Medicaid Drug Utilization Review
State Comparison/Summary Report FFY 2013
Annual Report

Prescription Drug Fee For Service Programs

December 2014

Executive Summary of 2013 State Medicaid DUR Annual Reports

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

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

On May 19th, 2014 CMS sent the states the newly revised Medicaid DUR Annual Report Survey to complete. The new survey included a significantly-expanded Fraud, Waste and Abuse section, new questions about Prescription Drug Monitoring Programs (PDMP) section and inquiries regarding state Managed Care Organizations (MCOs). Below is a brief summary of the findings.

I. **Demographics – Page 1**

All states and the District of Columbia submitted a 2013 Medicaid DUR Annual Report, with the exception of Arizona because almost all of its beneficiaries are enrolled in MCOs. The information reported is focused primarily on Medicaid Fee For Service DUR activities. States are not currently required to submit an annual report on MCO DUR activities.

II. Prospective DUR (ProDUR) – Page 2

ProDUR functions are done at the point-of-sale (POS) when the prescription is being filled at the pharmacy. Forty-four states (88%) contract with an outside vendor to process their POS claims. Thirty-seven states (74%) 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. Regarding refills for non- controlled drugs, states vary from a threshold of having used 70 to 90% before it can be refilled, with an average of 79%. For controlled drugs the range is 70 to 100% with an average of 83%.

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

III. Retrospecitve DUR (RetroDUR) –Page 8

RetroDUR functions reside primarily with a contractor in 36 states and with and academic organization in 10 states. Several states use a combination of several sources. In 42 states (84%), the DUR Board approves the RetroDUR criteria to be followed by the contracted organization.

IV. DUR Board Activity - Page 10

All states provided a summary of their DUR Board activities which can be found in each individual state report. Seven states have Medication Therapy Management Programs approved by CMS.

V. Physician Administered Drugs – Page 12

To date, only ten states have designed or redesigned their MMIS systems to incorporate Physician Administered Drugs (those drugs paid through the physicians and hospitals programs) into their DUR criteria.

VI. Generic Policy and Utilization Data - Page 13

All states reported generic utilization percentages for all covered outpatient drugs reimbursed during the 2013 reporting period. The average percentage generic utilization was 79%, which accounts for an average of 22% of the total dollars reimbursed for drugs during the reporting period.

VII. Program Evaluation /Cost Savings/Avoidance - Page 15

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

VIII. Fraud, Waste and Abuse Detection - Page 18

A. Lock- In Programs – Page 18

All Medicaid agencies, except South Dakota, have a Lock-In or Restrictive Program when the state identifies potential fraud or misuse of controlled drugs by a beneficiary. Thirty-eight states (76%) have a process to identify potential fraudulent practices by prescribers and 34 states (68%) have a process to identify potential fraudulent practices by pharmacies. This triggers actions such as denying claims written by that prescriber or claims submitted by that pharmacy, alerting the Integrity or Compliance Unit to investigate, or referring to the appropriate licensing Board or another governmental agency (e.g. Attorney General, OIG, DEA) for follow-up.

B. Prescription Drug Monitioring Programs – Page 23

In 2013, 47 states (94%) reported having a Prescription Drug Monitoring Program (PDMP) in their state. Twenty-seven states (58%) have some ability to query the PDMP database, while the remaining 20 states (43%) do not have the ability to do so. Only seven states require that prescribers access the patient history in the database prior to prescribing restricted (controlled) substances. Thirty-six states (72%) indicated that they face a range of barriers that hinder their ability to fully access and utilize the database to curb abuse. At the end of 2014, Missouri remains the only state that has yet to implement a PDMP.

C. Pain Management Control – Page **27**

Twelve states reported that they obtain the DEA Active Controlled Substance Registrant's File in order to identify those prescribers not authorized to prescribe controlled drugs. Forty-nine states report having measures in place to monitor/ manage prescribing of methadone for pain management.

D. Opioids – Page 29

Forty-two states (84%) have edits in place to limit the quantity of short-acting opioids, 41states (82%) have edits in place to limit the quantity of long-acting opioids.

E. Morphine Equivalent Daily Dose (MEDD) – Page 31

Only 9 states have set recommended Maximum Equivalent Daily Dose (MEDD) limits, however, 11 states report that they give providers information on how to calculate the MEDD.

F. Buprenorphine – Page 32

Thirty-nine states (78%) set limits on the daily milligrams of buprenorphine that can prescribed. Details on the limit amounts, length of treatment and maintenance dosing can be found in the report.

G. Psychotropic Drugs/Stimulants – Page **35**

Forty-one states (82%) have programs in place to manage /monitor the appropriate use of psychotropic medications in children. Thirty-seven states (74%) monitor all children, not just those children in foster care. These states have provided a brief synopsis of the specifics of their programs. South Dakota only monitors children in foster care. It should be noted that some states have legislation in place that prohibits any restriction being place on the prescribing of medications used to treat mental or behavioral health conditions. Forty-one states (82%) have restrictions or special programs in place to monitor/control the use of stimulants.

IX. Innovative Practices - Page 40

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

X. E-Prescribing - Page 41

As of the end of this reporting period, 29 states (58%) have implemented e-prescribing ; 20 states have the capability to enable the prescriber to access patient data history and pharmacy coverage limitations prior to prescribing for a specific patient.

XI. Managed Care Organizations (MCOs) – Page 42

States are not required to report on oversight of DUR activities in their MCOs, even though more states are moving their beneficiaries into MCOs. Twenty-eight states report that prescription coverage is included (carved-in) to the capitation rate. Twenty-three (46%) states report the agency sets requirements for the MCO pharmacy benefit. Fifteen states require their MCOs to monitor or report their MCO DUR activities.

Medicaid Fee for Service Program Drug Utilization Review Annual Report

Comparison/Summary Report FFY 2013

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I. DEMOGRAPHIC INFORMATION

49 States plus DC completed FFY 2013 DUR Survey. AZ has the majority of its Medicaid population in Managed Care Organizations (MCOs)s, therefore, currently it is not required to submit an annual DUR report..

II. PROSPECTIVE DUR (ProDUR)

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

Answer	State	Number of States (Percentage)
State-operated	IL, MN, ND, SD	4 (8%)
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, UT, VA, VT, WI, WV, WY 44	44 (88%)
Other	TX, WA	2 (4%)

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

State	Note
*IN	HP Enterprise Services_(October 1, 2012~ May 23, 2013) Catamaran (May 24, 2013 ~ September 30, 2013).
*OR	Hewlett Packard Enterprise Services operates the POS claims system and Prospective DUR services. Oregon Health Sciences University (OHSU) College of Pharmacy is subcontracted to operate the Retrospective DUR services.
*NC	HP Enterprise Services October 1, 2012 to June 30, 2013 CSC (Computer Sciences Corporation) July 1, 2013 to 09/30/2013.
*TX	Prospective criteria is developed both in-house via contract with the University of Texas Health Science Center, contracted pharmacy claim services vendor, and through First Data Bank DUR modules.
*WA	System and transaction processing provided by CatamaranRx, but all non-infrastructure operation and configuration of the system is done by the State.

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

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

II-3. Identify the prospective DUR criteria source.

Answer	State	Number of States (Percentage)
First Data Bank	AK, AL, AR, CA, CO, CT, DC, FL, HI, ID, IL, KS, KY, MA, MD, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NY, OH, OK, OR, RI, SC, SD, TN, TX, WI, WV	37 (74%)
Other	DE, GA, IA, IN, LA, ME, NV, PA, UT, VA, VT, WA, WY	13 (26%)

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

State	Explanation
DE	Delaware employed Micromedex during this fiscal year, but Micromedex is stopping this service in the future so adjustments are being made.
GA	Medi-Span
IA	Medispan
IN	Medi-Span (Catamaran)
LA	In addition to FDB DUR modules, criteria are developed through collaboration of pharmacists at DHH, ULM, and Molina Medicaid Solutions, with approval by the Louisiana DUR Board.
ME	Medispan, Clinical Literature and other State programs
NV	Medispan
PA	The Prospective DUR criteria used in Pennsylvania comes from both First Data Bank as well as criteria developed by Department staff.
UT	Medispan
VA	Xerox
VT	MediSpan FDA Safety Alerts
WA	Medispan drug file with threshold levels determined by Medicaid clinical and operational staff.
WY	Medispan and University of Wyoming School of Pharmacy

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

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

If the answer to II-4 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.
DE	New prospective DUR criterion automatically was entered the system through our Micromedex source and then are reviewed after by claim count that hits the criterion. Adjustments are proposed to the DUR board if DUR criterion is not achieving the desired clinical outcomes.
GA	Criteria is from Medi-Span
IA	This is a collaborative effort between the State, POS Contractor and DUR. Most new proposed criteria are reviewed by the DUR Board.
ID	The DUR Board review; 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 are reviewed and discussed at all DUR Board meetings. Individual criteria may be recommended by the Board for implementation. All new severity level 1 drug interaction criteria are automatically implemented by the POS vendor as they become available from First Data Bank.
MN	High dose and/or quantity limits which cause the claim to reject are reviewed by the DUR Board. Informational edits are not reviewed by the DUR Board.
MO	Automatic updates are made from First Data Bank which is incorporated in our prospective DUR criteria.

ND	We have never had the DUR Board review the FDB pro-DUR criteria as FDB is the standard.
NE	The DUR Board recommends criteria; however, final approval is made by DHHS.
NV	Medispan provides the criteria, the DUR Board does not review criteria
OK	Guidelines have been approved, and new criteria are updated as it comes from FDB as long as it meets the set parameters.
OR	DUR criteria are updated by FDB. There is an ability to modify how the alerts are responded to (override required or informational only), but not to change the criteria itself.
RI	The prospective DUR criteria are auto loaded from First Data Bank.
SD	DUR Board does not review prospective criteria
TN	Difficult to review all new ProDUR edits. Custom or non-industry standard criteria are approved by the DUR Board when the Board has seen issues that arise.
WA	New prospective Drug Utilization Review that is implemented as part of the Fee-for-Service Prior Authorization program is reviewed by the board if they are not based solely on FDA labeling. Automated Pro-DUR criteria is accepted as received from the Medispan drug file and is not reviewed by the DUR Board.

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

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

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

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

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

Answer	State	Number of States (Percentage)
Monthly	AL, DC, ID, KY, MI, MS, NC, NE, NH, NM, SC, VA, WA	13 (57%)
Quarterly	DE, FL, NV, OK, OR, TN, TX, VT	8 (35%)
Annually	CA, OH	2 (9%)

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

Answer	State	Number of States (Percentage)
Yes	AL, DC, DE, MI, NC, NE	6 (26%)
No	CA, FL, ID, KY, MS, NH, NM, NV, OH, OK, OR, SC, TN, TX, VA, VT, WA	17 (74%)

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

Answer	State	Number of States (Percentage)
Contact pharmacy	NE	1 (17%)
Refer to Program Integrity for Review	DC, DE, MI, NC	4 (67%)
Other(explain)	AL	1 (17%)

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 with providers.

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	83%	70%	100%

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

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

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

Answer	State	Number of States (Percentage)
Pharmacist	MN, MT, OK, TX, WA	5 (14%)
Prescriber	ID, MS, NY	3 (9%)
Either	AK, AL, CO, CT, DC, DE, FL, GA, HI, IL, IN, KY, MA, MD, ME, MO, NM NV, OH, PA, SC, TN, UT, VA, VT, WV	27 (77%)

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

Answer	State	Number of States (Percentage)
Yes	AR, KS, LA, MI, NC, ND, NE, OR, RI, WI	10 (67%)
No	CA, IA, NH, NJ, SD	5 (33%)

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

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

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

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

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

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

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

a) Lost/stolen Rx

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

b) Vacation

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

c) Other

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

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

State	Explanation
CA	The pharmacist can override the early refill DUR alert message for any medically necessary reason.
DE	Can be overridden if directions changed
IL	Informational edits regarding duplicate therapy
KS	Spilled medications
LA	Other situations may be overridden using the pharmacist's professional judgment.
ME	for admissions to Nursing Homes with override
MI	Long-term care pharmacies may override using Submission Clarification Code. Point-Of-Sale system verifies the patient has LTC enrollment
MO	All early refill denials require the pharmacist to contact the pharmacy help desk for individual override each time the edit posts.
NC	Change of Therapy (This is the only override allowed for controlled substances)
ND	Dose or drug change
NE	Lost or stolen controlled substance prescriptions require PA
NH	Early Refill override options include destroyed, transferred between facilities, school/daycare supply and wrong days supply
NM	Additional inhaler or anaphylactic Rx for school or work
OR	Change in therapy, medically necessary, LTC leave is among other accepted clarifications.
SC	Therapeutic duplication may be overridden by the pharmacist for the following classes of medications: bronchial dilators, ophthalmic preparations, antivirals, anticonvulsants, diabetic therapy and cardiovascular medications.
WA	Override also provided for the following situations: Multiple prescriptions for multiple locations (school, camp, nursing home take home supply, etc...); nursing home admit or discharge; short fills actively monitored by prescriber. State not only does not provide an override for vacation fills, they are non-covered.
WI	Dose Change, Member misunderstood directions from prescriber, Natural Disaster

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

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

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

Answer	State	Number of States (Percentage)
Yes	DC, IA, MA, NE, TX, VT, WA	7 (25%)
No	CA, CO, CT, DE, HI, IN, KS, LA, MD, ME, MN, MO, NH, NJ, OH, OR, PA, SD, UT, VA, WI	21 (75%)

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

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

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

Answer	State	Number of States (Percentage)
Medicaid agency	AK, CO, CT, DE, FL, HI, MI, SC	8 (16%)
State Board of Pharmacy	AK, AL, AR, CA, DC, 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	42 (84%)
Other- please explain	HI, IL, ME, MO, NY	5 (10%)

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

State	Explanation
HI	Monitoring pharmacy compliance with the oral counseling requirement was not done by contract this year.
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.
ME	Program Integrity
MO	The Missouri Medicaid Audit & Compliance Unit monitors compliance with the oral counseling requirement.
NY	On-site pharmacy inspections performed by Office of Professional Discipline.

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

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

III. RETROSPECTIVE DUR (RetroDUR)

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

Answer	State	Number of States (Percentage)
Company	AK, AL, AR, CT, DC, DE, FL, GA, HI, IA, ID, IN, KS, KY, LA, ME, MI, MN, MO, MT, NC, ND, NH, NJ, NM, NV, PA, RI, SC, SD, TN, TX, VA, VT, WI, WV	36 (72%)
Academic institution	CA, CO, IL, MA, MS, OH, OK, OR, UT, WY	10 (20%)
Other organization	MD, NE, NY, WA	4 (8%)

Vendor by Name and Type

Organization	State
Catamaran	NV,VT
Goold Health Systems	IA,ME
Health Information Design	AL, AR, CT, DE, KS, MD, ND, NY*, PA, RI, SD*, WI
Magellan	AK,FL, ID, KY, MI, NC, NH, SC, TN,
Molina Medicaid Solution	LA, NJ
Mountain Pacific Quality Health Foundation	MT
Nebraska Pharmacists Association	NE
NorthStar HealthCare Consulting	GA
Washington State Health Care Authority	WA
Xerox	DC, HI, IN, MN, MO, NM, TX, VA, WV
Academic Institution	
OHSU College of Pharmacy	OR
University of California, San Francisco (UCSF)	CA
University of Cincinnati College of Pharmacy	OH
University of Colorado School of Pharmacy	CO
University of Illinois College of Pharmacy	IL
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	UT
University of Wyoming, utilizing Xerox Cyberformance and other data sources	WY
Other	SD
* SD State University College of Pharmacy	NY
* State University of NY at Buffalo	

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, ID, IL, IN, KS, KY, MA, MD, ME, MN, MO, MS, MT, ND, NH, NJ, NM, NV, NY, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	42 (84%)
No	CA, HI, LA, MI, NC, NE, OH, OK	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. The final approval is by DHCS.
HI	The DUR Board and the DUR Coordinator develop and supply the retrospective DUR criteria.
LA	Retrospective DUR criteria are developed through collaboration of pharmacists at DHH, ULM, and Molina Medicaid Solutions, with approval by the Louisiana DUR Board.
MI	This is a joint effort between Medicaid agency staff and the vendor staff. The DUR Board identifies and defines the RetroDUR topics and the vendor operationalizes.
NC	NC DMA AND DUR BOARD MEMBERS
NE	Retrospective reports are generated by the POS vendor. Criteria may be developed by POS vendor and/or DUR Board.
OH	Retrospective DUR criteria are formulated internally with assistance from the University of Cincinnati
OK	The University utilizes Medi-Span drug information applications.

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

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

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

State	Explanation
CA	The DUR board advises and makes recommendations regarding retrospective DUR criteria; however, final approval is by DHCS.
GA	DUR Board is advisory only; Department of Community Health approves criteria
IA	Goold Health Systems utilizes MediSpan for retrospective DUR criteria involving a complex screening process.
IL	in its first year, the reformulated Illinois DUR Board discussed general criteria for choosing diseases and drugs for retrospective review. They approved prospective criteria that resulted from retrospective review of select medications.
NV	The DUR Board offers topics and reviews results, but does not approve before letters are sent
OK	Guidelines have been approved, and new criteria are updated as it comes from FDB as long as it meets the set parameters.
WA	The DUR Board does not approve all retrospective DUR criteria. Retrospective DUR is performed on a regular basis to identify potential utilization problems. Only those which State staff believes require intervention are presented to the Board for approval. The DUR Board also does not approve any retro-DUR performed through SURS or Program Integrity functions.
WY	Retrospective DUR criteria are evidence-based and created by a clinical team and considered proprietary by the sub-contractor. Retrospective DUR contractor (University of Wyoming School of Pharmacy) as well as the Department of Health as needed.

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

Answer	Number of States	Percentage
Yes	50	100%

IV. DUR BOARD ACTIVITY

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

Answer	Number of States	Percentage
Yes	50	100%

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

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

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

Answer	State	Number of States (Percentage)
Yes	IN, MA, ME, UT, VT	5 (26%)
No	CA, DC, FL, IA, MO, MS, ND, NY, OK, OR, PA, TX, WA, WY	14 (74%)

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

State	Findings
IN	The Managed Care Entities (MCEs) provide disease management programs which are monitored and evaluated through the MCEs quality improvement processes. This is accomplished at the individual health plan level and not at the state level.
MA	Educational outreach interventions to prescribers increased medication possession and demonstrated cost avoidance.
ME	We were able to abate 1.2 million in inappropriate drug therapy.
UT	In addition to saving Utah Medicaid millions of dollars per year, the hemophilia management program results in better outcomes for our patients (prevented ED visits, prevented supplemental doses of factor, etc.).
VT	The primary foundation of the Vermont Chronic Care Initiative (VCCI) effort has been to use health analytics to identify the high risk/high cost members, then to identify gaps in care that a VCCI case manager could address with the member and their providers. A careful review of the outcomes of this effort shows success for the VCCI interventions in 2013. The expected Per Member Per Month (PMPM) rate of increase in the cost of care for this group was 13.38% over the previous two years, or from $2,688.26 PMPM in the baseline year (SFY 2011) to $3,047.68 PMPM in SFY 2013. The outcome data indicates the actual PMPM for the high risk/high cost population was $2,767.20 PMPM. Thus, overall care expenses were $27,633,227 lower than projected, an average of $280.48 PMPM for SFY 2013. After subtracting total administrative program costs, the total net savings were $23,475,731, an average of $238.28 PMPM for SFY 2013. VCCI has been successful in its focus on the high risk/high cost members and as part of the larger health care reform strategy pursued by the state of Vermont to

	stabilize the cost of care for Medicaid members and all Vermonters.
IN	The Managed Care Entities (MCEs) provide disease management programs which are monitored and evaluated through the MCEs quality improvement processes. This is accomplished at the individual health plan level and not at the state level.
MA	Educational outreach interventions to prescribers increased medication possession and demonstrated cost avoidance.
ME	We were able to abate 1.2 million in inappropriate drug therapy.

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

Answer	State	Number of States (Percentage)
Yes	DC, MA, ME, MO, WY	5 (26%)
No	CA, FL, IA, IN, MS, ND, NY, OK, OR, PA, TX, UT, VT, WA	14 (74%)

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

Answer	State	Number of States (Percentage)
Yes	CO, FL, IA, MN, MO, OR, WI	7 (14%)
No	AK, AL, AR, CA, CT, DC, DE, GA, HI, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WV, WY	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)
Yes	FL, MO, WI	3 (43%)
No	CO, IA, MN, OR	4 (57%)

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

State	Findings
FL	The MEDS-AD/MTM program meets all of the CMS requirements, including annual Comprehensive Medication Reviews (CMR) with the provision of a Personalized Medication List (PML) and Medication-Related Action Plan (MAP) mailed to patients following the CMR. Prescribers are notified of potential issues or problems via phone and/or facsimile, depending on the urgency of the issue, following the review. MTM services are provided to patients mainly via telephone. All encounters are documented within the MTM software system with follow-up reviews performed quarterly for patients that receive a CMR. The MTM services that are delivered are designed to resolve medication-related and health-related problems, optimize medication use for improved patient outcomes, and promote patient self-management of medication and disease states
MO	Using DirectCarePro, MO HealthNet has successfully increased pharmacist's involvement with primary care providers and empowered participants to have more control over their health issues. To date, around 200 pharmacists have enrolled in the program. Combined with the efforts of primary care physicians, the initiative has generated a savings of $35.07 per member per month in prescription costs as compared to the control population. Gross savings for 12 months of 2013 were $149,417. Including $29,510 for the cost of MTM payments to local pharmacists, the program produced a net savings of $119,507 for 2013.
WI	To date we have paid about 46,000 MTM claims for 28,000 members. 1238 pharmacists are providing MTM services. As a result of MTM services, childrens' medication dosages are being adjusted to age-appropriate levels, use of high-risk medications among the elderly has decreased, and members with asthma are being instructed on proper use of their inhalers.

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

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

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

Answer	State	Number of States (Percentage)
Yes	CO	1 (20%)
No	FL, IA, MN, OR	4 (80%)

V. PHYSICIAN ADMINISTERED DRUGS

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

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

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

Answer	State	Number of States (Percentage)
Yes	AK, CA, CO, DC, FL, GA, IA, ID, IL, MD, MS, MT, NC, ND, NH, NJ, NM, NV, OR, SD, TX, UT, VT, WV	24 (60%)
No	AL, AR, CT, IN, KS, LA, MN, NE, NY, OH, OK, RI, TN, VA, WI, WY	16 (40%)

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

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

Answer	State	Number of States (Percentage)
Require that a MedWatch Form be submitted	AK, AL, AR, DE, IA, ID, IN, KS, MD, MI, MS, NC, ND, NH, SD, WV, WY	17 (44%)
Require medical reason for override accompany prescription	AL, DE, ID, KS, MO, MS, MT, ND, NH, NV, OK, SD, UT, WV	14 (36%)
Preauthorization is required	AK, AL, AR, CO, DC, DE, GA, IA, ID, IL, IN, KS, MA, MD, MI, MN, MO, MS, MT, NC, ND, NH, NJ, NV, OK, OR, PA, SD, TN, UT, VT, WA, WI, WV, WY	35 (90%)
Other – please explain	AR, CA, CT, ID, ME, MI, NE	7 (18%)

If the response is “Other”, please explain:

State	Explanation
AR	In the context of this policy, Brand Medically Necessary brand name medication when the use of a generic product has resulted in 1) adverse reaction(s) to the generic drug, 2) allergic reaction(s) to the generic drug, or 3) therapeutic failure of the generic drug. The prescriber shall submit, to the PA Help desk, documentation to substantiate the claim using the FDA MedWatch Form to support dispensing a brand name medication instead of the generic equivalent. Once all data is received regarding the reason for the request, several factors are reviewed, such as the beneficiary's Medicaid drug profile for compliance and a comparison of the inactive ingredients between the generic and the brand name drug, and then a decision is rendered.
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 brand medically necessary prior authorization is required unless the brand name drug is on the PDL.
ID	Failure of two different generic products in the same GSN
ME	Maine does not allow DAW 1 for Medicaid
MI	No prior authorization for selected drug classes determined by the State legislature to be exempt from prior authorization
NE	Prescribers must attest that the brand name is medically necessary by completing a form.

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

State	Generic Utilization Percentage
DC	66%
MS	70%
CA	71%
TX	71%
LA	73%
NJ	73%
CT	74%
MI	74%
VT	74%
NC	76%
SC	76%
MD	77%
NH	77%
WV	77%
AK	78%
DE	78%
ME	78%
MO	78%
MT	78%
SD	78%
WY	78%
AR	79%
IA	79%
ND	79%
UT	79%
AL	80%
CO	80%
FL	80%
ID	80%
NY	80%
WI	80%
GA	81%
MN	81%
NM	81%
NV	81%
OH	81%
OK	81%
TN	81%
IL	82%
IN	82%
NE	82%
WA	82%
OR	83%
PA	83%
MA	84%
VA	84%
KS	85%
KY	87%
RI	88%
HI	89%
Average	**79%**

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

State	Percentage Dollars Paid for Generics in relation to Total Drug Spend
NJ	9%
DC	12%
CA	13%
MI	13%
FL	15%
NH	15%
NY	16%
MD	17%
SC	17%
DE	18%
ME	18%
KS	19%
WV	19%
IN	20%
NC	20%
OH	20%
PA	20%
TX	20%
WY	20%
GA	21%
MT	21%
NE	21%
CT	22%
IA	22%
NV	22%
TN	22%
WI	22%
AK	23%
OR	23%
MN	24%
RI	24%
UT	24%
VT	24%
WA	24%
ID	25%
LA	25%
SD	25%
VA	25%
CO	26%
MA	26%
MO	26%
MS	26%
OK	26%
AL	27%
AR	27%
IL	27%
KY	27%
ND	28%
HI	29%
NM	30%
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, HI, IA, ID, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WI, WV	41 (82%)
Academic institution	CA, MA, OK, WY	4 (8%)
Other institution	CO, GA, IL, OH, WA	5 (10%)

Organization Name and Type

Organization	States
Catamaran	GA, IN, NV, VT
DUR Coordinator, pharmacy consultant	HI
Goold Health System	IA, ME, UT*
Health Information Designs	AL, AR*, CT, KS*, MD*, ND, NY, PA,RI, SD, TX*, WI*,
HFS Bureau of Pharmacy Services	IL
HP Enterprise Services	AR*, CO*, DE, KS*, OR, WI*
Magellan Medicaid Administration	AK, FL, ID, KY, NE, NH, TN, MI, SC
Mercer	NC
Molina Medicaid Solutions	LA, NJ, WV*
Mountain Pacific Quality Health Foundation	MT
Xerox	AR*, DC, MD*, MN*, MO, MS*, NM, TX*, VA, WV*
Academic Institution	
University of California, San Francisco	CA
University of Cincinnati	OH
University of Massachusetts Medical School	MA
University of Oklahoma College of Pharmacy, Pharmacy Management Consultants	OK
University of Wyoming School of Pharmacy	WY
Washington State Health Care Authority	WA
Other	
*MS- University of Mississippi, School of Pharmacy	
*UT- University of Utah College of Pharmacy Drug Regimen Review Center	
*CO- Colorado Department of Health Care Policy and Financing Prospective DUR cost savings estimate was conducted by Hewlett-Packard Enterprise Services (HP).	
*MN- is a combination of MN State for all but RetroDUR which Xerox performs.	

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	1,951,526	21,071	-	1,972,597
AL	-	1,162,402	-	1,162,402
AR	19,306,820	1,844,056	31,964,730	53,115,606
CA	80,060,972	-	-	80,060,972
CO	-	-	2,976,000	2,976,000
CT	26,259,835	3,650,229	-	29,910,064
DC	572,176	1,052,582	-	1,624,758
DE	2,574,000	215,278	-	2,789,278
FL	49,981,298	3,855,504	167,865,388	221,702,190
GA	40,085,642	n/a	n/a	40,085,642
HI	-	-	6,100	6,100
IA	-	2,458,998	-	2,458,998
ID	17,796,500	581,368	-	18,377,868
IL	-	-	675,851,586	675,851,586
IN	137,550,000	400,205	-	137,950,000
KS	96,671	54,311	65,599	216,581
KY	31,440,330	751,833	9,423,841	41,616,004
LA	76,381,838	627,076	-	77,008,914
MA	230,310,056	-	162,842	230,472,898
MD	21,798,996	291,534	-	22,090,530
ME	-	-	-	-
MI	294,844,709	3,513,775	N/A	298,380,484
MN	28,675,613	436,991	-	29,112,604
MO	55,360,494	39,528	-	55,400,022
MS	10,013,146	-	901,185	10,914,331
MT	9,943,000	257,000	2,416,000	12,617,000
NC	337,016,400	109,616	133,095,000	470,221,016
ND	-	698,543	-	698,543
NE	7,964,030	-	66,409	8,030,439
NH	13,367,608	802,776	11,266,730	25,437,114
NJ	15,480,409	-	-	15,480,409
NM	1,771,520	747	-	1,772,266
NV	6,392,225	-	-	63,922,225
NY	141,057,461	3,037,954	N/A	144,095,415
OH	37,632,903	1,692,412	-	39,325,315
OK	143,417,343	-	3,604,291	139,813,053
OR	113,338	15,400	-	128,738
PA	-	838,939	-	838,939
RI	3,188,746	124,979	-	3,313,725
SC	45,942,239	768,533	-	46,710,771
SD	-	271,293	-	271,293
TN	16,521,429	-	3,524	16,524,953
TX	28,025,368	26,615,755	-	54,641,123
UT	11,031,639	934,776	531,580,460	543,546,875
VA	29,352,239	399,850	7,788,739	37,540,828
VT	59,386,852	435,912	-	59,822,764
WA	25,914,542	-	34,606,412	60,520,954
WI	-	761,707	-	761,707
WV	15,796,087	6,367,864	81,741,016	103,904,967
WY	19,108,951	82,153	-	19,191,104
Average	**41,869,699**	**1,357,770**	**33,050,258**	**78,087,759**

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
WI	0%
ME	0%
CO	1%
HI	1%
IA	1%
OR	1%
PA	1%
SD	1%
DC	2%
DE	2%
KS	2%
ND	2%
TN	2%
AK	3%
CA	3%
CT	4%
MS	4%
NJ	4%
MO	5%
MD	7%
GA	8%
OH	8%
TX	8%
NM	10%
ID	14%
MN	14%
LA	15%
MT	15%
UT	15%
AR	17%
FL	17%
IN	17%
AL	22%
NY	22%
SC	24%
NE	25%
RI	25%
NH	26%
VA	28%
OK	33%
WA	36%
NC	38%
WV	39%
VT	44%
MI	48%
MA	49%
NV	49%
WY	49%
KY	69%
IL	73%
Average	**18%**

VIII. FRAUD, WASTE AND ABUSE DETECTION

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

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

Answer	Number of States	Percentage
Yes	50	100%

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

Answer	State	Number of States (Percentage)
Deny claims and require pre-authorization	CO, CT, DE, GA, IL, IN, KY, MA, MD, ME, MI, MO, MT, ND, NE, NJ, NV, OK, OR, SC, TN, TX, UT, VT, WV	25 (50%)
Refer to lock-in program	AK, AL, AR, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NJ, NV, OH, OK, OR, RI, SC, TN TX, UT, VA, VT, WA, WI, WV, WY	43 (86%)
Refer to Program Integrity Unit	AK, AL, AR, CO, CT, DC, DE, FL, GA, IA, IL, IN, KY, MA, MD, ME, MI, MO, MS, NC, ND, NE, NH, NJ, NM, NV, OK, PA, RI, SC, SD, UT, VA, VT, WV	35 (70%)
Other (e.g. SURS,Office of Inspector General)	AK, AL, CA, GA, MA, MD, MN, MS, MT, NC, NJ, NV, NY, OH, SD, TN, UT, VA, VT, WI, WY	21 (42%)

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 & Investigation 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
MA	Referral to Care Management
MD	SURS, OIG, and CDSIU (Controlled Dangerous Substance Integration Unit)
MN	Questionable utilization is referred to the SURS program and they determine the action from there.
MS	Refer to managed care plans
MT	Upon determination by our internal Pharmacy Fraud Control Committee, that a member is apparently committing fraud through the abusive use or apparent diversion, the member is referred to law enforcement (Division of Criminal Investigation) or the Office of Public Assistance.
NC	ALL POTENTIAL RECIPIENT FRAUD AND ABUSE LEADS ARE REFERRED TO THE RECIPIENTS COUNTY DEPT OF SOCIAL SERVICES FOR FURTHER INVESTIGATION AND DISPOSITION
NJ	A Surveillance and Utilization Review (SURS) reporting tool is used by the Data Mining Unit within the Medicaid Fraud Division to for unusual patterns in claim reimbursement from providers and refers findings to the Audit or Investigations Units for further analysis. The reporting tool is also used by other users to identify aberrant billing practices.
NV	Refer the recipient to Welfare for eligibility verification, refer to Board of Pharmacy
NY	Professional RetroDUR case reviewers refer potential fraud cases to the DUR program, from which they are forwarded to the Office of the Medicaid Inspector General (OMIG) for further review and/or possible investigation.
OH	Refer to county department of job and family services
SD	Medicaid Fraud Control Unit
TN	Refer to State of Tennessee's Office of Inspector General, which is the agency that investigates and enforces

	Tennessee's Doctor Shopping and TennCare enrollee fraud laws.
UT	Refer to Medicaid Fraud Control Unit
VA	Java-Server utilization Review System (JSURS) identifies member to review for enrollment in DMAS Client Medical Management Program (Lock-In program)
VT	Referrals are also made to law enforcement
WI	The Office of the Inspector General (OIG) has department wide responsibilities for auditing use of department funds in support of the department's commitment to be an effective steward of the public resources DHS is entrusted to manage. The OIG, which reports directly to the DHS Secretary, conducts audits of providers who receive department funds, performs internal audits of department programs and operations, and investigates allegations of fraud, waste, or abuse of DHS resources by contractors, providers and recipients. The OIG also is responsible for working with DHS program divisions and partners to develop policies and practices to prevent fraud, waste and abuse
WY	Patients are referred to Program Integrity as necessary depending on findings

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

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

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

Answer	State	Number of States (Percentage)
Number of controlled substances (CS)	AK, AL, AR, CT, DC, DE, FL, GA, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, ND, NH, NJ, NM, NV, NY, OH, OK, OR, PA, SC, TN, TX, VA, VT, WA, WI, WV	41 (84%)
Different prescribers of CS	AK, AL, AR, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, TN, TX, UT, VA, VT, WA, WI, WV, WY	47 (96%)
Multiple pharmacies	AK, AL, AR, CO, CT, DC, DE, FL, 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	47 (96%)
Number days’ supply of CS	AL, AR, CT, DC, GA, IA, ID, KS, LA, MO, MS, ND, NH, NY, OR, PA, SC, TX, VT, WI, WV	21 (43%)
Exclusivity of short-acting opioids	GA, IA, KS, MI, NJ, OK, PA, SC, TX, VT, WV	11 (23%)
Multiple ER visits	AK, AL, CO, GA, HI, IA, ID, IN, KS, KY, ME, MI, MN, MO, MS, MT, ND, NH, NJ, NM, NV, NY, OK, OR, PA, TN, TX, UT, VA, VT, WA, WI, WV	33 (67%)
Other	AL, CA, CO, IA, ID, IL, LA, MS, MT, NE, NV, OR, PA, TN, VA, WA, WV	17 (35%)

If the response is “Yes”, do you restrict the beneficiary to:

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

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

Answer	State	Number of States (Percentage)
6 months	AK, FL, HI, SC	4 (8%)
12 months	AL, CO, CT, DC, DE, IL, MA, MI, MS, MT, NC, NH, RI, UT, WV, WY	16 (33%)
Other	AR, CA, GA, IA, ID, IN, KS, KY, LA, MD, ME, MN, MO, ND, NE, NJ, NM, NV, NY, OH, OK, OR, PA, TN, TX, VA, VT, WA, WI	29 (59%)

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

State	Explanation
AR	Beneficiary is re-reviewed through the process every 12 months. However, the state may determine to continue the lock-in.
CA	Two years, according to 22CCR 50793
GA	2 years
IA	24 months or longer
ID	24 months
IN	2 years and then re-evaluation for graduation or re-enrollment
KS	2 years
KY	Initially for 24 months with annual review of member history/claims thereafter.
LA	24 months
MD	24 months
ME	Varies on severity and also dependent of review and potential test/chart review
MN	24 months.
MO	Participant is locked in for a period of 24 months of eligibility
ND	Until a subsequent review shows that they are properly utilizing services and their lock-in doctor agrees they should be removed from the lock-in program
NE	Reviewed every 2 months
NJ	Time period is decided on a case by case basis.
NM	Continuous
NV	Indefinite
NY	Two years for the first offense. Thereafter, for a continuation (due to continued abuse or overuse while restriction/lock-in still in place) or re-restriction/lock-in, the second term would be three years, and the third time or more would be six years.
OH	18 Months
OK	24 months for new lock-in referrals, then reviewed yearly
OR	18 months
PA	5 years as approved by CMS in 1985 audit of PA's Lock-In Program
TN	Enrollees stay on Lock-In until they are re-reviewed and their TennCare prescription claims and State PMP claims show that they have met the criteria to be unlocked. 50 enrollees are re-reviewed monthly, and a full review is made every January for those whose paid TennCare claims appear to show that the enrollee has qualified for unlock. This guarantees that the enrollee has an opportunity to be unlocked at least once yearly. Any enrollee who has been convicted of Doctor Shopping or TennCare fraud is not ever eligible to be unlocked, and remains in the Lock-In program as long as they are eligible for TennCare benefits.
TX	First lock-in is 36 months; second duration is 60 months; third lock-in is lifetime. If convicted of a felony, first lock -in could be a lifetime.
VA	36 months for the initial and continued lock-in period. Regulations are being promulgated to change the initial lock-in period to 24 months and the continued lock-in period to 12 months.
VT	2 years
WA	No less than 24 months.
WI	2 Years

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

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

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

Answer	State	Number of States (Percentage)
Deny claims written by this prescriber	CA, GA, IN, KY, ME, MI, MO, NJ, TN, VT	10 (26%)
Refer to Program Integrity Unit	AL, AR, CA, CO, DC, DE, FL, GA, HI, IA, IL, IN, KS, KY, MA, MD, ME, MI, MO, MS, NC, ND, NJ, OH, OK, PA, RI, SC, SD, TN, UT, VA, VT, WA, WY	35 (92%)
Refer to the appropriate Medical Board	AL, AR, CO, DC, DE, GA, IA, IL, IN, KS, KY, MD, ME, MI, MO, MS, NC, ND, NJ, NM, OK, PA, SD, TN, TX, VT, WA, WY	28 (74%)
Other - please explain:	AL, CA, GA, IL, KS, MD, MI, MO, MS, NC, NY, PA, TN, TX, UT, VT, WA	17 (45%)

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

State	Explanation
AL	Refer to MFCU if necessary
CA	Propose new policy such as quantity restrictions, and further review by A&I (IB) and 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, and CDSIU (Controlled Dangerous Substance Integration Unit)
MI	Prescribers may be suspended or sanctioned which results in prescriptions written by the prescriber to deny at point-of-sale
MO	DUR board review of provider/patient cases.
MS	Refer to DEA
NC	AN AUDIT OF PARTICULAR CLAIMS WOULD BE PERFORMED
NY	Professional RetroDUR case reviewers refer potential prescriber fraud cases to the DUR program, from which they are forwarded to the Office of the Medicaid Inspector General (OMIG) for further review and/or possible investigation.
PA	MFCS
TN	As noted in our attachment for Innovative Practices, DUR Board has authority to block prescriptions from outlier non-participating providers.
TX	Refer to Attorney General
UT	Refer to Medicaid Fraud Control Unit
VT	Refer to MFCU
WA	When the agency has identified a prescriber as having committed fraud or abuse, they will be terminated as a Medicaid provider and referred to Medicaid Fraud Control Unit.

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

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

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

Answer	State	Number of States (Percentage)
Deny claim	GA, IN, KY, LA, ME, MI, MO, NJ, PA, TN	10 (29%)
Refer to Program Integrity Unit	AR, CA, CO, DC, DE, FL, GA, HI, IA, IL, IN, KS, KY, MA, ME, MI, MO, MS, NC, ND, NJ, NY, OK, PA, RI, SC, SD, TN, UT, VA, VT, WA	32 (94%)
Refer to Board of Pharmacy	AR, CO, DC, GA, IA, IL, IN, KS, KY, ME, MI, MO, MS, NC, ND, NJ, OK, PA, SD, TN, TX, VT, WA	23 (68%)
Other - please explain:	CA, DE, GA, IL, IN, KS, KY, MI, MO, MS, NC, NY, TN, TX, UT, VT, WA	17 (50%)

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

State	Explanation
CA	Propose new policy such as quantity restrictions, and further review by A&I (IB) and Medical Review Branch (MRB).
DE	Monthly reports print that show usage of key demographics and drug categories for each pharmacy comparative to other pharmacies in their area and the state overall.
GA	Referral to Office of Inspector General
IL	Report to the Illinois Department of Financial and Professional Regulation, which issues professional licenses.
IN	Audit recoupment, Prepayment review program
KS	Referrals are sometimes made to the Attorney General's office.
KY	Desk Audits
MI	Pharmacies may be suspended or sanctioned which results in prescription claims submitted by the pharmacy to deny at point-of-sale
MO	DUR board review of provider/patient cases.
MS	Medicaid Fraud Control Unit
NC	AN AUDIT OF PARTICULAR CLAIMS
NY	Professional RetroDUR case reviewers refer potential prescriber fraud cases to the DUR program, from which they are forwarded to the Office of the Medicaid Inspector General (OMIG) for further review and/or possible investigation.
TN	We would also terminate pharmacy's provider agreement if fraud is found. We did not take this action against any pharmacy provider in FFY13
TX	Refer to the Texas Office of Inspector General
UT	Refer to Medicaid Fraud Control Unit
VT	Refer to MFCU
WA	When the agency has identified a pharmacy as having committed fraud or abuse, they will be terminated as a Medicaid provider and referred to Medicaid Fraud Control Unit.

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, CT, DC, DE, FL, GA, HI, IA ID, IL, IN, KS, KY, LA, MA, 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	47 (94%)
No	CO, MD, MO	3 (6%)

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

Answer	State	Number of States (Percentage)
Yes	CA, DE, ID, IL, IN, KS, KY, LA, MA, ME, MI, MN, MS, MT, NC, ND, NM, NV, OH, OK, SC, SD, TN, VT, WA, WV, WY	27 (58%)
No	AK, AL, AR, CT, DC, FL, GA, HI, IA, NE, NH, NJ, NY, OR, PA, RI, TX, UT, VA, WI	20 (43%)

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

Answer	State	Number of States (Percentage)
Yes	CA, DE, KY, NY, TX, VT, WV	7 (15%)
No	AK, AL, AR, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, LA, MA, ME, MI, MN, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, UT, VA, WA, WI, WY	40 (85%)

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

State	Explanation
AK	agency does not have access
AL	Not applicable
AR	Medicaid Pharmacy Program is not allowed to access the PDMP program.
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.
CT	The Prescription Drug Monitoring Program (PMP) allows CT Drug Control to obtain detailed information on prescription activity and is a valuable tool in helping identify potential savings to the State due to fraud and abuse.
DC	The PDMP has been legislated and is anticipated to be implemented during FY15. Particulars of agreements with bordering states have not been finalized.
DE	For all controlled medications that require prior authorization or quantity limit overrides, a prescriber must verify that they have checked the PDMP
FL	Prescribers and dispensing pharmacists are encouraged to check PDMP. Pharmacies are required to upload dispensing records
GA	The state does not have access to this database.
HI	Providers have access to the system to check their patient's profile.
IA	The state is unable to access this data. The PMP is only available to authorized health care practitioners (prescribers and pharmacists) to review their patients' use of controlled substances.
ID	PDMP is accessed in cases where it is brought to the attention of the clinical staff at IDHW that fraud and/or abuse is occurring. The PDMP is also accessed in specific RetroDUR activities.
IL	In adjudicating claims, staff checks PDMP to help with pertinent approvals or denials. Helps identify potential patients for narc edit. Require for suboxone requests to ensure not using "prohibited" substances.
IN	INSPECT Program
KS	This information is used to evaluate patients for lock-in
KY	Prescribers must attest to the fact that the PDMP has been consulted before prior authorizations for certain drugs are approved. The Office of Inspector General has 7 pharmacy consultants who are licensed pharmacists as well as certified peace officers who conduct investigations related to patients shopping prescribers for controlled substances as well as investigations of prescribers who may be prescribing illegally. PI also has a staff to handle pharmacy fraud and abuse cases.
LA	The additional data accessed through PDMP assists the DHH pharmacy staff in determining fraud and abuse.
MA	Database accessible to prescribers on a per patient basis.
ME	it is suggested to review the PDMP but not a requirement

MI	We are in the process of promulgating policy to require PDMP utilization review prior to prescribing controlled substances for our program beneficiaries
MN	SURS unit has limited access in the case of a recipient under investigation for fraud and abuse.
MS	Used to evaluate potential abuse for PA process related to Suboxone and other therapies
MT	Answer to question above if no.
NC	For treatment of opioid dependence, prescribers are required to access the PDMP patient history before a PA will be granted.
ND	The answer to #72 was no.
NE	Medicaid does not have access to this information.
NH	Agency does not have access to the PMP program.
NJ	Before issuing a prescription or dispensing a prescribed drug, qualified prescribers and pharmacists who have registered to use the NJPMP are able to access the NJPMP website and request the CDS and HGH prescription history of the patient. When prescribers or pharmacists identify a patient as potentially having an issue of concern regarding drug use, they are encouraged to help the patient locate assistance and take any other action the prescriber or pharmacist deems appropriate.
NM	Ad hoc reports are available to query database for controlled substances when fraud and abuse occurs.
NV	Used for Lock-in and monitoring reported cases from the community.
NY	In NYS, all prescribers writing a prescription for a Schedule II-IV controlled substance have a mandatory duty to consult the Prescription Monitoring Program Registry, with limited exceptions. The mandatory duty to consult the PDMP provision affords practitioners with current, patient-specific controlled substance prescription information intended to inform the practitioner of controlled substance utilization by their patient at the point of prescribing.
OH	n/a
OK	n/a
OR	We do not apply this information to control fraud and abuse.
PA	The answer to the question was "no".
RI	Function of Department of Health
SC	Currently State does not use PDMP for this purpose (due to no requirement of prescribers/auth party to verify database, lag in information) these issues are being addressed by the PDMP program provider
SD	N/A
TN	The agency is full managed care, so the provider agreement is in place between the MCO and the provider, not the agency and provider, so there is no way to answer this question other than "NA".
TX	This is managed by Texas Department of Public Safety.
UT	Utah Medicaid is limited by State Statute in how it may access and use data from the PDMP.
VA	VA uses the PDMP to promote the appropriate use of controlled substances for legitimate medical purposes, while deterring the misuse, abuse, and diversion of controlled substances.
VT	"Vermont providers are required to register for the VPMS and are mandated to use it in the following circumstances: 1.
WA	PDMP is queried by clinical reviewers when making authorization determinations for some drugs, to validate compliance and lack of abuse. During the reporting period, PDMP data was used to assist in identification of clients for lock in.
WI	N/A
WV	We require prescribers to access the PDMP before prescribing buprenorphine/naloxone or buprenorphine for substance abuse treatment.
WY	This is available on a very limited basis to the Lock-in manager only for clinical review purposes. It is used to determine the need to lock in patients and monitor continuing therapy after lock-in.

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

Answer	State	Number of States (Percentage)
Yes	CA, DC, ID, IL, IN, KS, KY, MI, ND	9 (19%)
No	AK, AL, AR, CT, DE, FL, GA, HI, IA, LA, MA, ME, MN, MS, MT, NC, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	38 (81%)

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 to curb abuse?

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

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

State	Explanation
AK	Barriers include lag time in prescription data being submitted which contributes to prescribers and pharmacy providers not having timely access to necessary information, low utilization by prescribers, inability of agency to query, thus unable to identify recipients paying cash for controlled substances.
AL	PDMP State Law prohibited Medicaid access. Prescriber/Pharmacy not accessing prior to filling/dispensing prescriptions.
AR	The AR Medicaid Pharmacy Program does not have access to the Prescription Monitoring Program (PMP) and cannot use the program for monitoring suspected fraud and abuse cases in the Medicaid Pharmacy Program. Any suspected beneficiary fraud and abuse cases will be handled in the same manner as in the past, which is to turn over any suspected cases to the Medicaid Fraud Investigation unit who has access to the PMP.
CA	Enrollment by California€™s prescribers and pharmacists has experienced some delays due to restructuring of the CURES program under the Department of Justice and state budgetary restrictions. Funds have been secured for personnel and upgrades to the system, but these funds will not be released until the 2015-2016 state fiscal year.
CO	We are prohibited by state legislation from accessing the PDMP data. Patient privacy issues were cited as the reason for not granting us access.
CT	There is a lag time up to a month with the data being submitted by pharmacies and when it is posted. Another barrier is blocked access to the PDMP system for DSS pharmacy operations unit employees and both DUR and MMIS contractors. Program Integrity can only view if they have an active case open on that beneficiary.
DC	Implementation of the District's PDMP is scheduled for FY15. It is not possible to report on barriers to access at this time.
FL	Legislatively prohibited from accessing PDMP unless doing actual prescribing or dispensing; not allowed to access for investigative purposes otherwise
GA	No funding, legal concerns about who can access the data.
HI	Only providers with provider numbers have access.
IA	Currently, only authorized health care practitioners (prescribers and pharmacists) are able to access the PMP information regarding their patients' use of controlled substances.
ID	Lag time in prescription data being submitted. Prescribers not accessing. Washington and Oregon - our major border states do not use.
IL	Need to view one patient at a time and re-enter data if checking neighboring state. Not all pharmacies submit data in a timely manner as evidenced by claims filled, but not visible in PDMP. Not all prescribers access prior to writing prescription.
IN	Lag time in prescription data being submitted, prescribers not accessing, pharmacists not accessing before filling script .
KS	Medicaid only has Administrative Access, which means the administrator of our PDMP has to release reports to us (as opposed to having full, real-time access).
MA	No aggregate queries No access to border states' data
MI	There is some lag time in prescription data being submitted, prescribers are not required by State law or Medicaid policy (yet) to access and review prior to writing a prescription. Our program is continuing discussions for more querying privileges of the PDMP database to more proactively identify potential fraud, waste, abuse of controlled substance medications.
MN	At DHS, SURS can access only for unique recipients under investigation. PDMP cannot be accessed for purpose of DUR. Pharmacy policy & Health Plan staff can't access.
NC	Many pharmacies restricted internet access, payer source not identified, lag time in data submitted
NE	Medicaid does not have legal authority to access information. Data is incomplete, as patients may opt out. Pharmacies are not mandatorily reporting data.
NH	Legislation did not allow agency access.
NJ	Access to PDMP is controlled by each individual State and for what purpose. Currently, NJ PMP grants access to prescribers and pharmacists who are licensed by the State of New Jersey and in good standing with their respective

	licensing boards. Licensed pharmacy staff conducting DUR are considered unauthorized users since they are not directly delivering healthcare.
NM	Access is granted to appropriate authorities.
NV	Limited access by some health care professionals.
OK	The agency has very limited access to the PMP. Access cannot be granted to contractors who perform lock-in functions. The agency may only query one member data at a time. There is no way to access aggregated prescriber data.
OR	Payers do not have access to PDMP for our State.
PA	The current PDMP is housed in the Attorney General's office to be used by law enforcement only. Dispensing and prescribing providers do not have access to the PDMP.
RI	State law requires the user of the PDMP must have a DEA number.
SC	Prescribers not accessing the database, prescriptions paid by cash, lag in data submission (all three are currently being addressed)
TN	Cannot access the raw data, and cannot efficiently pull data for multiple patients to query against TennCare paid claims and medical data.
TX	DPS does not allow access to the agency.
UT	Utah Medicaid is limited by State Statute in how it can use data from the PDMP. Utah Medicaid can access the Utah Controlled Substance Database but pharmacy managed care providers cannot. Legislation has been proposed. Lag time also limits its usefulness.
VA	Agency does not have access to PDMP.
VT	"1. Currently, the VPMS has legislation enacted to enter into a reciprocal agreement with boarder states. The VPMS is waiting for the vendor to provide an enhancement that will allow a provider to see what other substances their bonafide patient is obtaining in other states. 2.
WI	Managed by a different agency
WY	The legislation creating the PDMP in Wyoming does not allow for use by payers for general purposes.

VIII C. Pain Management Controls

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

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

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

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

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

Answer	State	Number of States (Percentage)
Yes	AL, IA, MA, MO, ND, NH, SC, WA, WV	9 (75%)
No	ID, IN, MI	3 (25%)

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

State	Explanation
AL	Claims are denied for controlled drugs by provider not on DEA file.
IA	Claims are blocked at the point of sale for prescribers not authorized to prescribe controlled drugs.
MA	DEA Active Controlled Substance Registrant's File is entered into Pharmacy On Line Processing System
MO	If a provider's DEA is inactive or restricted claims for controlled substances will be denied POS.
ND	If no active DEA #, claims for controlled substances are denied.
NH	The HCIDEA file links the prescriber NPI to the DEA file to prevent unauthorized prescribing.
SC	Controlled substances are checked for valid DEA license
WA	At this time it is applied specifically to only Schedule II drugs. Any claim for a schedule II written by a prescriber not associable with a DEA number is rejected, with no opportunity for authorization.
WV	We create a table of prescriber NPI numbers of unauthorized prescribers from the DEA file and claims bump against this table when they process. If the NPI is contained in the table, the claims will not pay.

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

Answer	State	Number of States (Percentage)
Yes	MI	1 (33%)
No	ID, IN	2 (67%)

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

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

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

State	Explanation
MI	Our RetroDUR vendor's system loads the DEA file and creates monitoring reports
SC	DEA file can be accessed/incorporated in reporting The vendors system loads the DEA file.
WA	The agency is in a transitional period in its data set. DEA is used to bridge the gap between claims that were submitted with DEA as a prescriber identifier and claims submitted with NPI. Linking through DEA allows claims for prescriptions written by the same prescriber to be associated.

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

Answer	State	Number of States (Percentage)
pharmacist override	KY, MO, NV, OH, PA	5 (10%)
deny claim and require PA	AK, DC, DE, IN, KS, MO, NC, NJ, NM, OR, TN, VA, VT, WV	14 (29%)
quantity limits	AK, AL, CA, DC, DE, FL, GA, ID, KS, LA, MA, ME, MI, MN, MO, MS, MT, NC, ND, NE, NY, OH, OK, OR, PA, SD, TN, TX, UT, VT	30 (61%)
intervention letters	AR, CO, CT, IA, IL, MD, MI, NH, RI, SC, TN, WA, WI, WY	14 (29%)

VIII D. OPIOIDS

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

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

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

Answer	State	Number of States (Percentage)
30 day supply	AK, AL, DC, IA, ID, KY, MS, NC, NE, NV, OK, SD, VA, VT, WI	15 (36%)
90 day supply	NY	1 (2%)
other, please explain	AR, CA, CO, DE, FL, GA, IL, KS, LA, MA, MD, ME, MI, MN, MO, ND, NJ, OH, OR, PA, SC, TN, TX, UT, WA, WV	26 (62%)

Other, please explain:

State	Explanation
AR	All short-acting pain meds have a maximum daily quantity edit and a monthly cumulative quantity edit. Most short-acting pain meds have a daily max quantity of 6 per day, a few may be limited to 4 per day or 8 per day. However, the maximum monthly quantity edit for each drug does not exceed 124 units, and there is also an accumulation quantity edit that applies the 124 units across the whole short-acting drug category so that no matter the combination of drugs filled during the month, the accumulated quantity cannot exceed 124 units in a rolling 31-day supply. In addition, there are therapeutic duplication edits that prevent claims of short-acting opioids with overlapping days' supply from being filled. The short-acting pain meds also have an edit that will reject any pain medication at point-of-sale if the beneficiary has filled a Suboxone or Subutex claim in the previous 60 days.
CA	Short-acting opioids have an established maximum quantity per dispensing and a maximum of three (3) dispensing within any 75-day period.
CO	Beginning 8/1/2014, we set limits of 120 units per 30 days with an exception for sickle cell, terminal illness and certain acute pain scenarios. Our plan is to tighten this limit in the future.
DE	Delaware allows 120 units per 30 days, and then 720 units per year. This format allows for more doses in an acute situation could last a month or more.
FL	Total of 4 controlled substance prescriptions per month; dx of sickle cell disease or cancer allowed 6 per month

GA	30 day supply and 5 opioid fills per 30 days
IL	- 30 day supply -Only 1 short and 1 long-acting opioid allowed at a time - Patients flagged via the Four Prescription Policy with first request receive short-term approval if appropriate. If have used opioids 3 or more months, must fill out pain management
KS	Driven by drug-specific individual quantity limits.
LA	120 units per rolling 30 days for most short-acting opioids.
MA	Dose limits, Polypharmacy edits, Quantity Limits
MD	Some opioids are limited by number of dosage units per day and are included in listing of all quantity limits at this link https://mmcp.dhmh.maryland.gov/pap/docs/QL.pdf
ME	57 day limits
MI	34 days' supply with specific quantity limits for individual drugs based on clinical information
MN	Quantity limits on most but not all drugs.
MO	Quantity limits are based on the FDA approved maximum for each product
ND	Limit qty / day on all of them and that qty varies by drug and strength
NJ	Initial prescriptions are limited to a 34 day supply.
OH	34 days' supply and dose per day limits
OR	120 morphine equivalents per day
PA	The quantity is based on dose/day limits. Additionally, recipients are limited to 4 short-acting and/or long-acting opioid prescriptions per month.
SC	Maximum 31 day supply
TN	1200mg per month limit on hydrocodone and oxycodone products without PA, and 300mg per month limit on hydromorphone IR products without PA.
TX	depending on the scheduling assigned to the drug for the CII we don't allow for more than 30 days. For other schedules we allow longer days' supply. Also, there is a limit on the number of providers from whom a client may receive prescriptions.
UT	30 day supply, less-than-or-equal-to 180 tablets
WA	Maximum of 30 day supply. Daily dose and shorter days' supply depending on drug and labeling.
WV	120 units per 30 days

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

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

Answer	State	Number of States (Percentage)
30 day supply	AK, AL, DC, HI, IA, ID, KY, MS, MT, NC, NV, OK, SD, VA, WV	15 (37%)
other, please explain	AR, CA, DE, FL, GA, IL, IN, KS, LA, MA, MD, ME, MI, MN, MO, ND, NY, OH, OR, PA, SC, TN, TX, UT, VT, WA	26 (63%)

Other, please explain:

State	Explanation
AR	Long-acting opioids have a dose-optimization quantity edits on each strength based on the FDA approved indication and daily dose (e.g., twice daily, once daily, etc.). Maximum daily dose edits, maximum cumulative quantity edits, and dose-optimization edits were implemented for all strengths of each chemical entity except for the single highest strength of long-acting opioid agents to prevent large quantities of smaller strengths from being dispensed. The single highest strength of a long-acting opioid agent does not have a quantity limit in order for those patients who may require higher doses to be able to receive the dose they require (e.g., malignant cancer patients). For example, for morphine SR that is indicated for TID dosing, the maximum daily quantity for any strength is 3 tablets per day or 93 tablets per 31 days, except for the single highest strength which is unlimited. In addition, there

	are therapeutic duplication (TD) edits that only allow one long-acting agent dispensed at a time; the TD edit prevents claims with overlapping days' supply from being filled and rejects the incoming claim at point-of-sale.
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 require prior authorization. Total dose of all the narcotic therapy must be below 120 morphine equivalents.
FL	Total of 4 controlled substance prescriptions per month; dx of sickle cell disease or cancer allowed 6 per month
GA	30 day supply and 5 opioid fills per 30 days
IL	- 30 day supply -Only 1 short and 1 long-acting opioid allowed at a time - Patients flagged via the Four Prescription Policy with first request receive short-term approval if appropriate. If have used opioids 3 or more months, must fill out pain management
IN	Quantity limits placed on certain long-acting opioid products for a maximum quantity of each agent per month.
KS	Driven by drug-specific individual quantity limits.
LA	60 units per 30 rolling days for most long-acting opioids.
MA	Dose limits, Polypharmacy edits, Quantity Limits
MD	Some opioids are limited by number of dosage units per day and are included in listing of all quantity limits at this link https://mmcp.dhmh.maryland.gov/pap/docs/QL.pdf
ME	same limits for short acting
MI	34 days' supply with specific quantity limits on certain long acting narcotics such as fentanyl patches and extended release oxycodone
MN	Oxy-Contin is on PA. New formulations are always on PA until reviewed. Quantity limits on most but not all.
MO	Quantity limits are based on the FDA approved maximum for each product
ND	Limit qty / day on all of them and that qty varies by drug and strength
NY	Point of service edit for any long acting opioid prescription for opioid naive patients. Absence of evidence of recent opioid use in patient's claim history or medical history will require prescriber involvement. Exemption for diagnosis of cancer or sickle cell disease. Point of service edit for any additional long acting opioid prescription for patients currently on long acting opioid therapy. Override will require prescriber involvement. Exemption for diagnosis of cancer or sickle cell disease. Educational interventions at the individual prescriber level targeting potentially inappropriate opioid use based on: ï,§ Prescribing of LAOs in opioid-naive patients. ï,§ SAO utilization >4 units/day with concurrent LAO therapy. ï,§ Concurrent prescribing of more than one LAO (per patient). Consideration for future evaluation: SAO utilization in patients utilizing LAOs.
OH	34 days' supply and dose per day limits
OR	120 morphine equivalents per day
PA	The quantity is based on dose/day limits. Additionally, recipients are limited to 4 short-acting and/or long-acting opioid prescriptions per month.
SC	Two concomitant agents should not be approved & 31 day supply on specified long acting agents Qty limits greater than 136/mth. approved if pt. has a diagnosis of cancer, is on a long acting narcotic and prescription was written by an oncologist
TN	Fentanyl patches = 10 patches/30 days. Kadian = 130, 150, 200mg: 1/day; all other strengths: 2/day. Morphine sulfate = 15, 30, 60mg 3/day, 100mg 2/day, 200mg, 1/day. OpanaER = 2/day. Exalgo = 1 per day. Avinza = 1/day. Butrans = 4 patches/28 days. Methadone = 40mg/day. NucyntaER = 2/day. Most ER tramadol = 1/day.
TX	Depending on the scheduling assigned to the drug for the CII we don't allow for more than 30 days. For other schedules we allow longer days' supply.
UT	30 day supply, less-than-or-equal-to 90 tablets
VT	30 day supply and daily quantity limit
WA	Quantities are limited to 30 day supplies. A daily dose limit is applied, but only to verify sig is appropriate to the medication. Total daily dose limit is not applied.

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

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

DE	KS	MA	ME	MI	NC	OR	WA	WY
120	200	360	30	30	750	120	120	120

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

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

If the response is “Yes”, how is the information disseminated?

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

Other, please explain:

State	Explanation
AR	An Opioid Dosing Conversion Calculator is posted on the Medicaid website.
ID	Provided via targeted DUR intervention letters
MI	The information was sent as a quantity limit via soft POS edit message on 3/4/2014 and then hard denial on 5/1/2014. Oxycodone 20mg, oxycodone 30mg and meperidine 100mg require prior authorization for any quantity
OR	Prior Authorization Criteria provides a conversion table
TN	Information is listed extensively on our PA form for Long Acting Opioids
WA	Multiple. Website, provider notice, and when requesting information for prior authorization.

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

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

VIII F. BUPRENORPHINE

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

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

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

Answer	State	Number of States (Percentage)
12mg	DE, PA	2 (5%)
16mg	DC, GA, IL, ME, MT, NV, VA, VT	8 (21%)
other, please explain	AK, AL, AR, CO, IA, ID, KS, KY, LA, MA, MD, MI, MN, MO, MS, NC, ND, NE, NH, NJ, NY, OH, OK, OR, TN, UT, WA, WV, WY	29 (74%)

Other, please explain:

State	Explanation
AK	24mg
AL	All buprenorphine, brand and generic, require prior authorization. Dosage above 32 mg/day are not approved.
AR	dose optimization is used for all strengths to limit to 3 tablets or film per day, with the highest 8 mg units set at 24 mg per day.
CO	24mg/day
IA	24mg/day for maximum of 3 months
ID	24mg, based on Product Package Insert.
KS	24 mg
KY	24 mg
LA	24 mg/day
MA	32mg per day
MD	32mg
MI	24mg/day
MN	32mg per day.
MO	Limit first 180 days=32mg/day, limit after 180 day=16mg/day
MS	Step-down therapy: up to 24mg 1 month, up to 16mg 4 months, up to 8mg months 6-24
NC	24
ND	24 mg
NE	24 mg
NH	24mg
NJ	24 mg for opiate dependence
NY	Maximum daily dosage on 8 mg. units is 24 mg.
OH	24 mg per day
OK	24mg
OR	24mg
TN	16mg/day for the 1st 6 months of treatment, then 8mg/day thereafter.
UT	Suboxone: 24mg per day Zubsolv: 17.1mg per day
WA	24mg/day
WV	24 mg per day for a sixty day induction period once in a lifetime
WY	24 mg per day

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

Answer	State	Number of States (Percentage)
6 months	FL, GA	2 (4%)
12 months	IL, MI	2 (4%)
no limit	AK, AL, CO, CT, DC, HI, IA, ID, KS, KY, MA, MD, MN, MO, NC, ND, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, VT, WI, WV	33 (66%)
other, please explain	AR, CA, DE, IN, LA, ME, MS, MT, NE, UT, VA, WA, WY	13 (26%)

Other, please explain:

State	Explanation
AR	Buprenorphine used for opioid addiction limit is 24 months
CA	During FFY 2013, buprenorphine was dispensed only with an approved Treatment Authorization Request.
DE	no current limit, but have urged providers at 2 years to consider titration off.
IN	Prior authorizations are granted for a 34-day initial supply, and then every 6 months thereafter if all criteria is met.
LA	3 months
ME	2 years
MS	cumulative maximum of 24 months with 1 restart
MT	Two years.
NE	Initial request is for 6 months, 6 month renewal if needed.
UT	36 months (18 mo. initial authorization, one 18 mo. reauthorization)
VA	Approved for 3 months
WA	Treatment limited to 6 months, with opportunity to extend 6 months if patient is doing well in treatment, for total treatment duration of one year.
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, WV	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, WY	39 (78%)

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

Answer	State	Number of States (Percentage)
8mg	MS, TN	2 (18%)
12mg	DE	1 (9%)
other, please explain	IA, LA, ME, MI, MO, MT, UT, WV	8 (73%)

Other, please explain:

State	Explanation
IA	16mg or less
LA	16 mg/day
ME	we look for reductions over time at any type of dose reduction
MI	Tapering required based on individualized plain of care
MO	Limit first 180 days=32mg/day, limit after 180 day=16mg/day
MT	Upon starting a member may use up to 24 mg/day but must reduce to 16 mg/day by 6 months of treatment.
UT	No set dose. A taper must have at least been attempted to receive reauthorizations
WV	16 mg per day

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

Answer	State	Number of States (Percentage)
6 months	GA	1 (2%)
12 months	IL, MI	2 (4%)
no limit	AK, AL, CO, CT, DC, FL, HI, IA, ID, KS, KY, LA, MA, MD, MN, MO, NC, ND, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TX, VT, WI, WV	34 (68%)
other, please explain	AR, CA, DE, IN, ME, MS, MT, NE, TN, UT, VA, WA, WY	13 (26%)

Other, please explain:

State	Explanation
AR	Duplicate question. See question #102 above. Buprenorphine used for opioid addiction limit is 24 months
CA	During FFY 2013, buprenorphine was dispensed only with an approved Treatment Authorization Request.
DE	no current limit, but have urged providers at 2 years to consider titration
IN	Prior authorizations are granted for a 34-day initial supply, and then every 6 months thereafter if all criteria is met.
ME	indicated above
MS	cumulative maximum of 24 months with 1 restart
MT	2 years
NE	Review request of medical necessity for longer treatment.
TN	No limit for therapy. Only a 6-month limitation for the 16mg/day dose. Then 8mg/day is allowable at this time ongoing.
UT	This question has already been asked, see Qs 107 & 108. 36 months (18 mo. initial authorization, one 18 mo. reauthorization
VA	3-month authorizations may be repeated as needed.
WA	Please see 105
WY	2 years

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

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

VIII G. PSYCHOTROPIC DRUGS/STIMULANTS

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

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

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

Answer	State	Number of States (Percentage)
only children in foster care	SD	1 (2%)
all children	AK, AL, AR, CA, CO, CT, DE, FL, GA, ID, IL, IN, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NJ, NV, NY, OK, OR, PA, RI, SC, UT, VA, VT, WA, WY	37 (90%)
other, please explain	TX, WI, WV	3 (7%)

Other, please explain:

State	Explanation
TX	Children and adults
WI	6 years of age and younger for antipsychotics
WV	All atypical antipsychotics for children under six years of age require a prior authorization

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

State	Explanation
AK	Atypical antipsychotics for children less than 5 years old require PA. Therapeutic duplication edit also in place.
AL	Prior authorization is required for all antipsychotics (generic; atypicals and typicals). Prescriptions written by psychiatrist and prescriptions for FDA-approved diagnoses are processed through electronic PA at the point-of-sale. Medical justification is required for antipsychotic polytherapy. Metabolic monitoring is required for children (less than 6 years of age) using antipsychotics and monitoring must be indicated on the PA request form.
AR	The monitoring program is quite extensive and this small space is not adequate to describe. The highlights are: The initial PA request for an antipsychotic agent requires a copy of the signed informed consent form and copy of the initial glucose and lipid lab work. PA renewals for same chemical entity require lab work every 6 months. Any change to a new chemical entity requires new signed informed consent and current lab work. Daily dose and monthly quantity edits are in place for each antipsychotic agent and every strength broken down for 4 age groups: less than 6 yrs.; 6 yrs. - 9 yrs.; 10 yrs-12 yrs., and 13 yrs. -17 yrs. A child psychiatrist with our program must review and approve all antipsychotic PA requests before the claim will pay for children less than 6 yrs. of age, all PA requests for therapeutic duplications for any age child (i.e., receiving more than 1 antipsychotic agent with overlapping days' supply), and all long-acting injectable antipsychotic agents for any age child. This child psychiatrist may elect to call a prescriber and discuss a case, may require chart notes to substantiate the request, may give only a short-term PA and require additional follow-up chart information before another PA is given, etc. All drug profiles of children receiving 5 or more psychotropic agents are reviewed by our senior psychiatrist who in turn contacts the prescriber(s). Some cases are turned over to the System of Care program in the Division of Behavioral Health for closer follow-up when it is necessary to gather data from family members as well as the prescriber(s).
CA	The use of antipsychotics for Medi-Cal beneficiaries under 6 years of age requires treatment authorization approval and the use of antipsychotics for Medi-Cal beneficiaries aged 6 through 17 is restricted to use of one antipsychotic, except during titration period. Within this age group, concurrent use of two or more antipsychotics requires treatment authorization approval. In addition, DHCS Pharmacy Benefits Division, DHCS Behavioral Health

	Division, and California Department of Social Services (CDSS) jointly initiated a Quality Improvement Project entitled, Improve Psychotropic Medication Use for Children and Youth in Foster Care. The purpose of this program is to reduce the rate of antipsychotic polypharmacy, improve the rate of compliance with age-specific antipsychotic dose recommended guidelines, and improve the rate of children and youth in foster care with at least one psychotropic medication who have an annual metabolic risk assessment. The goals are to reduce polypharmacy to 15%, achieve 80% rate for both, compliance with dosing guidelines and annual metabolic risk assessment. The €™s kick off meeting was on 10/29/12 and over 75 people attended, representing over 40 stakeholders groups. Work groups began January 2013, including the following three work groups: 1) data and technology work group, 2) clinical work group, and 3) youth and family education workgroup.
CO	Atypical antipsychotic (AAP) prescriptions are manually reviewed for all patient under 5 years old. This requires justification for use and explanation of monitoring that will take place. All AAPs are restricted to their FDA approved ages. We also look at the indications through our retrospective letter process.
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	The utilization of pediatric psychotropic is reviewed primarily at this time through RetroDUR. Lower age limits are set to FDA approved guidelines as well
FL	While recognizing that the individualized care of patients is ultimately the responsibility of the treating physician, by working collaboratively with Medicaid prescribers, it is the Medicaid Drug Therapy Management Program for Behavior Health's mission and commitment - with a particular emphasis on children - to improve the overall quality and efficiency of the prescribing of mental health drugs and the health outcomes of those Medicaid beneficiaries with a mental illness Components of the program include: Development of adults and children/adolescents psychotherapeutic guidelines Identification of complex care indicators Analysis of claims for mental health medications Interventions with clinicians Ongoing surveillance, follow-up and re-measurement Project designed to promote integration of medical and mental healthcare Implementation of a state-wide Child Psychiatry Access Call Line Development of a registry to track the use of antipsychotics in children Project to promote the appropriate use of clozapine Implementation of a clinical trial designed to assess the risks and benefits of switching patients with schizophrenia from two to one antipsychotic medication
GA	Use of atypical antipsychotics outside of FDA approved age and indications requires prior authorization.
ID	Red Flag Program
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; adults or children prescribed long-acting atypical antipsychotics; and all long-term care residents prescribed antipsychotic medications.
IN	Antipsychotics require prior authorization when used in duplication, low doses, or when a drug specific quantity limit has been exceeded.
KY	A diagnosis driven prior authorization is required for all second-generation antipsychotics. These products are also limited to a per daily maximum dose. These edits apply to both children and adults.
LA	Psychotropic drugs are reviewed in the retrospective DUR program for concurrent use, maximum doses, and non-adherence. Prospective edits address duplication of therapy, quantity limits, and age limits.
MA	Polypharmacy edits for all members, Quantity Limits
MD	In October 2011, MMPP established The Peer Review Program for Mental Health Drugs. This peer-review authorization process informs clinicians of relevant pharmacologic and non-pharmacological clinical information for decision-making and ensures the appropriate use while limiting adverse sequelae in Medicaid€™s vulnerable pediatric patients. The program initially addressed the use of antipsychotics in Medicaid patients under five years of age. During FFY 2013, all children under age 10 required prior authorization. As of January 2014, the program expanded to include all children and adolescents less than 18 years of age.
ME	we have Pa requirements on age, length of therapy as well as metabolic monitoring
MI	We utilize a program called EnhanceMed which is operationalized through our Magellan Medicaid Admin contract. It is a monthly academic detailing mailing and face-to-face pharmacy consultant intervention with the most exceptional providers for particular educational topics.
MN	Requirement of a psychiatric consultation for high dose second generation antipsychotics per age for recipients under 18 yrs.
MO	There are several Clinical Edits in place to manage the appropriate utilization of psychotropic medications in children which include an ADHD Therapy Clinical Edit, Atypical Antipsychotic Clinical Edit, SSRI Clinical Edit, SNRI Clinical Edit and a Psychotropic Medication Polypharmacy Clinical Edit. 1.) The ADHD Clinical Edit automatically sends all requests for any FDA approved stimulant/non-stimulant ADHD medication prescribed for any child under the age of 6 years to a Clinical Consultant review and requires documentation to be submitted to perform that review. Documentation required includes a confirmed diagnosis of ADHD using a standardized rating scale such as a Conners' or Vanderbilt and requires yearly (at minimum) evaluation. Children ages 6-18 years require an appropriate diagnosis of ADHD and to be dosed within established dosing parameters. Any requests outside of established dosing parameters require a Clinical Consultant review. 2.) The Atypical Antipsychotic, SSRI and SNRI Edits automatically send all requests for any FDA approved Atypical Antipsychotic, SSRI or SNRI

	medication prescribed for any child under the age of 5 years old to a Clinical Consultant review. Children under the age of 18 require appropriate diagnosis, doses that do not exceed maximum dosing, monotherapy and use of 2 atypical psychotics, SSRI's or SNRI's for no more than 30 days to allow for cross-tapering. 3.) The Psychotropic Medications Polypharmacy Clinical Edit looks to make sure that children under the age of 5 years old are on 3 or less different psychotropic medications simultaneously within a 60 day period and that children 5 years of age and older are on 5 or less different psychotropic medications simultaneously within a 60 day period.
MS	Manual PA requiring prescriber to document age waiver, appropriate diagnosis, and benefit outweighs risk.
MT	We provide pharmacy case management for children on psychotropic medications. This started as only foster children and has branched to management of all children.
NC	Due to well documented safety considerations and limited efficacy information on the use of antipsychotic agents in children, NC Medicaid developed a policy titled Off Label Antipsychotic Monitoring in Children through Age 17. NC Medicaid and Community Care of North Carolina (CCNC) have partnered with child psychiatry experts from our four NC medical schools to develop and implement a registry (Antipsychotics-Keeping It Documented for Safety or A+KIDS) for providers to document the use of antipsychotic therapy in the child and adolescent Medicaid population. This safety monitoring program is designed to make sure that children enrolled in NC Medicaid who are prescribed an antipsychotic medication for an "off label" indication are monitored according to generally accepted guidelines. Via participation in this registry, the use of best practice baseline and follow-up monitoring parameters are encouraged, to facilitate the safe and effective use of these agents in this population, while maintaining open access to all antipsychotic medications.
NE	There are minimum and maximum age limits, quantity limits, & child and adolescent psychiatrist review requests outside of label.
NJ	The Department of Children and Families has established a policy that outlines the Department's: Basic principles, Expectations regarding the development and monitoring of treatment plans,·Principles for informed consent; and Principles governing medication safety.
NV	All recipients under 18 require Prior Authorization for psych related drugs. Foster children are reported monthly for psych and diagnosis to state agency.
NY	DUR Board recommended drug-specific minimum age parameters utilized by the FFS program.(Automatic bypass for established therapy.) FFS diagnosis parameters* for second-generation antipsychotics in the pediatric population.*Diagnosis requirement for the initial prescription for patients between minimum age (as defined by the DURB for the FFS population) and 18 years of age.(Automatic bypass for established therapy.)
OK	Educational mailings to prescribers of psychotropic drugs in children, particularly when prescribers deviate from evidence based norms in this patient population.
OR	For foster children, each child is reviewed annually. For non-foster children, children meeting certain "red flags" generate a notice to the provider requesting certain clinical information. See ATT3-2013-OR-SDBA.docx for complete details.
PA	A prescription for either a preferred or non-preferred Antipsychotic regardless of quantity limit when prescribed for a child under 18 years of age requires prior authorization.
RI	HID specific criteria identifies the use of psychotropic drugs and stimulants in children. The criteria is monitored monthly during the clinical criteria review. If a reviewer identifies a recipient who may have inappropriate use, an educational letter is sent to the prescriber.
SC	Prior Authorization Criteria in place for Antipsychotics in children less than or =6 years of age including, but not limited to: Psych assessment w/diagnosis, target & tx plan; informed consent; family assessment; psychosocial tx w/o adequate response and psychosocial tx must continue for the duration of medication therapy; one agent at a time-exceptions to tapering while titrating.
SD	Child Protective Services runs the program
TX	Prospective (POS) clinical edit is in place for children and adults. For children the goal is to look at the age limit and appropriate indications. For adults we review inappropriate use and overutilization. Retrospective interventions are also performed.
UT	An appropriate diagnosis code must be on the face of the prescription.
VA	Service authorizations (SAs) are required for the use of atypical antipsychotics in children under the age of six (6) years. See ATT6-2013-VA-IPN for details.
VT	PA required for all antipsychotics. Antipsychotics limited to those with FDA approval for use in children. Certain stimulants require PA and/or quantity limits.
WA	A variety of review thresholds for several categories of drugs has been established, including stratified dose limits by patient age for AAPs and ADHD medications, therapeutic duplication stops, any use of sedative hypnotics, and polypharmacy of 5 or more drugs. When thresholds are exceeded the prescriber is required to have a consultation with our contracted Pediatric Mental Health experts. After consultation on the child's case, our contracted Pediatric Psychiatrists make recommendation to the agency as to what to approve or deny, a plan of care, and what is medically necessary for the patient.
WI	Requires Prior Authorization (PA). Child adolescent psychiatrists review and adjudicate PAs.
WV	A PA is required for atypical antipsychotics for children under six years of age. The initial approval is for six months and laboratory work for metabolic adverse effects and testing for tardive dyskinesia is required for subsequent approvals.
WY	Patients that exceed limits (too young, high dose, therapeutic duplication, greater than 5 psychotropics) are identified and referred to Seattle Children's Hospital (contractor) for second opinion review.

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

Answer	State	Number of States (Percentage)
Yes	DC, IA, KS, NH, OH	5 (56%)
No	HI, ND, NM, TN	4 (44%)

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

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

If the response is “Yes”, is your program limited to:

Answer	State	Number of States (Percentage)
children	MN, MT, SC, VA	4 (10%)
adults	AR, DC, DE, GA, IA, NJ, RI, TN	8 (20%)
both	AK, AL, CA, CO, CT, HI, ID, IL, IN, KY, LA, MA, ME, MI, MO, MS, NE, NM, NV, NY, OK, OR, PA, SD, UT, VT, WA, WI, WY	29 (71%)

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

State	Explanation
AK	Quantity limits
AL	Maximum quantity limits
AR	All requests for an adult for a C-II stimulant for a beneficiary who does not have a diagnosis of narcolepsy in Medicaid history requires a manual review PA request. Criteria is fashioned after the DSM-5 and requires the symptoms to be in more than one location (i.e., school, work, or home), and requires that prescribers must list the symptoms he/she is treating in the beneficiary. The DUR Board approved that the adults must have at least 5 symptoms in one type, either the inattentive type or the hyperactivity type. The prescriber must supply information regarding name of school, level, and how many hours per semester the beneficiary is taking, and/or name of employer if either of these are marked as "yes". In addition, there are specific maximum daily and monthly cumulative quantity limits and therapeutic duplication limits for all C-II stimulants that apply to all ages for all uses.
CA	The use of stimulants for Medi-Cal beneficiaries is restricted to use in Attention Deficit Disorder in individuals from 4 years through 16 years of age only. Any use outside of these restrictions requires treatment authorization approval.
CO	We review for children under 5 years. Maximum doses are applied to all stimulants. Some products require verification of an approved diagnosis. All of these would require a prior authorization.
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. Additionally, stimulant use is also reviewed during the monthly RetroDUR adult reviews.
DC	There is a POS prior authorization requirement for the entire antihyperkinesis therapeutic class to allow determination of appropriate diagnosis, age and dosing of these medications.
DE	Adults must fail 2 long-acting stimulants before they can go to a short-acting stimulant. Our covered long-acting

	drugs have an abuse deterrent mechanism on them. Adults can only receive one agent, not both a long and short-acting.
GA	Stimulants require prior authorization for adults.
HI	diagnosis code and age requirements
IA	Require PA for members 21 years of age and older. Documentation diagnosis of ADD/ADHD meets the DSM-IV criteria and is confirmed by a standardized rating scale. Symptoms must have been present before 12 years of age and there must be clear evidence of clinically significant impairment in two or more environments (social, academic, or occupational).
ID	Age and quantity limits. Adults must have documented diagnosis of ADHD. Adults with any substance abuse diagnosis cannot receive ever.
IL	All attention deficit hyperactivity medications (ADHD) in children less than 6 years of age require special prior authorization request form. Medications for ADHD are allowed for clients who are 6 to 18 years of age. Adults require prior authorization
IN	Stimulants require prior authorization when used in duplication or when a drug specific quantity limit has been exceeded.
KY	A diagnosis driven prior authorization is required for all stimulants. All stimulants are also limited to a daily maximum dose. Recipients are not allowed to take two long-acting or two short-acting stimulants concurrently.
LA	Stimulants are reviewed in the retrospective DUR program for stimulant-induced insomnia. Prospective edits include duplication of therapy with stimulants and with narcolepsy agents.
MA	Dose Limits, Quantity Limits, ADHD Prescriber Education on Website
ME	managing of daily dose requirements
MI	Prior authorization required for members over the age of 18 and under the age of 6
MN	Requirement of a psychiatric consultation for high dose drugs to treat ADHD of which stimulants would be included.
MO	The ADHD Clinical Edit automatically sends all requests for any FDA approved stimulant/non-stimulant ADHD medication prescribed for any child under the age of 6 years to a Clinical Consultant review and requires documentation to be submitted to perform that review. Documentation required includes a confirmed diagnosis of ADHD using a standardized rating scale such as a Conners' or Vanderbilt and requires yearly (at minimum) evaluation. Children ages 6-18 years require an appropriate diagnosis of ADHD and to be dosed within established dosing parameters. For ages 18-23 years requires Clinical Consultant review with an appropriate diagnosis of ADHD and documentation submitted that documents the goals of therapy from the provider. For adults 23 years of age and older requires a Clinical Consultant review with positive diagnosis including childhood onset, clear evidence of clinical symptoms in 2 or more environments which may require diagnostic verification using a standardized rating scale such as an ASRS or ADHD-RS, participants with psychiatric co-morbidities requires a Psychiatric Specialist consult and goals of therapy that is clearly defined by prescriber. Any requests outside of established dosing parameters require a Clinical Consultant review.
MS	Manual PA for appropriate diagnosis and appropriate age
MT	We monitor the use of stimulants in children to verify that long acting meds are not given more than 2 doses per day, except with Vyvanse where doses are limited to once daily.
NE	Non-preferred drugs require review for compliance, doses are monitored.
NJ	Prescriptions for stimulants deny and require a PA for adults older than 18 years of age.
NM	CNS Stimulants require Prior Authorization for ages 19 and older.
NV	All require prior authorization
NY	Quantity limits for patients less than 18 years of age to include: 1. Short-acting CNS stimulants, not to exceed 3 dosage units daily with a maximum of 90 days per strength (for titration). 2. Long-acting CNS stimulants, not to exceed 1 dosage unit daily with a maximum of 90 days. Quantity limits for patients 18 years of age and older to include: 1. Short-acting CNS stimulants, not to exceed 3
OK	Psychiatrist Consult for patient under age of 5, must fill out Prior Authorization for patient over the age of 21
OR	Doses exceeding quantity limits require prior authorization and prescribing by a specialist.
PA	A prescription for a preferred or a non-preferred Stimulant and Related Agent for a recipient under 4 years of age or for a recipient 18 years of age or older requires prior authorization
RI	Prior authorization program.
SC	Age specific indications for medications (based on FDA approved age indications; eg.Intuniv/Kapvay indicated for those greater than or = 6 yrs. of age)
SD	Quantity Limits
TN	Dose per day limit for adults age 21 and over is 60mg/day, with the exception of the 70mg Vyvanse dose. No amphetamines allowed concomitantly with buprenorphine addiction treatment.
UT	An appropriate diagnosis code must be on the face of the prescription. Off-label use for children, and any use for adults requires prior authorization.
VA	A clinical edit is used to restrict the use of stimulants to the FDA approved age for each product.
VT	Certain stimulants require PA and/or quantity limits.
WA	Stimulant for the treatment of ADHD have dose limits for children and adults. Stimulants not indicated for ADHD are on full prior authorization. In addition to dose limits, pharmacies must submit a code when filling for adults to indicate it has been prescribed for a legal diagnosis. Otherwise, the pharmacy must initiate prior authorization.
WI	Documented restrictions and special programs: -Diagnosis restrictions, allowable diagnoses are ADHD and

	narcolepsy -Prior authorization required for non-preferred stimulants on the Preferred Drug List -System edits for early refills that can only be overridden in certain circumstances by calling a specialized pharmacy call center - Children's mental health work group has focused on high dose stimulant use. Interventions have included several targeted mailings to prescribers as well as peer to peer outreach from consultant child psychiatrists
WY	A diagnosis of ADHD must be on file, or narcolepsy for approved medications. Dosing limits are in place. Patients under age 3 require prior authorization.

IX. INNOVATIVE PRACTICES

The 35 states listed below have initiated innovative practices during the past year. A description of their innovative practice can be found in Attachment 6 of the individual state report: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Medicaid-Drug-Programs-Data-and-Resources.html?filterBy=Drug%20Utilization%20Review%20(DUR)

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

X. E-PRESCRIBING

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

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

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

Answer	State	Number of States (Percentage)
Yes	AK, CA, IA, IL, MD, NC, ND, OK, SD, WA, WY	11 (52%)
No	CO, KS, KY, NE, NJ, OR, RI, TN, VA, WI	10 (48%)

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

Answer	State	Number of States (Percentage)
Yes	CT, DC, DE, FL, GA, ID, IN, LA, MA, MI, MO, MS, MT, NH, NM, NV, NY, OH, PA, SC, TX, UT, VT, WV	24 (83%)
No	AL, AR, HI, ME, MN	5 (17%)

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

Answer	State	Number of States (Percentage)
Yes	AL, CT, DE, FL, GA, IN, ME, MI, MN, MO, MS, MT, NH, NM, OH, PA, SC, UT, VT, WV	20 (69%)
No	AR, DC, HI, ID, LA, MA, NV, NY, TX	9 (31%)

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

Answer	State	Number of States (Percentage)
Yes	CT, DE, FL, MO, NH, SC, UT	7 (35%)
No	AL, GA, IN, ME, MI, MN, MS, MT, NM, OH, PA, VT, WV	13 (65%)

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

Answer	State	Number of States (Percentage)
Yes	AR, DC, ID, MA, NV, NY, TX	7 (78%)
No	HI, LA	2 (22%)

XI. MANAGED CARE ORGANIZATIONS (MCOs)

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

Answer	State	Number of States (Percentage)
Yes	CO, FL, IL, KS, KY, LA, MA, MN, MS, ND, NJ, NM, NV, NY, OH, OR, PA, RI, SC, TX, VA, WA, WV	23 (46%)
No	AK, AL, AR, CT, DE, GA, HI, IA, ID, IN, ME, MO, MT, NC, NE, NH, OK, SD, TN, VT, WI, WY	22 (44%)
Partial	CA, DC, MD, MI, UT	5 (10%)

If the response is "Partial", please specify:

State	Explanation
CA	Selected HIV/AIDS treatment drugs;
DC	HIV antiretrovirals
MD	Antiretroviral agents and mental health agents are carved out of the MCO pharmacy benefit.
MI	HIV, mental health and substance abuse, hemophilia, and select drug products for rare metabolic disease
UT	Substance abuse (e.g. Suboxone), antidepressants, anticonvulsants, anxiolytics, sedatives/hypnotics and stimulants.

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

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

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

State	Explanation
CA	Medi-Cal MCO's are required to provide a pharmacy benefit that is comparable to the Medi-Cal Fee-For-Service Pharmacy Program
DC	MCOs must provide coverage of most drug categories but there is not a shared PDL requirement. Each MCOs lock-in program's provisions must not conflict with the FFS lock-in program policies.
DE	Carve in will be initiated January 2015. MCOs must follow the state PDL, current prior authorizations, and quantity limitations.
HI	RFP states basic coverage. RSV criteria is set for all plans by FFS collaborating with providers.
IL	Managed care organizations may have medication edits in place, but may not be more restrictive than HFS. The pharmacy benefit was carved in to the three voluntary managed programs effective 4/1/2013. HFS Bureau of Pharmacy Services has reviewed the formularies of the managed care organizations for compliance.
IN	The pharmacy benefit is managed entirely by the State. Physician administered drugs that are submitted through the medical benefit are managed through the MCO's benefit.
KS	State has oversight of virtually all components of pharmacy program. MCOs to have ability to implement quantity, gender, diagnosis, age, etc. limitations
MA	Similar benefits must be offered.
MD	A comprehensive Drug Use Management Program has been in place for several years which evaluates each MCO drug benefits including; P&T Committee procedures, formulary content and formulary management, prior authorization criteria and procedures, generic substitution, drug use review and disease management. A review and assessment of each MCO Drug Use Management Program is conducted annually.
MI	The MCO contract requires that the plans formulary include coverage available for all outpatient covered drugs identified on the Fee-For-Service Michigan Pharmaceutical Product List (MPPL)
MN	The MCO contracts state there must be the same scope of coverage.
MO	Managed care pharmacy benefits are carved out to the state. All pharmacy benefits are the same as fee for service participants.
MS	Must pay equal or higher reimbursement and must cover same drugs, but may have different preferred drugs
ND	EHB plus we require specific early refill edits
NJ	The HMO shall establish and maintain a DUR program that satisfies the minimum requirements for PDUR and RDUR as established in Section 1927(g) of the SSA. In addition, PDUR and RDUR standards established by the HMO shall be consistent with those same standards established by the DURB.
NY	Members enrolled in mainstream Medicaid managed care and Family Health Plus (FHP) plans receive pharmacy benefits directly through their MCOs. Members are issued health plan cards by their plans and are instructed to present their card at the pharmacy, rather than their Medicaid card. Network pharmacies submit claims directly to the member's managed care plan. Plans establish their own formularies and prior authorization processes. However, plan formularies must include all categories of prescription drugs on the NYS Medicaid fee-for-service list of reimbursable drugs. Plans are also be required to maintain an internal and external review process for exceptions. Managed care plans administer the enrollment and credentialing of their network providers. Reimbursement rates are set by the plan and/or their Pharmacy Benefit Manager (PBM). Plans are also responsible for managing and auditing their pharmacy networks.
OH	MCOs must cover all drugs covered by the fee-for-service program, and maintain a minimum level of agreement on which drugs require PA.
PA	Their contracts outline the coverage of outpatient covered drugs as defined in the Social Security Act as well as oversight requirements for their pharmacy related programs and prior authorization guidelines.
RI	Prescriptions must be written by participating MCO prescribers. Benefit must include both OTC and Rx with generic first policy.
TX	HHSC controls Formulary and Preferred Drug List (PDL)
UT	MCOs must cover anything that Utah Medicaid covers. They are contractually able to extend coverage and can develop their own PDLs.
WA	The State approves the managed care plan formularies, and when necessary requires coverage of specific products to ensure the medical needs of the Medicaid population will be met. Medicaid also dictates some policies the

	MCOs must have in place such as emergency fill policies and continuity of care provisions. And finally the state dictates that the plans set the same children's mental health limits as established for the FFS program, and participate in our children's mental health program. Medicaid requires the MCOs to follow our formulary for atypical antipsychotics, but the plans are otherwise free to develop their own formulary, as long as we deem it sufficient to meet client needs.
WV	The MCO's must follow the FFS Preferred Drug List.

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

Answer	State	Number of States (Percentage)
Yes	FL, SC	2 (7%)
No	AK, AL, AR, CO, CT, GA, IA, ID, KY, LA, ME, MT, NC, NE, NH, NM, NV, OK, OR, SD, TN, VA, VT, WI, WY	25 (93%)

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

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

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

Answer	State	Number of States (Percentage)
Yes	DC, IL, KY, ME, MS, ND, OH, SC, WA	9 (26%)
No	AK, AL, AR, CO, CT, FL, GA, IA, ID, IN, MN, MO, MT, NC, NE, NH, NV, NY, OK, OR, SD, TN, VA, VT, WI, WY	26 (74%)

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

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