National Medicaid Fee-For-Service (FFS) 2018 Drug Utilization Review (DUR)

Executive Summary
National Medicaid Drug Utilization Review (DUR)
Federal Fiscal Year (FFY) 2019 Fee-For-Service (FFS)
Annual Report
(for the period October 2017-September 2018)

Consistent with Section 1927(g)(3)(D) of the Social Security Act (the Act), the Centers for Medicare and Medicaid Services (CMS) requires each State Medicaid Program to submit to CMS an annual survey on the operation of its Medicaid Drug Utilization Review (DUR) fee-for-service (FFS) program. States are required to report on the nature and scope of the prospective and retrospective DUR programs, including a summary of the interventions used in retrospective DUR, an assessment of the education programs deployed, a description of DUR Board activities, as well as an overall assessment of the DUR program's impact on quality of care, and cost savings generated from their DUR programs.[1]

Prospective DUR (ProDUR) is one component of the DUR process, and requires the electronic monitoring of 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 prior to dispensing of the prescription to the patient. Retrospective DUR (RetroDUR) involves an ongoing periodic examination of claims data to identify patterns of fraud, abuse, gross overuse, medically unnecessary care and implementation of corrective action(s) when applicable after a prescription has been dispensed.

A high level comparison of states' DUR FFS survey responses can be found in this report summary. Detailed individual state responses including this national summary can also be found on Medicaid.gov-Drug Utilization Review.

1. **Demographic Information**

   For 2019, all states, including the District of Columbia, have submitted a FFY 2019 Medicaid DUR Annual Survey encompassing FFY 2018 data.[2] The information in this report is focused on national Medicaid FFS DUR activities. Also available on Medicaid.gov-Drug Utilization Review are the individual state FFS DUR Survey responses used to correlate this report.

   - FFY 2018 data includes 21,589,142 beneficiaries (29%) enrolled in national FFS Medicaid programs and 52,627,576 beneficiaries (71%) enrolled in national Medicaid Managed Care programs.

2. **Prospective DUR (ProDUR)**

   ProDUR functions are performed at the point-of-sale (POS) when the prescription is being processed at the pharmacy.
   - 47 states (94%) contract with an outside vendor to process their POS claims, an increase of 2 states (4%) from the national DUR FFY 2018 report.
   - 39 states (78%) allow the pharmacist to supersede (override) ProDUR alert messages as 11 states (22%) impart limitations to the pharmacists' role.

[1] All data presented within these reports originate from state responses to the FFY 2018 DUR FFS Survey.
[2] The Annual DUR survey was not submitted by Arizona because of the states existing waiver of these DUR requirements included in their approved 1115 Demonstration valid until September 2021.

- All states set early prescription refill thresholds as a way of preventing prescriptions from being refilled too soon:
    - Non-controlled substances: State reported thresholds range from 75% to 93% of the prescription being used, with a national average of 80% of the prescription being used, before a prescription could be refilled.
    - Controlled substances (CIII to CV): State reported thresholds range from 75% to 95% of the prescription being used, with a national average of 84% of the prescription being used, before a prescription can be refilled; No change identified from the national DUR FFY 2018 report.
    - Controlled substances (CII): State reported thresholds range from 75% to 100% with a national average of 85% of the prescription being used before a new prescription can be filled (this survey question was added to the national DUR FFY 2019 Survey).
- A new question for the DUR FFY 2019 Survey asks if the Medicaid agency has any policy that requires synchronization of prescription refills to prevent the beneficiary from making multiple trips to the pharmacy within the same month. 10 states (20%) do have a policy in effect as 40 states (80%) do not.

3. **Retrospective DUR (RetroDUR)**

The RetroDUR process allows states to screen literature, clinical data, existing guidelines, and evaluate collected data to identify patterns of clinical concerns. These functions reside primarily with a state vendor in 37 states (74%) and with an academic institution in 10 states (20%). The remainder of the states utilize a combination of sources including internal resources. The DUR Board identifies those categories of prescription claims to be examined to screen for patterns of fraud, abuse, gross overuse, or medically unnecessary care and then take corrective actions. In 40 states (80%), the DUR Board reviews/approves the RetroDUR criteria as 10 states (20%) utilize other internal and external resources for review/approval of RetroDUR criteria.

4. **DUR Board Activity**

Each State provides for the establishment of a DUR board for application, review, evaluation, and re-evaluation of DUR standards, reviews and interventions on an ongoing basis. All states provided a summary of their DUR Board activities. These activities can be found in each individual state report at Medicaid.gov-Drug Utilization Review. Based on this year's survey, 8 states (16%) reported utilization of a Medication Therapy Management (MTM) program, a professional service provided by pharmacists, and 13 states (31%) have plans to implement a program in the future.

5. **Physician Administered Drugs**

A total of 15 states (30%), an increase of 3 states (6%) from the national DUR FFY 2018 report, have incorporated physician administered drugs into DUR criteria for ProDUR reviews and 9 states (26%) plan to incorporate these drugs in the future. Additionally, 20 states (40%), an increase of 4 states (8%) from the national DUR FFY 2018 report, have incorporated these NDCs into their DUR criteria for RetroDUR and 10 states (34%) plan to incorporate these drugs in the future.

6. **Generic Policy and Utilization Data**

In an ongoing effort to reduce spending on prescription drugs, states continue to encourage the use of lower-cost generic drugs. The national average percentage generic utilization rate was 82%, a decrease of 1% from the national DUR FFY 2018 report, likely due to the increased use of branded specialty drugs that have entered the market. However, many states, even those with lower generic utilization percentages, base

decisions of brand versus generic product preferred status on net price, taking into consideration federal and supplemental rebate dollars on brand and generics in their particular state.

7. **Program Evaluation / Cost Savings / Cost Avoidance**

Based on states' reported estimates for FFY 2018, ProDUR, RetroDUR, and other activities saved Medicaid programs a total of $3,235,074,971 which equates to an average of 19%, a decrease of 1% from the national DUR FFY 2018 report, on the estimated national impact percentage of drug cost savings/cost avoidance compared to the total Medicaid drug spend.

8. **Fraud, Waste and Abuse Detection**

A. Lock- In or Patient Review and Restriction Programs

Lock-In or Patient Review and Restriction Programs restrict beneficiaries whose utilization of medical services is documented as being potentially unsafe, excessive or could benefit from increased coordination of care. In some instances, beneficiaries are restricted to specific provider(s) in order to monitor services being utilized and reduce unnecessary or inappropriate utilization. A total of 46 states (92%) have a Lock-In program. Nationally, the average state cost savings to those states with a Lock-In program equates to an estimated $2,278,927 per state. A total of 26 states (52%) also have a documented process in place that identifies potential fraud or misuse of non-controlled drugs by a beneficiary.

Additionally, 36 states (72%) have processes in place to identify potential fraudulent practices by prescribers, and 37 states (74%) have processes in place to identify potential fraudulent practices by pharmacies. These processes trigger actions such as denying claims written by that prescriber or claims submitted by that pharmacy, alerting the state Integrity or Compliance Unit to investigate, or referring to the appropriate licensing Board.

B. Prescription Drug Monitoring Program (PDMP)

Prescription Drug Monitoring Programs (PDMPs) are statewide electronic databases that collect designated data on controlled substances that are dispensed in the state. Depending on the state, physicians and pharmacists have access to these databases to identify prescribers and patients that are engaging in potential fraud or misuse of controlled substances.

In FFY 2018:

- 49 states (98%) reported having a PDMP in their state.
  - 32 of these states (65%), an increase of 2 states (4%) from the national DUR FFY 2018 report, have some ability to query the PDMP database, while the remaining 17 states (35%) do not have the ability to query their PDMP database.
  - 16 of these states (33%) require that prescribers access the patient history in the PDMP database prior to prescribing restricted (controlled) substances.
  - 36 of these states (73%) indicated that they face a range of barriers that hinder their ability to fully access and utilize the PDMP database to curb abuse.

C. Pain Management Controls

To prevent unauthorized prescribing of controlled substances, states have used numerous approaches for monitoring these claims. The DEA Active Controlled Substance Registrant's File is utilized by 15 states (30%) to identify prescribers not authorized to prescribe controlled substances. Only 9 of

these states (60%) apply the DEA Active Controlled Substance Registrant's File to their ProDUR edits and 3 of these states (20%) also apply the DEA Active Controlled Substance Registrant's File to their RetroDUR reviews. Additionally, 46 states (92%) have measures in place to either monitor or manage the prescribing of methadone.

D. Opioids

The average maximum number of days allowed for an initial opioid prescription ranges nationally from 5 to 34 days. This initial opioid prescription policy applies to all opioids dispensed by 66% of the states while 34% of the states apply other limitations and restrictions to opioid prescription dispensing. These limitations and restrictions include both short-acting and long-acting opioid formulations depending on state specific criteria. Clinical criteria, such as step therapy, may assist in avoiding the prescribing of more high potency addictive therapies. Other approaches to controlling and managing the amount of opioids dispensed include: prescriber intervention letters, morphine equivalent daily dose (MEDD) programs and pharmacist overrides. Requirements for obtaining high dose or large quantities of opioids may include documentation of urine drug screening results, pain management contract or patient-provider agreement.

Additionally:

- 29 states (58%) monitor for concurrent prescribing and use of opioids and benzodiazepines, and
- 33 states (66%) encourage abuse-deterrent opioid utilization.

E. Morphine Equivalent Daily Dose (MEDD)

A total of 32 states (64%) limit the amount of opioid products containing morphine or morphine derivatives that a patient may receive in a specific time frame in order to reduce potential abuse or diversion. The national range of MEDD values vary from 30 to 300mg/day, each state having their specific methodology used for MEDD calculation. In addition, 18 states (36%) are either in the process of implementing MEDD limits or have other processes in place to measure MEDDs.

F. Buprenorphine, Naloxone, Buprenorphine/Naloxone Combinations and Methadone for Opioid Use Disorder (OUD)

Buprenorphine and Buprenorphine/naloxone combination drugs, in conjunction with behavioral health counselling, are used to treat opioid use disorder (OUD). Currently, 41 states (82%) set total milligrams per day limits on the use of Buprenorphine and Buprenorphine/Naloxone combination drugs. Of these states, 14 states (28%) set limitations on allowable length of treatment for a beneficiary receiving Buprenorphine and Buprenorphine/naloxone combination drugs while 36 states (72%) have no limits assessed. Additionally, 34 states (68%) provide Buprenorphine and Buprenorphine/naloxone combination drugs without a prior authorization requirement while 16 (32%) of states require prior authorization for these products.

Methadone is a drug that is indicated for both chronic pain and/or as part of an Opioid Treatment Program (OTP) (formerly referred to as a methadone treatment center). Due to methadone's potential opioid-related harms, CMS, in conjunction with the CDC recommends states to remove methadone for pain (outside of end of life care) from their preferred drug lists and not be considered a drug of first choice by prescribers for chronic non-cancer pain. However, the FDA has approved methadone as one of three drugs for treatment of opioid use disorder within an OTP. A total of 38 states (76%)

provide coverage for methadone for opioid use disorder (OUD) through an OTP while 12 states (24%) provide no Methadone coverage for OUD.

Naloxone, used to treat opioid overdose, is available without prior authorization in 50 states (100%) and 47 states (94%) allow pharmacists to dispense naloxone prescribed independently or by collaborative practice agreements, standing orders, or other predetermined protocols.

G. Antipsychotics / Stimulants

Antipsychotic Medication

According to survey results, 48 states (96%) have a program in place for managing or monitoring appropriate use of antipsychotic drugs in children, an increase of 5 states (10%) from the national DUR FFY 2018 report. 42 of these states (88%) manage or monitor for all children.

Stimulant Medication

According to survey results, 41 states (82%) have a program in place for managing or monitoring appropriate use of stimulant drugs in children. 36 of these states (88%) manage or monitor for all children.

Note: Some states have legislation in place that prohibits any restriction being placed on the prescribing of medications used to treat mental or behavioral health conditions.

IX. Innovative Practices

A total of 42 states (84%) submitted an Innovative Practices Narrative (Attachment 6). These attachments can be accessed through the Innovative Practices Narrative link on Medicaid.gov-Drug Utilization Review.

X. E-Prescribing

Electronic (E)-prescribing helps to improve the quality of the prescribing process, provides the provider patient drug history, limitations to pharmacy coverage, and enables providers to identify more cost effective drugs. 25 states (50%) have the ability to electronically provide patient drug history and pharmacy coverage limitations to a prescriber prior to prescribing upon inquiry. Of the 25 states (50%) without an electronic portal, 9 states (36%) plan to implement in the future.

XI. Managed Care Organizations (MCOs)

This is the initial year for MCO DUR activities to be separately reported. A total of 38 states (76%) (Non-inclusive of Arizona) have active MCO programs encompassing 229 organizations. Only 5 states (13%) carve out the drug benefit and therefore did not submit an MCO annual survey. The MCO National DUR report can be found on Medicaid.gov-Drug Utilization Review.

- 22 states (58%) mandate requirements for their MCO pharmacy benefit. These requirements include, but not limited to formulary reviews, preferred drug lists, ProDUR, and RetroDUR. Of the 16 states not mandating MCO requirements for their pharmacy benefit, 7 states (44%) plan to implement standards in the future.

XII. Executive Summary

Attachment 8, the states DUR FFS Executive Summary can be requested by contacting CMSDUR@cms.hhs.gov.

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PLEASE NOTE: This is a standalone report posted on Medicaid.gov. Attachments to the report have not been posted. To obtain related report attachments, please contact CMSDUR@cms.hhs.gov.

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Section 1 - Enrollees

1. On average, how many beneficiaries are enrolled in your state's Medicaid Fee-For-Service (FFS) program that have a pharmacy benefit?

Figure 1 - Number of Beneficiaries Enrolled in FFS with Pharmacy Benefit

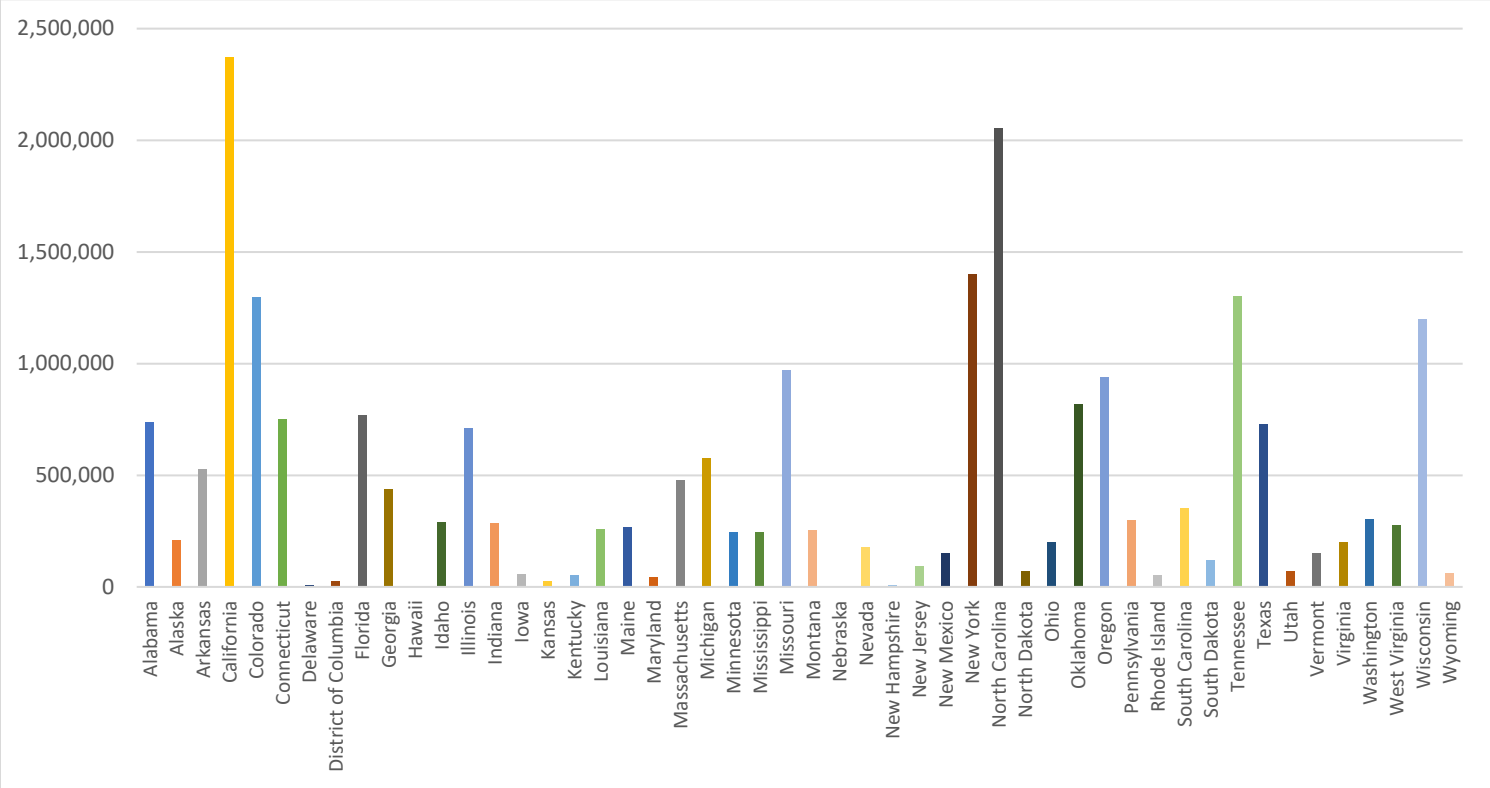

Table 1 - Number of Beneficiaries Enrolled in FFS with Pharmacy Benefit

State	Number of Beneficiaries Enrolled in FFS with Pharmacy Benefit
Alabama	734,760
Alaska	210,000
Arkansas	527,564
California	2,373,221
Colorado	1,297,927

State	Number of Beneficiaries Enrolled in FFS with Pharmacy Benefit
Connecticut	750,000
Delaware	8,445
District of Columbia	25,000
Florida	767,854
Georgia	436,095
Hawaii	108
Idaho	287,000
Illinois	708,142
Indiana	283,593
Iowa	54,545
Kansas	26,486
Kentucky	50,000
Louisiana	256,884
Maine	268,000
Maryland	43,166
Massachusetts	477,952
Michigan	576,801
Minnesota	244,567
Mississippi	242,833
Missouri	967,588
Montana	255,103
Nebraska	1,030
Nevada	179,119
New Hampshire	8,384
New Jersey	92,570
New Mexico	148,904
New York	1,400,000
North Carolina	2,054,497
North Dakota	70,000
Ohio	200,000
Oklahoma	818,481
Oregon	936,086
Pennsylvania	300,000
Rhode Island	51,200
South Carolina	350,000
South Dakota	119,000
Tennessee	1,300,000
Texas	729,879
Utah	68,273
Vermont	148,797
Virginia	198,067

State	Number of Beneficiaries Enrolled in FFS with Pharmacy Benefit
Washington	304,427
West Virginia	277,176
Wisconsin	1,200,000
Wyoming	59,617
Total	**21,589,142**

2. On average, how many of your state's Medicaid beneficiaries are enrolled in managed care plan(s)?

Figure 2 - Medicaid Beneficiaries Enrolled in MCOs by State

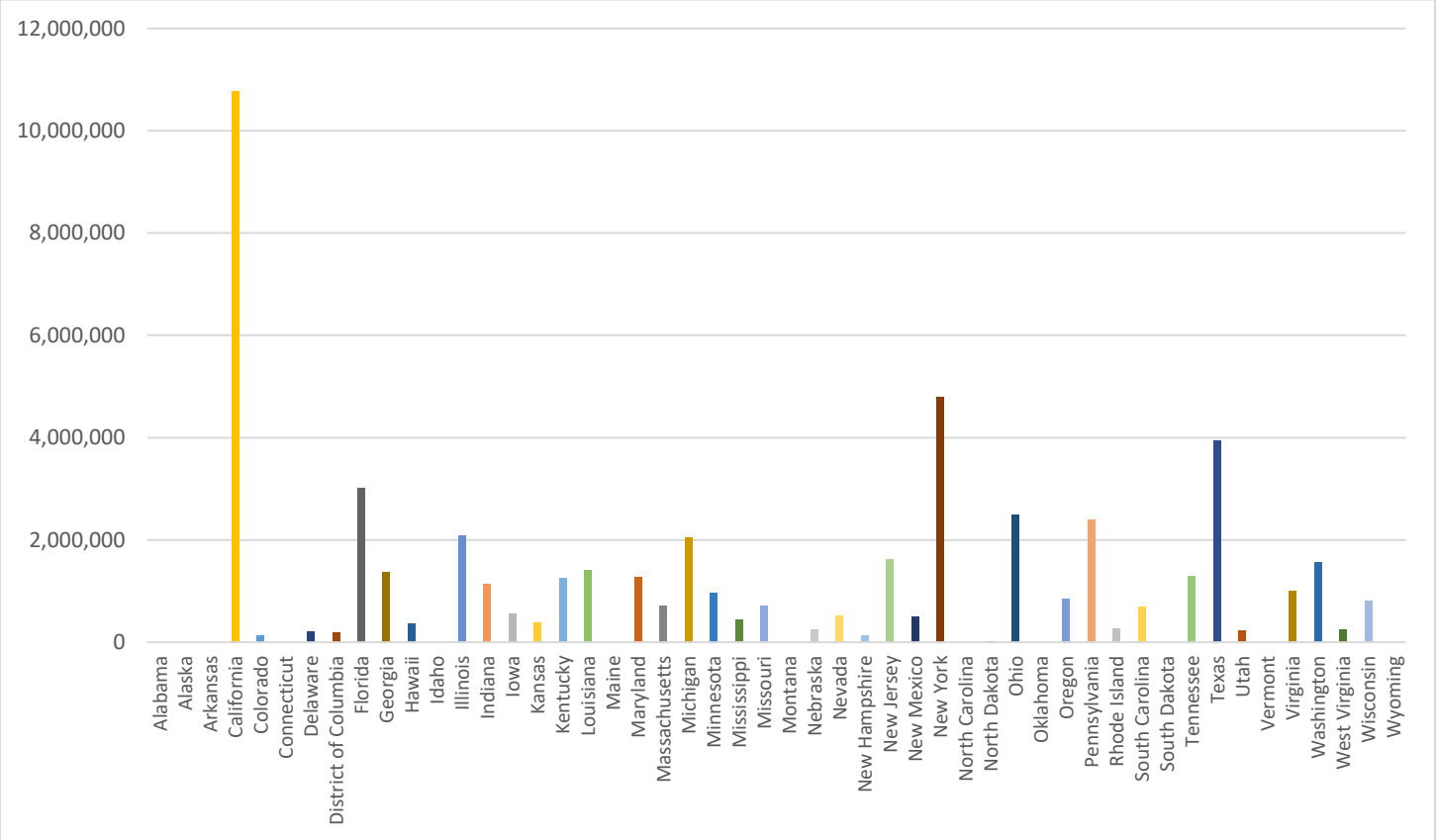

Table 2 - Medicaid Beneficiaries Enrolled in MCOs by State

State	Number of Beneficiaries Enrolled in MCO Plans
Alabama	0
Alaska	0
Arkansas	0
California	10,779,691
Colorado	121,660

State	Number of Beneficiaries Enrolled in MCO Plans
Connecticut	0
Delaware	210,000
District of Columbia	190,000
Florida	3,008,914
Georgia	1,368,234
Hawaii	361,000
Idaho	0
Illinois	2,076,079
Indiana	1,146,132
Iowa	557,313
Kansas	374,345
Kentucky	1,250,000
Louisiana	1,413,413
Maine	0
Maryland	1,281,225
Massachusetts	701,660
Michigan	2,045,023
Minnesota	962,650
Mississippi	432,195
Missouri	707,952
Montana	0
Nebraska	248,365
Nevada	509,453
New Hampshire	133,500
New Jersey	1,616,020
New Mexico	497,610
New York	4,800,000
North Carolina	0
North Dakota	20,000
Ohio	2,500,000
Oklahoma	0
Oregon	842,155
Pennsylvania	2,400,000
Rhode Island	273,600
South Carolina	700,000
South Dakota	0
Tennessee	1,300,000
Texas	3,947,976
Utah	231,210
Vermont	0
Virginia	993,423

State	Number of Beneficiaries Enrolled in MCO Plans
Washington	1,562,318
West Virginia	252,198
Wisconsin	812,262
Wyoming	0
Total	**52,627,576**

Section II - Prospective DUR

1. Indicate the type of your pharmacy POS Vendor.

Figure 3 - Pharmacy POS Type of Vendor

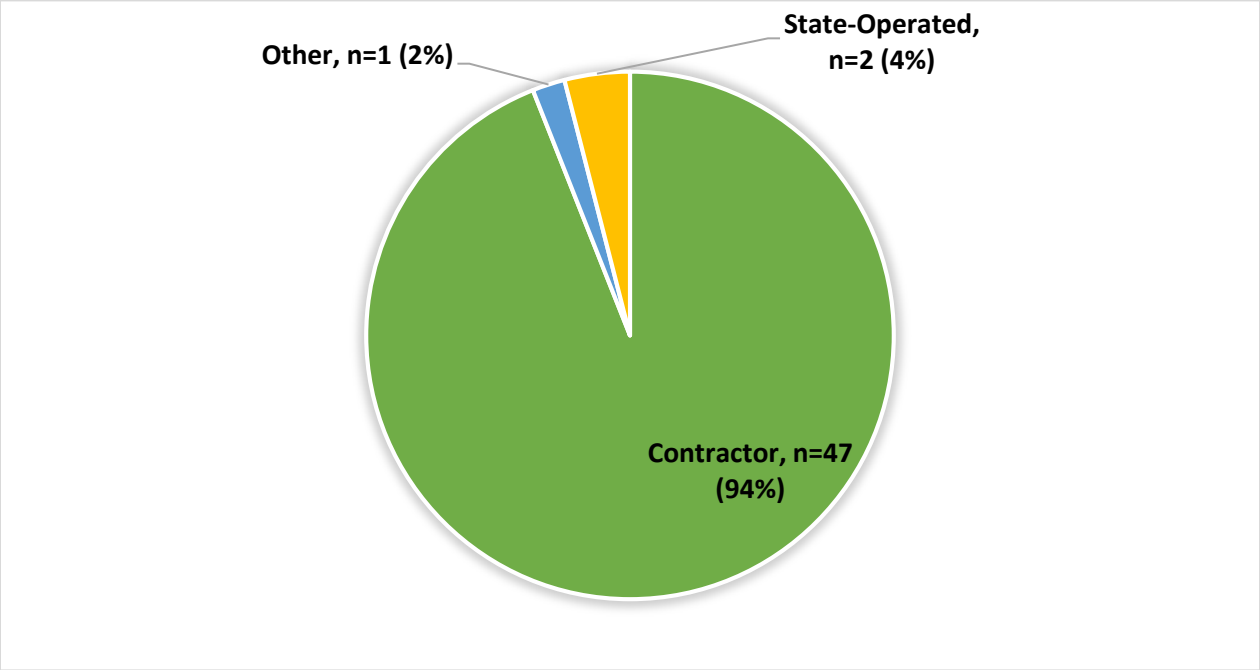

Table 3 - Pharmacy POS Type of Vendor

Response	States	Count	Percentage
Contractor	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming	47	94.00%
State-Operated	North Dakota, Washington	2	4.00%
Other	Illinois	1	2.00%

a. Vendor Name

Table 4 - POS Vendor Name

Response	States	Count	Percentage
DXC Technology	Alabama, Connecticut, Delaware, Kansas, Oklahoma, Oregon, Pennsylvania, Rhode Island, West Virginia, Wisconsin	10	21.28%
Magellan	Alaska, Arkansas, Colorado, District of Columbia, Florida, Idaho, Kentucky, Michigan, Nebraska, New Hampshire, South Carolina, Tennessee, Virginia	13	27.66%
Conduent	California, Hawaii, Maryland, Massachusetts, Mississippi, Missouri, Montana, New Mexico, Texas	9	19.15%
OptumRx	Georgia, Indiana, Nevada, South Dakota	4	8.51%
Change Healthcare	Iowa, Maine, Ohio, Utah, Vermont, Wyoming	6	12.77%
Molina Medicaid Solutions	Louisiana, New Jersey	2	4.26%
First Data Bank	Minnesota	1	2.13%
CSRA	New York	1	2.13%
CSRA/GDIT	North Carolina	1	2.13%

b. Is the POS vendor also the MMIS fiscal agent?

Figure 4 - Is the Vendor also your MMIS Fiscal Agent

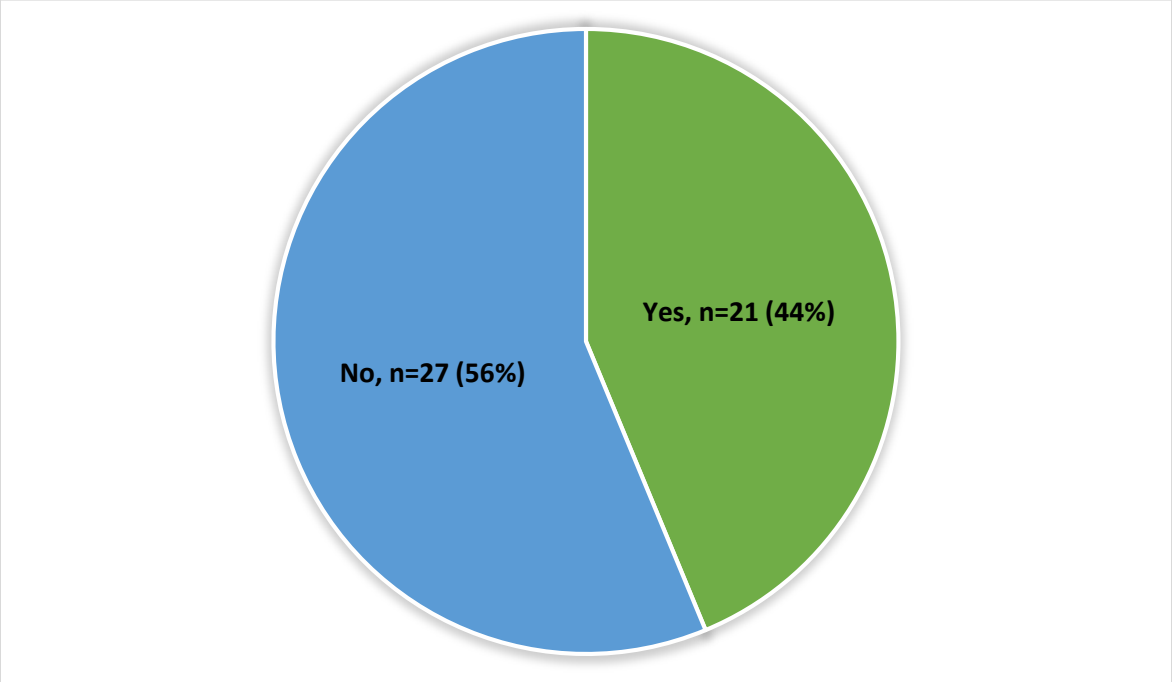

Table 5 - Is the Vendor also your MMIS Fiscal Agent

Response	States	Count	Percentage
Yes	Alabama, California, Connecticut, Delaware, Hawaii, Kansas, Louisiana, Mississippi, Montana, New Jersey, New Mexico, New	21	43.75%

Response	States	Count	Percentage
	York, North Carolina, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas, Virginia, West Virginia, Wisconsin		
No	Alaska, Arkansas, Colorado, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, Ohio, South Carolina, South Dakota, Tennessee, Utah, Vermont, Wyoming	27	56.25%

2. Identify prospective DUR criteria source.

Figure 5 - Prospective DUR Criteria Source

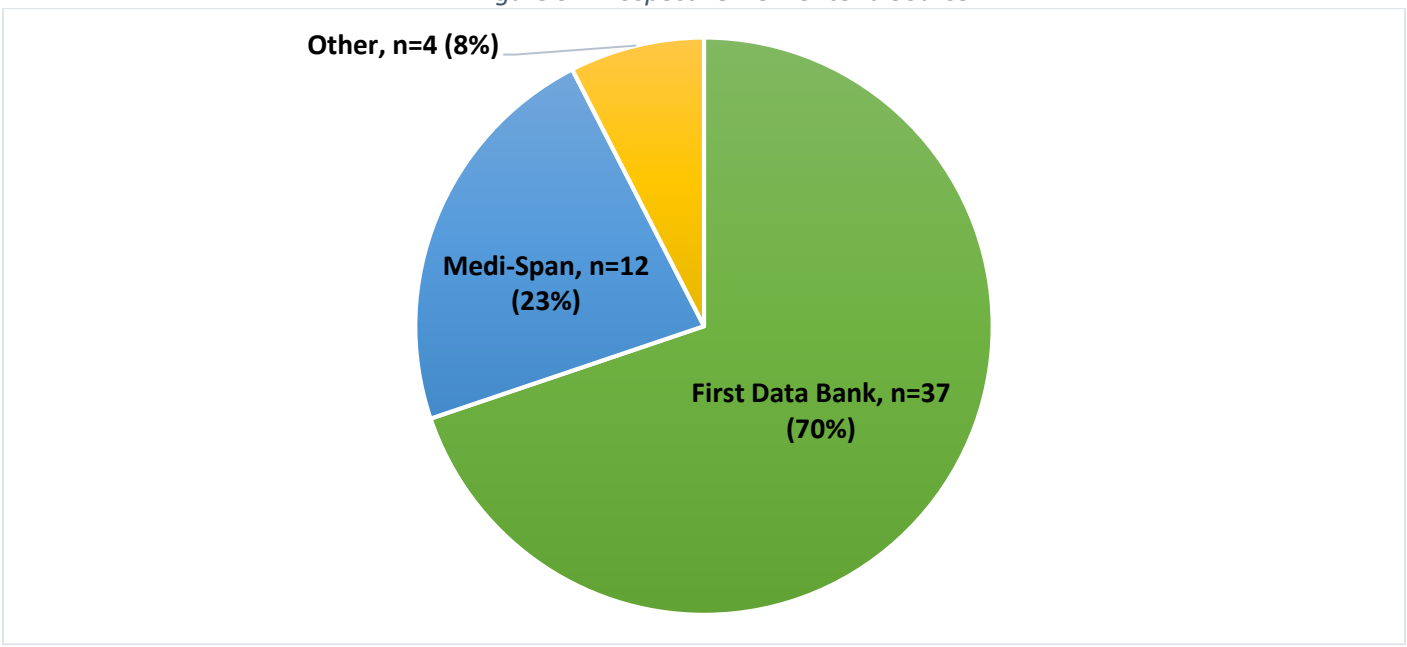

Table 6 - Prospective DUR Criteria Source

Response	States	Count	Percentage
First Data Bank	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Idaho, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Virginia, West Virginia, Wisconsin	37	69.81%
Medi-Span	Georgia, Illinois, Indiana, Iowa, Maine, Nevada, Ohio, South Dakota, Utah, Vermont, Washington, Wyoming	12	22.64%
Other	Louisiana, Texas, Vermont, Washington	4	7.55%

Table 7 - "Other" State Explanations for Prospective DUR Criteria Source

State	"Other" Explanations
Louisiana	First Data Bank is the data source. The prospective DUR criteria source is the result of collaboration by pharmacists at LDH, Molina Medicaid Solutions, and the University of Louisiana-Monroe.
Texas	Some of the pro-DUR criteria are from First Data Bank and some others are set by the state.
Vermont	Clinical Literature, FDA Safety Alerts
Washington	Washington Apple Health's (Medicaid) Fee-for-Service (FFS) program uses pre-set DUR criteria and functionality as provided through the POS vendor's (Optum Rx) built in DUR module, based on Medispan drug file data. Additional DUR criteria based on medically accepted indications and compendia of medical literature are developed by State staff and approved by the Drug Utilization Review Board for implementation as utilization limits (quantity, duration, and dose) and prior authorization requirements.

3. Are new ProDUR criteria approved by the DUR Board?

Figure 6 – New ProDUR Criteria Approved by DUR Board

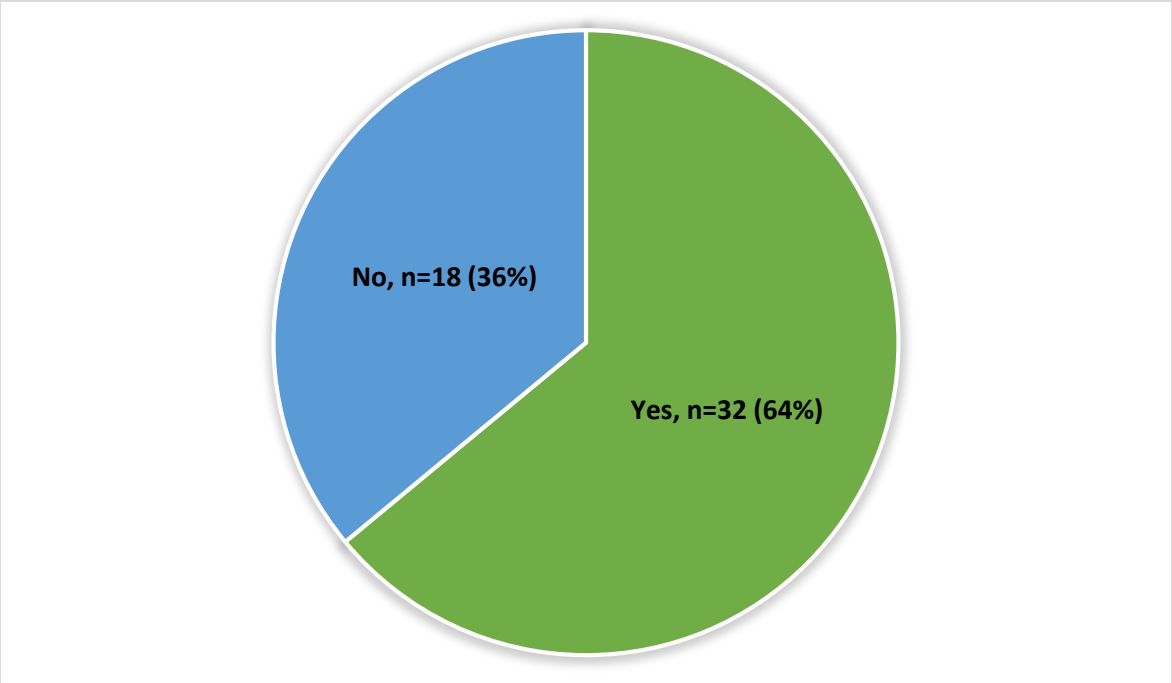

Table 8 – New ProDUR Criteria Approved by DUR Board

Response	States	Count	Percentage
Yes	Alabama, Alaska, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Mississippi, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming	32	64.00%
No	Arkansas, California, Colorado, Georgia, Idaho, Iowa, Maryland, Michigan, Minnesota, Missouri, Nebraska, Nevada, North	18	36.00%

Response	States	Count	Percentage
	Dakota, Oklahoma, Rhode Island, South Dakota, Tennessee, Washington		

Table 9 - Explanations by States when ProDUR Criteria Not Approved by DUR Board

State	Explanations
Arkansas	New ProDUR criteria for new drugs to system are automatically updated as new drugs are added to the system.
California	The DUR Board advises and makes recommendations regarding prospective DUR criteria; however, final approval is made by DHCS.
Colorado	The DUR Board reviews new ProDUR criteria and makes recommendations to the State.
Georgia	Criteria is from MediSpan
Idaho	The DUR Board reviews, but they do not approve or disapprove any vendor criteria.
Iowa	This is a collaborative effort between the State, POS Contractor and DUR. Most new proposed criteria are reviewed by the DUR.
Maryland	Although the DUR Board does not review and approve all new prospective DUR criteria, a summary of prospective DUR alerts is reviewed and discussed at all DUR Board meetings. Individual criteria may be recommended by the Board for implementation. All new security level 1 drug interaction criteria is automatically implemented by the point of sale (POS) vendor as it becomes available from First Data Bank.
Michigan	MDHHS and the DUR Board reviewed the ProDUR criteria when First Data Bank (FDB) criteria were first implemented. After that, the Board felt comfortable with the completeness of the FDB criteria.
Minnesota	Informational edits are not reviewed by the DUR Board. High dose or quantity limits edits which cause the claim to reject are reviewed by the DUR Board.
Missouri	Automatic updates are made from First DataBank which are incorporated in our DUR criteria.
Nebraska	New ProDUR criteria are created by the DUR Board, pharmacy POS vendor and are approved by the Medicaid Program.
Nevada	New ProDUR criteria is provided by Medispan.
North Dakota	Weekly updates from FDB does not lend itself to quarterly review by DUR Board.
Oklahoma	Guidelines have been approved and new criteria are updated as it comes from FDB, as long as parameters are met.
Rhode Island	The prospective DUR Criteria is auto loaded from First Data Bank.
South Dakota	The vendor maintains the general ProDUR criteria. Criteria are approved by the P&T Committee as they relate to specific Committee discussions.
Tennessee	DUR Board reviews products that become an issue. With a 3 hour quarterly meeting, it's not possible to review all new products, nor do we feel it's necessary.
Washington	Standard DUR criteria as provided by the POS (Optum Rx) and drug file (Medispan) vendors are automatically loaded into the POS system without additional review by State staff or the DUR Board. All such DUR criteria are 'soft' criteria, overridable by Pharmacists at the point of sale via the use of submitted DUR codes. All "hard edit" criteria requiring prior authorization and clinical review are established by State staff based on review and / or recommendation by the DUR Board.

4. When the pharmacist receives a level-one ProDUR alert message that requires a pharmacist's review, does your system allow the pharmacist to override the alert using the NCPDP drug use evaluation codes (reason for service, professional service and resolution)?

Figure 7 - ProDUR Alert Message for Pharmacist Override using NDPDP Drug Use Evaluation Codes

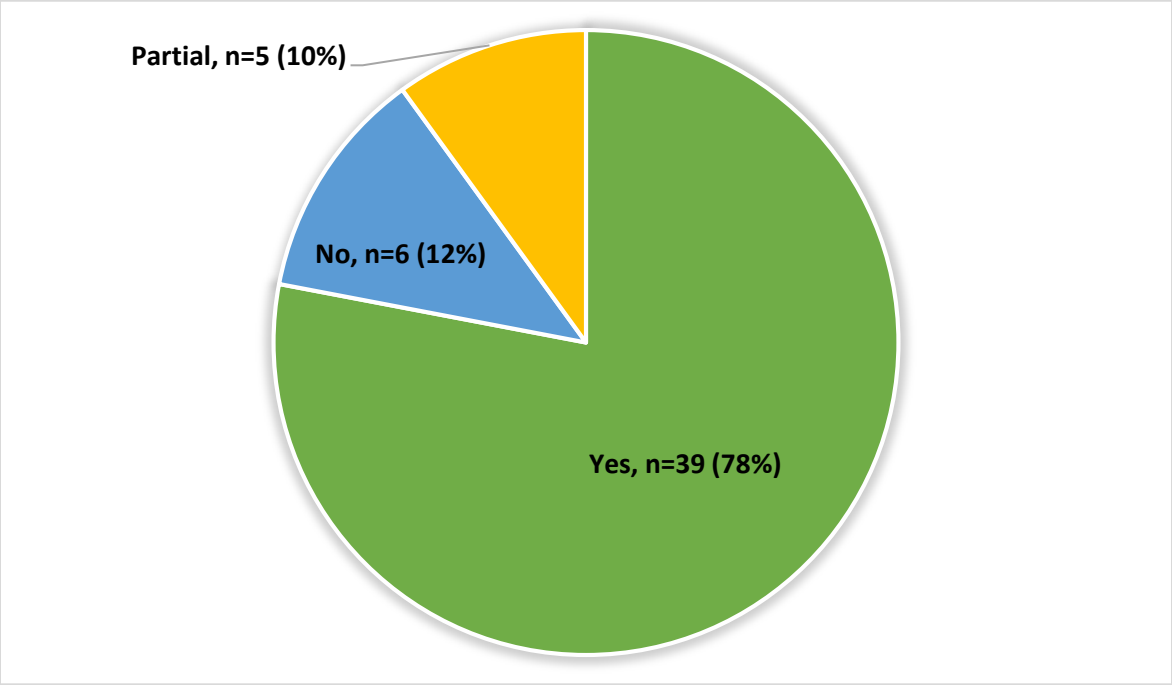

Table 10 - ProDUR Alert Message for Pharmacist Override using NDPDP Drug Use Evaluation Codes

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Indiana, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, Wyoming	39	78.00%
No	Colorado, Hawaii, Illinois, Iowa, Maine, New Jersey	6	12.00%
Partial	Kentucky, New York, North Dakota, Tennessee, West Virginia	5	10.00%

Table 11 - Explanation for Pharmacist Partial Override using NDPDP Drug Use Evaluation Codes

State	Explanations
Kentucky	Most can be overridden, with exceptions. These exceptions include therapeutic duplication of opioids, stimulants, or antipsychotics.
New York	Any HIV level 1 drug interactions encountered cannot be overridden by the pharmacist and the prescriber must obtain a PA. All other level one ProDUR edits are allowed to be overridden using NCPDP drug use evaluation code.

State	Explanations
North Dakota	Pharmacy can only override early refill denials for non-controlled substances that are at least 60% utilized.
Tennessee	Most can be overridden. Some categories cannot be overridden by pharmacy, e.g., controlled substances for early refill, skeletal muscle relaxants for duplicate therapy.
West Virginia	The retail pharmacist cannot override this, but the pharmacist at our prior authorization vendor can.

5. Do you receive and review follow-up periodic reports providing individual pharmacy provider DUR alert override activity in summary and/or in detail?

Figure 8 - Receive/Review Follow-up Periodic Reports Providing Individual Pharmacy Provider DUR Alerts Override

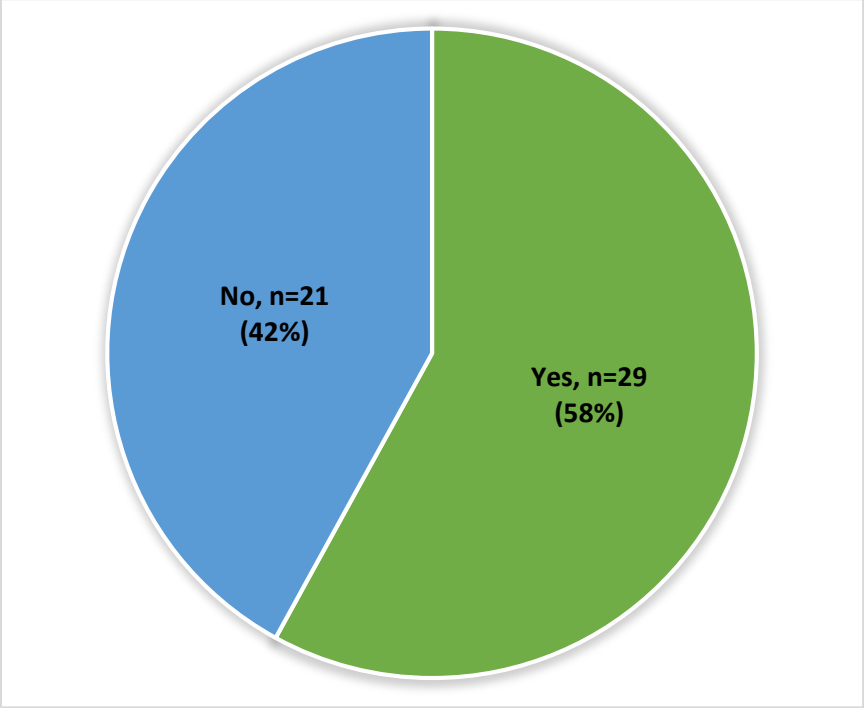

Table 12 - Receive/Review Follow-up Periodic Reports Providing Individual Pharmacy Provider DUR Alerts Override

Response	States	Count	Percentage
Yes	Alabama, Alaska, California, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Kentucky, Louisiana, Massachusetts, Michigan, Mississippi, Nebraska, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Utah, Vermont, Virginia	29	58.00%
No	Arkansas, Florida, Idaho, Illinois, Indiana, Iowa, Kansas, Maine, Maryland, Minnesota, Missouri, Montana, Nevada, New Jersey, Ohio, South Dakota, Tennessee, Washington, West Virginia, Wisconsin, Wyoming	21	42.00%

If “No,” please explain.

Table 13 – State Explanations for no Follow-up Methods for Providers who routinely override with Interventions

State	Explanations
Arkansas	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
Florida	ProDUR alerts are an indication of the edits previously established by the DUR Board. The DUR board makes upfront decisions on whether edits should be overridden at the pharmacy level (based on clinical judgement). The programming is then implemented to reflect soft or hard edits. Therefore, a pharmacist is only able to override those alerts that the board has pre-determined should be left to their discretion (as soft edits). ProDUR monitoring reports are not generated outside of the standard fiscal monitoring of Medicaid Program integrity.
Idaho	No individual pharmacy provider reports are generated currently.
Illinois	Claims reject instead of sending informational soft edits for ProDUR.
Indiana	The claims processing system has logic in place to determine appropriate pharmacy provider submissions of conflict, intervention, and outcome codes. We continue to evaluate the utility of this type of reporting.
Iowa	We do not allow overrides at the pharmacy level. Individual pharmacy claim activity is reviewed bimonthly by the top 100 pharmacies by paid amount and top 100 pharmacies by prescription count.
Kansas	Currently we are focusing on improving clinical safety through hard stop PA edits. Re-evaluation of the soft edits at POS will be a future area of closer monitoring.
Maine	Currently we do not allow pharmacies to override conflict code/interventions, soft messaging is sent back to the pharmacies.
Maryland	Reports are generated and reviewed ad hoc or as necessary.
Minnesota	We can get information from data warehouse queries.
Missouri	We can request reports as needed, but do not do so on a scheduled basis.
Montana	While we can run these reports as needed, very few ProDUR alerts are able to be overridden by the pharmacist. We are not concerned that these are being used inappropriately.
Nevada	Follow-up reports providing DUR alert override activity data have not been established at this time.
New Jersey	Pharmacy providers are not allowed to override DUR alerts.
Ohio	No problems identified
South Dakota	We are currently working with our vendor to establish this report.
Tennessee	This type of a report/overview/analysis might be valuable if it was very specific and targeted because of an issue that had been found, or to verify a suspicion or a referral. To this point, the Board or the State's staff has not needed to use this information.
Washington	Regular reporting of DUR override use are not reviewed as a whole. Utilization of DUR codes is reviewed on a case by case basis in the course of Pharmacy provider audits. Any findings of inappropriate or undocumented DUR use are extrapolated across the audited claim set for recoupment from the Pharmacy provider. During FFY 2018, Washington Medicaid performed XXX targeted pharmacy provider specific audits, [fill in DUR findings and recovery]
West Virginia	We can request these reports as needed.
Wisconsin	The Wisconsin DUR Board has previously reviewed pharmacy overrides and the Board members have cautioned the State on the validity of the answers received from the pharmacy. Pharmacies will often override a Prospective DUR alert in order to move the prescription to the next phase of

State	Explanations
	review; either outreach to the prescriber or counseling of the patient. The response may not accurately reflect the final decision that occurred for the prescription.
Wyoming	We have reviewed these reports in the past and did not find them useful or actionable.

a. How often?

Figure 9 - Frequency of Reports Regarding Individual Pharmacy Provider DUR Alerts: Monthly. Quarterly, Annual, Other

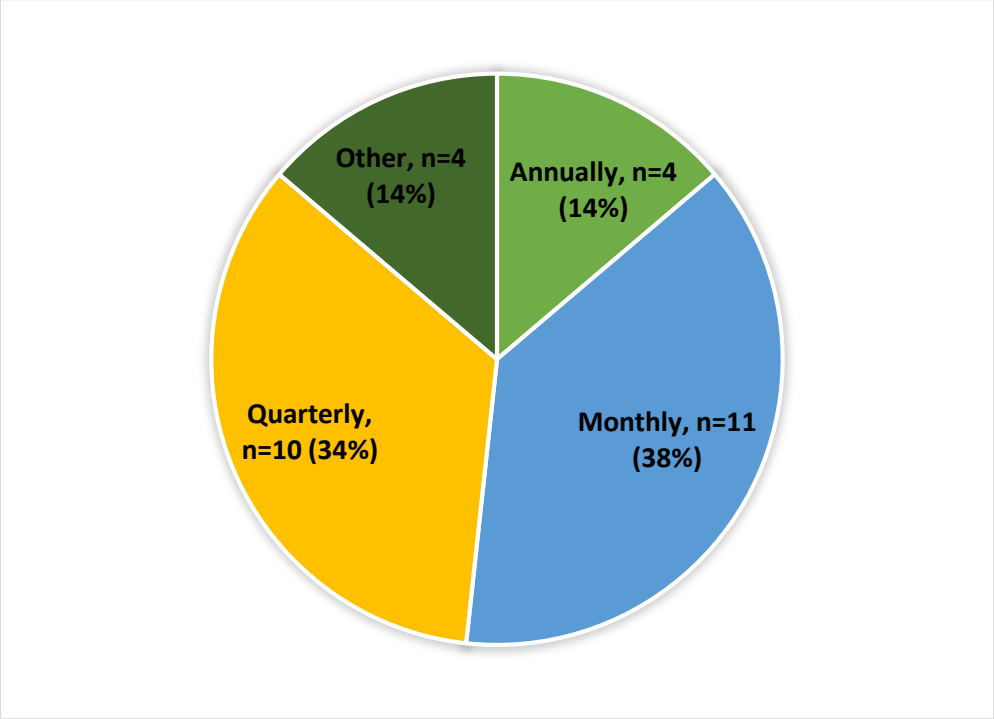

Table 14 - Frequency of Reports Regarding Individual Pharmacy Provider DUR Alerts: Monthly. Quarterly, Annual, Other

Response	States	Count	Percentage
Annually	California, New York, Pennsylvania, Texas	4	13.79%
Monthly	Connecticut, District of Columbia, Kentucky, Massachusetts, Mississippi, Nebraska, New Hampshire, New Mexico, North Carolina, Rhode Island, Virginia	11	37.93%
Quarterly	Alaska, Delaware, Georgia, Hawaii, Louisiana, Michigan, Oklahoma, Oregon, South Carolina, Vermont	10	34.48%
Other	Alabama, Colorado, North Dakota, Utah	4	13.79%

Table 15 – "Other" Explanation for Frequency of Reports Regarding Individual Pharmacy Provider DUR Alerts

State	"Other" Explanations
Alabama	Reports are received and reviewed monthly and quarterly.
Colorado	Ad hoc reporting is conducted for individual pharmacy provider activity
North Dakota	Report can be run at any time for any time period.
Utah	As needed.

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

Figure 10 - Follow-up with Providers who routinely override with Interventions

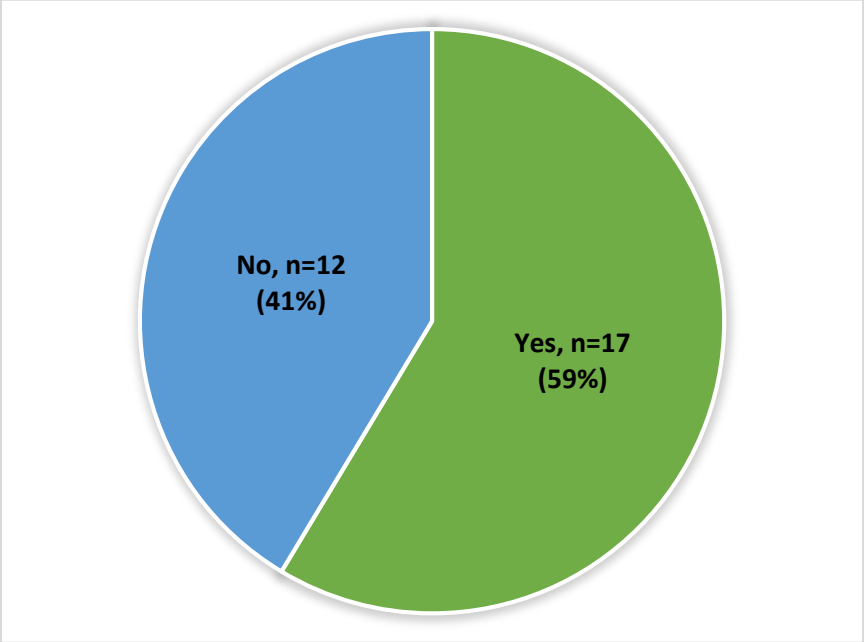

Table 16 - Follow-up with Providers who routinely override with Interventions

Response	States	Count	Percentage
Yes	Alabama, Alaska, California, Colorado, Delaware, District of Columbia, Hawaii, Kentucky, Louisiana, Massachusetts, Michigan, Nebraska, North Carolina, North Dakota, South Carolina, Utah, Virginia	17	58.62%
No	Connecticut, Georgia, Mississippi, New Hampshire, New Mexico, New York, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas, Vermont	12	41.38%

If "No," please explain.

Table 17 – Explanations for no Follow-up Methods for Providers who routinely override with Interventions

State	Explanations
Connecticut	Interventions have not been performed based on review of the monthly report.
Georgia	While the functionality to override is present, we currently do not require soft edit overrides.
Mississippi	Staff's time is concentrated on review of other issues programs such as CMS covered outpatient reimbursement changes and resultant claims reprocessing, the Complex Pharmacy Care program, managed care organization implementation pharmacy related issues, etc.
New Hampshire	NH has not found any trend in this information requiring follow up with providers
New Mexico	System edit overrides are allowed through the Conduent Help Desk at this time. Follow-up is only on a case by case basis.
New York	Program activity that appears to have a high level of overrides is evaluated through clinical review of utilization and system edits by the DUR Board and potential upgrade/modification of ProDUR edits, RetroDUR edits or both.

State	Explanations
Oklahoma	Yes. We contact the pharmacy. Few ProDUR edits allow provider overrides.
Oregon	We do not specifically audit provider's use of the intervention and outcome codes. We can identify if a provider seems to be overriding alerts, but that has not been an issue in our State. Only 2 ProDUR alerts are set to deny claims-Early refill and Pregnancy.
Pennsylvania	If the conflict is significant and pharmacists are overriding routinely, then the Department recommends to DUR Board a hard stop prior authorization requirement.
Rhode Island	Fee for Service is routinely secondary payer.
Texas	For the FFY 2018, the Health and Human Services Commission (HHSC) did not have a pharmacy claims oversight team to follow up with those providers.
Vermont	Policy allows the pharmacist to override the interventions as allowed by NCPDP format. This is used to alert the Pharmacist of potential DDI , therapy conflict sand other requirements

If "Yes," by what method do you follow up?

Figure 11 – Follow-up Methods for Providers who routinely override with Interventions

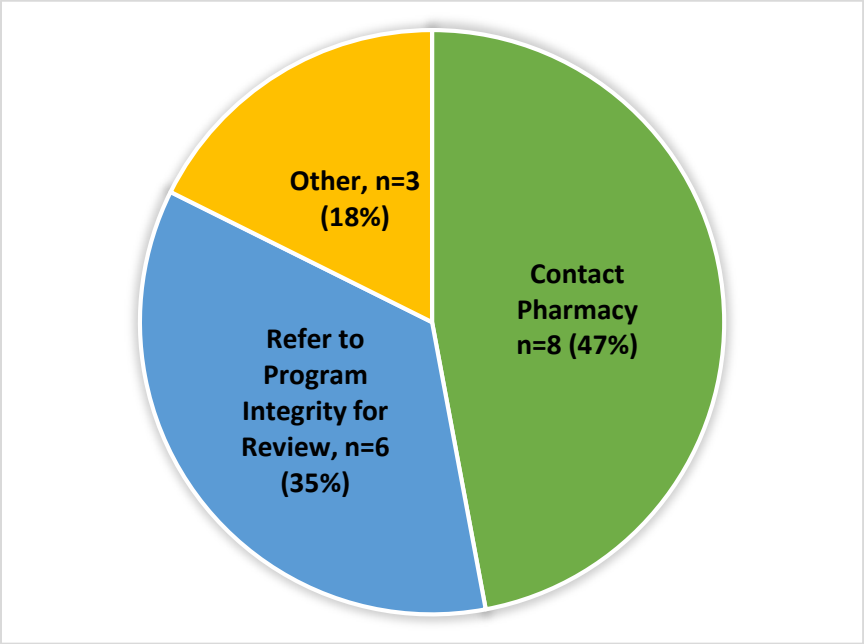

Table 18 –Follow-up Methods for Providers who routinely override with Interventions

Response	States	Count	Percentage
Contact Pharmacy	Alaska, California, District of Columbia, Hawaii, Louisiana, Massachusetts, Nebraska, North Dakota	8	47.06%
Refer to Program Integrity for Review	Colorado, Delaware, Michigan, North Carolina, South Carolina, Virginia	6	35.29%
Other	Alabama, Kentucky, Utah	3	17.65%

Table 19 – "Other" Explanations for Follow-up Methods for Providers who routinely override with Interventions

State	"Other" Explanations
Alabama	Alabama Medicaid has an Academic Detailing program that provides scheduled face to face visits to providers.
Kentucky	Both/either - may contact pharmacy or refer to Program Integrity depending on the case.
Utah	Contact method is situationally specific.

6. Early Refill

a. At what percent do you set your system to edit?

Figure 12 - Non-Controlled Drugs Early Refill Percent Edit Threshold

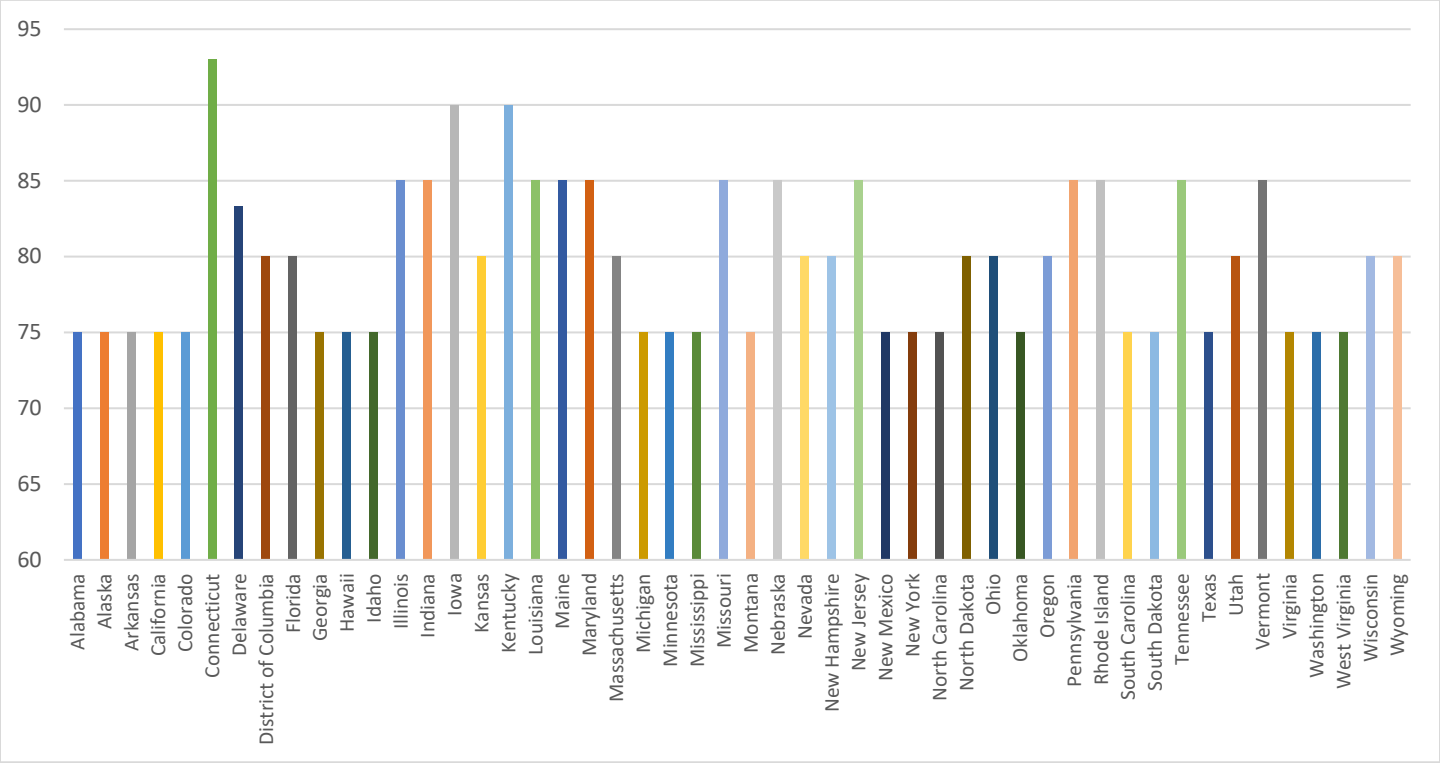

Figure 13 - Schedule II Controlled Drugs Early Refill Percent Edit Threshold

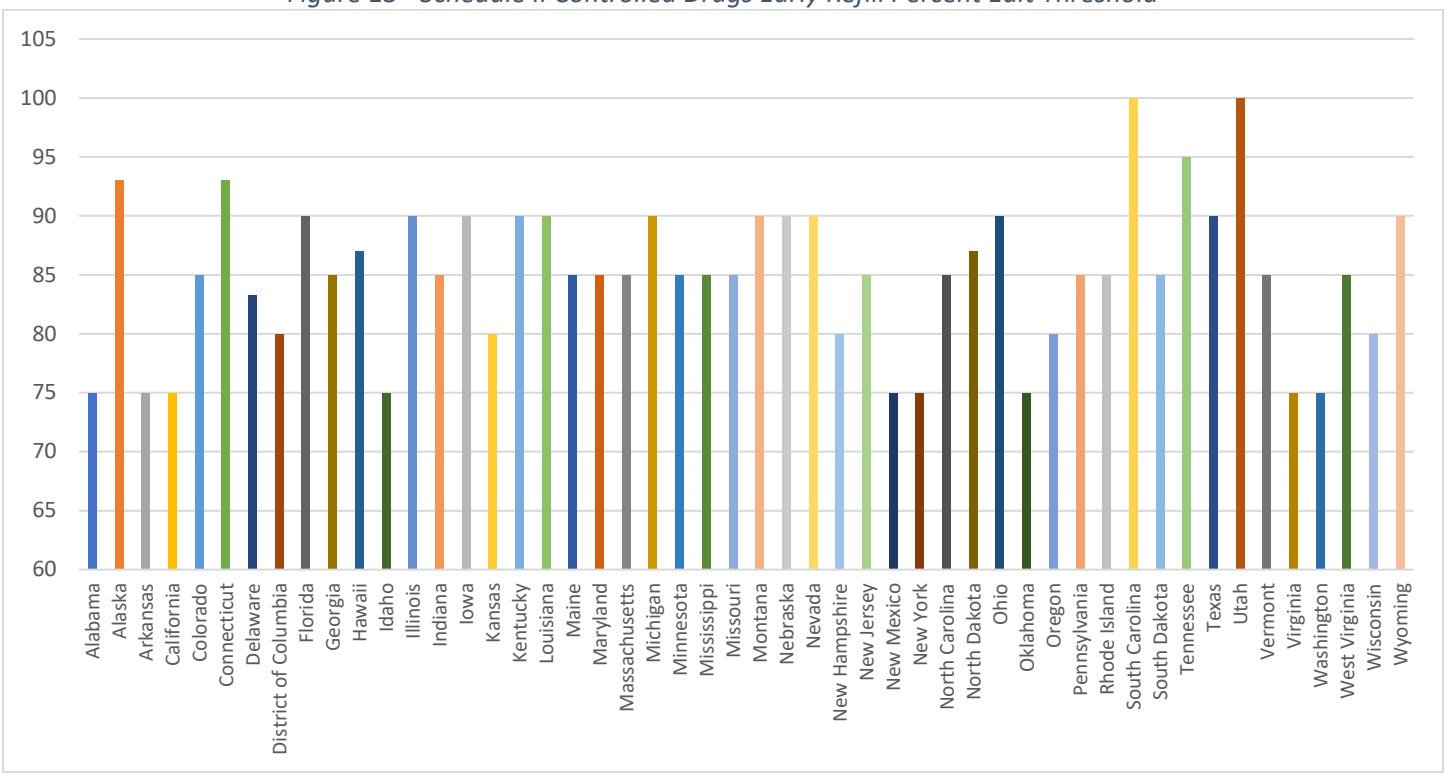

Figure 14 - Schedule III through V Controlled Drugs Early Refill Percent Edit Threshold

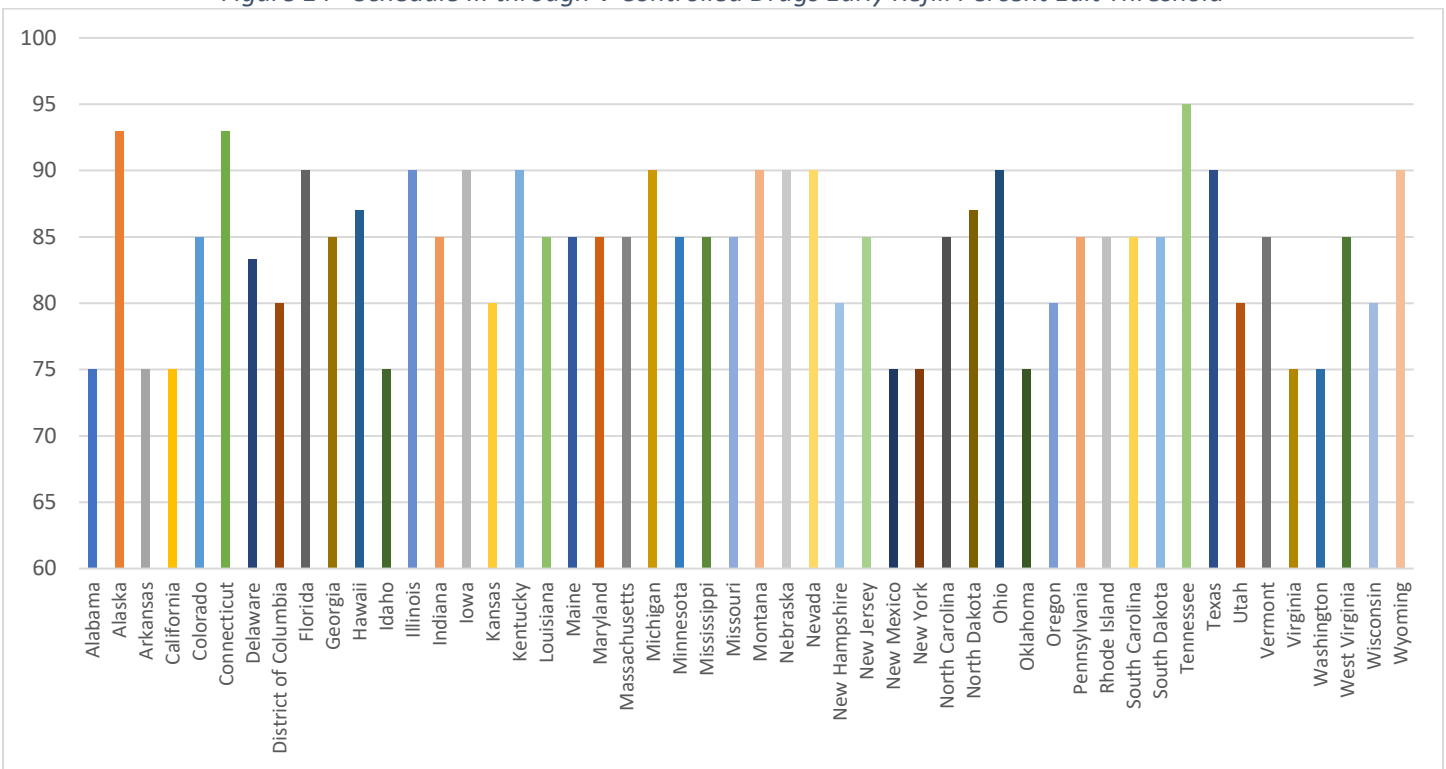

Table 20 - Early Refill Percent Threshold

State	Non-controlled Drugs	Schedule II Controlled Drugs	Schedule III through V Controlled Drugs
Alabama	75.00%	75.00%	75.00%
Alaska	75.00%	93.00%	93.00%
Arkansas	75.00%	75.00%	75.00%
California	75.00%	75.00%	75.00%
Colorado	75.00%	85.00%	85.00%
Connecticut	93.00%	93.00%	93.00%
Delaware	83.30%	83.30%	83.30%
District of Columbia	80.00%	80.00%	80.00%
Florida	80.00%	90.00%	90.00%
Georgia	75.00%	85.00%	85.00%
Hawaii	75.00%	87.00%	87.00%
Idaho	75.00%	75.00%	75.00%
Illinois	85.00%	90.00%	90.00%
Indiana	85.00%	85.00%	85.00%
Iowa	90.00%	90.00%	90.00%
Kansas	80.00%	80.00%	80.00%
Kentucky	90.00%	90.00%	90.00%
Louisiana	85.00%	90.00%	85.00%
Maine	85.00%	85.00%	85.00%
Maryland	85.00%	85.00%	85.00%
Massachusetts	80.00%	85.00%	85.00%
Michigan	75.00%	90.00%	90.00%
Minnesota	75.00%	85.00%	85.00%
Mississippi	75.00%	85.00%	85.00%
Missouri	85.00%	85.00%	85.00%
Montana	75.00%	90.00%	90.00%
Nebraska	85.00%	90.00%	90.00%
Nevada	80.00%	90.00%	90.00%
New Hampshire	80.00%	80.00%	80.00%
New Jersey	85.00%	85.00%	85.00%
New Mexico	75.00%	75.00%	75.00%
New York	75.00%	75.00%	75.00%
North Carolina	75.00%	85.00%	85.00%
North Dakota	80.00%	87.00%	87.00%
Ohio	80.00%	90.00%	90.00%
Oklahoma	75.00%	75.00%	75.00%
Oregon	80.00%	80.00%	80.00%
Pennsylvania	85.00%	85.00%	85.00%
Rhode Island	85.00%	85.00%	85.00%
South Carolina	75.00%	100.00%	85.00%
South Dakota	75.00%	85.00%	85.00%
Tennessee	85.00%	95.00%	95.00%
Texas	75.00%	90.00%	90.00%
Utah	80.00%	100.00%	80.00%
Vermont	85.00%	85.00%	85.00%

State	Non-controlled Drugs	Schedule II Controlled Drugs	Schedule III through V Controlled Drugs
Virginia	75.00%	75.00%	75.00%
Washington	75.00%	75.00%	75.00%
West Virginia	75.00%	85.00%	85.00%
Wisconsin	80.00%	80.00%	80.00%
Wyoming	80.00%	90.00%	90.00%
Average	**79.73%**	**85.07%**	**84.27%**

b. For non-controlled drugs, when an early refill message occurs, does the state require prior authorization?

Figure 15 -Non-Controlled Drugs, Early Refill Requirement for Prior Authorization

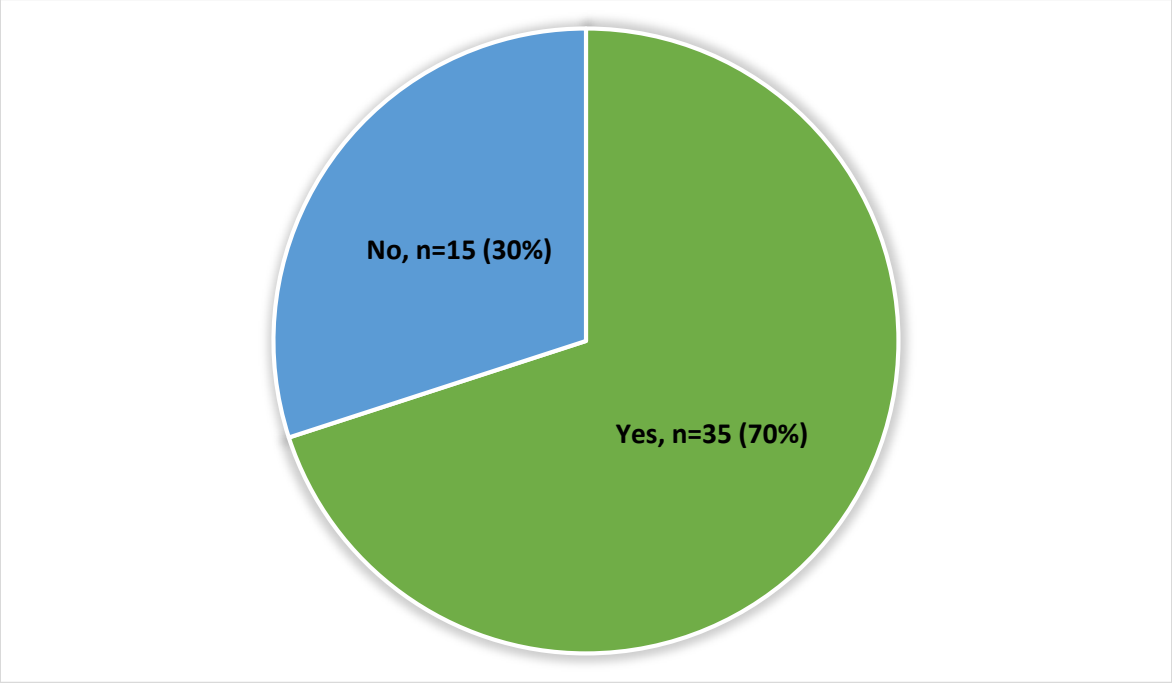

Table 21 -Non-Controlled Drugs, Early Refill Requirement for Prior Authorization

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nevada, New Mexico, New York, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	35	70.00%
No	California, Iowa, Kansas, Louisiana, Michigan, Nebraska, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oregon, Rhode Island, South Dakota, Wisconsin	15	30.00%

i. If "Yes", who obtains authorization?

Figure 16 - Non-Controlled Drugs Early Refill Authorization Sources

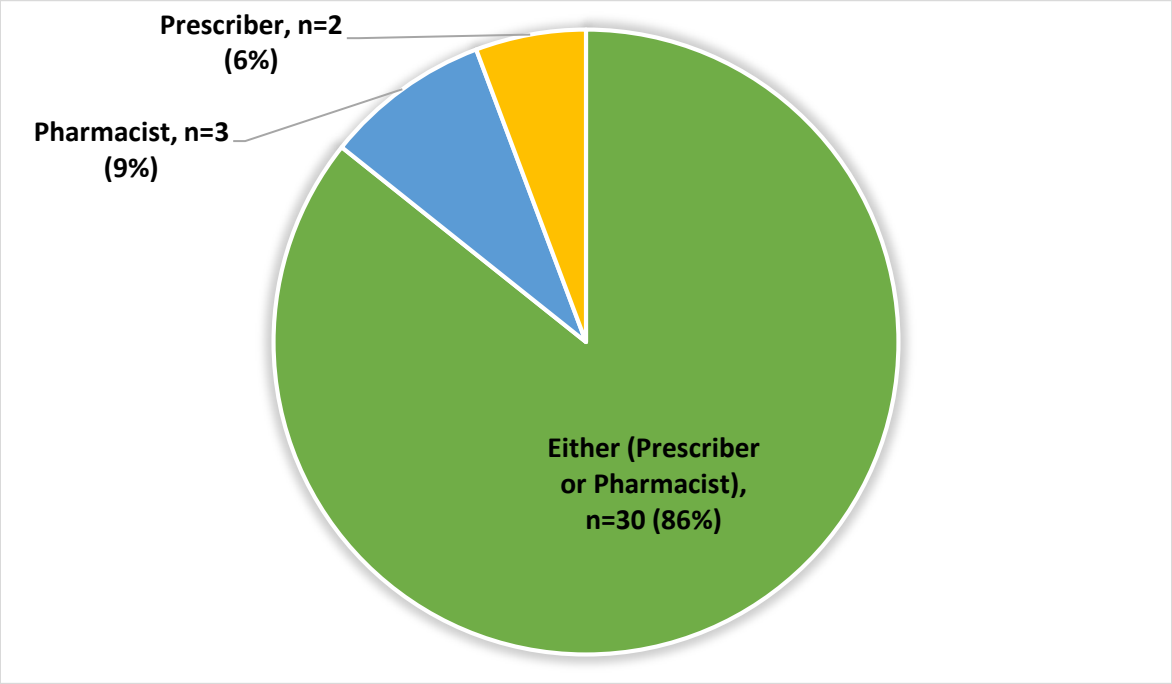

Table 22 - Non-Controlled Drugs Early Refill Authorization Sources

Response	States	Count	Percentage
Either (Prescriber or Pharmacist)	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nevada, New Mexico, Pennsylvania, South Carolina, Tennessee, Utah, Vermont, Virginia, West Virginia, Wyoming	30	85.71%
Pharmacist	Oklahoma, Texas, Washington	3	8.57%
Prescriber	Idaho, New York	2	5.71%

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

Figure 17 - Non-Controlled Drugs: Pharmacist Override at Point of Service

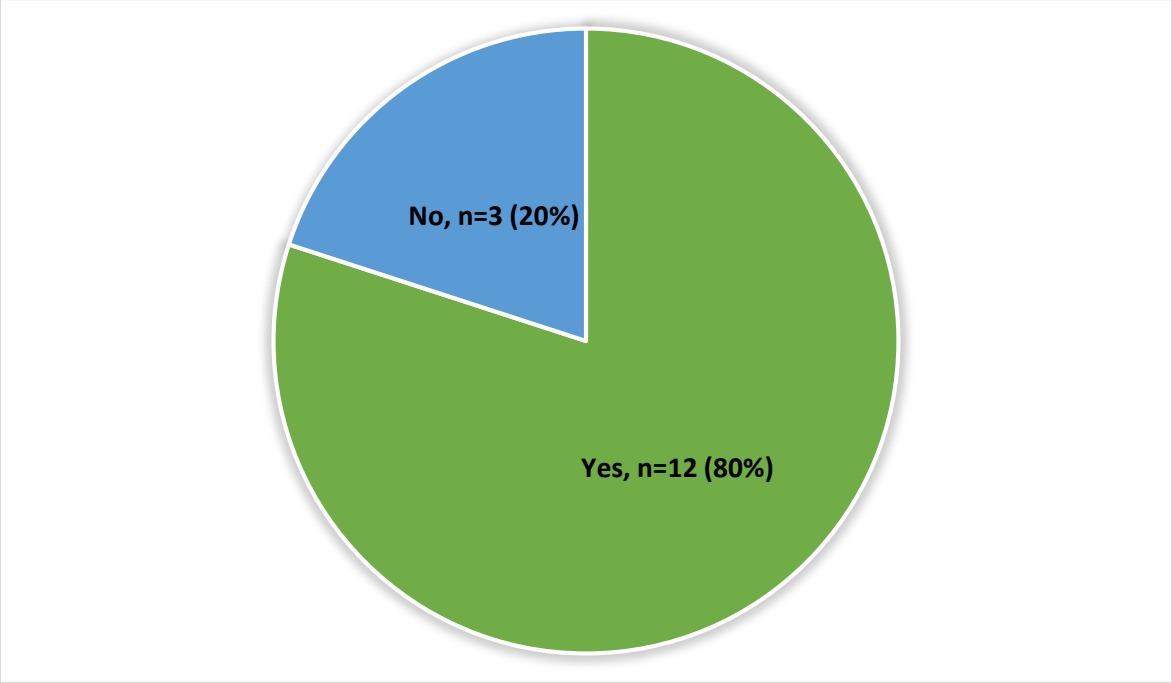

Table 23 - Non-Controlled Drugs: Pharmacist Override at Point of Service

Response	States	Count	Percentage
Yes	California, Kansas, Louisiana, Michigan, Nebraska, North Carolina, North Dakota, Ohio, Oregon, Rhode Island, South Dakota, Wisconsin	12	80.00%
No	Iowa, New Hampshire, New Jersey	3	20.00%

c. For controlled drugs, when an early refill message occurs, does the state require prior authorization?

Figure 18 - For Controlled Drugs, Early Refill Requirement for Prior Authorization

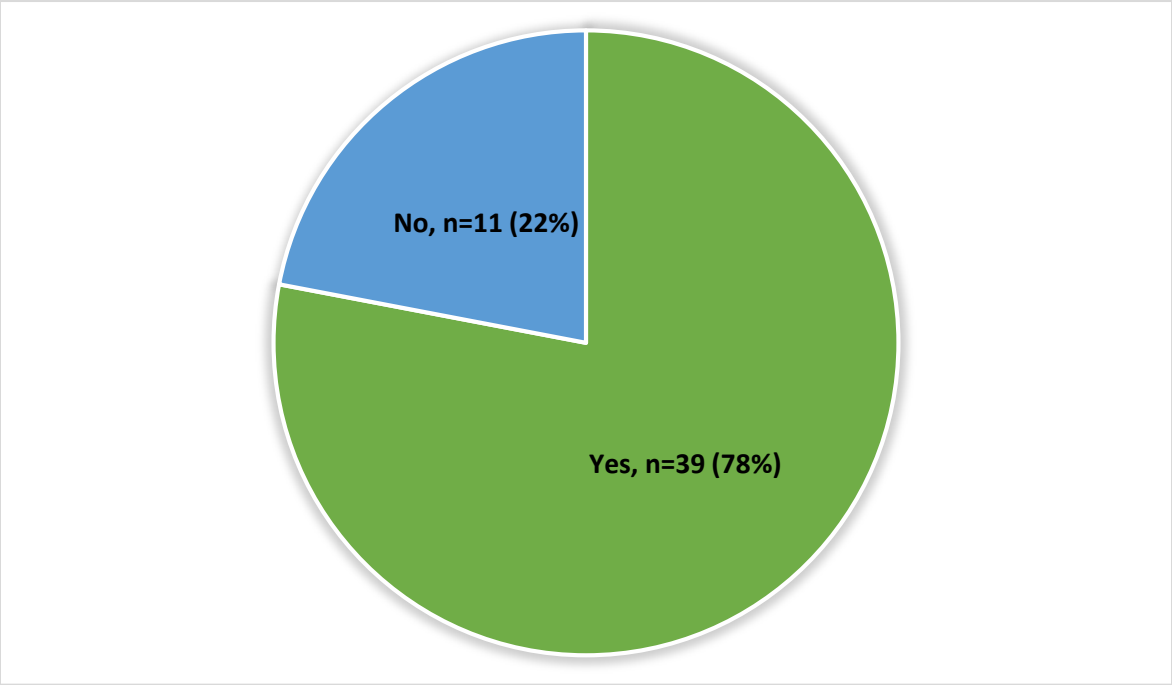

Table 24 - For Controlled Drugs, Early Refill Requirement for Prior Authorization

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, New York, North Dakota, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	39	78.00%
No	California, Iowa, Kansas, Louisiana, New Hampshire, New Jersey, North Carolina, Ohio, Oregon, Rhode Island, South Dakota	11	22.00%

i. If "Yes", who obtains authorization?

Figure 19 - Controlled Drugs Early Refill Authorization Source

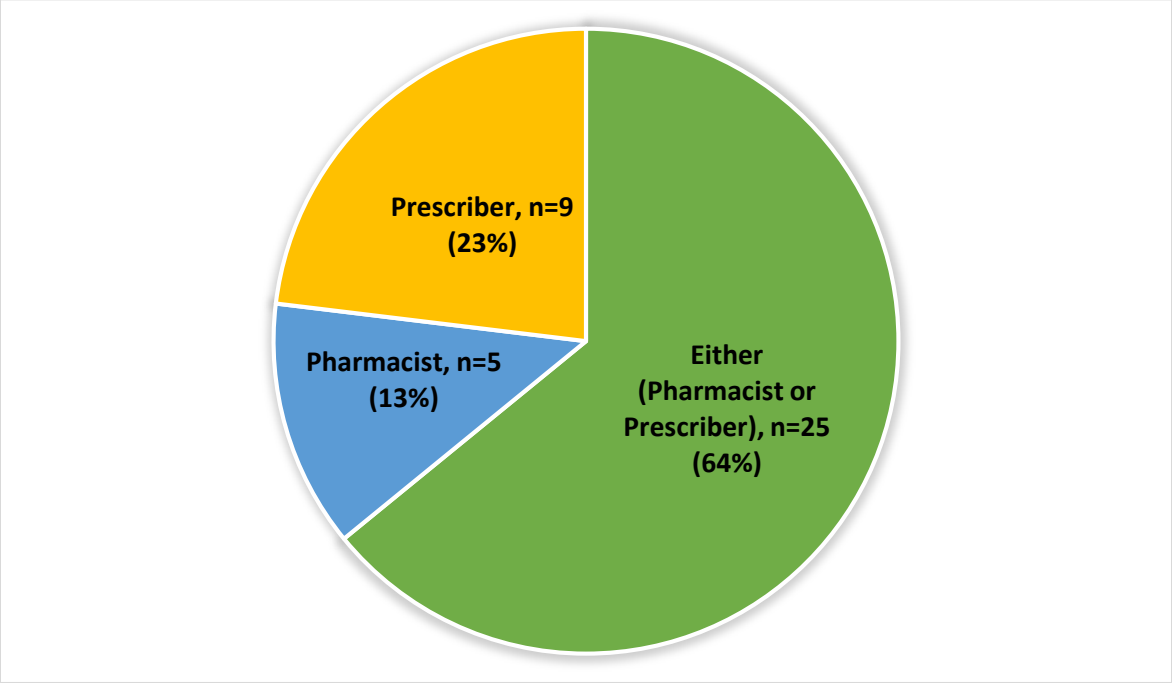

Table 25 - Controlled Drugs Early Refill Authorization Source

Response	States	Count	Percentage
Either (Pharmacist or Prescriber)	Alabama, Alaska, Arkansas, Colorado, Delaware, District of Columbia, Georgia, Illinois, Maine, Maryland, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Mexico, North Dakota, South Carolina, Tennessee, Utah, Vermont, Virginia, West Virginia, Wyoming	25	64.10%
Pharmacist	Massachusetts, Oklahoma, Texas, Washington, Wisconsin	5	12.82%
Prescriber	Connecticut, Florida, Hawaii, Idaho, Indiana, Kentucky, Missouri, New York, Pennsylvania	9	23.08%

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

Figure 20 - Controlled Drugs: Pharmacist Override at Point of Service

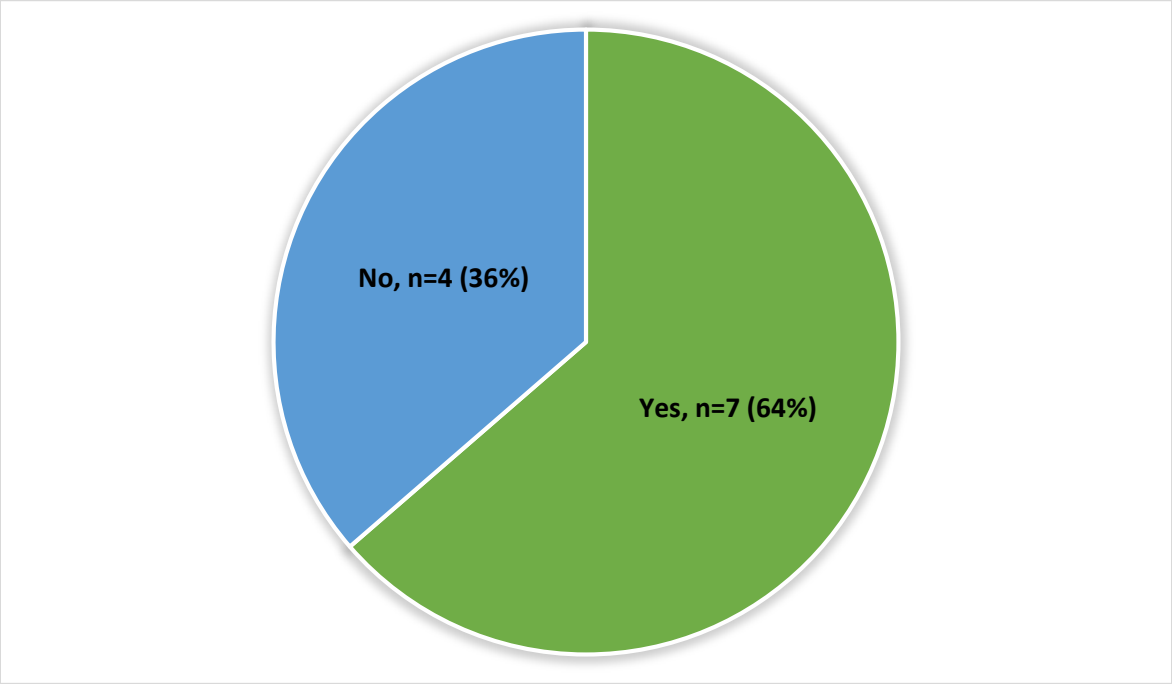

Table 26 - Controlled Drugs: Pharmacist Override at Point of Service

Response	States	Count	Percentage
Yes	California, Kansas, Louisiana, North Carolina, Oregon, Rhode Island, South Dakota	7	63.64%
No	Iowa, New Hampshire, New Jersey, Ohio	4	36.36%

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

Figure 21 - Situations the State Allows for Pharmacist Overrides for an Early Refill DUR Alert Message

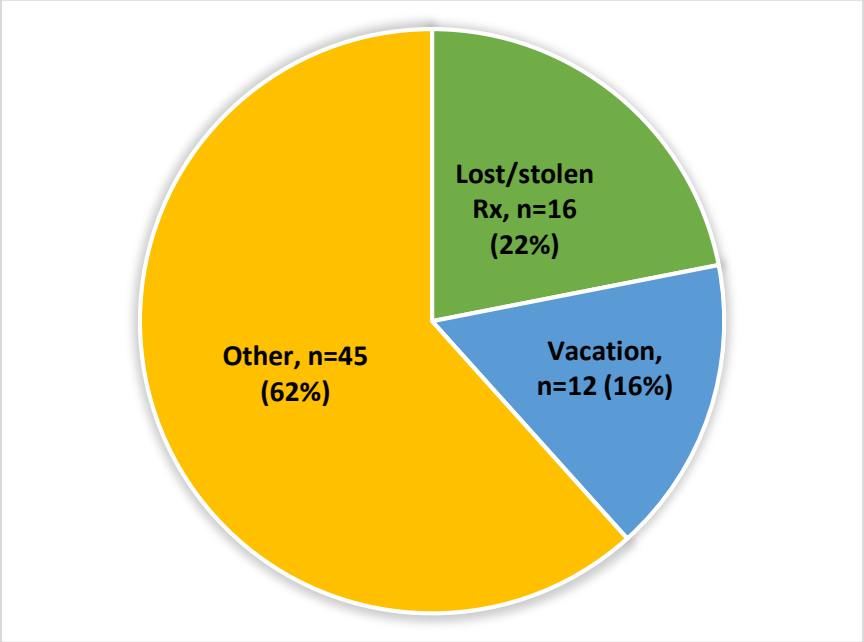

Table 27 - Situations the State Allows for Pharmacist Overrides for an Early Refill DUR Alert Message

Response	States	Count	Percentage
Lost/stolen Rx	California, Hawaii, Louisiana, Maryland, Massachusetts, Nebraska, New Hampshire, New Mexico, North Carolina, Oregon, Rhode Island, South Dakota, Texas, Virginia, Washington, Wisconsin	16	21.92%
Vacation	California, Louisiana, Maryland, Massachusetts, Nebraska, New Hampshire, New Mexico, North Carolina, Oregon, Texas, Virginia, Wisconsin	12	16.44%
Other	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin, Wyoming	45	61.64%

Other, please explain

Table 28 - "Other" Explanations for State Pharmacist Override Situations

State	"Other" Explanations
Alabama	We do not allow pharmacists to override early refill DUR alert messages.

State	"Other" Explanations
Alaska	Lost/stolen Rx only in the event a police report has been filled and upon coordination / approval of the prescriber.
Arkansas	Arkansas Medicaid Pharmacy Program does not allow dispensing pharmacists to override an early refill DUR message even for lost/stolen RXs and Vacation. Early refill requests must be reviewed by the state with a prior authorization request.
California	The pharmacist can override the early refill DUR alert message if medically necessary.
Colorado	Pharmacist override at POS is not allowed for these circumstances, but the pharmacist may contact the pharmacy call center help desk for authorization to override the edit.
Connecticut	A PA is required to override lost/stolen or vacation override requests.
Delaware	Pharmacist can request override for change in directions with a prior authorization
District of Columbia	Pharmacists are allowed to override early refill edit due to dose adjustments
Florida	Lost/stolen Rx and Vacation overrides are not allowed.
Georgia	Pharmacists not allowed to override early refill
Hawaii	dosage change, additional therapy authorized, readmit to a long term care facility, or discharged from hospital without medication
Idaho	For change in dose only.
Illinois	We do not allow pharmacist overrides for lost/stolen Rx or vacation. Prior authorization required for refill-too-soon for these situations.
Indiana	Pharmacist is not permitted to override
Iowa	Pharmacists are not able to do any override at the point of sale (POS). Any lost/stolen rx or vacation overrides are handled through a call to the POS help desk where the technician can provide an override it appropriate.
Kansas	Spilled medications, therapy change.
Kentucky	None apply.
Louisiana	Other situations may be overridden using the pharmacist's professional judgment.
Maine	Nursing home admissions
Michigan	Early refill DUR alerts are not allowed to be overridden.
Minnesota	MN does not allow an override without a PA.
Mississippi	The pharmacist is not allowed to override for any of the above situations.
Missouri	MO allows for override for both lost/stolen Rx and for vacation however it does require the provider to contact the help desk for prior authorization.
Montana	We do not allow the pharmacist to override an early refill DUR message for any reason. However, that was not an option for this question.
Nebraska	Lost or stolen controlled substance prescriptions require a prior authorization.
Nevada	Pharmacists are not currently allowed to override for these types of situations.
New Hampshire	NH allows for other early refill reasons such as increased/variable dose, transitioning to facility, school/daycare supply and destroyed medications. Pharmacists must call the technical call center to request an override.
New Jersey	Prospective DUR alerts cannot be overridden by the pharmacy provider.
New Mexico	The pharmacy must contact the State of New Mexico staff or Conduent Help Desk for approval prior to overriding.
New York	Pharmacist is not allowed to override.
North Carolina	Other=Change of therapy. Cannot override controlled drugs for early refill for lost/stolen or vacation. Therapy change is the only valid reason for overriding an early refill alert for controlled substances.
North Dakota	We do not allow them to override any of these.

State	"Other" Explanations
Ohio	The pharmacist must call Change Healthcare for an override
Oklahoma	Pharmacists cannot override for early refill.
Oregon	As long as they enter a valid Submission Clarification Code and the appropriate intervention and outcome codes, they can use whichever ones apply to the situation. We do not limit which ones can be used.
Pennsylvania	No. A pharmacist must call for a prior authorization.
South Carolina	Therapeutic duplication, titration dosing, DDI (severity level one)
Tennessee	All lost/stolen/vacation supply early refills must be called in by pharmacy to the PBM's call center, and the State makes a decision for each request.
Texas	For any early refill reasons, the state requires a phone call from dispensing pharmacy. It requires an HHSC clinical staff to review and, if necessary, reach out to the prescribing provider for a reasonable explanation.
Utah	Pharmacies may place a 72 hour override on a pharmacy claim for emergency situations.
Vermont	The Pharmacist cannot override the DUR alert without first contacting the Pharmacy Helpdesk. If appropriate then an override may be applied.
Washington	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
West Virginia	The retail pharmacist cannot override the early refill edit
Wisconsin	Wisconsin allows for a dosage change, natural disaster and when the member misunderstood directions from the prescriber.
Wyoming	Pharmacists are not allowed to override refill too soon for any reason.

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

Figure 22 - System Accumulation Edit for Prevention of Early Prescription Filling

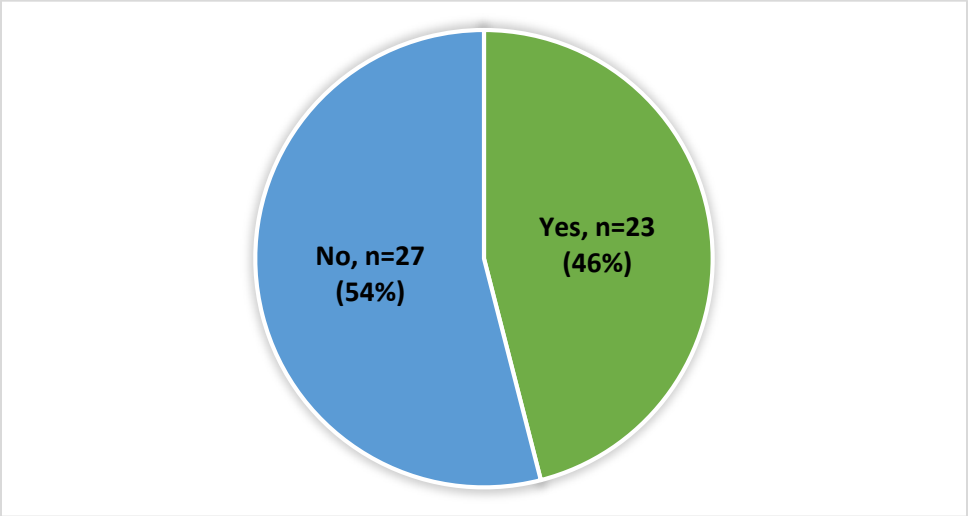

Table 29 - System Accumulation Edit for Prevention of Early Prescription Filling

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine,	23	46.00%

Response	States	Count	Percentage
	Michigan, New Mexico, New York, North Dakota, Oklahoma, Rhode Island, South Carolina, Virginia, West Virginia, Wyoming		
No	California, Connecticut, District of Columbia, Hawaii, Iowa, Kansas, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, North Carolina, Ohio, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Utah, Vermont, Washington, Wisconsin	27	54.00%

If "Yes", please explain your edit

Table 30 - Explanations for System Accumulation Edit for Prevention of Early Prescription Filling

State	Explanations
Alabama	Claims that exceed, or result in, the accumulation of more than 7 days' worth of medication in a 120-day time period will deny at the point-of-sale (POS).
Alaska	Allow for a 7 day accumulation over a 120 day look back for control medications and a 21 day accumulation over 120 days for non-control medications filled for 90 day supply.
Arkansas	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
Colorado	A cumulative twenty days are allowed over a 180 day period.
Delaware	If the accumulative refills are greater than 4 in a 120 day time period, post the audit. Early refill date: From date of service plus (days' supply *.83)
Florida	Certain classes have accumulation edits (proton pump inhibitors, skeletal muscle relaxants, controlled substances). The edit counts refills over a particular time frame to prohibit a total accumulation amount.
Georgia	Refill-too-soon edit, which allows patients to only obtain next fill if 75% of previous fill would be completed by that time.
Idaho	The pharmacy claims system is set to look at a maximum quantity per day as well as a rolling accumulation edit to not allow for early refill.
Illinois	Refill too soon edit where early refill days accumulate from month to month and refill tolerance must be met based on day supply on hand
Indiana	The claims processing system will evaluate the days' supply for historical claims against the days' supply of new claims. If the new claim's daily dose has increased, the system will calculate the next date of fill automatically based on remaining supply. If the new daily dose has not increased, the system will calculate the next date of fill based on the remaining supply from all historical claims.
Kentucky	Kentucky allows a three (3) day tolerance per month.
Louisiana	We have accumulation edits on proton pump inhibitors. The edit requires clinical override from our prior authorization center.
Maine	On controlled substances we accumulate days' supply until reaching 7 days of additional quantity then a hard stop is in place for prior authorization.
Michigan	Michigan has refill tolerance and dispensing fee accumulation edits to prevent patients from continuously filling prescriptions early.
New Mexico	An exception code posts to the pharmacy indicating the date when the medication can be filled.
New York	Schedule II-V no more than a 7 day excess supply calculated over the previous 90 days; Non-Controlled drug, no more than a 10-day excess supply calculated over the previous 90 days.

State	Explanations
North Dakota	Up to 15 days of accumulation allowed in 180 days for non-controlled medications (10 days of accumulation for controlled).
Oklahoma	We have this for stimulants only. Cumulative early refill when the member received an early fill in the past 240 days and the combined extra days' supply is 110% of the days' supply on the new day claim being submitted.
Rhode Island	State only allows one original RX and five refills per prescription.
South Carolina	75% of fill required non control; 85% for control
Virginia	If the patient accumulates more than 15 days early in a 183 day period the claim will deny.
West Virginia	The edit keeps members from getting a thirteen month supply in 12 months by not allowing them to refill their prescriptions early each month, based on the total number of units obtained during a rolling 12-month period.
Wyoming	For each claim that is filled, the number of days that the claim is filled early will be added to the day supply submitted on the claim, and the refill tolerance will be calculated on that accumulated total.

If “No”, do you plan to implement this edit?

Figure 23 - Plans to Implement a System Accumulation Edit

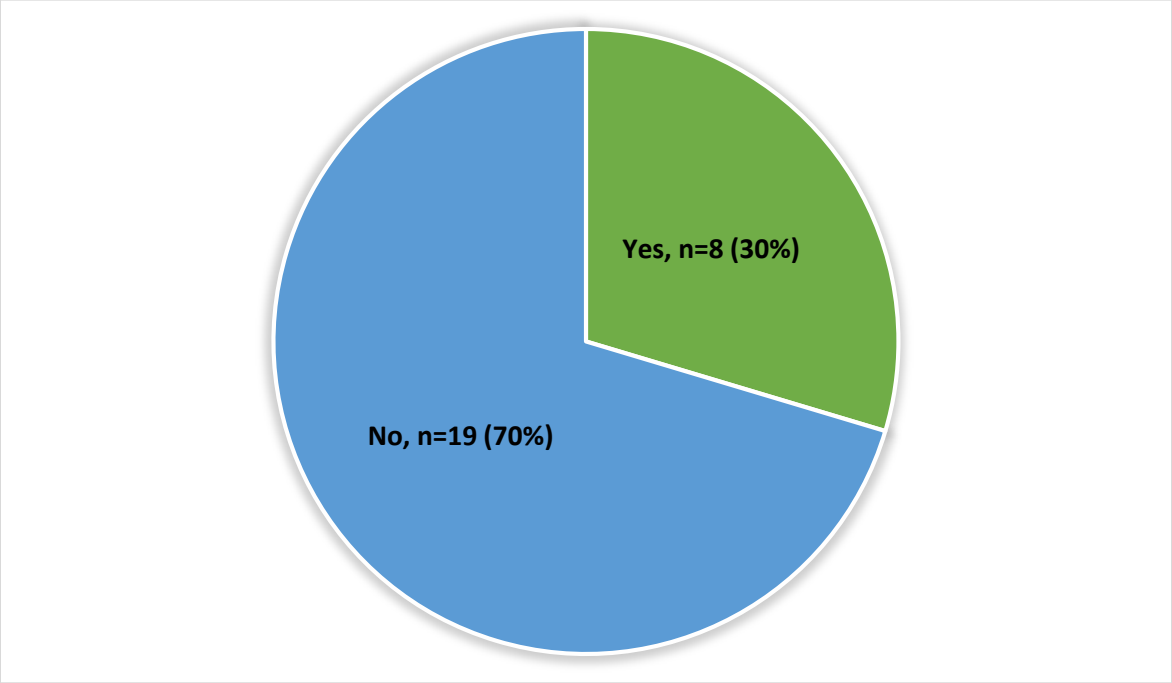

Table 31 - Plans to Implement a System Accumulation Edit

Response	States	Count	Percentage
Yes	District of Columbia, Maryland, Massachusetts, Mississippi, Montana, North Carolina, South Dakota, Vermont	8	29.63%
No	California, Connecticut, Hawaii, Iowa, Kansas, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, New Jersey,	19	70.37%

Response	States	Count	Percentage
	Ohio, Oregon, Pennsylvania, Tennessee, Texas, Utah, Washington, Wisconsin		

9. Does the state Medicaid agency or the state's Board of Pharmacy have any policy prohibiting the auto-refill process that occurs at the POS (i.e. must obtain beneficiary's consent prior to enrolling in the auto-refill program)?

Figure 24 - State Auto-Refill Policy Prohibiting Auto Refill

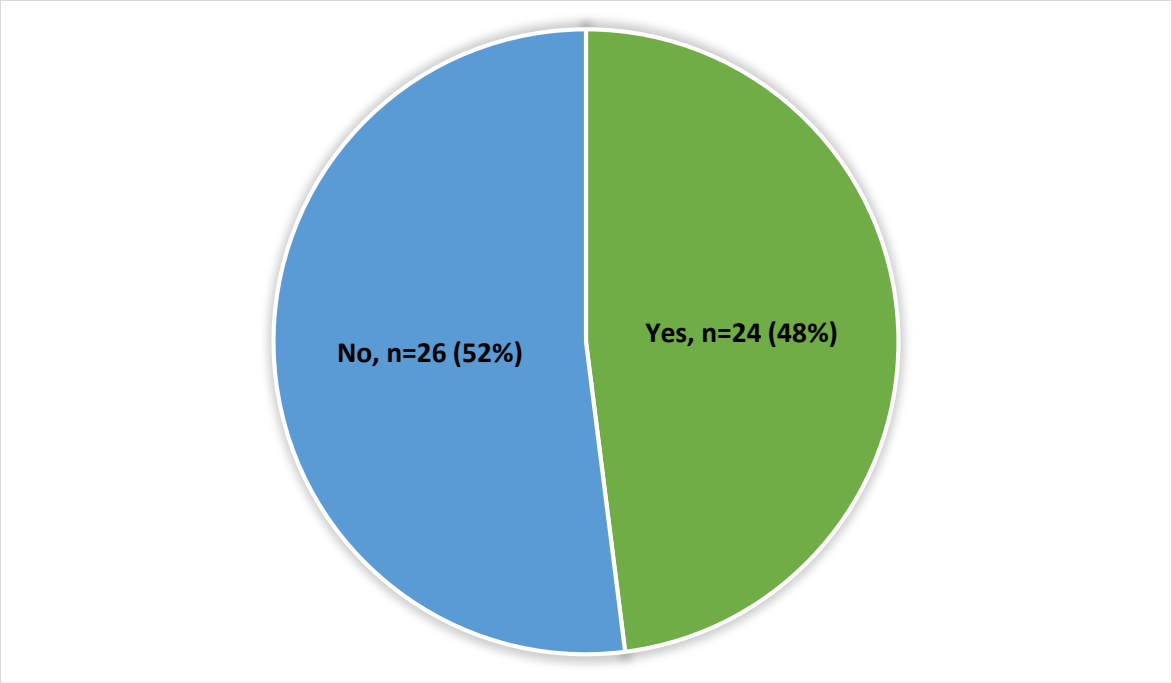

Table 32 - State Auto-Refill Policy Prohibiting Auto Refill

Response	States	Count	Percentage
Yes	Alabama, Delaware, Florida, Georgia, Illinois, Maryland, Massachusetts, Minnesota, Mississippi, Nebraska, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wyoming	24	48.00%
No	Alaska, Arkansas, California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Missouri, Montana, Nevada, New Hampshire, New Jersey, Ohio, Pennsylvania, Rhode Island, Vermont, Washington, Wisconsin	26	52.00%

10. Does the state Medicaid agency have any policy that requires for the synchronization of prescription refills (i.e. if the patients want and pharmacy provider permits the patients to obtain non-controlled, chronic medication refills at the same time, the state would allow this to occur to prevent the beneficiary from making multiple trips to the pharmacy within the same month)?

Figure 25 - State Policy for Synchronization of Prescription Refills

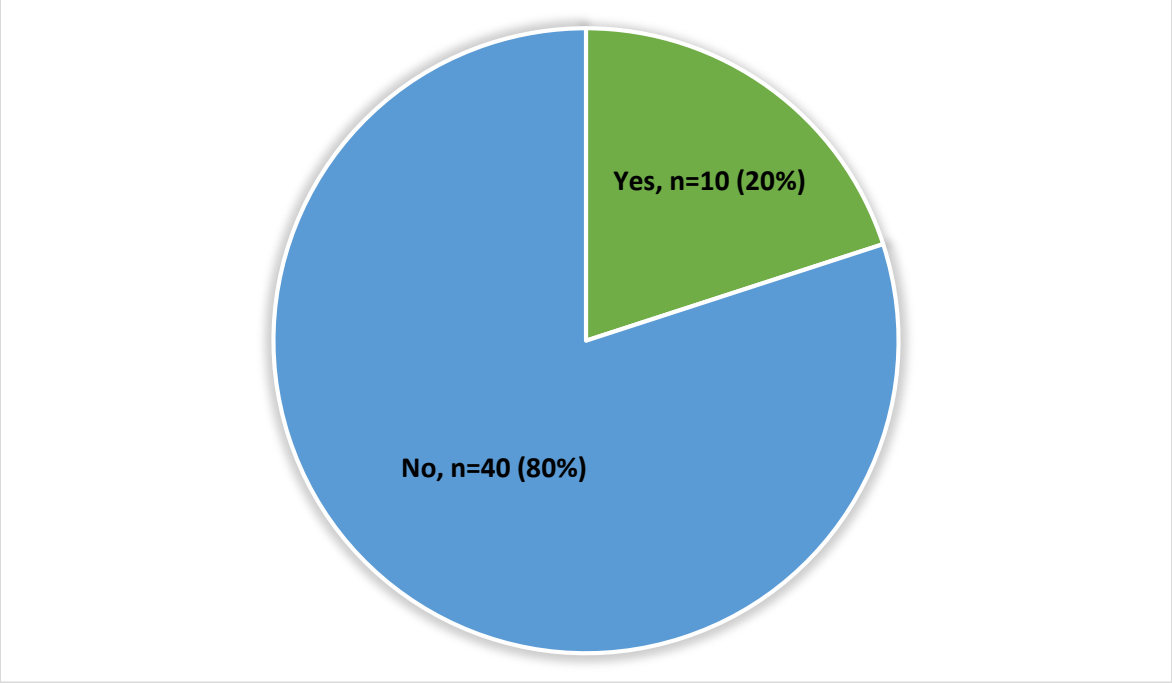

Table 33 - State Policy for Synchronization of Prescription Refills

Response	States	Count	Percentage
Yes	Kentucky, Michigan, New Hampshire, North Dakota, Ohio, Oregon, South Carolina, Texas, Virginia, Washington	10	20.00%
No	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Tennessee, Utah, Vermont, West Virginia, Wisconsin, Wyoming	40	80.00%

11. Please list the requested data in each category in Table 1 – Top Drug Claims Data Reviewed by the DUR Board in the table below:

*Table 34 - Top Drug Claims Data Reviewed by the DUR Board**

Top 10 Prior Authorization (PA) Requests by Drug Name	Top 10 Prior Authorization (PA) Request by Drug Class	Top 5 Claim Denial Reasons Other than Eligibility	Top 10 Drug Names by Amount Paid	Top 10 Drug Names by Claim Count
Methylphenidate	Opioids	Prior Authorization Required	Mavyret	Ibuprofen
Hydrocodone - Acetaminophen	Antipsychotics	Refill Too Soon	Aripiprazole	Albuterol
Aripiprazole	Adhd Agents/stimulants	Therapeutic Duplication	Lurasidone	Gabapentin
Quetiapine	Anticonvulsants	Claim Requires An Approved Treatment Authorization Request (tar)	Paliperidone	Amoxicillin
Risperdone	Antidepressants	Drug-drug Interaction	Humira	Cetirizine
Oxycodone - Acetaminophen	Inhaled Steroids/bronchodilators/respiratory Agents		Vyvanse	Hydrocodone - Acetaminophen
Omeprazole	Opioid Dependence Treatment Agents		Latuda	Quetiapine
Buprenorphine	Antidiabetic Agents		Methylphenidate	Fluticasone
Suboxone	Proton Pump Inhibitors		Epclusa	Proair
Dextroamphetamine/ amphetamine	Anticoagulants		Suboxone	Sertraline

* This table has been developed and formulated using weighted averages to reflect the relative beneficiary size of each reporting State.

12. Section 1927(g)(A) of the Social Security Act requires that the pharmacists offer patients counseling at the time of dispensing. Who in your state has responsibilities for monitoring compliance with the oral counseling requirements? Check all that apply:

Figure 26 - Oral Counseling Requirements

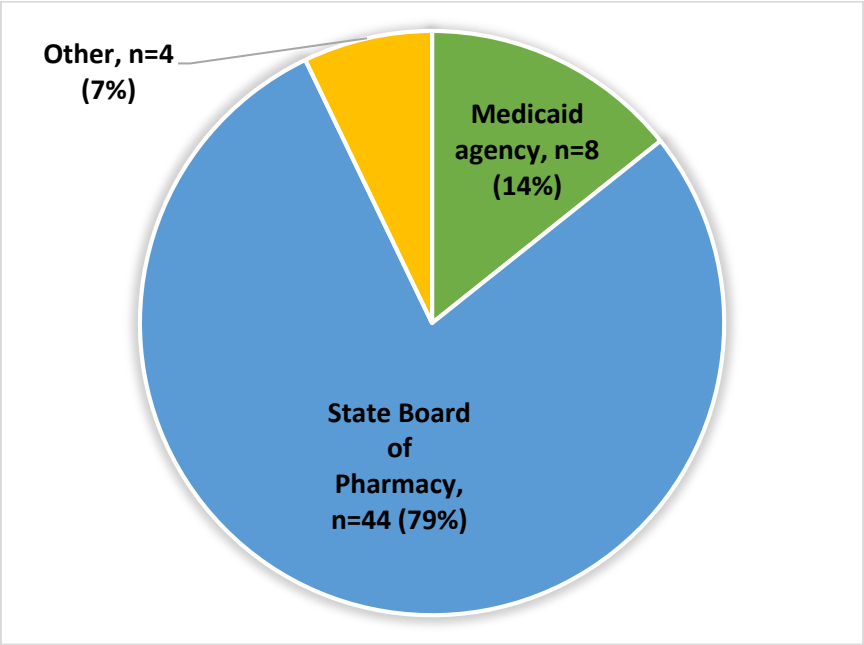

Table 35 - Oral Counseling Requirements

Response	States	Count	Percentage
Medicaid agency	Alaska, Colorado, Connecticut, Florida, Hawaii, Kansas, Michigan, South Carolina	8	14.29%
State Board of Pharmacy	Alabama, Alaska, Arkansas, California, Delaware, District of Columbia, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	44	78.57%
Other	Illinois, Missouri, New York, Utah	4	7.14%

Other, please explain

Table 36 - "Other" Explanations for Oral Counseling Requirements

State	"Other" Explanations
Illinois	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.
Missouri	The Missouri Medicaid Audit and Compliance Unit monitors compliance with the oral counseling requirement.
New York	Other - Onsite pharmacy inspectors as performed by the Office of Professional Discipline.

State	"Other" Explanations
Utah	The Utah State Board of Pharmacy, under the direction of the Department of Commerce Division of Occupational and Professional Licensing, is responsible for administering and enforcing all aspects of the State Pharmacy Practice Act, which has a provision mandating patient counseling on prescription drugs. Please see: Utah Code 58-17b-613. Patient counseling and Utah Administrative Code. R156-17b-610. Operating Standards "Patient Counseling.

13. Pharmacy Oral Counseling Compliance Report*

States have the option of reporting on monitoring of pharmacy compliance with all prospective DUR requirements performed by the State Medicaid Agency, the State Board of Pharmacy, or other entity responsible for monitoring pharmacy activities. If the State Medicaid Agency itself monitors compliance with these requirements, it may provide a survey of a random sample of pharmacies with regard to compliance with the Omnibus Budget Reduction Act (OBRA) of 1990 prospective DUR requirement. This report details state efforts to monitor pharmacy compliance with the oral counseling requirement. This report should describe in detail the monitoring efforts that were performed and how effective these efforts were in the fiscal year reported.

**This information is located in Attachment 1 in individual state specific DUR FFS Report. This attachment can be requested by contacting CMSDUR@cms.hhs.gov*

Figure 27 – Number of States Submitting Pharmacy Oral Counseling Compliance Reports

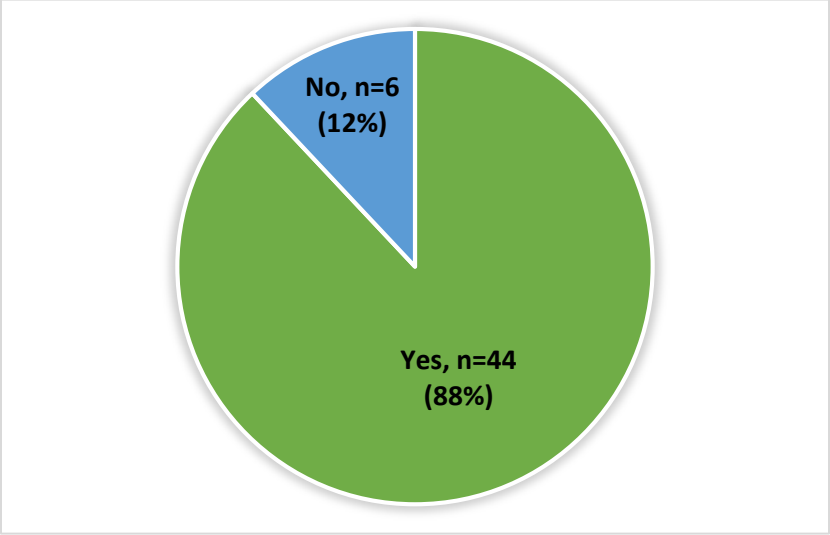

Table 37 – States Submitting Pharmacy Oral Counseling Compliance Reports

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Montana,	44	88.00%

Response	States	Count	Percentage
	Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wyoming		
No	Massachusetts, Missouri, New Jersey, Pennsylvania, Utah, Wisconsin	6	12.00%

Section III - Retrospective DUR

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

Figure 28 – Vendor Performing RetroDUR Activities

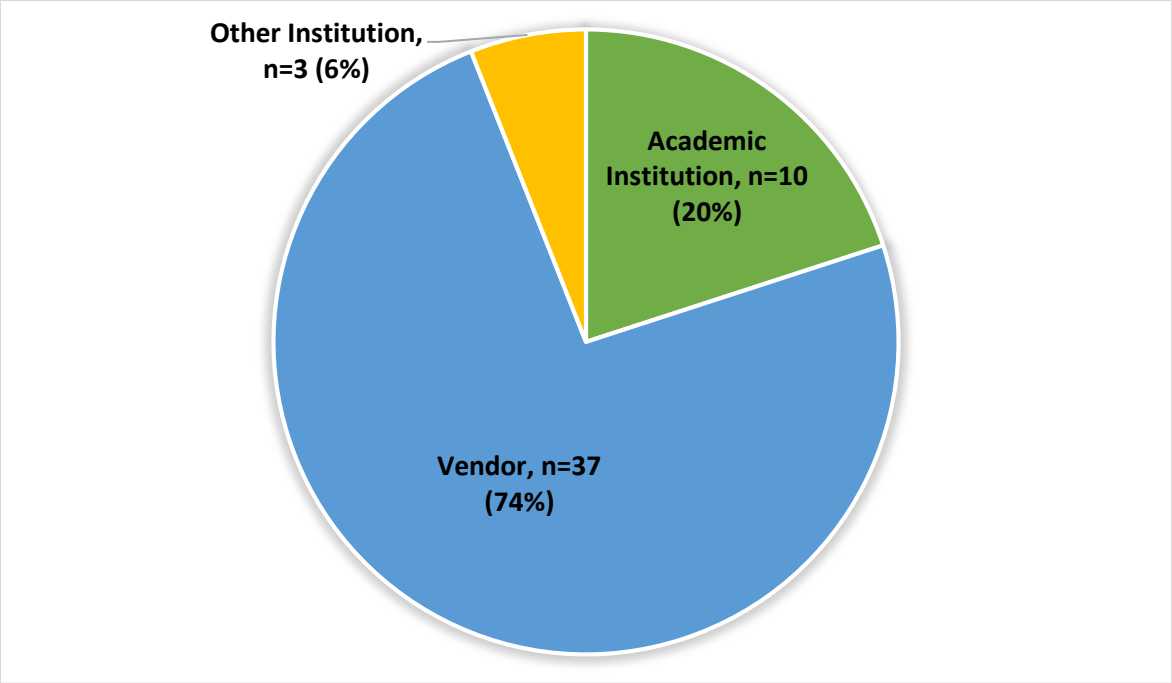

Table 38 - Vendor Performing RetroDUR Activities

Response	States	Count	Percentage
Academic Institution	California, Colorado, Illinois, Massachusetts, Mississippi, Oklahoma, Oregon, South Carolina, Utah, Wyoming	10	20.00%
Vendor	Alabama, Alaska, Arkansas, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Missouri, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Vermont, Virginia, West Virginia, Wisconsin	37	74.00%
Other Institution	Montana, Nebraska, Washington	3	6.00%

Table 39 - Vendor Names

Response	States	Count	Percentage
Health Information Designs	Alabama, Arkansas, Connecticut, Kansas, Maryland, New York, North Dakota, South Dakota, West Virginia, Wisconsin	10	27.03%
Magellan	Alaska, Florida, Idaho, Kentucky, Michigan, New Hampshire, North Carolina, Tennessee, Virginia	9	24.32%
DXC Technology	Delaware	1	2.70%
Conduent	District of Columbia, Hawaii, Minnesota, Missouri, New Mexico, Texas	6	16.22%
NorthStar Healthcare Consulting	Georgia	1	2.70%
OptumRx	Indiana, Nevada	2	5.41%
Change Healthcare	Iowa, Maine, Ohio, Pennsylvania, Vermont	5	13.51%
Molina Medicaid Solutions	Louisiana, New Jersey	2	5.41%
Kepro	Rhode Island	1	2.70%

Table 40 - Academic/Other Institution Names

Response	State	Count
University of California, San Francisco (UCSF)	California	1
The Regents of the University of Colorado, School of Pharmacy	Colorado	1
University of Illinois College of Pharmacy	Illinois	1
University of Massachusetts Medical School	Massachusetts	1
University of Mississippi School of Pharmacy	Mississippi	1
Mountain Pacific Quality Health Foundation	Montana	1
Nebraska Pharmacists Association	Nebraska	1
University of Oklahoma College of Pharmacy	Oklahoma	1
Oregon State University, College of Pharmacy	Oregon	1
MUSC	South Carolina	1
University of Utah	Utah	1
Self-administered by the single state Medicaid agency	Washington	1
University of Wyoming, School of Pharmacy	Wyoming	1

a. Is the RetroDUR vendor also the MMIS fiscal agent?

Figure 29 – Is Vendor the State MMIS Fiscal Agent

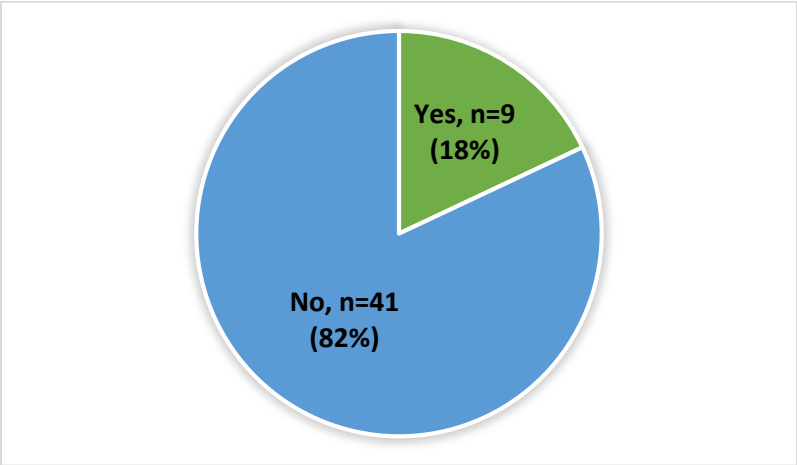

Table 41 – Is Vendor the State MMIS fiscal agent

Response	States	Count	Percentage
Yes	Arkansas, Delaware, District of Columbia, Hawaii, Louisiana, New Jersey, New Mexico, Virginia, Washington	9	18.00%
No	Alabama, Alaska, California, Colorado, Connecticut, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, West Virginia, Wisconsin, Wyoming	41	82.00%

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

Figure 30 – Is RetroDUR Vendor the Developer/Supplier of RetroDUR Criteria

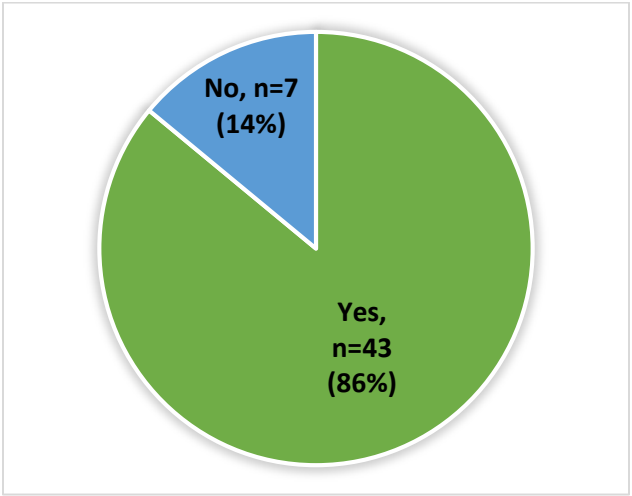

Table 42 - Is RetroDUR is Vendor the Developer/Supplier of Retrospective DUR Criteria

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	43	86.00%
No	California, Hawaii, Idaho, Louisiana, Michigan, Nebraska, Pennsylvania	7	14.00%

2. Who reviews and approves the RetroDUR criteria?

Figure 31 - RetroDUR Criteria Approval/Review Sources

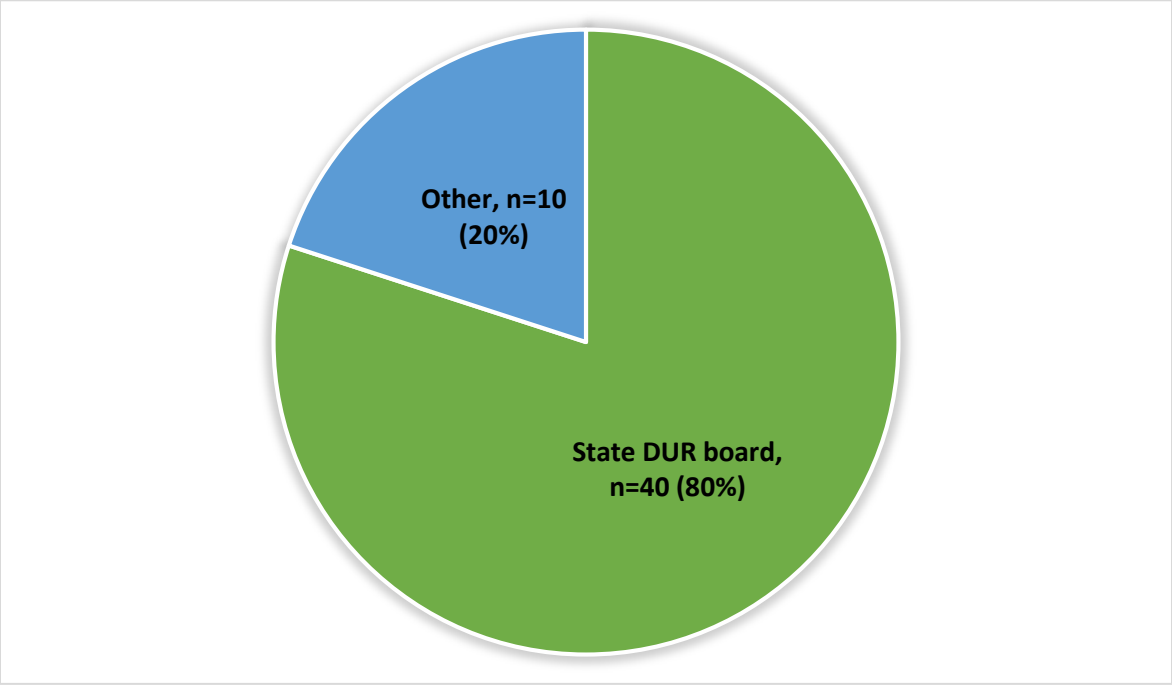

Table 43 - RetroDUR Criteria Approval/Review Sources

Response	States	Count	Percentage
State DUR board	Alabama, Alaska, Arkansas, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin	40	80.00%
Other	California, Colorado, Idaho, Illinois, Iowa, Nevada, Oklahoma, South Dakota, Utah, Wyoming	10	20.00%

Other, please explain.

Table 44 - "Other" Explanations for RetroDUR Criteria Approval/Review Sources

State	"Other" Explanations
California	Retrospective DUR criteria are developed jointly by UCSF and DHCS with input and recommendation by the DUR board. Final approval of criteria is made by DHCS.
Colorado	The State DUR Board reviews RetroDUR criteria and makes recommendations to the State. The State Department approves finalized RetroDUR criteria.
Idaho	Idaho Medicaid Pharmacy program reviews and approves RetroDUR criteria. Suggestions may come from the DUR Board.
Illinois	The State DUR Board will suggest and approve some criteria for retrospective reviews. Problem identification using PBMS RetroDUR application is based on MediSpan criteria.
Iowa	Change Healthcare utilizes MediSpan for retrospective DUR criteria involving a complex screening process.
Nevada	The DUR Board offers topics and reviews RetroDUR criteria but does not approve the letters and final initiatives. The contractor reviews and approves RetroDUR criteria.
Oklahoma	The University utilizes Medi-Span drug information applications.
South Dakota	The Drug Utilization Review Committee approves RetroDUR criteria
Utah	The University of Utah DRRC will select the RetroDUR criteria based off of contracted agreement with the State.
Wyoming	The DUR Manager creates all retrospective criteria. Retrospective projects are comparative provider reports that vary every quarter.

3. Retrospective DUR Educational Outreach Summary*

States have the option of reporting a year-end summary report on RetroDUR screening and educational interventions.

**This information is located in Attachment 2 in individual state specific DUR FFS Report. This attachment can be requested by contacting CMSDUR@cms.hhs.gov*

Figure 32 – Number of States Submitting RetroDUR Educational Outreach Summaries

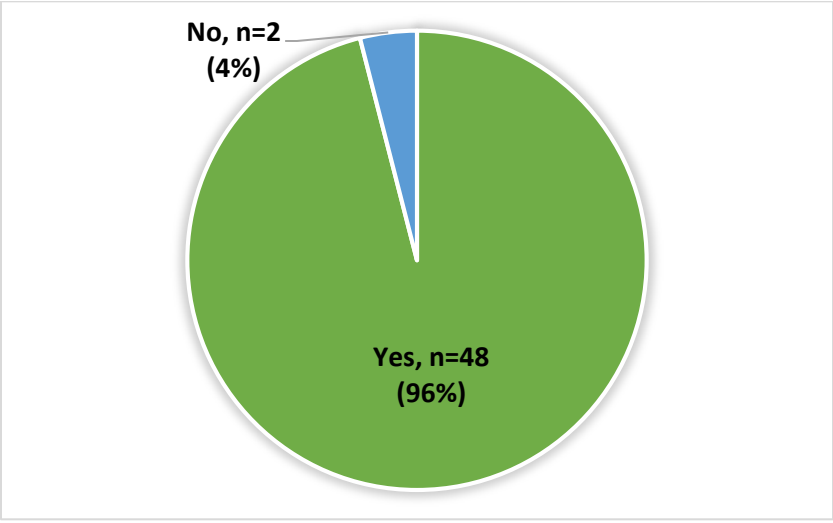

Table 45 -Number of States Submitting RetroDUR Educational Outreach Summaries

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, Wyoming	48	96.00%
No	New Mexico, West Virginia	2	4.00%

Section IV - DUR Board Activity

States have the option of reporting a summary of DUR Board Activities

**This information is located in Attachment 3 in individual state specific DUR FFS Report. This attachment can be requested by contacting CMSDUR@cms.hhs.gov*

1. Does the state have Attachment 3 which contains a Summary of DUR Board Activities to upload?

Figure 33 –Number of States Submitting DUR Board Activity Summaries

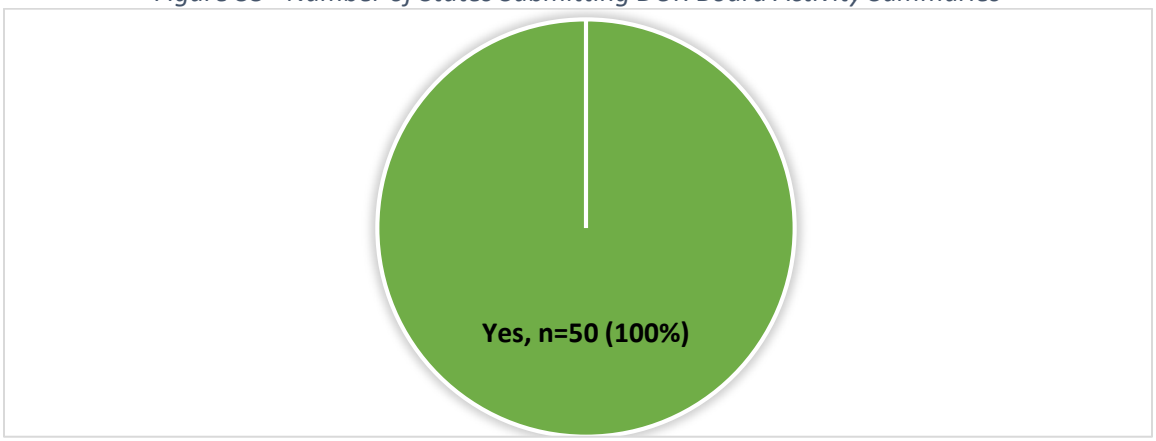

Table 46 – Number of States Submitting DUR Board Activity Summaries

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	50	100.00%

2. Does your state have an approved Medication Therapy Management Program?

Figure 34 - State Has a Medication Therapy Management Program

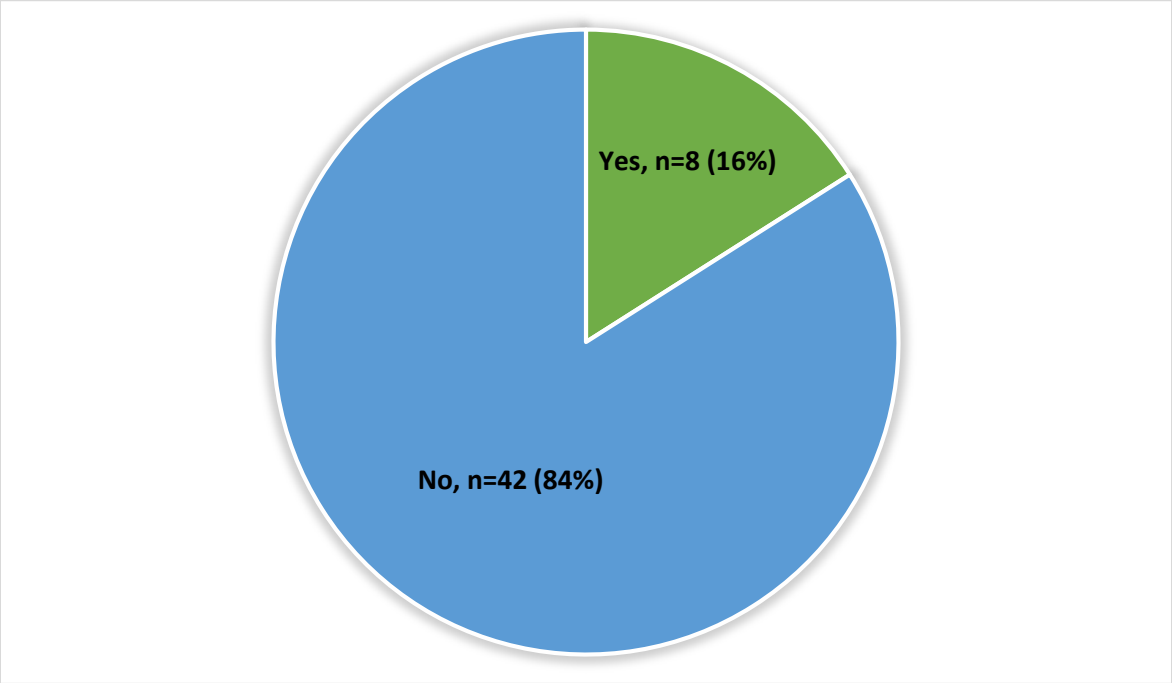

Table 47 - State Has a Medication Therapy Management Program

Response	States	Count	Percentage
Yes	Florida, Michigan, Minnesota, Missouri, North Dakota, Tennessee, Wisconsin, Wyoming	8	16.00%
No	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, Washington, West Virginia	42	84.00%

a. Have you performed an analysis of the program's effectiveness?

Figure 35 - Analysis Performed for Effectiveness of Medication Therapy Management Program

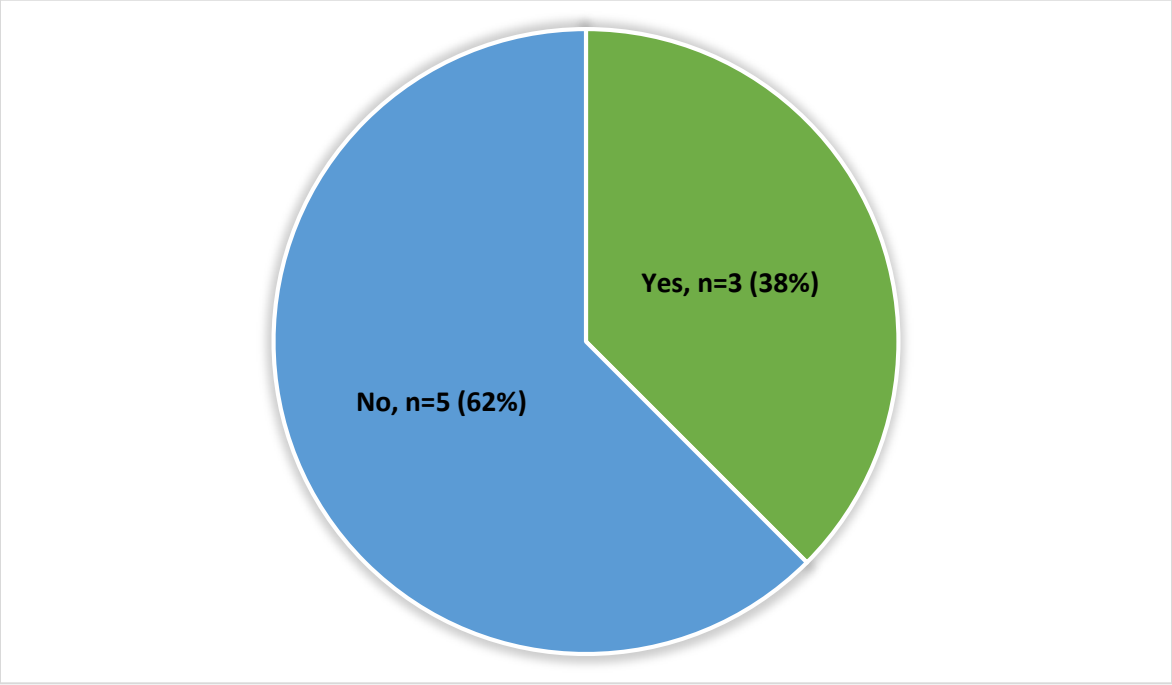

Table 48 - Analysis Performed for Effectiveness of Medication Therapy Management Programs

Response	States	Count	Percentage
Yes	Florida, Tennessee, Wisconsin	3	37.50%
No	Michigan, Minnesota, Missouri, North Dakota, Wyoming	5	62.50%

If "Yes," please provide a brief summary of your findings.

Table 49 – Explanations of Effectiveness of Medication Therapy Management Programs

State	Summary of Findings
Florida	The findings of the Medication Therapy Management research team have been used to support DUR board edits and activities.
Tennessee	Effectiveness study was performed by the University of Tennessee.
Wisconsin	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov

b. Is your DUR Board involved with this program?

Figure 36 – DUR Board Involved with Medication Therapy Management Program

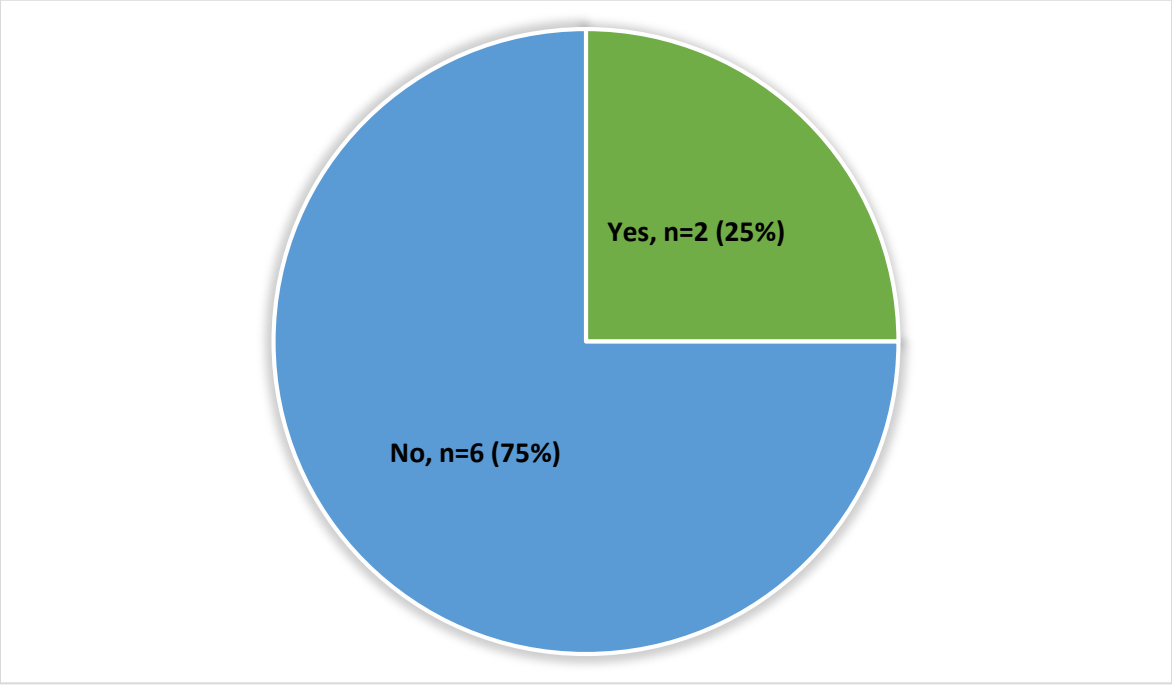

Table 50 - DUR Board Involved with Medication Therapy Management Program

Response	States	Count	Percentage
Yes	Missouri, Wisconsin	2	25.00%
No	Florida, Michigan, Minnesota, North Dakota, Tennessee, Wyoming	6	75.00%

If "No," are you planning to develop and implement a program?

Figure 37 - Plans to Implement a Medication Therapy Management Program

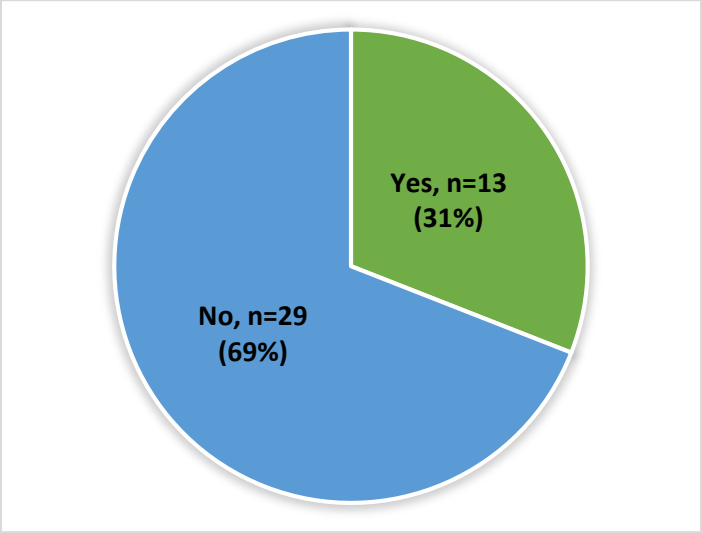

Table 51 - Plans to Implement a Medication Therapy Management Program

Response	States	Count	Percentage
Yes	Alaska, California, Colorado, District of Columbia, Maryland, Massachusetts, Mississippi, Nevada, Oklahoma, Oregon, South Carolina, Vermont, Virginia	13	30.95%
No	Alabama, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, Washington, West Virginia	29	69.05%

Section 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 pharmacy system been designed to incorporate this data into your DUR criteria for:

1. ProDUR?

Figure 38 - Incorporation of NDCs for Covered Outpatient Drugs Administered by Physicians into DUR Criteria for ProDUR

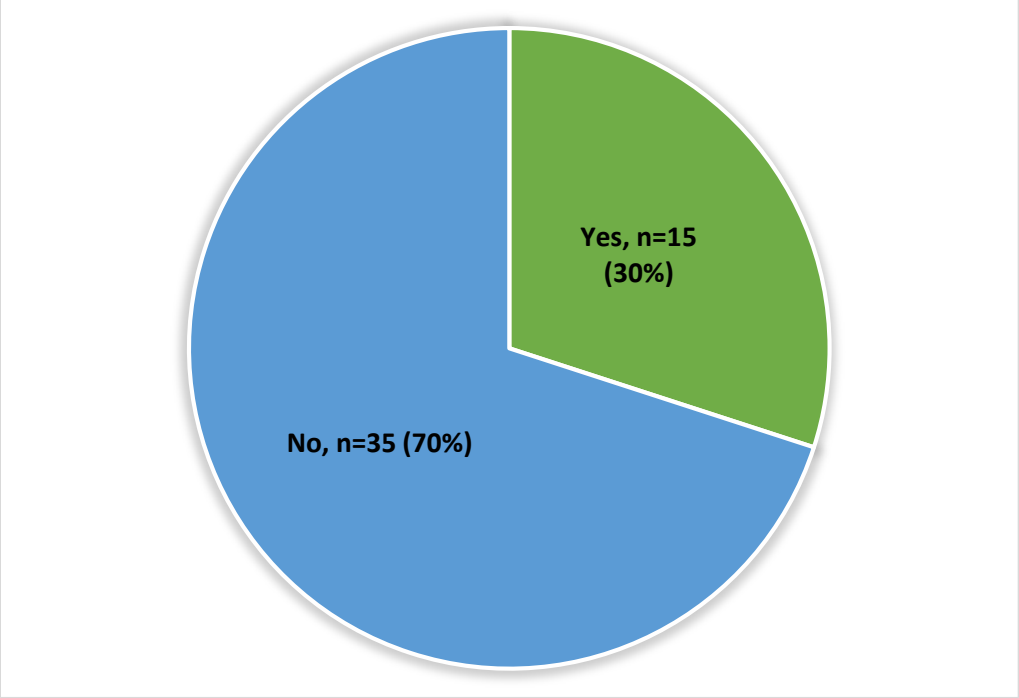

Table 52 - Incorporation of NDCs for Covered Outpatient Drugs Administered by Physicians into DUR Criteria for ProDUR

Response	States	Count	Percentage
Yes	Alaska, Delaware, Florida, Georgia, Hawaii, Kentucky, Maine, Massachusetts, Michigan, Missouri, Montana, New Jersey, Pennsylvania, Virginia, Washington	15	30.00%
No	Alabama, Arkansas, California, Colorado, Connecticut, District of Columbia, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maryland, Minnesota, Mississippi, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, West Virginia, Wisconsin, Wyoming	35	70.00%

If “No,” is implementation planned for the future?

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

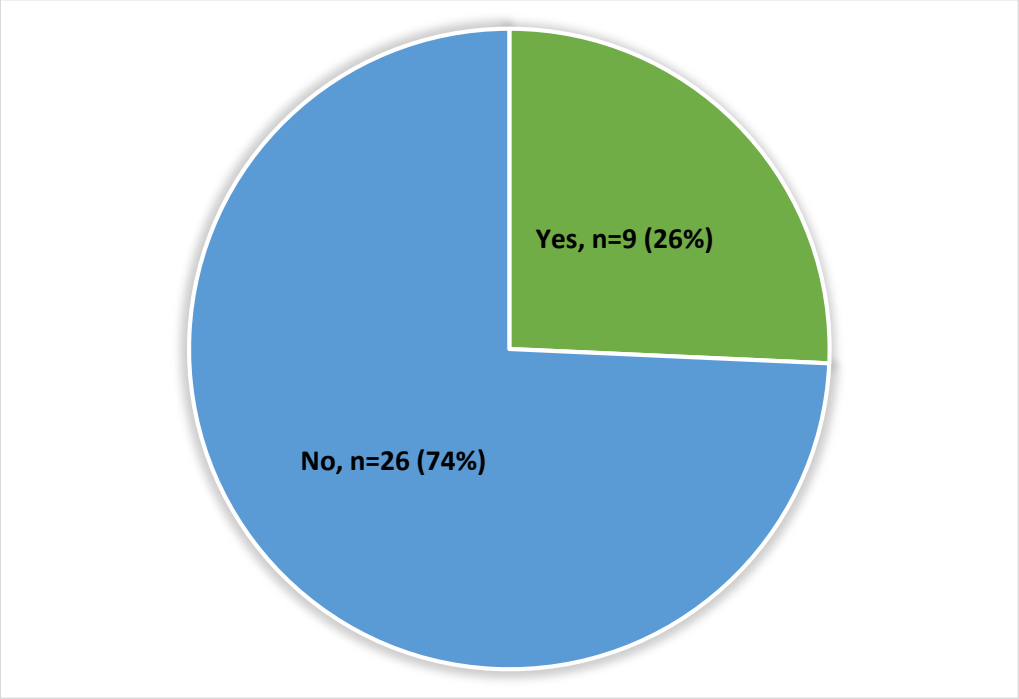

Table 53 - Future Plans to Incorporate NDCs for Covered Outpatient Physician Administered Drugs into DUR criteria for ProDUR

Response	States	Count	Percentage
Yes	Colorado, District of Columbia, Illinois, Mississippi, Nevada, North Dakota, Oregon, South Carolina, Vermont	9	25.71%
No	Alabama, Arkansas, California, Connecticut, Idaho, Indiana, Iowa, Kansas, Louisiana, Maryland, Minnesota, Nebraska, New Hampshire, New Mexico, New York, North Carolina, Ohio, Oklahoma, Rhode Island, South Dakota, Tennessee, Texas, Utah, West Virginia, Wisconsin, Wyoming	26	74.29%

2. RetroDUR?

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

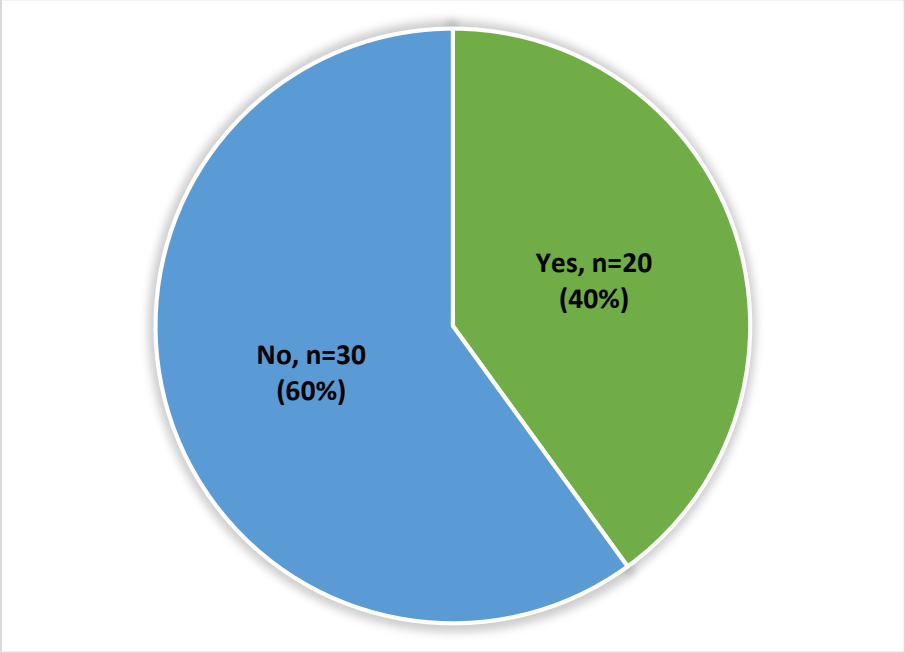

Table 54 - Incorporation of NDCs for Covered Outpatient Physician Administered Drugs into DUR criteria for RetroDUR

Response	States	Count	Percentage
Yes	Alaska, California, Florida, Georgia, Hawaii, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Nevada, New Hampshire, Ohio, Oregon, Pennsylvania, South Carolina, Virginia, Washington	20	40.00%
No	Alabama, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Idaho, Illinois, Indiana, Iowa, Kansas, Maryland, Mississippi, Montana, Nebraska, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, West Virginia, Wisconsin, Wyoming	30	60.00%

If “No,” is implementation planned for the future?

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

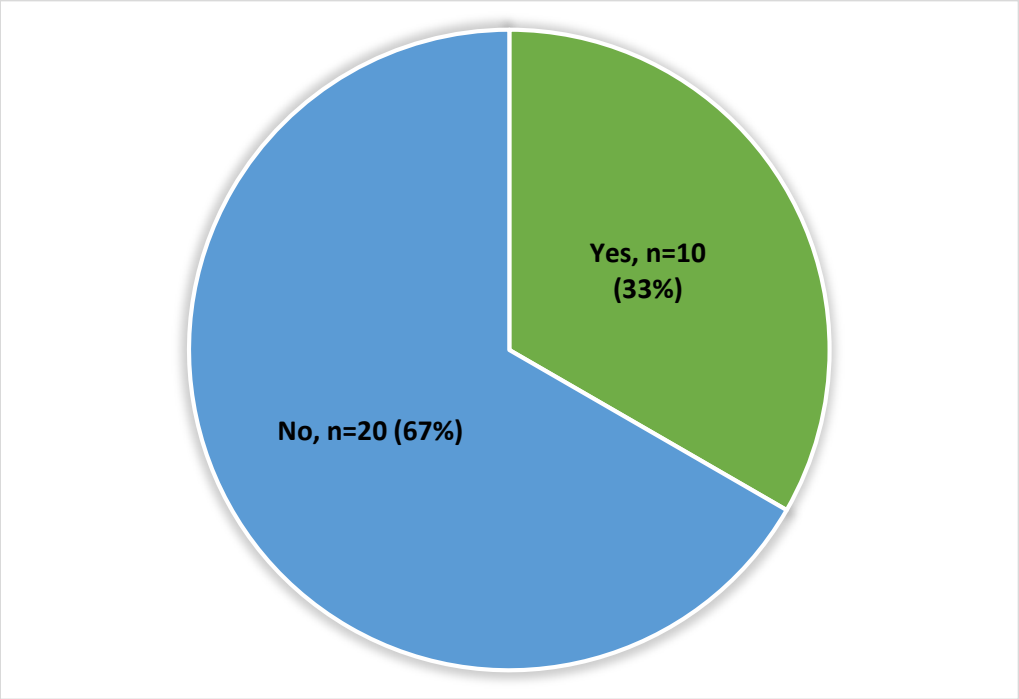

Table 55 - Future Plans to Incorporate NDCs for Covered Outpatient Physician Administered Drugs into DUR criteria for RetroDUR

Response	States	Count	Percentage
Yes	Colorado, District of Columbia, Idaho, Illinois, Maryland, Mississippi, New Jersey, North Carolina, North Dakota, Vermont	10	33.33%
No	Alabama, Arkansas, Connecticut, Delaware, Indiana, Iowa, Kansas, Montana, Nebraska, New Mexico, New York, Oklahoma, Rhode Island, South Dakota, Tennessee, Texas, Utah, West Virginia, Wisconsin, Wyoming	20	66.67%

Section VI - Generic Policy and Utilization Data*

1. States have the option of submitting summaries on generic drug substitution policies describing factors that could affect generic utilization percentage

**This information is located in Attachment 4 in individual state specific DUR FFS Report. This attachment can be requested by contacting CMSDUR@cms.hhs.gov*

Figure 42 – Number of States Submitting Generic Drug Substitution Policy Summaries

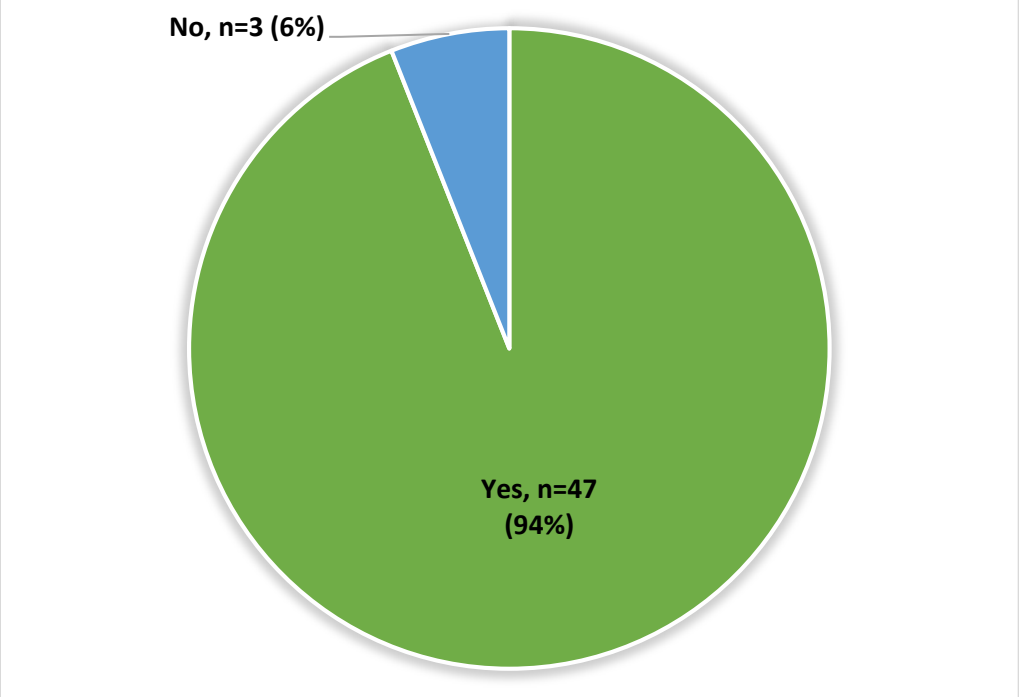

Table 56 - Number of States Submitting Generic Drug Substitution Policy Summaries

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	47	94.00%
No	Missouri, Pennsylvania, South Dakota	3	6.00%

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?

Figure 43 - More Restrictive State Requirements than the Prescriber Writing in His Own Handwriting “Brand Medically Necessary” for a Brand Name Drug

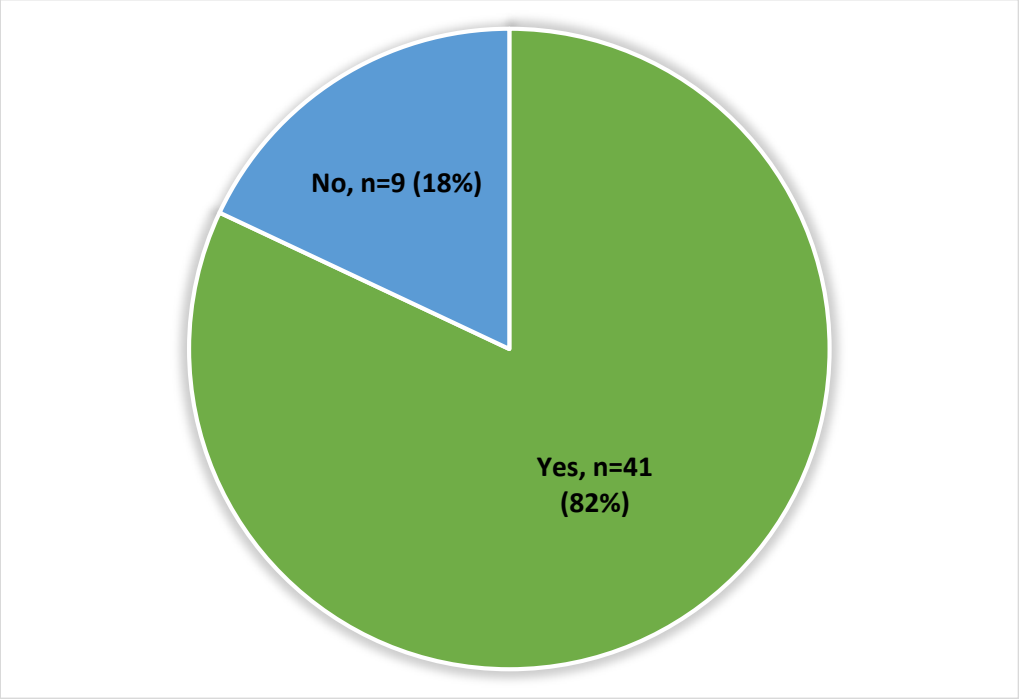

Table 57 - More Restrictive State Requirements than the Prescriber Writing in His Own Handwriting “Brand Medically Necessary” for a Brand Name Drug

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, District of Columbia, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Vermont, Washington, West Virginia, Wisconsin, Wyoming	41	82.00%
No	Delaware, Florida, Hawaii, Louisiana, New Mexico, North Carolina, Rhode Island, Utah, Virginia	9	18.00%

If “Yes,” check all that apply

Figure 44 - Additional Restrictive State Requirements than the Prescriber Writing in His Own Handwriting “Brand Medically Necessary” for a Brand Name Drug

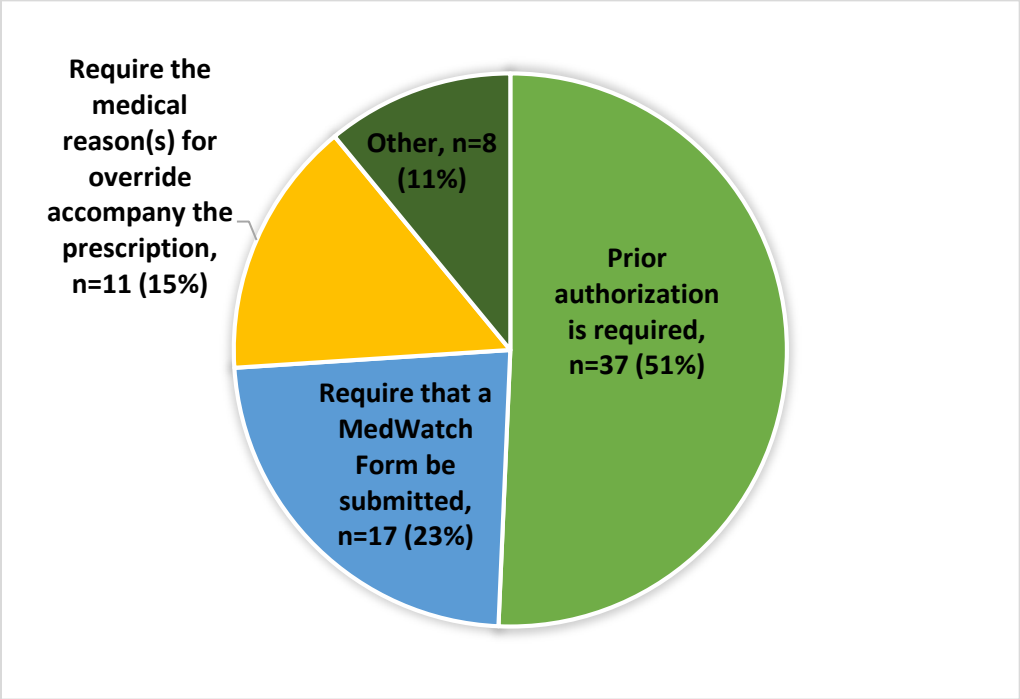

Table 58 - Additional Restrictive MCO Requirements than the Prescriber Writing in His Own Handwriting “Brand Medically Necessary” for a Brand Name Drug

Response	States	Count	Percentage
Prior authorization is required	Alabama, Alaska, Arkansas, Colorado, District of Columbia, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Vermont, Washington, West Virginia, Wisconsin, Wyoming	37	50.68%
Require that a MedWatch Form be submitted	Alabama, Alaska, Arkansas, Connecticut, Idaho, Indiana, Iowa, Kansas, Maine, Maryland, Mississippi, North Dakota, South Carolina, Tennessee, Vermont, West Virginia, Wyoming	17	23.29%
Require the medical reason(s) for override accompany the prescription	Alabama, Idaho, Kansas, Mississippi, Missouri, Montana, Nevada, North Dakota, Oklahoma, South Carolina, West Virginia	11	15.07%
Other	California, Colorado, Connecticut, Idaho, Maine, Michigan, Nebraska, Wisconsin	8	10.96%

Additional Information for states that answered "Other"

Table 59 – "Other" Explanations for Restrictive Brand Name Prescribing

State	"Other" Explanations
California	If a brand name drug does not appear on the Medi-Cal List of Contract Drugs, an approved Treatment Authorization Request demonstrating medical necessity may be required before dispensing.
Colorado	Require prescriber attestation that transition to the generic equivalent of the brand drug would be unacceptably disruptive to the patient's stabilized drug regimen or that the member is unable to continue treatment with the generic drug as determined by the prescriber following initial treatment.
Connecticut	A BMN PA is required unless the brand name drug is on the PDL. A DAW-1 submitted on electronic prescriptions is acceptable.
Idaho	Must fail two separate generic products.
Maine	Maine does not allow DAW 1 for prescriptions, must adhere to the Preferred Drug List.
Michigan	Select drug classes determined by the state legislature are exempt from prior authorization
Nebraska	Prescriber must complete an MC-6 Form, which declares that the brand name medication is medically necessary.
Wisconsin	Wisconsin has identified select drugs that do not require a prior authorization (i.e. anticonvulsants, thyroid replacement drugs).

Generic Drug Utilization Data (to be utilized for completion of question 3 and 4 below)

Computation Instructions KEY

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

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

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

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

$$\boldsymbol{N} \div (\boldsymbol{S} + \boldsymbol{N} + \boldsymbol{I}) \times 100 = \text{Generic Utilization Percentage}$$

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

$$\$\boldsymbol{N} \div (\$\boldsymbol{S} + \$\boldsymbol{N} + \$\boldsymbol{I}) \times 100 = \text{Generic Expenditure Percentage}$$

CMS has developed an extract file from the Medicaid Drug Rebate Program Drug Product Data File identifying each NDC along with sourcing status of each drug: S, N, or I, which can be found at Medicaid.gov (Click on the link "an NDC and Drug Category file [ZIP]," then open the Medicaid Drug Product File 4th Qtr 2018 Excel file).

Please provide the following utilization data for this DUR reporting period for all covered outpatient drugs paid. Exclude Third Party Liability.

Table 2: Generic Drug Utilization Data

Figure 45 – Single Source (S) Drugs Total Number of Claims by State

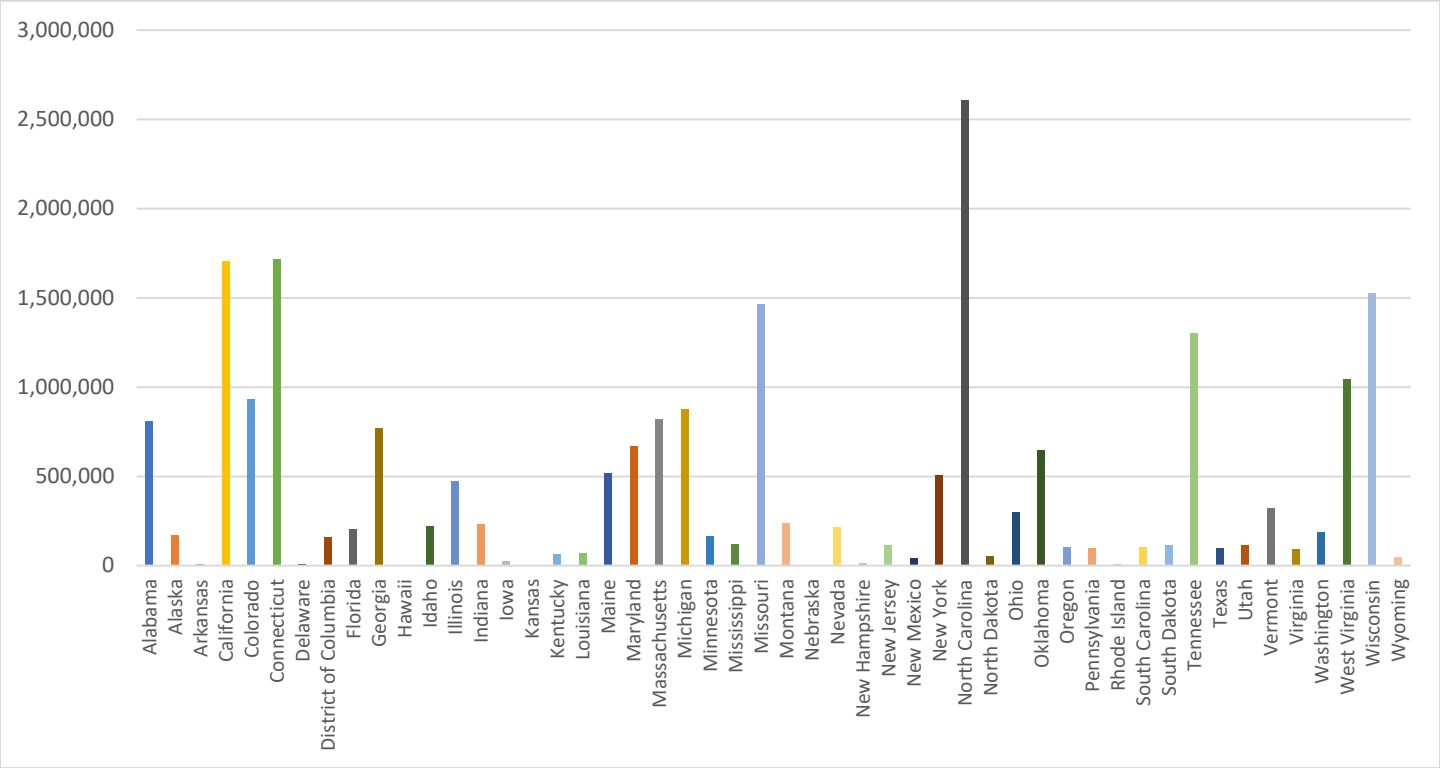

Figure 46 – Non-Innovator Source (N) Drugs Total Number of Claims by State

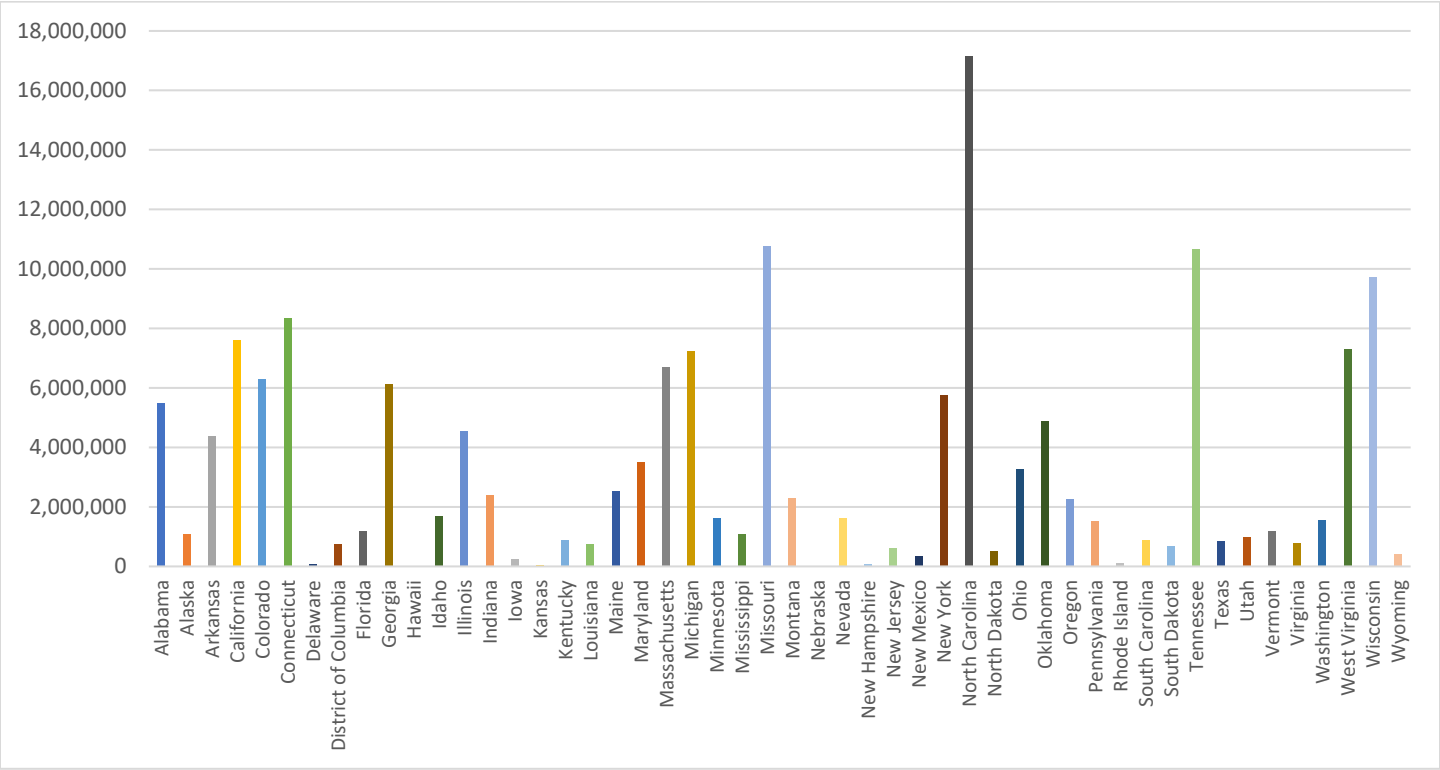

Figure 47 – Innovator Multi-Source (I) Drugs Total Number of Claims by State

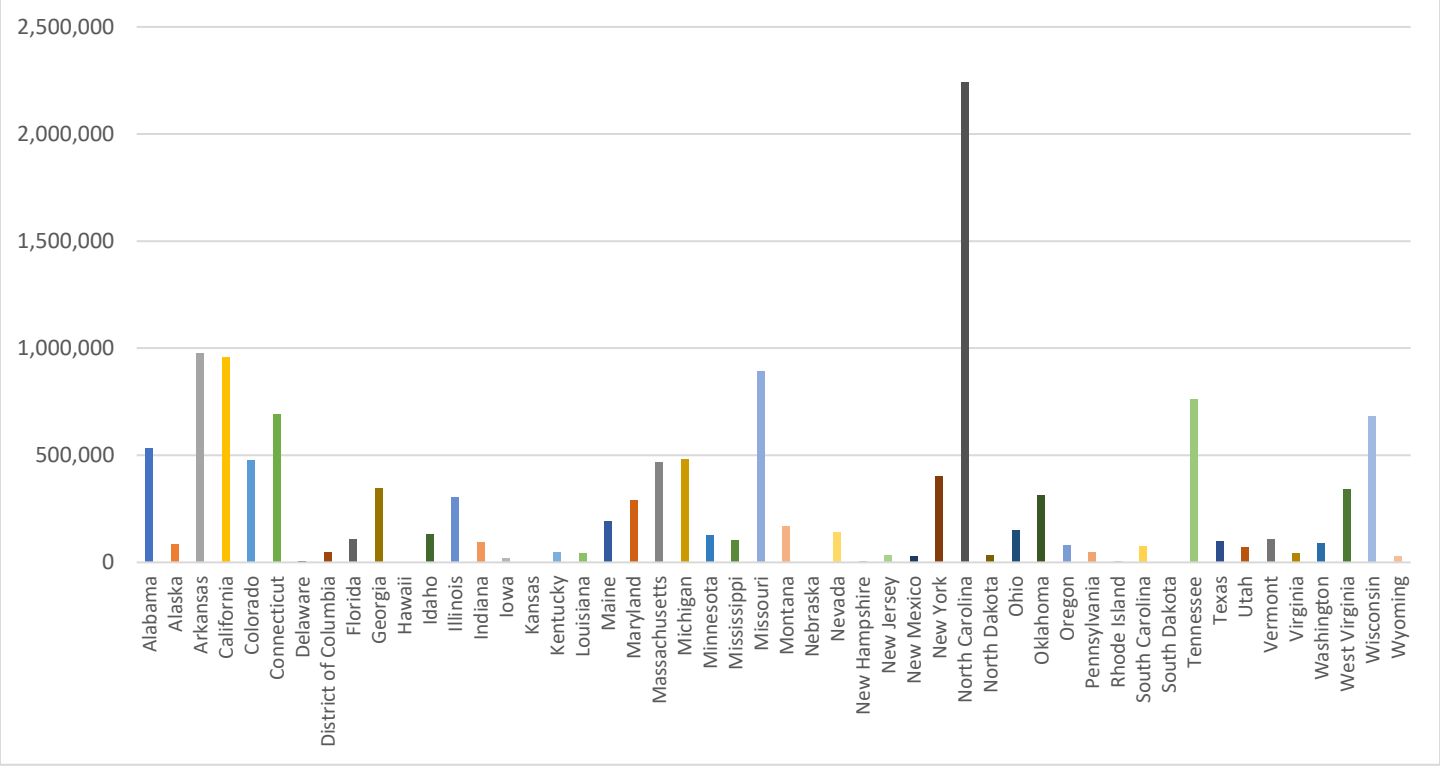

Table 60 – Drug Utilization Claims by Drug Category

State	"S" Drugs	"N" Drugs	"I" Drugs
Alabama	811,550	5,503,491	531,982
Alaska	169,496	1,097,340	83,143
Arkansas	8,084	4,374,899	976,507
California	1,703,731	7,598,080	957,215
Colorado	932,222	6,288,878	479,475
Connecticut	1,714,644	8,357,137	690,791
Delaware	10,093	90,983	4,308
District of Columbia	162,169	766,491	48,508
Florida	207,149	1,203,420	110,050
Georgia	767,904	6,134,501	345,262
Hawaii	390	7,248	108
Idaho	222,074	1,682,780	130,097
Illinois	473,311	4,551,156	302,962
Indiana	234,496	2,389,601	94,944
Iowa	27,000	259,296	18,519
Kansas	3,245	44,716	1,367
Kentucky	65,410	870,572	46,374
Louisiana	70,481	744,135	43,306
Maine	517,177	2,537,743	194,407
Maryland	668,597	3,509,638	288,398
Massachusetts	821,694	6,691,112	469,967
Michigan	875,304	7,243,508	481,437
Minnesota	167,632	1,634,853	127,223
Mississippi	123,250	1,081,263	103,857
Missouri	1,463,603	10,752,949	894,343
Montana	240,551	2,294,670	169,960
Nebraska	1,291	18,609	2,860
Nevada	213,078	1,610,435	142,618
New Hampshire	13,664	84,943	4,556
New Jersey	112,550	607,369	32,785
New Mexico	43,444	338,666	29,523
New York	508,907	5,772,166	403,503
North Carolina	2,609,391	17,140,025	2,242,086
North Dakota	55,028	501,933	33,801
Ohio	302,243	3,261,303	150,847
Oklahoma	649,263	4,889,214	315,298
Oregon	103,267	2,268,918	80,870
Pennsylvania	98,256	1,517,652	48,389

State	"S" Drugs	"N" Drugs	"I" Drugs
Rhode Island	6,986	109,371	3,890
South Carolina	101,209	885,740	75,658
South Dakota	115,798	694,962	1,334
Tennessee	1,304,737	10,655,184	760,118
Texas	99,978	840,743	97,059
Utah	114,909	977,643	71,863
Vermont	320,354	1,177,484	109,380
Virginia	92,765	792,786	44,722
Washington	188,618	1,544,420	90,687
West Virginia	1,046,035	7,290,032	342,748
Wisconsin	1,524,861	9,720,938	682,986
Wyoming	46,839	406,080	30,718
Total	**22,134,728**	**160,817,076**	**13,392,809**

Figure 48 – Single Source (S) Drugs Total Reimbursement Amount Less Co-Pay by State

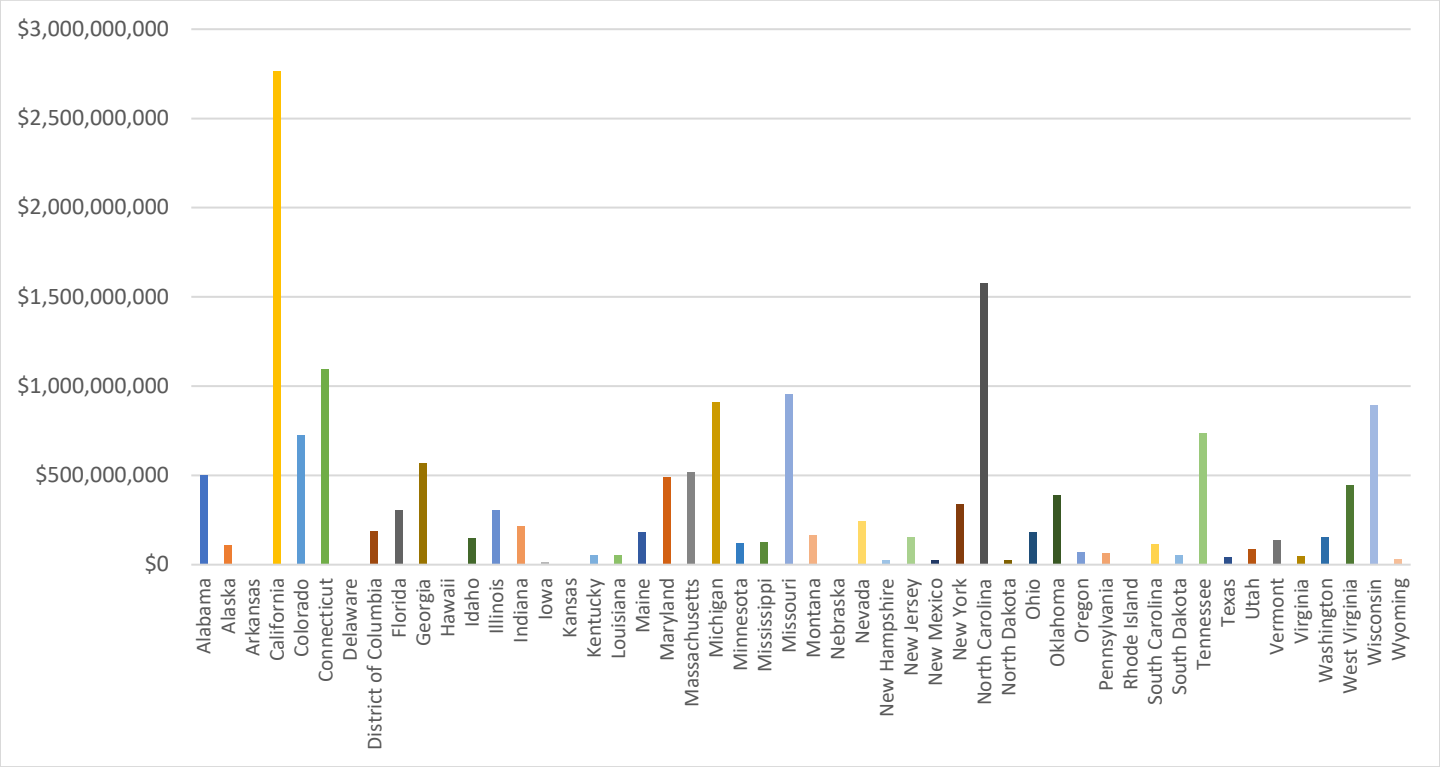

Figure 49 – Non-Innovator Source (N) Drugs Total Reimbursement Amount less Co-Pay by State

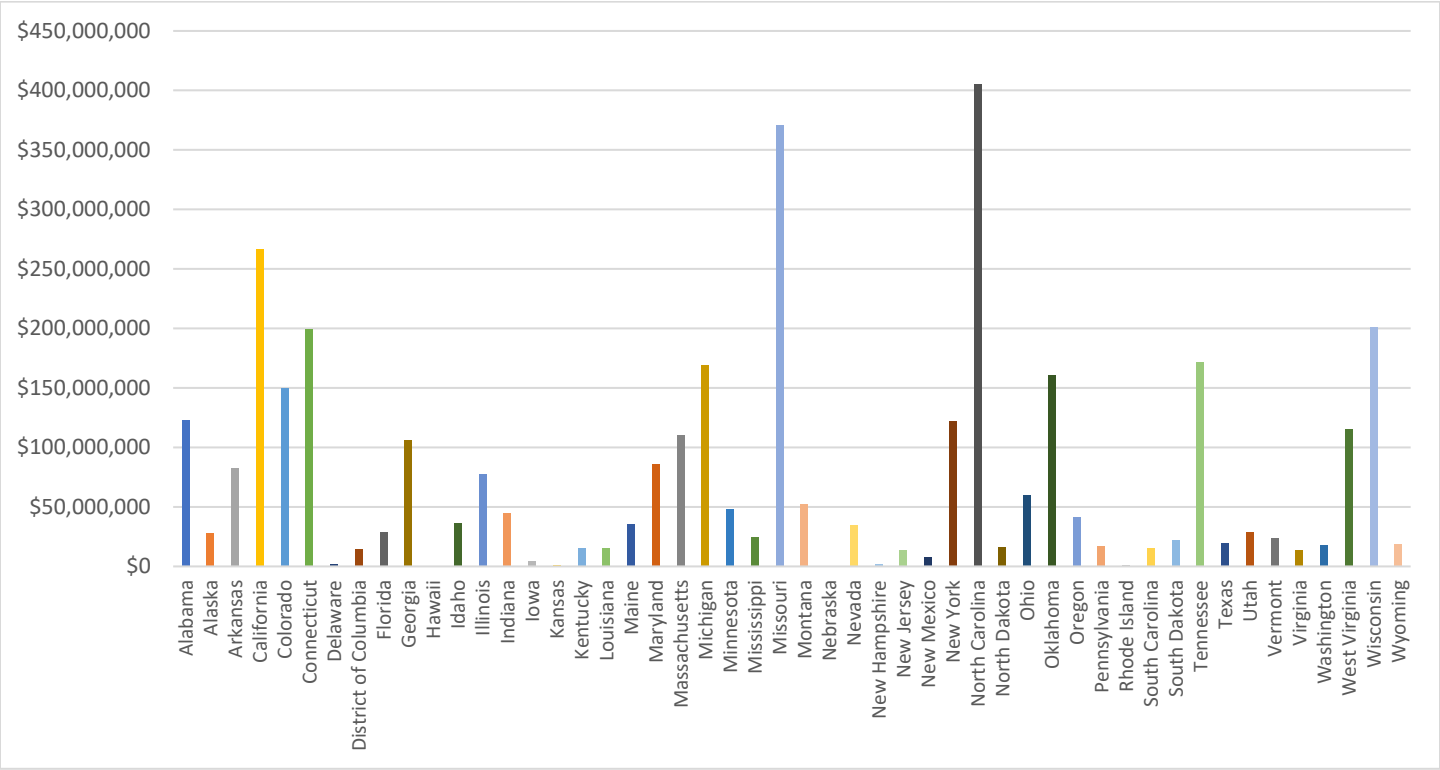

Figure 50 – Innovator Multi-Source (I) Drugs Total Reimbursement Amount less Co-Pay by State

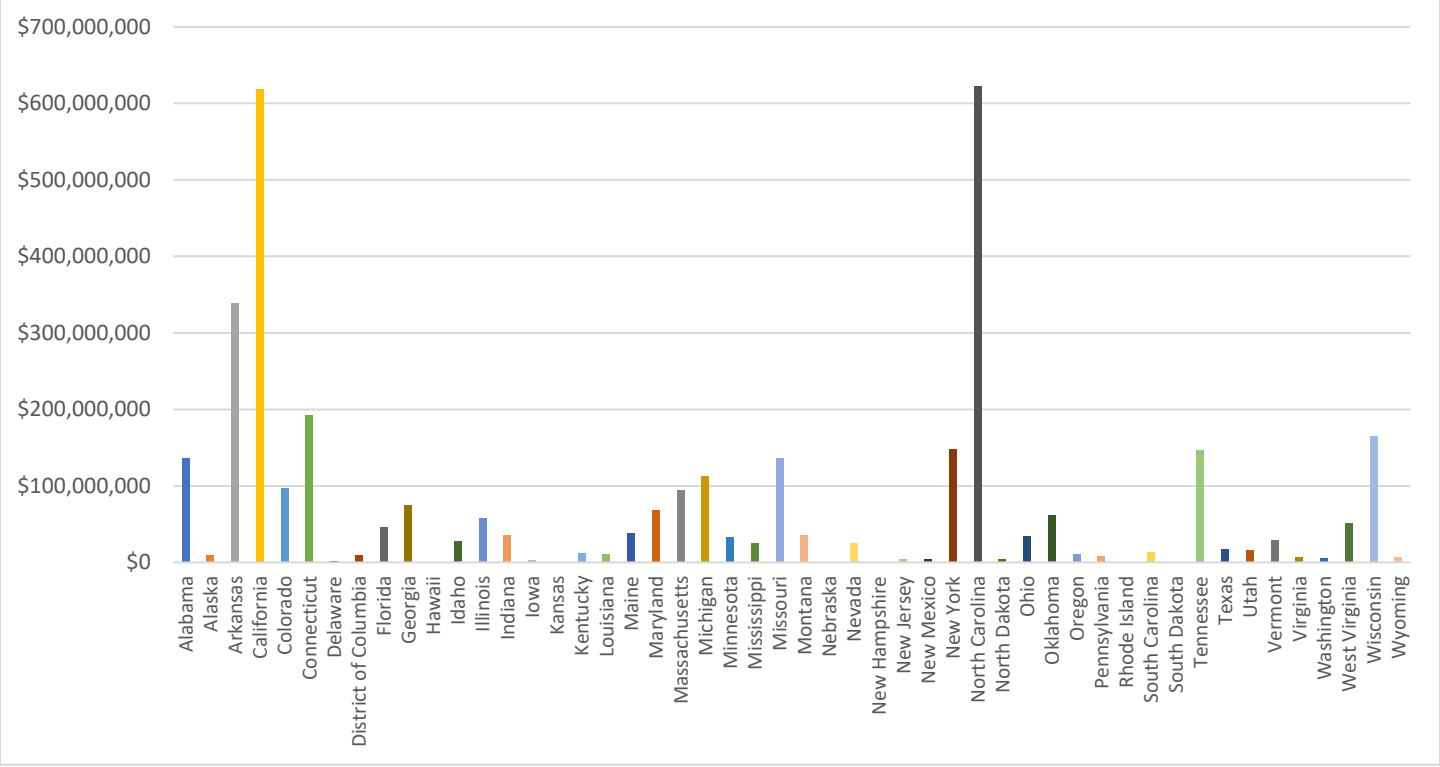

Table 61 – Drug Utilization Total Reimbursement Amount by Drug Category

State	"S" Drugs	"N" Drugs	"I" Drugs
Alabama	$500,088,327	$122,963,687	$136,379,665
Alaska	$107,228,322	$28,006,883	$10,004,181
Arkansas	$2,511,537	$82,582,390	$338,457,236
California	$2,766,806,174	$266,496,188	$619,150,812
Colorado	$725,071,066	$149,684,301	$96,817,996
Connecticut	$1,095,956,209	$199,226,856	$191,989,610
Delaware	$4,366,242	$1,740,009	$1,021,024
District of Columbia	$190,008,702	$14,457,388	$9,129,612
Florida	$305,961,028	$28,625,741	$46,537,092
Georgia	$570,402,000	$105,859,000	$75,126,000
Hawaii	$728,922	$393,721	$36,442
Idaho	$150,497,861	$36,096,826	$27,900,229
Illinois	$307,333,281	$77,458,786	$58,374,505
Indiana	$214,468,609	$44,975,046	$35,059,094
Iowa	$11,683,176	$4,687,058	$2,825,020
Kansas	$2,724,000	$884,000	$165,000
Kentucky	$54,974,067	$15,568,148	$12,231,304
Louisiana	$52,798,277	$15,678,275	$10,894,255
Maine	$179,533,687	$35,445,010	$38,411,572
Maryland	$489,499,000	$85,994,000	$67,788,000
Massachusetts	$516,848,049	$110,588,268	$94,230,973
Michigan	$912,385,899	$169,606,281	$113,194,922
Minnesota	$119,149,435	$48,119,571	$33,177,881
Mississippi	$124,191,135	$24,939,130	$25,020,109
Missouri	$955,236,831	$370,654,298	$136,308,175
Montana	$167,926,664	$52,342,036	$35,223,346
Nebraska	$903,796	$284,175	$174,629
Nevada	$243,970,702	$34,677,025	$24,805,848
New Hampshire	$25,010,680	$1,664,971	$597,929
New Jersey	$155,728,687	$13,347,402	$4,586,256
New Mexico	$25,386,109	$8,236,461	$3,867,230
New York	$340,313,280	$122,548,232	$148,121,534
North Carolina	$1,575,895,524	$405,627,923	$622,286,367
North Dakota	$26,747,613	$16,121,194	$4,425,913
Ohio	$184,624,331	$59,975,058	$33,804,994
Oklahoma	$386,976,685	$160,611,798	$61,695,259
Oregon	$72,094,280	$41,528,277	$10,436,309
Pennsylvania	$66,210,588	$17,364,297	$8,343,498

State	"S" Drugs	"N" Drugs	"I" Drugs
Rhode Island	$4,242,913	$1,466,370	$883,696
South Carolina	$113,816,577	$15,604,510	$13,404,489
South Dakota	$54,623,359	$22,309,082	$866,605
Tennessee	$736,773,620	$172,004,553	$147,247,678
Texas	$44,280,854	$19,288,711	$17,342,957
Utah	$84,835,394	$28,812,114	$16,063,769
Vermont	$135,908,781	$23,463,060	$29,406,906
Virginia	$47,508,953	$13,566,188	$7,020,145
Washington	$153,485,184	$18,273,479	$5,813,297
West Virginia	$446,758,068	$115,295,789	$50,675,956
Wisconsin	$891,856,818	$200,880,072	$164,699,241
Wyoming	$31,057,246	$18,727,006	$7,113,148
Total	**$17,534,022,997**	**$4,088,769,351**	**$3,878,814,689**

3. Indicate the generic utilization percentage for all covered outpatient drugs paid during this reporting period

Figure 51 - Generic & Total Claims by State

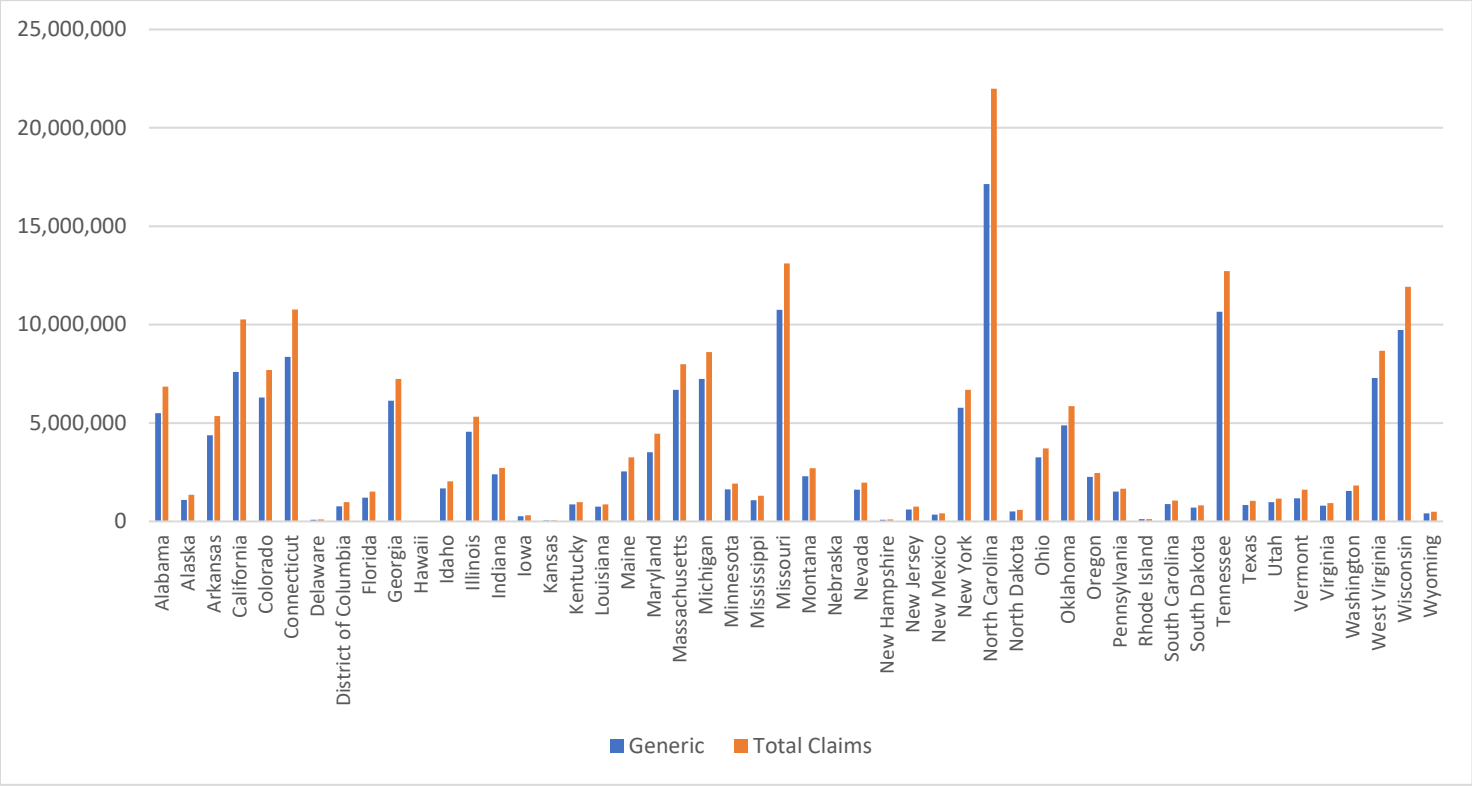

Table 62 - Generic & Total Claims by State

State	Generic Claim Count	Total Claim Count	Percentage
Alabama	5,503,491	6,847,023	80.38%
Alaska	1,097,340	1,349,979	81.29%
Arkansas	4,374,899	5,359,490	81.63%
California	7,598,080	10,259,026	74.06%
Colorado	6,288,878	7,700,575	81.67%
Connecticut	8,357,137	10,762,572	77.65%
Delaware	90,983	105,384	86.33%
District of Columbia	766,491	977,168	78.44%
Florida	1,203,420	1,520,619	79.14%
Georgia	6,134,501	7,247,667	84.64%
Hawaii	7,248	7,746	93.57%
Idaho	1,682,780	2,034,951	82.69%
Illinois	4,551,156	5,327,429	85.43%
Indiana	2,389,601	2,719,041	87.88%
Iowa	259,296	304,815	85.07%
Kansas	44,716	49,328	90.65%
Kentucky	870,572	982,356	88.62%
Louisiana	744,135	857,922	86.74%
Maine	2,537,743	3,249,327	78.10%
Maryland	3,509,638	4,466,633	78.57%
Massachusetts	6,691,112	7,982,773	83.82%
Michigan	7,243,508	8,600,249	84.22%
Minnesota	1,634,853	1,929,708	84.72%
Mississippi	1,081,263	1,308,370	82.64%
Missouri	10,752,949	13,110,895	82.02%
Montana	2,294,670	2,705,181	84.83%
Nebraska	18,609	22,760	81.76%
Nevada	1,610,435	1,966,131	81.91%
New Hampshire	84,943	103,163	82.34%
New Jersey	607,369	752,704	80.69%
New Mexico	338,666	411,633	82.27%
New York	5,772,166	6,684,576	86.35%
North Carolina	17,140,025	21,991,502	77.94%
North Dakota	501,933	590,762	84.96%
Ohio	3,261,303	3,714,393	87.80%
Oklahoma	4,889,214	5,853,775	83.52%

State	Generic Claim Count	Total Claim Count	Percentage
Oregon	2,268,918	2,453,055	92.49%
Pennsylvania	1,517,652	1,664,297	91.19%
Rhode Island	109,371	120,247	90.96%
South Carolina	885,740	1,062,607	83.36%
South Dakota	694,962	812,094	85.58%
Tennessee	10,655,184	12,720,039	83.77%
Texas	840,743	1,037,780	81.01%
Utah	977,643	1,164,415	83.96%
Vermont	1,177,484	1,607,218	73.26%
Virginia	792,786	930,273	85.22%
Washington	1,544,420	1,823,725	84.68%
West Virginia	7,290,032	8,678,815	84.00%
Wisconsin	9,720,938	11,928,785	81.49%
Wyoming	406,080	483,637	83.96%
Total	**160,817,076**	**196,344,613**	**81.91%**

4. Indicate the percentage dollars paid for generic covered outpatient drugs in relation to all covered outpatient drug claims paid during this reporting period.

Figure 52 - Generic/Total Amount Paid by State

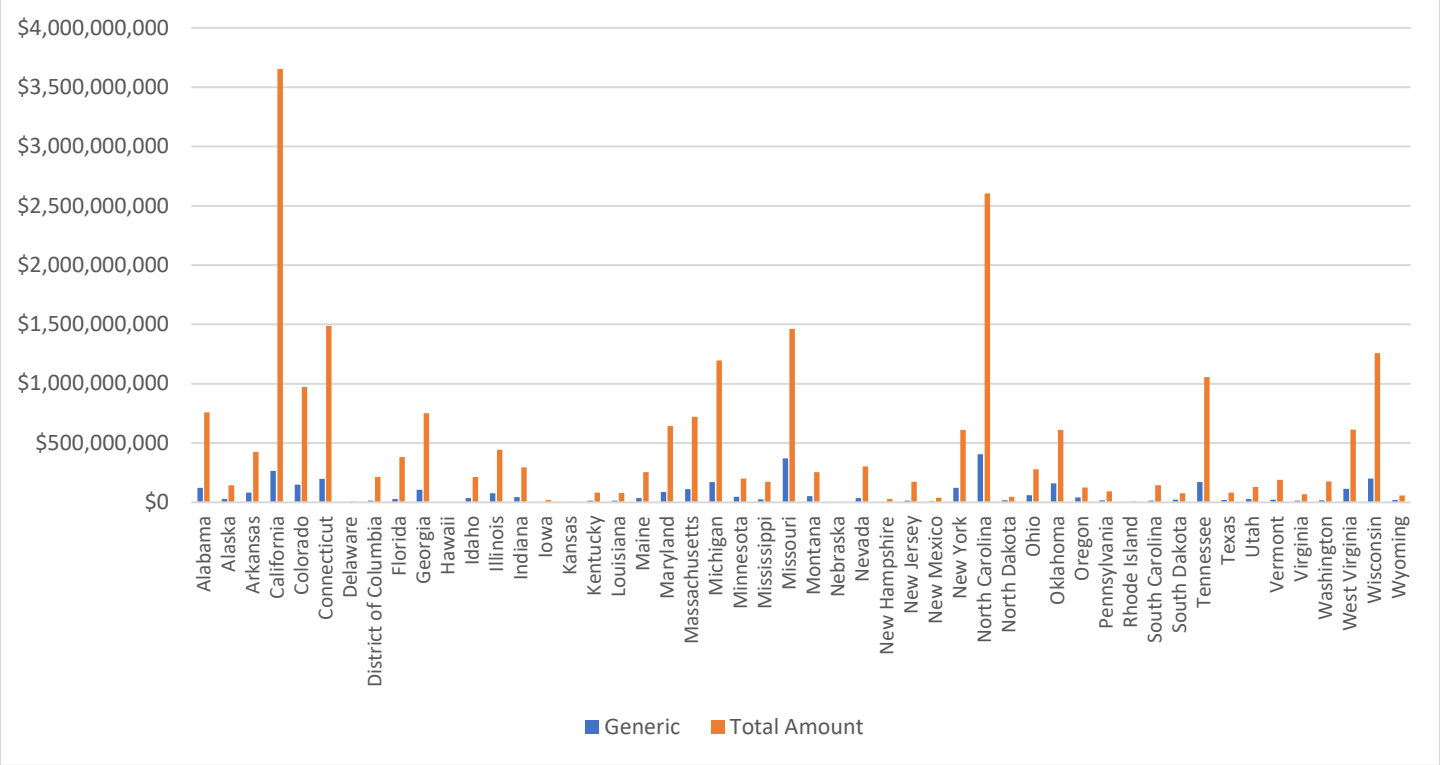

Table 63 - Generic/Total Amount Paid by State

State	Generic Claim Amount	Total Claim Amount	Percentage
Alabama	$122,963,687	$759,431,679	16.19%
Alaska	$28,006,883	$145,239,386	19.28%
Arkansas	$82,582,390	$423,551,163	19.50%
California	$266,496,188	$3,652,453,174	7.30%
Colorado	$149,684,301	$971,573,363	15.41%
Connecticut	$199,226,856	$1,487,172,675	13.40%
Delaware	$1,740,009	$7,127,275	24.41%
District of Columbia	$14,457,388	$213,595,702	6.77%
Florida	$28,625,741	$381,123,861	7.51%
Georgia	$105,859,000	$751,387,000	14.09%
Hawaii	$393,721	$1,159,085	33.97%
Idaho	$36,096,826	$214,494,916	16.83%
Illinois	$77,458,786	$443,166,572	17.48%
Indiana	$44,975,046	$294,502,749	15.27%
Iowa	$4,687,058	$19,195,254	24.42%
Kansas	$884,000	$3,773,000	23.43%
Kentucky	$15,568,148	$82,773,519	18.81%
Louisiana	$15,678,275	$79,370,807	19.75%
Maine	$35,445,010	$253,390,269	13.99%
Maryland	$85,994,000	$643,281,000	13.37%
Massachusetts	$110,588,268	$721,667,290	15.32%
Michigan	$169,606,281	$1,195,187,102	14.19%
Minnesota	$48,119,571	$200,446,887	24.01%
Mississippi	$24,939,130	$174,150,374	14.32%
Missouri	$370,654,298	$1,462,199,304	25.35%
Montana	$52,342,036	$255,492,046	20.49%
Nebraska	$284,175	$1,362,600	20.86%
Nevada	$34,677,025	$303,453,575	11.43%
New Hampshire	$1,664,971	$27,273,580	6.10%
New Jersey	$13,347,402	$173,662,345	7.69%
New Mexico	$8,236,461	$37,489,800	21.97%
New York	$122,548,232	$610,983,046	20.06%
North Carolina	$405,627,923	$2,603,809,814	15.58%
North Dakota	$16,121,194	$47,294,720	34.09%
Ohio	$59,975,058	$278,404,383	21.54%
Oklahoma	$160,611,798	$609,283,742	26.36%

State	Generic Claim Amount	Total Claim Amount	Percentage
Oregon	$41,528,277	$124,058,866	33.47%
Pennsylvania	$17,364,297	$91,918,383	18.89%
Rhode Island	$1,466,370	$6,592,979	22.24%
South Carolina	$15,604,510	$142,825,576	10.93%
South Dakota	$22,309,082	$77,799,046	28.68%
Tennessee	$172,004,553	$1,056,025,851	16.29%
Texas	$19,288,711	$80,912,522	23.84%
Utah	$28,812,114	$129,711,277	22.21%
Vermont	$23,463,060	$188,778,747	12.43%
Virginia	$13,566,188	$68,095,286	19.92%
Washington	$18,273,479	$177,571,960	10.29%
West Virginia	$115,295,789	$612,729,813	18.82%
Wisconsin	$200,880,072	$1,257,436,131	15.98%
Wyoming	$18,727,006	$56,897,400	32.91%
Total	**$4,088,769,351**	**$25,501,607,037**	**16.03%**

Section VII - Program Evaluation / Cost Savings / Cost Avoidance

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

Figure 53 –States Conducting DUR Program Evaluation of Estimated Cost Savings/Cost Avoidance

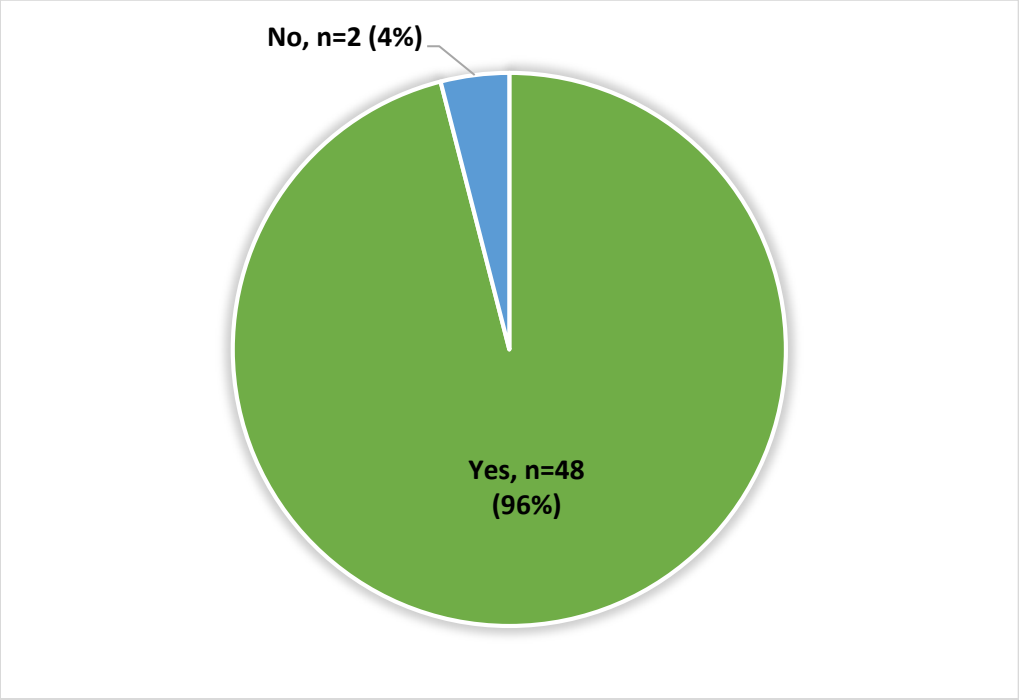

Table 64 - States Conducting DUR Program Evaluation of Estimated Cost Savings/Cost Avoidance

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	48	96.00%
No	Oklahoma, South Carolina	2	4.00%

If “Yes,” identify, by name and type, the institution that conducted the program evaluation.

Figure 54 - Institution Type that Conducted the Cost Savings/Avoidance Program Evaluation

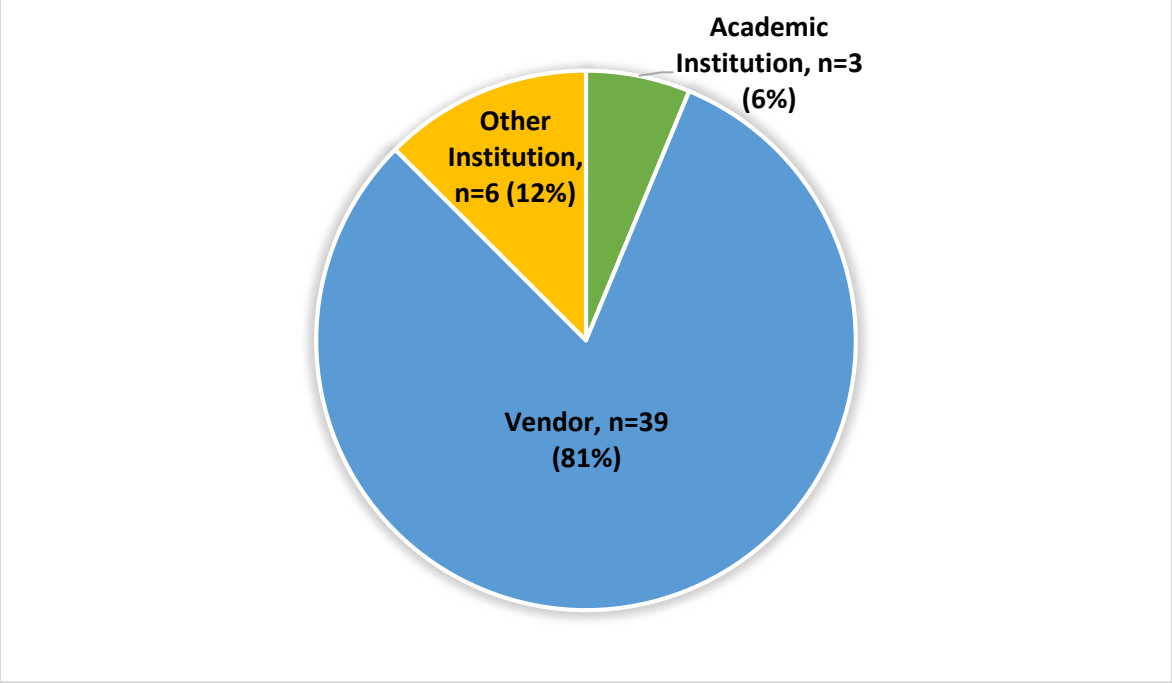

Table 65 - Institution Type that Conducted the Cost Savings/Avoidance Program Evaluation

Response	States	Count	Percentage
Academic Institution	California, Massachusetts, Wyoming	3	6.25%
Vendor	Alabama, Alaska, Arkansas, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin	39	81.25%
Other Institution	Colorado, Hawaii, Illinois, Montana, Oregon, Washington	6	12.50%

Table 66 - Vendors by State that Conducted the Cost Savings/Avoidance Program Evaluation

Response	States	Count	Percentage
Health Information Design	Alabama, Kansas, New York, North Dakota, South Dakota, Wisconsin	6	15.38%
Magellan	Alaska, Florida, Idaho, Kentucky, Michigan, Nebraska, New Hampshire, Tennessee, Virginia	9	23.08%
Health Information Design and Magellan Health	Arkansas	1	2.56%

Response	States	Count	Percentage
DXC Technology and Health Information Design	Connecticut	1	2.56%
DXC Technology	Delaware	1	2.56%
Magellan and Conduent	District of Columbia	1	2.56%
OptumRx	Georgia, Indiana, Nevada	3	7.69%
Change Healthcare	Iowa, Maine, Ohio, Pennsylvania, Utah, Vermont	6	15.38%
Molina Medicaid Solutions	Louisiana, New Jersey, West Virginia	3	7.69%
Conduent and Health Information Design	Maryland, Texas	2	5.13%
MN does internally except for RetroDUR	Minnesota	1	2.56%
Conduent and Change Healthcare	Mississippi	1	2.56%
Conduent	Missouri, New Mexico	2	5.13%
Myers and Stauffer	North Carolina	1	2.56%
KEPRO	Rhode Island	1	2.56%

Table 67 - Academic/Other Institutions that Conducted the Cost Savings/Avoidance Program Evaluation

Response	State	Count
University of California, San Francisco (UCSF)	California	1
Internal State analysis	Colorado	1
Hawaii State Medicaid DUR Coordinator	Hawaii	1
Illinois Department of Healthcare and Family Services (HFS) Bureau of Professional and Ancillary Services (BPAS) and Change Healthcare for SMAC	Illinois	1
University of Massachusetts Medical School	Massachusetts	1
Mountain Pacific Quality Health Foundation	Montana	1
Oregon State University (OSU) College of Pharmacy, Drug Use Research & Management Program and DXC Technologies	Oregon	1
Washington State Healthcare Authority	Washington	1
University of Wyoming School of Pharmacy	Wyoming	1

2. Cost Savings/Cost Avoidance Methodology

States have the option of including summaries on program evaluations/cost savings estimates prepared by state or contractor noting methodology used.

**This information is located in Attachment 5 in individual state specific DUR FFS Report. This attachment can be requested by contacting CMSDUR@cms.hhs.gov*

Figure 55 – Number of States Submitting Cost Savings/Cost Avoidance Methodology

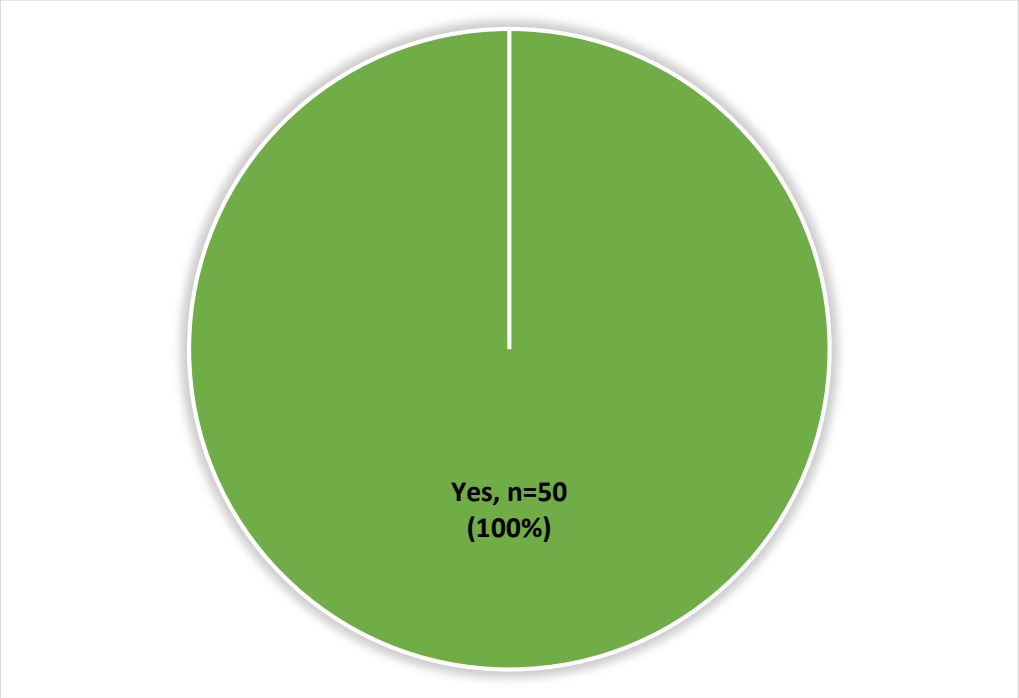

Table 68 - Number of States Submitting Cost Savings/Cost Avoidance Methodology

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	50	100.00%

VIII - Fraud, Waste and Abuse Detection

A. Lock-in or Patient Review and Restriction Programs

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

Figure 56 - Documented Process in Place by States to Identify Potential Fraud or Abuse of Controlled Drugs by Beneficiaries

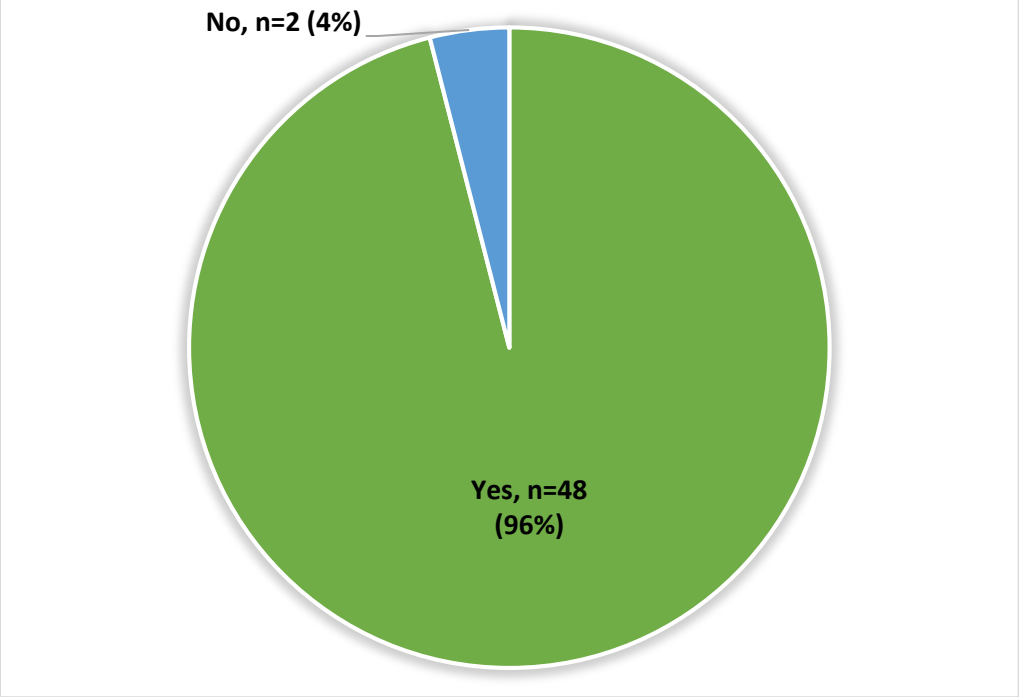

Table 69 - Documented Process in Place to Identify Potential Fraud or Abuse of Controlled Drugs by Beneficiaries

Response	States	Count	Percentage
Yes	Alabama, Alaska, California, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	48	96.00%
No	Arkansas, Florida	2	4.00%

If “Yes,” what actions does this process initiate? Check all that apply:

Figure 57 - Actions Process Initiates when Potential Fraud or Abuse of Controlled Drugs by Beneficiaries is detected

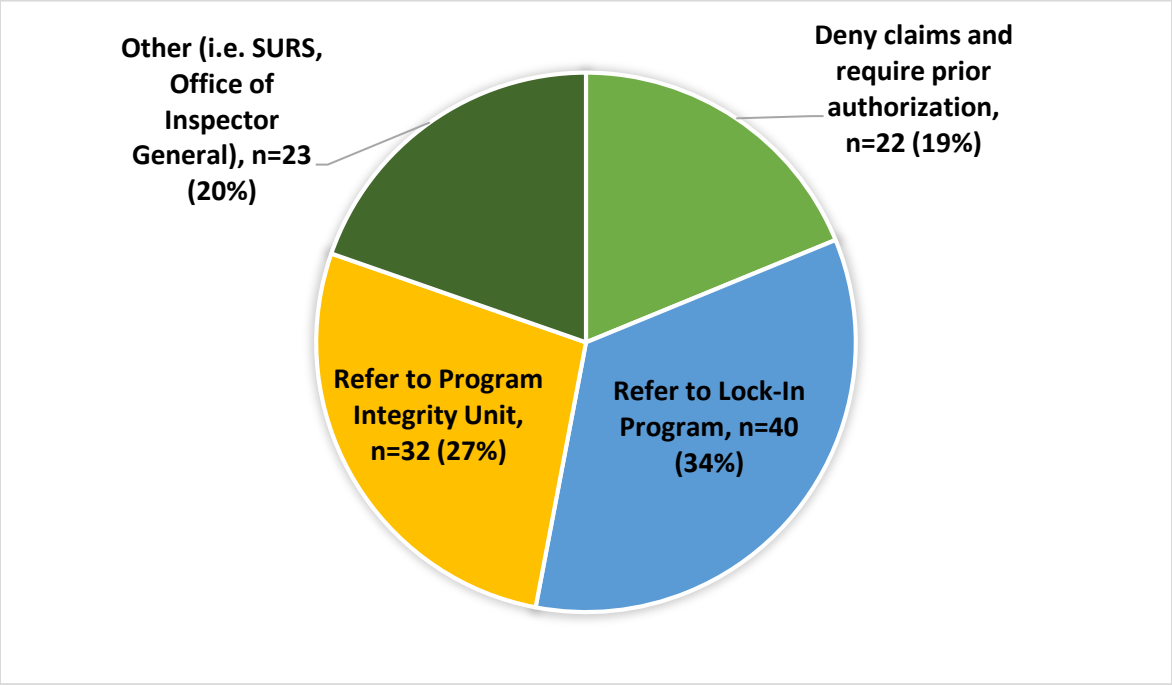

Table 70 - Actions Process Initiates when Potential Fraud or Abuse of Controlled Drugs by Beneficiaries is detected

Response	States	Count	Percentage
Deny claims and require prior authorization	Connecticut, Delaware, District of Columbia, Georgia, Idaho, Illinois, Indiana, Kentucky, Maine, Massachusetts, Michigan, Missouri, Montana, Nebraska, New Jersey, New York, Oregon, Tennessee, Texas, Vermont, Virginia, West Virginia	22	18.80%
Refer to Lock-In Program	Alabama, Alaska, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	40	34.19%
Refer to Program Integrity Unit	Alabama, Alaska, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Indiana, Iowa, Kansas, Kentucky, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	32	27.35%
Other (i.e. SURS, Office of Inspector General)	Alabama, Alaska, California, Indiana, Kentucky, Maryland, Michigan, Minnesota, Mississippi, Montana, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina,	23	19.66%

Response	States	Count	Percentage
	Pennsylvania, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, Wisconsin		

If answered “Other”, please explain.

Table 71 - “Other” Explanations for Actions Process Initiates when Potential Fraud or Abuse of Controlled Drugs by Beneficiaries is detected

State	“Other” Explanations
Alabama	Refer to MFCU if necessary.
Alaska	SURS, MFCU
California	22CCR 50793 details available utilization restrictions when the Department has determined that a beneficiary is misusing or abusing Medi-Cal benefits. Audit & Investigations, Investigations Branch (IB) is responsible for working beneficiary cases. IB has an intake process for complaints which entails an initial case review and if warranted, assignment of a case to an investigator. Subsequent actions are dependent upon the outcome of IBs investigation.
Indiana	Submit to FSSA Bureau of Investigations for member investigation.
Kentucky	Surveillance Utilization Review System (SURS), Special Investigative Unit (SIU), Attorney General (AG), Office of Inspector General (OIG)
Maryland	SURS, Office of Inspector General
Michigan	The Office of the Inspector General performs SURS for both providers and beneficiaries.
Minnesota	Questionable utilization is referred to the SURS program and they determine the action from there.
Mississippi	According to Code of Federal Regulations (CFR) 455.2 for (Abuse), beneficiary related issues are referred to appropriate areas from a Federal (CMS, DOJ, ATF); State (State Attorney General, Medicaid Fraud Control Units (MFCU); local law enforcement, or other entities such as federal/state task forces.
Montana	We follow a member through a fraud review determination and when fraud may be occurring the member is referred to the Division of Criminal Investigation
Nevada	The recipient information is provided to SURS for investigation.
New Hampshire	Members can be referred to the Program Integrity Unit. However, the Program Integrity Unit performs the review function and manages the Lock-In Program.
New Jersey	A Surveillance and Utilization Review (SURS) reporting tool is used by the Data Mining Unit within the Office of the State Comptroller's, Medicaid Fraud Division to look for unusual patterns in claim reimbursement from providers.
New Mexico	The process for identifying abuse of controlled drugs is currently in process with the implementation of narcotic edits.
North Carolina	All potential beneficiary fraud and abuse leads are referred by program integrity to the beneficiary’s county department of social services for further investigation and disposition.
Pennsylvania	Refer to OIG for criminal investigation.
South Dakota	SURS
Tennessee	Office of Inspector General is the State agency that monitors fraud, and drug offenses against the State's Medicaid program by enrollees.
Utah	Lock-in Program performs utilization review on members identified by the Surveillance report to assess necessity of beneficiary utilization.
Vermont	Referrals made to law enforcement when applicable

State	"Other" Explanations
Virginia	Java- Server Utilization Review System (JSURS) identified members to review for enrollment in DMAS Client Medical Management Program (Lock- In program)
Washington	Referral to Medicaid Fraud Control Unit
Wisconsin	The Office of the Inspector General (OIG) has department wide responsibility for auditing the use of department funds in support of the department's commitment to be an effective steward of public resources DHS is entrusted to manage. 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 and abuse, by DHS contractors, providers and members. OIG is responsible for working with DHS programs, divisions and partners to develop policies and practices to prevent fraud, waste and abuse.

2. Do you have a Lock-In program for beneficiaries with potential misuse or abuse of controlled substances?

Figure 58 - Lock-In Program

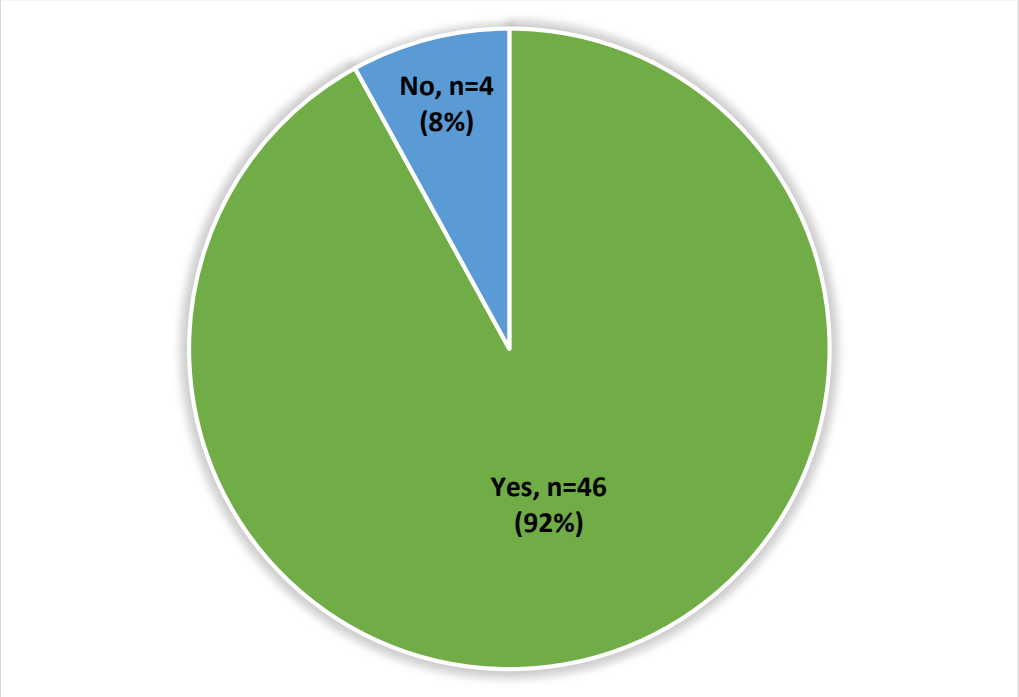

Table 72 - Lock-In Program

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee,	46	92.00%

Response	States	Count	Percentage
	Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming		
No	California, Florida, Iowa, South Dakota	4	8.00%

If the answer to question 2 is "Yes"

a. What criteria does your state use to identify candidates for Lock-In? Check all that apply:

Figure 59 - Lock-In Program Candidate Identification Criteria

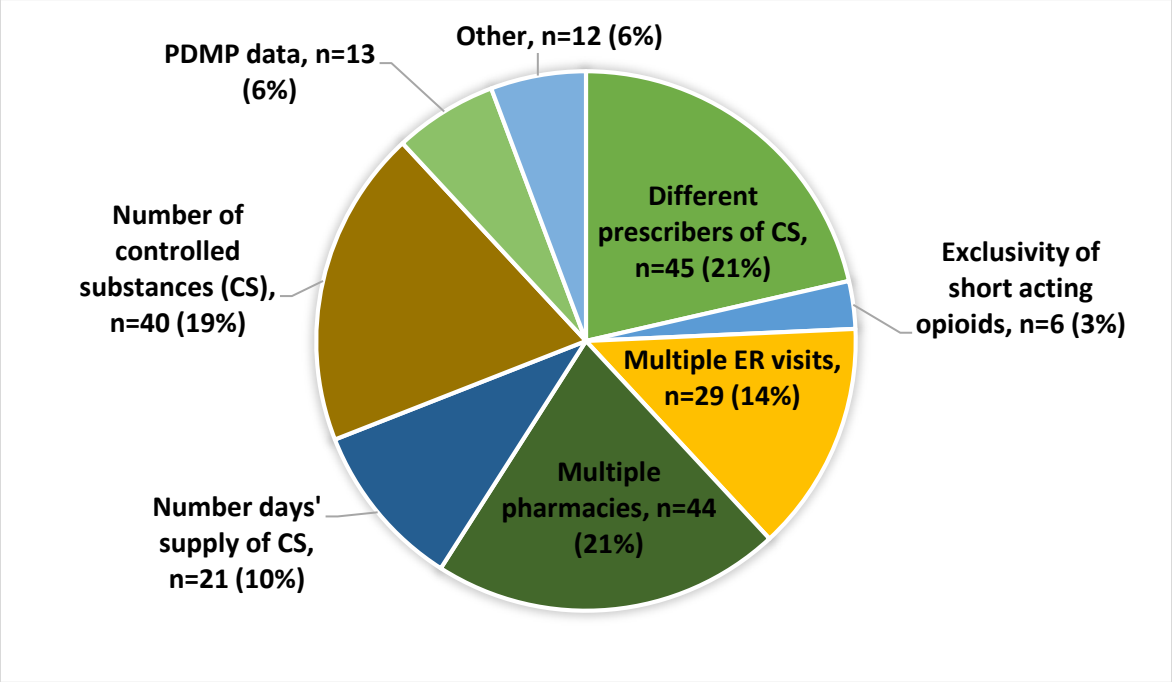

Table 73 - Lock-In Program Candidate Identification Criteria

Response	States	Count	Percentage
Different prescribers of Controlled Substances	Alabama, Alaska, Arkansas, Colorado, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	45	21.43%
Exclusivity of short acting opioids	Georgia, Maryland, New York, Oklahoma, Pennsylvania, Texas	6	2.86%
Multiple ER visits	Alabama, Alaska, Colorado, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Maine, Michigan, Minnesota, Mississippi,	29	13.81%

Response	States	Count	Percentage
	Missouri, Montana, Nebraska, New Hampshire, New York, North Dakota, Oklahoma, Oregon, Pennsylvania, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin		
Multiple pharmacies	Alabama, Alaska, Arkansas, Colorado, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	44	20.95%
Number days' supply of Controlled Substances	Alabama, Arkansas, Connecticut, Georgia, Kansas, Louisiana, Maryland, Michigan, Missouri, New Jersey, New Mexico, New York, Oklahoma, Oregon, Pennsylvania, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin	21	10.00%
Number of Controlled Substances	Alabama, Alaska, Arkansas, Colorado, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin	40	19.05%
PDMP data	Alaska, Arkansas, Georgia, Idaho, Indiana, Michigan, Mississippi, Nevada, New York, North Dakota, Utah, Washington, West Virginia	13	6.19%
Other	Arkansas, Connecticut, Idaho, Illinois, Indiana, Michigan, Nebraska, Nevada, Tennessee, Utah, Washington, West Virginia	12	5.71%

If answer is “Other”, please explain.

Table 74 - “Other” Explanations for Lock-In Program Candidate Identification Criteria

State	“Other” Explanations
Arkansas	Monitor for billed diagnoses consistent with "poisoning" for opioids, narcotics, barbiturates, benzodiazepines, or unspecified drug or substance.
Connecticut	CT uses the number of days’ supply of CS to initially identify patients for LI review but all methods listed above are used to assess whether a patient should be restricted to the LI program once they are identified initially by the days’ supply criteria.
Idaho	Provider and Board of Pharmacy Referrals
Illinois	Recipient Analysis Unit staff use the PMP as a reference only. Determination to restrict is based on claim history that may (or may not) include supporting diagnoses warranting quantities and durations of controlled substance prescribed, alternative options such as referrals to specialists and number of prescribing providers and pharmacies used.
Indiana	Number of office visits.
Michigan	The Office of the Inspector General performs SURS for both providers and beneficiaries.

State	"Other" Explanations
Nebraska	Provider referral.
Nevada	Diagnosis related to substance abuse.
Tennessee	2 levels to our Pharmacy Lock-In Program-- Lock-In and Prior Authorization Status. Once locked into a pharmacy, those who continue to use multiple physicians/pharmacies for controlled substances are then subjected to the PA Status edit, which requires a PA for every fill of every controlled substance. PA Status is also required for enrollees who have been convicted of or arrested for TennCare Fraud or Doctor Shopping, arrested for any drug offense, or if the enrollee has been found with a diagnosis of poisoning of an illicit substance.
Utah	Concurrent prescribing of abuse scheduled medications by different prescribers. Cash payments for Medicaid covered services. Criteria for lock-in include: 1. four or more primary care practitioners (PCPs) in 12 months 2. three or more different providers prescribing controlled substances 3. four or more pharmacies in 12 months 4. five or more non-emergent Emergency Room (ER), Multiple ER visits in 12 months
Washington	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
West Virginia	Use of opioids or other controlled substance with a history of overdose or abuse.

b. Do you have the capability to restrict the beneficiary to:

i. Prescriber only

Figure 60 - Prescriber Only Restriction Capability

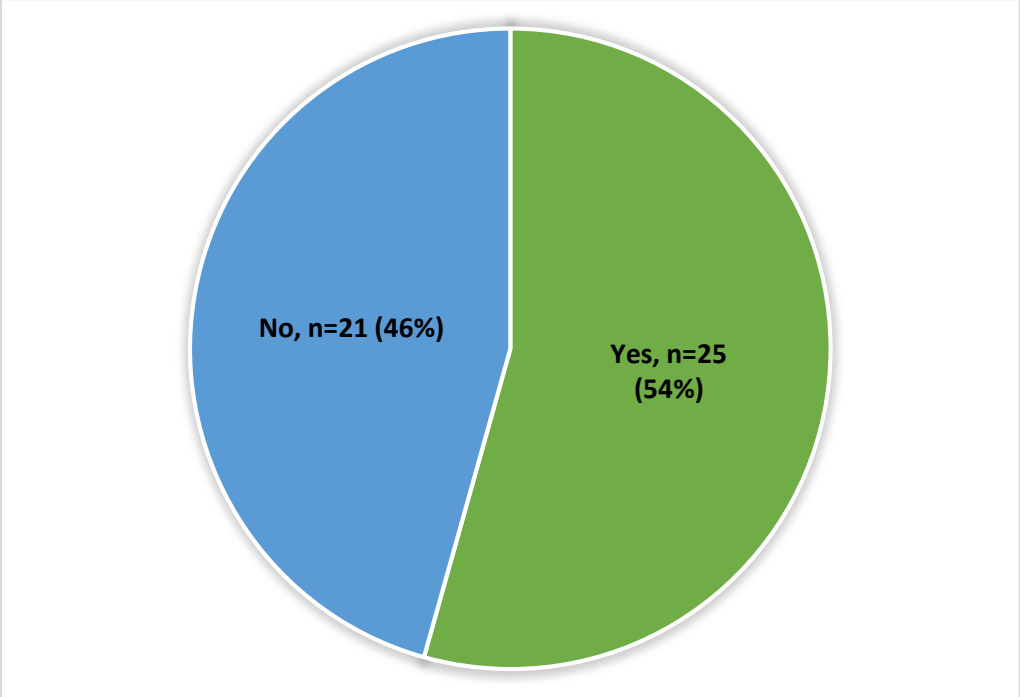

Table 75 - Prescriber Only Restriction Capability

Response	States	Count	Percentage
Yes	Colorado, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Texas, Utah, Vermont, Virginia, Washington, West Virginia	25	54.35%
No	Alabama, Alaska, Arkansas, Connecticut, Delaware, District of Columbia, Hawaii, Maryland, Massachusetts, Montana, Nebraska, New Hampshire, North Carolina, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Wisconsin, Wyoming	21	45.65%

ii. Pharmacy only

Figure 61 - Pharmacy Only Restriction Capability

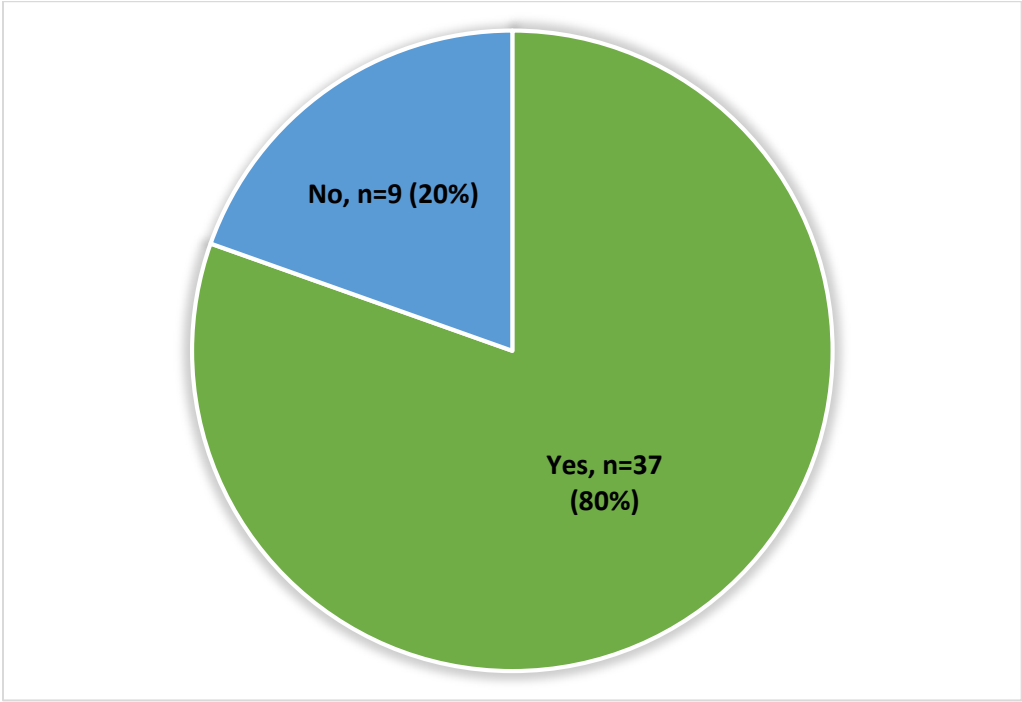

Table 76 - Pharmacy Only Restriction Capability

Response	States	Count	Percentage
Yes	Arkansas, Colorado, Connecticut, District of Columbia, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	37	80.43%

Response	States	Count	Percentage
No	Alabama, Alaska, Delaware, Hawaii, Montana, North Carolina, Oklahoma, Pennsylvania, Wisconsin	9	19.57%

iii. Prescriber and Pharmacy

Figure 62 - Prescriber and Pharmacy Restriction Capability

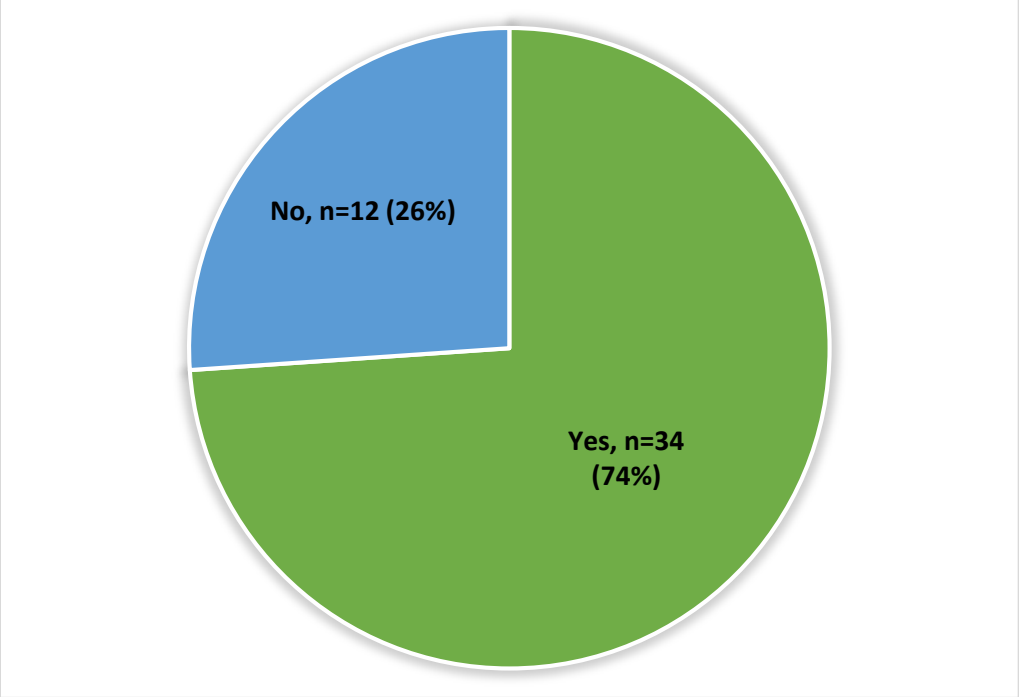

Table 77 - Prescriber and Pharmacy Restriction Capability

Response	States	Count	Percentage
Yes	Alabama, Alaska, Colorado, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin	34	73.91%
No	Arkansas, Connecticut, Delaware, District of Columbia, Maryland, Massachusetts, New Hampshire, Oregon, Rhode Island, South Carolina, Tennessee, Wyoming	12	26.09%

c. *What is the usual Lock-In time period?*

Figure 63 - Lock-In Time Period

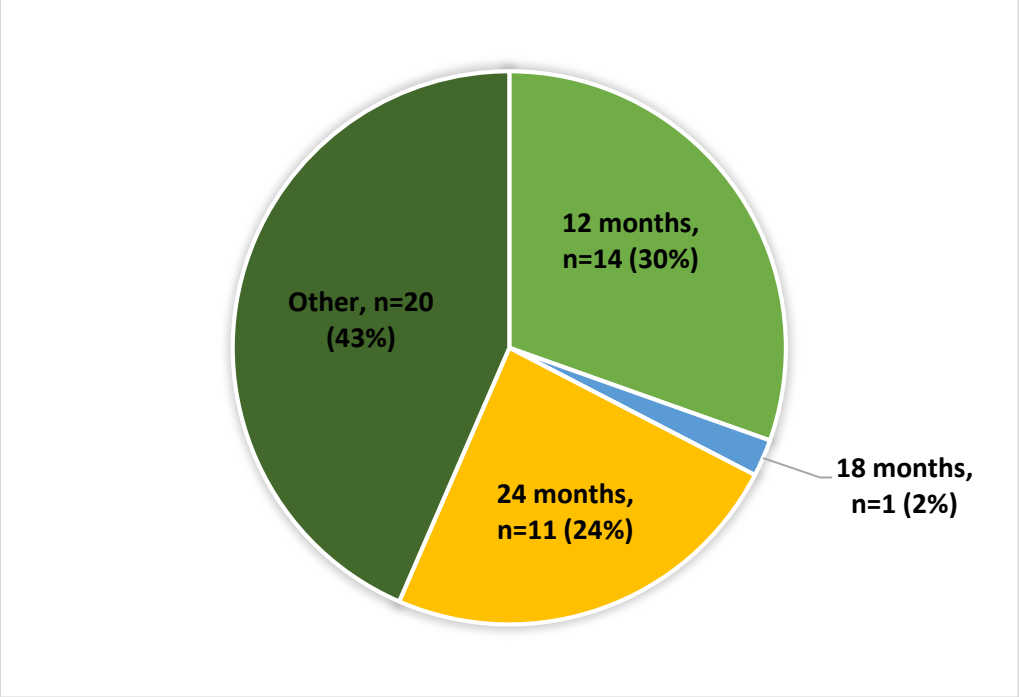

Table 78 - Lock-In Time Period

Response	States	Count	Percentage
12 months	Alabama, Alaska, Connecticut, District of Columbia, Georgia, Idaho, Massachusetts, Mississippi, Montana, New Hampshire, Rhode Island, South Carolina, Virginia, West Virginia	14	30.43%
18 months	Oregon	1	2.17%
24 months	Hawaii, Kansas, Kentucky, Louisiana, Maryland, Missouri, Nebraska, North Carolina, Ohio, Vermont, Wisconsin	11	23.91%
Other	Arkansas, Colorado, Delaware, Illinois, Indiana, Maine, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, North Dakota, Oklahoma, Pennsylvania, Tennessee, Texas, Utah, Washington, Wyoming	20	43.48%

If answer is “Other”, please explain.

Table 79 - "Other" Explanations for Lock-In Time Period

State	“Other” Explanations
Arkansas	Lock-in beneficiaries do not have a specific lock-in period. Beneficiaries are re-reviewed by the Lock-in committee yearly.
Colorado	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
Delaware	Lock in period does not have an end date but can be reviewed at the member's request

State	"Other" Explanations
Illinois	The initial FFS client lock-in is for 12 months. All subsequent lock-ins for same recipient are implemented for 24 months.
Indiana	2 years, and then re-evaluation for graduation or re-enrollment.
Maine	Varies on the severity and also the dependent on the review of urinalysis and medical chart notes and evidence of behavior changes.
Michigan	2 years
Minnesota	Initial 24 months with possibility of a 36 month renewal.
Nevada	There is no Lock-In time period. A recipient is locked-in indefinitely.
New Jersey	Time period is decided on a case by case basis.
New Mexico	The time period is determined on case by case situations.
New York	Two years of lock-in for first offense. Three years of lock-in for second offense. Six years of lock-in for third offence and any other offenses thereafter.
North Dakota	Their utilization patterns are reviewed and their lock-in providers are contacted every 18-24 months to see if they are coordinated enough to be removed from the program.
Oklahoma	New referrals are locked in for 24 months, then reviewed annually.
Pennsylvania	5 years as approved by CMS in 1985 audit of PA's Lock-In Program
Tennessee	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
Texas	First lock-in is 36 months; second lock-in is 60 months; third lock-in is lifetime. If convicted of felony, the first lock-in could be lifetime.
Utah	12 months of Medicaid eligibility with an annual review to decide appropriateness of dis-enrollment / continued enrollment of the recipient in the Lock-in Program
Washington	PRC placement: The initial PRC placement is no less than twenty-four consecutive months. A second PRC placement is no less than an additional thirty-six consecutive months. Any subsequent PRC placement is no less than seventy-two consecutive months.]
Wyoming	The first lock-in period is for 1 year. Second offense is 2 years. Third offense is six years.

d. On average, what percentage of the FFS population is in Lock-In status annually?

Figure 64 - Percentage of FFS Population in Lock-In Status Annually

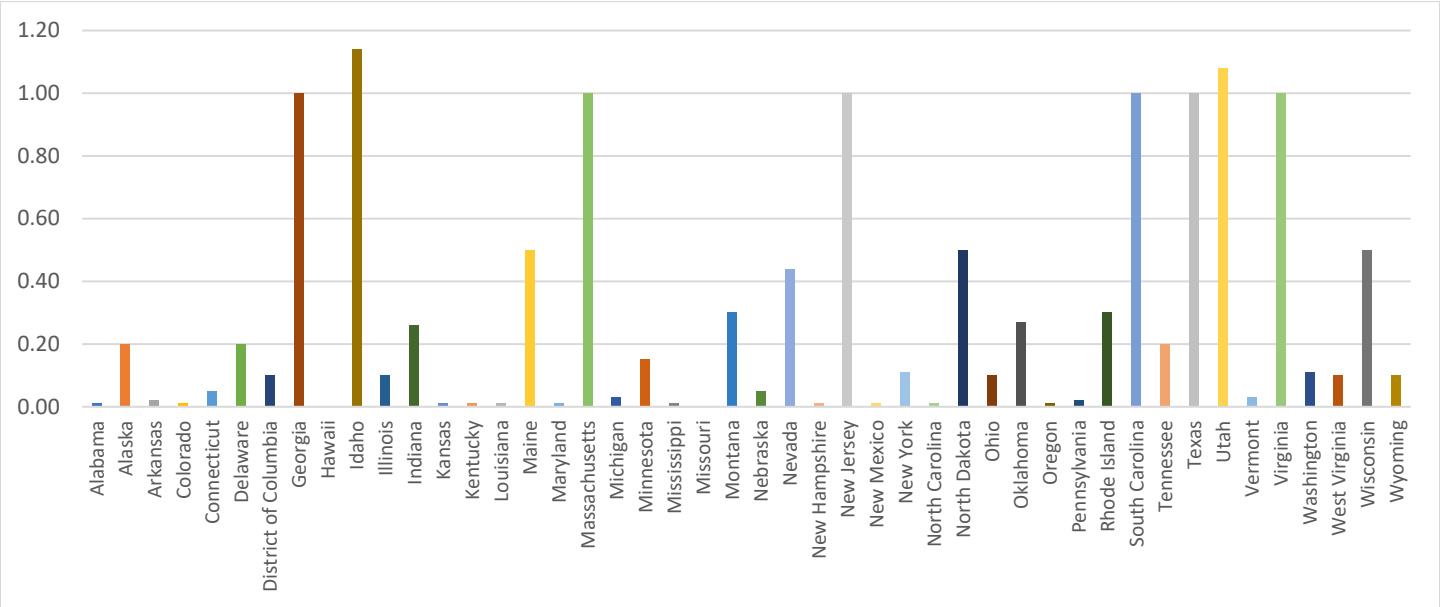

Table 80 - Percentage of FFS Population in Lock-In Status Annually

State	Percent
Alabama	0.0100%
Alaska	0.2000%
Arkansas	0.0200%
Colorado	0.0100%
Connecticut	0.0500%
Delaware	0.2000%
District of Columbia	0.1000%
Georgia	1.0000%
Hawaii	0.0000%
Idaho	1.1400%
Illinois	0.1000%
Indiana	0.2600%
Kansas	0.0100%
Kentucky	0.0100%
Louisiana	0.0100%
Maine	0.5000%
Maryland	0.0100%
Massachusetts	1.0000%
Michigan	0.0300%
Minnesota	0.1500%
Mississippi	0.0100%
Missouri	0.0017%
Montana	0.3000%
Nebraska	0.0500%
Nevada	0.4400%
New Hampshire	0.0100%
New Jersey	1.0000%
New Mexico	0.0100%
New York	0.1100%
North Carolina	0.0100%
North Dakota	0.5000%
Ohio	0.1000%
Oklahoma	0.2700%
Oregon	0.0100%
Pennsylvania	0.0200%
Rhode Island	0.3000%
South Carolina	1.0000%
Tennessee	0.2000%
Texas	1.0000%
Utah	1.0800%
Vermont	0.0300%
Virginia	1.0000%
Washington	0.1100%
West Virginia	0.1000%
Wisconsin	0.5000%
Wyoming	0.1000%

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

Figure 65 - Documented Process to Identify Possible Fraud or Abuse of Controlled Drugs by Prescribers

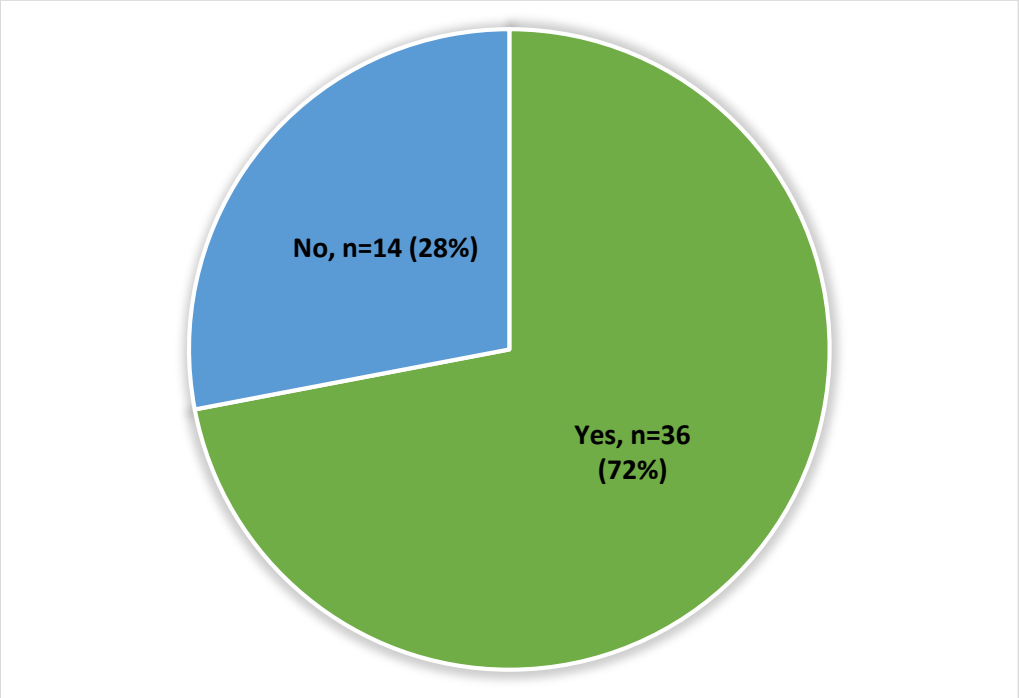

Table 81 - Documented Process to Identify Possible Fraud or Abuse of Controlled Drugs by Prescribers

Response	States	Count	Percentage
Yes	Alabama, California, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	36	72.00%
No	Alaska, Arkansas, Florida, Idaho, Louisiana, Maryland, Montana, Nevada, New Hampshire, New Mexico, North Dakota, Oregon, Texas, Wisconsin	14	28.00%

If “Yes”, what actions does this process initiate? Check all that apply:

Figure 66 - Actions Process Initiates when Possible Fraud or Abuse of Controlled Drugs by Prescribers is detected

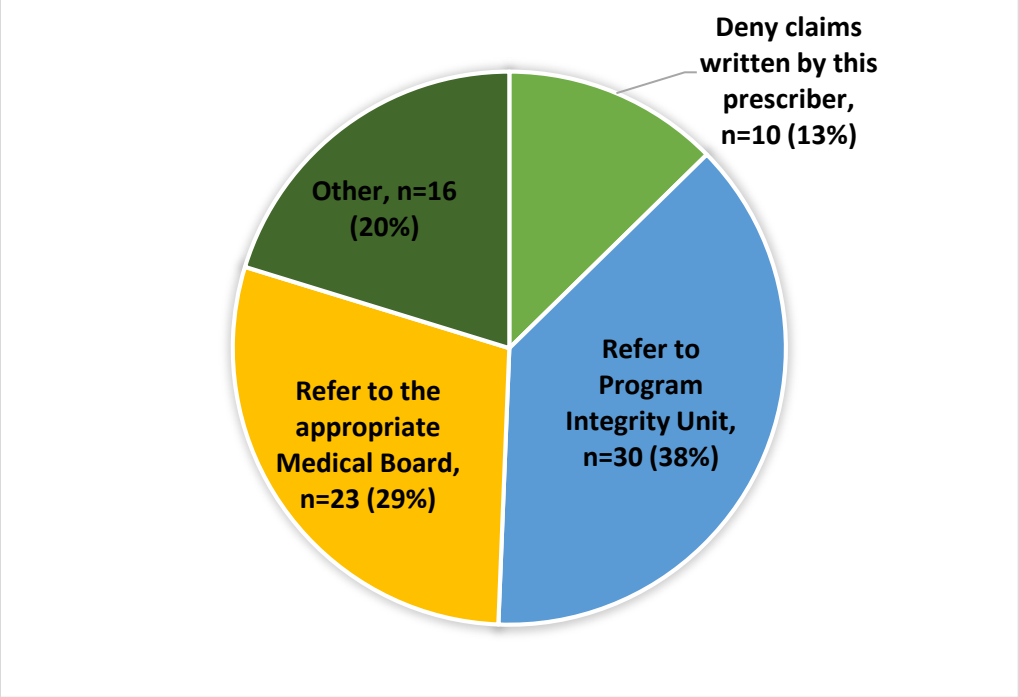

Table 82 - Actions Process Initiates when Possible Fraud or Abuse of Controlled Drugs by Prescribers is detected

Response	States	Count	Percentage
Deny claims written by this prescriber	California, Georgia, Indiana, Maine, Massachusetts, Michigan, New Jersey, Vermont, Washington, West Virginia	10	12.66%
Refer to Program Integrity Unit	Alabama, California, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Mississippi, Missouri, New Jersey, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	30	37.97%
Refer to the appropriate Medical Board	Alabama, Delaware, District of Columbia, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Mississippi, New Jersey, North Carolina, Oklahoma, Pennsylvania, South Dakota, Tennessee, Vermont, Washington, West Virginia, Wyoming	23	29.11%
Other	California, Illinois, Kansas, Michigan, Minnesota, Mississippi, Nebraska, New York, North Carolina, Pennsylvania, South Carolina, South Dakota, Tennessee, Utah, Vermont, Washington	16	20.25%

Other, please explain.

Table 83 - "Other" Explanations for Actions Process Initiates when Possible Fraud or Abuse of Controlled Drugs by Prescribers is detected

State	"Other" Explanations
California	Propose new policy such as quantity restrictions, and further review by Audit & Investigations, Investigations Branch (IB) and Medical Review Branch (MRB).
Illinois	Also report to the Illinois Department of Financial and Professional Regulation, which issues professional licenses. System edits will deny claims if the prescriber has been tagged in the system by HFS as prescriber not authorized to prescribe.
Kansas	Referrals can be made to the Attorney General's Office.
Michigan	Prescribers may be suspended or sanctioned and prescriptions written by these prescribers would then be denied at point-of-sale.
Minnesota	Refer to DHS's Office of Inspector General based on hotline tips. Also direct referrals from anyone including law enforcement, state agencies, and local advocates.
Mississippi	Refer to Mississippi Attorney General's Medicaid Fraud Control Unit
Nebraska	Program Integrity Unit is reviewing reports produced through the data warehouse of outliers for further review.
New York	Professional Retro-DUR case reviewers refer potential prescriber fraud cases to the DUR program from which they are forwarded to the Office of the Inspector General for further review and/or possible investigation.
North Carolina	An audit of specific claims would be performed.
Pennsylvania	Refer to MFCS and initiate payment suspension if appropriate.
South Carolina	Managed by PI (Program Integrity)
South Dakota	SURS
Tennessee	May also be referred to Tennessee's DUR Board for a vote of referral to Tennessee's Provider Review committee for further consideration.
Utah	Peer to peer outreach
Vermont	Refer to Medicaid Fraud and Residential Abuse Unit
Washington	Refer to Medicaid Fraud Control Unit. Depending on severity, terminate provider participation in Washington Medicaid.

4. Do you have a documented process in place that identifies possible fraud or abuse of controlled drugs by pharmacy providers?

Figure 67 - Documented Process to Identify Possible Fraud or Abuse of Controlled Drugs by Pharmacy Providers

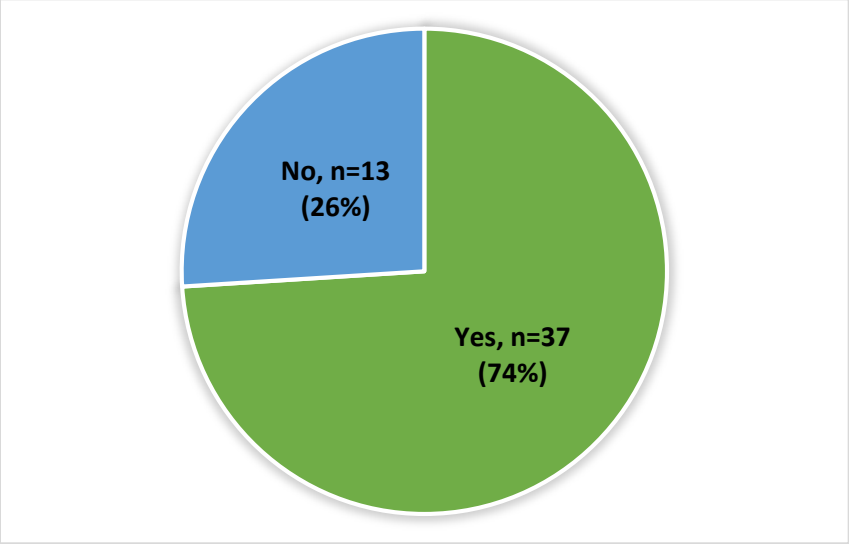

Table 84 - Documented Process to Identify Possible Fraud or Abuse of Controlled Drugs by Pharmacy Providers

Response	States	Count	Percentage
Yes	Alabama, California, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	37	74.00%
No	Alaska, Arkansas, Florida, Idaho, Kansas, Montana, Nevada, New Hampshire, New Mexico, North Dakota, Oregon, Texas, Wisconsin	13	26.00%

If "Yes", what actions does this process initiate? Check all that apply:

Figure 68 - Actions Process Initiates when Possible Fraud or Abuse of Controlled Drugs by Pharmacy Providers is detected

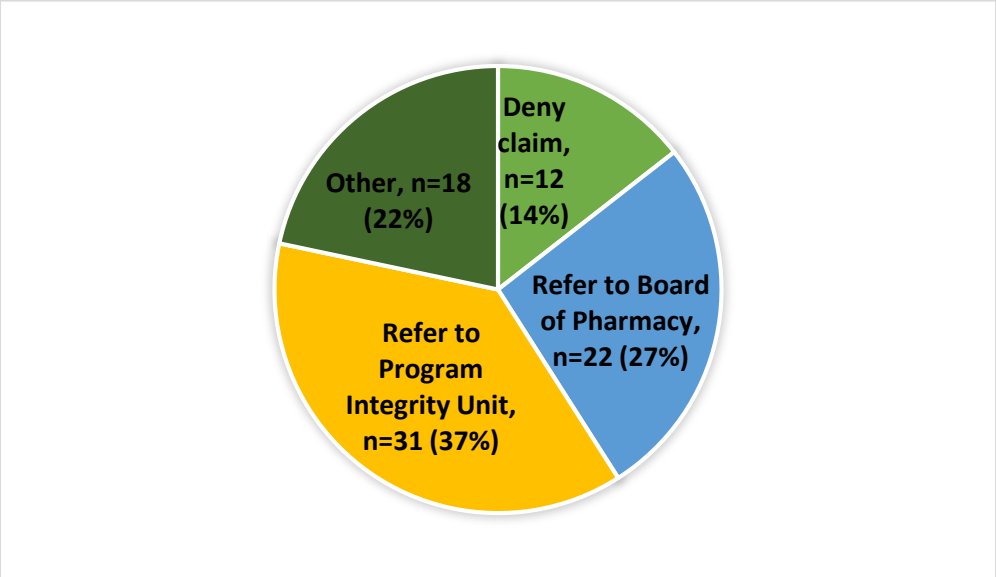

Table 85 - Actions Process Initiates when Possible Fraud or Abuse of Controlled Drugs by Pharmacy Providers is detected

Response	States	Count	Percentage
Deny claim	Georgia, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Missouri, New Jersey, Vermont, West Virginia	12	14.46%
Refer to Board of Pharmacy	Alabama, Delaware, District of Columbia, Georgia, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Michigan, Mississippi, New Jersey, North Carolina, Oklahoma, Pennsylvania, South Dakota, Tennessee, Vermont, Washington, West Virginia, Wyoming	22	26.51%
Refer to Program Integrity Unit	Alabama, California, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Mississippi,	31	37.35%

Response	States	Count	Percentage
	Missouri, New Jersey, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming		
Other	California, Georgia, Illinois, Indiana, Kentucky, Maryland, Michigan, Minnesota, Mississippi, Nebraska, New York, North Carolina, Pennsylvania, South Carolina, South Dakota, Tennessee, Utah, Washington	18	21.69%

Other, please explain.

Table 86 - "Other" Explanations for Actions Process Initiates when Possible Fraud or Abuse of Controlled Drugs by Pharmacy Providers is detected

State	"Other" Explanation
California	Propose new policy such as quantity restrictions, and further review by Audit & Investigations, Investigations Branch (IB) and Medical Review Branch (MRB).
Georgia	Pharmacy will be referred for audit; we have an active pharmacy audit program; explanation of benefit surveys to patients regarding pharmacy claims. Over 300 desk and field audits conducted in FY2018.
Illinois	Refer to Provider Analysis Unit for evaluation. Also report to the Illinois Department of Financial and Professional Regulation, which issues professional licenses.
Indiana	Audit recoupment, prepayment review program
Kentucky	Refer to audit vendor for desk audit.
Maryland	The Office of Inspector General conducts audits of Maryland pharmacies to ensure compliance with regulations for all medications for Medicaid. A compliance pharmacist performs desktop audits to identify potential fraud, waste and abuse for control substances over $400.
Michigan	Pharmacies may be suspended or sanctioned which results in in the denial of claims submitted by the pharmacy at point-of-sale.
Minnesota	Refer to DHS's Office of Inspector General based on hotline tips. Also direct referrals from anyone including law enforcement, state agencies, and local advocates.
Mississippi	Refer to Mississippi Attorney General's Medicaid Fraud Control Unit
Nebraska	Program Integrity Unit is reviewing reports produced through the data warehouse of outliers for further review.
New York	Professional Retro-DUR case reviewers refer potential prescriber fraud cases to the DUR program from which they are forwarded to the Office of the Inspector General (OMIG) for further review and/or possible investigation.
North Carolina	An audit of specific claims would be performed.
Pennsylvania	Refer to MFCS
South Carolina	Managed by PI (Program Integrity)
South Dakota	SURS
Tennessee	May also be referred to Tennessee's DUR Board for a vote of referral to Tennessee's Provider Review committee for further consideration.
Utah	Peer to peer outreach
Washington	Refer to Medicaid Fraud Control Unit. Recoup payment for inappropriately billed / paid claims. Depending on severity, terminate provider participation in Washington Medicaid.

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

Figure 69 - Documented Process to Identify Possible Fraud or Abuse of Non-Controlled Drugs by Beneficiaries

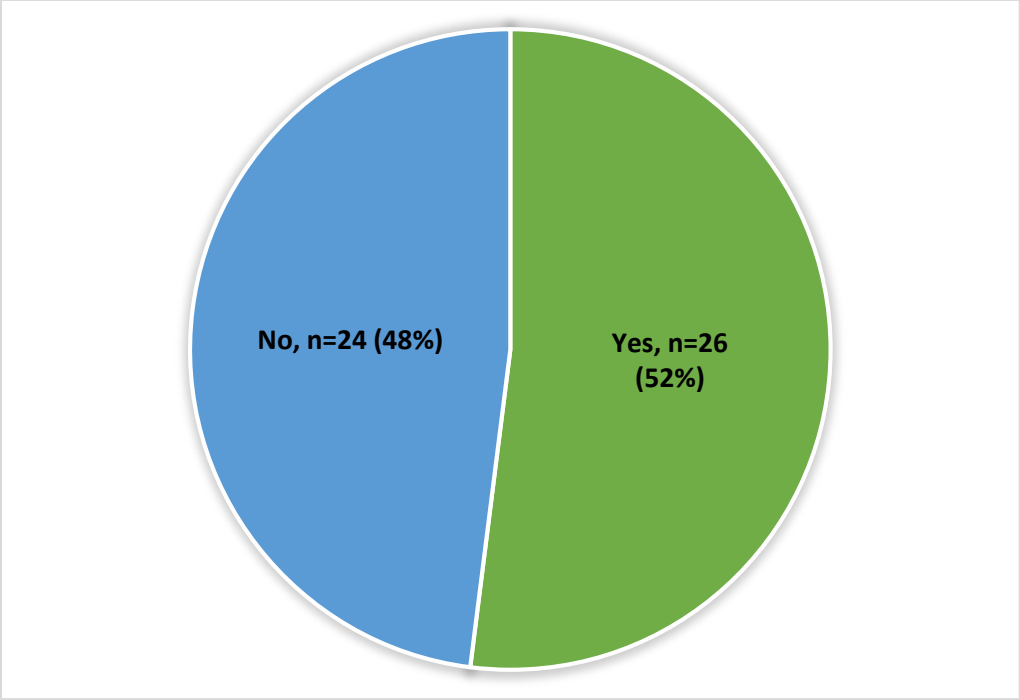

Table 87 - Documented Process to Identify Possible Fraud or Abuse of Non-Controlled Drugs by Beneficiaries

Response	States	Count	Percentage
Yes	Alabama, California, Colorado, Connecticut, Georgia, Hawaii, Illinois, Iowa, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Nebraska, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Texas, West Virginia, Wisconsin	26	52.00%
No	Alaska, Arkansas, Delaware, District of Columbia, Florida, Idaho, Indiana, Kansas, Maryland, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Rhode Island, Tennessee, Utah, Vermont, Virginia, Washington, Wyoming	24	48.00%

If "Yes," please explain your program for fraud, waste or abuse of non-controlled substances.

Table 88 – Explanations of Documented Processes to Identify Possible Fraud or Abuse of Non-Controlled Drugs by Beneficiaries

State	Explanations
Alabama	Through eligibility and URC, recipients are referred to MFCU.

State	Explanations
California	Audit & Investigations, Investigations Branch (IB) uses all available information to develop and work cases, initiates audits, and assists in investigations, including review of claims data and trends of non-controlled drugs.
Colorado	Retrospective DUR analysis and prior authorization are used to identify these issues. They are referred to the Program Integrity Unit, who works with the counties.
Connecticut	The quality assurance program at DSS performs random claims samples of controlled and non-controlled drugs to identify anomalies in payment and claims processing.
Georgia	Deny claims and require prior authorization; quantity limits; refer to Program Integrity
Hawaii	Prior authorization requests are reviewed for greater than established quantity limits and early refills.
Illinois	Recipient and Provider Analysis Units looks at correlating diagnoses to support use of all medications and medical benefits by beneficiaries. We also look to see if alternative services to drug therapy are ordered for recipients such as physical therapy, specialty providers, assistive devices etc. that would indicate standards of care being provided. We will also contact ordering provider to validate need. If fraud or abuse of non-narcotics are suspected we work together with appropriate unit(s) to implement cost avoidance measures such as quantity limits and product cost reduction.
Iowa	If fraud or abuse of a non-controlled substance is identified, the member would be referred to Program Integrity for further investigation.
Kentucky	Refill too soon, ProDUR checks, desk audits, RetroDUR audits, quantity limits for dose optimization, dose accumulation edits, and other general DUR activities or system edits enabled/supported by FirstDatabank and vendor capabilities.
Louisiana	Point of sale edits.
Maine	Review and referral system to identify over use and internal clinical review for placement in the lock-in program (IBM) Intensive Benefit Management
Massachusetts	MassHealth monitors through Quantity Limits and Dose limits
Michigan	Beneficiaries with high utilization of emergency room prescribers and pharmacies including those that paid with cash are subject to review.
Minnesota	Questionable utilization is referred to the SURS program and they determine the action from there.
Nebraska	Early refill limits and daily quantity limits.
New Jersey	Lock into a pharmacy and utilize negative PA. Negative PA will block payment of a prescription service.
New York	Professional Retro-DUR case reviewers refer potential prescriber fraud cases to the DUR program from which they are forwarded to the Office of the Inspector General (OMIG) for further review and/or possible investigation.
Ohio	We partner with other state agencies and investigative units to monitor potential misuse of prescriptions.
Oklahoma	Muscle relaxant and gabapentin claims are considered when locking in members.
Oregon	Early refill edit
Pennsylvania	Review for the Lock-In Program includes all medications. Beneficiaries may be restricted for fraud, waste, or abuse of non-controlled substances.
South Carolina	Managed by PI (Program Integrity)
South Dakota	Retrospective Drug Utilization Review
Texas	Yes. Referrals are made to the OIG-Lock-In Program, OIG-MPI; and Law Enforcement and Texas Department of Family and Protective Services as appropriate. Following the referral via the WAFERS (Waste, Abuse and Fraud Referral System), beneficiaries referred to the Lock-In Program are restricted to one specific pharmacy.

State	Explanations
West Virginia	Our early refill edit and quantity limit edit protect against a member obtaining more than 12 months' supply of any drug in a year. Drugs requiring a PA typically require a minimum an approved diagnosis.
Wisconsin	Fraud and abuse must be reported regardless if the drug is a controlled drug or a non-controlled drug. Providers may report fraud and abuse by going to the OIG fraud and abuse website or by calling the fraud and abuse hotline.

B. Prescription Drug Monitoring Program (PDMP)

1. Does your state have a Prescription Drug Monitoring Program (PDMP)?

Figure 70 - Prescription Drug Monitoring Program

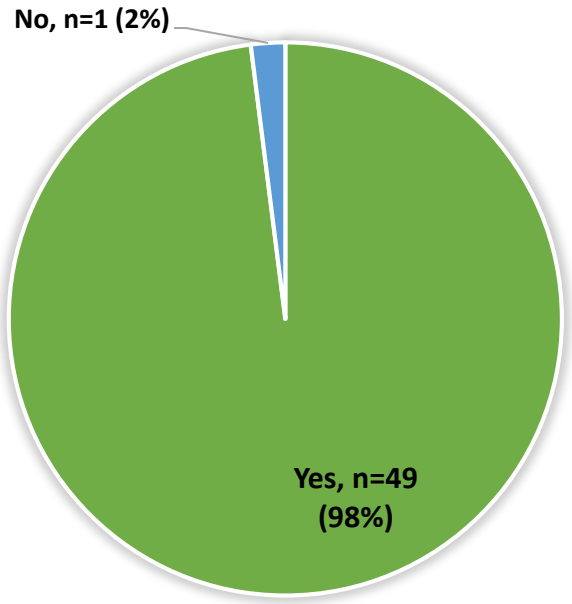

Table 89 - Prescription Drug Monitoring Program

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	49	98.00%
No	Missouri	1	2.00%

If answer to question 1 above is “Yes”:

a. *Does your state have the ability to query the state’s PDMP database?*

Figure 71 - Ability to Query State’s PDMP Database

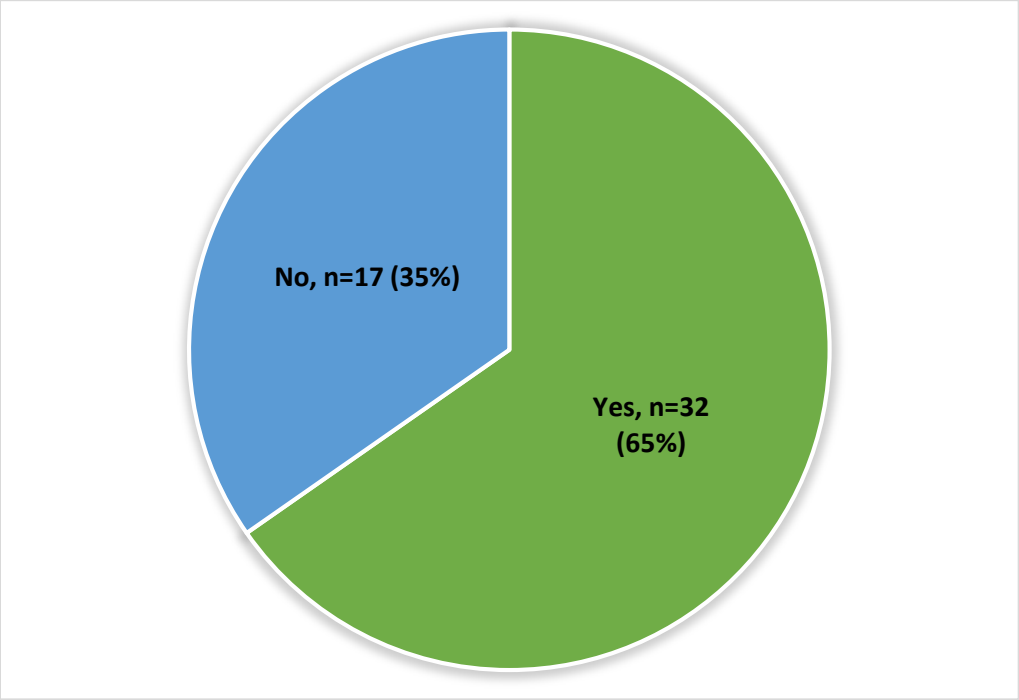

Table 90 - Ability to Query State’s PDMP Database

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Connecticut, Delaware, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Montana, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia	32	65.31%
No	Colorado, District of Columbia, Florida, Hawaii, Iowa, Minnesota, Nebraska, New Hampshire, New Jersey, New York, Oregon, Rhode Island, South Carolina, Texas, Virginia, Wisconsin, Wyoming	17	34.69%

i. If the answer to (number1a) above is "Yes," please explain how the state applies the information to control fraud and abuse.

Table 91 – Explanations of Application of Information to Control Fraud and Abuse

State	Explanations
Alabama	Alabama Medicaid has limited access to PDMP as the oversight is with another state agency.
Alaska	If fraud or abuse is suspected we are able to confirm it. This allows us to review individual cases to compare Medicaid data against what is reported in the PDMP.
Arkansas	The Arkansas State Medical Board requires prescribers to access the PDMP before prescribing controlled drugs.
California	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
Connecticut	State law requires all prescribers to review a patient's controlled substance history report if writing for more than a 72 hour supply. The provider agreement with the agency requires prescribers to adhere to all state laws and regulations.
Delaware	Cindy -- please review and add if appropriate. I thought I remembered you being able to access.
Georgia	Assessment for Lock-In Program
Idaho	The clinical pharmacy staff at IDHW will access the PDMP in cases where it is brought to their attention if fraud/abuse is thought to be occurring. The PDMP is also used to identify patients who are paying cash for controlled substances outside of Idaho Medicaid payment.
Illinois	Prescribers are asked to check ILPMP when prior authorization requests are received for hepatitis C medications, adult ADHD medications, and chronic opioid use.
Indiana	N/A
Kansas	We have access through our Medicaid SURS unit and through the FFS pharmacy team, but no process for real time use is in place.
Kentucky	Prescribers must attest to the fact that the PDMP report was reviewed in order for certain PAs to be approved.
Louisiana	The additional data accessed through PDMP assists the LDH pharmacy staff in determining fraud and abuse.
Maine	Purely as a reference source for prescription activity in the case of beneficiary review.
Maryland	Information obtained from the PDMP is used for the Corrective Managed Care Program through the FFS program if a formal investigation is being conducted.
Massachusetts	Medicaid checks MassPAT for outlier behavior episodically and develops corrective action.
Michigan	MDHHS requires prescribers of opioids and medication assisted therapy (MAT) agents to be registered and access the PDMP. In addition, the MI Department of Licensing and Regulatory Affairs (LARA) monitors prescribing patterns and investigates. MDHHS also works closely with the OIG and the AG offices.
Mississippi	State's Program Integrity Unit can audit the PDMP to verify suspected fraud and abuse. DUR vendor has access to both claims and cash-pay data to analyze claims for suspected fraud and abuse based on prescriber and pharmacy providers.
Montana	We review utilization between FlexibleRx and the PDMP looking for cash pay on the PDMP that are not found in FlexibleRx
Nevada	A query may be used during a Lock-In evaluation of a recipient. It may also be used for evaluation of suspicious recipient activity.
New Mexico	Information is obtained on a case by case situation.
North Carolina	Prescribers are required to access the PDMP patient history before prescribing an opioid and before a PA will be granted.

State	Explanations
North Dakota	PDMP reports are reviewed when receiving calls regarding early refill requests and other overrides for controlled substances. PDMP reports are also used in reviews for the lock-in program.
Ohio	Used to verify whether the Medicaid claims are controlled substances received by patients. This will identify patients that are paying cash for their controlled substances.
Oklahoma	Evaluate members for the lock-in program and individual review of members to prevent excess abuse.
Pennsylvania	Clinical staff in the Department's FFS Medicaid Program have access to the PDMP. The MA MCO clinicians do not have access to the PDMP.
South Dakota	On a case by case basis
Tennessee	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
Utah	Utah Medicaid is limited by the State Statute in how it may access and use data from the PDMP but the pharmacy program staff is able to send requests to restriction staff, who query PDMP on our behalf.
Vermont	Only the Medical Director has access to query PDMP The Medical Director of the Department of Vermont Health Access relating to a Medicaid recipient for whom a claim for a Schedule II, III, or IV was submitted. This access is for Medicaid quality assurance, utilization, and federal monitoring purposes
Washington	PDMP data is used by clinical staff when reviewing authorization requests for approval, allowing for denial of inappropriate prescriptions. Bulk data is analyzed to identify inappropriate cash payment of controlled substances, and such payments are grounds for enrollment in the lock-in program. Bulk data is shared with managed care plans, for assistance in operating their lock-in programs.
West Virginia	If the PDMP indicates that a member is obtaining a controlled substance by more than one payer source the matter is referred to the Medicaid Fraud unit. Information obtained through this query may also be used when evaluating a request for prior authorization.

ii. Do you have access to Border States' PDMP information?

Figure 72 - Access to Border State PDMP Information

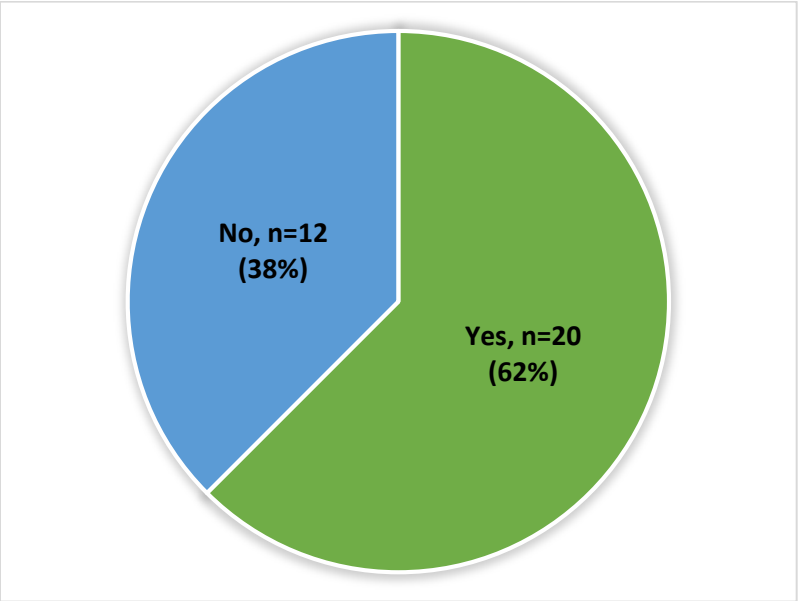

Table 92 - Access to Border State PDMP Information

Response	States	Count	Percentage
Yes	Connecticut, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Mississippi, Montana, Nevada, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Vermont	20	62.50%
No	Alabama, Alaska, Arkansas, California, Delaware, Georgia, Maine, Maryland, North Carolina, Utah, Washington, West Virginia	12	37.50%

iii. Do you have PDMP data (i.e. outside of MMIS, such as a controlled substance that was paid for by using cash) integrated into you POS edit?

Figure 73 - PDMP Data Integration into POS Edit

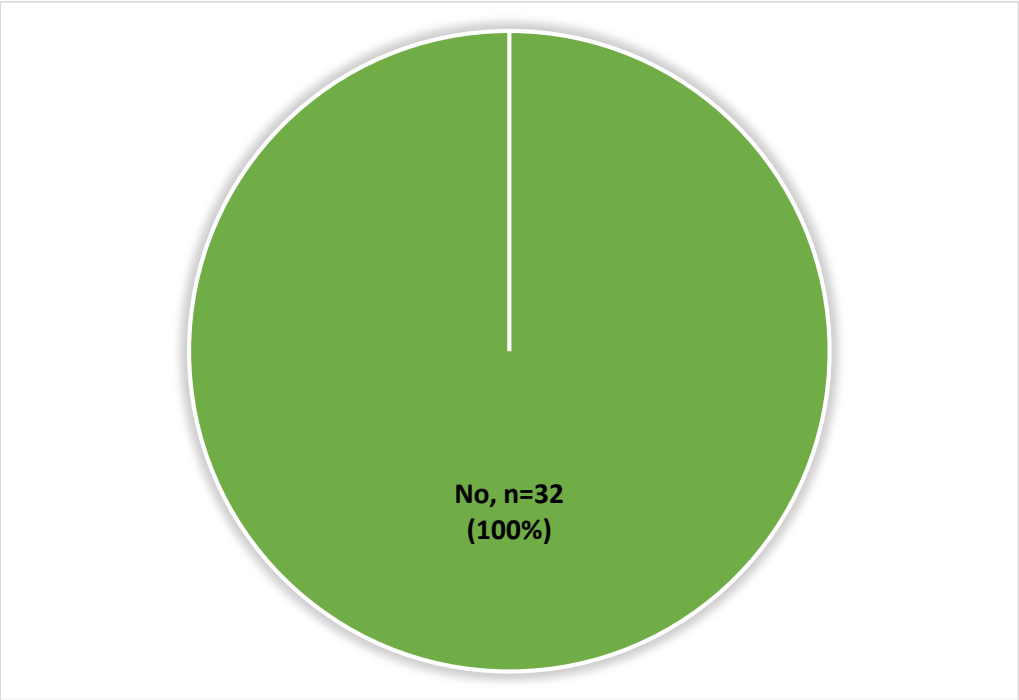

Table 93 - PDMP Data Integration into POS Edit

Response	States	Count	Percentage
No	Alabama, Alaska, Arkansas, California, Connecticut, Delaware, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Montana, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia	32	100.00%

b. Do you require prescribers (in your provider agreement with the agency) to access the PDMP patient history before prescribing controlled substances?

Figure 74 - Prescribers Requirement to Access the PDMP Patient History before Prescribing Controlled Substances

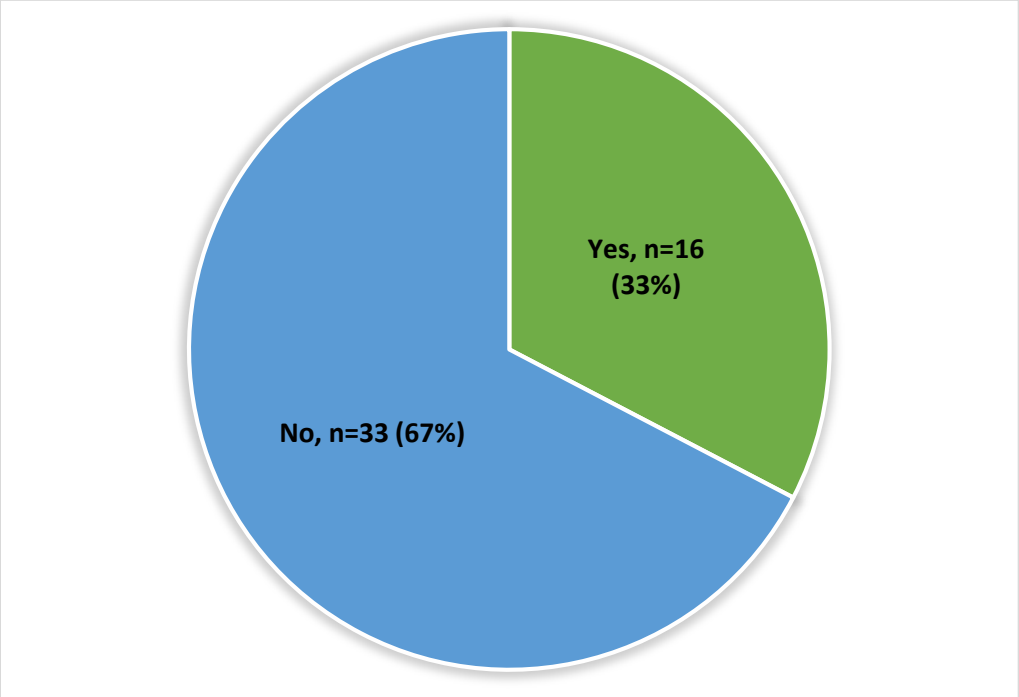

Table 94 - Prescribers Requirement to Access the PDMP Patient History before Prescribing Controlled Substances

Response	States	Count	Percentage
Yes	Connecticut, Delaware, Georgia, Kentucky, Maryland, Massachusetts, Michigan, New York, North Carolina, North Dakota, Pennsylvania, South Carolina, Tennessee, Vermont, Virginia, West Virginia	16	32.65%
No	Alabama, Alaska, Arkansas, California, Colorado, District of Columbia, Florida, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, Ohio, Oklahoma, Oregon, Rhode Island, South Dakota, Texas, Utah, Washington, Wisconsin, Wyoming	33	67.35%

c. *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?*

Figure 75 - Barriers that Hinder the Agency from Fully Accessing the PDMP

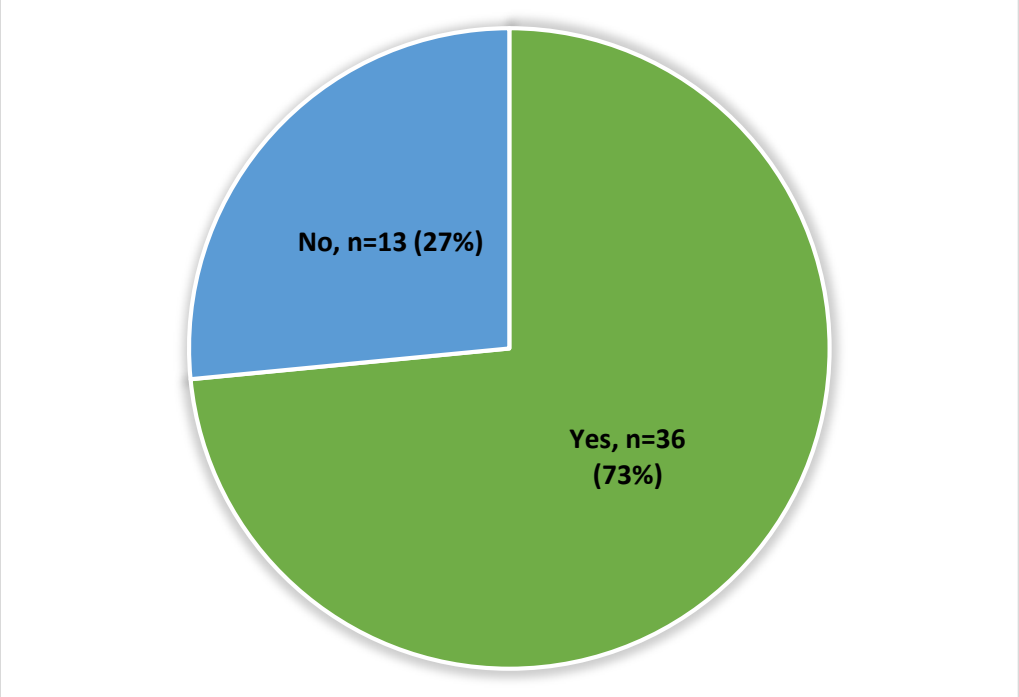

Table 95 - Barriers that Hinder the Agency from Fully Accessing the PDMP

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Maryland, Massachusetts, Minnesota, Nebraska, Nevada, New Hampshire, New Jersey, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	36	73.47%
No	Delaware, Kentucky, Louisiana, Maine, Michigan, Mississippi, Montana, New Mexico, New York, Ohio, Pennsylvania, South Carolina, South Dakota	13	26.53%

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

Table 96 – Explanations of PDMP Barriers

State	Barrier Explanations
Alabama	Alabama Medicaid has limited access to PDMP as the oversight is with another state agency. Prescribers/pharmacists are not required to access prior to writing/dispensing prescriptions.
Alaska	Lag time in data being submitted.
Arkansas	At this time, not all states have the PDMP and Arkansas cannot access all of the states with PDMP. This appears to be improving with the SUPPORT Act which will help have complete records for those moving from other states.
California	The following barriers exist that hinder the agency from fully accessing the PDMP in the way it was intended: Inability to access border states PDMP information Lag time for prescription data being submitted Ambiguous regulations governing access to PDMP data
Colorado	The State is prohibited by legislation from accessing the PDMP. In our criteria, we encourage providers to access the PDMP before prescribing any opioids.
Connecticut	Access is restricted to our Medicaid Fraud Unit only.
District of Columbia	The DC PDMP does include data from the bordering states of MD and VA, as well as data shared from DE, CT, RI, MA, NY, WV and PA. The main access barrier is that per the Department of Health's PDMP Administrator, the PDMP is not to be used by the Department of Health Care Finance (DC Medicaid) for efforts of its Pharmacy Lock-in Program or other pharmacy benefit management related initiatives. Such activity is considered to be "Fishing" or data-mining. Currently the PDMP can only be used by Medicaid's Program Integrity Unit to assist with providing information for an active fraud or criminal investigation.
Florida	Medicaid does not have access to PDMP.
Georgia	Limited to claim-level detail (cannot query by prescriber) and must have an NPI to access PDMP.
Hawaii	Lack of manpower in both agencies has limited collaboration. Meth is the problem in Hawaii, not opioids. By Hawaii law all practitioners, except veterinarians, and pharmacies shall be registered to utilize the PDMP and prescribers are required to consult the PDMP before prescribing as schedule II-IV controlled substance, in order reduce the risk of abuse of addiction to a controlled substance, to avoid harmful drug interactions, or as otherwise medically necessary. Entry is assumed but not mandated.
Idaho	Can only access by specific patient. Lag time in information available for border states. Not able to generate aggregate reports like cash payments and MME's over 500 from any payment source. Not being able to see methadone clinics.
Illinois	Need to view one patient at a time and re-enter data if checking neighboring state. Not all pharmacies submit data in a timely manner as evidenced by claims filled, but not yet visible in PDMP. No way to verify if prescriber checked ILPMP prior to writing prescription.
Indiana	Lag time in prescription data being submitted, prescribers not accessing, pharmacists not accessing before filling script, unable to query and monitor the database
Iowa	The Medicaid Program (under the Department of Human Services) is unable to access this data which is under the purview of the Iowa Board of Pharmacy under the Department of Public Health. The PMP is only available to authorized healthcare practitioners to review their patient's use of controlled substances.
Kansas	We do not have a process at the agency, but the Kansas pharmacies/pharmacists have access on demand.

State	Barrier Explanations
Maryland	The FFS program must have a bonafide formal investigation to access the PDMP. Requests must be approved by the Secretary of the Maryland Department Of Health (MDH). Information is obtained through the MDH's PDMP. This may lead to a lag time between requests and the receipt of information. Additionally, technical issues include system downtime maintenance and delay of claims submission by providers.
Massachusetts	No aggregate data 42CFR part 2 Methadone maintenance is not uploaded into MassPAT DUR Program does not have access to MassPAT
Minnesota	There is very strict criteria as to when SURS can access the PDMP in the case of a recipient under investigation for fraud and abuse.
Nebraska	Nebraska Medicaid does not have legal authority to access PDMP data.
Nevada	Only one State staff is allowed access to the PDMP. Contractors (including PBM and MCO's) are not allowed access to the PDMP. By not allowing access to the MCO's, there is inconsistencies with Lock-In Program evaluation between FFS and the MCO's.
New Hampshire	Medicaid program staff do not have access to the NH PDMP.
New Jersey	NJ PDMP grants access to prescribers and pharmacists who are licensed by the State of New Jersey and in good standing with their respective licensing boards. Licensed pharmacy staff conducting DUR is considered unauthorized users since they are not directly delivering healthcare.
North Carolina	Many pharmacies have restricted internet access, delay in processing data submitted, prescribers complain of time required to log in.
North Dakota	Some other states don't allow Medicaid administrators (even pharmacists) from accessing their PDMP data for these purposes.
Oklahoma	The agency has very limited access to the PMP. Access cannot be granted to contractors who perform lock-in functions. The agency may only query one member at a time. There is no way to access aggregated prescriber data.
Oregon	Payers do not have access to the PDMP in Oregon
Rhode Island	State law requires the user of the PDMP have a DEA number.
Tennessee	As mentioned above, barriers are very few at this time. The only issue is that we are authorized to use the data in aggregate.
Texas	Texas State Board of Pharmacy does not allow payers, including Medicaid, to access this portal.
Utah	Because Utah Medicaid is limited by State Statute in how it may access and use data from the PDMP, delays in real time with requested queries through another party occur. Also, while prescribers are required by State Law the check the PDMP prior to prescribing a controlled substance, there is no way of knowing if prescribers have accessed it to verify information.
Vermont	Currently according to rule only the Medical Director of the Department of Vermont Health Access has the Authority to Query VPMS directly.7.1.4 The Medical Director of the Department of Vermont Health Access relating to a Medicaid recipient for whom a claim for a Schedule II, III, or IV was submitted. This access is for Medicaid quality assurance, utilization, and federal monitoring purposes
Virginia	not allowed to access by state law
Washington	Washington State continues to struggle with improving usage by prescribing providers.
West Virginia	Access to the PDMP is limited to one person at our department and queries are capable of only pulling up one member at a time. We are also unable to access information outside our borders even though we enroll pharmacies as far as 30 miles from the border.
Wisconsin	The PDMP is managed by a different agency and the data is not readily available. The State is working with the PDMP agency to gain access to the data needed.

State	Barrier Explanations
Wyoming	The Board of Pharmacy's current understanding of the legislation prohibits the Department of Health from accessing the PDMP.

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

Figure 76 - Changes to Your State's PDMP during this Reporting Period that have Improved the Agency's Ability to Access PDMP Data

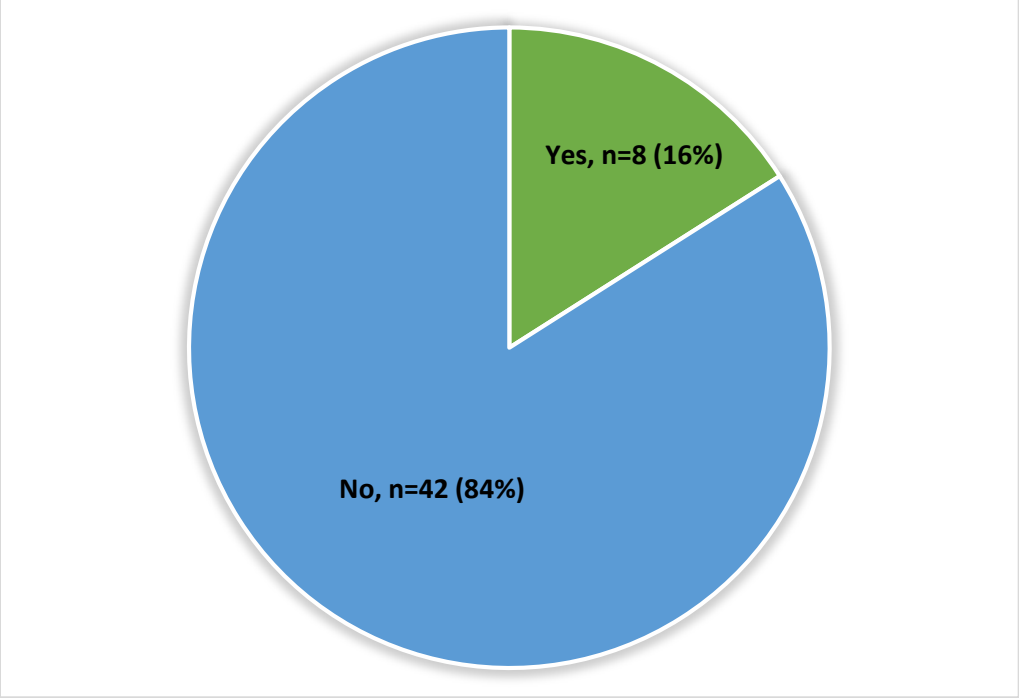

Table 97 - Changes to Your State's PDMP during this Reporting Period that have Improved the Agency's Ability to Access PDMP Data

Response	States	Count	Percentage
Yes	California, Idaho, Illinois, Michigan, Nevada, South Carolina, Tennessee, West Virginia	8	16.00%
No	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, Wyoming	42	84.00%

If “Yes”, please explain.

Table 98 - Explanations of PDMP Changes

State	Explanations
California	In 2016, California updated their prescription drug monitoring program, the Controlled Substance Utilization Review and Evaluation System (CURES), to CURES 2.0. Pursuant to Section 11165.4(e) of the Health and Safety Code, this upgraded database was certified for statewide use by the Department of Justice on April 2, 2018. As a result of the certification that took place in FFY 2018, effective for dates of service on or after October 2, 2018, it will be mandatory to consult the CURES 2.0 database prior to prescribing, ordering, administering, or furnishing a Schedule II to IV controlled substance.
Idaho	More states included in the national database. Addition of the VA and military information.
Illinois	ILPMP continues to expand the number of neighboring states' data that is visible. More prescribers now have access due to linkage directly to several medical systems EMRs
Michigan	The PDMP system was enhanced with additional user access roles and informative provider and patient risk scoring reports.
Nevada	In 2018, users were provided access to an advanced analytics and patient support tool called NarxCare. This enhancement provides aggregated and analyzed prescription information to providers and pharmacies. The analysis includes Narx Scores and Overdose Risks Scores.
South Carolina	State Pharmacy Director now has access (April 2019)
Tennessee	See above. Explained in 1.a.i.
West Virginia	We are now allowed to delegate authority to our PA vendor so that they may also review patients before granting overrides and PAs.

C. Pain Management Controls

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

Figure 77 - Possession of DEA Active Controlled Substance Registrant’s File to Identify Prescribers Not Authorized to Prescribe Controlled Drugs

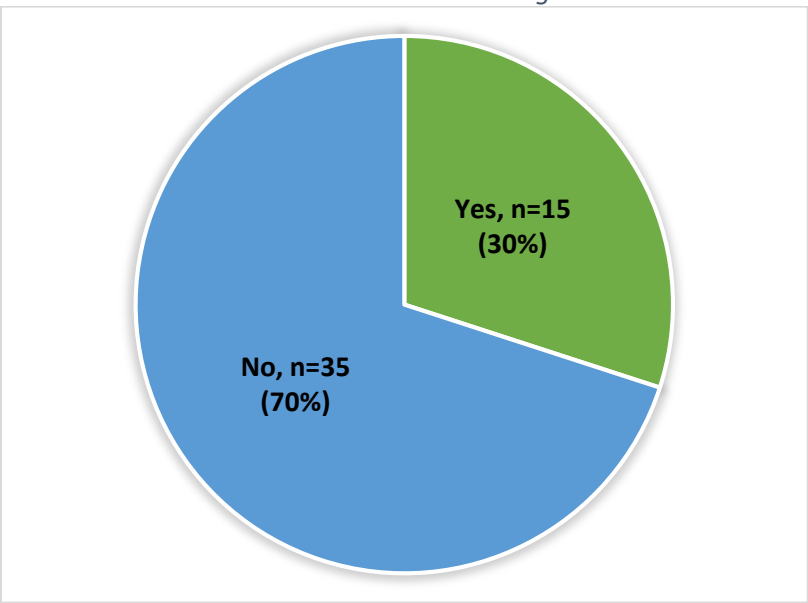

Table 99 - Possession of DEA Active Controlled Substance Registrant's File to Identify Prescribers Not Authorized to Prescribe Controlled Drugs

Response	States	Count	Percentage
Yes	Alabama, Alaska, Connecticut, Idaho, Maine, Michigan, Missouri, New Hampshire, North Dakota, Pennsylvania, South Carolina, South Dakota, Tennessee, Washington, West Virginia	15	30.00%
No	Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, Texas, Utah, Vermont, Virginia, Wisconsin, Wyoming	35	70.00%

a. *If the answer to question 1 is "Yes", do you apply this DEA file to your ProDUR POS edits to prevent unauthorized prescribing?*

Figure 78 - Application of the DEA Active Controlled Substance Registrant's File to Your ProDUR POS Edits to Prevent Unauthorized Prescribing

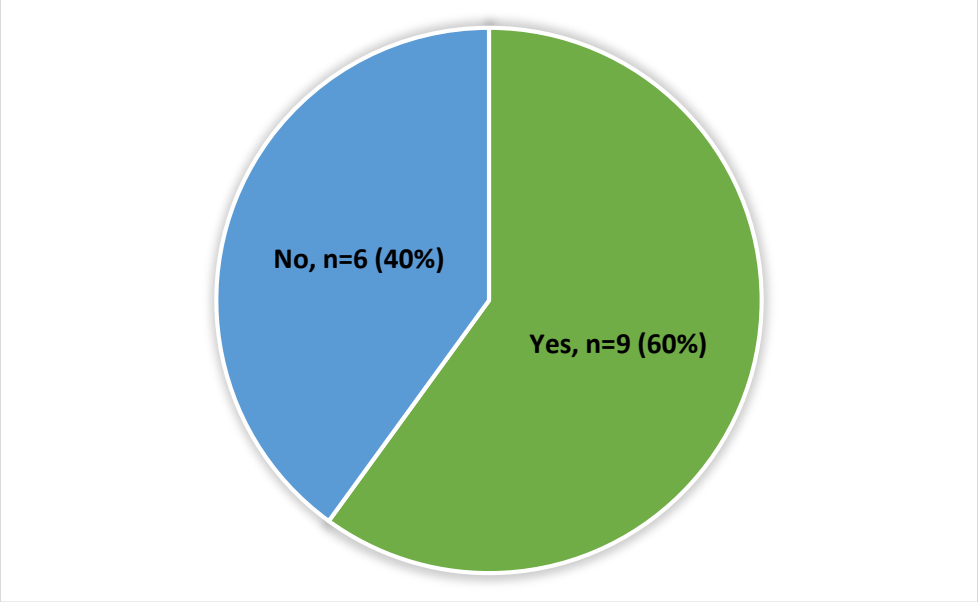

Table 100 - Application of the DEA Active Controlled Substance Registrant's File to Your ProDUR POS Edits to Prevent Unauthorized Prescribing

Response	States	Count	Percentage
Yes	Alabama, Connecticut, Maine, Michigan, Missouri, North Dakota, South Carolina, South Dakota, Washington	9	60.00%
No	Alaska, Idaho, New Hampshire, Pennsylvania, Tennessee, West Virginia	6	40.00%

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

Table 101 – Explanations of the Application of the DEA File to Your ProDUR POS Edits to Prevent Unauthorized Prescribing

State	Explanations
Alabama	Claims are denied for controlled drugs prescribed by a provider not on the DEA file.
Connecticut	The information is applied at the point of sale.
Maine	We utilize the NTIS DEA file in the adjudication of the pharmacy claim
Michigan	The POS system has business rules that check the XDEA license eligible prescribers of office-based opioid dependency drug therapies.
Missouri	If a DEA is submitted which is inactive or restricted, the claim is denied at POS.
North Dakota	They must have an active DEA license and authority to prescribe the specific DEA class they are prescribing.
South Carolina	System requires a valid DEA number in order for the claim to be paid
South Dakota	During claim adjudication
Washington	Claims for schedule II drugs prescribed by providers who do not have a recognized DEA number in the provider file are rejected.

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

Figure 79 – Plans to Obtain the DEA Active Controlled Substance Registrant’s File and apply it to Your POS Edits

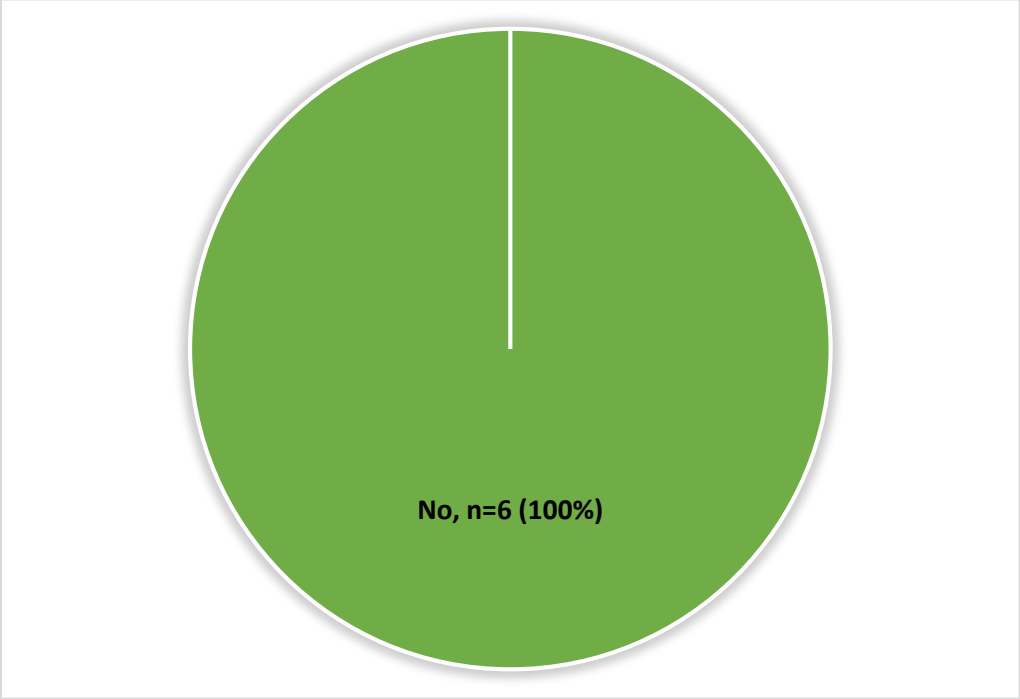

Table 102 - Plans to Obtain the DEA Active Controlled Substance Registrant’s File and apply it to Your POS Edits

Response	States	Count	Percentage
No	Alaska, Idaho, New Hampshire, Pennsylvania, Tennessee, West Virginia	6	100.00%

b. Do you apply this DEA file to your RetroDUR reviews?

Figure 80 - Apply DEA File to RetroDUR Reviews

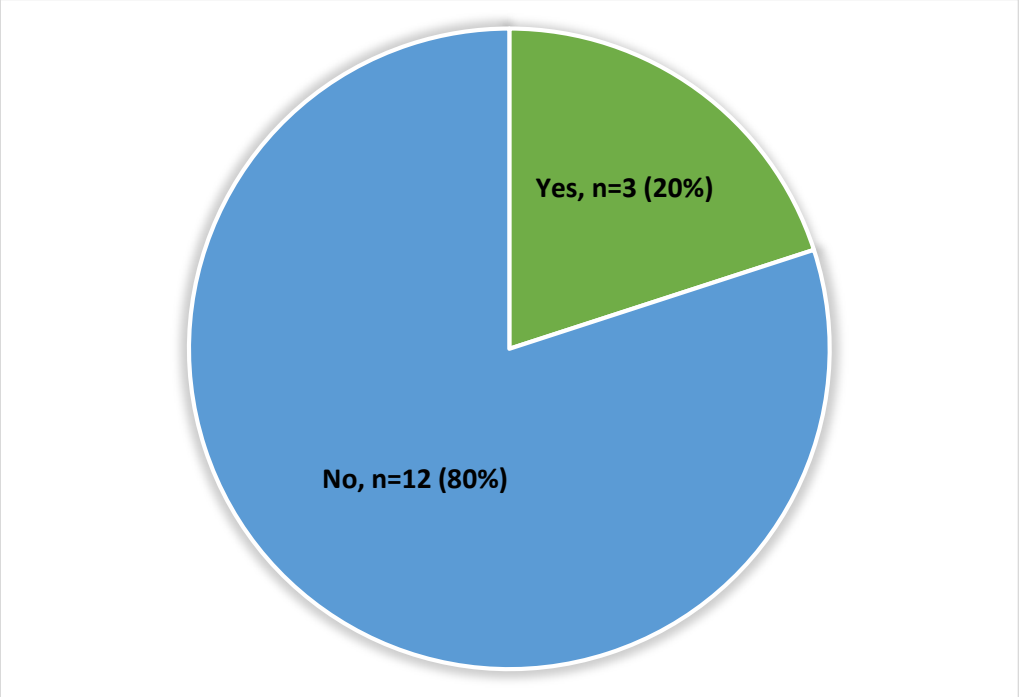

Table 103 - Apply DEA File to RetroDUR Reviews

Response	States	Count	Percentage
Yes	Maine, Michigan, New Hampshire	3	20.00%
No	Alabama, Alaska, Connecticut, Idaho, Missouri, North Dakota, Pennsylvania, South Carolina, South Dakota, Tennessee, Washington, West Virginia	12	80.00%

If "Yes", please explain how it is applied.

Table 104 - Explanatiosn of Application of DEA File to RetroDUR Reviews

State	Explanations
Maine	Deny claims and require PA, Qty Limits and MME daily dosing.
Michigan	Our vendor's RetroDUR system loads the DEA registrant file and can be queried for reports as needed, including prescribers without a valid DEA who are prescribing controlled substances, etc.
New Hampshire	The DEA file is used to identify prescribers that are not authorized to prescribe controlled substances

2. Do you have a measure (i.e. prior authorization, quantity limits) in place to either monitor or manage the prescribing of methadone for pain management?

Figure 81 - Measure in Place to either Monitor or Manage the Prescribing of Methadone for Pain Management

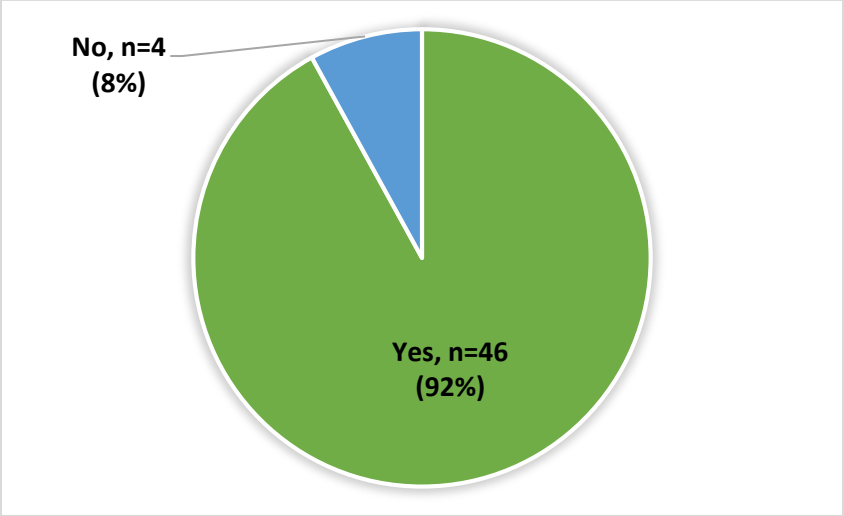

Table 105 - Measure in Place to Either Monitor or Manage the Prescribing of Methadone for Pain Management

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	46	92.00%
No	Hawaii, Nevada, New Mexico, Rhode Island	4	8.00%

If "No", please explain why you do not have measure in place to either manage or monitor the prescribing of methadone for pain management.

Table 106 - Explanations of Not Having a Measure in Place to either Manage or Monitor the Prescribing of Methadone for Pain Management

State	Explanations
Hawaii	Quarterly review continues to find no FFS patients are on methadone since 2009.
Nevada	Methadone is currently non-preferred on the FFS PDL. OptumRx is reviewing ways to support improved utilization.
New Mexico	Nothing in lieu of at this time, but the topic is under consideration.
Rhode Island	Pharmacy and Therapeutic Committee determines methadone would be a preferred agent. Fee for Service is usually a secondary claim and the primary insurance makes that determination.

D. Opioids

1. Do you currently have a POS edit in place to limit the quantity dispensed of an initial opioid prescription?

Figure 82 - POS Edit in Place to Limit the Quantity Dispensed of an Initial Opioid Prescription

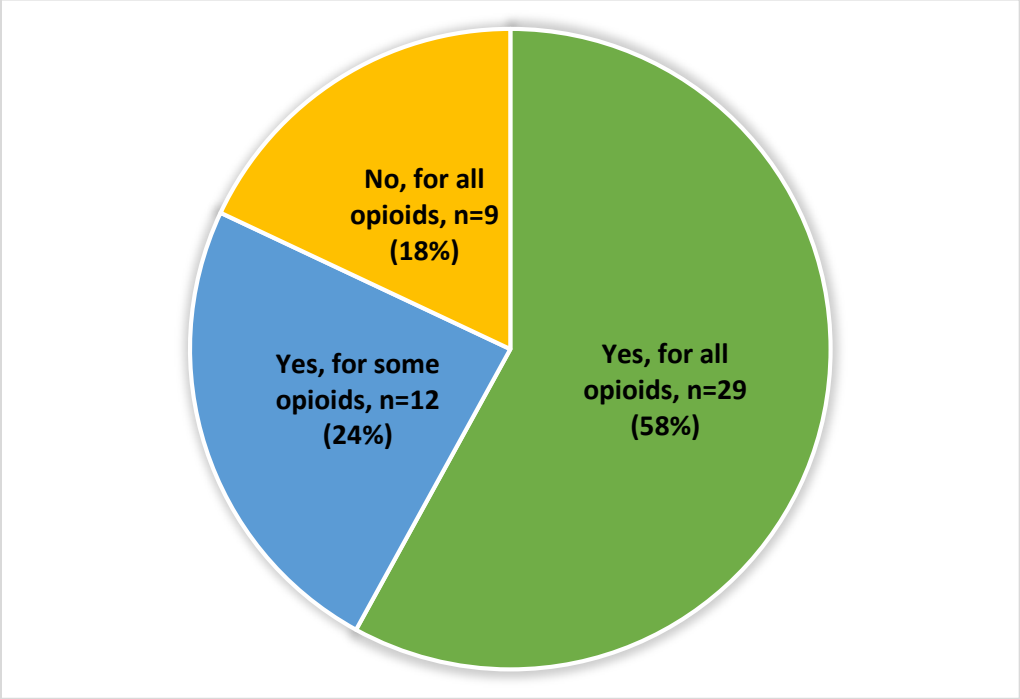

Table 107 - POS Edit in Place to Limit the Quantity Dispensed of an Initial Opioid Prescription

Response	States	Count	Percentage
Yes, for all opioids	Arkansas, Colorado, Connecticut, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Louisiana, Maine, Maryland, Minnesota, Mississippi, Nebraska, Nevada, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington	29	58.00%
Yes, for some opioids	Alabama, California, Delaware, Hawaii, Kentucky, Massachusetts, Michigan, Missouri, Montana, Rhode Island, West Virginia, Wisconsin	12	24.00%
No, for all opioids	Alaska, Iowa, Kansas, New Hampshire, New Jersey, New Mexico, Oklahoma, Texas, Wyoming	9	18.00%

If the answer to question 1 is “Yes, for all opioids” or “Yes, for some opioids”, please continue.

a. *Is there more than one quantity limit for the various opioids?*

Figure 83 - More than One Quantity Limit for Various Opioids

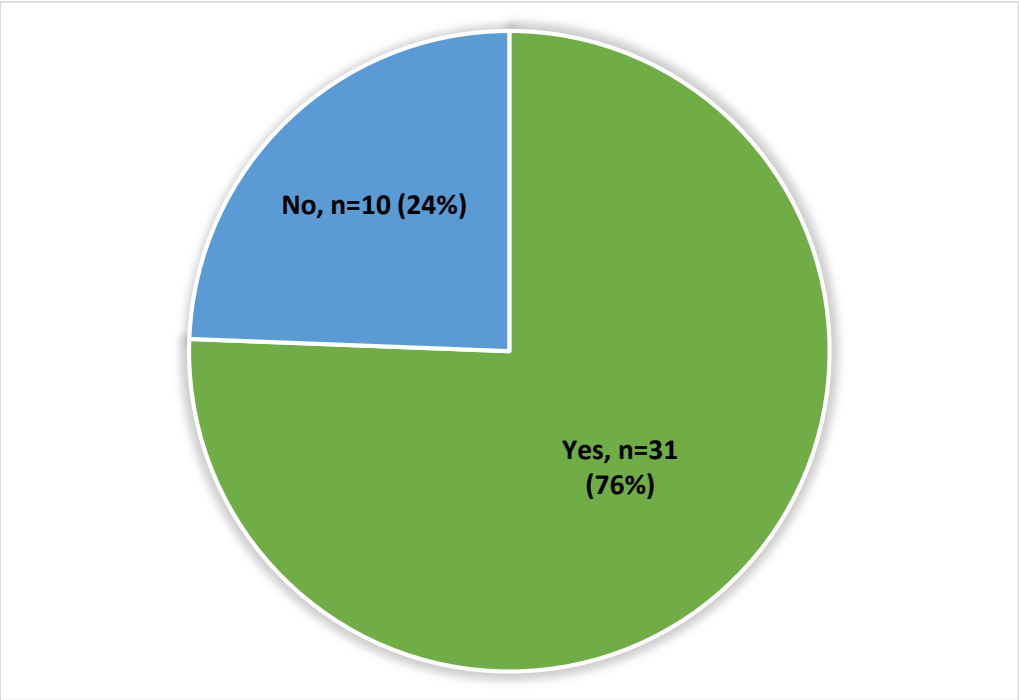

Table 108 - More than One Quantity Limit for Various Opioids

Response	States	Count	Percentage
Yes	Alabama, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Nebraska, New York, North Dakota, Ohio, Pennsylvania, Rhode Island, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin	31	75.61%
No	Arkansas, Connecticut, Maine, Minnesota, Montana, Nevada, North Carolina, Oregon, South Carolina, Virginia	10	24.39%

If "Yes", please explain.

Table 109 - Explanations for More Than One Quantity Limit for Various Opioids

State	Explanations
Alabama	Maximum daily limit is 2/day.
California	Opioids have an established maximum quantity per dispensing and a maximum of three (3) dispensings within any 75-day period.
Colorado	Opioid naive members are limited to short-acting opioids and quantities of 8 pills per day for up to a 7 day supply. Non-opioid naive members are limited to 4 pills per day of short-acting opioids for up to a 30 day supply. Long-acting opioids are subject of quantity limits listed for individual medications on the preferred drug list and are eligible for up to a 30 day supply for non-opioid naive members.
Delaware	DMMA limits the quantity based on day supply, MME per day, as well as a global number of units per year. Higher potency immediate release products all have 365 day maximum limits.

State	Explanations
District of Columbia	Short acting opioid claims are allowed for up to a 7 day supply without PA
Florida	For opioid treatment naive recipients the limit is 90 MME. There are also product specific limits per FDA package inserts.
Georgia	Quantity limit varies based on drug, duration of action (e.g., short-acting vs. long-acting), and drug strength.
Hawaii	Dental formulary addresses codeine, hydrocodone and oxycodone combinations separately.
Idaho	Apply quantity limit and MME for all RXs. Specific to each drug.
Illinois	Short-acting opioids: 186. Long-acting opioids: 124.
Indiana	60 MME for new opiate utilizers of short-acting only, quantity limits applied to all long-acting agents if approved via PA
Kentucky	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
Louisiana	Short-acting opiates, recipient is opiate naive: 28 units within a 7 day period Short-acting opiates, recipient is not opiate naive: 15 days' supply Long-acting opiates: 30 day supply per 30 rolling days There are exemptions for certain medical conditions.
Maryland	Units per day depend on the product. Please use link for further quantity limits. http://mmcp.health.maryland.gov/pap/docs/QL.pdf
Massachusetts	Dependent on 120mg per day of morphine equivalents
Michigan	In addition to the quantity limit for the initial fill of short-acting opioids, specific quantity limits are set for most of the short-acting and long-acting opioids.
Mississippi	Smaller monthly and cumulative quantity limits are set for select agents
Missouri	Missouri applies a day supply limit as well as an MME limit on short acting opioids for the first fill.
Nebraska	Patients are limited to a 30 day supply of all opioids and no more than 150 units can be dispensed in a 30-day rolling period.
New York	Except for a patient diagnosis of sickle cell or cancer, New York has a POS quantity limit of 7 days of therapy for: 1) Opioid nave patients 2) treatment of acute pain.
North Dakota	Every product has its own quantity limit.
Ohio	7 days for initial opioid prescription.
Pennsylvania	Varies by drug
Rhode Island	Based on 30 MMEs and 20 doses. Different depending on the drug
South Dakota	The limit is set by morphine equivalent so the quantity limit will vary by product.
Tennessee	all of the various opioids have different QL, as they are all based on MME.
Utah	Utah Medicaid FFS periodically reviews quantity limits of individual opioid medications to align with MME standards and safety practices. Some opioids, such as high dose Fentanyl patches and high dose methadone, are restricted to use in cancer related pain only. The opioid quantity limits are found on the Utah Medicaid Pharmacy website.
Vermont	Depends upon the potency (MME) of the medication being requested. Example: MEPERIDINE (compare to Demerol) (30 tabs or 5 day supply) OXYCODONE (plain) (For tablets, Qty limit = 12 tablets/day) HYDROMORPHONE tablets (compare to Dilaudid) (Qty limit = 16 tablets/day)

State	Explanations
Washington	Please see http://www.hca.wa.gov/assets/billers-and-providers/opioid-policy.pdf Methadone requires prior authorization. If authorized it is limited to a maximum of 40mg per day. Buprenorphine containing products for treatment of substance use disorders is limited to a maximum of 32mg per day. Long acting opioids with no history of short acting opioids require prior authorization. Long acting opioids are not allowed for acute use / initial dispense. Short acting opioids are limited to 42 units per dispense (18 for clients under 21), which is intended to approximate a 7 day supply prescribed at typical dose and dosing intervals.
West Virginia	Short-acting opioids are limited to 4 units/day. Long-acting opioids are limited to 2 units/day.
Wisconsin	Wisconsin has quantity limits on short-acting opioid analgesics of 30-360 tables/capsules per month depending on the opioid. Long-acting opioid analgesics have a quantity limit of 4-240 tablets/capsules/patches/films per month depending on the opioid.

b. What is your maximum number of days allowed for an initial opioid prescription?

Figure 84 - Maximum Number of Days Allowed for an Initial Opioid Prescription

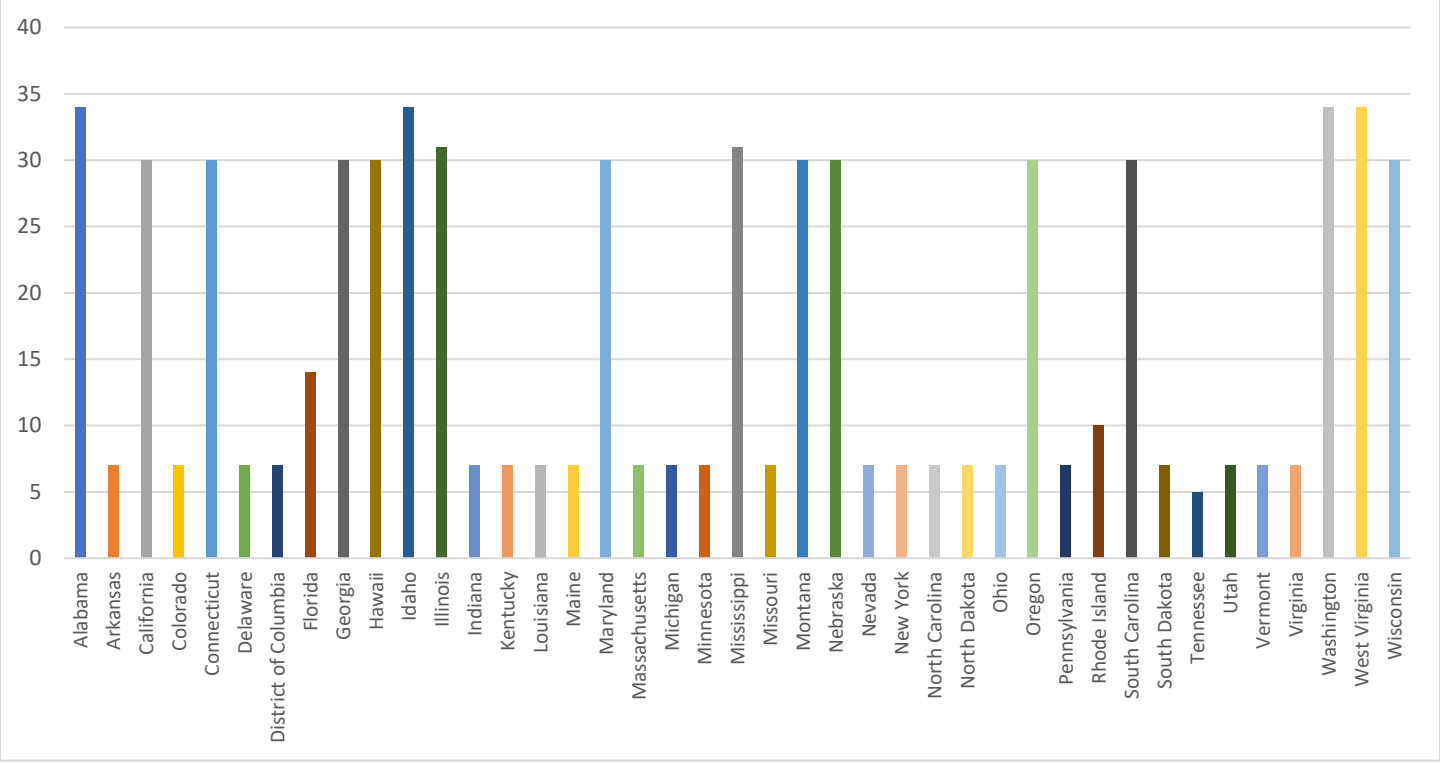

Table 110 - Maximum Number of Days Allowed for an Initial Opioid Prescription

State	Maximum Days
Alabama	34
Arkansas	7
California	30
Colorado	7
Connecticut	30
Delaware	7
District of Columbia	7
Florida	14
Georgia	30
Hawaii	30
Idaho	34
Illinois	31
Indiana	7
Kentucky	7
Louisiana	7
Maine	7
Maryland	30
Massachusetts	7
Michigan	7
Minnesota	7
Mississippi	31
Missouri	7
Montana	30
Nebraska	30
Nevada	7
New York	7
North Carolina	7
North Dakota	7
Ohio	7
Oregon	30
Pennsylvania	7
Rhode Island	10
South Carolina	30
South Dakota	7
Tennessee	5
Utah	7
Vermont	7
Virginia	7
Washington	34
West Virginia	34
Wisconsin	30

c. *Does this day limit apply to all opioid prescriptions?*

Figure 85 - Initial Day Limit Applies to All Opioid Prescriptions

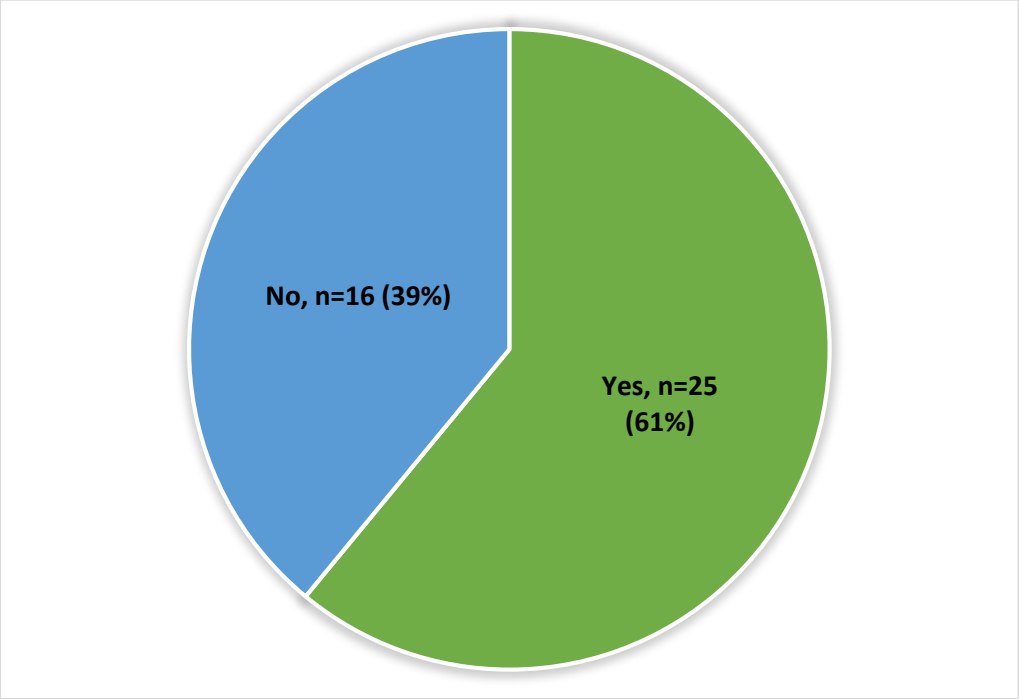

Table 111 - Initial Day Limit Applies to All Opioid Prescriptions

Response	States	Count	Percentage
Yes	Alabama, Arkansas, California, Connecticut, Georgia, Idaho, Illinois, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Montana, Nebraska, Nevada, New York, North Carolina, North Dakota, Oregon, South Carolina, South Dakota, Vermont, Washington, West Virginia, Wisconsin	25	60.98%
No	Colorado, Delaware, District of Columbia, Florida, Hawaii, Indiana, Kentucky, Louisiana, Michigan, Missouri, Ohio, Pennsylvania, Rhode Island, Tennessee, Utah, Virginia	16	39.02%

If "No", please explain.

Table 112 - Explanations of Different Days' Limit to various Opioid Prescriptions

State	Explanations
Colorado	Opioid prescriptions for opioid naive members are limited to a 7 day supply of short-acting opioids.
Delaware	short acting opioids for FFY 2018
District of Columbia	The 7 day supply limit only applies to short acting opioids

State	Explanations
Florida	Schedule II SA Narcotics: Max of 3-day supply & 2 fills per month "Acute Pain Exemption" on RX Max of 7-day supply & 2 fills per month Schedule III-V SA Narcotics: Max of 14-days of therapy per month. Restricts recipients to no more than 1 LA Narcotic every 30 days.
Hawaii	Dental formulary has 4 day supply maximum for adults.
Indiana	For initial utilizers of opiates, a seven day supply followed by an additional seven day supply in a rolling 45 day period is permitted without prior authorization.
Kentucky	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
Louisiana	Short-acting opiates, recipient is opiate naive: 28 units within a 7 day period Short-acting opiates, recipient is not opiate naive: 15 days' supply Long-acting opiates: 30 day supply per 30 rolling days There are exemptions for certain medical conditions.
Michigan	The 7-day initial fill limit is only for short-acting opioids at this time.
Missouri	This is limited to short acting opioids.
Ohio	Applies for short acting opioids.
Pennsylvania	Prior authorization is required for short acting opioids after 3 days for children under 21 and after 7 days for adults. All long acting opioids require prior authorization for all beneficiaries. The day supply approved is determined on a case-by-case basis.
Rhode Island	Based on 30 MMEs and 20 doses
Tennessee	Those enrollees who were chronic users prior to the benefit limit start of 1/16/2018 remain able to use opioids chronically. Those non-chronic users are limited to 15 days' supply at no greater than 60 MME/day per 180 days. Only exceptions are enrollees with active cancer/palliative care/hospice treatments (no days limits), those with sickle cell disease (45 days/90), those with severe burns or corrosive injury over a significant body area (45 days/90), and those in a skilled care LTC facility (45 days/90).
Utah	The initial fill edit applies only to short-acting opioids. The initial fill of a short-acting opioid is restricted to 7-day supply or less for non-dental prescribers and a 3-day supply or less for dental prescribers. The system will not allow the fill of a long-acting opioid without at least a 7 day trial of a short-acting opioid within the last 30 days.
Virginia	The initial 7 days limit is for short acting opioids

2. For subsequent prescriptions, do you have POS edits in place to limit the quantity dispensed of short-acting opioids?

Figure 86 - POS Edits in Place to Limit the Quantity Dispensed of Short-Acting Opioids

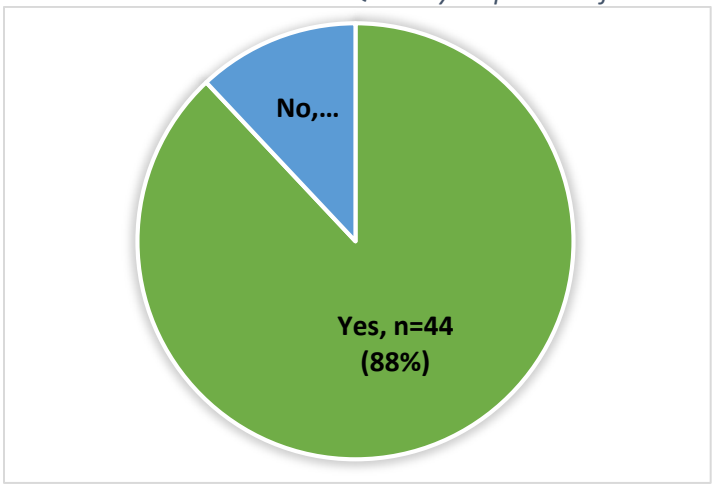

Table 113 - POS Edits in Place to Limit the Quantity Dispensed of Short-Acting Opioids

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	44	88.00%
No	Kansas, New Jersey, New Mexico, Rhode Island, Tennessee, Texas	6	12.00%

If "Yes", what is your maximum days' supply per prescription limitation?

Figure 87 - Short-Acting Opioid Maximum Days' Supply per Prescription Limitation

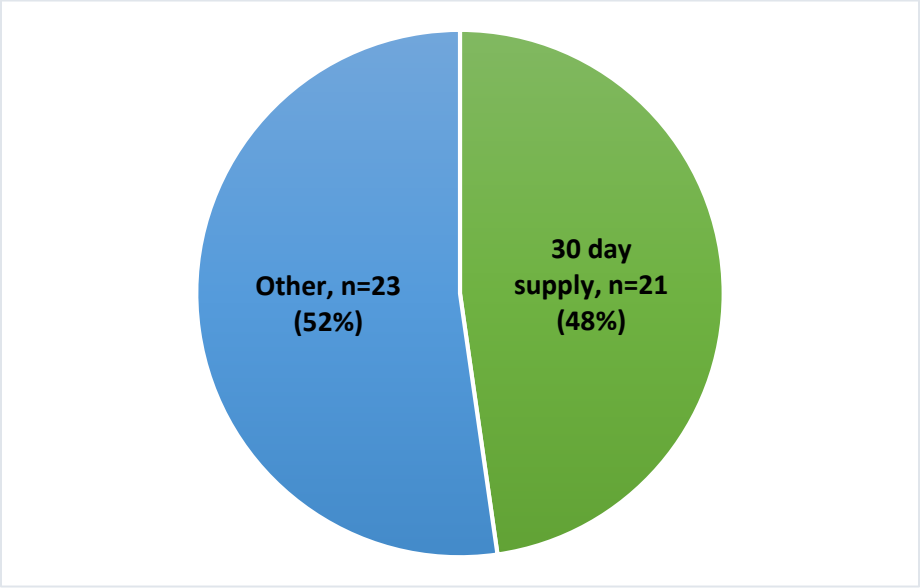

Table 114 - Short-Acting Opioid Maximum Days' Supply per Prescription Limitation

Response	States	Count	Percentage
30 day supply	Alabama, Connecticut, District of Columbia, Georgia, Hawaii, Idaho, Kentucky, Maine, Maryland, Massachusetts, Montana, Nebraska, New Hampshire, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Utah, Vermont, Wisconsin	21	47.73%
Other	Alaska, Arkansas, California, Colorado, Delaware, Florida, Illinois, Indiana, Iowa, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nevada, New York, North Carolina, Ohio, Pennsylvania, Virginia, Washington, West Virginia, Wyoming	23	52.27%

If “Other”, please explain.

Table 115 - “Other” Explanation of Short-Acting Opioid Maximum Days’ Supply per Prescription Limitation

State	“Other” Explanations
Alaska	34 day supply. For state laws regarding maximum dosage for opioid prescriptions, refer to AS.08.64.363, AS.08.68.705, AS.08.36.355, AS.08.72.276.
Arkansas	#93 pills per 31 days
California	Short-acting opioids have an established maximum quantity per dispensing and a maximum of three (3) dispensings within any 75-day period.
Colorado	Opioid naive members are limited to three 7 day supply prescriptions and require prior authorization for the fourth fill. Non-opioid naive members are limited to a 30 day supply per prescription fill.
Delaware	Total dose of opioid cannot exceed 90mg MME per 24 hours. Total quantity of short acting may not exceed 120 per 30 days with a total of 720 short acting units per year
Florida	7 Day Supply
Illinois	31 days
Indiana	For initial utilizers of opiates, a seven day supply followed by an additional seven day supply in a rolling 45 day period is permitted without prior authorization.
Iowa	Up to a 31 day supply is allowed
Louisiana	15 days
Michigan	34 day supply
Minnesota	Technically, in MN prescriptions have a 34-day limit per statute. Typically, either a 28 to 30 days’ supply is the max days’ supply dispensed by pharmacies.
Mississippi	31 days’ supply
Missouri	31 days
Nevada	Recipients are allowed to 13 seven-day supplies within a rolling twelve months without a prior authorization.
New York	Quantity limits are based upon FDA maximum daily doses extended for a maximum of a 30 day period.
North Carolina	The maximum days’ supply is 34.
Ohio	We have a 30 MED limit for short acting opioids
Pennsylvania	All prescriptions for short-acting opioids require prior authorization after 3 days for children under 21 and after 7 days for adults. The day supply approved is determined on a case-by-case basis.
Virginia	Any Short-Acting Opioid prescribed for > 7 days or two (2) 7 day supplies in a 60-day period will require a service authorization. The Virginia Board of Medicine Regulations limit the treatment of acute pain with opioids to 7 days and post-op pain to no more than 14 days.
Washington	All acute use of opioids (less than a total of 42 days’ supply in the last 90 days) are limited to 42 doses for those 21 and older and 18 doses for those 20 and younger unless the prescriber indicates that the patient meets specific exemption criteria, or the client is receiving active cancer treatment, hospice, palliative care, or end-of-life care are exempt from limitations.
West Virginia	34 day supply
Wyoming	Short-acting medications are limited to four units per day after a patient has been on opioids for 42 days.

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

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

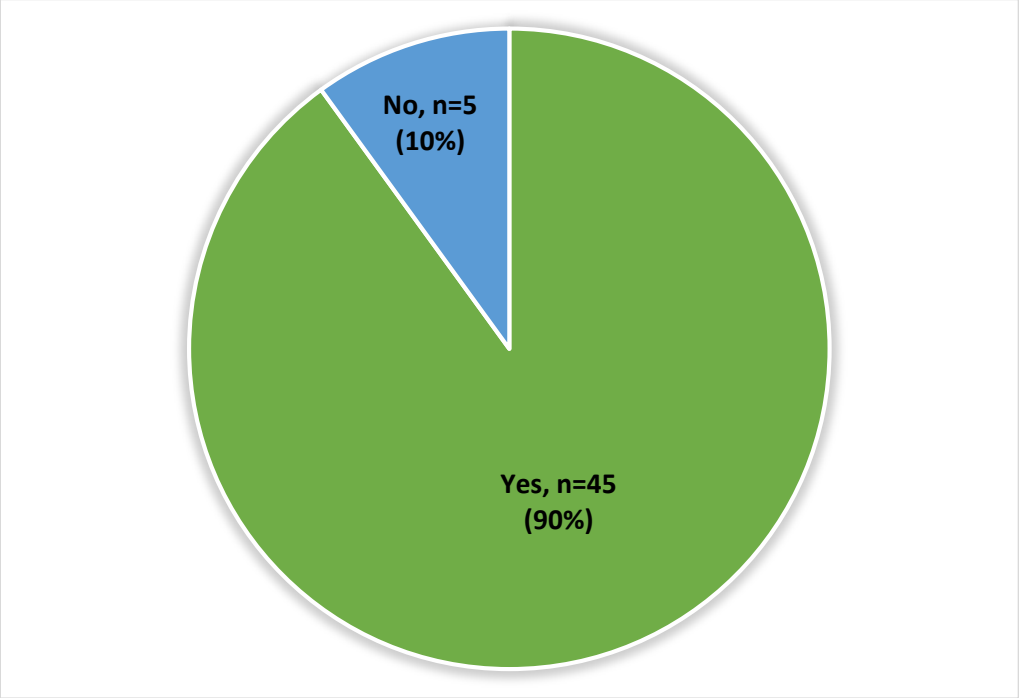

Table 116 - POS Edits In Place to Limit the Quantity Dispensed of Long-Acting Opioids

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	45	90.00%
No	New Jersey, New Mexico, Rhode Island, Tennessee, Texas	5	10.00%

If “Yes”, what your maximum days’ supply per prescription limitation?

Figure 89 - Long-Acting Opioid Maximum Days Supply per Prescription Limitation

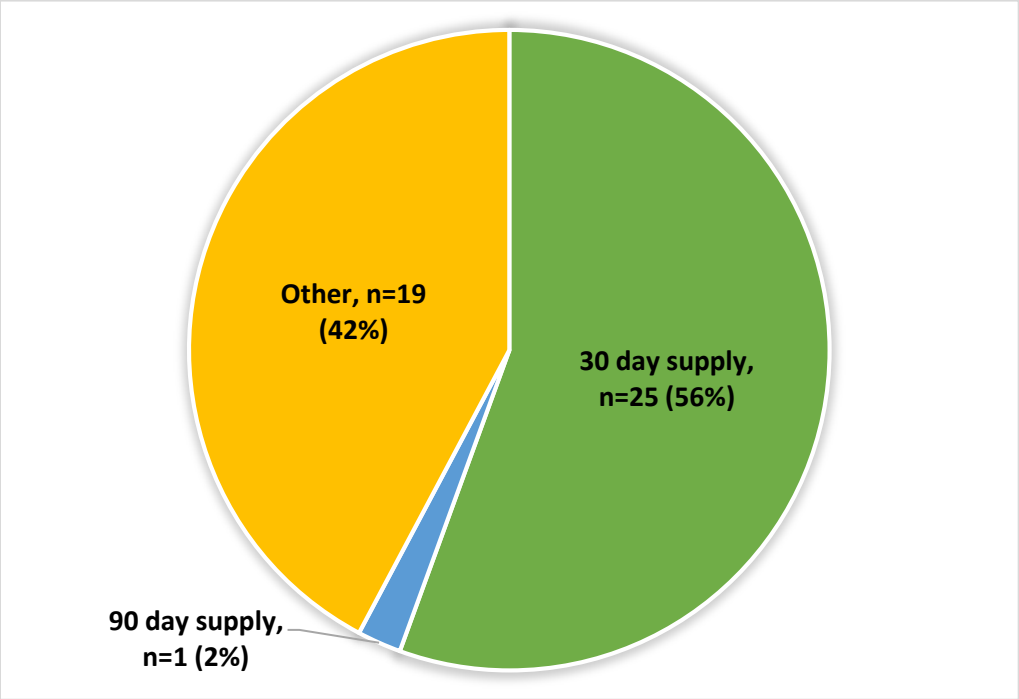

Table 117 - Maximum Days’ Supply per Prescription Limitation by State

Response	States	Count	Percentage
30 day supply	Alabama, Colorado, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Idaho, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Montana, Nebraska, New Hampshire, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Utah, Wisconsin, Wyoming	25	55.56%
90 day supply	Vermont	1	2.22%
Other	Alaska, Arkansas, California, Delaware, Illinois, Indiana, Iowa, Michigan, Minnesota, Mississippi, Missouri, Nevada, New York, North Carolina, Ohio, Pennsylvania, Virginia, Washington, West Virginia	19	42.22%

If “Other”, please explain.

Table 118 - “Other” Explanation of Long-Acting Opioid Maximum Days’ Supply per Prescription Limitation

State	”Other” Explanations
Alaska	34 day supply. For state laws regarding maximum dosage for opioid prescriptions, refer to AS.08.64.363, AS.08.68.705, AS.08.36.355, AS.08.72.276.
Arkansas	31 days--quantity is dependent upon the FDA approved dosing per the manufacturer's package insert.

State	"Other" Explanations
California	Long-acting opioids have an established maximum quantity per dispensing and a maximum of three (3) dispensings within any 75-day period.
Delaware	Total dose of opioid cannot exceed 90mg MME per 24 hours. Total quantity dispensed limits in place based on units per day, units per month and units per year.
Illinois	31 days
Indiana	For initial utilizers of opiates, PA is required. For current opiate utilizers, day supply is limited to 34 as a non-maintenance medication with quantity limits applied.
Iowa	Up to a 31 day supply is allowed
Michigan	34 day supply
Minnesota	Technically, in MN prescriptions have a 34-day limit per statute. Typically, either a 28 to 30 days' supply is the max days' supply dispensed by pharmacies.
Mississippi	Maximum days' supply is 31 days versus 30 due to monthly limit on number of prescriptions. Maximum monthly limit for 31 days' supply is 62 units. (Tablets/capsules).
Missouri	31 days
Nevada	Long-acting opioids have the same limit as short-acting opioids; Recipients are allowed to 13 seven-day supplies within a rolling twelve months without a prior authorization. If a recipient has an approved prior authorization on file, the maximum is 34 days' supply per fill.
New York	Quantity limits are based upon FDA maximum daily doses extended for a maximum of a 30 day period.
North Carolina	The maximum days' supply is 34.
Ohio	All long acting opioids require prior authorization
Pennsylvania	All long acting opioids require prior authorization for all beneficiaries. The day supply approved is determined on a case-by-case basis.
Virginia	34 days per prescription
Washington	34 days
West Virginia	34 day supply

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

Figure 90 - Measures other than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

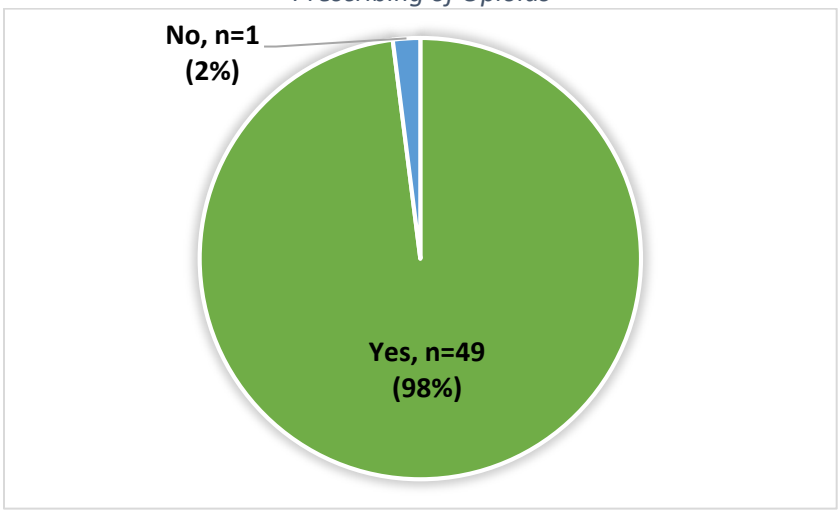

Table 119 - Measures other than Restricted Quantities and Days' Supply in Place to either Monitor or Manage the Prescribing of Opioids

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	49	98.00%
No	District of Columbia	1	2.00%

If "Yes", check all that apply:

Figure 91 - Measures other than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

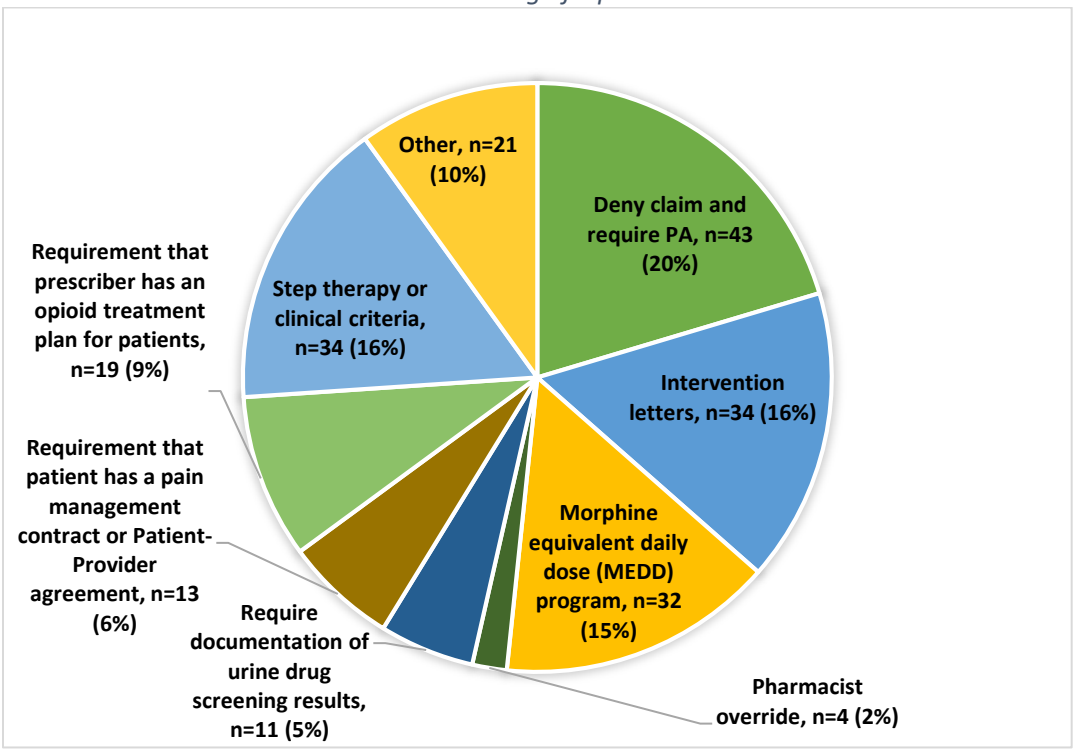

Table 120 - Measures other than Restricted Quantities and Days' Supply in Place to either Monitor or Manage the Prescribing of Opioids

Response	States	Count	Percentage
Deny claim and require PA	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, New Hampshire,	43	20.38%

Response	States	Count	Percentage
	New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming		
Intervention letters	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Louisiana, Maryland, Michigan, Mississippi, Missouri, Montana, Nevada, New Mexico, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, Wyoming	34	16.11%
Morphine equivalent daily dose (MEDD) program	Alaska, Arkansas, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nevada, New Hampshire, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Vermont, Virginia, West Virginia, Wyoming	32	15.17%
Pharmacist override	Georgia, Idaho, Vermont, West Virginia	4	1.90%
Require documentation of urine drug screening results	Alaska, Georgia, Illinois, Kentucky, Maine, Montana, Ohio, Oregon, Pennsylvania, Virginia, West Virginia	11	5.21%
Requirement that patient has a pain management contract or Patient-Provider agreement	Alaska, Delaware, Georgia, Illinois, Iowa, Maine, Massachusetts, Michigan, Minnesota, Nevada, Ohio, Virginia, West Virginia	13	6.16%
Requirement that prescriber has an opioid treatment plan for patients	Alaska, Colorado, Delaware, Florida, Georgia, Hawaii, Kansas, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Montana, North Carolina, Ohio, Pennsylvania, Rhode Island, Virginia, West Virginia	19	9.00%
Step therapy or clinical criteria	Alabama, Alaska, Colorado, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Michigan, Mississippi, Missouri, Montana, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia	34	16.11%
Other	Alaska, California, Colorado, Hawaii, Illinois, Indiana, Kansas, Louisiana, Maryland, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oregon, Texas, Vermont, West Virginia, Wisconsin	21	9.95%

If “Other”, please explain what additional opioid prescribing controls are in place.

Table 121 – “Other” Explanations of Additional Opioid Prescribing Controls

State	“Other” Explanations
Alaska	Require diagnosis code on the hard copy.
California	California has a Statewide Opioid Safety (SOS) Workgroup to improve coordination and expand joint efforts to address opioid misuse, addiction, and overdose deaths.

State	"Other" Explanations
Colorado	Limitation of only one long-acting opioid (including different strengths) and one short-acting opioid (including different strengths) for opioid prior authorization approvals. Opioid naive members are limited to short-acting opioids only. Prescriber opioid treatment plans are documented as part of prescriber-to-prescriber opioid consult services required for certain opioid prior authorizations.
Hawaii	These POS edits apply to OxyContin PA criteria, including provider specialty, diagnosis, dosage. PA criteria for over 160mg and non-cancer pain are age, pregnancy, strength and total daily dosage, documented failure or non-tolerance of at least one other long acting opioid analgesic.
Illinois	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
Indiana	Doctor-shopping edit evaluating number of prescribers, restrictions on use with concurrent benzodiazepines, carisoprodol products, buprenorphine or buprenorphine/naloxone, current utilizers limited to one long-acting and one short-acting opioid product.
Kansas	For long acting opioids- prescribed by a single FFS enrolled prescriber or practice, prescriber has reviewed the PDMP, patient has the correct diagnosis.
Louisiana	1) Therapeutic duplication edit for opiate prescriptions written by different prescribers. 2) Long-acting opiate prescriptions require the prior use of a short or long-acting opiate within the previous 90 days 3) Therapeutic duplication of short-acting opiates 4) Therapeutic duplication of long-acting opiates
Maryland	Providers must obtain a prior authorization every six months to prescribe long-acting opioids, fentanyl products, methadone for pain and opioids above 90 milligram equivalents per day. This includes: Attestation of a patient-provider agreement; A medical justification for high-dose and/or long-acting opioid prescription; Attestation of screen patient with random drug screen(s) before and during treatment; and Attestation that a naloxone prescription was given or offered to the patient/patient's household member.
Nebraska	Non-preferred opioids require PA. Some medications have daily quantity limits.
Nevada	If the recipient has chronic pain or requires extended opioid therapy and is under the supervision of a licensed prescriber, the pain cannot be controlled through the use of non-opioid therapy (acetaminophen, NSAIDs, antidepressants, anti-seizure medications, physical therapy, etc.); the lowest effective dose is being requested and a pain contract is on file.
New Jersey	NJ applies maximum daily dosage on long-acting opioids. We also apply a 90 day duration for short-acting opioids for prescribers to reconsider continuation of therapy. We apply first fill editing on high dose opioids to confirm opioid tolerance and ensure titration has occurred.
New Mexico	System edits in process.
North Carolina	Limitations may also be based on FDA recommendations and concurrent use with benzodiazepines.
North Dakota	Compliance edits to ensure extended release products are truly continuously used.
Ohio	PDMP check. Pharmacy/prescriber RDUR outreach calls.
Oregon	Prescriber must attest they are enrolled in the Oregon PDMP and that they have reviewed at least once in the past 3 months the scheduled substances the patient has recently been prescribed from other providers
Texas	Vendor Drug Program enforces the 90% refill policy to prevent early refills before 90% of day-supply of the previous opioid claim has passed.

State	"Other" Explanations
Vermont	50 MME limits for adults 24 MME limits for children both for initial fills
West Virginia	Patients who are receiving more than 50 MME/day for at least the last 90 days are required to receive a PA through our SEMPP (Safe and Effective Management of Pain) Program. The PA process requires identification of previous therapies, a plan of care and encourages providers to titrate to the lowest effective dose whenever possible.
Wisconsin	Wisconsin has an opioid script limit which limits opioids to five prescription fills a month.

If "No", please explain what you do in lieu of the above or why do you have measures in place to either manage or monitor the prescribing of opioids.

Table 122 - Explanations of Measures in lieu of above to Either Manage or Monitor the Prescribing of Opioids

State	Explanations
District of Columbia	A Morphine equivalent daily dose (MEDD) program will be implemented at the beginning of the next fiscal year.

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

Figure 92 - Edits in Place to Monitor Opioids and Benzodiazepines Being Used Concurrently

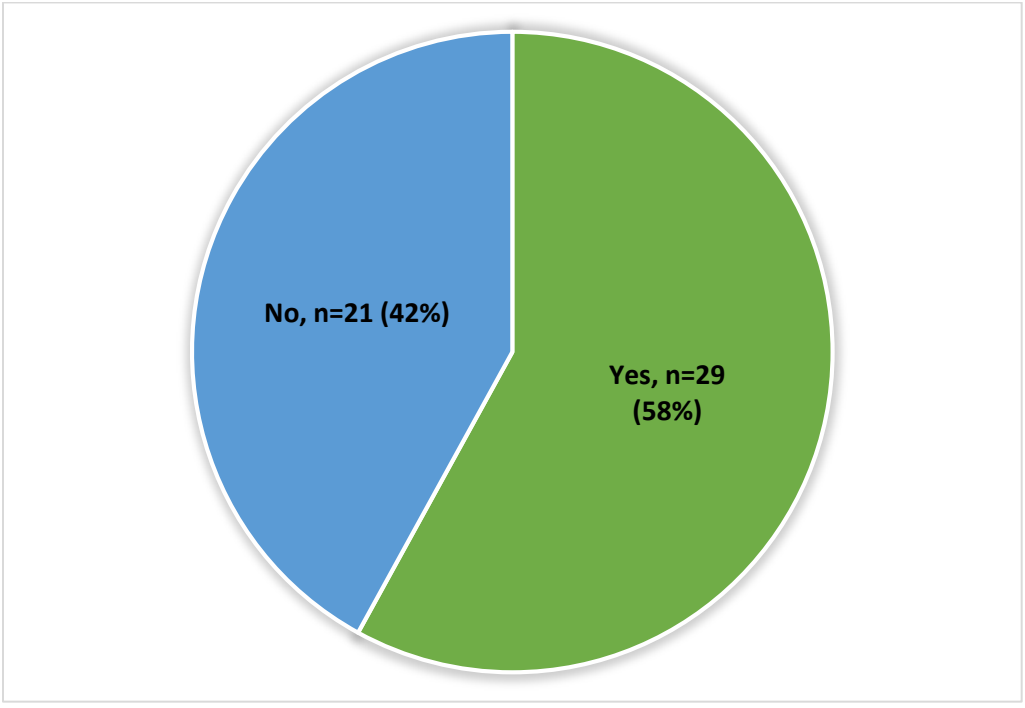

Table 123 - Edits in Place to Monitor Opioids and Benzodiazepines Being Used Concurrently

Response	States	Count	Percentage
Yes	Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Idaho, Indiana, Kentucky, Louisiana, Maine, Mississippi, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oregon, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wyoming	29	58.00%
No	Alabama, Alaska, Georgia, Hawaii, Illinois, Iowa, Kansas, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nevada, New Mexico, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, West Virginia, Wisconsin	21	42.00%

If "Yes", please explain.

Table 124 - Explanations of Edits in Place to Monitor Opioids and Benzodiazepines Being Used Concurrently

State	Explanations
Arkansas	Arkansas Medicaid has edits in place that manage the use of benzodiazepines and opioids in patients with a poisoning/overdose diagnosis billed in the previous year (this edit began as a 90 day look-back in March 2018 and was extended to a year look-back in November 2018). RetroDUR does review the utilization of concomitant opioids and benzodiazepines and provides education with intervention letters to affected providers.
California	Effective June 1, 2018, the Medi-Cal fee-for-service prospective DUR system was updated to generate an alert for additive toxicity (AT) when a patient reaches a threshold of four active prescriptions within the following therapeutic categories: opioid pain or cough medications, benzodiazepines, skeletal muscle relaxants, other sleep drugs and tranquilizers (non-benzodiazepine), antipsychotic medications, and other selected psychotropic medications with central nervous system (CNS) depressant properties.
Colorado	ProDUR alert systems edits are in place when concomitant opioid and benzodiazepine claims are submitted. Retrospective DUR is conducted and letters sent to providers regarding member concomitant use of these medications.
Connecticut	Retrospectively we have criteria to identify the concurrent use of opioids and benzodiazepines together but there is nothing at POS to identify and monitor the use of these medications. In FFY 2019 we plan to make modifications to the POS system to identify the concurrent use of these medications.
Delaware	Prior authorization for all long acting and high dose opiates can only be approved if the member is not receiving a benzodiazepine.
District of Columbia	ProDUR soft edits/messaging alerts to pharmacist
Florida	A soft edit to deny all prospective drug utilization review (ProDUR) therapeutic duplication (TD) and drug to drug interaction (DD) edits for any benzodiazepine and opioid combinations.
Idaho	PRODUR Edits from First Data Bank
Indiana	PA in place for concurrent utilization exceeding a seven day supply of either agent for new starts. Current utilizers are not yet applied to the PA.

State	Explanations
Kentucky	This is addressed in PA criteria and there is a "soft" stop at point-of-sale that can be overridden with DUE response codes. Opioid prescribers are required to provide a naloxone prescription and counseling in order to get a PA for members that are prescribed a benzodiazepine.
Louisiana	Pharmacy claims for an opioid will deny if there is an active claim on the recipients profile for a benzodiazepine, and for a benzodiazepine if there is an active claim on the profile for an opioid. There are exemptions for certain medical conditions.
Maine	ProDUR messaging is sent to the pharmacy.
Mississippi	Monthly Retro-DUR analysis and education letters are mailed to identified prescribers.
Montana	We limit benzodiazepines when used with methadone
Nebraska	Drug-drug alerts are sent to pharmacies with each fill.
New Hampshire	When a long acting narcotic is prescribed and approved for coverage, benzodiazepines cannot be dispensed for the length of the prior authorization without the benzodiazepine receiving prior authorization for concurrent use.
New Jersey	Drug conflicts between buprenorphine used for opioid dependence and benzodiazepines deny for possible intervention with the prescriber.
New York	Prior authorization required for initiation of opioid therapy in patients currently on benzodiazepines.
North Carolina	As of October 1, 2018, a claim edit was implemented to monitor concurrent use of opioids and benzodiazepines.
North Dakota	Concurrent use is denied for all benzodiazepines if the patient is on a high dose opioid.
Ohio	Soft edit in place.
Oregon	Prior authorization criteria for benzodiazepines and opioids restrict concurrent use
Tennessee	Prior to 2014, Tennessee did not cover BZO for adults. When mandated in 2014, our criteria was strong enough that we cover around 1% of our enrollees' total use of BZO (found from data from the PDMP. BZO criteria has always included a denial if the enrollee was using opioids. Opioids are now also denied if the enrollee is using BZO, unless the BZO is being prescribed by a mental health provider, per Tennessee's Chronic Opioid (non-cancer) Prescribing Guidelines.
Texas	VDP has a clinical prior authorization to prevent concomitant (more than 14 days overlapping day-supply) of any combinations of benzodiazepines and opioids, opioids and muscle relaxants, or all three of these products.
Utah	When a claim for a long-acting opioid is processed, the system will look back 45 days to see if a claim for a benzodiazepine has been filled. If the system identifies a paid claim, the claim for the long-acting opioid will reject.
Vermont	Soft edit in the POS alerting the pharmacist of the overlap. We also did a Retrospective DUR focused on concomitant use.
Virginia	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
Washington	Please see retrospective DUR attachment. As part of a onetime intervention, co-prescribing of benzodiazepines and other sedative prescriptions in combination with opioids was one of the measures triggering educational outreach letters in August of 2018.
Wyoming	Concurrent use of benzodiazepines and opioids is not allowed. Claims deny at point of sale.

6. Do you perform any RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis or history of opioid use disorder (OUD), or opioid poisoning diagnosis?

Figure 93 - RetroDUR Activity and/or Provider Education in Regard to Beneficiaries with a Diagnosis or History of Opioid Use Disorder (OUD), or Opioid Poisoning Diagnosis

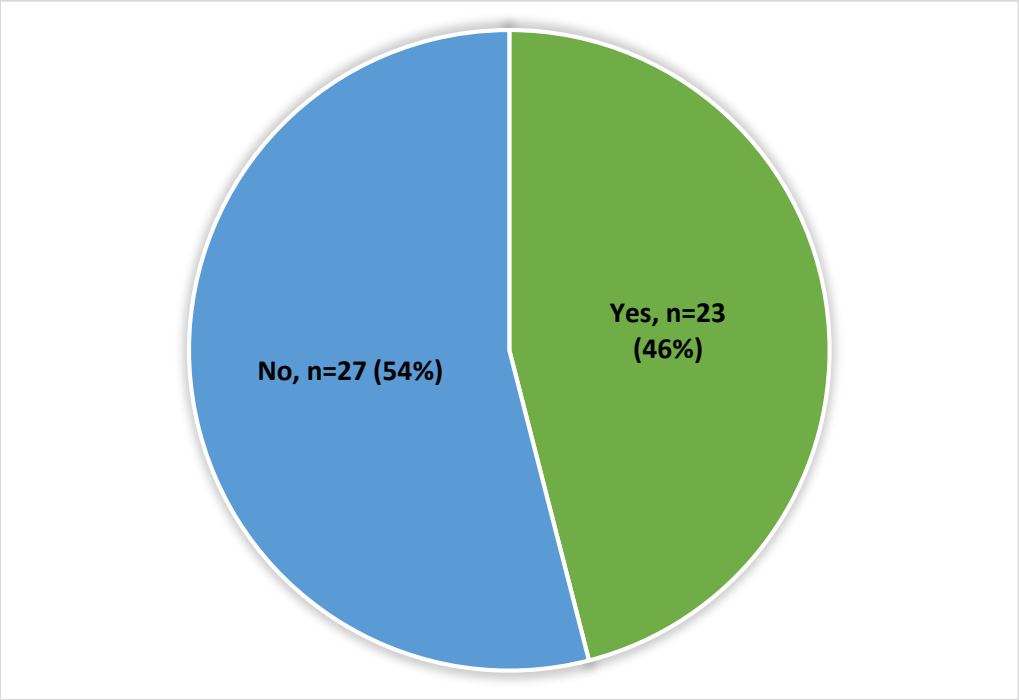

Table 125 - RetroDUR Activity and/or Provider Education in Regard to Beneficiaries with a Diagnosis or History of Opioid Use Disorder (OUD), or Opioid Poisoning Diagnosis

Response	States	Count	Percentage
Yes	Alabama, Arkansas, California, Connecticut, Florida, Georgia, Mississippi, Missouri, Montana, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Pennsylvania, South Dakota, Tennessee, Texas, Virginia, Washington, West Virginia, Wisconsin	23	46.00%
No	Alaska, Colorado, Delaware, District of Columbia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nebraska, Nevada, New Hampshire, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Wyoming	27	54.00%

a. ***If "Yes", please indicate how often***.

Figure 94 - Frequency of RetroDUR Activity and/or Provider Education for Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning

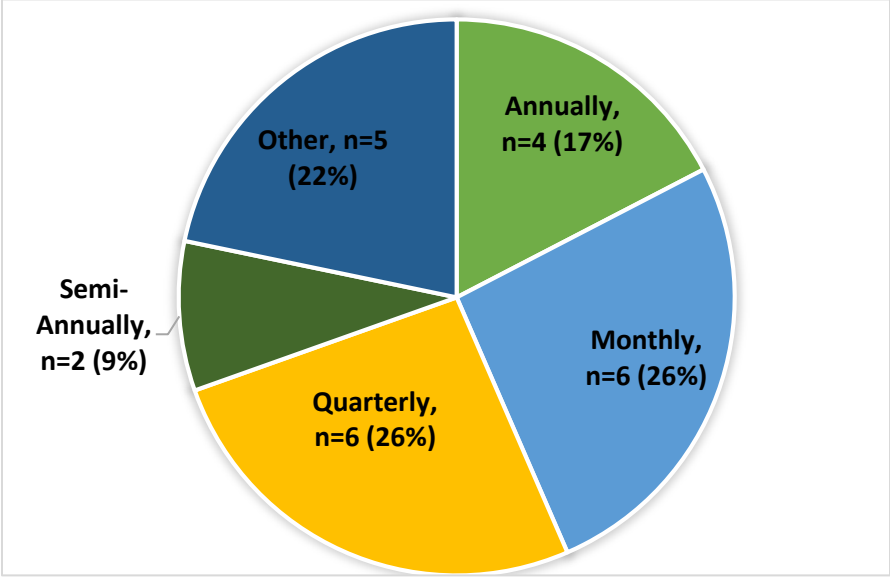

Table 126 - Frequency of RetroDUR Activity and/or Provider Education for Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning

Response	States	Count	Percentage
Annually	California, Connecticut, Georgia, Texas	4	17.39%
Monthly	Alabama, New York, Ohio, Pennsylvania, West Virginia, Wisconsin	6	26.09%
Quarterly	Arkansas, Florida, Mississippi, North Carolina, South Dakota, Virginia	6	26.09%
Semi-Annually	Tennessee, Washington	2	8.70%
Other	Missouri, Montana, New Jersey, New Mexico, North Dakota	5	21.74%

If "Other", please explain.

Table 127 - "Other" Explanation for Frequency of RetroDUR Activity and/or Provider Education for Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning

State	"Other" Explanations
Missouri	There is not a routine schedule for these mailings.
Montana	We review the member history and discuss/educate provider each time a member with a history of opioid use disorder receives a prescription for an opioid.
New Jersey	The NJDURB has reviewed and approved educational newsletters that were distributed to prescribers for the treatment options for Acute Pain.
New Mexico	A RetroDUR intervention was delivered on 6/18/18.
North Dakota	These activities are part of our monthly interventions, but not all issues are selected during each monthly process.

b. *If "No", do you plan on implementing a RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis or history of OUD, or opioid poisoning in the future?*

Figure 95 - Future Implementation of RetroDUR Activity and/or Provider Education in Regard to Beneficiaries with a Diagnosis or History of OUD or Opioid Poisoning

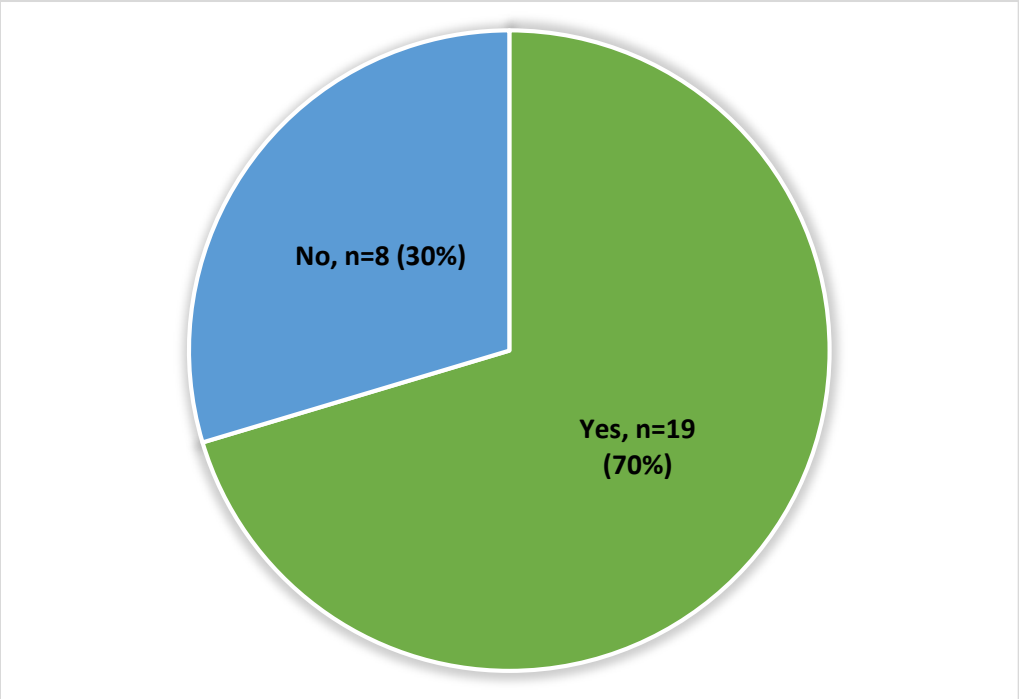

Table 128 - Future Implementation of RetroDUR Activity and/or Provider Education in Regard to Beneficiaries with a Diagnosis or History of OUD or Opioid Poisoning

Response	States	Count	Percentage
Yes	Alaska, Colorado, District of Columbia, Idaho, Illinois, Kentucky, Maine, Massachusetts, Michigan, Nebraska, Nevada, New Hampshire, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Wyoming	19	70.37%
No	Delaware, Hawaii, Indiana, Iowa, Kansas, Louisiana, Maryland, Minnesota	8	29.63%

7. Does your state Medicaid agency develop and provide prescribers with pain management or opioids prescribing guidelines?

Figure 96 - State Medicaid Agency Develop and Provide Prescribers with Pain Management or Opioids Prescribing Guidelines

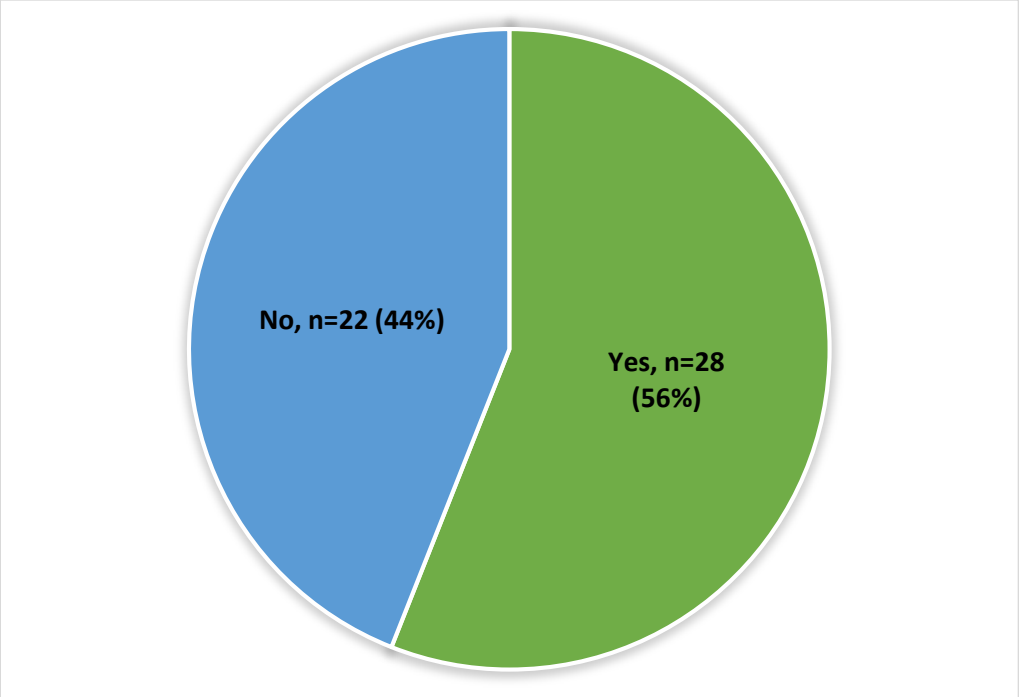

Table 129 - State Medicaid Agency Develop and Provide Prescribers with Pain Management or Opioids Prescribing Guidelines

Response	States	Count	Percentage
Yes	Alaska, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Idaho, Illinois, Indiana, Kansas, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nevada, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, South Dakota, Washington, West Virginia	28	56.00%
No	Alabama, Arkansas, Georgia, Hawaii, Iowa, Kentucky, Maryland, Missouri, Nebraska, New Hampshire, New Mexico, North Dakota, Ohio, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Wisconsin, Wyoming	22	44.00%

For either “Yes” or “No”, please check all that apply:

Figure 97 - State Medicaid Agency Provision of Pain Management or Opioid Prescription Guidelines

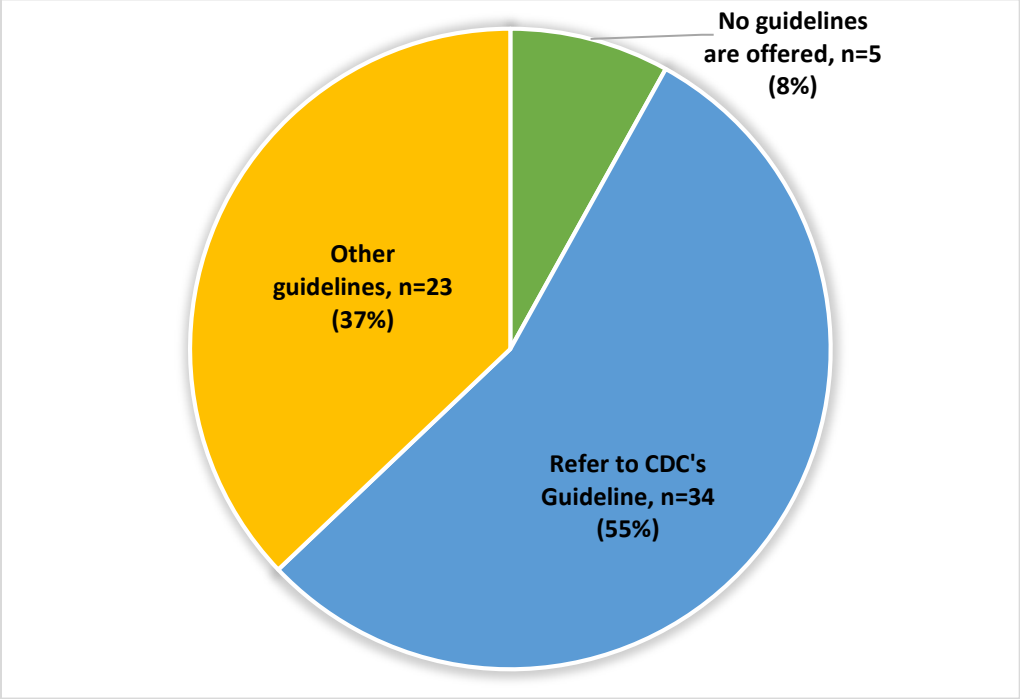

Table 130 - State Medicaid Agency Provision of Pain Management or Opioid Prescription Guidelines

Response	States	Count	Percentage
No guidelines are offered	Alabama, Arkansas, Missouri, South Carolina, Texas	5	8.06%
Refer to the CDC's Guideline	Alaska, California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Montana, Nevada, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming	34	54.84%
Other guidelines	Alaska, California, Colorado, Delaware, District of Columbia, Hawaii, Illinois, Kansas, Kentucky, Maryland, Massachusetts, Minnesota, Nebraska, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oregon, South Dakota, Tennessee, Washington, Wisconsin	23	37.10%

Please identify the “referred” guidelines.

Table 131 - Referred Opioid Prescription Guideline Identification

State	Referred Opioid Prescription Guideline Identification
Alaska	CDC Guidelines
California	CDC's Guideline for Prescribing Opioids for Chronic Pain
Colorado	CDC Guideline for Prescribing Opioids for Chronic Pain
Connecticut	cdc.gov
District of Columbia	http://www.cdc.gov/drugoverdose/prescribing/guideline.html
Florida	CDC's Guidelines for Prescribing Opioids for Chronic Pain
Georgia	CDC Guidelines for Prescribing Opioids for Chronic Pain
Idaho	Exact CDC Publications.
Indiana	CDC Guideline
Iowa	CDC Guideline for Prescribing Opioids for Chronic Pain
Kentucky	Announcements of the new PA criteria included the CDC's Checklist for prescribing opioids for chronic pain. http://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf and http://www.cdc.gov/drugoverdose/index.html
Louisiana	CDC's Guideline for Prescribing Opioids for Chronic Pain.
Maine	CDC guidelines
Maryland	http://mmcp.health.maryland.gov/healthchoice/opioid-dur-workgroup/Pages/healthchoice-opioid-response.aspx
Michigan	Guidelines for Prescribing Opioids for Chronic Pain found at: www.cdc.gov/drugoverdose/prescribing/guideline.html
Minnesota	Minnesota also has their own guidelines which follow the CDC's Guidelines.
Mississippi	The CDC Guidelines for Prescribing Opioids for Chronic Pain are referred in Retro-DUR educational letters.
Montana	We refer them to the 2016 CDC publication at "http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm" for treatment guidelines and stress that while these are guidelines, treatment and/or tapering plans must be individualized.
Nevada	The Medicaid Services Manual (MSM) Chapter 1200, Prescribed Drugs, refers prescribers to the CDC Guideline for Prescribing Opioids for Chronic Pain link at http://www.cdc.gov/drugoverdose/prescribing/guideline.html, directly following the prior authorization guidelines for opioids.
New Mexico	Opioid prescribing newsletters with CDC guideline recommendations are in process for FY19.
New York	CDC's Guideline for Prescribing Opioids for Chronic Pain
North Carolina	Prescribers are required to use the CDC guidelines for prescribing opioids for chronic pain. Additionally, the NC STOP (Strengthen Opioid Misuse Prevention) Act provides guidance for prescribing opioids.
North Dakota	We also refer to general peer reviewed literature.
Ohio	CDC guidelines
Oklahoma	Centers for Disease Control and Prevention (CDC) Guidelines for Prescribing Opioids
Pennsylvania	The Department has coordinated with other state agencies to develop Pennsylvania opioid prescribing guidelines to be used by all payers in the state.

State	Referred Opioid Prescription Guideline Identification
Rhode Island	Rules and Regulations for Pain Management, Opioid Use, and the Registration of Distributors of Controlled Substances in Rhode Island [216-RICR-20-20-4] Updated September 10, 2018
South Dakota	CDC
Utah	A link to the CDC Guidelines and other CDC Materials are posted on the State Medicaid Pharmacy web site.
Vermont	CDC guidelines The UVM College of Medicine Office of Primary Care and Area Health Education Centers (AHEC) provides CE, Opioid Prescription Management toolkits, safety tips guiding safe prescribing for providers as well as tips for patients on how to safely take prescribed opioids. They also provide academic detailing. http://www.med.uvm.edu/ahec/home . Continuing Ed and other resources are also available through the Vermont Medical Society.
Virginia	CDC Guideline for Prescribing Opioids for Chronic Pain
West Virginia	CDC Guidelines
Wisconsin	Wisconsin refers to the CDC guidelines.
Wyoming	The DUR program refers prescribers to the CDC guidelines.

Please identify the "other" guidelines.

Table 132 – "Other" Opioid Prescription Guideline Identification

State	"Other" Opioid Prescription Guideline Identification
Alaska	Washington State AMDG Guidelines
California	The Medical Board of California Guidelines for Prescribing Controlled Substances for Pain.
Colorado	Washington State Agency Medical Directors' Group Interagency Guideline on Prescribing Opioids for Pain; Colorado Dental Board, Colorado Medical Board, State Board of Nursing, and State Board of Pharmacy Policy for Prescribing and Dispensing Opioids; State developed policies for opioids
Delaware	Delaware has developed their own policy based on CDC guidelines and expert clinical opinion
District of Columbia	The District Medicaid program developed the Right Rx program to provide decision and administrative support to clinicians to facilitate ease of prescribing and appropriate use of medications by Medicaid beneficiaries. Guidelines are available at https;//dhcf.dc.gov/service/right-rx-initiative
Hawaii	None other than OxyContin.
Illinois	HFS uses criteria for opioid use for all long-acting narcotics and for the HFS Pain Management Program for medications that hit for the Four Prescription Policy. As applicable, the following are provided: CDC guideline for prescribing opioids for chronic pain, FDA warnings about concomitant benzodiazepines and narcotics, or Methadone safety: a clinical practice guideline from the American Pain Society and College on problems of drug dependence, in collaboration with the Heart Rhythm Society.
Kansas	A bulletin was posted that explained to prescribers the guidelines that were expected to be used when prescribing for Kansas Medicaid patients.
Kentucky	Kentucky Board of Medical Licensure - http://kbml.ky.gov/prescribing-substance-abuse/Pages/default.aspx

State	"Other" Opioid Prescription Guideline Identification
Maryland	Recommendations may be found at http://mmcp.health.maryland.gov/healthchoice/opioid-dur-workgroup/Pages/healthchoice-opioid-response.aspx
Massachusetts	The MassHealth Drug List provides a link to a reference containing the morphine equivalents of current opioid products.
Minnesota	http://mn.gov/dhs/opioid-guidelines/
Nebraska	We refer prescribers to the Nebraska Pain Management Guidance Document.
New Hampshire	The Medicaid agency refers prescribers to the Office of Professional Licensure and Certification (OPLC) administrative rules on opioid prescribing.
New Jersey	The NJ DURB has distributed an educational newsletter for the treatment options for acute pain.
New York	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
North Carolina	Local provider networks create recommendations for consideration when tapering opioids for chronic pain. Additionally, educational material and guidelines are available at www.nctracks.nc.gov.
Ohio	"Ohio guidelines for the management of acute pain outside of emergency department and Ohio emergency and acute care facility." Opioids and other controlled substances prescribing guidelines."
Oregon	Oregon Opioid Prescribing Guidelines: http://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Pages/task-force.aspx
South Dakota	State Medical Association Guidelines
Tennessee	Our agency did participate as panelists on the State of Tennessee's Chronic Opioid Prescribing Guidelines.
Washington	Washington State Agency Medical Director's Guidelines State law (Washington Administrative Code 246-919-850 through WAC 246-919-985.
Wisconsin	In addition to the CDC guidelines, Wisconsin refers to the Wisconsin Medical Examining Board guidelines.

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

Figure 98 - Drug Utilization Management Strategy that Supports Abuse Deterrent Opioid Use

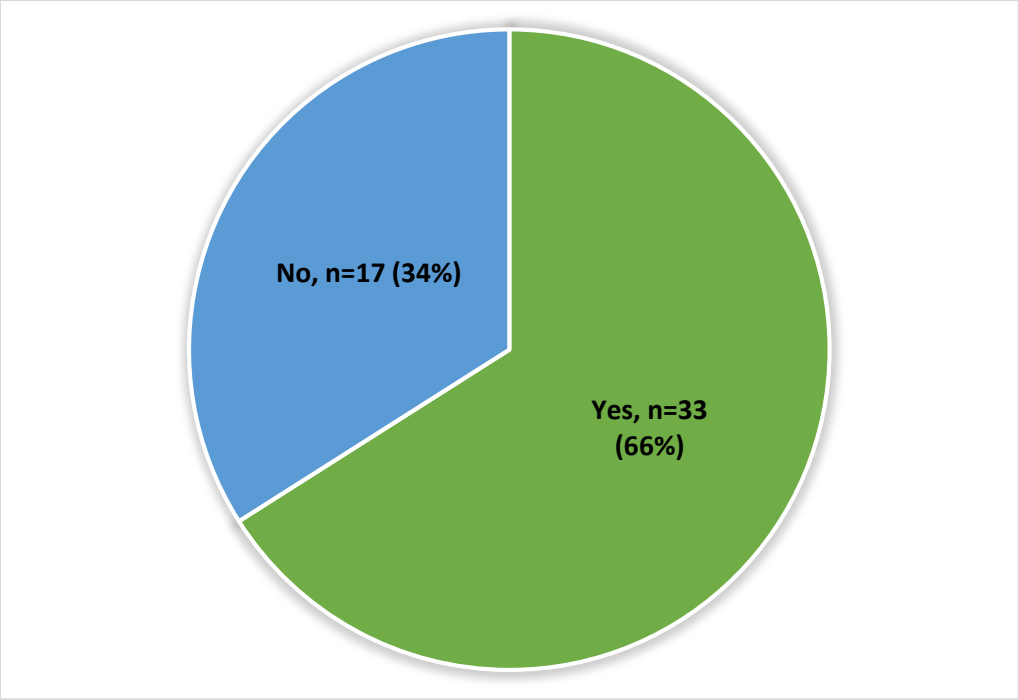

Table 133 - Drug Utilization Management Strategy that Supports Abuse Deterrent Opioid Use

Response	States	Count	Percentage
Yes	Alaska, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Michigan, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, North Dakota, Oklahoma, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, West Virginia, Wisconsin	33	66.00%
No	Alabama, Colorado, Hawaii, Idaho, Louisiana, Massachusetts, Minnesota, Missouri, New Jersey, New Mexico, Ohio, Oregon, Pennsylvania, South Dakota, Virginia, Washington, Wyoming	17	34.00%

If yes, please explain.

Table 134 - Explanations of Drug Utilization Management Strategy that Supports Abuse Deterrent Opioid Use

State	Explanations
Alaska	We currently have at least one abuse deterrent formulation on the PDL, per the recommendation of the Pharmacy and Therapeutics Committee.
Arkansas	Embeda (Morphine and Naltrexone) ER is a preferred long-acting opioid on the PDL.
California	Effective August 1, 2017, multiple strengths of morphine sulfate/naltrexone were added to the Medi-Cal List of Contract Drugs.
Connecticut	Abuse deterrent opioids are included on the PDL.
Delaware	Abuse deterrent medications do not require prior authorization if member is prescribed one unit per day. A select list of abuse deterrent medications are preferred in Delaware.
District of Columbia	An abuse deterrent opioid product has preferred status on the District PDL
Florida	To receive an abuse deterrent opioid system requires recipients to have 2 fills of a Short Acting (SA) Narcotic within 75 days plus a fill of Embeda within 60 days OR a fill of any Abuse Deterrent Narcotic (ADN) within 60 days to receive an ADN Note: Edit exclude Embeda as the product is preferred.
Georgia	Abuse deterrent opioids present on preferred drug list with preferred status.
Illinois	Embeda is preferred.
Indiana	Abuse deterrent opioids are present as preferred on the preferred drug list. Those agents with known high levels of abuse and no abuse deterrent are often placed as non-preferred.
Iowa	There is a minimum of one abuse deterrent opioid on the PDL.
Kansas	presence of an abuse deterrent opioid as a preferred drug on the PDL
Kentucky	Embeda (morphine sulfate/naltrexone HCl) is an FDA-approved abuse-deterrent formulation. It is preferred with a clinical PA with the same requirements as other non-ADF long-acting opioids (e.g., morphine sulfate ER, fentanyl transdermal system).
Maine	We make an Abuse deterrent product available on the PDL as a preferred product.
Maryland	The FFS has a preferred drug list with the opioid abuse deterrent product Embeda available as a preferred agent.
Michigan	MDHHS has a clinical prior authorization edit on the Opioid Abuse Deterrent agents to ensure appropriate prescribing. In addition, this class is on the PDL with several preferred agents.
Mississippi	Medication Assisted Treatment (MAT) agents are available and included as preferred agents on Mississippi's Universal PDL. Embeda is a preferred agent on the PDL.
Montana	Our DUR board has requested that we have at least one abuse deterrent opioid as a preferred product on our PDL and we have always adhered to that request.
Nebraska	In FFY 2018, Embeda, Hysingla and Butrans were preferred agents.
Nevada	There are several abuse deterrent opioids that are available as preferred products on the preferred drug list. However, the same quantity limits apply as other opioids.
New Hampshire	Embeda has preferred status on the NH Medicaid FFS PDL.
New York	New York has abuse deterrent products available on the preferred section of the States Preferred Drug List.
North Carolina	The drug utilization management strategy involves the placement of abuse deterrent opioids as preferred on the NC Medicaid Preferred Drug List.
North Dakota	An abuse deterrent opioid has preferred status on our preferred drug list.
Oklahoma	We cover Medication Assisted Treatments (MAT)
Rhode Island	Abuse deterrent opioids are on the preferred drug list with a preferred status.
South Carolina	PDL has an Opioid deterrent formulation (effective 7/1/17), as well as alternative to oral opioid (patch) added.

State	Explanations
Tennessee	In 2015, we stopped the use of generic Morphine ER as our primary preferred LAO, and we have preferred instead, Embeda, since that point in time.
Texas	Vendor Drug program places at least one abuse deterrent opioid, such as Embeda, on the preferred drug list.
Utah	The P&T Committee has recommended that one long-acting abuse deterrent opioid formulation be present on the PDL as preferred, and the State has applied these recommendations.
Vermont	Embeda preferred on PDL
West Virginia	We have attempted to provide preferred-status to at least one abuse-deterrent product, however the majority of our products are not abuse-deterrent.
Wisconsin	Wisconsin has an abuse deterrent agent preferred on the preferred drug list.

E. Morphine Equivalent Daily Dose (MEDD)

1. Have you set recommended maximum morphine equivalent daily dose measures?

Figure 99 - State Recommended Maximum Morphine Equivalent Daily Dose Measures

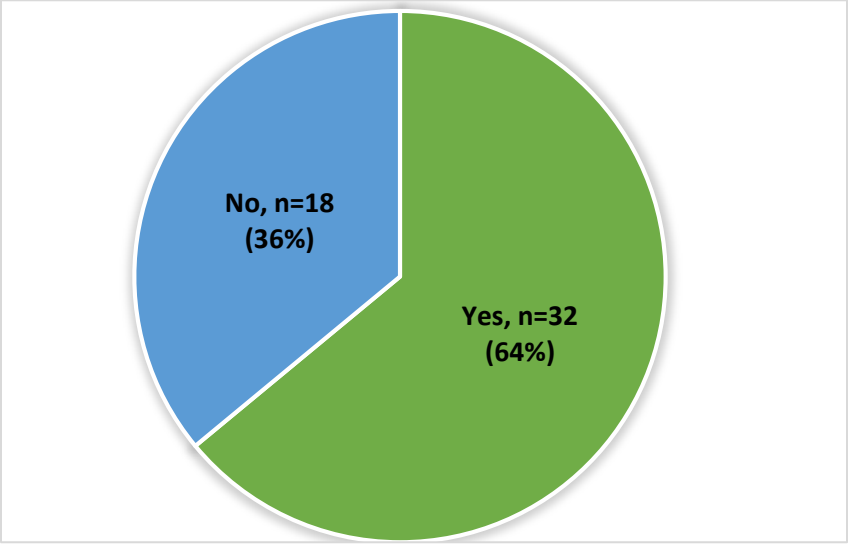

Table 135 - State Recommended Maximum Morphine Equivalent Daily Dose Measures

Response	States	Count	Percentage
Yes	Arkansas, Colorado, Delaware, Florida, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wyoming	32	64.00%
No	Alabama, Alaska, California, Connecticut, District of Columbia, Georgia, Hawaii, Illinois, Kansas, Nebraska, New Jersey, New Mexico, New York, North Dakota, Rhode Island, South Carolina, Utah, Wisconsin	18	36.00%

a. If "Yes", what is your maximum morphine equivalent daily dose limit in milligrams per day?

Figure 100 – Maximum Morphine Equivalent Daily Dose Limit in Milligrams per Day

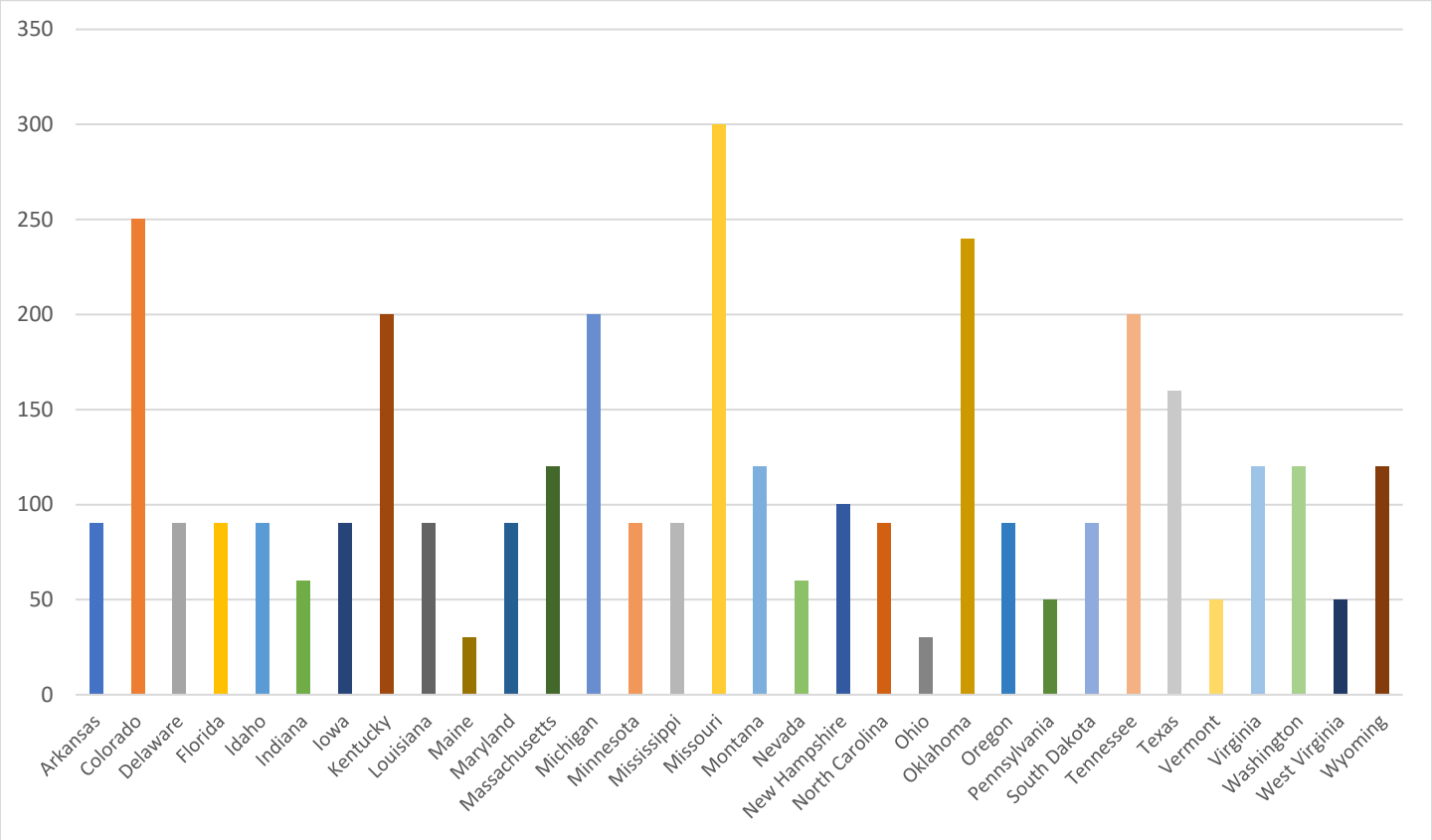

Table 136 - Maximum Morphine Equivalent Daily Dose Limit in Milligrams per Day

State	Maximum Daily Dosage Limit
Arkansas	90mg
Colorado	250mg
Delaware	90mg
Florida	90mg
Idaho	90mg
Indiana	60mg
Iowa	90mg
Kentucky	200mg
Louisiana	90mg
Maine	30mg
Maryland	90mg
Massachusetts	120mg
Michigan	200mg
Minnesota	90mg
Mississippi	90mg
Missouri	300mg
Montana	120mg

State	Maximum Daily Dosage Limit
Nevada	60mg
New Hampshire	100mg
North Carolina	90mg
Ohio	30mg
Oklahoma	240mg
Oregon	90mg
Pennsylvania	50mg
South Dakota	90mg
Tennessee	200mg
Texas	160mg
Vermont	50mg
Virginia	120mg
Washington	120mg
West Virginia	50mg
Wyoming	120mg

b. If "Yes", please explain (i.e. are you in the process of tapering patients to achieve this limit?).

Table 137 - Explanations to Achieve Maximum Morphine Equivalent Daily dose *Limit*

State	Explanations
Arkansas	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
Colorado	Prior authorization involving prescriber-to-prescriber consult is required for members' prescriptions exceeding MEDD limit. An opioid prescribing plan and recommendations for tapering are documented as part of this consult and approval may be placed to allow for tapering. In addition, we have further decreased the maximum morphine equivalent daily dose subsequent to the timeframe of this report.
Delaware	90 MME limit has been in place since July 1, 2018.
Florida	Applies only to treatment naive recipients defined as not receiving opioid prescriptions in previous 60 days.
Idaho	Already completed between July 2017 and July 2018. Some are still in process.
Indiana	Current limit applies to new starts. Indiana Medicaid anticipates adding tapering requirements and adding limits to current utilizers in the future.
Iowa	We are in the process of tapering to a maximum of 90 MME per day. The MME limit was initially set at 200 MME/day, with a plan to slowly decrease to 150 MME/day, then 120 MME/day, then 90 MME/day.
Kentucky	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
Louisiana	The current morphine equivalent daily dose of 90 MME per day was established in FFY17 and included prescriber notification and a tapering period, first from 120 MME per day, then to 90 MME per day, prior to the initiation of the edit.
Maine	Constantly evaluating any members exceeding the daily limits through Prior Authorization
Maryland	The morphine equivalent daily dose limit became effective during FFY 2018. Anyone exceeding a MEDD of 90mg is required to obtain a prior authorization. Patients with sickle cell anemia or

State	Explanations
	patients in Hospice are excluded from the prior authorization process, but should also be kept on the lowest effective dose of opioids for the shortest required duration to minimize risk of harm.
Massachusetts	Prior Authorization for MEDD over 120mg/day requires a tapering schedule or pain specialist consultation to support the dose.
Michigan	MDHHS implemented an accumulated MEDD edit in September 2018 with the initial threshold set at 500 MEDD and will continue to lower the MEDD limit in phases down to the CDC recommendation of 90 MEDD. Currently, the threshold is set at 200 MEDD. Prescribers are referred to CDC tapering tools for assistance.
Minnesota	It was 120 mg per day and last fall, it was decreased to 90 mg. Those that had a PA in place for 120 or greater would not be affected. There were approximately 200 FF recipients that would fall at the >90 mg and were under the previous 120 mg. Claims would reject at the POS. Prescribers would go through the prior authorization process to continue at the current dose else they would lower the dose to 90 mg or less.
Mississippi	Educational letters have been going out since September 2016. The DUR edit will be implemented August 2019. Providers will be given the opportunity to submit a manual PA for MEDD => 90.
Missouri	May 1, 2018, MO HealthNet implemented a Morphine Accumulation Clinical Edit to calculate the combined therapy MME level. Participants exceeding 300 MME per day required prior authorization unless they met specific clinical criteria.
Montana	We started with a limit of 180MME and are gradually lowering it to 90MME. We allow providers to taper at whatever rate is achievable for their patients. We also allow providers to keep patients at their current doses if they attest that they have tried other treatment options, they have evaluated patient for opioid use disorder, a pain treatment plan has been established as well as a monitoring plan, they attempted a dose reduction but it resulted in loss of pain control or function, they have provided counseling on overdose and provided a naloxone prescription, they have reviewed risk factors for respiratory depression and have certified that benefit outweighs risk for this patient.
Nevada	Initial fills are limited to 60 mg morphine equivalent daily dose.
New Hampshire	NH Medicaid chose 100MME to match the opioid prescribing administrative rules adopted by the OPLC.
North Carolina	In June of 2018, the clinical criteria was updated to limit the maximum morphine equivalency to 90mg per day including schedule III and IV opioids.
Ohio	30 MED is for short acting opioids, 80 MED for long acting opioids
Oklahoma	Edit was created and monitored as a "post and pay". Implementation of tapering January 2019.
Oregon	Tapering legacy patients already established on treatment and limiting new starts to not exceed this maximum MME
Pennsylvania	No
South Dakota	We are currently in the process of tapering to 90 with the expected completion date of 10/1/2019.
Tennessee	We are at this limit now with exceptions for cancer. We will be moving at some point to 120 (Tennessee's guidelines limit) and then 90.
Texas	Yes, the process of morphine equivalent (MME) per daily dose began at 300 MME in January 9th, 2018 and gradually tapered off to 240 MME in May 2018, and to 160 MME in September 2018. The final limit of 90 MME scheduled for January of 2019.
Vermont	50mg MME limit for adults 24 mg MME for children this applies to initial fills for ongoing therapy, as long as PA criteria and quantity limits are met, we do not enforce limits

State	Explanations
Virginia	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
Washington	Not at this time.
West Virginia	Yes, via our SEMPP program (previously described).
Wyoming	Long-acting medications are limited to 120 MED per day. A prior authorization is required with documentation of a plan to taper for doses above this level. Cancer diagnoses are excluded.

If "No", please explain the measure or program you utilize.

Table 138 - Explanations of the Measure or Program Utilized

State	Explanations
Alabama	Maximum quantity units placed manually.
Alaska	The program currently utilizes quantity limits and duplicate therapy edits to trigger prior authorization. During prior authorization process MME daily dose is evaluated.
California	All opioids have an established maximum quantity per dispensing and a maximum of three (3) dispensings within any 75-day period.
Connecticut	Effective 9/1/2016 we implemented a MEDD informational alert message at point of sale.
District of Columbia	The MEDD program will be implemented at the beginning of the next fiscal year
Georgia	Quantity limits are currently in place, but not based upon a pre-specified morphine equivalent daily dose.
Hawaii	Pain management has not been an issue since 2009. FDA approved quantity edits for excessive quantities per First Data Bank.
Illinois	Quantity limits for short and long-acting morphine
Kansas	FFS has currently not implemented this due to system delays from building the KMMS program.
Nebraska	Those limits were implemented in FFY 2019.
New Jersey	Protocol recently approved and will be implemented the next FFY.
New Mexico	Generating reports to review claims exceeding 90 MME.
New York	The NYS DURB has recommended quantity/frequency/duration limits to promote the safe and clinically effective use of opioids in the New York State Medicaid Program. The process examines FDA recommended dosages and considers equivalent MED levels. The combined efforts of the Medicaid Prescriber Education Program (MPEP), the Drug Information Response Center (DIRC) and Retrospective Drug Utilization Review (Retro-DUR) program promotes the clinical effectiveness and medical appropriateness of opioid utilization by way of point-of-sale (POS) prospective edits, Retro-DUR evaluations and the application of educational interventions for prescribers and pharmacists.
North Dakota	During the 2018 FFY, all individual narcotics were limited to < 90 MED and only one extended release and one immediate release narcotic were allowed to be used concurrently. Starting in July 2019, programming will be implemented to limit the overall dosing to 90 MED.
Rhode Island	Partial plan in place for nave patients
South Carolina	Quantity Limits/Day Supply; 90MME will be implemented 7/1/19 (opioid naive prescriptions)
Utah	For FFY2018, Utah Medicaid had several measures in place to support the appropriate use of opioids. 1. Initial fills of short-acting opioids are restricted to 7 days or less for non-dental prescribers and as of July 1, 2018, 3 days or less for dental prescribers. There are daily and monthly quantity limits placed on all opioids. High dose opioids are restricted to use in cancer related pain. Pediatric patients cannot use a long-acting opioid without a prior authorization. Methadone that is used for pain (not MAT) requires a PA.

State	Explanations
Wisconsin	Wisconsin monitors these drugs through edits, such as quantity limits, early refill and therapeutic duplication prospective DUR alerts. Wisconsin has reviewed greater than or equal to 50MME through retrospective DUR targeted interventions. Prescribers identified during these processes receive a letter alerting them to a clinical concern

2. Do you provide information to your prescribers on how to calculate the morphine equivalent daily dosage or do you provide a calculator developed elsewhere?

Figure 101 - Provides Information to Your Prescribers on How to Calculate the Morphine Equivalent Daily Dosage or Provides a Calculator Developed Elsewhere?

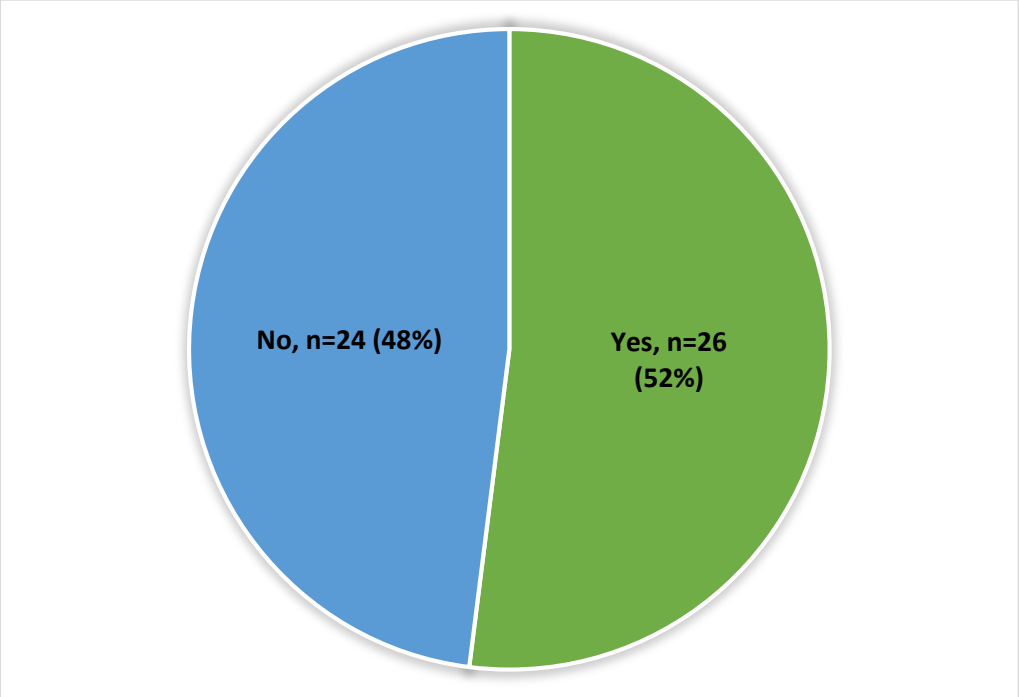

Table 139 - Provides Information to Your Prescribers on How to Calculate the Morphine Equivalent Daily Dosage or Provides a Calculator Developed Elsewhere

Response	States	Count	Percentage
Yes	Alaska, California, Colorado, Connecticut, District of Columbia, Florida, Indiana, Iowa, Kansas, Maine, Maryland, Massachusetts, Mississippi, Montana, Nebraska, New Hampshire, North Carolina, Ohio, Oregon, Rhode Island, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia	26	52.00%
No	Alabama, Arkansas, Delaware, Georgia, Hawaii, Idaho, Illinois, Kentucky, Louisiana, Michigan, Minnesota, Missouri, Nevada, New Jersey, New Mexico, New York, North Dakota, Oklahoma, Pennsylvania, South Carolina, South Dakota, Utah, Wisconsin, Wyoming	24	48.00%

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

Table 140 - Name of the Developer of the Calculator

State	Developer of the Calculator
Alaska	Washington State Agency Medical Director's Group (AMDG), State PDMP website provides additional resources for online and mobile apps.
California	1) the New York City Department of Health and Mental Hygiene (DOHMH); 2) the Washington State Agency Medical Directors Group; and 3) the Centers for Disease Control and Prevention
Colorado	Washington Agency Medical Directors' Group
Connecticut	http://www.cdc.gov/drugoverdose/prescribing/app.html
District of Columbia	The District Medicaid program developed the Right Rx program to provide decision and administrative support to clinicians to facilitate ease of prescribing and appropriate use of medications by Medicaid beneficiaries. Guidelines are available at https;//dhcf.dc.gov/service/right-rx-initiative
Florida	CDC
Indiana	CDC
Iowa	A link to the CDC Guideline for Prescribing Opioids is provided on the website which brings prescribers to the clinical tools section, which includes information on how to calculate the total daily opioid dose.
Kansas	We used and referenced the calculator from the CMS website in our provider bulletin.
Maine	Using CDC MME calculator
Maryland	CDC guidelines
Massachusetts	MassHealth distributed a prescriber letter re Updated Opioid High Dose Limits with an included table of MEDD equivalents for long acting opioids.
Mississippi	Providers are referred to the CDC MEDD conversion table.
Montana	We provide 2 online calculators: http://www.cdc.gov/drugoverdose/prescribing/app.html http://www.agencymeddirectors.wa.gov/opioiddosing.asp
Nebraska	Nebraska Pain Management Guidance Document
New Hampshire	Washington State Agency Medical Director's Group.
North Carolina	NC Department of Health Benefits maintains a table of morphine equivalency factors on their public website for providers to access.
Ohio	Take Charge Ohio, OARRS
Oregon	The OSU College of Pharmacy, Drug Use Research & Management Program
Rhode Island	http://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf
Tennessee	We have a conversion chart on our Pharmacy Program website, which is hosted by our PBM. The link to the conversion chart is: http://tenncare.magellanhealth.com/static/docs/Program_Information/TennCare_MME_Conversion_Chart.pdf
Texas	VDP provided the information from the CDC guidelines which includes the conversion table from the source adopted from Von Korff M, Saunders K, Ray GT, et al. Clin J Pain 2008; 24:521-7 and Washington State Interagency Guideline on Prescribing Opioids for Pain (http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf).
Vermont	We use the CDC calculator

State	Developer of the Calculator
Virginia	The service authorization fax form states for the prescriber to provide the patients Active Daily MME from the PMP (http://virginia.pmpaware.net/login)
Washington	University of Washington
West Virginia	We use the CDC guidelines.

b. *If "Yes", how is the information disseminated? Check all that apply:*

Figure 102 - Information Dissemination Routes

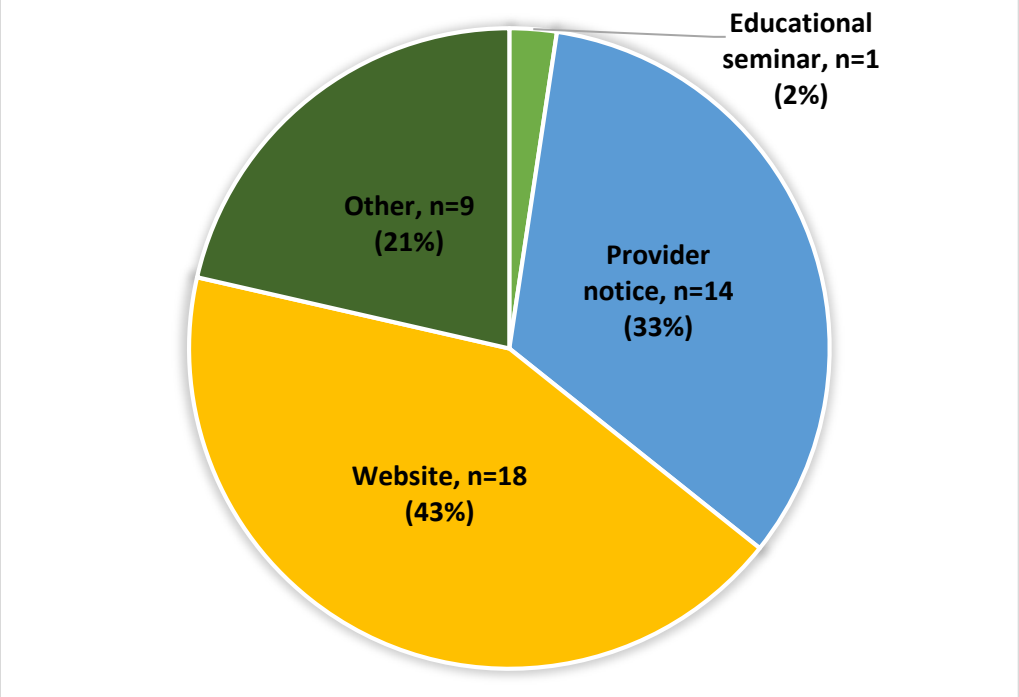

Table 141 - Information Dissemination Routes

Response	States	Count	Percentage
Educational seminar	Maryland	1	2.38%
Provider notice	California, District of Columbia, Florida, Iowa, Maine, Maryland, Mississippi, Montana, Ohio, Rhode Island, Texas, Vermont, Virginia, West Virginia	14	33.33%
Website	Alaska, Colorado, Connecticut, District of Columbia, Iowa, Kansas, Maine, Maryland, Montana, New Hampshire, North Carolina, Oregon, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia	18	42.86%
Other	Alaska, California, Colorado, Indiana, Massachusetts, Montana, Nebraska, Oregon, Virginia	9	21.43%

If “Other”, please explain.

Table 142 - “Other” Explanations for Information Dissemination Route

State	“Other” Explanations
Alaska	Website, prior authorization form and criteria documents.
California	The Medi-Cal DUR program published an educational bulletin entitled, Clinical Review: Morphine Equivalent Daily Dose to Prevent Opioid Overuse to the Medi-Cal DUR website. This bulletin defined morphine equivalent daily dose (MEDD) and provided evidence to support using MEDD as an indicator of potential dose-related risk for prescription opioid overdose. The bulletin provided links to several online MEDD calculators, as well as additional resources to providers. The bulletin was also emailed to all providers who subscribe to the Medi-Cal Subscription Service.
Colorado	Link for MEDD calculator is on preferred drug list. There is also a link on the State Department's pain management resources and opioid use webpage.
Indiana	Drug Utilization Review Board Newsletter, posted electronically, provides opiate conversion charts.
Massachusetts	Direct mail to opioid prescribers
Montana	For providers who have patients over the MME limit, we send out educational letters so that they can work to develop a treatment plan for those patients and get a prior authorization in place.
Nebraska	DUR Newsletter
Oregon	We have included a table of morphine equivalents in the long-acting opioid PA criteria: http://www.orpdl.org/durm/PA_Docs/opioids_long_acting.pdf and short-acting opioid PA criteria: http://www.orpdl.org/durm/PA_Docs/opioids_short_acting.pdf
Virginia	A Medicaid Memo was posted to the state website with a blast email sent to those enrolled in the service. A patient specific letter was sent to those prescribers whose patients had received a prescription above the new limit.

3. Do you have an edit in your POS system that alerts the pharmacy provider that the morphine equivalent daily dose prescribed has been exceeded?

Figure 103 - Edit in Your POS System that Alerts the Pharmacy Provider that the Morphine Equivalent Daily Dose Prescribed Has Been Exceeded

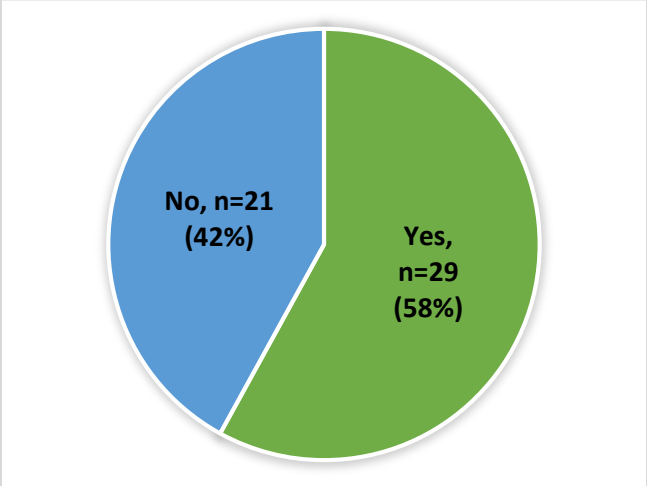

Table 143 - Edit in Your POS System that Alerts the Pharmacy Provider that the Morphine Equivalent Daily Dose Prescribed Has Been Exceeded

Response	State	Count	Percentage
Yes	Arkansas, Colorado, Delaware, Florida, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Missouri, Montana, Nevada, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Dakota, Tennessee, Texas, Vermont, Virginia, West Virginia, Wyoming	29	58.00%
No	Alabama, Alaska, California, Connecticut, District of Columbia, Georgia, Hawaii, Illinois, Kansas, Minnesota, Mississippi, Nebraska, New Jersey, New Mexico, New York, Pennsylvania, Rhode Island, South Carolina, Utah, Washington, Wisconsin	21	42.00%

If “Yes”, do you require prior authorization if the Morphine Equivalent Daily Dose limit is exceeded?

Figure 104 - Prior Authorization Requirement If the Morphine Equivalent Daily Dose Limit Is Exceeded

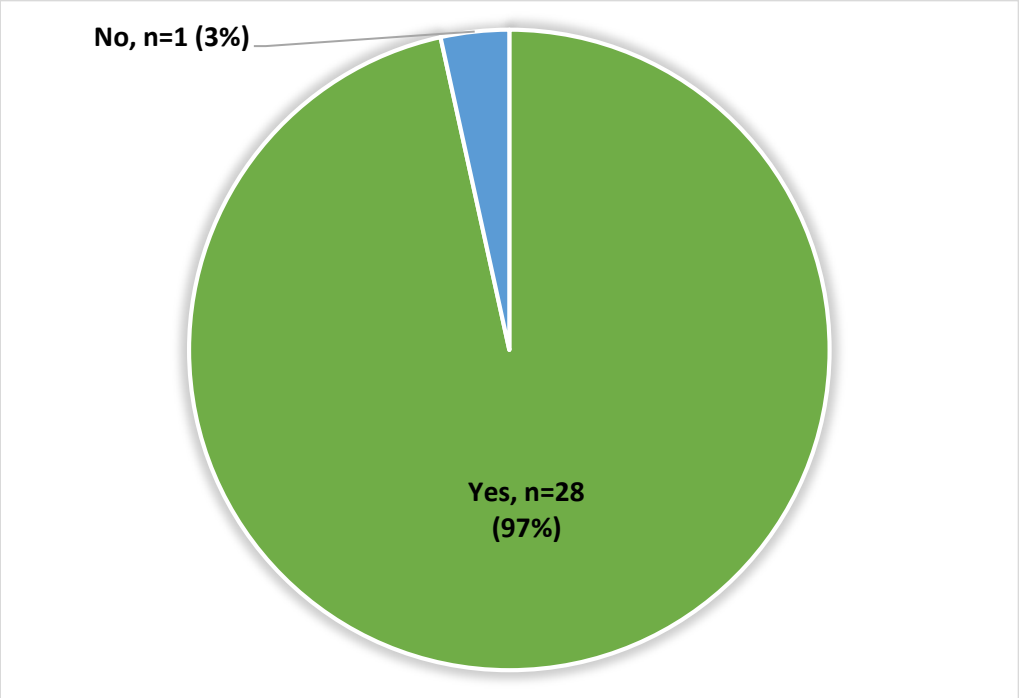

Table 144 - Prior Authorization Requirement If the Morphine Equivalent Daily Dose Limit Is Exceeded

Response	States	Count	Percentage
Yes	Arkansas, Colorado, Delaware, Florida, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Missouri, Montana, Nevada, New Hampshire, North Carolina, North Dakota, Ohio, Oregon, South Dakota, Tennessee, Texas, Vermont, Virginia, West Virginia, Wyoming	28	96.55%

Response	States	Count	Percentage
No	Oklahoma	1	3.45%

F. Buprenorphine, Naloxone, Buprenorphine/Naloxone Combinations and Methadone for Opioid use Disorder (OUD)

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

Figure 105 - Agency Sets Total Milligram per Day Limits on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

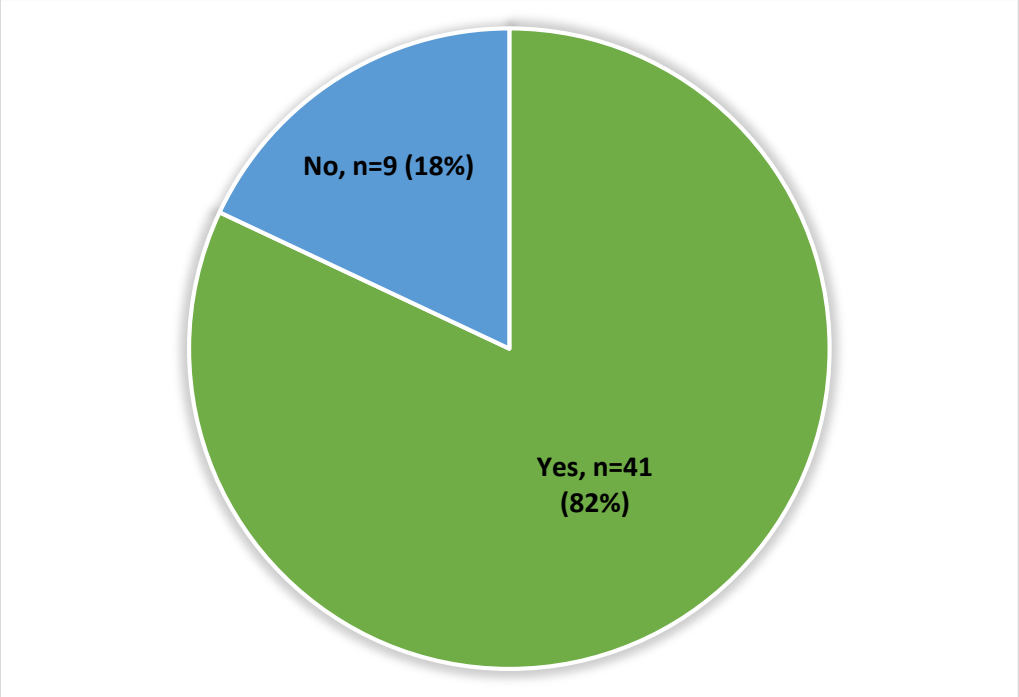

Table 145 - Agency Sets Total Milligrams per Day Limits on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

Response	State	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Tennessee, Vermont, Virginia, Washington, West Virginia, Wyoming	41	82.00%
No	Delaware, Hawaii, New Mexico, Rhode Island, South Carolina, South Dakota, Texas, Utah, Wisconsin	9	18.00%

If “Yes”, please specify the total milligrams/day:

Figure 106 - Total Milligrams/Day Limit on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

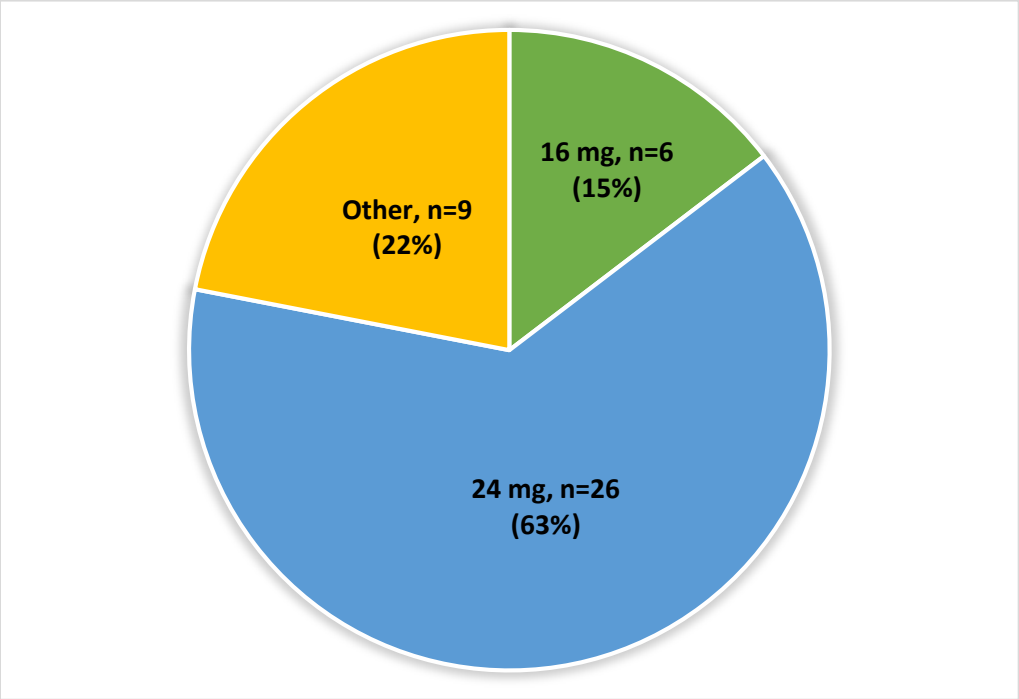

Table 146 - Total Milligrams/Day Limit on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

Response	State	Count	Percentage
16 mg	Ohio, Pennsylvania, Tennessee, Vermont, Virginia, Wyoming	6	14.63%
24 mg	Alaska, Arkansas, Colorado, District of Columbia, Florida, Georgia, Idaho, Indiana, Iowa, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Oklahoma, Oregon, West Virginia	26	63.41%
Other	Alabama, California, Connecticut, Illinois, Kansas, Maine, Maryland, Massachusetts, Washington	9	21.95%

If “Other”, please explain.

Table 147 - “Other” Explanations for TotalMilligrams/Day Limit on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

State	“Other” Explanations
Alabama	Bunavail not approved for doses > 12.6mg/2.1mg/day. Buprenorphine SL tablets are not approved for doses > 24mg/day. Suboxone not approved for doses > 24mg/6mg/day. Zubsolv not approved for doses > 17.1mg/4.2mg/day.
California	There is a maximum quantity of four dosage units per day, regardless of strength. The maximum allowable total daily dose is 48 mg.

State	"Other" Explanations
Connecticut	An Informational alert is set at point of sale for any buprenorphine prescription that exceeds 24 mg per day.
Illinois	Buprenorphine tablets total mg/day is 24 mg. A group accumulator edit allows up to 93 units per month of any buprenorphine and/or buprenorphine/naloxone combination claims. If prior authorization is requested, the regimen, PMP, and submitted clinical notes are reviewed.
Kansas	Only Subutex. 24mg.
Maine	16mg for maintenance but allow 60 day induction allowances up to 32mg/day
Maryland	MMPP utilizes quantity limits that vary by drug and dosage form for buprenorphine and buprenorphine-naloxone combination products. Quantity limits are available online at: http://mmcp.health.maryland.gov/pap/docs/QL.pdf
Massachusetts	No Prior Authorization required for 16 daily dose. For daily doses above 16 to 24mg, 180 days without Prior Authorization, afterward will require PA. For daily does >24mg /day and </= 32mg/day, 90 days without Prior Authorization , afterward will require PA
Washington	32 mg per day

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

Figure 107 - Limitations on Allowable Length of Treatment of Buprenorphine/Naloxone Combination Drugs

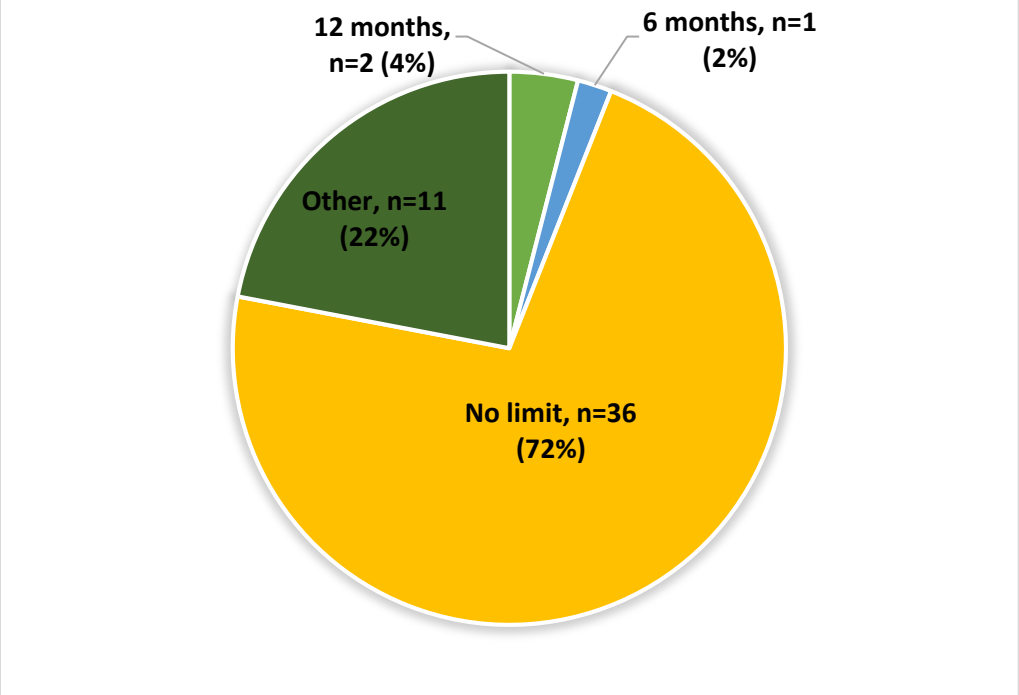

Table 148 - Limitations on Allowable Length of Treatment of Buprenorphine/Naloxone Combination Drugs

Response	States	Count	Percentage
12 months	District of Columbia, Nebraska	2	4.00%
6 months	Tennessee	1	2.00%
No limit	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Kentucky,	36	72.00%

Response	States	Count	Percentage
	Maryland, Massachusetts, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Washington, Wisconsin		
Other	Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Oregon, Virginia, West Virginia, Wyoming	11	22.00%

If "Other", please explain.

Table 149 – "Other" Explanations for Limitations on Allowable Length of Treatment of Buprenorphine/Naloxone Combination Drugs

State	"Other" Explanations
Indiana	Buprenorphine/naloxone prior authorizations are granted every 6 months with a maximum 34-day supply if all criteria are met. Buprenorphine prior authorizations are granted for a 34-day supply if all criteria are met.
Iowa	24mg/day for a maximum of 3 months
Kansas	3 months for Subutex. No limit for combination products.
Louisiana	90 days.
Maine	24 months for FFY 2018, but recently removed limits on length of treatment
Michigan	The initial authorization is for 12 months, then renewal requests are evaluated on a case by case basis.
Mississippi	60 days
Oregon	No PA required and no limit on duration for preferred buprenorphine/naloxone combination products that do not exceed an average daily dose of 24 mg per day of buprenorphine
Virginia	3 months
West Virginia	We allow a one-time-only 24 mg initiation dose with a limit if 60-days.
Wyoming	A limit of 24 months is allowed on 16 mg per day.

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

Figure 108 - Maximum Milligrams per Day Reduction after a Set Period of Time

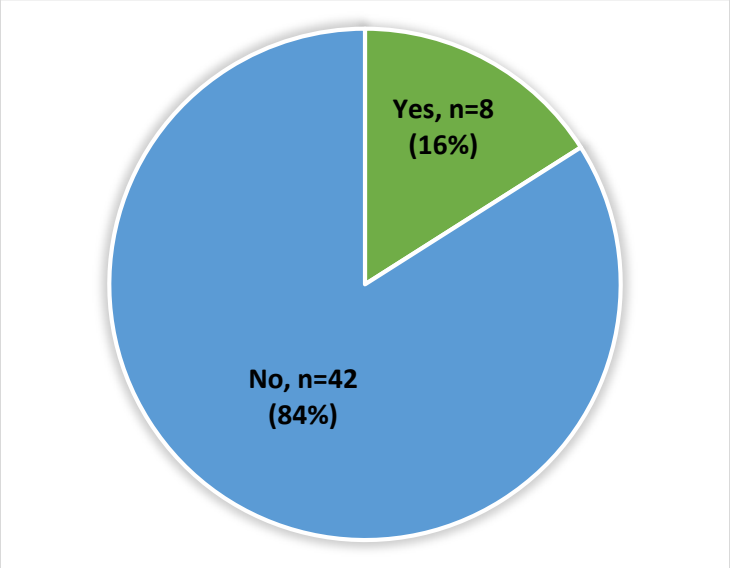

Table 150 - Maximum Milligrams per Day Reduction after a Set Period of Time

Response	States	Count	Percentage
Yes	Iowa, Louisiana, Maine, Michigan, Mississippi, Tennessee, West Virginia, Wyoming	8	16.00%
No	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Maryland, Massachusetts, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, Washington, Wisconsin	42	84.00%

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

Figure 109 - Reduced (Maintenance) Dosage

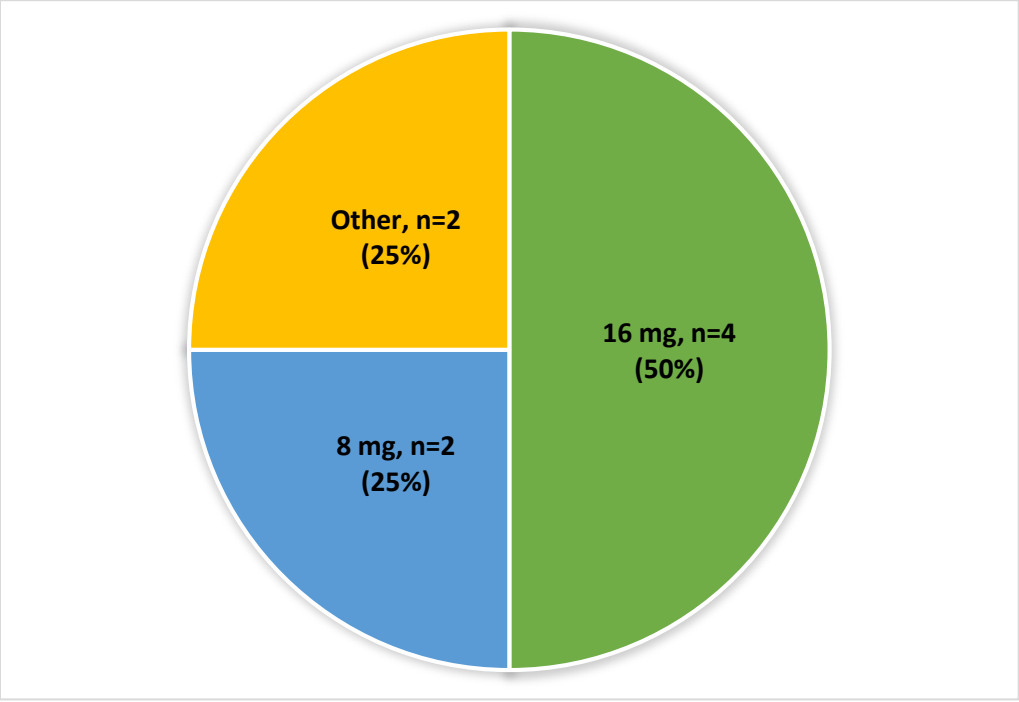

Table 151 - Reduced (Maintenance) Dosage

Response	States	Count	Percentage
16 mg	Iowa, Louisiana, Mississippi, West Virginia	4	50.00%
8 mg	Tennessee, Wyoming	2	25.00%
Other	Maine, Michigan	2	25.00%

If “Other”, please explain.

Table 152 – “Other” Explanations for Reduced (Maintenance) Dosage

State	“Other” Explanations
Maine	We look to reductions in total daily dose if the patient is able to lower dose and maintain sobriety
Michigan	Tapering is required based on an individualized care plan.

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

Figure 110 - Limitations on the Allowable Length of the Reduced Dosage Treatment of Buprenorphine/Naloxone Combination Drugs

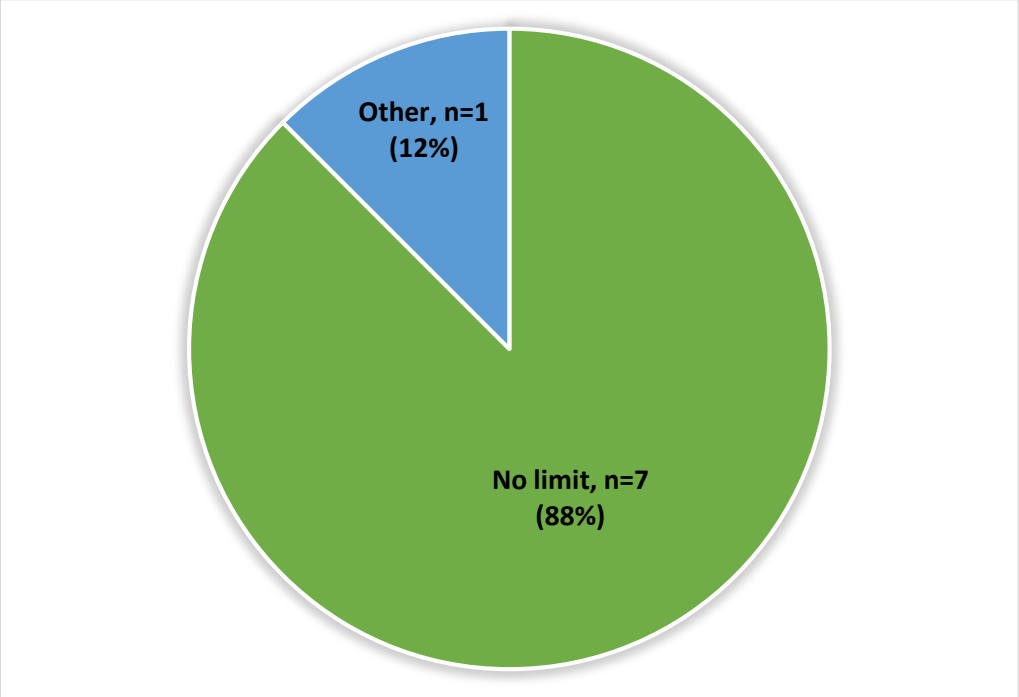

Table 153 - Limitations on the Allowable Length of the Reduced Dosage Treatment on Buprenorphine/Naloxone Combination Drugs

Response	States	Count	Percentage
No limit	Iowa, Louisiana, Maine, Mississippi, Tennessee, West Virginia, Wyoming	7	87.50%
Other	Michigan	1	12.50%

If “Other”, please explain.

Table 154 – "Other" Explanations for Limitations on the Allowable Length of the Reduced Dosage Treatment on Buprenorphine/Naloxone Combination Drugs

State	"Other" Explanations
Michigan	These are reviewed on a case by case basis.

4. Do you have at least one buprenorphine/naloxone combination product available without prior authorization?

Figure 111 - Buprenorphine/Naloxone Combination Product Available Without Prior Authorization

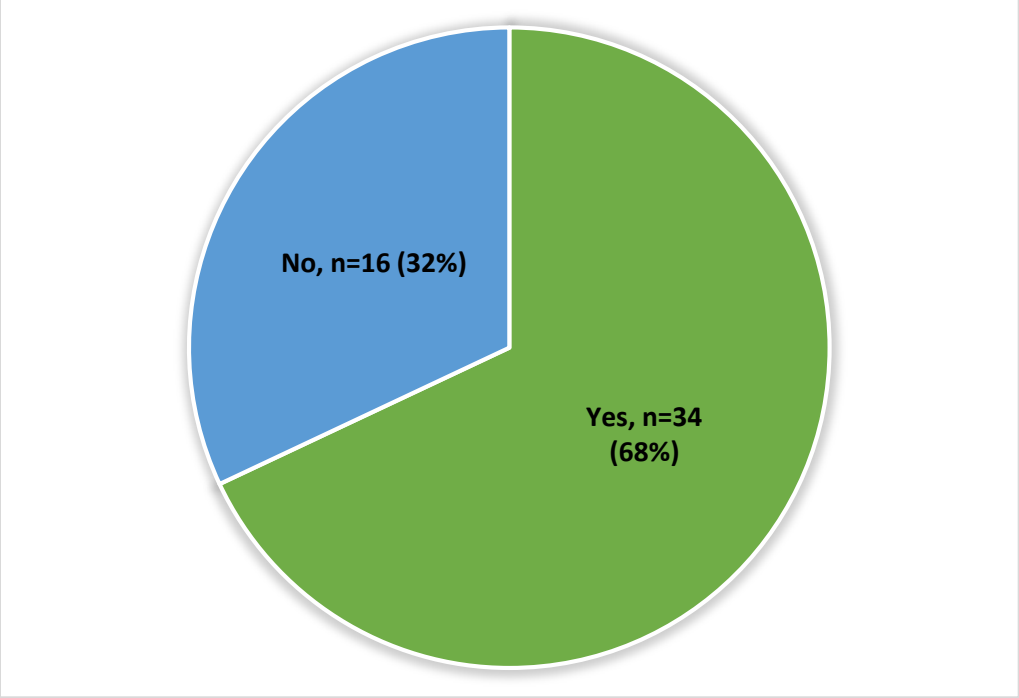

Table 155 - Buprenorphine/Naloxone Combination Product Available Without Prior Authorization

Response	States	Count	Percentage
Yes	Alaska, California, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Kansas, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin	34	68.00%
No	Alabama, Arkansas, Colorado, District of Columbia, Indiana, Iowa, Kentucky, Michigan, Montana, New Jersey, North Dakota, Ohio, Oklahoma, South Dakota, Tennessee, Wyoming	16	32.00%

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

Figure 112 - Edits in Place to Monitor Opioids Being Used Concurrently with any Buprenorphine Drug

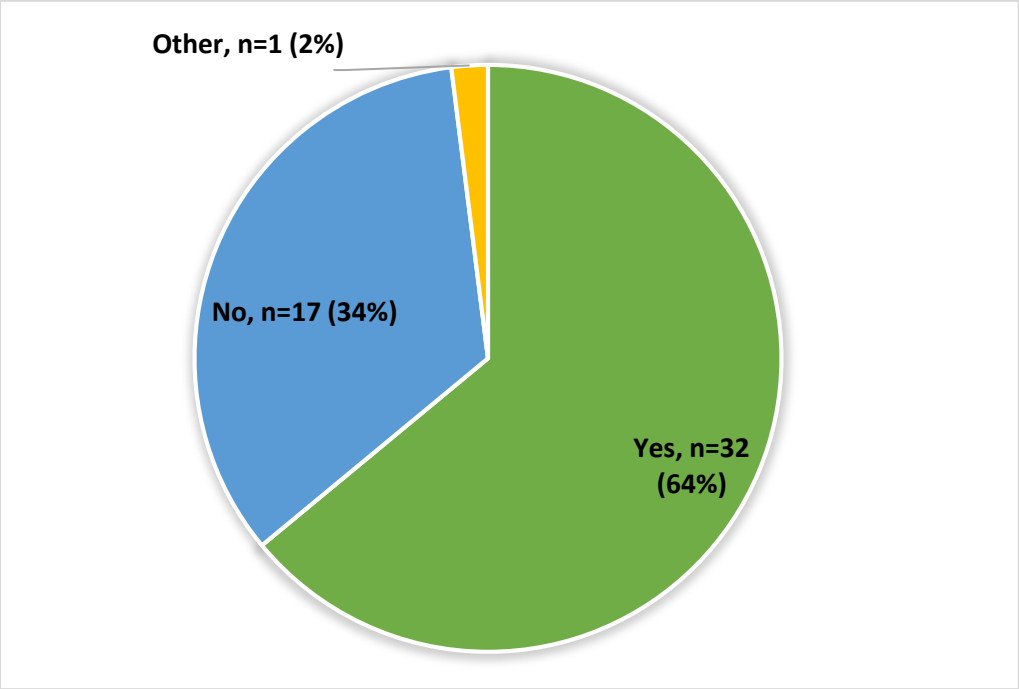

Table 156 - Edits in Place to Monitor Opioids Being Used Concurrently with any Buprenorphine Drug

Response	States	Count	Percentage
Yes	Alaska, Arkansas, Colorado, District of Columbia, Georgia, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New York, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Texas, Vermont, Virginia, West Virginia, Wyoming	32	64.00%
No	Alabama, California, Connecticut, Delaware, Florida, Hawaii, Iowa, Minnesota, Nevada, New Mexico, North Carolina, Oregon, Rhode Island, South Carolina, Utah, Washington, Wisconsin	17	34.00%
Other	Kansas	1	2.00%

If "Other", please explain.

Table 157 – "Other" Explanations for Edits in Place to Monitor Opioids Being Used Concurrently with any Buprenorphine Drug

State	"Other" Explanations
Kansas	Only Subutex.

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

Figure 113 - POS Pharmacist Override Edit

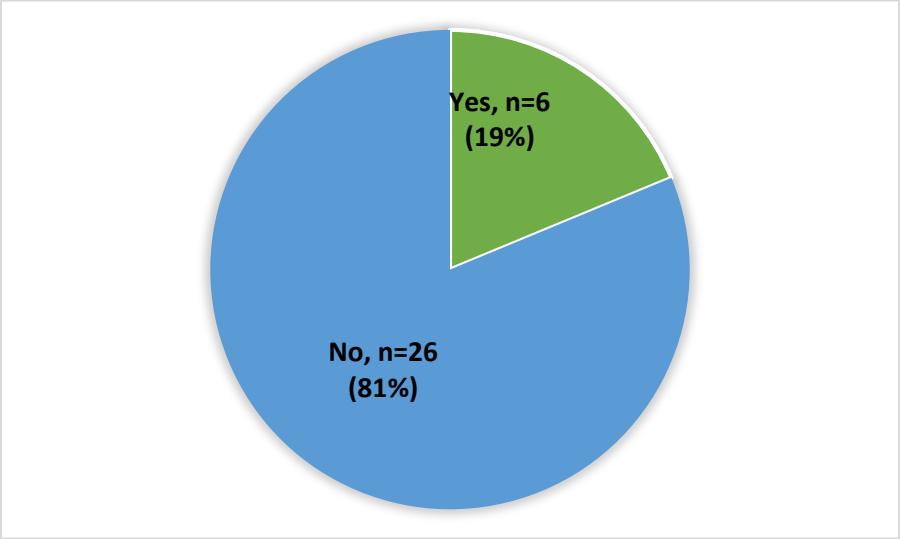

Table 158 - POS Pharmacist Override Edit

Response	States	Count	Percentage
Yes	District of Columbia, Louisiana, Maryland, Ohio, Vermont, Virginia	6	18.75%
No	Alaska, Arkansas, Colorado, Georgia, Idaho, Illinois, Indiana, Kentucky, Maine, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New York, North Dakota, Oklahoma, Pennsylvania, South Dakota, Tennessee, Texas, West Virginia, Wyoming	26	81.25%

6. Do you have at least one naloxone opioid overdose product available without prior authorization?

Figure 114 - Naloxone Opioid Overdose Product Available Without Prior Authorization

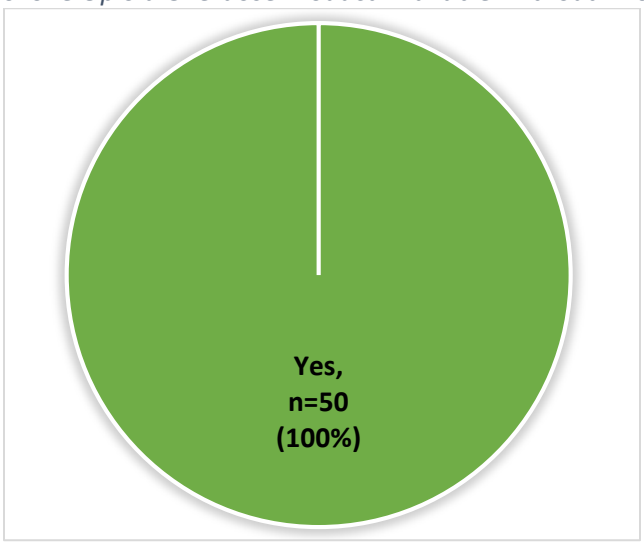

Table 159 - Naloxone Opioid Overdose Product Available Without Prior Authorization

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	50	100.00%

7. Does your state board of pharmacy and/or state Medicaid agency allow pharmacists to dispense naloxone prescribed independently or by collaborative practice agreements, standing orders, or other predetermined protocols?

Figure 115 - State Board of Pharmacy and/or State Medicaid Agency Allow Pharmacists to Dispense Naloxone Prescribed Independently or by Collaborative Practice Agreements, Standing Orders, or Other Predetermined Protocols

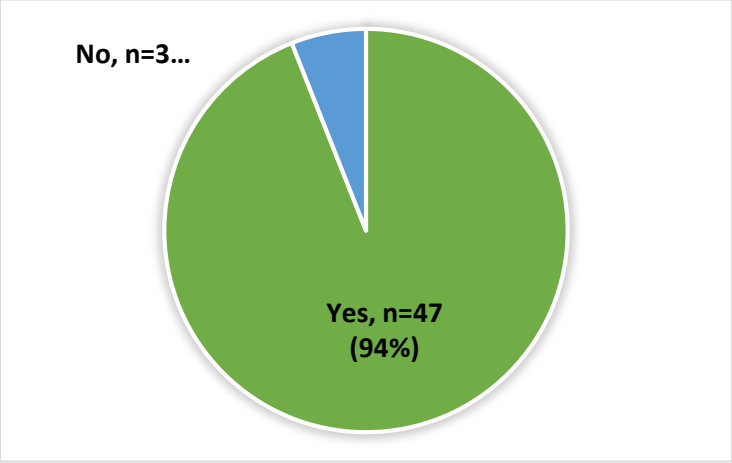

Table 160 - State Board of Pharmacy and/or State Medicaid Agency Allow Pharmacists to Dispense Naloxone Prescribed Independently or by Collaborative Practice Agreements, Standing Orders, or Other Predetermined Protocols

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	47	94.00%
No	District of Columbia, Rhode Island, South Dakota	3	6.00%

8. Does your state agency cover Methadone for a substance use disorder (i.e. Methadone Treatment Center)?

Figure 116 - State Agency Coverage for Methadone for a Substance Use Disorder

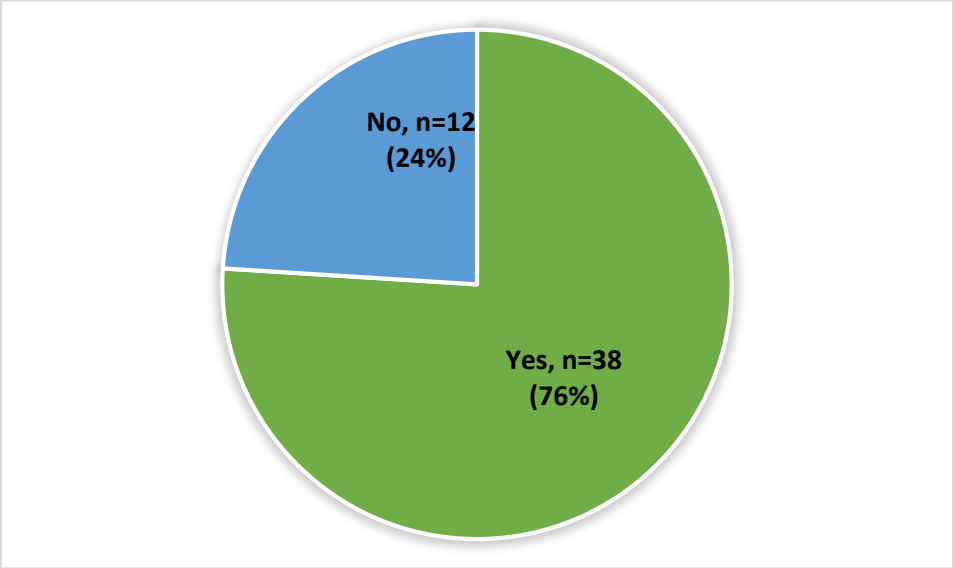

Table 161 - State Agency Coverage for Methadone for a Substance Use Disorder

Response	States	Count	Percentage
Yes	Alaska, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, Washington, Wisconsin	38	76.00%
No	Alabama, Arkansas, Illinois, Kansas, Kentucky, Louisiana, Nebraska, North Dakota, Oklahoma, Tennessee, West Virginia, Wyoming	12	24.00%

G. Antipsychotics / Stimulants

Antipsychotics

1. Do you currently have restrictions in place to limit the quantity of antipsychotics?

Figure 117 - Restrictions to Limit Quantity of Antipsychotics

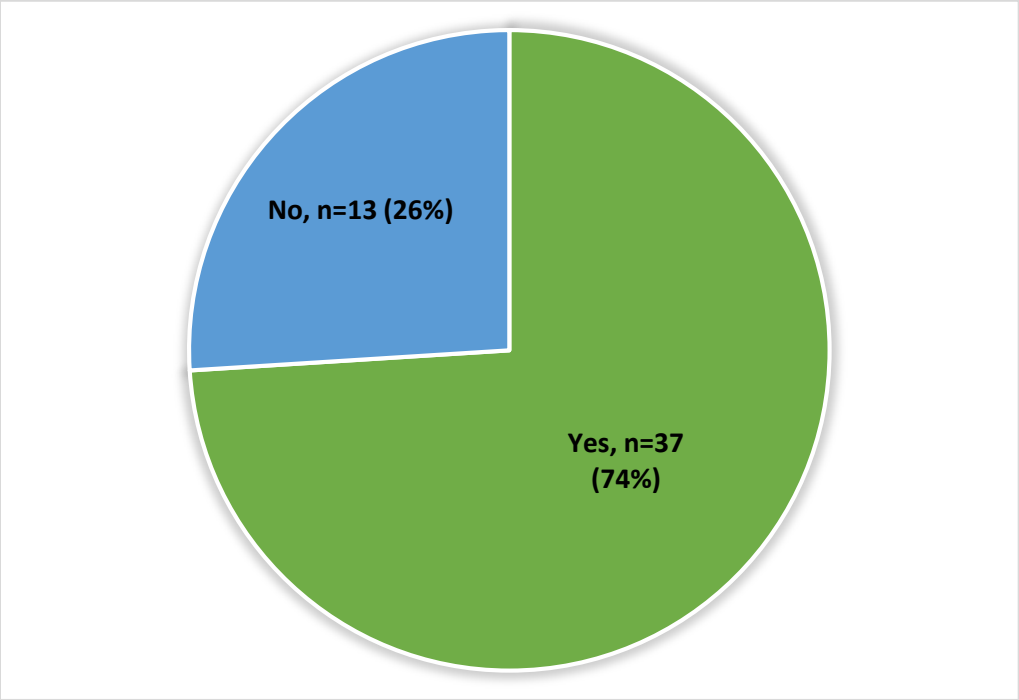

Table 162 - Restrictions to Limit Quantity of Antipsychotics

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Texas, Vermont, Virginia, Washington, Wisconsin, Wyoming	37	74.00%
No	California, Hawaii, Louisiana, Massachusetts, Michigan, Montana, New Mexico, Oklahoma, Oregon, Rhode Island, Tennessee, Utah, West Virginia	13	26.00%

If “Yes”, please explain.

Table 163 - Explanations of Restrictions to Limit Quantity of Antipsychotics

State	Explanations
Alabama	Prior authorization is required for all antipsychotics (brand and generic; typical and atypical). Prescriptions written by a psychiatrist and prescriptions for FDA-approved diagnoses are processed through electronic PA at the POS. Medical justification is required for polytherapy.
Alaska	N/A

State	Explanations
Arkansas	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
California	An approved Treatment Authorization Request is required for any antipsychotic medication for all Medi-Cal beneficiaries 0 to 17 years of age. An approved Treatment Authorization Request is also required for beneficiaries residing in skilled nursing facilities (SNFs).
Colorado	Also have age limitations
Connecticut	N/A
Delaware	Prior authorization is required if the drug is not FDA approved for the child's age.
District of Columbia	Injectable antipsychotic medications are available via pharmacies participating in the Mental Health Pharmacy Network. Some products require clinical prior authorization.
Florida	There are age limits according to FDA package inserts.
Georgia	Clinical prior authorization also in place for certain antipsychotics. Pediatric off-label use of antipsychotics reviewed on case-by-case basis.
Hawaii	By law FDA approved criteria cannot have edits on antipsychotics. Age edits are in place.
Idaho	Limits for age. Specifically do not allow in less than 6 without prior authorization. Also dose per day limits for all.
Illinois	Prior authorization is required for use of antipsychotic medications for long-term care residents, for long acting atypical antipsychotics.
Indiana	Age limitations, duplicate therapy edits, low-dose edits, 15-day initial supply limits
Iowa	N/A
Kansas	We have multiple concurrent use limits, dose limits, and age limits.
Kentucky	Yes, there is a diagnosis code required for any atypical/second generation antipsychotic. There are quantity limits and dose accumulation limits on many of the second-gen and long-acting agents. Also, a PA is required for the member to receive more than 2 antipsychotics concurrently.
Louisiana	Louisiana does not limit the quantity of antipsychotics. However, safety edits are in place at POS and include age-dose limits, diagnosis requirements, and therapeutic duplication. Additionally, preauthorization is required for behavioral health agents for recipients less than 6 years old.
Maine	Limits on utilization of multiple antipsychotics concurrently and in children 5 years or less.
Maryland	N/A
Massachusetts	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
Michigan	Current state law prohibits the Fee-For-Service (FFS) pharmacy program from prior authorizing, delaying, or denying coverage of psychotropic medications that are not controlled substances. All psychotropics are carved-out of MCO pharmacy benefit and paid FFS.
Minnesota	N/A
Mississippi	Electronic PA age edits, quantity limits for all beneficiaries, multiple antipsychotic edit for children, and manual PA criteria for multiple antipsychotic continued use in children.
Missouri	Missouri utilizes a Dose Optimization Fiscal Edit to help reduce the utilization of drug therapies that comprise of multiple units of lower strength dosage forms, when single units of higher strength dosage forms deliver the same drug therapy, with lower cost to the program. Dosing that exceeds the set limitation requires prior authorization. Additionally there are clinical criteria surrounding atypical antipsychotics that must be met including dosing limits.
Montana	For children 6 and under we require prior authorization including documentation of metabolic labs and parental notification of potential side effects. Case management is performed on all foster children on psychotropic medications. Dosages and quantities are reviewed for appropriateness.
Nebraska	Age restrictions.

State	Explanations
Nevada	Recipients under 18 years old are limited to a single anti-psychotic without prior authorization.
New Hampshire	Non-preferred products require prior authorization. We also use prospective DUR edits such as Therapeutic Duplication, Over Utilization, Drug-Drug Interaction and Ingredient Duplication.
New Jersey	Maximum daily dosages are set according to State defined limits or FDB max module.
New Mexico	N/A
New York	Drug specific minimum age parameters Diagnosis parameters for second-generation antipsychotics in the pediatric population Diagnosis requirements for the initial prescription for patients between minimum age parameter Prior authorization required for utilization of 3 or more different oral second generation antipsychotic agents for greater than 180 days.
North Carolina	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
North Dakota	All individual products are limited to their FDA approved dosing.
Ohio	Days' supply and dose edits on long acting
Oklahoma	Prior authorization for members younger than five years of age are reviewed by an OHCA-contracted child psychiatrist.
Oregon	N/A
Pennsylvania	N/A
Rhode Island	KEPRO has specific RDUR criteria that identifies use of psychotropic drugs and stimulants in children. Criteria is monitored monthly. If a reviewer identifies an issue a letter is sent to the prescriber.
South Carolina	Only one anti-psychotic approved at a time (exception: tapering off one agent while initiating another)
South Dakota	N/A - quantity limits only
Tennessee	We have limits, however they have not been enforced. Since Medicaid is the largest mental health provider in the State, we get the worst of the worst patients, and providers treat according to necessity instead of dose.
Texas	VDP has a clinical prior authorization in place for all antipsychotics. The approval criteria include: appropriate age, approved diagnosis, no mono-therapy for either insomnia or major depressive disorder, and no concomitant use of more than two different antipsychotics at any given time (the incoming claim will deny if more than two antipsychotics with different ingredients found in patient's claims history).
Utah	Retro-DUR work may focus on the use of 2 or more antipsychotics and also non-preferred antipsychotic use.
Vermont	Dependent on FDA maximum recommended doses
Virginia	ALL antipsychotics for children 0 to 17 years of age (preferred and nonpreferred) require the submission of a Clinical Service Authorization. Also there is quantity limits.
Washington	Stratified dose limits by patient age for children, individually determined for each antipsychotic medication.
West Virginia	We use a therapeutic duplication edit to limit the use of multiple antipsychotics. Quantity limits are by FDA label.
Wisconsin	Wisconsin requires a prior authorization for children less than 9 years of age who are on an antipsychotic.
Wyoming	Antipsychotics are limited to label dosing.

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

Figure 118 - Program in Place for either Managing or Monitoring Appropriate Use of Antipsychotic Drugs in Children

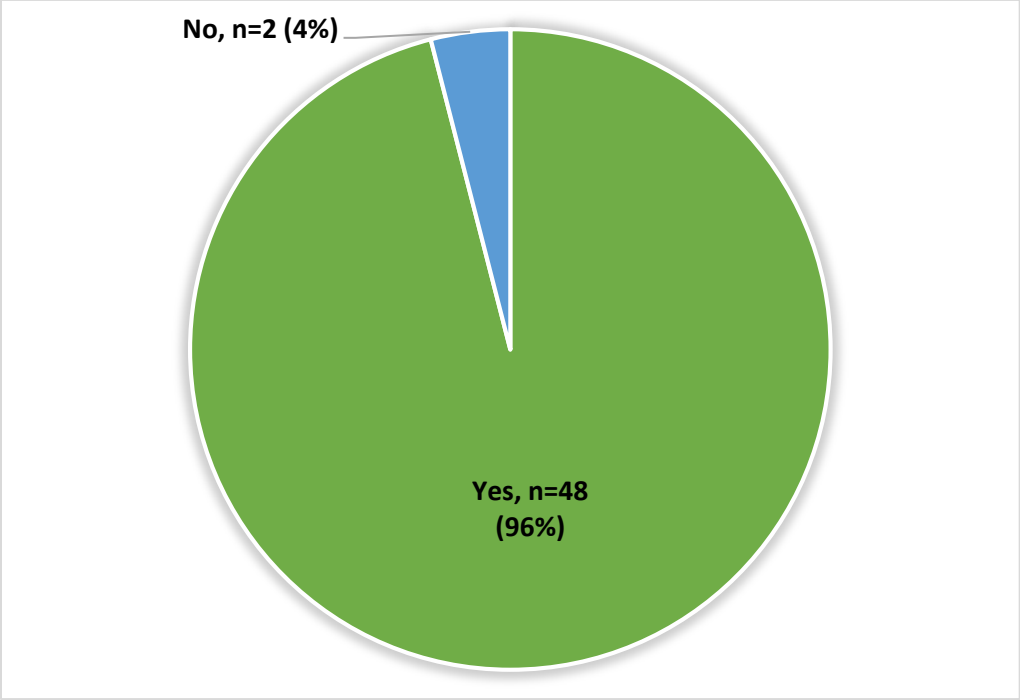

Table 164 - Monitoring Program in Place for Either Managing or Monitoring Appropriate Use of Antipsychotic Drugs in Children

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	48	96.00%
No	District of Columbia, North Dakota	2	4.00%

a. *If "Yes," do you either manager or monitor: Only children in foster care, all children, or other?*

Figure 119 - Categories of Children either Managed or Monitored for Appropriate Use of Antipsychotic Drugs

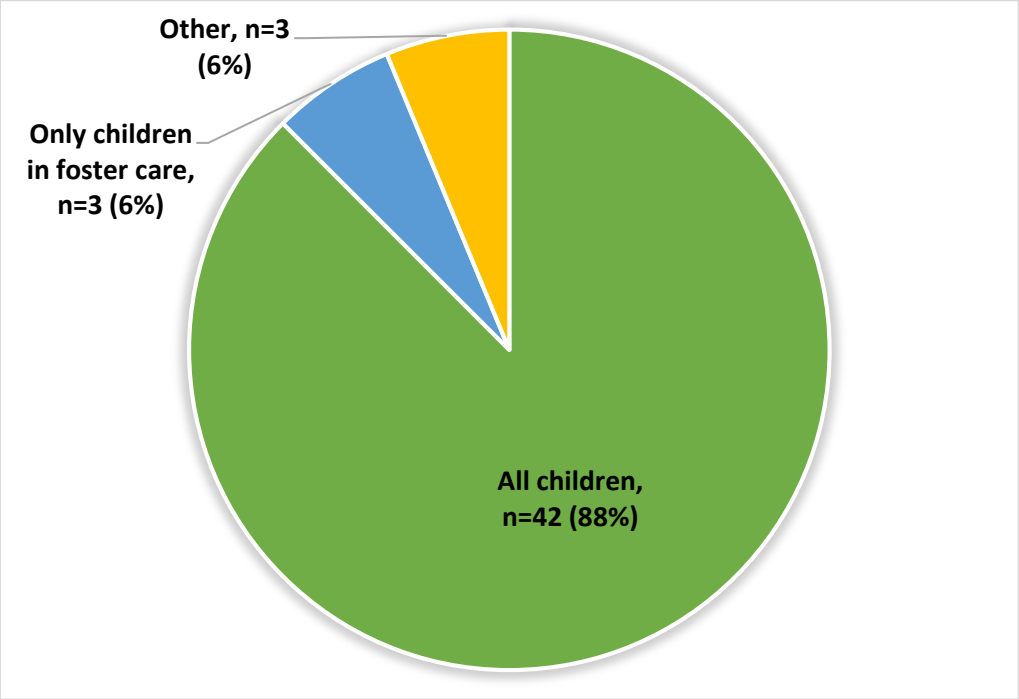

Table 165 - Categories of Children either Managed or Monitored for Appropriate Use of Antipsychotic Drugs

Response	States	Count	Percentage
All children	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wyoming	42	87.50%
Only children in foster care	Delaware, Oregon, Utah	3	6.25%
Other	Illinois, New Mexico, Wisconsin	3	6.25%

If "Other", please explain.

Table 166 - "Other" Explanations for either Managing or Monitoring Categories

State	"Other" Explanations
Illinois	Prior authorization is required for all children under the Department of Child and Family Services (DCFS) Youth in Care; all children less than 8 years of age who are prescribed atypical antipsychotic medications; and all children prescribed long-acting atypical antipsychotics. Doc Assist review and peer-to-peer consultation are also available.
New Mexico	Children prescribed antipsychotics from non-IHS prescribers are identified as requiring metabolic monitoring.

State	"Other" Explanations
Wisconsin	Wisconsin requires a prior authorization for children less than 9 years of age, including those children in foster care.

b. If "Yes," do you have edits in place to monitor:

Figure 120 - Antipsychotic Edits in Place to Monitor Children

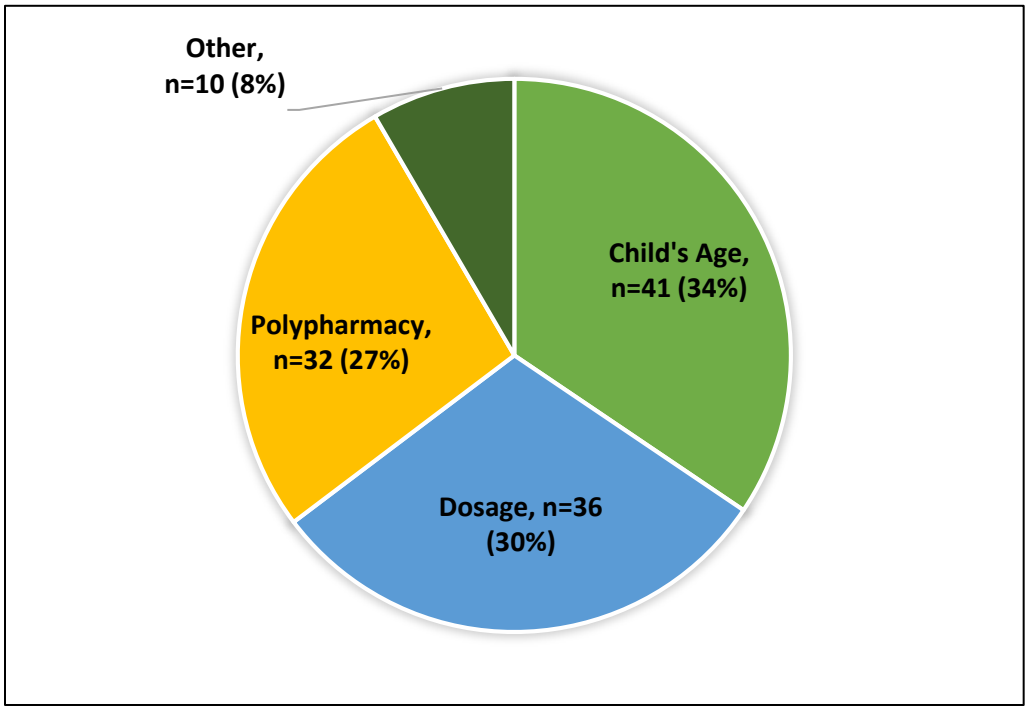

Table 167 - Antipsychotic Edits in Place to Monitor Children

Response	States	Count	Percentage
Child's Age	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	41	34.45%
Dosage	Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Jersey, New York, North Carolina, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	36	30.25%
Polypharmacy	Alabama, Alaska, Arkansas, California, Connecticut, Florida, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri,	32	26.89%

Response	States	Count	Percentage
	Montana, Nevada, New Hampshire, New Jersey, New York, Ohio, South Dakota, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming		
Other	California, Kansas, Kentucky, Louisiana, New Mexico, North Carolina, Oregon, South Carolina, Tennessee, Utah	10	8.40%

If "Other", please explain.

Table 168 - "Other" Explanations for Antipsychotic Edits in Place to Monitor Children

State	"Other" Explanations
California	Diagnosis
Kansas	multiple concurrent drug use
Kentucky	A diagnosis-drive PA is required for all second-generation antipsychotics and there is a therapeutic duplication limit of 2 antipsychotics at a time as well as maximum daily dosage accumulations. Some individual agents have an age limit in line with the FDA-approved indications.
Louisiana	Safety edits are in place at POS and include age-dose limits, diagnosis requirements, and therapeutic duplication. Additionally, preauthorization is required for behavioral health agents for recipients less than 6 years old.
New Mexico	RetroDUR interventions to identify children requiring metabolic monitoring.
North Carolina	Edits to monitor therapeutic duplication of antipsychotics.
Oregon	No pharmacy POS edits, but monitoring is performed retrospectively
South Carolina	Indication
Tennessee	Prior Authorization
Utah	These edits are in development for FFY19.

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

Table 169 - Explanations of Antipsychotic Monitoring Program

State	Explanation of Antipsychotic Monitoring Program
Alabama	Metabolic monitoring is required for children < 6 years of age and must be documented on the PA request form.
Alaska	Quantity limits and therapeutic duplication edits. Special edits for children under 5 years of age. Under contract with pediatric psychiatry specialists.
Arkansas	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
California	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
Colorado	Edits in place identify doses exceeding maximum and off-label uses for patient age, and require prior authorization potentially involving a child/adolescent psychiatrist consult. Retrospective DUR is conducted and letters are sent to providers regarding member pediatric antipsychotic use.
Connecticut	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
Delaware	Ages on the atypical antipsychotic agents are set to the FDA approved indications. Synergy is also achieved in Delaware by the Department of Family Services working with Medicaid on foster children to reduce unnecessary therapies. Doses are edited based on FDA approved doses.

State	Explanation of Antipsychotic Monitoring Program
Florida	Florida continues to perform second medical review. The second medical review is performed by a board certified child psychiatrist. The psychiatrist review is required for all children under six and select children over six depending on antipsychotic selection and dosage.
Georgia	All pediatric use of antipsychotics requires submission for review using an Atypical Antipsychotic PA Form. The requests are reviewed on a case-by-case basis by a clinical pharmacist.
Hawaii	Law does not allow edits to antipsychotic drugs. DUR and provider intervention have proven successful in the past. Very rarely are antipsychotics utilized by current population, since 2009.
Idaho	Targeted DUR interventions for all children less than 6 years old. In process PA form specific for that age group. Will include attestation that an informed consent has occurred.
Illinois	Atypical antipsychotics in children < 8 years of age: Ensures appropriate use in schizophrenia, bipolar disorder, and other requested conditions. Check indication and comorbidities. Behavioral/psychosocial interventions before or with drug therapy. Preferred mood stabilizer used alone or in combination before atypical is used. In some cases atypical may be first line therapy: Risperidone first-line, preferred. Polypharmacy.
Indiana	Antipsychotics require prior authorization when used in duplication, low doses, age outside of FDA-approved limits, or when a drug-specific quantity limit has been exceeded.
Iowa	Age edit on risperidone for members less than five (5) years of age. Age edit on all other antipsychotics for members less than six (6) years of age. Duplicate therapy edit on all antipsychotics for members 0 through 17 years of age. A 30 day grace period is allowed to allow transition between antipsychotic medications.
Kansas	We have a PA at the POS and have done RDUR for this drug class.
Kentucky	Prospective monitoring
Louisiana	Safety edits are in place at POS and include age-dose limits, diagnosis requirements, and therapeutic duplication. Additionally, preauthorization is required for behavioral health agents for recipients less than 6 years old.
Maine	PA requirements limiting age, length of therapy as well as metabolic monitoring
Maryland	In October 2011, MMPP established the peer review program for mental health drugs. This peer reviewed authorization process informs clinicians of relevant pharmacologic and non-pharmacologic clinical information for decision making and ensures the appropriate use while limiting adverse sequelae in Medicaid's vulnerable pediatric population. The program initially addressed the use of antipsychotics in participants less than 5 years of age. During FFY 2013, all participants less than 10 years of age required prior authorization. As of January 2014, the program was expanded to include all participants less than 18 years of age.
Massachusetts	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
Michigan	We utilize a program called WholehealthRx which is operationalized through our Magellan contract. It is a monthly academic detailing mailing and face-to-face pharmacy consultation intervention with the most exceptional providers on specific educational topics.
Minnesota	Monthly the DHS Children's Mental Health Division receives monthly reports that identifies children on multiple psychotropic drugs, lack of monitoring for those on antipsychotic drugs, and high dose antipsychotic and stimulant drugs using DHS retrospective criteria developed for this project. The Children's Mental Health Division uses this information in many ways one of which is to do outreach to the provider community especially to those in foster care. Additionally, there are two RetroDUR mailings per year regarding psychotropic drug use in youth.
Mississippi	Electronic PA age edits, quantity limits for all beneficiaries, and polypharmacy edit for children.

State	Explanation of Antipsychotic Monitoring Program
Missouri	For children 0 to 9 years old, atypical antipsychotics deny at point of sale and must be reviewed by a clinical consultant for approval or denial. For children 9 to 18 years old, atypical antipsychotics will approve as long as they are on only 1 atypical, have appropriate diagnosis, and dose does not exceed recommended maximum doses.
Montana	We require metabolic monitoring and parental consent for antipsychotics for children 6 and under. Case management is provided for all foster children taking psychotropics. These are reviewed for dosage, quantities, polypharmacy, etc.
Nebraska	Minimum age limits, quantity limits, daily dose limits and a review by a board-certified child and adolescent psychiatrist is required for requests outside of these limits.
Nevada	Children age 7 to 17 years old are allowed one drug from each class (antidepressant, anti-anxiety, anti-psychotic, anticonvulsant) without a prior authorization for up to three medications total. The fourth medication would require a prior authorization.
New Hampshire	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
New Jersey	There are guidelines provided by the New Jersey Department of Children and Families for the use of psychotropic medications in children.
New Mexico	A RetroDUR intervention was delivered to identify children who require metabolic monitoring of atypical antipsychotics on 3/27/18.
New York	Drug specific minimum age parameters Diagnosis parameters for second-generation antipsychotics in the pediatric population Diagnosis requirements for the initial prescription for patients between minimum age parameter Prior authorization required for utilization of 3 or more different oral second generation antipsychotic agents for greater than 180 days.
North Carolina	The Division implemented their Off Label Antipsychotic Safety Monitoring in Beneficiaries through Age 17 (A+KIDS) in April 2011 and Off Label Antipsychotic Safety (ASAP-adults) programs in March 2012. These programs require prior authorization for any preferred or non-preferred antipsychotic medication for children 17 years of age and younger or off label atypical antipsychotic use for adults 18 and older. The focus of both programs is safe and effective use of antipsychotics.
Ohio	Prospective edits to monitor dosage and a retrospective review of antipsychotics in children
Oklahoma	Educational mailings to prescribers of psychotropic drugs used in children. Particularly when prescribers deviate from evidence-based norms in patient population.
Oregon	All children in foster care have their medication regimens reviewed annually and when there are changes to their prescribed medications
Pennsylvania	All prescriptions for antipsychotics for children under 18 years of age require prior authorization.
Rhode Island	KEPRO has specific RDUR criteria that identifies use of psychotropic drugs and stimulants in children. Criteria is monitored monthly. If a reviewer identifies an issue a letter is sent to the prescriber.
South Carolina	Patient must have received developmentally-appropriate, comprehensive psychiatric assessment with diagnoses, impairments, treatment target and treatment plans clearly identified and documented; documented informed consent; family assessment must have been performed to include parental psychopathology and treatment needs; Psychosocial treatment required prior to approval and must continue (exception: danger of harm to self/others); approvable for continuation of therapy.
South Dakota	Atypical claims for children require PA.
Tennessee	Prior authorization is required to ensure that antipsychotics are used appropriately, on-label, and when medically necessary.

State	Explanation of Antipsychotic Monitoring Program
Texas	The clinical prior authorization for antipsychotics allows only the dispensing of the first generation antipsychotics in children less than 3 years of age with the approved diagnosis for children between 3 - 5 years of age, it only allows aripiprazole or risperidone to approve for the diagnosis of autism. For children older than 5 and adults, it requires the concomitant use of antidepressants if the diagnosed with insomnia and/or major depressive disorder (MDD). The client may be approved to receive up to two different antipsychotics.
Utah	Utah Code 62A-4a-213 creates a Psychotropic medication oversight pilot program for children in foster care to ensure that foster children are being prescribed psychotropic medication consistent with their needs. The oversight team consists of an APRN and a child psychiatrist. The goals of the program are for the oversight team to monitor foster children who are" six years old or younger who are being prescribed one or more psychotropic medications; and seven years or older who are being prescribed two or more psychotropic medications." The oversight team will review medication lists and may make recommendations to the foster child's health care providers concerning the psychotropic medications.
Vermont	All antipsychotics for children have a PA process involved 18 years old or less PA for diagnosis and Max daily dose Less than 5 years of age PA is reviewed by medical director Non specialists have access to psychiatrists at UVM for psychiatric consultation. Interdepartmental Committee reviews bi-annual utilization reports for all children for clinical appropriateness.
Virginia	ALL antipsychotics for children 0 to 17 years of age (preferred and nonpreferred) require the submission of a Clinical Service Authorization.
Washington	Washington State's Pediatric Mental Health Workgroup is tasked with making recommendations on maximum doses of antipsychotic medications, based on the age of the child. These recommendations are presented to the Washington DUR Board for acceptance or modification, and a final recommendation is made to the Medicaid program. All children prescribed an antipsychotic at doses higher than those recommended for their age must receive a Second Opinion review from an agency designated pediatric mental health specialist. These providers perform a comprehensive review of the child's mental health prescriptions, and consult with the prescribing practitioner to provide recommendations. These recommendations are passed on to the State, and medications are authorized accordingly.
West Virginia	An edit will fire if the prescriber attempts to use multiple antipsychotics. We are in the process of changing this edit to prevent pharmacist-override. All antipsychotic agents require prior authorization for children up to eighteen (18) years of age. All PA requests for antipsychotics for children 6 years of age and younger will be reviewed by Medicaid’s consultant psychiatrist.
Wisconsin	Wisconsin monitors the use of antipsychotic drugs in young children through prior authorization (PA). The PA process is intended to scrutinize the prescribing of antipsychotic drugs for mood disorders and the monitoring of metabolic effects of this drug class. Child psychiatrists who are contracted with the State perform peer to peer outreach calls when needed.
Wyoming	Children are referred for consultation with Seattle Children's Hospital if they are under age 5, or on more than 5 psychoactive medications. Dosages above the labeled max deny at point of sale.

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

Figure 121 - Future Monitoring Program for Appropriate Use of Antipsychotic Drugs in Children

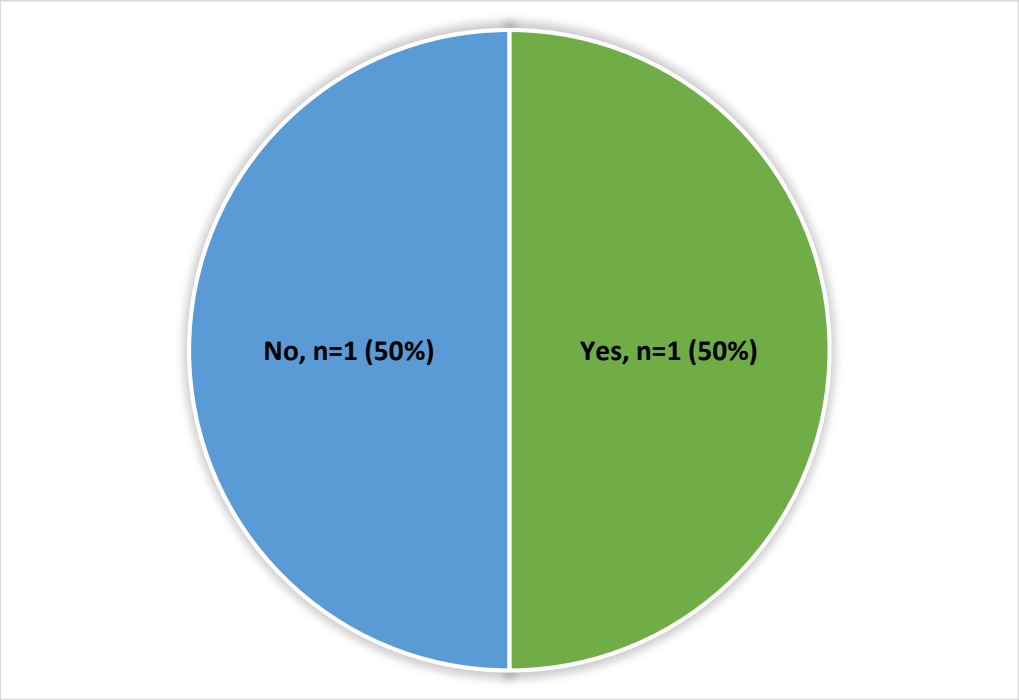

Table 170 - Future Monitoring Program for Appropriate Use of Antipsychotic Drugs in Children

Response	States	Count	Percentage
Yes	District of Columbia	1	50.00%
No	North Dakota	1	50.00%

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

Table 171 - Explanations for not implementing a Program to Monitor Appropriate use of Antipsychotic Drugs in Children

State	Explanations
North Dakota	The ND Legislature has rejected our requests to manage at any level other than children receiving their 5th concurrent psych med, and even then, after review the law mandates that we must pay if the prescriber still wants it.

Stimulants

3. Do you currently have restrictions in place to limit the quantity of stimulants?

Figure 122 - Restrictions in Place to Limit the Quantity of Stimulants

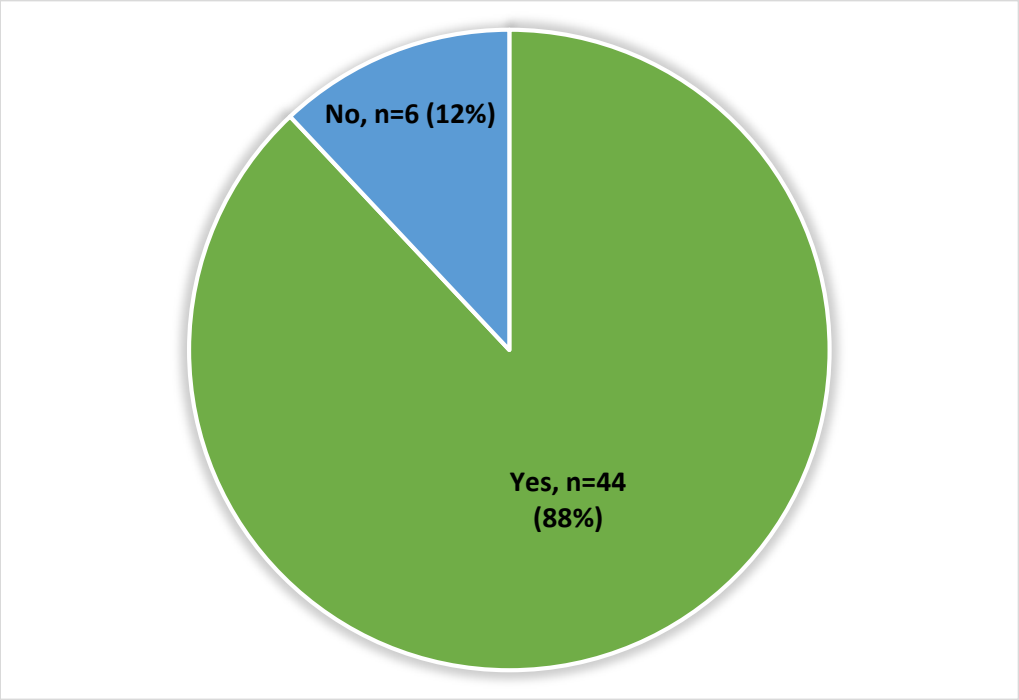

Table 172 - Restrictions in Place to Limit the Quantity of Stimulants

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	44	88.00%
No	California, Louisiana, Maryland, North Carolina, Rhode Island, Utah	6	12.00%

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

Figure 123 - Documented Program in Place to either Manage or Monitor the Appropriate Use of Stimulant Drugs in Children

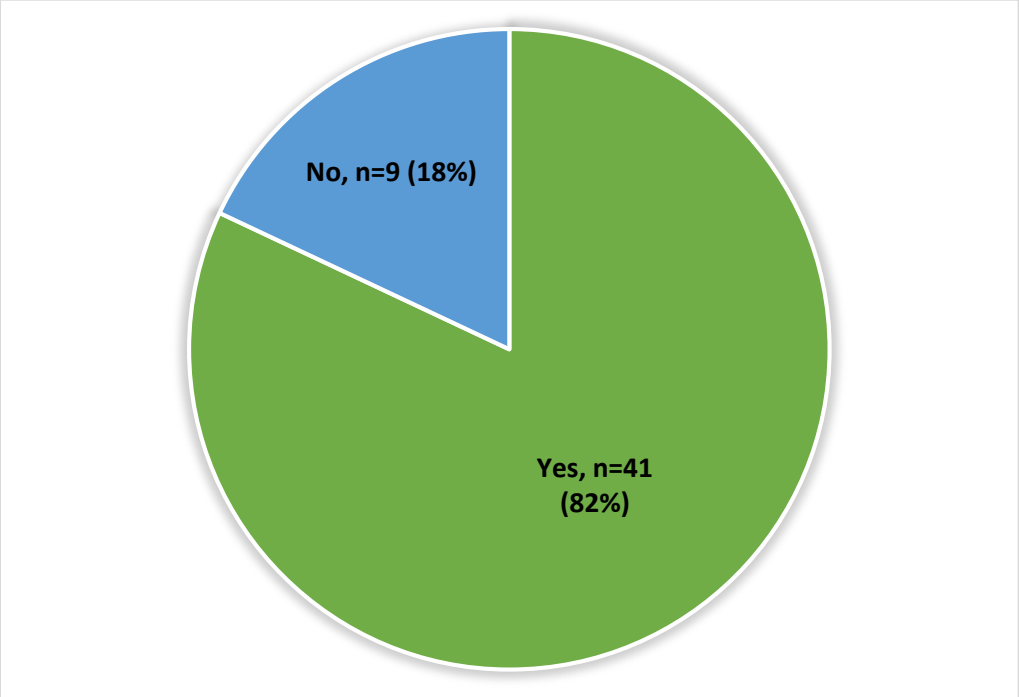

Table 173 - Documented Program in Place to either Manage or Monitor the Appropriate Use of Stimulant Drugs in Children

Response	States	Count	Percentage
Yes	Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	41	82.00%
No	Alaska, District of Columbia, Hawaii, Maryland, New Jersey, North Carolina, North Dakota, South Dakota, Utah	9	18.00%

a. If "Yes", do you either manage or monitor:

Figure 124 – Categories of Children either Managing or Monitoring the Appropriate Use of Stimulant Drugs

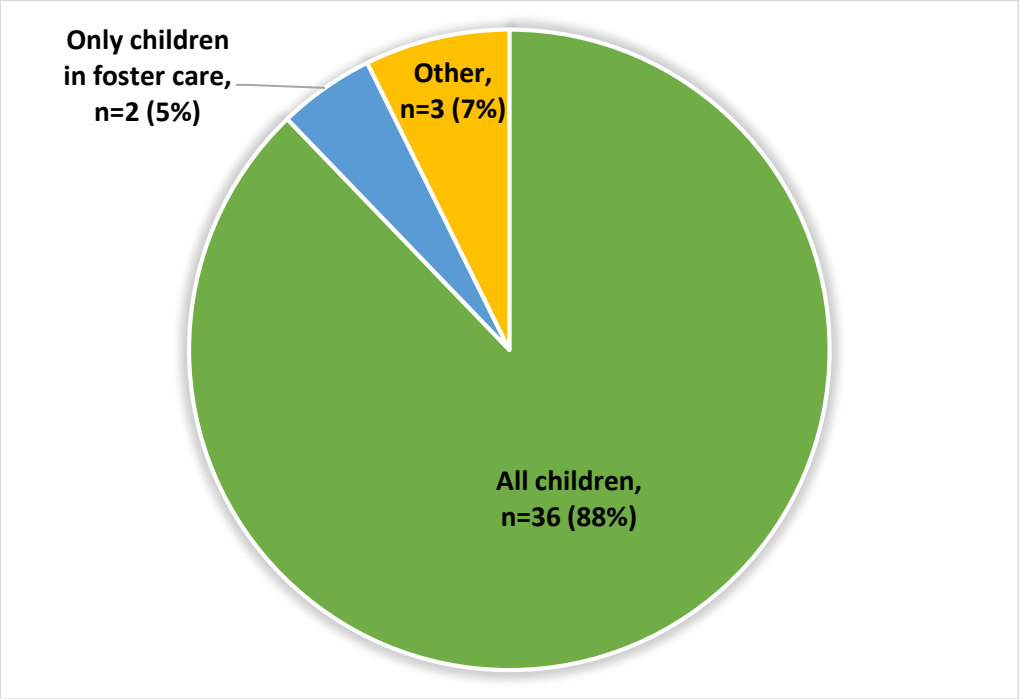

Table 174 - Categories of Children either Managing or Monitoring the Appropriate Use of Stimulant Drugs

Response	States	Count	Percentage
All children	Alabama, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	36	87.80%
Only children in foster care	Delaware, Montana	2	4.88%
Other	Illinois, Massachusetts, Texas	3	7.32%

If “Other”, please explain.

Table 175 - “Other” Explanations to Manage or Monitor the Appropriate Use of Stimulant Drugs in Children

State	“Other” Explanation
Illinois	All DCFS Youth in Care require Prior authorization All attention deficit hyperactivity medications (ADHD) in children less than 6 years of age require a special prior authorization request form. Medications for ADHD are allowed for clients who are 6 through 18 years of age. Adults (19 years and older) require prior authorization for ADHD medications. Implemented a pilot program with DocAssist to address stimulant use in younger children. Child psychiatrists from DocAssist review specific cases and discussed cases with prescriber. Pharmacy will evaluate benefit of expanding to wider age groups.
Massachusetts	Use of behavioral health medications in children, including stimulants, are managed through a comprehensive monitoring program. Prior authorization is required for members less than 18 years of age if there is polypharmacy with four or more behavioral health medications (including stimulants) across all behavioral health classes. Also for all children less than 18 years of age, PA is required for polypharmacy with two or more stimulants (defined as an amphetamine used in combination with a methylphenidate). Stimulant polypharmacy would not apply solely due to use of a short-acting stimulant and a long-acting stimulant (unless one is a methylphenidate and one is an amphetamine product). Additionally, PA is required for stimulants for all children less than three years of age.
Texas	The use of stimulants is monitored through an automated clinical prior authorization for both children and adults. The use of stimulants for adults is only permitted with the right diagnosis, and it will deny claim if a diagnosis of drug/substance abuse disorder found.

b. If “Yes”, do you have edits in place to monitor (check all that apply)?

Figure 125 - Edits in Place to either Manage or Monitor the Appropriate Use of Stimulant Drugs in Children

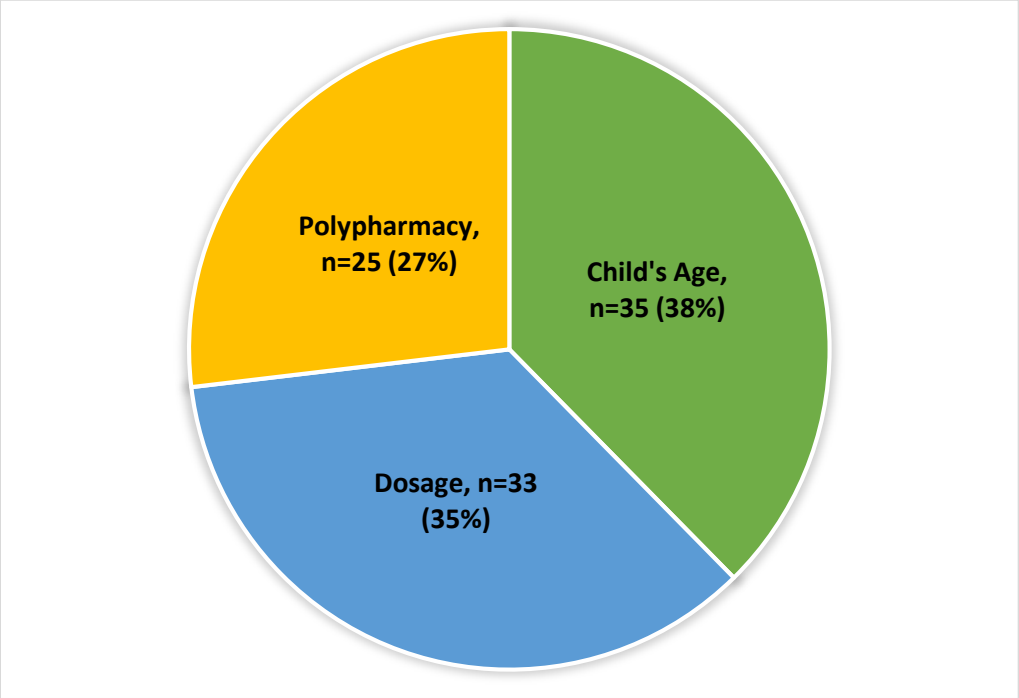

Table 176 - Edits in Place to either Manage or Monitor the Appropriate Use of Stimulant Drugs in Children

Response	States	Count	Percentage
Child's Age	Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Vermont, Virginia, Washington, West Virginia, Wyoming	35	37.63%
Dosage	Alabama, Arkansas, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, New York, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	33	35.48%
Polypharmacy	Arkansas, Connecticut, Delaware, Florida, Idaho, Indiana, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New York, Ohio, Rhode Island, South Carolina, Texas, Vermont, Virginia, Washington, West Virginia, Wyoming	25	26.88%

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

Table 177 - Explanation of the Specifics of Your Documented Stimulant Monitoring Program(s)

State	Explanations
Alabama	Stimulants are included in the Preferred Drug List. Preferred stimulants have quantity limits.
Arkansas	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
California	The use of stimulants for Medi-Cal beneficiaries is restricted to use in Attention Deficit Disorder in individuals from 4 years through 16 years of age only. Any use outside of these restrictions requires an approved Treatment Authorization Request.
Colorado	Edits in place identify doses exceeding maximum and off-label uses for patient age, and require prior authorization potentially involving a child/adolescent psychiatrist consult. Retrospective DUR is conducted and letters are sent to providers regarding member pediatric stimulant use. Maximum doses were implemented for the stimulant drug class during the time frame for this report.
Connecticut	HID performs 1,000 RetroDUR reviews for the adult and pediatric populations each month and the majority of the criteria used to review the pediatric population have to do with mental health drugs, including stimulants. An additional program exists and is administered by the Department of Children and Families for children in foster care only. The Psychotropic Medication Advisory Committee (PMAC) oversee the use of psychotropic medications in the foster care population and have specific edits, maximum doses, monitoring guidelines, etc. associated with prescribing of these medications. Some of the criteria used for the pediatric RetroDUR program have been adopted from the PMAC criteria. Additionally, stimulant use is also reviewed during the monthly RetroDUR adult reviews.
Delaware	Ages on stimulant agents are set to the FDA approved indications. Doses are edited based on FDA approved doses and Pro-DUR edits are in place to monitor for therapeutic duplication within

State	Explanations
	the stimulant class of medications. Synergy is also achieved in Delaware by the Department of Family Services working with Medicaid on foster children to reduce unnecessary therapies.
Florida	High dose limitation are placed on all stimulants. A close prior authorization review is performed on all children less than six.
Georgia	Quantity limits, clinical prior authorizations, age requirements in place for stimulants.
Idaho	All have age and quantity limits.
Illinois	All attention deficit hyperactivity medications (ADHD) in children less than 6 years of age require a special prior authorization request form.
Indiana	Stimulants require prior authorization when used in duplication or when a drug-specific quantity and age limits have been exceeded.
Iowa	Prior authorization (PA) is required for stimulants above the set quantity limits. Additionally, prescribers are required to check the Iowa PMP for any stimulant that requires PA. The DUR Commission recently recommended ProDUR age edits for stimulants and restrictions on the use of short-acting stimulants, to promote the use of long-acting agents, by limiting the use of short-acting stimulants to one unit per day. These program updates will be implemented in FFY2019.
Kansas	We have a PA at the POS and have provider type and diagnosis requirements.
Kentucky	A diagnosis-driven prior authorization (PA) is required on all stimulants. There are also max dose per day edits and therapeutic duplication edits (e.g., cannot have more than one (1) long acting agent). Some individual agents have an age limit in line with the FDA-approved indications; no age limit exists for the class. Several agents have dose accumulations to limit maximum dose and clinical criteria guide call center staff to consider age-appropriate dosing (where available in the package insert) when approving PAs.
Louisiana	Preauthorization is required for ADHD agents for recipients less than 48 months of age. POS edits include diagnosis requirement, therapeutic duplication of short acting ADHD agents, of long acting ADHD agents, and ADHD agents from different prescribers.
Maine	manage daily dosing requirements
Massachusetts	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
Michigan	In addition to the WholehealthRx academic detailing program and monthly interventions, prior authorization is required for members under the age of 6 years and those age of 18 years or older.
Minnesota	Monthly the DHS Children's Mental Health Division receives monthly reports that identifies children on multiple psychotropic drugs, lack of monitoring for those on antipsychotic drugs, and high dose antipsychotic and stimulant drugs using DHS retrospective criteria developed for this project. The Children's Mental Health Division uses this information in many ways one of which is to do outreach to the provider community especially to those in foster care. Additionally, there are two RetroDUR mailings per year regarding psychotropic drug use in youth.
Mississippi	Age edits follow FDA indicated ages. Indication edits follow FDA approved or compendia supported diagnoses.
Missouri	For children 0 to 18 years old, requires appropriate diagnosis on file and within approved dosage limitations for it to approve transparently.
Montana	Children in foster care taking more than one stimulant medication are reviewed for treatment appropriateness including indication, age, dosage, etc. Children in foster care are monitored for polypharmacy.
Nebraska	Non-preferred drugs require review for compliance and doses are monitored. Edits are in place to prevent use of more than one stimulant and high doses in children.

State	Explanations
Nevada	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
New Hampshire	Non-preferred products require prior authorization. We also use prospective DUR edits such as Therapeutic Duplication, Over Utilization, Drug-Drug Interaction and Ingredient Duplication.
New Mexico	Stimulants require prior authorization for individuals over the age of 18 and follow the DSM-5 criteria.
New York	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
Ohio	Prospective edits to monitor the child's age, quantity and dosage limits and RetroDUR to monitor polypharmacy
Oklahoma	Children under 5 require psychiatric consultant. Adults over 21 require a prior authorization. Quantity limits in place based on FDA approved dosing.
Oregon	quantity and age limits that require PA
Pennsylvania	All prescriptions for Stimulants and Related Agents require prior authorization for children less than 4 years of age and adults age 18 and older.
Rhode Island	KEPRO has specific RDUR criteria that identifies use of psychotropic drugs and stimulants in children. Criteria is monitored monthly. If a reviewer identifies an issue a letter is sent to the prescriber.
South Carolina	PRODUR edits, as well as clinical edits for age/indication.
Tennessee	Amphetamines and methylphenidate products are limited to 70mg per day. Prior authorization is required for all adults 21 and over, and for children under 21 only if dose is higher than 80mg/day for all combined products.
Texas	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
Vermont	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
Virginia	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
Washington	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
West Virginia	We require a PA for all stimulants prescribed in patients older than the age of 18. We have set up edits to allow the use of one short-acting and one-long acting stimulant. Limits are set to the FDA recommended maximum dosages and are designed to provide all available dosages with the fewest number of tablets/capsules dispensed.
Wisconsin	Question 4b does not have the option for other, which is how Wisconsin would have answered. Wisconsin has both documented restrictions and special programs to monitor, manage or control the use of stimulants for adults and children on stimulants. This includes diagnosis restrictions (allowable diagnoses are ADHD and narcolepsy), a prior authorization requirement for non-preferred stimulants on the preferred drug list, system edits for early refill that are allowed to be overridden in certain circumstances by calling a specialized pharmacy call center, a Children's Mental Health workgroup that has focused on stimulant use, interventions that include targeted mailings to prescribers as well as peer to peer outreach from child psychiatrists.
Wyoming	Children under the age of 4 require a prior authorization. Dosage limits above the labeled max deny at point of sale. Children who have more than 5 psychoactive medications (including stimulants) are referred to Seattle Children's for consultation.

If you do not have a documented stimulant monitoring program in place, do you plan on implementing a program in the future?

Figure 126 - Future Implementation of a Stimulant Monitoring Program

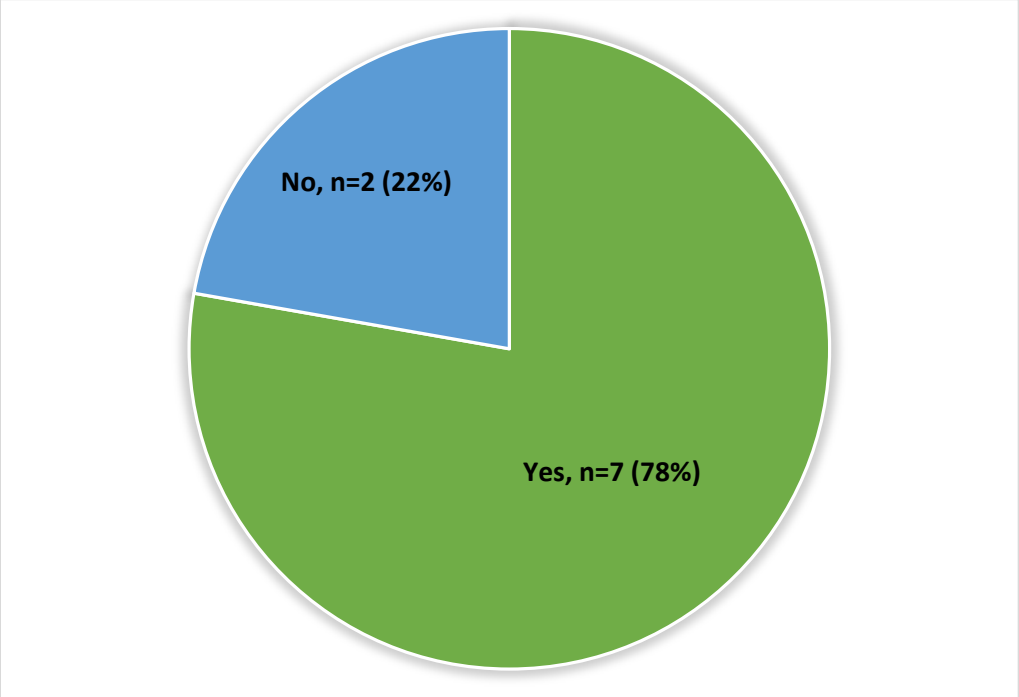

Table 178 - Future Implementation of a Stimulant Monitoring Program

Response	States	Count	Percentage
Yes	Alaska, District of Columbia, Maryland, New Jersey, North Carolina, South Dakota, Utah	7	77.78%
No	Hawaii, North Dakota	2	22.22%

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

Table 179 - Explanations for not implementing a Program to Monitor the Appropriate Use of Stimulant Drugs in Children

State	Explanations
Hawaii	Services are rendered elsewhere. The majority of children prescribed stimulant drugs are also enrolled in the Child and Adolescent Mental Health Division (CAMHD) program. The child-serving agency integrates services and programs across agencies in the best interest of youth and their families. Most of the youth served by CAMHD attend public schools, and may be involved with the child welfare system, juvenile justice system, or other DOH Divisions, including Alcohol & Drug Abuse (ADAD), Developmental Disabilities Division (DDD), and Early Intervention Services (EIS). Psychosocial and pharmacological intervention include medication management and/or monitoring: a service component of "utilizing the smallest number of medications as well as the smallest dosages necessary to achieve optional results".

State	Explanations
North Dakota	The ND Legislature has rejected our requests to manage at any level other than children receiving their 5th concurrent psych med, and even then, after review the law mandates that we must pay if the prescriber still wants it.

IX - Innovative Practices

States have the option of submitting innovative practices narratives.

This information is located in Attachment 6 in individual state specific DUR FFS Report. This attachment can be requested by contacting CMSDUR@cms.hhs.gov

Figure 127 – Number of States Submitting Innovative Practices Narrative Attachments

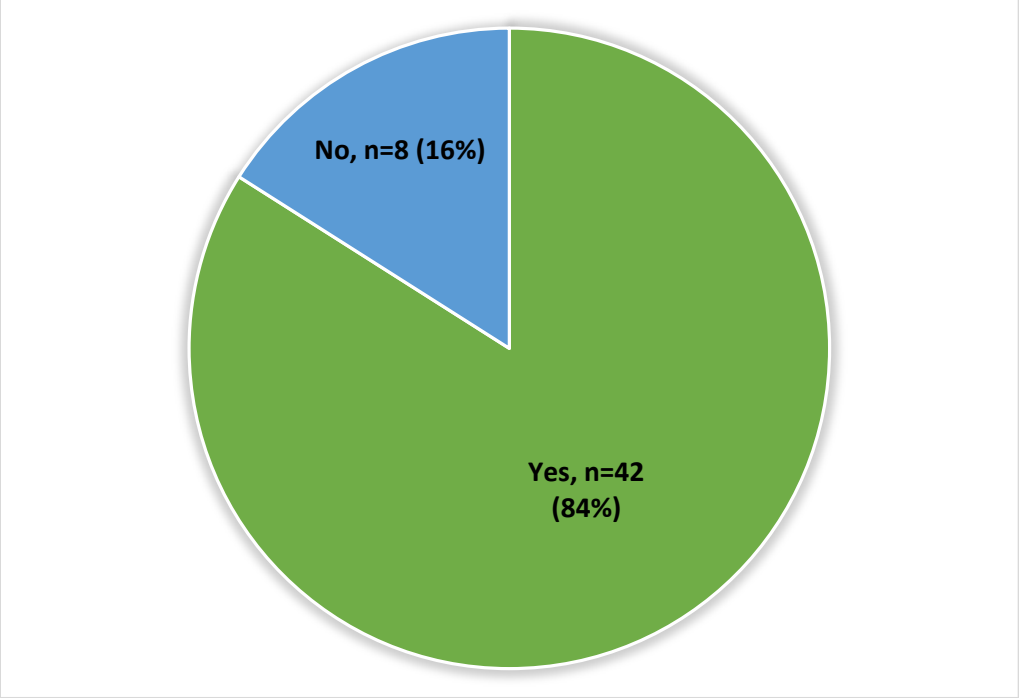

Table 180 - Number of States Submitting Innovative Practices Narrative Attachments

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin	42	84.00%

Response	States	Count	Percentage
No	Hawaii, Iowa, Louisiana, Minnesota, Nebraska, Oregon, South Dakota, Wyoming	8	16.00%

X - E-Prescribing

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

Figure 128 – MMIS or Vendor Ability to Electronically Provide Patient Drug History Data and Pharmacy Coverage Limitations to a Prescriber Prior to Prescribing Upon Inquiry

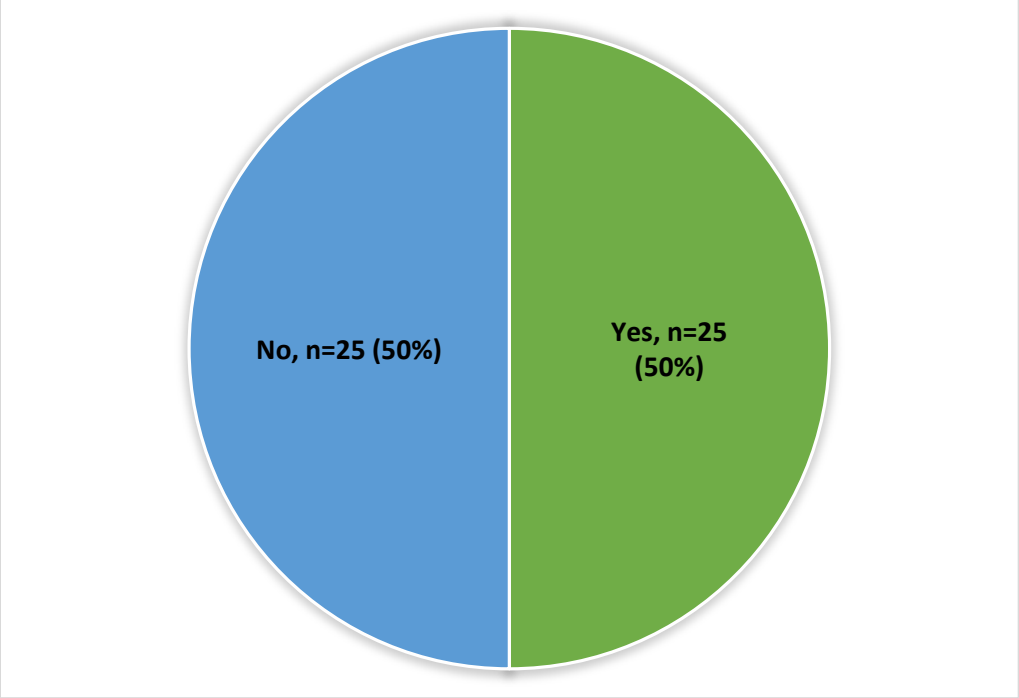

Table 181 – MMIS or Vendor Ability to Electronically Provide Patient Drug History Data and Pharmacy Coverage Limitations to a Prescriber Prior to Prescribing Upon Inquiry

Response	States	Count	Percentage
Yes	Alabama, Arkansas, Connecticut, Florida, Georgia, Idaho, Indiana, Iowa, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, North Carolina, Oklahoma, Texas, Utah, Vermont, Virginia, West Virginia	25	50.00%
No	Alaska, California, Colorado, Delaware, District of Columbia, Hawaii, Illinois, Kansas, Kentucky, Maryland, Massachusetts, Nebraska, New Jersey, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Washington, Wisconsin, Wyoming	25	50.00%

If “Yes”, do you have a methodology to evaluate the effectiveness of providing drug information and medication history prior to prescribing?

Figure 129 - Methodology to Evaluate the Effectiveness of Providing Drug Information and Medication History Prior to Prescribing

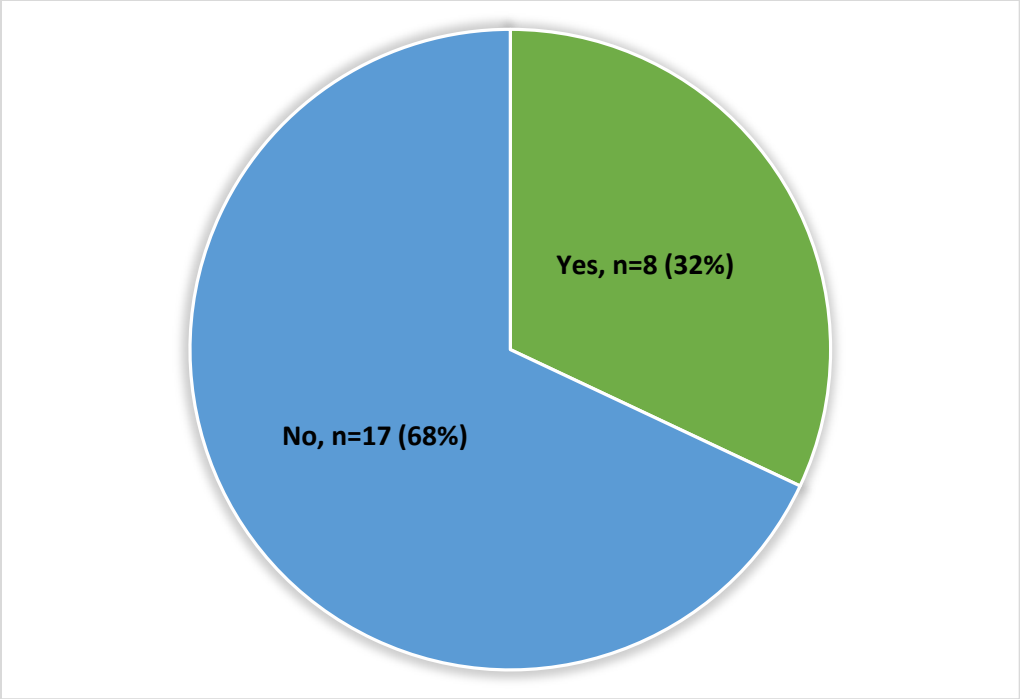

Table 182 - Methodology to Evaluate the Effectiveness of Providing Drug Information and Medication History Prior to Prescribing

Response	States	Count	Percentage
Yes	Arkansas, Connecticut, Florida, Michigan, Missouri, New Mexico, Texas, Virginia	8	32.00%
No	Alabama, Georgia, Idaho, Indiana, Iowa, Louisiana, Maine, Minnesota, Mississippi, Montana, Nevada, New Hampshire, North Carolina, Oklahoma, Utah, Vermont, West Virginia	17	68.00%

If “Yes,” please explain the evaluation methodology.

State explanations of evaluation methodology and accomplishments in the area of e-prescribing is located in Attachment 7 in individual state specific DUR FFS reports. Attachments for the DUR FFS Reports can be requested by contacting CMSDUR@cms.hhs.gov

If “No”, are you planning to develop a portal to electronically provide patient drug history data and pharmacy coverage limitations to a prescriber prior to prescribing upon inquiry?

Figure 130 - Future Development of an Electronic Portal

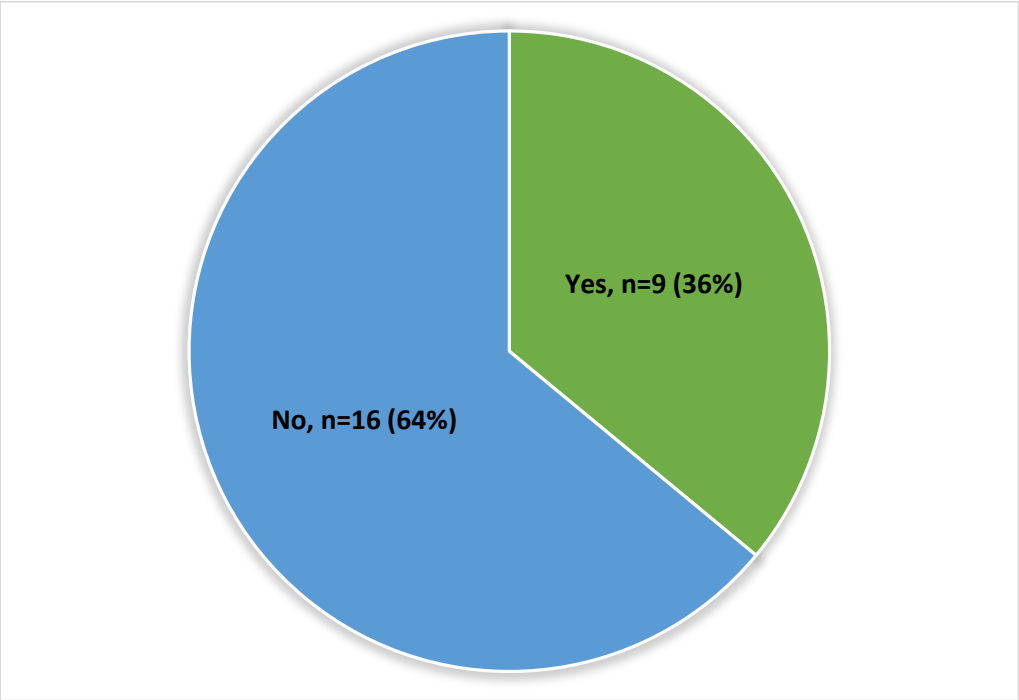

Table 183 - Future Development of an Electronic Portal

Response	States	Count	Percentage
Yes	Colorado, District of Columbia, Maryland, Massachusetts, North Dakota, South Dakota, Tennessee, Washington, Wyoming	9	36.00%
No	Alaska, California, Delaware, Hawaii, Illinois, Kansas, Kentucky, Nebraska, New Jersey, New York, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Wisconsin	16	64.00%

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

Figure 131 - System Use of the NCPDP Origin Code that Indicates the Prescription Source

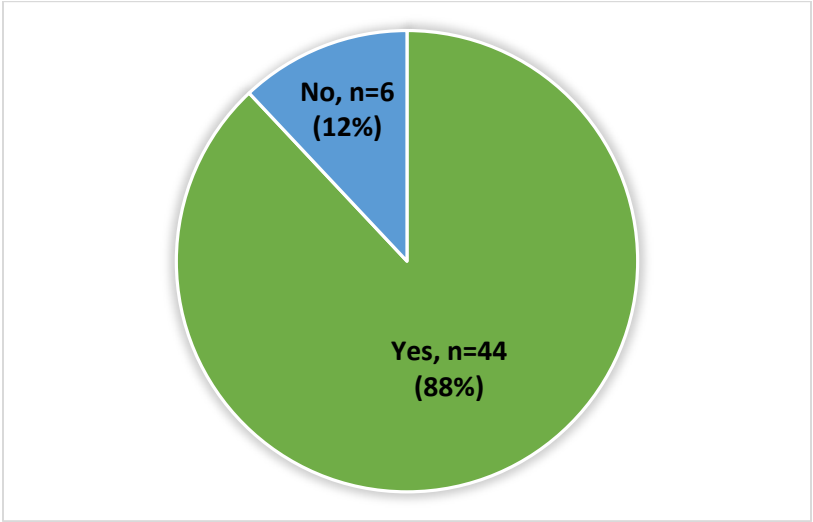

Table 184 - System Use of the NCPDP Origin Code that Indicates the Prescription Source

Response	States	Count	Percentage
Yes	Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	44	88.00%
No	Alabama, California, Iowa, Maryland, Minnesota, Rhode Island	6	12.00%

XI - Managed Care Organizations (MCOs)

1. How many MCOs are enrolled in your state Medicaid program?

Figure 132 - Number of MCOs Enrolled in State Medicaid Program

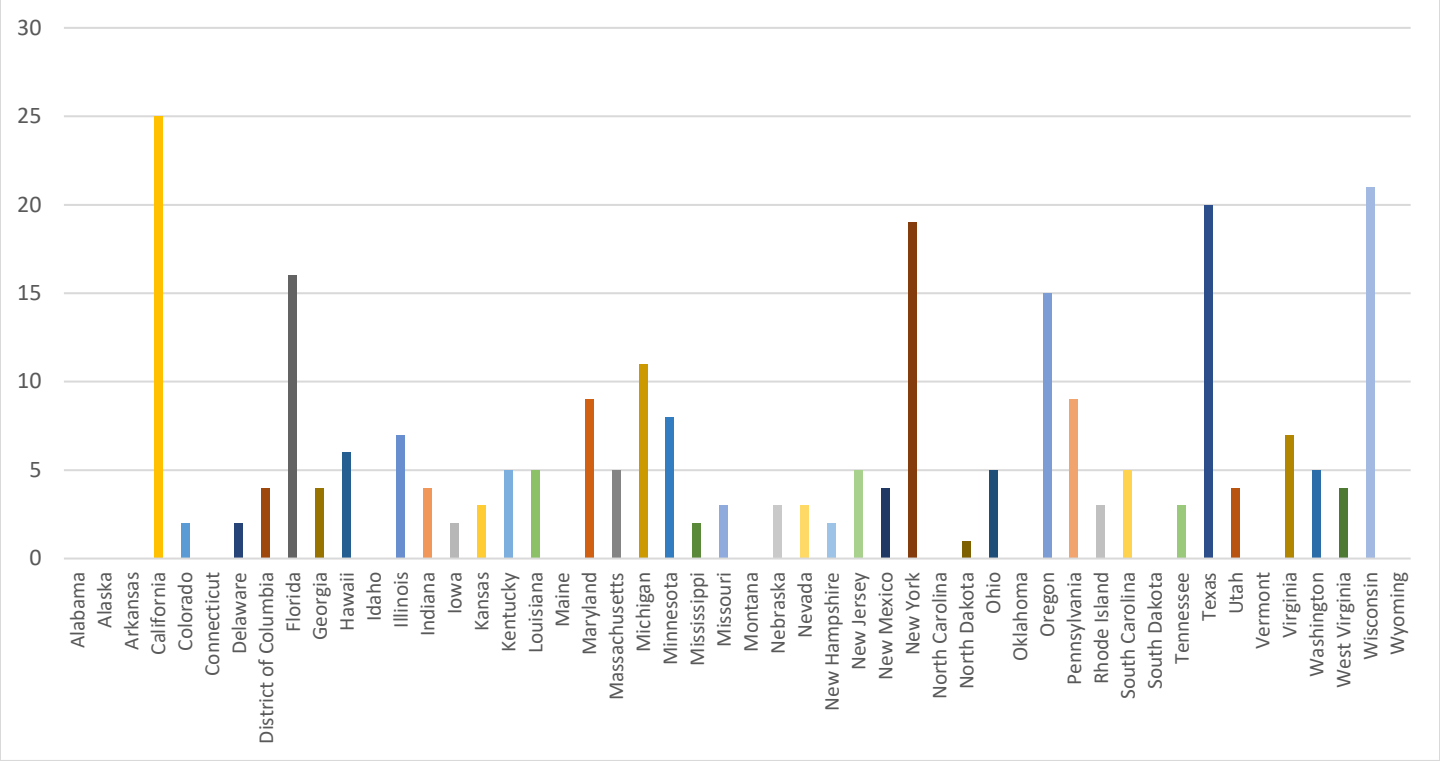

Table 185 - Number of MCOs Enrolled in State Medicaid Program

State	Number of MCOs
Alabama	0
Alaska	0
Arkansas	0
California	25
Colorado	2
Connecticut	0
Delaware	2
District of Columbia	4
Florida	16
Georgia	4
Hawaii	6
Idaho	0
Illinois	7
Indiana	4
Iowa	2
Kansas	3
Kentucky	5
Louisiana	5
Maine	0
Maryland	9
Massachusetts	5
Michigan	11
Minnesota	8
Mississippi	2
Missouri	3
Montana	0
Nebraska	3
Nevada	3
New Hampshire	2
New Jersey	5
New Mexico	4
New York	19
North Carolina	0
North Dakota	1
Ohio	5
Oklahoma	0
Oregon	15
Pennsylvania	9
Rhode Island	3
South Carolina	5
South Dakota	0
Tennessee	3
Texas	20
Utah	4
Vermont	0
Virginia	7

State	Number of MCOs
Washington	5
West Virginia	4
Wisconsin	21
Wyoming	0

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

Figure 133 - Pharmacy Program Included in the Capitation Rate (Carved In)

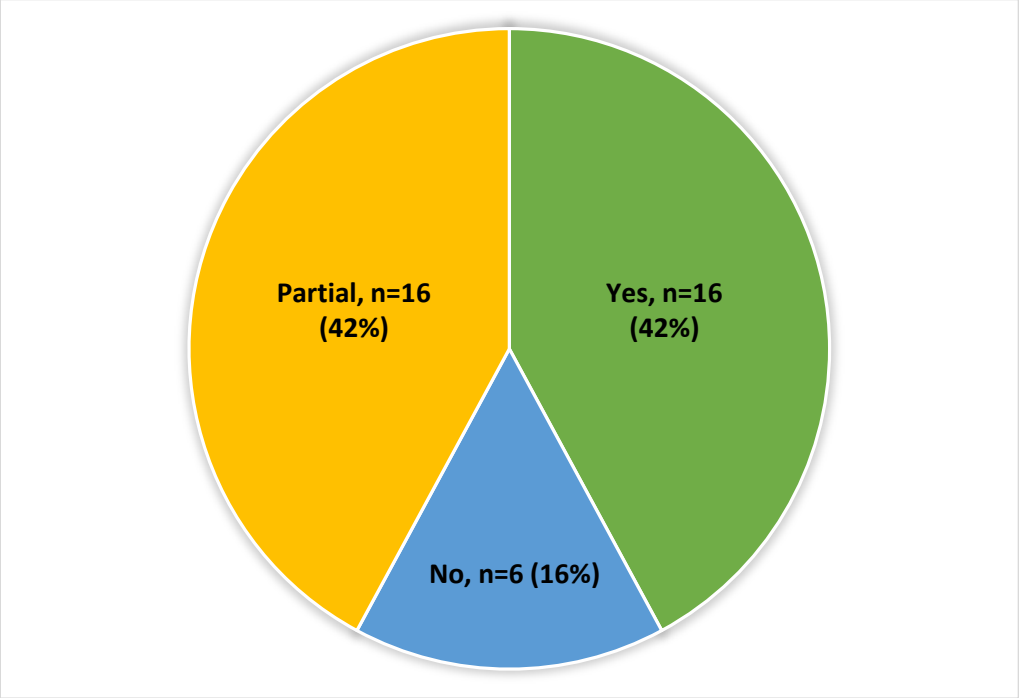

Table 186 - Pharmacy Program Included in the Capitation Rate (Carved In)

Response	States	Count	Percentage
Yes	Delaware, Georgia, Illinois, Kansas, Kentucky, Louisiana, Minnesota, Nebraska, New Jersey, New Mexico, New York, North Dakota, Ohio, Pennsylvania, South Carolina, Virginia	16	42.11%
No	Hawaii, Massachusetts, Missouri, Nevada, Tennessee, West Virginia	6	15.79%
Partial	California, Colorado, District of Columbia, Florida, Indiana, Iowa, Maryland, Michigan, Mississippi, New Hampshire, Oregon, Rhode Island, Texas, Utah, Washington, Wisconsin	16	42.11%

If “Partial”, please specify the drug categories that are carved out.

Table 187 - Drug Categories that are Carved Out

State	Drug Categories
California	Selected HIV/AIDS/Hepatitis B treatment drugs; Selected alcohol and heroin detoxification and dependency treatment drugs; Selected coagulation factors; and Selected drugs used to treat psychiatric conditions (including antipsychotics and MAO inhibitors)
Colorado	The hepatitis C category was carved out from 10/01/17 through 06/30/18. It was carved back in on 07/01/18.
District of Columbia	HIV antiretroviral medications
Florida	Hemophilia, Spinraza and Exondys
Indiana	Healthy Indiana Plan (HIP) 2.0, Hoosier Healthwise, and Hoosier Care Connect (HCC) are carved-in. Fee-for-service members, hepatitis C agents, cystic fibrosis agents, Spinraza, Exondys 51, and clotting factor agents are carved-out.
Iowa	Antihemophilia Factor Agents
Maryland	During FFY2018, antiretrovirals for the treatment of HIV/AIDS, select mental health medications and substance use disorder products were carved out of the MCO benefit and paid FFS.
Michigan	Mental health drugs/psychotropics, substance abuse treatment, hemophilia clotting factors, HIV antivirals, Hepatitis C treatments and drugs used to treat rare metabolic diseases.
Mississippi	Beneficiaries diagnosed with hemophilia are carved out and enrolled in FFS. A Member must be disenrolled from the Contractor (MCO) and enrolled in FFS if the Member is diagnosed with hemophilia. The category of hemophilia products are not included in the MCO capitation rate. Long-term Care beneficiaries are also carved out and enrolled in FFS.
New Hampshire	Medications used to treat Hepatitis C, Hemophilia and the drugs Carbaglu and Ravicti are carved out of managed care.
Oregon	mental health drugs
Rhode Island	Stop loss arrangement for Hepatitis C Drugs.
Texas	In FFY 2018, the following drugs were not included in the capitation rate: hepatitis C treatment drugs Orkambi Kalydeco
Utah	The following classes of medications and individual drugs are carved-out from ACO coverage and are part of the FFS Medicaid benefit: Transplant immunosuppressive drugs, Attention Deficit Hyperactivity Disorder (ADHD) Stimulant Drugs, Anti-psychotic Drugs, Anti-depressant Drugs, Anti-anxiety Drugs, Anticonvulsant Drugs, Hemophilia Drugs, and Opioid Use Disorder Treatments.
Washington	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
Wisconsin	Three MCOs have pharmacy included in the capitation rate for calendar years 2017 and 2018. Eighteen MCOs have the pharmacy benefit carved out and it is not included in their rate. Managed Care Organizations in Wisconsin carve-out by specific program rather than by drug categories.

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

Figure 134 - State Mandating Requirements for the MCO's Pharmacy Benefit

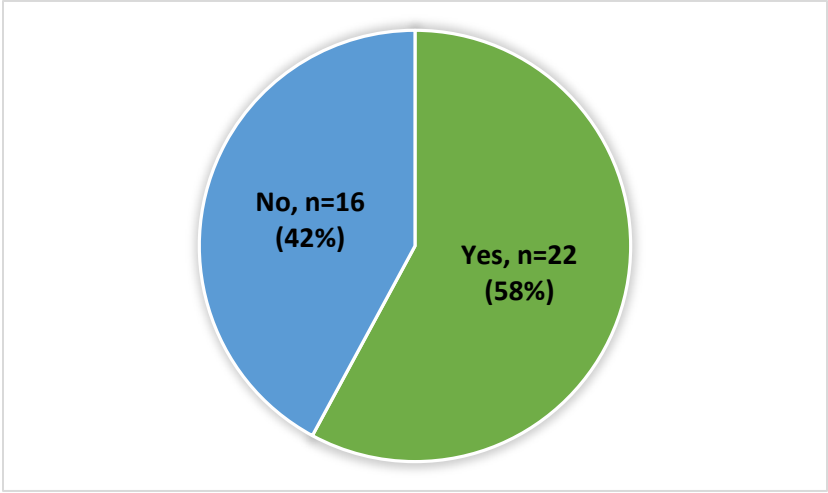

Table 188 - State Mandating Requirements for the MCO's Pharmacy Benefit

Response	States	Count	Percentage
Yes	California, Colorado, Delaware, District of Columbia, Florida, Illinois, Iowa, Kansas, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, New York, North Dakota, Ohio, Pennsylvania, Texas, Virginia, Washington, West Virginia	22	57.89%
No	Georgia, Hawaii, Indiana, Kentucky, Louisiana, Missouri, Nevada, New Hampshire, New Jersey, New Mexico, Oregon, Rhode Island, South Carolina, Tennessee, Utah, Wisconsin	16	42.11%

a. If "Yes", please check all requirements that apply below:

Figure 135 - State Requirements for the MCO's Pharmacy Benefit

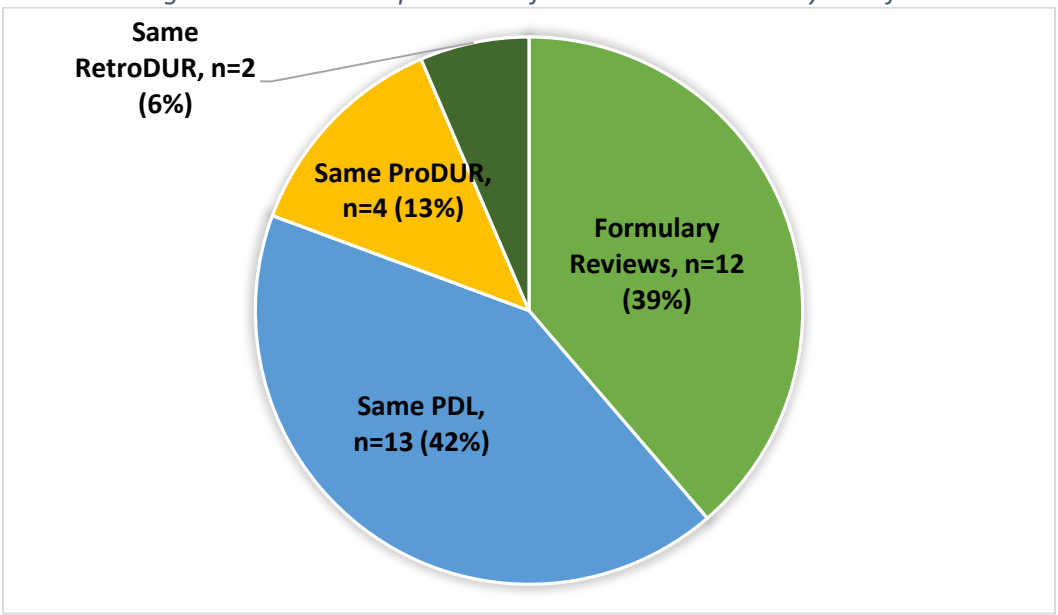

Table 189 - State Requirements for the MCO's Pharmacy Benefit

Response	States	Count	Percentage
Formulary Reviews	California, Colorado, District of Columbia, Florida, Illinois, Kansas, Maryland, Michigan, New York, Ohio, Pennsylvania, Washington	12	38.71%
Same PDL	Delaware, Florida, Iowa, Kansas, Massachusetts, Minnesota, Mississippi, Nebraska, North Dakota, Texas, Virginia, Washington, West Virginia	13	41.94%
Same ProDUR	Florida, Iowa, Kansas, Mississippi	4	12.90%
Same RetroDUR	Florida, Iowa	2	6.45%

b. If "Yes", please briefly explain your policy.

Table 190 - Policy Explanations

State	Explanations
California	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
Colorado	The State's policy is that MCO medication coverage and utilization limitations cannot be more stringent than current limitations in place for FFS. If a drug is carved out, then MCOs must follow the State's FFS PDL and associated prior authorization criteria.
Delaware	MCO and FFS follow a unified PDL.
District of Columbia	Each MCO submits proposed formulary and drug coverage changes to DHCF for review and approval on a quarterly basis.
Florida	MCO plans criteria, edits, etc. cannot be more restrictive than the Agency.
Illinois	MCO shall provide coverage of drugs in all classes of drugs for which the Departments FFS program provides coverage.
Iowa	MCO Pharmacy representatives are required to attend meetings of the DUR and P&T Committee. One MCO representative is a non-voting member of the DUR as well.
Kansas	The MCOs are to follow state drug coverage, but may set day supply or quantity limits.
Maryland	A comprehensive drug use management program has been in place for several years which evaluates each MCO drug benefits, including P&T Committee management and procedures, formulary content/management, prior authorization procedures and criteria, generic substitution, drug utilization review and disease management programs. A review and assessment of each MCO Drug Use Management Program is conducted annually.
Massachusetts	MassHealth ACPP/MCO Uniform Preferred Drug List In order to provide the most cost effective, sustainable pharmacy benefit, MassHealth has designated preferred drugs within certain therapeutic classes. Preferred drugs are either subject to supplemental rebate agreements between the manufacturer and the State or brand name drugs preferred over their generic equivalents based on net costs to the State. This Uniform Preferred Drug List identifies the therapeutic classes for which preferred drugs have been designated and the obligations of MassHealth Accountable Care Partnership Plans (ACPPs) and Managed Care Organizations (MCOs) with respect to those classes. This list is subject to change at any time, and may be updated frequently
Michigan	The MCO contract requires that the plan's formulary include coverage available for all outpatient covered drugs identified on the Fee-For-Service Michigan Pharmaceutical Product List (MPPL).

State	Explanations
	In addition, the MCOs can only be less restrictive than the MDHHS approved MCO Common Formulary.
Minnesota	In FFY 2018, work was done to move to a uniform PDL. This is in the MCO contract beginning January 1, 2019.
Mississippi	MCOs have been required to reimburse at same amount or higher than FFS. As of January 2015, MCOs were required to use Universal Preferred Drug List and same clinical criteria.
Nebraska	This information is located in individual state specific DUR FFS reports and can be found at Medicaid.gov
New York	Managed Care Plan formularies must include all categories of prescription drugs on the NYS Medicaid fee for service list of reimbursable drugs. The DUR Board evaluates Fee for Service and Managed Care claims data including pharmacy and medical history. The DUR Board makes recommendations that are communicated to the Managed Care Plans as considerations for ProDUR and/or RetroDUR interventions
North Dakota	We require the MCO to follow our PDL and follow our prior authorization criteria for a few other medications that are not currently on the PDL.
Ohio	70% agreement on PDL and they cannot be more restrictive than fee for service
Pennsylvania	The requirements for the outpatient drug services provided by the Medicaid MCOs are defined in Exhibit BBB of the HealthChoices Agreement and Exhibit D of the Community HealthChoices Agreement. The amount, duration, and scope of covered outpatient drugs must be consistent with coverage under the Fee-For-Service Program. The Department reviews and approves all MCO formularies, prior authorization policies, and drug utilization management programs prior to implementation. There are select classes of drugs (i.e. Hepatitis C and opioids) that the MCOs must use the FFS guidelines for prior authorization.
Texas	The MCOs follow the same formulary and PDL managed by Vendor Drug Program. The MCOs may implement the same or a less restrictive pro-DUR clinical prior authorization criteria. The MCOs may implement other utilization management tools and strategies that are above and beyond the Vendor Drug Program's criteria and policies. The MCOs, also, do not follow the state's retro-DUR intervention and strategies.
Virginia	All preferred drugs on the DMAS PDL will be included on the CCC Plus plans formularies. With the Common Core Formulary (CCF), health plans may add drugs to most drug classes but cannot remove drugs or place additional utilization management criteria on the CCF drugs. The Virginia Medicaid preferred drug list has 13 closed classes for which only the drugs listed within the classes are covered. For the closed classes, the plans will NOT be able to add or delete any drugs to these classes. DMAS will collect supplemental drug rebates for the drugs in these closed classes. The primary focus of this is for the ease of the providers and the members. It will decrease the administrative burden for prescribers while ensuring continuity of care for the members.
Washington	Washington Apple Health (Medicaid) began implementation of a Medicaid wide Preferred Drug List in January 2018. Managed Care Organizations are required to follow the Washington PDL for those drugs in classes which have been added to the PDL, which is being developed progressively over time. With the goal of eventually having a comprehensive formulary, new drug classes are added on a quarterly basis. By the third quarter of CY2018 (4qFFY2018), Washington Apple Health had implemented 92 drug classes. At the time of writing this report there are over 200 drug classes on the PDL. For drugs not included in the Apple Health PDL, formulary review is required to determine adequacy of coverage, applying the same standards as applied by CMS for Medicare Part D formulary review.
West Virginia	All pharmacy is carved out. Previously the MCOs were required to use the same PDL.

If “No”, do you plan to set standards in the future?

Figure 136 - State Plan to Set Standards in the Future

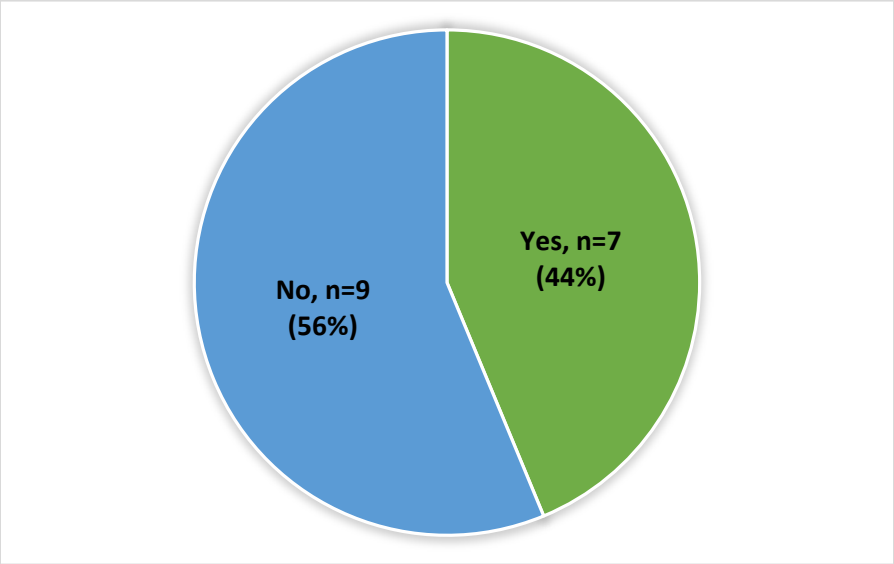

Table 191 - State Plan to Set Standards in the Future

Response	States	Count	Percentage
Yes	Georgia, Hawaii, Louisiana, Nevada, New Hampshire, Oregon, South Carolina	7	43.75%
No	Indiana, Kentucky, Missouri, New Jersey, New Mexico, Rhode Island, Tennessee, Utah, Wisconsin	9	56.25%

4. Did all of your managed care plans submit their DUR reports?

Figure 137 - Managed Care Plans Submission of DUR Reports

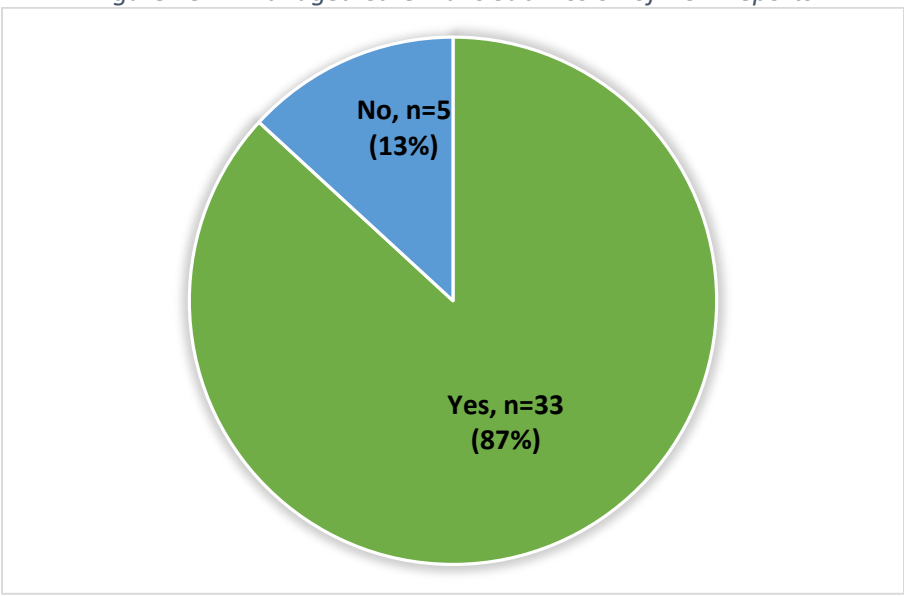

Table 192 - Managed Care Plans Submission of DUR Reports

Response	States	Count	Percentage
Yes	California, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Utah, Virginia, Washington	33	86.84%
No	Missouri, Tennessee, Texas, West Virginia, Wisconsin	5	13.16%

If "No", please explain why.

Table 193 - Explanations for Managed Care Plans Not Submitting DUR Reports

State	Explanations
Missouri	Missouri's MCOs do not provide pharmacy benefits
Tennessee	There is no pharmacy benefit through the MCO's. Pharmacy is 100% carved out.
Texas	Since FFY 2018, two of the managed care plans are no longer contracted with the Texas Medicaid for pharmacy benefit coverage.
West Virginia	Pharmacy is carved out, therefore the MCOs do not perform DUR
Wisconsin	There are only three MCOs that have included the pharmacy benefit in the managed care contract and completed the annual DUR report.

XII - Executive Summary

1. Executive Summary

Attachments for the DUR FFS Reports Executive Summary located in Attachment 8 can be requested by contacting CMSDUR@cms.hhs.gov