Medicaid Drug Utilization Review
State Comparison / Summary Report
FFY 2016 Annual Report
Prescription Drug Fee-For-Service Programs

October 2017

Executive Summary of 2016 State Medicaid DUR Annual Reports

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

Each State Medicaid program under Section 1927(g)(3)(D) of the Social Security Act (the Act) is required to submit an annual report on the operation of its Medicaid Drug Utilization Review (DUR) program. States are required to report on their prescribing patterns, cost savings generated from their DUR programs and their programs' operations, including adoption of new innovative DUR practices. On February 23, 2017, the Centers for Medicare & Medicaid Services (CMS) sent the FFY 2016 Medicaid DUR Annual Reporting tool to states for completion. The Medicaid DUR Utilization Review State / Comparison Summary Report, which compiles the state report findings, is published on Medicaid.gov annually and serves as a resource for states, researchers and CMS on the topic of DUR in Medicaid programs. Below is a brief summary of the findings.

I. Demographics

All states including the District of Columbia submitted a 2016 Medicaid DUR Annual Report, with the exception of Arizona. The information reported is focused primarily on Medicaid Fee-For-Service DUR activities. For Federal Fiscal Year (FFY) 2016 and 2017, states were not required to submit an annual report on the specifics of Medicaid managed care organization (MCO) DUR activities. However, states and MCOs are required to submit an annual report for the FFY 2018 DUR reporting period and every FFY period thereafter.

II. Prospective DUR (ProDUR)

ProDUR functions are done at the point-of-sale (POS) when the prescription is being filled at the pharmacy. Forty-five states (90%) contract with an outside vendor to process their POS claims. Thirty-eight states (76%) use First Data Bank as their ProDUR criteria source. All states set early refill thresholds as a way of preventing prescriptions from being refilled too soon. States reported thresholds ranging from 70% to 90%, with an average of 79% of the prescription being used before a non-controlled prescription could be refilled. For controlled drugs, which include opioids for example, the range reported is 70% to 100%, with an average of 84% of the prescription being used before the prescription could be refilled.

III. Retrospective DUR (RetroDUR)

RetroDUR allows states to examine drug claims to identify patterns of abuse or misuse. These functions reside primarily with a contractor in 34 states and with an academic organization in 11 states. The DUR Board identifies those categories of prescription claims to be examined to screen for patterns of fraud, abuse, gross overuse, or medically unnecessary care and then takes corrective actions. In 43 states (86%), the DUR Board approves the RetroDUR criteria to be followed by the contracted organization.

IV. DUR Board Activity

The states provided a summary of their DUR Board activities, which can be found in each individual state report. Seven states (14%) reported that they have Medication Therapy Management (MTM) programs approved by CMS. MTM is a professional service, separate from the function of dispensing prescriptions, provided by pharmacists whose aim is to optimize drug therapy and improve therapeutic outcomes for patients.

V. Physician Administered Drugs

To date, 13 states (26%) for the Prospective DUR and 22 states (44%) for the Retrospective DUR have designed or redesigned their Medicaid Management Information System (MMIS) systems to incorporate Physician Administered Drugs (i.e. drugs paid through the physicians and hospitals programs) into their DUR criteria.

VI. Generic Policy and Utilization Data

All states reported generic utilization percentages for all covered outpatient drugs reimbursed during the 2016 reporting period. The average percentage generic utilization was 82%, which accounts for an average of 22% of the total dollars reimbursed by Medicaid for drugs during the reporting period.

VII. Program Evaluation /Cost Savings/Avoidance

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

VIII. Fraud, Waste and Abuse Detection

A. Lock- In Programs

Almost all Medicaid agencies, except Florida, have a Lock-In or Patient Review and Restriction Program in which the state identifies potential fraud or misuse of controlled drugs by a beneficiary. Lock-In programs restrict beneficiaries whose utilization of medical services is documented as being excessive. Beneficiaries are restricted to specific provider(s) in order to monitor services being utilized and reduce unnecessary or inappropriate utilization. In addition, 24 states (48%) have a documented process in place that identifies potential fraud or misuse of non-controlled drugs by a beneficiary.

Thirty-nine states (78%) have a process to identify potential fraudulent practices by prescribers and thirty-six states (72%) have a process to identify potential fraudulent practices by pharmacies. These processes trigger actions such as denying claims written by that prescriber or claims submitted by that pharmacy, alerting the state Integrity or Compliance Unit to investigate, or referring to the appropriate licensing Board or another state governmental agency (e.g. Attorney General, OIG and DEA) for follow-up.

B. Prescription Drug Monitoring Programs

Prescription Drug Monitoring Programs (PDMPs) are statewide electronic databases that collect designated data on controlled substances that are dispensed in the state. Depending on the state, physicians and pharmacists have access to these databases to identify prescribers and patients that are engaging in potential fraud or misuse of controlled substances. In 2016, forty-nine states (98%) reported having a PDMP in their state. Twenty-six states (53%) have some ability to query the PDMP database, while the remaining twenty-three states (47%) do not have the ability to do so.

Only 13 states (27%) require that prescribers access the patient history in the database prior to prescribing restricted (controlled) substances. As of the close of this reporting period, Missouri reports to be the only state that is not implementing a PDMP. While 19 states (39%) report that they also have access to Border States PDMPs, thirty-six states (73%) indicated that they face a range of barriers that hinder their ability to fully access and utilize the database to curb abuse.

C. Pain Management Control

Fourteen states (28%) reported that they obtained the Drug Enforcement Administration (DEA) Active Controlled Substance Registrant's File in order to identify those prescribers not authorized to prescribe controlled drugs. Forty-four states (88%) reported having measures in place to either monitor or manage the prescribing of methadone for pain management.

D. Opioids

Thirty-seven states (74%) have edits in place to limit the quantity of short-acting opioids and thirty-nine states (78%) have edits in place to limit the quantity of long-acting opioids.

E. Morphine Equivalent Daily Dose (MEDD)

Eighteen states (36%) have set recommended Morphine Equivalent Daily Dose (MEDD) screens. The state limits the amount of products containing morphine or morphine derivatives that a patient may receive in a specific time frame in order to reduce potential abuse or diversion. Twelve states (24%) report that they give providers information on how to calculate the MEDD.

F. Buprenorphine and Buprenorphine/Naloxone Combinations

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

G. Antipsychotics/Stimulants

Forty-three states (86%) have programs in place to either manage or monitor the appropriate use of antipsychotic medications in children. Thirty-eight of these states (88%) monitor all children, not just those children in foster care or a subset of children specified by a young age limit. The 43 states have provided a brief synopsis of the specifics of their programs. Delaware and Montana only monitor children in foster care. It should be noted that some states have legislation in place that prohibits any restriction being placed on the prescribing of medications used to treat mental or behavioral health conditions. Forty-seven states (94%) have restrictions or special programs in place to either monitor or control the use of stimulants.

IX. Innovative Practices

Thirty-seven states (74%) listed in the full report have submitted Innovative Practices that they initiated.

X. E-Prescribing

Twenty-one states (42%) have the capability to enable the prescriber to access patient data history and pharmacy coverage limitations prior to prescribing for a specific patient. Electronic prescribing helps to improve the quality of the prescribing process and helps providers identify drugs that have lower-cost generics or are more cost effective.

XI. Managed Care Organizations (MCOs)

States are currently not required to report on the nature and scope of DUR activities in their MCOs, even though more states are moving their beneficiaries into MCOs. Thirty-eight states (76%) have MCOs. Nineteen states (50%) report that prescription coverage is included (carved-in) to the capitation rate. Eighteen states (47%) report the agency sets requirements for the MCO pharmacy benefit. Twenty-nine states (76%) require their MCOs to have a targeted intervention program (i.e. CMC/ Lock-In) for the misuse or abuse of controlled substances. Lastly, only 10 states (26%) require their MCOs to monitor or report their MCO DUR activities.

As stated above, for Federal Fiscal Year (FFY) 2016 and 2017, states were not required to submit an annual report on the specifics of Medicaid managed care organization (MCO) DUR activities. However, states and MCOs are required to submit an annual report for the FFY 2018 DUR reporting period and every FFY period thereafter.

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1. In the Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) published on May 6, 2016, CMS finalized that states require MCOs to operate DUR programs that comply with Section 1927(g) of the Social Security Act as well as have the MCOs provide a detailed report of their DUR program activities to the state on an annual basis.

Medicaid Fee for Service Program Drug Utilization Review Annual Report

Comparison/Summary Report FFY 2016

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I. DEMOGRAPHIC INFORMATION

49 States plus DC completed the FFY 2016 Medicaid DUR Annual Report. AZ has the majority of its Medicaid population in Managed Care Organizations (MCOs); therefore, the state is not currently required to submit an annual DUR report.

II. PROSPECTIVE DUR (ProDUR)

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

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

Vendor	State
Change Healthcare*	IA, ME, UT, VT, WY
Conduent*	CA, HI, MA, MS, MT, NM
CSRA	NC, NY
DXC*	AL, KS, PA, RI
HID*	TX
HPE*	CT, DE, OK, OR*, WI
Magellan	AK, AR, DC, FL, ID, KY, MI, NE, NH, SC, TN
Molina	LA, NJ, WV
OptumRx	GA, IN, NV
Other	N/A
State-operated	IL, MN, ND, SD, WA
Wipro Infocrossing Healthcare Services Inc.	MO
Xerox	CO, MD, OH*, VA

State	Note
*Change Healthcare	Formerly Goold Health Systems
*Conduent	Formerly Xerox State Healthcare, LLC
*DXC	Formerly Hewlett Packard Enterprise Services
*HID	Health Information Designs
*HPE	Hewlett Packard Enterprise
*OR	Hewlett Packard Enterprise Services operates the POS claims system and Prospective DUR services. Oregon State University (OSU)/Oregon Health Sciences University (OHSU) College of Pharmacy is subcontracted to operate the Retrospective DUR services.
*OH	Xerox State Healthcare through June 11, 2016 Goold Health Systems beginning June 12, 2016

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

Answer	State	Number of States (Percentage of 45 States)
Yes	AL, CA, CO, CT, DE, HI, KS, LA, MO, MS, MT, NC, NJ, NM, NY, OK, PA, RI, VA, WI, WV	21 (47%)
No	AK, AR, DC, FL, GA, IA, ID, IN, KY, MA, MD, ME, MI, NE, NH, NV, OH, OR, SC, TN, TX, UT, VT, WY	24 (53%)

II-3. Identify the prospective DUR criteria source.

Answer	State	Number of States (Percentage)
First Data Bank	AK, AL, AR, CA, CO, CT, DC, FL, HI, ID, IL, KS, KY, LA, MA, MD, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NY, OK, OR, PA, RI, SC, SD, TN, VA, WI, WV	38 (76%)
MediSpan	GA, IA, IN, NV, UT, WA, WY	7 (14%)
Other	DE, ME, OH, TX, VT	5 (10 %)

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

State	Explanation
DE	Micromedex
ME	Medispan, Clinical Literature, CMS and FDA alerts and other State programs.
OH	First DataBank through June 11, 2016 Medispan beginning June 12, 2016
TX	Some of the pro-DUR criteria are from First Data Bank and some others, such as the high acetaminophen dose, are set by the state.
VT	Medispan, Clinical Literature, FDA Safety Alerts

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

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

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

State	Explanation
AR	New ProDUR criteria for new drugs to system are automatically updated as new drugs are added to the system.
CA	The DUR board advises and makes recommendations regarding prospective DUR criteria; however, final approval is made by DHCS.
GA	Criteria is from MediSpan
IA	This is a collaborative effort between the State, POS Contractor and DUR. Most new Proposed criteria are reviewed by the DUR
ID	The DUR Board reviews; however, they do not approve or disapprove any vendor criteria
MD	Although the DUR Board does not review and approve all new prospective DUR criteria, a summary of prospective DUR alerts is reviewed and discussed at all DUR meetings. Individual criteria may be recommended by the Board for implementation. All new severity level 1 drug intervention criteria is automatically implemented by the point-of-sale (POS) vendor as it becomes available from First Data Bank.
MI	MDHHS and the DUR Board reviewed the ProDUR criteria when the First Data Bank (FDB) criteria was first implemented. After that, the Board felt comfortable with the completeness of the FDB criteria.
MN	Informational edits are not reviewed by the DUR Board. High dose or quantity limit edits which cause the claim to reject are reviewed by the DUR Board.
MO	Automatic updates are made from FirstDatabank which are incorporated in our DUR criteria.
ND	The DUR Board meets quarterly so their responsibility is to review all new retrospective DUR criteria.
NE	The DUR Board recommends criteria, however, final approval is made by DHHS.
NV	Medispan provides the criteria, the DUR Board does not review or approve new criteria.
OK	Guidelines have been approved, and new criteria are updated as it comes from FDB as long as it meets the set parameters.
OR	DUR criteria are updated by FDB. There is an ability to modify how the alerts are responded to (override required or information only), but not to change the criteria itself.
RI	The prospective DUR criteria is auto loaded from First Data Bank.
SC	Criteria is primarily provided by FDB and not reviewed by the DUR Board. Edits outside of these provided by FDB or existing edits may reviewed/recommended by the State.
SD	DUR reviews retrospective claims data
TN	DUR Board reviews products that become an issue. With a 3-hr quarterly meeting, it's not possible to review all new products, nor is it necessary.
WA	Standard automated DUR criteria which are overridable by pharmacists with the use of submitted DUR codes are provided through the Medispan drug file and applied by the OptumRx claim processing system. These DUR criteria are not reviewed by the DUR Board. Active DUR criteria in the form of prior authorization requirements (including quantity and dosing limits, step therapy, etc..) applied by the state which are based solely on the definition of medically accepted indications are also not reviewed by the DUR Board, as federal rule already requires the state to use medically accepted indications as a standard. The DUR Board reviews those active Prospective DUR criteria which represent predetermined standards more stringent than medically accepted indication alone.

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

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

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

Answer	State	Number of States (Percentage)
Monthly	AL, CT, DC, KY, MA, MS, MT, NC, ND, NE, NH, NM, VA	13 (26%)
Quarterly	AK, DE, GA, HI, MI, NV, NY, OK, OR, SC, VT	11 (24%)
Annually	CA, LA, PA, RI, SD, TX, UT	7 (14%)
Never	AR, CO, FL, IA, ID, IL, IN, KS, MD, ME, MN, MO, NJ, TN, WA, WI, WV, WY	18 (36%)

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

State	Explanation
AR	We have not requested the contractor to provide ProDUR response reports on individual pharmacies. Instead, we requested the contractor to provide reports on the drugs involved in ProDUR edits with the highest number of overrides (therapeutic duplication (TD), early refill (ER), drug-drug interaction (DD) to look for reasons for the overrides. It was found that the vast majority of the overrides were for the 2 drug classes that had TD of 2 concurrent agents and were the 2 drug classes where we allow TD in the PA point of sale criteria algorithm (LA opioid + SA opioid, and SA C-II stimulant for booster dose + LA C-II stimulant). For the early refill override, after changing to Magellan as the pharmacy vendor, we were able to implement a hard edit on ER of non-controlled drugs if pharmacy tried to fill earlier than 75% of days' supply expended. In addition, we were able to place an "accumulation" edit on all drugs (controlled drugs and non-controlled drugs) that were filled early (e.g., 7 days early, which is at the 75% level that is set for almost all drugs and does not require a PA) and the beneficiary can now only "accumulate" a total of 15 days' supply "early" on each drug entity (same drug/same strength/same dosage form) during a 180 day look-back period to decrease/stop excessive stockpiling/abuse of drugs. The ProDUR edit for drug-drug interactions that were overridden were not contraindicated in the literature, they only said dispense with caution, which leaves it up to the professional judgment of the pharmacist filling the prescription. It was more beneficial to actually review the drugs involved in the ProDUR categories than to review massive reports on individual pharmacies that would tell us nothing helpful.
CO	This will be changing in February 2017, when transitioning to Magellan PBMS.
FL	The Medicaid Program Integrity department reviews the pharmacy provider activity, not Pharmacy Policy.
IA	We do not allow overrides at the pharmacy level. Individual pharmacy claim activity is reviewed bimonthly, by the top 100 pharmacies by paid amount and top 100 pharmacies by prescription count.
ID	An individual pharmacy provider report is not generated at this time.
IL	The MMIS system in place for FY16 does not have this capability
IN	The claims processing system has logic in place to determine appropriate pharmacy provider submissions of conflict, intervention, and outcome codes. We continue to evaluate the utility of this type of reporting.
KS	The State pharmacy department is currently discussing what process can be used to monitor this.
MD	Reports are generated and reviewed adhoc or as necessary.
ME	Currently we do allow pharmacies to override conflict code/interventions as they are soft messaging back to the pharmacies.
MN	We do not have plans to use them. If the concern is large enough, then we require the claim to reject, then it cannot be override without a PA.
MO	We can run/request reports as needed, but do not do so on a scheduled basis.
NJ	Prospective DUR alerts cannot be overridden by the pharmacy provider.
TN	Haven't thought about it. We have to trust our network pharmacists' judgment. At the same time, some DUR edits that are routinely overridden should be investigated. This type of a report/overview/analysis might be valuable if it was very specific and a target was identified. To this point, the Board or the State's staff has not considered this. Perhaps in the future.
WA	Washington Medicaid considers potential misuse of submitted DUR codes to be an issue of fraud and abuse, rather than a clinical issue, and defers review of submitted DUR codes to the SURS/ audit function as permitted under 42 CFR 456.714, and limits the review activities of DUR staff to those that focus on what constitutes appropriate and medically necessary care. Use of DUR codes is not specifically followed up on in reporting across all pharmacy providers, but are reviewed for accuracy and appropriateness during individual pharmacy audits.
WI	Wisconsin is currently in the process of modifying the DUR alerts. After completion of this work, Wisconsin will need to evaluate and revise the prospective DUR reports.
WV	They are received upon request.
WY	They have been reviewed in the past and were not found very useful.

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

Answer	State	Number of States (Percentage of 32 States)
Yes	AK, AL, DC, DE, KY, LA, MA, MI, NC, ND, NE, SC, SD, UT	14 (44%)
No	CA, CT, GA, HI, MS, MT, NH, NM, NV, NY, OH, OK, OR, PA, RI, TX, VA, VT	18 (56%)

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

Answer	State	Number of States (Percentage of 14 States)
Contact pharmacy	AK, DC, LA, MA, ND, NE, SD	7 (50%)
Refer to Program Integrity for Review	DE, NC, SC	3 (21%)
Other (explain)	AL, KY, MI, UT	4 (29%)

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

State	Explanation
AL	Alabama Medicaid has an Academic Detailing program that provides scheduled face-to face visits to providers.
KY	We do both Contact Pharmacy and Refer to Program Integrity for Review
MI	We would contact pharmacy and may refer to program integrity for review.
UT	Situationally specific

II-7. Early Refill:

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

Category	Number of States	Percentage Threshold		
		Average	Minimum	Maximum
Non-controlled drugs:	50	79%	70%	90%
Controlled drugs:	50	84%	70%	100%

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

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

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

Answer	State	Number of States (Percentage of 36 states)
Pharmacist	OK, TX, WA	3 (8%)
Prescriber	ID, MS, NY, TN	4 (11%)
Either	AK, AL, AR, CO, CT, DC, DE, FL, GA, HI, IL, IN, KY, MA, MD, ME, MO, MT, NM, NV, OH, PA, SC, TN, UT, VA, VT, WV, WY	29 (81%)

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

Answer	State	Number of States (Percentage of 14 states)
Yes	CA, KS, LA, MI, NC, ND, NE, OR, RI, WI	10 (71%)
No	IA, NH, NJ, SD	4 (29%)

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

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

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

Answer	State	Number of States (Percentage of 41 states)
Pharmacist	MN, OK, TX, WA, WI	5 (12%)
Prescriber	CT, DE, FL, HI, ID, IN, MS, NY, PA, TN	10 (24%)
Either	AK, AL, AR, CO, DC, GA, IL, KY, MA, MD, ME, MI, MO, MT, ND, NE, NM, NV, OH, SC, SD, UT, VA, VT, WV, WY	26 (64%)

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

Answer	State	Number of States (Percentage of 9 states)
Yes	CA, KS, LA, NC, OR, RI	6 (67%)
No	IA, NH, NJ	3 (33%)

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

a) Lost/stolen Rx

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

b) Vacation

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

c) Other

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

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

State	Explanation
AK	Lost/stolen only in the event a police report has been filed and upon coordination/approval from prescriber
CA	The pharmacist can override the early refill DUR alert message if medically necessary.
DE	Change in directions can have pharmacist override
KS	Spilled Medications
LA	Other situations may be overridden using the pharmacist's professional judgment.
ME	Nursing Home admissions
MO	All early refill denials require the pharmacist to contact the helpdesk for individual override each time the edit posts.
NC	Change of Therapy
ND	Prescription must be 60% utilized. Will make exceptions for seizure medication.
NE	Lost or stolen controlled substances require a prior authorization.
NH	Other early refills reasons include change in dose, patient transitioning to a nursing facility, patient requires two prescriptions of the same RX, and wrong days supply.
OH	No explanation provided by state.
OR	Change in therapy, medically necessary, LTC, are among other accepted clarifications.
SC	Lost/stole/destroyed meds may be overridden by Magellan. Appropriate report (Police/fire) required and only one occurrence per beneficiary per year.
SD	Situational
TX	For any early refill reasons, the State requires a phone call from dispensing pharmacy. It requires an HHSC clinical staff to review and, if necessary, reach out to the prescriber for a reasonable explanation.
WA	Washington State has two levels of early refill rejections, one of which is a 'hard' edit requiring authorization, the other being a 'soft' DUR edit overridable by pharmacists. 'Soft' early refill edits occur at an ingredient level and are primarily information regarding what a client has filled at other pharmacies than the one submitting the current claim. 'Hard' early refill edits are specific to the particular pharmacy and prescription being filled, and require authorization. Pharmacists can self-authorize

	some early refill situations. They may use an override for lost or stolen prescriptions once per drug per client in a six month period. Additional instances of loss require an active request of authorization from the state. The state does not allow early refill overrides for vacations. Pharmacists may also self-authorize early refills for situations where separate supplies are needed for separate locations, such as a home supply and a school supply, or when the patient is being actively monitored by the prescriber.
WI	Dose change, member misunderstood directions from prescriber and natural disaster. Dose change, member misunderstood directions from the prescriber and natural disaster.

II-9. Does your system have an accumulation edit to prevent patients from continuously filling prescriptions early?

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

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

State	Explanation
AK	Allows for 7 days accumulation over a 120 day look-back period
AL	Claims that exceed, or result in, the accumulation of more than 7 days' worth of medication in a 120-day time period will deny at the POS.
AR	The Refill Too Soon logic is an Early Refill Accumulation Limit that allows a beneficiary, who fills prescriptions early, a maximum accumulation of 15-days' supply filled early during a 180-day look-back period of time. The Refill Too Soon logic applies to both controlled drugs and non-controlled drugs. The RTS logic is not based on the prescription number; the RTS logic identifies the same drug/same strength/same dosage form and adds up the days' supply for each time the drug is filled early during the look-back period. The RTS logic starts with the date of service on the incoming claim and looks back 180 days for the number of days filled early during that time period. Once the beneficiary has reached an accumulation of 15 days' supply filled early for same drug/same strength/same dosage form in the previous 180 days, the drug cannot be filled early again until the oldest "early" fill is outside of the date range.
FL	Certain classes have accumulation edits (proton pump inhibitors, skeletal muscle relaxants, controlled substances). The edit counts refills over a particular time frame to prohibit continuous filling without review.
GA	Refill-too-soon edit, which allows patients to only obtain next fill if 75% of previous fill would be completed by that time.
ID	The pharmacy claims system is set to look at a maximum quantity per day as well as a rolling accumulation edit to not allow for early refills.
IL	Refill too soon - carryover days accumulate from month to month
IN	The claims processing system will evaluate the days supply for historical claims against the days supply of new claims. If the new claim's daily dose has increased, the system will calculate the next date of fill automatically based on remaining supply. If the new daily dose has not increased, the system will calculate the next date of fill based on the remaining supply from all historical claims.
KY	The system does have this capability and Kentucky does currently use a three (3) day tolerance per month.
LA	We have accumulation edits on hydrocodone and on proton pump inhibitors. Both edits require clinical override from our prior authorization center.
MI	MI has refill tolerance and dispensing fee accumulation edits to prevent patients from continuously filling prescriptions early.
ND	Max 15 days accumulation in 180 days for non-controlled. Max 10 days accumulation in 180 days for controlled.
NM	An exception code posts to the pharmacy indicating the date when the medication can be refilled.
NY	The enhanced edit denies a claim if more than a 10-day supply of medication is remaining of the cumulative amount that has been dispensed over the previous 90 days, and will augment current editing where claims are denied when less than 75% of the previously dispensed amount has been used (the more stringent rule will apply). Members may, with prescriber intervention, have the ability to refill their prescription(s) early through the process of prior authorization, allowing for ample supply of their medication(s) on hand.
OK	Cumulative Early Refill edit is triggered when the member has received early fills for the medication in the past 240days and the combined extra day's supply of the early fills is equal to 110% or more of the days' supply on the current claim being submitted. The edit is set up stimulant medications only.
RI	Only allows one original and 5 refills per prescription.
SC	Claim will deny if 75% of previous supply has not been used in non-controls, 85% in controls.
WV	The edit keeps members from getting a thirteen month supply in 12 months by not allowing them to refill their prescriptions early each month, based on the total number of units obtained during a rolling 12-month period.

WY	Scheduled drugs II-V require 90% of the days supply to be used and no more than seven (7) days accumulation over a one hundred eighty (180) day look back period before a refill or new claim for the same medication will be allowed. ï,· All other medications require 80% of the days supply be used and no more than fifteen (15) days of accumulated medication over a one hundred eighty (180) day look back period before a refill or a claim for the same medication will be allowed.

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

Answer	State	Number of States (Percentage of 31 states)
Yes	CO, DC, DE, MA, MD, MS, MT, NC, NE, SD, UT, VT	12 (39%)
No	CA, CT, HI, IA, KS, ME, MN, MO, NH, NJ, NV, OH, OR, PA, TN, TX, VA, WA, WI	19 (61%)

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

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

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

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

II-12. Section 1927(g)(A) of the Social Security Act requires that the pharmacist offer patient counseling at the time of dispensing. Who in your state has responsibility for monitoring compliance with the oral counseling requirement? Check all that apply.

Answer	State	Number of States (Percentage)
Medicaid agency	AK, CO, CT, FL, HI, MI, SC	7 (14%)
State Board of Pharmacy	AK, AL, AR, CA, DC, DE, GA, IA, ID, IN, KS, KY, LA, MA, MD, ME, MI, MN, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	43 (86%)
Other- please explain	IL, MO, NY	3 (6 %)

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

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

II-13. Has the state included Attachment 1 – Pharmacy Oral Counseling Compliance Report, a report on state efforts to monitor pharmacy compliance with the oral counseling requirement?

Answer	State	Number of States (Percentage)
Yes	AK, AL, CA, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NM, NV, NY, OH, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, WA, WV, WY	45 (90%)
No	AR, MA, NJ, PA, WI	5 (10%)

III. RETROSPECTIVE DUR (RetroDUR)

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

Answer	State	Number of States (Percentage)
Company	AK, AL, AR, CT, DC, DE, FL, GA, HI, IA, ID, IN, KS, KY, LA, ME, MI, MN, MO, NC, ND, NH, NJ, NM, PA, RI, SC, SD, TN, TX, VA, VT, WI, WV	34 (68%)
Academic institution	CA, CO, IL, MA, MS, NV, OH, OK, OR, UT, WY	11 (22%)
Other organization	MD, MT, NE, NY, WA	5 (10 %)

Organization by Name and Type

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

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

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

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

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

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

State	Explanation
CA	Retrospective DUR criteria are developed jointly by UCSF and DHCS with input and recommendation by the DUR board. Final approval of criteria is made by DHCS.
HI	Developed in-house by Hawaii Medicaid with DUR Board input.
ID	Idaho Medicaid pharmacy program clinical pharmacists develop the Retro-DUR criteria
LA	Retrospective DUR criteria are developed through collaboration of pharmacists at DHH, Molina Medicaid Solutions, and the University of Louisiana-Monroe.
NE	Retrospective DUR criteria are developed jointly by DHHS, the POS vendor and the RetroDUR vendor.
OH	Developed in house
OK	The University utilizes MediSpan drug information applications.
UT	The DRRC may or may not recommend Retrospective DUR criteria, and Utah Medicaid may or may not accept presented or modified criteria.

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

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

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

State	Explanation
CA	The DUR board advises and makes recommendations regarding prospective DUR criteria; however, final approval is made by DHCS.
GA	The DUR Board is advisory only; the Department of Community Health approves criteria.
IA	Change Healthcare utilizes MediSpan for retrospective DUR criteria involving a complex screening process.
NV	The DUR Board offers topics and reviews results, but does not approve before letters are sent.
OK	Guidelines have been approved, and new criteria are updated as it comes from MediSpan as long as it meets the set parameters.
WA	Washington State Medicaid performs ongoing periodic retrospective review of pharmacy claims at least quarterly to identify areas of clinical concern. In general these are performed for the purpose of identifying potential problems for presentation to the DUR Board, prior to the Board's involvement. Review which does not result in identification of a significant problem does not lead to Board presentation. When data and analysis of areas of concern are presented to the Board, in most instances their recommended follow up is Prospective DUR interventions, which the State wraps educational components into.
WY	Retrospective topics are often discussed with the Board, but specifics are handled by the DUR Manager independently.

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

Answer	Number of States	Percentage
Yes	49	98%
No	1	2%

IV. DUR BOARD ACTIVITY

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

Answer	Number of States	Percentage
Yes	50	100%

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

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

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

Answer	State	Number of States (Percentage of 18 states)
Yes	IN, MA, ME, TX, UT, VT	6 (33%)
No	CA, DC, IA, MO, ND, NY, OK, OR, PA, WA, WV, WY	12 (67%)

If the answer to above is “Yes”, please provide a brief summary of your findings.

State Findings

IN The Managed Care Entities (MCEs) provide disease management programs which are monitored and evaluated through the MCE's quality improvement processes. This is accomplished at the individual health plan level and not at the state level.

MA Educational outreach interventions to prescribers increased medication possession and demonstrated cost avoidance.

ME We were able to Abate xx million in inappropriate drug therapy through the State Pharmacy Care Management program (PCM)

TX Texas Medicaid Wellness Program Overview.

1. Background-The Texas Medicaid Wellness Program, launched in March 2011, is a targeted care management program provided by the Texas Health and Human Services Commission and McKesson Health Solutions Care Management. The program operates under the authority of a 1915(b) waiver approved by the Centers for Medicare and Medicaid Services (CMS) and serves certain Medicaid clients in fee-for-service (traditional Medicaid) who are not in another waiver program, who have one or more chronic conditions, and are high cost and high risk based on existence of clinical gaps in care. The majority of clients currently served are Supplemental Security Income (SSI) clients under the age of 21. The goal of the program is to improve clinical outcomes while decreasing the overall cost of care for high-risk Medicaid members through targeted clinical intervention and care management. The Wellness Program replaced the Texas Medicaid Enhanced Care Program, the previous Medicaid disease management program that originated in 2004. The Enhanced Care Program served mostly adults with specified chronic health conditions.

2. Population Served -The Wellness Program serves Medicaid clients enrolled on in fee-for-service (FFS), or otherwise known as traditional Medicaid who are not in another waiver program, have one or more chronic conditions, and are high cost and high risk clients based on existence of clinical gaps in care. The Wellness Program serves approximately 12,000 Medicaid clients. While the majority of clients served by the program are SSI clients under age 21, some adults are also served by the program. Of the total SSI pediatric population, approximately 59% of unique members have one or more of these top five conditions: - Developmental disability, - Attention deficit disorder) (ADD) or attention deficit and hyperactivity disorder (ADHD), -Asthma, -Depression, - Cancer. The same top five conditions are the top five cost drivers, making up 77% of the total claims costs of program eligible SSI children.

3. Services -The goal of the Wellness Program is to promote improved health outcomes by supporting and sustaining the client-provider relationship and building connections between HHSC, providers, clients, and community resources. A focused provider outreach team informs providers of services available through the program, provides practice support, and enables collaboration among providers and regional care teams. Community-based multidisciplinary care teams provide intensive care coordination, one-on-one patient counseling, health assessments, and personalized care plans to help clients better self-manage their conditions. The team includes: - Primary registered nurses, - Social workers, - Behavioral health workers, and - Promotors/community health workers. The teams live in their clients' communities and use evidence-based clinical guidelines to coordinate care with the clients' physicians and treatment teams and advocate on their clients' behalf. The clients benefit by having access to regionally-based resources that help implement personalized care plans, manage follow-up appointments, obtain equipment and medications, and arrange transportation to appointments. Also included for educational purposes are program mailings and focused communications applicable to the Wellness Program population, including children and their caregivers.

4. Summary of the Program Performance Evaluation -As specified in the contract with AxisPoint Health, a total of 20% of AxisPoint Health's per member per month (PMPM) fees for Texas Medicaid Wellness Program (TMWP) is at risk based on performance related to the following three areas: 1. Cost Savings, 2. Humanistic Measures, 3. Clinical Measures. For all three performance areas, Mercer relied on the eligibility, claims fees and AxisPoint Health survey and clinical results provided by HHSC and did not audit the data or verify the survey or clinical results independently. Mercer did assess the eligibility and claims data for consistency and reasonableness. Financial Reconciliation and methodology The Texas Health and Human Services Commission (HHSC) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC to determine a savings reconciliation based on the performance of AxisPoint Health in Program Period 5 (PP5), March 1, 2015 through February 29, 2016.

The TMWP's financial reconciliation is a cost saving evaluation that compares the actual costs against the expected costs during PP5 for those members that meet the Reconciliation Population criteria, as defined in the contract. The expected costs are determined by projecting the baseline costs (March 1, 2010 - February 29, 2011) of the Reconciliation Population to PP5 using appropriate trend factors. To calculate the net savings Mercer used the following methodology: 1. Determined the total expected costs by multiplying the total Participants' member months (MMs) for PP5 by the risk-adjusted expected PMPM claim costs in PP5. 2. Subtracted the risk-adjusted expected PMPM claims costs for the participants from the actual PMPM claims costs incurred by the participant to determine PMPM gross savings for each of the four aid categories: TANF Adults, TANF, Child, SSI-Adults, SSI, Child. 3. Multiplied the PMPM gross savings by the Participants' total MMs for PP5 to arrive at the aggregate gross savings. 4. Calculated net savings as the aggregate gross savings less the fees for the participating members, aggregated in total for the TMWP. 5. Determined net savings as the percentage of claims by dividing the net savings by the expected claims cost, aggregated in total for the TMWP.

The net saving percentage determined is $56,092,419. To determine the fee payback, Mercer used the following formula per the contract: Payback - (Reconciled Fees) x (Percent of Fees at Risk for the Net Savings) x [1-(Actual Net Savings% from above 5%)] if net savings as a percent of expected costs fall below 5% guarantee. The net savings percentage is above the guaranteed minimum of 5%. Mercer determined that no portion of the 8% of total fees paid to AxisPoint Health was due back to HHSC. Humanist Measures: To evaluate the impact of humanistic quality measures on the percentage of reconciled fees at risk, Mercer relied on the AxisPoint Health survey data provided by HHSC. According to the results of the survey provided by AxisPoint Health:
• Measure one (Participants Satisfaction Survey) was met and included the following two metrics:
1) Survey collected, by clients who completed a biannual assessment, exceeded the goal of 955 for this metric (3842 surveys collected).
2) The overall Participant satisfaction point estimated benchmark of 95 was achieved (actual of 95.2).
• Measure two (Participant Health Status Survey) was met and included the following two metrics:
1) Survey collected by clients who completed an initial assessment exceeded the goal of 941 for the Short-Form (SF)-10 (for clients age 5-17). On the follow-up Physical Health Summary (PHS) and Psychosocial health Summary (PSS) scores, the mean PHS value of 40.54 and the mean PSS value of 45.56 showed improvements of 1.94 and 3.30 respectively over the baseline results.
2) Survey results for clients who completed an initial assessment for the SF-12 for clients age 18 and older were not reported as less than 25% of the population was in this age group. As stipulated by the contract, the FS-12 survey tool would be used only if at least 25% of the managed clients were age 18 and older.

Clinical Quality
For performance related to the clinical quality, the following 15 clinical quality measures agreed to by the parties for program period 2 and after. These quality measures may be reconsidered and reevaluated annually to determine their applicability to the actual population resulting from predictive modeling outcomes.
1) Follow-up Care for Children prescribed ADHD Medication (Continuation and Maintenance Phase)
2) Annual Hemoglobin A1c Testing Assessment
3) HEDIS: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
4) Follow-Up after Hospitalization for Mental Illness (FUH)
5) HEDIS (EOC): Use of Appropriate Medications for People with Asthma
6) Annual Number of Children with Asthma ER Visits
7) Well Child Visit in the Third, Fourth, Fifth, and Sixth Years of Life

	8) Adolescent Well-Care Visits 9) Influenza Vaccination 10) Emergency Department Utilization 11) Children and Adolescents Access to Primary Care Practitioners by Age and Total 12) Asthma Assessment 13) Texas Medicaid Pediatric PDI Measures: Asthma admission rate; Diabetes Short-term Complications 14) Gastroenteritis Admission Rate; UTI Admission Rate 15) Provider Satisfaction Survey Based on the results provided by AxisPoint Health, the payback for clinical quality guarantee is $616, 952, 32.5% of the portion of the reconciled fees at risk for clinical results.
UT	The hemophilia management program results in better clinical and quality of life outcomes for our patients (prevented ED visits, prevented supplemental doses, etc.). Another result is cost savings due to the favorable pricing of hemophilia clotting factor through the 340b program.
VT	The Vermont Chronic Initiative has been an evolving, legislatively endorsed effort by the State of Vermont since 2007. The goal is to help Medicaid Members to better manage the chronic conditions. VCCI has positively impacted utilization as well as improved adherence to evidence based pharmacy treatment. Due to a new system deployment, we are not able to provide any data on our outcomes during this FFY given the progressive deployment of our new care management system. Our pharmacy gaps in care and prescription fill data and related system generated alerts are expected in SFY 2018.

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

Answer	State	Number of States (Percentage of 18 states)
Yes	MA, ME, MO, WV	4 (24%)
No	CA, DC, IA, IN, ND, NY, OK, OR, PA, TX, UT, VT, WA, WY	14 (76%)

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

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

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

Answer	State	Number of States (Percentage of 7 states)
Yes	FL, WI	2 (29 %)
No	IA, ME, MN, MO, OR	5 (71 %)

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

State Findings	
FL	Qualitative findings support several benefits based on the responses to open-ended questions and survey items. For example, MTM participants consistently stated that their medication adherence was positively enhanced by participation in the program. Furthermore, they also indicated greater understanding of their medications.
WI	A report titled, "Medication Therapy Management: Evaluation and Lessons Learned" was published in July 2016. Among a variety of measures and demographic findings, the report included a comparison of Medicaid members receiving MTM service to a control group (that did not receive MTM services), since the program was initiated in September 2012. Key findings include: -The MTM program increased all medical costs by $556 per member per year compared to the control group. This includes a $389 increase in pharmacy costs (approximately 70% of the total cost increase). -Inpatient costs for members receiving MTM services were $102 per member per month less than the control group (with nearly the same number of claims among both groups), suggesting the MTM program may be improving member health. -The full report can be viewed at: https://www.dhs.wisconsin.gov/publications/p01558.pdf. A similar report will be conducted in the future to determine if MTM services have an impact on the health of members with chronic conditions over time

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

Answer	State	Number of States (Percentage of 7 states)
Yes	MO,WI	2 (29%)
No	FL, IA, ME, MN, OR	5 (71%)

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

Answer	State	Number of States (Percentage of 43 states)
Yes	CA, CO, DC, IL, MA, MI, MS, ND, OK, SC, TN, TX, VT, WY	14 (33%)
No	AK, AL, AR, CT, DE, GA, HI, ID, IN, KS, KY, LA, MD, MT, NC, NE, NH, NJ, NM, NV, NY, OH, PA, RI, SD, UT, VA, WA, WV	29 (67%)

V. PHYSICIAN ADMINISTERED DRUGS

The Deficit Reduction Act requires collection of NDC numbers for covered outpatient physician administered drugs. These drugs are paid through the physician and hospital programs.

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

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

If answer to V-1 above is "No", do you have a plan to include this information in your DUR criteria in the future?

Answer	State	Number of States (Percentage of 37 states)
Yes	CA, CO, DC, DE, IA, ID, IL, MS, ND, NV, OR, SD, VA, VT, WV	15 (41%)
No	AL, AR, FL, GA, IN, KS, LA, MD, MN, MT, NC, NE, NH, NM, OH, OK, RI, TN, TX, UT, WI, WY	22 (59%)

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

Answer	State	Number of States (Percentage)
Yes	AK, CA, CT, FL, GA, HI, KY, LA, MA, ME, MI, MN, MO, ND, NV, OH, OR, PA, SC, SD, VT, WA	22 (44%)
No	AL, AR, CO, DC, DE, IA, ID, IL, IN, KS, MD, MS, MT, NC, NE, NH, NJ, NM, NY, OK, RI, TN, TX, UT, VA, WI, WV, WY	28 (56%)

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

Answer	State	Number of States (Percentage of 28 states)
Yes	CO, DC, IA, ID, IL, MS, NC, VA, WV	9 (32%)
No	AL, AR, DE, IN, KS, MD, MT, NE, NH, NJ, NM, NY, OK, RI, TN, TX, UT, WI, WY	19 (68%)

VI. GENERIC POLICY AND UTILIZATION DATA

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

Answer	Number of States	Percentage
Yes	50	100%

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

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

If the response is “Yes” to VI-2 above, check all that apply.

Answer	State	Number of States (Percentage of 42 states)
Require that a MedWatch Form be submitted	AK, AL, AR, CT, DE, IA, ID, IN, KS, MD, MI, MS, ND, NH, NV, SD, TN, WV, WY	19 (45%)
Require medical reason for override accompany prescription	AL, DE, ID, KS, MO, MS, MT, ND, NH, NV, OK, SD, UT, WV	14 (33%)
Prior authorization is required	AK, AL, AR, CO, DE, GA, IA, ID, IL, IN, KS, MA, MD, ME, MI, MN, MO, MS, MT, ND, NH, NJ, NV, OH, OK, OR, PA, SD, TN, TX, UT, VT, WI, WV, WY	35 (83%)
Other – please explain	CA, CT, ID, KY, ME, MI, NC, NE, NY, WA	10 (24%)

If the response is “Other”, please explain:

State	Explanation
CA	If a brand name drug does not appear on the Medi-Cal List of Contract Drugs, an approved Treatment Authorization Request may be required before dispensing.
CT	A BMN PA is required unless the brand name drug is on the PDL. A DAW/1 submitted on electronic prescriptions is acceptable.
ID	Must fail 2 generic products
KY	In addition to DAW1, Kentucky also requires PA for non-preferred brands
ME	Maine does not allow DAW 1 for prescriptions, as everything is driven by the MaineCare PDL
MI	Selected drugs classes determined by the state legislature are exempt from prior authorization
NC	Detail information on how many brand names are non-preferred and require PA
NE	A prescriber must submit a MC-6 Form, which declares that the brand name is medically necessary.
NY	On April 26, 2010, New York Medicaid implemented a cost containment initiative which promotes the use of certain multi-source brand name drugs when the cost of the brand name drug is less expensive than the generic equivalent.
WA	Washington Medicaid allows a brand to be dispensed without authorization when prescribed Dispense as Written, but will only reimburse the dispensing pharmacy the same amount it would for the generic equivalent. If the pharmacy wishes to receive higher reimbursement for the brand, they must request authorization. When authorization is requested, the State contacts the prescriber to review the medical necessity for use of the branded product over a generic alternative.

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

State	Generic Utilization Percentage
CA	70%
TX	71%
DC	72%
FL	74%
CT	76%
NC	77%
VT	78%
MD	78%
MS	78%
ME	79%
NJ	79%
AL	80%
SC	80%
MO	81%
CO	81%
MT	81%
SD	81%
WI	81%
LA	81%
WY	81%
AK	81%
ID	82%
DE	82%
NV	82%
NM	82%
OK	82%
TN	82%
IN	82%
MI	83%
IA	83%
MN	83%
ND	83%
UT	83%
WV	83%
GA	84%
NH	84%
NE	84%
NY	84%
IL	84%
OH	85%
MA	85%
AR	86%
VA	86%
KY	87%
KS	88%
OR	89%
WA	89%
RI	90%
PA	91%
HI	95%
Average	**82%**

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

State	Percentage Dollars Paid for Generics in relation to Total Drug Spend
DC	6%
NJ	9%
WA	9%
FL	9%
CA	9%
NH	10%
MD	13%
SC	15%
GA	15%
ME	15%
NV	16%
TX	17%
CT	17%
TN	17%
DE	18%
WV	19%
MI	19%
MT	20%
PA	20%
MS	20%
WI	20%
ID	20%
KY	20%
WY	20%
OK	21%
MA	22%
VT	22%
OH	22%
CO	22%
AL	23%
IA	23%
AK	24%
NE	24%
MN	25%
UT	25%
MO	26%
KS	27%
IL	27%
SD	27%
VA	27%
NM	27%
NC	27%
LA	28%
RI	29%
IN	29%
AR	31%
OR	33%
HI	34%
ND	35%
NY	45%
Average	**22%**

VII. PROGRAM EVALUATION/COST SAVINGS/COST AVOIDANCE

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

Answer	Number of States	Percentage
Yes	50	100%

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

Answer	State	Number of States (Percentage)
Company	AK, AL, AR, CT, DC, DE, FL, GA, IA, ID, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OR, PA, RI, SC, SD, TN, TX, VA, VT, WI, WV	38 (76%)
Academic institution	CA, MA, OK, WY	4 (8%)
Other institution	CO, HI, IL, MD, NY, OH, UT, WA	8 (16%)

Organization Name and Type

Organization	State (* served by more than one organization)
Company	
Change HealthCare	IA, IL*, ME, VT
Conduent	DC, MS, NM, TX*
DXC	KS*
Goold Health System	OH*, UT*
Health Information Design	AL*, AR*, CT*, DE*, KS*, MD*, ND, NY*, PA, RI, SD, TX*, WI, WV*
Hewlet Packard Enterprise Services	CT*, DE*, OR,
Magellan	AK, AR*, FL, ID, KY, MI, NE, NH, SC, TN
Minnesota does internally except for RetroDUR	MN
Molina Medicaid Solution	LA, NJ, WV*
Mountain Pacific Quality Health	MT
Myers and Stauffer	NC
OptumRx Administrative Services	GA, IN, NV
Xerox	MD*, MO, VA
Academic Institution	
University of California, San Francisco (UCSF)	CA
University of Cincinnati College of Pharmacy	OH*
University of Massachusetts Medical School	MA
University of Oklahoma College of Pharmacy, Pharmacy Management Consultants	OK
University of Utah College of Pharmacy Drug Regimen Review Center (DRRC) provided calculations	UT*
University of Wyoming, School of Pharmacy	WY*

Other Organization	
Conduent (formerly known as Xerox) for retro-DUR. Health Information Designs (HID) for Prospective Clinical and PDL prior authorizations.	TX*
Change Healthcare Pharmacy Solutions for SMAC and HFS Bureau of Professional and Ancillary Services	IL*
Hawaii State Medicaid DUR Coordinator	HI
Internal State Analysis	CO
NYS Dept. of Health evaluates ProDUR and Health Information Designs, LLC evaluates RetroDUR.	NY*
Washington State Health Care Authority	WA
Molina Healthcare (ProDUR) and Health Information Designs (RetroDUR)	WV*
Pro-DUR is HPE; Retro-DUR is HID	DE*
Prospective DUR cost savings estimate was conducted by HPE. Retrospective DUR cost savings estimate was conducted by HID	CT*
RetroDUR cost savings performed by HID	AL*
Pro: Goold Health Systems; Retro: University of Cincinnati	OH*

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

State	ProDUR Total Estimated Avoided Costs	RetroDUR Total Estimated Avoided Costs	Other Cost Avoidance	Grand Total Estimated Avoided Costs
AK	4,413,924	-	-	4,413,924
AL	-	1,360,274	-	1,360,274
AR	13,771,693	2,307,028	68,212,488	84,291,209
CA	229,440,897	-	-	229,440,897
CO	-	-	18,534,394	18,534,394
CT	52,331,017	6,350,322	-	58,681,339
DC	-	135,442	-	135,442
DE	228,669	38,855	-	267,524
FL	305,736,319	1,141,935	21,832,727	328,710,981
GA	79,367,532	-	-	79,367,532
HI	-	45,000	-	45,000
IA	-	330,629	-	330,629
ID	17,031,162	11,325,875	-	28,357,037
IL	-	-	461,406,803	461,406,803
IN	123,090,000	587,004	-	123,680,000
KS	177,384	-	8,608	185,992
KY	43,062,709	380,241	16,965,249	60,408,199
LA	31,018,451	764,519	-	31,782,970
MA	201,759,043	-	4,799,635	206,558,678
MD	49,013,260	274,299	-	49,287,559
ME	2,316,411	-	58,317,162	60,633,573
MI	389,412,254	50,340	-	389,462,594
MN	48,442,135	1,357,179	-	49,799,314

State	ProDUR Total Estimated Avoided Costs	RetroDUR Total Estimated Avoided Costs	Other Cost Avoidance	Grand Total Estimated Avoided Costs
MO	44,276,042	581,729	-	44,857,771
MS	12,930,137	-	-	12,930,137
MT	8,503,090	6,548	18,970,371	46,810,308
NC	394,299,743	124,000	82,103,778	476,527,521
ND	-	147,121	-	147,121
NE	46,960,828	7,117	15,317	46,983,261
NH	388,145	127,660	1,069,610	1,585,414
NJ	10,847,453	-	-	10,847,453
NM	2,019,348	6,475	-	2,025,823
NV	124,701,632	-	-	124,701,632
NY	53,249,436	4,454,705	-	57,704,141
OH	8,596,979	-	-	8,596,979
OK	125,758,040	448,066	(4,308,363)	121,897,744
OR	35,167	9,391	22,213,655	22,258,213
PA	-	483,659	-	483,659
RI	3,055,302	973,016	-	4,028,318
SC	4,806,400	593,276	-	5,399,976
SD	-	76,900	-	76,900
TN	49,219,374	195,677	-	49,414,051
TX	35,427,072	15,558,578	-	50,985,650
UT	18,147,272	421,094	-	18,568,366
VA	25,660,741	309,451	6,922,306	32,892,498
VT	2,320,296	-	7,501,864	9,822,160
WA	38,617,018	-	11,792,642	50,409,660
WI	-	995,145	-	995,145
WV	19,233,219	4,085,921	115,757	23,434,897
WY	24,001,323	5,095,589	-	29,096,912
Average	**52,873,338**	**1,247,960**	**16,593,208**	**70,412,471**

VII-4. Please provide the estimated percent impact of your state's cost savings/cost avoidance program compared to total drug expenditures for covered outpatient drugs.

Grand Estimated Net Savings Amount / Total Dollar Amount X 100 = % Impact of Cost Savings /Avoidance compared to Total Drug Spend

State	Percent Impact of Cost Savings/Avoidance Compared to Total Drug Spend
AL	0%
DE	0%
IA	0%
ND	0%
SD	0%
WI	0%
DC	1%
PA	1%
CO	2%
OH	2%
MO	3%
AK	4%
CT	4%
HI	4%
SC	4%
TN	4%
TX	5%
VT	5%
NJ	6%
NM	6%
CA	7%
KS	8%
MD	8%
MS	9%
NH	10%
WV	10%
GA	12%
ID	14%
OR	14%
UT	15%
WA	16%
AR	17%
MN	20%
NY	21%
RI	21%
ME	24%
NE	24%
OK	24%
IN	26%
NC	27%
VA	29%
MT	34%
MA	35%
MI	36%
LA	37%
NV	44%
WY	62%
FL	66%
KY	79%
IL	87%
Average	**18%**

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

Answer	Number of States	Percentage
Yes	50	100%

VIII. FRAUD, WASTE AND ABUSE DETECTION

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

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

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

If the response to VIII-A1 above is “Yes”, what action(s) does this process initiate? Check all that apply.

Answer	State	Number of States (Percentage of 49 states)
Deny claims and require prior authorization	CO, CT, DC, DE, GA, ID, IL, IN, KY, MA, ME, MI, MO, MT, ND, NE, NJ, OR, SC, TN, TX, UT, VT, WV	24 (49%)
Refer to lock-in program	AK, AL, AR, CO, CT, DC, DE, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, ME, MI, MO, MS, MT, NC, ND, NE, NJ, NM, NV, OH, OK, OR, RI, SC, TN, TX, UT, VA, VT, WA, WI, WV, WY	42 (86%)
Refer to Program Integrity Unit	AK, AL, AR, CO, CT, DC, DE, GA, IA, IN, KY, MA, ME, MI, MO, MS, MT, NC, ND, NE, NJ, NV, OH, OK, PA, RI, SC, SD, UT, VA, VT, WV, WY	33 (67%)
Other (e.g. SURS, Office of Inspector General)	AK, AL, CA, GA, IN, KY, MD, MI, MN, MS, MT, NC, NH, NJ, NY, PA, SD, TN, VA, VT, WI	21 (43%)

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

State	Explanation
AK	SURS, MFCU
AL	Refer to MFCU if necessary.
CA	22CCR 50793 details available utilization restrictions when the Department has determined that a beneficiary is misusing or abusing Medi-Cal benefits. Audit & Investigations Branch (IB) is responsible for working beneficiary cases. IB has an intake process for complaints which entails an initial case review and if warranted, assignment of a case to an investigator. Subsequent actions are dependent upon the outcome of IB's investigation.
GA	Referral to Office of Inspector General
IN	Submit to FSSA Bureau of Investigations for member investigation
KY	Board of Pharmacy, Audit Vendors, Surveillance Utilization Review System (SURS), Special Investigative Unit (SIU), Attorney General (AG), Office of Inspector General (OIG)
MD	SURS, OIG, Controlled Dangerous Substance Integration Unit (CDSIU)
MI	The Office of Inspector General performs SURS for both providers and beneficiaries.
MN	Questionable utilization is referred to the SURS program and they determine the action from there.
MS	Depends on situation. Could refer to Mississippi Attorney General's Medicaid Fraud Control Unit
MT	We follow a member through a Fraud review determination and when Fraud may be occurring, the member is referred to the Division of Criminal Investigation.

NC	All potential beneficiary fraud and abuse leads are referred by Program Integrity to the beneficiary's county Department of Social Services for further investigation and disposition.
NH	The Program Integrity Unit performs this function and maintains the lock-in program.
NJ	A Surveillance and Utilization Review (SURS) reporting tool is used by the Data Mining Unit within the Medicaid Fraud Division to look for unusual patterns in claim reimbursement from providers
NY	Professional RetroDUR case reviewers refer potential prescriber fraud cases to the DUR program, from which they are forwarded to the Office of the Medicaid Inspector General (OMIG) for further review and/or possible investigation. OMIG administers the lock-in program.
PA	Refer to OIG for criminal investigation.
SD	Medicaid Fraud Control Unit
TN	Office of Inspector General is State agency that monitors fraud, and drug offenses against the State Medicaid program by enrollees.
VA	Java- Server Utilization Review System (JSURS) identified members to review for enrollment in DMAS Client Medical Management Program (Lock- In program)
VT	Referrals made to law enforcement
WI	The Office of the Inspector General (OIG) has department wide responsibility for auditing the use of department funds in support of the department's commitment to be an effective steward of the public resources DHS is instructed to manage. OIG, which reports directly to the DSH Secretary, conducts audits of providers who receive department funds, performs internal audits of department programs and operations and investigates allegations of fraud, waste and abuse of DHS resources by contractors, providers and members. OIG is responsible for working with DHS programs, divisions and partners to develop policies and practices to prevent fraud, waste and abuse.

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

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

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

Answer	State	Number of States (Percentage of 48 states)
Number of controlled substances (CS)	AK, AL, AR, DC, DE, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, NC, ND, NH, NJ, NM, NV, NY, OH, OK, OR, PA, SC, TN, TX, VA, VT, WA, WI, WV, WY	40 (83%)
Different prescribers of CS	AK, AL, AR, CO, DC, DE, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, TN, TX, UT, VA, VT, WA, WI, WV, WY	46 (96%)
Multiple pharmacies	AK, AL, AR, DC, DE, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, TN, TX, UT, VA, VT, WA, WI, WV, WY	44 (92%)
Number days’ supply of CS	AL, AR, CT, DC, GA, IA, KS, LA, MD, MI, MO, MS, ND, NM, NY, OK OR, PA, SC, TX, VT, WI, WV	23 (48%)
Exclusivity of short-acting opioids	GA, IA, KS, NM, NY, OK, PA, SC, TX, VT	10 (21%)
Multiple ER visits	AK, AL, CO, GA, IA, ID, IN, KS, KY, ME, MI, MN, MO, MS, MT, ND, NE, NH, NJ, NY, OK, OR, PA, TN, UT, VA, VT, WA, WI, WV	30 (63%)

Other	AL, CA, CT, IA, IL, IN, LA, MI, MS, NE, NV, OR, PA, TN, VA, VT, WA	17 (35%)

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

Answer	State	Number of States (Percentage of 48 states)
prescriber only		0 (0 %)
pharmacy only	AR, CT, DC, DE, MA, MD, NH, NJ, NV, OH, OR, RI, SC, TN, WV, WY	16 (33%)
Both prescriber and pharmacy	AK, AL, CA, CO, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, ND, NE, NM, NY, OK, PA, TX, UT, VA, VT, WA, WI	32 (67%)

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

Answer	State	Number of States (Percentage of 48 states)
6 months	AK	1 (2%)
12 months	AL, AR, CO, CT, DC, ID, IL, MA, MS, MT, NC, NH, RI, UT, VA, WV, WY	17 (35%)
Other	CA, DE, GA, HI, IA, IN, KS, KY, LA, MD, ME, MI, MN, MO, ND, NE, NJ, NM, NV, NY, OH, OK, OR, PA, SC, TN, TX, VT, WA, WI	30 (63%)

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

State	Explanation
CA	Two years according to 22CCR 50793.
DE	Lock in does not have an end date, but can be reviewed at the client's request
GA	9-12 months
HI	There has been no usual "lock-in" time period since 2009 when the ABD population moved into managed care plans. No one has been "locked-in" since 2009.
IA	24 months or longer. Note: During FFY 2016, the structure of the program changed with the transition to MCO.
IN	2 years, and then re-evaluation for graduation or re-enrollment
KS	2 years
KY	Twenty-four (24) months initial lock-in period with annual reviews thereafter for appropriateness of continuance in the program.
LA	24 months
MD	24 months
ME	Varies on severity and also dependent of review of urinalysis and medical charts
MI	2 Years
MN	24 months
MO	Participants are locked in for a period of 24 months of eligibility.
ND	Until a subsequent review shows that the patient is properly utilizing services and their lock-in doctor agrees the patient should be removed from the lock-in program.
NE	Each patient enrolled in the Lock-In Program is evaluated every 24 months for necessity of Lock-In status.
NJ	Time period is decided on a case by case basis.
NM	Case by case situations.
NV	Indefinite, we do not have a process for review to remove from lock-in
NY	Two years of lock-in for the first offense. Thereafter, for a continuation (due to continued abuse or overuse while restriction/lock-in still in place) or re-restriction/lock-in, the second term would be three years, and the third time or more would be six years.
OH	18 months
OK	24 months for new lock-in referrals, then reviewed yearly.
OR	18 months
PA	5 years as approved by CMS in 1985 audit of PA's Lock-In Program.
SC	Minimum of 2 years, with periodic evaluation at least annually.

TN	Indefinite. Each enrollee subject to Lock-In is re-reviewed at least once per year, and is eligible to have the Lock-In edit removed based on findings, all listed in Tennessee State Rules.
TX	First lock-in is 36 months; second lock-in is 60 months; third lock-in is lifetime. If convicted of felony, the first lock-in could be lifetime.
VT	2 years
WA	Clients are placed on "lock in" for three years. Periodic interim reviews are performed which may release them earlier.
WI	2 years

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

State	Percentage of the FFS population in lock-in status annually
CO	0.000%
HI	0.000%
KY	0.000%
MS	0.000%
NH	0.000%
NM	0.000%
OH	0.000%
MO	0.002%
LA	0.005%
TX	0.006%
OR	0.010%
MI	0.013%
AR	0.014%
MT	0.020%
SC	0.020%
AL	0.040%
CT	0.050%
IL	0.060%
PA	0.080%
DC	0.100%
KS	0.100%
MA	0.100%
WY	0.100%
NE	0.120%
IN	0.180%
AK	0.200%
DE	0.200%
GA	0.200%
ID	0.200%
NC	0.200%
NY	0.250%
TN	0.250%
UT	0.370%
OK	0.399%
ND	0.400%
NV	0.430%
IA	0.500%
ME	0.500%
RI	0.500%
WI	0.500%
CA	1.000%
MD	1.000%
MN	1.000%
NJ	1.000%
VA	1.000%
VT	1.000%
WA	1.500%
WV	2.000%
Average	**0.325%**

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

State	Estimate of the savings attributed to the lock-in program for the fiscal year under review
AK	$0
AR	$0
CA	$0
CO	$0
DE	$0
GA	$0
HI	$0
IA	$0
ID	$0
IN	$0
KS	$0
KY	$0
MA	$0
ME	$0
MN	$0
MS	$0
ND	$0
NE	$0
NH	$0
NM	$0
OH	$0
VA	$0
WA	$0
WI	$0
DC	$500
RI	$1,831
OR	$4,800
MD	$5,340
LA	$13,000
MI	$20,335
NJ	$30,488
WY	$47,242
AL	$57,002
SC	$100,000
TN	$109,116
TX	$112,161
WV	$115,757
OK	$192,708
MT	$252,868
NV	$374,787
VT	$451,434
CT	$506,948
UT	$679,250
IL	$684,033
NC	$4,606,631
NY	$5,000,000
MO	$6,635,649
PA	$55,190,000
Average	**$1,566,498**

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

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

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

Answer	State	Number of States (Percentage of 39 states)
Deny claims written by this prescriber	CA, CO, GA, IN, MA, MD, MI, MO, NJ, SC, TN, VT, WA, WV	14 (36%)
Refer to Program Integrity Unit	AL, AR, CA, CO, CT, DC, DE, GA, IA, IL, IN, KS, KY, MA, MD, ME, MI, MO, MS, NC, ND, NJ, OH, OK, PA, RI, SC, SD, TN, TX, VA, VT, WA, WV, WY	35 (90%)
Refer to the appropriate Medical Board	AL, CO, DC, DE, GA, IA, IL, IN, KS, KY, MA, MD, ME, MI, MO, MS, NC, ND, NJ, OK, PA, SD, TN, VT, WA, WV, WY	27 (69%)
Other - please explain:	CA, GA, IL, KS, MD, MI, MN, MO, MS, NC, NE, NY, PA, TN, VT, WA	16 (41%)

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

State	Explanation
CA	Propose new policy such as quantity restrictions, and further review by Audit & Investigations Branch (IB) Medical Review Branch (MRB).
GA	Referral to Office of Inspector General
IL	Also report to the Illinois Department of Financial and Professional Regulation, which issues professional licenses.
KS	Referrals are sometimes made to the Attorney General's Office
MD	SURS, OIG, Controlled Dangerous Substance Integration Unit (CDSIU)
MI	Prescribers may be suspended or sanctioned and prescriptions written by this prescriber would then be denied at point-of-sale
MN	Refer to DHS's Office of Inspector General.
MO	DUR Board review of provider/participant cases.
MS	Refer to DEA
NC	An audit of specific claims would be performed.
NE	Program Integrity Unit is reviewing reports produced through the data warehouse of outliers for further review.
NY	Professional RetroDUR case reviewers refer potential prescriber fraud cases to the DUR program, from which they are forwarded to the Office of the Medicaid Inspector General (OMIG) for further review and/or possible investigation.
PA	Refer to MFCS and initiate payment suspension if appropriate.
TN	Since pharmacy is carved out from the managed care plans and is FFS, all prescribers are contracted with the MCO's. Prior to referral to authoritative regulatory Boards, the prescriber would be referred to the MCO.
VT	refer to Medicaid Fraud and Residential Abuse unit
WA	Items A, B, and C are not applicable in every case. All three may be pursued, but only a single action may be taken in some cases.

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

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

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

Answer	State	Number of States (Percentage of 36 states)
Deny claim	CO, GA, IN, KY, LA, MA, MD, ME, MI, MO, NJ, WV	12 (33%)
Refer to Program Integrity Unit	AL, AR, CA, CO, CT, DC, DE, GA, IA, IL, IN, KY, MA, MD, ME, MI, MO, MS, NC, ND, NJ, OH, OK, PA, RI, SD, TX, UT, VA, WA, WV	31 (86%)
Refer to Board of Pharmacy	AL, CO, DC, DE, GA, IA, IL, IN, KY, MA, ME, MI, MO, MS, NC, ND, NJ, OK, PA, SD, WV	21 (58%)
Other - please explain:	CA, GA, IL, IN, KY, MD, MI, MN, MO, MS, NC, NE, NY, PA, SC	15 (42%)

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

State	Explanation
CA	Propose new policy such as quantity restrictions, and further review by Audit & Investigations Branch (IB) Medical Review Branch (MRB).
GA	Referral to Office of Inspector General
IL	Also report to the Illinois Department of Financial and Professional Regulation, which issues professional licenses
IN	Audit recoupment, Prepayment review program
KY	Desk audits are conducted by a vendor.
MD	OIG conducts audits of Maryland pharmacies to ensure compliance with regulations for all medications for Medicaid.
MI	Pharmacies may be suspended or sanctioned which results in the denial of claims submitted by the pharmacy at point-of-sale.
MN	Refer to DHS's Office of Inspector General
MO	DUR Board review of provider/participant cases.
MS	Refer to Mississippi Attorney General's Medicaid Fraud Control Unit
NC	An audit of specific claims would be performed.
NE	Program Integrity Unit is reviewing reports produced through the data warehouse of outliers for further review.
NY	Professional RetroDUR case reviewers refer potential prescriber fraud cases to the DUR program, from which they are forwarded to the Office of the Medicaid Inspector General (OMIG) for further review and/or possible investigation.
PA	Refer to MFCS
SC	Yes, a ranking report has been developed for pharmacy providers based on composite scores to several algorithms and numerous measures.

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

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

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

State	Explanation
AL	Through eligibility and URC, recipients are referred to MFCU.
CA	Audit & Investigations Branch (IB) uses all available information to develop and work cases, initiates audits, and assists in investigations, including review of claims data and trends of non-controlled drugs.
CO	Retrospective DUR analysis and prior authorization identifies these issues
CT	The quality assurance program at DSS performs random claims samples of controlled and non-controlled drugs to identify anomalies in payment and claims processing.
GA	Retrospective analyses of potential fraud/abuse on a case-by-case basis
HI	Establishing quantity limits or other DUR management strategies are documented processes.
IA	If fraud or abuse of a non-controlled substance is identified, the member would be referred to Program Integrity for further investigation.
KY	Refill too soon, ProDUR checks, desk audits, RetroDUR audits, quantity limits, accumulation edits, and other general DUR activities or system edits.
LA	Point of Sale edits.
MA	Medicaid checks MassPAT for outlier behavior episodically and develops corrective action
ME	Review and referral system to identify over use and internal clinical review for placement within the lock-in program.
MI	Beneficiaries with high utilization of emergency room prescribers and pharmacies including those that paid with cash are subject to review.
MN	Questionable utilization is referred to the SURS program and they determine the action from there.
MT	We run a statistical report that reviews usage for controlled substances.
NE	Quantity limits are in place for many non-controlled substances.
NH	The Program Integrity Unit performs this function and will refer as needed.
NJ	Lock into a pharmacy and negative PA. Negative PA is designed to block payment of a prescription service.
NY	Professional RetroDUR case reviewers refer potential prescriber fraud cases to the DUR program, from which they are forwarded to the Office of the Medicaid Inspector General (OMIG) for further review and/or possible investigation. OMIG administers the lock-in program.
OK	Muscle relaxants claims are considered when locking members in.
PA	Review for the Lock-In Program includes all medications. Recipients may be restricted for fraud, waste or abuse of non-controlled substances.
UT	The DRRC has algorithms to identify recipients who may be misusing or abusing non-controlled drugs.
WA	Washington Medicaid does not differentiate between controlled and non-controlled substances for its lock-in program. Although it is usually controlled substances which most easily result in a client be placed in lock-in, any documentable fraud, abuse, or even unintentional misuse of the prescription drug benefit can lead to placement.
WI	Fraud and abuse must be reported regardless if the drug is a controlled drug or non-controlled drug. Providers may report fraud and abuse by going to the OIG fraud and abuse website or by calling the fraud and abuse hotline.
WV	Our early refill edit and quantity limit edit protect against a member obtaining more than 12 months supply of any drug in a year. Drugs requiring a PA typically require at minimum an approved diagnosis.

VIII B. PRESCRPTION DRUG MONITORING PROGRAM (PDMP)

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

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

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

Answer	State	Number of States (Percentage of 49 States)
Yes	AL, CA, CT, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MS, MT, NC, ND, NV, OH, OK, SC, SD, TN, VT, WA, WV	26 (53%)
No	AK, AR, CO, DC, DE, FL, GA, HI, IA, MN, NE, NH, NJ, NM, NY, OR, PA, RI, TX, UT, VA, WI, WY	23 (47%)

If answer to VIII-B1 above is "Yes," do you require prescribers (in your provider agreement with the agency) to access the PDMP patient history before prescribing restricted substances?

Answer	State	Number of States (Percentage of 49 States)
Yes	CT, DE, KS, KY, MA, ND, NH, NY, PA, SC, VA, VT, WV	13 (27%)
No	AK, AL, AR, CA, CO, DC, FL, GA, HI, IA, ID, IL, IN, LA, MD, ME, MI, MN, MS, MT, NC, NE, NJ, NM, NV, OH, OK, OR, RI, SD, TN, TX, UT, WA, WI, WY	36 (73%)

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

State	Explanation
AK	n/a
AL	n/a
AR	Medicaid Pharmacy Program does not have access to the PDMP.
CA	The California Department of Justice has a Prescription Drug Monitoring Program (PDMP) system called The Controlled Substance Utilization Review and Evaluation System (CURES), which allows pre-registered users including licensed healthcare prescribers eligible to prescribe controlled substances, pharmacists authorized to dispense controlled substances, law enforcement, and regulatory boards to access timely patient controlled substance history information. Access to such information helps prescribers and pharmacists better evaluate their patients' care, allowing them to make better prescribing and dispensing decisions, and cut down on prescription drug abuse in California. The Audit & Investigations Branch (IB) uses all available information to develop and work cases, initiates audits, and assists in investigations. Audit & Investigations Branch (IB) examines PDMP information on prescribers, dispensers, and beneficiaries during the course of A&I's usual work.
CO	We cannot access the PDMP.
CT	State law requires all prescribers to review a patient's controlled substance history report if writing for more than a 72 hour supply. The provider agreement with the agency requires prescribers to adhere to all state laws and regulations.
DC	The Department of Health has jurisdiction over the PDMP.

DE	For prior authorizations on controlled substances, the prescriber must indicated on the prior authorization form that the PDMP was checked.
FL	n/a
GA	The State does not have access to the PDMP database.
HI	Review of all FFS narcotic claims is done quarterly for quantities greater than 25. Dental has low quantities and SHOTT rarely has a claim.
IA	The state is unable to access this data. The PMP is only available to authorized healthcare practitioners to review their patient's use of controlled substances.
ID	The clinical pharmacy staff at IDHW will access the PDMP in cases where it is brought to their attention if fraud/abuse is thought to be occurring. The PDMP is also accessed in RetroDUR topics that may require it in conducting reviews.
IL	Prescribers are asked to check ILPMP for hepatitis C medications, adult ADHD medications, and chronic opioid use. HFS checks ILPMP as well and information helps in understanding medication use as well as identifying patients for potential lock-in
IN	INSPECT Program
KS	We incorporated this into our Long-Acting Opioids criteria during FFY 2014.
KY	Prescribers must attest to the fact that the PDMP was consulted prior to particular drugs being approved.
LA	The additional data accessed through PDMP assists the LDH pharmacy staff in determining fraud and abuse.
MA	Medicaid checks MassPAT for outlier behavior episodically and develops corrective action
MD	Information obtained from the PDMP is used for the Corrective Managed Care (CMC) program through the FFS program if a formal investigation is being conducted.
ME	We answered no above.
MI	MDHHS requires prescribers of medication assisted therapy (MAT) agents to be registered and access the PDMP. In addition, the MI Department of Licensing and Regulatory Affairs (LARA) monitors prescribing patterns and investigates. MDHHS also works closely with the OIG and the AG offices.
MN	There is very strict criteria as to when SURS can access the PDMP in the case of a recipient under investigation for fraud and abuse.
MS	Program Integrity uses the data to evaluate suspicious cases involving beneficiaries and providers.
MT	We review utilization between Flexible Rx and the PDMP looking for cash pay on the PDMP, that are not found in Flexible Rx.
NC	For treatment of opioid dependence, prescribers are required to access the PDMP patient history before a PA will be granted.
ND	Require prescribers to access PDMP before approving prior authorizations on some narcotics.
NE	No access.
NH	For all long acting narcotic prescriptions, it is required that the physician access the PDMP prior to prescribing the medication.
NJ	Although our agency does not have the ability to access NJ PDMP, we ask prescribers and pharmacy providers to access PDMP before approving prior authorizations on controlled medications.
NM	The NM Board of Pharmacy has a PDMP accessible prescribers and pharmacists.
NV	Will check potential abusers for cash paid claims in the PMP. Lock-in recipients are also checked.
NY	In NYS, all prescribers writing a prescription for a Schedule II-IV controlled substance have a mandatory duty to consult the Prescription Monitoring Program Registry, with limited exceptions. The mandatory duty to consult the PDMP provision affords practitioners with current, patient-specific controlled substance prescription information intended to inform the practitioner of controlled substance utilization by their patient at the point of prescribing. As of June 14, 2016, New York State practitioners and pharmacists (if allowed under the participating state's data sharing agreement) have access to New Jersey, Connecticut, Massachusetts, Rhode Island, New Hampshire and Vermont's PMP data. NYS is working with Pennsylvania to share data once they are able. NYS is also sharing PDMP information with other states including Virginia, West Virginia, South Carolina, Minnesota, Indiana and the District of Columbia.
OH	Used to verify whether the Medicaid claims are all controlled substances received by patient
OK	Evaluate members for the lock-in program and individual review of members to prevent excess abuse.
OR	VIII-B1 = No
PA	Prescribers are required to query the PDMP for an existing patient when the following clinical situations apply: 1. 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 2. If a prescriber believes or has reason to believe, using sound clinical judgment, that a patient may be abusing or diverting drugs; or 3. Each time a patient is prescribed an opioid drug product or benzodiazepine by the prescriber.
RI	Requests the prescribers use the PDMP.
SC	State may pursue audits of PDMP - state may then recoup monies for office visit on those prescriptions where PDMP was not documented/verified
SD	The answer is no
TN	Providers are now required per State Law to check the CSMDB (Controlled Substance Monitoring DB), and are required within our P.A. requirements for specific medications in an effort to control fraud and abuse. CSMDB is also used during Lock-In re-reviews, as cash purchases are used during the process.

TX	This is managed by the Texas Department of Public Safety.
UT	Utah Medicaid is limited by the State Statute in how it may access and use data from the PDMP.
VA	Service authorizations
VT	Vermont providers are required to register for the VPMS and are mandated to use it in the following circumstances. 1. At least annually for patients who are receiving ongoing treatment with an opioid Schedule II, III, IV. 2. When starting a patient on a schedule II, III, IV for non-palliative long term therapy. 3. The first time the provider prescribes to treat chronic pain. 4. Prior to writing a replacement prescription for a Schedule II, III, IV. 5. In the future, the Department of Health may promulgate rules that require practitioners to check the VPMS in additional circumstances. 4289 Standards and guidelines for health care providers and dispensers (a) Each professional licensing authority for health care providers shall develop evidence-based standards to guide health care providers in the appropriate prescription of Schedules II, III, and IV controlled substances for treatment of chronic pain and for other medical conditions to be determined by the licensing authority. The standards developed by the licensing authorities shall be consistent with rules adopted by the Department of Health. (b)(1) Each health care provider who prescribes any Schedule II, III, or IV controlled substances shall register with the VPMS by November 15, 2013. (2) If the VPMS shows that a patient has filled a prescription for a controlled substance written by a health care provider who is not a registered user of VPMS, the Commissioner of Health shall notify the applicable licensing authority and the provider by mail of the provider's registration requirement pursuant to subdivision (1) of this subsection. (3) The Commissioner of Health shall develop additional procedures to ensure that all health care providers who prescribe controlled substances are registered in compliance with subdivision (1) of this subsection. (c) Each dispenser who dispenses any Schedule II, III, or IV controlled substances shall register with the VPMS. (d) Health care providers shall query the VPMS with respect to an individual patient in the following circumstances: (1) at least annually for patients who are receiving ongoing treatment with an opioid Schedule II, III, or IV controlled substance;(2) when starting a patient on a Schedule II, III, or IV controlled substance for non-palliative long-term pain therapy of 90 days or more; (3) the first time the provider prescribes an opioid Schedule II, III, or IV controlled substance written to treat chronic pain; and (4) prior to writing a replacement prescription for a Schedule II, III, or IV controlled substance pursuant to section 4290 of this title. (e) The Commissioner of Health shall, after consultation with the Unified Pain Management System Advisory Council, adopt rules necessary to effect the purposes of this section. The Commissioner and the Council shall consider additional circumstances under which health care providers should be required to query the VPMS, including whether health care providers should be required to query the VPMS when a patient requests renewal of a prescription for an opioid Schedule II, III, or IV controlled substance written to treat acute pain. (f) Each professional licensing authority for dispensers shall adopt standards, consistent with rules adopted by the Department of Health under this section, regarding the frequency and circumstances under which its respective licensees shall: (1) query the VPMS; and (2) report to the VPMS, which shall be no less than once every seven days. (g) Each professional licensing authority for health care providers and dispensers shall consider the statutory requirements, rules, and standards adopted pursuant to this section in disciplinary proceedings when determining whether a licensee has complied with the applicable standard of care. (Added 2013, No. 75, 11.) 86.
WA	The agency has regularly engaged in multiple projects to utilize PDMP data in controlling fraud and abuse. The agency supplies its MCOs with PDMP data for their use as well, primarily in identifying clients for possible restriction. PDMP data is also used by clinical staff performing clinical review of authorization requests.
WI	DHS currently does not have access to PDMP data.
WV	If the PDMP indicates that a member is obtaining a controlled substance by more than one payer source the matter is referred to the Medicaid Fraud unit. Information obtained through this query may also be used when evaluating a request for prior authorization.
WY	The Department of Health no longer has access to the PDMP and is unable to apply the information in any form.

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

Answer	State	Number of States (Percentage of 49 states)
Yes	CT, ID, IL, IN, KS, KY, LA, MA, MD, MI, MS, MT, ND, NV, NY, OH, TN, VA, VT	19 (39%)
No	AK, AL, AR, CA, CO, DC, DE, FL, GA, HI, IA, ME, MN, NC, NE, NH, NJ, NM, NV, OK, OR, PA, RI, SC, SD, TX, UT, WA, WI, WV, WY	30 (61%)

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

Answer	State	Number of States (Percentage of 49 states)
Yes	AK, AL, AR, CA, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, MA, MD, MI, MN, NC, NE, NH, NJ, NM, NV, OK, OR, PA, RI, TX, UT, VA, WA, WI, WV, WY	36 (73%)
No	DE, KY, LA, ME, MS, MT, ND, NY, OH, SC, SD, TN, VT	13 (37%)

If answer to VIII-B2 above is "Yes," please explain the barriers (e.g. lag time in prescription data being submitted, prescribers not accessing, and pharmacists unable to view prescription history before filling script).

State	Explanation
AK	No access during reporting period.
AL	The Agency has limited access. Prescribers/pharmacies are not required to access prior to writing/dispensing prescriptions.
AR	Medicaid Pharmacy Program does not have access to the PDMP.
CA	Enrollment by California's prescribers and pharmacists was experiencing some delays due to restructuring of the CURES program under the Department of Justice and state budgetary restrictions. A streamlined application and approval process for access to the Controlled Substance Utilization Review and Evaluation System (CURES) 2.0 was completed in FFY 2016. California law (Health and Safety Code Section 11165.1) required all California licensed prescribers authorized to prescribe scheduled drugs to register for access to CURES 2.0 by July 1, 2016 or upon issuance of a Drug Enforcement Administration Controlled Substance Registration Certificate, whichever occurs later. California licensed pharmacists must register for access to CURES 2.0 by July 1, 2016, or upon issuance of a Board of Pharmacy Pharmacist License, whichever occurs later.
CO	The State is prohibited by legislation from accessing the PDMP.
CT	Access is restricted to our Medicaid Fraud Unit only.
DC	Medicaid agency is not able to access the PDMP
FL	Legislatively prohibited to access PDMP.
GA	No access to PDMP for State Medicaid programs. No funding and legal concerns about who can access the data. Prescribers and pharmacies also do not access data like they should, although this seems to be trending in the right direction.
HI	No time resource is available within the agency to utilize PDMP.
IA	Medicaid agency is not granted access to the PMP. The PMP is only available to authorized healthcare practitioners to review their patients' use of controlled substances.
ID	Lag time can occur between dispensing and data being submitted to PDMP by other States. Rules requiring prescribers to access the system prior to prescribing. Not all bordering States are part of the PDMP.
IL	Need to view one patient at a time and re-enter data if checking neighboring state. Currently cannot get batch of Medicaid patient data in ILPMP. Not all pharmacies submit data in a timely manner as evidenced by claims filled, but not yet visible in PDMP. No way to verify if prescriber checked ILPMP prior to writing prescription.
IN	Lag time in prescription data being submitted, prescribers not accessing, pharmacists not accessing before filling script
KS	Our SURS team at our fiscal agents only has administrative access (they must submit report requests to the agency that administers our PDMP and are not able to pull reports real-time.)
MA	No aggregate data 42 CFR part 2 Methadone maintenance is not uploaded to MassPAT.
MD	The FFS program must have a bona fide formal investigation to access the PDMP. Requests must be approved by the DHMH Secretary. Information is obtained through the DHMH office. This may lead to a lagtime between request and receipt of information. Also, technical issues include system downtime maintenance and delay of claims submission by providers.
MI	Discussions have been ongoing to increase the Agency's ability to access the PDMP. System improvements are improving lag time and data availability.
MN	Only SURS can access for a unique recipient that is under investigation. DHS Pharmacy policy and Health Plan Staff cannot access the information.
NC	Many pharmacies have restricted internet access, delay in processing data submitted, prescribers complain of time required to log in.
NE	Nebraska Medicaid does not have the legal authority to access PDMP data. The data are incomplete, as patients may opt out. Pharmacies are not mandatorily reporting data.
NH	Legislation as written does not allow state staff to access the PDMP.

NJ	NJ PDMP grants access to prescribers and pharmacists who are licensed by the State of New Jersey and in good standing with their respective licensing boards. Licensed pharmacy staff conducting DUR is considered unauthorized users since they are not directly delivering healthcare.
NM	Access is only available at pharmacy and prescriber offices.
NV	Only the State staff have access to the data. Contractors for the State are not allowed to access the PMP unless they have responsibility for direct patient care. Unable to query by prescriber.
OK	The agency has very limited to the PMP. Access cannot be granted to contractors who perform lock-in functions. The agency may only query one member at a time. There is no way to access aggregated prescriber data.
OR	Payers do not have access to the PDMP in Oregon
PA	The PDMP is managed by the Department of Health and is not accessible to the Department of Human Services Medicaid Program for fraud and abuse.
RI	State law requires the user of the PDMP to have a DEA number.
TX	The Department of Public Safety does not allow the Medicaid program access to PDMP.
UT	Utah Medicaid is limited by the State Statute in how it may access and use data from the PDMP.
VA	not allowed to access by state law
WA	Washington State continues to struggle with uptake of PDMP usage by prescribers.
WI	The PDMP is managed by a different agency.
WV	Access to the PDMP is limited to one person at our department and queries are capable of only pulling up one member at a time.
WY	The Board of Pharmacy has reviewed their statute and rules and determined that the Department of Health should not have access to the PDMP.

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

Answer	State	Number of States (Percentage of 49 states)
Yes	AK, HI, IL, MA, MI, MS, MT, SC, VT	9 (18%)
No	AL, AR, CA, CO, CT, DC, DE, FL, GA, IA, ID, IN, KS, KY, LA, MD, ME, MN, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SD, TN, TX, UT, VA, WA, WI, WV, WY	40 (82%)

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

State	Explanation
AK	During FFY2016, the agency did not have access to the PDMP. New laws in 2016 made advancements in decreasing barriers; effective dates in 2017.
HI	Recent law opened PDMP to agency access.
IL	ILPMP continues to expand the number of neighboring states' data that is visible.
MA	Upgrades to the State PMP, now referred to as MassPAT, MassPAT also checks for slight changes in a patient's name or birth date -- an alternate spelling or inverted digits, as patients may provide variations on their information when trying to obtain extra drugs without drawing attention.
MI	The PDMP servers have been updated to improve data availability.
MS	Have executed a memorandum of agreement with State Board of Pharmacy for Medicaid to obtain all PMP claims for Medicaid beneficiaries each month for use in Retro-DUR program.
MT	We have access to other states now and delegate access.
SC	prescribers required to access PDMP (effective 4/1/2015)
VT	We are currently in the midst of transition, having just migrated to a new system on the 15th of June, 2017. This will greatly improve the interface and functionality to providers and others utilizing the system.

VIII C. PAIN MANAGEMENT CONTROLS

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

Answer	State	Number of States (Percentage)
Yes	NJ, OH, SC, TN, TX	5 (10 %)
No	AK, AL, AR, CA, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NM, NV, NY, OK, OR, PA, RI, SD, UT, VA, VT, WA, WI, WV, WY	45 (90%)

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

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

If answer to VIII-C2 above is "Yes," do you apply this DEA file to your ProDUR POS edits to prevent unauthorized prescribing?

Answer	State	Number of States (Percentage of 14 states)
Yes	AL, CT, IA, MI, MO, ND, SC, WA	8 (57%)
No	AK, ID, MS. NH, PA, WV	6 (43%)

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

State	Explanation
AL	Claims are denied for controlled drugs prescribed by a provider not on the DEA file.
CT	The information is applied at the point of sale.
IA	Claims are blocked at the point of sale for prescribers not authorized to prescribe controlled substances.
MI	The POS system has business rules that check for XDEA license eligible prescribers of office-based opioid dependency drug therapies.
MO	If the DEA is inactive or restricted, claims for controlled substances are denied POS.
ND	If no active DEA, claims for controlled substances are denied.
SC	Claims for unauthorized prescriber/invalid DEA are denied
WA	During automated prescriber file loads, providers without DEA numbers are identified and added to restricted prescriber networks which do not allow the dispensing of Schedule II medications written by the provider.

If answer to VIII-C2 above is "No," do you plan to obtain the DEA Active Controlled Substance Registrant's file and apply it to your POS edits?

Answer	State	Number of States (Percentage 36 states)
Yes	CO, DC, MA, ME, NJ, SD	6 (17%)
No	AR, CA, DE, FL, GA, HI, IL, IN, KS, KY, LA, MD, MN, MT, NC, NE, NM, NV, NY, OH, OK, OR, RI, TN, TX, UT, VA, VT, WI, WY	30 (83%)

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

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

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

State	Explanation
MI	Our vendor's RetroDUR system loads the DEA registrant file and can be queried for reports as needed, including prescribers without a valid DEA but prescribing controlled substances, etc.
NH	Used to identify prescribers not authorized to prescribe controlled substance medications.

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

Answer	State	Number of States (Percentage)
Yes	AK, AL, AR, CA, CO, CT, DC, DE, FL, GA, IA, ID, IL, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NY, OH, OK, OR, PA, SC, TN, TX, UT, VA, VT, WA, WI, WV, WY	44 (88 %)
No	HI, NM, NV, RI, SD	5 (10%)
Other	IN	1 (2 %)

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

Answer	State	Number of States (Percentage of 44 states)
Pharmacist override	ID, KY, MO, OH	4 (9%)
Deny claim and require PA	AK, AL, AR, CA, DC, DE, FL, ID, IL, KS, KY, LA, MA, MD, ME, MI, MO, NC, ND, NH, NJ, OR, PA, TN, VA, VT, WV	27 (61%)
Quantity limits	AK, AL, DC, DE, FL, GA, ID, KS, LA, MA, ME, MI, MN, MO, MS, MT, NC, ND, NE, NY, OH, OK, OR, PA, SC, TX, UT, VT, WA, WV, WY	31 (70%)
Intervention letters	CT, DE, IA, ID, IL, MD, MI, NC, ND, NH, SC, WI	12 (27%)
morphine equivalent daily dose program	AK, AR, CO, ID, MA, ME, MN, OR, WY	9 (20%)
step therapy or clinical criteria	AL, DC, DE, ID, IL, KY, MA, MI, MO, MT, ND, NH, NY, OK, OR, PA, UT, WA	18 (41%)

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

State	Explanation
HI	No FFS recipient since 2009 has been in need of a pain management program. This is an issue for our managed care plans though.
NM	Nothing in lieu of at this time, but the topic is under consideration.
NV	Methadone is non-preferred on our PDL. We are looking at ways to better control its use.
RI	The P & T Committee determined methadone would be a preferred agent. Fee for Service is a secondary claim for the most part and the primary payer makes that determination.
SD	Reviewing as a part of a broader opioid management program
IN	Indiana law requires methadone to be dispensed only for the treatment of pain in an outpatient setting. Prior authorization is required if the member is over the established dosing limit or has greater than four prescribers of opiates.

VIII D. OPIOIDS

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

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

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

State	Number of unit(s) per day
AK	varies; no more than 8 for some
AL	2
AR	6 units per day, but cannot exceed an accumulated quantity of total SAO of 93 units in previous 31-days.
CA	Short-acting opioids have an established maximum quantity per dispensing and a maximum of three (3) dispensings within any 75-day period.
CO	4
DE	4 units for acute period and then 2 units a day for chronic pain
FL	12
GA	Varies; 5 opioid fills per 30 days
IA	varies by drug
ID	Specific to each individual drug.
IL	6
IN	60 MME for new opiate utilizers
KS	other - drug specific
KY	depends on drug
LA	4
MD	Depends on product - please use link for further quantity limits. https://mmcp.dhmh.maryland.gov/pap/docs/QL.pdf
ME	15 day limit with continuation requiring PA for additional units and clinical rationale for long term use
MI	6
MO	40
MS	186
MT	Oxycodone 8/day
ND	Limit qty/day on all short-acting opioids and the quantity varies by drug and strength
NE	5
NH	N/A
NY	Edits for Opioids – Short-Acting-Limited to a total of four (4) opioid prescriptions every 30 days; Exemption for diagnosis of cancer or sickle cell disease-Initial prescription for opioid-naïve patients limited to a 15-day supply-Exception for diagnosis of cancer or sickle cell PA required for initiation of opioid therapy for patients on established buprenorphine opioid dependence therapy-PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy-----STEP THERAPY (ST)- Nucynta® (tapentadol IR) – Trial with tramadol and one (1) preferred opioid before tapentadol immediate-release (IR)---FREQUENCY/QUANTITY/DURATION (F/Q/D)--- Quantity Limits: Nucynta® (tapentadol IR):Maximum 6 (six) units per day; 180 units per 30 days-Nucynta® (tapentadol IR):Maximum daily dose of tapentadol IR and tapentadol ER formulations used in combination not to exceed 500mg/day- Morphine and congeners immediate-release (IR) non-combination products (codeine, hydromorphone, morphine, oxycodone, oxymorphone):Maximum 6 (six) units per day, 180 (one hundred eighty) units per 30 (thirty) days-Xartemis® XR (oxycodone/acetaminophen):Maximum 4 (four) units per day, 120 (one hundred twenty) units per 30 (thirty) days----Additional/alternate parameters: To be applied to patients without a documented cancer or sickle cell diagnosis---Morphine and congeners immediate-release (IR) combination products maximum recommended: acetaminophen (4 grams),aspirin (4 grams),ibuprofen (3.2 grams),or the FDA approved maximum opioid dosage as listed in the PI, whichever is less---Duration Limits:90 days for patients without a diagnosis of cancer or sickle-cell disease.
OH	based on MED or APAP dose
OK	4
OR	120 MME
PA	Varies by drug
SD	30 days supply
TN	1200mg/mo oxycodone & hydrocodone, 300mg/mo hydromorphone
UT	180 tablets per 30 days regardless or product or strength
VA	4
VT	dependent on the medication requested
WI	16
WV	4
WY	6

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

Answer	State	Number of States (Percentage of 37 states)
30 day supply	AL, CO, DE, FL, GA, ID, KY, LA, ME, MO, MS, MT, NE, NH, OK, OR, SD, TN, UT, WI, WY	21 (57%)
90 day supply		0 (0%)
Other, please explain	AK, AR, CA, IA, IL, IN, KS, MD, MI, ND, NY, OH, PA, VA, VT, WV	16 (43%)

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

State	Explanation
AK	34 days
AR	Prescription drug coverage is for up to a 31-day supply. SAO agents have a cumulative quantity edit. System adds units of every SAO claim in previous 31 days and if the incoming claim will cause the cumulative quantity of the opioid agents received in previous 31 days to exceed 93 units, the incoming claim will reject at point of sale.
CA	Short-acting opioids have an established maximum quantity per dispensing and a maximum of three (3) dispensings within any 75-day period.
IA	up to a 31 day supply
IL	- 30-day supply - 186 total quantity allowed for short-acting agents per month - Only 1 short-acting opioid allowed at a time - Requests that require prior authorization or Four Prescription Policy override: if appropriate, first request receives short-t
IN	For initial utilizers of opiates, a 7 day supply followed by an additional 7 day supply in a rolling 45 day period is permitted without prior authorization.
KS	driven by drug-specific individual quantity limits
MD	Allow up to 34 day supply
MI	34 days supply
ND	34 days max for all products unless primary insurance allows > 34 days or if product package size / dosing often results in > 34 days (e.g. insulins).
NY	90 day supply limit -Limited to a total of four (4) opioid prescriptions every 30 days; Exemption for diagnosis of cancer or sickle cell disease CLINICAL CRITERIA (CC) -For opioid: Naive patients - limited to a 15 days supply for all initial opioid prescriptions, except for patients with diagnosis of sickle cell disease or cancer -Medical necessity rationale for opioid therapy is required for patients on established buprenorphine opioid dependence therapy -PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy
OH	34 days
PA	Prior authorization is required for short acting opioids after 7 days for children under 21 and after 14 days for adults.
VA	10 days
VT	7-day supply for initial fill, 30 day limit overall for IR products. 50 MME limit for adults, 24 MME limit for children effective 7/1/17
WV	34 day supply

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

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

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

Answer	State	Number of States (Percentage of 39 states)
2 units/day	AL, AR, GA, IA, ID, KY, LA, MD, ME, MI, MS, MT, ND, NE, NV, OH, OR, PA, SC, TN, VT, WA, WV	23 (59%)
3 units/day	AK, CA, DE, FL, IL IN, KS, MA, NH, NJ, NY, OK, SD, UT, VA, WY	16 (41%)

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

Answer	State	Number of States (Percentage of 39 states)
30 day supply	AL, FL, GA, ID, KY, LA, MA, MS, MT, NE, NH, NV, OK, OR, SC, SD, UT, VT	18 (46%)
90 day supply		0 (0%)
Other, please explain	AK, AR, CA, DE, IA, IL, IN, KS, MD, ME, MI, ND, NJ, NY, OH, PA, TN, VA, WA, WV, WY	21 (54%)

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

State	Explanation
AK	34 days
AR	The long-action opioid (LAO) agents have a quantity limit based on FDA approved frequency of drug--e.g., once daily limit is 1 per day, q8h the limit is 3 per day, q12h the limit is 2 per day, or a patch applied every 72 hours the limit is 10 patches per 30 days, etc.. A claim can be filled for up to a 31-days' supply, so the max on a drug could be 31 for 31 days' supply, or 62 for a 31-days' supply, etc., depending on the FDA approved dosing frequency of the long-action opioid agent.
CA	Long-acting opioids have an established maximum quantity per dispensing and a maximum of three (3) dispensings within any 75-day period.
DE	All long acting opioids are prior authorized. Specific clinical reviews allow for individual entry. Routinely the authorization is for 1 year. If there is any concerns the authorized quantities are for a month at a time.
IA	up to a 31 day supply
IL	- 30-day supply - 120 max quantity total per month for long-acting agents - Only 1 long-acting opioid allowed at a time - Requests that require prior authorization or Four Prescription Policy override: if appropriate, first request receives short-term app
IN	Quantity limits placed on certain long-acting opioid products for a maximum quantity of each agent per month.
KS	driven by drug-specific individual quantity limits
MD	Allow up to 34 day supply
ME	15 day limit similar to short acting opioids
MI	34 days supply with specific quantity limitations on certain long-acting narcotics such as fentanyl patches and ER oxycodone.
ND	We limit all long acting products to no more than FDA approved dosing. 34 days max is our entire program max (unless primary insurance allows > 34 days)
NJ	30 day or 100 units whichever is greater.
NY	90 day supply -Hydromorphone ER, oxymorphone ER- Maximum 4 (four) units per day, 120 units per 30 days -Morphine ER (MS Contin 100mg only) - Maximum 4 units per day, up to 3 times a day, maximum 120 units per 30 days -All other long acting opioids are either 2 or 3 times a day.
OH	34 days
PA	All long acting opioids require prior authorization for all beneficiaries. The day supply approved is determined on a case-by-case basis.
TN	30 days. Fentanyl- 10 patches/30, Embeda- 2 capsules/day, Kadian- 130mg, 150mg, 200mg: 1 capsule/day, others 2/day.

VA	34 days
WA	The agency limits all long-acting opioids to dosage frequency according to FDA labeling, which may be 1, 2, or 3 units per day depending on the product. The maximum days supply is no more limited than for any other medication (34 days)
WV	34 day supply
WY	The limits for long-acting medications is 180 morphine equivalents per day with a maximum day supply of 30.

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

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

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

State	Explanation
CT	Retrospectively we have criteria to identify the concurrent use of opioids and benzodiazepines together but there is nothing at POS to identify and monitor the use of these medications.
DE	Prior authorization for all long acting and high dose opiates can only be approved if the client is not receiving a benzodiazepine.
ID	Use FDB edit to monitor.
IN	Retrospective DUR established to monitor concurrent claims for opioids and benzodiazepines. A near real-time letter is faxed to the prescriber notifying them of the combination therapy and risks associated with this therapy.
KY	Standard ProDUR system edits require a pharmacist intervention for this combination.
MT	We limit benzodiazepines when used with methadone.
NY	PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy
OR	Prior authorization criteria for benzodiazepines and opioids restrict concurrent use
TN	Benzos all require PA, and are denied if enrollee is using chronic opioid or a buprenorphine-containing opioid addiction product.
TX	Combination of Alprazolam, Carisoprodol, and Hydrocodone, effective since 2013: Claims with a 14-day overlap with each of the 3 drugs (alprazolam, Carisoprodol, and Hydrocodone) in the last 35 days, the claim will reject. This edit is applied to clients of all age groups. Also, during FFY 2016, an edit was approved by the DUR Board to monitor for any combination of opioids + benzodiazepines, muscle relaxants + benzodiazepines, or the combination of all three drugs (muscle relaxants, benzodiazepines, and opioids). The annual report for 2017 will include the implementation effective date for this pro-DUR edit.
VA	FirstDataBank's AlertSpace ProDUR edits.
WY	Prior authorization is required for concurrent use.

VIII E. MORPHINE EQUIVALENT DAILY DOSE (MEDD)

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

Answer	State	Number of States (Percentage)
Yes	CO, CT, DE, ID, IN, MA, ME, MI, MN, NC, ND, OH, OR, VA, VT, WA, WY	17 (34%)
No	AK, AL, AR, CA, DC, FL, GA, HI, IA, IL, KS, KY, LA, MD, MO, MS, MT, NE, NH, NJ, NM, NV, NY, OK, PA, RI, SC, SD, TN, TX, UT, WI, WV	33 (76%)

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

State	Milligrams per day
CO	300
CT	91
DE	120
ID	120
IN	60
MA	120
ME	30
MI	120
MN	120
NC	750
ND	90
OH	80
OR	120
VA	120
VT	50
WA	120
WY	180

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

State	Explanation
AK	No formal policy for a set maximum recommendation in FFY2016; prior authorization criteria and guidance references caution when using in excess of 100 MED
AL	Placed max units manually
AR	During FFY 2016, we utilized therapeutic duplication edits to prevent multiple concurrent therapy of SAO and multiple concurrent therapy of LAO. The clinical edits did allow 1 SAO + 1 LAO. Quantity limits on the SAO were reduced to a cumulative quantity of 93 units in previous 31 days-- this edit added all SAO claims filled in a rolling 31 days. Methadone was moved to non-preferred status for chronic pain patients-- only cancer patients could receive methadone without a PA, and no PAs were being approved for chronic pain patients. Quantity limits were already in place for LAO products. The MME program was implemented Nov. 8, 2016, which is FFY 2017. The MME program in FFY 17 does provide information to prescriber providers and pharmacy providers.
CA	All opioids have an established maximum quantity per dispensing and a maximum of three (3) dispensings within any 75-day period.
DC	FDA approved maximum daily dosing limits from the First Data Bank weekly file are edited at POS and are implemented prospectively during claims adjudication.
FL	A limitation will be implemented in the 3rd quarter of calendar year 2017.
GA	We are moving in the direction of implementing a max MED in the future. Currently, our QLLs vary not based on MED.
HI	FDA approved quantity edits for excessive quantity per First Data Bank.
IA	Currently, individual opioids have set quantity limits. A recommendation has been made by the DUR to implement a 90 MME/day edit. The edit will be implemented in the upcoming months.
IL	We do not do MEDD. Daily dose and max monthly quantities are used for individual agents.
KS	We have a policy that limits narcotic analgesic day supply based on the FDA maximum dose of each drug per day.
KY	Kentucky is considering moving to maximum morphine equivalent daily dosing. Currently the Commonwealth utilizes the maximum dosing guidelines found in package inserts (PIs).
LA	Dose limits are applied to opiate products with established maximum doses.
MD	During FFY 2016, quantity limits were used to limit opioid doses.
MO	We did not have a policy in effect for FFY16, however we recently implemented changes to our opioid edits in order to lower the MEDD.
MS	Approved by DUR Board in September 2016. Prospective edits being programmed.
MT	We plan to set the maximum at 180 mg MEDD in September 2017.
NE	The DUR Board made specific recommendations to limit opioid use and those limits are in the planning stages of implementation.
NH	MEDD was approved by the DUR in 2016 and will be implemented in 2017.
NJ	ProDUR editing in place
NM	Topic is under consideration.
NV	The DUR Board reviews utilization of these products at nearly all quarterly meetings. Implementation is planned for 2017.

NY	The NYS DURB has recommended quantity/ frequency/ duration limits to promote the safe and clinically effective use of opioids in the New York State Medicaid Program. The process examines FDA recommended dosages and considers equivalent MED levels. The combined efforts of the Medicaid Prescriber Education Program (MPEP), the Drug Information Response Center (DIRC) and Retrospective Drug Utilization Review (RetroDUR) program promotes the clinical effectiveness and medical appropriateness of opioid utilization by way of point-of-sale (POS) prospective edits, RetroDUR evaluations and the application of educational interventions for prescribers and pharmacists. In addition, on March 27, 2016 New York State began mandatory e-prescribing controlled substances.
OK	We review the number of medications taken on a monthly basis. Quantity limits along with only covering one short-acting and one long-acting concurrently.
PA	Quantity limits are drug specific based on FDA labeling and medical literature.
RI	Prescriber choice however we will be implementing limits in 2017.
SC	MED to be implemented First Quarter 2018
SD	No MED measures
TN	We are in the middle of the process, moving slowly towards a limit of 120mg/day.
TX	Maximum quantity measure per each prescription claim.
UT	Tablet limits
WI	Wisconsin monitors these drugs through edits such as quantity limits and early refill alerts. Wisconsin has also looked at specific drugs through RetroDUR and targeted interventions. Prescribers identified during these processes receive a letter which alerts them to the clinical concern.
WV	Drug edits are in place on each drug based on the number of units allowed. In FFY 2015 we had not initiated our MME edit yet. In 2017 we are using >50 MME per day over the last 90 days.

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

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

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

Answer	State	Number of States (Percentage of 20 states)
Website	CO, CT, DC, IA, MA, ME, NC, OR, TN, WA	10 (50%)
Provider notice		0 (0%)
Educational seminars	MS	1 (5%)
Other, please explain	AK, CA, ID, IN, MD, MI, ND, VA, VT	9 (47.5%)

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

State	Explanation
AK	Website, prior authorization criteria and form
CA	The Medi-Cal DUR program published an educational bulletin entitled, "Clinical Review: Morphine Equivalent Daily Dose to Prevent Opioid Overuse" to the Medi-Cal DUR website. This bulletin defined morphine equivalent daily dose (MEDD) and provided evidence to support using MEDD as an indicator of potential dose-related risk for prescription opioid overdose. The bulletin provided links to several online MEDD calculators, as well as additional resources to providers. The bulletin was also emailed to all providers who subscribe to the Medi-Cal Subscription Service.
ID	Targeted letters to prescribers based on RetroDUR Activity
IN	Drug Utilization Review Board Newsletter, posted electronically, provides opiate conversion charts.
MD	RDUR intervention outreach was created to provide references for dosing information as well as provider newsletters with conversion tables and references.
MI	Provider notices were sent. The information was sent to providers as a quantity limit via soft POS edit message and later coded as a hard denial.
ND	Limit of 90 is for immediate release products only. PRN doses limited to 15% of current extended release narcotic dosage. Providers are referred to a variety of website calculators.
VA	A Medicaid Memo was posted to the state website with a blast email sent to those enrolled in the service. A patient specific letter was sent to those prescribers whose patients had received a prescription above the new limit.
VT	provider notice and website

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

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

VIII F. BUPRENORPHINE and BUPRENORPHINE/NALOXONE COMBINATIONS

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

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

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

Answer	State	Number of States (Percentage of 43 states)
12mg	DE, PA	2 (4.5%)
16mg	GA, ME, MT, TN, TX, VA, VT, WV, WY	9 (21%)
24mg	AK, AL, AR, CO, DC, FL, IA, ID, IL, IN, KY, LA, MD, MI, MN, NC, ND, NE, NH, NV, NY, OK, UT, WA	24 (56%)
other, please explain	CA, CT, KS, MA, MO, MS, NJ, OH	8 (18.5%)

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

State	Explanation
CA	There is a maximum quantity of four dosage units per day, regardless of strength. The maximum allowable total daily dose is 48 mg.
CT	An Informational alert is set at point of sale for any buprenorphine prescription that exceeds 24 mg per day.
KS	24mg
MA	32mg
MO	The first 180 days are limited to 32mg/day. After 180 days the limit is 16mg/day.
MS	Step down therapy; up to 24 mg/day during induction and stabilization phase (month 1-2), up to 16 mg/day during maintenance phase (months 3 and beyond).
NJ	32 mg
OH	16mg Suboxone equivalent

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

Answer	State	Number of States (Percentage)
6 months	GA, TN	2 (4%)
12 months		0 (0%)
no limit	AK, AL, CA, CO, CT, DC, DE, FL, ID, IL, KS, KY, MA, MD, MN, MO, MS, MT, ND, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TX, VT, WA, WI, WV	36 (72%)
other, please explain	AR, HI, IA, IN, LA, ME, MI, NC, NE, UT, VA, WY	12 (24%)

If “Other”, please explain.

State	Explanation
AR	The standard PA form allows 24 months if criteria is met; after 24 months a prescriber request is reviewed on a case-by-case basis and prescriber must provide additional documentation for this review, such as taper schedule plan and progress notes.
HI	No pain management has been needed since 2009.
IA	24mg/d for a maximum of 3 months
IN	Buprenorphine/naloxone prior authorizations are granted every 6 months with a maximum 34-day supply if all criteria are met. Buprenorphine prior authorizations are granted for a 34-day supply if all criteria are met.
LA	3 months

ME	2 years without PA if within dosing limits
MI	The initial authorization is for 12 months, then renewal requests are evaluated on a case by case basis.
NC	Authorization for 12 months initially, then treatment plan required.
NE	6 months for initial treatment, with an option to renew for 6 additional months, if medically necessary.
UT	Each separate auth/re-auth allows up to 18 months of tx
VA	3 months
WY	2 years

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

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

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

Answer	State	Number of States (Percentage of 11 states)
8mg	TN, WY	2 (18%)
12mg	DE	1 (9%)
16mg	IA, LA, MO, MS	4 (36.5%)
other, please explain	ME, MI, MT, UT	4 (36.5%)

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

State	Explanation
ME	look at reduction in mg over a time period and PA submissions
MI	Tapering required based on an individualized care plan.
MT	As low as possible for each member
UT	No set dose, taper required for re-auth

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

Answer	State	Number of States (Percentage of 11 states)
6 months		0 (0%)
no limit	DE, IA, LA, MO, MS, MT, TN, WY	8 (72%)
other, please explain	ME, MI, UT	3 (28%)

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

State	Explanation
ME	as indicated in previous answer
MI	These are reviewed on a case by case basis.
UT	No set dose, taper required for re-auth.

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

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

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

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

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

Answer	State	Number of States (Percentage of 30 states)
Yes	MD, RI, VA	3 (10%)
No	AK, AR, CO, DC, DE, GA, ID, IL, IN, KS, KY, LA, MA, ME, MO, MS, MT, ND, NE, NH, NJ, NY, OK, PA, TN, TX, WY	27 (90%)

VIII G. ANTIPSYCHOTICS/STIMULANTS

VIII-G1. ANTIPSYCHOTICS

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

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

a) If answer to VIII-G1-1 above is "Yes," do you either manage or monitor:

Answer	State	Number of States (Percentage of 43 states)
only children in foster care	DE, MT	2 (5%)
all children	AK, AL, AR, CA, CO, CT, FL, GA, IA, ID, IN, KY, LA, MA, MD, ME, MI, MN, MO, MS, NC, NE, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, VA, VT, WA, WV, WY	38 (88%)
other, please explain	IL, KS, WI	3 (7%)

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

State	Explanation
IL	Prior authorization is required for all children under DCFS care; all children less than 8 years of age who are prescribed atypical antipsychotic medications; and all children prescribed long-acting atypical antipsychotics.
KS	children and adults
WI	7 years of age or younger.

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

Answer	State	Number of States (Percentage of 43 states)
Child' Age	AK, AR, CA, CO, CT, DE, FL, GA, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, VA, VT, WA, WI, WV, WY	42 (98%)
Dosage	AR, CA, CO, CT, FL, GA, ID, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, NE, NY, OH, OK, OR, RI, SC, SD, TN, TX, VA, VT, WA, WI, WV, WY	33 (77%)
Polypharmacy	AK, AL, CA, CO, CT, FL, GA, IA, ID, IN, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NV, OH, OR, RI, SC, SD, TN, TX, VA, WA, WI, WV, WY	33 (77%)

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

State	Explanation
AK	Atypical antipsychotics for children
AL	Medical justification is required for polytherapy.
AR	We use a point of sale (POS) algorithm for age and dose of specific antipsychotic after the initial prior authorization. All "new starts" to an antipsychotic agent for children age 9 years and younger (< 10 years) require a manual review prior authorization by the Medicaid Pharmacy Program child psychiatrist. Prescriber required to submit letter explaining medical necessity, along with chart notes & documentation to substantiate request, and lab data for fasting glucose and lipid panel. All requests for doses exceeding the allowed dose for age and all requests for additional antipsychotic agents are reviewed by the Medicaid Pharmacy Program child psychiatrist. Prescriber must submit all documentation to substantiate the request, including chart notes, etc.
CA	An approved Treatment Authorization Request is required for any antipsychotic medication for all Medi-Cal beneficiaries 0 - 17 years of age. In addition, DHCS Pharmacy Benefits Division, DHCS Behavioral Health Division, and California Department of Social Services (CDSS) continue to collaborate on a Quality Improvement Project entitled, "Improving the Use of Psychotropic Medication among Children and Youth in Foster Care." The purpose of this program is to reduce the rate of antipsychotic polypharmacy, improve the rate of compliance with age-specific antipsychotic dose recommended guidelines, and improve the rate of children and youth in foster care with at least one psychotropic medication who have an annual metabolic risk assessment. The goals are to reduce polypharmacy and improve compliance with dosing guidelines and annual metabolic risk assessment.
CO	Prior authorization for less than approved age groups and more than maximum doses are in place. Other complex cases go to our child psychiatrist for teleconsult.
CT	HID performs 1,000 RetroDUR reviews for the pediatric population each month and the majority of the criteria used to review the pediatric population have to do with mental health drugs. An additional program exists and is administered by the Department of Children and Families for children in foster care only. The Psychotropic Medication Advisory Committee (PMAC) oversee the use of psychotropic medications in the foster care population and have specific edits, maximum doses, monitoring guidelines, etc. associated with prescribing of these medications. Some of the criteria used for the pediatric RetroDUR program have been adopted from the PMAC criteria.
DE	Ages on the atypical antipsychotic agents are set to the FDA approved indications. Synergy is also achieved in Delaware by the Department of Family Services working with Medicaid on foster children to reduce unnecessary therapies.
FL	Florida continues to perform 2nd medical review. The second medical review is performed by a board certified child psychiatrist. The psychiatrist review is required for all prescriptions of children less than six and in some cases for children up to age 18.
GA	Require the use of an atypical antipsychotic form, which delineates important parameters such as use of psychiatrist, age of patient, off-label use of atypical agents, patient medication and family history, medical necessity of medication, etc.
IA	Age edit on risperidone for members less than five (5) years of age. Age edit on all other antipsychotics for members less than six (6) years of age. Duplicate therapy edit on all antipsychotics for members 0 through 17 years of age. A 30 day grace period is allowed to allow transition between antipsychotic medications.
ID	Targeted DUR interventions for foster children and children < or = 5 years.
IL	Atypical antipsychotics in children
IN	Antipsychotics require prior authorization when used in duplication, low doses, or when a drug-specific quantity limit has been exceeded.
KS	We have a PA in place for children and adult criteria for use and multiple use of antipsychotics. We have adult dose limits and are bringing the child dose limit to the DUR board July 2017.
KY	A diagnosis driven prior authorization is required for all second generation antipsychotics. There are max daily dosing edits and checks for therapeutic duplication. (Not more than one (1) antipsychotics at a time).
LA	Requirements for antipsychotics include appropriate diagnosis, therapeutic duplication (3rd agent), dose and age limit, and clinical preauthorization for age < 6 years.
MA	Behavioral health medication polypharmacy: pharmacy claims for 4 or more behavioral health medications (i.e., alpha2 agonists, antidepressants, antipsychotics, atomoxetine, benzodiazepines, buspirone, cerebral stimulants, hypnotics, and mood stabilizers) filled within a 60-day period Antipsychotic polypharmacy: overlapping pharmacy claims for 2 or more antipsychotics for 60 days within a 90 day period Any pharmacy claim for an antipsychotic, antidepressant, atomoxetine, benzodiazepine, buspirone, or mood stabilizer for members less than 6 years old. Cerebral stimulants and antipsychotics blocked for members less than 3 years old.
MD	In October 2011, MMPP established the peer review program for mental health drugs. This peer reviewed authorization process informs clinicians of relevant pharmacologic and non-pharmacologic clinical information for decision-making and ensures the appropriate use while limiting adverse sequelae in Medicaid's valuable pediatric population. The program initially addressed the use of antipsychotics in recipients < 5 years of age. During FFY 2013, all recipients < 10 years of age required prior authorization. As of January 2014, the program was expanded to include all recipients < 18 years of age.

ME	PA requirements limiting age, length of therapy as well as metabolic monitoring
MI	We utilize a behavioral health academic detailing program which is operationalized through our Magellan contract. It is a monthly academic detailing mailing and face-to-face pharmacy consultant intervention with the most exceptional provider or specific educational topics.
MN	Monthly the DHS Children's Division receives reports that identifies children on multiple psychotropic drugs.
MO	For children 0 to 5 years old, atypical antipsychotics deny at point of sale and must be reviewed by a clinical consultant for approval or denial. For children 5 to 9 years old, all new and non-adherent requests for atypical antipsychotics will deny at point of sale and must be reviewed by a clinical consultant for approval or denial. For children 5 to 9 years old, that are already established along with children 9 to 18 years old atypical antipsychotics will approve as long as they are on only 1 atypical, have appropriate diagnosis, dose does not exceed recommended maximum doses and are adherent to therapy 60 of the most recent 90 days. Requests that are reviewed by a clinical consultant require submission of at least the past 6 months of progress notes from the prescribing provider, results of a baseline fasting lipid profile and fasting glucose, BMI%tile and notation of any evidence-based behavioral therapy that the participant is or will be participating in.
MS	Electronic PA age edits, quantity limits for all beneficiaries, diagnosis edit for adults and polypharmacy edit for children.
MT	We require atypicals to be prescribed by a psychiatrist for those under six. We provide pharmacy case management for foster children.
NC	In April 2011, the N.C. Division of Medical Assistance partnered Community Care of North Carolina to implement a registry to document the use of anti-psychotic therapy in N.C. Medicaid and N.C. Health Choice beneficiaries ages 0 through 17. A+KIDS was created due to well-documented safety concerns and limited information about the efficacy of using anti-psychotic agents in children. A+KIDS encourages the use of appropriate baseline and follow-up monitoring parameters to facilitate the safe and effective use of anti-psychotics in this population.
NE	Minimum age limits, quantity limits, daily does limits and a review by a board-certified child and adolescent psychiatrist is required for requests outside of these limits.
NV	Children age 7-17 are allowed one drug from each class (antidepressant, antianxiety, antipsychotic, anticonvulsant) without PA up to three medications total. The fourth needs PA.
NY	DUR Board recommended drug-specific minimum age parameters have been established. (Automatic bypass for established therapy.) Fee for service diagnosis parameters for second-generation antipsychotics in the pediatric population. Diagnosis requirement for the initial prescription for patients between minimum age (as defined by the DURB for the FFS population) and 18 years of age. (Automatic bypass for established therapy.)
OH	Retrospective review of claims
OK	Educational mailings to prescribers of psychotropic drugs used in children particularly when prescribers deviate from evidence based norms in patient population.
OR	Please not that question #96 is required to complete the form because we "monitor" and perform educational outreach, but do not use edits.
PA	A prescription for either a preferred or non-preferred Antipsychotic regardless of quantity limit when prescribed for a child under 18 years of age requires prior authorization.
RI	Health Information Design has specific RDUR criteria that identifies use of psychotropics drugs and stimulants in children. Criteria is monitored monthly. If a reviewer identifies an issue a letter is sent to the prescriber.
SC	Patient must have received developmentally-appropriate, comprehensive psychiatric assessment with diagnoses, impairments, treatment target and treatment plans clearly identified and documented. ï,· Informed consent for this medication has been obtained from the parent or guardian ï,· Family assessment must have been performed to include parental psychopathology and treatment needs. Also family functioning and parent-child relationship must be evaluated. ï,· Psychosocial treatment MUST have been in place for at least 12 weeks without adequate clinical response. Psychosocial treatment must continue for the duration of medication therapy. Parental involvement is required. Exception: Patient is danger to self or others. Only approve one antipsychotic at a time. Exception: tapering of one agent while titrating another.
SD	Child Protective Services
TN	PA required for all atypical antipsychotics. Enrollee must meet all criteria to qualify for atypical use.
TX	The HHSC has a clinical prior authorization edit in place for both the typical and atypical antipsychotics for adults and the children enrolled in Medicaid. The edit screens for age limits, monotherapy for insomnia, or major depressive disorder, and for the concomitant use of more than two different antipsychotics. Psychotropic medication utilization review (PMUR) tool was developed to assist in identifying members whose psychotropic medications utilization fall outside the parameters. The criteria set forth by the 2013 version of the PMUR for Foster Children was developed by the Texas Department of Family and Protective Services (DFPS), the Department of State Health Services (DSHS), and the Health and Human Services Commission (HHSC). Some of the criteria include: 1) Four (4) or more psychotropic medication prescribed concomitantly. 2) Prescribing of: two (2) or more concomitant stimulants, two (2) or more concomitant alpha agonists, two (2) or more concomitant antidepressants, two (2) or more concomitant antipsychotics, two (2) or more concomitant mood stabilizers. 3) The psychotropic medication dose exceeds usual recommended doses (FDA and/or literature based maximum dose). 4) Psychotropic medications are prescribed for children of very young age including children receiving the following: stimulants - less than three (3) years of age, Alpha Agonists -less than four (4) years of age, Antidepressants - less than four (4) years of age, Antipsychotics - less than four (4) years of age, Mood Stabilizers - less than four (4) years of age. 5)

	Prescribing by primary care provider who has not documented previous specialty training for a diagnosis other than the following (unless recommended by a Psychiatrist consultant): attention Deficit Hyperactive Disorder (ADHD), uncomplicated anxiety disorders, uncomplicated depression. 6) Antipsychotic medication(s) prescribed continuously without appropriate monitoring of glucose and lipids at least every 6 months. 7) Multiple psychotropic medications for a given mental disorder. 8) Inappropriate medication for patient diagnosed with a mental disorder. 9) Absence of a thorough assessment of the Diagnostic and Statistical Manual of Mental Disorder-5 (DSM-V) diagnosis in the child's medical record. Finally, H.B. 915 Section 533.0161(b), Government Code, of the 2013 83rd legislature, requires quarterly report on monitoring psychotropic medication by the HHSC Medicaid Vendor Drug Program and to notify the home state of any child placed in Texas under Interstate Compact on the Placement of Children (ICPC) when the medication regimen is outside the parameters. The parameters mimic the PMUR parameters listed above.
VA	Service authorizations are required for the use of antipsychotics in children under the age of 18.
VT	a) PA process for all antipsychotics for children b) 18 years or less PA for diagnosis and max daily dose c) less than 5 years of age PA is reviewed by Medical Director. d) Non-specialists have access to Psychiatrists at University of Vermont for psychiatric consultation
WA	The agency maintains dose limits stratified by patient age, limitations against ongoing duplication, and polypharmacy. These limits have been recommended by a Pediatric Mental Health Workgroup and approved by the DUR Board. Exceeding any of these review thresholds triggers a required consultation through our Second Opinion Network program, in which pediatric psychiatrists engage in a one-on-one consultation with the prescriber.
WI	Wisconsin monitors the use of antipsychotic drugs in young children through prior authorization (PA). The PA process is intended to scrutinize the prescribing of antipsychotic drugs for mood disorders and the monitoring of metabolic effects of this class of drugs. Child psychiatrists who are contracted with the state perform peer to peer outreach when needed.
WV	A prior authorization is required for all children < 18 years of age.
WY	Children under 5, on high dose or multiple antipsychotics are referred to Seattle Children's for review.

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

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

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

State	Explanation
GA	Currently have a program in place. Plan on continuing current program.
HI	FFS is not in need of one because other programs cover and monitor antipsychotropic drugs for children (DOH CAMHD and Medicaid managed care plans).
KY	Kentucky already has one in place that is reviewed periodically.
MD	Question 93 does not apply to Maryland since we already have a program in place - see question 92c for explanation. There was no option for "N/A".
ND	Legislation prevents managing antipsychotic medications in North Dakota
NJ	There are guidelines provided by the New Jersey Department of Children and Families for the use of psychotropic medications in children.
UT	Utah Medicaid will consider this in the future.
VA	Already implemented
WI	The State of Wisconsin already has a program in place to monitor the appropriate use of antipsychotic drugs in children.

VIII-G2. STIMULANTS

VIII-G2-1 Do you have any documented restrictions or special program in place to monitor, manage or control the use of stimulants?

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

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

Answer	State	Number of States (Percentage of 47 states)
children	SC	1 (2%)
adults	CO, DE, GA, IA, NJ, NM, RI	7 (15%)
both	AK, AL, AR, CA, CT, DC, FL, HI, ID, IL, IN, KS, KY, LA, MA, ME, MI, MN, MO, MS, MT, ND, NE, NH, NV, NY, OK, OR, PA, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	39 (83%)

b) Please briefly explain your program.

State	Explanation
AK	Quantity limits
AL	Stimulants are included in the Preferred Drug List (PDL) and have maximum quantity limits.
AR	A manual review prior authorization is required for all adults age 18 and older. The prescriber must submit documentation and include documentation that symptoms are present in 2 locations, e.g., if beneficiary is working and where/what, or if in school and include where/number of hours. All beneficiaries must comply with the point of sale clinical dose edits and therapeutic duplication edits.
CA	The use of stimulants for Medi-Cal beneficiaries is restricted to use in Attention Deficit Disorder in individuals from 4 years through 16 years of age only. Any use outside of these restrictions requires an approved Treatment Authorization Request.
CO	Stimulants are managed on the PDL. Complex cases can also be referred to the child psychiatrist.
CT	HID performs 1,000 RetroDUR reviews for the adult and pediatric populations each month and the majority of the criteria used to review the pediatric population have to do with mental health drugs, including stimulants. An additional program exists and is administered by the Department of Children and Families for children in foster care only. The Psychotropic Medication Advisory Committee (PMAC) oversee the use of psychotropic medications in the foster care population and have specific edits, maximum doses, monitoring guidelines, etc. associated with prescribing of these medications. Some of the criteria used for the pediatric RetroDUR program have been adopted from the PMAC criteria. Additionally, stimulant use is also reviewed during the monthly RetroDUR adult reviews.
DC	Clinical criteria is in place for all stimulants with requirements for diagnosis, age appropriate use, anticipated length of therapy and days supply limits. Prior authorization can be set for up to one (1) year.
DE	Adults must be on the less abuse potential long-acting agents of generic Concerta and Vyvanse first and fail before approval of any other agent will be considered.
FL	High dose limitation are placed on all stimulants. A close prior authorization review is performed on all children less than 6.
GA	Stimulant use in adult population requires prior authorization.
HI	ICD-10 and age requirements are drug specific.
IA	Require PA for members 21 years of age and older. Documentation diagnosis of ADHD meets the DSM-V criteria and is confirmed by a standardized rating scale. Symptoms must have been present before 12 years of age and there

	must be clear evidence of clinically significant impairment in two or more environments (social, academic, or occupational). Prescriber must also review the patient's use of controlled substances on the Iowa PMP website and document the date reviewed on the PA form.
ID	All products have age and Quantity Limits. Adults must have documented diagnosis of ADHD and any Adults with any substance abuse diagnosis cannot receive medication.
IL	All attention deficit hyperactivity medications (ADHD) in children less than 6 years of age require special prior authorization request form. - Medications for ADHD are allowed for clients who are 6 through 18 years of age. - Adults (19 years and older) require prior authorization for ADHD medications.
IN	Stimulants require prior authorization when used in duplication or when a drug-specific quantity limit has been exceeded.
KS	We have PA criteria and dosing limits for both adults and children.
KY	A diagnosis driven prior authorization is required on all stimulants. There are also max dose per day edits and therapeutic duplication edits (not more than one (1) long-acting agent).
LA	Stimulants are reviewed in the retrospective DUR program for stimulant-induced insomnia and use in young children. Prospective edits include duplication of therapy with stimulants and with narcolepsy agents, diagnosis requirement, and clinical preauthorization for young children.
MA	Behavioral health medication polypharmacy: pharmacy claims for 4 or more behavioral health medications (i.e., alpha2 agonists, antidepressants, antipsychotics, atomoxetine, benzodiazepines, buspirone, cerebral stimulants, hypnotics, and mood stabilizers) filled within a 60-day period Cerebral stimulant polypharmacy: overlapping pharmacy claims for 2 or more cerebral stimulants (immediate-release and extended-release formulations of the same chemical entity are counted as one) for 60 days within a 90 day period
ME	Managing daily dosing requirements
MI	Prior authorization required for members over the age of 18 years and under the age of 6 years.
MN	We have quantity limits in place.
MO	Under 6 years old requires prior authorization. 6 to 18 years old requires appropriate diagnosis on file and within approved dosage limitations for it to approve transparently. Greater than 23 years of age requires prior authorization.
MS	Electronic PA age edits and quantity limits for all beneficiaries and diagnosis edit for adults.
MT	We use Smart PA to prevent overuse.
ND	First fill limitation (14 days initial supply), only one long acting and one short acting allowed concurrently and they must be the same molecule (e.g. they can't be on dexmethylphenidate extended release and methylphenidate immediate release concurrently), FDA max doses and age limits
NE	Non-preferred drugs require review for compliance and doses are monitored. Edits are in place to prevent use of more than one stimulant and high doses in children.
NH	When a stimulant is prescribed for an adult a Prior Authorization (PA) is required. A PA is required for non-preferred products for children.
NJ	A prior authorization is required to obtain an approved diagnosis from the prescriber.
NM	Stimulants require prior authorization for those 18 years of age or older.
NV	PA criteria for both adults and children established by the DUR Board.
NY	Quantity limits for patients less than 18 years of age to include: • Short-acting CNS stimulants: not to exceed 3 dosage units daily with maximum of 90 days per strength (for titration) • Long-acting CNS stimulants: not to exceed 1 dosage unit daily with maximum of 90 days. Concerta 36mg not to exceed 2 units daily. Quantity limits for patients 18 years of age and older to include: • Short-acting CNS stimulants: not to exceed 3 dosage units daily with maximum of 30 days • Long-acting CNS stimulants: not to exceed 1 dosage unit daily with maximum of 30 days. Concerta 36mg not to exceed 2 units daily. • For patients 18 years of age and older: a 90 day supply may be obtained with confirmation of FDA approved, Compendia supported or Medicaid covered diagnosis
OK	Under Age of 5 requires a psychiatrist consult, over age of 21 must fill out Prior Authorization. Quantity limits in placed based on FDA approved dosing.
OR	Doses exceeding quantity limits require prior authorization and prescribing by a specialist.
PA	A prescription for a preferred or non-preferred Stimulant and Related Agent for a recipient under 4 years of age or for a recipient 18 years of age or older requires prior authorization.
RI	Prior authorization program.
SC	Edits for indication and age = 6 years of age Narcolepsy products require diagnosis confirmed by sleep study (documentation required). Shift work d/o requires copy of work schedule.
SD	Quantity Limits
TN	PA required for all scheduled stimulants for adults, and required for children 21 and under only if daily dosage is higher than 80 mg/day of all products.

TX	HHSC has a clinical prior authorization (PA) for all stimulants and non-stimulants used for treatment of ADD/ADHD. The PA criteria screen for age limit, ADD/ADHD diagnosis codes for adults, concomitant use of two short acting or two long acting products, and diagnosis of history of drug abuse.
UT	Prior authorization requirements
VA	34 days supply, managed by P&T Committee criteria
VT	Certain Stimulants require PA and/or quantity limits
WA	Program for children is the same as described for antipsychotics above. Adults have maximum dose limits as well as expedited authorization requirements for validation of diagnosis.
WI	Wisconsin has both documented restrictions and special programs to monitor, manager or control the use of stimulants. These include diagnosis restrictions; allowed diagnoses are ADHD and narcolepsy; Prior authorization: required for non-preferred stimulants on the Preferred Drug List; System edits for early refill that can be overridden in certain circumstances by calling a specialized pharmacy call center; Children's Mental Health work group has focused on stimulant use; Interventions have included several targeted mailings to prescribers as well as peer to peer outreach from consultant child psychiatrists.
WV	Members are limited to 1 short-acting + 1 long-acting stimulant and these must be composed of the same chemical entity.
WY	Dosage limits apply to all ages. Diagnosis is required for those over 17 years of age.

IX. INNOVATIVE PRACTICES

The 37 states listed below have initiated innovative practices during the past year. A description of their innovative practice can be found in Attachment 6 of the individual state report: Drug Utilization Review Annual Report | Medicaid.gov

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

X. E-PRESCRIBING

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

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

a) If answer to X-1 above is "Yes," do you have a methodology to evaluate the effectiveness of providing drug information and medication history prior to prescribing?

Answer	State	Number of States (Percentage of 21 states)
Yes	AR, CT, DE, FL, MI, MO, NM, OK, TX	9 (43%)
No	AL, GA, ID, IN, KY, LA, ME, MN, MT, NH, UT, WV	12 (57%)

b) The 8 states listed below explain the evaluation methodology in Attachment 7 “E-Prescribing Activity Summary” and can be found in Attachment 7 of the individual state report: Drug Utilization Review Annual Report | Medicaid.gov

AR, CT, DE, FL, MI, NM, OK, TX

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

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

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

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

XI. MANAGED CARE ORGANIZATIONS (MCOs)

XI-1. Does your state have MCOs?

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

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

Answer	State	Number of States (Percentage of 38 states)
Yes	DE, HI, IA, IL, KS, KY, LA, MA, MS, ND, NJ, NM, NV, NY, OH, PA, SC, UT, VA	19 (50%)
No	CO, GA, MN, MO, NE, TN	6 (16%)
Partial	CA, DC, FL, IN, MD, MI, NH, OR, RI, TX, WA, WI, WV	13 (34%)

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

State	Explanation
CA	Selected HIV/AIDS/Hepatitis B treatment drugs; selected alcohol and heroin detoxification and dependency treatment drugs; selected coagulation factors; and selected drugs used to treat psychiatric conditions (including antipsychotics and MAO inhibitors)
DC	HIV antiretroviral medications
FL	Hemophilia claims
IN	Healthy Indiana Plan (HIP) 2.0, Hoosier Healthwise, and Hoosier Care Connect (HCC) are carved-in. Fee-for-service members are carved-out.
MD	During FFY 2016, antiretrovirals for the treatment of HIV/AIDS, mental health medications and substance use disorder medications were included in the carve-out program.
MI	Mental health drugs, substance abuse treatment, hemophilia drugs, HIV and selected drugs for rare metabolic diseases.
NH	Medications to treat Hepatitis C and hemophilia, and Carbaglu and Ravicti
OR	mental health drugs
RI	Stop loss arrangements for Hepatitis C drugs
TX	Hepatitis C treatment and Orkambi are carved out (non-risk payments).
WA	Hemophilia factor product for maintenance use in outpatient setting and HCV treatment are carved out.
WI	Managed Care Organizations carve-out drugs and provider-administered drugs in Wisconsin by specific program. In FFY 2016 the carve-out program was FamilyCare. FamilyCare is a long-term care program which helps frail elders and adults with disabilities get the services they need to remain in their homes.
WV	Hemophilia and Hepatitis C

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

Answer	State	Number of States (Percentage of 38 states)
Yes	CA, DE, FL, IA, IL, KS, MD, MI, MS, NJ, NY, OH, PA, SC, TX, UT, WA, WV	18 (47%)
No	CO, DC, GA, HI, IN, KY, LA, MA, MN, MO, ND, NE, NH, NM, NV, OR, RI, TN, VA, WI	20 (53%)

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

Answer	State	Number of States (Percentage of 18 states)
Formulary Reviews	CA, DE, FL, IL, MD, MI, NJ, NY, OH, PA, SC, UT, WA	13 (72%)
same PDL	DE, FL, IA, KS, MS, TX, WV	7 (39%)
same RetroDUR	IA, KS	2 (11%)
same ProDUR	IA, KS, MS	3 (17%)

If answer to XI-3 above is “Yes," please briefly explain your policy.

State	Explanation
CA	Medi-Cal MCOs are required to provide a pharmacy benefit that is comparable to the Medi-Cal FFS pharmacy program and their preferred drug lists (PDLs) are required to be comparable to the Medi-Cal List of Contract Drugs. While all drugs included on the Medi-Cal List of Contract Drugs do not need to be included on the MCOs' PDLs, comparable means that the drugs on the PDLs must have the same mechanism of action sub-class within all major therapeutic categories of drugs included in the Medi-Cal List of Contract Drugs. MCOs have their own DUR program that determines the most suitable treatment and prior authorization requirements for their organizations. They do not have the same ProDUR or RetroDUR as the fee-for-service program.
DE	MCOs must follow the state Medicaid PDL to a 95% compliance rate
FL	Plans may not be more restrictive with criteria, but must follow the same PDL.
IA	MCO Pharmacy representatives are required to attend meetings of the DUR and P&T Committee.
IL	MCO must have at least one preferred drug in each drug class available and cannot more restrictive than HFS.
KS	The state HID pharmacist prepares documents for the DUR board based on suggestions from the state and the MCOs. The MCOs follow the state PDL and all DUR approved PA as well as any state policy.
MD	A comprehensive drug use management program has been in place for several years which evaluates each MCO drug benefits, including: P&T Committee management and procedure, formulary content/management, prior authorization procedures and criteria, generic substitution, drug utilization review and disease management. A review and assessment of each MCO Drug Use Management Program is conducted annually.
MI	The MCO contract requires that the plan's formulary include coverage available for all outpatient covered drugs identified on the Fee-For-Service Michigan Pharmaceutical Product List (MPPL).
MS	MCOs have been required to reimburse at same amount or higher than FFS. As of January 2015, MCOs were required to use Universal Preferred Drug List and same clinical criteria.
NJ	MCOs contractually required to comply with NJ DURB standards
NY	Plans establish their own formularies and prior authorization processes. Plan formularies must include all categories of prescription drugs on the NYS Medicaid fee-for-service list of reimbursable drugs.
OH	70% agreement on PDLs
PA	The requirements for the outpatient drug services provided by the Medicaid MCOs are defined in Exhibit BBB of the HealthChoices Agreement. The amount, duration, and scope of covered outpatient drugs must be consistent with coverage under the Fee-For-Service Program. The Department reviews and approves all MCO formularies, prior authorization policies and drug utilization management programs prior to implementation.
SC	The MCO may implement a PDL with coverage of products meeting the State's coverage of products. Management of products within these classes - with the exception of any designated "protected classes" are decisions of the MCO
TX	Formulary and PDL requirements are enforced through Provider Contract Management team.
UT	MCO coverage and PA criteria must be the same or more lenient than FFS.
WA	The state selectively limits the pharmacy benefit. Review and approval by the state of all MCO formularies is required, according to standards of adequacy set out in contract. Generally MCOs are allowed to manage their own formularies after approval, but the state does dictate coverage in some specific areas to ensure consistent quality of care to clients. Currently the state is proscriptive with the plans in coverage criteria for antipsychotics and medication assisted treatments.
WV	The MCOs must follow our PDL criteria.

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

Answer	State	Number of States (Percentage of 20 states)
Yes	DC, HI, LA, MA, ND, NV, RI, VA	8 (40%)
No	CO, GA, IN, KY, MN, MO, NE, NH, NM, OR, TN, WI	12 (60%)

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

Answer	State	Number of States (Percentage of 38 states)
Yes	CA, DE, IA, KS, LA, MD, MI, PA, TX, UT	10 (26%)
No	CO, DC, FL, GA, HI, IL, IN, KY, MA, MN, MO, MS, ND, NE, NH, NJ, NM, NV, NY, OH, OR, RI, SC, TN, VA, WA, WI, WV	28 (74%)

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

State	Explanation
CA	MCOs are required to submit Policies and Procedures for DUR and treatment outcomes system to optimize the quality of pharmacy services. The DUR review includes: -Range and type of drugs taken by members -General drug utilization patterns of the plan -List of pharmacy interventions for Quality Improvement Projects (e.g., Asthma, Diabetes, HTN, etc.) -DUR alert/edit program to detect drug-drug interactions, high dose alert, etc., in order to alert dispensing pharmacy -Pharmacy service and drug utilization encounter data, including all pharmacy claims, which are provided to the state on a monthly basis
DE	The MCOs report their activities as part of their state specific P&T meetings. These is also an exchange of informal reports.
IA	MCOs submit their DUR activities to the state on a quarterly basis which are reviewed by the state and DUR Coordinator.
KS	The MCOs submit monthly reports regarding PDL and DUR approved criteria adherence. In addition, the MCOs present an annual report to the Kansas Medicaid DUR board.
LA	We have a monthly report that addresses DUR activities initiated by MCOs.
MD	Through the annual MCO Drug Use Management Assessment, each MCO is required to report all DUR policies and procedures, as well as specific documents related to oversight of the drug use evaluation process and maintenance of patient confidentiality. The assessment also requires reporting of types of prospective or retrospective programs, including any program specifically related to the use of controlled substances by participants.
MI	MCOs are contractually required to provide details about their DUR activities upon request.
PA	The MCOs are required to submit an annual DUR Report to the Department.
TX	The MCOs report to the Contract Performance Management (CPM) team on the number and the nature of their retro-DUR activities. They are not required to report on the financial outcomes of those activities. For the pro-DUR activities (clinical PAs), the MCOs must seek the DUR Board's approval before implementing a retro-DUR intervention. Otherwise, they must be presented to the DUR and Formulary team at Vendor Drug Program for approval.
UT	MCOs must submit a slightly modified version of this report to FFS Medicaid. The MCO reports are attached.

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

Answer	State	Number of States (Percentage of 28 states)
Yes	CO, DC, HI, IL, KY, MA, MN, MS, ND, NE, NH, NJ, NM, NV, NY, OH, OR, RI, SC, VA, WA, WI, WV	23 (82%)
No	FL, GA, IN, MO, TN	5 (18%)

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

State	Explanation
FL	The plans may not be more restrictive than the FFS criteria.
GA	The State does not plan to develop a program requiring MCOs to report their DUR activities in the future. The MCOs operate independently and report their DUR activities in ways they see fit without intervention from the State.
IN	The office continues to evaluate the effectiveness of this type of reporting.
MO	Our MCOs do not provide pharmacy benefits.
TN	TennCare is 100% managed care, but pharmacy is totally carved out. The MCO does not pay for any Covered Outpatient Drugs for Tennessee Medicaid enrollees.

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

Answer	State	Number of States (Percentage of 38 states)
Yes	CO, DC, DE, GA, IL, IN, KS, KY, MA, MD, MI, MN, MO, MS, ND, NH, NJ, NM, NV, OH, OR, PA, RI, SC, TX, UT, VA, WA, WV	29 (76%)
No	CA, FL, HI, IA, LA, NE, NY, TN, WI	9 (24%)

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

State	Explanation
CA	Some of the MCOs have Lock In programs, however not all of the MCOs have verified programs.
FL	The plans may have a lock in program, but it is not required.
HI	1-2 continue to work on their program.
IA	2 of the 3 MCOs have a lock in program for the misuse or abuse of controlled substances. One MCO did not have a program in place for FFY 2016.
LA	4 of the 5 existing MCO plans have a Lock-in Program. The other plan intends to create a Lock-in Program in the near future.
NE	Pharmacy was carved out of managed care in FFY 2016.
NY	In New York, the Office of the Medicaid Inspector General (OMIG) is the organizational component dedicated to anti-fraud and abuse activities. The OMIG is an independent entity within the New York State Department of Health. New York has implemented a rigorous lock-in program for beneficiaries with a demonstrated pattern of abusive utilization of Medicaid services. These primary providers may include a primary medical provider, pharmacy, hospital, durable medical equipment provider, dentist, and podiatrist. In addition, restricted beneficiaries who are eligible for managed care are transitioned into managed care. The MCOs also have their own restriction programs, which are monitored by OMIG.
TN	Not applicable. The State Pharmacy program runs the Lock-In program.
WI	The FamilyCare Partnership contract does not establish requirements for a Lock-In or CMC program.

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

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