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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Frequently Asked Questions: SUPPORT for Patients and Communities Act, Section 5042 – Medicaid PARTNERSHIP Act

On October 24, 2018, President Trump signed the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT for Patients and Communities Act) into law (Pub. L. No. 115-271). Section 5042 of the SUPPORT for Patients and Communities Act includes the "Medicaid Providers Are Required to Note Experiences in Record Systems to Help In-need Patients Act (Medicaid PARTNERSHIP Act), which added section 1944 to the Social Security Act (Act). Under section 1944 of the Act, beginning October 1, 2021, states must have a qualified prescription drug monitoring program (PDMP) and must require that certain Medicaid providers check information about certain Medicaid beneficiaries' prescription drug history in the qualified PDMP before prescribing controlled substances to the beneficiary. Below, CMS provides information to states about implementing section 1944 of the Act and about claiming the 100 percent federal Medicaid matching funds for certain expenditures related to qualified PDMPs described in section 1944(f) of the Act. The 100 percent federal match under section 1944(f) of the Act is available only for FY 2019 and FY 2020.

1. **How should states claim the 100% federal match available under section 1944(f) of the Act?**

   The Medicaid PARTNERSHIP Act did not specify any new processes for states with respect to claiming enhanced federal matching funds under section 1944(f) of the Act. If a state would seek enhanced federal match under section 1944(f) for expenditures on a qualified PDMP that is part of a mechanized claims processing and information retrieval system, as defined in 42 CFR 433.111(b), then the prior approval requirements in 42 CFR part 433, subpart C would apply. Additionally, prior approval requirements in 45 CFR part 95, subpart F may apply, even if the requirements at 42 CFR part 433, subpart C do not.

   CMS expects many states would integrate their qualified PDMPs with their existing Medicaid mechanized claims processing and information retrieval systems. If states choose to do so, they could potentially receive 75 percent federal match for operation of such systems under 42 CFR 433.116. Similarly, states that opt to integrate their qualified PDMPs with their existing Medicaid mechanized claims processing and information retrieval systems could potentially claim 90 percent federal match under 42 CFR 433.112 for design, development, installation, or enhancement activities related to the qualified PDMP that occurred after FY 2020, as described in State Medicaid Director Letter #18-006.

   CMS encourages states to submit with any applicable prior approval or advance planning documentation a plan for using the section 1944(f) federal matching funds that is likely to

help achieve the broader purposes of the SUPPORT for Patients and Communities Act, such as by decreasing the amount of opioid-related negative outcomes experienced by Medicaid beneficiaries. States should submit any applicable prior approval or advance planning documentation to the appropriate state lead for Medicaid systems in the CMS regional office and should coordinate with Thomas Novak on discussing scope, expectations, and process (thomas.novak@hhs.gov).

2. What kinds of activities can the enhanced match available under section 1944 of the Act support?

Section 1944(f) of the Act establishes a 100 percent federal matching percentage for FY 2019 and FY 2020, for state expenditures to design, develop, or implement a qualified PDMP and to make connections to the qualified PDMP. For the 100 percent federal matching percentage to apply, the PDMP must be qualified, which means it must satisfy the criteria described in section 1944(b)(1) through (2) of the Act. Additionally, the state must have in place agreements with all contiguous states to share certain qualified PDMP data, consistent with section 1944(f)(2) of the Act.

The criteria described in section 1944(b)(1) and (2) that a state's PDMP must meet in order for the state to claim enhanced match are as follows:

1. The PDMP must facilitate access by covered providers to, at a minimum, the following information with respect to a covered individual, in as close to real-time as possible:
    a. Information regarding the prescription drug history of a covered individual with respect to controlled substances.
    b. The number and type of controlled substances prescribed to and filled for the covered individual during at least the most recent 12-month period (data on "prescribed" and "filled" medication may be two data sources).
    c. The name, location, and contact information (or other identifying number selected by the state, such as a national provider identifier issued by the CMS National Plan and Provider Enumeration System) of each covered provider who prescribed a controlled substance to the covered individual during at least the most recent 12-month period.
2. The PDMP must also facilitate the integration of the information described in (1) into the workflow of a covered provider, which may include the provider's electronic prescribing system for controlled substances.

State expenditures on a qualified PDMP that can be matched at 100% under section 1944(f) of the Act could include expenditures on certain PDMP features that, in CMS's view, are consistent with section 1944's description of qualified PDMPs. A non-exhaustive list of potential expenditures on a qualified PDMP for which a state could

seek enhanced federal match under section 1944(f), subject to CMS review, might include the following:

- State expenditures to design, develop, or implement PDMP functionality that will enable connections between the qualified PDMP and providers' Electronic Prescriptions for Controlled Substances (ePCS) systems, or that will enable connections between the qualified PDMP and other provider electronic health records systems that might include prescription history information (because section 1944(b) describes monitoring the prescription of controlled substances and facilitating integration of the PDMP with provider workflow, including ePCS systems).
- State expenditures to design, develop, or implement systems or enhancements to existing systems which support the reporting described in section 1944(e)(1), if these expenditures can be cost-allocated to the qualified PDMP rather than to the state's implementation of section 1927 of the Act.
- If the qualified PDMP is part of the state's Medicaid mechanized claims processing and information retrieval system, state expenditures to design, develop, or implement systems or enhancements to existing systems that support any reporting that might be required under 42 CFR 433.112(b)(15), if those expenditures can be cost-allocated to the PDMP.
- State expenditures to design, develop, or implement upgrades to the functionality of a state's current PDMP, in order to ensure that it meets the statutory definition of a "qualified" PDMP.
- State expenditures to design, develop, or implement functionality to support the data sharing that section 1944(b) of the Act permits, but does not require, between a state Medicaid program or state Medicaid managed care entity and a qualified PDMP.

CMS will not, however, match state expenditures on provider-administered or provider-owned systems under section 1944(f) of the Act. Section 1944 of the Act clearly requires that, to be federally matched at 100%, expenditures must be a *state's* expenditures on a PDMP *administered by the State*.
We encourage states to contact thomas.novak@hhs.gov if they have questions about whether specific types of expenditures could be federally matched at 100% under section 1944(f) of the Act.

3. What kinds of information would CMS encourage states to include in any applicable prior approval materials submitted to CMS?

CMS asks states to include the following information in any advance planning documentation about activities under section 1944 that they provide to CMS. At a minimum, the information described in (4), (5), and (8) below should be included in any applicable advance planning documentation submitted to CMS. All other information

listed below is not required to be included in advance planning documentation, but CMS encourages states to submit it, as it would help CMS to understand how the state is implementing section 1944. States should be aware that some of the other information might be requested by CMS as part of a post-claim review or audit.

1. State has defined which health care providers are "covered providers," consistent with the definition in section 1944(h)(3) of the Act.
2. State has defined, consistent with section 1944(a)(1) of the Act, the "timing, manner, and form" under which a covered provider is required to check the qualified PDMP before prescribing a "covered individual" a controlled substance. For example, the state could show it has defined which Medicaid providers must query a qualified PDMP, for which beneficiaries they must do so, and under what circumstances they must do so.
3. For providers that make a good faith effort to check a qualified PDMP but cannot, we encourage states to describe what kinds of paper or electronic documentation the state would require to confirm that a good faith effort was made, consistent with section 1944(a)(2) of the Act.
4. State's Requests for Proposals (RFPs) (HHS sole source requirements and guidance may apply), contracts, IAPDs, or other documentation (as applicable) demonstrate that the system will be a qualified PDMP as defined in 1944(b) of the Act, because it will facilitate access by a covered provider to, at a minimum, the following information with respect to a covered individual, in as close to real-time as possible:
    a. Information regarding the prescription drug history of a covered individual with respect to controlled substances.
    b. The number and type of controlled substances prescribed to and filled for the covered individual during at least the most recent 12-month period (note that data on "prescribed" medication and "filled" medication may be two data sources).
    c. The name, location, and contact information (or other identifying number selected by the state, such as a national provider identifier issued by the CMS National Plan and Provider Enumeration System) of each covered provider who prescribed a controlled substance to the covered individual during at least the most recent 12-month period.
5. State demonstrates that the qualified PDMP will facilitate the integration of the information described in (4) above into the workflow of covered providers, which may include the provider's electronic prescribing system for controlled substances.
6. State has described whether there is a data sharing agreement in place between the qualified PDMP and the pharmacy director or medical director of the State Medicaid agency and whether the qualified PDMP will be capable of facilitating that connection.

7. State has described whether it is choosing to facilitate access between the qualified PDMP and the medical director or pharmacy director of any managed care entity.
8. State has documented that it has in place agreements with all contiguous states that meet the criteria described in section 1944(f)(2) of the Act, or has submitted preliminary information about these agreements and attested that the agreements will be in effect before the state claims any enhanced federal matching funds under section 1944(f) of the Act.

4. If the regulations at 42 CFR part 433, subpart C apply, how could a state ensure that its qualified PDMP aligns with and incorporates industry standards, consistent with 42 CFR 433.112(b)(12)?

We encourage states to refer to the information on standards in SMD Letter #18-006[1] and also to refer to the Interoperability Standards Advisory (ISA) published by the Office of the National Coordinator for Health Information Technology (ONC). Specifically, the section of the ISA describing "A Prescriber's Ability to Obtain a Patient's Medication History from a Prescription Drug Monitoring Program,"[2] describes recommended industry standards for PDMP and electronic health records (EHR) integration. We also encourage states to take a standards-based approach to the electronic prescribing of controlled substances, interstate data sharing of PDMP data, and electronic case reporting, and to refer to the ISA as appropriate to learn more about those industry standards.

5. In the existing process for complying with 42 CFR 433.112(b)(15), states provide CMS with benchmarks and metrics on outcomes associated with enhanced match. For states establishing qualified PDMPs that would be subject to 42 CFR part 433, subpart C, what information specific to qualified PDMPs does CMS expect states to submit with their prior approval documentation?

State RFPs (HHS sole source requirements and guidance may apply), contracts, IAPDs, or other documentation (as applicable) should clearly require that the qualified PDMP support the reporting requirements described in section 1944(e)(1) of the Act, so that the state would be able to include in its reports under section 1927(g)(3)(D) of the Act, beginning with reports submitted for 2023, the following information for the most recent 12-month period:

- The percentage of covered providers (as determined pursuant to a process established by the state) who checked the prescription drug history of a covered individual

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18006.pdf
[2] https://www.healthit.gov/isa/allows-a-prescriber-request-a-patients-medication-history-a-state-prescription-drug-monitoring

through a qualified PDMP described in section 1944(b) of the Act before prescribing to such individual a controlled substance.

- Aggregate trends with respect to prescribing controlled substances such as—
  - the quantity of daily morphine milligram equivalents prescribed for controlled substances;
  - the number and quantity of daily morphine milligram equivalents prescribed for controlled substances per covered individual; and
  - the types of controlled substances prescribed, including the dates of such prescriptions, the supplies authorized (including the duration of such supplies), and the period of validity of such prescriptions, in different populations (such as individuals who are elderly, individuals with disabilities, and individuals who are enrolled in both Medicaid and Medicare).
- Whether or not the state requires (and a detailed explanation as to why the state does or does not require) pharmacists to check the prescription drug history of a covered individual through a qualified PDMP described in section 1944(b) before dispensing a controlled substance to such individual.
- An accounting of any data or privacy breach of a qualified PDMP described in section 1944(b), the number of covered individuals impacted by each such breach, and a description of the steps the state has taken to address each such breach, including, to the extent required by state or Federal law or otherwise determined appropriate by the state, alerting any such impacted individual and law enforcement of the breach.

In the event states already have systems that can support such reporting requirements, states should reach out to their CMS regional office state officer for systems to discuss cost allocation.

6. If 42 CFR 433.112(b)(15) applies to the state's qualified PDMP, what transaction data, reports, and performance information should the PDMP be able to produce?

In addition to expecting states to develop PDMPs that will be capable of meeting the reporting requirements at section 1944(e)(1), CMS also encourages states to develop qualified PDMPs that would be capable of reporting on the measures described below, for purposes of 42 CFR 433.112(b)(15). CMS has consulted with the Centers for Disease Control and Prevention and has determined that if state PDMPs are able to report on these measures, that would contribute to program evaluation, continuous improvement in business operations, and transparency and accountability, consistent with 42 CFR 433.112(b)(15):

1. Concurrent Use of Opioids and Benzodiazepines: The percentage of individuals ≥18 years with concurrent use of prescription opioids and benzodiazepines for ≥30 cumulative days (excludes patients in hospice care and those with cancer).

2. Use of Opioids at High Dosage in Persons Without Cancer: The percentage of individuals ≥18 years of age who received prescriptions for opioids with an average daily dosage of ≥90 morphine milligram equivalents (MME) over a period of ≥90 days (excludes patients in hospice care and those with cancer).
3. Use of Opioids from Multiple Providers in Persons Without Cancer: The percentage of individuals ≥18 years of age who received prescriptions for opioids from ≥4 prescribers and ≥4 pharmacies within ≤180 days (excludes patients in hospice care and those with cancer).
4. Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer: The percentage of individuals ≥18 years of age who received prescriptions for opioids with an average daily dosage of ≥90 morphine milligram equivalents (MME) over a period of ≥90 days AND who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies within ≤180 days (excludes patients in hospice care and those with cancer).
5. The rate of events among individuals receiving prescription opioid medications captured via electronic case reporting as described in 45 CFR 170.315(f)(5) that have evidence of opioid-related hospitalizations, emergency department visits, and/or urgent care visits, expressed as number of unique events per month.

States should also consider if PDMP systems might also be leveraged to meet the Medicaid Drug Review and Utilization requirements in Section 1004 of the SUPPORT for Patients and Communities Act and specifically discuss with CMS which enhanced matching rate might be available, based on systems currently in place or that may be planned for design, development, or implementation.

7. How should states implement the requirement in section 1944(f)(2) of the Act to have agreements governing sharing of qualified PDMP data with contiguous states?

As a condition of receiving enhanced matching funds under section 1944(f) of the Act the administering state must "[have] in place agreements with all States that are contiguous to such administering State that, when combined, enable covered providers in all such contiguous States to access, through the [PDMP], the information that is described in [section 1944(b)(1)] of covered individuals of such administering State and that covered providers in such administering State are able to access through such program." Section 1944(f)(2). Therefore, before submitting claims for enhanced federal match under section 1944(f), states must be able to demonstrate that the required agreements are in place. If states are subject to prior approval requirements (such as under 45 CFR part 95, subpart F, or under 42 CFR part 433, subpart C), they could include in the prior approval materials a letter of intent to enter into the required agreements with final agreements to follow, and an attestation that the agreements will be in effect before the state claims any enhanced federal matching funds under section 1944(f) of the Act.

States that will integrate their qualified PDMPs with their existing Medicaid mechanized claims processing and information retrieval systems should refer to SMD Letter #18-006, which recommends states also refer to the Interoperability Standards Advisory (ISA) published by ONC. Specifically, the section of the ISA describing "A Prescriber's Ability to Obtain a Patient's Medication History from a Prescription Drug Monitoring Program," discusses industry standards for interstate data sharing of PDMP data.

8. What if a state's existing PDMP does not allow data sharing with the state Medicaid agency?

The section 1944(b) definition of "qualified PDMP" permits, but does not require, that a qualified PDMP facilitate data sharing with the state Medicaid program. Specifically, "A qualified [PDMP] described in [section 1944(b)], with respect to a State, may have in place, in accordance with applicable State and Federal law, a data-sharing agreement with the State Medicaid program that allows the medical director and pharmacy director of such program (and any designee of such a director who reports directly to such director) to access the information described in [section 1944(b)(1)] in an electronic format." While data sharing with the state Medicaid program is not required, states may find it difficult to leverage Medicaid to address the opioid crisis without allowing communications between states' qualified PDMPs and their Medicaid programs.