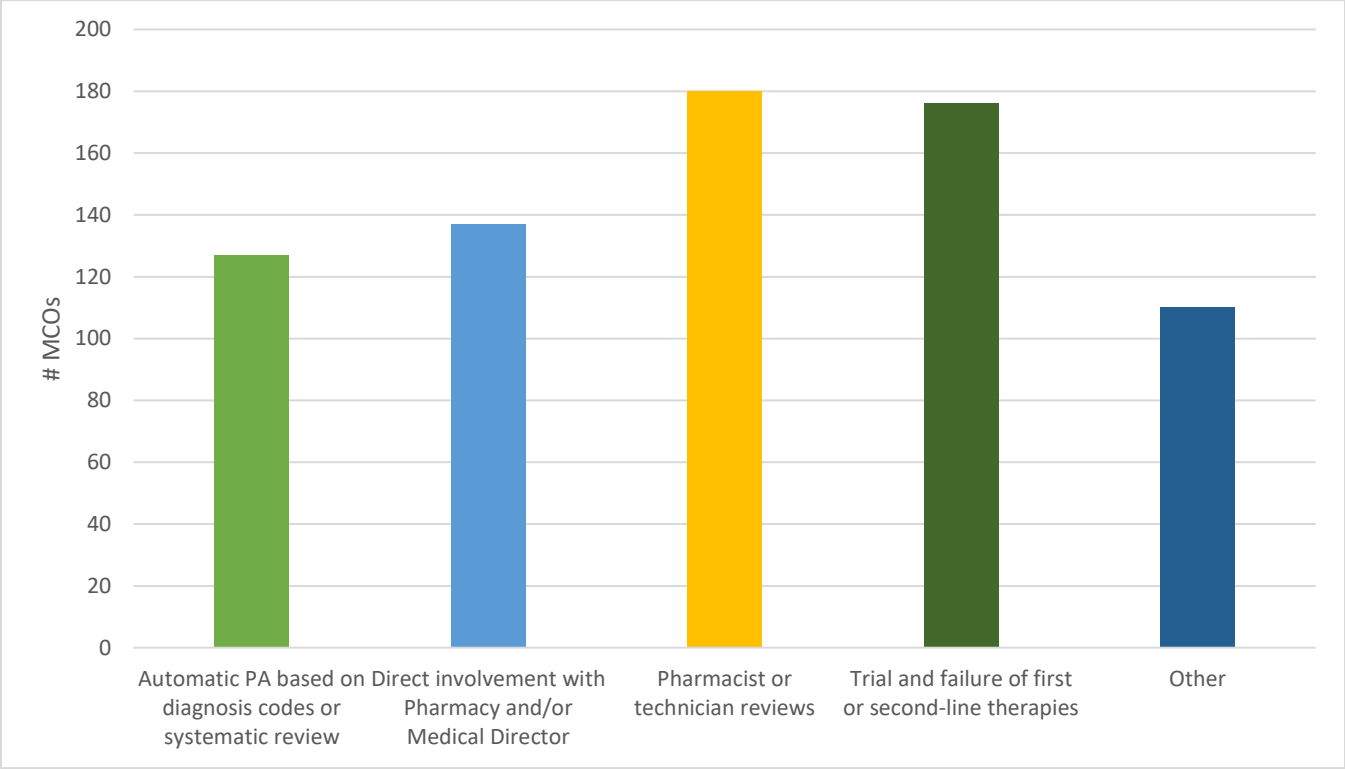

Table 26 - Documented Process in Place for Beneficiaries or their Prescribers to Access Any Covered Outpatient Drug (COD) When Medically Necessary

Response	States (Count of MCOs)	Count	Percentage
Automatic PA based on diagnosis codes or systematic review	Arkansas (2), Delaware (2), District of Columbia (2), Florida (8), Georgia (3), Hawaii (4), Illinois (4), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (4), Maryland (3), Michigan (5), Minnesota (2), Mississippi (2), Nebraska (3), Nevada (3), New Hampshire (1), New Jersey (4), New Mexico (2), New York (8), North Carolina (5), Ohio (4), Oregon (7), Pennsylvania (6), Rhode Island (1), South Carolina (3), Texas (14), Utah (1), Virginia (5), Washington (3)	127	17.40%
Direct involvement with Pharmacy and/or Medical Director	Arkansas (2), Colorado (1), Delaware (2), District of Columbia (3), Florida (6), Georgia (2), Hawaii (4), Illinois (3), Indiana (4), Kansas (3), Kentucky (6), Louisiana (2), Maryland (7), Massachusetts (3), Michigan (8), Minnesota (7), Mississippi (3), Nebraska (3), Nevada (1), New Hampshire (3), New Jersey (4), New Mexico (2), New York (13), North Carolina (4), Ohio (5), Oregon (10), Pennsylvania (7), Rhode Island (1), South Carolina (1), Texas (4), Utah (3), Virginia (6), Washington (4)	137	18.77%

Response	States (Count of MCOs)	Count	Percentage
Pharmacist or technician reviews	Arkansas (2), Colorado (2), Delaware (2), District of Columbia (1), Florida (8), Georgia (2), Hawaii (5), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (7), Massachusetts (4), Michigan (9), Minnesota (8), Mississippi (3), Nebraska (3), Nevada (2), New Hampshire (3), New Jersey (4), New Mexico (3), New York (13), North Carolina (5), Ohio (4), Oregon (21), Pennsylvania (7), Rhode Island (3), South Carolina (3), Texas (15), Utah (4), Virginia (6), Washington (4)	180	24.66%
Trial and failure of first or second-line therapies	Arkansas (2), Colorado (2), Delaware (2), District of Columbia (3), Florida (8), Georgia (3), Hawaii (5), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (7), Massachusetts (4), Michigan (9), Minnesota (8), Mississippi (3), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (5), New Mexico (3), New York (14), North Carolina (5), Ohio (5), Oregon (14), Pennsylvania (7), Rhode Island (3), South Carolina (3), Texas (12), Utah (3), Virginia (6), Washington (4)	176	24.11%
Other	Arkansas (2), Delaware (1), District of Columbia (2), Florida (5), Georgia (2), Hawaii (5), Illinois (4), Indiana (2), Iowa (2), Kansas (3), Louisiana (2), Maryland (7), Massachusetts (3), Michigan (6), Minnesota (4), Mississippi (2), Nebraska (1), Nevada (3), New Hampshire (3), New Jersey (2), New Mexico (1), New York (7), North Carolina (4), Ohio (4), Oregon (9), Pennsylvania (6), Rhode Island (2), South Carolina (4), Texas (4), Utah (2), Virginia (4), Washington (2)	110	15.07%
National Totals		**730**	**100%**

a. How does your MCO ensure PA criteria is no more restrictive than the FFS criteria and review?

Please reference individual State MCO reports on Medicaid.gov for more information.

b. Does your program provide for the dispensing of at least a 72-hour supply of a covered outpatient drug (COD) in an emergency situation?

Figure 26 - Program Provides for the Dispensing of at Least a 72-hour Supply of a COD in Emergency Situations

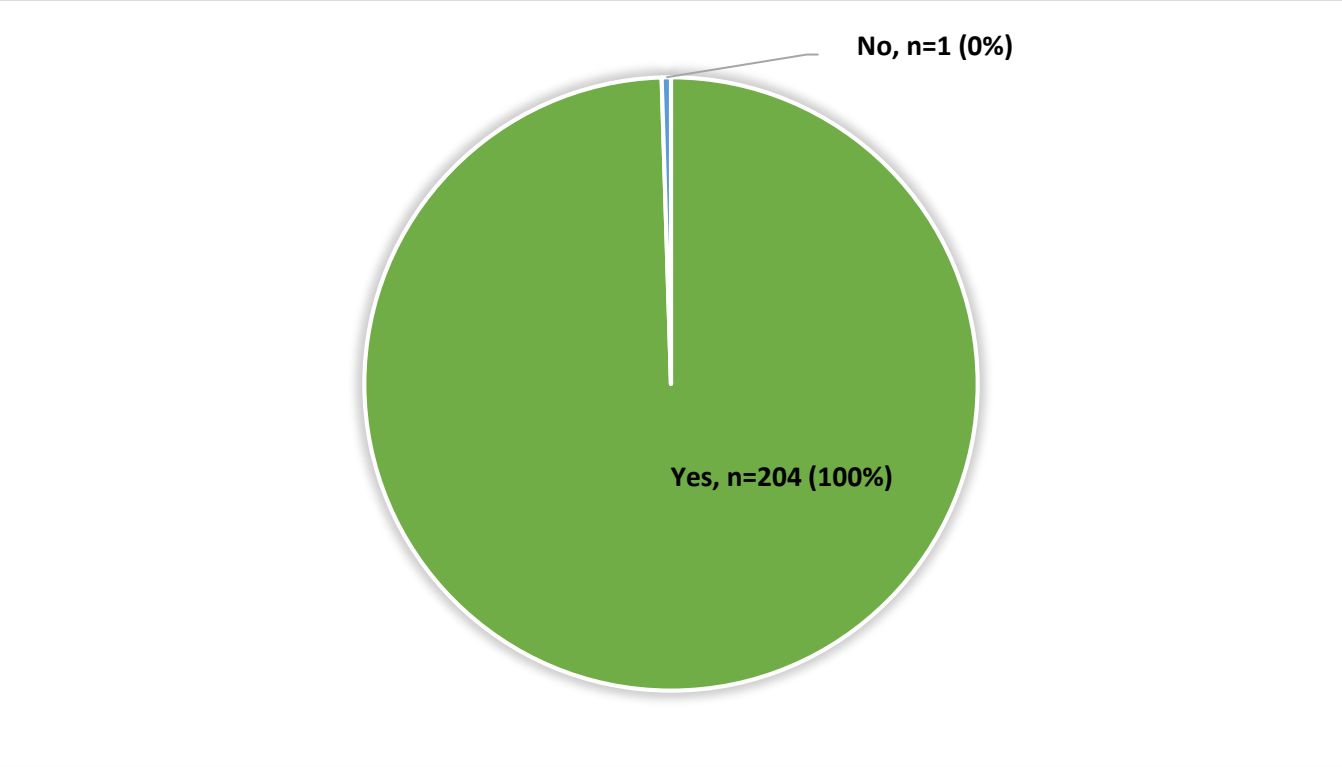

Table 27 - Program Provides for the Dispensing of at Least a 72-hour Supply of a COD in Emergency Situations

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (8), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	204	99.51%
No	Minnesota (1)	1	0.49%
National Totals		**205**	**100%**

If "Yes," check all that apply.

Figure 27 - Process for the Dispensing of At Least a 72-Hour Supply of CODs in Emergency Situations

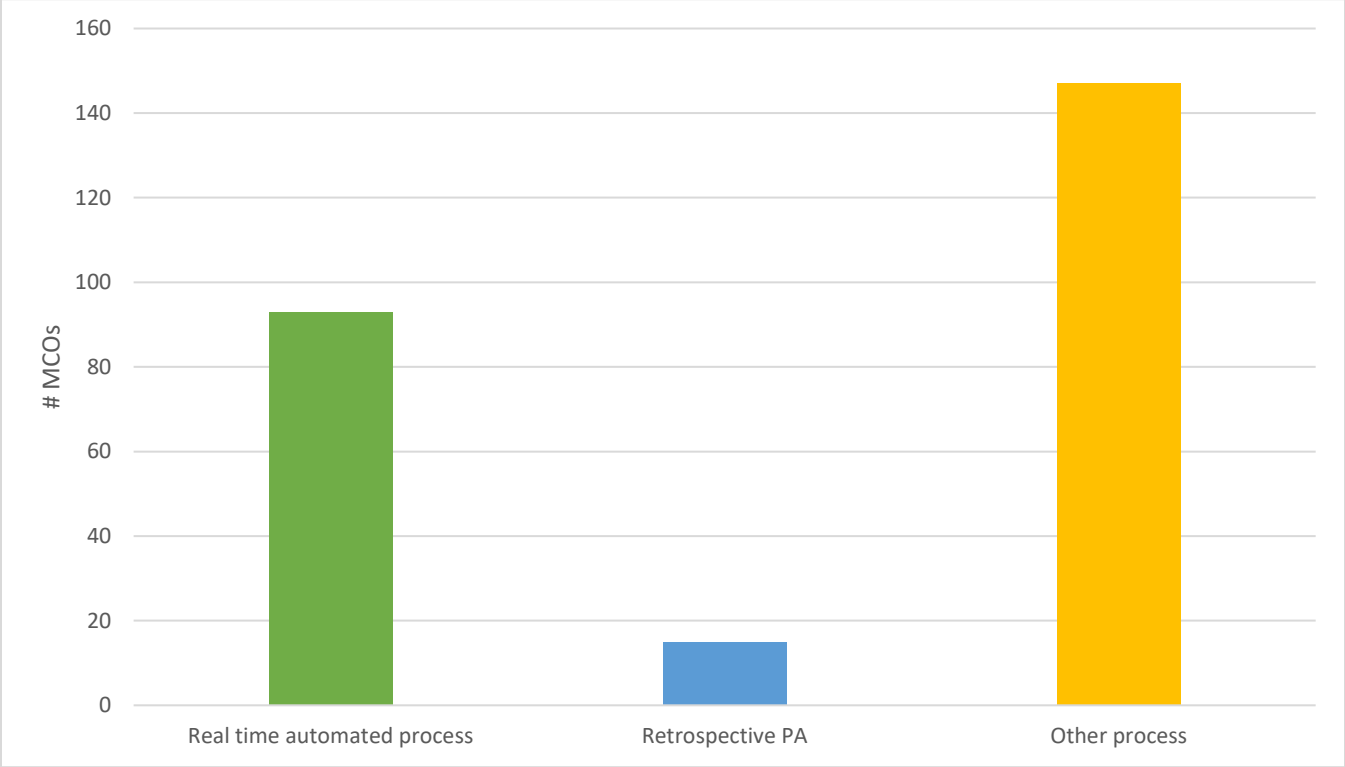

Table 28 - Process for the Dispensing of At Least a 72-Hour Supply of CODs in Emergency Situations

Response	States (Count of MCOs)	Count	Percentage
Real time automated process	Arkansas (2), Colorado (1), Delaware (2), District of Columbia (2), Florida (6), Georgia (2), Hawaii (2), Illinois (1), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (4), Maryland (3), Massachusetts (2), Michigan (4), Minnesota (2), Mississippi (3), Nebraska (1), Nevada (2), New Hampshire (2), New Jersey (2), New Mexico (1), New York (5), North Carolina (3), Ohio (2), Oregon (2), Pennsylvania (6), Rhode Island (1), South Carolina (3), Texas (4), Utah (1), Virginia (3), Washington (3)	93	36.47%
Retrospective PA	Colorado (1), Illinois (2), Michigan (1), Minnesota (2), New York (1), Oregon (3), Pennsylvania (1), Utah (2), Washington (2)	15	5.88%
Other process	Arkansas (3), Colorado (1), Delaware (1), District of Columbia (3), Florida (9), Georgia (2), Hawaii (5), Illinois (4), Indiana (4), Kansas (3), Louisiana (1), Maryland (7), Massachusetts (4), Michigan (6), Minnesota (7), Mississippi (1), Nebraska (3), Nevada (3), New Hampshire (2), New Jersey (3), New Mexico (3), New York (13), North Carolina (3), Ohio (5), Oregon (18), Pennsylvania (5), Rhode Island (3), South Carolina (3), Texas (13), Utah (2), Virginia (3), Washington (4)	147	57.65%
National Totals		**255**	**100%**

11. Top Drug Claims Data Reviewed by the DUR Board:

*Table 29 - Top Drug Claims Data Reviewed by the DUR Board**

Column 1 Top 10 PA Requests by Drug Name	Column 2 Top 10 PA Requests by Drug Class	Column 3 Top 5 Claim Denial Reasons (i.e. Quantity Limits (QL), Early Refill (ER), PA, Therapeutic Duplications (TD), and Age Edits (AE))	Column 4 Top 10 Drug Names by Amount Paid	Column 5 Top 10 Drug Names by Claim Count
Oxycodone - Acetaminophen	Opioids	Plan Limitations Exceeded	Adalimumab	Albuterol
Semaglutide	Antidiabetic Agents	Refill Too Soon	Bictegravir/ emtricitabine/ tenofovir	Ibuprofen
Methylphenidate	Adhd Agents/stimulants	Prior Authorization Required	Dulaglutide	Atorvastatin
Dextroamphetamine/ amphetamine	Analgesics, Narcotic Agents	Dur Reject Error	Insulin Glargine	Amoxicillin
Hydrocodone - Acetaminophen	Acne Therapy	Submit Bill To Other Processor Or Primary Payor	Ustekinumab	Cetirizine
Albuterol	Dermatologicals		Paliperidone	Gabapentin
Omeprazole	Antimigraine Agents		Lurasidone	Fluticasone
Lisdexamfetamine	Proton Pump Inhibitor Agents		Elexacaftor/ tezacaftor/ ivacaftor	Omeprazole
Pantoprazole	Antipsychotic Agents		Lisdexamfetamine	Metformin
Adalimumab	Sympathomimetics		Dupilumab	Lisinopril

* This table has been developed and formulated using weighted averages to reflect the relative beneficiary size of each reporting MCO. Drug names are reported at the generic ingredient level.

Section III - Retrospective DUR (RetroDUR)

1. Please indicate how your MCO operates and oversees RetroDUR reviews.

Figure 28 - Operation and Oversight of RetroDUR Reviews

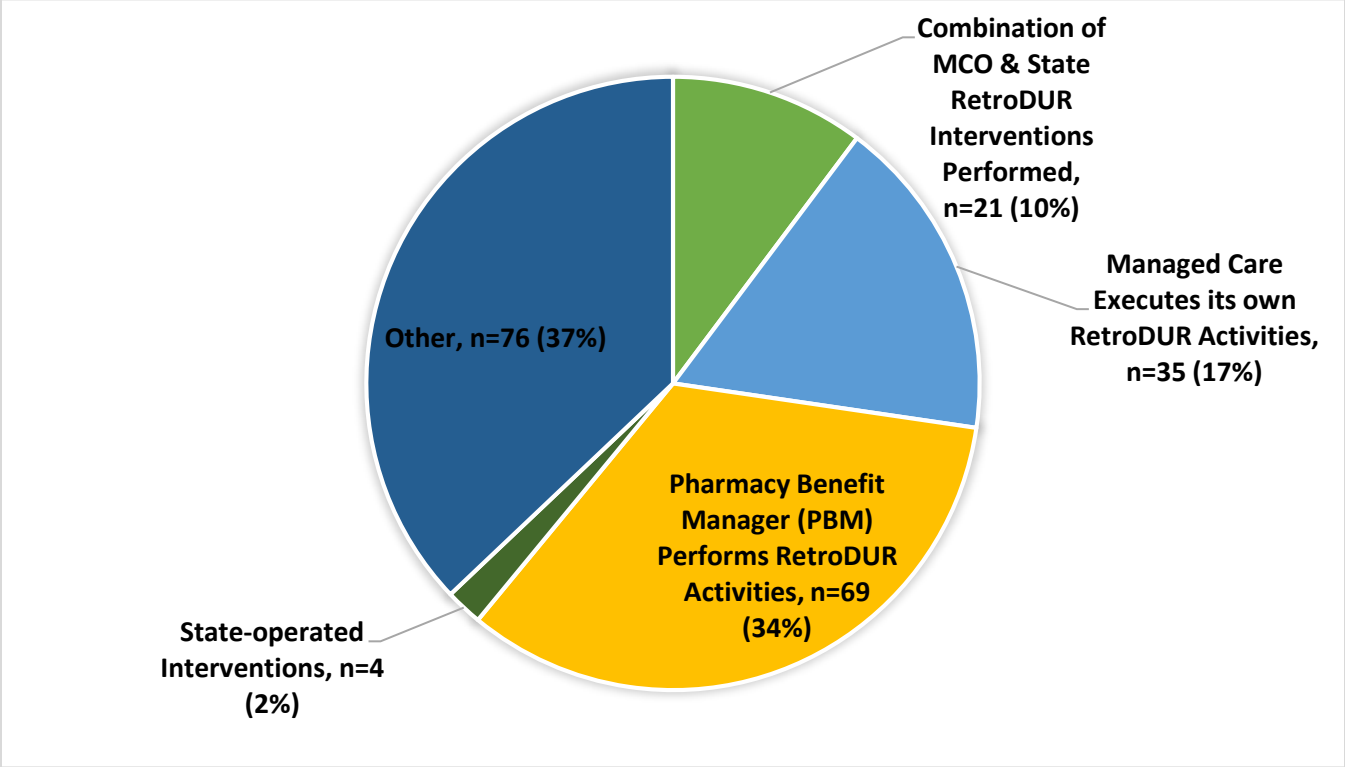

Table 30 - Operation and Oversight of RetroDUR Reviews

Response	States (Count of MCOs)	Count	Percentage
Combination of MCO & State RetroDUR interventions performed	Delaware (1), Florida (2), Hawaii (1), Indiana (2), Kansas (2), Louisiana (3), Minnesota (1), Mississippi (1), New Mexico (2), New York (1), North Carolina (1), Ohio (1), Pennsylvania (1), Rhode Island (1), Texas (1)	21	10.24%
Managed Care executes its own RetroDUR activities	District of Columbia (1), Hawaii (1), Illinois (1), Kentucky (2), Maryland (2), Massachusetts (1), Minnesota (1), Nevada (1), New Hampshire (1), New Jersey (1), New Mexico (1), New York (2), Oregon (13), Pennsylvania (3), Utah (3), Washington (1)	35	17.07%
Pharmacy Benefit Manager (PBM) performs RetroDUR activities	Colorado (1), Florida (5), Hawaii (2), Illinois (3), Indiana (1), Maryland (5), Massachusetts (4), Michigan (3), Minnesota (5), Mississippi (1), Nebraska (2), Nevada (1), New Hampshire (1), New Jersey (2), New York (9), North Carolina (2), Ohio (2), Oregon (2), Pennsylvania (1), Rhode Island (2), South Carolina (3), Texas (8), Virginia (2), Washington (2)	69	33.66%
State-operated interventions	Kentucky (2), Louisiana (2)	4	1.95%

Response	States (Count of MCOs)	Count	Percentage
Other	Arkansas (4), Colorado (1), Delaware (1), District of Columbia (3), Florida (4), Georgia (3), Hawaii (2), Illinois (2), Indiana (2), Iowa (2), Kansas (1), Kentucky (2), Maryland (2), Michigan (6), Minnesota (2), Mississippi (1), Nebraska (1), Nevada (2), New Hampshire (1), New Jersey (2), New York (3), North Carolina (2), Ohio (2), Oregon (6), Pennsylvania (3), South Carolina (2), Texas (7), Utah (1), Virginia (4), Washington (2)	76	37.07%
National Totals		**205**	**100%**

2. Identify the vendor, by name and type, that performed your RetroDUR activities during the time period covered by this report.

Figure 29 - Type of Vendor that Performed RetroDUR Activities

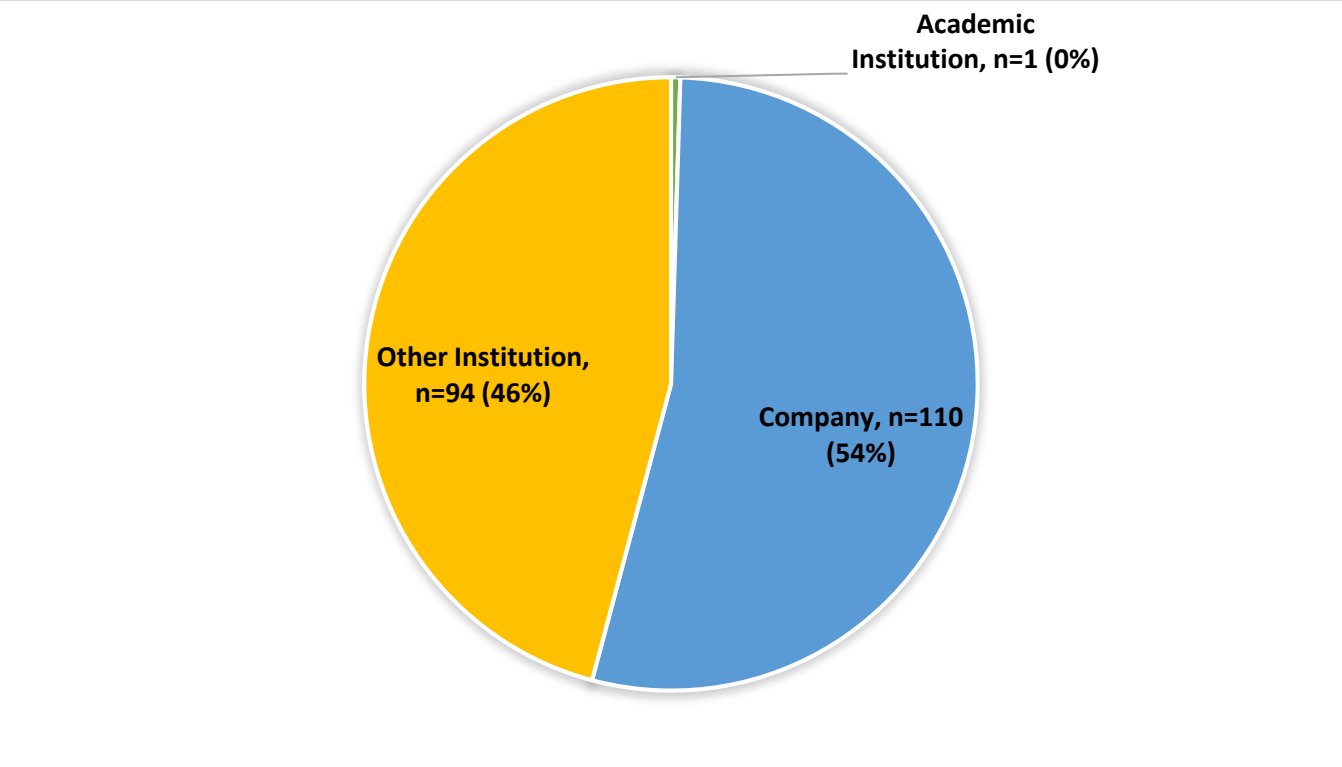

Table 31 - Type of Vendor that Performed RetroDUR Activities

Response	States (Count of MCOs)	Count	Percentage
Academic Institution	Mississippi (1)	1	0.49%
Company	Arkansas (3), Colorado (1), District of Columbia (3), Florida (6), Georgia (2), Hawaii (2), Illinois (5), Indiana (3), Kansas (2), Kentucky (2), Louisiana (3), Maryland (4), Massachusetts (2), Michigan (5), Minnesota (8), Mississippi (2), Nebraska (3), Nevada (3), New Hampshire (2), New Jersey (2), New Mexico (2), New York (9), North Carolina (1), Ohio (5), Oregon (8), Rhode Island (1), South Carolina (2), Texas (7), Utah (3), Virginia (4), Washington (5)	110	53.66%

Response	States (Count of MCOs)	Count	Percentage
Other Institution	Arkansas (1), Colorado (1), Delaware (2), District of Columbia (1), Florida (5), Georgia (1), Hawaii (4), Illinois (1), Indiana (2), Iowa (2), Kansas (1), Kentucky (4), Louisiana (2), Maryland (5), Massachusetts (3), Michigan (4), Minnesota (1), Nevada (1), New Hampshire (1), New Jersey (3), New Mexico (1), New York (6), North Carolina (4), Oregon (13), Pennsylvania (8), Rhode Island (2), South Carolina (3), Texas (9), Utah (1), Virginia (2)	94	45.85%
National Totals		**205**	**100%**

If “Other”, please identify by name and type.

Please reference individual State MCO reports on Medicaid.gov for more information.

a. Is the RetroDUR vendor the developer/supplier of your retrospective DUR criteria?

Figure 30 - RetroDUR Vendor is the Developer/Supplier of Retrospective DUR Criteria

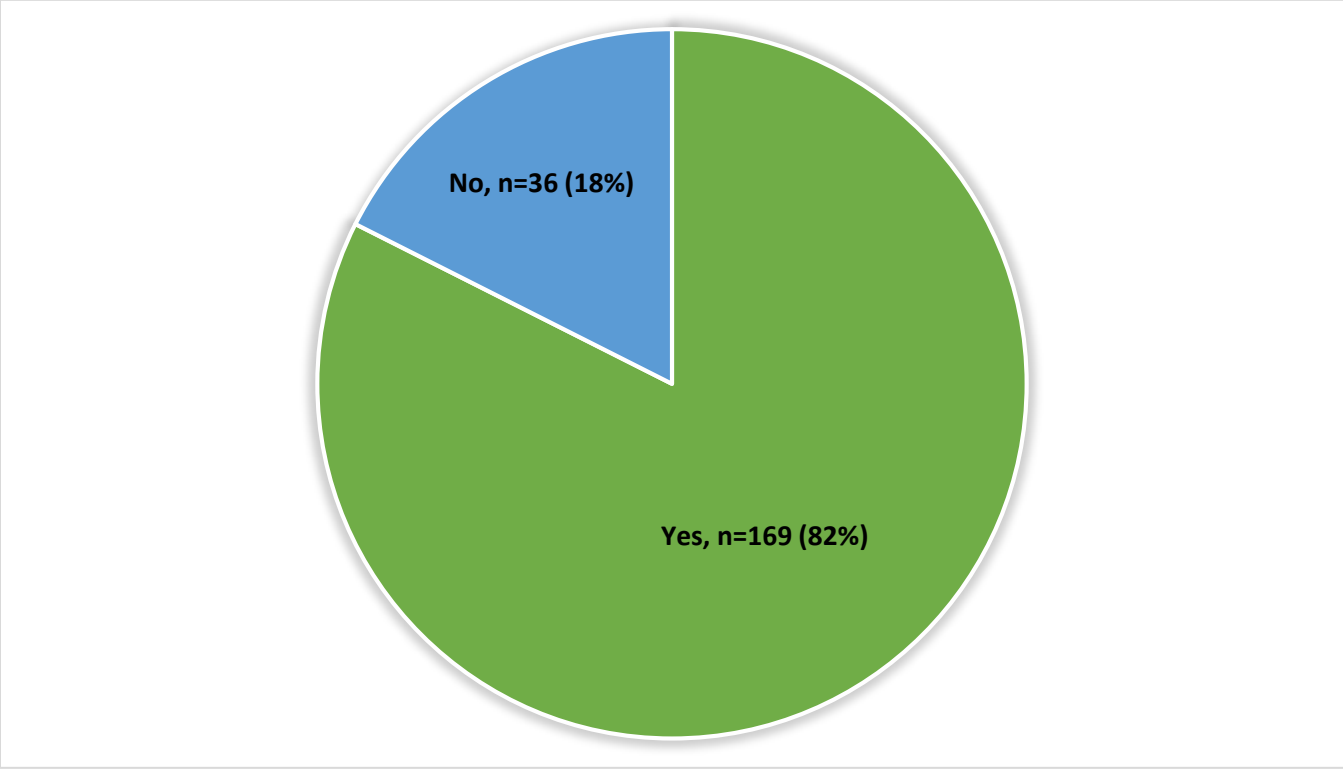

Table 32 - RetroDUR Vendor is the Developer/Supplier of Retrospective DUR Criteria

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (1), Delaware (2), District of Columbia (4), Florida (10), Georgia (3), Hawaii (6), Illinois (5), Indiana (5), Kansas (3), Kentucky (4), Louisiana (1), Maryland (8), Massachusetts (5), Michigan (8), Minnesota (7), Mississippi (2), Nebraska (3), Nevada (3), New Hampshire (2), New Jersey (4), New Mexico (2), New York (12), North Carolina (4), Ohio (5), Oregon (13), Pennsylvania (6), Rhode Island (3), South Carolina (5), Texas (16), Utah (2), Virginia (6), Washington (5)	169	82.44%

Response	States (Count of MCOs)	Count	Percentage
No	Colorado (1), Florida (1), Illinois (1), Iowa (2), Kentucky (2), Louisiana (4), Maryland (1), Michigan (1), Minnesota (2), Mississippi (1), Nevada (1), New Hampshire (1), New Jersey (1), New Mexico (1), New York (3), North Carolina (1), Oregon (8), Pennsylvania (2), Utah (2)	36	17.56%
National Totals		**205**	**100%**

b. Does your MCO customize your RetroDUR vendor criteria?

Figure 31 - MCO Customizes RetroDUR Vendor Criteria

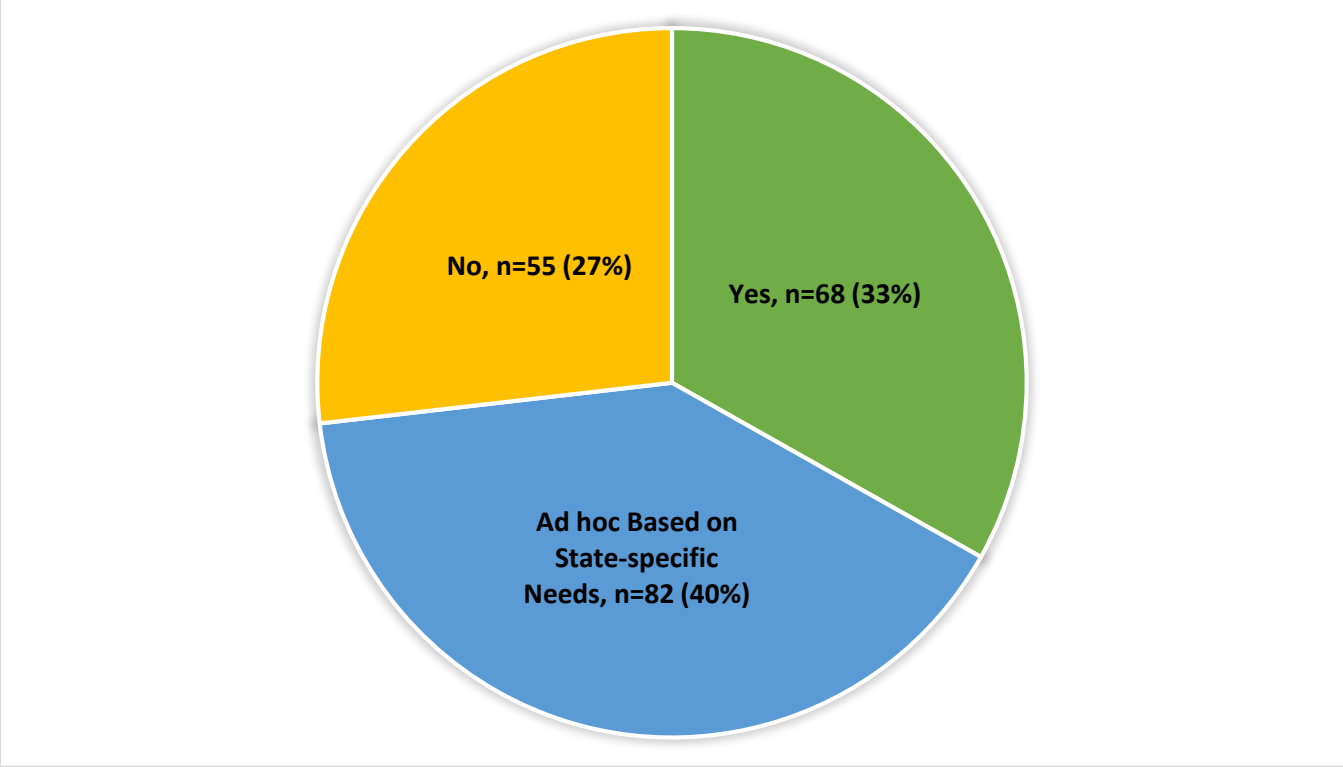

Table 33 - MCO Customizes RetroDUR Vendor Criteria

Response	States (Count of MCOs)	Count	Percentage
Ad hoc based on State-specific needs	Arkansas (1), Colorado (1), Delaware (1), Florida (7), Georgia (1), Hawaii (1), Illinois (1), Indiana (4), Kansas (2), Kentucky (2), Louisiana (3), Maryland (5), Michigan (5), Minnesota (3), Mississippi (2), Nebraska (3), Nevada (2), New Hampshire (2), New Jersey (4), New Mexico (1), New York (3), North Carolina (3), Ohio (1), Oregon (9), Pennsylvania (3), Rhode Island (2), South Carolina (2), Texas (3), Virginia (3), Washington (2)	82	40.00%
Yes	Arkansas (3), Delaware (1), District of Columbia (1), Florida (2), Georgia (2), Hawaii (3), Illinois (2), Indiana (1), Kansas (1), Kentucky (2), Maryland (1), Massachusetts (2), Michigan (2), Minnesota (1), New Hampshire (1), New Jersey (1), New Mexico (1), New York (5), North Carolina (2), Ohio (2), Oregon (9), Pennsylvania (4), South Carolina (2), Texas (11), Utah (3), Virginia (2), Washington (1)	68	33.17%

Response	States (Count of MCOs)	Count	Percentage
No	Colorado (1), District of Columbia (3), Florida (2), Hawaii (2), Illinois (3), Iowa (2), Kentucky (2), Louisiana (2), Maryland (3), Massachusetts (3), Michigan (2), Minnesota (5), Mississippi (1), Nevada (2), New Mexico (1), New York (7), Ohio (2), Oregon (3), Pennsylvania (1), Rhode Island (1), South Carolina (1), Texas (2), Utah (1), Virginia (1), Washington (2)	55	26.83%
National Totals		**205**	**100%**

3. Who reviews and approves your MCO RetroDUR criteria?

Figure 32 - RetroDUR Criteria Approval/Review Sources

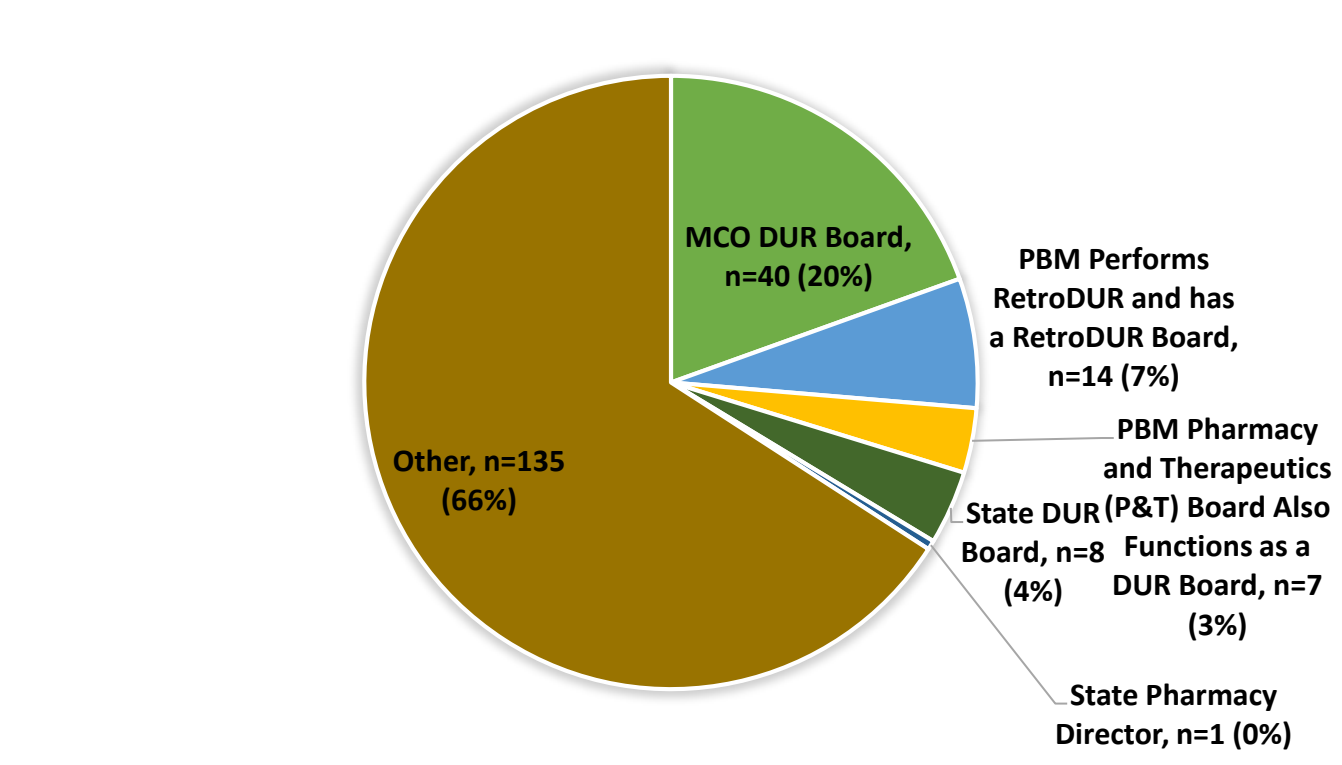

Table 34 - RetroDUR Criteria Approval/Review Sources

Response	States (Count of MCOs)	Count	Percentage
MCO DUR Board	Arkansas (1), Florida (2), Georgia (1), Kentucky (2), Maryland (1), Michigan (1), Minnesota (2), Nevada (1), New Hampshire (1), New York (2), North Carolina (2), Oregon (13), Pennsylvania (2), Rhode Island (1), South Carolina (1), Texas (1), Utah (3), Virginia (2), Washington (1)	40	19.51%
PBM performs RetroDUR and has a RetroDUR Board	Illinois (2), Indiana (1), Michigan (2), Minnesota (3), New Mexico (1), New York (3), Texas (1), Washington (1)	14	6.83%
PBM Pharmacy and Therapeutics (P&T) Board also functions as a DUR Board	Maryland (1), Michigan (1), Minnesota (3), New Hampshire (1), South Carolina (1)	7	3.41%
State DUR Board	Florida (1), Iowa (2), Kentucky (1), Louisiana (2), Mississippi (2)	8	3.90%

Response	States (Count of MCOs)	Count	Percentage
State Pharmacy Director	Delaware (1)	1	0.49%
Other	Arkansas (3), Colorado (2), Delaware (1), District of Columbia (4), Florida (8), Georgia (2), Hawaii (6), Illinois (4), Indiana (4), Kansas (3), Kentucky (3), Louisiana (3), Maryland (7), Massachusetts (5), Michigan (5), Minnesota (1), Mississippi (1), Nebraska (3), Nevada (3), New Hampshire (1), New Jersey (5), New Mexico (2), New York (10), North Carolina (3), Ohio (5), Oregon (8), Pennsylvania (6), Rhode Island (2), South Carolina (3), Texas (14), Utah (1), Virginia (4), Washington (3)	135	65.85%
National Totals		**205**	**100%**

4. How often does your MCO perform retrospective practitioner-based education?

Figure 33 - Frequency of Retrospective Practitioner-Based Education

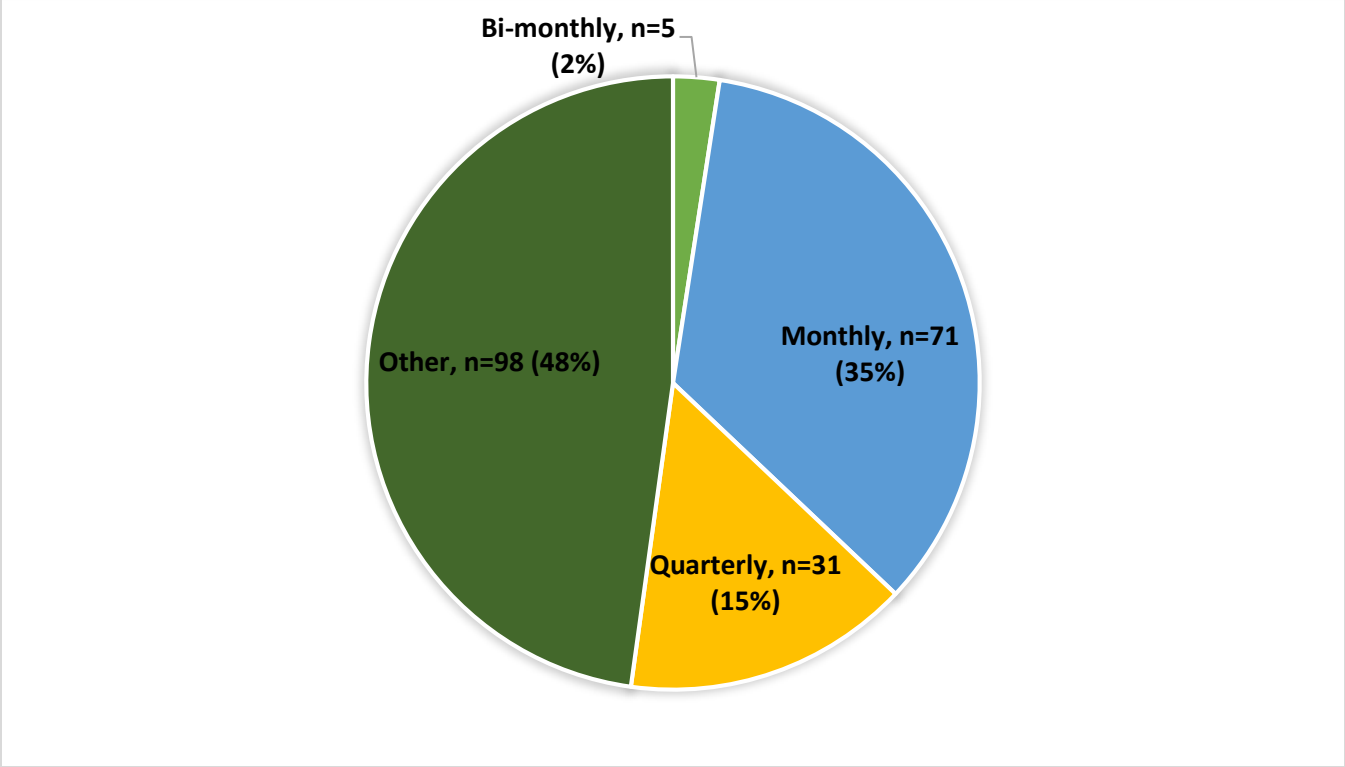

Table 35 - Frequency of Retrospective Practitioner-Based Education

Response	States (Count of MCOs)	Count	Percentage
Bi-monthly	Oregon (5)	5	2.44%
Monthly	Arkansas (3), Florida (6), Georgia (2), Hawaii (3), Illinois (2), Indiana (2), Kansas (1), Kentucky (3), Louisiana (4), Maryland (3), Massachusetts (2), Michigan (2), Minnesota (1), Mississippi (2), Nebraska (2), Nevada (3), New Hampshire (2), New Jersey (3), New York (6), North Carolina (3), Oregon (2), Pennsylvania (3), South Carolina (3), Texas (3), Virginia (3), Washington (2)	71	34.63%

Response	States (Count of MCOs)	Count	Percentage
Quarterly	Colorado (1), Delaware (1), District of Columbia (2), Florida (1), Illinois (2), Indiana (1), Kansas (1), Kentucky (1), Maryland (4), Michigan (2), Minnesota (3), New Jersey (1), New Mexico (1), North Carolina (1), Oregon (5), Texas (1), Utah (1), Virginia (1), Washington (1)	31	15.12%
Other	Arkansas (1), Colorado (1), Delaware (1), District of Columbia (2), Florida (4), Georgia (1), Hawaii (3), Illinois (2), Indiana (2), Iowa (2), Kansas (1), Kentucky (2), Louisiana (1), Maryland (2), Massachusetts (3), Michigan (5), Minnesota (5), Mississippi (1), Nebraska (1), Nevada (1), New Hampshire (1), New Jersey (1), New Mexico (2), New York (9), North Carolina (1), Ohio (5), Oregon (9), Pennsylvania (5), Rhode Island (3), South Carolina (2), Texas (12), Utah (3), Virginia (2), Washington (2)	98	47.80%
National Totals		**205**	**100%**

a. How often does your MCO perform retrospective reviews that involve- communication of client-specific information to healthcare practitioners (multiple responses allowed)?

Figure 34 - Frequency of Retrospective Reviews that Involve Communication of Client-Specific Information to Healthcare Practitioners

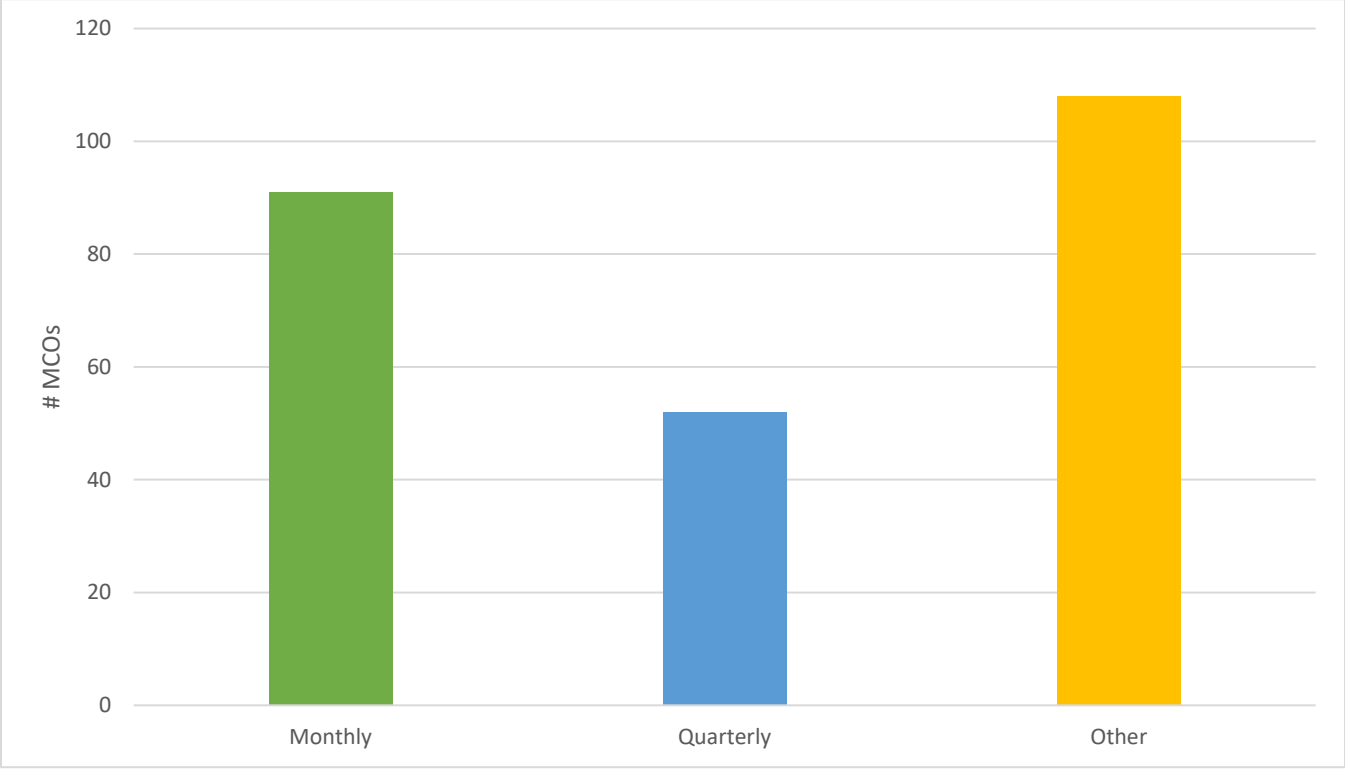

Table 36 - Frequency of Retrospective Reviews that Involve Communication of Client-Specific Information to Healthcare Practitioners

Response	States (Count of MCOs)	Count	Percentage
Monthly	Arkansas (3), District of Columbia (3), Florida (6), Georgia (2), Hawaii (3), Illinois (3), Indiana (3), Kansas (2), Kentucky (3), Louisiana (5), Maryland (5), Massachusetts (2), Michigan (5), Minnesota (1), Mississippi (2), Nebraska (2), Nevada (3), New Hampshire (2), New Jersey (4), New Mexico (1), New York (8), North Carolina (3), Ohio (1), Oregon (3), Pennsylvania (4), South Carolina (3), Texas (3), Utah (1), Virginia (3), Washington (2)	91	36.25%
Quarterly	Colorado (1), Delaware (1), District of Columbia (2), Florida (2), Illinois (1), Indiana (1), Iowa (2), Kansas (2), Kentucky (1), Maryland (5), Massachusetts (1), Michigan (4), Minnesota (3), Nevada (1), New Hampshire (1), New Jersey (1), New York (3), North Carolina (1), Ohio (1), Oregon (10), Pennsylvania (3), Texas (1), Utah (2), Virginia (1), Washington (1)	52	20.72%
Other	Arkansas (1), Colorado (1), Delaware (1), District of Columbia (2), Florida (5), Georgia (1), Hawaii (3), Illinois (2), Indiana (2), Kansas (2), Kentucky (2), Louisiana (1), Maryland (3), Massachusetts (3), Michigan (4), Minnesota (5), Mississippi (1), Nebraska (1), Nevada (1), New Hampshire (1), New Jersey (2), New Mexico (2), New York (10), North Carolina (2), Ohio (4), Oregon (14), Pennsylvania (4), Rhode Island (3), South Carolina (3), Texas (12), Utah (4), Virginia (3), Washington (3)	108	43.03%
National Totals		**251**	**100%**

b. What is the preferred mode of communication when performing RetroDUR initiatives (multiple responses allowed)?

Figure 35 - Preferred Mode of Communication When Performing RetroDUR Initiatives

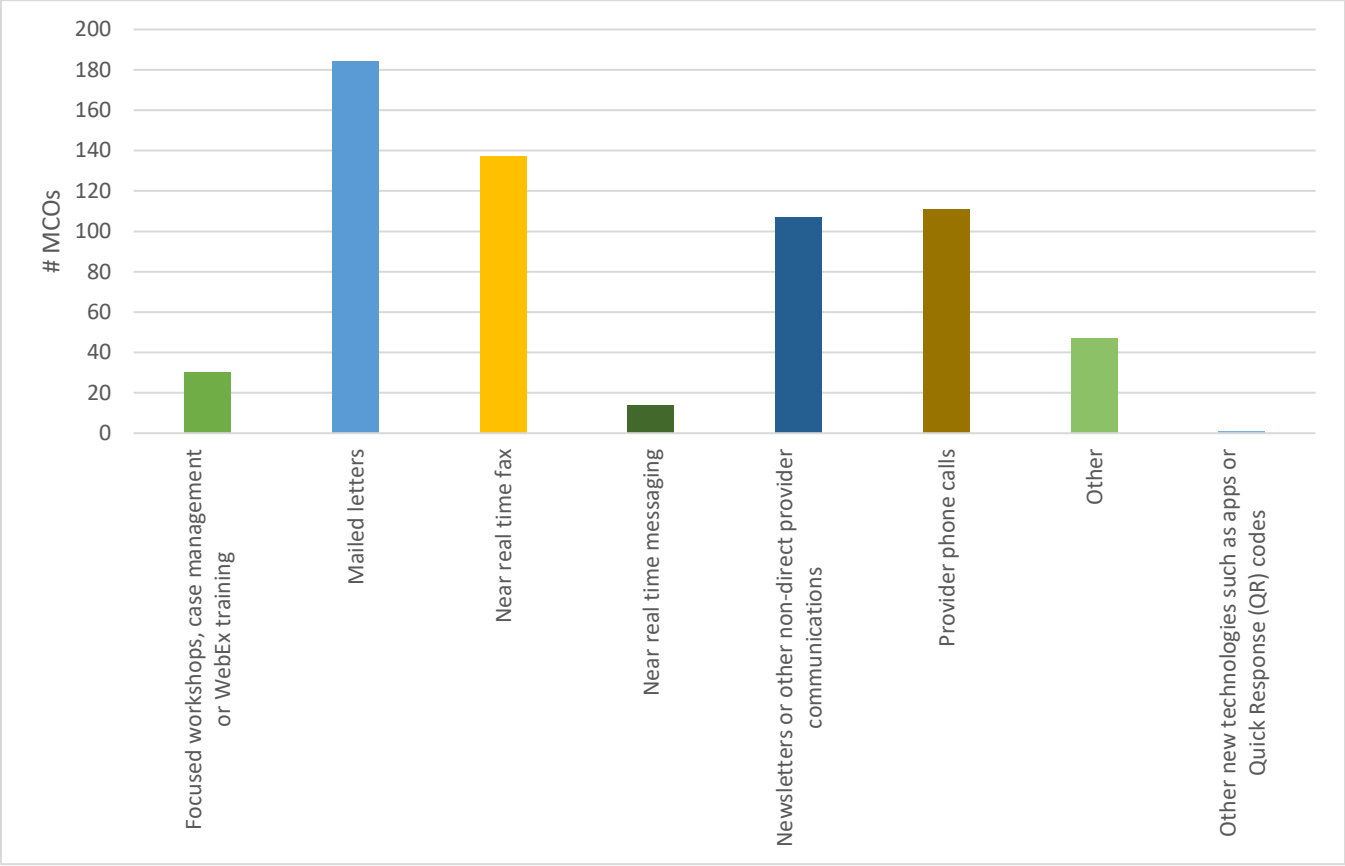

Table 37 - Preferred Mode of Communication When Performing RetroDUR Initiatives

Response	States (Count of MCOs)	Count	Percentage
Focused workshops, case management or WebEx training	Arkansas (1), District of Columbia (3), Illinois (1), Kansas (1), Kentucky (1), Maryland (2), Michigan (2), Minnesota (2), Mississippi (1), Nebraska (1), New Jersey (1), North Carolina (1), Ohio (1), Oregon (6), Pennsylvania (3), Texas (1), Utah (1), Virginia (1)	30	4.75%
Mailed letters	Arkansas (4), Colorado (2), Delaware (1), District of Columbia (3), Florida (11), Georgia (3), Hawaii (3), Illinois (5), Indiana (5), Iowa (2), Kansas (3), Kentucky (4), Louisiana (5), Maryland (9), Massachusetts (4), Michigan (8), Minnesota (8), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (13), Pennsylvania (7), Rhode Island (3), South Carolina (5), Texas (16), Utah (3), Virginia (6), Washington (5)	184	29.16%

Response	States (Count of MCOs)	Count	Percentage
Near real time fax	Arkansas (3), Colorado (1), Delaware (1), District of Columbia (3), Florida (10), Georgia (3), Hawaii (4), Illinois (4), Indiana (3), Kansas (2), Kentucky (3), Louisiana (3), Maryland (7), Massachusetts (4), Michigan (6), Minnesota (5), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (2), New York (11), North Carolina (5), Ohio (5), Oregon (4), Pennsylvania (5), Rhode Island (2), South Carolina (5), Texas (6), Utah (3), Virginia (5), Washington (4)	137	21.71%
Near real time messaging	Arkansas (1), Indiana (1), Maryland (1), Michigan (3), Minnesota (2), New York (1), Ohio (1), Oregon (2), Pennsylvania (1), Washington (1)	14	2.22%
Newsletters or other non-direct provider communications	Arkansas (2), Colorado (2), Delaware (1), District of Columbia (1), Florida (5), Georgia (1), Hawaii (2), Illinois (3), Indiana (3), Iowa (2), Kansas (2), Kentucky (2), Louisiana (2), Maryland (4), Massachusetts (3), Michigan (4), Minnesota (3), Mississippi (2), Nebraska (3), Nevada (3), New Hampshire (1), New Jersey (3), New Mexico (2), New York (7), North Carolina (3), Ohio (3), Oregon (13), Pennsylvania (4), Rhode Island (3), South Carolina (2), Texas (4), Utah (4), Virginia (5), Washington (3)	107	16.96%
Provider phone calls	Arkansas (2), Delaware (1), District of Columbia (4), Florida (8), Georgia (3), Hawaii (2), Illinois (3), Indiana (3), Iowa (2), Kansas (1), Kentucky (3), Louisiana (1), Maryland (5), Massachusetts (3), Michigan (5), Minnesota (2), Mississippi (1), Nebraska (2), Nevada (3), New Hampshire (3), New Jersey (4), New Mexico (3), New York (9), North Carolina (4), Ohio (3), Oregon (9), Pennsylvania (6), Rhode Island (1), South Carolina (4), Texas (4), Utah (1), Virginia (3), Washington (3)	111	17.59%
Other	Arkansas (2), Colorado (1), Delaware (1), Florida (1), Georgia (1), Hawaii (1), Illinois (2), Indiana (1), Kansas (1), Kentucky (3), Maryland (1), Michigan (3), Minnesota (2), Nebraska (1), New Jersey (1), New Mexico (1), New York (4), North Carolina (1), Ohio (1), Oregon (8), Pennsylvania (3), Rhode Island (1), South Carolina (2), Texas (2), Virginia (1), Washington (1)	47	7.45%
Other new technologies such as apps or Quick Response (QR) codes	New York (1)	1	0.16%
National Totals		**631**	**100%**

5. Summary 1 - RetroDUR Educational Outreach

RetroDUR Educational Outreach Summary should be a year-end summary report on retrospective screening and educational interventions. The summary should be limited to the most prominent problems with the largest number of exceptions.

Please reference individual State MCO reports on Medicaid.gov for more information.

Section IV - DUR Board Activity

1. Does your MCO utilize the same DUR Board as the State FFS Medicaid program or does your MCO have its own DUR Board?

Figure 36 - MCO Utilizes the Same DUR Board as the State FFS Program or Has Own DUR Board

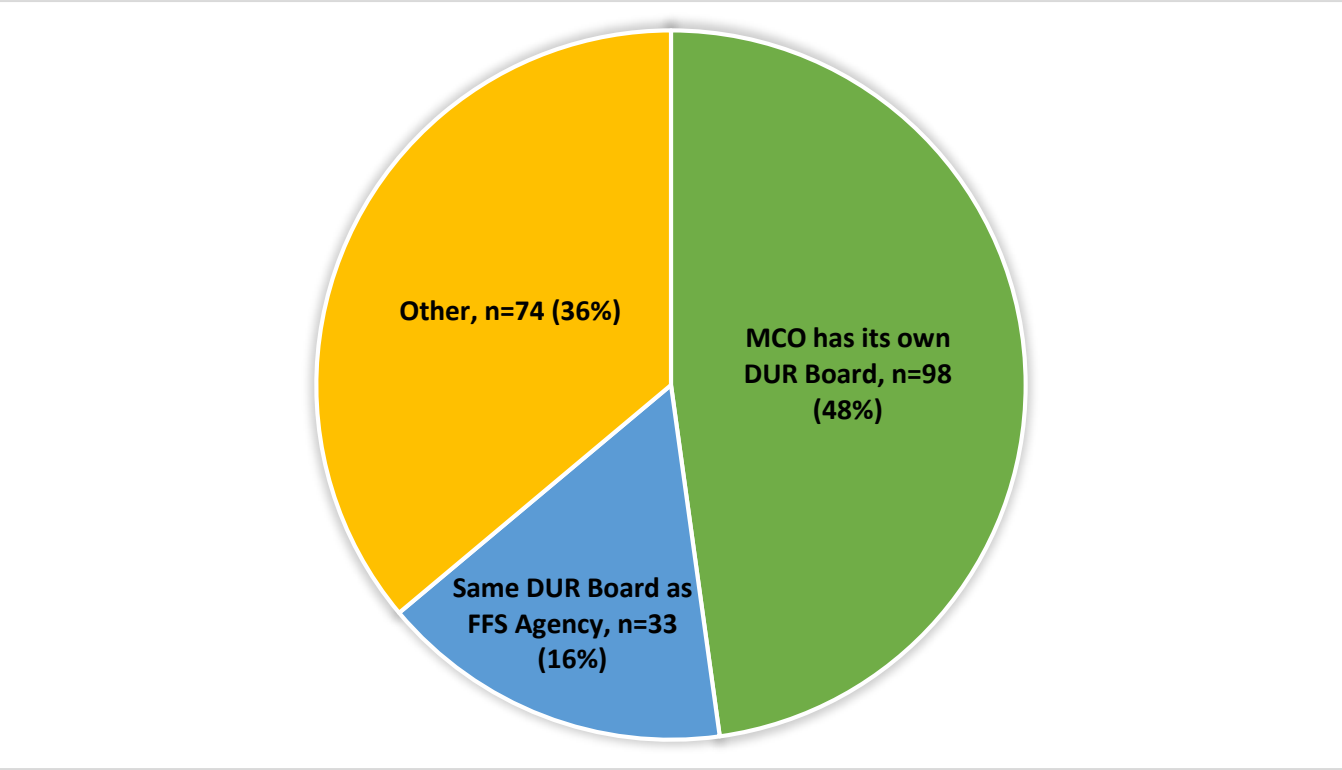

Table 38 - MCO Utilizes the Same DUR Board as the State FFS Program or Has Own DUR Board

Response	States (Count of MCOs)	Count	Percentage
MCO has its own DUR Board	Arkansas (2), Colorado (2), District of Columbia (2), Florida (4), Georgia (1), Hawaii (4), Illinois (3), Kentucky (1), Maryland (4), Michigan (5), Minnesota (7), Mississippi (1), Nebraska (1), Nevada (2), New Hampshire (1), New Jersey (3), New Mexico (1), New York (6), North Carolina (3), Ohio (4), Oregon (19), Pennsylvania (5), Rhode Island (2), South Carolina (3), Texas (3), Utah (4), Virginia (5)	98	47.80%
Same DUR Board as FFS agency	Florida (3), Indiana (3), Iowa (2), Kentucky (3), Louisiana (4), Massachusetts (1), Michigan (1), Mississippi (2), Nebraska (1), Nevada (1), North Carolina (1), Pennsylvania (1), Texas (10)	33	16.10%
Other	Arkansas (2), Delaware (2), District of Columbia (2), Florida (4), Georgia (2), Hawaii (2), Illinois (3), Indiana (2), Kansas (3), Kentucky (2), Louisiana (1), Maryland (5), Massachusetts (4), Michigan (3), Minnesota (2), Nebraska (1), Nevada (1), New Hampshire (2), New Jersey (2), New Mexico (2), New York (9), North Carolina (1), Ohio (1), Oregon (2), Pennsylvania (2), Rhode Island (1), South Carolina (2), Texas (3), Virginia (1), Washington (5)	74	36.10%
National Totals		**205**	**100%**

2. Does your MCO have a Medication Therapy Management (MTM) Program?

Figure 37 - MCO has a Medication Therapy Management Program

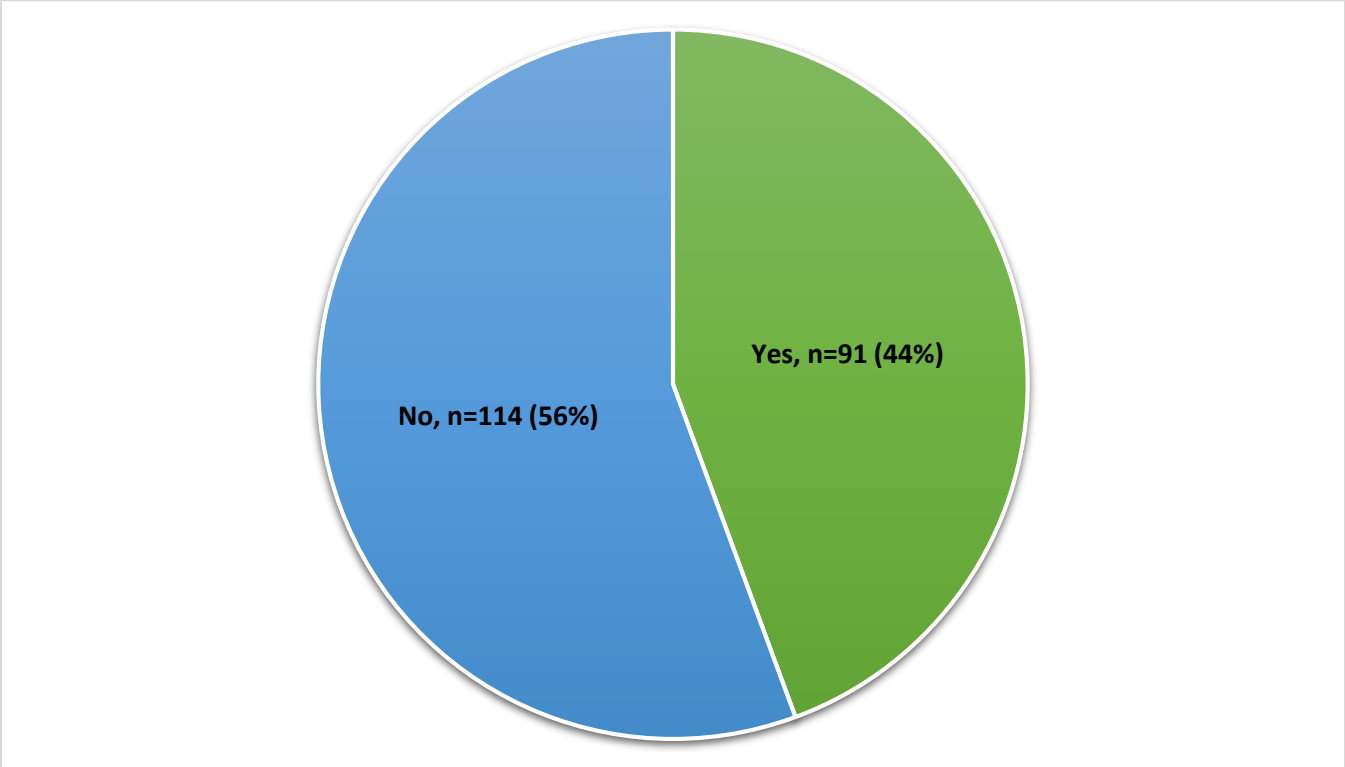

Table 39 - MCO has a Medication Therapy Management Program

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (3), Colorado (1), Delaware (2), District of Columbia (3), Florida (3), Georgia (2), Hawaii (1), Illinois (1), Indiana (5), Iowa (2), Kansas (3), Louisiana (5), Massachusetts (1), Michigan (4), Minnesota (9), Mississippi (2), Nebraska (3), Nevada (1), New Hampshire (3), New Mexico (1), New York (4), Ohio (5), Oregon (10), Pennsylvania (2), Rhode Island (1), South Carolina (1), Texas (1), Utah (3), Virginia (6), Washington (3)	91	44.39%
No	Arkansas (1), Colorado (1), District of Columbia (1), Florida (8), Georgia (1), Hawaii (5), Illinois (5), Kentucky (6), Maryland (9), Massachusetts (4), Michigan (5), Mississippi (1), Nevada (3), New Jersey (5), New Mexico (2), New York (11), North Carolina (5), Oregon (11), Pennsylvania (6), Rhode Island (2), South Carolina (4), Texas (15), Utah (1), Washington (2)	114	55.61%
National Totals		**205**	**100%**

3. Summary 2 - DUR Board Activities

DUR Board Activities Summary should include a brief descriptive report on DUR Board activities during the fiscal year reported.

Please reference individual State MCO reports on Medicaid.gov for more information.

Section V - Physician Administered Drugs (PAD)

The Deficit Reduction Act requires collection of national drug code (NDC) numbers for covered outpatient physician administered drugs. These drugs are paid through the physician and hospital programs. Has your pharmacy system been designed to incorporate this data into your DUR criteria for:

1. ProDUR?

Figure 38 - Incorporation of NDCs for Covered Outpatient Physician Administered Drugs into DUR criteria for ProDUR

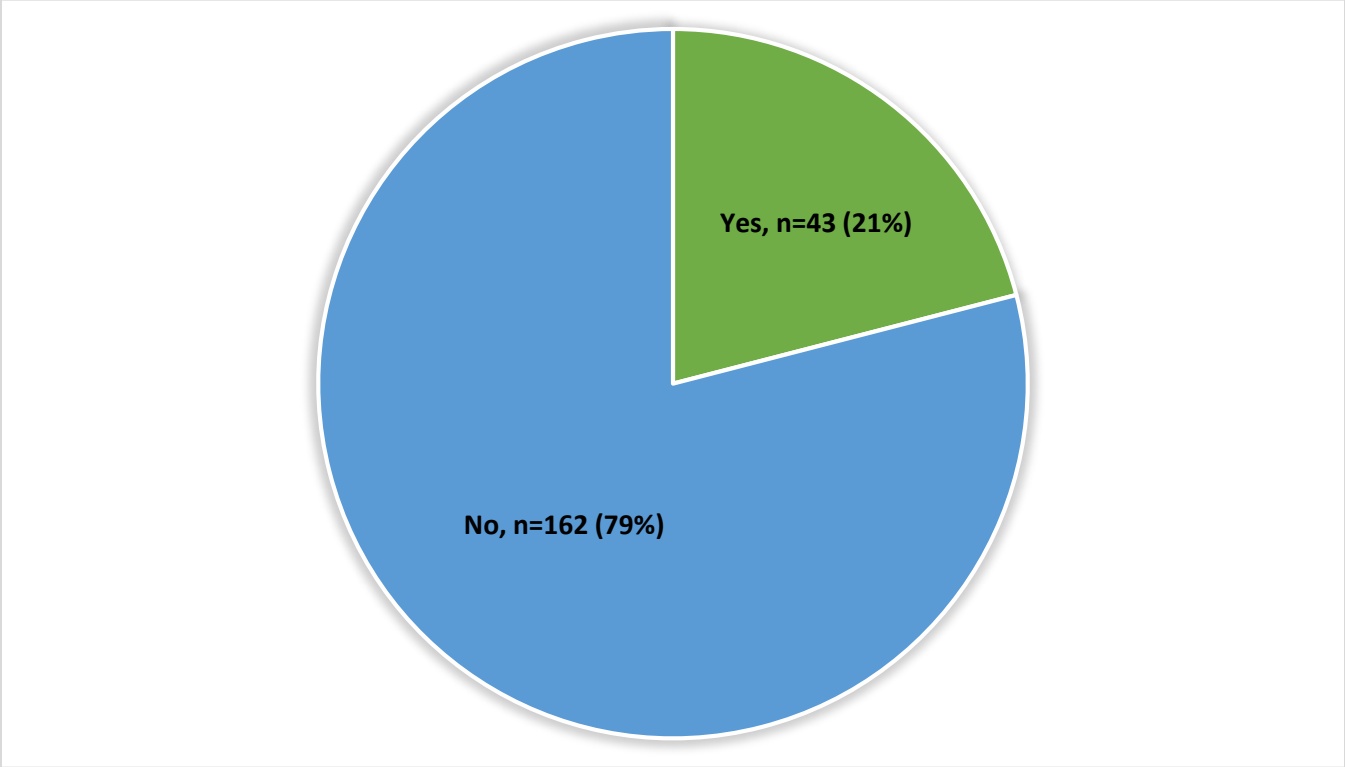

Table 40 - Incorporation of NDCs for Covered Outpatient Physician Administered Drugs into DUR criteria for ProDUR

Response	States (Count of MCOs)	Count	Percentage
Yes	Delaware (1), Florida (4), Georgia (1), Hawaii (1), Illinois (1), Indiana (1), Louisiana (1), Maryland (1), Michigan (2), Minnesota (1), Mississippi (1), Nebraska (1), Nevada (1), New Jersey (2), New York (4), Ohio (1), Oregon (7), Pennsylvania (2), South Carolina (1), Texas (3), Utah (3), Virginia (2), Washington (1)	43	20.98%
No	Arkansas (4), Colorado (2), Delaware (1), District of Columbia (4), Florida (7), Georgia (2), Hawaii (5), Illinois (5), Indiana (4), Iowa (2), Kansas (3), Kentucky (6), Louisiana (4), Maryland (8), Massachusetts (5), Michigan (7), Minnesota (8), Mississippi (2), Nebraska (2), Nevada (3), New Hampshire (3), New Jersey (3), New Mexico (3), New York (11), North Carolina (5), Ohio (4), Oregon (14), Pennsylvania (6), Rhode Island (3), South Carolina (4), Texas (13), Utah (1), Virginia (4), Washington (4)	162	79.02%
National Totals		**205**	**100%**

If "No," does your MCO have a plan to include this information in your DUR criteria in the future?

Figure 39 - Future Plans to Incorporate NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for ProDUR

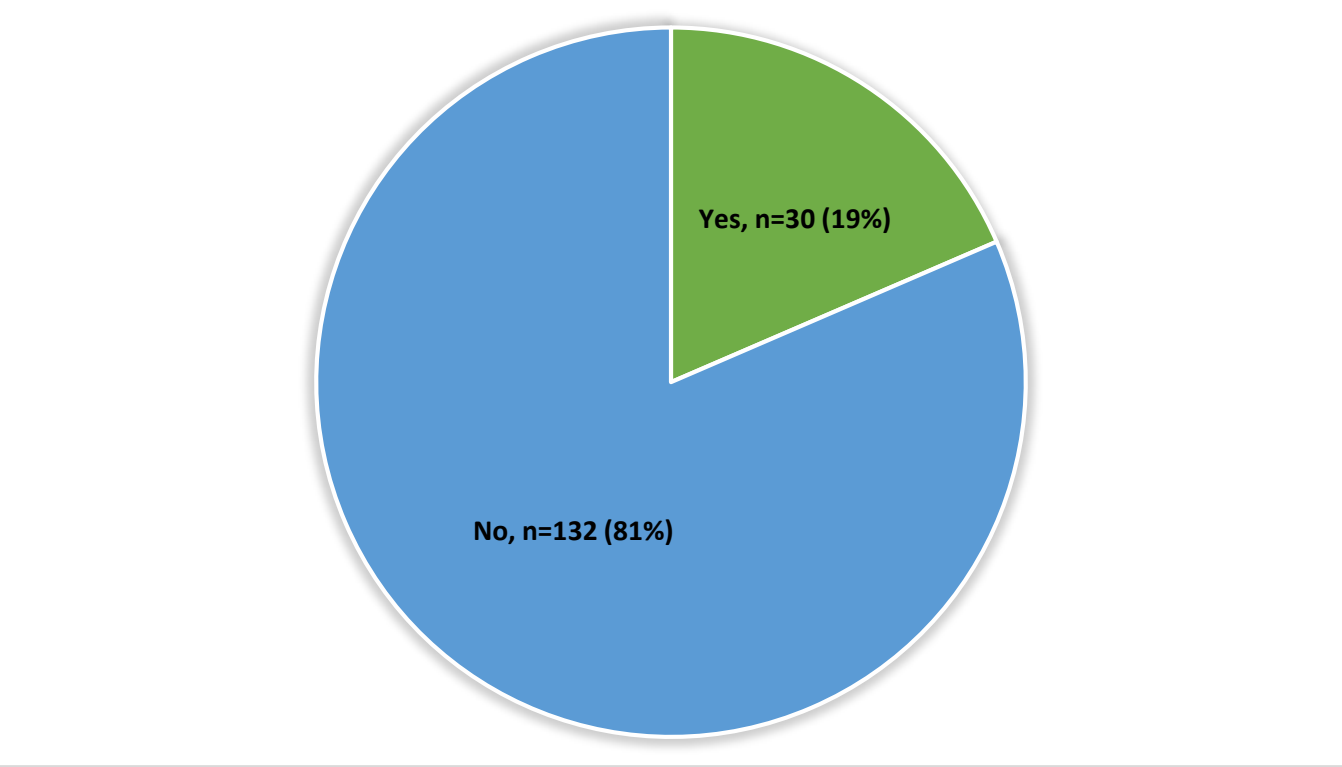

Table 41 - Future Plans to Incorporate NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for ProDUR

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (1), Colorado (1), Florida (1), Hawaii (1), Illinois (1), Indiana (1), Kentucky (2), Louisiana (2), Maryland (1), Massachusetts (1), Michigan (1), Minnesota (1), Mississippi (2), Nebraska (1), Nevada (1), New Jersey (1), New York (1), North Carolina (2), Ohio (1), Oregon (1), Pennsylvania (1), Rhode Island (1), South Carolina (1), Texas (1), Virginia (1), Washington (1)	30	18.52%
No	Arkansas (3), Colorado (1), Delaware (1), District of Columbia (4), Florida (6), Georgia (2), Hawaii (4), Illinois (4), Indiana (3), Iowa (2), Kansas (3), Kentucky (4), Louisiana (2), Maryland (7), Massachusetts (4), Michigan (6), Minnesota (7), Nebraska (1), Nevada (2), New Hampshire (3), New Jersey (2), New Mexico (3), New York (10), North Carolina (3), Ohio (3), Oregon (13), Pennsylvania (5), Rhode Island (2), South Carolina (3), Texas (12), Utah (1), Virginia (3), Washington (3)	132	81.48%
National Totals		**162**	**100%**

2. RetroDUR?

Figure 40 - Incorporation of NDCs for Covered Outpatient Physician Administered Drugs into DUR criteria for RetroDUR

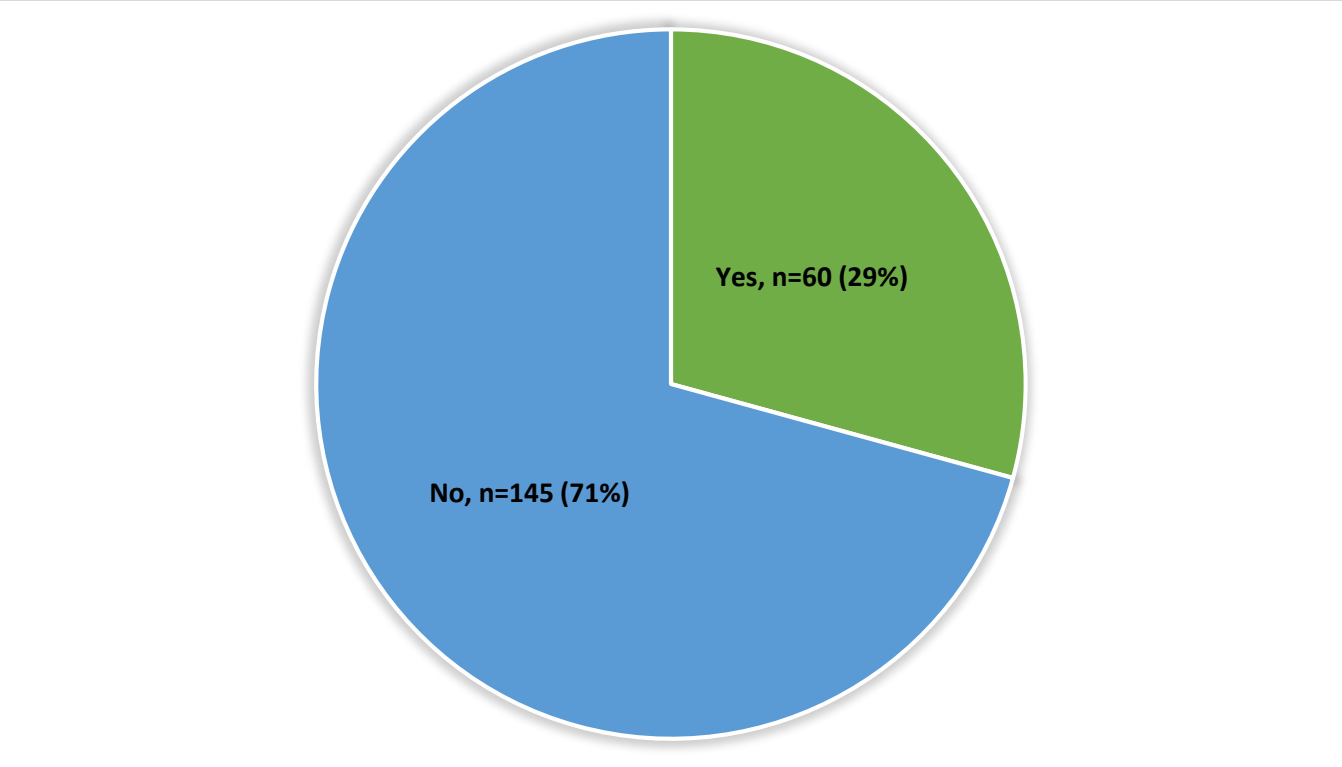

Table 42 - Incorporation of NDCs for Covered Outpatient Physician Administered Drugs into DUR criteria for RetroDUR

Response	States (Count of MCOs)	Count	Percentage
Yes	Delaware (1), Florida (3), Georgia (1), Hawaii (1), Illinois (2), Kentucky (1), Louisiana (1), Maryland (1), Massachusetts (1), Michigan (3), Minnesota (1), Mississippi (1), Nebraska (1), Nevada (1), New Hampshire (1), New Jersey (2), New Mexico (2), New York (8), Ohio (1), Oregon (9), Pennsylvania (2), Rhode Island (1), South Carolina (1), Texas (3), Utah (4), Virginia (4), Washington (3)	60	29.27%
No	Arkansas (4), Colorado (2), Delaware (1), District of Columbia (4), Florida (8), Georgia (2), Hawaii (5), Illinois (4), Indiana (5), Iowa (2), Kansas (3), Kentucky (5), Louisiana (4), Maryland (8), Massachusetts (4), Michigan (6), Minnesota (8), Mississippi (2), Nebraska (2), Nevada (3), New Hampshire (2), New Jersey (3), New Mexico (1), New York (7), North Carolina (5), Ohio (4), Oregon (12), Pennsylvania (6), Rhode Island (2), South Carolina (4), Texas (13), Virginia (2), Washington (2)	145	70.73%
National Totals		**205**	**100%**

If "No," does your MCO have a plan to include this information in your DUR criteria in the future?

Figure 41 - Future Plans to Incorporate NDCs for Covered Outpatient Physician Administered Drugs into DUR criteria for RetroDUR

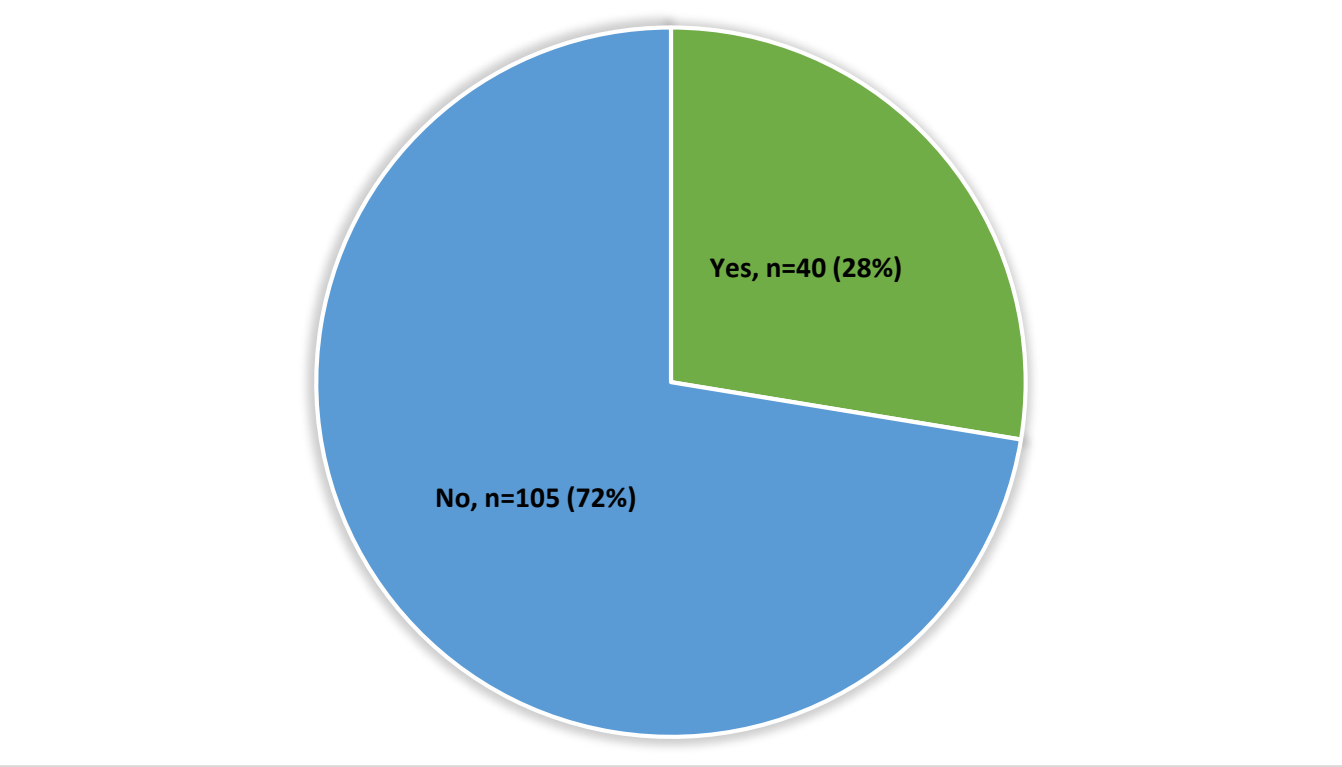

Table 43 - Future Plans to Incorporate NDCs for Covered Outpatient Physician Administered Drugs into DUR criteria for RetroDUR

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (1), Colorado (2), Florida (2), Hawaii (1), Illinois (2), Indiana (2), Kentucky (1), Louisiana (2), Maryland (2), Michigan (2), Minnesota (1), Mississippi (2), Nebraska (1), Nevada (1), New Jersey (1), New York (1), North Carolina (2), Ohio (1), Oregon (4), Pennsylvania (2), Rhode Island (1), South Carolina (1), Texas (2), Virginia (2), Washington (1)	40	27.59%
No	Arkansas (3), Delaware (1), District of Columbia (4), Florida (6), Georgia (2), Hawaii (4), Illinois (2), Indiana (3), Iowa (2), Kansas (3), Kentucky (4), Louisiana (2), Maryland (6), Massachusetts (4), Michigan (4), Minnesota (7), Nebraska (1), Nevada (2), New Hampshire (2), New Jersey (2), New Mexico (1), New York (6), North Carolina (3), Ohio (3), Oregon (8), Pennsylvania (4), Rhode Island (1), South Carolina (3), Texas (11), Washington (1)	105	72.41%
National Totals		**145**	**100%**

Section VI - Generic Policy and Utilization Data

1. Summary 3 - Generic Drug Substitution Policies

Generic Drug Substitution Policies Summary should summarize factors that could affect your generic utilization percentage. In describing these factors, please explain any formulary management or cost containment measures, PDL policies, educational initiatives, technology or promotional factors, or other State specific factors that affects your generic utilization rate.

Please reference individual State MCO reports on Medicaid.gov for more information.

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

Figure 42 - More Restrictive MCO Requirements than the Prescriber Writing in His Own Handwriting "Brand Medically Necessary" for a Brand Name Drug

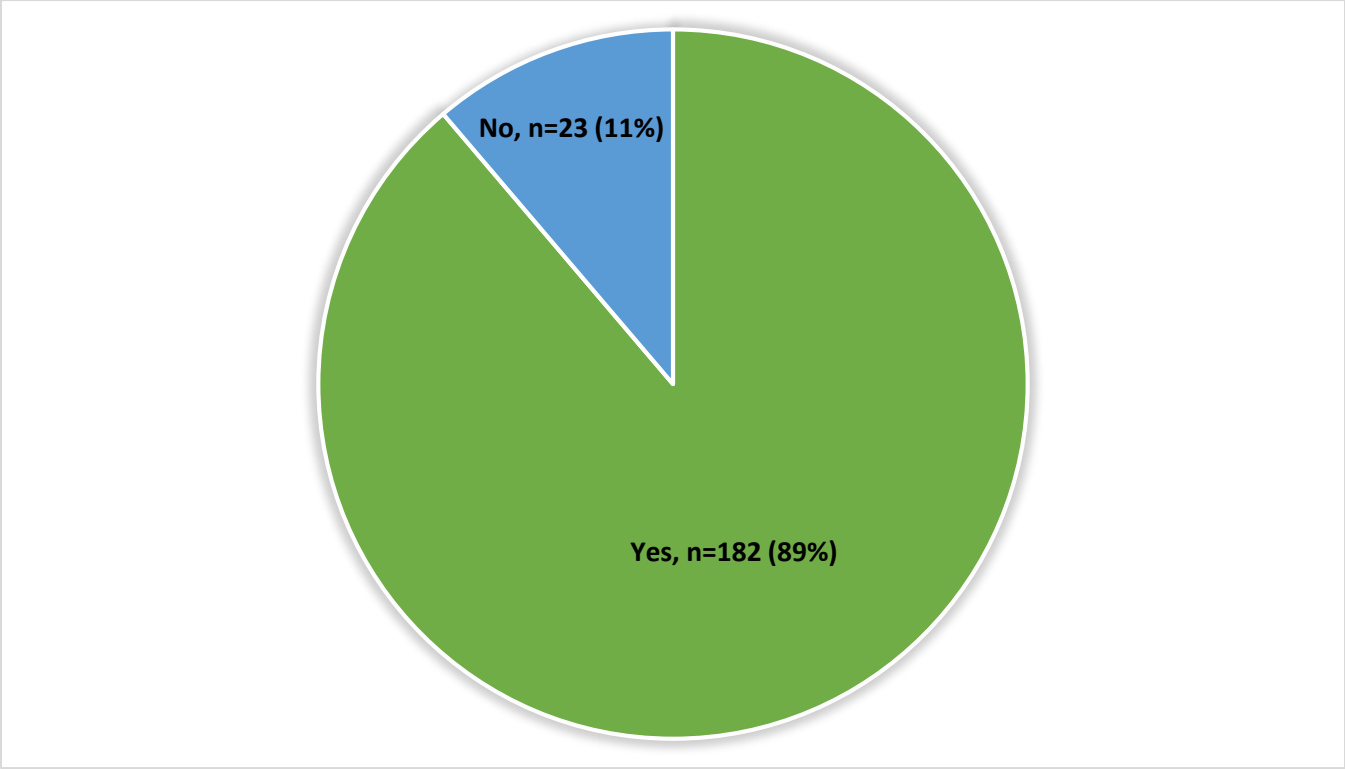

Table 44 - More Restrictive MCO Requirements than the Prescriber Writing in His Own Handwriting "Brand Medically Necessary" for a Brand Name Drug

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (1), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (4), Illinois (5), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Maryland (8), Massachusetts (4), Michigan (9), Minnesota (8), Mississippi (3), Nebraska (1), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (2), New York (15), North Carolina (1), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (13), Utah (4), Virginia (5), Washington (5)	182	88.78%
No	Colorado (1), Hawaii (2), Illinois (1), Louisiana (5), Maryland (1), Massachusetts (1), Minnesota (1), Nebraska (2), New Mexico (1), North Carolina (4), Texas (3), Virginia (1)	23	11.22%
National Totals		**205**	**100%**

If "Yes," check all that apply.

Figure 43 - Additional Restrictive MCO Requirements for Dispensing a Brand Name Drug

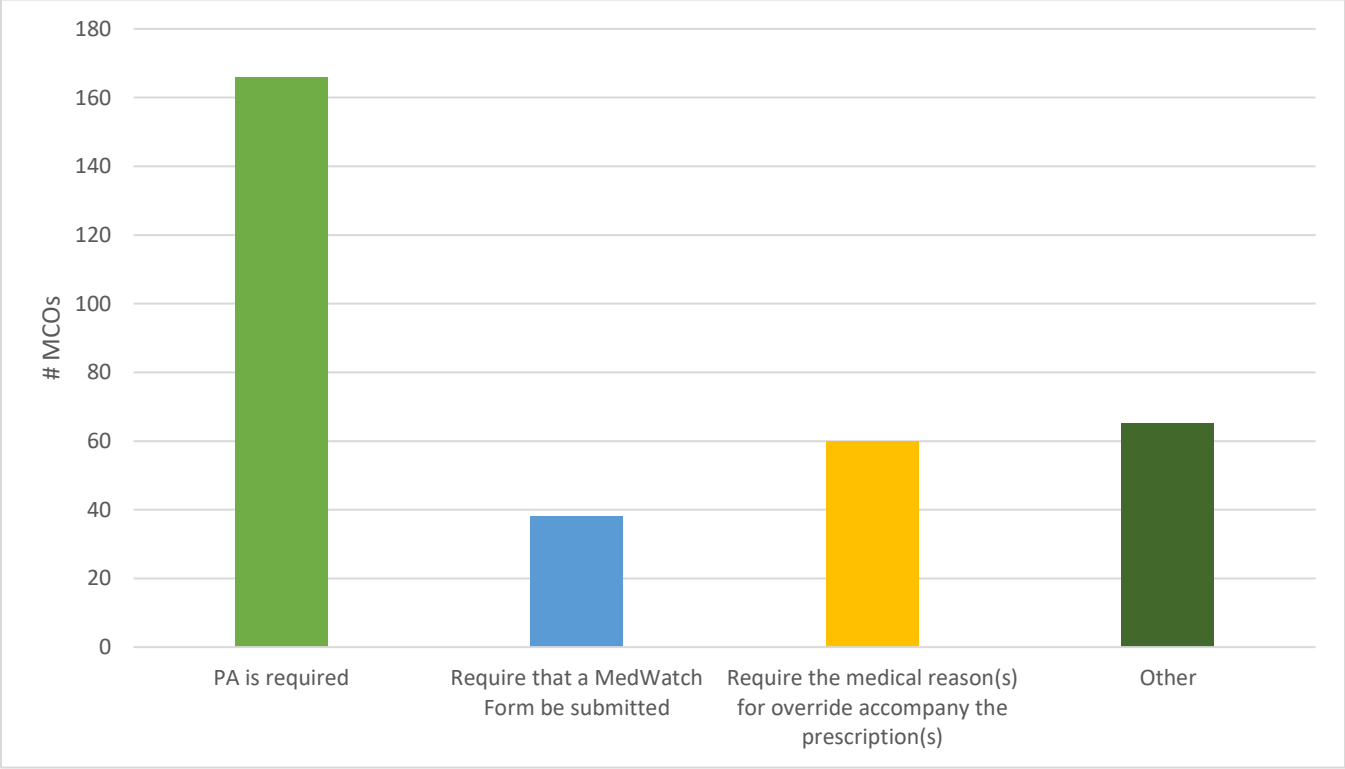

Table 45 - Additional Restrictive MCO Requirements for Dispensing a Brand Name Drug

Response	States (Count of MCOs)	Count	Percentage
PA is required	Arkansas (3), Colorado (1), Delaware (2), District of Columbia (4), Florida (10), Georgia (3), Hawaii (4), Illinois (4), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Maryland (5), Massachusetts (4), Michigan (9), Minnesota (8), Mississippi (3), Nebraska (1), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (2), New York (11), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (3), South Carolina (4), Texas (11), Utah (4), Virginia (4), Washington (4)	166	50.46%

Response	States (Count of MCOs)	Count	Percentage
Require that a MedWatch Form be submitted	Arkansas (2), Delaware (1), District of Columbia (1), Florida (1), Georgia (1), Illinois (2), Indiana (3), Iowa (2), Maryland (2), Michigan (3), Mississippi (2), New Hampshire (1), New York (2), Ohio (1), Pennsylvania (1), South Carolina (2), Texas (9), Virginia (2)	38	11.55%
Require the medical reason(s) for override accompany the prescription(s)	Arkansas (1), Delaware (1), District of Columbia (2), Florida (4), Georgia (1), Hawaii (1), Illinois (2), Indiana (4), Kansas (2), Maryland (1), Massachusetts (1), Michigan (2), Minnesota (2), Mississippi (1), Nebraska (1), Nevada (2), New Hampshire (1), New Mexico (1), New York (3), Ohio (3), Oregon (5), Pennsylvania (1), South Carolina (2), Texas (10), Utah (3), Virginia (2), Washington (1)	60	18.24%
Other	Arkansas (2), District of Columbia (1), Florida (7), Georgia (2), Hawaii (4), Illinois (2), Indiana (2), Kansas (1), Maryland (4), Michigan (4), Minnesota (1), Mississippi (2), Nevada (2), New Hampshire (1), New Jersey (1), New Mexico (1), New York (6), North Carolina (1), Ohio (4), Oregon (2), Pennsylvania (2), South Carolina (4), Texas (2), Utah (1), Virginia (2), Washington (4)	65	19.76%
National Totals		**329**	**100%**

Computation Instructions

KEY

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

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

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

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

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

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

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

CMS has developed an extract file from the Medicaid Drug Rebate Program Drug Product Data File identifying each NDC along with sourcing status of each drug: S, N, or I, which can be found on Medicaid.gov (Click on the link "*National Drug Code and Drug Category file* [ZIP]," then open the Medicaid Drug Product File 4th Qtr. 2021 Excel file).

Figure 44 - State MCO Average Single Source (S) Drug Claims

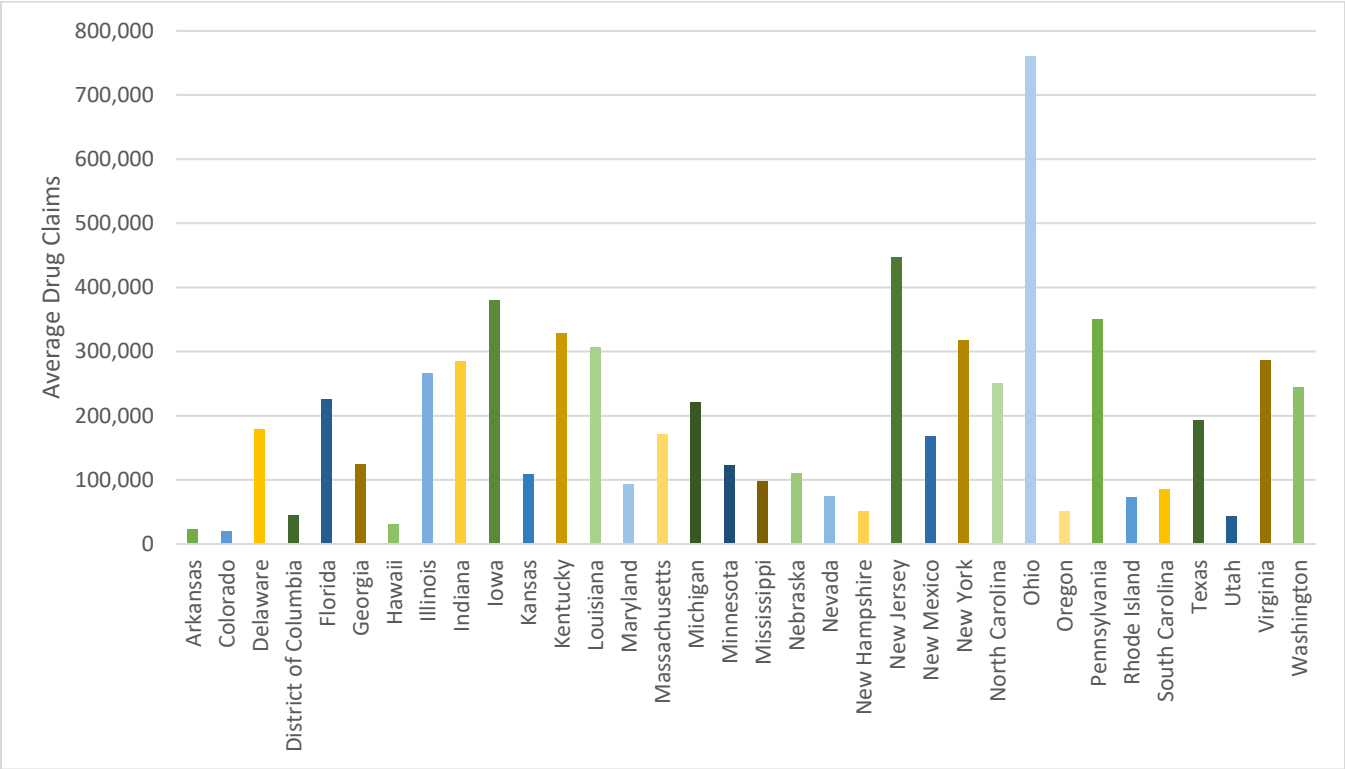

Figure 45 - State MCO Average Non-Innovator Multiple-Source (N) Drug Claims

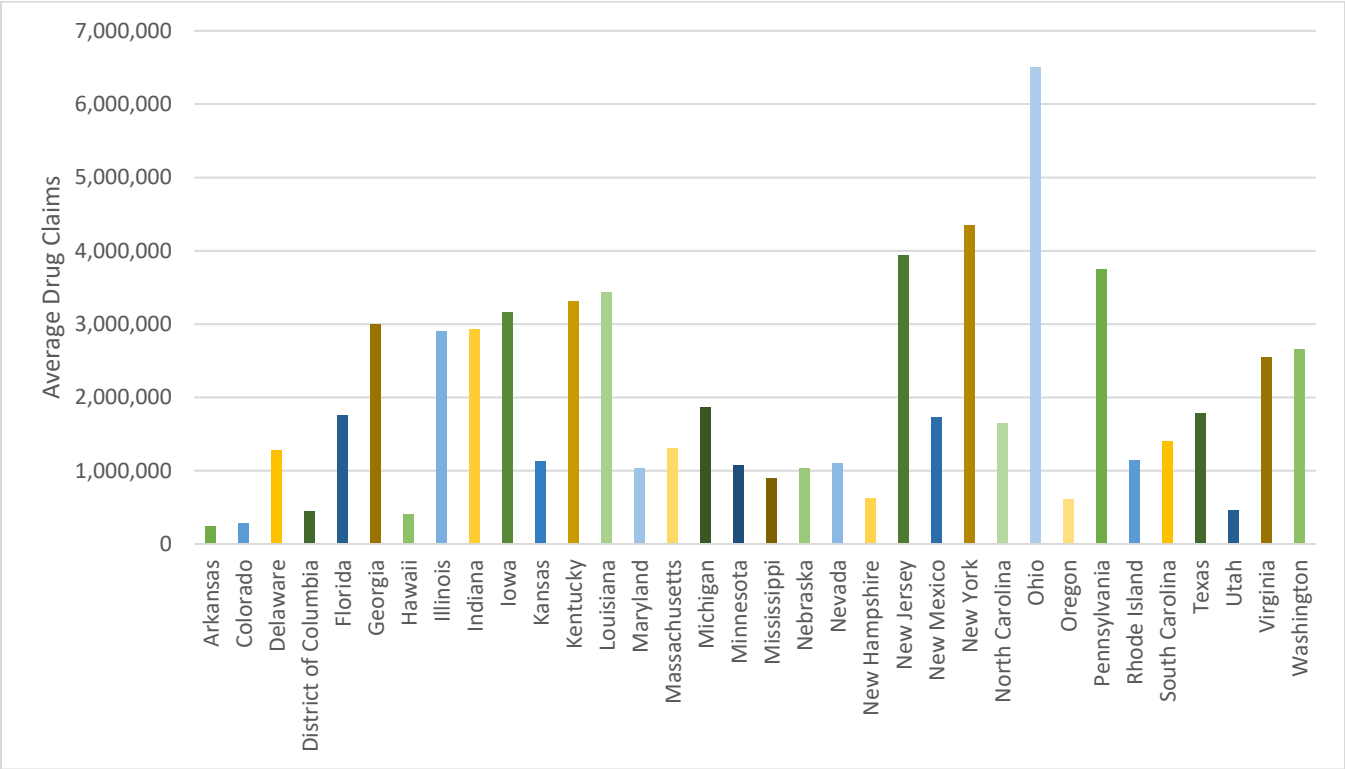

Figure 46 - State MCO Average Innovator Multiple-Source (I) Drug Claims

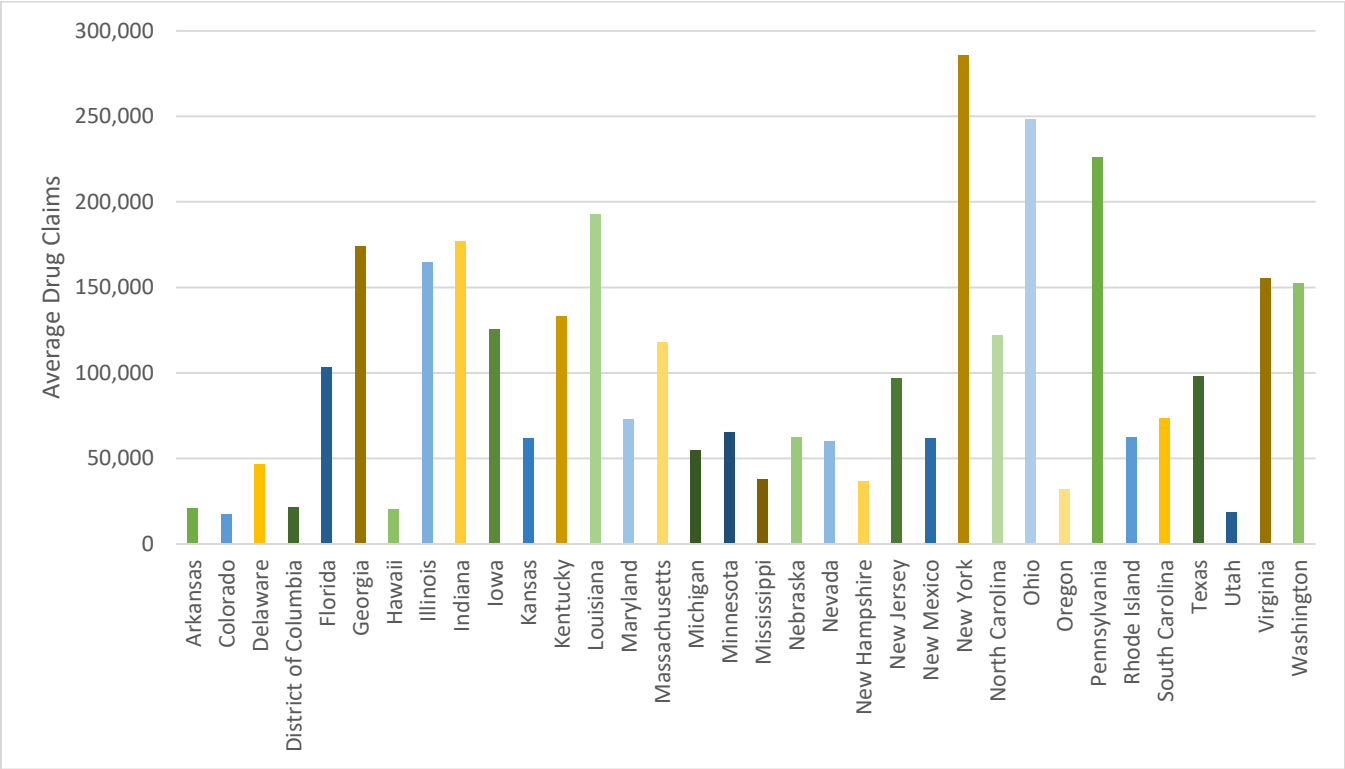

Figure 47 - State MCO Average Single Source (S) Reimbursement Amount Less Co-Pay

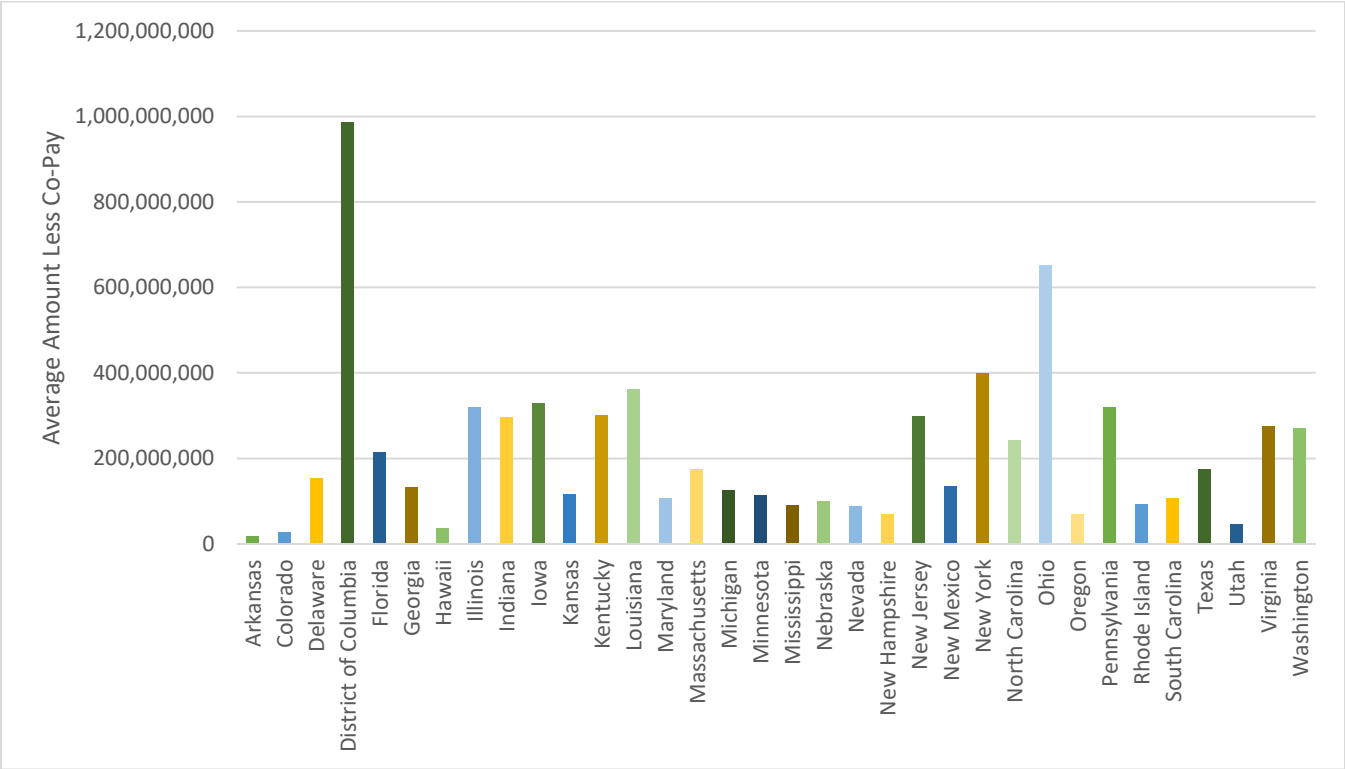

Figure 48 - State MCO Average Non-Innovator Multiple-Source (N) Reimbursement Amount Less Co-Pay

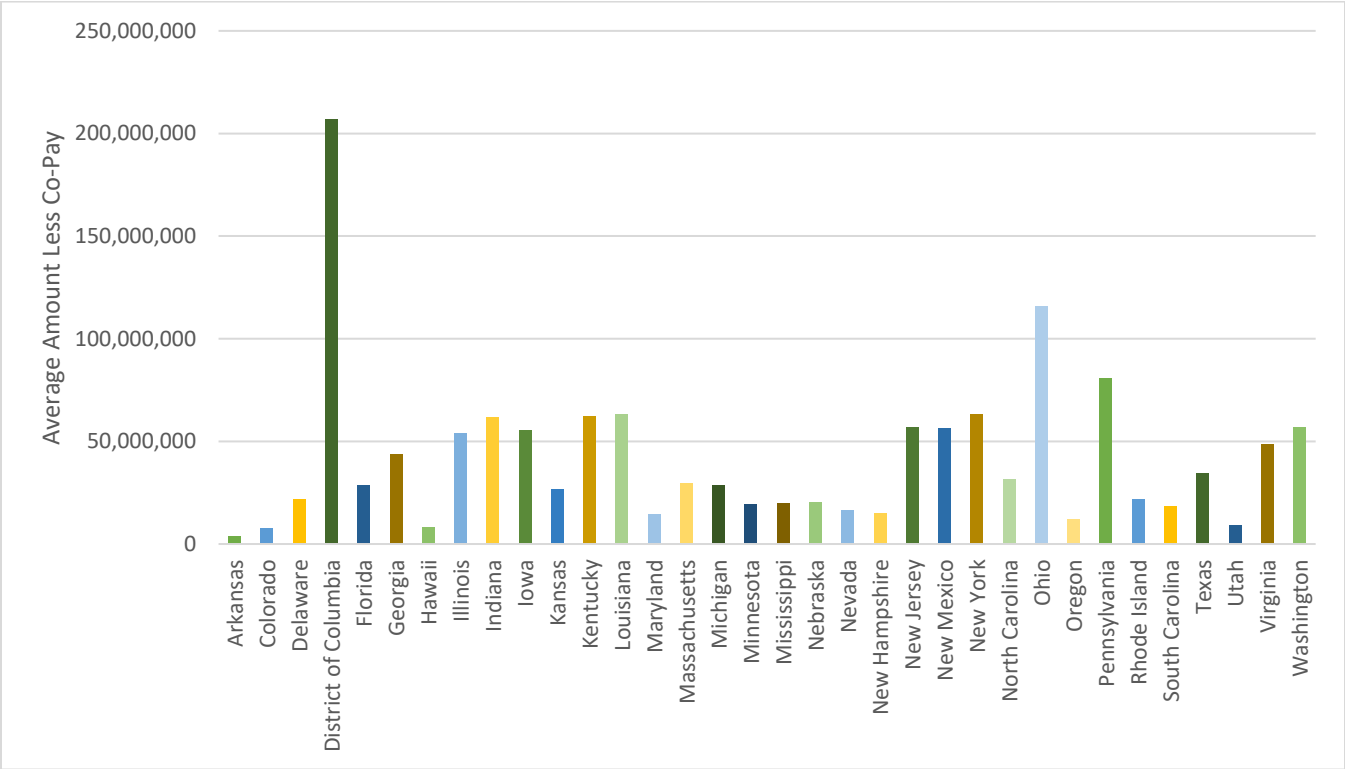

Figure 49 - State MCO Average Innovator Multiple-Source (I) Reimbursement Amount Less Co-Pay

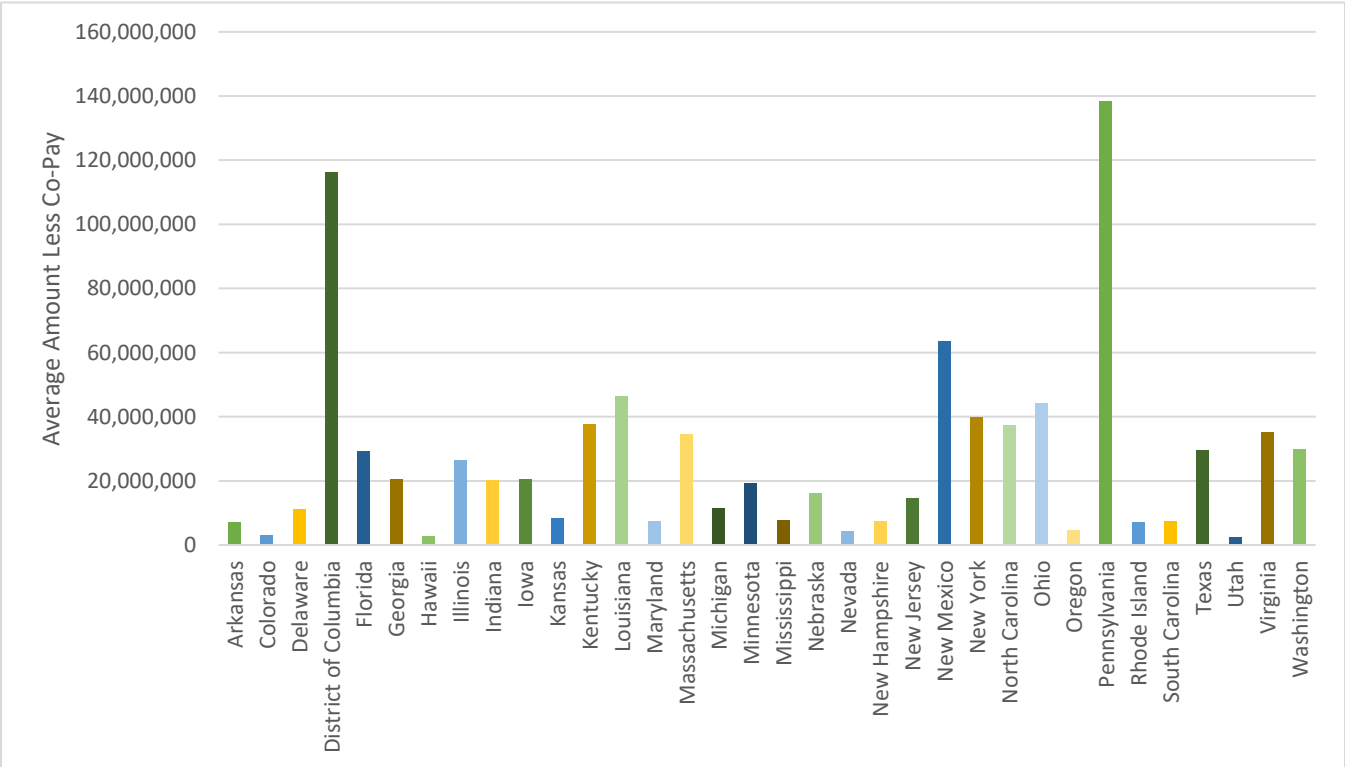

Table 46 - State MCO Average Drug Claims and Reimbursement Amount Less Co-Pay: Single Source Innovator (S), Non-Innovator Multiple-Source (N), Innovator Multiple-Source (I)

State	State Average Single Source "S" Number of Drug Claims	State Average Single Source "S" Reimbursement Amount Less Co-Pay	State Average Non-Innovator Multiple Source "N" Number of Drug Claims	State Average Non-Innovator Multiple Source "N" Reimbursement Amount Less Co-Pay	State Average Innovator Multiple Source "I" Number of Drug Claims	State Average Innovator Multiple Source "I" Reimbursement Amount Less Co-Pay
Arkansas	23,306	$17,971,848	233,252	$3,609,131	20,867	$6,969,205
Colorado	19,838	$27,211,278	284,899	$7,440,818	17,556	$2,880,569
Delaware	178,297	$153,793,545	1,273,629	$21,471,873	46,666	$11,036,619
District of Columbia	44,017	$986,275,354	439,689	$206,930,731	21,623	$116,163,263
Florida	225,571	$214,023,413	1,756,904	$28,309,529	102,940	$29,309,360
Georgia	123,720	$132,151,388	2,996,674	$43,739,475	173,786	$20,484,020
Hawaii	30,012	$36,490,919	399,849	$8,275,942	20,028	$2,562,990
Illinois	266,353	$318,248,719	2,896,078	$53,827,858	164,797	$26,331,290
Indiana	284,532	$295,067,735	2,922,953	$61,519,373	176,797	$20,047,843
Iowa	379,036	$328,514,003	3,156,396	$55,284,896	125,250	$20,479,139
Kansas	108,302	$116,194,133	1,131,980	$26,467,430	61,704	$8,398,661
Kentucky	328,516	$299,644,993	3,307,509	$61,953,814	133,066	$37,590,011
Louisiana	307,055	$361,244,404	3,435,218	$63,321,282	192,882	$46,369,903
Maryland	92,516	$106,629,243	1,026,851	$14,319,045	72,815	$7,237,855
Massachusetts	170,643	$173,076,664	1,303,946	$29,409,966	117,949	$34,409,067
Michigan	220,740	$124,852,638	1,857,518	$28,629,698	54,817	$11,341,581
Minnesota	122,638	$113,272,996	1,074,944	$19,119,380	65,496	$19,219,684
Mississippi	97,935	$89,833,275	892,647	$19,669,357	37,732	$7,575,479
Nebraska	110,450	$100,444,482	1,036,529	$20,442,210	62,319	$15,914,926
Nevada	73,467	$87,157,859	1,097,725	$16,179,102	60,077	$4,345,961
New Hampshire	50,803	$68,678,772	624,211	$14,687,600	36,638	$7,293,436
New Jersey	446,113	$298,648,430	3,935,898	$56,999,122	96,785	$14,437,918
New Mexico	167,324	$133,700,863	1,719,621	$56,281,880	61,943	$63,339,035
New York	316,894	$399,055,018	4,341,420	$63,025,271	285,535	$39,840,232
North Carolina	250,642	$242,828,382	1,639,868	$31,289,256	121,893	$37,176,379
Ohio	760,471	$650,975,364	6,494,199	$115,785,082	248,365	$44,124,036
Oregon	50,437	$68,013,459	609,045	$11,932,512	31,806	$4,538,010
Pennsylvania	349,962	$318,235,885	3,745,470	$80,430,877	225,924	$138,389,493
Rhode Island	72,976	$91,759,114	1,139,812	$21,747,345	62,466	$6,998,774
South Carolina	84,609	$106,954,226	1,397,215	$18,469,673	73,411	$7,285,625
Texas	192,865	$173,802,046	1,780,929	$34,205,737	97,691	$29,551,995
Utah	43,516	$46,324,332	450,733	$9,196,109	18,300	$2,326,690

State	State Average Single Source "S" Number of Drug Claims	State Average Single Source "S" Reimbursement Amount Less Co-Pay	State Average Non-Innovator Multiple Source "N" Number of Drug Claims	State Average Non-Innovator Multiple Source "N" Reimbursement Amount Less Co-Pay	State Average Innovator Multiple Source "I" Number of Drug Claims	State Average Innovator Multiple Source "I" Reimbursement Amount Less Co-Pay
Virginia	285,669	$274,003,270	2,542,133	$48,584,650	155,157	$35,076,919
Washington	244,476	$269,040,606	2,649,023	$56,695,364	152,035	$29,879,583
National	**191,874**	**$212,474,078**	**1,929,258**	**$41,448,570**	**99,915**	**$26,733,104**

3. Indicate the generic utilization percentage for all CODs paid during this reporting period.

Figure 50 - Average State Generic Utilization Percentage Across all MCOs

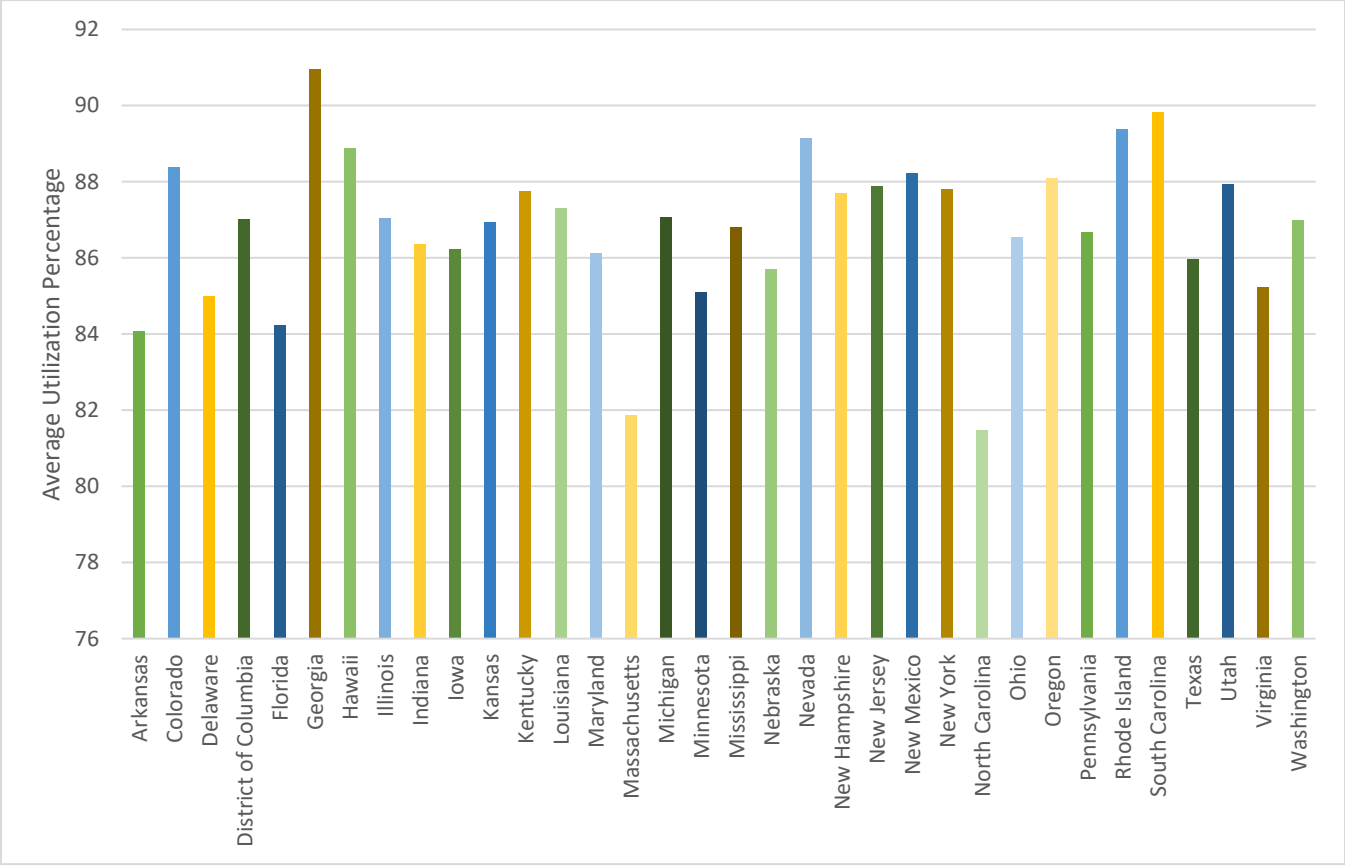

Table 47 - Average State Generic Utilization Percentage Across all MCOs

State	State Average Generic Utilization Percentage
Arkansas	84.08%
Colorado	88.40%
Delaware	84.99%
District of Columbia	87.01%
Florida	84.25%
Georgia	90.97%
Hawaii	88.88%
Illinois	87.04%
Indiana	86.37%
Iowa	86.22%
Kansas	86.94%
Kentucky	87.75%
Louisiana	87.30%
Maryland	86.13%
Massachusetts	81.88%
Michigan	87.08%
Minnesota	85.11%
Mississippi	86.81%
Nebraska	85.71%
Nevada	89.15%
New Hampshire	87.71%
New Jersey	87.88%
New Mexico	88.24%
New York	87.81%
North Carolina	81.49%
Ohio	86.55%
Oregon	88.10%
Pennsylvania	86.67%
Rhode Island	89.38%
South Carolina	89.84%
Texas	85.97%
Utah	87.94%
Virginia	85.22%
Washington	86.98%
National Average	**86.82%**

4. How many innovator drugs are the preferred product instead of their multi-source counterpart based on net pricing (i.e. brand name drug is preferred over equivalent generic product on the PDL)?

Figure 51 - Average State Count of Innovator Drugs that are the Preferred Product over their Multi-Source Counterpart Across all MCOs

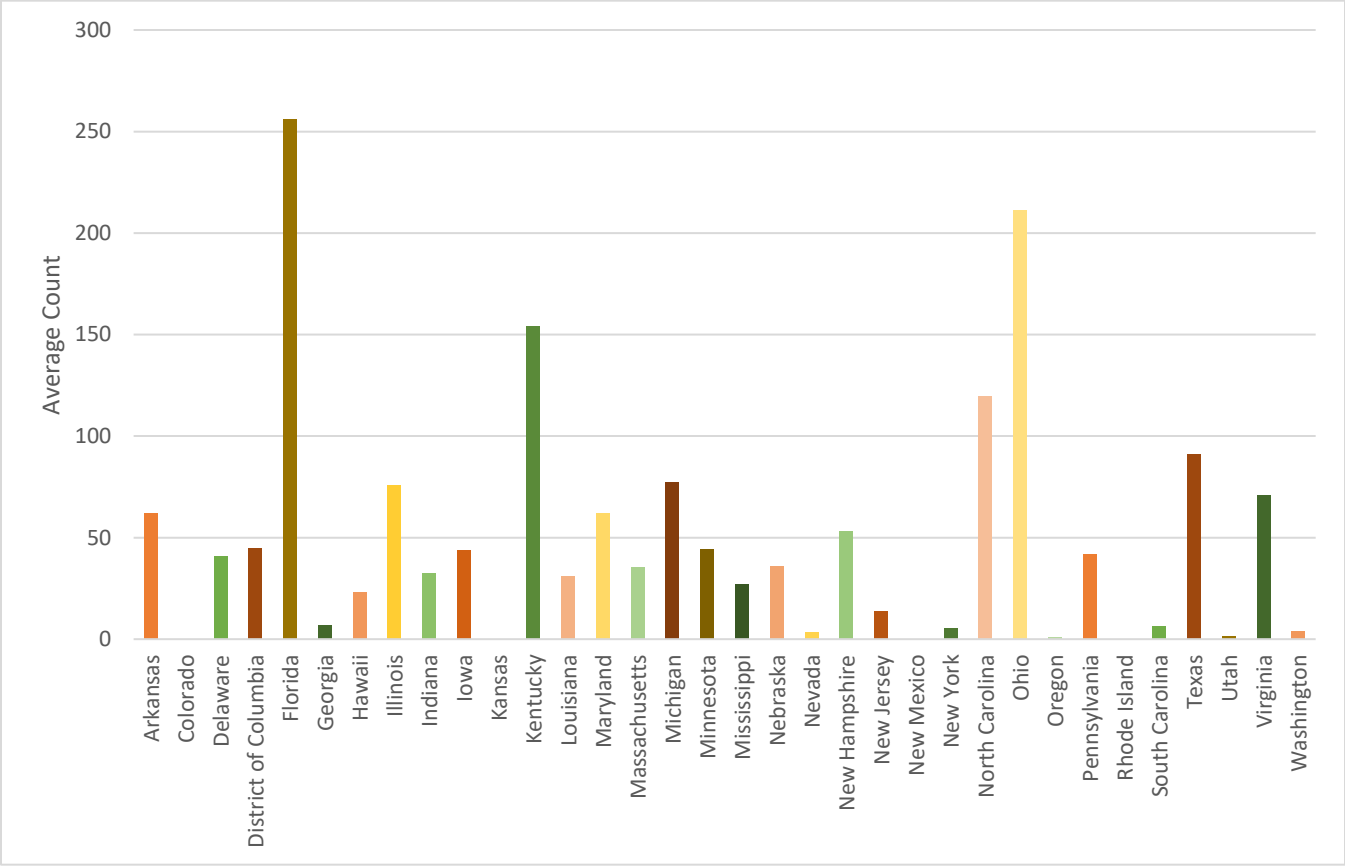

Table 48 - Average State Count of Innovator Drugs that are the Preferred Product over their Multi-Source Counterpart Across all MCOs

State	Average Count
Arkansas	62
Colorado	0
Delaware	41
District of Columbia	45
Florida	256
Georgia	7
Hawaii	23
Illinois	76
Indiana	33
Iowa	44
Kansas	0
Kentucky	154
Louisiana	31
Maryland	62
Massachusetts	36
Michigan	77
Minnesota	44
Mississippi	27
Nebraska	36
Nevada	3
New Hampshire	53
New Jersey	14
New Mexico	0
New York	5
North Carolina	119
Ohio	211
Oregon	1
Pennsylvania	42
Rhode Island	0
South Carolina	6
Texas	91
Utah	2
Virginia	71
Washington	4
National Average	**49**

5. Indicate the percentage dollars paid for generic CODs in relation to all COD claims paid during this reporting period.

Figure 52 - Average State Generic Expenditure Percentage Across all MCOs

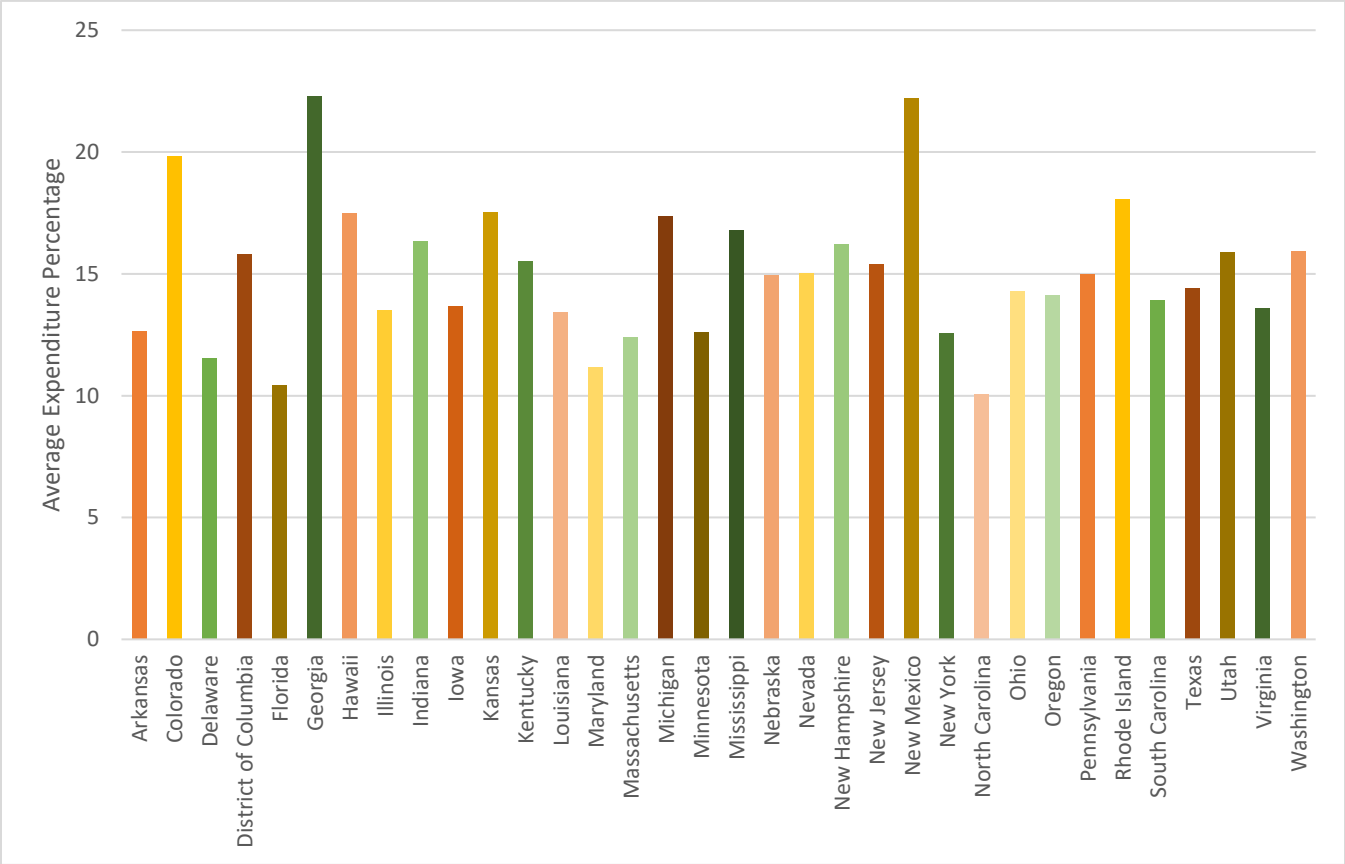

Table 49 - Average State Generic Expenditure Percentage Across all MCOs

State	State Average Generic Expenditure Percentage
Arkansas	12.64%
Colorado	19.82%
Delaware	11.53%
District of Columbia	15.80%
Florida	10.42%
Georgia	22.27%
Hawaii	17.49%
Illinois	13.51%
Indiana	16.33%
Iowa	13.67%
Kansas	17.52%
Kentucky	15.52%
Louisiana	13.45%
Maryland	11.17%
Massachusetts	12.41%
Michigan	17.37%
Minnesota	12.61%
Mississippi	16.80%
Nebraska	14.94%
Nevada	15.02%
New Hampshire	16.20%
New Jersey	15.40%
New Mexico	22.22%
New York	12.56%
North Carolina	10.05%
Ohio	14.28%
Oregon	14.12%
Pennsylvania	14.98%
Rhode Island	18.05%
South Carolina	13.92%
Texas	14.40%
Utah	15.90%
Virginia	13.58%
Washington	15.94%
National Average	**15.06%**

6. Does your MCO have any policies related to Biosimilars?

Please reference individual State MCO reports on Medicaid.gov for more information.

7. Does your Medicaid program provide coverage of over-the-counter medications when prescribed by an authorized prescriber?

Figure 53 - Medicaid Program Providing Coverage of Over-the-Counter Medications When Prescribed by an Authorized Prescriber

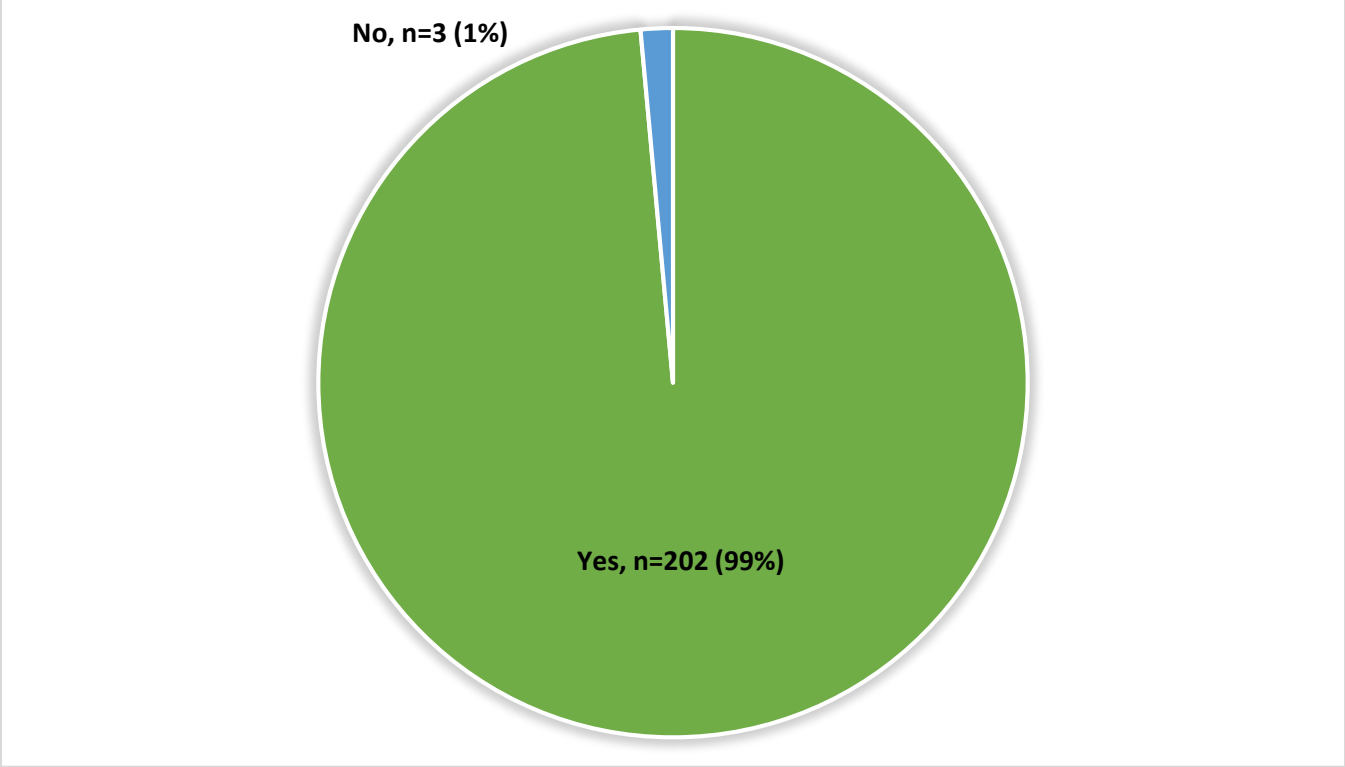

Table 50 - Medicaid Program Providing Coverage of Over-the-Counter Medications When Prescribed by an Authorized Prescriber

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (1), Delaware (2), District of Columbia (4), Florida (10), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (8), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	202	98.54%
No	Colorado (1), Florida (1), Maryland (1)	3	1.46%
National Totals		**205**	**100%**

If "No," please explain why not.

Table 51 - Explanations for Medicaid Program Not Providing Coverage of Over-the-Counter Medications When Prescribed by an Authorized Prescriber

State	MCO Name	Explanation
CO	Denver Health Medicaid Choice	Over-the-counter medications are covered if they are on the formulary. Otherwise, a prior authorization is required.

State	MCO Name	Explanation
FL	Community Care Plan	OTC medications that are on the PDL are payable at the pharmacy via prescription. If the medication is not on the PDL it will not pay. CCP is working on providing OTC benefits for members.
MD	Jai Medical Systems Managed Care Organization, Inc.	Some but not all OTC medications are covered with a prescription. The only over-the-counter medications that are covered are those that are included on the drug list. Most of the over-the-counter medications that are covered on the drug list require a prescription, except where otherwise required by State or Federal regulation.

Section VII - Fraud, Waste and Abuse Detection (FWA)

A. Lock-in or Patient Review and Restriction Programs

1. Does your MCO have a documented process in place that identifies potential FWA of controlled drugs by beneficiaries?

Figure 54 - Documented Process in Place to Identify Potential FWA of Controlled Drugs by Beneficiaries

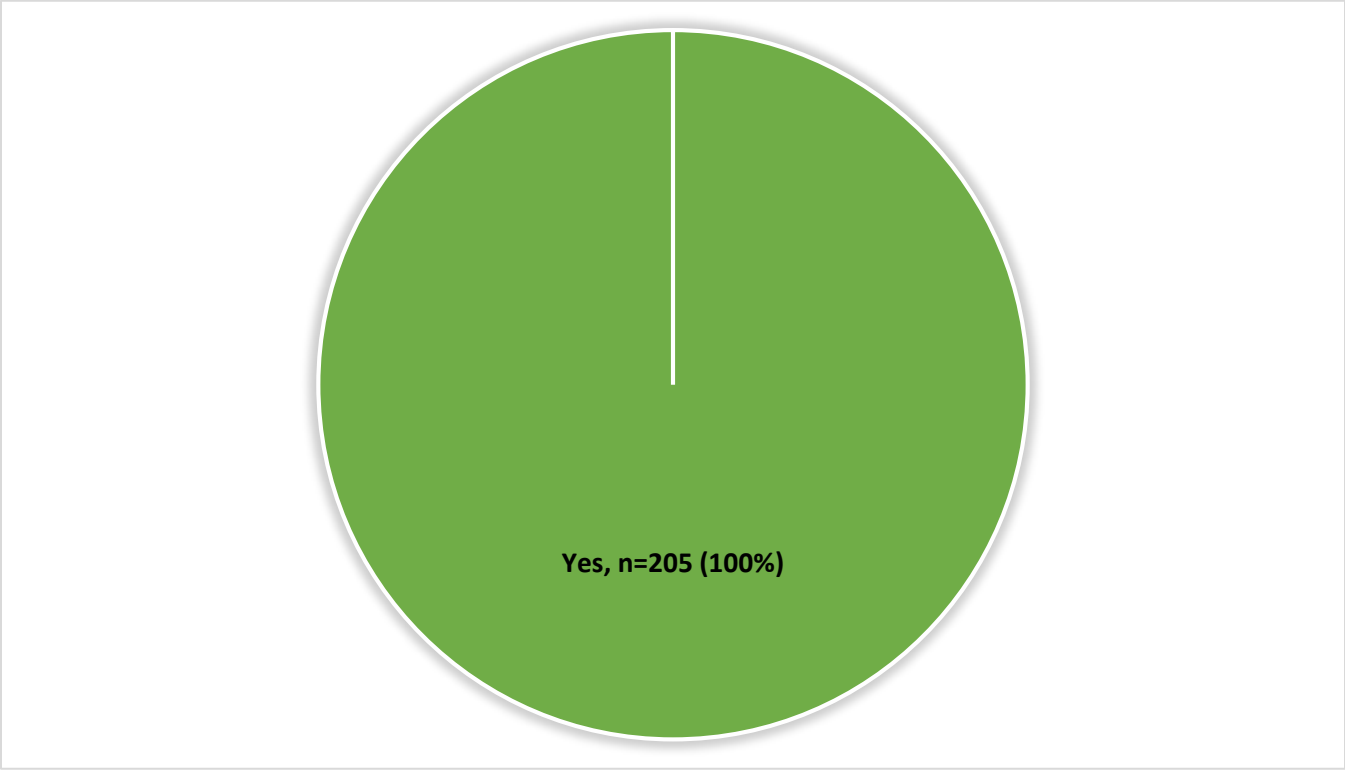

Table 52 - Documented Process in Place to Identify Potential FWA of Controlled Drugs by Beneficiaries

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	205	100.00%
National Totals		**205**	**100%**

If "Yes," what actions does this process initiate (multiple responses allowed)?

Figure 55 - Actions Process Initiates when Potential FWA of Controlled Drugs by Beneficiaries is Detected

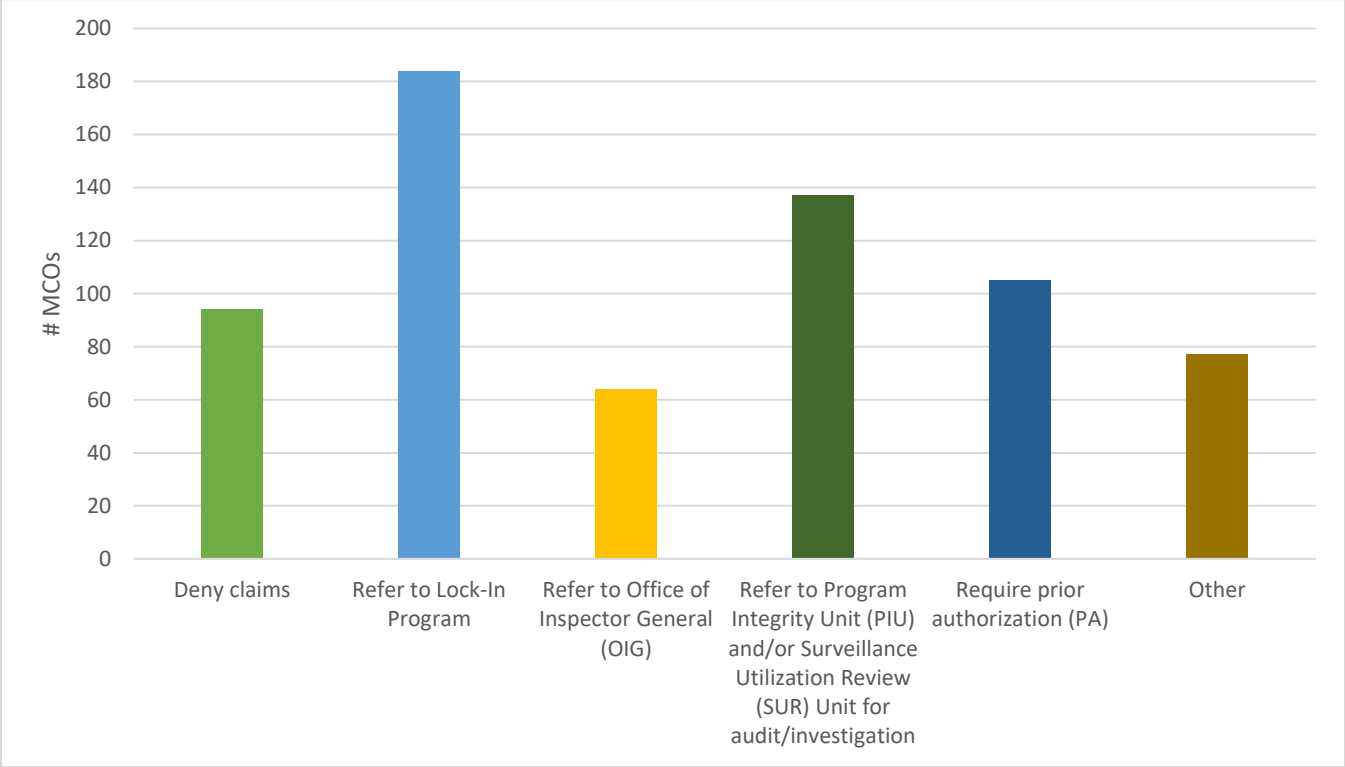

Table 53 - Actions Process Initiates when Potential FWA of Controlled Drugs by Beneficiaries is Detected

Response	States (Count of MCOs)	Count	Percentage
Deny claims	Arkansas (4), Colorado (2), District of Columbia (2), Florida (5), Georgia (2), Hawaii (2), Illinois (5), Indiana (3), Kansas (2), Louisiana (2), Maryland (7), Massachusetts (1), Michigan (3), Minnesota (4), Mississippi (1), Nevada (1), New Hampshire (1), New Jersey (3), New Mexico (3), New York (5), North Carolina (2), Ohio (2), Oregon (4), Pennsylvania (3), Rhode Island (1), South Carolina (2), Texas (13), Utah (3), Virginia (5), Washington (1)	94	14.22%
Refer to Lock-In Program	Arkansas (3), Colorado (1), Delaware (2), District of Columbia (4), Florida (9), Georgia (3), Hawaii (5), Illinois (6), Indiana (5), Iowa (1), Kansas (3), Kentucky (5), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (14), North Carolina (5), Ohio (5), Oregon (9), Pennsylvania (8), Rhode Island (3), South Carolina (4), Texas (16), Utah (4), Virginia (6), Washington (5)	184	27.84%
Refer to Office of Inspector General (OIG)	Arkansas (3), District of Columbia (1), Florida (2), Georgia (1), Hawaii (2), Illinois (3), Indiana (3), Kansas (2), Louisiana (1), Maryland (6), Massachusetts (1), Michigan (7), Minnesota (3), Mississippi (2), Nebraska (1), New Jersey (2), New York (4), North Carolina (1), Ohio (2), Oregon (1), Pennsylvania (3), Rhode Island (1), Texas (5), Utah (3), Virginia (3), Washington (1)	64	9.68%

Response	States (Count of MCOs)	Count	Percentage
Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation	Arkansas (3), Delaware (2), District of Columbia (2), Florida (8), Georgia (2), Hawaii (5), Illinois (3), Indiana (4), Iowa (1), Kansas (2), Kentucky (2), Louisiana (4), Maryland (7), Massachusetts (4), Michigan (9), Minnesota (5), Mississippi (2), Nebraska (2), Nevada (2), New Hampshire (3), New Jersey (5), New Mexico (2), New York (11), North Carolina (5), Ohio (3), Oregon (10), Pennsylvania (7), Rhode Island (3), South Carolina (3), Texas (5), Utah (4), Virginia (5), Washington (2)	137	20.73%
Require prior authorization (PA)	Arkansas (2), Colorado (2), District of Columbia (3), Florida (6), Georgia (1), Hawaii (2), Illinois (5), Indiana (2), Kansas (2), Kentucky (6), Louisiana (2), Maryland (7), Michigan (5), Minnesota (5), Mississippi (2), Nebraska (1), Nevada (1), New Hampshire (1), New Jersey (4), New Mexico (3), New York (4), North Carolina (2), Ohio (2), Oregon (5), Pennsylvania (2), Rhode Island (1), South Carolina (2), Texas (13), Utah (4), Virginia (6), Washington (2)	105	15.89%
Other	Arkansas (2), Colorado (1), District of Columbia (3), Florida (5), Hawaii (3), Illinois (2), Indiana (2), Iowa (1), Kansas (3), Louisiana (3), Maryland (6), Massachusetts (1), Michigan (3), Minnesota (2), Mississippi (1), Nebraska (1), New Hampshire (1), New Jersey (2), New Mexico (1), New York (3), North Carolina (2), Ohio (2), Oregon (8), Pennsylvania (3), Rhode Island (2), South Carolina (2), Texas (8), Virginia (3), Washington (1)	77	11.65%
National Totals		**661**	**100%**

2. Does your MCO have a lock-in program for beneficiaries with potential FWA of controlled substances

Figure 56 - Lock-In Program

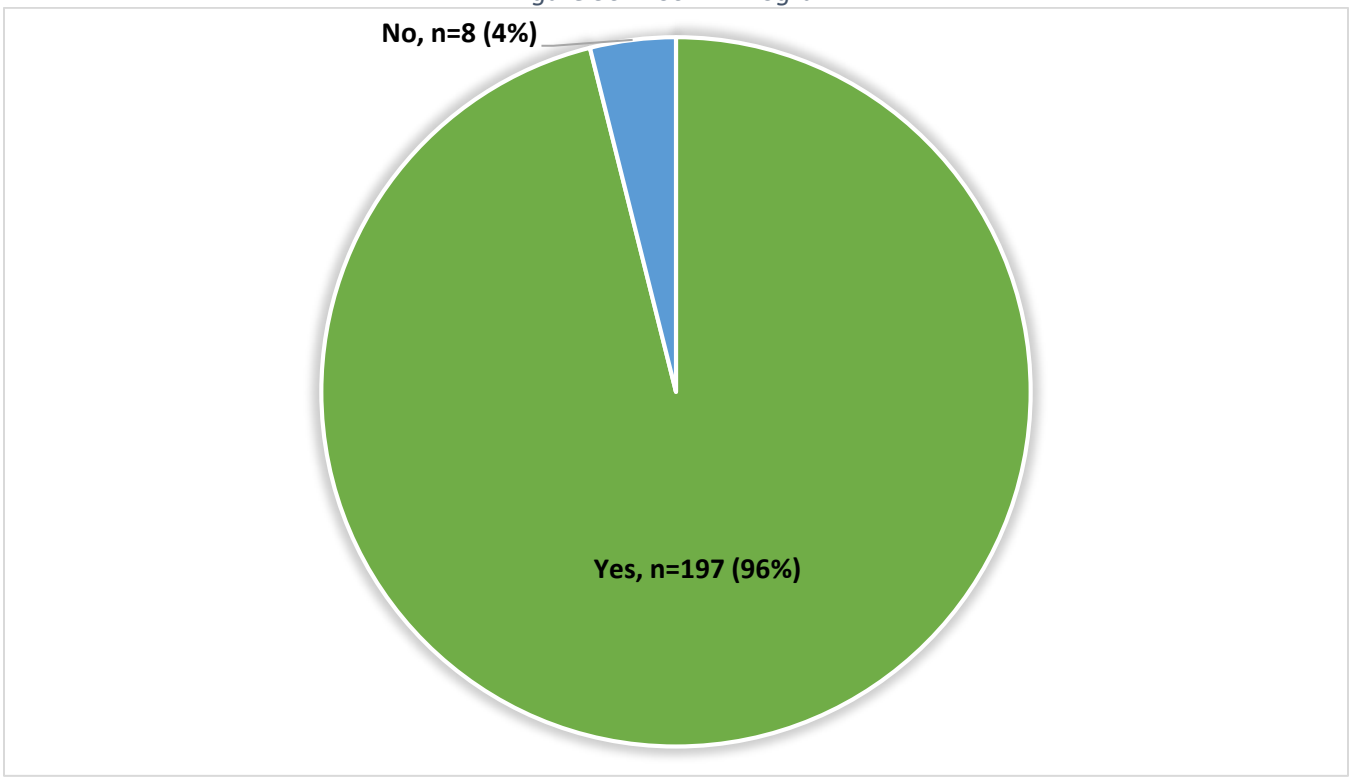

Table 54 - Lock-In Program

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (3), Colorado (2), Delaware (2), District of Columbia (4), Florida (10), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (5), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (16), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	197	96.10%
No	Arkansas (1), Florida (1), Kentucky (1), Oregon (5)	8	3.90%
National Totals		**205**	**100%**

a. If "Yes," what criteria does your MCO use to identify candidates for lock-in (multiple responses allowed)?

Figure 57 - Lock-In Program Candidate Identification Criteria

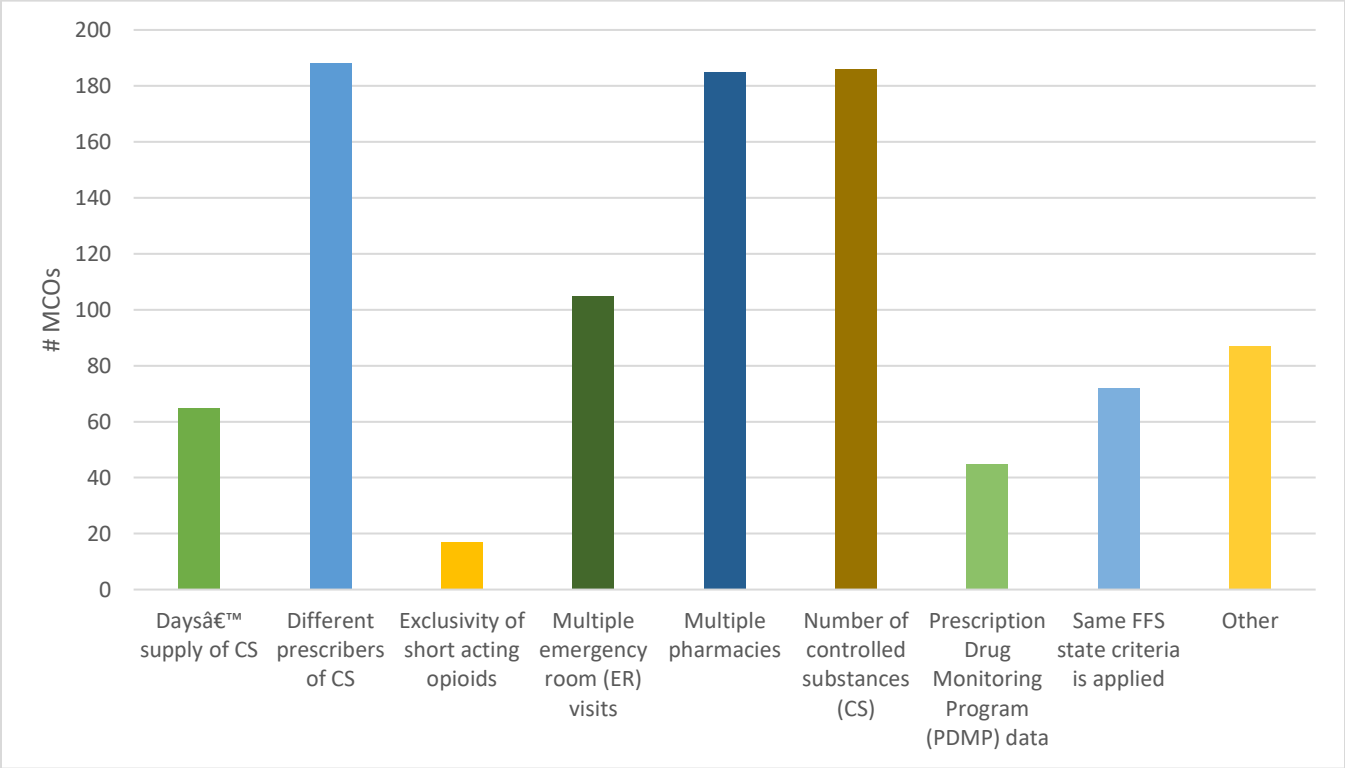

Table 55 - Lock-In Program Candidate Identification Criteria

Response	States (Count of MCOs)	Count	Percentage
Days' supply of CS	Delaware (1), Florida (1), Georgia (1), Hawaii (2), Illinois (3), Indiana (1), Kansas (2), Louisiana (3), Maryland (2), Massachusetts (1), Michigan (1), Minnesota (3), Nevada (1), New Hampshire (2), New Jersey (1), New Mexico (2), New York (4), North Carolina (1), Ohio (1), Oregon (7), Pennsylvania (5), South Carolina (3), Texas (13), Virginia (2), Washington (2)	65	6.84%

Response	States (Count of MCOs)	Count	Percentage
Different prescribers of CS	Arkansas (3), Colorado (2), Delaware (2), District of Columbia (4), Florida (10), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (5), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (3), Ohio (5), Oregon (13), Pennsylvania (8), Rhode Island (3), South Carolina (4), Texas (15), Utah (4), Virginia (6), Washington (4)	188	19.79%
Exclusivity of short acting opioids	Delaware (1), Indiana (1), Kansas (1), Maryland (1), Michigan (1), Minnesota (2), Nebraska (1), New Hampshire (1), New Jersey (1), New York (1), Pennsylvania (3), Texas (1), Virginia (1), Washington (1)	17	1.79%
Multiple emergency room (ER) visits	Arkansas (1), Colorado (2), Delaware (1), District of Columbia (1), Florida (1), Georgia (2), Hawaii (2), Illinois (4), Indiana (4), Kansas (3), Kentucky (2), Louisiana (1), Maryland (1), Massachusetts (3), Michigan (9), Minnesota (9), Mississippi (1), Nebraska (1), Nevada (1), New Hampshire (3), New Jersey (3), New Mexico (3), New York (12), Ohio (2), Pennsylvania (7), Rhode Island (1), South Carolina (1), Texas (14), Utah (4), Virginia (3), Washington (3)	105	11.05%
Multiple pharmacies	Arkansas (3), Colorado (2), Delaware (2), District of Columbia (4), Florida (10), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (5), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (8), Minnesota (9), Mississippi (2), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (5), New Mexico (3), New York (14), North Carolina (3), Ohio (5), Oregon (13), Pennsylvania (8), Rhode Island (3), South Carolina (4), Texas (15), Utah (4), Virginia (6), Washington (4)	185	19.47%
Number of controlled substances (CS)	Arkansas (3), Colorado (2), Delaware (2), District of Columbia (4), Florida (10), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (5), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (3), Ohio (5), Oregon (12), Pennsylvania (8), Rhode Island (3), South Carolina (4), Texas (15), Utah (4), Virginia (5), Washington (4)	186	19.58%
Prescription Drug Monitoring Program (PDMP) data	District of Columbia (1), Florida (2), Hawaii (1), Illinois (4), Indiana (2), Kansas (3), Michigan (4), Minnesota (9), Mississippi (2), New Mexico (3), Ohio (1), Pennsylvania (1), Texas (1), Utah (3), Virginia (5), Washington (3)	45	4.74%
Same FFS State criteria is applied	District of Columbia (3), Florida (5), Hawaii (2), Indiana (2), Kansas (2), Louisiana (3), Maryland (7), Massachusetts (3), Michigan (5), Minnesota (5), Nevada (1), New Hampshire (2), New York (4), North Carolina (5), Ohio (1), Oregon (3), Pennsylvania (3), South Carolina (2), Texas (3), Utah (4), Virginia (5), Washington (2)	72	7.58%

Response	States (Count of MCOs)	Count	Percentage
Other	Arkansas (2), Delaware (2), District of Columbia (1), Florida (2), Georgia (1), Hawaii (3), Illinois (3), Indiana (1), Kansas (2), Kentucky (1), Louisiana (2), Maryland (1), Massachusetts (2), Michigan (3), Minnesota (1), Mississippi (2), Nebraska (1), Nevada (1), New Jersey (2), New York (7), North Carolina (3), Ohio (4), Oregon (14), Pennsylvania (6), Rhode Island (3), South Carolina (3), Texas (12), Washington (2)	87	9.16%
National Totals		**950**	**100%**

b. If "Yes," does your MCO have the capability to restrict the beneficiary to:

i. Prescriber only

Figure 58 - Prescriber Only Restriction Capability

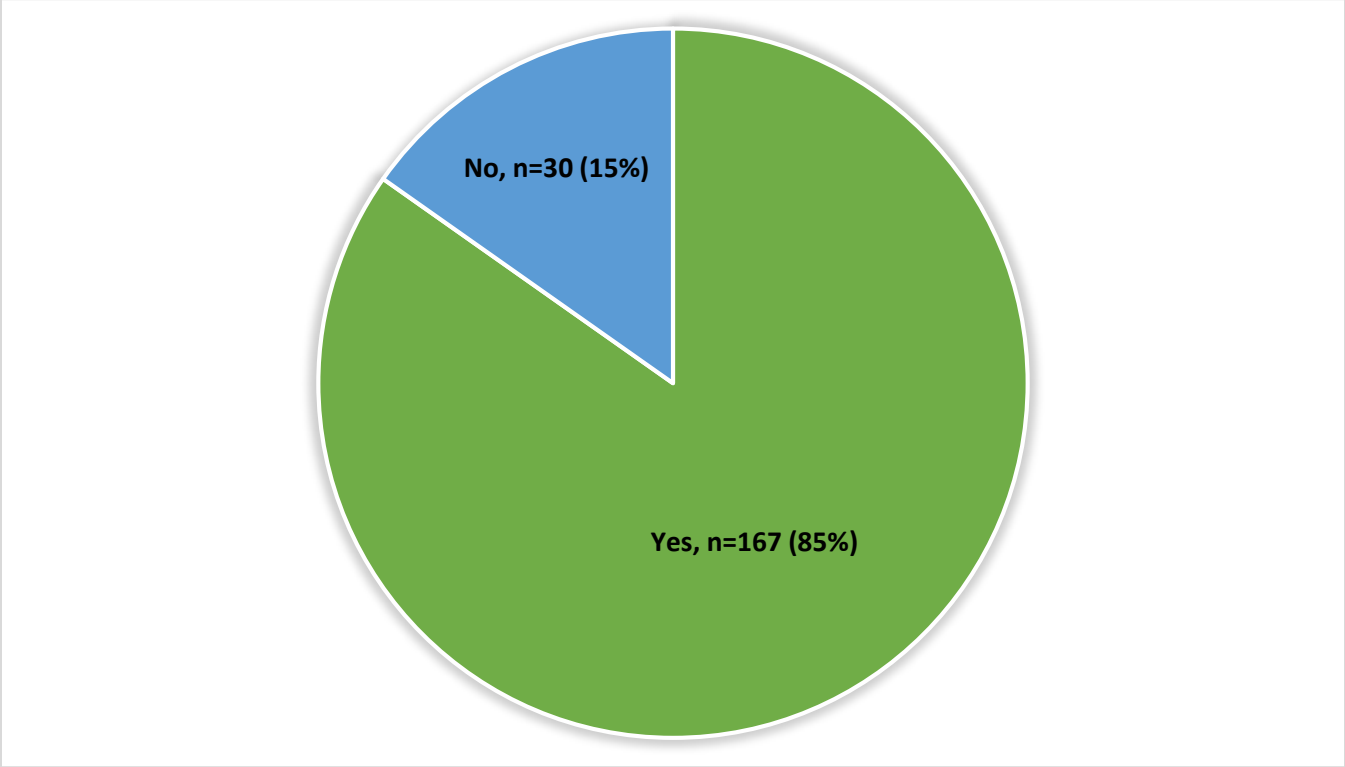

Table 56 - Prescriber Only Restriction Capability

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (2), Colorado (2), Delaware (2), District of Columbia (3), Florida (5), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (1), Kansas (3), Kentucky (5), Louisiana (5), Maryland (7), Massachusetts (4), Michigan (9), Minnesota (6), Mississippi (2), Nebraska (3), Nevada (2), New Hampshire (2), New Jersey (5), New Mexico (3), New York (14), North Carolina (4), Ohio (5), Oregon (16), Pennsylvania (8), Rhode Island (3), South Carolina (4), Texas (9), Utah (4), Virginia (4), Washington (5)	167	84.77%

Response	States (Count of MCOs)	Count	Percentage
No	Arkansas (1), District of Columbia (1), Florida (5), Iowa (1), Maryland (2), Massachusetts (1), Minnesota (3), Mississippi (1), Nevada (2), New Hampshire (1), New York (1), North Carolina (1), South Carolina (1), Texas (7), Virginia (2)	30	15.23%
National Totals		**197**	**100%**

ii. Pharmacy only

Figure 59 - Pharmacy Only Restriction Capability

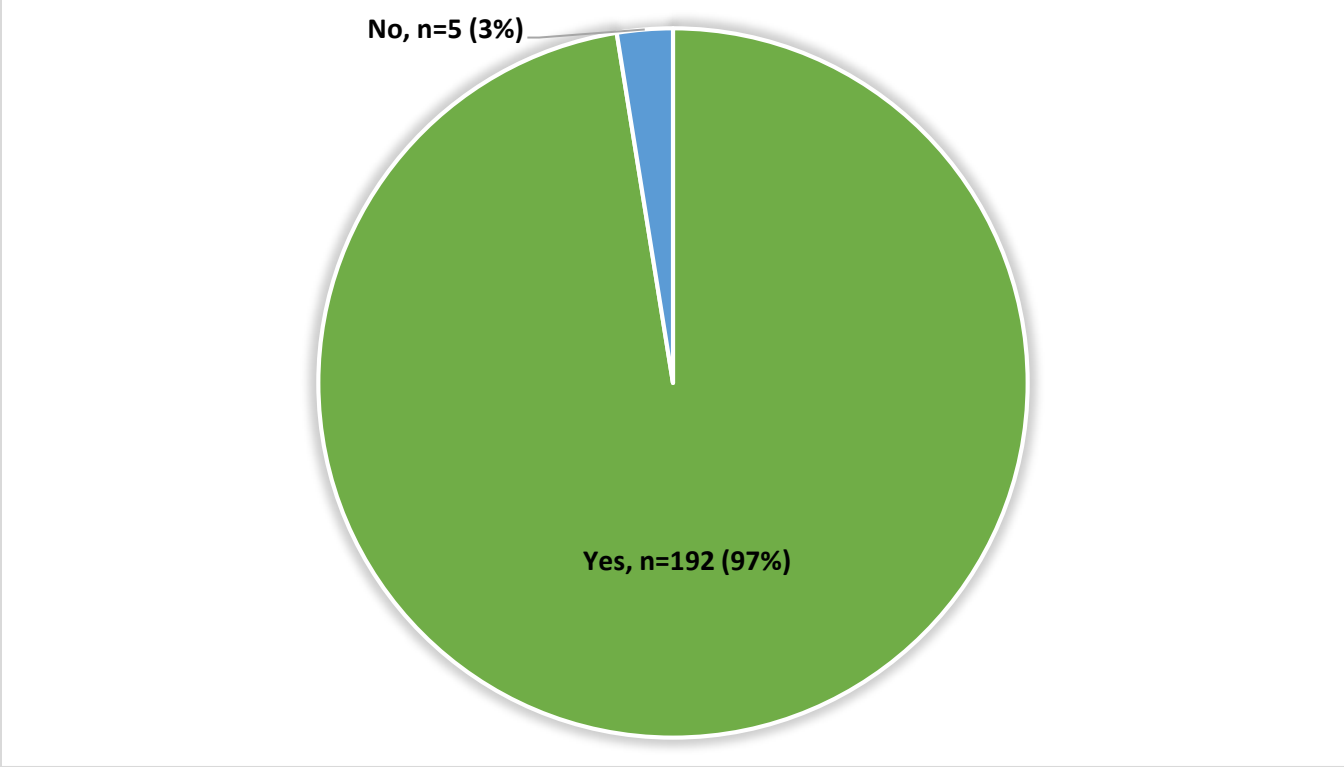

Table 57 - Pharmacy Only Restriction Capability

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (3), Colorado (2), Delaware (2), District of Columbia (4), Florida (10), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (1), Kansas (3), Kentucky (5), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (7), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (14), North Carolina (4), Ohio (5), Oregon (16), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	192	97.46%
No	Iowa (1), Minnesota (2), New York (1), North Carolina (1)	5	2.54%
National Totals		**197**	**100%**

iii. Prescriber and pharmacy

Figure 60 - Prescriber and Pharmacy Restriction Capability

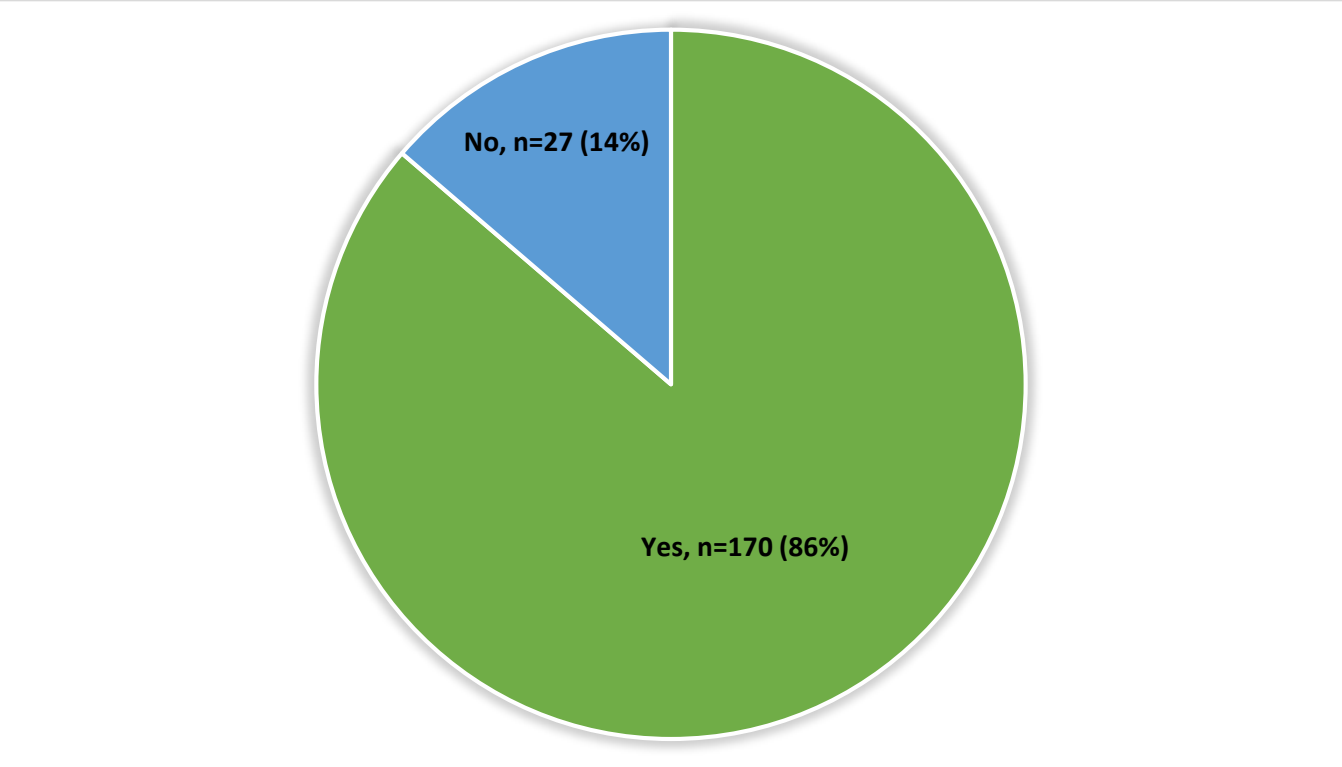

Table 58 - Prescriber and Pharmacy Restriction Capability

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (2), Colorado (2), Delaware (2), District of Columbia (3), Florida (5), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (5), Louisiana (5), Maryland (6), Massachusetts (4), Michigan (9), Minnesota (8), Mississippi (2), Nebraska (3), Nevada (2), New Hampshire (2), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (16), Pennsylvania (8), Rhode Island (3), South Carolina (4), Texas (8), Utah (4), Virginia (4), Washington (5)	170	86.29%
No	Arkansas (1), District of Columbia (1), Florida (5), Maryland (3), Massachusetts (1), Minnesota (1), Mississippi (1), Nevada (2), New Hampshire (1), South Carolina (1), Texas (8), Virginia (2)	27	13.71%
National Totals		**197**	**100%**

c. If "Yes," what is the usual lock-in time period?

Figure 61 - Lock-In Time Period

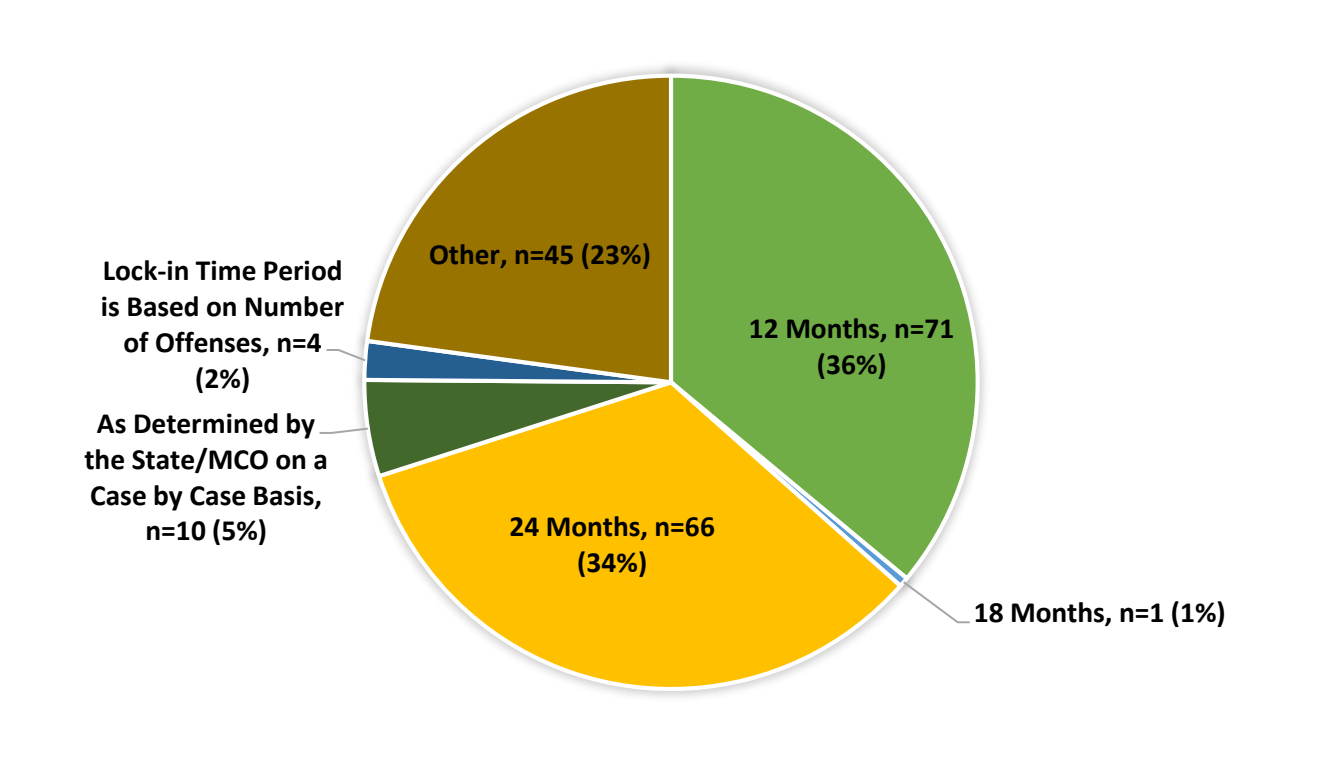

Table 59 - Lock-In Time Period

Response	States (Count of MCOs)	Count	Percentage
12 months	Arkansas (3), District of Columbia (4), Florida (9), Georgia (3), Hawaii (4), Illinois (5), Iowa (1), Kentucky (1), Louisiana (2), Massachusetts (4), Mississippi (3), Nebraska (1), Nevada (2), New Hampshire (3), New York (1), Oregon (14), Texas (2), Utah (4), Virginia (5)	71	36.04%
18 months	Hawaii (1)	1	0.51%
24 months	Illinois (1), Indiana (5), Iowa (1), Kansas (3), Kentucky (3), Louisiana (3), Maryland (9), Michigan (9), Minnesota (3), Nebraska (2), New Jersey (4), New York (3), North Carolina (5), Ohio (5), Rhode Island (2), South Carolina (5), Washington (3)	66	33.50%
As determined by the State/MCO on a case by case basis	Colorado (2), Delaware (1), Hawaii (1), New Mexico (2), New York (2), Oregon (2)	10	5.08%
Lock-in time period is based on number of offenses	Kentucky (1), New York (3)	4	2.03%
Other	Delaware (1), Florida (1), Massachusetts (1), Minnesota (6), Nevada (2), New Jersey (1), New Mexico (1), New York (6), Pennsylvania (8), Rhode Island (1), Texas (14), Virginia (1), Washington (2)	45	22.84%
National Totals		**197**	**100%**

d. If "Yes," on average, what percentage of your Medicaid MCO population is in lock-in status annually?

Figure 62 - Percentage of Medicaid MCO Population in Lock-In Status Annually (State Average)

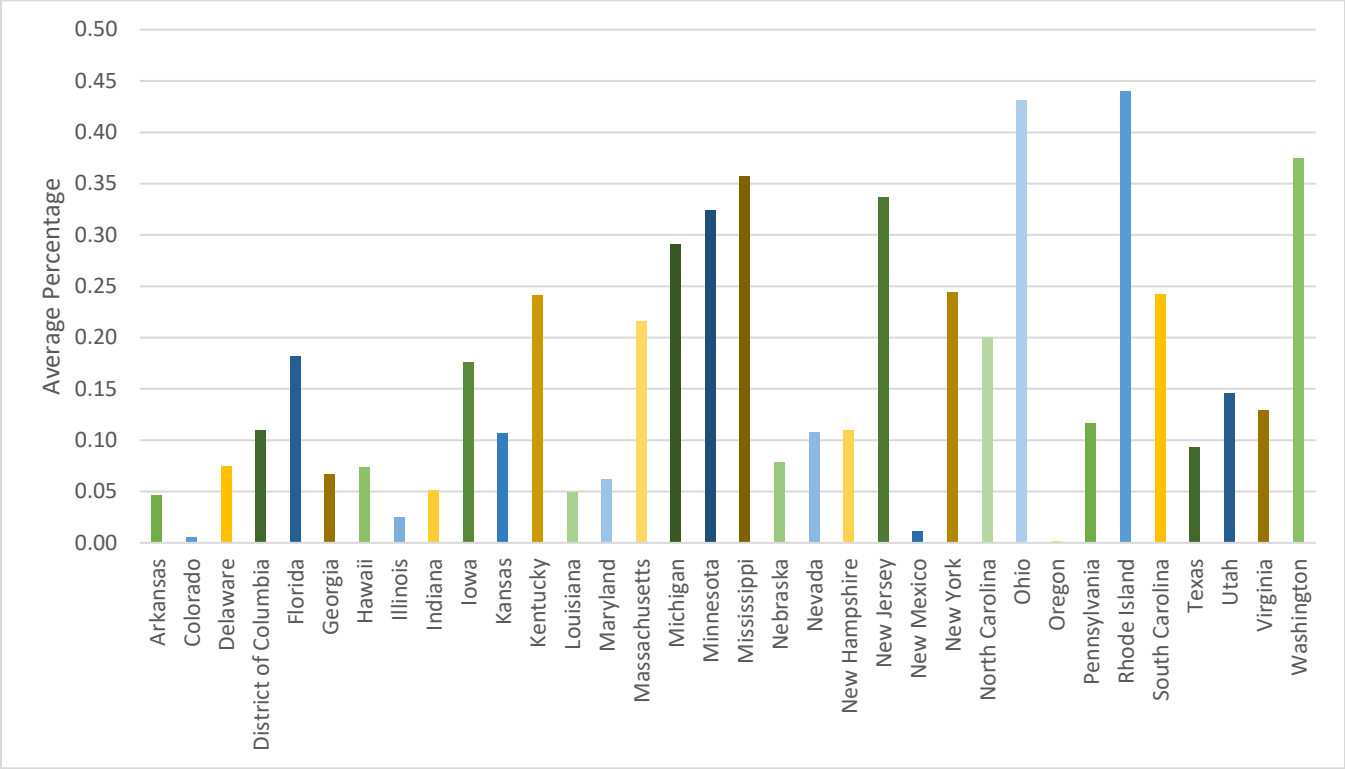

Table 60 - Percentage of Medicaid MCO Population in Lock-In Status Annually (State Average)

State	State Average Percentage
Arkansas	0.05%
Colorado	0.01%
Delaware	0.08%
District of Columbia	0.11%
Florida	0.18%
Georgia	0.07%
Hawaii	0.07%
Illinois	0.03%
Indiana	0.05%
Iowa	0.18%
Kansas	0.11%
Kentucky	0.24%
Louisiana	0.05%
Maryland	0.06%
Massachusetts	0.22%
Michigan	0.29%
Minnesota	0.32%
Mississippi	0.36%
Nebraska	0.08%
Nevada	0.11%

State	State Average Percentage
New Hampshire	0.11%
New Jersey	0.34%
New Mexico	0.01%
New York	0.24%
North Carolina	0.20%
Ohio	0.43%
Oregon	0.00%
Pennsylvania	0.12%
Rhode Island	0.44%
South Carolina	0.24%
Texas	0.09%
Utah	0.15%
Virginia	0.13%
Washington	0.37%
National Average	**0.16%**

3. Does your MCO have a documented process in place that identifies potential FWA of controlled drugs by prescribers?

Figure 63 - Documented Process to Identify Potential FWA of Controlled Drugs by Prescribers

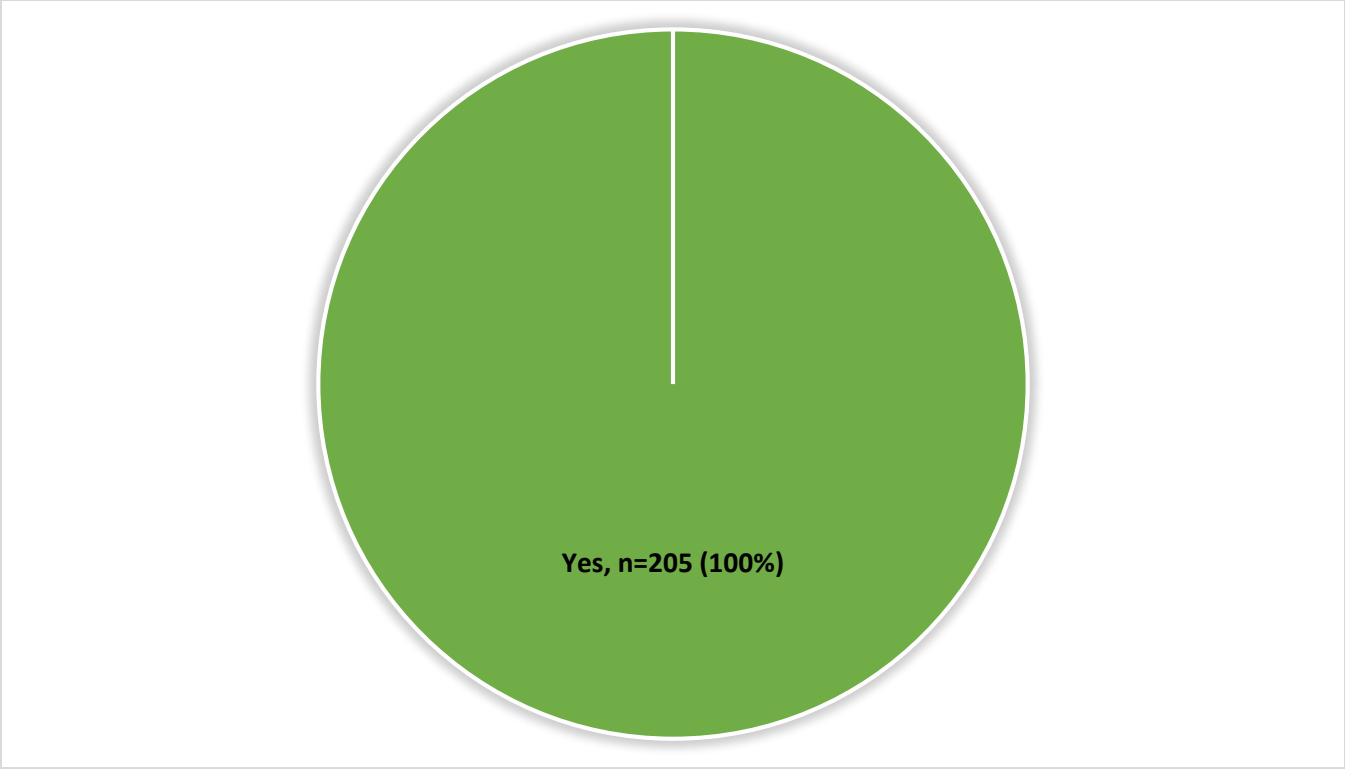

Table 61 - Documented Process to Identify Potential FWA of Controlled Drugs by Prescribers

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	205	100.00%
National Totals		**205**	**100%**

If "Yes," what actions does this process initiate (multiple responses allowed)?

Figure 64 - Actions Process Initiates when Potential FWA of Controlled Drugs by Prescribers is Detected

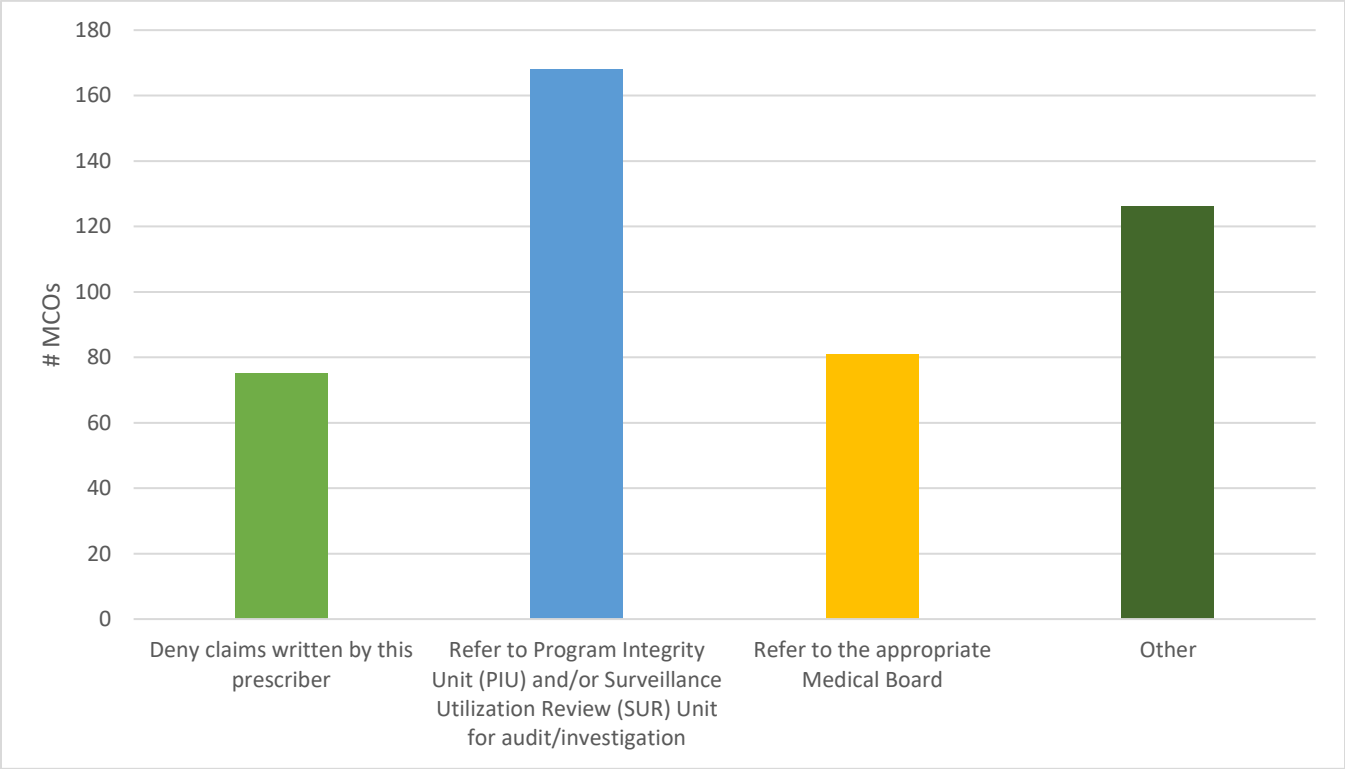

Table 62 - Actions Process Initiates when Potential FWA of Controlled Drugs by Prescribers is Detected

Response	States (Count of MCOs)	Count	Percentage
Deny claims written by this prescriber	Arkansas (2), Colorado (1), District of Columbia (3), Florida (3), Georgia (3), Hawaii (3), Illinois (3), Indiana (3), Kansas (1), Kentucky (1), Louisiana (1), Maryland (5), Massachusetts (1), Michigan (6), Minnesota (5), Mississippi (1), Nebraska (1), New Hampshire (1), New Jersey (3), New Mexico (2), New York (6), North Carolina (1), Ohio (1), Oregon (5), Pennsylvania (3), South Carolina (1), Texas (2), Utah (2), Virginia (2), Washington (3)	75	16.67%

Response	States (Count of MCOs)	Count	Percentage
Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation	Arkansas (4), Colorado (1), Delaware (2), District of Columbia (4), Florida (9), Georgia (3), Hawaii (6), Illinois (5), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (8), Massachusetts (4), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (3), New Hampshire (2), New Jersey (5), New Mexico (3), New York (12), North Carolina (5), Ohio (3), Oregon (11), Pennsylvania (6), Rhode Island (3), South Carolina (4), Texas (7), Utah (4), Virginia (5), Washington (4)	168	37.33%
Refer to the appropriate Medical Board	Arkansas (2), Colorado (1), Delaware (1), District of Columbia (1), Florida (3), Georgia (1), Hawaii (3), Illinois (2), Indiana (4), Kansas (2), Kentucky (2), Louisiana (3), Maryland (4), Massachusetts (2), Michigan (5), Minnesota (7), Mississippi (2), Nebraska (2), Nevada (1), New Hampshire (1), New Jersey (3), New Mexico (1), New York (7), North Carolina (1), Ohio (2), Oregon (1), Pennsylvania (3), Rhode Island (1), South Carolina (2), Texas (3), Utah (2), Virginia (4), Washington (2)	81	18.00%
Other	Arkansas (3), Delaware (1), District of Columbia (2), Florida (8), Georgia (3), Hawaii (4), Illinois (3), Indiana (3), Iowa (1), Kansas (2), Louisiana (2), Maryland (7), Massachusetts (3), Michigan (6), Minnesota (2), Mississippi (2), Nebraska (1), Nevada (2), New Hampshire (2), New Jersey (3), New Mexico (2), New York (9), North Carolina (3), Ohio (4), Oregon (13), Pennsylvania (5), Rhode Island (2), South Carolina (5), Texas (13), Utah (3), Virginia (4), Washington (3)	126	28.00%
National Totals		**450**	**100%**

4. Does your MCO have a documented process in place that identifies potential FWA of controlled drugs by pharmacy providers?

Figure 65 - Documented Process to Identify Potential FWA of Controlled Drugs by Pharmacy Providers

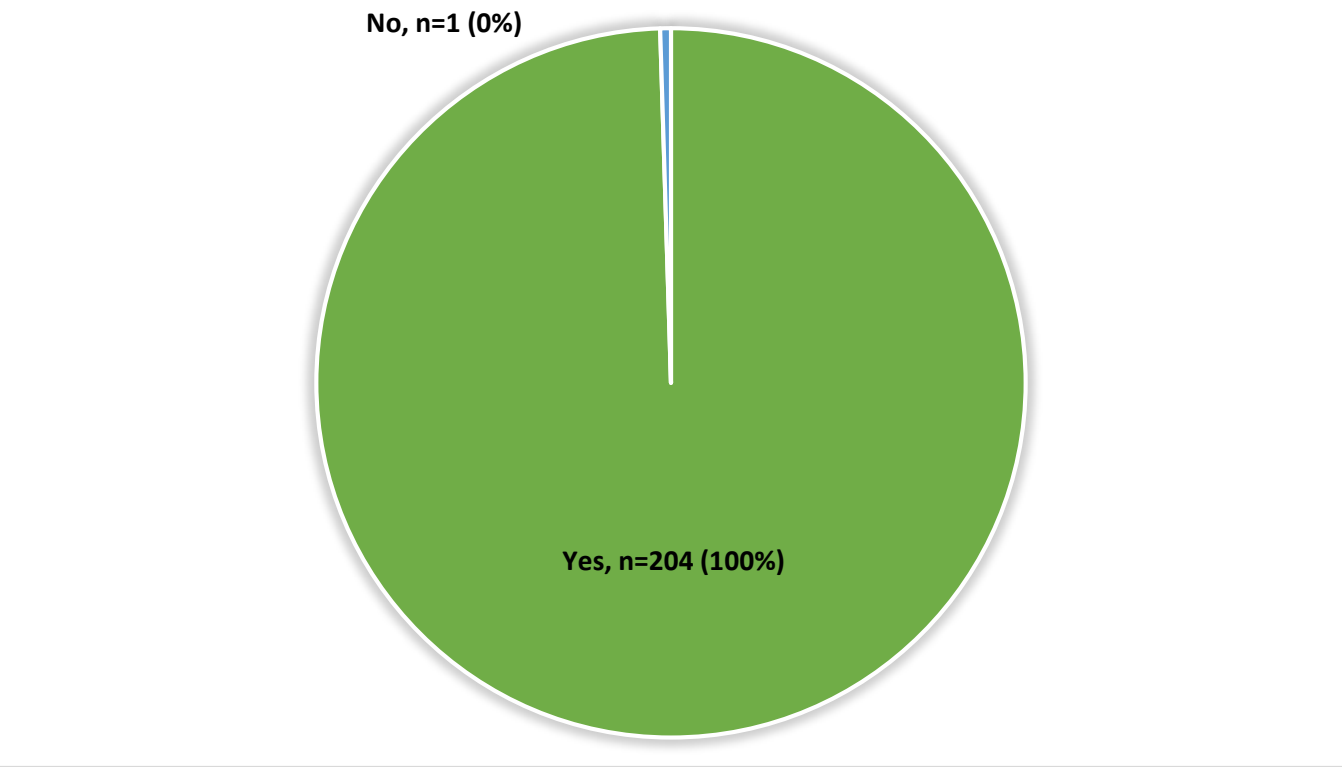

Table 63 - Documented Process to Identify Potential FWA of Controlled Drugs by Pharmacy Providers

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (7), Rhode Island (3), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	204	99.51%
No	Pennsylvania (1)	1	0.49%
National Totals		**205**	**100%**

If "Yes," what actions does this process initiate (multiple responses allowed)?

Figure 66 - Actions Process Initiates when Potential FWA of Controlled Drugs by Pharmacy Providers is Detected

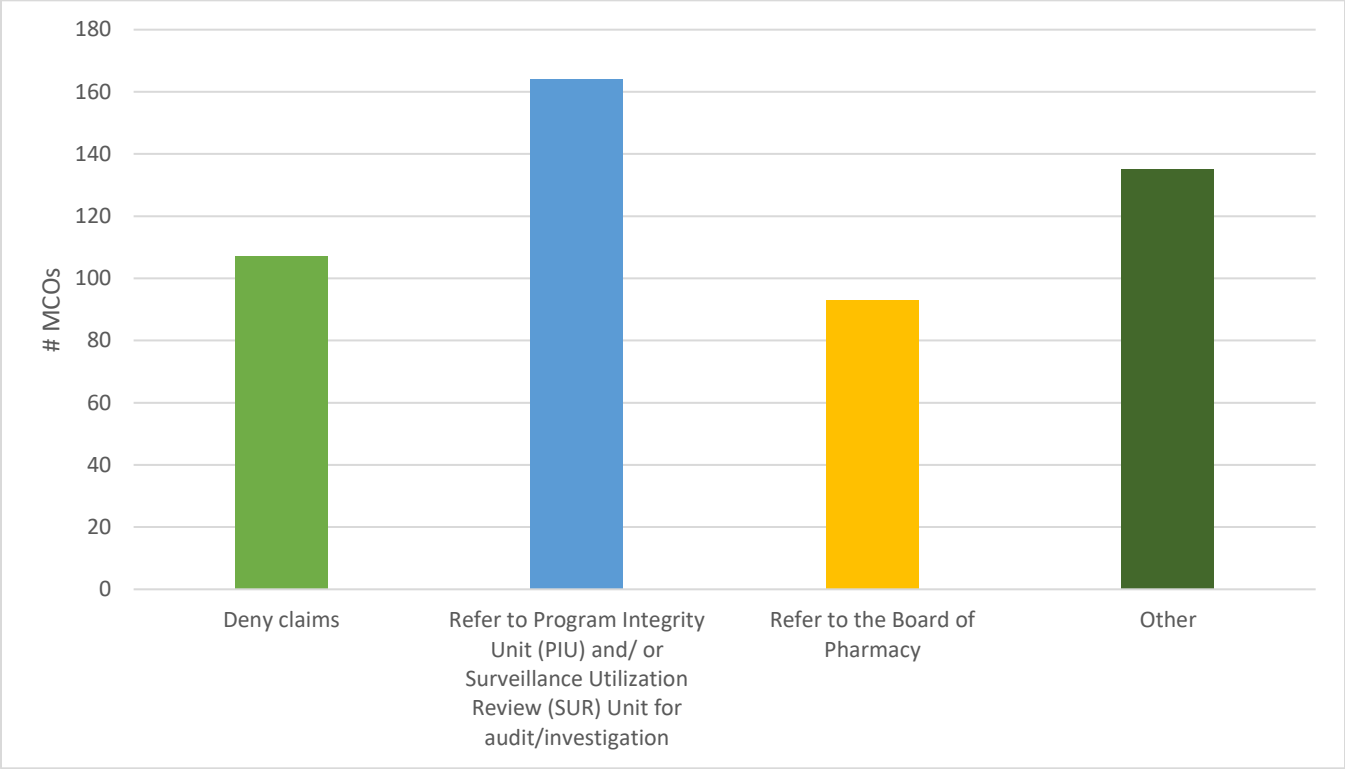

Table 64 - Actions Process Initiates when Potential FWA of Controlled Drugs by Pharmacy Providers is Detected

Response	States (Count of MCOs)	Count	Percentage
Deny claims	Arkansas (2), Colorado (1), District of Columbia (3), Florida (6), Georgia (3), Hawaii (4), Illinois (3), Indiana (4), Iowa (1), Kentucky (6), Louisiana (4), Maryland (3), Massachusetts (3), Michigan (5), Minnesota (6), Nebraska (1), Nevada (1), New Hampshire (3), New Jersey (3), New Mexico (3), New York (5), North Carolina (3), Ohio (2), Oregon (10), Pennsylvania (1), Rhode Island (1), South Carolina (1), Texas (12), Utah (2), Virginia (2), Washington (3)	107	21.44%
Refer to Program Integrity Unit (PIU) and/ or Surveillance Utilization Review (SUR) Unit for audit/investigation	Arkansas (3), Colorado (1), Delaware (2), District of Columbia (3), Florida (8), Georgia (3), Hawaii (5), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (6), Massachusetts (3), Michigan (9), Minnesota (8), Mississippi (2), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (5), New Mexico (3), New York (10), North Carolina (5), Ohio (3), Oregon (18), Pennsylvania (6), Rhode Island (3), South Carolina (4), Texas (6), Utah (4), Virginia (5), Washington (3)	164	32.87%
Refer to the Board of Pharmacy	Arkansas (1), Colorado (1), Delaware (1), District of Columbia (1), Florida (4), Georgia (1), Hawaii (3), Illinois (1), Indiana (3), Kansas (1), Kentucky (6), Louisiana (1), Maryland (3), Massachusetts (2), Michigan (5), Minnesota (7), Mississippi (1), Nebraska (2), Nevada (1), New Hampshire (2), New Jersey (3), New Mexico (3), New York (3), North Carolina (3), Ohio (3), Oregon (13), Pennsylvania (5), Rhode Island (2), South Carolina (1), Texas (3), Utah (2), Virginia (3), Washington (2)	93	18.64%

Response	States (Count of MCOs)	Count	Percentage
Other	Arkansas (3), Delaware (2), District of Columbia (2), Florida (8), Georgia (2), Hawaii (5), Illinois (3), Indiana (3), Kansas (2), Louisiana (4), Maryland (6), Massachusetts (4), Michigan (9), Minnesota (6), Mississippi (2), Nevada (2), New Hampshire (3), New Jersey (4), New Mexico (2), New York (14), North Carolina (2), Ohio (5), Oregon (5), Pennsylvania (6), Rhode Island (3), South Carolina (4), Texas (13), Utah (3), Virginia (5), Washington (3)	135	27.05%
National Totals		**499**	**100%**

If "No," please explain why not.

Table 65 - Explanations for Lack of Documented Process to Identify Potential FWA of Controlled Drugs by Pharmacy Providers

State	MCO Name	Explanation
PA	Health Partners	Pharmacy completes ad-hoc requests based on claims data, member complaints, and high utilization of certain medications.

5. Does your MCO have a documented process in place that identifies and/or prevents potential fraud or abuse of non-controlled drugs by beneficiaries, prescribers, and pharmacy providers?

Figure 67 - Documented Process to Identify Potential Fraud or Abuse of Non-Controlled Drugs by Beneficiaries, Prescribers, and Pharmacy Providers

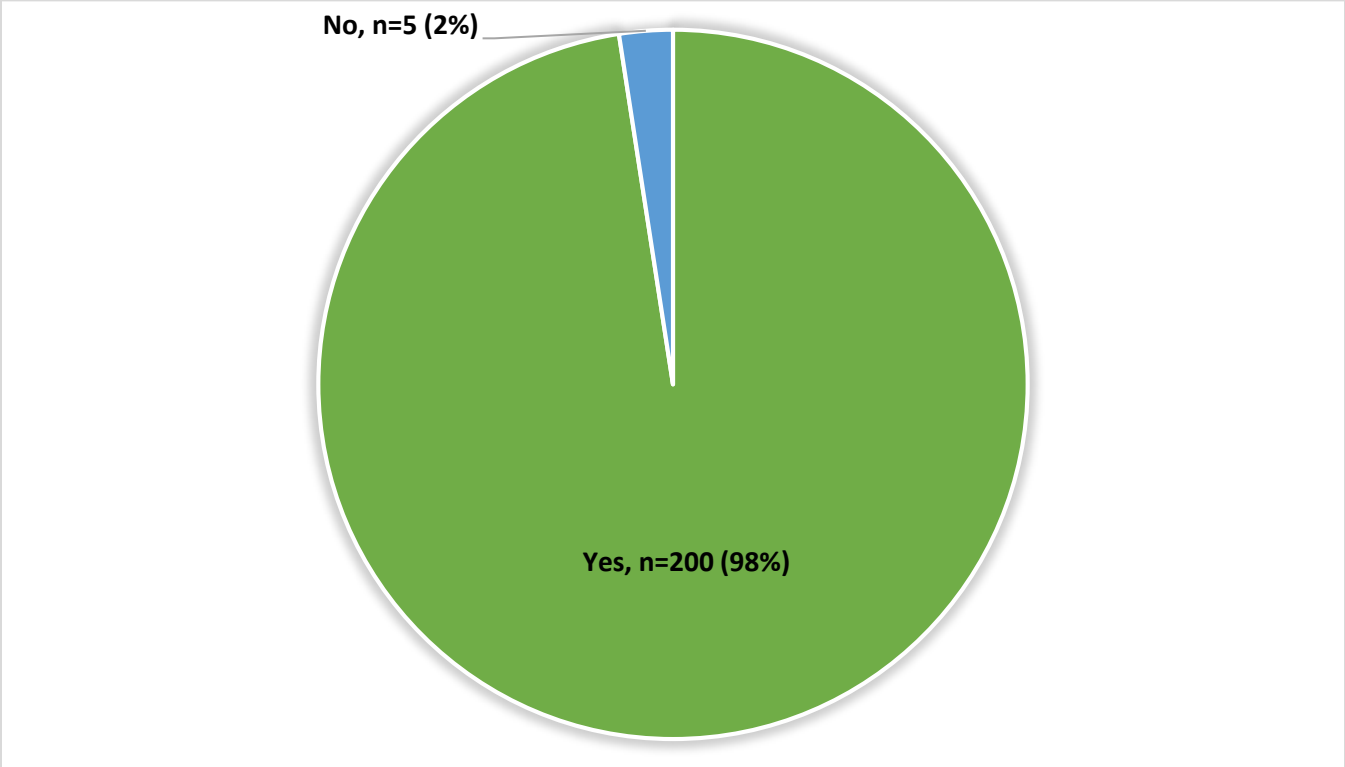

Table 66 - Documented Process to Identify Potential Fraud or Abuse of Non-Controlled Drugs by Beneficiaries, Prescribers, and Pharmacy Providers

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (1), Delaware (2), District of Columbia (4), Florida (10), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (4), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (14), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (3), South Carolina (4), Texas (16), Utah (4), Virginia (6), Washington (5)	200	97.56%
No	Colorado (1), Florida (1), Massachusetts (1), New York (1), South Carolina (1)	5	2.44%
National Totals		**205**	**100%**

If “No,” please explain why not.

Table 67 - Explanations for Lock of Documented Process to Identify Potential Fraud or Abuse of Non-Controlled Drugs by Beneficiaries, Prescribers, and Pharmacy Providers

State	MCO Name	Explanation
CO	Rocky Mountain Health Plans	RMHP does not have an outlined policy to prevent fraud, waste, and abuse from beneficiaries for non-controlled drugs but we do have guard rails in place via formulary, UM, and DUR processes. Our formulary includes PA, ST, and QL to decrease opportunities to exceed normal doses or access to excessive amounts of drug. Our POS system has refill limits, duplicate script rejections, max cost limits, and other built in rejections to prevent fraud, waste, or abuse. We have specific limitations on compounds and DMRs to also promote appropriate access to drugs.
FL	Humana Medical Plan	Our lock in program is only for controlled medication. Our audit targeting is done at the pharmacy level and their dispensing outliers for waste and/or abuse, but it's not specific to beneficiary patterns. Any evidence of fraud or potential fraud is referred to Special Investigations Unit.
MA	Health New England, Inc.	However, we do review monthly reject and other PBM reporting as it relates to suspect claims.
NY	Capital District Physicians' Health Plan	CDPHP does not have a formal process documented. ProDUR edits and retrospective review of claims will identify concerning utilization. If fraud or abuse is suspected, cases are referred to the plan SIU (Special Investigation Unit) for further investigation.
SC	Humana	Our lock in program is only for controlled medication. Our audit targeting is done at the pharmacy level and their dispensing outliers for waste and/or abuse, but it's not specific to beneficiary patterns. Any evidence of fraud or potential fraud is referred to Special Investigations Unit.

B. Prescription Drug Monitoring Program (PDMP)

1. Does your MCO have the ability to query the State's PDMP database?

Figure 68 - MCO Has Ability to Query the State's PDMP Database

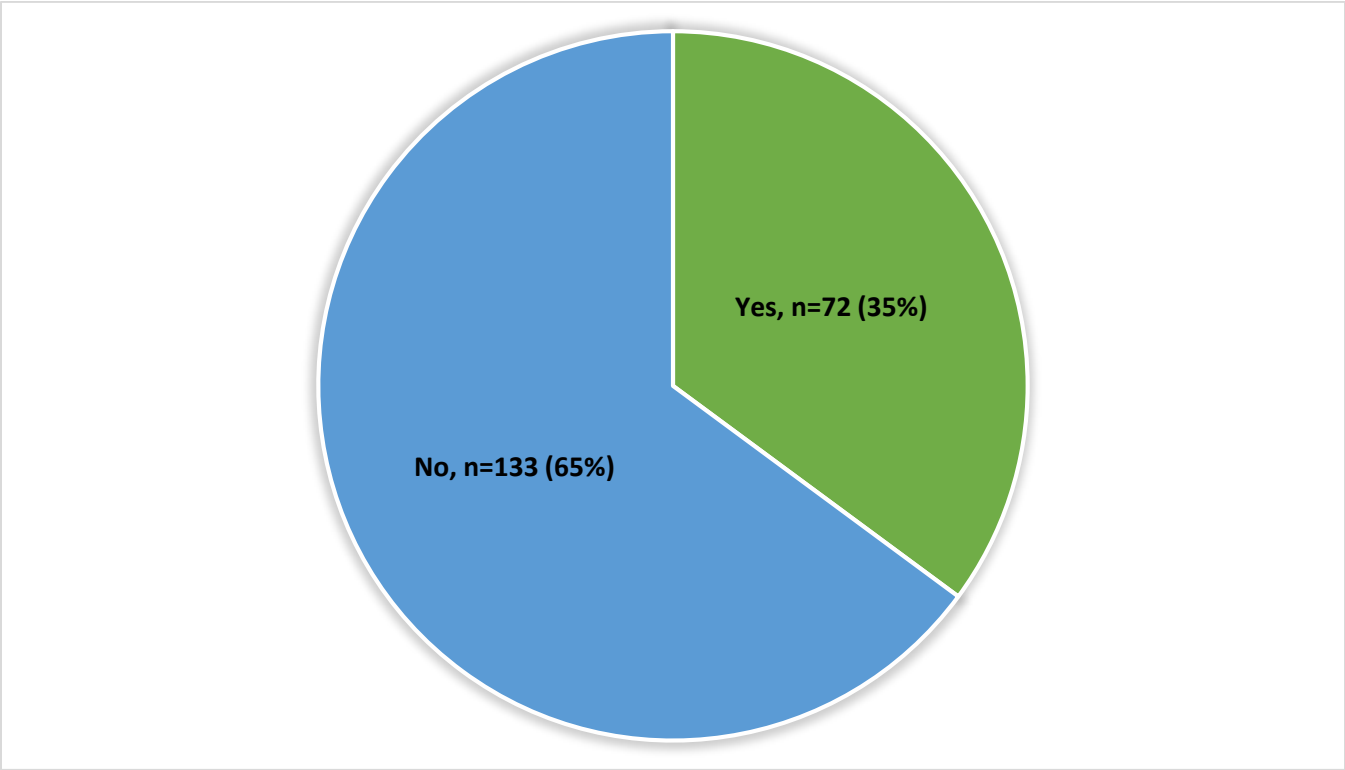

Table 68 - MCO Has Ability to Query the State's PDMP Database

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), District of Columbia (4), Florida (2), Georgia (1), Hawaii (1), Illinois (2), Indiana (5), Kansas (3), Kentucky (2), Michigan (6), Minnesota (8), Mississippi (1), Nebraska (2), New Mexico (3), Ohio (5), Oregon (4), Pennsylvania (4), Texas (1), Utah (4), Virginia (5), Washington (5)	72	35.12%
No	Colorado (2), Delaware (2), Florida (9), Georgia (2), Hawaii (5), Illinois (4), Iowa (2), Kentucky (4), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (3), Minnesota (1), Mississippi (2), Nebraska (1), Nevada (4), New Hampshire (3), New Jersey (5), New York (15), North Carolina (5), Oregon (17), Pennsylvania (4), Rhode Island (3), South Carolina (5), Texas (15), Virginia (1)	133	64.88%
National Totals		**205**	**100%**

a. If "Yes," please check all applicable ways your MCO accesses the PDMP database.

Figure 69 - Ways the MCO Has the Ability to Query the State's PDMP Database

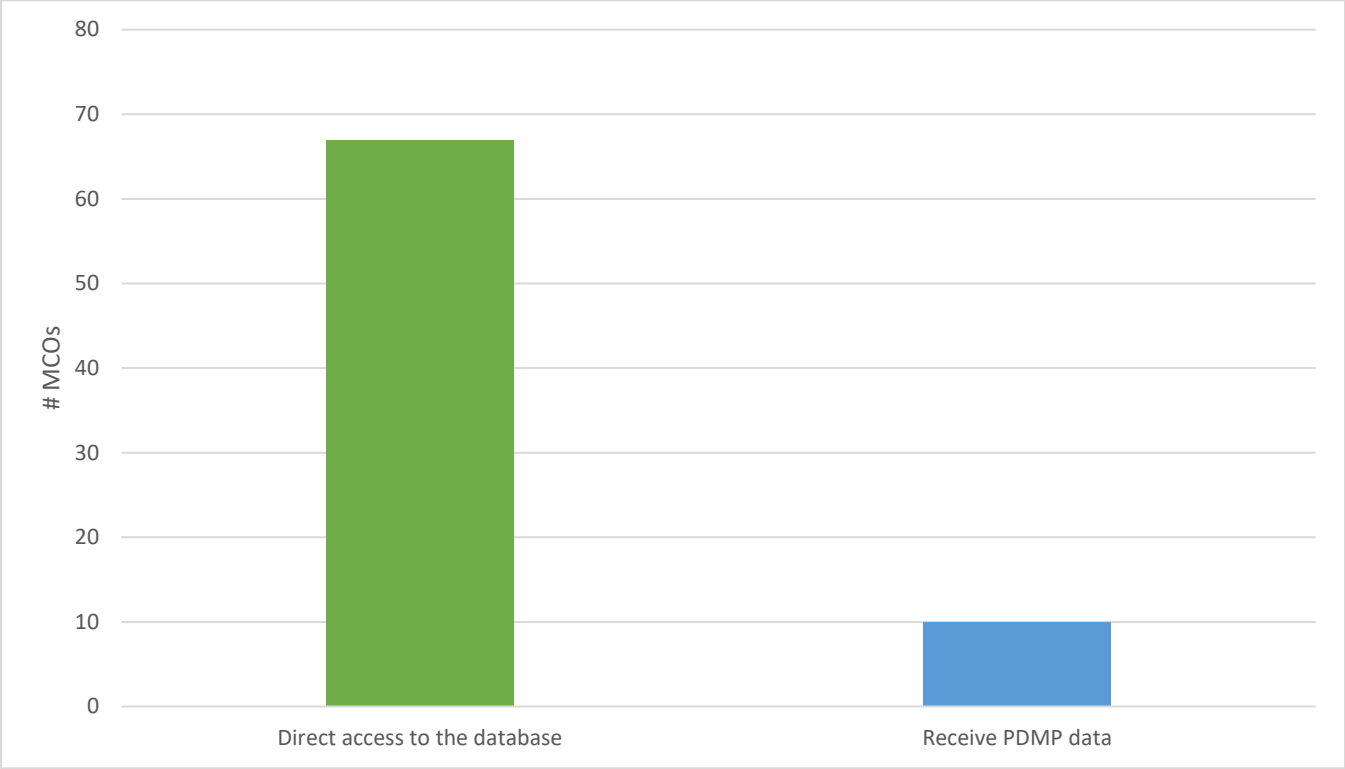

Table 69 - Ways the MCO Has the Ability to Query the State's PDMP Database

Response	States (Count of MCOs)	Count	Percentage
Direct access to the database	Arkansas (4), District of Columbia (4), Florida (2), Georgia (1), Hawaii (1), Illinois (2), Indiana (5), Kansas (3), Kentucky (1), Michigan (5), Minnesota (8), Mississippi (1), Nebraska (2), New Mexico (3), Ohio (5), Oregon (3), Pennsylvania (4), Texas (1), Utah (3), Virginia (5), Washington (4)	67	87.01%
Receive PDMP data	District of Columbia (1), Kansas (3), Kentucky (1), Michigan (1), Oregon (1), Utah (1), Washington (2)	10	12.99%
National Totals		**77**	**100%**

i. If "Receive PDMP data," please indicate how often (multiple responses allowed).

Figure 70 Frequency of PDMP Data Received

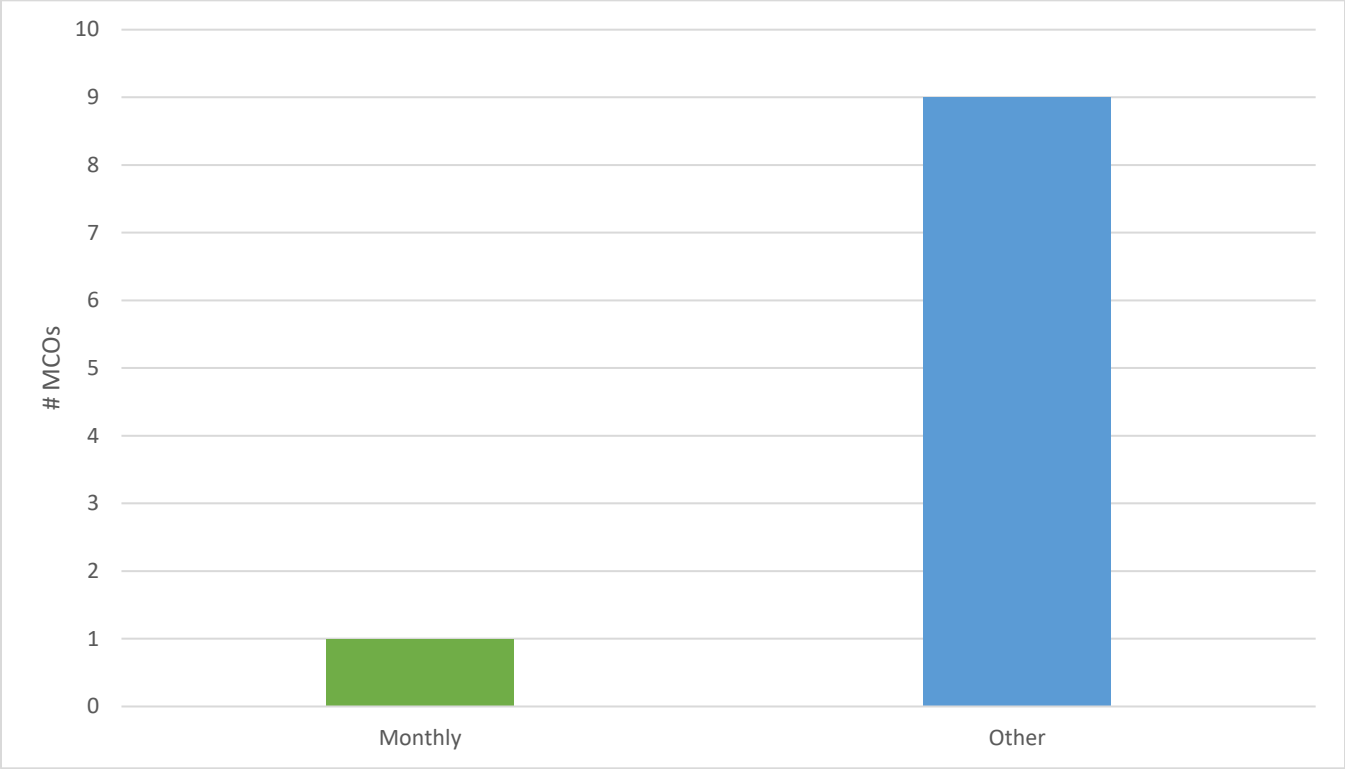

Table 70 Frequency of PDMP Data Received

Response	States (Count of MCOs)	Count	Percentage
Monthly	Washington (1)	1	10.00%
Other	District of Columbia (1), Kansas (3), Kentucky (1), Michigan (1), Oregon (1), Utah (1), Washington (1)	9	90.00%
National Totals		**10**	**100%**

If "Other," please specify.

Table 71 - "Other" Explanations for Frequency of PDMP Data Received

State	MCO Name	Explanation
DC	AmeriHealth Caritas DC	Login to look up individual enrollees.
KS	Aetna Better Health of Kansas	Ad hoc query used a clinical decision-making tool to promote patient safety and healthy communities through prevention of prescription drug misuse, abuse and diversion.
KS	Sunflower Health Plan	Data can be requested from the PDMP on an as-needed basis.
KS	UnitedHealthcare	Ad hoc reporting request as necessary for FWA case review
KY	Passport Health Plan By Molina Healthcare	Can query by client as needed
MI	HAP Empowered	We receive data ad hoc based on requests submitted in the MAPS system (at HAP member level).
OR	AllCare CCO	upon request.
UT	SelectHealth	Ad hoc
WA	Coordinated Care Corporation	Quarterly

ii. If "Direct access to the database," please specify your query capability (multiple responses allowed).

Figure 71 - Query Capability

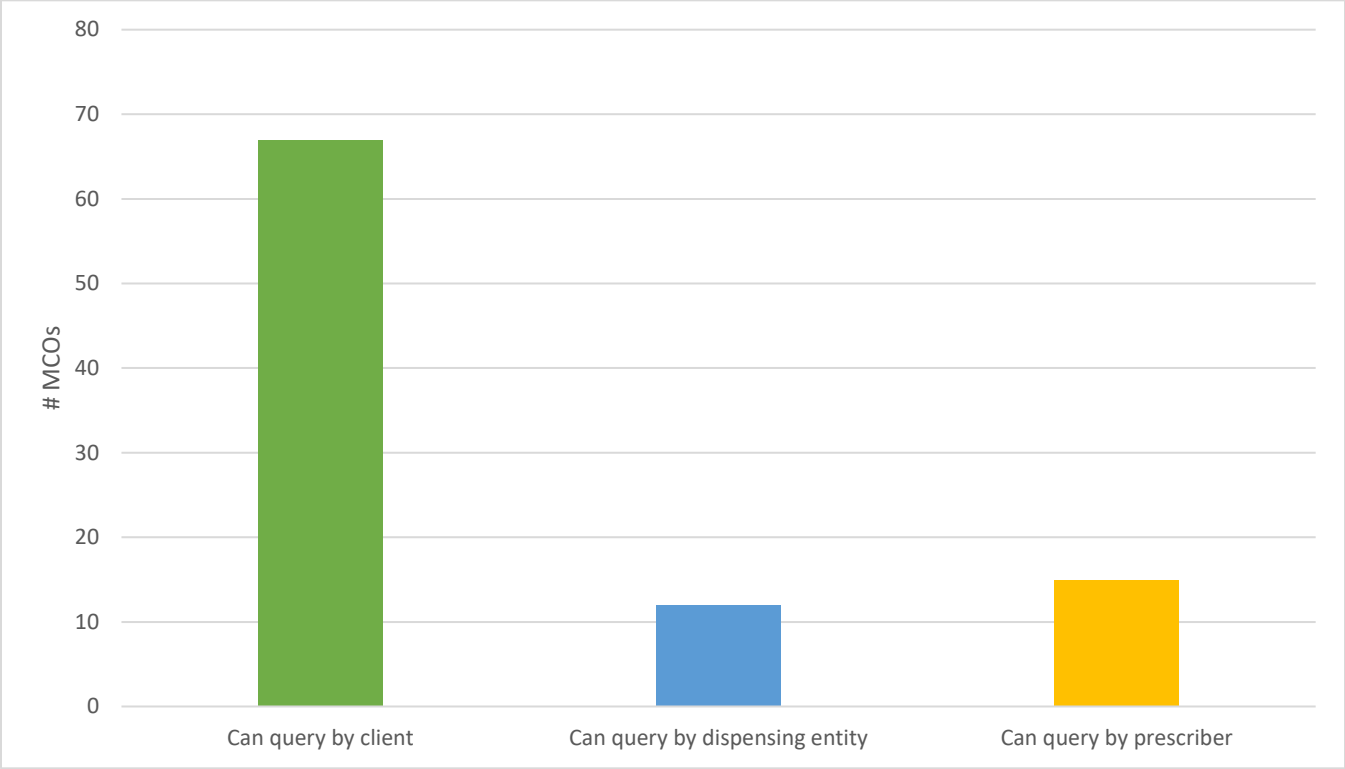

Table 72 - Query Capability

Response	States (Count of MCOs)	Count	Percentage
Can query by client	Arkansas (4), District of Columbia (4), Florida (2), Georgia (1), Hawaii (1), Illinois (2), Indiana (5), Kansas (3), Kentucky (1), Michigan (5), Minnesota (8), Mississippi (1), Nebraska (2), New Mexico (3), Ohio (5), Oregon (3), Pennsylvania (4), Texas (1), Utah (3), Virginia (5), Washington (4)	67	71.28%
Can query by dispensing entity	Arkansas (1), District of Columbia (1), Florida (2), Indiana (5), Pennsylvania (1), Virginia (1), Washington (1)	12	12.77%
Can query by prescriber	Arkansas (1), District of Columbia (1), Florida (2), Indiana (5), Ohio (1), Oregon (1), Pennsylvania (2), Virginia (1), Washington (1)	15	15.96%
National Totals		**94**	**100%**

If "No," please explain.

Table 73 - Explanations for No Ability to Query PDMP Database

State	MCO Name	Explanation
CO	Denver Health Medicaid Choice	The State is prohibited by law from accessing the PDMP.
CO	Rocky Mountain Health Plans	As an MCO we are not able to access PDMP data for use of coverage determinations at this time. If this were to change, RMHP would like to take advantage of this data to make more informed decisions.
DE	AmeriHealth Caritas Delaware	Access is not available to managed care organizations at this time.

State	MCO Name	Explanation
DE	HighmarkHealthOptions	As a Health Plan, Highmark Health Options associates do not prescribe or dispense controlled substances. To date, there has been no update on whether Highmark Health Options responsibilities would constitute a reasonable need to access the PDMP. Outreach has been made to the Delaware State Board of Pharmacy .
FL	Aetna Better Health	The State does not permit the MCO to access the PDMP.
FL	Children's Medical Services	N/A - we do not have access to PDMP data
FL	Clear Health Alliance	Although MCO as an entity has no access to the State PDMP, our local and State licensed Pharmacy Director can query as needed.
FL	Community Care Plan	The PDMP allows access to pharmacies, Pharmacist and prescribers that work with controlled substances. MCO's are not given access. Although we do not have direct access CCP has implemented a process via the PBM to have in-network pharmacies sign a yearly affidavit declaring that they check e-forcse when processing controlled substance prescriptions. This has been added to the annual pharmacy audit process conducted by the PBM.
FL	Humana Medical Plan	It is a FL law that pharmacists and prescribers have access to the system for controlled substance prescribing.
FL	Molina Healthcare	Molina follows State regulations around privacy and requirements for direct member care providers to leverage PDMP databases. Currently Molina does not have the ability to query the State's PDMP database.
FL	Simply Healthcare	Although MCO as an entity has no access to the State PDMP, our local and State licensed Pharmacy Director can query as needed.
FL	Sunshine	The MCO does not have access to PDMP data.
FL	United Healthcare	Only dispensing pharmacists and licensed prescribers can currently access the State PDMP per FL statute.
GA	Amerigroup GA	Health plans are not allowed to register in the PDMP. However, information may be shared with a patient's insurer if the patient has authorized the prescriber to make the disclosure, or if the patient's insurer needs that information in order to provide treatment, payment or health care.
GA	Peach State Health Plan	The Georgia PDMP only allows prescribers and pharmacists to access.
HI	AlohaCare	MCOs do not have access to the Hawaii PDMP database.
HI	HMSAQI	MCOs in the State of Hawaii are not granted access to the PDMP and cannot query the State's PDMP database.
HI	UnitedHealthcare	Our MCO (pharmacy department) does not have access to the PDMP, although our Medical Director is authorized to use the program. Our plan's pharmacy account manager has not been granted access to the PDMP since the queries performed are not on behalf of the doctor-patient prescribing practice per the Narcotics Enforcement Division.
HI	WellCareHealthPlans	Hawaii does not allow MCO pharmacist to have access to the State PDMP, so any reporting on data collection/validation is not available to the MCO.
HI	WellCareHealthPlansCCS	Hawaii does not allow MCO pharmacist to have access to the State PDMP, so any reporting on data collection/validation is not available to the MCO.
IA	Amerigroup	The Iowa Board of Pharmacy only allows access to the PMP to authorized prescribers and pharmacists to obtain the information regarding their patients' use of controlled substances when actively engaged in their patient's healthcare.

State	MCO Name	Explanation
IA	Iowa Total Care	The Iowa Board of Pharmacy only allows access to the PMP to authorized prescribers and pharmacists to obtain information regarding their patients' use of controlled substances when actively engaged in the patient's healthcare.
IL	Aetna_Better_Health_of_Illinois	Use of the State PDMP requires a pharmacist registering with the ILPMP to be associated with a pharmacy provider, not allowing staff employed at the health plan to register. Similarly, any prescriber registering with the ILPMP must be affiliated with a practice, and have a valid DEA number, which health plan medical directors may not have.
IL	MeridianHealth	No - the plan does not have access. Individual providers may have access.
IL	Molina_Healthcare_of_Illinois,_Inc	Molina follows State regulations around privacy and requirements for direct member care providers to leverage PDMP databases
IL	YouthCare_HealthChoice	No - the plan does not have access. Individual providers may have access.
KY	Aetna Better Health of Kentucky	Aetna Better Health KY did not have access to the database
KY	Anthem Inc. Kentucky	Prescribers are to query PDMP before writing for controlled substances.
KY	Humana Healthy Horizons in Kentucky	Pharmacies are required in the contract to follow all State and federal laws for checking the PDMP.
KY	WellCare Health Plans	We do not have access to PDMP at the health plan level
LA	Aetna Better Health of Louisiana	Prescribers can submit PDMP data with Prior Authorization and when necessary the MCO can request information from Fee for Service pharmacy team.
LA	AmeriHealth Caritas Louisiana	AmeriHealth Caritas does not have the ability to query the system ourselves. Access to the PDMP data is via the LDH pharmacy dept. A request for information can be made and LDH will provide the information.
LA	Healthy Blue Louisiana	We do not have access to the State's PDMD. We have the ability to retrieve PDMP information from our State partners upon request.
LA	Louisiana Healthcare Connections	MCOs do not have the ability to query the PDMP database ourselves. Access to the PDMP data is via the LDH pharmacy dept. A request for information can be made and LDH will provide the information.
LA	UnitedHealthcare Community Plan	In order to receive PDMP related information UHC must submit a request to the State department about a member and then a follow up phone call is received from the State explaining the findings.
MA	AllWays Health Partners	Health Plans do not have access to State PDMP
MA	Boston Medical Center Health Plan, Inc	The MCO does not currently have the ability to query the State's PDMP database.
MA	Fallon Community Health Plan, Inc.	we do not have access to State PDMP data base
MA	Health New England, Inc.	MCO does not have access to State of MA PDMP
MA	Tufts Health Public Plans, Inc	Massachusetts does not permit MCOs to access the PDMP database, so the MCO cannot use PDMP information in its FWA investigations. We do educate our providers to access the PDMP prior to prescribing an opioid or a benzodiazepine.
MD	Aetna Better Health of Maryland	State does not permit the MCO to access the PDMP
MD	Amerigroup Community Care	MCO's don't have direct access to query PDMP
MD	CareFirst Community Health Plan Maryland	CHPMD provider contract and provider manual requires network providers to be compliant with all federal and State laws. The State of Maryland requires

State	MCO Name	Explanation
		prescribers to check the PDMP prior to prescribing any controlled substances and requires pharmacies to check the PDMP prior to dispensing all controlled substances, which helps prevent FWA.
MD	Jai Medical Systems Managed Care Organization, Inc.	Under Maryland law PDMP data is confidential/privileged and cannot be queried by the MCO.
MD	Kaiser Foundation Health Plan of the Mid-Atlantic States	Consistent with the Code of Maryland regulation COMAR 10.47.07.02 and COMAR 10.47.07.05, only pharmacists and physicians can check the State's PDMP once registered with the State and PDMP as part of their practice in the State.
MD	Maryland Physicians Care	Access to PDMP database is restricted for Maryland HealthChoice MCO's.
MD	MedStar Family Choice	MCOs may be granted special permission to access on a case by case basis, but otherwise are legislatively prohibited from accessing the Maryland PDMP.
MD	Priority Partners MCO	PDMP Access to prescription data is made available at no-cost to physicians, nurse practitioners, pharmacists and others that provide pharmaceutical care to their patients. By law, healthcare providers may only access information on patients under their care.
MD	United Healthcare	At this time, administrators in UnitedHealthcare Community Plan do not have access, but credentialed users have access to the PDMP.
MI	Aetna Better Health of Michigan	State does not permit the MCO to access the PDMP
MI	McLaren Health Plan	This is scheduled to be implemented before the end of the 2023 State required timeframe.
MI	Meridian Health Plan	Meridian does not have access to the PDMP data in a systematic way to promote query.
MN	UCare	Per Minnesota State regulations, pharmacists and MCO's are not permitted to access the PDMP for information.
MS	MS-MOLINA	Molina follows State regulations around privacy and requirements for direct member care providers to leverage PDMP databases.
MS	MS-UNITED	Access provided is only to query by a specific member search. Information is used on an ad hoc basis to support member engagement and care management activities.
NC	AMHC FFY22	MCO does not have access to State's PDMP database
NC	CCH FFY22	Based on NC Board of Pharmacy law we do not interpret MCO to be eligible accessors of the PDMP data.
NC	HB FFY22	The State does not provide access to the PDMP database.
NC	UHC FFY22	MCO's do not have access to query States PDMP database.
NC	WC FFY22	The MCO does not have access to PDMP data.
NE	HealthyBlueNebraska	We have access to the PDMP, but we can't query the system and we do not receive PDMP data.
NH	AmeriHealth Caritas NH	All PDMP system users must apply individually. This includes healthcare providers, pharmacists, and their staff applying as delegates. Access is granted to individuals onlyï¿½not to clinics, hospitals, pharmacies, or any other health care facility. Health Plans/Insurers are not allowed to access the NH PDMP.
NH	NH Healthy Families	MCO's do not meet State regulatory requirements to view the PDMP.
NH	Well Sense	The Plan does not currently have the ability to query the State's PDMP database.

State	MCO Name	Explanation
NJ	Aetna Better Health of New Jersey	The State does not allow the MCOs to have access and utilize this systems
NJ	Amerigroup Community Care	Access to PDMP is currently only for practicing prescribers and pharmacists who write prescriptions for or dispense schedule II, III and IV drugs.
NJ	Horizon NJ Health	In the State of New Jersey, MCOs do not have access to the PDMP database.
NJ	NJ United	MCO's do not have access to query States PDMP database.
NJ	Wellcare health plans	We do not have access to PDMP data
NV	Anthem Blue Cross Blue Shield	The State of Nevada only allows prescribers and dispensers access to a patient's controlled substance prescription medication history.
NV	Health Plan of Nevada	The State of Nevada only allows prescribers and dispensers access to a patient's controlled substance prescription medication history.
NV	Molina	The State of Nevada only allows prescribers and dispensers access to a patient's controlled substance prescription medication history.
NV	Silver Summit Health Plan	The State of Nevada only allows prescribers and dispensers access to a patient's controlled substance prescription medication history.
NY	AMIDA CARE	At this time Managed Care plans do not have access to query NY State's Prescription Monitoring Program (PMP).
NY	Capital District Physicians' Health Plan	New York State gives access to prescribers and pharmacists
NY	EmblemHealth	EmblemHealth does not have the requirement to query the State's PDMP database. EmblemHealth's utilization management policies that are in place for long and short acting opioids require prescriber's to access the PDMP (NYS I-STOP) patient history prior to prescribing these substances.
NY	Empire Blue Cross Blue Shield HealthPlus	Access to NYS i-STOP is currently only for practicing prescribers and pharmacists who write prescriptions for or dispense schedule II, III and IV drugs.
NY	Excellus Health Plan	No, the MCO does not receive access to the PDMP in their State, access is limited to dispensing pharmacists and prescriber's.
NY	Fidelis Care	New York State Dept does not allow health plans to access the PDMP.
NY	Healthfirst	Managed Care plans do not have access to query NY State's Prescription Monitoring Program (PMP) at this time.
NY	Highmark Blue Cross Blue Shield of Western New York	The State does not provide access to the State PDMP database.
NY	Independent Health	Plans do not have access per State regulations
NY	MetroPlus Health Plan	MCOs do not have access
NY	Molina Healthcare of New York	Molina follows State regulations around privacy and requirements for direct member care providers to leverage PDMP databases.
NY	MVP Health Care	No access to State database
NY	United HealthCare	MCO's are prohibited from using the States PDMP database.
NY	Univera Healthcare	The MCO does not receive access to the PDMP in their State, access is limited to dispensing pharmacists and prescriber's.
NY	VNSNY CHOICE SelectHealth	SelectHealth from VNS Health does not have access to database.
OR	Advanced Health	Advanced Health does not have access to query the State's PDMP database.

State	MCO Name	Explanation
OR	Cascade Health Alliance	Access to the PDMPM was not needed as clinical decisions are based on documented medical necessity. Furthermore, all pharmacies are expected to review the database prior to dispensing a controlled substance.
OR	Columbia Pacific CCO	We understand medical directors have direct access, but that it is not available for usual CCO business or reviews.
OR	Eastern Oregon Coordinated Care Organization (EOCCO)	EOCCO currently did not have access to query the Oregon PDMP.
OR	Health Share of Oregon-CareOregon RAE	We understand medical directors have direct access, but that it is not available for usual CCO business or reviews.
OR	Health Share of Oregon - Legacy Health/PacificSource	Oregon PDMP does not allow MCO organizations to query at this time.
OR	InterCommunity Health Network	We understand medical directors and pharmacy directors have direct access, but that it is not available for usual CCO business or reviews.
OR	Jackson Care Connect	We understand medical directors have direct access, but that it is not available for usual CCO business or reviews.
OR	PacificSource Community Solutions- Central Oregon	Oregon PDMP does not allow MCO organizations to query at this time.
OR	PacificSource Community Solutions- Columbia Gorge	Oregon PDMP does not allow MCO organizations to query at this time.
OR	PacificSource Community Solutions - Lane	Oregon PDMP does not allow MCO organizations to query at this time.
OR	PacificSource Community Solutions - Marion/Polk	Oregon PDMP does not allow MCO organizations to query at this time.
OR	Providence / Health Share of Oregon	For FFY 2022 PDMP data is not available to MCO in Oregon
OR	Trillium Community Health Plan - North	Per the Oregon Health Authority Healthcare providers and their authorized staff can access the system, but only for information regarding their own patients. Pharmacists and their authorized staff can access the system, but only for information regarding their own customers. MCO's are not permitted access.
OR	Trillium Community Health Plan - South	Per the Oregon Health Authority Healthcare providers and their authorized staff can access the system, but only for information regarding their own patients. Pharmacists and their authorized staff can access the system, but only for information regarding their own customers. MCO's are not permitted access.
OR	Umpqua Health Alliance (UHA)	UHA does not currently have access in place to query the State's PDMP database.
OR	Yamhill Community Care Organization	For FFY 2022 PDMP data is not available to MCO in Oregon
PA	Health Partners	HPP did not have access to PDMP during this reporting period. HPP has obtained access as of April 2023
PA	Highmark Wholecare	Highmark Wholecare is currently working with the Pennsylvania Department of Health to gain access to the Pennsylvania PDMP for select pharmacy personnel and medical directors. All necessary documentation has been submitted and we are awaiting access.

State	MCO Name	Explanation
PA	United Healthcare	At this time, administrators in UnitedHealthcare Community Plan do not have access, but credentialed users have access to the PDMP.
PA	Vista	MCO is in the process of securing access to the PDMP
RI	NHPRI	Neighborhood Health Plan of Rhode Island Pharmacy Department does not have access to the PDMP database.
RI	THP	Rhode Island does not permit MCOs to access the PDMP database, so the MCO cannot use PDMP information in its FWA investigations.
RI	UHCCP	MCO's do not have access to query the State's PDMP database.
SC	Absolute Total Care	The MCO does not have access to the PDMP.
SC	Healthy Blue South Carolina	We do not have the ability to query the State's PDMP database.
SC	Humana	It is a SC law that pharmacists and prescriber's have access to the system for controlled substance prescribing.
SC	Molina Healthcare	State guideline around patient privacy and access to records require a direct patient care relationship in order to access the PDMP.
SC	Select Health of South Carolina, Inc.	MCO's are not permitted to request PDMP reports.
TX	Aetna Better Health of Texas	Texas law does not allow the Texas Medicaid program to access the PDMP at this time.
TX	Amerigroup	Texas law does not allow the Texas Medicaid program to access the PDMP at this time.
TX	Blue Cross and Blue Shield of Texas	Texas law does not allow the Texas Medicaid program to access the PDMP at this time.
TX	Community First Health Plans	Texas law does not allow the Texas Medicaid program to access the PDMP at this time.
TX	Community Health Choice	Community Health Choice does not have access to the State's PDMP database
TX	Cook Children's Health Plan	Texas law does not allow the Texas Medicaid program to access the PDMP at this time.
TX	Dell Children's Health Plan	Texas law does not allow the Texas Medicaid program to access the PDMP at this time. The PMP collects and monitors prescription data for all Schedule II, III, IV and V controlled substances dispensed by a pharmacy in Texas or to a Texas resident from a pharmacy located in another State. The PMP database is only available to statutorily authorized persons (practitioners and pharmacists), to protect patient privacy.
TX	Driscoll Health Plan	Texas law does not allow the Texas Medicaid program to access the PDMP at this time.
TX	El Paso Health	Texas law does not allow the Texas Medicaid program to access the PDMP at this time.
TX	FirstCare Health Plans	Texas law does not allow the Texas Medicaid program to access the PDMP at this time.
TX	Molina Healthcare of Texas	Texas law does not allow the Texas Medicaid program to access the PDMP at this time.

State	MCO Name	Explanation
TX	Parkland Community Health Plan	Texas law does not allow the Texas Medicaid program to access the PDMP at this time.
TX	Scott and White Health Plan	Texas law does not allow the Texas Medicaid program to access the PDMP at this time.
TX	Texas Children's Health Plan	Texas law does not allow the Texas Medicaid program to access the PDMP at this time.
TX	UnitedHealthcare Community Plan	Texas law does not allow the Texas Medicaid program to access the PDMP at this time.
VA	MolinaCompleteCareofVirginia	Molina follows State regulations around privacy and requirements for direct member care providers to leverage PDMP databases.

b. If "Yes," please explain how your MCO program applies this information to control FWA of controlled substances.

Please reference individual State MCO reports on Medicaid.gov for more information.

c. If "Yes," does your MCO have access to contiguous States' PDMP Information?

Figure 72 - MCO Access to Contiguous States' PDMP Information

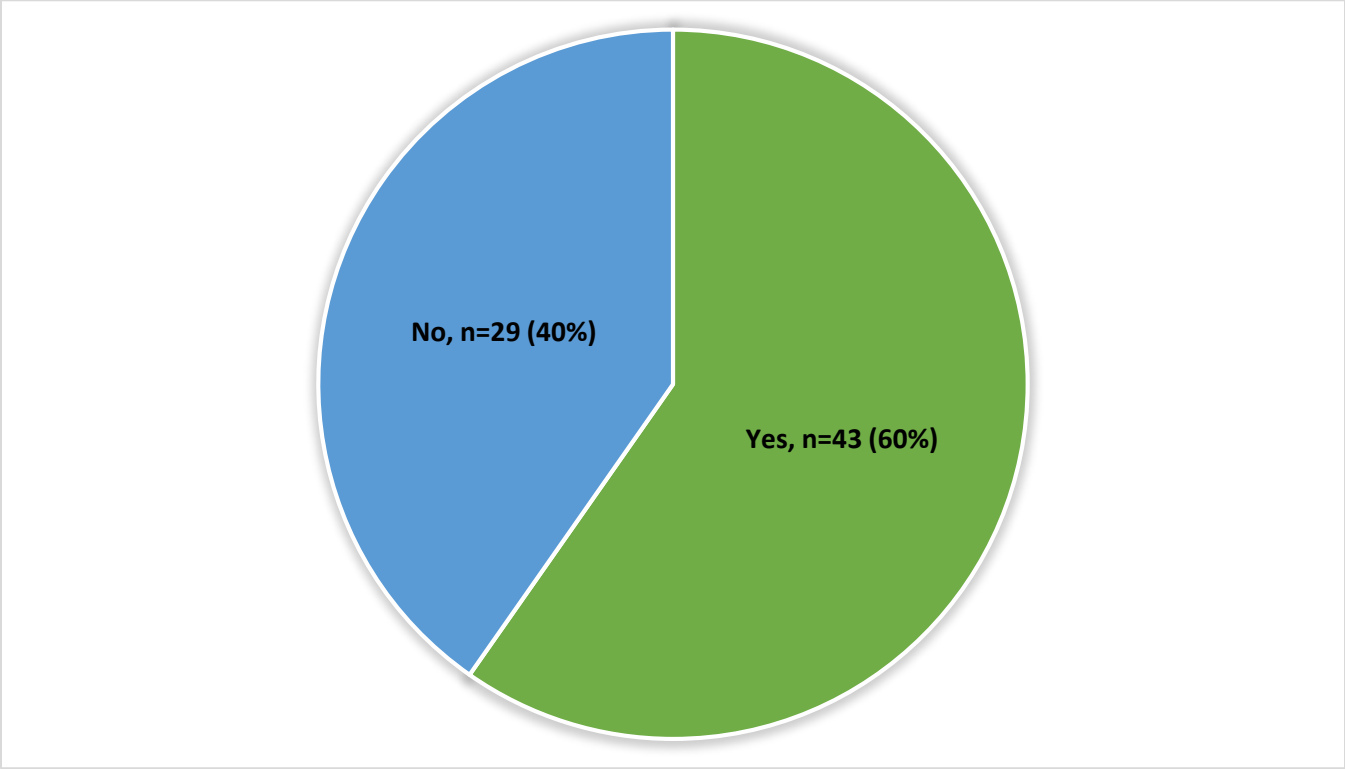

Table 74 - MCO Access to Border States' PDMP Information

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (1), District of Columbia (4), Florida (1), Georgia (1), Hawaii (1), Illinois (2), Indiana (5), Kansas (3), Kentucky (2), Michigan (3), Mississippi (1), New Mexico (3), Ohio (5), Oregon (3), Texas (1), Utah (3), Virginia (1), Washington (3)	43	59.72%
No	Arkansas (3), Florida (1), Michigan (3), Minnesota (8), Nebraska (2), Oregon (1), Pennsylvania (4), Utah (1), Virginia (4), Washington (2)	29	40.28%

Response	States (Count of MCOs)	Count	Percentage
National Totals		**72**	**100%**

d. If "Yes," does your MCO also have PDMP data integrated into your POS edits?

Figure 73 - MCO Has PDMP Data Integrated into POS Edits

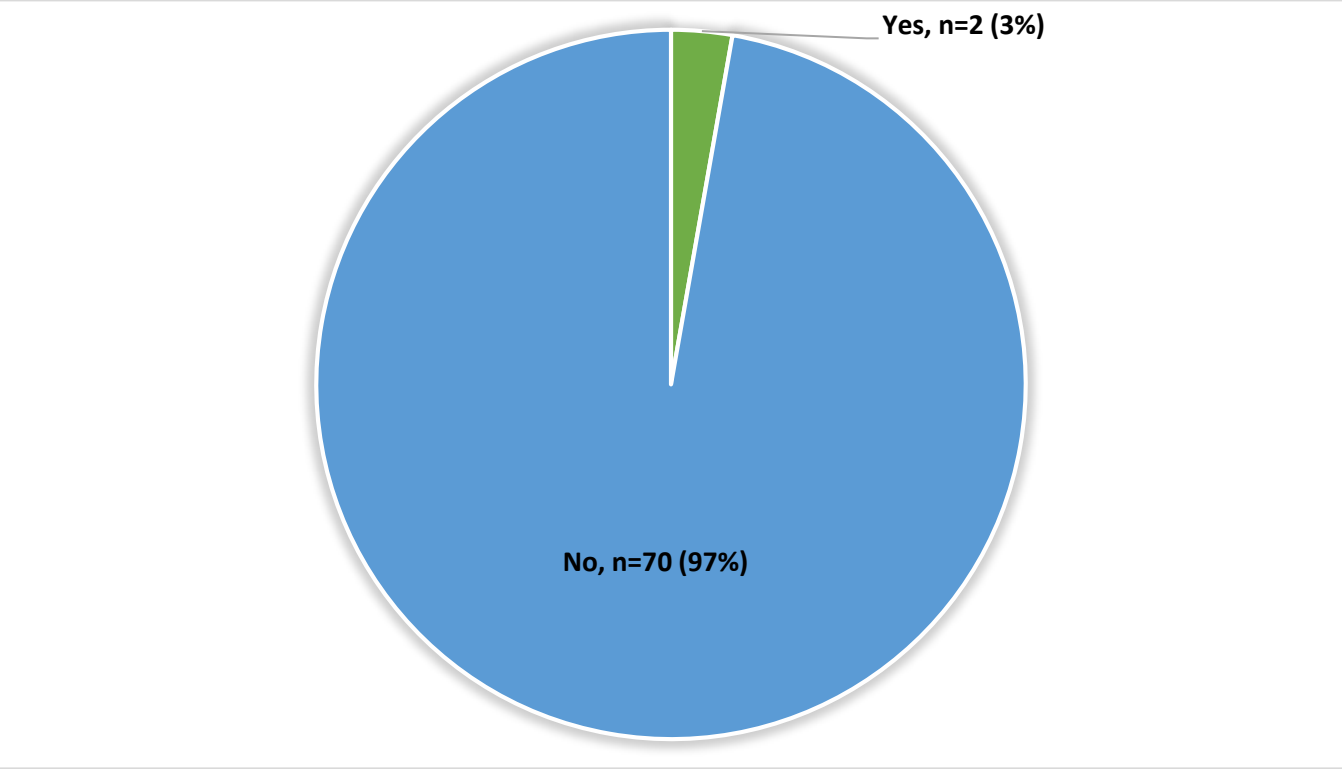

Table 75 - MCO Has PDMP Data Integrated into POS Edits

Response	States (Count of MCOs)	Count	Percentage
Yes	Florida (1), Indiana (1)	2	2.78%
No	Arkansas (4), District of Columbia (4), Florida (1), Georgia (1), Hawaii (1), Illinois (2), Indiana (4), Kansas (3), Kentucky (2), Michigan (6), Minnesota (8), Mississippi (1), Nebraska (2), New Mexico (3), Ohio (5), Oregon (4), Pennsylvania (4), Texas (1), Utah (4), Virginia (5), Washington (5)	70	97.22%
National Totals		**72**	**100%**

2. Have you communicated to prescribers who are covered providers that as of October 1, 2021, they are required to check the PDMP before prescribing controlled substances to beneficiaries who are covered individuals?

Figure 74 - Communicated that Prescribers are Required to Access the PDMP Patient History Before Prescribing Controlled Substances

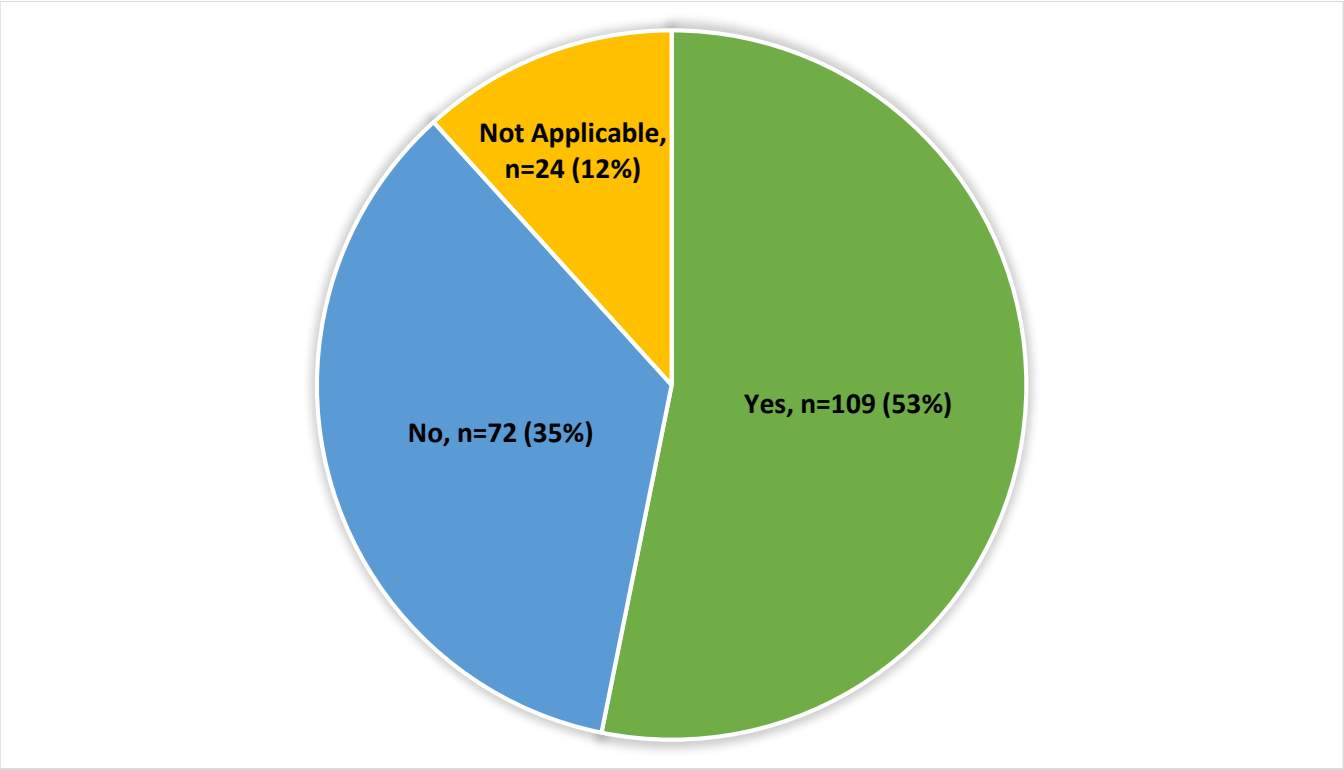

Table 76 - Communicated that Prescribers are Required to Access the PDMP Patient History Before Prescribing Controlled Substances

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (1), Colorado (2), Delaware (2), District of Columbia (4), Florida (6), Georgia (1), Hawaii (4), Illinois (2), Indiana (1), Iowa (2), Kansas (3), Kentucky (1), Louisiana (2), Maryland (7), Massachusetts (2), Michigan (3), Minnesota (3), Mississippi (2), Nebraska (3), New Hampshire (2), New Jersey (1), New Mexico (1), New York (2), North Carolina (2), Ohio (3), Oregon (21), Pennsylvania (6), Rhode Island (1), South Carolina (2), Texas (7), Utah (2), Virginia (3), Washington (5)	109	53.17%
No	Arkansas (1), Florida (4), Georgia (1), Hawaii (2), Illinois (4), Indiana (2), Kentucky (4), Louisiana (2), Maryland (1), Massachusetts (2), Michigan (6), Minnesota (5), Mississippi (1), Nevada (4), New Hampshire (1), New Jersey (2), New Mexico (2), New York (8), North Carolina (2), Ohio (1), Pennsylvania (2), Rhode Island (2), South Carolina (2), Texas (7), Utah (2), Virginia (2)	72	35.12%

Not Applicable	Arkansas (2), Florida (1), Georgia (1), Indiana (2), Kentucky (1), Louisiana (1), Maryland (1), Massachusetts (1), Minnesota (1), New Jersey (2), New York (5), North Carolina (1), Ohio (1), South Carolina (1), Texas (2), Virginia (1)	24	11.71%
National Totals		**205**	**100%**

If "Yes," check all that apply.

Figure 75 - Ways MCO Has Communicated Requirement

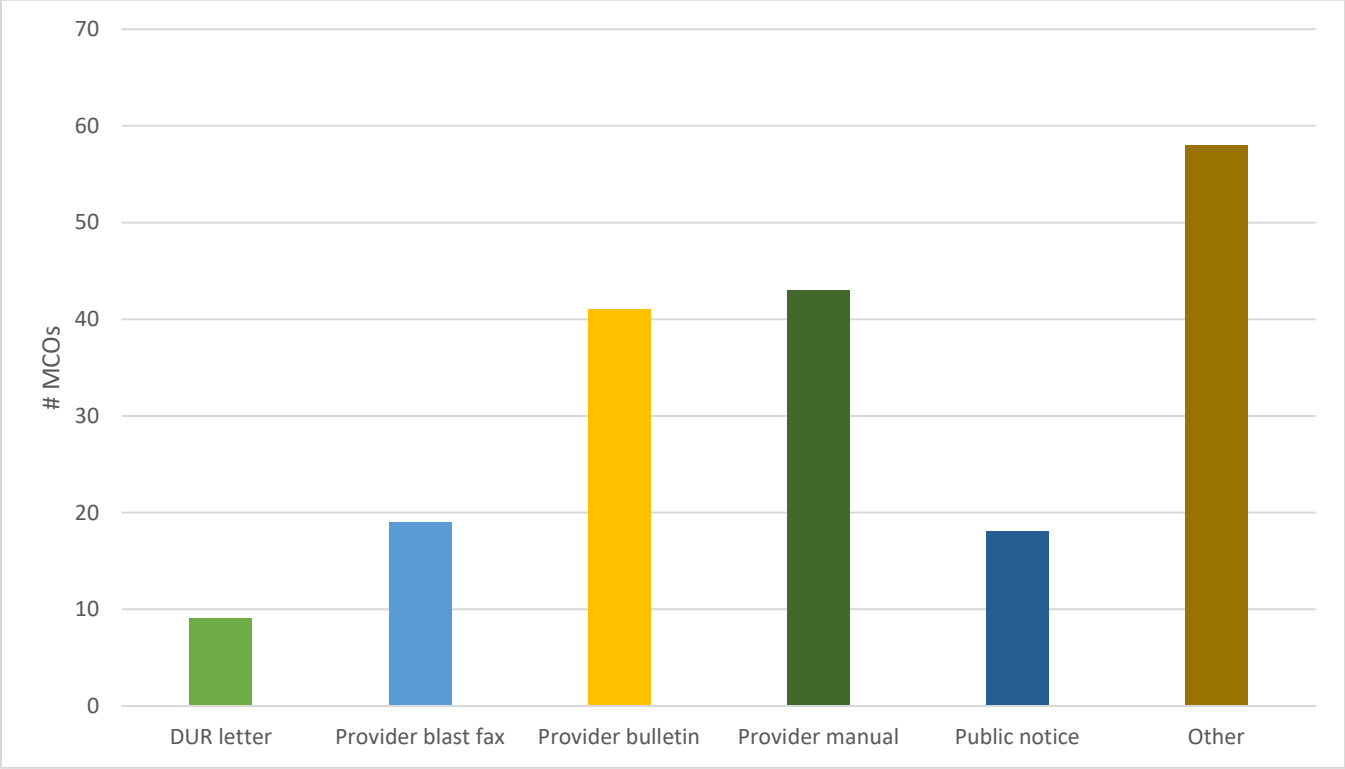

Table 77 - Ways MCO Has Communicated Requirement

Response	States	Count	Percentage
DUR letter	District of Columbia (1), Georgia (1), Louisiana (1), Maryland (1), New Jersey (1), Pennsylvania (1), Virginia (1), Washington (2)	9	4.79%
Provider blast fax	District of Columbia (3), Florida (1), Georgia (1), Hawaii (1), Kentucky (1), Louisiana (1), Maryland (1), Michigan (1), New York (1), Oregon (2), South Carolina (1), Texas (1), Washington (4)	19	10.11%
Provider bulletin	Delaware (1), District of Columbia (2), Florida (1), Hawaii (2), Illinois (1), Indiana (1), Iowa (2), Kansas (3), Kentucky (1), Louisiana (1), Maryland (2), Michigan (3), Mississippi (2), Nebraska (3), New Jersey (1), Ohio (1), Oregon (5), Pennsylvania (2), South Carolina (1), Texas (1), Virginia (1), Washington (4)	41	21.81%
Provider manual	Colorado (2), District of Columbia (2), Florida (1), Hawaii (2), Indiana (1), Louisiana (2), Maryland (5), Michigan (2), Minnesota (3), Nebraska (1), New Hampshire (2), New Mexico (1), New York (2), Ohio (1), Oregon (6), Pennsylvania (1), Texas (3), Virginia (2), Washington (4)	43	22.87%

Response	States	Count	Percentage
Public notice	Colorado (2), District of Columbia (1), Florida (1), Iowa (2), Louisiana (2), Maryland (1), Minnesota (1), Nebraska (1), Oregon (1), Rhode Island (1), Texas (1), Washington (4)	18	9.57%
Other	Arkansas (1), Delaware (2), District of Columbia (3), Florida (3), Illinois (1), Iowa (2), Kansas (1), Maryland (3), Massachusetts (2), Mississippi (1), Nebraska (1), New Hampshire (1), New York (1), North Carolina (2), Ohio (2), Oregon (13), Pennsylvania (5), Rhode Island (1), South Carolina (1), Texas (3), Utah (2), Virginia (2), Washington (5)	58	30.85%
National Totals		**188**	**100%**

If “Other,” please explain.

Table 78 - "Other" Ways MCO Has Communicated Requirement

State	MCO Name	Explanation
AR	Arkansas_Total_Care_Inc.	While we did not create specific communication to prescribers prior to the October 1, 2021 date, we did rely on a number of other communications such as 1) Arkansas Code Â§ 20-7-604, 2) Arkansas State Medical Board Arkansas Medical Practice Act Statutes and 3) Arkansas Health Department Rules Pertaining to Arkansas Prescription Drug Monitoring Program. We have subsequently added links to our Opioid Resources page for these documents as well as the link to the Social Security Act Section Â§1944.
DC	CareFirst BCBS Community Health Plan DC	Provider forum
DC	HealthServicesforSpecial NeedsChildren	Notification to providers was made by email blast, website, and provider manual.
DC	MedStar Family Choice - District of Columbia	Prescribers must attest to checking the PDMP when prescribing opioid medications and acknowledge this as a part of completing the Opioid Prior Authorization request form. Pharmacy and Formulary Information available for providers on the MFC-DC website also includes details about this requirement on the Opioid Prior Authorization Requirements page.
DE	AmeriHealth Caritas Delaware	Our prior authorization form for opiates details that the PDMP must be checked prior to prescribing controlled substances. On audits of provider records, one of the items the prescribers are graded on is documentation of checking the PDMP when prescribing controlled substances.
DE	HighmarkHealthOptions	Criteria as part of the Opioid prior authorization requirement States: The prescribing provider, or the prescribing provider's delegate, confirms they have reviewed the Delaware Prescription Monitoring Program (DPMP) database for the member's controlled substance prescription history.
FL	Aetna Better Health	Some of the State PA criteria (e.g., the Opioid PA form) asks prescribers if they have reviewed the PDMP prior to prescribing the medication as required by FL statute. If the prescriber says "no," the form asks them to explain why.
FL	Children's Medical Services	The requirement is a part of the prior authorization form for opioids.
FL	Sunshine	The requirement is a part of the prior authorization form for opioids.
IA	Amerigroup	Administrative Rule Change
IA	Iowa Total Care	Administrative rule change

State	MCO Name	Explanation
IL	Aetna_Better_Health_of_Illinois	The requirement for prescribers to check the PDMP for the name, location, and contact information, or other identifying number, such as a national provider identifier, for previous beneficiary fills is documented and communicated to providers via Aetna's opioid guideline. The guideline is published on Aetna's website.
KS	Sunflower Health Plan	Information was also shared in MCO Provider Training.
MA	Boston Medical Center Health Plan, Inc	Guidance is provided on the Plan's website.
MA	Fallon Community Health Plan, Inc.	Our provider contracts require compliance with all State regulations. This would include Massachusetts State law requiring prescribers to access the PDMP
MD	Aetna Better Health of Maryland	Prior authorization criteria for opioids: Member who is being discharged from the hospital or Emergency Room (ER), acute care inpatient Hospital (Hospital), Ambulatory Surgery Center (ASC), prescribers must meet following requirements: ï¿½ Prescriber has reviewed controlled substance prescriptions in a Prescription Drug monitoring program (e.g. CRISP- Chesapeake Regional Information System) Member who are receiving opioid treatment for ongoing care must meet following requirements (i.e., requests by an outpatient provider): ï¿½ Prescriber has reviewed controlled substance prescriptions in a Prescription Drug monitoring program (e.g. CRISP- Chesapeake Regional Information System)
MD	Kaiser Foundation Health Plan of the Mid-Atlantic States	Kaiser Permanente's prescribers follow State of MD requirements for checking PDMP. Providers are educated as part of their provider orientation, at Yearly Pain Summit CME, and "Lunch and Learn" meetings that PDMP must be checked. The requirement for checking PDMP is part of the training for opioid prescribing. An attestation for checking PDMP is required as part of the Prior Authorization clinical criteria when prescribing opioids for Health Choice Members.
MD	MedStar Family Choice	Prescribers must attest to checking the PDMP when prescribing opioid medications and acknowledge this as a part of completing the Opioid Prior Authorization request form. Pharmacy and Formulary Information available for providers on the MFC-MD website also includes details about this requirement on the Opioid Prior Authorization Requirements page.
MS	MS-MAGNOLIA	This information is included as a provider attestation section of our opioid prior authorization form.
NC	AMHC FFY22	AMHC is required to follow NCDHB policy and clinical criteria for controlled substances. Checking the PDMP is required per NCDHB policy and the NC STOP Act.
NC	CCH FFY22	Clinical Policy regarding Opiod Analgesics Prior Approval Requests States the requirement for the prescribing clinician to check the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System.
NE	Nebraska Total Care	Provider website and quarterly meetings with value-based contract partners.
NH	AmeriHealth Caritas NH	Prior Authorization Criteria Document
NY	MetroPlus Health Plan	Provider facing webpage
OH	Molina Healthcare of Ohio	OARRS registration and State PDL provides guidance regarding requirements.

State	MCO Name	Explanation
OH	Paramount	There was communication about the changes pertaining to opioids that went out to providers. However, due to changes in personnel secondary to losing the Medicaid line of business, we were unable to track down the exact communication piece(s) in time to meet the DUR deadline.
OR	Cascade Health Alliance	The information is communicated in CHA's Guidelines which is posted on our website.
OR	Eastern Oregon Coordinated Care Organization (EOCCO)	Provider contract.
OR	Health Share of Oregon/Kaiser Permanente	We have a built in "pop up" alert in Epic when a controlled substance is prescribed. It asks prescribers whether they have checked Oregon PDMP before proceeding with authorization of new or renewing controlled substance prescriptions.
OR	Health Share of Oregon - Legacy Health/PacificSource	Updated contracting
OR	Health Share of Oregon - OHSU	Providers are educated on this requirement via the OHSU Health IDS Opioid Utilization Policy and provider forums.
OR	PacificSource Community Solutions- Central Oregon	Updated contracting
OR	PacificSource Community Solutions- Columbia Gorge	Updated contracting
OR	PacificSource Community Solutions/Kaiser Permanente	We have a built in "pop up" alert in Epic when a controlled substance is prescribed. It asks prescribers whether they have checked Oregon PDMP before proceeding with authorization of new or renewing controlled substance prescriptions.
OR	PacificSource Community Solutions - Lane	Updated contracting
OR	PacificSource Community Solutions - Marion/Polk	Updated contracting
OR	Providence / Health Share of Oregon	Provider contracts: Providers agree to comply with all applicable State and/or federal laws and regulations.
OR	Umpqua Health Alliance (UHA)	The requirement for providers to check the PDMP is included in OAR 410-141-3885(15) and in Oregon's general provider enrollment rule. For controlled substances that require a prior authorization, the prescriber must attest that they checked the PDMP or submit documentation showing this review was completed.
OR	Yamhill Community Care Organization	Provider contracts: Providers agree to comply with all applicable State and/or federal laws and regulations.
PA	Aetna Better Health of Pennsylvania	Prior authorization requirements
PA	Health Partners	part of the prior authorization process for opioids.
PA	Highmark Wholecare	Prior authorization criteria for opioids and other controlled substances outlines the requirement for checking the PDMP prior to prescribing.
PA	PA Health and Wellness	PHW prior authorization policies for opioids and certain controlled substances requires a provider to review PDMP history as part of criteria.
PA	UPMC	Prior authorization criteria requirement in controlled substances policies.

State	MCO Name	Explanation
RI	NHPRI	Neighborhood requires prescribers to access the PDMP patient history before initially prescribing opioids and every three months thereafter. This is in alignment with the State of Rhode Islands' controlled substances prescribing requirements.
SC	Select Health of South Carolina, Inc.	Quarterly provider education sessions.
TX	Dell Children's Health Plan	Education was included on the Dell Children's Health Plan provider website.
TX	FirstCare Health Plans	Quarterly provider advisory group webinars
TX	Scott and White Health Plan	Quarterly provider advisory group webinars
UT	Healthy U	PA criteria on website that pre-dates October 2021 and denial letters back to 2017. Prescribers know our criteria.
UT	Steward Health Choice Utah	'- Prior authorization criteria on our website. - Prior authorization response letters outline criteria that has not been met for opioid coverage, including the requirement to check the PDMP if applicable.
VA	MolinaCompleteCareofVirginia	Requirements to check the PDMP are included on respective prior authorization forms (e.g., Opiates, Oral Buprenorphine, CNS Stimulants, Methadone). Requirements are also posted in Chapter 25.2 of Title 54.1 of the Code of Virginia Prescription Monitoring Program and by the Virginia Board of Medicine.
VA	VirginiaPremier	Virginia Premier, through its prior authorization process, notifies providers they must review the member's PDMP prior to dispensing controlled substances.
WA	Amerigroup Washington Inc.	HCA held stakeholder conferences.
WA	Community Health Plan of Washington	WAC 246-919-985 explains the Washington Prescription monitoring programï¿½Requires physicians to perform a PMP query to prescribe controlled substances.
WA	Coordinated Care Corporation	Various methods of communication were used prior to 10/2/21 to inform prescribers of the requirement to check with PDMP. This included conferences with external stakeholders, and forms of written communication including faxes, website updates, and updates to the provider manual.
WA	Molina Healthcare of Washington, Inc.	Conferences with Stakeholders
WA	UnitedHealthcare Community Plan	Stakeholder conferences

If “Not applicable”, please explain.

Table 79 - "Not Applicable" Explanations for Communicating to Prescribers they are Required to Access the PDMP Patient History Before Prescribing Controlled Substances

State	MCO Name	Explanation
AR	CareSource	Prescribers are already aware of this requirement.
AR	Empower_HealthCare_Solutions_LLC	The Arkansas Prescription Drug Monitoring Program (PDMP) requires that the prescribers check the PDMP before prescribing a new prescription for an opiate and every additional time an opiate is prescribed. The Arkansas State medical board monitors compliance. Therefore, outliers would be identified during the credentialing process.
FL	Amerihealth Caritas Florida	AmeriHealth Caritas FL (ACFL) does not mandate in its provider agreement that providers access the PDMP as this is a requirement of Florida's EFORSCE

State	MCO Name	Explanation
		program which indicates "A prescriber or his or her designee must consult the PDMP to review their patient's controlled substance dispensing history prior to prescribing a controlled substance in Schedules II-V, as defined in section 893.03, F.S., for patients age 16 and older." However, ACFL's provider agreements do require providers to follow State and federal laws, which include section 893.03, F.S
GA	CareSource	Prescribers are already aware of this requirement.
IN	Anthem, Inc.	Our contract does not require the PDMP check, but rather the law that requires such.
IN	UnitedHealthcare Community Plan, Inc.	Indiana SEA 221 requires all practitioners who prescribe controlled substances to be registered and search INSPECT (Indiana's PDMP) to see a patient's prescription history prior to prescribing an opioid or benzodiazepine as of January 2021.
KY	Aetna Better Health of Kentucky	Did not have access to the Database
LA	Aetna Better Health of Louisiana	This is communicated by the LA Board of Pharmacy and when a member requires a prior authorization for a control substance.
MA	AllWays Health Partners	Health Plans do not have access to State PDMP
MD	Amerigroup Community Care	State Law requires Prescribers to check PDMP prior to prescribing controlled substances.
MN	UnitedHealthcare	Minnesota Statutes Sect. 152.126 subd. 6(d) reads in part... a prescriber or an agent or employee of the prescriber to whom the prescriber has delegated the task of accessing the data, must access the ...MN PMP database... to the extent the information relates specifically to the patient: (1) before the prescriber issues an initial prescription order for a Schedules II through IV opiate controlled substance to the patient; and (2) at least once every three months for patients receiving an opiate for treatment of chronic pain or participating in medically assisted treatment for an opioid addiction.
NC	HB FFY22	Mandated by the NC Stop Act, professional boards of practice (medical, pharmacy), and required per the FFS clinical criteria for Opioid Analgesics.
NJ	Aetna Better Health of New Jersey	The MCOs does not have the ablilty to monitor this system
NJ	Wellcare health plans	We require providers to follow all local, State and federal laws governing their practice.
NY	AMIDA CARE	At this time Managed Care plans do not have access to query NY State's Prescription Monitoring Program (PMP).
NY	Excellus Health Plan	The NY State PDMP requirements have been in place since 2013.
NY	Healthfirst	NY State has required most State-registered prescribers to consult the PMP registry when writing prescriptions for Schedule II, III, and IV controlled substances since August 27, 2013. Healthfirst would not have communicated this separately in 2021 as it was not a change to current process at that point.
NY	Independent Health	New York has had the requirement to check the PDMP prior to 2021 and education has been sent reminding prescribers of the New York requirement to check the PDMP.
NY	Univera Healthcare	The NY State PDMP requirements have been in place since 2013
OH	CareSource	Prescribers are already aware of this requirement per State law. This requirement is noted on the Ohio UPDL.

State	MCO Name	Explanation
SC	Healthy Blue South Carolina	In certain circumstances, prescribers are required by their professional board to check the PDMP prior to issuing prescriptions for controlled substances. Additionally, for both short acing and long acting opioids, our prior authorization criteria includes that prescribers check the PDMP - if available.
TX	Blue Cross and Blue Shield of Texas	Prescribers need to use their best clinical judgement to check the PDMP. It is up to the prescriber how to implement a process to check PDMP.
TX	Community Health Choice	Prescribers are required to monitor and follow changes to regulations applicable to their scope of practice as required by their respective licensing boards
VA	AetnaBetterHealthofVirginia	There has been prior work done to advocate for checking the PMP prior to prescribing which included said need when writing opioids, MAT, or stimulants for adults, however no formal work has been done around this area at the plan based on the specified date above.

If “No,” please explain.

Table 80 - "No" Explanations for Communicating to Prescribers they are Required to Access the PDMP Patient History Before Prescribing Controlled Substances

State	MCO Name	Explanation
AR	Summit_Community_Care	The MCO has not communicated this to prescribers. Prescribers are expected to follow State and Federal regulations.
FL	Clear Health Alliance	The DOH requires each prescriber and dispenser or his or her designee has a duty to consult the PDMP system to review a patient's controlled substance dispensing history each time a controlled substance is prescribed or dispensed to a patient age 16 or older unless a statutory exemption applies. The prior authorization criteria for opiates requires that the prescriber check the PDMP, and asks for an explanation why the PDMP wasn't reviewed.
FL	Community Care Plan	CCP did not reach out to prescribers because this practice is part of the prescribers DEA licensure responsibilities. The PDMP questions noted in the previous survey FFY 2021 did not address provider notification as a required activity. CCP 's providers operation team will notify providers moving forward.
FL	Molina Healthcare	Molina relies on language within the prior authorization criteria set for short and long acting opioids that requires prescribers to review the PDMP prior to prescribing. The criteria set is what the Health Plan utilization management pharmacists use to review cases. If prescriber does not complete this step, it may be grounds for prior authorization to be denied.
FL	Simply Healthcare	The DOH requires each prescriber and dispenser or his or her designee has a duty to consult the PDMP system to review a patient's controlled substance dispensing history each time a controlled substance is prescribed or dispensed to a patient aged 16 or older unless a statutory exemption applies. The prior authorization criteria for opioids requires prescribers to check the PDMP and asks for an explanation why the PDMP wasn't reviewed.
GA	Amerigroup GA	As of July 1, 2018, prescribers are required by the State of Georgia to check PDMP before prescribing a schedule II opioid or any benzodiazepines.
HI	HMSAQI	As of July 1, 2018, HRS 329-38 already required prescribers in Hawaii to request, receive, and consider dispensation records within the State's PDMP before prescribing a Schedule II, III, or IV controlled substance.
HI	UnitedHealthcare	UnitedHealthcare's Provider website contains information on the value and importance of reviewing a patient's profile via the PDMP. Clinicians are advised

State	MCO Name	Explanation
		to review and utilize the PDMP data to assess for concurrent substance use that may put patients at higher risk for opioid use disorder and overdose. The OptumRx Professional Website also acknowledges that PDMP data should be reviewed before every opioid prescription is issued. Clinicians should also review the PDMP to verify if patients are receiving opioids and other controlled medications from other prescribers to determine if combinations and total opioid dosages put the patient at risk for overdose. Our provider agreements require compliance with all State and federal laws in Hawaii, including the checking of the PDMP before prescribing any controlled substance.
IL	Blue_Cross_and_Blue_Shield_of_Illinois	Requirements for PDMP are regulated by the State of Illinois. BCBSIL requires prescribers to follow the Illinois Controlled Substance Act.
IL	MeridianHealth	The MCO requires prescribers to follow the Illinois Controlled Substance Act.
IL	Molina_Healthcare_of_Illinois,_Inc	State law dictates this for providers. Provider must comply with all applicable laws (including any implementing regulations in performing its Pharmacy Services under the Provider Agreement).
IL	YouthCare_HealthChoice	Requirements for PDMP are regulated by the State of Illinois. The MCO requires prescribers to follow the Illinois Controlled Substance Act.
IN	CareSource	Prescribers are already aware of this requirement due to State law (SEA 221).
IN	MDwise, Inc.	It is a State law that prescribers are required to check the PDMP before prescribing controlled substances.
KY	Anthem Inc. Kentucky	State Law requires prescribers to check PDMP prior to prescribing controlled substances.
KY	Passport Health Plan By Molina Healthcare	Providers must comply with all laws and implement any regulation under the Provider Agreement
KY	United Healthcare Community Plan of Kentucky	UnitedHealthcare Community Plan of KY does not include language in the provider agreements specifically related to checking the PDMP before prescribing controlled substances. However, provider agreements do contain language requiring compliance with all State and federal laws which in the State of KY includes the checking of the PDMP before prescribing of controlled substances.
KY	WellCare Health Plans	Providers are required to check PDMP before prescribing controlled substances as outlined in PA criteria and best practice for these medications for these medications. The State is responsible for creating and maintaining PA criteria, not the MCO
LA	AmeriHealth Caritas Louisiana	State law requires prescribers to check the PDMP before prescribing controlled substances.
LA	Healthy Blue Louisiana	We defer to applicable prescriber professional board. MCO does not dictate prescriber requirement to check PDMP before prescribing controlled substances. State also does not provide MCO access to PDMP database. Current law requires prescribers to access and review patients' records in the PMP database prior to initially writing prescription for opioids in certain circumstances
MA	Health New England, Inc.	The MCO did not communicate this to covered providers because it is required by the State of Massachusetts

State	MCO Name	Explanation
MA	Tufts Health Public Plans, Inc	The Plan has not sent a communication to providers, however, plan provider agreements require providers to comply with State law and all conditions of licensure, including Commonwealth of Massachusetts Board of Registration in Medicine Prescribing Practices, Policies and Guidelines Part II.5 .
MD	Jai Medical Systems Managed Care Organization, Inc.	The MCO requires prescribers to follow State and federal law. State law requires prescribers to request and assess PDMP data: 1. Before beginning a new course of treatment with an opioid or benzodiazepine. 2. When a course of treatment with an opioid or benzodiazepine extends beyond 90 days. In this case, prescribers must query again at least every 90 days thereafter before prescribing or dispensing the opioid or benzodiazepine. 3. Prescribers must view at least the last 4 months of data (This will always be available within a PDMP data view.) 4. A prescriber delegate may pull the PDMP data, but the prescriber remains responsible for assessing the data prior to making a prescribing decision.
MI	Aetna Better Health of Michigan	Aetna is currently exploring posting PDMP information and links to applicable State laws detailing best prescribing practices.
MI	McLaren Health Plan	Tyhpise i ste sxct hheedrueled to be implemented by the 2023 State required timeframe.
MI	Meridian Health Plan	The plan has not sent out any direct provider communication on checking PDMP prior to prescribing controlled substances as it's expected provider best practice. We will evaluate adding communication into our provider newsletter.
MI	Molina Healthcare of Michigan	Providers are required to check the Prescription Drug Monitoring Program (PDMP) before prescribing controlled substances to beneficiaries.
MI	Priority Health Choice	MDHHS issued MSA 21-30 Prescription Drug Monitoring Program Requirement for Providers to all providers in July 2021.
MI	Upper Peninsula Health Plan	UPHP has not done target outreach directing providers to check the PDMP before prescribing controlled substances to beneficiaries who are covered individuals.
MN	BluePlus	Blue Plus did not send out communication to prescribers as professional board(s) sent out communication to licensed prescribers notifying them of this requirement when it was added.
MN	HennepinHealth	This information has not been shared.
MN	Medica	There are currently no requirements in the Medica provider agreements in relation to requiring prescribers to query the PDMP. The provider agreements contain a requirement of general compliance with all laws section, but the PDMP is not specifically referenced.
MN	PrimeWest	The Minnesota PMP has robust communications with providers.
MN	UCare	No direct communication was provided since UCare's provider agreement does not require prescribers to access the PDMP before prescribing a controlled substance. UCare does utilize UM criteria for several controlled substances which requires provider attestation that they have reviewed the beneficiary's PDMP record before prescribing the controlled substance. If this is not satisfied, the prior authorization decision would be unfavorable.
MS	MS-UNITED	Providers are aware through their provider agreements that UnitedHealthcare Community Plan of MS requires compliance with all State and federal laws which in the State of MS includes checking the PDMP before prescribing controlled substances.
NC	UHC FFY22	UnitedHealthcare Community Plan does not include language in the provider agreements specifically related to checking the PDMP before prescribing

State	MCO Name	Explanation
		controlled substances. However, provider agreements do contain language requiring compliance with all State and federal laws which in the State of North Carolina includes the checking of the PDMP before prescribing of controlled substances.
NC	WC FFY22	The MCO expects providers to utilize the PDMP as a best practice.
NH	NH Healthy Families	NH Healthy Families has PDMP requirements built into the opioid analgesics policy requiring PDMP utilization for treatments of 100mg morphine milliequivalent or higher.
NJ	Amerigroup Community Care	Prescribers are required by the State of NJ to check PDMP before prescribing a controlled substance.
NJ	NJ United	Provider agreements contain language requiring compliance with all State and federal laws which in the State of New Jersey includes the checking of the PDMP before prescribing of controlled substances.
NM	Blue Cross Blue Shield of New Mexico	The regulatory "flow down" language in our provider contracts mirror the requirements detailed in the BCBSNM agreement with HSD (Section 4.9). This contract language was reviewed and approved by HSD per contract requirements.
NM	Western Sky Community Care	State of NM already has the requirement for prescribers to check PDMP when prescribing controlled substance medications. This is required by regulation by NM Board of Pharmacy PDMP and also by each individual licensing board (medical board, nursing board, pharmacy board, etc.) .
NV	Anthem Blue Cross Blue Shield	Under Nevada law, prescribers are required to check the PDMP patient history with every initial controlled substance prescription and every 90 days during the course of treatment.
NV	Health Plan of Nevada	Health Plan of Nevada does not include language in the provider agreements specifically related to checking the PDMP before prescribing controlled substances. However, provider agreements do contain language requiring compliance with all State and federal laws which in the State of Nevada includes the checking of the PDMP before prescribing of controlled substances.
NV	Molina	Nevada State law requires practitioners to check the PDMP patient history.
NV	Silver Summit Health Plan	Nevada State law requires the prescribing physicians obtain a patient utilization report from the prescription drug monitoring program (PDMP) before (1) initiation of a schedule II, III, or IV prescription drug for a new patient or (2) a course of treatment longer than 7 days that is part of a new course of treatment for an existing patient. Nevada State law established an additional requirement to obtain a new report at least every 90 days during extended courses or treatment.
NY	Capital District Physicians' Health Plan	CDPHP does not include a requirement to access PDMP before prescribing controlled substances. Effective August 27, 2013, practitioners in New York State are required, with limited exceptions, to check the PMP Registry prior to writing a prescription for a controlled substance in schedule II, III, and IV for a patient.
NY	EmblemHealth	No, however EmblemHealth is in progress of deploying a provider communication.
NY	Empire Blue Cross Blue Shield HealthPlus	PDMP check is not enforced through MCO or professional board provider agreement. Prescribers are expected to follow State PDMP regulations under their State licensure regulations.

State	MCO Name	Explanation
NY	Fidelis Care	Most prescribers are required to consult the Prescription Drug Monitoring Program (PDMP) Registry when writing prescriptions for most controlled substances by New York State.
NY	Highmark Blue Cross Blue Shield of Western New York	We defer to applicable prescriber professional board. MCO does not dictate prescriber requirement to check PDMP before prescribing controlled substances. State also does not provide MCO access to PDMP database.
NY	Molina Healthcare of New York	The requirement of providers to check the PDMP prior to prescribing a controlled substances has not directly been communicated to providers outside of the utilization management process, however this will be included in the next provider newsletter, website, and/or provider manual update.
NY	United HealthCare	Provider agreements do contain language requiring compliance with all State and federal laws which in the State includes the checking of the PDMP before prescribing of controlled substances. This is not a new requirement for NY. NY has had this requirement since August 27th, 2013.
NY	VNSNY CHOICE SelectHealth	Changes regarding prescribing practices are sent by the New York State Department of Health. VNS Health did not send a communication to our network prescribing providers.
OH	Buckeye Health Plan	This notification was provided by both the State Board of Pharmacy and the State Medical Board to both providers and pharmacists. This is a State law.
PA	Geisinger	Is an ongoing State requirement
PA	Vista	MCO provider agreements require prescribers to adhere to State and federal regulations. This would include the mandate in Pennsylvania for prescribers to query the Pennsylvania Prescription Drug Monitoring Program (PA PDMP): each time a patient is prescribed any controlled substance for the first time, each time a patient is prescribed an opioid or benzodiazepine, or if there is suspected abuse or diversion.
RI	THP	The Plan has not sent a communication to providers, however, plan provider agreements require providers to comply with State law and all conditions of licensure, including 216-RICR-20-20-4.
RI	UHCCP	UnitedHealthcare Community Plan does not include language in the provider agreements specifically related to checking the PDMP before prescribing controlled substances. However, provider agreements contain language requiring compliance with all State and Federal laws which in the State of RI includes the checking of the PDMP before prescribing of controlled substances (216-RICR-20-20-4.4 (E).
SC	Absolute Total Care	The South Carolina Department of Health and Human Services (SCDHHS) requires that all providers use the PDMP before prescribing any control substances class II through IV and any communications would come from SCDHHS or this program specifically.
SC	Molina Healthcare	SC State law dictates that Practitioners are required to review a patient's controlled substance prescription history and opioid antidote administration history, pursuant to Section 44-130-60 or 44-130-80, before issuing a prescription for a Schedule II controlled substance in accordance with Section

State	MCO Name	Explanation
		44-53-1645(A). Molina does provide website access to Opioid Safety Provider Education Resources that explain use of PMP resources.
TX	Aetna Better Health of Texas	Texas providers are required by State law to meet this requirement.
TX	Amerigroup	Texas providers are required by State law to meet this requirement.
TX	Cook Children's Health Plan	All providers were notified by multiples agencies and licensing boards so MCO did not send any communications.
TX	Driscoll Health Plan	Texas law requires prescribers to check the PDMP for patient's medication history before dispensing or prescribing opioids, benzodiazepines, barbiturates, or carisoprodol.
TX	El Paso Health	Texas providers are required by State law to meet this requirement.
TX	Parkland Community Health Plan	Texas law does not allow the Texas Medicaid program to access the PDMP at this time.
TX	UnitedHealthcare Community Plan	Per Texas State Board of Pharmacy website: Beginning March 1, 2020, pharmacists and prescribers are required to check the patient's PMP history before dispensing or prescribing opioids, benzodiazepines, barbiturates, or carisoprodol.
UT	Molina Healthcare of Utah	It is our understanding that it is the prescribers' responsibility to comply with Utah law and check the PDMP for our members. Molina does not receive reporting or information for which providers do or do not check the PDMP for our members.
UT	SelectHealth	Prescribers are not required by the contract to check the PDMP prior to prescribing a controlled substance. Prescribers are permitted to use their clinical judgment to make sure the prescription they are writing is appropriate for the patient.
VA	Anthem	Prescribers are expected to follow State regulations (code of Virginia).
VA	UnitedHealthCare	UnitedHealthcare Community Plan does not include language in the provider agreements specifically related to checking the PDMP before prescribing controlled substances. However, provider agreements do contain language requiring compliance with all State and federal laws which in the State of VA includes the checking of the PDMP before prescribing of controlled substances. Additionally, the prior authorization process requires the prescriber to attest to review of the PDMP as a requirement for approval.

a. Has your MCO specified protocols for prescribers checking the PDMP?

Figure 76 - Protocols Involved in Checking the PDMP

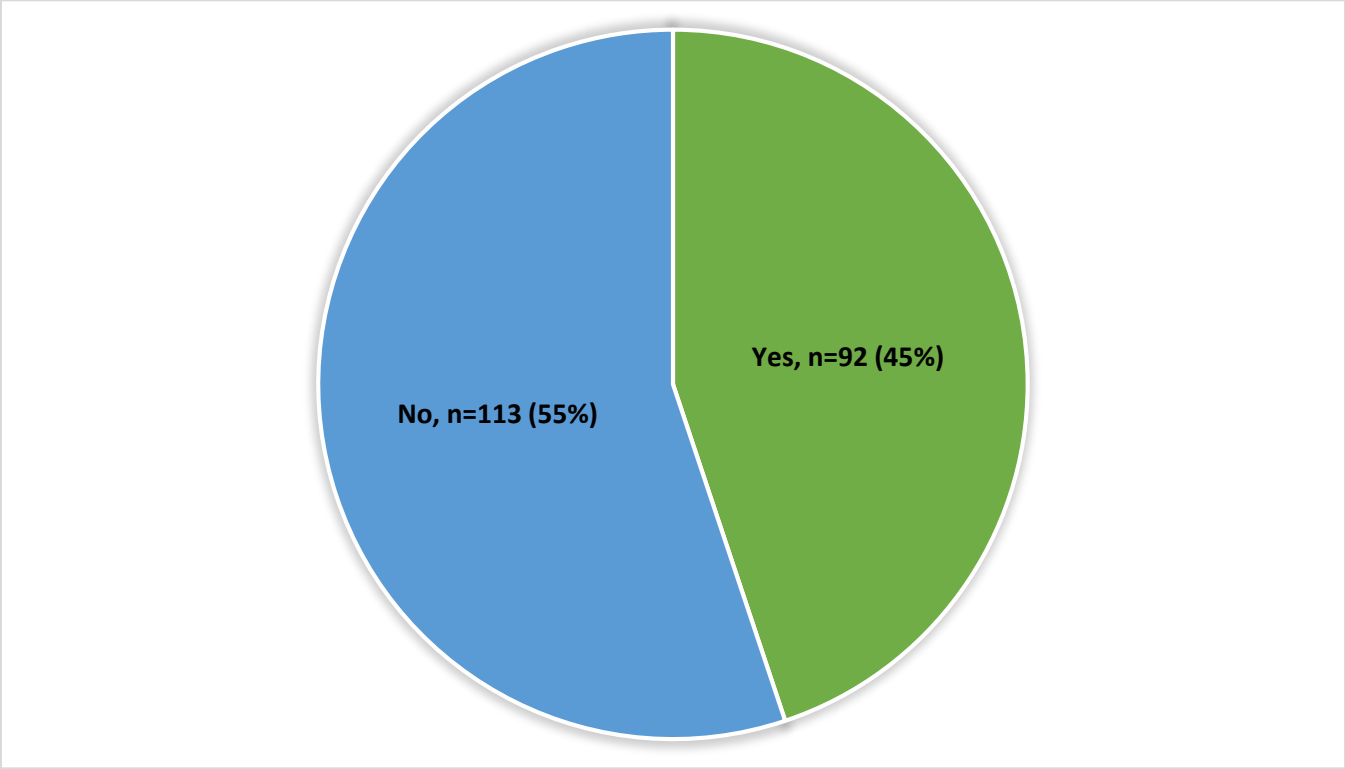

Table 81 - Protocols Involved in Checking the PDMP

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (2), Colorado (2), Delaware (2), District of Columbia (2), Florida (5), Illinois (3), Indiana (3), Iowa (2), Kansas (3), Kentucky (1), Louisiana (1), Maryland (3), Massachusetts (1), Michigan (2), Minnesota (4), Mississippi (1), Nebraska (1), Nevada (1), New Hampshire (2), New Mexico (2), New York (6), North Carolina (2), Ohio (3), Oregon (3), Pennsylvania (6), Rhode Island (3), South Carolina (2), Texas (14), Utah (2), Virginia (4), Washington (4)	92	44.88%
No	Arkansas (2), District of Columbia (2), Florida (6), Georgia (3), Hawaii (6), Illinois (3), Indiana (2), Kentucky (5), Louisiana (4), Maryland (6), Massachusetts (4), Michigan (7), Minnesota (5), Mississippi (2), Nebraska (2), Nevada (3), New Hampshire (1), New Jersey (5), New Mexico (1), New York (9), North Carolina (3), Ohio (2), Oregon (18), Pennsylvania (2), South Carolina (3), Texas (2), Utah (2), Virginia (2), Washington (1)	113	55.12%
National Totals		**205**	**100%**

If “Yes,” please explain.

Table 82 - Explanations of Protocols Involved in Checking the PDMP

State	MCO Name	Explanation
AR	Arkansas_Total_Care_Inc.	The MCO requires prescribers to follow all applicable laws. Arkansas Code Â§ 20-7-604(d) requires that:

State	MCO Name	Explanation
		(2)(A) A prescriber shall check the information in the Prescription Drug Monitoring Program when prescribing: (i) An opioid from Schedule II or Schedule III for every time prescribing the medication to a patient; and (ii) A benzodiazepine medication for the first time prescribing the medication to a patient.
AR	Empower_HealthCare_Solutions_LLC	The Arkansas State Medical Board requires providers check the PDMP before prescribing controlled substances. It must also be rechecked every time a new controlled substance is prescribed even if the patient might be a well-know regular patient
CO	Denver Health Medicaid Choice	Colorado law requires that prescribers query the PDMP prior to prescribing any opioid or benzodiazepine prescription unless the patient receiving the prescription meets specific exceptions to this requirement as defined in statute (Colorado Revised Statutes Title 12 Professions and Occupations). MCO protocols align with Department policy stating that Colorado Medicaid providers permitted to prescribe controlled substances must query the Colorado Drug Monitoring Program (PDMP) before prescribing controlled substances to Medicaid members, in accordance with Section 5042 of the "Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and the Communities Act (SUPPORT Act)". The requirement to check the PDMP does not apply when a member: Is receiving the controlled substance in a hospital, skilled nursing facility, residential facility, or correctional facility Has been diagnosed with cancer and is experiencing cancer-related pain Is undergoing palliative care or hospice care Is experiencing post-surgical pain that, because of the nature of the procedure, is expected to last more than 14 days Is receiving treatment during a natural disaster or during an incident where mass casualties have taken place Has received only a single dose to relieve pain for a single test or procedure
CO	Rocky Mountain Health Plans	Colorado law requires that prescribers query the PDMP prior to prescribing any opioid or benzodiazepine prescription unless the patient receiving the prescription meets specific exceptions to this requirement as defined in statute (Colorado Revised Statutes Title 12 Professions and Occupations). MCO protocol is in alignment with Department policy stating that Colorado Medicaid providers permitted to prescribe controlled substances must query the Colorado Drug Monitoring Program (PDMP) before prescribing controlled substances to Medicaid members, in accordance with Section 5042 of the "Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and the Communities Act (SUPPORT Act)". The requirement to check the PDMP does not apply when a member: Is receiving the controlled substance in a hospital, skilled nursing facility, residential facility, or correctional facility Has been diagnosed with cancer and is experiencing cancer-related pain Is undergoing palliative care or hospice care Is experiencing post-surgical pain that, because of the nature of the procedure, is expected to last more than 14 days Is receiving treatment during a natural disaster or during an incident where mass casualties have taken place

State	MCO Name	Explanation
		Has received only a single dose to relieve pain for a single test or procedure
DC	AmeriHealth Caritas DC	Mandatory query is now in effect in the District of Columbia. DC Law 23-251. Prescription Drug Monitoring Program Query and Omnibus Health Amendments Act of 2020 became effective on March 16, 2021. The law requires prescribers and dispensers to query the PDMP: Prior to prescribing or dispensing an opioid or benzodiazepine for more than seven consecutive days, and Every ninety days thereafter while the course of treatment or therapy continues, or Prior to dispensing another refill after ninety days.
DC	CareFirst BCBS Community Health Plan DC	DC Law requires that all providers query the PDMP before prescribing or dispensing a controlled substance
DE	AmeriHealth Caritas Delaware	The protocols for checking the PDMP are specified by the board of professional regulations and enforced the MCOs. On prior authorizations for controlled substances, providers must note that the PDMP was checked. AmeriHealth Caritas Delaware has quality checked our top opiate providers previously and graded them on all necessary aspects of opiate prescribing being notated including PDMP being checked. When prescriber audit are necessary due to quality concerns, checking the PDMP is one of the items reviewed.
DE	HighmarkHealthOptions	Criteria as part of the Opioid prior authorization requirement States: The prescribing provider, or the prescribing provider's delegate, confirms they have reviewed the Delaware Prescription Monitoring Program (DPMP) database for the member's controlled substance prescription history.
FL	Clear Health Alliance	The DOH requires each prescriber and dispenser or his or her designee has a duty to consult the PDMP system to review a patient's controlled substance dispensing history each time a controlled substance is prescribed or dispensed to a patient age 16 or older unless a statutory exemption applies. The prior authorization criteria for opiates requires that the prescriber check the PDMP, and asks for an explanation why the PDMP wasn't reviewed.
FL	Florida Community Care	Each prescriber and dispenser or his or her designee has a duty to consult the PDMP system to review a patient's controlled substance dispensing history each time a controlled substance is prescribed or dispensed to a patient age 16 or older unless a statutory exemption applies. Statutory exemptions include: If the patient is less than 16 years of age Drug being prescribed is a nonopioid schedule V System is not operational Requestor has technological or electrical failure Failure to consult in the PDMP may result in a non-disciplinary citation by the regulatory board.
FL	Humana Medical Plan	Pharmacies are required in the contract to follow all State and federal laws for checking the PDMP. In Florida, it is a State law for a pharmacist to abide by this rule.
FL	Molina Healthcare	Molina relies on language within the prior authorization criteria set for short and long acting opioids that requires prescribers to review the PDMP prior to prescribing. The criteria set is what the Health Plan utilization management

State	MCO Name	Explanation
		pharmacists use to review cases. If prescriber does not complete this step, it may be grounds for prior authorization to be denied.
FL	Simply Healthcare	The DOH requires each prescriber and dispenser or his or her designee has a duty to consult the PDMP system to review a patient's controlled substance dispensing history each time a controlled substance is prescribed or dispensed to a patient aged 16 or older unless a statutory exemption applies. The prior authorization criteria for opioids requires prescribers to check the PDMP and asks for an explanation why the PDMP wasn't reviewed.
IA	Amerigroup	Recommended prescribers following licensing board requirements and rules. In CY 2020 Iowa licensing boards adopted rules requiring their respective licensees to utilize the PMP database prior to issuing an opioid prescription. PMP Program rules and protocols are in Iowa Administration Code 657 Chapter 37 under the purview of the Board of Pharmacy. Providers are not obligated to take any action in response to reports or alerts from the PMP Program but should use their professional judgement in determining any subsequent action based on the information. Effective October 2021 Medicaid promulgated Rules requiring those who participate in Medicaid to query qualified PMP before prescribing controlled substances to most Medicaid beneficiaries consistent with Section 5042 of the SUPPORT Act.
IA	Iowa Total Care	Recommended prescribers follow licensing board requirements and rules. In CY 2020 Iowa licensing boards adopted rules requiring their respective licensees to utilize the PMP database prior to issuing an opioid prescription. PMP Program rules and protocols are in Iowa Administrative Code 657 Chapter 37 under the purview of the Board of Pharmacy. Providers are not obligated to take any action in response to reports or alerts from the PMP program but should use their professional judgment in determining any subsequent action based on the information. Effective October 2021 Medicaid promulgated Rules requiring those who participate in Medicaid to query qualified PMP before prescribing controlled substances to most Medicaid beneficiaries consistent with Section 5042 of the SUPPORT Act.
IL	Aetna_Better_Health_of_Illinois	The requirement for prescribers to check the PDMP is documented and communicated to providers via Aetna's opioid guideline. The guideline is published on Aetna's website.
IL	Blue_Cross_and_Blue_Shield_of_Illinois	BCBSIL expects our network providers to access the PDMP and use that information to ensure safe prescribing of controlled substances as well as to identify possible diversion. BCBSIL uses information from the PDMP to identify members at risk or that exhibit drug seeking behavior. This data is used as part of our ongoing lock-in activities.
IL	CountyCare_Health_Plan	Effective January 1, 2018, each prescriber or his/her designee shall document an attempt to access patient information in the PDMP to assess patient access to controlled substances when providing an initial prescription for Schedule II narcotics such as opioids, except for prescriptions for oncology treatment or palliative care, or a 7-day or less supply provided by a hospital emergency department when treating an acute, traumatic medical condition. This attempt to access shall be documented in the patient's medical record.
IN	CareSource	State law mandates review of PDMP.
IN	Managed Health Services Indiana (MHS)	MHS will look to see if member is paying cash for controlled substances because this would not show up on our claims report.

State	MCO Name	Explanation
IN	UnitedHealthcare Community Plan, Inc.	UnitedHealthcare Community Plan does not include language in the provider agreements specifically related to checking the PDMP before prescribing controlled substances. However, provider agreements do contain language requiring compliance with all State and federal laws which in the State of IN includes the checking of the PDMP before prescribing of controlled substances.
KS	Aetna Better Health of Kansas	Through the State website and bulletins noted below: Provider Bulletins: KMAP GENERAL BULLETIN 21169 - Medicaid Required PDMP (KTRACS) Review (PDF) KMAP GENERAL BULLETIN 21229 - PDMP Review - Policy Clarifications (PDF) KMAP GENERAL BULLETIN 21268 - PDMP Review - Frequency Clarification (PDF) KMAP GENERAL BULLETIN 22041 - PDMP Review - Age Requirement Update (PDF) KMAP GENERAL BULLETIN 23071 - PDMP Review - Attestation (PDF)
KS	Sunflower Health Plan	State specific protocol. MCOs direct providers to submit attestation to the State and follow State process.
KS	UnitedHealthcare	UHC requires our prescribing providers to follow all applicable State laws and KDHE policies. The UHC provider website links to the KDHE Provider Bulletin State protocols could be applied from KDHE Provider Bulletin which outlines all required protocols and requirements regarding use of PDMP.
KY	Humana Healthy Horizons in Kentucky	It is part of our education letter sent to prescribers.
LA	AmeriHealth Caritas Louisiana	The following requirement to check the PMP is only in our BH provider contracts as it is a provision required by the Office of Behavioral Health. BH providers must conduct member specific queries in the PMP upon writing the first prescription for a controlled substance, then annually. The BH provider shall print the PMP query and file it as part of the member's record.
MA	Tufts Health Public Plans, Inc	Plan provider agreements require providers to comply with State law and all conditions of licensure, including Commonwealth of Massachusetts Board of Registration in Medicine Prescribing Practices, Policies and Guidelines Part II.5 Required and Exempted Usage, which specifies when prescribers must check the PDMP.
MD	Kaiser Foundation Health Plan of the Mid-Atlantic States	Documentation of checking the PDMP through checking the reviewed tab on the PDMP site, and documenting in the encounter note are required. Additionally, as part of the prior authorization criteria for opioids, prescribers are required to attest and document in the encounter, the date that PDMP was checked and the average daily MME. If due to checking PDMP, discrepancies are identified between PDMP medication fill history and member's reported history of current disease State, providers are expected to discuss with the patient such discrepancies, and document the discussion and outcome. If there is no acceptable explanation for the discrepancy, depending on the situation, they would escalate to their lead/chief physician and/or consult the pain management/chemical dependency department for further guidance.
MD	Maryland Physicians Care	Providers are required to check the PDMP as part of the Opioid Prior Authorization process.

State	MCO Name	Explanation
MD	United Healthcare	UnitedHealthcare Community Plan provider agreements do not contain protocols regarding the PDMP. Provider agreements do contain certain language requiring compliance with all State and federal laws which in the State of MD includes the checking of the PDMP before prescribing of controlled substances.
MI	Blue Cross Complete of Michigan	Protocols and requirements are outlined in Public Acts 246 - 255 of 2017 and went into effect June 2018. Acts outline various opioid related requirements including a requirement for medical providers to check PDMP prior to prescribing. Pharmacy providers are also encouraged to check PDMP prior to dispensing.
MI	HAP Empowered	Protocols are established by the regulatory agencies (State legislation, medical and pharmacy boards, LARA). We shared the new requirements for providers who prescribe a controlled substance, and included the following guidance: -Check the Michigan Automated Prescription System (MAPS) for the member's 12- month prescription drug history before prescribing controlled substances. -Document this required MAPS check in the member's record according to Medicaid record retention policy.
MN	BluePlus	The ProDUR criteria for Morphine Equivalent Dose (MED) Limit requires the prescriber to review the patient's records in the State's prescription drug monitoring program (PDMP) prior to approval.
MN	HealthPartners	In 2022, HealthPartners developed an administrative policy related to the MN PDMP outlining provider responsibilities when prescribing controlled substances. Provider responsibilities include, required enrollment in the MN PMP database, querying the database on every initial fill of an opoid medication and querying the database every 3 months for OTP (Opioid Treatment Program) members, MAT program members, and any member receiving opiate treatment for chronic pain.
MN	SouthCountry	Prescribers are required to comply with section 5042 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act when prescribing controlled substances to South Country members. Section 5042 of the SUPPORT for Patients and Communities Act requires prescribers to check the prescription drug monitoring program (PDMP), hosted by the Minnesota Board of Pharmacy, before prescribing a controlled substance to a South Country member.
MN	UnitedHealthcare	UnitedHealthCare Community Plan does not include language in the provider agreements specifically related to checking the PDMP before prescribing controlled substances. However, provider agreements do contain language requiring compliance with all State and federal laws which in the State of MN includes the checking of the PDMP in accordance with MN Statute Minnesota Statutes Sect. 152.126 subd. 6(d)
MS	MS-MOLINA	All licensees must register with MPMP â—¦ Must check on all opioid prescriptions for acute and/or chronic non cancerous/non-terminal pain upon issuance â—¦ Must utilize the MPMP upon initial contact with new patients and at least every 3 months thereafter for all controlled medications other than opioids â—¦ Must document MPMP review (must include time from last check) â—¦ PMP check not required for inpatients but must be checked if

State	MCO Name	Explanation
		discharged on opioids
NC	AMHC FFY22	AMHC is required to follow NCDHB policy and clinical criteria for controlled substances. Checking the PDMP is required per NCDHB policy and the NC STOP Act.
NC	HB FFY22	Healthy Blue follows the FFS clinical criteria for Opioid Analgesics, which requires the prescriber to check the member's utilization on the NC Controlled Substance Reporting System (CSRS).
NE	Nebraska Total Care	Each provider prescribing a controlled substance in Nebraska to a Medicaid client must check the prescription drug monitoring program (PDMP) before prescribing a schedule II medication and at dosage adjustment. Provider may delegate checking of the prescription drug monitoring program to a delegate. Good faith exceptions must be documented in the client's medical record and provided upon request to the Department. These requirements do not include a prescription to a client as set forth under 42 U.S.C. Sec.1396w-3a and to a resident of a facility where schedule II medications are dispensed to a client through a single pharmacy.
NH	AmeriHealth Caritas NH	AmeriHealth Caritas New Hampshire providers are required to follow all requirements of the New Hampshire Prescription Drug Monitoring Program including mandatory registration to access the PMP AWARxE system. The PMP system collects information on all controlled substances (schedules II-IV) prescriptions. Prescribers registered with the PMP may obtain immediate access to an online report of their current or prospective patient's controlled substance prescription history. Pharmacies and prescribers are not permitted to distribute prescription history reports from the PMP system to patients. AmeriHealth Caritas New Hampshire providers must query the PMP to view information about our member's usage before prescribing any controlled substances to them. All PMP users must comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule requirements.
NH	NH Healthy Families	NH Healthy Families requires PDMP utilization from providers when obtaining an opioid for morphine milligram equivalent of greater than 100mg. This requirement is incorporated into the opioid analgesic policy criteria for approval and requires prescriber attestation that they have utilized the PDMP.
NM	Presbyterian Health Plan	Pursuant to 16.19.29 NMAC.
NM	Western Sky Community Care	WSCC requires documentation of PDMP use as part of the prior authorization criteria for opioids.
NV	Molina	Providers must comply with all applicable Laws (including any implementing regulations in performing its Pharmacy Services under the Provider Agreement)
NY	EmblemHealth	EmblemHealth's utilization management policies that are in place for long and short acting opioids require prescriber's to access the PDMP (NYS I-STOP) patient history prior to prescribing these substances.
NY	Excellus Health Plan	Yes, the MCO has a Opioid Management and Health Safety Program policy that requires prescriber attestation that the patient's history of controlled substance prescriptions has been checked using the State prescription drug monitoring program (PDMP).
NY	Independent Health	Our MCO mirrors the language in the New York laws on consulting the PDMP

State	MCO Name	Explanation
NY	Molina Healthcare of New York	As part of our Opioid Use Criteria for prescribing of controlled substances, providers must document that the member has been evaluated and will be monitored regularly for the development of addiction, abuse, or misuse of the requested drug, with confirmation of Prescription Drug Monitoring Program monitoring.
NY	MVP Health Care	Utilization management of chronic opiate use (greater than 3 months) requires documented verification of the Prescription Monitoring Program Registry.
NY	Univera Healthcare	The MCO has an Opioid Management and Health Safety Program policy that requires prescriber attestation that the patient's history of controlled substance prescriptions has been checked using the State prescription drug monitoring program (PDMP).
OH	CareSource	State law mandates review of PDMP.
OH	Paramount	Opioid claims will reject at point of sale for prior authorization. Prescribers of opioid agents are required to attest to reviewing State appropriate PDMP patient history before prescribing opioids for patients when submitting a prior authorization request for approval.
OH	UnitedHealthcare Community Plan of Ohio	Ohio Board of Pharmacy and Ohio Medical Board follow Ohio law, which establishes requirements for Ohio prescribers related to the Ohio Automated Rx Reporting System (OARRS). Prescribers are required to review OARRS before initially prescribing or personally furnishing an opioid analgesic or a benzodiazepine to a patient, the prescriber must request patient information from OARRS that covers at least the previous 12 months. The prescriber must also make periodic requests for patient information from OARRS if the course of treatment continues for more than 90 days. Under the circumstances described above, the prescriber is required to assess the OARRS information and document in the patient record that a patient prescription history report was received and assessed. For all controlled substances, OARRS is to be reviewed if any red flag is noticed. Exceptions to mandatory checks prior to prescribing an opioid analgesic or benzodiazepine are also in place where PDMP review is not considered necessary.
OR	Health Share of Oregon - OHSU	Opioid PA criteria require that the PDMP is monitored by the provider as part of PA approval process.
OR	InterCommunity Health Network	IHN-CCO and Samaritan Health Plans expects prescribers of opioid medications, in accordance with the SUPPORT Act, to check the Prescription Drug Monitoring Program database prior to the prescribing of such medications. All Oregon-licensed physicians and PAs who have a DEA number are required to register for the PDMP.
OR	Umpqua Health Alliance (UHA)	For controlled substances that require a prior authorization, the prescriber must attest that they checked the PDMP or submit documentation showing this review was completed.
PA	Aetna Better Health of Pennsylvania	Prescriber must attest or show records that PDMP was checked for all prior authorization criteria related to controlled substances. In addition, per Act 191 of 2014, a prescriber is a person who is licensed, registered or otherwise lawfully authorized to distribute, dispense or administer a controlled substance, other drug or device in the course of professional practice or research in this Commonwealth. The term does not include a veterinarian.

State	MCO Name	Explanation
		Prescribers must now query the PA PDMP each time a patient is prescribed an opioid drug product or benzodiazepine by the prescriber. Prescribers must continue to query the PA PDMP: For each patient the first time the patient is prescribed a controlled substance by the prescriber for purposes of establishing a baseline and a thorough medical record; or If a prescriber believes or has reason to believe, using sound clinical judgment, that a patient may be abusing or diverting drugs. Dispensing prescribers or pharmacies must now submit data to the PA PDMP no later than the close of the subsequent business day (Monday through Friday) after dispensing the controlled substance, as opposed to the previous requirement of within 72 hours.
PA	Geisinger	As part of prior authorization process
PA	Health Partners	Prior authorization requires prescribers to answer that they checked the PDMP in yes/no format
PA	Highmark Wholecare	Prior authorization criteria for opioids and other controlled substances outlines the requirement for checking the PDMP prior to prescribing.
PA	United Healthcare	UnitedHealthcare Community Plan provider agreements do not contain protocols regarding the PDMP. Provider agreements do contain certain language requiring compliance with all State and federal laws which in the State of MD includes the checking of the PDMP before prescribing of controlled substances.
PA	Vista	MCO provider agreements require prescribers to adhere to State and federal regulations. This would include the mandate in Pennsylvania for prescribers to query the Pennsylvania Prescription Drug Monitoring Program (PA PDMP): each time a patient is prescribed any controlled substance for the first time, each time a patient is prescribed an opioid or benzodiazepine, or if there is suspected abuse or diversion. Additional referrals could result as described in Section VII.A. above if an audit or record review found that the prescriber was negligent in checking the PDMP as required.
RI	NHPRI	Neighborhood requires prescribers to access the PDMP patient history before initially prescribing opioids and every three months thereafter. This is in alignment with the State of Rhode Islands' controlled substances prescribing requirements.
RI	THP	Plan provider agreements require providers to comply with State law and all conditions of licensure, including 216-RICR-20-20-4.E Mandatory PDMP Review
RI	UHCCP	United Healthcare Community Plan's provider agreements contain language requiring compliance with all State and Federal laws which in the State of RI includes the checking of the PDMP before prescribing of controlled substances (216-RICR-20-20-4.4 (E).
SC	Humana	It is part of the education letter sent to prescribers.
SC	Select Health of South Carolina, Inc.	Initial and reauthorization criteria for all long acting opioids require prescribers to check the PDMP prior to each authorization request. Initial and reauthorization criteria for short acting opioids for naive members requesting a dose > 90 MME, >5 day supply, and/or more than 1 prescription

State	MCO Name	Explanation
		per 30 days require prescribers to check the PDMP prior to each authorization request.
TX	Aetna Better Health of Texas	Texas requires prescribers to check the patient's PDMP history before dispensing or prescribing opioids, benzodiazepines, barbiturates, or carisoprodol.
TX	Amerigroup	Texas requires prescribers to check the patient's PDMP history before dispensing or prescribing opioids, benzodiazepines, barbiturates, or carisoprodol.
TX	Blue Cross and Blue Shield of Texas	Texas requires prescribers to check the patient's PDMP history before dispensing or prescribing opioids, benzodiazepines, barbiturates, or carisoprodol."
TX	Community First Health Plans	Texas requires pharmacists and prescribers to check the patient's PDMP history before dispensing or prescribing opioids, benzodiazepines, barbiturates, or carisoprodol.
TX	Community Health Choice	Texas requires prescribers to check the patient's PDMP history before dispensing or prescribing opioids, benzodiazepines, barbiturates, or carisoprodol
TX	Dell Children's Health Plan	Texas requires prescribers to check the patient's PDMP history before dispensing or prescribing opioids, benzodiazepines, barbiturates, or carisoprodol.
TX	Driscoll Health Plan	Texas requires prescribers to check the patient's PDMP history before dispensing or prescribing opioids, benzodiazepines, barbiturates, or carisoprodol.
TX	El Paso Health	Texas requires prescribers to check the patient's PDMP history before dispensing or prescribing opioids, benzodiazepines, barbiturates, or carisoprodol.
TX	FirstCare Health Plans	Texas requires prescribers to check the patient's PDMP history before dispensing or prescribing opioids, benzodiazepines, barbiturates, or carisoprodol.
TX	Molina Healthcare of Texas	Texas requires prescribers to check the patient's PDMP history before dispensing or prescribing opioids, benzodiazepines, barbiturates, or carisoprodol.
TX	Scott and White Health Plan	Texas requires prescribers to check the patient's PDMP history before dispensing or prescribing opioids, benzodiazepines, barbiturates, or carisoprodol.
TX	Superior HealthPlan	Texas Board of Pharmacy and Texas Medical Association regulations require pharmacies and prescribers to check the PDMP prior to prescribing/dispensing any of the following: opioids, benzodiazepines, barbiturates, or carisoprodol.
TX	Texas Children's Health Plan	Texas requires prescribers to check the patient's PDMP history before dispensing or prescribing opioids, benzodiazepines, barbiturates, or carisoprodol.
TX	UnitedHealthcare Community Plan	Texas requires prescribers to check the patient's PDMP history before dispensing or prescribing opioids, benzodiazepines, barbiturates, or carisoprodol.
UT	Healthy U	All controlled substances require a prior authorization at some point. At that time, the provider must submit documentation showing they monitor the PDMP for the member. If this is not supplied, the authorization may be denied.

State	MCO Name	Explanation
UT	Steward Health Choice Utah	Health Choice Utah requires prior authorization for several opioids. Prior Authorization criteria which must be satisfied prior to coverage, which requires prescriber attestation that the PDMP patient history has been accessed and reviewed prior to prescribing. Authorization may be denied if documentation of attestation was not provided.
VA	AetnaBetterHealthofVirginia	Select drug classes require documentation when the PMP was checked prior to submitting a PA.
VA	MolinaCompleteCareofVirginia	Requirements to check the PDMP are included on respective prior authorization forms (e.g., Opiates, Oral Buprenorphine, CNS Stimulants, Methadone). Requirements are also posted in Chapter 25.2 of Title 54.1 of the Code of Virginia Prescription Monitoring Program and by the Virginia Board of Medicine.
VA	OptimaHealth	The protocols in place involved in checking the PDMP are confined to the criteria outlined in State-mandated service authorization policy, and exclude the use of any PDMP data for any other purpose.
VA	VirginiaPremier	In accordance with the State's criteria for controlled substances, Virginia Premier has on its prior authorization forms the frequency of which a provider should review a member's PDMP prior to dispensing.
WA	Amerigroup Washington Inc.	Based on requirements from WAC 182-530-1080 (implemented Oct 1, 2021). If a prescriber, or their delegate is unable to access the client's record in the PMP after a good faith effort, that attempt must be documented in the client's record along with the reason or reasons they were unable to conduct the check.
WA	Community Health Plan of Washington	WAC 246-919-985 explains the Washington Prescription monitoring programï¿½Required registration, queries, and documentation.
WA	Coordinated Care Corporation	As part of the HCA's Support Act policy, the attestation form requires provider to review the PDMP. Requirements are also included in WAC 182-530-1080.
WA	UnitedHealthcare Community Plan	UnitedHealthcare Community Plan does not include language in the provider agreements specifically related to checking the PDMP before prescribing controlled substances. However, provider agreements do contain language requiring compliance with all State and federal laws which in the State of Washington includes the checking of the PDMP before prescribing of controlled substances.

b. Do providers have protocols for responses to information from the PDMP that is contradictory to information that the practitioner expects to receive, based on information from the client (example: when a provider prescribing pain management medication finds medications for opioid use disorder (OUD) during a PDMP check, when client denies opioid use disorder)?

Figure 77 - Providers Having Protocols for Responses to Information from the PDMP that is Contradictory to the Information the Practitioner Expects

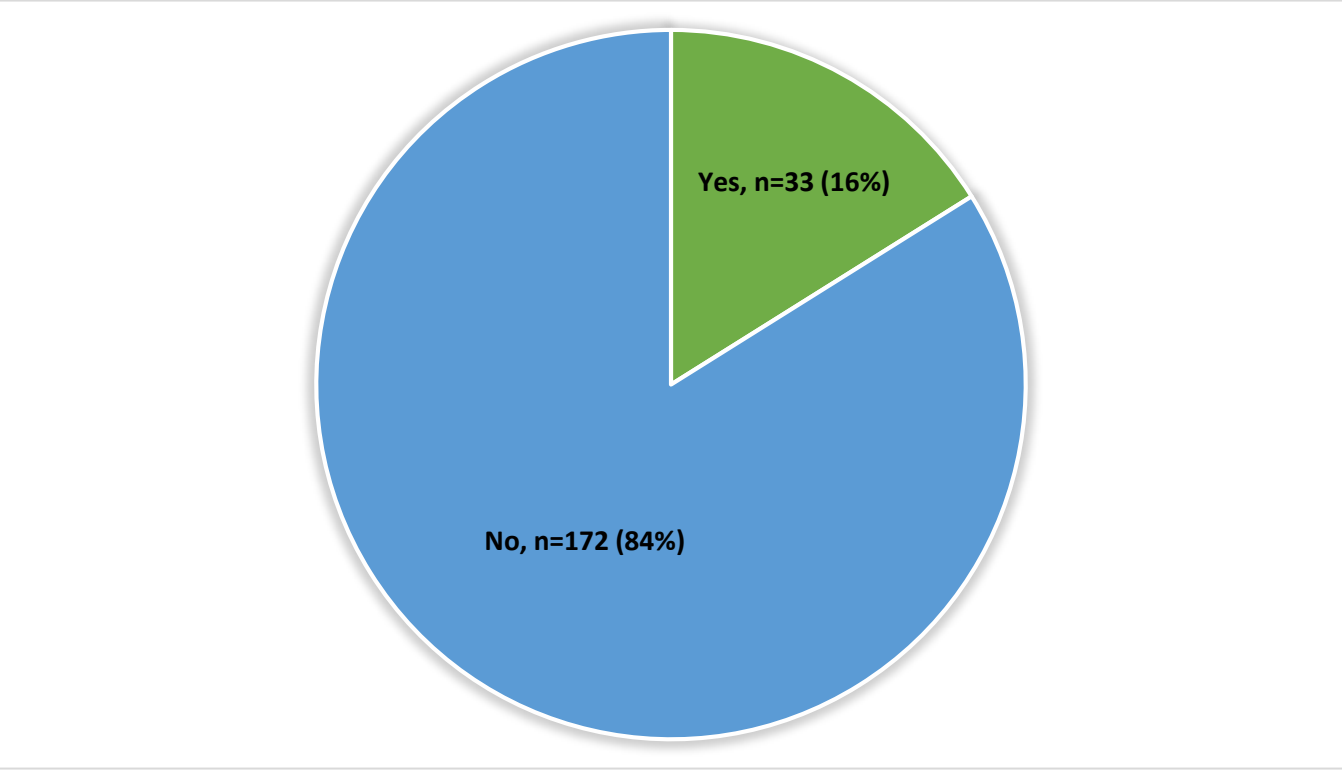

Table 83 - Providers Having Protocols for Responses to Information from the PDMP that is Contradictory to the Information the Practitioner Expects

Response	States (Count of MCOs)	Count	Percentage
Yes	Delaware (1), Florida (2), Illinois (2), Kentucky (1), Maryland (4), Michigan (3), Minnesota (2), Mississippi (1), Nebraska (1), Nevada (2), New Mexico (1), Oregon (3), Pennsylvania (2), Texas (2), Utah (3), Virginia (2), Washington (1)	33	16.10%
No	Arkansas (4), Colorado (2), Delaware (1), District of Columbia (4), Florida (9), Georgia (3), Hawaii (6), Illinois (4), Indiana (5), Iowa (2), Kansas (3), Kentucky (5), Louisiana (5), Maryland (5), Massachusetts (5), Michigan (6), Minnesota (7), Mississippi (2), Nebraska (2), Nevada (2), New Hampshire (3), New Jersey (5), New Mexico (2), New York (15), North Carolina (5), Ohio (5), Oregon (18), Pennsylvania (6), Rhode Island (3), South Carolina (5), Texas (14), Utah (1), Virginia (4), Washington (4)	172	83.90%
National Totals		**205**	**100%**

c. If a provider is not able to conduct PDMP checks, does your MCO require the prescriber to document a good faith effort, including the reasons why the provider was not able to conduct the check?

Figure 78 - MCO Requires Prescriber to Document a Good Faith Effort if Unable to Conduct a PDMP Check

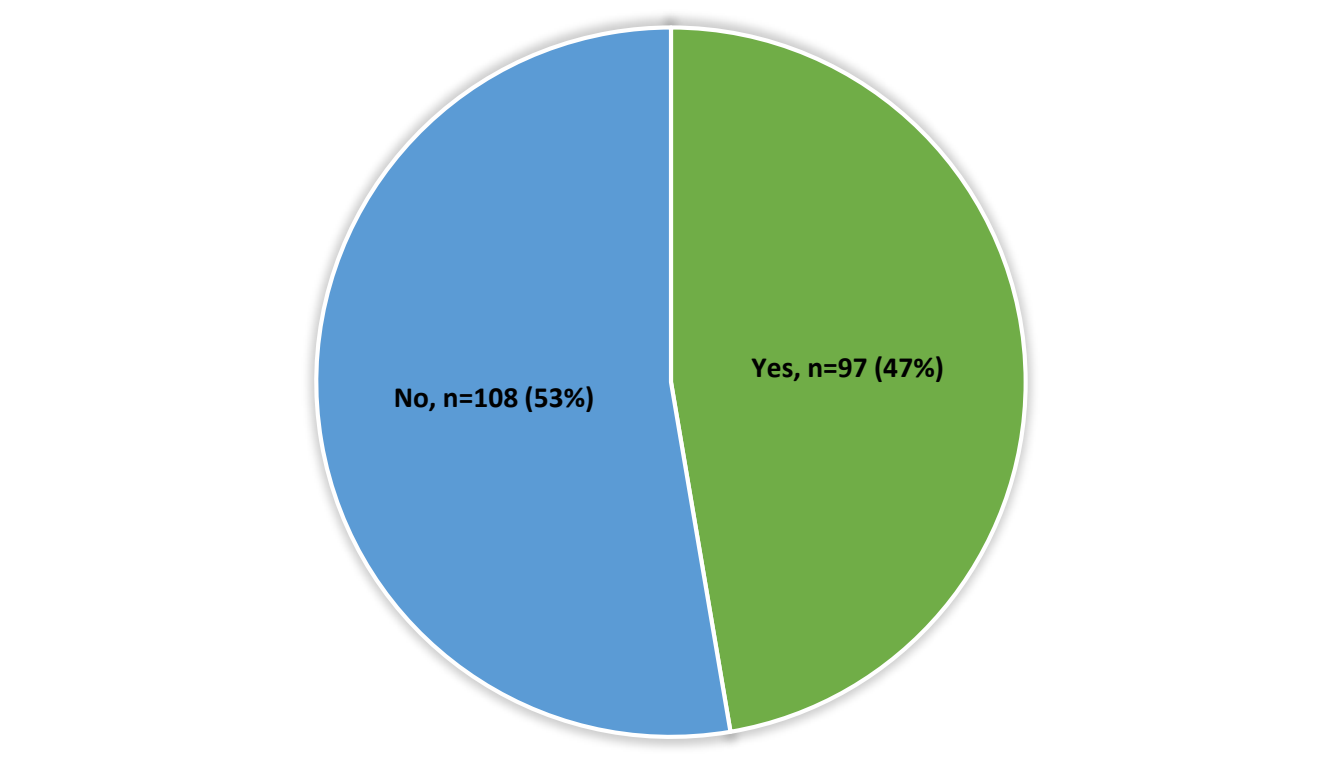

Table 84 - MCO Requires Prescriber to Document a Good Faith Effort if Unable to Conduct a PDMP Check

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (1), Colorado (2), Delaware (2), District of Columbia (2), Florida (7), Illinois (3), Iowa (2), Kansas (3), Louisiana (2), Maryland (7), Michigan (3), Minnesota (4), Mississippi (2), Nebraska (1), Nevada (1), New Jersey (1), New Mexico (1), New York (4), Ohio (3), Oregon (17), Pennsylvania (6), South Carolina (1), Texas (13), Utah (2), Virginia (4), Washington (3)	97	47.32%
No	Arkansas (3), District of Columbia (2), Florida (4), Georgia (3), Hawaii (6), Illinois (3), Indiana (5), Kentucky (6), Louisiana (3), Maryland (2), Massachusetts (5), Michigan (6), Minnesota (5), Mississippi (1), Nebraska (2), Nevada (3), New Hampshire (3), New Jersey (4), New Mexico (2), New York (11), North Carolina (5), Ohio (2), Oregon (4), Pennsylvania (2), Rhode Island (3), South Carolina (4), Texas (3), Utah (2), Virginia (2), Washington (2)	108	52.68%
National Totals		**205**	**100%**

If "No," please explain why not.

Table 85 - Explanations for Not Requiring Prescribers to Document a Good Faith Effort

State	MCO Name	Explanation
AR	CareSource	State law places this responsibility on the provider.
AR	Empower_HealthCare_Solutions_LLC	Empower requires the provider to adhere to current Arkansas State Medical Board requirements.

State	MCO Name	Explanation
AR	Summit_Community_Care	The MCO does not require this. However, prescribers are expected to follow State and Federal regulations.
DC	CareFirst BCBS Community Health Plan DC	DC law requires all prescribers and pharmacists to query the PDMP before prescribing or dispensing controlled substances. Although it is the law to query the PDMP MCOs do not have a way to know which provider and pharmacists actually perform the query
DC	HealthServicesforSpecialNeedsChildren	HSCSN has not established a process for this and has no method for monitoring PDMP access by providers.
FL	Amerihealth Caritas Florida	AmeriHealth Caritas FL (ACFL) does not mandate in its provider agreement that providers access the PDMP as this is a requirement of Florida's EFORSCE program which indicates "A prescriber or his or her designee must consult the PDMP to review their patient's controlled substance dispensing history prior to prescribing a controlled substance in Schedules II-V, as defined in section 893.03, F.S., for patients age 16 and older." However, ACFL's provider agreements do require providers to follow State and federal laws, which include section 893.03, F.S
FL	Community Care Plan	CCP does not monitored this process and expects the prescribers to follow the requirements provided the State for appropriate use of E-forcse. Prescribers are expected to follow the rules of prescribing only a 3-day supply of controlled substance and documenting in the patients record the reason they did not use PDMP.
FL	Humana Medical Plan	Pharmacies are required in the contract to follow all State and federal laws for checking the PDMP. In Florida, it is a State law for a pharmacist to abide by this rule.
FL	United Healthcare	The requirement to check the PDMP is done at the point of prescribing and MCOs do not have access to review PDMP information to further evaluate prescribing.
GA	Amerigroup GA	Prescribers are required by the State of Georgia to check PDMP before prescribing a schedule II opioid or any benzodiazepines.
GA	CareSource	Effective, 1/1/2018, prescribers have had to attest to checking the PDMP. This helps ensure legitimate use of controlled substances by beneficiaries.
GA	Peach State Health Plan	All of our opioid-related letters going to providers are given the reminder that the Georgia Prescription Drug Monitoring Program (GA PDMP) is available to monitor and help reduce risk of abuse.
HI	AlohaCare	While PDMP is required by State law, AlohaCare has no way to know if the prescriber checks PDMP or not prior to prescribing.
HI	HMSAQI	HRS 329-38 requires prescribers in Hawaii to request, receive, and consider dispensation records within the State's PDMP before prescribing a Schedule II, III, or IV controlled substance so providers must comply with this law before prescribing controlled substances.
HI	Kaiser	We do not have a requirement to provide documentation.
HI	UnitedHealthcare	UnitedHealthcare Community Plan does not include language in the provider agreements specifically related to checking the PDMP before prescribing controlled substances. However, provider agreements do contain language requiring compliance with all State and federal laws which in the State of Hawaii, includes the checking of the PDMP before prescribing of controlled substances.
HI	WellCareHealthPlans	The MCO expects prescribers to utilize the PDMP as a best practice, but it is not required in order to a contracted provider.

State	MCO Name	Explanation
HI	WellCareHealthPlansCCS	The MCO expects prescribers to utilize the PDMP as a best practice, but it is not required in order to a contracted provider.
IL	MeridianHealth	The MCO requires prescribers to follow the Illinois Controlled Substance Act.
IL	Molina_Healthcare_of_Illinois,_Inc	Molina requires providers to adhere to State laws. The Illinois Controlled Substances Act requires this already.
IL	YouthCare_HealthChoice	Requirements for PDMP are regulated by the State of Illinois. The MCO requires prescribers to follow the Illinois Controlled Substance Act.
IN	Anthem, Inc.	Our contract does not require the PDMP check, but rather the law that requires such.
IN	CareSource	State law places the responsibility on the provider.
IN	Managed Health Services Indiana (MHS)	IN has suggestions regarding prescribers checking this data base. We assume the provider is following the State program.
IN	MDwise, Inc.	It is a State law that prescribers are required to check the PDMP before prescribing controlled substances.
IN	UnitedHealthcare Community Plan, Inc.	Checking the PDMP is required by Indiana law.
KY	Aetna Better Health of Kentucky	N/A
KY	Anthem Inc. Kentucky	State Law requires prescribers to check PDMP prior to prescribing controlled substances.
KY	Humana Healthy Horizons in Kentucky	It is best practice for providers to check KASPER before prescribing opioids. Also, when the member goes tot he pharmacy a check will be conducted by the pharmacist. If there is an issue with member usage of opioids, the pharmacy will intervene and contact the provider.
KY	Passport Health Plan By Molina Healthcare	Not part of KY legislation
KY	United Healthcare Community Plan of Kentucky	UnitedHealthcare Community Plan of KY does not include language in the provider agreements specifically related to checking the PDMP before prescribing controlled substances. However, provider agreements do contain language requiring compliance with all State and federal laws which in the State of KY includes the checking of the PDMP before prescribing of controlled substances.
KY	WellCare Health Plans	Currently not an MCO responsibility
LA	AmeriHealth Caritas Louisiana	The BH provider agreement requires that the PDMP is checked and a printed copy of the query be placed in the member's record.
LA	Healthy Blue Louisiana	We defer to applicable prescriber professional board. MCO does not dictate prescriber requirement to check PDMP before prescribing controlled substances. State also does not provide MCO access to PDMP database.
LA	Louisiana Healthcare Connections	The MCO does not require/enforce these practices. The Louisiana Board of Pharmacy provides all PDMP utilization guidance and oversight.
MA	AllWays Health Partners	Provider actions governed by statute
MA	Boston Medical Center Health Plan, Inc	Providers are obligated to adhere to regulatory requirements that include following State PDMP requirements or other regulations. We would expect Providers to ensure adequate protocols are established for prescribing opioids and documentation.

State	MCO Name	Explanation
MA	Fallon Community Health Plan, Inc.	we do not have access to PDMP and do not have protocols set up
MA	Health New England, Inc.	N/A - health plan does not have access to PDMP
MA	Tufts Health Public Plans, Inc	Our provider agreements require providers to comply with State law and all conditions of licensure. Commonwealth of Massachusetts Board of Registration in Medicine Prescribing Practices, Policies and Guidelines Part II.5 does not require good faith documentation of an effort to check the PDMP.
MD	Amerigroup Community Care	Providers are expected to follow the State regulations regarding PDMP
MD	Jai Medical Systems Managed Care Organization, Inc.	The MCO requires prescribers to follow State and federal law. State law requires prescribers to request and assess PDMP data: 1. Before beginning a new course of treatment with an opioid or benzodiazepine. 2. When a course of treatment with an opioid or benzodiazepine extends beyond 90 days. In this case, prescribers must query again at least every 90 days thereafter before prescribing or dispensing the opioid or benzodiazepine. 3. Prescribers must view at least the last 4 months of data (This will always be available within a PDMP data view.) 4. A prescriber delegate may pull the PDMP data, but the prescriber remains responsible for assessing the data prior to making a prescribing decision.
MI	McLaren Health Plan	Not currently required. However, we do require prescribers to review the member's MAPS and have an executed pain contract signed by the member.
MI	Meridian Health Plan	The plan expects prescribers to utilize the PDMP as a best practice but it is not required in order to a contracted provider.
MI	Molina Healthcare of Michigan	Providers are required to check the Prescription Drug Monitoring Program (PDMP) before prescribing controlled substances to beneficiaries.
MI	Priority Health Choice	Priority Health defers to State laws and regulations for prescribing and dispensing controlled substances and requirements around accessing PDMPs.
MI	UnitedHealthcare Community Plan	UnitedHealthcare Community Plan does not include language in the provider agreements specifically related to checking the PDMP before prescribing controlled substances. However, provider agreements do contain language requiring compliance with all State and federal laws which in the State of MI includes the checking of the PDMP before prescribing of controlled substances.
MI	Upper Peninsula Health Plan	Review of the PDMP patient history before prescribing controlled substances is not required by the MCO.
MN	HealthPartners	Minnesota State law does not currently allow managed Medicaid plans to oversee PDMP access in this manner.
MN	HennepinHealth	This information is not shared with the MCO.
MN	Medica	There are currently no requirements in the Medica provider agreements in relation to document a good faith effort in conducting PDMP checks. The provider agreements contain a requirement of general compliance with all laws section, but the PDMP is not specifically referenced.
MN	PrimeWest	State laws govern prescriber PDMP checks.
MN	UnitedHealthcare	Providers are to comply with Minnesota Statutes Sect. 152.126 subd. 6(d)
MS	MS-UNITED	The Mississippi Board of Medical Licensure does not allow for good faith efforts in lieu of conducting PDMP checks when required to prescribe controlled substances.
NC	AMHC FFY22	NCDHB prior authorization criteria for opioid analgesics requires the prescriber to attest/confirm the PDMP was reviewed to confirm the member's controlled substance use.

State	MCO Name	Explanation
NC	CCH FFY22	The MCO expects prescribers to utilize the PDMP as a best practice but it is not required in order to a contracted provider.
NC	HB FFY22	The prior approval criteria for opioid analgesics requires the prescribing clinician to check the NC Controlled Substance Reporting System.
NC	UHC FFY22	Provider agreements do contain language requiring compliance with all State and federal laws which in the State of North Carolina includes the checking of the PDMP before prescribing of controlled substances.
NC	WC FFY22	The MCO expects providers to utilize the PDMP as a best practice but it is not required in order to a contracted provider.
NE	HealthyBlueNebraska	The provider must document in the patient's record per State regulations.
NE	United Healthcare	We are currently looking into operationalizing this process
NH	AmeriHealth Caritas NH	PA criteria for opioid medication above 100MME and long acting opioid medication require that the provider attest that the PDMP was checked.
NH	NH Healthy Families	If the prescriber is unable to query the State PDMP they would need to perform an appeal or peer to peer to provide justification for why this is not feasible. Determination would be made based on the justification provided.
NH	Well Sense	Providers are obligated to adhere to regulatory requirements that include following State PDMP requirements or other regulations. We would expect Providers to ensure adequate protocols are established for prescribing opioids and documentation.
NJ	Aetna Better Health of New Jersey	The MCO do not have the ability to monitor this system
NJ	Amerigroup Community Care	No, the MCO does not require this. However, prescribers are expected to follow all State and Federal regulations.
NJ	Horizon NJ Health	In the State of New Jersey, a prescriber or the prescriber's delegate is required to access prescription monitoring information for new or current patient consistent with administrative code.
NJ	NJ United	Provider agreements do contain language requiring compliance with all State and federal laws which in the State of New Jersey includes the checking of the PDMP before prescribing of controlled substances.
NM	Blue Cross Blue Shield of New Mexico	The regulatory "flow down" language in our provider contracts mirror the requirements detailed in the BCBSNM agreement with HSD (Section 4.9). This contract language was reviewed and approved by HSD per contract requirements.
NM	Western Sky Community Care	PDMP use and record keeping around it's use is required by the State of NM for practitioners prescribing controlled substances and includes requirements for documentation when PDMP is unavailable or not used.
NV	Anthem Blue Cross Blue Shield	We do not require the prescriber to submit information to the MCO. The information must be documented in the patient's chart.
NV	Health Plan of Nevada	Health Plan of Nevada does not include language in the provider agreements specifically related to checking the PDMP before prescribing controlled substances. However, provider agreements do contain language requiring compliance with all State and federal laws which in the State of Nevada includes the checking of the PDMP before prescribing of controlled substances.
NV	Silver Summit Health Plan	The MCO hasn't specified protocols for prescribers checking the PDMP. Nevada Revised Statutes Â§ 422.4025 has provisions that address the prescribing of opioids, these provisions would supersede protocols implemented by the plan.

State	MCO Name	Explanation
NY	AMIDA CARE	At this time Managed Care plans do not have access to query NY State's Prescription Monitoring Program (PMP).
NY	Capital District Physicians' Health Plan	CDPHP does not include a requirement to access PDMP before prescribing controlled substances. Effective August 27, 2013, practitioners in New York State are required, with limited exceptions, to check the PMP Registry prior to writing a prescription for a controlled substance in schedule II, III, and IV for a patient.
NY	EmblemHealth	Documentation of a good faith effort to check the PDMP is not required by EmblemHealth at this time. The NYS PMP does require practitioners to document in their charts the reason they were unable to perform the check.
NY	Empire Blue Cross Blue Shield HealthPlus	According to NYSPMP guidance issued in June 2017, if prescriber cannot access PDMP, they can still prescribe, use your medical judgment and document in the patients chart the reason why you could not consult. The duty to consult the PMP Registry shall not apply to a situation where the registry is not operational as determined by the department or where it cannot be accessed by the practitioner due to a temporary technological or electrical failure, as set forth in the regulations
NY	Excellus Health Plan	No, The MCO requires provider attestation that the PDMP was checked for prescription drugs that require prior authorization. For drugs that do not require prior authorization, the MCO does not have a process to hold providers accountable to checking the PDMP.
NY	Fidelis Care	Most prescribers are required to consult the Prescription Drug Monitoring Program (PDMP) Registry when writing prescriptions for most controlled substances by New York State.
NY	Healthfirst	This is a direct requirement by NYS in order to maintain their licensure and participation in the NYS Medicaid program, and thus participation in our health plan.
NY	Highmark Blue Cross Blue Shield of Western New York	We defer to applicable prescriber professional board. MCO does not dictate prescriber requirement to check PDMP before prescribing controlled substances. State also does not provide MCO access to PDMP database.
NY	United HealthCare	Provider agreements do contain language requiring compliance with all State and federal laws which in the State includes documenting a good faith effort, including reasons why the provider was not able to conduct the check, such as but not limited to a power outage or system upgrade.
NY	Univera Healthcare	The MCO requires provider attestation that the PDMP was checked for prescription drugs that require prior authorization. For drugs that do not require prior authorization, the MCO does not have a process to hold providers accountable to checking the PDMP
NY	VNSNY CHOICE SelectHealth	SelectHealth from VNS Health contractual agreements with providers require their compliance to any State DOH regulations as applicable and in an up-to-date manner
OH	Buckeye Health Plan	The Ohio Board of Pharmacy requires that our providers access the Ohio Automated Rx Reporting System (OARRS) when prescribing controlled substances.
OH	CareSource	State law places the responsibility on the provider.
OR	Cascade Health Alliance	Controlled medications on formulary will pay at the POS for an initial fill limited to 7 days and 90MME per day. Subsequent fills will require clinical documentation . In instances where a clinical review is conducted, CHA's decisions are based on medical necessity, patient safety and care.

State	MCO Name	Explanation
OR	Columbia Pacific CCO	While the provider manual does refer providers to the OAR requirement itself, the language can be strengthened to be more clear of the obligation. However, as a CCO we have struggled to identify the correct balance of enforcement/auditing that does not become an unnecessary burden on providers.
OR	Health Share of Oregon-CareOregon RAE	There is an implied obligation by our provider manual's reference to the OAR which does State a "good faith effort" documentation is required. But this language could be strengthened. Efforts to audit/enforce these obligations are limited without becoming a provider burden.
OR	Jackson Care Connect	There is an implied obligation by our provider manual's reference to the OAR which does State a "good faith effort" documentation is required. But this language could be strengthened. Efforts to audit/enforce these obligations are limited without becoming a provider burden.
PA	PA Health and Wellness	Per the State's policy for opioids, PDMP review is required for most opioids and certain controlled drug classes. There is an PDMP exception for patients that have a diagnosis of active cancer, sickle cell with crisis, or neonatal abstinence syndrome or is receiving palliative care or hospice services.
PA	UPMC	Reviewing the PDMP is a requirement in certain prior authorization policies for controlled substance medications. However, the provider may submit clinical documentation supporting medical necessity if the PDMP cannot be reviewed.
RI	NHPRI	Neighborhood does not require prescribers to document the reason why the provider was not able to conduct a PDMP check on a member. It is the expectation and State guidance that providers check the PDMP before writing the prescription.
RI	THP	The MCO's provider agreements require providers to comply with State law and all conditions of licensure. 216-RICR-20-20-4 does not require good faith documentation of an effort to check the PDMP.
RI	UHCCP	United Healthcare Community Plan's provider agreements contain language requiring compliance with all State and Federal laws which in the State of RI includes the mandatory checking of the PDMP before prescribing of controlled substances (216-RICR-20-20-4.4 (E).
SC	Absolute Total Care	The MCO expects prescribers to utilize the PDMP as a best practice but it is not required in order to be a contracted provider. The South Carolina Department of Health and Human Services (SCDHHS) requires that all providers use the PDMP before prescribing any control substances class II through IV and any documentation of good faith efforts or other possible requirements would need to be available to them. The MCO does not require this documentation.
SC	Humana	Pharmacies are required in the contract to follow all State and federal laws for checking the PDMP. In South Carolina it is a State law for a pharmacist to abide by this rule.
SC	Molina Healthcare	Accessing the SC PMP information is mandated by law. Exemption requests are allowed and managed by DHEC, not the MCO.
SC	Select Health of South Carolina, Inc.	If the criteria/fax form requires that the PDMP be assessed, the request will be denied if that requirement was not met.
TX	Community First Health Plans	Texas requires prescribers to make a good faith effort; however, since Texas law does not allow Texas Managed Care Organizations to access the PDMP, MCOs do not require prescribers to provide this documentation to the MCO.

State	MCO Name	Explanation
TX	Parkland Community Health Plan	Texas law does not allow the Texas Medicaid program to access the PDMP at this time.
TX	Superior HealthPlan	The health plan does not specifically regulate PDMP requirements of prescribers. The PDMP requirements are State regulated by the Texas Board of Pharmacy and Texas Medical Association.
UT	Molina Healthcare of Utah	Molina does not receive reporting or information for which providers do or do not check the PDMP for our members. It is our belief that all our network providers comply with State requirements for checking the PDMP for our members.
UT	SelectHealth	Prescribers are not required by the contract to check the PDMP prior to prescribing a controlled substance. Prescribers are permitted to use their clinical judgment to make sure the prescription they are writing is appropriate for the patient.
VA	Anthem	Prescribers are expected to follow State regulations (code of Virginia).
VA	UnitedHealthCare	UnitedHealthcare Community Plan does not include language in the provider agreements specifically related to checking the PDMP before prescribing controlled substances. However, provider agreements do contain language requiring compliance with all State and federal laws which in the State of VA includes the checking of the PDMP before prescribing of controlled substances. Additionally, the prior authorization process requires the prescriber to attest to review of the PDMP as a requirement for approval.
WA	Community Health Plan of Washington	CHPW adheres to WAC/DOH guidance. WAC 246-919-985 explains the Washington Prescription monitoring programï¿½Required registration, queries, and documentation. Section (8) For the purposes of this section, the requirement to consult the PMP does not apply when the PMP or the EMR cannot be accessed by the physician or their designee due to a temporary technological or electrical failure
WA	UnitedHealthcare Community Plan	UnitedHealthcare Community Plan requires providers to follow all State and federal laws as well as professional board requirements related to conducting and documenting PDMP checks. State regulations began requiring prescriber documentation of a good faith effort to check the PDMP starting in October 2021.

If “Yes,” does your MCO require the provider to submit, upon request, documentation to the MCO?

Figure 79 - MCO Requires Provider to Submit Documentation

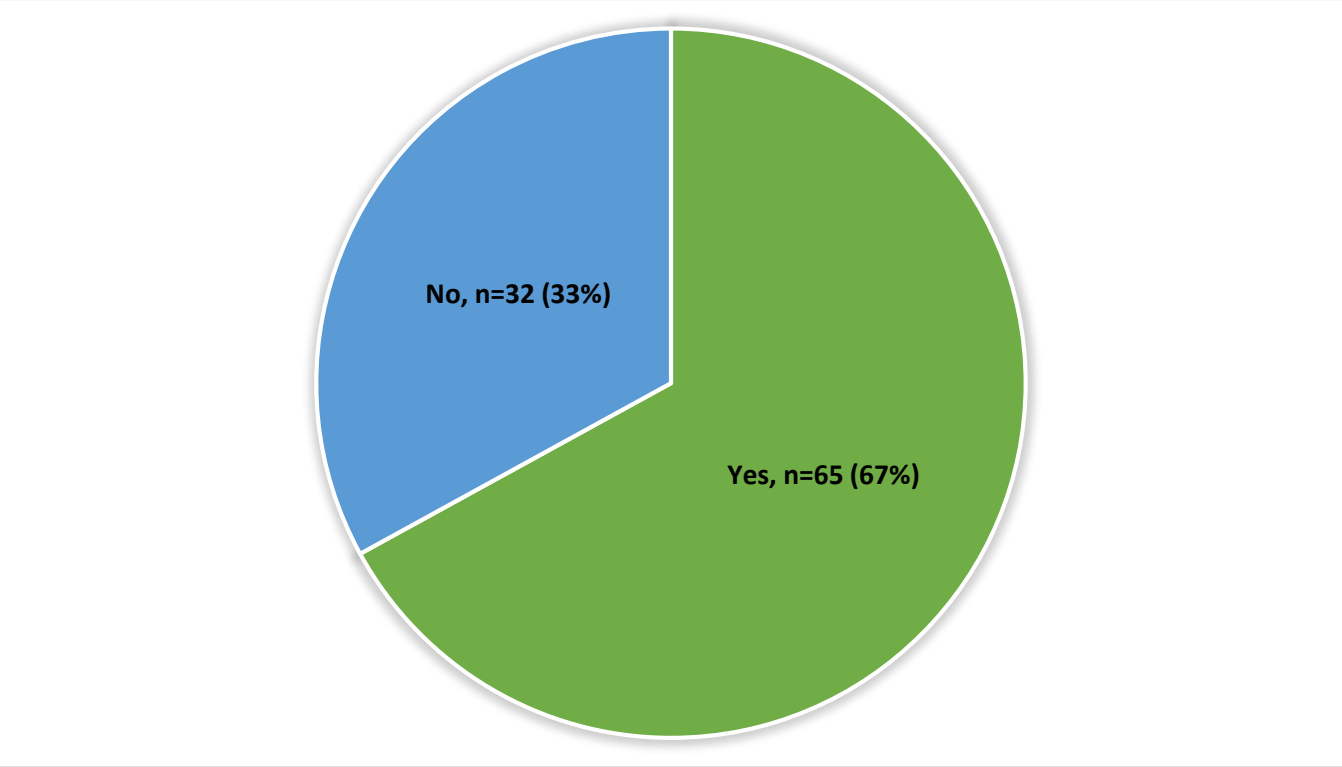

Table 86 - MCO Requires Provider to Submit Documentation

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (1), Delaware (2), District of Columbia (2), Florida (4), Illinois (3), Iowa (2), Kansas (3), Louisiana (1), Maryland (6), Michigan (1), Minnesota (3), Mississippi (2), Nebraska (1), Nevada (1), New York (3), Ohio (3), Oregon (16), Pennsylvania (4), Utah (2), Virginia (4), Washington (1)	65	67.01%
No	Colorado (2), Florida (3), Louisiana (1), Maryland (1), Michigan (2), Minnesota (1), New Jersey (1), New Mexico (1), New York (1), Oregon (1), Pennsylvania (2), South Carolina (1), Texas (13), Washington (2)	32	32.99%
National Totals		**97**	**100%**

If “No,” please explain.

Table 87 - Explanations for not Requiring Provider to Submit Documentation

State	MCO Name	Explanation
CO	Denver Health Medicaid Choice	Request for submission of documentation would be conducted by the State Department.
CO	Rocky Mountain Health Plans	Request for submission handled at the State Department level.
FL	Aetna Better Health	Some of the State PA criteria (e.g., the Opioid PA form) asks prescribers if they have reviewed the PDMP prior to prescribing the medication as required by FL statute. If the prescriber says "no," the form asks them to explain why. There is no Stated requirement that the provider must submit documentation to the MCO upon request.

State	MCO Name	Explanation
FL	Clear Health Alliance	The DOH requires each prescriber and dispenser or his or her designee has a duty to consult the PDMP system to review a patient's controlled substance dispensing history each time a controlled substance is prescribed or dispensed to a patient age 16 or older unless a statutory exemption applies. The prior authorization criteria for opiates requires that the prescriber check the PDMP, and asks for an explanation why the PDMP wasn't reviewed.
FL	Simply Healthcare	The DOH requires each prescriber and dispenser or his or her designee has a duty to consult the PDMP system to review a patient's controlled substance dispensing history each time a controlled substance is prescribed or dispensed to a patient aged 16 or older unless a statutory exemption applies. The prior authorization criteria for opiates requires that the prescriber check the PDMP and asks for an explanation why the PDMP wasn't reviewed.
LA	Aetna Better Health of Louisiana	Aetna Better Health of LA requests attestation from the provider that this database has been reviewed in accordance with Louisiana's State regulations for the databases for controlled substances requiring prior authorization.
MD	CareFirst Community Health Plan Maryland	CHPMD requires in the provider contract to follow federal and State laws, which requires providers document a good faith effort. CHPMD does not request of providers nor is it allowed for an MCO.
MI	Aetna Better Health of Michigan	Aetna is currently exploring an avenue in which providers may submit documentation to the MCO SIU team when further information is required for an investigation.
MI	HAP Empowered	Protocols are established by the regulatory agencies (State legislation, medical and pharmacy boards, LARA).Our contracts with providers include flow-down language to comply with all regulatory requirements. In this case, checking a MAPS report prior to prescribing a controlled substance is a regulatory requirement. In guidance shared with providers, the provider should document the required check in the member's medical record according to Medicaid record retention policy. This would include documenting a good faith effort that was not successful. Although we do not require the provider to submit, we often receive a MAPS confirmation Statement from the provider with requests for prior authorization for controlled substances.
MN	UCare	Documentation is not required but the provider is required to attest to checking the PDMP as part of prior authorization criteria.
NJ	Wellcare health plans	We require providers to follow all local, State and federal laws governing their practice, including subsection h. of section 26 of P.L.2007, c.244 (C.45:1-46) A pharmacist shall not dispense a Schedule II controlled dangerous substance, any opioid, or a benzodiazepine drug that is a Schedule III or IV controlled dangerous substance to any person without first accessing the prescription monitoring information
NM	Presbyterian Health Plan	Recipients of PDMP data cannot further disclose a client PMP report pursuant to 16.19.29 NMAC. However PHP can request an acknowledgment from the provider that they have queried the client.
NY	MetroPlus Health Plan	Providers are instructed to document a good faith attempt.
OR	InterCommunity Health Network	We have communicated with providers on the requirements of the SUPPORT Act and have also included it in the provider manual, however we haven't found a logistically feasible way of enforcing this on an individual member/provider basis.
PA	Health Partners	only yes/no question, most prescribers to submit, but not required

State	MCO Name	Explanation
PA	Vista	This is not required in the usual course of review or delineated in prior authorization criteria. However, MCO provider agreements require prescribers to adhere to State and federal regulations. This would include the mandate in Pennsylvania for prescribers to query the Pennsylvania Prescription Drug Monitoring Program (PA PDMP): each time a patient is prescribed any controlled substance for the first time, each time a patient is prescribed an opioid or benzodiazepine, or if there is suspected abuse or diversion. Additional referrals could result as described in Section VII.A. above if an audit or record review found that the prescriber was negligent in checking the PDMP as required.
SC	Healthy Blue South Carolina	A PDMP check is not a requirement in our current provider contract.
TX	Aetna Better Health of Texas	Texas requires prescribers to make a good faith effort. However, since Texas law does not allow Texas Medicaid to access the PDMP, MCOs do not require prescribers to provide this documentation to the MCO.
TX	Amerigroup	Texas requires prescribers to make a good faith effort. However, since Texas law does not allow Texas Medicaid to access the PDMP, MCOs do not require prescribers to provide this documentation to the MCO.
TX	Blue Cross and Blue Shield of Texas	Texas requires prescribers to make a good faith effort. However, since Texas law does not allow Texas Medicaid to access the PDMP, MCOs do not require prescribers to provide this documentation to the MCO
TX	Community Health Choice	Texas requires prescribers to make a good faith effort. However, since Texas law does not allow Texas Medicaid to access the PDMP, MCOs do not require prescribers to provide this documentation to the MCO
TX	Cook Children's Health Plan	Texas requires prescribers to make a good faith effort. However, since Texas law does not allow Texas Medicaid to access the PDMP, MCOs do not require prescribers to provide this documentation to the MCO.
TX	Dell Children's Health Plan	Texas requires prescribers to make a good faith effort. However, since Texas law does not allow Texas Medicaid to access the PDMP, MCOs do not require prescribers to provide this documentation to the MCO.
TX	Driscoll Health Plan	Texas requires prescribers to make a good faith effort. However, since Texas law does not allow Texas Medicaid to access the PDMP, MCOs do not require prescribers to provide this documentation to the MCO.
TX	El Paso Health	Texas requires prescribers to make a good faith effort. However, since Texas law does not allow Texas Medicaid to access the PDMP, MCOs do not require prescribers to provide this documentation to the MCO
TX	FirstCare Health Plans	Texas requires prescribers to make a good faith effort. However, since Texas law does not allow Texas Medicaid to access the PDMP, MCOs do not require prescribers to provide this documentation to the MCO.
TX	Molina Healthcare of Texas	Texas requires prescribers to make a good faith effort. However, since Texas law does not allow Texas Medicaid to access the PDMP, MCOs do not require prescribers to provide this documentation to the MCO.
TX	Scott and White Health Plan	Texas requires prescribers to make a good faith effort. However, since Texas law does not allow Texas Medicaid to access the PDMP, MCOs do not require prescribers to provide this documentation to the MCO.
TX	Texas Children's Health Plan	Texas requires prescribers to make a good faith effort. However, since Texas law does not allow Texas Medicaid to access the PDMP, MCOs do not require prescribers to provide this documentation to the MCO.

State	MCO Name	Explanation
TX	UnitedHealthcare Community Plan	Texas requires prescribers to make a good faith effort. However, since Texas law does not allow Texas Medicaid to access the PDMP, MCOs do not require prescribers to provide this documentation to the MCO.
WA	Coordinated Care Corporation	As part of the HCA's Support Act policy, the attestation form requires provider to review the PDMP. This is also a requirement included in WAC 182-530-1080.
WA	Molina Healthcare of Washington, Inc.	We do not have a mechanism for the provider to disclose this information or for us to check that it was done.

3. In the State's PDMP system, which of the following beneficiary information is available to prescribers as close to real-time as possible (multiple responses allowed)?

Figure 80 - Beneficiary Information Available to Prescribers as Close to Real-Time as Possible

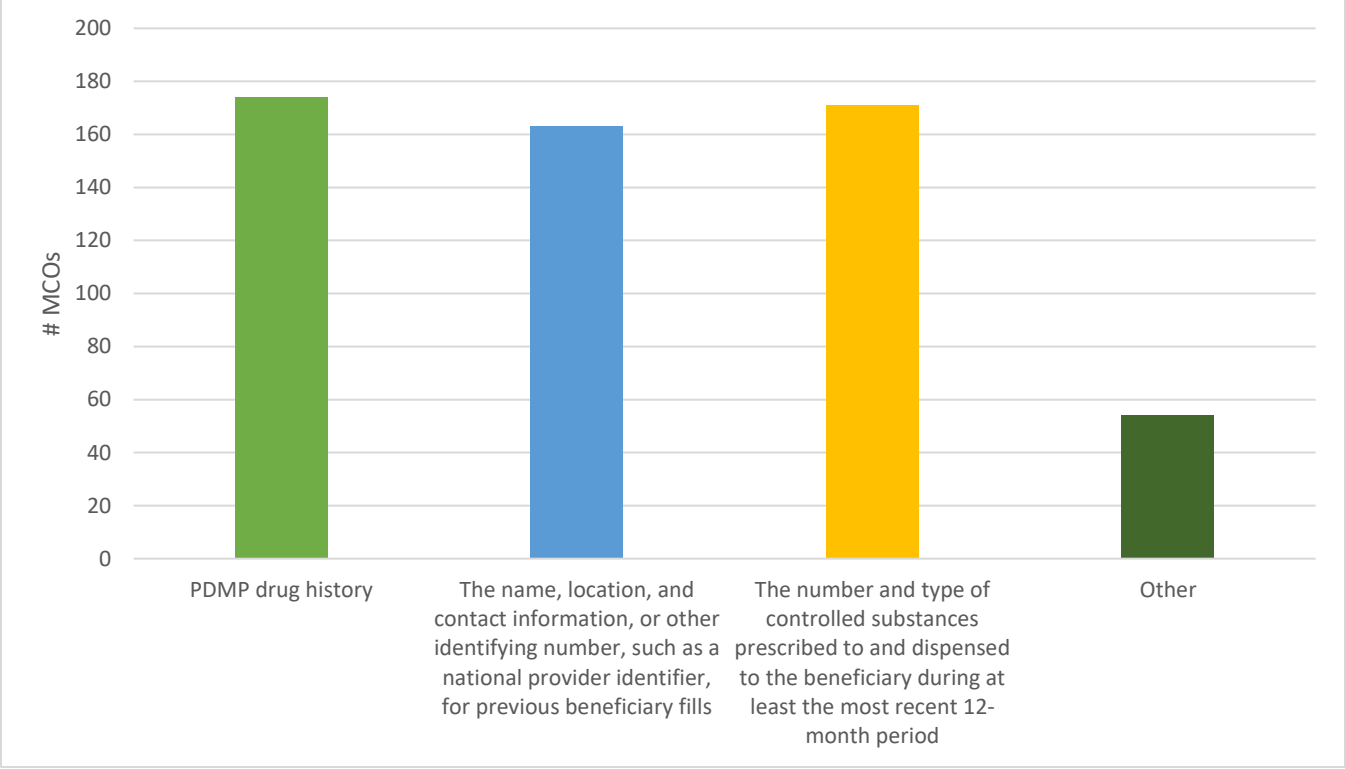

Table 88 - Beneficiary Information Available to Prescribers as Close to Real-Time as Possible

Response	States (Count of MCOs)	Count	Percentage
PDMP drug history	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (9), Georgia (3), Hawaii (4), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (5), Louisiana (4), Maryland (9), Massachusetts (1), Michigan (8), Minnesota (8), Mississippi (3), Nebraska (3), Nevada (2), New Hampshire (3), New Jersey (1), New Mexico (3), New York (11), North Carolina (4), Ohio (5), Oregon (14), Pennsylvania (8), Rhode Island (2), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	174	30.96%

Response	States (Count of MCOs)	Count	Percentage
The name, location, and contact information, or other identifying number, such as a national provider identifier, for previous beneficiary fills	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (9), Georgia (2), Hawaii (4), Illinois (5), Indiana (5), Iowa (2), Kansas (3), Kentucky (5), Louisiana (4), Maryland (9), Massachusetts (1), Michigan (8), Minnesota (8), Mississippi (3), Nebraska (3), Nevada (2), New Hampshire (3), New Jersey (1), New Mexico (3), New York (8), North Carolina (2), Ohio (5), Oregon (11), Pennsylvania (7), Rhode Island (2), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	163	29.00%
The number and type of controlled substances prescribed to and dispensed to the beneficiary during at least the most recent 12-month period	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (9), Georgia (2), Hawaii (4), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (5), Louisiana (4), Maryland (9), Massachusetts (1), Michigan (8), Minnesota (8), Mississippi (2), Nebraska (3), Nevada (2), New Hampshire (3), New Jersey (1), New Mexico (3), New York (10), North Carolina (4), Ohio (5), Oregon (14), Pennsylvania (8), Rhode Island (2), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	171	30.43%
Other	Delaware (2), District of Columbia (2), Florida (2), Hawaii (2), Illinois (1), Indiana (1), Kansas (3), Kentucky (2), Louisiana (1), Maryland (1), Massachusetts (4), Minnesota (1), Mississippi (2), Nevada (2), New Hampshire (1), New Jersey (4), New Mexico (2), New York (4), North Carolina (1), Ohio (1), Oregon (7), Pennsylvania (1), Rhode Island (1), Utah (3), Virginia (1), Washington (2)	54	9.61%
National Totals		**562**	**100%**

a. Are there barriers that hinder your MCO from fully accessing the PDMP that prevent the program from being utilized the way it was intended to be to curb FWA?

Figure 81 - Barriers Hinder MCO from Fully Accessing the PDMP to Curb FWA

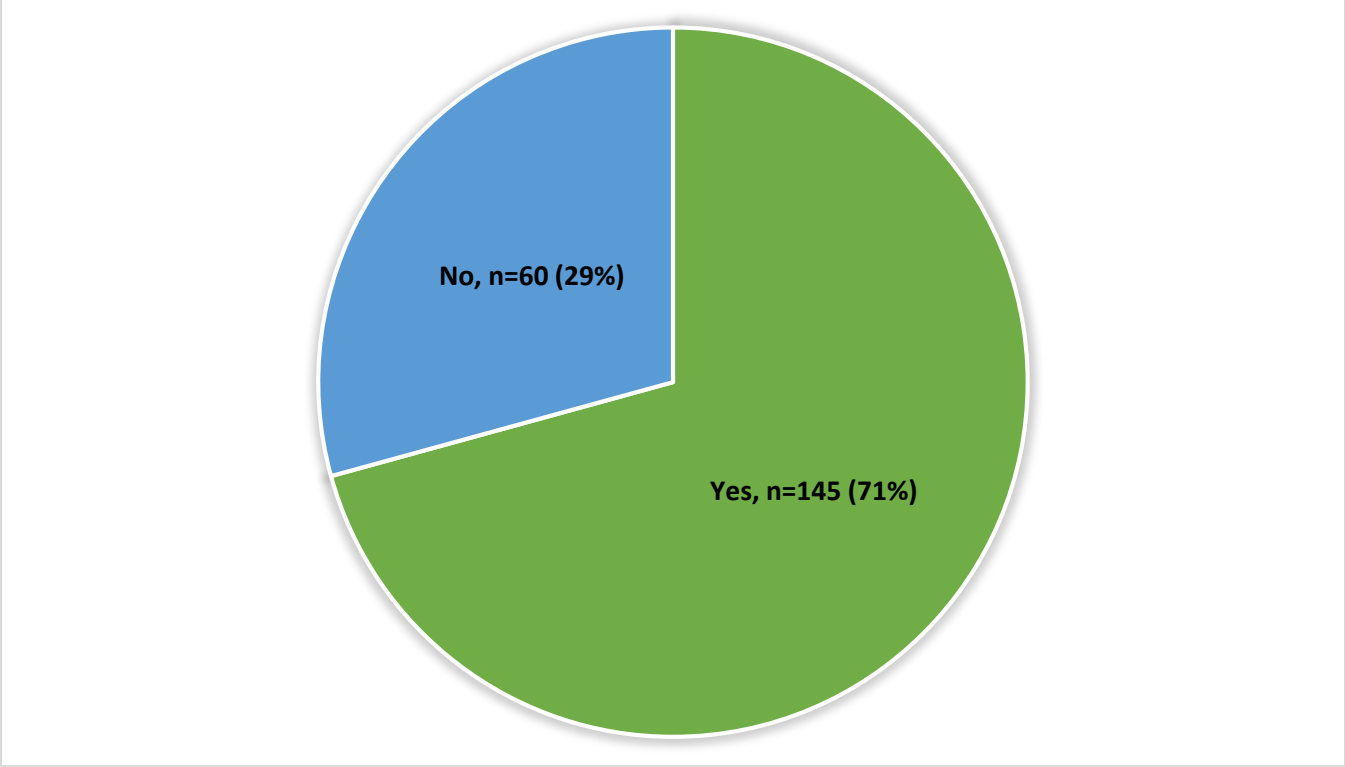

Table 89 - Barriers Hinder MCO from Fully Accessing the PDMP to Curb FWA

Response	States (Count of MCOs)	Count	Percentage
Yes	Colorado (2), Delaware (2), District of Columbia (3), Florida (8), Georgia (3), Hawaii (5), Illinois (5), Indiana (2), Iowa (2), Kansas (1), Kentucky (2), Louisiana (5), Maryland (7), Massachusetts (4), Michigan (5), Minnesota (6), Mississippi (2), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (5), New York (12), North Carolina (4), Ohio (3), Oregon (16), Pennsylvania (2), Rhode Island (3), South Carolina (4), Texas (15), Utah (3), Virginia (2), Washington (3)	145	70.73%
No	Arkansas (4), District of Columbia (1), Florida (3), Hawaii (1), Illinois (1), Indiana (3), Kansas (2), Kentucky (4), Maryland (2), Massachusetts (1), Michigan (4), Minnesota (3), Mississippi (1), Nevada (1), New Mexico (3), New York (3), North Carolina (1), Ohio (2), Oregon (5), Pennsylvania (6), South Carolina (1), Texas (1), Utah (1), Virginia (4), Washington (2)	60	29.27%
National Totals		**205**	**100%**

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

Table 90 - Explanation for Barriers that Hinder MCO from Fully Accessing the PDMP to Curb FWA

State	MCO Name	Explanation
CO	Denver Health Medicaid Choice	The State is prohibited by legislation from accessing the PDMP.

State	MCO Name	Explanation
CO	Rocky Mountain Health Plans	RMHP does not have access to PDMP data at this time.
DC	AmeriHealth Caritas DC	MCO use case needed to properly log in to PDMP
DC	CareFirst BCBS Community Health Plan DC	Although DC law requires prescribers and pharmacies to conduct a query, MCOs do not have access/credentials to find which prescribers and/or pharmacists are conducting the queries
DC	HealthServicesforSpecial NeedsChildren	HSCSN currently does not have the technology to verify that Providers are accessing PDMP before prescribing.
DE	AmeriHealth Caritas Delaware	MCOs are not currently allowed access to PDMP information. The information is currently limited to prescribers and dispensing pharmacists.
DE	HighmarkHealthOptions	Highmark Health Options does not currently have access to the Delaware PDMP.
FL	Aetna Better Health	FL has not given MCOs the ability to access the PDMP system.
FL	Children's Medical Services	MCOs are not provided with direct access to the State's PDMP. Access to the PDMP would allow MCOs the ability to conduct retrospective reviews on prescriber, dispensing, and utilization behavior that would help to curb FWA.
FL	Clear Health Alliance	the MCO as an entity has no access to the State PDMP; however, our local and State licensed Pharmacy Director can query as needed.
FL	Community Care Plan	Pharmacist that dispense in a facility with DEA license seem to be the only Rph's in the State of Florida that can access E-forcse. As a pharmacist in MCO access was denied.
FL	Molina Healthcare	Health Plans do not have the ability to query the State PDMP at this time
FL	Simply Healthcare	The MCO as an entity has no access to the State PDMP; however, our local and State licensed Pharmacy Director can query as needed.
FL	Sunshine	MCOs are not provided with direct access to the State's PDMP. Access to the PDMP would allow MCOs the ability to conduct retrospective reviews on prescriber, dispensing, and utilization behavior that would help to curb FWA.
FL	United Healthcare	The pharmacy contracts require compliance with all State and federal laws which the State of Florida identifies in PDMP monitoring Only licensed prescribers and dispensing pharmacists are permitted to access the PDMP therefore hindering the monitoring of prescribers and members by the MCO.
GA	Amerigroup GA	Health plans do not have access to the PDMP system in Georgia. However, information may be shared with a patient's insurer if the patient has authorized the prescriber to make the disclosure, or if the patient's insurer needs that information in order to provide treatment, payment or health care.
GA	CareSource	State doesn't share data. Can only access database when required by specific patient situation.
GA	Peach State Health Plan	The Georgia PDMP only allows prescribers and pharmacists to access.
HI	AlohaCare	MCOs are not granted access to PDMP data by the State.
HI	HMSAQI	MCOs in the State of Hawaii are not granted access to the PDMP and cannot query the State's PDMP database.
HI	UnitedHealthcare	The data that is in the PDMP is not in real time. There can be up to a 7 day lag period for prescriptions to be reported as being dispensed.
HI	WellCareHealthPlans	MCOs are not provided with direct access to the State's PDMP. Access to the PDMP would allow MCOs the ability to conduct retrospective reviews on prescriber, dispensing, and utilization behavior that would help to curb FWA.
HI	WellCareHealthPlansCCS	MCOs are not provided with direct access to the State's PDMP. Access to the PDMP would allow MCOs the ability to conduct retrospective reviews on prescriber, dispensing, and utilization behavior that would help to curb FWA.

State	MCO Name	Explanation
IA	Amerigroup	No access to the PMP by Medicaid as only authorized prescribers and pharmacists may to obtain information regarding their patients' use of controlled substances when actively engaged in the patient's healthcare.
IA	Iowa Total Care	No access to the PMP by Medicaid as only authorized prescribers and pharmacists may to obtain information regarding their patients' use of controlled substances when actively engaged in the patient's healthcare.
IL	Aetna_Better_Health_of_Illinois	Use of the State PDMP requires a pharmacist registering with the ILPMP to be associated with a pharmacy provider, not allowing staff employed at the health plan to register. Similarly, any prescriber registering with the ILPMP must be affiliated with a practice, and have a valid DEA number, which health plan medical directors may not have.
IL	CountyCare_Health_Plan	A system that would be able to track members nationwide would be helpful. Several members leave the State and thus their data is unavailable if their new location is to a State not sharing information with Illinois PMP.
IL	MeridianHealth	The MCOs do not have access to the IL PDMP.
IL	Molina_Healthcare_of_Illinois,_Inc	Molina lacks access PDMP data and reporting,
IL	YouthCare_HealthChoice	The MCOs do not have access to the IL PDMP.
IN	CareSource	Prescribers and pharmacies are not consistently checking the PDMP. State doesn't share data. Can only access database when required by specific patient situation.
IN	MDwise, Inc.	The system currently allows individual access per member only, not an electronic data access which would be more conducive to widespread application. However, the MCO does have concerns related to PHI integrity with respect to utilizing that data on a more widespread basis.
KS	Aetna Better Health of Kansas	Small delay in in receiving data, as MCO is considered delegate.
KY	Anthem Inc. Kentucky	MCO does not have access to PDMP.
KY	WellCare Health Plans	Yes- MCOs are not provided with direct access to the State's PDMP. Access to the PDMP would allow MCOs the ability to conduct retrospective reviews on prescriber, dispensing, and utilization behavior that would help to curb FWA
LA	Aetna Better Health of Louisiana	Yes, the MCO does not have direct access to the PDMP. The MCO has to request this data from the State pharmacy team.
LA	AmeriHealth Caritas Louisiana	Access to the PDMP data is via the LDH pharmacy dept. A request for information can be made and LDH will provide the information. ACLA does not have the ability to query the system ourselves.
LA	Healthy Blue Louisiana	We currently do not have full access to the PDMP. We have the ability to request this information from our State partners, but no immediate access is available.
LA	Louisiana Healthcare Connections	MCOs do not have the ability to query the PDMP database ourselves. Access to the PDMP data is via the LDH pharmacy dept. A request for information can be made and LDH will provide the information.
LA	UnitedHealthcare Community Plan	In order to receive PDMP related information UHC must submit a request to the State department about a member and then a follow up phone call is received from the State explaining the findings. This creates an obvious lag in our ability to monitor, track, and prevent potential cases of FWA.
MA	AllWays Health Partners	Health Plan does not have access to State PDMP. Non-medical (provider) use is prohibited.

State	MCO Name	Explanation
MA	Boston Medical Center Health Plan, Inc	The Plan is unable to register access to the PDMP database as an entity. Current registration options do not account for health plan access.
MA	Fallon Community Health Plan, Inc.	we do not have access to the States PDMP database
MA	Tufts Health Public Plans, Inc	MCOs do not have access to the database.
MD	Aetna Better Health of Maryland	State does not permit the MCO to access the PDMP
MD	Amerigroup Community Care	MCO's don't have direct access to PDMP
MD	CareFirst Community Health Plan Maryland	MCO medical directors (physicians) and clinical pharmacists may not have access to the PDMP if they do not currently prescribe or dispense, respectively, controlled substances.
MD	Jai Medical Systems Managed Care Organization, Inc.	Maryland law holds PDMP data confidential and does not allow MCO access to PDMP data. However, prescribers and pharmacists are able to register and check individual patient data before prescribing or dispensing.
MD	Kaiser Foundation Health Plan of the Mid-Atlantic States	One barrier is the two-step verification process required by CRISP which could create a barrier due to time constraints at times
MD	Maryland Physicians Care	MCO access is restricted to the PDMP database and prevents the utilization of the program to support internal FWA prevention processes.
MD	MedStar Family Choice	Maryland MCOs are legislatively prohibited from accessing PDMP data. MFC has twice petitioned the legislature to allow access but has been unsuccessful on both occasions.
MI	Aetna Better Health of Michigan	MCOs do not have permission to access the PDMP in the same manner which a prescriber or a dispensing pharmacist may. Permission must be granted by the State, lag time waiting for evaluation.
MI	HAP Empowered	In general, MAPS data for individual members is easy to obtain and extremely helpful. It would be helpful if the Pymt Type information was more clear. For example, if it says Comm Ins, we don't know if that means other insurance, or cash pay. Since Pymt Type never indicates Cash, we assume Comm Ins includes other insurance or cash pay. In addition, we do not have direct access to the database, so there are limitations in accessing information that would be helpful.
MI	Meridian Health Plan	Health Plans are not provided with direct access to the State's PDMP. Access to the PDMP would allow the health plan the ability to conduct retrospective reviews on prescriber, dispensing, and utilization behavior that would help to curb FWA
MI	Priority Health Choice	There are limitations in being able to query multiple beneficiaries. Michigan does not have a file feed to MCOs which includes PDMP data, so plans are unable to include PDMP data into point of sale DUR activities.
MI	Upper Peninsula Health Plan	Lag time
MN	BluePlus	MN State statute restricts who has access to PDMP. Currently, Blue Plus has only 2 permissions to access the PDMP. This potentially creates a bottleneck in the Lock-In Program placement for timely reviews. This limit does not allow our FWA team to utilize the PDMP information. Additionally, it is a barrier when providers do not access the PDMP prior to prescribing the controlled substance and the lag time in prescription data being submitted.

State	MCO Name	Explanation
MN	HennepinHealth	The PDMP can only be viewed by Restricted Recipient staff when considering restriction. No other use of the system by MCO staff is allowed.
MN	IMCare	Health plans cannot access the data, with the exception of a review for the State's restricted recipient program. It would be helpful to have a process to monitor for cash payments of controlled substances.
MN	PrimeWest	Data privacy laws in Minnesota make use of PDMP data difficult.
MN	SouthCountry	Minnesota regulatory restrictions on accessing PDMP.
MN	UCare	Per Minnesota State regulations, pharmacists and MCO's are not permitted to access the PDMP for information.
MS	MS-MAGNOLIA	The only barrier at this time, is the inability to receive information directly from the State PDMP to incorporate into our claims processing system (POS). Currently members are only able to be reviewed on an individual basis through manual entry.
MS	MS-UNITED	MCOs do not have the authority to query the PDMP in a way to access a single utilization report encompassing all current members. Access the PDMP is limited to query by a single patient at a time. This hinders the ability to monitor prescribing and dispensing across our population.
NC	AMHC FFY22	MCO does not have access to the PDMP in NC. An NPI is required to register for access to the PDMP.
NC	CCH FFY22	MCOs are not provided with direct access to the State's PDMP. Access to the PDMP would allow MCOs the ability to conduct retrospective reviews on prescriber, dispensing, and utilization behavior that would help to curb FWA.
NC	HB FFY22	The MCO does not have access to PDMP.
NC	UHC FFY22	MCOs do not have access to State PDMP.
NE	HealthyBlueNebraska	It is difficult to maneuver through data and requires additional system access for providers.
NE	Nebraska Total Care	As an MCO, enrollment is as a "payer" and MCOs can only see the medication history for their MCO patients only. The patient's information is HIPAA compliant. MCO personnel cannot sign in as a pharmacist to retrieve information for their MCO duties. This is not allowed and is a violation of HIPAA and carries the usual and customary prosecution and penalties.
NE	United Healthcare	Data can only be viewed per client. MCOs do not have the ability to run reports or queries thru the PDMP.
NH	AmeriHealth Caritas NH	Health Plans/Insurers do not have access to the NH PDMP due to current laws. NH would need a legislative change in order for health plans/Insurers to gain access to the PDMP.
NH	NH Healthy Families	NH State regulations prohibit MCO's from accessing the PDMP.
NH	Well Sense	WellSense is unable to register access to the PDMP database as an entity. Current registration options do not account for health plan access.
NJ	Aetna Better Health of New Jersey	The State has not given the MCOs the ability to access this system
NJ	Amerigroup Community Care	We do not have access to PDMP database.
NJ	Horizon NJ Health	In the State of New Jersey, MCOs do not have access to the PDMP database.
NJ	NJ United	MCOs do not have access to PDMP
NJ	Wellcare health plans	MCOs are not provided with direct access to the State's PDMP. Access to the PDMP would allow MCOs the ability to conduct retrospective reviews on prescriber, dispensing, and utilization behavior that would help to curb FWA

State	MCO Name	Explanation
NV	Anthem Blue Cross Blue Shield	MCOs are not allowed to access NV PDMP.
NV	Health Plan of Nevada	MCO access to PDMP is not allowed.
NV	Silver Summit Health Plan	The State of Nevada doesn't allow MCO access, only prescribers and dispensers are allowed access to a patient's controlled substance prescription medication history.
NY	AMIDA CARE	At this time Managed Care plans do not have access to query NY State's Prescription Monitoring Program (PMP).
NY	Capital District Physicians' Health Plan	New York State has not given health plans access to the PDMP
NY	Empire Blue Cross Blue Shield HealthPlus	Access to NYS i-STOP is currently only for practicing prescribers and pharmacists who write prescriptions for or dispense schedule II, III and IV drugs.
NY	Excellus Health Plan	The MCO does not have access to the State PDMP.
NY	Fidelis Care	State Dept of Health does not allow health plans to access the PDMP.
NY	Healthfirst	MCOs are not authorized to access PDMP data.
NY	Highmark Blue Cross Blue Shield of Western New York	Access to NYS i-STOP is currently only for practicing prescribers and pharmacists who write prescriptions for or dispense schedule II, III and IV drugs.
NY	Independent Health	We do not currently have access to this information
NY	Molina Healthcare of New York	MCO does not have access to PDMP.
NY	MVP Health Care	Pursuant to Section 3343-a of the New York State Public Health Law, only licensed practitioners or pharmacists who are authorized to prescribe or dispense a prescription drug and their designees are authorized to request and view this confidential information, and only in relation to the treatment and/or prescription of a patient or customer.
NY	United HealthCare	MCO's do not have access to the State PDMP
NY	Univera Healthcare	The MCO does not have access to the State PDMP.
OH	CareSource	Can only access the database when required by specific patient situation and in the course of care for that patient. Use of PDMP is limited to pharmacy and medical directors.
OH	Paramount	State Board rules prevent MCOs from doing broad comprehensive data queries which we believe could enhance our FWA activities.
OH	UnitedHealthcare Community Plan of Ohio	Inability for delegates to submit bulk patient requests.
OR	Advanced Health	Pharmacists do not have to use the system per State law. Not all providers access the system before prescribing controlled substances. Prescriptions are not reported on PDMP until after member has picked them up (lag time).
OR	Columbia Pacific CCO	We understand the PDMP to not be available to MCO Operations including access for PA and FWA.
OR	Health Share of Oregon-CareOregon RAE	We understand the PDMP to not be available to MCO Operations including access for PA and FWA.
OR	Health Share of Oregon - Legacy Health/PacificSource	MCOs do not have organizational access to the PDMP.
OR	Health Share of Oregon - OHSU	The major barriers include access limitations and inability to easily create internal provider cohorts.

State	MCO Name	Explanation
OR	InterCommunity Health Network	IHN is not currently able to regularly access the State's PDMP.
OR	Jackson Care Connect	We understand the PDMP to not be available to MCO Operations including access for PA and FWA.
OR	PacificSource Community Solutions- Central Oregon	MCOs do not have organizational access to the PDMP.
OR	PacificSource Community Solutions- Columbia Gorge	MCOs do not have organizational access to the PDMP.
OR	PacificSource Community Solutions - Lane	MCOs do not have organizational access to the PDMP.
OR	PacificSource Community Solutions - Marion/Polk	MCOs do not have organizational access to the PDMP.
OR	Providence / Health Share of Oregon	For FFY 2022 PDMP data is not available to MCO in Oregon
OR	Trillium Community Health Plan - North	MCO did not have access granted to the PDMP during FFY 2022.
OR	Trillium Community Health Plan - South	MCO did not have access granted to the PDMP during FFY 2022.
OR	Umpqua Health Alliance (UHA)	UHA does not have access to PDMP data for the purpose of utilization review.
OR	Yamhill Community Care Organization	For FFY 2022 PDMP data is not available to MCO in Oregon
PA	Highmark Wholecare	Highmark Wholecare does not currently have access.
PA	PA Health and Wellness	MCOs only have dispensing data for Pennsylvania for PDMP. We don't have access to information neighboring States
RI	NHPRI	Currently in the State of Rhode Island, MCO's are not able to have access to the PDMP.
RI	THP	MCOs do not have access to the database.
RI	UHCCP	MCO's do not have access to query the State's PDMP database.
SC	Absolute Total Care	MCOs are not provided with direct access to the State's PDMP. Access to the PDMP would allow MCOs the ability to conduct retrospective reviews on prescriber, dispensing, and utilization behavior that would help to curb FWA.
SC	Healthy Blue South Carolina	We do not have the ability to access the State's PDMP site.
SC	Molina Healthcare	MCO full access to State PDMP data is limited by requirement to have a direct patient care relationship.
SC	Select Health of South Carolina, Inc.	In SC, MCO's do NOT have access to the PDMP at all. A huge barrier in curbing FWA.
TX	Aetna Better Health of Texas	Medicaid MCOs do not have access to the Texas PDMP.
TX	Amerigroup	Medicaid MCOs do not have access to the Texas PDMP.
TX	Blue Cross and Blue Shield of Texas	Medicaid MCOs do not have access to the Texas PDMP.
TX	Community First Health Plans	Yes, Medicaid MCOs do not have access to the Texas PDMP.

State	MCO Name	Explanation
TX	Community Health Choice	Medicaid MCOs do not have access to the Texas PDMP
TX	Cook Children's Health Plan	Medicaid MCOs do not have access to the Texas PDMP
TX	Dell Children's Health Plan	Medicaid MCOs do not have access to the Texas PDMP.
TX	Driscoll Health Plan	Medicaid MCOs do not have access to the Texas PDMP
TX	El Paso Health	Medicaid MCOs do not have access to the Texas PDMP
TX	FirstCare Health Plans	Medicaid MCOs do not have access to the Texas PDMP.
TX	Molina Healthcare of Texas	Medicaid MCOs do not have access to the Texas PDMP.
TX	Parkland Community Health Plan	Texas law does not allow the Texas Medicaid program to access the PDMP at this time.
TX	Scott and White Health Plan	Medicaid MCOs do not have access to the Texas PDMP.
TX	Texas Children's Health Plan	Medicaid MCOs do not have access to the Texas PDMP
TX	UnitedHealthcare Community Plan	Medicaid MCOs do not have access to the Texas PDMP.
UT	Healthy U	Unable to query based on prescriber or pharmacy, only member.
UT	SelectHealth	SelectHealth is restricted on when they are able to access the PDMP to review patients history.
UT	Steward Health Choice Utah	Unable to query by prescriber or pharmacy. Can only query by member.
VA	UnitedHealthCare	Although the PDMP serves as a valuable tool to access available data, scripts filled at out-of-State pharmacies generally do not populate on the report. The State has multiple bordering States where members do frequently fill controlled substances.
VA	VirginiaPremier	Currently, there is no ability to query the system to review bordering State information.
WA	Amerigroup Washington Inc.	Our MCO only have access to run client level PDMP reports. That is one barrier. Additionally, our State does not require that all prescribers check the PDMP before prescribing opioid medications. That is another barrier to the PDMP being fully utilized the way it was intended to curb FWA.
WA	Coordinated Care Corporation	MCOs are not provided with direct access to the State's PDMP to review provider or member specific detail.
WA	UnitedHealthcare Community Plan	Data access is currently limited to look up by individual client query only ï¿½ there is no ability to look up by prescriber, pharmacy, or for more than one client at a time. In addition, different pharmacies classify the billing/payment information slightly differently. Here are two examples: 1) Managed Medicaid plans may be classified as commercial insurance while others report these claims as billed to Medicaid. 2) Use of a prescription discount card may be reported as billed to commercial insurance by some pharmacies while other pharmacies report these as private (out of pocket or cash) pay.

4. Have any changes to your State's PDMP during this reporting period improved or detracted from the Medicaid program's ability to access PDMP data?

Figure 82 - Changes to State PDMP That Have Improved or Detracted from the Medicaid Program's Ability to Access PDMP Data

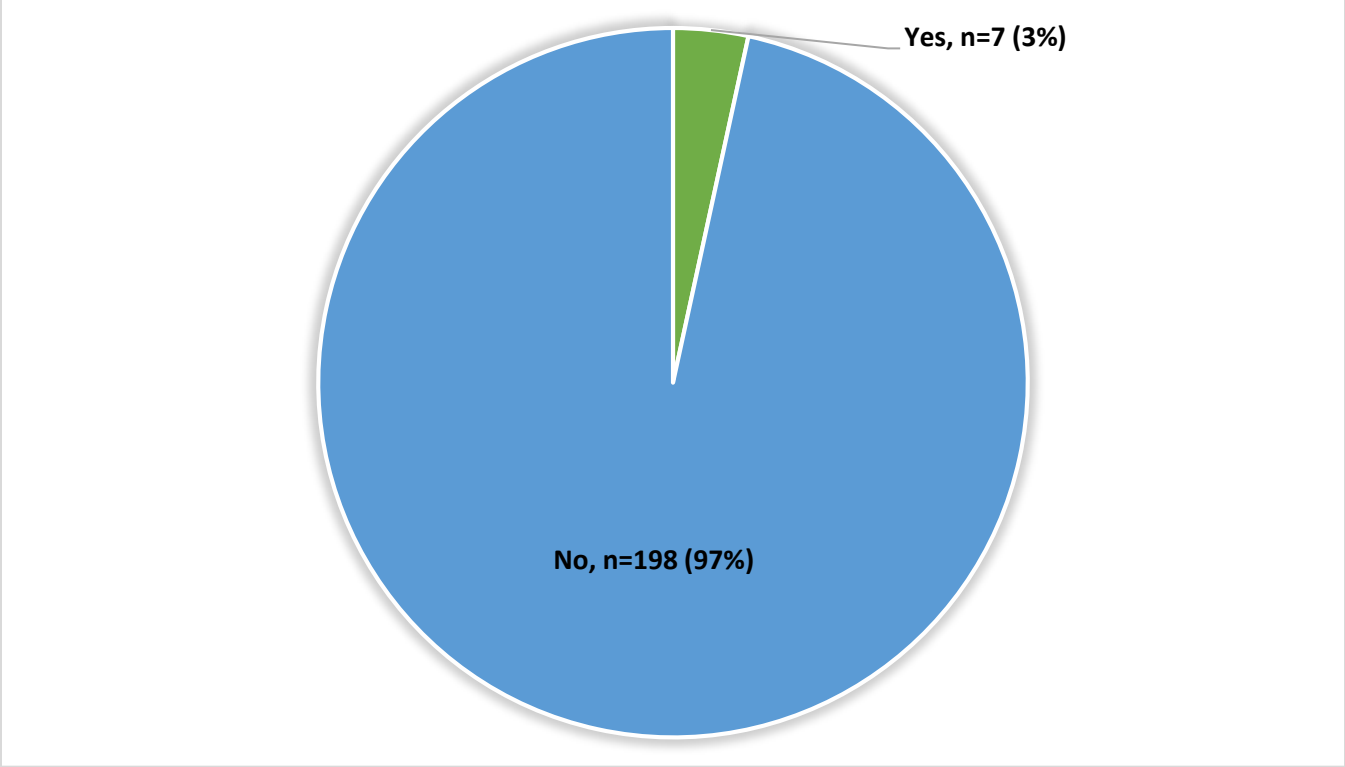

Table 91 - Changes to State PDMP That Have Improved or Detracted from the Medicaid Program's Ability to Access PDMP Data

Response	States (Count of MCOs)	Count	Percentage
Yes	Indiana (1), Kansas (3), Michigan (1), South Carolina (2)	7	3.41%
No	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (4), Iowa (2), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (8), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (3), South Carolina (3), Texas (16), Utah (4), Virginia (6), Washington (5)	198	96.59%
National Totals		**205**	**100%**

If "Yes," please explain.

Table 92 - Explanations of Changes to State PDMP That Have Improved or Detracted from the Medicaid Program's Ability to Access PDMP Data

State	MCO Name	Explanation
IN	MDwise, Inc.	Additions to reporting by adding summary MME values, along with visual and graphical data presentation make it easier to evaluate a patient's individual clinical situation. Those changes have been positive!

State	MCO Name	Explanation
KS	Aetna Better Health of Kansas	Access to the provider and pharmacy level data is now available due to State statute update
KS	Sunflower Health Plan	Access to the provider and pharmacy level data is now available due to State statute update.
KS	UnitedHealthcare	Due to State legislation, PDMP data became available to Medicaid and Managed Medicaid entities. This access has been very helpful in monitoring appropriate use and potential FWA.
MI	HAP Empowered	There were no changes related to access. However, in FY 2022, MME information at the member level was improved, with an added graph to show MME prescribed over time (making the report easier to read).
SC	Absolute Total Care	The MCO is forbidden access therefore we cannot comment on any changes to the program. We consider that a detraction.
SC	Select Health of South Carolina, Inc.	MCO's do not have access to the PDMP so please check with fee-for-service to clarify.

5. In this reporting period, have there been any data or privacy breaches of the PDMP or PDMP data?

Figure 83 - Data or Privacy Breaches of PDMP or PDMP Data During This Reporting Period

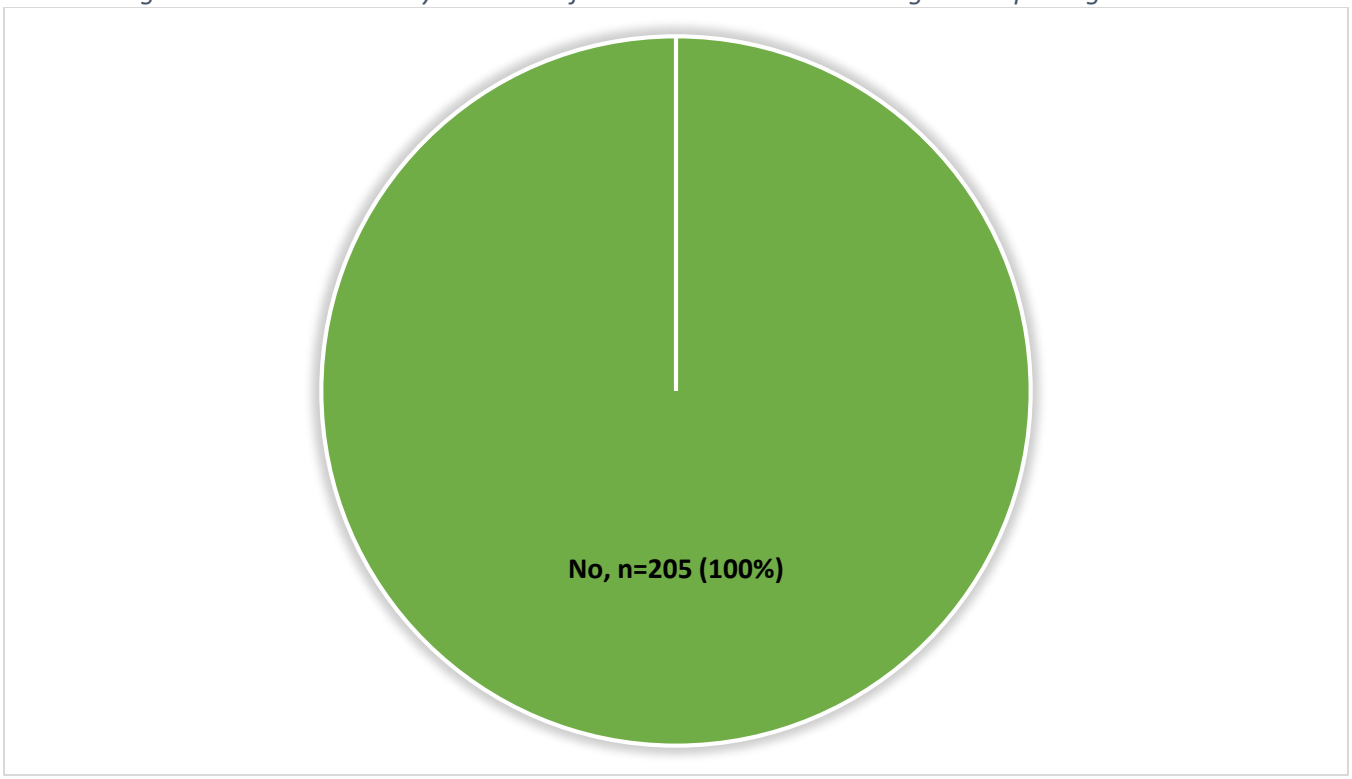

Table 93 - Data or Privacy Breaches of PDMP or PDMP Data During This Reporting Period

Response	States (Count of MCOs)	Count	Percentage
No	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	205	100.00%
National Totals		**205**	**100%**

C. Opioids

1. For your program, is this category of medications carved out and handled by the State?

Figure 84 - Opioid Category of Medications Carved Out and Handled by the State

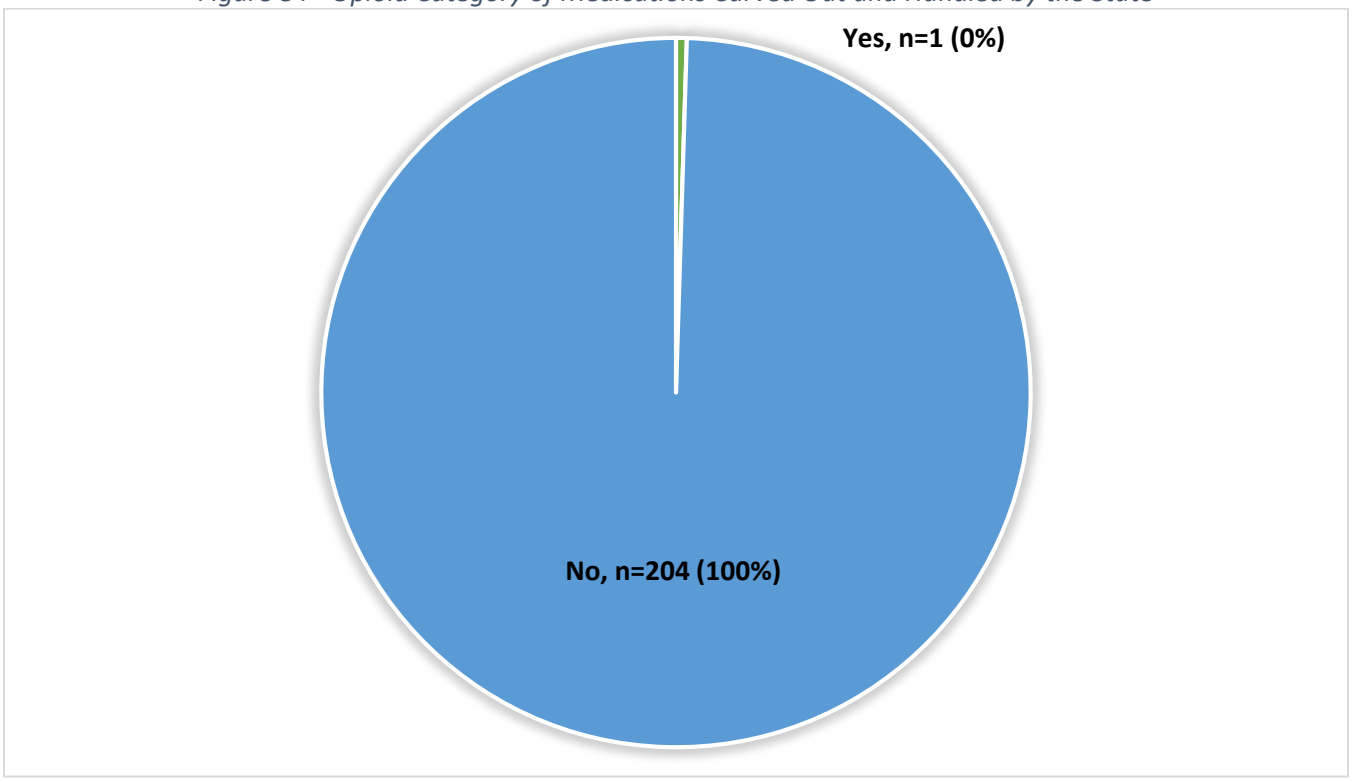

Table 94 - Opioid Category of Medications Carved Out and Handled by the State

Response	States (Count of MCOs)	Count	Percentage
Yes	New York (1)	1	0.49%

Response	States (Count of MCOs)	Count	Percentage
No	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (14), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	204	99.51%
National Totals		**205**	**100%**

If "Yes," please explain the nature and scope of the carve out.

Table 95 - Explanations for the Nature and Scope of the Opioid Category of Medications Carved Out and Handled by the State

State	MCO Name	Explanation
NY	Healthfirst	Initial prescriptions of immediate-release opioids are limited to a 7-day supply.

2. Does your MCO currently have a POS edit in place to limit the days' supply of an initial opioid prescription for opioid naïve patients?

Figure 85 - POS Edits in Place to Limit the Days' Supply Dispensed of an Initial Opioid Prescription for an Opioid Naïve Patient

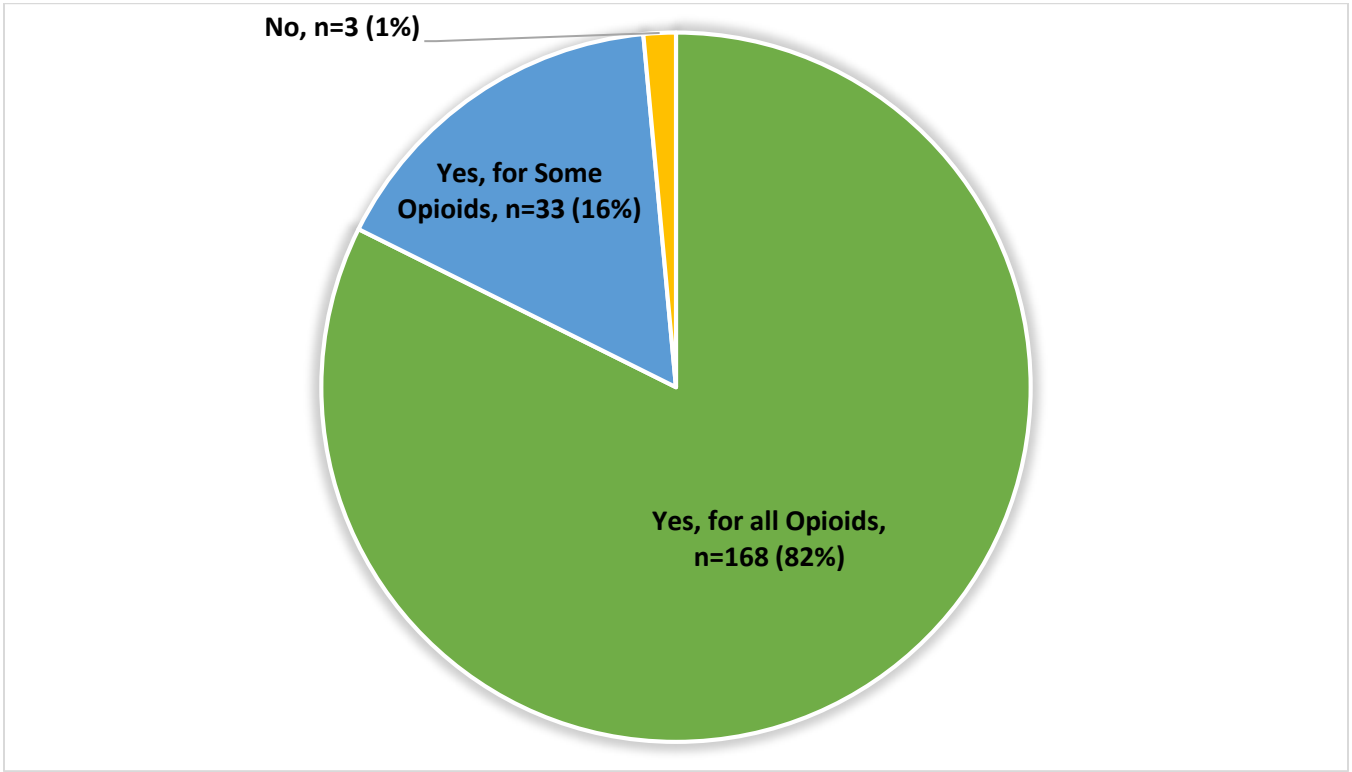

Table 96 - POS Edits in Place to Limit the Days' Supply Dispensed of An Initial Opioid Prescription for an Opioid Naïve Patient

Response	States (Count of MCOs)	Count	Percentage
Yes, for all opioids	Arkansas (4), Colorado (1), Delaware (1), District of Columbia (4), Florida (10), Georgia (3), Hawaii (6), Illinois (3), Indiana (4), Iowa (2), Kentucky (6), Louisiana (3), Maryland (7), Massachusetts (3), Michigan (6), Minnesota (7), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (10), North Carolina (5), Ohio (5), Oregon (19), Pennsylvania (6), Rhode Island (1), South Carolina (5), Texas (14), Utah (2), Virginia (5), Washington (5)	168	82.35%
Yes, for some opioids	Colorado (1), Delaware (1), Florida (1), Illinois (3), Indiana (1), Kansas (3), Louisiana (2), Maryland (2), Massachusetts (1), Michigan (3), Minnesota (2), New York (4), Oregon (2), Pennsylvania (2), Texas (2), Utah (2), Virginia (1)	33	16.18%
No	Massachusetts (1), Rhode Island (2)	3	1.47%
National Totals		**204**	**100%**

If "No," please explain why not.

Table 97 - Explanations for Lack of POS Edit in Place to Limit the Days' Supply Dispensed of an Initial Opioid Prescription for Opioid Naïve Patients

State	MCO Name	Explanation
Massachusetts	Tufts Health Public Plans, Inc	During FFY2022 the MCO did not have a DUR edit in place to inform pharmacies when an opioid naive member is filling more than a 7-day supply. Effective January 1, 2023, the MCO does have a DUR edit in place.
Rhode Island	THP	During FFY2022 the MCO did not have a DUR edit in place to inform pharmacies when an opioid naï¿½ve member is filling more than a 7-day supply. Effective January 1, 2023, the MCO does have a DUR edit in place.
Rhode Island	UHCCP	UnitedHealthcare Community Plan follows the State specific edits for opioid naive members at the point of sale. For select short-acting opioid products that meet the opioid naive requirements (no opioids in the last 60 days) a maximum of 30 MME per day dose and/or 20 units per fill limit is set. While the unit per fill limit is not a days supply specific limitation it indirectly limits initial opioid days supply.

a. If "Yes, for all opioids" or "Yes, for some opioids," what is your maximum number of days allowed for an initial opioid prescription for an opioid naïve patient?

Figure 86 - Maximum Number of Days Allowed for an Initial Opioid Prescription/Opioid Naïve Patient (State Average)

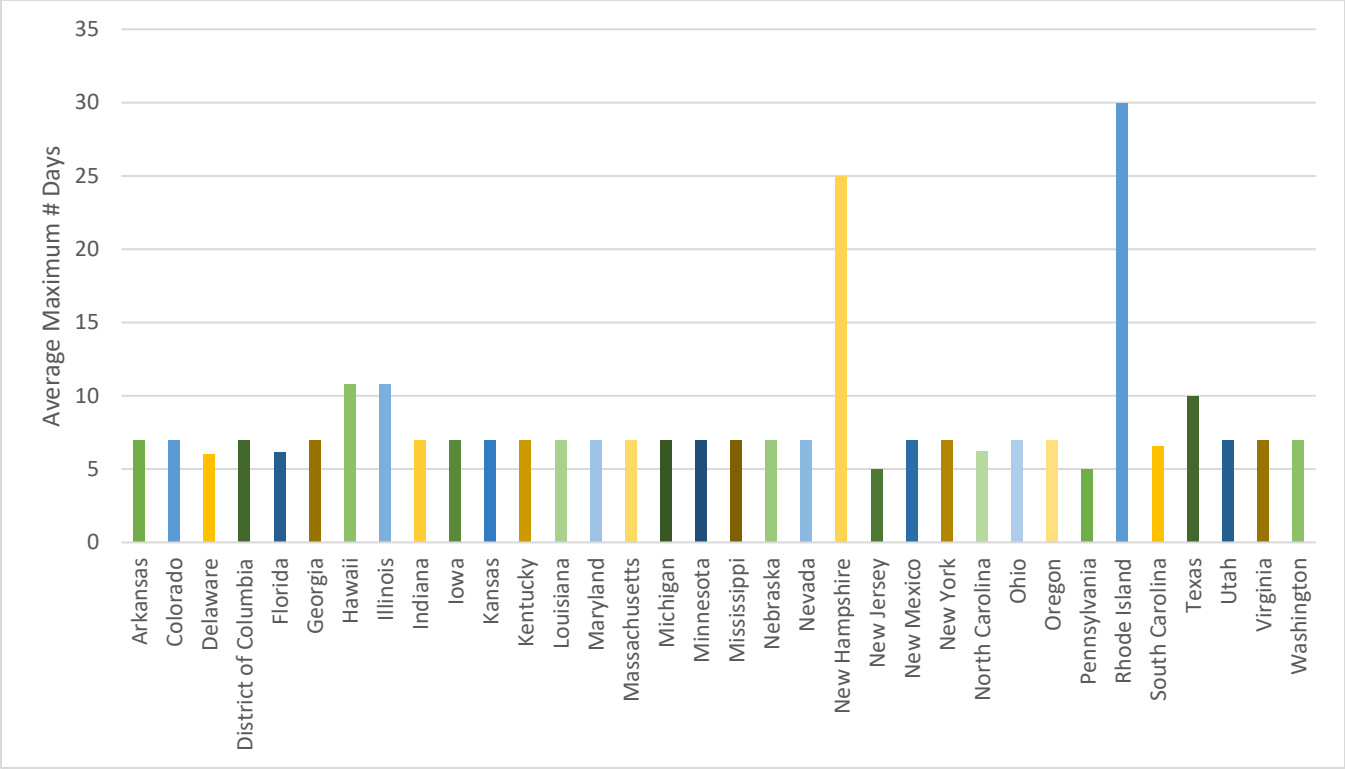

Table 98 - Maximum Number of Days Allowed for an Initial Opioid Prescription/Opioid Naïve Patient (State Average)

State	State Average Maximum Number of Days
Arkansas	7
Colorado	7
Delaware	6
District of Columbia	7
Florida	6
Georgia	7
Hawaii	11
Illinois	11
Indiana	7
Iowa	7
Kansas	7
Kentucky	7
Louisiana	7
Maryland	7
Massachusetts	7
Michigan	7

State	State Average Maximum Number of Days
Minnesota	7
Mississippi	7
Nebraska	7
Nevada	7
New Hampshire	25
New Jersey	5
New Mexico	7
New York	7
North Carolina	6
Ohio	7
Oregon	7
Pennsylvania	5
Rhode Island	30
South Carolina	7
Texas	10
Utah	7
Virginia	7
Washington	7
National Average	**8**

b. Does your MCO have POS edits in place to limit days' supply of subsequent opioid prescriptions? If yes, please indicate your days' supply limit.

Figure 87 - Days' Supply Limit of Subsequent Opioid Prescriptions

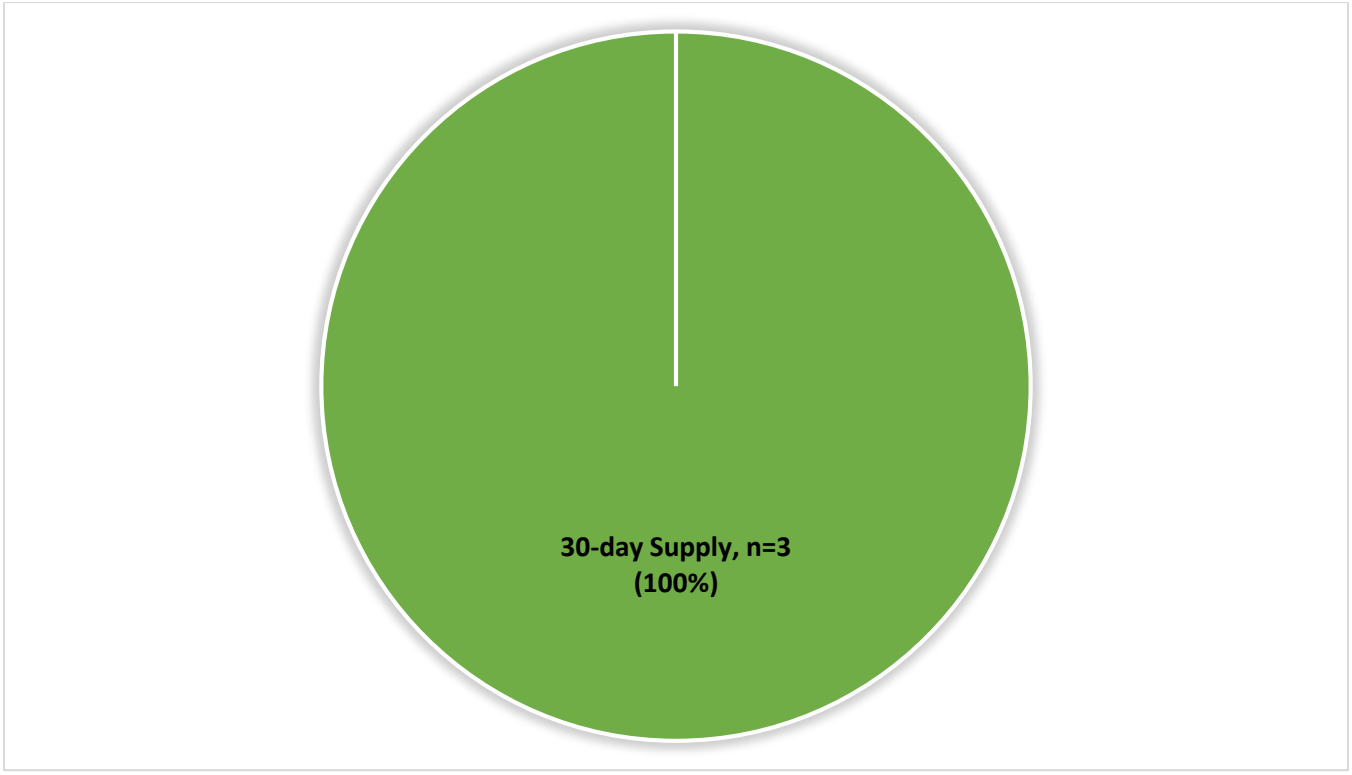

Table 99 - Days' Supply Limit of Subsequent Opioid Prescriptions

Response	States (Count of MCOs)	Count	Percentage
30-day supply	Massachusetts (1), Rhode Island (2)	3	100.00%
National Totals		**3**	**100%**

If "No," please explain.

Please reference individual State MCO reports on Medicaid.gov for more information.

3. Does your MCO have POS edits in place to limit the quantity dispensed of opioids?

Figure 88 - POS Edits in Place to Limit the Quantity Dispensed of Opioids

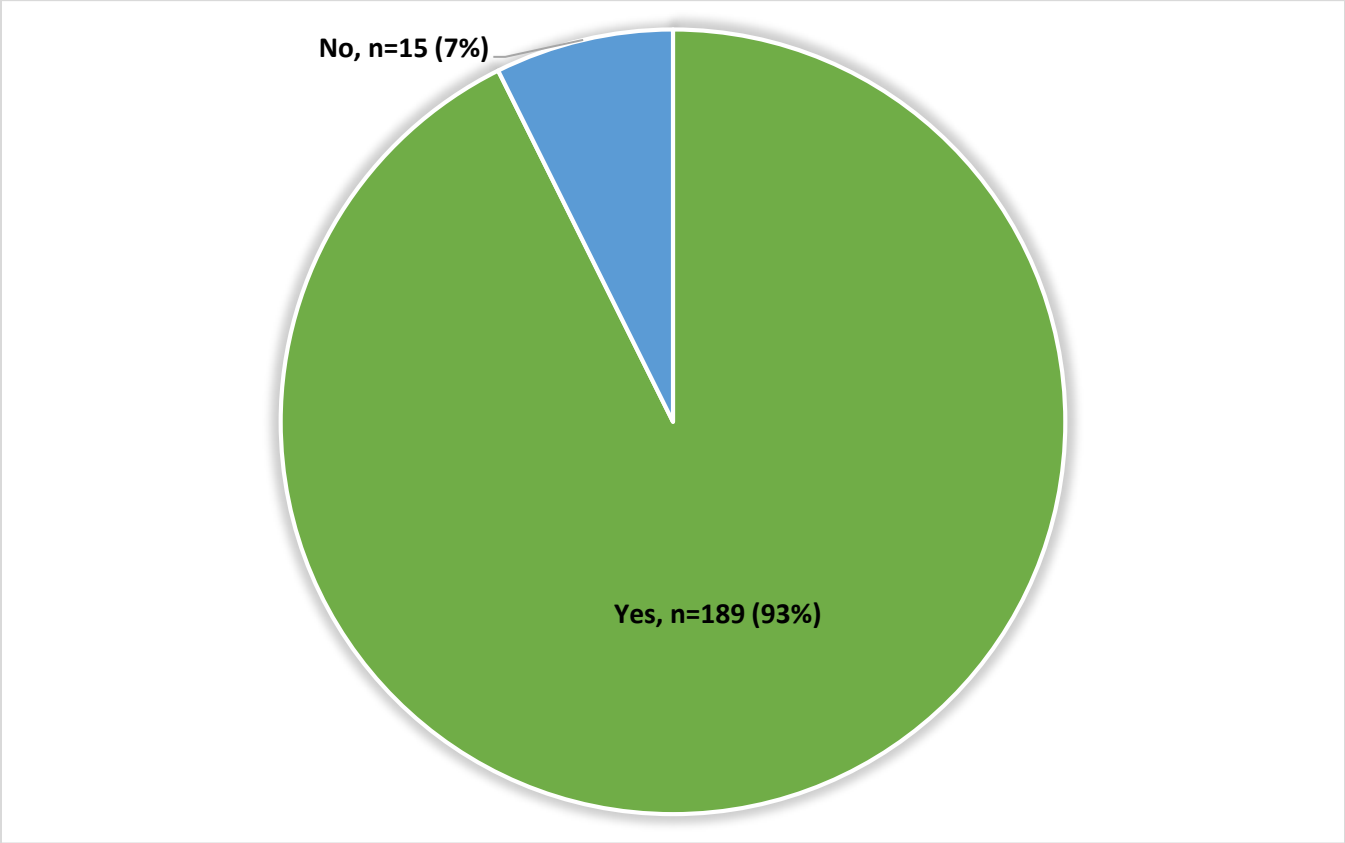

Table 100 - POS Edits in Place to Limit the Quantity Dispensed of Opioids

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (10), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (14), North Carolina (5), Ohio (5), Oregon (18), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (5), Utah (4), Virginia (6), Washington (5)	189	92.65%
No	Florida (1), Oregon (3), Texas (11)	15	7.35%
National Totals		**204**	**100%**

If “No,” please explain why not.

Table 101 - Explanations for Not Having POS Edits in Place to Limit the Quantity Dispensed of Opioids

State	MCO Name	Explanation
FL	Molina Healthcare	Point of sale edits will stop any opioid products (short or long acting or in combination) when the daily cumulative total reaches 90 MME. Also, per plan design, the maximum day supply is 34 days. Quantity limits do not apply when a patient has a diagnosis of palliative care, hospice, sickle cell disease, or cancer
OR	Cascade Health Alliance	The quantity is dependent on the medication; CHA covers an initial 7-day supply (up to 90MME/day) of selected opioids without a prior authorization. The quantity is based on morphine milligram equivalency conversion.
OR	Health Share of Oregon/Kaiser Permanente	Kaiser Permanente is a fully integrated health care system with a network comprised of Plan-owned pharmacies, medical facilities and hospitals. Kaiser Permanente physicians, clinicians and pharmacists work together to coordinate patient care. The partnership and integration with the Permanente Medical Group offers us a unique opportunity to influence opioid prescribing at the point of physician decision making. We have order sets built into our electronic health record system, Kaiser Permanente HealthConnect, with limited quantities and clinical decision support messaging to promote and drive opioid dose optimization. Our pharmacists apply Corresponding Responsibility review at the point of dispense for prescriptions that exceed quantity and/or day supply limits. We also apply high MME and days supply edits at the PBM, which have a direct impact on quantity limitations as well.
OR	PacificSource Community Solutions/Kaiser Permanente	Kaiser Permanente is a fully integrated health care system with a network comprised of Plan-owned pharmacies, medical facilities and hospitals. Kaiser Permanente physicians, clinicians and pharmacists work together to coordinate patient care. The partnership and integration with the Permanente Medical Group offers us a unique opportunity to influence opioid prescribing at the point of physician decision making. We have order sets built into our electronic health record system, Kaiser Permanente HealthConnect, with limited quantities and clinical decision support messaging to promote and drive opioid dose optimization. Our pharmacists apply Corresponding Responsibility review at the point of dispense for prescriptions that exceed quantity and/or day supply limits. We also apply high MME and days supply edits at the PBM, which have a direct impact on quantity limitations as well.
TX	Aetna Better Health of Texas	For clients who are opioid naive, providers must submit a one-time prior authorization request for: ï¿½ An opioid prescription that exceeds a ten-day supply. ï¿½ A prescription for a long-acting opioid formulation. ï¿½ A claim or combination of claims in which the total daily dose of opioids exceeds 90. The one-time requirement for prior authorization does not apply to subsequent claims because the member will no longer be opioid naive. The duration of the prior authorization is equal to the days' supply of the claim. For clients who are not opioid naï¿½ve, prior authorization is required for opioid prescriptions if the total daily dose of opioids exceeds 90 MME. For those patients who may require a tapering plan, providers would determine the development and management of a patient specific course of therapy to help manage withdrawal symptoms. A prescriber may request a tapering plan

State	MCO Name	Explanation
		through the pharmacy prior authorization process on a case-by-case basis. Prior authorization approvals last for six-months.
TX	Community First Health Plans	No, there is a concurrent DUR hard edit to identify members who have prescriptions for 90 mg morphine equivalent or greater of active opioid claims.
TX	Community Health Choice	There is a concurrent DUR hard edit to identify members who have prescriptions for 90 mg morphine equivalent or greater of active opioid claims
TX	Cook Children's Health Plan	No, there is a concurrent DUR hard edit to identify members who have prescriptions for 90 mg morphine equivalent or greater of active opioid claims
TX	Dell Children's Health Plan	There is a concurrent DUR hard edit to identify members who have prescriptions for 90 mg of morphine equivalent or greater of active opioid claims.
TX	Driscoll Health Plan	Driscoll Health Plan has a concurrent DUR hard edit identifying members with opioid prescriptions that reach the 90 mg morphine equivalent or greater threshold.
TX	El Paso Health	There is a concurrent DUR hard edit to identify members who have prescriptions for 90 mg morphine equivalent or greater of active opioid claims
TX	FirstCare Health Plans	There is a concurrent DUR hard edit to identify members who have prescriptions for 90 mg morphine equivalent or greater of active opioid claims.
TX	Parkland Community Health Plan	No, there is a limit for initial opioid prescriptions for opioid naï¿½ve patients
TX	Scott and White Health Plan	There is a concurrent DUR hard edit to identify members who have prescriptions for 90 mg morphine equivalent or greater of active opioid claims.
TX	Texas Children's Health Plan	There is a limit for initial opioid prescriptions for opioid naï¿½ve patients

a. If "Yes," does your MCO have POS edits in place to limit the quantity dispensed of short-acting (SA) opioids?

Figure 89 - POS Edits in Place to Limit the Quantity Dispensed of Short-Acting Opioids

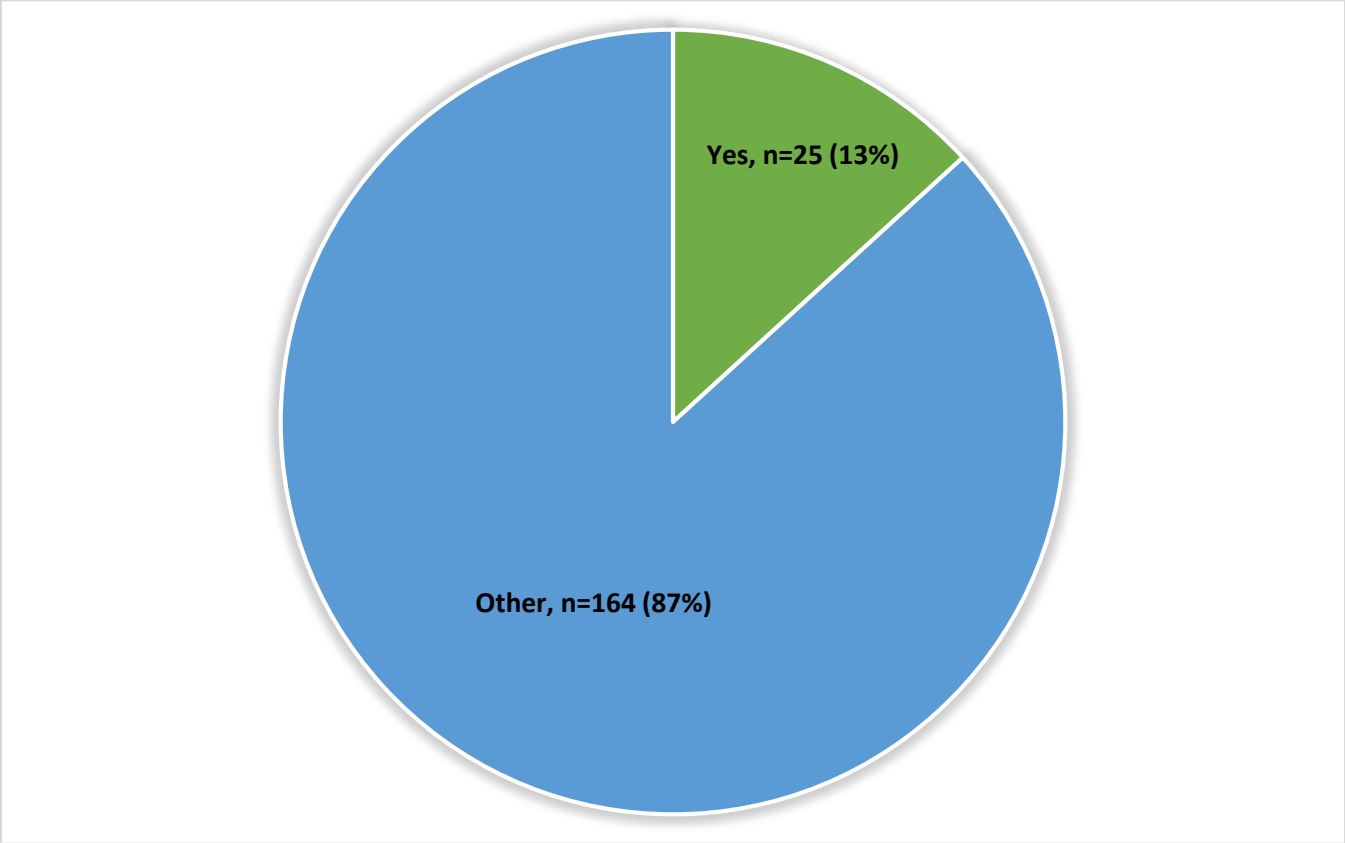

Table 102 - POS Edits in Place to Limit the Quantity Dispensed of Short-Acting Opioids

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (1), Delaware (1), District of Columbia (1), Indiana (2), Louisiana (3), Massachusetts (1), Mississippi (2), Nebraska (2), New York (3), Ohio (1), Oregon (3), Pennsylvania (1), South Carolina (1), Utah (3)	25	13.23%
Other	Arkansas (3), Colorado (2), Delaware (1), District of Columbia (3), Florida (10), Georgia (3), Hawaii (6), Illinois (6), Indiana (3), Iowa (2), Kansas (3), Kentucky (6), Louisiana (2), Maryland (9), Massachusetts (4), Michigan (9), Minnesota (9), Mississippi (1), Nebraska (1), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (11), North Carolina (5), Ohio (4), Oregon (15), Pennsylvania (7), Rhode Island (3), South Carolina (4), Texas (5), Utah (1), Virginia (6), Washington (5)	164	86.77%
National Totals		**189**	**100%**

If “Other”, please explain.

Table 103 - “Other” Explanations for POS Edits in Place to Limit the Quantity Dispensed of Short-Acting Opioids

State	MCO Name	Explanation
AR	Arkansas_Total_Care_Inc.	Initial prescriptions for SA opioids are limited to a 7-day supply. Subsequent fills are subject to maximum MME, daily quantity limits, and maximum quantity per fill edits.
AR	CareSource	Yes, 93 units/31 days standard, 124 units/31 days with cancer diagnosis. Can vary by drug.
AR	Empower_HealthCare_Solutions_LLC	Max of daily dose of 6 units for a new utilizer. There are also additional edits in place that will require prior authorization if the quantity exceeds 93 units per month for non-cancer members and also if the quantity exceeds 124 units per month for cancer members. Does not apply to non-solid dosage form.
CO	Denver Health Medicaid Choice	MCO uses formulary quantity limits for short-acting opioids that have an FDA approved maximum dose limit. The number of units varies by drug based on FDA labeling.
CO	Rocky Mountain Health Plans	UnitedHealthcare does have point-of-sale edits in place to limit the quantity dispensed of short-acting opioids. For members that meet the new to therapy requirements (less than or equal to 21 days of opioids in previous 180 days), a limit of a 7 day supply and 8 units per day and up to 56 units per dispense. Members are able to receive up to 3 fills of a 7 day supply and 56 units maximum. Members who are opioid experienced are limited to a 90 MME cumulative maximum which includes short-acting opioids, as well as long-acting opioids and narcotic containing cough and cold products.
DC	AmeriHealth Caritas DC	90 MME and 7 days supply
DC	CareFirst BCBS Community Health Plan DC	According to FDA approved dosage and CDC guideline
DC	MedStar Family Choice - District of Columbia	Quantity limits are in PBM system and vary by the short acting opioid. MFC-DC has provided guidance for the maximum number of units for 30 days.
DE	HighmarkHealthOptions	In addition to quantity limits, a cumulative morphine equivalent dose edit of 90MME per day is in place.
FL	Aetna Better Health	Schedule II Short Acting (SA) Narcotics: Max of 3-day supply and 2 fills per month. If "Acute Pain Exemption" is written on prescription, then max of 7-day supply and 2 fills per month. Schedule III-V SA Narcotics: Max of 14-days of therapy per month.
FL	Amerihealth Caritas Florida	ACFL has implemented pharmacy point of sale safety edits including: ï¿½ an early refill threshold of 90% for all medications including controlled substances; ï¿½ 7-day supply limit for all short acting opioid containing products. Note: Schedule CII short acting opioid medications are limited to a 3-day supply, and up to a maximum of 7 days if a prescriber indicates "Acute Pain exemption" on the prescription o Schedule CIII to CV medications will be limited to a maximum 7-day supply. ï¿½ Short acting opioids are limited to a 7 day supply ï¿½ Short acting opioids are limited to 2 fills in a 27 day period ï¿½ Long acting opioids are limited to 1 fill in a 27 day period *excluding recipients with a diagnosis of Cancer, Sickle Cell, or CNMP (chronic non-malignant pain)

State	MCO Name	Explanation
FL	Children's Medical Services	Quantity limits are in place for short-acting opioids and the limitations are drug specific.
FL	Clear Health Alliance	C II Opioids: We follow AHCA PDL opioid POS edits. For new prescriptions, there is a 3-day supply limit per fill, a maximum of two-3-day supplies per 30 days, or a 7-day supply limit with proper documentation on the prescription, or a maximum of two 7-day supplies per 30 days. Exceptions for: Members with certain documented conditions such as cancer-related pain, or Sickle Cell. Other conditions reviewed on a case-by-case basis. CIII - IV Opioids: For new prescriptions, there is a 14-day supply limit per 30 days. Limits are waived for members with certain diagnosis codes.
FL	Community Care Plan	CCP's PBM follows the AHCA weekly comprehensive drug list "summary of limitations" for quantity limits and have the AHCA parameters set of for POS activity. Based on the type of opioid and strength, the SA opioid may have a 30-day quantity limit identified in the weekly PDL (ex/Oxycodone ir). Additional info For Schedule II: Maximum day supply = 3 Maximum of two 3-day supplies per 30 days For Schedule II with 'Acute Pain Exemption' on Rx: Maximum day supply = 7 Maximum of two 7-day supplies per 30 days For Schedule III-V: Maximum days supply = 14 Maximum of 14 day supply per 30 days *excluding recipients with a diagnosis of Cancer, Sickle Cell, or CNMP (chronic non-malignant pain)
FL	Florida Community Care	Other. Yes, adherence to State SDL guidance; Quantity limits are in place for SA opioids dependent on the medication and its MME value.
FL	Humana Medical Plan	Limits are based on AHCAs summary of limitatons for Short acting opioids.
FL	Simply Healthcare	C II Opioids: We follow AHCA PDL opioid POS edits. For new prescriptions, there is a 3-day supply limit per fill, a maximum of two-3-day supplies per 30 days, or a 7-day supply limit with proper documentation on the prescription, or a maximum of two 7-day supplies per 30 days. Exceptions for: Members with certain documented conditions such as cancer-related pain, or Sickle Cell. Other conditions reviewed on a case-by-case basis. CIII - IV Opioids: For new prescriptions, there is a 14-day supply limit per 30 days. Limits are waived for members with certain diagnosis codes.
FL	Sunshine	Quantity limits are in place for short-acting opioids and the limitations are drug specific.
FL	United Healthcare	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of short acting opioids. All opioid naive members are limited to a 90 MME cumulative maximum of short-acting and long-acting opioids. In addition, UnitedHealthcare also implements product specific quantity limit on our short-acting opioid products for all members. Each quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.
GA	Amerigroup GA	Quantity limits per PA policy and/or label-based dosing apply.
GA	CareSource	Maximum of initial 7 day supply, then limited to 14 days in the past 45 days. Prior authorization is required for subsequent days supply after 14 days in the past 45 days is met.

State	MCO Name	Explanation
GA	Peach State Health Plan	Quantity limits are in place for short-acting opioids and the limits are drug specific.
HI	AlohaCare	Yes, in addition to initial day supply limits, SA opioids have daily quantity limits that vary according to the drug ingredient(s) and strengths. For example, this takes into consideration the acetaminophen maximum daily dose in combination opioids, FDA-approved maximum dosing, and morphine milligram equivalent (MME) limits. AlohaCare's DUR Board found no objections IngenioRx's quantity limit recommendations without changes because these applied to our population demographics.
HI	HMSAQI	Quantity limits are in place for all short-acting opioids. Quantity limits vary per drug and are based on product labeling, FDA guidance, standards of medical practice, evidence-based drug information, and published guidelines.
HI	Kaiser	30 day supply limitation for all opioids.
HI	UnitedHealthcare	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of short acting opioids. For our opioid naï¿½ve members, the quantity limits are product specific 50 MME maximums. All members, including our opioid experienced members, are limited to a 90 MME cumulative maximum of short-acting, long-acting, and opioid containing cough and cold products. In addition, UnitedHealthcare also implements product specific quantity limit on our short-acting opioid products for all members. Each quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.
HI	WellCareHealthPlans	Quantity Limit - 31 day supply (up to 120MME/day cumulatively)
HI	WellCareHealthPlansCCS	Quantity Limit - 31 day supply (up to 120MME/day cumulatively)
IA	Amerigroup	Maximum days' supply is up to a 31-day supply and up to 6 units per day, unless otherwise indicated on the Quantity Limit Chart.
IA	Iowa Total Care	Maximum days' supply is up to a 31 day supply and up to 6 units per day, unless otherwise indicated on the Quantity Limit Chart.
IL	Aetna_Better_Health_of_Illinois	POS edits limit the quantity of short-acting opioids based on the days supply or morphine milligram equivalence (MME).
IL	Blue_Cross_and_Blue_Shield_of_Illinois	34 Day Supply
IL	CountyCare_Health_Plan	Our Formulary management utilizes formulary quantity limits for short-acting opioids that have an FDA approved maximum dose limit.
IL	MeridianHealth	The quantity limit for SA opioids varies by medication. Quantity limits for each medication are based on FDA approved labeling and clinical data.
IL	Molina_Healthcare_of_Illinois,_Inc	Point of sale edits will stop any opioid products (short or long acting or in combination) when the total reaches 90 MME. Also, per plan design, the maximum day supply is 31. Quantity limits do not apply when a patient has a diagnosis of palliative care, hospice, MAT (medication assisted therapy), major surgery, major trauma, neonatal abstinence syndrome, chronic pain, sickle cell disease, and cancer.
IL	YouthCare_HealthChoice	Quantity limits for each medication are based on FDA approved labeling and clinical data.
IN	Anthem, Inc.	Quantity limits per PA policy and/or label-based dosing apply.
IN	CareSource	All short-acting (SA) opioids are limited to an initial 7 days' supply.
IN	UnitedHealthcare Community Plan, Inc.	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of short acting opioids. All members are limited to

State	MCO Name	Explanation
		the cumulative MME maximum of short-acting, long-acting, and opioid containing cough and cold products set by the State. In addition, UnitedHealthcare also implements product specific quantity limit on our short-acting opioid products for all members. Each quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.
KS	Aetna Better Health of Kansas	If continued opioid therapy is needed, a PA will be required in the days' supply going forward is 31 days. There are 14 and 21 day limits and concurrent use limits.
KS	Sunflower Health Plan	POS edit limits to a 7 day supply and 90 MME or FDA approved max dose.
KS	UnitedHealthcare	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of short acting opioids. All members are limited to a 90 MME cumulative maximum of short-acting and long-acting products. In addition, UnitedHealthcare also implements product specific quantity limit on our short-acting opioid products for all members. Each quantity limit is drug specific and aligns with the FFS KS opioid policy.
KY	Aetna Better Health of Kentucky	the number of units varies by drug based on FDA labeling
KY	Anthem Inc. Kentucky	The number of units varies by drug based on FDA labeling.
KY	Humana Healthy Horizons in Kentucky	The number of units varies by drug based on FDA labeling.
KY	Passport Health Plan By Molina Healthcare	The number of units varies by drug based on FDA labeling.
KY	United Healthcare Community Plan of Kentucky	The number of units varies by drug based on FDA labeling.
KY	WellCare Health Plans	The number of units varies by drug based on FDA labeling
LA	AmeriHealth Caritas Louisiana	Quantity limits vary by specific short-acting opioid. - 28 units: Oxycodone/Ibuprofen - 30 units: Hydrocodone/Ibuprofen - 40 units: Tramadol/Acetaminophen - 45 units: Benzhydrocodone/Acetaminophen, Hydrocodone/Acetaminophen, Hydromorphone, Meperidine, Morphine, Oxycodone, Oxycodone/Acetaminophen, Oxycodone/Aspirin, Oxymorphone, Tapentadol, tramadol -120 units: Fentanyl Buccal/Sublingual
LA	UnitedHealthcare Community Plan	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of short-acting opioids. Each short-acting opioid has a quantity limit of 28 units per 7 day supply for opioid naï¿½ve members. All members, including our opioid experienced members, are limited to a 90 MME cumulative maximum, that includes short-acting opioids, long-acting opioids, and opioid-containing cough and cold products. In addition, UnitedHealthcare also implements product specific quantity limit on our short-acting opioid products for opioid experienced members. Each quantity limit is drug specific and determined by the State.
MA	AllWays Health Partners	Initial prescriptions of immediate-release opioids are limited to a 7-day supply. For subsequent fills, opioids have an initial limit and a higher ceiling limit available through prior authorization. Quantity limits do not apply when a patient has a diagnosis for cancer (except for opioid combination products).

State	MCO Name	Explanation
MA	Boston Medical Center Health Plan, Inc	The Plan has drug specific quantity limits in place but not a single set limit in place for all SA opioids.
MA	Health New England, Inc.	Only MEQ and day limits
MA	Tufts Health Public Plans, Inc	There are POS edits in place to limit the quantity of short-acting opioids. The quantity is unique to each medication and depends on the dose listed in the package labeling as well as how many units equate to 90 MME/day.
MD	Aetna Better Health of Maryland	30 day supply at usual dosing frequency for the drug in question
MD	Amerigroup Community Care	7 days' supply per fill and 14 days' supply per 30 days for short-acting opioids - 3 days' supply per fill when prescribed by a dentist or for dental procedure pain. Additionally, quantity limits per PA policy (morphine equivalent daily dose (MEDD) program limits daily dose to 90 MEDD. Increased dosage requires Prior Authorization) and/or label based dosing applies.
MD	CareFirst Community Health Plan Maryland	The plan has POS edits in place to limit quantity dispensed via total MME and QL. There's no specific number of units limited to SA opioids, but the plan has quantity limits in place on the medication. Also, 30 day maximum allowed per fill.
MD	Jai Medical Systems Managed Care Organization, Inc.	POS edits are in place restricting opioids to a cumulative 90MME daily limit prior to prior authorization being required.
MD	Kaiser Foundation Health Plan of the Mid-Atlantic States	Consistent with MDH Opioid Management policy, select, most commonly used short-acting opioids prescribed are limited to less than 50 MME/day, and daily MME greater than 90 triggers a clinical PA. Opioid-naive patients-first fill of short-acting opioids is limited to 7 daily supplies. A second subsequent fill that does not exceed 90 MME and 30 DS is allowed within a 60-day look-back period from the initial fill. The exclusion applies to cancer, hospice, palliative care, and sickle cell.
MD	Maryland Physicians Care	There is a maximum of 30-day supply per prescription for short acting (SA) opioids.
MD	MedStar Family Choice	Quantity limits are in PBM system and vary by the short acting opioid. MDH has provided guidance for the maximum number of units for 30 days.
MD	Priority Partners MCO	Yes, Priority Partners has established a quantity limit of 180 tablets, capsules, or suppositories per a 30-day supply for all short-acting opioids. Other product formulations, such as liquids, nasal sprays, and patch have similar product-specific quantity limitations to align with the Plan's max 90 MME per day restriction.
MD	United Healthcare	For short-acting opioid claims that meet the new to therapy requirements (no opioid claims in the last 60 days), limits include a maximum of a 7 days supply for the initial fill. All members, including our opioid experienced members, are limited to a 90 MME cumulative maximum of short-acting, long-acting, and opioid containing cough and cold products. In addition, UnitedHealthcare also implements product specific quantity limit on our short-acting opioid products for all members. Each quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.
MI	Aetna Better Health of Michigan	Some SA agents limited to a 30 day supply per State mandated formulary. All products limited to 90MEQ

State	MCO Name	Explanation
MI	Blue Cross Complete of Michigan	Opioids, including short-acting dosage forms, have a daily cumulative daily MME limit of 90 mg/day. If a member exceeds that amount the claims processing system rejects the claim and a prior authorization is required.
MI	HAP Empowered	Opioid quantity limits are administered consistently with the Michigan MCO Medicaid Common Formulary/SPDL with a 30 day supply and 90 MME limit. Quantity limits may vary by drug; quantity limits apply to all applicable prescriptions (initial, subsequent, acute, chronic opioid utilization).
MI	McLaren Health Plan	The initial fill limit for short acing opioids is 7 days, not specified for "units", but must still be within the Max daily Morphine Equivalent and the FDA max.
MI	Meridian Health Plan	Quantity limits are in place for short-acting opioids and the limits are drug specific and defined by the State PDL.
MI	Molina Healthcare of Michigan	Point of sale edits will stop any opioid products (short or long acting or in combination) when the total reaches 90 MME. Maximum days' supply per prescription limitation is 30-day supply. Quantity limits do not apply when a patient has a diagnosis of palliative care, hospice, major surgery, major trauma, neonatal abstinence syndrome, chronic pain, sickle cell disease, and cancer.
MI	Priority Health Choice	For short acting opioid drugs being used for acute pain, per Michigan State law, initial opioid prescriptions for opioid naive patients may only be dispensed for up to a 7-day supply. If the short acting opioid is being utilized for chronic pain, fills are limited to 34 days per dispensing. Additionally, Michigan Medicaid has a cumulative 90 MME per day limit on all opioid drugs and there are individual drug quantity limit rules that would also be applied. If a member exceeds that amount the claims processing system rejects the claim and a prior authorization is required.
MI	UnitedHealthcare Community Plan	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of short acting opioids. All members are limited to a 90 MME cumulative maximum of short-acting, long-acting, and opioid containing cough and cold products. Opioids included on the Michigan Common Formulary are limited to drug-specific quantity limit determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.
MI	Upper Peninsula Health Plan	Restriction is based off cumulative morphine milligram equivalents no more than 90 per 30 days.
MN	BluePlus	Subsequent prescriptions for short-acting opioids are limited to a 34 day supply. Opioid quantity limits are set according to maximum dosages noted in FDA approved product labeling. If FDA approved dosage limits are not noted in the drug product's label, limits are set based on Centers for Disease Control and Prevention (CDC) guidelines.
MN	HealthPartners	Quantity limits are set for all short-acting (SA) opioids. The quantity limit can vary between agents. In general, all quantity limits follow a lower of 8 units per day or less than 90 MME dose. Initial fills are always limited to a 7 day supply.
MN	HennepinHealth	Quantities of all opioids combined are limited to a daily dose of 90 MME. The quantity dispensed is also limited to a 30 day supply.
MN	IMCare	Yes, we limit the amount dispensed to less than or equal to 90 MME per day.
MN	Medica	Limitations are based on maximum of 90 MME per day, which will vary based on the drug being dispensed.

State	MCO Name	Explanation
MN	PrimeWest	PrimeWest uses formulary quantity limits for short-acting opioids that have an FDA approved maximum dose limit. The number of units varies by drug based on FDA labeling.
MN	SouthCountry	Yes, Oxycodone-acetaminophen 5-325 mg tablet. acetaminophen-codeine 300-15 mg tablet, hydrocodone-acetaminophen 10-325 mg tab, hydrocodone-acetaminophen 325-5 mg tablet, hydrocodone-acetaminophen 7.5-325 mg tablet: 12 tablets per 1 day Butalbital-APAP-Caff-Codeine 50-325-40-30 mg capsule 5 tablets per 1 day acetaminophen-codeine 300-30 mg tablet, acetaminophen-codeine 300-60 mg tablet 6 tablets per 1 day
MN	UCare	Many short-acting (SA) opioids have quantity limits in place that are based on a maximum quantity (90 MME) that can be dispensed within a 30-day time period.
MN	UnitedHealthcare	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of short acting opioids. All members, including our opioid experienced members, are limited to a 90 MME cumulative maximum of short-acting, long-acting, and opioid containing cough and cold products. In addition, UnitedHealthcare also implements product specific quantity limit on our short-acting opioid products for all members. Each quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.
MS	MS-UNITED	Most solid dosage forms have a quantity limit of 62 units in a rolling 31 days, there are also various quantity limits of liquid formulations
NC	AMHC FFY22	Prior approval is required for greater than 90 MME per day, 5 days supply for acute pain and 7 days supply for postoperative pain.
NC	CCH FFY22	Edit is based on MME, members are not allowed to fill above 90 MME without a prior authorization. Unless pain is secondary to cancer.
NC	HB FFY22	5 days for acute pain, 7 days for post-operation pain, greater than or equal to 90 MME
NC	UHC FFY22	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of short acting opioids. All members are limited to a 90 MME cumulative maximum of short-acting and long-acting. In addition, UnitedHealthcare also implements product specific quantity limit on our short-acting opioid products for all members. Each quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.
NC	WC FFY22	Quantity limits are in place for short-acting opioids and the limits are drug specific.
NE	United Healthcare	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of short acting opioids. For our opioid naï¿½ve members, the quantities are limited to a 50 MME maximum. All members, including our opioid experienced members, are limited to a 90 MME cumulative maximum of short-acting, long-acting, and opioid containing cough and cold products and 150 tablets per 30 days for short-acting opioids. In addition, UnitedHealthcare also implements product specific quantity limit on our short-acting opioid products for all members. Each quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.
NH	AmeriHealth Caritas NH	Number of units varies by drug dosage and also limited by daily MME.

State	MCO Name	Explanation
NH	NH Healthy Families	Quantity limits are in place for short-acting opioids and the limits are drug specific.
NH	Well Sense	WellSense has drug specific quantity limits in place but not a single set limit in place for all SA opioids.
NJ	Aetna Better Health of New Jersey	Limit in place for 30day supply at usual dosing frequency for the drug in question
NJ	Amerigroup Community Care	Quantity limits per PA policy (morphine equivalent daily dose (MEDD) program limits daily dose to 50 MEDD for Opioid naive and 90 MEDD for opioid tolerant. Increased dosage requires Prior Authorization) and/or label based dosing applies.
NJ	Horizon NJ Health	Maximum quantity limits are in place in accordance with Food and Drug Administration prescribing information recommendations.
NJ	NJ United	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of short acting opioids. For our opioid naï¿½ve members, the quantity limits are product specific 50 MME maximums. All members, including our opioid experienced members, are limited to a 90 MME cumulative maximum of short-acting, long-acting, and opioid containing cough and cold products. In addition, UnitedHealthcare also implements product specific quantity limit on our short-acting opioid products for all members. Each quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.
NJ	Wellcare health plans	We limit to 31-day supply. (50MME/day)
NM	Blue Cross Blue Shield of New Mexico	31 day supply
NM	Presbyterian Health Plan	PHP has quantity limits on short-acting opioids based on FDA-approved prescribing dosing intervals. For example if the recommended dosing frequency is every 6 hours the quantity is limited to 4 units per day. PHP also has MME limits in place. A prior authorization is required for members filling cumulative opioid dose of 90 MME or greater.
NM	Western Sky Community Care	Limit of 2 opioid prescriptions per month (max of 7 days each) and a total limit of 90 morphine milligram equivalents (MME) per day on all opioid prescriptions. Members requiring a short acting opioid for long-term use for chronic pain will need to have a prior authorization submitted by their provider.
NV	Anthem Blue Cross Blue Shield	Quantity limits per PA policy (morphine equivalent daily dose (MEDD) program limits daily dose to 90 MEDD. Increased dosage requires Prior Authorization) and/or label based dosing applies.
NV	Health Plan of Nevada	Health Plan of Nevada does have point-of-sale edits in place to limit the quantity dispensed of short acting opioids. For our opioid naï¿½ve members, the quantity limits are product specific 50 MME maximums. All members, including our opioid experienced members, are limited to a 90 MME cumulative maximum of short-acting, long-acting, and opioid containing cough and cold products. In addition, Health Plan of Nevada also implements product specific quantity limit on our short-acting opioid products for all members. Each quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.

State	MCO Name	Explanation
NV	Molina	Yes, quantity limits are in place for SA opioids. QL is dependent on the medication and its MME value.
NV	Silver Summit Health Plan	There are POS edits in place to limit the day's supply of short-acting (SA) opioids but not quantity limits. Quantity limits vary per medication based on Morphine Milligram Equivalent (MME) and FDA recommendations.
NY	Capital District Physicians' Health Plan	Quantity limits are in place for short acting opioids but the number of units depend on the medication, the strength, and its MME value.
NY	EmblemHealth	Emblemhealth does not limit the quantity dispensed of short acting opioids. The rules in place target total MME. New patients starting opioid therapy, exceeding 90 MME and existing patients who are not opioid naive exceeding 200MME require prior authorization.
NY	Empire Blue Cross Blue Shield HealthPlus	Quantity limits per PA policy (morphine equivalent daily dose (MEDD) program limits daily dose to 90 MEDD. Increased dosage requires Prior Authorization) and/or label-based dosing applies.
NY	Excellus Health Plan	Quantity is limited based on cumulative MME threshold.
NY	Fidelis Care	QL is dependent on the medication and its MME value.
NY	Highmark Blue Cross Blue Shield of Western New York	Quantity limits per PA policy (morphine equivalent daily dose (MEDD) program limits daily dose to 90 MEDD). Increased dosage requires prior authorization and/or label-based dosing applies.
NY	Molina Healthcare of New York	Yes, QL is dependent on the medication and its MME value.
NY	MVP Health Care	Quantity limits based upon drug and strength.
NY	United HealthCare	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of short acting opioids. For our opioid naï¿½ve members, the quantity limits are product specific 50 MME maximums. All members, including our opioid experienced members, are limited to a 90 MME cumulative maximum of short-acting, long-acting, and opioid containing cough and cold products. In addition, UnitedHealthcare also implements product specific quantity limit on our short-acting opioid products for all members. Each quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.
NY	Univera Healthcare	Quantity is limited based on cumulative MME threshold
NY	VNSNY CHOICE SelectHealth	SelectHealth from VNS Health uses formulary quantity limits for short-acting opioids that have an FDA approved maximum dose limit. The number of units varies by drug based on FDA labeling.
OH	CareSource	Short-acting opioids are limited to a 7-day supply and 30 morphine equivalent doses per day with exception for treatment of certain conditions/prescription by an oncologist or oncology treatment in patient history.
OH	Molina Healthcare of Ohio	Opioids have an 80 MME limit.
OH	Paramount	Yes, quantity limits are in place for SA opioids. QL is dependent on the medication and its MME value.
OH	UnitedHealthcare Community Plan of Ohio	UnitedHealthcare does have point-of-sale edits in place to limit the quantity dispensed of short-acting opioids. Each opioid quantity limit is set at a drug specific 30 MME maximum dose.

State	MCO Name	Explanation
OR	AllCare CCO	Short-acting opioid prescriptions are limited to 90 MMED based on CMS equivalency tables. Quantity limits may vary depending on dosage form and/or diagnosis, but limited to 90MMED.
OR	Columbia Pacific CCO	Yes. All short-acting (SA) opioids have quantity limits on them. The specific number is unique to the drug/strength. For example, oxycodone 5 mg allows up to 16 per day. But for oxycodone 10 mg only 8 per day are allowed.
OR	Eastern Oregon Coordinated Care Organization (EOCCO)	MCO uses formulary quantity limits for short-acting opioids that have an FDA-approved maximum dose limit.
OR	Health Share of Oregon-CareOregon RAE	Yes, all short-acting (SA) opioids have daily dose quantity limits on them, but the unit amount varies by drug/strength. For example, oxycodone 5 mg allows up to 16 per day. But for oxycodone 10 mg, only 8 per day are allowed.
OR	Health Share of Oregon - Legacy Health/PacificSource	7- day supply limits for treatment naive members of all opioids, and early refill thresholds to identify potential misuse or abuse in place. Total cumulative point of sale opioid dose limited to 90 morphine milligram equivalent (MME) per day. For all opioids over MME 90/day will require prior authorization review to determine appropriateness of high dose and consideration for clinical rationale Yes, all short-acting (SA) opioids have daily dose quantity limits on them, but the unit amount varies by drug/strength. Short-acting opioids are limited by MME and FDA approved dosing.
OR	Health Share of Oregon - OHSU	Short-acting opioids are limited by MED, day supply, and FDA approved dosing.
OR	InterCommunity Health Network	Opioid naive members are limited to an initial fill of 7 days and a max MME of 50. Opioid experienced members are limited to MME of 90. This limits the quantity the member can get without an authorization.
OR	Jackson Care Connect	Yes. All short-acting (SA) opioids have quantify limits on them. The numerical amount varies by drug/strength. For example, oxycodone 5 mg allows up to 16 per day. But for oxycodone 10 mg only 8 per day are allowed.
OR	PacificSource Community Solutions- Central Oregon	7- day supply limits for treatment naive members of all opioids, and early refill thresholds to identify potential misuse or abuse in place. Total cumulative point of sale opioid dose limited to 90 morphine milligram equivalent (MME) per day. For all opioids over MME 90/day will require prior authorization review to determine appropriateness of high dose and consideration for clinical rationale Yes, all short-acting (SA) opioids have daily dose quantity limits on them, but the unit amount varies by drug/strength. Short-acting opioids are limited by MME and FDA approved dosing.
OR	PacificSource Community Solutions- Columbia Gorge	7- day supply limits for treatment naive members of all opioids, and early refill thresholds to identify potential misuse or abuse in place. Total cumulative point of sale opioid dose limited to 90 morphine milligram equivalent (MME) per day. For all opioids over MME 90/day will require prior authorization review to determine appropriateness of high dose and consideration for clinical rationale Yes, all short-acting (SA) opioids have daily dose quantity limits on them, but the unit amount varies by drug/strength.

State	MCO Name	Explanation
		Short-acting opioids are limited by MME and FDA approved dosing.
OR	PacificSource Community Solutions - Lane	7- day supply limits for treatment naive members of all opioids, and early refill thresholds to identify potential misuse or abuse in place. Total cumulative point of sale opioid dose limited to 90 morphine milligram equivalent (MME) per day. For all opioids over MME 90/day will require prior authorization review to determine appropriateness of high dose and consideration for clinical rationale Yes, all short-acting (SA) opioids have daily dose quantity limits on them, but the unit amount varies by drug/strength. Short-acting opioids are limited by MME and FDA approved dosing.
OR	PacificSource Community Solutions - Marion/Polk	7- day supply limits for treatment naive members of all opioids, and early refill thresholds to identify potential misuse or abuse in place. Total cumulative point of sale opioid dose limited to 90 morphine milligram equivalent (MME) per day. For all opioids over MME 90/day will require prior authorization review to determine appropriateness of high dose and consideration for clinical rationale Yes, all short-acting (SA) opioids have daily dose quantity limits on them, but the unit amount varies by drug/strength. Short-acting opioids are limited by MME and FDA approved dosing.
OR	Providence / Health Share of Oregon	7- day supply limits for treatment naive members of all opioids, and early refill thresholds to identify potential misuse or abuse in place. Total cumulative point of sale opiod dose limited to 90 morphine milligram equivalent (MME) per day. For all opioids over MME 90/day will require prior authorization review to determine appropriateness of high dose and consideration for clinical rationale and opioid tolerance. Some short acting opioids have quantity limits in place based on standard dosing recommendations.
OR	Umpqua Health Alliance (UHA)	Varies by substance and dosing form; maximum allowable is of 90 MMED based on CMS equivalency tables. UHA uses formulary quantity limits for short-acting opioids that have an FDA approved maximum dose limit.
OR	Yamhill Community Care Organization	7- day supply limits for treatment naive members of all opioids, and early refill thresholds to identify potential misuse or abuse in place. Total cumulative point of sale opioid dose limited to 90 morphine milligram equivalent (MME) per day. For all opioids over MME 90/day will require prior authorization review to determine appropriateness of high dose and consideration for clinical rationale and opioid tolerance. Some short acting opioids have quantity limits in place based on standard dosing recommendations.
PA	Aetna Better Health of Pennsylvania	There is no specific # of unit limit but other edits in place such as quantity limits and requirements with point-of-sale edit that limits initial fills to a 5-day supply for adults and 3-day supply for minors. Quantity limits are set based on MME and maximum doses per day based on package labeling.
PA	Geisinger	Quantity limits are set based on MME and maximum doses per day based on package labeling.
PA	Highmark Wholecare	Quantity limits vary per drug. In addition to quantity limits, a cumulative morphine equivalent dose edit of 50MME per day is in place.

State	MCO Name	Explanation
PA	PA Health and Wellness	Per Statewide PDL Policy, short-acting opioid are limited to 5 day supply for patients 21 years of age or older or prior authorization is needed. Also, prior authorization is needed if the patient has a history of 1 opioid paid claim in the past 180 days. All Long-acting opioids require prior authorization regardless of day
PA	United Healthcare	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of short acting opioids. All members are limited to a 50 MME cumulative maximum of short-acting, long-acting, and opioid containing cough and cold products. In addition, UnitedHealthcare also implements product specific quantity limit on our short-acting opioid products for all members. Each quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.
PA	UPMC	Short-acting opioids are limited to an initial fill of a 5-day supply for adults and a 3-day supply for children under the age of 21. UPMC has a Morphine Equivalent Dose quantity limit of 50 mg per day for all opioids. Additionally, there are quantity limits which limit the amount allowed for each individual opioid based on the drug's recommended dosing. Also, UPMC has a 30-day supply limit on all opioids and a quantity limit which limits opioid prescriptions to no more than 4 fills per 30 days.
PA	Vista	Quantity limits are set based on MME and maximum doses per day based on package labeling.
RI	NHPRI	30-day-supply
RI	THP	There are POS edits in place to limit the quantity dispensed of short-acting opioids. The quantity is unique to each medication and depends on the dose listed in the package labeling as well as how many units equate to 90 MME/day. Additionally, select short-acting opioids have an initial limit of 30 MME/day for members who are opioid naï¿½ve.
RI	UHCCP	UnitedHealthcare Community Plan has point-of-sale edits in place to limit the quantity dispensed of short acting opioids. For select short-acting opioid products that meet the opioid naive requirements a maximum of 30 MME per day dose and/or 20 units per fill limit is set. All members, including our opioid experienced members, are limited to a 90 MME cumulative maximum of short-acting, long-acting, and opioid containing cough and cold products.
SC	Absolute Total Care	Recipients may get an initial 7 day supply and then a second 7 day supply within a 30-day time period. Once this is exhausted they must receive approval through medical necessity review for continuation. If PA is granted, opioids are limited to a 31-day supply at a time.
SC	Healthy Blue South Carolina	QTY limits per PA policy and/ or label based dosing applies.
SC	Molina Healthcare	Point of sale edits will stop any opioid products (short or long acting or in combination) when the total reaches 90 MME. Also, per plan design, the maximum day supply is 31.
SC	Select Health of South Carolina, Inc.	Members are limited to a total daily dose of 90 MME which accumulates short and long acting opioids.
TX	Amerigroup	Members are limited to initial 10-day supplies that cannot exceed 90 MME (as a single claim and in the aggregate with other opioid medications).

State	MCO Name	Explanation
TX	Blue Cross and Blue Shield of Texas	Opioid policy for short-acting opioids limits to 10 days for opioid naï¿½ve. Subsequent prescriptions for short-acting opioids are limited to a 34 day supply. Opioid quantity limits are set according to maximum dosages noted in FDA approved product labeling. If FDA approved dosage limits are not noted in the drug product's label, limits are set based on Centers for Disease Control and Prevention (CDC) guidelines.
TX	Molina Healthcare of Texas	Point of sale edits will stop any opioid products (short or long acting or in combination) when the total reaches 90 MME. Also, per plan design, the maximum day supply is up to 34 days for STAR and STAR PLUS plans and up to 90 days for the CHIP plan. Molina follows Fee for service Opioid Clinical Policy.
TX	Superior HealthPlan	Superior HealthPlan follows Texas Vendor Drug Opioid Policy. The policy limits initial day supply for opioid naï¿½ve members and members are not allowed to start on a long-acting opioid. Members are limited to a max daily 90 MME. For an opioid naï¿½ve member, they are limited to a max 10-day supply of opioids. Each individual opioid can have its own quantity limit.
TX	UnitedHealthcare Community Plan	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of short acting opioids. All members are limited to a 90 MME cumulative maximum of short-acting, long-acting, and opioid containing cough and cold products. In addition, UnitedHealthcare also implements product specific quantity limit on our short-acting opioid products for all members. Each quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.
UT	SelectHealth	Yes, varies by short-acting opioid, generally 6-12/day.
VA	AetnaBetterHealthofVirginia	Daily QLs exist however differ by SA opioid. No more than a 7 day supply can be dispensed.
VA	Anthem	All quantity limits on opioids are followed according to the State PDL.
VA	MolinaCompleteCareofVirginia	Limit depends on the specific SA opioid and strength
VA	OptimaHealth	Short-acting opioids have a 7-day supply limit and no more than two 7-day supplies will pay within a 60-day window without prior authorization.
VA	UnitedHealthCare	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of short acting opioids. All members are limited to a 90 MME cumulative maximum of short-acting, long-acting, and opioid containing cough and cold products. In addition, UnitedHealthcare also implements product specific quantity limit on our short-acting opioid products for all members. Each quantity limit is drug specific and set at a drug specific 90 MME maximum dose and in alignment with the Virginia FFS PDL.
VA	VirginiaPremier	The State's PDL has daily dose limits for all short acting opioids.
WA	Amerigroup Washington Inc.	A quantity limit of 18 dosages per prescription for children (â‰¤20 years of age) up to and including 120 MME per day; OR A quantity limit of 42 dosages per prescription for adults (â‰¥21 years of age) up to and including 120 MME per day; AND Days supply limits of up to and including 42 calendar days of opioid use within a rolling 90-day period.
WA	Community Health Plan of Washington	Limited to 42 calendar days within a rolling 90-day period

State	MCO Name	Explanation
WA	Coordinated Care Corporation	SA opioids have quantity limit of 18 dosages per prescription for children <20 years of age, or 42 dosage per prescriptions for adult > 21 years of age. There is also a limit of 42 calendar days of opioid use within a rolling 90-day period.
WA	Molina Healthcare of Washington, Inc.	Maximum quantity limit of 42 units for patients greater than 21 years of age and max Quantity limit of 18 units for patients under 21 years of age.
WA	UnitedHealthcare Community Plan	For short-acting opioids, initial acute use is limited as follows: - For children 20 years of age and younger: 18 tablets or capsules (or 90mL) per prescription of short acting opioids. - For adults 21 years of age and older: 42 tablets or capsules (or 210mL) per prescription of short acting opioids. When exceptions are met these limits no longer apply. Exceptions include active cancer treatment, hospice, care, palliative care, or end-of-life care, or if the pharmacy submitted the claim with an expedited authorization code due to a provider writing EXEMPT on the prescription. When one or more exceptions apply, up to a 30 day supply may be dispensed. If the exception is not related to cancer, hospice, palliative, or end of life care, a maximum of 42 days supply may be dispensed during any rolling 90 day period and a prior authorization is required to exceed this limit. Where the need for pain management is related to cancer treatment or hospice, palliative, or end of life care, there is no limit to the number of 30 day supplies that may be received.

If "Yes," please specify limit as # of units.

Figure 90 - Limits for Quantity Dispensed of Short-Acting Opioids (State Average)

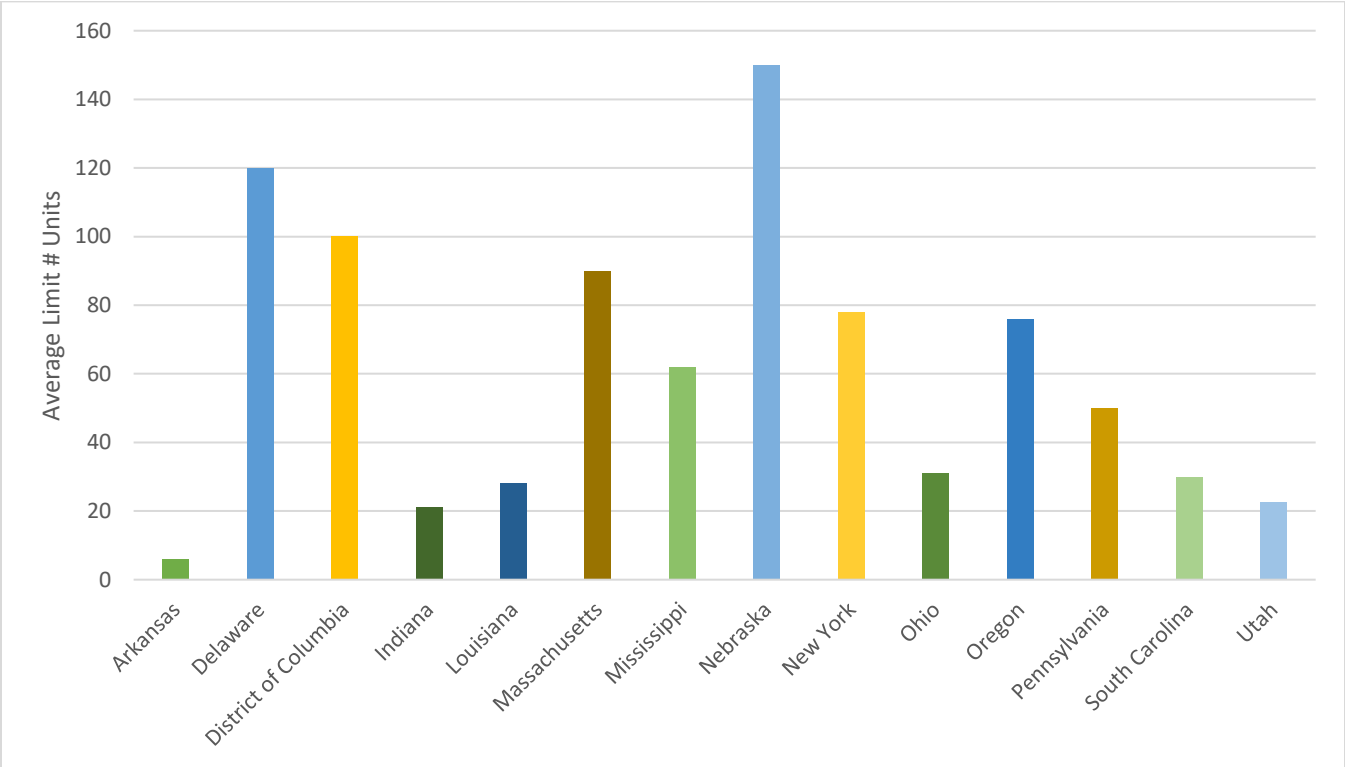

Table 104 - Limits for Quantity Dispensed of Short-Acting Opioids (State Average)

State	Average Limit in Units
Arkansas	6
Delaware	120
District of Columbia	100
Indiana	21
Louisiana	28
Massachusetts	90
Mississippi	62
Nebraska	150
New York	78
Ohio	31
Oregon	76
Pennsylvania	50
South Carolina	30
Utah	23
National Average	**62**

b. Does your MCO currently have POS edits in place to limit the quantity dispensed of long-acting (LA) opioids?

Figure 91 - POS Edits in Place to Limit the Quantity Dispensed of Long-Acting Opioids

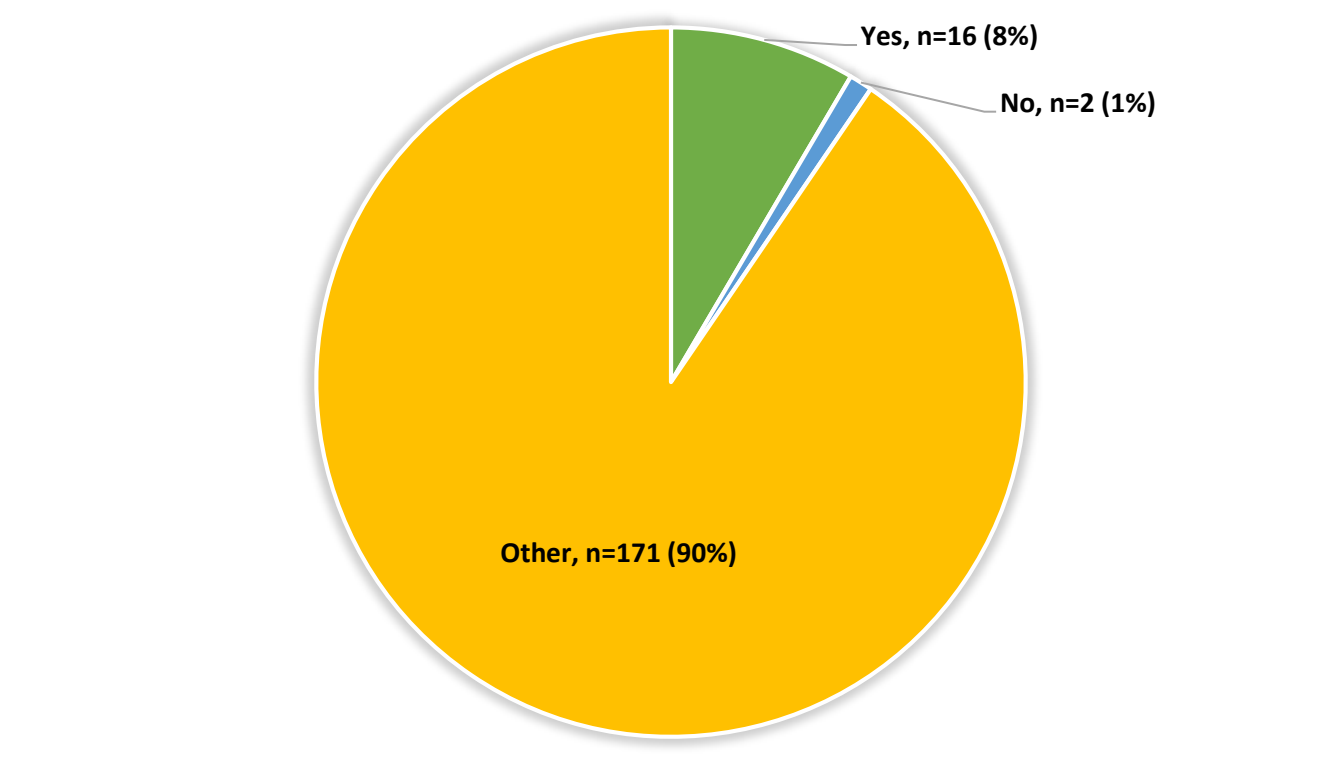

Table 105 - POS Edits in Place to Limit the Quantity Dispensed of Long-Acting Opioids

Response	States (Count of MCOs)	Count	Percentage
Yes	Florida (1), Indiana (2), Louisiana (2), Massachusetts (1), Mississippi (2), New York (3), Pennsylvania (1), South Carolina (1), Utah (3)	16	8.47%
No	Minnesota (1), Pennsylvania (1)	2	1.06%
Other	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (9), Georgia (3), Hawaii (6), Illinois (6), Indiana (3), Iowa (2), Kansas (3), Kentucky (6), Louisiana (3), Maryland (9), Massachusetts (4), Michigan (9), Minnesota (8), Mississippi (1), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (11), North Carolina (5), Ohio (5), Oregon (18), Pennsylvania (6), Rhode Island (3), South Carolina (4), Texas (5), Utah (1), Virginia (6), Washington (5)	171	90.48%
National Totals		**189**	**100%**

If "No," please explain

Table 106 - Explanation for not Having POS Edits in Place to Limit the Quantity Dispensed of Long-Acting Opioids

State	MCO Name	Explanation
MN	SouthCountry	Long acting opioids require prior authorization and will undergo clinical review by a clinical pharmacist reviewer during the prior authorization process.
PA	United Healthcare	UnitedHealthcare does have point-of-sale edits in place to limit the quantity dispensed of long-acting opioids. Each opioid quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable

If "Other," please explain.

Table 107 - "Other" Explanations for POS Edits in Place to Limit the Quantity Dispensed of Long-Acting Opioids

State	MCO Name	Explanation
AR	Arkansas_Total_Care_Inc.	LA opioids are limited to maximum MME, daily quantity limits, and maximum quantity per fill edits.
AR	CareSource	Yes, varies by drug.
AR	Empower_HealthCare_Solutions_LLC	Prior authorization is required if the quantity requested exceeds 90 MMEs.
AR	Summit_Community_Care	Claims are limited to a one-month supply (maximum of a 31-day supply).
CO	Denver Health Medicaid Choice	MCO uses formulary quantity limits for extended release/long-acting (LA) opioids that have an FDA approved maximum dose limit. The number of units varies by drug based on FDA labeling and dose consolidation for cost reduction strategies.
CO	Rocky Mountain Health Plans	UnitedHealthcare does have point-of-sale edits in place to limit the quantity dispensed of long-acting opioids. Each opioid quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable. Members who are opioid experienced are limited to a 90 MME cumulative maximum which includes short-acting opioids, as well as long-acting opioids and narcotic containing cough and cold products.
DC	AmeriHealth Caritas DC	90 MME and 7 days supply

State	MCO Name	Explanation
DC	CareFirst BCBS Community Health Plan DC	According to FDA approved dosage and CDC guideline
DC	HealthServicesforSpecial NeedsChildren	High-dose alerts require prior authorization. Edits for MME and the use of step therapy or clinical criteria, and PDMP are utilized at POS. -DC law requires that pharmacists and physicians refer to the tool for opioid review by using the PDMP application. According to the CVS Provider Manual, the Provider (Pharmacist) must review State prescription drug monitoring programs (PDMP) prior to prescribing as required by applicable law, must report information to PDMPs, and review PDMPs as a dispensing practitioner. -Denied claims for an initial prescription for opioids are limited to a 7-day supply. -the Plan design is a closed formulary. Certain medications on the formulary are covered when utilization management criteria are met (step therapy or clinical criteria). Formulary exception requests will be reviewed based on drug-specific prior authorization criteria or standard non-formulary prescription request criteria. -MME daily dose is monitored and high dose alerts are sent;90 MME per day and not to exceed 200 MME daily are messaged to the pharmacist upon dispensing.
DC	MedStar Family Choice - District of Columbia	Quantity limits are set for a 30 day supply and vary by the specific long acting opioid.
DE	AmeriHealth Caritas Delaware	All long-acting opioids require a prior authorization, and the morphine milliequivalent must be below 90 MMEs. Any dose above 90 MMEs must specify a tapering down dose or a previous failure in attempting to taper down a member.
DE	HighmarkHealthOptions	All long-acting opioids reject at POS unless a prior authorization is placed after member has met criteria. The maximum day supply would be a 34-day supply per fill. Each drug has a unique QL as well as a backup safety measure to ensure appropriate dosing. Also, a 90MME limit as well per State requirements.
FL	Aetna Better Health	Yes, 30 day supply. Dosing frequency per day varies by opioid medication and aligns with State PDL requirements.
FL	Amerihealth Caritas Florida	Varies based on the products being dispensed based on State quantity limits guidelines
FL	Children's Medical Services	Quantity limits are in place for long-acting opioids and the limits are drug specific.
FL	Clear Health Alliance	Quantity limits for LAO are per the AHCA PDL requirements and summary of drug limitations.
FL	Community Care Plan	CCP's PBM follows the AHCA weekly comprehensive drug list "summary of limitations" for quantity limits and have the AHCA parameters set of for POS activity. Based on the type of opioid, dosage form and strength.
FL	Florida Community Care	Other. Yes, adherence to State SDL guidance.
FL	Simply Healthcare	Quantity limits for LAO are per the AHCA PDL requirements and summary of drug limitations.
FL	Sunshine	Quantity limits are in place for long-acting opioids and the limits are drug specific.
FL	United Healthcare	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of long-acting opioids. All opioid naive members are limited to a 90 MME cumulative maximum of short-acting and long-acting

State	MCO Name	Explanation
		opioids. Each opioid quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.
GA	Amerigroup GA	We apply various quantity depending upon the daily quantity limit of the LA opioid according to PA policy and/ or labe-based dosing.
GA	CareSource	Long-acting opioids are limited to 3 months, or 6-month approvals based on initial or reauthorization upon PA review and are limited to a 30 days' supply. Long-acting opioids also require use of IR opioids in previous treatment plan prior to approval.
GA	Peach State Health Plan	Quantity limits are in place for long-acting opioids and the limits are drug specific.
HI	AlohaCare	Yes, LA opioids have daily quantity limits that vary according to the drug ingredient(s) and strengths. LA opioids are also limited to a 30 day supply. For example, this takes into consideration the acetaminophen maximum daily dose in combination opioids, FDA-approved maximum dosing, and morphine milligram equivalent (MME) limits. AlohaCare's DUR Board found no objections IngenioRx's quantity limit recommendations without changes because these applied to our population demographics.
HI	HMSAQI	Quantity limits are in place for all long-acting opioids. Quantity limits vary per drug and are based on product labeling, FDA guidance, standards of medical practice, evidence-based drug information, and published guidelines.
HI	Kaiser	30 day supply limitation for all opioids.
HI	UnitedHealthcare	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of long-acting opioids. All members, including our opioid experienced members, are limited to a 90 MME cumulative maximum of short-acting, long-acting, and opioid containing cough and cold products. Each opioid quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.
HI	WellCareHealthPlans	Quantity Limit - 31 day supply (up to 120MME/day cumulatively)
HI	WellCareHealthPlansCCS	Quantity Limit - 31 day supply (up to 120MME/day cumulatively)
IA	Amerigroup	Maximum days' supply is up to a 31-day supply.
IA	Iowa Total Care	Maximum days' supply is up to a 31 day supply.
IL	Aetna_Better_Health_of_Illinois	POS edits limit the quantity of long-acting opioids based on the days supply or morphine milligram equivalence (MME).
IL	Blue_Cross_and_Blue_Shield_of_Illinois	34 Day Supply
IL	CountyCare_Health_Plan	Our Formulary management utilizes formulary quantity limits for extended release/long-acting (LA) opioids that have an FDA approved maximum dose limit.
IL	MeridianHealth	The quantity limit for LA opioids varies by medication. Quantity limits for each medication are based on FDA approved labeling and clinical data.
IL	Molina_Healthcare_of_Illinois,_Inc	Point of sale edits will stop any opioid products (short or long acting or in combination) when the total reaches 90 MME. Also, per plan design, the maximum day supply is 31. Quantity limits do not apply when a patient has a diagnosis of palliative care, hospice, MAT (medication assisted therapy), major surgery, major trauma, neonatal abstinence syndrome, chronic pain, sickle cell disease, and cancer.

State	MCO Name	Explanation
IL	YouthCare_HealthChoice	Quantity limits for each medication are based on FDA approved labeling and clinical data.
IN	Anthem, Inc.	Quantity limits per PA policy and/or label-based dosing apply.
IN	CareSource	Long-acting (LA) opioids are limited to 3 month or 6-month approval based on initial or reauthorization upon PA review and are limited to a 30 days' supply. LA opioids also require use of SA opioids in previous treatment plan prior to approval.
IN	UnitedHealthcare Community Plan, Inc.	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of long acting opioids. All members are limited to the cumulative MME maximum of short-acting, long-acting, and opioid containing cough and cold products set by the State. In addition, UnitedHealthcare also implements product specific quantity limit on our long-acting opioid products for all members. Each quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.
KS	Aetna Better Health of Kansas	After meeting SA opioid drug requirements and LA opioid use has been approved, then there is a 31 days' supply limit allowed. Multiple concurrent SA and LA edits
KS	Sunflower Health Plan	PA is required for long-acting opioids regardless of day supply. Step through of short-acting opioid is required by Opioid PA criteria.
KS	UnitedHealthcare	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of long-acting opioids. All members are limited to a 90 MME cumulative maximum of short-acting and long-acting products. In addition, UnitedHealthcare also implements product specific quantity limit on our short-acting opioid products for all members. Each quantity limit is drug specific and aligns with the FFS KS opioid policy.
KY	Aetna Better Health of Kentucky	The number of units varies by drug based on FDA labeling and dose consolidation for cost reduction strategies.
KY	Anthem Inc. Kentucky	The number of units varies by drug based on FDA labeling and dose consolidation for cost reduction strategies.
KY	Humana Healthy Horizons in Kentucky	The number of units varies by drug based on FDA labeling and dose consolidation for cost reduction strategies.
KY	Passport Health Plan By Molina Healthcare	The number of units varies by drug based on FDA labeling and dose consolidation for cost reduction strategies.
KY	United Healthcare Community Plan of Kentucky	The number of units varies by drug based on FDA labeling and dose consolidation for cost reduction strategies.
KY	WellCare Health Plans	The number of units varies by drug based on FDA labeling and dose consolidation for cost reduction strategies
LA	Aetna Better Health of Louisiana	The units are limited per 30-day supply and may vary
LA	AmeriHealth Caritas Louisiana	Quantity limits vary by specific long-acting opioid: Fentanyl Patch (Duragesicï¿½) 12mcg/hr, 25mcg/hr, 37.5mcg/hr, 50mcg/hr 10 units Fentanyl Patch (Duragesicï¿½) 62.5mcg/hr, 75mcg/hr, 87.5mcg/hr, 100mcg/hr 20 units Hydromorphone (Exalgoï¿½) 30 units Hydrocodone (Zohydro ERï¿½) 60 units

State	MCO Name	Explanation
		Hydrocodone (Hysingla ERï¿½) 30 units Methadone 45 units Morphine (Avinzaï¿½) 30 units Morphine (Kadianï¿½) 30 units Morphine (MS Continï¿½) 60 units Morphine/Naltrexone (Embedaï¿½) 60 units Oxycodone (Oxycontinï¿½) 60 units Oxycodone (Xtampza ERï¿½) 60 units Oxymorphone (Opana ERï¿½) 60 units Tapentadol (Nucynta ERï¿½) 60 units Tramadol ER (Conzipï¿½) 30 units
LA	UnitedHealthcare Community Plan	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of long-acting opioids. All members are limited to a 90 MME cumulative maximum of short-acting, long-acting, and opioid containing cough and cold products. Each opioid quantity limit is drug specific and determined by the State.
MA	AllWays Health Partners	Requests for long-acting opioids will be covered with prior authorization when the following criteria are met: Â· The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through hospice or palliative care or Â· The requested drug is being prescribed for CHRONIC pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid [Note: Chronic pain is generally defined as pain that typically lasts greater than 3 months.AND The patient can safely take the requested dose based on their history of opioid use AND The patient has been evaluated and the patient will be monitored regularly for the development of opioid use disorder AND The patient's pain will be reassessed in the first month after the initial prescription or any dose increase AND every 3 months thereafter to ensure that clinically meaningful improvement in pain and function outweigh risks to patient safety AND This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR The patient has taken an immediate-release opioid for at least one week AND If the request is for a methadone product, then it is NOT being prescribed for detoxification treatment or as part of a maintenance treatment plan for opioid/substance abuse or addiction [Note: These drugs should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.]
MA	Boston Medical Center Health Plan, Inc	The Plan has drug specific quantity limits in place but not a single set limit in place for all LA opioids.
MA	Health New England, Inc.	QLs after approval based on FDA daily dosing
MA	Tufts Health Public Plans, Inc	There are POS edits in place to limit the quantity dispensed of long-acting opioids. The quantity is unique to each medication and takes into consideration the dosing listed in the FDA-approved package labeling.
MD	Aetna Better Health of Maryland	All Long Acting opioids require prior authorization and evidence of prior opioid use (i.e. not opioid naï¿½ve) are limited to a 30 days supply of usual dosing frequency of the product requested.

State	MCO Name	Explanation
MD	Amerigroup Community Care	QTY limits per PA policy and/ or label based dosing applies
MD	CareFirst Community Health Plan Maryland	The plan has POS edits in place to limit quantity dispensed via total MME and QL. There's no specific number of units limited to LA opioids, but the plan has quantity limits in place on the medication. Also, 30 day maximum allowed per fill.
MD	Jai Medical Systems Managed Care Organization, Inc.	Prior Authorization is required for all long acting opioids.
MD	Kaiser Foundation Health Plan of the Mid-Atlantic States	All long-acting opioids including fentanyl, require prior authorization, regardless of the number of units prescribed per day. Maximum day supply of 30 applies. Long-acting opioid prescribing is reserved for non-treatment naive members non-responsive to other therapies. Excluded: cancer, hospice, palliative care, sickle cell disease, and long-term care from clinical prior authorization requirements.
MD	Maryland Physicians Care	There is a maximum of 30-day supply per prescription for long acting (LA) opioids.
MD	MedStar Family Choice	Quantity limits are set for a 30 day supply and vary by the specfic long acting opioid.
MD	Priority Partners MCO	Yes, Priority Partners has established a 30-day supply limit and prior authorization requirement for all long-acting opioids to limit the quantities dispensed.
MD	United Healthcare	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of long-acting opioids. All members, including our opioid experienced members, are limited to a 90 MME cumulative maximum of short-acting, long-acting, and opioid containing cough and cold products. Each quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.
MI	Aetna Better Health of Michigan	All LA opioids require prior auth and evidence of prior opioid use (i.e. not opioid naï¿½ve) are limited to a 30 days supply of usual dosing frequency of the product requested.
MI	Blue Cross Complete of Michigan	Opioids, including long-acting dosage forms, have a daily cumulative daily MME limit of 90 mg/day. If a member exceeds that amount the claims processing system rejects the claim and a prior authorization is required.
MI	HAP Empowered	Opioid quantity limits are administered consistently with the Michigan MCO Medicaid Common Formulary/SPDL with a 30 day supply and 90 MME limit. Quantity limits may vary by drug; quantity limits apply to all applicable prescriptions (initial, subsequent, acute, chronic opioid utilization).
MI	McLaren Health Plan	MCO uses formulary quantity limits for extended release/long-acting (LA) opioids that have an FDA approved maximum dose limit, also limitations edits in place for Max Daily Morphine Equivelants.
MI	Meridian Health Plan	Quantity limits are in place for long-acting opioids and the limits are drug specific and defined by the State PDL.
MI	Molina Healthcare of Michigan	Point of sale edits will stop any opioid products (short or long acting or in combination) when the total reaches 90 MME. Maximum days' supply per prescription limitation is 30-day supply.

State	MCO Name	Explanation
		Quantity limits do not apply when a patient has a diagnosis of palliative care, hospice, major surgery, major trauma, neonatal abstinence syndrome, chronic pain, sickle cell disease, and cancer.
MI	Priority Health Choice	For any opioid being used for acute pain, per Michigan State law, initial opioid prescriptions for opioid naive patients may only be dispensed for up to a 7-day supply. If the long-acting opioid is being utilized for chronic pain, fills are limited to 34 days per dispensing. Additionally, Michigan Medicaid has a cumulative 90 MME per day limit on all opioid drugs and there are individual drug quantity limit rules that would also be applied. If a member exceeds that amount the claims processing system rejects the claim and a prior authorization is required.
MI	UnitedHealthcare Community Plan	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of long-acting opioids. All members, including our opioid experienced members, are limited to a 90 MME cumulative maximum of short-acting, long-acting, and opioid containing cough and cold products. Opioids included on the Michigan Common Formulary are limited to drug-specific quantity limit determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.
MI	Upper Peninsula Health Plan	Restriction is based off cumulative morphine milligram equivalents no more than 90 per 30 days.
MN	BluePlus	Subsequent prescriptions for long-acting opioids are limited to a 34 day supply. Opioid quantity limits are set according to maximum dosages noted in FDA approved product labeling. If FDA approved dosage limits are not noted in the drug product's label, limits are set based on Centers for Disease Control and Prevention (CDC) guidelines.
MN	HealthPartners	Long-acting opioids require a provider attestation, that therapy for this patient is being managed per standard opioid prescribing guidelines, including reserving for patients with an inadequate response to a recent adequate trial (minimum of 30 days of continuous use) with a short-acting opioid. In addition, for non-preferred products on the PDL, patients must meet the Minnesota Department of Human Services Non-Preferred Drug Prior Authorization Criteria.
MN	HennepinHealth	Quantities of all opioids combined are limited to a daily dose of 90 MME. The quantity dispensed is also limited to a 30 day supply.
MN	IMCare	Yes, we limit the amount dispensed to less than or equal to 90 MME per day.
MN	Medica	Limitations are based on maximum of 90 MME per day, which will vary based on the drug being dispensed.
MN	PrimeWest	PrimeWest uses formulary quantity limits for extended release/long-acting (LA) opioids that have an FDA approved maximum dose limit. The number of units varies by drug based on FDA labeling and dose consolidation for cost reduction strategies.
MN	UCare	Many long-acting (LA) opioids have quantity limits in place that are based on maximum quantity (90 MME) that can be dispensed within a 30-day time period.
MN	UnitedHealthcare	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of long-acting opioids. All members, including our opioid experienced members, are limited to a 90 MME cumulative maximum of short-acting, long-acting, and opioid containing cough and cold products. Each opioid quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.

State	MCO Name	Explanation
MS	MS-UNITED	Each opioid quantity limit is drug specific and determined by the MS Division of Medicaid utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable
NC	AMHC FFY22	Prior approval required for greater than 90MME/day and 7 days supply for postoperative pain.
NC	CCH FFY22	Edit is based on MME, members are not allowed to fill above 90 MME without a prior authorization. Unless pain is secondary to cancer.
NC	HB FFY22	The prior approval criteria for long-acting opioids includes daily dose limits by drug that are equivalent to 90 MME/day.
NC	UHC FFY22	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of long-acting opioids. All members, including our opioid experienced members, are limited to a 90 MME cumulative maximum of short-acting and long-acting. Each opioid quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.
NC	WC FFY22	Quantity limits are in place for short-acting opioids and the limits are drug specific.
NE	HealthyBlueNebraska	Limited to a one-month supply.
NE	Nebraska Total Care	Long Acting Opioids have QL that vary by drug and dosage form. For example, Oxycontin has a QL of 2 per day, and Butrans patch has a QL of 4 per 28 days.
NE	United Healthcare	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of long-acting opioids. All members, including our opioid experienced members, are limited to a 90 MME cumulative maximum of short-acting, long-acting, and opioid containing cough and cold products. Each opioid quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.
NH	AmeriHealth Caritas NH	Number of units limitation is drug specific, and limited by daily MME and prior authorization request.
NH	NH Healthy Families	Quantity limits are in place for long-acting opioids and the limits are drug specific.
NH	Well Sense	WellSense has drug specific quantity limits in place but not a single set limit in place for all LA opioids.
NJ	Aetna Better Health of New Jersey	All LA opioids require prior auth and evidence of prior opioid use (i.e., not opioid naive) are limited to a 30 days' supply of usual dosing frequency of the product requested. However, ABHNJ does follow the State guidelines and based on the Diagnosis PAs might have different approval, for example. Initial Approval Duration: o Cancer, End-of-Life, Palliative Care: 1 year o Chronic Pain: 3 months o Acute Pain: 30 days or less o Acute Pain in Pediatric Members: 3 days or less o Total treatment duration should not exceed 7 days Renewal Approval Duration: ï¿½ Chronic Pain: 6 months ï¿½ Acute Pain: 30 days or less

State	MCO Name	Explanation
NJ	Amerigroup Community Care	QTY limits per PA policy and/ or label based dosing applies.
NJ	Horizon NJ Health	Maximum quantity limits are in place in accordance with Food and Drug Administration prescribing information recommendations.
NJ	NJ United	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of long-acting opioids. All members, including our opioid experienced members, are limited to a 90 MME cumulative maximum of short-acting, long-acting, and opioid containing cough and cold products. Each opioid quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.
NJ	Wellcare health plans	We limit to 31 day supply (90MME/day)
NM	Blue Cross Blue Shield of New Mexico	31 day supply
NM	Presbyterian Health Plan	PHP has quantity limits on long-acting opioids based on FDA-approved dosing intervals. For example if the recommended dosing frequency is every 12 hours the quantity is limited to 2 units per day. PHP also has MME limits in place. A prior authorization is required for members filling cumulative opioid dose of 90 MME or greater.
NM	Western Sky Community Care	Limit of 2 opioid prescriptions per month and a total limit of 90 morphine milligram equivalents (MME) per day on all opioid prescriptions. In order for any long acting opioid to be approved, a member must have had a trial of short acting/immediate-release opioids for a minimum of 81 days in the last 120 days and/or their prescriber needs to submit a prior authorization.
NV	Anthem Blue Cross Blue Shield	QTY limits per PA policy and/ or label based dosing applies
NV	Health Plan of Nevada	Health Plan of Nevada does have point-of-sale edits in place to limit the quantity dispensed of long-acting opioids. All members, including our opioid experienced members, are limited to a 90 MME cumulative maximum of short-acting, long-acting, and opioid containing cough and cold products. Each opioid quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.
NV	Molina	Yes, quantity limits are in place for LA opioids. QL is dependent on the medication and its MME value.
NV	Silver Summit Health Plan	There are POS edits in place to limit the day's supply of long-acting (LA) opioids but not quantity limits. Quantity limits vary per medication based on Morphine Milligram Equivalent (MME) and FDA recommendations.
NY	Capital District Physicians' Health Plan	Quantity limits are in place for long acting opioids but the number of units depend on the medication, the FDA approved dosing frequency, the strength, and its MME value.
NY	EmblemHealth	Emblemhealth does not limit the quantity dispensed of long-acting opioids. All long-acting opioids require prior authorization. The rules in place target total MME and medical necessity.
NY	Empire Blue Cross Blue Shield HealthPlus	QTY limits per PA policy and/ or label-based dosing applies.
NY	Excellus Health Plan	Quantity is limited based on cumulative MME threshold.
NY	Fidelis Care	QL is dependent on the medication and its MME value.

State	MCO Name	Explanation
NY	Highmark Blue Cross Blue Shield of Western New York	Quantity limits per PA policy (morphine equivalent daily dose (MEDD) program limits daily dose to 90 MEDD). Increased dosage requires prior authorization and/or label-based dosing applies.
NY	Molina Healthcare of New York	Yes, QL is dependent on the medication and its MME value.
NY	MVP Health Care	Quantity limits based upon drug and strength.
NY	United HealthCare	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of long-acting opioids. All members, including our opioid experienced members, are limited to a 90 MME cumulative maximum of short-acting, long-acting, and opioid containing cough and cold products. Each opioid quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.
NY	Univera Healthcare	Quantity is limited based on cumulative MME threshold
NY	VNSNY CHOICE SelectHealth	SelectHealth from VNS Health uses formulary quantity limits for extended release/long-acting (LA) opioids that have an FDA approved maximum dose limit. The number of units varies by drug based on FDA labeling and dose consolidation for cost reduction strategies.
OH	Buckeye Health Plan	The 7 day limit applies to short-acting opioids. Long-acting opioids (methadone, fentanyl, MS Contin) require prior authorization, regardless of day supply. Maximum 7 day supply for opioid naï¿½ve patients; no more than 5 prescriptions for any opioids in rolling 30 day period. Some opioids have individual specific quantity limits. For example, morphine sulfate 30mg has a quantity limit of 6 tablets per day. Additionally, we have MED limits for opioid naï¿½ve members at 30 MED. The sub-acute population has a 60 MED limit.
OH	CareSource	Long-acting opioids require prior authorization and have a 30-day supply limit.
OH	Molina Healthcare of Ohio	Opioids have an 80 MME limit.
OH	Paramount	Yes, quantity limits are in place for long acting opioids. QL is dependent on the medication and its MME value.
OH	UnitedHealthcare Community Plan of Ohio	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of long-acting opioids. All members, including our opioid experienced members, are limited to a 90 MME cumulative maximum of short-acting, long-acting, and opioid containing cough and cold products. Each opioid quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.
OR	Advanced Health	Advanced Health requires all long-acting opioids to have a prior authorization. If the long-acting opioid is approved, the maximum day supply is 30. Advanced Health uses quantity limits for long-acting/extended release opioids that do not exceed the FDA approved maximum dose limit.
OR	AllCare CCO	Long-acting opioid prescriptions are limited to 90 MMED based on CMS equivalency tables. Quantity limits may vary depending on dosage form and/or diagnosis, but limited to 90MMED.
OR	Columbia Pacific CCO	Yes. All long-acting (LA) opioids have quantity limits on them. The number allowed varies by drug based on clinical appropriateness for usual dosing. For example, morphine ER tablets are allowed up to 3 per day. Whereas fentanyl allows only 1 patch for every 3 days (10 per month).

State	MCO Name	Explanation
OR	Eastern Oregon Coordinated Care Organization (EOCCO)	MCO uses formulary quantity limits for extended release/long-acting opioid medications that have an FDA approved maximum dose limit.
OR	Health Share of Oregon-CareOregon RAE	Yes, all long-acting (LA) opioids have quantity limits on them. These are based on typical appropriate clinical dosing which varies by drug. For example, oxycodone ER allows up to 3 per day. Fentanyl patches allow the equivalent of 1 per 3 days.
OR	Health Share of Oregon - Legacy Health/PacificSource	7- day supply limits for treatment naive members of all opioids, and early refill thresholds to identify potential misuse or abuse in place. Total cumulative point of sale opioid dose limited to 90 morphine milligram equivalent (MME) per day. For all opioids over MME 90/day will require prior authorization review to determine appropriateness of high dose and consideration for clinical rationale Yes, all long-acting (LA) opioids have daily dose quantity limits on them, but the unit amount varies by drug/strength. Long-acting opioids are limited by MME and FDA approved dosing.
OR	Health Share of Oregon - OHSU	All long-acting opioids require prior authorization review. Additionally, long-acting opioids are limited by a 30 day supply, quantity limits, and FDA approved dosing. Quantity limits are established to limit quantities of dispensed medication and promote dose optimization.
OR	InterCommunity Health Network	Opioid naive members are limited to an initial fill of 7 days and a max MME of 50. Opioid experienced members are limited to MME of 90. In addition, there are quantity limits of LA opioids coded into the formulary. These QL are based on FDA-approved labeling.
OR	Jackson Care Connect	Yes. All long-acting opioids have quantity limits on them. The amount varies by drug product and usual clinically appropriate dose. For example, morphine ER allows up to 3 per day. Fentanyl patches allow the equivalent of 1 patch every 72 hours (10 per month).
OR	PacificSource Community Solutions- Central Oregon	7- day supply limits for treatment naive members of all opioids, and early refill thresholds to identify potential misuse or abuse in place. Total cumulative point of sale opioid dose limited to 90 morphine milligram equivalent (MME) per day. For all opioids over MME 90/day will require prior authorization review to determine appropriateness of high dose and consideration for clinical rationale Yes, all long-acting (LA) opioids have daily dose quantity limits on them, but the unit amount varies by drug/strength. Long-acting opioids are limited by MME and FDA approved dosing.
OR	PacificSource Community Solutions- Columbia Gorge	7- day supply limits for treatment naive members of all opioids, and early refill thresholds to identify potential misuse or abuse in place. Total cumulative point of sale opioid dose limited to 90 morphine milligram equivalent (MME) per day. For all opioids over MME 90/day will require prior authorization review to determine appropriateness of high dose and consideration for clinical rationale Yes, all long-acting (LA) opioids have daily dose quantity limits on them, but the unit amount varies by drug/strength. Long-acting opioids are limited by MME and FDA approved dosing.
OR	PacificSource Community Solutions - Lane	7- day supply limits for treatment naive members of all opioids, and early refill thresholds to identify potential misuse or abuse in place. Total cumulative point

State	MCO Name	Explanation
		of sale opioid dose limited to 90 morphine milligram equivalent (MME) per day. For all opioids over MME 90/day will require prior authorization review to determine appropriateness of high dose and consideration for clinical rationale Yes, all long-acting (LA) opioids have daily dose quantity limits on them, but the unit amount varies by drug/strength. Long-acting opioids are limited by MME and FDA approved dosing.
OR	PacificSource Community Solutions - Marion/Polk	7- day supply limits for treatment naive members of all opioids, and early refill thresholds to identify potential misuse or abuse in place. Total cumulative point of sale opioid dose limited to 90 morphine milligram equivalent (MME) per day. For all opioids over MME 90/day will require prior authorization review to determine appropriateness of high dose and consideration for clinical rationale Yes, all long-acting (LA) opioids have daily dose quantity limits on them, but the unit amount varies by drug/strength. Long-acting opioids are limited by MME and FDA approved dosing.
OR	Providence / Health Share of Oregon	7- day supply limits for treatment naive members of all opioids, and early refill thresholds to identify potential misuse or abuse in place. Total cumulative point of sale opiod dose limited to 90 morphine milligram equivalent (MME) per day. For all opioids over MME 90/day will require prior authorization review to determine appropriateness of high dose and consideration for clinical rationale and opioid tolerance. Some long acting opioids have quantity limits in place based on standard dosing recommendations, such as quantity limit of 15 patches for 30 day supply for fentanyl.
OR	Trillium Community Health Plan - North	Prior authorization is required for coverage of all long-acting opioids
OR	Trillium Community Health Plan - South	Prior authorization is required for coverage of all long-acting opioids
OR	Umpqua Health Alliance (UHA)	Varies by substance and dosing form; maximum allowable is of 90 MMED based on CMS equivalency tables. UHA requires a prior authorization for all long-acting opioids. LA opioids are limited to 90 mg MME, 30 days per 180 days and variable quantity limits based on FDA-approved dosing.
OR	Yamhill Community Care Organization	7- day supply limits for treatment naive members of all opioids, and early refill thresholds to identify potential misuse or abuse in place. Total cumulative point of sale opiod dose limited to 90 morphine milligram equivalent (MME) per day. For all opioids over MME 90/day will require prior authorization review to determine appropriateness of high dose and consideration for clinical rationale and opioid tolerance. Some long acting opioids have quantity limits in place based on standard dosing recommendations, such as quantity limit of 15 patches for 30 day supply for fentanyl.
PA	Aetna Better Health of Pennsylvania	Quantity limits are set based on MME and maximum doses per day based on package labeling.
PA	Geisinger	Quantity limits are set based on MME and maximum doses per day based on package labeling.
PA	Highmark Wholecare	Quantity limits vary per drug. In addition to quantity limits, a cumulative morphine equivalent dose edit of 50MME per day is in place.

State	MCO Name	Explanation
PA	PA Health and Wellness	Per Statewide PDL Policy, short-acting opioid are limited to 5 day supply for patients 21 years of age or older or prior authorization is needed. Also, prior authorization is needed if the patient has a history of 1 opioid paid claim in the past 180 days. All Long-acting opioids require prior authorization regardless of day
PA	UPMC	UPMC has a Morphine Equivalent Dose quantity limit of 50 mg per day for all opioids. Additionally, there are quantity limits which limit the amount allowed for each individual opioid based on the drug's recommended dosing. Also, UPMC has a 30-day supply limit on all opioids and a quantity limit which limits opioid prescriptions to no more than 4 fills per 30 days.
PA	Vista	Quantity limits are set based on MME and maximum doses per day based on package labeling.
RI	NHPRI	30-day-supply
RI	THP	There are POS edits in place to limit the quantity dispensed of long-acting opioids. The quantity is unique to each medication and takes into consideration the dosing listed in the FDA-approved package labeling.
RI	UHCCP	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of long-acting opioids. All members, including our opioid experienced members, are limited to a 90 MME cumulative maximum of short-acting, long-acting, and opioid containing cough and cold products. Each opioid quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.
SC	Absolute Total Care	Maximum 31 day supply and must obtain prior authorization for medical necessity.
SC	Healthy Blue South Carolina	QTY limits per PA policy and/ or label based dosing applies.
SC	Molina Healthcare	Point of sale edits will stop any opioid products (short or long acting or in combination) when the total reaches 90 MME. Also,nper plan design, the maximum day supply is 31.
SC	Select Health of South Carolina, Inc.	Members are limited to a total daily dose of 90 MME which accumulates short and long acting opioids.
TX	Amerigroup	Members are limited to initial 10-day supplies that cannot exceed 90 MME (as a single claim and in the aggregate with other opioid medications).
TX	Blue Cross and Blue Shield of Texas	Opioid policy for long-acting opioids requires prior use of another opioid for opioid naive members. Subsequent prescriptions for long-acting opioids are limited to a 34 day supply. Opioid quantity limits are set according to maximum dosages noted in FDA approved product labeling. If FDA approved dosage limits are not noted in the drug product's label, limits are set based on Centers for Disease Control and Prevention (CDC) guidelines.
TX	Molina Healthcare of Texas	Point-of-sale edits will stop any opioid products (short or long-acting or in combination) when the total reaches 90 MME. Also, per plan design, the maximum day supply is 34 days for STAR and STAR PLUS plans and up to 90 days for the CHIP plan. Molina follows the Fee for service Opioid Clinical Policy.
TX	Superior HealthPlan	Superior HealthPlan follows Texas Vendor Drug Opioid Policy. The policy limits initial day supply for opioid naï¿½ve members and members are not allowed to

State	MCO Name	Explanation
		start on a long-acting opioid. Members are limited to a max daily 90 MME. Each individual opioid can have its own quantity limit.
TX	UnitedHealthcare Community Plan	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of long-acting opioids. All members are limited to a 90 MME cumulative maximum of short-acting, long-acting, and opioid containing cough and cold products. Each opioid quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.
UT	SelectHealth	Yes, 2/day (may vary but ranges between 2-4/day)
VA	AetnaBetterHealthofVirginia	All LA opioids require PA and possess daily quantity limits.
VA	Anthem	All quantity limits on opioids are followed according to the State PDL.
VA	MolinaCompleteCareofVirginia	Limit depends on the specific LA opioid and strength
VA	OptimaHealth	All long-acting opioids (preferred and non-preferred) require submission of a prior authorizations. Quantity limits vary by drug and dosage. Optima Health has POS edits in place that align with quantity limits mandated by the State PDL. Resource: https://www.virginiamedicaidpharmacyservices.com/provider/external/medicaid/vamps/doc/en-us/VAMPS_Short_and_Long_Acting_Opioid_Daily_Dose_Limit.pdf.
VA	UnitedHealthCare	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of long-acting opioids. All members, including our opioid experienced members, are limited to a 90 MME cumulative maximum of short-acting, long-acting, and opioid containing cough and cold products. In addition, UnitedHealthcare also implements product specific quantity limit on our long-acting opioid products for all members. Each quantity limit is drug specific and set at a drug specific 90 MME maximum dose and in alignment with the Virginia FFS PDL.
VA	VirginiaPremier	All long acting opioids require a prior authorization. Also, the State's PDL has daily dose limits for long acting opioids.
WA	Amerigroup Washington Inc.	Limited to Maximum daily MME limited to 120 MME; and 30 days supply.
WA	Community Health Plan of Washington	Limited to 34-day supply and limited to 42 calendar days within a rolling 90-day period
WA	Coordinated Care Corporation	LA opioids are limited to 30-day supply per fill and up to 42 calendar days of use within a rolling 90-day period.
WA	Molina Healthcare of Washington, Inc.	Limited to 30-day supply and limited to 42 calendar days within a rolling 90-day period. Long-acting opioids are not allowed for acute use unless one of the exceptions applies i.e. cancer, hospice, palliative care or end of life care or provider wrote "EXEMPT" on the prescription.
WA	UnitedHealthcare Community Plan	Use of long-acting opioids requires prior authorization as these products are not indicated for initial or acute use. The coverage criteria for long-acting opioids include an adequate trial of short-acting opioid therapy before switching to a long-acting product. Due to its unique risk profile, methadone coverage requires adequate trial of multiple other long-acting opioids before it can be approved. Its more extensive

State	MCO Name	Explanation
		criteria are outlined in a separate guideline that is related to the overarching opioid analgesics coverage policy.

If "Yes," please specify limit as # of units.

Figure 92 - Limits for Quantity Dispensed of Long-Acting Opioids (State Average)

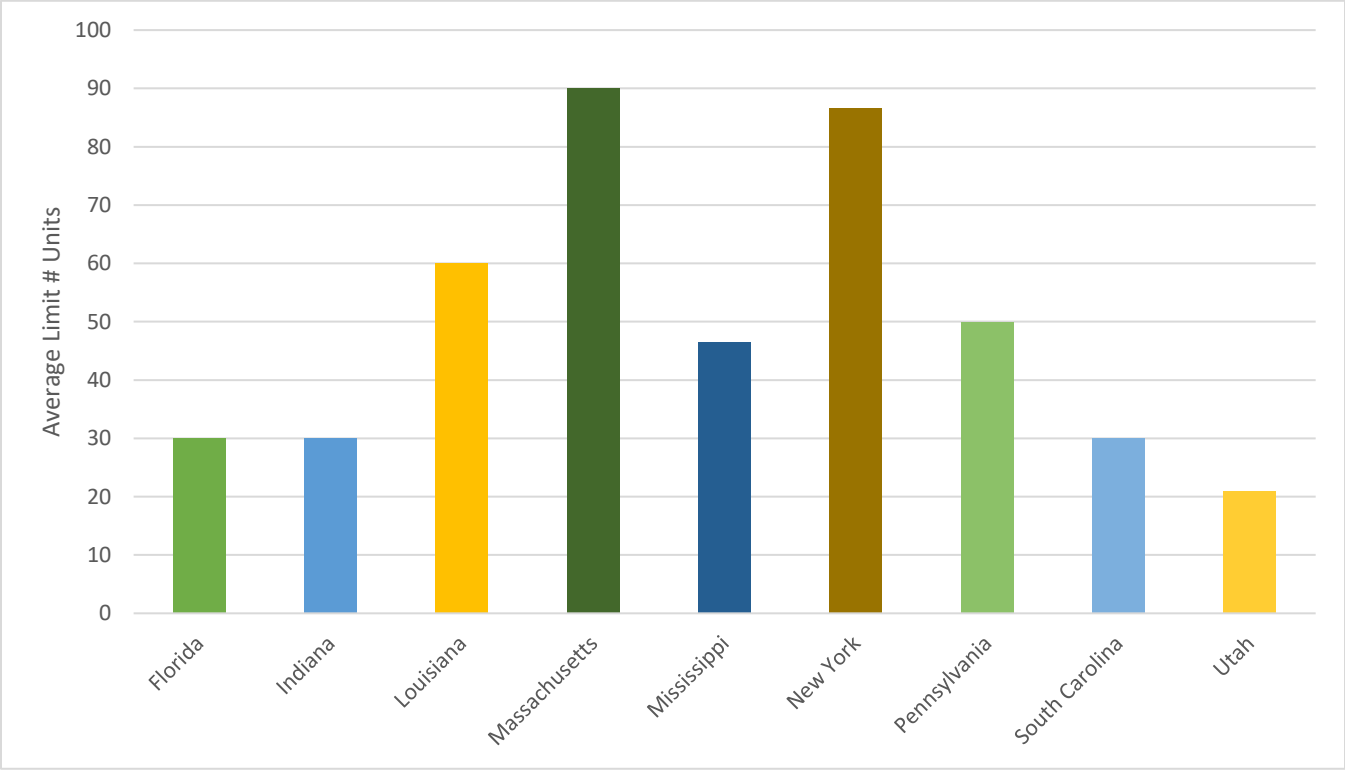

Table 108 - Limits for Quantity Dispensed of Long-Acting Opioids (State Average)

State	Average Limit in Units
Florida	30
Indiana	30
Louisiana	60
Massachusetts	90
Mississippi	47
New York	87
Pennsylvania	50
South Carolina	30
Utah	21
National Average	**49**

4. Does your MCO have measures other than restricted quantities and days' supply in place to either monitor or manage the prescribing of opioids?

Figure 93 - Have Measures Other Than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

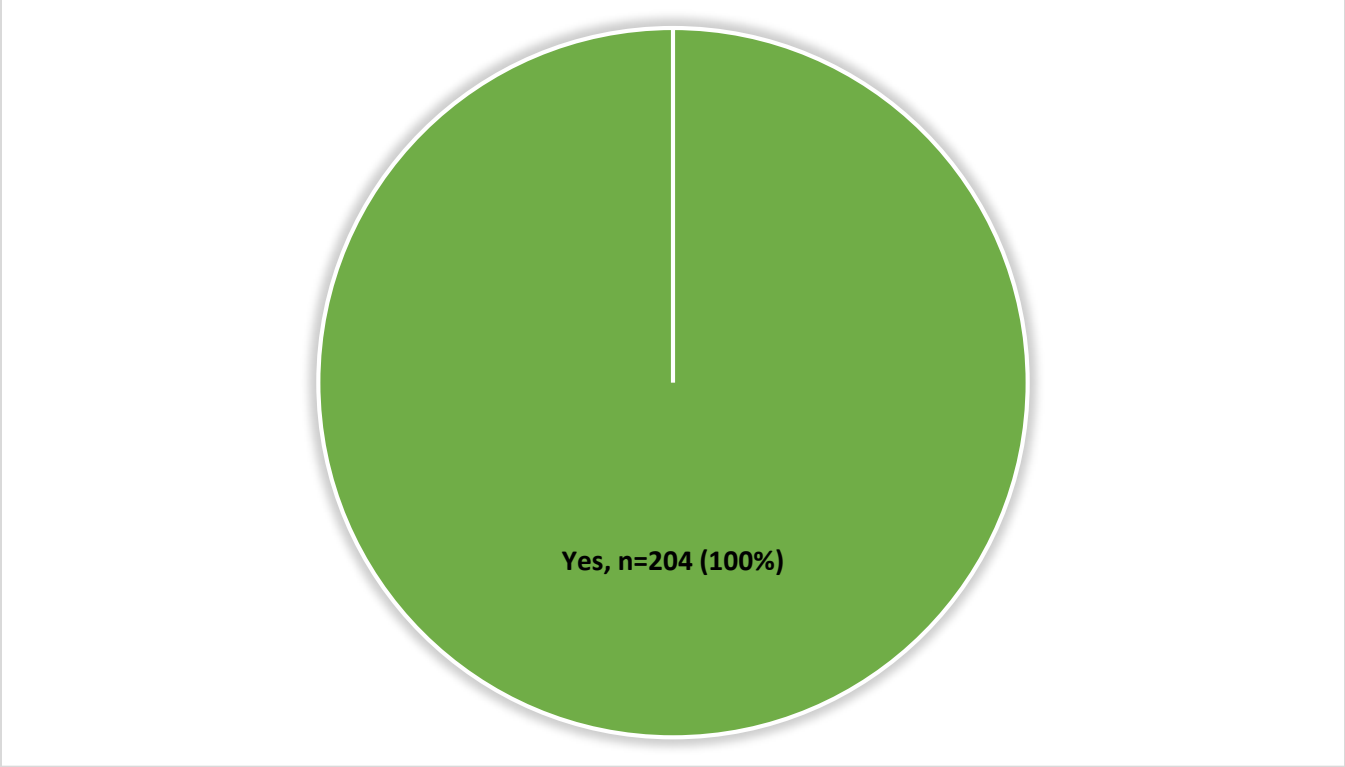

Table 109 - Have Measures Other Than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (14), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	204	100.00%
National Totals		**204**	**100%**

If "Yes," check all that apply.

Figure 94 - Measures Other Than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

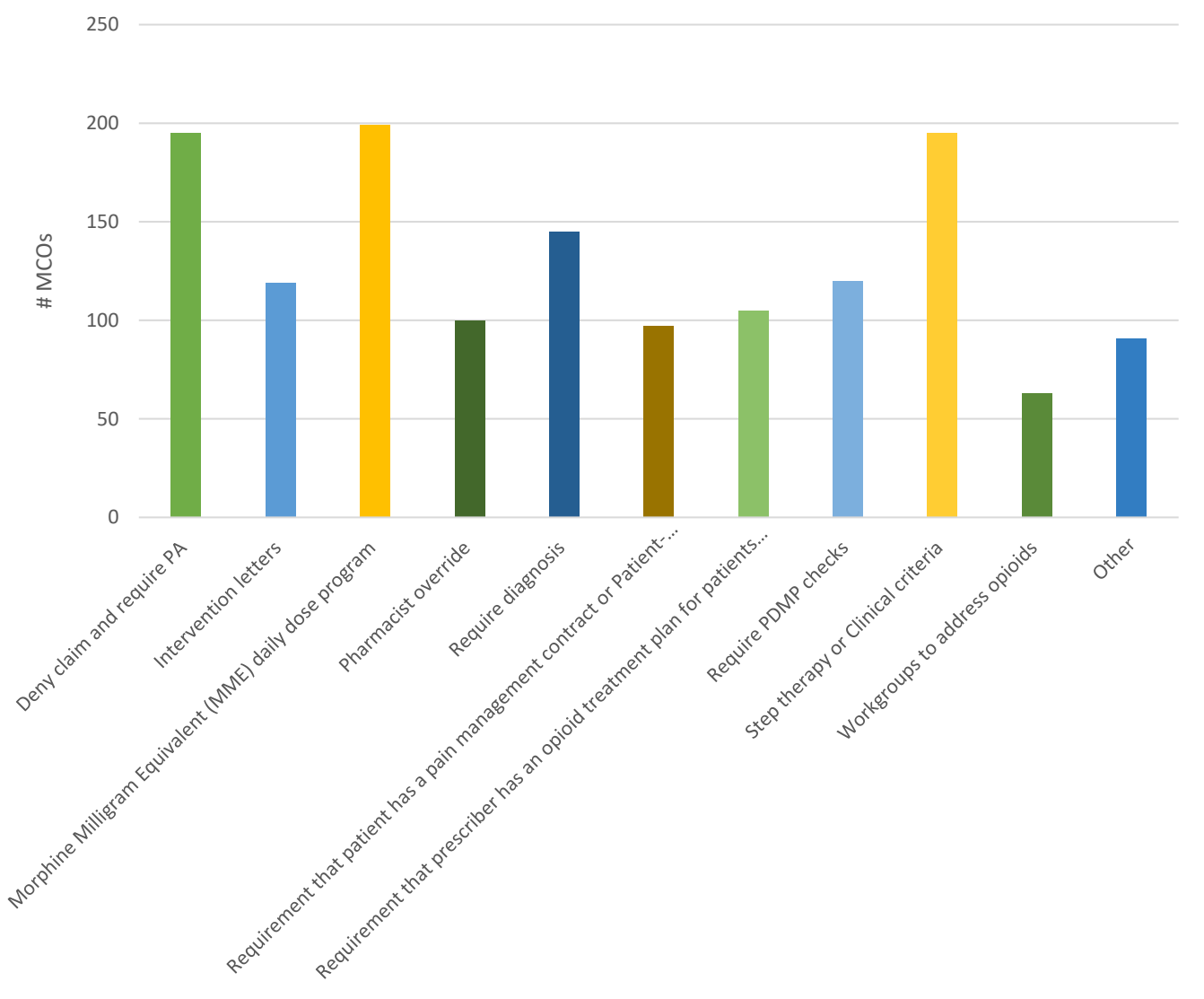

Table 110 - Measures Other Than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

Response	States (Count of MCOs)	Count	Percentage
Deny claim and require PA	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (5), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (4), Maryland (8), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (4), New Mexico (3), New York (14), North Carolina (5), Ohio (5), Oregon (19), Pennsylvania (8), Rhode Island (3), South Carolina (4), Texas (15), Utah (4), Virginia (6), Washington (5)	195	13.65%

Response	States (Count of MCOs)	Count	Percentage
Intervention letters	Arkansas (4), Colorado (1), Delaware (2), District of Columbia (2), Florida (8), Georgia (3), Hawaii (3), Illinois (3), Indiana (4), Kansas (2), Louisiana (5), Maryland (4), Massachusetts (2), Michigan (3), Minnesota (4), Mississippi (3), Nebraska (2), Nevada (4), New Hampshire (2), New Jersey (2), New Mexico (2), New York (9), North Carolina (3), Ohio (4), Oregon (14), Pennsylvania (4), Rhode Island (2), South Carolina (3), Texas (5), Utah (2), Virginia (5), Washington (3)	119	8.33%
Morphine Milligram Equivalent (MME) daily dose program	Arkansas (4), Colorado (2), Delaware (1), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (4), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (13), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (2), South Carolina (5), Texas (15), Utah (4), Virginia (6), Washington (5)	199	13.93%
Pharmacist override	Arkansas (3), Colorado (2), Delaware (1), Florida (7), Hawaii (4), Illinois (2), Indiana (2), Kansas (1), Kentucky (6), Louisiana (1), Maryland (3), Massachusetts (3), Michigan (6), Minnesota (5), Mississippi (2), Nebraska (2), Nevada (1), New Hampshire (1), New Jersey (3), New Mexico (1), New York (7), North Carolina (3), Ohio (2), Oregon (16), Pennsylvania (2), Rhode Island (1), South Carolina (2), Texas (1), Utah (2), Virginia (3), Washington (5)	100	7.00%
Require diagnosis	Arkansas (3), Delaware (2), District of Columbia (2), Florida (10), Georgia (2), Hawaii (4), Illinois (3), Indiana (5), Kansas (2), Kentucky (4), Louisiana (3), Maryland (6), Massachusetts (3), Michigan (5), Minnesota (5), Mississippi (1), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (4), New Mexico (2), New York (8), North Carolina (3), Ohio (4), Oregon (16), Pennsylvania (7), Rhode Island (3), South Carolina (4), Texas (12), Utah (3), Virginia (6), Washington (4)	145	10.15%
Require PDMP checks	Arkansas (1), Colorado (1), Delaware (2), District of Columbia (4), Florida (10), Georgia (2), Hawaii (3), Illinois (3), Indiana (1), Iowa (2), Kansas (3), Kentucky (6), Louisiana (2), Maryland (8), Massachusetts (1), Michigan (5), Minnesota (5), Mississippi (2), Nebraska (1), Nevada (3), New Hampshire (3), New Jersey (2), New Mexico (2), New York (7), North Carolina (3), Ohio (5), Oregon (7), Pennsylvania (7), Rhode Island (1), South Carolina (3), Texas (1), Utah (3), Virginia (6), Washington (5)	120	8.40%
Requirement that patient has a pain management contract or Patient-Provider agreement	Colorado (1), Delaware (2), District of Columbia (3), Florida (9), Georgia (1), Hawaii (3), Illinois (3), Indiana (1), Iowa (2), Kansas (3), Louisiana (4), Maryland (8), Massachusetts (3), Michigan (5), Minnesota (4), Nebraska (2), New Hampshire (3), New Jersey (1), New Mexico (1), New York (5), North Carolina (2), Ohio (3), Oregon (7), Pennsylvania (4), Rhode Island (2), South Carolina (3), Utah (3), Virginia (5), Washington (4)	97	6.79%

Response	States (Count of MCOs)	Count	Percentage
Requirement that prescriber has an opioid treatment plan for patients Require documentation of urine drug screening results	Colorado (1), Delaware (2), District of Columbia (3), Florida (9), Georgia (2), Hawaii (3), Illinois (2), Indiana (3), Kansas (2), Kentucky (6), Maryland (5), Massachusetts (2), Michigan (5), Minnesota (4), Mississippi (1), Nebraska (2), Nevada (3), New Hampshire (2), New Jersey (2), New Mexico (1), New York (5), North Carolina (2), Ohio (4), Oregon (8), Pennsylvania (6), Rhode Island (1), South Carolina (4), Texas (2), Utah (3), Virginia (6), Washington (4)	105	7.35%
Step therapy or Clinical criteria	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (3), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (4), Maryland (7), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (13), North Carolina (5), Ohio (5), Oregon (19), Pennsylvania (7), Rhode Island (3), South Carolina (5), Texas (15), Utah (4), Virginia (6), Washington (5)	195	13.65%
Workgroups to address opioids	Arkansas (1), Delaware (1), Florida (2), Georgia (1), Hawaii (2), Illinois (2), Indiana (1), Kansas (1), Louisiana (2), Maryland (4), Michigan (2), Minnesota (2), Mississippi (1), Nebraska (1), Nevada (2), New Jersey (1), New Mexico (2), New York (5), North Carolina (2), Ohio (2), Oregon (11), Pennsylvania (4), South Carolina (3), Texas (3), Utah (2), Virginia (1), Washington (2)	63	4.41%
Other	Arkansas (3), Colorado (1), Delaware (2), Florida (5), Georgia (2), Hawaii (2), Illinois (3), Indiana (4), Kansas (2), Kentucky (2), Louisiana (4), Maryland (2), Massachusetts (3), Michigan (4), Minnesota (4), Mississippi (2), Nebraska (1), Nevada (3), New Hampshire (1), New Jersey (2), New Mexico (2), New York (7), North Carolina (2), Ohio (2), Oregon (6), Pennsylvania (4), Rhode Island (2), South Carolina (2), Texas (6), Utah (3), Virginia (2), Washington (1)	91	6.37%
National Totals		**1,429**	**100%**

5. Does your MCO have POS edits to monitor duplicate therapy of opioid prescriptions? This excludes regimens that include a single extended release product and a breakthrough short acting agent.

Figure 95 - POS Edits in Place to Monitor Duplicate Therapy of Opioids Prescriptions

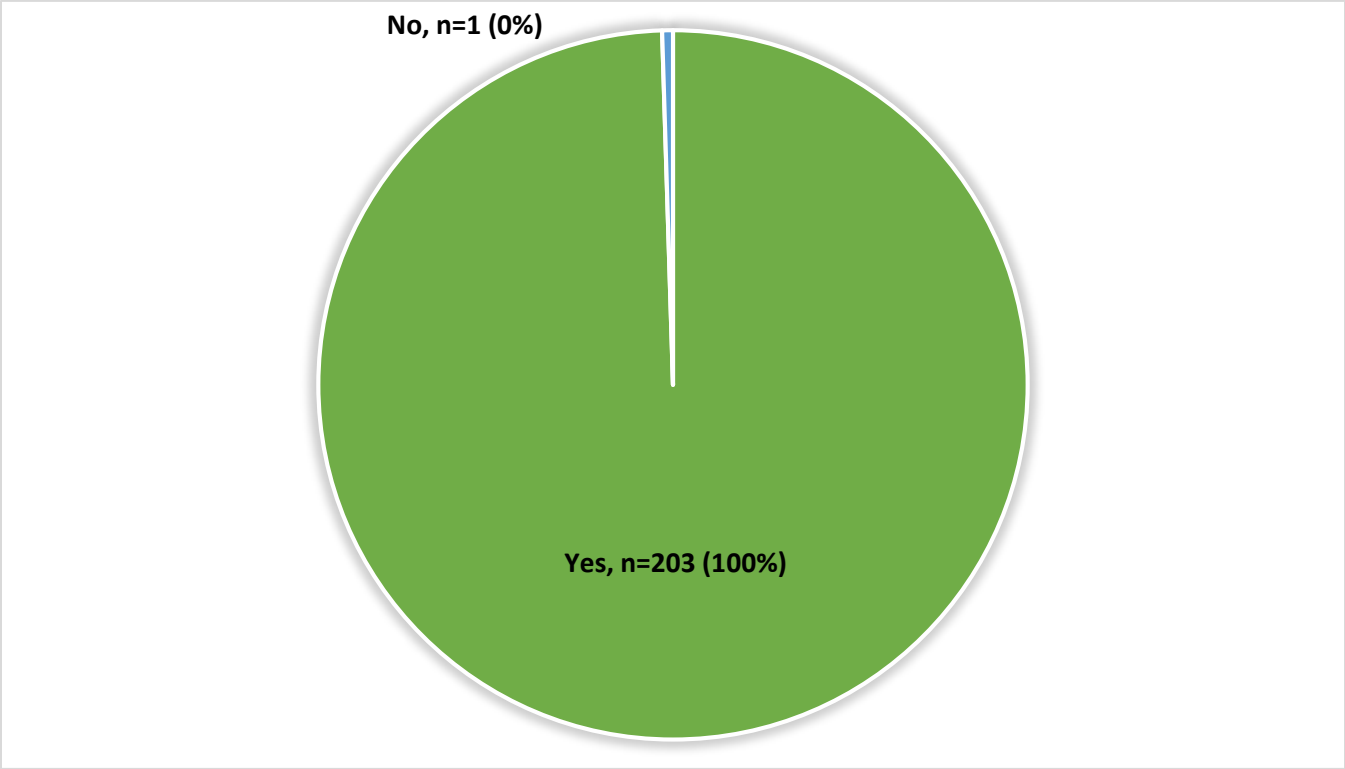

Table 111 - POS Edits in Place to Monitor Duplicate Therapy of Opioids Prescriptions

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (8), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (14), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	203	99.51%
No	Michigan (1)	1	0.49%
National Totals		**204**	**100%**

If "No," please explain why not.

Table 112 - Explanations for Not Having POS Edits to Monitor Duplicate Therapy of Opioid Prescriptions

State	MCO Name	Explanation
MI	Upper Peninsula Health Plan	No, as per the MDHHS Common Formulary guidance edits are related to the MME cumulative daily dose.

6. Does your MCO have POS edits to monitor early refills of opioid prescriptions dispensed?

Figure 96 - POS Edits to Monitor Early Refills of Opioid Prescriptions Dispensed

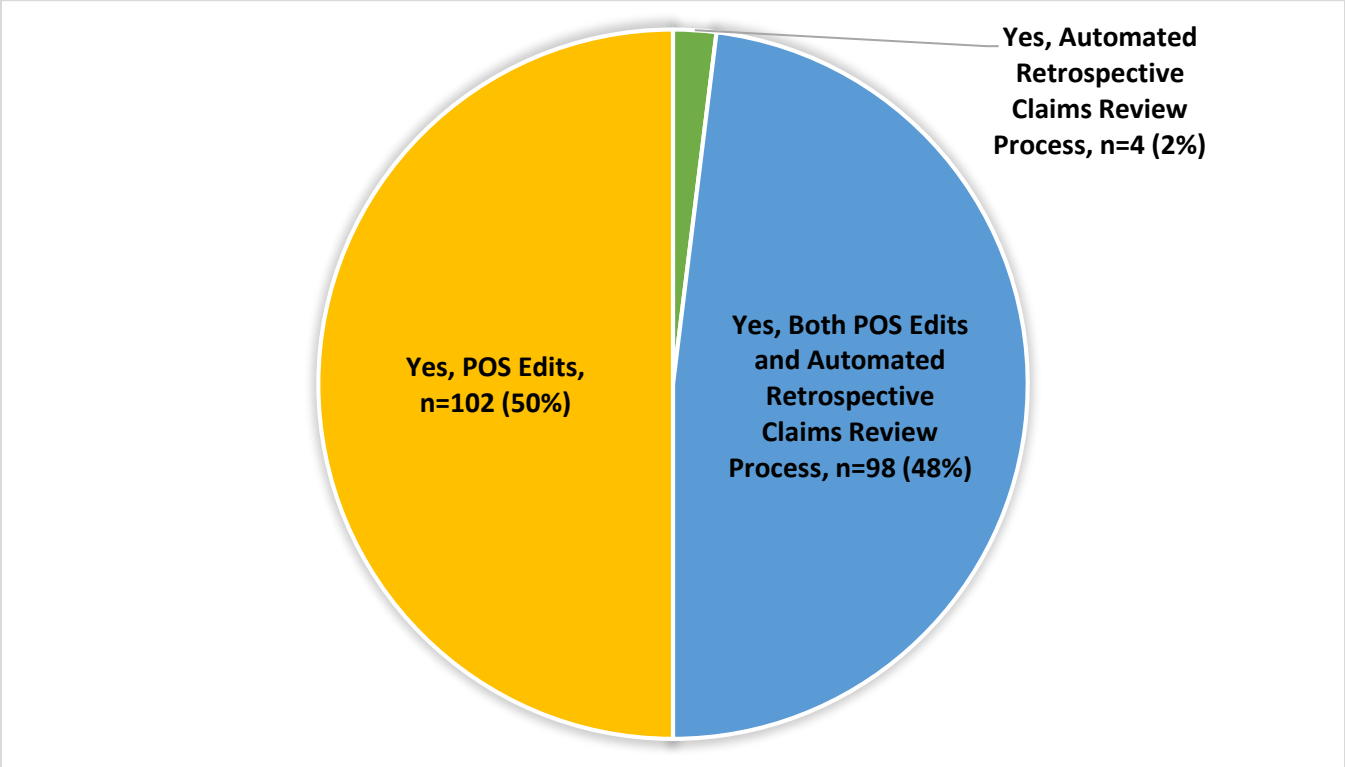

Table 113 - POS Edits to Monitor Early Refills of Opioid Prescriptions Dispensed

Response	States (Count of MCOs)	Count	Percentage
Yes, automated retrospective claims review process	Florida (1), Minnesota (3)	4	1.96%
Yes, both POS edits and automated retrospective claims review process	Colorado (2), Delaware (1), District of Columbia (2), Florida (4), Hawaii (2), Illinois (2), Indiana (1), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (3), Massachusetts (1), Michigan (5), Minnesota (3), Mississippi (2), Nebraska (2), Nevada (2), New Jersey (3), New York (7), North Carolina (2), Ohio (3), Oregon (21), Pennsylvania (5), Rhode Island (1), South Carolina (1), Texas (1), Virginia (3), Washington (3)	98	48.04%
Yes, POS edits	Arkansas (4), Delaware (1), District of Columbia (2), Florida (6), Georgia (3), Hawaii (4), Illinois (4), Indiana (4), Maryland (6), Massachusetts (4), Michigan (4), Minnesota (3), Mississippi (1), Nebraska (1), Nevada (2), New Hampshire (3), New Jersey (2), New Mexico (3), New York (7), North Carolina (3), Ohio (2), Pennsylvania (3), Rhode Island (2), South Carolina (4), Texas (15), Utah (4), Virginia (3), Washington (2)	102	50.00%
National Totals		**204**	**100%**

7. Does your MCO have comprehensive automated retrospective claim reviews to monitor opioid prescriptions exceeding program limitations (early refills, duplicate fills, quantity limits and days' supply)?

Figure 97 - Comprehensive Automated Retrospective Claim Reviews to Monitor Opioid Prescriptions in Excess of Program Limitations

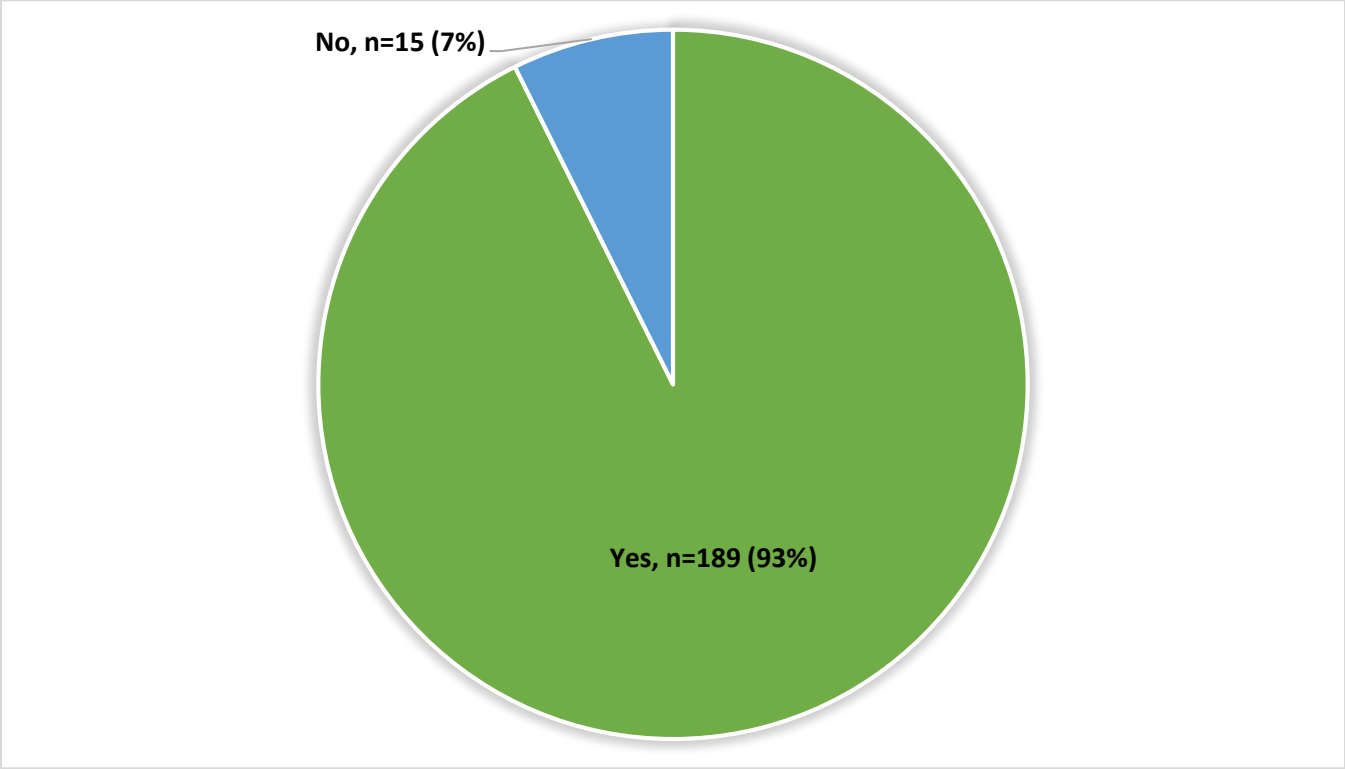

Table 114 - Comprehensive Automated Retrospective Claim Reviews to Monitor Opioid Prescriptions in Excess of Program Limitations

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (4), Iowa (2), Kansas (2), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (6), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (11), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (7), Rhode Island (3), South Carolina (5), Texas (13), Utah (2), Virginia (5), Washington (5)	189	92.65%
No	Indiana (1), Kansas (1), Minnesota (3), New York (3), Pennsylvania (1), Texas (3), Utah (2), Virginia (1)	15	7.35%
National Totals		**204**	**100%**

If "No," please explain why not.

Table 115 - Explanation for Not Having Comprehensive Automated Retrospective Claim Reviews to Monitor Opioid Prescriptions in Excess of Program Limitations

State	MCO Name	Explanation
IN	Managed Health Services Indiana (MHS)	Our opioid edits and PA process prevent exceeding State limitations.

State	MCO Name	Explanation
KS	UnitedHealthcare	In the FFY 2021report, it was identified that there was misalignment in the configuration of UnitedHealthcare's automated retrospective claims review when compared to the State of Kansas' specific program requirements and limits. In May 2023 UnitedHealthcare Community Plan completed the alignment of the automated retrospective claim reviews and intervention mailings with the State of KS specific program and limits.
MN	HealthPartners	HealthPartners did not have an automated retrospective claims review process, as defined by the Support Act, in place during the reporting period indicated for this survey. Instead, HealthPartners relied on prospective utilization management edits to meet the need for preventing fraud, waste and abuse. A new process was developed during quarter 4 of 2022. The new process developed fulfills the requirements outlined in the Support Act regarding automated retrospective claim reviews to monitor opioid prescriptions exceeding program limitations.
MN	IMCare	Prescriptions exceeding State limitations generally do not exist or have been determined to be medically necessary by a medical professional for a set amount of time.
MN	UCare	There is not currently an automated RDUR process. However, there is a hard concurrent/prospective DUR edit in place that stops claims at the point-of-sale if exceeding 90 MME per product. Additionally, each opioid product has a quantity limit in accordance with the State requirements.
NY	Capital District Physicians' Health Plan	CDPHP has comprehensive automated prospective edits to limit the days supply on initial fills, prevent early refills, enforce maximum MME through quantity limits and have editing for identification of duplicate therapy. Any claim adjudicated outside of the coded limitations would required a prior authorization and review by a clinical pharmacist.
NY	Independent Health	Independent Health utilizes all POS and pre-service to manage limits.
NY	MVP Health Care	MVP Health Care prospectively reviews these claims through hard edits and prior authorizations.
PA	Geisinger	MED limit, day supply limit, and PA criteria allows for prospective review
TX	Cook Children's Health Plan	No, we do not have an automated retrospective claims review process to monitor opioid prescriptions exceeding State limitations (early refills, duplicate fills, quantity limits and days supply); however, any prescription exceeding State limitations are stopped at the POS. Texas implemented a mandatory Opioid Policy that limits intial opioid prescriptions to 10 days when the member is classified as opioid naï¿½ve. The State defines which drugs the limits apply to. Members with Sickle cell, cancer, palliative care or hospice in the last 365 days are excluded from this policy. In addition, the clinical PA edit for oxycodone ER agents approves only those requests that are <= to 3 untis per day.
TX	FirstCare Health Plans	No, we do not have an automated retrospective claims review process to monitor opioid prescriptions exceeding State limitations (early refills, duplicate fills, quantity limits and days supply); however, any prescription exceeding State limitations are stopped at the POS. Texas implemented a mandatory Opioid Policy that limits initial opioid prescriptions to 10 days when the member is classified as opioid naï¿½ve. The State defines which drugs the limits apply to. Members with Sickle cell, cancer, palliative care or hospice in the last 365 days are excluded from this policy.

State	MCO Name	Explanation
		In addition, the clinical PA edit for oxycodone ER agents approves only those requests that are less than or equal to 3 units per day.
TX	Parkland Community Health Plan	"No, we do not have an automated retrospective claims review process to monitor opioid prescriptions exceeding State limitations (early refills, duplicate fills, quantity limits and days supply); however, any prescription exceeding State limitations are stopped at the POS. Texas implemented a mandatory Opioid Policy that limits intial opioid prescriptions to 10 days when the member is classified as opioid naï¿½ve. The State defines which drugs the limits apply to. Members with Sickle cell, cancer, palliative care or hospice in the last 365 days are excluded from this policy. In addition, the clinical PA edit for oxycodone ER agents approves only those requests that are <= to 3 untis per day."
UT	Healthy U	Due to our rigorous PA criteria for opioids, Healthy U catches prescriptions exceeding limits proactively rather than retrospectively. Healthy U also has an ongoing retrospective process, through the DUR Board, to monitor opioids.
UT	Steward Health Choice Utah	Health Choice Utah has rigorous PA criteria for opioids. We capture prescriptions exceeding limits proactively, rather than retrospectively. We also have a continued monitoring retrospective process through the DUR Board.
VA	VirginiaPremier	Virginia Premier does not have an automated process to retrospectively review opioid claims. Virginia Premier utilizes the monthly PUMS program to manually identify members whose opioid therapy exceeds 90 MME. These members are then enrolled in case management and educational letters are provided to the prescribers. The PBM also provides Virginia Premier with monthly reporting containing high risk members based on utilization and outlier analytics for review.

8. Does your MCO currently have POS edits in place or automated retrospective claim reviews to monitor opioids and benzodiazepines being used concurrently?

Figure 98 - POS Edits or Retrospective Claim Reviews to Monitor Opioids and Benzodiazepines Used Concurrently

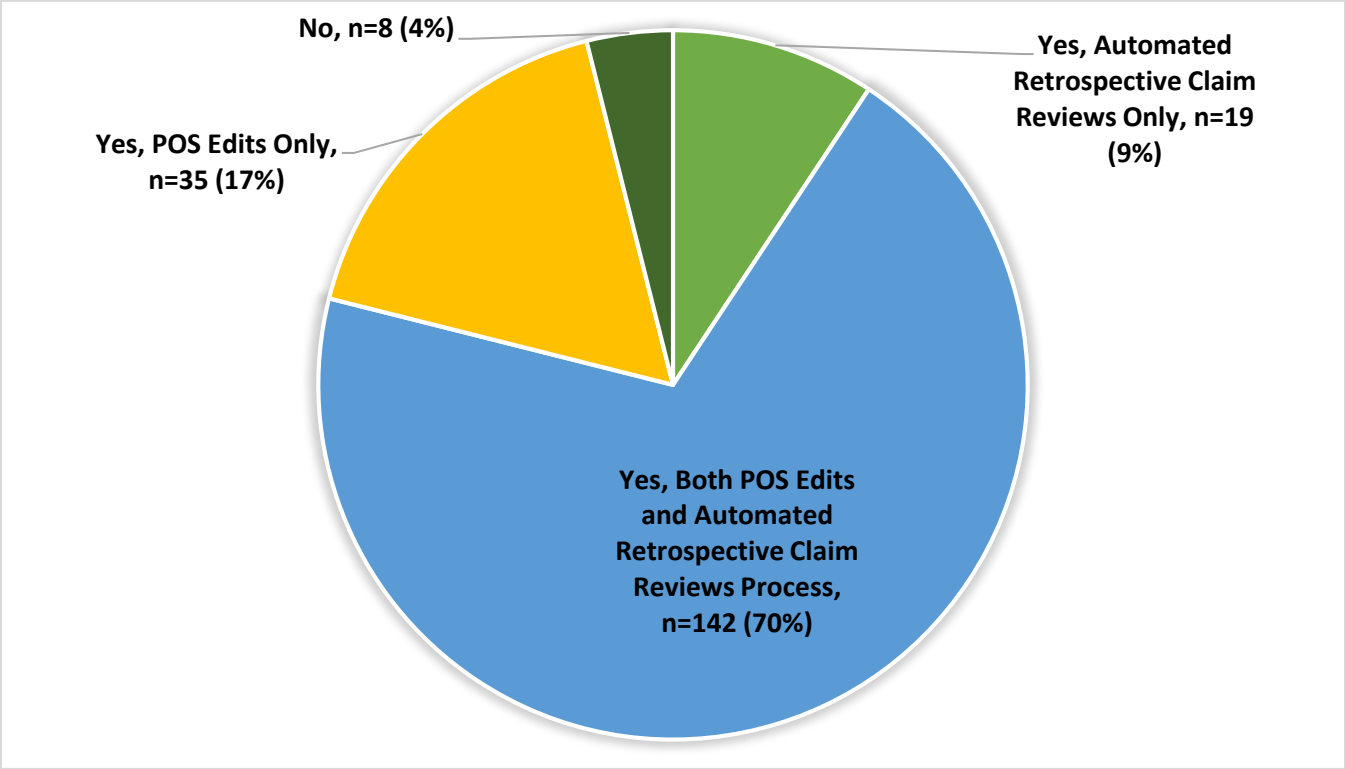

Table 116 - POS Edits or Retrospective Claim Reviews to Monitor Opioids and Benzodiazepines Used Concurrently

Response	States (Count of MCOs)	Count	Percentage
Yes, automated retrospective claim reviews only	Maryland (4), Massachusetts (1), Michigan (2), Minnesota (1), Nebraska (1), Ohio (1), Oregon (6), Utah (1), Virginia (1), Washington (1)	19	9.31%
Yes, both POS edits and automated retrospective claim reviews process	Arkansas (3), Colorado (2), Delaware (2), District of Columbia (2), Florida (9), Georgia (2), Hawaii (5), Illinois (4), Indiana (2), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (2), Massachusetts (2), Michigan (3), Minnesota (7), Mississippi (3), Nebraska (2), Nevada (4), New Hampshire (2), New Jersey (5), New Mexico (3), New York (13), North Carolina (5), Ohio (4), Oregon (15), Pennsylvania (5), Rhode Island (3), South Carolina (3), Texas (6), Utah (1), Virginia (4), Washington (3)	142	69.61%
Yes, POS edits only	Arkansas (1), District of Columbia (2), Florida (2), Georgia (1), Hawaii (1), Illinois (2), Indiana (3), Massachusetts (2), Minnesota (1), New Hampshire (1), New York (1), Pennsylvania (3), South Carolina (2), Texas (10), Utah (1), Virginia (1), Washington (1)	35	17.16%
No	Maryland (3), Michigan (4), Utah (1)	8	3.92%
National Totals		**204**	**100%**

If “No,” please explain why not.

Table 117 - Explanations for Not Having POS Edits or Automated Retrospective Claim Reviews to Monitor Opioids and Benzodiazepines Being Used Concurrently

State	MCO Name	Explanation
MD	Jai Medical Systems Managed Care Organization, Inc.	Benzodiazepines are covered directly by Maryland Medicaid and are not covered by the MCO, so any POS limitations are administered by Maryland Medicaid. Carved out pharmacy utilization data was not shared with the MCOs in a format that could be stored in the Rx engine at the PBM until late in the measurement year so retrospective monitoring could not be implemented until after the measurement year.
MD	Maryland Physicians Care	Benzodiazepines are covered through MD Fee for Service Medicaid Program; therefore, there is no current coordination in the monitoring of these medications with opioid prescriptions.
MD	Priority Partners MCO	Priority Partners does not have POS edits or retrospective reviews for concurrent use of opioid and benzodiazepines. Benzodiazepines are carved out of MCO coverage and are processed separately under the FFS program.
MI	Aetna Better Health of Michigan	benzodiazepines are carved out to FFS
MI	HAP Empowered	We perform a retrospective review at least quarterly, but it is not currently automated. Behavioral health medications, including benzodiazepines, are carved out to the State and are processed through the State's PBM. We receive adjudicated claims data from the State but the data must be combined with our PBM-processed opioid claims data retrospectively to perform a manual review. We look at the data in various ways: -Opioids and benzodiazepines in combination with potential overuse/misuse, which may result in reach-out to the provider or referral to Case Management

State	MCO Name	Explanation
		-Utilization from multiple prescribers with overlapping prescription fills for opioid and benzodiazepine medications, resulting in educational information and resources to the prescriber(s).
MI	McLaren Health Plan	Benzodiazapines are carved out medications billed to FFS. MCO is unable upload FFS claims history data into MedImpact's adjudication system.
MI	Priority Health Choice	Our PBMs RetroDUR program has functionality to achieve both POS edits and automated retrospective claim reviews, however, coverage of benzodiazepines is carved out to the Michigan Fee For Service Medicaid Plan. Additionally, Priority Health does retrospectively review cases where opioids and benzodiazepines are being used concurrently as required by the SUPPORT Act, but there is not an automated process in place. Coverage of benzodiazepine medications is carved out to the Michigan Fee For Service Medicaid program so MCO PBMs do not have claim data within their POS system to enable POS edits.
UT	SelectHealth	Benzodiazepines are carved-out to State Medicaid.

9. Does your MCO currently have POS edits in place or automated retrospective claim reviews to monitor opioids and sedatives being used concurrently?

Figure 99 - POS Edits or Retrospective Claim Reviews to Monitor Opioids and Sedatives Being Used Concurrently

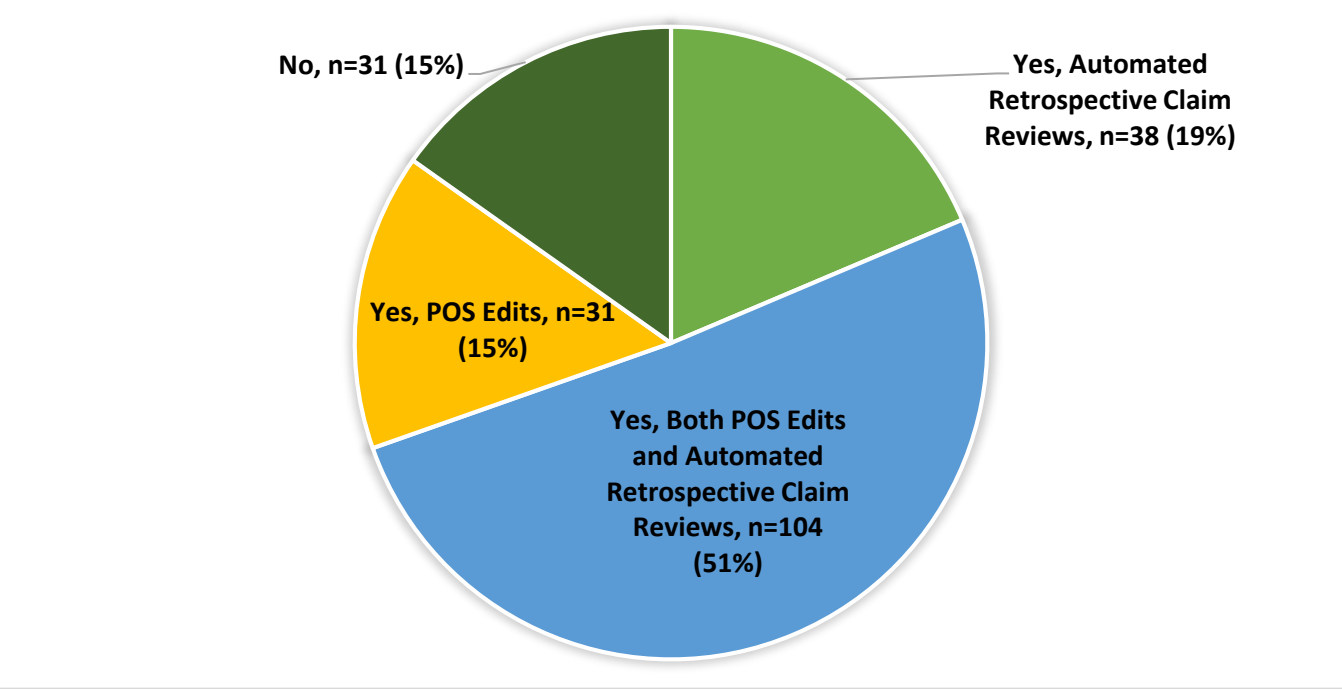

Table 118 - POS Edits or Retrospective Claim Reviews to Monitor Opioids and Sedatives Being Used Concurrently

Response	States (Count of MCOs)	Count	Percentage
Yes, automated retrospective claim reviews	Delaware (1), Georgia (1), Illinois (1), Indiana (1), Louisiana (4), Maryland (3), Michigan (2), Minnesota (1), Nebraska (1), Nevada (1), New Jersey (1), New York (2), Oregon (10), Pennsylvania (1), South Carolina (1), Texas (3), Utah (2), Virginia (1), Washington (1)	38	18.63%

Response	States (Count of MCOs)	Count	Percentage
Yes, both POS edits and automated retrospective claim reviews	Arkansas (2), Colorado (1), Delaware (1), District of Columbia (3), Florida (9), Georgia (1), Hawaii (4), Illinois (3), Indiana (2), Kansas (3), Kentucky (6), Louisiana (1), Maryland (2), Massachusetts (2), Michigan (2), Minnesota (6), Mississippi (3), Nebraska (2), Nevada (3), New Hampshire (1), New Jersey (2), New Mexico (3), New York (9), North Carolina (5), Ohio (4), Oregon (7), Pennsylvania (3), Rhode Island (2), South Carolina (2), Texas (3), Utah (1), Virginia (3), Washington (3)	104	50.98%
Yes, POS edits	Arkansas (2), Colorado (1), Florida (2), Georgia (1), Hawaii (2), Illinois (1), Indiana (2), Massachusetts (2), New Hampshire (1), New Jersey (2), New York (3), Oregon (1), Pennsylvania (4), South Carolina (2), Texas (3), Virginia (1), Washington (1)	31	15.20%
No	District of Columbia (1), Illinois (1), Iowa (2), Maryland (4), Massachusetts (1), Michigan (5), Minnesota (2), New Hampshire (1), Ohio (1), Oregon (3), Rhode Island (1), Texas (7), Utah (1), Virginia (1)	31	15.20%
National Totals		**204**	**100%**

If “No,” please explain why not.

Table 119 - Explanations for Not Having POS Edits or Automated Retrospective Claim Reviews in Place to Monitor Opioids and Sedatives Being Used Concurrently

State	MCO Name	Explanation
DC	AmeriHealth Caritas DC	We did not have a POS edit in place during the reporting period. An edit at POS was implemented effective 4/1/2023 to alert the pharmacist of concomitant opioid and sedative use.
IA	Amerigroup	Will be a future DUR meeting topic for discussion and consideration of appropriate initiatives.
IA	Iowa Total Care	It is a DUR meeting topic currently under discussion for consideration of appropriate initiatives
IL	Aetna_Better_Health_of_Illinois	This POS edit review is limited to those sedatives that are benzodiazepines.
MA	Health New England, Inc.	There are currently no opioid-sedative point-of-service, drug-drug interaction concurrent DUR rules. However, as we work with our PBM, this is on the concurrent DUR roadmap for future development and deployment. There is no opioid-sedative retrospective claims review, but our PBM is in the process of expanding the program to include this.
MD	Jai Medical Systems Managed Care Organization, Inc.	Anxiolytics, Sedatives and Hypnotics are covered directly by Maryland Medicaid and are not covered by the MCO, so any POS limitations are administered by Maryland Medicaid. Carved out pharmacy utilization data was not shared with the MCOs in a format that could be stored in the Rx engine at the PBM until late in the measurement year so retrospective monitoring could not be implemented until after the measurement year.
MD	Maryland Physicians Care	Sedatives are covered through MD Fee for Service Medicaid Program; therefore, there is no current coordination in the monitoring of these medications with opioid prescriptions.
MD	MedStar Family Choice	At the present time, MFC is focusing on opioids prescribed concurrently with benzodiazepines, antipsychotics, substance use disorder medications (ex: Suboxone), and members with a recent overdose claim.

State	MCO Name	Explanation
MD	Priority Partners MCO	Priority Partners does not have POS edits or retrospective reviews for concurrent use of opioid and sedatives. Sedatives are carved out of MCO coverage and are processed separately under the FFS program.
MI	Aetna Better Health of Michigan	Sedatives and benzodiazepines are carved out
MI	HAP Empowered	In Michigan, behavioral health medications including sedatives are carved out and managed by the State. Since these claims are not processed by the Plan, the claims are not available for POS edits or automated retrospective DUR programs. We are currently doing manual reviews for opioids with benzodiazepines and antipsychotic medications, but we do not currently review sedative utilization with opioid utilization.
MI	McLaren Health Plan	Sedatives are carved out medications billed to FFS. MCO is unable upload FFS claims history data into MedImpact's adjudication system.
MI	Molina Healthcare of Michigan	Sedatives are carved out to State FFS benefit.
MI	Priority Health Choice	Our PBMs RetroDUR program has functionality to achieve both POS edits and automated retrospective claim reviews, however, coverage of sedatives is carved out to the Michigan Fee For Service Medicaid Plan. Additionally, Priority Health does retrospectively review cases where opioids and sedatives are being used concurrently as required by the SUPPORT Act, but there is not an automated process in place. In Michigan, sedative medication coverage is carved out to Fee For Service Medicaid so MCO PBMs do not have claim data within their POS system to enable POS edits.
MN	Medica	At this time Medica does not have edits related to concurrent use of nonbenzodiazepine sedatives and opioids.
MN	SouthCountry	The retrospective program aligns with requirements set forth by the SUPPORT Act.
NH	AmeriHealth Caritas NH	If the member is above 100 MME, a prior authorization is required. The clinical reviewer then reviews concurrent therapies, and the member cannot be on concomitant opioid/sedative therapy without explanation of medical necessity if above 100 MME.
OH	Buckeye Health Plan	We currently do not have this edit in place but continue to explore.
OR	Columbia Pacific CCO	Currently, benzodiazepines and antipsychotics are reviewed. An obvious identification of a list of sedative drugs to monitor has not been identified.
OR	Health Share of Oregon-CareOregon RAE	Currently, benzodiazepines and antipsychotics are reviewed. An obvious identification of a list of sedative drugs to monitor has not been identified.
OR	Jackson Care Connect	Currently, benzodiazepines and antipsychotics are reviewed. An obvious identification of a list of sedative drugs to monitor has not been identified.
RI	NHPRI	Neighborhood does not currently have POS edits or a retrospective claims review to monitor opioids and sedatives being used concurrently. Neighborhood does have a retrospective DUR review on opioids in combination with benzodiazepines and opioids in combination with muscle relaxants and benzodiazepines.
TX	Community First Health Plans	No, there are currently no POS or RDUR programs that monitor the concurrent use of opioids and sedatives.
TX	Community Health Choice	There are currently no POS or RDUR programs that monitor the concurrent use of opioids and sedatives

State	MCO Name	Explanation
TX	Cook Children's Health Plan	No, there are currently no POS or RDUR programs that monitor the concurrent use of opioids and sedatives.
TX	Dell Children's Health Plan	There are currently no POS or RDUR programs that monitor the concurrent use of opioids and sedatives.
TX	El Paso Health	There are currently no POS or RDUR programs that monitor the concurrent use of opioids and sedatives.
TX	Parkland Community Health Plan	No, there are currently no POS or RDUR programs that monitor the concurrent use of opioids and sedatives.
TX	Texas Children's Health Plan	There are currently no POS or RDUR programs that monitor the concurrent use of opioid and sedatives.
UT	SelectHealth	Manual reviews are completed as part of the retrospective review for concurrent use.
VA	VirginiaPremier	Currently, the MCO has no POS edits in place for concurrent opioid and sedative utilization. Will be reviewed for potential future implementation.

10. Does your MCO currently have POS edits in place or an automated retrospective claims review process to monitor opioids and antipsychotics being used concurrently?

Figure 100 - POS Edits or Retrospective Claim Reviews to Monitor Opioids and Antipsychotics Being Used Concurrently

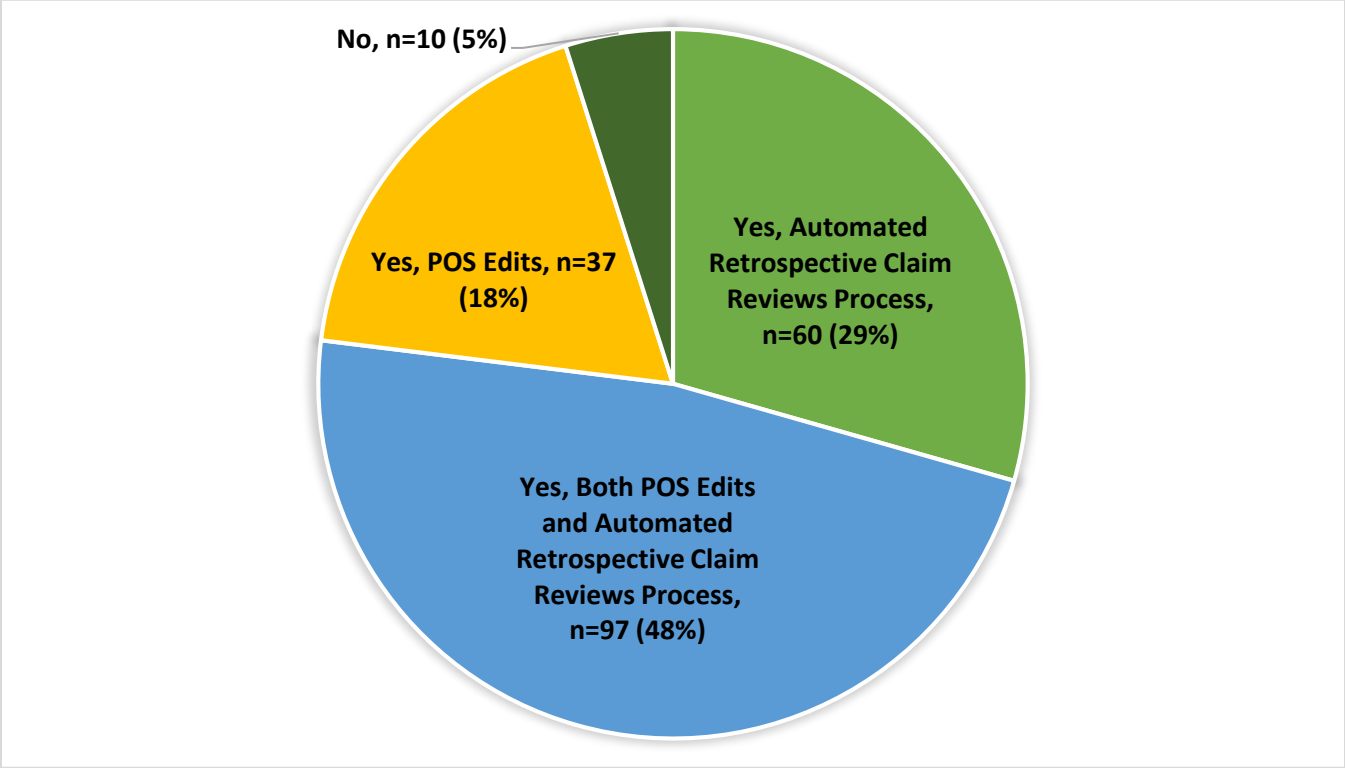

Table 120 - POS Edits or Retrospective Claim Reviews to Monitor Opioids and Antipsychotics Being Used Concurrently

Response	States (Count of MCOs)	Count	Percentage
Yes, automated retrospective claim reviews process	Hawaii (2), Illinois (2), Indiana (1), Kansas (2), Louisiana (3), Maryland (6), Michigan (4), Minnesota (3), Mississippi (1), Nebraska (2), Nevada (1), New Jersey (2), New York (1), North Carolina (1), Ohio (1), Oregon (16), Pennsylvania (3), Texas (2), Utah (2), Virginia (3), Washington (2)	60	29.41%
Yes, both POS edits and automated retrospective claim reviews process	Arkansas (3), Colorado (1), Delaware (1), District of Columbia (2), Florida (9), Georgia (2), Hawaii (3), Illinois (3), Indiana (1), Iowa (2), Kansas (1), Kentucky (6), Louisiana (2), Massachusetts (3), Michigan (1), Minnesota (6), Mississippi (2), Nebraska (1), Nevada (3), New Hampshire (1), New Jersey (3), New Mexico (2), New York (10), North Carolina (4), Ohio (4), Oregon (4), Pennsylvania (3), Rhode Island (3), South Carolina (3), Texas (3), Utah (1), Virginia (2), Washington (2)	97	47.55%
Yes, POS edits	Arkansas (1), Colorado (1), Delaware (1), District of Columbia (2), Florida (2), Georgia (1), Hawaii (1), Illinois (1), Indiana (3), Massachusetts (2), New Hampshire (2), New Mexico (1), New York (3), Pennsylvania (1), South Carolina (2), Texas (11), Virginia (1), Washington (1)	37	18.14%
No	Maryland (3), Michigan (4), Oregon (1), Pennsylvania (1), Utah (1)	10	4.90%
National Totals		**204**	**100%**

If “No,” please explain why not.

Table 121 - Explanations for not Having POS Edits or Automated Retrospective Claim Reviews in Place to Monitor Opioids and Antipsychotics Being Used Concurrently

State	MCO Name	Explanation
MD	Jai Medical Systems Managed Care Organization, Inc.	Antipsychotics are covered directly by Maryland Medicaid and are not covered by the MCO, so any limitations are administered by Maryland Medicaid. Carved out pharmacy utilization data was not shared with the MCOs in a format that could be stored in the Rx engine at the PBM until late in the measurement year so retrospective monitoring could not be implemented until after the measurement year.
MD	Maryland Physicians Care	Antipsychotics are covered through MD Fee for Service (FFS) Medicaid Program; therefore, there is no current coordination in the monitoring of these medications with opioid prescriptions.
MD	Priority Partners MCO	Priority Partners does not have POS edits or retrospective reviews for concurrent use of opioid and antipsychotics. Antipsychotics are carved out of MCO coverage and are processed separately under the FFS program.
MI	Aetna Better Health of Michigan	anti-psychotics are carved out to FFS
MI	HAP Empowered	We perform a retrospective review at least quarterly, but it is not currently automated. Behavioral health medications, including antipsychotics, are carved out to the State and are processed through the State's PBM. These claims are not available for POS edits or automated retrospective DUR programs. We combine this data with opioid claims data retrospectively and perform a manual

State	MCO Name	Explanation
		review. This may result in reach-out to the provider or referral to Case Management.
MI	McLaren Health Plan	Antipsychotics are carved out medications billed to FFS. MCO is unable upload FFS claims history data into MedImpact's adjudication system.
MI	Priority Health Choice	Our PBMs RetroDUR program has functionality to achieve both POS edits and automated retrospective claim reviews, however, coverage of antipsychotics is carved out to the Michigan Fee For Service Medicaid Plan. Additionally, Priority Health does retrospectively review cases where opioids and antipsychotics are being used concurrently as required by the SUPPORT Act, but there is not an automated process in place. In Michigan, antipsychotic medication coverage is carved out to Fee For Service Medicaid so MCO PBMs do not have claim data within their POS system to enable POS edits
OR	Cascade Health Alliance	Antipsychotics are covered by the State Fee for Service drug benefit.
PA	Health Partners	No current plans to implement this edit. HPP works closely with regional behavioral health and would collaborate with them on implementation of this edit if needed.
UT	SelectHealth	Antipsychotics are carved-out to State Medicaid.

11. Does your MCO have POS safety edits or perform automated respective claims review and/or provider education regarding beneficiaries with a diagnosis or history of opioid use disorder (OUD) or opioid poisoning diagnosis (multiple responses allowed)?

Figure 101 - POS Safety Edits, Automated Retrospective Claim Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning Diagnosis

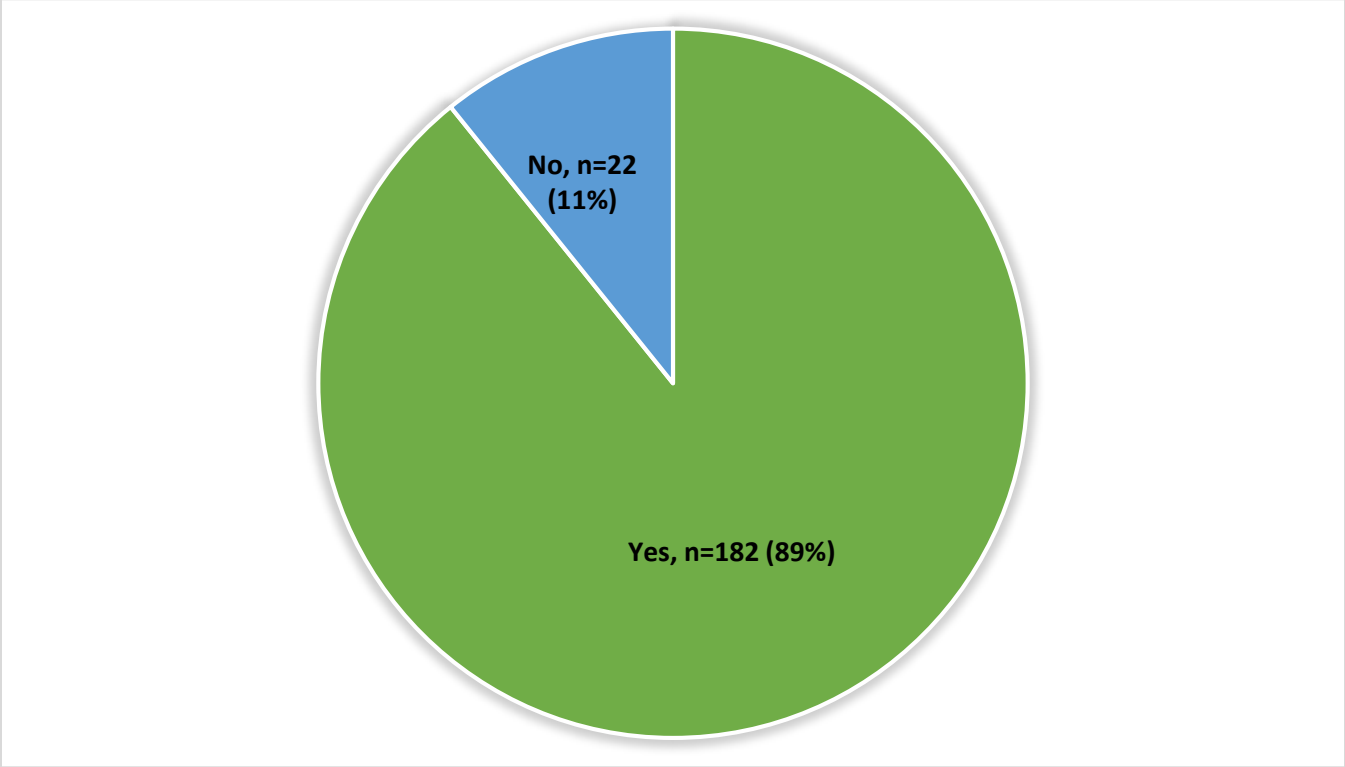

Table 122 - POS Safety Edits, Automated Retrospective Claims Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis or History of OUD or Opioid Poisoning Diagnosis

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (1), Delaware (2), District of Columbia (3), Florida (11), Georgia (3), Hawaii (5), Illinois (5), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (4), Massachusetts (4), Michigan (7), Minnesota (6), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (13), North Carolina (4), Ohio (4), Oregon (21), Pennsylvania (6), Rhode Island (3), South Carolina (5), Texas (16), Utah (2), Virginia (6), Washington (5)	182	89.22%
No	Colorado (1), District of Columbia (1), Hawaii (1), Illinois (1), Maryland (5), Massachusetts (1), Michigan (2), Minnesota (3), New York (1), North Carolina (1), Ohio (1), Pennsylvania (2), Utah (2)	22	10.78%
National Totals		**204**	**100%**

If "No," please explain why not.

Table 123 - "No" Explanations for POS Safety Edits, Automated Retrospective Claims Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis or History of OUD or Opioid Poisoning Diagnosis

State	MCO Name	Explanation
CO	Denver Health Medicaid Choice	MCO would like to implement a claims review and provider education regarding beneficiaries with a diagnosis or history of opioid use disorder (OUD) or opioid poisoning diagnosis. There is no specific timeline for this program implementation.
DC	HealthServicesforSpecialNeedsChildren	The diagnosis is not a part of the pharmacy claim and CVS/Caremark system.
HI	AlohaCare	Our PBM doesn't offer this program, however, AlohaCare may offer provider education on the use of opioids in those with a history of OUD or opioid poisoning. We continue to monitor this at this time and review on a case-by-case basis. Our population is not in need of this at this time.
IL	YouthCare_HealthChoice	A process is in development to identify these members and conduct outreach.
MA	Health New England, Inc.	POS edits, retroDUR disclosures, and/or provider education of this nature may violate substance abuse confidentiality regulations 42 CFR Part 2.
MD	Amerigroup Community Care	Substance use disorder (SUD) drugs are carved out to the State and paid for by the FFS program
MD	CareFirst Community Health Plan Maryland	Implementation of such programs would depend on funding. Prescription Safety Management programs review higher risk member utilization of all controlled substances for potential intervention including prescriber lettering and/or additional enhanced interventions and restrictions. During the course of member case interventions, prescribers may respond with diagnosis or history of OUD or opioid poisoning. These member cases may lead to additional interventions or discussions regarding the members' drug therapies, including referral of individual prescribers

State	MCO Name	Explanation
		to an online educational toolkit. Member reviews are conducted Monthly and Quarterly for members with high-risk utilization. Prescriber letters are sent and prescriber response are reviewed for diagnosis and additional treatment information or changes. Member reviews are conducted an ad hoc basis depending on case need for Prescription Safety Management for members with high-risk utilization. Prescriber letters and calls are communicated, and prescriber response are reviewed for diagnosis and additional treatment information or changes.
MD	Jai Medical Systems Managed Care Organization, Inc.	Currently there is no plan in place to implement a retroDUR program/targeted provider education to prescribers of opioids with a patient with a diagnosis of OUD/opioid poisoning but the possibility will be examined.
MD	Maryland Physicians Care	MPC does not have access to appropriate OUD diagnosis or history which prevents the plan from implementing RetroDUR activities or education.
MD	Priority Partners MCO	Priority Partners does not have POS edits, retrospective reviews, or provider education that specifically targets beneficiaries with a diagnosis or history of OUD or opioid poisoning. However, POS edits have been implemented through the PBM, which include quantity limit of 180 tablets, capsules, or suppositories per a 30-day supply for all short-acting opioids. Other product formulations, such as liquids, nasal sprays, and patch have similar product-specific quantity limitations to align with the Plan's max 90 MME per day restriction. Long-acting opioids require prior authorization for coverage. All these edits are applicable to all covered beneficiaries.
MI	Priority Health Choice	In Michigan, behavioral health medications (inclusive of substance use disorder drugs) are carved out to FFS Medicaid. Additionally, associated medical behavioral services are carved out to PIHPs.
MI	Upper Peninsula Health Plan	Claims for opioid use disorder or opioid poisoning are carve out per the MDHHS Common Formulary.
MN	IMCare	Diagnosis of OUD is protected health information and interfacing that data would be challenging in the automation process and rely on providers to input the diagnosis codes with the patients permission.
MN	SouthCountry	Retrospective claims review are being completed; however, current process is not automated. We are in the process of developing this with implementation planned over the next few months.
MN	UCare	While not automated, UCare does perform monthly opioid overutilization reviews and case management which considers beneficiary's opioid related diagnoses and any associated poisoning/overdose diagnoses or history. Beneficiaries that are identified as high risk may be subject to further review and potential restriction resulting in notification/education to the provider.
NC	AMHC FFY22	AMHC is required to align with NCDHB POS safety edits. This is not a requirement.
NY	Fidelis Care	Implementation of such programs would depend on funding.
OH	Paramount	Safety and Monitoring programs review higher risk member utilization of all controlled substances for potential intervention

State	MCO Name	Explanation
		including prescriber lettering. During the course of member case interventions, prescribers may respond with diagnosis or history of OUD or opioid poisoning. These member cases may lead to additional interventions or discussions regarding the members' drug therapies.
PA	Geisinger	Difficult to determine who has OUD/opioid poisoning based on diagnosis. Not always present on medical claims. We do capture and address members who have filled and opioid medication after having recent claims for an opioid dependence treatment medication.
PA	Health Partners	No current plans to implement this edit. HPP works closely with regional behavioral health and would collaborate with them on implementation if edit is needed.
UT	Healthy U	Drugs for OUD are carved out to the State. We will look at this as a future item for DUR consideration.
UT	Steward Health Choice Utah	Drugs for OUD are carved out to the State. We will review this for DUR consideration in the future.

If "Yes," please check all that apply.

Figure 102 - POS Safety Edits, Automated Retrospective Claims Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis or History of OUD or Opioid Poisoning Diagnosis

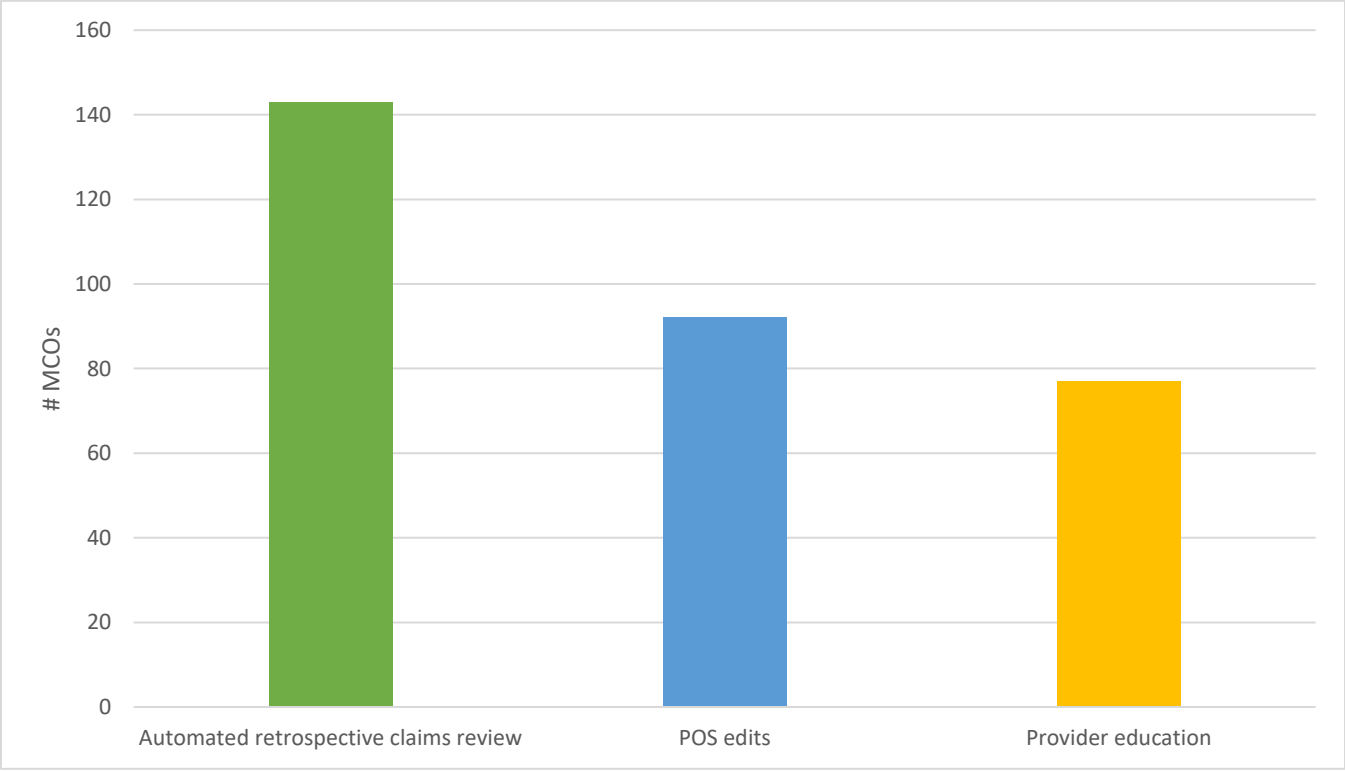

Table 124 - POS Safety Edits, Automated Retrospective Claim Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning Diagnosis

Response	States (Count of MCOs)	Count	Percentage
Automated retrospective claims review	Arkansas (3), Colorado (1), Delaware (2), District of Columbia (2), Florida (8), Georgia (2), Hawaii (4), Illinois (4), Indiana (4), Kansas (3), Kentucky (5), Louisiana (4), Maryland (4), Massachusetts (2), Michigan (6), Minnesota (5), Mississippi (3), Nebraska (3), Nevada (3), New Jersey (4), New Mexico (3), New York (10), North Carolina (4), Ohio (4), Oregon (21), Pennsylvania (6), Rhode Island (2), South Carolina (3), Texas (6), Utah (2), Virginia (5), Washington (5)	143	45.83%
POS edits	Arkansas (3), Delaware (1), District of Columbia (2), Florida (6), Georgia (1), Hawaii (1), Illinois (1), Indiana (2), Iowa (2), Kansas (1), Kentucky (6), Louisiana (1), Maryland (1), Massachusetts (2), Michigan (1), Minnesota (1), Nebraska (2), Nevada (2), New Hampshire (2), New Jersey (2), New Mexico (2), New York (6), North Carolina (1), Ohio (3), Oregon (21), Pennsylvania (1), South Carolina (4), Texas (10), Virginia (2), Washington (2)	92	29.49%
Provider education	Arkansas (1), Delaware (1), District of Columbia (3), Florida (6), Georgia (1), Hawaii (1), Illinois (2), Indiana (2), Kansas (1), Louisiana (1), Maryland (2), Massachusetts (4), Michigan (4), Minnesota (3), Mississippi (2), Nebraska (2), Nevada (1), New Hampshire (1), New Jersey (2), New Mexico (3), New York (10), North Carolina (1), Oregon (10), Pennsylvania (2), Rhode Island (2), South Carolina (2), Texas (3), Utah (1), Virginia (1), Washington (2)	77	24.68%
National Totals		**312**	**100%**

If "Yes, automated retrospective claim reviews" and/or "Yes, provider education," please indicate how often.

Figure 103 - Frequency of Automated Retrospective Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning Diagnosis

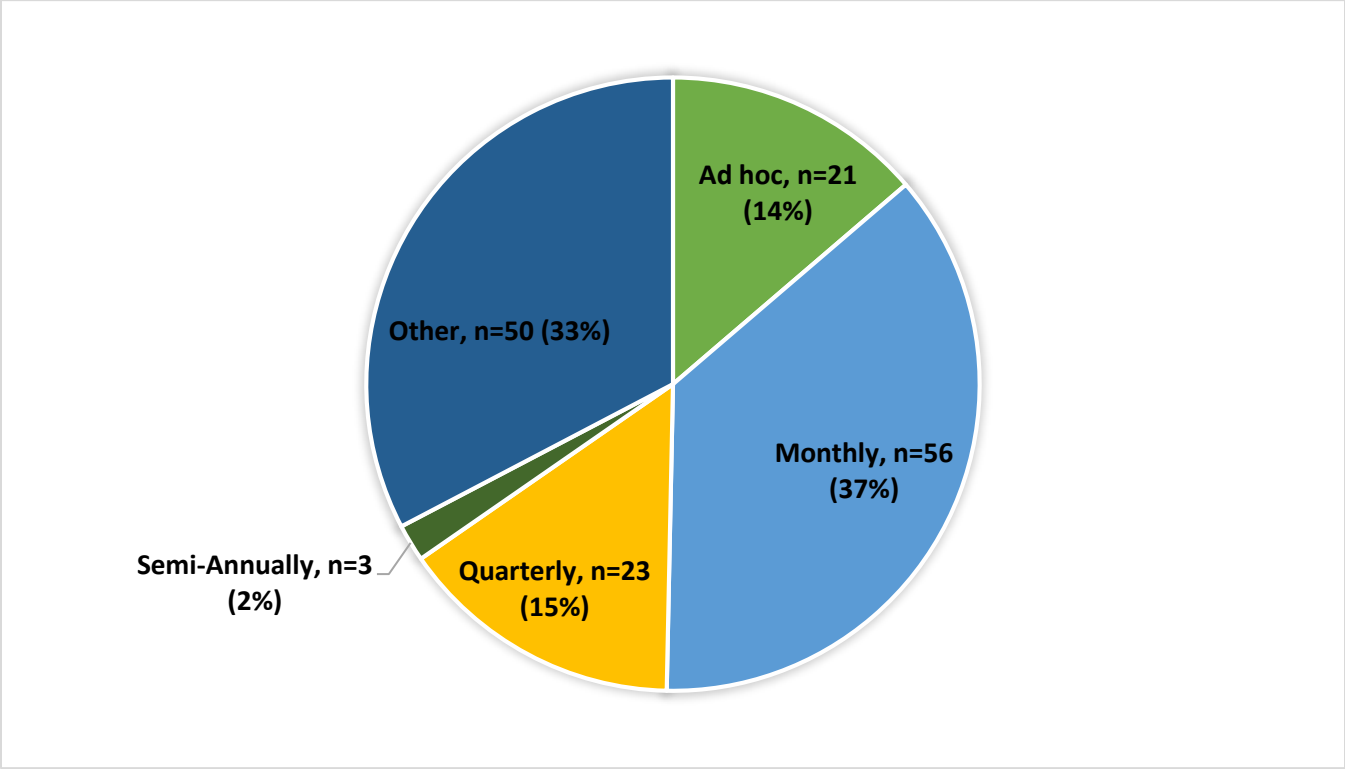

Table 125 - Frequency of Automated Retrospective Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning Diagnosis

Response	States (Count of MCOs)	Count	Percentage
Ad hoc	District of Columbia (1), Florida (2), Hawaii (1), Indiana (1), Louisiana (1), New York (3), Oregon (9), Pennsylvania (1), Utah (1), Washington (1)	21	13.73%
Monthly	Arkansas (3), Delaware (1), District of Columbia (2), Florida (3), Georgia (2), Illinois (3), Indiana (2), Kansas (1), Louisiana (2), Maryland (2), Massachusetts (1), Michigan (1), Minnesota (1), Mississippi (1), Nebraska (2), Nevada (1), New Hampshire (1), New Jersey (3), New Mexico (1), New York (5), North Carolina (2), Ohio (1), Oregon (3), Pennsylvania (1), South Carolina (2), Texas (4), Utah (1), Virginia (2), Washington (2)	56	36.60%
Quarterly	Illinois (1), Kansas (1), Kentucky (5), Massachusetts (1), Michigan (3), Minnesota (2), Mississippi (1), New Mexico (1), New York (1), Ohio (1), Oregon (5), Rhode Island (1)	23	15.03%
Semi-Annually	Hawaii (1), Oregon (2)	3	1.96%

Response	States (Count of MCOs)	Count	Percentage
Other	Colorado (1), Delaware (1), Florida (3), Hawaii (3), Illinois (1), Indiana (1), Kansas (1), Louisiana (1), Maryland (2), Massachusetts (2), Michigan (3), Minnesota (2), Mississippi (1), Nebraska (1), Nevada (2), New Jersey (1), New Mexico (1), New York (3), North Carolina (2), Ohio (2), Oregon (2), Pennsylvania (4), Rhode Island (2), South Carolina (1), Texas (2), Virginia (3), Washington (2)	50	32.68%
National Totals		**153**	**100%**

If “No”, does your MCO plan on implementing POS edits, automated retrospective claim reviews and/or provider education regarding beneficiaries with a diagnosis or history of OUD or opioid poisoning in the future?

Figure 104 - Plans to Implement POS edits, Automated Retrospective Claim Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning in the Future

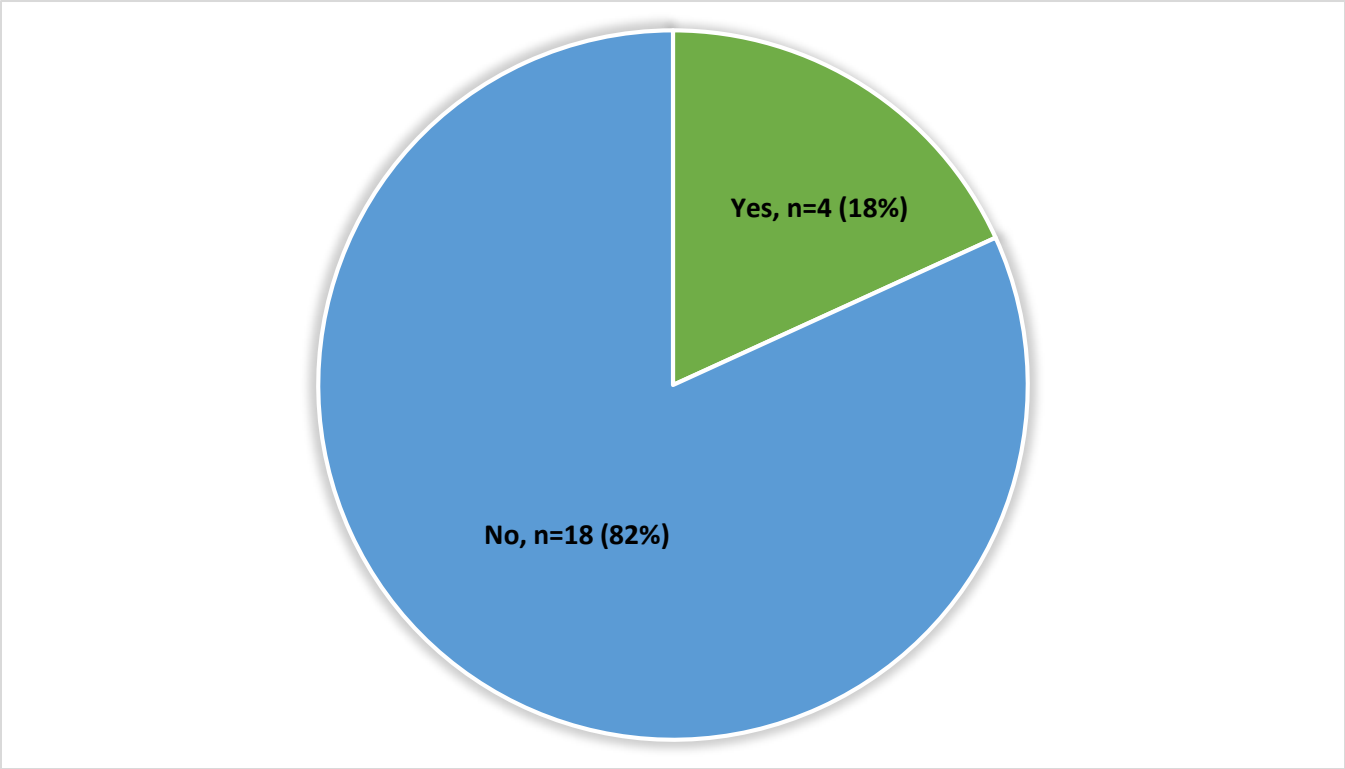

Table 126 - Plans to Implement POS Edits, Automated Retrospective Claim Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning in the Future

Response	States (Count of MCOs)	Count	Percentage
Yes	Colorado (1), Illinois (1), Minnesota (1), Pennsylvania (1)	4	18.18%
No	District of Columbia (1), Hawaii (1), Maryland (5), Massachusetts (1), Michigan (2), Minnesota (2), New York (1), North Carolina (1), Ohio (1), Pennsylvania (1), Utah (2)	18	81.82%
National Totals		**22**	**100%**

If "Yes," when does your MCO plan on implementing?

Table 127 - "Yes" Explanations for Plans to Implement POS Edits, Automated Retrospective Claim Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning in the Future

State	MCO Name	Explanation
CO	Denver Health Medicaid Choice	No timeline yet
IL	YouthCare_HealthChoice	During calendar year 2023
MN	SouthCountry	Retrospective claims review are being completed; however, current process is not automated. We are in the process of developing this with implementation planned over the next few months.
PA	Geisinger	By the end of 2023 we will have a retrospective claim review process in place.

If "No," please explain why not.

Table 128 - "No" Explanations for Plans to Implement POS Edits, Automated Retrospective Claim Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis or History of OUD or Opioid Poisoning in the Future

State	MCO Name	Explanation
DC	HealthServicesforSpecial NeedsChildren	We shall work with our PBM to determine if this is feasible.
HI	AlohaCare	Our PBM doesn't offer this program, however, AlohaCare may offer provider education on the use of opioids in those with a history of OUD or opioid poisoning. We continue to monitor this at this time and review on a case-by-case basis. Our population is not in need of this at this time.
LA	AmeriHealth Caritas Louisiana	N/A
MA	Health New England, Inc.	POS edits, retroDUR disclosures, and/or provider education of this nature may violate substance abuse confidentiality regulations 42 CFR Part 2.
MD	Amerigroup Community Care	Substance use disorder (SUD) drugs are carved out to the State and paid for by the FFS program
MD	CareFirst Community Health Plan Maryland	The plan used to send overdose letters to the member, the Primary Care Provider, and at least one of the providers who prescribed at least one controlled dangerous substance within the past 90 days of an opioid poisoning incidence. In April 2022, the plan decided not to send provider educational letters anymore to protect the confidentiality of substance use disorder (SUD), HIPAA Privacy act 42CRF PART 2. Instead, Special Needs team from the plan only communicates with the member who has OUD to connect them with behavioral health services or a substance use treatment provider.
MD	Jai Medical Systems Managed Care Organization, Inc.	Currently there is no plan in place to implement a retroDUR program/targeted provider education to prescribers of opioids with a patient with a diagnosis of OUD/opioid poisoning but the possibility will be examined.
MD	Maryland Physicians Care	MPC does not have access to appropriate OUD diagnosis or history which prevents the plan from implementing RetroDUR activities or education.
MD	Priority Partners MCO	Priority Partners has POS edits through the PBM, which include quantity limit of 180 tablets, capsules, or suppositories per a 30-day supply for all short-acting opioids. Other product formulations, such as liquids, nasal sprays, and patch have similar product-specific quantity limitations to align with the Plan's max 90 MME per day restriction. Long-acting opioids require prior authorization for coverage. All these edits are applicable to all covered beneficiaries.

State	MCO Name	Explanation
MI	Priority Health Choice	In Michigan, behavioral health medications (inclusive of substance use disorder drugs) are carved out to FFS Medicaid. Additionally, associated medical behavioral services are carved out to PIHPs.
MI	Upper Peninsula Health Plan	Claims for opioid use disorder or opioid poisoning are carve out per the MDHHS Common Formulary.
MN	IMCare	MCare would need further guidance from CMS on this process.
MN	UCare	At this time UCare does not plan to implement a RetroDUR activity and instead considers beneficiaries' opioid related diagnoses in conjunction with other medical factors and claims data during a monthly opioid overutilization review.
NC	AMHC FFY22	AMHC is required to align with NCDHB POS safety edits. AMHC will await request from NCDHB.
NY	Fidelis Care	Implementation of such programs would depend on funding.
OH	Paramount	Paramount is no longer an Ohio Medicaid plan, therefore, we do not plan to implement any of these processes.
PA	Health Partners	No current plans to implement this edit. HPP works closely with regional behavioral health and would collaborate with them on implementation if edit is needed.
UT	Healthy U	We will consider this for future implementation but don't currently have a plan in place.
UT	Steward Health Choice Utah	We do not have a plan in place for this. We will consider for future implementation.

12. Does your MCO program develop and provide prescribers with pain management or opioid prescribing guidelines?

Figure 105 - Provide Prescribers with Pain Management or Opioid Prescribing Guidelines

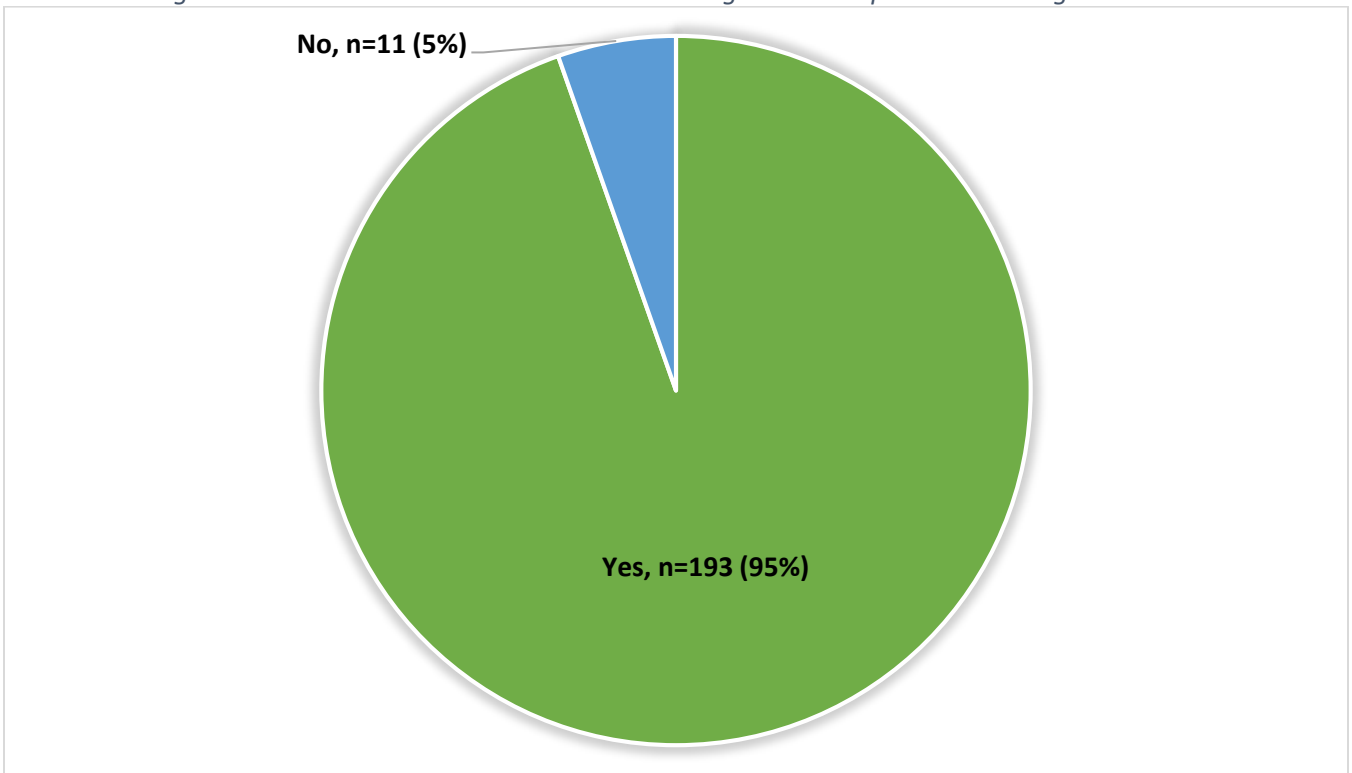

Table 129 - Provide Prescribers with Pain Management or Opioid Prescribing Guidelines

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (1), Delaware (2), District of Columbia (4), Florida (10), Georgia (3), Hawaii (6), Illinois (5), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (14), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (7), Rhode Island (2), South Carolina (4), Texas (11), Utah (4), Virginia (6), Washington (5)	193	94.61%
No	Colorado (1), Florida (1), Illinois (1), Pennsylvania (1), Rhode Island (1), South Carolina (1), Texas (5)	11	5.39%
National Totals		**204**	**100%**

If "Yes," check all that apply.

Figure 106 - Pain Management / Opioid Prescribing Guidelines Provided

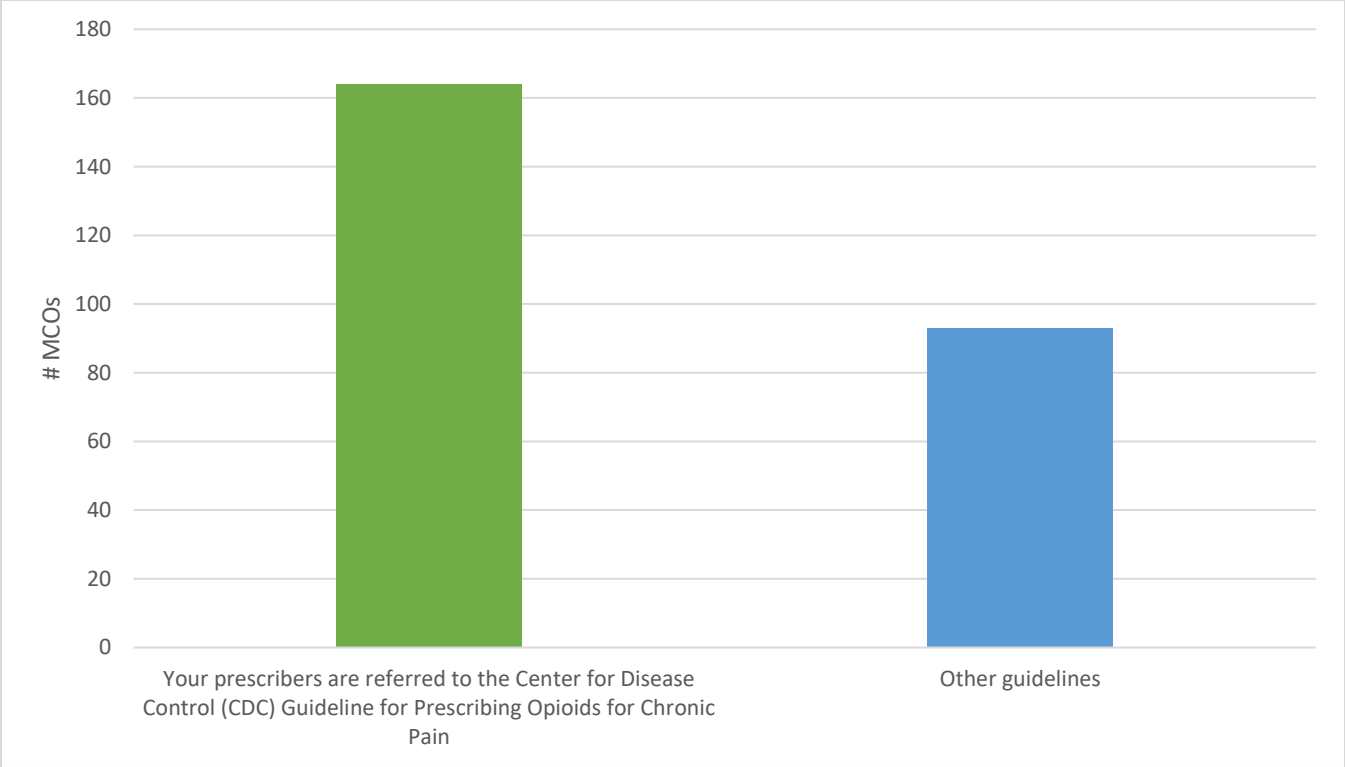

Table 130 - Pain Management / Opioid Prescribing Guidelines Provided

Response	States (Count of MCOs)	Count	Percentage
Your prescribers are referred to the Center for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain	Arkansas (3), Colorado (1), Delaware (2), District of Columbia (4), Florida (8), Georgia (2), Hawaii (6), Illinois (5), Indiana (2), Iowa (2), Kansas (3), Kentucky (5), Louisiana (5), Maryland (8), Massachusetts (4), Michigan (8), Minnesota (6), Mississippi (3), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (5), New Mexico (3), New York (13), North Carolina (5), Ohio (3), Oregon (19), Pennsylvania (7), Rhode Island (2), South Carolina (4), Texas (8), Utah (3), Virginia (3), Washington (3)	164	63.81%

Response	States (Count of MCOs)	Count	Percentage
Other guidelines	Arkansas (2), Colorado (1), Delaware (1), District of Columbia (2), Florida (3), Georgia (2), Hawaii (1), Illinois (1), Indiana (4), Kansas (2), Kentucky (1), Louisiana (1), Maryland (4), Massachusetts (2), Michigan (4), Minnesota (7), Mississippi (1), Nebraska (1), Nevada (2), New Hampshire (1), New Jersey (1), New York (3), North Carolina (2), Ohio (4), Oregon (17), Pennsylvania (2), Rhode Island (2), South Carolina (2), Texas (6), Utah (1), Virginia (6), Washington (4)	93	36.19%
National Totals		**257**	**100%**

13. Does your MCO have a drug utilization management strategy that supports abuse deterrent opioid use to prevent opioid misuse and abuse (i.e. presence of an abuse deterrent opioid with preferred status on your preferred drug list)?

Figure 107 - Drug Utilization Management Strategy that Supports Abuse Deterrent Opioid Use

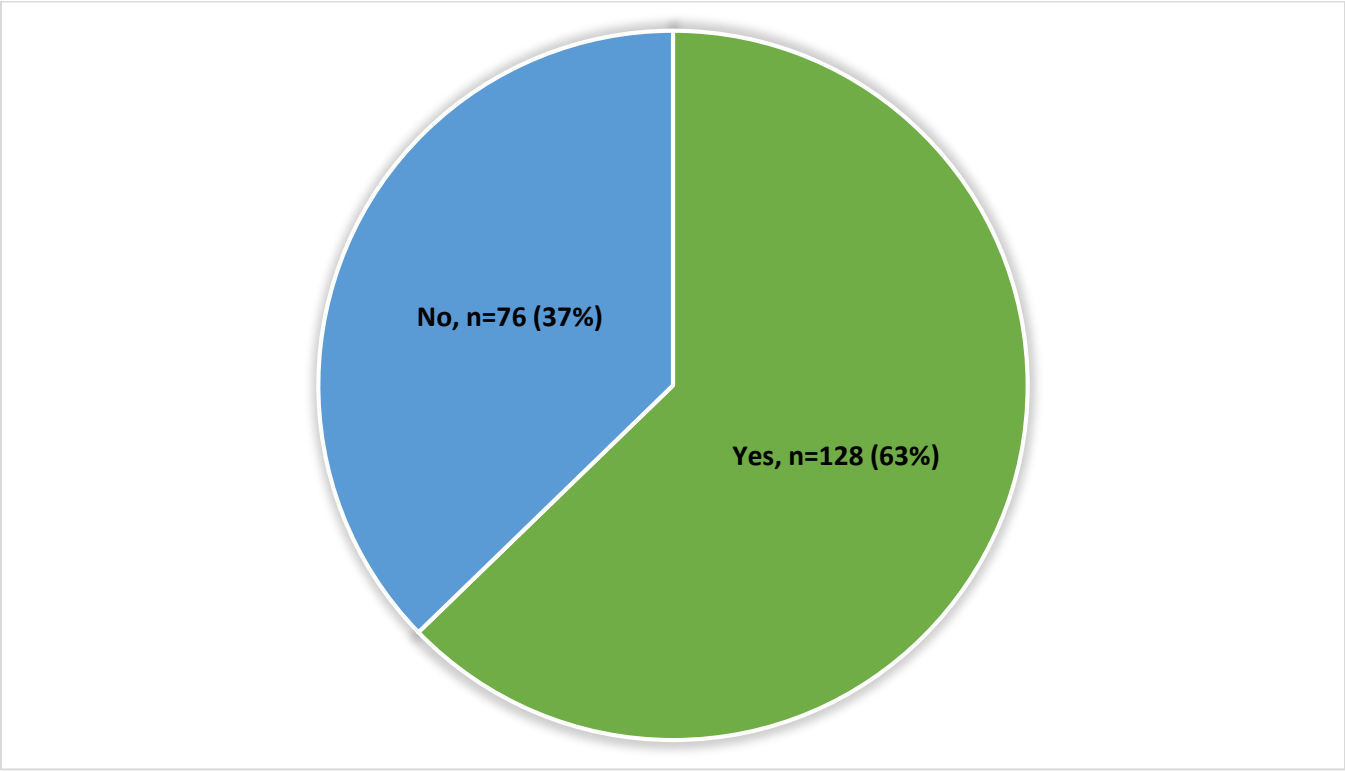

Table 131 - Drug Utilization Management Strategy that Supports Abuse Deterrent Opioid Use

Response	States (Count of MCOs)	Count	Percentage
Yes	Colorado (1), Delaware (2), Florida (11), Georgia (1), Hawaii (5), Illinois (4), Indiana (2), Kansas (3), Louisiana (2), Maryland (1), Massachusetts (3), Michigan (5), Minnesota (5), Mississippi (2), Nebraska (3), Nevada (2), New Hampshire (3), New Jersey (3), New Mexico (1), New York (7), North Carolina (5), Ohio (3), Oregon (13), Pennsylvania (8), Rhode Island (1), South Carolina (3), Texas (16), Utah (3), Virginia (5), Washington (5)	128	62.75%

Response	States (Count of MCOs)	Count	Percentage
No	Arkansas (4), Colorado (1), District of Columbia (4), Georgia (2), Hawaii (1), Illinois (2), Indiana (3), Iowa (2), Kentucky (6), Louisiana (3), Maryland (8), Massachusetts (2), Michigan (4), Minnesota (4), Mississippi (1), Nevada (2), New Jersey (2), New Mexico (2), New York (7), Ohio (2), Oregon (8), Rhode Island (2), South Carolina (2), Utah (1), Virginia (1)	76	37.25%
National Totals		**204**	**100%**

If "No," please explain.

Table 132 - "No" Explanation for Drug Utilization Management Strategy that Supports Abuse Deterrent Opioid Use

State	MCO Name	Explanation
AR	Arkansas_Total_Care_Inc.	ARTC has to follow the Arkansas FFS Medicaid PDL, which does not include any preferred abuse deterrent opioids.
AR	CareSource	CareSource follows the Arkansas Preferred Drug List.
AR	Empower_HealthCare_Solutions_LLC	Empower follows State formulary for opioid use disorder and opioid deterrent medications.
AR	Summit_Community_Care	We are required to follow State FFS formulary
CO	Rocky Mountain Health Plans	RMHP includes abuse deterrent opioids on the preferred drug list however, RMHP does not have a specific management strategy for providers to utilize opioids with some form of abuse deterrent over those that do not as data is lacking that proves abuse deterrent formulations reduce misuse/abuse in real world settings.
DC	AmeriHealth Caritas DC	We support the use of Narcan and conduct telephonic outreach to enrollees who claims substance use disorder encounters. Washington, DC has a standing order for Narcan so it can be obtained at local pharmacies.
DC	CareFirst BCBS Community Health Plan DC	With our current ProDUR, RetroDUR, PA requirements, we have enough control on prevention of opioid misuse and abuse
DC	HealthServicesforSpecialNeedsChildren	This is an area for opportunity improvement by the Plan.
DC	MedStar Family Choice - District of Columbia	Abuse deterrent opioids have not been added to the formulary due to price and uncertain efficacy but requests are reviewed on a case-by-case basis.
GA	Amerigroup GA	Abuse deterrent agents can be obtained via prior authorization if there is concern regarding misuse/abuse by individual or individual's family member.
GA	CareSource	Abuse deterrent opioids are available through PA only.
HI	AlohaCare	Although abuse deterrent opioids are not available on our PDL with preferred status, these formulations of opioids are available with prior authorization for those with a history of substance abuse disorder or lives in a household with someone who has active or a history of substance abuse disorder.
IA	Amerigroup	MCO follows FFS PDL and abuse deterrent opioids may be considered dependent on the patient specific need.
IA	Iowa Total Care	MCO follows FFS PDL and abuse deterrent opioids may be considered dependent on the patient specific need.

State	MCO Name	Explanation
IL	Aetna_Better_Health_of_Illinois	Availability of opioid deterrent products is determined by the single State Medicaid Preferred Drug List, which is not driven by the MCO
IL	Blue_Cross_and_Blue_Shield_of_Illinois	BCBSIL follows the State run PDL. We cover medications based on the preferred and non-preferred status of the PDL managed by the State.
IN	CareSource	Abuse deterrent opioids are available through PA only.
IN	Managed Health Services Indiana (MHS)	The opioid utilization is managed by diagnoses, POS edits, quantity limits, age edits and prior authorizations. Providers are asked to step through preferred products but can skip over these with a prior authorization.
IN	UnitedHealthcare Community Plan, Inc.	Our preferred drug list and opioid policies allow for opioid-naï¿½ve members to a 7-day supply of medications. Long term use of opioids requires a clinical prior authorization for review, which includes abuse deterrent formulations.
KY	Aetna Better Health of Kentucky	MCO's follow State PDL and utilization criteria
KY	Anthem Inc. Kentucky	MCOs follow State PDL and utilization criteria.
KY	Humana Healthy Horizons in Kentucky	MCOs follow State PDL and utilization criteria.
KY	Passport Health Plan By Molina Healthcare	MCOs follow State PDL and utilization criteria.
KY	United Healthcare Community Plan of Kentucky	MCO's follow State PDL and utilization criteria.
KY	WellCare Health Plans	MCOs follow State PDL and utilization criteria
LA	AmeriHealth Caritas Louisiana	Preferred status of abuse deterrent opioids is determined by the State.
LA	Louisiana Healthcare Connections	LHCC follows the LDH single PDL and there are no preferred abuse deterrents opioids.
LA	UnitedHealthcare Community Plan	Embeda was no longer on the market at this time.
MA	Boston Medical Center Health Plan, Inc	The Plan does not specifically prefer abuse-deterrent opioids on the formulary. The formulary is managed based on several factors including effectiveness, adverse events, risks/benefits, cost, and place in therapy. Other POS and RDur edits are leveraged to manage opioid utilization and promoting appropriate prescribing.
MA	Tufts Health Public Plans, Inc	Abuse deterrent formulations are not preferred on the formulary but can be reviewed for medical necessity through the prior authorization process.
MD	Aetna Better Health of Maryland	Opioid antagonists are carved out of the pharmacy benefit, and covered by Fee For Service plan. However, we have a POS edit in place that will display a message at POS instructing the pharmacist to recommend naloxone when cumulative morphine equivalent dose exceeds 50mg.
MD	Amerigroup Community Care	Abuse Deterrent medication doesn't have a preferred status on the Preferred Drug List (PDL) however, a medical exception and prior authorization route are available to obtain should the prescriber chooses to do so.
MD	CareFirst Community Health Plan Maryland	All brand opioid drugs are non-formulary due to cost savings efforts. The four opioids with FDA approved labeling describing abuse deterrent properties are brand name drugs; OxyContin,

State	MCO Name	Explanation
		Hysingla ER, Xtampza ER, and RoxyBond. The plan is currently in the process of evaluating the one generic opioid with FDA-approved labeling describing abuse-deterrent properties; Hydrocodone bitartrate.
MD	Jai Medical Systems Managed Care Organization, Inc.	All long-acting opioids on the drug list require prior authorization in order to be filled. This includes Oxycontin, which has abuse-deterrent properties. If Oxycontin is not an appropriate treatment for the member, the provider could request authorization of a nonformulary opioid with abuse deterrent properties under medical necessity if they provide an explanation of why formulary alternatives are not appropriate.
MD	Maryland Physicians Care	Though abuse deterrent medication option is not available as a preferred medication on the Preferred Drug List (PDL), quantity limitations and prior authorization restrictions are in place.
MD	MedStar Family Choice	Abuse deterrent opioids were not added to the formulary due to price and uncertain efficacy but requests are reviewed on a case-by-case basis.
MD	Priority Partners MCO	Priority Partners has enacted a combination of prior authorization requirements and quantity limitations to closely manage the utilization of long and short-acting opioids to prevent both the misuse and abuse of these drug products.
MD	United Healthcare	Abuse deterrent opioid products are non-preferred and require a prior authorization.
MI	Aetna Better Health of Michigan	Aetna Better Health of MI follows the MDHSS PDL/Common Formulary which does not list these agents as preferred.
MI	Blue Cross Complete of Michigan	Opioid coverage is PDL dependent as established by MDHHS and many of the abuse deterrent dosage forms are included in tier 3, PDL Non-Preferred, status.
MI	Priority Health Choice	There are no medications specifically formulated as "abuse deterrent" that are preferred on the formulary.
MI	UnitedHealthcare Community Plan	Management of formulary status of opioid analgesics is maintained by MDHHS by requiring MCOs to align with their FFS formulary. MCO does have rDUR program that identifies potential opioid discretions and opioid prescribing references provided to prescribers.
MN	BluePlus	The Minnesota Department of Human Services (DHS) does not prefer any abuse deterrent opioid products on the State mandatory Preferred Drug List (PDL)
MN	HealthPartners	HealthPartners follows the MN State preferred drug list (PDL) for opioid management.
MN	IMCare	The State dictates preferred drug status. Abuse deterrent formulations have not provided enough evidence to support preferred status.
MN	UCare	In July 2019 the Minnesota Department of Human Services implemented the Preferred Drug List (PDL) which distinguishes between preferred and non-preferred medications for many drug classes. The opioid/narcotic analgesic drug class is a PDL managed drug category and does not include any abuse deterrent opioids within the preferred drug list which is determined by the State.

State	MCO Name	Explanation
MS	MS-UNITED	MCOs are required to adhere to the Mississippi Division of Medicaid single PDL, there are no abuse deterrent opioids with preferred status on the single PDL
NJ	Amerigroup Community Care	Abuse deterrent agents can be obtained via prior authorization if there is concern regarding misuse/abuse by individual or individual's family member.
NJ	NJ United	Abuse deterrent opioid products are non-preferred and require a prior authorization.
NM	Blue Cross Blue Shield of New Mexico	Abuse deterrent opioid are not on the formulary.
NM	Western Sky Community Care	Even though not preferred, prior authorization can be requested and approved when warranted for a non-formulary abuse deterrent product.
NV	Anthem Blue Cross Blue Shield	Abuse deterrent agents can be obtained via prior authorization if there is concern regarding misuse/abuse by individual or individual's family member
NV	Health Plan of Nevada	Strategic decision by the plan for opioid coverage
NY	Capital District Physicians' Health Plan	Robust clinical literature does not exist or support the preference of abuse deterrent opioids over other opioid products prescribed judiciously.
NY	EmblemHealth	EmblemHealth implores strict controls via POS edits to ensure safe and appropriate use of opioids. Although the abuse-deterrent formulations may make it more difficult for someone to abuse opioids, it does not mean that they cannot be abused as well. We feel that the controls we have in place are the best way to manage a patient's pain safely while not overspending on branded products.
NY	Empire Blue Cross Blue Shield HealthPlus	Abuse deterrent agents can be obtained via prior authorization if there is concern regarding misuse/abuse by individual or individual's family member.
NY	Fidelis Care	The MCO does not have a drug utilization management strategy that supports abuse deterrent opioids.
NY	Highmark Blue Cross Blue Shield of Western New York	Abuse deterrent agents can be obtained via prior authorization if there is concern regarding misuse/abuse by individual or individual's family member.
NY	MVP Health Care	Abuse deterrent opioid products are available through clinical review and exception process.
NY	United HealthCare	Abuse deterrent opioid products are non-preferred and require a prior authorization.
OH	Buckeye Health Plan	Unified Preferred Drug list is used in Ohio
OH	CareSource	CareSource follows the Ohio Unified Preferred Drug List (UPDL).
OR	Advanced Health	Advanced Health does not have an abuse deterrent opioid with preferred status. Review of chart notes is required and attestation of prior/current substance use disorder must be documented and addressed when reviewing for use of an opioid.
OR	AllCare CCO	AllCare CCO's drug utilization management strategy to prevent opioid misuse and abuse is based on clinical review and prior authorization of all long-acting opioids and short-acting opioids (prescribed beyond a 7-day supply every 60 days). This measure

State	MCO Name	Explanation
		promotes adherence to CDC, evidence-based guidelines, and aligns with Stated limitations of use in approved labeling.
OR	Cascade Health Alliance	Initial fills for all long acting opioids require a PA for medical necessity. When approved, subsequent fills are monitored for appropriate day supply.
OR	Health Share of Oregon - Legacy Health/PacificSource	We encourage alternative pain treatment modalities when possible to limit chronic opioid use.
OR	PacificSource Community Solutions-Central Oregon	We encourage alternative pain treatment modalities when possible to limit chronic opioid use.
OR	PacificSource Community Solutions-Columbia Gorge	We encourage alternative pain treatment modalities when possible to limit chronic opioid use.
OR	PacificSource Community Solutions - Lane	We encourage alternative pain treatment modalities when possible to limit chronic opioid use.
OR	PacificSource Community Solutions - Marion/Polk	We encourage alternative pain treatment modalities when possible to limit chronic opioid use.
RI	THP	Abuse deterrent formulations are not preferred on the formulary but can be reviewed for medical necessity through the prior authorization process.
RI	UHCCP	Abuse deterrent opioid products are non-preferred and require a prior authorization.
SC	Healthy Blue South Carolina	Abuse deterrent agents can be obtained via prior authorization if there is concern regarding misuse/abuse by individual or individual's family member.
SC	Select Health of South Carolina, Inc.	No; requests for non-preferred, abuse deterrent, opioid formulations require a trial on 2 to 3 preferred alternatives or a medical reason why those alternatives cannot be used.
UT	SelectHealth	Our utilization management strategies revolve around reducing MME and reducing the concurrent use of opioids with benzodiazepines. In an effort to balance clinical efficacy and cost-effectiveness, we prioritize the use of low cost and low MME products rather than promoting the use of abuse-deterrent formulations.
VA	OptimaHealth	The MCO adheres to the preferred drug list set forth by the Virginia Department of Medical Assistance Services. Abuse deterrent opioids do not have a preferred status on this list; however, providers can convey medical necessity through the prior authorization process, and our clinical review procedure will support abuse deterrent strategies.

14. Were there COVID-19 ramifications on edits and reviews on controlled substances during the public health emergency?

Figure 108 - COVID-19 Ramifications on Edits and Reviews on Controlled Substances During the Public Health Emergency

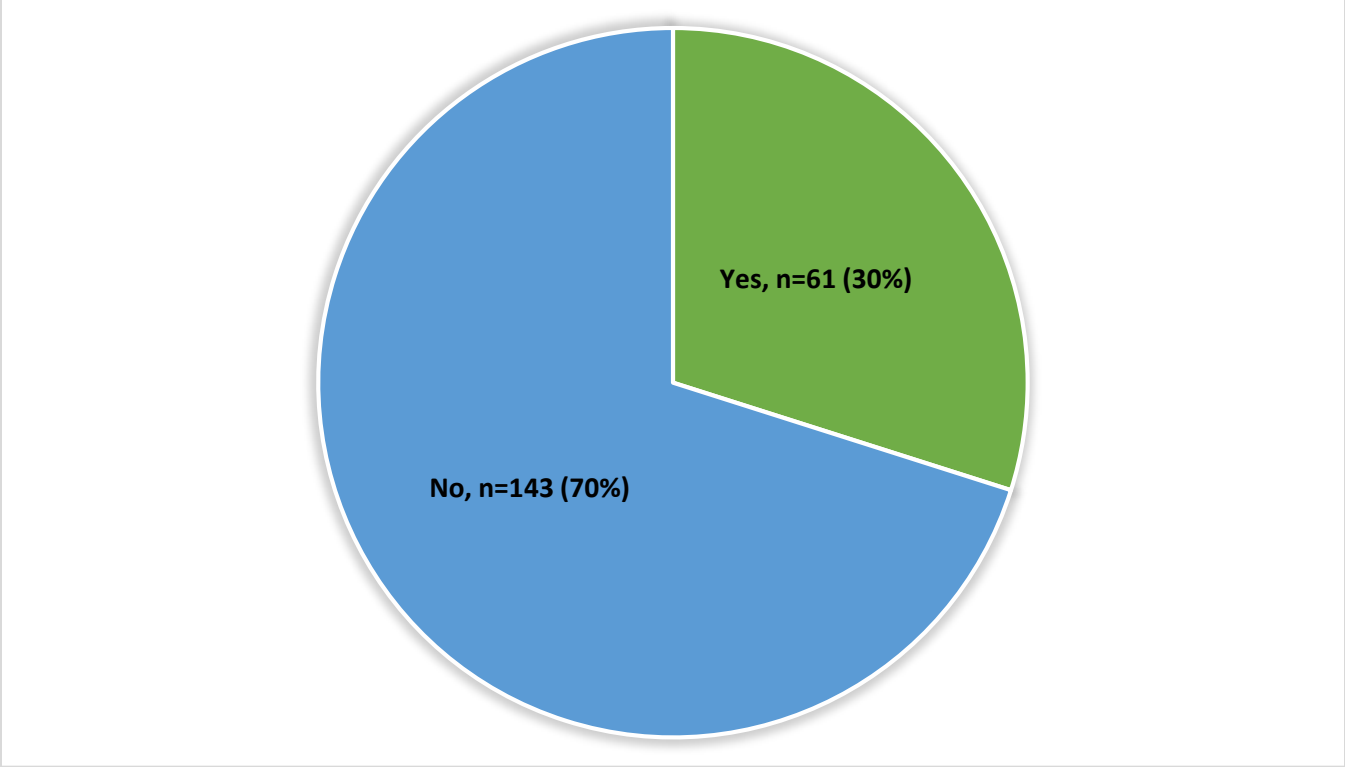

Table 133 - COVID-19 Ramifications on Edits and Reviews on Controlled Substances During the Public Health Emergency

Response	States (Count of MCOs)	Count	Percentage
Yes	Delaware (2), District of Columbia (1), Florida (3), Georgia (1), Hawaii (1), Illinois (1), Indiana (1), Iowa (2), Kansas (3), Kentucky (6), Maryland (2), Michigan (1), Nevada (1), New Hampshire (2), New Jersey (1), New York (2), North Carolina (5), Ohio (1), Oregon (4), Pennsylvania (5), South Carolina (1), Texas (5), Utah (1), Virginia (4), Washington (5)	61	29.90%
No	Arkansas (4), Colorado (2), District of Columbia (3), Florida (8), Georgia (2), Hawaii (5), Illinois (5), Indiana (4), Louisiana (5), Maryland (7), Massachusetts (5), Michigan (8), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (3), New Hampshire (1), New Jersey (4), New Mexico (3), New York (12), Ohio (4), Oregon (17), Pennsylvania (3), Rhode Island (3), South Carolina (4), Texas (11), Utah (3), Virginia (2)	143	70.10%
National Totals		**204**	**100%**

D. Morphine Milligram Equivalent (MME) Daily Dose

1. Have you set recommended maximum MME daily dose measures?

Figure 109 - MCO Recommended MME Daily Dose Measures

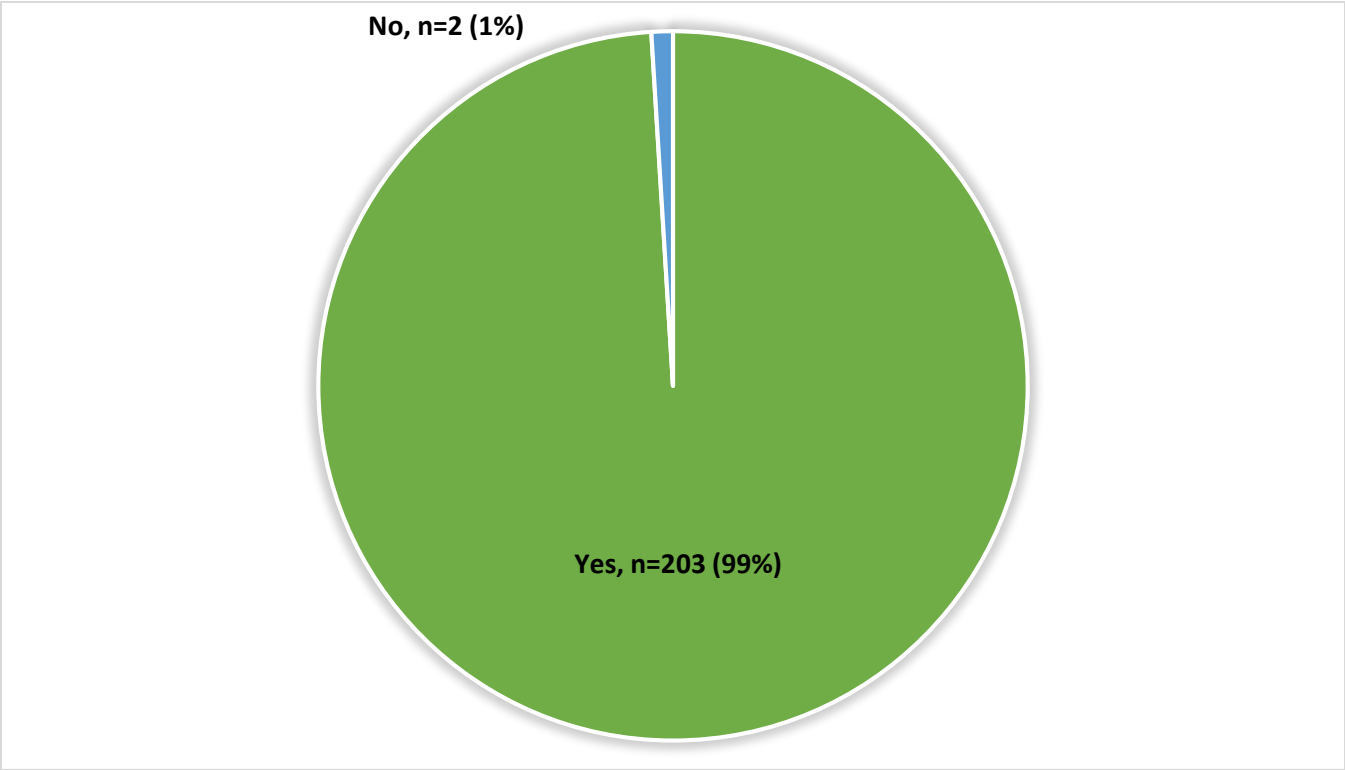

Table 134 - MCO Recommended MME Daily Dose Measures

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (14), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (7), Rhode Island (3), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	203	99.02%
No	New York (1), Pennsylvania (1)	2	0.98%
National Totals		**205**	**100%**

If "No," please explain why not.

Table 135 - Explanations for Why There is No Recommended Maximum MME Daily Dose Measures

State	MCO Name	Explanation
NY	MVP Health Care	All opioid medications have a quantity limit and require a clinical review to determine medical necessity for quantities greater than the allowed amount. Requests for quantities greater than the allowed amount may be considered when the documentation identifies an inadequate response to recommended dosing intervals, persistent, moderate to severe pain that requires continuous

State	MCO Name	Explanation
		analgesia, and the provider has addressed opioid overdose risk management if MME >90.
PA	Geisinger	all LA opioids require prior authorization, SA opioids for > 5 day supply require prior authorization, opioids have quantity limits

a. If "Yes," what is your maximum MME daily dose limit in milligrams?

Figure 110 - Maximum MME Daily Dose Limit in Milligrams

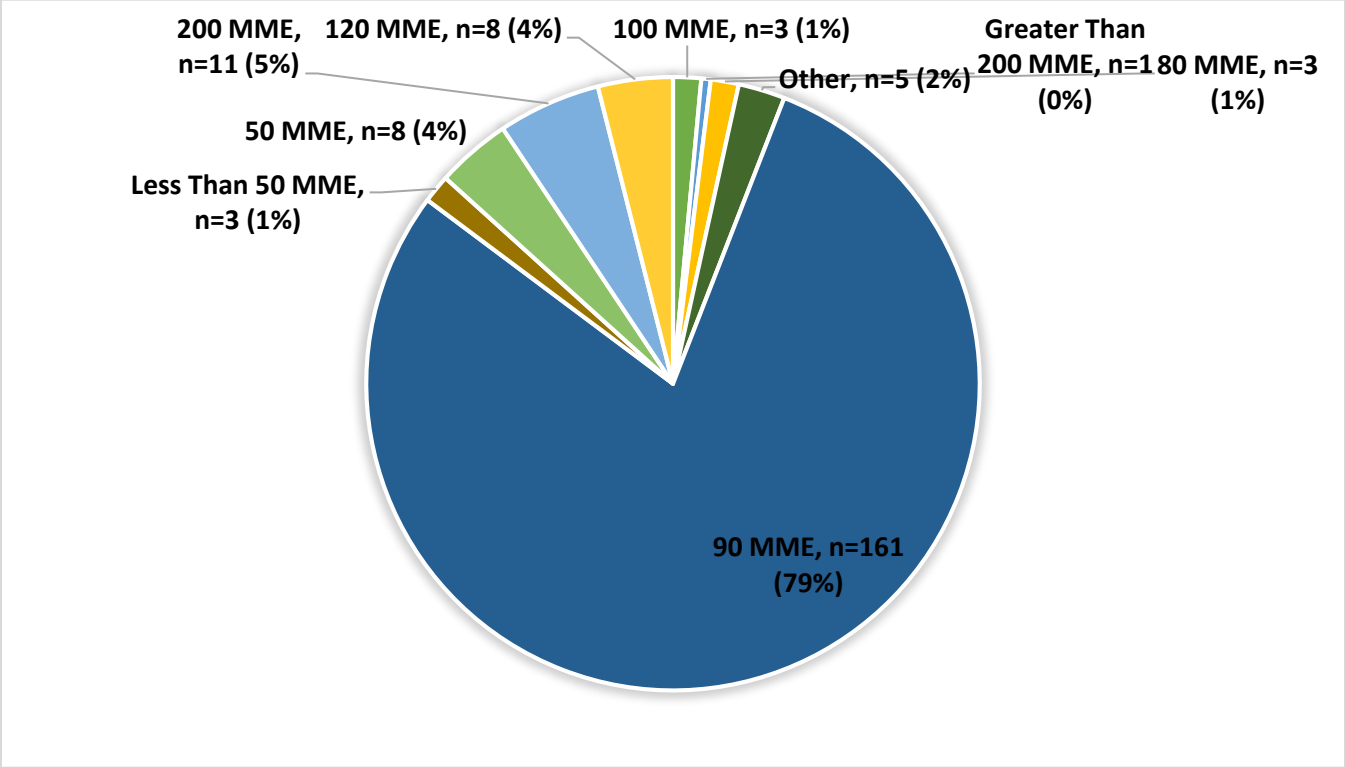

Table 136 - Maximum MME Daily Dose Limit in Milligrams

Response	States (Count of MCOs)	Count	Percentage
100 MME	New Hampshire (3)	3	1.48%
120 MME	Hawaii (3), Washington (5)	8	3.94%
200 MME	Colorado (1), Florida (1), Illinois (2), Maryland (1), Massachusetts (1), New York (4), Oregon (1)	11	5.42%
50 MME	Florida (1), Georgia (1), Pennsylvania (6)	8	3.94%
80 MME	Ohio (3)	3	1.48%
90 MME	Arkansas (4), Colorado (1), Delaware (2), District of Columbia (4), Florida (9), Georgia (2), Hawaii (3), Illinois (4), Indiana (2), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (8), Massachusetts (3), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (3), New Jersey (5), New Mexico (3), New York (10), North Carolina (5), Ohio (1), Oregon (20), Rhode Island (3), South Carolina (4), Texas (15), Utah (4), Virginia (6)	161	79.31%
Greater than 200 MME	South Carolina (1)	1	0.49%
Less than 50 MME	Massachusetts (1), Ohio (1), Pennsylvania (1)	3	1.48%

Response	States (Count of MCOs)	Count	Percentage
Other	Indiana (3), Nevada (1), Texas (1)	5	2.46%
National Totals		**203**	**100%**

If “Less than 50 MME,” please specify amount in mg per day.

Table 137 - Maximum MME Daily Dose Limit When Less than 50 MME

State	MCO Name	Response
MA	Health New England, Inc.	49
OH	Buckeye Health Plan	30
PA	Vista	49

If “Greater than 200 MME,” please specify amount in mg per day.

Table 138 - Maximum MME Daily Dose Limit When Greater than 200 MME

State	MCO Name	Response
SC	Humana	250

If “Other,” please specify amount in mg per day.

Table 139 - “Other” Maximum MME Daily Dose Limit

State	MCO Name	Response
IN	CareSource	60
IN	Managed Health Services Indiana (MHS)	60
IN	MDwise, Inc.	60
NV	Molina	60
TX	Parkland Community Health Plan	90

2. Does your MCO have an edit in your POS system that alerts the pharmacy provider that the MME daily dose prescribed has been exceeded?

Figure 111 - Edit in POS System that Alerts Pharmacy Provider MME Daily Dose Exceeded

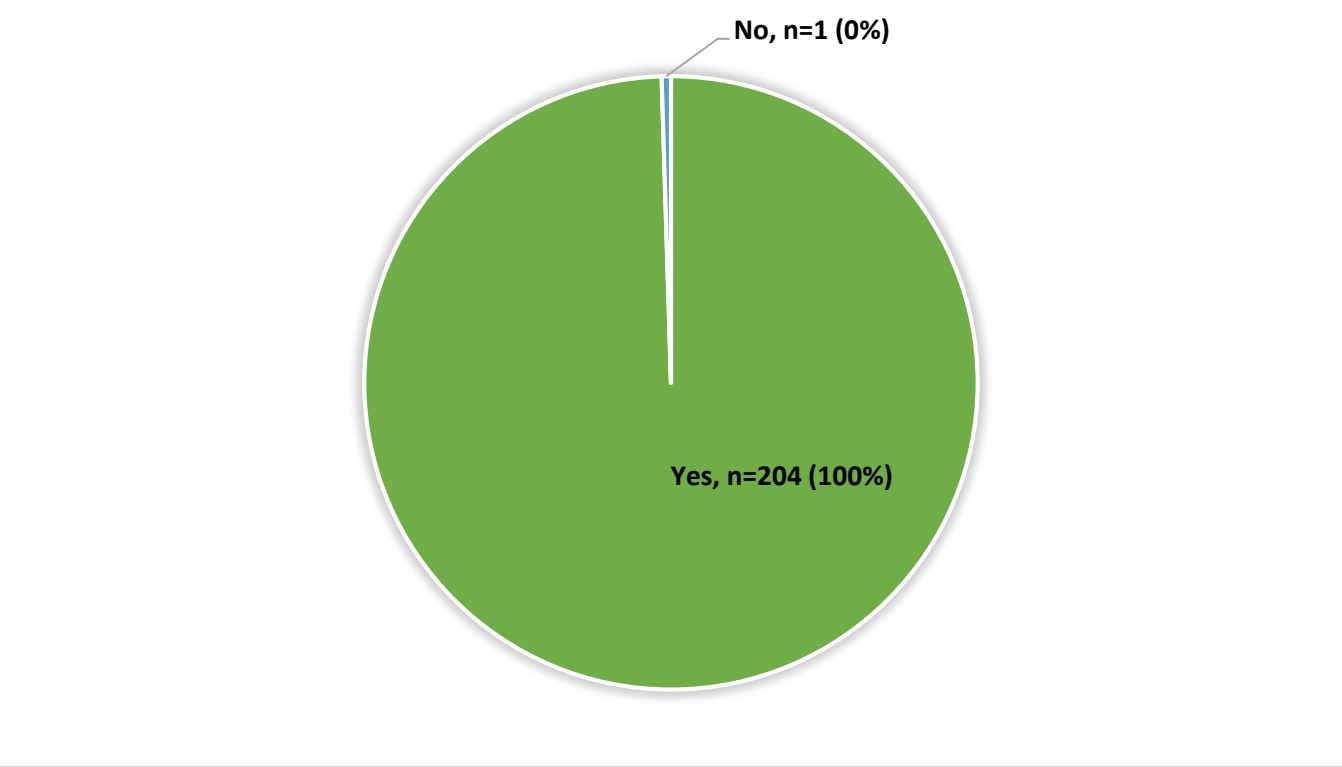

Table 140 - Edit in POS System that Alerts Pharmacy Provider MME Daily Dose Exceeded

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (7), Rhode Island (3), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	204	99.51%
No	Pennsylvania (1)	1	0.49%
National Totals		**205**	**100%**

If “No,” please explain why not.

Table 141 - Explanations for Not Having an Edit in POS System that Alerts the Pharmacy Provider that the MME Daily Dose has been Exceeded

State	MCO Name	Explanation
PA	Geisinger	prior authorization is required for doses exceeding QL

If “Yes,” does your MCO require PA if the MME limit is exceeded?

Figure 112 - MCO Requires PA if MME Limit Exceeded

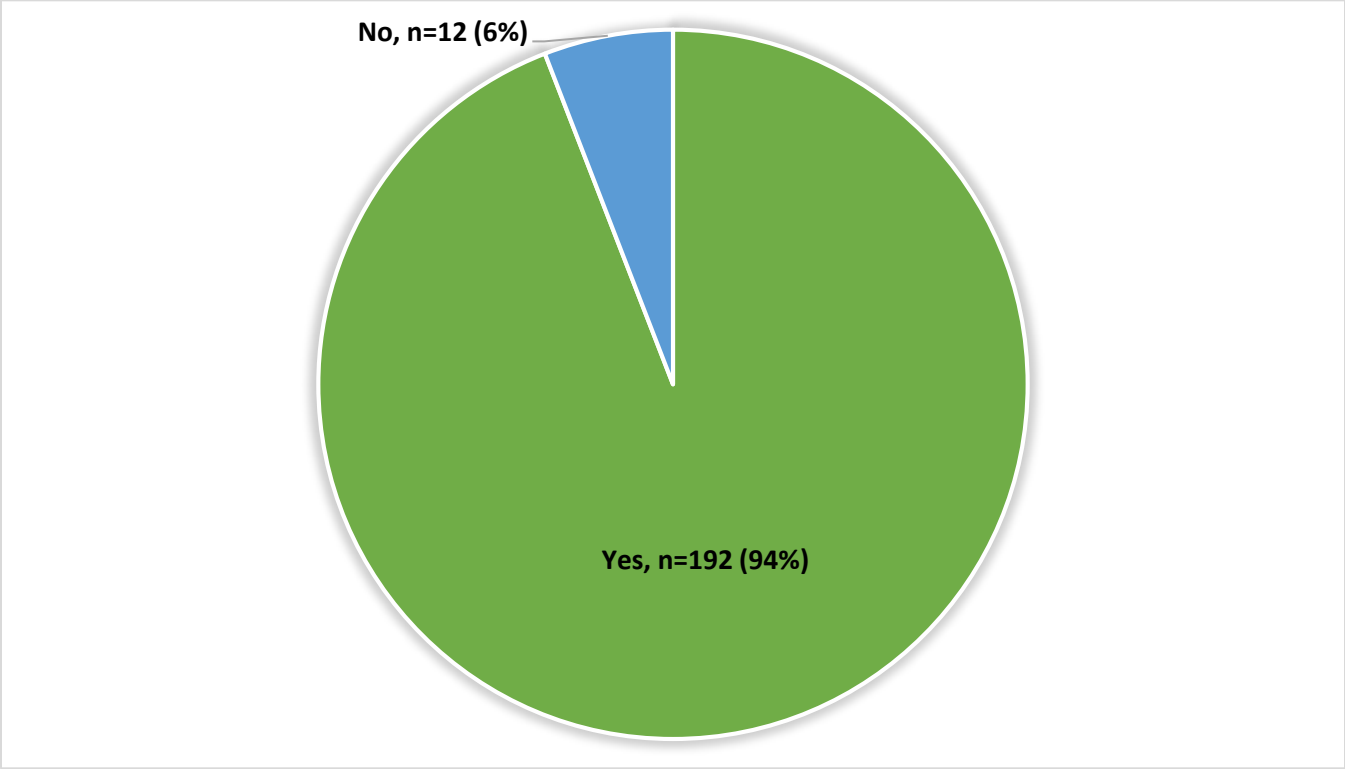

Table 142 - MCO Requires PA if MME Limit Exceeded

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (10), Georgia (3), Hawaii (5), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (4), Michigan (9), Minnesota (8), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (4), New Mexico (3), New York (14), North Carolina (5), Ohio (5), Oregon (16), Pennsylvania (7), Rhode Island (2), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	192	94.12%
No	Florida (1), Hawaii (1), Massachusetts (1), Minnesota (1), New Jersey (1), New York (1), Oregon (5), Rhode Island (1)	12	5.88%
National Totals		**204**	**100%**

3. Does your MCO have automated retrospective claims review to monitor the MME total daily dose of opioid prescriptions dispensed?

Figure 113 - MCO Has Automated Retrospective Claim Reviews to Monitor MME Total Daily Dose

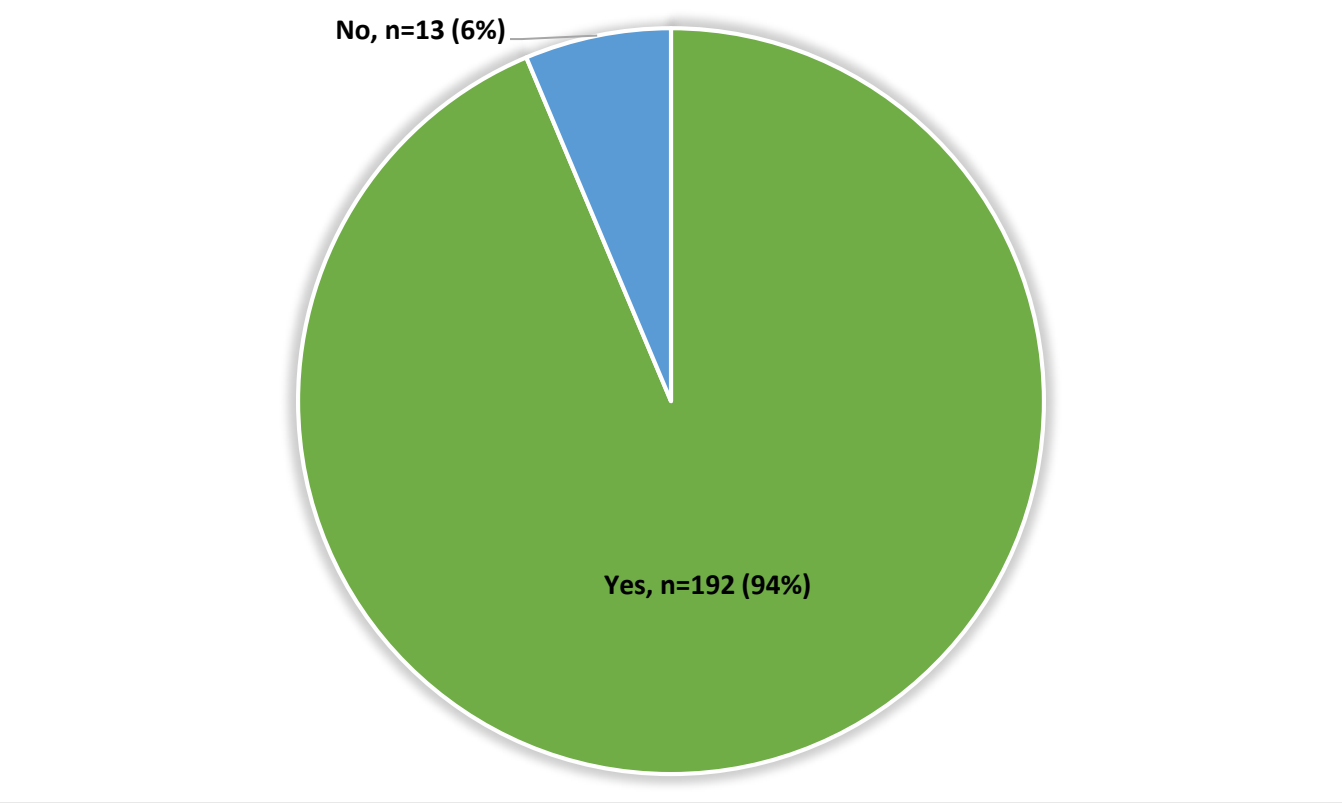

Table 143 - MCO Has Automated Retrospective Claims Review to Monitor MME Total Daily Dose

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (3), Colorado (2), Delaware (2), District of Columbia (2), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (4), Michigan (9), Minnesota (8), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (13), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (6), Rhode Island (3), South Carolina (5), Texas (14), Utah (4), Virginia (5), Washington (4)	192	93.66%
No	Arkansas (1), District of Columbia (2), Massachusetts (1), Minnesota (1), New York (2), Pennsylvania (2), Texas (2), Virginia (1), Washington (1)	13	6.34%
National Totals		**205**	**100%**

If "No," please explain why not.

Table 144 - Explanations as to Why MCO Does Not Have Automated Retrospective Claim Reviews to Monitor MME Total Daily Dose

State	MCO Name	Explanation
AR	Empower_HealthCare_Solutions_LLC	Prospective edits are in place. Retrospective reviews are performed monthly by a clinical pharmacist.
DC	AmeriHealth Caritas DC	The MCO performs a prospective claims review.

State	MCO Name	Explanation
DC	CareFirst BCBS Community Health Plan DC	With the edits already in place and the requirement for clinical review for all long acting and long term opioid use we already know and control the opioid utilization.
MA	Boston Medical Center Health Plan, Inc	The Plan conducts retrospective claims reviews identifying members who exceed daily doses of opioid prescriptions. This is not done automatically, but is a part of the Plan's lock-in criteria for management of controlled substance utilization.
MN	SouthCountry	Opioid MME and 7-day limit edits are in place. Prior authorization for requests exceeding these limits are reviewed on a case by case basis for approval or denial based on a set of criteria and medical necessity. No additional claims review is completed.
NY	AMIDA CARE	all are reviewed prospectively through PA
NY	Independent Health	All limits are set pre-service
PA	Geisinger	done at POS/prospective DUR
PA	Health Partners	These are addressed on prior authorization reviews
TX	FirstCare Health Plans	RDUR programs are not automated since it requires someone to run reports to identify the targeted members. However, FirstCare monitors the MME total daily dose of opioid prescriptions. Letters are sent to prescribers if the member has an average daily MME â‰¥90 during 4 month timeframe; excludes members with cancer.
TX	Scott and White Health Plan	RDUR programs are not automated since it requires someone to run reports to identify the targeted members. However, Scott and White monitors the MME total daily dose of opioid prescriptions. Letters are sent to prescribers if the member has an average daily MME â‰¥90 during 4 month timeframe; excludes members with cancer.
VA	Anthem	We do not have an automated retrospective claim review to monitor MME of opioid prescriptions dispensed due to the currently running PUMS program.
WA	Coordinated Care Corporation	The POS system is programmed to prospectively review opioid prescriptions exceeding MME limit.

4. Does your MCO provide information to your prescribers on how to calculate the MME daily dosage or does your MCO provide a calculator developed elsewhere?

Figure 114 - Provides Information to Prescribers on How to Calculate the MME Daily Dosage or Provides a Calculator Developed Elsewhere

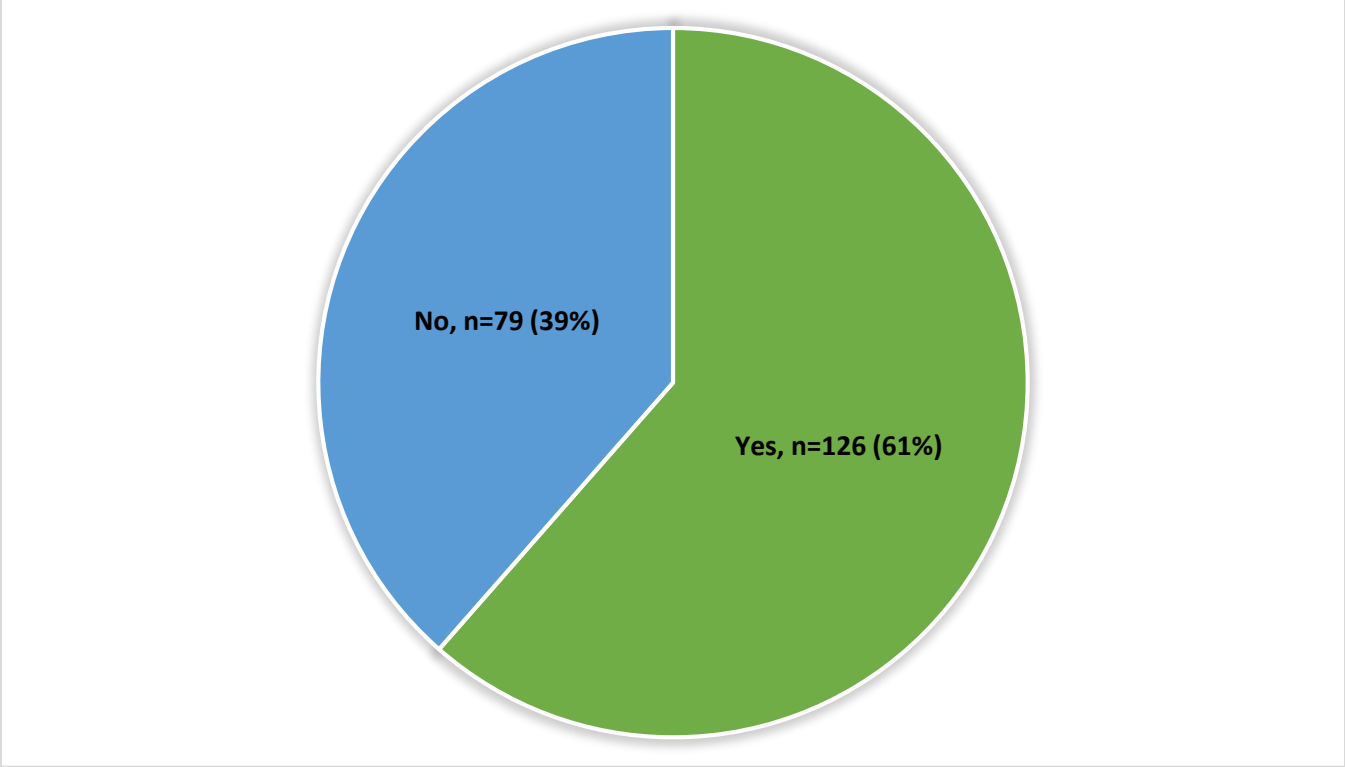

Table 145 - Provides Information to Prescribers on How to Calculate the MME Daily Dosage or Provides a Calculator Developed Elsewhere

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (2), Colorado (1), Delaware (1), District of Columbia (2), Florida (9), Georgia (1), Hawaii (3), Illinois (4), Indiana (3), Iowa (2), Kansas (3), Kentucky (3), Louisiana (2), Maryland (6), Massachusetts (3), Michigan (5), Minnesota (4), Mississippi (3), Nebraska (1), Nevada (2), New Hampshire (2), New Jersey (4), New Mexico (2), New York (7), North Carolina (1), Ohio (4), Oregon (19), Pennsylvania (4), Rhode Island (2), South Carolina (3), Texas (6), Utah (2), Virginia (5), Washington (5)	126	61.46%
No	Arkansas (2), Colorado (1), Delaware (1), District of Columbia (2), Florida (2), Georgia (2), Hawaii (3), Illinois (2), Indiana (2), Kentucky (3), Louisiana (3), Maryland (3), Massachusetts (2), Michigan (4), Minnesota (5), Nebraska (2), Nevada (2), New Hampshire (1), New Jersey (1), New Mexico (1), New York (8), North Carolina (4), Ohio (1), Oregon (2), Pennsylvania (4), Rhode Island (1), South Carolina (2), Texas (10), Utah (2), Virginia (1)	79	38.54%
National Totals		**205**	**100%**

a. If "Yes," please name the developer of the calculator.

Figure 115 - Developer of the MME Daily Dosage Calculator

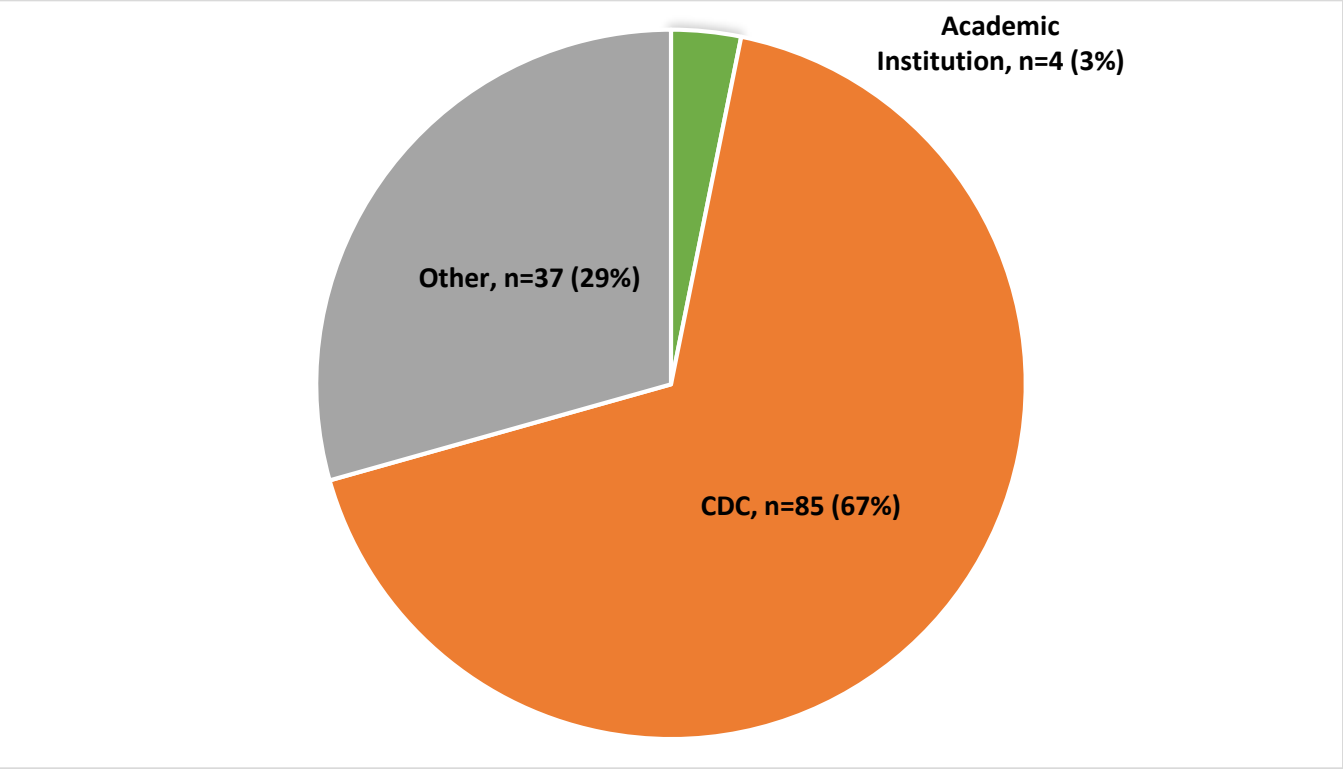

Table 146 - Developer of the MME Daily Dosage Calculator

Developer	State (Count of MCOs)	Count	Percentage
Academic Institution	Massachusetts (1), Oregon (3)	4	3.17%
CDC	Arkansas (1), Colorado (1), Delaware (1), District of Columbia (2), Florida (6), Georgia (1), Hawaii (1), Illinois (3), Indiana (2), Iowa (2), Kansas (3), Kentucky (2), Louisiana (2), Maryland (5), Massachusetts (1), Michigan (5), Minnesota (4), Mississippi (3), Nebraska (1), Nevada (2), New Hampshire (1), New Jersey (4), New Mexico (2), New York (7), North Carolina (1), Ohio (3), Oregon (3), Pennsylvania (4), Rhode Island (1), South Carolina (1), Texas (5), Utah (1), Virginia (4)	85	67.46%
Other	Arkansas (1), Florida (3), Hawaii (2), Illinois (1), Indiana (1), Kentucky (1), Maryland (1), Massachusetts (1), New Hampshire (1), Ohio (1), Oregon (13), Rhode Island (1), South Carolina (2), Texas (1), Utah (1), Virginia (1), Washington (5)	37	29.37%
National Totals		**126**	**100%**

b. If "Yes," how is the information disseminated (multiple responses allowed)?

Figure 116 - Information Dissemination Routes

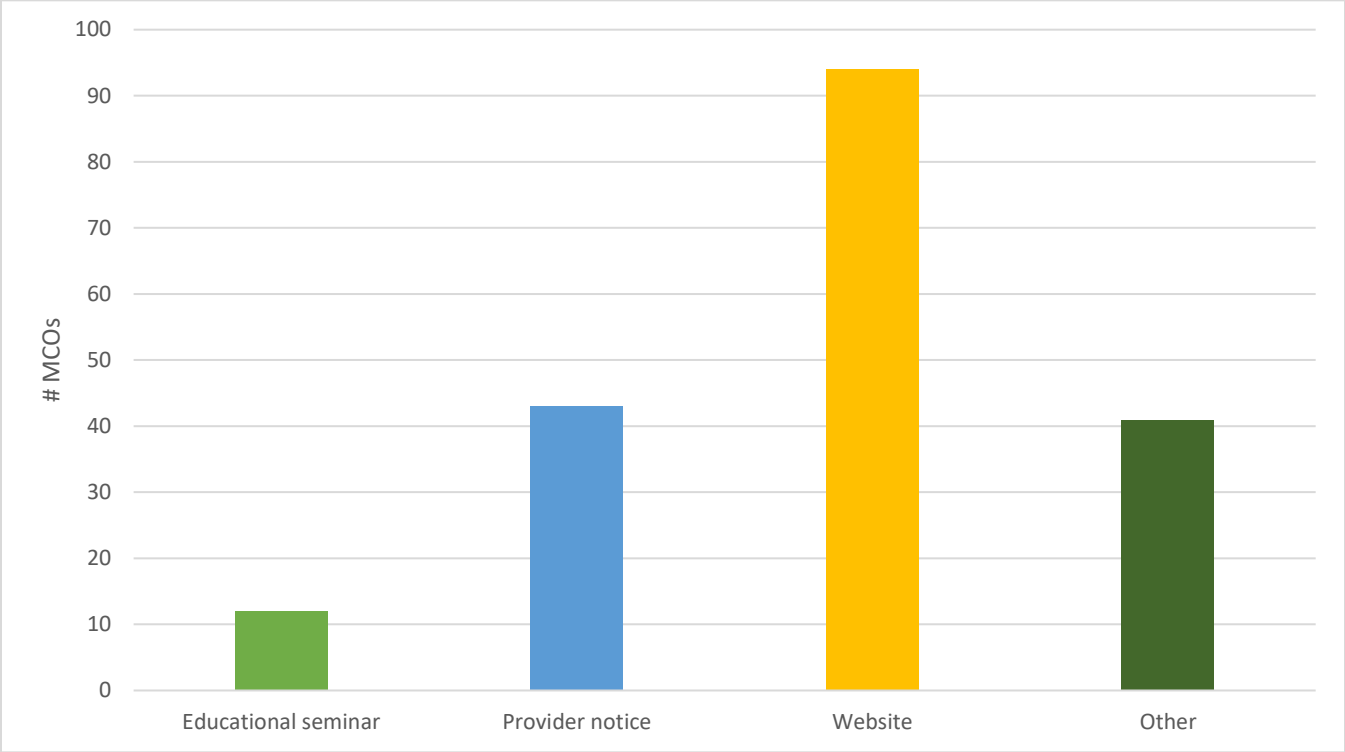

Table 147 - Information Dissemination Routes

Response	States (Count of MCOs)	Count	Percentage
Educational seminar	Hawaii (1), Maryland (1), Minnesota (1), New Mexico (1), Oregon (7), Washington (1)	12	6.32%
Provider notice	District of Columbia (1), Florida (4), Hawaii (1), Illinois (2), Kentucky (1), Maryland (1), Massachusetts (2), Michigan (2), Mississippi (2), Nevada (1), New Hampshire (1), New Jersey (1), New York (6), Ohio (1), Oregon (9), Pennsylvania (1), South Carolina (2), Texas (1), Utah (1), Virginia (2), Washington (1)	43	22.63%
Website	Arkansas (2), Colorado (1), Delaware (1), District of Columbia (1), Florida (4), Georgia (1), Hawaii (2), Illinois (4), Indiana (2), Iowa (2), Kansas (3), Kentucky (1), Louisiana (2), Maryland (6), Massachusetts (2), Michigan (5), Minnesota (3), Mississippi (2), Nebraska (1), Nevada (1), New Hampshire (2), New Jersey (2), New York (3), North Carolina (1), Ohio (4), Oregon (15), Pennsylvania (4), Rhode Island (2), South Carolina (2), Texas (6), Virginia (3), Washington (4)	94	49.47%
Other	District of Columbia (1), Florida (2), Hawaii (1), Illinois (2), Indiana (1), Kansas (1), Kentucky (2), Louisiana (1), Maryland (3), Michigan (2), Minnesota (2), New Hampshire (1), New Jersey (2), New Mexico (2), New York (2), Oregon (7), Pennsylvania (1), South Carolina (1), Texas (2), Utah (1), Virginia (2), Washington (2)	41	21.58%
National Totals		**190**	**100%**

E. Opioid Use Disorder (OUD) Treatment

1. Does your MCO have utilization controls (i.e. PDL, PA, QL) to either monitor or manage the prescribing of Medication Assisted Treatment (MAT) drugs for OUD?

Figure 117 - MCO Has Utilization Controls to Monitor/Manage Prescribing MAT Drugs for OUD

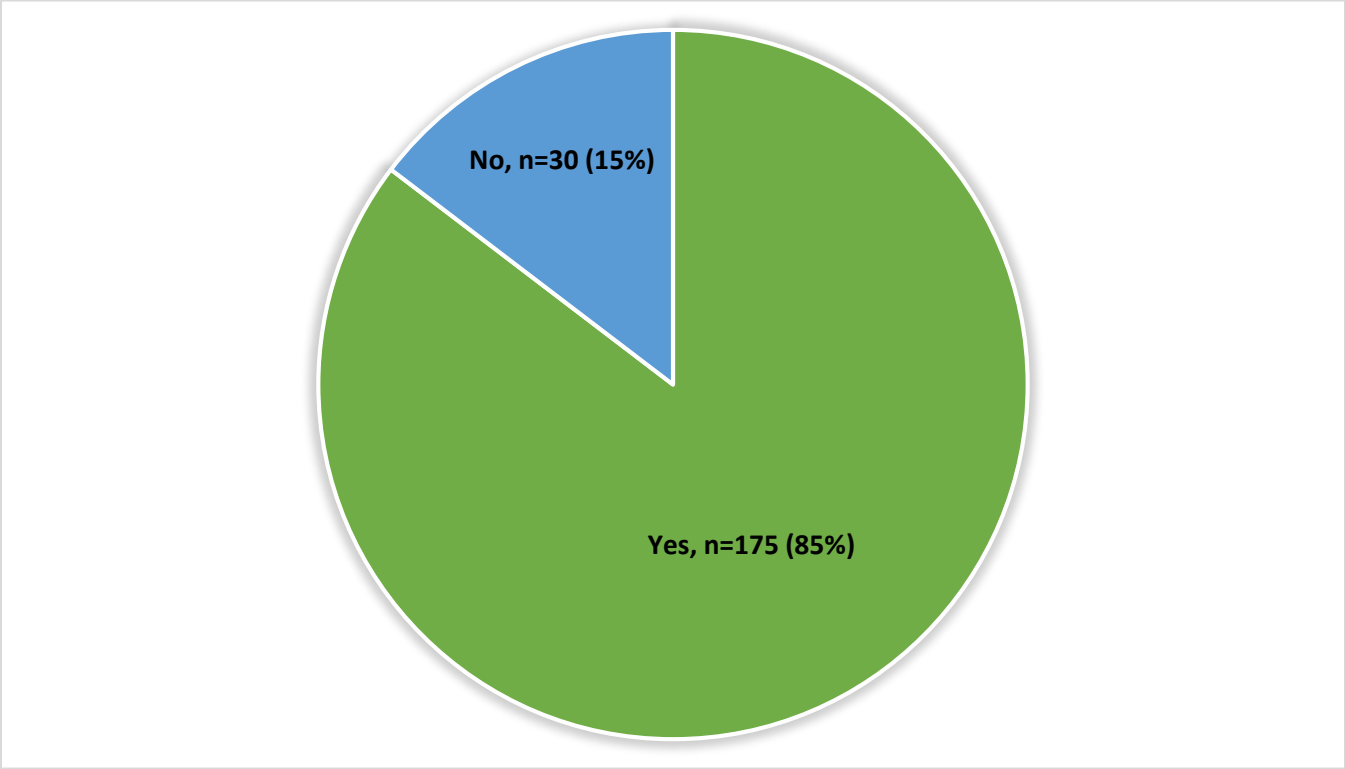

Table 148 - MCO Has Utilization Controls to Monitor/Manage Prescribing MAT Drugs for OUD

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (3), Florida (11), Georgia (3), Hawaii (5), Illinois (3), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Massachusetts (5), Michigan (2), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (4), New Mexico (3), New York (12), North Carolina (5), Ohio (5), Oregon (20), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (16), Virginia (6), Washington (5)	175	85.37%
No	District of Columbia (1), Hawaii (1), Illinois (3), Maryland (9), Michigan (7), New Jersey (1), New York (3), Oregon (1), Utah (4)	30	14.63%
National Totals		**205**	**100%**

If "No," please explain.

Table 149 - Explanation for Not Having MCO Utilization Controls to Monitor/Manage Prescribing of MAT Drugs for OUD

State	MCO Name	Explanation
DC	HealthServicesforSpecialNeedsChildren	HSCSN in accordance with District of Columbia requirements removed all PA requirements for Medication Assisted Treatment

State	MCO Name	Explanation
		(MAT). HSCSN allows up to FDA-approved doses as a 30 days supply.
HI	HMSAQI	HMSA does not have edits on MAT drugs for OUD to ensure these medications are accessible to patients who need it.
IL	Aetna_Better_Health_of_Illinois	Aetna Better Health of Illinois does not enforce utilization controls for MAT drugs per house bill (HB0001), which prohibits use of utilization controls, prior authorizations mandates, or lifetime restriction mandates.
IL	CountyCare_Health_Plan	CountyCare does not require PA nor quantity limits for MAT drugs for OUD. These drugs are currently available on the Preferred Drug List as preferred without PA.
IL	YouthCare_HealthChoice	There are no UM edits for MAT to allow members to receive medications without restriction.
MD	Aetna Better Health of Maryland	Medication Assisted Therapy drugs used to treat substance use disorder are carved out of the pharmacy benefit and claims are not adjudicated by our PBM. The plan combines our opioid pharmacy claims with the MAT pharmacy post adjudication files from the State into a monthly Retrospective DUR report. This report monitors concurrent opioid and MAT drug utilization as well as concurrent opioid, benzodiazepine/sedative, and antipsychotic utilization.
MD	Amerigroup Community Care	MAT drugs are carved out of MCO and paid for by the FFS program
MD	CareFirst Community Health Plan Maryland	MAT drugs, buprenorphine, and buprenorphine/naloxone combination drugs are carved out to the Maryland Department of Health.
MD	Jai Medical Systems Managed Care Organization, Inc.	MAT drugs for OUD are covered directly by Maryland Medicaid and are not covered by the MCO, so any limitations are administered by Maryland Medicaid.
MD	Kaiser Foundation Health Plan of the Mid-Atlantic States	OUD is Carved Out and managed by Fee for Service
MD	Maryland Physicians Care	All Treatments and Medications for Opioid Use Disorder are carved out to the State of Maryland (FFS).
MD	MedStar Family Choice	The MAT drugs for OUD are part of the MD State behavioral health medication carveout.
MD	Priority Partners MCO	The Opioid Use Disorder (OUD) treatment class is carved-out of MCO coverage. It is administered separately by the FFS program.
MD	United Healthcare	MAT medications for OUD are a carved out benefit in Maryland and the MCOs do not manage the coverage or claim adjudication for this class of drugs.
MI	Aetna Better Health of Michigan	OUD Treatment are carved out to FFS.
MI	Blue Cross Complete of Michigan	MAT drugs for OUD are carved out by MDHHS.
MI	HAP Empowered	Services for behavioral health and substance use disorder, including OUD, are carved out and managed by the State.
MI	Molina Healthcare of Michigan	Carved out benefit.
MI	Priority Health Choice	Coverage of Medication Assisted Treatment (MAT) drugs for Opioid Use Disorder (OUD) are carved out to the Michigan Fee For Service Medicaid program. This is a specialty service that would be provided through CMH or PIHP. The State of Michigan works with local Community Mental Health (CMH) providers for specialty mental

State	MCO Name	Explanation
		health services, intellectual/developmental disability services and substance abuse services. Members are required to contact their local CMH to access substance use treatment.
MI	UnitedHealthcare Community Plan	Medications indicated for OUD are carved-out with pharmacy claims managed by FFS.
MI	Upper Peninsula Health Plan	Claims for opioid use disorder or opioid poisoning are carve out per the MDHSS Common Formulary.
NJ	Wellcare health plans	State Policy prevents us from applying any utilization management on MAT drugs except safety edits.
NY	Excellus Health Plan	We want to ensure our members have access to these medications without any barriers due to the sensitivity of the diagnosis.
NY	Independent Health	We do not put utilization limits (outside of maximum daily doses and early fill limits) on medications for MAT. The intent is to remove as many barriers to treatment as possible.
NY	Univera Healthcare	We want to ensure our members have access to these medications without any barriers due to the sensitivity of the diagnosis.
OR	Eastern Oregon Coordinated Care Organization (EOCCO)	MCO believe in reducing barriers to MAT for increased access and adherence.
UT	Healthy U	Carved out to the State.
UT	Molina Healthcare of Utah	MAT drugs are carved out to FFS UT Medicaid
UT	SelectHealth	MAT drugs are carved-out to State Medicaid.
UT	Steward Health Choice Utah	These are carved out to the State.

2. Does your MCO set total mg per day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs?

Figure 118 - MCO Sets Total Milligram per Day Limits on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

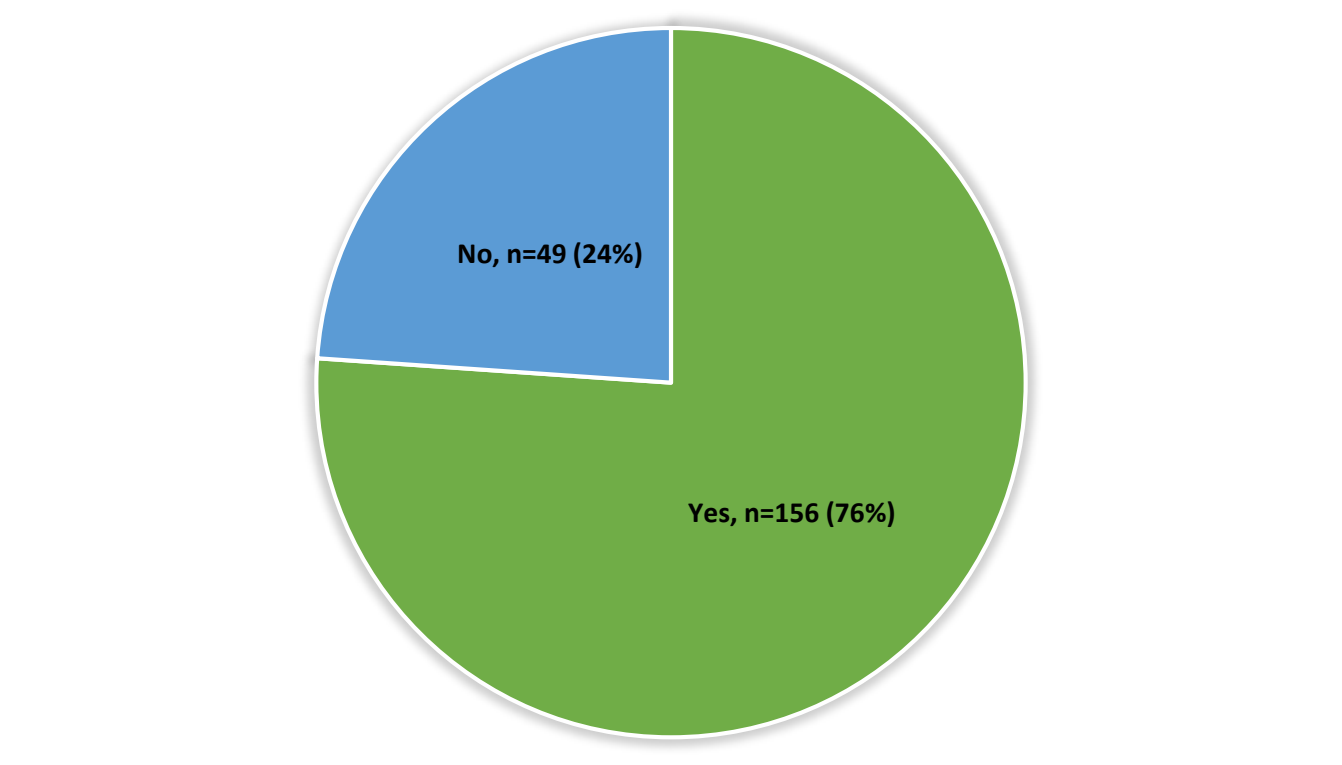

Table 150 - MCO Sets Total Milligram per Day Limits on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (3), Florida (11), Georgia (3), Hawaii (4), Illinois (2), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Massachusetts (5), Minnesota (9), Mississippi (3), Nebraska (2), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (12), North Carolina (5), Ohio (5), Oregon (17), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (4), Virginia (6), Washington (5)	156	76.10%
No	District of Columbia (1), Hawaii (2), Illinois (4), Maryland (9), Michigan (9), Nebraska (1), New York (3), Oregon (4), Texas (12), Utah (4)	49	23.90%
National Totals		**205**	**100%**

If "Yes," please specify the total mg/day.

Figure 119 - Total Milligrams/Day Limit on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

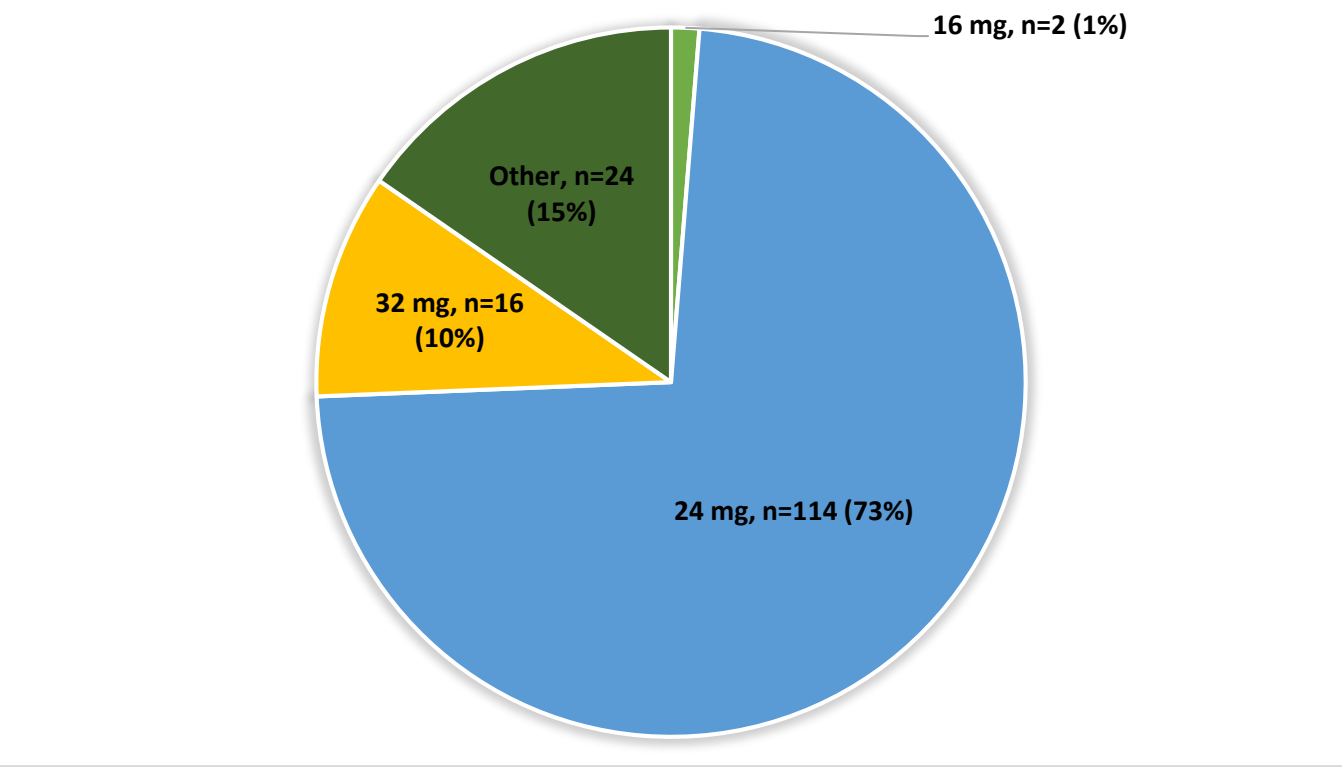

Table 151 - Total Milligrams/Day Limit on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

Response	States (Count of MCOs)	Count	Percentage
16 mg	Minnesota (1), Mississippi (1)	2	1.28%
24 mg	Arkansas (3), Colorado (2), District of Columbia (2), Florida (6), Georgia (3), Hawaii (4), Illinois (2), Indiana (5), Iowa (2), Kansas (2), Kentucky (6), Louisiana (5), Massachusetts (2), Minnesota (8), Mississippi (1), Nebraska (1), Nevada (4), New Hampshire (3), New Mexico (1), New York (11), North Carolina (1), Ohio (5), Oregon (14), Pennsylvania (6), Rhode Island (1), South Carolina (5), Texas (3), Virginia (6)	114	73.08%
32 mg	Massachusetts (1), Nebraska (1), New Jersey (5), Oregon (3), Pennsylvania (1), Washington (5)	16	10.26%
Other	Arkansas (1), Delaware (2), District of Columbia (1), Florida (5), Kansas (1), Massachusetts (2), Mississippi (1), New Mexico (2), New York (1), North Carolina (4), Pennsylvania (1), Rhode Island (2), Texas (1)	24	15.38%
National Totals		**156**	**100%**

3. What are your limitations on the allowable length of this treatment?

Figure 120 - Limitations on Allowable Length of Treatment of Buprenorphine/Naloxone Combination Drugs

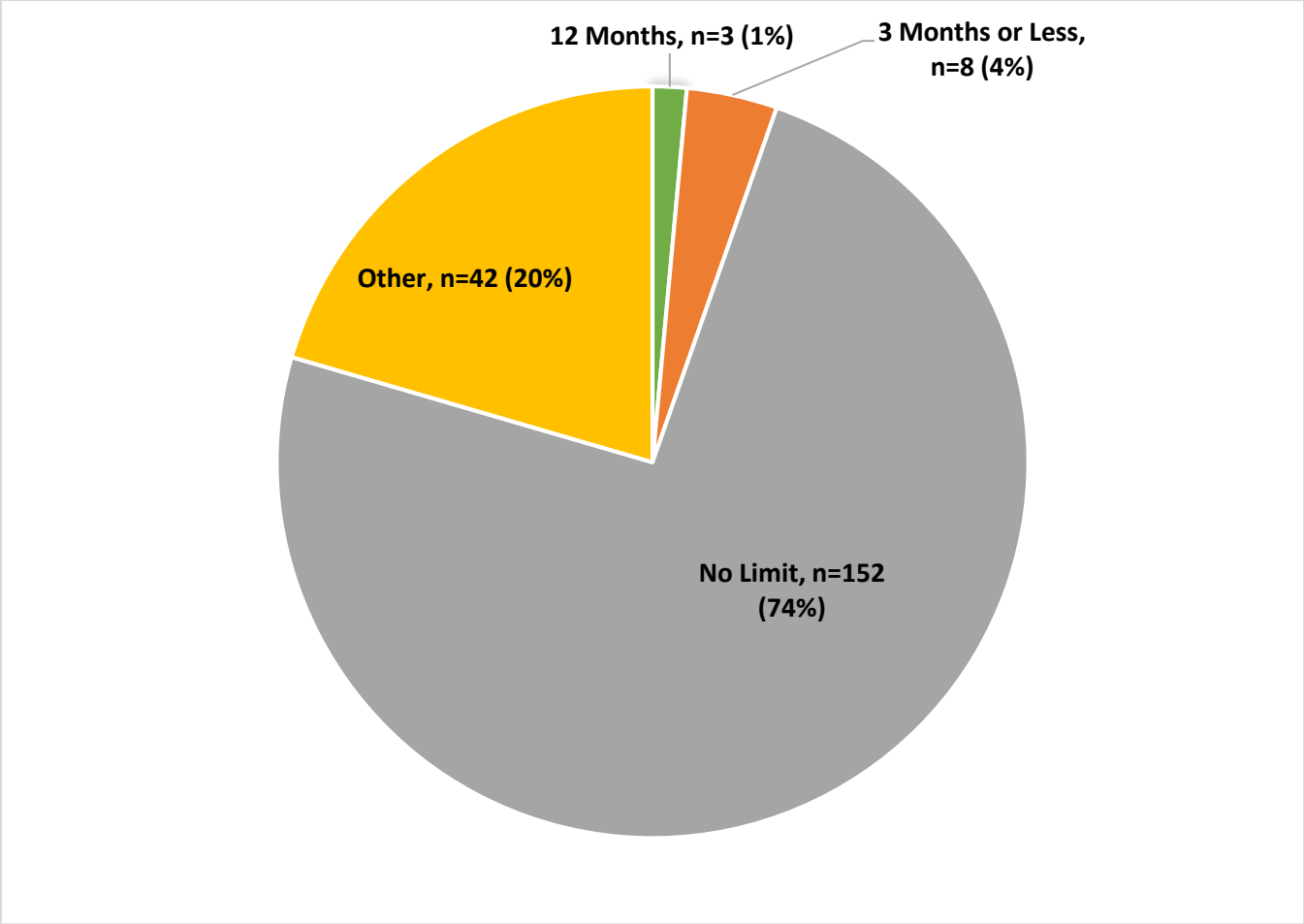

Table 152 - Limitations on Allowable Length of Treatment of Buprenorphine/Naloxone Combination Drugs

Response	States (Count of MCOs)	Count	Percentage
12 months	Hawaii (1), Nebraska (1), North Carolina (1)	3	1.46%
3 months or less	Mississippi (1), Ohio (4), Texas (3)	8	3.90%
No limit	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (8), Georgia (3), Hawaii (4), Illinois (6), Indiana (5), Iowa (2), Kansas (1), Kentucky (6), Louisiana (5), Massachusetts (4), Michigan (1), Minnesota (8), Mississippi (2), Nebraska (2), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (11), North Carolina (3), Oregon (21), Pennsylvania (7), Rhode Island (3), South Carolina (5), Texas (9), Virginia (5), Washington (4)	152	74.15%
Other	Florida (3), Hawaii (1), Kansas (2), Maryland (9), Massachusetts (1), Michigan (8), Minnesota (1), New York (4), North Carolina (1), Ohio (1), Pennsylvania (1), Texas (4), Utah (4), Virginia (1), Washington (1)	42	20.49%
National Totals		**205**	**100%**

4. Does your MCO require that the maximum mg per day allowable be reduced after a set period of time?

Figure 121 - Maximum Milligrams per Day Reduction After a Set Period of Time

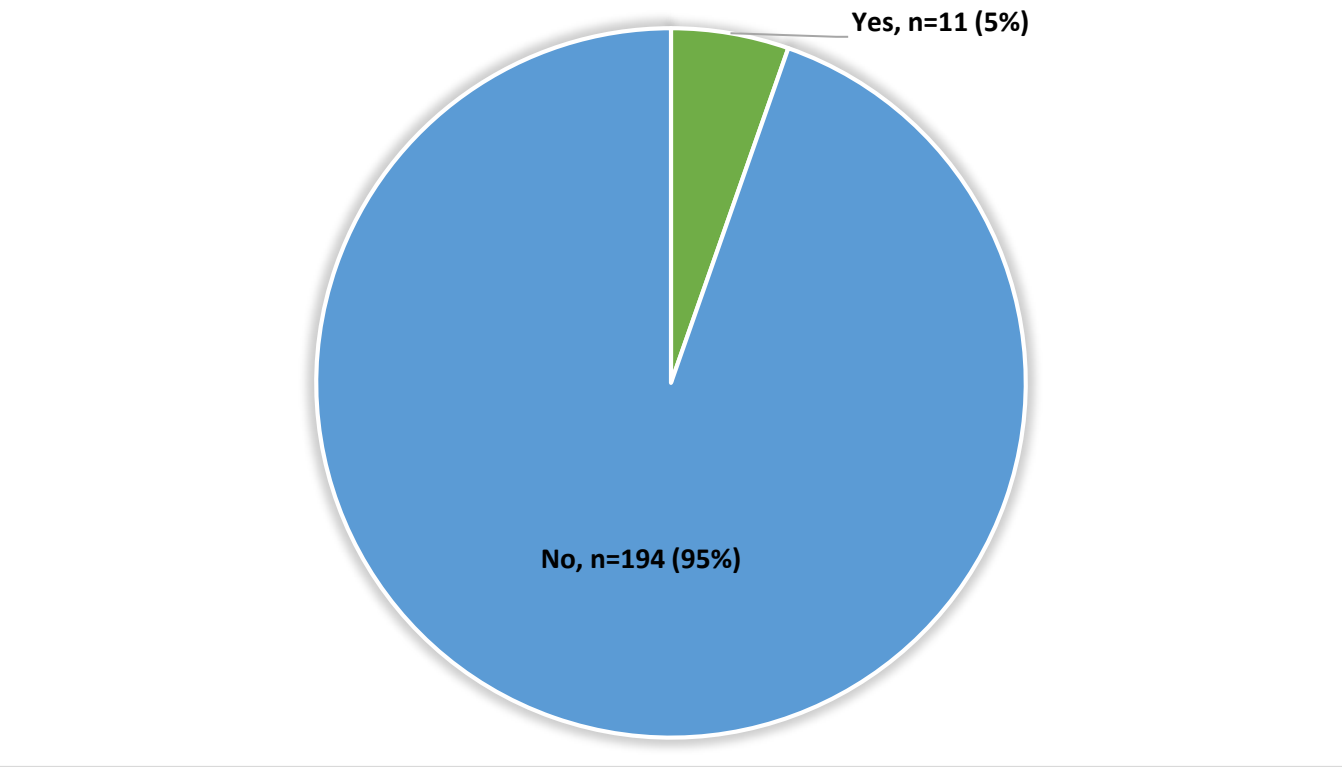

Table 153 - Maximum Milligrams per Day Reduction After a Set Period of Time

Response	States (Count of MCOs)	Count	Percentage
Yes	Florida (1), Massachusetts (1), Mississippi (2), Ohio (5), Pennsylvania (1), Rhode Island (1)	11	5.37%
No	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (10), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (4), Michigan (9), Minnesota (9), Mississippi (1), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Oregon (21), Pennsylvania (7), Rhode Island (2), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	194	94.63%
National Totals		**205**	**100%**

a. If "Yes," what is your reduced (maintenance) dosage?

Figure 122 - Reduced (Maintenance) Dosage

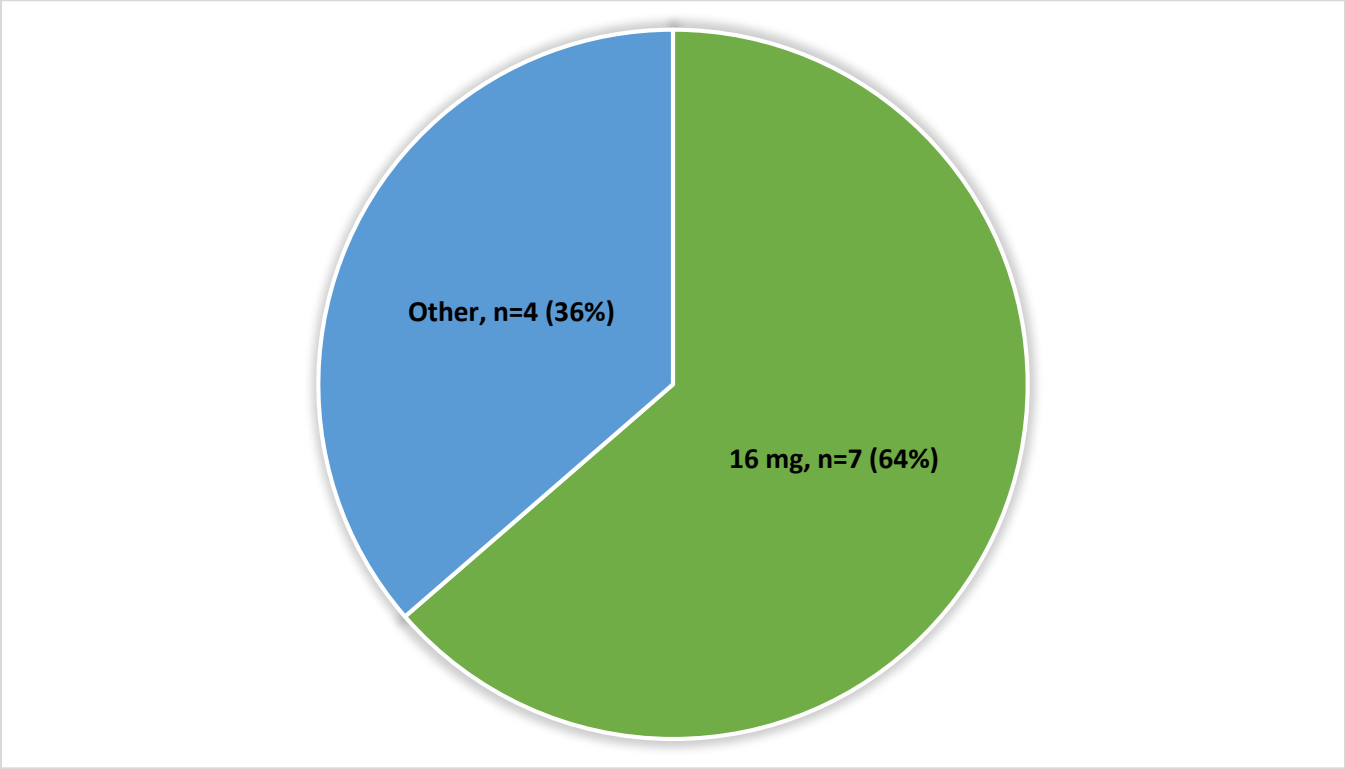

Table 154 - Reduced (Maintenance) Dosage

Response	States (Count of MCOs)	Count	Percentage
16 mg	Mississippi (2), Ohio (5)	7	63.64%
Other	Florida (1), Massachusetts (1), Pennsylvania (1), Rhode Island (1)	4	36.36%
National Totals		**11**	**100%**

b. If "Yes," what are your limitations on the allowable length of the reduced dosage treatment?

Figure 123 - Limitations on the Allowable Length of the Reduced Dosage Treatment

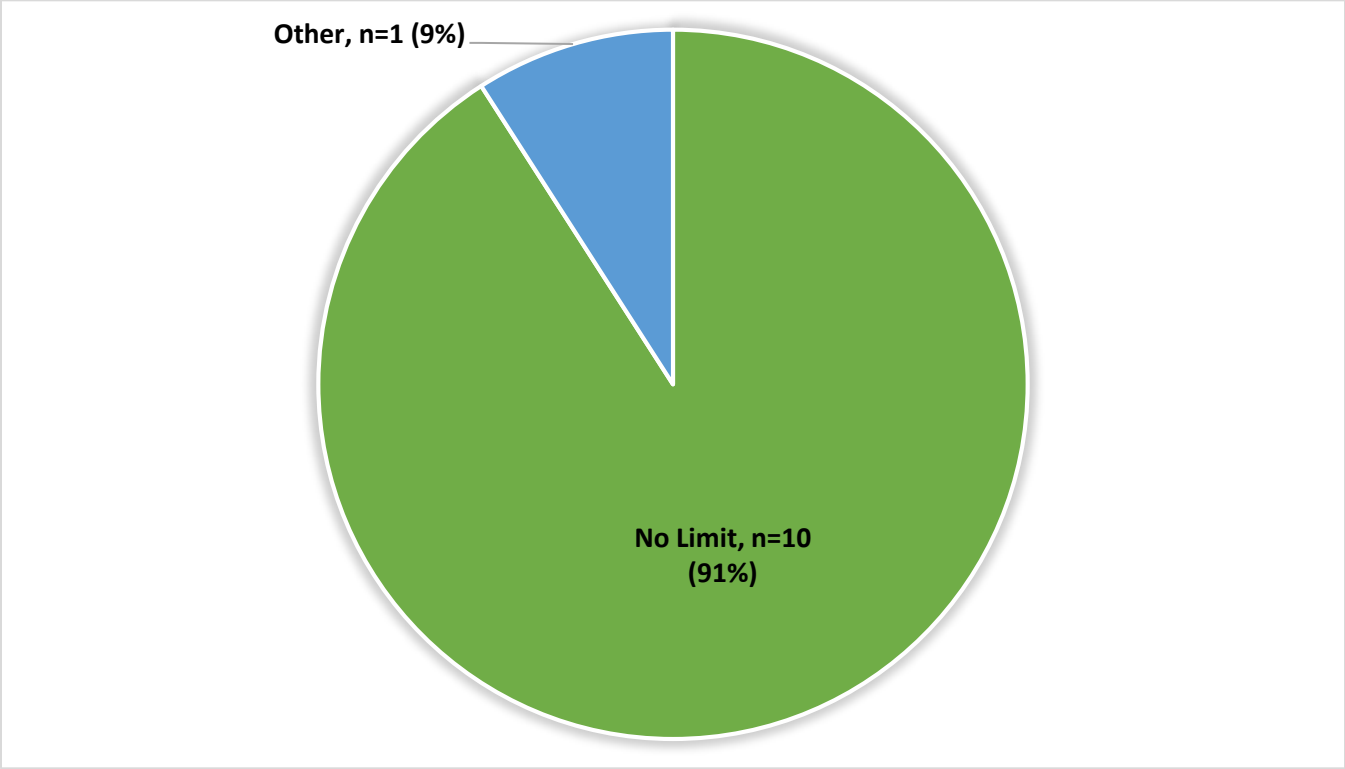

Table 155 - Limitations on Allowable Length of the Reduced Dosage Treatment

Response	States (Count of MCOs)	Count	Percentage
No limit	Massachusetts (1), Mississippi (2), Ohio (5), Pennsylvania (1), Rhode Island (1)	10	90.91%
Other	Florida (1)	1	9.09%
National Totals		**11**	**100%**

5. Does your MCO have at least one buprenorphine/naloxone combination product available without PA?

Figure 124 - Buprenorphine/Naloxone Combination Product Available Without Prior Authorization

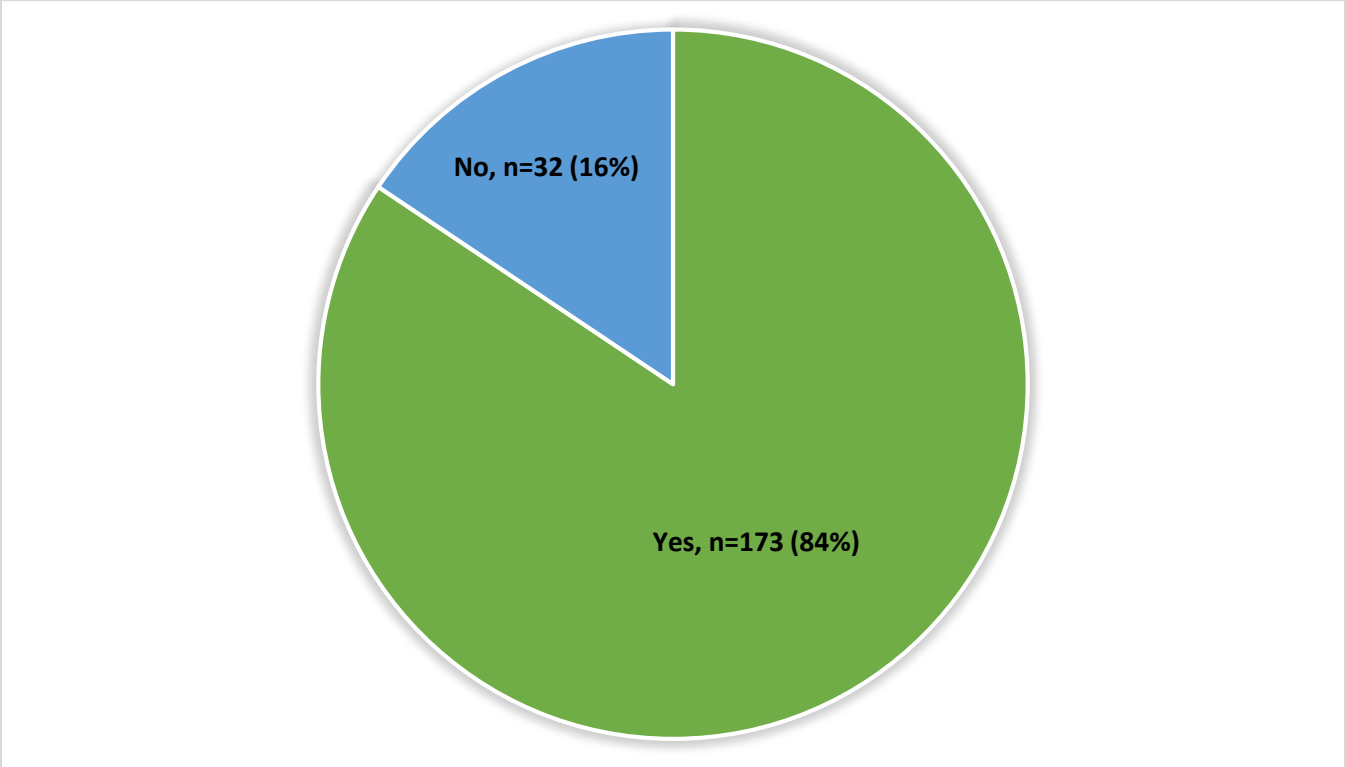

Table 156 - Buprenorphine/Naloxone Combination Product Available Without Prior Authorization

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (9), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Massachusetts (5), Michigan (1), Minnesota (9), Mississippi (2), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (8), Virginia (6), Washington (5)	173	84.39%
No	Florida (2), Maryland (9), Michigan (8), Mississippi (1), Texas (8), Utah (4)	32	15.61%
National Totals		**205**	**100%**

6. Does your MCO currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug or any form of MAT?

Figure 125 - Edits in Place to Monitor Opioids Being Used Concurrently with Any Buprenorphine Drug or Any Form of MAT

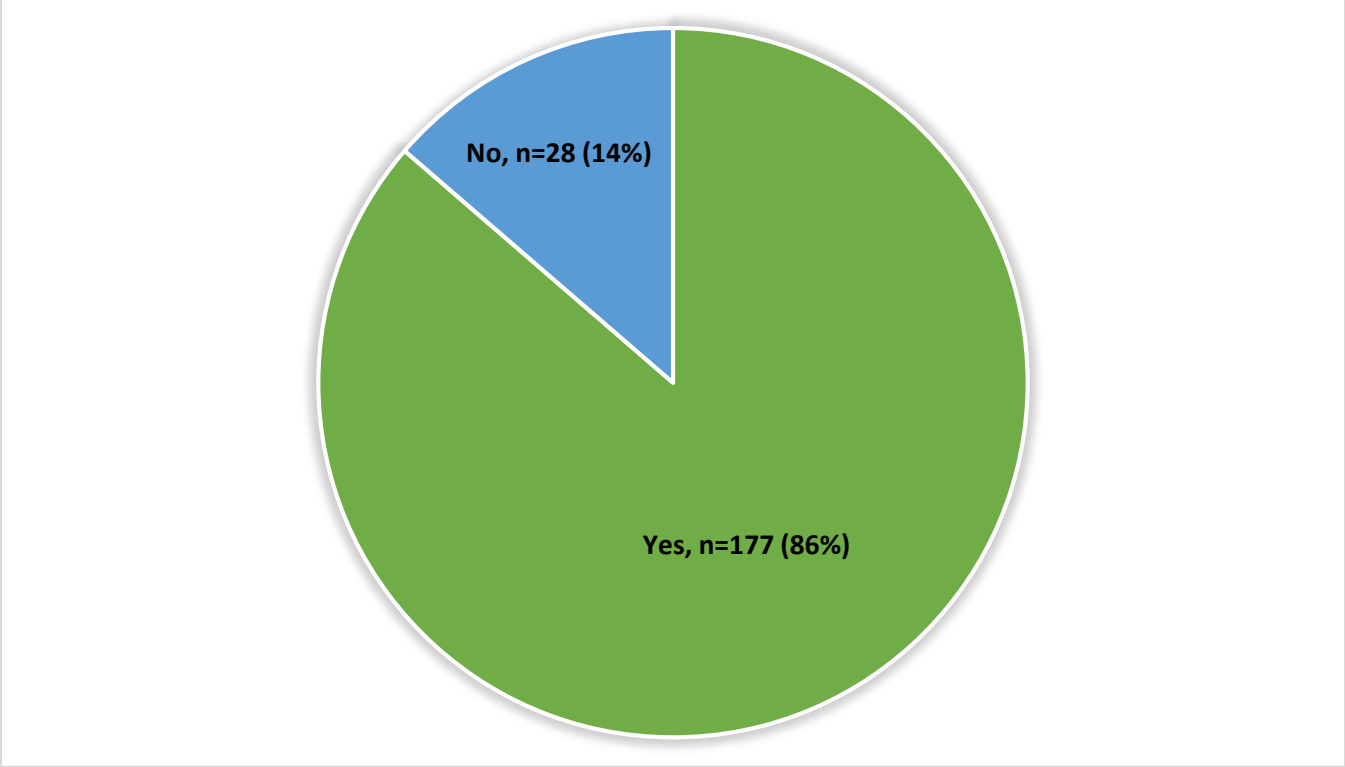

Table 157 - Edits in Place to Monitor Opioids Being Used Concurrently with any Buprenorphine Drug or Any Form of MAT

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (5), Illinois (4), Indiana (5), Kansas (1), Kentucky (6), Louisiana (5), Maryland (2), Massachusetts (5), Michigan (2), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (3), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (15), Utah (1), Virginia (6), Washington (4)	177	86.34%
No	Hawaii (1), Illinois (2), Iowa (2), Kansas (2), Maryland (7), Michigan (7), North Carolina (2), Texas (1), Utah (3), Washington (1)	28	13.66%
National Totals		**205**	**100%**

If "No," please explain why not.

Table 158 - Explanations for Not Having Edits in Place to Monitor Opioids Being Used Concurrently with Any Buprenorphine Drug or Any Form of MAT

State	MCO Name	Explanation
HI	HMSAQI	HMSA has a retrospective DUR buprenorphine program which is a prescriber-based lettering program that identifies members taking oral

State	MCO Name	Explanation
		buprenorphine products and opioids concurrently and educates the prescriber of the potentially inappropriate combination.
IA	Amerigroup	Other - There is a soft edit in place for the pharmacist to review and consult the prescriber as needed.
IA	Iowa Total Care	There is a soft edit in place for the pharmacist to review and consult the prescriber as needed.
IL	Molina_Healthcare_of_Illinois,_Inc	Molina plans to implement this edit to require prior authorization if MAT therapy is present in patient's profile in 2023.
IL	YouthCare_HealthChoice	No edits are in place to monitor concurrent opioid and buprenorphine/MAT therapy. This allows for member to receive MAT without interference.
KS	Aetna Better Health of Kansas	State guidelines require the SUD providers to monitor the PDMP for their patients med use and reach out to the opioid provider if a patient receives an opioid for pain med.
KS	Sunflower Health Plan	The State Support Act policy details the State expects the OBOT and OTP providers to review PDMP for their patient's opioid use. Should the OTP or OBOT provider see claims history for an opioid for pain use, the provider is to reach out to the prescribing provider and collaboratively determine the patient's new treatment needs. The provider is required to check at a minimum of every 2 weeks.
MD	Aetna Better Health of Maryland	Medication Assisted Therapy drugs used to treat substance use disorder are carved out of the pharmacy benefit and claims are not adjudicated by our PBM.
MD	Amerigroup Community Care	Substance Use Disorder (SUD) treatment class is carved-out of MCO and paid by FFS program.
MD	CareFirst Community Health Plan Maryland	MAT drugs, buprenorphine, and buprenorphine/naloxone combination drugs are carved out to the Maryland Department of Health.
MD	Jai Medical Systems Managed Care Organization, Inc.	MAT drugs for OUD are covered directly by Maryland Medicaid and are not covered by the MCO; progress was made in the measurement year to consolidate data but the process was completed late in the measurement year. Effort was made after the measurement year to investigate implementing this type of edit.
MD	Maryland Physicians Care	All Treatments and Medications for Opioid Use Disorder are carved out to the State of Maryland (FFS).
MD	MedStar Family Choice	The MAT drugs for OUD are part of the MD State behavioral health medication carveout.
MD	Priority Partners MCO	The Opioid Use Disorder (OUD) treatment class is carved-out of MCO coverage. It is administered separately by the FFS program.
MI	Aetna Better Health of Michigan	MAT are carved out to FFS. The health plan does monitor retrospective carve out claims detail for MAT agents as well as other medications.
MI	Blue Cross Complete of Michigan	Medications for OUD are carved out by MDHHS.
MI	HAP Empowered	Opioids are covered and processed by the MCO but substance use disorder medications and services are carved out and managed by the State.
MI	McLaren Health Plan	Buprenorphine and Buprenorphine/Naloxone combination products are carved out to FFS in the State of Michigan.
MI	Molina Healthcare of Michigan	These medications are carved out to FFS.

State	MCO Name	Explanation
MI	Priority Health Choice	Coverage of Medication Assisted Treatment (MAT) drugs for Opioid Use Disorder (OUD) are carved out to the Michigan Fee For Service Medicaid program.
MI	Upper Peninsula Health Plan	OUD agents are carved out of the health plan benefit by the State.
NC	AMHC FFY22	Not required by NCDHB pharmacy policy
NC	UHC FFY22	N/A
TX	Amerigroup	It is built into the prior authorization criteria, not a point of sale edit review. Renewal of the PA is required every 3 months.
UT	Healthy U	MAT carved out to the State, but consideration for future.
UT	SelectHealth	Medication is carved out to State Medicaid.
UT	Steward Health Choice Utah	These are carved out to the State, but will consider for the future.
WA	Molina Healthcare of Washington, Inc.	Molina follows the States guidelines.

If “Yes,” can the POS pharmacist override the edit?

Figure 126 - POS Pharmacist Override Edit for Opioids Being Used Concurrently with Any Buprenorphine Drug or Any Form of MAT

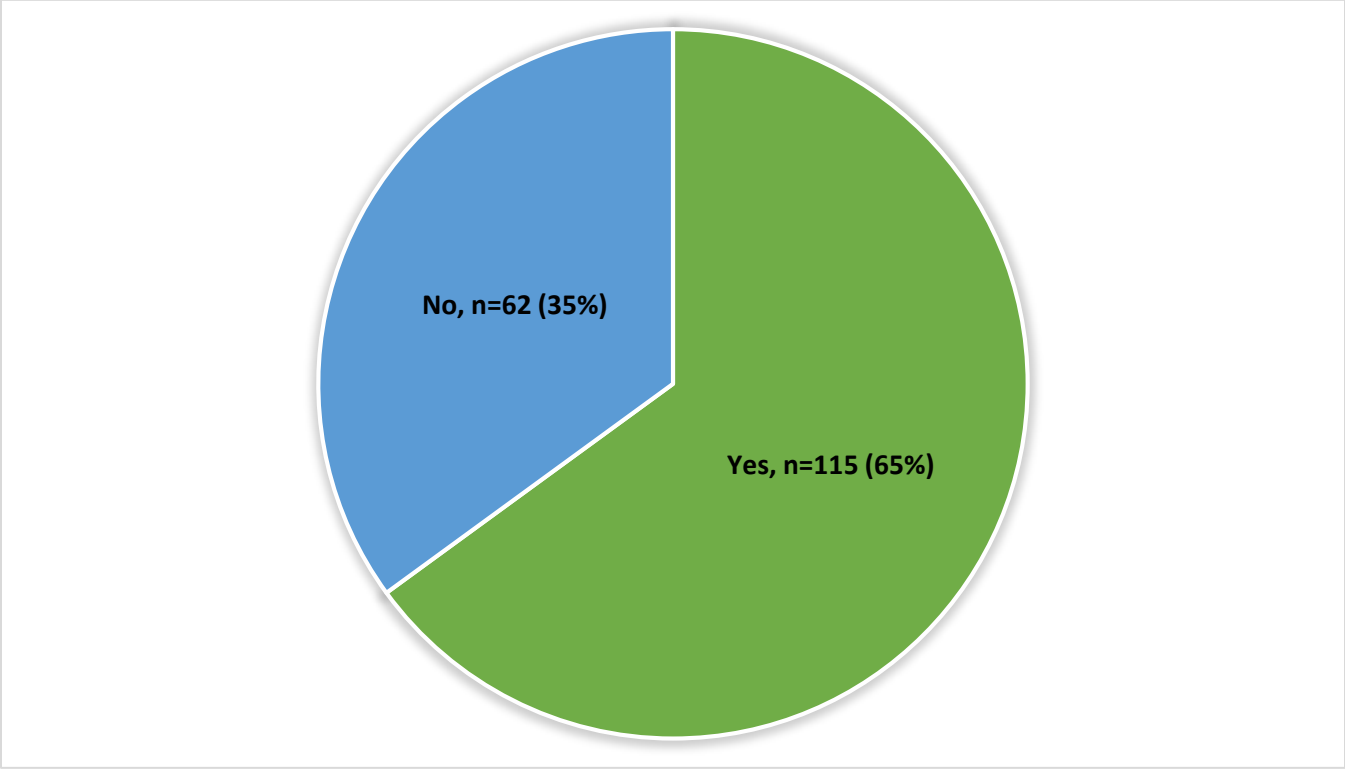

Table 159 - POS Pharmacist Override Edit for Opioids Being Used Concurrently with Any Buprenorphine Drug or Any Form of MAT

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (2), Colorado (2), Delaware (1), District of Columbia (1), Florida (10), Georgia (3), Hawaii (5), Illinois (2), Indiana (3), Kansas (1), Louisiana (2), Maryland (1), Massachusetts (5), Michigan (2), Minnesota (5), Nebraska (1), Nevada (3), New Hampshire (2), New Jersey (4), New Mexico (2), New York (6), North Carolina (3), Ohio (4), Oregon (18), Pennsylvania (1), Rhode Island (3), South Carolina (3), Texas (11), Utah (1), Virginia (4), Washington (4)	115	64.97%
No	Arkansas (2), Delaware (1), District of Columbia (3), Florida (1), Illinois (2), Indiana (2), Kentucky (6), Louisiana (3), Maryland (1), Minnesota (4), Mississippi (3), Nebraska (2), Nevada (1), New Hampshire (1), New Jersey (1), New Mexico (1), New York (9), Ohio (1), Oregon (3), Pennsylvania (7), South Carolina (2), Texas (4), Virginia (2)	62	35.03%
National Totals		**177**	**100%**

7. Is there at least one formulation of naltrexone for OUD available without PA?

Figure 127 - Formulation of Naltrexone for OUD Available Without PA

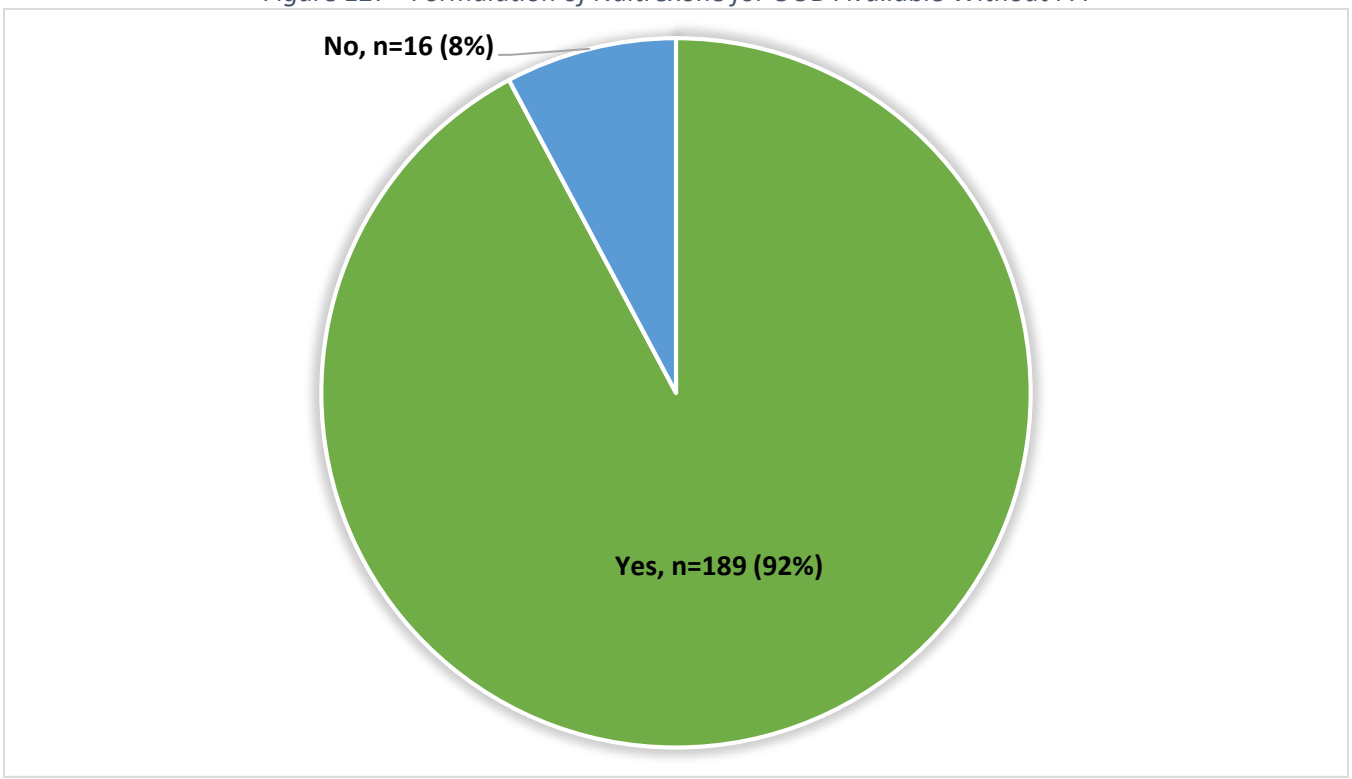

Table 160 - Formulation of Naltrexone for OUD Available Without PA

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (1), Massachusetts (5), Michigan (5), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (16), Virginia (6), Washington (5)	189	92.20%
No	Maryland (8), Michigan (4), Utah (4)	16	7.80%
National Totals		**205**	**100%**

8. Does your MCO have at least one naloxone opioid overdose product available without PA?

Figure 128 - Naloxone Opioid Overdose Product Available Without PA

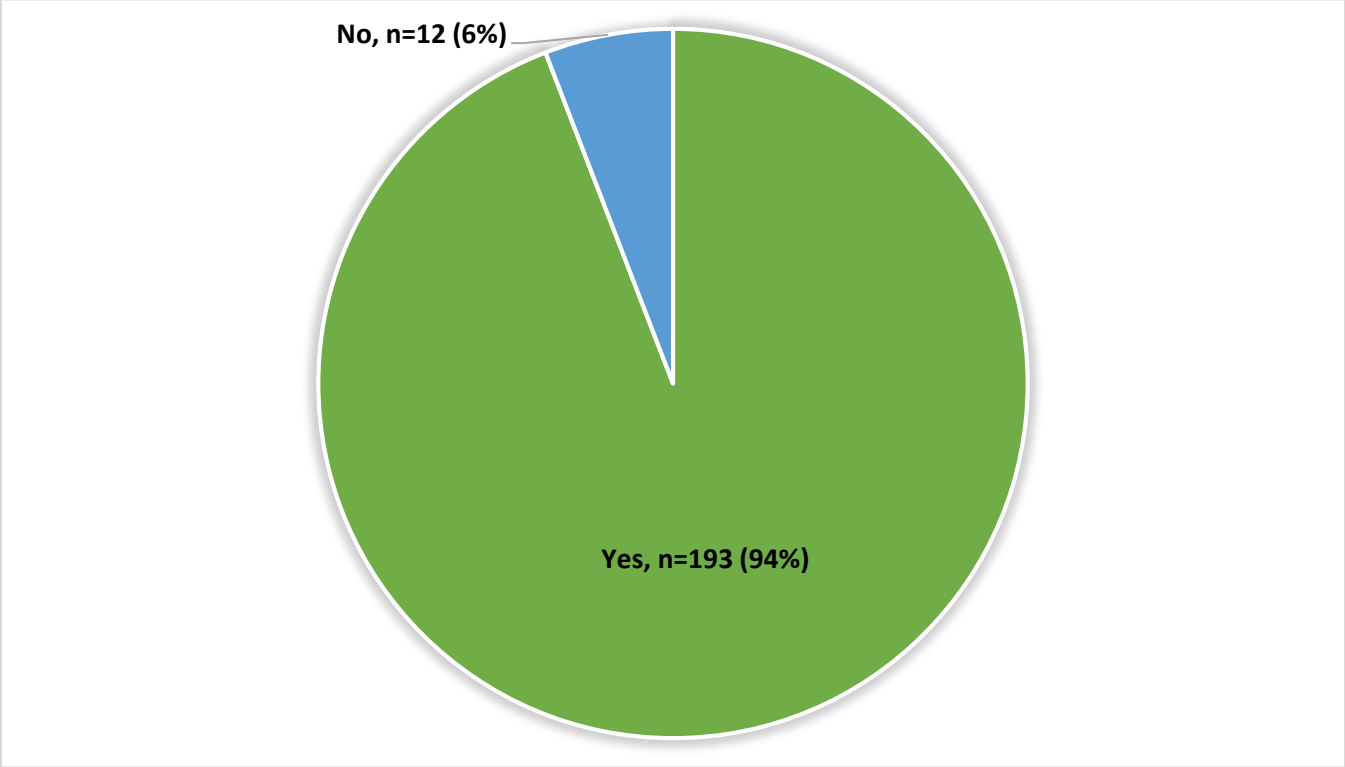

Table 161 - Naloxone Opioid Overdose Product Available Without PA

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (1), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (16), Virginia (6), Washington (5)	193	94.15%

Response	States (Count of MCOs)	Count	Percentage
No	Maryland (8), Utah (4)	12	5.85%
National Totals		**205**	**100%**

9. Does your MCO monitor and manage appropriate use of naloxone to persons at risk of overdose?

Figure 129 - Monitor and Manage Appropriate Use of Naloxone to Persons at Risk of Overdose

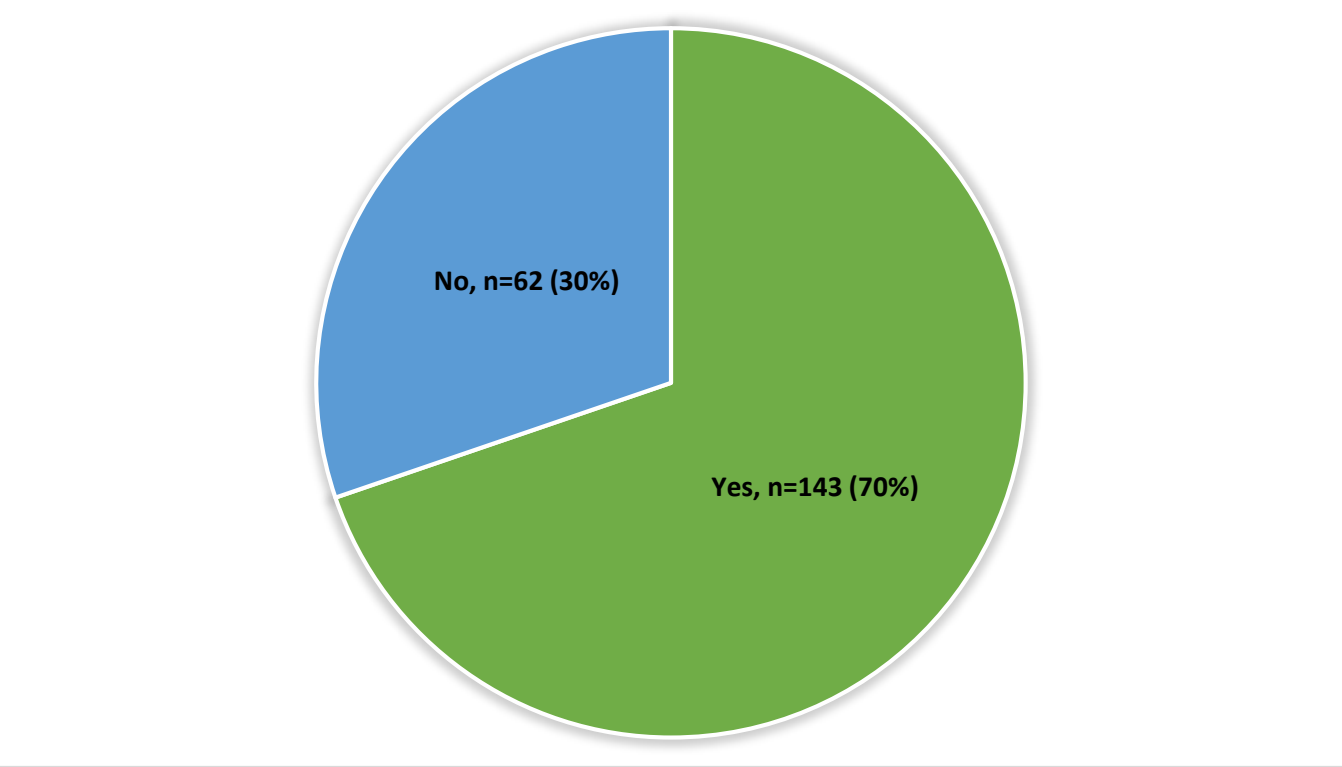

Table 162 - Monitor and Manage Appropriate use of Naloxone to Persons at Risk of Overdose

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (3), Colorado (2), Delaware (2), District of Columbia (4), Florida (7), Georgia (2), Hawaii (3), Illinois (3), Indiana (4), Iowa (2), Kansas (3), Kentucky (6), Louisiana (4), Maryland (3), Massachusetts (2), Michigan (8), Minnesota (6), Mississippi (3), Nebraska (1), Nevada (4), New Hampshire (3), New Jersey (4), New Mexico (2), New York (12), North Carolina (3), Ohio (5), Oregon (14), Pennsylvania (5), Rhode Island (1), South Carolina (3), Texas (6), Utah (3), Virginia (5), Washington (5)	143	69.76%
No	Arkansas (1), Florida (4), Georgia (1), Hawaii (3), Illinois (3), Indiana (1), Louisiana (1), Maryland (6), Massachusetts (3), Michigan (1), Minnesota (3), Nebraska (2), New Jersey (1), New Mexico (1), New York (3), North Carolina (2), Oregon (7), Pennsylvania (3), Rhode Island (2), South Carolina (2), Texas (10), Utah (1), Virginia (1)	62	30.24%
National Totals		**205**	**100%**

If "No," please explain why not.

Table 163 - Explanation for Not Monitoring and Managing Appropriate use of Naloxone to Persons at Risk of Overdose

State	MCO Name	Explanation
AR	Arkansas_Total_Care_Inc.	Per Act 651 of the 2021 Arkansas Legislative Session, prescribers are required to co-prescribe naloxone when prescribing an opioid in certain high-risk situations.
FL	Aetna Better Health	A high-level overview of MCO retrospective trends is shared with the plans at the AHCA Medicaid quarterly DUR Board meetings. Topics reviewed include opioid claims utilization, top opioid prescribers including specialty and region, top opioid recipients, Narcan/naloxone utilization, and overdose data if available.
FL	Amerihealth Caritas Florida	The use of Naloxone is managed according to agency DUR Board and State board of pharmacy dispensing edits and guidelines to ensure members have open access to medication use for treatment of opioid overdose.
FL	Children's Medical Services	This will be evaluated and implemented as needed and dependent on resources
FL	Sunshine	This will be evaluated and implemented as needed and dependent on resources.
GA	Peach State Health Plan	Peach State Health Plan has a retrospective drug utilization review programs in which we outreach to prescribers for our members in order to decrease the utilization of high risk opioid drug combinations, decrease the use of high dose opioids, and increase the use of medication assisted treatment (MAT) in members with opioid dependency. As a part of these programs, we recommend the prescribing and utilization of naloxone for these groups that are high risk for opioid overdose.
HI	AlohaCare	We will evaluate the use of naloxone in persons at risk of an overdose in the future.
HI	WellCareHealthPlans	This will be evaluated and implemented as needed and dependent on resources.
HI	WellCareHealthPlansCCS	This will be evaluated and implemented as needed and dependent on resources.
IL	Aetna_Better_Health_of_Illinois	Although specific use of naloxone is not tracked, members with opioid dependence are referred to care coordination for outreach and monitoring.
IL	MeridianHealth	When naloxone is listed on a drug request with PA, therapy is reviewed and managed. Otherwise naloxone is provided without PA. There is no current review to identify persons who are at risk for an overdose.
IL	YouthCare_HealthChoice	A review process is in development.
IN	Managed Health Services Indiana (MHS)	We follow IN Medicaid guideline for dispensation of Naloxone.
LA	AmeriHealth Caritas Louisiana	LDH has not incorporated this yet; however, a retrospective measure for persons at risk of overdose (>50 MME) was performed in November 2021.
MA	Fallon Community Health Plan, Inc.	Medication Adherence program monitors Medication Assisted-Therapy Treatment

State	MCO Name	Explanation
MA	Health New England, Inc.	Care Management services for Health New England Be Healthy members are provided at the clinic level
MA	Tufts Health Public Plans, Inc	Because members can fill naloxone at a pharmacy under a standing order and have on hand for anyone, the MCO does not monitor who is filling naloxone.
MD	Amerigroup Community Care	Naloxone is carved out of MCO and paid for by FFS program.
MD	CareFirst Community Health Plan Maryland	We do not retrospectively monitor appropriate use of Naloxone in persons at risk of overdose at this time. CHPMD's Special Needs Coordinators encourage all members in the safety & monitoring component of the CMC to obtain a prescription for Naloxone. However, members' receptivity and actual engagement varies.
MD	Jai Medical Systems Managed Care Organization, Inc.	Because naloxone is covered directly by Maryland Medicaid, any POS edits or monitoring would be implemented by Maryland Medicaid.
MD	Maryland Physicians Care	The management for the activities pertaining to Opioid Use Disorder are carved out to the State of Maryland FFS.
MD	MedStar Family Choice	The MAT drugs for OUD are part of the MD State behavioral health medication carveout.
MD	Priority Partners MCO	The monitoring and management of naloxone is conducted by the FFS program as part of the OUD treatment class carve-out.
MI	Meridian Health Plan	Naloxone is only managed and monitored when naloxone is listed on a drug request with Prior authorization. In that situation therapy is reviewed and managed. Otherwise naloxone provided without prior authorization.
MN	Medica	Medica encourages that prescribers prescribe for naloxone to their member if they believe that the member may be at risk of an overdose. There are no activities to limit or discourage access to this drug at this time. To promote naloxone prescribing, physician alerts are sent retrospectively to members filling high doses of opioids.
MN	SouthCountry	Naloxone is available without restrictions and monitoring of claims is not conducted.
MN	UCare	At this time, there is no retrospective review or management of naloxone use for beneficiaries at risk of overdose.
NC	CCH FFY22	The health plan asses naloxone use quarterly to understand use and determine if action is warranted
NC	WC FFY22	This will be evaluated and implemented as needed and is dependent upon resources.
NE	Nebraska Total Care	NTC is evaluating the feasibility of retrospectively monitoring patients that have high doses of opioids for use of naloxone.
NE	United Healthcare	High utilizers of highly abused meds are reviewed thru the rDUR program and prescribers are contacted in real-time once a member trigger/meets criteria.
NJ	Wellcare health plans	this will be evaluated and implemented as needed
NM	Presbyterian Health Plan	Naloxone use for patients at risk for overdose is monitored prospectively. Prior authorizatoin is required for opioid cumulative doses exceeding 90 MME. Part of the criteria for

State	MCO Name	Explanation
		coverage for doses exceeding 90 MME is that the member has been prescribed naloxone and counseled on it's use.
NY	Capital District Physicians' Health Plan	CDPHP does not monitor or manage the use of naloxone. Possession of naloxone is encouraged for any person at risk of overdose and in households where opioids are stored.
NY	Fidelis Care	We do not retrospectively monitor appropriate use of naloxone in persons at risk of overdose at this time. We do, however, put this Statement on our Safety & Monitoring letters to prescribers: "NALOXONE is available for patients on high dose pain medications or otherwise at risk of opioid overdose."
NY	Healthfirst	We do not retrospectively monitor appropriate use of Naloxone in persons at risk of overdose at this time. We do, however, put this Statement on our Safety & Monitoring Letters to prescribers: "Naloxone is available for patients on high dose pain medication or otherwise at risk of opioid overdose
OR	Health Share of Oregon - Legacy Health/PacificSource	We provide open access to naloxone on formulary with a quantity limit on the cartridge.
OR	PacificSource Community Solutions-Central Oregon	We provide open access to naloxone on formulary with a quantity limit on the cartridge.
OR	PacificSource Community Solutions-Columbia Gorge	We provide open access to naloxone on formulary with a quantity limit on the cartridge.
OR	PacificSource Community Solutions - Lane	We provide open access to naloxone on formulary with a quantity limit on the cartridge.
OR	PacificSource Community Solutions - Marion/Polk	We provide open access to naloxone on formulary with a quantity limit on the cartridge.
OR	Providence / Health Share of Oregon	We encourage naloxone use, however, we do not have a management program. We do periodic monitoring of claims data to continue to review trends related to usage and any concerns (such as unfilled prescriptions).
OR	Yamhill Community Care Organization	We encourage naloxone use, however, we do not have a management program. We do periodic monitoring of claims data to continue to review trends related to usage and any concerns (such as unfilled prescriptions).
PA	Geisinger	part of prior authorization criteria
PA	PA Health and Wellness	This is part of the Opioid policy for the Statewide PDL. We do not currently have a monitoring program in regards to Naloxone utilization for patients at risk of overdose.
PA	Vista	State requirements and standing order allow naloxone dispensing to family members, friends, or other persons who are in a position to assist a person at risk of experiencing an opioid-related overdose, and also prevent MCOs from applying limits to total naloxone dispensing. These provisions, along with Vista's understanding of the public health benefit provided by naloxone supply, would render attempts to manage or otherwise limit the dispensing of naloxone ultimately fruitless and perhaps inadvisable.
RI	NHPRI	Neighborhood does not manage use of naloxone retrospectively, but does track utilization on a quarterly basis.

State	MCO Name	Explanation
RI	THP	Because members can fill naloxone at a pharmacy under a standing order and have on hand for anyone, the MCO does not monitor who is filling naloxone.
SC	Absolute Total Care	This will be evaluated and implemented as needed and dependent on resources.
SC	Select Health of South Carolina, Inc.	Prior authorization criteria require prescriber attestation of discussion with high risk patients the heightened risks of opioid use and has educated patient on naloxone use and has considered prescribing naloxone.
TX	Aetna Better Health of Texas	We continue to evaluate the possibility of performing retrospective reviews but continue to encounter issues and concerns on the regulations that limit the sharing of PHI on matters related to OUD.
TX	Community Health Choice	We currently have no programs in place to retrospectively monitor and manage appropriate use of naloxone to persons at risk for overdose
TX	Cook Children's Health Plan	No, we currently have no programs in place to retrospectively monitor and manage appropriate use of naloxone to persons at risk for overdose
TX	Dell Children's Health Plan	We currently have no programs in place to retrospectively monitor and manage appropriate use of naloxone to persons at risk of overdose.
TX	Driscoll Health Plan	Driscoll Health Plan does not have a program in place to retrospectively monitor and manage appropriate use of naloxone to members at risk for overdose.
TX	El Paso Health	We currently have no programs in place to retrospectively monitor and manage appropriate use of naloxone to persons at risk for overdose
TX	Molina Healthcare of Texas	Molina does not retrospectively monitor appropriate use of Naloxone in persons at risk of overdose at this time. We do, however, put this Statement on our Safety & Monitoring letters to prescribers: "NALOXONE is available for patients on high dose pain medications or otherwise at risk of opioid overdose.
TX	Parkland Community Health Plan	No, we currently have no programs in place to retrospectively monitor and manage appropriate use of naloxone to persons at risk for overdose
TX	Superior HealthPlan	We suggest providers and/or pharmacies provide naloxone access for members who are at risk for overdose through provider education. However, we do not actively give providers or pharmacies a list of high risk members to target for naloxone prescriptions.
TX	Texas Children's Health Plan	We currently have no programs in place to retrospectively monitor and manage appropriate use of naloxone to persons at risk for overdose.
UT	SelectHealth	Medication is carved out to State Medicaid.
VA	Anthem	We currently do not have an additional naloxone retroDUR program due to the State PUMS program.

10. Does your MCO allow pharmacists to dispense naloxone prescribed independently or by collaborative practice agreements, or standing orders, or other predetermined protocols?

Figure 130 - MCO Allows Pharmacists to Dispense Naloxone Prescribed Independently or By Collaborative Practice Agreements, Standing Orders, Or Other Predetermined Protocols

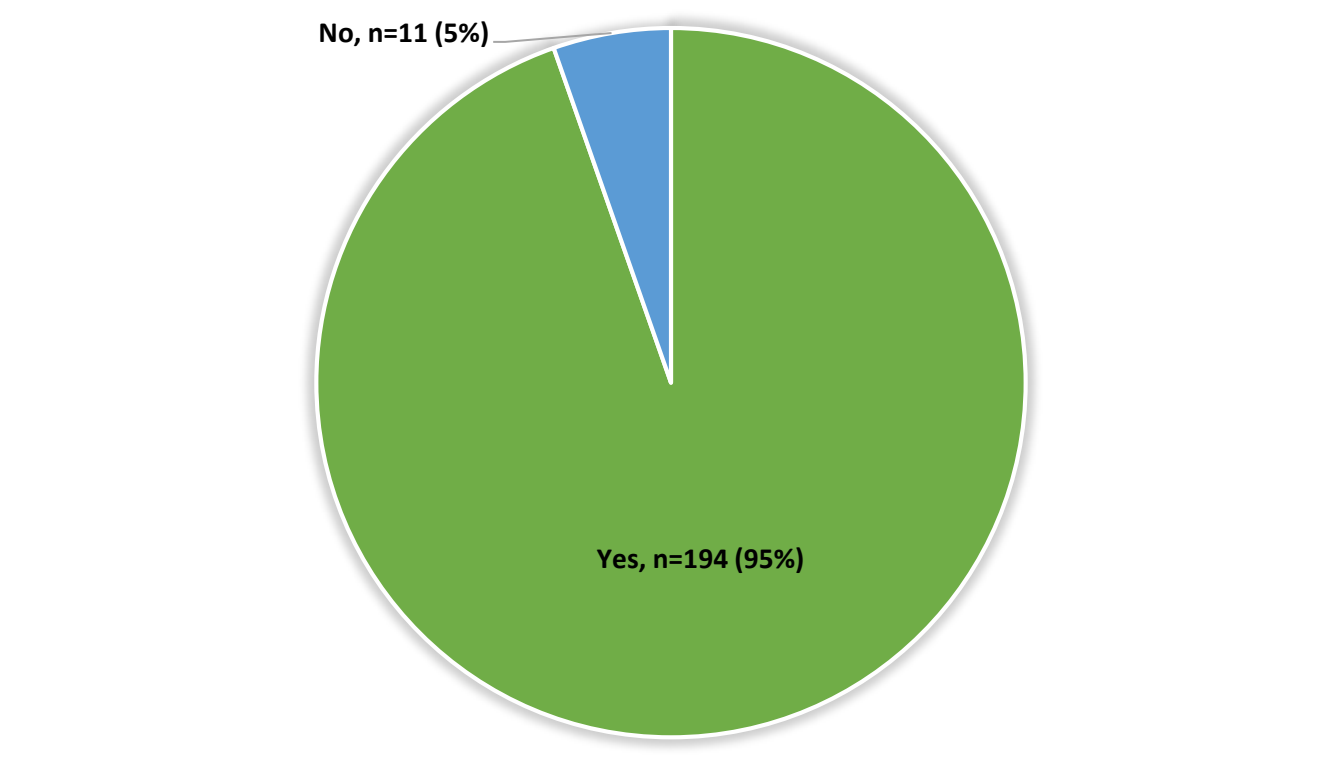

Table 164 - MCO Allows Pharmacists to Dispense Naloxone Prescribed Independently or By Collaborative Practice Agreements, Standing Orders, Or Other Predetermined Protocols

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (10), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (3), Massachusetts (5), Michigan (9), Minnesota (8), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (13), Utah (4), Virginia (6), Washington (5)	194	94.63%
No	Florida (1), Maryland (6), Minnesota (1), Texas (3)	11	5.37%
National Totals		**205**	**100%**

F. Outpatient Treatment Programs (OTP)

1. Does your MCO cover OTPs that provide behavioral health (BH) and MAT through OTPs?

Figure 131 - MCO Covers OTPs That Provide BH and MAT Through OTPs

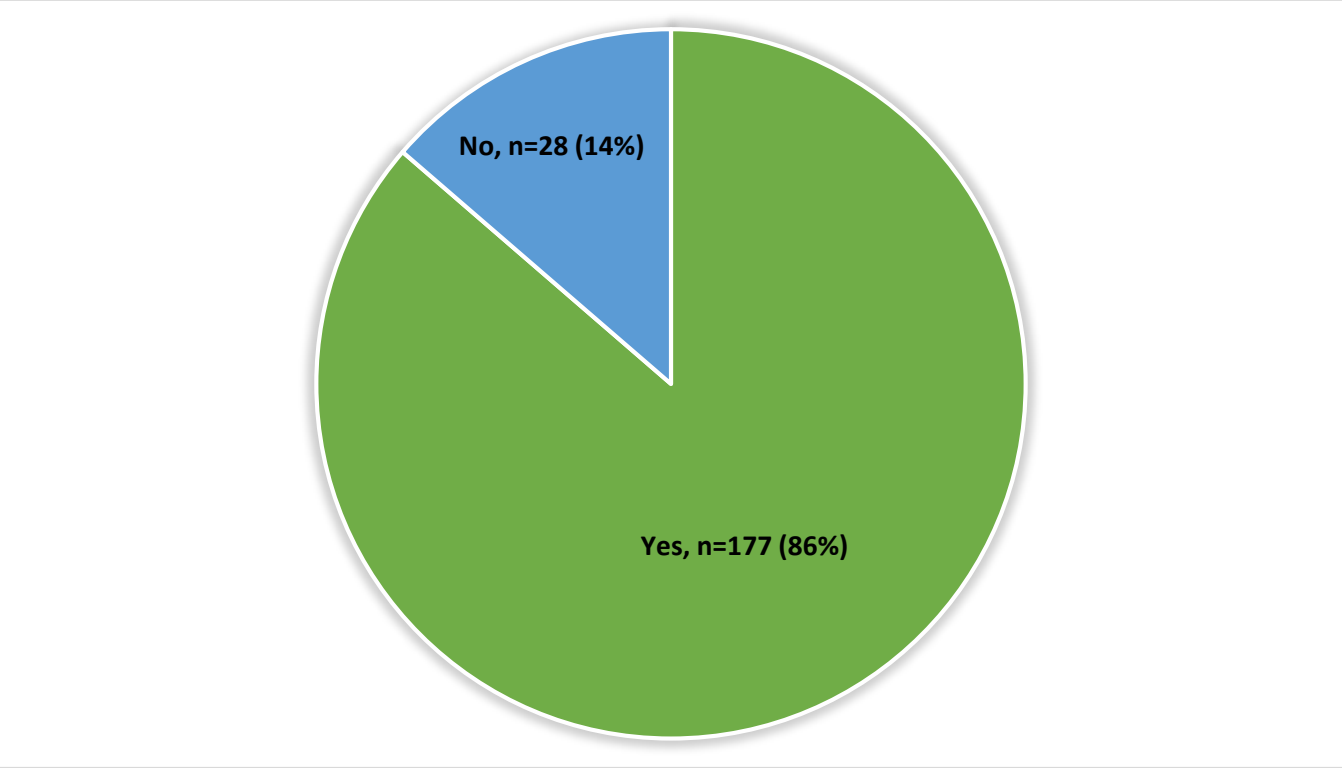

Table 165 - MCO Covers OTPs That Provide BH and MAT Through OTPs

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (3), Florida (11), Georgia (3), Hawaii (6), Illinois (5), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (4), Massachusetts (4), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (14), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (6), Rhode Island (3), South Carolina (5), Texas (16), Utah (1), Virginia (6), Washington (5)	177	86.34%
No	District of Columbia (1), Illinois (1), Louisiana (1), Maryland (9), Massachusetts (1), Michigan (9), New York (1), Pennsylvania (2), Utah (3)	28	13.66%
National Totals		**205**	**100%**

If “Yes,” is a referral needed for OUD treatment through OTPs?

Figure 132 - Referral Required for OUD Treatment Through OTPs

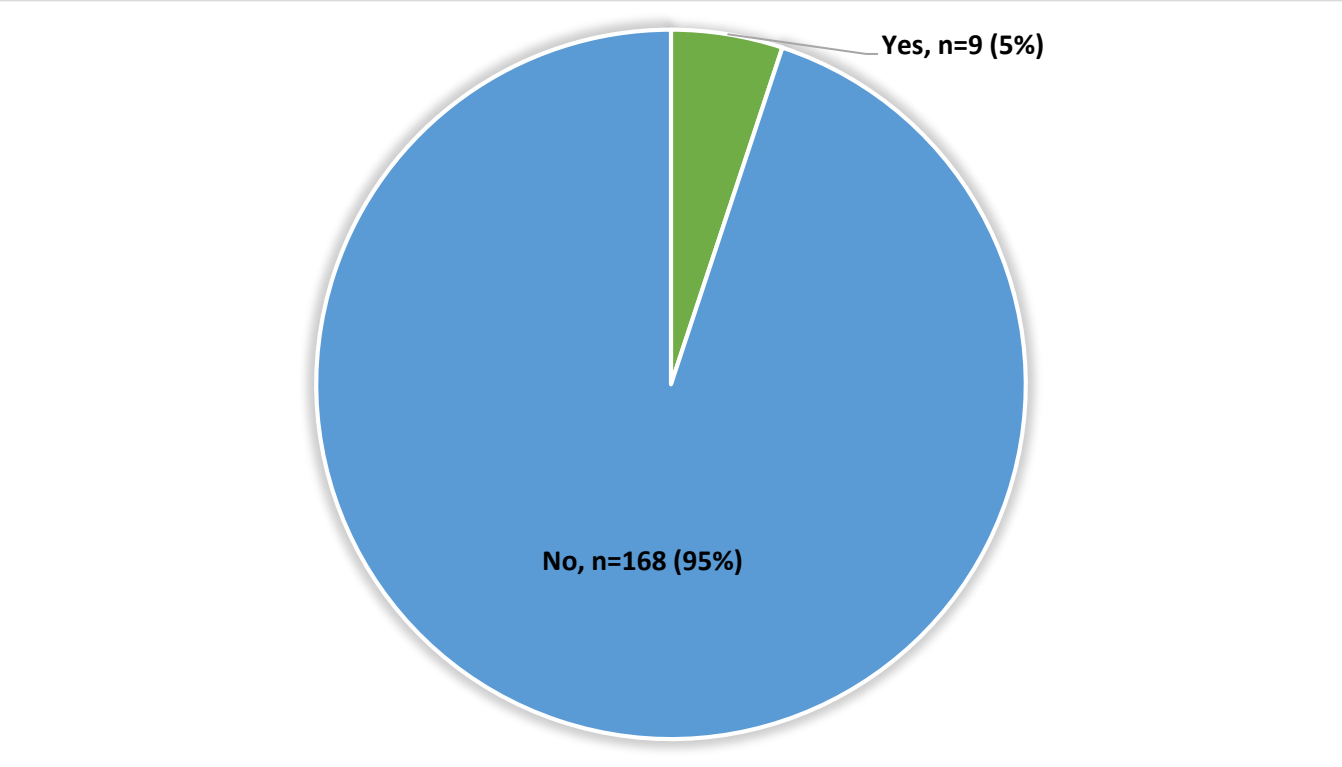

Table 166 - Referral Required for OUD Treatment Through OTPs

Response	States (Count of MCOs)	Count	Percentage
Yes	District of Columbia (1), Hawaii (1), Kentucky (1), Mississippi (2), New Jersey (1), Texas (1), Washington (2)	9	5.08%
No	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (2), Florida (11), Georgia (3), Hawaii (5), Illinois (5), Indiana (5), Iowa (2), Kansas (3), Kentucky (5), Louisiana (4), Massachusetts (4), Minnesota (9), Mississippi (1), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (4), New Mexico (3), New York (14), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (6), Rhode Island (3), South Carolina (5), Texas (15), Utah (1), Virginia (6), Washington (3)	168	94.92%
National Totals		**177**	**100%**

2. Does your MCO cover buprenorphine or buprenorphine/naloxone for diagnoses of OUD as part of a comprehensive MAT treatment plan through OTPs?

Figure 133 - MCO Covers Buprenorphine or Buprenorphine/Naloxone for Diagnoses of OUD as Part of a MAT Treatment Plan

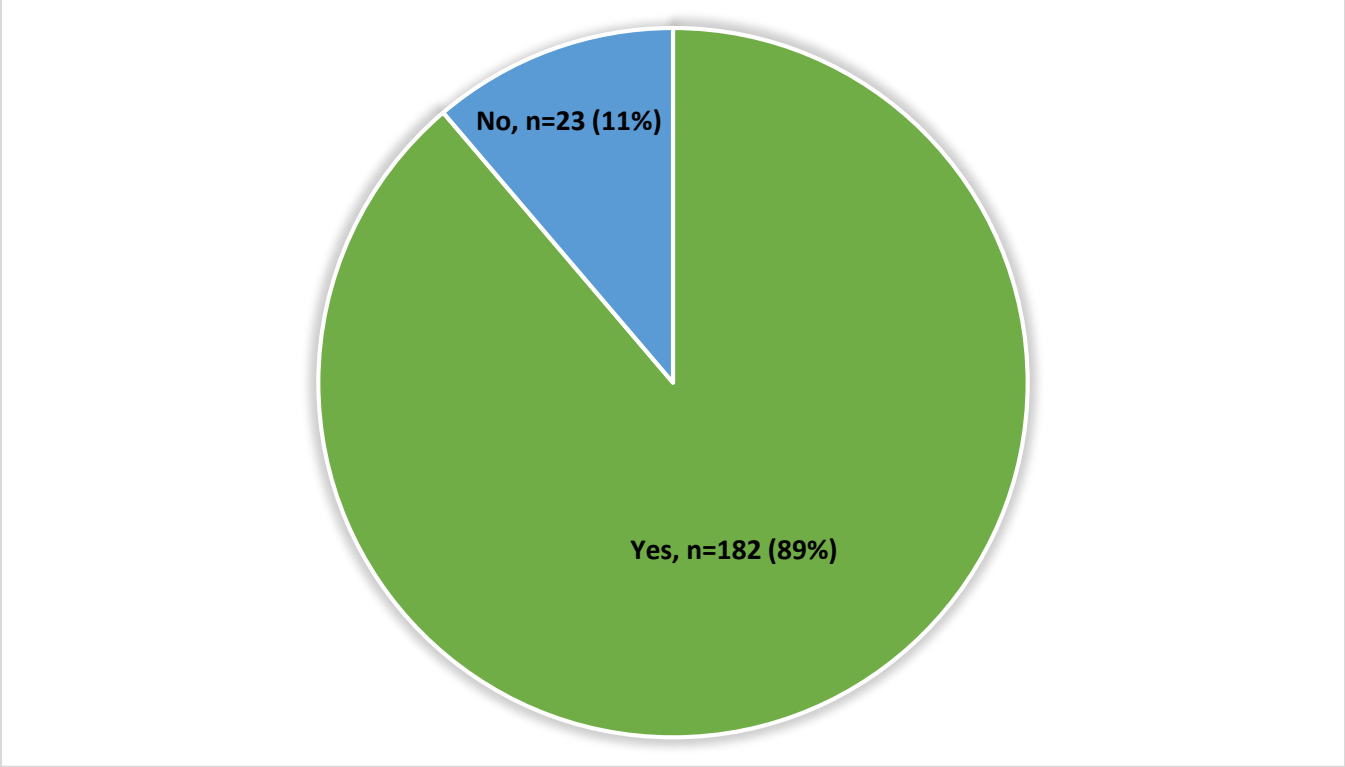

Table 167 - MCO Covers Buprenorphine or Buprenorphine/Naloxone for Diagnoses of OUD as Part of a MAT Treatment Plan

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (5), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Massachusetts (5), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (16), Virginia (6), Washington (5)	182	88.78%
No	Illinois (1), Maryland (9), Michigan (9), Utah (4)	23	11.22%
National Totals		**205**	**100%**

3. Does your MCO cover naltrexone for diagnoses of OUD as part of a comprehensive MAT treatment plan?

Figure 134 - MCO Covers Naltrexone for Diagnoses of OUD as Part of a MAT Treatment Plan

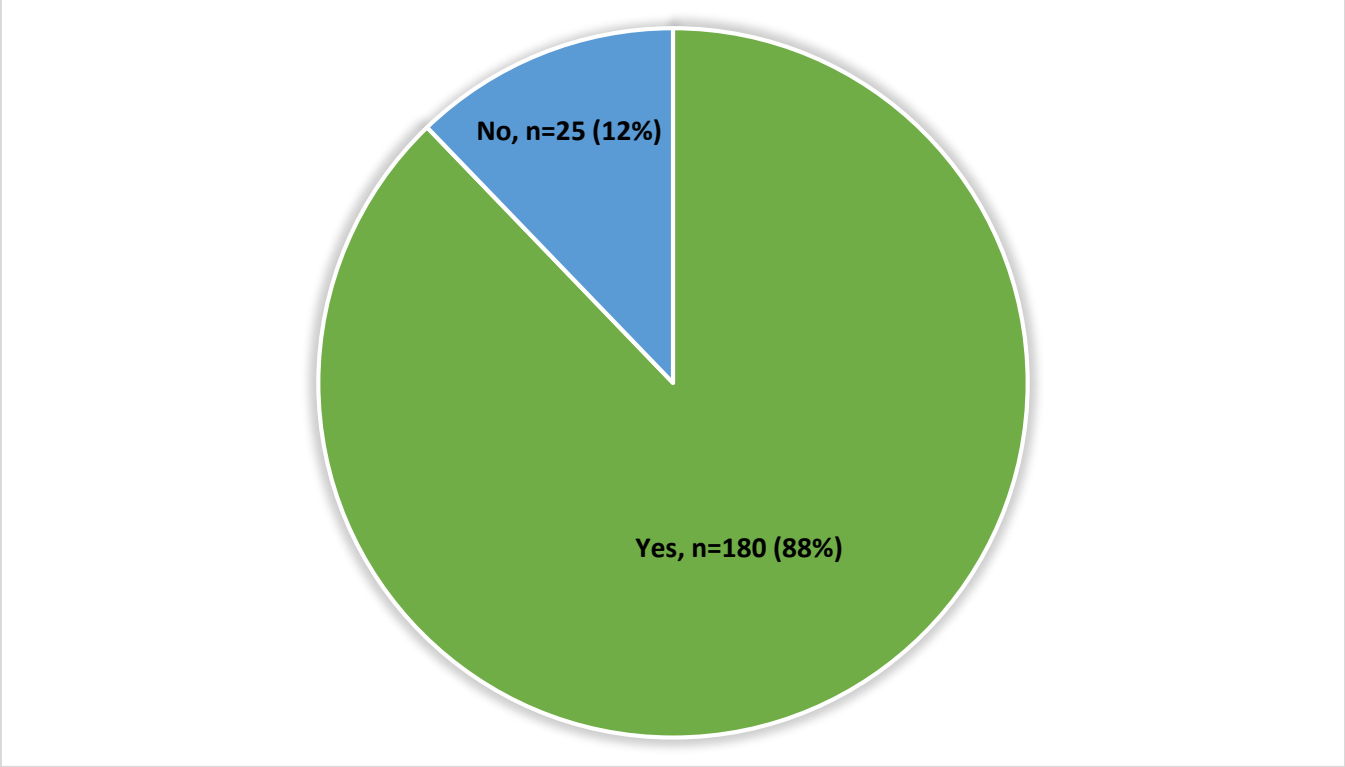

Table 168 - MCO Covers Naltrexone for Diagnoses of OUD as Part of a MAT Treatment Plan

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (1), Massachusetts (5), Michigan (1), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (16), Virginia (6), Washington (5)	180	87.80%
No	Louisiana (4), Maryland (9), Michigan (8), Utah (4)	25	12.20%
National Totals		**205**	**100%**

If “No,” please explain.

Table 169 - Explanation for MCO Not Covering Naltrexone for Diagnoses of OUD as Part of a MAT Treatment Plan

State	MCO Name	Explanation
LA	Aetna Better Health of Louisiana	Available as a pharmacy benefit.
LA	AmeriHealth Caritas Louisiana	It's not covered under medical services.
LA	Healthy Blue Louisiana	This currently not covered under the medical benefit

State	MCO Name	Explanation
LA	Louisiana Healthcare Connections	Naltrexone is not listed on the State's Specialized Behavioral Health fee schedule.
MD	Aetna Better Health of Maryland	Opioid antagonists are carved out of the pharmacy benefit, and covered by Fee For Service plan. However, we have a POS edit in place that will display a message at POS instructing the pharmacist to recommend naloxone when cumulative morphine equivalent dose exceeds 50mg.
MD	Amerigroup Community Care	naltrexone products are carved out of MCO and paid for by FFS program
MD	CareFirst Community Health Plan Maryland	Behavioral Health (BH) services and drugs, including buprenorphine or buprenorphine/naloxone, are covered and carved-out to MDH. CHPMD's Case Managers coordinate with MDH's BH vendor to ensure members have access to these services.
MD	Jai Medical Systems Managed Care Organization, Inc.	Behavioral Health and MAT treatments, including use of naltrexone, are covered through FFS and are carved out from MCO coverage.
MD	Kaiser Foundation Health Plan of the Mid-Atlantic States	Carved Out to Fee For Service
MD	Maryland Physicians Care	The management for the activities pertaining to Opioid Use Disorder are carved out to the State of Maryland FFS.
MD	MedStar Family Choice	MFC does not manage this benefit as OUD treatment is carved out to the State.
MD	Priority Partners MCO	The monitoring and management of naloxone is conducted by the FFS program as part of the OUD treatment class carved-out.
MD	United Healthcare	Naltrexone and MAT medications are a carved out benefit in Maryland and the MCOs do not manage the coverage or claim adjudication for this class of drugs.
MI	Aetna Better Health of Michigan	FFS carve out
MI	Blue Cross Complete of Michigan	This service is carved out by MDHHS under the pharmacy benefit. We do cover forms of naltrexone under the medical benefit.
MI	HAP Empowered	Medications for behavioral health and substance use disorder are carved out to the State and are managed by the State.
MI	McLaren Health Plan	Naltrexone is a carved out benefit managed by the State of Michigan FFS Medicaid.
MI	Meridian Health Plan	This is carved out.
MI	Molina Healthcare of Michigan	This is covered under the FFS pharmacy benefit.
MI	Priority Health Choice	In Michigan, coverage of these drugs is carved out to the Fee For Service Medicaid program.
MI	UnitedHealthcare Community Plan	Naltrexone used for the diagnosis of OUD is a carved-out benefit and managed by the State
UT	Healthy U	Carved out to the State.
UT	Molina Healthcare of Utah	Naltrexone is carved out to the UT FFS Medicaid program.
UT	SelectHealth	Medication is carved out to State Medicaid.
UT	Steward Health Choice Utah	These are carved out to the State.

4. Does your MCO cover Methadone for substance use disorder (i.e. OTPs, Methadone Clinics)?

Figure 135 - MCO Covers Methadone for Substance Use Disorder

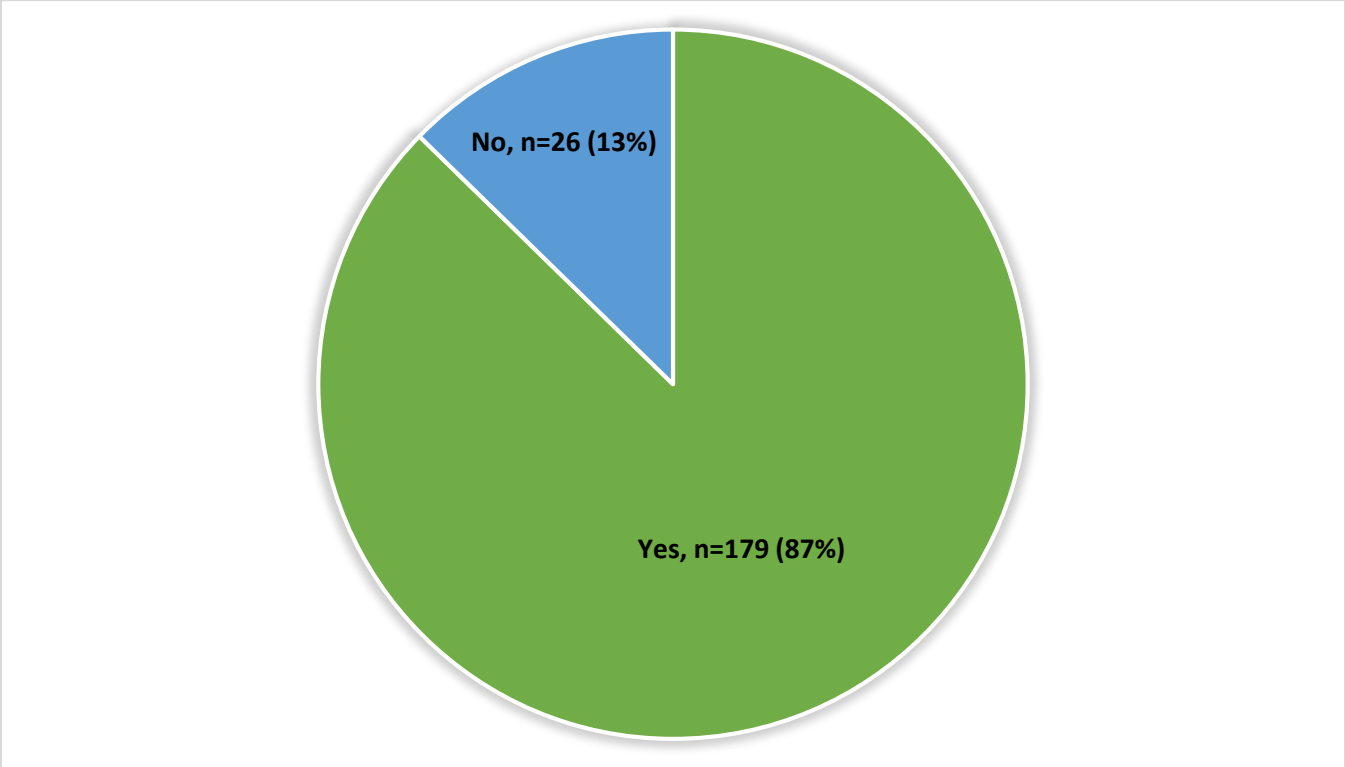

Table 170 - MCO Covers Methadone for Substance Use Disorder

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (2), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Massachusetts (5), Michigan (3), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (5), New Mexico (3), New York (14), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (5), Rhode Island (3), South Carolina (5), Texas (16), Virginia (6), Washington (5)	179	87.32%
No	District of Columbia (2), Maryland (9), Michigan (6), Nevada (1), New York (1), Pennsylvania (3), Utah (4)	26	12.68%
National Totals		**205**	**100%**

If "No," please explain why not.

Table 171 - Explanation for MCO Not Covering Methadone for Substance Use Disorder

State	MCO Name	Explanation
DC	AmeriHealth Caritas DC	OTPs are carved-out until 5/2024.
DC	CareFirst BCBS Community Health Plan DC	Carved out benefit
MD	Aetna Better Health of Maryland	Methadone for substance use disorder is carved out of the pharmacy benefit, and covered by Fee For Service plan.

State	MCO Name	Explanation
MD	Amerigroup Community Care	Methadone for SUD is carved out to the State and paid for by FFS program
MD	CareFirst Community Health Plan Maryland	Behavioral Health (BH) services and drugs, including buprenorphine or buprenorphine/naloxone, and Methadone are covered and carved-out to MDH. CHPMD's Case Managers coordinate with MDH's BH vendor to ensure members have access to these services.
MD	Jai Medical Systems Managed Care Organization, Inc.	Behavioral Health and MAT treatments, including methadone clinics, are covered through FFS and are carved out from MCO coverage.
MD	Kaiser Foundation Health Plan of the Mid-Atlantic States	Carved Out to Fee For Service
MD	Maryland Physicians Care	The management for the activities pertaining to Opioid Use Disorder are carved out to the State of Maryland FFS.
MD	MedStar Family Choice	MFC does not manage this benefit as OUD treatment is carved out to the State.
MD	Priority Partners MCO	The management of methadone for substance use disorder treatment is conducted by the FFS program as part of the OUD treatment class carved-out.
MD	United Healthcare	Methadone is a carved out benefit in Maryland and the MCOs do not manage the coverage or claim adjudication for this class of drugs.
MI	Aetna Better Health of Michigan	FFS carve out
MI	Blue Cross Complete of Michigan	This service is carved out by MDHHS.
MI	HAP Empowered	Outpatient treatment programs related to behavioral health and substance use disorder, including medications, are carved out to the State and are the responsibility of CMH/PIHP and the State.
MI	Molina Healthcare of Michigan	Carved out benefit
MI	Priority Health Choice	In Michigan, coverage of these drugs is carved out to the Fee For Service Medicaid program.
MI	UnitedHealthcare Community Plan	Methadone is considered a non-preferred opioid analgesic as listed in State-managed single PDL. Requirement is trial of preferred opioid analgesic. There is no associated clinical criteria for methadone.
NV	Anthem Blue Cross Blue Shield	Safer alternatives such as buprenorphine products are available.
NY	Fidelis Care	Methadone for opioid use disorder is covered in Methadone clinics only and billed via the medical benefit.
PA	Geisinger	covered by BH-MCO
PA	Highmark Wholecare	Behavioral Health MCO (BH-MCO) services are carved out per the Pennsylvania HealthChoices Agreement and methadone, when utilized for OUD is covered by the BH-MCO.
PA	Vista	Covered by BH-MCOs or possibly FFS program depending on recipient's coverage.
UT	Healthy U	Carved out to the State.
UT	Molina Healthcare of Utah	All MAT drugs, including Methadone for SUD, are carved out to the UT FFS Medicaid program.
UT	SelectHealth	Medication is carved out to State Medicaid.

State	MCO Name	Explanation
UT	Steward Health Choice Utah	These are carved out to the State.

G. Psychotropic Medication For Children

Antipsychotics

1. Does your MCO currently have restrictions in place to limit the quantity of antipsychotic drugs?

Figure 136 - Restrictions to Limit Quantity of Antipsychotic Drugs

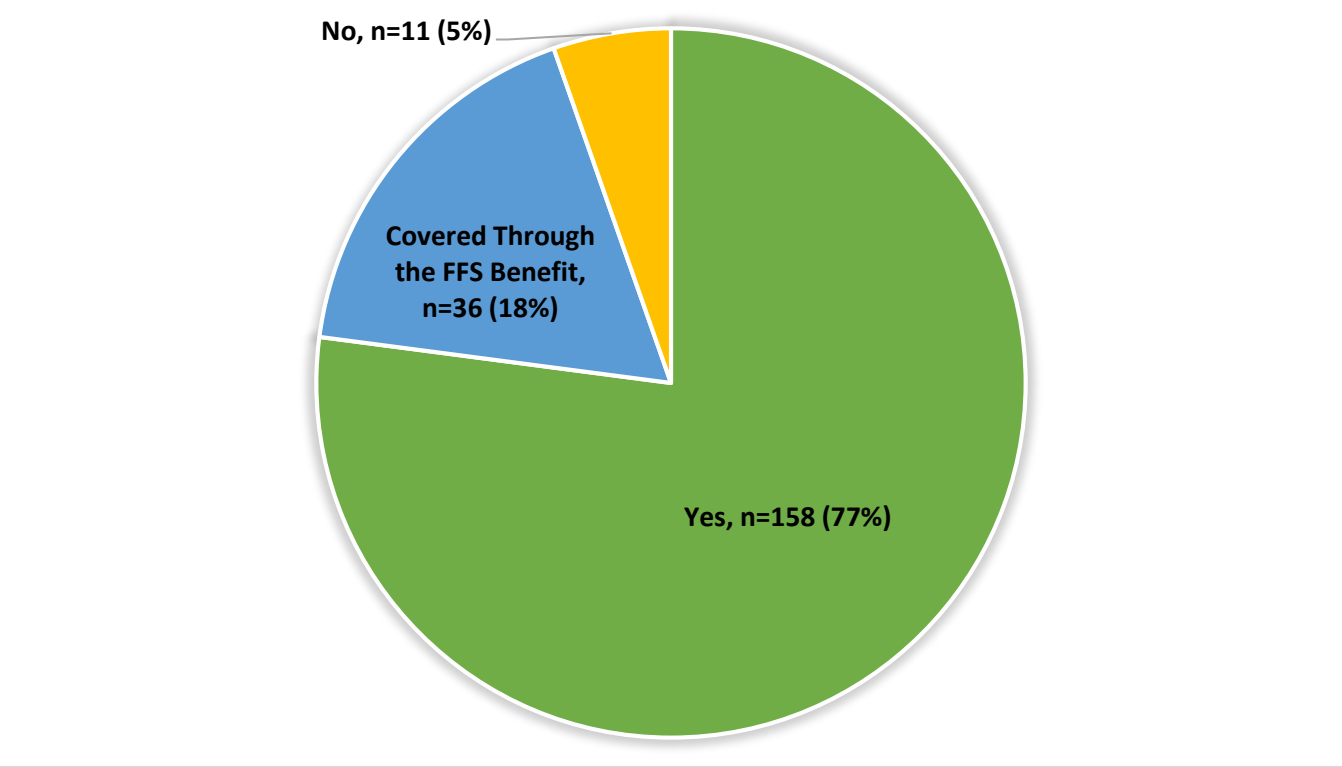

Table 172 - Restrictions to Limit Quantity of Antipsychotic Drugs

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (3), Florida (11), Georgia (3), Hawaii (4), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Massachusetts (4), Minnesota (7), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (14), North Carolina (5), Ohio (4), Oregon (5), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (16), Virginia (5), Washington (5)	158	77.07%
Covered through the FFS benefit	Maryland (9), Michigan (9), Oregon (15), Utah (3)	36	17.56%
No	District of Columbia (1), Hawaii (2), Massachusetts (1), Minnesota (2), New York (1), Ohio (1), Oregon (1), Utah (1), Virginia (1)	11	5.37%
National Totals		**205**	**100%**

2. Does your MCO have a documented program in place to either manage or monitor the appropriate use of antipsychotic drugs in children?

Figure 137 - Documented Program in Place to Either Manage or Monitor Appropriate Use of Antipsychotic Drugs in Children

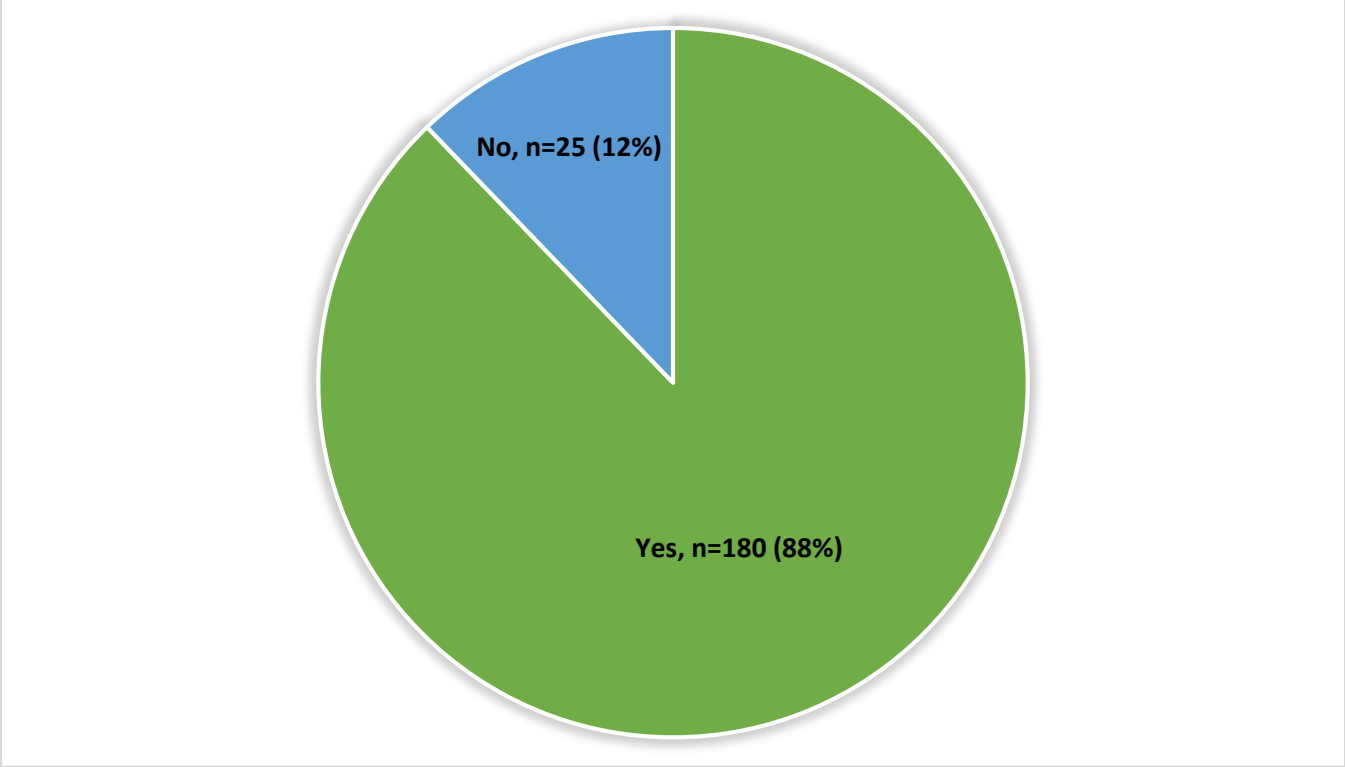

Table 173 - Documented Program in Place to Either Manage or Monitor Appropriate Use of Antipsychotic Drugs in Children

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (3), Florida (10), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (3), Massachusetts (5), Michigan (8), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (7), Pennsylvania (7), Rhode Island (3), South Carolina (5), Texas (16), Utah (3), Virginia (6), Washington (5)	180	87.80%
No	District of Columbia (1), Florida (1), Maryland (6), Michigan (1), Oregon (14), Pennsylvania (1), Utah (1)	25	12.20%
National Totals		**205**	**100%**

a. If "Yes," does your MCO either manage or monitor:

Figure 138 - Categories of Children Either Managed or Monitored for Appropriate Use of Antipsychotic Drugs

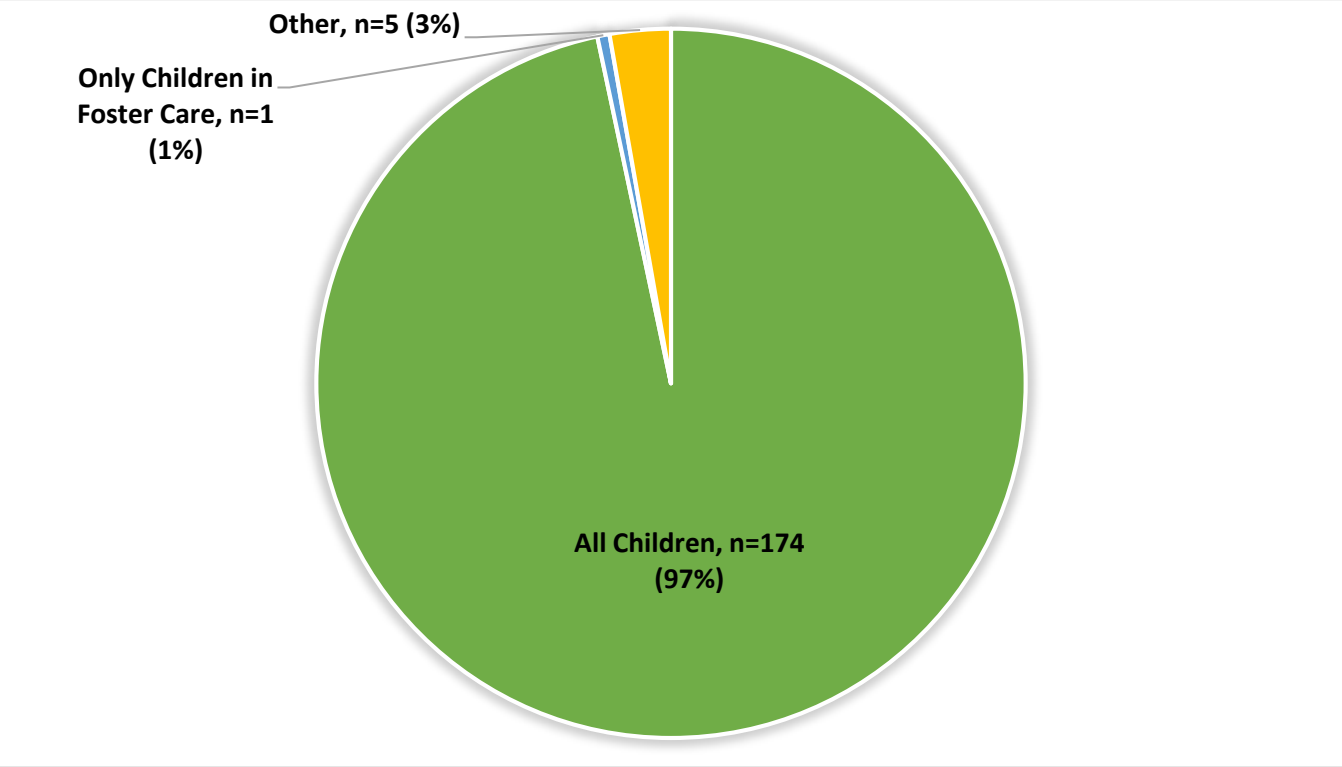

Table 174 - Categories of Children Either Managed or Monitored for Appropriate Use of Antipsychotic Drugs

Response	States (Count of MCOs)	Count	Percentage
All children	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (2), Florida (10), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (3), Massachusetts (5), Michigan (8), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (2), New York (15), North Carolina (5), Ohio (4), Oregon (4), Pennsylvania (7), Rhode Island (3), South Carolina (5), Texas (16), Utah (3), Virginia (6), Washington (5)	174	96.67%
Only children in foster care	New Mexico (1)	1	0.56%
Other	District of Columbia (1), Ohio (1), Oregon (3)	5	2.78%
National Totals		**180**	**100%**

b. If "Yes," does your MCO have edits in place to monitor (multiple responses allowed):

Figure 139 - Edits in Place to Monitor the Appropriate Use of Antipsychotic Drugs in Children

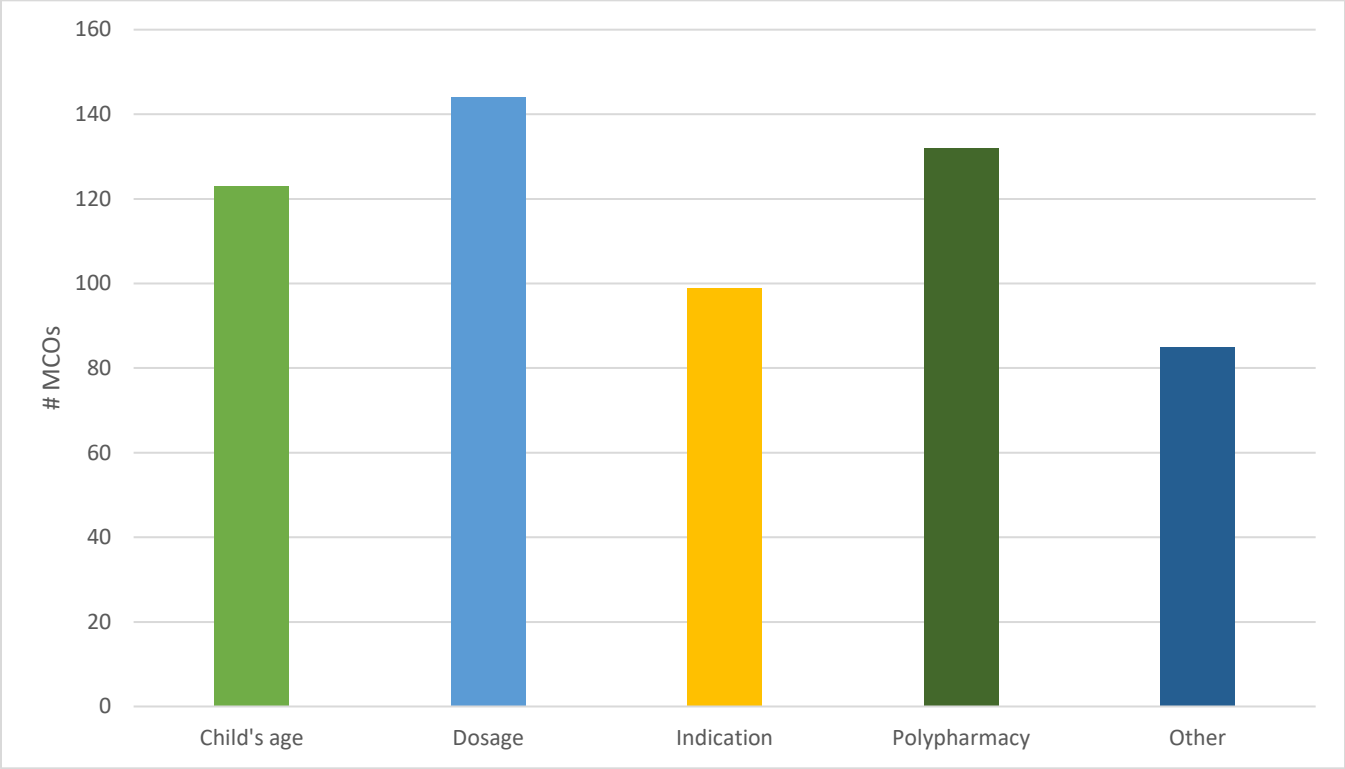

Table 175 - Edits in Place to Monitor the Appropriate Use of Antipsychotic Drugs in Children

Response	States (Count of MCOs)	Count	Percentage
Child's age	Arkansas (4), Delaware (2), District of Columbia (2), Florida (7), Georgia (2), Hawaii (1), Illinois (5), Indiana (4), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (1), Massachusetts (5), Michigan (2), Minnesota (7), Mississippi (1), Nebraska (2), Nevada (3), New Hampshire (2), New Jersey (3), New Mexico (2), New York (12), North Carolina (3), Ohio (2), Pennsylvania (7), South Carolina (3), Texas (14), Virginia (6), Washington (5)	123	21.10%
Dosage	Arkansas (4), Colorado (1), Delaware (2), District of Columbia (3), Florida (9), Georgia (3), Hawaii (5), Illinois (5), Indiana (5), Kansas (3), Kentucky (5), Louisiana (5), Massachusetts (4), Michigan (3), Minnesota (6), Mississippi (3), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (5), New Mexico (3), New York (10), North Carolina (5), Ohio (4), Oregon (2), Pennsylvania (7), Rhode Island (2), South Carolina (5), Texas (16), Virginia (5), Washington (5)	144	24.70%
Indication	Arkansas (3), Colorado (1), Delaware (2), District of Columbia (1), Florida (4), Georgia (1), Hawaii (3), Illinois (2), Indiana (3), Kansas (2), Kentucky (6), Louisiana (5), Massachusetts (2), Michigan (3), Minnesota (3), Mississippi (2), Nebraska (3), Nevada (1), New Hampshire (3), New Jersey (4), New Mexico (2), New York (8), North Carolina (5), Ohio (2), Oregon (2), Pennsylvania (4), South Carolina (3), Texas (13), Virginia (4), Washington (2)	99	16.98%

Response	States (Count of MCOs)	Count	Percentage
Polypharmacy	Arkansas (4), Colorado (1), Delaware (2), District of Columbia (3), Florida (9), Georgia (3), Hawaii (5), Illinois (3), Indiana (5), Iowa (2), Kansas (2), Louisiana (3), Maryland (1), Massachusetts (5), Michigan (2), Minnesota (6), Mississippi (3), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (3), New Mexico (1), New York (13), North Carolina (4), Ohio (5), Oregon (1), Pennsylvania (6), Rhode Island (1), South Carolina (4), Texas (15), Utah (2), Virginia (4), Washington (5)	132	22.64%
Other	Arkansas (3), Colorado (2), District of Columbia (2), Florida (7), Georgia (2), Hawaii (3), Illinois (4), Indiana (4), Kansas (2), Kentucky (1), Louisiana (2), Maryland (2), Michigan (7), Minnesota (3), Mississippi (2), Nebraska (1), Nevada (1), New Hampshire (3), New Jersey (3), New Mexico (1), New York (5), North Carolina (2), Ohio (2), Oregon (4), Pennsylvania (3), Rhode Island (2), South Carolina (1), Texas (4), Utah (1), Virginia (2), Washington (4)	85	14.58%
National Totals		**583**	**100%**

If “Child’s age,” please specify age limit in years.

Table 176 - Child’s Age Limits for Edits in Place to Monitor the Appropriate Use of Antipsychotic Drugs in Children

State	MCO Name	Age Limit in Years
AR	Arkansas_Total_Care_Inc.	10
AR	CareSource	18
AR	Empower_HealthCare_Solutions_LLC	17
AR	Summit_Community_Care	6
DC	CareFirst BCBS Community Health Plan DC	18
DC	MedStar Family Choice - District of Columbia	18
DE	AmeriHealth Caritas Delaware	18
DE	HighmarkHealthOptions	18
FL	Children's Medical Services	18
FL	Clear Health Alliance	6
FL	Community Care Plan	6
FL	Humana Medical Plan	17
FL	Molina Healthcare	17
FL	Simply Healthcare	6
FL	Sunshine	18
GA	Amerigroup GA	17
GA	CareSource	18
HI	AlohaCare	18
IA	Amerigroup	5
IA	Iowa Total Care	5
IL	Aetna_Better_Health_of_Illinois	8
IL	Blue_Cross_and_Blue_Shield_of_Illinois	18
IL	CountyCare_Health_Plan	8

State	MCO Name	Age Limit in Years
IL	Molina_Healthcare_of_Illinois,_Inc	8
IL	YouthCare_HealthChoice	8
IN	Anthem, Inc.	6
IN	CareSource	18
IN	Managed Health Services Indiana (MHS)	3
IN	MDwise, Inc.	12
KS	Aetna Better Health of Kansas	17
KS	Sunflower Health Plan	17
KS	UnitedHealthcare	6
KY	Aetna Better Health of Kentucky	18
KY	Anthem Inc. Kentucky	18
KY	Humana Healthy Horizons in Kentucky	18
KY	Passport Health Plan By Molina Healthcare	18
KY	United Healthcare Community Plan of Kentucky	18
KY	WellCare Health Plans	18
LA	Aetna Better Health of Louisiana	6
LA	AmeriHealth Caritas Louisiana	6
LA	Healthy Blue Louisiana	6
LA	Louisiana Healthcare Connections	6
LA	UnitedHealthcare Community Plan	6
MA	AllWays Health Partners	18
MA	Boston Medical Center Health Plan, Inc	6
MA	Fallon Community Health Plan, Inc.	17
MA	Health New England, Inc.	6
MA	Tufts Health Public Plans, Inc	6
MD	Aetna Better Health of Maryland	18
MI	Priority Health Choice	18
MI	Upper Peninsula Health Plan	17
MN	BluePlus	18
MN	HealthPartners	7
MN	HennepinHealth	18
MN	IMCare	6
MN	Medica	18
MN	PrimeWest	17
MN	UCare	18
MS	MS-MOLINA	18
NC	AMHC FFY22	17
NC	HB FFY22	18
NC	UHC FFY22	6
NE	HealthyBlueNebraska	18
NE	Nebraska Total Care	5
NH	AmeriHealth Caritas NH	18
NH	Well Sense	18
NJ	Aetna Better Health of New Jersey	18
NJ	Amerigroup Community Care	18

State	MCO Name	Age Limit in Years
NJ	Horizon NJ Health	18
NM	Blue Cross Blue Shield of New Mexico	18
NM	Presbyterian Health Plan	5
NV	Anthem Blue Cross Blue Shield	18
NV	Molina	18
NV	Silver Summit Health Plan	18
NY	AMIDA CARE	18
NY	Capital District Physicians' Health Plan	21
NY	Empire Blue Cross Blue Shield HealthPlus	6
NY	Excellus Health Plan	21
NY	Fidelis Care	20
NY	Healthfirst	21
NY	Highmark Blue Cross Blue Shield of Western New York	18
NY	Independent Health	6
NY	MetroPlus Health Plan	21
NY	MVP Health Care	20
NY	Univera Healthcare	21
NY	VNSNY CHOICE SelectHealth	20
OH	Buckeye Health Plan	18
OH	Molina Healthcare of Ohio	18
PA	Aetna Better Health of Pennsylvania	18
PA	Geisinger	18
PA	Health Partners	18
PA	Highmark Wholecare	18
PA	United Healthcare	18
PA	UPMC	17
PA	Vista	18
SC	Healthy Blue South Carolina	18
SC	Humana	17
SC	Molina Healthcare	18
TX	Aetna Better Health of Texas	3
TX	Blue Cross and Blue Shield of Texas	18
TX	Community First Health Plans	3
TX	Community Health Choice	18
TX	Cook Children's Health Plan	3
TX	Dell Children's Health Plan	3
TX	Driscoll Health Plan	3
TX	El Paso Health	5
TX	FirstCare Health Plans	3
TX	Molina Healthcare of Texas	3
TX	Parkland Community Health Plan	3
TX	Scott and White Health Plan	3
TX	Superior HealthPlan	21
TX	Texas Children's Health Plan	3
VA	AetnaBetterHealthofVirginia	18

State	MCO Name	Age Limit in Years
VA	Anthem	6
VA	MolinaCompleteCareofVirginia	17
VA	OptimaHealth	18
VA	UnitedHealthCare	18
VA	VirginiaPremier	18
WA	Amerigroup Washington Inc.	18
WA	Community Health Plan of Washington	17
WA	Coordinated Care Corporation	17
WA	Molina Healthcare of Washington, Inc.	17
WA	UnitedHealthcare Community Plan	17

c. If "Yes," please briefly explain the specifics of your documented antipsychotic monitoring program(s).

Please reference individual State MCO reports on Medicaid.gov for more information.

d. d. If "No" or "Covered through the FFS benefit ," does your MCO plan on implementing an antipsychotic program in the future?

Figure 140 - Future Plans to Implement an Antipsychotic Monitoring Program

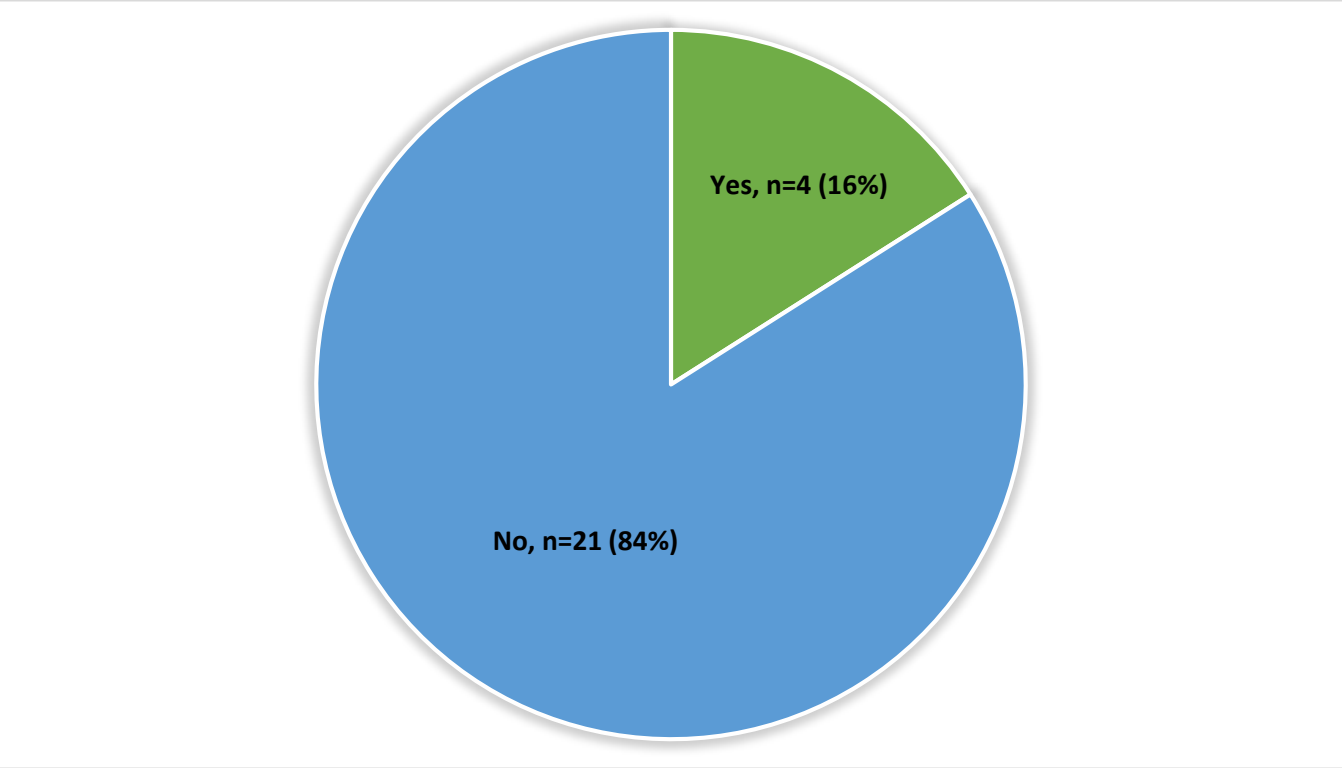

Table 177 - Future Plans to Implement an Antipsychotic Monitoring Program

Response	States (Count of MCOs)	Count	Percentage
Yes	District of Columbia (1), Maryland (1), Michigan (1), Oregon (1)	4	16.00%
No	Florida (1), Maryland (5), Oregon (13), Pennsylvania (1), Utah (1)	21	84.00%
National Totals		**25**	**100%**

If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of antipsychotic drugs in children.

Table 178 - When MCOs Plan to Implement a Program to Monitor Appropriate Use of Antipsychotic Drugs in Children

State	MCO Name	Explanation
DC	HealthServicesforSpecial NeedsChildren	HSCSN plans to develop the criteria in FY 2023 and implement in FY 2024.
MD	Jai Medical Systems Managed Care Organization, Inc.	Coverage of antipsychotic medications is carved out and covered under FFS Medicaid. Carved out pharmacy utilization data was not shared with the MCOs in a format that could be stored in the Rx engine at the PBM until late in the measurement year so retrospective monitoring could not be implemented until after the measurement year.
MI	McLaren Health Plan	MHP has implemented an monitoring program to monitor the appropriate use of antipsychotics in children FY23.
OR	Eastern Oregon Coordinated Care Organization (EOCCO)	We continue to work closely with the EOCCO Clinical Advisory Panel to effectively provide data in a digestible manner for validation of the appropriateness of prescription drug use. EOCCO provides a beneficiary roster to associated prescribers which may specify utilization data fields to aid in their retrospective monitoring of antipsychotic medications from which claims are provided by the FFS data feed. More conversations are being had on this front.

If "No," please explain why you will not be implementing a program to monitor the appropriate use of antipsychotic drugs in children.

Table 179 - Explanations for not Implementing a Program to Monitor Appropriate Use of Antipsychotic Drugs in Children

State	MCO Name	Explanation
FL	Florida Community Care	As a Long Term Care plan, our population is restricted to beneficiaries age 18 and above. We have no population of children.
MD	Amerigroup Community Care	Behavioral/Mental Health treatment class is carved-out of MCO and paid for by FFS program.
MD	CareFirst Community Health Plan Maryland	N/A. Antipsychotics are carved-out to the State.
MD	Maryland Physicians Care	FFS and Optum is responsible for managing programs for the Behavioral Health benefit.
MD	MedStar Family Choice	MFC does not manage this benefit as behavioral health treatment including medication is carved out to the State.
MD	Priority Partners MCO	The Behavioral/Mental Health treatment class is carved-out of MCO coverage and is administered by the FFS program.
OR	Advanced Health	Oregon FFS Medicaid has a program for monitoring appropriate use of antipsychotics in children. FFS pays for all antipsychotic medications for Medicaid beneficiaries in Oregon.
OR	Cascade Health Alliance	Antipsychotics are covered under the State's Fee For Service drug benefit.
OR	Health Share of Oregon/Kaiser Permanente	Appropriate prescribing is managed through our integrated medical record system [KP HealthConnect]. NOTE: Mental health drugs and services are carved out of our Medicaid agreement. POS edits are defined and managed by the State Medicaid agency.

State	MCO Name	Explanation
OR	Health Share of Oregon - Legacy Health/PacificSource	We will not be implementing a monitoring program as mental health medications are a benefit provided directly by the State and we coordinate all activities with Oregon Health Authority.
OR	Health Share of Oregon - OHSU	The Oregon Health Authority Prescription Drug Program monitors use of antipsychotic drugs in children that includes members of Oregon MCOs.
OR	InterCommunity Health Network	These medications are carved out by the State.
OR	PacificSource Community Solutions- Central Oregon	We will not be implementing a monitoring program as mental health medications are a benefit provided directly by the State and we coordinate all activities with Oregon Health Authority.
OR	PacificSource Community Solutions- Columbia Gorge	We will not be implementing a monitoring program as mental health medications are a benefit provided directly by the State and we coordinate all activities with Oregon Health Authority.
OR	PacificSource Community Solutions/Kaiser Permanente	Appropriate prescribing is managed through our integrated medical record system [KP HealthConnect]. NOTE: Mental health drugs and services are carved out of our Medicaid agreement. POS edits are defined and managed by the State Medicaid agency.
OR	PacificSource Community Solutions - Lane	We will not be implementing a monitoring program as mental health medications are a benefit provided directly by the State and we coordinate all activities with Oregon Health Authority.
OR	PacificSource Community Solutions - Marion/Polk	We will not be implementing a monitoring program as mental health medications are a benefit provided directly by the State and we coordinate all activities with Oregon Health Authority.
OR	Providence / Health Share of Oregon	Prescribers of antipsychotics in children are referred to State program known as OPAL-K.
OR	Yamhill Community Care Organization	Prescribers of antipsychotics in children are referred to State program known as OPAL-K.
PA	PA Health and Wellness	Currently our membership does not include patients under 18 years of age.
UT	SelectHealth	These products are carved-out to State Medicaid. However, SelectHealth will contact members who were recently discharged from a hospitalization or when a referral/request is made to SelectHealth.

Stimulants

3. Does your MCO currently have restrictions in place to limit the quantity of stimulant drugs?

Figure 141 - Restrictions in Place to Limit the Quantity of Stimulant Drugs

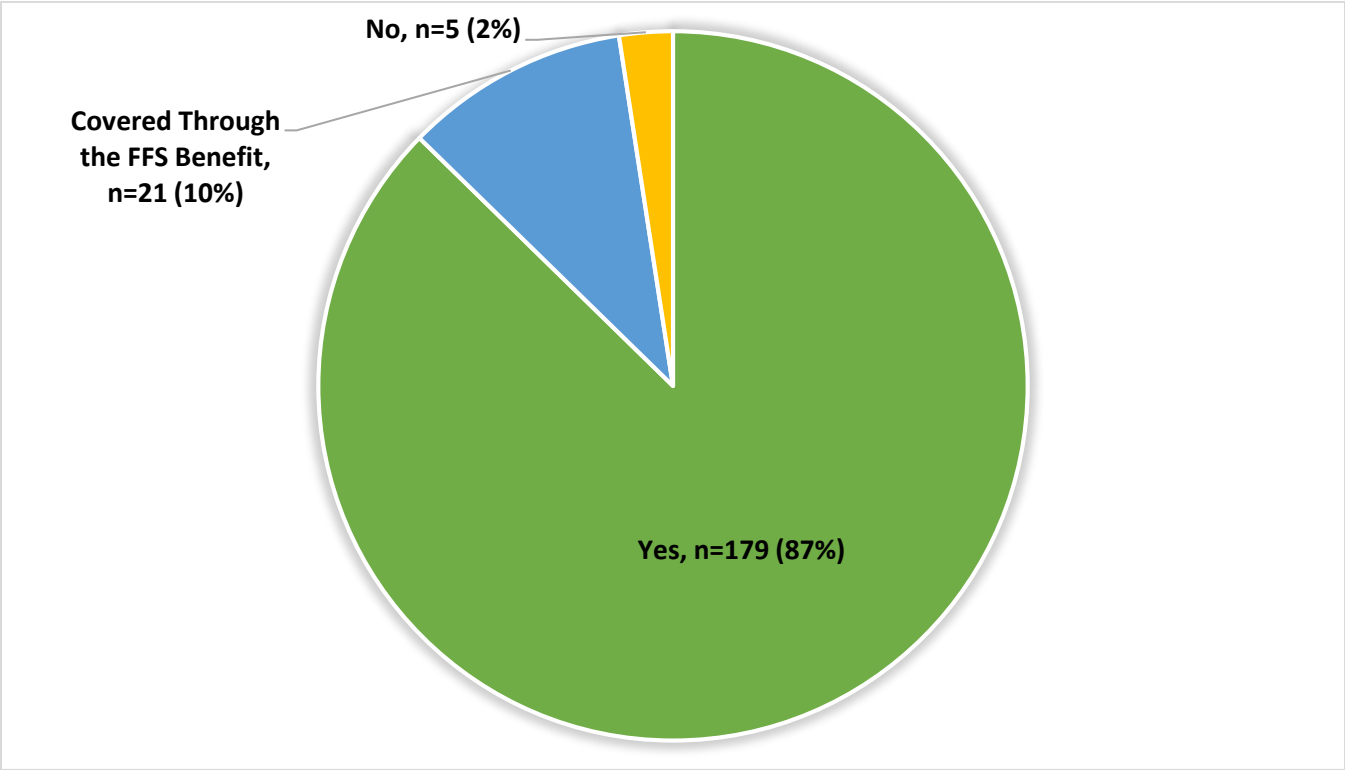

Table 180 - Restrictions in Place to Limit the Quantity of Stimulant Drugs

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (3), Massachusetts (5), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (19), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (16), Virginia (6), Washington (5)	179	87.32%
Covered through the FFS benefit	Maryland (9), Michigan (9), Utah (3)	21	10.24%
No	Louisiana (2), Oregon (2), Utah (1)	5	2.44%
National Totals		**205**	**100%**

4. Does your MCO have a documented program in place to either manage or monitor the appropriate use of stimulant drugs in children?

Figure 142 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Stimulant Drugs in Children

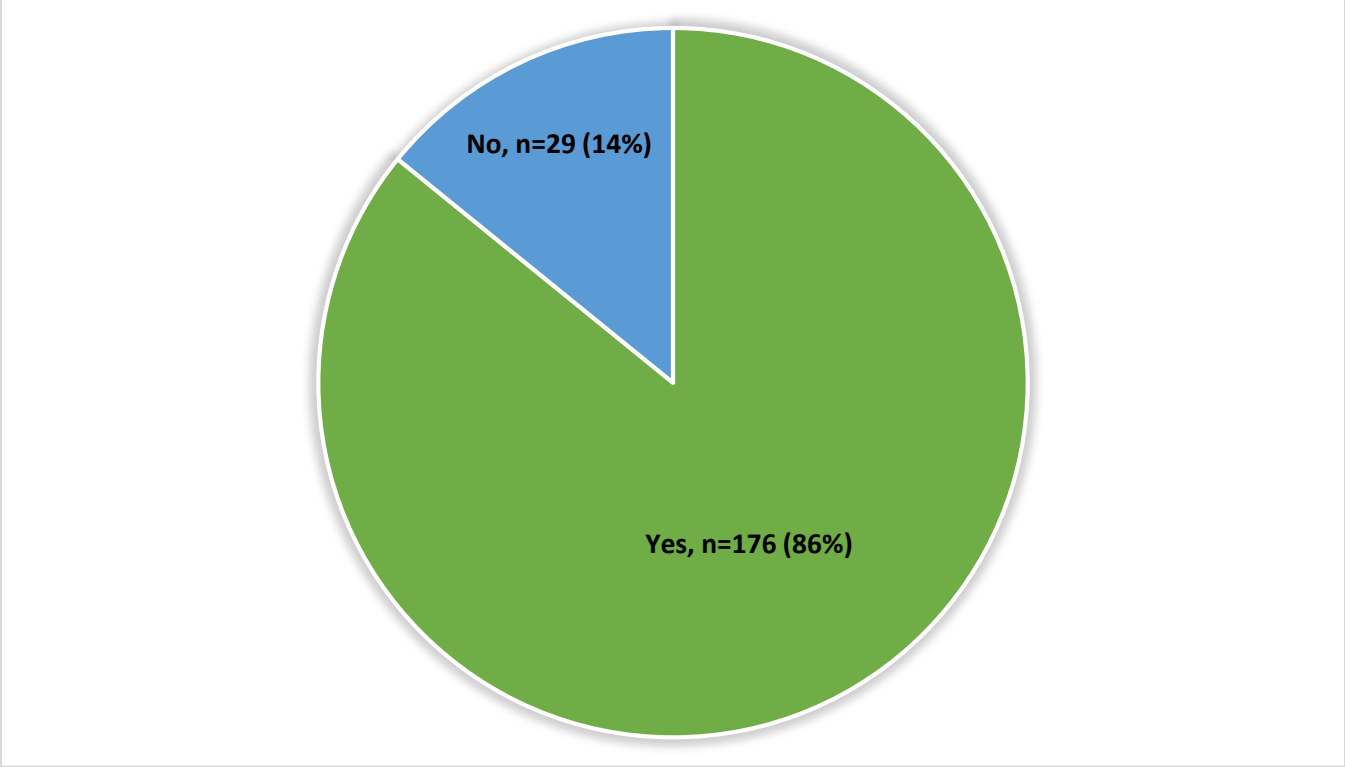

Table 181 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Stimulant Drugs in Children

Responses	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (1), Delaware (2), District of Columbia (1), Florida (10), Georgia (3), Hawaii (6), Illinois (5), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (1), Massachusetts (5), Michigan (4), Minnesota (6), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (19), Pennsylvania (6), Rhode Island (2), South Carolina (5), Texas (16), Utah (3), Virginia (5), Washington (5)	176	85.85%
No	Colorado (1), District of Columbia (3), Florida (1), Illinois (1), Maryland (8), Michigan (5), Minnesota (3), Oregon (2), Pennsylvania (2), Rhode Island (1), Utah (1), Virginia (1)	29	14.15%
National Totals		**205**	**100%**

a. If "Yes," does your MCO either manage or monitor:

Figure 143 - Categories of Children Either Managed or Monitored for Appropriate Use of Stimulant Drugs

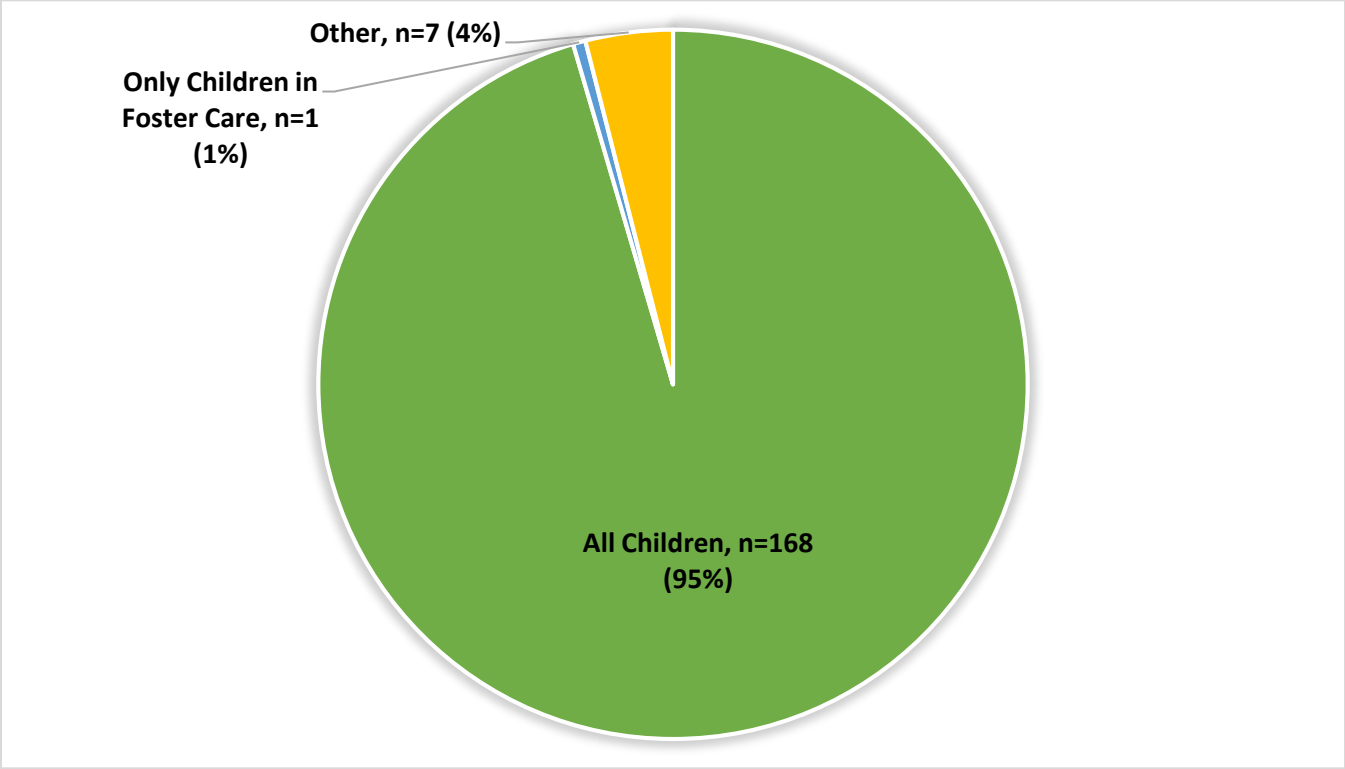

Table 182 - Categories of Children Either Managed or Monitored for Appropriate Use of Stimulant Drugs

Response	States (Count of MCOs)	Count	Percentage
All children	Arkansas (4), Colorado (1), Delaware (1), Florida (10), Georgia (3), Hawaii (6), Illinois (4), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (1), Massachusetts (5), Michigan (3), Minnesota (5), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (4), Oregon (19), Pennsylvania (4), Rhode Island (2), South Carolina (5), Texas (16), Utah (3), Virginia (5), Washington (5)	168	95.45%
Only children in foster care	Michigan (1)	1	0.57%
Other	Delaware (1), District of Columbia (1), Illinois (1), Minnesota (1), Ohio (1), Pennsylvania (2)	7	3.98%
National Totals		**176**	**100%**

b. If "Yes," does your MCO have edits in place to monitor (multiple responses allowed):

Figure 144 - Edits in Place to Monitor the Appropriate Use of Stimulant Drugs in Children

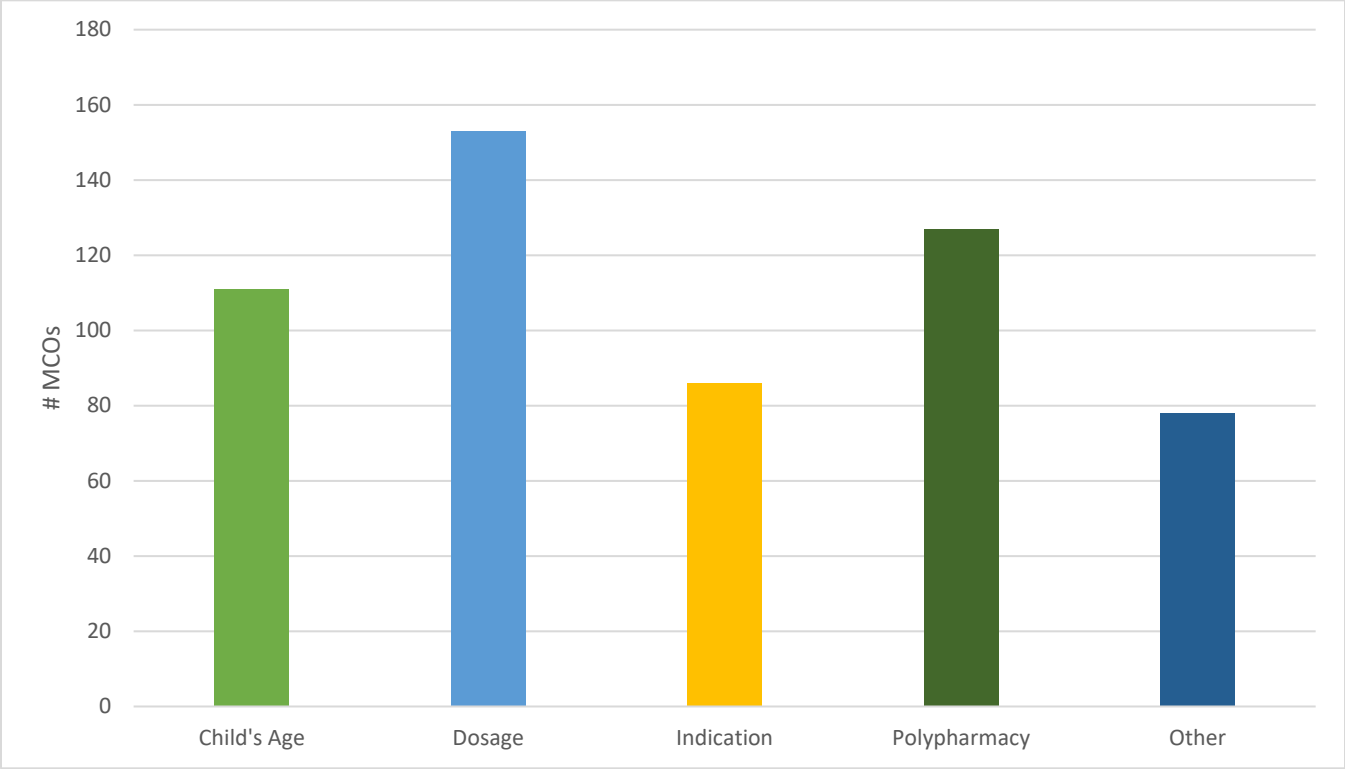

Table 183 - Edits in Place to Monitor the Appropriate Use of Stimulant Drugs in Children

Response	States (Count of MCOs)	Count	Percentage
Child's Age	Arkansas (4), Delaware (2), Florida (7), Georgia (1), Hawaii (1), Illinois (4), Indiana (4), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Massachusetts (5), Michigan (1), Minnesota (2), Mississippi (1), Nebraska (2), Nevada (2), New Hampshire (2), New Jersey (3), New Mexico (1), New York (11), North Carolina (3), Ohio (3), Oregon (4), Pennsylvania (5), South Carolina (3), Texas (14), Virginia (5), Washington (5)	111	20.00%
Dosage	Arkansas (4), Colorado (1), Delaware (2), District of Columbia (1), Florida (9), Georgia (3), Hawaii (5), Illinois (4), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (3), Massachusetts (5), Minnesota (4), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (12), North Carolina (5), Ohio (4), Oregon (16), Pennsylvania (6), Rhode Island (1), South Carolina (5), Texas (16), Virginia (5), Washington (5)	153	27.57%
Indication	Arkansas (3), Colorado (1), Delaware (1), Florida (4), Georgia (2), Hawaii (4), Illinois (1), Indiana (4), Kansas (2), Kentucky (6), Louisiana (4), Massachusetts (2), Minnesota (1), Mississippi (2), Nebraska (2), New Hampshire (3), New Jersey (4), New Mexico (2), New York (8), North Carolina (2), Ohio (1), Oregon (2), Pennsylvania (3), Rhode Island (1), South Carolina (3), Texas (14), Virginia (2), Washington (2)	86	15.50%

Response	States (Count of MCOs)	Count	Percentage
Polypharmacy	Arkansas (4), Colorado (1), Delaware (1), District of Columbia (1), Florida (8), Georgia (2), Hawaii (5), Illinois (3), Indiana (4), Kansas (2), Louisiana (4), Massachusetts (5), Minnesota (4), Mississippi (3), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (4), New Mexico (2), New York (13), North Carolina (4), Ohio (4), Oregon (6), Pennsylvania (6), Rhode Island (1), South Carolina (5), Texas (15), Utah (2), Virginia (4), Washington (5)	127	22.88%
Other	Arkansas (3), Colorado (1), Delaware (1), Florida (7), Georgia (1), Hawaii (4), Illinois (4), Indiana (4), Kansas (2), Kentucky (1), Louisiana (2), Maryland (1), Michigan (3), Minnesota (2), Mississippi (2), Nevada (2), New Hampshire (3), New Jersey (4), New Mexico (2), New York (4), North Carolina (1), Ohio (3), Oregon (4), Pennsylvania (3), Rhode Island (2), South Carolina (2), Texas (3), Utah (1), Virginia (2), Washington (4)	78	14.05%
National Totals		**555**	**100%**

If “Child’s age,” please specify age limit in years.

Table 184 - Child’s Age Limits for Edits in Place to Monitor the Appropriate Use of Stimulant Drugs in Children

State	MCO Name	Age Limit in Years
AR	Arkansas_Total_Care_Inc.	6
AR	CareSource	6
AR	Empower_HealthCare_Solutions_LLC	18
AR	Summit_Community_Care	6
DE	AmeriHealth Caritas Delaware	3
DE	HighmarkHealthOptions	4
FL	Children's Medical Services	18
FL	Clear Health Alliance	3
FL	Community Care Plan	6
FL	Humana Medical Plan	13
FL	Molina Healthcare	17
FL	Simply Healthcare	3
FL	Sunshine	18
GA	Amerigroup GA	5
HI	AlohaCare	21
IA	Amerigroup	3
IA	Iowa Total Care	3
IL	Aetna_Better_Health_of_Illinois	6
IL	Blue_Cross_and_Blue_Shield_of_Illinois	18
IL	CountyCare_Health_Plan	6
IL	Molina_Healthcare_of_Illinois,_Inc	6
IN	Anthem, Inc.	6
IN	CareSource	6
IN	Managed Health Services Indiana (MHS)	3
IN	MDwise, Inc.	12

State	MCO Name	Age Limit in Years
KS	Aetna Better Health of Kansas	3
KS	Sunflower Health Plan	3
KS	UnitedHealthcare	3
KY	Aetna Better Health of Kentucky	18
KY	Anthem Inc. Kentucky	18
KY	Humana Healthy Horizons in Kentucky	18
KY	Passport Health Plan By Molina Healthcare	18
KY	United Healthcare Community Plan of Kentucky	18
KY	WellCare Health Plans	18
LA	Aetna Better Health of Louisiana	6
LA	AmeriHealth Caritas Louisiana	6
LA	Healthy Blue Louisiana	6
LA	Louisiana Healthcare Connections	6
LA	UnitedHealthcare Community Plan	6
MA	AllWays Health Partners	18
MA	Boston Medical Center Health Plan, Inc	3
MA	Fallon Community Health Plan, Inc.	3
MA	Health New England, Inc.	3
MA	Tufts Health Public Plans, Inc	3
MI	Upper Peninsula Health Plan	12
MN	Medica	18
MN	UCare	6
MS	MS-MOLINA	18
NC	AMHC FFY22	17
NC	HB FFY22	18
NC	UHC FFY22	6
NE	HealthyBlueNebraska	18
NE	Nebraska Total Care	5
NH	AmeriHealth Caritas NH	18
NH	Well Sense	18
NJ	Aetna Better Health of New Jersey	18
NJ	Amerigroup Community Care	6
NJ	Horizon NJ Health	18
NM	Blue Cross Blue Shield of New Mexico	18
NV	Molina	18
NV	Silver Summit Health Plan	18
NY	AMIDA CARE	17
NY	Empire Blue Cross Blue Shield HealthPlus	6
NY	Excellus Health Plan	21
NY	Fidelis Care	20
NY	Healthfirst	21
NY	Highmark Blue Cross Blue Shield of Western New York	6

State	MCO Name	Age Limit in Years
NY	Independent Health	6
NY	MetroPlus Health Plan	21
NY	Molina Healthcare of New York	18
NY	Univera Healthcare	21
NY	VNSNY CHOICE SelectHealth	20
OH	Buckeye Health Plan	18
OH	CareSource	12
OH	Molina Healthcare of Ohio	18
OR	Advanced Health	5
OR	AllCare CCO	6
OR	InterCommunity Health Network	18
OR	Umpqua Health Alliance (UHA)	6
PA	Aetna Better Health of Pennsylvania	18
PA	Highmark Wholecare	4
PA	United Healthcare	4
PA	UPMC	3
PA	Vista	4
SC	Healthy Blue South Carolina	5
SC	Humana	17
SC	Molina Healthcare	18
TX	Aetna Better Health of Texas	3
TX	Blue Cross and Blue Shield of Texas	18
TX	Community First Health Plans	18
TX	Community Health Choice	18
TX	Cook Children's Health Plan	3
TX	Dell Children's Health Plan	18
TX	Driscoll Health Plan	3
TX	El Paso Health	3
TX	FirstCare Health Plans	3
TX	Molina Healthcare of Texas	6
TX	Parkland Community Health Plan	18
TX	Scott and White Health Plan	3
TX	Superior HealthPlan	21
TX	Texas Children's Health Plan	18
VA	Anthem	6
VA	MolinaCompleteCareofVirginia	4
VA	OptimaHealth	18
VA	UnitedHealthCare	4
VA	VirginiaPremier	18
WA	Amerigroup Washington Inc.	18
WA	Community Health Plan of Washington	17
WA	Coordinated Care Corporation	17
WA	Molina Healthcare of Washington, Inc.	17
WA	UnitedHealthcare Community Plan	17

c. If "Yes," please briefly explain the specifics of your documented stimulant monitoring program(s).

Please reference individual State MCO reports on Medicaid.gov for more information.

d. If "No" or "Covered through the FFS benefit," does your MCO plan on implementing a stimulant monitoring program in the future?

Figure 145 - Future Plans to Implement a Stimulant Monitoring Program

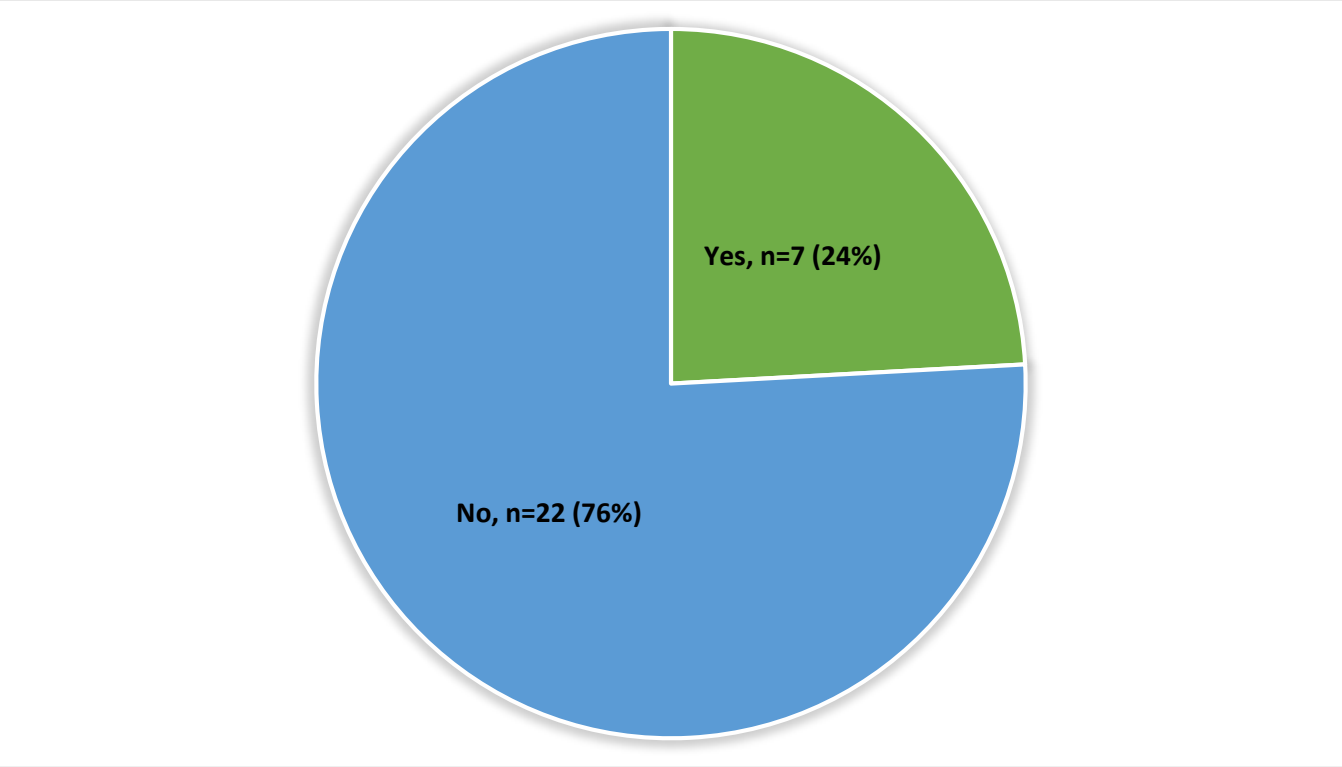

Table 185 Future Plans to Implement a Stimulant Monitoring Program

Response	States (Count of MCOs)	Count	Percentage
Yes	Colorado (1), District of Columbia (1), Maryland (2), Michigan (1), Minnesota (1), Virginia (1)	7	24.14%
No	District of Columbia (2), Florida (1), Illinois (1), Maryland (6), Michigan (4), Minnesota (2), Oregon (2), Pennsylvania (2), Rhode Island (1), Utah (1)	22	75.86%
National Totals		**29**	**100%**

If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of stimulant drugs in children.

Table 186 - When MCOs Plan to Implement a Program to Monitor the Appropriate Use of Stimulant Drugs in Children

State	MCO Name	Explanation
CO	Denver Health Medicaid Choice	No specific timeline, but trying to implement in Fiscal Year 2023
DC	HealthServicesforSpecialNeedsChildren	HSCSN plans to develop the criteria in FY 2023 and implement in FY 2024.
MD	Aetna Better Health of Maryland	Our plan is working with Informatics team to build a retrospective controlled substance utilization report that will capture overutilization and concurrent

State	MCO Name	Explanation
		utilization for all controlled substances including stimulants. This report will be used to identify members who are candidate for pharmacy restriction as well as case management outreach. Current timeline is 2023
MD	Jai Medical Systems Managed Care Organization, Inc.	Coverage of stimulant medications is carved out and covered under FFS Medicaid. Carved out pharmacy utilization data was not shared with the MCOs in a format that could be stored in the Rx engine at the PBM until late in the measurement year so retrospective monitoring could not be implemented until after the measurement year.
MI	McLaren Health Plan	Stimulant medications are a carved out benefit managed by the State of Michigan FFS Medicaid. The plan is working towards implementing a monitoring program FY23.
MN	IMCare	Yes. Have been discussing as State wide program but there has been lack of buy in.
VA	AetnaBetterHealthofVirginia	The program is less directed at the assessment of utilization upon prescribing. Instead, the program implemented after this survey was directed at the HEDIS measure- Follow-Up Care for Children Prescribed ADHD Medication (ADD).

If "No," please explain why you will not be implementing a program to monitor the appropriate use of stimulant drugs in children.

Table 187 - Explanation for Not Implementing a Program to Monitor Use of Stimulant Drugs in Children

State	MCO Name	Explanation
DC	CareFirst BCBS Community Health Plan DC	In the 2021 DUR MCO Annual Survey submission, CareFirst CHPDC had planned to implement a program to monitor the use of stimulant drugs in children similar to the current policy in place for monitoring the use of antipsychotic in pediatrics. We had planned to implement the program by October 2022, which is when the new contract procurement from Department of Healthcare Finance (DHCF) was finalized. Despite the MCO's preparations to create a report that would capture prescription and medical claims data to conduct the DUR, the monitoring program was not carried out due to CareFirst CHPDC not being awarded the contract in 2022
DC	MedStar Family Choice - District of Columbia	Various components of MFC's pharmacy oversight include review of stimulant medications in children. The Pharmacy Lock-in program provides oversight for FWA, including misuse of controlled substance medications such as stimulants. Enrollees are screened for use of 3 or more controlled substances, controls from 3 or more prescribers, and/or controls filled at 3 or more pharmacies. Additionally, antipsychotic medications requiring prior authorization must include clinical documentation from the prescribing provider to justify medication selection and dosing regimen.
FL	Florida Community Care	As a Long Term Care plan, our population is restricted to beneficiaries age 18 and above. We have no population of children.
IL	MeridianHealth	No plans to implement at this time. Providers have access to medical information and are able to prescribe according the preferred drug list.
MD	Amerigroup Community Care	Behavioral/Mental Health treatment class is carved-out of MCO and paid for by FFS program.
MD	CareFirst Community Health Plan Maryland	N/A. Stimulant drugs in children are carved-out to the State.

State	MCO Name	Explanation
MD	Kaiser Foundation Health Plan of the Mid-Atlantic States	Covered through Fee for Service.
MD	Maryland Physicians Care	FFS and Optum is responsible for managing programs for the Behavioral Health benefit.
MD	MedStar Family Choice	MFC does not manage this benefit as behavioral health treatment including medication is carved out to the State.
MD	Priority Partners MCO	The Behavioral/Mental Health treatment class is carved-out of MCO benefit coverage and is administered by the FFS program.
MI	HAP Empowered	These medications are carved out and managed by the State through FFS Medicaid.
MI	Meridian Health Plan	This is currently carve out. Our Pharmacy Benefit Manger has programs in place for other plans without a carve out so we could explore the options in the future if we have data that can be formatted into the logic for the pharmacy benefit manager program.
MI	Molina Healthcare of Michigan	These medications are carved out to FFS.
MI	Priority Health Choice	In Michigan, coverage of these drugs is carved out to the Fee For Service Medicaid program.
MN	BluePlus	Implementing a stimulant retrospective DUR program in MN would be difficult due to MN Statute 144.293 which allows us to only share information with providers in the same practice. The benefit of a retroDUR stimulant program would be to encourage the coordination of care amongst multiple providers but that opportunity is quite difficult without sharing information on diagnoses and/or medications with all relevant providers. Blue Plus does have an ADHD mail campaign that encourages the parents of a child with newly prescribed stimulants to follow up with their prescribers within 30 days of the first fill of an ADHD medication and two additional prescriber appointments within 270 days.
MN	HealthPartners	HealthPartners has quantity limits to ensure reasonable doses, but is not planning diagnosis reviews for prescriptions within the quantity limit at this time. HealthPartners does review the diagnosis for all prescriptions for children over the quantity limit. HealthPartners does have a retrospective review program, for controlled substances (including stimulants), without a recent clinic visit for monitoring.
OR	Health Share of Oregon/Kaiser Permanente	Appropriate prescribing is managed through our integrated medical record system [KP HealthConnect].
OR	PacificSource Community Solutions/Kaiser Permanente	Appropriate prescribing is managed through our integrated medical record system [KP HealthConnect].
PA	Health Partners	no plans are in place at this time. Currently, stimulants will pay at POS for under 21 year of age
PA	PA Health and Wellness	Currently our membership does not include patients under 18 years of age

State	MCO Name	Explanation
RI	THP	The MCO does have dose edits in place for all members. The MCO will implement additional program edits (e.g., age, polypharmacy) if claims data indicate it is needed for our members or the State directs us to do so.
UT	SelectHealth	These products are carved-out to State Medicaid. However, SelectHealth will contact members who were recently discharged from a hospitalization or when a referral/request is made to SelectHealth.

Antidepressants

5. Does your MCO have a documented program in place to either manage or monitor the appropriate use of antidepressant drugs in children?

Figure 146 - Documented Program in Place to Either Manage or Monitor Appropriate Use of Antidepressant Drugs in Children

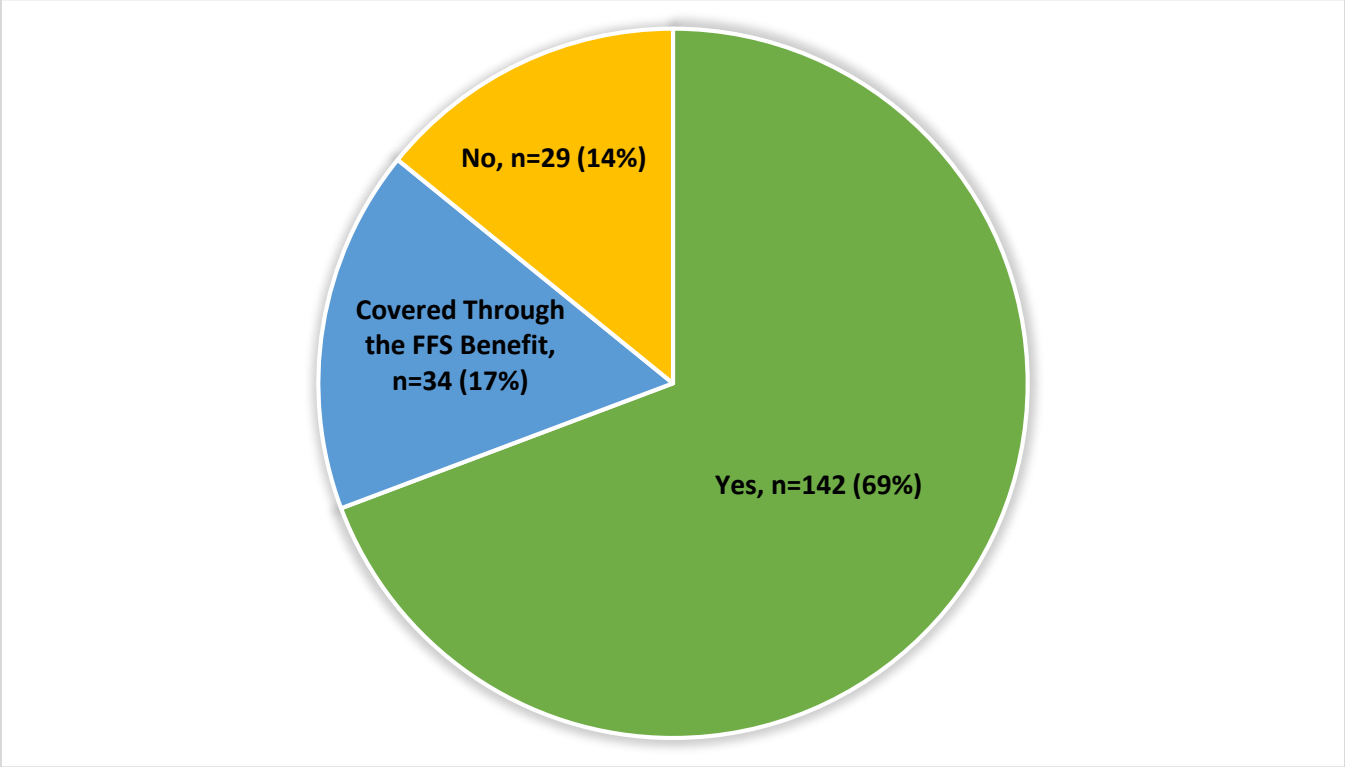

Table 188 - Documented Program in Place to Either Manage or Monitor Appropriate Use of Antidepressant Drugs in Children

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (3), Colorado (1), Delaware (2), Florida (10), Georgia (3), Hawaii (6), Illinois (5), Indiana (5), Kansas (3), Louisiana (5), Maryland (1), Massachusetts (5), Michigan (3), Minnesota (5), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (4), Oregon (3), Pennsylvania (5), Rhode Island (2), South Carolina (5), Texas (15), Virginia (5), Washington (5)	142	69.27%
Covered through the FFS benefit	Maryland (8), Michigan (6), Oregon (17), Utah (3)	34	16.59%

Response	States (Count of MCOs)	Count	Percentage
No	Arkansas (1), Colorado (1), District of Columbia (4), Florida (1), Illinois (1), Iowa (2), Kentucky (6), Minnesota (4), Ohio (1), Oregon (1), Pennsylvania (3), Rhode Island (1), Texas (1), Utah (1), Virginia (1)	29	14.15%
National Totals		**205**	**100%**

a. If "Yes," does your MCO either manage or monitor:

Figure 147 - Categories of Children Either Managed or Monitored for Appropriate Use of Antidepressant Drugs

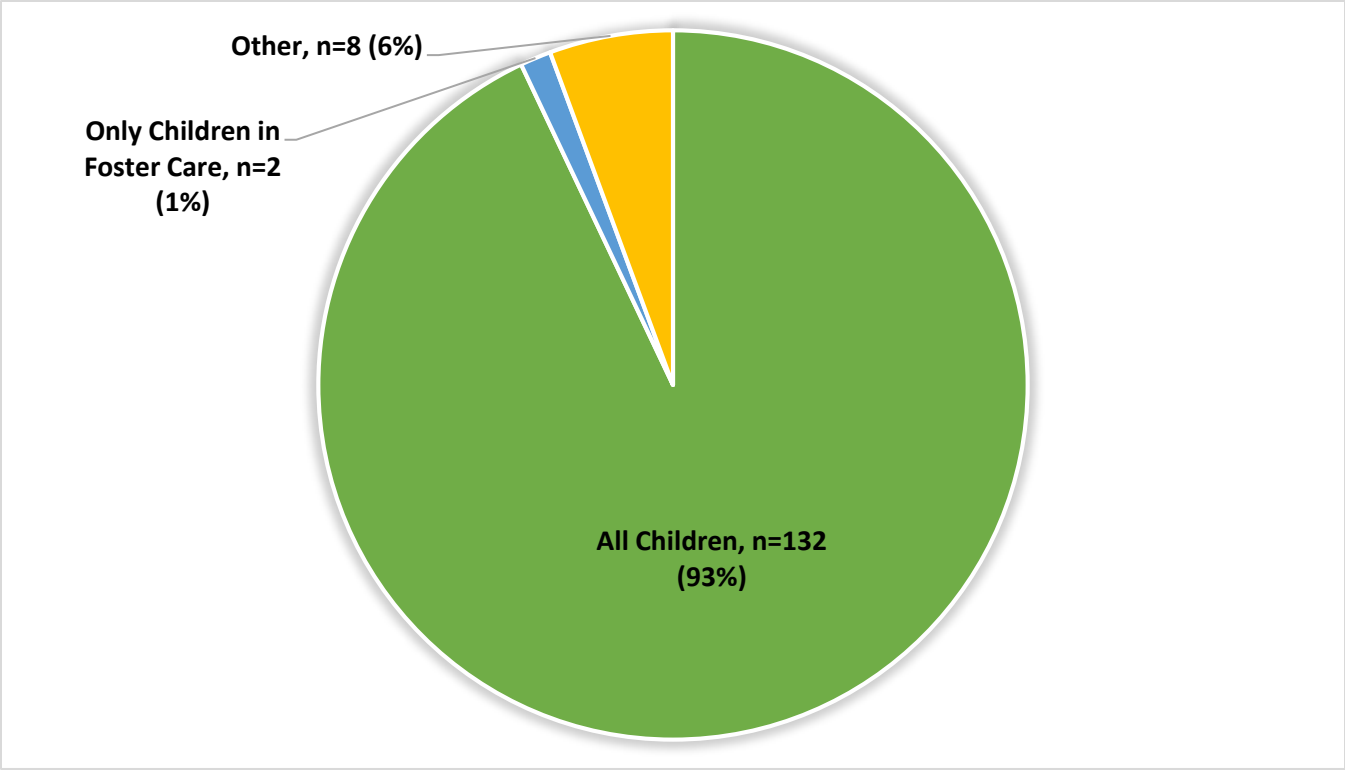

Table 189 - Categories of Children Either Managed or Monitored for Appropriate Use of Antidepressant Drugs

Response	States (Count of MCOs)	Count	Percentage
All children	Arkansas (3), Colorado (1), Delaware (2), Florida (10), Georgia (3), Hawaii (4), Illinois (4), Indiana (5), Kansas (3), Louisiana (5), Maryland (1), Massachusetts (5), Michigan (2), Minnesota (5), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (4), New Mexico (3), New York (15), North Carolina (4), Ohio (3), Oregon (3), Pennsylvania (4), Rhode Island (2), South Carolina (4), Texas (14), Virginia (5), Washington (5)	132	92.96%
Only children in foster care	Michigan (1), South Carolina (1)	2	1.41%
Other	Hawaii (2), Illinois (1), New Jersey (1), North Carolina (1), Ohio (1), Pennsylvania (1), Texas (1)	8	5.63%
National Totals		**142**	**100%**

b. If "Yes," does your MCO have edits in place to monitor (multiple responses allowed):

Figure 148 - Edits in Place to Monitor the Appropriate Use of Antidepressant Drugs in Children

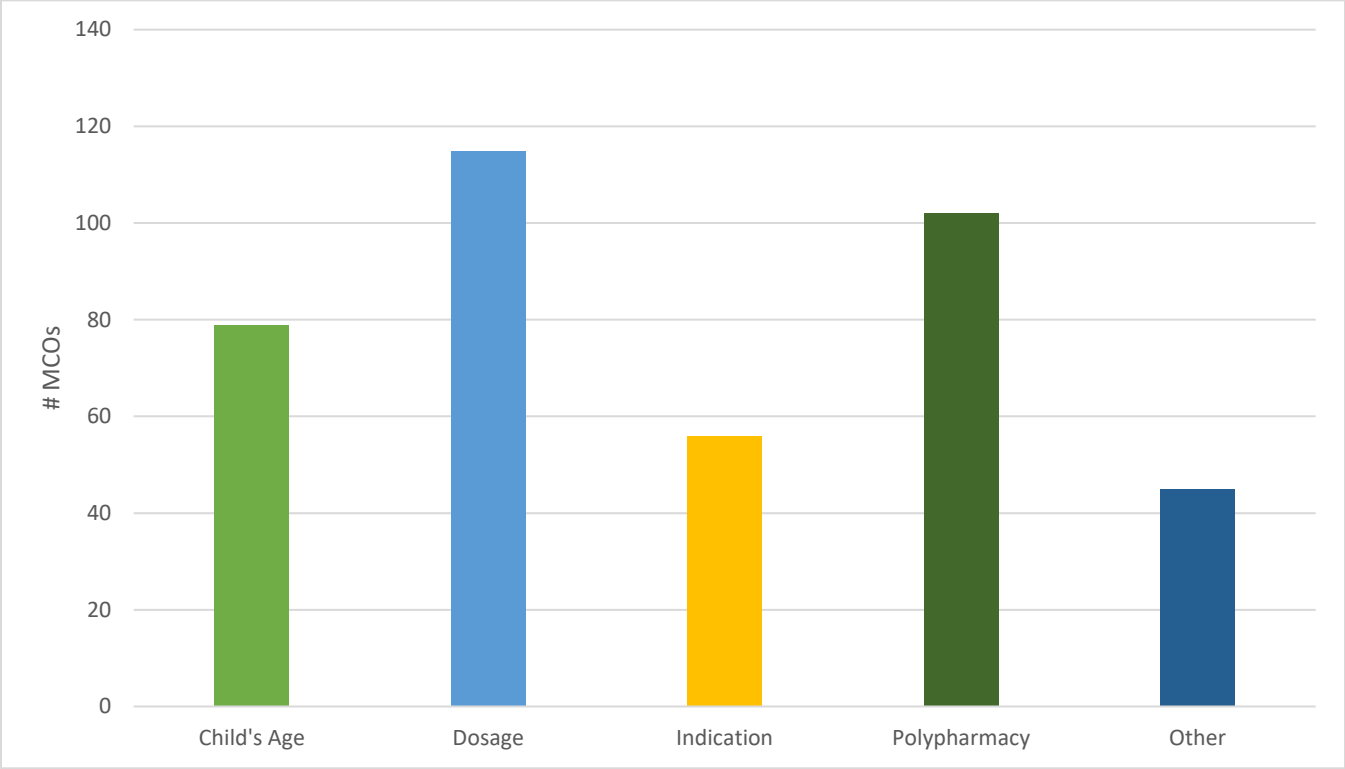

Table 190 - Edits in Place to Monitor the Appropriate Use of Antidepressant Drugs in Children

Response	States (Count of MCOs)	Count	Percentage
Child's Age	Arkansas (3), Delaware (2), Florida (7), Georgia (1), Illinois (1), Indiana (4), Kansas (1), Louisiana (5), Massachusetts (5), Minnesota (4), Mississippi (1), Nebraska (2), Nevada (2), New Hampshire (2), New Jersey (3), New Mexico (1), New York (12), North Carolina (3), Ohio (1), Pennsylvania (1), South Carolina (4), Texas (6), Virginia (3), Washington (5)	79	19.90%
Dosage	Arkansas (3), Colorado (1), Delaware (1), Florida (9), Georgia (3), Hawaii (5), Illinois (4), Indiana (5), Kansas (3), Louisiana (3), Massachusetts (4), Minnesota (4), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (11), North Carolina (5), Ohio (4), Oregon (1), Pennsylvania (5), Rhode Island (1), South Carolina (4), Texas (11), Virginia (3), Washington (4)	115	28.97%
Indication	Arkansas (3), Delaware (1), Florida (3), Georgia (2), Hawaii (1), Indiana (2), Kansas (1), Louisiana (3), Massachusetts (2), Mississippi (1), Nebraska (2), Nevada (2), New Hampshire (3), New Jersey (3), New Mexico (2), New York (6), North Carolina (2), Ohio (1), Oregon (2), Pennsylvania (1), South Carolina (5), Texas (5), Virginia (1), Washington (2)	56	14.11%

Response	States (Count of MCOs)	Count	Percentage
Polypharmacy	Arkansas (3), Delaware (1), Florida (7), Georgia (2), Hawaii (3), Illinois (3), Indiana (4), Kansas (3), Louisiana (2), Massachusetts (5), Minnesota (4), Mississippi (3), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (2), New Mexico (1), New York (11), North Carolina (4), Ohio (3), Oregon (1), Pennsylvania (5), Rhode Island (1), South Carolina (4), Texas (12), Virginia (5), Washington (4)	102	25.69%
Other	Arkansas (3), Delaware (1), Florida (4), Georgia (1), Hawaii (1), Illinois (2), Indiana (3), Kansas (2), Louisiana (2), Maryland (1), Michigan (3), Mississippi (2), Nevada (1), New Hampshire (3), New Jersey (2), New Mexico (2), New York (3), Ohio (1), Oregon (1), Rhode Island (1), Texas (2), Washington (4)	45	11.34%
National Totals		**397**	**100%**

If “Child’s age,” please specify age limit in years.

Table 191 - Child’s Age Limits for Edits in Place to Monitor the Appropriate Use of Antidepressant Drugs in Children

State	MCO Name	Age Limit in Years
AR	Arkansas_Total_Care_Inc.	0
AR	CareSource	4
AR	Summit_Community_Care	6
DE	AmeriHealth Caritas Delaware	6
DE	HighmarkHealthOptions	18
FL	Children's Medical Services	18
FL	Clear Health Alliance	6
FL	Community Care Plan	6
FL	Humana Medical Plan	13
FL	Molina Healthcare	17
FL	Simply Healthcare	6
FL	Sunshine	18
GA	Amerigroup GA	5
IL	Blue_Cross_and_Blue_Shield_of_Illinois	18
IN	Anthem, Inc.	6
IN	CareSource	18
IN	Managed Health Services Indiana (MHS)	3
IN	MDwise, Inc.	12
KS	Aetna Better Health of Kansas	17
LA	Aetna Better Health of Louisiana	6
LA	AmeriHealth Caritas Louisiana	6
LA	Healthy Blue Louisiana	6
LA	Louisiana Healthcare Connections	6
LA	UnitedHealthcare Community Plan	6
MA	AllWays Health Partners	18
MA	Boston Medical Center Health Plan, Inc	6
MA	Fallon Community Health Plan, Inc.	6
MA	Health New England, Inc.	6

State	MCO Name	Age Limit in Years
MA	Tufts Health Public Plans, Inc	6
MN	BluePlus	18
MN	HennepinHealth	18
MN	Medica	18
MN	UCare	18
MS	MS-MOLINA	18
NC	AMHC FFY22	17
NC	HB FFY22	18
NC	UHC FFY22	6
NE	HealthyBlueNebraska	18
NE	Nebraska Total Care	4
NH	AmeriHealth Caritas NH	18
NH	Well Sense	18
NJ	Aetna Better Health of New Jersey	18
NJ	Amerigroup Community Care	6
NJ	Horizon NJ Health	18
NM	Blue Cross Blue Shield of New Mexico	18
NV	Molina	18
NV	Silver Summit Health Plan	18
NY	AMIDA CARE	17
NY	Empire Blue Cross Blue Shield HealthPlus	6
NY	Excellus Health Plan	21
NY	Fidelis Care	20
NY	Healthfirst	21
NY	Highmark Blue Cross Blue Shield of Western New York	6
NY	Independent Health	6
NY	MetroPlus Health Plan	21
NY	Molina Healthcare of New York	0
NY	MVP Health Care	20
NY	Univera Healthcare	21
NY	VNSNY CHOICE SelectHealth	20
OH	Buckeye Health Plan	18
PA	Aetna Better Health of Pennsylvania	18
SC	Healthy Blue South Carolina	5
SC	Humana	17
SC	Molina Healthcare	18
SC	Select Health of South Carolina, Inc.	6
TX	Blue Cross and Blue Shield of Texas	18
TX	Cook Children's Health Plan	18
TX	El Paso Health	18
TX	Molina Healthcare of Texas	18
TX	Parkland Community Health Plan	18
TX	Superior HealthPlan	21
VA	Anthem	6
VA	MolinaCompleteCareofVirginia	18

State	MCO Name	Age Limit in Years
VA	OptimaHealth	18
WA	Amerigroup Washington Inc.	18
WA	Community Health Plan of Washington	17
WA	Coordinated Care Corporation	17
WA	Molina Healthcare of Washington, Inc.	17
WA	UnitedHealthcare Community Plan	17

c. If "Yes," please briefly explain the specifics of your documented antidepressant monitoring program(s).

Please reference individual State MCO reports on Medicaid.gov for more information.

d. If "No" or "Covered through the FFS benefit," does your MCO plan on implementing an antidepressant program in the future?

Figure 149 - Future Plans to Implement an Antidepressant Monitoring Program

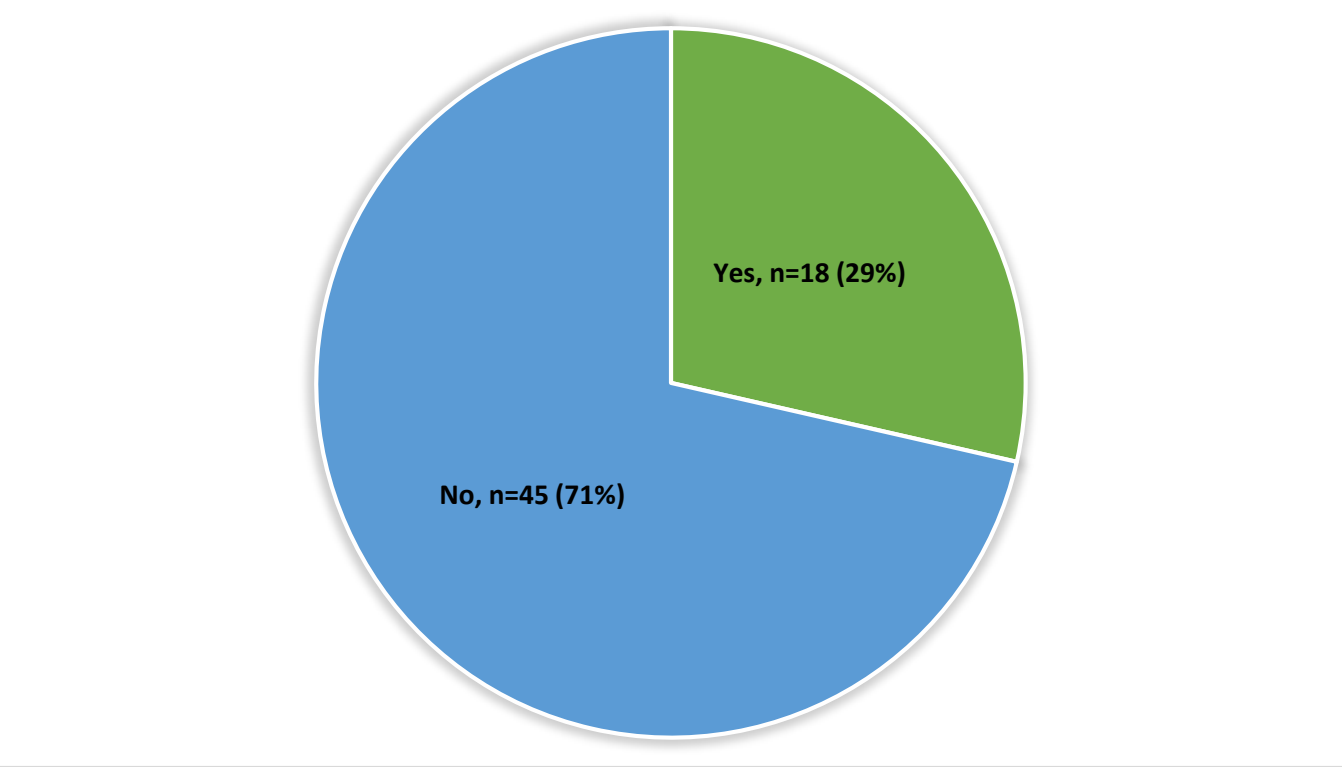

Table 192 - Future Plans to Implement an Antidepressant Monitoring Program

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (1), Colorado (1), District of Columbia (1), Iowa (2), Kentucky (6), Maryland (2), Michigan (1), Utah (3), Virginia (1)	18	28.57%
No	District of Columbia (3), Florida (1), Illinois (1), Maryland (6), Michigan (5), Minnesota (4), Ohio (1), Oregon (18), Pennsylvania (3), Rhode Island (1), Texas (1), Utah (1)	45	71.43%
National Totals		**63**	**100%**

If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of antidepressant drugs in children.

Table 193 - When MCOs Plan to Implement a Program to Monitor the Appropriate Use of Antidepressant Drugs in Children

State	MCO Name	Explanation
AR	Empower_HealthCare_Solutions_LLC	This is an opportunity that is still under review
CO	Denver Health Medicaid Choice	The MCO would like to implement this program, but there are no plans currently.
DC	HealthServicesforSpecialNeedsChildren	HSCSN plans to develop the criteria in FY 2023 and implement in FY 2024.
IA	Amerigroup	Can look at as a future topic for DUR Commission, date to be determined.
IA	Iowa Total Care	Can look at as a future topic for the DUR Commission, date to be determined
KY	Aetna Better Health of Kentucky	Monitoring program will start in 3Q2023
KY	Anthem Inc. Kentucky	Monitoring program will start in 3Q23.
KY	Humana Healthy Horizons in Kentucky	Monitoring program will start in 3Q23.
KY	Passport Health Plan By Molina Healthcare	Monitoring program will begin in 3Q23
KY	United Healthcare Community Plan of Kentucky	Monitoring program will start in 3Q2023.
KY	WellCare Health Plans	Monitoring program will start in 3Q23
MD	Aetna Better Health of Maryland	The plan's Pharmacy Director will leverage behavioral health pharmacy claims from the State (received as post adjudication files from FFS) to incorporate into monthly RetroDUR report to look at antidepressant prescribing in children (less than 18 years old). Program currently in place.
MD	Jai Medical Systems Managed Care Organization, Inc.	Coverage of antidepressant medications is carved out and covered under FFS Medicaid. Carved out pharmacy utilization data was not shared with the MCOs in a format that could be stored in the Rx engine at the PBM until late in the measurement year so retrospective monitoring could not be implemented until after the measurement year.
MI	McLaren Health Plan	Antidepressant medications are a carved out benefit managed by the State of Michigan FFS Medicaid. The plan is working towards implementing a monitoring program FY23.
UT	Healthy U	Q1CY2024
UT	Molina Healthcare of Utah	Molina has begun monitoring antidepressant adherence and utilization by children.
UT	Steward Health Choice Utah	We plan to implement Q1CY2024.
VA	VirginiaPremier	The plan will review this class and identify potential areas for concern and implement future monitoring.

If "No," please explain why you will not be implementing a program to monitor the appropriate use of antidepressant drugs in children.

Table 194 - Explanation for Not Implementing a Program to Monitor Use of Antidepressant Drugs in Children

State	MCO Name	Explanation
DC	AmeriHealth Caritas DC	We already have prospective and retrospective edits in place that monitor for duplicate therapy and safety edits for dosing, quantity limits, drug interactions, and high dosage that are already a part of our proDUR and retroDUR programs.
DC	CareFirst BCBS Community Health Plan DC	In the 2021 DUR MCO Annual Survey submission, CareFirst CHPDC had planned to implement a program to monitor the use of antidepressant drugs in children similar to the current policy in place for monitoring the use of antipsychotic in pediatrics. We had planned to implement the program by October 2022 which is when the new contract procurement from Department of Healthcare Finance (DHCF) was finalized. Despite the MCO's preparations to create a report that would capture prescription and medical claims data to conduct the DUR, this monitoring program was not carried out due to CareFirst CHPDC not being awarded the contract in 2022.
DC	MedStar Family Choice - District of Columbia	MFC recognizes the importance of oversight of use of antidepressants in children. After we conclude the process of integrating behavioral health we will specify a process to implement a monitoring program.
FL	Florida Community Care	As a Long Term Care plan, our population is restricted to beneficiaries age 18 and above. We have no population of children.
IL	MeridianHealth	No plans to implement at this time. Providers have access to medical information and are able to prescribe according the preferred drug list.
MD	Amerigroup Community Care	Behavioral/Mental Health treatment class is carved-out of MCO and paid for by FFS program.
MD	CareFirst Community Health Plan Maryland	N/A. Antidepressant drugs in children are carved-out to the State.
MD	Kaiser Foundation Health Plan of the Mid-Atlantic States	Covered through Fee for Service.
MD	Maryland Physicians Care	FFS and Optum is responsible for managing programs for the Behavioral Health benefit.
MD	MedStar Family Choice	MFC does not manage this benefit as behavioral health treatment including medication is carved out to the State.
MD	Priority Partners MCO	The Behavioral/Mental Health treatment class is carved-out of MCO benefit coverage and is administered by the FFS program.
MI	HAP Empowered	These medications are carved out and managed by the State through FFS Medicaid.
MI	Meridian Health Plan	This is currently carve out. Our Pharmacy Benefit Manger has programs in place for other plans without a carve out so we could explore the options in the future if we have data.
MI	Molina Healthcare of Michigan	These medications are carved out to FFS.
MI	Priority Health Choice	In Michigan, coverage of these drugs is carved out to the Fee For Service Medicaid program.
MI	Upper Peninsula Health Plan	Antidepressants are a carve-out benefit from the health plan.
MN	HealthPartners	Current Medication Monitoring programs for BH medications align with HEDIS which monitors antidepressant adherence for members 18+ years old.

State	MCO Name	Explanation
MN	IMCare	Current practice and behavioral health status of our members does not warrant a monitoring program specifically, although we do monitor trends to assess if use is going up and if there are adequate providers to meet these patients needs.
MN	PrimeWest	At this time, use of antidepressant drugs in children has not been identified as an at-risk area for members. Claims review and authorizations have not demonstrated areas of concern. Consideration will be given to implementing a program to monitor the appropriate use of mood stabilizing drugs in children in the future.
MN	SouthCountry	The DUR Board continues its ongoing review of a variety of medication classes with information derived from a variety of sources. Antidepressant medications will be considered, along with others, for more in-depth review and possible action as we continue to prioritize effective use of our resources.
OH	Paramount	Currently, limitations/edits for antidepressants are drug-specific and apply to all members regardless of age. Edits for antidepressants are dependent on the details outlined on the Ohio Department of Medicaid's UPDL. Drugs that are not on the UPDL must be reviewed for age, dosage, and FDA approved use. Paramount does not plan to implement a new program due to the fact that the pharmacy benefit will be handled by the State's chosen single PBM.
OR	Advanced Health	Antidepressants are paid for by FFS Medicaid in Oregon. They are not covered by Advanced Health.
OR	Cascade Health Alliance	Antidepressants are covered under the State's Fee For Service drug benefit.
OR	Columbia Pacific CCO	As Oregon Medicaid Fee For Service carves out the coverage of mental health medications, there is no ability to directly manage claims with DUR pharmacy edits. CCO Regional Care Teams currently provide support for all admissions to inpatient psych, subacute, Psychiatric Residential (PRTS), and Psychiatric Day Treatment. This provides support for the most vulnerable within this population.
OR	Eastern Oregon Coordinated Care Organization (EOCCO)	Antidepressant medications are carved out of EOCCO, as Oregon Health Authority pays for covered mental health drugs on a fee-for-service basis. These products are defined as those drugs classified in the Standard Therapeutic Class equal to class 07 and 11. Therefore, EOCCO does not manage utilization of this therapeutic class.
OR	Health Share of Oregon-CareOregon RAE	As Oregon Medicaid Fee For Service carves out the coverage of mental health medications, there is no ability to directly manage claims with DUR pharmacy edits. CCO Regional Care Teams currently provide support for all admissions to inpatient psych, sub-acute, Psychiatric Residential (PRTS), and Psychiatric Day Treatment. This provides support for the most vulnerable within this population.
OR	Health Share of Oregon/Kaiser Permanente	Appropriate prescribing is managed through our integrated medical record system [KP HealthConnect]. Mental health drugs and services are carved out of our Medicaid agreement. POS edits are defined and managed by the State Medicaid agency.
OR	Health Share of Oregon - Legacy Health/PacificSource	We will not be implementing a monitoring program as mental health medications are a benefit provided directly by the State and we coordinate all activities with Oregon Health Authority.
OR	Health Share of Oregon - OHSU	The Oregon Health Authority Prescription Drug Program monitors use of antidepressant drugs in children that includes members of Oregon MCOs.

State	MCO Name	Explanation
OR	InterCommunity Health Network	Antidepressant drugs are carved out by the State.
OR	Jackson Care Connect	As Oregon Medicaid Fee For Service carves out the coverage of mental health medications, there is no ability to directly manage claims with DUR pharmacy edits. CCO Regional Care Teams currently provide support for all admissions to inpatient psych, subacute, Psychiatric Residential (PRTS), and Psychiatric Day Treatment. This provides support for the most vulnerable within this population.
OR	PacificSource Community Solutions- Central Oregon	We will not be implementing a monitoring program as mental health medications are a benefit provided directly by the State and we coordinate all activities with Oregon Health Authority.
OR	PacificSource Community Solutions- Columbia Gorge	We will not be implementing a monitoring program as mental health medications are a benefit provided directly by the State and we coordinate all activities with Oregon Health Authority.
OR	PacificSource Community Solutions/Kaiser Permanente	Appropriate prescribing is managed through our integrated medical record system [KP HealthConnect]. Mental health drugs and services are carved out of our Medicaid agreement. POS edits are defined and managed by the State Medicaid agency.
OR	PacificSource Community Solutions - Lane	We will not be implementing a monitoring program as mental health medications are a benefit provided directly by the State and we coordinate all activities with Oregon Health Authority.
OR	PacificSource Community Solutions - Marion/Polk	We will not be implementing a monitoring program as mental health medications are a benefit provided directly by the State and we coordinate all activities with Oregon Health Authority.
OR	Providence / Health Share of Oregon	Not currently monitoring FFS drugs, however, will evaluate claims data to determine if implementing plan is necessary.
OR	Umpqua Health Alliance (UHA)	Antidepressants are part of the mental health carveout and are covered exclusively by FFS.
OR	Yamhill Community Care Organization	Not currently monitoring FFS drugs, however, will evaluate claims data to determine if implementing plan is necessary.
PA	Health Partners	HPP will work with Regional Behavior Health MCO to implement this edit if necessary
PA	Highmark Wholecare	Highmark Wholecare follows the Pennsylvania Department of Human Services (DHS) Statewide preferred drug list (PDL) and associated prior authorization policies. At this time there are no prior authorization criteria associated with antidepressants in children.
PA	PA Health and Wellness	Currently our membership does not include patients under 18 years of age.
RI	THP	The MCO does have dose edits in place for all members. The MCO will implement additional program edits (e.g., age, polypharmacy) if claims data indicate it is needed for our members or the State directs us to do so.
TX	Driscoll Health Plan	Driscoll Health Plan does not plan on implementing a program to monitor the appropriate use of antidepressant drugs in children because this is not a current area of concern compared to other psychotropic utilization parameters we have chosen to focus on in the psychotropic medication utilization review (PMUR). We do have clinical edits in place that monitors for polypharmacy.
UT	SelectHealth	These products are carved-out to State Medicaid.

Mood Stabilizers

6. Does your MCO have a documented program in place to either manage or monitor the appropriate use of mood stabilizing drugs in children?

Figure 150 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Mood Stabilizing Drugs in Children

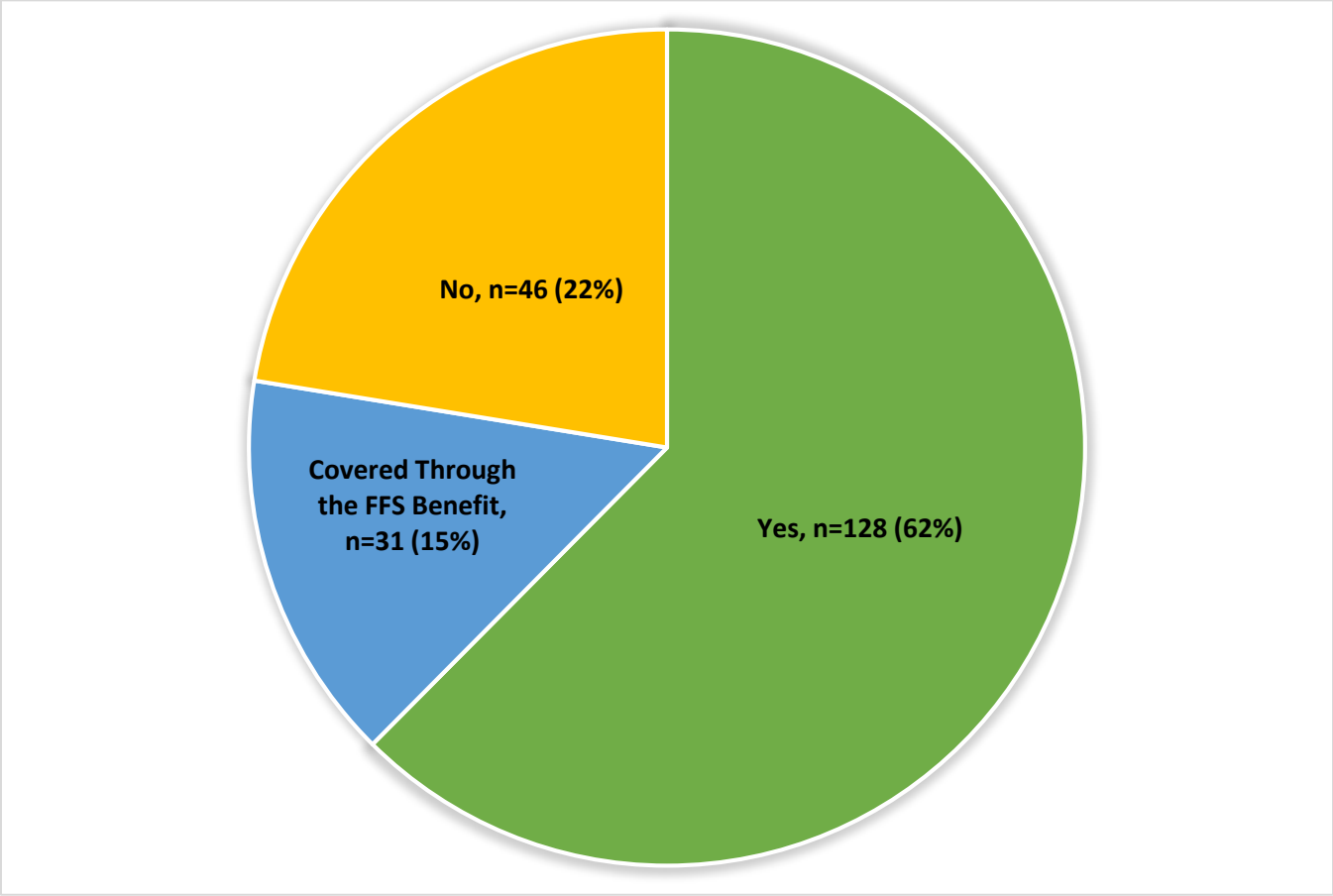

Table 195 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Mood Stabilizing Drugs in Children

Responses	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (1), Delaware (1), Florida (10), Georgia (3), Hawaii (5), Illinois (4), Indiana (5), Kansas (3), Louisiana (5), Maryland (1), Massachusetts (5), Michigan (3), Minnesota (4), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (4), New Mexico (3), New York (14), North Carolina (3), Ohio (4), Oregon (3), Pennsylvania (2), Rhode Island (2), South Carolina (5), Texas (11), Virginia (5), Washington (5)	128	62.44%
Covered through the FFS benefit	Maryland (8), Michigan (6), Oregon (14), Utah (3)	31	15.12%

Responses	States (Count of MCOs)	Count	Percentage
No	Colorado (1), Delaware (1), District of Columbia (4), Florida (1), Hawaii (1), Illinois (2), Iowa (2), Kentucky (6), Minnesota (5), New Jersey (1), New York (1), North Carolina (2), Ohio (1), Oregon (4), Pennsylvania (6), Rhode Island (1), Texas (5), Utah (1), Virginia (1)	46	22.44%
National Totals		**205**	**100%**

a. If "Yes," does your MCO either manage or monitor:

Figure 151 - Categories of Children Either Managed or Monitored for Appropriate Use of Mood Stabilizing Drugs

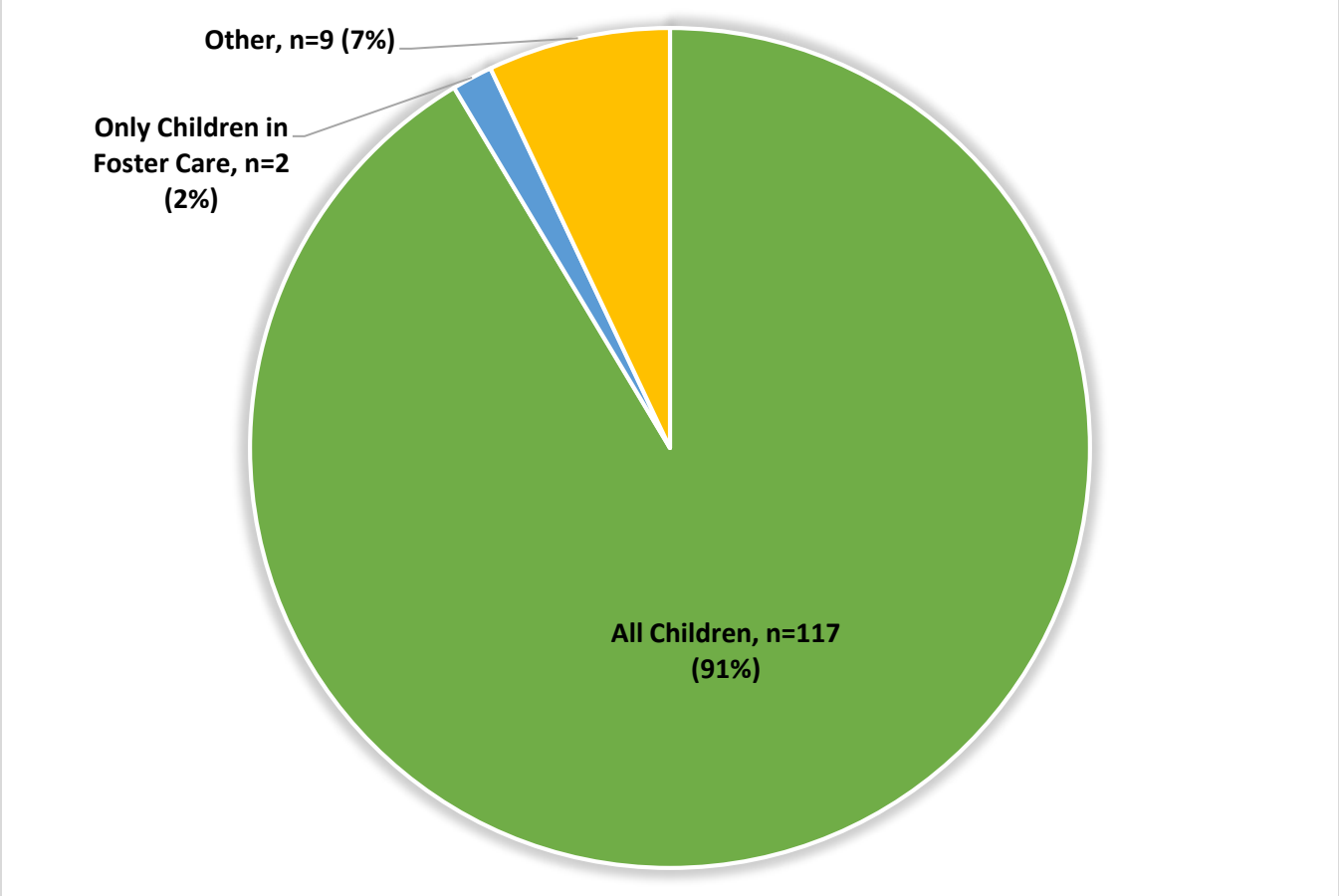

Table 196 - Categories of Children Either Managed or Monitored for Appropriate Use of Mood Stabilizing Drugs

Response	States (Count of MCOs)	Count	Percentage
All children	Arkansas (3), Colorado (1), Delaware (1), Florida (10), Georgia (3), Hawaii (3), Illinois (3), Indiana (5), Kansas (1), Louisiana (5), Maryland (1), Massachusetts (5), Michigan (2), Minnesota (4), Mississippi (2), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (4), New Mexico (3), New York (14), North Carolina (2), Ohio (3), Oregon (3), Pennsylvania (2), Rhode Island (2), South Carolina (4), Texas (11), Virginia (5), Washington (5)	117	91.41%
Only children in foster care	Michigan (1), South Carolina (1)	2	1.56%

Response	States (Count of MCOs)	Count	Percentage
Other	Arkansas (1), Hawaii (2), Illinois (1), Kansas (2), Mississippi (1), North Carolina (1), Ohio (1)	9	7.03%
National Totals		**128**	**100%**

b. If "Yes," does your MCO have edits in place to monitor (multiple responses allowed):

Figure 152 - Edits in Place to Monitor the Appropriate Use of Mood Stabilizing Drugs in Children

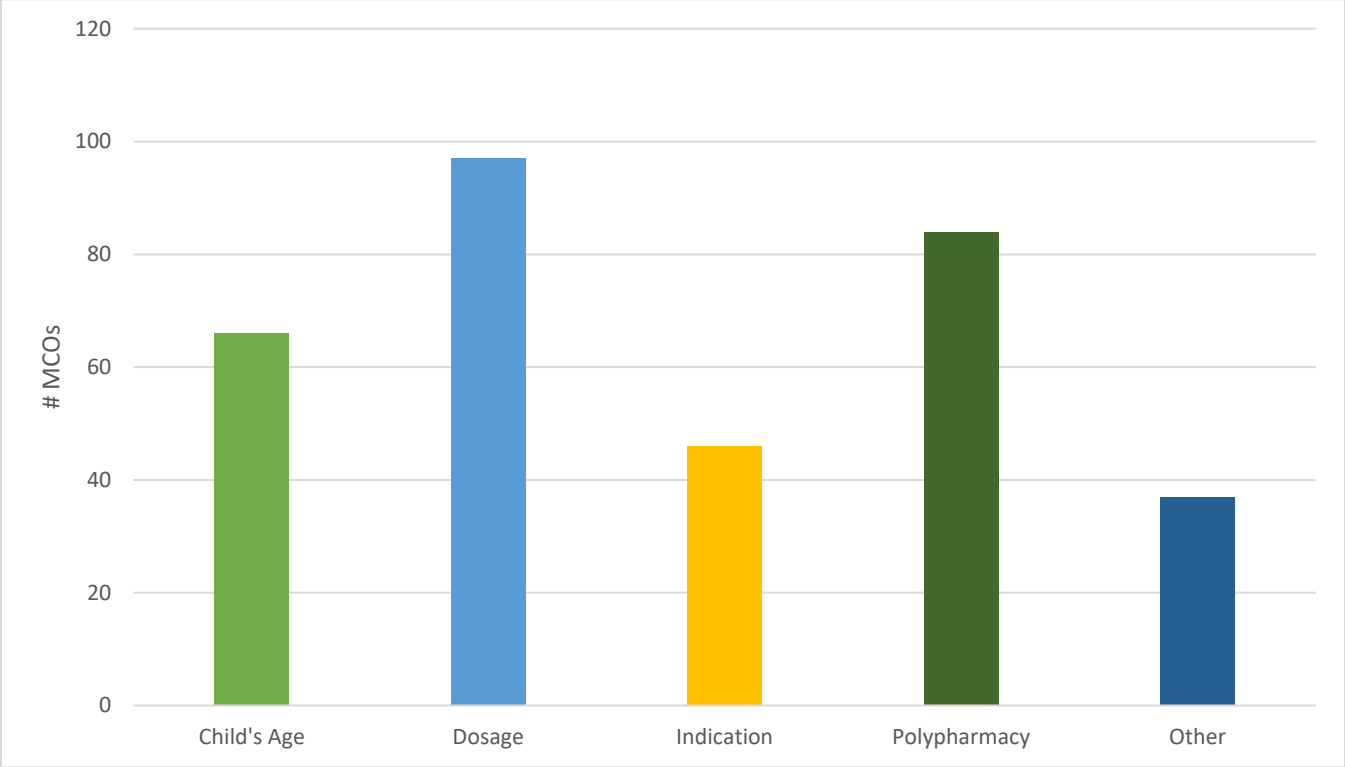

Table 197 - Edits in Place to Monitor the Appropriate Use of Mood Stabilizing Drugs in Children

Response	States (Count of MCOs)	Count	Percentage
Child's Age	Arkansas (2), Delaware (1), Florida (7), Georgia (1), Illinois (1), Indiana (2), Louisiana (5), Massachusetts (5), Minnesota (3), Mississippi (1), Nebraska (2), Nevada (3), New Hampshire (2), New Jersey (1), New Mexico (1), New York (10), North Carolina (1), Ohio (2), South Carolina (4), Texas (4), Virginia (4), Washington (4)	66	20.00%
Dosage	Arkansas (3), Colorado (1), Delaware (1), Florida (9), Georgia (3), Hawaii (4), Illinois (3), Indiana (5), Kansas (1), Louisiana (2), Massachusetts (4), Minnesota (3), Mississippi (2), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (4), New Mexico (3), New York (10), North Carolina (2), Ohio (4), Oregon (1), Pennsylvania (2), Rhode Island (1), South Carolina (5), Texas (6), Virginia (5), Washington (4)	97	29.39%

Response	States (Count of MCOs)	Count	Percentage
Indication	Arkansas (2), Delaware (1), Florida (4), Georgia (2), Illinois (1), Indiana (1), Louisiana (3), Massachusetts (2), Mississippi (1), Nebraska (2), Nevada (1), New Hampshire (3), New Jersey (1), New Mexico (1), New York (6), North Carolina (1), Ohio (1), Oregon (2), Pennsylvania (1), South Carolina (5), Texas (3), Virginia (1), Washington (1)	46	13.94%
Polypharmacy	Arkansas (2), Delaware (1), Florida (7), Georgia (2), Hawaii (1), Illinois (1), Indiana (4), Kansas (1), Louisiana (3), Massachusetts (5), Minnesota (3), Mississippi (2), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (2), New Mexico (1), New York (12), North Carolina (2), Ohio (4), Oregon (1), Pennsylvania (1), South Carolina (4), Texas (9), Virginia (2), Washington (5)	84	25.45%
Other	Arkansas (4), Delaware (1), Florida (4), Georgia (1), Hawaii (1), Illinois (2), Indiana (2), Kansas (1), Louisiana (2), Maryland (1), Michigan (3), Nebraska (1), New Hampshire (3), New Jersey (1), New Mexico (2), New York (2), Ohio (1), Oregon (1), Rhode Island (1), Texas (1), Washington (2)	37	11.21%
National Totals		**330**	**100%**

If “Child’s age,” please specify age limit in years.

Table 198 - Child’s Age Limits for Edits in Place to Monitor the Appropriate Use of Mood Stabilizing Drugs in Children

State	MCO Name	Age Limit in Years
AR	Empower_HealthCare_Solutions_LLC	17
AR	Summit_Community_Care	6
DE	HighmarkHealthOptions	18
FL	Children's Medical Services	18
FL	Clear Health Alliance	6
FL	Community Care Plan	6
FL	Humana Medical Plan	13
FL	Molina Healthcare	17
FL	Simply Healthcare	6
FL	Sunshine	18
GA	Amerigroup GA	18
IL	Blue_Cross_and_Blue_Shield_of_Illinois	18
IN	Managed Health Services Indiana (MHS)	3
IN	MDwise, Inc.	12
LA	Aetna Better Health of Louisiana	6
LA	AmeriHealth Caritas Louisiana	6
LA	Healthy Blue Louisiana	6
LA	Louisiana Healthcare Connections	6
LA	UnitedHealthcare Community Plan	6
MA	AllWays Health Partners	18
MA	Boston Medical Center Health Plan, Inc	6
MA	Fallon Community Health Plan, Inc.	6

State	MCO Name	Age Limit in Years
MA	Health New England, Inc.	6
MA	Tufts Health Public Plans, Inc	6
MN	BluePlus	18
MN	HealthPartners	7
MN	UCare	13
MS	MS-MOLINA	18
NC	HB FFY22	18
NE	HealthyBlueNebraska	18
NE	Nebraska Total Care	4
NH	AmeriHealth Caritas NH	18
NH	Well Sense	18
NJ	Horizon NJ Health	18
NM	Blue Cross Blue Shield of New Mexico	18
NV	Anthem Blue Cross Blue Shield	18
NV	Molina	18
NV	Silver Summit Health Plan	18
NY	AMIDA CARE	17
NY	Excellus Health Plan	21
NY	Fidelis Care	20
NY	Healthfirst	21
NY	Highmark Blue Cross Blue Shield of Western New York	18
NY	Independent Health	6
NY	MetroPlus Health Plan	21
NY	Molina Healthcare of New York	18
NY	Univera Healthcare	21
NY	VNSNY CHOICE SelectHealth	20
OH	Buckeye Health Plan	18
OH	Molina Healthcare of Ohio	18
SC	Healthy Blue South Carolina	18
SC	Humana	17
SC	Molina Healthcare	18
SC	Select Health of South Carolina, Inc.	6
TX	Blue Cross and Blue Shield of Texas	18
TX	Molina Healthcare of Texas	3
TX	Parkland Community Health Plan	18
TX	Superior HealthPlan	21
VA	Anthem	18
VA	MolinaCompleteCareofVirginia	18
VA	OptimaHealth	18
VA	VirginiaPremier	18
WA	Amerigroup Washington Inc.	18
WA	Community Health Plan of Washington	17
WA	Coordinated Care Corporation	17
WA	Molina Healthcare of Washington, Inc.	17

c. If "Yes," please briefly explain the specifics of your documented mood stabilizer monitoring program(s).

Please reference individual State MCO reports on Medicaid.gov for more information.

d. If "No" or "Covered through the FFS benefit," does your MCO plan on implementing a mood stabilizer monitoring program in the future?

Figure 153 - Future Plans to Implement a Mood Stabilizer Monitoring Program

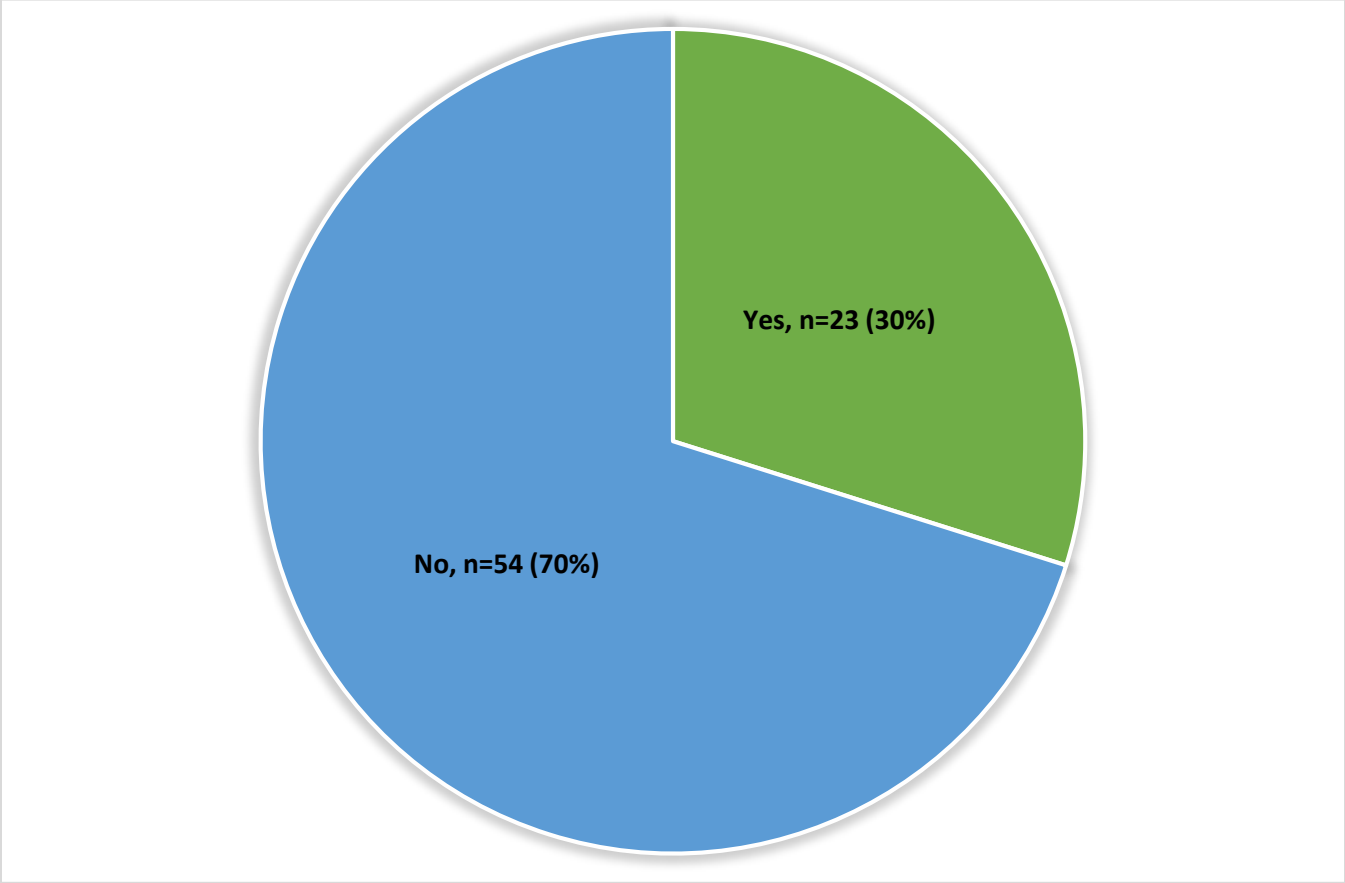

Table 199 Future Plans to Implement a Mood Stabilizer Monitoring Program

Response	States (Count of MCOs)	Count	Percentage
Yes	Colorado (1), District of Columbia (1), Hawaii (1), Illinois (1), Iowa (2), Kentucky (6), Maryland (2), Michigan (1), Minnesota (2), New Jersey (1), North Carolina (1), Pennsylvania (1), Utah (2), Virginia (1)	23	29.87%
No	Delaware (1), District of Columbia (3), Florida (1), Illinois (1), Maryland (6), Michigan (5), Minnesota (3), New York (1), North Carolina (1), Ohio (1), Oregon (18), Pennsylvania (5), Rhode Island (1), Texas (5), Utah (2)	54	70.13%
National Totals		**77**	**100%**

If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of mood stabilizing drugs in children.

Table 200 - When MCOs Plan to Implement a Program to Monitor the Appropriate Use of Mood Stabilizing Drugs in Children

State	MCO Name	Explanation
CO	Denver Health Medicaid Choice	The MCO would like to implement this program, but there are no plans currently.
DC	HealthServicesforSpecial NeedsChildren	HSCSN plans to develop the criteria in FY 2023 and implement in FY 2024.
HI	AlohaCare	We will evaluate the need for a monitoring program for children on a mood stabilizer in the future.
IA	Amerigroup	Can look at as a future topic for DUR Commission, date to be determined.
IA	Iowa Total Care	Can look at as a future topic for the DUR Commission, date to be determined
IL	Aetna_Better_Health_of _Illinois	Current timeline is unknown
KY	Aetna Better Health of Kentucky	Monitoring Program will start in 3Q23
KY	Anthem Inc. Kentucky	Monitoring program will start in 3Q23.
KY	Humana Healthy Horizons in Kentucky	Monitoring program will start in 3Q23.
KY	Passport Health Plan By Molina Healthcare	Monitoring program will start in 3Q23
KY	United Healthcare Community Plan of Kentucky	Monitoring program will start in 3Q2023.
KY	WellCare Health Plans	Monitoring program will start in 3Q23
MD	Aetna Better Health of Maryland	Our plan is working with Informatics team to build a retrospective controlled substance utilization report that will capture overutilization and concurrent utilization for all controlled substances including mood disorder drugs. This report will be used to identify members who are candidate for pharmacy restriction as well as case management outreach. Timeline is 2023
MD	Jai Medical Systems Managed Care Organization, Inc.	Coverage of mood stabilizer medications is carved out and covered under FFS Medicaid. Carved out pharmacy utilization data was not shared with the MCOs in a format that could be stored in the Rx engine at the PBM until late in the measurement year so retrospective monitoring could not be implemented until after the measurement year.
MI	McLaren Health Plan	Mood stabilizer medications are a carved out benefit managed by the State of Michigan FFS Medicaid. The plan is working towards implementing a monitoring program FY23.
MN	HennepinHealth	2024
MN	Medica	Medica is contemplating clinical program options and will implement as soon as possible.
NC	CCH FFY22	Appropriate utilization management is in place that aligns with the FDA approved label, duration limits, and age restrictions for applicable mood stabilizers. MCO also ensures that that any State guidance on age and QL limits are followed and in place where applicable.
NJ	Aetna Better Health of New Jersey	Current timeline is unknown

State	MCO Name	Explanation
PA	Aetna Better Health of Pennsylvania	Current timeline is unknown.
UT	Healthy U	Q1CY2024
UT	Steward Health Choice Utah	We plan to implement Q1CY2024.
VA	AetnaBetterHealthofVirginia	Timeline unknown at this time.

If "No," please explain why you will not be implementing a program to monitor the appropriate use of mood stabilizing drugs in children.

Table 201 - Explanation for Not Implementing a Program to Monitor Use of Mood Stabilizing Drugs in Children

State	MCO Name	Explanation
DC	AmeriHealth Caritas DC	We already have prospective and retrospective edits in place that monitor for duplicate therapy and safety edits for dosing, quantity limits, drug interactions, and high dosage that are already a part of our proDUR and retroDUR programs.
DC	CareFirst BCBS Community Health Plan DC	In the 2021 DUR MCO Annual Survey submission, CareFirst CHPDC had planned to implement a program to monitor the use of mood stabilizing drugs in children similar to the current policy in place for monitoring the use of antipsychotics in pediatrics. We had planned to implement the program by October 2022 which is when the new contract procurement from Department of Healthcare Finance (DHCF) was finalized. Despite the MCO's preparations to create a report that would capture prescription and medical claims data to conduct the DUR, this monitoring program was not carried out due to CareFirst CHPDC not being awarded the contract in 2022
DC	MedStar Family Choice - District of Columbia	MFC recognizes the importance of oversight of use of moodstabilizers in children. After we conclude the process of integrating behavioral health we will specify a process to implement a monitoring program.
DE	AmeriHealth Caritas Delaware	Mood stabilizer are currently monitored by FDA approved ages only and we have not seen issues with the prescribing patterns in this area.
FL	Florida Community Care	As a Long Term Care plan, our population is restricted to beneficiaries age 18 and above. We have no population of children.
IL	MeridianHealth	No plans to implement at this time. Providers have access to medical information and are able to prescribe according the preferred drug list.
MD	Amerigroup Community Care	Behavioral/Mental Health treatment class is carved-out of MCO and paid for by FFS program.
MD	CareFirst Community Health Plan Maryland	N/A. Mood stabilizing drugs in children are carved-out to the State.
MD	Kaiser Foundation Health Plan of the Mid-Atlantic States	Covered through Fee for Service.
MD	Maryland Physicians Care	FFS and Optum is responsible for managing programs for the Behavioral Health benefit.
MD	MedStar Family Choice	MFC does not manage this benefit as behavioral health treatment including medication is carved out to the State.
MD	Priority Partners MCO	The Behavioral/Mental Health treatment class is carved-out of MCO benefit coverage and is administered by the FFS program.
MI	HAP Empowered	These medications are carved out and managed by the State through FFS Medicaid.

State	MCO Name	Explanation
MI	Meridian Health Plan	This is a carve out benefit. The pharmacy benefit manager has programming to support so we could look to expand if the plan was provided the data in file that could easily be applied to the logic with with PBM programming.
MI	Molina Healthcare of Michigan	These medications are carved out to FFS.
MI	Priority Health Choice	In Michigan, coverage of these drugs is carved out to the Fee For Service Medicaid program.
MI	Upper Peninsula Health Plan	Mood stabilizing medications are a carve out from the health plan benefit.
MN	IMCare	Use of mood stabilizers in children is currently not a current safety priority.
MN	PrimeWest	At this time, use of mood stabilizing drugs in children has not been identified as an at-risk area for members. Consideration will be given to implementing a program to monitor the appropriate use of mood stabilizing drugs in children in the future. ProDUR Drug-Dosing edits compare the dosage of the submitted mood stabilizer with FDB recommended dosing limits and 'not to exceed' values based on Member's age. FDB defines the daily recommended mood stabilizer quantities as well as the 'not to exceed values' specified for Pediatrics. This area is also monitored with DUR edits. The ProDUR age edit sends information to the pharmacy if the requested mood stabilizer claim is determined to have a precaution based on the member's age. FDB defines mood stabilizer age precautions and severity levels. The ProDUR therapeutic duplication edit returns DUR information to the pharmacy if the incoming mood stabilizer claim overlaps with a mood stabilizer claim in the member's MedImpact prescription history.
MN	SouthCountry	The DUR Board monitors mood stabilizers of the antipsychotic class as noted above. While the definition of "mood stabilizer" may be open to interpretation, assuming lithium and anticonvulsants are considered mood stabilizers along with antipsychotics, the DUR Board has reviewed some preliminary data on lithium and found no actionable steps for that at this time. Lithium and anticonvulsant medications will be considered, along with others, for more in-depth review and possible action as we continue to prioritize effective use of our resources.
NC	AMHC FFY22	AMHC is required to follow NCDHB policies per our contract. NCDHB does not have a mood stabilizer policy.
NY	MVP Health Care	We will continue to review our utilization patterns and work with pediatric behavioral specialists to review necessity to implement a program to monitor mood stabilizing drugs in children.
OH	Paramount	Currently, limitations/edits for mood stabilizers are drug-specific and apply to all members regardless of age. Edits for mood stabilizers are dependent on the details outlined on the Ohio Department of Medicaid's UPDL. Drugs that are not on the UPDL must be reviewed for age, dosage, and FDA approved use. Paramount does not plan to implement a new program due to the fact that the pharmacy benefit will be handled by the State's chosen single PBM.
OR	Advanced Health	Mood Stabilizers are paid for by FFS Medicaid in Oregon. They are not covered by Advanced Health.
OR	Cascade Health Alliance	Mood stabilizers are covered under the State's Fee For Service drug benefit.

State	MCO Name	Explanation
OR	Columbia Pacific CCO	As Oregon Medicaid Fee For Service carves out the coverage of mental health medications, there is no ability to directly manage claims with DUR pharmacy edits. CCO Regional Care Teams currently provide support for all admissions to inpatient psych, subacute, Psychiatric Residential (PRTS), and Psychiatric Day Treatment. This provides support for the most vulnerable within this population.
OR	Eastern Oregon Coordinated Care Organization (EOCCO)	Mood stabilizing medications are carved out of EOCCO, as Oregon Health Authority pays for covered mental health drugs on a fee-for-service basis. These products are defined as those drugs classified in the Standard Therapeutic Class equal to class 07 and 11. Therefore, EOCCO does not manage utilization of this therapeutic class.
OR	Health Share of Oregon-CareOregon RAE	As Oregon Medicaid Fee For Service carves out the coverage of mental health medications, there is no ability to directly manage claims with DUR pharmacy edits. CCO Regional Care Teams currently provide support for all admissions to inpatient psych, sub-acute, Psychiatric Residential (PRTS), and Psychiatric Day Treatment. This provides support for the most vulnerable within this population.
OR	Health Share of Oregon/Kaiser Permanente	Appropriate prescribing is managed through our integrated medical record system [KP HealthConnect]. Mental health drugs and services are carved out of our Medicaid agreement. POS edits are defined and managed by the State Medicaid agency.
OR	Health Share of Oregon - Legacy Health/PacificSource	We will not be implementing a monitoring program as mental health medications are a benefit provided directly by the State and we coordinate all activities with Oregon Health Authority.
OR	Health Share of Oregon - OHSU	The Oregon Health Authority Prescription Drug Program monitors use of mood stabilizers in children that includes members of Oregon MCOs.
OR	InterCommunity Health Network	These drugs are carved out by the State.
OR	Jackson Care Connect	As Oregon Medicaid Fee For Service carves out the coverage of mental health medications, there is no ability to directly manage claims with DUR pharmacy edits. CCO Regional Care Teams currently provide support for all admissions to inpatient psych, subacute, Psychiatric Residential (PRTS), and Psychiatric Day Treatment. This provides support for the most vulnerable within this population.
OR	PacificSource Community Solutions- Central Oregon	We will not be implementing a monitoring program as mental health medications are a benefit provided directly by the State and we coordinate all activities with Oregon Health Authority.
OR	PacificSource Community Solutions- Columbia Gorge	We will not be implementing a monitoring program as mental health medications are a benefit provided directly by the State and we coordinate all activities with Oregon Health Authority.
OR	PacificSource Community Solutions/Kaiser Permanente	Appropriate prescribing is managed through our integrated medical record system [KP HealthConnect]. Mental health drugs and services are carved out of our Medicaid agreement. POS edits are defined and managed by the State Medicaid agency.
OR	PacificSource Community Solutions - Lane	We will not be implementing a monitoring program as mental health medications are a benefit provided directly by the State and we coordinate all activities with Oregon Health Authority.

State	MCO Name	Explanation
OR	PacificSource Community Solutions - Marion/Polk	We will not be implementing a monitoring program as mental health medications are a benefit provided directly by the State and we coordinate all activities with Oregon Health Authority.
OR	Providence / Health Share of Oregon	Not currently monitoring FFS drugs, however, will evaluate claims data to determine if implementing plan is necessary.
OR	Umpqua Health Alliance (UHA)	Mood stabilizers are part of the mental health carveout and are covered exclusively by FFS
OR	Yamhill Community Care Organization	Not currently monitoring FFS drugs, however, will evaluate claims data to determine if implementing plan is necessary.
PA	Geisinger	Antipsychotics and antidepressants are monitored
PA	Health Partners	HPP will work with Regional Behavior Health MCO to implement this edit if necessary
PA	Highmark Wholecare	Highmark Wholecare follows the Pennsylvania Department of Human Services (DHS) Statewide preferred drug list (PDL) and associated prior authorization policies. At this time there are no prior authorization criteria associated with mood stabilizers.
PA	PA Health and Wellness	Currently our membership does not include patients under 18 years of age.
PA	Vista	No apparent need for our population at this time.
RI	THP	The MCO does have dose edits in place for all members. The MCO will implement additional program edits (e.g., age, polypharmacy) if claims data indicate it is needed for our members or the State directs us to do so.
TX	Community Health Choice	System is not set at this time to manage or monitor mood stabilizers
TX	Cook Children's Health Plan	The majority of CCHP's membership is comprised of children. At this time, monitoring mood stabilizers is not currently in our immediate plans.
TX	Driscoll Health Plan	Driscoll Health Plan does not plan on implementing a program to monitor the appropriate use of mood stabilizing drugs in children because this is not an area of concern compared to other parameters we have chosen to focus on in the psychotropic medication utilization review (PMUR). We do have clinical edits in place that monitors for polypharmacy.
TX	El Paso Health	MCO's current PMUR plan does not focus on mood stabilizing drugs in children at this time.
TX	Texas Children's Health Plan	Mood stabilizing medications can be used for many bipolar or seizure related disorders. These medications are carefully monitored by providers, parents, and pharmacies. We currently have clinical PA, Quantity Limit, and other point of sale UM edits in place to ensure appropriate utilization. We will look into enhanced utilization review of these medications in the future.
UT	Molina Healthcare of Utah	Previous data has shown the majority of members use mood stabilizers appropriately. We will continue to pull data and initiate a program as needed depending on prescribing and utilization trends.
UT	SelectHealth	These products are carved-out to State Medicaid.

Antianxiety/Sedatives

7. Does your MCO have a documented program in place to either manage or monitor the appropriate use of antianxiety/sedative drugs in children?

Figure 154 - Documented Program in Place to Either Manage or Monitor Appropriate Use of Antianxiety/Sedative Drugs in Children

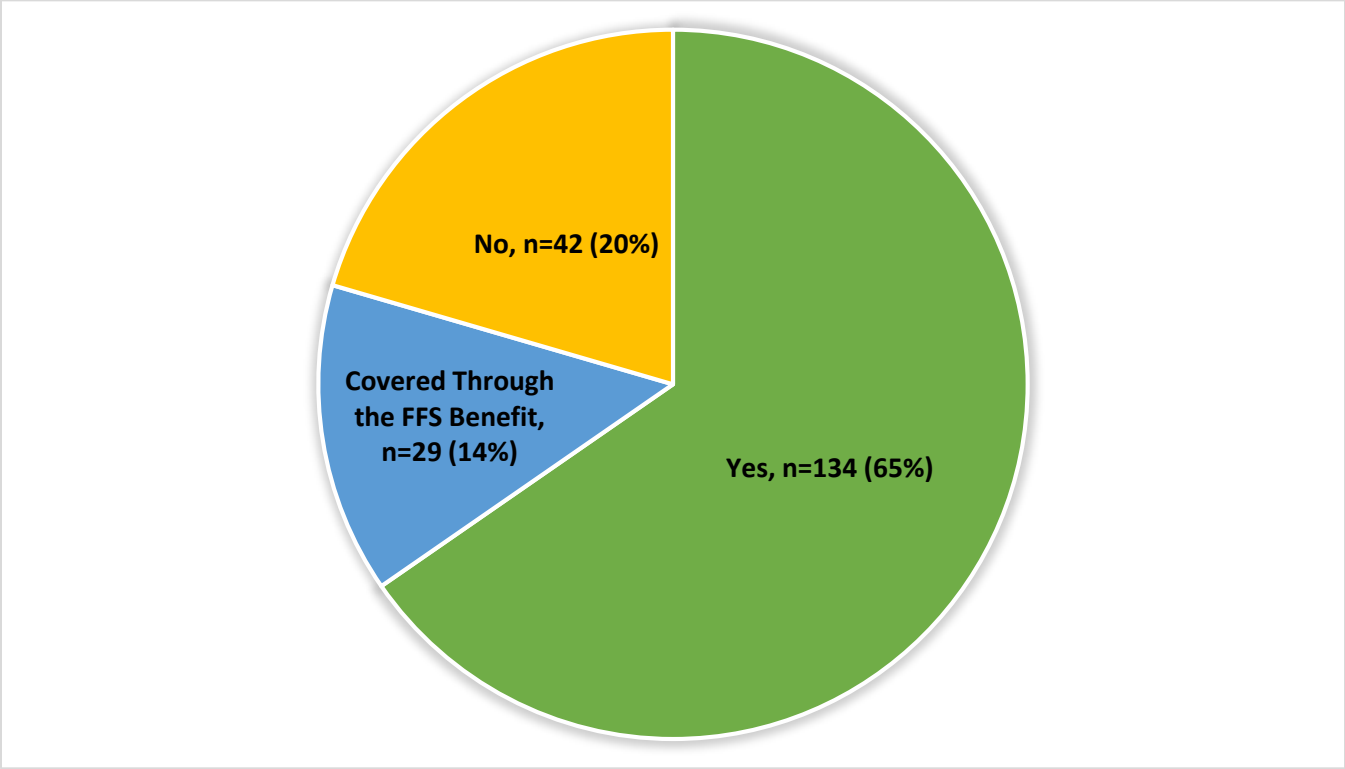

Table 202 - Documented Program in Place to Either Manage or Monitor Appropriate Use of Antianxiety/Sedative Drugs in Children

Response	States (Count of MCOs)	Count	Percentage
Yes	Arkansas (4), Colorado (1), Delaware (2), Florida (10), Georgia (3), Hawaii (5), Illinois (4), Indiana (5), Kansas (3), Louisiana (5), Maryland (1), Massachusetts (5), Michigan (2), Minnesota (4), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (4), New Mexico (3), New York (14), North Carolina (5), Ohio (4), Oregon (4), Pennsylvania (6), Rhode Island (2), South Carolina (5), Texas (11), Virginia (4), Washington (5)	134	65.37%
Covered through the FFS benefit	Maryland (8), Michigan (7), Oregon (11), Utah (3)	29	14.15%
No	Colorado (1), District of Columbia (4), Florida (1), Hawaii (1), Illinois (2), Iowa (2), Kentucky (6), Minnesota (5), New Jersey (1), New York (1), Ohio (1), Oregon (6), Pennsylvania (2), Rhode Island (1), Texas (5), Utah (1), Virginia (2)	42	20.49%
National Totals		**205**	**100%**

a. If "Yes," does your MCO either manage or monitor:

Figure 155 - Categories of Children Either Managed or Monitored for Appropriate Use of Antianxiety/Sedative Drugs

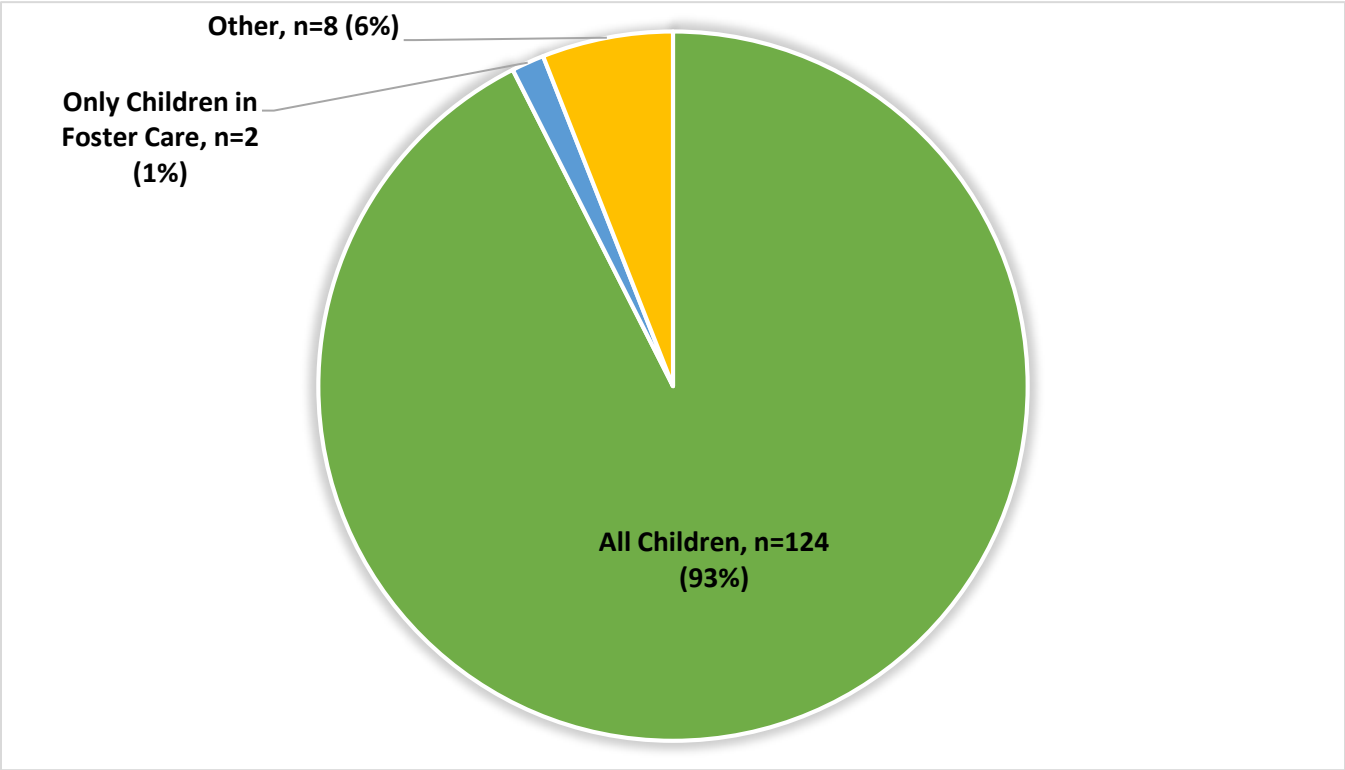

Table 203 - Categories of Children Either Managed or Monitored for Appropriate Use of Antianxiety/Sedative Drugs

Response	States (Count of MCOs)	Count	Percentage
All children	Arkansas (4), Colorado (1), Delaware (2), Florida (10), Georgia (3), Hawaii (3), Illinois (3), Indiana (5), Kansas (1), Louisiana (5), Maryland (1), Massachusetts (5), Michigan (1), Minnesota (4), Mississippi (2), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (4), New Mexico (3), New York (14), North Carolina (4), Ohio (3), Oregon (4), Pennsylvania (6), Rhode Island (2), South Carolina (4), Texas (11), Virginia (4), Washington (5)	124	92.54%
Only children in foster care	Michigan (1), South Carolina (1)	2	1.49%
Other	Hawaii (2), Illinois (1), Kansas (2), Mississippi (1), North Carolina (1), Ohio (1)	8	5.97%
National Totals		**134**	**100%**

b. If "Yes," does your MCO have edits in place to monitor (multiple responses allowed):

Figure 156 - Edits in Place to Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children

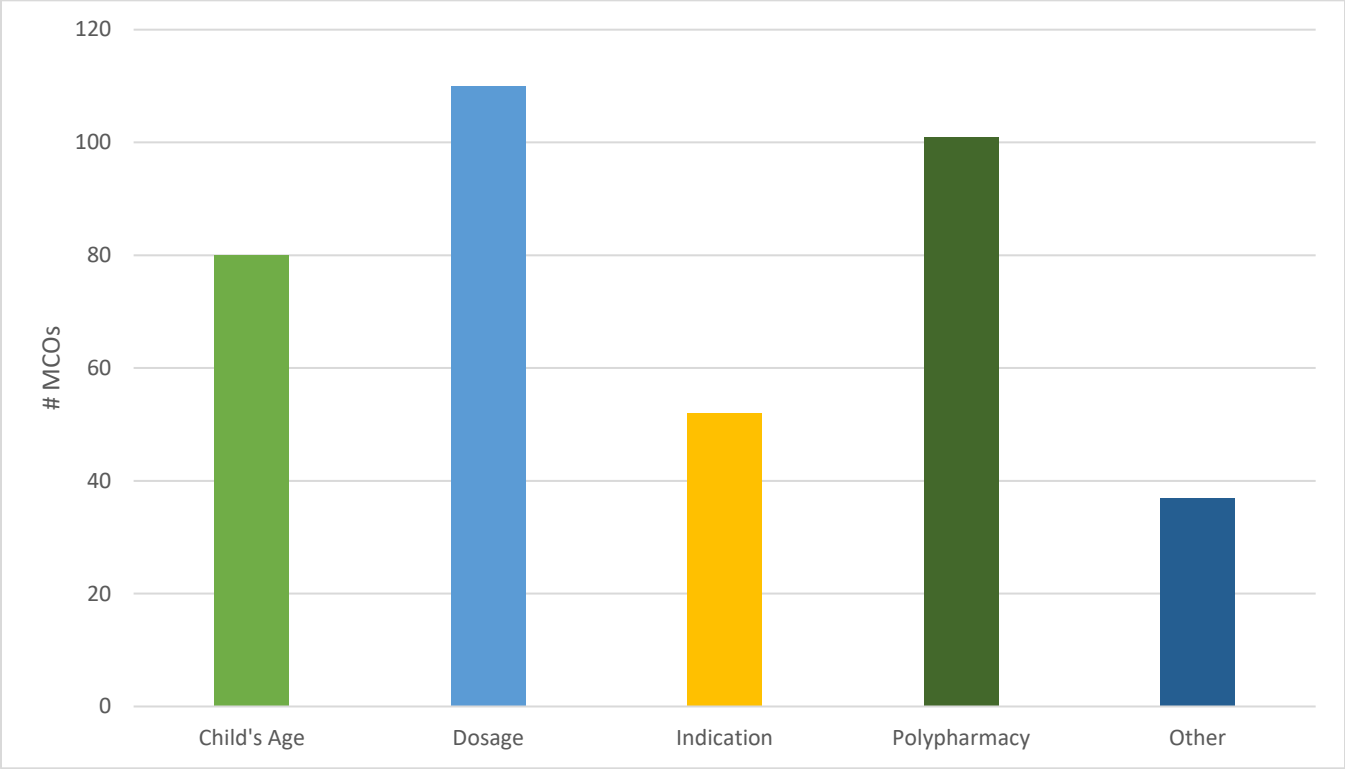

Table 204 - Edits in Place to Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children

Response	States (Count of MCOs)	Count	Percentage
Child's Age	Arkansas (4), Florida (7), Georgia (3), Illinois (1), Indiana (4), Louisiana (5), Massachusetts (5), Minnesota (3), Mississippi (1), Nebraska (2), Nevada (3), New Hampshire (2), New Jersey (2), New Mexico (1), New York (11), North Carolina (2), Ohio (2), Pennsylvania (5), South Carolina (4), Texas (6), Virginia (3), Washington (4)	80	21.05%
Dosage	Arkansas (3), Colorado (1), Delaware (1), Florida (8), Georgia (3), Hawaii (4), Illinois (3), Indiana (5), Kansas (3), Louisiana (4), Massachusetts (5), Minnesota (3), Mississippi (3), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (4), New Mexico (3), New York (10), North Carolina (4), Ohio (4), Oregon (2), Pennsylvania (4), Rhode Island (1), South Carolina (5), Texas (10), Virginia (4), Washington (4)	110	28.95%
Indication	Arkansas (2), Delaware (1), Florida (3), Georgia (2), Indiana (1), Louisiana (5), Massachusetts (2), Nebraska (2), Nevada (1), New Hampshire (3), New Jersey (1), New Mexico (2), New York (6), North Carolina (1), Ohio (1), Oregon (3), Pennsylvania (2), South Carolina (5), Texas (8), Washington (1)	52	13.68%

Response	States (Count of MCOs)	Count	Percentage
Polypharmacy	Arkansas (3), Colorado (1), Delaware (1), Florida (7), Georgia (2), Hawaii (2), Illinois (3), Indiana (5), Kansas (3), Louisiana (3), Massachusetts (5), Minnesota (3), Mississippi (3), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (3), New Mexico (1), New York (11), North Carolina (4), Ohio (3), Oregon (2), Pennsylvania (4), Rhode Island (1), South Carolina (5), Texas (10), Virginia (2), Washington (5)	101	26.58%
Other	Arkansas (1), Delaware (1), Florida (4), Georgia (1), Hawaii (1), Illinois (2), Indiana (3), Louisiana (2), Maryland (1), Michigan (2), Mississippi (1), New Hampshire (3), New Jersey (2), New Mexico (2), New York (3), Ohio (2), Oregon (1), Rhode Island (1), Texas (2), Washington (2)	37	9.74%
National Totals		**380**	**100%**

If “Child’s age,” please specify age limit in years.

Table 205 - Child’s Age Limits for Edits in Place to Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children

State	MCO Name	Age Limit in Years
AR	Arkansas_Total_Care_Inc.	0
AR	CareSource	18
AR	Empower_HealthCare_Solutions_LLC	17
AR	Summit_Community_Care	6
FL	Children's Medical Services	18
FL	Clear Health Alliance	6
FL	Community Care Plan	6
FL	Humana Medical Plan	13
FL	Molina Healthcare	17
FL	Simply Healthcare	18
FL	Sunshine	18
GA	Amerigroup GA	18
GA	CareSource	6
GA	Peach State Health Plan	18
IL	Blue_Cross_and_Blue_Shield_of_Illinois	18
IN	Anthem, Inc.	18
IN	CareSource	18
IN	Managed Health Services Indiana (MHS)	3
IN	MDwise, Inc.	12
LA	Aetna Better Health of Louisiana	6
LA	AmeriHealth Caritas Louisiana	6
LA	Healthy Blue Louisiana	6
LA	Louisiana Healthcare Connections	6
LA	UnitedHealthcare Community Plan	6
MA	AllWays Health Partners	18
MA	Boston Medical Center Health Plan, Inc	6
MA	Fallon Community Health Plan, Inc.	6
MA	Health New England, Inc.	6

State	MCO Name	Age Limit in Years
MA	Tufts Health Public Plans, Inc	6
MN	BluePlus	18
MN	HennepinHealth	18
MN	UCare	18
MS	MS-MOLINA	18
NC	HB FFY22	18
NC	UHC FFY22	6
NE	HealthyBlueNebraska	18
NE	Nebraska Total Care	18
NH	AmeriHealth Caritas NH	18
NH	Well Sense	18
NJ	Amerigroup Community Care	18
NJ	Horizon NJ Health	18
NM	Blue Cross Blue Shield of New Mexico	18
NV	Anthem Blue Cross Blue Shield	18
NV	Molina	18
NV	Silver Summit Health Plan	18
NY	AMIDA CARE	17
NY	Empire Blue Cross Blue Shield HealthPlus	18
NY	Excellus Health Plan	21
NY	Fidelis Care	20
NY	Healthfirst	21
NY	Highmark Blue Cross Blue Shield of Western New York	18
NY	Independent Health	6
NY	MetroPlus Health Plan	21
NY	Molina Healthcare of New York	0
NY	Univera Healthcare	21
NY	VNSNY CHOICE SelectHealth	20
OH	Buckeye Health Plan	18
OH	CareSource	6
PA	Geisinger	21
PA	Health Partners	18
PA	Highmark Wholecare	21
PA	UPMC	20
PA	Vista	20
SC	Healthy Blue South Carolina	18
SC	Humana	17
SC	Molina Healthcare	18
SC	Select Health of South Carolina, Inc.	6
TX	Blue Cross and Blue Shield of Texas	18
TX	Driscoll Health Plan	12
TX	FirstCare Health Plans	0.5
TX	Molina Healthcare of Texas	2
TX	Scott and White Health Plan	0.5
TX	Superior HealthPlan	21

State	MCO Name	Age Limit in Years
VA	Anthem	18
VA	MolinaCompleteCareofVirginia	18
VA	OptimaHealth	18
WA	Amerigroup Washington Inc.	18
WA	Community Health Plan of Washington	17
WA	Coordinated Care Corporation	17
WA	Molina Healthcare of Washington, Inc.	17

c. If "Yes," please briefly explain the specifics of your documented antianxiety/sedative monitoring program(s).

Please reference individual State MCO reports on Medicaid.gov for more information.

d. If "No" or "Covered through the FFS benefit," does your MCO plan on implementing an antianxiety/sedative monitoring program in the future?

Figure 157 - Future Plans to Implement an Antianxiety/Sedative Monitoring Program

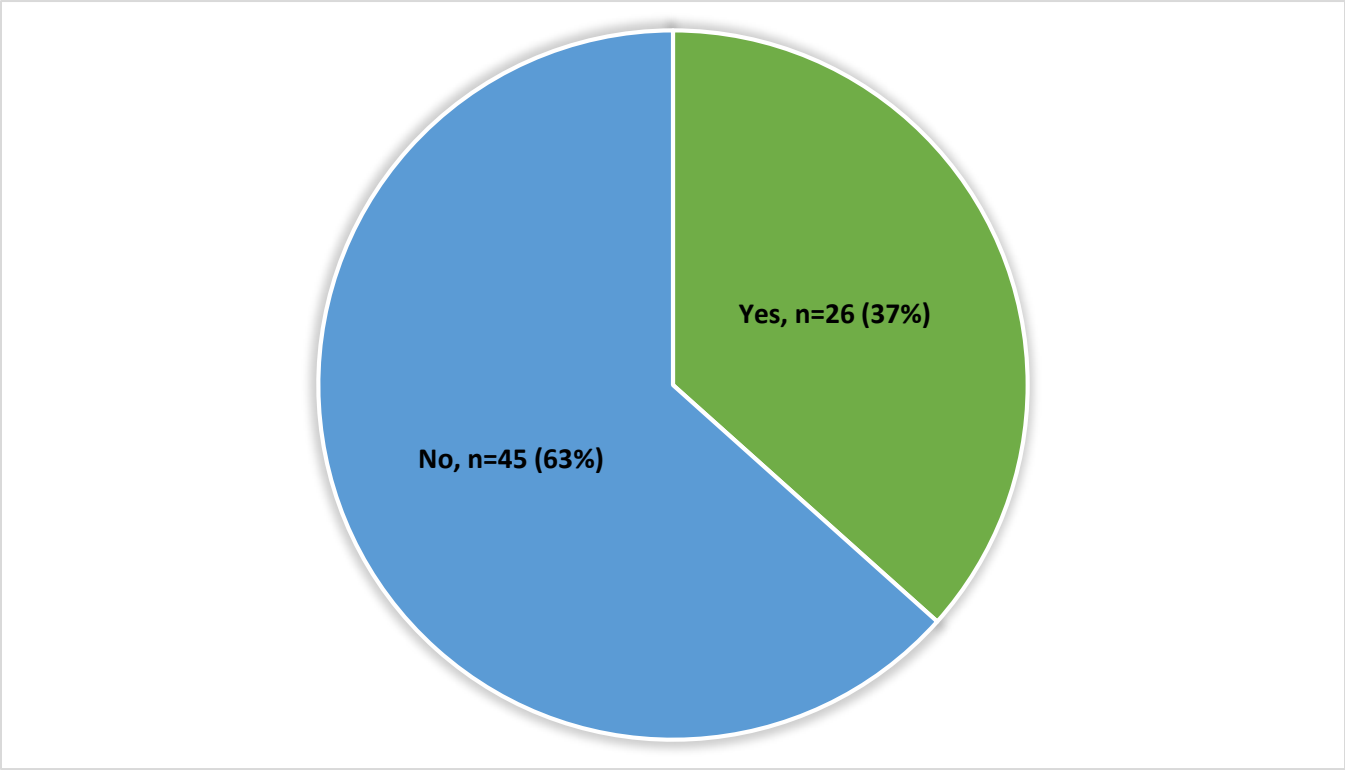

Table 206 - Future Plans to Implement an Antianxiety/Sedative Monitoring Program

Response	States (Count of MCOs)	Count	Percentage
Yes	Colorado (1), District of Columbia (1), Hawaii (1), Illinois (1), Iowa (2), Kentucky (6), Maryland (2), Michigan (2), Minnesota (2), New Jersey (1), Pennsylvania (1), Texas (1), Utah (3), Virginia (2)	26	36.62%
No	District of Columbia (3), Florida (1), Illinois (1), Maryland (6), Michigan (5), Minnesota (3), New York (1), Ohio (1), Oregon (17), Pennsylvania (1), Rhode Island (1), Texas (4), Utah (1)	45	63.38%
National Totals		**71**	**100%**

If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of antianxiety/sedative drugs in children.

Table 207 - When MCOs Plan to Implement a Program to Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children

State	MCO Name	Explanation
CO	Denver Health Medicaid Choice	The MCO would like to implement this program, but there are no plans currently.
DC	HealthServicesforSpecial NeedsChildren	HSCSN plans to develop the criteria in FY 2023 and implement in FY 2024.
HI	AlohaCare	We will evaluate the need for a monitoring program for children on antianxiety/sedative drugs in the future.
IA	Amerigroup	Can look at as a future topic for DUR Commission, date to be determined.
IA	Iowa Total Care	Can look at as a future topic for the DUR Commission, date to be determined
IL	Aetna_Better_Health_of _Illinois	Current timeline is unknown
KY	Aetna Better Health of Kentucky	Monitoring program will start in 3Q23
KY	Anthem Inc. Kentucky	Monitoring program will start in 3Q23.
KY	Humana Healthy Horizons in Kentucky	Monitoring program will start in 3Q23.
KY	Passport Health Plan By Molina Healthcare	Monitoring program will start in 3Q23
KY	United Healthcare Community Plan of Kentucky	Monitoring program will start in 3Q2023.
KY	WellCare Health Plans	Monitoring program will start in 3Q23
MD	Aetna Better Health of Maryland	Our plan is working with Informatics team to build a retrospective controlled substance utilization report that will capture overutilization and concurrent utilization for all controlled substances including antianxiety/sedative drugs. This report will be used to identify members who are candidate for pharmacy restriction as well as case management outreach. Current timeline is 2023.
MD	Jai Medical Systems Managed Care Organization, Inc.	Coverage of Anxiety/Sedative medications is carved out and covered under FFS Medicaid. Carved out pharmacy utilization data was not shared with the MCOs in a format that could be stored in the Rx engine at the PBM until late in the measurement year so retrospective monitoring could not be implemented until after the measurement year.
MI	Aetna Better Health of Michigan	We are currently retroactive monitoring of carve out data. We are investigating programs to include specific actions and outcomes for FY24.
MI	McLaren Health Plan	Antianxiety/sedative medications are a carved out benefit managed by the State of Michigan FFS Medicaid. The plan is working towards implementing a monitoring program FY23.
MN	IMCare	We are considering monitoring benzodiazipine use in children and poly pharmacy with stimulants in a focus study.
MN	Medica	Medica is contemplating clinical program options and will implement as soon as possible.
NJ	Aetna Better Health of New Jersey	Current timeline is unknown

State	MCO Name	Explanation
PA	Aetna Better Health of Pennsylvania	Current timeline is unknown.
TX	Aetna Better Health of Texas	Current timeline is unknown
UT	Healthy U	Q1CY2024
UT	Molina Healthcare of Utah	Molina has DUR edits for unsafe drug combinations with antianxiety or sedative drugs, we will set up reporting to monitor use of these drugs in children.
UT	Steward Health Choice Utah	We plan to implement Q1CY2024.
VA	AetnaBetterHealthofVirginia	Timeline unknown at this time.
VA	VirginiaPremier	The plan will review this class and identify potential areas for concern and implement future monitoring. Currently, age related POS edits occur for inappropriate prescribing outside of FDA guidelines.

If "No," please explain why you will not be implementing a program to monitor the appropriate use of antianxiety/sedative drugs in children.

Table 208 - Explanation for Not Implementing a Program to Monitor Use of Antianxiety/Sedative Drugs in Children

State	MCO Name	Explanation
DC	AmeriHealth Caritas DC	We already have prospective and retrospective edits in place that monitor for duplicate therapy and safety edits for dosing, quantity limits, drug interactions, and high dosage that are already a part of our proDUR and retroDUR programs.
DC	CareFirst BCBS Community Health Plan DC	In the 2021 DUR MCO Annual Survey submission, CareFirst CHPDC had planned to implement a program to monitor the use of anti-anxiety/sedative drugs in children similar to the current policy in place for monitoring the use of antipsychotics in pediatrics. We had planned to implement the program by October 2022 which is when the new contract procurement from Department of Healthcare Finance (DHCF) was finalized. Despite the MCO's preparations to create a report that would capture prescription and medical claims data to conduct the DUR, this monitoring program was not carried out due to CareFirst CHPDC not being awarded the contract in 2022
DC	MedStar Family Choice - District of Columbia	MFC recognizes the importance of oversight of use of antianxiety/sedative drugs in children. After we conclude the process of integrating behavioral health we will specify a process to implement a monitoring program.
FL	Florida Community Care	As a Long Term Care plan, our population is restricted to beneficiaries age 18 and above. We have no population of children.
IL	MeridianHealth	No plans to implement at this time. Providers have access to medical information and are able to prescribe according the preferred drug list.
MD	Amerigroup Community Care	Behavioral/Mental Health treatment class is carved-out of MCO and paid for by FFS program.
MD	CareFirst Community Health Plan Maryland	N/A. Antianxiety/sedative drugs in children are carved-out to the State.
MD	Kaiser Foundation Health Plan of the Mid-Atlantic States	Covered through Fee for Service.
MD	Maryland Physicians Care	FFS and Optum is responsible for managing programs for the Behavioral Health benefit.

State	MCO Name	Explanation
MD	MedStar Family Choice	MFC does not manage this benefit as behavioral health treatment including medication is carved out to the State.
MD	Priority Partners MCO	The Behavioral/Mental Health treatment class is carved-out of MCO benefit coverage and is administered by the FFS program.
MI	HAP Empowered	These medications are carved out and managed by the State through FFS Medicaid.
MI	Meridian Health Plan	This is a carve out benefit. The pharmacy benefit manager has programming to support so we could look to expand if the plan was provided the data in file that could easily be applied to the logic with with PBM programming.
MI	Molina Healthcare of Michigan	These medications are carved out to FFS.
MI	Priority Health Choice	In Michigan, coverage of these drugs is carved out to the Fee For Service Medicaid program.
MI	Upper Peninsula Health Plan	Antianxiety and sedative drugs are a carve out from the health plan benefit.
MN	HealthPartners	Current Medication programs for anti-anxiety medications target members 18+ years old.
MN	PrimeWest	At this time, use of antianxiety drugs in children has not been identified as an at-risk area for members. Claims review and authorization monitoring have not demonstrated concern. Consideration will be given to implementing a program to monitor the appropriate use of antianxiety/sedative drugs in children in the future. MedImpact formulary age limit DUR edit varies by antianxiety/sedative drugs generic ingredient and indication based on to FDA labeling.
MN	SouthCountry	The DUR Board continues its ongoing review of a variety of medication classes with information derived from a variety of sources. Antianxiety/Sedative medications will be considered, along with others, for more in-depth review and possible action as we continue to prioritize effective use of our resources.
NY	MVP Health Care	We will continue to review our utilization patterns and work with pediatric behavioral specialists to review necessity to implement a program to monitor antianxiety/sedative drugs in children.
OH	Paramount	Currently, limitations/edits for anti-anxiety and sedative medications are drug-specific and apply to all members regardless of age. Edits for anti-anxiety and sedative medications are dependent on the details outlined on the Ohio Department of Medicaid's UPDL. Drugs that are not on the UPDL must be reviewed for age, dosage, and FDA approved use. Paramount does not plan to implement a new program due to the fact that the pharmacy benefit will be handled by the State's chosen single PBM.
OR	Advanced Health	Most antianxiety/sedatives are paid for by FFS Medicaid in Oregon. They are not covered by Advanced Health. Melatonin (ages less than 18) and diphenhydramine are on formulary without a prior authorization.
OR	Cascade Health Alliance	Covered under the State's Fee For Service drug benefit.
OR	Columbia Pacific CCO	As Oregon Medicaid Fee For Service carves out the coverage of mental health medications, there is no ability to directly manage claims with DUR pharmacy edits. CCO Regional Care Teams currently provide support for all admissions to inpatient psych, subacute, Psychiatric Residential (PRTS), and Psychiatric Day Treatment. This provides support for the most vulnerable within this population.

State	MCO Name	Explanation
OR	Eastern Oregon Coordinated Care Organization (EOCCO)	Antianxiety/sedative medications are carved out of EOCCO, as Oregon Health Authority pays for covered mental health drugs on a fee-for-service basis. These products are defined as those drugs classified in the Standard Therapeutic Class equal to class 07 and 11. Therefore, EOCCO does not manage utilization of this therapeutic class.
OR	Health Share of Oregon-CareOregon RAE	As Oregon Medicaid Fee For Service carves out the coverage of mental health medications, there is no ability to directly manage claims with DUR pharmacy edits. CCO Regional Care Teams currently provide support for all admissions to inpatient psych, sub-acute, Psychiatric Residential (PRTS), and Psychiatric Day Treatment. This provides support for the most vulnerable within this population.
OR	Health Share of Oregon/Kaiser Permanente	Appropriate prescribing is managed through our integrated medical record system [KP HealthConnect]. Mental health drugs and services are carved out of our Medicaid agreement. POS edits are defined and managed by the State Medicaid agency.
OR	Health Share of Oregon - Legacy Health/PacificSource	We will not be implementing a monitoring program as mental health medications are a benefit provided directly by the State and we coordinate all activities with Oregon Health Authority.
OR	Health Share of Oregon - OHSU	The Oregon Health Authority Prescription Drug Program monitors use of antianxiety/sedatives in children that includes members of Oregon MCOs.
OR	InterCommunity Health Network	These drugs are carved out by the State.
OR	Jackson Care Connect	As Oregon Medicaid Fee For Service carves out the coverage of mental health medications, there is no ability to directly manage claims with DUR pharmacy edits. CCO Regional Care Teams currently provide support for all admissions to inpatient psych, subacute, Psychiatric Residential (PRTS), and Psychiatric Day Treatment. This provides support for the most vulnerable within this population.
OR	PacificSource Community Solutions- Central Oregon	We will not be implementing a monitoring program as mental health medications are a benefit provided directly by the State and we coordinate all activities with Oregon Health Authority.
OR	PacificSource Community Solutions- Columbia Gorge	We will not be implementing a monitoring program as mental health medications are a benefit provided directly by the State and we coordinate all activities with Oregon Health Authority.
OR	PacificSource Community Solutions/Kaiser Permanente	Appropriate prescribing is managed through our integrated medical record system [KP HealthConnect]. Mental health drugs and services are carved out of our Medicaid agreement. POS edits are defined and managed by the State Medicaid agency.
OR	PacificSource Community Solutions - Lane	We will not be implementing a monitoring program as mental health medications are a benefit provided directly by the State and we coordinate all activities with Oregon Health Authority.
OR	PacificSource Community Solutions - Marion/Polk	We will not be implementing a monitoring program as mental health medications are a benefit provided directly by the State and we coordinate all activities with Oregon Health Authority.
OR	Providence / Health Share of Oregon	Not currently monitoring FFS drugs, however, will evaluate claims data to determine if implementing plan is necessary.
OR	Yamhill Community Care Organization	Not currently monitoring FFS drugs, however, will evaluate claims data to determine if implementing plan is necessary.

State	MCO Name	Explanation
PA	PA Health and Wellness	Currently our membership does not include patients under 18 years of age.
RI	THP	The MCO does have dose edits in place for all members. The MCO will implement additional program edits (e.g., age, polypharmacy) if claims data indicates it is needed for our members or the State directs us to do so.
TX	Community Health Choice	System is not set at this time to manage or monitor antianxiety/sedative drugs
TX	Cook Children's Health Plan	The majority of CCHP's membership is comprised of children. At this time, monitoring mood stabilizers is not currently in our immediate plans.
TX	El Paso Health	MCO's current PMUR plan does not focus on mood antianxiety/sedative drugs in children at this time.
TX	Parkland Community Health Plan	Once we have determined the best acceptable criterion for selection and put the necessary changes in place, PCHP will begin implementing the anti-anxiety/sedative medications for children. We must also evaluate staffing capacity because extra staff may be required to help with monitoring.
UT	SelectHealth	These products are carved-out to State Medicaid.

Section VIII - Innovative Practices

1. Does your MCO participate in any demonstrations or have any waivers to allow importation of certain drugs from Canada or other countries that are versions of FDA-approved drugs for dispensing to Medicaid Beneficiaries?

Figure 158 - MCO Participates in Demonstrations Has Waivers to Allow Importation of Certain Drugs from Other Countries that are FDA-Approved for Dispensing to Medicaid Beneficiaries

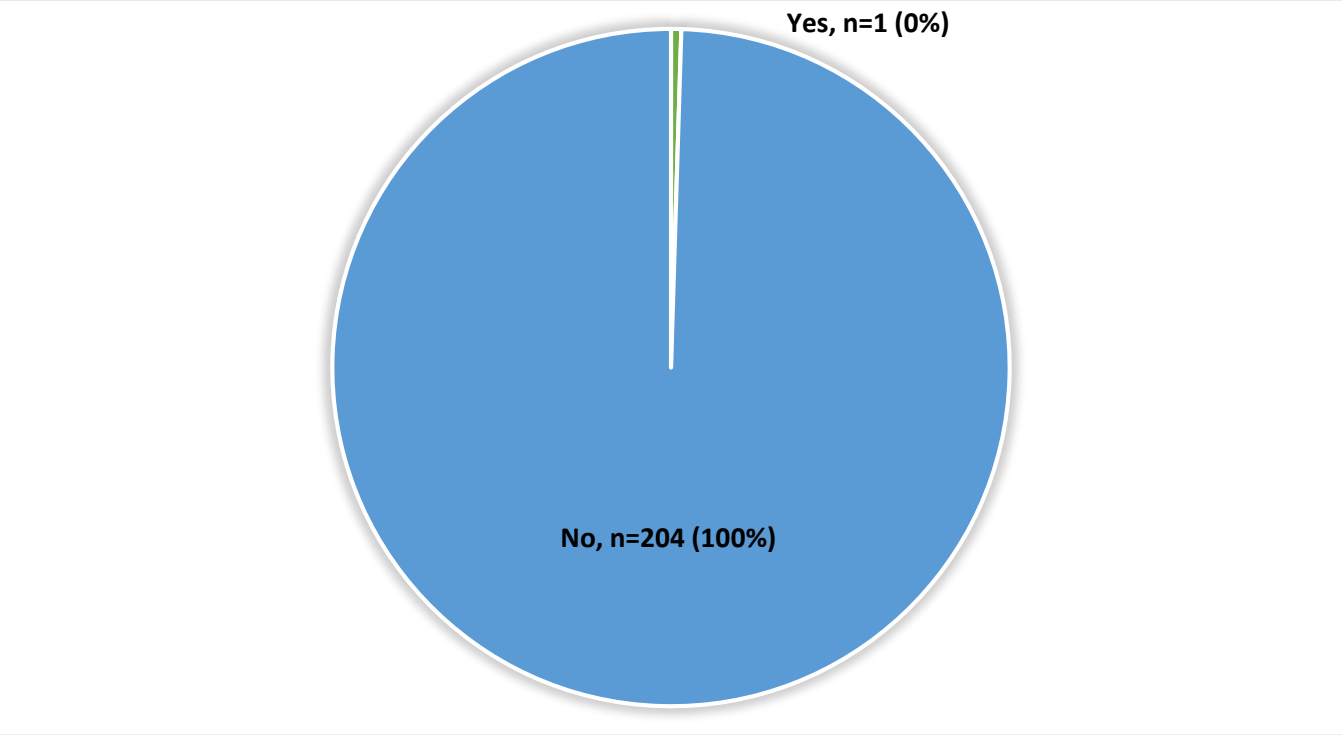

Table 209 - MCO Participates in Demonstrations/Has Waivers to Allow Importation of Certain Drugs from Other Countries that are FDA-Approved for Dispensing to Medicaid Beneficiaries

Response	States (Count of MCOs)	Count	Percentage
Yes	Michigan (1)	1	0.49%
No	Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (8), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	204	99.51%
National Totals		**205**	**100%**

2. Summary 4 - Innovative Practices

Innovative Practices Summary should discuss development of innovative practices during the past year (i.e. Substance Use Disorder, Hepatitis C, Cystic Fibrosis, MMEs, and Value Based Purchasing).

Please reference individual State MCO reports on Medicaid.gov for more information.

Section IX - Executive Summary

1. Summary 5 - Executive Summary

Executive Summary should include a general overview and summary of program highlights from FFY 2021 as well as objectives, tools and outcomes of initiatives accomplished, and goals for FFY 2022.

Please reference individual State MCO reports on Medicaid.gov for more information.